Northern Inyo Healthcare District

Board Meeting

Board Meeting - April 15, 2026

Mission

* Strong Stewardship * Ethical Oversight *
*Eternal Local Access *

Vision Statement

To be an energized, high performing advocate for the communities we serve, our patients and our staff. The board governs with an eye on the future of health care and its effects on the District and patient care. The Board is committed to continuous evaluation, dedication to our mission, and improvements as a board.

Values

* Integrity * Innovate Vision * Stewardship * Teamwork *

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

April 15, 2026, 5:00 pm

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.

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)
https://us06web.zoom.us/s/86114057527
Webinar ID: 861 1405 7527
Passcode: 898843

PHONE CONNECTION:
(669) 444-9171
(719) 359-4580
Webinar ID: 861 1405 7527

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1. Call to order at 5:00 pm
2. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. 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 March 18, 2026, Regular Board Meeting
    b. Approval of minutes for March 31, 2026, Special Board Meeting
    c. Approval of Policies and Procedures

   i. Code Gray
   ii. Standards of Care in the Outpatient Infusion Unit
   iii. Use of Human Donor Breastmilk/Storage of Breastmilk
4. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
   a. Medical Staff Initial Appointments 2026-2027
   b. Medical Staff Proxy Appointments 2026-2027
5. Chief Executive Officer Report
   a. HPSA re-designation – Information Item
   b. City Council and Board of Supervisors updates in May – Information Item
   c. Wipfli Lean Event – Information Item
6. Finance Committee
   a. Capital Spending Update – Information Item
   b. GO Bond Update – Information Item
   c. ESEP Contract – Action Item
   d. Financial and Statistical Report – Action Item
7. Governance Committee
   a. Board Self-Assessment Action Plan Checklist – Action Item
   b. Joint Board Meeting Update – Information Item
   c. Advocacy Update – Information Item
      i. Legislative Affairs Lobbyist – Action Item
      ii. AB 2311 - Support Association of California Healthcare District – Action Item
      iii. AB 2665 - Support Tangipa – Action Item
   d. Mission and Vision– Action Item
8. General Information from Board Members

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9. Adjournment

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

Northern Inyo Healthcare District
One Team. One Goal. Your Health.

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

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

TO: NIHD Board of Directors
FROM: Samantha Jeppsen, MD, Chief of Medical Staff
DATE: April 7, 2026
RE: Medical Executive Committee Report

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

A. Medical Staff Initial Appointments 2026-2027 (*action item*)
    1. Samantha Wagner, MD (*obstetrics/gynecology*) – Active Staff
    2. Laura Kearsley, MD (*ophthalmology*) – Active Staff

B. Medical Staff Proxy Appointments 2026-2027 (*action item*)

    As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon the Distant-Site entity's credentialing and privileging decisions.

    1. Jesse Corry, MD (*neurology*) – Telemedicine Staff – Sevaro
    2. Taylor Haight, MD (*neurology*) – Telemedicine Staff – Sevaro

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Best-Baker called the meeting to order at 5:01 pm.
PRESENT	Melissa Best-Baker, Chair David Lent, Vice-Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. **Public Comment:** Community members expressed concern about the hospital's financial condition, questioning continued borrowing, spending, and the use of consultants without clear cost-cutting measures. Speakers emphasized the need for greater transparency, community engagement, and rebuilding public trust, including requests for a dedicated agenda item or open forum to address concerns. Additional comments highlighted operational challenges such as emergency services, facility planning constraints, and the limits of local resources, while acknowledging the importance of sustaining healthcare services in the community.
CONSENT AGENDA	**Public Comment:** None **Motion by Turner** to approve the consent agenda **2nd: Egan** **Pass: 5-0**
CONSIDERATION OF CREDENTIALING	**ACTIONS RECOMMENDED BY THE MEDICAL EXECUTIVE COMMITTEE** **Public Comment:** None **Motion by Egan** to approve Medical Staff initial Appointments 2026/2027 **2nd: Smith** **Pass: 5-0**
SCORE SURVEY	CEO Wallis reported an increase in the employee score survey response rate from approximately 52–54% last year to 66% this year, exceeding the 60% goal

and improving data reliability. The next steps include departmental debriefs, staff feedback collection, and leadership-driven action plans based on results.

Public Comment: None

Board Discussion:
Board members asked about accountability and follow-through, confirming that leadership teams present their action plans annually and report progress to ensure implementation.

ACHD BOARD OF DIRECTORS MEETING

CEO Wallis reported on recent engagement with HCAI leadership, highlighting discussions around rural healthcare collaboration, regional partnerships, and eligibility for the Rural Health Transformation Program. He noted that cross-state coordination with providers like Renown is supported, as long as funds are spent within California.

Public Comment: None

Board Discussion:
The board emphasized the importance of Eastern Sierra collaboration and confirmed that current regional strategies align well with state program goals and funding priorities.

COMPLIANCE REPORT

Compliance Officer Dickson presented a dashboard-style compliance report highlighting key metrics, including a slight increase in UORs compared to the prior year. She also introduced new low-cost compliance branding and posters aimed at reinforcing teamwork, patient trust, and organizational awareness.

Public Comment: None

Board Discussion:
Board members expressed appreciation for the report and suggested improving readability, particularly increasing the size of printed materials. Dickson noted the dashboard is still evolving and welcomed feedback for further refinement.

Motion by Smith to accept the Compliance Report
2nd: Lent
Pass: 5-0

QUALITY COMMITTEE

Community Health Needs Assessment (CHNA)
Ovation Health presented an overview of the CHNA process, a required three-year assessment incorporating public health data and nearly 400 community survey responses to identify local health priorities. Key findings included healthcare affordability, access to care, mental health, and senior services as top concerns, with an implementation plan organized into three focus areas: access to services, care coordination/disease management, and mental health. The report is being brought forward for board approval to finalize and publish as the hospital's official three-year plan.

Public Comment:
A question was raised regarding the survey sample size and whether outreach methods were sufficient to reach a broader portion of the community. CEO Wallis responded by outlining distribution efforts including online platforms, paper copies, media outreach, and regional coordination, while acknowledging typical participation limitations. Board Member Best-Baker added that the survey's timing during November may have reduced engagement and suggested aligning future surveys with public health timelines to improve response rates.

Board Discussion:
The board asked about the cost of the survey and whether it could be completed in-house; staff responded that the approximately $18,000 cost covered both hospitals and that a third-party is required to ensure objectivity and meet regulatory standards.

A technical question was raised regarding how population-based metrics (e.g., rates per 100,000) are calculated and applied to a smaller population like Inyo County. CEO Wallis provided context on how such metrics are normalized proportionally for smaller populations, and Ovation Health will review the report, and include additional explanation in the document to show how those figures are calculated.

Motion by Egan to accept the CHNA Report
2nd: Turner
Pass: 5-0

Quality Dashboard
Infection Prevention Manager Robin Christensen provided additional detail on quality dashboard metrics related to central line (CLABSI) and catheter-associated (CAUTI) infections, explaining the clinical definitions and surveillance criteria used for tracking. She reviewed benchmarking through national databases, noting that small patient volumes can significantly impact standardized infection ratios and comparisons. Christensen emphasized prevention strategies, including minimizing device use, daily necessity reviews, staff training, and monitoring protocols, reporting that the hospital has maintained zero infections in these categories.

Public Comment: None

Board Discussion:
Board members expressed appreciation for the presentation and acknowledged the strong infection prevention outcomes, including maintaining zero infections.

FINANCE COMMITTEE

Financial Strategy, short-term
CEO Wallis presented short-term financial strategies in response to recent financial challenges, including a $6 million revenue shortfall tied to IGT funding loss and resulting bond pressures. CEO Wallis emphasized that while

long-term strategic plans remain in place, the immediate focus is on stabilizing operations over the next 3–12 months through increased revenue and reduced expenses.

CEO Wallis outlined actions already underway, including improvements to revenue cycle management to increase reimbursement accuracy and speed, stabilization of labor costs through negotiated agreements, and restructuring of orthopedic services through a long-term partnership. CEO Wallis also described in-progress initiatives such as transitioning providers to productivity-based compensation models, improving patient throughput and scheduling efficiency, addressing space constraints, exploring inpatient dialysis services, and pursuing a women's health partnership with Mammoth Hospital.

Public Comment: None

Board Discussion:
The board discussed the hospital's current financial challenges and the need for immediate, data-driven actions to stabilize operations. Members emphasized balancing expense reductions with maintaining essential services, while also acknowledging the importance of workforce stability and community trust. Discussion reflected a shared understanding that difficult operational and financial decisions may be necessary to ensure long-term sustainability.

HealthTrust Contract
HealthTrust representative Lopez presented a workforce benchmarking process that analyzes staffing levels using worked hours per unit of service and compares them to peer hospitals to identify opportunities for efficiency. CEO Wallis noted that the organization has not previously conducted formal, data-driven benchmarking and that current staffing decisions are often reactive and department-specific. CEO Wallis emphasized the goal of using this process to establish system-wide benchmarks, ensure staff are working at the top of their license, and implement ongoing data-driven staffing management practices.

Public Comment: None

Board Discussion:
The board asked questions regarding current staffing practices, expected financial impact, and how workforce changes would be implemented. In response, CEO Wallis and HealthTrust representative Lopez explained that current staffing decisions are largely reactive and not based on system-wide data, and that the benchmarking process would provide a structured, data-driven approach to staffing across departments. They noted that similar engagements typically identify potential labor savings of approximately 8–12% and help determine appropriate staffing levels based on comparable hospitals.

Additional questions addressed how changes would affect employees and operations. Responses clarified that the process is collaborative and not prescriptive, with input from department leaders, and that any adjustments could include reassigning staff, addressing vacancies, or improving role

alignment rather than immediate reductions. Leadership also emphasized that implementation would be phased and tailored to the organization, balancing financial sustainability with workforce stability and the challenges of staffing in a rural environment.

Motion by Lent to approve the HealthTrust Contract
2nd: Egan
Pass: 4-1
Oppose: Smith

Tele-nephrology Contract
Dr. Hawkins presented a proposal to establish an inpatient dialysis service using tele-nephrology, addressing a major regional gap in care across a 400-mile corridor with no local inpatient dialysis services. He explained that many patients are currently transferred or delay care, and that implementing a portable dialysis system with remote nephrologist support could improve access, quality, and patient outcomes. Financial projections estimate net revenue annually (before operating expenses) with minimal additional staffing, based on capturing a portion of existing patient demand.

Public Comment:
Public comment expressed support for the proposed inpatient dialysis program, particularly the benefit of keeping patients in the community and reducing the need for transfers to outside facilities. Comments highlighted the positive impact on patient access, continuity of care, and reduced travel burden for patients and families. Additional input reflected interest in the financial and operational aspects of the program, including potential equipment costs and implementation approaches.

Board Discussion:
The board asked questions regarding patient care settings, staffing, equipment, regulatory requirements, and overall program implementation. In response, Dr. Hawkins explained that dialysis would not require ICU-level care in all cases and could be performed in appropriate inpatient settings based on patient condition, with policies still under development. He further clarified that dialysis could be provided in standard patient rooms, supported by specially trained nursing staff, with care overseen by hospitalists and remote nephrologists available 24/7, including on-site support during implementation.

Additional questions addressed equipment, supplies, licensing, and program structure. Dr. Hawkins, CEO Wallis, and CNO/COO Partridge explained that the program would operate as an inpatient service without establishing a separately licensed dialysis unit, reducing regulatory requirements. They also confirmed that vendor partners would provide equipment, training, and ongoing operational support. Board members acknowledged the benefit of improving local access to care and reducing patient transfers.

Motion by Egan to approve the approval of the Professional Nephrology Services Agreement with TeleNeph, LLC and approval of the purchase of two

NextStage dialysis machines at an estimated total cost of $74,000
2nd: Smith
Pass: 5-0

Skilled Nursing Facility (SNF) Project
CEO Wallis provided an update on the skilled nursing facility partnership, noting a decision to move away from a previously proposed 15-year contract due to concerns about long-term financial obligations. He outlined a revised approach that includes conducting a financial feasibility study and engaging a consulting group to evaluate regulatory, licensing, and operational requirements. He explained that the proposed Distinct Part Nursing Facility (DPNF) model would allow a partnership with Bishop Care Center under the hospital's license, potentially increasing reimbursement rates and improving care coordination.

Public Comment:
Questions were raised regarding the structure of the proposed partnership with Bishop Care Center, including whether the hospital would assume ownership of the skilled nursing facility and how revenue would be managed. In response, CEO Wallis explained that the model would be a joint partnership under the Distinct Part Nursing Facility (DPNF) program, with the facility operating under the hospital's license, allowing increased reimbursement rates and shared financial benefit.

Board Discussion:
Questions addressed risks, licensing implications, and long-term commitments. CEO Wallis clarified that the revised approach prioritizes flexibility through shorter-term consulting engagements and phased evaluation, allowing the organization to assess feasibility while avoiding long-term contractual obligations.

Financial & Statistical Reports
CFO Mossman presented the financial and statistical reports, noting that January outperformed budget with net income of approximately $1.9 million, driven by payer mix and orthopedic volume. CFO Mossman also reported improved cash collections, a reduction in accounts receivable over 90 days, and an increase in days cash on hand.

Public Comment: None

Board Discussion: None

Motion by Smith to accept the financial and statistical report
2nd: Turner
Pass: 5-0

Public Comment, Constituent Complaint
CEO Wallis reported on a constituent complaint regarding an unexpected upfront cost for imaging services, explaining that the patient had been referred

in September but did not complete the appointment until January after deductible reset, and did not return follow-up calls from staff regarding pricing. CEO Wallis stated that while processes were followed, the organization will review customer service practices and improve upfront pricing communication tools.

Public Comment: None

Board Discussion: None

Fiscal Year 26/27 Budget
CEO Wallis provided an update on the FY 2026/2027 budget process, stating that the expense budget has been completed with department leaders who reviewed and adjusted departmental expenses, resulting in a position aligned with anticipated increases. He reported that the next phase will focus on development of the revenue budget, including projected growth and current initiatives, and confirmed the organization remains on track to present a completed budget to the board by May.

Public Comment: None

Board Discussion: None

GOVERNANCE COMMITTEE

Board Resolution, Consolidated Election
Board Clerk Reed presented a resolution to consolidate the hospital district election with the general election and authorize the Inyo County Elections Office to conduct the election. She noted that zones 1, 2, 3, and 5 will be open, with zones 1 and 2 serving two-year terms and zones 3 and 5 serving four-year terms, and that the candidate filing period is scheduled from July 13 through August 7.

Public Comment: None

Board Discussion: None

Motion by Smith to approve Board Resolution, Consolidated Election
2nd: Turner
Pass: 5-0

CSDA Site visit with legislators
CEO Wallis provided an update on the upcoming CSDA site visit with legislators, noting it as an opportunity to highlight the hospital's operations and challenges. Members of the Governance Committee will attend on behalf of the board, and will report back following the visit.

Public Comment: None

Board Discussion:

A board member suggested that Anna Scott from Health and Human Services be invited to participate in the visit.

Representative Tangipa, Bill for Financial Support
CEO Wallis provided an update regarding engagement with Representative Tangipa related to potential legislative support, noting ongoing discussions around a bill that could provide financial assistance to support hospital operations.

Public Comment: None

Board Discussion:
The board requested the bill number associated with the proposed legislation. The bill number was not immediately available during the meeting; subsequent review identified the bill as Assembly Bill 2665 (AB 2665)

Potential for Joint Meeting with Mammoth Board of Directors and SMHD Board of Directors, CEOs
CEO Wallis discussed the potential for a joint meeting between the Northern Inyo Board, Mammoth Hospital Board, and Southern Mono Health District Board and executive teams to align on strategy, policy direction, and opportunities for collaboration across organizations.

Public Comment: None

Board Discussion:
The board discussed the value of increased coordination and communication between organizations to support regional healthcare delivery and strategic alignment.

Motion by Turner to approve the potential joint board meeting
2nd: Smith
Pass: 5-0

Board Bylaws
CEO Wallis introduced the board bylaws update, explaining that revisions were needed to align current governance practices, committee structure, and operational processes with how the board is functioning. Board Clerk Reed requested the board approve the updates including the supplemental changes included in the board packet.

Public Comment: None

Board Discussion:
A board member expressed appreciation for the revisions to the Board Chair's role.

Motion by Lent to approve the Board Bylaws with changes
2nd: Egan

Pass: 5-0

GENERAL INFORMATION FROM BOARD MEMBERS

Board members acknowledged the passing of Joanne Hunt's husband and expressed condolences to the family.

Board members noted participation in employee appreciation activities and the opportunity to engage directly with staff.

The board noted the upcoming Foundation fundraiser, Bunco, to be held at the fairgrounds on April 23, with tickets available for purchase through board members or the Board Clerk.

Board members emphasized the importance of community engagement and stated that the board will work together to make difficult decisions in the best interest of the hospital, its patients, and the community.

ADJOURNMENT

Adjournment at 7:57 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Vice-Chair Lent called the meeting to order at 9:00 am.
PRESENT	David Lent, Vice-Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large Christian Wallis, Chief Executive Officer
ABSENT	Melissa Best-Baker, Chair
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Vice-Chair Lent reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. **Public Comment:** None
ROLES AND RESPONSIBILITIES	Consultant Jacob Green presented on governance structure and alignment, explaining that the board defines organizational direction while the CEO and staff are responsible for execution. He emphasized best practices, including acting only as a body in public meetings, maintaining clear boundaries with staff, and building alignment to support effective CEO evaluation and organizational success. **Public Comment:** None. **Board Discussion:** Board members discussed community trust, governance roles, and public perception of hospital services, with differing viewpoints on the extent of mistrust and factors influencing patient decisions. The discussion underscored the need for consistent communication, stability, and unified leadership.
VISION, MISSION, GOALS/OBJECTIVES, VALUES	Consultant Jacob Green presented a framework for aligning vision, mission, and organizational goals with the CEO performance evaluation process, emphasizing that clear priorities must be established before evaluating performance. He introduced a draft vision and mission statement, along with key goals focused on service delivery, staff development, community trust, and fiscal sustainability. **Public Comment:** None. **Board Discussion:** Board members discussed revisions to the draft vision and mission statements, including adding “compassionate” care, concerns about emphasizing community trust, and removing limiting language such as “within district

boundaries."

OVERVIEW OF THE CEO PERFORMANCE EVALUATION PROCESS	Consultant Jacob Green outlined a structured, five-step process for CEO performance evaluation, emphasizing that evaluations must be based on clearly defined and board-adopted goals, priorities, and measurable criteria. He highlighted a simplified evaluation approach using agreed-upon criteria, along with a supplemental "one-off" feedback document to capture individual board member input while maintaining alignment and fairness. **Public Comment:** None. **Board Discussion:** Board members expressed support for the simplified and structured evaluation process, noting it would be more effective and less burdensome than prior approaches. There was general agreement that aligning expectations in advance would improve clarity, fairness, and communication between the board and CEO.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Adjournment to closed session for: Public Employee Performance Evaluation pursuant to Government Code § 54957(b)(1) Chief Executive Officer: Christian Wallis
RETURN TO OPEN SESSION	There was no report from closed session.
ADJOURNMENT	Adjournment at 11:20 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Code Gray		
Owner: Interim CEO, COO, CNO		Department: Nursing Administration
Scope: District Wide		
Date Last Modified: 11/07/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors		Original Approval Date: 07/01/2018

PURPOSE:

To provide an expedient intervention response to situations involving individual(s) who display escalating, aggressive, hostile, violent, combative, or potentially dangerous behavior that exceed a workforce member's resources and require additional support to de-escalate.

POLICY:

1. Responders to a Code Gray will take responsibility and proactive measures for the safety and security of all individuals within the hospital building by effectively responding to an escalating event and minimizing the number of potential harm and injuries. Staff members outside of the hospital building, including outpatient clinics and Rehab, should immediately call 9-1-1 for assistance during an escalating event.
2. Code Gray response should be in accordance with the procedure defined in this policy.
3. A Code Gray should be initiated for situations involving patients, visitors and/or other individuals exhibiting escalating, unarmed, violent, aggressive, and/or combative behavior. Situations involving active shooters and weapon violence require different response strategies. Follow the facilities protocol for reporting and addressing other situations.
4. Workforce members who are assigned to respond to a Code Gray must have completed the training requirements in order to respond to the code. This code is not intended for all workforce members to respond.
5. This policy does not disallow any workforce member from contacting law enforcement. Any workforce member may seek assistance and intervention from law enforcement when an escalating and/or violent incident occurs.

DEFINITIONS:

Code Gray Team is a group of key individuals who are in-house or immediately available at the time of a Code Gray and can quickly respond to the situation within the hospital building, notify internal leaders and law enforcement if required, and mitigate further harm. The team in collaboration with the Workplace Violence Prevention Assessment Team (V-PAT) to follow-up after the incident has occurred, further investigate the problem, and to create strategies to mitigate, communicate and provide support when needed.

The Code Gray is intended for a situation in which a patient, visitor, or other individual on hospital premises behaving in an aggressive, violent, combative, and/or potentially dangerous manner towards themselves, a workforce member, or others and indicates a potential for escalating or is escalating beyond a workforce

member's resources. The Code responders use non-violent intervention strategies to defuse or regain control of a situation by using verbal de-escalation techniques or physical techniques that employ the least restrictive measure possible.

GUIDELINES:

Code Gray Team Responders and their responsibilities include:

1. House Supervisor
    a. Can act as the Team Leader
    b. Excuses excess personnel when there are an adequate number of responders
    c. Assures unit safety and order is maintained
    d. Responsible for ensuring an informal debriefing session is held immediately following the incident for the team members and others involved in the event.
2. Social Worker (if available)
    a. Can act as a Team Leader
    b. Supports the workforce member with de-escalation techniques
    c. Can assist with Post Incident Response for workforce members
3. Emergency Department Charge Nurse
    a. Supports the workforce member with de-escalation techniques
    b. Assures the safety and security of the unit
    c. Can act as the Team Leader
4. Security Personnel (if available)
    a. Takes immediate steps to assure safety of environment and workforce members
    b. Is positioned within close proximity to take immediate action, as necessary
    c. May assist with de-escalation
    d. Provides advice regarding need for involvement of Law Enforcement

During an intervention, there should be one and only one identified person talking to the individual. There should be an agreed-upon plan and assigned duties for workforce members before a restraint or escort is initiated. All response team members should know their role and duties.

Training Requirements:

1. Workforce Members assigned to respond to a Code Gray, will receive education and training annually.

PROCEDURE:

1. Escalating Behavior Levels for initiating the Code Gray:
    a. Threats and intimidation or refusing to follow instructions.
    b. Verbal or physical expressions of violence.
    c. Uncontrolled anger characterized by aggressive body postures and disposition.

2. Initiating the Code Gray:
    a. As an individual escalates past the workforce member's resources to de-escalate and/or their behavior escalates Code Gray will be called by a workforce member or designee, by dialing "71" and paging "Code Gray" to report to designated location.
    b. If an escalating situation arises outside of the hospital building, in outpatient clinics or Rehab, staff should immediately dial 9-1-1.

3. Workforce Member Responsibilities:

a. The primary care nurse or workforce member who encounters or is caring for the escalating individual, take the following steps:
    - Remain calm
    - Provide details of the incident to the Team Leader including:
        A. Brief history of the incident
        B. Medical status
        C. Events leading to the current situation
        D. What action has been taken
        E. What action is believed to be required of the team
    - Assist team as directed by the Team Leader.
    - Complete Workplace Violence Incident Report Form
b. If a "Code Gray" is initiated in your area, take the following steps:
    - If possible, remove all individuals in immediate danger to a safe area
    - Reduce noise producing equipment
    - Speak calmly
    - Remove any loose equipment that could be used as a weapon or cause injury
    - The workforce member with the most knowledge of the individual or the situation will remain with the individual and report information to the Team Leader.

4. Code Gray team responders responsibilities:
    a. Report to scene of incident as quickly as possible
    b. The Team Leader role is assumed by:
        - The first person on the scene, or
        - A team member with confidence and competence in handling crisis situations, or
        - A team member who has a rapport with the acting-out individual
    c. The Team Leader briefs the responders of the situation and coordinates the response and action plan.
        - Possible incident action plan (IAP) objectives may include:
            A. Utilize de-escalation techniques
            B. Prevent harm and injury to self and other workforce members
    d. If the situation cannot be resolved using the Code Gray Team, contact Law Enforcement for assistance, if they have not yet been contacted or responded to the situation.
    e. Report any injuries immediately to Team Leader and refer personnel to obtain medical treatment and follow the Injury and Illness Prevention Program.
    f. Assure area is safe and secure for personnel and other patients to return.
    g. The Team Leader or designee, completes and submits a UOR. All personnel resume their normal duties.

5. Post incident response:
    a. In the event of a patient, family member and/or workforce member injury or at the request of the Code Gray Team, a Root Cause Analysis (RCA) and/or After Action Review (AAR) will be conducted by the Risk Manager or designee.
    b. Employee Assistance Program, defusing, crisis management briefing, critical incident stress debriefing, and/or other workforce member assistance programs will be offered to workforce members involved in the response, as appropriate.

REFERENCES:

1. California Occupations Safety and Health Standards Board (2016). *Section 3342. Workplace Violence Prevention in Health care*. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/workplace-violence-prevention-in-health-care-15day.pdf
2. Kelley, E. "Reducing Violence in the Emergency Department: A Rapid Response Team Approach." *Journal of Emergency Nursing* 2014; 40.1: 60-4.
3. Techniques for Effective Aggression Management Workbook, HSS (2017).

RECORD RETENTION AND DESTRUCTION:

Records related to workplace violence will be maintained for a minimum of six (6) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Injury and Illness Prevention Program
2. Patient Restraints
3. Active Shooter

Supersedes: v.2 De-escalation Team

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Standards of Care in the Outpatient Infusion Unit		
Owner: Perioperative Manager	Department: Infusion – Standards of Care (S of C)	
Scope: Perioperative Unit		
Date Last Modified:	Last Review Date:	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 7/21/19	

POLICY STATEMENT:

1. The Outpatient Infusion Unit nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient needs, capabilities, and limitations; nursing diagnosis; planning; interventions; and evaluation of patient response.
2. The patient age-specific population served is:
   - Pediatric: 28 days of age to 13 years of age
   - Adult: 13 years of age to 65 years of age
   - Geriatric: > 65 years of age

PROCEDURE:

The Outpatient Infusion patient and/or family-caregiver can expect:

1. **THROUGHOUT THE STAY**
   a. To be treated in accordance with NIHD's policy entitled "Patients' Rights"
   b. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
   c. To have care delivered based on standards of practice for the diagnosis identified.

2. **PRIOR TO ADMISSION**
   A. The patient will be scheduled for the infusion or other Outpatient service (injection, transfusion, wound care, central line care, therapeutic phlebotomy) after the provider orders have been received, insurance authorization has been obtained, and the NIHD Pharmacy has verified that any needed medication is available.

3. **ON ADMISSION OR TRANSFER INTO THE DEPARTMENT:**
   A. To be greeted immediately upon arrival to the unit including:
      a. Introduction of nursing and ancillary staff
         i. Explanation of what to expect during the Outpatient stay
         ii. Expected timing of the procedure
      b. A clean patient cubicle with appropriate supplies and equipment and orientation to:
         i. Call light use and TV controls
         ii. Bathroom location
         iii. Equipment in use including IV pumps or wound care equipment
   B. Within 30 minutes of arrival the RN will assess the patient and initiate the procedure. As appropriate to diagnosis and MD/APP orders the following will be provided:
      a. Vital signs taken and recorded as well as height / weight if needed
      b. Physical assessment (skin, lungs, heart)

c. IV access obtained if needed for the procedure
d. Informed consent for an initial chemotherapy administration, any blood product administration and therapeutic phlebotomy reviewed / signed per policy
e. Review of post-procedure appointments or equipment if needed
f. Documentation of the care given will be completed in the Electronic Medical Record (EMR) and patient assessments will be used to formulate an ongoing plan of care which will be documented in the EMR

C. The nursing care of patients will be supervised by RNs adept in skills and knowledge of the outpatient procedures performed in the Infusion Unit.
   a. RN will review and initiate the procedure orders
   b. RN will initiate discharge planning at time of admission, to be readdressed throughout stay including:
      i. Patient goals for outpatient procedure
      ii. Referral to interdisciplinary team, including but not limited to: dietary, social services, physical therapy, speech therapy, and pharmacy as needed.
   c. The Outpatient Infusion RN's practice is guided by the Infusion Nurses Society, and the Oncology Nursing Society.
   d. The AHA ACLS protocol will be instituted when necessary for all Outpatient and Infusion patients, older than 13 years of age, and the AHA PALS protocol instituted when necessary for all patients younger than 13 years of age.
   a. Medication will be labeled and bar code scanned
   b. Aseptic technique will be implemented and maintained for central line care and IV access.
D. Universal Protocol will be followed.
E. The patient will be monitored throughout the procedure by an RN. Patients will receive nursing care based on an assessment of their needs.
F. Vital signs including Blood Pressure, Pulse, Respiratory rate and O2 saturation will be completed per policy. A temperature will be obtained on unit admission and as the condition / procedure dictates.
G. All completed assessments will be documented in the EHR in a timely manner
H. An intravenous infusion pump will be used on all patients receiving IV drugs.
I. In the event that the patient's status deteriorates, the Infusion RN will immediately notify the primary care physician or hospitalist.
   a. Abnormal or worsening critical signs specific to patient's baseline
   b. Abnormal or worsening lab values
   c. Significant change in Level of Consciousness (LOC)
   d. Significant or worsening change in physical assessment
   e. Significant change or imbalance in Input and Output (I&O)
   f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment
   g. Inability to control pain or obtain pain relief
   h. Any untoward occurrence/event occurring in the hospital
   i. Significant change in cardiac rhythm
J. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response Team initiation.
K. Care of the Infusion patient will be guided by the policies and procedures at Northern Inyo Healthcare District.
L. A FSBS may be performed by the RN if the patient is demonstrating signs or symptoms suspicious for hypo/hyperglycemia. The physician will be informed of all abnormal results.

M. Nursing staff will be responsible for knowledge of medication given and utilizing appropriate resources to gain that knowledge.
N. All sedation/analgesia will be given according to the Procedural Sedation guidelines.
O. To have pain assessed and managed in a systematic way to achieve optimal relief.
P. Environment assessment, to include maintenance of clean, quiet, and therapeutic atmosphere.
Q. To have safety measures identified specific to each patient including:
    a. Patient identification band in place; staff to use two patient identifiers (name and date of birth) for medications and procedures.
    b. 5 rights of medication administration practiced.
    c. Fall risk assessment completed at admission (pre-operatively) and discharge from hospital.
    d. Smoke-free environment
R. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.
S. Patients have the right to refuse care, treatment and services in accordance with the law and regulation
T. All Outpatient Procedure patients will be entered in the Outpatient Procedure logbook.

4. **ON TRANSFER WITHIN NIHD:**
    A. To have patient assessment completed by receiving RN.
    B. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
    C. To have patient/family updated on reason for transfer, location moved, and expected time of transfer.
    D. To be transferred with all belongings.

5. **ON DISCHARGE:**
    A. To have written discharge instructions provided to patient/family member by RN, including clarification of:
        a. Who to call for questions.
        b. Nature of medical condition and what symptoms to report to MD.
        c. Follow-up appointment, including outpatient diagnostic test and lab work orders.
        d. Medical equipment needed at home, including vendor to call for assistance.
    B. To be discharged with all belongings and medications.

REFERENCE(S):

1. American Nurses Association. (2010). Nursing Scope and Standards of Practice. Silver Spring, MD: Nursesbooks.org
2. CA Code of Regulations Div. 5, Title 22: 70211, 70213, 70215, 70217 (2018)
3. Journal of Infusion Nursing: Infusion Therapy Standards of Practice, 2016
4. ONS (Oncology Nursing Society) Chemotherapy and Biotherapy Guidelines Fourth Edition (2014)

CROSS REFERENCE HOSPITAL P&P:

1. Chemotherapy Administration and Precautions
2. Nursing Care of the Interventional Radiology Patient
3. Staffing Plan OP/PACU
4. Patients' Rights
5. Universal Protocol

Supersedes: v.1 Standards of Care in the Outpatient Infusion Unit

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Use of Human Donor Breastmilk/Storage of Breastmilk		
Owner: : Perinatal Manager	Department: : Perinatal	
Scope: Perinatal, Women's Clinic, Pediatric Clinic, MedSurg		
Date Last Modified:	Last Review Date:	Version:
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To support patients in providing exclusive breastmilk nutrition to their babies and to provide optimum nutrition for infants and neonates that require supplementation for medical indications

SUPPORTIVE DATA:

POLICY:
Human donor breastmilk (HDBM) will be provided, per provider order, to breastfed infants being cared for at NIHD or their affiliated clinic when short term supplementation is indicated.

PROCEDURE:
1. Human Donor Breastmilk will be obtained from a member bank of the Human Milk Bank Association of North America (HMBANA) which complies with the guidelines for the establishment and operation of a donor human milk bank.
2. Obtain an order/prescription for HDBM supplementation from the provider.
3. An informational handout discussing the risks and benefits will be provided to the parents/caregiver, and a consent will be signed prior to giving HDBM.
4. HDBM will be stored in designated breast milk freezers. The freezer temperatures will be set at -20 degrees Celsius/-4 degrees Fahrenheit or below and temperatures will be checked and logged daily. Freezer alarms will be set and monitored.
5. Thawed HDBM/pumped breastmilk will be refrigerated and used within 48 hours or discarded.
6. Prior to feeding, HDBM will be checked with second RN utilizing two patient identifiers and the lot number and expiration date will be documented in the EMR.
7. Receiving and Logging HDBM:
   Upon receipt of a shipment of HDBM the Perinatal Nurse or their designee will:
   a. Verify that dry ice is still present
   b. Insure milk is frozen and bottles are intact.
   c. Match the shipping receipt expirations dates and lot numbers. If there are discrepancies, notify the milk bank for instructions on discarding or returning the HDBM.
   d. Log each bottle in the designated HDBM log.
   e. Prior to feeding, the RN will record the following in the Human Donor Milk log: Date and time, RN initials, patient label, donor milk lot number and expiration date, and amount of milk dispensed to patient.
   f. The HDBM will be labeled with the patient sticker and the date and time the milk is thawed. The thawed milk will be refrigerated 4 hours after thawing and discarded 24 hours after thawing.

g. HDBM will be defrosted and warmed in a breast milk warmer prior to feeding. Individual liners are to be kept on the infant's crib in a clean bag. The warmer is to be cleaned with food grade wipes with each patient use.
h. Parent/guardian coming from the clinic will pay for the donor human milk at the registration desk.
i. Parent/guardian will pick up the HDBM on the Perinatal Unit and will provide a receipt of purchase and a prescription from a clinic provider.

REFERENCES:

1. Human Milk Banking Association of California (2024). HMBANA Standards for Donor Human Milk Banking: An Overview
2. Kilpatrick, S. J., Papile, L.-A., & Macones, G. A. (Eds.). (2017). Guidelines for perinatal care (8th ed.). American Academy of Pediatrics.

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: Not Set

Capital Purchases

Approved Budget	$ 2,000,000.00
Spent	$ 843,152.12
Remaining	$ 1,156,847.88

Completed

DESCRIPTION	Department	Category	Urgency	FINAL SPEND	Notes
Myosure	OR	Quality	2 - Emergent	$ 33,462	
Viper extractor (floor cleaner) cex410 nil 5000545	POM	End of Life	3 - Moderate	$ 2,833	
Drager TCB	OB	Safety	1 - Critical	$ 12,905	
Chemistry Analyzer	LAB	End of Life	2 - Emergent	$ 412,978	
APC UPS replacement (cooling)	IT&S	End of Life	2 - Emergent	$ 44,528	
Echo Table	Echo	Safety	1 - Critical	$ 16,579	
Echo	Echo	Financial Impact	2 - Emergent	$ 142,543	
Clinic Ultrasound	Clinic	End of Life	1 - Critical	$ 35,388	
Blood Bank Freezer	Lab	Contingency		$ 13,386	
Ortho Power Tool	OR	Contingency		$ 59,716	
Clock system (server)	IT&S	Contingency		$ 8,959	
Nitrous system	OB	Contingency		$ 8,003	
Omni	Pharmacy	Contingency		$ 8,993	
APC cooling system overage	IT&S	Contingency		$ 34,918	
Myosure cost overage	OR	Contingency		$ 7,962	
Medrano Roofing	Facilties	Contingency		$ -	Might be expenses (under $3k)
			Total	**$ 843,152**	

In Progress or Not Completed

DESCRIPTION	Department	Category	Urgency	ESTIMATE	Notes
Campus signage	POM	End of Life	3 - Moderate	$ 35,000	Partially completed - expensed not capital
Domestic cold water skid (HCAI project)	POM	End of Life	2 - Emergent	$ 225,000	Did in house - budget spent not needed - would like to apply to medical air replacement
Women's Clinic remodel	POM	Quality	2 - Emergent	$ 40,000	Ordered flooring $11k & installed - all else on hold
Berkeley D&C	OR	End of Life	2 - Emergent	$ 11,000	Trying to get ordered - rep not responding
Dura Fold Furniture	MS & ED & Front Lobby	End of Life	1 - Critical	$ 80,000	In progress - ordered $30k - ER lobby, front lobby, and med/surg
Vital Sign portable	MS	Safety	3 - Moderate	$ 4,100	
IR Room 1 replacement	DI	End of Life	3 - Moderate	$ 190,000	
Parking lot/handicap spot upgrades	POM	Safety	2 - Emergent	$ 30,000	Will roll to next year
Medical air compressor replacement (HCAI)	POM	End of Life	2 - Emergent	$ 234,500	Spent $55k already - will cost $450k - would like to use cold water skid
Accounting & Billing Office combo	Billing	Safety	4 - Low	$ 11,000	Done for $0 cost
Phone System (hardware)	IT&S	End of Life	2 - Emergent	$ 63,000	Set to go live 5/7 - phones are rental
Portable X-Ray	Radiology	End of Life	2 - Emergent	$ 135,000	
Contingency Balance				$ 98,248	
			Total	**$ 1,156,848**	
		Approved not needed		$ 354,000	Can be moved to Medical Air and Contingency

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

DATE: April 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: ESEP Contract

MEMORANDUM

Background

Eastern Sierra Emergency Physicians is a medical group that has been serving the Northern Inyo Healthcare District since 2010. Northern Inyo Healthcare District is presenting for Board consideration two related agreements with Eastern Sierra Emergency Physicians ("ESEP") which continues these physician services for three more years effective July 1, 2026:

> Professional Services Agreement for Hospitalist Medicine Clinic ("HMC") and Medication Assisted Treatment ("MAT") clinic services (the "PSA")
>
> Emergency Department and Hospitalist Coverage Agreement (the "Emergency Department and Hospitalist Agreement")

The agreements are intended to continue to establish ESEP as the physician group providing outpatient clinic services and hospital-based services, including emergency department coverage and inpatient hospitalist services, for a proposed three-year term through June 30, 2029.

Discussion

Professional Services Agreement (PSA)

Under the PSA, ESEP would provide physicians for outpatient clinic services, including HMC and MAT services.

The hospital system would be responsible for clinic operations, staffing, and billing, and would retain revenue generated from clinic services.

ESEP would be compensated on an hourly basis at rates of $215 per hour for HMC services and $238 per hour for MAT services, with total compensation dependent on the number of hours worked.

Emergency Department and Hospitalist Agreement

Under the Emergency Department and Hospitalist Agreement, ESEP would provide continuous emergency department and inpatient hospitalist coverage.

The hospital system would provide facilities, staffing, and billing services and would bill for professional services on behalf of ESEP and remit collections to ESEP.

The hospital system would pay ESEP an annual amount of approximately $6 million, which is intended to support required coverage and is reduced by professional fee collections, with reconciliation occurring on a regular basis.

Recommendation

It is recommended that the Board consider approval of both the Professional Services Agreement (PSA) and the Emergency Department and Hospitalist Agreement as part of a coordinated physician services arrangement with Eastern Sierra Emergency Physicians.

Approval of both agreements would establish ESEP as the physician group providing outpatient clinic services and hospital-based services, including emergency department and inpatient hospitalist coverage, under the proposed terms and financial structure described above.

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

DATE: April 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights February 2026

Financial Summary

1. **Net Income (Loss):** February's net income was $6.3M, which was $7.2M favorable to budget. This was due to $5M in supplemental income, including IGT, and a one-time credit of employer payroll taxes from the IRS. Additionally, a favorable payor mix, fewer write-offs, and higher volumes in several key areas increased our net revenue compared to budget by $2.9M.
2. **Operating Income (Loss):** February's operating income was $1.1M, favorable to budget by $2.1M, due to a favorable payor mix and higher volumes in several areas, including admissions, ER visits, and orthopedic surgeries.

Action Plan: Revenue has improved due to growth in orthopedic surgical cases and a better payor mix. We will continue to focus on service line strategies and operational efficiency projects.

Stats Summary

1. **Admits (excluding Nursery):** Admits were over budget by 15 due to three additional inpatient surgeries and higher ER volumes leading to more admissions.
2. **Inpatient Days (excluding Nursery):** Inpatient days were over budget by 48 days (+24%) due to higher admissions and a slightly higher length of stay (+6%).
3. **Average Daily Census:** Average daily census was over budget by 1.9 (+32%).
4. **Average Length of Stay (ALOS):** Length of stay was higher than budget by 0.2 days (+6%).
5. **Deliveries:** Deliveries were under budget by 4 (-27%).
6. **Surgical Procedures:** Total surgeries were under budget by 10 (-7%) due to Dr. Reid's retirement. However, orthopedic surgeries were over budget by 7 (+37%), and general surgeries were over budget by 18 (+29%).
7. **Emergency Department (ED) Visits:** ED visits were 51 over budget (+6%).
8. **Diagnostic Imaging (DI) Exams:** Exams were 151 over budget (+8%).
9. **Rehab Visits:** Visits were 232 over budget (+37%) due to increased orthopedic volume.
10. **Outpatient Infusion / Injections / Wound Care Visits:** These visits were 192 under budget (-28%).
11. **Observation Hours:** Observation hours were over budget by 449 (+39%) due to higher ED volumes.
12. **Rural Health Clinic (RHC) Visits:** RHC visits were 87 under budget (-3%) due to declines in primary care and behavioral health.
13. **Other Clinics:** Clinic visits were flat, with increases in orthopedics and specialty services offset by declines in surgery and virtual care.

Action Plan: Volumes were strong in most areas, driving higher gross revenue. We are working on projects to improve scheduling efficiency in both clinics and the operating room. We are also marketing the new orthopedics group, including outreach in Ridgecrest.

Revenue Summary

1. **Gross Revenue:** Gross revenue was $3.1M over budget due to an unbudgeted price increase and higher volumes across most areas of the hospital and clinics.

Action Plan: We will continue to improve scheduling efficiency and increase surgical volume.

Deductions Summary

1. **Deductions:** Deductions were higher than budget by $376K due to higher-than-budgeted revenue. Net revenue as a percentage of gross charges was 7% higher than budget due to a favorable payor mix (shifting from Medicaid to Medicare), fewer write-offs, and increased acute care activity (inpatient admits and orthopedic surgeries).

Action Plan: Net revenue as a percentage of gross revenue is now closer to both budget and prior year levels. As orthopedic volume improves, we anticipate this metric returning to baseline. We will continue to improve revenue cycle processes to reduce denials and coding issues.

Salaries

1. **Total Salaries:** Salaries were over budget by 11% due to unbudgeted raises and aggressive budget reductions.
2. **Average Hourly Rate:** The average hourly rate was 8% higher than budget due to unbudgeted raises.

Action Plan: We have signed a HealthTrust benchmarking contract to ensure appropriate staffing levels and skill mix across all areas of the hospital.

Benefits

1. **Total Benefits:** Benefits were over budget by $82K (6%) due to higher-than-budgeted medical, dental, and vision claims.
2. **Benefits % of Wages:** Benefits were 43% for February, which was 2% under budget.

Action Plan: We will continue working with our benefits broker to identify cost-saving opportunities while maintaining high-quality employee benefits.

Total Salaries, Wages, and Benefits (SWB)

1. **SWB / Adjusted Patient Day:** This metric was 20% higher than budget due to unbudgeted raises.
2. **SWB % of Total Expenses:** This was 49% without contract labor and 52% with contract labor. Our goal is 50% or less, which is the industry standard.

Contract Labor

1. **Contract Labor Expense:** Contract labor was under budget by $79K due to lower FTE usage.
2. **Contract Labor Rates:** Rates were 2% under budget.
3. **Contract Labor Full-Time Equivalents (FTEs):** Usage was 22% lower than budgeted.

Action Plan: We are improving employee retention and reducing reliance on contract labor.

Other Expenses

1. **Physician Expense / Adjusted Patient Day:** Physician expenses were 15% over budget due to unbudgeted contract increases; however, this has contributed to increased surgeries and improved net revenue.
2. **Other Professional Fees:** These were 7% over budget due to higher billing and collection fees. However, AR days and write-offs have decreased, improving cash flow. Net revenue as a percentage of gross charges has increased steadily over the past few months.
3. **Supplies:** Supplies were over budget by $94K due to higher orthopedic surgical volumes. We are working to reduce implant costs with support from MOI.
4. **Total Expenses:** Expenses were over budget by $774K (8%) due to higher depreciation, supply costs, physician fees, and unbudgeted raises.

Action Plan: Leaders are effectively managing their budgets. We will continue reviewing expenses to identify additional savings opportunities.

Cash Summary

1. **Days Cash on Hand:** Days cash on hand was 74, driven by receipt of our largest IGT payment. Our bond requirement is 75 days when profitable and 100 days when not profitable.
2. **Estimated Days Until Depletion (excluding supplements/IGT):** Cash is being depleted at a rate of $53K per day. At this rate, cash would be fully depleted in 411 days.
3. **Estimated Days Until Depletion (all cash sources):** Cash is being depleted at a rate of $23K per day. At this rate, we have approximately two years until full depletion. However, this includes one-time payments and supplements that are being reduced by the government.
4. **Unrestricted Cash:** The unrestricted cash balance is now $23.8M, which is $8.7M higher than last February.

Action Plan: The cash flow action team continues to reduce billing delays and improve collections. AR days have improved by 22 days since last February, accelerating cash inflow. Jorie AI billing has reduced write-offs by $568k compared to budget and $2.2M compared to last year. AR >90 days has reduced by $3.2M compared to last February.

Northern Inyo Healthcare District

February 2026 – 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)	6,301,475	(899,890)	7,201,365	(800%)	(1,218,870)	7,520,345	617%	4,957,636	6,289,099	(1,331,463)	21%	7,922,778	(2,965,142)	(37%)
Operating Income (Loss)	1,086,276	(1,043,092)	2,129,368	(204%)	(1,310,424)	2,396,700	183%	(9,391,885)	(5,917,086)	(3,474,798)	(59%)	(3,413,121)	(5,978,764)	175%
EBIDA (Loss)	6,944,209	(482,737)	7,426,945	(1,539%)	(809,707)	7,753,915	958%	8,607,286	9,626,330	(1,019,044)	11%	11,291,969	(2,684,683)	(24%)
IP Gross Revenue	5,180,099	3,355,879	1,824,220	54%	2,845,791	2,334,308	82%	30,790,523	29,203,392	1,587,132	5%	27,497,198	3,293,325	12%
OP Gross Revenue	14,213,119	13,070,432	1,142,687	9%	12,402,184	1,810,935	15%	115,524,015	115,230,421	293,594	0%	113,062,416	2,461,599	2%
Clinic Gross Revenue	1,856,889	1,706,899	149,990	9%	1,689,999	166,890	10%	15,763,247	14,104,307	1,658,939	12%	14,002,333	1,760,914	13%
Total Gross Revenue	**21,250,107**	**18,133,209**	**3,116,897**	**17%**	**16,937,974**	**4,312,133**	**25%**	**162,077,786**	**158,538,120**	**3,539,666**	**2%**	**154,561,947**	**7,515,839**	**5%**
Net Patient Revenue	**11,124,971**	**8,221,343**	**2,903,628**	**35%**	**7,369,517**	**3,755,454**	**51%**	**72,868,663**	**72,517,283**	**351,380**	**0%**	**72,000,344**	**868,319**	**1%**
Cash Net Revenue % of Gross	*52%*	*45%*	*7%*	*15%*	*44%*	*9%*	*20%*	*45%*	*46%*	*(1%)*	*(2%)*	*47%*	*(2%)*	*(3%)*
Admits (excl. Nursery)	76	61	15	25%	61	15	25%	558	586	(28)	(5%)	586	(28)	(5%)
IP Days	250	202	48	24%	202	48	24%	1,851	2,036	(185)	(9%)	2,036	(185)	(9%)
IP Days (excl. Nursery)	220	167	53	32%	167	53	32%	1,576	1,747	(172)	(10%)	1,747	(172)	(10%)
Average Daily Census	7.9	6.0	1.9	32%	6.0	1.9	32%	6.5	7.2	(0.7)	(10%)	7.2	(0.7)	(10%)
ALOS	2.9	2.7	0.2	6%	2.7	0.2	6%	2.8	3.0	(0.2)	(5%)	3.0	(0.2)	(5%)
Deliveries	11	15	(4)	(27%)	15	(4)	(27%)	135	146	(11)	(8%)	146	(11)	(8%)
OP Visits	3,692	3,640	52	1%	3,640	52	1%	31,901	30,950	951	3%	30,950	951	3%
Rural Health Clinic Visits	2,141	2,188	(47)	(2%)	2,188	(47)	(2%)	18,720	18,252	468	3%	18,252	468	3%
Rural Health Women Visits	561	479	82	17%	479	82	17%	4,320	4,106	214	5%	4,106	214	5%
Rural Health Behavioral Visits	93	215	(122)	(57%)	215	(122)	(57%)	929	1,575	(646)	(41%)	1,575	(646)	(41%)
Total RHC Visits	**2,795**	**2,882**	**(87)**	**(3%)**	**2,882**	**(87)**	**(3%)**	**23,969**	**23,933**	**36**	**0%**	**23,933**	**36**	**0%**
Bronco Clinic Visits	38	44	(6)	(14%)	44	(6)	(14%)	278	309	(31)	(10%)	309	(31)	(10%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	323	294	29	10%	294	29	10%	2,624	2,810	(186)	(7%)	2,810	(186)	(7%)
Pediatric Clinic Visits	584	584	-	-%	584	-	-%	4,624	4,817	(193)	(4%)	4,817	(193)	(4%)
Specialty Clinic Visits	549	498	51	10%	498	51	10%	5,254	4,292	962	22%	4,292	962	22%
Surgery Clinic Visits	146	168	(22)	(13%)	168	(22)	(13%)	1,093	1,269	(176)	(14%)	1,269	(176)	(14%)
Virtual Care Clinic Visits	13	61	(48)	(79%)	61	(48)	(79%)	309	467	(158)	(34%)	467	(158)	(34%)
Total NIA Clinic Visits	**1,653**	**1,649**	**4**	**0%**	**1,649**	**4**	**0%**	**14,182**	**13,964**	**218**	**2%**	**13,964**	**218**	**2%**
IP Surgeries	13	10	3	30%	10	3	30%	77	88	(11)	(13%)	88	(11)	(13%)
OP Surgeries	114	127	(13)	(10%)	127	(13)	(10%)	992	1,048	(56)	(5%)	1,048	(56)	(5%)
Total Surgeries	**127**	**137**	**(10)**	**(7%)**	**137**	**(10)**	**(7%)**	**1,069**	**1,136**	**(67)**	**(6%)**	**1,136**	**(67)**	**(6%)**
Cardiology	3	-	3	-%	-	3	100%	16	4	12	300%	4	12	300%
General	81	63	18	29%	63	18	29%	620	564	56	10%	564	56	10%
Gynecology & Obstetrics	7	12	(5)	(42%)	12	(5)	(42%)	83	93	(10)	(11%)	93	(10)	(11%)
Ophthalmology	-	34	(34)	(100%)	34	(34)	(100%)	68	188	(120)	(64%)	188	(120)	(64%)
Orthopedic	26	19	7	37%	19	7	37%	160	179	(19)	(11%)	179	(19)	(11%)
Pediatric	-	-	-	-%	-	-	-%	-	1	(1)	(100%)	1	(1)	(100%)
Plastics	1	-	1	-%	-	1	100%	2	1	1	100%	1	1	100%
Podiatry	-	-	-	-%	-	-	-%	3	4	(1)	(25%)	4	(1)	(25%)
Urology	9	9	-	-%	9	-	-%	117	100	17	17%	100	17	17%
Diagnostic Image Exams	2,070	1,919	151	8%	1,919	151	8%	17,549	16,734	815	5%	16,734	815	5%
Emergency Visits	838	787	51	6%	787	51	6%	6,772	6,812	(40)	(1%)	6,812	(40)	(1%)
ED Admits	52	36	16	44%	36	16	44%	346	352	(6)	(2%)	352	(6)	(2%)
ED Admits % of ED Visits	6%	5%	2%	36%	5%	2%	36%	5%	5%	0%	(1%)	5%	0%	(1%)
Rehab Visits	867	635	232	37%	635	232	37%	6,237	6,559	(322)	(5%)	6,559	(322)	(5%)
OP Infusion/Wound Care Visits	496	688	(192)	(28%)	688	(192)	(28%)	4,971	4,209	762	18%	4,209	762	18%
Observation Hours	1,605	1,156	449	39%	1,156	449	39%	9,588	12,473	(2,885)	(23%)	12,473	(2,885)	(23%)

Provided by: Chief Financial Officer
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** 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 (Patient Days)														
Blue Cross	19.3%	21.1%	(1.8%)	(8.4%)	21.1%	(1.8%)	(8.4%)	24.0%	24.0%	(0.1%)	(0.4%)	24.0%	(0.1%)	(0.4%)
Commercial	3.5%	9.5%	(6.1%)	(63.7%)	9.5%	(6.1%)	(63.7%)	6.2%	7.5%	(1.3%)	(17.6%)	7.5%	(1.3%)	(17.6%)
Medicaid	26.6%	30.4%	(3.8%)	(12.6%)	30.4%	(3.8%)	(12.6%)	22.8%	27.5%	(4.7%)	(17.0%)	27.5%	(4.7%)	(17.0%)
Medicare	50.2%	36.0%	14.2%	39.4%	36.0%	14.2%	39.4%	45.0%	38.5%	6.4%	16.7%	38.5%	6.4%	16.7%
Self-pay	0.4%	2.9%	(2.5%)	(86.2%)	2.9%	(2.5%)	(86.2%)	2.1%	1.9%	0.2%	9.1%	1.9%	0.2%	9.1%
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	-%	0.5%	(0.5%)	(100.0%)	0.5%	(0.5%)	(100.0%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.0%	(0.0%)	(100.0%)	0.0%	(0.0%)	(100.0%)
PAYOR MIX (Gross Revenue)														
Blue Cross	30.6%	24.5%	6.1%	24.8%	24.5%	6.1%	24.8%	28.3%	26.6%	1.8%	6.6%	26.6%	1.8%	6.6%
Commercial	6.7%	11.6%	(4.9%)	(42.4%)	11.6%	(4.9%)	(42.4%)	6.2%	7.1%	(0.9%)	(13.3%)	7.1%	(0.9%)	(13.3%)
Medicaid	16.1%	21.0%	(4.9%)	(23.4%)	21.0%	(4.9%)	(23.4%)	17.8%	19.7%	(1.9%)	(9.6%)	19.7%	(1.9%)	(9.6%)
Medicare	44.5%	40.1%	4.4%	11.0%	40.1%	4.4%	11.0%	44.8%	43.0%	1.9%	4.3%	43.0%	1.9%	4.3%
Self-pay	1.0%	1.6%	(0.6%)	(38.6%)	1.6%	(0.6%)	(38.6%)	1.9%	2.3%	(0.4%)	(19.3%)	2.3%	(0.4%)	(19.3%)
Worker's Comp	0.8%	1.0%	(0.2%)	(18.4%)	1.0%	(0.2%)	(18.4%)	0.8%	1.2%	(0.4%)	(31.5%)	1.2%	(0.4%)	(31.5%)
Other	0.3%	0.1%	0.2%	184.7%	0.1%	0.2%	184.7%	0.2%	0.2%	0.0%	17.7%	0.2%	0.0%	17.7%
DEDUCTIONS														
Contract Adjust	(9,511,723)	(8,980,922)	(530,801)	6%	(8,529,361)	(982,362)	12%	(83,105,513)	(77,941,576)	(5,163,938)	7%	(74,670,886)	(8,434,627)	11%
Bad Debt	(324,918)	(108,143)	(216,774)	200%	(194,637)	(130,280)	67%	(2,669,018)	(938,531)	(1,730,488)	184%	11,290	(2,680,308)	(23,741%)
Write-off	(288,495)	(660,615)	372,120	(56%)	(844,459)	555,964	(66%)	(3,434,591)	(5,733,197)	2,298,606	(40%)	(7,753,823)	4,319,232	(56%)
CENSUS														
Patient Days	220	167	53	32%	167	53	32%	1,576	1,747	(172)	(10%)	1,747	(172)	(10%)
Adjusted ADC	32	33	(1)	(3%)	33	(1)	(3%)	35	40	(6)	(14%)	40	(6)	(14%)
Adjusted Days	903	993	(90)	(9%)	993	(90)	(9%)	8,294	9,823	(1,529)	(16%)	9,823	(1,529)	(16%)
Employed FTE	374.4	365.2	9.3	3%	365.2	9.3	3%	374.4	367.5	6.9	2%	367.5	6.9	2%
Contract Labor FTE	19.4	24.9	(5.4)	(22%)	24.9	(5.4)	(22%)	19.4	25.4	(6.0)	(23%)	25.4	(6.0)	(23%)
Total Paid FTE	393.9	390.0	3.8	1%	390.0	3.8	1%	393.9	392.9	1.0	0%	392.9	1.0	0%
EPOB (Employee per Occupied Bed)	1.8	2.3	(0.5)	(23%)	2.3	(0.5)	(23%)	2.2	2.0	0.2	11%	2.0	0.2	11%
EPOC (Employee per Occupied Case)	0.4	0.4	0.0	5%	0.4	0.0	5%	0.0	0.0	0.0	17%	0.0	0.0	17%
Adjusted EPOB	7.3	13.9	(6.6)	(47%)	13.9	(6.6)	(47%)	11.4	11.0	0.5	4%	11.0	0.5	4%
Adjusted EPOC	1.8	2.5	(0.7)	(28%)	2.5	(0.7)	(28%)	0.2	0.2	0.0	10%	0.2	0.0	10%
SALARIES														
Per Adjust Bed Day	3,814	3,132	681	22%	2,854	960	34%	3,535	2,717	819	30%	2,599	936	36%
Total Salaries	3,442,161	3,109,178	332,983	11%	2,832,505	609,656	22%	29,321,977	26,684,043	2,637,934	10%	25,533,295	3,788,682	15%
Average Hourly Rate	57.46	53.22	4.24	8%	48.48	8.97	19%	56.40	52.29	4.11	8%	50.03	6.36	13%
Employed Paid FTEs	374.4	365.2	9.3	355.9	365.2	9.3	3%	374.4	367.5	6.9	2%	367.5	6.9	2%
BENEFITS														
Per Adjust Bed Day	1,650	1,418	232	16%	1,414	236	17%	1,343	1,228	115	9%	1,220	122	10%
Total Benefits	1,489,133	1,407,463	81,670	6%	1,403,544	85,590	6%	11,134,843	12,059,869	(925,026)	(8%)	11,987,780	(852,937)	(7%)
Benefits % of Wages	43%	45%	(2%)	(4%)	50%	-6%	(13%)	38%	45%	(7%)	(16%)	47%	(9%)	(19%)
Pension Expense	358,720	368,820	(10,100)	(3%)	376,804	(18,084)	(5%)	2,858,416	3,114,404	(255,988)	(8%)	3,181,726	(323,310)	(10%)
MDV Expense	878,842	706,461	172,381	24%	682,759	196,083	29%	5,746,261	6,131,071	(384,810)	(6%)	6,240,676	(494,415)	(8%)
Taxes, PTO accrued, Other	251,572	332,182	(80,610)	(24%)	343,981	(92,409)	(27%)	2,530,166	2,814,394	(284,228)	(10%)	2,565,378	(35,213)	(1%)
Salaries, Wages & Benefits	4,931,295	4,516,641	414,654	9%	4,236,048	695,246	16%	40,456,820	38,743,912	1,712,908	4%	37,521,075	2,935,745	8%
SWB/APD	5,463	4,550	913	20%	4,268	1,196	28%	4,878	3,944	934	24%	3,820	1,058	28%
SWB % of Total Expenses	49%	49%	0%	1%	49%	0%	1%	49%	49%	(0%)	(0%)	50%	(1%)	(1%)

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** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,980	2,670	310	12%	2,588	392	15%	2,782	2,253	529	23%	2,058	724	35%
Total Physician Fee	1,737,862	1,665,250	72,612	4%	1,524,202	213,660	14%	13,976,892	13,654,074	322,818	2%	12,383,875	1,593,017	13%
Total Contract Labor	256,756	335,595	(78,839)	(23%)	367,306	(110,550)	(30%)	2,748,009	3,210,701	(462,692)	(14%)	3,703,831	(955,822)	(26%)
Total Other Pro-Fees	695,236	649,389	45,846	7%	677,350	17,886	3%	6,350,401	5,269,583	1,080,818	21%	4,126,365	2,224,036	54%
Total Professional Fees	2,689,853	2,650,234	39,619	1%	2,568,858	120,996	5%	23,075,302	22,134,358	940,944	4%	20,214,071	2,861,231	14%
Contract AHR	82.57	84.35	(1.78)	(2%)	92.32	(9.75)	(11%)	101.82	91.07	10.76	12%	105.06	(3.23)	(3%)
Contract Paid FTEs	19.4	24.9	(5.4)	(22%)	24.9	(5.4)	(22%)	19.4	25.4	(6.0)	(23%)	25.4	(6.0)	(23%)
Physician Fee per Adjust Bed Day	1,925	1,678	248	15%	1,536	390	25%	1,685	1,390	295	21%	1,261	424	34%
PHARMACY														
Per Adjust Bed Day	373	411	(38)	(9%)	209	164	78%	394	360	34	9%	285	109	38%
Total Rx Expense	336,237	407,876	(71,639)	(18%)	207,210	129,027	62%	3,270,390	3,539,779	(269,389)	(8%)	2,801,894	468,497	17%
MEDICAL SUPPLIES														
Per Adjust Bed Day	625	402	224	56%	361	265	73%	498	353	145	41%	401	97	24%
Total Medical Supplies	564,437	398,630	165,807	42%	357,873	206,564	58%	4,130,599	3,464,606	665,992	19%	3,939,650	190,949	5%
EHR SYSTEM														
Per Adjust Bed Day	44	32	12	37%	33	12	36%	36	26	10	37%	28	8	29%
Total EHR Expense	39,971	32,115	7,857	24%	32,417	7,555	23%	298,087	256,918	41,168	16%	273,682	24,405	9%
OTHER EXPENSE														
Per Adjust Bed Day	924	848	76	9%	875	49	6%	890	708	181	26%	743	147	20%
Total Other	834,168	841,786	(7,618)	(1%)	868,371	(34,204)	(4%)	7,379,701	6,957,564	422,136	6%	7,293,903	85,797	1%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	712	420	292	69%	412	300	73%	440	340	100	30%	343	97	28%
Total Depreciation and Amortization	642,734	417,154	225,580	54%	409,164	233,570	57%	3,649,650	3,337,231	312,419	9%	3,369,191	280,459	8%
TOTAL EXPENSES	10,038,695	9,264,435	774,260	8%	8,679,941	1,358,754	16%	82,260,548	78,434,369	3,826,178	5%	75,413,465	6,847,082	9%
Per Adjust Bed Day	11,122	9,334	1,789	19%	8,745	2,377	27%	9,918	7,985	1,933	24%	7,677	2,241	29%
Per Calendar Day	358,525	330,873	27,652	8%	309,998	48,527	16%	338,521	322,775	15,746	5%	310,343	28,177	9%

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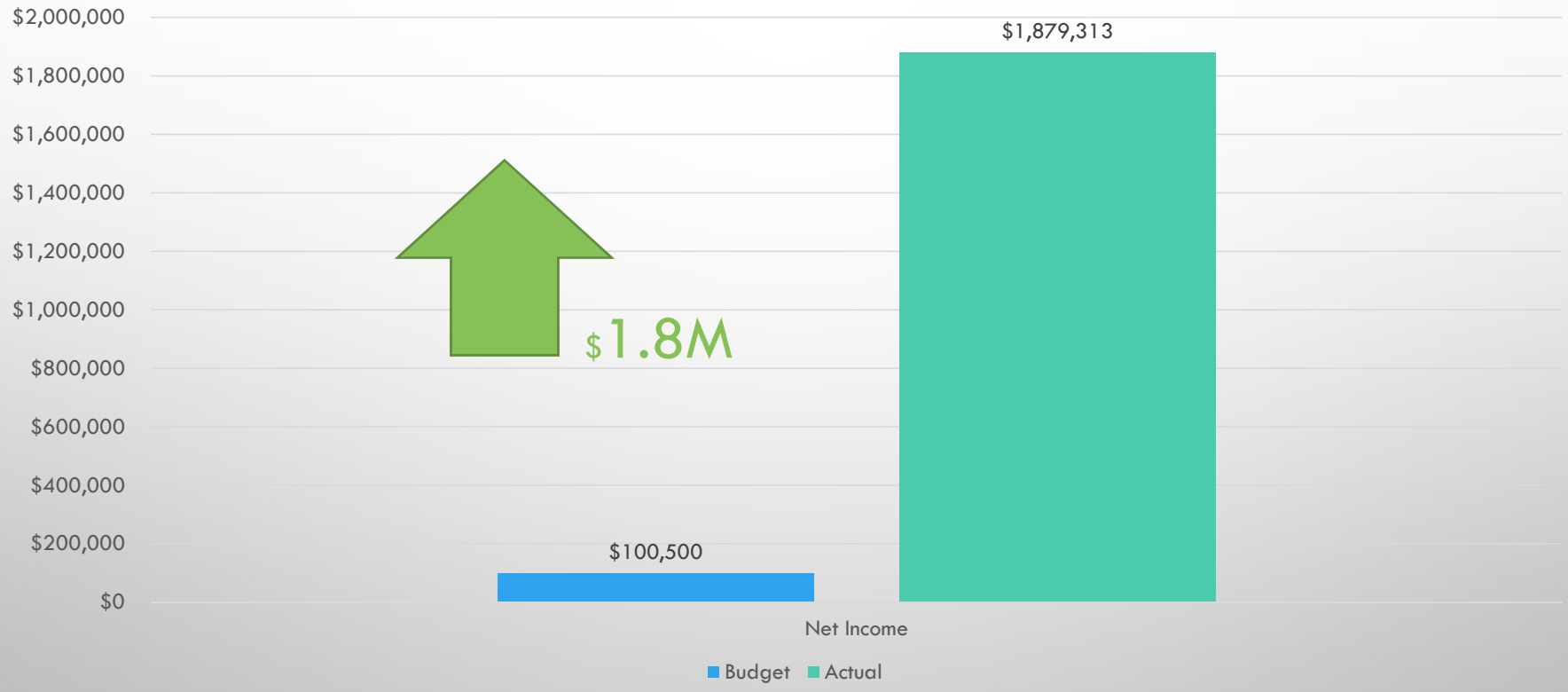
Key Financial Performance Indicators	Industry Benchmark	Feb-24	FYE 2024 Average	Feb-25	FYE 2025 Average	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Volume													
Admits	41	77	69	61	71	76	67	73	73	76	3	5	15
Deliveries	n/a	20	17	15	17	15	18	17	14	11	(3)	(6)	(4)
Adjusted Patient Days	n/a	942	977	969	1,125	1,161	880	1,022	1,317	903	(414)	(222)	(67)
Total Surgeries	153	133	146	137	140	147	112	131	115	127	12	(13)	(10)
ER Visits	659	753	826	787	852	819	726	886	876	838	(38)	(14)	51
RHC and Clinic Visits	n/a	4,246	4,607	4,531	4,772	5,154	4,384	4,976	5,001	4,448	(553)	(324)	(83)
Diagnostic Imaging Services	n/a	1,953	2,069	1,919	2,129	2,274	1,957	2,157	2,304	2,070	(234)	(59)	151
Rehab Services	n/a	690	662	635	838	764	769	703	796	867	71	29	232
AR & Income													
Gross AR (Cerner only)	n/a	$ 55,489,238	$ 52,823,707	$ 49,708,783	$ 50,813,697	$ 38,777,469	$ 37,941,078	$ 40,266,148	$ 42,782,472	$ 45,756,586	$ 2,974,114	$ (5,057,112)	$ (3,952,197)
AR > 90 Days	$ 6,599,901.18	$ 27,534,816	$ 23,112,391	$ 17,112,621	$ 20,669,422	$ 14,855,434	$ 14,887,324	$ 14,240,093	$ 13,540,953	$ 13,901,792	$ 360,839	$ (6,767,630)	$ (3,210,829)
AR % > 90 Days	15%	50.37%	44.2%	34.43%	40.6%	38.3%	39.2%	35.4%	31.7%	30.4%	-1.3%	-10.2%	-4.0%
Gross AR Days (per financial statements)	60	93	85	82	80	58	66	53	61	60	(0)	(20)	(22)
Net AR Days (per financial statements)	30	77	58	65	71	36	55	67	63	35	(28)	(36)	(30)
Net AR	n/a	$ 19,458,681	$ 16,938,200	$ 17,511,087	$ 19,370,868	$ 11,138,154	$ 13,862,975	$ 21,831,732	$ 21,330,628	$ 26,841,775	$ 5,511,147	$ 7,470,907	$ 9,330,687
Net AR % of Gross	n/a	35.1%	31.9%	35.2%	38.5%	28.7%	36.5%	54.2%	49.9%	58.7%	8.8%	20.2%	23.4%
Gross Patient Revenue/Calendar Day	n/a	$ 595,966	$ 619,457	$ 604,928	$ 634,418	$ 671,419	$ 571,795	$ 752,964	$ 707,068	$ 758,932	$ 51,865	$ 124,514	$ 154,005
Net Patient Revenue/Calendar Day	n/a	$ 253,914	$ 292,759	$ 263,197	$ 273,563	$ 308,780	$ 253,195	$ 324,041	$ 340,613	$ 397,320	$ 56,708	$ 123,757	$ 134,123
Net Patient Revenue/APD	n/a	$ 7,817	$ 8,757	$ 7,603	$ 8,088	$ 8,246	$ 8,631	$ 9,832	$ 8,018	$ 12,326	$ 4,307	$ 4,237	$ 4,723
Wages													
Wages	n/a	$ 2,944,019	$ 3,285,431	$ 2,832,505	$ 3,661,965	$ 3,694,416	$ 3,562,811	$ 4,037,755	$ 3,714,863	$ 3,442,161	$ (272,701)	$ (219,804)	$ 609,656
Employed paid FTEs	n/a	346.25	353.69	365.16	370.77	377.37	378.81	386.31	373.41	374.44	1.03	3.67	9.28
Employed Average Hourly Rate	$55.50	$ 51.31	$ 53.49	$ 48.61	$ 56.89	$ 55.42	$ 55.02	$ 59.17	$ 56.32	$ 57.61	$ 1.30	$ 0.72	$ 9.00
Benefits	n/a	$ 1,802,249	$ 1,640,216	$ 1,403,544	$ 1,401,858	$ 1,826,000	$ 1,547,641	$ 1,094,758	$ 997,381	$ 1,489,133	$ 491,752	$ 87,275	$ 85,590
Benefits % of Wages	30%	61.2%	48.8%	49.6%	39.8%	49.4%	43.4%	27.1%	26.8%	43.3%	16.4%	3.5%	-6.3%
Contract Labor	n/a	$ 429,743	$ 518,351	$ 367,306	$ 447,445	$ 358,976	$ 504,270	$ 131,351	$ 318,690	$ 256,756	$ (61,934)	$ (190,689)	$ (110,550)
Contract Labor Paid FTEs	n/a	23.86	23.49	24.87	23.89	19.09	19.88	18.89	18.71	19.44	0.73	(4.45)	(5.43)
Total Paid FTEs	n/a	370.11	377.18	390.02	394.65	396.46	398.69	405.19	392.12	393.87	1.75	(0.78)	3.85
Contract Labor Average Hourly Rate	$ 81.04	$ 108.69	$ 123.22	$ 92.57	$ 120.98	$ 106.43	$ 148.37	$ 39.36	$ 96.42	$ 82.79	$ (13.62)	$ (38.19)	$ (9.78)
Total Salaries, Wages, & Benefits	n/a	$ 5,176,011	$ 5,443,998	$ 4,603,354	$ 5,511,268	$ 5,879,392	$ 5,614,723	$ 5,263,863	$ 5,030,934	$ 5,188,050	$ 157,116	$ (323,218)	$ 584,696
SWB% of NR	50%	70.3%	62.1%	62.5%	72.0%	61.4%	73.9%	52.4%	47.6%	46.6%	-1.0%	-25.4%	-15.8%
SWB/APD	2,204	$ 5,495	$ 5,104	$ 4,749	$ 5,284	$ 5,065	$ 6,380	$ 5,152	$ 3,820	$ 5,748	$ 1,927	$ 464	$ 999
SWB % of total expenses	50%	56.3%	55.4%	53.0%	55.6%	52.5%	53.5%	50.2%	49.4%	51.7%	2.2%	-4.0%	-1.4%

Physician Spend	Industry Benchmark	Feb-24	FYE 2024 Average	Feb-25	FYE 2025 Average	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Physician Expenses	n/a	$ 1,524,202	$ 1,613,172	$ 1,378,852	$ 1,507,510	$ 1,932,281	$ 1,597,620	$ 1,946,664	$ 1,942,693	$ 1,737,862	$ (204,831)	$ 230,352	$ 359,010
Physician expenses/APD	n/a	$ 1,572	$ 1,565	$ 1,422	$ 1,476	$ 1,664	$ 1,815	$ 1,905	$ 1,475	$ 1,925	$ 450	$ 449	$ 503
Supplies													
Supply Expenses	n/a	$ 564,895	$ 832,644	$ 692,988	$ 776,504	$ 1,004,885	$ 835,043	$ 1,169,433	$ 995,550	$ 900,674	$ (94,876)	$ 124,170	$ 207,686
Supply expenses/APD		$ 583	$ 822	$ 715	$ 744	$ 866	$ 949	$ 1,145	$ 756	$ 998	$ 242	$ 254	$ 283
Other Expenses													
Other Expenses	n/a	$ 1,987,302	$ 1,939,040	$ 2,513,398	$ 1,824,207	$ 2,376,590	$ 2,440,391	$ 2,116,095	$ 2,204,650	$ 2,212,109	$ 7,459	$ 387,902	$ (301,289)
Other Expenses/APD	n/a	$ 2,050	$ 1,861	$ 2,593	$ 1,787	$ 2,047	$ 2,773	$ 2,071	$ 1,674	$ 2,451	$ 777	$ 664	$ (142)
Margin													
Net Income	n/a	$ (1,218,683)	$ 253,100	$ 7,291,804	$ 383,722	$ (1,132,695)	$ 3,176,018	$ (632,700)	$ 1,879,313	$ 6,301,475	$ 4,422,162	$ 5,917,753	$ (990,329)
Net Profit Margin	n/a	-16.5%	3.7%	99.0%	3.0%	-11.8%	41.8%	-6.3%	17.8%	56.6%	38.8%	53.7%	-42.4%
Operating Income	n/a	$ (1,310,237)	$ (1,557,761)	$ (1,825,078)	$ (686,444)	$ (1,620,972)	$ (2,891,928)	$ (450,779)	$ 385,170	$ 1,086,276	$ 701,105	$ 1,772,720	$ 2,911,354
Operating Margin	2.9%	-17.8%	-26.1%	-24.8%	-10.9%	-16.9%	-38.1%	-4.5%	3.6%	9.8%	6.1%	20.7%	34.6%
EBITDA	n/a	$ (809,519)	$ 676,999	$ 7,678,588	$ 841,891	$ (697,302)	$ 3,593,558	$ (197,022)	$ 2,303,607	$ 6,944,209	$ 4,640,602	$ 6,102,318	$ (734,379)
EBITDA Margin	12.7%	-11.0%	9.4%	104.3%	8.7%	-7.3%	47.3%	-2.0%	21.8%	62.4%	40.6%	53.7%	-41.9%
Debt Service Coverage Ratio	3.70	692.0%	3.9	6.3	3.3	(5.0)	(0.6)	(0.7)	0.4	4.7	4.3	1.4	(1.6)
Cash													
Avg Daily Disbursements (excl. IGT)	n/a	$ 413,756	$ 350,828	$ 390,998	$ 355,328	$ 416,814	$ 388,940	$ 380,372	$ 354,878	$ 388,193	$ 33,316	$ 32,865	$ (2,804)
Average Daily Cash Collections (excl. IGT)	n/a	$ 271,384	$ 340,919	$ 307,834	$ 299,110	$ 388,454	$ 278,666	$ 325,614	$ 289,881	$ 313,515	$ 23,633	$ 14,404	$ 5,681
Average Daily Net Cash		$ (142,373)	$ (9,908)	$ (83,164)	$ (56,218)	$ (28,360)	$ (110,274)	$ (54,758)	$ (64,996)	$ (74,679)	$ (9,682)	$ (18,461)	$ 8,485
Upfront Cash Collections		$ 83,209	$ 54,286	$ 20,936	$ 36,146	$ 77,539	$ 43,734	$ 42,688	$ 62,345	$ 67,508	$ 5,162	$ 31,362	$ 46,571
Upfront Cash % of Gross Charges	1%	0.5%	0.3%	0.1%	0.2%	0.4%	0.3%	0.2%	0.3%	0.3%	0.0%	0.1%	0.2%
Unrestricted Funds	n/a	$ 23,805,870	$ 23,774,285	$ 15,105,562	$ 23,536,438	$ 26,719,622	$ 21,356,431	$ 21,028,877	$ 23,124,630	$ 23,811,084	$ 686,454	$ 274,646	$ 8,705,522
Change of cash per balance sheet	n/a	$ 1,061,144	$ 321,485	$ (3,782,743)	$ (321,485)	$ 300,674	$ (5,363,191)	$ (327,554)	$ 2,095,753	$ 686,454	$ (1,409,299)	$ 1,007,939	$ 4,469,197
Days Cash on Hand (assume no more cash is collected)	196	86	73	48	72	84	66	65	72	74	2	2	26
Estimated Days Until Depleted (operating cash only)		332	2,399	254	406	671	396	389	416	411	(5)	5	157
Years Until Cash Depletion (operating cash only)		0.91	6.57	0.70	1.11	1.84	1.09	1.07	1.14	1.12	(0.01)	0.01	0.43

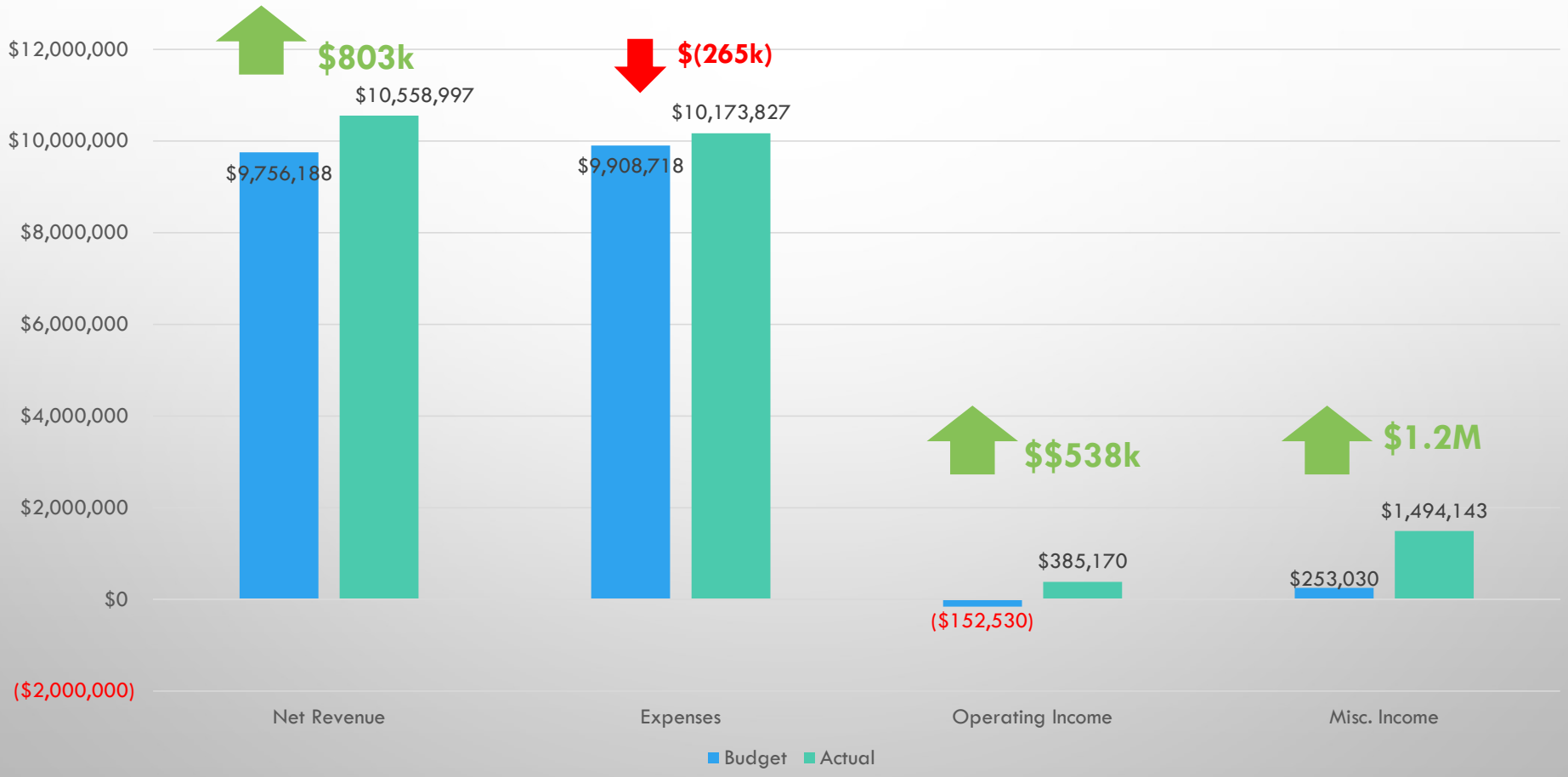
NIHD Financial Update
Chief Financial Officer
January 2026

VOLUME & INCOME

NET INCOME


$2,000,000
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
$1,879,313
$1.8M
$100,500
Net Income
Budget
Actual

INCOME TO BUDGET



VOLUME & INCOME ACTION PLAN

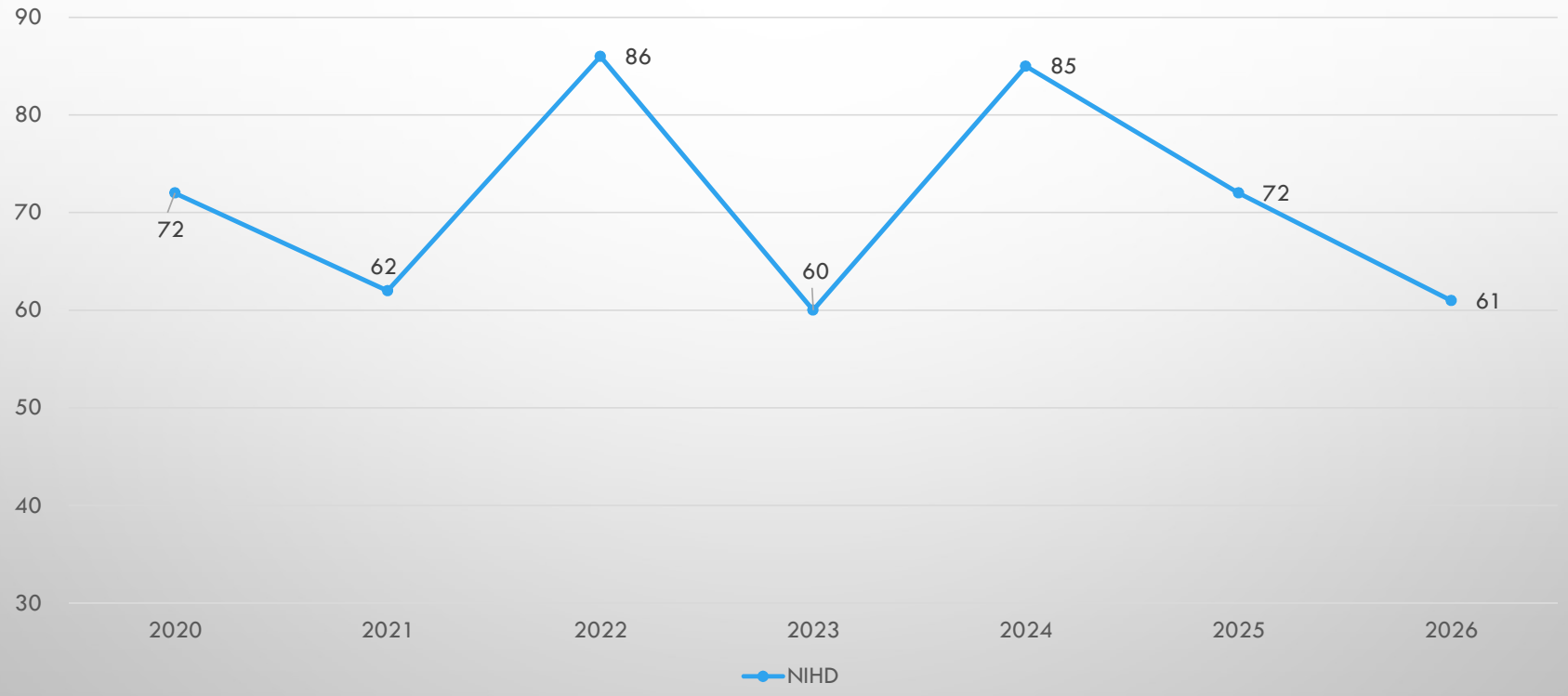
- THE MAMMOTH ORTHOPEDIC INSTITUTE BEGAN ORTHOPEDIC SURGERIES IN JULY. THEIR SURGICAL VOLUME HAS STEADILY INCREASED THE PAST FEW MONTH. ORTHOPEDICS SURGERIES WERE ABOVE BUDGET.
- WE ARE WORKING ON REVIEWING OPERATIONAL EFFICIENCY INCLUDING OR UTILIZATION AND SPACE UTILIZATION REVIEWS TO MAXIMIZE PATIENT FLOW AND CARE.
- WE ARE BEING MORE DELIBERATE IN OUR SERVICE LINE STRATEGY.
- ADDITIONALLY, WE ARE EDUCATING LEADERS TO BE THE “CEO OF THEIR OWN COST CENTER” AND MANAGE THEIR EXPENSES TO BUDGETS FYE 2026.
- WE HAVE DEVELOPED REPORTS TO MONITOR OUR LARGEST EXPENSE BETTER INCLUDING OVERTIME, MISSED MEAL AND REST BREAKS, AND CALL PAY TO ENSURE WE ARE STAFFING EFFECTIVELY. REPORTS WILL BE SENT TO LEADERS MONTHLY WITH ACCOUNTABILITY PLANS BEING PUT IN PLACE TO REDUCE PREMIUM PAY.

CASH PERFORMANCE

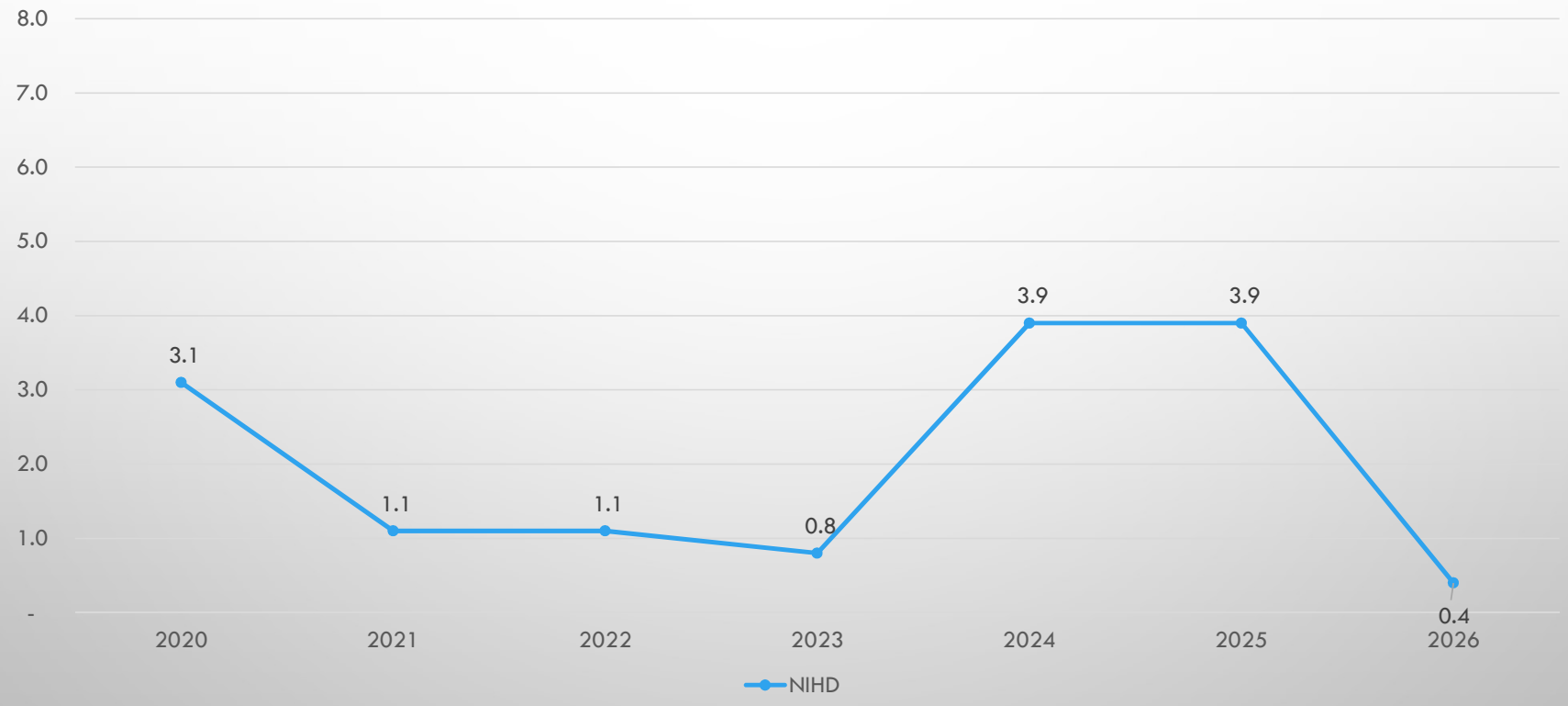
INCOME TO CASH

	FYE 2026
Net Income (loss)	**$(1,343,839)**
Principal Payments on Long-Term Debt (balance sheet only)	$(1,861,947)
Other Debt (long-term leases & subscriptions – balance sheet only)	$(563,846)
Capital purchases (balance sheet only)	$(568,351)
IGT Revenue Recognized but Cash Not Received (cash vs. accruals)	$(1,036,942)
Impact to Cash	**$(4,031,086)**
Adjusted Net Income (cash basis)	**$(5,374,925)**

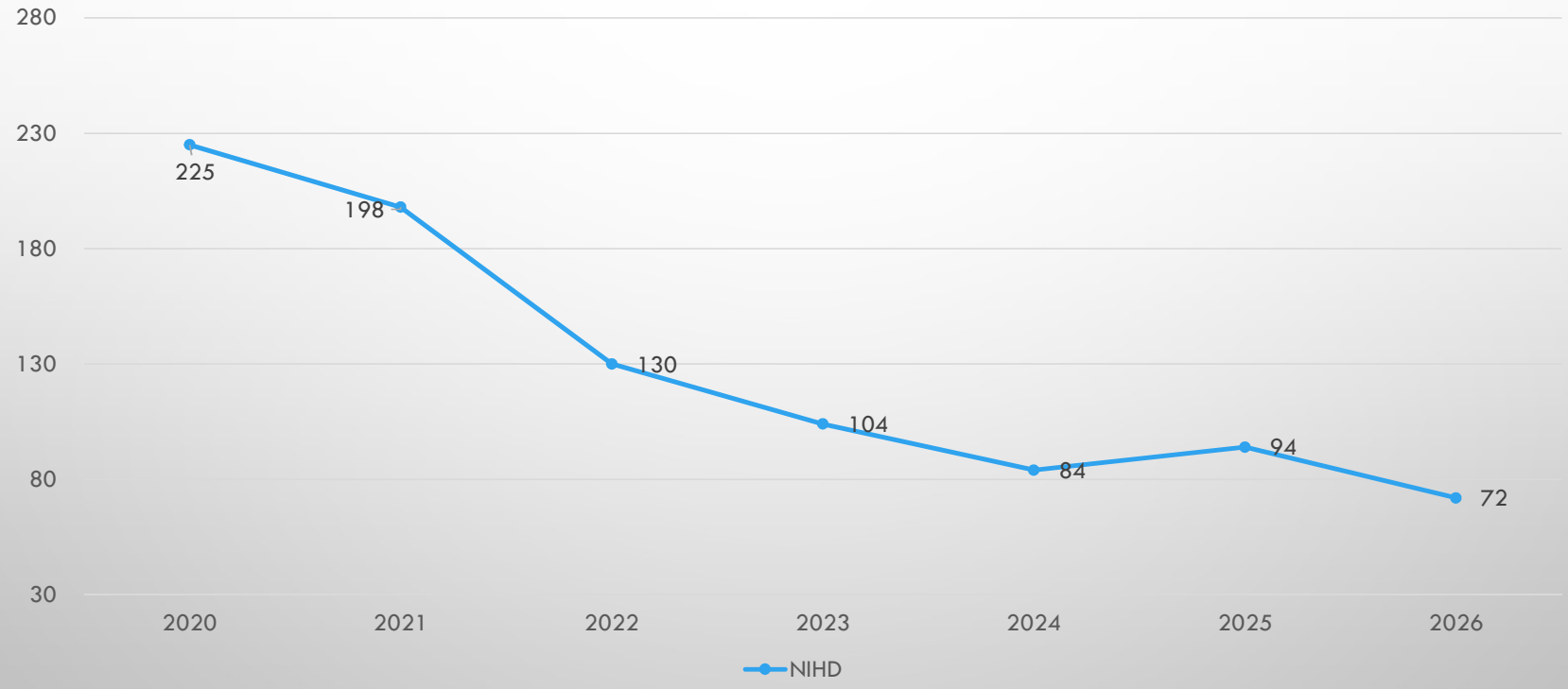
GROSS AR DAYS



DEBT SERVICE COVERAGE RATIO



DAYS CASH ON HAND



UNRESTRICTED FUNDS

CASH ACTION PLAN

- THE CASH FLOW ACTION TEAM IS WORKING TO IMPROVE PROCESSES IN ALL ASPECTS OF BILLING AND COLLECTIONS.
- WE HAVE HIRED A NEW AI-BASED BILLING COMPANY, JORIE, AND HAVE HIT RECORD CASH COLLECTIONS THE PAST FEW MONTHS. THE AUTOMATION IS NOW LIVE IN SEVERAL AREAS.
- WE HAVE MOVED $11M IN CASH TO FIVE STAR BANK TO EARN BETTER RETURNS ON OUR CASH.
- WE HAVE ANOTHER $5.5M IN THE LAIF EARNING 3.8% INTEREST.
- WE COLLECTED $220K MORE IN CY 2025 UPFRONT THAN WE DID IN EITHER CY 2023 OR CY 2024.
- AR DAYS ARE AT A RECORD LOW FOR THE ORGANIZATION.
- WE HAVE SWITCHED OUR MEDI-CAL BILLING TO JORIE AS OF DECEMBER TO IMPROVE COLLECTIONS EVEN FURTHER.
- WE HAVE RECEIVED A NET OF $900K FROM UNDERPAYMENTS ON CLAIMS

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2026

	12/31/2025	Dec Budget	12/31/2024	1/31/2026	Jan Budget	1/31/2025	2/28/2026	Feb Budget	2/28/2025	2026 YTD	Budget Variance	PYM Change
Gross Patient Service Revenue												
Inpatient Patient Revenue	4,837,635	3,265,690	2,658,147	3,998,937	3,720,076	3,280,133	5,180,099	3,355,879	2,845,791	30,790,523	1,824,220	2,334,308
Outpatient Revenue	16,353,865	14,301,930	12,983,214	15,795,037	15,129,676	14,664,711	14,213,119	13,070,432	12,402,184	115,524,015	1,142,687	1,810,935
Clinic Revenue	2,150,379	1,649,095	1,632,767	2,125,119	1,880,288	1,862,148	1,856,889	1,706,899	1,689,999	15,763,247	149,990	166,890
Gross Patient Service Revenue	23,341,878	19,216,715	17,274,128	21,919,093	20,730,040	19,806,992	21,250,107	18,133,209	16,937,974	162,077,786	3,116,897	4,312,133
Deductions from Revenue												
Contractual Adjustments	(11,815,242)	(9,943,164)	(8,575,086)	(11,166,102)	(9,943,164)	(8,951,555)	(9,511,723)	(8,980,922)	(8,529,361)	(83,105,513)	(530,801)	(982,362)
Bad Debt	(1,124,188)	(119,730)	(526,905)	117,631	(119,730)	1,386,194	(324,918)	(108,143)	(194,637)	(2,669,018)	(216,774)	(130,280)
A/R Writeoffs	(357,172)	(731,396)	(1,479,007)	(311,625)	(731,396)	(1,723,376)	(288,495)	(660,615)	(844,459)	(3,434,591)	372,120	555,964
Other Deductions from Revenue	-	(179,562)	-	-	(179,562)	-	-	(162,185)	-	-	162,185	-
Deductions from Revenue	(13,296,602)	(10,973,852)	(10,580,998)	(11,360,096)	(10,973,852)	(9,288,737)	(10,125,136)	(9,911,866)	(9,568,457)	(89,209,123)	(213,270)	(556,679)
Other Patient Revenue												
Incentive Income	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-	-	-	-	-	-	-
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	-	-	-	-	-	-	-	-	-
Net Patient Service Revenue	**10,045,276**	**8,242,864**	**6,693,130**	**10,558,997**	**9,756,188**	**10,518,255**	**11,124,971**	**8,221,343**	**7,369,517**	**72,868,663**	**2,903,628**	**3,755,454**
CNR%	**43.0%**	**42.9%**	**38.7%**	**48.2%**	**47.1%**	**53.1%**	**52.4%**	**45.3%**	**43.5%**	**45.0%**	**7.0%**	**8.8%**
Cost of Services - Direct												
Salaries and Wages	3,435,111	2,888,220	3,119,241	3,119,201	2,884,813	3,402,211	2,929,179	3,109,178	2,430,386	24,933,570	(179,999)	498,793
Benefits	933,385	1,288,785	1,445,404	846,729	1,285,519	1,412,693	1,351,414	1,407,463	1,184,125	9,520,391	(56,049)	167,289
Professional Fees	2,193,430	1,864,795	1,757,982	2,160,806	1,878,634	1,769,446	1,947,795	2,314,639	1,772,635	15,638,789	(366,844)	175,160
Contract Labor	84,298	270,699	366,331	210,212	238,645	373,323	216,406	335,595	377,408	2,099,109	(119,189)	(161,002)
Pharmacy	491,024	451,577	446,090	474,261	451,577	473,056	336,237	407,876	207,210	3,270,390	(71,639)	129,027
Medical Supplies	678,410	442,141	348,884	521,289	442,141	428,092	564,437	398,630	357,873	4,130,599	165,807	206,564
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	35,831	32,115	12,263	23,914	32,115	41,264	39,971	32,115	32,417	298,087	7,857	7,555
Other Direct Expenses	566,683	630,395	554,226	677,001	615,178	764,432	604,322	841,786	615,234	5,487,670	(237,464)	(10,911)
Total Cost of Services - Direct	8,418,171	7,868,725	8,050,420	8,033,412	7,828,621	8,664,517	7,989,762	8,847,281	6,977,287	65,378,605	(857,520)	1,012,474
General and Administrative Overhead												
Salaries and Wages	602,644	506,699	540,406	595,662	550,901	564,143	512,982	-	402,119	4,388,406	512,982	110,863
Benefits	161,373	222,818	233,464	150,653	228,724	261,366	137,719	-	219,418	1,614,452	137,719	(81,699)
Professional Fees	609,538	518,213	235,635	573,136	498,292	478,210	485,303	-	428,917	4,688,503	485,303	56,386
Contract Labor	47,053	151,097	306,137	108,478	123,151	(61,083)	40,350	-	(10,102)	648,900	40,350	50,452
Depreciation and Amortization	435,678	417,154	409,164	424,294	417,154	409,164	642,734	417,154	409,164	3,649,650	225,580	233,570
Other Administative Expenses	221,599	246,514	262,025	288,192	261,875	244,700	229,845	-	253,138	1,892,031	229,845	(23,292)
Total General and Administrative Overhead	2,077,884	2,062,494	1,986,831	2,140,415	2,080,097	1,896,500	2,048,934	417,154	1,702,654	16,881,943	1,631,780	346,280
Total Expenses	**10,496,055**	**9,931,219**	**10,037,251**	**10,173,827**	**9,908,718**	**10,561,017**	**10,038,695**	**9,264,435**	**8,679,941**	**82,260,548**	**774,260**	**1,358,754**
Financing Expense	174,430	196,180	201,339	171,708	196,180	205,348	164,468	196,180	195,369	1,421,278	(31,712)	(30,901)
Financing Income	260,000	181,031	181,031	1,393,000	181,031	181,031	(260,102)	78,984	78,984	2,692,898	(339,086)	(339,086)
Investment Income	347,664	47,322	45,165	102,405	47,322	46,487	67,568	47,322	37,373	799,658	20,245	30,195
Miscellaneous Income	(615,154)	9,215,471	9,187,671	170,446	220,857	201,059	5,572,201	213,075	170,566	12,278,242	5,359,126	5,401,635
Net Income (Change in Financial Position)	**(632,700)**	**7,559,289**	**5,868,407**	**1,879,313**	**100,500**	**180,468**	**6,301,475**	**(899,890)**	**(1,218,870)**	**4,957,636**	**7,201,365**	**7,520,345**
Operating Income	(450,779)	(1,688,355)	(3,344,121)	385,170	(152,530)	(42,761)	1,086,276	(1,043,092)	(1,310,424)	(9,391,885)	2,129,368	2,396,700
EBIDA	(197,022)	7,976,443	6,277,571	2,303,607	517,654	589,632	6,944,209	(482,737)	(809,707)	8,607,286	7,426,945	7,753,915
Net Profit Margin	-6.3%	91.7%	87.7%	17.8%	1.0%	1.7%	56.6%	-10.9%	-16.5%	6.8%	67.6%	18.3%
Operating Margin	-4.5%	-20.5%	-50.0%	3.6%	-1.6%	-0.4%	9.8%	-12.7%	-17.8%	-12.9%	22.5%	17.4%
EBIDA Margin	-2.0%	96.8%	93.8%	21.8%	5.3%	5.6%	62.4%	-5.9%	-11.0%	11.8%	68.3%	16.6%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2026

	PY Balances	12/31/2025	12/31/2024	1/31/2026	1/31/2025	2/28/2026	2/28/2025	PM Change	PY Change
Assets									
Current Assets									
Cash and Liquid Capital	20,757,956	14,510,441	9,262,111	16,796,957	16,381,395	17,484,375	17,437,514	687,418	46,860
Short Term Investments	7,741,599	6,021,285	6,873,880	6,069,608	7,420,527	6,076,527	7,419,400	6,919	(1,342,873)
PMA Partnership	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	16,645,748	21,831,732	18,106,671	21,330,628	21,232,772	26,841,775	17,511,087	5,511,147	9,330,687
Other Receivables	9,238,007	13,490,140	18,665,903	12,584,787	8,279,368	12,744,646	10,409,887	159,859	2,334,760
Inventory	5,334,241	5,368,712	6,141,928	5,345,822	6,129,163	5,343,895	6,125,219	(1,927)	(781,324)
Prepaid Expenses	1,106,127	1,500,971	852,094	1,904,391	1,483,581	1,892,288	810,066	(12,103)	1,082,222
Total Current Assets	**60,823,678**	**62,723,281**	**59,902,587**	**64,032,193**	**60,926,806**	**70,383,505**	**59,713,172**	**6,351,312**	**10,670,333**
Assets Limited as to Use									
Internally Designated for Capital Acquisitior	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,469,292	(711,423)	1,468,545	(711,295)	1,468,673	(711,179)	1,468,789	116	(2,179,968)
Limited Use Assets			-		-		-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	9,393,030	9,393,030	10,346,490	9,393,030	10,346,490	9,393,030	10,346,490	-	(953,460)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	9,966,127	9,966,127	10,919,587	9,966,127	10,919,587	9,966,127	10,919,587	-	(953,460)
Revenue Bonds Held by a Trustee	297,382	262,916	342,104	257,439	336,360	251,962	330,616	(5,477)	(78,654)
Total Assets Limited as to Use	**11,732,801**	**9,517,621**	**12,730,236**	**9,512,271**	**12,724,620**	**9,506,909**	**12,718,991**	**(5,362)**	**(3,212,082)**
Long Term Assets									
Long Term Investment	497,086	497,152	748,961	258,065	747,838	250,182	748,360	(7,883)	(498,178)
Fixed Assets, Net of Depreciation	81,644,252	80,152,672	83,368,289	79,823,636	83,497,234	79,236,372	83,122,430	(587,263)	(3,886,057)
Total Long Term Assets	**82,141,338**	**80,649,823**	**84,117,250**	**80,081,701**	**84,245,072**	**79,486,555**	**83,870,790**	**(595,146)**	**(4,384,235)**
Total Assets	**154,697,817**	**152,890,725**	**156,750,074**	**153,626,165**	**157,896,498**	**159,376,969**	**156,302,954**	**5,750,804**	**3,074,016**
Liabilities									
Current Liabilities									
Current Maturities of Long-Term Debt	3,599,764	3,734,182	4,616,414	3,735,906	4,601,872	3,827,808	4,586,959	91,902	(759,150)
Accounts Payable	4,413,297	4,804,574	4,496,145	6,329,466	4,559,038	5,397,508	4,086,194	(931,958)	1,311,314
Accrued Payroll and Related	3,525,333	4,825,174	2,073,837	4,441,717	2,929,795	4,726,435	2,991,863	284,717	1,734,572
Accrued Interest and Sales Tax	83,538	80,904	275,828	142,138	358,675	200,396	424,010	58,257	(223,615)
Notes Payable	339,892	339,892	446,860	339,892	446,860	339,892	446,860	-	(106,968)
Unearned Revenue	-	-	(4,542)	-	(4,542)	-	(4,542)	-	4,542
Due to 3rd Party Payors	3,324,903	4,331,882	693,247	4,331,882	693,247	4,331,882	693,247	-	3,638,635
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	8,758,790	8,746,372	12,589,475	8,744,302	12,585,336	8,742,233	12,583,266	(2,070)	(3,841,033)
Total Current Liabilities	**24,045,518**	**26,862,981**	**25,187,264**	**28,065,305**	**26,170,281**	**27,566,154**	**25,807,857**	**(499,151)**	**1,758,296**
Long Term Liabilities									
Long Term Debt	33,367,666	30,808,805	33,927,979	30,675,496	33,830,169	30,483,481	33,732,107	(192,015)	(3,248,626)
Bond Premium	127,973	109,151	146,796	106,014	143,659	102,877	140,522	(3,137)	(37,645)
Accreted Interest	17,272,679	16,877,539	16,742,795	16,961,927	16,831,830	17,046,315	16,920,864	84,388	125,450
Other Non-Current Liability - Pension	31,874,258	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	-	(1,072,097)
Total Long Term Liabilities	**82,642,576**	**79,669,753**	**83,763,925**	**79,617,695**	**83,752,012**	**79,506,931**	**83,739,848**	**(110,764)**	**(4,232,917)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	61,310	34,957	127,821	34,957	127,821	94,957	127,821	60,000	(32,864)
Total Liabilities	**106,749,404**	**106,567,691**	**109,079,010**	**107,717,956**	**110,050,114**	**107,168,041**	**109,675,526**	**(549,915)**	**(2,507,485)**
Fund Balance									
Fund Balance	40,722,935	48,076,134	37,241,338	45,781,867	37,236,063	45,780,996	37,235,861	(871)	8,545,135
Temporarily Restricted	1,469,292	1,470,052	1,468,545	1,470,180	1,468,673	1,470,296	1,468,789	116	1,507
Net Income	5,756,186	(3,223,152)	8,961,180	(1,343,839)	9,141,648	4,957,636	7,922,778	6,301,475	(2,965,142)
Total Fund Balance	**47,948,412**	**46,323,034**	**47,671,064**	**45,908,208**	**47,846,384**	**52,208,928**	**46,627,427**	**6,300,720**	**5,581,501**
Liabilities + Fund Balance	**154,697,817**	**152,890,725**	**156,750,074**	**153,626,165**	**157,896,498**	**159,376,969**	**156,302,954**	**5,750,804**	**3,074,016**
(Decline)/Gain		(37,742)	5,820,871	735,439	1,146,425	5,750,804	(1,593,545)	5,015,365	7,344,349

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2026

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	$ 4,957,636
+ Depreciation Expense	3,649,650
+ Interest Expense	1,421,278
Less GO Property Tax revenue	1,885,029
Less GO Interest Expense	308,461
"Income available for debt service"	**$ 7,835,074**
Denominator:	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	892,400
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,506,725
Total Maximum Annual Debt Service	**$ 2,511,825**
Ratio: (numerator / denominator)	**3.12**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**No**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 23,560,901
Cash and Investments-non current	250,182
Sub-total	23,811,084
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 23,811,084**
Total Operating Expenses	$ 82,260,548
Less Depreciation	3,649,650
Net Expenses	78,610,898
Average Daily Operating Expense	$ 323,502
Days Cash on Hand	**74**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2026

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	72,907,336
Payments to Suppliers and Contractors	(44,621,301)
Payments to and on Behalf of Employees	(43,204,829)
Other Receipts and Payments, Net	4,513,754
Net Cash Provided (Used) by Operating Activities	(10,405,042)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	5,872,458
Property Taxes Received	807,869
Net Cash Provided (Used) by Noncapital Financing Activities	6,680,327
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,942,891)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,421,278)
Purchase and Construction of Capital Assets	2,217,739
Payments on Lease Liability	(61,226)
Payments on Subscription Liability	(603,974)
Property Taxes Received	0
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(1,811,630)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	799,658
Rental Income	48,215
Net Cash Provided (Used) by Investing Activities	847,873
NET CHANGE IN CASH AND CASH EQUIVALENTS	(4,688,471)
Cash and Cash Equivalents - Beginning of Year	28,499,555
CASH AND CASH EQUIVALENTS - END OF YEAR	23,811,084

Board Self-Assessment Action Plan

August 2025 – Early Starts (Already in Progress)

Board Communication & Engagement Foundations

☒ CEO begins weekly updates (emails), urgent calls, and voice memos for non-urgent issues.

☒ Board Clerk clarifies process for Board members to request agenda items (Governance Committee discussion).

☒ COO coordinates hospital tours or rounding opportunities for Board members.

Governance & Strategic Direction

☒ Share Board self-assessment presentation slides with the Board.

☒ Governance Committee reviews Mission, Vision, and Values alongside the Strategic Plan.

☒ Document shared expectations for incoming CEO to guide hiring/onboarding.

☒ Board remains actively involved in finalizing CEO hiring process.

Community Engagement

☒ Marketing and Board Clerk draft public-facing calendar of community events.

☒ Board and CEO (with Marketing/Clerk) maintain and promote the community event calendar.

September 2025 – Foundations, Compliance & Meeting Conduct

Compliance & Meeting Rules

☒ Confirm Directors and Officers (D&O) liability coverage for executive staff.

☒ Legal Counsel conducts Brown Act training.

☒ Chair implements Robert's Rules of Order sequencing consistently at meetings.

☒ CEO informs staff that non-presenters attend Board meetings as members of the public only.

☒ Board sustains collaborative tone and incorporates individual member strengths into decision-making.

Governance Tools & Communication Protocols

☒ Governance Committee reviews and updates the Board's Code of Conduct.

☒ CEO and Executive Team develop vetting process for staff-generated agenda items.

☒ Board and CEO define the Board's role at community events.

Financial Oversight & Engagement

☒ Finance Committee continues monitoring financial turnaround progress (standing).

☒ Board participates in staff appreciation efforts (employees, providers, volunteers).

October 2025 – Strategic Direction & Partnerships

Governance & Culture

☒Board begins discussion on documenting/formalizing how Board diversity and member strengths support governance.

Strategic Planning

☒ Governance Committee meets to discuss long-term vision and service line strategy. Includes physician recruitment as part of service line strategy.

☒ Board explores partnership opportunities (Mammoth, Toiyabe, Southern Inyo, Valley Health).

☒ Board and CEO discuss Northern Inyo Healthcare District's (NIHD) role in restoring access in Northern Mono County (Bridgeport Clinic).

November 2025 – Engagement & Oversight

Community & Staff Engagement

☒ Foundation and Auxiliary begin presenting regular updates at Board meetings.

☒ Board and Foundation host a provider/community recognition event.

Workforce Development

☒ Executive Team updates Board on physician recruitment and workforce development initiatives.

Oversight & Infrastructure

☒ CEO and IT Team review IT infrastructure and report findings.

☒ Finance Committee reviews billing issues and reports to the Board.

December 2025 – CEO Evaluation & Closing the Loop

CEO Evaluation Process

☒ Board refines CEO evaluation process (format, frequency, 360-degree feedback).

Board Development

☒ Full Board revisits Board self-assessment themes to close the feedback loop.

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

DATE: April 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: Legislative Affairs Lobbyist

MEMORANDUM

Background

Each year, the California Legislature introduces a large number of bills that may affect healthcare providers, public hospital districts, and rural healthcare systems. These proposals may address healthcare funding, regulatory requirements, workforce issues, and public health policy. Legislative decisions at the state level can directly impact the District's operations and its ability to serve the community.

As part of ongoing efforts to strengthen the District's legislative engagement and advocacy efforts, staff has identified a potential partner. The proposed lobbyist specializes in representing healthcare organizations and has experience navigating state-level policy issues relevant to hospitals and specifically healthcare districts.

Discussion

Given the volume and complexity of legislation introduced each year, engaging a legislative affairs lobbyist would help the District proactively identify, analyze, and respond to legislative and regulatory developments.

Staff is exploring a partnership with a firm that could provide the following services:

- **Legislative Monitoring and Analysis**
    - Review approximately 2,000 bills and narrow to ~350 relevant to healthcare and special districts
    - Further refine to 20–30 bills with direct impact to NIHD
    - Track legislative progress and provide insight into the political landscape
- **Advocacy and Representation**
    - Draft letters of support or opposition
    - Communicate directly with legislators

  - Provide testimony or assist NIHD in preparing testimony for legislative committees

- **Budget and Funding Support**
  - Provide guidance on the state budget process and its development
  - Assist with identifying and pursuing funding opportunities, including grants, loans, and state budget requests (e.g., Rural Health Clinics)
- **Strategic Relationships and Access**
  - Facilitate connections with key state agencies and leadership, including HCAI (OHCA, RHTP), CDPH, and HHS
  - Coordinate meetings with legislators and support development of a communication strategy
- **Policy Engagement Support**
  - Draft comments and materials for NIHD participation in legislative and regulatory processes

These services would enhance the District's ability to stay informed, respond strategically to legislation, and pursue opportunities that support its operational and financial goals.

Recommendation

Staff recommends that the District consider engaging a qualified advocacy partner to provide legislative monitoring, analysis, and advocacy services at a cost of $4,000 per month for a 12-month term (total $48,000).

Given the firm's healthcare-specific focus and experience with similar healthcare districts, this engagement would support NIHD in navigating the legislative environment, advocating for District priorities, and identifying funding opportunities.

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

March 12, 2026

The Honorable Mia Bonta
Chair, Assembly Health Committee
1020 O St., Room 390
Sacramento, CA 95814

RE: Assembly Bill 2311 (Schiavo) Healthcare District: Employment — SUPPORT

Dear Assemblymember Bonta:

On behalf of the Northern Inyo Healthcare District, I write to express support for Assembly Bill 2311, which would allow district hospitals to directly employ physicians without interfering with the professional judgment of the physicians they hire.

Northern Inyo Healthcare District is a public healthcare district serving residents of Inyo County and surrounding Eastern Sierra communities. Through Northern Inyo Hospital and its network of outpatient clinics, the District provides essential emergency, primary, and specialty care services to a large rural region. As a community-owned district hospital, our mission is to ensure local residents have access to high-quality healthcare close to home.

The California Future Health Workforce Commission has found that California is projected to have a shortage of 4,100 primary care clinicians by 2030.[1] At the same time, the state has significantly expanded access to care through Medi-Cal, increasing the number of patients accessing all types of health care services. We applaud increased access to health care, but recognize that providers who serve the most vulnerable populations continue to struggle meeting the demand for care.

District hospitals serving rural communities and large numbers of Medi-Cal patients often face significant challenges in recruiting and retaining physicians. Many hospitals must rely on contracting arrangements rather than offering direct employment, which makes it harder to compete for physicians in today's workforce environment. For hospitals with higher levels of Medi-Cal coverage and uncompensated care, these limitations can make recruitment especially difficult.

Northern Inyo Healthcare District serves a patient population with a significant reliance on public coverage. Approximately 41% of our patients are covered by Medi-Cal, and in the most recent fiscal year, the District provided more than $6.7 million in uncompensated care, including charity care and bad debt. These financial realities make recruiting and retaining physicians particularly challenging for rural district hospitals that serve a high proportion of publicly insured patients.

AB 2311 is a modest approach to allow public district hospitals to effectively recruit and retain providers to their facilities, giving a small number of public hospitals a tool that has proven to be effective. California is one of only five states that still interprets the Ban on the Corporate Practice of Medicine Doctrine to include a prohibition on direct employment of physicians. However, the University of California and county hospitals have long enjoyed the ability to employ doctors as public providers regardless of their location.

The ability to employ physicians would allow district hospitals to attract specialty providers that otherwise may not reach our communities through physician groups, including OBGYNs, cardiologists, and behavioral health doctors. Employment

[1] https://futurehealthworkforce.org/wp-content/uploads/2025/10/FutureHealthWorkforceCommission_FinalReport.pdf

or similar models are extremely attractive to graduates coming out of residency or doctors who practice in other states. Allowing district hospitals the opportunity to offer set salaries, generous benefits, set schedules, and align with the model of 45 states will make serving in public settings more attractive.

Simply put, AB 2311 is about provider equity and will ensure California's underserved populations get quality and timely access to primary and specialty care. For these reasons, Northern Inyo Healthcare District is pleased to support AB 2311. Please don't hesitate to contact me at Christian.wallis@nih.org if I can be of additional assistance.

Sincerely,

Christian Wallis

Christian Wallis, CEO
Northern Inyo Healthcare District

cc: The Honorable Pilar Schiavo, Member, California State Assembly
Lara Flynn, Chief Consultant, Assembly Health Committee
Justin Boman, Consultant, Assembly Republican Caucus
All Legislative Members, California State Assembly

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

April 7, 2026

The Honorable Mia Bonta, Chair
Assembly Committee on Health
1021 O Street, Suite 3900
Sacramento, CA 95814

RE: AB 2665 (Tangipa) – SUPPORT

Dear Chair Bonta and Members of the Committee:

On behalf of Northern Inyo Healthcare District, I am pleased to express strong support for AB 2665 (Tangipa), which provides critical supplemental Medi-Cal funding to sustain hospital operations in a remote and medically underserved region of California.

Residents in our region rely on a limited number of hospital facilities to provide emergency, inpatient, and outpatient services across an expansive and geographically isolated area. Due to small population size, workforce challenges, and high operational costs, maintaining financially stable hospital services in rural communities is uniquely difficult. Existing supplemental funding mechanisms have not been sufficient to address these challenges, placing continued access to care at serious risk.

AB 2665 directly addresses this gap by appropriating $5.5 million in General Fund dollars for supplemental Medi-Cal payments to support hospital providers serving this region. These targeted investments are intended to stabilize operations and prevent potential service reductions or closures that would otherwise leave residents without timely access to care.

Without this support, patients could be forced to travel significant distances, often exceeding 100 miles, to reach the nearest hospital, delaying access to life-saving emergency care and increasing the likelihood of adverse health outcomes. Preserving local hospital access is essential not only for emergency response, but also for maintaining continuity of care, supporting local economies, and ensuring that vulnerable populations, including seniors, Medi-Cal beneficiaries, and low-income residents, are not disproportionately impacted.

Hospitals in rural communities serve as critical infrastructure. They are often among the largest employers in the region and provide essential services that extend far beyond traditional healthcare, including stabilization for patients requiring transfer to higher levels of care. As outlined in prior funding requests, these facilities have already taken significant steps to reduce

costs, including staffing reductions and service limitations, underscoring the urgency of state intervention.

AB 2665 recognizes the unique and urgent circumstances facing these providers and offers a targeted, practical solution to preserve access to care in one of California's most remote regions. By ensuring the continued operation of these hospitals, the bill helps protect the health and safety of entire communities that would otherwise face significant barriers to care.

For these reasons, we respectfully urge your AYE vote on AB 2665.

Sincerely,

Christian Wallis
Chief Executive Officer
Northern Inyo Healthcare District

Proposed Vision:

"Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, compassionate, comprehensive care in coordination with regional partners."

Mission Statement

A Mission Statement is a concise, actionable summary of an organization's fundamental purpose, defining why it exists, what it does, and/or who it serves.

“Northern Inyo Healthcare District provides health care services to improve the quality of life and health for all we serve.”

JACOB GREEN & ASSOCIATES