Northern Inyo Hospital

December 16 2015 Regular Meeting

December 16 2015 Regular Meeting - December 16 2015 Reg

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

December 16, 2015 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 p.m.).
2. Quarterly report, Northern Inyo Hospital Auxiliary (*information item*).
3. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.)*
4. Auditors' report for fiscal year ending June 30, 2015, Wipfli LLP (*action item*).

Consent Agenda (action items)

5. Approval of minutes of the November18 2015 regular meeting
6. Financial and Statistical reports for October 2015

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7. Chief Executive Officer's Report; Kevin S. Flanigan, MD, MBA (*information items*)
   - A. Hospital Team Vision, Goals
   - B. Physician Group Model
   - C. Lockdown Report
   - D. Need for locums anesthesia
   - E. 340B Audit
   - F. Thanksgiving Day, Dietary compliment
   - G. Interim Pharmacy Director
   - H. New Employee Totals Since Last Meeting
   - I. I.T. Governance
   - J. Propane Tank follow-up
8. Chief of Staff Report; Mark Robinson, M.D.

   A. Hospital wide Policy and Procedure approvals (*action items*):

   1. *Admission and Care of Newborn*
   2. *Amniocenteses*
   3. *Blood Glucose Monitoring Protocol Newborn*
   4. *Admission Assessment of Obstetrical Patient*
   5. *Shoulder Dystocia*
   6. *Postpartum Hemorrhage*

7. Telephone Triage

8. Opioids Waste Policy

9. Pharmacy Operations During the Temporary Absence of a Pharmacist

10. Medications in the Absence of the Pharmacist

11. Protecting Public from Impaired or Dishonest Pharmacy Employee

12. Automated External Defibrillators

B. Acceptance of the resignations of D. Scott Clark, M.D.; Shawn Rosen, M.D.; Eric Wallace, M.D.; and Thomas Davee, M.D. (*action items*).

C. Medical Staff Privileging, Credentialing, Advancements (*action items*):

1. Peter Bloomfield, M.D.: Advancement from Provisional Active Staff to Active Staff with Emergency Room Service clinical privileges as requested.
2. Charlie Wolf, M.D.: Advancement from Provisional Active Staff to Active Staff with Emergency Room Service clinical privileges as requested.
3. William Timbers, M.D.: Release from Emergency Room Service proctorship.
4. Anne Goshgarian, M.D.: Release from Emergency Room Service proctorship.
5. Charles Hooper, D.O.: Extension of temporary locum tenens assignment at the RHC until 4/30/16.

D. Medical Staff Reappointments and Recredentialing (*action items*):

1. Alexander Adduci, M.D. (*Radiology*)
2. Sandra Althaus, M.D. (*Radiology*)
3. Helena L. Black, M.D. (*Emergency Medicine*)
4. Stacey L. Brown, M.D. (*Family Practice*)
5. Thomas Bryce, M.D. (*Teleradiology*)
6. Nicholas J. Carlevato, M.D. (*Radiology*)
7. Michael L. Dillon, M.D. (*Emergency Medicine*)
8. John Erogul, M.D. (*Radiology*)
9. Aamer Farooki, M.D. (*Teleradiology*)
10. Nickoline Hathaway, M.D. (*Internal Medicine*)
11. Andrew Hewchuck, D.P.M. (*Podiatry*)
12. Asao Kamei, M.D. (*Internal Medicine*)
13. Felix Karp, M.D. (*Internal Medicine/Hospitalist*)
14. Ara Kassarjian, M.D. (*Teleradiology*)

15. Martha Kim, M.D. (*OB/Gyn*)
16. Sheldon M. Kop, M.D. (*Radiology*)
17. David N. Landis, M.D. (*Radiology*)
18. Doris Lin, M.D. (*Emergency Medicine*)
19. Stephen J. Loos, M.D. (*Radiology*)
20. Richard Meredick, M.D. (*Orthopedic Medicine*)
21. Thomas O. McNamara, M.D. (*Radiology*)
22. Michael W. Phillips, M.D. (*Emergency Medicine*)
23. Leo M. Pisculli, M.D. (*Psychiatry*)
24. Amr H. Ramadan, M.D. (*Family Practice/C-Section*)
25. Thomas K. Reid, M.D. (*Ophthalmology*)
26. James Richardson, M.D. (*Internal Medicine*)
27. Curtis Schweizer, M.D. (*Anesthesia*)
28. Jennifer A. Scott, M.D. (*Emergency Medicine*)
29. Richard Seher, M.D. (*Cardiology*)
30. Keith M. Shonnard, M.D. (*Radiology*)
31. Robert Swackhammer, M.D. (*Cardiology*)
32. Gregory M. Taylor, M.D. (*Emergency Medicine*)
33. Carolyn J. Tiernan, M.D. (*Emergency Medicine*)
34. Rajesh Vaid, M.D. (*Teleradiology*)
35. Eva S. Wasef, M.D. (*Pathology*)
36. Steven Wei, M.D. (*Teleradiology*)
37. Taema F. Weiss, M.D. (*Family Practice*)
38. Albert Douglas Will, M.D. (*Neurology*)
39. Harry Wolf, M.D. (*Emergency Medicine*)
40. Robert Frankel, P.A. (*Allied Health Professional*)
41. Tammy O'Neill, P.A. (*Allied Health Professional*)
42. Jennifer Norris, CNM (*Allied Health Professional*)

9. Chief Nursing Officer Report (*information item*).
10. Chief Performance Excellence Officer Report (*information item*).
11. New Business

A. Acceptance of Fiscal Strategy Proposal (*action item*).

B. Extension of Private Practice Physician Agreement with Stacey Brown, M.D. (*action item*).

C. Extension of Private Practice Physician Income Guarantee and Practice Management Agreement with James Englesby, M.D. (*action item*).

D. NIH Foundation Board Member approvals; Sharon Moore, and Linda Emerson (*action items*).

E. Appointment of Board member for Northern Inyo Healthcare District Zone 4 (*action item*).

F. Purchase of Hill ROM VersaCare Bed (*action item*).

G. Election of Board officers for 2016 (*action item*).

H. Date for January 2016 regular Board meeting (*action item*).

I. Hospital wide Policy and Procedure manual approvals (*action items*):

1. AHA Training Center Manual
2. Anesthesia
3. Biomedical Engineering Operations Manual
4. Case Management Manual
5. Central Supply
6. Clinical Practice Manual (Interdisciplinary Direct Care)
7. Dietary
8. EKG
9. Emergency Department Manual
10. Emergency Management Manual
11. Employee Health Manual
12. Environmental Services
13. Human Resources – Employee Handbook
14. ICU Unit
15. Infection Control
16. Infusion Center Manual
17. Laboratory Manual
18. Language Services
22. MRI Safety
23. Nuclear Medicine
24. Nursing Administration
25. OB Unit
26. Outpatient Unit
27. PACU Unit
28. Pediatric Unit
29. Pharmacy
30. Quality Assurance & Performance Improvement
31. Radiology Policy & Procedures Manual
32. Radiation Safety
33. Rehabilitation Services Manual
34. Respiratory and PFT Manual
35. Rural Health Clinic
36. Safety Manuals (10)
37. Social Services
38. Staff Development

19. Mammography & MSQA
20. Med-Surg Unit
21. Medical Staff Office Manual
39. Surgical Services Unit
40. Surgery Lithotripsy Service
41. Swing Bed Manual

J. Northern Inyo Hospital 401(a) Retirement Plan – Restated Plan Document effective 1/1/2016 (*possible action*).

K. Recommended Pay Scale Range Adjustments (*possible action*).

L. Use of Association of California Healthcare Districts CEO Performance Review tool (*action item*).

12. Reports from Board members (*information items*).
13. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
    B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation (*pursuant to Government Code Section 54956.9*).
    C. Discussion involving trade secrets, concerning new programs, services or facilities (*pursuant to Health and Safety Code Section 32106*).
14. Return to open session and report of any action taken in closed session.
15. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

Northern Inyo Healthcare District

Bishop, California

Financial Statements and Supplementary Information

Years Ended June 30, 2015 and 2014

Northern Inyo Healthcare District

Financial Statements and Supplementary Information
Error! Reference source not found. Ended June 30, 2015 and 2014

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WIPFLI LLP

Independent Auditor's Report

Board of Directors
Northern Inyo Healthcare District
Bishop, California

Report on the Financial Statements

We have audited the accompanying financial statements of the Northern Healthcare District, its discretely presented component unit and the aggregate remaining fund information as of and for the year ended June 30, 2015, and 2014, the related notes to the financial statements, which collectively comprise the Northern Inyo Hospital's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the Northern Inyo Healthcare District, its discretely presented component unit and the aggregate remaining fund information as of June 30, 2015 and 2014, and the respective changes in financial position and, cash flows thereof, for the year then ended in accordance with accounting principles generally accepted in the United States.

Other Matters

As part of our audit of the 2014 financial statements, we also audited the adjustments described in Note 20 that were applied to restate the 2014 financial statements. In our opinion, such adjustments are appropriate and have been properly applied.

As described in Note 1 to the financial statements, in 2015, the District adopted new accounting guidance, GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—an amendment of GASB Statement No. 27*. Our opinion is not modified with respect to this matter.

Required Supplementary Information

Accounting principles generally accepted in the United States require the schedule of funding progress and employer contributions on page 53 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinions on the basic financial statements are not affected by this missing information.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the Northern Inyo Healthcare District's financial statements as a whole. The combining financial statements and statistical section are presented for purposes of additional analysis and are not a required part of the financial statements. The combining financial statements are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the financial statements.

Such information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the combining financial statements are fairly stated in all material respects in relation to the financial statements as a whole.

The statistical information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and accordingly, we do not express an opinion or provided any assurance on it.

Wipfli LLP

Wipfli LLP

December 8, 2015
Spokane, Washington

Northern Inyo Healthcare District

Statements of Net Position

Years Ended June 30, 2015 and 2014

Assets	2015 Hospital	2015 Pioneer Medical Associates	2014 Restated Hospital	2014 Pioneer Medical Associates
Current assets:				
Cash and cash equivalents	$ 5,716,631	$ 58,057	$ 1,342,272	$ 109,835
Current portion of assets limited as to use	1,470,000	-	1,240,000	-
Receivables:				
Patient - Net	10,745,200	-	11,224,470	-
Other	28,067	-	11,069	-
Inventory	3,031,041	-	2,793,677	-
Prepaid expenses and deposits	1,349,328	-	1,223,052	-
Total current assets	22,340,267	58,057	17,834,540	109,835
Other assets:				
Noncurrent assets limited as to use	15,781,236	-	15,052,282	-
Investment in PMA	397,493	-	464,019	-
Goodwill in PMA	581,219	-	581,219	-
Total other assets	16,759,948	-	16,097,520	-
Capital assets:				
Nondepreciable capital assets	1,027,452	341,260	1,087,351	341,260
Depreciable capital assets - Net	86,090,873	242,267	88,953,577	259,670
Capital assets - Net	87,118,325	583,527	90,040,928	600,930
Deferred outflows of resources	782,887	-	-	-
TOTAL ASSETS & DEFERRED OUTFLOWS OF RESOURCES	$ 127,001,427	$ 641,584	$ 123,972,988	$ 710,765

Liabilities and Net Position	2015 Hospital	2015 Pioneer Medical Associates	2014 Restated Hospital	2014 Pioneer Medical Associates
Current liabilities:				
Current maturities of long-term liabilities:				
Bonds payable	$ 1,390,000	$ -	$ 1,240,000	$ -
Capital lease obligation	1,007,957	-	961,992	-
Line of credit	-	-	299,988	-
Accounts payable	1,521,678	-	1,647,428	-
Accrued interest and sales tax	261,509	-	265,106	-
Accrued payroll and related liabilities	5,289,388	-	4,563,834	-
Estimated third-party payor settlements	3,496,996	-	1,372,657	-
Total current liabilities	12,967,528	-	10,351,005	-
Long-term liabilities:				
Bonds payable	47,997,149	-	49,454,313	-
Accreted interest	8,213,924	-	6,887,339	-
Capital lease obligation	1,090,103	-	2,098,060	-
Net pension liability	18,601,120	-	-	-
Total long-term liabilities	75,902,296	-	58,439,712	-
Total liabilities	88,869,824	-	68,790,717	-
Deferred inflows of resources	1,634,407	-	-	-
Net position:				
Net investment in capital assets	35,377,830	-	36,025,861	-
Restricted for debt service	3,280,754	-	3,193,718	-
Restricted for programs	66,039	426,846	113,279	237,893
Unrestricted	(2,227,427)	214,738	15,849,413	472,872
Total net position	36,497,196	641,584	55,182,271	710,765
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 127,001,427	$ 641,584	$ 123,972,988	$ 710,765

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Revenue, Expenses, and Changes in Net Position

Error! Reference source not found. Ended June 30, 2015 and 2014

	2015		2014	
	Hospital	Pioneer Medical Associates	Restated Hospital	Pioneer Medical Associates
Revenue:				
Net patient service revenue	$ 70,694,160	$ -	$ 69,247,976	$ -
Other operating revenue	1,029,392	192,779	1,111,546	192,779
Total revenue	71,723,552	192,779	70,359,522	192,779
Expenses:				
Salaries and wages	21,591,747	-	21,750,463	-
Employee benefits	16,799,660	-	14,523,265	-
Professional fees	6,707,405	2,610	7,285,040	-
Supplies	7,074,128	-	6,948,215	-
Purchased services	3,720,516	-	3,634,963	-
Depreciation	4,955,527	17,403	5,197,825	17,751
Other operating expense	3,759,124	41,993	3,951,452	43,743
Total expenses	64,608,107	62,006	63,291,223	61,494
Income from operations	7,115,445	130,773	7,068,299	131,285
Nonoperating revenue (expenses):				
Tax revenue for operations	520,257	-	564,643	-
Tax revenue for debt services	1,376,890	-	1,306,715	-
Interest income	155,749	46	135,087	74
Interest expense	(3,529,802)	-	(3,626,175)	-
Loss on sale of asset	(94,603)	-	(55,006)	-
Noncapital grants and contributions	251,407	-	217,905	-
Medical office building, net	(4,695,700)	-	(4,536,814)	-
Total nonoperating revenue (expenses)	(6,015,802)	46	(5,993,645)	74
Excess of revenue over expenses	1,099,643	130,819	1,074,654	131,359
Capital grants and contributions	53,038	-	131,212	-
Distributions to PMA investors	-	(200,000)	-	(100,000)
Increase (decrease) in net position	1,152,681	(69,181)	1,205,866	31,359
Net position at beginning, as previously stated	55,182,271	710,765	53,976,405	679,406
Cumulative effect for change in accounting principle	(19,837,756)	-	-	-
Net position at beginning, restated	35,344,515	710,765	53,976,405	679,406
Net position at end	$ 36,497,196	$ 641,584	$ 55,182,271	$ 710,765

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Cash Flows

Error! Reference source not found. Ended June 30, 2015 and 2014

	2015		2014	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Increase (decrease) in cash and cash equivalents:				
Cash flows from operating activities:				
Receipts from and on behalf of patients and third-party payors	$ 73,297,769	$ -	$ 71,390,998	$ -
Receipts from other operating revenue	1,017,684	192,779	1,302,132	192,779
Payments to employee	(38,050,969)	-	(36,143,492)	-
Payments to suppliers, contractors, and others	(21,742,603)	(44,603)	(24,389,880)	(43,743)
Net cash provided by operating activities	14,521,881	148,176	12,159,758	149,036
Cash flows from noncapital financing activities:				
District tax revenue for operations	520,257	-	564,643	-
Net decrease in line of credit	(299,988)	-	(90,670)	-
Medical office building, net	(4,695,700)	-	(4,536,814)	-
Other nonoperating revenue	251,407	-	217,906	-
Net cash used in noncapital financing activities	(4,224,024)	-	(3,844,935)	-
Cash flows from capital financing activities:				
District tax revenue for debt services	1,376,890	-	1,306,715	-
Capital grants and contributions	53,038	(200,000)	131,212	(100,000)
Principal paid on long-term debt	(1,240,000)	-	(1,140,000)	-
Principal paid on capital lease obligations	(961,992)	-	(1,247,461)	-
Interest paid	(2,273,978)	-	(2,484,779)	-
Payments for purchase of property and equipment	(2,135,487)	-	(2,012,285)	-
Net cash used in capital and related financing activities	(5,181,529)	(200,000)	(5,446,598)	(100,000)
Cash flows from investing activites:				
Interest received	150,459	46	129,797	74
Net sales (purchases) of assets limited as to use	(958,954)	-	(3,488,605)	-
Partnership earnings received	66,526	-	133,052	-
Net cash provided by (used in) investing activites	(741,969)	46	(3,225,756)	74
Net increase (decrease) in cash and cash equivalents	4,374,359	(51,778)	(357,531)	49,110
Cash and cash equivalents at beginning	1,342,272	109,835	1,699,803	60,725
Cash and cash equivalents at end	$ 5,716,631	$ 58,057	$ 1,342,272	$ 109,835

Northern Inyo Healthcare District

Statements of Cash Flows (Continued)

Error! Reference source not found. Ended June 30, 2015 and 2014

	2015		2014	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Reconciliation of income from operations to net cash provided by operating activities:				
Income from operations	$ 7,115,445	$ 130,773	$ 7,068,299	$ 131,285
Adjustments to reconcile income from operations to net cash provided by operating activities:				
Depreciation and amortization	4,955,527	17,403	5,197,825	17,751
Provision for bad debts	3,567,339	-	4,041,566	-
Loss on sale of asset	7,960	-	-	-
Changes in operating assets and liabilites:				
Receivables:				
Patient - Net	(3,088,069)	-	(4,013,509)	-
Other	(11,708)	-	190,586	-
Inventories	(237,364)	-	124,940	-
Prepaid expense and deposits	(126,276)	-	(152,570)	-
Accounts payable	(125,750)	-	91,602	-
Accrued payroll and related liabilities	725,554	-	130,236	-
Estimated third-party settlements payor settlements	2,124,339	-	(519,217)	-
Net pension liability and related deferred inflows/outflows	(385,116)	-	-	-
Total adjustments	7,406,436	17,403	5,091,459	17,751
Net cash provided by operating activities	$ 14,521,881	$ 148,176	$ 12,159,758	$ 149,036

Northern Inyo Healthcare District

Statement of Net Position of Pension Trust Fund

Year Ended December 31, 2015

Assets		
Assets:		
Fixed dollar account	$	19,938,730
Indexed bond fund		10,529,895
TOTAL ASSETS	$	30,468,625
Net Position		
Net position		
Net position held in trust for pension benefits	$	30,468,625
TOTAL NET POSITION	$	30,468,625

See accompanying notes to financial statements

Northern Inyo Healthcare District

Statement of Changes in Net Position of Pension Trust Fund

Year Ended December 31, 2015

Additions:		
Employer contributions	$	4,236,000
Return on plan assets		1,575,309
Total additions		5,811,309
Deductions:		
Benefits paid		9,172,910
Total deductions		9,172,910
Change in net postion		(3,361,601)
Net position at beginning		33,830,226
Net position at end	$	30,468,625

See accompanying notes to financial statements

Northern Inyo Healthcare District

Notes to Financial Statements

Note 1 Summary of Significant Accounting Policies

Reporting Entity

Northern Inyo Healthcare District (the "District") was organized in 1946 under the terms of the Local Health Care District Law and is operated and governed by an elected Board of Directors. The District includes a 25-bed acute care facility that provides inpatient, outpatient, emergency care services, and a rural health clinic in Bishop, California and its surrounding area.

Northern Inyo Hospital Foundation, Inc. (the "Foundation") is a legally separate, 501(c)(3) tax-exempt, nonprofit public benefit corporation. The Foundation acts primarily as a fund-raising organization to supplement the resources that are available to the District. Although the District does not control the timing or amount of receipts from the Foundation, the majority of the resources, or income thereon that the Foundation holds and invests, are restricted to the activities of the District by the Foundation's bylaws. The Foundation's Board of Directors may also restrict the use of such funds for capital asset replacement, expansion, or other specific purposes. The District shall appoint the board of directors for the Foundation per the Foundation bylaws, and for this reason it is a blended component unit of the District.

Northern Inyo Hospital Auxiliary, Inc. (the "Auxiliary") is also a legally separate, 501(c)(3) tax-exempt, public benefit corporation. The Auxiliary's actions are subject to the approval of the District, and for this reason is a blended component unit of the District.

Discretely Presented Component Unit

The Pioneer Medical Associates (PMA) is a partnership established by a group of physician and practitioners in 1986 on hospital property at 152 Pioneer Lane. In an effort to support the continued recruitment for physicians and services, it has been the practice of Northern Inyo Healthcare District to work with the PMA partners when appropriate and directed by the Board of Directors, to purchase practices of individuals or groups who are leaving the area or retiring. The District currently owns a 66.67% interest in the partnership through acquisitions. PMA is reported in a separate column in the accompanying financial statements to emphasize that it is legally separate from the District. Separate financial statements for the component unit are not available.

Note 1 Summary of Significant Accounting Policies (Continued)

Basis of Presentation

The financial statements have been prepared in accordance with the accounting principles generally accepted in the United States (GAAP) as prescribed by Governmental Accounting Standards Board (GASB).

Use of Estimates in Preparation of Financial Statements

The preparation of the accompanying financial statements in conformity with GAAP requires management to make estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

The District considers critical accounting estimates to be those that require more significant judgments and include the valuation of accounts receivable, including contractual allowances and provision for uncollectible accounts, estimated third-party payor settlements, and an estimate for claims incurred but not reported under a self-funded health insurance plan.

Cash and Cash Equivalents

The District considers all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents, excluding assets limited as to use.

The District is authorized under California Government Code to make direct investments in local agency bonds, notes, or warrants within the state; U.S. Treasury instruments; registered state warrants or treasury notes; securities of the U.S. Government or its agencies; bankers' acceptances; commercial paper; certificates of deposit placed with commercial banks and/or savings and loan companies; repurchase or reverse repurchase agreements; medium-term corporate notes; shares of beneficial interest issued by diversified management companies, certificates of participation, obligations with first priority security; and collateralized mortgage obligations.

Note 1 Summary of Significant Accounting Policies (Continued)

Cash and Cash Equivalents (Continued)

All investments are stated at fair value. Investment gain (loss) includes changes in fair value of investments, interest, and realized gains and losses.

Patient Receivables and Credit Policy

Patient receivables are uncollateralized patient obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' behalf, or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed, and patients are billed for copay and deductible amounts that are the patient's responsibility. Payments on patient receivables are applied to the specific claim identified on the remittance advice or statement. The District does not have a policy to charge interest on past due accounts.

The carrying amounts of patient receivables are reduced by allowances that reflect management's best estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross revenue and a credit to patient receivables. In addition, management provides for probable uncollectible amounts, primarily from uninsured patients and amounts patients are personally responsible for, through a reduction of gross revenue and a credit to the allowance for uncollectible accounts based on its assessment of historical collection likelihood and the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the allowance for uncollectible accounts and a credit to patient receivables.

Patient receivables are recorded in the accompanying statements of net position net of contractual adjustments and an allowance for uncollectible accounts.

Note 1 Summary of Significant Accounting Policies (Continued)

Investment in PMA

Investment in a partnership is carried at the District's equity in the partnership's net assets. The partnership was organized to provide real estate for Pioneer Medical Associates (PMA). Ownership of the partnership consists of the District and local physicians.

Goodwill in PMA

Goodwill represents the excess of purchase price of an acquired business over the identifiable intangible assets acquired and liabilities assumed in connection with the acquisition of practices in the PMA. The District reviews for impairment of goodwill on an annual basis and is amortized when a change in the expected duration of the intangible asset has occurred. No goodwill impairment was recognized in 2014 and 2013.

Inventory

Inventory is valued at the average unit cost, determined using the average of cost per unit extended by inventory quantity.

Assets Limited as to Use

Assets limited as to use include assets held under indenture agreements, assets held to service debt under the bond issue, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

Capital Assets and Depreciation

Capital assets are recorded at cost if purchased or fair value at date received if contributed. The District maintains a threshold level of a unit or group cost of $5,000 or more for capitalizing capital assets. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Estimated useful lives range from 2 to 25 years for land improvements, buildings and improvements, leasehold improvements, and fixed equipment, and from 3 to 20 years for equipment.

Note 1 Summary of Significant Accounting Policies (Continued)

Accreted Interest

Interest expense on capital appreciation bonds are being accreted on the straight line basis to maturity of the individual bonds.

Asset Impairment

Capital assets are reviewed for impairment when events or changes in circumstances suggest that the service utility of the capital asset may have significantly and unexpectedly declined. Capital assets are considered impaired if both the decline in service utility of the capital asset is large in magnitude and the event or change in circumstance is outside the normal life cycle of the capital asset. Such events or changes in circumstances that may be indicative of impairment include evidence of physical damage, enactment, or approval of laws or regulations or other changes in environmental factors, technological changes or evidence of obsolescence, changes in the manner or duration of use of a capital asset, and construction stoppage. The determination of the impairment loss is dependent upon the event or circumstance in which the impairment occurred. Impairment losses, if any, are recorded in the statements of revenue, expenses, and changes in net position. There were no impairment losses recorded in the years ended June 30, 2015 and 2014.

Compensated Absences

The District accrues all leave time for employees as Paid Time-Off (PTO) and is accrued in the financial statements. In addition, employees hired prior to January 1, 2003, may have accumulated additional sick leave for major medical health problems. Usage of the additional sick leave must be approved by management. The total potential liability to the District for major medical is approximately $358,896 and $514,843 for the years ended June 30, 2015 and 2014. Such benefits do not vest; therefore, no liability has been accrued.

Note 1 Summary of Significant Accounting Policies (Continued)

Retirement Plan

For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the pension net position of the Northern Inyo County Local Hospital District Retirement Plan ("the Plan") and additions to/deductions from the Plans' pension net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Net Position

Net position of the District is classified in four components. Net investment in capital assets consists of capital assets net of accumulated depreciation reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted for debt service is cash that must be used for payments towards debt service. Restricted for programs is cash that must be used for nursing scholarships, as specified by contributors external to the District. Restricted nonexpendable net position is the minority interest of the partnership's net position. Unrestricted is remaining net position that does not meet the definitions above.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

Note 1 Summary of Significant Accounting Policies (Continued)

Electronic Health Record Incentive Funding

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for incentive payments under the Medicare and Medi-Cal programs for certain hospitals and physician practices that demonstrate meaningful use of certified electronic health records (EHR) technology. These provisions of ARRA, collectively referred to as the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") are intended to promote the adoption and meaningful use of health information technology and qualified EHR technology.

The District recognizes revenue for EHR incentive payments when there is reasonable assurance that the District will meet the conditions of the program, primarily demonstrating meaningful use of certified EHR technology for the applicable period. The demonstration of meaningful use is based on meeting a series of objectives. Meeting the series of objectives in order to demonstrate meaningful use becomes progressively more stringent as its implementation is phased in through stages as outlined by the Centers for Medicare and Medicaid Services (CMS).

Amounts recognized under the Medicare and Medi-Cal EHR incentive programs are based on management's best estimates. Management uses EHR incentive program guidelines to calculate the estimates which may include cost report data that is subject to audit by fiscal intermediaries.

Accordingly, amounts recognized are subject to change. In addition, the District's attestation of its compliance with the meaningful use criteria is subject to audit by the federal government or its designee.

The District incurs both capital expenditures and operating expenses in connection with the implementation of its EHR initiative. The amount and timing of these expenditures does not directly correlate with the timing of the District's receipt or recognition of the EHR incentive payments.

Note 1 Summary of Significant Accounting Policies (Continued)

Charity Care

The District provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District maintains records to identify the amount of charges forgone for services and supplies furnished under the charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Operating Revenue and Expenses

The District's statements of revenue, expenses, and changes in net position distinguish between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing health care services. Nonexchange revenue, including taxes, investment gain, grants, contributions received for purposes other than capital asset acquisition, and certain other revenue, are reported as nonoperating revenue. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

District Property Tax Revenue

The District has the authority to impose taxes on property within the boundaries of the health care district. Taxes are received from Inyo County (the "County"), which bills and collects the taxes for the District. Secured property taxes attach as an enforceable lien on property as of January 1 and are payable in two installments on November 1 and February 1.

Note 1 Summary of Significant Accounting Policies (Continued)

Grants and Contributions

The District receives grants as well as contributions from individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue (expenses).

Advertising Costs

Advertising costs are expensed as incurred. Advertising expense totaled approximately $23,000 and $108,000 in 2015 and 2014, respectively.

Tax Status

The District is a local agency of the State of California within the meaning of Section 56054 of the California Government Code. Accordingly, the District is exempt from federal income and state income, property, and franchise taxes.

Unemployment Compensation

The District is a part of a pooled unemployment insurance group through California Association of Hospital and Healthcare Systems (CAHHS) for unemployment insurance and do not pay state unemployment tax.

Note 1 Summary of Significant Accounting Policies (Continued)

New Accounting Pronouncements

GASB Statement No. 67, *Financial Reporting for Pension Plans—an amendment of GASB Statement No. 25*, will improve financial reporting primarily through enhanced note disclosures and schedules of required supplementary information that will be presented by the pension plans that are within its scope. The new information will enhance the decision-usefulness of the financial reports of these pension plans, their value for assessing accountability, and their transparency by providing information about measures of net pension liabilities and explanations of how and why those liabilities changed from year to year. The provisions of this statement have been implemented in the financial statements for the fiscal year ending June 30, 2015.

GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* (GASB 68), establishes new financial reporting requirements for most governments that provide their employees with pension benefits through these types of plans. GASB 68 will be effective for the District beginning with its year ending June 30, 2015. GASB 68 replaces the requirements of GASB Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers,* and GASB Statement No. 50, *Pension Disclosures,* as they relate to governments that provide pensions through pension plans administered as trusts or similar arrangements that meet certain criteria. GASB 68 requires governments providing defined benefit pensions to recognize their long-term obligation for pension benefits as a liability for the first time, and to more comprehensively and comparably measure the annual costs of pension benefits. The statement also enhances accountability and transparency through revised and new note disclosures and required supplementary information. The District has not determined the impact of this statement. In the year ended June 30, 2015, the District adopted Statement No. 68 and restated the opening net position as of July 1, 2014, net pension liability for benefits of $19,837,756.

Subsequent Events

Subsequent events have been evaluated through December 8, 2015, which is the date the financial statements were available to be issued.

Note 2 Reimbursement Arrangements With Third-Party Payors

The District has agreements with third-party payors that provide for reimbursement to the District at amounts that vary from its established rates. A summary of the basis of reimbursement with major third-party payors follows:

Hospital

Medicare - The Medicare program has designated the District as a critical access hospital (CAH) for Medicare reimbursement purposes. Under this designation, District inpatient, outpatient, and swing-bed services rendered to Medicare program beneficiaries are paid based upon a cost-reimbursement methodology with the exception of certain lab and mammography services which are reimbursed based on fee schedules.

Medi-Cal - Under CAH designation, District inpatient and swing-bed services rendered to Medi-Cal program beneficiaries are paid based upon a cost-reimbursement methodology. The reimbursement for outpatient services is based upon a fee schedule. The District also applies for and receives supplemental reimbursement for its inpatient and outpatient services. The supplemental reimbursement is based upon a cost reimbursement methodology.

Physician and Professional Services in Rural Health Clinics

Certain physician and professional services rendered to Medicare and Medi-Cal beneficiaries qualify for reimbursement as Medicare-approved rural health clinic services. Qualifying services are reimbursed based on a cost-reimbursement methodology.

Other

The District has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes discounts from established charges and prospectively determined daily rates.

Note 2 Reimbursement Arrangements With Third-Party Payors (Continued)

Accounting for Contractual Arrangements

The District is reimbursed for certain cost reimbursable items at an interim rate, with final settlements determined after an audit of the District's related annual cost reports by the respective Medicare and Medi-Cal fiscal intermediaries. Estimated provisions to approximate the final expected settlements after review by the intermediaries are included in the accompanying financial statements. The cost reports for the District have been audited by Medicare and Medi-Cal through June 30, 2012 and 2011, respectively.

Medi-Cal Electronic Health Record Incentive Funding

During 2013, the District received funding from Medi-Cal under the eligible hospital EHR incentive program. The funding period for the Medi-Cal EHR incentive program is based on eligible hospitals submitting applications to the Medi-Cal program each year for four years. It was determined by Medi-Cal that the District was entitled to approximately $1,390,000 in funding in 2013 and the District has recognized this amount in other operating revenue in the accompanying financial statements. The District anticipates that additional funding will be available from the Medi-Cal EHR incentive program in subsequent years and will record amounts when future applications are filed and funding can reasonably be determined.

Compliance

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, particularly those relating to the Medicare and Medi-Cal programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Violation of these laws and regulations could result in the imposition of fines and penalties, as well as repayments of previously billed and collected revenue from patient services. Management believes the District is in substantial compliance with current laws and regulations.

Note 2 Reimbursement Arrangements With Third-Party Payors (Continued)

Compliance (Continued)

CMS uses recovery audit contractors (RACs) to search for potentially inaccurate Medicare payments that may have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. As of June 30, 2015, the District has not been notified by the RAC of any potential significant reimbursement adjustments.

Note 3 Cash, Cash Equivalents, and Investments

Deposits

Custodial Credit Risk - Custodial credit risk is the risk that, in the event of a bank failure, the District's deposits may not be returned. The District does not have a deposit policy for custodial credit risk.

The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure public deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits and letters of credit issued by the Federal Home Loan Bank of San Francisco having a value of 105% of the secured deposits.

At June 30, 2015, the net carrying amount of deposits was $5,507,024 and the bank balance was $6,673,501. Of the bank balance, $250,000 was covered by federal deposit insurance and $6,423,501 was collateralized (i.e., collateralized with securities held by the pledging financial institutions of at least 110% of the District's cash deposits, in accordance with the California Government Code).

Note 3 Cash, Cash Equivalents, and Investments (Continued)

Investments

Interest Rate Risk – As a means of limiting its exposure to fair value losses arising from rising interest rates, the District's investment policy includes its investment portfolio to the Local Agency Investment Guidelines promulgated by the California Debt & Investment Advisory Commission.

The District is a participant in the Local Agency Investment Fund (LAIF) which is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the State of California. The fair value of the District's investment in this pool is reported in the accompanying financial statements at amounts based upon the District's pro rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis. The LAIF investment portfolio consists primarily of treasury bills, notes, and certificates of deposit.

Investments included in assets limited as of use consisted of the following at June 30:

		Remaining Maturity (in Years)			
	Fair Value	0-1	1-5	5-10	More Than 10
2015:					
Certificates of deposit	$ 1,002,190	$ 151,451	$ 850,739	$ -	$ -
LAIF	11,042,457	11,042,457	-	-	-
Total	$ 12,044,647	$ 11,193,908	$ 850,739	$ -	$ -
2014:					
Certificates of deposit	$ 902,141	$ 100,000	$ 802,141	$ -	$ -
LAIF	10,838,249	10,838,249	-	-	-
Total	$ 11,740,390	$ 10,938,249	$ 802,141	$ -	$ -

Note 3 Cash, Cash Equivalents, and Investments (Continued)

Investments (Continued)

Employees' Retirement System - The District's governing body has the responsibility and authority to oversee the investment portfolio. Various professional investment managers are contracted to assist in managing the District's investments; all investment decisions are subject to California law and the investment policy established by the governing body. The District's investments are held by an independent trust company.

The District's retirement system investments are stated at fair value which is determined as follows: (a) short-term investments are reported at cost, which approximates fair value; (b) securities traded on a national or international exchange are valued at the last reported sales price at current exchange rates; (c) investments for which market quotations are not readily available are valued at their fair values as determined by the custodian under the direction of the District's governing body, with the assistance of a valuation service; and (d) cash deposits are reported at carrying amounts which reasonably approximates fair value.

Following is a summary of the District's investments as of June 30, 2015: (investments at fair value, as determined by quoted market price).

	2015	2014
Fixed dollar	19,938,730	23,872,677
Indexed bond fund	10,529,895	9,957,549
Total	30,468,625	33,830,226

Credit Risk - Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by assignment of a rating by a nationally recognized statistical rating organization. The District has an investment policy that limits its investment choices by credit rating. LAIF is not rated.

Note 3 Cash, Cash Equivalents, and Investments (Continued)

Investments (Continued)

Concentration of Credit Risk - The California Government Code limits the purchase of certain investments to defined percentages of the investment portfolio.

Custodial Credit Risk - For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to the transaction, the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The District's investment policy does not limit the exposure to custodial credit risk for investments. All investments are held by the District's agent in the District's name, and therefore, are not exposed to custodial risk.

Note 4 Assets Limited as to Use

Assets limited as to use that are required for obligations classified as current liabilities are reported in current assets. Investments designated as assets limited as to use are stated at fair value.

Assets limited as to use consisted of the following at June 30:

	2015	2014
LAIF Investements:		
Board designated - Capital improvements	$ 10,733,335	$ 10,838,249
Internal designated - Pension plan	309,122	-
Total LAIF investments	11,042,457	10,838,249
Cash and money market accounts:		
External restrictions:		
Bond payment funds - Under indenture agreement	2,660,378	2,635,145
Nursing scholarship fund	17,679	25,123
Bonds and interest	875,662	819,275
Board designations:		
Internally designated for capital acquisitions	1,124,210	1,033,639
Fixed income, corporate bonds - Future operations	528,660	550,996
Certificates of deposit - Future operations	1,002,190	389,855
Total cash and money market accounts	6,208,779	5,454,033
Total assets limited as to use	17,251,236	16,292,282
Less - Current portion	1,470,000	1,240,000
Noncurrent assets limited as to use	$ 15,781,236	$ 15,052,282

Note 5 Patient Receivables - Net

Patient receivables - net consisted of the following at June 30:

	2015	2014
Patient receivables	$ 20,424,778	$ 20,775,356
Less:		
Contractual adjustments	8,662,776	8,516,940
Allowance for uncollectible accounts	1,016,802	1,033,946
Patient receivables - Net	$ 10,745,200	$ 11,224,470

Note 6 Net Patient Service Revenue

Net patient service revenue consisted of the following for the years ended June 30:

	2015	2014
Gross patient service revenue:		
Inpatient services	$ 41,625,191	$ 36,039,746
Outpatient services	83,523,572	80,613,628
Totals	125,148,763	116,653,374
Less:		
Contractual adjustments	50,787,264	43,363,832
Provision for uncollectible accounts	3,567,339	4,041,566
Net patient service revenue	$ 70,794,160	$ 69,247,976

Note 6 Net Patient Service Revenue (Continued)

The following table reflects the percentage of gross patient service revenue by payor source for the years ended June 30:

	2015	2014
Medicare	43%	44%
Medi-Cal	22%	19%
Other third-party payors	31%	31%
Patients	4%	6%
Totals	100%	100%

Note 7 Charity Care

The District provides health care services and other financial support through various programs that are designed, among other matters, to enhance the health of the community including the health of low-income patients. Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources.

Patients who meet certain criteria for charity care, generally based on federal poverty guidelines, are provided care based on criteria defined in the District's charity care policy. The District maintains records to identify and monitor the level of charity care it provides. The amount of charges foregone for services and supplies furnished under the District's charity care policy aggregated approximately $1,215,123 and $1,877,000 for the years ended June 30, 2015 and 2014, respectively.

The estimated cost of providing care to patients under the District's charity care policy aggregated approximately $646,000 and $1,007,000 in 2015 and 2014, respectively. The cost was calculated by multiplying the ratio of cost to gross charges for the District times the gross uncompensated charges associated with providing charity care.

Note 8 Capital Assets

The District's capital assets activity consisted of the following for the years ended June 30:

	2015				
	Balance July 1, 2014	Additions	Transfers and Adjustments	Deletions	Balance June 30, 2015
Nondepreciable capital assets:					
Land	$ 735,330	$ -	$ -	$ -	$ 735,330
Construction in progress	352,021	462,089	(521,988)	-	292,122
Total nondepreciable capital assets	1,087,351	462,089	(521,988)	-	1,027,452
Depreciable capital assets:					
Land improvements	860,394	3,191	-	-	863,585
Buildings	88,071,712	34,376	63,195	(52,899)	88,116,384
Equipment	28,972,326	1,635,831	454,919	(1,303,470)	29,759,606
Total depreciable capital assets	117,904,432	1,673,398	518,114	(1,356,369)	118,739,575
Less - Accumulated depreciation	28,950,855	4,974,125	-	(1,276,278)	32,648,702
Net depreciable capital assets	88,953,577	(3,300,727)	518,114	(80,091)	86,090,873
Totals	$ 90,040,928	$ (2,838,638)	$ (3,874)	$ (80,091)	$ 87,118,325

At June 30, 2015, construction in progress consisted of Kronos Module, rural health clinic construction, and hospital repairs and remodeling. All of the projects are expected to be completed during 2016. The estimated completion costs of the projects are approximately $127,000. The District is considering funding alternatives including LAIF Walker Fund and internal funding.

Note 8 Capital Assets (Continued)

	2014				
	Balance July 1, 2013	Additions	Transfers and Adjustments	Deletions	Balance June 30, 2014
Nondepreciable capital assets:					
Land	$ 735,330	$ -	$ -	$ -	$ 735,330
Construction in progress	332,022	442,211	(422,212)	-	352,021
Total nondepreciable capital assets	1,067,352	442,211	(422,212)	-	1,087,351
Depreciable capital assets:					
Land improvements	854,630	5,764	-	-	860,394
Buildings	87,555,050	516,662	-	-	88,071,712
Equipment	31,234,386	1,047,648	422,212	(3,731,920)	28,972,326
Total depreciable capital assets	119,644,066	1,570,074	422,212	(3,731,920)	117,904,432
Less - Accumulated depreciation	27,429,943	5,197,825	-	(3,676,913)	28,950,855
Net depreciable capital assets	92,214,123	(3,627,751)	422,212	(55,007)	88,953,577
Totals	$ 93,281,475	$ (3,185,540)	$ -	$ (55,007)	$ 90,040,928

Note 8 Capital Assets

The PMA's capital assets activity consisted of the following for the years ended June 30:

	2015			
	Balance July 1, 2014	Additions	Deletions	Balance June 30, 2015
Nondepreciable capital assets - Land	$ 341,260	$ -	$ -	$ 341,260
Total nondepreciable capital assets	341,260	-	-	341,260
Depreciable capital assets - Buildings	1,043,214	-	-	1,043,214
Less - Accumulated depreciation	783,544	17,403	-	800,947
Net depreciable capital assets	259,670	(17,403)	-	242,267
Totals	$ 600,930	$ (17,403)	$ -	$ 583,527

	2014			
	Balance July 1, 2013	Additions	Deletions	Balance June 30, 2014
Nondepreciable capital assets - Land	341,260	$ -	$ -	$ 341,260
Total nondepreciable capital assets	341,260	-	-	341,260
Depreciable capital assets - Buildings	1,043,214		-	1,043,214
Less - Accumulated depreciation	765,793	17,751	-	783,544
Net depreciable capital assets	277,421	(17,751)	-	259,670
Totals	$ 618,681	$ (17,751)	$ -	$ 600,930

Note 9 Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations activity for the years ended June 30 was as follows:

	2014	Additions	Reductions	2015	Current Due
Bonds payable:					
General Obligation Bonds, 2005 Series	$ 14,200,000	$ -	$ (165,000)	$ 14,035,000	$ 195,000
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	6,140,000	-	(190,000)	5,950,000	265,000
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	-
Revenue Bonds, 2010 Series	9,990,000	-	(590,000)	9,400,000	620,000
Revenue Bonds, 2013 Series	11,020,000	-	(295,000)	10,725,000	310,000
Sub total bonds payable	49,494,947	-	(1,240,000)	48,254,947	1,390,000
Bond premiums:					
General Obligation Bonds:					
2005 Series	305,004	-	(14,466)	290,538	-
2009 Series	691,142	-	(37,645)	653,497	-
Revenue Bonds, 2013 Series	203,220	-	(15,053)	188,167	-
Total bonds payable	50,694,313	-	(1,307,164)	49,387,149	1,390,000
Accreted interest - General Obligation Bonds, 2009 Series, Capital Appreciation Bonds	6,887,339	1,326,585	-	8,213,924	-
Capital leases obligations:					
Bank of the West-Trinity McKesson Paragon	1,232,828	-	(415,369)	817,459	436,567
Bank of the West-Taycor Turner Log Hospital Equipment	352,804	-	(123,227)	229,577	128,949
Bank of the West-Trinity Hospital Equipment	766,534	-	(228,715)	537,819	240,788
GE Financing 2	482,995	-	(138,422)	344,573	143,346
GE Financing 3	224,891	-	(56,259)	168,632	58,307
Total capital leases payable	3,060,052	-	(961,992)	2,098,060	1,007,957
Total long-term debt, capital leases payable, and other noncurrent liabilities	$ 60,641,704	$ 1,326,585	$ (2,269,156)	$ 59,699,133	$ 2,397,957

Note 9 Long-Term Debt and Capital Lease Obligations (Continued)

	2013	Additions	Reductions	2014	Current Due
Bonds payable:					
General Obligation Bonds, 2005 Series	$ 14,340,000	$ -	$ (140,000)	$ 14,200,000	$ 165,000
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	6,260,000	-	(120,000)	6,140,000	190,000
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	-
Revenue Bonds, 2010 Series	10,555,000	-	(565,000)	9,990,000	590,000
Revenue Bonds, 2013 Series	11,335,000	-	(315,000)	11,020,000	295,000
Sub total bonds payable	50,634,947	-	(1,140,000)	49,494,947	1,240,000
Bond premiums:					
General Obligation Bonds:					
2005 Series	319,471	-	(14,467)	305,004	-
2009 Series	770,885	-	(79,743)	691,142	-
Revenue Bonds, 2013 Series	218,273	-	(15,053)	203,220	-
Total bonds payable	51,943,576	-	(1,249,263)	50,694,313	1,240,000
Accreted interest - General Obligation Bonds, 2009 Series, Capital Appreciation Bonds	5,560,754	1,326,585	-	6,887,339	-
Capital leases obligations:					
GE Financing	368,574	-	(368,574)	-	-
Bank of the West-Trinity McKesson Paragon	1,627,524	-	(394,696)	1,232,828	415,368
Bank of the West-Taycor Turner Log Hospital Equipment	470,128	-	(117,324)	352,804	123,226
Bank of the West-Trinity Hospital Equipment	960,084	-	(193,550)	766,534	228,715
GE Financing 2	609,434	-	(126,439)	482,995	138,423
GE Financing 3	271,769	-	(46,878)	224,891	56,260
Total capital leases payable	4,307,513	-	(1,247,461)	3,060,052	961,992
Total long-term debt, capital leases payable, and other noncurrent liabilities	$ 61,811,843	$ 1,326,585	$ (2,496,724)	$ 60,641,704	$ 2,201,992

Note 9 Long-Term Debt and Capital Lease Obligations (Continued)

The terms and due dates of the District's long-term debt and capital lease obligations at June 30, 2015, follow:

Long-Term Debt

General Obligation Bonds, 2005 Series

On September 28, 2005, the District issued $15,035,000 in General Obligation Bonds, 2005 election, 2005 Series to finance the expanding, equipping, and upgrading of hospital facilities. The 2005 bonds are comprised of two types of bonds, Current Interest Serial Bonds and Current Interest Term Bonds, issued in the amounts of $7,845,000 and $7,190,000, respectively.

Interest on the Current Interest Serial Bonds is payable semiannually on May 1 and November 1 at rates of 4.25% to 6.00%. The Current Interest Serial Bonds mature annually commencing on November 1, 2006 through November 1, 2030, in amounts ranging from $25,000 to $995,000. Interest on the Current Interest Term Bonds is payable semiannually at 5.60%. The Current Interest Term Bonds mature annually commencing on November 1, 2031 through August 1, 2035, in amounts ranging from $1,100,000 to $1,790,000.

The Current Interest Serial Bonds maturing on or after November 1, 2016, may be called by the District on or after November 1, 2015.

General Obligation Bonds, 2009 Series

On April 21, 2009, the District issued $14,464,947 in General Obligation Bonds, 2005 Election, 2009 Series to finance the construction and equipping of an expansion and renovation of the Hospital. The 2009 bonds are comprised of two types of bonds, Current Interest Bonds and Capital Appreciation Bonds, issued in the amounts of $6,320,000 and $8,144,947, respectively.

Note 9 Long-Term Debt and Capital Lease Obligations (Continued)

Interest on the Current Interest Bonds is payable semiannually on May 1 and November 1 at 5.75%. Current Interest Bonds mature annually commencing on November 1, 2012 through November 1 2019, in amounts ranging from $60,000 to $865,000 as well as a bond maturing on November 1, 2038 for $3,150,000. Interest on the Capital Appreciation Bonds is accreted annually and paid at maturity. The Capital Appreciation Bonds mature annually commencing on November 1, 2020 through November 1, 2038, in amounts ranging from $1,020,000 to $3,420,000, inclusive of interest accreted through such maturity dates.

The Current Interest Bonds maturing on November 1, 2038, may be called by the District beginning November 1, 2017. The Capital Appreciation Bonds are not subject to redemption prior to their fixed maturity dates.

Revenue Bonds, 2010 Series

On April 14, 2010, the District issued $11,600,000 in Revenue Bonds, 2010 Series to finance the replacement hospital, to finance the bond reserve account, and to pay certain costs of issuance related to the 2010 Bonds.

Interest on the 2010 Bonds is payable semiannually on June 1 and December 1 at rates ranging from 5.00% to 6.375%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates ranging from $510,000 to $1,145,000 are due annually through December 2025.

The 2010 Bonds maturing on December 1, 2015, may be called by the District beginning December 1, 2011.

The District is required to maintain certain covenants and provide various reporting under the agreement. Management believes the District is in compliance with all covenants at June 30, 2014.

Note 9 Long-Term Debt and Capital Lease Obligations (Continued)

Revenue Bonds, 2013 Series

On January 17, 2013, the District issued $11,335,000 in Revenue Bonds, 2013 Series to finance the replacement hospital, to finance the bond reserve account, and to pay certain costs of issuance related to the 2013 Bonds.

Interest on the 2013 Bonds is payable annually on December 1 at rates ranging from 3.875% to 5.00%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates ranging from $295,000 to $1,805,000 are due annually through December 2029.

The 2013 Bonds maturing on December 1, 2027, may be called, without premium, by the District on December 1, 2013 through December 1, 2015.

Capital Lease Obligations

Lease obligation to GE Government Finance Inc. leases due in total monthly installments of $62,213 in March 2007 through 2013, collateralized by equipment at a cost of $3,712,016 and is fully depreciated. The lease obligation was paid in full in December 2013.

Lease obligation to Bank of the West Taycor due in monthly installments of $11,394 in 2012 through 2017, including interest at 4.548% collateralized by equipment at a cost of $612,754 and related accumulated amortization of $88,607.

The District has two Bank of the West Trinity leases due in total monthly installments of $60,877 in March 2012 through 2018, collateralized by equipment at a cost of $2,839,609 and related accumulated amortization of $576,264.

Lease obligation to GE Government Finance Inc. (No. 2) leases due in total monthly installments of $5,289 in March 2013 through 2018, collateralized by equipment at a cost of $290,000 and related accumulated amortization of $33,021.

Note 9 Long-Term Debt and Capital Lease Obligations (Continued)

Capital Lease Obligations (Continued)

Lease obligation to GE Government Finance Inc. (No. 3) leases due in total monthly installments of $12,754 in September 2012 through 2017, collateralized by equipment at a cost of $700,719 and related accumulated amortization of $71,282.

Lease obligation to Healthcare Capital due in total monthly installments of $33,590 in 2009 through 2013, collateralized by equipment at a cost of $1,138,630 and is fully accumulated.

Scheduled principal and interest repayments on long-term obligations are as follows as of June 30, 2015:

	Long-Term Debt		Capital Lease Obligations	
	Principal	Interest	Principal	Interest
2016	$ 1,390,000	$ 2,031,636	$ 1,007,957	$ 75,808
2017	1,647,187	1,958,757	943,892	27,751
2018	1,827,187	1,877,887	146,211	1,509
2019	2,012,187	1,790,252	-	-
2020	2,207,187	1,894,675	-	-
2021-2025	10,510,180	10,871,556	-	-
2026-2030	14,014,494	10,641,011	-	-
2031-2035	8,860,686	11,632,854	-	-
2036-2040	6,918,041	10,049,326	-	-
Totals	$ 49,387,149	$ 52,747,954	$ 2,098,060	$ 105,068

Note 10 Line of Credit

The District has a bank line of credit agreement with Oak Valley Community Bank that provides for maximum borrowing of $600,000 at 6.50% as of June 30, 2015 and 2014. The purpose of the line of credit is for the District to cover expenses incurred from the additional building added to the facility for physician practices. Line of credit activities as of June 30, was as follows:

	Beginning Balance	Additions	Reductions	Ending Balance
2015	$ 299,988	$ -	$ 299,988	$ -
2014	$ 390,658	$ -	$ 90,670	$ 299,988

Note 11 Leases

The District leases office space in a medical office building under a noncancelable operating lease as an agreement with PMA that expires in 2018.

The future required payments by year end in the aggregate under the noncancelable operating lease, as of June 30, 2015, are as follows:

2016	$ 106,845
2017	45,144
2018	762
2019	-
2020	-
Total minimum lease payments	$ 152,751

Total building rent expense for the years ended June 30, 2015 and 2014, was $1,043,850 and $1,068,150, respectively.

Note 12 Pledged Revenues

The District has pledged future revenues to repay $11,600,000 million in District revenue bonds issued in March 2010. Proceeds from the bonds are to provide a portion of the funding for its replacement hospital project. The bonds are payable solely from revenues and are payable through 2025. The total principal and interest remaining to be paid on the bonds is $12,983,794. Principal and interest paid for the current year and revenues were $1,178,188 and $71,823,552, respectively.

The District has pledged future revenues to repay $11,335,000 in District revenue bonds issued in January 2013. Proceeds from the bonds are to provide a portion of the funding for its remodeling, expansion, improvement and equipping of the facility. The bonds are payable solely from revenues and are payable through 2029. The total principal and interest remaining to be paid on the bonds is $15,757,753. Principal and interest paid for the current year and revenues were $772,672 and $71,823,552, respectively.

Note 13 Retirement Plans

Defined Benefit Plan

The District sponsors a defined benefit pension plan, a single employer defined benefit plan for employees over age 21 with at least one year of service. The plan is governed by the board of directors which may amend benefits and other plan provisions, and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels.

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full time employment. Members with five years of total service are eligible to retire at age 55 with statutorily reduced benefits. All members are eligible for pre-retirement death benefits after 5 years of service. The benefit vesting schedule is 50% vesting after 5 years increasing 10% per year to 100% vested after 10 years of service.

Note 13 Retirement Plans (Continued)

Defined Benefit Plan (Continued)

Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

The Plan's provisions and benefits in effect at June 30, 2015, are summarized as follows:

	"The Plan"
Hire date	Prior to January 1, 2013
Benefit payments	Life Annuity
Retirement age	65-70
Monthly benefits , as a % of eligible compensation	2.50%, not less than $600
Required employer contribution rates	22.1% of applicable payroll

Employees covered at January 1, 2015, that were covered by the benefit terms for the Plan are as follows:

	January 1, 2015
Inactive employees or beneficiaries currently receiving benefits	59
Active employees	266
Total	325

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the Plan is determined annually on an actuarial basis as of January 1 by the Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability.

Note 13 Retirement Plans (Continued)

Defined Benefit Plan (Continued)

The District's net pension liability for the Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the Plan is measured as of June 30, 2015, using an annual actuarial valuation as of January 1, 2015 rolled forward to June 30, 2015 using standard update procedures. A summary of principal assumptions and methods used to determine the net pension liability is shown below.

The total pension liabilities in the January 1, 2015 actuarial valuations were determined using the following actuarial assumptions:

	"The Plan"
Valuation Date (actuarial valuation date)	January 1, 2015
Measurement Date (net pension liability measured)	June 30, 2015
Actuarial Cost Method	Entry-Age Normal Cost Method
Actuarial Assumptions:	
Discount Rate	6.25%
Projected Salary Increase	4.00%
Investment Rate of Return	5.20%
Mortality	Based on Date of Participation (DOP*)

* DOP Before 7/1/2009: 1984 UP Mortality Table set back 4 years.
* DOP On/After 7/1/2009: RP-2000 Table for Males set back 4 years.

Note 13 Retirement Plans (Continued)

Defined Benefit Plan (Continued)

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Target Asset Allocation	Long-Term Expected Real Rate of Return
US Core Fixed Income	30%	4.95%
US High Yield Bonds	62%	7.32%
Private Real Estate Property	8%	6.49%
Total	100%	

Note 13 Retirement Plans (Continued)

Defined Benefit Plan (Continued)

The changes in the net pension liability of the Plan are as follows:

	Increase (Decrease)		
	Total Pension Liability	Plan Net Position	Net Pension Liability (Asset)
Balance as of June 30, 2014	$ 55,606,452	$ 35,768,696	$19,837,756
Changes in the Year:			
Service cost incurred	2,683,298	-	2,683,298
interest in total pension liability	3,356,235	-	3,356,235
Differences between actual and expected	108,261	-	108,261
Change in assumption	(1,841,294)	-	(1,841,294)
Benefit payments	(9,321,200)	-	(9,321,200)
Contribution - employer	-	4,320,000	(4,320,000)
Net investment income	-	1,223,136	(1,223,136)
Benefit payments	-	(9,321,200)	9,321,200
Current year net changes	(5,014,700)	(3,778,064)	(1,236,636)
Balance as of June 30, 2015	$ 50,591,752	$ 31,990,632	$ 18,601,120

Note 13 Retirement Plans (Continued)

Defined Benefit Plan (Continued)

The following presents the net pension liability of the District's Plan, calculated using the discount rate, as well as what the Districts net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate:

	"The Plan"
1% Decrease	5.25%
Net Pension Liability	$22,182,821
Current Discount Rate	6.25%
Net Pension Liability	$18,601,120
1% Increase	7.25%
Net Pension Liability	$15,327,293

For the year ended June 30, 2015, the District recognized pension expense of $3,934,884. At June 30, 2015, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Inflows of Resources	Deferred Outflows of Resources
Differences between actual and expected experience	-	96,097
Changes in assumptions	(1,634,407)	-
Net differences between projected and actual earnings on plan investments	-	-
	-	686,790
Total	(1,634,407)	782,887

Note 13 Retirement Plans (Continued)

Defined Benefit Plan (Continued)

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended June 30	Deferred Outflows	Deferred Inflows	Total
2016	$ 183,862	$ (206,887)	$ (23,025)
2017	183,862	(206,887)	(23,025)
2018	183,862	(206,887)	(23,025)
2019	183,860	(206,887)	(23,027)
2020	12,164	(206,887)	(194,723)
Thereafter	35,277	(599,972)	(564,695)
Total	$ 782,887	$ (1,634,407)	$ (851,520)

Note 13 Retirement Plans (Continued)

Defined Contribution Plan

The District sponsors and contributes to the Northern Inyo County Local Hospital District 401(a) Retirement Plan (NICLHD), a defined contribution pension plan, for its employees. The plan covers its employees who has attained the age of 21 years and was not a participant in the District's defined benefit plan prior to January 1, 2013, and completion of one year of service. NICLHD is administered by the District.

Benefit terms, including contribution requirements, for NICLHD are established and may be amended by the District board of directors. For each employee in the pension plan, the District is required to contribute as a percent of annual salary not to exceed 10% of net income, exclusive of overtime pay, to an individual employee account. Employees are not permitted to make contributions to the pension plan. For the year ended June 30, 2015 and 2014, the District recognized pension expense of $120,981 and $127,708, respectively.

Each Participant shall have a nonforfeitable and vested right to his or her account for each year of service completed while an employee of the employer, in accordance with the following schedule:

Years	Nonforfeitable percentage
5	50.0%
6	60.0%
7	70.0%
8	80.0%
9	90.0%
10 or more	100.0%

Nonvested District contributions are forfeited upon termination of employment. Such forfeitures are used to cover a portion of the pension plan's administrative expenses. There have been no forfeitures to date.

Note 14 Medical Office Building, Net

The District has a number of Board-approved management practice arrangements with physicians to provide services for primary care and specialty services in the district. These managed contracts are nonoperating activities of the District and are listed in the nonoperating section of the income statement. The hospital provides an income guarantee against net revenue while also providing all services for operating of the physician practices. The District has practice management agreements for the following physician practices: Family and Women's Clinic, Urology, Pediatrics, Obstetrics and Gynecology, Internal Medicine, Orthopedic Surgery, and General Surgery. The net cost of this activity is included under medical office building, net in the accompanying statements of revenue, expenses, and changes in net position for the years ended June 30, 2015 and 2014.

Note 15 Risk Management

The District is exposed to various risks of loss related to medical malpractice; torts; theft of, damage to, and destruction of assets; errors and omissions; injuries of employees; and natural disasters.

The District's comprehensive general liability insurance covers losses of up to $20,000,000 per claim with $30,000,000 annual aggregate for occurrence basis during a policy year regardless of when the claim was filed (occurrence-based coverage). The District's professional liability insurance covers losses up to $5,000,000 per claim with $5,000,000 annual aggregate for claims reported during a policy year (claims-made coverage). Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District.

Although there exists the possibility of claims arising from services provided to patients through June 30, 2015, which have not yet been asserted, the District is unable to determine the ultimate cost, if any, of such possible claims and, accordingly, no provision has been made for them. Settled claims have not exceeded commercial coverage in any of the three preceding years.

Note 15 Risk Management (Continued)

The District is a participant in the Association of California Healthcare Districts' ALPHA Fund which administers a self-insured workers' compensation plan for participating member hospitals and their employees. The District pays a premium to the ALPHA Fund which is adjusted annually. If participation in the ALPHA Fund is terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund.

Note 16 Self-Funded Insurance

The District has a self-funded health care plan that provides medical and dental benefits to employees and their dependents. Employees share in the cost of health benefits. Health care expense is based on actual claims paid, reinsurance premiums, administration fees, and unpaid claims at year-end. The District buys reinsurance to cover catastrophic individual claims over $90,000. The District records a liability for claims incurred but not reported that is recorded in accrued liabilities in the accompanying statements of net position. The following represents the health plan activity for the District and estimated claims outstanding at June 30:

	Beginning of Fiscal Year Liability	Current Year Claims and Changes in Estimates	Claim Payments	Balance at Fiscal Year End
2015	$ 1,271,299	$ 7,232,723	$ 6,803,218	$ 1,700,804
2014	$ 1,261,003	$ 5,091,033	$ 5,080,737	$ 1,271,299

Note 17 Functional Expenses

The District provides general health care services to residents within its geographic area. Expenses related to providing these services consisted of the following for the years ended June 30:

	2015	2014
Health care services	$ 55,820,707	$ 61,733,038
Management and administration	12,317,202	5,184,360
Total expenses	$ 68,137,909	$ 66,917,398

Note 18 Concentration of Credit Risk

Financial instruments that potentially subject the District to credit risk consist principally of patient receivables.

Patient receivables consist of amounts due from patients, their insurers, or governmental agencies (primarily Medicare and Medi-Cal) for health care provided to the patients. The majority of the District's patients are from Lake Arrowhead, California, and the surrounding area.

The mix of receivables from patients and third-party payors was as follows at June 30:

	2015	2014
Medicare	39%	24%
Medicaid, including CMSP	23%	34%
Other third-party payors	30%	27%
Patients	8%	15%
Totals	100%	100%

Note 19 Commitments and Contingencies

Litigation

The District may from time to time be involved in litigation and regulatory investigations which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters, if applicable, existing as of June 30, 2014, will be resolved without material adverse effect on the District's future financial position, results from operations, or cash flows.

Pollution Remediation Obligations

Pollution remediation obligations are triggered by an obligating event. An obligating event is when a government is compelled to take action to protect the public from pollution, has violated a pollution permit, license, or law, has or will be named in a law suit, or the government voluntarily engages in a clean-up. Management has considered this guidance specifically as it relates to its legal obligations related to asbestos removal on its existing properties. Management of the District believes there has not been an obligating event, and if there had been, the amount of the potential liability could not be reasonably estimated. Therefore, no obligations have been recorded for pollution remediation as of June 30, 2015 and 2014.

Seismic Compliance

Earthquakes affecting California hospitals have prompted the State of California to impose new hospital seismic safety standards pursuant to Senate Bill 1953 (SB 1953) adopted in 1998. Under these new standards, California hospitals will be required to meet stringent seismic safety criteria, which may necessitate major renovation in certain facilities or even partial or full replacement. The District's recently building construction project complies with all seismic requirements.

Note 20 Restatement of Net Position

As a result of the items described below, beginning net position and change in net position as reflected on the statement of revenue, expenses, and changes in net position for the year ended June 30, 2014, have been restated as follows:

	Change in Net Position	Beginning Net Position
Balance before restatement	$ 1,358,060	$ 49,486,687
Capitalized portion of accreditive interest from prior years	-	4,565,815
Depreciation on capitalized interest	(152,194)	(76,097)
Total	$ 1,205,866	$ 53,976,405

Note 21 Reclassifications

Certain reclassifications have been made to the 2014 financial statements to conform to the 2015 classifications.

Required Supplementary Information

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions

Year Ended June 30, 2015

SCHEDULE OF CHANGES IN THE NET PENSION LIABILITY
AND RELATED RATIOS

Total Pension Liability		2015*
Service cost incurred	$	2,683,298
interest in total pension liability		3,356,235
Differences between actual and expected		108,261
Change in assumption		(1,841,294)
Benefit payments		(9,321,200)
Net change in total pension liability		(5,014,700)
Total pension liability - Beginning		55,606,452
Total pension liability - Ending (a)	$	50,591,752
Plan net position		
Contribution - employer	$	4,320,000
Net investment income		1,223,136
Benefit payments		(9,321,200)
Net change in plan net position		(3,778,064)
Plan net position - Beginning		35,768,696
Plan net position - Ending (b)	$	31,990,632
Net pension liability - Ending (a) - (b)	$	18,601,120
Plan fiduciary net position as a percentage of the total pension liability		66%
Covered - employee payroll	$	17,664,833
Net pension liability as percentage of covered employee payroll		93%

Notes to Schedule:

* - Fiscal year 2015 was the 1st year of implementation, therefore only one year is shown.

Changes in assumptions: In 2015, amounts reported as changes in assumptions resulted primarily from adjustments to expected retirement ages of plan employees.

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions

Year Ended June 30, 2015

SCHEDULE OF CONTRIBUTIONS

	2015*
Actuarially determined contribution	$ 4,320,000
Contributions in relation to the actuarially determined contributions	4,320,000
Contribution deficiency (excess)	$ -
Covered-employee payroll	$ 19,429,331
Contributions as a percentage of covered employee payroll	22%

Notes to Schedule

Valuation date:	January 1, 2015
Methods and assumptions used to determine contribution rates:	
Single Employer Plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	17 years
Asset valuation method	Market value
Inflation	2.5%
Salary increases	4%, including inflation
Investment rate of return	6.54%
Retirement age	65, or 70 **
Mortality	Based on Date of Participation (DOP**)

* - Fiscal year 2015 was the 1st year of implementation, therefore only one year is shown.

** - The later of age 65 or the 5th anniversary of date of participation; or age 70, if earlier.

*** DOP Before 7/1/2009: 1984 UP Mortality Table set back 4 years.
*** DOP On/After 7/1/2009: RP-2000 Table for Males set back 4 years.

Supplementary Information

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

Year Ended June 30, 2015, Auxiliary Year Ended May 31, 2015

Assets	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Eliminations	Total
Current assets:					
Cash and cash equivalents	$ 5,509,074	$ 159,197	$ 48,360	$ -	$ 5,716,631
Current portion of assets limited as to use	1,470,000	-	-	-	1,470,000
Receivables:					
Patient - Net	10,745,200	-	-	-	10,745,200
Other	28,067	-	-	-	28,067
Inventory	3,031,041	-	-	-	3,031,041
Prepaid expenses and deposits	1,349,328	-	-	-	1,349,328
Total current assets	22,132,710	159,197	48,360	-	22,340,267
Other assets:					
Noncurrent assets limited as to use	15,781,236	-	-	-	15,781,236
Investment in PMA	397,493	-	-	-	397,493
Goodwill in PMA	581,219	-	-	-	581,219
Total other assets	16,759,948	-	-	-	16,759,948
Capital assets:					
Nondepreciable capital assets	1,027,452	-	-	-	1,027,452
Depreciable capital assets - Net	86,090,873	-	-	-	86,090,873
Capital assets - Net	87,118,325	-	-	-	87,118,325
Deferred outflows of resources	782,887	-	-	-	782,887
TOTAL ASSETS & DEFERRED OUTFLOWS OF RESOURCES	$126,793,870	$ 159,197	$ 48,360	$ -	$127,001,427

Liabilities and Net Position	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Eliminations	Total
Current liabilities:					
Current maturities of long-term liabilities:					
Bonds payable	$ 1,390,000	$ -	$ -	$ -	$ 1,390,000
Capital lease obligation	1,007,957	-	-	-	1,007,957
Line of credit	-	-	-	-	-
Accounts payable	1,521,678	-	-	-	1,521,678
Accrued interest and sales tax	261,509	-	-	-	261,509
Accrued payroll and related liabilities	5,289,388	-	-	-	5,289,388
Estimated third-party payor settlements	3,496,996	-	-	-	3,496,996
Total current liabilities	12,967,528	-	-	-	12,967,528
Long-term liabilities:					
Bonds payable	47,997,149	-	-	-	47,997,149
Accreted interest	8,213,924	-	-	-	8,213,924
Capital lease obligation	1,090,103	-	-	-	1,090,103
Net pension liability	18,601,120	-	-	-	18,601,120
Total long-term liabilities	75,902,296	-	-	-	75,902,296
Total liabilities	88,869,824	-	-	-	88,869,824
Deferred inflows of resources	1,634,407	-	-	-	1,634,407
Net position:					
Net investment in capital assets	35,377,830	-	-	-	35,377,830
Restricted for debt service	3,280,754	-	-	-	3,280,754
Restricted for programs	17,679	-	48,360	-	66,039
Unrestricted	(2,386,624)	159,197	-	-	(2,227,427)
Total net position	36,289,639	159,197	48,360	-	36,497,196
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 126,793,870	$ 159,197	$ 48,360	$ -	$ 127,001,427

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

Year Ended June 30, 2014, Auxiliary Year Ended May 31, 2014

Assets	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Eliminations	Total
Current assets:					
Cash and cash equivalents	$ 1,172,321	$ 120,504	$ 49,447	$ -	$ 1,342,272
Current portion of assets limited as to use	1,240,000	-	-	-	1,240,000
Receivables:					
Patient - Net	11,224,470	-	-	-	11,224,470
Other	11,069	-	-	-	11,069
Inventory	2,793,677	-	-	-	2,793,677
Prepaid expenses and deposits	1,223,052	-	-	-	1,223,052
Total current assets	17,664,589	120,504	49,447	-	17,834,540
Other assets:					
Noncurrent assets limited as to use	15,013,573	38,709	-	-	15,052,282
Investment in PMA	464,019	-	-	-	464,019
Goodwill in PMA	581,219	-	-	-	581,219
Total other assets	16,058,811	38,709	-	-	16,097,520
Capital assets:					
Nondepreciable capital assets	1,087,351	-	-	-	1,087,351
Depreciable capital assets - Net	88,953,577	-	-	-	88,953,577
Capital assets - Net	90,040,928	-	-	-	90,040,928
TOTAL ASSETS	$ 123,764,328	$ 159,213	$ 49,447	$ -	$ 123,972,988

Liabilities and Net Position	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Eliminations	Total
Current liabilities:					
Current maturities of long-term liabilities:					
Bonds payable	$ 1,240,000	$ -	$ -	$ -	$ 1,240,000
Capital lease obligation	961,992	-	-	-	961,992
Line of credit	299,988	-	-	-	299,988
Accounts payable	1,647,428	-	-	-	1,647,428
Accrued interest and sales tax	265,106	-	-	-	265,106
Accrued payroll and related liabilities	4,563,834	-	-	-	4,563,834
Estimated third-party payor settlements	1,372,657	-	-	-	1,372,657
Total current liabilities	10,351,005	-	-	-	10,351,005
Long-term liabilities:					
Bonds payable	49,454,313	-	-	-	49,454,313
Accreted interest	6,887,339	-	-	-	6,887,339
Capital lease obligation	2,098,060	-	-	-	2,098,060
Total long-term liabilities	58,439,712	-	-	-	58,439,712
Total liabilities	68,790,717	-	-	-	68,790,717
Net position:					
Net investment in capital assets	36,025,861	-	-	-	36,025,861
Restricted for debt service	3,193,718	-	-	-	3,193,718
Restricted for programs	25,123	38,709	49,447	-	113,279
Unrestricted	15,728,909	120,504	-	-	15,849,413
Total net position	54,973,611	159,213	49,447	-	55,182,271
TOTAL LIABILITIES AND NET POSITION	$ 123,764,328	$ 159,213	$ 49,447	$ -	$ 123,972,988

Northern Inyo Healthcare District

Combining Statement of Revenue, Expenses, and Changes in Net Position of the District and Component Units

Year Ended June 30, 2015, Auxiliary Year Ended May 31, 2015

	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Eliminations	Total
Revenue:					
Net patient service revenue	$ 70,694,160	$ -	$ -	$ -	$ 70,694,160
Other operating revenue	1,015,016	-	14,376	-	1,029,392
Total revenue	71,709,176	-	14,376	-	71,723,552
Expenses:					
Salaries and wages	21,591,747	-	-	-	21,591,747
Employee benefits	16,799,660	-	-	-	16,799,660
Professional fees	6,706,810	595	-	-	6,707,405
Supplies	7,073,688	440	-	-	7,074,128
Purchased services	3,720,516	-	-	-	3,720,516
Depreciation	4,955,527	-	-	-	4,955,527
Other operating expense	3,756,638	2,486	-	-	3,759,124
Total expenses	64,604,586	3,521	-	-	64,608,107
Income from operations	7,104,590	(3,521)	14,376	-	7,115,445
Nonoperating revenue (expenses):					
Tax revenue for operations	520,257	-	-	-	520,257
Tax revenue for debt services	1,376,890	-	-	-	1,376,890
Interest income	155,746	3	-	-	155,749
Interest expense	(3,529,802)	-	-	-	(3,529,802)
Loss on sale of asset	(94,603)	-	-	-	(94,603)
Noncapital grants and contributions	244,905	3,502	3,000	-	251,407
Medical office building, net	(4,695,700)	-	-	-	(4,695,700)
Total nonoperating revenue (expenses)	(6,022,307)	3,505	3,000	-	(6,015,802)
Excess of revenue over expenses	1,082,283	(16)	17,376	-	1,099,643
Capital grants and contributions	71,501	-	(18,463)	-	53,038
Increase (decrease) in net position	1,153,784	(16)	(1,087)	-	1,152,681
Net position at beginning, as previously stated	54,973,611	159,213	49,447	-	55,182,271
Cumulative effect for change in accounting principle	(19,837,756)	-	-	-	(19,837,756)
Net position at beginning, restated	35,135,855	159,213	49,447	-	35,344,515
Net position at end	$ 36,289,639	$ 159,197	$ 48,360	$ -	$ 36,497,196

Northern Inyo Healthcare District

Combining Statement of Revenue, Expenses, and Changes in Net Position of the District and Component Units

Year Ended June 30, 2014, Auxiliary Year Ended May 31, 2014

	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Eliminations	Total
Revenue:					
Net patient service revenue	$ 69,247,976	$ -	$ -	$ -	$ 69,247,976
Other operating revenue	1,100,363	-	11,183	-	1,111,546
Total revenue	70,348,339	-	11,183	-	70,359,522
Expenses:					
Salaries and wages	21,750,463	-	-	-	21,750,463
Employee benefits	14,523,265	-	-	-	14,523,265
Professional fees	7,283,755	1,285	-	-	7,285,040
Supplies	6,948,168	47	-	-	6,948,215
Purchased services	3,634,963	-	-	-	3,634,963
Depreciation	5,197,825	-	-	-	5,197,825
Other operating expense	3,947,951	3,501	-	-	3,951,452
Total expenses	63,286,390	4,833	-	-	63,291,223
Income from operations	7,061,949	(4,833)	11,183	-	7,068,299
Nonoperating revenue (expenses):					
Tax revenue for operations	564,643	-	-	-	564,643
Tax revenue for debt services	1,306,715	-	-	-	1,306,715
Interest income	135,084	3	-	-	135,087
Interest expense	(3,626,175)	-	-	-	(3,626,175)
Loss on sale of asset	(55,006)	-	-	-	(55,006)
Noncapital grants and contributions	207,216	7,338	3,351	-	217,905
Medical office building, net	(4,536,814)	-	-	-	(4,536,814)
Total nonoperating revenue (expenses)	(6,004,337)	7,341	3,351	-	(5,993,645)
Excess of revenue over expenses	1,057,612	2,508	14,534	-	1,074,654
Capital grants and contributions	145,865	-	(14,653)	-	131,212
Increase (decrease) in net position	1,203,477	2,508	(119)	-	1,205,866
Net position at beginning as restated	53,770,134	156,705	49,566	-	53,976,405
Net position at end	$ 54,973,611	$ 159,213	$ 49,447	$ -	$ 55,182,271

Northern Inyo Healthcare District

Statistical Information

Year Ended June 30, 2015

Bed Complement

	2015	2014	2013
Medical/ Surgical	11	11	11
Prematal/Obstetrics	6	6	6
Pediatric	4	4	4
Intesive Care	4	4	4
Total licensed bed capacity	25	25	25

Utilization

	2015	2014	2013	2012	2011	2010
Licensed beds	25	25	25	25	25	25
Patient days	3,804	3,070	2,737	2,735	2,987	3,437
Discharges	1,069	1,145	1,031	1,036	1,049	1,181
Occupancy	42%	34%	25%	26%	29%	33%
Average stay (days)	3.3	2.7	2.8	3.0	3.0	3.1
Emergency room visits	7,948	8,191	8,658	7,898	7,852	7,863
Outpatient visits	37,684	38,545	37,368	38,822	42,270	39,530

Medical Staff

	2015	2014	2013
Active	36	36	37
Consulting	30	30	27
Honorary	9	9	7
AHP	8	6	5
Total practitioners	83	81	76

Employees

	2015	2014	2013
Full-time	290	273	284
Part-time and per diem	105	116	106
Total employees	395	389	390
Full-time equivalents	298.00	321.37	297.51

Bond Debt Service Coverage

	2015	2014*	2013	2012	2011	2010
Excess of revenue over expenses	$ 815	$ 1,075	$ 625	$ 1,980	$ 4,827	$ 3,174
Add:						
Depreciation and amortization expenes	4,956	5,274	3,523	2,917	2,724	2,697
Interest expense	3,530	3,626	3,731	1,401	1,261	1,301
Available to meet debt service	$ 9,301	$ 9,975	$ 7,879	$ 6,298	$ 8,812	$ 7,172
Actual debt service:						
General obligation bonds	$ -	$ -	$ -	$ -	$ -	$ 34
1998 Revenue bonds	-	-	-	563	564	565
2005 General obligation bonds	899	884	884	866	858	933
2009 General obligation bonds	487	423	423	467	309	316
2010 Revenue bonds	1,178	1,182	1,182	1,179	1,181	-
2013 Revenue bonds	788	778	804	-	-	-
	$ 3,352	$ 3,267	$ 3,293	$ 3,075	$ 2,912	$ 1,848
Historical debt service coverage ratio	2.77	3.05	2.39	2.05	3.03	3.88

* 2014 restated, see Note 20.

CALL TO ORDER

The meeting was called to order at 5:30 pm by M.C. Hubbard, President.

PRESENT

M.C. Hubbard, President
Denise Hayden, Vice President
Peter Watercott, Treasurer
John Ungersma M.D., Member at Large

ALSO PRESENT

Kevin S. Flanigan M.D., M.B.A., Acting Chief Executive Officer
Mark Robinson M.D., Chief of Staff
Sandy Blumberg, Executive Assistant

PUBLIC COMMENT

Ms. Hubbard announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. The following persons spoke during public comment:

- Richard Hanley
- Becky Taylor

CONSENT AGENDA

Ms. Hubbard called attention to the consent agenda for this meeting, which contained the following items:
- Approval of minutes of the October 16 2015 special meeting
- Approval of minutes of the October 21 2015 regular meeting
- Approval of minutes of the October 29 2015 special meeting
- Approval of Financial and statistical reports for September 2015

It was moved by Denise Hayden, seconded by John Ungersma, M.D. and unanimously passed to approve all four consent agenda items as presented, with Director Watercott noting that he was not present at the October meetings.

CHIEF EXECUTIVE OFFICER REPORT

Acting Chief Executive Officer Kevin S. Flanigan, M.D., MBA stated he was pleased to report that the second round of leadership training for Northern Inyo Hospital (NIH) managers and future managers is going well. He congratulated Diagnostic Imaging Director Patty Dickson for completing her Bachelors' degree in Healthcare Management; and congratulated Alison Murray, Human Relations Manager for completing her Masters Degree in Business Administration with a Human Resources emphasis. Doctor Flanigan additionally reported the leadership transition at NIH is moving forward, and the hospital will roll out a marketing strategy this winter that emphasizes the fact that the hospital team is focused on its purpose, which is to provide the best healthcare possible for members of this community. Inpatient volume is up, and it is possible that an additional hospitalist physician will be recruited to help provide coverage and to enable the hospitalist program to provide additional services for our patients. The Northern Inyo Hospital Rural Health Clinic

(RHC) is transitioning toward a patient-centered medical home model, in order to function as efficiently as possible within the framework of the Affordable Care Act. A community needs assessment will be conducted in the near future, and following that a second assessment will be done to determine the best future model for the RHC.

CHIEF OF STAFF REPORT

Chief of Staff Mark Robinson, M.D. reported following careful review and consideration and approval by the appropriate committees the Medical Executive Committee recommends Board approval of the following Hospital wide Policies and Procedures:

POLICY AND PROCEDURE APPROVALS

1. *ALARA Program Changes*
2. *Radiation Safety Committee*
3. *Responsibilities and Duties of Radiation Safety Committee*
4. *Dosimetry Program - Occupational Radiation Exposure Monitoring Program*
5. *Universal Protocol*
6. *Waste Anesthetic Gases: Trace Gas Testing*
7. *RHC Hours of Operation*

It was moved by Mr. Watercott, seconded by Ms. Hayden, and unanimously passed to approve policies and procedures 1 through 7 as presented.

PEER REVIEW REPORT FORM

Doctor Robinson also requested approval of a proposed *NIHD Medical Staff Peer Review Repo*rt form, which combines several forms that were previously separate documents. It was moved by Doctor Ungersma, seconded by Mr. Watercott, and unanimously passed to approve the *NIHD Medical Staff Peer Review Report* form as presented.

HONORARY MEDICAL STAFF MEMBERSHIP, D. SCOTT CLARK, M.D.

Doctor Robinson additionally reported that the Medical Staff has voted to bestow Honorary Medical Staff membership upon D. Scott Clark M.D., who recently retired after providing decades of dedicated service to the residents of this community. It was moved by Doctor Ungersma, seconded by Mr. Watercott, and unanimously passed to approve Honorary Medical Staff designation for D. Scott Clark, M.D. as requested.

MEDICAL STAFF APPOINTMENT

Doctor Robinson also reported following careful review, consideration, and approval by the appropriate committees, the Medical Executive Committee recommends approval of appointment to the NIH Provisional Consulting Staff for Radiology for Ryan Berecky, M.D.. It was moved by Mr. Watercott, seconded by Doctor Ungersma, and unanimously passed to approve the appointment to the NIH Provisional Consulting Medical Staff of Dr. Ryan Berecky as requested.

CHIEF NURSING OFFICER REPORT

Chief Nursing Officer Kathryn Decker, RN provided a monthly report on activities of the NIH Nursing Department which included the following:

- The American Hospital Association has renewed the hospital's training certification largely thanks to the efforts of Kathryn Erickson, R.N.
- Hospital staff participated in a bioterrorism training exercise today,

which proved to be a beneficial learning experience for the hospital team
- The hospital will increase its focus on workplace violence prevention, and the staff will participate in specialized trainings
- NIH will work with Inyo County in an effort to the address mental and behavioral health issues of our patients
- New end-of-life legislation will necessitate compliance training for NIH staff
- Beta Healthcare has recognized Northern Inyo Hospital for its efforts to reduce errors in the workplace
- The NIH staff flu vaccination rate for this year is at 98 percent

NEW BUSINESS

HOSPITAL DISTRICT FISCAL STRATEGY

Doctor Flanigan requested Board approval to move forward to outline a fiscal strategy plan for Northern Inyo Healthcare District (NIHD), including enlisting the consulting services of the hospital's current auditors, Wipfli LLP. The intention is to have Wipfli do a general fiscal assessment then make recommendations for the appropriate fiscal strategy for the District moving forward. It was moved by Doctor Ungersma, seconded by Ms. Hayden, and unanimously passed to consult with Wipfli LLP to establish a fiscal strategy for NIHD in an effort to potentially realize additional revenue and cost savings for the District.

AMENDMENT TO PHYSICIAN AGREEMENT WITH LARA JEANING ARNDAL, M.D.

Doctor Flanigan called attention to a proposed addendum to the NIH physician agreement with Lara Jeanine Arndal, M.D., which stipulates that Dr. Arndal will act as lead practice liaison for the OB/Gyn service. She will additionally provide monthly educational sessions and an assessment of the value of those sessions being conducted after a period of six months. It was moved by Mr. Watercott, seconded by Doctor Ungersma, and unanimously passed to approve the Amendment to the NIH physician agreement with Lara Jeanine Arndal, M.D. as presented.

M.O.U. FOR UROLOGY SERVICES WITH SOUTHERN MONO HEALTHCARE DISTRICT

Doctor Flanigan then asked for authorization to move forward with Inyo County Counsel/Inyo County LAFCO to draft a Urology Services Memorandum of Understanding (M.O.U.) between Southern Mono Healthcare District and Northern Inyo Healthcare District, following the untimely passing of urologist Tomi Bortolazzo, M.D.. It was moved by Doctor Ungersma, seconded by Mr. Watercott, and unanimously passed to move forward to establish a cooperative M.O.U. for Urology Services with Southern Mono Healthcare District as requested.

MISSION STATEMENT FOR N.I.H.D.

Doctor Flanigan then called attention to a proposed Mission Statement for the Northern Inyo Healthcare District team, which reads as follows: "*Improving our communities one life at a time. One team. One goal. Your health!"* It was moved by Ms. Hayden, seconded by Doctor Ungersma, and unanimously passed to approve the proposed Mission Statement for NIHD as presented.

LAB EQUIPMENT LEASE RENEWAL

Doctor Flanigan then called attention to a request for consideration of renewal of a 5-year lease agreement with ThermoFisher Scientific for Lab equipment, which would result in significant cost savings for the Hospital. It was moved by Mr. Watercott, seconded by Doctor Ungersma, and unanimously passed to approve the renewal of the Lab equipment lease with ThermoFisher Scientific as requested.

PROCESS FOR FILLING DISTRICT BOARD VACANCY FOR ZONE 4

Ms. Hubbard then addressed the process for filling the vacancy on the District Board of Directors resulting from the recent retirement and resignation from the Board of Director D. Scott Clark, M.D.. Ms. Hubbard stated that the posting requirement for the vacancy has been met, and applications are open for submission until November 30 2015. Applicants are asked to submit a letter of interest, plus a completed Form 700 in order to identify any potential conflicts of interest. Applicants must also be a registered voter and must live within the specified boundaries of District Zone 4. Following brief discussion, it was determined that an Ad Hoc Committee consisting of two Directors (Directors Hayden and Watercott) will conduct initial interviews of potential candidates prior to the next regular Board meeting. Ms. Hubbard then asked for a motion to accept the Board resignation of D. Scott Clark, M.D., and it was moved by Doctor Ungersma, seconded by Ms. Hayden, and unanimously passed to accept the resignation of Director D. Scott Clark, M.D. as submitted.

BOARD MEMBER REPORTS

Ms. Hubbard asked if any members of the Board of Directors wished to report on any items of interest. Dr. Ungersma commented that the Association of Healthcare Districts Leadership Academy will take place in January 2016, and he encouraged as many Board members as possible to attend. It was also suggested that perhaps the incoming Director for District Zone 4 might attend the training as well. No other reports were heard.

ADJOURNMENT TO CLOSED SESSION

At 6:42 pm Ms. Hubbard announced that the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation (*pursuant to Government Code Section 54956.9*).
C. Confer regarding action filed against Northern Inyo Healthcare District and other Defendants (*Government Code Section 54956.9(a)*).
D. Conference with Labor Negotiator. Agency designated representative: Georgan Stottlemyre; Employee organization: AFSCME (*Government Code section 5495 7.6*).
E. Discussion of existing litigation, United States District Court Case

Number 1:15-CV-01607-LJO-JLT (*Government Code Section 54956.9(d)(1)*).

F. Discussion of labor negotiations. Agency negotiator, M.C. Hubbard; Employee position: CEO (*Government Code section 5495 7.6*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:00 pm the meeting returned to open session. Ms. Hubbard reported the Board took no reportable action.

APPROVAL OF CEO AGREEMENT WITH KEVIN S. FLANIGAN, M.D., M.B.A.

Ms. Hubbard then called attention to approval of the Chief Executive Officer Agreement with Kevin S. Flanigan, M.D., M.B.A.. It was moved by Doctor Ungersma, seconded by Mr. Watercott, and unanimously passed to approve the Chief Executive Officer Agreement with Kevin S. Flanigan, M.D., M.B.A. as presented.

ADJOURNMENT

The meeting was adjourned at 8:01pm.

_____

M.C. Hubbard, President

_____

Attest: Denise Hayden, Vice President

Northern Inyo Hospital
Balance Sheet
Period Ending October 31, 2015

Current Assets:	**Current Month**	**Prior Month**	**Change**
Cash and Equivalents	3,991,881	3,660,732	331,149
Short-Term Investments	11,199,608	11,191,016	8,593
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	912,186	912,186	-
Patient Receivable	47,951,568	48,195,480	(243,912)
Less: Allowances	(37,208,441)	(37,943,242)	734,800
Other Receivables	(140,813)	841,199	(982,013)
Inventories	3,578,787	3,594,611	(15,824)
Prepaid Expenses	1,460,197	1,627,174	(166,977)
Total Current Assets	**31,744,974**	**32,079,158**	**(334,184)**
Internally Designated for Capital Acquisitions	1,124,247	1,124,238	9
Special Purpose Assets	110,243	954,700	(844,457)
Limited Use Asset; Defined Contribution Pension	389,701	389,398	303
Revenue Bonds Held by a Trustee	3,307,385	3,145,623	161,763
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**4,931,576**	**5,613,958**	**(682,382)**
Long Term Investments	1,000,000	1,000,000	-
			-
Property & equipment, net Accumulated Depreciation	86,128,554	86,313,864	(185,310)
Unamortized Bond Costs	-	-	-
			-
Total Assets	**123,805,104**	**125,006,980**	**(1,201,876)**

Northern Inyo Hospital
Balance Sheet
Period Ending October 31, 2015

Liabilities and Net Assets			
Current Liabilities:			
Current Maturities of Long-Term Debt	1,607,199	1,690,422	(83,223)
Accounts Payable	1,731,000	2,435,488	(704,488)
Accrued Salaries, Wages & Benefits	4,906,911	4,760,725	146,186
Accrued Interest and Sales Tax	431,026	258,600	172,425
Deferred Income	368,724	414,815	(46,091)
Due to 3rd Party Payors	1,958,064	1,572,594	385,470
Due to Specific Purpose Funds	(92,563)	-	(92,563)
Total Current Liabilities	**10,910,361**	**11,132,644**	**(222,283)**
Long Term Debt, Net of Current Maturities	47,955,050	47,955,050	-
Bond Premium	1,109,813	1,115,410	(5,597)
Accreted Interest	8,656,119	8,545,570	110,549
Total Long Term Debt	**57,720,982**	**57,616,031**	**104,952**
Net Assets			
Unrestricted Net Assets less Income Clearing	55,303,614	55,572,931	(269,318)
Temporarily Restricted	110,243	954,700	(844,457)
Net Income (Income Clearing)	(240,096)	(269,326)	29,231
Total Net Assets	**55,173,761**	**56,258,305**	**(1,084,544)**
Total Liabilities and Net Assets	**123,805,104**	**125,006,980**	**(1,201,876)**

NORTHERN INYO HOSPITAL
STATEMENT OF OPERATIONS
for period ending October 31, 2015

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	806,545	799,007	7,538	3,356,227	3,196,028	160,199
Ancillary	2,558,653	2,714,930	(156,277)	10,465,822	10,859,720	(393,898)
Total Inpatient Service Revenue	3,365,198	3,513,937	(148,739)	13,822,049	14,055,748	(233,699)
Outpatient Service Revenue	6,796,164	7,011,065	(214,901)	27,763,242	28,044,260	(281,018)
Gross Patient Service Revenue	10,161,362	10,525,002	(363,640)	41,585,290	42,100,008	(514,718)
Less Deductions from Revenue						
Patient Service Revenue Deductions	178,704	244,148	(65,444)	744,869	976,592	(231,723)
Contractual Adjustments	3,804,740	4,161,336	(356,596)	17,020,602	16,645,344	375,258
Prior Period Adjustments	(279,536)	(9,167)	(270,369)	(489,236)	(36,668)	(452,568)
Total Deductions from Patient Service Revenue	3,703,907	4,396,317	(692,410)	17,276,235	17,585,268	(309,033)
Net Patient Service Revenue	6,457,455	6,128,685	328,770	24,309,055	24,514,740	(205,685)
Other revenue	750	41,082	(40,332)	107,237	164,328	(57,091)
Total Other Revenue	750	41,082	(40,332)	107,237	164,328	(57,091)
Expenses:						
Salaries and Wages	1,837,797	2,031,988	(194,191)	7,128,626	8,127,952	(999,326)
Employee Benefits	1,092,827	1,270,352	(177,525)	4,894,236	5,081,408	(187,172)
Professional Fees	1,068,765	588,624	480,141	3,209,356	2,354,496	854,860
Supplies	656,591	512,905	143,686	1,924,858	2,051,620	(126,762)
Purchased Services	567,680	319,385	248,295	1,425,889	1,277,540	148,349
Depreciation	445,804	425,849	19,955	1,714,723	1,703,396	11,327
Bad Debts	(30,463)	200,193	(230,656)	763,675	800,772	(37,097)
Other Expense	408,675	322,535	86,140	1,501,179	1,290,140	211,039
Total Expenses	6,047,676	5,671,831	375,845	22,562,542	22,687,324	(124,783)
Operating Income (Loss)	410,529	497,936	(87,407)	1,853,751	1,991,744	(137,993)
Other Income:						
District Tax Receipts	46,091	44,416	1,675	184,362	177,664	6,698
Tax Revenue for Debt	84,288	83,979	309	337,152	335,916	1,236
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted		3,047	(3,047)	316,705	12,188	304,517
Interest Income	14,589	13,830	759	87,401	55,320	32,081
Interest Expense	(287,434)	(285,656)	(1,778)	(1,151,841)	(1,142,624)	(9,217)
Other Non-Operating Income	2,038	439	1,599	8,922	1,756	7,166
Net Medical Office Activity	(519,074)	(294,181)	(224,893)	(1,593,411)	(1,176,724)	(416,687)
340B Net Activity	8,878	31,237	(22,360)	71,488	124,948	(53,460)
Non-Operating Income/Loss	(650,625)	(402,889)	(247,736)	(1,739,222)	(1,611,556)	(127,666)
Net Income/Loss	(240,096)	95,047	(335,143)	114,529	380,188	(265,659)

NORTHERN INYO HOSPITAL
OPERATING STATISTICS
for period ending October 31, 2015

	Month to Date	FYE 2016 Year-to-Date	FYE 2015 Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	340	1,380	1,376	4	0%
Total Patient Days without NB	324	1,269	1,234	35	
Swing Bed Days	89	231	275	(44)	
Discharges without NB	90	391	358	33	
Swing Discharges	10	37	38	(1)	
Days in Month	31	123	123		
Occupancy	10.97	11.22	11.19	0.0	
Average Stay (days) with NB	3.60	3.25	3.45	(0.2)	
Average LOS without NB/Swing	2.94	2.93	3.00	(0.1)	
Hours of Observation (OSHPD)	508	1,931	2,506	(575)	
Observation Adj Days	21	80	59	21	
ER Visits (OSHPD)	643	2,617	2,665	(48)	
RHC Visits (OSHPD)	2,072	7,927	7,171	756	
Outpatient Visits (OSHPD)	3,287	12,781	12,905	(124)	
IP Surgeries (OSHPD)	28	112	94	18	
OP Surgery (OSHPD)	136	419	370	49	
Worked FTE's	285.00	323.00	282.00	41	
Paid FTE's	317.00	367.00	320.00	47	
Hours Worked to Hours Paid%	89.9%	88.0%	88.1%	-0.1%	
Payor %					
Medicare		38%	40%	-2%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		36%	35%	1%	
Indigent (Charity Care)		0.6%	0%	0%	
All Other		3%	2%	1%	
Total		100%	100%		

BUDGET VARIANCE ANALYSIS

Oct-15 Fiscal Year Ending June 30, 2016

Year to date for the period ending October 31, 2015

35	or	3%	less IP days than in the prior fiscal year
$ (233,699)	or	-1.66%	under budget in IP Ancillary Revenue and
$ (281,018)	or	-1.0%	under budget in OP Revenue resulting in
$ (514,718)	or	-1.2%	under budget in gross patient revenue &
$ (205,685)	or	-0.8%	under budget in net patient revenue

Year-to-date Net Revenue was	$	24,309,055
Total Operating Expenses were:	$	22,562,542

for the fiscal year to date

$ (124,783)	or	-0.6%	under budget. Wages and Salaries were
$ (999,326)	or	-12.3%	under budget and Employee Benefits
$ (187,172)	or	-3.7%	under budget.
		69%	Employee Benefits Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$ 854,860	or	36.3%	Professional Fees due to Contract Employees
$ 148,349	or	11.6%	Purchased Services includes Microsoft License "True-up" as approved by Board
$ 211,039	or	16.4%	Other Expenses

Other Information:

$ 1,853,751		Operating Income, less
$ (1,739,222)		loss in non-operating activities created a net income of;
$ 114,529	$ (265,659)	under budget.
	41.54%	Contractual Percentages for Year and
	41.77%	Budgeted Contractual Percentages including
$ 489,236		in prior year cost report settlement activity for Medicare & Medi-Cal

Non-Operating actives included:

$ (1,593,411) loss	$ 416,687	over budget in Medical Office Activities
$ 71,488	$ (53,460)	under budget in 340B Pharmacy Activity

Financial Indicators as of October 31, 2015											
	Target	Oct-15	Sep-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15	Feb-15	Jan-15
Current Ratio	>1.5-2.0	2.91	2.88	2.85	3.05	2.55	3.01	3.20	3.21	3.41	3.46
Quick Ratio	>1.33-1.5	2.46	2.34	2.36	2.52	2.21	2.56	2.68	2.66	2.81	2.89
Days Cash on Hand prior method	>75	154.32	153.99	152.62	169.64	147.86	159.00	139.61	126.67	138.83	130.36
Days Cash on Hand Short Term Sources	>75	82.82	82.74	77.07	89.59	82.92	83.33	78.31	71.26	61.69	60.80
Debt Service Coverage	>1.5-2.0	1.98	2.21	2.71	4.56	1.97	2.02	2.16	1.94	1.93	1.97
Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district											
has a debt service coverate ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)											
Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement											
PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle											
for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods											
Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities											
Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through											
Net Patient Accounts Receivlable Only divided by Current Liabilities											
Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year											

Investments as of 10/31/2015

ID	Purchase Date	Maturity Date	Institution	Broker	Rate	Principal Invested
1	16-Oct-15	01-Nov-15	LAIF Defined Cont Plan	Northern Inyo Hospital	0.36%	389,700.98
2	15-Oct-15	01-Nov-15	Local Agency Investment Fund	Northern Inyo Hospital	0.36%	10,667,683.25
3	16-Apr-14	15-Oct-16	Wachovia Corp New Note	Multi-Bank Service	1.38%	552,142.50
4	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	250,000.00
				Short Term Investments		11,469,825.75
5	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
6	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
7	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
8	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	100,000.00
				Long Term Investments		$750,000.00
				Total Investments		$ 12,219,825.75

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Mark Robinson, MD, Chief of Medical Staff
DATE: December 1, 2015

RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

1. Approval of the following policies/procedures, which have been reviewed and recommended by appropriate Medical Staff committees (Action Items):
   - *Admission and Care of Newborn*
   - *Amniocenteses*
   - *Blood Glucose Monitoring Protocol Newborn*
   - *Admission Assessment of Obstetrical Patient*
   - *Shoulder Dystocia*
   - *Postpartum Hemorrhage*
   - *Telephone Triage*
   - *Opioids Waste Policy*
   - *Pharmacy Operations During the Temporary Absence of a Pharmacist*
   - *Medications in the Absence of the Pharmacist*
   - *Protecting Public from Impaired or Dishonest Pharmacy Employee*
   - *Automated External Defibrillators*
2. Acceptance of the resignations of D. Scott Clark, MD, Shawn Rosen, MD, Eric Wallace, MD, and Thomas Davee, MD. (Action Items)
3. Peter Bloomfield, MD: Advancement from Provisional Active Staff to Active Staff with Emergency Room Service clinical privileges as requested. This recommendation is made consequent to careful review of the applicant's applications and supporting documentation. (Action Item)
4. Charlie Wolf, MD: Advancement from Provisional Active Staff to Active Staff with Emergency Room Service clinical privileges as requested. This recommendation is made consequent to careful review of the applicant's applications and supporting documentation. (Action Item)
5. William Timbers, MD: Release from Emergency Room Service proctorship based upon Dr. Jennie Walker's review of Dr. Timbers's charts. (Action Item)
6. Anne Goshgarian, MD: Release from Emergency Room Service proctorship based upon Dr. Jennie Walker's review of Dr. Goshgarian's charts. (Action Item)
7. Charles Hooper, MD: Extension of temporary locum tenens assignment at the RHC until 4/30/2016. (Action Item)

8. Charles Hooper, MD: Release from Family Practice proctorship based upon Dr. Catherine Leja's and Dr. Anne Gasior's review of Dr. Hooper's charts. (Action Item)

9. Reappointment to the NIH Medical Staff of the attached list of 39 NIH Medical Staff members with requested privileges, for the period not to exceed January 1, 2016 through December 31, 2017, in the Staff category noted. This recommendation is made pursuant to careful review of each Staff member's reappointment application and supporting documentation, including patient care data and performance evaluations. (Action Item)

10. Robert Nalumaluhia, PA-C: Reprivileging to function according to the NIH protocols for physician assistants at the NIH Rural Health Clinic, as requested, under the Delegations of Services Agreements (DSA) and written supervision guidelines with supervising physicians as stipulated on the physician assistants' DSAs, for the period not to exceed January 1, 2016 through December 31, 2017. This recommendation is made pursuant to careful review of the physician assistant's application and supporting documentation.(Action Item)

11. Tammy O'Neill, PA-C: Reprivileging to function according to the NIH protocols for physician assistants at Sierra Crest Orthopedics and Neurology, as requested, under the Delegations of Services Agreements (DSA) and written supervision guidelines with supervising physicians as stipulated on the physician assistants' DSAs, for the period not to exceed January 1, 2016 through December 31, 2017. This recommendation is made pursuant to careful review of the physician assistant's application and supporting documentation. (Action Item)

12. Jennifer Norris, RN/CNM: Reprivileging to function according to the NIH standardized procedures at NIH Rural Health Women's Clinic, as requested, under the direction of supervising physicians Jeanine Arndal, MD and Matthew Wise, MD for the period not to exceed January 1, 2016 through December 31, 2017. This recommendation is made pursuant to careful review of the practitioner's application and supporting documentation.(Action Item)

Mark Robinson, MD, Chief of Staff

REAPPOINTMENT 2016-2017		
Staff Member	**Category**	**Specialty**
Adduci, Alexander	PC	Radiology
Althaus, Sandra	PC	Radiology
Black, Helena L	A	ER
Brown, Stacey L	A	FP
Bryce, Thomas	PC	Telerad
Carlevato, Nicholas J	C	Radiology
Dillon, Michael L	A	ER
Erogul, John	PC	Radiology
Farooki, Aamer	PC	Telerad
Hathaway, Nickoline M	A	Int Med
Hewchuck, Andrew D	LLP-A	DPM
Kamei, Asao	A	Int Med
Karp, Felix	PA	Int Med/Hospitalist
Kassarjian, Ara	PC	Telerad
Kim, Martha	PA	OB/GYN
Kop, Sheldon M	C	Radiology
Landis, David N	C	Radiology
Lin, Doris	A	ER
Loos, Stephen J	C	Radiology
Meredick, Richard	A	Ortho
McNamara, Thomas O	A	Radiology
Phillips, Michael W	A	ER
Pisculli, Leo M	C	Psych
Ramadan, Amr H	A	FP/C-sxns
Reid, Thomas K	A	Ophthal
Richardson, James A	A	Int Med
Schweizer, Curtis	A	Anesthesia
Scott, Jennifer A	A	FP/ER
Seher, Richard	PC	Cardio
Shonnard, Keith M	C	Radiology
Swackhamer, Robert	PC	Cardio
Taylor, Gregory M	A	ER
Tiernan, Carolyn J	A	ER
Vaid, Rajesh	PC	Telerad
Wasef, Eva S	C	Pathology
Wei, Steven	PC	Telerad
Weiss, Taema F	A	FP
Will, Albert Douglas	C	Neurology
Wolf, Harry	PA	ER
ALLIED HEALTH PROFESSIONAL		
Frankel, Robert		RHC - PA
O'neill, Tammy		Ortho PA
Norris, Jennifer		CNM

C = CONSULTING
A = ACTIVE
PC = PROVISIONAL CONSULTING
PA = PROVISIONAL ACTIVE

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Admission and Care of Newborn**	
Scope: Perinatal	Manual: Perinatal- Communication (COM)
Source: DON Perinatal Services Traveler	Effective Date: 11/2015

PURPOSE:
To ensure a safe transition after delivery, and upon conclusion of initial skin to skin bonding.
To obtain a baseline Head to Toe newborn assessment.
To provide basic physical and emotional care.

POLICY:
A qualified Perinatal Unit or cross-trained RN will assess and monitor all newborns admitted to the newborn nursery. Continued assessment and monitoring may be performed by any Perinatal Unit or cross-trained nurse.

SPECIAL CONSIDERATIONS:
Physician/CNM order not required for assessment and monitoring.
Physician/CNM order required for admission.
Procedure may be performed by: RN, LVN
Special education required to perform procedure: *** yes**
Age specific considerations: refer below under Procedure.

***A qualified Perinatal Unit or cross-trained RN who has successfully completed unit orientation and/or cross-training program and who is able to independently care for newborn patients as determined by the Perinatal Unit Nurse Manager, will be responsible for admitting and/or supervising care of all newborns. Qualified Perinatal Unit or cross-trained LVN's who have successfully completed unit orientation and/or cross-training program (as determined by the Perinatal Unit Nurse Manager), may take a patient assignment and work under the supervision of a Perinatal Unit or cross-trained RN.**

EQUIPMENT:

1. Open crib or isolette	2. Paper measuring tape	3. Clean linen
4. Stethoscope, infant size	5. Disposable diapers	6. Scale & Scale Paper
7. Infant Security Tag	8. Non sterile exam gloves	9. Crib Card
10. Fine-toothed comb & brush (contained in Mom's admit pack)	11. Thermometer (contained in mother's admit pack)	12. 4x4 (optional)
13. Newborn Hat & T-shirt	14. Bulb Syringe	15. Baby book

PROCEDURE:
I. Admission:

A. Perform Hand Hygiene. Gloves should be worn when handling infant before the first bath or when changing diapers with stool.
B. Place infant in open crib or under radiant warmer. Observe infant for signs of respiratory distress (nasal flaring, grunting with respirations, sternal or

intercostal retractions) skin color, presence or absence of reflexes (sucking, rooting, Moro, etc.) and muscle tone.

C. Observe infant for signs of hypoglycemia; follow Blood Glucose Monitoring Policy.

D If infant stable, turn on the scale and "zero" it, then weigh the infant. If the infant is not stable, weights may be done with the infant under the radiant warmer using the in the bed scale.

1. Record the weight in grams and pounds on the newborn exam sheet, the labor and delivery summary, the nursery flowsheet, and infant ID form.
2. Record the weight in pounds and ounces on the crib card.

E. Measure the infant's length from the crown of the head to the sole of the feet using the meter stick and footboard or a paper measuring tape.

1. Record the length in centimeters and inches on the newborn exam sheet, the labor and delivery summary, the nursery flowsheet, and the Infant ID form.
2 Record the length in inches on the crib card.

F. Measure the head and the chest circumferences.

1. Record in centimeters and inches on the newborn exam sheet.
2. Record in inches on the crib card.

G. If the infant's temperature has been 98 degrees F. or above for at least one hour during the recovery period and his condition is stable, bathe the infant using mild soap.

1. Dress the infant in a diaper, undershirt and a stocking cap.
2. Initial cord care: Clean the cord and surrounding skin surface as part of the initial bath. Dry thoroughly with clean absorbent gauze to remove excess moisture and discard gauze. Leave umbilical area and clamped cord stump clean, dry and uncovered. Best practice is to keep the area clean dry and uncovered.

H. Place infant in an open crib. Take temperature (axillary or temporal), apical pulse and respirations. All temperatures should be axillary or temporal unless rectal temperatures are requested by the provider or deemed appropriate by the nurse. If the infant's temperature is less than 98 degrees F., apply ISC probe to infant and observe under radiant warmer, place the infant in a pre-warmed isolette, or place the infant skin-to-skin with mother and observe closely until temperature is above 98 degrees. If temperature is stable after bath, double wrap infant and place infant on back in crib with a hat on. Complete and document the neonatal physical assessment on the nursery flowsheet.

I. If medications were not given during the recovery period, if the infant was born via C-section or if the infant was born outside the hospital, prophylactic eye treatment and Vitamin K injection will need to be administered within two hours following delivery, as ordered by the MD/CNM.

J. Attach infant security band noting tag number. Follow Infant Security Policy and Procedure.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Admission and Care of Newborn**	
Scope: Perinatal	Manual: Perinatal- Communication (COM)
Source: DON Perinatal Services Traveler	Effective Date: 11/2015

II. ROUTINE CARE OF INFANT:

A. Axillary or temporal temperatures, apical pulse and respirations should be taken every hour until stable and temperature above 98 degrees F.; then vital signs should be taken q shift and PRN. If pulse or respirations appear abnormal, the nurse may place the infant on the apnea monitor to provide closer observation.

Normal pulse 110-160, Respirations= 30-60. Notify MD/CNM if infant's vital signs fall out of the normal range. If temperature is below 98 degrees F (axillary), provide for thermoregulation by any of the following measures:

1. Place infant under radiant warmer with ISC probe attached,
2. Place infant in pre-warmed isolette, set at 1.5 degrees F above infant's temperature,
3. Place on Porta-warm blanket,
4. Place infant skin-to-skin with mother or father, or
5. Triple wrap with thermal blanket between two regular blankets and place stocking cap on infant's head.

B. Infant Bath every other day ok.
C. Remove cord clamp when stump is dry, usually after 16-24 hours.
D. Daily weight. Record in both grams and pounds/ounces.
E. Observe infant for signs of respiratory distress, presence of reflexes, muscle tone and changes in skin color q shift. If skin becomes jaundiced, refer to Hyperbilirubin Policy/Procedure.
Any unusual or abnormal findings will be reported to provider, and documented.
F. Observe for signs of hypoglycemia and perform heel-stick blood sugars PRN symptoms. Follow newborn orders for blood sugar levels below 40 mg% and notify MD/CNM as directed.
G. Investigate cause of crying:
   1. Check diaper and change PRN. Wear gloves when changing diaper to avoid direct contact.
   2. Reposition infant
   3. Check for gas bubble, burp infant
   4. Encourage breastfeeding

H. Keep open cribs at least three feet apart and six inches from wall
I. Perform hand hygiene before and after contact
J. Provide for feedings on demand but at least q 3-4 hours or as directed by MD/CNM orders.
K. Document the following on nursery flowsheet at least q 8-hour shift:
   1. Complete neonatal physical assessment.

Title: **Admission and Care of Newborn**	
Scope: Perinatal	Manual: Perinatal- Communication (COM)
Source: DON Perinatal Services Traveler	Effective Date: 11/2015

2. Temperature, apical pulse, and respirations.
3. Number of voids and stools (may weigh diapers if necessary for more accurate output).
4. Feedings: If formula fed, document time and amount taken, as well as amount of any emesis. If infant breastfeeding, document time infant nursed, whether on one or both breasts, and any emesis following feedings. Document teaching. If mother's milk is in, baby may be weighed before and after nursing if needed for more accurate intake.

Approval	**Date**
Peri-Peds	11/5/15
MEC	12/01/15
Board	

Developed: 11/2015 jb
Reviewed:
Revised:
Supersedes: Admission and Care of Newborn

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Amniocentesis**	
Scope: Perinatal	Manual: Perinatal-Communication (COM)
Source: DON Perinatal Services Traveler	Effective Date: 11/15

Purpose:
To obtain, under aseptic conditions, samples of amniotic fluid for analysis of fetal lung maturity or the presence of infection

Policy:
All obstetrical inpatients and outpatients undergoing amniocentesis will be attended by a Perinatal Unit nurse while the procedure is performed.

Special Consideration:
Physician order is required for amniocentesis.
Procedure may be performed by: RN
Special education required to perform procedure: yes*
***Basic fetal monitoring certification; Perinatal Unit RN**
Age specific considerations: Adjust explanations/communication for teenage patients according to level of maturity/understanding.

Precautions:
1. Unless otherwise requested by the physician, all amniocentesis procedures will be performed in the Perinatal Unit.
2. All patients undergoing amniocentesis on an outpatient basis will be registered through admission services.

Procedure:
1. Obtain patient's signed consent for amniocentesis.
2. Instruct patient to void just prior to the procedure.
3. Apply EFM and run a 20 minute baseline strip.
4. Notify radiology and place order in the HIS.
5. Place amniocentesis tray and appropriate sized sterile gloves for MD on procedure table in the room
6. Place patient in Semi Fowlers with tilt to side.
7. Have available:
    a. Extra sterile gloves
    b. Extra spinal needles
    c. Extra towels
8. Pour Betadine, using aseptic technique, into appropriate area of amniocentesis tray for MD when requested.
9. Label collection tube with patient sticker, date and time collected, and collector's initials.
10. Complete specimen collect slip with date and time amniocentesis, "amniotic fluid" and the specific test(s) ordered. Indicate if MD is requesting this also be sent to referral lab for further testing.
11. Tightly cap the sterile collection tube.
12. Call Lab for transport of the amniotic fluid and completed lab slip to Lab.
13. Observe patient for vaginal bleeding, uterine contractions, and signs of weakness or fainting; take patient's blood pressure as needed, for one hour or time specified by physician.
14. Apply Betadine ointment and/or Band-aide to puncture site.
15. Reapply EFM for Non stress Test as ordered by physician.
16. On discharge, instruct patient to notify physician if cramping, bleeding, or oozing from amniocentesis site, or fever occur.

Title: **Amniocentesis**	
Scope: Perinatal	Manual: Perinatal-Communication (COM)
Source: DON Perinatal Services Traveler	Effective Date: 11/15

17. Properly dispose of amniocentesis tray's contents.

Documentation:

1. Complete Obstetric Evaluation Record.
2. Document patient/fetus response to procedure and condition at discharge (if outpatient).
3. Complete charge sheet as appropriate.
4. Discharge patient from computer
5. Complete the OB log data

Approval	**Date**
Peri-Peds	11/5/2015
MEC	12/1/15
Board	

Developed: 11/2015 jb
Reviewed:
Revised:
Supersedes: Amniocentesis

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal Communication (COM)
Source: Perinatal Director of Nursing	Effective Date: 11/2015

PURPOSE: Identification and management of term and late preterm (34 to 36 6/7 week gestation) infants at risk for hypoglycemia.

POLICY:

A. All well infants will be fed within 1 hour of birth. Sustained skin-to-skin contact with the mother is recommended for all infants, to support bonding, breastfeeding, and newborn thermoregulation.

B. All infants will be weighed and measured shortly after birth. The infant's head circumference, length, and weight measurements will be plotted against the estimated gestational age by date to determine whether the infant is small, appropriate, or large for gestational age. For infants with unknown dates, a new Ballard scale may be used to determine gestational age before graphing.

C. Careful monitoring for the symptoms of neonatal hypoglycemia is required for all infants. These symptoms are not specific to hypoglycemia, however, and may be present in infants with other clinical conditions (e.g. infection). Any infant displaying symptoms should have a glucose level immediately checked with a bedside monitor. These symptoms include:

- **Jitteriness**
- **Cyanosis**
- **Seizures**
- **Apneic episode**
- **Tachypnea**
- **Weak or high-pitched cry**
- **Floppiness or lethargy**
- **Poor feeding**
- **Eye rolling**

D. The following infants are considered at risk for neonatal hypoglycemia, and will receive bedside blood glucose checks regardless of symptoms. At-risk infants include those who are:

- **Small for gestational age (SGA) as plotted on the growth chart**
- **Large for gestational age (LGA) as plotted on the growth chart**
- **Born to mothers with any diabetic condition**
- **Late preterm (born at 34-36 6/7 weeks gestation)**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal Communication (COM)
Source: Perinatal Director of Nursing	Effective Date: 11/2015

E. Infants who are asymptomatic and not at risk do not require routine blood glucose checks.

PROCEDURE:

A. If the at-risk infant symptomatic at any time, immediately check glucose with a bedside monitor. If the level is less than 45 mg/dl, feed infant and immediately contact the infant's care provider, and anticipate orders for IV glucose (typically 200 mg/kg[2ml/kg] of D10W). Before administering the IV glucose, draw a blood sample to be sent to the laboratory for a stat plasma glucose level. Do not delay treatment waiting for the results. Ongoing glucose monitoring is indicated with a target goal of 40 to 50 mg/dl. A continuous IV infusion of D10W at 5 to 8 mg/kg/minute, 80 to 100 ml/kg/day may be needed to obtain glucose homeostasis.

Birth to 4 hours of Age:

B. If the at-risk infant is asymptomatic, perform an initial glucose screen 30 minutes after the initial feeding. If the level is less than 25 mg/dl, feed again and recheck glucose level in 1 hour.

1. If the second glucose result is less than 25mg/dl, immediately contact the infant's care provider, and anticipate orders for IV glucose (typically 200 mg/kg[2ml/kg] of D10W). Before administrating the IV glucose, draw a blood sample to be sent to the laboratory for a stat plasma glucose level. Do not delay treatment waiting for the results.

2. If the second glucose is 25 to 40 mg/dl, continue to assess for symptoms of neonatal hypoglycemia. Consider re-feeding or IV glucose as needed.

4 to 24 hours of age

C. Continue to feed the at-risk infant every 2 to 3 hours. Check glucose levels before feeding. The target glucose level before routine feedings is 45 mg/dl or greater. If the glucose level is less than 35 mg/dl, feed the infant again and re-check glucose level in 1hour.

1. If the repeat glucose level remains less than 35 mg/dl, immediately contact the infant's care provider, and anticipate orders for IV glucose (typically 200 mg/kg[2ml/kg] of D10W). Before administering the IV glucose, draw a blood sample to be sent to the laboratory for a stat plasma glucose level. Do not delay treatment waiting for the results.

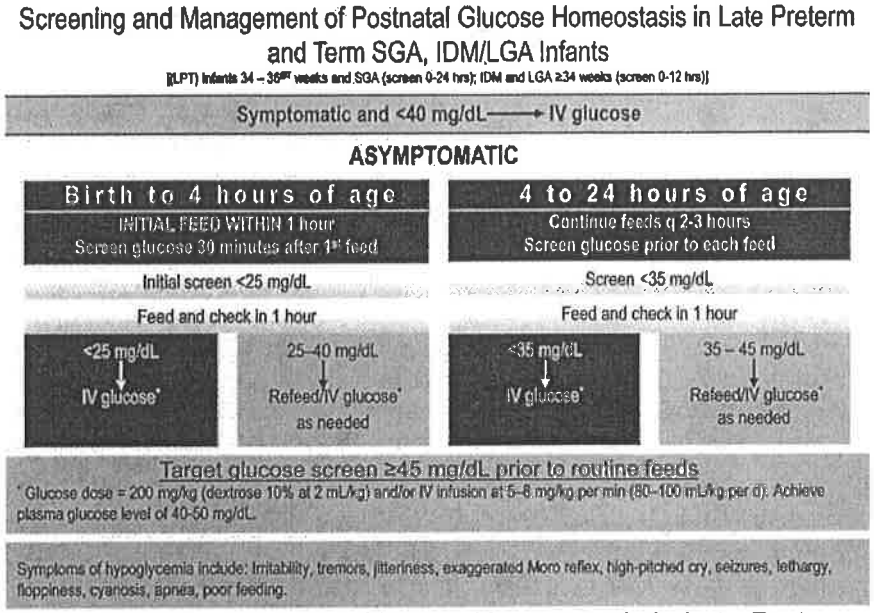
2. If the repeat glucose level is 35 to 45 mg/dl, continue to assess for symptoms of neonatal hypoglycemia. Consider re-feeding or IV glucose as needed.

D. An at-risk infant with a low glucose level will have repeated glucose screening before feedings until a target value of 45 mg/dl or greater is obtained at least 3 times before discharge. Glucose screening for infants who are LGA, or born to mothers who have diabetes, will be continued until at least 12 hours of age, regardless of levels. Glucose screenings for

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal Communication (COM)
Source: Perinatal Director of Nursing	Effective Date: 11/2015

infants who are SGA or late preterm will be continued until at least 24 hours of age, regardless of levels.

E. See Figure 1.



From: "Clinical Report—Postnatal Glucose Homeostasis in Late-Preterm and Term Infants," by the Committee on the Fetus and Newborn, L. A., Papile, D. H. Adamkin, J. E. Baley, V. K. Bhutani, W. A. Carlo, P. Kumar, R. A. Polin, R. C. Tan, K. S. Wang, & K. L.

REFERENCES:

Committee on the Fetus and Newborn, Papile, L.A., Adakim, D.H., Baley, J.E., Bhutani, V.K., Carlo, W.A. Watterberg, K.L. (2011). Clinical report: Postnatal glucose homeostasis in late-preterm and term infants. *Pediatrics, 127*(3), (575-579).

CROSS REFERENCE P&P:

1.

Approval	Date
Peri-Peds	11/5/2015
MEC	12/1/15
Board	

Developed: 11/2015 jb
Reviewed:
Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal Communication (COM)
Source: Perinatal Director of Nursing	Effective Date: 11/2015

Supersedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Admission Assessment of Obstetrical Patient	
Scope: Perinatal	Manual: **Perinatal –Communication (COM)**
Source: DON Perinatal Services Traveler	Effective Date: 11/2015

PURPOSE: To maintain optimal patient safety while observing and monitoring obstetrical patients prior to admission, and to provide guidelines for care of women admitted to the Perinatal unit.

POLICY
A qualified Perinatal Unit RN will assess and monitor all obstetrical patients presenting to the hospital for possible admission and/or treatment. Perinatal nurses will use the nursing process in the care of patients including: assessment, interpretation and diagnosis, interventions, and evaluation. Licensed, and unlicensed assistive personnel may assist in the nursing process by collecting assessment data, and orienting the patient and her family to the hospital/unit environment. The Perinatal nurse collects and interprets all fetal monitoring data.

SPECIAL CONSIDERATIONS
Physician order not required for observation and assessment.
Physician order required for admission or discharge.
Procedure may be performed by: X RN
Special education required to perform procedure: **X yes***
Age specific considerations: Explanations to teenage patients may need to be more detailed and geared to level of understanding/maturity.

***Qualified Perinatal unit RN who has successfully completed unit orientation, basic fetal monitoring class and who is able to independently care for intrapartum patients as determined by Perinatal Unit Nurse Manager.**

PROCEDURE

Each patient will be seen by a Perinatal Unit Nurse within 10 minutes of the patient's arrival in the unit. At this time at least a minimal assessment including maternal vital signs and Fetal Heart Tones (FHT's) will be taken and recorded

A. On arrival to the unit, obtain a clean catch urine sample and complete urine dip test, and obtain her current weight. If patient appears to be in very active labor have the patient change into a hospital gown, apply Electronic Fetal Monitoring ,(EFM), and TOCO equipment; complete OB assessment first.
B. Complete the obstetrical assessment, as follows:
    1. Apply the EFM to obtain baseline fetal monitor strip. If the patient refuses the application of the fetal monitor, auscultate FHR briefly with the Doppler and then perform vaginal exam to assess status.
    2. Obtain a complete set of the patient's vital signs and document on the obstetrical evaluation record or directly on the L&D flow sheet.
    3. Ask the patient if her membranes have ruptured; spontaneous rupture of membranes may be verified by a sterile speculum exam and or AmniSure as well as testing for ferning. Perform a sterile vaginal exam to determine dilatation, effacement, station, and presenting part; document on OB evaluation record or L&D flow sheet.
    4. Obtain a 20-minute baseline fetal monitor strip or auscultate the fetal heart rate (FHR) for one-minute before, during and after a contraction (the physician's or the C.N.M.'s preference/order or patient's request will dictate which method should be used).

Evaluate strip or palpate uterus for frequency, strength and duration of contractions. If fetal monitor used, evaluate fetal status including FHR baseline, presence of variability and periodic changes.

5. Notify MD or CNM of patient's status.
6. Review all available prenatal data, gather a complete history, and perform a physical assessment. Document.
7. Review laboratory data and collect any ordered laboratory specimens.
8. Document ongoing nursing assessments and care provided.

C. If the physician or the C.N.M. discharges the patient, discharge patient in the HIS (computerized hospital information system). Instruct the patient to return to the hospital if any of the following occur:
   1. Membranes rupture;
   2. Contractions increase in strength or in frequency;
   3. Vaginal bleeding occurs (bright red or heavier than normal menses);
   4. Any decrease in fetal movements.

D. If the patient remains in the hospital as a labor patient, initiate the NIH Admission Nursing Assessment Record, the Labor and Delivery flow sheet, and Labor and Delivery record. Notify admitting to change from an outpatient to an inpatient medical OB. When appropriate complete all other required forms such as the medication reconciliation form, patient care plan and obtain the various consents such as for photography or newborn hearing testing.

E. A Perinatal Staff R.N. will be assigned to monitor a actively laboring patient. The patient's vital signs, FHR and labor progress will be assessed at regular intervals (refer to Intrapartum Care Policy/Procedure).

Addendum: How to perform a Nonstress Test

NONSTRESS TEST

Purpose: To assess fetal well-being using electronic fetal heart rate monitoring (EFM).

Policy: A nonstress test (NST) is used during the antepartum period to determine fetal well-being. It is typically ordered for patients at 28 weeks of gestation or greater, and may be a one-time test or repeated weekly or biweekly.

Procedure:

A. Obtain a 20-minute (minimum) fetal heart rate (FHR) tracing using EFM. Monitoring may be extended to 40 minutes to accommodate normal fetal sleep-wake cycles.

B. Interpret the tracing using the following criteria:

1. Reactive NST: At least two accelerations in the fetal heart rate in a 20-minute window, with or without detectable fetal movement.

- For a fetus at 32 weeks of gestation or greater: An acceleration is defined as a visually apparent, abrupt increase in the FHR with the peak at least 15 bpm above baseline, lasting at least 15 seconds from onset to return.

- For a fetus less than 32 weeks of gestation: An acceleration is defined as a visually apparent, abrupt increase in the FHR with the peak at least 10 bpm above baseline, lasting at least 10 seconds from onset to return. If on previous NST a fetus less than 32 weeks of gestation has exhibited mature accelerations (15 bpm x 15 seconds), the higher amplitude criteria must be met.

2. Nonreactive: Fewer than two accelerations meeting the criteria during a 40-minute period.

A vibroacoustic stimulator may be used to elicit FHR acceleration during an NST. Acoustic stimulation is used only after a minimum of 5 minutes of established FHR baseline. The acoustic stimulator is placed on the mother's abdomen over the fetal vertex, and the stimulu

DOCUMENTATION:
As outlined above under "Procedure"

Resources:
American Academy of Pediatrics and American College of Obsetricians and Gynecologists. (2009). *Guidelines for perinatal care* (6th ed.). Elk Grove Village, IL: Authors

Association of Women's Health, Obstetric and Neonatal Nurses. (2009). *The role of unlicensed assistive personnel (nursing assistive personnel) in the care of women and newborns* (AWHONN Position Statement). *JOGGN, 38,* 745-747.

Committee Approval Needed: X no,_ yes
Responsiblity for Review and Maintenance: Perinatal Unit Nurse Manager
Index Listings: Admission Assessment of Obstetrical Patient; Labor Patient, Admission of
Revised: 8/97; 01/01; 01/03; 1/2004, 6/11jk, 7/15jb

Approval	Date
Peri-Peds	11/5/2015
MEC	
Board	

Developed: 11/2015 jb
Reviewed:
Revised:
Supersedes: Admission Assessment of Obstetrical Patient

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Shoulder Dystocia	
Scope: Perinatal	Manual: Perinatal Communication (COM)
Source: DON of Perinatal Services-Traveler	Effective Date: 11/2015

PURPOSE: To rapidly identify and manage shoulder Dystocia during a vaginal delivery.

POLICY: The following factors place the patient at risk for Shoulder Dystocia; therefore, a Cesarean birth should be considered for patients with these conditions:

- **Previous Shoulder Dystocia**
- **Diabetes and an estimated fetal weight greater than 4500 grams**
- **Estimated fetal weight greater than 5000 grams in a non-diabetic mother**
- **Estimated fetal weight greater than 4000 grams with mid-pelvic arrest of descent**

Communication is vital for the successful management of Shoulder Dystocia. Nurses and physicians will participate in yearly Shoulder Dystocia simulation drills to practice maneuvers, interventions, and the tam communication necessary for successful management of this emergency condition.

PROCEDURE:

A. Review patient history for risk factors related to Shoulder Dystocia, and estimated fetal weight as listed above.

B. Record the time of the delivery of the fetal head.

C. Record the time of initial identification of Shoulder Dystocia, the time of each maneuver, and the arrival of additional personnel.

D. Initiate nursing interventions to facilitate delivery such as:

- Lower the head of the bed, placing the patient in a supine lithotomy position
- Use McRoberts maneuver to open the patient's pelvic girdle
- Empty the bladder with straight catheter
- Apply suprapubic pressure when directed

E. Contact additional personnel (e.g., House Supervisor, anesthesia provider, additional obstetrician, neonatal resuscitation team, respiratory therapy).

F. Assist delivery provider with other maneuvers as directed such as:

- Posterior arm delivery
- Woods screw maneuver
- Rubin's maneuver
- Gaskin maneuver

Title: Shoulder Dystocia	
Scope: Perinatal	Manual: Perinatal Communication (COM)
Source: DON of Perinatal Services-Traveler	Effective Date: 11/2015

- Performance or extension of the episiotomy

G. If the shoulders have not delivered with the above interventions, emergency steps such as clavicle fracture, abdominal rescue, or the Zavanelli maneuver may be indicated.

REFERENCES:

1. American College of Obstetricians and Gynecologists. (2002, reaffirmed 2010). *ShoulderDystocia* (ACOG Practice Bulletin No. 40). Washington, D.C.: Author.

CROSS REFERENCE P&P:

1.

Approval	Date
Peri-Peds	11/5/15
MEC	12/1/15
Board	

Developed: 11/5/15 jb
Reviewed:
Revised:
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Postpartum Hemorrhage	
Scope: Perinatal	Manual: Perinatal-Communication (COM)
Source: DON of Perinatal Services-Traveler	Effective Date: 11/2015

PURPOSE: To rapidly identify and treat hemorrhage in the postpartum patient.

POLICY: All patients will be assessed for signs and symptoms of hemorrhage. While postpartum hemorrhage is described as blood loss greater than 500 ml for a vaginal delivery and greater than 1000 ml for a cesarean delivery, any abnormal findings should trigger the nurse to begin interventions, and to communicate with the patient's health-care provider.

PROCEDURE:

A. Review patient history for the following risk factors, which are associated with higher rates of postpartum hemorrhage:

- Grand multiparty
- Obesity
- Macrosomic infant
- Previous history of hemorrhage
- Bicornate uterus
- Prolonged labor
- Malpresentation
- Uterine fibroids
- Infection
- Polyhydramnios
- Multiple gestation
- Tocolytics used in labor
- Retained placenta
- Prolapsed or inverted uterus

B. Active management of the third stage of labor to prevent hemorrhage:

- 10-20 units Oxytocin IV, or 10 units IM, with delivery of placenta
- Vigorous massage of uterus q 15 minutes for 2 hours after delivery
- Controlled cord traction on placenta; closely examine for signs of retained tissue
- Careful examination of vagina and cervix for lacerations
- Quantification and documentation of blood loss with each assessment

C. With each assessment during the postpartum period, assess for abnormalities such as:

- Heavier lochia than anticipated
- Fundus displaced and/or boggy
- Bladder distended; decreased urine output
- Blood clots

- Vital signs alterations: B/P decreased, pulse increased, respiratory rate increased
- Alteration in level of consciousness
- Skin changes such as pallor, cyanosis, clamminess
- Visible hematoma or laceration
- Vaginal hematoma: ecchymosis, swelling, tenderness of perineum, and rectal pressure. Note; patient with a vaginal hematoma may not have excessive lochia

PROCEDURE FOR PATIENTS WITH HEMORRHAGE:

A. Notify patient's health-care provider and anticipate orders

B. Massage fundus and note pressure of clot formation, amount of bleeding, and/or presence of tissue

C. Ask for hemorrhage cart to be placed in or near patient's room

D. Assure adequacy IV access and give IV bolus: consider second line

E. Administer oxygen at 10 L/min via mask

F. Empty bladder: insert Foley catheter with a urimeter if indicated

G. Monitor hourly intake and output

H. Draw blood for lab work as ordered (e.g., H&H, coagulation studies)

I. Prepare to administer medications as ordered to treat uterine atony (the most common cause of postpartum hemorrhage):

- **Oxytocin (Pitocin)** 30 units in 500 ml normal saline, or 20 units in 1000 ml normal saline, or 10 units IM
- **Methylergonovine Maleate (Methergine)** 0.2 mg IM or PO every 2 to 4 hours. Caution: may cause vomiting. Contraindicated with hypertension and/or severe preeclampsia
- **Misoprostol (Cytotec)** 800 to 1000 mcg PO or rectally. One-time dose.
- **Carboprost Tromethamine (Hemabate)** 250 mcg IM, may repeat every 15 to 90 minutes to a maximum of 8 doses. Caution: may cause vomiting, diarrhea, fever, headaches, broncho constriction, and uterine rupture. Contraindicated with active cardiac, pulmonary, renal, or hepatic disease.
- **Calcium Gluconate** 100 to 1000 mg IV slowly (1 amp=1000mg) if patient has been on magnesium sulfate

J. Have intrauterine tamponade balloon catheter available

K. Anticipate and prepare for possible surgical interventions

Title: Postpartum Hemorrhage	
Scope: Perinatal	Manual: Perinatal-Communication (COM)
Source: DON of Perinatal Services-Traveler	Effective Date: 11/2015

L. Invoke the chain of command to support emergency

M. Complete all consents

N. Alert OR team

REFERENCES:

1. American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2007). *Guidelines for perinatal care (6th ed).* Elk Grove Village , IL: Authors.

2. Leduc, D., Senikas, V., Lalonde, A.B., Ballerman, C., Biringer, A., et al. (2009). Active management of the third stage of labor: Prevention and treatment of postpartum hemorrhage. *Journal of Obstetrics and Gynecology, 31,* 980-993.

Approval	**Date**
Peri-Peds	11/5/2015
MEC	12/1/15
Board	

Developed: 11/2015 jb
Reviewed:
Revised:
Supersedes:

Responsibility for review and maintenance: Perinatal Director of Nursing
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Telephone Triage	
Scope: Perinatal	Manual: Perinatal – Communication (COM)
Source: DON of Perinatal services-Traveler	Effective Date:

PURPOSE: To provide guidelines for Perinatal nursing staff to provide medical advice without the benefit of a physical exam

1. **POLICY: All patient phone calls will be triaged by a Perinatal staff nurse who has completed competency in telephone triage.**
2. **Nurses will ensure patient understands she is speaking with a nurse, not a physician.**
3. **Telephone triage should incorporate open ended questions and active listening.**
4. **All patients will be advised to seek immediate medical treatment if she feels she is having a medical emergency.**
5. **If the patient is not experiencing a medical emergency; the nurse will determine in which category the patient falls:**
   - **A. Patients who should be assessed without delay in the hospital Perinatal Department**
   - **B. Patients whose complaints may be addressed by her primary care provider**
   - **C. Patients whose complaints may be addressed by self-care methods.**

PROCEDURE:

1. Obtain the patient's name, age, parity, provider
2. Gestational age and EDD
3. Ask patient for specific complaint(s)/question(s)
4. Confirm any underlying conditions/prenatal problems or issues
5. Past obstetric history, i.e.-prior Cesarean Section
6. Contraction
   - A. Onset
   - B. Frequency
   - C. Duration
   - D. Intensity
7. Membrane status
   - A. Ruptured
     - a. Time of rupture
     - b. Amount, color, odor of fluid
   - B. Intact
8. Presence of vaginal bleeding
   - A. Amount/color
   - B. Pain
9. Recent illness
10. Recent activity or injury
11. Distance from Northern Inyo Hospital (NIH)
12. Documentation of the phone encounter will be placed in the Phone Triage log book located on the Perinatal floor

REFERENCES:

1. Association of Women's Health, Obstetric, and Neonatal Nurses. (2012). *Standards for Professional Nursing Practice in the Care of Women and Newborns, 7th edition,* Washington, DC:Author.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Telephone Triage	
Scope: Perinatal	Manual: Perinatal – Communication (COM)
Source: DON of Perinatal services-Traveler	Effective Date:

Approval	Date
Peri-Peds	**11/5/2015**
MEC	**12/1/2015**
Board	

Developed: 7/27/15 jb
Reviewed:
Revised:
Supercedes:

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioids Waste Policy	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

PURPOSE:
To ensure the safe handling and wasting of opioids.

DEFINITION: Two licensed personnel (i.e. 2 RN's, or 1 RN + Pharmacist) shall document wasted controlled substances, the person who wastes the medication and a witness. The witness must physically witness all wastes.

POLICY:

1. Medications must be stored and transferred to the patient for administration in their original container, containers prepared by the pharmacy, or in labeled syringes together with the original container.
2. Medications must be in the possession of a licensed person at all times from the receipt of the medication to the time of administration.
3. Medications may be administered to the patient, returned to the omnicell as credit if not administered to the patient, or wasted in accordance with this policy.
4. Controlled substances shall be handled in accordance with the procedure in this policy.
5. Any unused portion of the controlled substances must be witnessed, discarded and documented appropriately on the medication automated dispensing cabinet (Omnicell). Documentation including initials or signature of both RNs is done on the medication automated dispensing cabinet (Omnicell).
6. Return any non-administered controlled substances to the automated dispensing cabinet (Omnicell) return bin by selecting the name of the drug to be returned; this also cancels the charge.
7. All controlled medications (CII to CV) wasted must be recorded in Omnicell).
8. Pharmacy runs an Omnicell report daily and tracks all controlled substances which are dispensed, administered and wastes.

PROCEDURE:

1. Retrieve the opioid from the Omnicell (automated dispensing cabinet)

2. Compare and verify the medication against the electronic medication administration record (eMAR).

3. When controlled substances are unusable, the dose should be discarded in the pharmaceutical waster container (blue lid with white container) and the "WASTE" function should be used to document the waste. Do not dispose of a medication in the (automated dispensing cabinet (Omnicell). Only use the Omnicell to document the procedure.

Title: Opioids Waste Policy	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

4. Utilize a second RN to witness opioid wasting. The witness must physically witness all wastes.
    a. Administration and wasting of **parenteral opioids**:
        i. Open the vial or carpuject with the second RN as witness
        ii. Withdraw the correct dosage amount into a syringe
        iii. Label the syringe with the correct medication and dose
        iv. Withdraw the remainder of the medication into another syringe and measure for accuracy
        v. Once the accurate amount of waste is confirmed by both RN's, waste the fluid into the pharmaceutical waste container (blue lid with white container)
        vi. Dispose of the sharps into red sharps container
        vii. Record the waste in the Omnicell utilizing the second RN as witness
        viii. The administering RN will immediately take the medication along with the empty vial or carpuject to the patient
        ix. The administering RN will follow standard medication administration procedures in accordance with the Medication Bar Code Administration Policy

    b. Wasting of epidural remaining parental infusion or PCA cassettes with remaining solutions not completed:
        - Any residual volume in the PCA container is measured, wasted in the pharmaceutical waste bin, witnessed, and documented and recorded by two licensed staff in the EMAR.
        - One RN will draw up the remaining solution with syringe (i.e. PCA cassette) and the second RN will witness the disposal of the total amount solution being wasted into the pharmaceutical blue container.

    c. Wasting of patches (i.e. Fentanyl):
        i. Documentation of actual disposition for a full dose or any other remaining partial dose
        ii. One RN must wear gloves before cutting the patch into four (4 pieces) and the second RN will witness the disposal of the 4 pieces of patch disposed into the pharmaceutical container (blue lid with white container)

    d. Administration and wasting of **oral opioids**:
        i. Waste of oral medication will be witnessed, crushed and disposed of in the pharmaceutical waste container (blue lid with white container)
        ii. Two RN's will take the opioid tablet to the patient. The same RN that removes the controlled substance from the Omnicell should be the one to administer the medication via electronic bar code scanning
        iii. RN's will follow the standard medication administration procedures in accordance with the Medication Bar Code Administration Policy. The same RN removing the controlled substance from the Omnicell will be the one to administer the medication via electronic bar code scanning.
        iv. Open oral dose container

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioids Waste Policy	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

v. Cut tablet and place the tablet portion to be administered into an administration cup
vi. Place the tablet portion to be wasted into a separate administration cup
vii. Both RN's confirm waste amount
viii. Administer the oral dose to the patient
ix. Both RN's return with the opioid waste to the medication room
x. Both RN's witness the waste of the tablet portion into the pharmaceutical waste container
xi. Record the waste in the Omnicell utilizing the second RN as witness

CROSS REFERENCE P&P:
1. Omnicell Automated Dispensing Cabinet Policy
2. Administration of Medications and Biological
3. Pharmaceutical and Biohazardous Waste Policy

Approval	Date
Pharmacy and Therapeutics Committee	9/15/2015
Medical Executive Committee	12/01/15
Board of Directors	

Developed: 6/3/15
Reviewed:
Revised:
Supersedes:

Responsibility for review and maintenance: Director of Pharmacy
Index Listings:
Medication storage
Handling
Narcotic
Opiate
Waste
Return
Disposition

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Pharmacy Operations During the Temporary Absence of a Pharmacist**	
Scope: Departmental	Department: **Pharmacy**
Source: Pharmacy Director	Effective Date: 9/21/2005

PURPOSE:

To ensure that pharmacists are able to have duty free breaks and meal periods to which they are entitled under Section 512 of the Labor Code and the orders of the Industrial Welfare Commission, without unreasonably impairing the ability of a pharmacy to remain open

POLICY:

1. When NIH pharmacy is staffed by a single pharmacist, the pharmacist may leave the pharmacy temporarily for breaks and meal periods pursuant to Section 512 of the Labor Code and the orders of the Industrial Welfare Commission without closing the pharmacy and removing ancillary staff from the pharmacy if the pharmacist reasonably believes that the security of the dangerous drugs and devices will be maintained in his or her absence.

2. During the pharmacist's temporary absence, no prescription medication may be provided to a patient or to a patient's agent.

3. During such times that the pharmacist is temporarily absent from the pharmacy, the ancillary staff may continue to perform the non-discretionary duties authorized to them by pharmacy law. However, any duty performed by any member of the ancillary staff shall be checked, verified and documented by a pharmacist upon his or her return to the pharmacy.

4. The temporary absence authorized by this section shall be limited to the minimum period authorized for pharmacists by section 512 of Labor Code or orders of the Industrial Welfare Commission, and any meal shall be limited to 30 minutes. The pharmacist who is on break shall not be required to remain in the pharmacy area during the break period.

5. The pharmacy shall remain locked at all times.

References:
California Code of Regulations, Title 16, Section 1714.1 [f]

Committee Approval	**Date**
Pharmacy and Therapeutics	09-15-15
MEC	12/01/15
Board of Directors	

Revised:
Reviewed: 9/08, 9/11, 9/13
Supercedes:

Responsibility for review and maintenance:
Index Listings:
Initiated:
Revised/Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medications in the Absence of the Pharmacist	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

PURPOSE:

To delineate a system for safely providing medications to meet patient needs when the pharmacy is closed.

POLICY:
Pharmacist-on-call

1. Pharmacy hours are 0700 to 1700. From 1701 through 0659, seven days a week, the units will be faxing all orders or entering orders in CPOE to the NIH Pharmacist on call.

2. The pharmacist on call will enter the orders in the pharmacy information system through a secure computer connection after reviewing the orders for appropriateness and safety.

3. The pharmacy shall maintain medications in the automated dispensing cabinets (Omnicell) for use when:

    - The pharmacy is closed
    - The pharmacy is unavailable
    - Drugs are not in the patient's supply and cannot be obtained from the pharmacy in a timely manner

PROCEDURES:

REMOVING DRUGS WHEN THE PHARMACY IS CLOSED:

Automated dispensing units

1. The Director of Pharmacy in consultation with the unit Supervisor shall determine nature and quantity of medications in ADC with approval by the Pharmacy and Therapeutics Committee.

2. The pharmacy will stock the Automatic Dispensing Units in accordance with the Automatic Dispensing Unit policy.

3. Diagnostic and ancillary departments of the hospital may stock pharmaceuticals peculiar to their departments only when the physician in charge of the department has authorized such.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medications in the Absence of the Pharmacist	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

4. Pharmacists and pharmacy personnel will ensure that all medications containers are labeled with the drug name, strength, manufacturer, lot number, and expiration date in the automated dispensing cabinets (Omnicell)

5. Pharmacy personnel will check for outdated medications in the automated dispensing cabinets (Omnicell) during monthly Pharmacy Quality Assurance Rounds.

6. Each business day when the pharmacy opens, the pharmacy personnel shall:

    a. Review the medication usage since the pharmacy last closed
    b. Restock the after-hours medication supply up to the established par level.

7. All pharmaceuticals stored or used by any department in the hospital shall be under the supervision of the Pharmacy Department.

8. Pharmaceutical supplies shall be ordered in writing on the Supplies Requisition form.

9. Any repackaging shall be done in the Pharmacy under the direction of the pharmacist. Repackaged items shall be labeled with the following information:

    a. Name of the ingredient(s)
    b. Strength and dosage form (if indicated)
    c. Manufacturer and lot number
    d. Expiration date
    e. Date of repackaging, followed by the initials of the preparer (For example, 040295KK)

10. Repackaging, transferring medications from one container to another, and labeling or relabeling of medications is prohibited by other than pharmacy personnel.

11. The pharmacist shall check the filled stock requisition for accuracy and will initial the requisition to document the check before the requested items leave the pharmacy.

12. Amount of Drugs to Remove: Only amounts of drugs sufficient for immediate therapeutic needs may be removed from the automated dispensing cabinets.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medications in the Absence of the Pharmacist	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

Pharmacy Access after Pharmacy Hours

1. There shall be no access to the pharmacy by anyone other than a registered pharmacist.

Pharmacist Verification of After-Hours Removals of Medications from ADU

1. Overrides are not permitted except in extreme emergencies.

2. Only medications determined by the Director of Pharmacy with approval of the Pharmacy and Therapeutics Committee will be available for override including the following categories:
   Drugs available for override by all nurses without Pharmacist authorization:
   a. Emergency Medications including:
      1. Naloxone
      2. Dextrose 50%
      3. Diphenydramine
      4. Flumazenil
      5. Injectable pain medications
      6. Ondansetron Injectable and Orally Disintegrating Tablets
      7. Promethazine
      8. Prochlorperazine
      9. Volume expanders limited to solutions without potassium
      10. Nitroglycerin tablets
      11. RSI Kit-Rapid Sequence Intubation
      12. Hemorrhage Kit – OB---access to Perinatal RN
      13. Injectable Benzodiazepines
      14. Pitocin Bag

3. Medications removed without a pharmacist review via override should be reviewed for appropriateness prior to administration:
   a. Drug, dose, frequency, and route of administration
   b. Therapeutic duplication
   c. Drug allergies or sensitivities
   d. Potential interactions between other medications, food, and laboratory values

4. Patient safety will be considered in all decisions involving override medications.

5. Prior to accessing medications available for override, the pharmacist on call must be called for consultation.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medications in the Absence of the Pharmacist	
Scope: Hospital wide	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

6. An override report will be generated automatically each day by the ADU system and will be analyzed by the pharmacist on duty for appropriateness.

7. Performance improvement action will be taken by the Director of Pharmacy for any unnecessary overrides.

Cross-Reference:
Medication Over-ride policy

Committee Approval	**Date**
Pharmacy and Therapeutics	9/16/2015
Medical Executive Committee	12/01/15
Board of Directors	

Revised 4/15/04, 8/06
Reviewed 10/05,04/08 BSS/JBF,
10/08bss, **9/12 BS**
Supercedes

Index Listing: After Hours Access to Drugs
1. Maintain accountability for the drugs in the After-hours Medication Supply.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Protecting Public from Impaired or Dishonest Pharmacy Employee	
Scope: Departmental	Manual: Pharmacy
Source: Pharmacy Staff Pharmacist	Effective Date:

PURPOSE:

To define actions that will be taken by the hospital when confronted with a licensed pharmacy employee with sufficient impairment that it effects his or her ability to practice the profession or occupation authorized by his or her license (B&PC 4104[a])

To define actions that will be taken by the hospital when confronted with a licensed pharmacy employee who has engaged in the theft or diversion or self-use of prescription drugs belonging to the pharmacy (B&PC 4104[b])

DEFINITIONS:

1. Licensed pharmacy employee (LPE), for purposes of this policy, include Licensed Pharmacists and Registered Pharmacy Technicians.

2. Impairment includes sufficient chemical impairment that an alcohol or drug test is positive, or impaired mental or physical status that the emergency room physician on duty judges that the LPE cannot safely perform his/her duties.

3. Theft and diversion mean the legal or illegal removal, without authorization of prescription drugs owned by the hospital.

4. Self-use means the consumption of prescription drugs belonging to the hospital that have not been obtained pursuant to a lawfully filled prescription.

POLICY:

Impairment due to alcohol or drugs:

1. Any hospital department manager suspecting that an LPE appears impaired due to alcohol or drug consumption may require that the suspected employee submit to a drug and or alcohol test in accordance with the "Employee Drug and Alcohol Testing for Reasonable Suspicion Policy." In addition, the pharmacist on duty may require that a suspected technician submit to a drug and or alcohol test in accordance with the "Employee Drug and Alcohol Testing for Reasonable Suspicion Policy."

2. If found positive for alcohol or drug consumption, the Pharmacist-in-Charge (PIC) shall be notified as soon as possible and the LPE shall be sent home in accordance with the "Employee Drug and Alcohol Testing for Reasonable Suspicion Policy."

3. If the LPE found impaired is a pharmacist, a back-up pharmacist will be called in by the PIC or by the Nursing Supervisor to finish the shift of the impaired pharmacist.

4. Should a back-up pharmacist (including the PIC) NOT be available to take over the shift of the pharmacist who was sent home, then the pharmacy shall be closed and after-pharmacy-hours procedures followed until another pharmacist can resume services.

5. During any delay in the time that a backup pharmacist can take over a shift, the pharmacy shall be closed and after-pharmacy-hours procedures shall be followed.

6. If the LPE found impaired is a technician, then the pharmacist on duty will decide if a back-up technician is to be called in.

Impairment due to mental or physical defect

1. Any hospital department manager suspecting that an LPE appears impaired due to mental or physical illness shall require that the LPE go to the emergency room for evaluation and treatment.

2. The suspected employee shall be processed as an emergency case.

3. If the LPE is a pharmacist and the emergency room physician on duty judges that the LPE is too mentally or physically impaired to return to duty, then a back up pharmacist shall be called in by the PIC or the Nursing Supervisor.

4. Should a back-up pharmacist (including the PIC) NOT be available to take over the shift of the pharmacist who was deemed too impaired to return to duty, then the pharmacy shall be closed and after-pharmacy-hours procedures followed until another pharmacist can resume services.

5. During any delay in the time before a backup pharmacist can take over a shift, the pharmacy shall be closed and after-pharmacy-hours procedures shall be followed.

6. If the LPE found to be mentally or physically impaired is a technician, then the pharmacist on duty will decide if a back-up technician is to be called in.

7. Any LPE found to be mentally or physically impaired in accordance with this policy may return to full duty when released to do so by a physician caring for the LPE with the mental or physical illness.

Theft, diversion or self-use of prescription drugs

1. If hospital management has sufficient evidence of theft, diversion or self-use of prescription drugs by an LPE to undertake disciplinary action, then, the LPE shall be placed on administrative leave and the evidence shall be turned over to the California State Board of Pharmacy.

2. If the California State Board of Pharmacy investigation finds that the LPE has indeed engaged in theft, diversion or self-use of prescription drugs and the Board takes disciplinary action that suspends or revokes the LPE's license, then the hospital shall terminate the LPE's employment.

3. If the California State Board of Pharmacy investigation finds that the LPE has indeed engaged in theft, diversion or self-use of prescription drugs and the Board takes disciplinary action that

places the LPE's license on probation, then the hospital will make a disciplinary decision appropriate to the case.

4. If the California State Board of Pharmacy investigation finds that the LPE has not engaged in theft, diversion or self-use of prescription drugs and takes no disciplinary action, the hospital shall make a disciplinary decision appropriate to the case.

PROCEDURES

1. The Director of Pharmacy shall be responsible for taking action in compliance with the California Board of Regulations. The Board of Pharmacy regulatory mandates to protect the public whenever a pharmacy staff member is discovered or is known to be chemically, mentally, or physically impaired to the extent that the impairment affects job performance [section 4104].

2. It is the professional responsibility of pharmacy staff to report suspected chemical, mental or physical impairment to a supervisor. Impaired pharmacy personnel shall be reported to the Director of Pharmacy. If the Director of Pharmacy is suspected to be impaired, the report shall be made to the CEO.

3. The Director of Pharmacy shall notify the California State Board of Pharmacy of any employee's admission of impairment, documented evidence of impairment, or termination as a result of impairment within 14 days of discovery of impairment or termination.

4. The report to the State Board of Pharmacy shall include sufficient detail to inform the board of the facts upon which the report is based, including an estimate of the type and quantity of all dangerous drugs involved, the timeframe over which the losses are suspected, and the date of the last controlled substances inventory. Upon request of the board, the pharmacy shall prepare and submit an audit involving the dangerous drugs suspected to be missing [section 4104].

REFERENCE:

- California Business and Professions Code, Section 4104

Committee Approval	**Date**
Pharmacy and Therapeutics Committee	9/16/2015
MEC	12/01/15
Board of Directors	

Revised
Reviewed 10/08,10/11.3-14
Supercedes

NORTHERN INYO HEALTH DISTRICT
POLICY AND PROCEDURE

Title: Automated External Defibrillators	
Scope: District (Hospital and Clinics)	Manual: Clinical Practice Manual
Source: Director of Nursing, Critical Care	Effective Date:

PURPOSE:

To provide guidance for staff in the use of automated external defibrillators (AED) and to outline the quality assurance and preventative maintenance to insure AEDs are available and in working order in areas where a Crash Cart may not arrive in a timely manner.

POLICY:

It is the policy of Northern Inyo Health District that any staff member trained and current in American Heart Association Basic Life Support for Healthcare providers (CPR and AED) Program who finds an individual in cardiac arrest or unresponsive shall start CPR and follow Cardiopulmonary Resuscitation guidelines.

PROCEDURE:

1. Maintenance of the HeartStart FR3 Defibrillator (FR3):

    a. Maintenance of the HeartStart FR3 Defibrillator (FR3) is very simple, but it is a very important factor in its dependability. When in standby (i.e., the battery is installed), the FR3 performs many maintenance activities itself. These include daily, weekly, and monthly self-tests of respectively increasing detail to verify readiness for use. In addition, each time the FR3 is turned on, it executes a power-on self-test. You can also run a detailed user-initiated test when desired.
    b. The FR3 also checks its performance while it is in use. The FR3 requires no calibration or external verification of defibrillation therapy delivery. The FR3 has no user-serviceable parts.
    c. Maintenance Schedule:
        a. The department will check the Ready light.
            i. If the green Ready light is flashing: The FR3 has passed its last self-test and is ready to use. No action required
            ii. If the green Ready light is off and the FR3 is continuously chirping: The FR3 needs attention. If it is giving single chirps, press the On/Off button to start the FR3. When voice prompts begin, press the button again to display the status screen for information about the status of the FR3 and how to resolve the problem.
            iii. If the FR3 is giving triple chirps, press the On/Off button to start the FR3. The FR3 will display the status screen for the error message. Record the error, turn off the FR3, and remove it from service. Then contact Philips at www.philips.com/ AEDSupport for technical support.

iv. If the green Ready light is off but the FR3 is not chirping and the display screen is blank: There is no battery inserted, the battery is depleted, or the defibrillator needs repair. Insert/replace battery and let it run the power-on self-test. If the FR3 passes the self-test, it is ready for use.

d. The following will be checked and documented on an AED log every six months by the BioMedical department.

i. Check supplies, accessories, and spares for damage and expiration dating. Do not use damaged or expired accessories. BioMedical to follow – up with the department where AED is located in order to replace damaged or expired items.

ii. If the green Ready light is off and the FR3 is giving single chirps: Press the On/Off button to start the FR3. When voice prompts begin, press the button again to display the status screen. If a REPLACE BATTERY message is displayed: Replace the battery and run the self-test. If a REPLACE PADS message is displayed: Replace the pads and run the self-test.

iii. If the FR3 is giving triple chirps, press the On/Off button to start the FR3. The FR3 will display the status screen for the error message. Record the error, turn off the FR3, and remove it from service. Then contact Philips at www.philips.com/ AEDSupport for technical support.

iv. Check the outside of the FR3 and the connector socket for cracks or other signs of damage.

v. If you anyone in the department sees signs of damage: Remove from service and contact BioMedical immediately.

2. Use of the AED:

a. Upon finding an individual in cardiac arrest, activate the EMS system (call 911 or hospital resuscitation team if within the hospital).
b. Start CPR; always follow Cardiopulmonary Resuscitation guidelines.

3. Event checklist after use:

a. Responders working on the victim shall document and communicate the following information to the resuscitation team or EMS provider if the event occurs in the Rural Health Clinic or the other physician's offices:

a. Victim's name
b. Known medical problems, allergies or medical history
c. Time the victim was found, condition and vital signs, if obtained

d. Type and time of intervention(s) provided, to include the number of shocks delivered and length of time the defibrillator was used
e. Victim's response to intervention(s) and information from the AED screen.

b. As soon as possible after the event, the shift ADON shall check the AED, restock the supplies immediately after the event and perform the after-patient-use maintenance on the AED.

a. Clean and disinfect the device
b. Check the battery and replace it, if needed
c. Check the device and housing for cracks or other damage
d. Return the AED to its designated place with appropriate supplies

Title: Automated External Defibrillators	
Scope: District (Hospital and Clinics)	Manual: Clinical Practice Manual
Source: Director of Nursing, Critical Care	Effective Date:

Main Building First Floor	Crash Cart/Defib.	AED	Response with Crash Cart/Defib.
Registration Lobby		In progress with Philips FRC AED (ordered)	Code Team response. HS to bring PACU crash cart/defib and gurney until AED purchased.
Registration Parking Lots Healing Garden		In progress with backpack Philips FRC AED (ordered)	Code team to parking lot with AED, First Response backpack with AED, and stretcher.
Satellite Lab			Code Team response. HS to bring PACU crash cart/defib.
ED	Crash cart/Phillips MRX room 7 next to 7A.. Crash cart/Phillips MRX in room 1 next to bed 1.		Code Team response.
SDS/PACU	Crash cart/Phillips MRX West wall next to public entrance.		Code Team response.
Surgery (OR)	Crash cart/Phillips MRX Anesthesia Room		Code Team response. Will drill for response.
Infusion Center			Code Team response. Future – ADON to bring EKG crash cart/defib.
Employee Health, Nursing Informatics & Nursing Practice			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
EKG	Crash cart/Phillips MRX room		Code Team response.
Respiratory Therapy			Code Team response. HS to bring EKG crash cart/defib.

Title: Automated External Defibrillators	
Scope: District (Hospital and Clinics)	Manual: Clinical Practice Manual
Source: Director of Nursing, Critical Care	Effective Date:

Main Building First Floor	Crash Cart/Defib.	AED	Response with Crash Cart/Defib.
Diagnostic Imaging	Crash cart/Phillips MRX located in CT control room		Code Team response
Pharmacy			Code Team response. AED outside cafeteria, Code I will bring AED/Backpack/Gurney in future state.
Cafeteria		Outside cafeteria Phillips FR3 AED (ordered)	Code Team response. AED outside cafeteria, Code I will bring AED/Backpack/Gurney in future state.
Hallway Office Suites (PI etc)			Code Team response. AED outside cafeteria, Code I will bring AED/Backpack/Gurney in future state.
Meeting Rooms Old Main 1			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
Training Center Medical Staff Suites			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
Medical Records			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
HR			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
IT			Code Team response. Code I will bring AED/Backpack/Gurney in future state.

Title: Automated External Defibrillators	
Scope: District (Hospital and Clinics)	Manual: Clinical Practice Manual
Source: Director of Nursing, Critical Care	Effective Date:

Main Building First Floor	Crash Cart/Defib.	AED	Response with Crash Cart/Defib.
Finance			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
Nursing Administration			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
Hospital Administration and AMR			Code Team response. Code I will bring AED/Backpack/Gurney in future state.
Main Building Second Floor	**Crash Cart/Defib.**	**AED**	**Response with Crash Cart/Defib.**
ICU	Crash cart/Phillips MRX		Code Team Response
Medical-Surgical SWING	Crash cart/Phillips MRX		Code Team Response
Women's Services		Philips FR3 AED	Med/Surg RN Response with Med/Surg crash cart/defib to WS.
Second Floor Waiting Room			Med/Surg RN Response with Med/Surg crash cart/defib to waiting room
Parking Lots, Clinics, and Medical Offices	**Crash Cart/Defib.**	**AED**	**Response with Crash Cart/Defib.**
Administrative Parking Lot			Code team to parking lot with AED, First Response backpack and stretcher.

Title: Automated External Defibrillators	
Scope: District (Hospital and Clinics)	Manual: Clinical Practice Manual
Source: Director of Nursing, Critical Care	Effective Date:

Line Street Parking Lot			Code team to parking lot with AED, First Response backpack and stretcher.
Parking Lots, Clinics, and Medical Offices	**Crash Cart/Defib.**	**AED**	**Response with Crash Cart/Defib.**
RHC Office Building		Philips FR3 AED	No Code Team response RHC staff response with AED and emergency response cart. Call 911.
RHC Women's Health		Philips FRX AED FR3 AED (ordered)	
Rehab Services		Philips FR3 AED	
Orthopedic Office		Philips FR3 AED	
Surgery Office		Philips FRX AED FR3 AED (ordered)	

Dev 11/15

REFERENCES:

Title: Automated External Defibrillators	
Scope: District (Hospital and Clinics)	Manual: Clinical Practice Manual
Source: Director of Nursing, Critical Care	Effective Date:

Philips HeartStart FR2+: http://onesourcedocs.com/member/show-document.html?id=417680

Philips HeartStart FR3:
http://incenter.medical.philips.com/doclib/enc/fetch/2000/4504/577242/577243/577245/577817/577818/FR3_Owner_s_Manual_-_Instructions_for_Administrators_(IFA)_861388_861389_(ENG)_ed._3.pdf%3fnodeid%3d8957241%26vernum%3d-2

Circulation, ECC Guidelines, *Part 4: The Automated External Defibrillator, Key Link in the Chain of Survival*, http://circ.ahajournals.org/content/102/suppl_1/I-60.full#cited-by

Occupational Safety and Health Administration (OSHA), Technical Information Bulletin, *Cardiac Arrest and Automated External Defibrillators (AEDs)*, TIB 01-12-17

American Heart Association, *Automated External Defibrillator, Implementing an AED Program*, http://www.heart.org/idc/groups/heart-public/@wcm/@ecc/documents/downloadable/ucm_438703.pdf

American Heart Association, Automated External Defibrillation, Implementation Guide, http://www.uiltexas.org/files/health/aed-implementation.pdf

Emergency Room Medical Services Committee	**11/11/2015**
MEC	**12/01/2015**
Board	

Developed: 11/15
Reviewed:
Revised:
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
People you know, caring for people you love.

NORTHERN INYO HOSPITAL
Northern Inyo County Local Hospital District

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 voice
(760) 872-2768 fax

Performance Excellence (PEX) December 16, 2015

Quality Assurance and Performance Improvement (QAPI) Report

QAPI Staffing Update

1. PI Assistant hired to replace vacant position; PI Assistant and Quality Improvement Analyst will report to Wendy Runley, who has been promoted to QAPI Coordinator. The QAPI Coordinator will receive additional training on regulatory affairs and basic data analysis.

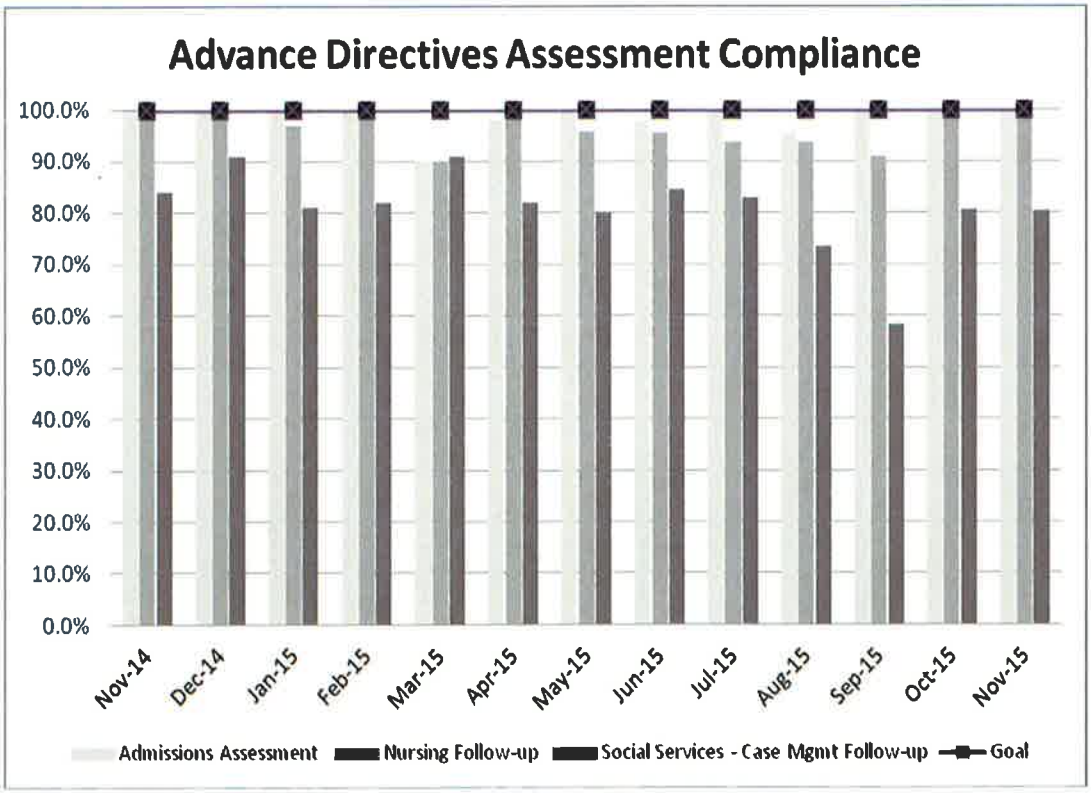
Joint Commission Survey Readiness

2. Focused Standards Assessment. NIH continues to make improvements based on the FSA findings, in preparation for an on-site survey. *Performance Excellence staff have been assigned to work on some improvements in the TJC functional chapters of Leadership (LD), Performance Improvement (PI) and Medical Staff (MS). PEX will be partnering with senior managers to prepare for a TJC survey.*
3. *General application being completed to reflect licensure changes.*

2013 CMS Validation Survey Monitoring

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

   a. Advance Directives Monitoring.

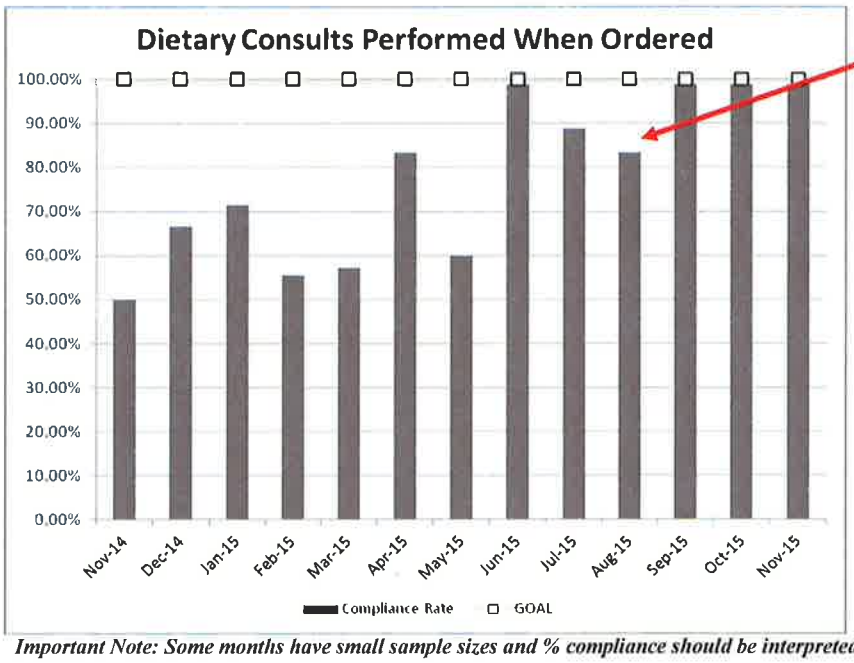


b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013. The Dietary department has developed and is testing new handwashing logs with the help of Nel Hecht, Infection Preventionist, to provide more meaningful data.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.

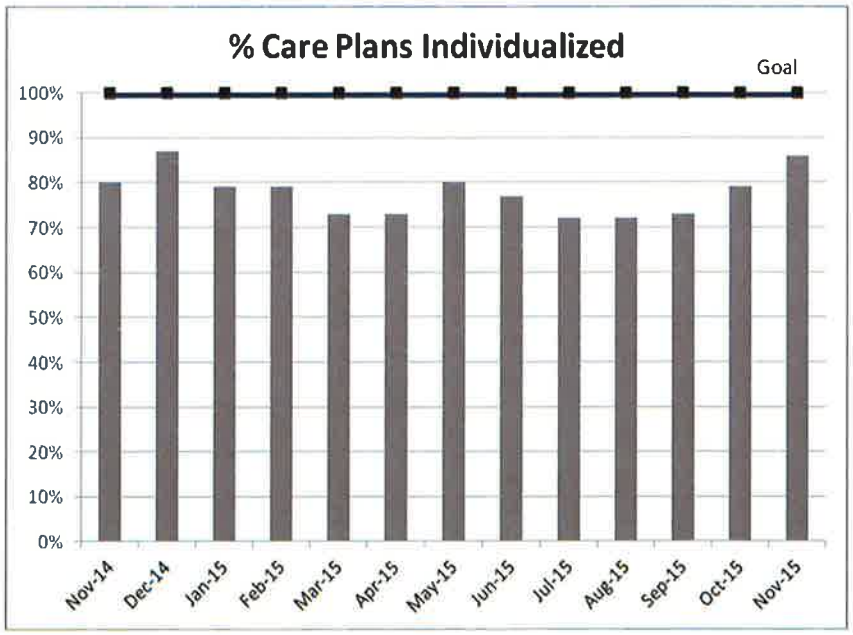


Small tests of change:

- Dietary referral log checked 2x/day 1100 and 1700 with results documented
- Dietician on call put on white board every morning
- Referrals print to Dietician office
- Increased weekend dietician coverage

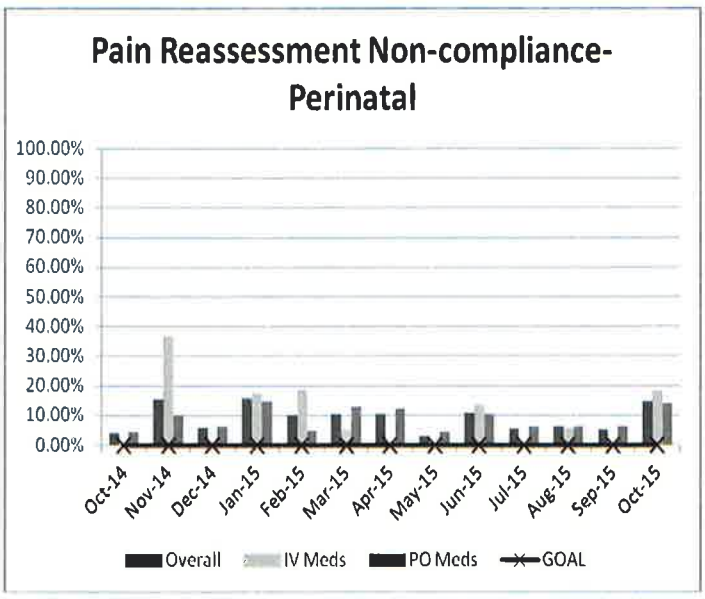
Important Note: Some months have small sample sizes and % compliance should be interpreted with caution.

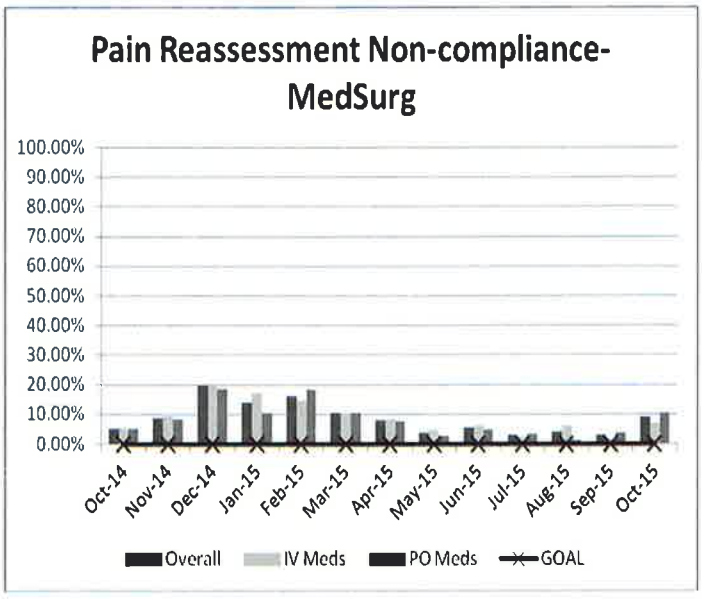
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

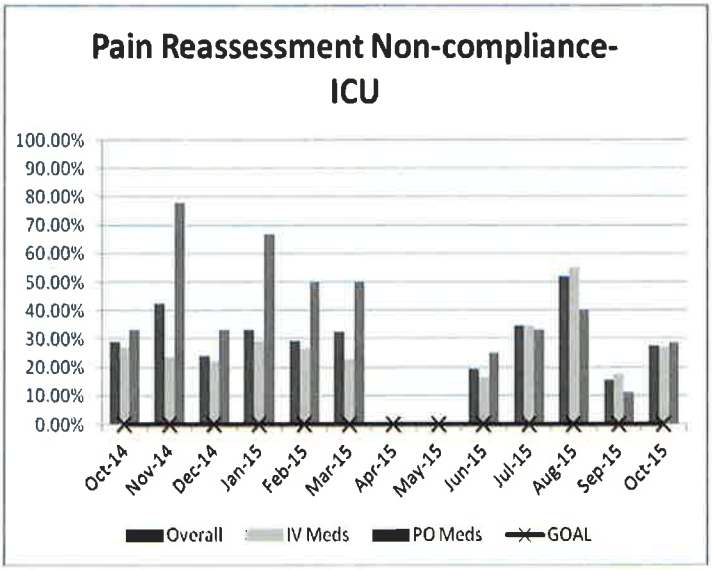


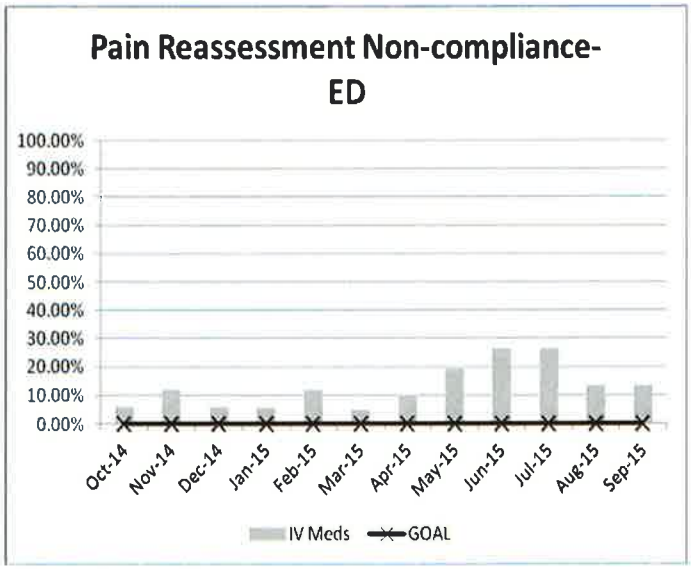
g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale. Please not that different scales are used for different departments for easier visualization, but that the scale will be used starting in October for better inter-departmental comparison. No new data since last BOD meeting.









5S Projects (See Attachment for 5S process diagram)

1. *Incident Report Re-organization - Set*
2. *Performance Improvement & Medical Staff Office Desktop Shared Drive Re-organization – Sort*

CMS Core Measures Project (DMAIC)

3. Project Progress (Analyze/Improve)
   a. Improve: In process of brainstorming solutions with many ideas focusing on mistake-proofing, automation and standard work strategies.
      - Solutions selected for testing include creating usable, validated query reports to be used for submission process and creation of training modules for submission process.
      - *Reports being developed and validated.*

Important Note: After completion of this project, other regulatory reporting projects will be conducted to improve the efficiency of these processes and increase opportunity for spending more time on value-added projects.

Clinical Documentation Improvement

1. Emergency Department Charge Capture Improvement Project (DMAIC)

2. OB Biliscan Charge Capture Improvement Project (DMAIC)-
   a. Improve:
      1. *Bili Scan Transcutaneious Bilirubin Testing Policy & Procedure revisions now reflect more appropriate clinical documentation process.*
      2. *Next steps will include revising the software data entry interface for improved usability, especially with regard to the following factors: Recognition versus recall, visibility of system status. Users will see cues of required data versus depending on recall.*
      3. *Physicians will be able to see a series of readings and have better information for making clinical decisions.*

3. Perinatal Chargemaster Improvement Project. (DMAIC)-
   a. Measure:
      1. *QAPI Coordinator is collecting data from draft Level of Care worksheets being completed by Nursing to determine identify documentation discrepancies, training needs and assist with development of training materials and job aids.*

Performance Excellence Training

- Training QAPI staff to conduct QAPI/Risk Management orientation

1. Lean Six Sigma Green Belt training. (For more information about this methodology, please visit http://asq.org/cert/six-sigma-green-belt/bok. Lean Six Sigma is a scientific, data-driven methodology for improving processes and systems.

   - Class participant projects using a Lean Six Sigma or PMBOK methodology include the following:

     - CMS Core Measures Improvement project (Analyze/Improve)
     - OB Biliscan Charge Capture Improvement Project (Improve)
     - Perinatal Chargemaster Improvement Project (Initiate/Define)
     - EVS Route Standardizaton Improvement Project (Initiate)
     - Medical Records Lean Work Board Project (FOCUS-PDSA-Understand)
     - Emergency Department Charge Capture Improvement Project (Control & Close-Out)
     - Physician On/Offboarding Improvement Project (Initiate/Define)

2. *Project Management Consulting/Mentoring.*

   - Projects mentored and/or facilitated by CPEO:

     - *Orthopedic Patient Flow Improvement Project (Initiate/Define)*
     - *Workplace Violence Risk Assessment (Initiate/Define)*

- *Wound Care Standardization & Improvement Project (Initiate/Define)*

- Project charters reviewed:
  - *340 B Program*

Strategic Communications Report

Marketing/Internal Communication Projects (See Attachments)

Events

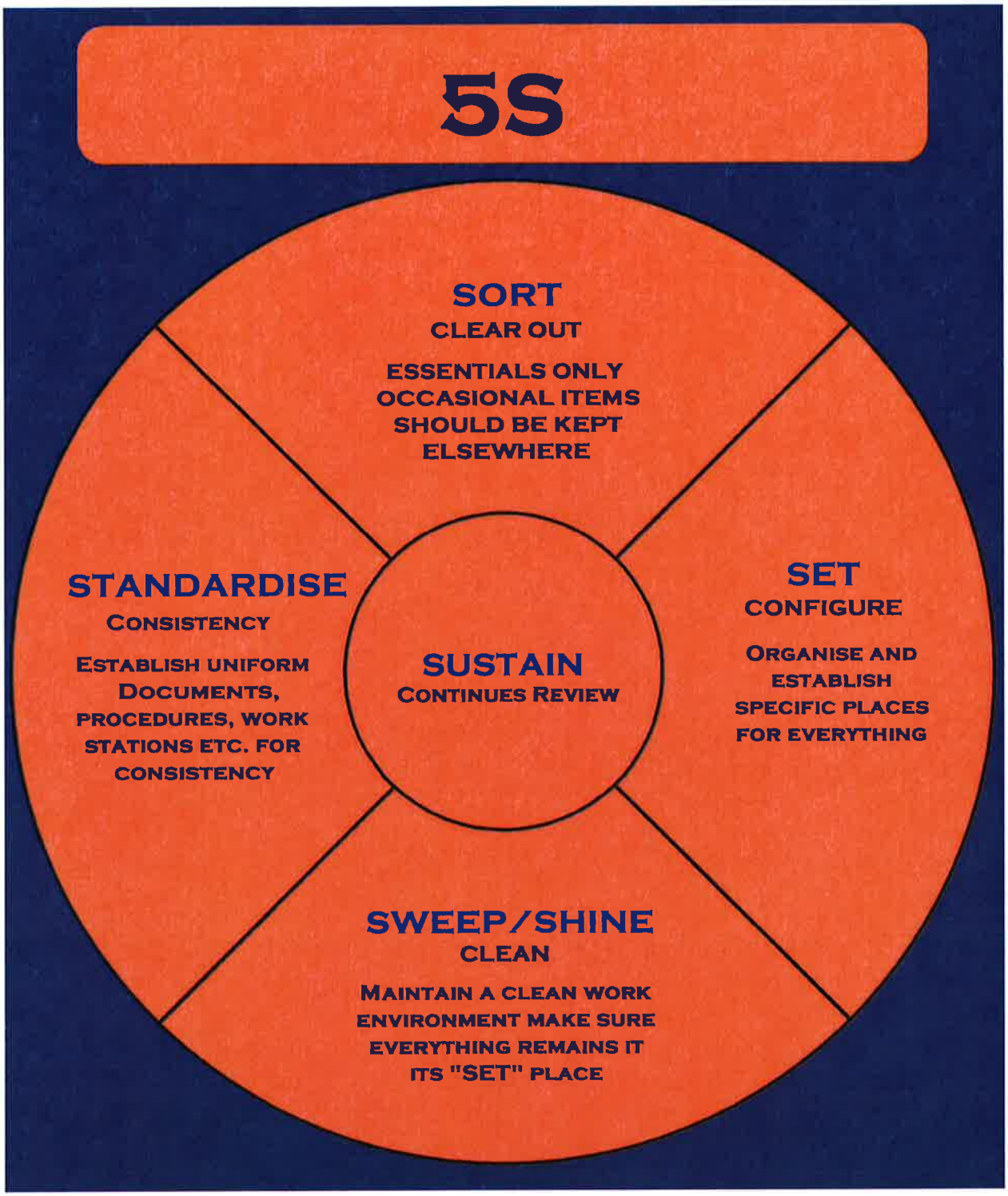
1. *Dr. Brown, Board-certified family physician, scheduled to speak about "Bone Density & Your Health" to the community on 12/17/15, 6:30 PM at NIHD Birch Street Annex.*
2. *Reception for emergency room physicians, 11/23/15, 5:00-6:30 PM*

Medical Staff Office Report

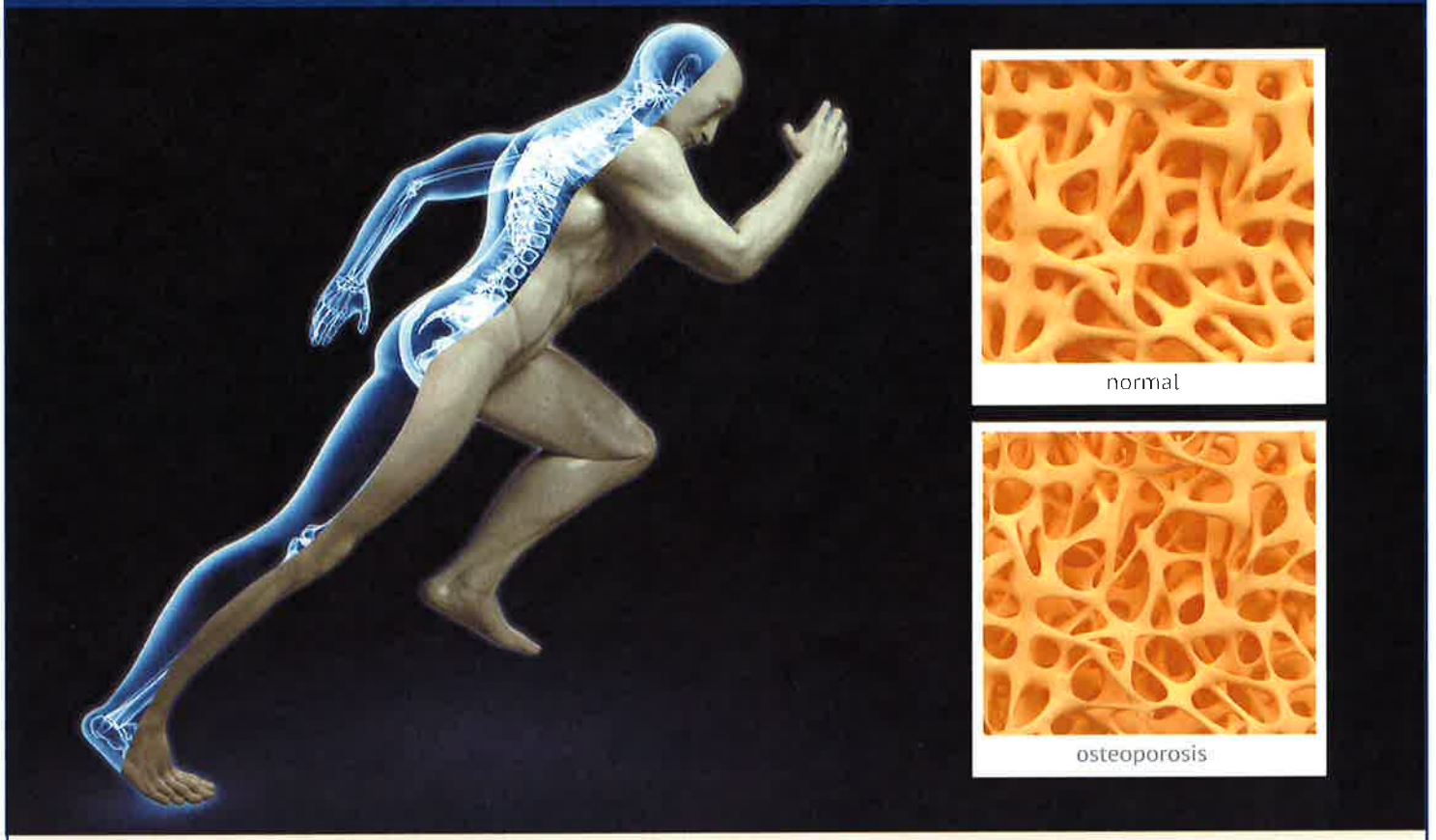
Medical Staff Office Updates

1. Medical Staff Office is working on re-appointment packages.

Project Management Methodology Keys
FOCUS-PDSA CYCLE: F (Find), O (Organize), C (Clarify), U (understand), S(Select), P(Plan), D(DO), S (Study), A (Act)
5S: Sort, Set, Sweep/Shine, Standardize, Sustain
DMAIC: Define –Measure-Analyze-Improve-Control
DMADV: Define-Measure-Analyze-Design-Verify
PMBOK: Initiate-Plan-Execute-Monitor & Control-Close-Out


5S
SORT
CLEAR OUT
ESSENTIALS ONLY
OCCASIONAL ITEMS
SHOULD BE KEPT
ELSEWHERE
STANDARDISE
CONSISTENCY
ESTABLISH UNIFORM
DOCUMENTS,
PROCEDURES, WORK
STATIONS ETC. FOR
CONSISTENCY
SUSTAIN
CONTINUES REVIEW
SET
CONFIGURE
ORGANISE AND
ESTABLISH
SPECIFIC PLACES
FOR EVERYTHING
SWEEP/SHINE
CLEAN
MAINTAIN A CLEAN WORK
ENVIRONMENT MAKE SURE
EVERYTHING REMAINS IT
ITS "SET" PLACE

NIH Healthy Lifestyle Talks – Free, Open to Public



Speaker

Stacey Brown, MD

Board-certified family physician, specializing in all aspects of primary care

Improving Our Communities, One Life at a Time

Bone Density & Your Health

Focusing on the health of our skeleton, including normal bone metabolism and bone disorders, osteoporosis, bone density screening and bone metabolism

Thursday, Dec. 17, 6:30 pm

Northern Inyo Hospital's Birch Street Annex
2957 Birch St., Bishop

Northern Inyo Healthcare District

One team. One Goal. Your Health.

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(760) 873-5811 | www.NIH.org

FOR IMMEDIATE RELEASE
Contact: Barbara Laughon
NIH Strategic Communications
(760) 873-5811 ext. 3415

NIH Reception welcomes new emergency care providers

Northern Inyo Healthcare District will host a "Meet and Greet" reception introducing some of its newest emergency care providers to the community.

The reception is set for **Monday, Nov. 23rd, 5 - 6:30 p.m.** at the main lobby of Northern Inyo Hospital. The physicians spotlighted during the event include:

- **Peter Bloomfield, MD**, a veteran emergency care physician, has enjoyed time abroad, offering his services as an earthquake relief worker in Haiti, as a Peace Corps volunteer in Belize, and back home again as a Pharmaceutical Assistant at a Washington, DC free clinic. Dr. Bloomfield earned his Bachelor of Arts degree in History from Williams College in Williamstown, Massachusetts. He earned a Masters in Public Health and his Medical degree from Johns Hopkins University in Baltimore, Maryland. A residency at UCLA brought him west. In his off-time, Dr. Bloomfield practices yoga and meditation, and studies Kung Fu.

- **Anne Goshgarian, MD**, earned her Bachelor of Science degree in Kinesiology, with Highest Honors from University of Illinois in Urbana-Champaign, Illinois. She earned her Medical degree from Creighton University School of Medicine in Omaha, Nebraska. Dr. Goshgarian completed her residency in Emergency Medicine at the University Medical Center of Southern Nevada in Las Vegas, Nevada. Dr. Goshgarian provides voluntary medical care to many artistic festivals including Nevada's Burning Man Festival and the Electric Daisy Carnival.

- **William "Will" Timbers, MD**, hails from Vermont and grew up with a zest for outdoor living. An avid skier, accomplished high school and collegiate Lacrosse player, and climbing enthusiast, Dr. Timbers enjoys many of the outdoor activities Bishop offers and looks forward to learning more about our area. Dr. Timbers earned his Bachelor of Arts degree in English Literature from Saint Lawrence University in Canton, New York, and his Medical degree from the University of Vermont's College of Medicine. He completed his Harvard-affiliated Emergency Medicine residency at the Beth Israel Deaconess Medical Center in Boston, Massachusetts.

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Northern Inyo County Local Hospital District

Bishop, California

Proposal to provide
Strategic and Financial Planning Services

December 8, 2015

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

Table of Contents

Appendixes

Wipfli LLP
201 W. North River Drive, Suite 400
Spokane, WA 99201

509.489.4524
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www.wipfli.com

Our Understanding of Your Needs

Based on our discussion it is our understanding that Northern Inyo County Local Hospital District (NIH or "Hospital") is interested a data driven plan for decision making on the future direction and strategic financial positioning for the organization. The Hospital wants to prepare for the changing health care delivery system, while remaining independent and ensuring that the community provides essential health services to a large geographic service area.

In terms of immediate needs, NIH wants to understand the finanical impact of refinancing a portion of their existing debt. Specifically, NIH would like a summary of the impact on CAH reimbursement of the new debt and the associated financial ratios, which affect credit rating.

Furthermore, NIH would like to conduct additional analysis to develop a data driven strategic plan in coordination with the annual strategic planning efforts and systems already in place. NIH is seeking robust information about the current state in terms of market position, operational efficiency, departmental profitability, finanical performance, physician/provider staff needs in order to make good decisions about the future direction of the organization.

The result will be a strategic plan developed from information specific to NIH's market and centered on best practices for CAHs in an era of healthcare reform.

The purpose of this engagement is to assist NIH in twofold, first to evaluate the impact of refinancing the existing debt and second to provide for a data driven strategic planning process. This engagement includes two phases.

Phase 1: Evaluate the impact of refinancing existing debt and establish a baseline scenario or "status quo" scenario, which illustrates a financial picture of the organization for the next five years.

Using the historical information we already have and any additional information you may provide, we will assess the Hospital's present financial position and its prior growth patterns and make conservative assumptions about the future. Specifically, we will:

- Review three to five years of financial statements and year-to-date results for operating and capital budgets (if available)
- Calculate prior annual growth rates
- Compile and review selected financial indicators for historical comparison and future performance measurement
- Incorporate the new debt structure
- Calculate finanical ratios
- Identify the impact on CAH reimbursement of less interest rate

Phase 2: Develop data driven future initiatives for NIH considering the current state, expected changes in the healthcare delivery model and best practices for successful CAHs.

Overview of the Process for Phase 2:

"Kick Off" Meeting

The planning process will begin with a conference call focused on accomplishing the following:

- Discuss deliverables and set expectations.
- Finalize scope and timeline for the planning process.
- Finalize attendee list for the facilitated planning meeting
- Discussion of data collection needs

Office-based Analysis

Prior to the facilitated meeting, Wipfli will perform an existing-state environmental assessment. This assessment will include information gathering and analysis related to the following:

- Market and Trend Analysis (internal data, California State Data other third-party data sources)
  - Demographics

  - Competitive position
  - Services demand
  - Comparative metrics
  - Local and regional economics including area hospital affiliation trends
  - New delivery models

- Physician Demand Analysis and Recruitment Needs
  - Primary care need vs. supply
  - Medical and surgical subspecialty need vs. supply

- Organizational Analysis
  - Financial health
  - Departmental performance and profitability
  - Capital requirements/needs
  - Quality indicators/outcomes
  - Operating statistics
  - Patient satisfaction
  - Consumer perception
  - Employee/Physician satisfaction
  - Wipfli CAH Benchmarking (Proprietary Wipfli National CAH Database)
    - Patient statistics
    - Cost report statistics
    - Profitability, liquidity, capital, and staffing
  - Wipfli Rural Health Clinic Benchmarking (Proprietary Wipfli National RHC Database)
    - Productivity indicators
    - Operating indicators

- Finanical Assessment
  - Wipfli departmental profitability analysis
  - Reimbursement by department in current state

Agenda for In Person Facilitated Meeting

Wipfli would be on-site to conduct an approximately 6 hour meeting with Board Members, Leadership and Other Key Constituents TBD (i.e., physician leaders) with the agenda to cover the following (subject to further refinement as appropriate):

- Review current state
  - Review the results of the current state assessment components described above.
  - Identify the implications of the qualitative results and quantitative assessment of the market and environment in which your organization will be operating in over the next three to five years.
  - Conduct a "self-assessment" of the organization; identify strengths to leverage, opportunities to pursue, and challenges needing to be addressed.
- Facilitated discussion of future state - *"How do we position our organization for continued success?"*
  - Prioritize and react to potential strategic initiatives resulting from work completed to date such as, but not limited to:
    - Areas of potential growth
    - Services to monitor carefully for minimizing financial losses
    - Opportunities for quality, operational and financial improvement potential
    - Key initiatives for healthcare reform around consumer-readiness, further collaboration with other providers across the care continuum
    - Other TBD

Finalizing Work and Deliverable

Wipfli will conclude Phase 2 via webinar/conference call to review a summary document which contains:

- Findings and conclusions of the existing-state assessment
- Summary of future challenges
- Summary of self-assessment analysis
- Description of identified strategic initiatives and associated priorities that will be management and monitored using existing processes

Key Members of Wipfli's Engagement Team

We expect that our most experienced partners and analysts will participate in this project–all employed by Wipfli. The leaders defined below all have significant financial modeling experience in rural health care, payment reform committees, as well as excellent presentation skills.

Kelly Arduino, MA, MBA, Partner, has over 20 years of experience in health care finance and strategy with an academic research background in patient outcomes. She participates in the RISS committee sponsored by NOSORH looking at alternative CAH reimbursement and is a frequent panelist on various committees and activities on rural health in Washington, DC, such as the White House Rural Council Symposium, Access to Capital for Rural Health Care, the Rural Opportunity Investment Conference, as well as being a regular advisor to the National Office for USDA's Rural Development Community Facilities Program.

Jeffrey M. Johnson, CPA, Partner, is a health care partner in Wipfli's Spokane, Washington office. He leads the West Coast health care audit and reimbursement practice teams and has overall audit responsibility for many of our hospital clients. He has consulted on various health system management issues, including operational, strategic financial planning, third-party reimbursement issues, and physician/hospital relations. Jeff is a frequent speaker for national organizations dealing with hospital and RHC reimbursement issues.

Erik Prosser, Manager, is based in Wipfli's Spokane office. He specializes in critical access hospital Medicare and Medicaid reimbursement and audit. Erik provides cost reporting, audit, and consulting services to numerous providers in the region. This has allowed him to develop a solid understanding of the issues that concern the health care industry.

Detailed profiles of these key team members are included in Appendix B. These leaders would be assisted as needed by other associates with health care industry expertise and experience. Contract personnel will not be used for this project.

Your Investment

Our compensation goals are as follows:

- To establish a well-defined project understanding and scope of services so an appropriate fee structure can be determined.
- To establish professional fees where both our client and our firm feel they are being treated fairly (i.e., value received for dollar spent).
- To establish fees that fairly compensate us for the services required to achieve our client's project goals.

Our projects are billed on a time and material basis, if it takes us less time than the range quoted below we will only bill you for the amount of fee accrued. Based on our past experience working with similar projects, we project our professional fees for the scope of services we have described, including an on-site facilitated meeting and travel (billed at 50% of hourly rates) to be $41,500 – $44,500 with the following breakdown.

• Analysis of Refinancing on Future Performance	$4,000
• Supplement Strategic Analysis (market and trend analysis, physician demand calculation, departmental profitability, organizational analysis, and CAH & RHC benchmarking)	$30,000 - $33,000
• In person facilitated meeting	$7,500

Any circumstances that are encountered during the engagement that warrant additional procedures or expense and would cause us to be unable to complete the engagement at the estimated fee provided will discussed and approved in advance. You may terminate this engagement at any time upon written notice. You will only be responsible for services rendered prior to the receipt of the termination letter.

Our fees will be billed as work progresses. We expect payment of our billings within 30 days after submission. Interest of 1.5% per month (equivalent to 18% per annum computed monthly) will be charged on the portion of your balance that is more than 30 days past due. This fee quote is valid for a period of 60 days from the date of this proposal.

About Wipfli

Appendix A

About Our Firm

In 1930, Clarence J. Wipfli & Company was established in Wausau, Wisconsin. Clarence founded the company with a clear vision for creating value and securing the future of his clients, their businesses, and the community at large.

Today, more than 1,300 Wipfli LLP ("Wipfli") associates with an unmatched breadth and depth of experience are trained to help individuals and businesses of all sizes, but primarily small- to middle-sized businesses and family-owned companies, streamline processes, improve performance, leverage the right technology, and stimulate financial growth. Although a lot has changed over the years, the deeply ingrained values passed down from our founders still remain an evident part of our business. Every day we aim to be the firm of choice by exemplifying excellence, teamwork, perseverance, integrity, and caring.

With 32 offices in the United States and two offices in India, Wipfli ranks among the top 21 accounting and business consulting firms in the nation. We provide industry-focused assurance, accounting, tax, and consulting services to help our clients overcome their business challenges today—and we help them plan for tomorrow. Our clients include health care organizations, manufacturers, construction companies, contractors and developers, real estate companies, financial institutions, insurance companies, nonprofit organizations, units of government, dealerships, and individuals in all 50 states and internationally.

Our Commitment to the Health Care Industry

Wipfli's national health care practice currently serves more than 1,800 health care clients in 45 states, including more than 200 critical access hospitals (CAHs), 600 medical clinics, and 380 long-term care facilities.

Our health care practice consists of 16 partners and over 100 associates—many of whom have more than 20 years of experience serving in executive leadership roles in provider settings. In addition, the team includes technology, strategic consultants, and CPAs who combine an understanding of the market with a depth of specialized expertise in the health care industry.

Our professionals are recognized for their expertise, speaking at national, regional, and state conferences and publishing informative articles in a variety of industry publications. We create health care thought leadership for our clients, including newsletters, webinars, speaking engagements, and educational seminars. In addition, Wipfli publishes *Guide to Performance Measurement: Benchmarking,* which is a tool we developed to serve as a resource for small and rural hospitals that are pursuing performance improvement or management initiatives. This is the accompaniment to our CAH benchmarking tool described in later sections.

Members of Wipfli's health care team meet regularly to discuss best practices and industry issues and updates. These meetings ensure our associates continue to provide our clients with exceptional expertise and service. In addition, Wipfli devotes considerable time to monitoring developments in the health care industry. We identify key issues for our clients and ensure they are aware of those issues and their impact.

Services Provided by Wipfli

In the past 15 years, Wipfli has had a particularly robust national health care practice, offering a wide range of services in addition to traditional audit and compliance services, such as but not limited to: revenue cycle optimization, facility and capital planning, Medicare and Medicaid cost reporting, reimbursement and regulatory compliance, financial and market feasibility studies, community health needs assessments, valuation, litigation, and transaction support, service line strategy, market analysis and planning, information technology assessments and vendor selection, HIPAA security risk assessment, balanced scorecard, lean process improvement, activity-based costing, physician compensation design, analysis, and fair market value review, and strategic partnerships, alliances, and networks. Information about Wipfli's extensive health care services can be found on our website: www.wipfli.com/healthcare.

Throughout all projects, Wipfli professionals act as facilitators/educators to our client by generating ideas and solutions and empowering its staff to learn the concepts underlying the issues, providing the foundation for successful long-term solutions. This also enables staff to take ownership of process improvements.

More information regarding Wipfli's extensive health care services can be found at our webpage: www.wipfli.com/healthcare.

Examples of Wipfli's Relevant Experience with Rural and Critical Access Hospitals

We have numerous examples of projects for Rural and CAHs. While there is not enough room here to list them all, we have provided a few samples of recent and relevant projects. We are able to provide additional examples upon request.

State of Missouri - Improve the Financial Performance of CAH Project

Wipfli was awarded a three-year project with the State of Missouri to "Improve the Financial Performance of CAHs." The objective was to improve the financial health of each hospital and ensure the rural areas of the state continue to have access to health care by providing the following services:

- Capture, report, and analyze financial data and compare certain metrics for each hospital to the group and national databases.
- Identify the "at risk" hospitals in the state and perform an on-site "review" to identity opportunities for improving financial performance.
- Develop and provide educational programs related to performance improvement opportunities for various levels of the organization.
- Facilitate shared learning and other shared initiatives among all of the hospitals.

As part of this project, Wipfli developed an Internet portal where the hospitals can access a number of services in addition to uploading data and viewing their performance metrics relative to peers. Furthermore, we complied with the essential reporting and documentation required by the grant. To date, several of the hospitals have taken additional initiatives to improve financial performance in their hospitals.

Role of CAH Within a Health System

The engagement included modeling the best location for services throughout the continuum of care within this health system that was contemplating a new hospital facility within its market area due to capacity challenges within its current facility. As part of this, we worked with St. Benedicts, a CAH located outside of Boise, Idaho, to understand how this CAH could continue to serve the community (which was rural and underserved) in a financially viable way. The focus was to underscore the importance of integrating services of a rural facility within the larger network and demonstrating the value of keeping health care local. Specifically, we created financial models to understand the potential to better manage the cost/quality and patient satisfaction of post acute services through the use of CAH swing bed services within the health system. As we know today, patient "handoffs" from acute care settings to post acute settings and/or home creates the largest risk for clinical errors, miscommunication, and other consequences that negatively impact patient care. We were able to demonstrate the value of a CAH within a large multi-hospital system from the prespective of the "Triple Aim." Following our work, the CAH became an integrated provider of this multi-hospital system and achieved financial stability and success in caring for patients within a broader community.

Evaluating the Profitability of Services within a Five-CAH and One-PPS Health System in Minnesota

Our work on this project included creating a detailed financial model to understand the charges/ reimbursement, direct, and total cost (and ultimately profitability) associated with all services within each CAH. We were able to help the health system understand the relative financial profitability of services by patient type, physician, location, and payor. This model was also used to model the impact of reimbursement changes under various scenarios to identify potential future state risk. We also identified patients with ambulatory sensitive conditions who were served in the CAH inpatient setting today, but would likely transition to outpatient care in the future.

This important work is setting the foundation for designing future strategies for caring for a community of people under risk-based (and likely capitated) reimbursement systems in the future. Through the use of more effective health-related transportation systems and more effective use of telemedicine and other innovative care redesign programs within ambulatory as well as within hospital-based settings, the health system is seeking ways to most effectively care for a market region of people who depend on them.

Examples of Wipfli's Relevant Experience with Rural and Critical Access Hospitals (Continued)

Wipfli's Experience with Creating and Analyzing Data to Create, Measure, and Monitor Benchmarks for Financial and Operational Improvement

Our health care consulting group utilizes many different models to estimate the financial impact of future decision making by our clients as part of our engagements. Many of these applications are developed for our internal use and some are shared and installed on the client's system. Furthermore, we have developed databases of comparative data to provide context around various financial and operational measures which helps in our operational assessment projects to identify areas of focus for the hospital to improve financial performance. Below are several examples:

- CAH Model to determine financial impact of losing CAH designation. This model was developed in response to the Office of the Inspector General (OIG) report that recommended re-certification of many CAHs. The model looks several years into the future and projects the impact of the initial loss in reimbursement, but also assists the hospital in determining a course of action to mitigate the loss in reimbursement by looking at different alternatives available based on the needs within the hospital's service area.
- Future Financial Projection Model – We have developed this financial projection model to create a five-year pro-forma financial statement under different assumptions of reimbursement, debt, volume changes, FTEs, etc. We have utilized this model extensively with CAHs in strategic and facility planning and our feasibility studies for the issuance of new debt.
- Medicare Cost Report Estimation Model – We have developed this Medicare cost report model for CAHs to estimate the ultimate reimbursement settlement with Medicare during the year using year-to-date information. We have provided this model free to any CAH that would like to use it since we believe it is critical for CAHs to be estimating their final settlement throughout the year without having to prepare a complete Medicare cost report. We have several clients and others utilizing this model with great success to ensure their financial statements are being fairly reported as they relate to third-party settlements.
- Strategic Pricing Model – We developed this pricing model to assist hospitals in comparing their pricing at the procedure level with their competitors as well as other databases. Utilizing this model, we can evaluate the financial impact of changes in reimbursement for payors and assist in developing pricing strategies appropriate for the hospital. This model can also be utilized in determining the impact on overall reimbursement of proposed changes in contracts with commercial insurance payors during contract negations.

Wipfli's Experience with Creating and Analyzing Data to Create, Measure, and Monitor Benchmarks for Financial and Operational Improvement (Continued)

- Rural Health Clinic (RHC) Benchmarking – A benchmark database developed by Wipfli at the request of the National Association of Rural Health Clinics (NARHC) to compare operational and financial metrics of an individual RHC to a peer group, by region, by state, or nationally. Utilizing the filed Medicare cost reports, we have collected and organized the RHC data from every RHC in the country and maintain this database to provide free reports for rural providers who are members of the NARHC.
- CAH Benchmarking – A benchmark database developed internally that compares metrics for CAHs with other CAHs on a regional, state, and national level. The metrics include patient statistics, reimbursement information, and profitability ratios. The benchmark reports can be used to identify areas of opportunity for the hospital to improve its financial performance and focus its resources and investments. See Appendix H page 2 for a sample of this report.
- Customized Application for Instantaneous Analysis – Wipfli utilizes Qlik, a customizable software application, for which we are an approved provider (since 2007) to pull data from various sources (e.g., EHR, billing systems, claims data, market share, time, and attendance) and combine the data so that it can be analyzed instantaneously. Utilizing the Qlik software and the customized application Wipfli developed, we can manage large datasets from disparate sources and view the information graphically in a meaningful way to assist the hospital in understanding its service line profitability at a detailed level, either at the patient level, the service level, or by physician. This information can then be utilized to develop a plan to address the outliers with the intent to improve overall financial performance of the hospital.

  Wipfli has our own programming team and has developed both customized and standard applications for hospitals. The application manages large datasets from disparate sources and is capable of creating graphical views of data for easy digestion of results while also allowing for exportability to Excel.

Wipfli's Relationship and Involvement with Rural Health Care Constituencies

Wipfli is well known among rural constituencies and participates in a number of national and regional committees. We are regular speakers at many of the CAH meetings with attendance sponsored by Flex Grants and other agencies such as, but not limited to:

- Ohio Critical Access Hospital Network: Benchmarking in Preparation for a Financing: What Really Matters
- Montana Hospital Association Annual Conference: How to Evaluate & Make Decisions on Affiliations: The Perspective of a Rural Hospital
- Michigan Rural Health Conference: The Role of Quality in an Environment of Accountable Care
- North Dakota Hospital Association and North Dakota HFMA Annual Meeting: Managing Debt Today and in the Future
- American Hospital Association Rural Health Care Leadership Conference: Strategies for Enhancing Collaboration Between Rural Hospital and Foundation Boards
- Minnesota Hospital Association: Successful Rural Hospitals in Today's Changing Health Care Environment
- National Association of Rural Health Clinics: Provider-Based Rural Health Clinic Reimbursement and Billing Workshop
- National Rural Health Association: EHR Selection and Implementation on a Budget
- Idaho State Office of Rural Health and Primary Care: "Improving Financial Performance for Hospitals and Rural Health Clinics"
- Iowa Office of Rural Health: "Capital Financing/Strategic Capital Planning"
- Minnesota Hospital Association (MHA) Trustees Conference: "Employed Physician Compensation: Trends and Formulas That Work"
- National Resource Center: "Physician Integration Strategies for Rural Provider
- Iowa Office of Rural Health: Capital Financing/Strategic Capital Planning
- Minnesota Health Information Management Association: E/M Coding and Documentation
- National Resource Center: Physician Integration Strategies for Rural Providers
- Nevada Rural Hospital Partners: Billing, Coding, and Reimbursement Conference for Critical Access Hospitals and Rural Health Clinics

Wipfli's Relationship and Involvement with Rural Health Care Constituencies (Continued)

Other examples of our collaborative relationships include our participation on the RISS Committee for the National Office of State Offices of Rural Health, USDA Rural Development, State Offices of Rural Health (e.g., Missouri, Michigan, Wisconsin, Minnesota, and Washington) and the Illinois Critical Access Hospital Network. We have and continue to participate with other agency initiatives such as, the Critical Access Hospital Performance Project, conducted by the National Rural Health Resource Center, the CAH Performance Improvement Project conducted by the Washington State Rural Health Collaboration, the RUPRI Center for Rural Health Policy Analysis and their work on development of a new CAH reimbursement model. We have served as panelists on various committees and activities on rural health in Washington DC, such as the White House Rural Council Symposium, Access to Capital for Rural Health Care, National Rural Health Associations' Capital Options Committee, the Rural Opportunity Investment Conference, as well as being a regular advisor to the National Office for USDA's Rural Development Community Facilities Program on reimbursement changes and the ability of a $1 billion rural health care portfolio to continue servicing loans.

Furthermore, our work with the State of Missouri to improve financially distressed CAHs is particularly relevant to sharing lessons learned and best practices for this project, and we are also finalizing a proposal with the Arkansas Department of Health – Office of Rural Health and Primary Care for an initial financial analysis of Arkansas CAHs.

Feel free to contact the following for information about our associates and our firm:

Melissa Van Dyne, Rural Health Manager
Missouri Department of Health and Senior Services
Office of Primary Care and Rural Health
Jefferson City, MO
573.526.9687

Terry Hill, Executive Director
National Rural Health Resource Center
Duluth, Minnesota
218.727.9390

Clinton MacKinney, MD, MS
Clinical Associate Professor and Deputy Director
RUPRI Center for Rural Health Policy Analysis
Department of Health Management and Policy
College of Public Health University of Iowa
Iowa City, Iowa
320.363.8150

Teryl Eisinger, Executive Director
National Organization of State Offices of Rural Health
586.739.9940

Holly Greenwood, Executive Director
Washington Rural Health Collaborative
Seattle, Washington
360.346.2351

Kim Kelley, MSW
Critical Access Hospital Program Manager
Rural Hospital Flexibility Grant Program Manager
Washington State Department of Health
Olympia, Washington
360.236.2807

Pat Schou, Executive Director
Illinois Critical Access Hospital Network
Princeton, IL
815.875.2999

Joseph Ben-Israel, Director
Rural Development Community Facilities Program
United States Department of Agriculture
Washington, DC
202.720.1505

Engagement Team Professional Profiles

Appendix B

Kelly E. Arduino

Health Care Partner

Certifications:

Master of Business Administration (MBA)

Current Position and Responsibilities

Kelly Arduino is a partner in Wipfli LLP's health care practice. She has over 20 years of experience in health care, with an emphasis in health care finance and strategy. Kelly functions as a business advisor and facilitator interacting with the Board and C-Suite as health care organizations plan for their future viability.

Specializations

- Strategic planning and board facilitation
- Organizational design and restructuring of health systems
- Development of strategic affiliations and alliances
- Debt capacity assessment and evaluation of financing options
- USDA loan assistance
- Market assessment and new business planning
- Hospital/foundation relations
- Service line planning for orthopedics, cardiac services, and women's health

Past Experience

- Health care investment banker
- Director of health care consulting services at a top national firm
- Psychotherapist in a private practice
- Academic researcher in patient outcomes research at several leading medical schools
- Project manager for multi-million-dollar Agency for Healthcare Quality and Research grant
- Professional book reviewer for health care texts

Professional Memberships and Activities

- National Rural Health Association, Capital Options Committee - Co-chair
- American Hospital Association Rural Healthcare Leadership Conference - Speaker
- Montana Hospital Association - Speaker
- Michigan Rural Health Conference - Speaker
- NW Rural CAH Conference - Speaker
- Dakota Conference on Rural and Public Health - Speaker
- Wisconsin Health Education Finance Authority - Speaker
- National Association of Health Education & Facility Finance Authority - Speaker

Education

Northwestern University, Kellogg School of Management - Chicago, Illinois

- Master of business administration degree in finance and management and strategy

Loyola University - Chicago, Illinois

- Master degree in counseling psychology

Northwestern University - Evanston, Illinois

- Bachelor degree in organizational development

Contact Information:
Please contact Kelly at:
Office: 773.771.4576
E-mail: karduino@wipfli.com

wipfli.com/healthcare

Jeffrey M. Johnson

Health Care Partner

Certifications:

Certified Public Accountant

Contact Information:
Please contact Jeff in our Spokane office.
Office: 509.489.4524
E-mail: jjohnson@wipfli.com

www.wipfli.com/healthcare

Current Position and Responsibilities

Jeff Johnson provides audit, reimbursement, and consulting services to a variety of health care organizations. Specifically, he provides strategic and financial solutions to hospitals, medical practices, and other health care providers. A certified public accountant with more than 20 years of in-depth experience in the field, Jeff is able to offer specialized services to this highly complex and ever-changing industry sector.

Specializations

- Hospital audit and cost reporting (including critical access hospitals)
- Strategic financial planning
- Hospital/physician integration
- Operational reviews
- Reimbursement analysis
- Medical practice management/performance reporting
- Fee schedule analysis
- Physician compensation development and design
- Medicare-certified rural health clinic and federally qualified health center development and compliance reviews
- Board governance education
- Financial feasibility studies for new services and programs
- OMB Circular A-133 audit services

Professional Memberships and Activities

- American Institute of Certified Public Accountants (AICPA) - Member
- Washington State Society of Certified Public Accountants - Member
- Minnesota Society of Certified Public Accountants (MNCPA) - Member
- Medical Group Management Association (MGMA) - Member
- Healthcare Financial Management Association (HFMA) - Member
- Washington State Hospital Association - Member
- Minnesota Hospital Association - Member
- Iowa Hospital Association - Member
- National Association of Rural Health Clinics - Member
- National CPA Health Care Advisor Association - Member

Education

Iowa State University

- Bachelor degree in accounting

Erik D. Prosser

Manager

Current Position and Responsibilities

Erik Prosser is a manager in Wipfli LLP's Spokane office. He specializes in critical access hospital Medicare and Medicaid reimbursement and audit. Erik provides cost reporting, audit, and consulting services to numerous providers in the region. This has allowed him to develop a solid understanding of the issues that concern the health care industry.

Specializations

- Medicare and Medicaid cost reporting
- Medicare and Medicaid cost report estimates
- Medicare and Medicaid reimbursement consulting
- Medicare and Medicaid cost report adjustment review
- Reimbursement appeals
- Express View cost modeling
- Financial compilations

Professional Memberships and Activities

- Healthcare Financial Management Association (HFMA) - Member

Education

Whitworth College

- Bachelor of arts degree with a major in accounting

Contact Information:
Please contact Erik in our Spokane office.
Office: 509.489.4524
E-mail: eprosser@wipfli.com

wipfli.com/healthcare

NORTHERN INYO HOSPITAL

RURAL HEALTH CLINIC STAFF PHYSICIAN

PROFESSTIONAL SERVICES AGREEMENT

EXTENSION

The term of the Professional Services Agreement ("Agreement") titled "*Northern Inyo Hospital Rural Health Clinic Staff Physician Professional Services Agreement*" with Stacey Brown, M.D. ("Physician), with a term beginning October 1, 2012 will be extended through March 31, 2016 when this extension is signed below by both parties.

Stacey Brown, M.D.
Physician

Date: 12/7/15.

Kevin S. Flanigan, MD, MBA
Chief Executive Officer

Date: DEC 07 2015

NORTHERN INYO HOSPITAL

PRIVATE PRACTICE PHYSICIAN INCOME GUARANTEE AND PRACTICE MANAGEMENT AGREEMENT

EXTENSION

The term of the Professional Services Agreement ("Agreement") titled "*Private Practice Physician Income Guarantee and Practice Management Agreement*" with James Englesby, M.D. ("Physician), with a term beginning January 1, 2013 will be extended through March 31, 2016 when this extension is signed below by both parties.

James Englesby, M.D.
Physician

Date: 12/4/15

Kevin S. Flanigan, MD, MBA
Chief Executive Officer

Date: 12-4-15

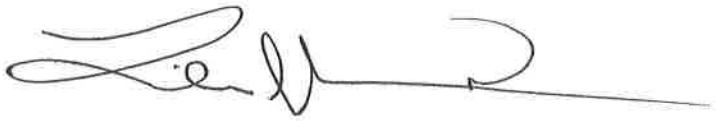
Dear Executive Management Team,

October 20, 2015

Med/Surg needs to purchase a patient bed for room #9 which was a pediatric playroom and now has been deemed by the state as a patient room. The purchase was not a part of FY 16 budget due to the states' decision in late July, 2015.

Currently we do not have a bed for this room. With the increasing census, and with the winter months rapidly approaching, I am requesting to purchase the Versacare bed. Please see the Capital Expenditure Budget request form with details of the bed.

Thank you,



Linda Andreas RN, DON

Acute/Subacute services

Hill-Rom

PROPOSAL #:	SP 14308802
Proposal Date:	08/12/2015
Expiration Date:	10/12/2015

Attn: RYAN MCVEITTY
NORTHERN INYO HOSPITAL
150 PIONEER LN
BISHOP CA 93514-2556

For Questions / Correspondence Please Contact:
Hill-Rom Customer Service @ 800-445-3730
Fax: 812-934-8189
Architectural Products Fax: 812-931-2264
Email: us.customerservice@hill-rom.com

Customer #: 606655
Phone #: 760-873-2604

Your Account Rep.: PAUL REED
Mobile Phone #: +1 559 269 0192
Email: paul.reed@hill-rom.com

Qty	Product Information	Unit Price	Extended Price
1	VERSACARE MED SURG BED	$12,669.96	$12,669.96

Standard Features:
LowChair Position
Point-of-Care Siderail Controls
Slide Guard Pivot Technology
Hands Free Foot Controls for Bed Height
Audible Brake Alarms
Smart Bed Ready (Sidecom Required)
FlexAfoot Adjustable Bed Length
4-Corner Brake & Steer
Battery Backup
Stationary Height Headboard
Line-of-Site Angle Indicators
Cord Wrap Clips with IV Pole Storage
Drainage Bag Holders
Night Light
Four IV Sockets
TuckAway Siderails with OneStep Siderail Release
Patient Controls Backlighting
Bed Controls in Siderail
Urethane Central Locking Caster System
OneStep Emergency CPR and Trendelenburg Release Mechanism
****

Included Options:
English Language Labels
Voltage: 120
In Bed-Scale Displays Kilograms and Pounds
Patient Position Monitoring/Bed Exit System
Air Surface
5" Casters
Light Neutral End Panels
Patient Helper Adapter-Headend
Patient Helper Sleeve
IV Pole
****

Itemized Options:

VC755	Base Frame	$12077.16
VC-NUL	Nurse Call, Univ TV & Lighting	$402.04
VC-OSI	Patient Helper Sleeve	$190.76

****

Total Order(USD) **12,669.96**

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Cancellation: This contract when signed is an agreement of performance by both parties. In the event either party requests a termination of the contract, the other party must agree.

Payment Terms: Invoices are payable net thirty (30) days from date of invoice. Unless waived by Hill-Rom in writing, overdue invoices shall be subject to a late payment charge equal to the lesser of (i) one and one half percent (1 1/2%) per month or (ii) the maximum rate allowed by law. Customer agrees to pay Hill-Rom for any and all costs and expenses (including without limitation reasonable attorneys' fees) incurred by Hill-Rom to collect any amounts owed to it, enforce any of its rights or seek any of its remedies hereunder. In the event Customer has directed that the charges hereunder be billed to another person or organization, and payment is not made by such person or organization within ten (10) day after invoice date, Customer shall still remain liable hereunder. Customer is advised that the Customer may be obligated to properly reflect and/or report any discount, rebate or reduction in price in its costs claimed or charges made to federal (e.g. Medicare) or state (e.g. Medicaid) health care programs requiring such disclosure. The invoices provided by Hill-Rom to Customer may not reflect the net cost to the Customer. Customer shall make written request to Hill-Rom in the event Customer requires additional Information in order to meet applicable reporting or disclosure obligations.

Installation: Unless otherwise agreed in writing, Customer shall perform any installation of products sold hereunder at Customer's expense. Hill-Rom agrees to furnish appropriate instructions and information to assist with the installation and/or first operation of the products.

Limited Warranty: For specific warranty information on Hill-Rom products and parts, please see owner's manual or review manuals on line at our website, www.hill-rom.com. THE FOREGOING WARRANTY CONSTITUTES THE SOLE WARRANTY MADE BY HILL-ROM AND IS IN LIEU OF ALL OTHER REPRESENTATIONS OR WARRANTIES EXPRESS OR IMPLIED OR STATUTORY, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, AND ALL OTHER REMEDIES. IN NO CASE SHALL HILL-ROM BE LIABLE TO CUSTOMER OR ANY THIRD PARTY FOR INDIRECT, SPECIAL, CONSEQUENTIAL OR INCIDENTAL DAMAGES OR DELAYS. NO EMPLOYEE OR REPRESENTATIVE OF HILL-ROM IS AUTHORIZED TO CHANGE THIS WARRANTY IN ANY WAY OR GRANT ANY OTHER WARRANTY.

Product Interface: Customer shall be responsible for ensuring to Customer's satisfaction that any equipment and accessories not supplied by Hill-Rom that are used with Hill-Rom products properly interface or operate with Hill-Rom products. Hill-Rom shall not be liable to Customer or any third person for personal Injury or property damage arising from the use of third party equipment and accessories with Hill-Rom products.

Limitation of Liability: Hill-Rom shall not be liable for loss or damages due to delay in manufacture or shipment resulting from any cause beyond the Hill-Rom's control. Delays resulting from any such cause shall extend shipment date correspondingly. IN NO EVENT SHALL HILL-ROM BE LIABLE FOR SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES, EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THIS CONTRACT IS BETWEEN CUSTOMER AND HILL-ROM. Customer must make claims for shortages or errors within a reasonable time after receipt of the products. Hill-Rom reserves the right to use remanufactured or used components that meet new component specifications and are warranted as new.

Security Interest, Default and Insurance: Hill-Rom shall retain a security interest in the products until Hill-Rom has received full payment including taxes. Customer agrees to sign and deliver to Hill-Rom any additional documents required by Hill-Rom to protect its security interest. If Customer defaults or Hill-Rom deems itself insecure of the products in danger of confiscation, the full amount unpaid shall immediately become due and payable at the option of the Hill-Rom and on proper notice to the Customer, the Hill-Rom may retake possession of the products wherever located without court order and can resell or retain according to the laws of the state where products are located. The products shall not be considered a fixture if attached to any realty. Customer shall assume all loss relating from damage to the products occurring after the products leave Hill-Rom's control and shall provide adequate insurance therefore at all times until the purchase price shall have been fully paid. Hill-Rom reserves the right to request proof of such insurance at any time prior to full payment along with a statement from such insurer limiting cancellation or changes to said policy within ten (10) days after written notice of same to Hill-Rom.

Specifications: Specifications and drawings and any other information shall remain the property of Hill-Rom and are subject to recall at any time. Such information shall not be disclosed or used for manufacture of any products. In accordance with Hill-Rom's established policy of constant improvement, Hill-Rom reserves the right to amend its specifications at any time without notice.

Merger: These terms and conditions supersede any inconsistent agreements and understandings, oral or written, between the parties, including any terms and conditions in any documentation submitted by Customer to Hill-Rom, unless agreed to in writing by an authorized representative of Hill-Rom. Customer agrees and acknowledges that if Customer issues any further purchase orders, Hill-Rom will have no obligation to accept or otherwise honor any such purchase order.

Acceptance: This contract is subject to Hill-Rom's approval of Customer's credit. Written notice shall be given to Customer within 60-days of the date hereof if Customer's credit is deemed, is the sole discretion of the Hill-Rom, to be unsatisfactory. This contract of purchase and sale between the Customer and Hill-Rom relating to the products identified herein shall be subject to and shall include the terms and conditions hereof.

Choice of Law: This contract shall be governed by, and construed in accordance with, the laws of the State of Indiana.

Delivery and Shipment: Date of delivery shall be determined by mutual written agreement of the parties. No delivery date set forth in a Purchase Order shall be binding on Hill-Rom unless Hill-Rom explicitly agrees to such delivery date in a writing signed by an authorized representative of Hill-Rom. Shipment of all products shall be Net Freight on Board (FOB) Customer, with all costs of transportation and related insurance being the responsibility of Hill-Rom with the exception of costs of transportation and insurance for (i) service parts, (ii) shipments to points outside the contiguous U.S., or (iii) special delivery and/or air shipments requested by Customer. Unless otherwise explicitly agreed to by Hill-Rom in a writing signed by an authorized representative of Hill-Rom, Hill-Rom will prepay and add to the invoice for reimbursement by Customer any and all costs of transportation and insurance for delivery of service parts, shipments to points outside the contiguous U.S., and any special delivery and/or air shipments requested by Customer. Terms for shipping to Alaska and Hawaii shall be F.O.B. port of embarkment, prepaid and add from port of embarkment to destination.

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Hill-Rom Company, Inc.	Hill-Rom Company
Attn: Customer Service	Attn: Customer Service
1069 State Route 46 East	1705 Tech Avenue, Unit 3
Batesville, Indiana 47006	Mississauga, Ontario L4W 0A2
Phone: 800/445-3730	Phone: 800-267-2337
Fax: 812/934-8189	Telefax: 905-206-0561

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Customer #: 606655
Phone #: 760-873-2604

Your Account Rep.: PAUL REED
Mobile Phone #: +1 559 269 0192
Email: paul.reed@hill-rom.com

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1	VERSACARE MED SURG BED	$12,669.96	$12,669.96

Standard Features:
LowChair Position
Point-of-Care Siderail Controls
Slide Guard Pivot Technology
Hands Free Foot Controls for Bed Height
Audible Brake Alarms
Smart Bed Ready (Sidecom Required)
FlexAfoot Adjustable Bed Length
4-Corner Brake & Steer
Battery Backup
Stationary Height Headboard
Line-of-Site Angle Indicators
Cord Wrap Clips with IV Pole Storage
Drainage Bag Holders
Night Light
Four IV Sockets
TuckAway Siderails with OneStep Siderail Release
Patient Controls Backlighting
Bed Controls in Siderail
Urethane Central Locking Caster System
OneStep Emergency CPR and Trendelenburg Release Mechanism
****

Included Options:
English Language Labels
Voltage: 120
In Bed-Scale Displays Kilograms and Pounds
Patient Position Monitoring/Bed Exit System
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Itemized Options:

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Fax: 812/934-8189

Hill-Rom Company
Attn: Customer Service
1705 Tech Avenue, Unit 3
Mississauga, Ontario L4W 0A2
Phone: 800-267-2337
Telefax: 905-206-0561

CAPITAL EXPENDITURE BUDGET REQUEST

Department:	Med/Surg Acute/Subacute services	Budget year:	*2015/2016*
Requested by:	Linda Andreas RN, DON	Estimated cost:	$12,669.96
		Requested Priority:	ASAP

GENERAL INFORMATION:

Item description:
Hill ROM VersaCare A.I.R. surface Bed

Purpose:
To compelte room #9 for patient use thus increasing Med/Surg capacity to 16.

Is this item required or recommended by third-party or regulatory agencies?
Yes ☐ No ☒ N/A ☐
If yes, please explain:

Is this item a replacement item?
Yes ☐ No ☒ N/A ☐
If yes, please explain:

Will this request require more than one purchase?
Yes ☐ No ☒

Describe any associated installation costs, site preparation, construction costs, additional equipment or supply costs or additional staffing requirements:
Training for Hill ROM requiring no extra cost

Additional comments:
Bed needed to accommodate increasing census and added swing beds. Med/Surg Room #9 converted from pediatric play room to patient care room. No bed available at this time.

Department Head Signature: _____ Date: 4/19/15