Northern Inyo Healthcare District

# Board Meetings

## Board Meeting - April 16, 2025

NORTHERN INYO HEALTHCARE DISTRICT
*One Team. One Goal. Your Health.*

# AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS - REGULAR MEETING

April 16, 2025, 5:00 pm
Northern Inyo Healthcare District invites you to join this meeting

Connect via Zoom: A link is also available on the NIHD Website
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

Phone Connection:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

The Board meets in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via Zoom. Public comments can be made in person or via Zoom.

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1. Call to Order at 5:00 pm
2. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. Public comments on closed session items
4. Adjournment to closed session to/for:
    a. Discuss trade secrets (Health & Safety. Code § 32106 and Civ. Code 3426.1). The discussion will concern a new service line. The estimated date of public disclosure is September 2025.

b. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1). Title: Interim CEO performance.

5. Return to open session and report on any actions taken in closed session

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6. Consent Agenda – *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*
    a. Approval of minutes for the March 19, 2025, Regular Board Meeting
    b. Approval of minutes for the March 24, 2025, Special Meeting
    c. Approval of minutes for the March 27, 2025, Special Meeting
    d. Approval of minutes for the April 7, 2025, Special Meeting
    e. CEO Credit Card Statement
    f. Approval of Compliance, Quality, Safety, and Risk Charter
    g. Approval of Compliance, Quality, Safety, and Risk Work Plan
    h. Approval of Employee Health and Infection Control Report
    i. Approval of Policies and Procedures
        i. Cleaning the Pharmacy Sterile IV Preparation Area
        ii. Critical Value Reporting of Lab Results
        iii. Patient Identification for Clinical Care and Treatment/Armband Usage
        iv. Patient's Rights and Responsibilities
        v. Sterile Products Cytotoxic Agents

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7. New Business:
    a. Interim CEO Contract – *Action Item*
    b. Chief of Staff Report, Sierra Bourne MD
        i. Medical Staff Initial Appointments 2025-2025 – *Action Item*
            1. David Paz, MD (*anesthesiology*) – Courtesy Staff
            2. Orlando Ricci, MD (*anesthesiology*) – Courtesy Staff
            3. Eric Ladenheim, MD (*general surgery*) – Consulting Staff
        ii. Medical Staff Initial Appointments 2025-2026 – Proxy Credentialing – *Action Item*
            1. *As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the*

*following practitioners for Telemedicine privileges relying upon the Distant-Site entity's credentialing and privileging decisions.*

2. Daniel Baker, MD (*diagnostic radiology*) – Telemedicine Staff (Direct Radiology)

iii. Chief of Staff Written Report – *Information Item*

c. Chief Executive Officer Report *(Board will receive this report)*

i. CEO Report

1. Approving the Deposit and Investment of Funds to Eligible Certificates of Deposit and the Local Agency Investment Funds – *Action Item*
2. ACHD recertification – Complete January 23, 2025 – *Information Item*
3. Pharmacy Project – *Information Item*
4. Stereotactic mammography– *Information Item*
5. Employee of the Month March 2025: Leroy Charley - *Information Item*
6. Employee of the Month April 2025: Terry Tye - *Information Item*

ii. Chief Medical Officer Report

1. CMO Report – *Information Item*
2. Mono Hantavirus – *Information Item*

iii. Chief Financial Officer Report

1. Audit of Financial Statements – *Action Item*
2. Financial Statement and Supplemental Information – *Action Item*
3. Financial & Statistical Reports – *Action Item*

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8. General Information from Board Members (*Board will provide this information)*
9. Adjournment

*In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact the administration at (760) 873-2838 at least 24 hours prior to the meeting.*

| | |
|---|---|
| CALL TO ORDER | Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm. |
| PRESENT | Jean Turner, Chair<br>Melissa Best-Baker, Vice Chair<br>David Lent, Secretary<br>David McCoy Barrett, Treasurer<br>Laura Smith, Member at Large<br><br>Stephen DelRossi, Chief Executive Officer<br>Allison Partridge, Chief Operations Officer / Chief Nursing Officer<br>Adam Hawkins, DO, Chief Medical Officer<br>Alison Murray, Chief Human Resources Officer, Chief Business Development Officer<br>Andrea Mossman, Chief Financial Officer<br>Sierra Bourne, MD, Chief of Staff |
| TELECONFERENCING | Notice has been posted and a quorum participated from locations within the jurisdiction. |
| PUBLIC COMMENT | Chair Turner reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board.<br><br>There were no comments from the public. |
| PUBLIC COMMENT ON CLOSED SESSION ITEMS | There were no comments from the public. |
| ADJOURNMENT TO CLOSED SESSION | Adjournment to closed session at 5:02 pm |
| RETURN TO OPEN SESSION | Called back to order at 5:18 pm<br><br>Chair Turner stated there were no reportable actions from the closed session |
| NEW BUSINESS | |
| CONSENT AGENDA | Chair Turner called attention to the Consent Agenda.<br><br>1. Employee Dissatisfaction Policy<br>Discussion ensued. Murray expressed that the Board could receive information from Employee Dissatisfaction if the information is not confidential. Murray noted that an annual employee satisfaction survey is provided.<br><br>The following items were removed from the consent agenda for further discussion.<br>1. 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedures<br>2. Weapons Policy |

Motion to approve consent agenda with removed items: Best-Baker
2nd: Smith
Roll Call Vote
Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass
Pass: 5-0

3. 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedures

Discussion ensued.

Motion to approve 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedures
Motion: Lent
2nd: Best-Baker
Roll Call Vote
Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass
Pass 5-0

1. Weapons policy

Discussion ensued. The policy will undergo further review by the District and will be presented to the Board at a later date. The District will review the section on pocket knives, and present an updated version of the policy in the future.

CHIEF OF STAFF REPORT

Chair Turner called attention to the Chief of Staff Report.

Dr. Connor Wiles shared how his practice is growing.

The Medical Executive Committee Meeting Report outlined quality measures that the District is focused on.

Discussion ensued.

CHIEF EXECUTIVE OFFICER REPORT

Chair Turner called attention to the CEO Report.

Beta Heart – NIH staff attended a workshop focused on safety culture and organizational response to harm events, aligning with the hospital's strategic goals, and previous training.

CHIEF OF HUMAN RESOURCES / CHIEF BUSINESS

Chair Turner called attention to the CHRO / CBDO report.

Discussion ensued.

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|---|---|
| DEVELOPMENT OFFICER REPORT | |
| CHIEF NURSING OFFICER / CHIEF OPERATING OFFICER REPORT | Chair Turner called attention to the CNO / COO Report.<br><br>Discussion ensued. |
| CHIEF FINANCIAL OFFICER REPORT | Chair Turner called attention to the Chief Financial Officer Report.<br><br>Discussion ensued.<br><br>Motion to accept the Financial reports: Best-Baker<br>2nd: Smith<br>Roll Call Vote<br>Barrett - Pass<br>Smith - Pass<br>Lent - Pass<br>Best-Baker - Pass<br>Turner - Pass<br>Pass: 5-0 |
| GENERAL INFORMATION FROM BOARD MEMBERS | Chair Turner called attention to the General information from board members.<br><br>Discussion ensued. |
| ADJOURNMENT | Adjournment at 6:20 pm. |

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

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|---|---|
| CALL TO ORDER | Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm. |
| PRESENT | Jean Turner, Chair<br>Melissa Best-Baker, Vice Chair<br>David Lent, Secretary<br>David McCoy Barrett, Treasurer<br>Laura Smith, Member at Large<br><br>Allison Partridge, Chief Operations Officer / Chief Nursing Officer<br>Adam Hawkins, DO, Chief Medical Officer<br>Alison Murray, Chief Human Resources Officer, Chief Business Development Officer<br>Andrea Mossman, Chief Financial Officer |
| ABSENT | Stephen DelRossi, Chief Executive Officer |
| TELECONFERENCING | Notice has been posted and a quorum participated from locations within the jurisdiction. |
| PUBLIC COMMENT | Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board.<br><br>There were no comments from the public. |
| PUBLIC COMMENT ON CLOSED SESSION ITEMS | There were no comments from the public. |
| ADJOURNMENT TO CLOSED SESSION | Adjournment to closed session at 5:01 pm |
| RETURN TO OPEN SESSION | Called back to order at 6:53 pm<br><br>Chair Turner stated there were no reportable actions from the closed session |
| ADJOURNMENT | Adjournment at 6:53 pm. |

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

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|---|---|
| CALL TO ORDER | Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 4:00 pm. |
| PRESENT | Jean Turner, Chair<br>Melissa Best-Baker, Vice Chair<br>David Lent, Secretary<br>David McCoy Barrett, Treasurer<br>Laura Smith, Member at Large<br><br>Allison Partridge, Chief Operations Officer / Chief Nursing Officer<br>Alison Murray, Chief Human Resources Officer, Chief Business Development Officer<br>Andrea Mossman, Chief Financial Officer |
| ABSENT | Adam Hawkins, DO, Chief Medical Officer |
| TELECONFERENCING | Notice has been posted and a quorum participated from locations within the jurisdiction. |
| PUBLIC COMMENT | Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board.<br><br>There were no comments from the public. |
| PUBLIC COMMENT ON CLOSED SESSION ITEMS | There were no comments from the public. |
| ADJOURNMENT TO CLOSED SESSION | Adjournment to closed session at 4:01 pm |
| RETURN TO OPEN SESSION | Called back to order at 4:51 pm<br><br>Chair Turner stated there was a unanimous vote to appoint Allison Partridge as Acting Chief Executive Officer.<br>Roll Call Vote<br>Barrett - Pass<br>Smith - Pass<br>Lent - Pass<br>Best-Baker - Pass<br>Turner - Pass<br><br>Allison Partridge accepted the appointment of Acting Chief Executive Officer. |
| ADJOURNMENT | Adjournment at 4:55 pm. |

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Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

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|---|---|
| CALL TO ORDER | Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm. |
| PRESENT | Jean Turner, Chair<br>Melissa Best-Baker, Vice Chair<br>David Lent, Secretary<br>David McCoy Barrett, Treasurer<br>Laura Smith, Member at Large<br><br>Allison Partridge, Acting CEO, Chief Operations Officer / Chief Nursing Officer<br>Adam Hawkins, DO, Chief Medical Officer<br>Alison Murray, Chief Human Resources Officer, Chief Business Development Officer<br>Andrea Mossman, Chief Financial Officer |
| TELECONFERENCING | Notice has been posted and a quorum participated from locations within the jurisdiction. |
| PUBLIC COMMENT | Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board.<br><br>There were no comments from the public. |
| PUBLIC COMMENT ON CLOSED SESSION ITEMS | There were no comments from the public. |
| ADJOURNMENT TO CLOSED SESSION | Adjournment to closed session at 5:03 pm |
| RETURN TO OPEN SESSION | Called back to order at 7:08 pm<br><br>Chair Turner stated they were entering negotiations with an Interim CEO candidate, Christian Wallis. |
| ADJOURNMENT | Adjournment at 7:09 pm. |

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

**April 2025 Statement**



Open Date: 03/06/2025 Closing Date: 04/03/2025

Account: [redacted]

**U.S. Bank Business Platinum Card**
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

**Cardmember Service**
[redacted]
( [redacted] 3

| | |
|---|---|
| **New Balance** | **$30.81** |
| **Minimum Payment Due** | **$10.00** |
| **Payment Due Date** | **05/01/2025** |

## Activity Summary

| | | |
|---|---|---|
| Previous Balance | + | $1,152.96 |
| Payments | - | $13,402.04CR |
| Other Credits | - | $1,248.87CR |
| Purchases | + | $13,528.76 |
| Balance Transfers | | $0.00 |
| Advances | | $0.00 |
| Other Debits | | $0.00 |
| Fees Charged | | $0.00 |
| Interest Charged | | $0.00 |
| **New Balance** | = | **$30.81** |
| **Past Due** | | **$0.00** |
| **Minimum Payment Due** | | **$10.00** |
| Credit Line | | $37,500.00 |
| Available Credit | | $37,469.19 |
| Days in Billing Period | | 29 |

**Payment Options:**

Mail payment coupon with a check

Pay online at usbank.com

Pay by phone 1-866-485-4545

Pay at your local U.S. Bank branch

*Please detach and send coupon with check payable to: U.S. Bank* [redacted]

[redacted]

24-Hour Cardmember Service: [redacted]

( . to pay by phone
( . to change your address

[redacted]

NORTHERN INYO HOSPITA
STEPHEN DELROSSI
150 PIONEER LN
BISHOP CA 93514-2556

| | |
|---|---|
| **Account Number** | [redacted] |
| **Payment Due Date** | 5/01/2025 |
| **New Balance** | $30.81 |
| **Minimum Payment Due** | $10.00 |

**Amount Enclosed** $_____

**U.S. Bank**
P.O. Box 790408
St. Louis, MO 63179-0408

**What To Do If You Think You Find A Mistake On Your Statement**

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at: Cardmember Service, P.O. Box 6335, Fargo, ND 58125-6335.

In your letter or call, give us the following information:

- *Account information:* Your name and account number.
- *Dollar amount:* The dollar amount of the suspected error.
- *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.

You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:

- We cannot try to collect the amount in question, or report you as delinquent on that amount.
- The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
- While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
- We can apply any unpaid amount against your credit limit.

**Your Rights If You Are Dissatisfied With Your Credit Card Purchases**

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service, P.O. Box 6335, Fargo, ND 58125-6335

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

**Important Information Regarding Your Account**

1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you. To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, P.O. Box 790408, St. Louis, MO 63179-0408 or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.
3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

**Cardmember Service** 1-866-485-4545

## Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at usbank.com/login.

## Transactions

### Payments and Other Credits

| Post Date | Trans Date | Ref # | Transaction Description | Amount | Notation |
|---|---|---|---|---|---|
| 03/26 | 03/26 | 0000 | INTERNET PAYMENT THANK YOU | $1,152.96CR | |
| 03/31 | 03/28 | 4613 | UNITED 0164465726885 UNITED.COM TX MERCHANDISE/SERVICE RETURN DELROSSI /OTH 03/28/25 OHARE TO HOUSTON | $109.99CR | Beckers |
| 03/31 | 03/28 | 4621 | UNITED 0164465726886 UNITED.COM TX MERCHANDISE/SERVICE RETURN DELROSSI /OTH 03/28/25 OHARE TO HOUSTON | $109.99CR | Beckers |
| 03/31 | 03/29 | 3724 | UNITED 0162452288970 UNITED.COM TX MERCHANDISE/SERVICE RETURN | $1,028.89CR | Beckers |
| 04/02 | 04/02 | 0000 | INTERNET PAYMENT THANK YOU | $12,249.08CR | |
| | | | **TOTAL THIS PERIOD** | **$14,650.91CR** | |

### Purchases and Other Debits

| Post Date | Trans Date | Ref # | Transaction Description | Amount | Notation |
|---|---|---|---|---|---|
| 03/06 | 03/05 | 0249 | USPS PO 0507560514 BISHOP CA | $16.00 | Postage |
| 03/10 | 03/06 | 4026 | JetBrains Americas INC 165-05772345 CA | $173.00 | IT Subscription |
| 03/12 | 03/10 | 5372 | DIGICERT 801-7019681 UT | $1,334.00 | IT Subscription |
| 03/13 | 03/12 | 7060 | YETI 1-833-225-9384 512-3949384 DE | $5,689.20 | Hospital Week |
| 03/14 | 03/13 | 4386 | NPDB NPDB.HRSA.GOV 800-767-6732 VA | $2.50 | Med Staff Credentialing |
| 03/18 | 03/17 | 1047 | HASC.ORG WWW.HASC.ORG CA | $4,635.00 | HQ Program |
| 03/20 | 03/19 | 8580 | Sharefile LLC 800-4248749 FL | $900.00 | IT Subscription |
| 03/26 | 03/25 | 0308 | FSP*MOUNTAIN RAMBLER B BISHOP CA | $202.55 | Recruitment |
| 03/27 | 03/26 | 5191 | TST* WHISKEY CREEK BISHOP CA | $254.46 | Recruitment |
| 04/01 | 03/31 | 1904 | NPDB NPDB.HRSA.GOV 800-767-6732 VA | $2.50 | Med Staff Credentialing |
| 04/01 | 03/31 | 2084 | NPDB NPDB.HRSA.GOV 800-767-6732 VA | $2.50 | Med Staff Credentialing |
| 04/01 | 03/31 | 2167 | NPDB NPDB.HRSA.GOV 800-767-6732 VA | $2.50 | Med Staff Credentialing |
| 04/01 | 03/31 | 2241 | NPDB NPDB.HRSA.GOV 800-767-6732 VA | $2.50 | Med Staff Credentialing |
| 04/01 | 03/31 | 2324 | NPDB NPDB.HRSA.GOV 800-767-6732 VA | $2.50 | Med Staff Credentialing |
| 04/01 | 03/31 | 9025 | FACEBK *K757UMYKU2 650-5434800 CA | $278.74 | Marketing |
| 04/03 | 04/02 | 9054 | ETSY, INC. 718-8557955 NY | $30.81 | Hospital Week |
| | | | **TOTAL THIS PERIOD** | **$13,528.76** | |

*Continued on Next Page*

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

**Cardmember Service** 1-866-485-4545

| 2025 Totals Year-to-Date | |
|---|---|
| Total Fees Charged in 2025 | $0.00 |
| Total Interest Charged in 2025 | $0.00 |

## Company Approval

*(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

## Interest Charge Calculation

**Your Annual Percentage Rate (APR) is the annual interest rate on your account.**

**APR for current and future transactions.

| Balance Type | Balance By Type | Balance Subject to Interest Rate | Variable | Interest Charge | Annual Percentage Rate | Expires with Statement |
|---|---|---|---|---|---|---|
| **BALANCE TRANSFER | $0.00 | $0.00 | YES | $0.00 | 23.24% | |
| **PURCHASES | $30.81 | $0.00 | YES | $0.00 | 23.24% | |
| **ADVANCES | $0.00 | $0.00 | YES | $0.00 | 29.99% | |

## Contact Us

**Phone**
Voice: 1-866-485-4545
TDD: 1-888-352-6455
Fax: 1-866-807-9053

**Questions**
Cardmember Service
P.O. Box 6353
Fargo, ND 58125-6353

**Mail payment coupon with a check**
U.S. Bank
P.O. Box 790408
St. Louis, MO 63179-0408

**Online**
usbank.com

*End of Statement*

*NORTHERN INYO HOSPITA*

**NORTHERN INYO HEALTHCARE DISTRICT**
**COMMITTEE CHARTER**

| | | |
|---|---|---|
| Title: Compliance, Quality, Safety, and Risk Committee Charter | | |
| Owner: Chief Executive Officer | Department: Administration | |
| Scope: | | |
| Date Last Modified: 04/09/2025 | Last Review Date: No Review Date | Version: 1 |
| Final Approval by: | Original Approval Date: | |

## COMMITTEE PURPOSE

The purpose of the Compliance, Quality, Safety, and Risk Committee (CQSRC) is to guide and assist the Governing Board and Executive Staff in their responsibility to oversee compliance, quality, safety, and risk in order to meet or exceed regulations and standards that govern health care organizations.

## COMMITTEE RESPONSIBILITIES

The committee is responsible for reviewing, monitoring, and ensuring that the organization maintains high standards in CQSR critical areas to ensure patient safety, compliance with applicable regulations, and the overall well-being of the community served.

## COMMITTEE GOALS

1. Directly oversee that quality assurance and improvement processes are in place and operating effectively in the District.
2. Review reports and data to provide strategic oversight for quality of care and treatment, and recommend new services or programs to the Board of Directors.
3. Review reports and data to provide strategic oversight for compliance, risk, and safety to ensure conformity with regulations and standards that govern health care organizations, and to make recommendations to the Board of Directors.
4. Create and review CQSRC Annual Work plan.
5. Educate the Board within the areas authorized by this committee.

## COMMITTEE MEMBERSHIP

1. The CQSRC shall include the Board of Directors, Executive Team, and the following subject matter experts:
    a. Information Security Officer
    b. Compliance Officer
    c. Director of Facilities
    d. Director of Medical Staff
    e. Manager of Infection Prevention and Employee Health
    f. Manager of Quality and Survey Readiness
2. The members of the Board of Directors are the only members with voting privileges
3. On an ad hoc basis, the Board may allow a member of the community to participate in the proceedings. The community member will not have voting rights and will exist solely to gauge feedback or recommendations to the Board.

## FREQUENCY OF MEETINGS

1. The CQSRC shall meet quarterly.
2. Additional meetings may be scheduled on an as-needed basis.

## PUBLIC PARTICIPATION

1. All CQSRC meetings shall be announced and conducted according to the Brown Act. The general public, patients, their families and friends, Medical Staff, and District staff are always welcome to attend and provide input.

## FREQUENCY REVIEW/REVISION

1. The CQSRC shall review the Charter biennially and as needed.
2. Revisions will be reviewed at CQSRC and a recommendation will be presented to the full Northern Inyo Healthcare District Board of Directors for approval.

## RETENTION AND DESTRUCTION OF RECORDS

Information packets and minutes for these committee meetings are part of the permanent records of the District.

## REFERENCES


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8. General Compliance Program Guidance 2023. Retrieved from https://oig.hhs.gov/compliance/general-compliance-program-guidance/
9. The Joint Commission 2025. Critical Access Hospital. IM.02.01.03.
10. The Joint Commission 2025. Critical Access Hospital. LD.01.03.01
11. The Joint Commission 2025. Critical Access Hospital. LD.07.01.01.
12. The Joint Commission 2025. Critical Access Hospital. LD.03.01.01.
13. The Joint Commission 2025. Critical Access Hospital. LD.04.01.01.
14. The Joint Commission 2025. Critical Access Hospital. EC.01.01.01.


| Supersedes: Not Set |
|---|

| | Goal/Information | Notes | Timeline |
|---|---|---|---|
| 1. | Committee 2025 Work plan Review | | Annual review |
| 2. | Track and trend individually identifiable medical information breaches and reduce associated risk. | Compliance | Annually |
| 3. | Review audits to prevent and detect fraud, waste, and abuse, ensure compliance and reduce risk for the District. | Compliance | As needed |
| 3. | Review HIPAA (Health Information Portability and Accountability Act) Risk Assessment and Security Risk Assessment to ensure a maximal risk reduction strategy. | Compliance/ITS | Annually |
| | Cyber Security Penetration Testing tracking and trending to monitor risk reduction. | ITS | Annually and as needed |
| 5. | Review Workplace Violence Trends to ensure strategic guidance to increase safety and reduce risk. | Safety/Facilities | Annually |
| 6. | Review the Medical Staff credentialing and privileging processes and understand their impacts to patient safety and the delivery of care | Medical Staff Office | Annually |
| 7. | Review Hospital-Acquired Infections Data Related to Surgical Site Infections, Device-Associated Infections, and Multi-Drug Resistant Reporting to NHSN | Infection Prevention | Quarterly |
| 8. | Track and trend Antibiotic Stewardship Activities and its impact on District patients. | Infection Prevention | Quarterly |
| 9. | Review Employee Sharps Injury Data | Infection Prevention | Annually |
| 10. | Review Healthcare-Worker Influenza Vaccination Rates | Employee Health | Annually |
| 11. | Review Employee Safe Patient Handling Injuries | Employee Health | Annually |
| 12. | Quality Incentive Pool (QIP) Program | Quality | Annually |
| 13. | Quality reporting education | Quality | Annually |
| 14. | Review the Environment of Care to ensure conformance with regulatory agencies. | Safety/Facilities | Annually |

NORTHERN INYO HEALTHCARE DISTRICT
*One Team. One Goal. Your Health.*

DATE: March 2025

TO: Board of Directors, Northern Inyo Healthcare District (NIHD)

FROM: Robin Christensen BSN, RN, HIC Manager Infection Preventions/Employee Health

RE: Infection Preventions/Employee Health FY 2025 Q2

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**Introduction**
This report provides an update on the NIHD ongoing infection prevention and employee health initiatives. The purpose is to keep the Board of Directors informed about NIHD continuous efforts, recent outcomes, and plans aimed at maintaining a healthy safe environment and workplace for all patients, staff members and visitors.

The Infection Prevention (IP) and Employee Health (EH) teams are dedicated to promoting and implementing evidence-based practices (EBPs) related to the prevention and control of infections, ensuring the safety of both patients and employees. The IP & EH teams emphasize the importance of infection control and employee health strategies, recognizing that these are everyone's responsibility. It is essential for all staff to prioritize these efforts in order to protect patients from preventable Hospital-Associated Infections (HAIs) and ensure employees contribute to maintaining a safe environment by following safety protocols and reporting hazards.

**Focus Areas:**
Infection Prevention

a. Review Hospital-Acquired Infections Data Related to Surgical Site Infections, Device-Associated Infections, and Multi-Drug Resistant Reporting to NHSN
b. Track and trend Antibiotic Stewardship Activities and its impact on District patients.
c. Review Employee Sharps Injury Data

Employee Health

a. Review Healthcare-Worker Influenza Vaccination Rates
b. Review Employee Safe Patient Handling (SPH) Injuries

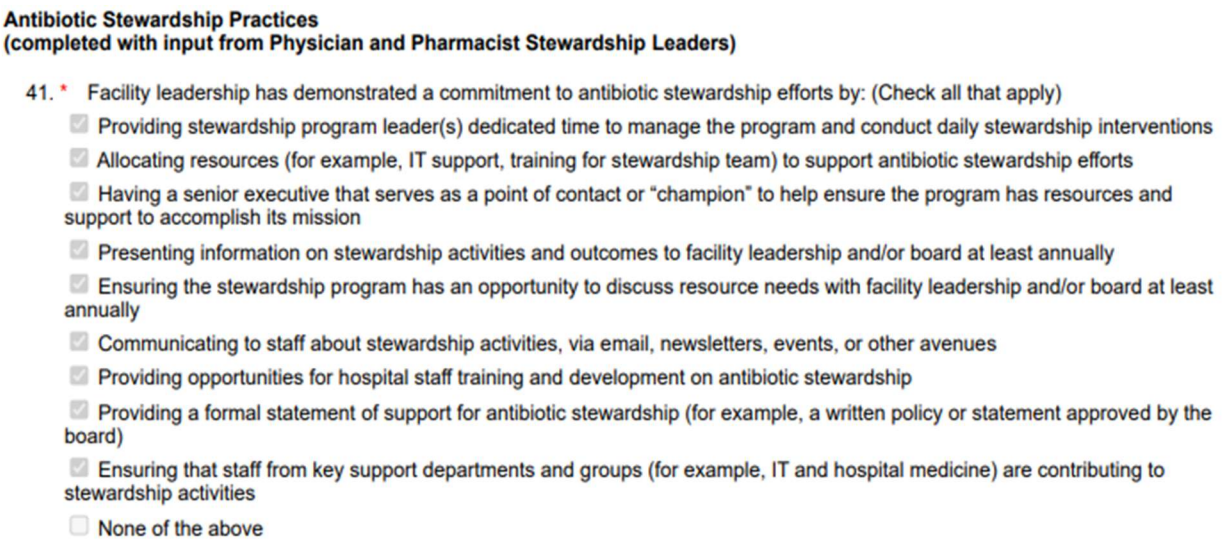
**Key Outcomes and Next Steps**

1. Infection Prevention:
    a. HAI:
        - **Ensure Timely NHSN Reporting:** Continue to monitor and ensure that all NHSN-required data is submitted on time, particularly focusing on the accurate reporting of infection rates for compliance with Centers for Medicare & Medicaid Services (CMS) requirements.

- **Review and Update Protocols:** Conduct a comprehensive review of current infection control protocols to ensure they align with the latest evidence-based practices (EBP) and regulatory requirements.
    - Evidenced-based practices will include the Society for Healthcare Epidemiology of America (SHEA) Compendium of Strategies to Prevent HAIs in Acute Care Hospitals. With initial focus on prevention of:
        - Prevention of device-associated infections
        - Prevention of Clostridioides difficile infections (CDI)
        - Prevention of surgical site infections (SSI)
        - Prevention of multi-drug resistant organisms (MDROs) through transmission based precautions and hand hygiene
- Continue tracer activities and department rounding
- Identified hospital-onset C-diff FY 2025 Q2. Patient high risk for developing C-diff. Action plan is to educate clinical teams on risk factors. See ATB Stewardship section for further details.

**b. Antibiotic Stewardship Activities:**

- Strengthen Antibiotic Stewardship Programs: Further promote antibiotic stewardship initiatives to prevent the overuse of antibiotics, which contributes to the emergence of resistant infections.
- Met 2024 annual goals See report.
- Next step is to create 2025 annual goals, which will be presented at next CQSR committee meeting. One key objective for 2025 is to create C. diff order sets and provide education to clinical staff on their use.
- Continue to meet quarterly and report monthly antibiotic use (AU) & antibiotic resistance (AR) patterns.
- Will continue to monitor the 2024 goal on decreasing mixed flora urine cultures.
- The team worked together to complete the required CMS/NHSN 2024 annual survey, and the information has been successfully submitted. Notably, we were able to answer "yes" to all the options indicating that facility leadership is committed to Antibiotic Stewardship (ATB) efforts. In 2023, we were able to meet only five of these options. Please see the attached screenshot for more details.



**Antibiotic Stewardship Practices**
**(completed with input from Physician and Pharmacist Stewardship Leaders)**

41. * Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply)

- ☑ Providing stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions
- ☑ Allocating resources (for example, IT support, training for stewardship team) to support antibiotic stewardship efforts
- ☑ Having a senior executive that serves as a point of contact or "champion" to help ensure the program has resources and support to accomplish its mission
- ☑ Presenting information on stewardship activities and outcomes to facility leadership and/or board at least annually
- ☑ Ensuring the stewardship program has an opportunity to discuss resource needs with facility leadership and/or board at least annually
- ☑ Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues
- ☑ Providing opportunities for hospital staff training and development on antibiotic stewardship
- ☑ Providing a formal statement of support for antibiotic stewardship (for example, a written policy or statement approved by the board)
- ☑ Ensuring that staff from key support departments and groups (for example, IT and hospital medicine) are contributing to stewardship activities
- ☐ None of the above

**c. Sharps Injury:**

- There have been no sharps injuries reported for the year 2025 marking an achievement in our ongoing efforts to enhance safety protocols and prevent sharps-related incidents.
- Ongoing Education and Training: Continue to provide education on sharps safety and proper disposal techniques to maintain a high level of awareness and compliance among staff.
- Enhance Safety Protocols: We continue to explore additional engineered sharps safety devices for sharps injury prevention.

2. Employee Health:

a. **HCW Influenza Vaccination Rates:**

- Continue to educate staff on the importance of receiving the seasonal influenza vaccine.
- NIHD offers a free influenza vaccine to all NIHD workforce members.
- Continue sending weekly reminders to workforce members who have not provided influenza vaccination information or a declination.
- Infection Prevention continues to report respiratory illnesses to Inyo County Public Health on a weekly basis.
- As of February 21, 2025, the (HCW) influenza vaccination rate 80%.

| **Flu stats as of 2/21/25** | | |
|---|---|---|
| Total NIH HCW (Employees, Providers, Contracted Workers on site, Students, Volunteers) | **632** | |
| Flu Vaccinated | 505 | 80% |
| Signed Declinations | 69 | 11% |
| Medically Contraindicated | 3 | 0.4% |
| Unknown:<br>• Employees 17<br>• Providers 26<br>• Travelers 1<br>• Separated 9<br>• Volunteers 2 | 55 | 8.6% |

b. **SPH Injuries:**

- On February 19, 2025, a **Train-the-Trainer** class was held for Clinical Staff Educators (CSEs) and department leads. A make-up course was offered on March 5, 2025. The trainers were Marcia Male Employee Health Nurse Specialist, Joanne Henze Director of Rehab, Marjorie Routt Manager Human Resources.
- CSEs continue to train new clinical workforce members upon hire and provide annual skills day training within their respective departments
- The Employee Health team, with assistance from Lynda Vance**,** developed a Safe Patient Handling (SPH) Dashboard. This dashboard includes training plans for all departments, new hire orientation, and department-specific safe patient handling equipment. The SmartSheet also stores SPH agendas and meeting minutes, making the information more easily accessible.

**Regulatory Reporting and Requirements**

Infection Prevention:

The Centers for Medicare & Medicaid Services (CMS) requires healthcare facilities participating in the Inpatient Quality Reporting Program to complete the National Healthcare Safety Network (NHSN) Annual Facility Survey by March 1st each year. This survey collects essential data on facility characteristics, infection prevention practices, and patient demographics, which are used for risk adjustment in generating Standardized Infection Ratios (SIRs).

Ensuring timely submission by the deadline is crucial, as failure to do so will result in the inability to enter new monthly reporting plans until the survey is completed.

a. HAI Reporting Compliance: The infection prevention team continues to meet all required reporting deadlines for NSHN**,** ensuring that data on key infections (e.g., CLABSI, CAUTI, and SSI) is submitted accurately and on time to comply with federal and state reporting requirements.
b. Successfully attested to 2024 Promoting Interoperability Antibiotic Use and Resistance.
c. Sharps Injuries: Please refer to the **2020-2024 Sharps Injury Data** for a detailed comparison of past trends and the effectiveness of our prevention measures over the years. The data demonstrates a reduction in sharps injuries, reflecting the success of our targeted interventions and employee safety programs.
d. Sharp Injuries: Our internal reporting system remains in place, with committee reviews and updates to ensure that all data is accurately collected, tracked, and addressed.

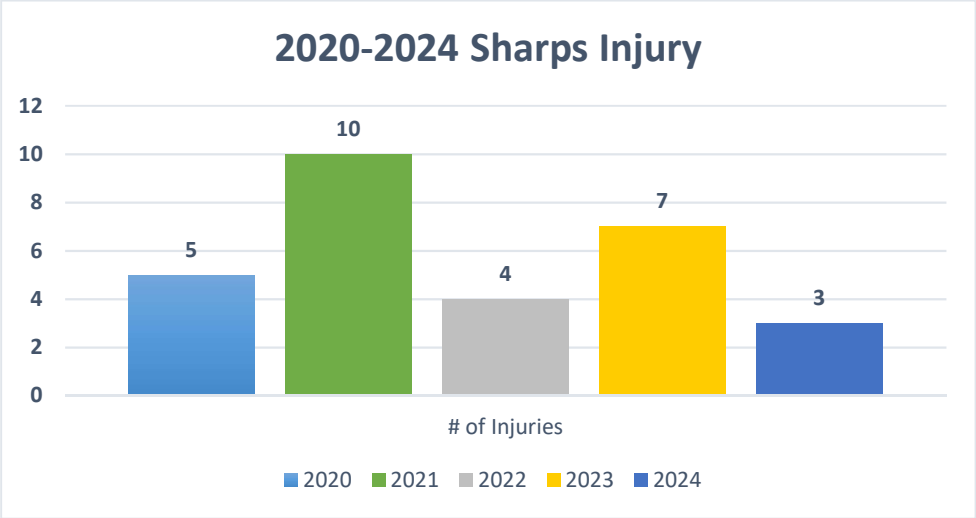
Employee Health:

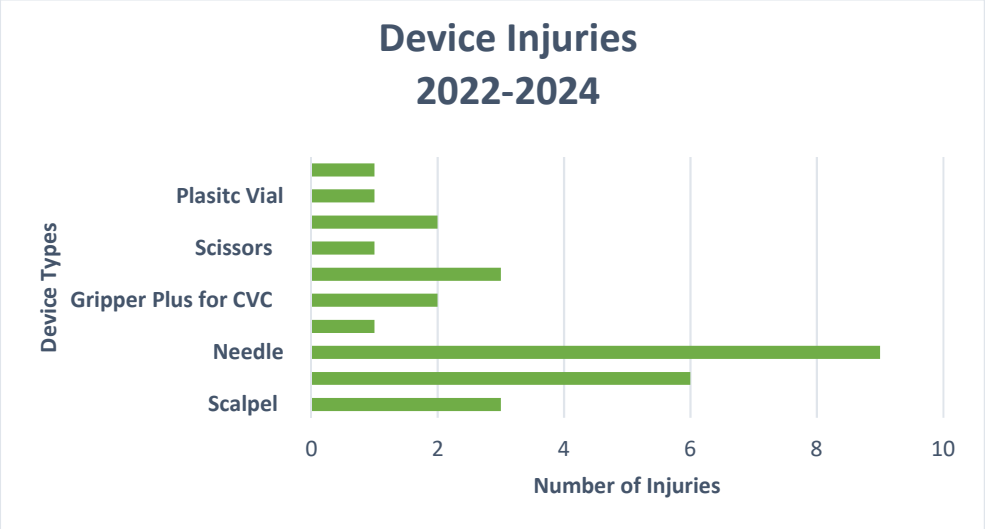
a. Influenza Vaccination
    - The reporting period for the 2024-2025 influenza season is from **October 1, 2024, to March 31, 2025**.
    - To comply with CMS (Centers for Medicare & Medicaid Services) reporting requirements, Healthcare Provider (HCP) influenza vaccination summary data must be entered into NSHN by **May 15, 2025**.
b. Safe Patient Handling (SPH) Injuries:
    - SPH injuries are reported monthly to both the Safety Committee and the SPH Committee.
    - All SPH injuries are also reported to Human Resources for OSHA injury tracking and compliance.
    - Departments that provide direct patient care ensure that employees receive SPH training upon hire, annually, and when any new SPH equipment is introduced.

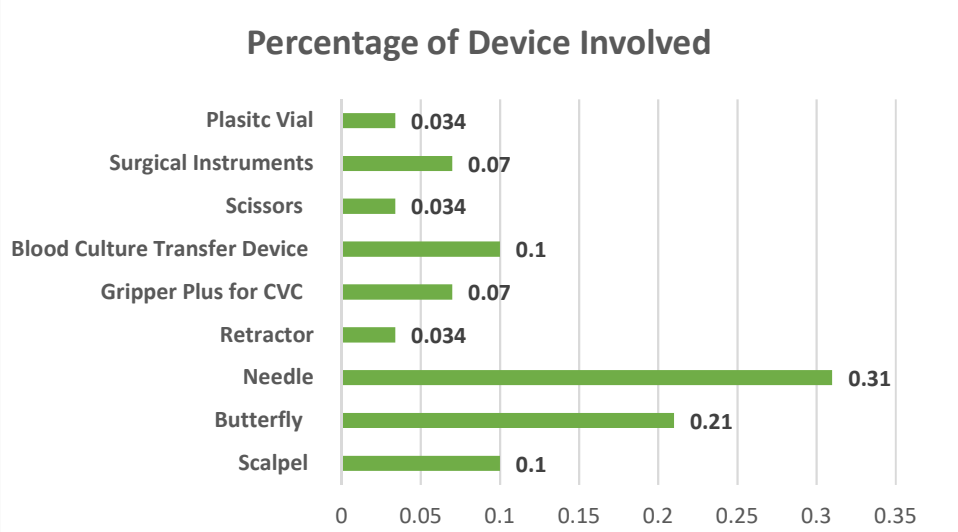
**Conclusion:**

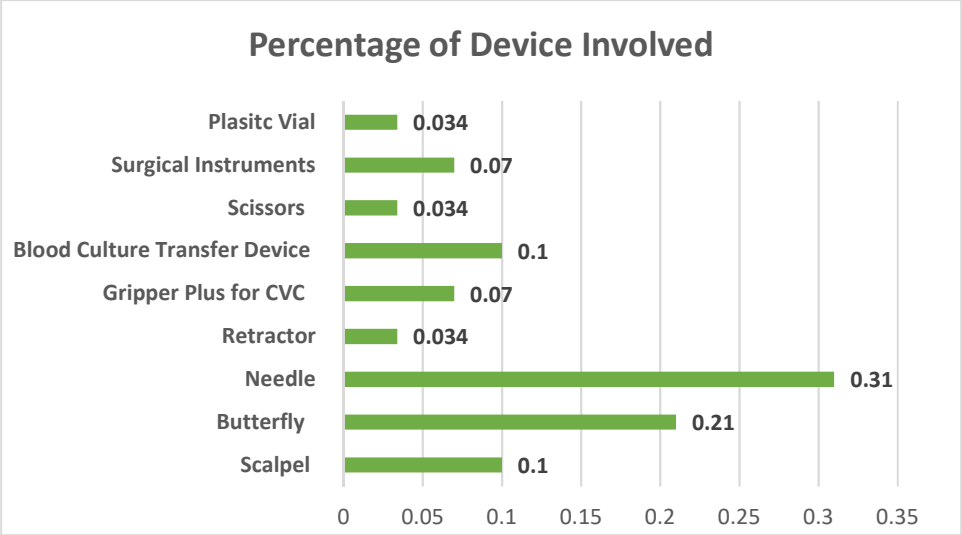
The Infection Prevention and Employee Health teams have made significant strides in maintaining a safe and healthy environment for all staff and patients. The ongoing implementation of evidence-based practices, regular monitoring of infection rates, and continuous education on safety protocols demonstrate our commitment to reducing hospital-acquired infections and enhancing employee well-being. The successful completion of our regulatory reporting, including the CMS/NHSN surveys and compliance with influenza vaccination and sharps injury protocols, underscores our dedication to meeting regulatory requirements and ensuring the highest standards of care.

Looking ahead, the teams will continue to focus on strengthening key initiatives, including infection prevention, antibiotic stewardship, and safe patient handling practices, to further improve patient outcomes and staff safety.


2020-2024 Sharps Injury
12
10
8
6
4
2
0
5
10
4
7
3
# of Injuries
2020
2021
2022
2023
2024


Device Injuries
2022-2024
Device Types
Plasitc Vial
Scissors
Gripper Plus for CVC
Needle
Scalpel
0
2
4
6
8
10
Number of Injuries


Percentage of Device Involved
Plasitc Vial
0.034
Surgical Instruments
0.07
Scissors
0.034
Blood Culture Transfer Device
0.1
Gripper Plus for CVC
0.07
Retractor
0.034
Needle
0.31
Butterfly
0.21
Scalpel
0.1
0
0.05
0.1
0.15
0.2
0.25
0.3
0.35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Plasitc Vial
0.034
Surgical Instruments
0.07
Scissors
0.034
Blood Culture Transfer Device
0.1
Gripper Plus for CVC
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Retractor
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Needle
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Butterfly
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Scalpel
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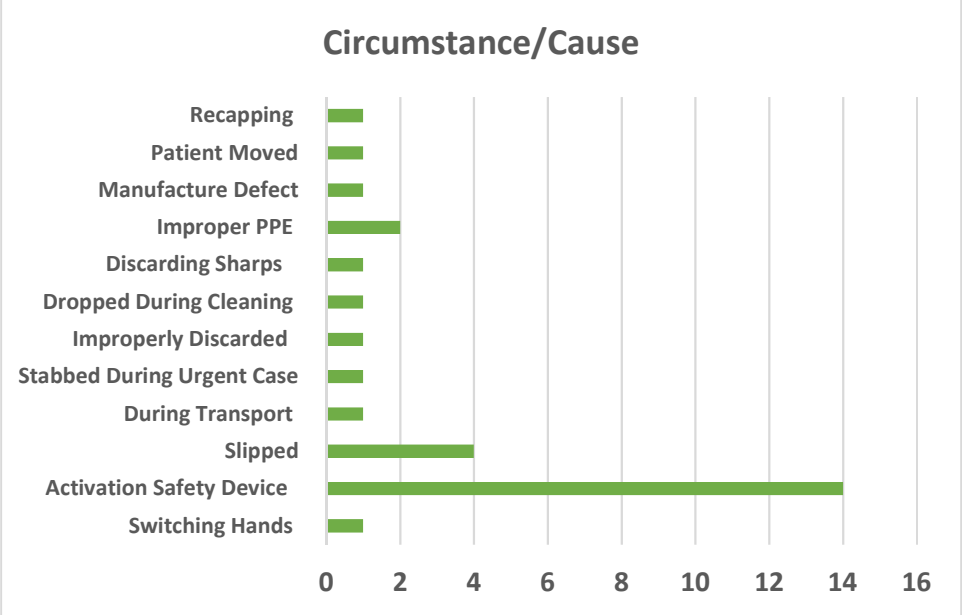
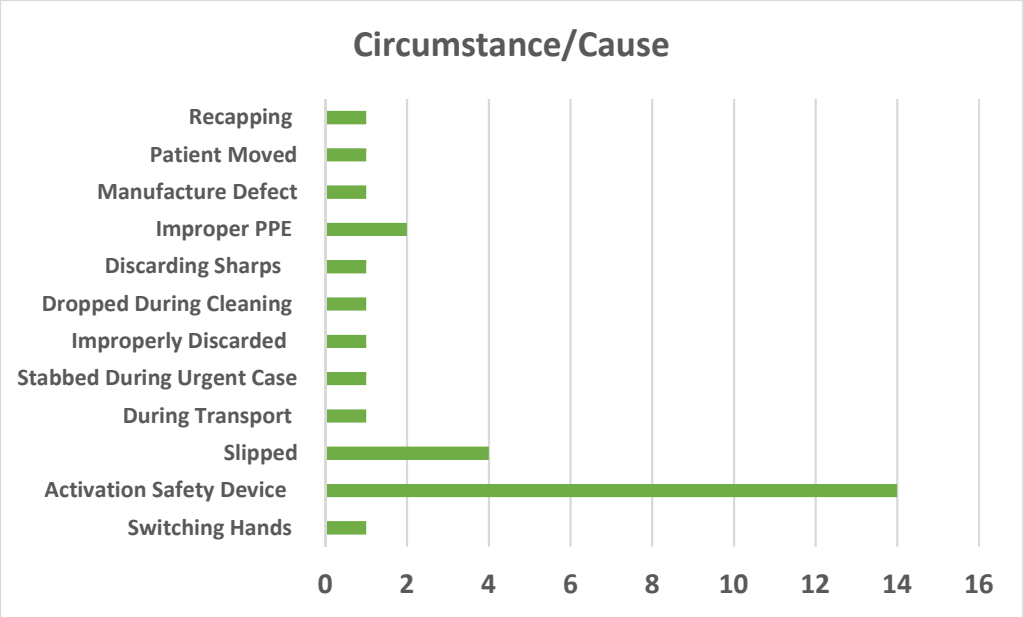

Circumstance/Cause
Recapping
Patient Moved
Manufacture Defect
Improper PPE
Discarding Sharps
Dropped During Cleaning
Improperly Discarded
Stabbed During Urgent Case
During Transport
Slipped
Activation Safety Device
Switching Hands
0
2
4
6
8
10
12
14
16




## 2023-2024 Surgical Site Infections

## 2024

| Month Surgery Performed | Month SSI Identified/Reported | Surgery Type | # of Surgeries Performed | PATOS Yes Does not impact SIR Rate | SSI Risk Ranking | Type of Infection | Reported NHSN or Internally |
|---|---|---|---|---|---|---|---|
| January | January | Colon | 2 | **YES** | 2 | Organ Space | NHSN |
| January | January | Small Bowel | 2 | NO | 4 | Organ Space | NHSN |
| March | March | Amputation | 1 | **YES** | NA | Organ Space | Internal |
| April | May | Chole | 2 | No | 17 | Deep Incisional | NHSN |
| July | August | Appy | 3 | NO | 12 | Organ Space | NHSN |
| August | Sept | Ovarian | 6 | NO | 18 | Superficial Incisional Primary (SIP) | NHSN |
| August | Sept | Ovarian | 6 | NO | 18 | Superficial Incisional Primary (SIP) | NHSN |
| September | September | Appy | 2 | **YES** | 12 | Organ Space IAB | NHSN |

# 2023

| Month Reported | Surgery Type | SSI Rank | Type of Infection | Report Internal/NHSN |
|---|---|---|---|---|
| January | Hernia | 13 | Superficial (SIP) | Internal |
| January | C-section | 10 | Deep Incisional (DIP) | NHSN |
| April | Cholecystectomy | 17 | Organ Space ( IAB) | NHSN |
| April | Tendon Repair | NA | Superficial (SIP) | Internal |
| August | Colon | 2 | Organ Space ( IAB) | NHSN |
| August | Colon | 2 | Deep Incisional (DIP) | NHSN |
| September | Colon | 2 | Superficial (SIP) | NHSN |
| October | Colon | 2 | Superficial (SIP) | NHSN |
| October | C-section | 10 | Organ Space (OREP) | NHSN |

***NOTE: PATOS =YES Does not impact Standardized Infection Ratio (SIR) but required to report to NHSN for reportable procedures.***

The standardized infection ratio (SIR) is a risk-adjusted summary measure that compares the observed number of infections to the predicted number of infections based on NHSN aggregate data. Used to track HAIs over time at a national, state, or facility level.

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room) | | |
| Owner: Manager Employee Health & Infection Control | Department: Infection Prevention | |
| Scope: Pharmacy, Environmental Services, Infection Prevention | | |
| Date Last Modified: 01/20/2025 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/21/2018 | |

**PURPOSE:**

To give Environmental Services (EVS) personnel the proper guidelines and training to ensure proper cleaning and disinfecting of the Pharmacy Sterile IV Preparation area (Clean Room).

**POLICY:**

1. Monthly: Use an EPA-registered sporicidal detergent to clean. This will occur on the first Saturday of the month.
2. Daily: Cleaning will be completed using an EPA and NIHD approved sterile germicidal product. Alcohol has no detergent properties, so is unacceptable for this purpose.
3. All cleaning and disinfection supplies (e.g., wipers, sponges, pads, and mop heads) with the exception of tool handles must be low lint.
4. Designated cleaning equipment must be used when cleaning Pharmacy Sterile IV Preparation area.
5. Disposable mops are preferred. Reusable mops may be acceptable if they are laundered to clean room standards.
6. Personal Protective Equipment (PPE) must be applied prior to entering Pharmacy Clean Room and removed when exiting.
7. Remove hand, wrist and other exposed jewelry including piercings that could interfere with donning and doffing PPE.
8. A daily cleaning and a monthly log must be posted inside of pharmacy this will be completed by EVS staff.
9. Every EVS attendant must be trained upon hire and annually if they are responsible for cleaning the Pharmacy Sterile IV Preparation area. Documentation of training will be located in Pharmacy and in the employee file.
10. Cleaning of Pharmacy Sterile IV Preparation (clean room) areas will occur when there are no compounding activities being performed.
11. Makeup, nail polish, and artificial nails ***are prohibited*** in Pharmacy Sterile IV Area (clean room). Per CCR section 1751.5 (a) (6).
12. Individuals must clean and disinfect their personal eyeglasses prior to entering compounding area.
13. No food, drinks, gum, or candy allowed in the clean room.
14. Remove headphones and earbuds before entering clean room.
15. Documentation of each occurrence with cleaning and sanitizing of the compounding area shall include a record of the identity of the person completing the cleaning and sanitizing as well as the product name of the cleaning and sanitizing agent.

**Table: Purpose of Cleaning, Disinfecting, and Sporicidal Disinfectants:**

| Type of Agent | Purpose |
|---|---|
| Cleaning | An agent, usually containing a surfactant, used for the removal of substances (e.g. dirt, debris ,microbes, and residual drugs or chemicals) from surfaces |
| Disinfectant | A chemical or physical agent used on inanimate surfaces and objects to destroy fungi, viruses, and bacteria |
| Sporicidal | A chemical or physical agent that destroys bacterial and fungi spores when used at a sufficient concentration for a specified contact time. It is expected to kill all vegetative microorganisms |

**Table: Minimum Frequency for Cleaning and Disinfecting Surfaces and Applying ~~Sporicidial~~Sporicidal Disinfectants**

| Site | Cleaning | Disinfecting | ~~Sporicidial~~Sterile Sporicidal Disinfectant |
|---|---|---|---|
| Pass-through chamber | **Daily** on days compounding occurs | **Daily** on days compounding occurs | • **Monthly** if compounding Category 1 and/or Category 2 Compounding sterile preparations (CSPs)<br>• **Weekly** if compounding Category 3 CSPs |
| Work surfaces outside the Primary Engineering Control (PEC) | **Daily** on days compounding occurs | **Daily** on days compounding occurs | |
| Floors | **Daily** on days compounding occurs | **Daily** on days compounding occurs | |
| Walls, doors, and door frames | **Monthly** | **Monthly** | **Monthly** |
| Ceilings | | | |
| Storage shelving and bins | | | |
| Equipment outside PEC | | | |

**PROCEDURE:**

1. Perform Hand Hygiene
2. Don Proper Personal Protective Equipment prior to entering clean room (Gown, mask, gloves, hairnet, booties, and eye protection). Remove and discard PPE when exiting.
3. Disposable soap containers must be replaced they are not to be refilled or topped off.
4. Daily: clean- wipe all horizontal surfaces, mop the floor with a designated mop and wipe the plastic curtains inside and out using EPA germicidal agent.
5. Monthly cleaning: Walls, doorframes, ceilings, storage shelving and bins, tables, stools, and all other items and surfaces in the Pharmacy Clean Room using approved sporicidal/germicidal product; after cleaning repeat with sterile water using new disposable mop pad.
6. No sweeping, dusting or spraying will be done while in Pharmacy Clean Room.
7. Daily: Empty all trash containers. The outside of the waste containers shall be wiped out with the approved germicidal cleaning and disinfecting solutions.

8. Monthly: Cleaning of the inside and outside of trash containers with approved sporicidal agent.
9. All waste containers will be properly disposed of when at fill line.
10. Complete daily and monthly log.

**REFERENCES:**


1. Association for Professionals in Infection Control and Epidemiology (APIC). August 2023. Ten Key Points the Infection Preventionist Needs to Know about (USP) >797>: Pharmaceutical Compounding-Sterile Preparations. Retrieved from https://apic.org/wp-content/uploads/2023/08/APIC_PGC_Ten-Key-Points-the-Infection-Preventionist-Needs-to-Know.pdf
2. California Hospital Association. (2018). Record and Data Retention Schedule. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf
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6. United States Pharmacopeia (USP). 11/1/23. <797> Faqs. Retrieved from https://go.usp.org/USP_GC_797_FAQs
7. United States Pharmacopeia (USP). 11/22. <797> Pharmaceutical Compounding-Sterile Preparations. Retrieved from https://online.uspnf.com/uspnf/document/1_GUID-A4CAAA8B-6F02-4AB8-8628-09E102CBD703_7_en-US
8. United States Pharmacopeia (USP). 2017. USP General Chapter <800> Hazardous Drugs-Handling in Healthcare Settings. Retrieved from www.usp.org


**RECORD RETENTION AND DESTRUCTION:**

Cleaning and disinfecting records must be kept for at least 3 years.

**CROSS-REFERENCE P&P:**

1. MEDICAL WASTE MANAGEMENT PLAN
2. Sterile Products: Compounding Quality Assurance Program*
3. Pharmacy Sterile Compounding: Training Requirements, General Conduct, and Aseptic Compounding

| Supersedes: v.2 Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room) |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Critical Value Reporting of Lab Results | | |
| Owner: Medical Laboratory Services Manager | Department: Laboratory | |
| Scope: Lab, Nursing, Respiratory Care Practitioners, NIHD Clinics | | |
| Date Last Modified: 12/12/2023 | Last Review Date: 04/03/2025 | Version: 6 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/01/2005 | |

**PURPOSE:**

To define critical values and establish a communication/documentation process

**POLICY:**

1. A current listing of Critical Values will be maintained in this policy. Critical values are also defined in the LIS to allow automated flagging and also appear in bold red type in the Electronic Medical Record
2. Critical results generated by automated analyzers are **not** required to be verified by repeat analysis
3. All critical values will be called and documented, except for **decreasing** critical Troponin results within the same visit
4. When a patient is transferred to another healthcare facility: Critical results will be called to the primary nurse. If unable to deliver critical results to the appropriate personnel, the results may be given to a Clinical Laboratory Scientist (CLS) at that facility.

**DEFINITION:**

1. Critical results are those findings whose value reflects a potential life threatening situation that requires rapid communication of results.
2. Critical results can be relayed to licensed providers (such as Registered Nurses, Licensed Vocational Nurses) or clerical office staff as determined by the outpatient clinic or call facility.

HEMATOLOGY:

| Test | Critical Low | Critical High | Units |
|---|---|---|---|
| **Fibrinogen** | 100 | -- | mg/dL |
| **Hematocrit** | 15 | 66 | % |
| **Hemoglobin (<21 days)** | 7 | 22 | g/dL |
| **Hemoglobin (>21 days)** | 7 | 20 | g/dL |
| **INR** | -- | 4.5 | ratio |
| **WBC (<21 days)** | 2.5 | 30 | x10^3/mcl |
| **WBC (>21 days)** | 2.5 | 20 | x10^3/mcl |
| **Platelet** | 30 | 800 | x10^3/mcl |
| **PTT** | -- | 90 | Seconds |

CHEMISTRY:

| Test | Critical Low | Critical High | Units |
|---|---|---|---|
| **Acetaminophen** | -- | 50 | ug/mL |
| **Neonatal bilirubin** | -- | 15.0 | mg/dL |
| **Total bilirubin (adult)** | | 15.0 | mg/dL |
| **Calcium** | 6.0 | 14.0 | mg/dL |
| **Carbamazepine** | -- | 12 | ug/mL |
| **Creatinine** | -- | 5.0 | mg/dL |
| **CO2** | 10 | 40 | mmol/L |
| **Digoxin** | -- | 2.5 | ng/mL |
| **Ethanol** | -- | 300 | mg/dL |
| **Gentamicin (Random)** | -- | 8.0 | ug/mL |
| **Gentamicin (Peak)** | -- | 10.0 | ug/mL |
| **Gentamicin (Trough)** | -- | 2.1 | ug/mL |
| **Glucose (>1 year)** | 50 | 400 | mg/dL |
| **Glucose (0 - 28 days)** | 30 | 300 | mg/dL |
| **Glucose (28 days - 1 year)** | 40 | 400 | mg/dL |
| **Lactic acid** | -- | 5.0 | mmol/L |
| **Lithium** | -- | 2.0 | mmol/L |
| **Phenobarbital** | -- | 40 | ug/mL |
| **Phenytoin** | -- | 30 | ug/mL |
| **Potassium (<9 days)** | 3.0 | 8.0 | mmol/L |
| **Potassium (>9 days)** | 3.0 | 6.0 | mmol/L |
| **Salicylate** | -- | 30 | mg/dL |
| **Sodium** | 120 | 160 | mmol/L |
| **Tobramycin (Random)** | -- | 8 | ug/mL |
| **Tobramycin (Peak)** | -- | 10 | ug/mL |
| **Tobramycin (Trough)** | -- | 2.1 | ug/mL |
| **Troponin-I** | -- | 0.3 | ng/mL |
| **Valproic Acid** | -- | 200 | ug/mL |
| **Vancomycin (Random)** | -- | 30 | ug/mL |
| **Vancomycin (Peak)** | -- | 40 | ug/mL |
| **Vancomycin (Trough)** | -- | 25 | ug/mL |

BLOOD GAS:

| Test | Critical Low | Critical High | Units |
|---|---|---|---|
| **pH (arterial, venous, cord)** | 7.2 | 7.6 | -- |
| **pO2 (arterial)** | 40 | -- | mmHg |
| **pCO2 (arterial)** | 20 | 70 | mmHg |
| **pCO2 (venous)** | 15 | 70 | mmHg |
| **HCO3 (arterial, cord arterial)** | 15 | 40 | mmol/L |
| **Hemoglobin (arterial)** | 7 | 20 | g/dL |

TRANSFUSION SERVICE:

1. All units crossmatched are incompatible
2. Blood products are unavailable

MICROBIOLOGY:

1. Positive gram stains (organisms seen) from these sites:
   A. Blood cultures
      i. **Inpatients**: only call first positive bottle if the organism morphology is consistent across bottles
      ii. **Outpatients and discharged patients**: call all positive bottles
   B. CSF
   C. Body fluids (from normally sterile sites)
      i. Pleural
      ii. Pericardial
      iii. Thoracentesis
      iv. Joint fluid
      v. Peritoneal fluid
2. EHEC organism (O:157) and Shiga toxin positive stool specimen
3. Suspicion of *Salmonella typhi*
4. Suspicion of bioterrorism organism
   - *B. anthracis*
   - *C. botulinum*
   - *Brucella* species
   - *F. tularensis*
   - *Y. pestis*
   - *B. mallei*
   - *B. pseudomallei*
5. Positive Acid Fast Bacilli (AFB) stains and organism identification (result will originate from reference laboratory)

*Note: See Microbiology SOP "Direct Notification of Abnormal Findings" for reporting instructions of non-critical microbiology culture results*

**PROCEDURE:**

LABORATORY AND RESPIRATORY THERAPY

1. The critical test result reporting time frame is from the time the result is available to the time the result is documented as received.
   A. Inpatients and Emergency Department: Report within 30 minutes of the availability of result
   B. Outpatient clinics: Report within 60 minutes of the availability of the result.
2. Clinical Laboratory Scientists (CLS) are responsible for notifying a nurse, on-call Provider, or other qualified recipient such as a call center representative or CLS at an outside facility. The notification (and any attempts) must be documented.
3. Respiratory Therapists are responsible for analyzing, reporting, and notifying the provider of critical blood gas results. The notification (and any attempts) must be documented.
4. If unable to reach a nurse, attempt to contact an on-call provider respective to the ordering provider's clinic/location.

5. If unable to contact a nurse or provider within 60 minutes after initial contact attempt, notify an Emergency Department Physician to help assess situation and contact patient if appropriate. The notification (and any attempts) must be documented.
6. Once a contact has been found:
   A. Report the patient's name and date of birth
      i. A room number is not a proper identifier, per The Joint Commission
   B. Report the ordering provider's name if speaking with an on-call contact or a clinic
   C. Report the name of the test and the critical value
   D. Ask the contact to repeat the above information back to you
7. **Required information to be documented in the LIS by the CLS or RT:**
   **A. First name and last initial/last name of contact person**
   **B. Location of contact person (i.e. ED, RHC, Med/Surg, City of Hope, etc)**
   **C. Date and time contact notified**
   **D. Reporting CLS or RT initials**
   **E. Documentation of any delays or problems in notification**
8. To ensure all necessary documentation is included, use the Cerner comments:
   A. **29crit** (for Result Entry) or **29mbcrit** (for Microbiology Result Entry):
      *Critical Result called to _ (location:_) on _ by _. Read back and verified*.
9. CLS and RTs are required to verbally report all critical values, regardless of whether they are returning to "normal".

NURSING

1. The nurse is responsible for notifying the ordering provider of critical values that are reported from the CLS or RT within 30 minutes of being notified.
2. **The nurse is responsible for documenting the conversation with the provider. Documentation will include:**
   **A. Date and time nurse was notified by lab**
   **B. Date, time and name of provider notified**
   **C. Name and value of critical result reported**
   **D. Documentation of any delays or problems in notification**
3. If consecutive critical values from the same test are improving (trending closer to the normal range) or staying at the same level, the nurse is not required to contact the provider.

**REFERENCES:**

1. The Joint Commission E-dition Critical Access Hospital, current edition.

**RECORD RETENTION AND DESTRUCTION:**

Documentation of critical values is kept in the patient's medical record, which is maintained by the NIHD Medical Records Department.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Direct Notification of Abnormal Findings Microbiology SOP

| Supersedes: v.5 Critical Value Reporting of Lab Results* |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Patient Identification for Clinical Care and Treatment/Armband Usage | | |
| Owner: Director of Patient Access | Department: Patient Access | |
| Scope: Acute/Subacute, ED, Outpatient Infusion, PACU, Perinatal, ICU, Surgery, DI for Invasive Procedures and Admission Services | | |
| Date Last Modified: 01/11/2023 | Last Review Date: 04/03/2025 | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/2003 | |

## PURPOSE:

In an effort to improve the safety and quality of healthcare delivery at Northern Inyo Healthcare (NIHD), development of a standardized process to issue armbands to patient's types listed in this policy, will ensure the following:

1. Provides positive identification of patients from the time of admittance or acceptance for treatment.
2. Allows for barcode usage as best practice to improve medication administration safety.
3. Provides a positive method of linking patients to their medical records and treatment.
4. Minimizes the possibility that identifying data can be lost or transferred from one patient to another.
5. Improves the accuracy of patient identification, decreases error occurrence and promotes patient safety.

## POLICY:

It is the policy of NIHD to ensure that all patients are properly identified by our workforce prior to any services, care, or treatments being rendered. Where possible, identification shall be performed with the two-identifier process (name and date-of-birth). District armbands will be applied in the following areas/specific patient types as soon as possible:

1. Inpatient settings (ICU/Acute-Subacute and Perinatal Units).
2. Hospital armbands will be used in the following Outpatient settings:
    a. Emergency Department
    b. Same Day Surgery (PACU)
    c. Diagnostic Imaging
        i. Invasive Procedures that require nursing support for anxiolysis/sedation
        ii. Nuclear Medicine
    d. Infusion Center
    e. Patients whose care requires transportation that crosses multiple hospital departments
    f. Patients receiving medications (excluding in Clinics)
    g. Observation patients
    h. Perinatal Outpatients
    i. Pulmonary Function Testing (PFT)

A District armband is a tamperproof, nontransferable identification band. It will include the patient's full name, District identification number, medical record number, patient's date of birth, age, sex and the attending physician's name. It also contains a unique barcode for each patient. If the District armband is cut off or

becomes unreadable, staff will contact Admission Services and request a new District armband or print if armband printer is available in their department for the patient.

**PROCEDURE:**

**A. Patient Identification**

1. Upon arrival at NIHD, the use of at least two identifiers (patient name and date of birth) will be used to properly match the correct patient with the correct care to be administered. The patient will be asked to state their name and date of birth; and that information will be compared to the patient's armband.
2. A NIHD armband shall be placed on the patient as soon as possible after the identification has been made for patients receiving care in the departments or for services requiring use of armband identification.
3. Application of the District armband will be done by District Workforce after confirmation of the two-patient identifier process.
4. Patients unable to provide identifying information or who experience conditions requiring emergency care will not have emergency care delayed. If the patient or family/caregiver is unable to actively participate in the patient identification process, the patient will receive a District armband with a temporary or fictitious name and identification number assigned by Admission Services until identification is confirmed, at which time the armband will be replaced.
5. Before any elective procedure is carried out, the District armband shall be placed on the patient and will be checked by the receiving and each subsequent care provider.
6. Whenever possible staff should also verbally assess the patient to assure proper identification by asking the patient's name and date of birth and matching the verbal confirmation to the written information on the District armband. If the patient's date of birth is not available, other acceptable identifiers defined by the National Patient Safety Goals 01.01.01, include another specific assigned identification number, telephone number, or other person-specific identifier.
7. Procedures and/or activities include, but are not limited to:
    a. Placement/replacement of patient District armband
    b. When a patient is introduced to a caregiver
    c. Transfer/discharge
    d. Medication administration (Barcode usage)
    e. Transportation from one District area/department to another area/department
    f. Diagnostic/therapeutic treatments
    g. Meal/snack trays
    h. Transfusions of blood or blood components
    i. Obtaining informed consent
    j. Vital sign checks per shift/per provider orders
    k. Surgical procedures
    l. When performing a treatment
8. No procedure shall be conducted when the patient's identity cannot be verified because the imprinted band is illegible or missing except in an emergent situation.
9. Defective or missing District armbands shall be replaced immediately with a new District armband.
10. Each healthcare provider conducting assessments on the patient shall include a check of the patient's District armband to assure the band is present and legible, as a routine component of the patient assessment process.

**B. Temporary/Downtime District Armband Procedure:**

In the event of a delay in the creation or placement of a District armband, or a system downtime occurs where use of a computer and printer is available, Admission Services will print labels that affix onto the armband for patient identification. If there is loss of computer and/or printer functions, a legible handwritten label with the patient's name, date of birth, date and time of admission, and attending physician will be affixed to the armband and placed on the patient. Once the system is operational again, an armband with the appropriate information will be printed and placed on the patient. The handwritten armband will be removed and discarded.

**C. Children:**

A parent or guardian should verify the identification of minor patients, when present at the time of the patient encounter.

**D. Unconscious/Confused/Incompetent Patients:**

In order to complete the verification process, any unconscious/confused/incompetent patients should, whenever possible, have their identification confirmed by a person (relative, transferring facility, etc.) before the District armband is placed on the patient. For the unconscious/confused/incompetent patient who arrives at NIHD without someone accompanying them, or identifying paperwork from a transferring facility, a temporary name (e.g. Jane or John Doe) and identifying number (e.g. medical record number) are assigned to the patient. These identifiers can be used to identify the patient and match against specimen labels, medications ordered for the patient or blood product labels. Formal identification of the patient should occur as soon as possible and once confirmed, the confirmed identifying information should be used instead of the temporary identification. Under no circumstance, except for lifesaving or emergency measures, should any patient encounter occur if a District armband is not present as required in the policy statement above.

**E. Patient Refusal:**

If the patient is capable and refuses to wear the District armband, an explanation of the risks will be provided to the patient and/or family. The designated staff member will reinforce that is the patient's and/or family's opportunity to participate in efforts to prevent medical errors, and it is their responsibility as part of the healthcare team. The designated staff member will document in the medical record patient's refusal, and the explanation provided by the patient or their family member.

**REFERENCES:**


1. Floyd Memorial Hospital. *Patient Safety-Patients*. Floyd Memorial Hospital, n.d. Web. 29 Sept. 2015. <http://floydmemorial.com/patients/patient-safety/>.
2. Applied Ergonomics Vol 52, Jan 2016 pg 1-7. *Human factors engineering approaches to patient identification armband design.*
3. The Joint Commission. "National Patient Safety Goals (NPSG)." *Comprehensive Accreditation Manual for Critical Access Hospitals*. Oak Brook: Joint Commission Resource, 2022. NPSG-3.
4. Main Line Health, Inc. *Administrative Policy and Procedure Manual, Patient Identification*. Main Line Health, n.d. Web. 31 Aug. 2016. <http://www.mainlinehealth.org/doc/Page.asp?PageID=DOC001368>.


**RECORD RETENTION AND DESTRUCTION:** N/A

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Color-Coded Wristband Use
2. Patient Identification and Preparation, specimen collection, labeling and transport

3. Barcode Medication Administration
4. Universal Protocol

| Supersedes: v.3 Patient Identification for Clinical Care and Treatment/Armband Usage* |
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**NORTHERN INYO HEALTHCARE DISTRICT**

**ANNUAL PLAN**

| | | |
|---|---|---|
| Title: Patient's Rights and Responsibilities | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 03/15/2023 | Last Review Date: 04/03/2025 | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 01/2001 | |

## PURPOSE:

To inform all patients and workforce of the rights and responsibilities of all patients while undergoing treatment in our District facilities.

## POLICY:

1. Northern Inyo Healthcare District shall comply with the California statues regarding patient rights and responsibilities.
2. A list of patients' rights shall be posted in both English and Spanish in appropriate areas within the District, making them available to all patients.
3. Patients shall receive written 'Patient Rights and Responsibilities' as part of the admission packet.
4. All District workforce performing patient care shall observe these patient rights.

## PATIENT RIGHTS - As a patient of Northern Inyo Healthcare District (NIHD), you have the right to:

1. Exercise theses rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, marital status, or the source of payment for care.
2. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.
3. Know the name of the licensed health care provider acting within the scope of his or her professional licensure, who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care during hospitalization and for discharge planning, to meet your medical and psychological needs. You have the right to participate in the ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment, or to request an Ethics Consult.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or

non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

6. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment. However, the patient does not have the right to demand treatment or services deemed medically unnecessary or inappropriate.
7. Full consideration of privacy concerning medical care will be maintained. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence and consent to the presence of any individual.
    a. Patient has the right to have visitors leave prior to an examination and/or prior to discussion about treatment.
    b. Privacy curtains will be used in non-private patient care areas.
8. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Basic information may be released to the public, unless specifically prohibited in writing by the patient. Written permission must be obtained before medical records can be made available to anyone not directly concerned with the care of the patient except as may otherwise be required or permitted by law.
9. Reasonable responses to any reasonable requests he or she may make for service.
10. Leave the hospital even against the advice of physicians, to the extent permitted by law.
11. Reasonable continuity of care, to know in advance the time and location of appointments, as well as the identity of persons providing the care.
12. Be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed of continuing health care requirements following discharge from the hospital.
14. Examine and receive and explanation of the bill regardless of source of payment.
15. Know which District rules and policies apply to the patient's conduct while a patient.
16. Have all of his or her rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Designate visitors of his or her choosing, if the patient has decision making capacity, whether or not the visitor is related by blood or marriage, unless:
    a. No visitors are allowed.
    b. The Healthcare District reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the Healthcare District workforce, or other visitor to the Healthcare District campus, or would significantly disrupt the operations of the District.
    c. The patient has indicated to the District workforce that the patient no longer wants this person to visit.
18. Have his or her wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the Healthcare District policy on visitation. At a minimum, the Healthcare District shall include any person living in the household. Verbally designate a support person, who may exercise the patient's visitation rights if the patient is unable.
19. Right to know the identity of persons caring for you, including your caregivers. Workforce is required to wear name badge with name and job title.
20. Right to be informed of continuing care requirements after discharge. If the patient authorizes, a friend or family member maybe given information on continuing care requirements after discharge.

21. Formulate advance directives for healthcare and have hospital staff and practitioners who provide care in the hospital comply with these directives. This includes the designation of a decision maker if he or she becomes incapable of understanding a proposed treatment or becomes unable to communicate his or her wishes regarding care. The patient has the right to have a family member (or representative of the patient's choice) and the patient's own physician notified promptly of the patient's admission to the hospital.
22. The patient has the right to appropriate assessment and management of his or her pain, information about pain, pain relief measures and to participate in pain management decisions. If the patient suffers from severe chronic intractable pain, the patient has the option to request or reject the use of any or all modalities to relieve pain, including opiate medication. The patient's doctor may refuse to prescribe opiate medication, but if so, must inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
23. Right to have family member and personal physician notified within 24 hours of admission, should you be incapable of communication. Reasonable efforts to reach the person with authority to make health care decisions for the patient will be made by NIHD workforce.
24. Have District documents communicated/printed to make them readable/understandable. NIHD provides these documents in English and Spanish. Other language needs are met via the 'Language Access Services Procedure.' Aids will be utilized to assist in effective communication for those with disabilities or limited English proficiency.
25. Receive care in a safe setting. Be free from physical or mental abuse, corporal punishment, restrain or seclusion, or any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restrain or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
26. Access, request amendment to, and obtain information on disclosures of your health information (medical records) in a reasonable amount of time.
27. Examine and receive an explanation of District's bill regardless of source of payment.
28. These patient rights may not be construed to prohibit the Healthcare District from otherwise establishing restrictions on visitation, including restrictions upon the hours of visitations and number of visitors.

**PATIENT RESPONSIBILITIES – As a patient of Northern Inyo Healthcare District (NIHD), you have the responsibility to:**

1. Provide complete and accurate information regarding his or her medical history to those involved with his or her care.
2. Inform the physician or nurse of any changes in his or her health.
3. Inform the provider and the nurse of any pain he or she has and results of pain control measures.
4. Make it known whether he or she clearly understands the course of action and expectations set by NIHD.
5. Make it known to appropriate Healthcare District staff and/or his or her provider that he or she is in need of interpreter services or other assistance because of language or communication barriers.
6. Work with your provider and the District's patient care staff in developing and carrying out agreed upon treatment plans.
7. The patient shall follow Healthcare District rules and regulations affecting patient care and conduct.
8. Fulfill the financial rules and obligations of his or her health care as promptly as possible.
9. Be considerate of the rights or other patients and Healthcare District personnel.
10. The patient shall take responsibility for maximizing health habits, such as exercising, not smoking, and eating a healthy diet.

11. Avoid knowingly spreading disease.
12. Recognize the reality of risks and limits of the science of medical care, and the human fallibility of the health care professional.
13. Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
14. Report wrongdoing and fraud to appropriate resources or legal authorities.

**Grievance Instructions for Patients:**

Should there be a conflict between the care expectations of the patient (or the care expectations of the parents and/or guardians of neonate, child or adolescent patients); the patient (or patient's representative) should request a care conference by speaking to the physician or NIHD Leader of the department. The conference should involve the patient (and/or the patient's representative) and District staff members involved in the conflict, and should be conducted within 24 hours of the request for the conference.

If those attending the patient care conference cannot resolve the conflict, the patient or the representative should file a grievance verbally or in writing. Presentation of a grievance or complaint will not compromise a patient's access to care. File a grievance in writing or via phone.

To report a grievance, call the Northern Inyo Healthcare District Compliance Department @ (760) 873-2083 or send a written correspondence to NIHD Compliance Officer, 150 Pioneer Lane, Bishop, CA 93514.

The District Compliance staff will review each grievance and provide the patient with response in accordance with the Grievance Policy. The written response will contain the name of a person to contact at the Healthcare District, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Refer concerns regarding quality of care or premature discharge to the appropriate utilization and Quality Control Peer Review Organization (PRO).

The patient has the right to file a complaint with the State Department of Health Services regardless of whether the Healthcare District's grievance process is used or not.
The State Department of Health Service's phone number and address is **California Department of Health Services, Licensing and Certification**, San Bernardino District Office, 464 West 4th Street, Suite 529, San Bernardino, Ca 92401, phone 909-383-4777 or 800-344-2896.

**REFERENCES:**


1. Centers for Medicare and Medicaid Services, §482.13 Condition of participation: Patient's rights. December 2, 2011.
2. Title 22, California Code of Regulations, Section 70707 and 70715.
3. UNRUH Civil Rights Act – Civil Code Sections 51-53.
4. U.S. Department of Health and Human Services, Office for Civil Rights: Patient Protection and Affordable Care Act (ACA), Section 1557.
5. California Hospital Association Consent Manual, 2021.

**CROSS-REFERENCE POLICIES AND PROCEDURES:**

1. Management of Discharge Disputes from Medicare Patients
2. Patient Visitation Rights Complaint or Grievance Process for Reporting, Tracking, Investigating and Resolution Discharge Planning for the Hospitalized Patient
3. Advance Directives
4. Language Access Services Policy
5. Language Access Services Program
6. Therapy Animals and Pets in District Buildings

**RECORD RETENTION AND DESTRUCTION:**

Maintain all unusual occurrence reports (UOR) at NIHD for 10 years.

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| Supersedes: v.2 Patient's Rights |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Sterile Products: Cytotoxic Agents | | |
| Owner: Pharmacy Director | Department: Pharmacy | |
| Scope: Pharmacy | | |
| Date Last Modified: 01/31/2025 | Last Review Date: Not Approved Yet | Version: |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 08/20/2014 | |



**PURPOSE:**
To provide continuity in handling and processing of chemotherapy medications so that safety is maintained for both patients who receive chemotherapy and personnel who prepare these agents.

**POLICY:**
**Personnel training-**
Chemotherapy training and competency assessment will be incorporated into the Sterile Preparation training and competency assessments and will be conducted at initial orientation and annually. This is an online module provided by the American Society of Health-System Pharmacists (ASHP). The modules include competency checklists, written exams including math calculations.

***Handling of Antineoplastic Agents-***
All mixing of antineoplastic drugs shall be performed in the Class II biological safety cabinet located in the negative pressure buffer area of the IV room. Because of its design and decontamination limitations, the biological safety cabinet (BSC) is considered a contaminated environment and treated as such. The use of the BSC is restricted to the sterile preparation of hazardous drugs, no other IV admixtures will be prepared in biological safety cabinets (chemo hood).

All personnel compounding cytotoxic agents shall wear chemo-grade gowns and gloves. They will also wear booties, hair cover (facial hair cover if needed), and mask. They will double glove with the first pair of gloves under the cuffs of the gown and the second pair of sterile gloves stretched over the cuffs.

**Safety and Precautions-**
All personnel having direct contact with chemotherapy will be trained in the handling of hazardous materials and the proper use of personal protective equipment (PPE).
Access to the compounding area will be limited to necessary authorized personnel only.
Special procedures shall be followed for major spills or acute exposures.

**Chemotherapy doses and final product will be checked by two pharmacists or a pharmacist and a registered nurse prior to dispensing.**

**Maintenance-**

A qualified technician will certify the biological safety cabinets at least every 6 months or any time the cabinet is moved or repaired. The Class II BSC will be certified according to specifications of NSF Standard 49 and Class 100 specifications of Federal Standard 209C.

***PROCEDURES***

**Training of Pharmacy Personnel**
Prior to initial chemotherapy compounding, personnel must complete the ASHP modules on chapters 797 and 800 annually.

Complete chemotherapy training and competency assessment as part of the Sterile Preparation training and competency assessments. This evaluation will include a written exam and practical exam (by return demonstration).

All inventory personnel will be trained in the safe handling of incoming hazardous materials and the proper use of PPE.

***Biological Safety Cabinet Setup***

1. The BSC is to remain on 24/7 to create a negative pressure in the chemo room. However, if the BSC has been turned off, lift the glass window, turn on the blower and allow to run for 30 minutes prior to set up.
2. All necessary equipment needed for the preparation of chemotherapy should be assembled prior to entering the hood for compounding. Remove all packaging in the BSC and discard into the red biohazard waste bag that has been placed in the BSC.
3. Select syringes of sufficient size to avoid filling more than three-quarters full when final drug measurement is made. Syringes and IV sets with a closed system transfer device (CTSD) will be used whenever possible. Use of safety needles with luer-lock fittings is recommended.
4. Sterile gauze should be available to prevent leaks from dripping on gloves and work surface.
5. A plastic-backed absorbent spill mat will be placed on the work surface during mixing procedures. The mat will be exchanged whenever significant spillage occurs, or at the end of each production sequence.
6. Disinfection of the work surface prior to aseptic manipulations is done by applying a small amount of sterile 70% alcohol with a disposable wipe. Do not spray alcohol in the hood to avoid alcohol vapor buildup in the BSC.

***Biological Safety Cabinet Setup***

7. The BSC is to remain on 24/7 to create a negative pressure in the chemo room. However, if the BSC has been turned off, lift the glass window, turn on the blower and allow to run for 30 minutes prior to set up.
8. All necessary equipment needed for the preparation of chemotherapy should be assembled prior to entering the hood for compounding. Remove all packaging in the BSC and discard into the red biohazard waste bag that has been placed in the BSC.
9. Select syringes of sufficient size to avoid filling more than three-quarters full when final drug measurement is made. Syringes and IV sets with luer-lock fittings will be used whenever possible. Use of safety needles with luer-lock fittings is recommended.
10. Sterile gauze should be available to prevent leaks from dripping on gloves and work surface.
11. A plastic-backed absorbent spill mat will be placed on the work surface during mixing procedures. The mat will be exchanged whenever significant spillage occurs, or at the end of each production sequence.

12. Disinfection of the work surface prior to aseptic manipulations is done by applying a small amount of sterile 70% alcohol with a disposable wipe. Do not spray alcohol in the hood to avoid alcohol vapor buildup in the BSC.

**Compounding Techniques**

1. Drug preparations shall be performed only with the viewing window at the required access height (hood will alarm if this height is exceeded).
2. Hands must be washed thoroughly before gloving and immediately after gloves are removed. The outer gloves must be washed thoroughly or disinfected with sterile 70% isopropyl alcohol prior to chemotherapy preparation.
3. Don appropriate PPE.
4. Care must be taken to avoid puncturing of gloves and possible self-inoculation. Gloves should be changed approximately every 30-60 minutes and immediately after any visible contamination.
5. Sterilize ports on IV solution containers and vial stoppers with alcohol prep pads.
6. Vials can be accessed using 18-20 gauge needles (safety needles preferred) while maintaining negative pressure in the vials. (Negative pressure is maintained by injecting a total volume of air into the vial that is slightly less than the volume of fluid that is being removed. The air is introduced into the vial in small increments so that the pressure in the vial is kept to a minimum).
7. All manipulations must assure that the sterile surfaces are not blocked from the vertical laminar airflow. This requires that vials and syringes be angled to the air flow during vial entry.
8. Final drug measurement should be performed prior to removing the needle from the stopper of the vial. Ejecting droplets of drug on the cabinet surface or into the air should always be avoided. Expelling air from a syringe containing chemotherapy into the cabinet should be avoided. A closed collection vessel can be used to contain small volumes of excess drug and/or air. Alternately, recap needles and slowly eject excess air into the cap to avoid aerosolizing drug (additionally, a sterile gauze swab can be wrapped around the needle hub to prevent aerosolization).
9. For drugs that are to be dispensed in syringes, it is necessary to clear the hub with a small volume of air after final drug measurement and prior to capping. This is an added safety precaution to decrease chemotherapy exposure for the person administering the drug.
10. Before opening ampules, care should be taken to insure that no liquid remains in the tip of the ampule. A sterile gauze sponge should be wrapped around the neck of the ampule while opening and in the direction away from the operator. Fluid remaining in ampules after compounding should remain in the ampules and be placed in a zip-lock bag containing absorbent gauze pads before disposal in chemotherapy waste container.
11. Sharps container should be used for all needles and sharps.
12. Wipe surface of finished product with moist gauze and add-ports will be wiped with sterile alcohol gauze and covered with a chemo-caution IVA seal before placing in transport bag.
13. Label finished product with appropriate labels and auxiliary warning labels as required. All cytotoxic products will be labeled with a "Chemotherapy – Dispose of Properly" label and vesicants should also have VESICANT** label, Vincristine requires additional labeling as required by the FDA (see package insert).
14. All materials used in the chemo preparation shall be placed in a zip lock bag with a biohazard label within the hood and removed at the end of the preparation session. This will keep movement in and out of the hood to a minimum during preparation. All disposable items used during chemo preparation must be sealed in a red biohazard bag and place in the sealed biohazard waste container (this includes personnel protective

equipment such as gowns and gloves). Dispose of the sharps container in the red biohazard bag along with all other waste.
15. Clean the hood (see BSC Maintenance and Cleaning procedure).

****Vesicant:** A substance that causes tissue blistering. A blister agent. Also called a vesicatory.Vesicants are highly reactive chemicals that combine with proteins, DNA, and other cellular components to result in cellular changes immediately after exposure. (medterms.com)

**Disposal of Cytotoxic, hazardous materials and infectious waste**

1. All cytotoxic, hazardous material and infectious waste will be disposed of according to hospital policy.
2. All disposable items that have potentially come in contact with antineoplastic drugs during compounding or administration must be disposed of in specifically designated biohazard containers.
3. General cleaning of the work area must be performed using dust containment procedures.

**Biological Safety Cabinet (BSC) Maintenance and Cleaning**:

1. Routine cleaning of the BSC should be done prior to, and after, chemotherapy preparation.
   a. Disinfection of the work surface prior to aseptic manipulations is done by applying a small amount of sterile 70% isopropyl alcohol with a lint-free disposable towel. Do not spray alcohol in the hood to avoid alcohol vapor buildup in the BSC.
   b. Routine cleaning and decontamination of the BSC work surface after each chemotherapy mixing session should include using the 2-step cleaning packets (Surface Safe or like product) followed by sterile water. Cleaning of the side and rear panels is not required unless there was a known spill or aerosolization within the cabinet (refer to monthly cleaning procedure if known contamination has occurred).
2. Thorough cleaning and decontamination of the BSC (from top to bottom) should be done on a monthly basis using the 2-step cleaning packets followed by sterile water. Personnel will wear a gown, gloves, goggles, hair covering and when cleaning of this magnitude is required (requires raising of the glass panel above the maximum allowable height and physical entry of upper body within the cabinet to reach back wall panel and corners). The HEPA filter must not become wet during cleaning of the protective covering (grill front).
3. Dispose of all cleaning materials in the 'Biohazardous Waste Container.'
4. Cleaning of the undersurface of the work tray should be done on a quarterly basis. Personnel will wear a gown, powder-free gloves, goggles, hair covering when cleaning the hood. Lift the work tray and rest it against the back wall of the hood during cleaning of the undersurfaces. Removable parts of the BSC should not be removed from the cabinet during cleaning.
5. The biological safety cabinets should be operated with the blower on, 24 hours per day, seven days per week.
6. Do NOT turn the blower off while the sliding glass front is in the open position.
7. Leave the sliding glass front in the open position with the blower on.

**Handling of Accidental Exposures**

1. In case of skin contact with a cytotoxic agent, the affected area should be washed thoroughly with soap and water. Notify immediate supervisor and refer for medical attention as soon as possible.
2. For eye exposure, flush affected eye with copious amounts of water, and refer for medical attention immediately.

3. Any exposed/injured employee will be assessed in the emergency department.

**REFERENCES:**


1. **USP 797:** United States Pharmacopeia. (2022). *USP Chapter <797>: Pharmaceutical compounding – sterile preparations*. United States Pharmacopeial Convention.
2. **USP 800:** United States Pharmacopeia. (2022). *USP Chapter <800>: Hazardous drugs – handling in healthcare settings*. United States Pharmacopeial Convention.


**RECORD RETENTION AND DESTRUCTION: N/A**

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. The Hazardous Material & Waste Management Plan

| |
|---|
| Supersedes: v.2 Sterile Products: Cytotoxic Agents |

# AGREEMENT FOR EMPLOYMENT OF INTERIM CHIEF EXECUTIVE OFFICER

This EMPLOYMENT AGREEMENT is made as of this 16 day of April, 2025, by and between CHRISTIAN T. WALLIS ("WALLIS") and NORTHERN INYO HEALTHCARE DISTRICT ("DISTRICT").

## RECITALS

A. DISTRICT is a Local Healthcare District duly organized and existing under the laws of the State of California and more specifically pursuant to the provision of Health and Safety Code *§§ 32000*, et seq. known as the Local Healthcare District Law.

B. DISTRICT owns and operates NORTHERN INYO HOSPITAL ("HOSPITAL"), an acute care licensed hospital facility, a Rural Health Clinic (1206(d)), and multiple 1206(b) clinics, all located in Bishop, California.

C. The DISTRICT desires to engage and employ WALLIS as its Interim Chief Executive Officer to serve at the pleasure of the Board of Directors of the DISTRICT pursuant to the terms and provisions of this Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL COVENANTS AND CONDITIONS CONTAINED HEREIN, THE PARTIES AGREE AS FOLLOWS:

## AGREEMENT

### 1. Title and Scope of Employment

A. WALLIS shall be the Interim Chief Executive Officer ("CEO") of DISTRICT. In this regard, WALLIS agrees to devote such amount of time to the conduct of the business of DISTRICT as may be reasonably required to effectively discharge his duties, subject to the supervision and direction of District's Board of Directors. WALLIS agrees to perform those duties and have such authority and powers as are customarily associated with the office of Administrator and Chief Executive Officer of a licensed general acute care hospital and as more fully set forth in **Exhibit 1**, attached hereto and made a part hereof. In addition to the foregoing, the specific duties and obligations of WALLIS shall include, without limitation, as prescribed by the California Health Care District Law (*Health & Safety Code § 32000, et seq.,* and other applicable State and Federal law). The DISTRICT reserves the right to modify this position and duties at any time in its sole and reasonable discretion. WALLIS acknowledges and understands that as the Interim CEO and administrator of a Healthcare District, he is a public officer and a public employee pursuant to California Law.

### 2. Term of Employment/At-Will Employment

A. The term of employment shall be for a four-month period beginning on April 28, 2025 at 8:00 a.m. (the "Effective Date") and shall automatically renew for successive one-month

terms unless and until this Agreement is terminated as provided herein. At all times, WALLIS shall be an "at will" employee as provided in Section 32121(h) of the *California Health & Safety Code ("the CODE")* and shall serve at the pleasure of the Board of Directors of the DISTRICT. WALLIS acknowledges that "at will" employees may be terminated by the DISTRICT at any time, with or without cause and without notice or an opportunity to be heard regarding such employment decisions and all such employees may voluntarily terminate their employment at any time.

## 3. Place of Employment

Performance of services under this Agreement shall be rendered in the City of Bishop and the County of Inyo and within the boundaries of the DISTRICT (including satellite offices and facilities), subject to necessary travel requirements for the position and duties described herein.

## 4. Loyal and Conscientious Performance of Duties

WALLIS represents and warrants to the best of his ability and experience, that he will at all times loyally and conscientiously perform all duties and obligations to the DISTRICT during the term of this Agreement. As an exempt salaried senior management employee, he shall work such hours as is required by the nature of his job description and duties.

## 5. Devotion of Full Time to the DISTRICT Business

5.1 WALLIS shall diligently and conscientiously devote his entire productive time, ability, energy, knowledge, skill, attention and diligent efforts to the furtherance of his duties and obligations to the DISTRICT during the term of this Agreement.

5.2. During the term of this Agreement, WALLIS shall not engage in any other business duties or pursuits, nor render any services of a commercial or a professional nature, to any other person, organization or entity, whether for compensation or otherwise, without written consent of the DISTRICT, which consent shall be within the sole and absolute discretion of the DISTRICT.

5.3 This Agreement shall not be interpreted to prohibit WALLIS from making personal investments or conducting private business affairs, so long as those activities do not materially or substantially interfere or compete in any way with the services required under this Agreement. WALLIS shall not directly or indirectly, acquire, hold, or obtain any ownership of other financial interest in any business enterprise competing with a or similar in nature to the business of the DISTRICT or which may be in contravention of any conflict-of-interest code or regulations adopted by any federal, state or local agency, prohibition, law, rule, regulation, or ordinance, including any conflict-of-interest code adopted by the DISTRICT. The DISTRICT and WALLIS agree that he will continue his work as an adjunct professor with Northwestern University's School of Professional Studies (online). This work will be performed after working hours and on his own times.

## 6. Compensation and Benefits

6.1. Base Salary and Additional Wages. As of the Effective Date, WALLIS shall be paid an annual salary of Five Hundred and Eighteen Thousand, Four Hundred Eighty-One Dollars and Sixty Cents ($518,481.60) ("Base Salary"). Said sum shall be paid in equal installments structured, and on the same schedule as, pay periods for DISTRICT employees.

6.2. Retirement or Pension Benefits. WALLIS shall be eligible to participate in all employee benefit programs of the DISTRICT offered from time to time during the term of this Agreement by the DISTRICT to employees or management employees, to the extent WALLIS qualifies under the eligibility provisions of the applicable plan or plans, in each case consistent with the DISTRICT's then-current practice as approved by the Board of Directors from time to time. WALLIS expressly understands and agrees that he is not eligible for participation in the DISTRICT's 401(a) Defined Contribution Plan.

6.3 Paid Time Off. WALLIS shall be entitled to Paid Time Off ("PTO") as described in DISTRICTS's PTO policy.

6.4. Health Insurance and other Miscellaneous Benefits. WALLIS shall, at all relevant times during the term of this Agreement, receive health insurance, dental coverage, and other miscellaneous fringe benefits of employment that are similar to those offered to managerial and other full-time supervisory employees of the DISTRICT. Miscellaneous fringe benefits shall include, but not be limited to, life insurance, plus the opportunity to purchase, at his own expense and subject to applicable Internal Revenue Service regulations, additional life insurance beyond that already provided by the DISTRICT to all employees in multiples of one, two or three times his annual base salary.

6.5 Holidays and Additional Leave Time. WALLIS shall be entitled to paid holidays and additional leave time in a manner substantially similar to that provided for other full-time managerial and supervisory employees of the DISTRICT.

6.6 Continuing Education and Professional Activities. The DISTRICT encourages WALLIS to participate in community functions, continuing education programs, seminars, and other gatherings of professional organizations. In connection herewith, the parties shall meet and confer on a periodic basis to enable WALLIS to participate in a reasonable number of these activities, with reasonable tuition, attendance fees, travel and lodging costs being paid by the DISTRICT. Benefits provided under this Paragraph shall include annual dues for membership in one Bishop service club.

6.7 Expenses. Travel expenses to the city of Bishop, California at the commencement of the Employment Term and return travel expenses from the city of Bishop, California to WALLIS' primary place of residence following the completion of the Employment Term paid at the most current IRS guidelines for mileage reimbursement.

## 7. Indemnification; Directors & Officers Insurance

7.1 Indemnification. The DISTRICT shall indemnify and defend WALLIS against reasonable expenses (including reasonable attorney's fees), judgments (excluding any award of punitive damages), administrative fines (but excluding fines levied after conviction of

any crime), and settlement payments incurred by him in connection with such actions, suits or proceedings to the maximum extent permitted by law and by the bylaws and governing documents of the DISTRICT in the event WALLIS is made a party, or threatened to be made a party, to any threatened or pending civil, administrative, and/or investigative action, suit or proceeding, by reason of the fact that he is or was an officer, manager, or employee of the DISTRICT, in which capacity he is or was performing services within the course and scope of the employment relationship of this Agreement.

7.2 D&O Insurance. The DISTRICT shall use reasonable commercial efforts to maintain Directors & Officers insurance for the benefits of WALLIS with a level of coverage comparable to other hospitals and healthcare districts similarity situated with regard to geography, location, and scope of operations.

## 8. Severance Compensation

8.1 Termination by DISTRICT Without Cause; Pay in Lieu of Notice. In the event WALLIS' employment is terminated by the DISTRICT for any reason other than: (1) "For Cause" (as defined in Section 9.4 below); or (2) due to the death of WALLIS, DISTRICT will pay to WALLIS, subject to WALLIS signing a full release in a form set forth in **Exhibit 2**, a lump sum severance pay equal to one month of WALLIS' Base Salary ("Severance Pay"). The Severance Pay will be paid as specified in in Exhibit 2. Notwithstanding the foregoing, in no event during the term of this Agreement may Severance Pay exceed the number of months remaining of the term of the Agreement at the time of termination.

8.2 Termination by DISTRICT For Cause. In the event WALLIS' employment is terminated by the DISTRICT "For Cause" (as defined in Section 8.4 below), WALLIS shall not be entitled to any Severance Pay.

8.3 Termination by WALLIS for any Reason; No Severance; Thirty-Day Notice Requested. In the event WALLIS terminates his employment with DISTRICT for any reason, WALLIS or WALLIS' estate will not be entitled to any Severance Pay. Except in cases of death, WALLIS is requested to give the DISTRICT thirty (30) days' prior written notice of his intent to terminate this Agreement for any reason.

8.4 Definitions. For purposes of this Agreement, the following terms have the following meanings:

"For Cause" means termination by DISTRICT of WALLIS' employment: (i) by reason of WALLIS' serious abuse such as fraud, embezzlement, misappropriation of DISTRICT property, willful dishonesty towards, or deliberate injury or attempted injury to, the DISTRICT; (ii) by reason of WALLIS' material breach of this Agreement, including, but not limited to, performing services for a competitor during the term of this Agreement; (iii) by reason of WALLIS' intentional misconduct with respect to the performance of WALLIS' duties under this Agreement; or (iv) WALLIS' repeated failure to perform the essential functions of his job in a satisfactory fashion; provided, however, that no such termination will be deemed to be a termination For Cause unless the DISTRICT has provided WALLIS with written notice of what it reasonably believes are the grounds for any termination For Cause and WALLIS fails to take

appropriate remedial actions during the ten (10) day period following receipt of such written notice.

**9. Business Expenses.** The DISTRICT shall promptly reimburse WALLIS for reasonable and necessary expenditures incurred by his for travel, entertainment, and similar items made in furtherance of his duties under this Agreement and consistent with the policies of the DISTRICT as applied to all management staff. WALLIS shall document and substantiate such expenditures as required by the policies of the DISTRICT, including an itemized list of all expenses incurred, the business purposes of which such expenses were incurred, and such receipts reasonably can provide.

**10. No Assignment**. Due to the unique nature of services being rendered by WALLIS to the DISTRICT as provided for herein and that this Agreement is for personal services of WALLIS who shall not assign, sublet, delegate, or otherwise convey his rights and obligations pursuant to this Agreement. Any attempt to so assign by WALLIS shall be deemed null, void and shall entitle the DISTRICT to immediately terminate this Agreement, and WALLIS shall not be entitled to compel payment of Severance Pay.

**11. Remedies**. Enforcement of any provisions of this Agreement shall be by proceedings at law or in equity against any person of entities violating or attempting to violate any promise, covenant, or condition contained herein, either to restrain violation, compel action, or to recover damages. Any and all remedies provided by this Agreement, operation of law, or otherwise, shall be deemed to be cumulative, and the choice or implementation of any particular remedy shall not be deemed to be an election of remedies to the mutual exclusion of any other remedy provided for herein, by operation of law, or otherwise.

**12. Attorney's Fee.** In the event any action at law or in equity is initiated to enforce or interpret the terms of this Agreement, or arises out of or pertains to this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, costs, and necessary disbursements in addition to any other relief to which that party may be entitled.

**13. Integration.** It is intended by the parties that this Agreement be the final expression of the intentions and agreements of the Parties. This Agreement supersedes any and all prior or contemporaneous agreements, either oral or in writing, between the parties hereto and contains all the covenants and agreements between the parties. No other agreements, representations, inducements, or promises, not contained in this Agreement shall be valid or binding. Any modification of this Agreement shall be effective only if it is in writing and signed by the party to be charged. In the event of any conflict or inconsistency with any term or provision of this Agreement and any written personnel policy or procedure of the DISTRICT, this Agreement shall prevail, except as may otherwise be prohibited by law.

**14. Effect of Waiver** No waiver of any breach of any term, covenant, agreement, restriction, or condition of this Agreement shall be construed as a waiver of any succeeding breach of the same or any other covenant, agreement, term, restriction, or condition of this Agreement. The consent or approval of either party to or of any action or matter requiring consent or approval

shall not be deemed to waive or render unnecessary any consent to or approval of any subsequent or similar act or matter.

**15. Binding Effect.** This Agreement shall be binding upon and inure to the benefit of the heirs, executors, administrators, personal representatives, successors, and assigns of each of the parties hereto. This provision shall not supersede or abrogate the provisions of Paragraph 11.

**16. Severance.** In the event any term or provision of this Agreement is deemed to be in violation of law, null and void, or otherwise of no force or effect, the remaining terms and provisions of this Agreement shall remain in full force and effect.

**17. Governing Law, Venue.** This Agreement shall be interpreted under the laws of the State of California. Exclusive venue for any legal action under California law shall be Inyo, County, California and, if brought under federal law, the United States District Court for Eastern California in Fresno, California.

**18. Attorney Representation.** This Agreement has been prepared by Irma Rodriguez Moisa, Atkinson, Andelson, Loya, Ruud & Romo, outside labor counsel of the DISTRICT. WALLIS has been advised to seek the advice and counsel of his own legal counsel in reviewing and executing this Agreement. Legal counsel for the DISTRICT has not rendered any advice to WALLIS in any matter or form whatsoever.

**19. Gender Neutral.** All personal pronouns used in this Agreement, whether used in the masculine, feminine or neutral gender, shall include all other genders, and the singular shall include the plural and vice versa.

**20. Facsimile Signature.** Facsimile signature pages shall be deemed original signature pages and shall be admissible as the same in a court or other tribunal as though such were originals.

**21. Counterparts**. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

**22. Notice.** Any written notice given pursuant to this Agreement shall be deemed when either (a) personally served or (b) deposited in the United States Mail, first-class postage prepaid, addressed to the respective parties as follows:

| | |
|---|---|
| To the District: | Chair, Board of Directors<br>Northern Inyo County Local Hospital District<br>150 Pioneer Lane<br>Bishop, California 93514 |
| To WALLIS | CHRISTIAN WALLIS, INTERIM CEO<br>_____<br>_____<br>_____ |

IN WITNESS WHEREOF, this Agreement is executed as of the day and year first above written.

**NORTHERN INYO HEALTHCARE DISTRICT**

By _____
Jean Turner, Board Chair
Board of Directors

**CHRISTIAN WALLIS**

_____
CHRISTIAN WALLIS, DHA, MBA, FACHE

**EXHIBIT 1**
**Job Duties**

The job duties of the Interim Chief Executive Officer shall include, but not be limited to, the following:

- To temporarily designate an individual to act for himself in his absence, in order to provide the DISTRICT with administrative direction at all times.
- To carry out all policies established by the Board of Directors and medical staff of HOSPITAL.
- To serve as a liaison officer and channel of communications between the DISTRICT Board of Directors and any of its committees, professional staff and independent contractors, and the medical staff.
- To prepare an annual budget showing the expected receipts and expenditures as required by the Board of Directors and prepare the DISTRICT forecasts.
- To recruit, select, employ, control, manage and discharge all employees.
- To develop and maintain personnel policies and practices for the DISTRICT.
- To insure that all physical plant facilities and properties are kept in good state of repair and in operating condition.
- To supervise all business affairs and insure that all funds are collected and expended to the best possible advantage of the DISTRICT.
- To submit not less than monthly to the Board of Directors or its authorized committees or officers reports showing the professional service and financial activities of the DISTRICT and to prepare and submit such special reports from time to time as may be required or requested by the Board of Directors.
- To attend all meetings of the Board of Directors and, if requested, attend meetings from time to time of board committees, both standing and *ad hoc.*
- To perfect and submit to the Board of Directors for approval and maintain a plan of organization of the personnel and others concerned with the operations of the DISTRICT.
- To prepare or cause to be prepared all plans and specifications for the construction and repair of buildings, improvements, works, and facilities of the DISTRICT.
- To maintain proper financial and patient statistical data and records; data required by governmental, regulatory, and accrediting agencies; and special studies and reports required for the efficient operation of the DISTRICT.
- To represent the Board of Directors as a member, ex-officio, of all its committees and adjunct organizations, including the Medical Staff, the Medical Staff Executive Committee, and Auxiliary organizations, unless the Board of Directors directs otherwise or unless it or WALLIS determine that his attendance and participation would be inappropriate or otherwise not in the best interests of the District.

- Attend, or name a designee to attend, in his capacity as an *ex officio member*, all meetings of the Medical Staff and its committees, within the parameters of the Medical Staff Bylaws adopted by the DISTRICT.
- To report to the Board of Directors on a regular basis within the scope of purview of informing the Board concerning the competency and performance of all individuals who provide patient care services at DISTRICT but who are not subject to the medical staff peer review and privilege delineation process. Such reports shall be received by the Board in executive or closed session pursuant to *Health & Safety Code §32155* and applicable portions of the Ralph M. Brown Act (*Government Code §54900, et seq.*)
- To recruit physicians and other medical providers as same may be needed from time to time to meet medical service needs of the communities served by the DISTRICT.
- To supervise independent contractor professional services agreements between physicians and other medical providers and the DISTRICT.
- To perform any other duties that the Board of Directors may deem to be in the best interests of the DISTRICT.

**EXHIBIT 2**
**Form of Release**

## SEPARATION AND RELEASE AGREEMENT

This Separation and Release Agreement ("Agreement") is made by and between Northern Inyo County Local Hospital District ("Employer") and CHRISTIAN WALLIS, an individual ("Employee").

In consideration of the covenants undertaken and the releases contained in this Agreement Employer and Employee agree as follows:

1. Separation of Employment. Employee's last day of employment with Employer is XXXXX.

2. Consideration. For and in consideration of the release of all claims as set forth hereafter, Employer shall pay to Employee the total sum of $**xxxxxxx**_(the "Severance Payment"). *The Severance Payment shall be subject to all applicable state and federal withholdings.*

The Severance Payment shall be reported by Employer on an IRS form W-2. Employee hereby declares that that the sum paid pursuant to this paragraph 2 represents adequate consideration for the execution of this Agreement and the release of all claims as set forth herein.

The Severance Payment shall be made on the eighth ($8^{th}$) day after this Agreement is executed by Employee, provided Employee has, before this date, forwarded a copy of the executed Agreement to Employer and returned all Employer-issued equipment and passcards and provided all passwords. If the $8^{th}$ day falls on a weekend or holiday, the Severance Payment shall be made on the next business day.

The Severance Payment shall be direct deposited to the bank account on file with payroll.

It is understood and agreed that Employer is not involved with nor liable for the apportionment, if any, of the settlement proceeds between Employee and her attorney(s), if any, and any other person or entity, including, but not limited to, any payment of applicable taxes, other than those payroll taxes withheld in accordance with this paragraph.

3. General Release and Discharge. Employee on behalf of their descendants, dependents, heirs, executors, administrators, assigns, and successors, and each of them, hereby covenants not to sue and fully releases and discharges Employer, its subsidiaries, affiliates and joint ventures, past, present and future, and each of them, as well as its and their trustees, directors, officers, agents, attorneys, insurers, employees, representatives, partners, shareholders, assigns, predecessors and successors, past, present and future, and each of them (hereinafter together and

collectively referred to as "Releasees") and District hereby releases and discharges Employee with respect to and from any and all claims, demands, rights, liens, agreements, contracts, covenants, actions, suits, causes of action, obligations, debts, costs, expenses, attorneys' fees, damages, judgments, orders and liabilities of whatever kind or nature in law, equity or otherwise, whether now known or unknown, suspected or unsuspected, absolute or contingent, and whether or not concealed or hidden, which Employee now owns or holds or which Employee has at any time heretofore owned or held or may in the future hold against said Releasees, arising out of or in any way connected with Employee's employment relationship with Employer, the termination of Employee's employment with Employer, or any other transactions, occurrences, acts or omissions or any loss, damage or injury whatever, known or unknown, suspected or unsuspected, resulting from any act or omission by or on the part of said Releasees, or any of them, committed or omitted prior to the date of this Agreement. With the exception of the amount set forth under Paragraph 2 of this Agreement, such released and discharged claims include, but are not limited to, without limiting the generality of the foregoing, any claim under Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, the Age Discrimination in Employment Act, the Family and Medical Leave Act, the California Fair Employment and Housing Act, the California Family Rights Act, the California Labor Code (excluding a claim under the California Workers' Compensation Act, or a claim for wages due and owing as of the date of this Agreement), ERISA, any claim for retirement benefits pursuant to a retirement plan sponsored by Employer, or any claim for severance pay, bonus, sick leave, holiday pay, life insurance, health or medical insurance or any other fringe benefit. In addition, Employee agrees and covenants not to file any suit, charge or complaint against Releasees with any administrative agency with regard to any claim, demand liability or obligation arising out of her employment with Employer or separation there from. However, nothing in this Agreement shall be construed to prohibit Employee from filing a charge with or participating in any investigation or proceeding conducted by the EEOC or a comparable state or local agency. Notwithstanding the foregoing sentence, Employee agrees to waive her right to recover monetary damages in any charge, complaint or lawsuit filed by Employee or by anyone else on Employee's behalf in any charge or proceeding conducted by the EEOC or a comparable state or local agency.

4. Waiver of Statutory Provision. It is the intention of Employee in executing this instrument that the same shall be effective as a bar to each and every claim, demand and cause of action hereinabove specified. In furtherance of this intention, Employee and District hereby expressly waives any and all rights and benefits conferred upon her by the provisions of Section 1542 of the California Civil Code and expressly consents that this Agreement shall be given full force and effect according to each and all of its express terms and provisions, including those related to unknown and unsuspected claims, demands and causes of action, if any, as well as those relating to any other claims, demands and causes of action hereinabove specified. Section 1542 provides:

**"A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY**."

Employee and District acknowledge that they may hereafter discover claims or facts in addition to or different from those which they now knows or believes to exist with respect to the subject matter of this Agreement and which, if known or suspected at the time of executing this Agreement, may have materially affected this settlement.

Nevertheless Employee and District hereby waives any right, claim or cause of action that might arise as a result of such different or additional claims or facts. Employee and District acknowledges that they understands the significance and consequence of such release and such specific waiver of Section 1542.

5. Waiver of ADEA and OWBPA Claims. Employee expressly acknowledges and agrees that, by entering into this Agreement, heis waiving any and all rights or claims that he may have arising under the Age Discrimination in Employment Act of 1967, as amended by the Older Workers' Benefit Protection Act, 29 U.S.C. § 621 et seq., and as provided under the Older Workers' Benefit Protection Act of 1990 which have arisen on or before the date of execution of the Agreement. Employee further expressly acknowledges and agrees that:

A. In return for the execution of this Agreement, Employee will receive compensation beyond that which he was already entitled to receive before entering into this Agreement;

B. Employee has read and understands the terms of this Agreement.

C. Employee has been advised to consult with legal counsel before signing this Agreement;

D. Employee has been provided full and ample opportunity to study this Agreement, including a period of at least twenty-one (21) days within which to consider it.

E. To the extent Employee takes less than twenty-one (21) days to consider this Agreement before execution, Employee acknowledges that he has had sufficient time to consider this Agreement with her counsel and that he expressly, voluntarily and knowingly waives any additional time;

F. Employee is informed hereby that he has seven (7) days following the date of execution of this Agreement in which to revoke the Agreement. and that the Agreement shall not become effective or enforceable until the seven (7) day

revocation period expires. Notice of revocation must be made in writing and must be received by the EMPLOYER by sending a letter to Irma Rodriguez Moisa, Atkinson, Andelson, Loya, Ruud & Romo, 12800 Center Court Drive, Suite 300, Cerritos, CA 90703; Email imoisa@aalrr.com; or by FAX (562) 653-3657.

Employee understands that the right of revocation set forth in this section of this Agreement applies only to the release of any claim under the ADEA, and if Employee elects to revoke this Agreement for ADEA claims, the District will have the option to: (i) enforce this Agreement in its totality, excluding waived ADEA claims, or (ii) rescind the entire Agreement

6. Confidentiality of Release Agreement. Employee shall keep confidential the terms and conditions of this Agreement, all communications made during the negotiation of this Agreement, and all facts and claims upon which this Agreement is based (collectively referred to as the "*Confidential Settlement Information*"). Neither Employee nor their agents or attorneys shall, directly or indirectly, disclose, publish or otherwise communicate such Confidential Settlement Information to any person or in any way respond to, participate in or contribute to any inquiry, discussion, notice or publicity concerning any aspect of the Confidential Settlement Information. Notwithstanding the foregoing, Employee may disclose the Confidential Settlement Information to the extent they are required to do so to his/her legal counsel, accountants and/or financial advisors, or to anyone else as required by applicable law or regulation. Employee agrees to take all steps necessary to ensure that confidentiality is maintained by any and all of the persons to whom authorized disclosure is or was made, and agree to accept responsibility for any breach of confidentiality by any of said persons. Employee shall not make any public, oral or written or otherwise derogatory or negative comments about Employer concerning Employee's employment or the separation thereof; provided, however, that this Agreement does not preclude Employee from giving testimony as may be required by legal process. In the event that Employee is served with legal process which potentially could require the disclosure of the contents of this Agreement, he/ shall provide prompt written notice (including a copy of the legal process served) to Employer.

7. Non-Disparagement. Employee shall not make any public, oral or written or otherwise derogatory or negative comments about Employer or anyone associated with Employer concerning Employee's employment or the separation thereof; provided, however, that this Agreement does not preclude Employee from giving testimony as may be required by legal process. District's current Board of Directors agree not to disparage Employee in public, oral, or written, or otherwise, with negative statements which are injurious to Employee's reputation. Additionally, nothing in this Agreement prohibits Employee from discussing or disclosing information about unlawful acts in the workplace, such as harassment or discrimination or or any other conduct that Employee has reason to believe is unlawful. Employee acknowledges and agrees that the obligations set forth in this paragraph 7 are essential and important. Employee agrees his breach of this paragraph will result in irreparable injury to Employer, the exact amount of which will be difficult to ascertain. Accordingly, Employee agrees that if he violates the

provisions of this paragraph 7, Employer shall be entitled to seek specific performance of Employee's obligations under this paragraph and liquidated damages in the sum of $10,000.

8. Trade Secrets. Employee acknowledges that they have occupied a position of trust and confidence with the Employer prior to the date hereof and has become familiar with the following, any and all of which constitute trade secrets of Employer (collectively, the *"Trade Secrets"*): (i) all information related to customers including, without limitation, customer lists, the identities of existing, past or prospective customers, customer contacts, special customer requirements and all related information; (ii) all marketing plans, materials and techniques including but not limited to strategic planning ; (iii) all methods of business operation and related procedures of the Employer; and (iv) all patterns, devices, compilations of information, copyrightable material, technical information, manufacturing procedures and processes, formulas, improvements, specifications, research and development, and designs, in each case which relates in any way to the business of Employer. Employee acknowledges and agrees that all Trade Secrets known or obtained by his, as of the date hereof, is the property of Employer. Therefore, Employee agrees that he will not, at any time, disclose to any unauthorized persons or use for his own account or for the benefit of any third party any Trade Secrets, whether Employee has such information in his memory or embodied in writing or other physical form, without Employer's prior written consent (which it may grant or withhold in its discretion), unless and to the extent that the Trade Secrets are or becomes generally known to and available for use by the public other than as a result of Employee's fault or the fault of any other person bound by a duty of confidentiality to the Employer, Employee agrees to deliver to Employer at any time Employer may request, all documents, memoranda, notes, plans, records, reports, and other documentation, models, components, devices, or computer software, whether embodied in a disk or in other form (and all copies of all of the foregoing), relating to the businesses, operations, or affairs of Employer and any other Trade Secrets that Employee may then possess or have under his control. Employee agrees his breach of this paragraph will result in irreparable injury to Employer, the exact amount of which will be difficult to ascertain. Accordingly, Employee agrees that if he violates the provisions of this paragraph 8, Employer shall be entitled to seek specific performance of Employee's obligations under this paragraph.

9. No Admission of Liability. This Agreement is the result of compromise and negotiation and shall never at any time or for any purpose be deemed or construed as an admission of liability or responsibility by any party to this Agreement. The parties continue to deny fully such liability and to disclaim any responsibility whatsoever for any alleged misconduct in connection with this Agreement.

10. Complete Agreement/Modification. This instrument constitutes and contains the entire agreement and understanding concerning Employee's employment, the separation of that employment and the other subject matters addressed herein between the parties, and supersedes and replaces all prior or contemporaneous negotiations, representations, understandings and agreements, proposed or otherwise, whether written or oral, concerning the subject matters hereof.

This is an integrated document. This Agreement may be amended and modified only by a writing signed by Employer and Employee.

11. Severability of Invalid Provisions. If any provision of this Agreement or the application thereof is held invalid, such provisions shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to alter substantially this Agreement or obligations of the parties hereto, in which case the Agreement may be immediately terminated.

12. Counterpart Execution; Effect; Photocopies. This Agreement may be executed in counterparts, and each counterpart, when executed, shall have the efficacy of a signed original. Photographic copies of such signed counterparts may be used in lieu of the originals for any purpose.

13. No Assignment. Employee hereby represents that he has not heretofore assigned or transferred, or caused or purported to assign or transfer, to any person any of the claims released herein. If any such transfer or assignment or purported transfer or assignment occurred prior to the execution of this Agreement, Employee hereby agrees to indemnify and hold Employer harmless from and against any and all claims, demands, obligations, debts, liabilities, costs, expenses, rights of action, causes of action or judgments based upon or arising from any such transfer or assignment or purported transfer or assignment. Any assignment after the execution of this Agreement may only be made with the express written approval of all parties hereto. Employer and Employee represent and warrant that, prior to executing this Agreement, each has not filed any complaints or charges of lawsuits with any court or governmental agency against the other based in whole or in part upon any matter covered, related to or referred to in this Agreement.

14. No Third Party Beneficiaries. Nothing contained in this Agreement is intended nor shall be construed to create rights running to the benefit of third parties.

15. Prior Litigation. Employee represents and warrants that, prior to executing this Agreement, he has not filed any complaints or charges of lawsuits with any court or governmental agency against the Employer based in whole or in part upon any matter covered, related to or referred to in this Agreement.

16. Governing Law. This Agreement shall be interpreted under the laws of the State of California. Exclusive venue for any legal action under California law shall be Inyo, County, California and, if brought under federal law, the United States District Court for Eastern California in Fresno, California.

17. Complete Defense. This Agreement may be pled as a full and complete defense, and may be used as the basis for an injunction against any action, claim, suit, worker's compensation action or any other proceeding which may subsequently be instituted, prosecuted or

attempted, which is based in whole or in part upon any matter covered, related to or referred to in this Agreement.

18. Attorneys' Fees. In the event of litigation between Employee and Employer relating to or arising from this Agreement, the prevailing party or the party designated as such by the arbitrator or judge shall be entitled to receive reasonable attorneys' fees, costs, and other expenses, in addition to whatever other relief may be awarded, including such fees and costs any may be incurred in enforcing a judgment or order entered in any arbitration or action. Any judgment or order entered in such arbitration or action shall contain a specific provision providing for the recovery of such attorneys' fees and costs. In addition, any award of damages as a result of the breach of this Agreement or any of its provisions shall include an award of prejudgment interest from the date of the breach at the maximum rate of interest allowed by law.

19. Advice from Counsel. Employee represents and agrees that they have been advised and fully understands that they have the right to discuss all aspects of the Agreement with legal counsel; that they have carefully read and fully understand and appreciate all provisions of this Agreement, and the effect thereof; and that they are voluntarily entering into this Agreement.

20. Cooperation in Litigation. Employee agrees to cooperate with Employer and its legal counsel with respect to any litigation now pending, or filed in the future in which Employee may be called as a witness to testify either at trial or deposition and to reasonably cooperate with Employer in the preparation of his testimony for same.

21. Notice. All notices and other communications required by this Agreement shall be in writing, and shall be deemed effective: (a) when personally delivered; (b) when mailed by certified or registered mail, return receipt requested; or (c) when deposited with a comparably reliable postage delivery service (such as Federal Express); addressed to the other party at the following address:

**EMPLOYER:**

**Chair of the Board**
**150 Pioneer Lane**
**Bishop, CA 93514**

**EMPLOYEE:**

**IT IS SO AGREED**

**FOR CHRISTIAN WALLIS**
DATE:

_____
CHRISTIAN WALLIS

**FOR THE NORTHERN INYO HEALTHCARE DISTRICT**
DATE:

_____
, Chair of the Board

Chief of Staff Report 4/16/25

Apologies I am not in person tonight, I am attending a celebration of life/memorial tonight but will plan to be present next month.

MEC report:
The perinatal/pediatrics department will be arranging multispecialty meetings and trainings focusing on high risk deliveries given the increased volume and complexity of OB patients.

We have changed our credentialing applications to not include intrusive mental health questions, per recommendations and activism by the Lorna Breen Heroes in order to remove barriers to mental health care for health care providers.

The emergency department mourns the loss of one of our beloved nurses, Maya Eismont.

The MEC would like to acknowledge and thank the work of Stephen DelRossi as our Chief Executive Officer and wish him the best in his next endeavors.

There are multiple physician kudos:

- Per Allison Partridge: Drs Quach and Cromer-Tyler gave excellent care to an emergency surgery patient.
- The participation of Drs Cromer-Tyler, Chamberlain, and Lindsey Ricci in recent Root Cause Analyses is appreciated.
- A patient's family member reached out in appreciation to Dr. Amsalem for his compassion in their family member's end of life care.

Thank you,
Sierra Bourne,
Chief of Staff, Northern Inyo Healthcare District

**NORTHERN INYO HEALTHCARE DISTRICT**
**DISTRICT BOARD RESOLUTION 25-01**
**APPROVING THE DEPOSIT AND INVESTMENT OF FUNDS TO ELIGIBLE CERTIFICATES OF DEPOSIT AND THE LOCAL AGENCY INVESTMENT FUND**

**WHEREAS,** the Legislature of the State of California has declared that the deposit and investment of public funds by local officials and local agencies is an issue of statewide concern (California Government Code Sections 53600.6 and 53630.1); and

**WHEREAS**, the Board of Directors (the "Board") of the Northern Inyo Healthcare District (the "District") may invest surplus monies not required for the immediate necessities of the District in accordance with the provisions of California Government Code Section 53600 *et seq*.; and

**WHEREAS**, the District may also deposit its moneys with an eligible state or national bank, savings association or federal association, and state or federal credit union located in California, as provided in Government Code Section 53630 *et seq*.; and

**WHEREAS**, the District now wishes to approve the deposit and/or investment of surplus District moneys in eligible certificates of deposit and with the Local Agency Investment Fund ("LAIF"), in accordance with the law and as provided herein.

**NOW, THEREFORE, BE IT RESOLVED, DETERMINED, AND ORDERED** by the Board of Directors of the Northern Inyo Healthcare District as follows:

1. The above recitals are true and correct, and the Board of the District so finds and determines.

2. All deposits and/or investments of District funds shall be done in compliance with law and the limitations applicable to public agencies, including pursuant to Government Code Sections 53600 *et seq*. and 53630 *et seq*.

3. The Board hereby approves the deposit and investment of moneys not required for the immediate needs of the District in the LAIF, in compliance with the California Government Code Section 16429.1.

4. The Board hereby approves the deposit of moneys not required for the immediate needs of the District in non-negotiable certificates of deposit with eligible financial institutions and securities, for a term not to exceed 5 years in compliance with the California Government Code.

5. The Board hereby delegates the authority to manage and authorize the deposits and investments of funds in eligible certificates of deposit and LAIF to its Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, Chief Human Resources Officer, and Chief Medical Officer. The Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, Chief Human Resources Officer, and Chief Medical Officer shall confirm that any deposit of funds into a certificate of deposit is done with an eligible financial institution that can

hold public funds, in compliance with the limitations and requirements of the California Government Code, including with respect to limitations on securities and required collateral described in California Government Code Section 53652.

**BE IT FURTHER RESOLVED BE IT FURTHER RESOLVED** that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

**PASSED, APPROVED, AND ADOPTED** by the Northern Inyo Healthcare District this 16th day of April 2025 by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By:_____
Chair of the Board
Northern Inyo Healthcare District

ATTEST:_____
Clerk of the Board
Northern Inyo Healthcare District

**Northern Inyo Healthcare District**
*www.nih.org*

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

Date: 04/05/2025
To: Board of Directors
From: J. Adam Hawkins, DO Chief Medical Officer
Re: Bi-Monthly CMO Report

Project Updates:

**BETA HEART:**
NIHD has continued its progress towards achieving a structured and reliable culture of safety throughout our organization. With some of the recent turnover at The District, there has never been a better time for our organization to focus our attention on what matters most: the delivery of safe and high-quality medical care. As a reminder, BETA HEART is a multiyear initiative designed to support leadership and staff in cultivating an authentic culture of safety and transparency. I would like to highlight some of the recent work that has taken place as a part of this project:

1.) BETA HEART Workshop I. Pasadena, CA.
Allison Partridge, Alison Murray, Ali Feinberg, Patty Dickson, and I attended the first of 3 BETA HEART workshops that will take place this calendar year. This first workshop focused on two of the five BETA HEART domains, **Rapid Event Response and Analysis** and **Culture of Safety**.
   a.) **Rapid Event Response and Analysis**:
   This domain emphasizes how our organization responds to events where harm has occurred to a patient. The goal is to restore trust with patients and their families while minimizing further trauma. While we currently have systems in place to address physical, emotional, or financial harm, there is room for improvement in how these systems are organized, communicate with one another, and activate promptly.
   b.) **Culture of Safety**:
   This domain is the cornerstone of BETA HEART. The SCORE survey and GAP analysis that I discuss below provide more updates related to work being implemented to establish an authentic and robust culture of safety throughout The District.

2.) SCORE Survey: Safety Culture and Workforce Well-being Survey
As part of our commitment to BETA HEART, NIHD conducted its first-ever **Safety Culture and Workforce Well-being Survey** earlier this year. This annual survey assesses the overall safety culture both organization-wide and within individual

departments. Completing this survey was a significant achievement made possible by the efforts of Cori Stearns and the Quality Department. Results are expected within 1–2 weeks of this report, after which key leadership members will be trained to conduct debriefing sessions with staff. These sessions will promote transparency and drive engagement as we implement process improvements based on survey findings.

3.) GAP Analysis Focus Group Session Results:

As you are aware, members of the BETA HEART team conducted in-person focus group meetings with different groups within our organization back in February. The intention of these focus group interviews was to determine an organizational baseline for our current culture of safety and to help guide the development and operationalization of initial action plans. The BETA HEART team came back on campus last week and provided an executive leadership report of the findings from the Gap Analysis. The executive team plans on sharing the results of the GAP analysis with our workforce and board in the near future. However, our executive report included anonymous staff member quotes to the two following questions. I think these quotes provide insights into some great work being done throughout The District as well as the multitude of challenges our workforce faces:

Question 1: *If you had a magic wand, what one thing would bring you more joy or improve the quality of care for the patients?*

Employee / Medical Staff Responses:

- "Stability is one word that comes to mind – financially, leadership. We are putting out fires so when can we be more proactive?"
- "More resources. It's a lot of putting out fires, and we cant get to proactive things."
- "Better communication throughout The District."
- "Openness to input – not allowed to give input on high-level things."

Question 2: *What brings you the most joy in your work?*

- "Being part of the patient's medical journey and getting them the procedures / care they need."
- "This is my community and providing care to the community is rewarding."
- "When our teams are thriving we provide great care."
- "We are it – we are still here to provide rural medicine when so many are closing."

**Community Health Update: Hanta Virus Town Hall:**

The Mono County Public Health Officer, Dr. Tom Boo, officially announced a third Hantavirus related death in the Town of Mammoth Lakes on April 3rd, 2025. The official announcement has been included at the end of my report. Hantavirus is contracted by individuals who come into contact with infected deer mouse droppings, urine, or saliva. There is concern amongst regional experts that the local deer mouse populations are unusually high this year due to recent high snowpack winters. With a larger deer mouse population, there is increased potential for human interaction with infected deer mouse material.

Dr. Boo has been in contact with the Inyo County Public Health Officer, Dr. Jim Richardson, NIHD clinical leadership, as well as worldwide leading experts on Hantavirus. NIHD is planning on hosting a virtual live Town Hall at 5:30pm on April 17th. Dr. Boo and others will be providing

education targeted to local community members. We will also host a Q&A at the conclusion of the talk.

Hantavirus is a very scary and often misunderstood infectious disease. With the recent tragic passing of the three Mono County residents, there are many questions and concerns related to how to prevent contracting this disease. Please encourage your constituents to attend the talk on April 17th via zoom. Additionally, you can direct them to the links located at the end of Dr. Boo's press release attached to my CMO report.

**Cerner Clinical AI Agent (CAA):**
The Cerner Clinical AI Agent is an AI-assisted multimodal voice user interface that automates provider documentation. NIHD's primary goal when choosing to invest in this project was to reduce the documentation burden on our clinic providers. Our Rural Health Clinic providers recently completed an internal survey (RHC Primary Care Provider Assessment Survey) that aimed to better understand our providers' career and workplace satisfaction along with identifying sources of career and workplace burnout and frustration. The top 3 factors that contributed to provider burnout included administrative tasks, workload, and documentation.

The goal of investing in the CAA is to reduce the documentation burden that our providers face as a result of recent changes provider templates. As you will likely recall, our per provider appointment availability recently increased from 18 patients per day to 20. Although this increases access for our patients, this also increases the daily demands on our providers. The CAA is one tool we are using to try and partner with our providers to ensure they have a sustainable work environment.

Currently, the CAA is available to our RHC and General Surgery providers. We are still working through some early implementation issues. Once these issues have been mitigated, we hope to make this product available to many more members of our medical staff.

**Physician Recruitment:**
The medical staff office has been incredibly busy over the past two months. In addition to some ongoing vitally important and time-consuming medical staff governance projects, we have robust recruitment efforts ongoing. As always, my priorities in physician recruitment include finding qualified providers that fit a clinical community need, represent our organizational values, and drive fiscal sustainability. With that in mind, the following is a list of active recruitment efforts:

1) **Women's Health**: I am proud to announce that we have recently hired Robyn Lee, a Certified Nurse Midwife (CNM) who will be providing additional clinic coverage in our Women's Health Clinic. Robyn worked as an L&D RN at NIHD before completing her training to become a CNM. She will be an amazing addition to our team and will enable a much-needed increase in capacity at the Women's Health Clinic. Additionally, we are actively recruiting for an additional full-time OB/GYN.
2) **Pediatrics:** We continue our recruiting efforts for a full-time pediatrician. As we all are aware, this has been a challenging position for us to fill for over a year. That being said, we have had some encouraging developments and look forward to staffing stability in the near future.
3) **Cardiology:** Our cardiology program has demonstrated continued growth and demand. This is reflected in our echocardiogram program. March 2025 represented our 2nd busiest month in program history, with us completing 111 studies. We also just concluded our busiest quarter in program history. Dr. Rowan continues to provide

consistent and excellent clinical care to our community members. As a result of the ongoing demand for cardiology services, we are working with Dr. Rowan to add a nurse practitioner to his practice, which will allow expanded access. This nurse practitioner will work alongside and in conjunction with Dr. Rowan, starting as early as later this month.

4) **General Surgery**: We recently hosted a general surgeon for a formal site visit and interview. We hope to increase our general surgery offerings in the near future.

**Healthy Lifestyle Talks:**

I want to thank Barbara Laughon for organizing our March 2024 Health Lifestyles Talk. Our General surgeon Dr. Conor Wiles, provided a presentation on colorectal cancer awareness. This talk was hosted by our Chief of Staff Dr. Sierra Bourne.

# MONO COUNTY HEALTH AND HUMAN SERVICES
## Public Health Division

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 · FAX (760) 932-5284
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 · FAX (760) 924-1831

**MEDIA CONTACT**:
Justin Caporusso/Caporusso Communications
justin@caporussocommunications.com
(916) 412-0571


**FOR IMMEDIATE RELEASE**

## Third Hantavirus-Related Death Confirmed in Mono County

**MONO COUNTY, Calif. (April 3, 2025)** – Mono County Public Health has confirmed a third death due to Hantavirus in the Town of Mammoth Lakes. Hantavirus is a serious and often fatal illness which people can get through contact with infected deer mouse droppings, urine, or saliva. Deer mice are widespread in the Eastern Sierra region.

*"A third case of Hantavirus Pulmonary Syndrome (HPS), each of which has been fatal, is tragic and alarming,"* said Dr. Tom Boo, Mono County Public Health Officer. *"We don't have a clear sense of where this young adult may have contracted the virus. The home had no evidence of mouse activity. We observed some mice in the workplace, which is not unusual for indoor spaces this time of year in Mammoth Lakes. We haven't identified any other activities in the weeks before illness that would have increased this person's exposure to mice or their droppings.*

*We've been aware of this suspected case for some weeks, but it has taken time to obtain testing. The occurrence of three cases in a short period has me worried, especially this early in the year. Historically, we tend to see Hantavirus cases later in the spring and in the summer. We've now gone about a month without any additional suspect cases, but remain concerned about the increase in activity.*

*We believe that deer mouse numbers are high this year in Mammoth (and probably elsewhere in the Eastern Sierra). An increase in indoor mice elevates the risk of Hantavirus exposure. Therefore, it is crucial to take precautions and follow the prevention steps outlined below.*

*I want to emphasize that as far as we know, none of these deceased individuals engaged in activities typically associated with exposure, such as cleaning out poorly ventilated indoor areas or outbuildings with a lot of mouse waste. Instead, these folks may have been exposed during normal daily activities, either in the home or the workplace. Many of us encounter deer mice in our daily lives and there*

*is some risk. We should pay attention to the presence of mice and be careful around their waste."*

**Ongoing Investigation**

Each Hantavirus case is investigated by local and state public health officials. Each of our recent cases lived and worked in Mammoth Lakes and experienced illness beginning in February. When a person has died, we can only talk to people who knew them about the places they were and things that they did in the weeks before they got sick. We know that one person had numerous mice in their home. No evidence of mice was found in the other two homes. In all three cases there was some evidence of mice in places they had worked, but no major infestations were found. Investigators did note that one person did some vacuuming in one or more areas where investigators later found mouse droppings. Vacuuming can aerosolize the virus from mouse waste spreading the virus through the air and lead to infection.

Mono County has now recorded 27 cases since it was first reported here in 1993, the most in the State of California. Twenty-one of these infections affected County residents, and six occurred in visitors who were infected in Mono. Hantavirus more commonly occurs in the late spring or summer, so three cases this early in the year is strikingly unusual.

**Health Risks and Symptoms**

People get infected with Hantavirus through contact with the feces, urine, or saliva of infected deer mice. Most often this happens by inhaling contaminated particles in the air, although getting waste in your mouth from contaminated hands can cause infection too.

The incubation period after infection is usually two or three weeks but can range from one to more than seven weeks, after which illness typically begins as a non-specific flu-like illness with fever, headache and body aches, also often with gastrointestinal symptoms such as nausea, vomiting, diarrhea and occasionally abdominal pain. These early symptoms are usually not mild. Muscle aches, for example, are often severe.

Typically, there is no cough in this early phase, and the presence of cough, runny nose or sore throat in the first day or two points more to common respiratory viruses such as flu or COVID.

Hantavirus often, though not always, progresses to involve the lungs after a few days, at which time a cough develops. Shortness of breath is a worrisome sign of worsening disease. This is Hantavirus Pulmonary Syndrome (HPS) and it frequently worsens rapidly, with potential death within a day or two.

MONO COUNTY HEALTH AND HUMAN SERVICES
Public Health Division
P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 · FAX (760) 932-5284
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About one-third of people with Hantavirus infections die. Prompt diagnosis and treatment improve outcomes, but testing is only available in specialized laboratories, making early recognition challenging.

The only source of Hantavirus in our area is from deer mice. It does not spread between people and other rodents do not carry it.

**Prevention is Key**

Be vigilant for signs of indoor rodent activity. Risk is highest in poorly ventilated spaces and with cleaning, which may stir up the virus. Infested vehicles may be risky too. Follow these guidelines to reduce your risk:

- Seal up all gaps in your home larger than a pencil's width to prevent mice from entering.
- Store food in rodent-proof containers.
- Trap mice using snap traps (not glue or live traps).
- Avoid vacuuming or sweeping rodent droppings, nests, or urine.
- Air out enclosed spaces for at least 30 minutes before activities.
- Spray contaminated areas with a disinfectant or a freshly made 10% bleach solution and let sit for five minutes before wiping clean.
- Wear gloves and an N-95 (or higher) mask when cleaning. Contact Public Health for free N-95 masks.

Do not eat food that may have been contaminated by rodents, and always wash your hands thoroughly after any potential exposure.

**For more information please visit:**

The Mono County Public Health Division at
https://monohealth.com/environmental-health/page/hantavirus-0

The California Department of Public Health at:
go.cdph.ca.gov/hantavirus

**-###-**

NORTHERN INYO HEALTHCARE DISTRICT
*One Team. One Goal. Your Health.*

# NIHD ANNUAL AUDIT PRESENTATION - CFO

FYE 2024

## PURPOSE

# RESPONSIBILITIES

***Responsibilities of Management for the Financial Statements***

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; and for 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.

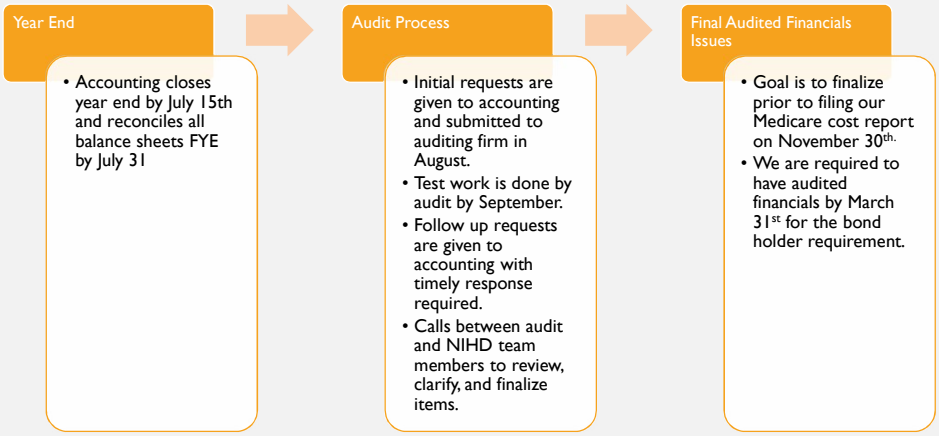
In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

***Auditor's Responsibilities for the Audit of the Financial Statements***

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and Government Auditing Standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

# AUDIT PROCESS

# PROCESS




# CHALLENGES & HISTORY

# CHALLENGES

- New firms
- New systems
- Unreconciled accounts
- Training & expectations

# AUDIT HISTORY

| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|
| Firm | Wipfli | Eide Bailly | Eide Bailly | Eide Bailly | Clifton Larson and Associates (CLA) | Clifton Larson and Associates (CLA) |
| Reconciled Accounts (out of 220) | 5* | 10* | 63* | 28* | 136 | 200 |
| Audit Completed | May 5, 2020 | July 16, 2021 | December 7, 2021 | April 28, 2023 | February 22, 2024 | April 2, 2025 |
| Audit Findings | Material weaknesses: 3 | Material weaknesses: 7 Significant deficiencies: 3 | Material weaknesses: 1 Significant deficiencies: 3 | Material weaknesses: 3 Significant deficiencies: 1 | Material weaknesses: 2 Significant deficiencies: 0 | Material weaknesses: 2 Significant deficiencies: 0 |
| Total Corrections | 250 entries – 13 for prior year corrections – over $50M | 32 entries – $25.6M | 5 entries - $23.4M | 31 entries - $41.6M | 24 entries - $40M | 18 entries – $14.1M |

# KEY INFORMATION

## STATEMENT OF NET POSITION

| | |
|---|---|
| **Current Assets** | • Cash and Investments – amount of cash available for operations and debt |
| **Current Liabilities** | • Current Maturities of Long-Term Debt / Related to Leases / Related to Subscription Based Information Technology Agreements (SBITA) – upcoming debt obligations |
| **Long-term Debt, less current maturities** | • The amount of long-term debt obligations |
| **Net Pension Liability** | • The amount of unfunded pension liability |

## STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

| | |
|---|---|
| **Net Patient Service Revenue** | • This is the actual revenue anticipated after applying discounts for contractual agreements (cash) |
| **Operating Expenses** | • These are the costs of providing services associated with the revenue above |
| **Operating Income (loss)** | • This is the earnings (or losses) for providing care |
| **Non-operating Revenues (expenses)** | • This includes tax appropriations, intergovernmental transfers, and investments |
| **Change in net position** | • This is the earnings for the year (or losses) |

## STATEMENT OF CASH FLOWS

This reports shows how the district spent cash

CASH FLOWS FROM OPERATING ACTIVITIES
- This is the cash spent to provide care to the community

CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES
- This is the cash received from other government entities (county and state)

CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES
- This is the cash we spent on debt obligations and capital
- Purchase and Construction of Capital Assets
  - This shows the amount of capital investment we made this year

CASH FLOWS FROM INVESTING ACTIVITIES
- This is the cash received from investments

NET CHANGE IN CASH AND CASH EQUIVALENTS
- This shows the net impact on cash for the year

## STATEMENT OF CHANGES IN FIDUCIARY NET POSITION – PENSION TRUST FUND

- This report shows the activity in the pension plan trust fund

## NOTES

- This section has details of accounting methods, principles, and calculations
- This section is intended to compliment/clarify the financials

## FINDINGS & ACTION PLAN

# FYE 2024 FINDINGS

- NIHD self reported - Inventory: FYE 2023 values were incorrect
  - Received feedback on best practices
  - Accounting team education
  - Audit will observe FYE 2025
- Balance Sheet Reconciliations
  - Auditing firm's outsourced department is helping with remaining unreconciled accounts
  - Accounting is trained on expectations with new team members who have healthcare experience committed to catching up backlog and hitting deadlines on a monthly basis

# Northern Inyo Healthcare District

## 2024 Audit Results and Report to the Board of Directors

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

# Table of Contents

# Executive Summary

## Results of Professional Services

# Results of Professional Services

## Significant Events and Transactions

- Disclaimer of opinion on Inventory and related expense and cash flows line items

## Audit Adjustments

- One passed adjustment – Bond Amortization

## Subsequent Events

- No significant subsequent events affecting the financial statements

## Internal Controls

- Material weaknesses identified

# Your Business

# Comparative Data Used

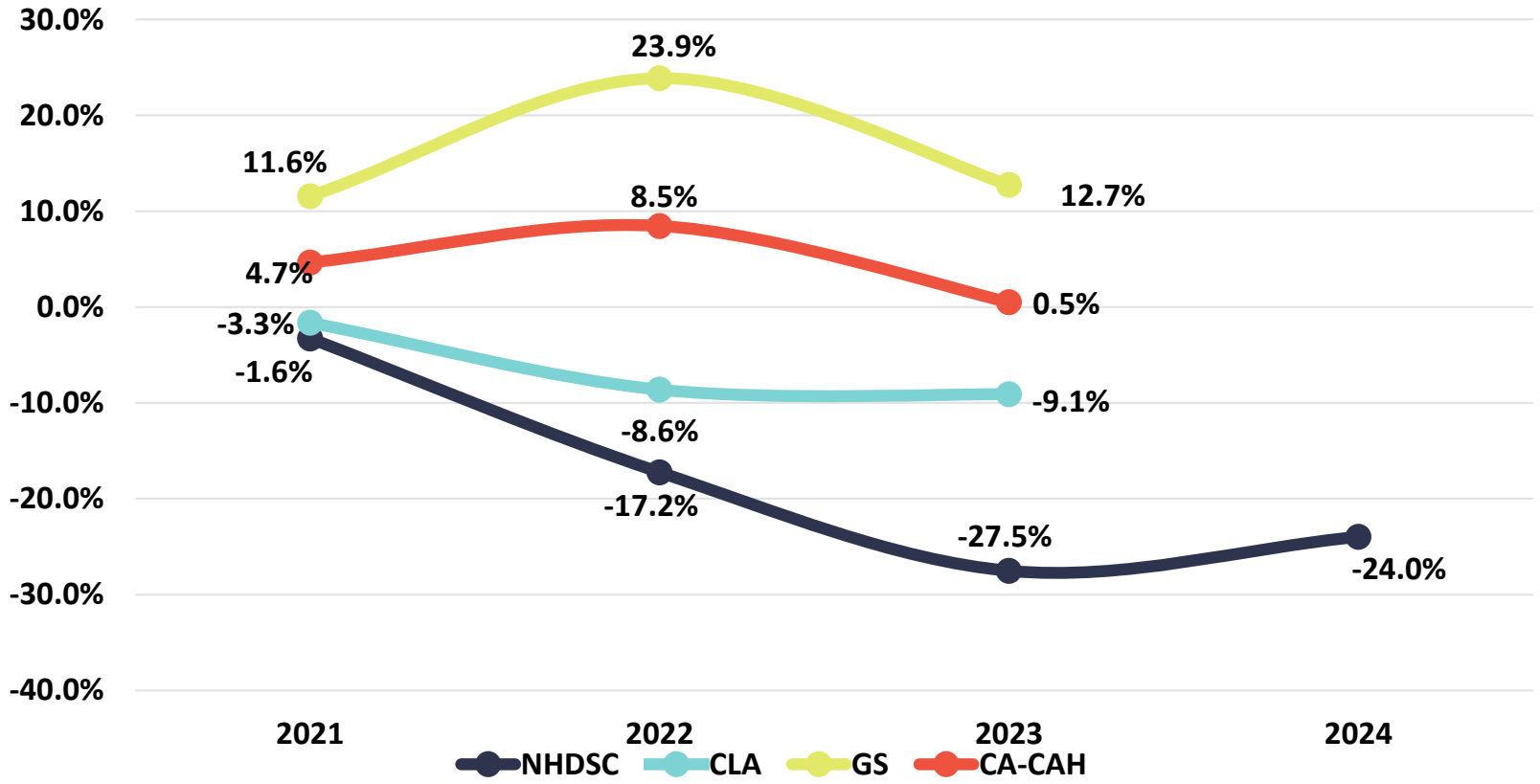
- Northern Inyo Healthcare District
  - 2021 to 2024

- CLA Benchmark
  - Selected CAH Hospitals between $25 and $100M in Net Patient Revenue

- S&P Rating (BBB+ to BBB-)

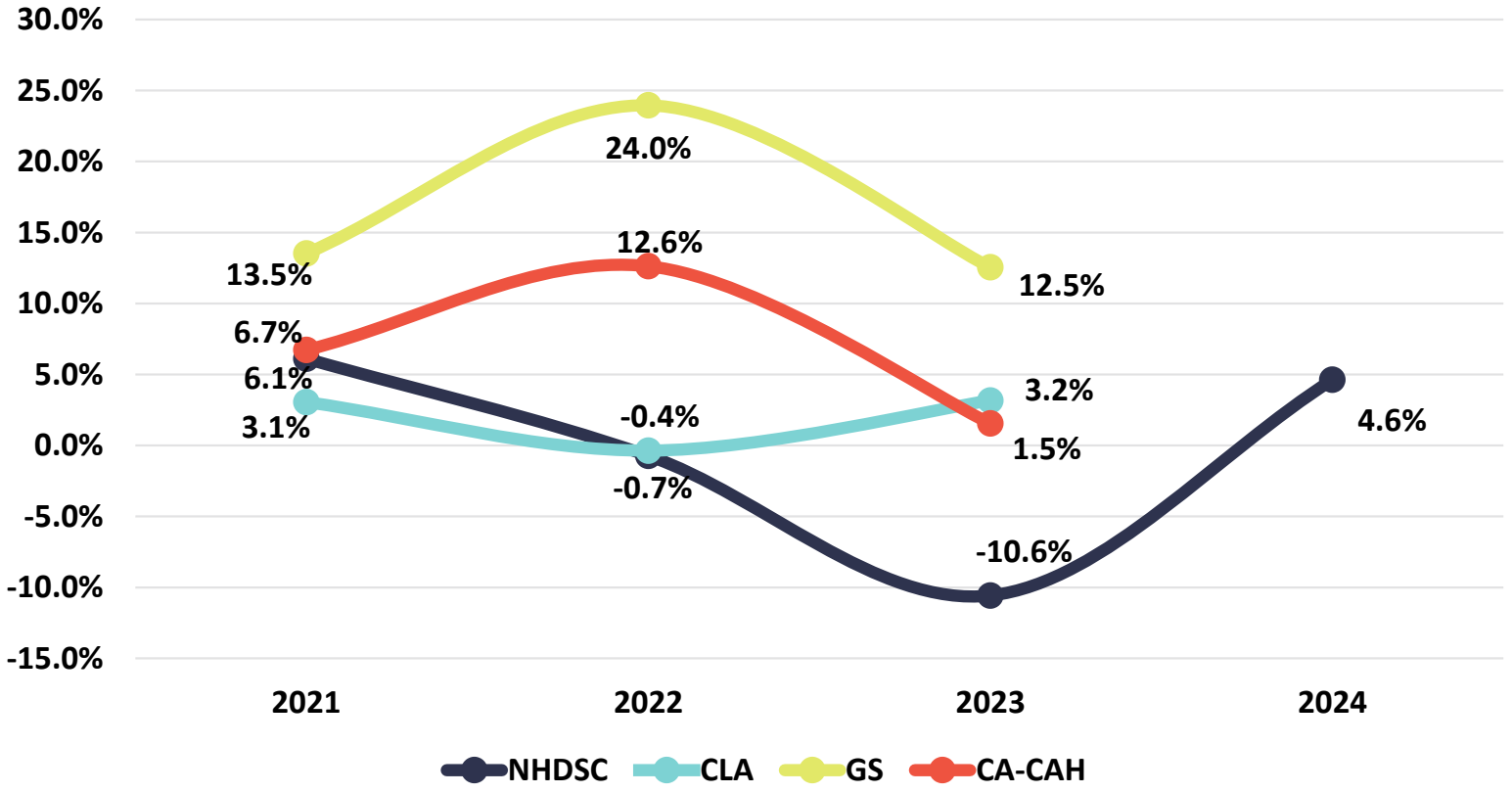
# Financial Highlights

## Operating Margin



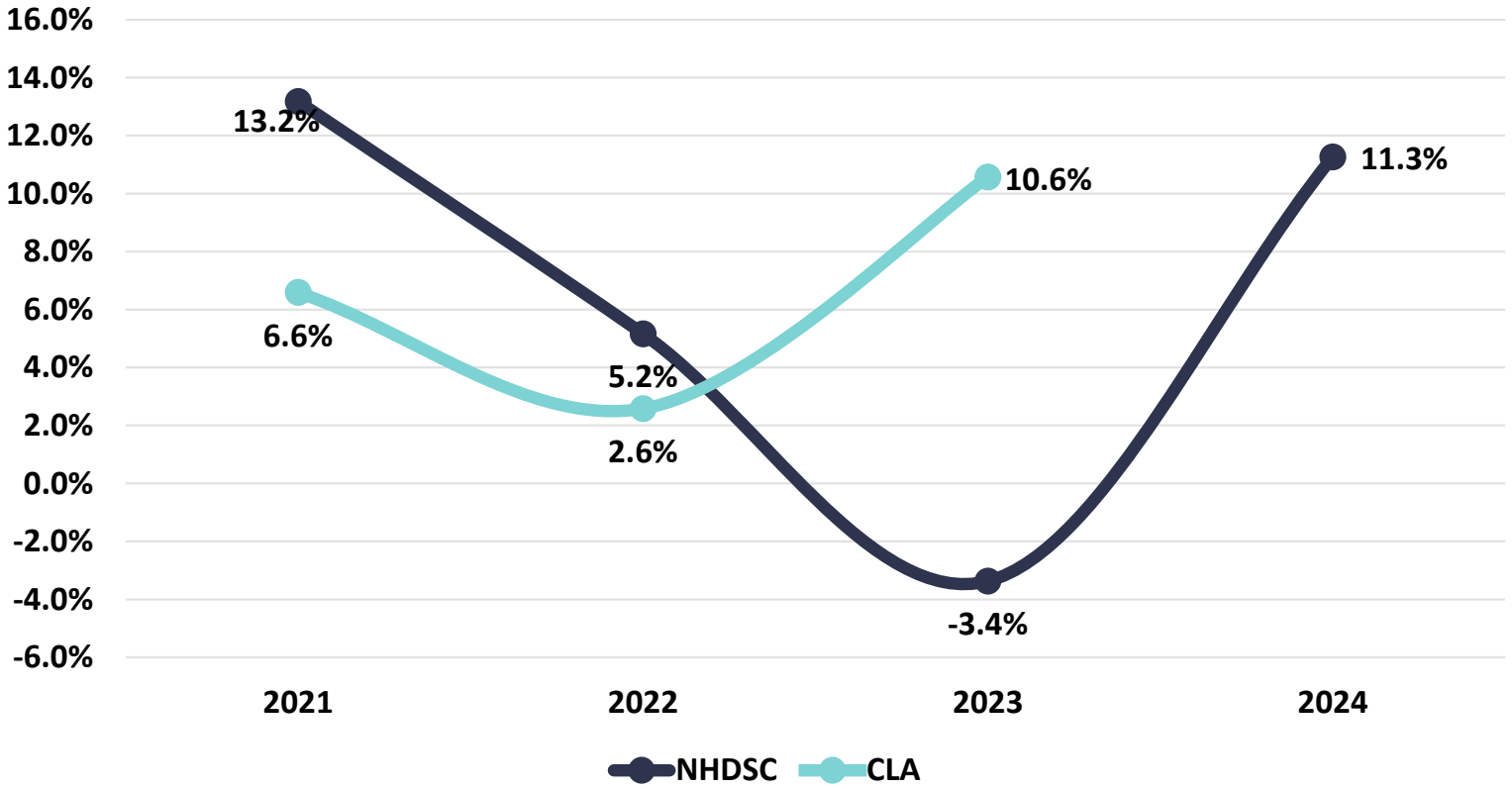
# Financial Highlights

## Total Margin



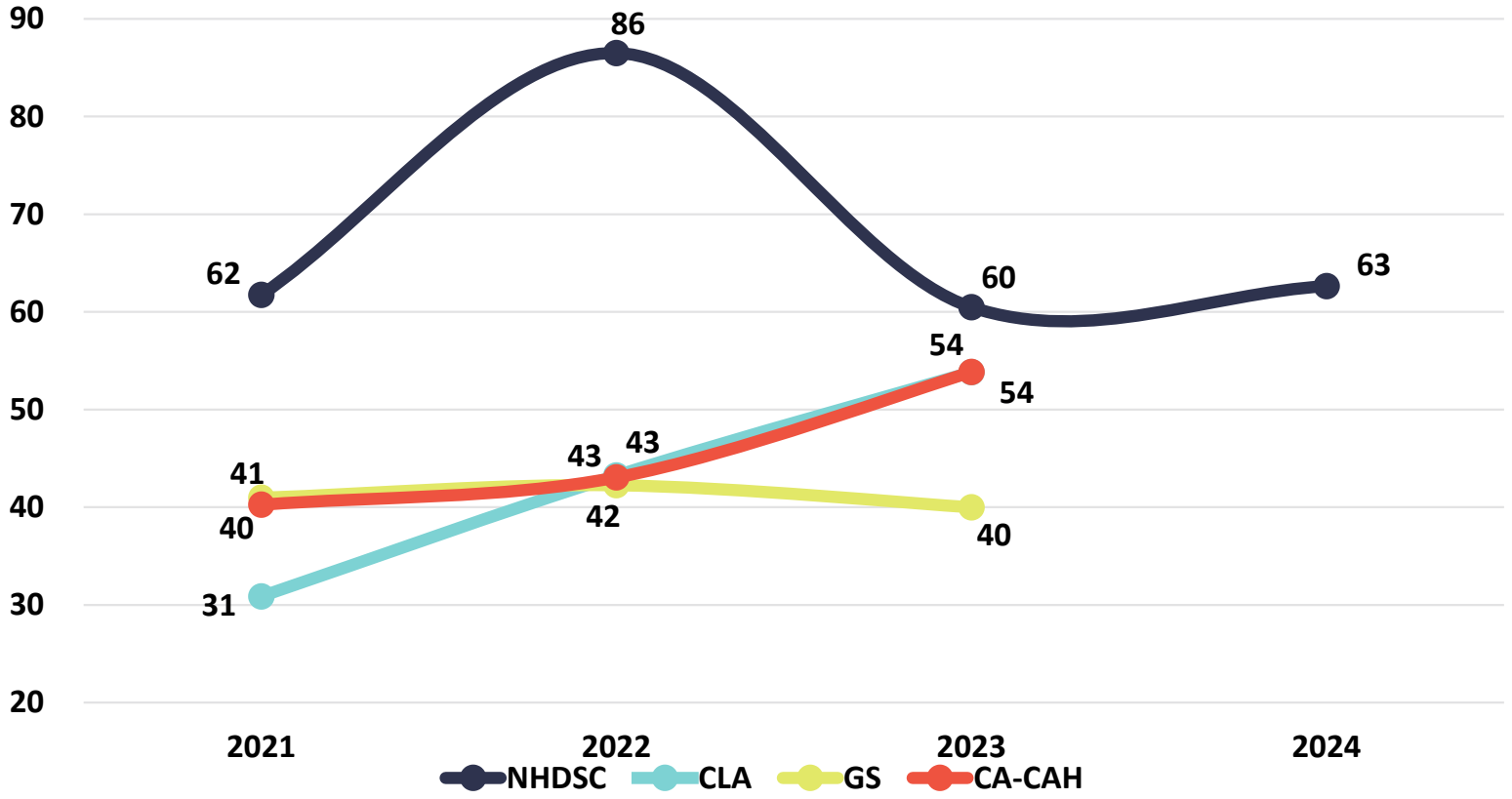
# Financial Highlights

## Total EBIDA Margin



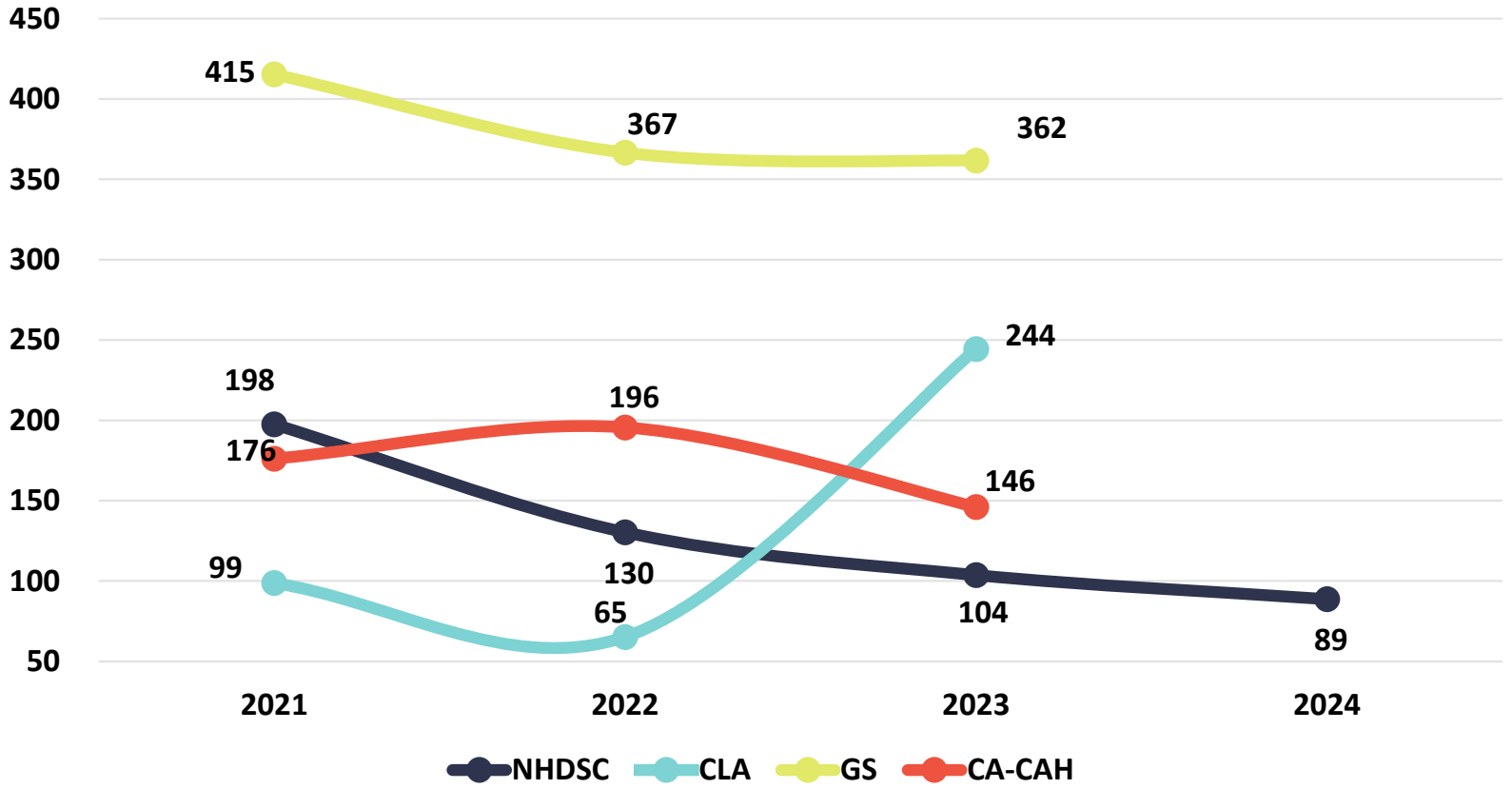
# Financial Highlights

## Net Days in Accounts Receivable



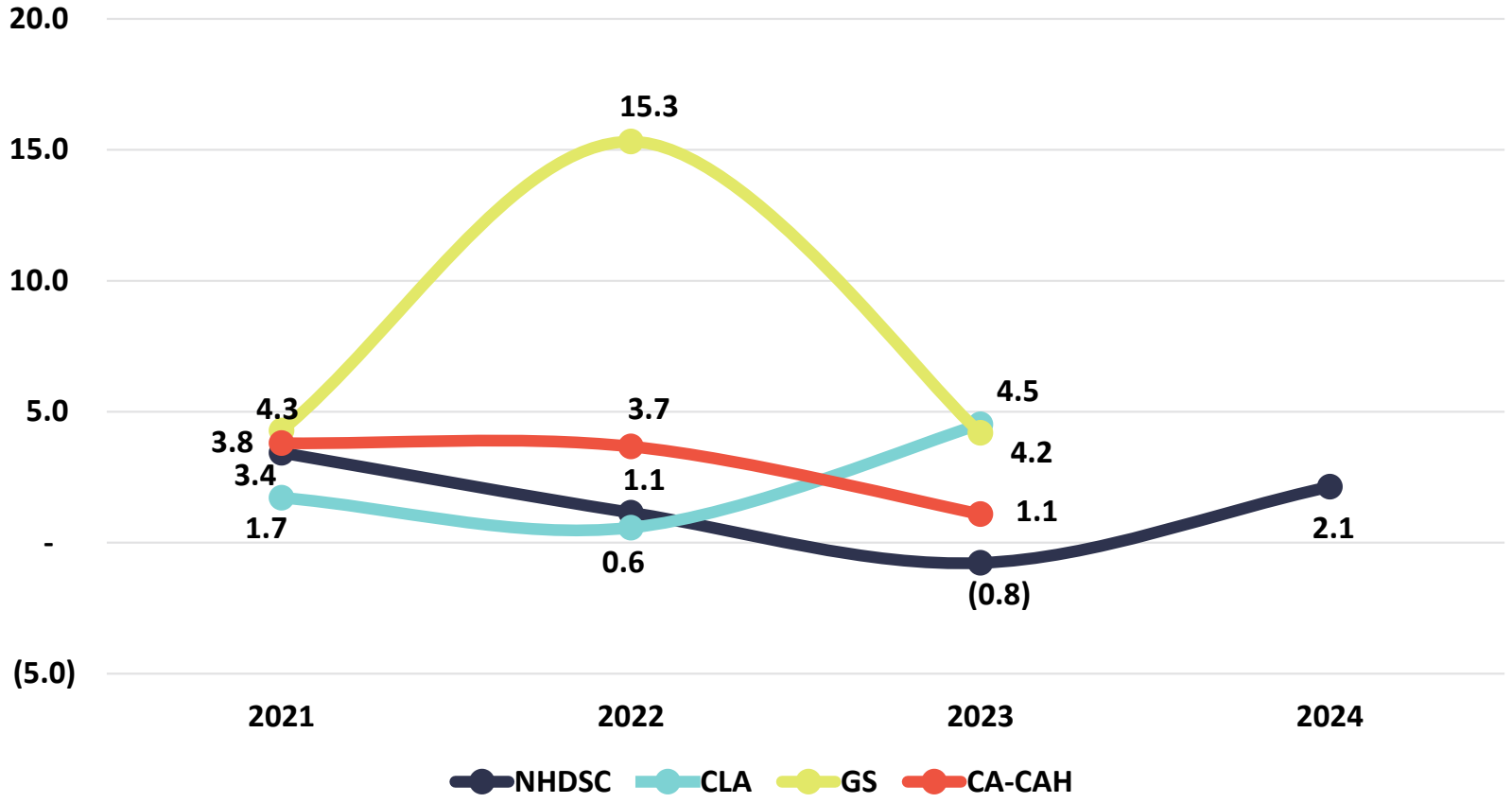
# Financial Highlights

## Days Cash on Hand



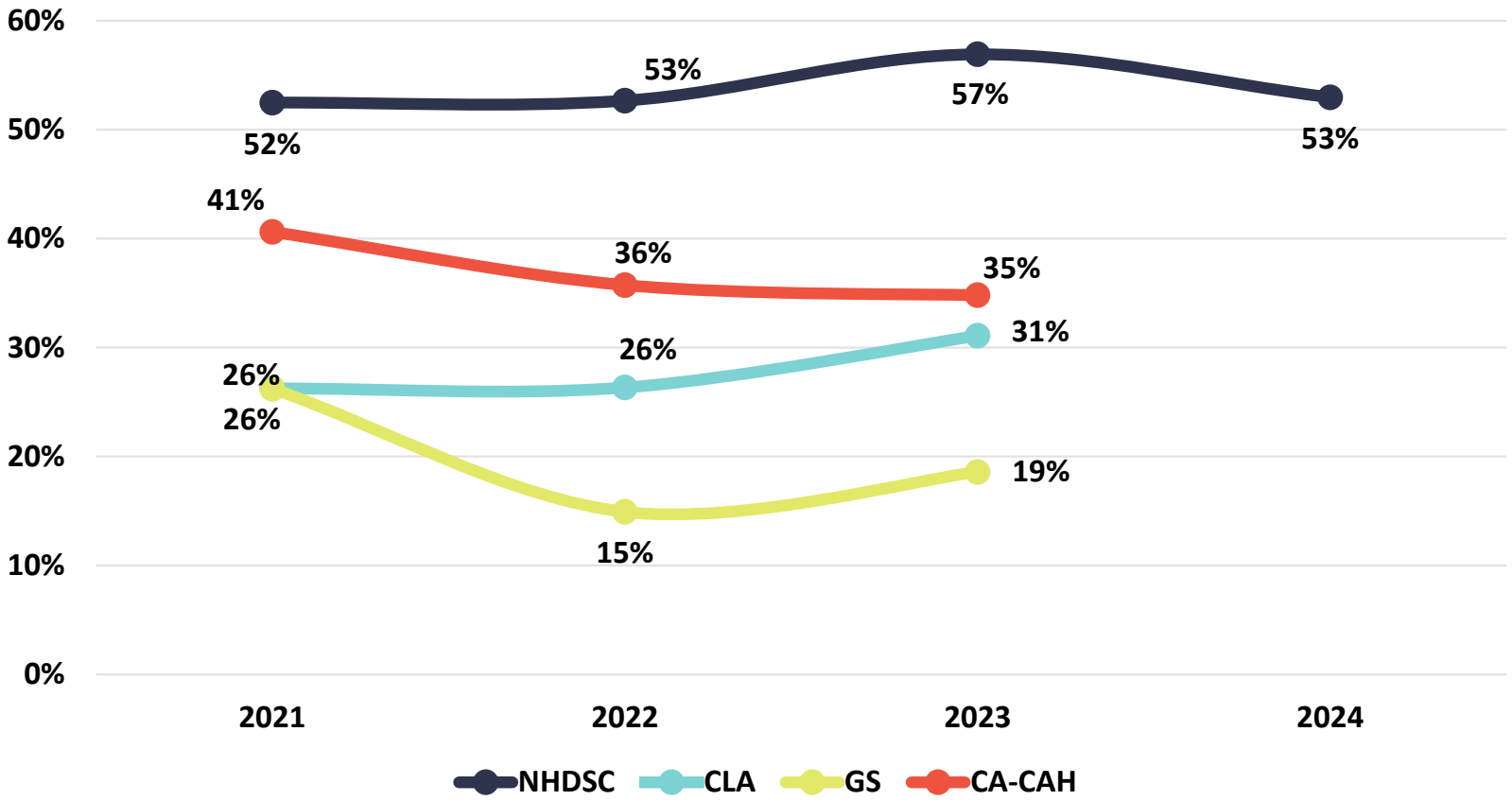
# Financial Highlights

## Debt Service Coverage



# Financial Highlights

## Debt to Capitalization



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# 2024 Trends

- Health Care Consolidation
- Labor Market
- Margin Compression
- Capitol Hill, Election Year Impacts
- Artificial Intelligence
- Rising Role of Medicare Advantage

# #1: Health Care Consolidation, Deals

For any number of reasons, there is ongoing consolidation and dealmaking in health care and life sciences.

Labor expenses skyrocketed during the pandemic and then reset at higher rates. These higher labor rates and a tight labor market plus ongoing inflationary pressures are wreaking havoc on some operating margins.

A ripple effect has resulted in closures or mergers and acquisitions. Private equity interest has been piqued. Due to M&A, there is more regulatory scrutiny.

A few things we're watching:

- Private equity moves
- Hospital/health and SNF deals/consolidation
- Impact of insurer market moves
- Regulatory anti-trust focus

# #2: Labor Market

A very tight labor market has loosened a bit and employment has stabilized over the past year. That said, wages have reset at higher rates. This places enormous financial and operational pressure on employers.

Key roles in health care are still experiencing burnout, leading to job changes, reduced hours, retirements, and an uptick in union activity.

Demographics will complicate this picture as millions of eligible beneficiaries move into Medicare in the coming years. This will have ripple effects felt throughout all of health care and life sciences.

A few things we're watching:

- Demographic changes
- New workforce pipelines
- Heightened focus on recruitment/retention
- Career ladders, upskilling
- Use of AI

# #3: Margin Compression

Higher labor costs compounded by overall high operating costs due to inflation and economic uncertainly has created margin pressures. Plus, for many, higher reimbursement rates have not materialized to accommodate those higher operating expenses. This is particularly true for providers dependent on government payers.

Add on an aging population and demographics will skew the financial picture towards Medicaid and Medicare. Rural providers are particularly vulnerable here.

Commercial contract negotiations are getting tougher.

Across all of health care, administrative expenses for compliance and paperwork are leading to growing frustration and inefficiencies.


A few things we're watching:

- Tough contract negotiations
- Heightened focus on care delivery models, alternative payments
- Potential labor reductions
- Reducing inefficiencies
- Use of AI

# #4: Rising Role of Medicare Advantage

Medicare Advantage's (MA) rise continues. It now comprises half of all Medicare eligibles. As growth increases so, too, does scrutiny. This has led to more regulatory and legislative attention.

There are growing contract fights between providers-insurers over inadequate reimbursements and administrative burden.

Due to its popularity, size and demographic trends, providers must pay attention to MA long-term. The program is where many patients will consume health care dollars.

Also, various Medicare value-based models look to or use MA's risk adjustment and financing methodologies as a basis.

A few things we're watching:

- Impact of vertical integration by insurers
- Regulatory, legislative scrutiny, and lawsuits
- Tougher negotiations

# #5: Capitol Hill/Regulatory/Election Year

This will be a rough year on Capitol Hill. There are small majorities in either chamber which always makes passing bills more difficult, compounded by competing issues.

It is also an election year, which means all issues are viewed through that lens.

The number one issue to address is funding government which is magnified by a growing annual deficit and national debt.

Regulatory activities will be robust, especially in first half of 2024.

A few things we're watching:

- March 1, 8 government funding deadlines
- Reducing physician fee cuts
- Site neutral cuts to hospitals
- Election year politics impacts

# #6: Artificial Intelligence

Throughout the industry, AI is rapidly being deployed. Whether that's for medical scribes, revenue cycle applications, patient information, data analytics/predictive analytics, and much more.

Because there isn't a statutory or legal construct specific to AI, the landscape is wide open for a host of lawsuits (copyright infringement, patient rights, privacy violations and more). Regulators and legislators are also weighing in.

With all of it, those creating and adopting AI must also work to protect against inherent bias of its outputs and address cybersecurity.

A few things we're watching:

- Increased use of AI
- Lawsuits
- Legislative/regulatory focus
- Cybersecurity

# Appendix

# Required Communications

| Topic | Communication |
|---|---|
| Our responsibility under Generally Accepted Auditing Standards | • Plan and perform the audit to obtain reasonable, not absolute assurance that the financial statements are free of material misstatement<br>  • Qualified Opinion on Financial Statements related to the possible effects on the statements of net position, revenues, expenses, and changes in net position, and cash flows related to the valuation of inventory for the year ended June 30, 2023<br>• Utilize a risk based audit approach<br>• Communicate significant matters to appropriate parties |
| Planned Scope and Timing of the Audit | • Performed the audit according to the planned scope and timing previously communicated. |
| Other Information in Documents Containing the Audited Financial Statements | • Financial statements may only be used in their entirety<br>• Our approval is required to use our audit report in a client prepared document<br>• We have no responsibility to perform procedures beyond those related to the financial statements |

# Required Communications

| Topic | Communication |
|---|---|
| Significant Accounting Policies | • Management is responsible for the accounting policies of the organization<br>• Accounting policies are outlined in Note 1 to the consolidated financial statements<br>• Accounting policies deemed appropriate<br>• No significant change to accounting policies during the year<br>• No unusual transactions occurred |
| Significant Accounting Estimates | • An area of focus under a risk based audit approach<br>• Significant estimates include: allowance for contractual allowances, and third-party payor settlements & IGT Receivable/Payables, and pension liabilities<br>• Estimates determined by management based on their knowledge and experience<br>• No management bias indicated<br>• Estimates were deemed reasonable<br>• Estimate uncertainty is disclosed in the financial statements |
| Significant Financial Statement Disclosures | No sensitive disclosures<br>GASB 87 Leases - Note 8<br>GASB 96 SBITA – Note 8<br>Long-term liabilities – Note 7<br>Pension Liabilities – Note 9 |

# Required Communications

| Topic | Communication |
|---|---|
| Supplemental Information | • Schedule of Changes in the Net Pension Liability and Related Ratios – Pension Plan<br>• Schedules of Contributions – Pension Plan<br>• Schedule of Investment Returns – Pension Plan<br>• Combining Statement of Net Position<br>• Combining Statement of Revenues, Expenses, and Changes in Net Position<br>• Combining Statement of Cash Flows<br>• Statistical Information |
| Management Representation Letter | • Management provided signed representation letter prior to finalization of the audit report |
| Other | • No difficulties encountered in performing the audit<br>• No issues discussed prior to retention as independent auditors<br>• No disagreements with management regarding accounting, reporting, or other matters<br>• No consultations with other independent auditors<br>• No other findings or issues were discussed with, or communicated to, management |

# Internal Control Matters

| Topic | Communication |
|---|---|
| Purpose | • Express an opinion on the financial statements, not on the effectiveness of internal controls.<br>• Our consideration of internal controls was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore material weaknesses or significant deficiencies may exist that were not identified. In addition, because of inherent limitations in internal control, including the possibility of management override of controls, misstatements due to fraud or error may occur and not be detected by such controls. |
| Material Weakness | • Reasonable possibility that a material misstatement would not be prevented or detected and corrected on a timely basis. |
| Significant Deficiencies | • Less significant than a material weakness, yet important enough to merit the attention of governance. |
| Restricted Use | • This communication is intended solely for the information and use of management, the audit committee, and others within the Organization, and is not intended to be, and should not be, used by anyone other than these specified parties. |
| Results | • Two Material Weaknesses identified, Reconciliations, and Inventory |

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WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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# INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Northern Inyo Healthcare District
Bishop, California

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the Northern Inyo Healthcare District (the District), as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the District's basic financial statements, and have issued our report thereon dated April 2, 2025.

## *Report on Internal Control Over Financial Reporting*

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that have not been identified. We identified certain deficiencies in internal control, described in the accompanying schedule of findings and responses as items 2024-001 through 2024-002 that we consider to be material weaknesses.

***Report on Compliance and Other Matters***

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

***District's Response to Findings***

*Government Auditing Standards* requires the auditor to perform limited procedures on District's response to the findings identified in our audit is described in the accompanying schedule of findings and responses. The District's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

***Purpose of This Report***

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CliftonLarsonAllen LLP

**CliftonLarsonAllen LLP**

Roseville, California
April 2, 2025

**NORTHERN INYO HEALTHCARE DISTRICT**
**SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS**
**JUNE 30, 2024**

## 2024 – 001 Balance Sheet Reconciliations

Type of Finding:

- Material Weakness in Internal Control Over Financial Reporting

**Condition:** As a result of our audit procedures, we noted that there were several accounts that were not reconciled to the trial balance, which resulted in client proposed adjustments subsequent to audit procedures being performed.

**Criteria or specific requirement:** The District should maintain procedures to ensure that year-end closing procedures address all balance sheet accounts in a timely manner.

**Context:** The above condition was identified during our audit procedures over the District's year-end account balances.

**Effect:** Additional post-closing adjustments to the District's financial statements.

**Cause:** The District made improvements to the policies and procedures over monthly and year-end account reconciliations. However, the District experienced delays in their close process due to significant audit adjustments from the prior period that delayed the reconciliation process. This resulted in many accounts needing to be reconciled for all 12 months for prior period adjustments.

**Repeat finding:** 2023-001

**Recommendation:** We recommend that management continue to implement internal controls and procedures to ensure that the proper analysis and reconciliation of balance sheet accounts during the year and for the year-end close.

**Views of responsible officials and planned corrective actions:** Management agrees with the finding. The accountants understand the importance of accurate and timely financials. We have their commitment to catching up all reconciliations by July 31st prior to the fiscal year 2024/2025 audit starting. They will then begin a monthly reconciliation process for all reconciliations going forward.

**NORTHERN INYO HEALTHCARE DISTRICT**
**SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS**
**JUNE 30, 2024**

**2024 – 002** **Inventory**

Type of Finding:

- Material Weakness in Internal Control Over Financial Reporting

**Condition:** As a result of our audit procedures performed over inventory, we observed that inventory counts performed in fiscal year 2023 were not accurate in relation to the unit of measure.

**Criteria or specific requirement:** Healthcare entities should count and value significant inventory balances at a minimum annually and record these balances in the current year. Careful consideration should be given to review the unit of measure during the count to properly value the inventory.

**Context:** The condition above was noted during our procedures over inventory.

**Effect:** This resulted in the Districts supplies expense and cash flows related to purchases of inventory to be misstated in the current year, resulting in a disclaimer on the financial statement opinion.

**Cause:** The issue was related to new departments that were counted in fiscal year 2023 that had not been previously counted. The employees performing the count had no previous history of performing counts, and there were no historical counts to compare to.

**Repeat finding:** 2023-002

**Recommendation:** We recommend that the District instruct the people performing the count on the procedures before each count, including having them review if the unit of measure is a single item, box, ML, etc. to accurately reflect the extended value.

**Views of responsible officials and planned corrective actions:** Management agrees with the finding. Management has improved processes for the fiscal year 2024/2025 physical inventory count including having key members of the accounting team on site for the count to assist with the count. In addition, our auditors have informed management that they will have team members onsite to observe the physical count for the 2024/2025 fiscal year.

**NORTHERN INYO HEALTHCARE DISTRICT**
**SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS**
**JUNE 30, 2024**

Summarized below is the current status of the corrective action on audit findings reported in the prior year schedule of audit findings and responses.

| Finding No. | Description | Status of Corrective Action |
|---|---|---|
| 2023-001 | Balance Sheet Reconciliations | Partially Implemented.<br>See Finding 2024-001 |
| 2023-002 | Inventory | Partially Implemented.<br>See Finding 2024-002 |

# NORTHERN INYO HEALTHCARE DISTRICT

## FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

## YEAR ENDED JUNE 30, 2024

CPAs | CONSULTANTS | WEALTH ADVISORS

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**NORTHERN INYO HEALTHCARE DISTRICT**
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**YEAR ENDED JUNE 30, 2024**

CliftonLarsonAllen LLP
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# INDEPENDENT AUDITORS' REPORT

Board of Directors
Northern Inyo Healthcare District
Bishop, California

## Report on the Audit of the Financial Statements

### *Qualified Opinion*

We have audited the financial statements of the business-type activities and fiduciary activities of the Northern Inyo Healthcare District (District), as of and for the year then ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

In our opinion, except for the possible effects on the statements of net position, revenues, expenses, and changes in net position, and cash flows of the matter described in the Basis for Qualified Opinion section of our report, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and fiduciary activities the District, as of June 30, 2024, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

### *Basis for Qualified Opinion*

Procedures performed in the current year indicated that there was an error in the valuation of inventory for the year ended June 30, 2023 (stated at $5,159,472). As the District's records do not permit adequate retroactive tests of inventory quantities, we are unable to determine whether any adjustments were necessary in the statements of net position, revenues, expenses, and changes in net position, or cash flows.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States *(Government Auditing Standards)*. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

***Responsibilities of Management for the Financial Statements***

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; and for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

***Auditor's Responsibilities for the Audit of the Financial Statements***

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and Government Auditing Standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

***Required Supplementary Information***

Accounting principles generally accepted in the United States of America require that the schedule of changes in the net pension liability and related ratios, schedule of pension contributions, and schedule of investment returns, as listed in the table of content be presented to supplement the basic financial statements. Such information is the responsibility of management and, 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 of America, 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 of America 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 the missing information.

***Supplementary Information***

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the District's basic financial statements. The combining financial statements of the District and component units are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the combining financial statements of the District and component units are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

***Other Information***

Management is responsible for the other information included in the basic financial statements. The other information comprises the statistical information of the District but does not include the basic financial statements and our auditor's report thereon. Our opinions on the basic financial statements do not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the basic financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the basic financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

**Other Reporting Required by *Government Auditing Standards***

In accordance with *Government Auditing Standards*, we have also issued our report dated April 2, 2025 on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering District's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

**CliftonLarsonAllen LLP**

Roseville, California
April 2, 2025

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF NET POSITION**
**JUNE 30, 2024**

## ASSETS

| | |
|---|---|
| **CURRENT ASSETS** | |
| Cash and Investments | $ 27,284,892 |
| Receivables: | |
| Patient, Net of Estimated Uncollectibles | 17,952,286 |
| Leases Receivable | 44,470 |
| Estimated Third-Party Payor Settlements | (1,637,684) |
| Other Receivables | 3,115,972 |
| Inventory | 7,014,167 |
| Prepaid Expenses and Other Assets | 1,114,104 |
| Total Current Assets | 54,888,207 |
| **NONCURRENT CASH AND INVESTMENTS** | |
| Restricted for Specific Operating Purposes and Capital Improvements | 1,467,786 |
| Restricted by Trustee for Debt Reserve | 10,101 |
| Total Noncurrent Cash and Investments | 1,477,887 |
| **CAPITAL ASSETS** | |
| Capital Assets not Being Depreciated/Amortized | 11,875,125 |
| Capital Assets Being Depreciated/Amortized, Net | 73,008,374 |
| Total Capital Assets | 84,883,499 |
| Total Assets | 141,249,593 |
| **DEFERRED OUTFLOWS OF RESOURCES** | |
| Deferred Outflows Related to Pensions | 13,882,457 |
| Deferred Outflows Related to Refunding | 366,312 |
| Deferred Outflows Related to Acquisition | 492,863 |
| Total Deferred Outflows of Resources | 14,741,632 |
| Total Assets and Deferred Outflows of Resources | $ 155,991,225 |

*See accompanying Notes to Financial Statements.*

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF NET POSITION (CONTINUED)**
**JUNE 30, 2024**

## LIABILITIES

| | |
|---|---|
| **CURRENT LIABILITIES** | |
| Current Maturities of Long-Term Debt | $ 1,912,457 |
| Current Maturities Related to Leases | 131,319 |
| Current Maturities Related to SBITA's | 1,202,223 |
| Other Liabilities | 390,867 |
| Accounts Payable: | |
| Trade | 3,576,147 |
| Accrued Expenses: | |
| Salaries and Wages | 5,480,639 |
| Interest and Sales Taxes | 155,844 |
| Self-Insurance Claims | 886,017 |
| Total Current Liabilities | 13,735,513 |
| **LEASE LIABILITY, Less Current Maturities** | 380,047 |
| **SBITA LIABILITY, Less Current Maturities** | 6,232,492 |
| **LONG-TERM DEBT, Less Current Maturities** | 47,619,803 |
| **NET PENSION LIABILITY** | 32,946,355 |
| Total Liabilities | 100,914,210 |
| **DEFERRED INFLOWS OF RESOURCES** | |
| Deferred Inflows Related to Pensions | 12,556,361 |
| Deferred Inflows Related to Lease Receivables | 43,462 |
| Total Deferred Inflows of Resources | 12,599,823 |
| **NET POSITION** | |
| Net Investment in Capital Assets | 27,405,158 |
| Restricted: | |
| Programs | 25,079 |
| Capital Improvements | 1,442,589 |
| Unrestricted | 13,604,366 |
| Total Net Position | 42,477,192 |
| Total Liabilities, Deferred Inflows of Resources, and Net Position | $ 155,991,225 |

*See accompanying Notes to Financial Statements.*

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION**
**YEAR ENDED JUNE 30, 2024**

| | |
|---|---|
| **OPERATING REVENUES** | |
| Net Patient Service Revenue | $ 104,622,474 |
| Other Revenue | 2,617,122 |
| Total Operating Revenues | 107,239,596 |
| **OPERATING EXPENSES** | |
| Salaries and Wages | 43,973,065 |
| Employee Benefits | 18,923,640 |
| Professional Fees and Purchased Services | 18,568,419 |
| Supplies | 11,328,288 |
| Purchased Services | 6,399,832 |
| Depreciation and Amortization | 5,209,724 |
| Other | 7,565,282 |
| Total Operating Expenses | 111,968,250 |
| **OPERATING LOSS** | (4,728,654) |
| **NONOPERATING REVENUES (EXPENSES)** | |
| Property Tax for Operations | 1,092,860 |
| Property Tax for Debt Service | 2,062,672 |
| Investment Income | 183,176 |
| Interest Expenses | (2,782,380) |
| Noncapital Contributions and Grants | 9,705,699 |
| Rental Income | 24,835 |
| Miscellaneous Income (Expense) | 190,361 |
| Net Nonoperating Revenues (Expenses) | 10,477,223 |
| **CHANGE IN NET POSITION** | 5,748,569 |
| Net Position - Beginning of Year | 36,728,623 |
| **NET POSITION - END OF YEAR** | $ 42,477,192 |

*See accompanying Notes to Financial Statements.*

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF CASH FLOWS**
**YEAR ENDED JUNE 30, 2024**

| | |
|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | |
| Receipts from and on Behalf of Patients | $ 102,722,670 |
| Payments to Suppliers and Contractors | (38,656,283) |
| Payments to and on Behalf of Employees | (66,674,721) |
| Other Receipts and Payments, Net | (5,053,439) |
| Net Cash Used by Operating Activities | (7,661,773) |
| **CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES** | |
| Noncapital Contributions and Grants | 9,705,699 |
| Property Taxes Received | 1,092,860 |
| Net Cash Provided by Noncapital Financing Activities | 10,770,814 |
| **CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES** | |
| Principal Payments on Long-Term Debt | (3,561,742) |
| Interest Paid | (1,569,091) |
| Purchase and Construction of Capital Assets | (3,957,543) |
| Payments on Lease Liability | (370,888) |
| Payments on Subscription Liability | (1,176,680) |
| Property Taxes Received | 2,062,672 |
| Net Cash Used by Capital and Capital Related Financing Activities | (8,573,272) |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | |
| Investment Income | 183,176 |
| Rental Income | 48,975 |
| Net Cash Provided by Investing Activities | 232,151 |
| **NET CHANGE IN CASH AND CASH EQUIVALENTS** | (5,232,080) |
| Cash and Cash Equivalents - Beginning of Year | 33,994,859 |
| **CASH AND CASH EQUIVALENTS - END OF YEAR** | $ 28,762,779 |

*See accompanying Notes to Financial Statements.*

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF CASH FLOWS (CONTINUED)**
**YEAR ENDED JUNE 30, 2024**

| | |
|---|---|
| **RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION** | |
| Cash and Cash Equivalents in Current Assets | $ 27,284,892 |
| Cash and Cash Equivalents in Noncurrent Cash and Investments | 1,477,887 |
| Total Cash and Cash Equivalents | $ 28,762,779 |
| **RECONCILIATION OF OPERATING LOSS TO NET CASH USED BY OPERATING ACTIVITIES** | |
| Operating Loss | $ (4,728,654) |
| Adjustments to Reconcile Operating Income to Net Cash Used by Operating Activities | |
| Depreciation and Amortization | 5,209,724 |
| Pension Expense | 3,621,047 |
| Provision for Bad Debts | 7,438,714 |
| (Increase) Decrease in Assets: | |
| Patient Receivables | (10,546,372) |
| Other Receivables | (130,455) |
| Inventory | (1,854,695) |
| Prepaid Expenses | 679,525 |
| Deferred Outflow of Resources | 1,802,389 |
| Increase (Decrease) in Liabilities: | |
| Accounts Payable | (1,382,718) |
| Estimated Third-Party Payor Settlements | 1,207,854 |
| Accrued Expenses | (1,949,327) |
| Other Liabilities | 221,184 |
| Net Pension Liability | (17,932,355) |
| Deferred Inflow of Resources | 10,682,366 |
| Net Cash Used by Operating Activities | $ (7,661,773) |
| **SUPPLEMENTAL DISCLOSURE OF NONCASH CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES** | |
| Gain on Extinguishment of Debt | $ 218,106 |
| Lease Assets Received in Exchange for Lease Liability | $ 399,606 |
| Subscription Assets Received in Exchange for Subscription Liability | $ 577,228 |

*See accompanying Notes to Financial Statements.*

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF FIDUCIARY NET POSITION**
**DECEMBER 31, 2023**

| | |
|---|---|
| **ASSETS** | |
| **INVESTMENTS AT FAIR VALUE** | |
| Cash and Cash Equivalents | $ 1,995,847 |
| Mutual Funds | 5,136,050 |
| Indexed Bond Fund | 5,020,105 |
| Total Assets | $ 12,152,002 |
| **NET POSITION** | |
| Restricted for Pensions | $ 12,152,002 |
| Total Net Position | $ 12,152,002 |

*See accompanying Notes to Financial Statements.*

**NORTHERN INYO HEALTHCARE DISTRICT**
**STATEMENT OF CHANGES IN FIDUCIARY NET POSITION – PENSION TRUST FUND**
**YEAR ENDED DECEMBER 31, 2023**

| | |
|---|---|
| **ADDITIONS** | |
| Contributions: | |
| Employer | $ 5,331,816 |
| **INVESTMENT EARNINGS** | |
| Interest, Dividends, and Other | (1,336,658) |
| Total Investment Earnings | (1,336,658) |
| Total Additions | 3,995,158 |
| **DEDUCTIONS** | |
| Benefits Paid to Participants or Beneficiaries | (3,924,140) |
| Administrative Expenses | (16,352) |
| Total Deductions | (3,940,492) |
| **CHANGE IN NET POSITION** | 54,666 |
| Net Position - Beginning of Year | 12,097,336 |
| **NET POSITION - END OF YEAR** | $ 12,152,002 |

*See accompanying Notes to Financial Statements.*

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements of Northern Inyo Healthcare District (the District) have been prepared in accordance with accounting principles generally accepted in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the District are described below.

### Reporting Entity

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.

### Blended Component Units

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 fundraising 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's bylaws, and for this reason it is a blended component unit of the District. No separate financial report is prepared for the Foundation.

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 it is a blended component unit of the District. The Auxiliary's fiscal year end is May 31, 2023. No separate financial report is prepared for the Auxiliary.

All intercompany balances and transactions, if any, have been eliminated.

### Fiduciary Component Unit

Northern Inyo Local Hospital District Retirement Plan (the Plan) is a single employer defined benefit retirement plan organized under Internal Revenue Code (IRC) Section 415 for District employees who meet certain eligibility criteria. The Pension Trust Fund Plan is reported in the accompanying financial statements in separate statements of fiduciary net position and changes in fiduciary net position to emphasize that it is legally separate from the District. The Plan's fiscal year end is December 31, 2023. Separate financial statements for the fiduciary component unit are not available.

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

### Basis of Presentation

The statements of net position displays the District's assets, deferred outflows, liabilities, and deferred inflows, with the difference reported as net position. Net position is reported in the following categories/components:

*Net investment in capital assets* consists of capital assets, net of accumulated depreciation and reduced by outstanding balances of bonds, notes, and other debt that are attributable to the acquisition, construction, or improvement of those assets. Deferred outflows of resources and deferred inflows of resources that are attributable to the acquisition, construction, or improvement of those assets or related debt are included in this component of net position.

*Restricted net position* consists of restricted assets reduced by liabilities and deferred inflows of resources related to those assets. Assets are reported as restricted when constraints are placed on asset use either by external parties or by law through constitutional provision or enabling legislation.

*Unrestricted net position* is the net amount of the assets, deferred outflows of resources, liabilities, and deferred inflows of resources that does not meet the definition of the two preceding categories.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the District's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

### Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding internally designated or restricted cash and investments. For purposes of the statement of cash flows, the District considers its investment in the Local Agency Investment Fund (LAIF) and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents, excluding noncurrent cash and investments.

The District is authorized under California Government Code (CGC) 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, and obligations with first-priority security; and collateralized mortgage obligations.

All investments are stated at fair value, except for guaranteed investment contracts, which are stated at amortized cost. Investment gain (loss) includes changes in fair value of investments, interest, and realized gains and losses.

### Restricted Cash and Investments

Restricted cash consists of cash and investments held under indenture agreements or restricted for programs.

### Patient Receivables

Patient receivables are uncollateralized customer and third-party payor obligations. The District does not charge interest on unpaid patient receivables. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the District analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts.

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Patient Receivables (Continued)

For receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

The District has a discount policy established for residents of the District. Details of forgone charges related to discounts are discussed further in Note 5.

### Inventories

Inventories are stated at the lower of cost, determined on the average cost method, or net realizable value.

### Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A three-tier hierarchy prioritizes the inputs used in measuring fair value. These tiers include Level 1, defined as quoted market prices in active markets for identical assets or liabilities; Level 2, defined as inputs other than quoted market prices in active markets that are either directly or indirectly observable; and Level 3, defined as significant unobservable inputs therefore, requiring an entity to develop its own assumptions. The asset's or liability's fair value measurement within the hierarchy is based on techniques that maximize the use of relevant observable inputs and minimizes the use of unobservable inputs.

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Fair Value Measurement (Continued)

Assets or liabilities measured and reported at fair value are classified and disclosed in one of the three following categories:

Level 1 - Inputs to the valuation methodology are unadjusted quoted priced for identical assets or liabilities in active markets that the District has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets.
- Quoted prices for identical or similar assets or liabilities in inactive markets.
- Inputs, other than quoted prices, those are observable for the asset or liability.
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified contractual term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

### Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments and deposits are included in nonoperating revenues when earned.

### Capital Assets

Capital asset acquisitions in excess of $3,000 are capitalized and recorded at cost. Contributed capital assets are reported at their acquisition value at the date of donation. All capital assets other than land and construction in progress are depreciated using the straight-line method of depreciation using the following asset lives:

| | |
|---|---|
| Land Improvements | 2 to 25 Years |
| Buildings and Improvements | 2 to 25 Years |
| Equipment | 3 to 20 Years |

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Accreted Interest

Interest expense on capital appreciation bonds is being accreted on the straight-line basis to maturity of the individual bonds, which approximates interest accreted on the effective interest method.

### Bond Premiums

Bond premiums relating to the General Obligation Bonds are netted against the debt payable on the Statement of Net Position. Bond premiums are amortized over the period the related obligation is outstanding using the straight-line method, which approximates the effective interest method. The amortization is included in interest expense.

### Compensated Absences

The District employees earn paid-time off (PTO) at varying rates, depending on years of service. PTO accumulates up to a specific amount, as defined in the District's employee manual. Employees are paid for accumulated PTO if employment is terminated. The liability for compensated absences is included with accrued salaries and benefits in the accompanying financial statements.

### Estimated Health Claims Payable

The District provides for self-insurance reserves for estimated incurred but not reported claims for its employee health plan. These reserves, which are included in current liabilities on the statement of net position, are estimated based upon historical submission and payment data, cost trends, utilization history, and other relevant factors. Adjustments to reserves are reflected in the operating results in the period in which the change in estimate is identified.

### 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 does not pay state unemployment tax.

### Retirement Plan

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Northern Inyo County Local Hospital District Retirement Plan (Plan) and additions to/deductions from the Plan's fiduciary 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.

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Deferred Outflows/Inflows of Resources

In addition to assets, the statement of financial position includes a separate section for deferred outflows of resources. Deferred outflows of resources represent a consumption of net assets that applies to a future period(s) and so will not be recognized as an outflow of resources (expense/expenditure) until then. The District has three items that qualify for reporting in this category It is the deferred charge on refunding reported in the statement of net position, the deferred amounts related to pensions, and the deferred amounts related to acquisitions. The deferred charge on refunding resulted from the difference between the carrying value of refunded debt and its reacquisition price. This amount is deferred and amortized over the shorter of the life of the refunded or refunding debt. The deferred amounts related to pensions relates to the differences between expected and actual experience, changes in actuarial assumptions, contributions made after the measurement date, and the net difference between estimated and actual investment earnings. The deferred amounts relate to the acquisition of Pioneer Medical Associates.

In addition to liabilities, the statement of financial position includes a separate section for deferred inflows of resources. Deferred inflows of resources represent an acquisition of net assets that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. The District has one item that qualifies for reporting in this category. It is the deferred amounts related to pensions for the differences between expected and actual experience and changes in actuarial assumptions.

### Property Tax

Property taxes are levied by the County on the District's behalf and are intended to support operations and to service debt. The amount of property tax received is dependent upon the assessed real property valuations as determined by the County Assessor. Secured property taxes are levied July 1 and are due in two equal installments on November 1 and February 1 each year and are delinquent if not paid by December 10 and April 10. Secured property taxes become a lien on the property on January 1.

### Operating Revenues and Expenses

The District's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues of the District result from exchange transactions associated with providing healthcare services, the District's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as nonoperating.

## NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

### Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. 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 adjusted in future periods as final settlements are determined.

### Charity Care

The District provides healthcare services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the District does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was $31,340 for the year ended June 30, 2024, calculated by multiplying the ratio of cost to gross charges for the District by the gross uncompensated charges associated with providing charity care to its patients.

### Grants and Contributions

The District receives grants and contributions from governmental and private entities. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted for capital acquisitions are reported after nonoperating revenues and expenses.

### Right-of-Use Lease Asset and Liability

In June 2017, the Governmental Accounting Standards Board (GASB) issued GASB Statement No. 87, *Leases*. This standard requires the recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and as inflows of resources or outflows of resources recognized based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right-to-use an underlying asset. Under this standard, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources.

### Subscription-Based Information Technology Arrangements (SBITA)

SBITA assets are initially measured as the sum of the present value of payments expected to be made during the subscription term, payments associated with the SBITA contract made to the SBITA vendor at the commencement of the subscription term, when applicable, and capitalizable implementation costs, less any SBITA vendor incentives received from the SBITA vendor at the commencement of the SBITA term. SBITA assets are amortized in a systematic and rational manner over the shorter of the subscription term or the useful life of the underlying IT assets.

## NOTE 2 NET PATIENT SERVICE REVENUE

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare: Inpatient acute and outpatient services rendered to Medicare program beneficiaries are reimbursed primarily under a cost reimbursement methodology pursuant to the District's designation as a critical access hospital. Costs are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor (MAC). The District's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. Medicare cost reports have been audited by the fiscal intermediary through June 30, 2017.

Medi-Cal: Reimbursement for hospital inpatient services provided to Medi-Cal beneficiaries are based on a diagnosis-related group (DRG)-based methodology and uses the All-Patient Refined DRGs (APR- DRGs) algorithm. Medi-Cal cost reports have been audited through June 30, 2019. Outpatient services are paid at prospectively determined rates per procedure determined by the state of California.

Outpatient services delivered at the clinic are reimbursed using a prospectively determined payment system.

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 prospectively determined rates and discounts from established charges.

Patient revenue from the Medicare and Medi-Cal programs accounted for approximately 31% and 2% of the District's net patient service revenue for the year ended June 30, 2024.

Laws and regulations governing the Medicare, Medi-Cal, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The net patient service revenue for the year ended June 30, 2024 decreased by $-0- due to removal of allowances previously estimated that are no longer necessary as a result of final settlements, adjustments to amounts previously estimated and years that are no longer likely subject to audits, reviews, and investigations.

### Medi-Cal Payments

California legislation (AB-915) provides for a Medi-Cal supplemental payment for Medi-Cal outpatient hospital services. As a result of this program, payments received were $1,697,061 in the year ended June 30, 2024.

## NOTE 2 NET PATIENT SERVICE REVENUE (CONTINUED)

**Medi-Cal Payments (Continued)**

The California Department of Healthcare Services (DHCS) implemented The Hospital Quality Assurance Fee (HQAF) program in 2010. The program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The District received $599,868 in the year ended June 30, 2024, under this program.

California legislation also provides for a Nondesignated Public Hospital Intergovernmental Transfer Program (IGT) for additional payments for outpatient managed care hospital services. As a result of this program, net payments recognized were $9,587,089 in the year ended June 30, 2024. Amounts due under this program total $1,648,130 as of June 30, 2024 and are reported as other receivables on the statement of net position.

The District records these amounts as other operating revenue, when the revenue is estimable and is reasonably assured of being collected, generally when payments are received or expected to be received.

## NOTE 3 DEPOSITS AND INVESTMENTS

The carrying amounts of deposits and investments as of June 30, 2024 are as follows:

| | |
|---|---|
| Carrying Amount | |
| Petty Cash | $ 2,051 |
| Cash and Deposits | 21,848,570 |
| Investments | 6,912,158 |
| Total | $ 28,762,779 |

Deposits and investments are reported in the following statement of net position captions:

| | |
|---|---|
| Cash and Investments | $ 27,284,892 |
| Restricted for Specific Operating Purposes and Capital Improvements | 1,467,786 |
| Restricted for Debt Service Reserve | 10,101 |
| Total | $ 28,762,779 |

## NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

### Investments Authorized by the California Government Code and the Entity's Investment Policy

The table below identifies the investment types that are authorized for the District by the California Government Code (or the District's investment policy, where more restrictive). The table also identifies certain provisions of the California Government Code (or the District's investment policy, where more restrictive) that address interest rate risk, credit risk, and concentration of credit risk. This table does not address investments of debt proceeds held by bond trustee that are governed by the provisions of debt agreements of the District, rather than the general provisions of the California Government Code or the District's investment policy.

| Authorized Investment Type | Maximum Maturity | Maximum Percentage of Portfolio* | Maximum Investment in One Issuer |
|---|---|---|---|
| Local Agency Bonds | 5 Years | None | None |
| U.S. Treasury Obligations | 5 Years | None | None |
| U.S. Agency Securities | 5 Years | None | None |
| Banker's Acceptances | 180 Days | 40% | 30% |
| Commercial Paper | 270 Days | 25% | 10% |
| Negotiable Certificates of Deposit | 5 Years | 30% | None |
| Repurchase Agreements | 1 Year | None | None |
| Reverse Repurchase Agreements | 92 Days | 20% of Base Value | None |
| Medium-Term Notes | 5 Years | 30% | None |
| Mutual Funds | N/A | 20% | 10% |
| Money Market Mutual Funds | N/A | 20% | 10% |
| Mortgage Pass-Through Securities | 5 Years | 20% | None |
| County Pooled Investment Funds | N/A | None | None |
| Local Agency Investment Fund (LAIF) | N/A | None | $75M per Account |
| JPA Pools (Other Investment Pools) | N/A | None | None |

* Excluding amounts held by bond trustee that are not subject to CGC restrictions.

## NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

### Investments Authorized by Debt Agreements

Investment of debt proceeds held by bond trustee are governed by provisions of the debt agreements, rather than the general provisions of the California Government Code or the Entity's investment policy. The table below identifies the investment types that are authorized for investments held by bond trustee. The table also identifies certain provisions of these debt agreements that address interest rate risk, credit risk, and concentration of credit risk.

| Authorized Investment Type | Maximum Maturity | Maximum Percentage of Portfolio* | Maximum Investment in One Issuer |
|---|---|---|---|
| U.S. Treasury Obligations | None | None | None |
| U.S. Agency Securities | None | None | None |
| Banker's Acceptances | 180 Days | None | None |
| Commercial Paper | 270 Days | None | None |
| Money Market Mutual Funds | N/A | None | None |
| Investment Contracts | 30 Years | None | None |
| Local Agency Investment Fund (LAIF) | N/A | None | $75M per Account |

* Excluding amounts held by bond trustee that are not subject to CGC restrictions.

### Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. One of the ways that the District manages its exposure to interest rate risk is by purchasing a combination of shorter term and longer term investments and by timing cash flows from maturities so that a portion of the portfolio is maturing or coming close to maturity evenly over time as necessary to provide the cash flow and liquidity needed for operations. Information about the sensitivity of the fair values of the District's investments (including investments held by bond trustee) to market interest rate fluctuation is provided by the following table that shows the distribution of the District's investments by maturity at June 30, 2024:

| | | | Investment Maturities (in Years) | | |
|---|---|---|---|---|---|
| Investment Type | Carrying Amount | Rating | Less Than 1 | 1-5 | 6-10 |
| Certificates of Deposits | $ 1,590,923 | P-1/Aa1 | $ 1,590,923 | $ - | $ - |
| Mutual Funds | 89,604 | AAAm | 89,604 | - | - |
| Equities | 69,875 | AAAm | 69,875 | - | - |
| Local Agency Investment Fund | 5,161,756 | Not Rated | 5,161,756 | - | - |
| Total | $ 6,912,158 | | $ 6,912,158 | $ - | $ - |

### Credit Risk

Generally, 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 the assignment of a rating by a nationally recognized statistical rating organization. The CGC limits the minimum rating required for each investment type. The LAIF is not rated.

## NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

### Custodial Credit Risk

Custodial credit risk for *deposits* is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for *investments* is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code and the District's investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits or investments, other than the following provision for deposits: 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 the District's deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits.

As of June 30, 2024, $17,895,773 of the District's deposits with financial institutions in excess of federal depository insurance limits were held in uncollateralized accounts.

### Investment in State Investment Pool

The District is a voluntary participant in the Local Agency Investment Fund (LAIF) that is regulated by the California Government Code 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.

## NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

### Fair Value Measurements

Assets measured at fair value on a recurring basis and the related fair value of these assets as of June 30, 2024 are as follows:

| Investments by Fair Value | Fair Value | Quoted Prices in Active Markets for Identical Assets (Level I) | Significant Other Observable Inputs (Level 2) | Significant Unobservable Inputs (Level 3) |
|---|---|---|---|---|
| District Investments: | | | | |
| Certificates of Deposit | $ 1,590,923 | $ 1,590,923 | $ - | $ - |
| Mutual Funds | 89,604 | 89,604 | - | - |
| Equities | 69,875 | 69,875 | - | - |
| Total District Investments Measured at Fair Value | 1,750,402 | $ 1,750,402 | $ - | $ - |
| Investments not Measured at Fair Value or Subject to Fair Value Hierarchy: | | | | |
| Local Agency Investment Fund | 5,161,756 | | | |
| Total District Investments | $ 6,912,158 | | | |

The value of publicly-traded assets, which would be listed as Level 1, are based on unaffiliated industry sources believed to be reliable. Values for nonpublicly traded assets, listed as Level 2, may be determined from other unaffiliated sources. Assets for which a current value is unavailable, which would be listed as Level 3, may be reflected at the last reported price or at par, using the best information available in the circumstances.

The District's investments in traded certificates of deposit and U.S. Government obligations, which are reported in short-term and long-term investments, are based on quoted market prices for identical investments in an inactive market or similar investments in markets that are either active or inactive. Guaranteed investment contracts are valued at cost.

Deposits and withdrawals in governmental investment pools, such as LAIF are made on the basis of $1 and not fair value. Accordingly, the District's proportionate share in these types of investments is an uncategorized input not defined as a Level 1, Level 2, or Level 3 input.

### 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 a trust company.

## NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

### Pension Plan Investment Policy

The Plan's investment policy authorizes the Plan to invest in all investments allowed by state statue. These include deposits/investments in insured commercial banks, savings and loan institutions, interest-bearing obligations of the U.S. Treasury and U.S. agencies, interest-bearing bonds of the state of California or any county, township, or municipal corporation of the state of California, money market mutual funds whose investments consist of obligations of the U.S. Treasury or U.S. agencies, separate accounts managed by life insurance companies, mutual funds, and California Funds (created by the State Legislature under the control of the State Treasurer that maintains a $1 per share value, which is equal to the participant's fair value). During the year ended June 30, 2024, there were no changes to the investment policy.

### Pension Plan 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 Plan has and investment policy that limit investment choices by credit rating.

| Investment Type | Carrying Amount | Rating | Investment Maturities (in Years) | | |
|---|---|---|---|---|---|
| | | | Less Than 1 | 1-5 | 6-10 |
| Mutual Funds | $ 5,136,050 | AA+ | $ 5,136,050 | $ - | $ - |
| Indexed Bond Fund | 5,020,105 | A | 5,020,105 | - | - |
| Total | $ 10,156,155 | | $ 10,156,155 | $ - | $ - |

### Pension Plan Custodial Credit Risk

For an investment, custodial credit risk is the risk that, in the event of the failure of the counter party (e.g., broker-dealer) to the transaction, the Plan will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The Plan's investment policies do not limit the exposure to custodial credit risk for investments.

### Pension Plan Fair Value Measurements

The District's retirement system investments are stated at net asset value (NAV) and fair value. The fixed dollar fund is stated at NAV, which is determined based on the total value of all investments in its portfolio minus the value of liabilities. The index bond fund is stated at fair value and is considered a Level 2 investment on the fair value hierarchy. The fixed dollar fund is stated at cost.

## NOTE 4 PATIENT RECEIVABLES, NET

Patient receivables - net for the District consisted of the following at June 30, 2024:

| | |
|---|---|
| Gross Accounts Receivable | $ 56,030,076 |
| Less: | |
| Contractual Adjustments | (24,401,108) |
| Provision for Uncollectible Accounts | (13,676,682) |
| Patient Receivables, Net | $ 17,952,286 |

## NOTE 5 NET PATIENT SERVICE REVENUE

Net patient service revenue for the District consisted of the following for the year ended June 30, 2024:

| | |
|---|---|
| Gross Patient Service Revenue | $ 226,785,516 |
| Less: | |
| Contractual Adjustments | (114,724,328) |
| Provision for Uncollectible Accounts | (7,438,714) |
| Net Patient Service Revenue | $ 104,622,474 |

## NOTE 6 CAPITAL ASSETS

Capital assets additions, retirements, transfers and balances for the year ended June 30, 2024 are as follows:

| | Balance July 1, 2023 | Additions | Transfers and Retirements | Balance June 30, 2024 |
|---|---|---|---|---|
| Capital Assets not Being Depreciated: | | | | |
| Land | $ 1,353,966 | $ - | $ - | $ 1,353,966 |
| Construction in Progress | 8,939,124 | 3,075,361 | (1,493,326) | 10,521,159 |
| Total Capital Assets not Being Depreciated | 10,293,090 | 3,075,361 | (1,493,326) | 11,875,125 |
| Capital Assets Being Depreciated: | | | | |
| Land Improvements | 867,086 | - | - | 867,086 |
| Buildings and Improvements | 92,336,294 | 100,045 | 65,583 | 92,501,922 |
| Equipment | 37,971,220 | 823,490 | 1,386,390 | 40,181,100 |
| Total Capital Assets Being Depreciated | 131,174,600 | 923,535 | 1,451,973 | 133,550,108 |
| Lease Assets Being Amortized: | | | | |
| Equipment | 1,813,065 | 399,606 | (1,574,379) | 638,292 |
| SBITAs | 9,112,239 | 577,228 | | 9,689,467 |
| Total Lease Assets Being Amortized | 10,925,304 | 976,834 | (1,574,379) | 10,327,759 |
| Less Accumulated Depreciation for: | | | | |
| Land Improvements | 783,009 | 4,260 | - | 787,269 |
| Buildings and Improvements | 30,525,613 | 2,537,645 | - | 33,063,258 |
| Equipment | 33,409,887 | 1,040,971 | - | 34,450,858 |
| Total Accumulated Depreciation | 64,718,509 | 3,582,876 | - | 68,301,385 |
| Net Capital Assets Being Depreciated | 66,456,091 | (2,659,341) | 1,451,973 | 65,248,723 |
| Less Lease Asset Accumulated Amortization for: | | | | |
| Equipment | 1,364,858 | 354,258 | (1,574,379) | 144,737 |
| SBITAs | 1,173,704 | 1,249,667 | - | 2,423,371 |
| Total Accumulated Amortization | 2,538,562 | 1,603,925 | (1,574,379) | 2,568,108 |
| Net Lease Assets Being Amortized | 8,386,742 | (627,091) | - | 7,759,651 |
| Capital Assets, Net | $ 85,135,923 | $ (211,071) | $ (41,353) | $ 84,883,499 |

Depreciation expense for the year ended June 30, 2024 was $3,963,056 and is reported with depreciation and amortization expense on the statement of revenues, expenses and changes in net position.

Construction in progress at June 30, 2024 represents the ICU Building Retrofit, Chiller/Condenser Replacement and Pharmacy Building Constructions. The estimated cost to complete this project is $2.5 million with construction commitments of $2.5 million as of June 30, 2024, which will be financed with District funds.

## NOTE 7 LONG-TERM DEBT

Long-term debt consists of the following at June 30, 2024:

| | Balance July 1, 2023 | Additions | Deletions | Debt Forgiveness | Balance June 30, 2024 | Due Within One Year |
|---|---|---|---|---|---|---|
| General Obligation Bonds: | | | | | | |
| Direct Placement - 2016 General Obligation Refunding Bonds | $ 15,323,000 | $ - | $ (725,000) | $ - | $ 14,598,000 | $ 761,000 |
| 2009 General Obligation Bonds | 6,907,915 | - | (329,855) | - | 6,578,060 | 345,909 |
| Revenue Bonds: | | | | | | |
| Direct Placement - Refunding Revenue Bonds, Series 2021A | 3,220,000 | - | - | - | 3,220,000 | - |
| Direct Placement - Refunding Revenue Bonds, Series 2021B | 8,005,000 | - | (665,000) | - | 7,340,000 | 670,000 |
| Subtotal Bonds Payable | 33,455,915 | - | (1,719,855) | - | 31,736,060 | 1,776,909 |
| Bond Premiums: | | | | | | |
| 2009 General Obligation Bonds | 203,263 | - | (37,644) | - | 165,619 | - |
| Total Bonds Payable | 33,659,178 | - | (1,757,499) | - | 31,901,679 | 1,776,909 |
| Accreted Interest - 2009 General: | | | | | | |
| Obligation Bonds | 16,540,170 | 1,136,040 | (685,145) | - | 16,991,065 | - |
| Financed Purchases - Direct Borrowings: | | | | | | |
| Equipment Purchase | 750,000 | - | - | (218,106) | 531,894 | 85,034 |
| Alcon | 102,764 | - | (22,208) | - | 80,556 | 23,448 |
| 7 Medical | 142,079 | - | (115,013) | - | 27,066 | 27,066 |
| Total Financed Purchase Obligations | 994,843 | - | (137,221) | (218,106) | 639,516 | 135,548 |
| Subtotal Long-Term Debt | 51,194,191 | 1,136,040 | (2,579,865) | (218,106) | 49,750,366 | 1,912,457 |
| Other Liabilities: | | | | | | |
| Direct Borrowings: | | | | | | |
| CHFFA Bridge Loan #1 | 497,000 | - | (497,000) | - | - | - |
| CHFFA Bridge Loan #2 | 484,877 | - | (484,877) | - | - | - |
| Total Long-Term Debt | $ 52,176,068 | $ 1,136,040 | $ (3,561,742) | $ (218,106) | $ 49,532,260 | $ 1,912,457 |

The terms and due dates of the District's general obligation bonds at June 30, 2024 are as follows:

### 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 consist 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. The Current Interest Bonds maturing through November 1, 2019 have been fully paid. The Term Bond maturing November 1, 2038 was partially extinguished in 2016 using proceeds from the issuance of the 2016 General Obligation Refunding Bond.

## NOTE 7 LONG-TERM DEBT (CONTINUED)

### General Obligation Bonds, 2009 Series (Continued)

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, including interest accreted through such maturity dates. The Capital Appreciation Bonds are not subject to redemption prior to their fixed maturity dates.

The District has pledged its tax revenue as security for the General Obligation Bonds, 2009 Series and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

The general obligation bonds are general obligations of the District. The District has the power and is obligated to cause to be levied and collected the annual ad valorem taxes for payment of the bonds and the interest thereon upon all property within the District and without limitation as to rate or amount.

Accreted interest is to be added to the Capital Appreciation Bonds in future years. Principal maturities, which commenced October 2021, and future accreted interest on the Capital Appreciation Bonds, are included in Accreted Interest Payable.

### Direct Placements

2016 General Obligation Refunding Bond

On May 12, 2016, the District issued $17,557,000 in a 2016 General Obligation Refunding Bond, to refinance the General Obligation Bonds, 2005 Series in whole and to pay the term portion of General Obligation Bonds, 2009.

Interest on the 2016 bond is payable semiannually on November 1 and May 1 at a rate of 3.450%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $278,000 to $1,874,000, are due annually through December 2035.

The District has pledged its tax revenue as security for the 2016 General Obligation Refunding Bond and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

The general obligation bonds are general obligations of the District. The District has the power and is obligated to cause to be levied and collected the annual ad valorem taxes for payment of the bonds and the interest thereon upon all property within the District and without limitation as to rate or amount.

## NOTE 7 LONG-TERM DEBT (CONTINUED)

### Direct Placements (Continued)

Refunding Revenue Bonds, Series 2021A

On December 1, 2021, the District issued $3,220,000 in a Refunding Revenue Bond, Series 2021A, to provide funds to refund, on a current basis, the District's Revenue Bonds, Series 2010 and paying the costs of issuing the 2021A bonds.

Interest on the Refunding Revenue Bonds, Series 2021A is payable semiannually on December 1 and June 1 at a rate of 3.50%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $380,000 to $$980,000, are due annually through December 2036.

The proceeds were used to refund on a current basis $4,170,000 of the outstanding Series 2010 bonds. The net proceeds of $4,209,137 (including $1,065,337 of existing 2010 debt service reserve funds and after payment of $76,200 in underwriting fees and other issuance costs) were deposited in an irrevocable trust with an escrow agent to provide funds for the future debt service payment on the refunded bonds. As a result, the 2010 Bonds are considered defeased and the liability for those bonds has been removed from the statement of net position. The reacquisition price exceeded the net carrying amount of the old debt by $39,137. This amount is reported as a deferred outflow of resources and amortized over the remaining life of the refunded debt, which had a shorter remaining life than the refunding debt. The advance refunding reduced its total debt service payments by $91,241 and to obtain an economic gain (difference between the present values of the debt service payments on the old and new debt) of $189,091. As a result, the Series 2010 bonds are considered defeased and the liability for those bonds has been removed from the statement of net position.

The District has pledged its gross revenue as security for the Refunding Revenue Bonds, Series 2021A and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment. The District is required to maintain a long-term debt service coverage ratio at the end of each fiscal year that is not less than 1.25 to 1 (or 1.1 to 1, if the District has 75 or more days cash on hand) and provide various reporting under the agreement.

Taxable Refunding Revenue Bonds, Series 2021B

On December 1, 2021 the District issued $8,625,000 in Taxable Refunding Revenue Bonds, to refund, on an advanced basis, the District's Revenue Bonds, Series 2013 and paying the cost of issuing the 2021B Bonds.

Interest on Taxable Refunding Revenue Bonds, Series 2021B is payable semiannually on December 1 and June 1 at rates ranging from 2.93% to 3.200%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $505,000 to $860,000, are due annually through December 2033.

## NOTE 7 LONG-TERM DEBT (CONTINUED)

### Direct Placements (Continued)

Taxable Refunding Revenue Bonds, Series 2021B (Continued)

The proceeds were used to advance refund $8,360,000 of the outstanding Series 2013 bonds. The net proceeds of $9,011,315 (including $587,785 of existing 2013 debt service reserve funds and after payment of $201,470 in underwriting fees and other issuance costs) were deposited in an irrevocable trust with an escrow agent to provide funds for the future debt service payment on the refunded bonds. As a result, the 2013 Bonds are considered defeased and the liability for those bonds has been removed from the statement of net position. The reacquisition price exceeded the net carrying amount of the old debt by $555,251. This amount is reported as a deferred outflow of resources and amortized over the remaining life of the refunded debt, which had a shorter remaining life than the refunding debt. The advance refunding reduced its total debt service payments by $189,723 and to obtain an economic loss (difference between the present values of the debt service payments on the old and new debt) of $154,639. As a result, the Series 2013 bonds are considered defeased and the liability for those bonds has been removed from the statement of net position.

The District has pledged its gross revenue as security for the Refunding Revenue Bonds, Series 2021B and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment. The District is required to maintain a long-term debt service coverage ratio at the end of each fiscal year that is not less than 1.25 to 1 (or 1.1 to 1, if the District has 75 or more days cash on hand) and provide various reporting under the agreement.

Defeased Debt

At June 30, 2024, $10,560,000 of the Series 2021 defeased revenue bonds remain outstanding.

### Direct Borrowings

Financed Purchases

Finance obligations to Intuitive Surgical are due in total monthly installments of $29,815 in May 2020 through 2024, including interest at 3.500%.

Finance obligations to Ascension Capital for 3C Cares are due in total monthly installments of $5,447 in October 2021 through 2025, including interest at 2.500%.

Finance obligations are secured by equipment and contain provisions that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

## NOTE 7 LONG-TERM DEBT (CONTINUED)

### Direct Borrowings (Continued)

Purchase Agreement

Purchase agreement with Stryker Mako with an original principal amount of $750,000, with payments due in annual installments of $119,936 due March 2023 through 2029, including interest at 2.900%.

Nondesignated Public Hospital Bridge Loan Program

In September 2021, the Governor signed into law the Nondesignated Public Hospital Bridge Loan Program (NDPH Program), which enables California Health Facilities Financing Authority (CHFFA) to issue up to a total of $40 million in working capital loans. The NDPH Program provides zero interest rate low-cost loans to eligible nondesignated public hospitals (as defined in paragraph (25) of subdivision (a) of Section 14105.98 of the Welfare and Institutions Code, excluding designated public hospitals) that are affected by financial delays associated with the transition from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program to the Quality Incentive Program (QIP). These loans are required to be paid back in two years. The loans issued by CHFFA are secured by a borrower's Medi-Cal reimbursements.

Scheduled principal and interest payments on long-term debt are as follows:

| | General Obligation Bonds | | Revenue Bonds | | Direct Borrowings | | Totals | |
|---|---|---|---|---|---|---|---|---|
| Year Ending June 30, | Principal | Interest | Principal | Interest | Principal | Interest | Principal | Interest |
| 2025 | $ 1,106,909 | $ 1,294,595 | $ 670,000 | $ 336,860 | $ 135,548 | $ 19,602 | $ 1,912,457 | $ 1,651,057 |
| 2026 | 1,171,947 | 1,397,429 | 690,000 | 315,100 | 129,767 | 15,306 | 1,991,714 | 1,727,835 |
| 2027 | 1,232,891 | 1,503,299 | 710,000 | 292,700 | 134,037 | 11,036 | 2,076,928 | 1,807,035 |
| 2028 | 1,328,490 | 1,576,789 | 735,000 | 269,580 | 126,508 | 6,800 | 2,189,998 | 1,853,169 |
| 2029 | 1,363,759 | 1,730,192 | 755,000 | 245,740 | 113,656 | 3,383 | 2,232,415 | 1,979,315 |
| 2030-2034 | 9,057,218 | 9,600,905 | 4,160,000 | 843,410 | - | - | 13,217,218 | 10,444,315 |
| 2035-2039 | 5,914,846 | 12,750,081 | 2,840,000 | 151,375 | - | - | 8,754,846 | 12,901,456 |
| 2040-2044 | - | - | - | - | - | - | - | - |
| Subtotal | $ 21,176,060 | $ 29,853,290 | $ 10,560,000 | $ 2,454,765 | $ 639,516 | $ 56,127 | 32,375,576 | $ 32,364,182 |
| | | | | | Premium on Bonds | | 165,619 | |
| | | | | | Accreted Interest | | 16,991,065 | |
| | | | | | Total | | $ 49,532,260 | |

Under the terms of the revenue bonds and general obligation bonds agreements, the District is required to maintain certain deposits with a trustee. Such deposits are included with assets limited as to use in the financial statements. The loan agreement also places limits on the incurrence of additional borrowings and requires that the District satisfy certain measures of financial performance.

## NOTE 8 LEASES AND SBITAS

Lease obligations and receivables consist of the following for the year ended June 30, 2024:

| | Balance July 1, 2023 | Additions | Deletions | Balance June 30, 2024 | Due Within One Year |
|---|---|---|---|---|---|
| Lease Liabilities | $ 482,648 | $ 399,606 | $ (370,888) | $ 511,366 | $ 131,318 |
| Lease Receivables | $ 68,610 | $ - | $ (24,140) | $ 44,470 | $ 24,140 |

Total future minimum lease payments under lease agreements are as follows:

| Year Ending June 30, | Principal | Interest | Total |
|---|---|---|---|
| 2025 | $ 131,318 | $ 155,900 | $ 287,218 |
| 2026 | 137,315 | 153,989 | 291,304 |
| 2027 | 118,815 | 127,790 | 246,605 |
| 2028 | 107,521 | 110,500 | 218,021 |
| 2029 | 16,397 | 16,527 | 32,924 |
| Total Minimum Lease Payments | $ 511,366 | $ 564,706 | $ 1,076,072 |

SBITA obligations consist of the following for the year ended June 30, 2024:

| | Balance July 1, 2023 | Additions | Deletions | Balance June 30, 2024 | Due Within One Year |
|---|---|---|---|---|---|
| SBITA Liabilities | $ 8,034,167 | $ 577,228 | $ (1,176,680) | $ 7,434,715 | $ 1,202,223 |

Total future minimum payments under SBITA agreements are as follows:

| Year Ending June 30, | Principal | Interest | Total |
|---|---|---|---|
| 2025 | $ 1,202,223 | $ 246,427 | $ 1,448,650 |
| 2026 | 1,236,304 | 211,623 | 1,447,927 |
| 2027 | 1,224,690 | 134,444 | 1,359,134 |
| 2028 | 1,248,637 | 91,427 | 1,340,064 |
| 2029 | 1,269,312 | 53,920 | 1,323,232 |
| Thereafter | 1,253,549 | 18,206 | 1,271,755 |
| Total Minimum Lease Payments | $ 7,434,715 | $ 756,047 | $ 8,190,762 |

## NOTE 9 RETIREMENT PLANS

### Defined Benefit Plan - Plan Description

The District sponsors a single-employer defined benefit pension plan for employees over age 21 with at least one year of service. The plan is governed by the District's 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. A separate financial report is not prepared for the plan.

## NOTE 9 RETIREMENT PLANS (CONTINUED)

### Benefits Provided

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 five years of service. The benefit vesting schedule is 50% vesting after five years, increasing 10% per year to 100% vested after 10 years of service. The Plan was closed to new entrants effective January 1, 2013.

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, 2024 are summarized as follows:

| | |
|---|---|
| Hire Date | Prior to January 1, 2013 |
| Benefit Payments | Life Annuity or Lump Sum |
| Retirement Age | 65 to 70 Years |
| Monthly Benefits, as a % of Eligible Compensation | 2.5%, Not Less Than $600 |
| Required Employer Contribution Rates | 55.0% |
| Required Employee Contribution Rates | 3.5% |

Employees covered at December 31, 2023, by the benefit terms for the Plan are as follows:

| | |
|---|---|
| Inactive Employees or Beneficiaries Currently Receiving Benefits | 15 |
| Inactive Employees Entitled to but Not Yet Receiving Benefits | 68 |
| Active Employees | 81 |
| Total | 164 |

### Contributions

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 are 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. For the year ended June 30, 2024, the employer contribution was $5,331,816.

### Rate of Return

For the year ended December 31, 2023, the annual money-weighted rate of return on pension plan investments, net of pension plan investment expense, was -10.45%. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

## NOTE 9 RETIREMENT PLANS (CONTINUED)

### Concentration of Credit Risk

The Plan's policy does not limit the percentage of any asset in the Plan portfolio. The composition of plan assets consisted of the following at December 31, 2023:

| Asset Allocation | Percent of Total Plan Assets |
|---|---|
| Cash and Cash Equivalents | 16.4 % |
| Mutual Funds | 42.3 |
| Indexed Bond Fund | 41.3 |
| Total | 100.0 % |

### Net Pension Liability

The District's net pension liability was measured as of December 31, 2023, and the total pension liability used to calculate the net pension liability was determined by an actuarial as of December 31, 2023.

*Actuarial Assumptions* - The total pension liability in the January 1, 2023 actuarial valuation were determined using the following actuarial assumptions:

| | |
|---|---|
| Valuation Date | January 1, 2023 |
| Measurement Date | December 31, 2023 |
| Actuarial Cost Method | Entry-Age Normal Cost Method |
| Actuarial Assumptions: | |
| Discount Rate | 6.25% |
| Projected Salary Increase | 5.25% |
| Investment Rate of Return | 6.25% |

Mortality rates for pre-retirement were based on the RP-2014 scale adjusted to 2006 Total Dataset Mortality Table projected to the valuation date with Scale MP-2021. Mortality rates for post-retirement (Lump-Sum) were based date of participation (DOP). DOP before July 1, 2009 based on the 1984 Uninsured Pensioner Mortality Table (UP) set back four years. DOP on or after July 1, 2009 based on the RP-2000 Table for Males set back four years.

The long-term expected rate of return on plan investments was determined using a building block method which best estimate ranges of expected future real rates of return (expected return, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The table below reflects geometric average 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 geometric rates of return are net of administrative expenses.

## NOTE 9 RETIREMENT PLANS (CONTINUED)

### Net Pension Liability (Continued)

| Asset Class | Asset Allocation | Long-Term Expected Real Rate of Return |
|---|---|---|
| Large Cap | 41.00 % | 5.10 % |
| Mid/Small Cap | 30.00 | 2.06 |
| International | 22.00 | 5.73 |
| Specialty/Alts | 7.00 | 3.12 |
| Total | 100.00 % | |

*Discount Rate* – The discount rate used to measure the total pension liability was 6.25% for the plan. The project of cash flows used to determine the discount rate assumed that employee contributions will be made at the current contribution rate and that the District's contributions will be made at rates equal to the difference between actuarially determined contribution rates and the employee rate. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

### Changes in the Net Pension Liability

The changes in the net pension liability for the plan are as follows:

| | Increase (Decrease) | | |
|---|---|---|---|
| | Total Pension Liability | Plan Fiduciary Net Position | Net Pension Liability(Asset) |
| Balance at December 31, 2021 | $ 59,354,999 | $ 12,097,336 | $ 47,257,663 |
| Changes in the Year: | | | |
| Service Cost | 1,240,702 | - | 1,240,702 |
| Interest on Total Pension Liability | 2,346,115 | - | 2,346,115 |
| Differences between Expected and Actual Experience | 1,766,631 | - | 1,766,631 |
| Change of Assumptions | (15,685,950) | - | (15,685,950) |
| Contribution - Employer | - | 5,331,816 | (5,331,816) |
| Net Investment Income | - | (1,336,658) | 1,336,658 |
| Benefit Payments Including Refunds of Member Contributions | (3,924,140) | (3,924,140) | - |
| Administrative Expense | - | (16,352) | 16,352 |
| Net Changes | (14,256,642) | 54,666 | (14,311,308) |
| Balance at December 31, 2022 | $ 45,098,357 | $ 12,152,002 | $ 32,946,355 |

## NOTE 9 RETIREMENT PLANS (CONTINUED)

### Changes in the Net Pension Liability (Continued)

*Sensitivity of the Net Pension Liability to Changes in the Discount Rate* – The following presents the net pension liability of the District calculated using the discount rate of 6.25%, as well as what the District's 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.

| | 1% Decrease (5.25%) | Current Discount Rate (6.25%) | 1% Increase (7.25%) |
|---|---|---|---|
| District Net Pension Liability | $ 39,085,344 | $ 32,946,355 | $ 27,853,740 |

### Pension Expenses and Deferred Outflows/Inflows of Resources Related to Pensions

For the fiscal year ended June 30, 2024, the District recognized pension expense of $3,621,047. At June 30, 2024, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

| | Deferred Outflows of Resources | Deferred Inflow of Resources |
|---|---|---|
| Differences Between Expected and Actual Experience | $ 5,943,757 | $ (265,173) |
| Changes of Assumptions | 3,639,247 | (12,291,188) |
| Net Differences Between Projected and Actual Earnings on Plan Investments | 763,486 | - |
| Contributions Made Subsequent to the Measurement Date | 3,535,967 | - |
| Total | $ 13,882,457 | $ (12,556,361) |

Amounts reported as deferred outflows and deferred inflows of resources related to pensions will be recognized in future pension expense as follows:

| Year Ending June 30, | Amount |
|---|---|
| 2025 | $ 46,855 |
| 2026 | (625,048) |
| 2027 | (1,180,857) |
| 2028 | (514,681) |
| 2029 | 63,860 |
| Total | $ (2,209,871) |

## NOTE 9 RETIREMENT PLANS (CONTINUED)

**Defined Contribution Plan – Plan Description**

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 have attained the age of 21 years and were not a participant in the District's defined benefit plan prior to January 1, 2013, and completed 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's board of directors. Beginning August 1, 2023 for each employee in the pension plan, the District is required to match up to 3.5% of contributions elected by employees who are allowed to contribute to the plan. Employees are not permitted to make contributions to the pension plan. The District does not contribute to this plan if an employee does not elect to contribute. For the year ended June 30, 2024, the District made employer contributions in the amount of $1,030,617.

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 |

## NOTE 10 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 $3,000,000 per claim with $3,000,000 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.

## NOTE 10 RISK MANAGEMENT (CONTINUED)

Although there exists the possibility of claims arising from services provided to patients through June 30, 2024, 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.

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; the premium is adjusted annually. If participation in the ALPHA Fund were 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 11 SELF-INSURED HEALTHCARE PLAN

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 $215,000. The District records a liability for claims incurred but not reported that is recorded in accrued payroll and related liabilities in the accompanying statements of net position.

| Year | Beginning Liability | Current Year Claims and Changes in Estimates | Claim Payments | Ending Liability |
|---|---|---|---|---|
| 2023 | $ (1,202,957) | $ (9,789,013) | $ 10,242,689 | $ (749,280) |
| 2024 | (749,280) | (12,777,176) | 12,679,129 | (847,327) |

## NOTE 12 CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at June 30, 2024 was as follows:

| | |
|---|---|
| Medicare | 25.0 % |
| MediCal | 32.0 |
| Other Third-Party Payors | 34.0 |
| Patients | 9.0 |
| Total | 100.0 % |

## NOTE 13 CONTINGENCIES

### Malpractice Insurance

The District has malpractice insurance coverage to provide protection for professional liability losses on claims-made basis subject to a limit of $6 million per claim and an annual aggregate limit of $20 million. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured.

### Litigation, Claims, and Disputes

The District is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs or operating activities, some of which could be material. In the opinion of management, the ultimate settlement of litigation, claims, and disputes will not be material to the financial position, operations, or cash flows of the District.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Department of Health and Human Services (HHS) and 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. Federal government activity has increased with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

## NOTE 14 CONDENSED COMBINING INFORMATION

Statement of net position as of June 30, 2024:

| | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| **Assets and Deferred Outflows of Resources** | | | | |
| Assets: | | | | |
| Current Assets | $ 54,601,568 | $ 209,125 | $ 77,514 | $ 54,888,207 |
| Capital Assets, Net | 84,883,499 | - | - | 84,883,499 |
| Other Assets | 1,477,887 | - | - | 1,477,887 |
| Total Assets | 140,962,954 | 209,125 | 77,514 | 141,249,593 |
| Deferred Outflows of Resources: | 14,741,632 | - | - | 14,741,632 |
| Total Assets and Deferred Outflows of Resources | 155,704,586 | 209,125 | 77,514 | 155,991,225 |
| **Liabilities, Deferred Inflows of Resources, and Net Position** | | | | |
| Liabilities: | | | | |
| Current Liabilities | 13,735,450 | 63 | - | 13,735,513 |
| Long-Term Liabilities | 87,178,697 | - | - | 87,178,697 |
| Total Liabilities | 100,914,147 | 63 | - | 100,914,210 |
| Deferred Inflows of Resources | 12,599,823 | - | - | 12,599,823 |
| Net Position: | | | | |
| Net Investment in Capital Assets | 27,405,158 | - | - | 27,405,158 |
| Restricted | 1,467,668 | - | - | 1,467,668 |
| Unrestricted | 13,317,790 | 209,062 | 77,514 | 13,604,366 |
| Total Net Position | 42,190,616 | 209,062 | 77,514 | 42,477,192 |
| Total Liabilities, Deferred Inflows of Resources and Net Position | $ 155,704,586 | $ 209,125 | $ 77,514 | $ 155,991,225 |

Operating results and changes in net position for the year ended June 30, 2024:

| | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| **OPERATING REVENUES** | | | | |
| Net Patient Service Revenue | $ 104,622,474 | $ - | $ - | $ 104,622,474 |
| Other Operating Revenue | 2,577,264 | 7,859 | 31,999 | 2,617,122 |
| Total Operating Revenues | 107,199,738 | 7,859 | 31,999 | 107,239,596 |
| **OPERATING EXPENSES** | | | | |
| Depreciation and Amortization | 5,209,724 | - | - | 5,209,724 |
| Other Operating Expenses | 106,733,041 | 9,531 | 15,954 | 106,758,526 |
| Total Operating Expenses | 111,942,765 | 9,531 | 15,954 | 111,968,250 |
| **OPERATING LOSS** | (4,743,027) | (1,672) | 16,045 | (4,728,654) |
| **NET NONOPERATING REVENUES** | 10,454,194 | 23,029 | - | 10,477,223 |
| Revenues in Excess of (Less Than) Expenses and Change in Net Position | 5,711,167 | 21,357 | 16,045 | 5,748,569 |
| Net Position - Beginning of Year | 36,479,449 | 187,705 | 61,469 | 36,728,623 |
| **NET POSITION - END OF YEAR** | $ 42,190,616 | $ 209,062 | $ 77,514 | $ 42,477,192 |

## NOTE 14 CONDENSED COMBINING INFORMATION (CONTINUED)

Statement of cash flows as of June 30, 2024:

| | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| Net Cash Provided (Used) by Operating Activities | $ (7,676,146) | $ (1,672) | $ 16,045 | $ (7,661,773) |
| Net Cash Provided (Used) by Noncapital Financing Activities | 10,752,209 | 18,605 | - | 10,770,814 |
| Net Cash Provided (Used) by Capital and Capital Related Financing Activities | (8,573,272) | - | - | (8,573,272) |
| Net Cash Provided (Used) by Investing Activities | 227,727 | 4,424 | - | 232,151 |
| **NET CHANGE IN CASH AND CASH EQUIVALENTS** | (5,269,482) | 21,357 | 16,045 | (5,232,080) |
| Cash and Cash Equivalents - Beginning of Year | 33,745,622 | 187,768 | 61,469 | 33,994,859 |
| **CASH AND CASH EQUIVALENTS - END OF YEAR** | $ 28,476,140 | $ 209,125 | $ 77,514 | $ 28,762,779 |

## NOTE 15 RELATED PARTY TRANSACTIONS

In the ordinary course of business, the District has and expects to continue to have transactions with its employees and elected officials. In the opinion of management, such transactions were on substantially the same terms, including interest rates and collateral, as those prevailing at the time of comparable transactions with other persons and did not involve more than a normal risk of collectability or present any other unfavorable features to the District.

# NORTHERN INYO HEALTHCARE DISTRICT
# SCHEDULE OF CHANGES IN THE NET PENSION LIABILITY AND RELATED RATIOS – PENSION PLAN
# LAST TEN FISCAL YEARS

| | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Pension Liability: | | | | | | | | | | |
| Service Cost | $ 1,240,702 | $ 1,376,714 | $ 1,706,921 | $ 1,951,401 | $ 1,781,772 | $ 2,121,997 | $ 2,281,116 | $ 2,812,178 | $ 2,219,985 | $ 2,683,298 |
| Interest on the Total Pension Liability | 2,346,115 | 2,183,032 | 2,179,367 | 2,298,637 | 2,694,973 | 2,726,359 | 2,805,649 | 3,053,437 | 3,047,939 | 3,356,235 |
| Differences Between Expected and Actual Experience | 1,766,631 | 3,910,725 | 769,805 | 880,397 | 2,640,361 | 3,016,650 | 1,343,607 | (3,295,677) | 1,385,608 | 108,261 |
| Changes in Assumptions | (15,685,950) | - | 96,057 | 1,737,567 | 6,850,017 | (84,200) | (185,137) | (417,283) | 12,966,856 | (1,841,294) |
| Benefit Payments | (3,924,140) | (2,603,583) | (6,023,511) | (13,117,516) | (8,053,422) | (8,082,821) | (5,554,354) | (7,575,753) | (8,213,871) | (9,321,220) |
| Net Change in Total Pension Liability | (14,256,642) | 4,866,888 | (1,271,361) | (6,249,514) | 5,913,701 | (302,015) | 690,881 | (5,423,098) | 11,406,517 | (5,014,720) |
| Total Pension Liability - Beginning | 59,354,999 | 54,488,111 | 55,759,472 | 62,008,986 | 56,095,285 | 56,397,300 | 56,575,151 | 61,998,249 | 50,591,732 | 55,606,452 |
| Total Pension Liability - Ending (a) | $ 45,098,357 | $ 59,354,999 | $ 54,488,111 | $ 55,759,472 | $ 62,008,986 | $ 56,095,285 | $ 57,266,032 | $ 56,575,151 | $ 61,998,249 | $ 50,591,732 |
| Plan Fiduciary Net Position: | | | | | | | | | | |
| Contributions - Employer | $ 5,331,816 | $ 7,403,934 | $ 347,300 | $ 3,000,000 | $ 5,242,000 | $ 6,300,000 | $ 5,340,000 | $ 5,340,000 | $ 3,900,000 | $ 4,320,000 |
| Net Investment Income (Loss) | (1,336,658) | 817,781 | 2,082,706 | (746,702) | 1,893,587 | (116,063) | (292,381) | (126,769) | 880,376 | 1,223,136 |
| Benefit Payments | (3,924,140) | (2,603,583) | (6,023,511) | (13,117,516) | (8,053,422) | (8,082,821) | (5,554,354) | (7,575,753) | (8,213,871) | (9,321,220) |
| Administrative Expense | (16,352) | (58,167) | (57,983) | (54,472) | (58,625) | (64,562) | (88,502) | (55,640) | (51,336) | - |
| Net Change in Plan Fiduciary Net Position | 54,666 | 5,559,965 | (3,651,488) | (10,918,690) | (976,460) | (1,963,446) | (595,237) | (2,418,162) | (3,484,831) | (3,778,084) |
| Plan Fiduciary Net Position - Beginning | 12,097,336 | 6,537,371 | 10,188,859 | 21,107,549 | 22,084,009 | 24,047,455 | 26,087,619 | 28,505,781 | 31,990,612 | 35,768,696 |
| Plan Fiduciary Net Position - Ending (b) | 12,152,002 | 12,097,336 | 6,537,371 | 10,188,859 | 21,107,549 | 22,084,009 | 25,492,382 | 26,087,619 | 28,505,781 | 31,990,612 |
| Net Pension Liability - Ending (a)-(b) | $ 32,946,355 | $ 47,257,663 | $ 47,950,740 | $ 45,570,613 | $ 40,901,437 | $ 34,011,276 | $ 31,773,650 | $ 30,487,532 | $ 33,492,468 | $ 18,601,120 |
| Plan Fiduciary Net Position as a Percentage of the Total Pension Liability | | | | | | | | | | |
| Covered Payroll | $ 8,563,359 | $ 8,609,073 | $ 9,243,630 | $ 9,302,388 | $ 10,780,522 | $ 11,537,345 | $ 12,968,106 | $ 13,529,712 | $ 15,892,425 | $ 17,664,833 |
| Net Pension Liability as Percentage of Covered Payroll | 384.74 % | 548.93 % | 518.74 % | 489.88 % | 379.40 % | 294.79 % | 245.01 % | 225.34 % | 210.74 % | 105.30 % |
| Measurement Date | December 31, 2023 | December 30, 2022 | December 30, 2021 | December 31, 2020 | December 31, 2019 | December 31, 2018 | December 31, 2017 | December 31, 2016 | December 31, 2015 | December 31, 2014 |

# NORTHERN INYO HEALTHCARE DISTRICT
# SCHEDULE OF CONTRIBUTIONS – PENSION PLAN
# LAST TEN FISCAL YEARS

| | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|
| Actuarially Determined Contribution | $ 4,730,922 | $ 4,960,082 | $ 9,056,000 | $ 7,752,000 | $ 6,072,000 | $ 5,484,000 | $ 4,716,000 | $ 5,340,000 | $ 3,900,000 | $ 4,320,000 |
| Contributions in Relation to the Actuarily Determined Contributions | 4,743,446 | 5,973,722 | 5,599,234 | 3,000,000 | 5,500,000 | 6,060,000 | 5,340,000 | 5,340,000 | 3,900,000 | 4,320,000 |
| Contribution Deficiency (Excess) | $ (12,524) | $ (1,013,640) | $ 3,456,766 | $ 4,752,000 | $ 572,000 | $ (576,000) | $ (624,000) | $ - | $ - | $ - |
| Covered Payroll | $ 8,563,359 | $ 8,609,073 | $ 9,243,630 | $ 9,302,388 | $ 10,780,522 | $ 11,537,345 | $ 12,968,106 | $ 13,529,712 | $ 15,892,425 | $ 17,664,833 |
| Contributions as a Percentage of Covered Payroll | 55.39 % | 69.39 % | 60.57 % | 32.25 % | 51.02 % | 52.53 % | 41.18 % | 39.47 % | 24.54 % | 24.46 % |

Notes to Schedule:

Valuation Date: January 1, 2024

Methods and Assumptions Used to Determine Contribution Rates

| | |
|---|---|
| Actuarial Cost Method | Entry Age Normal Cost Method |
| Amortization Method | Level Percent of Payroll |
| Remaining Amortization Period | 15 Years |
| Asset Valuation Method | Market Value |
| Inflation | 2.40% |
| Salary Increases | 5.25%, Including Inflation |
| Investment Rate of Return | 6.25% |
| Retirement Age | 65 or 70 |

# NORTHERN INYO HEALTHCARE DISTRICT
# SCHEDULE OF INVESTMENT RETURNS – PENSION PLAN
# LAST TEN FISCAL YEARS

| | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|
| Annual Money-Weighted Rate of Return, Net of Investment Expense | (10.45)% | 9.33 % | 36.17 % | (4.36)% | 8.74 % | (0.47)% | (1.16)% | (0.48)% | 3.11 % | 3.86 % |

# NORTHERN INYO HEALTHCARE DISTRICT
# COMBINING STATEMENT OF NET POSITION
# JUNE 30, 2024

| Assets and Deferred Outflows of Resources | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| Current Assets: | | | | |
| Cash and Investments | $ 26,998,253 | $ 209,125 | $ 77,514 | $ 27,284,892 |
| Receivables: | | | | |
| Patient, Net of Estimated Uncollectibles | 17,952,286 | - | - | 17,952,286 |
| Leases Receivable | 44,470 | | | 44,470 |
| Estimated Third-Party Payor Settlements | (1,637,684) | - | - | (1,637,684) |
| Other Receivables | 3,115,972 | - | - | 3,115,972 |
| Inventory | 7,014,167 | - | - | 7,014,167 |
| Prepaid Expenses and Other Assets | 1,114,104 | - | - | 1,114,104 |
| Total Current Assets | 54,601,568 | 209,125 | 77,514 | 54,888,207 |
| Noncurrent Cash and Investments: | | | | |
| Restricted for Specific Operating Purposes and Capital Improvements | 1,467,786 | - | - | 1,467,786 |
| Restricted by Trustee for Debt Reserve | 10,101 | - | - | 10,101 |
| Total Noncurrent Cash and Investments | 1,477,887 | - | - | 1,477,887 |
| Capital Assets: | | | | |
| Capital Assets not Being Depreciated/Amortized | 11,875,125 | - | - | 11,875,125 |
| Capital Assets Being Depreciated/Amortized, Net | 73,008,374 | - | - | 73,008,374 |
| Total Capital Assets | 84,883,499 | - | - | 84,883,499 |
| Total Assets | 140,962,954 | 209,125 | 77,514 | 141,249,593 |
| Deferred Outflows of Resources: | | | | |
| Deferred Outflows Related to Pensions | 13,882,457 | - | - | 13,882,457 |
| Deferred Outflows Related to Refunding | 366,312 | - | - | 366,312 |
| Deferred Outflows Related to Acquisition | 492,863 | - | - | 492,863 |
| Total Deferred Outflows of Resources | 14,741,632 | - | - | 14,741,632 |
| Total Assets and Deferred Outflows of Resources | $ 155,704,586 | $ 209,125 | $ 77,514 | $ 155,991,225 |

# NORTHERN INYO HEALTHCARE DISTRICT
# COMBINING STATEMENT OF NET POSITION (CONTINUED)
# JUNE 30, 2024

| Liabilities, Deferred Inflows of Resources, and Net Position | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| Current Liabilities: | | | | |
| Current Maturities of Long-Term Debt | $ 1,912,457 | $ - | $ - | $ 1,912,457 |
| Current Maturities Related to Leases | 131,319 | - | - | 131,319 |
| Current Maturities Related to SBITA's | 1,202,223 | - | - | 1,202,223 |
| Other Liabilities | 390,867 | - | - | 390,867 |
| Accounts Payable: | | | | |
| Trade | 3,576,084 | 63 | - | 3,576,147 |
| Accrued Expenses: | | | | |
| Salaries and Wages | 5,480,639 | - | - | 5,480,639 |
| Interest and Sales Taxes | 155,844 | - | - | 155,844 |
| Self-Insurance Claims | 886,017 | - | - | 886,017 |
| Total Current Liabilities | 13,735,450 | 63 | - | 13,735,513 |
| Lease Liability, Less Current Maturities | 380,047 | - | - | 380,047 |
| SBITA Liability, Less Current Maturities | 6,232,492 | - | - | 6,232,492 |
| Long-Term Debt, Less Current Maturities | 47,619,803 | - | - | 47,619,803 |
| Net Pension Liability | 32,946,355 | - | - | 32,946,355 |
| Total Liabilities | 100,914,147 | 63 | - | 100,914,210 |
| Deferred Inflows of Resources: | | | | |
| Deferred Inflows Related to Pensions | 12,556,361 | - | - | 12,556,361 |
| Deferred Inflows Related to Lease Receivables | 43,462 | - | - | 43,462 |
| Total Deferred Inflows of Resources | 12,599,823 | - | - | 12,599,823 |
| Net Position: | | | | |
| Net Investment in Capital Assets | 27,405,158 | - | - | 27,405,158 |
| Restricted: | | | | |
| Programs | 25,079 | - | - | 25,079 |
| Capital Improvements | 1,442,589 | - | - | 1,442,589 |
| Unrestricted: | 13,317,790 | 209,062 | 77,514 | 13,604,366 |
| Total Net Position | 42,190,616 | 209,062 | 77,514 | 42,477,192 |
| Total Liabilities, Deferred Inflows of Resources, and Net Position | $ 155,704,586 | $ 209,125 | $ 77,514 | $ 155,991,225 |

# NORTHERN INYO HEALTHCARE DISTRICT
## COMBINING STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
## YEAR ENDED JUNE 30, 2024

| | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| Operating Revenues: | | | | |
| Net Patient Service Revenue | $ 104,622,474 | $ - | $ - | $ 104,622,474 |
| Other Revenue | 2,577,264 | 7,859 | 31,999 | 2,617,122 |
| Total Operating Revenues | 107,199,738 | 7,859 | 31,999 | 107,239,596 |
| Operating Expenses: | | | | |
| Salaries and Wages | 43,973,065 | - | - | 43,973,065 |
| Employee Benefits | 18,923,640 | - | - | 18,923,640 |
| Professional Fees and Purchased Services | 18,568,419 | - | - | 18,568,419 |
| Supplies | 11,325,843 | 2,445 | - | 11,328,288 |
| Purchased Services | 6,399,832 | - | - | 6,399,832 |
| Depreciation and Amortization | 5,209,724 | - | - | 5,209,724 |
| Other | 7,542,242 | 7,086 | 15,954 | 7,565,282 |
| Total Operating Expenses | 111,942,765 | 9,531 | 15,954 | 111,968,250 |
| **OPERATING INCOME (LOSS)** | (4,743,027) | (1,672) | 16,045 | (4,728,654) |
| Nonoperating Revenues (Expenses): | | | | |
| Property Tax for Operations | 1,092,860 | - | - | 1,092,860 |
| Property Tax for Debt Service | 2,062,672 | - | - | 2,062,672 |
| Investment Income | 178,752 | 4,424 | - | 183,176 |
| Interest Expense | (2,782,380) | - | - | (2,782,380) |
| Noncapital Contributions and Grants | 9,691,414 | 14,285 | - | 9,705,699 |
| Rental Income | 24,835 | - | - | 24,835 |
| Miscellaneous Income (Expense) | 186,041 | 4,320 | - | 190,361 |
| Net Nonoperating Revenues | 10,454,194 | 23,029 | - | 10,477,223 |
| **CHANGE IN NET POSITION** | 5,711,167 | 21,357 | 16,045 | 5,748,569 |
| Net Position - Beginning of Year | 36,479,449 | 187,705 | 61,469 | 36,728,623 |
| **NET POSITION - END OF YEAR** | $ 42,190,616 | $ 209,062 | $ 77,514 | $ 42,477,192 |

# NORTHERN INYO HEALTHCARE DISTRICT
# COMBINING STATEMENT OF CASH FLOWS
# YEAR ENDED JUNE 30, 2024

| | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | | |
| Receipts from and on Behalf of Patients | $ 102,722,670 | $ - | $ - | $ 102,722,670 |
| Payments to Suppliers and Contractors | (38,630,798) | (9,531) | (15,954) | (38,656,283) |
| Payments to and on Behalf of Employees | (66,674,721) | - | - | (66,674,721) |
| Other Receipts and Payments, Net | (5,093,297) | 7,859 | 31,999 | (5,053,439) |
| Net Cash Provided (Used) by Operating Activities | (7,676,146) | (1,672) | 16,045 | (7,661,773) |
| **CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES** | | | | |
| Noncapital Contributions and Grants | 9,691,414 | 14,285 | - | 9,705,699 |
| Property Taxes Received | 1,092,860 | | - | 1,092,860 |
| Other | (32,065) | 4,320 | - | (27,745) |
| Net Cash Provided by Noncapital Financing Activities | 10,752,209 | 18,605 | - | 10,770,814 |
| **CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES** | | | | |
| Principal Payments on Long-Term Debt | (3,561,742) | - | - | (3,561,742) |
| Interest Paid | (1,569,091) | - | - | (1,569,091) |
| Purchase and Construction of Capital Assets | (3,957,543) | - | - | (3,957,543) |
| Payments on Lease Liability | (370,888) | - | - | (370,888) |
| Payments on Subscription Liability | (1,176,680) | - | - | (1,176,680) |
| Property Taxes Received | 2,062,672 | - | - | 2,062,672 |
| Net Cash Used by Capital and Capital Related Financing Activities | (8,573,272) | - | - | (8,573,272) |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | | |
| Investment Income | 178,752 | 4,424 | - | 183,176 |
| Rental Income | 48,975 | - | - | 48,975 |
| Net Cash Provided by Investing Activities | 227,727 | 4,424 | - | 232,151 |
| **NET CHANGE IN CASH AND CASH EQUIVALENTS** | (5,269,482) | 21,357 | 16,045 | (5,232,080) |
| Cash and Cash Equivalents - Beginning of Year | 33,745,622 | 187,768 | 61,469 | 33,994,859 |
| **CASH AND CASH EQUIVALENTS - END OF YEAR** | $ 28,476,140 | $ 209,125 | $ 77,514 | $ 28,762,779 |

# NORTHERN INYO HEALTHCARE DISTRICT
# COMBINING STATEMENT OF CASH FLOWS (CONTINUED)
# YEAR ENDED JUNE 30, 2024

| | Hospital | Foundation | Auxiliary | Total |
|---|---|---|---|---|
| **RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION** | | | | |
| Cash and Investments in Current Assets | $ 26,998,253 | $ 209,125 | $ 77,514 | $ 27,284,892 |
| Cash and Investments in Noncurrent Cash and Investments | 1,477,887 | - | - | 1,477,887 |
| Total Cash and Cash Equivalents | 28,476,140 | 209,125 | 77,514 | 28,762,779 |
| **RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES** | | | | |
| Operating Loss | (4,743,027) | (1,672) | 16,045 | (4,728,654) |
| Adjustments to Reconcile Operating Income to Net Cash Provided (Used) by Operating Activities | | | | |
| Depreciation and Amortization | 5,209,724 | - | - | 5,209,724 |
| Pension Expense | 3,621,047 | - | - | 3,621,047 |
| Provision for Bad Debts | 7,438,714 | - | - | 7,438,714 |
| (Increase) Decrease in Assets: | | | | |
| Patient Receivables | (10,546,372) | - | - | (10,546,372) |
| Other Receivables | (130,455) | - | - | (130,455) |
| Inventory | (1,854,695) | - | - | (1,854,695) |
| Prepaid Expenses | 679,525 | - | - | 679,525 |
| Deferred Outflow of Resources | 1,802,389 | - | - | 1,802,389 |
| Increase (Decrease) in Liabilities: | | | | |
| Accounts Payable | (1,382,718) | - | - | (1,382,718) |
| Estimated Third-Party Payor Settlements | 1,207,854 | - | - | 1,207,854 |
| Accrued Expenses | (1,949,327) | - | - | (1,949,327) |
| Other Liabilites | 221,184 | - | - | 221,184 |
| Net Pension Liability | (17,932,355) | - | - | (17,932,355) |
| Deferred Inflow of Resources | 10,682,366 | - | - | 10,682,366 |
| Net Cash Provided (Used) by Operating Activities | $ (7,676,146) | $ (1,672) | $ 16,045 | $ (7,661,773) |
| **SUPPLEMENTAL DISCLOSURE OF NONCASH CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES** | | | | |
| Gain on Extinguishment of Debt | $ 218,106 | $ - | $ - | $ 218,106 |
| Lease Assets Received in Exchange for Lease Liability | $ 399,606 | $ - | $ - | $ 399,606 |
| Subscription Assets Received in Exchange for Subscription Liability | $ 577,228 | $ - | $ - | $ 577,228 |

# NORTHERN INYO HEALTHCARE DISTRICT
# STATISTICAL INFORMATION
# LAST SEVEN YEARS

| | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 |
|---|---|---|---|---|---|---|---|
| **Bed Complement** | | | | | | | |
| Medical/Surgical | 12 | 11 | 11 | 11 | 11 | 11 | 11 |
| Prenatal/Obstetrics | 5 | 6 | 6 | 6 | 6 | 6 | 6 |
| Pediatric | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Intensive Care | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Total Licensed Bed Capacity | 25 | 25 | 25 | 25 | 25 | 25 | 25 |
| **Utilization** | | | | | | | |
| License Beds | 25 | 25 | 25 | 25 | 25 | 25 | 25 |
| Patient Days | 2,562 | 2,458 | 2,646 | 2,931 | 2,968 | 3,257 | 3,474 |
| Discharges | 1,048 | 1,019 | 993 | 1,050 | 1,104 | 1,037 | 1,106 |
| Occupancy Percentage | 0% | 27% | 29% | 32% | 33% | 36% | 38% |
| Average Stay (Days) | 2 | 2 | 3 | 3 | 3 | 3 | 3 |
| Emergency Room Visits | 10,080 | 9,866 | 8,730 | 7,066 | 8,262 | 9,153 | 8,798 |
| Outpatient Visits | 42,374 | 43,678 | 44,067 | 48,938 | 40,472 | 38,960 | 38,651 |
| **Medical Staff** | | | | | | | |
| Active | 51 | 50 | 49 | 50 | 54 | 50 | 53 |
| Consulting | 33 | 26 | 21 | 25 | 19 | 17 | 17 |
| Honorary | 2 | 2 | 2 | 2 | 11 | 11 | 11 |
| AHP | 14 | 16 | 16 | 18 | 18 | 12 | 10 |
| Other - Telemedicine | 34 | 38 | 32 | 30 | 33 | 27 | - |
| Total Practitioners | 134 | 132 | 120 | 125 | 135 | 117 | 91 |
| **Employees** | | | | | | | |
| Full-Time | 332 | 329 | 350 | 370 | 361 | 362 | 330 |
| Part-Time and Per Diem | 94 | 112 | 104 | 113 | 124 | 131 | 126 |
| Total Employees | 426 | 441 | 454 | 483 | 485 | 493 | 456 |
| Full-Time Equivalents | 356 | 384 | 348 | 349 | 374 | 375 | 393 |

# NORTHERN INYO HEALTHCARE DISTRICT
# STATISTICAL INFORMATION (CONTINUED)
# LAST SEVEN YEARS

| **Bond Debt Service Cover (Thousands)** | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 |
|---|---|---|---|---|---|---|---|
| Excess (Deficit) of Revenue Over Expenses | $ 5,749 | $ (11,414) | $ (842) | $ 8,650 | $ (2,641) | $ 1,725 | $ 1,696 |
| Add: | | | | | | | |
| Depreciation Expense | 5,210 | 5,221 | 4,161 | 4,170 | 4,302 | 4,267 | 4,457 |
| Interest Expense | 2,782 | 2,611 | 2,616 | 3,890 | 2,377 | 2,912 | 2,893 |
| Available to Meet Debt Service | $ 13,741 | $ (3,582) | $ 5,935 | $ 16,710 | $ 4,038 | $ 8,904 | $ 9,046 |
| Actual Debt Service (Principal and Interest): | | | | | | | |
| 2009 General Obligation Bonds | $ 1,015 | $ 1,145 | $ 1,100 | $ 1,020 | $ 860 | $ 1,364 | $ 955 |
| 2016 General Obligation Bonds | 1,254 | 981 | 1,317 | 865 | 1,242 | 1,178 | 1,179 |
| 2010 Revenue Bonds | 1,211 | 1,211 | 1,209 | 1,204 | 1,179 | 765 | 769 |
| 2013 Revenue Bonds | 765 | 765 | 765 | 769 | 762 | 864 | 814 |
| 2021 A Refunding Revenue Bonds | 113 | 113 | 48 | - | - | - | - |
| 2021 B Refunding Revenue Bonds | 905 | 864 | 84 | - | - | - | - |
| Financed Purchases | 1,578 | 20 | 394 | 382 | - | - | - |
| Totals | $ 6,841 | $ 5,099 | $ 4,917 | $ 4,240 | $ 4,043 | $ 4,171 | $ 3,717 |
| Historical Debt Service Coverage Ratio | 2.01 | (1.15) | 1.21 | 3.94 | 1.00 | 2.13 | 2.43 |

Details regarding the District's outstanding debt can be found in the notes to the financial statements. General obligation bonds are secured by ad valorem taxes on all property within the District subject to taxation by the District. Revenue bonds are secured by a pledge of revenue set forth under the indenture. The coverage calculations presented in this schedule differ from those required by the 2021A and 2021B bond indentures.

NORTHERN INYO HEALTHCARE DISTRICT
*One Team. One Goal. Your Health.*

DATE: April 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights as of February 2025

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**Financial Summary**

1. Net Income: February's net loss was a $(1.2M), which was $(8.5M) lower than last February. This was due to timing of rate range IGT (posted this year in December and last year in February). For the year, net income was at $8.3M which was $(353k) lower than last year-to-date. This was due to lower net revenue due to less surgical volume in orthopedics.
2. Operating Income: February's operating loss was $(1.3M), which was $514k better than last year due to decreased expenses. For the year, operating loss was worse than last year by $(173k) due to unfavorable net revenue caused by declining surgical volumes along with higher expenses.
3. EBIDA: February's EBIDA was $(810k) which was unfavorable to last February due to timing of IGT. For the year, EBIDA was favorable by $108k.
4. Revenue Breakdown: February's gross revenue was down $(345k) due to less medical admits, deliveries and observations compared to last year. For the year, gross revenue was higher by 3% due to increased volumes in most areas but net revenue is lower due to less surgical volume, which was reimbursed at a higher rate than other services.

**Deductions Summary**

1. Contractual Adjustments: Contractual discounts were lower for the month due to better write-off rates compared to last February. For the year, contractual discounts are 10% higher primarily due to Medicare outpatient rates declining. Net revenue as a % of gross revenue is at 47% for the year which is a (2%) decline from last year.
2. Bad Debt: For February, bad debt declined (32%) due to AR >270 days declining significantly.
3. Write-offs: Other write-offs were higher than prior year and budget due to continued aged AR cleanup.

**Salaries**

1. Per Adjusted Patient Day / Adjusted Employee per Occupied Bed (Adjusted EPOB): For February and year-to-date, wages per patient were lower than last year due to higher volumes.
2. Total Salaries: For February and year-to-date, wages were lower due to slightly lower wage rates due to less premium pay.
3. Average Hourly Rate: For the year, average hourly rate was lower than budget and prior year due to less overtime and premium pay.

**Benefits**

1. Total Benefits: For February and year-to-date, benefits were lower than prior year due to pension and medical expenses.
2. Benefits % of Wages: For the year, we were at 47% of wages, which was lower than prior year by (4%).

**Total Salaries, Wages and Benefits (SWB)**

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For the year, we were (31%) under budget and (21%) under prior year-to-date. This was due to lower benefit costs.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For February, we were under budget by (6%). For the year, we were lower than prior year by (1%). This was due to benefits being lower. For the year, we were at 50% of total expenses, which is our goal. However, when you include contract labor, we are at 53%.

**Contract Labor**

1. Contract Labor Expense: For the year, contract labor was 5% higher than prior year due to staffing challenges and rates higher than planned.
2. Contract Labor Rates: Rates are higher than budgeted by 32% and higher than prior year by 4%. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor was 1% higher than prior year.

**Other Expenses**

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were (14%) under budget and (15%) under prior year-to-date.
2. Supplies: For the year, supplies were lower than prior year-to-date due to lower pharmacy costs and less surgical supply costs.

3. Total Expenses: For the year, expenses were under budget by (7%) and under prior year by (2%). This was due to lower benefits and supplies.

**Stats Summary**

1. Admits (excluding Nursery): For February, admits were (21%) lower due to lower medical admits from the ER along with lower deliveries. For the year, admits were 4% higher due to higher deliveries and medical admits with declines in inpatient surgeries.
2. Inpatient Days (excluding Nursery): For February, inpatient days were relatively flat. For the year, inpatient days increased 23%.
3. Average Daily Census: Average census increased 17% compared to last year-to-date.
4. Average Length of Stay (ALOS): For the year, average length of stay increased 13% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 16% higher than last year.
6. Surgical Procedures: For February, surgeries were 3% higher than last February. For the year, surgical procedures were (3%) lower with increases in general, cardiology, podiatry, and urology offsetting with decreases in orthopedics, ophthalmology, and gynecology.
7. Emergency Department (ED) Visits: Emergency visits were higher by 5% compared to last February and 2% higher year-to-date leading to higher medical admits.
8. Diagnostic Imaging (DI) Exams: For the month, DI exams were under by (2%). For the year-to-date, DI exams were higher by 2%. Approximately 25% of volume in this cost center comes from orthopedic clinic, which was down (7%) compared, to last February.
9. Rehab Visits: For February, rehab visits were down (8%) but they were up 38% for the year. Approximately 36% of volume in this cost center comes from orthopedic clinic, which was down (7%) compared, to last February.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were up 81% compared to last year-to-date.
11. Observation Hours: Observations hours were down (21%) compared to last year-to-date due to change in observation methodology in the women and surgical service lines.
12. Rural Health Clinic (RHC) Visits: For February, RHC was up 8% and year-to-date, RHC flat compared to last year.
13. Other Clinics: For the year, all clinics increased 12% due to new providers.

# Northern Inyo Healthcare District

## February 2025 – Financial Summary

| ** Variances are B / (W) | Current Month | | | | Prior MTD | | | Year to Date | | | | Prior YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Variance %** | **Actual** | **Change** | **Change %** | **Actual** | **Budget** | **Variance** | **Variance %** | **Actual** | **Change** | **Change %** |
| **Net Income (Loss)** | (1,218,683) | 9,041,331 | (10,260,014) | (113%) | 7,291,804 | (8,510,487) | 117% | 8,256,493 | 3,220,786 | 5,035,707 | (156%) | 8,609,695 | (353,202) | (4%) |
| **Operating Income (Loss)** | (1,310,237) | (614,934) | (695,302) | 113% | (1,825,078) | 514,842 | 28% | (3,079,406) | (8,478,757) | 5,399,351 | 64% | (2,906,943) | (172,463) | 6% |
| **EBIDA (Loss)** | (809,519) | 9,404,909 | (10,214,428) | (109%) | 7,678,588 | (8,488,107) | 111% | 11,625,684 | 6,129,410 | 5,496,274 | (90%) | 11,517,782 | 107,901 | 1% |
| IP Gross Revenue | 2,845,791 | 3,478,230 | (632,438) | (18%) | 3,063,000 | (217,208) | (7%) | 27,497,198 | 28,780,858 | (1,283,660) | (4%) | 27,951,320 | (454,122) | (2%) |
| OP Gross Revenue | 12,402,184 | 14,066,268 | (1,664,084) | (12%) | 12,719,309 | (317,125) | (2%) | 113,062,416 | 115,168,463 | (2,106,047) | (2%) | 109,721,389 | 3,341,027 | 3% |
| Clinic Gross Revenue | 1,689,999 | 1,599,414 | 90,585 | 6% | 1,500,716 | 189,283 | 13% | 14,002,333 | 13,306,236 | 696,096 | 5% | 12,535,466 | 1,466,866 | 12% |
| **Total Gross Revenue** | **16,937,974** | **19,143,911** | **(2,205,938)** | **(12%)** | **17,283,024** | **(345,051)** | **(2%)** | **154,561,947** | **157,255,557** | **(2,693,611)** | **(2%)** | **150,208,176** | **4,353,771** | **3%** |
| **Net Patient Revenue** | **7,369,517** | **9,172,114** | **(1,802,597)** | **(20%)** | **7,363,514** | **6,003** | **0%** | **72,000,344** | **71,895,352** | **104,993** | **0%** | **73,332,224** | **(1,331,880)** | **(2%)** |
| ***Cash Net Revenue % of Gross*** | *44%* | *48%* | *(4%)* | *(9%)* | *43%* | *1%* | *2%* | *47%* | *46%* | *1%* | *2%* | *49%* | *(2%)* | *(5%)* |
| **Admits (excl. Nursery)** | 61 | 77 | (16) | (21%) | 77 | (16) | (21%) | 585 | 562 | 23 | 4% | 562 | 23 | 4% |
| **IP Days** | 198 | 198 | 0 | 0% | 198 | 0 | 0% | 2,031 | 1,655 | 376 | 23% | 1,655 | 376 | 23% |
| **IP Days (excl. Nursery)** | 163 | 165 | (2) | (1%) | 165 | (2) | (1%) | 1,714 | 1,461 | 253 | 17% | 1,461 | 253 | 17% |
| **Average Daily Census** | 5.8 | 5.9 | (0.1) | (1%) | 5.9 | (0.1) | (1%) | 7.1 | 6.0 | 1.0 | 17% | 6.0 | 1.0 | 17% |
| **ALOS** | 2.7 | 2.1 | 0.5 | 25% | 2.1 | 0.5 | 25% | 2.9 | 2.6 | 0.3 | 13% | 2.6 | 0.3 | 13% |
| **Deliveries** | 15 | 20 | (5) | (25%) | 20 | (5) | (25%) | 146 | 126 | 20 | 16% | 126 | 20 | 16% |
| **OP Visits** | 3,640 | 3,491 | 149 | 4% | 3,491 | 149 | 4% | 30,950 | 27,666 | 3,284 | 12% | 27,666 | 3,284 | 12% |
| Rural Health Clinic Visits | 2,188 | 2,069 | 119 | 6% | 2,069 | 119 | 6% | 18,252 | 18,893 | (641) | (3%) | 18,893 | (641) | (3%) |
| Rural Health Women Visits | 479 | 457 | 22 | 5% | 457 | 22 | 5% | 4,106 | 3,657 | 449 | 12% | 3,657 | 449 | 12% |
| Rural Health Behavioral Visits | 215 | 144 | 71 | 49% | 144 | 71 | 49% | 1,575 | 1,329 | 246 | 19% | 1,329 | 246 | 19% |
| **Total RHC Visits** | **2,882** | **2,670** | **212** | **8%** | **2,670** | **212** | **8%** | **23,933** | **23,879** | **54** | **0%** | **23,879** | **54** | **0%** |
| Bronco Clinic Visits | 44 | 55 | (11) | (20%) | 55 | (11) | (20%) | 309 | 244 | 65 | 27% | 244 | 65 | 27% |
| Internal Medicine Clinic Visits | - | - | - | -% | - | - | -% | - | 201 | (201) | (100%) | 201 | (201) | (100%) |
| Orthopedic Clinic Visits | 294 | 317 | (23) | (7%) | 317 | (23) | (7%) | 2,810 | 2,740 | 70 | 3% | 2,740 | 70 | 3% |
| Pediatric Clinic Visits | 584 | 539 | 45 | 8% | 539 | 45 | 8% | 4,817 | 4,900 | (83) | (2%) | 4,900 | (83) | (2%) |
| Specialty Clinic Visits | 498 | 479 | 19 | 4% | 479 | 19 | 4% | 4,292 | 3,013 | 1,279 | 42% | 3,013 | 1,279 | 42% |
| Surgery Clinic Visits | 168 | 126 | 42 | 33% | 126 | 42 | 33% | 1,269 | 1,009 | 260 | 26% | 1,009 | 260 | 26% |
| Virtual Care Clinic Visits | 61 | 60 | 1 | 2% | 60 | 1 | 2% | 467 | 370 | 97 | 26% | 370 | 97 | 26% |
| **Total NIA Clinic Visits** | **1,649** | **1,576** | **73** | **5%** | **1,576** | **73** | **5%** | **13,964** | **12,477** | **1,487** | **12%** | **12,477** | **1,487** | **12%** |
| IP Surgeries | 10 | 12 | (2) | (17%) | 12 | (2) | (17%) | 88 | 170 | (82) | (48%) | 170 | (82) | (48%) |
| OP Surgeries | 127 | 121 | 6 | 5% | 121 | 6 | 5% | 1,048 | 999 | 49 | 5% | 999 | 49 | 5% |
| **Total Surgeries** | **137** | **133** | **4** | **3%** | **133** | **4** | **3%** | **1,136** | **1,169** | **(33)** | **(3%)** | **1,169** | **(33)** | **(3%)** |
| Cardiology | - | - | - | -% | - | - | -% | 4 | 1 | 3 | 300% | 1 | 3 | 300% |
| General | 63 | 71 | (8) | (11%) | 71 | (8) | (11%) | 564 | 545 | 19 | 3% | 545 | 19 | 3% |
| Gynecology & Obstetrics | 12 | 13 | (1) | (8%) | 13 | (1) | (8%) | 93 | 122 | (29) | (24%) | 122 | (29) | (24%) |
| Ophthalmology | 34 | 22 | 12 | 55% | 22 | 12 | 55% | 188 | 199 | (11) | (6%) | 199 | (11) | (6%) |
| Orthopedic | 19 | 16 | 3 | 19% | 16 | 3 | 19% | 179 | 216 | (37) | (17%) | 216 | (37) | (17%) |
| Pediatric | - | - | - | -% | - | - | -% | 1 | - | 1 | -% | - | 1 | -% |
| Plastics | - | - | - | -% | - | - | -% | 1 | - | 1 | -% | - | 1 | -% |
| Podiatry | - | - | - | -% | - | - | -% | 4 | 1 | 3 | 300% | 1 | 3 | 300% |
| Urology | 9 | 11 | (2) | (18%) | 11 | (2) | (18%) | 100 | 85 | 15 | 18% | 85 | 15 | 18% |
| **Diagnostic Image Exams** | 1,919 | 1,953 | (34) | (2%) | 1,953 | (34) | (2%) | 16,734 | 16,430 | 304 | 2% | 16,430 | 304 | 2% |
| **Emergency Visits** | 787 | 753 | 34 | 5% | 753 | 34 | 5% | 6,812 | 6,669 | 143 | 2% | 6,669 | 143 | 2% |
| **ED Admits** | 36 | 45 | (9) | (20%) | 45 | (9) | (20%) | 351 | 266 | 85 | 32% | 266 | 85 | 32% |
| **ED Admits % of ED Visits** | 5% | 6% | -1% | (23%) | 6% | -1% | (23%) | 5% | 4% | 1% | 29% | 4% | 1% | 29% |
| **Rehab Visits** | 635 | 690 | (55) | (8%) | 690 | (55) | (8%) | 6,559 | 4,767 | 1,792 | 38% | 4,767 | 1,792 | 38% |
| **OP Infusion/Wound Care Visits** | 688 | 290 | 398 | 137% | 290 | 398 | 137% | 4,209 | 2,330 | 1,879 | 81% | 2,330 | 1,879 | 81% |
| **Observation Hours** | 1,156 | 1,901 | (745) | (39%) | 1,901 | (745) | (39%) | 12,473 | 16,314 | (3,841) | (24%) | 16,314 | (3,841) | (24%) |

**Provided by**: Chief Financial Officer
**Report Name:** February 2025 Financial Summary

# Northern Inyo Healthcare District

## February 2025 – Financial Summary

| ** Variances are B / (W) | Current Month | | | | Prior MTD | | | Year to Date | | | | Prior YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance % | Actual | Change | Change % | Actual | Budget | Variance | Variance % | Actual | Change | Change % |
| **PAYOR MIX** | | | | | | | | | | | | | | |
| Blue Cross | 21.5% | 21.2% | 0.3% | 1.5% | 21.2% | 0.3% | 1.5% | 24.1% | 18.5% | 5.6% | 30.5% | 18.5% | 5.6% | 30.5% |
| Commercial | 7.8% | 9.1% | (1.3%) | (14.6%) | 9.1% | (1.3%) | (14.6%) | 7.3% | 4.0% | 3.3% | 81.0% | 4.0% | 3.3% | 81.0% |
| Medicaid | 31.0% | 24.7% | 6.3% | 25.4% | 24.7% | 6.3% | 25.4% | 27.6% | 24.8% | 2.8% | 11.2% | 24.8% | 2.8% | 11.2% |
| Medicare | 36.7% | 41.4% | (4.7%) | (11.3%) | 41.4% | (4.7%) | (11.3%) | 38.6% | 48.9% | (10.2%) | (20.9%) | 48.9% | (10.2%) | (20.9%) |
| Self-pay | 3.0% | 1.5% | 1.4% | 95.2% | 1.5% | 1.4% | 95.2% | 1.9% | 3.2% | (1.3%) | (40.1%) | 3.2% | (1.3%) | (40.1%) |
| Worker's Comp | -% | 2.0% | (2.0%) | (100.0%) | 2.0% | (2.0%) | (100.0%) | 0.5% | 0.6% | (0.1%) | (17.3%) | 0.6% | (0.1%) | (17.3%) |
| Other | -% | -% | -% | -% | -% | -% | -% | -% | 0.1% | (0.1%) | (100.0%) | 0.1% | (0.1%) | (100.0%) |
| **DEDUCTIONS** | | | | | | | | | | | | | | |
| Contract Adjust | (8,529,361) | (8,800,983) | 271,623 | (3%) | (9,066,535) | 537,175 | (6%) | (74,670,886) | (75,221,768) | 550,882 | (1%) | (67,644,575) | (7,026,311) | 10% |
| Bad Debt | (194,637) | (627,905) | 433,268 | (69%) | (285,977) | 91,340 | (32%) | 11,290 | (5,431,797) | 5,443,087 | (100%) | (5,496,184) | 5,507,474 | (100%) |
| Write-off | (844,459) | (542,909) | (301,550) | 56% | (567,860) | (276,599) | 49% | (7,753,823) | (4,706,641) | (3,047,183) | 65% | (3,739,008) | (4,014,815) | 107% |
| **CENSUS** | | | | | | | | | | | | | | |
| Patient Days | 163 | 165 | (2) | (1%) | 165 | (2) | (1%) | 1,714 | 1,461 | 253 | 17% | 1,461 | 253 | 17% |
| Adjusted ADC | 33 | 30 | 2 | 7% | 30 | 2 | 7% | 39 | 32 | 7 | 22% | 32 | 7 | 22% |
| Adjusted Days | 969 | 931 | 38 | 4% | 931 | 38 | 4% | 9,635 | 7,851 | 1,784 | 23% | 7,851 | 1,784 | 23% |
| Employed FTE | 359.7 | 346.3 | 13.4 | 4% | 346.3 | 13.4 | 4% | 353.2 | 352.2 | 1.0 | 0% | 352.2 | 1.0 | 0% |
| Contract Labor FTE | 27.7 | 26.1 | 1.6 | 6% | 26.1 | 1.6 | 6% | 26.7 | 26.5 | 0.2 | 1% | 26.5 | 0.2 | 1% |
| Total Paid FTE | 387.4 | 372.4 | 15.0 | 4% | 372.4 | 15.0 | 4% | 379.9 | 378.7 | 1.2 | 0% | 378.7 | 1.2 | 0% |
| EPOB (Employee per Occupied Bed) | 2.4 | 2.3 | 0.1 | 5% | 2.3 | 0.1 | 5% | 1.9 | 2.2 | (0.3) | (14%) | 2.2 | (0.3) | (14%) |
| EPOC (Employee per Occupied Case) | 0.4 | 0.4 | (0.0) | (3%) | 0.4 | (0.0) | (3%) | 0.0 | 0.0 | (0.0) | (18%) | 0.0 | (0.0) | (18%) |
| Adjusted EPOB | 14.2 | 12.7 | 1.4 | 11% | 12.7 | 1.4 | 11% | 10.8 | 12.1 | (1.3) | (11%) | 12.1 | (1.3) | (11%) |
| Adjusted EPOC | 2.5 | 2.5 | 0.1 | 2% | 2.5 | 0.1 | 2% | 0.2 | 0.3 | (0.0) | (14%) | 0.3 | (0.0) | (14%) |
| **SALARIES** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 2,922 | 3,554 | (632) | (18%) | 3,162 | (240) | (8%) | 2,650 | 3,561 | (911) | (26%) | 3,288 | (638) | (19%) |
| Total Salaries | 2,832,505 | 3,309,193 | (476,688) | (14%) | 2,944,019 | (111,514) | (4%) | 25,533,295 | 27,962,027 | (2,428,732) | (9%) | 25,817,082 | (283,787) | (1%) |
| Average Hourly Rate | 49.22 | 59.73 | (10.51) | (18%) | 53.14 | (3.92) | (7%) | 52.06 | 57.17 | (5.12) | (9%) | 52.79 | (0.73) | (1%) |
| Employed Paid FTEs | 359.7 | 346.3 | 13.4 | 332.8 | 346.3 | 13.4 | 4% | 353.2 | 352.2 | 1.0 | 0% | 352.2 | 1.0 | 0% |
| **BENEFITS** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 1,448 | 2,171 | (723) | (33%) | 1,936 | (488) | (25%) | 1,244 | 2,106 | (862) | (41%) | 1,668 | (423) | (25%) |
| Total Benefits | 1,403,544 | 2,021,621 | (618,077) | (31%) | 1,802,249 | (398,705) | (22%) | 11,987,780 | 16,537,276 | (4,549,496) | (28%) | 13,092,810 | (1,105,029) | (8%) |
| Benefits % of Wages | 50% | 61% | (12%) | (19%) | 61% | -12% | (19%) | 47% | 59% | (12%) | (21%) | 51% | (4%) | (7%) |
| Pension Expense | 376,804 | 496,881 | (120,077) | (24%) | 542,575 | (165,771) | (31%) | 3,181,726 | 3,983,000 | (801,274) | (20%) | 3,705,457 | (523,731) | (14%) |
| MDV Expense | 682,759 | 748,612 | (65,853) | (9%) | 926,124 | (243,365) | (26%) | 6,240,676 | 5,988,896 | 251,780 | 4% | 6,933,723 | (693,047) | (10%) |
| Taxes, PTO accrued, Other | 343,981 | 776,128 | (432,147) | (56%) | 333,550 | 10,431 | 3% | 2,565,378 | 6,565,380 | (4,000,002) | (61%) | 2,453,630 | 111,748 | 5% |
| **Salaries, Wages & Benefits** | 4,236,048 | 5,330,813 | (1,094,765) | (21%) | 4,746,268 | (510,219) | (11%) | 37,521,075 | 44,499,303 | (6,978,228) | (16%) | 38,909,892 | (1,388,817) | (4%) |
| **SWB/APD** | 4,370 | 5,726 | (1,356) | (24%) | 5,098 | (728) | (14%) | 3,894 | 5,668 | (1,773) | (31%) | 4,956 | (1,062) | (21%) |
| **SWB % of Total Expenses** | 49% | 54% | (6%) | (10%) | 52% | (3%) | (6%) | 50% | 55% | (5%) | (10%) | 51% | (1%) | (2%) |

**Provided by**: Chief Financial Officer
**Report Name:** February 2025 Financial Summary

# Northern Inyo Healthcare District

## February 2025 – Financial Summary

| ** Variances are B / (W) | Current Month | | | | Prior MTD | | | Year to Date | | | | Prior YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance % | Actual | Change | Change % | Actual | Budget | Variance | Variance % | Actual | Change | Change % |
| **PROFESSIONAL FEES** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 2,650 | 2,388 | 262 | 11% | 2,575 | 75 | 3% | 2,098 | 2,273 | (175) | (8%) | 2,475 | (377) | (15%) |
| Total Physician Fee | 1,524,202 | 1,463,822 | 60,380 | 4% | 1,378,852 | 145,350 | 11% | 12,383,875 | 11,708,978 | 674,897 | 6% | 11,817,408 | 566,466 | 5% |
| Total Contract Labor | 367,306 | 340,148 | 27,158 | 8% | 429,743 | (62,437) | (15%) | 3,703,831 | 2,785,834 | 917,997 | 33% | 3,533,123 | 170,707 | 5% |
| Total Other Pro-Fees | 677,350 | 419,396 | 257,954 | 62% | 589,036 | 88,314 | 15% | 4,126,365 | 3,352,821 | 773,543 | 23% | 4,079,091 | 47,273 | 1% |
| Total Professional Fees | 2,568,858 | 2,223,366 | 345,491 | 16% | 2,397,631 | 171,227 | 7% | 20,214,071 | 17,847,633 | 2,366,438 | 13% | 19,429,623 | 784,447 | 4% |
| Contract AHR | 82.77 | 81.42 | 1.35 | 2% | 102.86 | (20.10) | (20%) | 100.01 | 75.81 | 24.20 | 32% | 96.15 | 3.86 | 4% |
| Contract Paid FTEs | 27.7 | 26.1 | 1.6 | 6% | 26.1 | 1.6 | 6% | 26.7 | 26.5 | 0.2 | 1% | 26.5 | 0.2 | 1% |
| Physician Fee per Adjust Bed Day | 1,572 | 1,572 | 0 | 0% | 1,481 | 91 | 6% | 1,285 | 1,491 | (206) | (14%) | 1,505 | (220) | (15%) |
| **PHARMACY** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 214 | 496 | (282) | (57%) | 510 | (296) | (58%) | 290 | 470 | (180) | (38%) | 441 | (151) | (34%) |
| Total Rx Expense | 207,210 | 461,460 | (254,250) | (55%) | 474,631 | (267,421) | (56%) | 2,795,403 | 3,691,677 | (896,275) | (24%) | 3,463,543 | (668,140) | (19%) |
| **MEDICAL SUPPLIES** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 369 | 462 | (93) | (20%) | 235 | 134 | 57% | 375 | 437 | (62) | (14%) | 488 | (113) | (23%) |
| Total Medical Supplies | 357,686 | 430,271 | (72,586) | (17%) | 218,356 | 139,329 | 64% | 3,612,426 | 3,431,788 | 180,638 | 5% | 3,833,874 | (221,448) | (6%) |
| **EHR SYSTEM** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 33 | 145 | (112) | (77%) | 135 | (102) | (75%) | 28 | 138 | (109) | (79%) | 126 | (98) | (78%) |
| Total EHR Expense | 32,417 | 135,000 | (102,583) | (76%) | 126,094 | (93,677) | (74%) | 273,682 | 1,080,000 | (806,318) | (75%) | 992,479 | (718,797) | (72%) |
| **OTHER EXPENSE** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 896 | 905 | (9) | (1%) | 901 | (5) | (1%) | 757 | 881 | (124) | (14%) | 854 | (97) | (11%) |
| Total Other | 868,371 | 842,560 | 25,812 | 3% | 838,829 | 29,542 | 4% | 7,293,903 | 6,915,084 | 378,820 | 5% | 6,701,668 | 592,236 | 9% |
| **DEPRECIATION AND AMORTIZATION** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 422 | 391 | 32 | 8% | 415 | 7 | 2% | 350 | 370 | (21) | (6%) | 370 | (21) | (6%) |
| Total Depreciation and Amortization | 409,164 | 363,578 | 45,586 | 13% | 386,783 | 22,381 | 6% | 3,369,191 | 2,908,624 | 460,567 | 16% | 2,908,087 | 461,104 | 16% |
| **TOTAL EXPENSES** | 8,679,753 | 9,787,048 | (1,107,295) | (11%) | 9,188,592 | (508,839) | (6%) | 75,079,750 | 80,374,109 | (5,294,358) | (7%) | 76,239,166 | (1,159,416) | (2%) |
| Per Adjust Bed Day | 8,954 | 10,512 | (1,558) | (15%) | 9,869 | (915) | (9%) | 7,792 | 10,237 | (2,445) | (24%) | 9,710 | (1,918) | (20%) |
| Per Calendar Day | 309,991 | 349,537 | (39,546) | (11%) | 328,164 | (18,173) | (6%) | 308,970 | 330,758 | (21,787) | (7%) | 313,741 | (4,771) | (2%) |

**Provided by**: Chief Financial Officer
**Report Name:** February 2025 Financial Summary

| Key Financial Performance Indicators | Industry Benchmark | Feb-23 | Feb-24 | FYE 2024 Average | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Variance to Prior Month | Variance to FYE 2024 Average | Variance to Prior Year Month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Volume** | | | | | | | | | | | | | | | |
| Admits | 41 | 59 | 77 | 71 | 75 | 75 | 83 | 68 | 77 | 62 | 90 | 61 | (29) | (10) | (16) |
| Deliveries | n/a | 16 | 20 | 17 | 18 | 19 | 17 | 21 | 14 | 21 | 20 | 15 | (5) | (2) | (5) |
| Adjusted Patient Days | n/a | 805 | 942 | 1,035 | 1,164 | 1,362 | 1,312 | 1,335 | 970 | 1,169 | 1,432 | 969 | (462) | (65) | 27 |
| Total Surgeries | 153 | 109 | 133 | 146 | 134 | 168 | 133 | 176 | 129 | 122 | 137 | 137 | - | (9) | 4 |
| ER Visits | 659 | 765 | 753 | 840 | 903 | 905 | 947 | 859 | 789 | 789 | 833 | 787 | (46) | (53) | 34 |
| RHC and Clinic Visits | n/a | 3,950 | 4,246 | 4,607 | 4,252 | 4,921 | 4,808 | 5,479 | 4,515 | 4,444 | 4,943 | 4,531 | (412) | (76) | 285 |
| Diagnostic Imaging Services | n/a | 1,799 | 1,953 | 2,069 | 2,274 | 2,221 | 2,194 | 2,344 | 1,880 | 1,955 | 2,283 | 1,919 | (364) | (150) | (34) |
| Rehab Services | n/a | 573 | 690 | 662 | 719 | 808 | 887 | 1,142 | 903 | 740 | 725 | 635 | (90) | (27) | (55) |
| **AR & Income** | | | | | | | | | | | | | | | |
| Gross AR (Cerner only) | n/a | $ 57,856,486 | $ 55,489,238 | $ 52,823,707 | $ 56,859,164 | $ 57,648,281 | $ 58,109,192 | $ 51,585,302 | $ 48,660,966 | $ 46,678,451 | $ 45,458,077 | $ 49,708,783 | $ 4,250,706 | $ (3,114,925) | $ (5,780,455) |
| AR > 90 Days | $ 7,001,767.65 | $ 26,753,439 | $ 27,534,816 | $ 24,488,432 | $ 24,988,857 | $ 24,824,364 | $ 26,062,067 | $ 22,515,618 | $ 21,134,023 | $ 19,761,172 | $ 17,533,888 | $ 17,112,621 | $ (421,267) | $ (7,375,811) | $ (10,422,195) |
| AR % > 90 Days | 15% | 52.78% | 50.37% | 46.7% | 44.5% | 43.1% | 44.9% | 43.6% | 43.4% | 42.3% | 38.6% | 34.4% | -4.1% | -12.2% | -15.9% |
| Gross AR Days (per financial statements) | 60 | 109 | 93 | 85 | 92 | 84 | 83 | 74 | 83 | 84 | 71 | 82 | 11 | (3) | (11) |
| Net AR Days (per financial statements) | 30 | 86 | 77 | 58 | 54 | 64 | 69 | 64 | 67 | 84 | 76 | 65 | (11) | 7 | (12) |
| Net AR | n/a | $ 19,699,808 | $ 19,458,681 | $ 16,938,200 | $ 18,219,994 | $ 20,277,373 | $ 19,842,483 | $ 18,705,429 | $ 20,054,289 | $ 18,106,671 | $ 25,749,510 | $ 17,511,087 | $ (8,238,423) | $ 572,887 | $ (1,947,594) |
| Net AR % of Gross | n/a | 34.0% | 35.1% | 31.9% | 32.0% | 35.2% | 34.1% | 36.3% | 41.2% | 38.8% | 56.6% | 35.2% | -21.4% | 3.3% | 0.2% |
| Gross Patient Revenue/Calendar Day | n/a | $ 530,100 | $ 595,966 | $ 619,457 | $ 617,364 | $ 683,348 | $ 702,988 | $ 698,314 | $ 582,780 | $ 557,230 | $ 638,935 | $ 604,928 | $ (34,008) | $ (14,529) | $ 8,961 |
| Net Patient Revenue/Calendar Day | n/a | $ 228,328 | $ 253,914 | $ 292,759 | $ 337,843 | $ 315,574 | $ 285,805 | $ 290,232 | $ 301,501 | $ 215,907 | $ 339,299 | $ 263,197 | $ (76,102) | $ (29,562) | $ 9,283 |
| Net Patient Revenue/APD | n/a | $ 7,942 | $ 7,817 | $ 8,757 | $ 8,998 | $ 7,183 | $ 6,537 | $ 6,740 | $ 9,321 | $ 5,727 | $ 7,346 | $ 7,603 | $ 257 | $ (1,155) | $ (214) |
| **Wages** | | | | | | | | | | | | | | | |
| Wages | n/a | $ 2,604,870 | $ 2,944,019 | $ 3,285,431 | $ 3,359,076 | $ 3,241,107 | $ 3,372,236 | $ 3,622,038 | $ 3,463,941 | $ 3,659,647 | $ 3,966,354 | $ 2,832,505 | $ (1,133,849) | $ (452,926) | $ (111,514) |
| Employed paid FTEs | n/a | 378.50 | 346.25 | 353.69 | 366.38 | 366.24 | 391.40 | 369.11 | 364.72 | 367.90 | 369.48 | 359.66 | (9.82) | 5.97 | 13.41 |
| Employed Average Hourly Rate | $55.50 | $ 43.01 | $ 51.31 | $ 53.32 | $ 51.76 | $ 49.96 | $ 50.26 | $ 55.40 | $ 55.40 | $ 56.15 | $ 60.60 | $ 49.22 | $ (11.38) | $ (4.10) | $ (2.09) |
| Benefits | n/a | $ 1,676,029 | $ 1,802,249 | $ 1,640,216 | $ 1,509,407 | $ 1,478,605 | $ 1,634,036 | $ 1,896,266 | $ 713,356 | $ 1,678,868 | $ 1,674,059 | $ 1,403,544 | $ (270,516) | $ (236,673) | $ (398,705) |
| Benefits % of Wages | 30% | 64.3% | 61.2% | 50.3% | 44.9% | 45.6% | 48.5% | 52.4% | 20.6% | 45.9% | 42.2% | 49.6% | 7.3% | -0.8% | -11.7% |
| Contract Labor | n/a | $ 247,771 | $ 429,743 | $ 518,351 | $ 507,387 | $ 829,876 | $ (112,642) | $ 543,829 | $ 583,367 | $ 672,468 | $ 312,240 | $ 367,306 | $ 55,066 | $ (151,045) | $ (62,437) |
| Contract Labor Paid FTEs | n/a | 36.15 | 23.86 | 23.49 | 29.45 | 32.19 | 24.84 | 21.32 | 23.57 | 26.14 | 25.69 | 27.74 | 2.05 | 4.24 | 3.88 |
| Total Paid FTEs | n/a | 414.65 | 370.11 | 377.18 | 395.83 | 398.43 | 416.25 | 390.44 | 388.29 | 394.04 | 395.17 | 387.39 | (7.78) | 10.21 | 17.28 |
| Contract Labor Average Hourly Rate | $ 81.04 | $ 42.84 | $ 108.69 | $ 126.74 | $ 97.26 | $ 145.55 | $ 118.60 | $ 143.96 | $ 144.39 | $ 145.23 | $ 68.61 | $ 82.77 | $ 14.16 | $ (43.97) | $ (25.92) |
| Total Salaries, Wages, & Benefits | n/a | $ 4,528,670 | $ 5,176,011 | $ 5,443,998 | $ 5,375,870 | $ 5,549,587 | $ 4,893,631 | $ 6,062,133 | $ 4,760,664 | $ 6,010,983 | $ 5,952,653 | $ 4,603,354 | $ (1,349,298) | $ (840,644) | $ (572,657) |
| SWB% of NR | 50% | 70.8% | 70.3% | 63.2% | 51.3% | 56.7% | 57.1% | 67.4% | 52.6% | 89.8% | 56.6% | 62.5% | 5.9% | -0.7% | -7.8% |
| SWB/APD | 2,572 | $ 5,626 | $ 5,495 | $ 5,346 | $ 4,618 | $ 4,075 | $ 3,731 | $ 4,541 | $ 4,906 | $ 5,144 | $ 4,157 | $ 4,749 | $ 592 | $ (597) | $ (746) |
| SWB % of total expenses | 50% | 49.9% | 56.3% | 56.7% | 59.6% | 56.3% | 55.1% | 58.0% | 49.7% | 59.9% | 56.3% | 53.0% | -3.3% | -3.7% | -3.3% |

| Physician Spend | Industry Benchmark | Feb-23 | Feb-24 | FYE 2024 Average | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Variance to Prior Month | Variance to FYE 2024 Average | Variance to Prior Year Month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Physician Expenses | n/a | $ 1,353,272 | $ 1,378,852 | $ 1,507,510 | $ 1,553,004 | $ 1,399,376 | $ 1,621,308 | $ 1,699,955 | $ 1,508,531 | $ 1,498,281 | $ 1,586,690 | $ 1,524,202 | $ (62,488) | $ 16,692 | $ 145,350 |
| Physician expenses/APD | n/a | $ 1,681 | $ 1,464 | $ 1,478 | $ 1,334 | $ 1,028 | $ 1,236 | $ 1,273 | $ 1,555 | $ 1,282 | $ 1,108 | $ 1,572 | $ 464 | $ 94 | $ 109 |
| | | | | | | | | | | | | | $ - | $ - | $ - |
| **Supplies** | | | | | | | | | | | | | | | |
| Supply Expenses | n/a | $ 530,612 | $ 692,988 | $ 776,504 | $ 387,610 | $ 1,078,077 | $ 785,983 | $ 860,663 | $ 1,034,853 | $ 794,786 | $ 900,961 | $ 564,895 | $ (336,066) | $ (211,608) | $ (128,093) |
| Supply expenses/APD | | $ 659 | $ 736 | $ 780 | $ 333 | $ 792 | $ 599 | $ 645 | $ 1,066 | $ 680 | $ 629 | $ 583 | $ (46) | $ (197) | $ (153) |
| **Other Expenses** | | | | | | | | | | | | | | | |
| Other Expenses | n/a | $ 2,667,892 | $ 1,940,741 | $ 1,891,477 | $ 1,696,938 | $ 1,833,270 | $ 1,576,147 | $ 1,824,069 | $ 2,271,303 | $ 1,733,013 | $ 2,127,997 | $ 1,987,302 | $ (140,695) | $ 95,825 | $ 46,561 |
| Other Expenses/APD | n/a | $ 3,314 | $ 2,060 | $ 1,878 | $ 1,458 | $ 1,346 | $ 1,202 | $ 1,366 | $ 2,341 | $ 1,483 | $ 1,486 | $ 2,050 | $ 564 | $ 172 | $ (10) |
| **Margin** | | | | | | | | | | | | | | | |
| Net Income | n/a | $ (148,502) | $ 7,291,804 | $ 383,722 | $ 2,041,456 | $ 248,064 | $ 19,121 | $ (1,152,036) | $ (250,823) | $ 5,868,595 | $ 173,184 | $ (1,218,683) | $ (1,391,867) | $ (1,602,405) | $ (8,510,487) |
| Net Profit Margin | n/a | -2.3% | 99.0% | 3.0% | 19.5% | 2.5% | 0.2% | -12.8% | -2.8% | 87.7% | 1.6% | -16.5% | -18.2% | -19.5% | -115.5% |
| Operating Income | n/a | $ (2,074,854) | $ (1,825,078) | $ (686,444) | $ 1,459,716 | $ (77,526) | $ (302,930) | $ (1,449,616) | $ (530,332) | $ (3,343,933) | $ (50,046) | $ (1,310,237) | $ (1,260,191) | $ (623,792) | $ 514,841 |
| Operating Margin | 2.9% | -32.5% | -24.8% | -10.9% | 13.9% | -0.8% | -3.1% | -16.1% | -5.9% | -50.0% | -0.5% | -17.8% | -17.3% | -6.9% | 7.0% |
| EBITDA | n/a | $ (492,817) | $ 7,678,588 | $ 841,891 | $ 2,482,790 | $ 689,172 | $ 459,316 | $ (742,505) | $ 158,708 | $ 6,277,759 | $ 582,348 | $ (809,519) | $ (1,391,867) | $ (1,651,410) | $ (8,488,107) |
| EBITDA Margin | 12.7% | -7.7% | 104.3% | 8.7% | 23.7% | 7.0% | 4.7% | -8.3% | 1.8% | 93.8% | 5.5% | -11.0% | -16.5% | -19.7% | -115.3% |
| Debt Service Coverage Ratio | 3.70 | 6.3 | 3.3 | 0.8 | 7.3 | 5.5 | 3.3 | 3.4 | 7.7 | 7.1 | 6.9 | (0.1) | 3.6 | 0.6 | |
| **Cash** | | | | | | | | | | | | | | | |
| Avg Daily Disbursements (excl. IGT) | n/a | $ 559,596 | $ 390,998 | $ 355,328 | $ 367,107 | $ 398,922 | $ 315,796 | $ 399,234 | $ 296,503 | $ 367,542 | $ 359,843 | $ 413,756 | $ 53,913 | $ 58,428 | $ 22,759 |
| Average Daily Cash Collections (excl. IGT) | n/a | $ 261,927 | $ 307,834 | $ 299,110 | $ 349,783 | $ 262,199 | $ 302,042 | $ 359,292 | $ 288,101 | $ 273,563 | $ 239,449 | $ 271,384 | $ 31,934 | $ (27,727) | $ (36,450) |
| Average Daily Net Cash | | $ (297,669) | $ (83,164) | $ (56,218) | $ (17,324) | $ (136,723) | $ (13,754) | $ (39,942) | $ (8,402) | $ (93,979) | $ (120,394) | $ (142,373) | $ (21,979) | $ (86,155) | $ (59,209) |
| Upfront Cash Collections | | | $ 20,936 | $ 36,146 | $ 32,509 | $ 37,333 | $ 36,220 | $ 57,023 | $ 26,687 | $ 22,508 | $ 60,336 | $ 83,209 | $ 22,873 | $ 47,063 | $ 62,273 |
| Upfront Cash % of Gross Charges | 1% | 0.0% | 0.1% | 0.2% | 0.2% | 0.2% | 0.2% | 0.3% | 0.2% | 0.1% | 0.3% | 0.5% | $ 0 | $ 0 | $ 0 |
| Unrestricted Funds | n/a | $ 22,402,009 | $ 15,105,562 | $ 23,536,438 | $ 27,015,779 | $ 24,366,780 | $ 24,708,310 | $ 22,963,678 | $ 16,099,369 | $ 15,074,303 | $ 22,744,726 | $ 23,805,870 | $ 1,061,144 | $ 269,432 | $ 8,700,308 |
| Change of cash per balance sheet | n/a | $ (1,708,434) | $ (3,782,743) | $ (541,459) | $ 1,876,964 | $ (2,648,999) | $ 341,530 | $ (1,744,632) | $ (6,864,309) | $ (1,025,067) | $ 7,670,424 | $ 1,061,144 | $ (6,609,280) | $ 1,602,602 | $ 4,843,887 |
| Days Cash on Hand (assume no more cash is collected) | 196 | 69 | 48 | 72 | 98 | 84 | 58 | 77 | 43 | 50 | 74 | 86 | 12 | 14 | 38 |
| Estimated Days Until Depleted (operating cash only) | | 75 | 254 | 406 | 506 | 413 | 440 | 442 | 372 | 292 | 370 | 332 | (37) | (73) | 79 |
| Years Until Cash Depletion (operating cash only) | | 0.21 | 0.70 | 1.11 | 1.39 | 1.13 | 1.21 | 1.21 | 1.02 | 0.80 | 1.01 | 0.91 | (0.10) | (0.20) | 0.22 |

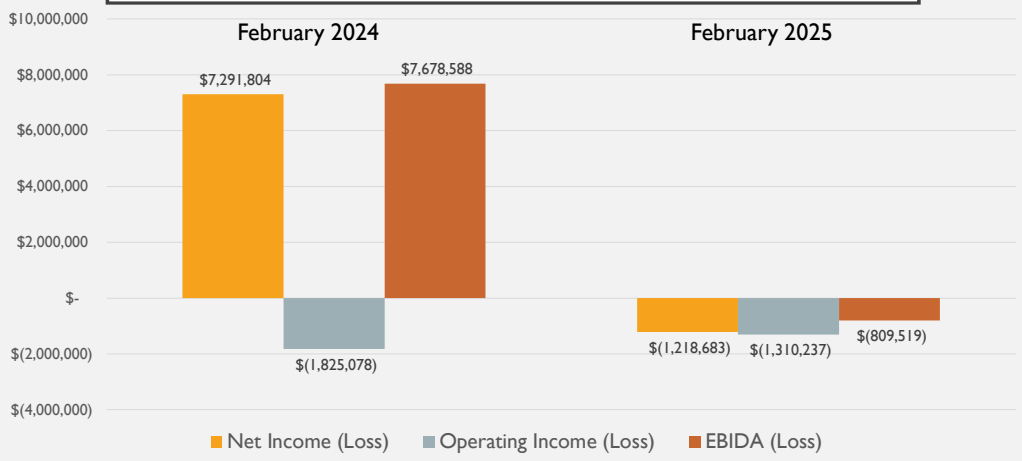
NORTHERN INYO HEALTHCARE DISTRICT
*One Team. One Goal. Your Health.*

# NIHD FINANCIAL UPDATE

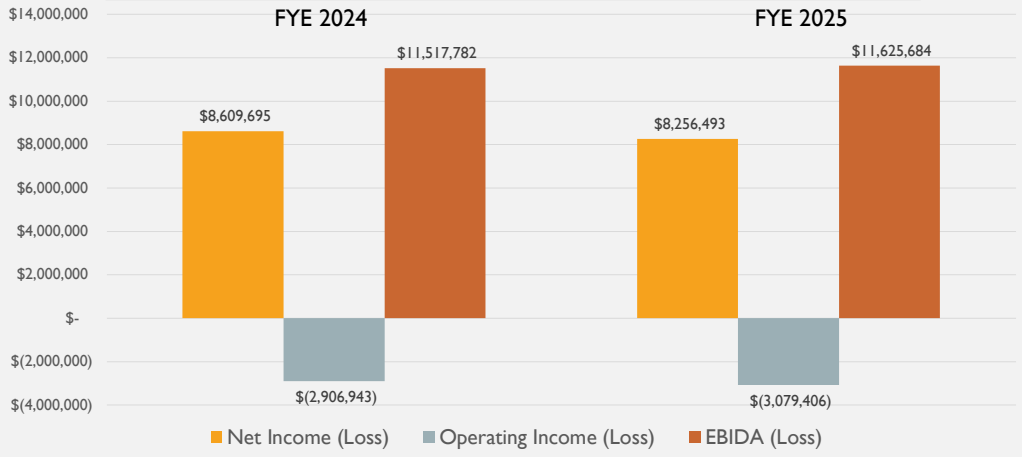
February 2025

# INCOME

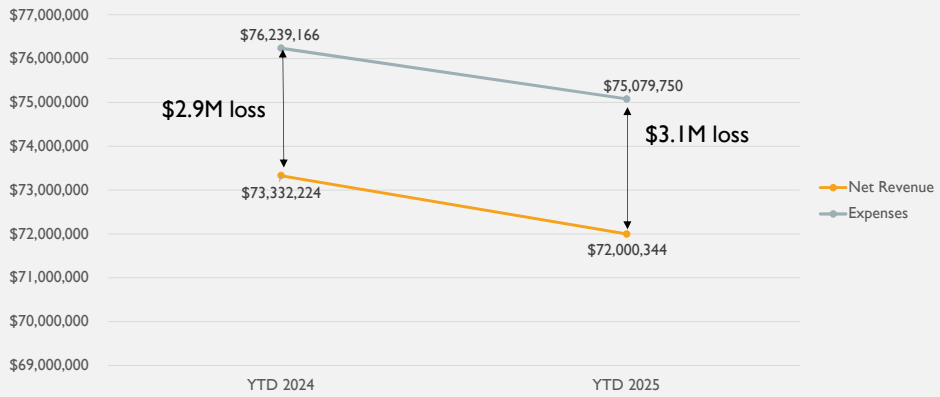
# FEBRUARY 2025 FINANCIAL PERFORMANCE



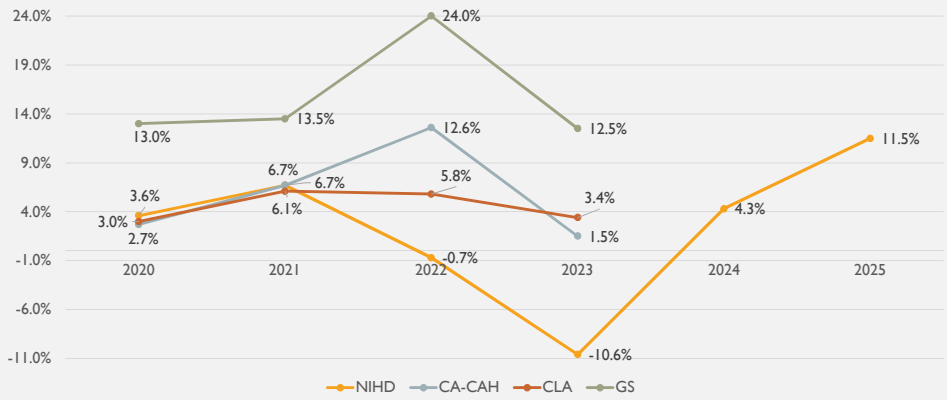

# FYE 2025 FINANCIAL PERFORMANCE



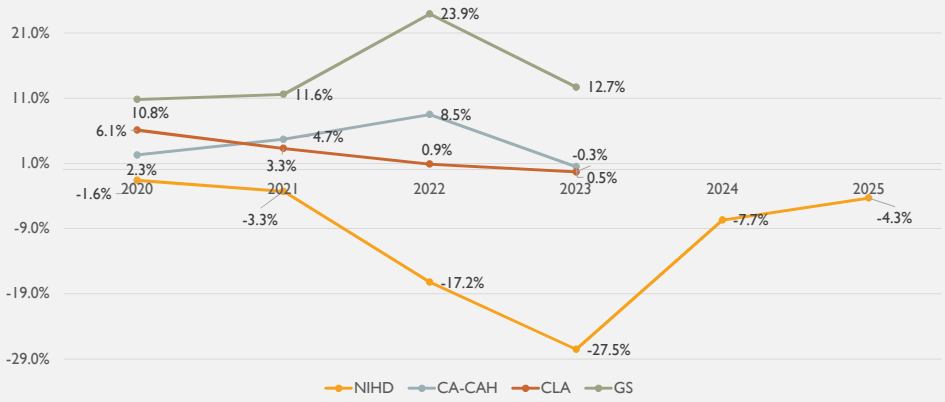
# YTD OPERATING INCOME (LOSS) PERFORMANCE



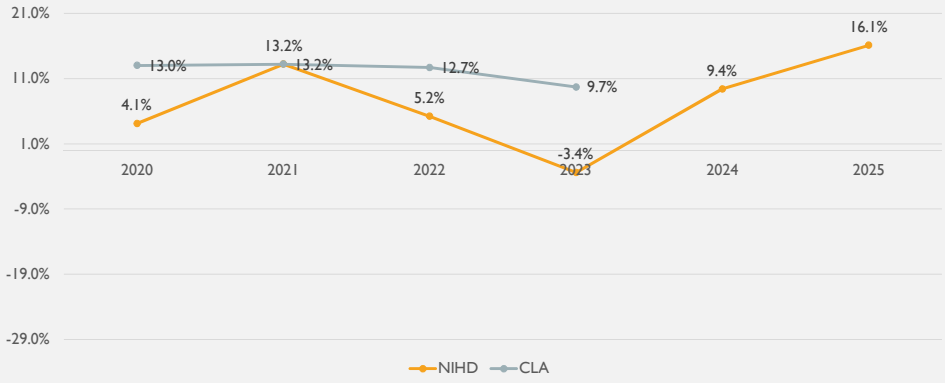

# NET PROFIT MARGIN



# OPERATING MARGIN

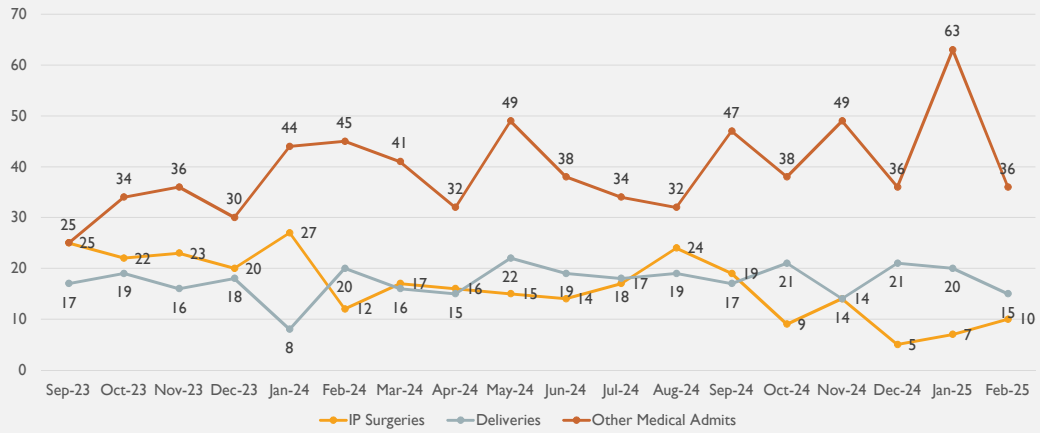



# EBIDA MARGIN

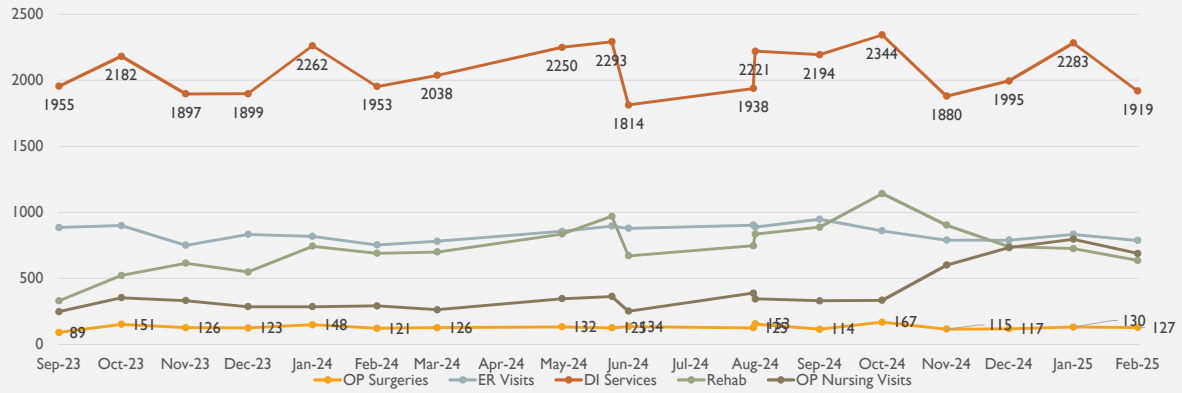


# VOLUMES

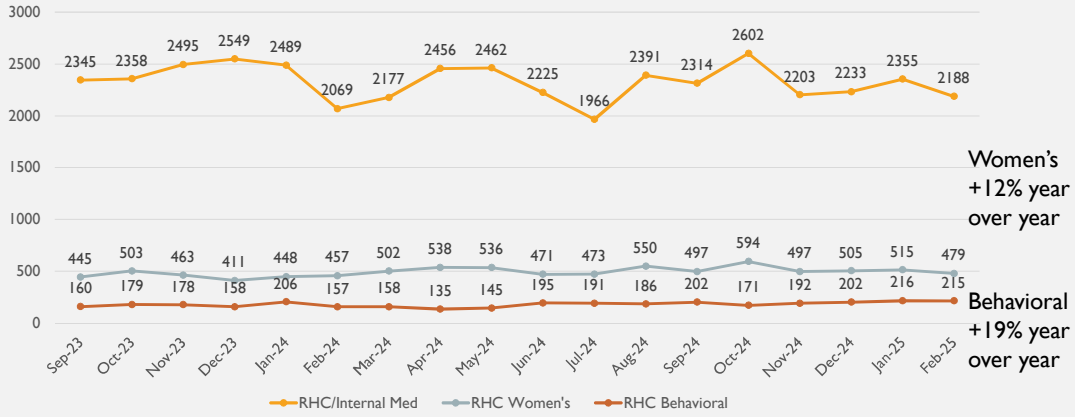
## INPATIENT VOLUME PERFORMANCE



# OUTPATIENT VOLUME PERFORMANCE



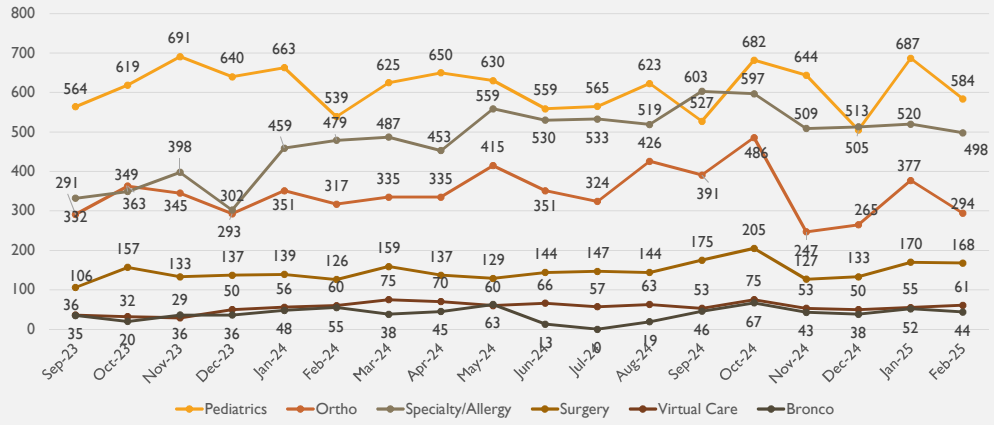

# RHC VOLUME PERFORMANCE




Women's +12% year over year

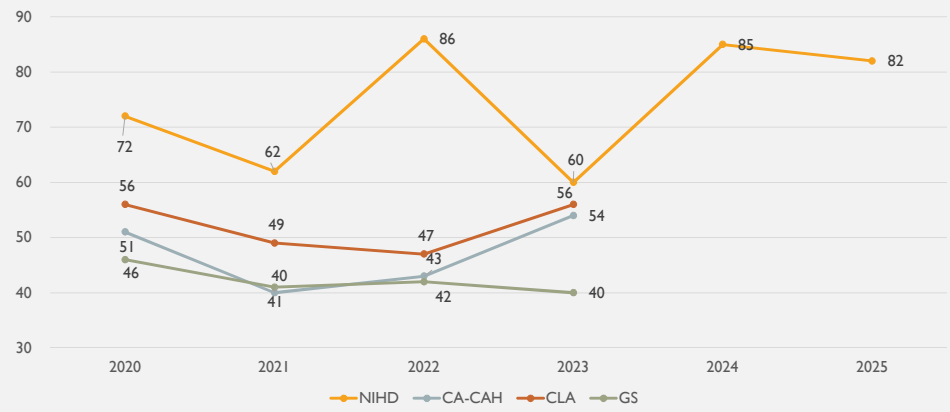
Behavioral +19% year over year

# CLINIC VOLUME PERFORMANCE

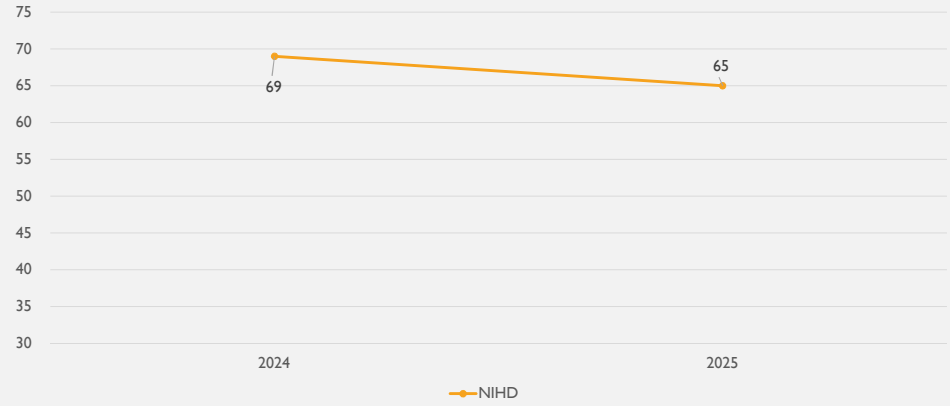



# KEY PERFORMANCE INDICATORS

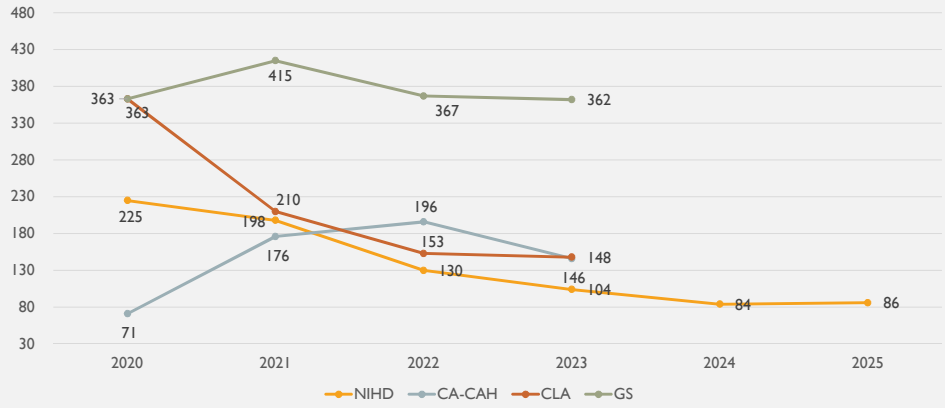
# GROSS AR DAYS



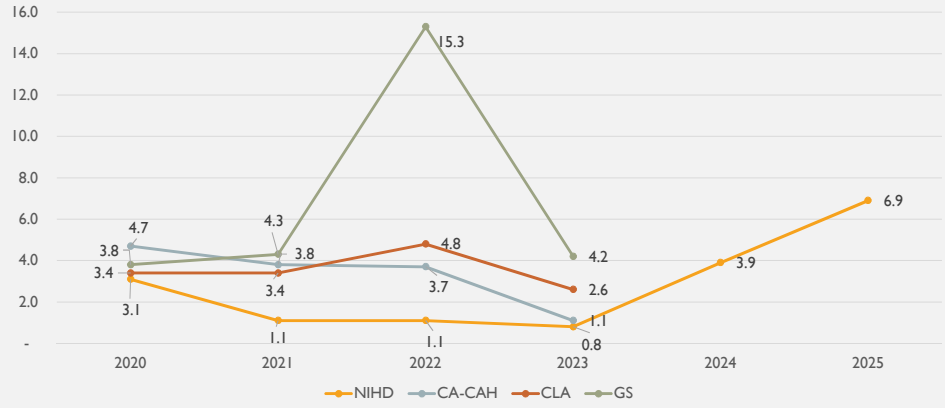

# NET AR DAYS



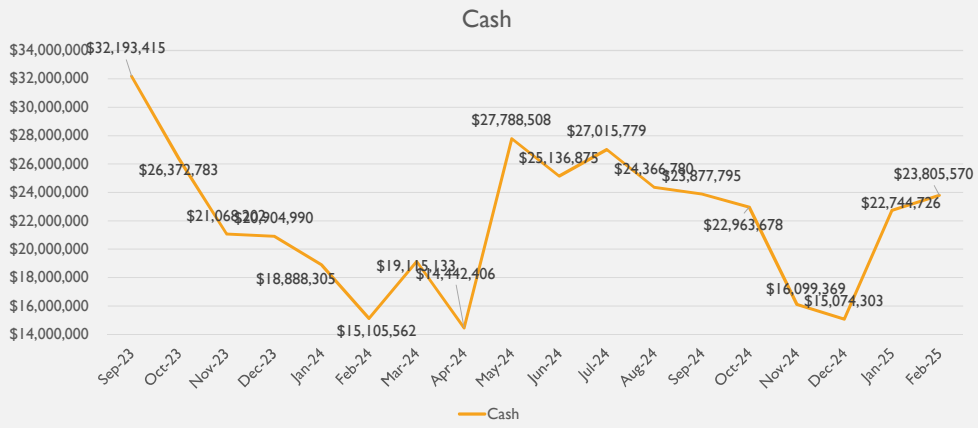
# DAYS CASH ON HAND



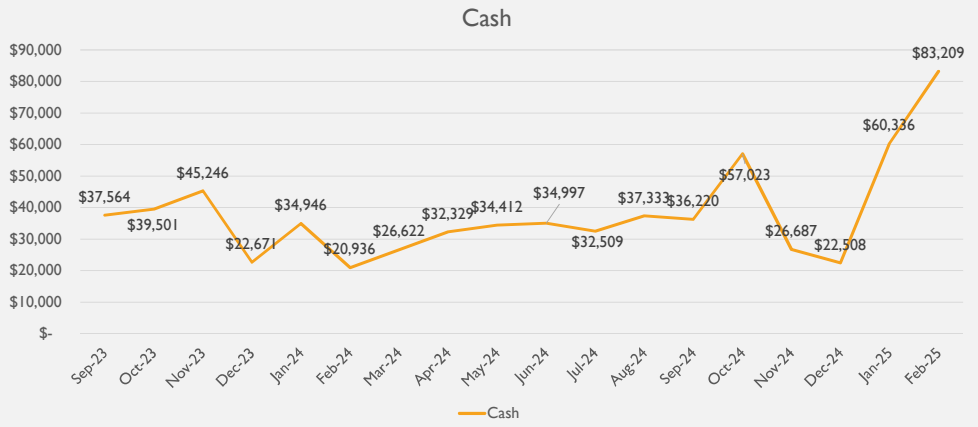

# DEBT SERVICE COVERAGE RATIO



# UNRESTRICTED FUNDS




# UPFRONT CASH COLLECTIONS



# WAGE COSTS

| | YTD 2024 | YTD 2025 |
|---|---|---|
| Total Paid FTEs | 379 | 380 |
| Salaries, Wages, Benefits (SWB) Expense (incl. contract labor) | $42,443,015 | $41,224,906 |
| SWB % of total expenses (including contract labor) | 56% | 53% |
| Employed Average Hourly Rate | $52.79 | $52.06 |
| Benefits % of Wages | 51% | 47% |

| | Final FYE 2024 | 2025 YTD Feb Actual | Annualized FYE 2025 | Adjustment | FYE 2025 Projection | Variance to PYTD | Comment |
|---|---|---|---|---|---|---|---|
| **Revenue** | | | | | | | |
| Inpatient Patient Revenue | $ 41,350,077 | $ 27,840,843 | $ 41,761,265 | $ (1,120,400) | $ 40,640,865 | -1.7% | Inpatient surgical volume is down due to orthopedic & gynecology |
| Outpatient Revenue | $ 166,037,287 | $ 113,062,416 | $ 169,593,624 | $ (4,324,888) | $ 165,268,736 | -0.5% | Starting to see decline in surgeries due to ortho, opthamology along with less rehab and DI services. Also, observation hours process change in surgeries and women's |
| Clinic Revenue | $ 19,388,997 | $ 14,002,333 | $ 21,003,499 | $ (120,322) | $ 20,883,177 | 7.7% | Starting to see decline in RHC (primary care) visits along with decline in ortho clinic offset by increases in RHC women's, behavioral, specialty, and surgical clinics |
| Cerner Unaliased | | $ (343,646) | $ (515,469) | | $ (515,469) | 100% | |
| **Gross Patient Service Revenue** | **$ 226,776,361** | **$ 154,561,946** | **$ 231,842,919** | **$ (5,565,610)** | **$ 226,277,309** | -0.2% | |
| Deductions from Revenue | $ (122,193,745) | $ (82,566,037) | $ (123,849,056) | $ 3,000,000 | $ (120,849,056) | -1.1% | adjusting to keep NR% of GR consistent |
| Other Revenue | $ 2,617,122 | $ 4,435 | $ 6,652 | | $ 6,652 | -100% | Prior year was one time item |
| **Net Patient Service Revenue** | **$ 107,199,738** | **$ 72,000,344** | **$ 108,000,516** | **$ (2,565,610)** | **$ 105,434,906** | **-1.6%** | |
| Net Revenue % of Gross Revenue | 47.3% | 46.6% | 46.6% | 46.1% | 46.6% | -1.4% | |
| **Expense** | | | | | | | |
| Salaries and Wages | $ 43,973,065 | $ 25,533,295 | $ 38,299,943 | | $ 38,299,943 | -12.9% | Increased employee average rate |
| Benefits | $ 18,923,640 | $ 11,987,780 | $ 17,981,670 | | $ 17,981,670 | -5.0% | Achieved $1M in pension plan savings due to better rate of return on investments. |
| Contract Labor | $ 6,399,832 | $ 3,703,831 | $ 5,555,746 | $ 1,175,000 | $ 6,730,746 | 5.2% | Consistently running over - keep at 5% over prior year |
| Professional Fees | $ 18,568,419 | $ 16,510,240 | $ 24,765,360 | $ 800,000 | $ 25,565,360 | 37.7% | Consistently running over compared to prior year - Jorie's invoice is higher than previous biller |
| Pharmacy | $ 5,832,893 | $ 2,795,403 | $ 4,193,104 | $ 800,000 | $ 4,993,104 | -14.4% | Surgical volume decline causing decline in drug costs |
| Medical Supplies | $ 5,492,950 | $ 3,612,426 | $ 5,418,639 | $ (1,000,000) | $ 4,418,639 | -19.6% | Inventory adjustment expected to be higher (more supplies on hand) due to lower surgical volume |
| Other Expenses | $ 7,542,242 | $ 7,569,085 | $ 11,353,628 | $ (3,050,000) | $ 8,303,628 | 10.1% | Increased utilities, insurance, repairs, and cerner expenses. |
| Depreciation and Amortization | $ 5,209,724 | $ 3,369,191 | $ 5,053,786 | $ 500,000 | $ 5,553,786 | 6.6% | Asset inventory/cleanup and pharmacy additions causing increase from last year |
| **Total Expenses** | **$ 111,942,765** | **$ 75,081,250** | **$ 112,621,875** | **$ (775,000)** | **$ 111,846,875** | **-0.1%** | |
| Financing Expense | $ 2,782,380 | $ 1,603,868 | $ 2,405,802 | | $ 2,405,802 | -13.5% | Less interest expense on debt |
| Financing Income | $ 3,155,532 | $ 1,663,707 | $ 2,495,560 | $ (515,917) | $ 1,979,643 | -37.3% | Recent income has lowered to $78k monthly |
| Investment Income | $ 178,752 | $ 369,110 | $ 553,664 | | $ 553,664 | 209.7% | Investing more short term cash |
| Total Grant Revenue | | | | | | | |
| Miscellaneous Income | $ 9,902,290 | $ 10,906,950 | $ 16,360,425 | $ (3,000,000) | $ 13,360,425 | 34.9% | IGT - receiving higher QIP this year |
| **Net Income/(Loss)** | **$ 5,711,167** | **$ 8,254,992** | **$ 12,382,488** | | **$ 7,075,961** | **23.9%** | |
| **Net Profit Margin %** | **5.3%** | **11.5%** | **11.5%** | | **6.7%** | **1.4%** | |
| **Operating Income/(Loss)** | **$ (4,743,027)** | **$ (3,080,907)** | **$ (4,621,360)** | | **$ (6,411,970)** | **-35.2%** | |
| **Operating Margin %** | **-4.4%** | **-4.3%** | **-4.3%** | | **-6.1%** | **-1.7%** | |

**NIHD FYE 2025 Cash Projection**

| | | FYE 2025 | Comment |
|---|---|---|---|
| YTD Cash Collections (March 2025) | $ | 99,583,181 | Consistent with prior year (when removing rate range which had not been paid in cash this time last year) |
| One time items: | | | |
| Grants | $ | 103,312 | |
| IGT | $ | 14,470,714 | |
| Tax Appropriations | $ | 1,942,847 | |
| Other | $ | 365,630 | Voya Stoploss (medical benefits) |
| Total non-recurring cash | $ | 16,882,503 | |
| Expected one-time items: | | | |
| Grants | $ | - | Nothing approved |
| IGT | $ | 7,899,518 | 2 more quarterly HQAF, 6 month directed payment, AB 915, AB 113, and QIP - should be recouped by June |
| Tax Appropriations | $ | 1,100,000 | Based on prior year - receipt in May |
| ERC | $ | - | IRS Covid employee retention credit - IRS is slow to processing ~$5M. It is questionable whether we will get approved |
| Other | $ | 135,000 | Voya Stoploss (medical benefits) |
| Other | $ | 5,000,000 | Adjust for annual run rate |
| Total expected one-time items | $ | 14,134,518 | |
| Projected FYE 2025 cash intake | **$** | **130,029,589** | Prior year was $133.9M, FYE 2023 was $124.4M |
| YTD Disbursements | $ | (102,839,753) | Higher than prior year by $2M |
| One time items: | | | |
| Bond payments | $ | (1,967,350) | |
| SB1334 Retro | $ | (1,600,000) | Missed rest breaks paid in August |
| Capital | $ | (1,452,290) | Q1 approved budget |
| IGT | $ | (5,797,277) | Rate range, QIP, directed payments, HQAF |
| Total non-recurring disbursements | $ | (10,816,917) | |
| Expected one-time items: | | | |
| Bond payments | $ | (376,625) | |
| Capital | $ | (1,500,000) | Q2 - Q4 approved budget |
| Other | $ | (6,000,000) | Adjustment for monthly average increasing |
| Total expected one-time items | $ | (7,876,625) | |
| Projected FYE 2025 disbursements | **$** | **(134,179,380)** | Prior year was $132.3M |
| Projected 2025 Net Cash | **$** | **(4,149,791)** | |
| Daily Deficit | **$** | **(11,338)** | |

| Available Balances at 2/28/25 | |
|---|---|
| ESBC General Checking | 15,467,264 |
| US Bank Checking | 954,816 |
| US Bank RHC | 274,267 |
| US Bank Athena | 539,522 |
| Petty Cash | 1,650 |
| LAIF | 5,343,294 |
| CDs maturing within 3 months | 1,076,105 |
| Cash or cash equivalents | **$ 23,656,918** |
| CD - not available as cash equivalent | $ 1,000,000 |
| Total with investments | $ 24,656,918.29 |

| | | | | |
|---|---|---|---|---|
| June 2024 cash balances | $ | 27,284,892 | | |
| February 2025 cash balances | $ | 23,656,918 | | |
| Depletion | $ | (3,627,974) | | |
| Average Depletion per month | $ | (453,496.71) | Using projected daily deficit | |
| Average Daily Depletion | | (14,930) | $ | (11,338) |
| Days until depleted | | 1,585 | | 2,086 |
| Years until depleted | | **4.3** | | 5.7 |
| Estimated Ending Cash Balances | **$** | **25,015,542** | | |
| Days cash on hand | | **82** | | |