Northern Inyo Healthcare District

# Board Meeting

## Board Meeting - August 19, 2026

**Quality Committee**

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

**Mission**
Northern Inyo Healthcare District provides health care services to improve the quality of life and health for all we serve

**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.

# AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

August 19, 2026, 3:30 pm
Open Session scheduled to begin at 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 3:30 pm
2. Public comment on closed session items
3. Adjournment to closed session for:
    a. Conference Concerning Trade Secrets

       Pursuant to Health and Safety Code § 32106 and Civil Code § 3426.1

       Subject: Discussion of a new service line

       Estimated Date of Public Disclosure: August 2027
    b. Public Employee Performance Evaluation

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

       Chief Executive Officer: Christian Wallis
    c. Conference with Labor Negotiators

       Pursuant to Government Code Section 54957.6

       Agency designated representative: Board Chair

       Unrepresented employee: Chief Executive Officer

Open Session Scheduled to begin at 5:00 pm

4. Return to open session and report on any actions taken in closed session.
5. Pledge of Allegiance
6. 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.
7. 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 July 15, 2026 Regular Board Meeting
    b. Approval of minutes for August 5, 2026 Special Board Meeting
    c. Approval of Policies and Procedures
        i. Decorations, Receptacles, and Power Strips
        ii. Medical Staff Department Policy – Hospital Medicine
        iii. Medical Students in the OR
        iv. Mifeprex (Mifeprstone) Risk Evaluation and Mitigation Strategies (REMS) Program
        v. NIHD Antibiotic Stewardship Committee Charter
        vi. Pre and Post-Operative Anesthesia Visits
        vii. Scope of Anesthesia Practice
        viii. Standardized Procedure – Medical Screening Exam for the Obstetrical Patient
        ix. Telephone Triage in the Perinatal Department
8. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
    a. Medical Staff Initial Appointments 2026-2027
    b. Medical Staff Telemedicine Privileges 2026-2027 – Proxy Credentialing
    c. Additional Privileges
9. Extension of Temporary Privileges for Good Cause – Action Item
    a. 30-day extension of temporary clinical privileges for Megan Smith-Zagone, MD
10. Chief Executive Officer Report
    a. Renown Leadership on Rural Health Strategy – Information Item
11. Finance Committee
    a. NIH Foundation and Auxiliary Donation – Information Item
    b. RHTP (Rural Health Transformation Project) Update – Information Item

c. Service Line Update – Information Item
d. Radiology Request for Proposal – Information Item
e. Investment Report – Action Item
f. Financial and Statistical Report – Action Item

12. Governance Committee
    a. Advocacy Update – Action Item
    b. Joint Board Meeting – Information Item
    c. Board Request for Agenda Items
        i. Code of Conduct and Civility Policy – Action Item
    d. Consideration of Changing Regular Board Meetings from Evening to Daytime Hours – Action Item
13. Quality Committee
    a. Quality Dashboard – Information Item
    b. Security Screening Update – Information Item
14. General Information from Board Members
15. 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.*

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|---|---|
| CALL TO ORDER | Northern Inyo Healthcare District (NIHD) Board Vice-Chair Lent called the meeting to order at 3:30 pm. |
| PRESENT | Melissa Best-Baker, Chair<br>David Lent, Vice-Chair<br>Maggie Egan, Secretary<br>Laura Smith, Treasurer<br>Jean Turner, Member at Large<br><br>Adam Hawkins, Chief Medical Officer<br>Allison Partridge, Chief Operations Officer / Chief Nursing Officer<br>Alison Murray, Chief Human Resources Officer, Chief Business Development Officer<br>Andrea Mossman, Chief Financial Officer |
| ABSENT | Recused from closed session:<br>Melissa Best-Baker, Chair<br><br>Absent from closed session:<br>Laura Smith, Treasurer<br><br>Absent from entire meeting:<br>Christian Wallis, Chief Executive Officer |
| TELECONFERENCING | Notice has been posted, and a quorum participated from locations within the jurisdiction. |
| PUBLIC COMMENT ON CLOSED SESSION ITEMS | Vice-Chair Lent reported that at this time, audience members may speak only on closed session agenda items.<br><br>**Public Comment:** None |
| ADJOURN TO CLOSED SESSION | Adjourn to closed session at 3:30 pm. |
| RETURN TO OPEN SESSION | Return to open session at 4:20 pm. |
| BREAK | Break 4:20-5:00 pm. |
| REPORT OUT FROM CLOSED SESSION | Attorney Giragosian stated there was no reportable action. |
| 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.<br><br>**Public Comment:** None |
| CONSENT AGENDA | **Public Comment:** None |

**Board Discussion:** None

**Motion by** Lent to approve the consent agenda.
**2nd:** Turner
**Pass:** 5-0

**The following items were approved:**
Approval of minutes for June 17, 2026 Regular Board Meeting
California Public Records Act – Information Requests
Compliance Program for Northern Inyo Healthcare District
Governmental and Regulatory Agency Access Policy
Just Culture Policy
Language Access Services
Record Retention and Destruction Policy
Sanctions for Breach of Patient Privacy Policies
Service and Therapy Animals and Pets in District Buildings
Standardized Protocol – Minor Surgical Policy for the Physician Assistant

CONSIDERATION OF CREDENTIALING ACTIONS RECOMMENDED BY THE MEDICAL EXECUTIVE COMMITTEE

**Public Comment:** None

**Board Discussion: None**

**Motion by** Egan to approve the credentialing actions recommended by the Medical Executive Committee
**2nd:** Smith
**Pass:** 5-0

**The following credentials were approved:**
Medical Staff Initial Appointments 2026-2027 (*action item*)
Holly Wilbur, NP (*women's health nurse practitioner*) – Advanced Practice Provider Staff
David Sarver, MD (*diagnostic radiology*) - Telemedicine Staff (GTR)

MEDICAL STAFF OFFICERS 2026-2027

**Public Comment:** None

**Board Discussion:** None

**Motion by** Smith to approve the Medical Staff Officers for 2026-2027
**2nd:** Turner
**Pass:** 5-0

The Board approved the following Medical Staff Officers for July 1, 2026 through June 30, 2027.
Chief of Staff: Samantha Jeppsen, M.D.
Vice Chief of Staff: Anne Wakamiya, M.D.
Immediate Past Chief of Staff: Sierra Bourne, M.D.

Member-at-large: David Lichtenfeld, M.D.
Member-at-large: Chelsea Robinson, M.D.
Chief/Chair of Emergency Services: Samantha Jeppsen, M.D.
Chief/Chair Inpatient Medicine: James Tur, M.D.
Chief/Chair Outpatient Medicine: Anne Wakamiya, M.D.
Chief/Chair Radiology: Bradley Clark, M.D.
Chief of Obstetrics: Martha Kim, M.D.
Chief of Pediatrics: Lindsey Ricci, M.D.
Chief of Surgery: Connor Wiles, M.D.
Chief of Orthopedics: Brian Gilmer, M.D.
Chief of Anesthesia: Theodore Rasoumoff, M.D.
Chair of Peri-peds: Lindsey Ricci, M.D.
Chair of SITA: Theodore Rasoumoff, M.D.

MEDICAL STAFF BYLAW AMENDMENTS

**Public Comment:** None

**Board Discussion:**

**Motion by** Egan to approve the Medical Staff Bylaw amendments
**2nd:** Lent
**Pass:** 5-0

RESOLUTION 26-02 FINDING OF EXEMPTION FROM APPROPRIATIONS LIMIT

Best-Baker recused herself from consideration of this item. Vice Chair Lent presided over the discussion.

Consultant Scaglione presented Resolution 26-02, explaining that the District qualifies for an exemption from the Gann Appropriations Limit because its share of the one percent property tax was less than 12.5 percent in 1979. He reported that the District had continued submitting Gann limit calculations to Inyo County since 1995, resulting in property tax credits to taxpayers and corresponding withholdings from the District. He stated that the proposed resolution would discontinue the unnecessary calculations going forward and eliminate future tax withholdings.

**Public Comment:** None

**Board Discussion:**
The Board clarified that the proposed action applies prospectively and does not address recovery of previously withheld funds. Board members thanked Scaglione for identifying the issue and conducting the research supporting the recommendation.

**Motion by** Turner to approve Resolution 26-02
**2nd:** Smith
**Pass:** 4-0
**Recused:** Best-Baker

RESOLUTION 26-03 REQUESTING THE LEVY OF TAX ON THE TAXABLE PROPERTY OF THE DISTRICT TO BE COLLECTED ON THE TAX ROLLS OF THE COUNYT OF INYO FOR FISCAL YEAR 2026-27

Best-Baker recused herself from consideration of this item. Vice Chair Lent presided over the discussion.

Consultant Scaglione presented the proposed General Obligation (GO) Bond tax levy for fiscal year 2026–2027, providing an overview of the District's outstanding GO bonds, the statutory requirement to levy property taxes sufficient to meet debt service obligations, and the methodology used to evaluate tax rate options. He reviewed several scenarios designed to balance long-term financial stability with minimizing the impact on taxpayers, discussed reserve funding projections and underlying financial assumptions, and recommended adopting a stable tax rate of $74.05 per $100,000 of assessed valuation to fully fund reserves over a five-year period.

**Public Comment:** None

**Board Discussion:**

**Motion by** Smith to approve Resolution 26-03 using option 3
**2nd:** Egan
**Pass:** 4-0
**Recused:** Best-Baker

CHIEF OPERATION OFFICER / CHIEF NURSING OFFICER REPORT

**Capital Update**

CNO/COO Partridge reported that capital purchases had been prioritized and scheduled across all four fiscal quarters and that several first-quarter projects were underway, including procurement of an ultrasonic cleaner for Sterile Processing, evaluation of a new arthroscope set for surgical services, and initiation of asphalt repairs throughout the District campus. She also reported that planning had begun for the District's MRI replacement project, which will include installation of a temporary mobile MRI unit during construction. The new MRI system is expected to provide advanced imaging capabilities, improve patient comfort through reduced scan times, and increase appointment capacity.

**Public Comment:** None

**Board Discussion:** None

**Inpatient Dialysis**

CNO/COO Partridge reported that the contract for the District's inpatient dialysis program had been fully executed following resolution of legal and regulatory requirements. She stated that equipment procurement would be the next phase of the project and noted that the District anticipates receiving grant funding to offset a significant portion of the equipment costs. She emphasized that the inpatient dialysis program will complement, Toiyabe’s Renal Care outpatient dialysis services by allowing hospitalized patients to receive dialysis locally.

**Public Comment:** None

**Board Discussion:**
Board members expressed support for the program, recognizing its benefit to patients by providing inpatient dialysis services within the community and reducing the need for travel.

FINANCE COMMITTEE

**Strategic Growth Wipfli/WOLD Update**

CNO/COO Partridge reported that Wipfli/Wold continues to analyze healthcare utilization data received from HCAI, supplemented by patient utilization data provided by Renown Health, to identify service line expansion opportunities that best meet community needs. She stated that planning for the proposed medical office building is progressing, including refinement of preliminary cost estimates and financing considerations. She also reported that Wipfli/Wold assisted the District in developing a transitional plan to reconfigure the existing PMA building, increasing exam room capacity to support expanded specialty services while planning for the future medical office building

**Public Comment:** None

**Board Discussion:**
Board members requested a copy of the current draft PMA building layout, noting that multiple versions had been circulated within the community.

**RHTP (Rural Health Transformation Project)**

CNO/COO Partridge reported that the District is preparing applications for several upcoming grant opportunities, including an accelerator grant focused on recruitment and retention of maternal health providers. The proposed regional partnership includes Mammoth Hospital and Southern Inyo Hospital. She also reported that additional grant opportunities related to health information technology and electronic health record advancements are being pursued as funding opportunities become available.

**Public Comment:** None

**Board Discussion:** None

**Tele-nephrology Equipment Update**

CNO/COO Partridge reported that the District anticipates receiving grant funding to support the purchase of tele-nephrology equipment for the inpatient dialysis program. She stated that the funding would offset a significant portion of the equipment costs and support implementation of the new service.

**Public Comment:** None

**Board Discussion:** None

**Grant Update**
**Telemedicine Equipment (USDA)**

CNO/COO Partridge reported that the District is pursuing a USDA grant to assist with funding telemedicine equipment. She stated that the grant would support the District's efforts to expand access to specialty care through telemedicine services and help offset equipment costs

**Public Comment:** None

**Board Discussion:** None

**Financial and Statistical Report**
CFO Mossman reported favorable financial results, with net income exceeding budget due to strong orthopedic surgical volumes, a favorable payer mix, supplemental revenue, and higher-than-expected interest income. She noted that operating expenses exceeded budget primarily due to unbudgeted salary increases and higher service volumes, while the District continues to improve operational efficiency, strengthen physician recruitment, manage labor costs, and enhance revenue cycle performance. She also reported continued improvement in the District's financial position, including increased cash reserves, reduced accounts receivable days, compliance with bond covenants, and positive cash flow, while noting that the one-time Employee Retention Credit contributed significantly to year-to-date results.

**Public Comment:** None

**Board Discussion:**

**Motion by** Lent to accept the Financial and Statistical Report
**2nd:** Egan
**Pass: 5-0**

GOVERNANCE COMMITTEE

**Advocacy Update**
**Presentation:**
Legislative Advocate Madden provided an update on the 2026 legislative session, State budget, and priority healthcare legislation.

- **AB 1923** – Continues to advance and establishes loan forgiveness criteria for the Distressed Hospital Loan Program. Funding for the program was included in the State budget.
- **AB 2353** – Would have required fiscal impact analyses for new hospital mandates but is no longer moving forward following an agreement between the California Hospital Association and SEIU.
- **AB 2208** – Aligns California Medi-Cal law with H.R. 1 by addressing Medi-Cal copay requirements and maintaining retroactive eligibility provisions.

- **AB 1607** – Extends the Maddy Emergency Medical Services Fund to continue supporting reimbursement for uncompensated emergency care.
- **H.R. 8209** – Would establish a federal grant program to support school-based health centers.
- **SB 101** – Includes funding for the Distressed Hospital Loan Program and Distressed Hospital Grant Program and delays several proposed Medi-Cal program reductions.
- **SB 110** – Establishes a new Managed Care Organization (MCO) tax consistent with updated federal requirements. Madden reported the tax will not apply to the District's self-funded employee health plan.
- **SB 132** – Applies California sales tax to digital prewritten software beginning January 1, 2027. District staff are evaluating the potential financial impact.
- **AB 177** – Requires the Department of Finance to develop options for employer contributions toward Medi-Cal costs. Madden reported that any future funding structure would require additional legislative action.

**Public Comment:** None

**Board Discussion:**
Board members discussed the potential impact of the Fair Share from Big Corporations Act on Medi-Cal funding. Madden explained that any future revenue distribution methodology has not yet been established and would require additional legislative

**Media Policy**

**Public Comment:** None

**Board Discussion:** None

**Motion by** Egan to approve the Media Policy
**2nd:** Turner
**Pass:** 5-0

GENERAL INFORMATION FROM BOARD MEMBERS

Board members recognized the life and legacy of Judd Symons, acknowledging his decades of service to emergency medical services throughout the Eastern Sierra and his lasting impact on the community. Members reflected on his commitment to patient care, his leadership in developing local ambulance services, and his later work supporting air medical transport. Several members also noted the strong community attendance at his memorial service and recognized the District staff who attended in support of his family and legacy.

Director Smith reported attending a community meet-and-greet with Congressman Tom McClintock and noted that the small attendance provided an opportunity to discuss healthcare-related issues affecting the region.

Director Turner also reported participating in the Association of California Healthcare Districts Education Committee, which continues planning for the

upcoming annual conference. She noted that a proposed presentation on the District's General Obligation Bond work was not selected because it was considered unique to the District's circumstances.

ADJOURNMENT — Adjournment at 6:30 pm.

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Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

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|---|---|
| CALL TO ORDER | Northern Inyo Healthcare District (NIHD) Board Chair Best-Baker called the meeting to order at 11:30 am. |
| PRESENT | Melissa Best-Baker, Chair<br>David Lent, Vice-Chair<br>Maggie Egan, Secretary<br>Laura Smith, Treasurer<br>Jean Turner, Member at Large<br><br>Christian Wallis, Chief Executive Officer<br>Adam Hawkins, Chief Medical Officer<br>Allison Partridge, Chief Operations Officer / Chief Nursing Officer<br>Alison Murray, Chief Human Resources Officer, Chief Business Development Officer |
| ABSENT | Andrea Mossman, Chief Financial Officer |
| TELECONFERENCING | Notice has been posted, and a quorum participated from locations within the jurisdiction. |
| PUBLIC COMMENT ON CLOSED SESSION ITEMS | Chair Best-Baker reported that at this time, audience members may speak only on closed session agenda items.<br><br>**Public Comment:** None |
| ADJOURN TO CLOSED SESSION | Adjourn to closed session at 11:32 am. |
| RETURN TO OPEN SESSION | Return to open session at 12:30 pm. |
| REPORT OUT FROM CLOSED SESSION | The Board took the following actions:<br><br>**Legal Representation**<br>Motion by Egan to approve David Balfour as legal counsel in the Loy, M.D. v. Northern Inyo Hospital, et al. matter<br>2nd: Smith<br>Pass: 5-0<br><br>**Conflict Waiver**<br>Motion by Turner to waive the conflict and consent to David' Balfour's representation of all named defendants<br>2nd: Egan<br>Pass: 5-0 |
| ADJOURNMENT | Adjournment at 12:34 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: Decorations, Receptacles & Power Strips | | |
| Owner: Maintenance Manager | Department: Maintenance | |
| Scope: Districtwide | | |
| Date Last Modified: 02/02/2026 | Last Review Date: No Last Periodic Review Date Set | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

**PURPOSE:**
To establish guidelines and procedures for the safe use of decorations and electrical receptacles/power strips within Northern Inyo Healthcare District (NIHD), to reduce fire and electrical hazards and support compliance with applicable California regulations**,** NFPA codes, and Joint Commission safety expectations.

**POLICY:**
NIHD requires that decorations and electrical receptacles/power strips are selected, installed, and maintained in a manner that prevents ignition sources, limits combustible loading, protects egress, and reduces electrical shock/fire risk. Requirements are based on, at minimum, applicable portions of:

- **California Code of Regulations (CCR)**, including **Title 8 (Cal/OSHA)** and **Title 19 (State Fire Marshal)**
- **California Building Standards Code (Title 24)**, including the **California Electrical Code (CEC)** (as adopted/amended and effective)
- **NFPA 99** and **NFPA 101 (Life Safety Code)** (as adopted/required by CMS and accrediting bodies)
- **Joint Commission** Environment of Care / Life Safety expectations (as applicable to Critical Access Hospitals)

Where requirements conflict, the **more stringent** requirement applies, and the **Authority Having Jurisdiction (AHJ)** (e.g., local fire authority, State Fire Marshal, and/or HCAI as applicable) will govern.
**SCOPE:**

This policy applies to **all NIHD departments**, staff, volunteers, contractors, and vendors operating within the Critical Access Hospital and associated NIHD-controlled facilities.

**DEFINITIONS:**

1. **Decorations:** Temporary or permanent ornamental items, including seasonal décor, wall postings, and decorative vegetation/trees.
2. **Receptacles:** Fixed wall outlets and approved power distribution devices used to supply power to equipment.
3. **Relocatable Power Tap (RPT):** Common “power strip” type devices intended for temporary power distribution.
4. **Patient Care Vicinity:** The space within a patient care location extending **6 feet** beyond the normal location of the bed/chair/table/treadmill (and vertically to 7 ft 6 in), as referenced by NFPA 99 and reinforced in Joint Commission guidance.

**RESPONSIBILITIES:**

1. **Facilities/Maintenance Supervisor (or designee):**
   - Oversees implementation, performs/coordinates inspections, and enforces corrective actions.
   - Approves (or denies) non-routine decoration installations and any non-standard electrical distribution needs.
2. **Department Managers:** Ensure department compliance and promptly correct deficiencies.
3. **All Staff:** Follow requirements and report hazards or non-compliance immediately.

**TRAINING REQUIREMENTS:**

1. **Annual** training for applicable staff on **fire safety**, **means of egress protection**, and **electrical safety** related to decorations and power distribution.
2. Staff must understand reporting procedures for damaged cords, overheating odors, tripped breakers, sparks, or any unsafe conditions.
3. Documentation of training must be maintained per NIHD record retention requirements.

**PROCEDURE:**

**A. Decorations (General Requirements)**

1. **Flame resistance:** Decorative materials that could increase fire/panic hazard (including decorative vegetation/trees) must be **nonflammable** or treated/maintained in a **flame-retardant condition** using a State Fire Marshal–approved process when required.
2. **Egress and fire protection devices:** Decorations shall **not** obstruct or conceal: exits, exit signs, fire alarm pull stations, sprinkler heads, fire extinguisher cabinets/locations, standpipe hose cabinets, emergency lighting, smoke doors, or any required fire-rated door operation.
3. **Combustible posting limits:** Combustible decorations/postings attached to walls/ceilings/doors must remain within Life Safety Code limitations (which vary based on sprinkler protection and room use). NIHD will manage postings to stay within those limits.
4. **No interference with doors:** Decorations shall not impede door latching, closing, or swing, including smoke barrier doors and fire doors.
5. **Prohibited locations:** Decorations are not permitted in a manner that reduces corridor width below code/required clearance or creates trip hazards.

**B. Seasonal Trees / Decorative Vegetation**

1. Decorative trees/vegetation must meet the same **nonflammable or flame-retardant** requirements applicable to decorative materials.
2. Trees/vegetation shall not be placed in required exit corridors, stairways, or other locations where they increase fire/panic hazard or obstruct egress or safety equipment.
3. If a department proposes decorative vegetation beyond minimal tabletop décor, **Facilities/Maintenance** must review placement before installation.

**C. Electrically Powered Decorations (Lights, Displays, etc.)**

1. Must be **listed/labeled** (e.g., UL or equivalent NRTL), used per manufacturer instructions, and inspected prior to use for damage, overheating, or altered plugs/cords.
2. Must be turned off/unplugged when not in use where feasible, and removed immediately if there are signs of overheating, arcing, burning odor, or repeated breaker trips.

**D. Electrical Receptacles, Power Strips, and Extension Cords**

1. **Wall receptacles first:** Fixed wall outlets are the primary power source; power strips must not be used as a substitute for installing adequate permanent receptacles.

2. **No daisy chaining:** Power strips (RPTs) shall **not** be connected to other power strips or extension cords.
3. **Clinical/patient care areas (NFPA 99 / Joint Commission expectations):**
    - In **patient care rooms**, any power strip use must meet Joint Commission/NFPA 99 expectations for the location and equipment type.
    - **Within the patient care vicinity**, power strips must meet special-purpose requirements (e.g., UL 1363A / UL 60601-1 as applicable) and are limited to appropriate patient-care-related equipment configurations.
    - Power strips used for **non-patient-care equipment** in patient care rooms but **outside** the patient care vicinity must meet applicable UL requirements (e.g., UL 1363) per Joint Commission guidance.
4. **Non-patient care areas (offices, admin areas):** Power strips may be used only for low-load equipment (computers/monitors, etc.), must be listed/labeled, and must be kept accessible (not covered by rugs, pinched in doors, or routed through walls/ceilings).
5. **California electrical compliance:** All receptacles/power distribution must comply with **Title 24 California Electrical Code (CEC)** as adopted/amended and effective, and any applicable AHJ requirements.

**E. Inspections and Corrective Actions**

1. **Monthly environment of care rounds** (or equivalent) will include checks for:
    - Obstructed egress and concealed safety devices related to decorations
    - Damaged receptacles, missing faceplates, damaged cords, overheating indicators
    - Improper power strip use (daisy-chaining, use in prohibited areas, poor routing)
2. Findings and corrective actions must be documented. Non-compliant items must be removed from service immediately when they present an imminent hazard.

**F. Emergency Procedures**

1. In case of fire, smoke, electrical arcing, or burning odor: follow the hospital's fire response plan and notify Facilities/Maintenance and the supervisor on duty.
2. Report and preserve the device/cord/power strip involved (do not re-energize) for evaluation.

**REFERENCES:**

1. **CCR Title 8 (Cal/OSHA)**: §3217 Decorative Materials
2. **CCR Title 19 (State Fire Marshal)**: §3.08 Decorative Materials
3. **Title 24 California Building Standards Code** (incl. **CEC / California Electrical Code**)
4. **NFPA 101 (Life Safety Code)** combustible decoration limitations (as referenced by TJC/CMS)
5. **NFPA 99** power strip and patient care vicinity expectations (as referenced by TJC/CMS)
6. **Joint Commission** Standards FAQs (Combustible postings; Relocatable power taps)
7. **HCAI (OSHPD) codes/regulations resources** (as applicable to healthcare facilities)

**RECORD RETENTION AND DESTRUCTION:**

Training records must be kept for at least **five (5) years**. Inspection documentation should be retained per NIHD retention schedules (recommended: not less than 3 years unless NIHD policy requires longer).

**CROSS REFERENCE POLICIES AND PROCEDURES:**

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| Supersedes: v.2 Decorations, Receptacles & Heating Devices |

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

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|---|---|---|
| Title: Medical Staff Department Policy - Hospital Medicine | | |
| Owner: Medical Staff Director | Department: Medical Staff | |
| Scope: Hospitalist Practitioners | | |
| Date Last Modified: 06/04/2026 | Last Review Date: No Last Periodic Review Date Set | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 04/22/2021 | |

**PURPOSE:**
To delineate clear expectations for practitioners in the Department of Hospital Medicine at Northern Inyo Healthcare District (NIHD).

**POLICY:**
All practitioners granted privileges in the Department of Hospital Medicine will adhere to the following procedures.

**PROCEDURE:**
1. Admissions and Consults
    a. Any admission or consultation called to the Physician will become the responsibility of that Physician. If the admission or consult is called to Physician during the final 60 minutes of their shift AND the admission along with uncompleted work from his/her shift would significantly prevent the Physician from completing their shift in a reasonable amount of time, the Physician may choose to hand-off the admission or other work to the oncoming hospitalist, within reason. This decision must be made in mutual agreement with the Emergency Department (ED) physician AND the Physician must make every effort to not slow throughput in the ED or delay patient care. Exceptions to the hand-off would be if the admission or consultation is an ICU patient, critically ill, requires time sensitive testing or treatment, or there are more than one other pending admission(s) in the ED.
2. Credentialing:
    a. Physician practitioners in the Department of Hospital Medicine must be board certified or board eligible by the American Board of Family Medicine or the American Board of Internal Medicine and are strongly encouraged to be members of the Society of Hospital Medicine.
3. Emergencies/Codes:
    a. Physician shall respond to in-house emergencies in the same manner as other members of the Medical Staff of Northern Inyo Hospital. If physician is not in house, he/she is expected to return to the hospital within 20 minutes.
4. In-House Coverage
    a. Physicians performing Hospitalist Services are not required to be in house at all times however, they are generally expected to be in house from 8 am to 5 pm if not longer for a full census. It is the expectation that day shift hospitalist will be fully prepared (have seen all patients and reviewed all charts) for the morning Multidisciplinary Team meeting and will fully participate in

the discussion of each patient presented. Night shift Physician is encouraged but not required to stay in-house and utilize the hospitalist call room especially if the Emergency Department is busy, the census is full or there is a critically ill or concerning patient(s). If Physician is off-campus, they are still expected to answer all calls, enter their own orders and return to the hospital for patient care within twenty (20) minutes. At any point in time, Hospitalist Director or Chief of Inpatient Medicine may request a revocation of off-campus privileges and may request Physician to provide in-house coverage for the entirety of their 12 hour shift.

5. Response time
    a. Physician shall respond to NIHD Emergency Department or other NIHD staff requests within twenty (20) minutes of call. If the request is for an admission or consultation, a reasonable goal is to see the patient within 20 minutes so as to formulate a plan and disposition. If the Physician is otherwise preoccupied with patient care that takes a higher precedence such as a critically ill patient, Physician will discuss with ED physician or other NIHD staff to let them know when they can reasonably expect to see the patient. Every effort should be made to see the patient, determine disposition and have orders in one (1) hour after admission request.
6. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to complete FPPE as per policy. Hospitalists sign out to each other at the start/end of each shift so multiple charts are reviewed on an ongoing basis. Verbal sign outs are the standard (email sign outs are acceptable but the exception) and feedback is given in real time. Peer review results and Unusual Occurrence Reports are incorporated into FPPE as appropriate.
7. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per medical staff policy. Hospitalists sign out to each other at the start/end of each shift so multiple charts are reviewed on an ongoing basis. Verbal sign outs are the standard (email sign outs are acceptable but the exception) and feedback is given in real time. Peer review results and Unusual Occurrence Reports are incorporated into OPPE as appropriate.
8. Peer Review:
    a. All inpatient charts identified by critical indicators will be peer reviewed by the Chief of Inpatient Medicine or delegated practitioner. ~~Selected cases will be reviewed at the Inpatient Medicine committee at its next scheduled meeting.~~ Records are confidential and will be kept by the Medical Staff Office.
9. Re-Entry:
    a. Hospitalist practitioners may be eligible for re-entry per policy.
10. Services Provided
    a. Physician should address and/or manage, within the scope of their training and responsibility, all internal medicine issues, as requested for all patients admitted to NIHD. Physician should also provide consultation and management services to patients as requested by NIHD Medical Staff members, visiting Specialist Physicians, the Emergency Department, and other departments as appropriate.

**REFERENCES:**

1. N/A

**RECORD RETENTION AND DESTRUCTION:**

1. Life of policy, plus 6 years

**CROSS-REFERENCED POLICIES AND PROCEDURES:**

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. Medical Staff Peer Review and Professional Practice Evaluations
3. Practitioner Re-Entry Policy
4. *InQuiseek – Referral Policy*

| Supersedes: v.2 Medical Staff Department Policy - Hospital Medicine |
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**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Medical Students in the OR | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Surgery | |
| Scope: Surgery | | |
| Date Last Modified: 12/03/2021 | Last Review Date: 02/17/2022 | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/28/2009 | |

**PURPOSE:**

To outline the role of the medical student and staff in the Operating Room.

**POLICY:**

1. A medical student, who is currently enrolled in a qualified medical school, may assist with surgical procedures providing the attending surgeon has determined that the medical student can provide the type of assistance needed during the specific surgery. The medical student functions under the direct supervision of the attending surgeon. (Physical presence of attending surgeon in the operating room).

2. The medical student may assist the attending surgeon during a surgical procedure by providing aid in exposure, which will help the surgeon carry out a safe operation with optimal results for the patient.

3. Medical students must demonstrate knowledge of surgical anatomy and physiology and skill in applying principles of asepsis and infection control.

4. Medical students must demonstrate the ability to function effectively and harmoniously as a team member and perform effectively in stressful and emergency situations.

5. The Medical Student may, at the discretion of the attending surgeon:
    a. Assist with the surgical positioning and draping of the patient if so directed by the surgeon.
    b. Provide retraction at the direction of the attending surgeon.
    c. Help the surgeon provide homeostasis.
    d. Perform knot tying if qualified in the estimation of surgeon.
    e. Perform assistance in the closure of tissue as directed by the surgeon; sutures fascia, subcutaneous tissue and skin.
    f. Assist the surgeon at the completion of the surgical procedure by:
        i. Affixing and stabilizing all drains.
        ii. Cleaning the wound and applying the dressings.
        iii. Assist with applying cast; splints, bulky dressings, abduction devices.
    g. The medical student practices within the appropriate limitations and may choose not to perform functions for which he/she has not been prepared or feel capable of performing.
    h. The activities outlined are determined based on the experience and education of the medical student. The performance of other activities in the role of the medical student is dependent on the ability of the medical student to safely perform the activities under the direction of the surgeon in a competent manner.

**REFERENCES:**

1. N/A

**RECORD RETENTION AND DESTRUCTION:**

1. N/A

**CROSS REFERENCE POLICIES / PROCEDURES:**

1. Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities
2. Medical Student Rotations and Documentation

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| Supersedes: v.1 Medical Students in the OR |

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

| | | |
|---|---|---|
| Title: Mifeprex™ (Mifepristone): Risk Evaluation and Mitigation Strategies (REMS) program | | |
| Owner: Director of Pharmacy | Department: Pharmacy | |
| Scope: ED, RHC Women's Clinic, Pharmacy | | |
| Date Last Modified: | Last Review Date: | Version: |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

**PURPOSE:**
To establish procedures ensuring compliance with the Risk Evaluation and Mitigation Strategy (REMS) requirements mandated by the U.S. Food and Drug Administration (FDA) for mifepristone 200 mg tablets when stocked by the pharmacy and dispensed directly to patients by Emergency Department (ED) physicians.

**POLICY:**
- The facility shall maintain active certification under the Mifepristone REMS Program if required for stocking and dispensing.
- Mifepristone may only be dispensed to patients by REMS-certified prescribers.
- The pharmacy shall maintain procurement, inventory control, and documentation oversight.
- The dispensing ED physician is responsible for ensuring completion of the Patient Agreement Form (if required), providing the Medication Guide, and counseling the patient.
- Nursing staff are responsible for documenting lot number, NDC, expiration date (if required), and dispensing details in the medical record.
- All REMS requirements must be satisfied prior to medication release to the patient.
- No mifepristone shall be dispensed if REMS requirements are not fully met.

**PROCEDURE**:

**A. Facility Certification**
The organization shall complete and maintain required REMS enrollment documentation. Certification records shall be maintained within pharmacy administration files and be readily retrievable.

**B. Procurement and Inventory Control**
Pharmacy shall purchase mifepristone only from authorized distributors, verify product integrity upon receipt, store per manufacturer labeling, and maintain routine inventory reconciliation with documentation.

**C. Prescriber Requirements**
Only physicians certified under the Mifepristone REMS Program may prescribe and dispense. Certification shall be verified prior to initial dispensing.

**D. Patient Agreement Form**
If required by current REMS requirements, the ED physician shall review and complete the Patient Agreement Form with the patient and ensure documentation is retained within the electronic health record.

**E. Dispensing Process**

1. Physician Responsibilities:

- Confirm REMS certification status and patient eligibility.
- Provide Medication Guide and counseling.
- Document REMS compliance and counseling in the EHR.

2. Nursing Responsibilities:

- Retrieve medication from secured storage or ADC.
- Verify correct medication and strength.
- Document lot number, NDC, expiration date (if required), and date/time of dispensing in the EHR.
- Notify pharmacy of discrepancies.

**F. Documentation & Record Retention**

Pharmacy shall maintain REMS certification documentation, procurement records, inventory logs, and prescriber certification lists. Medical records shall maintain Patient Agreement documentation and nursing lot/NDC documentation. Records shall be retained per REMS requirements, state law, and hospital policy.

**G. Quality Assurance & Audit**

Pharmacy shall conduct periodic audits (at least annually) to ensure compliance with REMS requirements, inventory reconciliation accuracy, and documentation completeness. Findings shall be reported to the Pharmacy & Therapeutics Committee.

**REFERENCES:**


3. U.S. Food and Drug Administration. (2023). Mifepristone Risk Evaluation and Mitigation Strategy (REMS). https://www.fda.gov
4. U.S. Food and Drug Administration. (2023). Mifepristone tablets, 200 mg: Prescribing information. https://www.fda.gov
5. U.S. Food and Drug Administration. (2023). Mifepristone tablets, 200 mg: Medication guide. https://www.fda.gov
6. U.S. Food and Drug Administration. (2022). MedWatch: The FDA safety information and adverse event reporting program. https://www.fda.gov
7. U.S. Congress. (1938). Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301 et seq.


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

**CROSS REFERENCE POLICIES AND PROCEDURES:**

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|---|
| Supersedes: Not Set |

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

| | | |
|---|---|---|
| Title: NIHD Antibiotic Stewardship Committee Charter | | |
| Owner: Manager Employee Health & Infection Control | Department: Infection Prevention | |
| Scope: District Wide | | |
| Date Last Modified: 02/09/2026 | Last Review Date: No Last Periodic Review Date Set | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 07/17/2024 | |

## COMMITTEE PURPOSE

1. To comply with evidence-based guidelines or best practices by promoting the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration and route of administration in order to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.
2. Serves as the foundation of the commitment to ~~continuously improve~~continuously improve antimicrobial stewardship practices at Northern Inyo Healthcare District (NIHD) and to monitor outcomes and antimicrobial use.

## COMMITTEE MEMBERSHIP

In order to assure appropriate and quality utilization of antimicrobial agents The Antimicrobial Stewardship Committee has developed a multi-disciplinary team that consists of the following:

1. Chief Executive Officer (s) (ad hoc)
2. Physician: Chair
3. Director of Pharmacy: Co-chair
4. Medical staff representatives
5. Clinical Microbiologist
6. Infection Prevention staff member
7. Quality Assurance and Performance Improvement
8. Clinical Informatics and/or Information Technology (ad hoc)
9. Pharmacy representative (ad hoc)
10. Nursing representative (ad hoc)
11. Remote consultation services as needed ( ad hoc)
12. Representatives from Sharp (ad hoc)

*Note: One individual may fulfill multiple roles within the subcommittee*

## FREQUENCY OF MEETINGS

The team meets quarterly no fewer than three times a year. If unable to meet, approval of documents must occur electronically and minutes recorded

## COMMITTEE GOALS ~~2025~~2026

1. Update Neonatal Sepsis Order Sets, provider and nursing education.
2. Create C-diff order sets, provider and nursing education.
3. Provide patient education to inpatients discharged home on antibiotics about promoting appropriate antibiotic use.
4. Continued Monitoring of Mixed Flora Urine Culture Post-implementation.

*Note: For further details on annual goals see attachment in Antibiotic Stewardship Program Policy*

The following are the ongoing *LONG-TERM/ONGOING* goals for NIHD ASP plan:

1. Minimize the development of antimicrobial resistance by selecting the appropriate antibiotics and eliminating redundant and unnecessary antibiotic use.
2. Control of Clostridium difficile infections and the emergence of multi-drug resistant organisms (MDROs)
3. Develop the ASP Team. Our team is committed to working on our intra-team communication and strengthening our team through internal development and team-building.
4. Support the education of healthcare providers, partners and patients about antimicrobial stewardship practices, including antimicrobial resistance and appropriate antimicrobial use.
5. Drive Performance with Data. To bring managers, clinicians and staff together to review antibiotic stewardship data and related clinical adverse occurrences to identify problems and make improvements.
6. Collaboration/Partnerships. Develop relationships with external organizations.

## COMMITTEE RESPONSIBILITIES

1. Developing, approving and overseeing the implementation of the Antibiotic Stewardship Program plan and related tactical/action plans.
    a. Review of processes pertaining to core strategies for conducting antimicrobial stewardship including
        - Prospective audit with intervention and feedback to the physician which may include but is not limited to provider education on antimicrobial resistance patterns, antimicrobial dosing, duration, spectrum of activity, compliance to national and institutional guidelines, etc.
        - Formulary restriction and pre-authorization requirements
2. Evaluate and make recommendations for improvement to ASP plan and send to the Pharmacy & Therapeutics Committee for approval.
3. The ASP Subcommittee is responsible to report at least annually to the following committees:
    a. Pharmacy & Therapeutics
    b. Infection Prevention Committee
    c. ~~Quality Council~~Executive Committee
    ~~d.~~
    e. Medical Staff
    f. Medical Executive Committee
    ~~g.~~
4. ~~4.~~ Establishing measurable objectives based upon priorities identified through use of established criteria for improving the ASP Program.
5. Evaluation of annual goals
6. Reporting to the Board of Directors on ASP activities of NIHD at least annually.

## RETENTION AND DESTRUCTION OF RECORDS

Keep at least three years or until next CDPH and Joint Commission Surveys

| Supersedes: v.2 NIHD Antibiotic Stewardship Committee Charter |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Pre- and Post-Operative Anesthesia Visits | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Practitioners Privileged in Anesthesia | | |
| Date Last Modified: 03/21/2024 | Last Review Date: 06/16/2022 | Version: 6 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 05/03/2013 | |

**PURPOSE:**

To clarify requirements for pre- and post-operative anesthesia visits.

**POLICY:**

1. Pre-Anesthesia
    a. The preoperative visit shall be conducted personally, whenever possible, by the anesthesiologist who is scheduled to provide care for the patient.
    b. The pre-operative visit shall include a disclosure of risks and options, a formulation of the plan of anesthesia and informed consent given to the patient and or patient representative, if the patient is not competent.
    c. A pre-operative note of the findings relating to anesthesia including the plan of anesthesia, and the patient's informed consent shall be placed in the medical record.
    d. A history and physical examination will be available in the patient's medical record at the time of the anesthesiologist's visit. This document shall not replace the anesthesiologist's responsibility for personally evaluating the patient.
2. Post-Operative
    a. Post-operative visits are recorded on the evaluation form or progress notes.
    b. At least one note will describe the presence or absence of anesthesia related complications.
    c. The number and timing of post-anesthesia visits will be determined by the status of the patient. It is recommended that a visit be made early in the post-operative period and after complete recovery from anesthesia.
    d. Post-anesthesia notes should specify time and date and be completed within 48 hours after surgery.
    e. Post-anesthetic assessment by an anesthesiologist shall be performed and entered in the medical records of all patients discharged directly from the PACU.

**REFERENCES:**

1. CMS Conditions of Participation: Anesthesia Services 482.52(b)1,3.

**RECORD RETENTION AND DESTRUCTION:**

1. Life of policy, plus 6 years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Anesthesia Clinical Standards and Professional Conduct
2. Anesthesia in Ancillary Departments
3. Medical Staff Department Policy - Anesthesia
4. Scope of Anesthesia Practice

Supersedes: v.5 Pre and Post Operative Anesthesia Visits

**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Scope of Anesthesia Practice | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Practitioners Privileged in Anesthesia | | |
| Date Last Modified: 03/21/2024 | Last Review Date: 06/16/2022 | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 06/20/2018 | |

**PURPOSE:**

To delineate the practice of anesthesia, which is a recognized medical and advanced practice nursing specialty unified by the same standard of care

**POLICY:**

1. The scope anesthesia practice at Northern Inyo Healthcare District includes, but is not limited to:
    a. The preoperative, intraoperative and postoperative evaluation and treatment of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical, radiological therapeutic and diagnostic or other medical procedures and participation in the overall coordination of care;
    b. The protection and maintenance of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver, endocrine, skin integrity, nerve [sensory and muscular]) under the stress of anesthetic, surgical and other medical procedures;
    c. Monitoring and maintenance of acceptable physiology during the perioperative period;
    d. Diagnosis and treatment of acute, chronic and cancer-related pain;
    e. Clinical management of cardiac and pulmonary resuscitation;
    f. Evaluation of respiratory function and application of respiratory therapy;
    g. Management of critically ill patients;
    h. Conduct of clinical, translational, basic science and outcomes/best practice research;
    i. Supervision, teaching and evaluation of performance of both medical and paramedical personnel involved in perioperative care and cardiac and pulmonary resuscitation;
    j. Management and preservation of patient safety;
    k. Communication of patient-care concerns with the surgeon/proceduralist and other members of the healthcare team whenever indicated.
2. The anesthesia provider's responsibilities to patients include:
    a. Assessment of, consultation for and preparation of patients for anesthesia;
    b. Management of patients and the anesthetic for the planned procedures;
    c. Post anesthetic evaluation and treatment;
    d. Perioperative pain management.

**REFERENCES:**


1. "Guidelines for Patient Care in Anesthesiology." American Society of Anesthesiologists. October 26, 2016 edition.
2. "Scope of Nurse Anesthesia Practice." American Association of Nurse Anesthetists 2013.

**RECORD RETENTION AND DESTRUCTION:**

1. Life of policy, plus 6 years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Anesthesia Clinical Standards and Professional Conduct
2. Anesthesia in Ancillary Departments
3. Medical Staff Department Policy - Anesthesia
4. Pre- and Post-Operative Anesthesia Visits

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| Supersedes: v.2 Scope of Anesthesia Practice |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROCEDURE**

| | | |
|---|---|---|
| Title: Standardized Procedure - Medical Screening Exam for the Obstetrical Patient | | |
| Owner: Perinatal Nurse Manager Trainee | Department: Perinatal | |
| Scope: Perinatal LDRP RN | | |
| Date Last Modified: 07/09/2026 | Last Review Date: No Last Periodic Review Date Set | Version: 6 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/04/2008 | |

**PURPOSE:**

The purpose of the policy is to outline the methodology for the Medical Screening Examination (MSE) of the Oobstetric patient that may be performed by the RN as a standardized procedure and to provide evidence based guidelines.

**POLICY:**

It is the policy of Northern Inyo Healthcare District (NIHD) that only standardized procedure functions based on defined circumstances as outlined in this document may be performed by a Registered Nurse (RN) in the Perinatal Unit and to provide evidence based guidelines for this process.~~inatal Department without previous written authorization of the Obstetric Provider and or Clinical Nurse Midwife (CNM).~~

**PROCEDURE:**

1. Competency Requirements:
    a. To be eligible to perform this Standardized Procedure in the Perinatal Department, the RN must:
        i. Hold a current California (CA) RN license.
        ii. Hold a current NRP and BLS certifications.
        iii. Completion of Electronic Fetal Monitoring program (Intermediate or Advanced Fetal Monitoring).
        iv. Complete an initial training course specific to the elements of the Standardized Procedure outlined in this policy.
        v. Competency is demonstrated annually and documented in the employee's competency assessment files.
            a. Travelers will complete competency upon onboarding process.

**Initial Evaluation**:

1. Successfully complete at least two (2) different obstetric patient medical screening examinations under the observation of a Provider or nurse preceptor.

2. A qualified “nurse preceptor” is a RN who may validate the competency of another RN to perform this procedure. A nurse preceptor must have completed at least five (5) obstetric patient MSE’s.
3. Determined competency must be documented on the MSE of Obstetric Patient Competency Validation Tool.

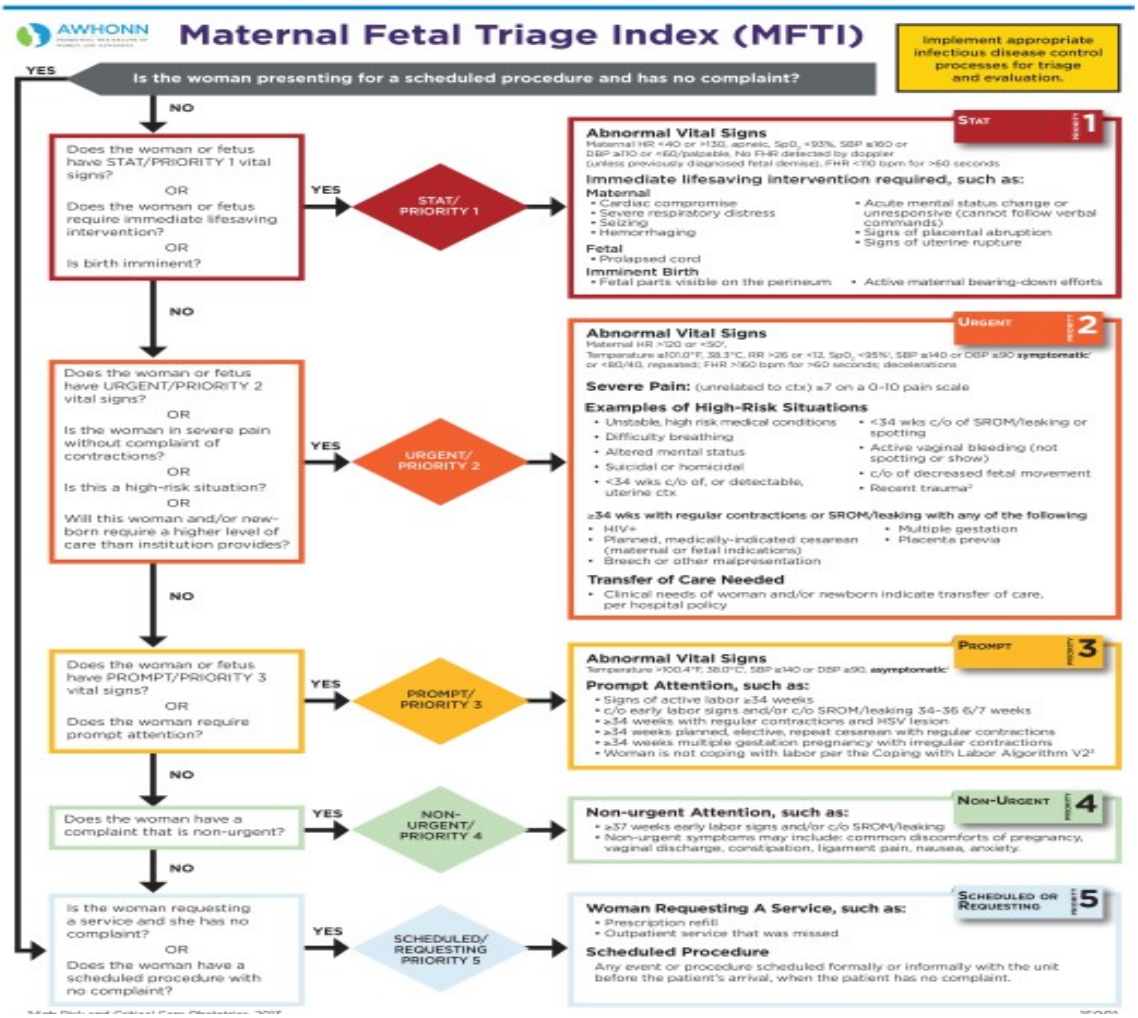
vi. A list of RN’s competent to perform this standardized is maintained. ~~with the Chief Nursing Officer and is updated annually.~~

vii. Standardized Procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

2. Settings where Standardized Procedure may be performed:

   a. The MSE may take place in the Perinatal Department or the Emergency Department if necessary.

3. Standardized Procedure:
   a. Circumstances under which Standardized Procedure may be performed:
      i. A pregnant women 20 weeks or greater presenting to Northern Inyo Healthcare District for care, with pregnancy related complaints ~~of labor~~.
   b. Following examination and assessment of the patient, the RN will notify the Provider and collaborate to develop course of care.
   c. ~~Circumstances under which the Provider/CNM must immediately notified:~~
      ~~i. Complications or abnormal assessments arise during the patient assessment. Such problems include:~~
         ~~1. Fever (greater than100.4°F), and/or signs of infection~~
         ~~2. Excessive vaginal bleeding (more than spotting)~~
         ~~3. Elevated blood pressure (SBP ≥140 or DBP ≥ 90)~~
         ~~4. Hyperreflexia (+3 Patellar DTRs)~~
         ~~5. Non-vertex presentation~~
         ~~6. Tetanic contraction pattern~~
         ~~7. Non-reactive NST, Category 3 or worsening Category 2 strip~~
         ~~8. Premature gestation presenting in labor (≤36 weeks gestation)~~
         ~~9. Ruptured membranes~~
   ~~d.~~ Contraindications to performing this procedure: Patient refusal
   e. The Provider will be notified immediately if criteria for Priority 1, 2 or 3 of the AWHONN Maternal Fetal Triage Index is identified. See below criteria:




Procedure

i. Validate appropriate patient selection criteria:
    1. Patient must be an obstetric patient presenting for care
    2. Patient must give consent
    3. ~~Patient must have absence of complications as listed under Procedure (Section 3.c. i.)~~

~~ii.~~ Explain procedure to patient.

iii. If Priority 1, 2, or 3 criteria are present~~delivery is imminent,~~ call the Provider and prepare for immediate delivery and/or provide stabilization measures per Provider order as appropriate.

iv. If delivery is not imminent, continue assessment which will include but is not limited to:
    1. Gravida, parity, EDC
    2. Chief compliant/reason for visit
    3. Vitals signs
    4. Review of prenatal record if available, including obstetric history and risk factors
    5. Woman's perceptions of fetal movement, if over 16-20 weeks gestation.
    6. Uterine Activity (if present).

a. Assess for:
    i. Frequency
    ii. Duration
    iii. Intensity
    iv. Resting tone
    v. If normal, include this information with report to provider when total assessment is completed

7. ~~Potential complications may include but are not limited to:~~
    ~~a. Preterm gestation (≤ 36 weeks gestation)~~
    ~~b. Tetanic contraction pattern~~
8. ~~If potential complications are present – call the Provider~~

~~v.~~ Determine the status of the membranes:

1. Ask and assess the patient for history or presence of leakage of fluid.
    a. If patient reports leakage of fluid or possible rupture of membranes:
        i. Check for pooling and/or gross rupture of membranes
        ii. ~~Collect fern sample for analysis~~
        ~~iii. If fern sample is indeterminate, laboratory sample may be sent with order~~
        ~~iv.~~ Assess the color, odor, or amount of fluid present
        v. Laboratory sample may be sent with order
        vi. Order AFI if indicated with Provider order
2. Include this information with report to provider when total assessment is completed.

vi. Determine the status of the cervix by performing a sterile digital cervical exam, unless contraindicated. If contraindications present, sterile digital cervical exam may only be performed with an order:

1. Contraindications include:
    a. Less than or equal to 36.0 weeks gestation
    b. Active vaginal bleeding
    c. Known or suspected placenta previa
    ~~d. Leakage of fluid~~
2. Asses the cervix for:
    a. Dilation
    b. Effacement
    c. Station
3. Include this information with report to provider when total assessment is completed.

vii. Determine presenting part during cervical examination, unless contraindicated (See 5.b.vi.1 above):

1. If fetus is cephalic, include this information with report to provider when total assessment is completed.
2. If presenting part is other than cephalic, call the Provider.

viii. Assess ~~for signs and symptoms of preeclampsia,~~ patient for the below utilizing the MFTI to determine Priority~~including~~:

1. Blood pressure
2. Temperature~~(Normal: less than 140/90)~~
3. Urine for Protein~~Proteinuria (Normal: using urine dip stick, less than +3)~~
4. Deep Tendon Reflexes~~Hyperreflexia (Normal: DTRs less than +3)~~
5. Epigastric pain ~~(Normal: absence of epigastric pain)~~

6. Visual disturbances ~~(Normal: absence of visual disturbance)~~
7. ~~If normal, include this information with report to provider when total assessment is completed~~
~~8.~~ Assess bleeding~~If abnormal – Notify the Provider immediately~~
~~9.~~
10. Identify fetal heart rate pattern with application of an electronic fetal monitoring system or, if gestation is less than 24 weeks, using a Doppler.
**11.** Assess for fetal activity**~~Assess for maternal infection:~~**

~~If temperature is greater than 100.4°F, suspect infection – Notify the Provider.~~
~~If temperature is equal to or less than 100.4°F, include this information with report to provider when total assessment is completed.~~

~~12. Assess bleeding:~~
~~13. Call the Provider if bleeding is more than spotting.~~
14. Report abnormal findings per MFTI
15. If all data is within normal limits i~~If bleeding is absent, i~~nclude this information with report to provider when total assessment is completed.

ix. ~~Assessment of fetal wellbeing:~~
~~1. Identify fetal heart rate pattern with application of an electronic fetal monitoring system or, if gestation is less than 24 weeks, using a Doppler.~~
~~2. Utilizing National Institute of Child Health and Human (NICHD) criteria and nomenclature, assess NST reactivity or strip Category.~~
~~3. If NST is reactive or Category 1, include this information with report to provider when total assessment is completed.~~
~~4. If NST is non-reactive, or if strip is Category 3 or worsening Category 2, immediately notify the Provider.~~

~~f. At the completion of the MSE, the RN will report to on-call Provider, by phone or in person, the findings of the examination and any other pertinent information before any further procedures are performed. Regardless of the assessment, any patient meeting the following criteria will be examined, in person, by a Provider, prior to discharge home:~~
~~i. Preterm (>36 weeks)~~
~~ii. Not an established patient (has not been seen by NIHD or Rural Health Women's' Clinic)~~
~~iii. No prenatal care~~
~~iv. Maternal temperature greater than 100.4°F, of uncertain etiology~~
~~v. Altered acute mental status change or level of consciousness~~
~~vi. Active vaginal bleeding~~
~~vii. Rupture of membranes~~
~~viii. Category 3 or worsening Category 2 strip~~
~~ix. Major maternal trauma~~

~~g.~~ In regards to a patient who is determined to not be in labor but needs additional evaluation to rule out an emergency condition:
i. This patient will be seen in the Emergency Department per OB Provider's order. The provider will communicate with the Emergency Department Provider to facilitate the transfer. ~~and be provided with a medical screening examination to rule out other medical conditions prior to being discharged home.~~ Prior to transfer back to the Emergency Department, the L&D RN will ~~report to the on-call Provider the findings of the labor examination and any other pertinent information. This RN will also~~ call report to the Emergency Department RN ~~and/or the Emergency Department Attending Provider to inform them of the patient's impending return to the Emergency Department.~~.

h. Documentation:

i. Patient assessment, including fetal assessment and any actions taken per standardized procedure will be documented in the EHR per department policy.

4. Review of Standardized Procedure

   a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

   b. Quality improvement monitoring of this standardized procedure is ongoing.
      i. Chart audits will be performed for all births occurring outside of a hospital facility following a Medical Screening Exam by a RN.

**REFERENCES:**


1. California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.
2. Association of Women's Health, Obstetrics,and Neonatal Nursing (AWHONN). High Risk & Critical Care Obstetrics (*4th Ed*.) Wolters Kluwer
3. AWHONN Maternal Fetal Triage Index (2013)


**CROSS-REFERNCED POLCIES:**

1. EMTALA Policy
2. Evaluation of Pregnant Patients in the Emergency Department
3. Fern Testing
4. Preeclampsia, Eclampsia: Management of the Patient with
5. Standards of Patient Care in the Perinatal Unit
6. Scope of Service Perinatal

**RECORD RETENTION AND DESTRUCTION:**

Documentation is maintained within the patient medical record, which is managed by the NIHD Medical Records Department.

Supersedes: v.5 Standardized Procedure - Medical Screening Exam for the Obstetrical Patient

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

| | | |
|---|---|---|
| Title: Telephone Triage in the Perinatal Department | | |
| Owner: Perinatal Nurse Manager Trainee | Department: Perinatal | |
| Scope: Perinatal Department | | |
| Date Last Modified: 06/02/2026 | Last Review Date: 08/24/2023 | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

**PURPOSE:** To provide guidelines for Perinatal Registered Nurses to telephonically assess risk and provide direction to pregnant and postpartum women calling the Perinatal Unit for advice.

**POLICY:** All patient phone calls will be triaged by a Perinatal Registered Nurse who has completed a medical screening exam and completed competency in telephone triage. Nurses will ensure patient understands they are speaking with a registered nurse, not a physician. Telephone triage will be guided by the enclosed telephone triage algorithm.

**PROCEDURE:**

1. Obtain patient name and assess for Airway, Breathing, and Circulation
2. Obtain the patient's ~~name,~~ age, parity, provider/where they receive care
3. Gestational age and EDD
4. Ask patient for specific complaint(s)/question(s)
5. Confirm any underlying conditions/prenatal problems or issues
6. ~~Where does the patient receive care?~~
7. Complete telephone triage utilizing the OB Telephone Triage Assessment Form in the Telephone Triage log and categorize according to Maternal Telephone Triage Index .(see Appendix A).
8. If the patient has an existing chart in our EMR, document the assessment in the patient chart.

**REFERENCES:**

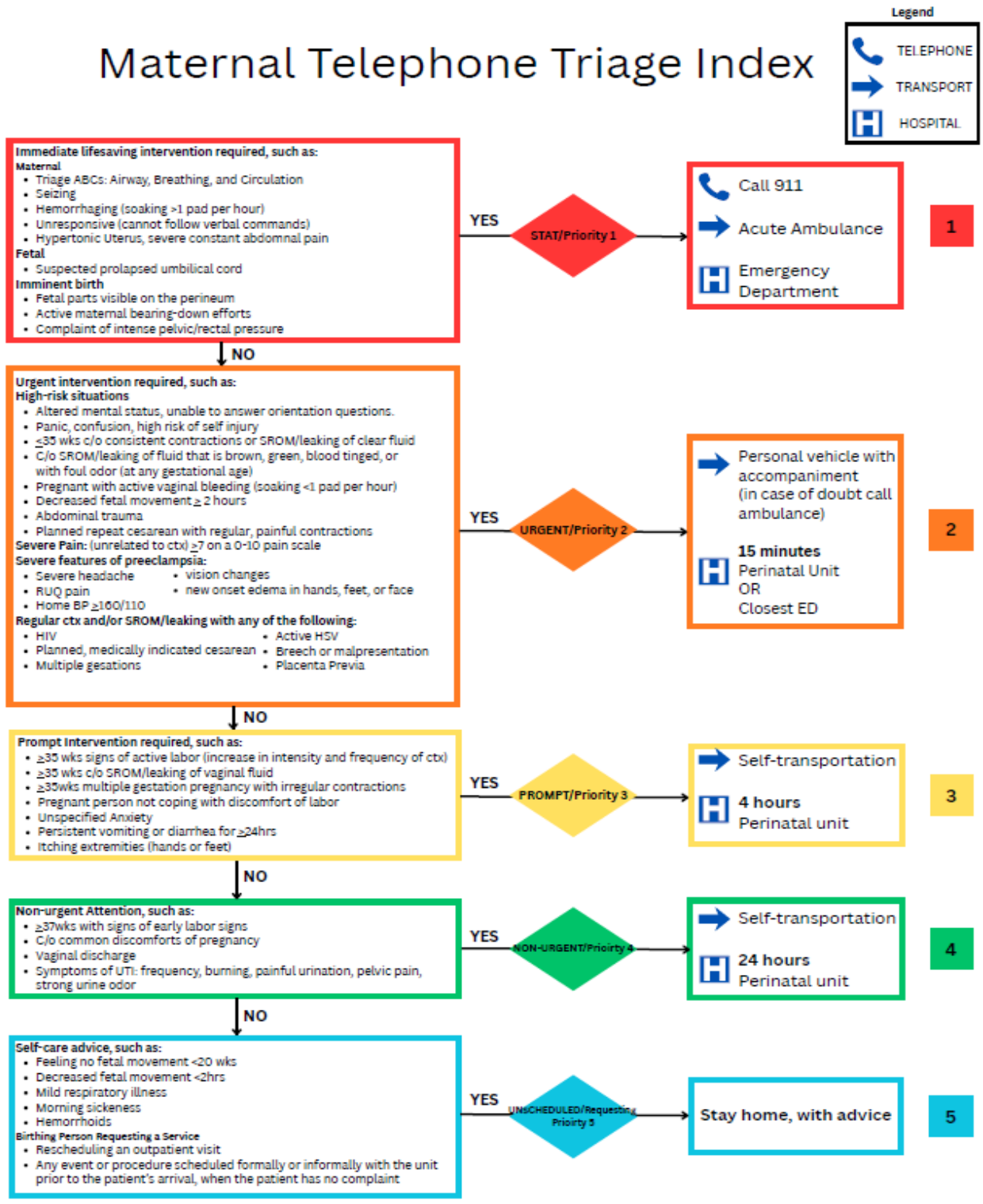

1. Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). (2012). *Standards for Professional Nursing Practice in the Care of Women and Newborns, 8th edition,* Washington, DC: Author.
2. AWHONN (2022). Maternal Fetal Triage Index (AWHONN Ed.) Review of Maternal Fetal Triage Index (MFTI).
3. Rashidi, F., Masoumeh, S., Simbar, S.& Kiani, Z.(2022). *The Design of an Obstetric Telephone Guideline (OTTG) a Mixed Method Study*. BMC Women's Health.


**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

| |
|---|
| Supersedes: v.1 Telephone Triage in the Perinatal Department |
| APPENDIX A |

# Maternal Telephone Triage Index




References:
1. AWHONN. (2022). maternal Fetal Triage Index (MFTI) (AWHONN, Ed.) [Review of maternal Fetal Triage Index (MFTI)].
2. Rashidi, F., Masoumeh Simbar, Safari, S., & Kiani, Z. (2024). The design of an Obstetric Telephone Triage Guideline (OTTG): a mixed method study. BMC Women's Health, 24(1). https://doi.org/10.1186/s12905-024-03076-1

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

DATE: August 6, 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Samantha Jeppsen, MD, Chief of Staff

RE: Chief of Staff Report

**MEMORANDUM**

**Recommendations**

The Medical Executive Committee met on August 4, 2026 and recommended that the Board of Directors approve the following Medical Staff Appointments and Privileges:

A. Medical Staff Initial Appointments 2026-2027 (*action item*)

1. Scott Thalman, MD *(radiology)* – Courtesy Staff
2. Collin LaPorte, MD *(orthopedic surgery*) – Courtesy Staff
3. Kathleen Ferguson, DO (*emergency medicine*) – Active Staff
4. Nicholas Herzik, MD (*emergency medicine*) – Active Staff

B. Medical Staff Telemedicine Privileges 2026-2027 – Proxy Credentialing (*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. Joshua Mendelson, MD (*teleneurology*) – Telemedicine Staff (Distant Site: Sevaro)

C. Additional Privileges (*action item*)

1. Tammy O'Neill, PA-C (*physician assistant*) – recommendation to add privileges in orthopedic services to Ms. O'Neill's current appointment, including surgical first assist privileges and inpatient rounding.

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

DATE: July 14, 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Samantha Jeppsen, MD, Chief of Staff

RE: Extension of Temporary Privileges for Good Cause

**MEMORANDUM**

## Background

Temporary privileges may be granted to a practitioner serving as a locum tenens for a current member of the Medical Staff to meet the care needs associated with that member's absence. Under Medical Staff Bylaws Section 4.8, temporary privileges are generally limited to a maximum of one hundred twenty (120) consecutive days, unless the Medical Executive Committee recommends and the Board of Directors approves a longer period for good cause.

## Discussion

Northern Inyo Healthcare District requires locum tenens pathology coverage from August 24, 2026 through August 27, 2026 during the temporary absence of the District's pathologist. During this period, the District's breast surgeon will be performing procedures that require on-site pathology services to support timely patient diagnosis and treatment.

To meet this patient care need, the District has engaged Megan Smith-Zagone, MD to provide locum tenens pathology coverage during the dates noted above. Dr. Smith-Zagone was granted temporary clinical privileges effective April 15, 2026, for a period of 120 consecutive days, which expire on August 13, 2026. Because the requested coverage occurs after the expiration of her current temporary privileges, an extension is required.

## Recommendations

The Medical Executive Committee recommends that the Board of Directors approve a 30-day extension of the temporary clinical privileges granted to Megan Smith-Zagone, MD (*pathology*), based on good cause, to ensure uninterrupted pathology coverage and continuity of patient care.


WE ARE
RENOWN
HEALTH.
Kerac Falk, MD
Female Pelvic Medicine &
Reconstructive Surgery
MEDICINE
Renown
HEALTH
August 2026 Northern
Inyo Healthcare District
Board Meeting
Renown®
HEALTH

# MISSION.

Established in 1864 as Nevada's first hospital, we proudly serve our community as the only not-for-profit academic health system, committed to saving lives, nurturing minds and caring for all people.

# VISION.


Create a healthier future through exceptional care and discovery.

# VALUES.


People First,
Compassion, Integrity,
Collaboration, Excellence

# Renown Health Board of Directors

**Tammy Dermody, Chair**
Business Owner,
Silver and Blue Investments, LLC

**Cliff Deveny, MD**
President and Chief Executive Officer,
Summa Health

**Bijel Doshi**
Managing Partner,
Sanskar Capital

**Jeff Eller**
Former Market CEO,
Adventist Health

**Brian Erling, MD**
President & Chief Executive Officer,
Renown Health

**Adam Kramer**
Partner,
Panattoni Development

**Stephanie Lepori**
Chief Administrative and Accounting Officer,
Caesars Entertainment

**Marc Mora, MD**
Senior Vice President Resource
Stewardship and Network Management,
Kaiser Permanente and Washington
Permanente Medical Group

**Christopher Ott, MD, FACEP**
Chief Medical Officer Physician Services,
HCA Healthcare Clinical Services Group

**Brian Sandoval, JD**
President,
University of Nevada, Reno

Renown® HEALTH

# Renown Health Leadership Team

**Brian Erling, MD, MBA**
President & Chief Executive Officer

**Chris Bosse**
Chief Government Relations Officer

**Paul Harris, JD**
Chief Legal Officer

**Paul Hauptman, MD**
Chief Academic Officer

**Suzanne Hendery, MA, APR**
Chief Marketing & Customer Experience Officer

**Anna Loomis, MBA**
Chief Financial Officer

**Rahul Mediwala, MD, MBA**
Chief Executive Officer, Medical Group

**Mark Neu, MHA, CHC, CCEP**
Chief Compliance Officer

**Chris Nicholas, MHA, FACHE**
Chief Operating Officer, Renown Health & Chief Executive Officer, Renown Regional

**Melodie Osborn, MBA, BSN, RN, NEA-BC**
Chief Nurse Executive

**Bill Plauth, MD, MMM, CPE**
Chief Medical Officer

**Chuck Podesta**
Chief Information Officer

**Sandeep Randhawa, MS**
Chief People Officer

**Samuel Weller, MHPA**
Chief Executive Officer, Renown South Meadows & Renown Rehabilitation Hospital

Updated March 2026

86ae5addw/EJM/2603

Renown® HEALTH

# RENOWN BY THE NUMBERS.

## PROVIDING ACCESS TO CARE IN YOUR NEIGHBORHOOD

AT OUR FACILITIES:

**1,003**
LICENSED BEDS

**142,350**
TOTAL ER VISITS AT RENOWN REGIONAL AND SOUTH MEADOWS

**1,556**
TOTAL PROVIDERS WITH PRIVILEGES AT OUR HOSPITALS

**29,390**
INPATIENT AND SAME-DAY SURGERIES

OUR SERVICES ALSO INCLUDE:

**713**
PROVIDERS

**205,042**
PATIENTS SEEN BY RENOWN MEDICAL GROUP PROVIDERS

**74,358**
KP NEVADA HEALTH PLAN MEMBERS

**20**
PRIMARY CARE LOCATIONS

**13**
URGENT CARE LOCATIONS

**29**
SPECIALTY CARE LOCATIONS

CY25 DATA

Renown® HEALTH

# Comprehensive Care

**Renown Health is home to a comprehensive network of health and hospital services in northern Nevada. Our 700+ providers and 120 locations provide exceptional care across our region, and Renown continues to actively recruit additional providers to the community.**

Behavioral Health & Psychiatry

Breast Health

Cancer Care, Oncology & Hematology

Cardiology

Dermatology, Laser & Skincare

Emergency Services

Endocrinology

Gastroenterology

Home Health Care

Hospice & Palliative Care

Infectious Diseases

Intensive Care Units (Adult, Trauma, Pediatric & Neonatal)

Lab Services

Labor & Delivery

Level II Trauma Care (Adult & Pediatric)

Nephrology (Kidney Care)

Neonatal Intensive Care Unit (Highest Level in the Region)

Neurosciences

Orthopedics

Otolaryngology

Pediatric Care & Specialties

Pharmacy

Physical Medicine

Physical Therapy & Rehabilitation

Primary Care (Family & Internal Medicine)

Pulmonary Medicine

Rheumatology

Sleep Medicine

Speech Pathology & Audiology

Sports Medicine

Surgical Services

Transplants

X-Ray & Imaging

Urgent Care

Urology

Women's Health (OB-GYN)

Wound Care

# ADVANCED ACUTE CARE


## RENOWN REGIONAL MEDICAL CENTER

Renown Regional Medical Center is the region's only Level II Trauma Center for adult and pediatrics, and is located in the heart of Reno.

- 24/7 ER and Trauma Center
- William N. Pennington Cancer Institute
- Institute for Heart & Vascular Health
- Surgical services
- Maternity services
- Specialty care
- 24/7 Pharmacy

## RENOWN CHILDREN'S HOSPITAL

Renown Children's Hospital is the home of the region's only Level II Pediatric Trauma Center and is located at the Renown Regional Medical Center campus. Additional primary care offices are located in the community.

- 24/7 Children's ER
- Pediatric specialists and services
- Pediatric Intensive Care Unit (PICU)
- Neonatal Intensive Care Unit (NICU)
- Pediatric diagnostic services
- Pediatric primary care


## RENOWN REHABILITATION HOSPITAL

Renown Rehabilitation Hospital is a the region's leading rehabilitation hospital, located one block away from Renown Regional Medical Center.

- 24/7 specialized care
- Comprehensive rehabilitation hospital
- Physical, occupational, speech, recreational and cognition therapy
- Outpatient physical medicine and rehabilitation


## RENOWN SOUTH MEADOWS MEDICAL CENTER

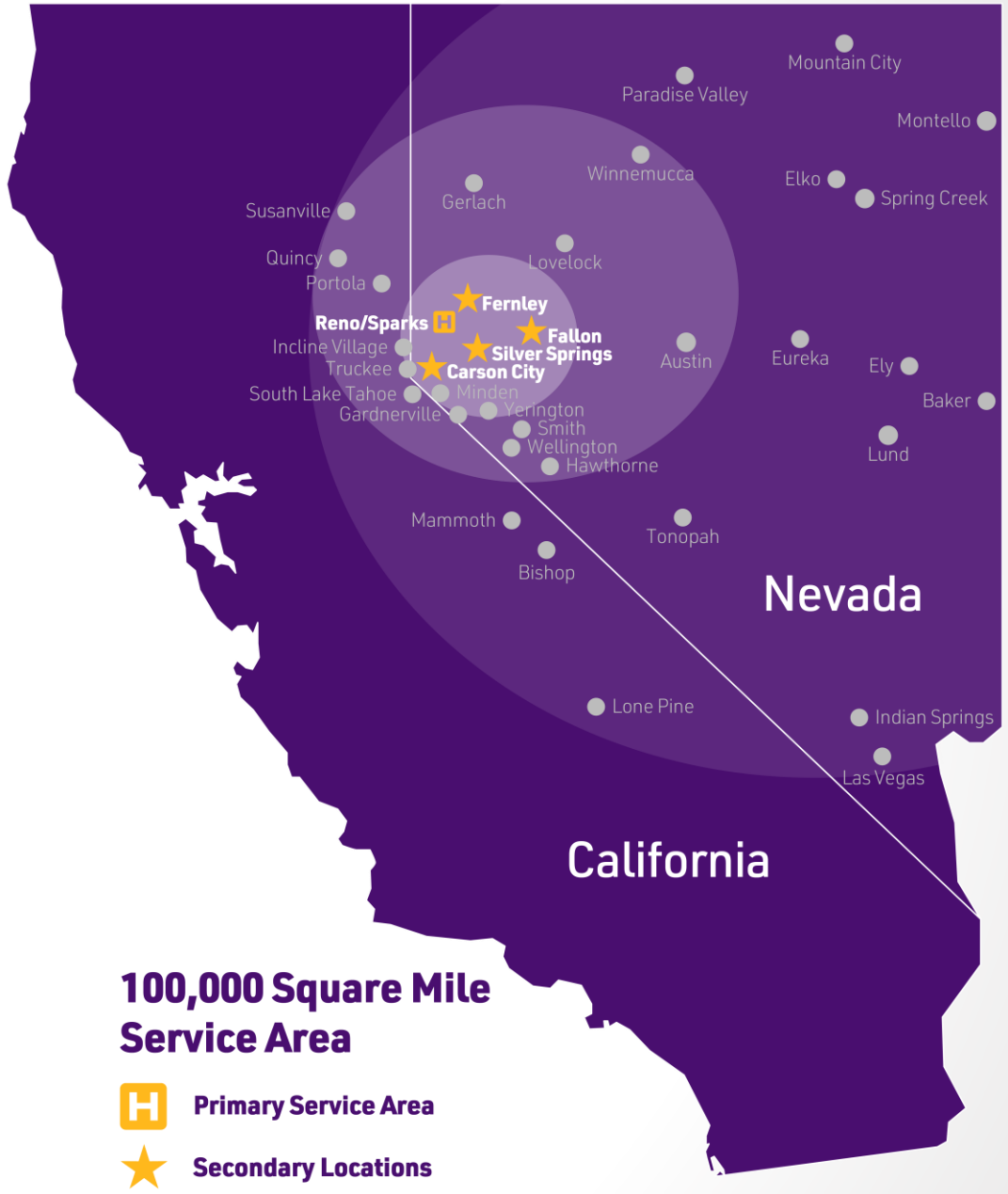
Renown South Meadows Medical Center is home to the first 24/7 ER in south Reno.

- 24/7 ER
- Diagnostic services
- Surgical services
- Primary care
- Specialty care
- Pharmacy

# Our Service Area

## Renown serves the region with a comprehensive healthcare network:

- **Hospitals**
  - Renown Regional Medical Center
  - Renown South Meadows Medical Center
  - Renown Children's Hospital
  - Renown Rehabilitation Hospital
- **Network Services**
  - Primary Care
  - Urgent Care
  - Advanced Specialty Care
  - Diagnostic Services



# Rural Impact

- 22 Independent and distinct rural hospital partners across 2 states
- Population in Communities Outside of Reno/Sparks is 43% of Total Market
- Of the 436,000 residents in our rural communities, 338,000 are in communities where RRMC is the closest tertiary hospital
- There are three distinct regions within our catchment that rely on Renown as their tertiary/quaternary hospital

# Renown Health

## Northern Nevada's First Not-for-Profit Academic Health System























# Strategic Direction Key Imperatives

Long-Term Aspiration:
Be the Destination for Care Across Our Region

Commit to a People-First Culture & Mindset

Ensure Access to High-Quality & Affordable Care

Expand Renown's Not-for-Profit Mission

Provide Essential & Advanced Care Options

Build an Integrated Academic Health System

Enablers: Physician Enterprise & Facility Plan

Foundational: Clinical & Operational Excellence

# Renown Health Strategic Plan

## Commit to a People First Culture & Mindset

- Strengthen Renown's People First values & culture
- Embrace the diversity of our people
- Invest in workforce sustainability
- Cultivate community partnerships

## Ensure Access to High-Quality & Affordable Care

- Develop value-based care infrastructure
- Establish a comprehensive managed care strategy that supports long term sustainability
- Develop partnership that support value-based offerings
- Grow Renown/Hometown Health's access to covered lives

## Expand Renown's Not-for-Profit Mission

- Ambulatory expansion & care model redesign
- Bring our model of care to new communities
- Explore new health system/hospital partnerships
- Enhance collaboration with rural health partners

## Provide Essential & Advanced Care Options

- Invest in vital clinical services to keep care local
- Strengthen network of physicians and providers
- Optimize care distribution and access
- Ensure highly reliable care and exceptional experience

## Build an Integrated Academic Health System

- Optimize our integration with UNR Med
- Foster the learning environment
- Expand access to clinical trials, research, and innovation for key specialties
- Broaden Renown/UNR Med branding opportunities

Renown® HEALTH

# NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT

## All Transfers that came into Renown through RTOC: Inpatients, Observations, Emergencies

| PatientClassDSC | 2024 | 2025 | 2026 | Total |
|---|---|---|---|---|
| Emergency | 15 | 12 | 9 | **36** |
| Inpatient | 306 | 285 | 192 | **783** |
| Observation-Outpatient | 12 | 11 | 9 | **32** |
| **Total** | **333** | **308** | **210** | **851** |

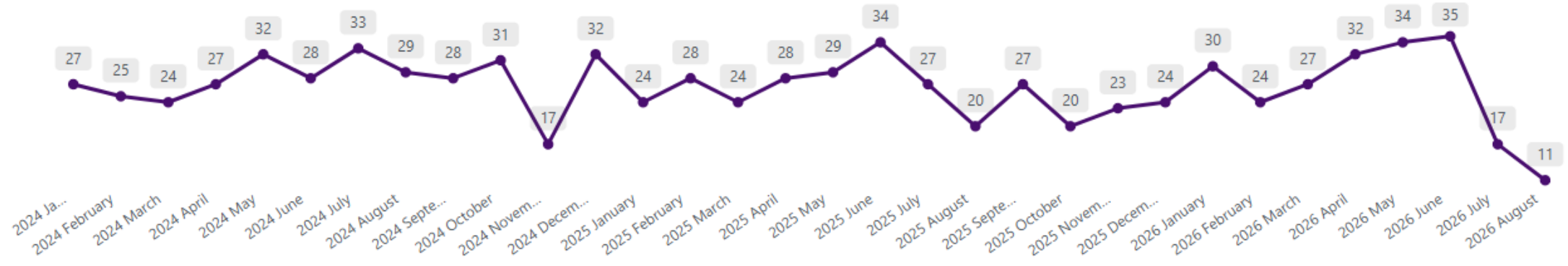
| Year | 2025 | | | | 2026 | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PatientClassDSC | October | November | December | Total | January | February | March | April | May | June | July | August | Total | |
| Observation-Outpatient | 1 | 3 | 1 | **11** | 1 | 2 | | 1 | 3 | 2 | | | **9** | **32** |
| Inpatient | 19 | 18 | 22 | **285** | 27 | 22 | 27 | 29 | 30 | 31 | 16 | 10 | **192** | **783** |
| Emergency | | 2 | 1 | **12** | 2 | | | 2 | 1 | 2 | 1 | 1 | **9** | **36** |
| **Total** | **20** | **23** | **24** | **308** | **30** | **24** | **27** | **32** | **34** | **35** | **17** | **11** | **210** | **851** |

## All **Inpatients** that came into Renown through RTOC

| | 2024 | 2025 | 2026 | Total |
|---|---|---|---|---|
| IP Discharges | 306 | 285 | 192 | **783** |
| CMI | 2.45 | 2.26 | 2.32 | **2.35** |
| Number of Mortalities | 16 | 18 | 16 | **50** |
| Inpatient Patient Days | 2180 | 1718 | 1091 | **4989** |
| Inpatient ALOS | 7.12 | 6.03 | 5.68 | **6.37** |
| Avg GMLOS | 4.89 | 4.49 | 4.42 | **4.63** |

| Year | 2025 | | | | 2026 | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | October | November | December | Total | January | February | March | April | May | June | July | August | Total | |
| IP Discharges | 19 | 18 | 22 | **285** | 27 | 22 | 27 | 29 | 30 | 31 | 16 | 10 | **192** | **783** |
| CMI | 2.74 | 2.37 | 2.09 | **2.26** | 2.38 | 2.13 | 2.01 | 1.95 | 1.71 | 3.36 | 2.48 | 3.66 | **2.32** | **2.35** |
| Number of Mortalities | 0 | 0 | 1 | **18** | 1 | 2 | 3 | 1 | 0 | 3 | 4 | 2 | **16** | **50** |
| Inpatient Patient Days | 162 | 112 | 128 | **1718** | 166 | 119 | 149 | 168 | 151 | 156 | 120 | 62 | **1091** | **4989** |
| Inpatient ALOS | 8.53 | 6.22 | 5.82 | **6.03** | 6.15 | 5.41 | 5.52 | 5.79 | 5.03 | 5.03 | 7.50 | 6.20 | **5.68** | **6.37** |
| Avg GMLOS | 5.11 | 4.59 | 4.17 | **4.49** | 4.67 | 4.32 | 4.09 | 3.94 | 3.59 | 5.55 | 5.04 | 3.35 | **4.42** | **4.63** |

Number of Transfers



# Future Cancer Tower

- 145K GSF
- Cell Therapy
- Bone-Marrow Transplant
- Oncology Ors
- Infusion
- Inpatient Floors
- Prostate Center
- Teaching & Research

# Future Children's Hospital

- 250K GSF
- Pediatric Emergency
- Trauma Services & ORs
- Labor & Delivery
- NICU
- PICU
- Pediatrics
- Teaching & Research

# Community Connect Program

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

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# What is Community Connect?

- **The Community Connect program allows smaller hospital and clinics direct access to the Epic EHR**
- **Renown manages the Epic platform and extends access to the partners while maintaining autonomy**
- **Enhanced Interoperability**
- **Regulatory and Technical Assurance**
- **Comprehensive Patient Record**

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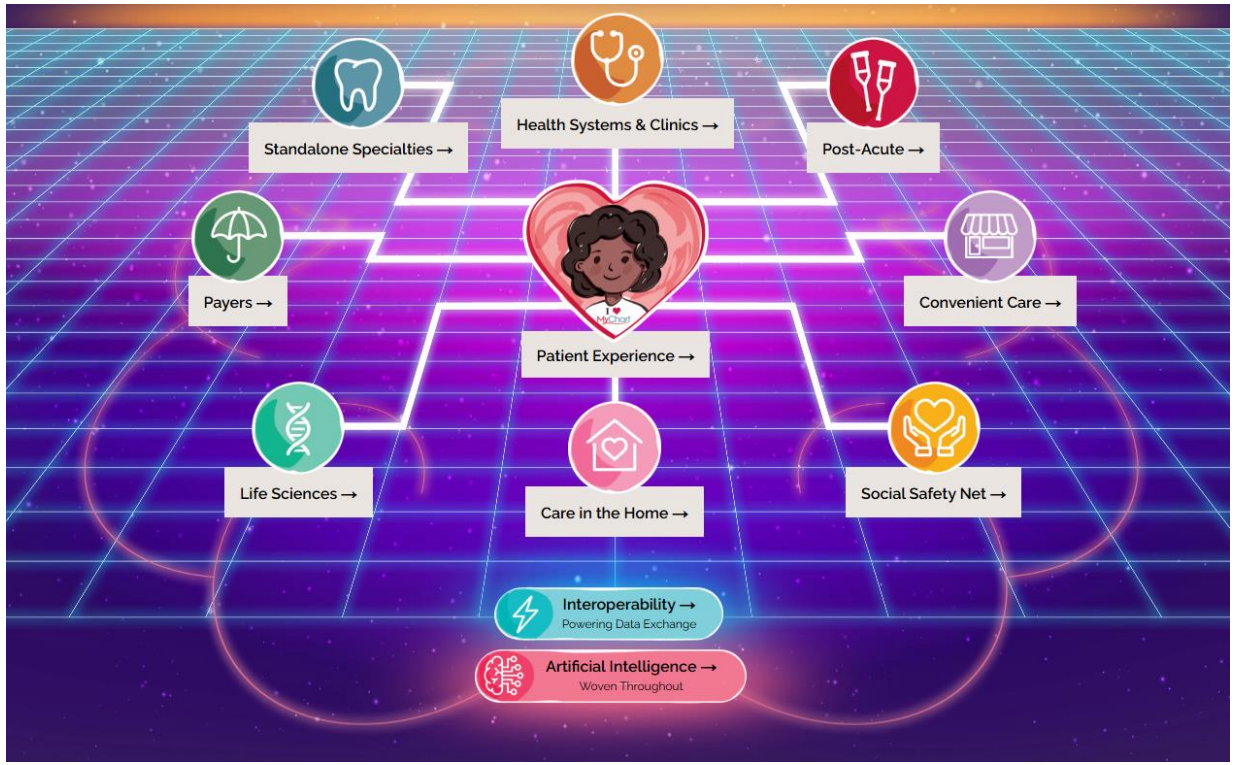
# Wide Range of Applications and Functionality

- **Core Clinical Applications**
- **Ancillary Clinical Applications**
- **Access Applications**
- **Revenue Applications**
- **Reporting**
- **Community Access**
- **Patient Portal**

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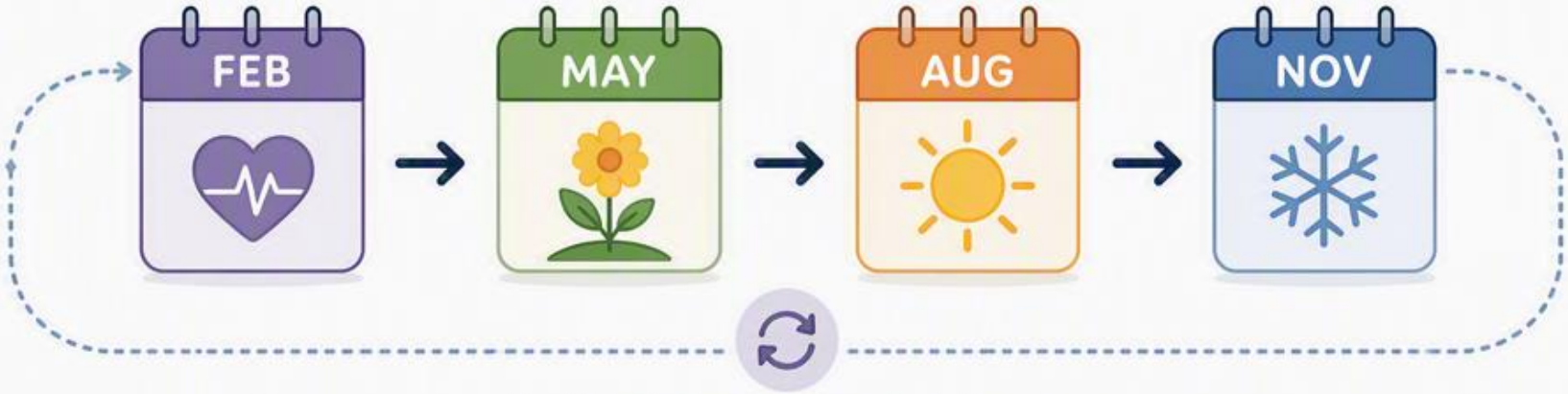
# EPIC UPGRADE CYCLE

Keeping our system current. Empowering our care.




## UPGRADES DELIVER VALUE

### ACCESS NEW FUNCTIONALITY

Take advantage of the latest Epic features and innovations.

### MAINTAIN REGULATORY COMPLIANCE

Stay aligned with industry standards and requirements.

### STAY SECURE & RELIABLE

Keep our system secure, stable, and supported.

Four upgrades a year keep our Epic environment innovative, compliant, and reliable.

# Shared Governance

*Stronger Together. Flexible for You.*

A balanced approach that standardizes where possible and allows local flexibility where it matters.


## STANDARDIZE
*where possible*

Common configurations, workflows, and processes set all of our sites up for success and improve the quality and efficacy of our support.

## SHARED GOVERNANCE

Working together to make the best decisions for our patients, providers, and communities.

## LOCALIZE
*where needed*

Recognizing rural and smaller organizations have unique needs that may require localized configuration.

## GUIDED BY OUR PRINCIPLES

### STANDARDIZATION FIRST
Adopt common configurations, workflows, and processes whenever possible.

### LOCAL FLEXIBILITY
Allow site-specific configuration when justified by a clear need.

### SHARED DECISION-MAKING
Engage host and Rural Connect representatives in governance discussions and decisions.

### SUPPORTABILITY & SUSTAINABILITY
Evaluate impact to system maintenance, upgrades, training, and support.

### TRANSPARENCY
Maintain clear documentation and communication of standards and decisions.

# Implementation Timelines

- **Approximately 8–9-month implementation**
- **2 weeks of Go-Live Support/Hypercare**
- **Post Live Check-Ins**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# Community Connect Pricing Estimate

- **Implementation costs include the implementation and one-time fees for licenses**

- **Maintenance Costs include software maintenance, break/fixes, small projects under 50 hours, optimizations, requests, and newly upgraded functionality 4 times a year**

| Cost Estimate Summary | |
|---|---|
| Implementation Costs | |
| One-Time Costs | $ 183,000.00 |
| Implementation | $ 560,000.00 |
| **Subtotal One-Time + Implementation** | $ 743,000.00 |
| 10% Contingency | $ 74,300.00 |
| **Subtotal with Contingency** | $ 817,300.00 |
| Maintenance Costs | |
| Monthly Maintenance* ($99,150 mth) | $ 1,189,800.00 |
| Quarterly Maintenance* ($7,500 qrt) | $ 30,000.00 |
| Annual Only Maintenance | $ 27,390 |
| **Yearly Subtotal** | $ 1,247,190.00 |

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renown.org

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

DATE: August 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Allison Partridge, CNO / COO

RE: Radiology Professional Services Request for Proposal (RFP)

**MEMORANDUM**

## Background

Northern Inyo Healthcare District is initiating a competitive Request for Proposal (RFP) process for Professional Radiology Services. Administration has initiated a competitive Request for Proposal (RFP) process to evaluate proposals from qualified providers for future Professional Radiology Services.

## Discussion

On August 5, 2026, the District released a Request for Proposal (RFP) for Professional Radiology Services. The RFP seeks proposals from qualified providers to furnish the physician professional services necessary to support the District's Diagnostic Imaging Department.

The scope of services includes 24-hour, seven-day-per-week radiology interpretation services (teleradiology), on-site radiologist coverage for interventional and therapeutic procedures, breast imaging services, medical direction, quality assurance activities, peer review, and collaboration with District staff to support patient care and regulatory requirements. The selected provider will support the District's existing Diagnostic Imaging Department, which offers X-ray, fluoroscopy, CT, MRI, ultrasound, DEXA, nuclear medicine, and mammography services.

The RFP establishes a competitive procurement process that includes proposal submission, evaluation, and, if appropriate, interviews or presentations before contract negotiations. Proposals are due August 31, 2026, with contractor selection anticipated in October 2026 and an anticipated service start date of May 3, 2027.

## Recommendations

This memorandum is provided for informational purposes. No Board action is requested at this time. Management will continue to administer the procurement process and will return to the Board with any items requiring Board approval.

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

July 27, 2026

REQUEST FOR PROPOSAL

Radiology Professional

Services RFP 2026-01

Due 5:00pm PDT Monday August 31, 2026

Table of Contents

**Section 1 – Introduction**

Northern Inyo Healthcare District is requesting proposals from qualified firms or individuals for Radiology Professional Services.

Proposers may deliver their proposals in the following ways:

1. Hard-copy proposals can be addressed and delivered to: Dianne Picken – Medical Staff Director, Northern Inyo Healthcare District, 150 Pioneer Lane, Bishop, CA 93514. If you will be submitting hard copies, please include two copies, with any Proprietary Information in a separate envelope. Proposals can also be delivered in person to the same address. (The Administration Building is generally open Monday-Friday, 0800- 1600 and can be accessed via Door #5.)

2. Proposals may be sent as one PDF file, with the exception of any Proprietary Information, which should be sent as a separate PDF file. Electronic submissions may be sent to: Dianne.Picken@nih.org

3. Proposals must be received on or before 5:00pm PDT Monday August 31, 2026, at which time a representative of the Executive Team will announce publicly the names of those firms or individuals submitting proposals. No proposals will be accepted after this time. Any public disclosure will be made in accordance with the California Public Records Act and the provisions of this RFP.

4. Proposers should not assume that proposals have been received until an Acknowledgement of Proposal receipt is provided by NIHD.

Northern Inyo Healthcare District's Overnight Delivery (FedEx, Airborne, and UPS)

address is: Dianne Picken, Medical Staff Director
Northern Inyo Healthcare
District 150 Pioneer Lane
Bishop, CA 93514

NORTHERN INYO HEALTHCARE DISTRICT

_____

Christian Wallis
Chief Executive Officer
Issuing Executive

**Section 2 – RFP Procedures**

Inquiries

All inquiries concerning this RFP must be submitted in writing to Dianne Picken, Medical Staff Director at **Dianne.Picken@nih.org** no later than 5:00pm PDT on August 21, 2026. Respondents will carefully examine all documents included in this Request for Proposal (RFP) and shall make a written request for interpretation or correction of any ambiguity, inconsistency, or error herein. Any interpretation or correction will be issued as an Addendum and be posted on the website, www.nih.org. Only a written interpretation or correction by Addendum shall be binding. Respondents are cautioned against relying upon any interpretation or correction given by any other method.

Proposal Withdrawal

Proposers may withdraw their proposals by notifying the District in writing at any time prior to the proposal response time deadline. Proposers may withdraw their proposals in person or through an authorized representative. Proposals, once opened (hard copy or email), become property of the District and will not be returned to the Proposers

Proposal Disclosure

Proposers should be aware that proposals will become public records when in judgment of the District, the Public Records Act, requires disclosure. Proposers must invoke, in writing, the exemptions to disclosure provided by law in their response to the RFP by providing a specific statutory authority for claimed exemptions, identifying the data or other materials to be protected, and stating the reasons why such exclusion from public disclosure is necessary.

Proposals will be made available for public inspection at the time the District posts notice of its decision or intended decision concerning contract awards.

Any resulting contract award may be reviewed by any person after the contract has been executed by the District. The District has the right to use any and all information/material submitted in response to this Request for Proposals and/or resulting contract from it. Disqualification of a Respondent does not eliminate this right.

Public Records Act

All material submitted regarding this RFP becomes the property of the District. Proposers should take special note of this as it relates to any proprietary information that might be included in their offer. Any resulting contract may be reviewed by any person after the contract has been executed by the District. The District has the right to use any or all information/material submitted in response to this RFP process and/or any resulting contract from the same.

Disqualification of a proposal does not eliminate this right.

Anticipated RFP Schedule

The following schedule is tentative and may be modified by the District in its discretion:

| | Event | Scheduled Dates | |
|---|---|---|---|
| 1. | RFP Public Announcement | August 5, 2026 | |
| 2. | Deadline for Receipt of Questions | August 21, 2026 | |
| 3. | NIHD Responses to Questions, if any | August 24, 2026 | |
| 4. | Deadline for Receipt of Proposals | August 31, 2026, at 5:00pm PDT | |
| 5. | Optional Interviews, Presentations, or Requests for Clarification | September 2026, if requested by NIHD | |
| 6. | Anticipated Contractor Selection/Award Notification | On or about October 2, 2026 | |
| 7. | Anticipated Contract Execution | On or about November 2, 2026 | |
| 8. | Anticipated Service Start Date | May 3, 2027 | |

Any selection or award is subject to completion of all applicable District review and approval processes and execution of a definitive agreement acceptable to the District.

Delays

The District may delay or modify scheduled event dates if it is to the advantage of the District to do so. The District will notify Proposers of all changes in scheduled due dates by posting any changes by addenda on the website.

Addenda

If revisions or clarifications to the RFP become necessary, the District will provide written addenda posted on the District website, www.nih.org.

It is the responsibility of Proposers to closely monitor postings on the District's website. A listing acknowledging any and all posted addenda must accompany your proposal. In the event this listing is not with your proposal, it will be assumed that the respondent is aware of any and all addenda.

The District will not issue addenda less than five (5) days prior to the scheduled deadline date and time for receiving proposals, unless said date is to be postponed.

Oral Presentations and/or Interviews

At its sole discretion, the District may invite short-listed respondents to conduct oral presentations or interviews. Presentations or interviews provide an opportunity for Proposers to clarify their proposals for the District. The District will schedule any such presentations or interviews.

Acceptance or Rejection of Proposals

The District reserves the right to reject any and all proposals when (1) such rejection is in the best interest of the District; or (2) the proposal contains any irregularities; provided, however, that the District reserves the right to waive any minor irregularities and to accept the proposal determined most responsive and responsible and best meeting its needs. The right to accept or reject proposals is completely within the District Board and management's discretion regardless of the scoring or competitive details of the proposals. The District reserves the right to select one or more Proposers to proceed to negotiate terms of a contract and to continue to choose to negotiate with any one or more Proposers until such time as the District awards a final contract.

The District also reserves the right to cancel this RFP at any time and/or to solicit and re-advertise for other proposals. This RFP does not commit the District to award a contract or contracts.

Communication & Lobbying Restrictions

From the time the District posts this RFP, until it awards a contract to a successful Proposer, any Proposer (or any of its representatives or agents) is prohibited from any communication concerning this RFP with the Hospital's Executives, Staff, District Board of Directors and/or any agents thereof, except through the designated RFP contact identified in the Inquiries section. This restriction does not prohibit ordinary course clinical or operational communications unrelated to this RFP, including communications required under an existing agreement with the District. No department or office at the District has the authority to solicit or receive official proposals except as specified in this RFP. All solicitation is performed under direct supervision of the Issuing Executive. This does not apply to oral presentations before evaluation/selection teams, contract negotiations or public presentations made to the Hospital during any duly noticed public meeting. Violation of these provisions may result in disqualification, in the District's discretion.

Development Costs

Neither the District nor its representatives shall be liable for any expenses incurred in connection with the preparation, submission or presentation of a response to this RFP.

Conflicts of Interest

All Proposers must disclose with their proposal the name of any officer, director, or agent who is an elected official, appointed official, independent contractor or an employee of Northern Inyo Healthcare District and/or Northern Inyo Hospital. Further, all Proposers must disclose the name of any elected

official, appointed official, independent contractor or employee of the Hospital or the District who owns directly or indirectly, any interest in the Proposer's firm or any of its branches.

Non-Collusion

By submitting and signing a proposal response, the Proposer certifies that their offer is made without prior understanding, agreement, or connection with any corporation, firm or person submitting an offer for the same materials, services, supplies or equipment and is in all respects fair and without collusion or fraud. No premiums, rebates or gratuities are permitted, either with, prior to or after any delivery of material or provision of services. Any violation of this provision may result in contract cancellation, return of materials, or discontinuation of services and possible removal from the District's Vendor/Bid List(s).

Subcontracting

Firms submitting proposals may subcontract portions of the engagement to other firms. If this is to be done, that fact, and the name of the proposed subcontracting firms, must be clearly identified in the proposal. However, following award of the contract, no additional subcontracting or changes in subcontractors will be allowed without express prior written consent of the District. No compromise to insurance requirement shall be made for under insured vendors. Any approved subcontractor and its physicians must satisfy the applicable requirements of this RFP, and the successful Proposer will remain responsible for all subcontracted services.

Licenses and Permitting

Proposers, both corporate and individuals, must be or, by contract execution, become legally authorized to provide the professional medical services described in this RFP in the State of California. Each physician proposed to provide services must hold, or be eligible to obtain, all licenses and certifications required to perform the services and must obtain them before providing services. Proposers must identify in their proposals any pending licensure or certification and the anticipated date of completion. The successful Proposer and all physicians providing services must satisfy the credentialing and privileging requirements in Section 5 before providing services. Should the Respondent be unable to satisfy these requirements before commencement of services, the District may reject the proposal or withdraw the award.

**Section 3 – Purpose of the RFP**

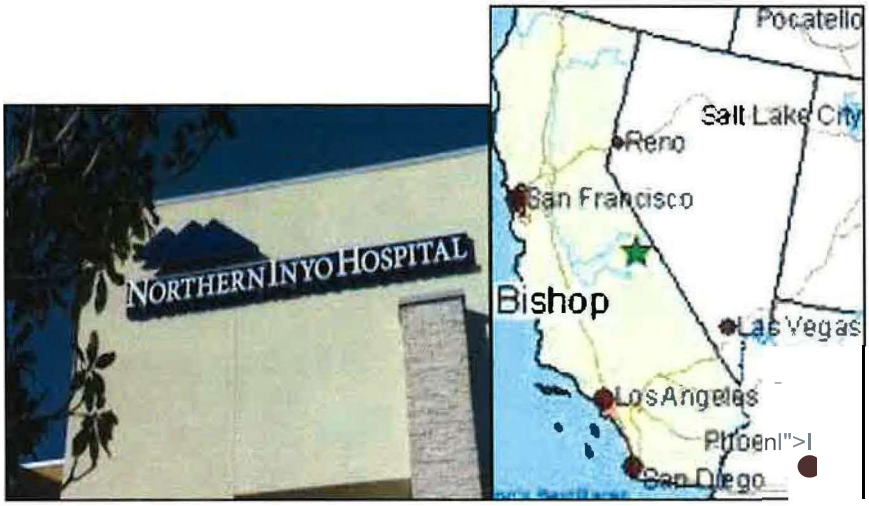
Intent

NIHD is seeking proposals to provide Radiology Professional Services that are able to deliver cost-effective, high quality service for our patients, NIHD and clinicians.

Background Information

About Us

NIHD is located in Bishop, California, a town in between two destination mountain ranges, the Sierra Nevada mountains to the West and the White Mountains to the East. There are many outdoor recreation opportunities to enjoy in and around Bishop and you can enjoy those activities in the most beautiful scenery most people will ever experience.




NIHD operates Northern Inyo Hospital, a 25-bed critical access, district designated, hospital. The hospital has 16 Medical-Surgical beds, 4 Intensive Care Unit beds and 5 Perinatal beds that has been providing healthcare in the Eastern Sierra region since 1946 and provides healthcare services in a county of 18,000+ people. There are also three state-of- the-art surgical suites and a large, modern Emergency Department. The district also operates a Rural Health Clinic that includes women's services and Northern Inyo Associates, which include outpatient clinics for General surgery, Orthopedics, Pediatrics, Allergy, Internal Medicine, and Telehealth Virtual Clinic Specialties.

There are approximately 1500 admissions per year; with 77% admitted through the ED. Our average inpatient daily census is approximately 6.98 with an average length of stay of about 3.64 days. (FY 2026).

Our Accreditation.

NIHD is the only acute care hospital for 150 miles that is accredited by The Joint Commission. This accreditation recognizes our healthcare quality improvement and risk management orientation. Staff from across the organization work together to develop and implement approaches that have the potential to improve care for the patients in our community.

Our DI department is accredited by the American College of Radiology for the following services:

- Computed Tomography
- Ultrasound
- Mammography
- Nuclear Medicine
- Magnetic Resonance Imaging
- Breast
- MRI

Our Mission

Improving our communities, one life at a time. One Team. One Goal. Your Health.

Our Vision

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with trusted regional partners.

NIHD Diagnostic Imaging (Radiology) Services

The Diagnostic Imaging (DI) Department provides emergency and inpatient radiography, CT and US services 24 hours per day, seven days per week. In addition, we provide in-patient, out-patient, and emergency patient services from Monday through Friday (excluding NIHD observed holidays) from 7am - 5:30pm. The DI Department requires 24-7-365 Teleradiology services that provide timely interpretations of all imaging exams and have the ability to provide subspecialized interpretations as requested / warranted.

In addition to the TeleRadiology coverage, NIHD requires on-site coverage by a provider(s) competent to perform the interventional / therapeutic procedures and breast health diagnostic / therapeutic procedures identified below. NIHD requires that on-site coverage provider schedule proposals account for the timely performance (within two weeks) of all on-site procedures outlined below.

The DI department includes the following modalities and services:

- General Radiography
- Fluoroscopy
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Ultrasound (including vascular)
- Dual Energy X-ray absorptiometry (DEXA)
- Nuclear Medicine (NM) - including Cardiac
- Mammography

- Diagnostic and therapeutic procedural services (described below)
- Breast health services (described below)

Therapeutic and diagnostic procedural services include but are not limited to the following:

- *Epidurals
- *Facet injections
- *SI joint injections
- *Myelograms
- *Lumbar punctures
- *Hip injections
- *Shoulder injections
- *Knee injections
- *Wrist injections
- *Ankle injections
- *Hysterosalpingograms
- *Thoracentesis / Paracentesis
- *CT guided biopsies
- *US guided biopsies
- *All GI fluoroscopic exams

*Require on-site Provider presence

The breast health program includes but may not be limited to the following:

- Screening Mammograms (w/ Tomography)
- Diagnostic Mammograms (w/ Tomography)
- MRI Breast
- Breast Ultrasound (whole breast and targeted)
- *Stereotactic Breast biopsies
- *US guided Breast biopsies
- *Breast Wire Localizations
- *Sentinel Node Imaging and Injections

*Require on-site Provider presence

Annual Volumes in the DI department for the most recent 12 month period (July 2025 – June 2026) are below.

| X-ray/ Fluoroscopy | CT | MRI | Ultrasound | DEXA | NM | Mammo | TOTAL |
|---|---|---|---|---|---|---|---|
| 10,475 | 4,814 | 1,985 | 6,025 | 659 | 361 | 2,575 | 26,894 |

An estimated overall payer mix for DI procedures is as follows:

| Payer | % |
|---|---|
| Medicare | 44% |
| Medicaid | 19% |
| Commercial | 32% |
| Worker's Compensation | 2% |
| All Other | 3% |
| Total | 100% |

Term of Contract

A three (3) year term with the possibility of a one-time 3-year renewal

**Section 4 – Specifications/Scope of Work**

It is the sole responsibility of the Proposer to read and understand the requirements and specifications herein, as well as the Mandatory Requirements in Section 5.

In this RFP, NIHD seeks the submission of proposal to provide services from any and all interested and qualified proposers. NIHD seeks, by way of this RFP, to obtain the services described in the Services section above, in a manner that maximizes the quality of services while also maximizing the value to the patients of NIHD.

Proposers must be able to show that they are capable of performing the services requested. Such evidence includes, but is not limited to, the respondent's demonstrated competency and experience in delivering services of a similar scope and type and local availability of the proposer's personnel and equipment resources.

The proposer's proposal should address the following:

1 Qualifications and Experience

1.1 Please provide the following information:

| Radiology Individual/Group Name - Key Contacts | | | |
|---|---|---|---|
| Name | Title | Email | Phone |
| | | | |
| | | | |

| Radiology Individual/Group Information | |
|---|---|
| # Radiologists | |
| # Specialists | |
| # Support Staff | |

| # Other Employees | |
|---|---|

| Key Medical Specialists | | |
|---|---|---|
| Name | Title | Specialty |
| | | |
| | | |

| Imaging Centers Owned or Operated | | |
|---|---|---|
| Imaging Center Name | Address | Home |
| | | |
| | | |

1.2 Please provide a list of all hospital contracts you have won in the last 12 months.

1.3 Please provide a list of all hospital contracts terminated or not renewed in the last 12 months and briefly explain the reason for each termination or nonrenewal.

1.4 List the professional qualifications for each individual that would be assigned to provide services requested by this RFP, including any applicable degrees, additional applicable training, and any professional certifications/licensing.

1.5 Describe the services provided by you (individual) or your organization and a statement of the extent of experience/history of providing services requested by this RFP.

1.6 Provide three (3) references of clients that you currently serve. Provide the company name and address and the name, positions, telephone number and email address of a contact person. Supply references that are most comparable to NIHD.

2 Staffing Model, Service Coverage & Staff Management

2.1 Describe how the individual or group proposes to provide radiologist coverage and services to the hospital 24x7x365. Include any 3rd party groups that would be included in the proposed services. Please include your on-site staffing plan, including the proposed on-site schedule and backup coverage, and indicate if you will assign radiologists to work exclusively at our hospital.

2.2 Describe any areas of sub-specialty provided by your group and how those services are provided. Please indicate the qualifications used to determine specialty service and describe the availability and expected turnaround times for those services.

2.3 What advantages does your organization have in its ability to recruit and hire quality radiologists?

2.4 How are your radiologists compensated and incentivized to achieve performance goals?

2.5 Describe your proposed transition plan and timeline, including licensing, credentialing and

privileging, staffing, technology integration, and readiness for the anticipated service start date.

3 Customer Service

3.1 What is your approach to patient satisfaction and/or patient experience?

3.2 In the event of the identification of a problem by NIHD, its patients and/or other applicable constituents, describe how you will address such problems and the time frame for addressing them.

3.3 Describe how referring consultations are supported. Please include hours of availability, how consultations are coordinated and access to second opinions.

4 Quality Assurance and Performance Improvement

4.1 Describe your approach towards ensuring delivery of high quality services.

4.2 Describe how identified quality issues are addressed, tracked, reported and communicated with the hospital.

4.3 Describe your standard approach to "Peer Review" and your peer review process. Please include tools used, "blinding" process, how quality is measured and the standards levels assessment used.

4.4 Describe your approach toward ensuring that "Critical Findings" are tracked and communicated effectively. Please include tools used, report tracking and team staff involved to support this process, including applicable communication timeframes and escalation procedures when the ordering or responsible provider cannot be reached, and include an example of the report that will be provided to the hospital.

4.5 In the event of a quality concern with an identified radiologist, describe the process to address and remove the radiologist from the hospital practice. Please describe any potential impact to the level of service for the hospital as a result of this process and how qualified replacement coverage will be provided without interruption of services.

4.6 Final Report Turn-around Times

4.6.1 Describe your current turnaround times based on a 24x7 environment?

4.6.2 Describe how report turnaround times are measured and reported to the hospital and include an example of a report that would be used to report turnaround time performance.

4.7 Describe any utilization reports, performance metrics, etc...that you will provide the hospital on an ongoing basis and the tools you will use to help us understand how our department is

performing.

4.8 Describe your experience in improving clinical effectiveness, such as experience with imaging protocol development, radiation dose reduction initiatives, review of order appropriateness, development of ordering guidelines, reducing practice variation.

4.9 Please provide the name and contact information for your identified quality officer.

5 Compliance/Risk Management

5.1 Please list and describe any claims and regulatory violations against your organization in the past five years.

5.2 Please describe the methods or processes that you use to maintain compliance and minimize risk?

6 Financial Considerations

6.1 How do you propose to structure this contract financially?

6.2 Provide a description of your capabilities and experience with professional billing.

6.3 How do you propose to address billing and collections? (Include complaint resolution and interaction with the hospital) If you will use an outside service, please provide the name, address and phone number of the proposed billing service.

6.4 Please provide financial statements for the last two years. If you are an individual and do not have business financial statements, please include pro-forma financial statements and a financial plan for the next three years. In the latter case, the payer mix and volumes shown in Section 3 may be useful.

7 Technology Capability

7.1 Describe capabilities and provide examples of how the Proposer would work with NIHD and the NIHD IT Department to store/transmit images from the NIHD Diagnostic Imaging Department to the proposer and from the proposer to provide results/images for providers to be viewed in the systems currently in use by NIHD.

**Section 5 – Mandatory Requirements**

The successful Proposer will provide Radiology Professional Services required to care for the patients treated at the Hospital and to operate the Department as determined by the Hospital and its Medical Staff in accordance with recognized professional standards. The Proposer will agree to the following:

1. There will be no relationship of employer or employee created by any subsequent agreement.

Any physician providing services for the service will not have a claim against the hospital for vacation pay, sick leave, retirement benefits of any kind.

2. The service provider shall supply a physician who shall act as Medical Director for the service.

3. Radiologists must be able to obtain appointment to the Hospital Medical Staff for the appropriate department and maintain such privileging.

4. Radiologists must maintain appropriate liability insurance coverage in the amounts of $1,000,000 per occurrence and $3,000,000 aggregate, as well as adequate "tail" coverage.

5. Participation in Performance Improvement and Peer review activities consistent with hospital licensing and accreditation standards.

6. Participation in the development of and adherence to protocols, which support evidence-based care, best practices and patient satisfaction.

7. Disaster coverage to be provided by one (1) on site Radiologist.

8. Complete required medical records/clinical documentation in accordance with time frames specified by Medical Staff By-Laws, Medical Staff Rules and Regulations and/or related hospital policies and procedures.

9. Regular consultation between the Administrator, Medical Executive Committee and/or other designated party or committees on matters related to the Department including productivity, quality, service and patient satisfaction.

10. Designate physician(s) to serve as Radiation Safety Officer and Magnetic Resonance Safety Officer.

11. Supervision and training of radiology personnel in conjunction with Director of Diagnostic Imaging.

12. Cooperation with NIHD to provide a Quality Assurance and Performance Improvement program consistent with agency and accreditation standards.

**Special Provisions**

A. Compliance with Laws/Permits/Licenses

Successful proposer shall give all notices and comply with all federal, state and municipal laws, ordinances, rules, statutes, regulations, code and orders of any public authority bearing on the performance of the contract including, but not limited to, the laws referred to in this RFP. Upon request, Proposer shall furnish copies of any licenses or permits required to comply with these laws, orders, ordinances, rules, statutes, regulations and codes, not currently maintained by the District. The successful Proposer shall be responsible for obtaining all necessary permits and licenses required for performance under any contract results from this RFP for which the District is not currently responsible.

B. Insurance and Liability

1. Within ten (10) days following the District Board's decision to award a contract to Proposer, such successful proposer shall provide Certificates of Insurance evidencing the required coverage. Throughout the term of the contract, successful Proposer shall submit original Certificates of Insurance reflecting the coverage herein.

2. The District shall be named as an additional insured party and a waiver of subrogation in favor of the District shall be issued on all policies of insurance, as its interest may appear as stated previously. The District shall be provided with 30 days' advance written notice prior to any termination, cancellation or material change to said insurance policies.

Rev. 07-15-2026 lew

Investment Accounts Report - August 2026

| Account Number | Account | Beginning Balance July 1,2025 | Ending Balance June 30, 2026 | Maturity Date | Beg Interest Rate | Ending Interest Rate | Interest Income/Accrued Interest FY26 |
|---|---|---|---|---|---|---|---|
| 600250 | *Mass Mutual Debt Service Reserve* | 575,000.00 | 575,000.00 | | 6.75% | 6.75% | 38,812.50 |
| 20-14-002 | *LAIF* | 5,402,176.98 | 10,640,619.20 | | 4.26% | 3.82% | 280,417.43 |
| XXXX1007 | *Five Star Bank* | - | 24,371,866.00 | | 4.21% | 3.81% | 371,866.00 |
| 6701642 | *Nursing Scholarship Fund* | 25,141.73 | 25,204.67 | | 0.02% | 0.02% | 63.00 |
| 66101029 | *ESCB B&I Fund Reconciliation* | 1,444,150.51 | 1,445,595.37 | | 0.82% | 0.82% | 1,444.86 |
| QRT-183196 | ***Financial Northeastern Companies*** | 1,851,035.72 | 249,897.50 | | | | 53,900.20 |
| 720121AR3 | Piedmont BK Peachtree Corners | 250,037.50 | - | Retired on 7/11/2025 | 5.10% | 5.10% | |
| 06428F4Z7 | Bank of China New York City BRH CFT | 249,982.50 | - | Retired on 7/15/2025 | 4.25% | 4.25% | |
| 5974OJ3U1 | Midfirst BK Okla City Dep | 249,985.00 | - | Retired on 7/10/2025 | 4.20% | 4.20% | |
| 85628AAC4 | State BK India Chicago Ill CTF | 249,812.50 | - | Retired on 10/6/2025 | 4.15% | 4.15% | |
| 06452OBMO | Bank Princeton New Jersey CTF | 99,905.00 | - | Retired on 10/23/2025 | 4.10% | 4.10% | |
| 33847GJW3 | Flagsstar BK Natl Assn Hicksville NY CTF | 251,077.50 | - | Retired on 01/12/2026 | 5.00% | 5.00% | |
| 12527CKU5 | CFG Cmnty BK Lutherville | 249,722.50 | - | Retired on 4/15/2026 | 4.15% | 4.15% | |
| 856487BL6 | State BK Reeseville Wis | 250,187.50 | | | | | |
| 06051X6Q0 | Bank Amer NA Charlotte NC | - | 249,897.50 | 10/22/2026 | 3.90% | 3.90% | |
| RMB-004151 | ***Multi-Bank-Securities*** | 985,820.47 | 247,029.64 | | | | 27,439.48 |
| 31762FAF6 | Financial Partners CR Downy | 249,902.50 | | | | | |
| 38149ME33 | Goldman Sachs | | | | | | |
| 208212BL3 | Connex CR Un North Haven Conn SH CT | 250,095.00 | | | | | |
| 46657VLZ1 | JPMorgan Chase BK | 238,902.01 | | | | | |
| 12527CGR7 | CFG Cmnty BK Lutherville | 246,575.16 | | | 4.25% | 4.25% | |
| **Total** | | **10,283,325.41** | **37,555,212.38** | | | | **773,943.47** |

# Northern Inyo Healthcare District

## Chief Financial Officer Report

**Financial Summary and Operational Insights – Fiscal Year Ended June 30, 2026 (FYE 2026)**

**Date:** August 2026
**To:** Board of Directors, Northern Inyo Healthcare District
**From:** Andrea Mossman, Chief Financial Officer

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# Executive Summary

Northern Inyo Healthcare District concluded Fiscal Year 2026 with financial results that exceeded budget despite continued inflationary pressures on labor and operating expenses. Strong patient volumes, particularly in surgical services, improved reimbursement, enhanced revenue cycle performance, and favorable non-operating income strengthened both earnings and liquidity throughout the year.

Although labor costs and supply expenses remain areas requiring continued attention, the organization is well positioned financially, with improved cash reserves, stronger collections, and continued growth in strategically important service lines.

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# Financial Performance

## June 2026 Results

June closed with a **net profit of $4.8 million**, exceeding budget by **$2.3 million**. Operating income totaled **$4.8 million**, outperforming budget by **$3.7 million**.

Performance for the month was primarily driven by:

- Year-end pension accounting adjustments
- A **$2.0 million Medicare interim rate review settlement** related to prior underpayments

- Strong orthopedic surgical volumes

These favorable results were partially offset by unbudgeted compensation adjustments and increased supply costs associated with higher surgical activity.

**Key Takeaway:** June produced exceptionally strong financial results driven by favorable year-end adjustments, Medicare reimbursement, and continued surgical growth.

## Fiscal Year 2026 Results

For Fiscal Year 2026, NIHD generated a **net profit of $10.5 million**, exceeding budget by **$3.5 million**.

Operating performance remained challenged by rising labor and supply costs, resulting in an **operating loss of $8.0 million**, approximately **$551,000 unfavorable to budget**.

The favorable year-end net income was primarily attributable to:

- An unbudgeted **Employee Retention Credit (ERC)** refund, including interest, related to 2021 employer payroll taxes
- Higher-than-budgeted surgical volumes
- Improved cash collections and investment income

Growth in general surgery, orthopedic surgery, and urology continued to drive revenue, partially offsetting increased compensation expenses resulting from wage adjustments and higher supply costs.

**Key Takeaway:** Fiscal Year 2026 exceeded budget due to sustained growth in key surgical service lines, improved revenue cycle performance, and favorable non-operating income despite continued operating cost pressures.

---

# Volume and Operational Performance

Patient activity remained strong throughout June, with nearly every major service line exceeding budget.

## June Highlights

- Admissions exceeded budget by **22 cases (34%)**
- Inpatient days increased **72 days (43%)** above budget

- Average Daily Census exceeded budget by **43%**
- Emergency Department visits were **1% above budget**
- Rehabilitation visits exceeded budget by **38%**
- Rural Health Clinic visits were **7% above budget**
- Diagnostic Imaging volumes were **12% above budget**
- Surgical volume exceeded budget by **10 cases (7%)**, driven by growth in general surgery, orthopedics, and urology. Lower gynecology and ophthalmology volumes reflected physician retirement and turnover.

**Key Takeaway:** June volume performance remained exceptionally strong, with broad-based growth across the organization and continued expansion of surgical services.

## Fiscal Year 2026 Highlights

For the fiscal year, several key indicators exceeded budget:

- Admissions increased by **46 cases (5%)**
- Inpatient days increased by **55 days (2%)**
- Average Daily Census exceeded budget by **2%**
- NIA clinic visits increased **3%**
- Diagnostic Imaging volumes increased **7%**

Areas below budget included:

- Emergency Department visits (33 visits below budget)
- Deliveries (10 below budget)
- Rehabilitation visits (3% below budget)
- Rural Health Clinic visits (2% below budget)
- Total surgeries finished **15 cases (1%) below budget**, primarily due to the unplanned retirement of an ophthalmologist, resulting in **277 fewer ophthalmology procedures**.

Despite this decline, several strategic surgical service lines significantly outperformed expectations:

- General Surgery: **108 cases above budget (13%)**
- Orthopedics: **79 cases above budget (38%)**
- Urology: **31 cases above budget (21%)**

**Key Takeaway:** Strategic surgical growth continues to offset declines in ophthalmology and remains a significant driver of organizational performance.

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# Revenue Performance

June gross patient revenue exceeded budget by **$3.8 million**, reflecting higher patient volumes and an unbudgeted reimbursement rate increase.

Contractual allowances increased proportionately with gross revenue, resulting in net patient revenue approximately **44% above budget** for the month.

For Fiscal Year 2026:

- Net patient revenue exceeded budget by **$8.0 million (7%)**
- Gross patient revenue also finished **7% above budget**

**Key Takeaway:** Revenue growth continues to be supported by sustained patient demand, favorable reimbursement, and expanded surgical activity.

---

# Expense Performance

## June

Operating expenses exceeded budget by **$186,000 (2%)**.

Key variances included:

- Salaries, wages, and benefits were **31% below budget** due to year-end pension adjustments.
- Supply expense exceeded budget by **$1.8 million**, consistent with increased patient volumes.
- Professional fees were **$278,000 below budget**.

## Fiscal Year 2026

Total operating expenses exceeded budget by **$8.6 million (7%)**.

Primary drivers included:

- Salaries, wages, and benefits were **3% above budget** due to negotiated wage increases.
- Supply expense exceeded budget by **$2.9 million**, reflecting increased surgical activity and orthopedic implant costs.
- Professional fees exceeded budget by **$2.2 million**, primarily due to productivity-based physician compensation and billing and collection fees that supported higher volumes and improved cash collections.

**Key Takeaway:** Expense growth reflects continued investment in patient care and increased clinical activity. Managing labor and supply costs remains a strategic priority.

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# Labor and Workforce

Labor management remains a key organizational focus.

Fiscal Year 2026 highlights include:

- Contract labor expense finished **$299,000 below budget**
- Contract labor staffing averaged **4.3 FTEs below budget**
- Agency labor costs remained elevated, particularly within Labor & Delivery
- Salaries, wages, and benefits represented **55% of operating expenses**, compared with the long-term organizational goal of **50% or less**

Achieving the labor target would represent approximately **$6 million in annual savings**.

**Key Takeaway:** Progress continues toward reducing reliance on contract labor while maintaining safe staffing levels. Workforce productivity and labor optimization remain strategic priorities.

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# Cash and Liquidity

Liquidity strengthened significantly during Fiscal Year 2026.

Highlights include:

- **122 Days Cash on Hand**
- **$39.6 million in unrestricted cash**, an increase of approximately **$11 million** from the prior year
- Approximately **$8 million** received through the Employee Retention Credit program

Revenue cycle improvements also strengthened cash flow:

- Accounts receivable days improved by **8 days**
- Bad debt and write-offs improved by **$1.6 million**
- Accounts receivable balances over 90 days decreased by **$1.8 million**

**Key Takeaway:** Strong operating performance, improved collections, and enhanced revenue cycle management significantly strengthened the organization's liquidity.

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# Overall Assessment

Fiscal Year 2026 demonstrated continued operational and financial improvement.

Growth in admissions, surgical services, diagnostic imaging, and outpatient clinics generated revenue above budget while ongoing revenue cycle initiatives improved cash flow and liquidity. Although labor and supply costs continue to create operating pressure, the organization successfully exceeded budget through sustained volume growth, disciplined financial management, and favorable non-operating income.

Overall, NIHD enters Fiscal Year 2027 from a position of improved financial strength.

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# Strategic Priorities for Fiscal Year 2027

Management will continue to focus on the following priorities:

- Expand orthopedic, urology, and general surgery programs
- Improve operating room utilization and clinic scheduling efficiency
- Continue revenue cycle optimization through enhanced coding, denials management, and collections
- Improve labor productivity and workforce optimization
- Implement supply chain and operating room cost reduction initiatives
- Maintain disciplined expense management while supporting strategic growth

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# Conclusion

Fiscal Year 2026 represents another year of meaningful financial progress for Northern Inyo Healthcare District. Strong growth in admissions, surgical services, and outpatient volumes, combined with improved reimbursement and enhanced revenue cycle performance, produced results that exceeded budget and significantly strengthened liquidity.

While labor and operating cost pressures remain, management continues to address these challenges through workforce optimization, operational efficiencies, and disciplined financial stewardship. These efforts position the organization well to continue investing in patient care while maintaining long-term financial sustainability.

# Northern Inyo Healthcare District

## June 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)** | 4,778,752 | 2,482,394 | 2,296,359 | 93% | 2,400,606 | 2,378,146 | (99%) | 10,529,020 | 6,978,975 | 3,550,045 | (51%) | 5,231,102 | 5,297,918 | 101% |
| **Operating Income (Loss)** | 4,760,792 | 1,042,099 | 3,718,692 | 357% | (6,735,735) | 11,496,526 | 171% | (8,058,576) | (7,507,651) | (550,925) | (7%) | (16,501,349) | 8,442,773 | (51%) |
| **EBIDA (Loss)** | 5,269,239 | 2,899,548 | 2,369,691 | 82% | 2,890,704 | 2,378,535 | (82%) | 16,162,133 | 11,984,821 | 4,177,312 | (35%) | 10,317,883 | 5,844,251 | 57% |
| IP Gross Revenue | 4,699,783 | 3,596,335 | 1,103,448 | 31% | 3,271,065 | 1,428,718 | 44% | 49,574,070 | 43,755,410 | 5,818,659 | 13% | 44,044,886 | 5,529,184 | 13% |
| OP Gross Revenue | 16,634,724 | 14,221,947 | 2,412,777 | 17% | 14,026,215 | 2,608,509 | 19% | 180,166,390 | 172,755,934 | 7,410,456 | 4% | 166,541,415 | 13,624,974 | 8% |
| Clinic Gross Revenue | 1,997,007 | 1,727,250 | 269,757 | 16% | 1,655,734 | 341,273 | 21% | 23,658,074 | 21,078,640 | 2,579,435 | 12% | 21,078,588 | 2,579,487 | 12% |
| **Total Gross Revenue** | **23,331,513** | **19,545,532** | **3,785,981** | **19%** | **18,953,014** | **4,378,499** | **23%** | **253,398,534** | **237,589,984** | **15,808,550** | **7%** | **231,664,888** | **21,733,645** | **9%** |
| **Net Patient Revenue** | **12,830,509** | **8,925,676** | **3,904,833** | **44%** | **4,449,499** | **8,381,009** | **188%** | **116,416,229** | **108,381,731** | **8,034,498** | **7%** | **100,607,508** | **15,808,721** | **16%** |
| ***Cash Net Revenue % of Gross*** | *55%* | *46%* | *9%* | *20%* | *23%* | *32%* | *134%* | *46%* | *46%* | *0%* | *1%* | *43%* | *3%* | *6%* |
| **Admits (excl. Nursery)** | 87 | 65 | 22 | 34% | 65 | 22 | 34% | 895 | 849 | 46 | 5% | 849 | 46 | 5% |
| **IP Days** | 271 | 199 | 72 | 36% | 199 | 72 | 36% | 2,935 | 2,887 | 48 | 2% | 2,887 | 48 | 2% |
| **IP Days (excl. Nursery)** | 239 | 167 | 72 | 43% | 167 | 72 | 43% | 2,540 | 2,485 | 55 | 2% | 2,485 | 55 | 2% |
| **Average Daily Census** | 8.0 | 5.6 | 2.4 | 43% | 5.6 | 2.4 | 43% | 7.0 | 6.8 | 0.2 | 2% | 6.8 | 0.2 | 2% |
| **ALOS** | 2.8 | 2.6 | 0.2 | 7% | 2.6 | 0.2 | 7% | 2.8 | 2.9 | (0.1) | (3%) | 2.9 | (0.1) | (3%) |
| **Deliveries** | 17 | 18 | (1) | (6%) | 18 | (1) | (6%) | 195 | 205 | (10) | (5%) | 205 | (10) | (5%) |
| **OP Visits** | 4,319 | 3,824 | 495 | 13% | 3,824 | 495 | 13% | 49,162 | 47,767 | 1,395 | 3% | 47,767 | 1,395 | 3% |
| Rural Health Clinic Visits | 2,380 | 2,159 | 221 | 10% | 2,159 | 221 | 10% | 27,866 | 27,720 | 146 | 1% | 27,720 | 146 | 1% |
| Rural Health Women Visits | 637 | 558 | 79 | 14% | 558 | 79 | 14% | 6,579 | 6,335 | 244 | 4% | 6,335 | 244 | 4% |
| Rural Health Behavioral Visits | 129 | 212 | (83) | (39%) | 212 | (83) | (39%) | 1,381 | 2,505 | (1,124) | (45%) | 2,505 | (1,124) | (45%) |
| **Total RHC Visits** | **3,146** | **2,929** | **217** | **7%** | **2,929** | **217** | **7%** | **35,826** | **36,560** | **(734)** | **(2%)** | **36,560** | **(734)** | **(2%)** |
| Bronco Clinic Visits | 10 | - | 10 | -% | - | 10 | 100% | 440 | 394 | 46 | 12% | 394 | 46 | 12% |
| Internal Medicine Clinic Visits | - | - | - | -% | - | - | -% | - | - | - | -% | - | - | -% |
| Orthopedic Clinic Visits | 302 | 238 | 64 | 27% | 238 | 64 | 27% | 3,931 | 4,038 | (107) | (3%) | 4,038 | (107) | (3%) |
| Pediatric Clinic Visits | 504 | 473 | 31 | 7% | 473 | 31 | 7% | 6,865 | 6,928 | (63) | (1%) | 6,928 | (63) | (1%) |
| Specialty Clinic Visits | 740 | 641 | 99 | 15% | 641 | 99 | 15% | 8,138 | 6,778 | 1,360 | 20% | 6,778 | 1,360 | 20% |
| Surgery Clinic Visits | 149 | 196 | (47) | (24%) | 196 | (47) | (24%) | 1,744 | 1,887 | (143) | (8%) | 1,887 | (143) | (8%) |
| Virtual Care Clinic Visits | - | 51 | (51) | (100%) | 51 | (51) | (100%) | 309 | 678 | (369) | (54%) | 678 | (369) | (54%) |
| **Total NIA Clinic Visits** | **1,705** | **1,599** | **106** | **7%** | **1,599** | **106** | **7%** | **21,427** | **20,703** | **724** | **3%** | **20,703** | **724** | **3%** |
| IP Surgeries | 13 | 3 | 10 | 333% | 3 | 10 | 333% | 142 | 129 | 13 | 10% | 129 | 13 | 10% |
| OP Surgeries | 139 | 139 | - | -% | 139 | - | -% | 1,518 | 1,546 | (28) | (2%) | 1,546 | (28) | (2%) |
| **Total Surgeries** | **152** | **142** | **10** | **7%** | **142** | **10** | **7%** | **1,660** | **1,675** | **(15)** | **(1%)** | **1,675** | **(15)** | **(1%)** |
| Cardiology | 4 | - | 4 | -% | - | 4 | 100% | 32 | 7 | 25 | 357% | 7 | 25 | 357% |
| General | 96 | 76 | 20 | 26% | 76 | 20 | 26% | 962 | 854 | 108 | 13% | 854 | 108 | 13% |
| Gynecology & Obstetrics | 6 | 23 | (17) | (74%) | 23 | (17) | (74%) | 126 | 151 | (25) | (17%) | 151 | (25) | (17%) |
| Ophthalmology | - | 30 | (30) | (100%) | 30 | (30) | (100%) | 68 | 295 | (227) | (77%) | 295 | (227) | (77%) |
| Orthopedic | 25 | 1 | 24 | 2,400% | 1 | 24 | 2,400% | 285 | 206 | 79 | 38% | 206 | 79 | 38% |
| Pediatric | - | - | - | -% | - | - | -% | - | 1 | (1) | (100%) | 1 | (1) | (100%) |
| Plastics | - | - | - | -% | - | - | -% | 2 | 2 | - | -% | 2 | - | -% |
| Podiatry | 1 | - | 1 | -% | - | 1 | -% | 4 | 6 | (2) | (33%) | 6 | (2) | (33%) |
| Urology | 19 | 11 | 8 | 73% | 11 | 8 | 73% | 180 | 149 | 31 | 21% | 149 | 31 | 21% |
| **Diagnostic Image Exams** | 2,381 | 2,134 | 247 | 12% | 2,134 | 247 | 12% | 26,895 | 25,216 | 1,679 | 7% | 25,216 | 1,679 | 7% |
| **Emergency Visits** | 897 | 889 | 8 | 1% | 889 | 8 | 1% | 10,186 | 10,219 | (33) | (0%) | 10,219 | (33) | (0%) |
| **ED Admits** | 57 | 44 | 13 | 30% | 44 | 13 | 30% | 558 | 515 | 43 | 8% | 515 | 43 | 8% |
| **ED Admits % of ED Visits** | 6% | 5% | 1% | 28% | 5% | 1% | 28% | 5% | 5% | 0% | 9% | 5% | 0% | 9% |
| **Rehab Visits** | 849 | 615 | 234 | 38% | 615 | 234 | 38% | 9,790 | 10,060 | (270) | (3%) | 10,060 | (270) | (3%) |
| **OP Infusion/Wound Care Visits** | 764 | 604 | 160 | 26% | 604 | 160 | 26% | 8,063 | 6,935 | 1,128 | 16% | 6,935 | 1,128 | 16% |
| **Observation Hours** | 1,532 | 1,196 | 335 | 28% | 1,196 | 335 | 28% | 15,284 | 17,469 | (2,185) | (13%) | 17,469 | (2,185) | (13%) |

**Provided by**: Chief Financial Officer
**Report Name:** June 2026 Financial Summary

# Northern Inyo Healthcare District

## June 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 % |
| **PAYOR MIX** (Patient Days) | | | | | | | | | | | | | | |
| Blue Cross | 18.4% | 22.2% | (3.7%) | (16.9%) | 22.2% | (3.7%) | (16.9%) | 22.6% | 23.2% | (0.6%) | (2.8%) | 23.2% | (0.6%) | (2.8%) |
| Commercial | 8.9% | 7.4% | 1.5% | 20.8% | 7.4% | 1.5% | 20.8% | 6.3% | 7.5% | (1.2%) | (16.4%) | 7.5% | (1.2%) | (16.4%) |
| Medicaid | 19.2% | 57.6% | (38.4%) | (66.6%) | 57.6% | (38.4%) | (66.6%) | 21.4% | 29.1% | (7.7%) | (26.4%) | 29.1% | (7.7%) | (26.4%) |
| Medicare | 51.5% | 8.0% | 43.5% | 542.5% | 8.0% | 43.5% | 542.5% | 47.6% | 37.5% | 10.1% | 26.8% | 37.5% | 10.1% | 26.8% |
| Self-pay | 0.7% | 1.0% | (0.2%) | (25.6%) | 1.0% | (0.2%) | (25.6%) | 1.9% | 1.9% | (0.0%) | (0.9%) | 1.9% | (0.0%) | (0.9%) |
| Worker's Comp | 1.2% | -% | 1.2% | -% | -% | 1.2% | -% | 0.2% | 0.3% | (0.1%) | (31.4%) | 0.3% | (0.1%) | (31.4%) |
| Other | -% | 3.9% | (3.9%) | (100.0%) | 3.9% | (3.9%) | (100.0%) | -% | 0.4% | (0.4%) | (100.0%) | 0.4% | (0.4%) | (100.0%) |
| **PAYOR MIX** (Gross Revenue) | | | | | | | | | | | | | | |
| Blue Cross | 24.7% | 27.2% | (2.5%) | (9.3%) | 27.2% | (2.5%) | (9.3%) | 27.8% | 26.7% | 1.1% | 4.1% | 26.7% | 1.1% | 4.1% |
| Commercial | 8.5% | 7.9% | 0.6% | 7.1% | 7.9% | 0.6% | 7.1% | 6.8% | 7.1% | (0.3%) | (4.5%) | 7.1% | (0.3%) | (4.5%) |
| Medicaid | 18.4% | 18.0% | 0.4% | 2.4% | 18.0% | 0.4% | 2.4% | 17.7% | 19.2% | (1.5%) | (7.7%) | 19.2% | (1.5%) | (7.7%) |
| Medicare | 44.4% | 44.3% | 0.1% | 0.3% | 44.3% | 0.1% | 0.3% | 44.7% | 43.6% | 1.1% | 2.5% | 43.6% | 1.1% | 2.5% |
| Self-pay | 2.9% | 1.9% | 1.0% | 52.7% | 1.9% | 1.0% | 52.7% | 2.0% | 2.2% | (0.2%) | (11.0%) | 2.2% | (0.2%) | (11.0%) |
| Worker's Comp | 0.9% | 0.6% | 0.4% | 63.4% | 0.6% | 0.4% | 63.4% | 0.8% | 1.0% | (0.2%) | (20.7%) | 1.0% | (0.2%) | (20.7%) |
| Other | 0.2% | 0.1% | 0.0% | 39.1% | 0.1% | 0.0% | 39.1% | 0.2% | 0.2% | 0.0% | 16.7% | 0.2% | 0.0% | 16.7% |
| **DEDUCTIONS** | | | | | | | | | | | | | | |
| Contract Adjust | (11,495,629) | (9,622,417) | (1,873,212) | 19% | (17,009,328) | 5,513,699 | (32%) | (131,086,874) | (117,072,737) | (14,014,137) | 12% | (118,159,553) | (12,927,321) | 11% |
| Bad Debt | (1,391,660) | (115,868) | (1,275,792) | 1,101% | 284,638 | (1,676,298) | (589%) | (5,077,770) | (1,409,728) | (3,668,043) | 260% | (6,686,608) | 1,608,838 | (24%) |
| Write-off | (493,717) | (707,802) | 214,086 | (30%) | (444,054) | (49,662) | 11% | (5,007,391) | (8,611,593) | 3,604,202 | (42%) | (8,730,569) | 3,723,178 | (43%) |
| **CENSUS** | | | | | | | | | | | | | | |
| Patient Days | 239 | 167 | 72 | 43% | 167 | 72 | 43% | 2,540 | 2,485 | 55 | 2% | 2,485 | 55 | 2% |
| Adjusted ADC | 40 | 31 | 8 | 27% | 31 | 8 | 27% | 36 | 36 | (0) | (0%) | 36 | (0) | (0%) |
| Adjusted Days | 1,189 | 968 | 221 | 23% | 968 | 221 | 23% | 12,985 | 13,070 | (85) | (1%) | 13,070 | (85) | (1%) |
| Employed FTE | 391.9 | 382.1 | 9.8 | 3% | 382.1 | 9.8 | 3% | 379.7 | 370.8 | 8.9 | 2% | 370.8 | 8.9 | 2% |
| Contract Labor FTE | 18.0 | 20.4 | (2.5) | (12%) | 20.4 | (2.5) | (12%) | 19.5 | 23.9 | (4.3) | (18%) | 23.9 | (4.3) | (18%) |
| Total Paid FTE | 409.9 | 402.6 | 7.3 | 2% | 402.6 | 7.3 | 2% | 399.2 | 394.7 | 4.5 | 1% | 394.7 | 4.5 | 1% |
| EPOB (Employee per Occupied Bed) | 1.7 | 2.4 | (0.7) | (29%) | 2.4 | (0.7) | (29%) | 1.9 | 1.9 | (0.0) | (1%) | 1.9 | (0.0) | (1%) |
| EPOC (Employee per Occupied Case) | 0.3 | 0.4 | (0.1) | (20%) | 0.4 | (0.1) | (20%) | 0.0 | 0.0 | 0.0 | 1% | 0.0 | 0.0 | 1% |
| Adjusted EPOB | 8.5 | 14.0 | (5.5) | (39%) | 14.0 | (5.5) | (39%) | 9.8 | 10.2 | (0.4) | (4%) | 10.2 | (0.4) | (4%) |
| Adjusted EPOC | 1.7 | 2.5 | (0.8) | (31%) | 2.5 | (0.8) | (31%) | 0.2 | 0.2 | (0.0) | (2%) | 0.2 | (0.0) | (2%) |
| **SALARIES** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 3,166 | 3,437 | (271) | (8%) | 5,695 | (2,528) | (44%) | 3,424 | 3,076 | 348 | 11% | 3,210 | 214 | 7% |
| Total Salaries | 3,763,985 | 3,326,869 | 437,116 | 13% | 5,511,992 | (1,748,007) | (32%) | 44,461,315 | 40,209,210 | 4,252,106 | 11% | 41,959,974 | 2,501,341 | 6% |
| Average Hourly Rate | 56.02 | 50.78 | 5.24 | 10% | 84.14 | (28.12) | (33%) | 56.15 | 52.00 | 4.15 | 8% | 54.26 | 1.89 | 3% |
| Employed Paid FTEs | 391.9 | 382.1 | 9.8 | 372.4 | 382.1 | 9.8 | 3% | 379.7 | 370.8 | 8.9 | 2% | 370.8 | 8.9 | 2% |
| **BENEFITS** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | (516) | 1,539 | (2,055) | (134%) | 615 | (1,131) | (184%) | 1,213 | 1,384 | (171) | (12%) | 1,287 | (74) | (6%) |
| Total Benefits | (613,596) | 1,489,410 | (2,103,006) | (141%) | 595,293 | (1,208,889) | (203%) | 15,745,463 | 18,087,698 | (2,342,236) | (13%) | 16,821,936 | (1,076,473) | (6%) |
| Benefits % of Wages | (16%) | 45% | (61%) | (136%) | 11% | -27% | (251%) | 35% | 45% | (10%) | (21%) | 40% | (5%) | (12%) |
| Pension Expense | (1,468,630) | 381,274 | (1,849,903) | (485%) | (288,661) | (1,179,968) | 409% | 2,496,187 | 4,640,194 | (2,144,007) | (46%) | 4,054,888 | (1,558,701) | (38%) |
| MDV Expense | 668,641 | 756,922 | (88,281) | (12%) | 510,871 | 157,770 | 31% | 9,374,347 | 9,209,222 | 165,125 | 2% | 8,790,515 | 583,832 | 7% |
| Taxes, PTO accrued, Other | 186,393 | 351,214 | (164,821) | (47%) | 373,083 | (186,690) | (50%) | 3,874,929 | 4,238,282 | (363,353) | (9%) | 3,976,533 | (101,604) | (3%) |
| **Salaries, Wages & Benefits** | 3,150,389 | 4,816,279 | (1,665,890) | (35%) | 6,107,285 | (2,956,896) | (48%) | 60,206,778 | 58,296,908 | 1,909,870 | 3% | 58,781,911 | 1,424,868 | 2% |
| **SWB/APD** | 2,650 | 4,976 | (2,326) | (47%) | 6,310 | (3,660) | (58%) | 4,637 | 4,460 | 176 | 4% | 4,497 | 139 | 3% |
| **SWB % of Total Expenses** | 39% | 61% | (22%) | (36%) | 54% | (15%) | (28%) | 52% | 54% | (2%) | (5%) | 55% | (3%) | (5%) |

**Provided by**: Chief Financial Officer
**Report Name:** June 2026 Financial Summary

# Northern Inyo Healthcare District

## June 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 % |
| **PROFESSIONAL FEES** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 2,251 | 2,799 | (548) | (20%) | 3,002 | (752) | (25%) | 2,714 | 2,529 | 185 | 7% | 2,459 | 255 | 10% |
| Total Physician Fee | 1,894,150 | 1,698,925 | 195,225 | 11% | 1,621,674 | 272,476 | 17% | 21,738,188 | 20,509,076 | 1,229,112 | 6% | 19,350,587 | 2,387,601 | 12% |
| Total Contract Labor | 402,182 | 353,063 | 49,120 | 14% | 537,390 | (135,208) | (25%) | 4,341,882 | 4,640,418 | (298,536) | (6%) | 5,369,335 | (1,027,453) | (19%) |
| Total Other Pro-Fees | 379,175 | 657,063 | (277,888) | (42%) | 746,924 | (367,749) | (49%) | 9,161,630 | 7,906,257 | 1,255,374 | 16% | 7,421,363 | 1,740,267 | 23% |
| Total Professional Fees | 2,675,507 | 2,709,051 | (33,543) | (1%) | 2,905,988 | (230,481) | (8%) | 35,241,700 | 33,055,751 | 2,185,949 | 7% | 32,141,285 | 3,100,415 | 10% |
| Contract AHR | 130.51 | 100.73 | 29.78 | 30% | 153.33 | (22.81) | (15%) | 106.51 | 93.14 | 13.37 | 14% | 107.77 | (1.26) | (1%) |
| Contract Paid FTEs | 18.0 | 20.4 | (2.5) | (12%) | 20.4 | (2.5) | (12%) | 19.5 | 23.9 | (4.3) | (18%) | 23.9 | (4.3) | (18%) |
| Physician Fee per Adjust Bed Day | 1,593 | 1,755 | (162) | (9%) | 1,675 | (82) | (5%) | 1,674 | 1,569 | 105 | 7% | 1,481 | 194 | 13% |
| **PHARMACY** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 308 | 451 | (144) | (32%) | 84 | 224 | 266% | 402 | 407 | (5) | (1%) | 329 | 73 | 22% |
| Total Rx Expense | 366,072 | 437,010 | (70,938) | (16%) | 81,516 | 284,556 | 349% | 5,223,395 | 5,316,953 | (93,557) | (2%) | 4,297,639 | 925,756 | 22% |
| **MEDICAL SUPPLIES** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 379 | (1,439) | 1,818 | (126%) | 1,289 | (910) | (71%) | 492 | 259 | 233 | 90% | 461 | 31 | 7% |
| Total Medical Supplies | 450,145 | (1,393,248) | 1,843,393 | (132%) | 1,247,647 | (797,503) | (64%) | 6,388,261 | 3,383,654 | 3,004,607 | 89% | 6,027,806 | 360,455 | 6% |
| **EHR SYSTEM** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 27 | 33 | (6) | (19%) | 45 | (19) | (41%) | 33 | 29 | 3 | 12% | 33 | (0) | (0%) |
| Total EHR Expense | 31,840 | 32,115 | (275) | (1%) | 44,018 | (12,178) | (28%) | 427,728 | 385,377 | 42,351 | 11% | 431,744 | (4,016) | (1%) |
| **OTHER EXPENSE** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 762 | 894 | (132) | (15%) | 343 | 418 | 122% | 874 | 799 | 75 | 9% | 793 | 81 | 10% |
| Total Other | 905,278 | 865,217 | 40,061 | 5% | 332,015 | 573,263 | 173% | 11,353,829 | 10,444,891 | 908,937 | 9% | 10,365,024 | 988,805 | 10% |
| **DEPRECIATION AND AMORTIZATION** | | | | | | | | | | | | | | |
| Per Adjust Bed Day | 413 | 431 | (18) | (4%) | 506 | (94) | (19%) | 434 | 383 | 51 | 13% | 389 | 45 | 11% |
| Total Depreciation and Amortization | 490,487 | 417,154 | 73,333 | 18% | 490,098 | 388 | 0% | 5,633,113 | 5,005,846 | 627,267 | 13% | 5,086,781 | 546,332 | 11% |
| **TOTAL EXPENSES** | 8,069,717 | 7,883,577 | 186,140 | 2% | 11,208,567 | (3,138,850) | (28%) | 124,474,804 | 115,889,382 | 8,585,423 | 7% | 117,132,190 | 7,342,614 | 6% |
| Per Adjust Bed Day | 6,788 | 8,145 | (1,357) | (17%) | 11,580 | (4,792) | (41%) | 9,586 | 8,867 | 719 | 8% | 8,962 | 624 | 7% |
| Per Calendar Day | 268,991 | 262,786 | 6,205 | 2% | 373,619 | (104,628) | (28%) | 341,027 | 317,505 | 23,522 | 7% | 320,910 | 20,117 | 6% |

**Provided by**: Chief Financial Officer
**Report Name:** June 2026 Financial Summary

| Key Financial Performance Indicators | Industry Benchmark | Jun-24 | FYE 2024 Average | Jun-25 | FYE 2025 Average | Mar-26 | Apr-26 | May-26 | Jun-26 | Variance to PM | Variance to FYE 2025 Average | Variance to PYM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Volume** | | | | | | | | | | | | |
| Admits | 41 | 71 | 69 | 65 | 71 | 92 | 72 | 86 | 87 | 1 | 16 | 22 |
| Deliveries | n/a | 22 | 17 | 18 | 17 | 18 | 12 | 13 | 17 | 4 | - | (1) |
| Adjusted Patient Days | n/a | 1,145 | 977 | 968 | 1,125 | 1,001 | 1,266 | 1,318 | 1,189 | (129) | 64 | 221 |
| Total Surgeries | 153 | 148 | 146 | 142 | 140 | 151 | 146 | 142 | 152 | 10 | 12 | 10 |
| ER Visits | 659 | 879 | 826 | 889 | 852 | 893 | 767 | 857 | 897 | 40 | 45 | 8 |
| RHC and Clinic Visits | n/a | 4,554 | 4,607 | 4,528 | 4,772 | 4,936 | 4,823 | 4,492 | 4,851 | 359 | 79 | 323 |
| Diagnostic Imaging Services | n/a | 1,814 | 2,069 | 2,134 | 2,129 | 2,368 | 2,311 | 2,286 | 2,381 | 95 | 252 | 247 |
| Rehab Services | n/a | 670 | 662 | 615 | 838 | 917 | 944 | 843 | 849 | 6 | 11 | 234 |
| **AR & Income** | | | | | | | | | | | | |
| Gross AR (Cerner only) | n/a | $ 54,287,686 | $ 52,823,707 | $ 45,165,161 | $ 50,813,697 | $ 48,086,679 | $ 46,907,846 | $ 48,573,893 | $ 49,621,284 | $ 1,047,391 | $ (1,192,413) | $ 4,456,123 |
| AR > 90 Days | $ 6,599,901.18 | $ 22,959,460 | $ 23,112,391 | $ 18,682,553 | $ 20,669,422 | $ 15,208,624 | $ 15,741,875 | $ 16,878,857 | $ 16,901,235 | $ 22,378 | $ (3,768,187) | $ (1,781,318) |
| AR % > 90 Days | 15% | 42.97% | 44.2% | 41.4% | 40.6% | 31.6% | 33.6% | 34.7% | 34.1% | -0.7% | -6.5% | -7.3% |
| Gross AR Days (per financial statements) | 60 | 89 | 85 | 71 | 80 | 62 | 66 | 66 | 64 | (2) | (16) | (8) |
| Net AR Days (per financial statements) | 30 | 63 | 58 | 126 | 71 | 40 | 52 | 53 | 40 | (14) | (31) | (86) |
| Net AR | n/a | $ 17,964,704 | $ 16,938,200 | $ 18,225,043 | $ 19,370,868 | $ 27,435,133 | $ 30,351,013 | $ 27,024,016 | $ 21,326,669 | $ (5,697,347) | $ 1,955,801 | $ 3,101,626 |
| Net AR % of Gross | n/a | 33.1% | 31.9% | 40.4% | 38.5% | 57.1% | 64.7% | 55.6% | 43.0% | -12.7% | 4.5% | 2.6% |
| Gross Patient Revenue/Calendar Day | n/a | $ 610,465 | $ 619,457 | $ 631,767 | $ 634,418 | $ 770,059 | $ 710,721 | $ 735,348 | $ 777,717 | $ 42,369 | $ 143,299 | $ 145,950 |
| Net Patient Revenue/Calendar Day | n/a | $ 284,303 | $ 292,759 | $ 148,317 | $ 273,563 | $ 378,447 | $ 305,566 | $ 316,717 | $ 427,684 | $ 110,967 | $ 154,120 | $ 279,367 |
| Net Patient Revenue/APD | n/a | $ 7,449 | $ 8,757 | $ 4,597 | $ 8,088 | $ 11,720 | $ 7,240 | $ 7,450 | $ 10,793 | $ 3,343 | $ 2,705 | $ 6,196 |
| **Wages** | | | | | | | | | | | | |
| Wages | n/a | $ 3,033,481 | $ 3,285,431 | $ 5,511,992 | $ 3,661,965 | $ 3,839,305 | $ 3,851,445 | $ 3,684,604 | $ 3,763,985 | $ 79,381 | $ 102,019 | $ (1,748,007) |
| Employed paid FTEs | n/a | 353.75 | 353.69 | 382.15 | 370.77 | 388.32 | 387.36 | 367.32 | 391.92 | 24.60 | 21.16 | 9.77 |
| Employed Average Hourly Rate | $55.50 | $ 50.02 | $ 53.49 | $ 84.37 | $ 56.89 | $ 55.97 | $ 58.16 | $ 56.78 | $ 56.18 | $ (0.61) | $ (0.71) | $ (28.19) |
| Benefits | n/a | $ 1,456,281 | $ 1,640,216 | $ 595,293 | $ 1,401,858 | $ 2,111,276 | $ 1,271,979 | $ 1,840,959 | $ (613,596) | $ (2,454,555) | $ (2,015,454) | $ (1,208,889) |
| Benefits % of Wages | 30% | 48.0% | 48.8% | 10.8% | 39.8% | 55.0% | 33.0% | 50.0% | -16.3% | -66.3% | -56.1% | -27.1% |
| Contract Labor | n/a | $ 774,264 | $ 518,351 | $ 537,390 | $ 447,445 | $ 280,557 | $ 426,165 | $ 484,968 | $ 402,182 | $ (82,786) | $ (45,263) | $ (135,208) |
| Contract Labor Paid FTEs | n/a | 25.95 | 23.49 | 20.45 | 23.89 | 19.83 | 21.77 | 19.76 | 17.06 | (2.69) | (6.83) | (3.38) |
| Total Paid FTEs | n/a | 379.71 | 377.18 | 402.59 | 394.65 | 408.16 | 409.13 | 387.08 | 408.98 | 21.91 | 14.33 | 6.39 |
| Contract Labor Average Hourly Rate | $ 81.04 | $ 174.03 | $ 123.22 | $ 153.75 | $ 120.98 | $ 80.07 | $ 114.49 | $ 138.96 | $ 137.89 | $ (1.07) | $ 16.91 | $ (15.86) |
| Total Salaries, Wages, & Benefits | n/a | $ 5,264,026 | $ 5,443,998 | $ 6,644,675 | $ 5,511,268 | $ 6,231,139 | $ 5,549,590 | $ 6,010,531 | $ 3,552,571 | $ (2,457,960) | $ (1,958,697) | $ (3,092,104) |
| SWB% of NR | 50% | 61.7% | 62.1% | 149.3% | 72.0% | 53.1% | 60.5% | 61.2% | 27.7% | -33.5% | -44.3% | -121.6% |
| SWB/APD | 2,204 | $ 4,597 | $ 5,104 | $ 6,865 | $ 5,284 | $ 6,225 | $ 4,383 | $ 4,561 | $ 2,988 | $ (1,572) | $ (2,296) | $ (3,877) |
| SWB % of total expenses | 50% | 64.4% | 55.4% | 59.4% | 55.6% | 52.9% | 50.2% | 53.1% | 44.0% | -9.1% | -11.6% | -15.4% |

| Physician Spend | Industry Benchmark | Jun-24 | FYE 2024 Average | Jun-25 | FYE 2025 Average | Mar-26 | Apr-26 | May-26 | Jun-26 | Variance to PM | Variance to FYE 2025 Average | Variance to PYM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Physician Expenses | n/a | $ 1,621,674 | $ 1,613,172 | $ 1,621,499 | $ 1,507,510 | $ 1,937,506 | $ 2,127,062 | $ 1,802,579 | $ 1,894,150 | $ 91,572 | $ 386,640 | $ 272,651 |
| Physician expenses/APD | n/a | $ 1,675 | $ 1,565 | $ 1,675 | $ 1,476 | $ 1,935 | $ 1,680 | $ 1,368 | $ 1,593 | $ 226 | $ 117 | $ (82) |
| **Supplies** | | | | | | | | | | | | |
| Supply Expenses | n/a | $ 1,329,163 | $ 832,644 | $ (820,071) | $ 776,504 | $ 930,897 | $ 1,201,928 | $ 1,261,625 | $ 816,217 | $ (445,409) | $ 39,713 | $ 1,636,288 |
| Supply expenses/APD | | $ 1,373 | $ 822 | $ (847) | $ 744 | $ 930 | $ 949 | $ 957 | $ 687 | $ (271) | $ (58) | $ 1,534 |
| **Other Expenses** | | | | | | | | | | | | |
| Other Expenses | n/a | $ 1,589,722 | $ 1,939,040 | $ 726,251 | $ 1,824,207 | $ 2,672,831 | $ 2,180,443 | $ 2,238,409 | $ 1,806,779 | $ (431,630) | $ (17,428) | $ 1,080,528 |
| Other Expenses/APD | n/a | $ 1,642 | $ 1,861 | $ 750 | $ 1,787 | $ 2,670 | $ 1,722 | $ 1,699 | $ 1,520 | $ (179) | $ (267) | $ 770 |
| **Margin** | | | | | | | | | | | | |
| Net Income | n/a | $ 2,400,606 | $ 253,100 | $ 785,068 | $ 383,722 | $ 486,988 | $ (1,013,007) | $ 1,318,651 | $ 4,778,752 | $ 3,460,101 | $ 4,395,031 | $ 3,993,684 |
| Net Profit Margin | n/a | 54.0% | 3.7% | 9.2% | 3.0% | 4.2% | -11.1% | 13.4% | 37.2% | 23.8% | 34.3% | 28.0% |
| Operating Income | n/a | $ (6,735,735) | $ (1,557,761) | $ 356,735 | $ (686,444) | $ (40,522) | $ (1,892,040) | $ (1,494,921) | $ 4,760,792 | $ 6,255,712 | $ 5,447,236 | $ 4,404,057 |
| Operating Margin | 2.9% | -151.4% | -26.1% | 4.2% | -10.9% | -0.3% | -20.6% | -15.2% | 37.1% | 52.3% | 48.0% | 32.9% |
| EBITDA | n/a | $ 2,890,704 | $ 676,999 | $ 1,224,650 | $ 841,891 | $ 980,998 | $ (514,664) | $ 1,819,274 | $ 5,269,239 | $ 3,449,965 | $ 4,427,348 | $ 4,044,589 |
| EBITDA Margin | 12.7% | 65.0% | 9.4% | 14.4% | 8.7% | 8.4% | -5.6% | 18.5% | 41.1% | 22.5% | 32.3% | 26.7% |
| Debt Service Coverage Ratio | 3.70 | 3.9 | 3.9 | 3.9 | 3.3 | 3.5 | 3.2 | 3.5 | 5.6 | 2.1 | 2.3 | 1.7 |
| **Cash** | | | | | | | | | | | | |
| Avg Daily Disbursements (excl. IGT) | n/a | $ 295,398 | $ 350,828 | $ 332,307 | $ 355,328 | $ 363,206 | $ 624,096 | $ 694,374 | $ 507,119 | $ (187,256) | $ 151,790 | $ 174,811 |
| Average Daily Cash Collections (excl. IGT) | n/a | $ 343,912 | $ 340,919 | $ 291,820 | $ 299,110 | $ 328,025 | $ 384,546 | $ 457,527 | $ 342,069 | $ (115,457) | $ 42,959 | $ 50,249 |
| Average Daily Net Cash | | $ 48,514 | $ (9,908) | $ (40,487) | $ (56,218) | $ (35,181) | $ (239,550) | $ (236,848) | $ (165,049) | $ 71,798 | $ (108,831) | $ (124,562) |
| Upfront Cash Collections | | $ 64,886 | $ 54,286 | $ 34,997 | $ 36,146 | $ 88,629 | $ 74,703 | $ 63,036 | $ 69,792 | $ 6,756 | $ 33,646 | $ 34,794 |
| Upfront Cash % of Gross Charges | 1% | 0.3% | 0.3% | 0.2% | 0.2% | 0.4% | 0.4% | 0.3% | 0.3% | 0.0% | 0.1% | 0.1% |
| Unrestricted Funds | n/a | $ 28,996,641 | $ 23,774,285 | $ 25,138,815 | $ 23,536,438 | $ 32,334,262 | $ 34,024,342 | $ 37,776,129 | $ 39,597,763 | $ 1,821,634 | $ 16,061,325 | $ 14,458,947 |
| Change of cash per balance sheet | n/a | $ 1,088,506 | $ 321,485 | $ (2,649,693) | $ (321,485) | $ 8,523,178 | $ 1,690,081 | $ 3,751,786 | $ 1,821,634 | $ (1,930,152) | $ 2,143,120 | $ 4,471,327 |
| Days Cash on Hand (assume no more cash is collected) | 196 | 94 | 73 | 84 | 72 | 99 | 103 | 114 | 122 | 8 | 49 | 38 |
| Estimated Days Until Depleted (operating cash only) | | 858 | 2,399 | 447 | 406 | 583 | 461 | 426 | 417 | (9) | 11 | (31) |
| Years Until Cash Depletion (operating cash only) | | 2.35 | 6.57 | 1.23 | 1.11 | 1.60 | 1.26 | 1.17 | 1.14 | (0.03) | 0.03 | (0.08) |

# NIHD Financial Update

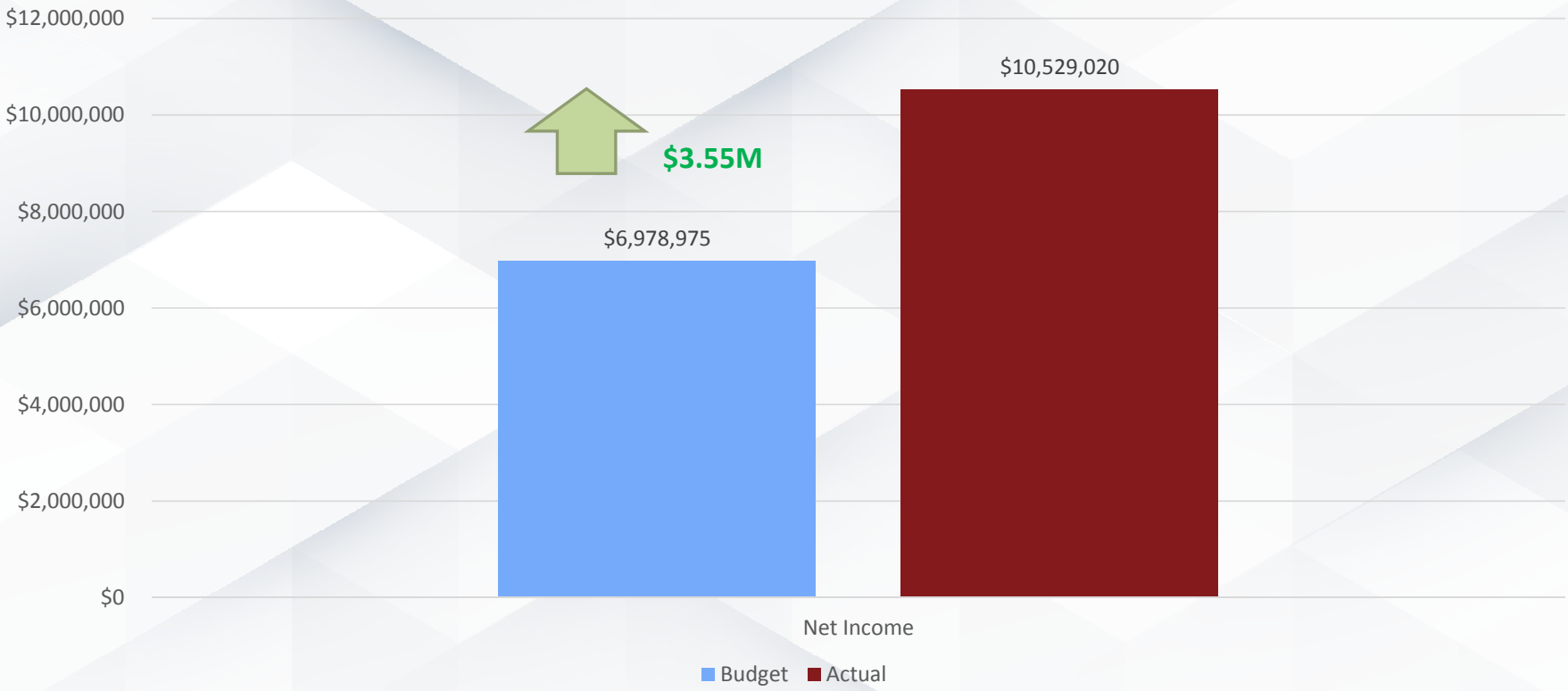
Chief Financial Officer

FYE 2026 Results

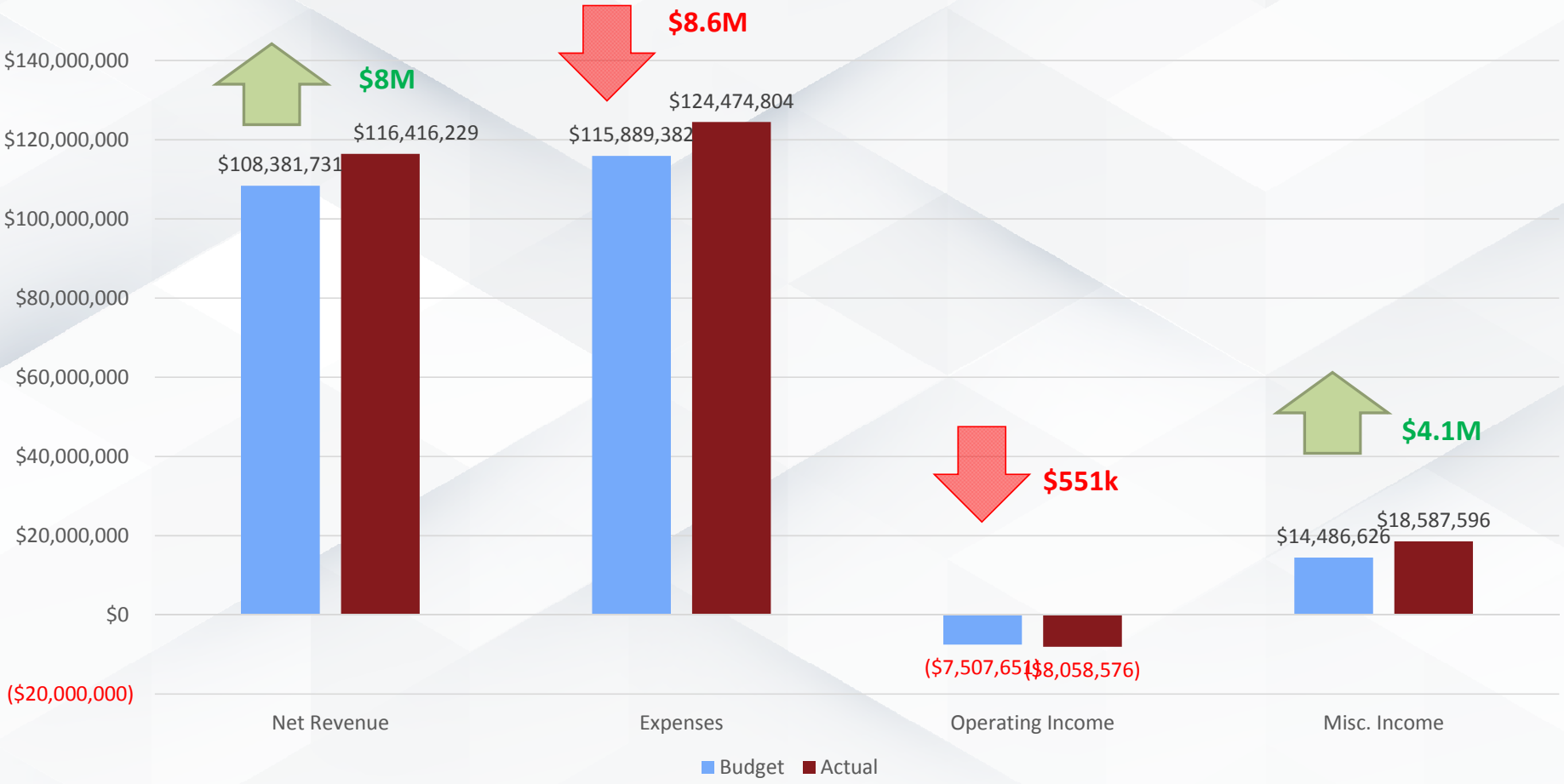

Northern Inyo Healthcare District

# INCOME PERFORMANCE

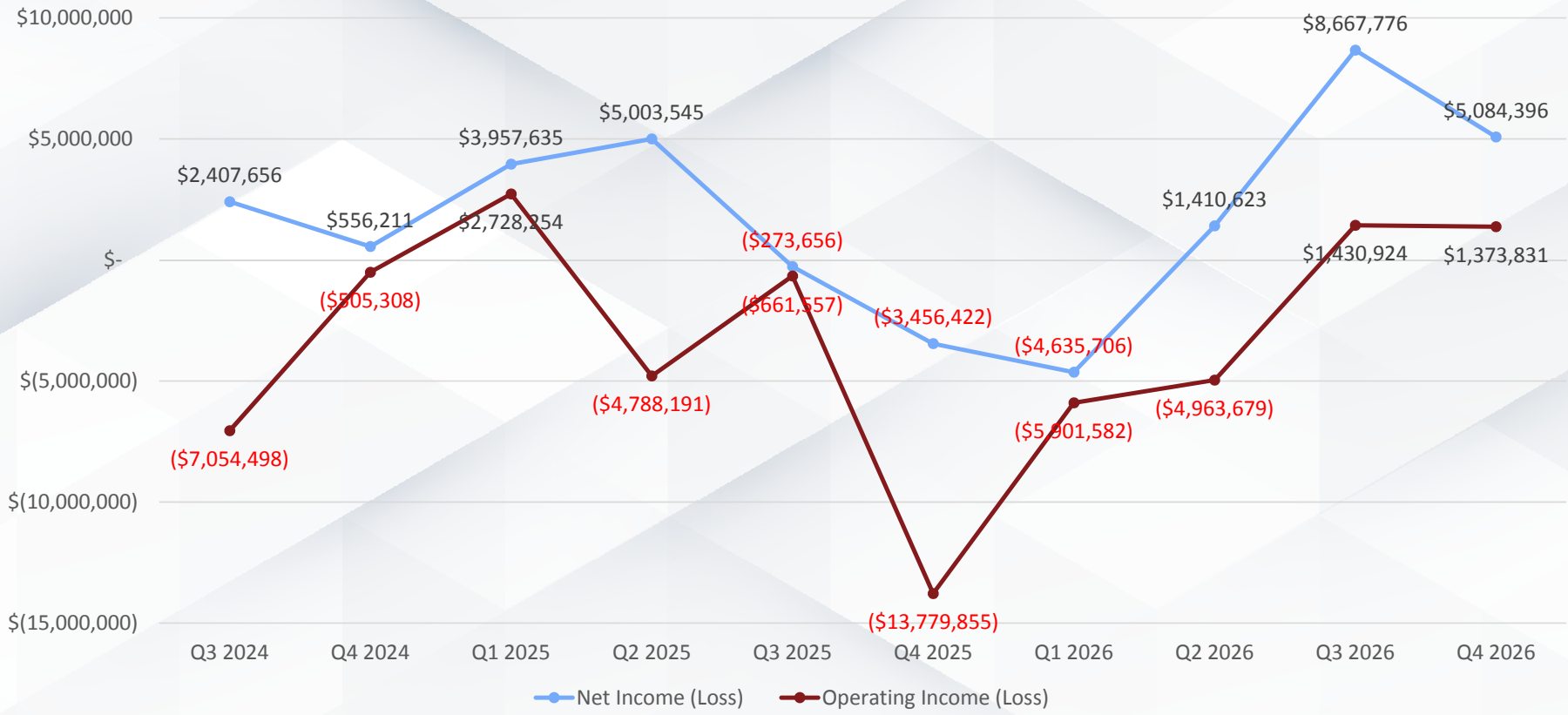
# Net Income


$12,000,000
$10,000,000
$8,000,000
$6,000,000
$4,000,000
$2,000,000
$0
$10,529,020
$3.55M
$6,978,975
Net Income
Budget
Actual

# Income to Budget

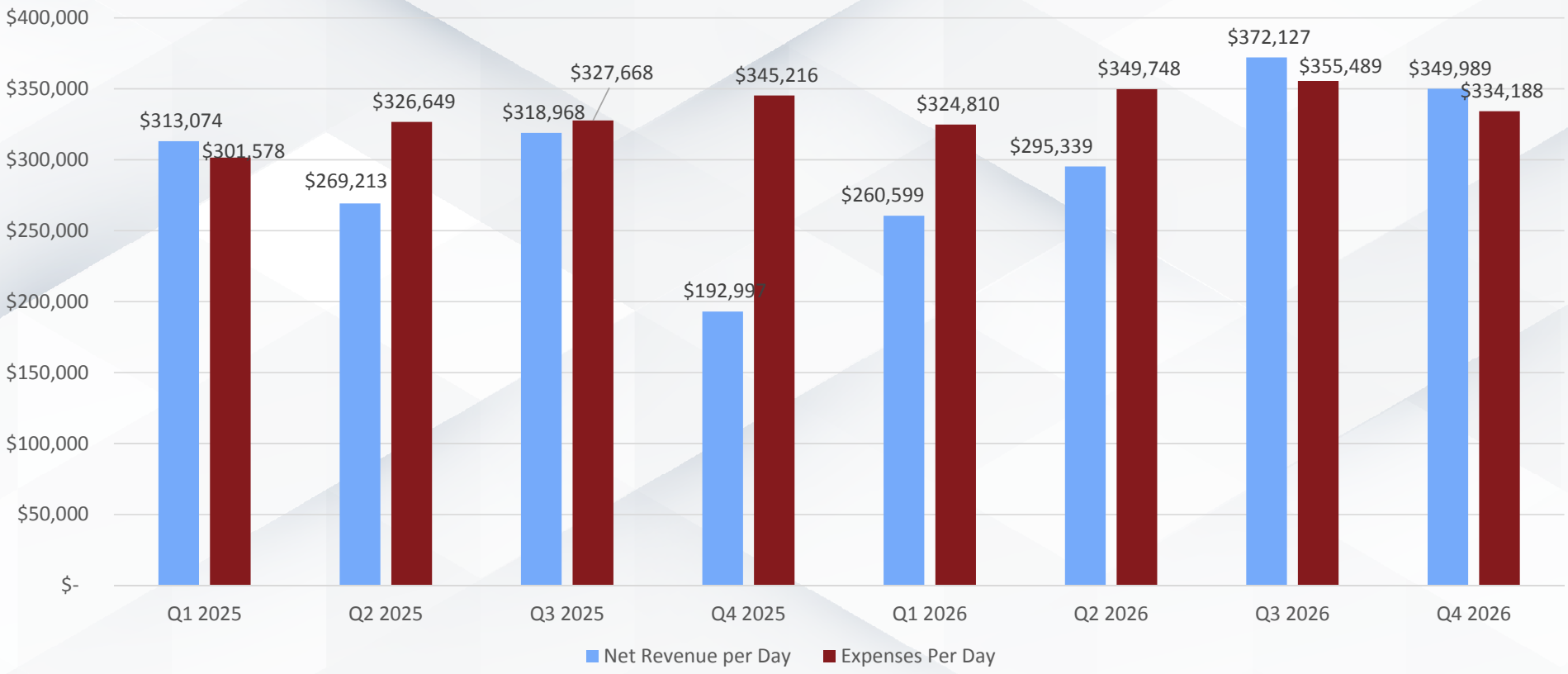


# income trend

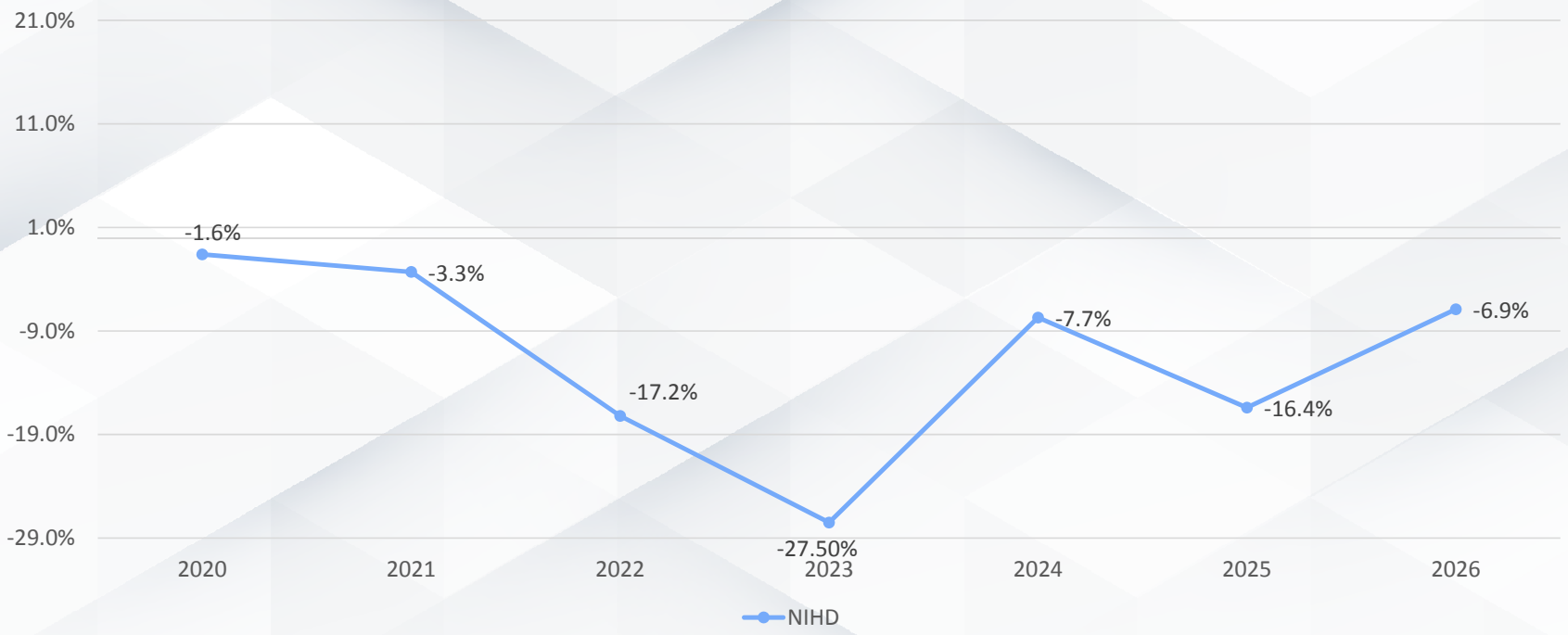


# Net Profit Margin

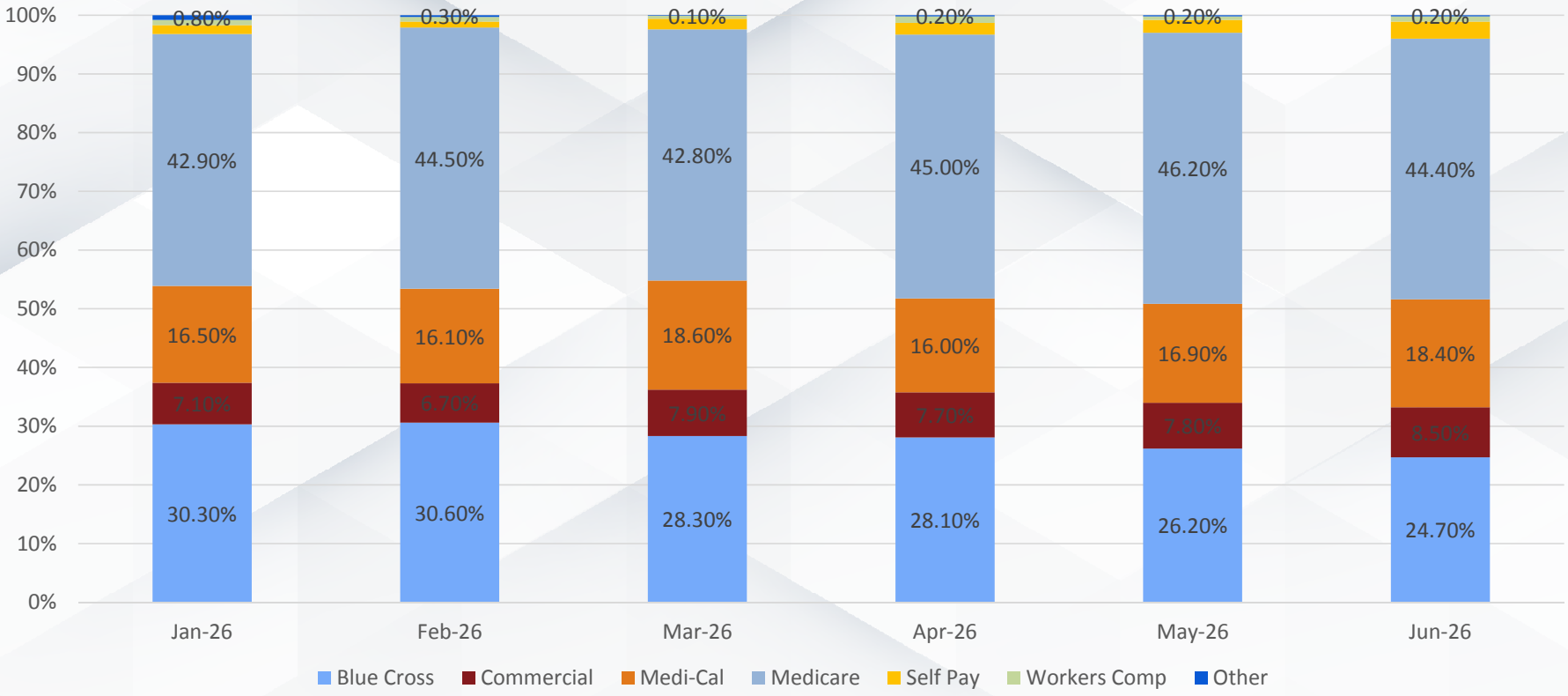
# Trend per calendar day



# Operating Margin



# Payor Mix trend



# WAGE Costs

| | FYE 2025 | FYE 2026 | FYE 2026 Budget |
|---|---|---|---|
| Total Paid FTEs | 394.7 | 399.2 | 394.7 |
| Salaries, Wages, Benefits (SWB) Expense (incl. contract labor) | $64,151,246 | $64,548,660 | $62,937,326 |
| SWB % of total expenses (including contract labor) | 55% | 52% | 54% |
| Employed Average Hourly Rate | $54.26 | $56.15 | $52.00 |
| Benefits % of Wages | 40% | 35% | 45% |

# VOLUME & Income Action plan

- Surgical volumes were better than budget in general, orthopedics, and urology services.
- 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.
- We are working on a staff benchmarking analysis to determine if we are appropriately staffing by skill mix in all departments.
- Leaders are doing a great job of managing their expenses and helping build budgets for the next fiscal year.

# Cash Performance

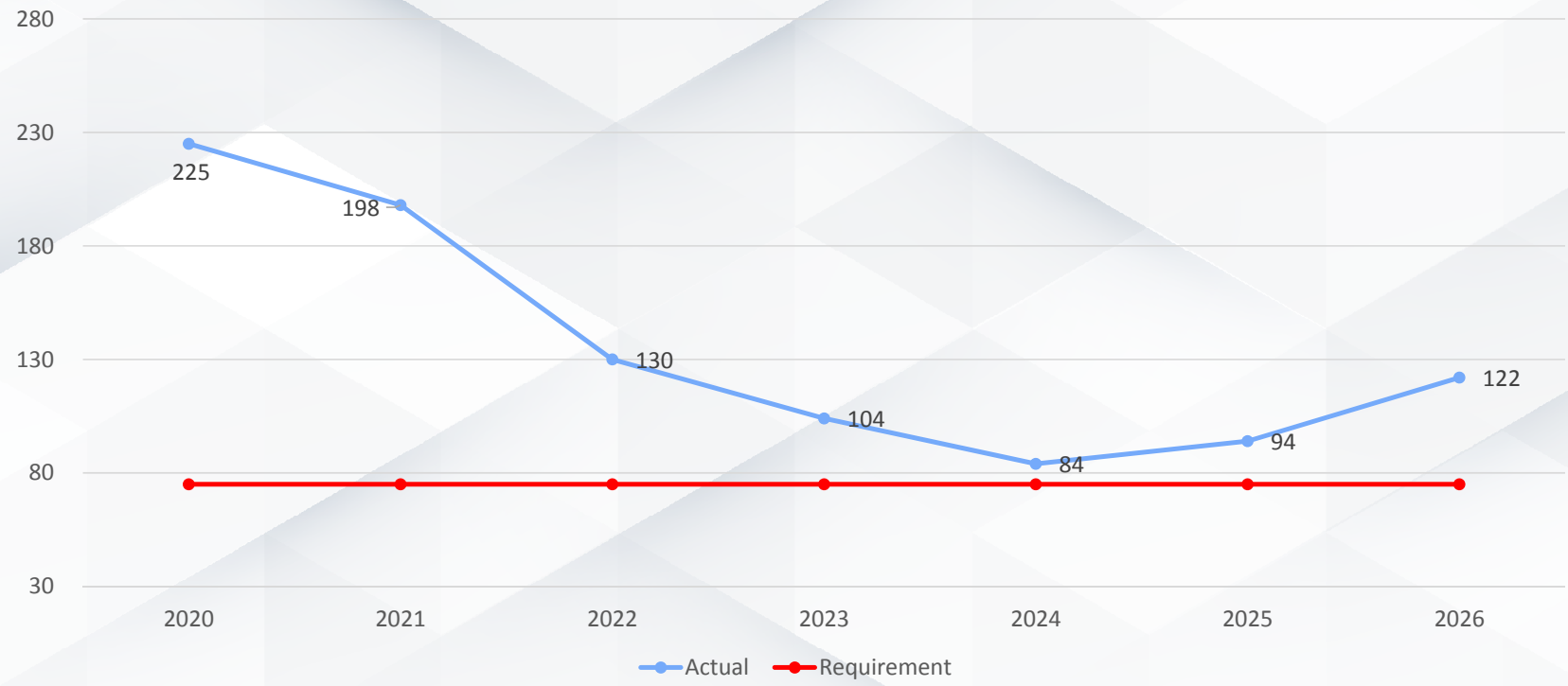
# Income to Cash

| | FYE 2026 |
|---|---|
| **Net Income (loss)** | **$10,529,020** |
| Principal Payments on Long-Term Debt (balance sheet only) | $(1,942,891) |
| Other Debt (long-term leases & subscriptions – balance sheet only) | $(1,133,486) |
| Capital purchases (balance sheet only) | $(2,317,970) |
| Timing of accruals vs cash for year end | $1,838,535 |
| Employee Retention Credit (accrued FYE 2025 and cash received FYE 2026) | $4,125,000 |
| **Impact to Cash** | **$569,188** |
| **Adjusted Net Income (cash basis)** | **$11,098,208** |

# 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 automation is working well and we continue to meet with them to find more opportunities to automate and improve cash.
- We have moved $24M in cash to Five Star Bank to earn better returns on our cash.
- We have another $11M in the LAIF Earning over 4% interest.
- AR days are at a record low for the organization.

**Northern Inyo Healthcare District**
**Income Statement**
**Fiscal Year 2026**

| | 4/30/2026 | Apr Budget | 4/30/2025 | 5/31/2026 | May Budget | 5/31/2025 | 6/30/2026 | Jun Budget | 6/30/2025 | 2026 YTD | Budget Variance | PYM Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gross Patient Service Revenue** | | | | | | | | | | | | |
| Inpatient Patient Revenue | 3,901,381 | 3,596,335 | 3,003,097 | 4,196,525 | 3,716,213 | 3,371,624 | 4,699,783 | 3,596,335 | 3,271,065 | 49,574,070 | 1,103,448 | 1,428,718 |
| Outpatient Revenue | 15,480,289 | 14,221,947 | 13,297,993 | 16,694,284 | 14,695,389 | 13,103,211 | 16,634,724 | 14,221,947 | 14,026,215 | 180,166,390 | 2,412,777 | 2,608,509 |
| Clinic Revenue | 1,939,954 | 1,727,250 | 1,891,743 | 1,904,971 | 1,784,825 | 1,810,472 | 1,997,007 | 1,727,250 | 1,655,734 | 23,658,074 | 269,757 | 341,273 |
| Gross Patient Service Revenue | 21,321,624 | 19,545,532 | 18,192,833 | 22,795,779 | 20,196,427 | 18,285,307 | 23,331,513 | 19,545,532 | 18,953,014 | 253,398,534 | 3,785,981 | 4,378,499 |
| **Deductions from Revenue** | | | | | | | | | | | | |
| Contractual Adjustments | (11,804,084) | (9,622,417) | (8,841,205) | (12,797,977) | (9,943,164) | (7,499,521) | (11,495,629) | (9,622,417) | (17,009,328) | (131,086,874) | (1,873,212) | 5,513,699 |
| Bad Debt | 26,871 | (115,868) | (3,774,465) | 63,117 | (119,730) | (2,837,626) | (1,391,660) | (115,868) | 284,638 | (5,077,770) | (1,275,792) | (1,676,298) |
| A/R Writeoffs | (377,429) | (707,802) | (179,014) | (242,695) | (731,396) | (177,633) | (493,717) | (707,802) | (444,054) | (5,007,391) | 214,086 | (49,662) |
| Other Deductions from Revenue | - | (173,770) | - | - | (179,562) | - | 2,880,000 | (173,770) | 2,665,229 | 4,189,730 | 3,053,770 | 214,771 |
| Deductions from Revenue | (12,154,642) | (10,619,856) | (12,794,684) | (12,977,555) | (10,973,852) | (10,514,779) | (10,501,005) | (10,619,856) | (14,503,515) | (136,982,305) | 118,851 | 4,002,510 |
| **Other Patient Revenue** | | | | | | | | | | | | |
| Incentive Income | - | - | - | - | - | 2,304 | 0 | - | - | 0 | 0 | 0 |
| Other Oper Rev - Rehab Thera Serv | - | - | - | - | - | - | - | - | - | - | - | - |
| Medical Office Net Revenue | - | - | - | - | - | - | - | - | - | - | - | - |
| Other Patient Revenue | - | - | - | - | - | 2,304 | 0 | - | - | 0 | 0 | 0 |
| **Net Patient Service Revenue** | **9,166,983** | **8,925,676** | **5,398,149** | **9,818,224** | **9,222,576** | **7,772,831** | **12,830,509** | **8,925,676** | **4,449,499** | **116,416,229** | **3,904,833** | **8,381,009** |
| **CNR%** | **43.0%** | **45.7%** | **29.7%** | **43.1%** | **45.7%** | **42.5%** | **55.0%** | **45.7%** | **23.5%** | **45.9%** | **9.3%** | **31.5%** |
| **Cost of Services - Direct** | | | | | | | | | | | | |
| Salaries and Wages | 3,241,797 | 2,800,257 | 3,078,978 | 3,158,248 | 2,944,913 | 3,089,016 | 3,211,627 | 2,838,657 | 4,625,502 | 37,816,793 | 372,970 | (1,413,874) |
| Benefits | 1,118,914 | 1,310,180 | 1,277,083 | 1,587,950 | 1,325,644 | 935,894 | (421,790) | 1,023,831 | 478,322 | 13,582,415 | (1,445,621) | (900,112) |
| Professional Fees | 2,354,887 | 2,005,418 | 1,903,652 | 1,997,032 | 1,894,850 | 2,159,742 | 2,078,099 | 2,153,662.69 | 1,897,471 | 24,173,220 | (75,564) | 180,627 |
| Contract Labor | 281,325 | 233,067.53 | 355,281 | 314,495 | 234,619.64 | 292,586 | 279,292 | 245,181.55 | 422,463 | 3,217,463 | 34,111 | (143,171) |
| Pharmacy | 571,051 | 437,010 | 327,061 | 485,963 | 451,577 | 331,813 | 366,072 | 437,010 | 81,516 | 5,223,395 | (70,938) | 284,556 |
| Medical Supplies | 630,877 | 427,637 | 289,061 | 775,662 | 442,142 | 247,645 | 450,145 | (1,393,248) | 1,247,647 | 6,388,261 | 1,843,393 | (797,503) |
| Hospice Operations | - | - | - | - | - | - | - | - | - | - | - | - |
| EHR System Expense | 34,915 | 32,115 | 44,592 | 31,361 | 32,115 | 49,037 | 31,840 | 32,115 | 44,018 | 427,728 | (275) | (12,178) |
| Other Direct Expenses | 750,237 | 644,159.13 | 602,461 | 728,903 | 643,142.53 | 737,203 | 687,577 | 657,149.21 | 484,303 | 8,411,035 | 30,427 | 203,274 |
| Total Cost of Services - Direct | 8,984,004 | 7,889,843 | 7,878,169 | 9,079,615 | 7,969,003 | 7,842,936 | 6,682,861 | 5,994,359 | 9,281,241 | 99,240,311 | 688,503 | (2,598,380) |
| | | | | | | | | | | | | |
| **General and Administrative Overhead** | | | | | | | | | | | | |
| Salaries and Wages | 609,648 | 526,612 | 724,391 | 526,356 | 490,801 | 510,479 | 552,357 | 488,211.43 | 886,490 | 6,644,523 | 64,146 | (334,133) |
| Benefits | 153,065 | 179,230 | 138,697 | 253,009 | 211,216 | 219,722 | (191,806) | 465,578.97 | 116,971 | 2,163,048 | (657,385) | (308,777) |
| Professional Fees | 411,662 | 350,570 | 431,885 | 514,713 | 488,377 | 890,001 | 195,227 | 202,325.47 | 447,793 | 6,726,598 | (7,099) | (252,567) |
| Contract Labor | 144,840 | 119,995 | 97,467 | 170,473 | 127,176 | 99,759 | 122,890 | 107,880.98 | 114,927 | 1,124,419 | 15,009 | 7,963 |
| Depreciation and Amortization | 498,344 | 417,154 | 409,164 | 500,623 | 417,154 | 409,164 | 490,487 | 417,154 | 490,098 | 5,633,113 | 73,333 | 388 |
| Other Administative Expenses | 257,460 | 221,057 | 277,268 | 268,356 | 236,782 | 285,999 | 217,701 | 208,067 | (152,287) | 2,942,794 | 9,634 | 369,989 |
| **Total General and Administrative Overhead** | 2,075,019 | 1,814,619 | 2,078,872 | 2,233,530 | 1,971,506 | 2,415,124 | 1,386,856 | 1,889,218 | 1,903,993 | 25,234,494 | (502,362) | (517,137) |
| **Total Expenses** | **11,059,023** | **9,704,462** | **9,957,041** | **11,313,145** | **9,940,509** | **10,258,060** | **8,069,717** | **7,883,577** | **11,185,234** | **124,474,804** | **186,140** | **(3,115,517)** |
| | | | | | | | | | | | - | - |
| Financing Expense | 162,781 | 196,180 | 194,928 | 171,352 | 196,180 | 198,265 | 163,307 | 196,180 | 95,292 | 2,089,291 | (32,873) | 68,015 |
| Financing Income | 414,751 | 190,806 | 903,825 | 1,067,033 | 197,166 | 250,741 | - | 190,806 | 260,000 | 4,556,611 | (190,806) | (260,000) |
| Investment Income | 339,523 | 47,322 | 58,156 | 113,844 | 47,322 | 54,996 | (192,999) | 47,322 | 28,984 | 1,142,268 | (240,321) | (221,982) |
| Miscellaneous Income | 287,539 | 209,364 | 69,492 | 1,804,046 | 212,613 | 243,075 | 374,267 | 1,398,346 | 8,942,649 | 14,978,008 | (1,024,080) | (8,568,382) |
| **Net Income (Change in Financial Position)** | **(1,013,007)** | **(527,473)** | **(3,722,346)** | **1,318,651** | **(457,012)** | **(2,134,682)** | **4,778,752** | **2,482,394** | **2,400,606** | **10,529,020** | **2,296,359** | **2,378,146** |
| Operating Income | (1,892,040) | (778,786) | (4,558,891) | (1,494,921) | (717,933) | (2,485,229) | 4,760,792 | 1,042,099 | (6,735,735) | (8,058,576) | 3,718,692 | 11,496,526 |
| EBIDA | (514,664) | (110,319) | (3,313,182) | 1,819,274 | (39,858) | (1,725,518) | 5,269,239 | 2,899,548 | 2,890,704 | 16,162,133 | 2,369,691 | 2,378,535 |
| Net Profit Margin | -11.1% | -5.9% | -69.0% | 13.4% | -5.0% | -27.5% | 37.2% | -18.6% | 54.0% | 9.0% | 55.8% | -52.2% |
| Operating Margin | -20.6% | -8.7% | -84.5% | -15.2% | -7.8% | -32.0% | 37.1% | -22.8% | -151.4% | -6.9% | 59.9% | 151.0% |
| EBIDA Margin | -5.6% | -1.2% | -61.4% | 18.5% | -0.4% | -22.2% | 41.1% | -13.4% | 65.0% | 13.9% | 54.5% | -59.4% |

**Northern Inyo Healthcare District**
**Balance Sheet**
**Fiscal Year 2026**

| | PY Balances | 4/30/2026 | 4/30/2025 | 5/31/2026 | 5/31/2025 | 6/30/2026 | 6/30/2025 | PM Change | PY Change |
|---|---|---|---|---|---|---|---|---|---|
| **Assets** | | | | | | | | | |
| **Current Assets** | | | | | | | | | |
| Cash and Liquid Capital | 20,757,956 | 22,886,679 | 19,449,093 | 26,638,540 | 19,669,998 | 28,460,217 | 20,757,956 | 1,821,676 | 7,702,261 |
| Short Term Investments | 7,741,599 | 11,137,664 | 7,742,770 | 11,137,589 | 7,741,372 | 11,137,546 | 7,741,599 | (42) | 3,395,947 |
| PMA Partnership | - | - | - | - | - | - | - | - | - |
| Accounts Receivable, Net of Allowance | 16,645,748 | 30,351,013 | 12,663,338 | 27,024,016 | 24,454,016 | 21,326,669 | 18,225,043 | (5,697,347) | 3,101,626 |
| Other Receivables | 9,238,007 | (1,058,088) | 9,700,579 | (1,480,505) | (1,534,786) | 3,028,579 | 9,295,249 | 4,509,085 | (6,266,670) |
| Inventory | 5,334,241 | 5,345,142 | 7,043,517 | 5,345,559 | 7,034,856 | 5,537,948 | 5,334,241 | 192,389 | 203,707 |
| Prepaid Expenses | 1,106,127 | 1,741,924 | 1,277,412 | 1,660,627 | 900,565 | 1,784,708 | 1,221,188 | 124,081 | 563,519 |
| **Total Current Assets** | **60,823,678** | **70,404,334** | **57,876,709** | **70,325,825** | **58,266,021** | **71,275,667** | **62,575,277** | **949,842** | **8,700,390** |
| **Assets Limited as to Use** | | | | | | | | | |
| Internally Designated for Capital Acquisitions | - | - | - | - | - | - | - | - | - |
| Short Term - Restricted | 1,469,292 | 129,810 | 1,469,040 | 129,939 | 1,469,168 | 1,470,800 | 1,469,292 | 1,340,861 | 1,508 |
| Limited Use Assets | | | - | | - | | - | - | - |
| LAIF - DC Pension Board Restricted | - | - | - | - | - | - | - | - | - |
| LAIF - DB Pension Board Restricted | 9,393,030 | 9,393,030 | 13,882,457 | 9,393,030 | 13,882,457 | 3,743,510 | 9,393,030 | (5,649,520) | (5,649,520) |
| 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 | 14,455,554 | 9,966,127 | 14,455,554 | 4,316,607 | 9,966,127 | (5,649,520) | (5,649,520) |
| Revenue Bonds Held by a Trustee | 297,382 | 241,007 | 319,127 | 235,529 | 313,383 | 230,052 | 297,382 | (5,477) | (67,330) |
| **Total Assets Limited as to Use** | **11,732,801** | **10,336,944** | **16,243,722** | **10,331,595** | **16,238,105** | **6,017,459** | **11,732,801** | **(4,314,136)** | **(5,715,342)** |
| **Long Term Assets** | | | | | | | | | |
| Long Term Investment | 497,086 | - | 497,075 | - | 496,765 | - | 497,086 | - | (497,086) |
| Fixed Assets, Net of Depreciation | 81,644,252 | 78,315,524 | 82,773,362 | 77,978,700 | 82,508,539 | 78,340,189 | 81,671,110 | 361,489 | (3,330,921) |
| **Total Long Term Assets** | **82,141,338** | **78,315,524** | **83,270,437** | **77,978,700** | **83,005,303** | **78,340,189** | **82,168,196** | **361,489** | **(3,828,007)** |
| **Total Assets** | **154,697,817** | **159,056,802** | **157,390,868** | **158,636,120** | **157,509,429** | **155,633,315** | **156,476,274** | **(3,002,805)** | **(842,959)** |
| **Liabilities** | | | | | | | | | |
| **Current Liabilities** | | | | | | | | | |
| Current Maturities of Long-Term Debt | 3,599,764 | 3,556,887 | 4,300,283 | 3,661,147 | 4,391,066 | 3,542,416 | 3,779,214 | (118,731) | (236,798) |
| Accounts Payable | 4,413,297 | 5,174,270 | 3,663,678 | 4,997,597 | 4,392,528 | 4,416,760 | 4,046,243 | (580,837) | 370,518 |
| Accrued Payroll and Related | 3,525,333 | 5,366,893 | 3,524,904 | 4,116,268 | 3,941,303 | 4,465,522 | 3,685,124 | 349,254 | 780,398 |
| Accrued Interest and Sales Tax | 83,538 | 102,872 | 220,309 | 14,720 | 141,308 | 76,912 | 162,526 | 62,191 | (85,615) |
| Notes Payable | 339,892 | 339,892 | 446,860 | 229,820 | 339,892 | 229,820 | 339,892 | - | (110,072) |
| Unearned Revenue | - | - | (4,542) | - | (4,542) | - | - | - | - |
| Due to 3rd Party Payors | 3,324,903 | 4,331,882 | 1,637,684 | 4,125,564 | (333,316) | 4,125,564 | 3,324,903 | - | 800,661 |
| Due to Specific Purpose Funds | - | - | - | - | - | - | - | - | - |
| Other Deferred Credits - Pension & Leases | 8,758,790 | 8,740,163 | 12,579,127 | 8,740,163 | 12,577,057 | 5,006,479 | 8,758,790 | (3,733,684) | (3,752,311) |
| **Total Current Liabilities** | **24,045,518** | **27,612,860** | **26,368,305** | **25,885,279** | **25,445,296** | **21,863,473** | **24,096,692** | **(4,021,807)** | **(2,233,219)** |
| **Long Term Liabilities** | | | | | | | | | |
| Long Term Debt | 33,367,666 | 30,283,079 | 33,648,895 | 30,178,498 | 33,547,552 | 30,065,301 | 33,252,083 | (113,196) | (3,186,782) |
| Bond Premium | 127,973 | 96,603 | 134,247 | 93,465 | 131,110 | 90,328 | 127,973 | (3,137) | (37,645) |
| Accreted Interest | 17,272,679 | 17,215,090 | 17,094,610 | 17,299,478 | 17,183,644 | 17,383,865 | 17,272,679 | 84,388 | 111,187 |
| Other Non-Current Liability - Pension | 31,874,258 | 31,874,258 | 32,946,355 | 31,874,258 | 32,946,355 | 28,132,971 | 31,874,258 | (3,741,287) | (3,741,287) |
| **Total Long Term Liabilities** | **82,642,576** | **79,469,030** | **83,824,107** | **79,445,699** | **83,808,662** | **75,672,466** | **82,526,993** | **(3,773,233)** | **(6,854,527)** |
| Suspense Liabilities | - | - | - | - | - | - | - | - | - |
| Uncategorized Liabilities (grants) | 61,310 | 114,957 | 139,321 | 114,957 | 139,321 | 130,985 | 61,310 | 16,028 | 69,674 |
| **Total Liabilities** | **106,749,404** | **107,196,846** | **110,331,732** | **105,445,935** | **109,393,279** | **97,666,924** | **106,684,996** | **(7,779,012)** | **(9,018,072)** |
| **Fund Balance** | | | | | | | | | |
| Fund Balance | 40,722,935 | 45,957,791 | 40,624,917 | 45,969,241 | 43,816,486 | 45,966,571 | 43,090,884 | (2,670) | 2,875,687 |
| Temporarily Restricted | 1,469,292 | 1,470,548 | 1,469,040 | 1,470,676 | 1,469,168 | 1,470,800 | 1,469,292 | 124 | 1,508 |
| Net Income | 5,756,186 | 4,431,616 | 4,965,178 | 5,750,268 | 2,830,496 | 10,529,020 | 5,231,102 | 4,778,752 | 5,297,918 |
| **Total Fund Balance** | **47,948,412** | **51,859,956** | **47,059,136** | **53,190,185** | **48,116,150** | **57,966,391** | **49,791,279** | **4,776,207** | **8,175,113** |
| **Liabilities + Fund Balance** | **154,697,817** | **159,056,802** | **157,390,868** | **158,636,120** | **157,509,429** | **155,633,315** | **156,476,274** | **(3,002,805)** | **(842,959)** |
| (Decline)/Gain | | (963,718) | (3,359,679) | (420,682) | 118,561 | (3,002,805) | (1,033,155) | (2,582,123) | (1,969,650) |

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

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**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 | $ 10,529,020 |
| + Depreciation Expense | 5,633,113 |
| + Interest Expense | 2,089,291 |
| Less GO Property Tax revenue | 3,697,439 |
| Less GO Interest Expense | 458,611 |
| ***"Income available for debt service"*** | **$ 14,095,374** |
| **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) | **5.61** |
| Required Debt Service Coverage Ratio: | 1.10 |
| In Compliance? (Y/N) | **Yes** |

## Unrestricted Funds and Days Cash on Hand

| | HOSPITAL FUND ONLY |
|---|---|
| Cash and Investments-current | $ 39,597,763 |
| Cash and Investments-non current | - |
| Sub-total | 39,597,763 |
| Less - Restricted: | |
| PRF and grants (Unearned Revenue) | - |
| Held with bond fiscal agent | - |
| Building and Nursing Fund | - |
| Total Unrestricted Funds | **$ 39,597,763** |
| Total Operating Expenses | $ 124,474,804 |
| Less Depreciation | 5,633,113 |
| Net Expenses | 118,841,691 |
| Average Daily Operating Expense | $ 325,594 |
| Days Cash on Hand | **122** |

**Northern Inyo Healthcare District**
**Statement of Cash Flows**
**Fiscal Year 2026**

| | |
|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | |
| Receipts from and on Behalf of Patients | 116,460,265 |
| Payments to Suppliers and Contractors | (40,840,455) |
| Payments to and on Behalf of Employees | (64,548,660) |
| Other Receipts and Payments, Net | 4,196,703 |
| Net Cash Provided (Used) by Operating Activities | 15,267,852 |
| **CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES** | |
| Noncapital Contributions and Grants | 7,838,511 |
| Property Taxes Received | 859,172 |
| Net Cash Provided (Used) by Noncapital Financing Activities | 8,697,683 |
| **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 | (2,089,291) |
| Purchase and Construction of Capital Assets | (8,879,428) |
| Payments on Lease Liability | (108,352) |
| Payments on Subscription Liability | (1,025,134) |
| Property Taxes Received | (32,822) |
| Net Cash Provided (Used) by Capital and Capital Related Financing Activities | (14,077,917) |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | |
| Investment Income | 1,142,268 |
| Rental Income | 68,322 |
| Net Cash Provided (Used) by Investing Activities | 1,210,590 |
| **NET CHANGE IN CASH AND CASH EQUIVALENTS** | 11,098,208 |
| Cash and Cash Equivalents - Beginning of Year | 28,499,555 |
| **CASH AND CASH EQUIVALENTS - END OF YEAR** | 39,597,763 |

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

DATE: August 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: Office of Health Care Affordability Spending Target Enforcement Framework

**MEMORANDUM**

## Background

The Office of Health Care Affordability (OHCA) was established in 2022 through the California Health Care Quality and Affordability Act (SB 184) within the California Department of Health Care Access and Information. OHCA was created in response to concerns regarding the continued growth of health care costs in California and is charged with slowing health care spending growth while promoting access, quality, equity, and workforce stability.

OHCA's responsibilities include collecting and analyzing health care expenditure data, identifying cost trends and drivers of health care spending, establishing strategies to improve affordability, promoting high-value system performance, assessing health care market consolidation, and enforcing health care spending targets established by the Health Care Affordability Board.

The Health Care Affordability Board established a statewide health care spending growth target of 3.5%. The 2026 target is the first year subject to enforcement. Under state law, OHCA's enforcement process is progressive and may include technical assistance, public testimony, performance improvement plans, and ultimately administrative financial penalties. Data for the 2026 enforcement year will be collected in 2027 and reported in 2028, with the earliest enforcement actions anticipated in 2028.

OHCA is currently developing the framework that will determine how these enforcement actions will be applied. OHCA has proposed an administrative penalty structure that could begin with the amount by which an organization exceeded its applicable spending target, subject to adjustments based on specified factors. The Health Care Affordability Board is anticipated to consider the scope, range, and justification factors for administrative penalties in late summer 2026.

## Discussion

There is broad support for the goal of improving health care affordability and establishing accountability for health care spending. The progressive enforcement model also provides mechanisms intended to help organizations identify cost drivers and improve performance before financial penalties are imposed. OHCA has stated that its approach is intended to balance spending growth with other priorities, including quality, equity, access to primary and behavioral health care, and workforce stability.

However, hospitals and other health care organizations have raised significant concerns regarding how the proposed enforcement framework would operate in practice. The California Hospital Association (CHA) has urged OHCA to provide greater clarity regarding how hospital spending will be measured, assess performance over multiple years rather than relying on year-to-year fluctuations, provide meaningful opportunities for performance improvement, and establish penalties that are reasonable and proportionate.

CHA has also raised concerns regarding the potential magnitude of the proposed penalties. Under the framework being considered, penalties could begin with the amount by which an organization exceeded its spending target. CHA has stated that this could result in penalties reaching tens or hundreds of millions of dollars for individual hospitals.

These concerns are particularly relevant to rural health care providers. Hospitals must manage increasing workforce, pharmaceutical, supply, technology, equipment, infrastructure, regulatory, and other operating costs while continuing to maintain and expand access to patient care. Investments that increase spending in the short term may also be necessary to recruit and retain employees, replace aging infrastructure, expand needed services, and reduce the need for rural patients to travel outside their communities for care.

NIHD shares CHA's concerns regarding the proposed enforcement framework. In particular, NIHD believes the enforcement process should distinguish between sustained excessive spending and legitimate cost increases or investments necessary to maintain or improve patient care. The process should also provide hospitals with a meaningful opportunity to understand their performance and demonstrate improvement before significant financial penalties are imposed.

NIHD has prepared the attached advocacy letter to Health Care Affordability Board Chair Kim Johnson outlining these concerns and requesting a transparent, predictable, and progressive enforcement process. The letter also highlights the particular challenges facing rural providers, including workforce costs and the need to continue investing in facilities, equipment, technology, and expanded access to care.

**Recommendation**

Administration recommends that the Board of Directors approve the attached letter to Health Care Affordability Board Chair Kim Johnson regarding the proposed spending target progressive enforcement framework and authorize the Chief Executive Officer to submit the letter on behalf of Northern Inyo Healthcare District.

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

August 19, 2026

Kim Johnson
Chair, Health Care Affordability Board
2020 W. El Camino Ave.
Sacramento, CA 95833

RE: NIHD Comments on Spending Target Progressive Enforcement Framework

Dear Chair Johnson:

NIHD supports the state's goal of making health care more affordable for Californians and recognizes the importance of accountability in controlling health care spending. However, affordability cannot be pursued in isolation from access, quality, workforce stability, and the financial sustainability of the hospitals upon which California communities depend. This is particularly important for rural hospitals, where significant financial penalties can have a disproportionate effect on the availability of local health care services.

The 3.5% spending target must also be considered in the context of the actual cost pressures hospitals face simply to maintain existing services. In 2025, NIHD provided employees with a 2.5% annual wage increase in addition to a 2.5% cost-of-living adjustment. For employees receiving both adjustments, this represented an approximately 5% increase in base wages — already greater than the 3.5% statewide spending growth target — before accounting for increases in employee benefits or other operating expenses. These workforce investments are necessary for NIHD to remain competitive in recruiting and retaining qualified health care professionals in a rural community.

These concerns are particularly relevant as NIHD plans for the future of health care in our community. NIHD is in the early planning stages of a significant investment in local health care infrastructure, including the development of a new Rural Health Clinic and medical office building. Our existing facilities and space limitations increasingly constrain our ability to expand services, accommodate specialists, and meet evolving community needs. NIHD is evaluating service-line and utilization data, including services for which patients currently travel outside the area, to identify opportunities to bring needed care closer to home. The project will require substantial investment, supported through a combination of grant funding, community and philanthropic support, and District resources.

The goal is not simply to construct a new building. It is to create the capacity necessary to expand needed services, provide modern technology and equipment, and allow more patients to receive high-quality care in their own community. An affordability framework should not place hospitals in the position of choosing between making responsible investments in workforce, infrastructure, equipment, and expanded access to care and avoiding potentially significant financial penalties.

NIHD also believes enforcement must provide hospitals with a meaningful opportunity to improve before financial penalties are imposed. Technical assistance and performance improvement plans should allow

sufficient time and flexibility to identify the causes of spending growth, implement appropriate corrective strategies, demonstrate improvement, and work collaboratively with OHCA toward compliance.

NIHD respectfully urges the Health Care Affordability Board not to approve the proposed enforcement framework in its current form. California can advance health care affordability without compromising access to care, workforce stability, necessary investments in infrastructure and technology, the ability to expand needed services, or the quality of patient care. For rural communities like ours, maintaining this balance is critical to ensuring a sustainable health care system that can continue to meet the needs of the communities we serve.

Sincerely,

Christian Wallis, CEO

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514
(760) 873-2109
christian.wallis@nih.org

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

DATE: August 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Ashley Reed, Board Clerk

RE: Board Request for Agenda Items

## MEMORANDUM

**Background**
The District's Civility and Code of Conduct Policy currently provides two methods for Board members to request future agenda items. A Board member may submit a request to the Chief Executive Officer and Board Chair for review, or request that an item be placed on a future agenda through the Board Clerk, who would confirm whether a second Board member supports the request.

Administration is proposing revisions to establish a single process for requesting future agenda items during regular Board meetings.

**Discussion**
The proposed amendment replaces the current process with a standing "Board Request for Future Agenda Items" item near the end of each regular Board and standing committee meeting. During this item, a member may identify a topic they would like placed on a future agenda and provide a brief, neutral synopsis explaining the topic and purpose of the request. No discussion, deliberation, or action on the underlying topic would occur at that time.

Following the request, the Chair would ask whether another member supports adding the topic to a future agenda. A member's support would indicate only that they support bringing the topic back for future discussion and would not indicate agreement with a particular position or outcome. If a member supports adding the topic to a future agenda, they would state, "I support adding this item to a future agenda." If no additional member indicates support, the Chair would proceed to the next request or agenda item.

If one additional member supports the request, the requesting member would work with the Board Clerk and Administration, as appropriate, to prepare the item for a future agenda. Supporting materials, such as a memorandum, presentation, or other relevant information, would be developed as appropriate to provide the Board and public with the information necessary for a properly noticed discussion of the topic.

Establishing a single process during a public meeting creates a consistent and transparent approach for all members and eliminates the need for requests to be routed through the Board Chair, Chief Executive Officer, or Board Clerk before being considered.

**Recommendations**
Replace the current **Agenda Management** section of the Civility and Code of Conduct Policy with the following:

**Agenda Management**
A standing agenda item titled **"Board Request for Future Agenda Items"** shall be included near the end of each regular Board meeting and each standing committee meeting.

- During this agenda item, a member may request that a topic be placed on a future Board or standing committee agenda, as applicable.

- The Chair shall ask whether another member supports the request.

- If one additional member indicates support, Administration shall work with the requesting member to prepare the item for a future Board or standing committee agenda, as applicable.

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Board Civility and Code of Conduct Policy | | |
| Owner: NIHD Board and Foundation Clerk | Department: Administration | |
| Scope: | | |
| Date Last Modified: 08/03/2026 | Last Review Date: No Last Periodic Review Date Set | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

**PURPOSE:** The Board of Directors is committed to creating a meeting environment where every voice is heard with respect, discussions are conducted with fairness, and decisions reflect the District's mission of serving our community.

This policy is designed to support productive, well-organized meetings that encourage open dialogue, foster collaboration, and build public trust. It provides clear guidance on how the Board and all participants will work together with civility, professionalism, and integrity.

Meetings will follow Robert's Rules of Order to ensure consistency and fairness. In the event of a conflict between this policy, Robert's Rules, and the Brown Act, the Brown Act and applicable law will control.

This policy applies to all members of the Board of Directors as well as participants in Board and standing committee meetings, including staff, consultants, advisory members, and members of the public.

## STANDARDS OF CIVILITY AND CODE OF CONDUCT

### Respectful Communication

- Members are expected to listen respectfully and speak courteously.
- Communication should foster constructive dialogue and avoid interruptions, raised voices, sarcasm, ridicule, dismissive gestures, profanity, or personal attacks.

### Equal Participation

- Each member will have an equal opportunity to contribute to discussion.
- The Chair may set reasonable time limits on remarks, generally not exceeding five (5) minutes per round, to help ensure balanced participation.

### Preparedness

- Members are expected to come prepared, having reviewed agenda packets and materials in advance.

- Meetings are most effective when discussion builds on the background information already provided, rather than revisiting it.

**Respect for Public Comment**

- Public comment is a valued opportunity for community input. Board members listen respectfully, and responses—when appropriate—may be provided at a later time through staff or subject-matter experts, or during an agendized discussion.

- The Chair may adjust speaking time limits for all speakers equally, consistent with the Brown Act (Gov. Code §54954.3).

**Cell Phones & Technology**

- During public comment, members are encouraged to give their full attention to speakers without using devices.

- Limited use is appropriate only for emergencies, agenda materials, or urgent District business.

**Confidentiality & Closed Session**

- Members must respect the confidentiality of closed session discussions as required by the Brown Act (Gov. Code §54963).

- Civility standards apply equally in closed session.

**Board–Staff Interaction**

- Requests for information should be directed through the Chief Executive Officer to ensure clarity and respect staff's reporting structure.

**Board Member Communications Outside of Meetings**

- Board members should avoid email, text, or phone chains to engage in "serial meetings" or reach a consensus outside of publicly noticed meetings, in compliance with the Brown Act (Gov. Code §54952.2).

- Board communications should be respectful and focused on logistics or information, with discussion of District business reserved for public meetings.

- Written communications between members should remain professional and respectful, recognizing they may become part of the public record.

**Out-of-Meeting Conduct**

- Civility standards apply outside the boardroom, including in emails, public events, and on social media.

- Board members model professionalism by speaking respectfully about the District, staff, and fellow directors in public settings.

- Concerns about civility violations outside of meetings may be reported in writing to the Board Chair and Governance Committee for review.

**Code of Conduct Commitments**

I will:

1. represent the best interests of NIHD and be a positive example to others within NIHD and within the community in both my attitude and actions, acting at all times with honesty, integrity, diligence, competence, and in good faith;
2. become and stay knowledgeable about the Board's bylaws, policies, and procedures;
3. become well-informed about each matter coming before the Board for decision;
4. bring matters to the Board's attention that I believe may have a significant effect on the well-being of NIHD, its services, employees, or mission;
5. participate actively in Board and committee discussions;
6. listen carefully to other members and consider their opinions respectfully, particularly if they differ from mine;
7. respect and support the majority decisions of the Board, even if I disagree with that result;
8. acknowledge conflicts that arise between my personal interests and the Board's activities, identifying them early and withdrawing from related discussions and votes;
9. maintain, in accordance with law, the confidentiality of information provided to me in my role as a Board Member;
10. refer Board member complaints promptly and directly to the Board Chair and to the Chief Executive Officer (CEO), as appropriate;
11. surrender all information related to NIHD matters to my successor, but continue to maintain related duties of confidentiality;
12. comply with all NIHD policies and procedures to support and model a work environment that discourages any form of inappropriate conduct, harassment, discrimination, or retaliation;
13. recognize and respect the differentiation between Board and staff responsibilities.

I will not:

1. share opinions elsewhere that I am unwilling to discuss before the Board or its committees;
2. decide how to vote before hearing discussion and becoming fully informed;
3. interfere with duties and activities of other Board members;
4. speak publicly on behalf of the Board unless specifically authorized to do so by the Board Chair or CEO, consistent with the NIHD Media Policy.

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**Meeting Procedures: Order of Discussion for Each Agenda Item**

1. **Chair Introduces the Item**

2. **Presentation of Item**

3. **Public Comment** – 3 minutes per speaker; 30 minutes total unless extended by the Chair

4. **Board Discussion**

- **Step 1 – Round-Robin Discussion**: Each Board member is called on in turn; Board members may speak or "pass." No interruptions.
- **Step 2 – Clarification and Responses**: Staff or other Board members may clarify, directed through the Chair.
- **Step 3 – Open Floor Discussion**: Board members may request recognition; repetition should be avoided.
- **Step 4 – Summarizing Key Points**: Chair summarizes the discussion.
- **Step 5 – Final Comments**: Chair invites final remarks.
- **Step 6 – Transition to Action**: Chair calls for a motion.

5. **Motion and Vote** – Motion made and seconded, restated by the Chair, then voted on. Roll call required if remote participation.

The Chair may adjust this process for routine or time-sensitive items, while ensuring all Board members have an opportunity to contribute.

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**Agenda Management**

- ~~**Adding Items –** Individual Board members may request items for a future agenda by submitting the request to the Chief Executive Officer and Board Chair in advance.~~
- ~~**Two-Member Request –** If two Board members wish to place an item on a future agenda, they may do so by notifying the **Board Clerk**. The Clerk will confirm whether a second Board member supports the request, without Board members contacting each other directly, to avoid Brown Act violations. Items supported by two Board members will be placed on a future agenda, generally within two regular meetings, unless additional preparation is required.~~
- ~~**Review –** For single-member requests, the Board Chair and CEO review the item to determine placement, timing, and whether additional background information is required.~~
- ~~**Final Authority –** The Board, acting as a body, may add items during a meeting only as allowed under the Brown Act (Gov. Code §54954.2(b)).~~
- ~~**No Off-the-Cuff Additions –** Items should not be added or acted upon during meetings unless they meet the legal urgency exception and are approved by a two-thirds vote.~~
- ~~**Applicability to Committees –** These procedures apply to all meetings of the Board of Directors and standing committees, unless otherwise modified by committee charter.~~

A standing agenda item titled **"Board Request for Future Agenda Items"** shall be included near the end of each regular Board meeting and each standing committee meeting.

- During this agenda item, a member may request that a topic be placed on a future Board or standing committee agenda, as applicable.
- The Chair shall ask whether another member supports the request.
- If one additional member indicates support, Administration shall work with the requesting member to prepare the item for a future Board or standing committee agenda, as applicable.

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**Public Disruptions**

- Members of the public are expected to maintain civility and respect during meetings.
- If a disruption occurs, the Chair may first issue a verbal warning and request that order be restored.
- If the disruption continues, the Chair may call a brief recess to address the matter privately with the individual.
- If disruption persists after these steps, the Chair may call the individual to order.
- If necessary, the Chair may direct the removal of the individual in accordance with Government Code §54957.9.
- In extreme cases, if willful interruptions make it unfeasible to continue the meeting, the Board may clear the meeting room and proceed in compliance with the Brown Act, while allowing members of the press and non-disruptive attendees to remain (Brown Act requirement).

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**Enforcement & Consequences**

**General**

This policy applies equally to all Board members, including the Chair. When concerns arise, they will be addressed promptly, consistently, and respectfully to maintain order and trust in the Board's work.

**If a Board Member Violates Civility or Meeting Procedure**

The Chair may take the following steps, escalating only as necessary:

1. **Reminder/Redirection** – The Chair provides a reminder or may call a brief recess to redirect discussion privately.
2. **Call to Order** – If needed, the Chair formally calls the Board member to order.
3. **Referral** – Repeated or disruptive violations are documented and referred to the Governance Committee, which may recommend corrective action or training and report findings to the full Board.

4. **Board Action** – If necessary, the full Board may take corrective action, such as:
    - Issuing a private or public warning.
    - Requiring additional training (such as governance, civility, or Brown Act training offered by CSDA or another recognized provider).

**If the Chair Violates this Policy**

If the Chair fails to follow these rules or does not apply them fairly, the Board may take the following actions:

1. **Point of Order** – Any Board member may raise a Point of Order. The Chair must allow it to be heard.
2. **Discussion** – The Board may briefly discuss whether the Chair's action violated this policy.
3. **Board Vote** – By majority vote, the Board may:
    - Overrule the Chair's ruling.
    - Direct the Chair to comply with the policy.
    - Appoint a temporary presiding officer.
4. **Documentation** – Any such action is recorded in the minutes.

**Removal from Office**

The Board does not have the authority to remove an elected director from office. Removal, if necessary, is governed by the District bylaws and California law, including voter recall and judicial declaration of vacancy.

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**Definitions**

- **Point of Order** – A procedural motion raised by a Board member to call attention to a violation of the rules or this policy.
- **Recess** – A temporary pause in a meeting called by the Chair to restore order or allow a break, after which the meeting resumes.
- **Serial Meeting** – A series of communications, directly or through intermediaries, that results in a majority of the Board discussing, deliberating, or reaching consensus outside of a publicly noticed meeting, prohibited by the Brown Act (Gov. Code §54952.2).
- **Brown Act** – California's open meeting law (Gov. Code §54950 et seq.), requiring transparency and public access to local government meetings.

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**Annual Acknowledgement**

I, _____, acknowledge that I have received and reviewed the Northern Inyo Healthcare District Board Civility & Code of Conduct Policy and commit to uphold its standards. I will annually reaffirm this commitment in writing.

_____ _____

Signature Date

| Supersedes: v.1 Board Civility and Code of Conduct Policy |
|---|

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

DATE: August 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Governance Committee

RE: Consideration of Changing Regular Board Meetings from Evening to Daytime Hours

**MEMORANDUM**

**Background**
Northern Inyo Healthcare District currently holds its regular Board meetings at 5:00 p.m. The Board is being asked to consider whether regular Board meetings should be moved to daytime hours.

**Discussion**
The Governance Committee reviewed the potential benefits and challenges associated with changing the regular Board meeting time.

**Potential Benefits:**
• Reduced late-night travel for Board members, staff, consultants, and presenters traveling to and from the District.
• Reduced staff overtime associated with evening Board meetings.
• Greater availability of District staff to participate in meetings during regular working hours.
• Easier scheduling for consultants, presenters, and other individuals participating in Board meetings.

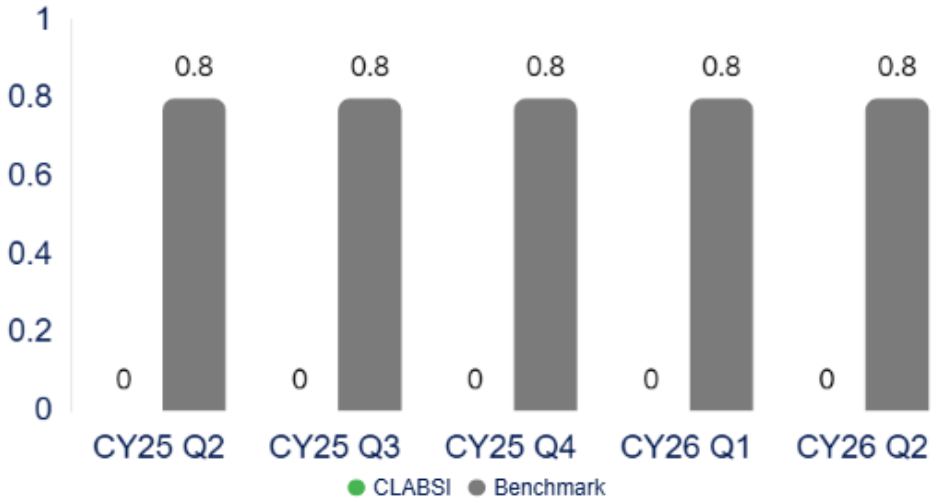
**Potential Challenges:**
• Daytime meetings may make attendance and public comment more difficult for members of the public who work during regular business hours.
• Board members who work during the day may need to take time off or make arrangements with their employers to attend meetings.
• Employees who wish to attend or provide public comment may have greater difficulty participating during their regular working hours.

The Governance Committee discussed maintaining flexibility to schedule meetings, or specific portions of meetings, during evening hours when the subject matter is expected to generate significant public or employee interest. For example, matters involving labor negotiations or other topics where substantial public or employee participation is anticipated could be scheduled at a time that provides greater opportunity for attendance and public comment.

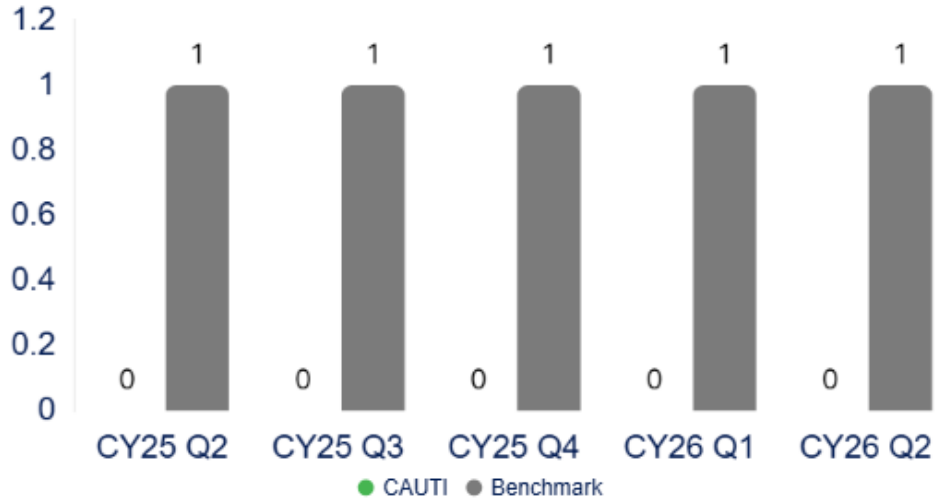
# NIHD Quality Committee Dashboard

"<" means lower is better

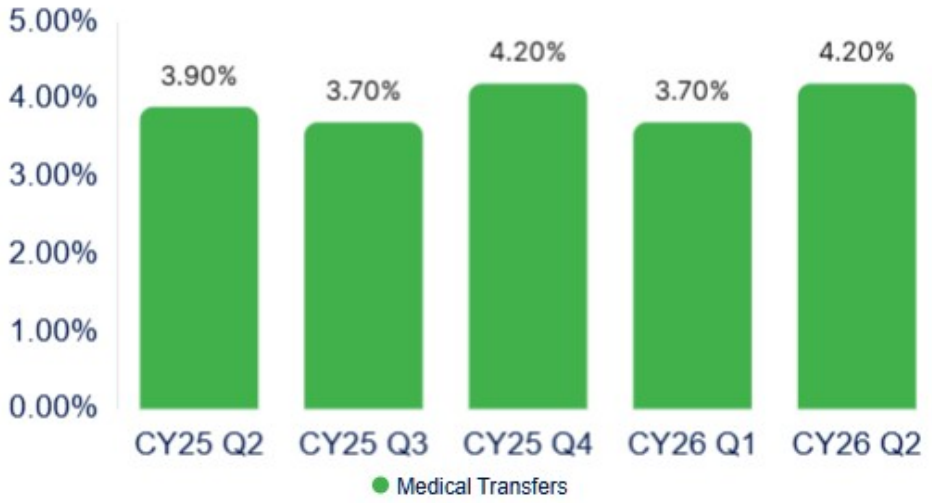
## Central Line-Associated Bloodstream Infect <



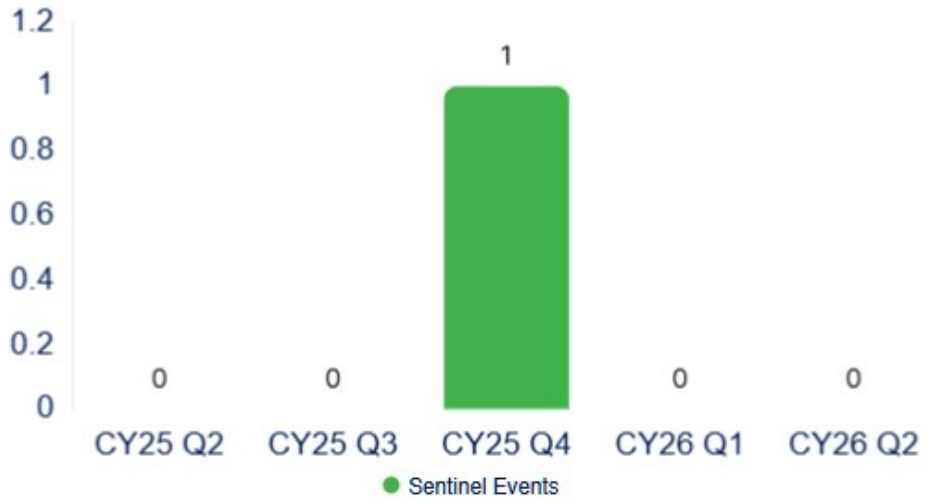

## Catheter-Associated Urinary Tract Infection <



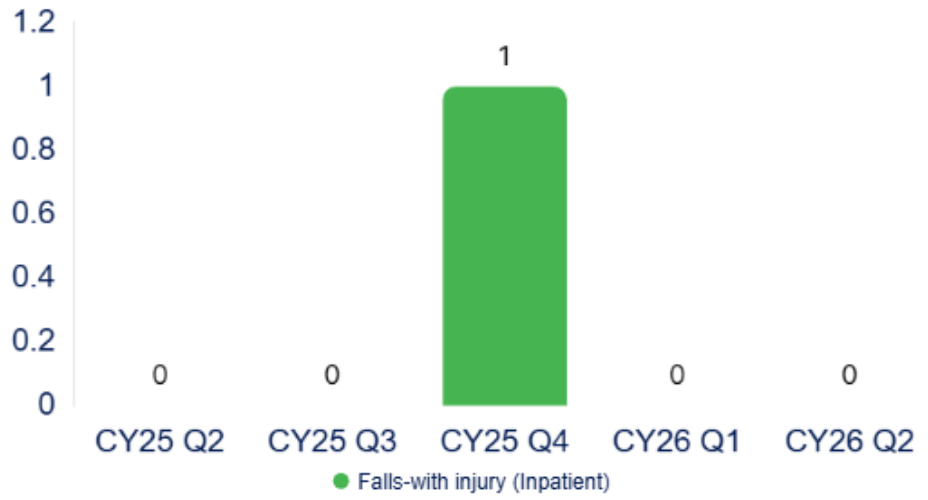
**Medical Transfer Rate from ED**



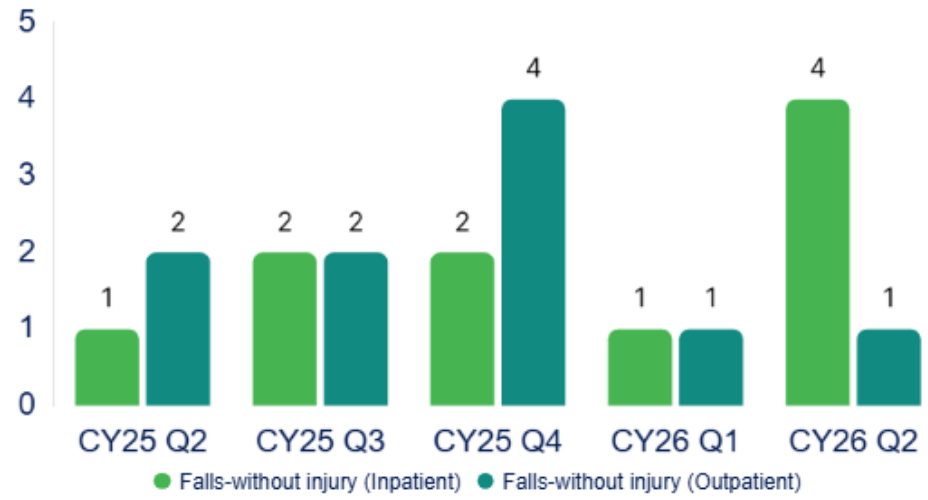

**Sentinel Events <**



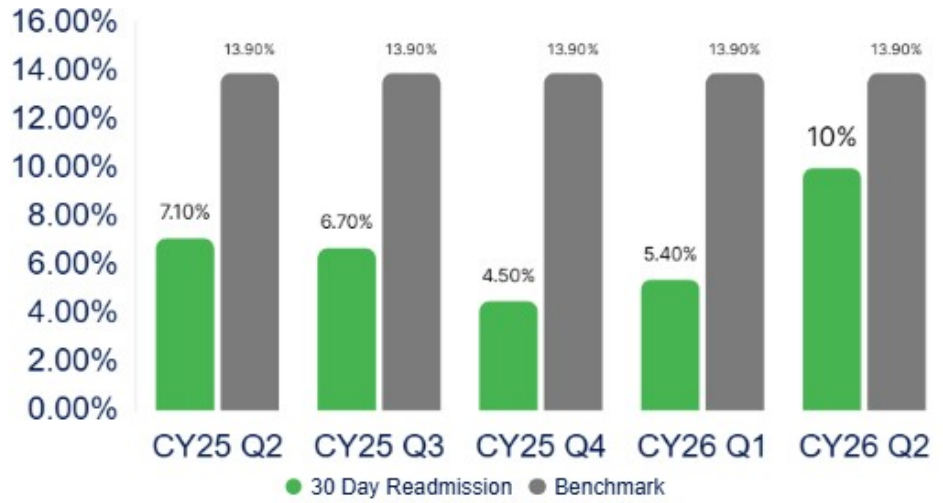
## Patient Falls- With Injury <



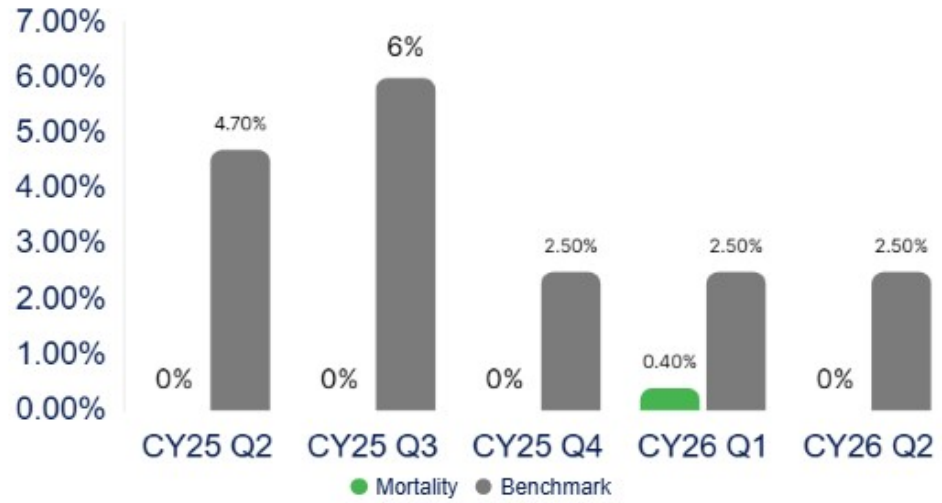

## Patient Falls- Without Injury <



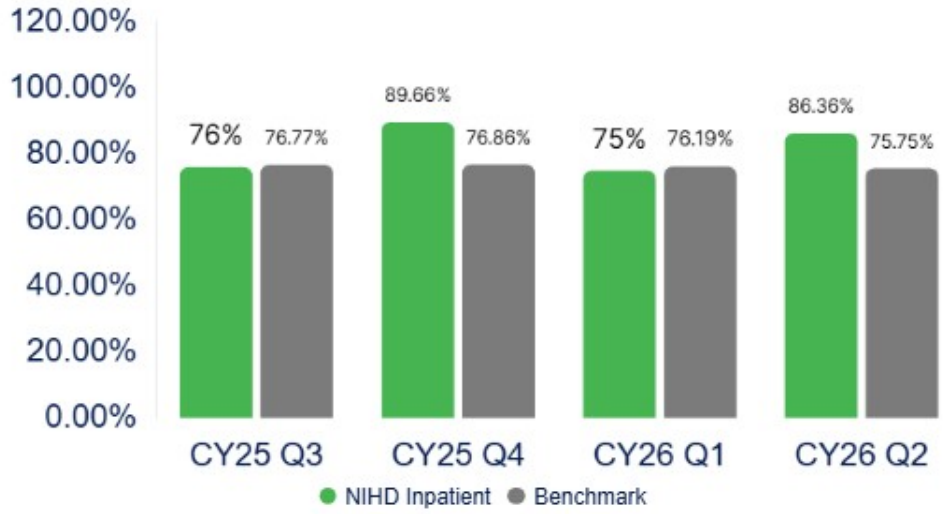
## 30 Day Readmission <



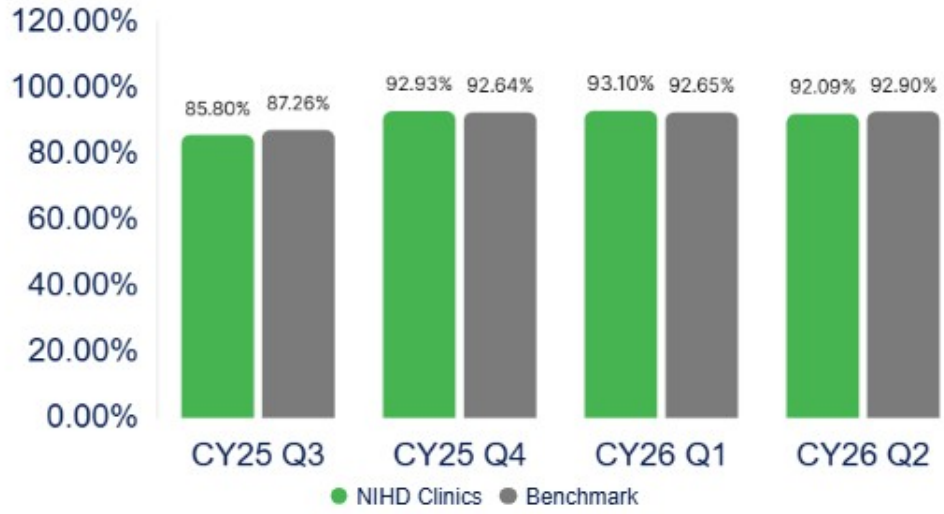

## Mortality <



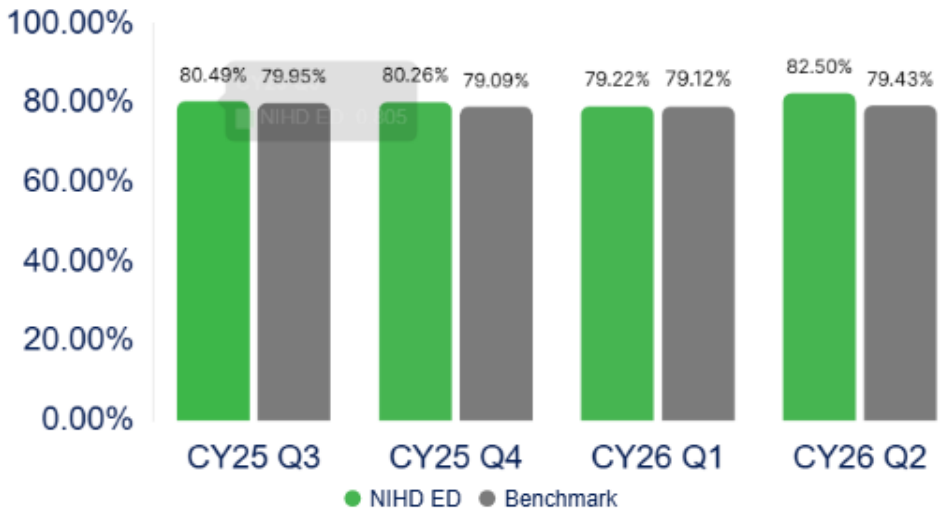
## Likelihood to Recommend Top Box Score (Inpatient)



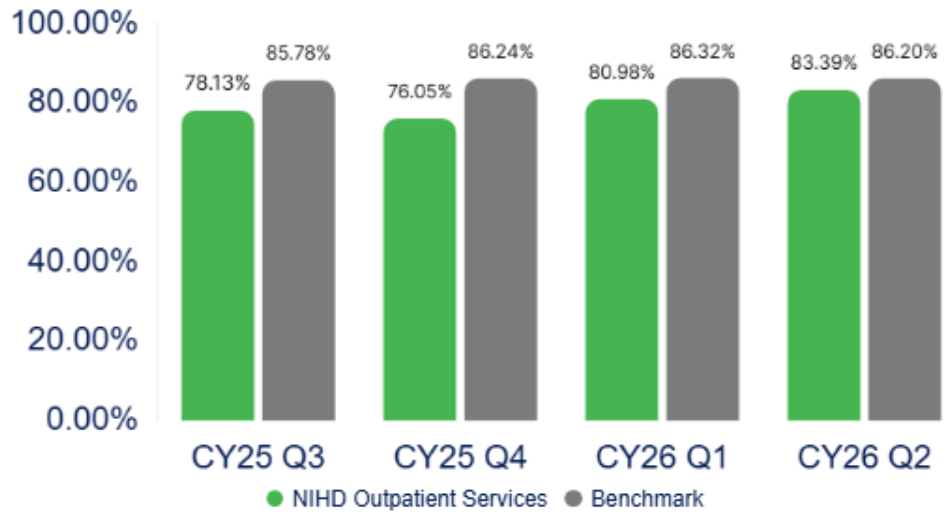

## Likelihood to Recommend Top Box Score (Clinic)



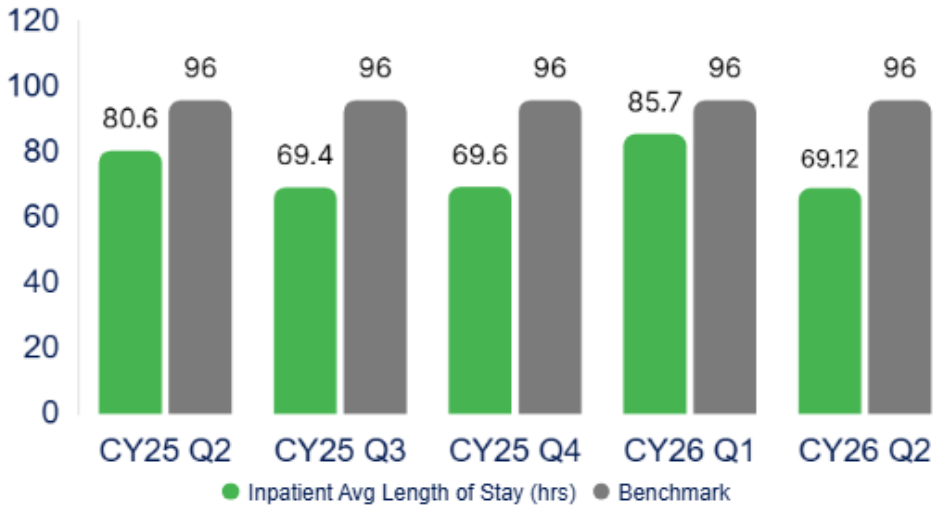
## Likelihood to Recommend Top Box Score (ED)



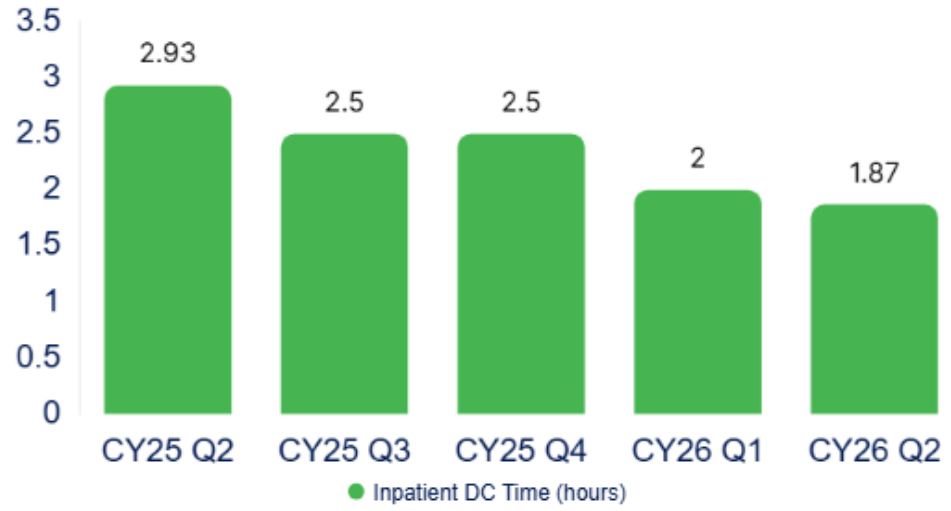

## Likelihood to Recommend Top Box Score (OP)



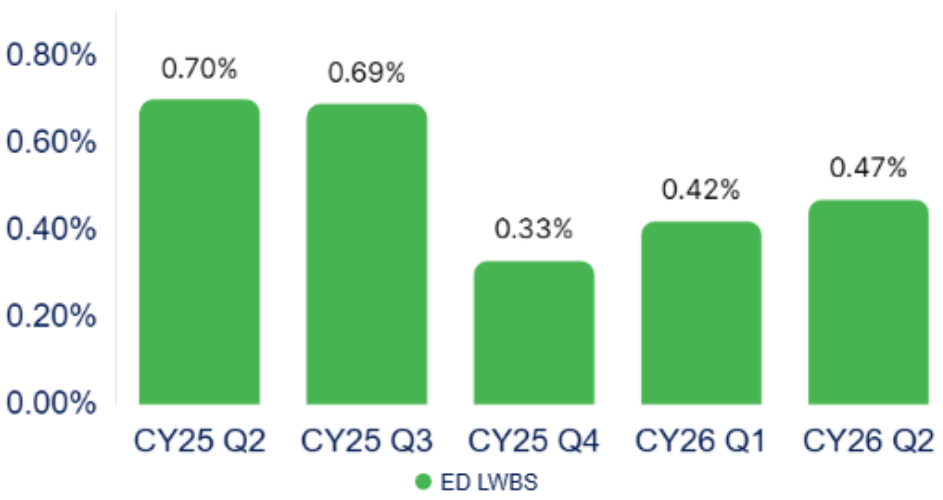
## Inpatient Average Length of Stay (hours) <



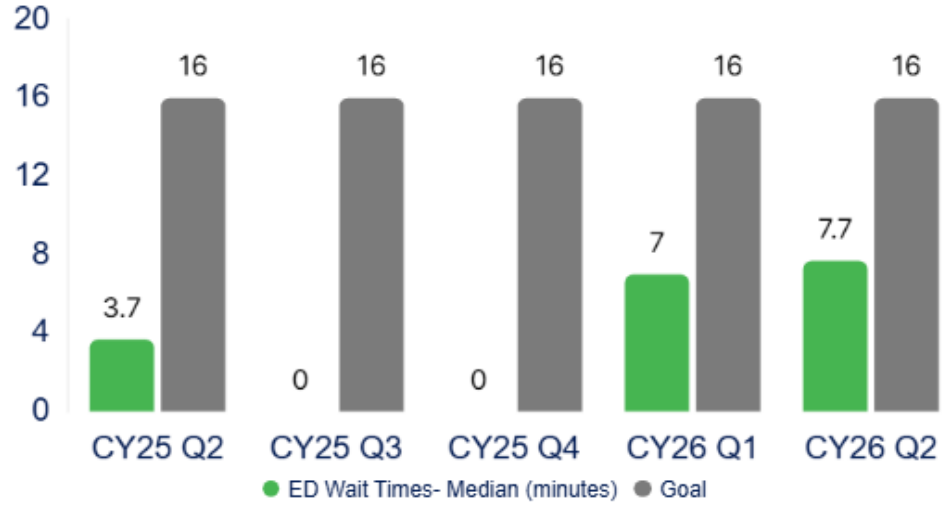

## Inpatient Discharge Time (hours) <



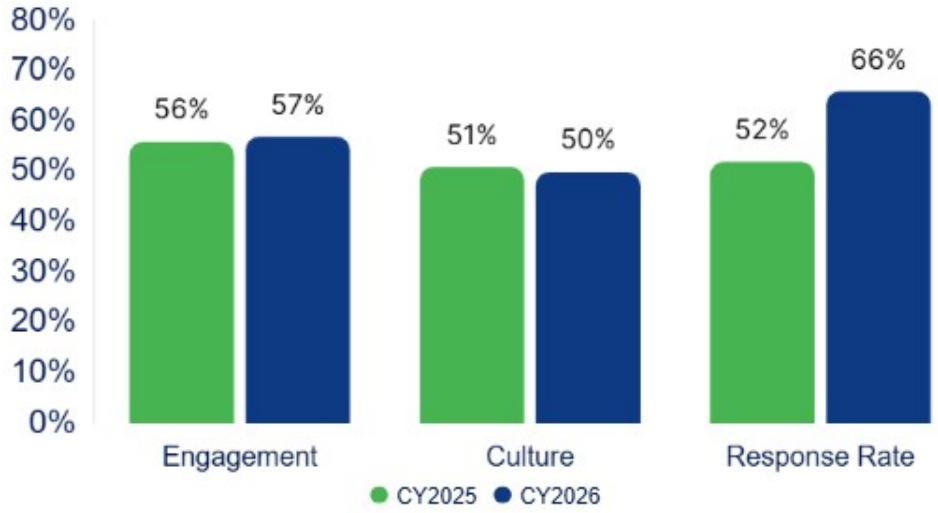
## ED Left Without Being Seen <




## ED Wait Times- Median (minutes) <



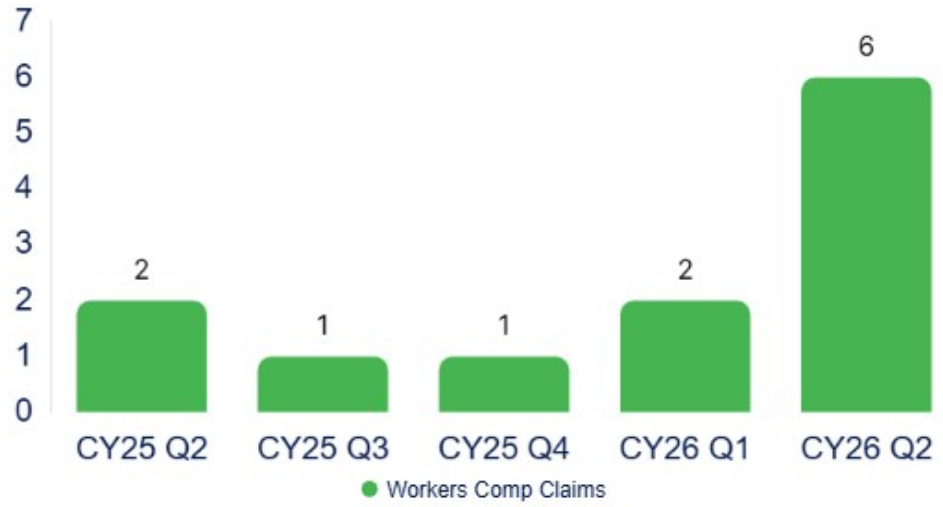
## Employee SCORE Survey Results




## Employee Turnover

## Reportable Incidents- Employees


## Workers Comp Claims



*August 4, 2026*

*News Release*

*Contact:*

*Barbara Laughon*
*(760) 873-5811 ext. 3415*
*barbara.laughon@nih.org*

# NIHD to test hospital entrance screening system Aug. 18-20

Patients and visitors coming to Northern Inyo Hospital Aug. 18-20 may notice something different when they arrive. Northern Inyo Healthcare District (NIHD) will test a hospital entrance screening system to learn how it works in a hospital setting while maintaining a positive experience for patients and visitors.

The three-day test is expected to have little or no impact on patient care or scheduled appointments.

The system will be set up at the Main Lobby and Emergency Department entrances. It is designed to detect weapons. Some patients and visitors may be asked to take part in the test. Staff will be nearby to answer questions and help visitors.

The test is part of NIHD's planning for new hospital weapons screening requirements established under California's Assembly Bill 2975. The law directs California to develop statewide standards for hospital weapons screening over the next few years. NIHD is testing the system now so it has time to learn what works best before making any decisions.

"We know people come to the hospital during some of life's most important moments," said Allison Partridge, Chief Operating Officer and Chief Nursing Officer at Northern Inyo Healthcare District. "They should feel welcome, cared for and safe from the moment they walk through our doors.

"Safety has been on many people's minds in recent days. This test is not a response to any one event. It is part of our long-term planning as hospitals across California prepare for new state

requirements. We want to understand what works best for our patients, visitors, employees and community before making any decisions."

Patients should arrive for appointments and services as they normally would. The test is not expected to affect patient care or scheduled appointments. Staff will be available to answer questions and assist visitors.

Northern Inyo Healthcare District appreciates the community's patience and understanding as it completes the three-day evaluation. What NIHD learns during the test will help guide future decisions as the District continues providing safe, compassionate care in a welcoming environment.

***About Northern Inyo Healthcare District:*** *Founded in 1946, Northern Inyo Healthcare District features a 25-bed critical access hospital, a 24-hour emergency department, a primary care rural health clinic, a diagnostic imaging center, and a rehabilitation service for physical, occupational, and speech-language therapy. We also offer clinics specializing in orthopedics, cardiology, urology, women's health, pediatrics and allergies, general surgery, colorectal surgery, and breast cancer surgery. Continually striving to improve the health outcomes for those who rely on us for care, NIHD aims to improve our communities, one life at a time. One team, one goal, your health.*