Northern Inyo Healthcare District

Board Meetings

Board Meeting - May 21, 2025

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS - REGULAR MEETING

May 21, 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.

Board Member David McCoy Barrett will participate in the meeting via teleconference from the following location, in accordance with Government Code § 54953(b):

61 Yorkville Ave
Toronto, ON M5R 3V6, Canada

This teleconference location will be accessible to the public, and the agenda will be posted at this location at least 72 hours in advance of the meeting. Members of the public may attend and participate from this location. All votes taken during the meeting will be conducted by roll call.

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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.

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3. Public comments on closed session items
4. Adjournment to closed session to/for:
    a. Threat to Public Services or Facilities
    Pursuant to Government Code § 54957(a)
    Subject: Consultation with security consultant regarding cybersecurity threats to critical infrastructure systems
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 April 16, 2025, Regular Board Meeting
    b. CEO Credit Card Statement
    c. Approval of Policies and Procedures
        i. Condition Code 44
        ii. Discharge Planning for the Hospitalized Patient
        iii. Informed Consent Policy – Practitioner's Responsibility
        iv. Management of the Behavioral Health Patient (5150 and non-5150)
        v. Medical Staff Department Policy – Outpatient Medicine
        vi. Patient Valuables
        vii. Patient Safety Attendant or 1:1 Staffing Guidelines
        viii. Pharmacy Hazardous Drugs: Receiving, Storage, Compounding and Transporting
        ix. Plan for the Provision of Social Services at NIHD
        x. Utility System Failure-Elevator

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7. New Business:
    a. Cybersecurity Contract – *Action Item*

b. Board Self-Assessment – *Information Item*
c. Board Meeting Location – *Information Item*
d. Marketing Report – *Information Item*
e. Quarterly Compliance Report – *Action Item*
f. Chief of Staff Report, Sierra Bourne MD
    i. Medical Executive Committee Meeting Report – *Information Item*
g. Chief Executive Officer Report
    i. CEO Comments – *Information Item*
h. Chief Human Resources Officer / Chief Business Development Officer
    i. AB 2561 (McKinnor): Local public employees: vacant positions
i. Chief Financial Officer Report
    i. Department Update – *Information Item*
    ii. Financial & Statistical Reports (*Board will consider the approval of these reports)*

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

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9. Public comments on closed session items
10. Adjournment to closed session to/for:
    a. Conference Concerning Trade Secrets
    Pursuant to Health and Safety Code § 32106 and Civil Code § 3426.1
    Subject: Discussion of a new service line
    Estimated Date of Public Disclosure: September 2025
    b. Conference with Labor Negotiator
    Pursuant to Government Code § 54957.6
    Agency Designated Representative: Northern Inyo Healthcare District Chief Human Resources Officer
    Employee Organization: AFSCME Council 57
    c. Public Employee Appointment / Discussion
    Pursuant to Government Code § 54957(b)(1)
    Title: Chief Executive Officer Candidate

d. Public Employee Performance Evaluation

Pursuant to Government Code § 54957(b)(1)

Title: Interim Chief Executive Officer

11. Return to open session and report on any actions taken in closed session.
12. 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 Melissa Best-Baker, Vice Chair David McCoy Barrett, Treasurer Laura Smith, Member at Large Allison Partridge, Acting Chief Executive Officer / Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Andrea Mossman, Chief Financial Officer
ABSENT	David Lent, Secretary Alison Murray, Chief Human Resources Officer, Chief Business Development Officer 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. A member of the public inquired about: 1. Orthopedics' current state 2. Suspension of Dr. Loy Chair Turner stated: 1. The District will provide an update on the Orthopedics Department at a future meeting. 2. The District is obligated to maintain confidentiality regarding personnel matters and cannot comment on individual employment actions.
INTERIM CEO CONTRACT	Chair Turner called attention to the Interim CEO Contract. Chair Turner called attention to the material compensation in the Interim CEO Contract. 1. Annual compensation $518,481.60 2. Start Date: April 28, 2025 3. Term: Four months, with the option to move to a month-to-month arrangement thereafter 4. Travel Reimbursement: Reimbursable travel between Bishop and the CEO’s primary residence at the start and end of service, based on the IRS-approved mileage rates 5. Employee Benefits: Eligibility for the same benefits as all other employees 6. Severance: One month's salary

Discussion ensued.

Motion to approve the Interim CEO Contract: Barrett
2nd: Best-Baker
Passed: 4-0

PUBLIC COMMENT ON CLOSED SESSION ITEMS

There were no comments from the public.

ADJOURNMENT TO CLOSED SESSION

Adjournment to closed session at 5:08 pm

RETURN TO OPEN SESSION

Called back to order at 6:08 pm

Chair Turner stated there were no reportable actions from the closed session.

CONSENT AGENDA

Chair Turner called attention to the Consent Agenda.

Motion to approve the consent agenda: Best Baker
2nd: Smith
Passed: 4-0

CHIEF OF STAFF REPORTS

Motion to approve Medical Staff Initial Appointments: Best Baker
2nd: Barrett
Passed: 4-0

Motion to approve Medical Staff Initial Appointments Proxy Credentialing: Best Baker
2nd: Smith
Passed: 4-0

NEW BUSINESS

CHIEF EXECUTIVE OFFICER REPORT

Chair Turner called attention to the CEO report.

Approving the Deposit and Investment of Funds to Eligible Certificates of Deposit and the Local Agency Investment Funds

1. Removed from the agenda will be added in a future meeting.

ACHD recertification

1. Recertification was completed in January 2025.

Pharmacy Project

1. It is in the final stages and preparing for the final submission for the license and certification.

Stereotactic mammography

1. The new machine provides advanced technology and comfort for patients. The goal is that the machine will be up and running at the end of the week.

Employee of the month

1. March 2025, the employee of the month was Leroy Charley, who is team-focused and has a great attitude.
2. April 2025, the employee of the month was Terry Tye, a patient, and his peers recognized him for his echocardiography program.

CHIEF MEDICAL OFFICER REPORT

Chair Turner called attention to the CMO report.

Discussion ensued.

1. Highlighted the Hantavirus Awareness, Prevention and Protection talk on zoom, April 17, 2025 @ 5:30 pm.
2. CMO Hawkins drew attention to the Hantavirus Article.

CHIEF FINANCIAL OFFICER REPORT

Chair Turner introduced the Chief Financial Officer Report.

Audit of Financial Statements

Discussion ensued.

Public Comments:

Debt-to-Capitalization Ratio and Pension Liabilities

1. Does our debt-to-capitalization ratio include pension liabilities?
   a. Yes, the debt-to-capitalization ratio includes pension liabilities.

Interest on Retired Bonds

2. We have $576k in interest on the retired bonds—can you clarify how this was missed in both last year's and the prior year's financials?
   a. The interest was missed in previous years because the accounting for the bond was not set up properly. The debt was extinguished this year, the auditing process revealed that a reserve remained on our ledger for a bond that had already been closed. This oversight wasn't identified until the auditors conducted their review and flagged the discrepancy.

Accounting Concerns with Other Bonds

3. Are there any similar accounting issues or unresolved reserves associated with other bonds currently held by the district?
   a. At this time, there are no known similar issues with other bonds held by the district. However, as part of our ongoing audit and reconciliation efforts, we are reviewing all bond-related accounts to ensure accuracy and prevent any future discrepancies.

Clarification on Margin Improvement

4. What factors contribute to the change from the operating loss margin to the overall positive margin? It was implied that this change came primarily from taxpayer funding; my understanding is that only 1% of the revenue is from taxpayer contributions. Can you clarify the actual sources of this margin improvement?

a. The change from the operating loss margin to the overall positive margin is mainly due to IGT funding, quality funding, and taxpayer contributions. While taxpayer contributions account for less than 1% of total revenue, the majority of the improvement comes from IGT and quality funding.

Motion to approve the Audit of Financial Statements: Smith
2nd: Best-Baker
Passed: 4-0

Financial Statement and Supplemental Information

Discussion ensued.

Motion to approve Financial Statement and Supplemental Information: Best-Baker
2nd: Smith
Passed: 4-0

Financial and Statistical Reports

Discussion ensued.

Motion to approve Financial and Statistical Reports: Best-Baker
2nd: Barrett
Passed: 4-0

GENERAL INFORMATION FROM BOARD MEMBERS

Director Smith expressed appreciation that the meetings were covered in the local paper, recognizing the value of public awareness and transparency.

Director Best-Baker expressed appreciation for NIHD's presentation at the City Council meeting, acknowledging the positive reception and support from the council members.

Chair Turner emphasized that the organization does not aim to turn people away from receiving services. The primary focus is on enhancing the district's financial sustainability and ensuring the long-term viability of the District.

ADJOURNMENT

Adjournment at 7:37 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____

David Lent
Northern Inyo Healthcare District Chair
Secretary

May 2025 Statement
Open Date: 04/04/2025 Closing Date: 05/06/2025

Account: [redacted]

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

New Balance	**$15,449.66**
Minimum Payment Due	**$155.00**
Payment Due Date	**06/01/2025**

Cardmember Service [redacted] 1-866-485-4545

Activity Summary

Previous Balance	+	$30.81
Payments	-	$30.81CR
Other Credits	-	$30.81CR
Purchases	+	$15,470.13
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged	+	$10.34
Interest Charged		$0.00
New Balance	=	**$15,449.66**
Past Due		**$0.00**
Minimum Payment Due		**$155.00**
Credit Line		$37,500.00
Available Credit		$22,050.34
Days in Billing Period		33

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 [redacted]

No payment is required.

[redacted]

Automatic Payment

[redacted]

24-Hour Cardmember Service: 1-866-485-4545

to pay by phone
to change your address

[redacted]

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

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.

Your payment of $15449.66 will be automatically deducted from your bank account on 05/29/2025. Please refer to your AutoPay Terms and Conditions for further information regarding this account feature.

*IMPORTANT NOTICE: Please see the enclosed insert for changes being made to your cardmember agreement.

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
04/29	04/28	7058	ETSY, INC. 718-8557955 NY MERCHANDISE/SERVICE RETURN	$30.81CR	Nurses Week
04/29	04/29	MTC	PAYMENT THANK YOU	$30.81CR	
			TOTAL THIS PERIOD	**$61.62CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
04/04	04/03	7241	IN *THE DAISY FOUNDATI 415-5952557 CA	$350.00	Nurse Awards
04/04	04/03	0985	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
04/04	04/03	5064	YETI 1-833-225-9384 512-3949384 DE	$9,482.00	Hospital Week
04/07	04/04	4467	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
04/09	04/08	7683	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
04/10	04/10	0303	CBI*TENABLE 800-799-9570 IL	$4,790.00	IT Subscription
04/14	04/11	2117	DEEPL* SUB:77E5BUFFLBO KOLN DE	$344.88	interpretive Services
04/16	04/15	8373	AMAZON MKTPL*M87YH7EN3 Amzn.com/bill WA	$42.39	Kids Day
04/17	04/16	6931	AMAZON MKTPL*MB1GQ84C3 Amzn.com/bill WA	$26.08	Kids Day
04/22	04/21	9487	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
04/22	04/21	9552	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
04/22	04/21	2085	ETSY, INC. 718-8557955 NY	$55.25	Nurses Week
04/24	04/23	9181	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
04/28	04/25	5028	Subway 572 Bishop CA	$118.77	City of Hope Lunch
04/30	04/28	0192	TST*GREAT BASIN BAKERY Bishop CA	$31.49	CNO
04/30	04/29	0859	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
05/01	04/30	9715	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
05/01	04/30	9897	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
05/01	04/30	9970	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0036	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0119	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0291	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Med Staff

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NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service 1-866-485-4545

Transactions

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description		Amount	Notation
05/01	04/30	0374	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0457	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0523	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0606	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0788	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0861	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0945	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1026	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1109	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1281	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1364	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1448	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1513	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1695	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	1778	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/01	04/30	0080	FACEBK *CRR89R8KU2	650-5434800 CA	$154.27	Marketing
05/05	05/02	3842	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
05/06	05/05	6260	NPDB NPDB.HRSA.GOV	800-767-6732 VA	$2.50	Med Staff
				TOTAL THIS PERIOD	**$15,470.13**	

Fees

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
04/14	04/11	2117	FRGN TRANS FEE-DEEPL* SUB:77E5BUFFLBO KO	$10.34	
			TOTAL FEES THIS PERIOD	**$10.34**	

2025 Totals Year-to-Date	
Total Fees Charged in 2025	$10.34
Total Interest Charged in 2025	$0.00

Company Approval *(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

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NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service 1-866-485-4545

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	$15,449.66	$0.00	YES	$0.00	23.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

[redacted]

End of Statement

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Condition Code 44		
Owner: DON Inpatient Services	Department: Case Management	
Scope: Inpatient Departments		
Date Last Modified: 01/06/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

approval

PURPOSE:

The Centers of Medicare and Medicaid Services (CMS) established Condition Code 44 to address relatively infrequent occasions, such as late-night or weekend admission when case management is not staffed, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered under observation status under ordinary circumstances. In no case may a non-physician make a final determination that a patient's stay is not medically necessary or inappropriate. However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and Utilization Review (UR) Chair and to assist the Utilization Review Chair in the decision making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management staff or for continued education of physicians and hospital staff about existing admission protocols. As education and staffing efforts continue to progress, the need for hospital to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare.

POLICY:

Condition Code 44 is used in cases where the UR Chair or, if UR chair is unavailable, UR Committee member in conjunction with the attending provider determines that an inpatient admission does not meet the hospital's inpatient criteria per Interqual. The hospital changes the beneficiary's status from inpatient to observation status and submits an observation status claim for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to observation is made prior to discharge or release, while the beneficiary is still a patient of the hospital; and
2. The hospital has not submitted a claim to Medicare for the inpatient admission; and
3. A physician concurs with the decision made by the UR Chair or UR Committee member; and
4. The physician's concurrence with the decision made by the UR Chair or UR Committee member is documented in the patient's medical record.

A written notice regarding the change in the patient's admission status must be provided to the hospital, patient, and physician responsible for the care of the patient no later than two days after the determination is made.

Condition Code 44 is used by CMS to track and monitor these occurrences. The reporting of Condition Code 44 on a claim does not affect the amount of the payment that would otherwise be made for a hospital observation status claim that did not require the reporting of Condition Code 44.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes, the medical record, with complete orders and notes that indicate why the change was made, the care that was furnished to the beneficiary and the participants in making the decision to change the patient's status, must be noted in the record.

PROCEDURE:

Medical Staff

One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria that the patient should have been registered as an observation patient. The physician responsible for the care of the patient must be consulted and allowed to present their views to the UR Chair or UR Committee Member to determine if the admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

When the physician responsible for the care of the patient concurs, then he/she must document in the medical record with a change in patient status order. *In Cerner, this would be a PSO. This order must be entered by the admitting/attending physician.* The order must indicate to change the patient status from inpatient to observation.

Case Management

The Case Manager (CM) will consult with the physician responsible for the care of the patient

When the physician responsible for the care of the patient concurs with the UR Chair/UR Committee member decision that the patient status should be changed from inpatient to observation, the Case Manager will ascertain that the following conditions are met and fully documented in the medical record:

1. The change in patient status from inpatient to observation is made prior to discharge or release, while the beneficiary is still a patient of the hospital; and
2. The hospital has not submitted a claim to Medicare for the inpatient admission; and
3. A physician concurs with the UR Chair/UR Committee member, and
4. The physician's concurrence with UR Chair/UR Committee member's decision is documented in the patient's medical record.
5. A written notice regarding the change to the patient's status will be given to the patient, to the provider, and a copy will be placed in the medical record. Additionally, Case Management will document in the medical record that the change has occurred.

If all the above conditions are met and fully documented in the medical record, the Case Manager will notify Registration that patient status has been changed and record on shared spreadsheet with Revenue Cycle. Following this notification, Registration will provide the Medicare Outpatient Observation Notice (MOON) to the patient.

If a UR committee member was consulted in place of the UR Chair and the physician responsible for the care of the patient does not concur with the decision of the UR committee member, the case will be forwarded to the UR Chair for review. If the UR Chair confirms that inpatient status is not appropriate, the determination regarding medical necessity is final. Condition code 44 will be applicable in this situation.

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REFERENCES:

1. 42 Code Federal Register 482.12 & 482.30
2. Medicare Claims Processing Manual, Chapter 1, sections 50.3.1 & 50.3.2
3. Medicare Benefit Policy Manual, Chapter 6, Section 10

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: Not Set

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Discharge Planning for the Hospitalized Patient		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: Emergency Department, Acute/Subacute, Perinatal, Intensive Care Unit		
Date Last Modified: 01/16/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2017	

approval

PURPOSE:

To ensure an effective discharge plan is in place to meet the patient's continuing healthcare needs post-hospitalization. Discharge planning is an integral part of the hospital's provision of care, involving the assessment and treatment of the patient's medical, psychological, and social needs that contribute to continuity of care to ensure a safe recovery post-hospitalization. The Case Management staff recognizes the relationship between psychosocial factors, the patients' health/illness, the influence these factors have on the patient's recovery, and the potential for re-hospitalization. The goal is to provide all patients with discharge planning that creates a continuity of care that includes the input and coordination of the interdisciplinary care team, the primary care practitioner, the patient and their family, and/or primary care givers.

POLICY:

1. Discharge planning will be conducted with all in-patients admitted to Northern Inyo Healthcare District (NIHD), or upon request from the Emergency Department or Post-Anesthesia Care Unit (PACU), according to state and federal regulatory requirements.
2. Discharge planning will be conducted by either a Registered Nurse (RN) or a Social Worker trained in the process of effective discharge planning and case management. Supervision and oversight of the discharge planning process shall be by the Chief Nursing Officer (CNO).
3. A hospitalized patient and the patient's family and/or caregiver shall be given the opportunity to participate in the discharge planning process.
4. Discharge planning evaluations will be initiated upon admission.
5. Patients shall be discharged based upon attainment of patient care goals as evident in the interdisciplinary plan of patient care and access to sufficient resources.
6. The entire interdisciplinary care team shall have input into the discharge planning process, including physicians, nursing staff, rehabilitation staff, social services/case managers, respiratory staff, pharmacists, etc.
7. The discharge planning needs of the patient shall be reassessed daily during the Interdisciplinary Care Team meetings. Changing needs of the patient or family/caregivers shall be taken into consideration and reflected in the discharge plan and documentation.
8. If discharge plans include transferring a patient to another facility, NIHD will collaborate with the patient and/or family to make arrangements for the transfer, and include all necessary medical information and documentation to facilitate continuity of care.

PROCEDURE:

1. **Screening-** Admission screenings will take place for all admitted patients to identify risk factors that have the potential to create adverse health consequences to the patient post-hospitalization. Screening risk factors can include bio, psycho, social components such as diagnosis, age, lack of adequate resources or sources of support, co-existing illnesses, behavioral health issues, etc.

2. **Evaluation-** This process involves interviewing the patient, family, and/or caregivers to determine their needs, preferences, challenges, resources and how they are coping and adjusting to the illness and hospitalization. The interview should attempt to ask the following questions and gather the following information:
   A. Current living situation, including identifying any potential safety issues
   B. Sources of support, both financial resources and family/caregiver assistance.
   C. Upon discharge, will the patient be capable of performing their own ADL's; if unable a plan for necessary types of assistance will be arranged.
   D. What equipment will the patient need if they are returning home?
   E. What referrals are important to facilitate a safe and effective discharge? (e.g. nursing home placement, out-pt. rehabilitation, home health services, etc.)
   F. Will the patient's insurance cover post-discharge services?
   G. Do they have transportation to follow up appointments?
   H. Are there any safety concerns with this patient? (e.g. fall risk, negligent spouse or caregiver, can the patient continue to safely drive)
   I. Are the patient's family and /or caregivers competent, capable and willing to help provide care or assistance to the patient? How much, for how long?
   J. What changes have occurred in the patient's physical or cognitive functioning that will require adjustments in the services or support provided to the patient post-discharge? (e.g. has the pt. moved from one level of care to another?)
   K. Has there been a change in the patient's cognitive functioning and executive decision-making ability? Are they capable of making sound decisions regarding their post-hospital needs?
   L. Does the patient have a behavioral health problem that adds a layer of complexity to their hospitalization and creates additional risk to their health and safety, such as a psychiatric diagnosis, suicidal ideations, or a history of substance abuse and dependence? If so, are they motivated to address these issues as part of the discharge plan?
   M. Does the patient and family and/or caregiver demonstrate good insight and awareness into the nature and contributing factors that led to the patient's hospitalization?
   N. Does the patient and family and/or caregivers have realistic expectations about post-hospitalization and recovery?
   O. Are the patient and family coping effectively with the patient's illness, hospitalization or diagnosis?
   P. What behavioral health needs do the patient and family and/or caregiver need in order to improve their functioning, enhance their hospital experience, or to ensure the patient's continuity of care upon discharge? (e.g. crisis intervention, brief grief counseling, education about illness or diagnosis)
   Q. Does the patient have an Advanced Directive or a Durable Power of Attorney? Make sure it's on file and up to date.
   R. If the patient is a minor, are they eligible and meet the criteria for California Children Services?
   S. If the patient is a minor, was the cause of the injury or illness the result of neglect or potential abuse on the part of an adult or legal guardian? While it is not our responsibility to investigate and decide the causes of such incidents leading to illness or injury, we are

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mandated reporters required to follow the state laws, which includes filing a verbal and written report to California Child Protective Services.

T. Any bio, psycho, social factors that have the potential to complicate a successful discharge in a timely manner, or create risk to the patient for continuity of care.

3. **Development-** This process requires that the case manager/social worker take the results and findings of the evaluation and present them to the Interdisciplinary Care Team for additional information and get their input, based upon their assessments or observations.
   A. All discharge plans will be developed in collaboration with the patient, the patient's family and/or caregivers, and the attending physician. Discharge options will be considered and reviewed.
   B. The patient's family members and/or caregivers may attend a care conference so that the care team can provide education and clarify goals and resources needed for an effective discharge and continuity of care.
   C. The attending physician will provide clarity and leadership about anticipated time frames for discharge and specific needs for the patient based upon diagnosis, recovery process, the patient's response to treatments and therapies, on-going medical needs, and continuity of care.
   D. The Case Manger or social worker will take any new or additional information obtained from the Interdisciplinary Care Team and incorporate it into the discharge plan.
   E. If the Interdisciplinary Care Team decides to transition the patient to a Swing Bed, the Case Manager or Social Worker are responsible for providing a written invitation to the daily interdisciplinary meeting for the portion of the meeting that the patient's care plan is discussed.
   F. Once a plan has been developed and agreed upon by the patient (whenever possible), their family and/or caregiver, and the Interdisciplinary Care Team the Case Manager/social worker will document the plans under the Medical Record Discharge Planning within the E.H.R. and begin the Implementation phase of discharge planning.
   G. Discharge plans will be reassessed daily with the Interdisciplinary Care Team so that changes in the care level or needs of the patient can be adequately modified in the discharge plan.
   H. The discharge planning process will assess and take into consideration patterns or trends that contributed to a patient readmission if prior hospitalization was within the last 30 days when appropriate.

4. **Implementation-** This process will be driven by the findings and results of the evaluation and will often include tasks such as:
   A. Calling various skilled nursing homes seeking short or long term placement for the patient, and making arrangements for patient transfers, along with relevant medical records necessary to provide continuity of care.
   B. If the patient is returning home, referring for home health services or durable medical equipment, if indicated.
   C. Researching alternative housing options if patient needs additional assistance but does not meet the criteria for skilled placement. (e.g. Assisted living, or family members)
   D. Ensuring the patient and family are aware of all follow-up appointment for the patient.
   E. Collaborating discharge plans and patient's post-hospitalization needs with other community providers (e.g. Toiyabe clinic and case management services)
   F. Making referrals for additional out-patient sources of support which could include referrals for drug and alcohol treatment, on-going counseling services, resources for homelessness, psychiatric evaluations, or other community based services.

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a. In Home Supportive Services
    i. Before the discharge from an acute care hospital of a Medi-Cal beneficiary diagnosed with a terminal illness, the hospital's designated case manager must evaluate the patient's likely need for posthospital services and their ability to access those services.
        - For patients anticipated to need in-home personal care, the hospital case manager or discharge planner must ask the patient, or another person authorized to make health care decisions for the patient, if they are interested in receiving information about the in-home supportive services (IHSS) program.
        - If the patient or authorized person expresses interest in receiving the IHSS information, the hospital case manager or discharge planner must provide the information, including how to initiate the application process and the option for a family member to provide care as an IHSS provider, subject to the IHSS provider enrollment conditions.
    ii. If the patient seeks to apply for services under the IHSS program, the hospital case manager or discharge planner must, as appropriate, communicate to the patient's primary care physician the patient's interest in applying for IHSS to support the timely completion of the health care certification form

G. Provide education (within scope of practice) to patients and their family/caregivers regarding rationale about discharge disposition, importance of adherence to discharge plan, and follow up with aftercare.
H. Daily documentation should be made in the patient's electronic medical record indicating progress made towards discharge plans or any changes or updates made to the discharge plan.
I. Each patient will receive a **Discharge Instructions Packet that will include:**
    a. Discharge instructions and directions related to discharge disposition.
    b. New Prescriptions and medication lists with directions
    c. Educational materials
    d. Relevant community resources, including contact information for Skilled Nursing facilities in the region, and home health services.

REFERENCES:

1. Department of Health and Human Services, Centers for Medicare & Medicaid Services; CMS Manual, Conditions of Participation 482.43(a) – 482.43 (e)
2. California Department of Public Health, Senate Bill 675: Hospital Discharge Planning and Family Caregivers; Health and Safety Code section 1262.5, Chapter 494
3. The Comprehensive Accreditation Manual for Critical Care Access Hospitals as published by The Joint Commission; Standards PC.04.01.03; PC.04.02.01; PC.04.01.05
4. California State Assembly AB 1005, Chapter 346

CROSS-REFERENCE P&P:

1. Documentation of Case Management Services
2. Discharge Medications
3. Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
4. Management of Discharge Disputes from Medicare Patients

Supersedes: v.2 Discharge Planning for the Hospitalized Patient

approval

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Informed Consent Policy - Practitioner's Responsibility		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers		
Date Last Modified: 03/06/2023	Last Review Date: 05/07/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/18/2020	

PURPOSE:

The purpose of this policy is to describe:

1. When informed consent must be obtained, and when exceptions can be made in an emergency;
2. Who has responsibility for obtaining informed consent; and
3. The properly executed informed consent process, which ensures that the patient, or patient's representative, is provided with the information and disclosures necessary to enable him/her to evaluate whether or not to submit to complicated (invasive) medical or surgical treatment.

DEFINITIONS:

1. **Informed Consent** – a process of communication between the patient, or the patient's legal representative, and the healthcare practitioner in which the nature of the illness and the purpose of the procedure are discussed and an opportunity for questions is allowed.

POLICY:

1. Informed consent must be obtained by the practitioner(s) responsible for the treatment or procedure prior to the procedure being performed.
    a. Separate consents must be obtained and documented by each practitioner when:
        i. Different practitioners are performing different aspects of the same operative procedure, each with different risks requiring different skill sets; or
        ii. Multiple sequential procedures will be performed on the same date by different practitioners.
2. The informed consent discussion must include the following:
    a. The nature of the procedure or treatment;
    b. The risks, complications, and expected benefits or effects of the procedure or treatment; and
    c. Any alternatives to the procedure or treatment and the risks and benefits, including the consequences of non-treatment.
3. Procedures which require informed consent are complex in nature and include, but are not limited to:
    a. Procedures involving penetration of the skin, with the exception of drawing blood or establishing peripheral access;
    b. Endoscopic procedures;
    c. Intraluminal procedures including transesophageal procedures, but excluding placement of transurethral bladder catheters, diagnostic cystoscopes, and nasogastric tubes;
    d. Procedures which are considered irreversible.
        i. Special procedures, such as elective sterilization, have a consent process described in the policy *Surgical Procedures that Require Special Consents.*

4. Documentation that informed consent was obtained must be included in the patient's medical record. Any special circumstances should also be documented.
5. A consent remains effective until the patient revokes it or until circumstances change so as to materially affect the nature of, or the risks of, the procedure and/or the alternatives to the procedure to which the patient consented.
6. In the event of an emergency, a procedure that would ordinarily require consent may be performed without informed consent. All of the following criteria must be met in order to qualify as an emergency situation:
    a. The patient's life or health is in immediate and substantial danger.
    b. The patient is incapable of consenting.
    c. Any potential risks associated with the treatment are materially outweighed by the potential benefits associated with treatment.
7. Informed consent from patients with Limited English Proficiency will be obtained and documented with the participation of a qualified interpreter.
8. For informed consent of minors, see policy *Minors with Legal Authority to Consent.*

PROCEDURE:

1. Northern Inyo Healthcare District has certain approved forms (e.g., Informed Consent to Surgery or Special Procedure Form) that may be used to document that informed consent was obtained.
2. The patient, or patient's legal representative, must sign and date the form.
3. The practitioner obtaining informed consent must sign and date the form.
4. A witness must sign the form to confirm that the patient, or patient's legal representative, is the person signing. The witness signature does not confirm that the informed consent process has taken place.
5. While the completion of the form may be delegated to a staff member as appropriate, the practitioner performing the procedure is responsible for carrying out the informed consent process and addressing any questions that a patient may have.

REFERENCES:

1. California Hospital Association. *California Hospital Consent Manual 2017*.
2. Centers for Medicare and Medicaid Services, Hospital Condition of Participation §482.51(b)(2), §482.13(b)(2) and §482.24(c)(4)(v).
3. Gossman W, Thornton I, Hipskind JE. "Informed Consent." July 2019. Treasure Island (FL): StatPearls Publishing.
4. Joint Commission. "Informed Consent: More than getting a signature." Issue 21. February 2016.
5. University of Connecticut Health. "Clinical Informed Consent – Obtaining and Documenting." Policy 2015-03. Retrieved March 23, 2018.

RECORD RETENTION AND DESTRUCTION:

1. Consents are maintained within the patient's medical record and are retained for a minimum of 15 years for adults and 25 years for minors.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Consent for Medical Treatment
2. Minors with Legal Authority to Consent
3. Surgical Procedures that Require Special Consents
4. Informed Consent (Nursing); Lippincott Procedures

Supersedes: v.1 Informed Consent Policy - Practitioner's Responsibility

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Management of the Behavioral Health Patient (5150 and non-5150)		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: Hospital Wide		
Date Last Modified: 05/08/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/01/2018	

approval

PURPOSE:

A. To provide a safe, private and confidential environment for the treatment of adult and pediatric patients with psychiatric concerns who require acute medical, surgical and/or maternal-child care.
B. To provide guidelines for care of patients on 5150 holds, at risk for suicide, or with psychiatric disorders; and to appropriately manage interventions, minimizing the risk of self-harm or harm to others.
C. To provide an assessment tool for risk stratification of the potentially suicidal patient by the non-psychiatric professional.

DEFINITIONS:

A. **Welfare & Institutions Code (WIC) Section 5150**: "When any adult, as a result of a mental disorder, is a danger to themselves or others, or is gravely disabled, a Peace Officer or a professional designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her into a designated facility for psychiatric evaluation and treatment."
B. **Welfare & Institutions Code (WIC) Section 5585**: Civil commitment as above, applied to minors.
C. **Minor**: A person 17 years old or younger who is not married or divorced, currently in active military duty, or legally emancipated.
D. **DTS-Danger to Self**: Because of a mental disorder, a person may be suicidal or expresses significant harm to himself or herself.
E. **DTO-Danger to Others**: Because of a mental disorder, a person expresses harm to others or demonstrates a reckless disregard for the safety of others.
F. **GDA-Gravely Disabled Adult**: Because of a mental disorder, a person is not able to provide for the basic needs of food, clothing, and shelter; or to voluntarily utilize such provisions when they are offered.
G. **GDM-Gravely Disabled Minor**: A person 17 years old or younger who, as a result of a mental disorder, is unable to utilize the elements of life which are essential to health, safety, and development including food, clothing, or shelter even though they are provided to the minor by others.

POLICY:

A. Deliver care in a respectful and dignified manner, utilizing safety measures to care for adult or pediatric patients in an environment that is safe for both the patient and our staff.
B. Northern Inyo Hospital recognizes the acute medical needs of potentially suicidal patients by providing compassionate care and utilizing evidence based practice assessment tools/interventions to prevent the patient from carrying out additional self-harm or harm to others.
C. Northern Inyo Hospital has limited capabilities in providing psychiatric services and will therefore provide immediate emergent services, assessment and appropriate referrals to those requiring psychiatric services. Transfer of the patient may be required after completion of acute medical services in order to continue further psychiatric treatment in an appropriate level of care.

MANAGEMENT CONSIDERATIONS:

A. Inpatient Admission: Patients with psychiatric concerns who require medical, surgical and/or maternal-child care may be admitted to the appropriate unit to meet their physical healthcare needs.
B. Continuous Observation: Medically unstable patients who have the potential to harm themselves and/or others will be provided with continuous observation until they are medically stable and a psychological evaluation has been completed. Patients who have been determined by law enforcement to have met WIC 5150/5585 criteria prior to their arrival at the hospital will be provided continuous observation until an assessment has been performed.
C. Joint Responsibility for Quality Services: NIHD agrees to partner with ICBH to assist with meeting patients' emergent psychiatric needs.

5150/5585 HOLDS FOR TRANSPORT:

A. Patients who are a danger to themselves or others, or who are gravely disabled, may be detained without consent while transfer arrangements are being made.
B. Meeting the WIC 5150/5585 criteria and with probable cause, a person may be taken into custody and transported to a facility designated for 72-hour treatment and evaluation of mental disorders.
C. The code section defines Peace Officers as having the authority to write WIC 5150 holds. In addition, Inyo County Behavioral Health (ICBH) designates on-call personnel who are authorized to place 5150 holds.

5150/5585 EVALUATION PROCEDURE:

A. Patients presenting to the hospital will be triaged by a nurse and seen by the physician upon arrival. Necessary precautions will be taken, as the nurse will follow the policy and procedure as instructed in the procedure portion of this policy.
B. The patient must first be medically cleared by the physician prior to calling Inyo County Behavioral Health's on-call staff. This may include labs such as toxicology screens to rule out substance abuse, ETOH levels, acetaminophen levels, aspirin levels, urinalysis, and any other medical tests deemed necessary by the physician. Behavioral Health professionals are not able to evaluate patients who are altered due to drug or alcohol intoxication.
C. After medical clearance has been obtained, contact the designated ICBH on-call staff to evaluate the patient and assist in placement.
D. Contact the hospital Social Worker during normal business hours if additional help is needed.
E. The designated ICBH professional will perform an assessment as soon as the patient's condition permits. Assessments will include collaborative information from parents/guardians, roommates, friends or other persons with relevant information. The assessor's written plan will include identified risk factors and recommendations for disposition, including transfer to an inpatient treatment facility, further evaluation, or discharge home with appropriate outpatient linkages to community programs and resources.
F. If a patient communicates a threat involving a third party, the physician, registered nurse, and the ICBH professional will follow relevant legal and ethical guidelines regarding privacy of information and duty to warn third parties (California Civil Code 43.92).
G. After risk assessment, the Behavioral Health professional or Peace Officer will decide if the patient meets WIC 5150/5585 criteria. If the patient does meet criteria, DHCS Form 1801 will be filled out by the professional placing the hold. The original copy must go with the patient when transferred; a copy will be scanned to the NIHD chart.
H. ICBH will identify placement options and coordinate transportation, keeping in contact with hospital staff for medical updates or other aid during the process.
I. If the patient is not able to be placed in a designated inpatient psychiatric facility within the 72 hour hold period, an ICBH professional must re-assess the patient and decide if the patient continues to meet criteria for another 72-hour hold or the patient must be released.

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J. The Behavioral Health professional may discontinue any previously-placed holds if the patient's condition changes and the ICBH professional determines the patient is safe to be discharged home.
K. High-risk patients who are medically cleared but have not yet been placed on a WIC 5150/5585 hold are an escape risk. Notify local law enforcement if a patient states intent to leave AMA. A "medical hold" pursuant to WIC 1799.111 may be applied for 24 hours pending a Behavioral Health/5150/5585 evaluation.

EMERGENCY DEPARTMENT PROCEDURES:

A. All patients aged 12 or older admitted to the Emergency Department will be assessed for suicidal risk by a Registered Nurse (RN) using the Columbia Suicide-Severity Rating Scale (C-SSRS). Patients with a behavioral health-related chief complaint or signs/symptoms of self-harm will be screened upon admission and at least every 12 hours thereafter. The results of the C-SSRS assessment will determine the patient's risk level and the necessary monitoring and interventions required to maintain patient safety.
B. Refer to the C-SSRS response protocol at the bottom of the C-SSRS screening document for recommendations of when to implement safety precautions, including immediate notification of the ED Physician and calling for an ICBH staff consult.
C. The nursing staff will implement suicide precautions and notify the Physician as soon as possible following the implementation of these precautions, and will document this in the patient's chart.
D. Contact the hospital Social Worker during normal business hours if additional help is needed.
E. Whenever possible, the patient will be placed in a private room closest to the nurse's station to ensure both privacy and safety. Undress the patient completely, placing the patient in a hospital gown with snap closures (not ties).
F. If the patient is deemed to be a risk to self or others, all patient belongings will be taken away, inventoried, placed in a belongings bag, and kept at the nurse's station or other area designated by staff.
G. Patients will be provided with a regular diet unless otherwise ordered by the physician. All meals will be served using the following precautions:
    a. Food items are to be placed on paper plates, cups, or bowls.
    b. Only plastic utensils will be placed on the food tray.
    c. No cans or bottles are to be placed on the food tray.
    d. Dietary will deliver the meal to the nurse's station.
H. The patient's primary Registered Nurse will provide 1:1 observation until a Safety Attendant arrives at bedside.
I. The nursing staff will complete an environmental patient safety check for a patient at risk of suicide initially and at the beginning of every shift. Any risks identified (e.g. carts, tubing, sharps, medical equipment, or any other implements the patient could use to cause self-harm or harm to others) will be removed from the room, the patient will be evaluated for relocation, and/or the patient will be placed under closer observation.
J. Any concerning or contributing history or circumstances that might indicate an increased risk of suicide shall be communicated to all hospital personnel involved in the care of the patient.
K. Patients may be restrained as necessary to prevent further injury per Physician's order. See *Patient Restraints (Behavioral and Non-Behavioral*) policy.
L. Contact hospital Security for additional assistance if needed.
M. If a patient cannot be assessed upon arrival due to the patient's medical status (e.g. the patient is unconscious, intubated, intoxicated, or mentally unable to respond), the screening will be postponed until the patient can be assessed. The suicide screening process should be performed as soon as the patient's condition permits.
N. When the patient is deemed medically stable and has been cleared by the Physician, contact ICBH on-call staff to request a WIC 5150/5585 evaluation. Refer to 5150/5585 Evaluation Procedure, above.

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O. If the patient cannot be medically stabilized in the Emergency Department and requires inpatient hospitalization, refer to Additional Procedures for Inpatients, below.
P. The following is the minimum that will be provided to individuals at risk for suicide and their families upon discharge from NIH. Additional materials, statements from the patient's assessment, etc. may be provided by the responsible ICBH employee on a case-by-case basis, with the goal of keeping the patient safe at home long term:
    a. Personal Safety Plan including post-discharge follow-up to be provided by ICBH. (The RN will also request a copy of this document and include it in the patient's chart.)
    b. Local community and state or national mental health resources

ADDITIONAL PROCEDURES FOR INPATIENTS:

A. All patients aged 12 or older admitted to an inpatient department, will be assessed for suicidal risk by a Registered Nurse (RN) using the Columbia Suicide-Severity Rating Scale (C-SSRS). The results of the C-SSRS assessment will determine the patient's risk level and the necessary monitoring and interventions required to maintain patient safety.
B. Ongoing mental health assessments will take place every 24 hours as part of the daily inpatient psychosocial nursing assessment. If at any time during hospitalization a patient previously assessed with no risk is identified to have a risk, the C-SSRS screening tool will be completed. RN's will notify the Hospitalist immediately of any need for additional precautions based on the results of this assessment.
C. Proper documentation for inpatients found to be at risk for suicide includes:
    a. Initial screening for suicidal risk (C-SSRS)
    b. Additional screenings every 24 hours (C-SSRS)
    c. Precautions taken to ensure a ligature-free environment
    d. Patient behavior and daily activities
D. Follow *Leaving Hospital against Medical Advice Refusal of Treatment or Transfer* and *Patient Safety Attendant or 1:1 Staffing Guidelines* policies as needed.

UNUSUAL OCCURANCES:

A. Notify the House Supervisor and the Administrator-on-Call if there is a self-harm or suicide attempt within the Emergency Department or other inpatient areas.
B. Complete an Unusual Occurrence Report (UOR) and follow mandatory reporting as required.
C. The Compliance department is responsible for collecting and distributing data regarding self-harm or suicide attempts via the quarterly UOR report.

COMPETENCY TRAINING:

Clinical team members will complete competency training upon hire and annually regarding appropriate care for patients at risk of self-harm and suicide.

REFERENCES:

A. Practical Management of the Suicidal Patient in the Emergency Department, Emergency Medicine Reports (2013).
B. Care of the Psychiatric Patient in the Emergency Department, ACEP Emergency Medicine Practice Committee (2014).
C. Sentinel Event Alert: New Alert Focuses on Suicidal Ideation, The Joint Commission Perspectives (2016).

CROSS REFERENCED POLICIES AND PROCEDURES:

A. Patient Restraints (Behavioral and Non-Behavioral)
B. Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer

approval

C. Patient Safety Attendant or 1:1 Staffing Guidelines

RECORD RETENTION AND DESTRUCTION:
Copies of all 5150 related documents will be placed into the patient's medical record and managed by the Health Information Management Department.

Supersedes: v.2 Management of the Behavioral Health Patient (5150 and non-5150)

approval

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Outpatient Medicine		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Outpatient Medicine Practitioners		
Date Last Modified: 05/10/2023	Last Review Date: 05/07/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/19/2021	

PURPOSE: To delineate clear expectations for Outpatient Medicine practitioners within Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners (physicians and Advanced Practice Providers) assigned to the Outpatient Medicine department will adhere to the following protocols.

PROTOCOLS:

1. Patient Care Responsibilities:
    a. Practitioners will be expected to see patients according to their individual schedules, which shall be arranged in conjunction with the Chief Medical Officer (CMO) and the director of their department.
    b. Practitioners will be expected to evaluate, diagnose, and manage conditions within their scope of practice.
    c. Advanced Practice Providers (APPs) will be assigned a supervising physician as per California regulations, if required.
    d. Practitioners will complete appropriate documentation for any given patient encounter within 72 hours.
    e. Lab, imaging, and pathology results should be reviewed within 96 hours of receipt. Critical values should be addressed within 24 hours.
2. Call
    a. Physicians will participate in after-hours call (remotely) on a rotating schedule as set by their home department. Advanced Practice Providers may participate in after-hours call, but must have physician back-up readily available. Call requirements and guidelines will be dictated by a practitioner's home department.
3. Credentialing:
    a. Outpatient Medicine physician practitioners must be board certified or board eligible by the American Board of Medical Specialties or the American Osteopathic Association in their field.
    b. Nurse Practitioners must be certified by a nationally-recognized agency in their field (ex., American Association of Nurse Practitioners).
    c. Physician Assistants must be certified by the National Commission on Certification of Physician Assistants (NCCPA).
4. Meeting Attendance:
    a. Practitioners are expected to attend committees as assigned:
        i. Outpatient Medicine Committee Meeting, quarterly
        ii. Provider meetings per home department
        iii. Additional meetings per Medical Staff Bylaws requirements (General Medical Staff meetings, specific committee meetings)

5. Coverage:
    a. During vacation times, practitioners will be expected to coordinate with other practitioners or team members to ensure continuous delivery of service.
6. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to undergo 100% chart review for a minimum of two weeks.
    b. Procedural competency will be demonstrated through five directly observed procedures by a practitioner who has privileges in the procedure.
7. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE.
8. Peer Review:
    a. Outpatient charts identified by critical indicators will be peer reviewed by the Chief of Outpatient Medicine or delegated practitioner. Selected cases will be reviewed at the Outpatient Medicine committee at its next scheduled meeting. A standardized peer review form will be utilized in the process (for example, refer to Attachment 1). Records are confidential and will be kept by the Medical Staff Office.
9. Re-Entry:
    a. Outpatient practitioners may be eligible for re-entry as per policy.

REFERENCES:

1. None

RECORD RETENTION AND DESTRUCTION:

1. Credentialing information will be kept for the duration of the practitioner's membership/privileges plus 6 years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. Medical Staff Peer Review and Professional Practice Evaluations
3. Practitioner Re-Entry Policy
4. Medical Records Delinquency Policy

Supersedes: v.1 Medical Staff Department Policy - Outpatient Medicine

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: Emergency Department and Inpatient Units		
Date Last Modified: 05/08/2025	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/1992	

approval

PURPOSE:

The purpose of a Patient Safety Attendant is to help keep the patient oriented to place and/or help assure the patient's safety by one-to-one observation.

POLICY:

1. A Medical Staff Provider may write an order for a Patient Safety Attendant however a nurse may also initiate the use of a Patient Safety Attendant through assessment and by collaboration with other team members. Patient Safety Attendant criteria include:
    a. Suicide precaution (All patients on suicide precautions will have a Patient Safety Attendant until a Medical Staff Provider has cleared the patient from such precautions.)
    b. Protecting patients from harm when they are at high risk for falls
    c. Patient disorientation/non cooperative
2. With the exception of a patient placed on suicide precautions (one-to-one observation), the patient's family may serve as a patient safety attendant.
3. Patient Safety Attendant may be from different levels of care providers, including Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nurse Aid (CNA), Clerk, Security, Environmental Services (EVS), etc.
4. Performance standards of a patient safety attendant (what the patient safety attendant may do for and with the patient) will be based on the patient safety attendant's job description.

PROCEDURE:

1. When a Patient Safety Attendant is deemed necessary for the safety of the patient, the RN or designee will notify the House Supervisor (HS) for coverage. The HS will find staffing coverage.
    a. Patient Safety Attendants are usually not provided in ICU or when staffing meets 1-2 patient ratio.
2. If a patient's family member chooses to sit with the patient, instructions will be given that the family member is to:
    a. Call for assistance as needed using the call bell.
    b. Not to leave the patient unattended.
3. A guest meal tray may be ordered for the family member who is sitting with the patient.
4. All patient care is under the direction of the RN assigned to the patient. The RN will:
    a. Give direction to the Patient Safety Attendant based on the workforce member's job description performance standards.
    b. Check on the Patient Safety Attendant when completing hourly rounding every hour from 0800-2200 and every two hours from 2200-0800.
5. The Patient Safety Attendant will be located in the room with the patient. The Patient Safety Attendant will:

a. Not leave the room (i.e. breaks and meals unless relieved by another person).
b. Notify the RN of any assistance needed or concerns.
c. Document utilizing the 'close observation' form every 15 minutes for patients requiring a safety attendant (see attached document).
d. Follow the 'Safety Attendant Guidelines' (see attached document).

6. The patient need for a Patient Safety Attendant should be re-assessed on an ongoing basis but not less that every 24 hours.
    a. Patient Safety Attendant continuation will be reviewed at the daily interdisciplinary team meeting.

REFERENCES:

1. McFarlane-Kolb, H. (2004) Falls Risk assessment, Multi-targeted Interventions and Impact on Hospital Falls. International Journal of Nursing Practice 10: 199-206
2. NCPS Falls Toolkit; 2004 National Center for Patient Safety.http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/completebooklet.pdf.
3. Care of the Psychiatric Patient in the Emergency Department, ACEP Emergency Medicine Practice Committee (2014)
4. Sentinel Event Alert: New Alert Focuses on Suicidal Ideation, The Joint Commission Perspectives, (2016)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Management of the Behavioral Health Patient (5150 and non-5150)
2. Fall prevention and management

RECORD RETENTION AND DESTRUCTION:

Safety Attendant and Guideline for Close Observation form is utilized for documentation. This is sent to NIHD Medical Records Department and scanned into the patient medical records. NIHD Medical Records Department is responsible for maintenance of the medical record.

Supersedes: v.5 Patient Safety Attendant or 1:1 Staffing Guidelines

approval

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Patient Valuables		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: Acute/Subacute ICU		
Date Last Modified: 12/18/2024	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date:	

approval

POLICY:
Every patient admitted to the hospital must be asked if they have (in their possession) valuables such as money, watch, jewelry, important papers, credit cards, etc. Family members should be encouraged to take these items home or they should be stored in the designated lock up area accessible by the House Supervisor.
The nurse admitting the patient to the hospital is responsible to see that the patient's valuables are safely secured either with the family or itemized on the valuables envelope and given to the House Supervisor to be securely held under lock in the designated area.

PROCEDURE:

A. Valuables Envelope
1. Print patient's name under "NORTHERN INYO HOSPITAL" (or add patient sticker to the envelope).
2. All cash must be counted and total documented in the presence of the patient or a witness.
3. Items such as wallets, purse, etc. should be described as to size and color, with a general description of the contents. E.g. credit cards, driver's license, etc.
4. Jewelry should be described by appearance. E.g. One yellow colored ring with a white stone; one ladies white colored watch with plastic band. **Do not attempt to identify a piece of jewelry as to the type of stone other than by color and possible size.**
5. Do not attempt to estimate the value of any item except the cash.
6. The patient **must** sign the envelope where it states "Signature of Depositor", when all items have been listed and the envelope is sealed. If the patient is unable to sign, secure a witness to sign for the patient and indicate reason patient is unable to sign.
7. The person who lists and places the valuables in the envelope must date and sign the envelope where it states "Received by" and "Date".
8. The "tear off" flap must have the same information as #1, #6, and #7 on the envelope. The "flap" is taped to the inside of the patient's medical record chart.
9. The envelope is given directly to the House Supervisor who is then responsible for locking it in the designated area.

B. Removing Items from the Envelope before Discharge
1. If, at a patient's request, cash or other items are removed from the envelope, such information needs to be recorded on the envelope as well as date and time. The valuables envelope may then be re-secured after the nurse and patient verify all contents and sign the acknowledgement. The Envelope is once again given to the House Supervisor.

C. Reclaiming Valuables
    1. The tear off flap must be presented to the House Supervisor by the Nurse discharging the patient before valuables can be returned.
    2. The contents must be checked in the patient's presence and the patient must sign and date the bottom of the envelope indicating that the patient has received the items listed on the envelope.
    3. The empty valuables envelope is placed inside the patient's chart and it becomes part of the record.

D. Documentation in the Patient Record
    1. The disposition of valuables must be documented on the admission assessment tab titled "Valuable Information".
    2. Upon discharge from the hospital, the return of valuables is noted in the discharge notes. Upon transfer to another facility, it should be noted that the patient's valuables were either returned to the patient or to a designated appointee.

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Patient's Rights – California Department of State Hospital: https://www.dsh.ca.gov/About_Us/Patients_Rights.html

Supersedes: v.5 Patient Valuables

approval

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Plan for the Provision of Social Services at NIHD		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit, ICU, OB, ED, PACU	
Scope: Social Services, House Supervision		
Date Last Modified: 05/09/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/13/2017	

approval

PURPOSE:

To achieve the goal of the Social Service Department to make timely, appropriate referrals for social service assistance, between Northern Inyo Hospital, Northern Inyo Healthcare District (NIHD) Clinics and other community resources.

POLICY:

1. While each patient will not require social services, it is the policy of Northern Inyo Healthcare District (NIHD) to have services available to every inpatient, outpatient, and his or her family by means of:
    a. The Licensed Clinical Social Worker (LCSW) during hours of availability.
    b. During hours of LCSW unavailability, the NIHD House Supervisor provides social service support to patients and their families.
2. The Social Service Department is an integral part of the total health care of the patient and family. Social services are planned and administered in combination with related medical, educational and public assistance services.

PROCEDURE:

1. Patient referral may come from physicians, nursing staff, the patient, family, and friends.
2. Contact the social worker as soon as possible after a request for social service has been made. The social worker will respond promptly to each referral (within 24 hours, weekends and holidays excluded) and record the results and referrals in the patient's medical record.
    a. During emergencies, social services assistance will be available by calling the social worker or in their absence, the House Supervisor.
3. After consultation with the patient, family and/or physician, a plan is established.
    a. When referrals are required, contact the community agency by telephone.
    b. A written referral to that service will follow as required.
4. Whenever circumstances indicate, the social worker shall contact the patient or family after discharge to determine the status of the patient.
5. All information received by the social worker shall be treated with the strictest confidentiality and shared with only the appropriate referral sources as required to ensure proper care for the patient.

REFERENCES:

1. Title 22- 70711. Social Services

RECORD RETENTION AND DESTRUCTION:

Maintained within the patient's medical record are documentation of social work interactions, plan development and referral orders. Retention of medical records is the responsibility of the Health Information Management Services (HIMS) Department at NIHD.

CROSS-REFERENCE P&P:

1. Utilization Review Plan
2. Discharge Planning
3. Social Services Resource List (NIHD Intranet>Resources>Links>Social Services Resource List) http://socialwork.root.nih.org/_layouts/15/start.aspx#/Lists/Resource%20List/All%20Items.aspx

Supersedes: v.3 Plan for the Provision of Social Services at NIHD

approval

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Utility System Failure-Elevator		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Northern Inyo Healthcare District (NIHD)		
Date Last Modified: 05/09/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

approval

PURPOSE:
To ensure the safety and well-being of patients, staff, and visitors in the event of an elevator failure, and to comply with The Joint Commission (TJC) and National Fire Protection Association (NFPA) standards for utility systems management.

SCOPE:
This policy applies to all personnel responsible for the operation, maintenance, and management of elevators within Northern Inyo Healthcare District (NIHD).

POLICY:
It is the policy of Northern Inyo Healthcare District (NIHD) to promptly and effectively respond to elevator failures to minimize risks to patients, staff, and visitors, and to maintain compliance with TJC and NFPA standards.

PROCEDURE:

1. Identification of Elevator Failure

1.1. All staff are responsible for reporting any elevator failure or malfunction immediately to the Facilities Management Department.

1.2. In the event of an elevator failure, the individual identifying the issue must immediately contact Security and the Facilities Management Department.

1.3. Security personnel must secure the area around the malfunctioning elevator to prevent unauthorized access.

2. Response Protocol

2.1. **Facilities Management Response:**

- Facilities Management personnel will assess the situation and determine the cause of the elevator failure.
- If individuals are trapped inside the elevator, Facilities Management will immediately contact the elevator service provider and/or emergency services to safely remove the occupants, following NFPA 101 requirements for safe egress.
- Facilities Management will deactivate the elevator from service until repairs are completed, ensuring compliance with NFPA 99 and NFPA 110 standards regarding electrical and emergency power systems.

2.2. **Communication:**

- Facilities Management will communicate the elevator's status and expected downtime to the affected departments, including the Command Center, if activated.
- Alternative routes or transportation methods will be provided for patients, staff, and visitors affected by the elevator outage.

2.3. **Patient Safety:**

- In the event of an elevator failure impacting patient transport or evacuation, staff will follow the organization's emergency patient movement plan, ensuring adherence to NFPA 101 standards.
- Clinical staff must assess any impacted patients for safety and provide necessary care until the elevator is operational or alternative arrangements are made.

3. Documentation and Reporting

3.1. All elevator failures must be documented in the facility's incident reporting system, including the time of failure, response actions, and resolution.
3.2. The Facilities Management Department will maintain records of all elevator maintenance and failures, including service reports from the elevator service provider.
3.3. A root cause analysis (RCA) may be conducted if the failure resulted in patient harm or significant operational disruption.

4. Training and Drills

4.1. All relevant staff must be trained on this policy and procedure as part of their orientation and annual refresher training.
4.2. Periodic drills may be conducted to ensure staff are prepared to respond effectively to an elevator failure, with particular emphasis on compliance with TJC and NFPA standards.

5. Compliance and Review

5.1. Compliance with this policy will be monitored by the Environment of Care Committee, and periodic audits will be conducted to ensure adherence.
5.2. This policy will be reviewed annually or as required by changes in TJC or NFPA standards or organizational needs.

REFERENCES:

1. **The Joint Commission (TJC) Environment of Care (EC) Standards**
   - EC.02.05.01: The hospital manages risks associated with its utility systems.
   - EC.02.05.03: The hospital has a process to manage disruptions to its utility systems.
2. **National Fire Protection Association (NFPA) Standards**
   - **NFPA 99:** Health Care Facilities Code
     - Chapter 5: Electrical Systems - Includes requirements for the reliability and safety of electrical and emergency systems, including those related to elevators.
   - **NFPA 101:** Life Safety Code
     - Chapter 7: Means of Egress - Includes requirements for elevators used as a means of egress during an emergency.
   - **NFPA 110:** Standard for Emergency and Standby Power Systems
     - Covers the performance of emergency power systems that may be required to support elevator operations during a power outage.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Utility System Failure-Elevator

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Pharmacy Hazardous Drugs: Receiving, Storage, Compounding and Transporting		
Owner: PHARMACY DIRECTOR	Department: Pharmacy	
Scope: Pharmacy Department		
Date Last Modified: 03/12/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

approval

PURPOSE:
The objective of chapter USP <800> is to protect personnel and the environment when handling hazardous drugs (HDs). This includes but is not limited to; receipt, storage, mixing, preparing, compounding, dispensing, administering, and disposing HDs. HDs shall be handled under conditions that promote patient safety, worker safety, environmental protection, and infection prevention. Manipulation of HDs requires appropriate engineering/environmental controls, safe handling and work practices.

POLICY:
It is the policy of NIHD Pharmacy to minimize personnel exposure to HDs by adhering to special handling procedures. It is understood that there is no acceptable level of personnel exposure to HDs.
It is crucial that pharmacy personnel will use appropriate; Personal Protective Equipment, Environmental Controls, Compounding Technique, and Packaging/ Containment strategies throughout the process of preparing hazardous medications for patients.
All pharmacy staff involved with handling HDs must maintain and verify current knowledge and safe practices as outlined in USP Chapter <800>. The primary responsibility for minimizing exposure to HDs ultimately lies on the pharmacy staff.
Applicability: This standard operating procedure (SOP) applies to the general pharmacy areas including:
Receiving area, storage, primary and secondary engineering controls - buffer area and ante-rooms.

Responsibilities: The Director of Pharmacy and Compliance department are responsible for enforcing this SOP. To ensure maximum protection to pharmacy personnel handling/preparing chemotherapeutic agents and to all personnel in the hospital, the following procedures for all steps in handling chemotherapy will be followed.
PROCEDURE:

1. **Personnel Training and Verification of Professional Competencies**
    a. All Personnel handling hazardous drugs at NIHD will follow established policies and procedures.
    b. Yearly training is mandatory and must be documented in the employees' permanent record. Competency in handling and compounding of hazardous drugs must be observed, evaluated and documented. This is expected of all pharmacists and technicians during
        i. Orientation and training
        ii. At least annually
        iii. Whenever unacceptable techniques are observed or detected
    c. Personnel who fail to complete all components of the hazardous drug training, will be reassigned until the mandatory training is complete and documented.

2. **Receiving and Unpacking**
    a. HDs should be received from the supplier sealed in impervious plastic and in separate bins to segregate them from other drugs
    b. PPE - A pair of Chemo resistant gloves are be to worn at all times while handling HD vials, and containers.

c. Damaged HD packages or shipping containers shall be a considered spill. Clean up will follow NIH Pharmacy Chemo spill procedures.

3. **Transport**
   a. All HDs/Chemo medications must be contained at all times in a sealed Chemo Bag during all transport
      i. Receiving to Storage
      ii. Immediately after compounding
      iii. Transit to the Infusion center.
4. **Storage of HDs**
   a. Chemo medications/HDs shall be stored separately from other inventory in order to prevent contamination and personnel exposure.
   b. Storage shelves shall be secured with raised front lips and not stored on the floor. HDs shall be stored at or below eye level, in containers that minimize risk of breakage and leakage.
   c. Refrigerated HD shall be stored in a dedicated refrigerator in the HD storage (negative pressure buffer room)
   d. All HD vials shall be stored at all times in the sealed Chemo Transport Bags. No vials are to be placed on the shelf without being in a sealed Chemo transport bag.
5. **Compounding**
   a. **PPE**
      i. All personnel protective equipment shall be worn while compounding. This includes, double gloves, gown, facemask, hair cover, and double shoe covers. Goggles should be considered if there is possibility of a vial spraying.
   b. **Aseptic preparation**
      i. All items used in the Biological Safety Cabinet (BSC) shall be disinfected with sterile 70% Isopropyl Alcohol (IPA) prior to being placed in the hood. Complete Aseptic preparation description is covered in the General Conduct and Aseptic Preparation SOP
   c. **Work practices in chemo hood**
      i. Compound only one chemo medication at a time in the BSC
      ii. Decontaminate, and clean the BSC work surface between each medication prepared.
      iii. Prepare and stock all needed equipment prior to starting compounding to minimize entry and exit from the BSC.
      iv. Have a Ziplock bag inside the hood for trash, place all used vials, syringes, needles, used contaminated gloves, and spill mat in the Ziplock bag. Then seal the Ziplock bag and dispose in appropriate waste
      v. Do not leave the buffer room with contaminated gloves. Remove and dispose all gloves in appropriate waste container prior to leaving the buffer room. Prior reentry to the buffer room perform complete antiseptic hand washing and don another set of sterile gloves
      vi. Remove contaminated outer gloves before leaving the hood, never touch items outside of BSC or yourself with dirty gloves. Consider the gloves to be contaminated once you have handled any chemo vials
   d. **CSTD – Closed System Transfer Devices and Negative Pressure**
      i. Closed system transfer devices/components must be used whenever physically and chemically compatible
      ii. Negative pressure (inserting less air volume into vial than solution volume to be removed from HD vial) shall be used to prevent spray or production of aerosols of a hazardous drug when it is not possible to use the CSTD.
   e. **Labeling**
      i. All Chemo preparations shall have labels that list all ingredients, and expiration time.
      ii. All Chemo preparations shall have a label stating that is a hazardous drug or Chemotherapy requiring special precautions
   f. **Preparing for transport**

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i. Only one chemo infusion bag per transport bag (never put two prepared Chemo infusions bags in same Chemo transport bag)
ii. To avoid spreading contamination, the compounding pharmacy personnel must not touch the outside of the Chemo transport bag with their outer Chemo gloves. Prior to mixing, set up the transport bag -- opened with the top edges folded out and down couple inches.

6. **Transport from pharmacy compounding to Outpatient Infusion area**
    a. During transport to the Outpatient Infusion area all HDs (at all times) are to be carried over in a sealed Chemo Transport Bag
    b. Only one Chemo/HD compounded product will be placed in Chemo Transport bag.
    c. The Chemo/HD infusion preparation shall be delivered to the infusion center immediately after being compounded.
    d. The Chemo Transport Bag shall be handled in such a manner to prevent a spill. The chemo transport bag shall not be handled roughly or carelessly to ensure that all connections of the infusion set are not disrupted.

REFERENCES:

1. U.S. Pharmacopeia Convention. (2020). *Chapter <800> hazardous drugs—handling in healthcare settings*.
2. U.S. Pharmacopeia Convention. (2020). *Chapter <797> pharmaceutical compounding—sterile preparations*.

RECORD RETENTION AND DESTRUCTION:

N/A

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Sterile Products: Cytotoxic Agents
2. Sterile Products: Compounding
3. Joint Commission CAH MM.01.01.03
4. Joint Commission CAH MM.05.01.07

Supersedes: Not Set

approval

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

DATE: May 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: IT Department

RE: Term Sheet – Cybersecurity

Overview

Cybersecurity is a critical pillar of healthcare operations. It safeguards sensitive patient data, ensures operational continuity, and directly impacts patient safety. Given the high volume of protected health information (PHI), financial records, and personally identifiable information (PII) stored within our systems, the healthcare industry remains a top target for cyberattacks.

To address these challenges, we propose engagement with CyberMaxx for their MDR Elite services.

Vendor Summary: CyberMaxx MDR Elite
Service Highlights:

- 24/7/365 Monitoring: U.S.-based Security Operations Center (SOC)
- Incident Response: Rapid containment and resolution support
- Proactive Threat Hunting: Identifies threats before they manifest into attacks
- Proprietary Threat Intelligence: Continuously updated and leveraged for real-time defense
- Sentinel One Endpoint Protection: Advanced endpoint detection and response (EDR)
- Risk Reduction: Comprehensive infrastructure coverage and protection

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Contract Summary

Vendor	CyberMaxx
Service Package	MDR Elite
Contract Term	1 Year
Device Coverage	800 Devices
Total Cost	$135,941.90
Cost Per Device/Year	$169.93

Strategic Justification

- Strengthens protection of critical patient and operational data

- Reduces vulnerability to ransomware, phishing, and zero-day attacks
- Enhances compliance with HIPAA and other regulatory standards
- Provides continuous threat oversight with rapid response capabilities
- Complements internal IT/security efforts with external expertise and intelligence

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Recommendation

Approve the 1-year engagement with CyberMaxx for MDR Elite services at the proposed cost to enhance cybersecurity posture and protect vital infrastructure and patient data.

SUMMARY RESULTS

Northern Inyo Healthcare District
2025 Governance Self-Assessment

Provided as a Member Service By

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Self-Assessment Overview

In April - May 2025 the Northern Inyo Healthcare District Board of Directors assessed the board's overall leadership performance. The board also identified issues and priorities for the future.

Board members assessed the board's overall performance in ten leadership areas, including:

- Mission, values and vision;
- Strategic direction;
- Leadership structure and processes;
- Quality and patient safety;
- Community relationships;
- Relationship with the CEO;
- Relationships with the medical staff;
- Financial leadership;
- Community health; and
- Organizational ethics.

Board members rated 167 total criteria in these ten areas.

How the Self-Assessment Was Conducted

The governance self-assessment was conducted using an online survey. All five Northern Inyo Healthcare District board members completed the self-assessment.

Respondents rated a variety of statements in the ten areas above, using a scale ranging from "Level 5 (Strongly Agree)" to "Level 1 (Completely Disagree)." "Not Sure" and "Not Applicable" choices were also available for each statement.

Mean scores for each statement were calculated using a five point scale (Level 5 - Level 1). No points were assigned to "Not Sure" and "Not Applicable" ratings.

Finally, board members provided insights about their priorities for the board in the next year; defined the board's strengths and weaknesses; identified key issues that should occupy the board's time and attention in the next year; provided insights about the most significant trends the board must be able to understand and deal with in the next year; and identified critical factors that must be addressed for the organization to successfully achieve its goals.

Rating Methodology

The following rating scale was used to evaluate overall board performance:

- Level 5: I *strongly agree* with this statement. We always practice this as a part of our governance. Our performance in this area is *outstanding*.
- Level 4: I *generally agree* with this statement. We usually practice this as a part of our governance, but not always. We perform *well* in this area.
- Level 3: I *somewhat agree* with this statement. We often practice this in our governance, but we are not consistent. We perform *fairly well* in this area.
- Level 2: I *somewhat disagree* with this statement. We inconsistently practice this as a part of our governance. We *do not perform well* in this area.
- Level 1: I *disagree* with this statement. We never practice this as a part of our governance. We perform *very poorly* in this area.
- N/S: Not sure. I do not have enough information to make a determination about our performance in this area.
- N/A: Not applicable.

Reviewing This Report

Board member ratings of board self-assessment criteria are depicted throughout this report in graphs.

The criteria in each graph are displayed in order from highest to lowest mean score. The mean score for each individual rating criterion appears to the right of the graph.

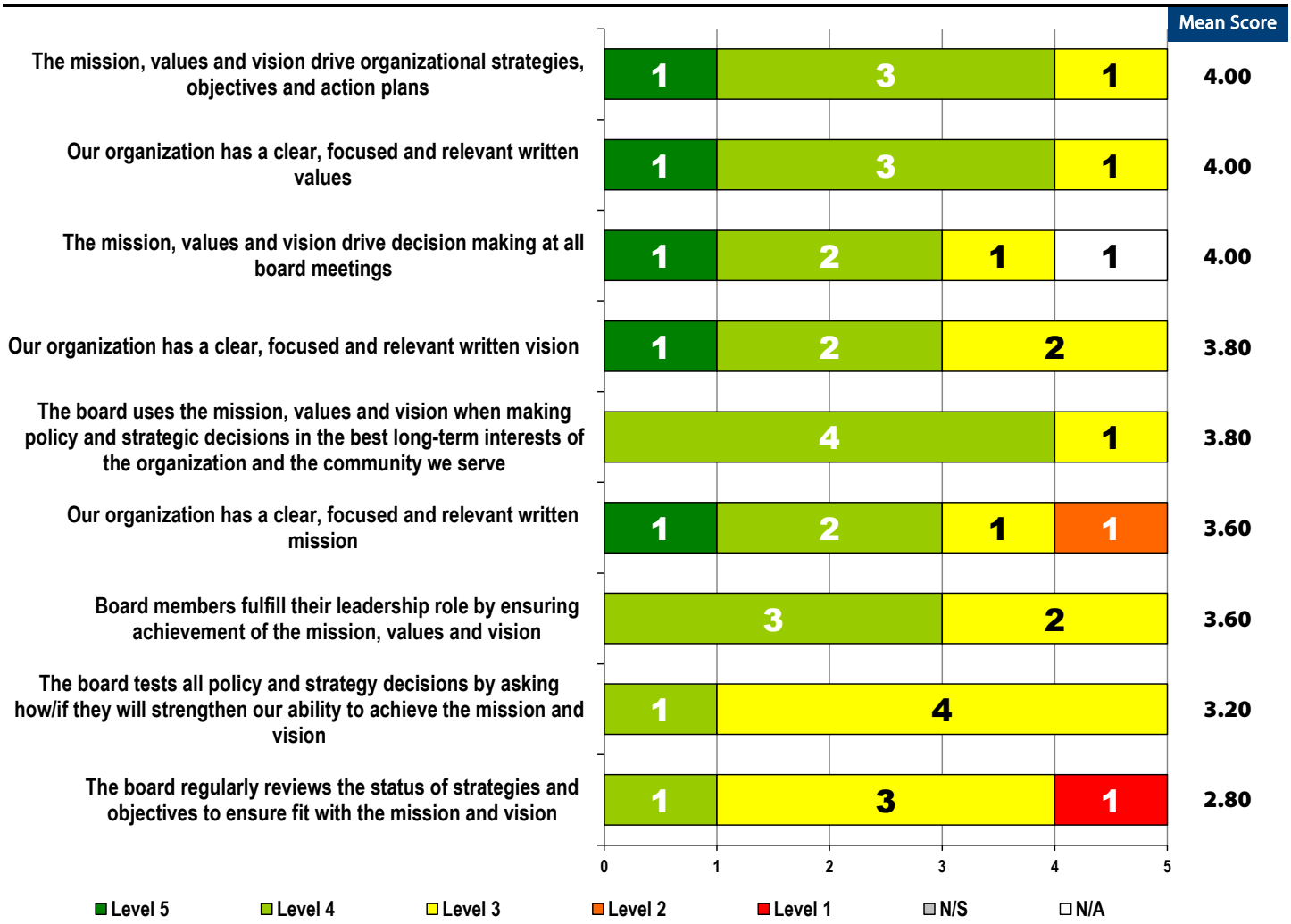
To facilitate the identification of areas that may require governance and/or management attention, each graph includes the number of Level 5 - Level 1 responses to each statement in the color-coded bars. Responses are grouped and color coded, with "Level 5" appearing in dark green, "Level 4" in light green, "Level 3" in yellow, "Level 2" in orange, and "Level 1" in red. "Not Sure" responses appear in gray, and "Not Applicable" responses appear in white.

Longer lists of criteria have been separated into higher and lower rated sections for ease of display and analysis.

Board member responses to all open-ended questions appear throughout the report, where applicable, and on pages 27-29.

Mission, Values and Vision

Mission, Values and Vision
(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

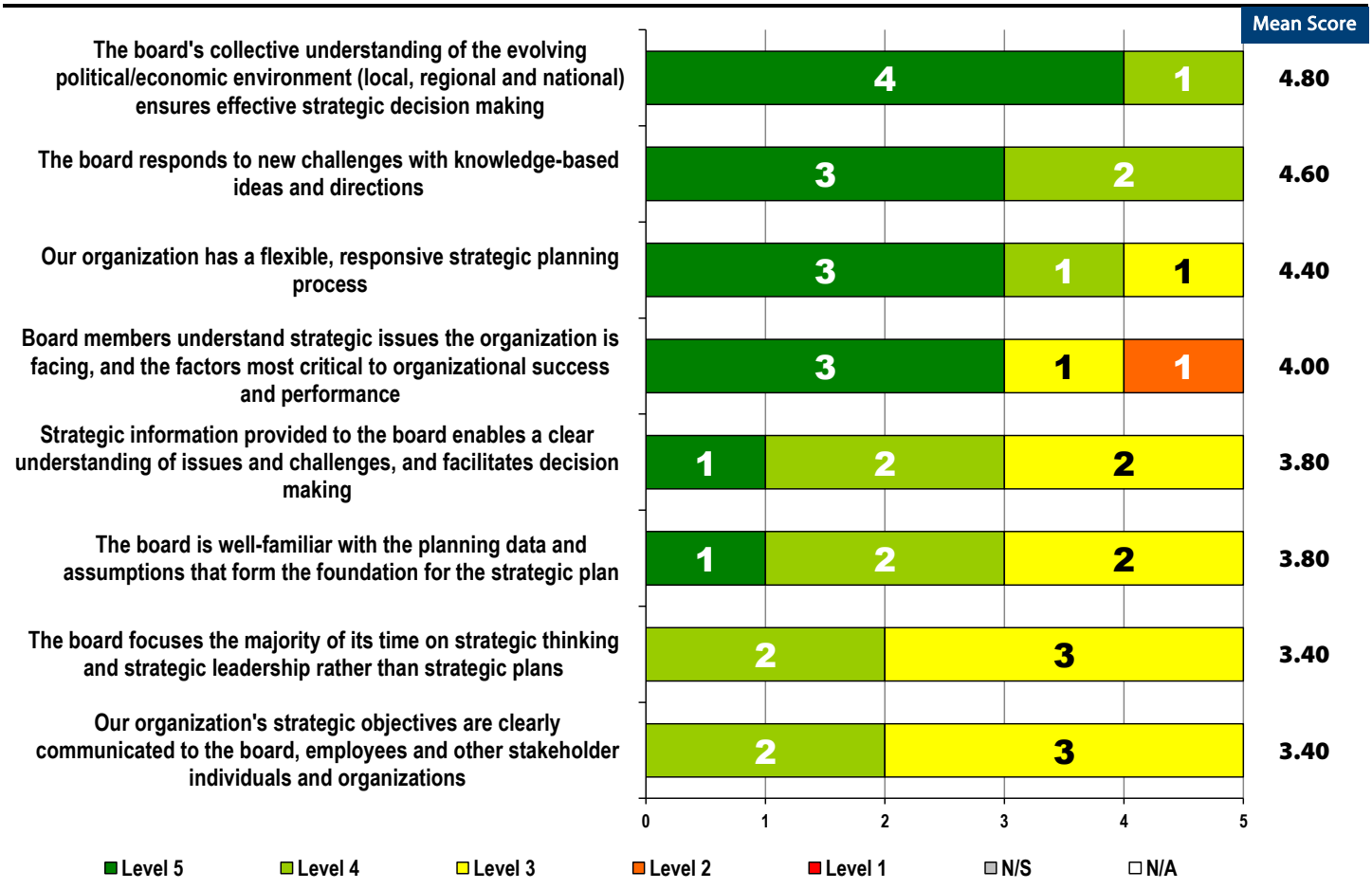
Board members provided the following suggestions for governance improvement in this section:

- Maybe the Board could have the vision, mission and values printed on the agenda for ensuring discussion and actions fit.
- Review of the mission, values, and vision with an open discussion.
- By being more informed and kept well up-to-date with real information regarding what's going on with staff and patients.
- More conversation in a private setting.

Strategic Direction

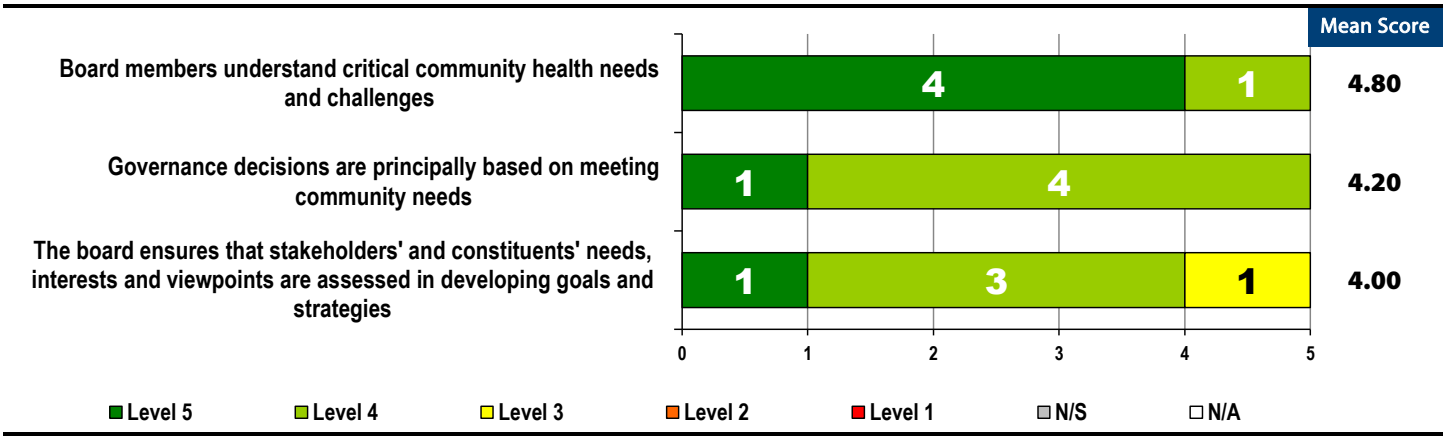
The Strategic Planning Process

(sorted by highest to lowest mean score)



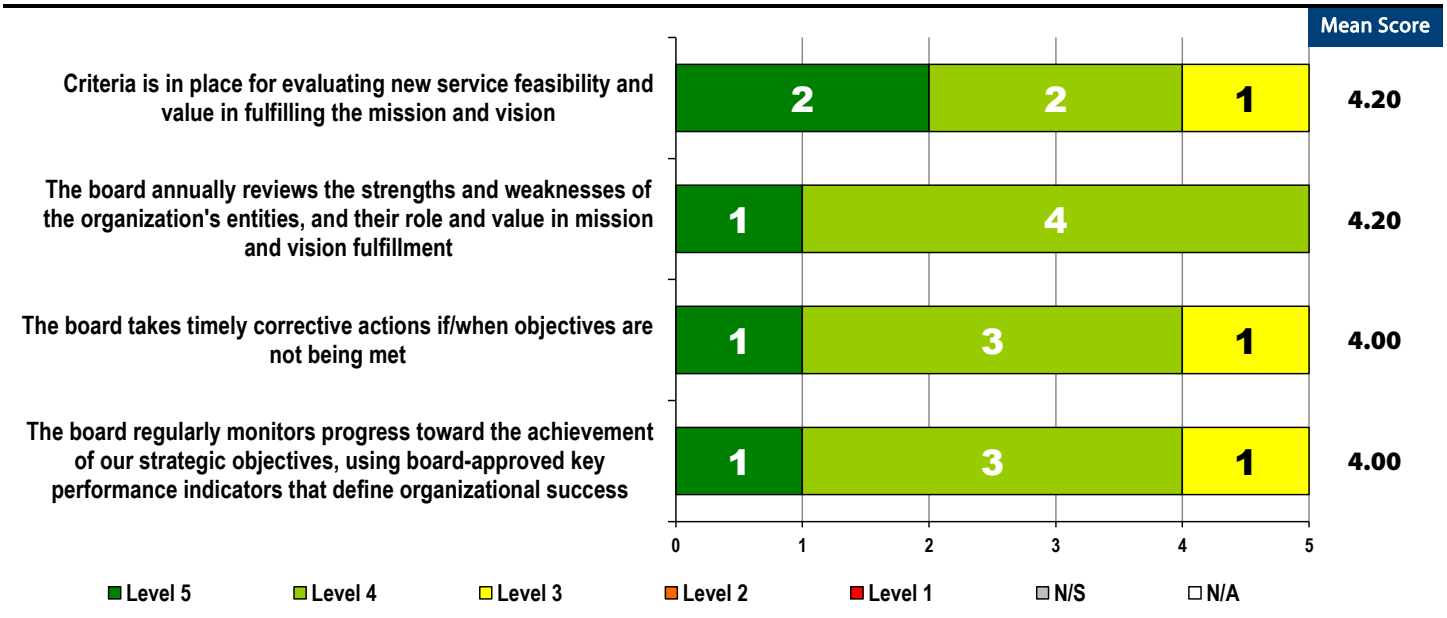
Community and Stakeholder Perspectives

(sorted by highest to lowest mean score)



Monitoring Progress

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

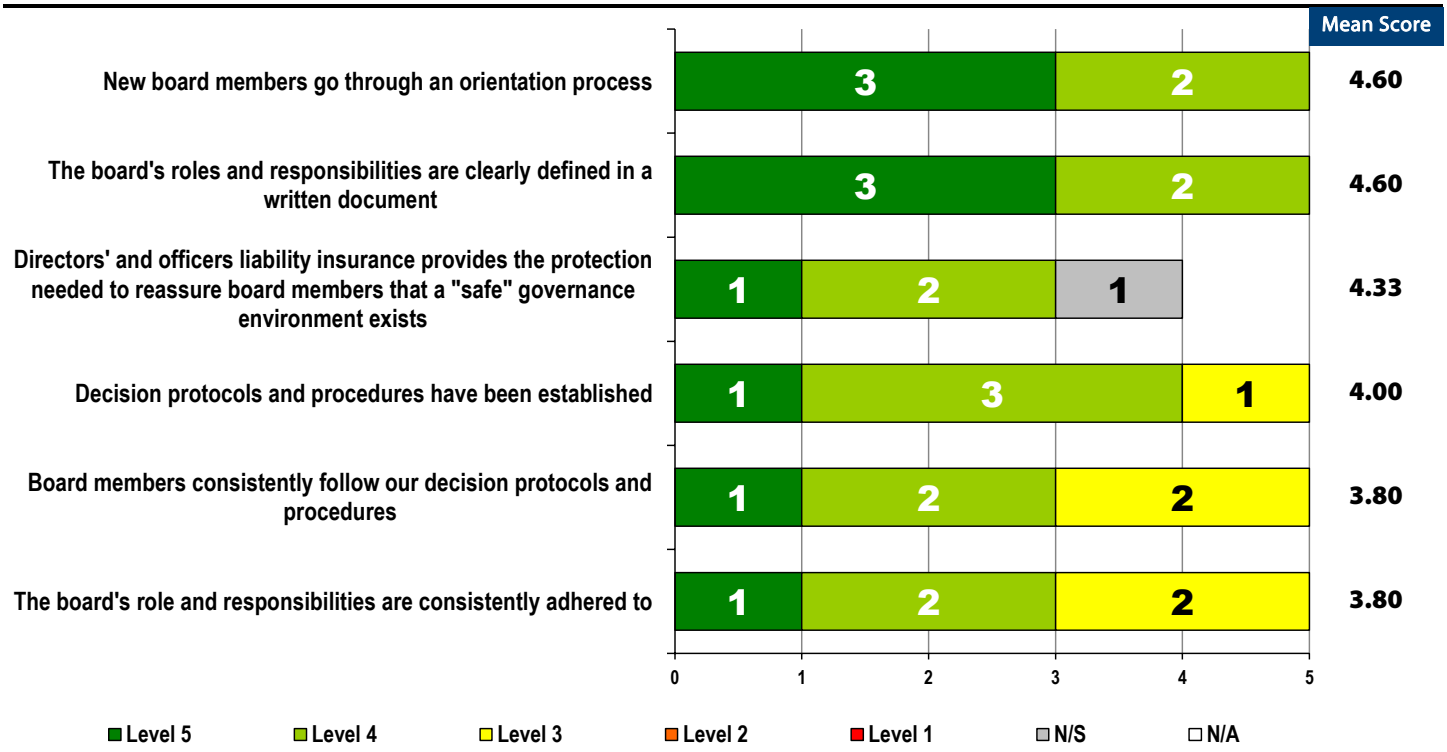
Board members provided the following suggestions for governance improvement in this section:

- Board needs more direct communication from members of the Executive Team.
- Receive more balanced and informative reports in order to monitor progress. Too much meeting time is dominated with lengthy financial reporting.
- We need to clearly understand our roles and legal responsibilities in making any involved decisions.

Leadership Structure and Processes

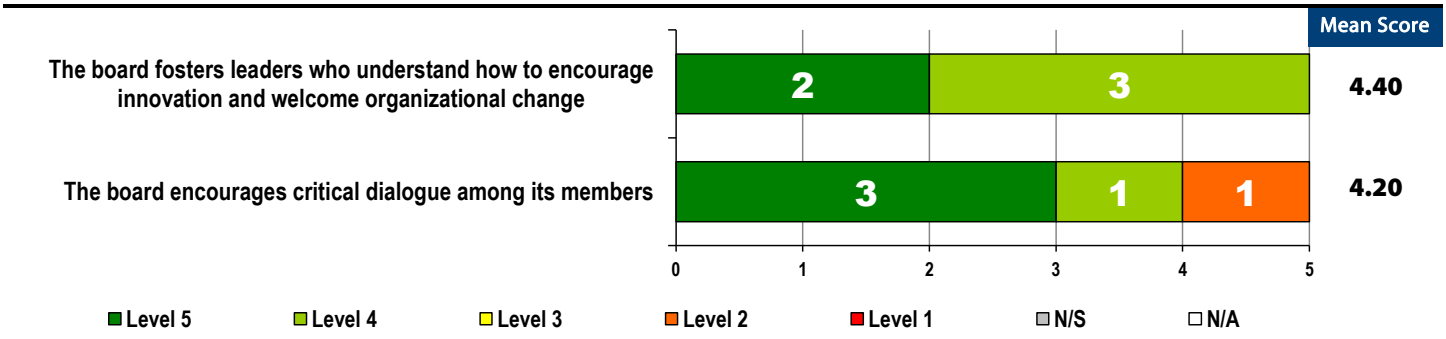
Board Roles and Responsibilities

(sorted by highest to lowest mean score)



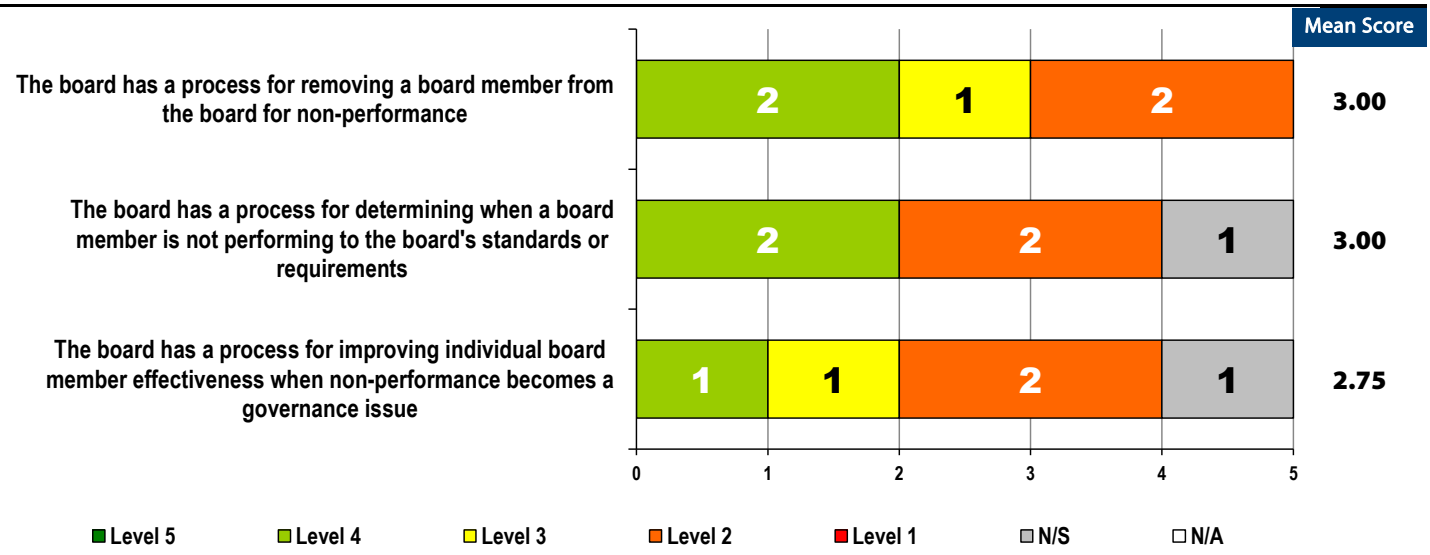
Board Structure and Composition

(sorted by highest to lowest mean score)



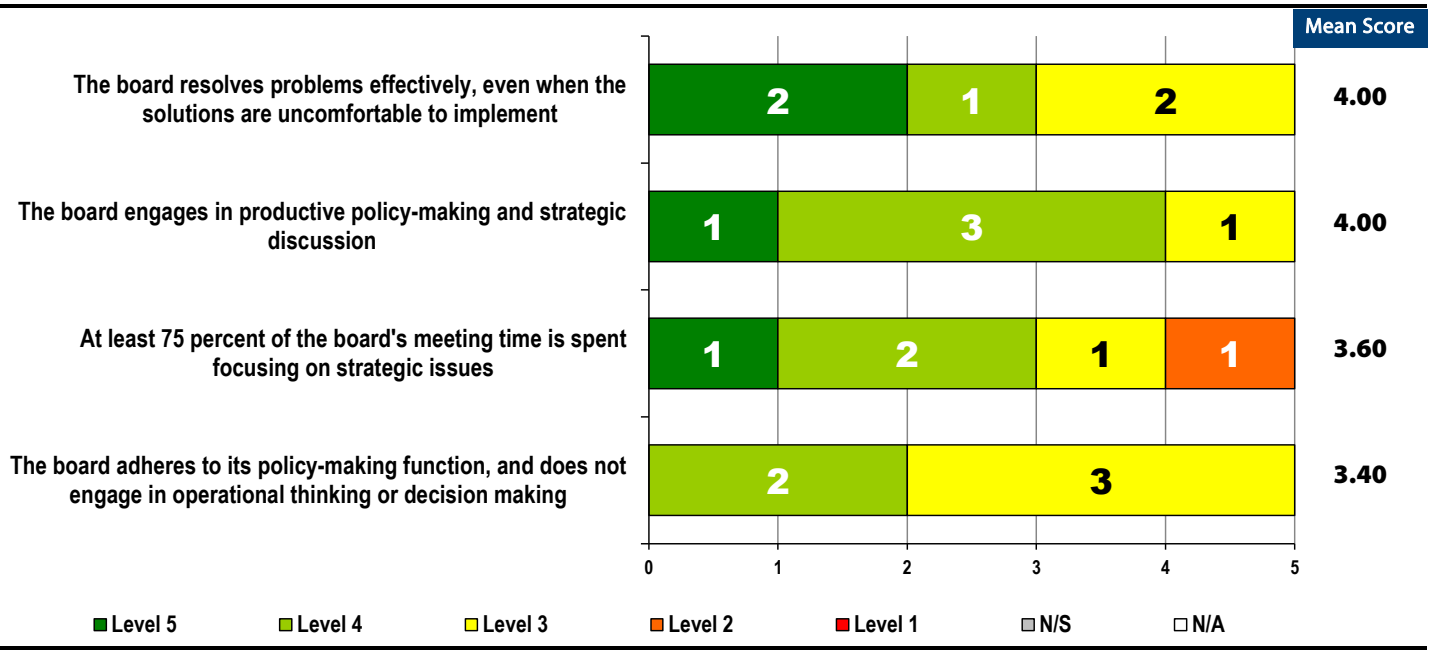
Board Member Performance

(sorted by highest to lowest mean score)



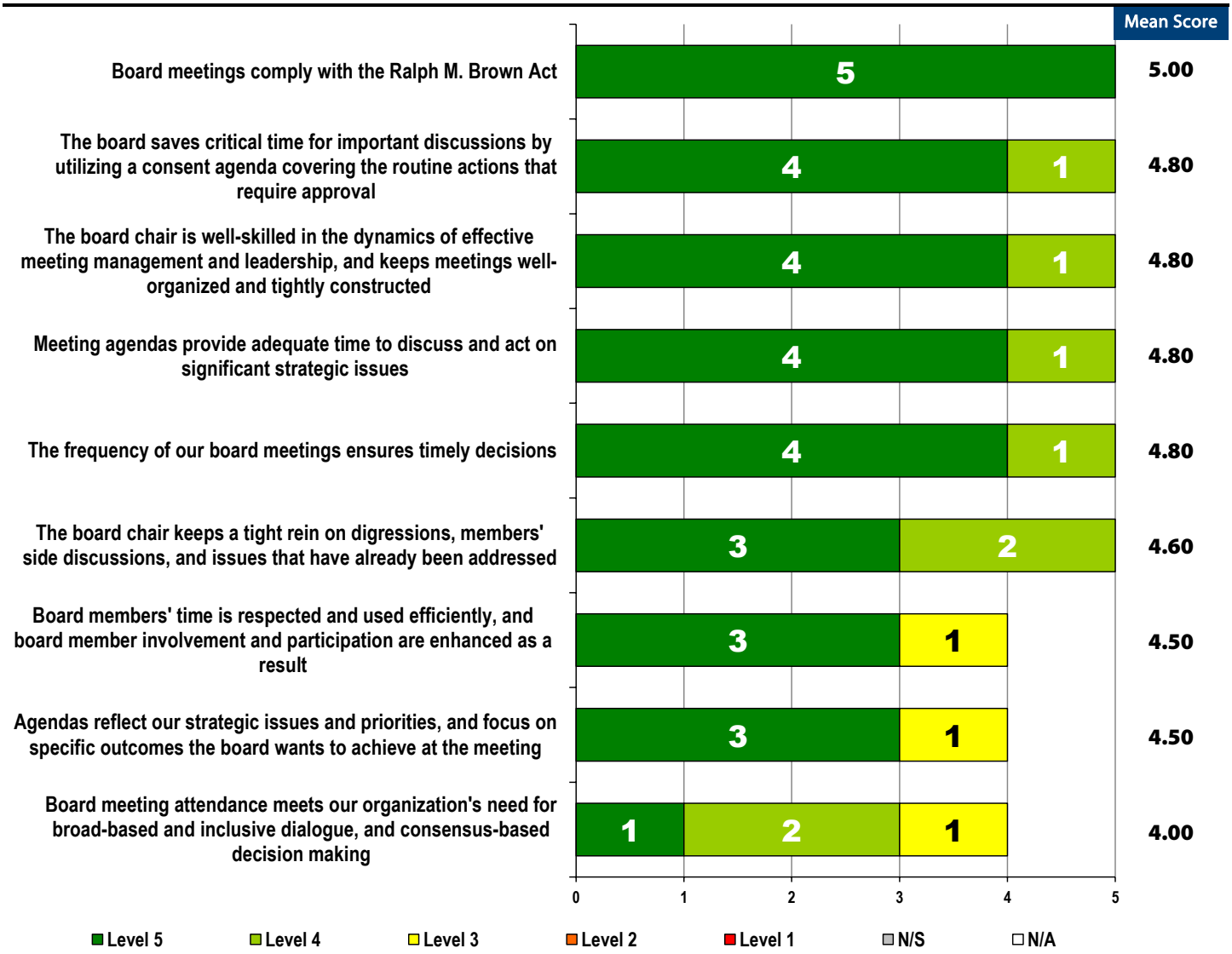
Strategic Focus

(sorted by highest to lowest mean score)



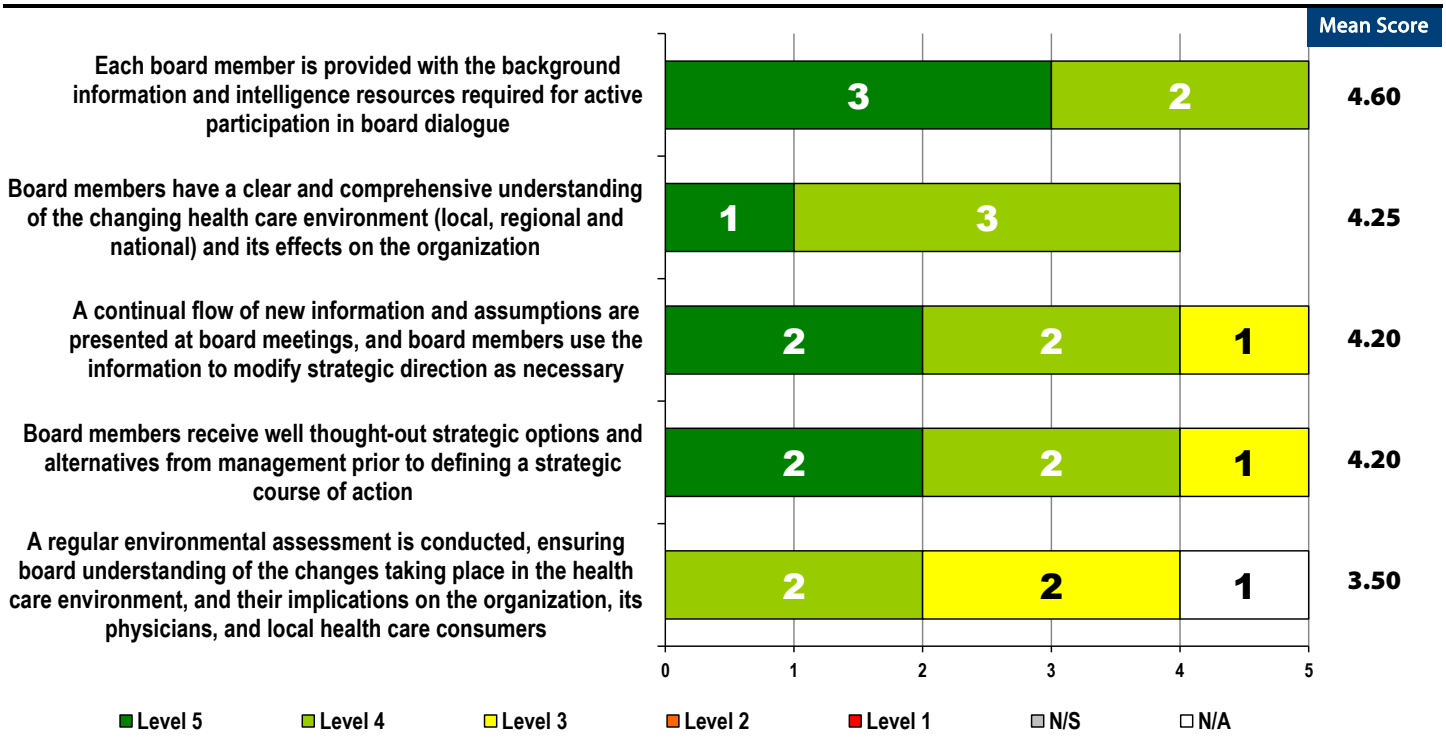
Board Meetings

(sorted by highest to lowest mean score)



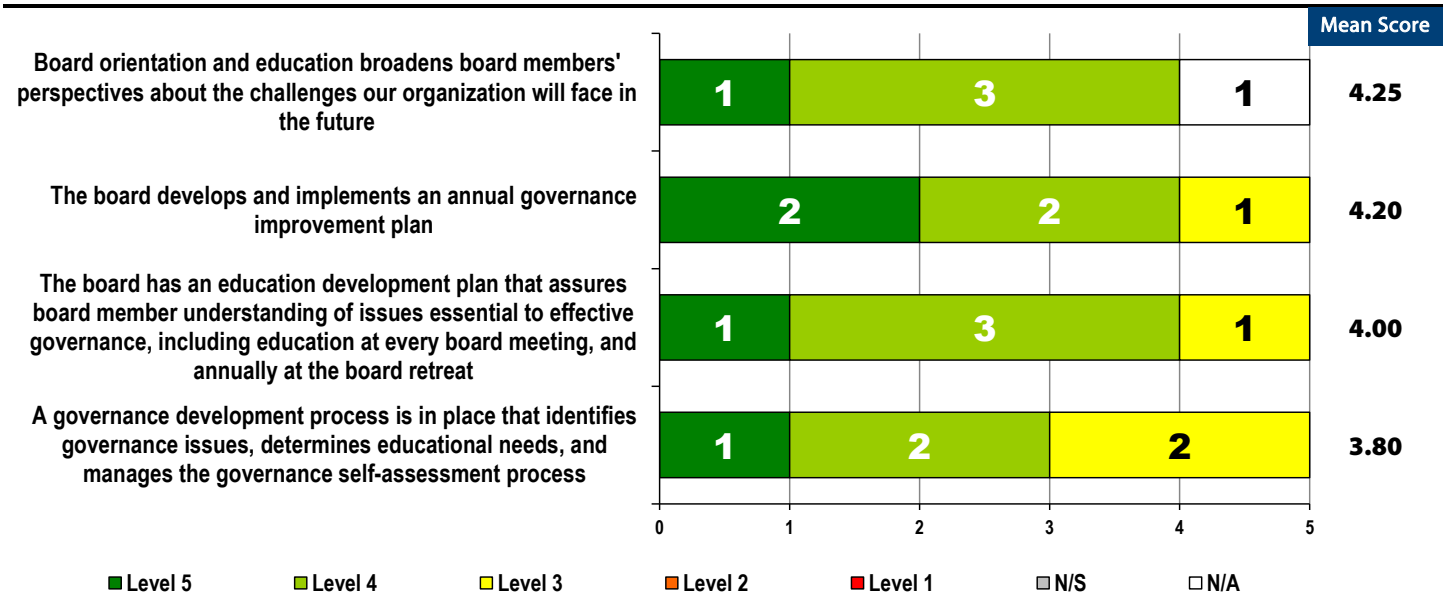
Board Member Knowledge

(sorted by highest to lowest mean score)



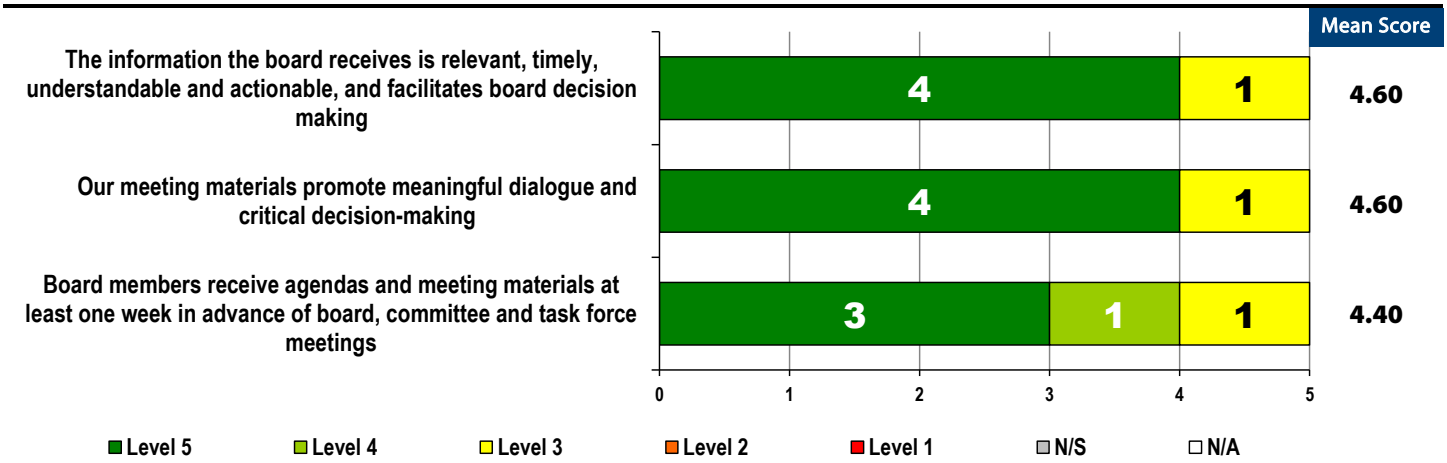
Governance Development

(sorted by highest to lowest mean score)



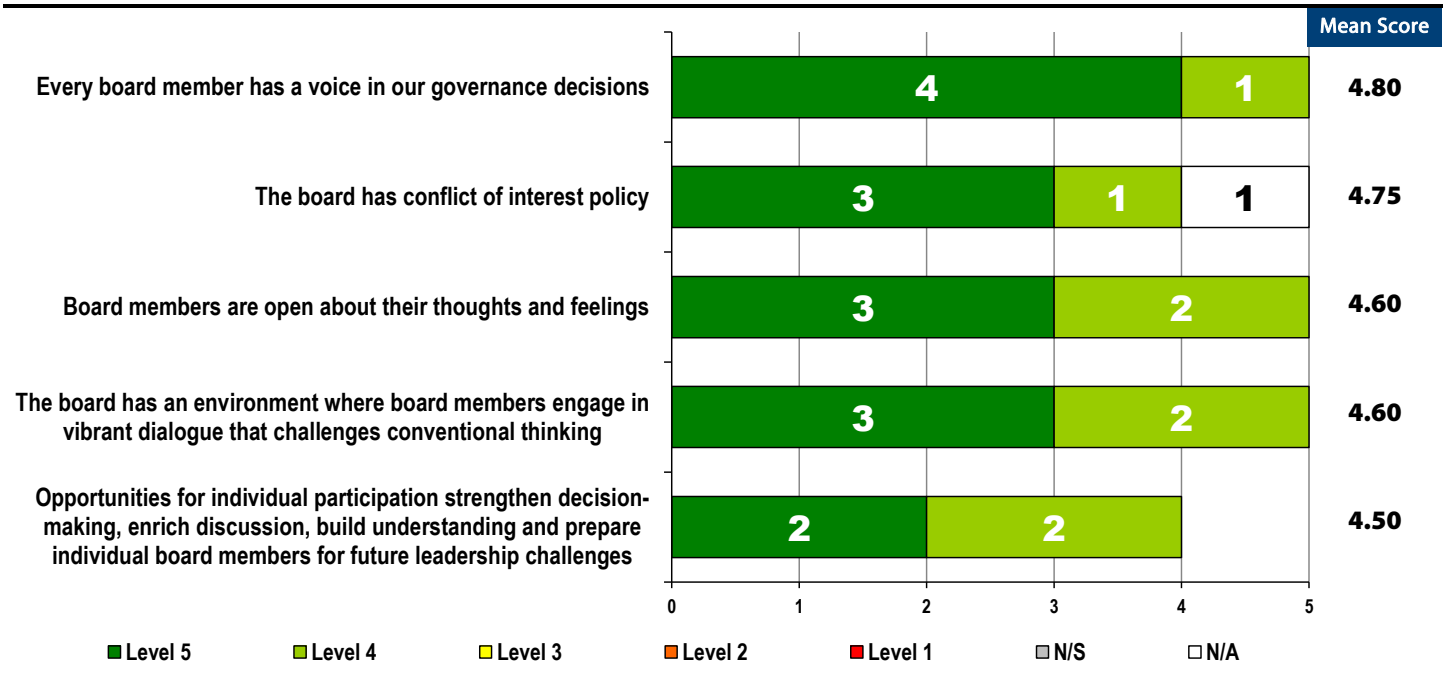
Meeting Materials

(sorted by highest to lowest mean score)



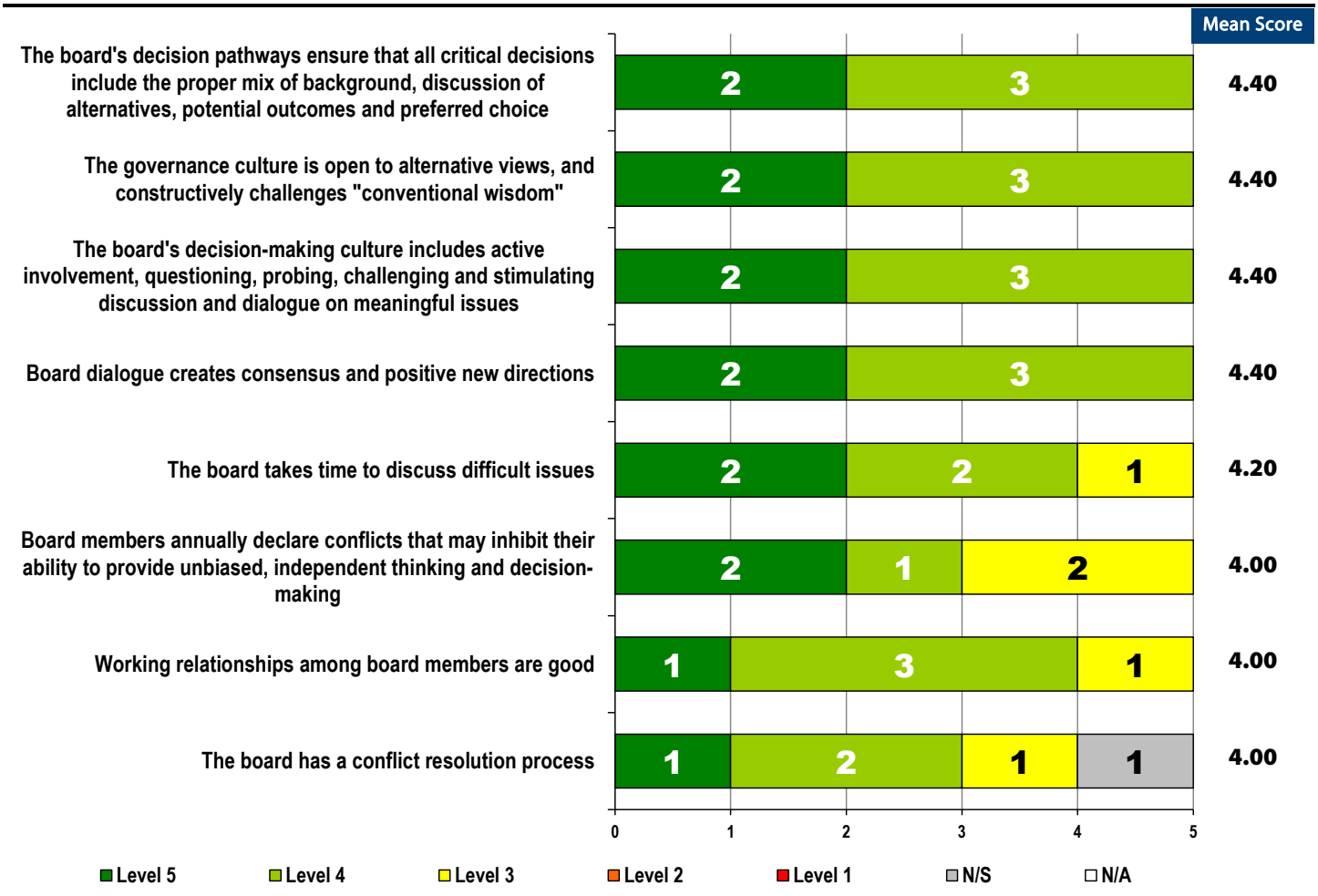
Board Relationships and Communication: Higher-Rated

(sorted by highest to lowest mean score)



Board Relationships and Communication: Lower Rated

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

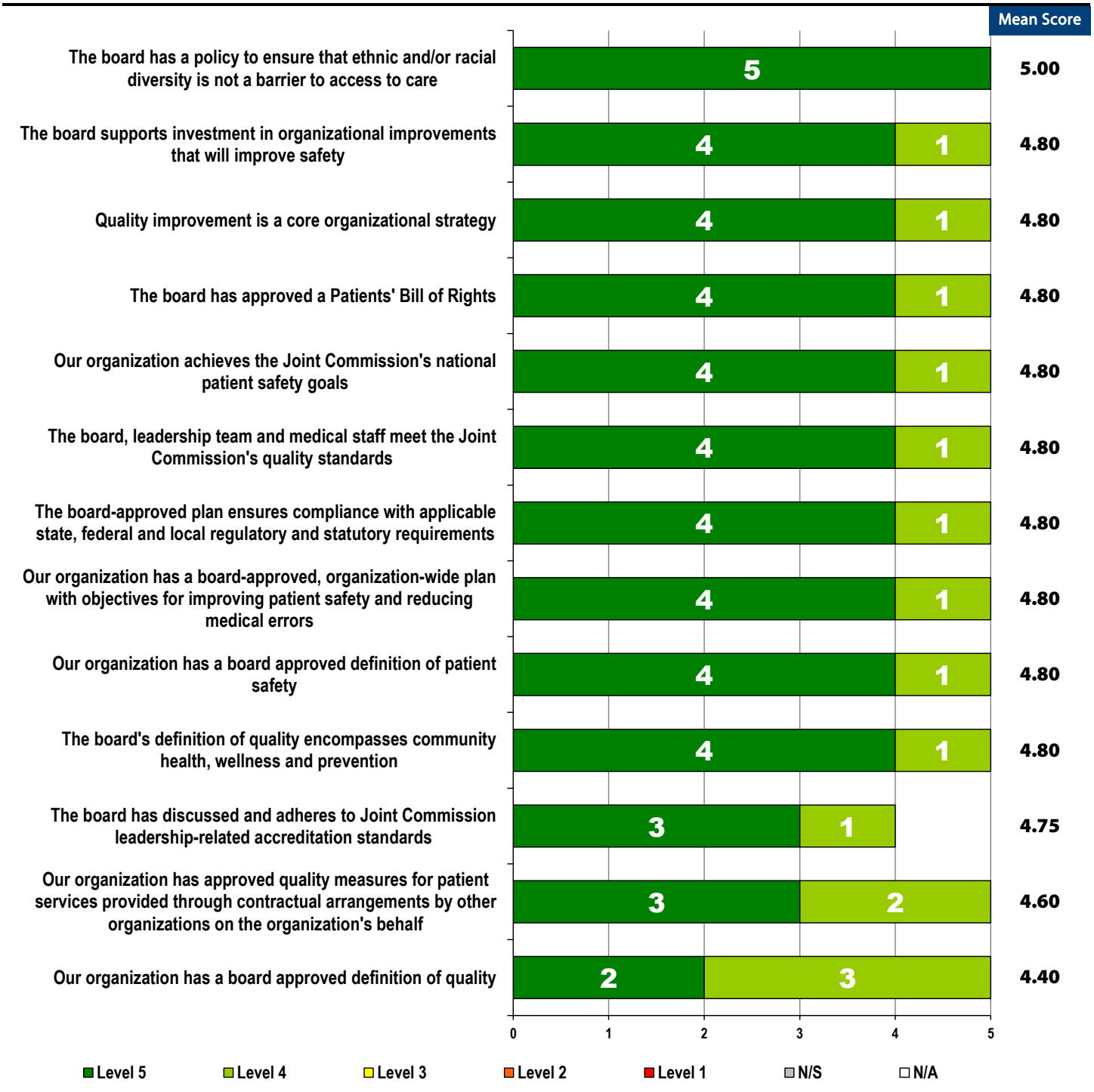
Board members provided the following suggestions for governance improvement in this section:

- It is important for all Board members to participate in Board education. Those sessions provide opportunities for discussing nuances and concerns about process.
- Improve communication between the Board and staff including the medical staff.
- We need to have serious discussions to resolve internal Board concerns.

Quality and Patient Safety

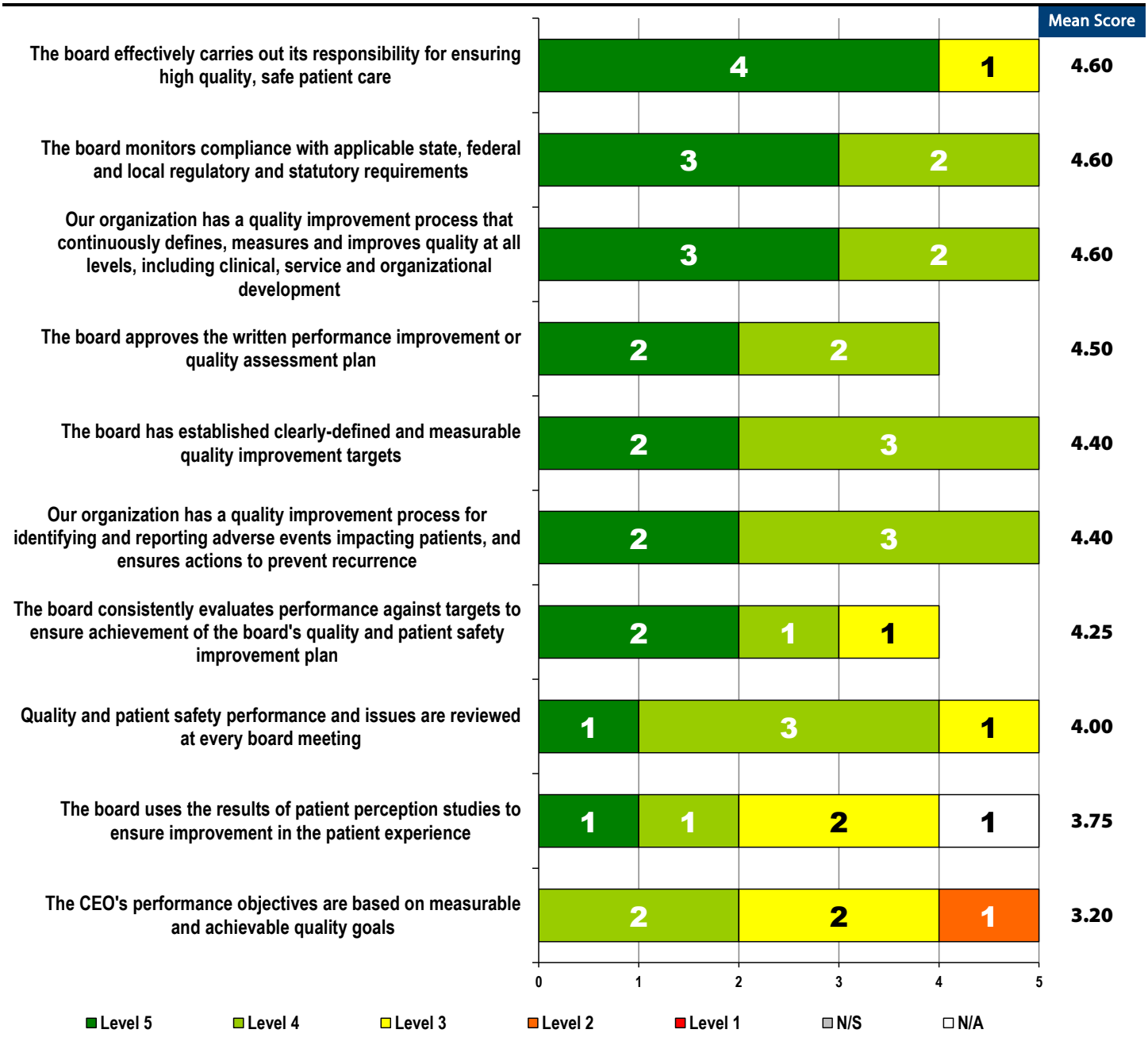
Defining and Understanding Quality and Patient Safety Issues

(sorted by highest to lowest mean score)



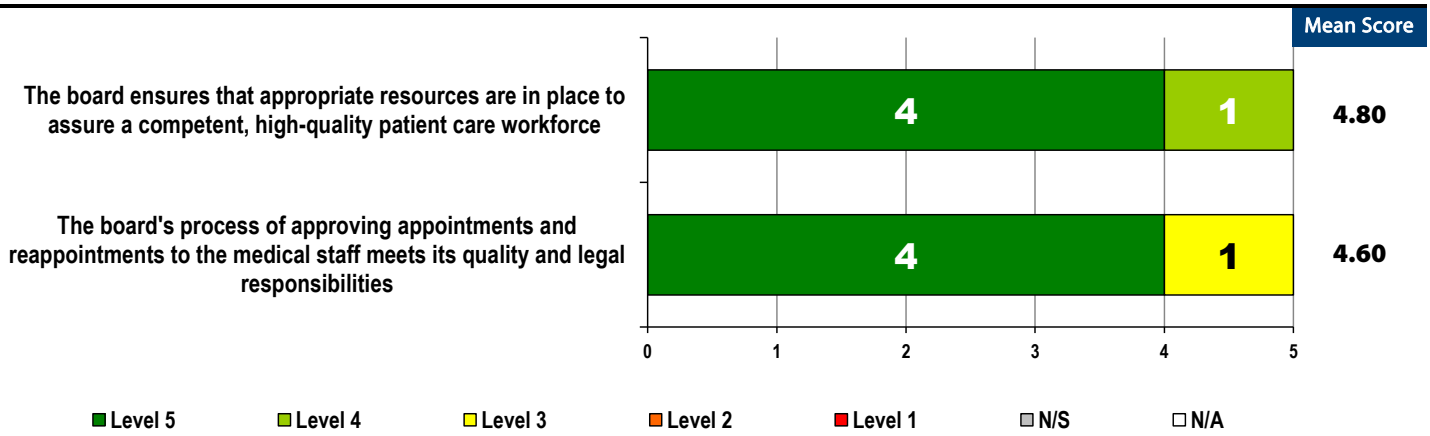
Monitoring Quality and Patient Safety

(sorted by highest to lowest mean score)



Ensuring a Workforce that Provides High Quality and Safe Care

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

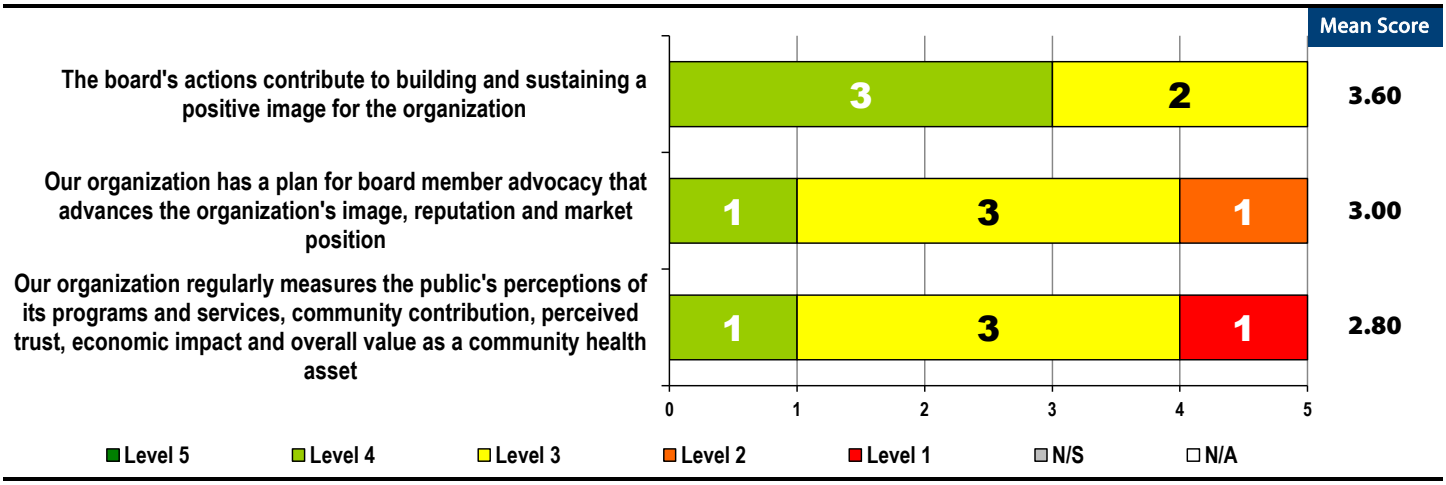
Board members provided the following suggestions for governance improvement in this section:

- Our staff performs great around patient safety. The Board continues to struggle with a few areas of quality performance among certain workforce groups.
- By being more informed and part of the decision making process

Community Relationships

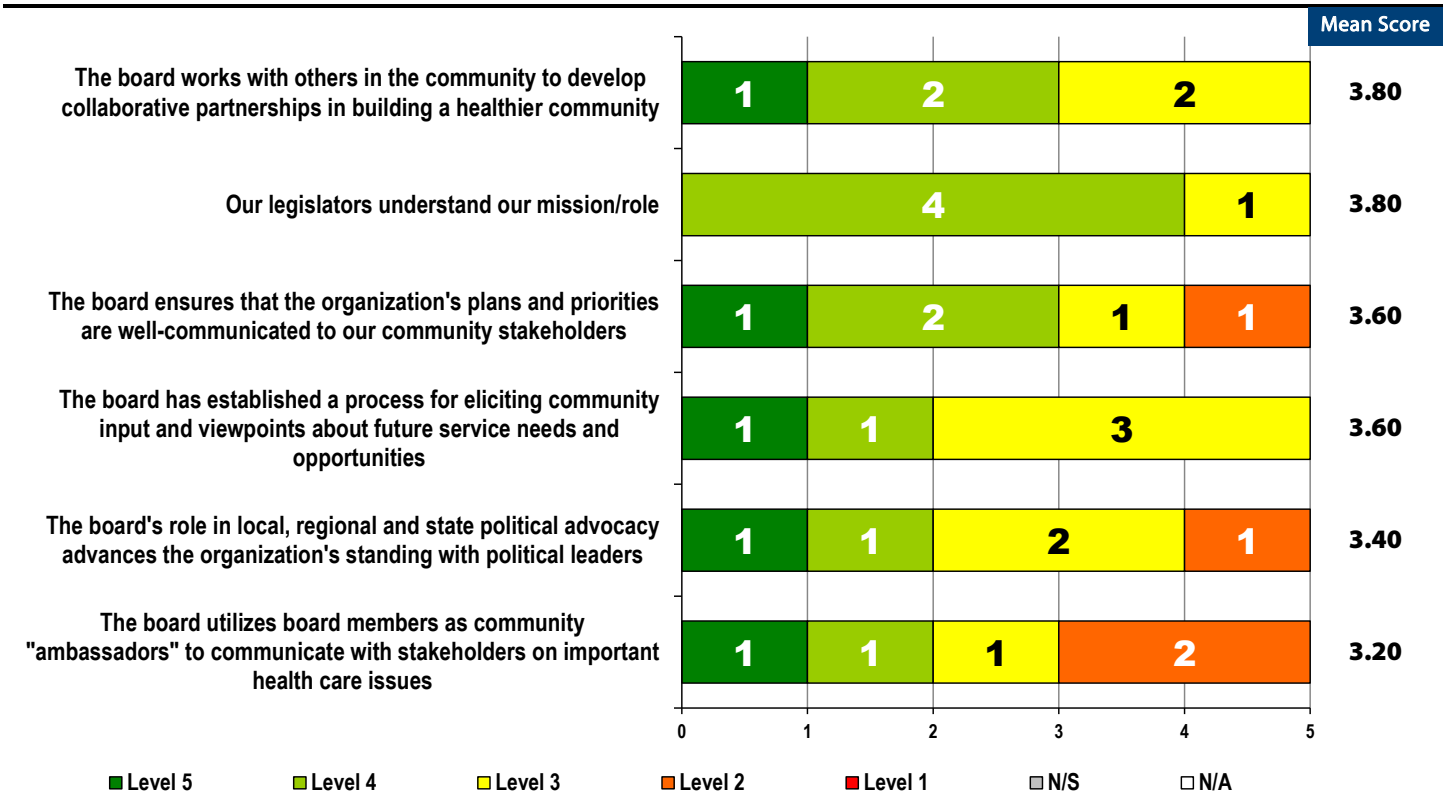
Ensuring Public Trust and Confidence

(sorted by highest to lowest mean score)



Ensuring Community Communication and Feedback

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

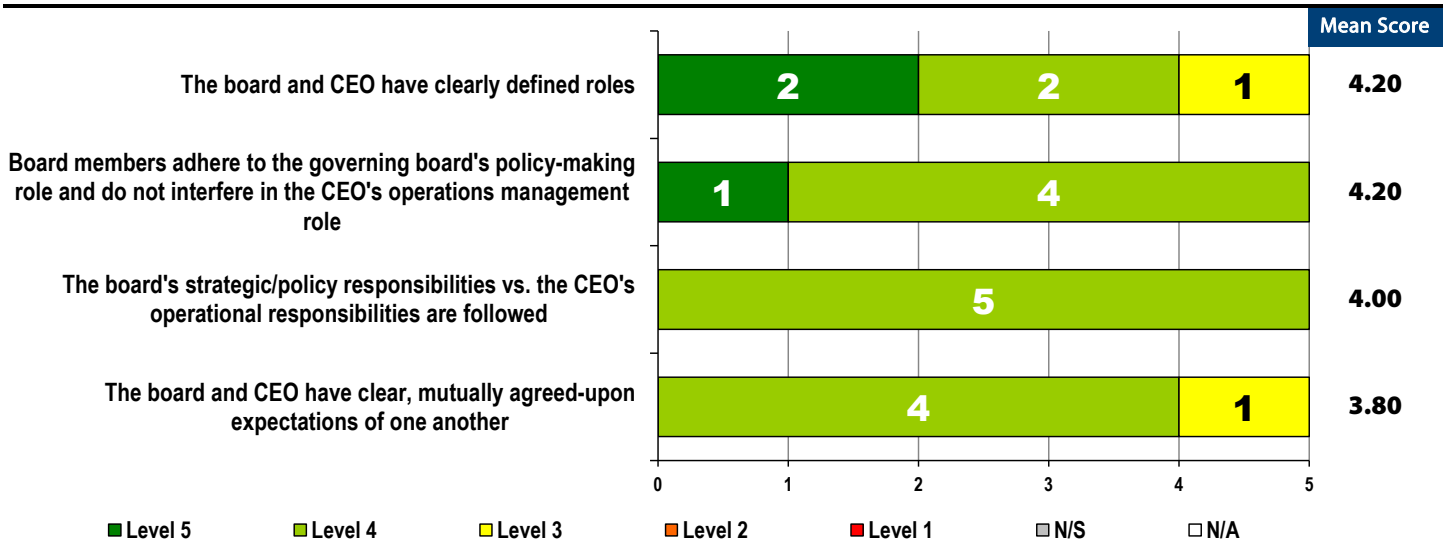
Board members provided the following suggestions for governance improvement in this section:

- Board members could take a more formalized ambassador role in the community.
- Greater community engagement.

Relationship with the CEO

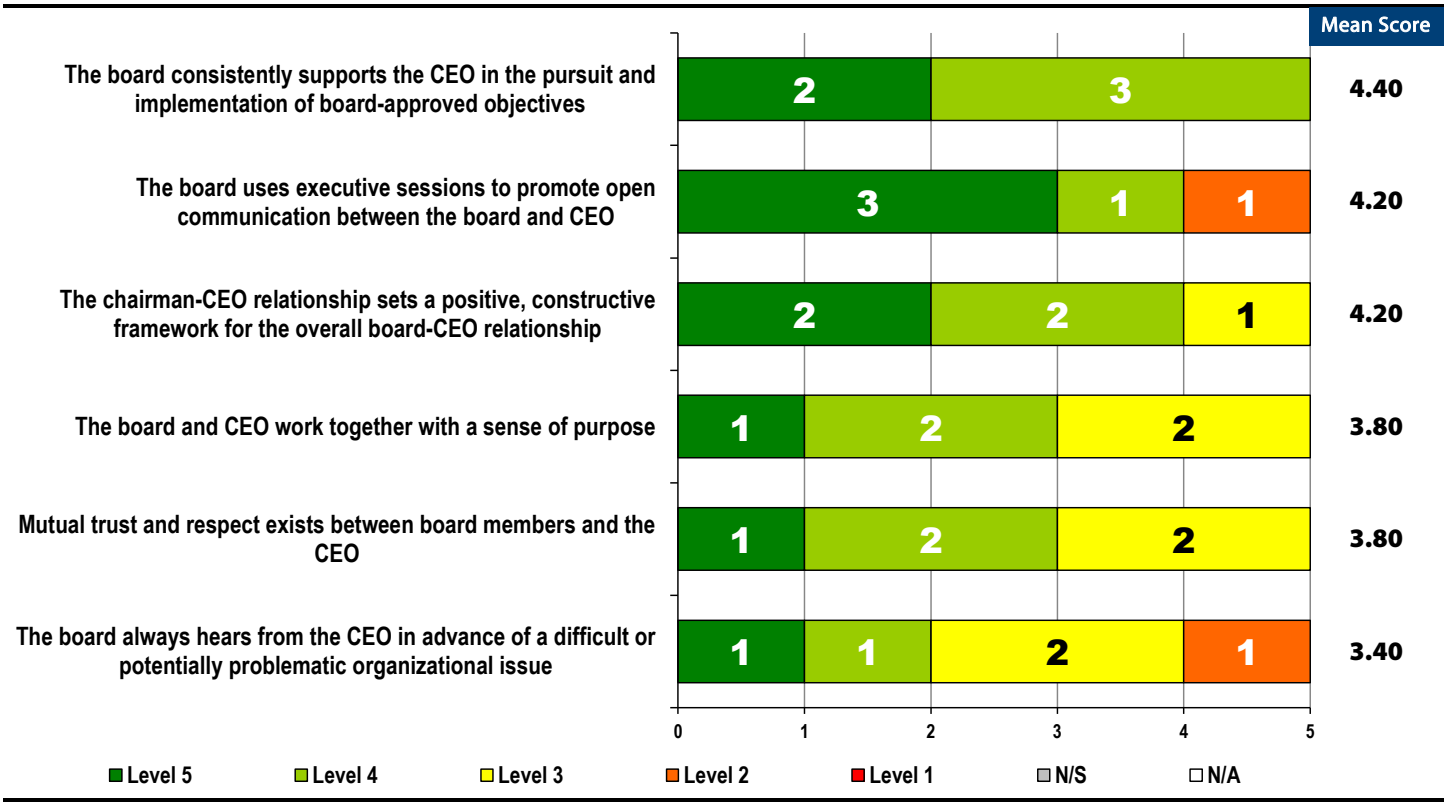
Board and CEO Roles

(sorted by highest to lowest mean score)



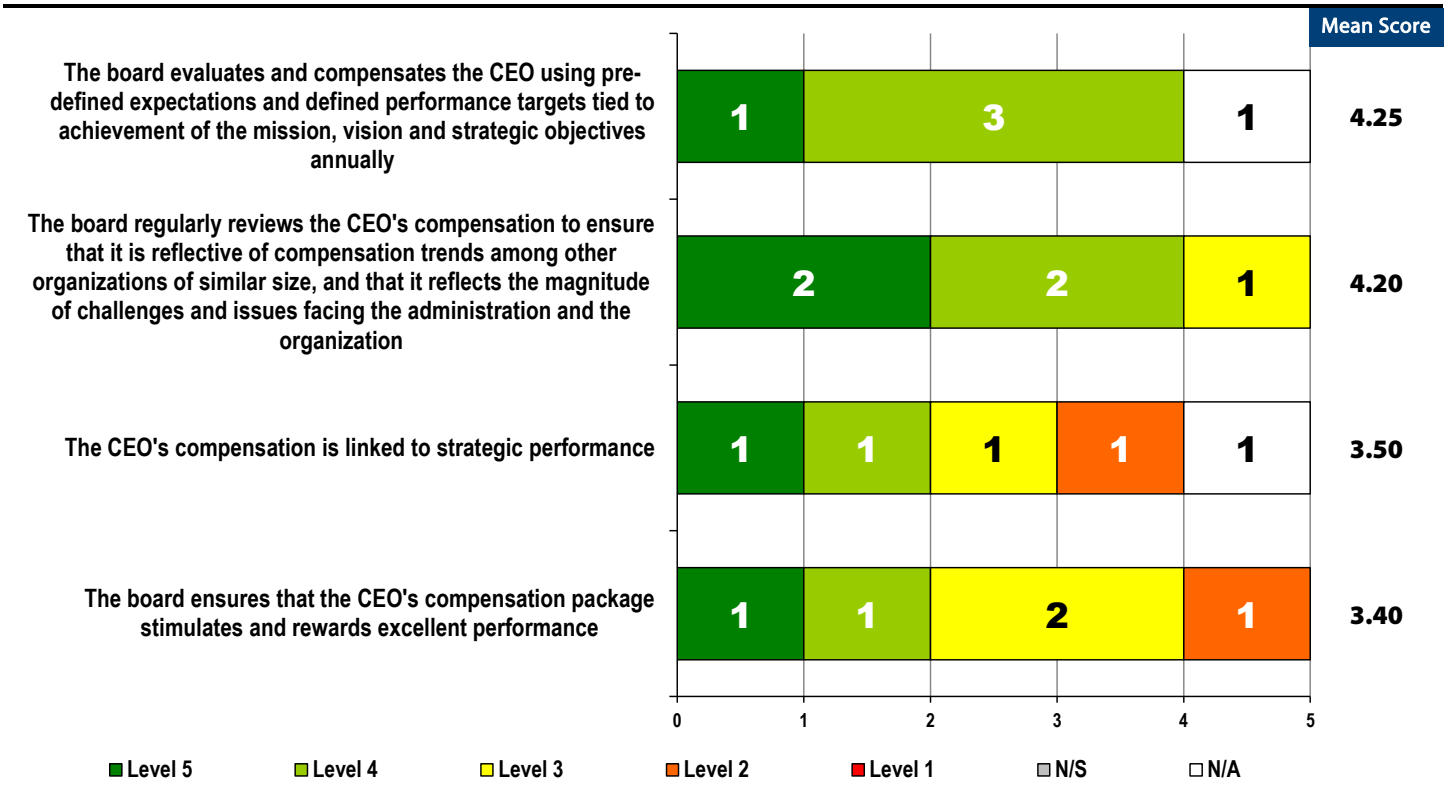
Communication, Support and Shared Goals

(sorted by highest to lowest mean score)



CEO Evaluation

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

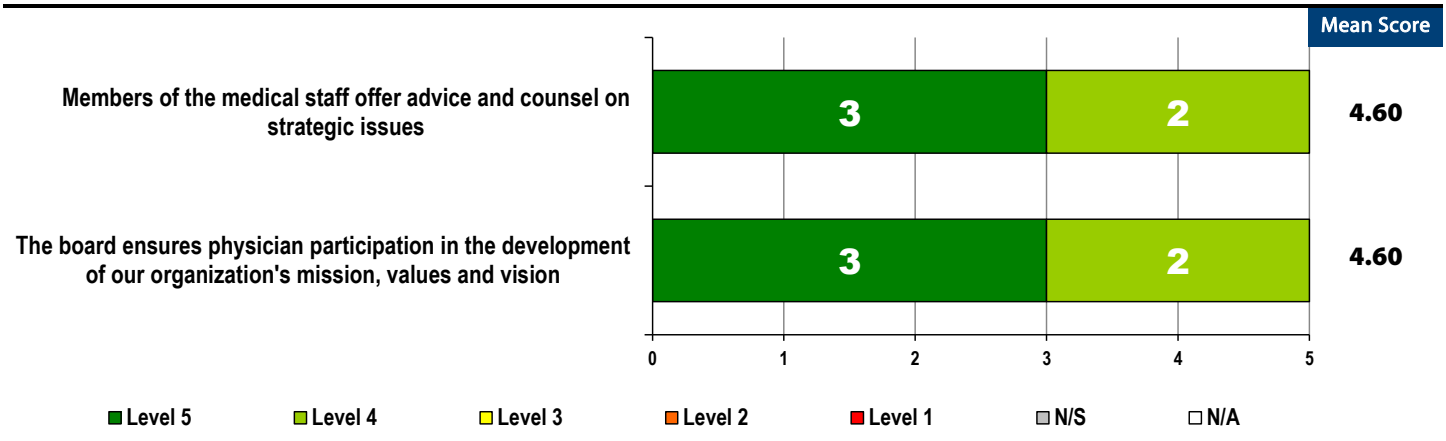
Board members provided the following suggestions for governance improvement in this section:

- Board is not always clear in setting performance goals for CEO, and ensuring compensation rewards excellent behavior.
- Be better informed about compensation trends in similar sized hospitals.

Relationships with the Medical Staff

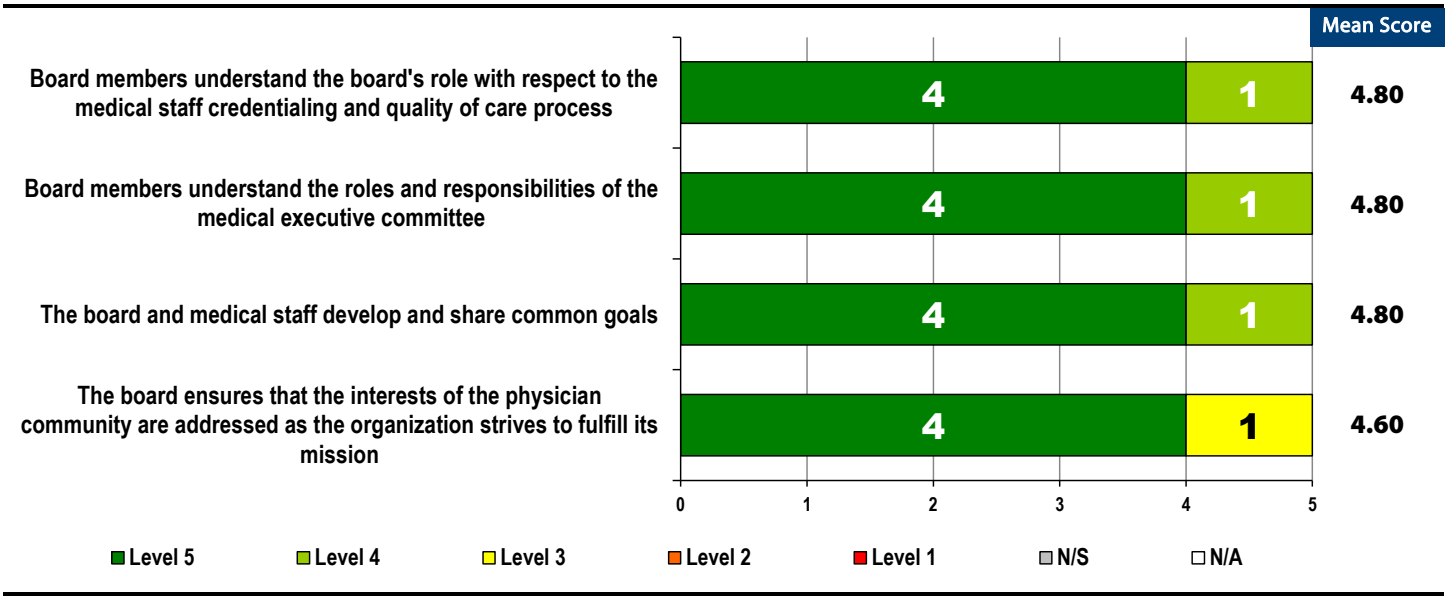
Physician Involvement in Decision Making

(sorted by highest to lowest mean score)



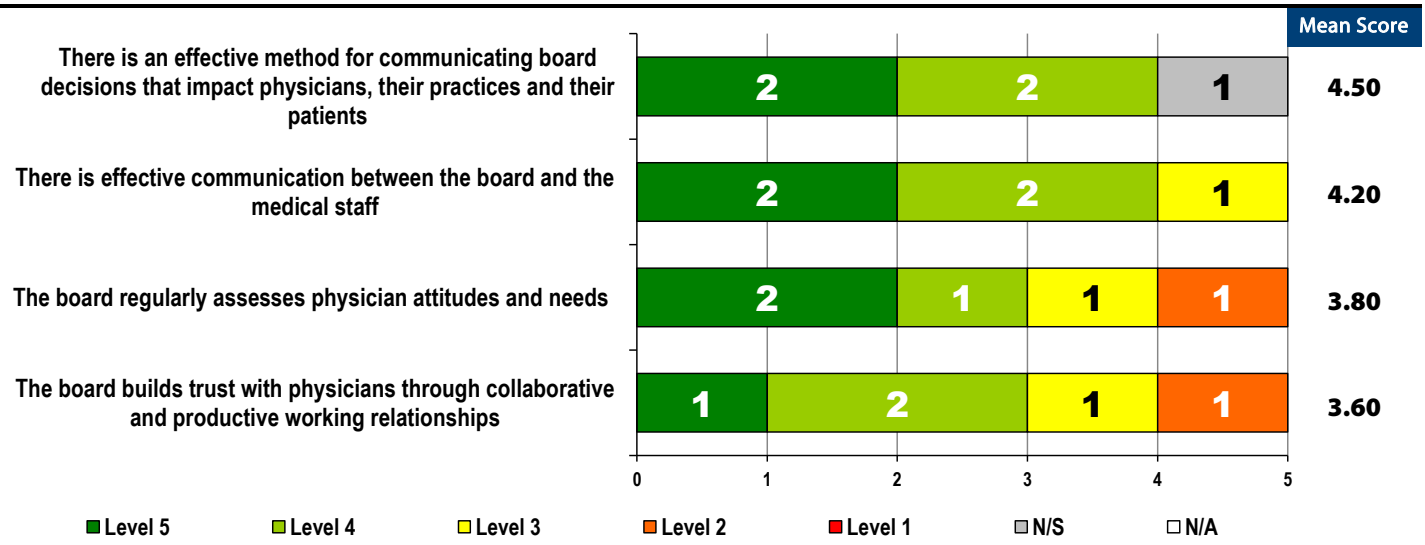
Shared Understanding

(sorted by highest to lowest mean score)



Communication and Interaction

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

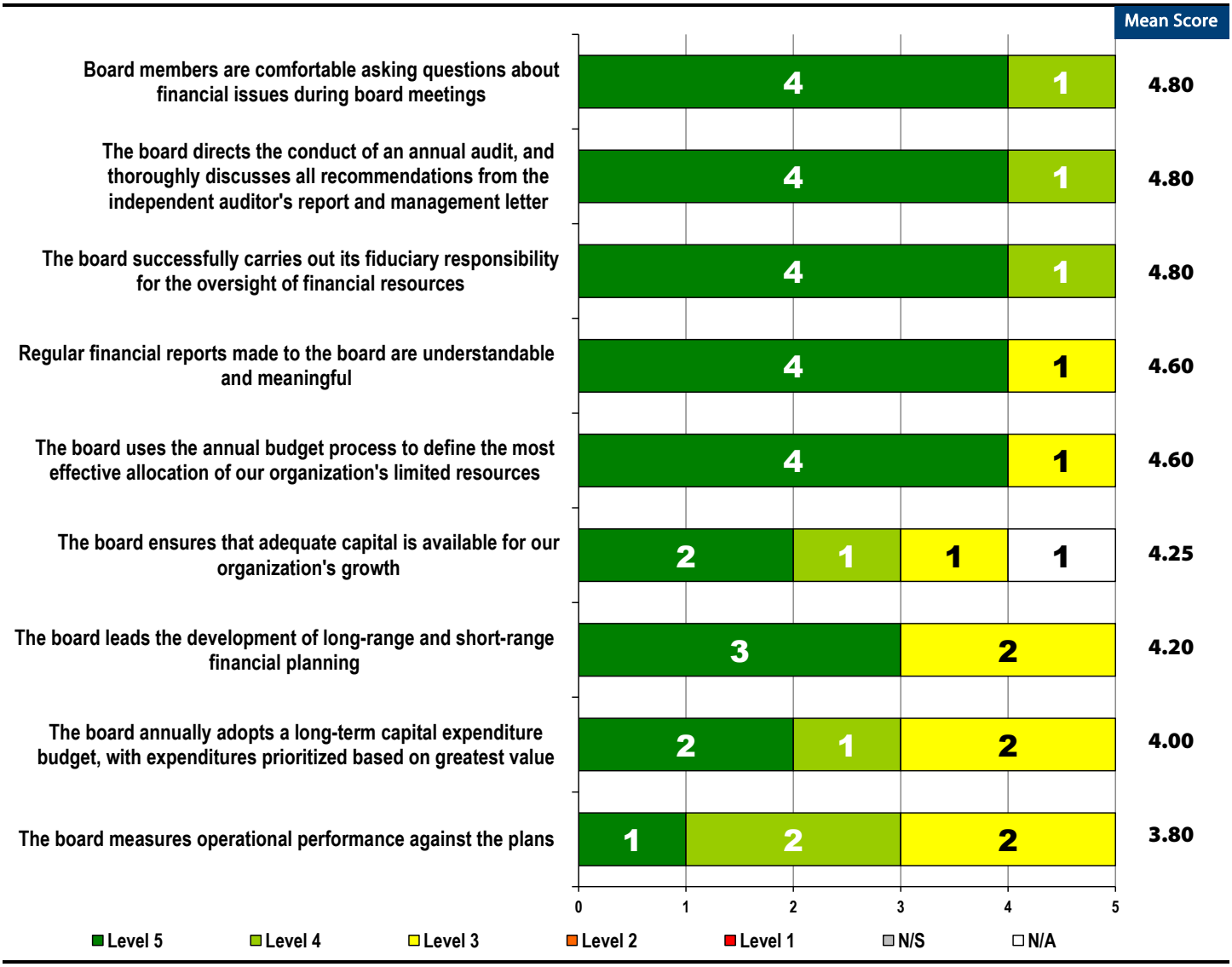
Board members provided the following suggestions for governance improvement in this section:

- I appreciate how the current Chief of Staff brings other physicians into Board meetings. It promotes more extensive collaborative working relationships.
- Better communication.

Financial Leadership

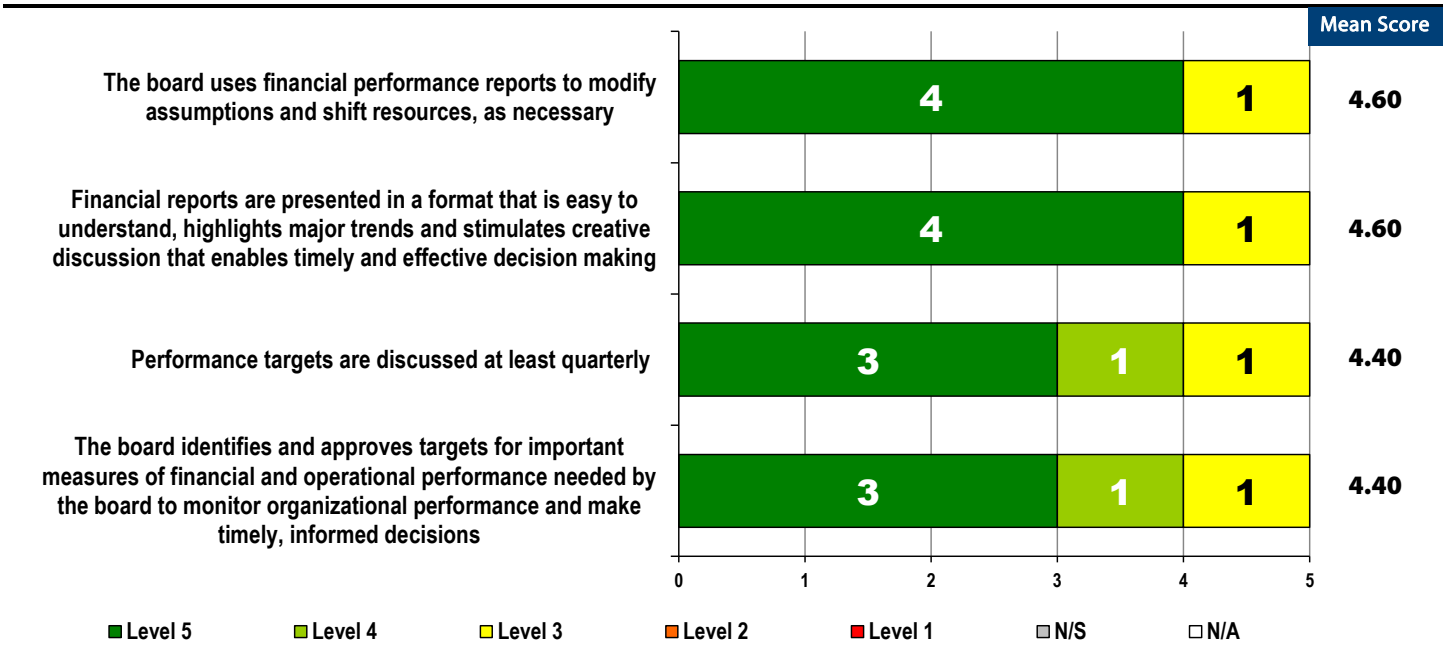
The Fiduciary Responsibility

(sorted by highest to lowest mean score)



Monitoring Progress

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

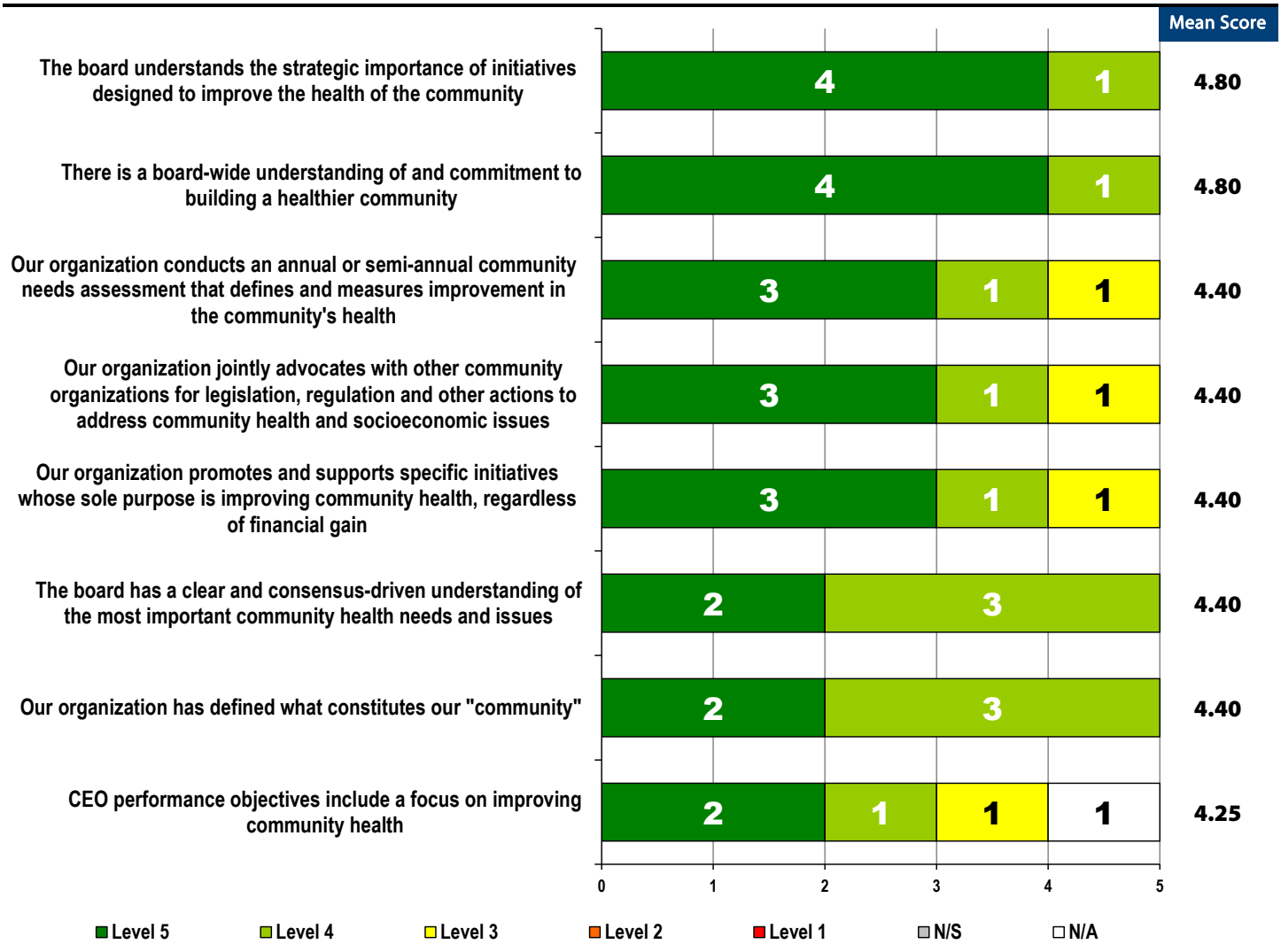
Board members provided the following suggestions for governance improvement in this section:

- Board could get clearer about financial performance targets and timelines.
- More involved in decision making.

Community Health

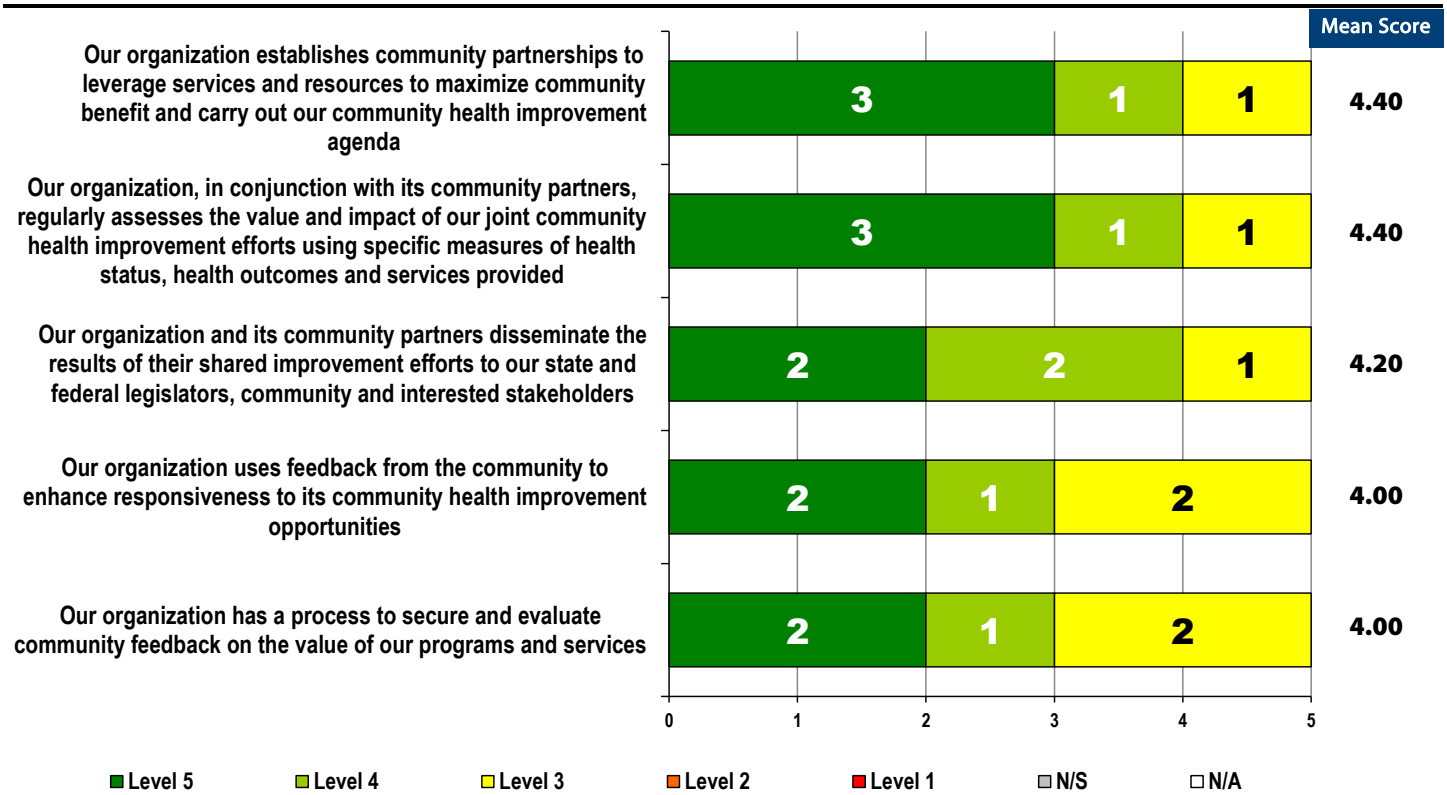
Development and Support of Community Health Initiatives

(sorted by highest to lowest mean score)



Community Involvement and Communication

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

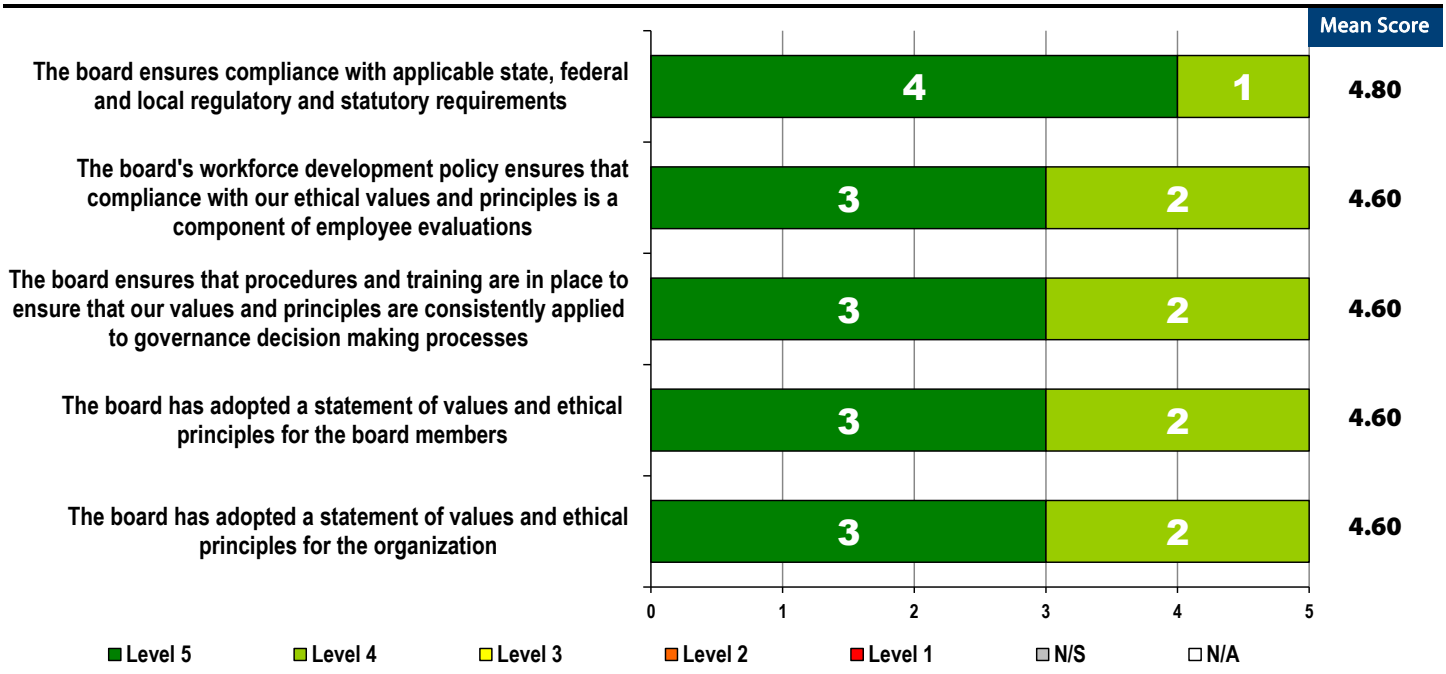
Board members provided the following suggestions for governance improvement in this section:

- Improve community partnerships.

Organizational Ethics

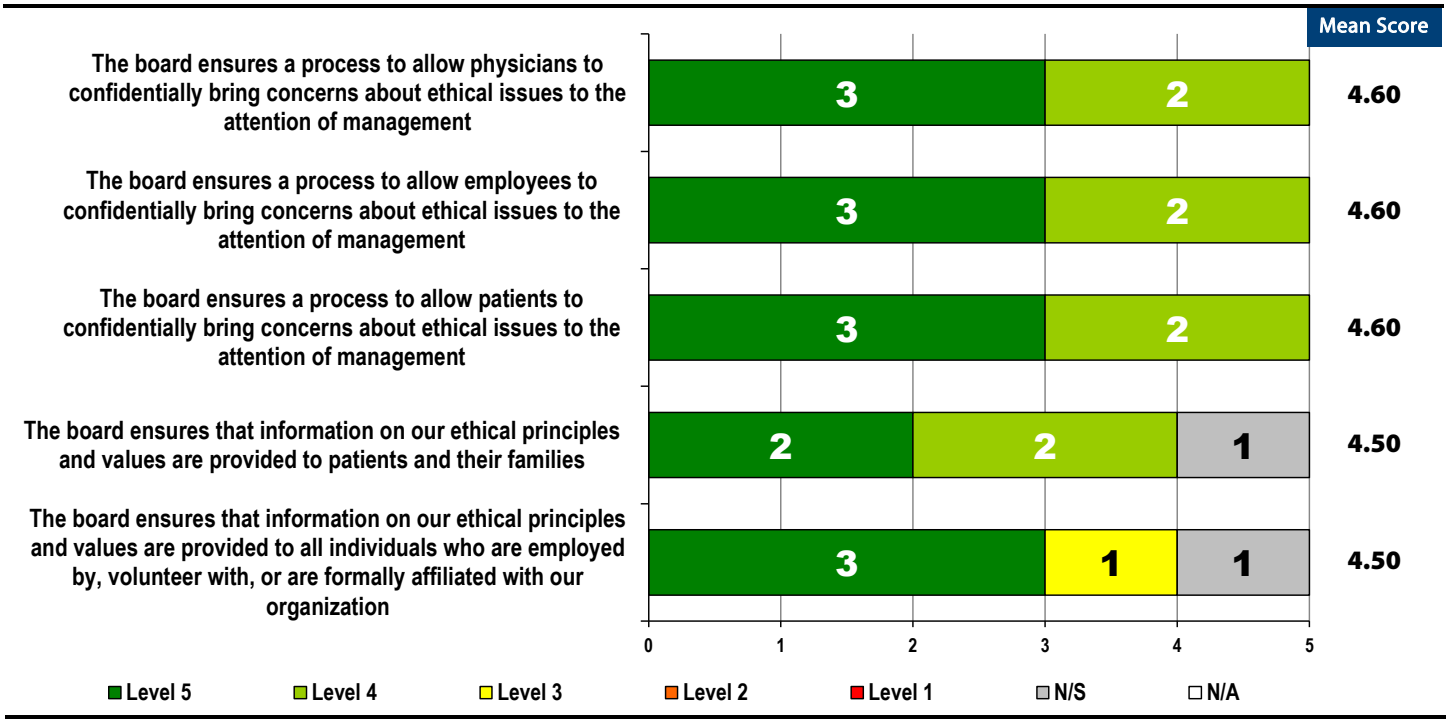
Ensuring Development and Implementation of Organizational Ethics

(sorted by highest to lowest mean score)



Awareness of Ethical Issues

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- Be more informed of concerns raised by physicians, staff, and patients.

Issues and Priorities

Highest Priority for the Board in the Next Year

Question: What is your single highest priority for the board in the next year?

- Hire a fiscally competent CEO who values transparency, the involvement of the Executive Team with the Board, and improvement of community perceptions of our healthcare.
- Finding a new CEO that will successfully lead our hospital.
- To find a CEO.
- Improving communication and a better connection with our employees and community.
- Better internal communication.

Most Significant Strengths

Question: What are the board's most significant strengths?

- Individual Board members bring leadership skills from various backgrounds in the community.
- All have different strengths and connections to make the hospital successful.
- Strong leaders.
- Sincere desire to serve our community and ensure the continued access to quality health care that meets the needs of most of our residents.
- Generally speaking, Board members appreciate robust discussion and value consensus decision-making.
- Communication.

Most Significant Weaknesses

Question: What are the board's most significant weaknesses?

- Not ensuring that information provided to the Board has always been vetted by legal, finance, HR, compliance, clinical or other necessary perspectives on a given issue.
- Lack of real information regarding the hospital's heartbeat.
- CEO and executive team relationships and management.
- Communication within the board.
- Financial security of hospital.
- Thinking out of the box.

Key Issues for Board Focus in the Next Year

Question: What key issues should occupy the board's time and attention in the next year?

- Supporting the Executive Team around the continued financial turnaround.
- Financial security of hospital.
- Budget.
- Billing.
- Hiring a well qualified CEO who is a great fit for our hospital and the area.
- CEO and executive team relationships and management.
- Hiring the right CEO.
- Supporting and improving performance expectations for staff.
- Become more involved and informed.
- Re-building Ortho.
- Strengthening IT.

Significant Trends the Board Must Understand and Deal with in the Next Year

Question: What do you see as the most significant trends that the board must be able to understand and deal with in the next year?

- Monitoring any changes at the federal level to Medicaid (Medi-Cal) and Medicare.
- Financial revenue and ways to improve it.
- Expense reimbursement from government and private insurance.
- Monetary survival of the hospital.
- The cash flow.
- Budget for specialized services locally.
- Services that are very needed and those that are not.
- Providing more treatment locally.
- Physician recruitment and retention.
- Labor and delivery and orthopedics.
- Staff training for skills and customer service.

Critical Factors to Address to Successfully Achieve Goals

Question: What factors are most critical to be addressed if the hospital is to successfully achieve its goals?

- Continued support for Chief Financial Officer to improve and sustain financial viability.
- Financial stability.
- Financial corrections.
- Funding.
- Re-build and sustain a viable ortho clinic responsive to community needs.
- Orthopedic services.
- Ophthalmology services.
- Recruitment of specialists for identified healthcare needs.
- Recruit and retain a very competent CEO.
- Better connection and communication.
- Everyone working together.
- The culture.
- Expect and reinforce excellent customer service.
- Review, update and identify emerging healthcare issues and needs for inclusion in current strategic plan.

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

DATE: May 15, 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Barbara Laughon, NIHD Marketing, Communications, and Strategy

RE: Marketing Update

Overview: Northern Inyo Healthcare District (NIHD) has developed a five-part video commercial series designed to share our story in a way that resonates with both local residents and surrounding communities. These videos highlight the exceptional care our medical team provides — from our commitment to personalized service and clinical excellence to our deep connection with the Eastern Sierra and its residents. The series includes:

- **"The Magic of Northern Inyo"** – Featuring Dr. Adam Hawkins, this video discusses the behind-the-scenes efforts that build lasting patient relationships.
- **Patient-Centered Care** – A look at NIHD's Emergency Room team, emphasizing rapid door-to-doctor time, patient privacy, and above all, high-quality, compassionate care. Narrated by Dr. Hawkins.
- **Quality Care Compilation** – A broader look at NIHD's collaborative and comforting approach to care, featuring Dr. Hawkins, Cardiologist Dr. Christopher Rowan, and long-time resident Penny McCoy.
- **Cardiology Care Close to Home** – A focused spotlight on Dr. Rowan and the high-quality cardiology care available right here at home.
- **The Best of Both Worlds** – Featuring Penny McCoy, this is a generational patient's story that captures the trust, continuity, and security NIHD has provided since its 1946 voter-based inception.

Director Kristin Kremers and Director of Photography Eric Bissell filmed the series during two days on campus with NIHD staff. Most of the individuals featured are employees who volunteered their time to help bring this campaign to life. To ensure a quiet and welcoming environment for more personal interviews, Board Member David McCoy Barrett generously offered his home as a filming location. Ms. Kremers and Film Editor Meg Stahl led post-production with the assistance of a special effects expert introduced by Mr. Barrett, resulting in a polished, professional finish that honors the authenticity of the NIHD story.

Rather than simply promoting services, this campaign underscores the deep-seated values that steadily define NIHD — compassion, reliability, and community pride.

Distribution: We are launching a soft rollout to avoid conflicting with major community events such as Mule Days and local graduations. The first video will be posted to NIH.org and social media this week. From there, each video will appear across NIHD's digital platforms and appear in rotation through a much broader campaign strategy that includes both external and internal content channels.

Note: Videos to air during the meeting for your review.

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR ACTION

Date: May 8, 2025

Title: May 2025 Compliance Report

Synopsis: The Compliance Department Report provides information needed for the Board of Directors to provide the oversight required by the Health and Human Services Office of Inspector General (OIG). It provides insight into the work occurring in all areas of the seven essential elements of a Compliance Program as outlined by the HHS OIG. All information in the report has been summarized; however, additional details will be provided to the Board of Directors upon request.

I recommend that the Board of Directors accept this report.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: _____
Name

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Compliance Report –CY 2025 January - April
May 7, 2025

Comprehensive Compliance Program Definitions:

1. **Audits** - A wide variety of audits in the Compliance Program review for privacy concerns, language access issues, and fraud, waste, and abuse. "Auditing and monitoring" is one of the seven essential elements of an effective compliance program.
2. **Security Risk Assessment**—The District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment is completed annually and as needed by Compliance and Information Technology (IT) Security.
3. **SAFER** - Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) is completed annually by IT, Informatics, and Compliance.
4. **Compliance Workplan** - The Compliance Workplan is updated annually and as needed to adjust the focus of certain audits in alignment with the Office of Inspector General of the Department of Health and Human Services, our local Medicare Administrative Contractor (MAC) Noridian, and other regulatory agency priorities.
5. **Conflicts of Interest** – This component of the Compliance Program ensures that no parties use or conduct District business for personal financial gain.
6. **Privacy Investigations –** Privacy investigations can arise due to complaints, access audits, HIMS audits, and anonymous reporting.
7. **Investigations—**Other compliance-related investigations are conducted to avoid regulatory non-compliance and respond to regulatory agency inquiries and investigations. "Enforcement and discipline" are among the seven essential elements of an effective compliance program, as is reporting as required to regulatory agencies and the Board.
8. **Compliance Committees—**This section provides a brief overview of the work of the Compliance committees and subcommittees.
9. **Issues and Prevention** – The Compliance Team researches numerous questions, concerns, and regulatory issues to allow other NIHD team members to take a proactive approach. "Education and training," along with "response and prevention," are two of the seven essential elements of an effective compliance program.
10. **California Public Records Act (CPRA) Requests**—The Compliance Officer is responsible for receiving and reviewing public records requests and researching, investigating, redacting, and fulfilling them.
11. **Policies and Procedures—**Policies and procedures are vital to the organization as they outline expectations and processes for the workforce. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program.

12. **Unusual Occurrence Reports**—The Compliance Team processes and tracks all unusual occurrence reports for the District. Compliance provides quality data to leadership and teams for monitoring and trending. Compliance also manages the software, reporting, user configuration, and resolution of all UORs.
13. **Regulatory Updates—**Compliance requires knowledge of updates and changes to state and federal regulations. The Compliance Department has implemented regulatory monitoring software to ensure we are aware of and plan for upcoming effective dates for new and changing regulations.

The Compliance Department consists of a team of two full-time employees: Conor Vaughan, Compliance Analyst, and Patty Dickson, Compliance Officer.

The Compliance Reports help the Board of Directors and Executives fulfill their governance and oversight roles. Governing board and executive oversight of compliance is one of the seven essential elements of an effective compliance program.

Report

1. Audits

A. Electronic Health Record Access Audits—The Compliance Department Analyst, Conor Vaughan, completes audits for patient information systems access to ensure employees, providers, contractors, and vendors access protected health information on a work-related, need-to-know, and minimum-necessary basis.

i. Cerner semi-automated audit software tracks all workforce interactions and provides a summary dashboard for the Compliance Team. The dashboard provides "flags" for unusual activity, which require further investigation and review by the Compliance Team. The majority of access audits are a manual process involving reviewing hundreds of thousands of lines of data in Excel spreadsheets.

ii. With assistance from ITS and Project Management, the Compliance Department is currently performing the due diligence necessary to implement a fully automated auditing solution, Protenus - PrivacyPro.

iii. The following is the CY24 activity:

a. New Employee Audits (30 days): 32
   I. Flags: 2
   II. Flags resulting in policy violations: 0
   III. The 30-day audit for new employees was added to the access audit plan in 2024 as a part of a Protected Health Information (PHI) breach corrective action plan.

b. New Employee Audits (90 days): 28
   I. Flags: 0
   II. Flags resulting in policy violations: 0

c. For-Cause Audits: 6
   I. Flags: 0
   II. Flags resulting in policy violations: 0
   III. Flags resulting in disciplinary action: 0

d. In "own" chart flags: 8
   I. Flags resulting in policy violations: 0
      i. Provided education and training: 0

ii. Repeat violations: 0

e. Same Last Name Search Flags: 99
   I. Resulted in follow-up with the employee: 3
   II. Flags resulting in policy violations: 0

f. Third-Party Vendors (ex. Our billing or coding company): 0
   I. Flags: 0
   II. Flags resulting in policy violations: 0

g. High Profile Persons: 1
   I. Flags: 0
   II. Flags resulting in policy violations: 0

h. Random Employee Audits: 10
   I. Flags: 0
   II. Flags resulting in policy violations: 0

B. Business Associates Agreements (BAA) audit
   i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor is accountable to the strict governmental regulations regarding using, transmitting, and storing protected information to protect NIHD and NIHD patient information.
   ii. Business Associates (Bas) security practices need to be vetted at engagement and on a regular basis.
      a. NIHD vetted the security practices of 4 high-priority vendors in quarter 1 of 2025. The priority of security vetting depends on how much or how often vendors interact with NIHD PHI.
         I. Jorie, Cerner, Keenan, and 3C Cares assessments are completed.
            i. All four have low risk of a data breach, indicating high compliance with HIPAA privacy and security controls and processes.
   iii. NIHD has nearly 100 BAAs.

C. Compliance Department Contract and Agreement reviews/audit
   i. Documents processed for January through April 2025
      a. Approximately 60 agreements, amendments, or termination notices have been reviewed and completed in 2025.
      b. ~20 are currently in progress

D. HIMs (Health Information Management) scanning audit
   i. Conducted by HIMS and summary reports will be sent to Compliance
   ii. No reports to date

E. Email security audit/reviews
   i. Review email security systems monthly for violations of data loss prevention rules
      a. Typically, it results in reminder emails to use email encryption sent to workforce members.
      b. Occasionally, audit results in full investigations of potential privacy violations.

F. Language Access Services Audits and Reviews
   i. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line and through HIPAA compliant Handheld interpreter (HHI) devices.

a. NIHD has provided ~27,500 minutes of interpreting services to our patients at a cost to the District of $50,674. See Attachment 1.
b. This total includes the initial cost of the HHI devices and management software for NIHD, which is $21,184 in 2025. The HHI devices/management software costs for 2026 and 2027 are under $2,100 each year.

ii. Translation services (written word) are provided via Language Line Translation Services, HHI devices, and an online subscription service. NIHD has spent $300.00 on translation services in 2025.
iii. NIHD provided services in the following languages in 2025:
a. Spanish (21 countries claim Spanish as an official language),
b. American Sign Language,
c. Mandarin (China, Taiwan, and Singapore),
d. Gujarati (India/Pakistan),
e. Thai (Thailand)
f. Arabic (25 countries claim Arabic as an official language),
g. Armenian (Armenia)
h. Vietnamese (Vietnam)
iv. Laws require providing language access services to all patients with limited English proficiency at no cost to the patient.
v. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.

G. 340B program audits
i. The 340B drug program is designed to provide rural and underserved communities with access to discount drug prices, allowing the facility to save several hundred thousand dollars annually. The District uses those funds to improve services provided to the community.
ii. SpendMend has completed the annual 340B External Audit for 2025.
a. A few minor process changes were recommended and implemented during the Audit.
b. Overall, the elements required to demonstrate 340B program requirements were present.
c. The Compliance Department recognizes Becky Wanamaker and Jeff Kneip for their excellent work maintaining the compliance of our 340B program.

H. Narcotic Administration/Reconciliation Audit
i. Compliance works with Pharmacy to review narcotic administration and compliance with professional standards and regulations.
ii. There has been one potential narcotic diversion investigation in 2025.
a. No definitive diversion was identified. Education and training have been provided.

I. Vendor Diversity Audit – NIHD has approximately 1200 vendors.
i. We are in the process of gathering the information for the CY 2024 submission.
ii. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI) to develop and administer a program to collect hospital supplier diversity reports, including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.

J. Provider Verification Audits
i. Compliance verified ~180 providers for state and federal exclusions so far in 2025.

ii. No exclusions have been identified through April 30, 2025.
iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

K. Coding Audits and Charge Master Audits
i. UASI has provided coding quality reports.
a. UASI has provided education to providers.
ii. Charge Master Audit
a. The audit conducted by CliftonLarsonAllen identified opportunities in multiple areas of the chargemaster. These are the focus of multiple revenue cycle committees.

2. **HIPAA Security Risk Assessment (SRA)** – Completed in December 2024.
A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG. A summary of the 2024 SRA was presented to the Board of Directors in February 2025.
B. The Compliance Officer (Patty Dickson) and Security Officer work on this risk assessment together.

3. **Office of National Coordinator of Health Information Technology SAFER Audit** ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience))
A. Informatics and Compliance have scheduled meetings to ensure all nine SAFER sections are completed by October 2025.
B. Completion of all nine sections is required for MIPS (Merit-based Incentive Payment System) data submission.
C. MIPS data is the quality-of-care data submitted by the Quality Team. MIPS documents improvements in patient care measures and outcomes, and is worth millions of dollars for NIHD.

4. **Compliance Work Plan** – Updated for Calendar Year (CY) 2025. See Attachment 2.

5. **Conflicts of Interest (COI)**
A. All new employees complete and return COI questionnaire forms.
B. We will send all current employees the new format COI questionnaire forms in the third quarter of 2025.
C. In 2024, no COI forms submitted to the Compliance Department noted any knowledge or concern for the following:
i. Business transactions with an aim for personal gain.
ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
iii. Use of NIHD resources for purposes other than NIHD business, NIHD-sponsored business activities, or activities allowed by policy.
iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
v. Use of NIHD money, goods, or services to influence government employees, for special consideration, or for political contribution.
vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.

6. **Privacy Investigations**- See Attachment 3.
A. Privacy investigations/potential breaches through April 30, 2025:
i. Reported to Compliance – 6
ii. Reported to CDPH/OCR – 2
iii. Investigations (2024) still active in the Compliance Department - 0
iv. Investigations closed by the Compliance Department with no reporting required - 4
B. Outstanding breach cases reported to CDPH

i. CDPH has notified NIHD that the Medical Breach Enforcement Section (MBES) will begin investigating its backlog of breaches. MBES can review and investigate breaches for seven years. The MBES team was reassigned to contact tracing during the pandemic and is now working to resolve the oldest reported potential breaches first.
    a. Privacy investigations from 2023
        I. Reported – 10
            i. 4 are closed
    b. Privacy investigations from 2022
        I. Reported – 6
            i. 3 are closed
            ii. NIHD received notice that CDPH assigned a $45,000 administrative penalty for a breach in 2022.
                1. This was an intentional breach by the former employee.
                2. Compliance was able to negotiate a $30,000 Settlement Stipulation. NIHD has paid this administrative penalty.
    c. Privacy investigations from 2021
        I. Reported – 4
            i. 3 are closed
    d. Privacy investigations from 2020
        I. Reported – 17
            i. 11 are closed
            ii. 3 may be assigned an administrative penalty or fine
    e. Privacy investigations from 2019
        I. Reported - 11
            i. 7 are closed
    f. Privacy investigations from 2018
        I. Reported - 23
            i. 22 are closed
    g. Privacy investigations from 2017
        I. Reported -22
            i. 17 are closed
    h. Privacy investigations from 2016
            i. CDPH is still investigating 1
ii. CDPH Status definitions
    a. Closed – CDPH investigation was completed, and a determination was made.
    b. In Progress – CDPH has assigned an intake ID and may have completed some portion of the investigation.
    c. Submitted – CDPH has not assigned an intake ID or reviewed the case.
iii. CDPH Determination definitions
    a. Unsubstantiated – CDPH was unable to prove a violation of the privacy laws occurred (or the privacy law was updated in the interim between submission and their processing of the report)
    b. Substantiated without deficiencies—CDPH found that a violation of the privacy laws occurred, but NIHD had the correct policies/procedures, training/education, and corrective actions to ensure any harm has been mitigated and reduced the risk for recurrence.

c. Substantiated with deficiencies—CDPH has found that a violation of the privacy laws occurred and determined that further action by NIHD is needed to reduce the risk of recurrence. CDPH requires a corrective action plan to be submitted within a few days of receipt of the determination letter. Once the corrective action plan has been accepted, CDPH sends the case to CDPH Administration to determine if fines and administrative penalties will be assessed.

7. Investigations

A. Compliance conducted or assisted with approximately 7 investigations and reviews through April 30, 2025, including, but not limited to, the following:
   i. California Department of Public Health, Licensing and Certification
   ii. Internal investigations

B. Regulatory Submissions
   i. Health Care Access and Information (HCAI – formerly OSHPD)
      a. Vendor Diversity—Due June 30, 2025 June 3, 2024
      b. Hospital Fair Billing Practices – All billing policies were updated and submitted to HCAI in March 2025. We are awaiting final compliance determination from HCAI.
      c. c. HCAI also requires all information on the "Help paying your bill" page of the facility website to be compliant with the Web Content Accessibility Guidelines (WCAG). NIHD works with Accessibe to ensure website compliance and is working toward full website accessibility.

C. CDPH Central Applications Branch (CAB)
   i. NIHD has submitted updates for Interim CEO Christian Wallis through the online applications branch.
   ii. NIHD has submitted updates to the hospital license for the new pharmacy and infusion areas.

D. Subpoenas
   i. The Compliance Department also accepts and completes subpoena service for cases related to District business. This includes subpoenas for NIHD business records and appearances. The Health Information Management Department (HIM) processes subpoenas for medical records.

8. Compliance Committees

A. Compliance and Business Ethics Committee (CBEC**)**
   i. No meetings since 2023

B. Billing and Coding Compliance Committee (BCCC) reports to the CBEC committee.
   i. This group reviews billing and coding issues, chargemaster changes, and policies that affect billing, coding, and accounting. The Manager of the Business Office chairs this committee.

C. Business Compliance Team (BCT) reports to the CBEC Committee.
   i. This group reviews all workforce Conflict of Interest questionnaires that list potential conflicts to determine the appropriate and consistent method of addressing any conflicts. The Compliance Officer chairs this subcommittee, which meets ad hoc or via serial meetings using Smartsheet.

D. Forms Committee
   i. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. Standardized templates, designated fonts, official translations, mandatory non-discrimination and language access information create compliant and consistent documentation for the District.

ii. We have added Barbara Laughon to this committee to ensure her review and approval of all signage and postings other than those posters legally required by employment law.
iii. The Forms Committee is transitioning to serial meetings via Smartsheet to facilitate faster form approvals.

9. Issues and Prevention

A. Compliance researches issues proactively to support District leadership and workforce.
B. NIHD subscribes to regulatory updates software that notifies the District when new state and federal regulations are published to allow NIHD to update policies and procedures prior to the effective date.

10. CPRA (California Public Records Act) Requests

A. Compliance has received five (5) CPRA requests in CY 2025.
    i. Four have been completed and one is in progress.

11. Policy and Procedures

A. The Board must review and approve policies every two years, and the Executive Team or the Medical Executive Committee must review and approve procedures every two years.
B. Written policies and procedures are one of the seven essential elements of an effective Compliance Program, per the Health and Human Services Office of Inspector General. The compliance officer manages user set-up, policy administration, and other software optimization.
A. Policy and Procedure Audits:
    i. NIHD has approximately 1155 policies and procedures.
    ii. NIHD leadership teams consistently work on regulatory compliance through policy updates and reviews.
B. Leaders can also use reporting from the system to ensure NIHD team members are current with reviewing policies.
C. A software administrative group that tracks policy life cycles and the approval process consists of Ashley Reed, Sarah Rice, Dianne Picken, Cori Stearns, Patty Dickson, and Veronica Gonzalez.

12. Unusual Occurrence Reports (UOR)

A. UOR data for Calendar Year 2025. See Attachment 4
    i. Notable trends out of 182 UORs received through April 30, 2025:
        a. Complaints and requests to review billing and care are the most frequent UORs. These two areas represent 53 of the 182 UORs (29%).
            I. Trending issues:
                i. Billing complaints
                ii. Communication and customer service concerns
        b. NIHD had seven reports of workplace violence.
        c. Medication occurrences and errors are the third highest volume in UORs. However, NIHD's medication error rates are well below national averages for error rates. Medication Errors are administration errors that reach the patient. See Attachment 5.
B. The current review process for UORs.
    i. The Compliance Team currently receives all UORs in Complytrack.
        a. Many patient complaints and concerns calls are transferred to the Compliance Team for intake and assistance.
        b. The Compliance Team provides response letters for patient complaints. Per District policy and regulatory guidance from CMS, the average response time for complaint letters should be no more than 7 days.

ii. UORs are triaged and assigned to appropriate department leaders for review. Leaders are contacted via email and phone for urgent UORs.
iii. The Compliance team reviews replies, ensures thorough responses and corrective actions, provides follow-up letters to patients, and ensures the executive team is aware of all areas of concern.
iv. The Compliance Team ensures that UORs are closed after a thorough review, corrective actions, and, in most cases, resolution.

13. Regulatory Updates

A. YouCompli software monitors around 50 different state and federal agencies, including CMS, for changes in requirements. See Attachment 6
   i. There have been 185 updates or new regulations since December 1, 2024.

Language Acess Services

Interpreting	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total
Language Line - Phone minutes provided	215	439	310	262									
Language Line - Phone - cost	$204.25	$417.50	$294.50	$248.90									
Language Line - Video - minutes provided	3,552	2,750	2,923	3,885									
Language Line - Video - Cost	$5,329.20	$4,128.50	$4,386.77	$5,829.42									
Cyracom - Phone - minutes provided	2,575	2,523	2,935	2,067									
Cyracom - Phone - Cost	$1,887.75	$1,861.39	$2,100.13	$1,486.81									
Cyracom - Video - minutes provided	347	635	377	305									
Cyracom - Video - Cost	$270.66	$495.30	$311.02	$237.90									
Pocketalk HHIs - Interpretations provided	NA	NA	NA	1,327									
Pocketalk HHIs - Expenses			**$21,183.50**	HHI Rollout									
Total Minutes of interpretive services provided	**6689**	**6347**	**6545**	**7846**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27427**
Total Cost of interpretive services provided	**$7,691.86**	**$6,902.69**	**$7,092.42**	**$7,803.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$29,490.00**
Translation													
Language Line Translation Services - Cost													**$0.00**

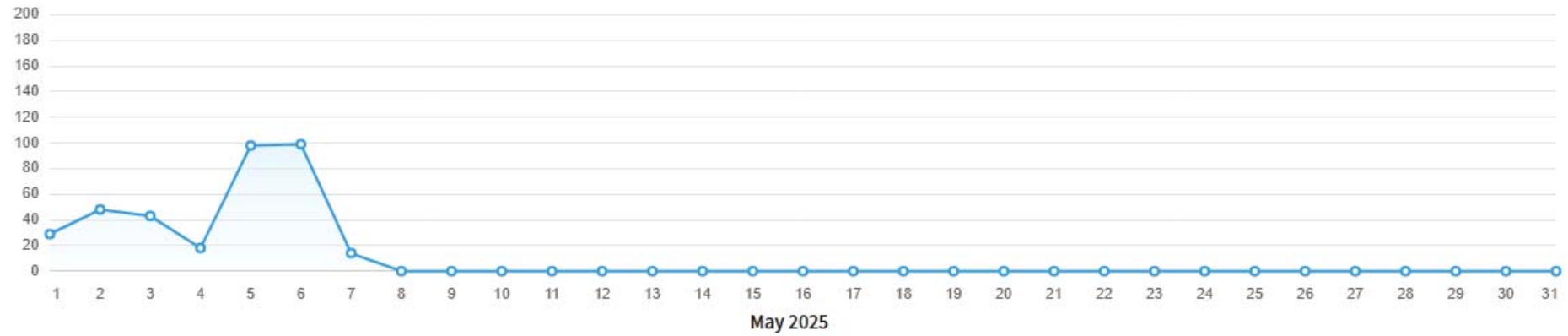
Language Acess Services

2024 for comparison

Interpreting	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	999	345	273	330	436	141	277	
Language Line - Phone - cost	$1,159.95	$1,380.35	$1,544.70	$1,619.75	$1,548.50	$949.05	$327.75	$259.35	$313.50	$414.20	$133.95	$263.15	
Language Line - Video - minutes provided	3,689	2,952	4,247	4,948	5,861	2,547	2,097	2,288	2,224	3,277	2,625	3,189	
Language Line - Video - Cost	$5,533.50	$4,426.00	$6,366.65	$7,422.00	$8,800.50	$3,820.50	$3,145.50	$3,432.00	$3,656.04	$4,915.20	$3,937.50	$4,783.50	
Cyracom - Phone - minutes provided	1,415	1,201	1,754	959	719	2,294	3,186	4,577	3,329	4,014	2,908	3,019	
Cyracom - Phone - Cost	$1,035.03	$855.15	$1,315.50	$616.65	$469.14	$1,720.50	$2,297.73	$3,183.48	$2,391.30	$2,841.21	$2,051.04	$2,161.85	
Cyracom - Video - minutes provided	154	142	232	77	243	1,692	1,689	1,844	775	823	689	314	
Cyracom - Video - Cost	$115.50	$106.50	$174.00	$57.75	$182.25	$1,269.00	$1,267.75	$1,389.50	$581.25	$617.25	$516.75	$298.45	
Total Minutes of interpretive services provided	**6479**	**5748**	**7859**	**7689**	**8453**	**7532**	**7317**	**8982**	**6658**	**8550**	**6363**	**6799**	**88429**
Total Cost of interpretive services provided	**$7,843.98**	**$6,768.00**	**$9,400.85**	**$9,716.15**	**$11,000.39**	**$7,759.05**	**$7,038.73**	**$8,264.33**	**$6,942.09**	**$8,787.86**	**$6,639.24**	**$7,506.95**	**$97,667.62**
Translation													
Language Line Translation Services - Cost	$1,000.85	$0.00	$107.55	$268.31	$1,265.07	$2,861.00	$99.00	$0.00	$1,105.86				**$6,707.64**

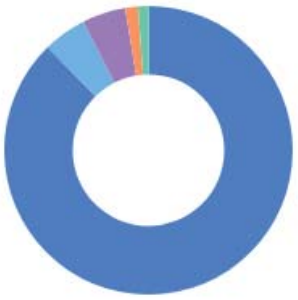
Handheld Interpreter Devices - HHI

Number of Translations



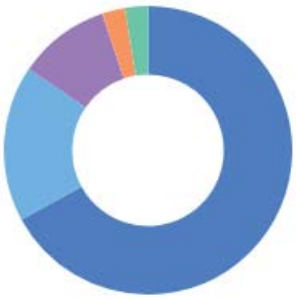
Languages Used for Translation From

English(US)	306
Spanish(Mexico)	17
Spanish(US)	17
English(Philippines)	5
Others	4



Languages Used for Translation To

Spanish(US)	234
Spanish(Mexico)	61
English(US)	36
Spanish(Spain)	9
Others	9



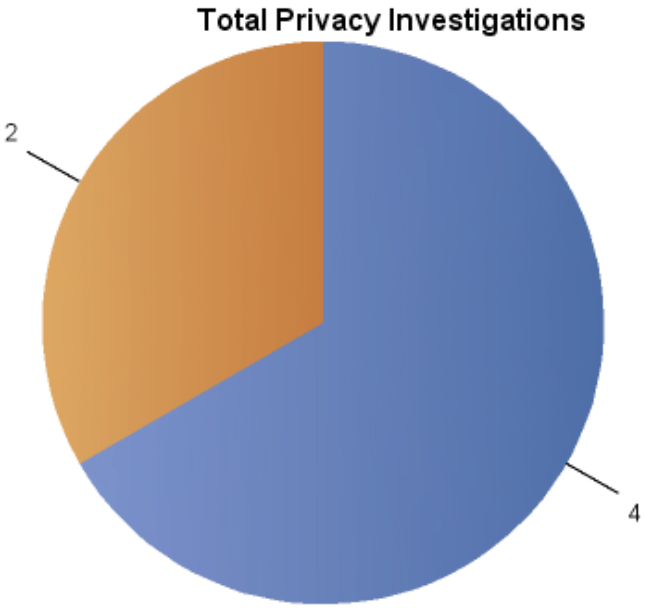
2025 Compliance Annual Workplan

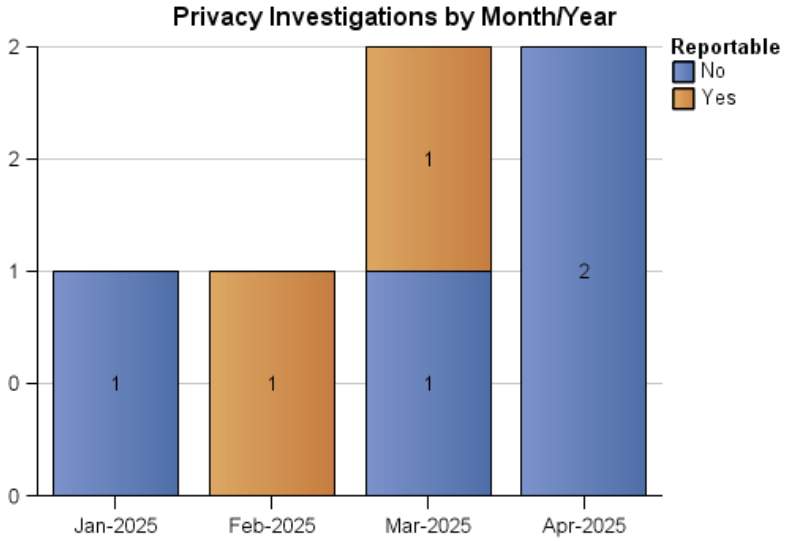
No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due CY2025 Q3
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Due CY2025 Q3
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Due CY2025 Q2
4.	District Policy and Procedure management		Ongoing
5.	Review, distribute, and assist leaders with new regulatory updates and guidance	Implemented YouCompli software December 2025	Ongoing
Written Compliance Guidance			
6.	Audit of required Compliance related policies.		Policies for Compliance are in the review process as of Jan 2025
7.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		Overdue – was due in CY2024 Q3
8.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Ongoing in conjunction with HR. Current to date.
Compliance Education and Training			
9.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.	Compliance and Business Ethics Committee has not met since 2023. Information reported to Executives and Board as needed.	Ongoing in conjunction with HR. Current to date.
10.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		External companies providing coding and claims processing services. New regulatory changes discussed at Billing and Coding Compliance Committee (BCCC

11.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		Updating all role-based access to EHR and systems determined by job description – ongoing May 2025 in conjunction with IT Asst Manager.
12.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.		Training completed at orientation, via policy/procedure review, Learning Management System, email, in-person, departmental meetings, and "Just-in-time training"
Compliance Communication			
13.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Annual and quarterly reports submitted to appropriate committees, Executives, and Board of Directors.
14.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Submitted to Executives and Board of Directors in quarterly and Annual Board reports	Current through April 2025
15.	Document test and review of Compliance Hotline.		Completed January 2025
16.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Completed January 2025
Compliance Enforcement and Sanction Screening			
17.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (OIG) List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new referring providers. Medical Staff Office (MSO) verifies all medical staff. Accounting and Compliance verifies all vendors.	Due CY2025 Q2 Annual re-validation for vendor exclusions completed for 2024.
18.	Develop an audit and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Due 2025

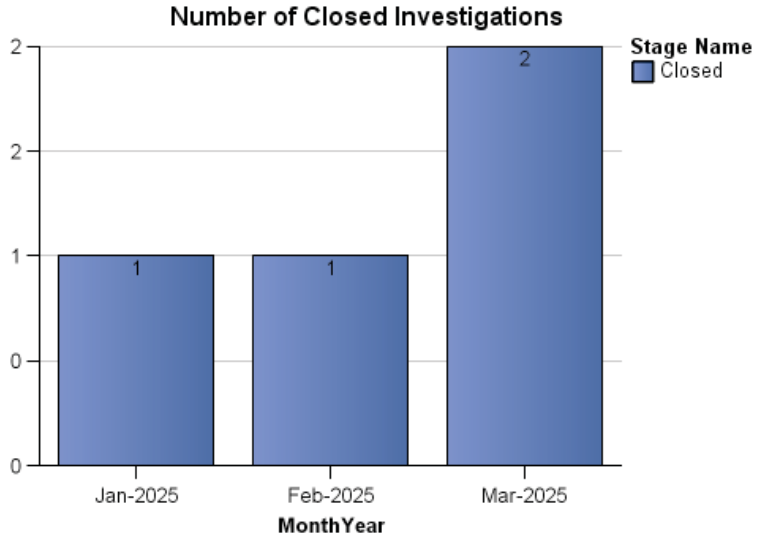
19.	Audits (Fraud, Waste, and Abuse)		
	a. Arrangements with physician (database)	Physician Contracts are now in a review cycle. All templates created/reviewed in conjunction with legal counsel (BBK).	Due CY2025 Q2
	b. Financial Audits	FY 2025	FY 2025 External Audit presented to Board in April 2025.
	c. Payment patterns		Due Q2 2025 – review with coding company
	d. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office. Presented to Board and Compliance monthly.
	e. Non-Physician vendor contract/payment audit		Due CY2025 Q3
	f. DME (Durable Medical Equipment)	HHS OIG target	Chargemaster audit due 2025 Q2
	g. Lab services	MAC target	Deferred
	h. Imaging services (high cost/high usage)	MAC target	Deferred
	i. Rehab services	HHS OIG workplan	Deferred
	j. Language Access Audits	OIG target	Due Q3 2024 – in progress
	k. Cash Box Audits		Random ongoing audits
	l. Imaging Report Compliance Audit	Corrective action plan received.	Follow up Audit – May 2025
	m. Compliance/Accounting – Vendor Conflict of Interest Verification Audit		Due CY2025 Q3
20.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Security risk assessment completed November 2024 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due Oct/Nov 2025
	b. Periodic update to Security Risk Assessment		As needed
	c. Monthly employee access audits		Daily, ongoing
	d. HIPAA Walkthrough Audits	Implementing ComplyAssistant Software	In progress April 2025
	e. BAA Vendor Assessments	Implementing ComplyAssistant Software	In progress April 2025

	f. HIPAA Privacy and Security Audit Compliance and Documentation	Implementing ComplyAssistant Software	In progress April 2025
21.	Audit required signage		Due 2025
22.	Audit HIMS (Health Information Management) scanned document accuracy		Due 2025
23.	Develop metrics to assess the effectiveness and progress of the Compliance Program	See new guidance from DOJ Evaluation of Corporate Compliance Program (ECCP published 2024)	Due 2025
24.	Review CMS Conditions of Participation		Ongoing
25.	CMS Hospital Price Transparency Audit	MRF, SSPE, PE	Conducted by Business Office
26.	EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 4/30/2025
Response to Detected Problems and Corrective Action			
27.	Verify that all identified issues related to potential fraud, waste, and abuse are promptly investigated and documented		Current through April 2025
28.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Monitored by Revenue Cycle Team and Accounting. Reporting to Compliance as needed.
29.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Annual Board Report for 2024 attached.
	a. Provide trend feedback to leadership to allow for data-driven decision-making		Quarterly
	I. Overall UOR process		April 2025
	II. Workplace Violence		April 2025
	III. Falls		April 2025
30.	Patient complaints		Documented and tracked in Unusual Occurrence Reporting system
31.	Breach Investigations	HIPAA, HITECH, CMIA	Ongoing. All state and federal reporting requirements have been met through April 30, 2025.



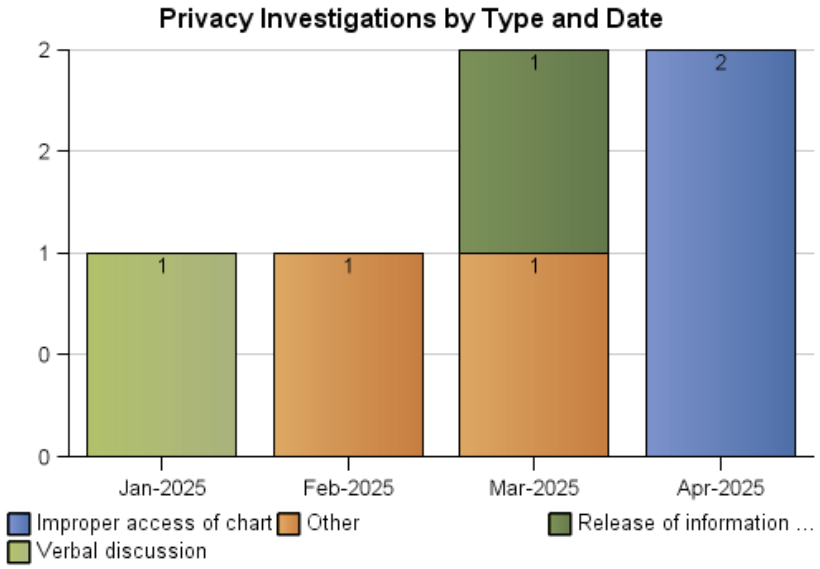


	No	Yes	Total
Jan-2025	1		1
Feb-2025		1	1
Mar-2025	1	1	2
Apr-2025	2		2
Total	4	2	6

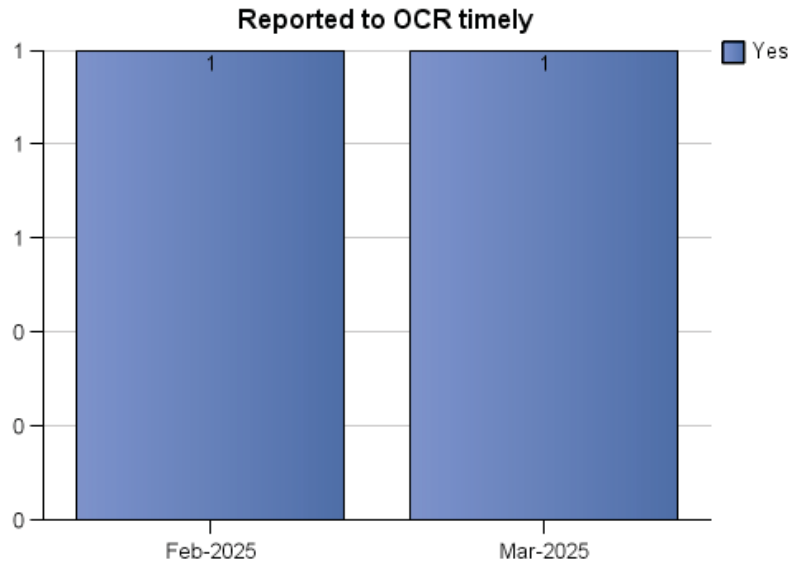


	Closed	Total
Mar-2025	2	2
Jan-2025	1	1
Feb-2025	1	1
Total	4	4
Total	4	4

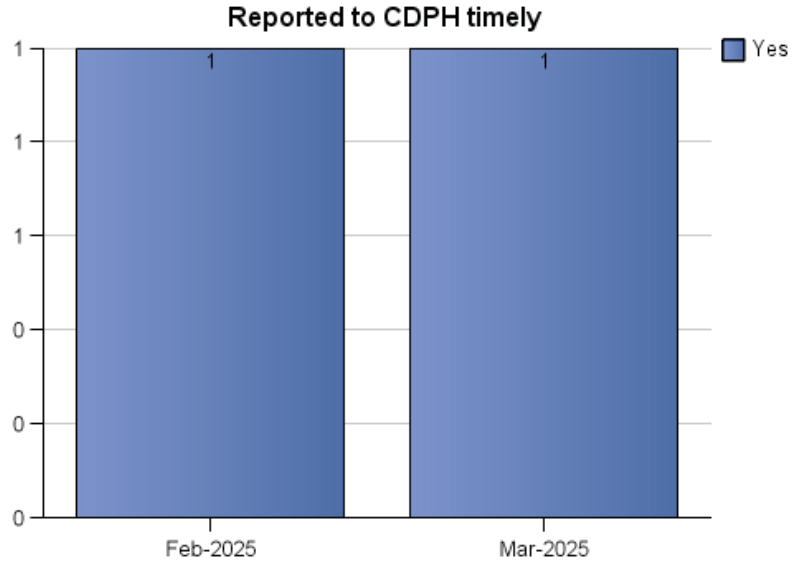
Attachment 3



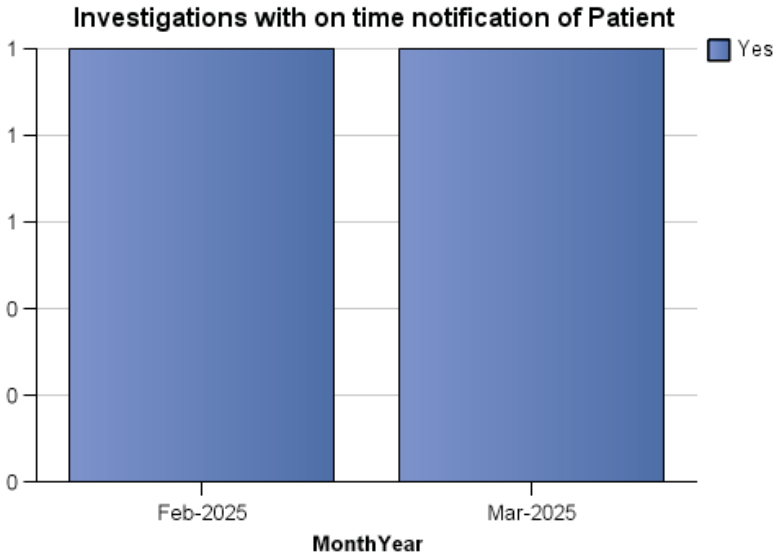
	Jan-2025	Feb-2025	Mar-2025	Apr-2025	Total
Improper access of chart				2	**2**
Other		1	1		**2**
Release of information concern			1		**1**
Verbal discussion	1				**1**
Total	**1**	**1**	**2**	**2**	**6**



	Yes	Total
Feb-2025	1	1
Mar-2025	1	1
Total	**2**	**2**

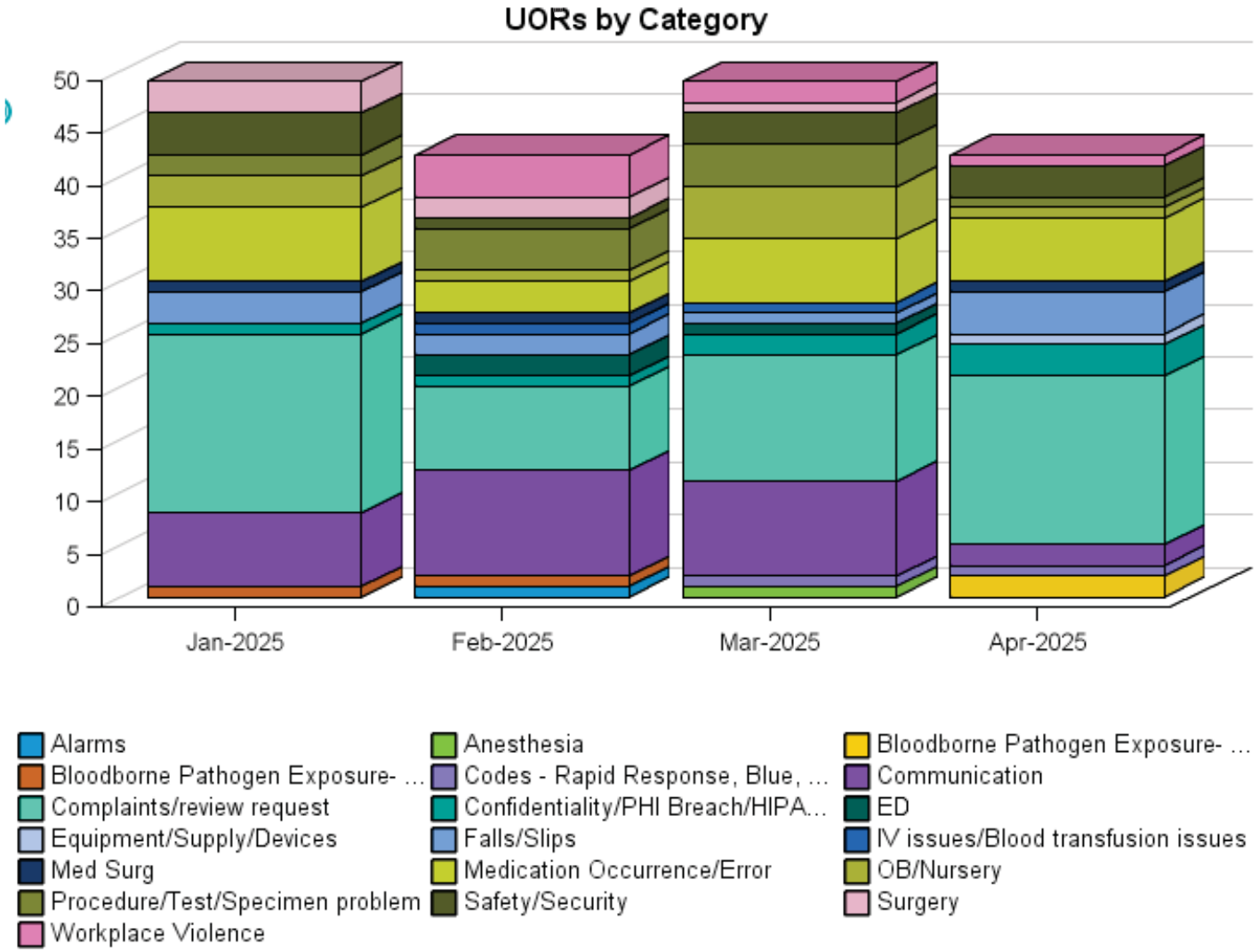


	Yes	Total
Feb-2025	1	1
Mar-2025	1	1
Total	**2**	**2**



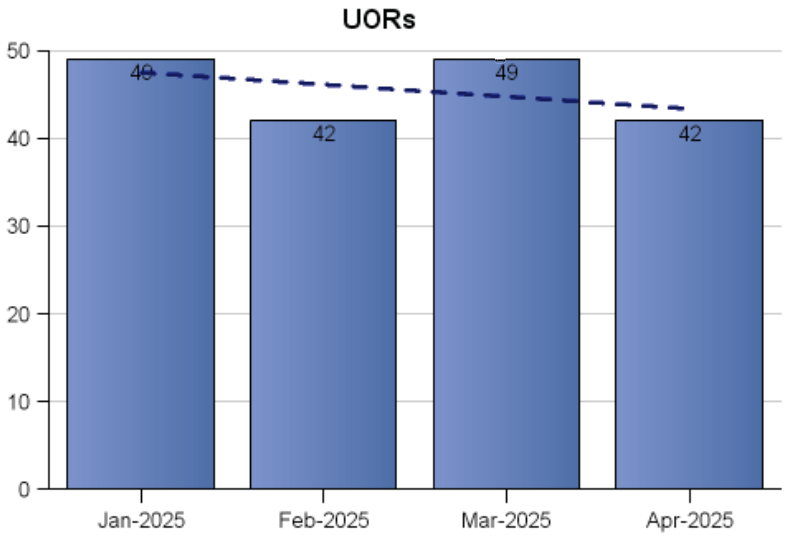
	Yes	Total
Feb-2025	1	1
Mar-2025	1	1
Total	**2**	**2**

Jan - May 2025
Unusual Occurrence Report (UOR) Data

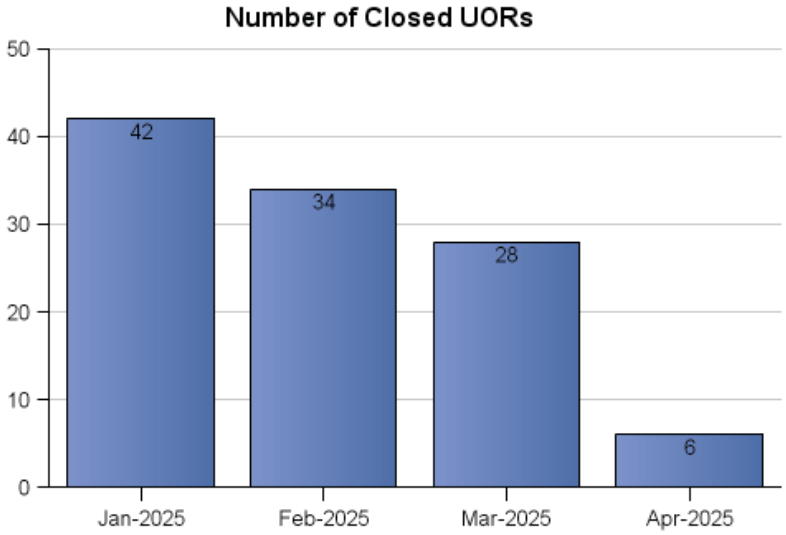

UORs by Category
50
45
40
35
30
25
20
15
10
5
0
Jan-2025
Feb-2025
Mar-2025
Apr-2025
Alarms
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Surgery
Workplace Violence

Data for previous slide

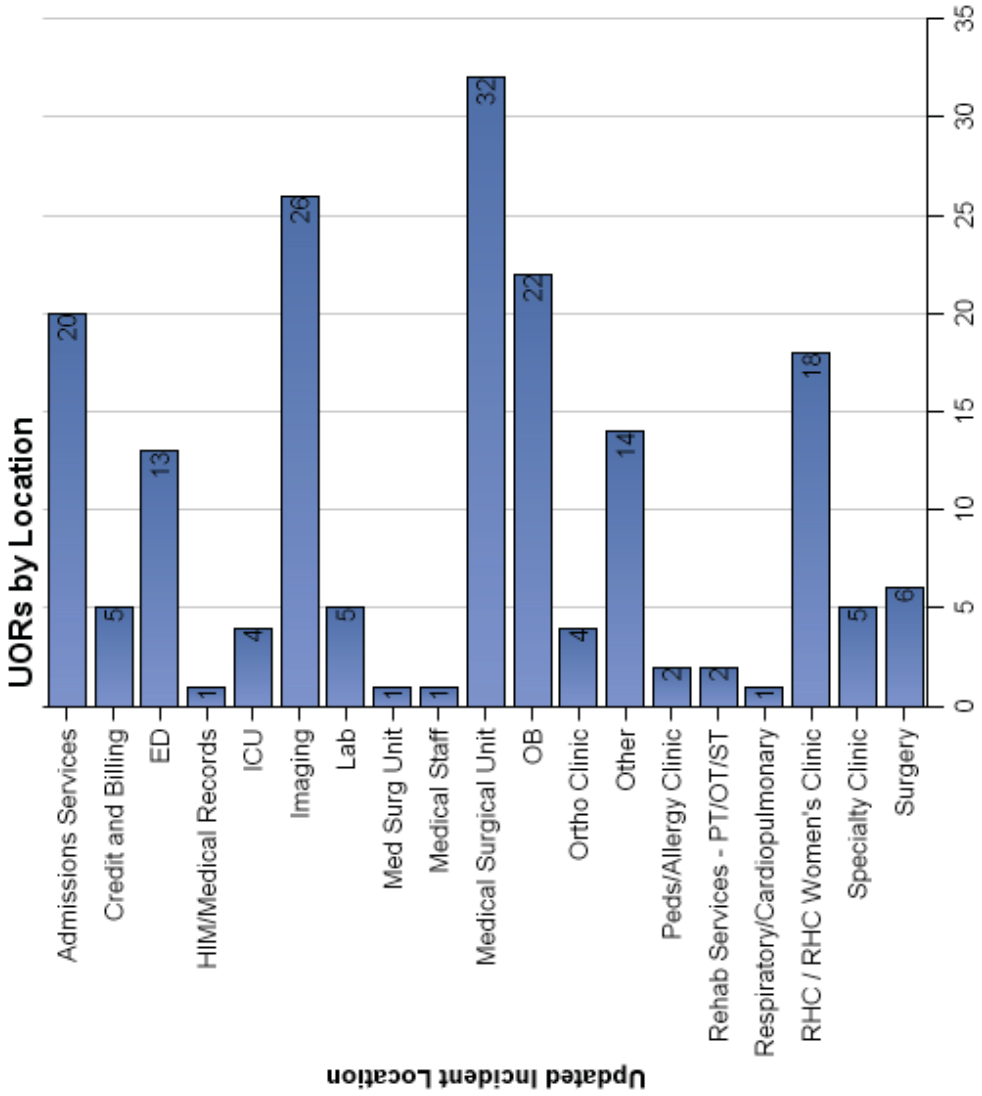
	Jan-2025	Feb-2025	Mar-2025	Apr-2025	Total
Alarms		1			**1**
Anesthesia			1		**1**
Bloodborne Pathogen Exposure- Sharps Injury				2	**2**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane	1	1			**2**
Codes - Rapid Response, Blue, Deescalation			1	1	**2**
Communication	7	10	9	2	**28**
Complaints/review request	17	8	12	16	**53**
Confidentiality/PHI Breach/HIPAA violation	1	1	2	3	**7**
ED		2	1		**3**
Equipment/Supply/Devices				1	**1**
Falls/Slips	3	2	1	4	**10**
IV issues/Blood transfusion issues		1	1		**2**
Med Surg	1	1		1	**3**
Medication Occurrence/Error	7	3	6	6	**22**
OB/Nursery	3	1	5	1	**10**
Procedure/Test/Specimen problem	2	4	4	1	**11**
Safety/Security	4	1	3	3	**11**
Surgery	3	2	1		**6**
Workplace Violence		4	2	1	**7**
Total	**49**	**42**	**49**	**42**	**182**



Jan-2025	49
Feb-2025	42
Mar-2025	49
Apr-2025	42
Total	**182**

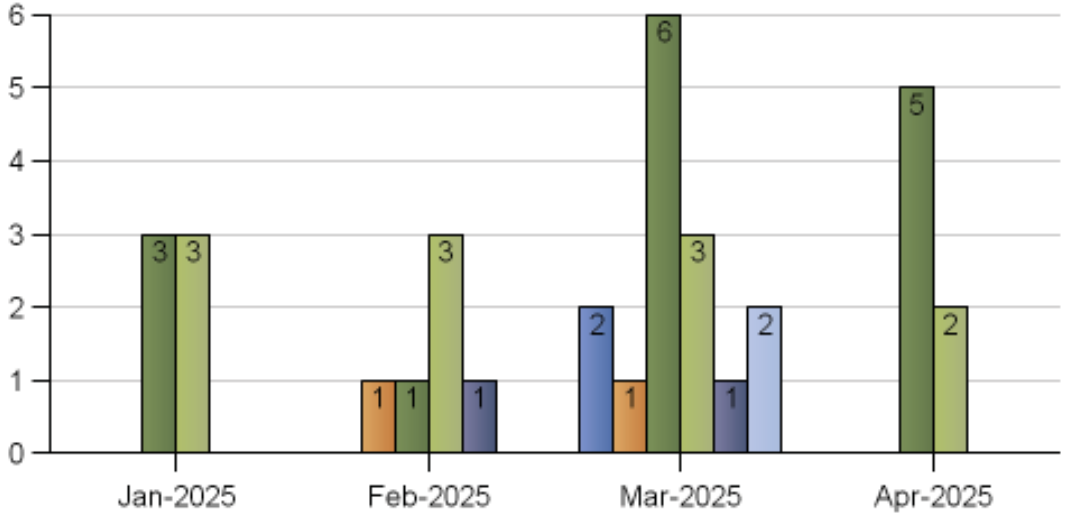


	Closed
Jan-2025	42
Feb-2025	34
Mar-2025	28
Apr-2025	6
Total	**110**

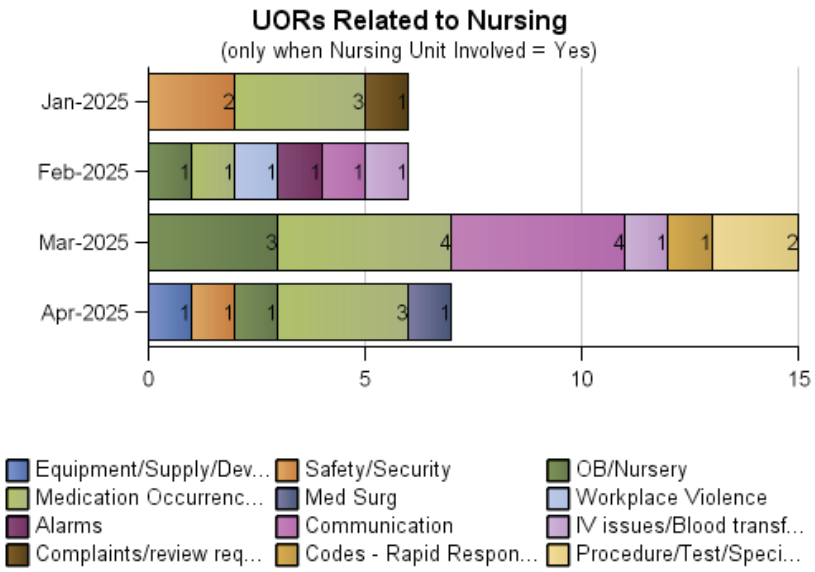

UORs by Location
Updated Incident Location
Admissions Services
Credit and Billing
ED
HIM/Medical Records
ICU
Imaging
Lab
Med Surg Unit
Medical Staff
Medical Surgical Unit
OB
Ortho Clinic
Other
Peds/Allergy Clinic
Rehab Services - PT/OT/ST
Respiratory/Cardiopulmonary
RHC / RHC Women's Clinic
Specialty Clinic
Surgery
20
5
13
1
4
26
5
1
1
32
22
4
14
2
2
1
18
5
6
0
5
10
15
20
25
30
35

UORs Related to Nursing by Nursing Unit Involved

(only when Nursing Unit Involved = Yes)

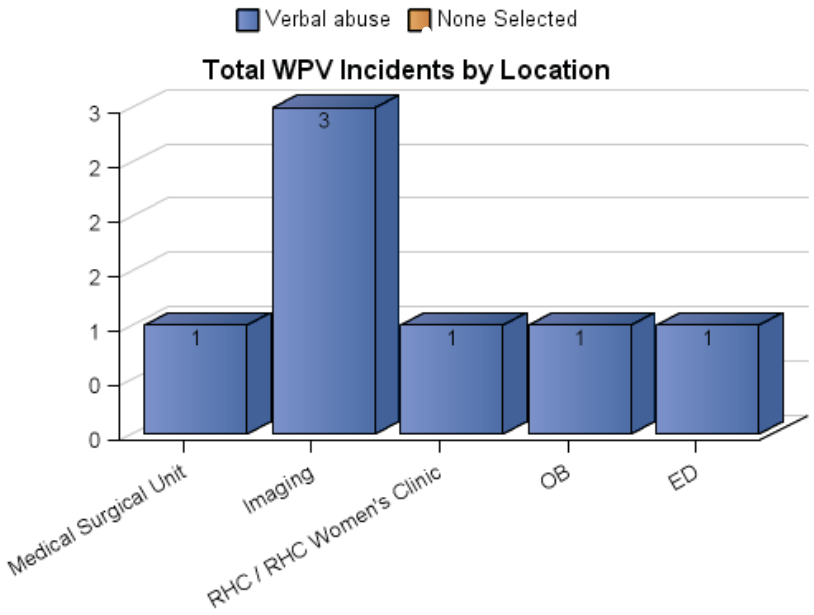


	Yes
Emergency	2
ICU	2
Medical/Surgical	15
OB	11
OR	2
RHC	2
Total	**34**



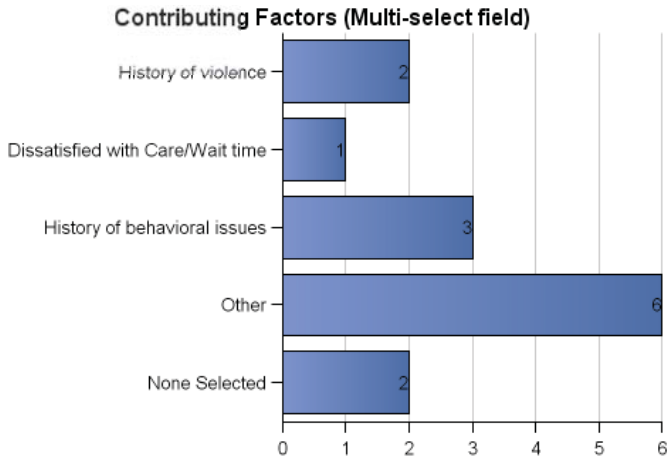
	Jan-2025	Feb-2025	Mar-2025	Apr-2025	Total
Equipment/Supply/Devices				1	**1**
Safety/Security	2			1	**3**
OB/Nursery		1	3	1	**5**
Medication Occurrence/Error	3	1	4	3	**11**
Med Surg				1	**1**
Workplace Violence		1			**1**
Alarms		1			**1**
Communication		1	4		**5**
IV issues/Blood transfusion issues		1	1		**2**
Complaints/review request	1				**1**
Codes - Rapid Response, Blue, Deescalation			1		**1**
Procedure/Test/Specimen problem			2		**2**
Total	**6**	**6**	**15**	**7**	**34**

WORKPLACE VIOLENCE



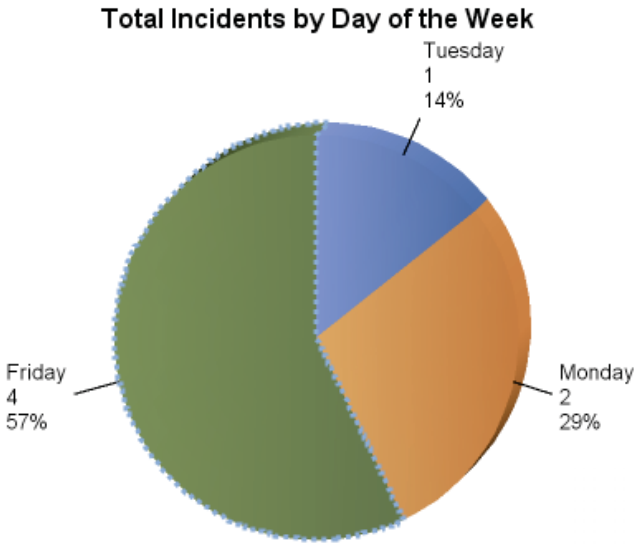
Medical Surgical Unit	1
Imaging	3
RHC / RHC Women's Clinic	1
OB	1
ED	1
Total	**7**

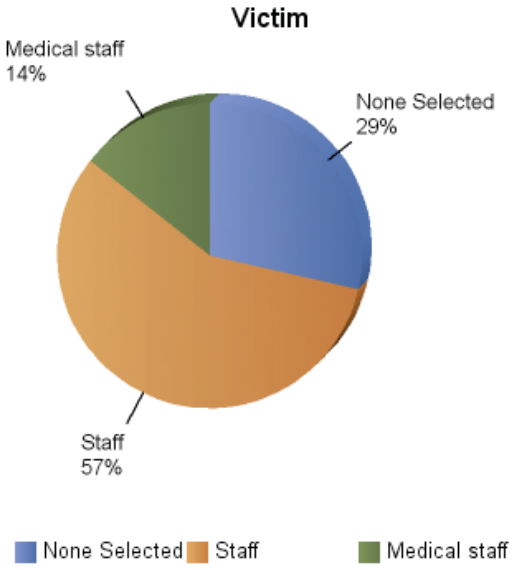
	Feb-2025	Mar-2025	Apr-2025	Total
Workplace Violence	4	2	1	7
Total	**4**	**2**	**1**	**7**

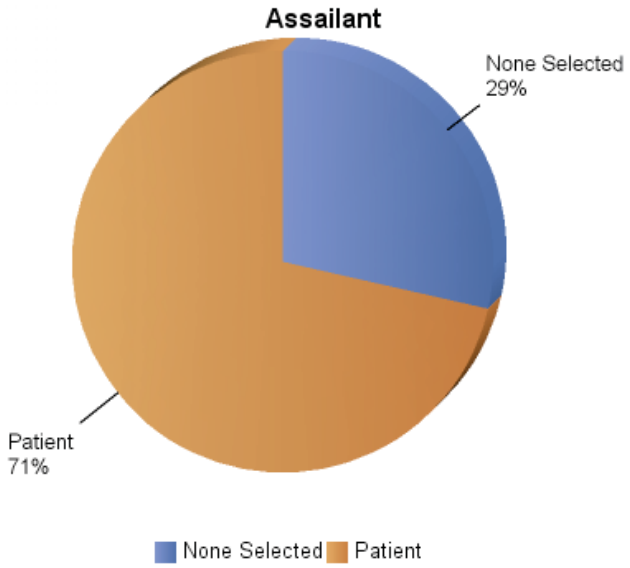


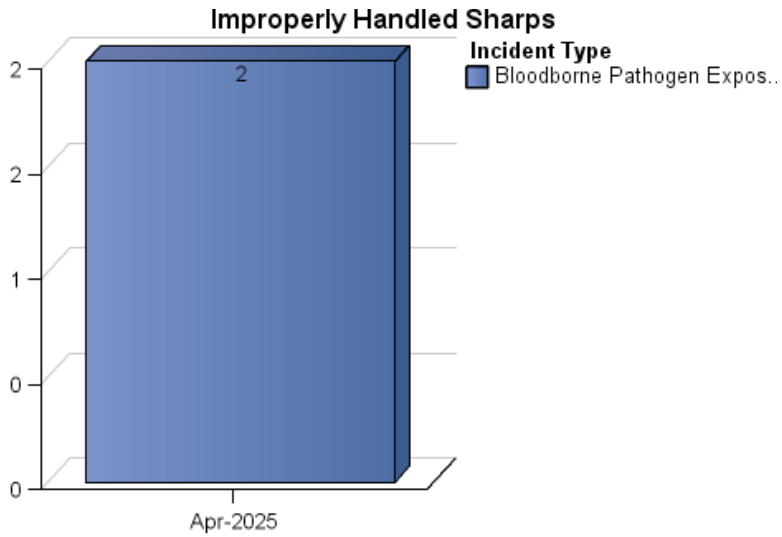
None Selected	2
Dissatisfied with Care/Wait time	1
History of behavioral issues	3
History of violence	2
Other	4
Total	**12**

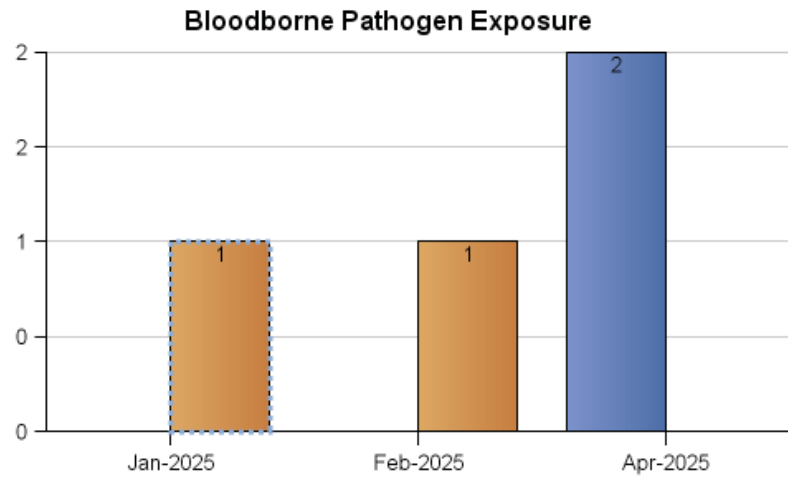
WORKPLACE VIOLENCE





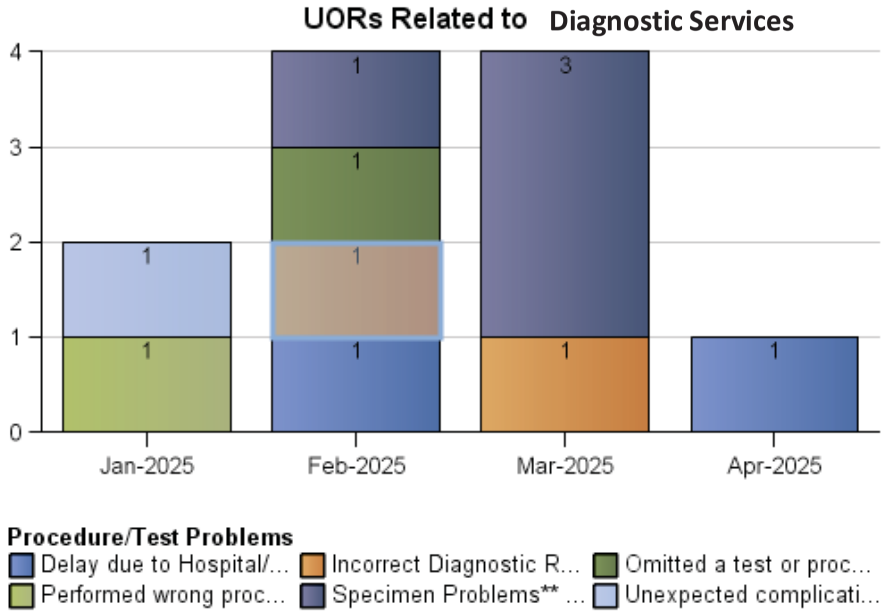






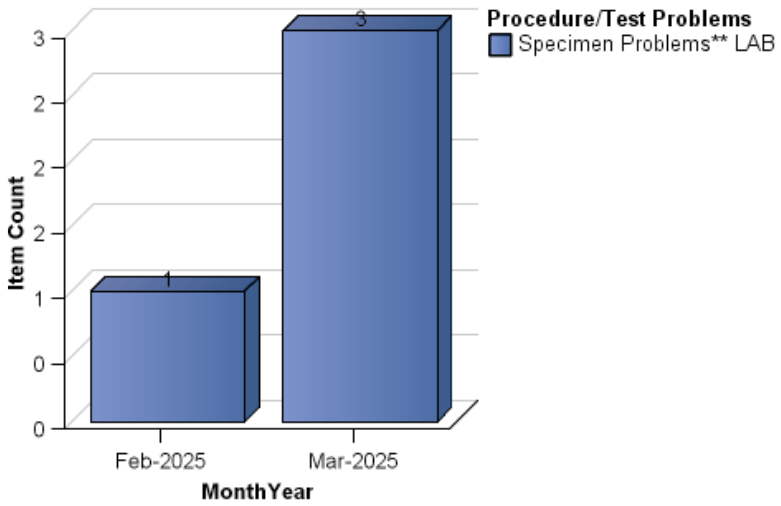
	Apr-2025	Total
Bloodborne Pathogen Exposure- Sharps Injury	2	**2**
Total	**2**	**2**

	Jan-2025	Feb-2025	Apr-2025	Total
Bloodborne Pathogen Exposure- Sharps Injury			2	**2**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane	1	1		**2**
Total	**1**	**1**	**2**	**4**

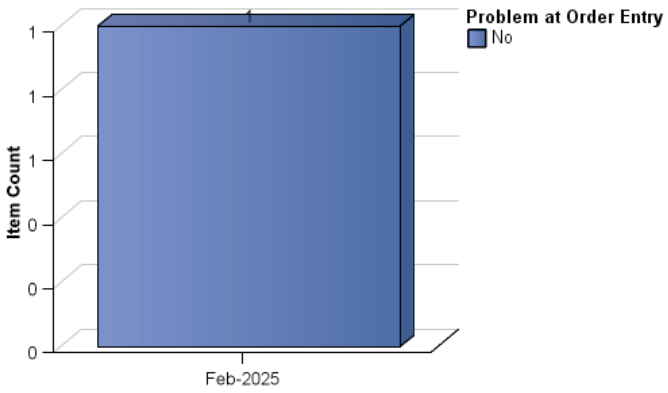


	Jan-2025	Feb-2025	Mar-2025	Apr-2025	Total
Delay due to Hospital/Radiology systems problems or communication issues		1		1	**2**
Incorrect Diagnostic Reading		1	1		**2**
Omitted a test or procedure		1			**1**
Performed wrong procedure	1				**1**
Specimen Problems** LAB ALWAYS SELECT THIS ONE***		1	3		**4**
Unexpected complications	1				**1**
Total	**2**	**4**	**4**	**1**	**11**

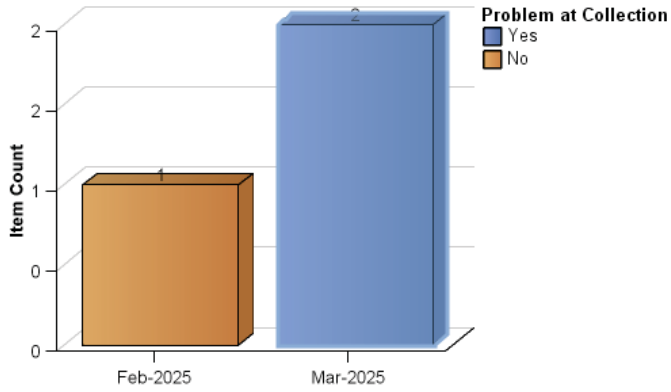
Number of Specimen Problems



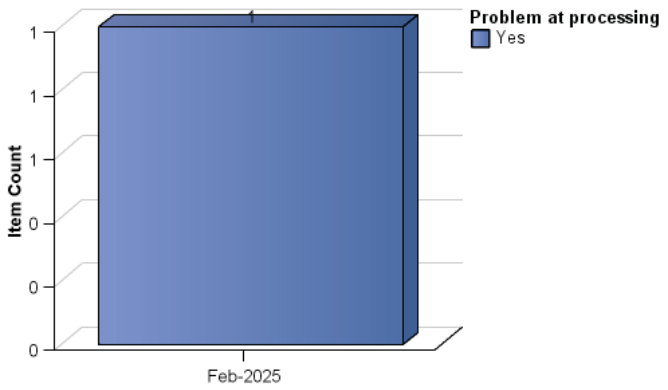
Problem at Order Entry

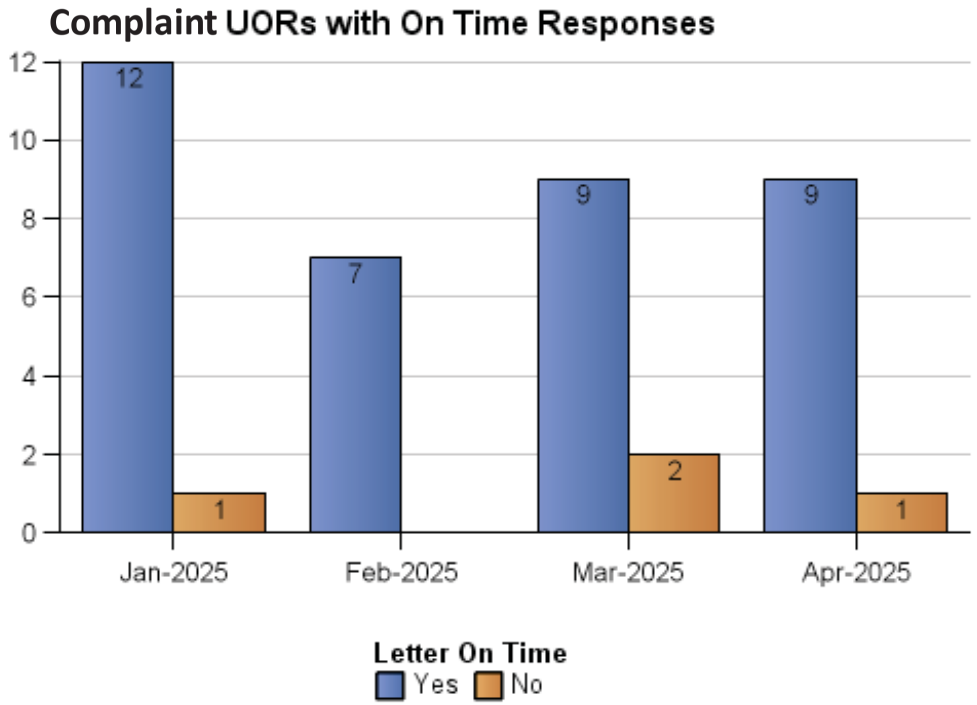


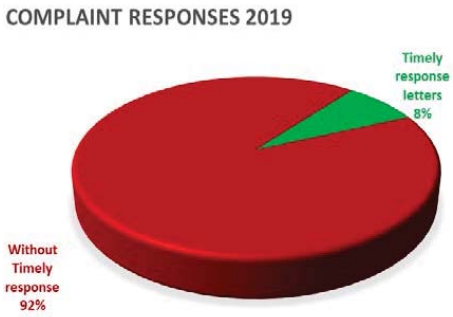
Problem at Collection

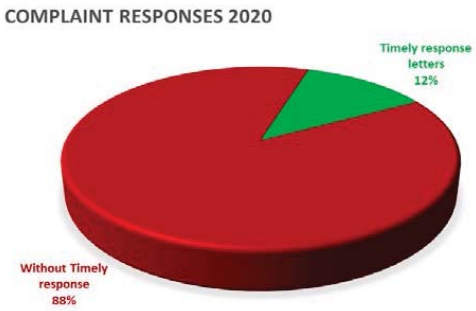


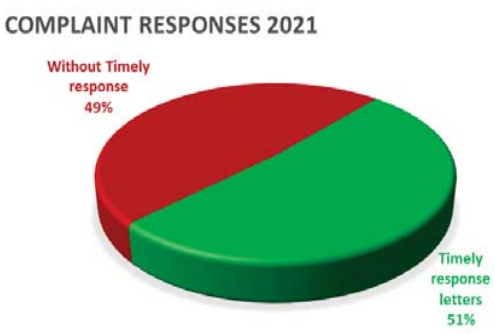
Problem at Processing

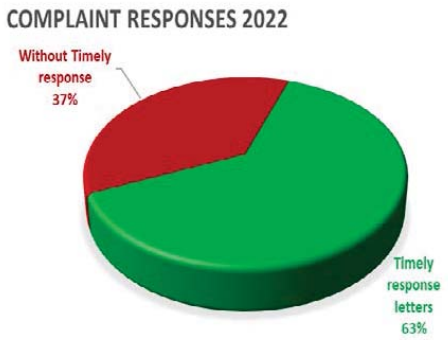


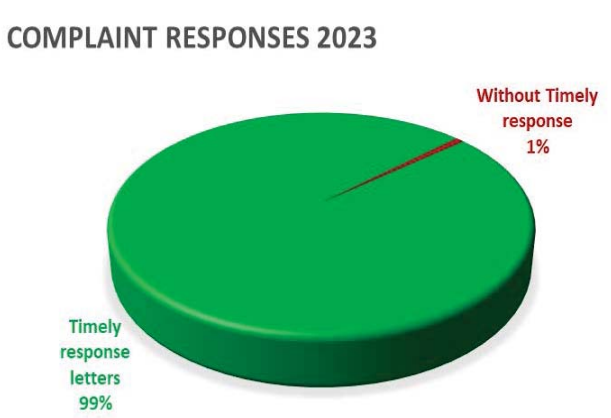

Complaint UORs with On Time Responses
12
10
8
6
4
2
0
12
1
7
9
2
9
1
Jan-2025
Feb-2025
Mar-2025
Apr-2025
Letter On Time
Yes
No

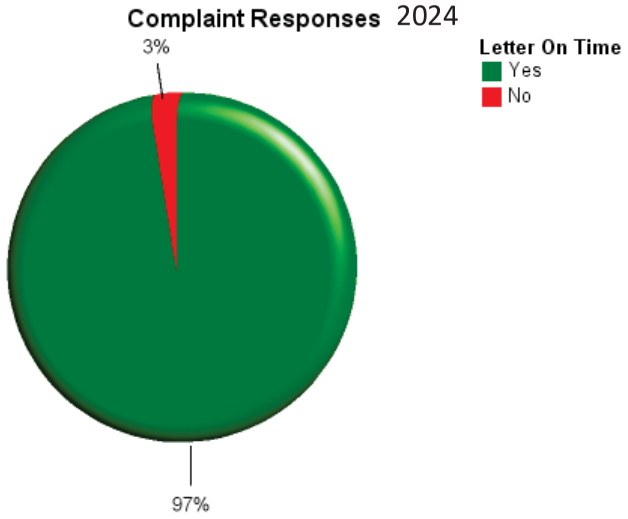


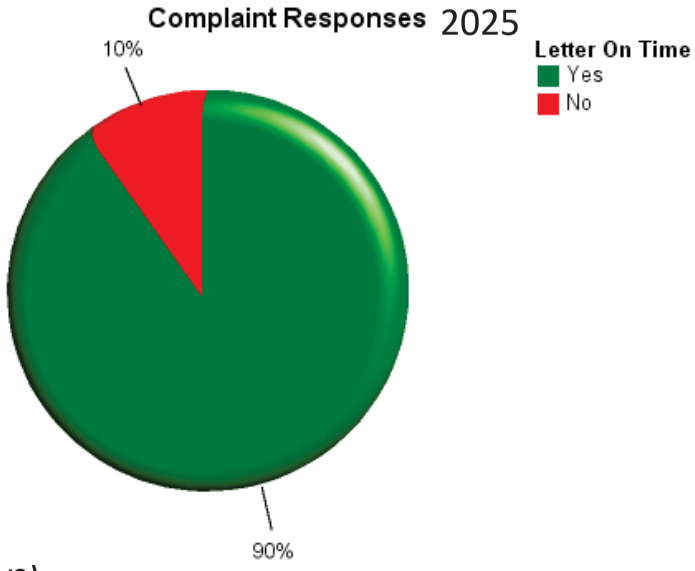






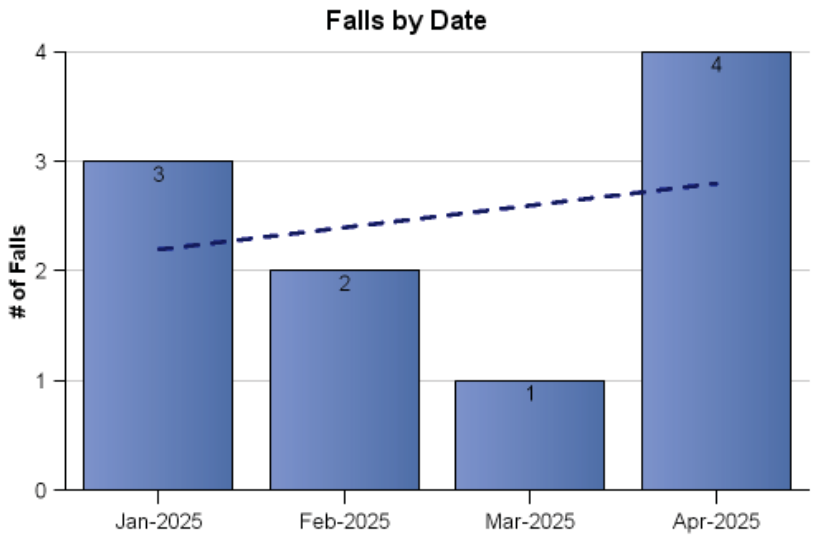






Goal is 100% Green (response letter within 7 days)

On average, a time frame of seven (7) business days for the provision of the response is the NIHD standard. (Requirement from NIHD POLICY)



# of Falls	Falls/Slip Problem(s)				Total
	Ambulating	Bathroom	Other	Other Person	
Not Identified	2		3	1	6
Oriented	1	2	1		4
Total	**3**	**2**	**4**	**1**	**10**

# of Falls	Was there any injury?				
	Not Identified	Yes	Unknown	No	Total
Not Identified	2				2
Inpatient		1	1	2	4
Outpatient	4				4
Total	**6**	**1**	**1**	**2**	**10**

# of Falls	Falls/Slips	Total
Imaging	3	3
Medical Surgical Unit	4	4
Other	1	1
Rehab Services - PT/OT/ST	1	1
RHC / RHC Women's Clinic	1	1
Total	**10**	**10**

# of Falls	Was the Patient Assessed for Fall Risk		
	Not assessed	Yes	Total
Workforce	2		2
Outpatient	4		4
Inpatient		4	4
Total	**6**	**4**	**10**

# of Falls	Was the Patient Assessed for Falls Protocol		
	Not assessed	Yes	Total
Workforce	2		2
Outpatient	4		4
Inpatient		4	4
Total	**6**	**4**	**10**

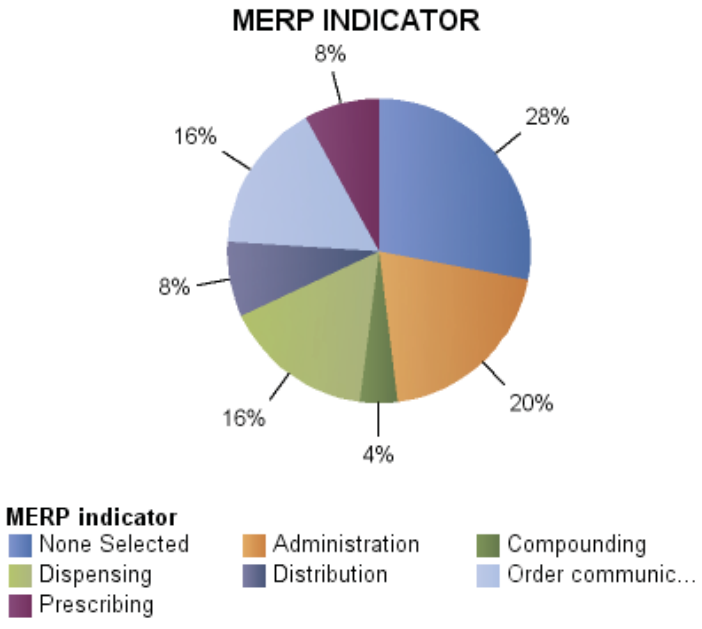
# of Falls	Received a Sedative w/in the Last 4 Hours		
	Not assessed	No	Total
Workforce	2		2
Outpatient	4		4
Inpatient		4	4
Total	**6**	**4**	**10**

# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	2		2
Inpatient		4	4
Outpatient	4		4
Total	**6**	**4**	**10**

# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	2			2
Outpatient	4			4
Inpatient		1	3	4
Total	**6**	**1**	**3**	**10**

# of Falls	Siderails		
	Not assessed	Siderails up	Total
Workforce	2		2
Outpatient	4		4
Inpatient		4	4
Total	**6**	**4**	**10**

Medication Error Reduction Plan (MERP)

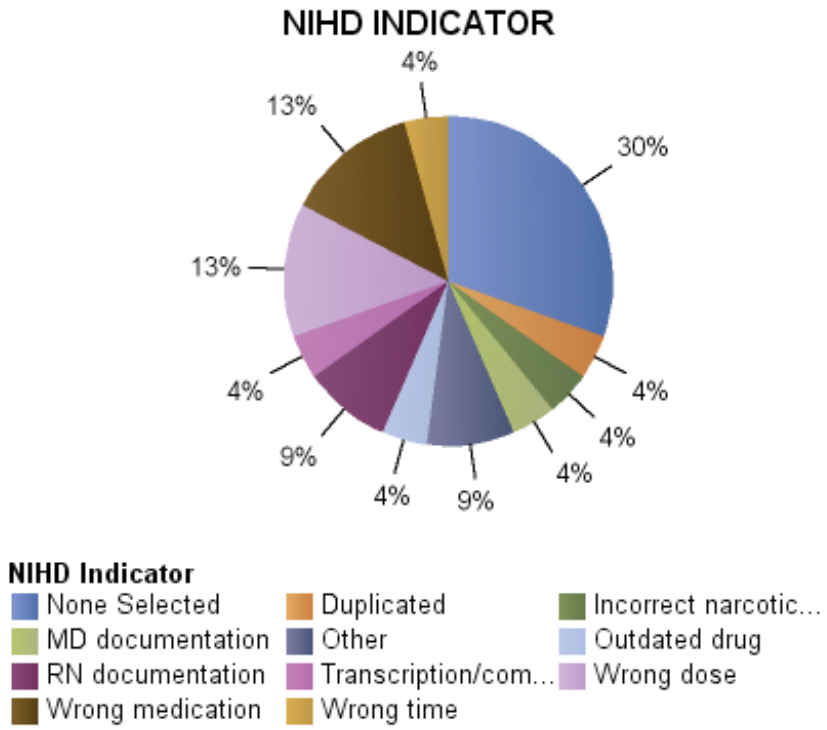


None Selected	7
Administration	5
Compounding	1
Dispensing	4
Distribution	2
Order communication	4
Prescribing	2
Total	**25**

	# of Errors	# of Occurrences	Total
Jan-2025	3	4	7
Feb-2025	2	1	3
Mar-2025	5	1	6
Apr-2025	5	1	6
Total	**15**	**7**	**22**

All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

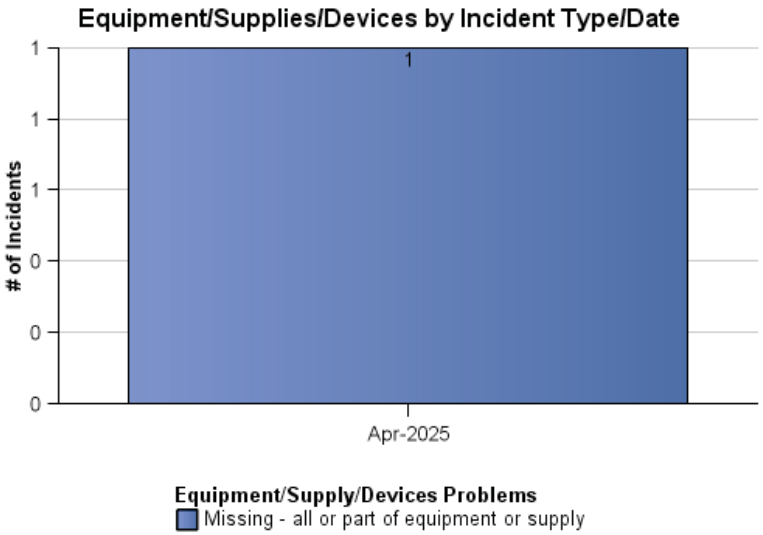
Medication errors are errors that reach the patient. Medication occurrences are errors that are caught before they reach the patient.

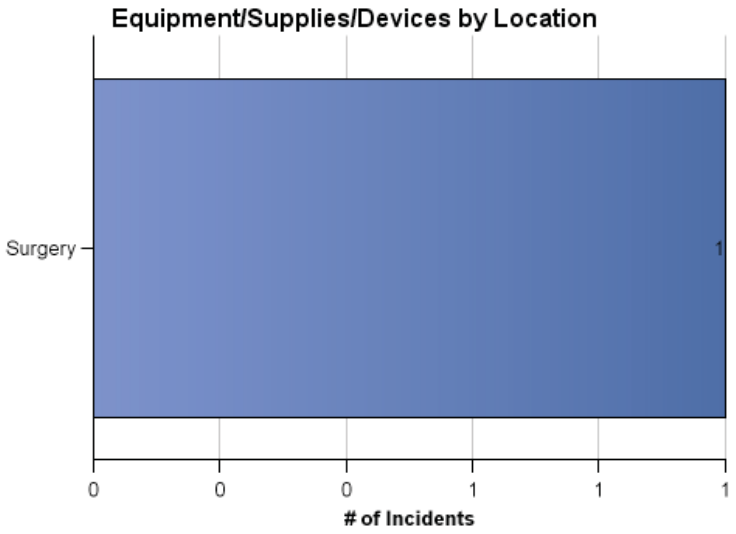


None Selected	7
Duplicated	1
Incorrect narcotic count	1
MD documentation	1
Other	2
Outdated drug	1
RN documentation	2

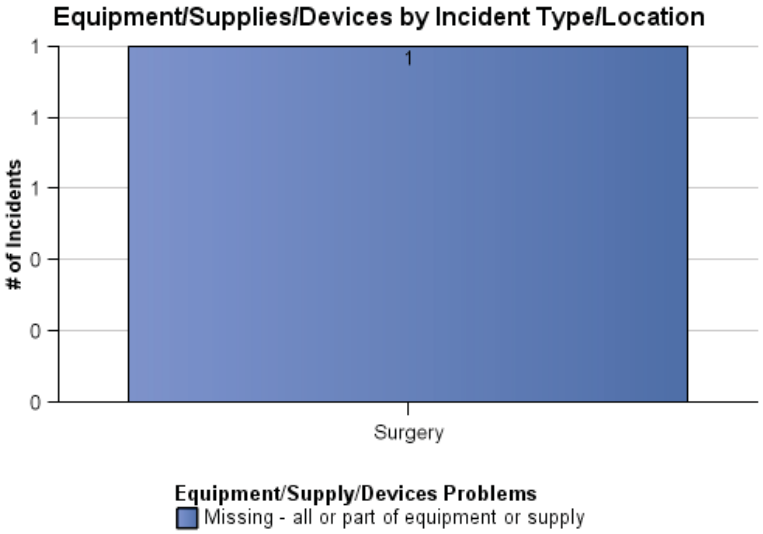
Transcription/computer entry errror	1
Wrong dose	3
Wrong medication	3
Wrong time	1
Total	**23**

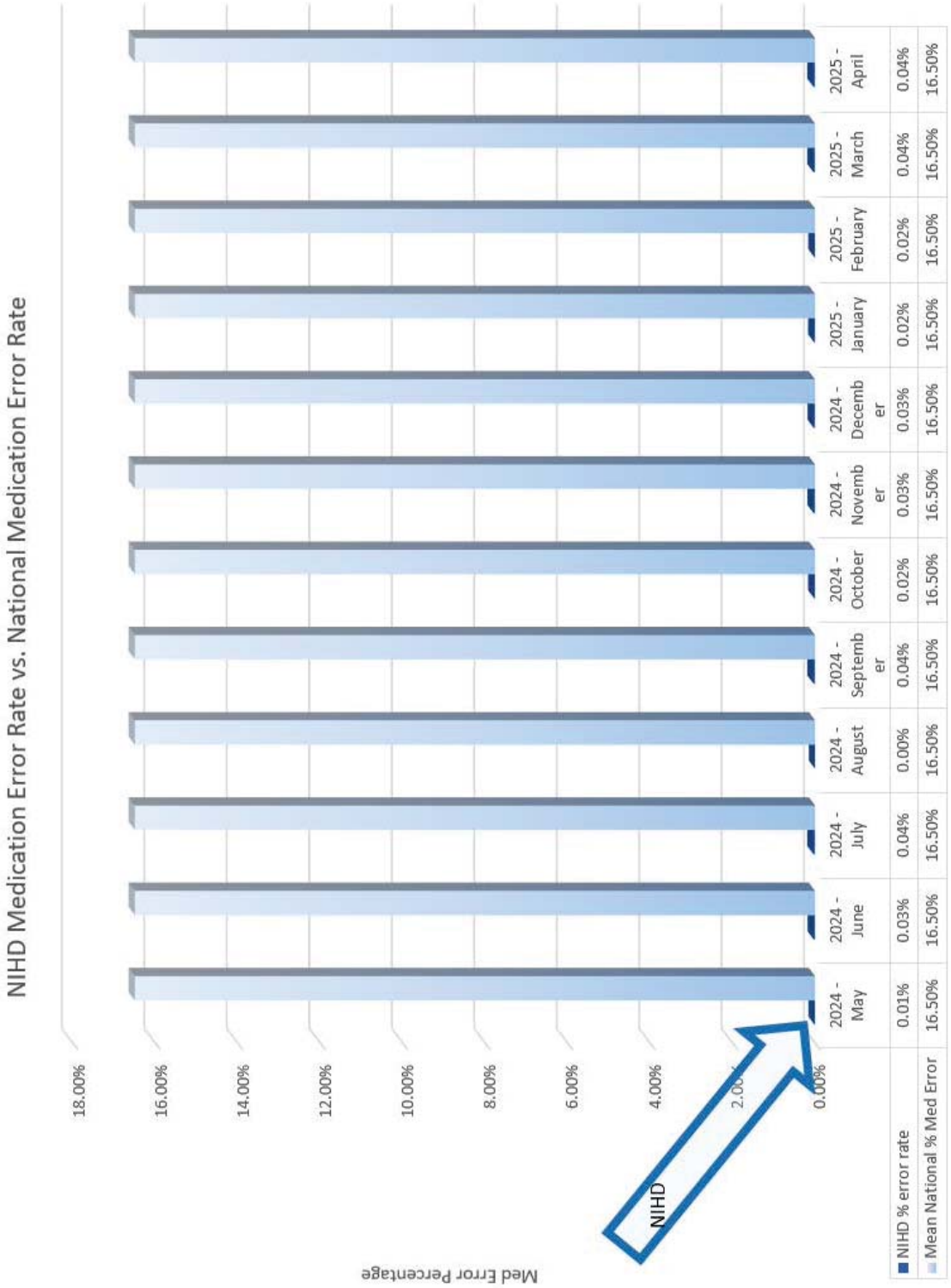
Total numbers of errors and occurrences are not equal to the indicators since some error/occurrences have more than one indicator.





No Data Available



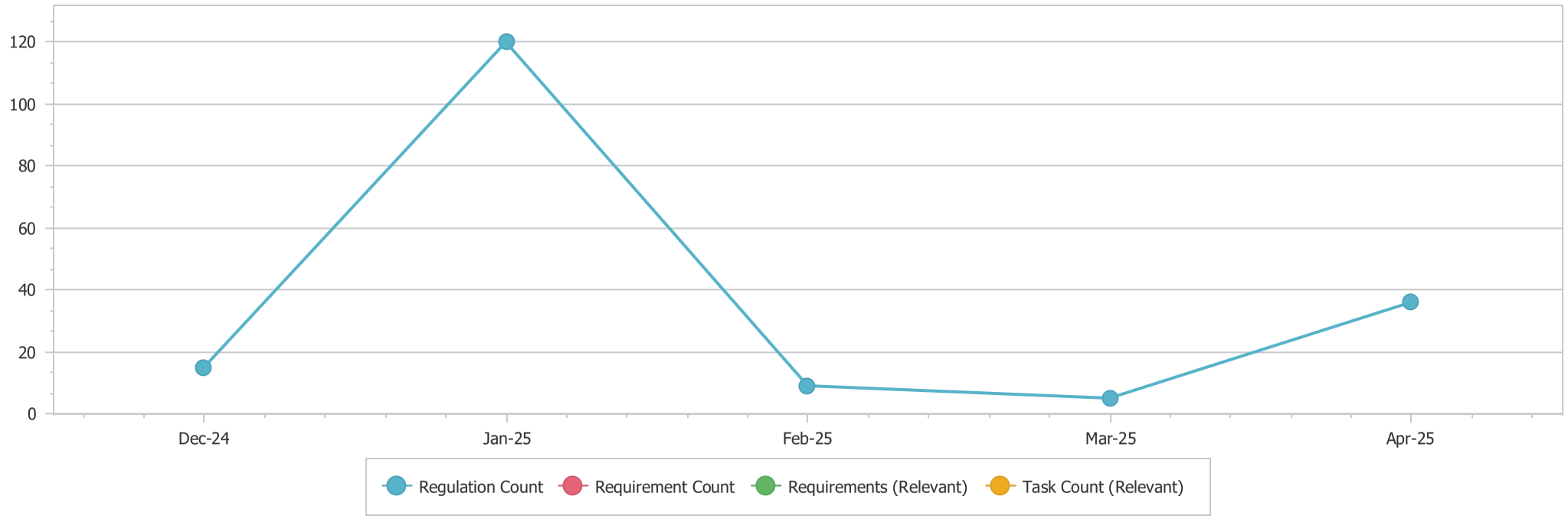

NIHD Medication Error Rate vs. National Medication Error Rate
Med Error Percentage
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
0.00%
NIHD
NIHD % error rate
Mean National % Med Error
2024 - May
2024 - June
2024 - July
2024 - August
2024 - September
2024 - October
2024 - November
2024 - December
2025 - January
2025 - February
2025 - March
2025 - April
0.01%
0.03%
0.04%
0.00%
0.04%
0.02%
0.03%
0.03%
0.02%
0.02%
0.04%
0.04%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%
16.50%

Data for previous slide

Month/Year	Total number of Medications administered	NIHD Total number of errors	NIHD % error rate	National % Medication Error	Mean National % Med Error	NIHD % Medication Administration accuracy	References
2024 - May	15,273	2	0.01%	8%-25%	16.50%	99.99%	
2024 - June	12,566	4	0.03%	8%-25%	16.50%	99.97%	
2024 - July	16,173	6	0.04%	8%-25%	16.50%	99.96%	
2024 - August	15,416	0	0.00%	8%-25%	16.50%	100.00%	In a review of 91 direct observation studies of medication errors in hospitals and long-term care facilities, investigators estimated median error rates of 8%–25% during medication administration.
2024 - September	16,250	6	0.04%	8%-25%	16.50%	99.96%	
2024 - October	14,778	3	0.02%	8%-25%	16.50%	99.98%	
2024 - November	11,959	4	0.03%	8%-25%	16.50%	99.97%	reference for above: https://psnet.ahrq.gov/primer/medication-administration-errors#:~:text=In%20a%20review%20of%2091,%E2%80%9325%25%20during%20medication%20administration.
2024 - December	12,532	4	0.03%	8%-25%	16.50%	99.97%	Occurrences not included, as they are not errors that are administered to a patient.
2025 - January	16,060	3	0.02%	8%-25%	16.50%	99.98%	
2025 - February	12,496	2	0.02%	8%-25%	16.50%	99.98%	
2025 - March	12,493	5	0.04%	8%-25%	16.50%	99.96%	
2025 - April	12,670	5	0.04%	8%-25%	16.50%	99.96%	

YouCompli
FROM CHAOS TO CONFIDENCE

Regulation, Requirement & Task Overview



Effective Date **12/01/2024 - 04/30/2025**

Months	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Total
Regulation Count	15	120	9	5	36	185

Months	Total
Requirement Count	

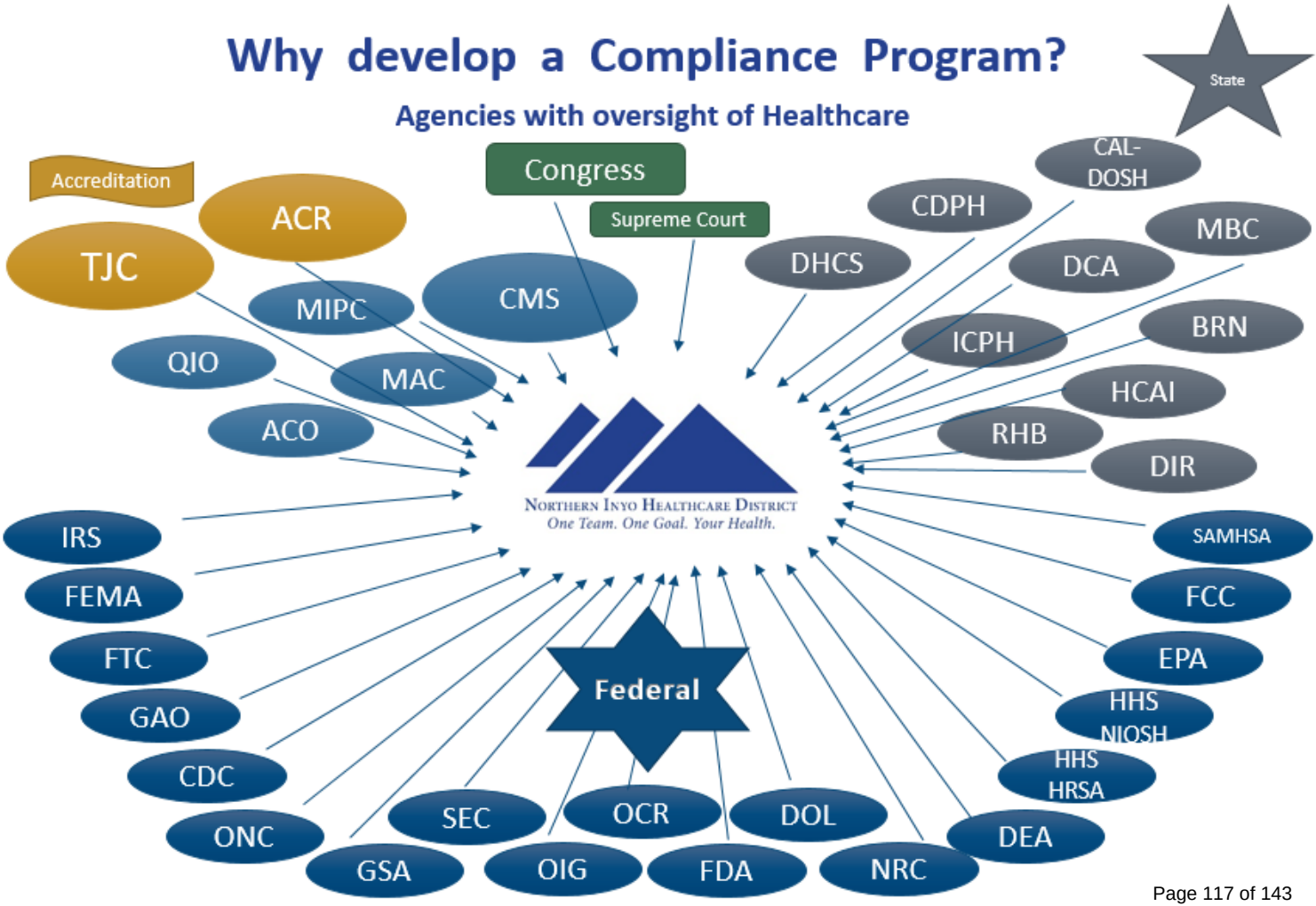
Months	Total
Requirements (Relevant)	

Months	Total
Task Count (Relevant)	

Attachment 6

Why develop a Compliance Program?

Agencies with oversight of Healthcare



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

DATE: May 2025

TO: Board of Directors

FROM: Tanya DeLeo, Director of Patient Access
Janai Lind, Director of Revenue Cycle
Larry Hooker, Accounting Office
Neil Lynch, Purchasing Director

RE: Department Update

Patient Access Update

1. Upfront cash collections improved significantly. In March 2025, we collected $78,000 compared to $27,000 in March 2024.
2. We continue training team members on upfront collections throughout the district.
    a. Training included how to use the estimator tool and how to communicate expected out-of-pocket costs to patients.
3. We validated the accuracy of our Price Estimator tool, enabling Patient Access staff to provide printed estimates to patients at the time of service.
4. We audited all upfront collections of $500 or more to ensure the estimator tool functioned correctly. When errors were identified, we retrained the team member and contacted the patient to resolve the issue.
5. We continued work on interfacing with Valley Health and Toiyabe Health to electronically transmit orders to NIHD.
6. Pediatric Patient Access collaborated with the Quality department on our Well Child Checks campaign, utilizing the i2i tool to ensure patients received regular checkups.

Billing Office

1. Jorie Artificial Intelligence Automation Projection:
    a. Payment Posting Bots went live and continued to ramp up in early 2025.
    b. Prior Authorization continues to move forward.

   c. Accounts Receivable (AR) Bots for Claims Status checks went live and are ramping up. However, AR continued to face challenges due to a lack of on-staff billers. We were not equipped to manage the volume of issues being returned, primarily because we did not have billers on staff to review, reroute, or respond to claim-related questions. To address this, we plan to engage a temporary billing consultant. This consultant would bring expertise and dedicated time to help train Jorie, refine new workflows, and support the recruitment and training of a permanent onsite biller.

2. Multiple areas underwent active process improvement efforts, including Patient Access, ChargeMaster, Authorizations & Referrals, Coding, and Billing.
3. Denials Management launched a campaign to appeal medical necessity denials in partnership with PayorWatch. The company works to collect necessary appeal documentation and submit it to payors to recoup reimbursement for claims initially denied as not medically necessary.

Accounting Office

1. The Ludi physician compensation tool went live in April 2025. All providers were paid accurately for services rendered in April.
   a. Ludi is a mobile app that enables providers to log time and track contract compliance. The tool automates payment calculations, manages approval workflows, and generates reports for providers and administration. It streamlines the compensation process and strengthens contract compliance controls.
2. The fiscal year-end (FYE) 2024 audit was finalized and reported in April. All adjustments have been posted, and the general ledger has been fully reconciled.
3. Amendments to the FYE 2024 HCAI and cost reports are underway to align with the audit. Completion is expected by the end of May 2025.
4. A full physical inventory count was conducted on April 30. External auditors were on site to observe and verify the process, with no audit findings reported. The Surgery Department is scheduled to complete its inventory count in early June 2025.
5. Ongoing audits with Medicare and the State continue for prior-year cost and financial reports.
6. New accounting team members have been hired and are working toward clearing the backlog by July 31.
7. Our audit firm’s outsourced accounting team has been engaged to assist with the backlog, providing approximately 20 hours per week of accounting support to ensure we are current for this fiscal year and to improve audit timeliness.

8. Automation projects within our accounting software, MultiView, are in progress to ensure report accuracy and timelines. For example, Payroll 360, will integrate payroll financial, and statistical data into the ledger, enhancing reporting and transparency for department leaders.

Purchasing Department

1. The Durable Medical Equipment (DME) project has launched. We are partnering with a third-party vendor who will directly bill patients for consigned DME. This change will reduce expenses for the district, as we will no longer absorb the cost of DME provided to patients.

Clinical Engineering Department

1. Completed routine break/fix service requests.
2. Completed scheduled preventative maintenance for Rural Health Clinic (RHC), Medical-Surgical (Med Surg), Obstetrics (OB), Physical Therapy, Respiratory Therapy, Pharmacy, and the Lab Blood Bank.
3. Ongoing project management efforts include support for the new Pharmacy build-out and the new Infusion area.

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

DATE: May 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights as of March 2025

Financial Summary

1. Net Income: March's net income was $765k, which was $5.3M higher than last March. This was due to higher gross revenue for a year-to-date inpatient accounting reclass along with favorable discount rates. For the year, net income was at $8.7M which was $4.6M higher than last year-to-date. This was due to timing of IGT.
2. Operating Income: March's operating income was $692k, which was $5.5M higher than last March due to higher revenue as mentioned above. For the year, operating loss was $(2.7M) which was $5M favorable to last year due to timing of IGT.
3. EBIDA: March's EBIDA was $1.2M, which was $4.4M favorable to last March due to timing of IGT. For the year, EBIDA was favorable by $4.3M.
4. Revenue Breakdown: March's gross revenue was favorable to last March by $4.4M due to a year-to-date correcting entry of $3.5M. For the year, gross revenue was higher by 5% due to increased volumes in most areas. Net revenue was higher as well due to the increase volume and revenue.

Deductions Summary

1. Contractual Adjustments: Contractual discounts were lower for the month due to better write-off rates compared to last March. For the year, contractual discounts are 2% higher primarily due to Medicare outpatient rates declining. Net revenue as a % of gross revenue is at 47% for the year which is consistent with last year-to-date.
2. Bad Debt: For the year, bad debt declined (71%) 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 March and year-to-date, wages per patient were lower than last year due to higher volumes.
2. Total Salaries: For year-to-date, wages were relatively flat to prior year even though volume increased meaning we are staffing more efficiently.
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 March 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 (23%) under budget and (11%) under prior year-to-date. This was due to lower benefit costs.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For March, 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 1% higher than prior year due to staffing challenges and increasing rates.
2. Contract Labor Rates: Rates are higher than budgeted by 33% and higher than prior year by 7%. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor was (6%) lower than prior year.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were (2%) under budget and (5%) 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 (5%) and under prior year by (1%). This was due to lower benefits and supplies.

Stats Summary

1. Admits (excluding Nursery): For March, admits were (19%) lower due to lower medical admits from the ER along with lower inpatient surgeries. For the year, admits were 1% higher due to higher deliveries and medical admits with declines in inpatient surgeries.
2. Inpatient Days (excluding Nursery): For March, inpatient days were (16%) lower. For the year, inpatient days increased 13%.
3. Average Daily Census: Average census increased 14% compared to last year-to-date.
4. Average Length of Stay (ALOS): For the year, average length of stay increased 12% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 13% higher than last year.
6. Surgical Procedures: For March, surgeries were (18%) lower than last March due to declines in most service lines. For the year, surgical procedures were (4%) 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 6% compared to last March and 2% higher year-to-date leading to higher medical admits.
8. Diagnostic Imaging (DI) Exams: For the month, DI exams were 1% higher than last March. For the year-to-date, DI exams were higher by 2%. Approximately 25% of volume in this cost center comes from orthopedic clinic.
9. Rehab Visits: For March, rehab visits were higher by 23% and they were up 36% for the year. Approximately 36% of volume in this cost center comes from orthopedic clinic.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were up 93% compared to last year-to-date.
11. Observation Hours: Observations hours were down (23%) compared to last year-to-date due to change in observation methodology in the women and surgical service lines along with less surgical volume.
12. Rural Health Clinic (RHC) Visits: For March, RHC was up 7% and year-to-date, RHC is relatively flat compared to last year.
13. Other Clinics: For the year, all clinics increased 10% due to new providers.

Northern Inyo Healthcare District

March 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)	764,746	(1,117,262)	1,882,008	(168%)	(4,561,299)	5,326,045	117%	8,687,524	2,632,090	6,055,435	(230%)	4,048,396	4,639,128	115%
Operating Income (Loss)	691,628	(1,739,052)	2,430,680	(140%)	(4,825,134)	5,516,762	114%	(2,721,493)	(9,689,243)	6,967,750	72%	(7,732,077)	5,010,584	(65%)
EBIDA (Loss)	1,173,910	(753,684)	1,927,594	(256%)	(3,296,981)	4,470,891	136%	12,465,879	5,904,292	6,561,587	(111%)	8,220,801	4,245,078	52%
IP Gross Revenue	6,901,902	3,536,492	3,365,410	95%	3,740,981	3,160,921	84%	34,399,100	32,317,350	2,081,750	6%	31,692,301	2,706,799	9%
OP Gross Revenue	13,051,580	13,918,914	(867,334)	(6%)	11,921,652	1,129,928	9%	126,113,996	129,087,377	(2,973,381)	(2%)	121,643,041	4,470,955	4%
Clinic Gross Revenue	1,718,306	1,594,299	124,007	8%	1,601,821	116,485	7%	15,720,638	14,900,535	820,103	6%	14,137,287	1,583,351	11%
Total Gross Revenue	**21,671,787**	**19,049,705**	**2,622,083**	**14%**	**17,264,454**	**4,407,333**	**26%**	**176,233,734**	**176,305,262**	**(71,528)**	**(0%)**	**167,472,630**	**8,761,104**	**5%**
Net Patient Revenue	**10,986,684**	**9,092,908**	**1,893,776**	**21%**	**5,652,661**	**5,334,023**	**94%**	**82,987,028**	**80,988,259**	**1,998,769**	**2%**	**78,984,885**	**4,002,144**	**5%**
Cash Net Revenue % of Gross	*51%*	*48%*	*3%*	*6%*	*33%*	*18%*	*55%*	*47%*	*46%*	*1%*	*3%*	*47%*	*(0%)*	*(0%)*
Admits (excl. Nursery)	60	74	(14)	(19%)	74	(14)	(19%)	645	636	9	1%	636	9	1%
IP Days	186	216	(30)	(14%)	216	(30)	(14%)	2,216	1,871	345	18%	1,871	345	18%
IP Days (excl. Nursery)	163	194	(31)	(16%)	194	(31)	(16%)	1,877	1,655	222	13%	1,655	222	13%
Average Daily Census	5.2	6.3	(1.0)	(16%)	6.3	(1.0)	(16%)	6.8	6.0	0.8	14%	6.0	0.8	14%
ALOS	2.7	2.6	0.1	3%	2.6	0.1	3%	2.9	2.6	0.3	12%	2.6	0.3	12%
Deliveries	14	15	(1)	(7%)	15	(1)	(7%)	160	141	19	13%	141	19	13%
OP Visits	4,238	3,613	625	17%	3,613	625	17%	35,188	31,279	3,909	12%	31,279	3,909	12%
Rural Health Clinic Visits	2,283	2,177	106	5%	2,177	106	5%	20,535	21,070	(535)	(3%)	21,070	(535)	(3%)
Rural Health Women Visits	523	502	21	4%	502	21	4%	4,629	4,159	470	11%	4,159	470	11%
Rural Health Behavioral Visits	225	158	67	42%	158	67	42%	1,800	1,487	313	21%	1,487	313	21%
Total RHC Visits	**3,031**	**2,837**	**194**	**7%**	**2,837**	**194**	**7%**	**26,964**	**26,716**	**248**	**1%**	**26,716**	**248**	**1%**
Bronco Clinic Visits	43	38	5	13%	38	5	13%	352	282	70	25%	282	70	25%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	348	335	13	4%	335	13	4%	3,158	3,075	83	3%	3,075	83	3%
Pediatric Clinic Visits	598	625	(27)	(4%)	625	(27)	(4%)	5,415	5,525	(110)	(2%)	5,525	(110)	(2%)
Specialty Clinic Visits	534	487	47	10%	487	47	10%	4,826	3,500	1,326	38%	3,500	1,326	38%
Surgery Clinic Visits	127	159	(32)	(20%)	159	(32)	(20%)	1,396	1,168	228	20%	1,168	228	20%
Virtual Care Clinic Visits	53	75	(22)	(29%)	75	(22)	(29%)	520	445	75	17%	445	75	17%
Total NIA Clinic Visits	**1,703**	**1,719**	**(16)**	**(1%)**	**1,719**	**(16)**	**(1%)**	**15,667**	**14,196**	**1,471**	**10%**	**14,196**	**1,471**	**10%**
IP Surgeries	8	17	(9)	(53%)	17	(9)	(53%)	96	187	(91)	(49%)	187	(91)	(49%)
OP Surgeries	109	126	(17)	(13%)	126	(17)	(13%)	1,157	1,125	32	3%	1,125	32	3%
Total Surgeries	**117**	**143**	**(26)**	**(18%)**	**143**	**(26)**	**(18%)**	**1,253**	**1,312**	**(59)**	**(4%)**	**1,312**	**(59)**	**(4%)**
Cardiology	-	-	-	-%	-	-	-%	4	1	3	300%	1	3	300%
General	72	79	(7)	(9%)	79	(7)	(9%)	636	624	12	2%	624	12	2%
Gynecology & Obstetrics	9	12	(3)	(25%)	12	(3)	(25%)	102	134	(32)	(24%)	134	(32)	(24%)
Ophthalmology	17	24	(7)	(29%)	24	(7)	(29%)	205	223	(18)	(8%)	223	(18)	(8%)
Orthopedic	9	17	(8)	(47%)	17	(8)	(47%)	188	233	(45)	(19%)	233	(45)	(19%)
Pediatric	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Plastics	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Podiatry	2	-	2	-%	-	2	-%	6	1	5	500%	1	5	500%
Urology	7	11	(4)	(36%)	11	(4)	(36%)	107	96	11	11%	96	11	11%
Diagnostic Image Exams	2,057	2,038	19	1%	2,038	19	1%	18,791	18,468	323	2%	18,468	323	2%
Emergency Visits	825	780	45	6%	780	45	6%	7,637	7,449	188	3%	7,449	188	3%
ED Admits	38	42	(4)	(10%)	42	(4)	(10%)	389	308	81	26%	308	81	26%
ED Admits % of ED Visits	5%	5%	-1%	(14%)	5%	-1%	(14%)	5%	4%	1%	23%	4%	1%	23%
Rehab Visits	860	699	161	23%	699	161	23%	7,419	5,466	1,953	36%	5,466	1,953	36%
OP Infusion/Wound Care Visits	790	261	529	203%	261	529	203%	4,999	2,591	2,408	93%	2,591	2,408	93%
Observation Hours	1,186	1,342	(157)	(12%)	1,342	(157)	(12%)	13,659	17,656	(3,997)	(23%)	17,656	(3,997)	(23%)

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

Northern Inyo Healthcare District

March 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	21.6%	12.0%	9.5%	79.3%	12.0%	9.5%	79.3%	23.8%	17.8%	6.1%	34.2%	17.8%	6.1%	34.2%
Commercial	2.9%	3.2%	(0.4%)	(11.9%)	3.2%	(0.4%)	(11.9%)	6.8%	3.9%	2.9%	72.5%	3.9%	2.9%	72.5%
Medicaid	38.1%	30.1%	8.0%	26.6%	30.1%	8.0%	26.6%	28.8%	25.4%	3.4%	13.2%	25.4%	3.4%	13.2%
Medicare	35.8%	51.9%	(16.1%)	(31.0%)	51.9%	(16.1%)	(31.0%)	38.3%	49.2%	(10.9%)	(22.1%)	49.2%	(10.9%)	(22.1%)
Self-pay	1.7%	2.8%	(1.1%)	(38.4%)	2.8%	(1.1%)	(38.4%)	1.9%	3.2%	(1.3%)	(40.0%)	3.2%	(1.3%)	(40.0%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.4%	0.5%	(0.1%)	(17.3%)	0.5%	(0.1%)	(17.3%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)
DEDUCTIONS														
Contract Adjust	(10,138,614)	(8,800,983)	(1,337,630)	15%	(15,144,877)	5,006,264	(33%)	(84,809,500)	(84,022,751)	(786,748)	1%	(82,789,453)	(2,020,047)	2%
Bad Debt	(370,446)	(612,905)	242,459	(40%)	4,239,262	(4,609,708)	(109%)	(359,156)	(6,044,702)	5,685,546	(94%)	(1,256,922)	897,766	(71%)
Write-off	(176,044)	(542,909)	366,865	(68%)	(706,178)	530,134	(75%)	(7,929,868)	(5,249,550)	(2,680,318)	51%	(4,445,187)	(3,484,681)	78%
CENSUS														
Patient Days	163	194	(31)	(16%)	194	(31)	(16%)	1,877	1,655	222	13%	1,655	222	13%
Adjusted ADC	29	29	(0)	(1%)	29	(0)	(1%)	38	32	6	20%	32	6	20%
Adjusted Days	511	895	(384)	(43%)	895	(384)	(43%)	9,615	8,746	870	10%	8,746	870	10%
Employed FTE	363.0	348.2	14.8	4%	348.2	14.8	4%	361.7	351.8	9.9	3%	351.8	9.9	3%
Contract Labor FTE	21.7	26.1	(4.4)	(17%)	26.1	(4.4)	(17%)	25.6	27.1	(1.5)	(6%)	27.1	(1.5)	(6%)
Total Paid FTE	384.7	374.3	10.4	3%	374.3	10.4	3%	387.3	378.8	8.4	2%	378.8	8.4	2%
EPOB (Employee per Occupied Bed)	2.4	1.9	0.4	23%	1.9	0.4	23%	1.8	2.0	(0.2)	(10%)	2.0	(0.2)	(10%)
EPOC (Employee per Occupied Case)	0.4	0.4	0.0	3%	0.4	0.0	3%	0.0	0.0	(0.0)	(15%)	0.0	(0.0)	(15%)
Adjusted EPOB	7.4	8.9	(1.5)	(17%)	8.9	(1.5)	(17%)	9.3	10.7	(1.4)	(13%)	10.7	(1.4)	(13%)
Adjusted EPOC	1.3	1.9	(0.6)	(30%)	1.9	(0.6)	(30%)	0.2	0.2	(0.0)	(17%)	0.2	(0.0)	(17%)
SALARIES														
Per Adjust Bed Day	6,872	3,955	2,918	74%	3,543	3,329	94%	3,021	3,602	(581)	(16%)	3,315	(294)	(9%)
Total Salaries	3,511,824	3,540,655	(28,830)	(1%)	3,172,350	339,474	11%	29,045,119	31,502,682	(2,457,563)	(8%)	28,989,432	55,687	0%
Average Hourly Rate	54.61	57.41	(2.80)	(5%)	51.44	3.18	6%	51.29	57.20	(5.91)	(10%)	52.44	(1.16)	(2%)
Employed Paid FTEs	363.0	348.2	14.8	333.3	348.2	14.8	4%	361.7	351.8	9.9	3%	351.8	9.9	3%
BENEFITS														
Per Adjust Bed Day	3,263	2,496	767	31%	1,983	1,280	65%	1,420	2,146	(726)	(34%)	1,700	(280)	(16%)
Total Benefits	1,667,467	2,234,956	(567,488)	(25%)	1,775,357	(107,890)	(6%)	13,655,247	18,772,231	(5,116,984)	(27%)	14,868,167	(1,212,919)	(8%)
Benefits % of Wages	47%	63%	(16%)	(25%)	56%	-8%	(15%)	47%	60%	(13%)	(21%)	51%	(4%)	(8%)
Pension Expense	377,507	498,151	(120,644)	(24%)	508,913	(131,406)	(26%)	3,559,233	4,481,150	(921,918)	(21%)	4,214,370	(655,137)	(16%)
MDV Expense	850,652	748,612	102,040	14%	950,310	(99,658)	(10%)	7,091,328	6,737,508	353,820	5%	7,884,033	(792,705)	(10%)
Taxes, PTO accrued, Other	439,309	988,193	(548,884)	(56%)	316,134	123,175	39%	3,004,687	7,553,573	(4,548,886)	(60%)	2,769,764	234,924	8%
Salaries, Wages & Benefits	5,179,292	5,775,611	(596,319)	(10%)	4,947,707	231,585	5%	42,700,367	50,274,914	(7,574,547)	(15%)	43,857,599	(1,157,232)	(3%)
SWB/APD	10,135	6,451	3,684	57%	5,526	4,609	83%	4,441	5,749	(1,308)	(23%)	5,015	(574)	(11%)
SWB % of Total Expenses	50%	56%	(6%)	(10%)	47%	3%	7%	50%	55%	(6%)	(10%)	51%	(1%)	(1%)

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

Northern Inyo Healthcare District

March 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	5,461	2,541	2,920	115%	3,190	2,271	71%	2,393	2,301	92	4%	2,548	(156)	(6%)
Total Physician Fee	1,809,889	1,463,822	346,066	24%	1,740,920	68,969	4%	14,193,764	13,172,800	1,020,963	8%	13,558,329	635,435	5%
Total Contract Labor	283,021	386,404	(103,383)	(27%)	428,159	(145,138)	(34%)	3,986,852	3,172,237	814,615	26%	3,961,282	25,570	1%
Total Other Pro-Fees	697,944	424,727	273,217	64%	686,962	10,982	2%	4,824,309	3,777,548	1,046,761	28%	4,766,054	58,255	1%
Total Professional Fees	2,790,854	2,274,952	515,901	23%	2,856,041	(65,187)	(2%)	23,004,924	20,122,585	2,882,339	14%	22,285,664	719,260	3%
Contract AHR	73.66	83.54	(9.87)	(12%)	92.57	(18.90)	(20%)	99.59	74.87	24.72	33%	93.16	6.43	7%
Contract Paid FTEs	21.7	26.1	(4.4)	(17%)	26.1	(4.4)	(17%)	25.6	27.1	(1.5)	(6%)	27.1	(1.5)	(6%)
Physician Fee per Adjust Bed Day	3,542	1,635	1,907	117%	1,945	1,597	82%	1,476	1,506	(30)	(2%)	1,550	(74)	(5%)
PHARMACY														
Per Adjust Bed Day	1,478	515	963	187%	494	984	199%	370	475	(105)	(22%)	447	(77)	(17%)
Total Rx Expense	755,356	461,460	293,896	64%	442,678	312,678	71%	3,557,249	4,153,137	(595,888)	(14%)	3,906,221	(348,972)	(9%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	595	479	115	24%	718	(123)	(17%)	441	441	(0)	(0%)	512	(71)	(14%)
Total Medical Supplies	303,803	429,135	(125,332)	(29%)	642,449	(338,646)	(53%)	4,243,453	3,860,923	382,530	10%	4,476,323	(232,870)	(5%)
EHR SYSTEM														
Per Adjust Bed Day	40	151	(111)	(74%)	(858)	898	(105%)	31	139	(108)	(78%)	26	5	19%
Total EHR Expense	20,415	135,000	(114,585)	(85%)	(768,589)	789,004	(103%)	294,097	1,215,000	(920,903)	(76%)	223,890	70,207	31%
OTHER EXPENSE														
Per Adjust Bed Day	1,636	965	672	70%	1,221	415	34%	846	889	(44)	(5%)	891	(46)	(5%)
Total Other	836,173	863,658	(27,485)	(3%)	1,093,192	(257,019)	(24%)	8,130,077	7,778,742	351,335	5%	7,794,860	335,217	4%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	801	406	395	97%	1,412	(611)	(43%)	393	374	19	5%	477	(84)	(18%)
Total Depreciation and Amortization	409,164	363,578	45,586	13%	1,264,318	(855,154)	(68%)	3,778,355	3,272,202	506,153	15%	4,172,405	(394,050)	(9%)
TOTAL EXPENSES	10,295,056	10,303,394	(8,338)	(0%)	10,477,795	(182,739)	(2%)	85,708,522	90,677,503	(4,968,981)	(5%)	86,716,962	(1,008,440)	(1%)
Per Adjust Bed Day	20,147	11,508	8,638	75%	11,703	8,443	72%	8,914	10,368	(1,455)	(14%)	9,916	(1,002)	(10%)
Per Calendar Day	332,099	332,368	(269)	(0%)	337,993	(5,895)	(2%)	312,805	330,940	(18,135)	(5%)	315,334	(2,530)	(1%)

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

Key Financial Performance Indicators	Industry Benchmark	Mar-23	Mar-24	FYE 2024 Average	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Volume																
Admits	41	72	74	71	75	75	83	68	77	62	90	61	60	(1)	(11)	(14)
Deliveries	n/a	19	16	17	18	19	17	21	14	21	20	15	14	(1)	(3)	(2)
Adjusted Patient Days	n/a	828	900	1,035	1,164	1,362	1,312	1,335	970	1,169	1,432	969	511	(458)	(523)	(389)
Total Surgeries	153	136	143	146	134	168	133	176	129	122	137	137	117	(20)	(29)	(26)
ER Visits	659	793	780	840	903	905	947	859	789	789	833	787	825	38	(15)	45
RHC and Clinic Visits	n/a	4,663	4,556	4,607	4,252	4,921	4,808	5,479	4,515	4,444	4,943	4,531	4,734	203	127	178
Diagnostic Imaging Services	n/a	2,037	2,038	2,069	2,274	2,221	2,194	2,344	1,880	1,955	2,283	1,919	2,057	138	(12)	19
Rehab Services	n/a	767	699	662	719	808	887	1,142	903	740	725	635	860	225	198	161
AR & Income																
Gross AR (Cerner only)	n/a	$ 58,599,789	$ 48,964,677	$ 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	$ 48,628,722	$ (1,080,061)	$ (4,194,986)	$ (335,955)
AR > 90 Days	$ 7,001,767.65	$ 25,286,960	$ 22,242,405	$ 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	$ 16,111,701	$ (1,000,920)	$ (8,376,731)	$ (6,130,704)
AR % > 90 Days	15%	50.97%	46.22%	46.7%	44.5%	43.1%	44.9%	43.6%	43.4%	42.3%	38.6%	34.4%	33.1%	-1.3%	-13.5%	-13.1%
Gross AR Days (per financial statements)	60	102	88	85	92	84	83	74	83	84	71	82	70	(13)	(16)	(18)
Net AR Days (per financial statements)	30	83	68	58	54	64	69	64	67	84	76	65	45	(20)	(12)	(23)
Net AR	n/a	$ 20,562,360	$ 12,458,272	$ 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	$ 18,641,177	$ 1,130,090	$ 1,702,978	$ 6,182,906
Net AR % of Gross	n/a	35.1%	25.4%	31.9%	32.0%	35.2%	34.1%	36.3%	41.2%	38.8%	56.6%	35.2%	38.3%	3.1%	6.4%	12.9%
Gross Patient Revenue/Calendar Day	n/a	$ 574,035	$ 556,918	$ 619,457	$ 617,364	$ 683,348	$ 702,988	$ 698,314	$ 582,780	$ 557,230	$ 638,935	$ 604,928	$ 699,090	$ 94,162	$ 79,633	$ 142,172
Net Patient Revenue/Calendar Day	n/a	$ 248,534	$ 182,344	$ 292,759	$ 337,843	$ 315,574	$ 285,805	$ 290,232	$ 301,501	$ 215,907	$ 339,299	$ 263,197	$ 354,409	$ 91,212	$ 61,650	$ 172,065
Net Patient Revenue/APD	n/a	$ 9,305	$ 6,281	$ 8,757	$ 8,998	$ 7,183	$ 6,537	$ 6,740	$ 9,321	$ 5,727	$ 7,346	$ 7,603	$ 21,500	$ 13,897	$ 12,743	$ 15,219
Wages																
Wages	n/a	$ 3,192,075	$ 3,172,350	$ 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	$ 3,511,824	$ 679,319	$ 226,393	$ 339,474
Employed paid FTEs	n/a	379.30	348.17	353.69	366.38	366.24	391.40	369.11	364.72	367.90	369.48	359.66	363.01	3.36	9.33	14.84
Employed Average Hourly Rate	$55.50	$ 47.51	$ 51.44	$ 53.32	$ 51.76	$ 49.96	$ 50.26	$ 55.40	$ 55.40	$ 56.15	$ 60.60	$ 49.22	$ 54.61	$ 5.39	$ 1.29	$ 3.18
Benefits	n/a	$ 4,478,865	$ 1,775,357	$ 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	$ 1,667,467	$ 263,924	$ 27,251	$ (107,890)
Benefits % of Wages	30%	140.3%	56.0%	50.3%	44.9%	45.6%	48.5%	52.4%	20.6%	45.9%	42.2%	49.6%	47.5%	-2.1%	-2.9%	-8.5%
Contract Labor	n/a	$ 815,399	$ 428,159	$ 518,351	$ 507,387	$ 829,876	$ (112,642)	$ 543,829	$ 583,367	$ 672,468	$ 312,240	$ 367,306	$ 283,021	$ (84,285)	$ (235,330)	$ (145,138)
Contract Labor Paid FTEs	n/a	29.83	23.27	23.49	29.45	32.19	24.84	21.32	23.57	26.14	25.69	27.74	21.69	(6.05)	(1.80)	(1.58)
Total Paid FTEs	n/a	409.13	371.44	377.18	395.83	398.43	416.25	390.44	388.29	394.04	395.17	387.39	384.70	(2.69)	7.53	13.26
Contract Labor Average Hourly Rate	$ 81.04	$ 154.31	$ 103.86	$ 126.74	$ 97.26	$ 145.55	$ 118.60	$ 143.96	$ 144.39	$ 145.23	$ 68.61	$ 82.77	$ 73.66	$ (9.10)	$ (53.07)	$ (30.19)
Total Salaries, Wages, & Benefits	n/a	$ 8,486,339	$ 5,375,866	$ 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	$ 5,462,313	$ 858,958	$ 18,315	$ 86,447
SWB% of NR	50%	110.1%	95.1%	63.2%	51.3%	56.7%	57.1%	67.4%	52.6%	89.8%	56.6%	62.5%	49.7%	-12.7%	-13.4%	-45.4%
SWB/APD	2,572	$ 10,249	$ 5,973	$ 5,346	$ 4,618	$ 4,075	$ 3,731	$ 4,541	$ 4,906	$ 5,144	$ 4,157	$ 4,749	$ 10,689	$ 5,940	$ 5,343	$ 4,716
SWB % of total expenses	50%	93.5%	51.3%	56.7%	59.6%	56.3%	55.1%	58.0%	49.7%	59.9%	56.3%	53.0%	53.1%	0.0%	-3.6%	1.8%

Physician Spend	Industry Benchmark	Mar-23	Mar-24	FYE 2024 Average	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Physician Expenses	n/a	$ 1,427,344	$ 1,724,855	$ 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	$ 1,809,889	$ 285,687	$ 302,379	$ 85,034
Physician expenses/APD	n/a	$ 1,724	$ 1,917	$ 1,478	$ 1,334	$ 1,028	$ 1,236	$ 1,273	$ 1,555	$ 1,282	$ 1,108	$ 1,572	$ 3,542	$ 1,969	$ 2,064	$ 1,625
														$ -	$ -	$ -
Supplies																
Supply Expenses	n/a	$ 818,939	$ 1,085,127	$ 776,504	$ 387,610	$ 1,078,077	$ 785,983	$ 860,663	$ 1,034,853	$ 794,786	$ 900,961	$ 564,895	$ 1,059,159	$ 494,263	$ 282,655	$ (25,968)
Supply expenses/APD		$ 989	$ 1,206	$ 780	$ 333	$ 792	$ 599	$ 645	$ 1,066	$ 680	$ 629	$ 583	$ 2,073	$ 1,490	$ 1,292	$ 867
Other Expenses																
Other Expenses	n/a	$ (1,652,176)	$ 2,291,947	$ 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	$ 1,963,696	$ (23,606)	$ 72,219	$ (328,251)
Other Expenses/APD	n/a	$ (1,995)	$ 2,547	$ 1,878	$ 1,458	$ 1,346	$ 1,202	$ 1,366	$ 2,341	$ 1,483	$ 1,486	$ 2,050	$ 3,843	$ 1,793	$ 1,965	$ 1,296
Margin																
Net Income	n/a	$ 804,101	$ (4,561,299)	$ 383,722	$ 2,041,456	$ 248,064	$ 19,121	$ (1,152,036)	$ (250,823)	$ 5,868,595	$ 173,184	$ (1,218,683)	$ 764,746	$ 1,983,429	$ 381,025	$ 5,326,045
Net Profit Margin	n/a	10.4%	-80.7%	3.0%	19.5%	2.5%	0.2%	-12.8%	-2.8%	87.7%	1.6%	-16.5%	7.0%	23.5%	4.0%	87.7%
Operating Income	n/a	$ (4,894,817)	$ (4,825,134)	$ (686,444)	$ 1,459,716	$ (77,526)	$ (302,930)	$ (1,449,616)	$ (530,332)	$ (3,343,933)	$ (50,046)	$ (1,310,237)	$ 691,628	$ 2,001,864	$ 1,378,072	$ 5,516,762
Operating Margin	2.9%	-63.5%	-85.4%	-10.9%	13.9%	-0.8%	-3.1%	-16.1%	-5.9%	-50.0%	-0.5%	-17.8%	6.3%	24.1%	17.2%	91.7%
EBITDA	n/a	$ 462,298	$ (3,296,981)	$ 841,891	$ 2,482,790	$ 689,172	$ 459,316	$ (742,505)	$ 158,708	$ 6,277,759	$ 582,348	$ (809,519)	$ 1,173,910	$ 1,983,429	$ 332,020	$ 4,470,891
EBITDA Margin	12.7%	6.0%	-58.3%	8.7%	23.7%	7.0%	4.7%	-8.3%	1.8%	93.8%	5.5%	-11.0%	10.7%	21.7%	1.9%	69.0%
Debt Service Coverage Ratio	3.70		4.1	3.3	0.8	7.3	5.5	3.3	3.4	7.7	7.1	6.9	6.6	(0.3)	3.3	2.6
Cash																
Avg Daily Disbursements (excl. IGT)	n/a	$ 375,541	$ 399,030	$ 355,328	$ 367,107	$ 398,922	$ 315,796	$ 399,234	$ 296,503	$ 367,542	$ 359,843	$ 413,756	$ 314,837	$ (98,920)	$ (40,492)	$ (84,193)
Average Daily Cash Collections (excl. IGT)	n/a	$ 373,885	$ 319,679	$ 299,110	$ 349,783	$ 262,199	$ 302,042	$ 359,292	$ 288,101	$ 273,563	$ 239,449	$ 271,384	$ 363,569	$ 92,186	$ 64,459	$ 43,890
Average Daily Net Cash		$ (1,655)	$ (79,351)	$ (56,218)	$ (17,324)	$ (136,723)	$ (13,754)	$ (39,942)	$ (8,402)	$ (93,979)	$ (120,394)	$ (142,373)	$ 48,733	$ 191,105	$ 104,950	$ 128,083
Upfront Cash Collections			$ 26,622	$ 36,146	$ 32,509	$ 37,333	$ 36,220	$ 57,023	$ 26,687	$ 22,508	$ 60,336	$ 83,209	$ 78,395	$ (4,814)	$ 42,249	$ 51,773
Upfront Cash % of Gross Charges	1%	0.0%	0.2%	0.2%	0.2%	0.2%	0.2%	0.3%	0.2%	0.1%	0.3%	0.5%	0.4%	(0)	0	0
Unrestricted Funds	n/a	$ 17,811,366	$ 19,115,133	$ 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	$ 23,918,889	$ 113,019	$ 382,451	$ 4,803,756
Change of cash per balance sheet	n/a	$ (4,590,643)	$ 4,009,571	$ (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	$ 113,019	$ (948,125)	$ 654,477	$ (3,896,552)
Days Cash on Hand (assume no more cash is collected)	196	61	61	72	98	84	58	77	43	50	74	86	80	(6)	8	19
Estimated Days Until Depleted (operating cash only)		10,761	310	406	506	413	440	442	372	292	370	332	411	78	5	101
Years Until Cash Depletion (operating cash only)		29.48	0.85	1.11	1.39	1.13	1.21	1.21	1.02	0.80	1.01	0.91	1.13	0.21	0.01	0.28

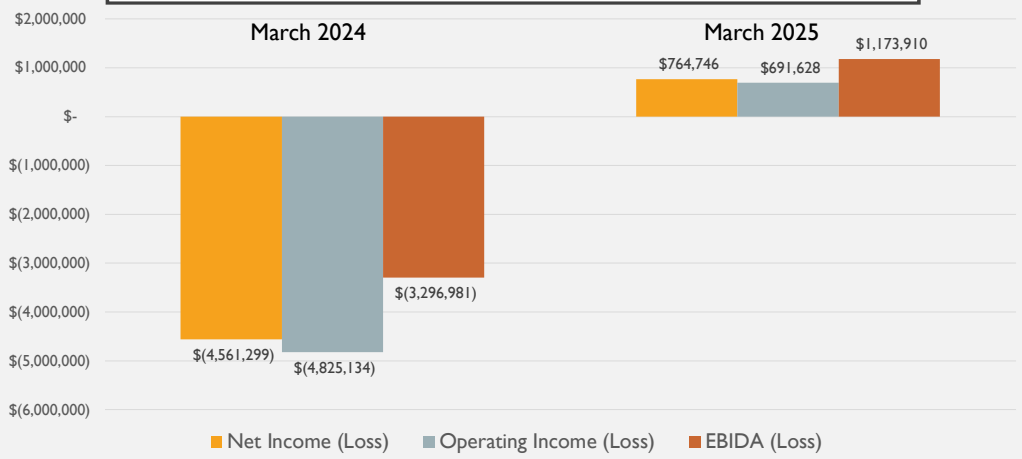
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NIHD FINANCIAL UPDATE

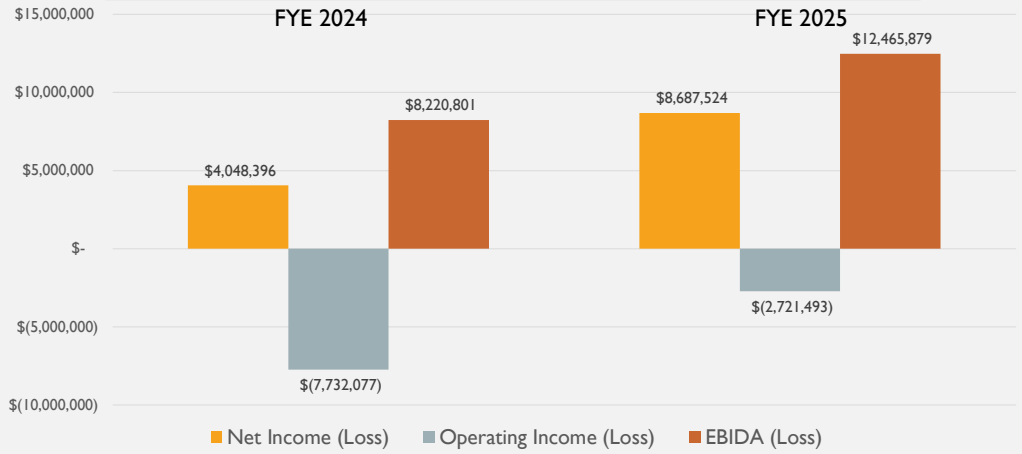
March 2025

INCOME

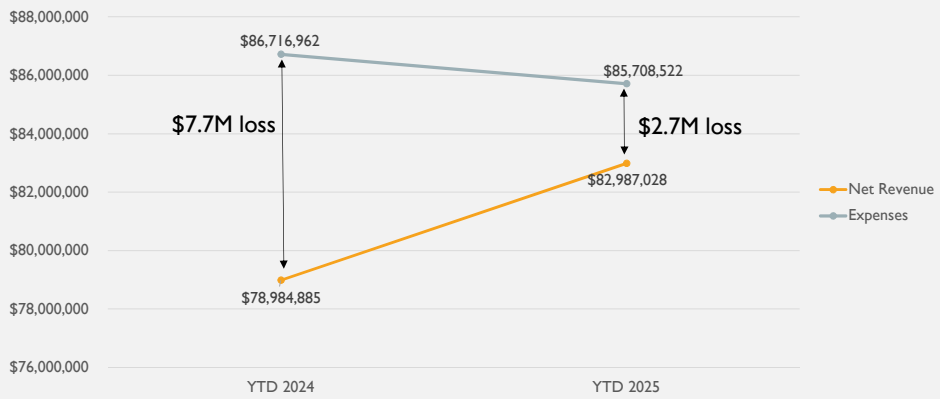
MARCH 2025 FINANCIAL PERFORMANCE



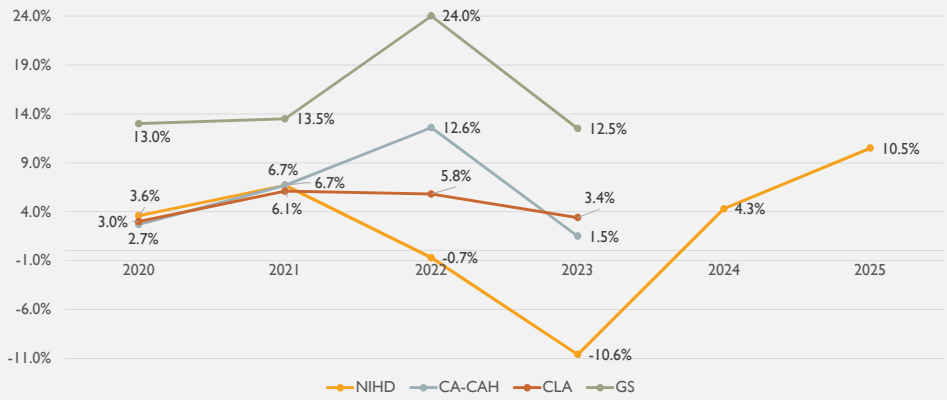
FYE 2025 FINANCIAL PERFORMANCE



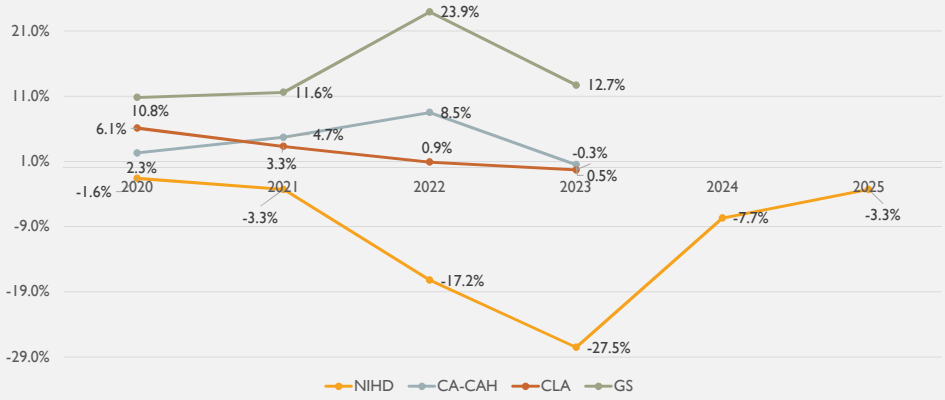
YTD OPERATING INCOME (LOSS) PERFORMANCE



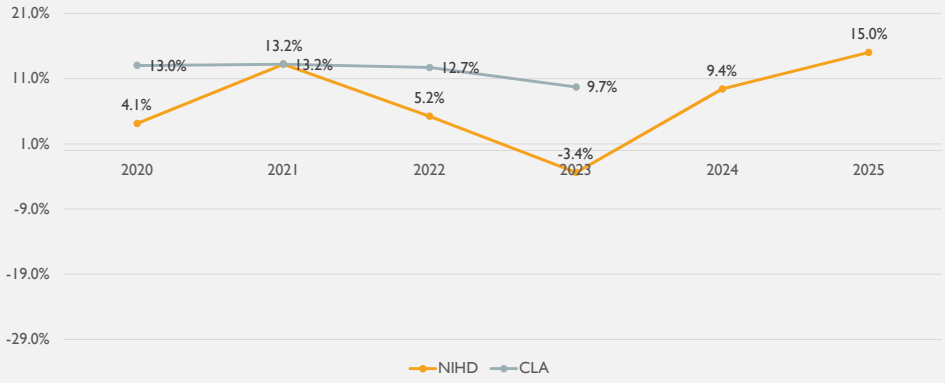
NET PROFIT MARGIN



OPERATING MARGIN

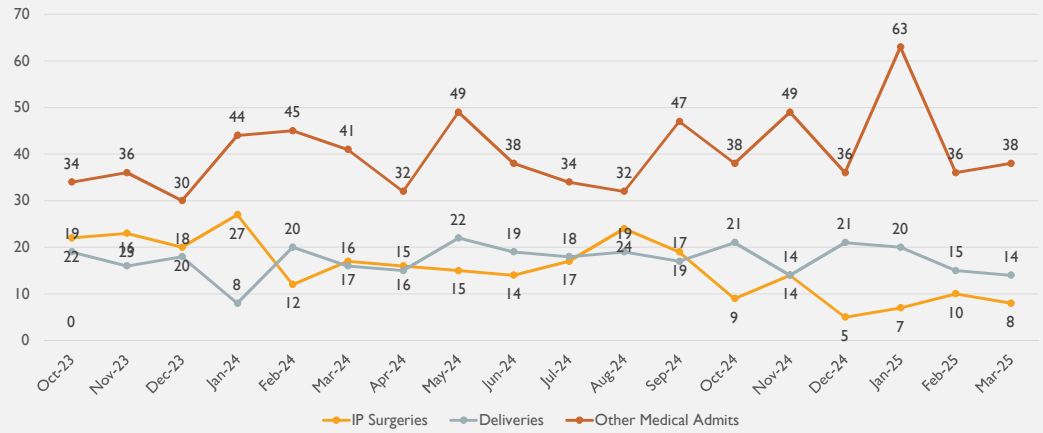


EBIDA MARGIN

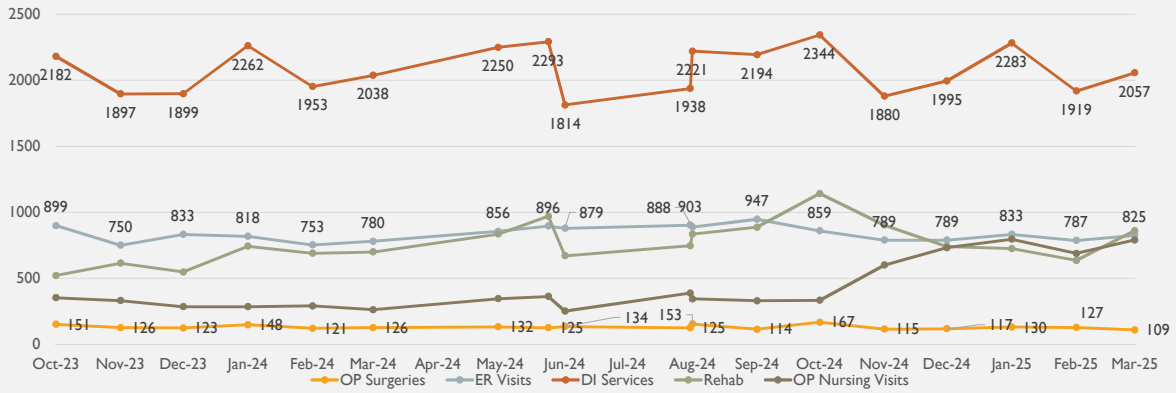


VOLUMES

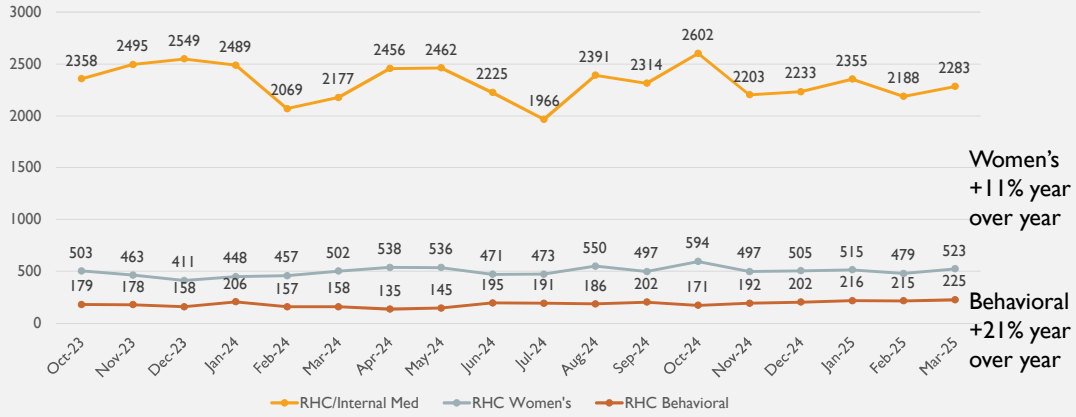
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE



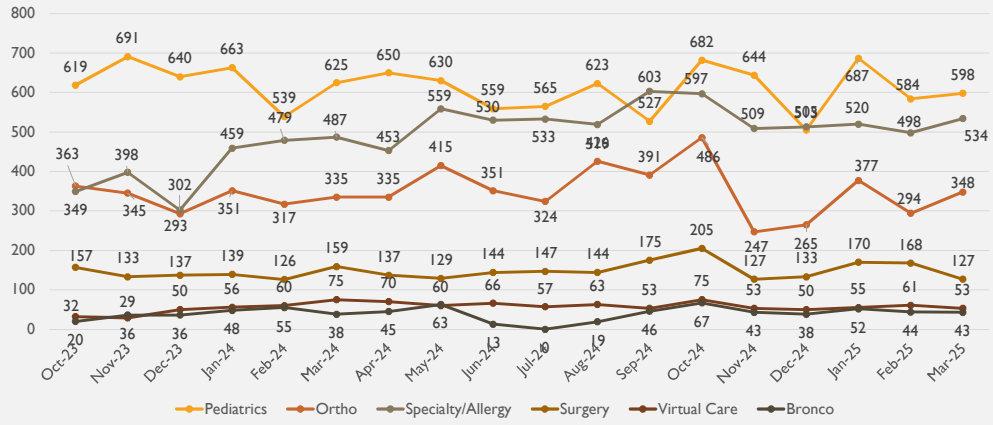
RHC VOLUME PERFORMANCE



Women's +11% year over year

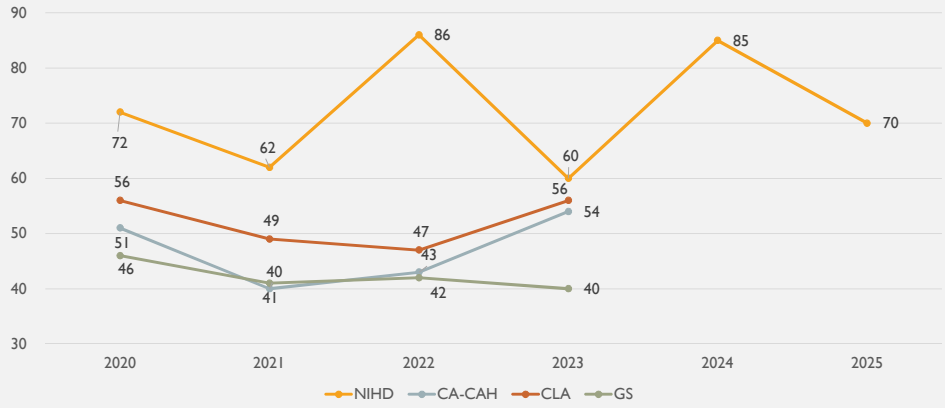
Behavioral +21% year over year

CLINIC VOLUME PERFORMANCE

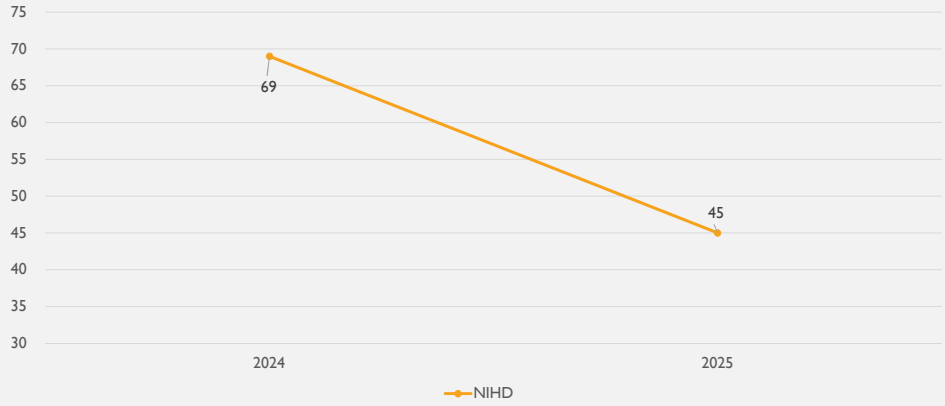


KEY PERFORMANCE INDICATORS

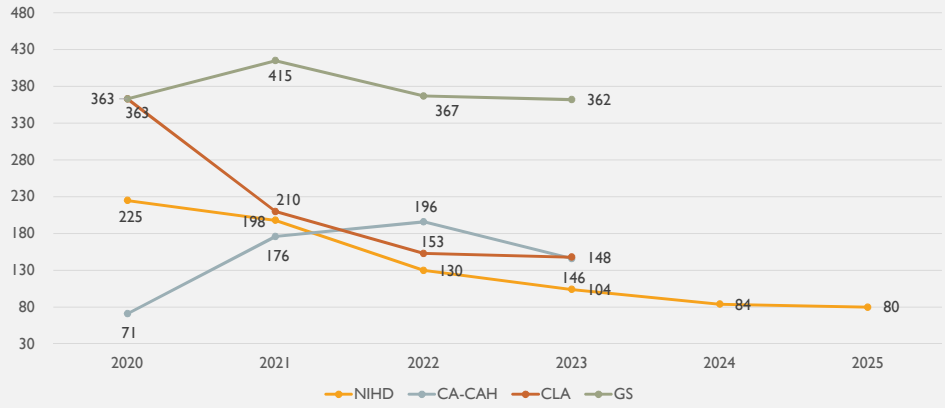
GROSS AR DAYS



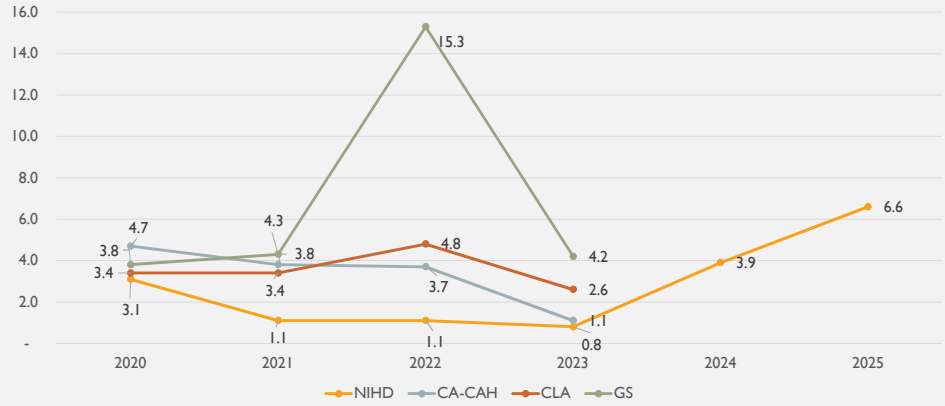
NET AR DAYS



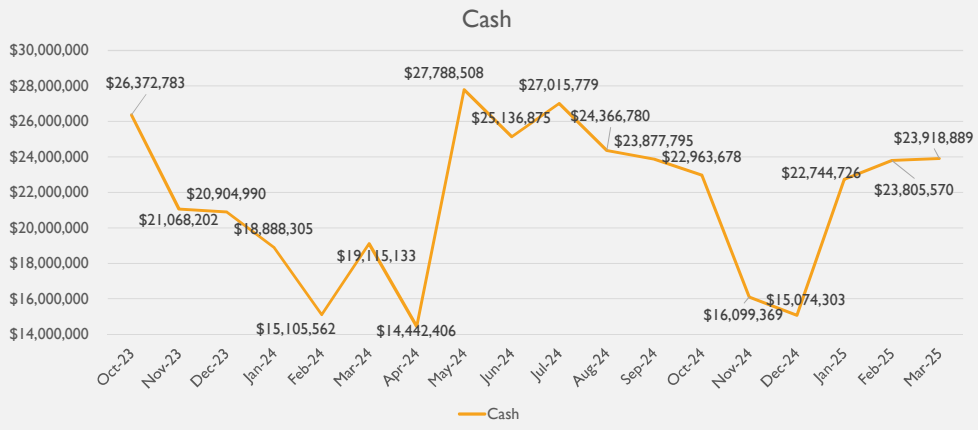
DAYS CASH ON HAND



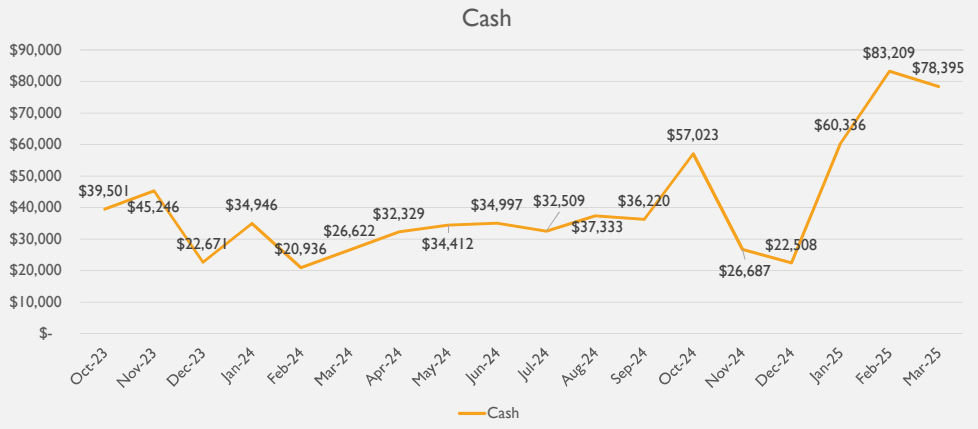
DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



UPFRONT CASH COLLECTIONS



WAGE COSTS

	YTD 2024	YTD 2025
Total Paid FTEs	379	387
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$47,818,881	$46,687,219
SWB % of total expenses (including contract labor)	55%	55%
Employed Average Hourly Rate	$52.44	$51.29
Benefits % of Wages	51%	47%

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	1/31/2025	Jan Budget	1/31/2024	2/29/2025	Feb Budget	2/28/2024	3/31/2025	Mar Budget	3/31/2024	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue														
Inpatient Patient Revenue	3,280,133	3,845,128	4,415,671	2,845,791	3,478,230	3,063,000	6,901,902	3,536,492	3,740,981	34,399,100	31,692,301	3,365,410	3,160,921	2,706,799
Outpatient Revenue	14,664,711	14,602,264	14,723,154	12,402,184	14,066,268	12,719,309	13,051,580	13,918,914	11,921,652	126,113,996	121,643,041	(867,334)	1,129,928	4,470,955
Clinic Revenue	1,862,148	1,720,837	1,668,331	1,689,999	1,599,414	1,500,716	1,718,306	1,594,299	1,601,821	15,720,638	14,137,287	124,007	116,485	1,583,351
Gross Patient Service Revenue	19,806,992	20,168,228	20,807,156	16,937,974	19,143,911	17,283,024	21,671,787	19,049,705	17,264,454	176,233,734	167,472,630	2,622,083	4,407,333	8,761,104
Deductions from Revenue												-		-
Contractual Adjustments	(8,951,555)	(9,517,222)	(9,802,285)	(8,529,361)	(8,800,983)	(9,066,535)	(10,138,614)	(8,800,983)	(15,144,877)	(84,809,500)	(82,789,453)	(1,337,630)	5,006,264	(2,020,047)
Bad Debt	1,386,194	(639,422)	(1,227,065)	(194,637)	(627,905)	(285,977)	(370,446)	(612,905)	4,239,262	(359,156)	(1,256,922)	242,459	(4,609,708)	897,766
A/R Writeoffs	(1,723,376)	(653,505)	(402,752)	(844,459)	(542,909)	(567,860)	(176,044)	(542,909)	(706,178)	(7,929,868)	(4,445,187)	366,865	530,134	(3,484,681)
Other Deductions from Revenue	-	-	-	-	-	-	-	-	-	(152,618)	-	-	-	(152,618)
Deductions from Revenue	(9,288,737)	(10,810,149)	(11,432,101)	(9,568,457)	(9,971,797)	(9,920,372)	(10,685,103)	(9,956,797)	(11,611,793)	(93,251,141)	(88,491,561)	(728,306)	926,690	(4,759,579)
Other Patient Revenue														-
Incentive Income	-	-	-	-	-	-	-	-	-	2,000	-	-	-	2,000
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	862	-	-	-	2,435	3,816	-	-	(1,382)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	-	-	862	-	862	-	4,435	3,816	(862)	-	618
Net Patient Service Revenue	**10,518,255**	**9,358,079**	**9,375,055**	**7,369,517**	**9,172,114**	**7,363,514**	**10,986,684**	**9,093,769**	**5,652,661**	**82,987,028**	**78,984,885**	**1,892,915**	**5,334,023**	**4,002,144**
CNR%	**53.1%**	**46.4%**	**45.1%**	**43.5%**	**47.9%**	**42.6%**	**50.7%**	**47.7%**	**32.7%**	**47.1%**	**47.2%**	**3.0%**	**18.0%**	**-0.1%**
Cost of Services - Direct														-
Salaries and Wages	3,402,211	3,047,389	2,783,144	2,430,386	2,839,400	2,516,276	2,997,295	3,021,901	2,677,613	24,719,486	24,826,571	(24,606)	319,682	(107,084)
Benefits	1,412,693	1,760,785	1,093,886	1,184,125	1,705,577	1,537,835	1,425,501	1,910,641	1,490,439	11,638,100	12,713,559	(485,140)	(64,938)	(1,075,459)
Professional Fees	1,769,446	1,493,012	1,923,668	1,772,635	1,516,321	1,623,461	2,013,306	1,516,140	1,976,553	16,271,728	15,986,770	497,165	36,752	284,958
Contract Labor	373,323	417,673	379,756	377,408	349,503	405,743	187,691	256,252	364,547	3,336,233	3,570,001	(68,560)	(176,856)	(233,768)
Pharmacy	473,056	461,460	373,723	207,210	461,460	474,631	755,356	461,460	442,678	3,557,249	3,906,221	293,896	312,678	(348,972)
Medical Supplies	428,092	427,618	785,869	357,873	430,271	218,356	303,803	429,135	642,449	4,243,453	4,476,323	(125,332)	(338,646)	(232,870)
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	41,264	135,000	150,509	32,417	135,000	126,094	20,415	135,000	(768,589)	294,097	223,890	(114,585)	789,004	70,207
Other Direct Expenses	764,432	659,199	839,875	615,234	596,946	696,431	585,010	604,239	834,238	5,938,512	6,165,800	(19,229)	(249,229)	(227,288)
Total Cost of Services - Direct	8,664,517	8,402,136	8,330,430	6,977,287	8,034,478	7,598,828	8,288,377	8,334,769	7,659,929	69,998,859	71,869,134	(46,392)	628,448	(1,870,275)
General and Administrative Overhead														
Salaries and Wages	564,143	505,307	468,569	402,119	469,792	427,743	514,529	1,024,379	494,737	4,325,633	4,162,862	(509,850)	19,792	162,771
Benefits	261,366	325,767	154,751	219,418	316,043	264,414	241,966	697,121	284,918	2,017,147	2,154,608	(455,155)	(42,951)	(137,461)
Professional Fees	478,210	403,501	139,446	428,917	366,898	344,426	494,527	265,088	451,329	2,746,344	2,337,613	229,439	43,198	408,732
Contract Labor	(61,083)	(68,340)	4,050	(10,102)	(9,355)	24,000	95,330	(19,340)	63,611	650,619	391,281	114,670	31,719	259,338
Depreciation and Amortization	409,164	363,578	520,628	409,164	363,578	386,783	409,164	363,578	1,264,318	3,778,355	4,172,405	45,586	(855,154)	(394,050)
Other Administative Expenses	244,700	211,015	161,466	253,138	245,614	142,398	251,163	167,227	258,954	2,191,565	1,629,060	83,936	(7,790)	562,505
Total General and Administrative Overhead	1,896,500	1,740,829	1,448,910	1,702,654	1,752,570	1,589,765	2,006,679	2,498,053	2,817,866	15,709,663	14,847,828	(491,374)	(811,187)	861,835
Total Expenses	**10,561,017**	**10,142,964**	**9,779,340**	**8,679,941**	**9,787,048**	**9,188,592**	**10,295,056**	**10,832,822**	**10,477,795**	**85,708,522**	**86,716,962**	**(537,765)**	**(182,739)**	**(1,008,440)**
Financing Expense	205,348	181,544	180,628	195,369	179,044	184,336	201,224	183,367	345,952	1,805,092	1,789,312	17,857	(144,728)	15,780
Financing Income	181,031	238,960	228,125	78,984	238,960	228,125	78,984	498,443	228,125	1,742,691	2,053,121	(419,459)	(149,141)	(310,430)
Investment Income	46,487	46,181	(186,959)	37,373	46,181	(105,802)	49,720	133,181	39,189	418,830	464,220	(83,461)	10,531	(45,390)
Miscellaneous Income	201,059	174,335	220,899	170,566	9,550,168	9,178,896	145,639	173,534	342,474	11,052,589	11,052,445	(27,895)	(196,835)	143
Net Income (Change in Financial Position)	**180,468**	**(506,953)**	**(322,849)**	**(1,218,870)**	**9,041,331**	**7,291,804**	**764,746**	**(1,117,262)**	**(4,561,299)**	**8,687,524**	**4,048,396**	**1,882,008**	**5,326,045**	**4,639,128**
Operating Income	(42,761)	(784,885)	(404,286)	(1,310,424)	(614,934)	(1,825,078)	691,628	(1,739,052)	(4,825,134)	(2,721,493)	(7,732,077)	2,430,680	5,516,762	5,010,584
EBIDA	589,632	(143,375)	197,779	(809,707)	9,404,909	7,678,588	1,173,910	(753,684)	(3,296,981)	12,465,879	8,220,801	1,927,594	4,470,891	4,245,078
Net Profit Margin	1.7%	-5.4%	-3.4%	-16.5%	98.6%	99.0%	7.0%	-12.3%	-80.7%	10.5%	5.1%	19.2%	87.7%	5.3%
Operating Margin	-0.4%	-8.4%	-4.3%	-17.8%	-6.7%	-24.8%	6.3%	-19.1%	-85.4%	-3.3%	-9.8%	25.4%	91.7%	6.5%
EBIDA Margin	5.6%	-1.5%	2.1%	-11.0%	102.5%	104.3%	10.7%	-8.3%	-58.3%	15.0%	10.4%	19.0%	69.0%	4.6%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	11/30/2023	12/31/2024	12/31/2023	1/31/2025	1/31/2024	2/29/2025	2/29/2024	3/31/2025	3/31/2024	PM Change	PY Change
Assets												
Current Assets												
Cash and Liquid Capital	18,718,414	9,784,681	9,262,111	9,536,326	16,381,395	8,555,307	17,437,514	8,770,199	17,262,770	12,778,438	(174,745)	4,484,332
Short Term Investments	6,418,451	8,158,191	6,873,880	10,810,616	7,420,527	10,332,998	7,419,400	6,335,363	7,253,236	6,336,695	(166,164)	916,540
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,924,674	20,460,545	18,106,671	20,452,310	21,232,772	20,997,993	17,511,087	19,458,681	18,641,177	12,458,272	1,130,090	6,182,906
Other Receivables	4,754,052	2,837,260	18,665,903	3,258,427	8,279,368	6,140,920	10,409,887	19,050,631	9,013,770	18,203,532	(1,396,116)	(9,189,762)
Inventory	6,103,723	5,211,962	6,141,928	5,159,051	6,129,163	5,161,688	6,125,219	5,158,222	7,049,031	5,162,663	923,813	1,886,368
Prepaid Expenses	1,119,559	2,269,168	852,094	1,773,403	1,483,581	1,707,730	810,066	1,276,680	1,195,648	1,744,260	385,582	(548,612)
Total Current Assets	**55,038,873**	**48,721,807**	**59,902,587**	**50,990,133**	**60,926,806**	**52,896,636**	**59,713,172**	**60,049,776**	**60,415,632**	**56,683,861**	**702,460**	**3,731,772**
Assets Limited as to Use												
Internally Designated for Capital Acquisitio	-		-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,467,786	1,466,910	1,468,545	1,467,036	1,468,673	1,467,164	1,468,789	1,467,283	1,468,917	1,467,411	128	1,506
Limited Use Assets				-		-		-		-	-	-
LAIF - DC Pension Board Restricted	-	828,417	-	175,992	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	15,684,846	10,346,490	15,684,846	13,882,457	15,684,846	3,535,967	(1,802,389)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisitio	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	10,919,587	14,478,344	10,919,587	13,825,919	10,919,587	16,257,943	10,919,587	16,257,943	14,455,554	16,257,943	3,535,967	(1,802,389)
Revenue Bonds Held by a Trustee	376,411	760,392	342,104	754,688	336,360	1,057,556	330,616	1,051,852	324,871	1,046,147	(5,744)	(721,275)
Total Assets Limited as to Use	**12,763,784**	**16,705,646**	**12,730,236**	**16,047,643**	**12,724,620**	**18,782,662**	**12,718,991**	**18,777,078**	**16,249,342**	**18,771,501**	**3,530,351**	**(2,522,159)**
Long Term Assets												
Long Term Investment	1,846,138	3,057,305	748,961	1,318,315	747,838	1,831,405	748,360	1,831,779	(597,117)	1,832,199	(1,345,477)	(2,429,316)
Fixed Assets, Net of Depreciation	84,474,743	77,109,988	83,235,289	76,904,399	83,392,600	85,031,471	83,017,839	85,151,277	82,893,099	84,393,675	(124,741)	(1,500,577)
Total Long Term Assets	**86,320,881**	**80,167,293**	**83,984,250**	**78,222,714**	**84,140,438**	**86,862,876**	**83,766,200**	**86,983,056**	**82,295,982**	**86,225,875**	**(1,470,218)**	**(3,929,893)**
Total Assets	**154,123,537**	**145,594,746**	**156,617,074**	**145,260,490**	**157,791,864**	**158,542,174**	**156,198,363**	**165,809,910**	**158,960,956**	**161,681,236**	**2,762,593**	**(2,720,280)**
Liabilities												
Current Liabilities												
Current Maturities of Long-Term Debt	4,146,183	676,353	4,616,414	1,339,056	4,601,872	11,675,726	4,586,959	11,105,240	4,248,938	3,907,233	(338,021)	341,705
Accounts Payable	5,010,089	5,370,018	4,496,145	6,383,025	4,559,038	4,881,333	4,086,194	4,346,694	3,592,092	5,131,234	(494,102)	(1,539,142)
Accrued Payroll and Related	6,224,657	8,534,376	2,073,837	6,924,804	2,929,795	6,556,620	2,991,863	7,226,154	3,268,949	7,439,170	277,086	(4,170,221)
Accrued Interest and Sales Tax	109,159	240,254	275,828	94,216	358,675	164,562	424,010	238,080	144,235	314,125	(279,775)	(169,890)
Notes Payable	446,860	1,633,708	446,860	1,633,708	446,860	1,532,689	446,860	1,035,689	446,860	931,738	-	(484,877)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	-	-
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	12,599,823	1,873,995	12,589,475	1,861,577	12,585,336	1,927,805	12,583,266	1,925,736	12,581,197	1,923,666	(2,070)	10,657,531
Total Current Liabilities	**29,225,475**	**19,017,409**	**25,187,264**	**18,925,091**	**26,170,281**	**27,427,440**	**25,807,857**	**26,566,297**	**24,970,976**	**20,335,871**	**(836,882)**	**4,635,105**
Long Term Liabilities												
Long Term Debt	36,301,355	31,715,530	33,927,979	30,380,530	33,830,169	28,565,060	33,732,107	29,290,060	33,749,977	35,863,988	17,870	(2,114,011)
Bond Premium	165,618	187,578	146,796	184,441	143,659	181,303	140,522	178,166	137,384	175,029	(3,137)	(37,645)
Accreted Interest	16,991,065	17,599,405	16,742,795	17,694,537	16,831,830	17,206,094	16,920,864	17,302,780	17,009,899	17,396,138	89,034	(386,239)
Other Non-Current Liability - Pension	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	-	(14,311,308)
Total Long Term Liabilities	**86,404,394**	**96,760,176**	**83,763,925**	**95,517,170**	**83,752,012**	**93,210,120**	**83,739,848**	**94,028,670**	**83,843,615**	**100,692,818**	**103,767**	**(16,849,203)**
Suspense Liabilities	-		-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	31,506	107,118	127,821	107,118	87,821	106,018	87,821	124,918	89,321	123,693	1,500	(34,372)
Total Liabilities	**115,661,375**	**115,884,703**	**109,079,010**	**114,549,379**	**110,010,114**	**120,743,579**	**109,635,526**	**120,719,885**	**108,903,912**	**121,152,382**	**(731,614)**	**(12,248,470)**
Fund Balance												
Fund Balance	31,992,031	26,459,404	37,108,338	26,459,404	37,171,429	35,013,048	37,171,271	35,013,046	39,900,722	35,013,047	2,729,451	4,887,675
Temporarily Restricted	1,467,786	2,610,841	1,468,545	2,610,967	1,468,673	1,467,163	1,468,789	1,467,283	1,468,799	1,467,411	10	1,388
Net Income	5,002,346	639,798	8,961,180	1,640,740	9,141,648	1,318,385	7,922,778	8,609,695	8,687,524	4,048,396	764,746	4,639,128
Total Fund Balance	**38,462,163**	**29,710,043**	**47,538,064**	**30,711,111**	**47,781,750**	**37,798,596**	**46,562,837**	**45,090,024**	**50,057,044**	**40,528,854**	**3,494,208**	**9,528,190**
Liabilities + Fund Balance	**154,123,537**	**145,594,746**	**156,617,074**	**145,260,490**	**157,791,864**	**158,542,174**	**156,198,363**	**165,809,909**	**158,960,956**	**161,681,236**	**2,762,593**	**(2,720,280)**
(Decline)/Gain		(3,937,458)	5,687,871	(334,256)	1,174,791	13,281,684	(1,593,501)	7,268,230	2,762,593	(4,128,674)	4,356,094	6,891,267

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2025

Calculation method agrees to SECOND and THIRD
SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ 8,687,524
+ Depreciation Expense	3,778,355
+ Interest Expense	1,805,092
Less GO Property Tax revenue	1,180,011
Less GO Interest Expense	367,460
"Income available for debt service"	**$ 12,723,499**
Denominator:	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	894,160
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,546,875
Total **Maximum Annual Debt Service**	**$ 2,553,735**
	1,915,302
Ratio: (numerator / denominator)	**6.64**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**Yes**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 24,516,006
Cash and Investments-non current	(597,117)
Sub-total	23,918,889
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 23,918,889**
Total Operating Expenses	$ 85,708,522
Less Depreciation	3,778,355
Net Expenses	81,930,167
Average Daily Operating Expense	$ 300,111
Days Cash on Hand	**80**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	83,028,758
Payments to Suppliers and Contractors	(35,776,978)
Payments to and on Behalf of Employees	(53,586,812)
Other Receipts and Payments, Net	8,798,774
Net Cash Provided (Used) by Operating Activities	2,463,742
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	62,250
Property Taxes Received	562,680
Other	1,742,691
Net Cash Provided (Used) by Noncapital Financing Activities	2,367,621
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,861,947)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,805,092)
Purchase and Construction of Capital Assets	(670,943)
Payments on Lease Liability	(629,795)
Payments on Subscription Liability	(422,964)
Property Taxes Received	(200,156)
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(5,590,897)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	418,830
Rental Income	60,755
Net Cash Provided (Used) by Investing Activities	479,585
NET CHANGE IN CASH AND CASH EQUIVALENTS	(279,950)
Cash and Cash Equivalents - Beginning of Year	25,136,864
CASH AND CASH EQUIVALENTS - END OF YEAR	24,856,914