



NOTICE OF REGULAR BOARD MEETING OF THE
 UPPER SAN JUAN HEALTH SERVICE DISTRICT d/b/a PAGOSA SPRINGS MEDICAL CENTER
Tuesday, February 24, 2026, at 5:00 p.m. MDT
 The Board Room (direct access – northeast entrance)
 95 South Pagosa Blvd., Pagosa Springs, CO 81147

The public may attend in person or via Teams.

Join on the web: <https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting?rtc=1>

Meeting ID: 214 642 159 533 32

Passcode: M8yR6fg6

AGENDA

1) CALL TO ORDER; ADMINISTRATIVE MATTERS OF THE BOARD

- a) Confirmation of quorum
- b) Board Director self-disclosure of actual, potential, or perceived conflicts of interest
- c) Approval of the Agenda (and changes, if any)

2) **PUBLIC COMMENT** This is an opportunity for the public to make comments and/or address USJHSD Board. Persons wishing to address the Board need to notify the Clerk to the Board, Antionette Martinez, prior to the start of the meeting. All public comments shall be limited to matters under the jurisdiction of the Board and shall be expressly limited to three (3) minutes per person. The Board is not required to respond to or discuss public comments. No action will be taken at this meeting on public comments.

3) **PRESENTATIONS:** *Quality Assurance and Performance Improvement (QAPI) –by Manager of Quality, Rebecca Cranston and Director of Compliance, Privacy & Quality, Amber Manwaring. The Board will receive a presentation providing an overview of the QAPI Program requirements and an overview of the 2026 QAPI Plan priorities, measurable targets, and performance improvement initiatives.*

4) REPORTS

- a) **Oral Reports** (may be accompanied by a written report)
 - i) Chair Report Chair Kate Alfred
 - ii) CEO Report (*2025 Accomplishments*) Rhonda Webb, M.D.
 - iii) Executive Committee Chair Alfred, Vice Chair Mees
 - iv) Foundation Board Dir. Foss, Dir. Wilson, and CEO Webb
 - v) Facilities Committee Vice Chair Mees, Dir. Taylor, CAO Bruzzese
 - vi) Strategic Planning Committee Chair Alfred, Treas. Floyd, CEO Webb

PSMC's Mission: To provide quality, compassionate healthcare and wellness for each person we serve.

- vii) [Finance Committee Report](#)
 - (a) [January 2026 Financials](#)

Treas. Floyd, Dir. Hooper, CFO Keplinger

- b) **Written Reports** (*no oral report unless the Board has questions*)

- i) [Medical Staff Report](#)

Chief of Staff, Dr. Corinne Reed

5) EXECUTIVE SESSION

There will be an executive session pursuant to the following subparagraphs of C.R.S. Section 24-6-402(4)(c): matters to remain confidential pursuant to other federal or state statute – specifically confidential annual quality and peer review statistics that are confidential per state statutes the Quality Management Act, C.R.S. Section 25-3-109, et seq. and the Professional Review Act, C.R.S. Section 12-36.5-101 et seq.

Further, the Board reserves the right to meet in executive session for any other purpose allowed and topic announced at open session of the meeting, in accordance with C.R.S. Section 24-6-402(4).

6) DECISION AGENDA

- a) Consideration of [Resolution 2026-03](#) regarding approval of PSMC’s QAPI Program and 2026 QAPI Plan.
- b) Consideration of [Resolution 2026-04](#) regarding acceptance of PSMC’s annual report of 2025 peer review activities (the annual peer review report presented to the Board in Executive Session).

7) CONSENT AGENDA (The Consent Agenda is intended to allow Board approval, by a single motion, of matters that are considered routine. There will be no separate discussion of Consent Agenda matters unless requested.)

- a) Approval of Board Member absences:
 - i) Regular meeting of 02/24/2026
- b) Approval of Minutes for the following meeting(s):
 - i) [Regular meeting of 01/27/2026](#)
- c) Approval of [Medical Staff report](#) recommendations for new or renewal of provider privileges.

8) OTHER BUSINESS

9) ADJOURN

Next Meeting: Tuesday, March 24, 2026, at 5:00 p.m. MT

Pagosa Springs Medical Center - Quality Assurance and Performance Improvement (QAPI) Program



Quality Assurance and Performance Improvement (QAPI) Program

Pagosa Springs Medical Center - Quality Assurance and Performance Improvement (QAPI) Program

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Pagosa Springs Medical Center - Quality Assurance and Performance Improvement (QAPI) Program

INTRODUCTION:

The Quality Assurance and Performance Improvement (QAPI) Program provides the framework through which PSMC systematically monitors, evaluates, and improves the quality, safety, and effectiveness of patient care and operational processes. The QAPI Program applies to **all departments, services, and patient populations** and supports continuous improvement through data-driven decision making.

The Quality Assurance and Performance Improvement Program was developed by the Quality Committee members using guidelines recommended by multiple leaders in healthcare quality management.¹ The QAPI Program Mission, Vision, and Values are based on the Mission, Vision and Values of the organization.

The program integrates quality assurance activities with performance improvement initiatives and emphasizes proactive risk identification, measurable outcomes, and sustained improvement. The Annual QAPI Plan outlines the specific clinical and non-clinical focus areas for the coming calendar year. The Annual QAPI Plan is the product of the evaluation of the previous year's QAPI activities, organizational priorities and issues identified by data gathering tools such as the Patient Safety Survey, adverse event reporting, community input and regulatory requirements. The Annual QAPI Plan is approved by the Board of Directors. The Annual QAPI Plan serves as the road map for all quality and performance improvement activities, both operational and clinical for the year.

QAPI Mission

Our mission is to ensure that we continually provide quality, compassionate healthcare and that any opportunities to improve on our performance are recognized and acted upon.

QAPI Vision

Our vision is to build an organization that is committed to doing the right thing for patients while securing a financially viable organization. To that end PSMC has identified the following as the foundational components of our QAPI Program:

- Quality of Care/Patient Safety
- Patient Satisfaction
- Financial Stability
- Strategic Growth

QAPI Values

QAPI decisions and efforts will be guided by this set of core values:

- The dignity and rights of each patient deserve our constant protection.
- All people deserve quality healthcare regardless of their ability to pay for that care.
- Patient safety is PSMC's first and foremost priority when providing patient care and services.

¹ Agency for Healthcare Research, <https://www.ahrq.gov/>
Centers for Medicare and Medicaid Services, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Programs>
Institute for Healthcare Improvement, <http://www.ihl.org/>

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- The safest care possible will be provided by creating and fostering a culture of safety that allows every member of our healthcare team the freedom to voice their opinions and/or concerns regarding safety.
- Vision must be accompanied by action to produce achievement.
- Improving organizational performance is the responsibility of all employees and staff. Contributions to this effort should be encouraged and acknowledged.
- Opportunities for improvement always exist.
- Lowering the cost of healthcare benefits everyone. The most effective way to lower health care cost is to improve our performance.
- Our healthcare delivery team will consist of well-qualified professionals, support staff, and volunteers.
- We must remain economically strong to best serve our patients and our community.
- As the needs of our community grow and change, we must grow and change to meet those needs.
- The work environment should inspire and enable people to achieve excellence.
- Innovative thinking is essential to performance improvement.

THE PROGRAM:**Our Strategies**

To continuously assess and improve organizational quality PSMC will utilize these core strategies:

- Utilize the Plan Do Study Act (PDSA) model of improvement to evaluate processes and systems.
- Utilize a multidisciplinary team approach for PI projects.
- Utilize information management systems to support QAPI functions.
- Aggregate and analyze data collected over time to identify improvement opportunities.
- Benchmark PSMC performance with other hospitals of similar size and structure.
- Create an environment that encourages employees and medical staff to identify and present opportunities for improvement.
- Provide education and training to employees and medical staff to enhance QAPI skills necessary for effective participation in the program.
- Obtain and utilize feedback from patients, families, and the community to assist in the development of QAPI activities.
- Design the QAPI program to facilitate organization-wide, multidisciplinary participation in QAPI activities.
- Evaluate improvement opportunities based on the anticipated assessed value of each available opportunity.

Governance

To accomplish its objectives, PSMC has developed a formal QAPI reporting structure that includes key entities. Each entity has specific responsibilities in the governance of the QAPI Program.

- PSMC Board of Directors (BOD):
 - Approves the organization-wide QAPI Program and Plan.

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- Provides oversight to PSMC's quality assurance and performance improvement priorities.
 - Ensures adequate resources to support improvement activities

- Senior Leadership:
 - Ensures alignment between QAPI activities and strategic priorities
 - Ensures that PSMC has adequate resources to support the QAPI program.
 - Ensures that the QAPI program is sufficiently broad in scope and authority to properly identify and correct areas of needed improvement.
 - Supports a culture of safety and transparency

- Medical Executive Committee:
 - Reports non-provider specific quality issues identified and makes recommendations for improvements.
 - Provides clinical oversight and peer review.
 - Reviews provider-related quality trends.
 - Investigate the credentials of all applicants and re-applicants for membership on the medical staff, review their privileges and make recommendations for their approval.

- Quality Committee:
 - Adopts the QAPI Program and Plan before it is submitted to Senior Leadership.
 - Receives and analyzes periodic QAPI data/reports from the members of the Committee ensuring that QAPI process is ongoing and effective.
 - Provide an opportunity for other hospital committees and departments to share problems identified and seek guidance on possible corrective actions.
 - Serves as the clearinghouse for QAPI activities

- Performance Improvement Committee:
 - Evaluates performance improvement projects for implementation based on standards outlined in the committee's charter.
 - Monitors the implementation of approved projects to support completion.

- Quality Subcommittees:
 - Subcommittees roll up and report out to the Quality Committee, and include the following:
 - Health Equity Committee
 - Ensures that issues are addressed regarding equal access and treatment regardless of any demographic category or community a patient may be a member of.
 - Attestation of the work done in the Health Equity Committee is submitted annually to HQIP/HCPF administrators.
 - Patient Safety Committee
 - Performs ongoing reviews of trends and priorities regarding patient safety issues.

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- Makes recommendations and tracks corrective actions and initiatives pertaining to safety in the hospital, including workplace violence, emergency preparedness, facilities and systems issues.
- Infection Control Committee
 - Identify and reduce the risks of acquiring and transmitting infections among patients, employees, physicians, other licensed practitioners, contract service workers, volunteers, students, and visitors.
 - Provide a quarterly summary of infection control activities to the Quality Committee.
- Pharmacy and Therapeutics Committee
 - Maintain the formulary; review adverse drug reactions and medication errors; and develop order sets to promote appropriate use of medications.
 - Provide a quarterly summary of committee activities to the Quality Committee.

Assuring Quality Care – Our Responsibilities:

Senior Leadership:

- Support an effective framework for planning, directing, providing, and improving the quality of health care services.
- Provide the right number of competent staff to meet the needs of the organization.
- Participation in the Quality Committee and Performance Improvement Committee by giving leadership perspective and support to QAPI committee functions.

QAPI Staff:

- Develop and administer the QAPI Program to ensure the program is designed to fit the needs of the organization, meets all regulatory requirements and results in the implementation of evidenced based best practices.
- Collect, aggregate, analyze and share information to improve patient outcomes and organizational performance.
- Support the Quality Committee by scheduling meetings and planning sessions; provide education and training for members and maintain documentation of all Quality Committee activities.
- Support the Performance Improvement Committee by scheduling meetings: providing education and training for members and maintaining documentation of all committee activities.
- Provide assistance to project teams including data sourcing, data analysis and project management.
- Ensure that the QAPI educational needs of the organization are met.
- Establish processes to ensure patient and community input into the QAPI function.
- Develop, implement and present periodic summary reports to the BOD.
- Assist clinical areas in choosing performance indicators that promote ongoing measurement and assessment of quality and patient safety.
- Manage PSMC's participation in mandated quality programs.

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- Participate in root cause analysis, sentinel event review, and near miss analysis.
- Clinical Staff:
 - Understand and protect the rights of patients.
 - Provide safe, effective care that is responsive to individual patient needs.
 - Promote healthy behaviors by involving the patient in their own care and care decisions.
 - Maintain clinical skills sufficient to provide excellent care.
 - Participate in the QAPI Program by providing ideas and reporting problems and joining performance improvement teams.
- Medical Staff:
 - Participate in the Peer Review Process by providing meaningful evaluation of clinician performance to order to improve clinical practice,
 - Maintain clinical skills sufficient to provide excellent care,
 - Participate in the QAPI Program by providing ideas, reporting problems and participating in performance improvement projects that require provider input.
- PSMC Department Managers
 - Identify quality and performance problems.
 - Submit performance improvement projects to the Performance Improvement Committee for approval.
 - Oversee the implementation of improvement activities in their respective departments.
 - Participate on multidisciplinary project teams as needed.
 - Maintain a complete and current list of their key performance indicators (KPI) as well as the data collected for each KPI.
 - Provide summaries of department activities to directors.
- PSMC Directors:
 - Receive quarterly reports from departments describing how their departments are participating in the overall QAPI process.

QUALITY COMMITTEE CHARTER:

The Quality Committee oversees the development and ongoing performance of the QAPI program.

Specific responsibilities include:

- Hold meetings at least quarterly and more often if necessary.
- Review and approve the QAPI Program (which includes presenting the Program to leadership and the BOD for approval annually).
- Review and approve the organization's Annual QAPI Plan (which includes presenting the Annual QAPI Plan to leadership and the BOD for input, review, and approval).
- Establish goals to guide in the development and evaluation of the QAPI annual plan.
- Receive and review quality activity reports from directors and committees making recommendations if necessary.
- Review and approve QAPI and patient safety educational programs.
- Evaluate and recommend the participation of the organization in quality related databases.
- Serve as the clearinghouse for all ongoing QAPI activities.

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PERFORMANCE IMPROVEMENT COMMITTEE CHARTER:

The Performance Improvement Committee reviews and approves multidisciplinary improvement projects. The committee follows and supports projects to their completion. Specific responsibilities include:

- Hold meetings monthly unless no project submissions or updates are submitted.
- Receive and review all requests for multidisciplinary PI projects. Serve as a resource to project teams especially if they encounter difficulty.
- Evaluate and approve PI projects based upon the following criteria:
 - PSMC mission, vision, values, and strategic plan;
 - Data that demonstrates need for proposed change;
 - Expressed needs and expectations of patients, families, and community;
 - Processes that are high risk, high volume, and/or high cost;
 - Availability of resources (time and money) required to pursue the improvement;
 - Regulatory requirements;
 - Input from staff affected by the process;
 - Impact on customer satisfaction;
 - Impact on patient safety, care, and outcomes.

QAPI METHODOLOGY:**The Quality Diamond:**

The Quality diamond illustrates the four basic principles that are followed by PSMC for quality and performance improvement.

- Management commitment: The leaders of PSMC provide direction, support, and resources for quality assurance and performance improvement activities which are to include patient safety.
- Customer focus: Quality is defined and performance evaluated by our internal and external customer expectations.
- Employee participation: The improvement of processes and systems is best accomplished by the people who participate in those processes and systems. The expertise, experience, ideas, and skills of all employees are required to fuel the process of continuous improvement and patient safety.
- Data-based decision making: Data is used to analyze, and prioritize opportunities for improvement. By performing root cause analyses, measuring the results of process changes, benchmarking our results against other organizations we can monitor our performance over time.

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Identification of Areas for Improvement:

- **On-going Monitoring:**
Identification of areas for improvement may result from continuous monitoring of current practices. Departments establish key indicators of performance. Some examples of key performance indicators (KPI's) might be: errors in medication delivery, response time from receipt of an order, timeliness of reporting critical values or unexpected patient outcomes and adverse event reports. When a benchmark for performance is established for a KPI it becomes a "measure". Measures include safety measures, clinical measures, financial efficiency measures and cultural and talent measures. On-going monitoring and benchmarking our performance on measures against like facilities helps us to focus our improvement efforts.
- **Input from Staff:**
PI projects may also be suggested by employees or medical staff by using the "Idea Form" or the "Staff Suggestion Form" on Clarity. Ideas will be reviewed and approved by the PI Committee.
- **Input from Patients or Visitors:**
Improvement projects may be the direct result of feedback from patients or visitors. For example, improvements might be made to the phone system if patients complain that it is difficult to make appointments.
- **Leadership Priorities:**
Strategic operational decisions may result in performance improvement activities. Expansion or create of new service lines, community needs assessments or regulatory compliance can result in the need to improve processes.

Project Submission:

When an area for improvement is identified, the project must be approved for implementation. A project that involves only one department may be approved by the department manager and applicable director. A single department project does not need to come before the PI Committee. A project involving two departments that are in full agreement regarding the scope of the project can also be approved by the managers and applicable directors. A complex project, involving multiple departments or one that impacts multiple departments must be reviewed and approved by the PI Committee. Individuals submitting a project for the PI to review must complete the PI Project Submission Form and submit it to the Quality Manager for placement on the committee agenda. Large projects require an executive sponsor to approve the project prior to submission to the committee. Once a project is approved, a project improvement team will be created. A team may be as small as two individuals for a small, single department function or may include many members from multiple departments for a complex facility-wide project. Often the team for a large project is created by the PI Committee at the time a project is approved.

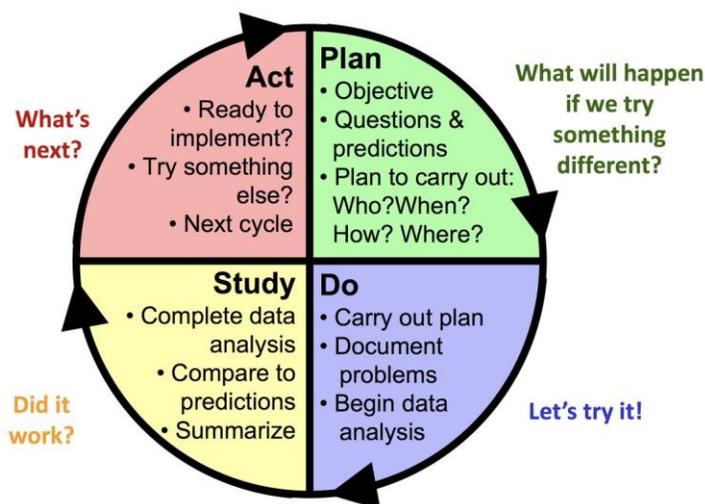
- **Departmental Teams:**
Report to: Department manager
Membership is defined by the project and is usually established by the department manager.
Responsibilities include the following:

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- Address department specific opportunities for performance improvement. Decisions and/or changes made by these teams should not significantly impact other departments
 - Report findings, recommendations and results to the department manager.
 - Department managers will provide a summary report of PI activities to the appropriate director for presentation at Quality Committee.
- Multidisciplinary Teams:
Reports to: PI Committee
Membership is defined by the project and is usually established by the PI Committee. Alternatively the project lead may be assigned by the PI Committee and membership established by the project leader.
Responsibilities include the following:
 - Address a specific opportunity for multidisciplinary performance improvement.
 - Report findings/recommendations/results to the PI Committee.

Project Management:

PSMC encourages the use of PLAN-DO-STUDY-ACT as the foundation for PI projects but many methodologies are effective and a team may choose the system that will work best for the project.

The PDSA Cycle for Learning and Improvement**Data Management:**

PSMC promotes the effective use of data to drive QAPI decision making. When the right data are collected and appropriate analytic techniques are applied, it enables the hospital to monitor the performance of a system, detect variation and identify opportunities to improve.

There are multiple data sources used in the assessment of organizational performance and the quality of care. They include internal occurrence reports, risk management information, patient/family concerns, employee input, medical staff input, medical records, financial data, and external data bases.

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PI Project Documentation:

A documentation file for each project will be maintained for reference. This should include but is not limited to:

- Description of the project
- Goals of the team
- Minutes of the meetings
- Data
- Results of the project.

A small project may only require the use of the PDSA Worksheet to provide sufficient documentation; while a large complex activity will require the use of project management software. PSMC subscribes to the AVAZA project management software and it is available to all staff members. The team leader is responsible for project documentation.

Communication of Results:

Results of process improvement initiatives will be communicated throughout the organization for the purpose of sharing ideas, understanding relevant processes, encouraging collaboration, instilling concepts of performance improvement into the organizational culture, and to stimulate creative and innovative improvement initiatives. The findings may be reviewed at other appropriate PSMC and departmental meetings.

THE ANNUAL QAPI PLAN:

The Annual QAPI Plan outlines the specific focus areas for the calendar year. The Annual QAPI Plan is established by the Quality Committee. The Annual QAPI Plan identifies the key performance indicators and measures that will be monitored in order to identify opportunities to improve services and resolve problems. The performance measures will be responsive to the identified health care needs of our community as well as PSMC's strategic plan and organizational goals. The Annual QAPI Plan may identify specific performance improvement projects already reviewed and approved by the PI Committee. The Plan will assure compliance with all mandatory regulatory oversight agencies as well as those agencies PSMC has selected for reporting. The plan may amended from time to time based on the priorities of the organization and availability of resources.

CONFIDENTIALITY:

Any and all documents and records that are part of the internal Quality Assurance and Performance Improvement Program as well as the proceedings, reports and records from any of the involved committees shall be considered and handled as confidential information in accordance with State of Colorado statutes.

The Colorado Revised Statutes that protect the confidentiality of quality management information include the following: CRS 25-3-109: Quality management functions-confidentiality and immunity, which addresses quality management information relating to the evaluation or improvement of the quality of health care services. CRS 12-36.5-104.4: Hospital professional review committees.

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APPENDIX I: QAPI Idea Form

Quality Assurance and Performance Improvement

IDEA FORM: For Improving Performance at PSMC

The Quality Team at PSMC wants and needs your ideas for improving the performance of our organization. Just complete this IDEA FORM and send it to the Quality Manager. Please include your name so we can come and talk to you about your idea. You can also submit it anonymously if you prefer.



My Idea is	Describe briefly a work process(es) that could be improved. Also, describe what the benefit to our patients and /or organization would be if we improved this process(es).

Print name _____

Department _____

Date _____



Reviewed/Revised 08/30/2016, 07/18/2018, 8/26/2020

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APPENDIX II: Project Request Submission Form

Project Request Submission Form

Project Name: _____

Date Submitted: _____

Project Owner: _____

Executive Sponsor: _____

Regulatory Requirement – Is this a compliance or regulatory requirement? If yes, please describe.

■

Project Description – Provide a summary of the project to include overall benefit to the organization as well as financial costs associated with it.

■

Project Stages/Milestones - Provide a timeline of the major project stages anticipated as well as a brief description for each.

■

Implementation & Sustainment Plan - Describe the anticipated implementation and sustainment plan to include necessary education and communication.

■

Stakeholders - Describe the stakeholders that will be either impacted or involved in the project and its implementation.

■

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Key Process Indicators (KPI's) – Identify the metrics that will be measured to track success of the project. What will be the frequency and method of measurement?

-

Selection Criteria - Provide how the project will impact (high, moderate or none) each of the following criteria:

- **Staff Efficiency**
 - High impact = Quantifiable reduction in process steps or individuals involved in process
 - Moderate impact = Potential improvement in efficiency, difficult to quantify
 - None = No improvement
- **Staff Satisfaction**
 - High impact = Improvements impact >50% of staff
 - Moderate impact = Improvements impact <50% of staff
 - None = No improvement
- **Patient Outcomes**
 - High impact = Direct improvement to individual patient or patient population
 - Moderate impact = Potential improvement to individual patient or patient population
 - None = No improvement
- **Patient Satisfaction**
 - High impact = Improvements impact >50% of patients
 - Moderate impact = Improvements impact <50% of patients
 - None = No improvement
- **Organizational Growth**
 - High impact = Direct increase to patient visits/volumes
 - Moderate impact = Potential increase to patient visits/volumes
 - None = No improvement
- **Financial Return**
 - High impact = Annualized improvement >\$10,000
 - Moderate impact = Annualized improvement < \$10,000
 - None = No improvement

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<u>Criteria</u>	<u>Impact</u> high/moderate/none	<u>Justification</u>
Staff Efficiency	high	
Staff Satisfaction	moderate	
Patient Outcomes	none	
Patient Satisfaction	high	
Organizational Growth	moderate	
Financial Return	none	
Total Value	20	



Quality Assurance and Performance Improvement Plan – 2026

Approved by PSMC Board of Directors February 24, 2026

Mandated Programs
(Regulatory)

The programs below are mandated by Medicare or Medicaid and consist of a variety of measures for which we submit data periodically and process improvement activities for which we must submit evidence of performance each year.

1. Hospital Quality Incentive Payment Program (HQIP)

- Administrator: HCPF
- Measures:
 - Health Equity and Patient Safety Measures
 - Management of Sepsis
 - Zero Suicide Program
 - Antibiotic Stewardship Program
 - Culture of Safety Survey
 - Hospital Acquired Infections
 - Workplace Violence metric (upcoming)
 - Adverse event reporting
 - Handoffs and Signouts
 - HCAHPS

2. Medicare Beneficiary Quality Improvement Program (MBQIP)

- Administrator: HRSA's Federal Office of Rural Health Policy
- Measures:
 - CAH Quality Infrastructure
 - Based on eight core elements, this measure is coming soon.
 - Patient Safety
 - HCP/IMM-3: Healthcare Workers vaccinated for influenza
 - Antibiotic Stewardship (measured via CDC)
 - National Healthcare Safety Network Annual Facility Survey
 - Safe use of Opioids (eCQM)
 - Patient Experience
 - HCAHPS survey
 - Care Coordination
 - Hybrid Hospital-wide readmission
 - SDOH Screening
 - Emergency Department
 - Emergency Department Transfer Communication
 - OP-18 Median time from ED Arrival to ED Departure for discharged ED Patients
 - OP-22 Patient left without being seen

3. Electronic Clinical Quality Measure

- CMS 122 Diabetes: Hemoglobin A1c Poor Control
 - ❖ CMS 146 Appropriate Testing for Pharyngitis
 - ❖ CMS 2 Screening for Depression and Follow Up Plan
- Promoting Interoperability Measures
 - Security Risk Assessment

- e-Prescribing
 - ❖ Query Prescription Drug Monitoring Program (**PDMP**)
 - ❖ Health Information Exchange Bi-directional Exchange
 - ❖ Provide Patients Electronic Access to their Health Information
 - ❖ Immunizations Registry (bi-directional)
 - ❖ Electronic Case Reporting
 - ❖ Improvement Activity - Implementation of Co-location PCP and Mental Health Services

4. Hospital Transformation Program (HTP)

- Administrator: HCPF
- Measures:
 - Reducing avoidable hospital utilization
 - SW-RAH1: 30 day All Cause Risk Adjusted Hospital Readmission
 - SW-RAH2: Pediatric All Condition Measure
 - RAH 1: Follow up appointment with a clinician and notification to RAE
 - RAH 2: ED Visits for which the member received follow up within 30 days of ED visit
 - RAH 3: Home Management plan of care document given to pediatric Asthma patient/caregiver
 - RAH4: Percentage of Patients with Ischemic Stroke who are discharged on statin medication (JC STK-06)
 - Core Populations
 - Social needs Screening Notification
 - Readmission rate for a high frequency chronic condition 30 day (Adult)
 - Pediatric Readmissions rate chronic condition 30 day
 - Pediatric Bronchiolitis Appropriate use of Bronchodilators
 - Pediatric Sepsis timely antibiotics
 - Screening for transitions of care supports in adults with disabilities
 - Reducing neonatal complications
 - Screening and referral for perinatal and postpartum depression and anxiety notification of positive screens to the RAE
 - Increase access to specialty care
 - Behavioral Health/Substance Use Disorder
 - Collaboratively develop and implement a mutually agreed upon discharge planning and notification process within the appropriate RAEs for eligible patients with MH diagnosis or SUD discharged from hospital or ED
 - Pediatric screening for depression in inpatient and ED including suicide risk
 - Using alternatives to opioids in ED setting (use and increased use)
 - Screening, Brief intervention, and referral to treatment
 - Initiation of MAT in ED or Hospital Owned RHC
 - Clinical and Operational Efficiencies
 - Hospital Index
 - Increase the successful transmission of Summary of Care record to patients PCP
 - Implementation/expansion of telemedicine visits
 - Implementation/expansion of e-consults
 - Energy star certification and score improvement
 - Population Health/Total Cost of Care

- Inpatient Hospital Transitions
- Increase percentage of patients who had a well visit with rolling 12-month period
- Increase number of patients seen by co-responder hospital staff
- Improve leadership diversity

5. Eligible Hospital Medicare Promoting Interoperability

- Electronic Clinical Quality Measures
 - Median Admit Decision Time to ED Departure Time for Admitted Patients
 - Venous Thromboembolism Prophylaxis
 - Severe Hyperglycemia
 - Safe Use of Opioids
- Promoting Interoperability Measures
 - Security Risk Assessment
 - e-Prescribing
 - Query Prescription Drug Monitoring Program
 - Health Information Exchange Bidirectional Exchange
 - Provide Patients with Electronic Access to their Health Information
 - Immunizations Registry (bi-directional)
 - Electronic Laboratory Reporting
 - Electronic Case Reporting

6. Key Performance Indicators (KPIs)

Each year, PSMC establishes department-level KPIs in SMART goal format that translate organizational strategy, regulatory requirements, and operational priorities into measurable outcomes across clinical and non-clinical departments. As demonstrated in 2025, these indicators span PSMC-wide, including but not limited to community engagement, patient safety, regulatory compliance, revenue cycle performance, infection prevention, clinical documentation integrity, service quality, laboratory accuracy, medication safety, behavioral health screening, operational efficiency, and staff development. KPIs are designed to be practical, time-bound, and outcome-focused—addressing both regulatory obligations (e.g., mock audits, quality program submissions, documentation compliance) and operational excellence (e.g., AR days, denial reduction, repeat/reject rates, hand hygiene compliance, chart completion timeliness). This structured approach ensures that every department contributes measurably to patient outcomes, financial sustainability, service viability, safety culture, and community value within PSMC’s integrated services framework.

PSMC Selected Quality/Performance Improvement Projects

These are projects that have been selected based on issues identified through our on-going monitoring programs, occurrence reporting, staff suggestions, patient suggestions, state initiatives and strategic planning.

Single vs. Double Encounter for Obs-->Inpatient
 Phase 2: PA/UM for after hours
 Patient Satisfaction Survey pilot in clinic with QR Code
 Alaris IV Pump change out and upgrade of all associated software*

ED Remodel

Infusion project, starting with heparin

Oracle Health Patient Accounting

Scheduling, Registration, Volume Surges

Pulmonary Rehab

Cardiac Rehab

Nursing Peer Review

Clinical Ladder program

TO: PSMC BOARD
FROM: RHONDA P. WEBB, M.D., CEO/CMO
RE: SUMMARY OF KEY 2025 ACCOMPLISHMENTS

In 2025, PSMC staff was incredibly busy accomplishing key objectives and improvements to our services and facility. Every project at PSMC that alters a service, a workflow or the facility is very time-intensive to ensure patient safety and appropriate practices. I recognize all the PSMC staff for their contributions to 2025 services and accomplishments. The accomplishments noted in this report are in addition to our main focus of caring for patients and we treated many as follows:

In-patient admissions	366
Observation hours	14,608
Emergency Department visits	7,802
Lab tests	79,242
Radiology/CT/MRI exams	20,601
Operating Room cases	1,106
Clinic visits	22,788
Specialty clinic visits	845
Oncology clinic visits	1,388
Infusion visits	3,986
EMS transports	1,276

1. **QUALITY OF CARE AND SERVICES.** PSMC’s staff continually prioritizes the delivery of safe quality care and made the following accomplishments in 2025 to further this goal:
 - a. Trauma Program Recertification. Successful recertification of Trauma level IV status and program with no recommendations from the State surveyor.
 - b. Medicare Beneficiary Quality Improvement Project (MBQIP). Required data reporting of antibiotic stewardship, safe use of opioids, employee vaccine coverage, consumer assessment, care coordination and hospital readmission, ED transfer communication. ED transfer communication submission started in 2024 and 2025 goals was 80% and PSMC actual score was 93.33%.
 - c. Promoting Interoperability: Required data reporting of IT Security Risk Assessment, Safety assurance factors for EHR Resilience, electronic prescribing, bi-directional health information exchange, patients have timely electronic access to their health information, public health clinical data exchange, antimicrobial use. Minimum required score is 79 and PSMC earned an overall score of 98 of 100.
 - d. Ambulatory Electronic Clinical Quality Measures (eCQMs): Part of the Medicare Merit-based Incentive Payment System (MIPS) and the Colorado Medicaid Accountable Care Collaborative. Data collection is largely from primary care and ancillary services (PSMC exceeded benchmarks on all 6 metrics).
 - e. Colorado Outpatient Clinic Transformation project: Continued to meet deliverables for this multi-year project for depression/suicide screening, A1c, pneumococcal vaccine, colorectal cancer screening, influenza vaccination, and hypertension.

- f. Colorado Hospital Transformation Project: Continued to meet deliverables for this multi-year project aimed at reducing use of the ED when outpatient clinic is a more efficient resource.
- g. Ongoing internal audits and a mock survey to refine PSMC compliant practices and improve survey readiness.

2. FINANCIAL MANAGEMENT

- a. Like prior years, PSMC received a clean audit.
- b. To improve quality of care and to maximize reimbursement for care (and avoid penalty reductions in reimbursement), PSMC continued to successfully participate and make required reporting of data to State of Colorado programs (see Section 1 above). PSMC received a Hospital Quality Incentive Supplemental Payment Program of \$190,352.58 (based upon a score of 90 of 100 across multiple quality and patient safety domains).
- c. PSMC had a positive financial year (based upon year-end, unaudited financials):
 - i. PSMC had a positive bottom line of \$1,964,016 (exceeding budget).
 - ii. Operationally, we met budgeted expenses within less than one-half percent.
 - iii. We had cash collections of 99.74% of our annual goal – which was a hefty goal.
 - iv. During 2025, days of cash on hand increased from 115.98 (year-end 2024) to 131.7 (year-end 2025) despite a significant investment in capital expenses during 2025.
 - v. Days of Accounts Receivable held steady and in excellent shape (year-end 2025 was 51 days, year-end 2024 was 52.8 days, and year-end 2023 was 52 days).
- d. Ongoing improvement activities included outsourcing more prior authorization in an effort to reduce denials for surgery and radiology; increased communication to department managers regarding denials in order to get to the root cause and correct.

3. OPERATIONAL LEADERSHIP AND STRATEGIC GROWTH

- a. Late in 2025, PSMC took ownership of a building for an EMS station on the east side of Pagosa Springs (as affirmed in January of 2026, the building is subject to rights of the Town of Pagosa Springs if PSMC ever ceases to use it for EMS services).
- b. Gallagher Benefit Services honored PSMC as a “U.S. Best In Class Employer.” Gallagher gathered survey information regarding compensation and benefit information across the U.S. as well as hospital in Colorado who are members of the Colorado Hospital Association (which is most). PSMC is one of only 3 mid-size Colorado hospitals (100-999 employees) who was honored with this designation. Key considerations were healthcare for employees (including a lower cost option), wellness incentives, paid time off (sick, holiday and vacation), retirement benefits, workforce engagement surveys.
- c. Continued to expand the scope of pulmonary services available in the community including: (i) operationalized PFT testing; (ii) bronchoscopy (diagnose and treat lung conditions including infections, tumors and airway blockages); and (iii) endobronchial ultrasound (diagnose lung cancer and inflammatory disease and to perform nonsurgical transbronchial needle aspiration to obtain tissue samples for cancer detection and staging).
- d. Provider recruiting was significant resulting in 11 new hires to provider staff during 2025.
- e. Significant facility improvements and operationalized facility improvements:
 - i. Sterile Processing: Completed substantial project to improve compliance and efficiency of space as well as replace very old equipment. Installed reverse osmosis system to sterile processing to meet compliance and improve longevity of equipment.

- ii. Surgery: Replaced humidifier set-up in OR1.
 - iii. Radiology: Project to de-install old X-ray machine and install and go live with new X-ray machine.
 - iv. Parking: Sealed parking lot asphalt.
 - v. Roof replacement: – Completed phase 1.
 - vi. MWB: Received approval from Medicare to offer services in the MWB. Operationalized and offer outpatient physical therapy services and occupational therapy services.
 - vii. Oxygen Generation Systems. Completed building work including installed the generator, complete work to medical gas codes (gas piping, alarming, monitors, fan control, control valves). Installed the equipment associated with the generation equipment, to bring it up to current (and anticipated future adoption) of applicable codes for medical gas systems (NFPA 99 and 8 CCR 1507). Trained staff on safe practices and operation.
- f. Implemented a quarterly internal newsletter to support internal strategic internal communication and reinforce quality, compliance, safety and a positive, supportive culture.

4. COMMUNITY RELATIONSHIPS

- a. Served on the 911 Dispatch Board under the 2025 MOU for shared responsibility. Extensive work with the other community partners (County Sheriff Office, County, Fire, Town and Police) to develop a different path forward in which the Sheriff Office assumed, on January 1, 2026, responsibility for 911 dispatch subject to contractual terms with each community partner.
- b. *Becker's Hospital Review*, again recognized CEO Dr. Rhonda Webb as one of 90 Critical Access Hospital CEOs across the U.S. for her focus on safe delivery of quality medical services and efforts on a statewide-basis to address roadblocks faced by rural healthcare.
- c. EMS/ambulance supported multiple area wildland fire incidents. In addition, EMS provided standby for certain high school sporting events and community events.

5. FUNDRAISING AND GRANTS

- a. 2025 was a very successful year. PSMC was budgeted to transfer \$450,000 of donated funds from the Foundation to PSMC, but as a result of our generous donors, the Foundation was able to transfer \$750,559 in donations to PSMC. The donations to the PSMC Foundation are used to address the needs of the medical.
- b. In 2025, PSMC submitted applications for, and was awarded, the following grants:
 - i. \$150,000 DOLA grant to be used toward safety improvements in the Emergency Department;
 - ii. USAC grant for expenses related to 3rd party internet technology services.
 - iii. CSD Safety pool.



PSMC BOARD FACILITIES COMMITTEE

Report for the PSMC Board Meeting on February 24, 2026

The Board's Facilities Committee met on February 17, 2026 with the following committee members present: Vice Chair Matt Mees (via Teams), Dir. Gwen Taylor (via Teams), at large member Kathee Douglas and the CEO, CAO, CNO, Director of IT/Facilities/Security and the Director of EMS. The report below summarizes discussions of the Committee. *New updates are in blue.*

1. The Facilities Committee talked about timing for 2026 projects and estimated budgets.
2. **302 San Juan St. – East Side EMS**
 - a) *Waiting for conceptual design plans.*
 - b) *In February, PSMC applied for a grant from DOLA (awards made in June)*
 - c) Use by EMS approved by the Town.
 - d) Retained Brad Ash for design work - as-built plans complete.
 - e) Code evaluation memo received from Brad Ash.
 - f) Flood evaluation/certificate received from Davis Engineering.
 - g) Basic actions for limited (daytime) use includes insurance, utilities, internet, new lock, clean up.
3. **Dodie Cassidy Remodel:**
 - a) *Waiting for conceptual design plans.*
 - b) This project is included in the Board-approved budget for 2026.
 - c) Overall goals:
 - (1) renovate the building to bring maintenance/repairs current;
 - (2) renovate the interior for safe, professional nonclinical staff offices and work stations;
 - (3) spaces vacated in the main hospital building will be renovated to better meet patient needs.
 - d) Scope of work:
 - (1) Fix water damage
 - (2) Paint the exterior
 - (3) Renovate to meet needs and efficient use of spaces:
 - (a) Uses
 - (i) Accounting staff – sensitive info. 3 staff and locking door (separate or one office)
 - (ii) Billing staff – separate office for director and billing staff in cubicles
 - (iii) IT staff – 2 persons – one room or 2 rooms. Need locking doors
 - (iv) Facilities staff – need one or 2 rooms for several staff; prefer no carpet for them, some storage.
 - (v) Education room – conference room for education.
 - (vi) What we don't need: big reception area.
 - (b) Needs



- (i) Interior face lift so it is nicer/cleaner for all in the building – update restrooms, paint, flooring, window coverings?
 - (ii) Sufficient restrooms
 - (iii) Small kitchen (microwave, refrigerator, sink, coffee maker) do not need table
 - e) Design work – alternatives:
 - (1) For financial savings, David Ball has a simple proposal to accommodate the uses with very few changes to walls and utilities.
 - (2) For best efficient use of space, PSMC has requested architect Brad Ash to evaluate the space and work that could be done to make more work space.
4. **ED Safety and Efficiency Remodel**
- a) [Onsite visit on 2/10/2026 from architect and contractor](#)
 - b) Remodel Emergency Department in later 2026:
 - (1) Included in the Board-approved 2026 capital budget. We were also awarded a DOLA matching grant of \$150,000 for this project.
 - (2) Scope of project includes renovations to improve safety, infection prevention and efficiency (reorganize the nurse’s station for a more efficient registration area and to accommodate more nurses; new flooring; new patient call system; deleting from scope bullet resistant glass/walls).
 - (3) ED trauma rooms – FGI and ASHRAE standards require positive air pressure.
5. **Other Facilities Work Planned for 2026** (this list omits construction projects estimated to cost less than \$50,000 and omits all capital projects that are equipment only)
- a) The Board-approved budget for 2026 includes funds to construct campus monument sign on the corner of 160 and Pagosa Blvd.



PSMC STRATEGIC PLANNING COMMITTEE
Report for the PSMC Board Meeting on February 24, 2026

The Board's Strategic Planning Committee met on February 17, 2026 (present: Chair/Dir. Kate Alfred, Treasurer/Dir. Mark Floyd (via Teams), at-large member Kathy Campbell (via Teams) as well as the CEO, CAO, CNO, EMS Chief/Director, Director of IT/Facilities/Security and Executive Assistant to the CEO). The report below summarizes discussions and comments or questions of the Committee.

- 1) The Board Strategic Planning Committee received a presentation and held discussions on the following:
 - a) Medicaid Changes as a result of the federal One Big Beautiful Bill (aka HR-1):
 - There will be fewer eligible participants in Medicaid. The expected impacts to hospitals are: substantial increases in ER visits, charity care and uncompensated care.
 - The CHASE Provider fee will be reduced: Starting Oct. 2027, it will reduce over a number of years from 6% to 3.5%.
 - The ongoing Medicaid program obligations remain challenging for small and rural hospitals. Small and/or rural hospitals have to hire the same number of staff as a system hospital to collect and report measures. This results in small hospital costs for administrative staff to be a higher percentage of total staff.
 - b) Upcoming Capital Budget Changes: In March, staff will need to present some changes to the 2026 Capital Budget as there are some additions (e.g., the EMS East remodel is not in the budget because PSMC did not have approval from the Town until January of 2026).
 - c) Brief Discussion about Possible Future Service Lines. There was a brief discussion about the sorts of services that PSMC may ultimately add in the future so these possible services can be considered in relation to facility needs.
 - d) Gallagher named PSMC a 2025 Midsize Best-in-Class-Employer (employers of 100-999 full-time employees). The Colorado Hospital Association reported that only three midsize CHA hospitals received this distinction with a focus on the trends summarized on the attached page.
- 2) Other topics
 - a) N/A
- 3) Adjourn

DATA DRIVES DECISIONS™

5 Trends to Watch

From 2025 Midsize Best-in-Class Employers (100-999 full-time employees)

More than 4,000 organizations responded to our 2025 US Benefits Strategy & Benchmarking Survey, providing insight from top-tier employers on how they're supporting benefits, financial and talent solutions for their employees. Their responses highlighted several noteworthy trends.

1 Investing more in employer-paid benefits.

Allocate 30% or more of total compensation to benefits

Best-in-class	33%
Other midsize employers	28%

The best-in-class allocate a larger share of total compensation to employer-paid benefits than their peers, emphasizing their commitment to employee wellbeing and overall value proposition.

2 Maximizing flexibility by self-insuring.

More than 1 in 2	38%
Have a self-insured medical plan	Other midsize employers

Best-in-class employers self-insure their medical plans for greater flexibility and cost control, allowing them to tailor benefits and invest in programs that improve employee health.

3 Embedding I&D.

Areas with integrated I&D standards

TALENT ANALYTICS AND ENGAGEMENT	LEADERSHIP ACCOUNTABILITY
54%	48%
Best-in-class	
38%	36%
Other midsize employers	

By aligning I&D strategies with core values, top performers embed inclusion standards throughout the organization. They demonstrate their commitment by integrating I&D into talent analytics, engagement and leadership accountability.

4 Fostering engagement with career development.

3 in 4	56%
Have a strategy for improving employee engagement	Other midsize employers

To foster engagement, the best-in-class employ formal strategies promoting career mobility and development. Their focus on leadership training, performance feedback and peer recognition advances employee growth and strengthens organizational attachment.

5 Providing robust retirement benefits.

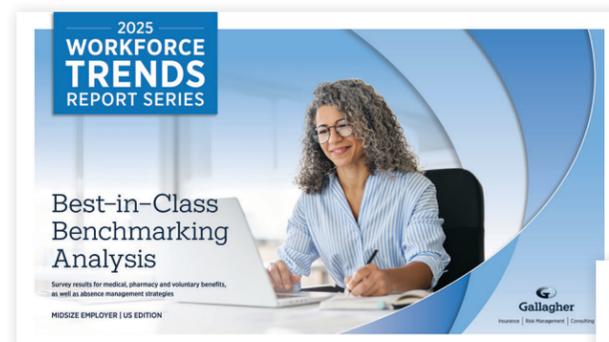
Methods used to enhance retirement plan participation

AUTO-ENROLLMENT	AUTO-ESCALATION
68%	39%
Best-in-class	
55%	29%
Other midsize employers:	

Leading employers support financial wellbeing by offering retirement benefits with flexible plan options and eligibility. They boost participation through auto-enrollment and auto-escalation, making it easy for employees to start and grow savings.

Making tough benefits and HR decisions? Our workforce trends data can help.

Download your complimentary copy of our 2025 Best-in-Class Benchmarking Analysis today.



Scan the QR code to download the report.

BOARD FINANCE COMMITTEE

Report for the PSMC Board Meeting on February 24, 2026

The PSMC Board's Finance Committee met on February 17, 2026 (present: Treasurer/Dir. Mark Floyd, at-large member Dwight Peters, at-large member David Cepoi as well as the CEO, CFO, CAO, CNO, and the Controller). The report below summarizes the January financials and any comments of the Committee.

1) **January Financial Reports:**

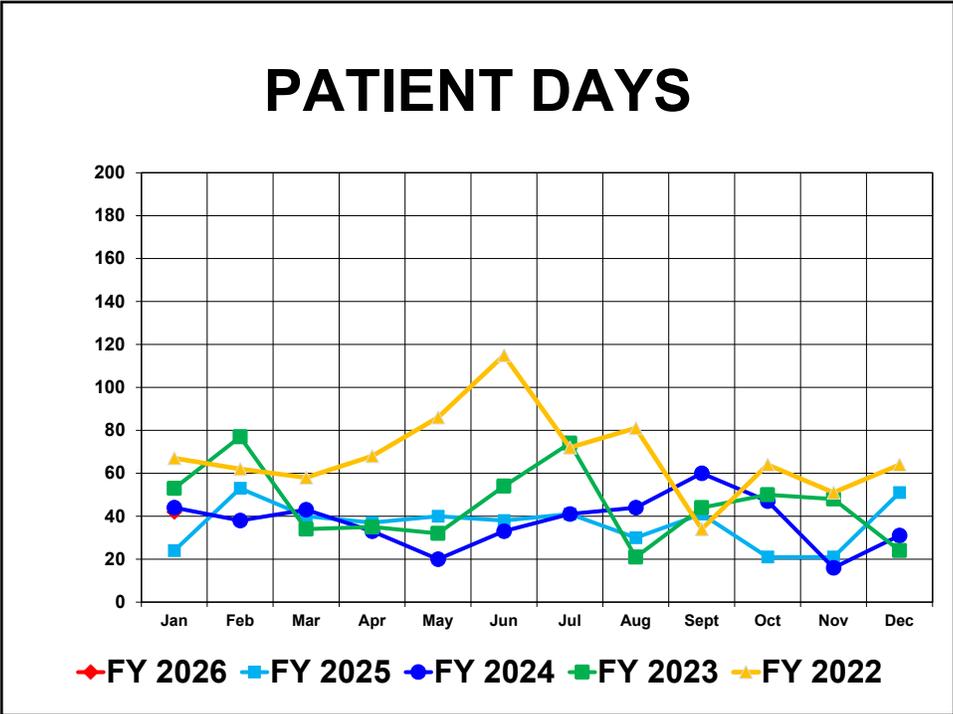
- a) **Bottom line for the Month of January:** PSMC had a loss for the month of January – a negative bottom line of <-\$428,372> (PSMC's actual loss for the month is less than the January budgeted loss of <-\$651,660>). The Finance Committee remarked that PSMC has a seasonal business and a loss at the beginning of the year is typical for PSMC. Despite a loss for the month, gross charges for January of 2026 were higher than any month of January in prior years.
- b) **Income statement for January:**
 - i) PSMC had gross charges of \$7,295,377; gross charges were reduced by payers (Medicare, Medicaid and commercial insurers) as well as reductions for charity care and bad debt together with a modest addition of provider fee dollars resulting in net patient revenue of \$3,639,788.
- c) **Accounts Receivable:** Accounts Receivable had a little increase to 52.1 days (some increase in A/R is expected at this time of the year as it is typically harder to collect around/after the holidays).
- d) **Cash on Hand and Statement of Cash Flows:** Cash decreased to 119.9 days of cash on hand. There were a few significant expenses in January that reduced cash. For example, PSMC pays all annual insurance premiums in January (approximately \$351,000) so this reduces cash all at once even though the expense is booked monthly.
- e) **Balance Sheet:** As a reminder, the auditor requires PSMC to add the 2026 anticipated tax revenue as a liability (deferred revenue) which liability is decreased during 2026 as tax revenue is received.

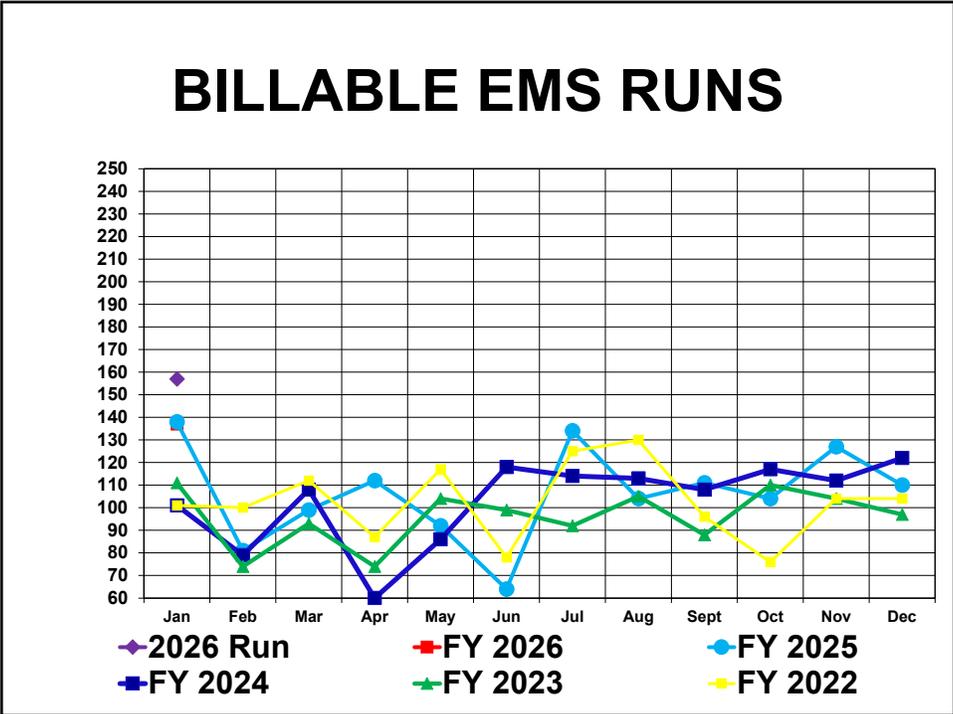
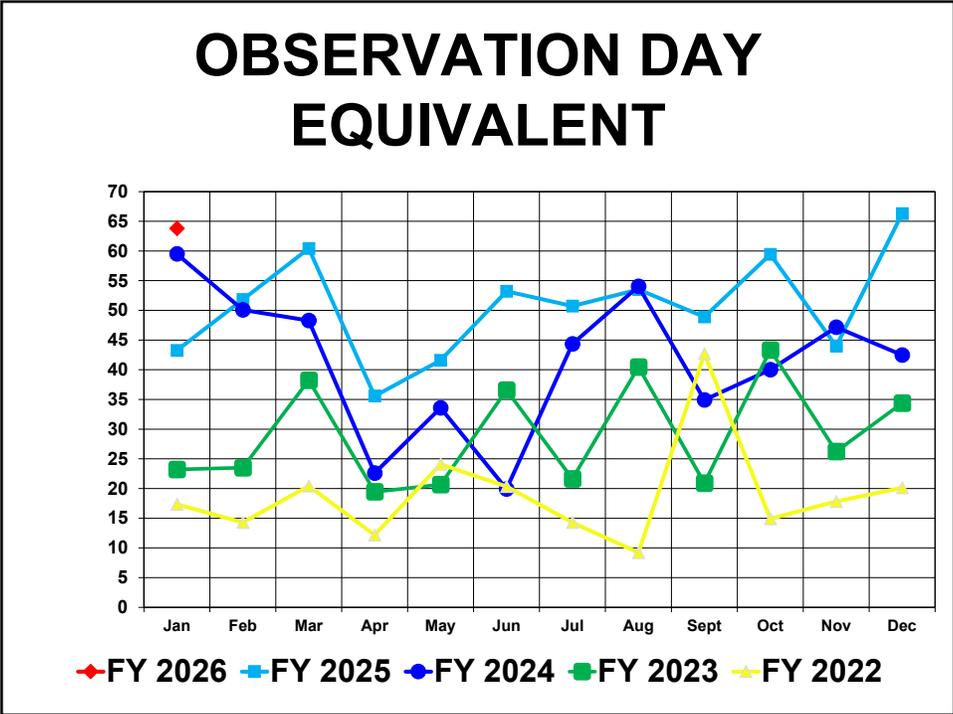
2) **Other**

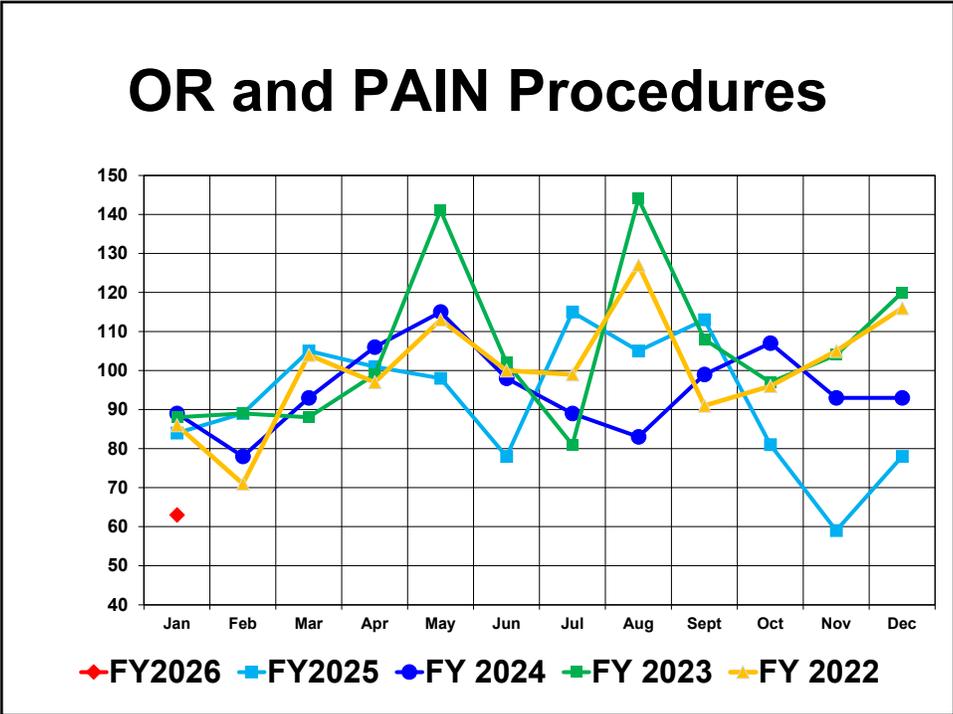
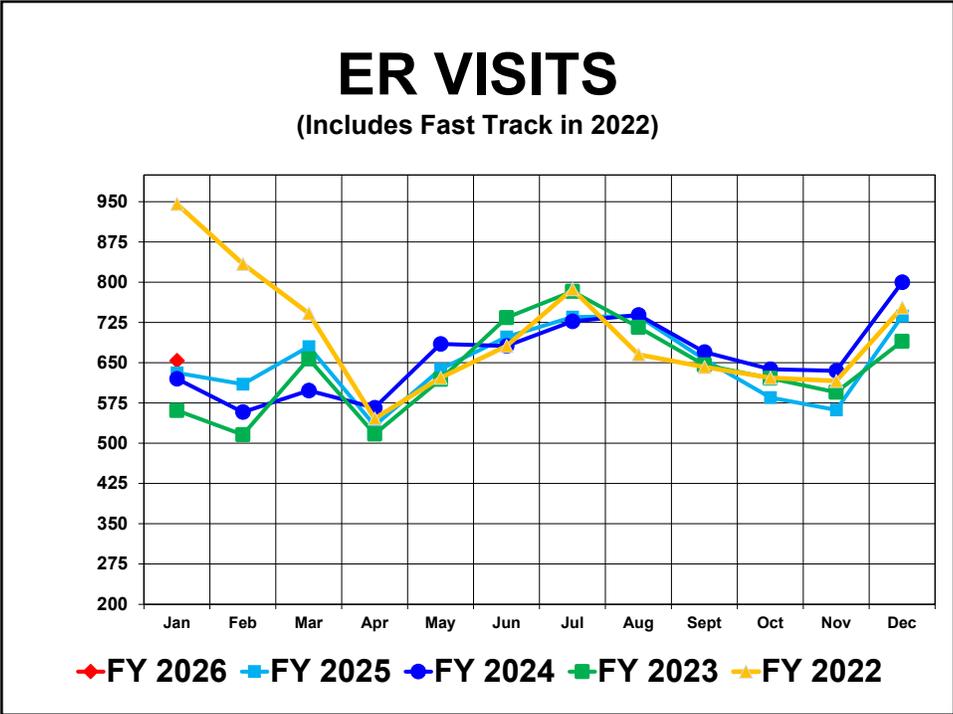
- 3)
- Comments of Finance Committee**
- No objections to the January financials.


PAGOSA SPRINGS
Medical Center
First-Class Care *Close to Home*

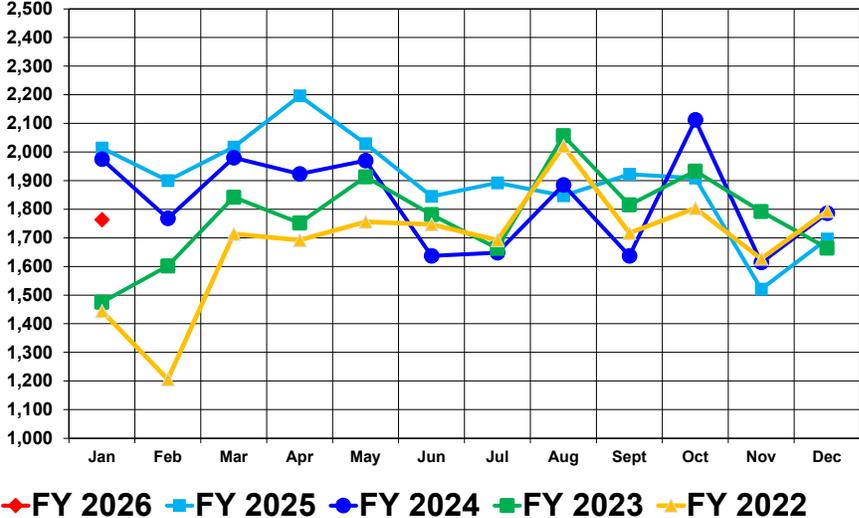
FINANCIAL PRESENTATION
YTD JANUARY 2026



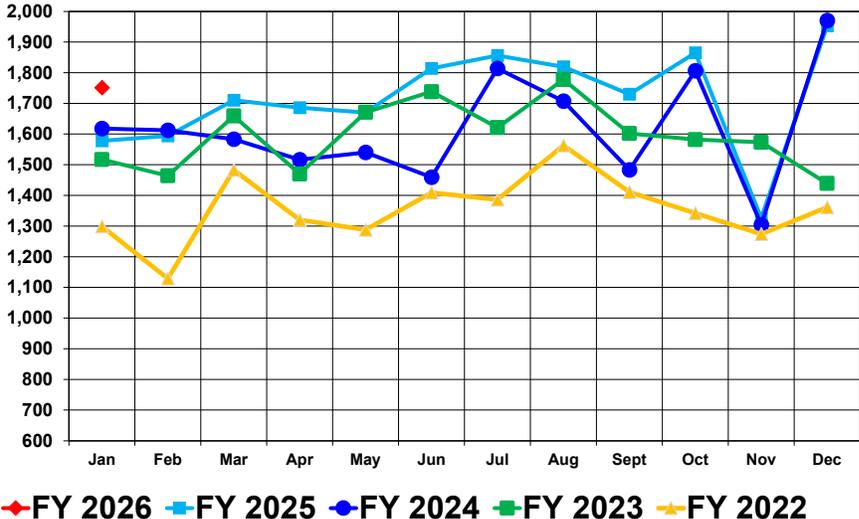




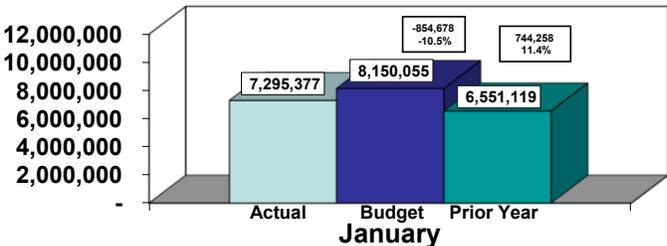
RURAL HEALTH CLINIC VISITS



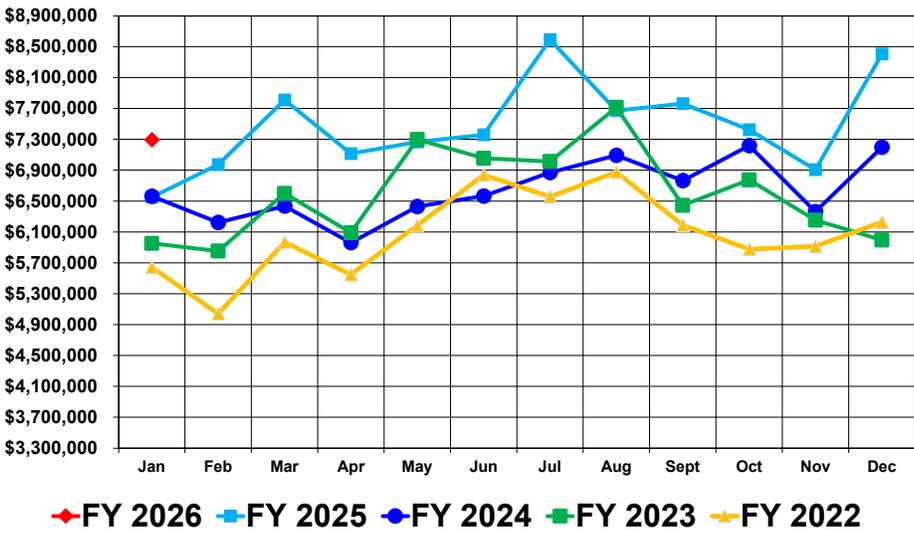
RADIOLOGY EXAMS

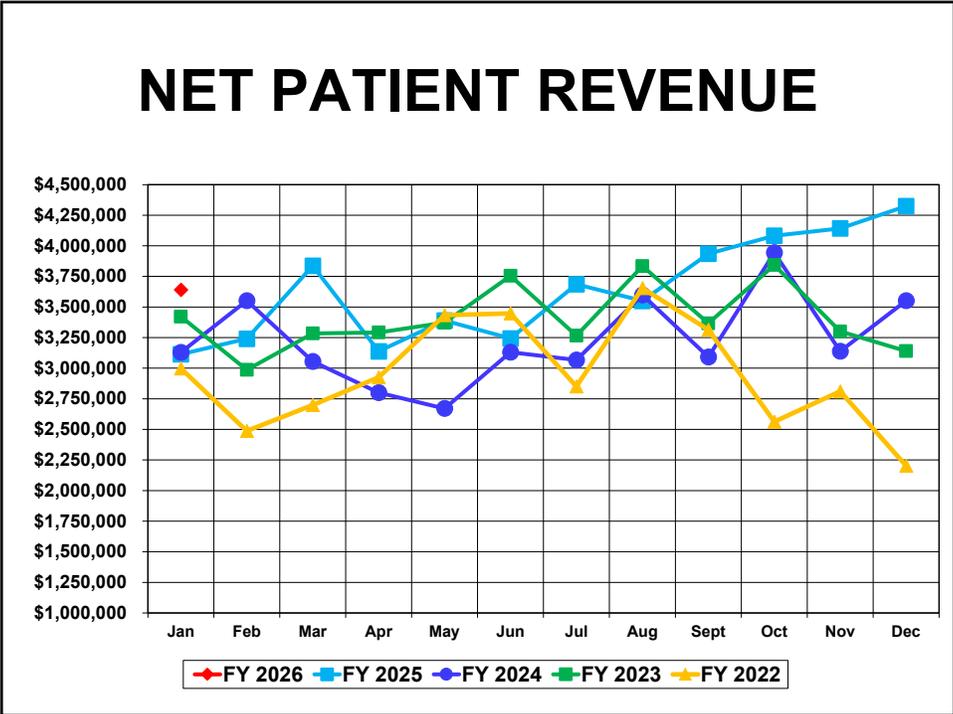
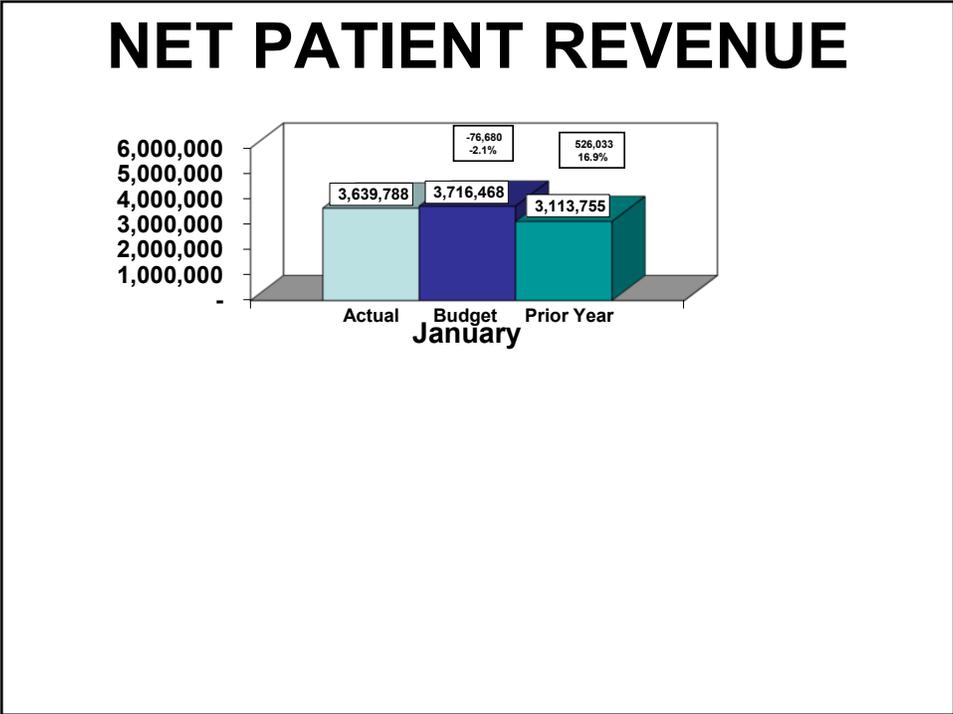


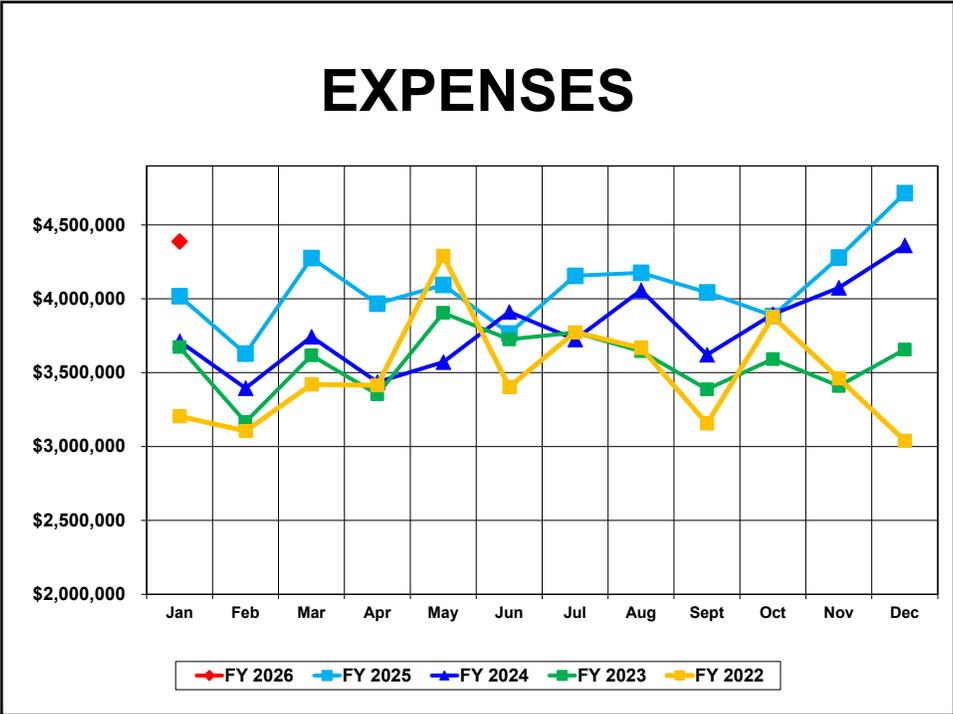
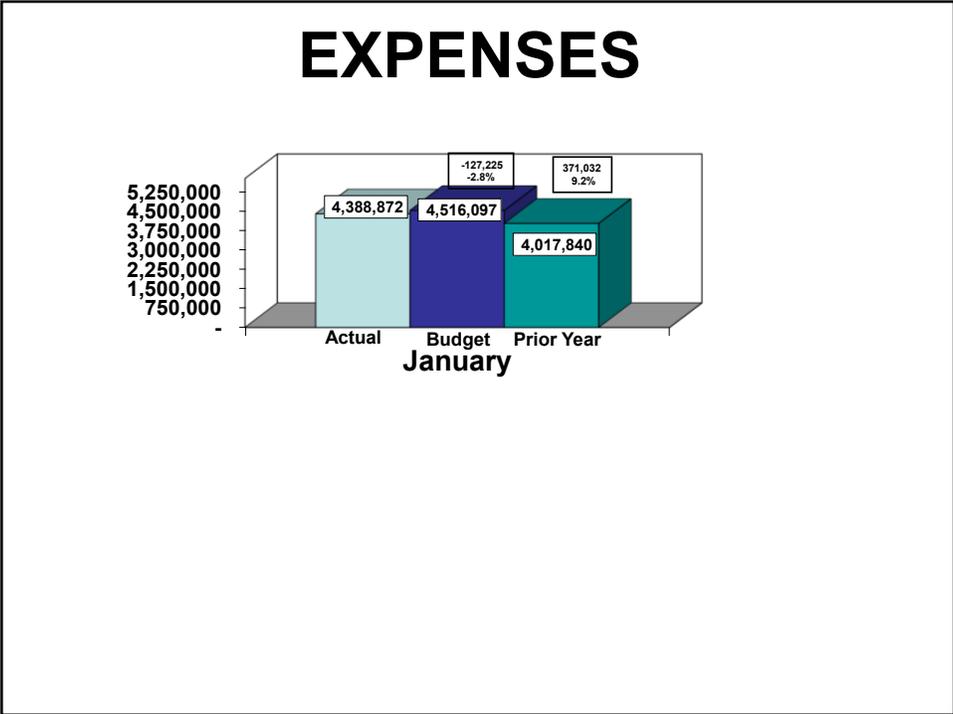
GROSS CHARGES

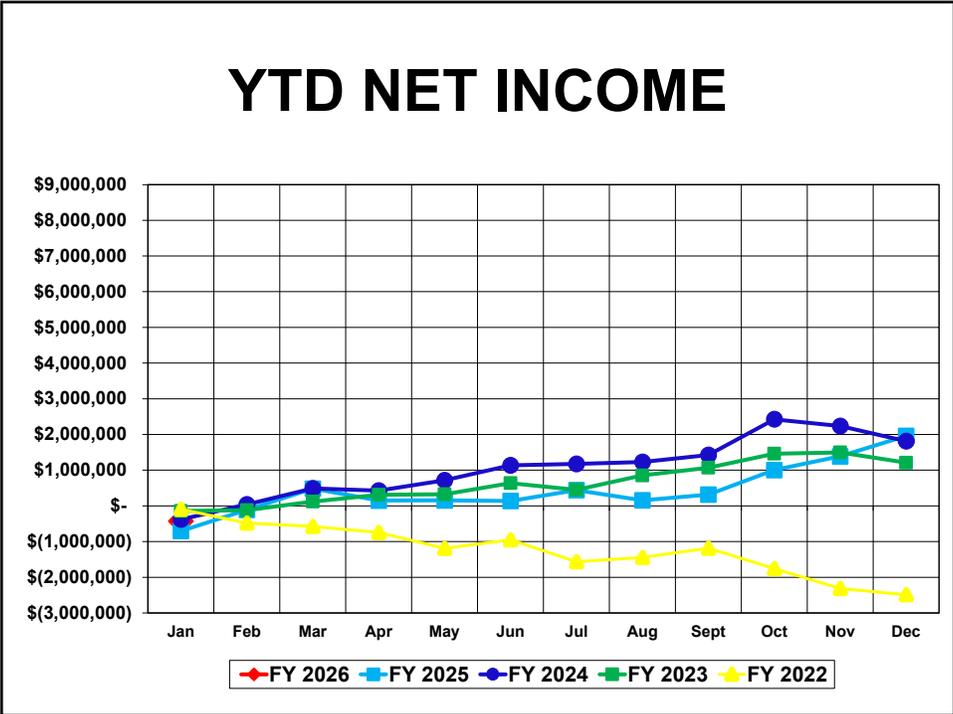
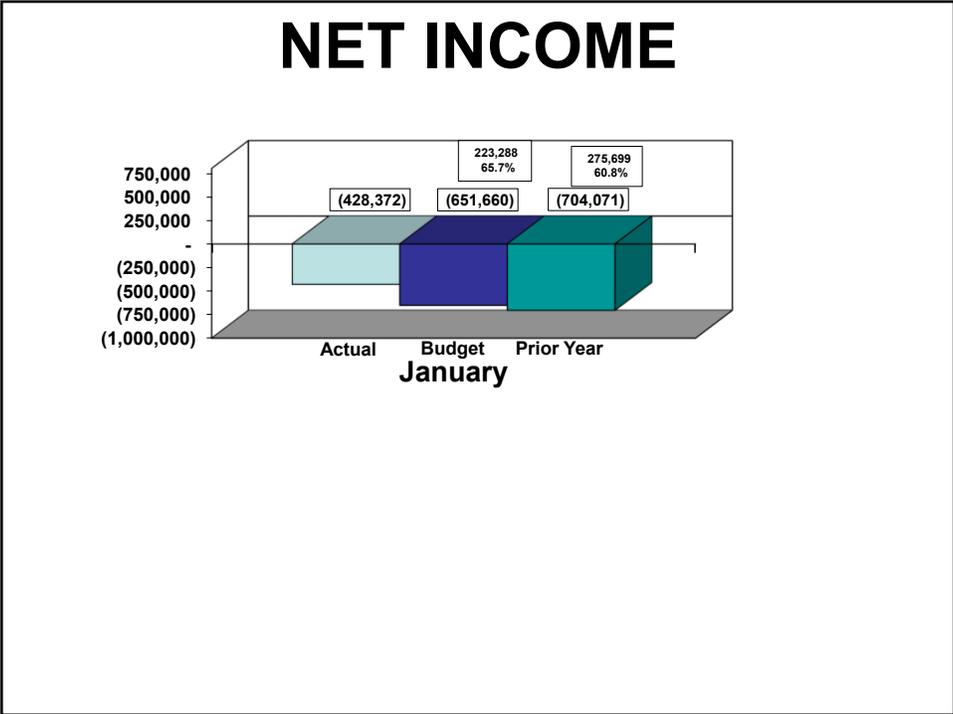


GROSS CHARGES





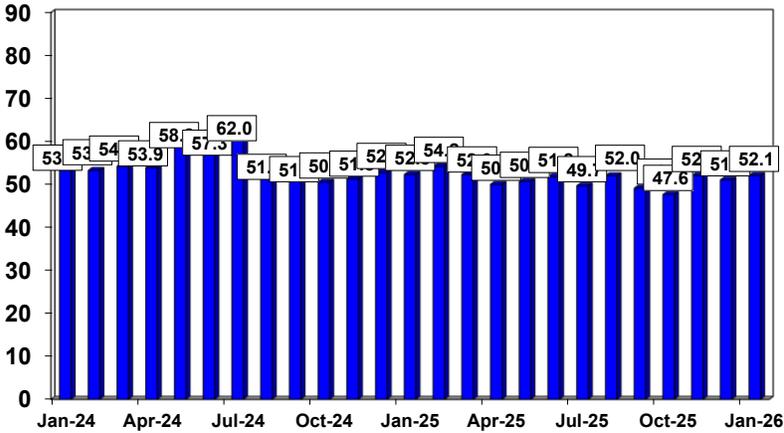




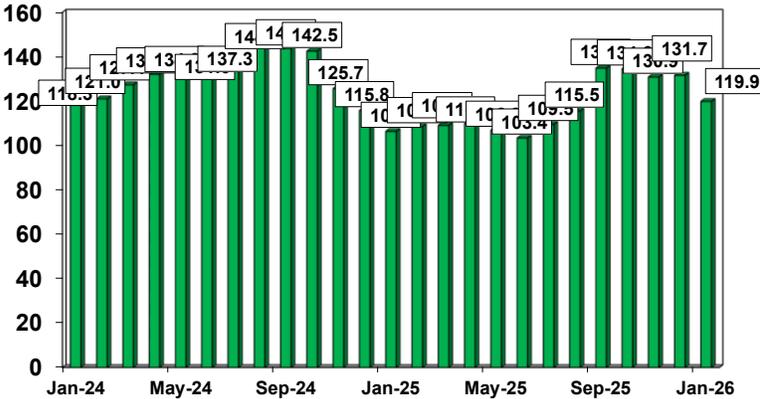
Summary of Financials

	December (Draft)	January	
Gross Charges	8,405,644	7,295,377	
Net Patient Revenue	4,323,833	3,639,788	
Expenses	4,715,549	4,388,872	
Grants, Misc and Tax Revenue	966,415	320,712	
	Grants and Misc	869,268	305,921
	Tax Revenue	97,147	14,791
Net Income	574,699	(428,372)	

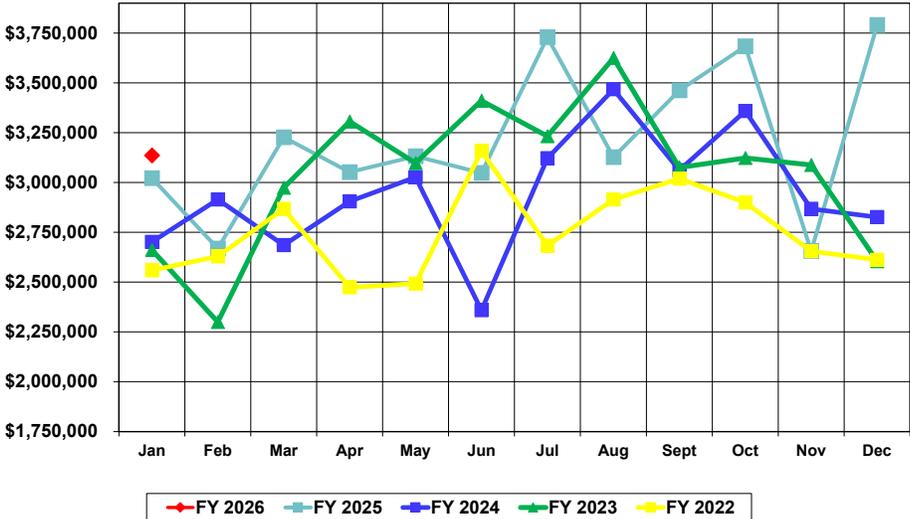
GROSS DAYS IN ACCOUNTS RECEIVABLE



DAYS CASH ON HAND



CASH COLLECTIONS



Pagosa Springs Medical Center

Income Statement Comparison - - - January 31, 2026

Page 1

	Current Month				Year-to-Date			
	2026	Budget	Difference	Variance	2026	Budget	Difference	Variance
Revenue								
7 Total In-patient Revenue	189,351	175,616	13,735	7.8%	189,351	175,616	13,735	7.8%
17 Total Out-patient Revenue	6,488,801	7,231,857	(743,056)	-10.3%	6,488,801	7,231,857	(743,056)	-10.3%
18 Professional Fees	617,225	742,582	(125,357)	-16.9%	617,225	742,582	(125,357)	-16.9%
19 Total Patient Charges	7,295,377	8,150,055	(854,678)	-10.5%	7,295,377	8,150,055	(854,678)	-10.5%
20 Revenue Deductions & Bad Debt								
21 Contractual Allowances	3,838,618	4,337,039	(498,421)	-11.5%	3,838,618	4,337,039	(498,421)	-11.5%
22 Charity	22,561	39,600	(17,039)	-43.0%	22,561	39,600	(17,039)	-43.0%
23 Bad Debt	113,070	367,634	(254,564)	-69.2%	113,070	367,634	(254,564)	-69.2%
24 Provider Fee & Other	(318,660)	(310,686)	(7,974)	2.6%	(318,660)	(310,686)	(7,974)	2.6%
25 Total Revenue Deductions & Bad Debt	3,655,589	4,433,587	(777,998)	-17.5%	3,655,589	4,433,587	(777,998)	-17.5%
26 Total Net Patient Revenue	3,639,788	3,716,468	(76,680)	-2.1%	3,639,788	3,716,468	(76,680)	-2.1%
27 Grants	-	4,768	(4,768)	-100.0%	-	4,768	(4,768)	-100.0%
28 HHS Stimulus Other Revenue	-	-	-	-	-	-	-	-
29 COVID PPP Loan Forgiveness	-	-	-	0%	-	-	-	0%
30 Other Operating Income - Misc	253,780	88,226	165,554	187.6%	253,780	88,226	165,554	187.6%
31 Total Net Revenues	3,893,568	3,809,462	84,106	2.2%	3,893,568	3,809,462	84,106	2.2%
32 Operating Expenses								
33 Salary & Wages	2,303,251	2,332,484	(29,233)	-1.3%	2,303,251	2,332,484	(29,233)	-1.3%
34 Benefits	316,644	320,222	(3,578)	-1.1%	316,644	320,222	(3,578)	-1.1%
35 Professional Fees/Contract Labor	206,603	136,925	69,678	50.9%	206,603	136,925	69,678	50.9%
36 Purchased Services	201,606	233,435	(31,829)	-13.6%	201,606	233,435	(31,829)	-13.6%
37 Supplies	681,642	792,871	(111,229)	-14.0%	681,642	792,871	(111,229)	-14.0%
38 Rent & Leases	10,199	20,650	(10,451)	-50.6%	10,199	20,650	(10,451)	-50.6%
39 Repairs & Maintenance	60,172	67,240	(7,068)	-10.5%	60,172	67,240	(7,068)	-10.5%
40 Utilities	39,125	47,170	(8,045)	-17.1%	39,125	47,170	(8,045)	-17.1%
41 Insurance	45,362	40,572	4,790	11.8%	45,362	40,572	4,790	11.8%
42 Depreciation & Amortization	263,662	257,230	6,432	2.5%	263,662	257,230	6,432	2.5%
43 Interest	97,601	97,994	(393)	-0.4%	97,601	97,994	(393)	-0.4%
44 Other	163,006	169,304	(6,298)	-3.7%	163,006	169,304	(6,298)	-3.7%
45 Total Operating Expenses	4,388,872	4,516,097	(127,225)	-2.8%	4,388,872	4,516,097	(127,225)	-2.8%
46 Operating Revenue Less Expenses	(495,304)	(706,635)	211,331	70.1%	(495,304)	(706,635)	211,331	70.1%
47 Non-Operating Income								
48 Interest Income	52,141	40,320	11,821	29.3%	52,141	40,320	11,821	29.3%
49 Tax Revenue	14,791	14,655	136	0.9%	14,791	14,655	136	0.9%
50 Donations	-	-	-	0.0%	-	-	-	-
51 Total Non-Operating Income	66,932	54,975	11,957	21.7%	66,932	54,975	11,957	21.7%
52 Total Revenue Less Total Expenses	\$ (428,372)	\$ (651,660)	\$ 223,288	65.7%	\$ (428,372)	\$ (651,660)	\$ 223,288	65.7%

The implementation of GASB 96 in 2023 has resulted in an increase of Depreciation and Interest Expense with a reduction of Purchase Service expenses.

Pagosa Springs Medical Center

Income Statement Comparison - - - January 31, 2026

	Current Month				Year-to-Date			
	2026	2025	Difference	Variance	2026	2025	Difference	Variance
Revenue								
7 Total In-patient Revenue	189,351	85,162	104,189	122.3%	189,351	85,162	104,189	122.3%
17 Total Out-patient Revenue	6,488,801	5,932,972	555,829	9.4%	6,488,801	5,932,972	555,829	9.4%
18 Professional Fees	617,225	532,985	84,240	15.8%	617,225	532,985	84,240	15.8%
19 Total Patient Charges	7,295,377	6,551,119	744,258	11.4%	7,295,377	6,551,119	744,258	11.36%
Revenue Deductions & Bad Debt								
21 Contractual Allowances	3,838,618	3,349,657	488,961	14.6%	3,838,618	3,349,657	488,961	14.6%
22 Charity	22,561	22,451	110	0.5%	22,561	22,451	110	0.5%
23 Bad Debt	113,070	389,065	(275,995)	-70.9%	113,070	389,065	(275,995)	-70.9%
24 Provider Fee & Other	(318,660)	(323,809)	5,149	-1.6%	(318,660)	(323,809)	5,149	-1.6%
25 Total Revenue Deductions & Bad Debt	3,655,589	3,437,364	218,225	6.3%	3,655,589	3,437,364	218,225	6.3%
26 Total Net Patient Revenue	3,639,788	3,113,755	526,033	16.9%	3,639,788	3,113,755	526,033	16.89%
27 Grants	-	50,044	(50,044)	-100.0%	-	50,044	(50,044)	-100.0%
28 HHS Stimulus Other Revenue	-	-	-	-	-	-	-	-
29 COVID PPP Loan Forgiveness	-	-	-	-	-	-	-	-
30 Other Operating Income - Misc	253,780	82,060	171,720	209.3%	253,780	82,060	171,720	209.3%
31 Total Net Revenues	3,893,568	3,245,859	647,709	20.0%	3,893,568	3,245,859	647,709	19.95%
Operating Expenses								
33 Salary & Wages	2,303,251	2,050,898	252,353	12.3%	2,303,251	2,050,898	252,353	12.3%
34 Benefits	316,644	319,126	(2,482)	-0.8%	316,644	319,126	(2,482)	-0.8%
35 Professional Fees/Contract Labor	206,603	185,861	20,742	11.2%	206,603	185,861	20,742	11.2%
36 Purchased Services	201,606	170,742	30,864	18.1%	201,606	170,742	30,864	18.1%
37 Supplies	681,642	609,885	71,757	11.8%	681,642	609,885	71,757	11.8%
38 Rent & Leases	10,199	29,250	(19,051)	-65.1%	10,199	29,250	(19,051)	-65.1%
39 Repairs & Maintenance	60,172	68,468	(8,296)	-12.1%	60,172	68,468	(8,296)	-12.1%
40 Utilities	39,125	39,858	(733)	-1.8%	39,125	39,858	(733)	-1.8%
41 Insurance	45,362	41,714	3,648	8.7%	45,362	41,714	3,648	8.7%
42 Depreciation & Amortization	263,662	216,293	47,369	21.9%	263,662	216,293	47,369	21.9%
43 Interest	97,601	102,324	(4,723)	-4.6%	97,601	102,324	(4,723)	-4.6%
44 Other	163,006	183,421	(20,415)	-11.1%	163,006	183,421	(20,415)	-11.1%
45 Total Operating Expenses	4,388,872	4,017,840	371,032	9.2%	4,388,872	4,017,840	371,032	9.23%
46 Operating Revenue Less Expenses	(495,304)	(771,981)	276,677	64.2%	(495,304)	(771,981)	276,677	64.2%
Non-Operating Income								
48 Interest Income	52,141	54,255	(2,114)	-3.9%	52,141	54,255	(2,114)	-3.9%
49 Tax Revenue	14,791	13,655	1,136	8.3%	14,791	13,655	1,136	8.3%
50 Donations	-	-	-	-	-	-	-	-
51 Total Non-Operating Income	66,932	67,910	(978)	-1.4%	66,932	67,910	(978)	-1.4%
52 Total Revenue Less Total Expenses	\$ (428,372)	\$ (704,071)	\$ 275,699	60.8%	\$ (428,372)	\$ (704,071)	\$ 275,699	60.8%

The implementation of GASB 96 in 2023 has resulted in an increase of Depreciation and Interest Expense with a reduction of Purchase Service expenses.

Pagosa Springs Medical Center

Balance Sheet - - January 31, 2026

Page 3

Assets	Current Month	Prior Month	Liabilities	Current Month	Prior Month
Current Assets			Current Liabilities		
Cash					
Operating (TBK)	\$ 2,408,539	\$ 3,149,275	Accts Payable - System	\$ 1,215,887	\$ 1,600,937
COLO Trust	1,897,857	1,891,691	Accrued Expenses	585,823	486,613
Debt Svc. Res. 2016 Bonds (UMB)	878,731	878,731	Cost Report Settlement Res	1,533,618	1,533,618
Bond Funds - 2016 Bonds (UMB)	1,090	1,089	Wages & Benefits Payable	2,633,210	2,121,224
Bond Funds - 2021 (UMB)	6,051,150	6,033,041	Deferred Revenue	2,330,772	2,325,672
CSIP Investments	5,593,542	5,575,323	COVID PPP Short Term Loan	-	-
Escrow - UMB	-	-	Relief Fund Liability	-	-
COVID PPP	-	-	Medicare Accelerated Pmt Liab	-	-
Relief Fund Cash Restricted	-	-	Current Portion of GASB 87 and 96 Liabilities	400,616	397,893
Medicare Accelerated Pmt	-	-	Current Portion of LT Debt-75 S Pagosa	130,000	130,000
Total Cash	16,830,909	17,529,150	Current Portion of LT Debt-2021	465,000	465,000
			Current Portion of LT Debt-2016	245,000	245,000
			Total Current Liabilities	9,539,926	9,305,957
Accounts Receivable					
Patient Revenue - Net	4,295,417	3,989,882	Long-Term Liabilities		
Other Receivables	2,854,077	2,948,007	Leases Payable - 75 S Pagosa	1,795,000	1,795,000
Total Accounts Receivable	7,149,494	6,937,889	GASB 87 and 96 Capital Leases	4,157,008	4,224,027
			Bond Premium (Net) - 2006 Def Outflows	151,254	152,366
Inventory	2,260,603	2,240,596	Bond Premium (Net) - 2016	103,230	103,655
			Bond Premium (Net) - 2021	567,880	571,851
Total Current Assets	26,241,006	26,707,635	Bonds Payable - 2021	6,115,000	6,115,000
			Bonds Payable - 2006	-	-
Fixed Assets			Bonds Payable - 2016	8,315,000	8,315,000
Property Plant & Equip (Net)	22,848,798	22,979,768	Total Long-Term Liabilities	21,204,372	21,276,899
GASB 87 & 96 Assets (Net)	3,754,411	3,863,272			
Work In Progress	777,743	792,062	Net Assets		
Land	704,021	704,021	Un-Restricted	24,717,189	22,820,268
Total Fixed Assets	28,084,973	28,339,123	Current Year Net Income/Loss	(428,372)	1,896,921
			Total Un-Restricted	24,288,817	24,717,189
Other Assets					
Prepays & Other Assets	707,136	253,287	Restricted	-	-
Total Other Assets	707,136	253,287	Total Net Assets	24,288,817	24,717,189
Total Assets	\$ 55,033,115	\$ 55,300,045	Total Liabilities & Net Assets	\$ 55,033,115	\$ 55,300,045

The implementation of GASB 96 in 2023 resulted an increase in Fixed Assets and Long and Short Term Liabilities

Pagosa Springs Medical Center

Monthly Trends

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	YTD Total
Activity	31	28	31	31	31	30	31	31	30	31	30	31	31	31
2 In-Patient Admissions	19	19	13	13	15	20	19	13	19	10	6	22	14	14
3 In-Patient Days	24	29	40	37	40	38	41	30	41	21	21	51	42	42
4 Avg Stay Days (In-patients)	1.3	1.5	3.1	2.8	2.7	1.9	2.2	2.3	2.2	2.1	3.5	2.3	3.0	3.0
8 Average Daily Census	0.8	1.0	1.3	1.2	1.3	1.3	1.3	1.0	1.4	0.7	0.7	1.6	1.4	1.4
Statistics														
9 E/R visits	631	610	680	533	638	698	735	737	656	585	562	737	654	654
10 Observ Hours	1,038	1,244	1,450	854	998	1,277	1,217	1,284	1,174	1,426	1,055	1,591	1,531	1,531
11 Lab Tests	6,948	6,361	7,085	6,962	6,774	6,681	6,418	6,437	6,641	6,488	5,648	6,799	6,708	6,708
12 Radiology/CT/MRI Exams	1,578	1,594	1,710	1,686	1,670	1,814	1,856	1,819	1,730	1,865	1,326	1,953	1,751	1,751
14 OR Cases	84	89	105	101	98	78	115	105	113	81	59	78	63	63
15 Clinic Visits	2,014	1,900	2,017	2,196	2,029	1,845	1,892	1,847	1,922	1,909	1,521	1,696	1,763	1,763
16 Spec. Clinic Visits	57	60	39	59	63	61	36	62	81	131	101	95	78	78
17 Oncology Clinic Visits	112	96	102	112	91	107	119	112	94	94	162	187	158	158
18 Oncology/Infusion Patients	219	260	307	366	340	397	470	360	330	298	302	337	303	303
19 EMS Transports	138	81	99	112	92	64	134	104	111	104	127	110	137	137
20 Total Stats	12,830	12,295	13,594	12,981	12,793	13,022	12,992	12,867	12,852	12,981	10,863	13,583	13,146	13,146

Pagosa Springs Medical Center - - - Statistical Review

Statistical Review

2026	January			January			January Prior Y-T-D			
	Current Month Actual	Current Month Budget	Variance	Y-T-D Actual	Y-T-D Budget	Variance	Y-T-D Actual	Prior Y-T-D Actual	Difference	Variance
In-Patient										
Admissions:										
Acute	14	12	2	14	12	2	14	19	(5)	-26%
Swing Bed	-	-	-	-	-	-	-	-	-	-
Total	14	12	2	14	12	2	14	19	(5)	-26%
Patient Days:										
Acute	42	26	16	42	26	16	42	24	18	75%
Swing Bed	-	-	-	-	-	-	-	-	-	-
Total	42	26	16	42	26	16	42	24	18	75%
Average Daily Census:										
# Of Days	31	31		31	31		31	31		
Acute	1.4	0.8	0.5	1.4	0.8	0.5	1.4	0.8	0.6	75%
Swing Bed	-	-	-	-	-	-	-	-	-	-
Total	1.4	0.8	0.5	1.4	0.8	0.5	1.4	0.8	0.6	75%
Length of Stay:										
Acute	3.0	2.2	0.8	3.0	2.2	0.8	3.0	1.3	1.7	138%
Swing Bed	-	-	-	-	-	-	-	-	-	0%
Total	3.0	2.2	0.8	3.0	2.2	0.8	3.0	1.3	1.7	138%
Out-Patient										
Out-Patient Visits										
E/R Visits	654	626	28	654	626	28	654	631	23	4%
Observ admissions	53	44	9	53	44	9	53	48	5	10%
Lab Tests	6,708	6,362	346	6,708	6,362	346	6,708	6,948	(240)	-3%
Radiology/CT/MRI Exams/M	1,751	1,661	90	1,751	1,661	90	1,751	1,578	173	11%
OR Cases	63	128	(65)	63	128	(65)	63	84	(21)	-25%
Clinic Visits	1,763	1,865	(102)	1,763	1,865	(102)	1,763	2,014	(251)	-12%
Spec. Clinic Visits	78	130	(52)	78	130	(52)	78	57	21	37%
Oncology Clinic Visits	158	115	43	158	115	43	158	112	46	41%
Oncology/Infusion Patients	303	344	(41)	303	344	(41)	303	219	84	38%
EMS Transports	137	102	35	137	102	35	137	138	(1)	-1%
Total	11,668	11,377	291	11,668	11,377	291	11,668	11,829	(161)	-1%

Pagosa Springs Medical Center

Cerner/Healthland Accounts Receivable for Hospital by Payor and Days Outstanding -- As of January 31, 2026

		0-30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151-180 Days	181+ Days	Total	Percent of Total	Accts sent to Collections
2 Medicare	\$	2,744,812	\$ 749,741	\$ 144,194	\$ 50,830	\$ 69,485	\$ 44,451	\$ 296,870	\$ 4,100,383	32%	Page 6
3 Medicaid		611,798	81,869	20,009	35,488	26,671	46,390	275,658	1,097,883	9%	
4 Third Party		1,991,255	728,099	319,577	49,248	61,104	109,145	327,592	3,586,020	28%	
5 Self-Pay		421,850	429,076	487,700	359,826	268,705	243,852	1,798,932	4,009,941	31%	
Current Month Total	\$	5,769,715	\$ 1,988,785	\$ 971,480	\$ 495,392	\$ 425,965	\$ 443,838	\$ 2,699,052	\$ 12,794,227	100%	
Pct of Total		45%	16%	8%	4%	3%	3%	21%	100%		
Dec-25	\$	5,999,489	\$ 1,663,324	\$ 603,539	\$ 673,304	\$ 489,793	\$ 461,434	\$ 2,744,437	\$ 12,635,320	100%	226,145
Pct of Total		47%	13%	5%	5%	4%	4%	22%	100%		
Nov-25	\$	5,999,489	\$ 1,663,324	\$ 603,539	\$ 673,304	\$ 489,793	\$ 461,434	\$ 2,744,437	\$ 12,635,320	100%	339,651
Pct of Total		47%	13%	5%	5%	4%	4%	22%	100%		
Oct-25	\$	6,123,193	\$ 1,328,841	\$ 820,844	\$ 688,288	\$ 640,583	\$ 318,682	\$ 2,899,140	\$ 12,819,571	100%	506,303
Pct of Total		48%	10%	6%	5%	5%	2%	23%	100%		
Sep-25	\$	6,123,193	\$ 1,328,841	\$ 820,844	\$ 688,288	\$ 640,583	\$ 318,682	\$ 2,899,140	\$ 12,819,571	100%	156,271
Pct of Total		48%	10%	6%	5%	5%	2%	23%	100%		
Aug-25	\$	6,272,646	\$ 1,806,115	\$ 845,162	\$ 730,191	\$ 378,195	\$ 476,017	\$ 2,845,054	\$ 13,353,380	100%	182,898
Pct of Total		47%	14%	6%	5%	3%	4%	21%	100%		
Jul-25	\$	6,148,429	\$ 1,343,970	\$ 783,163	\$ 448,955	\$ 586,189	\$ 578,471	\$ 2,602,752	\$ 12,534,286	100%	202,285
Pct of Total		49%	11%	6%	4%	5%	5%	21%	100%		
Jun-25	\$	5,798,998	\$ 1,423,088	\$ 620,781	\$ 640,656	\$ 718,548	\$ 480,775	\$ 2,696,981	\$ 12,379,827	100%	426,234
Pct of Total		47%	11%	5%	5%	6%	4%	22%	100%		
May-25	\$	5,510,786	\$ 1,134,338	\$ 881,123	\$ 782,446	\$ 640,205	\$ 450,511	\$ 2,821,741	\$ 12,221,150	100%	205,702
Pct of Total		45%	9%	7%	6%	5%	4%	23%	100%		
Apr-25	\$	5,380,677	\$ 1,531,216	\$ 959,957	\$ 852,535	\$ 491,263	\$ 632,503	\$ 2,457,407	\$ 12,305,558	100%	239,686
Pct of Total		44%	12%	8%	7%	4%	5%	20%	100%		
Mar-25	\$	5,878,116	\$ 1,431,709	\$ 887,139	\$ 553,759	\$ 745,582	\$ 497,247	\$ 2,403,650	\$ 12,397,202	100%	289,678
Pct of Total		47%	12%	7%	4%	6%	4%	19%	100%		
Feb-25	\$	5,935,029	\$ 1,445,312	\$ 682,201	\$ 898,763	\$ 621,321	\$ 308,121	\$ 2,580,511	\$ 12,471,258	100%	149,150
Pct of Total		48%	12%	5%	7%	5%	2%	21%	100%		
Jan-25	\$	5,068,971	\$ 1,305,124	\$ 973,961	\$ 777,031	\$ 472,520	\$ 378,367	\$ 2,458,458	\$ 11,434,432	100%	331,283
Pct of Total		44%	11%	9%	7%	4%	3%	22%	100%		
Dec-24	\$	5,319,743	\$ 1,598,544	\$ 909,266	\$ 579,703	\$ 559,746	\$ 384,342	\$ 2,563,856	\$ 11,915,200	100%	312,505
Pct of Total		45%	13%	8%	5%	5%	3%	22%	100%		
Nov-24	\$	5,041,955	\$ 942,675	\$ 702,565	\$ 632,660	\$ 619,716	\$ 376,424	\$ 2,168,293	\$ 10,484,288	100%	223,749
Pct of Total		48%	9%	7%	6%	6%	4%	21%	100%		
Oct-24	\$	5,410,175	\$ 1,342,098	\$ 895,631	\$ 514,484	\$ 618,148	\$ 364,283	\$ 2,428,748	\$ 11,573,567	100%	114,647
Pct of Total		47%	12%	8%	4%	5%	3%	21%	100%		
Sep-24	\$	5,336,881	\$ 1,545,826	\$ 660,113	\$ 801,160	\$ 504,361	\$ 385,052	\$ 2,430,015	\$ 11,663,408	100%	166,526
Pct of Total		46%	13%	6%	7%	4%	3%	21%	100%		

Pagosa Springs Medical Center

Cerner/Healthland Accounts Receivable for Hospital by Payor and Days Outstanding -- As of January 31, 2026

		0-30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151-180 Days	181+ Days	Total	Percent of Total	Accts sent to Collections
Aug-24	\$	5,398,392	\$ 1,267,909	\$ 941,782	\$ 562,535	\$ 502,383	\$ 410,323	\$ 2,371,609	\$ 11,454,933		255,891
Pct of Total		47%	11%	8%	5%	4%	4%	21%	100%		
Jul-24	\$	5,507,513	\$ 1,647,105	\$ 918,469	\$ 644,364	\$ 543,418	\$ 410,560	\$ 2,339,334	\$ 12,010,764		185,572
Pct of Total		46%	14%	8%	5%	5%	3%	19%	100%		
Jun-24	\$	5,629,904	\$ 1,537,357	\$ 787,921	\$ 717,968	\$ 578,896	\$ 459,480	\$ 2,222,990	\$ 11,934,516		305,775
Pct of Total		47%	13%	7%	6%	5%	4%	19%	100%		
May-24	\$	4,839,653	\$ 1,099,638	\$ 905,534	\$ 690,343	\$ 663,774	\$ 338,675	\$ 2,200,281	\$ 10,737,898		401,030
Pct of Total		45%	10%	8%	6%	6%	3%	20%	100%		
Apr-24	\$	4,505,943	\$ 1,549,541	\$ 1,079,814	\$ 894,665	\$ 562,615	\$ 282,622	\$ 2,280,611	\$ 11,155,811		284,663
Pct of Total		40%	14%	10%	8%	5%	3%	20%	100%		
Mar-24	\$	5,059,591	\$ 1,408,458	\$ 1,082,949	\$ 715,465	\$ 485,454	\$ 352,812	\$ 2,341,176	\$ 11,445,905		305,544
Pct of Total		44%	12%	9%	6%	4%	3%	20%	100%		
Feb-24	\$	4,965,411	\$ 1,409,644	\$ 782,310	\$ 607,945	\$ 488,055	\$ 355,262	\$ 2,382,519	\$ 10,991,146		407,438
Pct of Total		45%	13%	7%	6%	4%	3%	22%	100%		
Jan-24	\$	5,317,052	\$ 1,163,491	\$ 819,931	\$ 591,365	\$ 478,430	\$ 436,820	\$ 2,215,766	\$ 11,022,855		367,168
Pct of Total		48%	11%	7%	5%	4%	4%	20%	100%		
12	Pct Settled (Current)		66.9%	41.6%	17.9%	36.7%	9.4%	-484.9%			
13	Pct Settled (Dec from Nov)		72.3%	63.7%	-11.6%	27.3%	5.8%	-494.8%			
14	Pct Settled (Nov from Oct)		72.8%	54.6%	18.0%	28.8%	28.0%	-761.2%			
15	Pct Settled (Oct from Sept)		78.3%	38.2%	16.1%	6.9%	50.3%	-809.7%			
16	Pct Settled (Sept from Aug)		78.8%	54.6%	18.6%	12.3%	15.7%	-509.0%			

Pagosa Springs Medical Center
Financial Forecast
Statement of Cash Flows

	Jan-26
Cash Flows from operating activities	
Change in net assets	(428,372)
Adjustments to reconcile net assets to net cash	
Depreciation and amortization	263,662
Patient accounts receivable	(305,535)
Accounts payable and wages payable	126,935
Accrued liabilities	99,210
Pre-paid assets	(453,849)
Deferred revenues	5,100
Other receivables	93,930
Reserve for third party settlement	-
Inventory	(20,007)
Net Cash Provided by (used in) operating activities	(618,926)
Cash Flows from investing activities	
Purchase of property and equipment	(29,338)
Work in progress	14,319
Proceeds from sale of equipment/(Loss)	-
Net Cash Provided by (used in) investing activities	(15,019)
Cash Flows from financing activities	
Principal payments on long-term debt	-
Proceeds from debt (funding from 2021 Bond)	-
Proceeds from PPP Short Term Loan	-
Recognize Amounts from Relief Fund	-
Payments/Proceeds from Medicare Accelerated Payment	-
Change in Prior Year Net Assets	-
Change in leases payable	(64,296)
Net Cash Provided by (used in) financing activities	(64,296)
Net Increase(Decrease) in Cash	(698,241)
Cash Beginning of Month	17,529,150
Cash End of Month	16,830,909

2026 Cash						
Month	Cash Goal	Actual Cash	Variance	% Collected	GL Non AR	Total
Jan-26	\$3,818,135.00	\$3,135,761.71	(\$682,373.29)	82.13%	\$ 29,767.39	\$3,165,529.10
Feb-26						
Mar-26						
Apr-26						
May-26						
Jun-26						
Jul-26						
Aug-26						
Sep-26						
Oct-26						
Nov-26						
Dec-26						
	\$3,818,135.00	\$3,135,761.71	(\$682,373.29)	82.13%	\$ 29,767.39	\$3,165,529.10

2026 Revenue				
Month	Revenue Goal	Actual Revenue	Variance	% Generated
Jan-26	\$ 8,150,055.00	\$ 7,295,377.00	\$ (854,678.00)	89.51%
Feb-26				
Mar-26				
Apr-26				
May-26				
Jun-26				
Jul-26				
Jul-26				
Sep-26				
Oct-26				
Nov-26				
Dec-26				
Totals	\$ 8,150,055.00	\$ 7,295,377.00	\$ (854,678.00)	89.51%



**THE UPPER SAN JUAN HEALTH SERVICE DISTRICT
DOING BUSINESS AS PAGOSA SPRINGS MEDICAL CENTER**

**MEDICAL STAFF REPORT BY CHIEF OF STAFF, CORINNE REED
February 24th, 2026**

I. STATEMENT OF THE MEDICAL STAFF’S RECOMMENDATIONS FOR THE USJHSD BOARD ACCEPTANCE OF NEW POLICIES OR PROCEDURES ADOPTED BY THE MEDICAL STAFF:

RECOMMENDATION	DESCRIPTION
Nurse Practitioner Emergency Medicine Privilege Form	New privilege form for PRN NP support in the Emergency Department.

II. STATEMENT OF THE MEDICAL STAFF’S RECOMMENDATIONS FOR THE USJHSD BOARD ACCEPTANCE OF PROVIDER PRIVILEGES (ACCEPTANCE BY THE BOARD RESULTS IN THE GRANT OF PRIVILEGES):

NAME	INITIAL/REAPPOINT/CHANGE	TYPE OF PRIVILEGES	SPECIALTY
Jeremiah Brewer, DO	Initial Appointment	Telemedicine/Telepsychiatry	Psychiatry
Richard Nudd, PA-C	Initial Appointment	APP/Physician Assistant Emergency Medicine	Emergency Medicine
Robert Brown MD	Reappointment	Courtesy/Family Medicine	Family Medicine
Adam Graham, MD	Reappointment	Telemedicine/Teleneurology	Neurology
Orlin Hopper, MD	Reappointment	Telemedicine/Teleradiology	Diagnostic Radiology
Todd Kooy, MD	Reappointment	Telemedicine/Teleradiology	Interventional Radiology/Diagnostic Radiology
Gregory Martin, MD	Reappointment	Telemedicine/Teleradiology	Interventional Radiology/Diagnostic Radiology
Joseph Steele, MD	Reappointment	Telemedicine/Teleradiology	Interventional Radiology/Diagnostic Radiology

III. REPORT OF NUMBER OF PROVIDERS BY CATEGORY

Active: 18
 Courtesy: 20
 Telemedicine: 141
 Advanced Practice Providers & Behavioral Health Providers: 16
 Honorary: 2
 Total: 197

**UPPER SAN JUAN HEALTH SERVICE DISTRICT
D/B/A PAGOSA SPRINGS MEDICAL CENTER**

Formal Written Resolution 2026-03

February 24, 2026

WHEREAS, the Medicare Conditions of Participation for Critical Access Hospitals require the development, implementation, and maintenance of an effective Quality Assurance and Performance Improvement (QAPI) Program; and

WHEREAS, PSMC must assure an ongoing, data-driven QAPI Program that reflects PSMC's level of complexity and PSMC's services; and

WHEREAS, PSMC affirms its commitment to ongoing oversight of patient safety, quality of care, and regulatory compliance consistent with federal and state requirements; and

WHEREAS, on this day, PSMC management made a presentation to its Board of Directors providing an overview of the QAPI Program requirements and an overview of the 2026 QAPI Plan priorities, measurable targets, and performance improvement initiatives.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE UPPER SAN JUAN HEALTH SERVICE DISTRICT HEREBY RESOLVES to approve PSMC's **Quality Assurance and Performance Improvement Program** and PSMC's Quality Assurance and Performance Improvement 2026 Plan.

ADOPTED and APPROVED by the Board of Directors this 24th day of February, 2026.

Kate Alfred, Chair of the Board of Directors

**UPPER SAN JUAN HEALTH SERVICE DISTRICT
D/B/A PAGOSA SPRINGS MEDICAL CENTER**

Formal Written Resolution 2026-04

February 24, 2026

WHEREAS, the Board of Directors of Upper San Juan Health Service District d/b/a Pagosa Springs Medical Center (hereinafter “Board”) has reviewed, in executive session, the annual report of PSMC’s 2025 peer review activities and whereas such report is to be used and remain confidential in accordance with the Quality Management Act, C.R.S. Section 25-3-109, et seq. and the Professional Review Act, C.R.S. Section 12-36.5-101 et seq.

NOW, THEREFORE, THE BOARD HEREBY RESOLVES THAT it accepts the Annual Report of PSMC’s 2025 Peer Review Activities and that such report shall be used and remain confidential in accordance with the Quality Management Act, C.R.S. Section 25-3-109, et seq. and the Professional Review Act, C.R.S. Section 12-36.5-101 et seq.

Kate Alfred, as Chair and authorized signor for the Board of Directors of PSMC



MINUTES OF REGULAR BOARD MEETING
Tuesday, January 27, 2026, at 5:00 PM
The Board Room
95 South Pagosa Blvd., Pagosa Springs, CO 81147

The Board of Directors (the “Board”) of the Upper San Juan Health Service District doing business as Pagosa Springs Medical Center (“PSMC”) held its regular board meeting on January 27, 2026, at PSMC, Board Room, 95 South Pagosa Blvd., Pagosa Springs, Colorado as well as via Teams video communications.

Director’s Present: Chair Kate Alfred, Director Wayne Hooper, Director Erik Foss, Director Ashley Wilson

Board members present via Teams: Director Mark Floyd, Director Gwen Taylor

Board members present via telephone: Vice Chair Matthew Mees

1) CALL TO ORDER

- a) Call for quorum: Chair Alfred called the meeting to order at 5:00 p.m. MDT and Clerk to the Board, Antoinette Martinez, recorded the minutes. A quorum of directors was present and acknowledged.
- b) Board member self-disclosure of actual, potential or perceived conflicts of interest: None.
- c) Approval of the Agenda: Director Ashley Wilson motioned to approve the agenda with no changes. Director Erik Foss seconded; the Board unanimously approved the agenda.

2) PUBLIC COMMENT

None

3) PRESENTATIONS

Master Nursing Staffing Plan by Chief Nursing Officer, Dan Davis. Effective September 1, 2022, all hospitals must establish a Nurse Staffing Committee, with at least 60% nursing staff and 40% nursing leadership. The committee develops, oversees, and evaluates the hospital’s Nurse Staffing Plan, ensuring compliance with C.R.S. Section 25-3-128. Responsibilities include quarterly staffing evaluations, addressing staff feedback, implementing strategies to meet staffed-bed capacity, preparing an annual report for CDPHE, posting the plan publicly, providing it to new hires, and promoting staff and patient safety.

4) REPORTS

a) Oral Reports

i) Chair Report

- Chair Alfred reminded the board to regularly check emails from the clerk, especially as we begin the new year.

ii) CEO Report

CEO Webb advised the following update:

- CEO Rhonda Webb shared exciting news: we own the property located at 302 San Juan Street. Should the building no longer be used for EMS services, it would then be subject to the Town’s rights. CEO Webb also expressed sincere gratitude to the Town and the San Juan Rangers for their continued support.

PSMC’s Mission: To provide quality, compassionate healthcare and wellness for each person we serve.

- Fundraising efforts have begun to support renovations needed to enable 24/7 operations at the East Side EMS facility. David Ball and his team have already completed some preliminary work, and we are currently awaiting the architectural plans.
- T-shirts featuring the campaign slogan “Say Yes to EMS” have been received and distributed to PSMC staff and Board Members.
- Recruitment is underway for Emergency Department Advance Practice Provider (for example Physician Assistant or Nurse Practitioner) to work with, and in addition to, physician staff. Physician recruitment for the Surgery Department is ongoing, with several candidates in the pipeline. A new primary care provider, who trained locally as a medical student and resident and owns a home in the area, will begin in 2027. Two experienced PAs have joined the clinic, allowing patients to be seen more quickly.
- CEO Webb wishes to acknowledge all PSMC staff for an outstanding 2025, achieving the growth target within one-quarter of a percent, keeping expenses within half a percent of budget, and closing the year with a stronger-than-expected bottom line.
- Questions asked and answered.

iii) Executive Committee

- No Report

iv) Foundation Board

- No Report

v) Facilities Committee

The Facilities Committee met on January 20, 2026. Director Gwen Taylor summarized the written report in the Board Packet highlighting East Side EMS, CORE Building (formerly known as the Dodie Cassidy building) Remodel, and the Emergency Department Remodel. Questions asked and answered.

vi) Strategic Planning Committee Report

The Strategic Planning Committee met on January 20, 2026. Chair Kate Alfred Summarized the written report in the Board Packet highlighting the presentation by Chartis, which is a National Analytics firm, and a presentation by Jason Webb regarding an operational initiative to further PSMC’s Strategic Plan goals. Questions asked and answered.

vii) Finance Committee Report

CFO, Chelle Keplinger, presented and discussed financials for December 2025. Questions asked and answered.

b) Written Reports

- i) Medical Staff Report – Chief of Staff, Dr. Corinne Reed, MD.

5) EXECUTIVE SESSION

Director Wayne Hooper motioned to enter into executive session. Motion was seconded by Director Gwen Taylor. The Board entered into executive session at 5:56 p.m. MDT and the Board Members present unanimously approved, pursuant to C.R.S. Section 24-6-402 (4)(b): conferences with legal counsel regarding legal advice on specific legal questions. The topic announced in public/open session was: potential litigation. Board Directors present in executive session were: Chair Kate Alfred, Director Wayne Hooper, Director Erik Foss, and Director Ashley Wilson. Director Mark Floyd and Director Gwen Taylor were present via Teams and Director Matthew Mees was present via Phone. Operational administrators present in executive session: CEO Rhonda Webb, CAO Ann Bruzzese, and CNO Dan Davis. CFO Chelle Keplinger attended via Teams. Executive session adjourned at 6:24 p.m. MDT.

PSMC’s Mission: To provide quality, compassionate healthcare and wellness for each person we serve.

6) DECISION AGENDA

- a) Consideration of Resolution 2026-02 regarding acceptance of PSMC’s *Nursing Master Staffing Plan for Inpatient and Emergency Departments*.
- i) Director Wayne Hooper motioned to approved Resolution 2026-02 regarding acceptance of PSMC’s Nursing Master Staffing Plan for Inpatient and Emergency Departments. The motion was seconded by Director Ashley Wilson, and the Board Members present unanimously approved.

7) CONSENT AGENDA

Director Erik Foss motioned to approve the consent agenda (approval of Board Member absences, approval of the regular meeting minutes of 12/16/2025, and the special meeting minutes of 01/05/2026.) The motion was seconded by Wayne Hooper and the Board approved said consent agenda items. Director Matthew Mees abstained from the vote regarding the regular meeting minutes as he was not present at the December 16, 2025, meeting. Director Mark Floyd abstained from the vote regarding the special meeting minutes as he was not present at the January 5, 2026, special meeting.

8) OTHER BUSINESS

- Chair Alfred asked board members to complete and return their annual disclosures for conflicts of interest and gift disclosure form.
- Chair Alfred reminded Board Members that they received in their board packet a copy of the transparency notice and the 2026 dates for regular Board meetings.
- Next Board Meeting, February 24, 2026, at 5:00 pm.

9) ADJOURN

There being no further business, Chair Alfred adjourned the regular meeting at 6:26 p.m. MDT.

Respectfully submitted by:

Antoinette Martinez, serving as Clerk to the Board