



Alaska Health Care Commission 2014 Voting Record

January 5, 2015 Meeting (held via webinar; final CY 2014 meeting rescheduled from 12/9/14)

10 Voting Members Present: Jay Butler, Lincoln Bean, C. Keith Campbell, Allen Hippler, Becky Hultberg, Greg Loudon, David Morgan, Lawrence Stinson, Robert Urata, Susan Yeager

Voting Member Absent (approved): Emily Ennis

Motion	Vote
<p>Amend the draft Fraud & Abuse Recommendations by deleting Recommendation V.f. (recommending the Department of Health & Social Services' Medicaid Program investigate beneficiaries who pay cash for prescriptions for controlled substances, potentially with the intent of making the purchase more difficult to track, to ensure the drugs were not diverted for improper or illegal use).</p>	<p>Moved by Mr. Hippler; Seconded by Mr. Bean</p> <p>The motion failed to pass on a vote of 3 yeas and 6 nays, with one abstention.</p> <p>Voting in Favor: Mr. Bean, Mr. Hippler, Ms. Yeager</p> <p>Voting Opposed: Mr. Campbell, Mr. Loudon, Ms. Hultberg, Mr. Morgan, Dr. Stinson, Dr. Urata</p> <p>Abstaining: Dr. Butler</p>
<p>Adopt as final for the 2014 Annual Report the draft Fraud and Abuse Findings & Recommendations as amended in Version 2 of the 2014 Draft Report.</p>	<p>Moved by Mr. Campbell; Seconded by Dr. Urata</p> <p>The motion passed unanimously.</p>
<p>Amend proposed 2015 Opioid Control Facilitation Activity A.v. by deleting "and stories."</p>	<p>Moved by Mr. Hippler; Seconded by Dr. Urata</p> <p>The motion passed on a vote of 8 yeas, and 2 nays.</p> <p>Voting in Favor: Mr. Bean, Dr. Butler, Mr. Campbell, Mr. Hippler, Mr. Morgan, Dr. Stinson, Dr. Urata, Ms. Yeager</p> <p>Voting Opposed: Mr. Loudon, Ms. Hultberg</p>
<p>To adopt as final for the 2014 Annual Report the draft proposed 2015 priorities and facilitation activities, as amended.</p>	<p>Moved by Mr. Loudon Seconded by Mr. Campbell</p> <p>The motion passed unanimously.</p>



Alaska Health Care Commission 2014 Voting Record

<p>To adopt as final for the 2014 Annual Report the draft All-Payer Claims Database Key Provisions for State Legislation Policy Brief, as amended in Version 2 of the 2014 draft report.</p>	<p>Moved by Mr. Campbell Seconded by Dr. Urata</p> <p>The motion passed unanimously.</p>
<p>To adopt as final for the 2014 Annual Report the draft Health Benefit Recommendations for Alaska Employers Brief, presented in the 2014 public comment draft report.</p>	<p>Moved by Dr. Urata Seconded by Mr. Campbell</p> <p>The motion passed unanimously.</p>

October 2-3, 2014 Meeting

10 Voting Members Present: Ward Hurlburt, Lincoln Bean, Emily Ennis, Allen Hippler, Becky Hultberg, Greg Loudon, David Morgan, Lawrence Stinson, Robert Urata, Susan Yeager

Voting Member Absent (approved): C. Keith Campbell

Motion	Vote
<p>Release for public comment Commission plans to facilitate implementation of the following policy recommendations during 2015:</p> <ul style="list-style-type: none"> • I.1.a,d,e: Incorporate evidence-based medicine in pay and benefit design and provide decision-support tools • II.1: Investigate transparency legislation • IV.4: Reform Workers' Compensation Laws • VII.1: Encourage & support healthy lifestyles • IV.6: Adopt opioid control policies & programs • VIII.A.3: Foster telehealth 	<p>Moved by Dr. Urata; seconded by Mr. Loudon</p> <p>The motion passed unanimously.</p>
<p>Release as draft for public comment the Fraud & Abuse Findings and Recommendations with noted clarification to Finding #8 (change "Recipients" to "Medicaid beneficiaries").</p>	<p>Moved by Mr. Bean; seconded by Dr. Urata</p> <p>The motion passed unanimously.</p>
<p>Include in public comment draft of Commission plans to facilitate implementation of policy recommendations: III.1, Implement Payment Reform, and include care coordination (broadly defined).</p>	<p>Moved by Ms. Yeager; seconded by Dr. Urata</p> <p>The motion passed unanimously. Absent from room during vote: Ms. Hultberg</p>

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Lincoln A. Bean SR

MAILING ADDRESS: C-St Box 318 KAKE, AK 99830
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-947-5016 Fax: _____

E-MAIL: Lincoln.Bean

SPOUSE / DOMESTIC PARTNER: ()

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

Lincoln Bean Jr - Austin Brown

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Lincoln Bean Sr

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Linda B...

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input checked="" type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	ANTHC Brd
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: _____

NAME of FILER _____

DATE & PLACE SIGNED / FILED _____

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
 3601 C Street, Suite 902
 Anchorage, AK 99503-5923
 907-334-2474
 Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

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THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Jay C. Butler

MAILING ADDRESS: 10501 Schuss Dr, Anchorage, 99507
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-269-6680/907-744-6422 Fax: 907-269-2048

E-MAIL: JAY.BUTLER@ALASKA.GOV

SPOUSE / DOMESTIC PARTNER: Narda Butler

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

Jessica Vetsch, Zan Butler, Alison Butler,
Vanya Butler, Rebekah Butler

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Jay Butler

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Alaska Native Tribal Health Consortium

Address: 4000 Ambassadors Dr., Anchorage, AK, 99508

DESCRIPTION of WORK PERFORMED: Executive physician,
infectious diseases physician/clinical provider

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Providence Alaska Medical Center

Address: 3760 Piper St., Anchorage, AK 99508

DESCRIPTION of WORK PERFORMED: Central Sterile Supply Tech.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

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Name: Jay Butler

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

ALASKA HEALTH CARE COMMISSION
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Name: Jay Butler

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

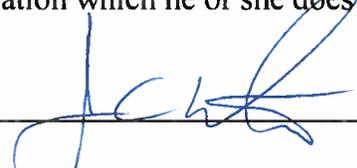
NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

JAY C. BUTLER
NAME of FILER

DEC 31, 2014
DATE & PLACE SIGNED / FILED
ANCHORAGE, AK

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ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
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Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
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THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Keith Campbell

MAILING ADDRESS: Box 722 Seward AK 99664
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-224-5631 Fax: Same

E-MAIL: Keithcampbell@gsi.net

SPOUSE / DOMESTIC PARTNER: Trickie

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Daniel, David, Douglas

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: C Keith Campbell

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: C. Keith Campbell

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

**ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Keith Campbell

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

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RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
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<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Keith Campbell

Keith Campbell
NAME of FILER

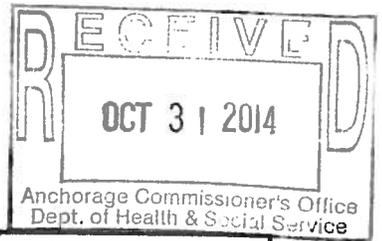
Seward AK
11-3-14
DATE & PLACE SIGNED / FILED

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ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
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FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

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THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Emily F. Ennis

MAILING ADDRESS: 1188 W. Chena Hills Dr., Fairbanks AK
Street Address or P.O. Box, City, Zip Code 99709

CONTACT PHONE(S): 907-479-4371 Fax: _____

E-MAIL: emily@fra-alaska.net

SPOUSE / DOMESTIC PARTNER: Lawrence A. Gooding

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

Alison C. Gifford
Megan V. Gooding

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Emily F. Ennis

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Fairbanks Resource Agency

Address: 805 Airport Way, Fairbanks, AK 99701

DESCRIPTION of WORK PERFORMED: Executive Director

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Emily F. Ennis

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

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EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Dr. Lawrence A. Gooding, Therapist

Business/Client/Customer address: 600 University Ave, Fairbanks, Ak 99709

DESCRIPTION of services provided: Counseling services, Psychotherapy

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

October 1, 2014

**List of Insurance Companies Paying Dr. Lawrence A. Gooding
Over \$5,000 Between 1/1/2013 and 12/12/2013**

Aetna
PO Box 14079
Lexington, KY 40512

Magellan Health Services
14100 Magellan Plaza
Maryland Heights, MO 63043

ComPsych EAP Corp
PO Box 8379
Chicago, IL 60680-8379

Federal Employees Blue Cross Blue Shield of Alaska
PO Box 240489
Anchorage, AK 99524

Premera Blue Cross Blue Shield of Alaska
PO Box 240609
Anchorage, AK 99524

CIGNA Behavioral Health
PO Box 188022
Chattanooga, TN 37422

WPAS
PO Box 34840
Seattle, WA 98124

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
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Name: Emily F. Ennis

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

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RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Emily F. Ennis

Emily F. Ennis
NAME of FILER

OCT 27, 2014
Fairbanks, Alaska
DATE & PLACE SIGNED / FILED

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THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: ALLEN M HIPPLER

MAILING ADDRESS: 6730 CROOKED TREE CIR ANCHORAGE AK 99507
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 261 3335 Fax: _____

E-MAIL: allen.hippler@nrim.com

SPOUSE / DOMESTIC PARTNER: CHRISTINE HIPPLER

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

ALLEN, ARRON, PERPETUA, ROSALIE, ANDREW, AIDAN, ALEXANDER

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: ALLEN HIPPLER

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: NORTHAM BANK 2014 - error -
2013 Allen Hippler

Address: 3111 C ST ANCHORAGE AK 99524

DESCRIPTION of WORK PERFORMED: RELATIONSHIP MANAGEMENT,
LOAN UNDERWRITING

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: FAULKNER WALSH CONSTRUCTORS

Address: PO BOX 233929 ANCHORAGE AK 99523

DESCRIPTION of WORK PERFORMED: ACCOUNTING, RELATIONSHIP MANAGEMENT

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: ALLEN NIPPLER

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: ALLEN HIPPLEY

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Allen Hippley

ALLEN HIPPLEY
NAME of FILER

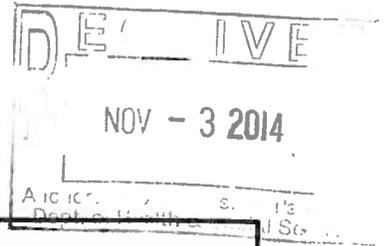
10-2-14 / ANCHORAGE
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013



FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Rebecca L Hultberg

MAILING ADDRESS: 4433 Windfall Ave Juneau AK 99801
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-586-1790 Fax: _____

E-MAIL: becky@ashnka.com

SPOUSE / DOMESTIC PARTNER: Jeff Hultberg

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Sophie, Brant, Dane Hultberg

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Rebecca L Haltberg

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Rebecca L. Hultberg

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Rebecca L. Hultberg

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

Rebecca L. Hultberg
NAME of FILER

10-30-14 Juneau, AK
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

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ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: WARD B. HURLBURT

MAILING ADDRESS: 17901 SPAIN DR. ANCHORAGE, AK 99516
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): (w) 907 269 6670 Fax: _____

E-MAIL: ward.hurlburt@alaska.gov

SPOUSE / DOMESTIC PARTNER: TUPARNA P. HURLBURT

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

CAROLEE E. DEKKER
WARD B. HURLBURT IV

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: WARD B. HURLBURT

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: STATE OF ALASKA, DEPT. OF HEALTH & SOCIAL SERVICES

Address: 3601 C Street, Suite 156, Anchorage, AK 99503

DESCRIPTION of WORK PERFORMED: Chief Medical Officer, DHSS

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: WARD B. HURBURT

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

**ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: WARD B. HURLBURT

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input checked="" type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	Pension - paid by U.S. Public Health Service
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Ward B Hurlburt

WARD B. HURLBURT
NAME of FILER

10/2/14
ANCHORAGE, AK
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

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ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Greg Loudon

MAILING ADDRESS: 14010 Venus Way, Anchorage, AK 99515
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907-345-9186/home Fax: _____

E-MAIL: gloudon@gmail.com

SPOUSE / DOMESTIC PARTNER: Jennifer Loudon

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Christopher, Catherine (Cate)

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Greg Loudon

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013- Dec. 31, 2013

Name: Greg London

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Greg Loudon

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

Greg Loudon
NAME of FILER

9/27/14 Anchorage
Alaska
DATE & PLACE SIGNED / FILED

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ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: David Morgan

MAILING ADDRESS: 2170 Stanford Dr Anchorage, Alaska 99508
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): (907) 317-5924 Fax: (907) 842-9377

E-MAIL: Davidconnie@gmail.com / dmorgan@alaska.org

SPOUSE / DOMESTIC PARTNER: Connie Morgan

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Avon Morgan, Paul Morgan

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: David Morgan

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Bristol Bay Area Health Corporation

Address: 6000 Kawakawak Rd/Box 130 - Dillingham, AK 99507

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: David Morgan

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

N/A

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

**ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: David Morgan

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

David Morgan
NAME of FILER

Oct. 10 2014
DATE & PLACE SIGNED / FILED

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THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION

3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: LAURENCE STINSON

MAILING ADDRESS: 1917 Abbott Rd, Anchorage, AK 99507
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 228 2741 Fax: _____

E-MAIL: _____

SPOUSE / DOMESTIC PARTNER: ELIZABETH STINSON

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):

LARRY STINSON, JAMES STINSON, MATTHEW STINSON,
SARAH MILLAR

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: LAWRENCE STINSON

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: ADVANCED PAIN CENTERS OF ALASKA

Address: 1917 Abbott Rd Anchorage, AK 99507

DESCRIPTION of WORK PERFORMED: PHYSICIAN

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: ~~BARRACUDA~~ ALASKA MEDICAL DEVELOPMENT

Address: 1917 Abbott Rd, Anchorage, AK 99507

DESCRIPTION of WORK PERFORMED: LLC partnership

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: South Anchorage Surgery Center

Address: 1917 Abbott Rd, Anchorage, AK

DESCRIPTION of WORK PERFORMED: Physician

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: _____

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: LAWRENCE STINSON

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

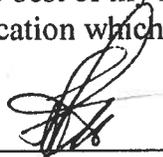
NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input checked="" type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	ALASKA MEDICAL DEVELOPMENT - FAIRBANKS
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

LAWRENCE STINSON
NAME of FILER

10-2-14 Denara Center
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Bob Urata MD

MAILING ADDRESS: 3750 Glacier Hwy
Street Address or P.O. Box, City, Zip Code

CONTACT PHONE(S): 907 723 4144 Fax: 907 586 2446

E-MAIL: bcurata@gci.net

SPOUSE / DOMESTIC PARTNER: Christine

NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
Kari Dipolo, Kiel Urata, Kimiko Urata

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Bob Urata MD

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Valley Medical Care

Address: 1801 Salmon Creek Lane Juneau AK 99801

DESCRIPTION of WORK PERFORMED: as a physician - medical care

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: University of Alaska Southeast

Address: Juneau, Alaska

DESCRIPTION of WORK PERFORMED: Director of Health Care
Teaches CNA students

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Kari Pipolo

Address: Volapell Montana

DESCRIPTION of WORK PERFORMED: - Aide in school system

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Student - medical school - WWAMI

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Bob Urate

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: Kimiko Urate

Business/Client/Customer address: waitress - Part time medical assistant at

DESCRIPTION of services provided: valley medical care

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

**ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT**

Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Bob Urzeta MD

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

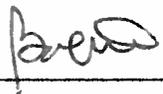
NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input checked="" type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	WDAKugel Medical Center - Medical Director - Part time
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: 

Bob Urzeta MD

10/21/14 - Anchorage Alaska

NAME of FILER

DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

FINANCIAL DISCLOSURE STATEMENT FOR:
ALASKA HEALTH CARE COMMISSION MEMBERS

In accordance with AS 18.09.060(4)(D), Alaska Health Care Commission members are required to report all potential conflicts of interest valued at more than \$5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

THIS REPORT IS A SWORN STATEMENT. YOUR SIGNATURE ON THE LAST PAGE CERTIFIES THAT THIS DISCLOSURE IS TRUE, CORRECT and COMPLETE.

NAME: Susan M Yeager
MAILING ADDRESS: PO Box 517764 Eagle River, AK 99577
Street Address or P.O. Box, City, Zip Code
CONTACT PHONE(S): 907 602-9610 Fax: 907 257-6774
E-MAIL: Susan.Yeager@
 SPOUSE / DOMESTIC PARTNER: Thomas Yeager III
NAMES of CHILDREN (biological, adoptive, and step children; including adult children not living in your home):
NA

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Susan Yeager

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

1. SALARIED EMPLOYMENT

NONE: check box →

Report each health care system employer who paid you, your spouse, domestic partner or children more than \$5,000.
Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: Department of Veterans Affairs

Address: 1201 N Muldoon Rd Anchorage AK 99504

DESCRIPTION of WORK PERFORMED: Healthcare System Director

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: La Touch Pediatrics

Address: Providence Dr Anchorage AK

DESCRIPTION of WORK PERFORMED: Pediatrician

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Employer: _____

Address: _____

DESCRIPTION of WORK PERFORMED: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Susan Yeager

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

2. SELF-EMPLOYMENT

NONE: check box →

Self-employment includes sole proprietors, partnerships, limited liability companies, and professional corporations. Disclose each health care client, customer or business that paid you, your spouse/domestic partner or child more than \$5,000. Income derived from patient care provided by you if you are a self-employed health care practitioner should be considered in aggregate for meeting the \$5,000 threshold, and the name of the practice listed as the client name. If the identity of other sources of income is confidential by law, you may be excused from disclosing the source. To obtain an exemption, you must file a written request with the commission.

Income means anything of value and covers all forms of compensation, including deferred income.

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

EARNED BY: Filer / Spouse/domestic partner / Child

Business/Client/Customer name: _____

Business/Client/Customer address: _____

DESCRIPTION of services provided: _____

Name: _____

ALASKA HEALTH CARE COMMISSION
2014 FINANCIAL DISCLOSURE STATEMENT
Covers the reporting period Jan. 1, 2013– Dec. 31, 2013

Name: Susan Yeager

SOURCES OF HEALTH CARE SYSTEM INCOME OVER \$5,000

3. OTHER INCOME

NONE: check box →

List sources of income valued over \$5,000 not listed elsewhere on this form, including sale of health care goods or services, pensions paid by health care organizations, monetary gifts and honorariums from health care organizations, dividends and interest derived from ownership in a health care business, profit made on the sale of shares in publicly and non-publicly traded health care corporations, and rent paid by a health care organization on property and real estate in which you hold a business interest.

RECIPIENT	SOURCE
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	
<input type="checkbox"/> Filer <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ partner	

CERTIFICATION

I certify under penalty of perjury that the foregoing is true and the information in this disclosure statement is, to the best of my knowledge, true, correct and complete. A person who makes a false sworn certification which he or she does not believe to be true is guilty of perjury.

SIGNATURE: Susan M Yeager

Susan M Yeager
NAME of FILER

October 1, 2014
DATE & PLACE SIGNED / FILED

*Alaska Health Care Commission members are solely responsible
for filing complete, accurate and truthful statements.*

THIS IS A PUBLIC DOCUMENT

ALASKA HEALTH CARE COMMISSION
3601 C Street, Suite 902
Anchorage, AK 99503-5923
907-334-2474
Fax 907-269-0060



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

Alaska Health Care Commission

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

MEMORANDUM

DATE: April 25, 2014

TO: Kimberly Halstead, Litigation Assistant
Opinions, Appeals, & Ethics Section
Office of the Attorney General

FROM: *Deborah L. Erickson for*
Ward Hurlburt, MD, MPH, Chair
Alaska Health Care Commission
Department of Health & Social Services

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report:
January 1 – March 31, 2014

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period Jan 1-Mar 31, 2014

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
Requests for Ethics Determination	<u>0</u>
Gifts	<u>0</u>
Gifts from Other Governments	<u>0</u>
Interests in Contracts, Grants, Leases, Loans	<u>0</u>

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
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** Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.*

** Attach this summary to your regular quarterly report.*



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

Alaska Health Care Commission

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

MEMORANDUM

DATE: July 7, 2014

TO: Kimberly Halstead, Litigation Assistant
Opinions, Appeals, & Ethics Section
Office of the Attorney General

FROM: Ward Hurlburt, MD, MPH, Chair 
Alaska Health Care Commission
Department of Health & Social Services

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report:
April 1 – June 30, 2014

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period April 1-June 30, 2014

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
--------------------------------	----------

Requests for Ethics Determination	<u>0</u>
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Gifts	<u>0</u>
-------	----------

Gifts from Other Governments	<u>0</u>
------------------------------	----------

Interests in Contracts, Grants, Leases, Loans	<u>0</u>
---	----------

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
---	----------

** Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.*

** Attach this summary to your regular quarterly report.*



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

Alaska Health Care Commission

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

MEMORANDUM

DATE: October 20, 2014

TO: Kimberly Halstead, Litigation Assistant
Opinions, Appeals, & Ethics Section
Office of the Attorney General

FROM: Ward Hurlburt, MD, MPH, Chair 
Alaska Health Care Commission
Department of Health & Social Services

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report:
July 1 – September 30, 2014

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period July 1-September 30, 2014

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
--------------------------------	----------

Requests for Ethics Determination	<u>0</u>
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Gifts	<u>0</u>
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Gifts from Other Governments	<u>0</u>
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Interests in Contracts, Grants, Leases, Loans	<u>0</u>
---	----------

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
---	----------

** Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.*

** Attach this summary to your regular quarterly report.*



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of
Health and Social Services**

Alaska Health Care Commission

Anchorage
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

MEMORANDUM

DATE: December 31, 2014

TO: Kimberly Halstead, Litigation Assistant
Opinions, Appeals, & Ethics Section
Office of the Attorney General

FROM: Jay Butler, MD, Chair
Alaska Health Care Commission
Department of Health & Social Services

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report:
October 1 – December 31, 2014

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

Ethics Supervisor Quarterly Statistical Summary*

Reporting Period Oct 1 - Dec 31, 2014

Alaska Health Care Commission

Reporting Agency, Board, Commission or Public Corporation

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

All agencies, boards, commissions and public corporations:

Notices of Potential Violation	<u>0</u>
--------------------------------	----------

Requests for Ethics Determination	<u>0</u>
-----------------------------------	----------

Gifts	<u>0</u>
-------	----------

Gifts from Other Governments	<u>0</u>
------------------------------	----------

Interests in Contracts, Grants, Leases, Loans	<u>0</u>
---	----------

Agencies only:

Outside Employment or Services	<u>0</u>
--------------------------------	----------

Boards, commissions and public corporations only:

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
---	----------

** Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.*

** Attach this summary to your regular quarterly report.*