Northern Inyo Healthcare District

Board Meeting

Board Meeting - February 18, 2026

Mission

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

Vision Statement

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

Values

* Integrity * Innovate Vision * Stewardship * Teamwork *

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

February 18, 2026, 3:30 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 with legal counsel - Anticipated litigation

       Significant exposure to litigation pursuant to Government Code § 54956.9(d)(2)

       One Case (1) Facts and circumstances: Consideration of Government Claim dated 1/27/26
    b. Conference with legal counsel - Anticipated litigation

       Significant exposure to litigation pursuant to Government Code § 54956.9(d)(2)

       One Case (1) Facts and circumstances: Consideration of Government Claim dated 1/30/26
4. Return to open session and report on any actions taken in closed session.
5. 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.

6. Consent Agenda – All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.
    a. Approval of minutes for January 21, 2025, Regular Board Meeting
    b. Approval of Policies and Procedures
        i. Computer Backup Policy
        ii. Cyber Security Policy
        iii. District Competency Plan
        iv. Electrical Distribution
        v. EOC Management Plan
        vi. NIHD Wireless Connectivity
7. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
    a. Medical Staff Reappointments 2026-2027
    b. Medical Staff Initial Appointments 2026-2027
    c. Medical Staff Initial Appointments 2026-2027 – Proxy Credentialing
8. Chief Executive Officer Report
    a. Strategic Growth – WIPFLI/WOLD – Information Item
    b. Auxiliary/Foundation Update – Information Item
    c. Go Bond - Information Item
9. Quality Committee
    a. Beta – Information Item
    b. Community Health Needs Assessment (CHNA) – Information Item
    c. Quality Committee Charter – Action Item
    d. Quality Dashboard – Information Item
10. Finance Committee
    a. Financial Audit – Action Item
    b. Financial & Statistical Reports – Action Item
    c. Financial Projection – Information Item
    d. Ortho Service Line – Information Item

11. General Information from Board Members

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12. Adjournment

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

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Computer Backup Policy		
Owner: Director of IT	Department: Information Technology	
Scope: Districtwide		
Date Last Modified: 02/02/2026	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/17/04	

PURPOSE:
These guidelines are intended to provide the optimum balance between maximum "up time" of individual workstations and protection from inadvertent loss or corruption of data.

POLICY:
1. The information technology department will back up all hospitals sensitive, valuable, and critical data saved to the NIHD network nightly.
2. Redundant encrypted copies will be moved off the main facility to separate on campus structures.
3. All data will be clearly identified with bar coding for ease of access and reclamation.
4. IT staff will perform daily maintenance, and periodic testing of restored data validity.
5. Data stored locally (on the PC's local hard drive or "C" drive) will **not be** backed up therefore it is the recommendation of the IT department to save all files to the network.
6. Extremely sensitive data should also be saved to the network with the use of encryption. Managers and supervisors my coordinate use of encryption with the IT department.

CROSS REFERENCE:
1. InQuiseek - #390 Health Information Technology/IT

Supersedes: v.1 Computer Backup Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Cyber Security Policy		
Owner: Director of IT	Department: Information Technology	
Scope: Districtwide		
Date Last Modified: 01/29/2026	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

~~Cybersecurity Policy~~

Purpose:
Northern Inyo Healthcare District (NIHD) is committed to protecting the confidentiality, integrity, and availability (CIA) of information assets, including Protected Health Information (PHI) and Electronic Protected Health Information (ePHI). This Cybersecurity Policy establishes governance requirements to ensure compliance with applicable federal and state regulations, including the HIPAA Security Rule, and alignment with nationally recognized cybersecurity frameworks.

Policy:
This policy establishes mandatory requirements. Supporting cybersecurity standards and procedures define minimum technical baselines and operational processes and may be updated independently of this policy.

Risk Analysis and Risk Management
NIHD shall conduct an enterprise-wide information security risk analysis at least annually and upon significant system or operational changes. Identified risks shall be documented, prioritized, and managed through formal risk treatment plans.

Incident Response and Breach Management
NIHD shall maintain an Incident Response Plan addressing detection, containment, eradication, recovery, and post-incident review. Security incidents involving PHI shall be managed in coordination with Compliance, Legal, and Communications and handled in accordance with HIPAA and applicable state breach notification laws.

Compliance and Enforcement
Violations of this policy may result in disciplinary action up to and including termination, contract termination, or legal action.

Cybersecurity Standards

1. **Access Control Standard**
   - Access shall be granted based on least privilege and minimum necessary principles.
   - Unique user IDs are required.
   - Multi-factor authentication (MFA) shall be used where technically feasible.

2. **Network Security Standard**
   - Network segmentation and security zones (secure, semi-secure, non-secure) shall be maintained.
   - Firewalls, IDS/IPS, and secure VPNs shall protect perimeter and internal networks.
   - Industry-standard secure configurations shall be applied.

3. **Encryption Standard**
   - Data at Rest**:** AES-256 or equivalent.
   - Data in Transit**:** TLS 1.2 or higher.
   - Cryptographic modules shall be FIPS 140-2 or 140-3 validated where applicable.

4. **Vulnerability Management Standard**
   - Vulnerability scanning shall occur regularly.
   - Remediation targets:
     - Critical: 7–14 days
     - High: 30 days
     - Medium: 90 days
     - Low: Risk acceptance or scheduled remediation

5. **Audit and Monitoring Standard**
   - Security controls shall be monitored continuously and audited at least annually.
   - Logs shall be protected and retained per retention policy.

6. **Third-Party Security Standard**
   - Vendors accessing NIHD systems or PHI must sign BAAs.
   - Security assessments or attestations shall be required for high-risk vendors.

Procedures:

Security Audit Procedure
- Audits must be approved by IT Director, HR, and Compliance.
- CEO approval is required only for executive-level or highly sensitive investigations.
- Audits shall follow documented scope, timeframe, and minimum necessary principles.

Access to Workforce Information Procedure
- Requests require documented business justification.
- HR and Compliance approval is mandatory.
- All access actions shall be logged and reviewed.

Vulnerability Assessment and Penetration Testing Procedure
- Authorized tools shall be used.
- Findings shall be documented with remediation plans.
- Annual penetration testing shall be coordinated by IT or a designated third-party provider.

Encryption Exception Procedure
- Exceptions must be documented, approved by the Security Officer, and reviewed annually.

References:
1. HIPAA Security Rule Mapping
   - Administrative Safeguards: 45 CFR §164.308
   - Physical Safeguards: 45 CFR §164.310
   - Technical Safeguards: 45 CFR §164.312
2. NIST Cybersecurity Framework (CSF) 2.0 Mapping
3. NIST SP 800-53 Rev. 5

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES: Emergency Management Plan

Supersedes: v.1 Cyber Security Policy

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: District Competency Plan		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/02/2023	Last Review Date: 12/11/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 1/17/2018	

PURPOSE:

The purpose of this policy is to establish a District-wide competency plan for the workforce at Northern Inyo Healthcare District ("District") so as to ensure that the competence of all employees is assessed, maintained, improved, and appropriately aligned with organizational needs on an ongoing basis.

POLICY:

The District believes that members of the workforce who have the required skills and who employ the knowledge necessary to perform their District positions provide safe and excellent patient care treatment and service. Therefore, in order to fulfill the District's Mission, Vision and Values, the District will provide an adequate number of employees whose demonstrated competencies are commensurate with their responsibilities. The District will define the competencies it requires of its employees who provide patient care, treatment, or services.

The competencies are defined based on mandated requirements, new or changed procedures or equipment, low-volume/high risk or high volume/high risk and/or problem prone activities that may be identified by aggregate data. Completed competency documentation will be housed in the employee's official personnel file.

Competence is defined as having adequate abilities and/or qualities to meet each District position's performance standards. Core (or Initial) Competencies are defined as the minimally necessary abilities and/or qualities to meet the District's basic performance standards at the conclusion of the departmental introductory period.

The District uses assessment methods to determine individuals' competence for each skill being assessed. An individual (content expert/supervisor/preceptor) with the educational background, experience, or knowledge related to the skill being reviewed assesses competence.

Competency validation occurs at the time of hire and on an ongoing basis at intervals outlined by external mandates, hospital and/or departmental requirements. When there are two or more conflicting interval requirements, the District will follow the stricter mandate. Competencies are predetermined for each position by District leadership and are reassessed annually for continued eligibility.

PROCEDURE:

1. Initial Competency verification at the Time of Hire. Initial competency assessment at the time of hire includes the following tools:

- Interview
- References
- Primary Source verification for required credentials (e.g. license).
- Job Qualification verification

2. Core (Initial) Competency Verification. Core Competency assessment post District-wide orientation and during the course of the departmental orientation can use the following methods of validation:

- Observation by an individual with the educational background, experience, or knowledge related to the skill being reviewed whom District Leaders deem eligible to assess competence;
- Online testing using case studies as the basis for questions;
- National testing deemed to be reliable and valid;
- Demonstration of required skill or activity;
- Evaluation of documentation;
- Documented return demonstration which may also be documented through any online Learning Management System.

3. Ongoing Competency Verification. Ongoing Competency Verification occurs at least annually and/or at intervals required by external mandates, District and departmental requirements including the following:

    - District annual training is required for all District employees.
    - Department specific competencies are assessed.
    - Population or condition specific competencies are assessed. Populations and/or conditions can include but are not limited to age and populations with high risk equipment or processes in place e.g., urinary catheters, IV's and transfusions and other populations as indicated.
    - Individualized competencies are assessed as identified by Leadership.
    - Items can be added or removed from the ongoing validation competency list throughout the year as determined by external mandates and/or Leadership
    - Skill and/or knowledge demonstration is a method used to determine competence.
    - Feedback will be provided to all employees who participate in competency demonstration and remediation may be offered as directed by District Leadership and employees who do not have completed competency documentation submitted to their Official Personnel File as required will not be permitted to work.
    - Employees will use the following resources as indicated for high risk high volume or high risk low volume activities when they recognize a potential gap in their skills: (a) Time out for expert consultation; (b) request placement in areas where staff competence is high; (c) practice processes or skills prior to execution; (d) use job aids as needed.

4. Responsibilities:

    a. District Leadership defines the job qualifications and competencies for all District positions in his/her respective areas and authorize content experts/ supervisors/ preceptors.

        - District Leaders and/or designee content experts/supervisors/preceptors must ensure their competencies are up to date and that employees meet competency requirements at least annually unless directed differently by external mandate, District or departmental requirements. Communication that is clear from Leader to employee is a priority to ensure the requirements under this Policy are timely met.

- Predetermine competency requirements for each position at the District and reassess continued eligibility annually.
- Maintain all completed competency documentation and ensure that it is submitted to Human Resources for inclusion in the official personnel file
- Align competency requirements across the District for the same topic in different departments/work areas. If it is recommended that a competency is required of more than the Leaders' department personnel, Leaders must coordinate these requirements with Executive Leadership before launching required competencies.
- Ensure that the competence of persons in each position are assessed, maintained, improved and appropriately aligned with business needs on an ongoing basis and periodically evaluate the overall performance of persons assigned to positions.
- Communicate information about resources to use when staff are unsure how to carry out duties during all evaluation times to all employees.
- Communicate to each employee by October 1 of each calendar year competencies to be completed by December 31 of that calendar year
- The District Leader and/or designee will determine the appropriate method/tools to validate the employee's competency within the guidelines of this Competency Plan.
- The District Leader and/or designee will determine appropriate training/re-training of the employee who does not demonstrate competence in any required area.

b. Employees exercise professional accountability as follows:

- Understanding what requirements are needed, scheduling/completing the requirements timely, and submitting completed documentation to their Leader on time.
- Recognizing skills that are high risk high volume or high risk low volume for his/her practice.
- Seeking out/implementing strategies identified within this policy to mitigate risk.
- Notifying supervisors immediately when gaps in competence are recognized.
- Maintaining competence in areas designated if designated by their Leader as a content expert/supervisor/preceptor.
- Complete their own competencies, including hands on demonstration, e-learning modules and other methods assigned.
- Any employee who fails any aspect of the competency requirements must engage in a remediation of that competency and satisfy the remediation requirements within 90 days (or other such time as designated by his/her District Leader) in order to continue District employment.

c. Methodology. Approved methods used in the assessment of employee competencies include, but are not limited to:

- Observation by an individual with the educational background, experience, or knowledge related to the skill being reviewed whom District Leaders deem eligible to assess competence;
- Online testing using case studies as the basis for questions;
- National testing deemed to be reliable and valid;
- Demonstration of required skill or activity;
- Evaluation of documentation;
- Documented return demonstration, which may also be documented through any online Learning Management System.

REFERENCES:

The Joint Commission Standards, HR.01.01.01, HR.01.06.01, PI.03.01.01

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Competency Notebook
2. Nursing Competency Plan

RECORD RETENTION AND DESTRUCTION:

Human Resources records are maintained the life of employment plus six years.

Supersedes: v.1 Competency Plan

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Electrical Distribution		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Facilities		
Date Last Modified: 12/02/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To define the classification of electrical distribution systems within Northern Inyo Healthcare District (NIHD) in accordance with **NFPA 99-2012**, **NFPA 70 (NEC)**, **NFPA 110**, **CMS CoPs**, and **The Joint Commission** standards for Critical Access Hospitals. This ensures electrical system reliability appropriate to the risk level of patient care areas.

POLICY
NIHD's electrical distribution system is designed and maintained in accordance with the system categories defined in **NFPA 99-2012, Chapter 4**, and the requirements for Essential Electrical Systems (EES) outlined in **NFPA 99, Chapter 6**, **NFPA 70 (NEC), Article 517**, and **NFPA 110** for emergency power supply systems (EPSS).

Category 1 Systems (Highest Risk)
Rooms and areas where electrical system failure **is likely to cause major injury or death** to patients or caregivers.
Examples include:
- Critical care rooms
- ORs
- PACU
- L&D (if performing C-sections)
- Any location where life-support equipment is required

Category 1 spaces must be served by a Type 1 Essential Electrical System (EES) consisting of:
- Life Safety Branch
- Critical Branch
- Equipment Branch
  (Ref: NFPA 99-2012, 6.4.2.2.1)

Category 2 Systems
Rooms where electrical system failure **is likely to cause minor injury** to patients or caregivers.
Examples:
- General care / med-surg rooms
- L&D / Nursery (if no surgical capability)
- Treatment rooms

Category 2 spaces may be served by either a **Type 1 or Type 2 EES**, depending on risk and system design. (Ref: NFPA 99-2012, 4.1 & 6.4.2.3)

Category 3 Systems (Lowest Risk)
Rooms where electrical system failure **is not likely to cause injury** to patients or caregivers.
Examples:

- Basic patient care rooms
- Long-term care settings
- Exam rooms in outpatient clinics

Category 3 requires a Type 3 EES, which includes:

- A life safety branch
- An alternate power source capable of supplying necessary loads for **at least 1.5 hours** (Ref: NFPA 99-2012, 6.5.2)

REFERENCES:

1. NFPA 99-2012**, Health Care Facilities Code – Chapters 4 & 6**
2. NFPA 70 (NEC) Article 517**, Health Care Facilities**
3. NFPA 110**, Standard for Emergency and Standby Power Systems**
4. CMS Conditions of Participation – 42 CFR 482.41 **(for CAHs: 485.623)**
5. California Building Code / Title 24 **(OSHPD/IB for CAH requirements)**
6. The Joint Commission CAMCAH Manual (Jan 2021)
7. Utility Systems Electrical and Generator Failure

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Electrical Equipment Management
2. Utility Systems – Electrical and Generator Failure
3. Utility Systems Inventory and Risk Assessment
4. Emergency Power Supply System (EPSS) Testing & Maintenance

Supersedes: v.1 Electrical Distribution EC.02.05.01 EP21

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: EOC Management Plan		
Owner: Director of Facilities	Department: Plant Services	
Scope: Districtwide		
Date Last Modified: 01/31/2026	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Environment of Care Management Plan
Safety
Security
Hazardous Materials and Disposal Management Plan
Fire Safety
Medical Equipment
Utility Systems

MISSION

The mission of NIHD is to improve the health, healthcare and well-being of all Eastern Sierra community members and surrounding areas through:

- Education of our health care providers
- Provision of quality, comprehensive clinical programs
- Extension of our services to the community and out of area healthcare providers

Consistent with our mission, values and goals, the Environment of Care, our healthcare providers and Leadership has established and provides ongoing support for the Environment of Care Management Program described in this plan.

The purpose of the Environment of Care Management Plan is to prevent the risk of injury and promote safety for patients, staff, visitors, and volunteers at NIHD. The plan also addresses specific responsibilities and employee education programs.

SCOPE

The Environment of Care Management Plan addresses specific responsibilities and employee education programs. These and other elements of the Environment of Care Management Plan are all directed toward managing district-wide staff activities to prevent injuries to patients, staff, visitors, and volunteers, and to ensure staff can respond appropriately in emergencies.

The Environment of Care Management Plan is applied to the Main Hospital, Clinics, Offices, and Satellite Buildings of Northern Inyo Healthcare District (NIHD).

REPRORTING OF INCDIENTS WITHIN EACH EOC PLAN:

1. Each incident within any of the plan must be reported via the Unusual Occurrence Reporting (UOR) Platform.
2. The leader where incident occurred must ensure that report is investigated and completed within an appropriate timeframe.
3. Incident must be reported to appropriate owner of the plan for analyzing of documents, final review and tracking and trending of incidents.

QUCIK REFERNCE FOR INCDENTS:

Refer to Rainbow Chart

Safety Management Plan

A. SCOPE

~~B.~~

The Safety Management Plan describes the programs used to manage the Safety Management Program to prevent the risk of injury and promote safety for patients, staff and visitors for Northern Inyo Healthcare District (NIHD). Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or may be related to situations beyond the organization's control. Safety incidents are most often accidental.

C. FUNDAMENTALS

~~D.~~

1. Department heads and managers need appropriate information and training to develop an understanding of safe working conditions and safe work practices within their areas of responsibility.

~~2.~~

3. Safe working conditions and practices are established by using knowledge of safety principles to educate staff, design appropriate work environments, purchase appropriate equipment and supplies, and monitor the implementation of the processes and policies.

~~4.~~

5. Regular evaluation of the environment for work practices and hazards is required to maintain a current relevant Safety Management Plan. The plan will change as needed to respond to identified risks, hazards and regulatory compliance issues arise.

E. GOALS & OBJECTIVES

~~F.~~

The goals and objectives for the Safety Management Plan are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, incident and injury reports and environmental rounds.

1. The hazard surveillance program includes all areas of the hospital, and clinics. The program includes the facilities, equipment; EOC rounds are completed bi-monthly in all departments of the Hospital and Clinics.

~~2.~~

3. The Safety Committee receives information from the Safety Management program, and other sources, identified key issues, recommendations and activities. The Safety Officer manages the monitoring, documentation and presentation of this information.

~~4.~~

5. There are processes for follow-up to product safety recalls. The Safety Training program includes new employee orientation, job and site specific orientation

G. ORGANIZATIONAL RESPONSIBILITIES

~~H.~~

1. The Chief Executive Officer assigns and signs the designation for the Safety Officer.

~~2.~~

3. The Executive Team, or other designated leader, collaborates with the Safety Officer, to establish operating, and capital budgets for the Safety Management Program.

~~4.~~

~~5.~~

6. The Safety Officer, in collaboration with the committee, is responsible for monitoring all aspects of the Safety Management Program. The Safety Officer advises the Safety Committee regarding safety issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

~~7.~~

8. The Safety Committee coordinates processes within accreditation and regulatory requirements. Membership on the committee includes representatives from administration, clinical services, and support services. This group meets at least 10 times per year to receive reports and conduct a timely review of safety issues. Additional meetings may be scheduled at the request of the Safety Officer or committee member.

~~9.~~

10. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific safety procedures. They are also responsible for the reporting and investigation of incidents occurring in their departments. When necessary, the Safety Officer provides department heads with assistance in developing department Safety Management Programs or policies.

~~11.~~

12. Individual staff members are responsible for learning, retaining and following job and task-specific procedures for safe operations.

I. PROCESSES OF MANAGING SAFETY RISKS

Safety Risk Management

The Safety Officer is designated to manage risk, coordinate risk prevention activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The Safety Officer assures compliance with applicable codes and regulations, as applied to the buildings and services.

Safety Risk Assessment

The Safety Officer manages the safety risk assessment process for the NIHD facilities. The Safety Officer is designated to manage risk, coordinate risk prevention activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results.

This assessment implements its process to identify safety risks associated with the environment of care. Risks are identified from internal sources, such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessment of high-risk processes, and from credible external sources.

Use of Risk Assessment Results

The current programs and processes to manage risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled action must be taken to eliminate or prevent the risk. The actions may create new programs, processes, procedures, or training programs. Monitoring programs may be developed to assure risks have been controlled to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and visitors.

Grounds & Equipment

The Maintenance Manager is responsible for maintaining the lawns, plantings, drives, walks, parking areas, building exterior and roofs, etc, of all properties covered by this management plan. An inspection of the grounds is conducted on an ongoing ~~bases~~basis.

DESIGN-CONSTRUCTION

The organization designs, constructs, and maintains features of the environment to promote patient safety while providing diagnosis, treatment and care for the appropriate needs of the patients. These features include:

- Quality of natural & artificial light
- Privacy
- Size & configuration of space
- Security for patients
- Clear access to internal & external doors
- Levels of noise
- Space that allows staff to work efficiently

To provide the appropriate environment, the organization conducts planning activities and inspections of the following items, title 22, 24 and all applicable code are used to insure:

- Interior spaces shall meet the needs of the patient population and are safe and suitable to the care, treatment and services provided.
- Lighting is suitable for care, treatment, and services.
- Ventilation, temperature and humidity are maintained at levels suitable for the care, treatment, and services provided.
- Areas used by patients are clean and free of offensive odors.
- Emergency access provision is provided to all locked and occupied spaces.
- Furnishing and equipment are maintained to be safe and in good repair.

Product Notices & Recalls

The District ensures responses to product recalls and/or notices for all applicable recalls.

Smoking Policy

NIHD provides a healthy and smoke-free environment for all who enter the grounds. Therefore, all smoking types—tobacco, electronic, or other, is not permitted.

Environmental Rounds

Environment of Care rounds are performed to identify and evaluate environmental deficiencies, hazards, unsafe practices, security deficiencies, hazardous materials and wastes practices, fire safety problems, medical equipment issues, access to utility system elements, and staff knowledge and other issues.

Security Management Plan

A. SCOPE

The Security Management Plan describes the methods of providing security for people, equipment and other material through risk assessment and management for Northern Inyo Healthcare District (NIHD). Security protects individuals and property against harm or loss, including workplace violence, theft, infant abduction, and unrestricted access to medications.

C. FUNDAMENTALS

1. A security presence in the District helps reduce crime and increase feelings of security by patients, visitors, and staff.
3. The assessment of risks to identify potential problems is central to reducing crime, injury, and other incidents.
5. Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.
7. Training District staff is critical to ensuring their performance. Staff is trained to recognize and report either potential or actual incidents to ensure a timely response.
9. Staff in high risk areas is trained about the protective measures designed for those areas and their responsibilities to assist in protection of patients, visitors, staff and property.
11. A workplace violence prevention program has been established by the District.

E. GOALS & OBJECTIVES

The goals and objectives for the Security Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, incident and injury reports, and environmental rounds.

The following are goals and objectives of the Security Management Plan:

1. Take appropriate and timely action to prevent crime, injury, or property loss.
3. Provide timely response to emergencies and requests for assistance. Report crime, fire, injury, or other incidents. Communicate externally with local, state, or federal law enforcement and other civil authorities. Provide internal communications, as needed.
5. Provide timely response to reports of violent activity. Provide training of all new employees, including how to report incidents and obtain assistance in an emergency.
7. Maintain a documentation system for security incidents.
9. Identify problems, failures, and user errors that require attention and action which are reported to the Safety Committee.

~~10.~~
11. Identify performance improvement opportunities and implement corrective action.

G. ORGANIZATIONAL RESPONSIBILITIES

~~H.~~

1. The Chief Executive Officer (CEO), or other designated leader, collaborates with the Director of Facilities to establish operating and capital budgets for Security needs.

~~2.~~

3. The Director of Facilities advises the Safety Committee, regarding security issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

~~4.~~

5. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific security procedures. They are also responsible for the reporting and investigation of incidents occurring in their departments. When necessary, the Security personnel or designee provides department heads with assistance in developing department security programs or policies.

~~6.~~

7. Individual staff members are responsible for learning, retaining and following job and task-specific procedures for safe operations.

I. PERFORMANCE ACTIVITIES

~~J.~~

The performance measurement process is one part of the evaluation of the effectiveness of the Security program. Performance measures have been established to measure at least one important aspect of the Security program.

K. PROCESSES FOR MANAGING SECURITY RISKS

Security Risk Assessment

An assessment is conducted to identify security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring, results of annual proactive risk assessment of high-risk processes, and from credible external sources.
The risk assessment is used to evaluate the impact of the environment of care on the ability of the District to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals. The assessment will evaluate the risk from a variety of functions, including structure of the environment, the performance of everyday tasks, workplace violence, theft, infant abduction, and unrestricted access to medications.

Use of Risk Assessment Results

The current programs and processes to manage risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled action must be taken to eliminate or prevent the risk. The actions may create new programs, processes, procedures, or training programs. Monitoring programs may be developed to assure risks have been controlled to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and visitors.

Identification Program

The Manager of Human Resources coordinates the identification program. All supervisory personnel manage enforcement of the identification program.
Human Resources maintain policies for identification. All personnel are required to display an identification badge while on duty. Identification badges are to be displayed picture side out. Personnel who fail to display identification badges are counseled individually by their department head. Identification badges are retrieved from personnel upon termination.
A visitor check-in process is established by the HR Department and a patient identification is provided at the nursing unit where the patient is first admitted.

High Risk Areas

The Facility Director works with leadership to identify high risk areas by utilizing risk assessments and analysis of incident reports. A high risk area is defined as one that has special security needs beyond the general hospital areas. Typically, this will be due to issues such as vulnerable patients, financial issues, drug issues, and access to protected information and critical equipment.

High Risk and Sensitive Areas include the below:

- Pharmacy
- Emergency Department
- Rural Health & NIA Clinics
- Main Lobby Registration
- Gift Shop
- Acute / Sub -Acute
- Perinatal
- ICU
- Parking areas

Security Incident Procedures

The Safety Officer, Maintenance Manager, Security Officer, Risk Manager in collaboration with the V-PAT Team identify security issues involving patients, personnel, visitors, and property, develops procedures to address them and collaborates on the development of department specific procedures as needed.

Security Incident Response

Upon notification of a security incident, the appropriate person will assess the situation and implement the appropriate response procedures. Administration will be notified if necessary to obtain additional support. The Officer on Duty or person responding will manage security incidents that occur. The Director of Facilities will be notified about the incident as soon as possible.

In the event of a child reported missing, is announced over the internal page system. Staff responds to doors and specified areas to observe for persons with children or packages, and notify Security.

Following any security incident, a UOR will be completed and the Security Department will be notified. The Director of Facilities, if necessary will review the report and any deficiencies identified in the report will be corrected.

Hazardous Materials (HAZMAT) Management Plan

A. SCOPE

~~B.~~

The Hazardous Material and Waste (HazMat) Management Plan describe the methods for handling hazardous materials and waste through risk assessment and management. The plan addresses the risks associated with those materials, wastes or energy sources that can pose a threat to the environment, staff, patients, and to minimize the risk of harm at Northern Inyo Healthcare District (NIHD). The program is also designed to assure compliance with applicable codes and regulations as applied to the buildings and services at NIHD. The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures.

The plan is applied to the Main Hospital, Clinics, Offices, and Satellite Buildings of Northern Inyo Healthcare District (NIHD).

C. FUNDAMENTALS

~~D.~~

1. The hazardous materials and waste are identified in the organization's inventory and the associated hazards defined as required by law or regulation in Safety Data Sheets (SDS), guidelines, good-practice recommendations, or similar available documents.

~~2.~~

3. Safe use of hazardous materials and handling of waste requires participation by leadership, at an organizational level and a departmental level, and other appropriate staff in the design and implementation of all parts of the plan.

~~4.~~

5. Protection from hazards requires all staff that use or are exposed to hazardous materials and waste to be educated as to the nature of the hazards and to use equipment provided for safe use and handling when working with or around hazardous materials and waste.

~~6.~~

7. Rapid, effective response is required in the event of a spill, release, or exposure to a hazardous materials or waste.

~~8.~~

9. Special monitoring processes or systems may be required to manage certain hazardous gases, vapors, or radiation undetectable by humans.

E. GOALS & OBJECTIVES

~~F.~~

The Objectives for the HazMat Management Plan are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, incident and injury reports, and environmental rounds.

ORGANIZATIONAL RESPONSIBILITIES

1. The Governing Body reviews and receives reports of the activities of the HazMat Management Plan as appropriate. They also provide financial and administrative support to facilitate the ongoing activities of the HazMat Management Plan.

2. The Chief Executive Officer (CEO), or other designated leader, collaborates with the Environmental Services Manager to establish operating, and capital budgets for the HazMat Management Plan.
3.
4. The Environmental Services Manager in collaboration with the Safety Committee is responsible for monitoring all aspects of the HazMat Management Plan. This individual advises the Safety Committee regarding HazMat issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.
5.
6. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific HazMat procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the Environmental Services Manager provides department heads with assistance in developing department HazMat management policies and procedures.

7. District staff members are responsible for learning, retaining and following job and task-specific procedures for safe HazMat operations.

G. PERFORMANCE ACTIVITIES

H.

The performance measurement process is one part of the evaluation of the effectiveness of the HazMat Management Plan. Performance measures have been established to measure at least one important aspects of the HazMat Management Plan.

I. PROCESSESS FOR MANAGING RISK

Hazardous Materials and Waste Inventory

The District develops and maintains an inventory of hazardous materials and waste, including chemicals, biological, radiological, chemotherapeutic, and chemicals. Each manager maintains information of the hazardous materials and waste used, stored, or generated in that department.

Spills and Exposures

The Environmental Services department develops and maintains emergency procedures for the HazMat Plan, including appropriate precautions and response to a spill. In the event that a spill has occurred, the individual will evaluate or respond to the spill and determine if outside assistance is necessary.
See below “Spill Response”

DEFINITIONS:

Hazardous Material & Waste (HAZMAT) Spill: Incidents involving hazardous materials or wastes. A general term used to define any activity related to hazardous material and wastes.

Health Hazard: includes those for which scientific evidence exists that acute or chronic adverse health effects may occur to exposed employees. This includes chemicals that are carcinogens, toxic, highly toxic, reproductive toxins, irritants, corrosives, and sensitizers or have target organ effects, including reproductive toxins, hepatotoxins, nephrotoxins, neurotoxins, agents that act on the hematopoietic system, and agents that damage the lungs, skin, eyes, or mucous membranes

MINOR (INCIDENT) SPILL: Spills of less than 5 ml and/or any spill that can be cleaned up by the people involved using the training and personal protection equipment (PPE) they have at hand or immediately available. Minor spills include most spills and cleanup of a routine nature. The training and PPE would be determined before the spill occurred and provided in the area the chemical is used.

Physical Hazard: includes combustible liquids, compressed gases, explosive, flammable, corrosive, ignitable, reactive (i.e., unstable)

SPECIAL CONTENT SPILL: Special content spills include mercury and hazardous medications, such as chemotherapeutic for which staff are trained in cleanup procedures and have specific spill kits. The volume of the spills is predictable in volume and hazard. Nurses and pharmacists who are trained to handle hazardous medications who are specifically trained and equipped to handle minor mercury spills will manage and clean up these materials.

MAJOR SPILL: Spills larger than 5ml and that are beyond the training and PPE available to the staff. These spills may represent an immediate danger to personnel in the area because of physical or health effects (e. g., large quantities of Formalin, Xylene). In most cases, this is a decision made by the Director of the Department at the point of the incident or by the department manager based on knowledge of the hazards of the material.

IDENTIFICATION OF HAZARDOUS MATERIALS:

All hazardous chemicals will be identified using the criteria defined by the OSHA Hazard Communication Standard 29 CFR 1910.1200. A brief summary of these identification criteria is as follows:

1. Chemical Characteristics:
~~2.~~
    a. Ignitability (flammable) - examples include: Xylene, Benzene, Ethyl Ether, Acetone, and Alcohols.
    ~~b.~~
    c. Corrosivity (pH. 2.0 or pH 12.5) - examples include: Sodium Hydroxide, Hydrochloric Acid, Sulfuric Acid, and Formic Acid.
    ~~d.~~
    e. Reactivity (unstable at normal temperatures and pressure or release of explosive vapors) - examples include: Azides, Hydrogen Peroxide (30%), Picric Acid, and Percholoric Acid (60%).
3. Toxicity (toxic due to contaminated heavy metals or specified chlorinated organics) - examples include: compounds containing Lead, Mercury, Chromium, Arsenic, Silver.
4. Acutely Hazardous Chemical Wastes (Section 261.33e) - examples include: Arsenate and Arsenic-containing compounds, Cyanide and Cyanide-containing compounds, Warfarin, Parathion, Osmium Tetroxide, Sodium Azide.
5. Commercial Chemical Products and Manufacturing Chemical Intermediates - examples include: Carbon Tetrachloride, Chlorambucil, Chlordane, Chloroform, DES, Mitomycin C., Pyridine, and Toluene.
6. Toxic Waste - examples include: Cyclophosphamide, Daunomycin, Phenol, and Reserpine, PCBs, ~~,~~ 2, 4-D. This also includes the waste products from contamination, overage and use of the other chemicals. ~~Also~~In addition, those, not used up, diluted to defined levels, and not recycled, such as laboratory chemicals and some chemicals from Engineering, Laundry, Food Services, Radiology, and other areas.

7. SDS's must be provided to employees who package/process drugs for distribution into final form if they contain hazardous chemicals.

STORAGE:

1. Materials that ignite easily under normal conditions (flammables) are considered fire hazards and are stored in a cool, dry, well-ventilated storage space well away from areas of fire hazard. Flammable liquids in excess of 10 gallons in any smoke / fire zone are stored in approved flammable liquid storage cabinets meeting NFPA requirements. Amounts less than 10 gallons per zone should be stored with respect to their hazard, away from flame or other sources of ignition (e.g., alcohol).
2. Highly flammable materials (ethyl ether, hydrocarbons) are kept in an area separate from oxidizing agents and materials susceptible to spontaneous heating (e. g., explosives). These are maintained in the minimum amounts needed for daily use.
3. The storage areas for flammables are supplied with appropriate fire-fighting equipment selected for the hazard, which may include automatic suppression systems and fire extinguishers as required by code.
4. Oxidizers are not to be stored close to flammable liquids.
5. Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids, or acid fumes should be stored in a cool, well ventilated place out of the direct rays of the sun. NOTE: Incompatible toxic materials should be isolated from each other. Alphabetical storage is discouraged.
6. Corrosive materials are stored in a cool, well-ventilated area (i.e., above their freeze point) and in containers that will contain spills or leaks. NOTE: The containers are inspected at regular intervals to ensure they are labeled and kept closed.
7. Corrosives are isolated from other materials.
8. Appropriate PPE is available for use when handling these materials. Managers are responsible for assuring that proper personal protection is regularly used.
9. Where approved chemical storage cabinets are provided, the chemicals will be stored in them in the following manner:
    a. Large containers of chemicals should be stored on lower shelves.
    b. Shelves with small containers should have lips or have the containers stored in larger boxes or trays to minimize potential for dropping onto the floor.
    c. Every chemical container will have legible labels with the chemical or product name, hazard type, and manufacturer or vendor.
    d. Combustible materials such as paper & plastic and other lab and electronic equipment should not be stored in the shelves or within the chemical storage area.

DISPOSAL:

1. When disposing of chemicals refer to the SDS to verify if chemical and container can be disposed through regular trash methods or if Federal, State, and Local regulations regarding that chemical require special disposal processes.
2. Some chemicals produce wastes. Chemical wastes are defined by Resource Conservation and Recovery Act (RCRA) and include wastes that are toxic, poison, flammable, corrosive, irritant, and carcinogenic. Some chemicals may be released to the sewage system when suitably diluted or mixed with other materials, but concentrated solutions and some kinds of non-miscible (not water soluble) wastes must be placed in containers and removed by licensed contractors.
3. Chemical products that are wastes, discarded, outdated and unusable will be collected and labeled as they are identified. Such wastes will be kept in safe areas for storage and identified as potential

hazardous wastes.

4. For disposal of hazardous medications, refer to Policy on Disposal of Hazardous Medications

RESPONSE TO SPILLS:

Minor Spill

1. A minor spill can be cleaned up by the person that discovered or caused the spill without any special equipment beyond what they normally use. These spills should be cleaned up promptly and no further action is needed. *Example: A few drops of blood or a few drops of a normally used chemical.*
2. –The personal protection required to clean up these spills is normally used for handling these materials and waste (e. g., Gloves, Apron, Eye Protection, etc.).
3. –Spill kits may be used on the specific material if the staff is properly training in their use (e. g., such as a formaldehyde-neutralization kit).
4. –If a spill kit is used, or if there is potential risk to patients, staff, or visitors, an incident report should be completed.
5. -Dispose of the materials in the appropriate waste containers.

Major Spill

1. Immediately evacuate the area while closing all of the doors. This will help contain the vapors and odor. Post staff at all doors into the area to control movement into the area.
2. Contact Maintenance to shut off the HVAC system serving the affected area.
3. Contact Security to assist in securing the area, security is not available 24-7 so other staff can be used for this task.
4. During normal business hours, contact the Director of the area affected, who will evaluate the situation and potentially notify the Fire Department.
5. During off-duty hours, contact the House Supervisor who is authorized in calling the Fire Department, or Administrator on Call (AOC), It may be useful to contact them, explain the situation, and ask for their advice.
6. Continue to secure the area and ensure that the area has been evacuated (to the extent practical without personal protection) and that all staff, visitors, and patients are accounted for and that all entrances have been secured. If noxious smells extend out of the area, secure a larger area. If necessary, use the Evacuation Plan to move patients and staff to alternate sites.
7. When the Fire Department arrives, provide them with the information of the spill and location. If possible, have an SDS for the chemical spilled available for their use. Attempt to have floor plans of the area available.
8. If practical, have the person that discovered the spill available to explain the situation. If they are not available, have someone familiar with the area.
9. Northern Inyo Hospital staff must **NOT** try to clean up spills for which they have not been trained or are not equipped.
10. The Fire Department will be responsible for the clean-up and disposal of the product, PPE, and any materials used for clean-up.
11. If in any event someone has been contaminated, respond immediately to the Emergency Room, report the chemical or bring the bottle of the chemical to the Emergency Room and report to Employee Health for the First Report of Injury. Immediate decontamination may be appropriate.

Response to Special Content Spill:

1. For these specific spills of hazardous materials such as chemotherapeutic medications or mercury, refer to their specific policy on that content: Policy on Managing Chemotherapeutic Material and Waste (refer to Infection Control or Pharmacy policy) and Policy on Mercury Spills (refer to policy on mercury)
2. An appropriate NIOSH-approved respirator should be used for either powder or liquid spills where an airborne powder or aerosol is or has been generated.
3. Liquids should be wiped with absorbent gauze pads and solids should be wiped with wet absorbent gauze. The spill areas should then be cleaned three times using a detergent solution followed by clean water. Special procedures are referred to for a mercury cleanup in the Mercury Policy (see reference policy).
4. Any broken glass fragments should be picked up using a small scoop or gauze pad (never the hands) and placed in a "sharps" container. The container should go into a heavy-duty disposal bag, along with contaminated absorbent pads and any other contaminated waste.
5. Contaminated reusable items, for example glassware and scoops, should be treated as outlined above under Reusable Items.
6. If the spill is manageable and poses no immediate risk to health or safety, proceed to use the spill kit according to the instructions provided. For large spills or those that present a potential risk, immediately alert appropriate personnel (e.g., Safety Officer, House Supervisor) while initiating spill containment and cleanup

SPILL RECOVERY:

1. Once the affected area has been declared "*safe*" by CEO, Fire Department, AOC, Department Director, housekeeping staff can enter the area to clean up the remainder of the incident. This process will generally include spent neutralizer, absorbent, packaging, and other materials.
2. The area should **NOT** be reoccupied for normal use until the CEO, AOC, Fire Department, Department Director determines that there are no remaining hazards from the clean-up process.
3. All significant spills will be reported to the Safety Committee and evaluated to potentially make improvements in the process.

SPILL INCIDENT REPORTING:

1. **Determine the Need for Reporting:**
   - Complete an Unusual Occurrence Report (UOR) if spill kit was used.
   - An UOR is also required if there is any injury to patients, staff, or visitors, regardless of whether the spill kit was used.
2. **Complete the Incident Report:**
   - Include details such as the type and quantity of the chemical spilled, the location of the spill, the actions taken, and any potential or actual impacts on health and safety.
   - Document any immediate corrective actions taken to mitigate the risk and prevent future occurrences.
3. **Report Submission and Incident Review**
   - Submit the completed incident report via the UOR system included designated safety officer or incident reporting system as per organizational protocols.
   - Ensure that the report is filed promptly to facilitate timely review and follow-up actions

MONITORING of CHEMICAL & EQUIPMENT:

1. Formaldehyde (Formulin)

a. **Workplace Atmosphere:** Levels of formaldehyde in the air of the work area should be monitored by appropriate monitoring tools, including passive monitors and electronic meters.
   i. Initial monitoring should be undertaken to assure that the levels do not exceed action levels.
   ii. If the levels exceed the action level (0.50 PPM / 8 hours) engineering and administrative controls will be instituted, and as needed, personal protective equipment used to protect staff in the exposed areas. Actions will be taken to reduce the level of formaldehyde in the air.
   iii. If the action levels are not exceeded, monitoring will be repeated when the work practices, equipment or area is changed, and no less than a year later, to assure that conditions have not changed in a manner that raises the levels.
   iv. Areas where formalin is used and handled should have a sign to warn people in the area, which says:

DANGER
FORMALDEHYDE
IRRITANT AND POTENTIAL CANCER HAZARD
AUTHORIZED PERSONNEL ONLY

Monitoring Equipment:

2. If the exposure to formaldehyde exceeds the 0.5 ppm action level or the 2 ppm STEL, the Department Director must monitor the staff's exposure. They need not measure every exposure if a "high exposure" employee can be identified. This person that spends the greatest amount of time nearest the process equipment. The "representative employee" will be asked to wear a sampling device to collect formaldehyde. This device may be a passive badge, a sorbent tube attached to a pump, or an impinger containing liquid. They should perform their work as usual, but inform the person who is conducting the monitoring of any difficulties they are having wearing the device. The results should be posted for all staff to be able to read.

TRAINING:

Staff, including housekeeping staff, is trained to recognize the potential for a spill that is not safe to handle, and to contact their manager, and/or the Environmental Services Manager or designee. Staff is cautioned to err on the side of safety, and not to handle chemical spills that exceed their training, or the personal protection they have available.

Hazardous Chemical Risks

A process has been established and maintained for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous chemical materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating the SDS for hazards before purchase of departmental supplies, to assure they are appropriate and the least hazardous alternative practical. The department leadership works with the Environmental Services Manager and appropriate individuals, such as the Radiation Safety Officer or Infection Preventionist to develop procedures for handling of hazardous materials.

The following materials and wastes are managed:

a. Chemical materials are identified and ordered by department leadership. Appropriate storage space is maintained by each department, and reviewed as part of environmental rounds in that area. Chemical materials are maintained in labeled containers, and staff is trained in understanding SDS, and in the appropriate and safe handling of the chemicals they use.

b. Chemical waste is held in the generating department or accumulation room, until arrival of the licensed contractor. The contractor packs the chemicals, completes the manifest and removes the packaged waste. A disposal copy of the manifest is returned to verify legal disposal of the waste.

Radioactive Risks

A process has been established and maintained for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous radioactive materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating SDS and other documentation for hazards before purchase of departmental supplies to assure they are appropriate, and the least hazardous alternative practical. The department managers work with the Environmental Services Manager and appropriate individuals, such as the Radiation Safety Officer, to develop procedures for handling of hazardous materials.

Radioactive material is handled subject to the hospital's NRC License, and the Radiation Safety Officer manages their safety. Materials are handled in accordance with the requirements of the facility license.

Radioactive waste is held in a 'hot room' until decayed to background, then handled as the underlying hazard of the materials for disposal. The Radiation Safety Officer manages the waste and determines when it is no longer considered a radioactive hazard.

Hazardous Energy Sources

Hazardous energy sources include, but are not limited to, ionizing and non-ionizing materials, and lasers will be selected and used in accordance to manufacturer's recommendation and regulatory requirements. Specific policies pertaining to operational safety and use of each hazardous energy sources are found in each department that utilizes such equipment. The Department Director or a designated representative will conduct identification and evaluation of hazardous energy sources.

The primary source of hazard information will be from the manufacturer and/or supplier. Engineering controls and/or work practices should be developed to reduce exposures and potential injury. All employees involved in the operation and use of hazardous energy sources will be provided with appropriate training as part of their initial departmental orientation. Staff will follow the procedures established in the departmental policies and procedures to identify and mitigate exposure to potential risks associated with hazardous energy sources. Department Directors will maintain required documentation including applicable regulations, required permits and licenses for each hazardous energy source.

Hazardous Medication Risks

1. Hazardous medications and waste are disposed in accordance with policy and procedure.
2. Department leadership assures safe disposal of their hazardous medications.
3. Pharmacy is responsible for evaluating available information for hazards prior to the purchase of hazardous mediations to assure they are appropriate and if possible, is the lease hazardous alternative practical.
4. Department leadership collaborates with the Environmental Services Manager, Director of Pharmacy and other appropriate individuals to develop procedures for handling hazardous medications.

A process has been established and maintained for disposing of hazardous medications and waste. Department leadership assures safe disposal of their hazardous medications. The pharmacy department is responsible for evaluating available information for hazards prior to the purchase of hazardous medications

to assure they are appropriate, and if possible is the least hazardous alternative practical. Department managers work with the Hazardous Material Coordinator and appropriate individuals, to develop procedures for handling of hazardous medications.

Chemotherapeutic (anti-neoplastic), other hazardous medications, and the materials used to prepare, administer, and control these materials are controlled and the waste materials collected for special disposal. Staff utilizing these materials is trained in the handling, and emergency response to spills or leaks.

Chemotherapeutic residual waste and other hazardous medications are handled as part of the Regulated Waste stream, with additional labeling to assure appropriate incineration and final destruction.

The disposal of hazardous pharmaceutical material is managed by the Pharmacy in accordance to the appropriate regulations and requirements.

Hazardous Gas & Vapor Risks

1. All hazardous gases and vapors will be managed by the respective department where the chemicals are utilized to ensure the protection of staff, patients, and visitors from unnecessary exposure. Any instances of unnecessary exposure will be reported to the Safety Committee immediately. We are committed to implementing all necessary measures to reduce the risk of exposure and uphold a safe environment for everyone.

Permits, Licenses, Manifests and Safety Data Sheets (SDS)

Permits and licenses have been obtained and maintained for handling and disposal of hazardous wastes, including chemical wastes, and radioactive materials from the appropriate federal, state, and municipal agencies and SDS for the chemical waste and hazardous medications waste.

Each load of hazardous waste removed from the facility is documented by a manifest, as mandated by federal or state agencies. The manifests have multiple copies, and a copy is left at the time the hazardous waste is removed. Another copy travels with the waste, and is returned to the hospital once the wastes have been legally disposed of, to document the completion of the activity. These copies are matched, to assure that no load has been lost or misplaced, and kept for the record. If a completed copy of the manifest is not returned within the deadline established by law and regulation Number of days, the appropriate governmental agency is notified, and the information is also shared with the Safety Committee.

Information identifying the hazards and emergency responses associated with these materials and wastes are available to staff, patients, and visitor at all times from such resources as SDS, Centers for Disease Control (CDC) Guidelines, Department of Transportation (DOT) and Nuclear Regulatory Commission (NRC) regulations. Various methods for retrieving the information are available from the vendor SDS Company, Internet, fax, and/or on-line severs. To ensure availability at all times, a hard copy of the SDS associated with the material is identified on the inventory in the Safety Officer's office.

Process for Labeling Hazardous Material & Waste

All hazardous materials and wastes are properly labeled from receipt or generation until disposal including secondary containers. Storage areas are also properly labeled.

Chemotherapeutic Waste: Chemotherapeutic waste is placed into labeled containers (labeled with the OSHA and international symbol for carcinogenic wastes). Bulk quantities of chemotherapeutic waste are handled as hazardous chemical waste.

Chemical Materials & Waste: Chemical materials are labeled throughout their use, handling, and disposal. The label is on the container prior to receipt or is placed on containers when filled or mixed within the hospital. Labeling is evaluated during environmental rounds, to assure the labels are maintained and legible. In many cases the waste is labeled by the original chemical name, in other cases, where collection cans or containers are used, the container is labeled. These labels are required by the vendors of chemical disposal services to maintain the identity of the materials, and if the identity is lost, the materials are tested and analyzed to identify them for proper handling and disposal.

Hazardous Energy Sources: Hazardous energy sources are labeled in accordance to OSHA, NRC and other appropriate agencies. Warning alarms may also be installed to identify the risk or radiation when these sources are energized.

Radioactive Materials & Waste: Radioactive materials are labeled according to NRC, OSHA, or International agencies. Wastes are held to decay to background, when the labels are removed or covered, and wastes handled as the other hazards they may reflect. Labeling is evaluated during environmental rounds, to assure the labels are maintained and legible.

Monitoring Staff
Staff who is in close proximity to computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) equipment will be monitored. Staff dosimetry results are reviewed at least quarterly by the RSO, diagnostic medical physicist or health physicist to assess whether staff radiation exposure levels are “As Low As Reasonably Achievable” (ALARA) and below regulatory limits. The<RSO will report all badge reports and over exposures to the Safety Committee.

Radiation Exposure
Staff that works with radiation will be checked periodically for radiation exposure. The method of exposure will be measured through exposure meter or badge tests. The results will be shared with the staff member and the Safety Committee.

Trash Disposal
The Environmental Services (EVS) Department has determined procedures for the proper routine storage and prompt disposal of trash information can be located on EVS Run Guide’s and departmental processes,

Fire Safety Management Plan

A. SCOPE

The Fire Safety Management Plan (FSMP) describes the methods for minimizing the potential for a fire through the use of building systems, equipment and training. The FSMP is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, and visitors, or the environment, and protect building occupants from fire and the products of combustion. The Plan is also designed to assure compliance with codes and regulations, as applied to the buildings and services provided.

The plan is applied to the Main Hospital, Clinics, Offices, and Satellite Buildings of Northern Inyo Healthcare District (NIHD).

B. FUNDAMENTALS

1. The hospital buildings must be designed and maintained in compliance with law, regulation, and accreditation requirements, including compliance with:

- ~~the~~ *NFPA 101" Life Safety Code"*®, ~~2012~~ 2022 Edition.
- NFP 99-2012 edition as it relates to "Features of Fire Protection"

2. The fire alarm, detection, and suppression systems must be designed, installed, and maintained to ensure reliable performance.
3. District staff training is an essential part of fire safety.

C. GOALS & OBJECTIVES

The goals and objectives for the FSMP are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental rounds.

The goals and objectives for this plan are as follows:

- The FSMP defines the Districts methods for protecting patients, visitors and staff from the hazards of fire, smoke and other products of combustion and is reviewed and evaluated annually.
- The fire detection and response systems are tested as scheduled, and the results forwarded to the Safety Committee.
- Summaries of identified problems with fire detection and response systems, NFPA code compliance, and fire response plans, drills and operations, in aggregate, are reported to the Safety Committee.
- The scope and objectives of this plan, as well as program effectiveness and performance are evaluated annually.
- Fire prevention and response training includes the response to fires, at the scene of the fire, and in other locations of the facility, and the use of the fire alarm system, processes for relocation and evacuation of patients if necessary, and the functions of the building in protection of staff and patients. Staff knowledge of these issues is evaluated.
- The FSMP defines the response to fire emergencies on a facility wide basis at the point of origin, and in other areas of the facility, as well as the specific roles and activity should patient relocation or evacuation become necessary.
- All fire extinguishers are inspected monthly maintained annually and are positioned to be in visible locations and are selected based on the hazards of the area in which they are installed.
- Automatic fire extinguishing systems, including sprinkler systems and packaged systems are tested according to NFPA standards.

D. ORGANIZATION & RESPONSIBILITY

1. The Governing Body receives reports of the activities of the FSMP as appropriate. They also provide financial and administrative support to facilitate the ongoing activities of the FSMP.
2. The Chief Executive Officer (CEO), or other designated leader, collaborates with the Maintenance Manager (Maintenance Manager), to establish operating, and capital budgets for the FSMP.
3. The Maintenance Manager, in collaboration with the Safety Committee, is responsible for monitoring all aspects of the FSMP. The Maintenance Manager advises the Safety Committee regarding fire safety issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.
4. Department heads are responsible for orienting new staff members to their department and, as appropriate, to job and task specific fire safety procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the Maintenance Manager provides department heads with assistance in developing department fire safety policies and procedures.
5. District staff members are responsible for learning, retaining and following job and task-specific procedures for fire safe operations.

E. PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the FSMP. Performance measures have been established to measure at least one important aspects of the FSMP.

The performance measure for the FSMP is: Staff knowledge and performance.

New staff members attend the general orientation program and complete an annual on-line learning management program that reviews items listed below:

- Responding appropriately to fire drills
- Knowledge on the Fire Response Plan (R.A.C.E.)
- Knowledge on the evacuation routes for the department (when advised to by the proper Authority.)
- Knowledge on how to use a fire extinguisher
- Procedure for completing a Fire Drill Sign In Sheet

F. PROCESSES FOR MANAGING FIRE SAFETY RISKS

Minimize Potential for Harm

The Maintenance Manager is responsible for managing the FSMP for minimizing potential harm from fire, smoke, and other products of combustion. The FSMP includes three phases.

1. The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. The District employs qualified architects and engineers to develop building and fire protection system designs. All designs are reviewed by local or state agencies as a part of the construction and permitting process. A vigorous construction monitoring and building commissioning program round out the design phase.
2. The second phase is testing, inspection, and maintenance of the fire prevention aspects of the facility including testing, inspection and maintenance documentation and frequency based on applicable codes, equipment history, and other parameters. Maintenance staff and contractors perform the fire system testing and inspection with oversight by the Maintenance Manager to ensure the end product of all work maintains or improves the level of life safety in each affected area.
3. The third phase is an active training program of fire prevention, fire safety, and fire response.

Unobstructed Exits/Stairs
All exits must be maintained free and unobstructed. The status of these areas will be determined routinely by the staff and during environmental rounds. Storage will not be allowed in any exit lobby, exit stairwell.

Fire Response Plan
The Fire Response Plan provides clear, specific instructions for staff responding to a fire emergency. The procedures provide information about notifying appropriate staff of the emergency and actions to take to protect patient safety. Each department head is responsible for maintaining copies of emergency procedures in a continuously accessible location.

The Maintenance Manager and the department heads are responsible for developing and training staff about department specific emergency fire response procedures. Each department head is responsible for providing departmental and area personnel with an orientation to emergency procedures related to their job. Additional departmental training is provided on an annual basis as part of the continuing education program or on an as-needed basis. Each department head is responsible for reviewing department specific fire safety emergency procedures.

The roles of all staff and licensed independent practitioners (LIP) are detailed specifically in the Fire Response Plan. The roles of all staff and LIP at and away from a fire's point of are defined.

The basic response plan in the hospital is based on the acronym "R.A.C.E.":

- **R**escue anyone in immediate danger from the fire.
- **A**larm by activating fire alarm pull station to sound alarm and Report the alarm by dialing "2400" on the phone to announce the location of the alarm to staff.
- **C**onfine by closing doors to help contain smoke and the products of combustion.
- **E**xtinguish, (P.A.S.S.) and, as needed, prepare to evacuate or relocate patients if directed.

The role of all staff and LIP away from the point of fire origin is to exit area, close doors and evaluate the situation, and follow RACE. If the fire is in horizontal, above, adjacent to the fire's origin, or in areas where relocation is planned, the Fire Response Plan should emphasize moving patients to assist and relocate patients to their appropriate area of refuge or evacuation if directed to. The Fire Response Plan discusses fire response equipment, response procedures and the necessity to identify the authority to shut off the oxygen valves. The Cardio Pulmonary Rehab Director or Cardio Pulmonary staff is responsible for shutting off the oxygen in the area that is on fire, if necessary.

Fire Hazards during Surgical Procedures
Periodic evaluations are made of potential fire hazards that could be encountered during surgical procedures. The surgical written fire prevention and response procedures include safety precautions related to the use of flammable germicides, antiseptics, oxygen, etc.

After initial protocol and procedures have been established it is the responsibility of the surgical team to assure compliance as per their Fire Safety in Surgery policy.

Fire Drills

1. Fire drills are a critical tool for maintaining the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and staff. Staff participation is necessary to maintain an acceptable level of readiness and to ensure staff knowledge of the equipment and

procedures necessary to protect the staff and patients. To evaluate staff knowledge, drill activities are observed and staff is questioned about their role and responsibilities during a fire emergency nearby and elsewhere in the building.

2. Fire drills are conducted in all healthcare facilities once per shift per quarter and evaluated on a randomly selected basis. The quarterly fire drill will occur each quarter (-/+ 10 days) from the previous shift quarter. All of the quarterly drills will be unannounced with the exception of those done as corrective training activities. Fire drills are held at unexpected times and under varying conditions.
3. Fire drills are conducted every 12 months from the last date of the last drill in all freestanding buildings classified as business occupancies (e. g., clinics, offices) in which patient care takes place. These drills are witnessed, documented, and evaluated to identify improvements that may need to be made. Additional drills are held as deemed appropriate.
4. All staff who work in the buildings where patients are housed or treated will participate in drills, according to the Fire Response Plan. This includes all hospital staff and all hospital staff in buildings where space is shared with others. *Fire drill during the shift hours of 9:00pm-6:00am may use alternative methods to notify staff instead of activating audible alarms and disturbing patients.*
5. Fire drills are observed and critiqued using the fire drill critique form to evaluate fire safety equipment, fire safety building features and staff response and knowledge.
6. The results of the critique and evaluation of drills and staff knowledge are used to identify improvements needed in training programs, fire protection equipment, and compliance issues. Such improvements are evaluated during monitoring activities and the results are to identify the effectiveness of the activities.

Education:
All staff members receive fire safety training in new employee orientation, at annual refresher training and during departmental in-servicing about their role in Fire Prevention and Fire Response (i.e., the Fire Plan). Education is reinforced through periodic fire drills. Departments provide additional training about subjects such as locations for relocation, fire extinguisher location, oxygen valve locations, and special hazards or situations in the department

Maintaining Fire Safety Equipment and Building Features

The Maintenance Manager is responsible for maintenance of the fire alarm and related systems. Troubleshooting fire alarm systems and performing corrective and preventive testing, inspection and maintenance is performed by staff and ~~Sierra Security~~fire safety vendor as appropriate. All testing, maintenance, inspection, and repairs are documented and reviewed by the Maintenance Manager. Any fire protection feature that is not operating properly will be evaluated for the appropriate Interim Life Safety Measure (ILSM).

The systems inspected, maintained, tested and documented on the inventory are completed as per Joint Commission Standards and Chapters.
When appropriate, competent contractors are used to test, inspect, maintain, and repair the fire protection features, when appropriate to assure the special skills and equipment they have are available.
Documentation is maintained as part of the database to assure activities are conducted in a timely fashion.

Documentation

The documentation for maintenance, testing and inspection activities for fire alarm and water-based fire protection systems will include, the date, test frequency, required frequency of the activity, inventory of devices, equipment, or other items, name and contact information of person performing the activity, NFPA standard(s) including year referenced for the activity, and the results of the activity.

G. COMPLIANCE

Northern Inyo Healthcare District (NIHD) meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012 Chapter 15.

Chapter 15 of NFPA 99-2012 edition relates to “Features of Fire Protection” and often references back to Life Safety Code NFPA 101-2012 edition as well as other applicable NFPA Codes.

H. Identify the Fire Control Agencies:

The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies.

1. After an inspection or approval is made by state or local fire control agencies, a copy of the report (if applicable) will be placed in the Bishop Fire Department Chiefs office. The original will be filed in the Maintenance Department filing cabinet under Bishop Fire Inspections.
2. A record of the visit will include the date, time, agency name, reason for inspection, and the inspector’s name. This will be kept in the Bishop Fire Departments Binder.
3. ~~3~~Any requested or granted equivalencies, or other approvals, will be documented in the additional comments and notes section of the electronic Basic Building Information (eBBI) on the Joint Commission website within 5 business days.

Medical Equipment Management Plan

A. SCOPE

The Medical Equipment Management Plan is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology. Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Northern Inyo Healthcare District. The plan is applied to the Main Hospital, Clinics, Offices, and Satellite Buildings of Northern Inyo Healthcare District (NIHD).

B. FUNDAMENTALS

1. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research.
2. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
3. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

C. GOALS & OBJECTIVES

The goals and objectives for the Medical Equipment Management Plan are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental rounds.

D. ORGANIZATIONAL RESPONSIBILITIES

1. Safety Committee and or governing body receive reports of the activities of the Medical Equipment Plan as appropriate. The Manager of Clinical Engineering reviews the reports and, as appropriate, communicates concerns about identified issues, and regulatory compliance. The Manager of Clinical Engineering provides support to facilitate the ongoing activities of the Medical Equipment Plan.
2. The Manager of Clinical Engineering assures that the Medical Equipment Plan is implemented in all key clinical areas. The program manages a variety of activities, including tracking of rental or leased equipment, repairs and contract services. The Plan also assists in the management of the activities of specialty contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.
3. The Manager of Clinical Engineering implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.
4. Department heads or designee orients new staff to their department and, as appropriate, specific uses of medical equipment. When requested, the Clinical Engineering Department provides assistance.
5. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

E. PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure at least one important aspect of the Medical Equipment Program.

F. PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS

Management Plan
The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks to the patients, staff, and visitors.

Selection & Acquisition
The Manager of Clinical Engineering has overall responsibility for coordinating the medical equipment selection and acquisition process. Department heads and others, as appropriate, collaborate to select and acquire medical equipment. Department heads develop recommendations related to equipment to purchase.

The Manager of Clinical Engineering coordinates vendor negotiations, and ensures medical equipment considered for purchase meets appropriate standards of performance and safety.
The Manager of Clinical Engineering works with design professionals and medical staff to identify needs for space and support of new equipment. They also manage the commissioning of new equipment. The commissioning process includes assembly, installation, and testing of new equipment prior to initial usage.

The managers of clinical departments where new equipment is installed collaborate with Materials Management and equipment suppliers to assure appropriate education and training are provided to all initial users of the equipment and a program for training additional future users is developed.

Capital equipment requests for medical equipment are included as part of the annual budget process. The CEO has final approval over all new medical equipment purchases. The Clinical Engineering Department maintains documentation related to the Medical Equipment.

Criteria & Inventory
Northern Inyo Healthcare District maintains either a written inventory of all medical equipment or an inventory of selected medical equipment categorized by physical risk associated with use and equipment incident history. This includes all high--risk and low-risk equipment. The Clinical Engineering Department evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.

Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety as well as location. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment. ***(See Medical Equipment Risk Assessment Matrix within attachments)***

Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.

Maintaining, Inspecting, and Testing Activities

The Manager of Clinical Engineering identifies the activities in writing used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment.

Potential activities may be selected to ensure reliable performance including:

- Preventative maintenance based on manufacturer's recommendations
- Reliability-centered maintenance based on equipment history
- Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity
- Corrective maintenance based on a request for service or failure of the equipment to pass internal self-tests (Such equipment is subject to an initial test on receipt, and asset management)
- Medical equipment will be randomly evaluated during periodic Environmental Tours and adverse findings (e.g., outdated stickers, and broken equipment, missing stickers) will be reported to biomedical engineering and the Environment of Care® (EOC) Committee.

Maintaining, Inspecting, and Testing Frequencies

The Clinical Engineering Department identifies in writing the frequencies for inspecting, testing, and maintaining medical equipment on the inventory. The frequency of planned maintenance is determined based on criteria including manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment based on the following:

- Interval testing
- Run-time based inspections
- Corrective maintenance
- Metered maintenance based on hours of use, or other time of use processes (This strategy uses on-board clocks or event recorders to trigger specific tests, inspections or service)
- Other strategies, based on the use of the equipment may include inspection immediate prior to each use, for equipment used infrequently, borrowed or rented from vendors or others

A work order is used to manage the work for each planned maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process.
Clinical Engineers perform assigned work orders and are available upon request. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract.
In addition, CS manages daily performance testing, Clinical Engineering manages routine maintenance.

Unavailable Equipment:

Clinical Engineering and the clinical manager will develop a strategy to conduct the required activities when medical equipment is not available for performing the appropriate maintenance, testing, and inspection activities because it is currently providing high-risk activities or a replacement unit is not available. This information will be documented and reported to the EOC Committee.

Safe Medical Devices Act

The Quality Department is responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Quality Department collects information about potentially reportable events through the incident reporting and investigation process. The Quality Department, appropriate clinical staff, Clinical Engineering and other administrative staff conduct

investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration.

The Quality Department uses the Sentinel Event Process to investigate and document reportable incidents. Monthly reports are prepared for the Safety Committee on those incidents determined to be reportable. The Manager of Clinical Engineering is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

Emergency Procedures

The Manager of Clinical Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The head of each department that uses high risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

Response to Medical Equipment Failure & Emergency Response:

Clinical Engineering Department will be available on a 24-hour a day basis to respond to emergencies involving medical equipment malfunctions and or failures. During normal business hours, the Clinical Engineering Department can be contacted directly by telephone or email. During evenings, nights, weekends and holidays, the on-call Clinical Engineering Department technician may be contacted by cell phone.

In the event of malfunction or failure of a piece of Life Support Equipment, staff shall follow the Clinical Intervention Protocol until replacement equipment can be obtained.

Initial Testing and Instillation of Medical Equipment Prior to Use:

~~Testing medical equipment prior to initial use~~

The Clinical Engineering Department will test all medical equipment on the inventory before initial use. This includes safety, operational, and functional checks. The inventory includes, equipment owned by the organization, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review. The Manager of Clinical Engineering manages the program of planned inspection and maintenance.

Installation:

1. All fixed and mounted equipment will be installed as specified in the purchasing agreement.
2. The manufacturer, supplier, or Clinical Engineering Department will install or mount the equipment as required.
3. All required power and signal lines will be installed and certified as specified in the purchasing agreement.

4. All fixed and mounted equipment will be tested for prior to initial use and after major repairs or upgrades and perform the appropriate safety, operational, functional and calibration checks as specified in the purchasing agreement. Clinical Engineering Department and appropriate clinical staff will witness all certification testing and calibration not performed by hospital staff.

Testing of High Risk Equipment
The Manager of Clinical Engineering assures that scheduled testing of all high risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each Month. If the quarterly rate of completion falls **below 100%,** the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the Clinical Engineering Department for review.

Testing of Low Risk Medical Equipment
The Manager of Clinical Engineering assures that scheduled testing of all low Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Manager of Clinical Engineering each quarter. If the quarterly rate of completion falls **below 95%,** the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review.

Testing of Sterilizers
Daily performance testing is performed by CS, routine maintenance is completed by the Clinical Engineering Department and Steris.

Testing of Dialysis of Equipment: NA NIHD does not have any Dialysis Equipment.

Testing of Nuclear Medicine Equipment
Nuclear Medicine equipment is currently maintained by *GE*. Daily performance test are completed by Nuclear Medicine Department.

Utility Systems Management Plan

A. SCOPE

The Utility Systems Program provides a process for the proper design, installation, and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment at Northern Inyo Healthcare District (NIHD). The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the utility systems, and manage risks associated with the operation and maintenance of utility systems. The Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education, and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at NIHD.

The plan is applied to the Main Hospital, Clinics, Offices, and Satellite Buildings of Northern Inyo Healthcare District.

B. FUNDAMENTALS

1. The complexity of utility systems required to support complex patient care continues to increase. Selecting new or upgraded utility system technology requires research and a team approach to assure all functional and medical needs are met.
2. Patient care providers need training to understand how utility systems support patient care, limitations of system performance, safe operating conditions, safe work practices, and emergency clinical interventions during interruptions.
3. Critical components of utility systems require maintenance to minimize the potential for failures.
4. Emergency response procedures are required to manage utility system failures or service disruptions.

C. GOALS & OBJECTIVES

The goals & objectives for the Utility Systems Plan are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental rounds.

D. ORGANIZATIONAL RESPONSIBILITIES

1. The Safety Committee and the Governing Body would provide financial and administrative support to facilitate the ongoing activities of the Utility Systems Program.
2. The Chief Executive Officer (CEO) or designee receives reports of the current status of the Utility Systems Program as appropriate. The CEO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Maintenance Manager (Maintenance Manager) or other appropriate staff. The CEO collaborates with the Maintenance Manager to establish operating and capital budgets for the Utility Systems program.
3. Department heads are responsible for orienting new staff to the department and, as appropriate, to job and task specific uses of utility systems. When requested, the Maintenance department provides assistance.
4. All staff members are responsible for learning, retaining and following job and task-specific procedures for safe utility operations. In addition, all staff members are responsible for timely reporting of Utility System problems.

E. PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Utility Systems Management Plan. -Performance measures have been established to measure at least one important aspect of the Plan.

F. PROCESSES MANAGING UTILITY SYSTEM RISKS

Design and Maintenance of Utility Systems

The Maintenance Manager is responsible for managing the planning, design, construction, and commissioning of utility systems according to National Fire Protection Association codes to meet the patient care and the operational needs of the organization. The construction and commissioning programs are designed to assure compliance with codes and standards, and to meet the specific needs of the occupants throughout the facility. The Maintenance Manager is responsible for setting maintenance standards and implementing a program of planned maintenance and customer service to ensure a safe comfortable environment.

Building Systems & Risk Assessment

Building systems are designed to meet the National Fire Protection Association's Categories 1-4 requirements.

Utility Inventory

The Maintenance department maintains a written inventory of all operating components of utility systems. The Maintenance Department evaluates new types of utility systems before initial use to determine whether to include these in the inventory.

Written criteria are used to identify risks associated with utility systems. Some of the risks include infections, occupant needs, and systems critical to patient care needs, including high-risk (life support) systems. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of the utility systems. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.

Systems requiring a program of planned maintenance are listed as part of a maintenance inventory. The list includes operational components of utility systems maintained by in-house staff as well as equipment maintained by vendors.

High-Risk Equipment

The Maintenance Manager identifies high-risk components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. High-risk utility system components include (life-support) equipment.

Maintaining, Inspecting, and Testing Frequencies

The Maintenance Manager identifies in writing the frequencies for inspecting, testing, and maintaining operational components of the utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations. The frequency of planned maintenance is determined based on criteria including manufacturer recommendations, risk levels, and current hospital experience.

A work order is used to manage the work for each planned maintenance event. Most intervals are annual, semi-annual, and quarterly, with few monthly and weekly maintenance activities. Work orders are issued

for maintenance performed by in-house staff and by contractors. The Maintenance Manager oversees the work order generation and completion process Maintenance staff performs assigned work orders and return completed work orders to the Maintenance Manager. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract. All of the operational components of the utility system on the inventory are included in these strategies. The results of the analysis are reported to the Safety Committee, and used internally for program improvements

Equipment Required Manufacturer Recommendations

NIHD activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements.
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies.

The Maintenance Manager will maintain documentation of testing of these devices. The documentation will include the maintenance history and any of the following documented evidence:

- Records provided by the hospital's contractors
- Information made public by nationally recognized sources
- Records of the hospital's experience over time

Criteria for Alternate Operations of Utility Systems

The Maintenance Manager is a qualified individual(s) that uses written criteria to support the determination whether it is safe to permit operating components of utility systems to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use
- Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
- Availability of alternative or back-up equipment in the event the equipment fails or malfunctions
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment

Labeling Controls for Emergency Shutdown

The Maintenance Department is responsible for labeling the locations of critical or emergency controls for a partial or complete shutdown of the utility systems. Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. Critical or emergency operating components of utility systems are identified on historical documents or computerized drawings. A variety of techniques such as legends, symbols, labels, numbers, and color-coding are used to identify the location and type of critical or emergency controls. A tag identifies the corresponding physical control or other indicator attached to the device. This process is designed to provide technicians with accurate information about the function of a control before it is activated for scheduled maintenance or during an emergency.

Utility System Disruptions
The Maintenance Department has identified and implemented procedures for responding to utility system disruptions or failures. These procedures are developed to include the criteria for implementing a utility response plan. The staff is responsible for making decisions about activities and resources used to mitigate the emergency (e. g., an emergency power system to mitigate external power failure); and preparation for the failure (e. g., flashlights, staff training about how to respond to a power failure). The initial staff response plans are also included in a quick chart, which is widely distributed and posted in a number of locations throughout the facility. The recovery plans focus on return to normal conditions, and the resetting and recovery of emergency equipment and supplies.

The Utility Systems include the following:

- Electrical Distribution
- Emergency Power
- Medical Gas
- HVAC
- Boiler & Steam
- Plumbing
- Vertical & Horizontal Transport
- Vacuum Systems
- Communication Systems

Shutting-off Malfunctioning Systems
The Maintenance Department has identified and implemented procedures for responding to shutting off malfunctioning utility systems and notifying staff in the affected areas. These procedures are reviewed as needed to maintain the appropriate information and notification process. These procedures are developed to include the criteria for implementing a utility response plan. The staff is responsible for making the decisions; activities and resources used to mitigate the emergency (e. g., an emergency power system to mitigate external power failure); and preparation for the failure (e. g., flashlights, staff training about how to respond to a power failure). The initial staff response plans are also included in a quick chart, which is widely distributed and posted in a number of locations throughout the facility. The recovery plans focus on return to normal conditions, and the resetting and recovery of emergency equipment and supplies.

Emergency Clinical Interventions
The Maintenance Department has identified and implemented emergency procedures for responding to utility system disruptions or failures that require emergency clinical interventions. The clinical staff will be trained on the proper response to the disruption of high risk (life support) utility services and the method of notifying the appropriate group. The initial staff response plans are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility.

Responds to Utility Disruptions
The Maintenance Department responds to utility system disruptions as described in their utility system failure or failures.

Management of Waterborne Pathogenic Agents
NIHD has partnered with a contract vendor who has identified and implemented processes to minimize pathogenic biological agents in domestic hot and cold-water systems, and other aerosolizing water systems through the proactive periodic treatment of these systems.

When the monitoring program of incidents for hospital-acquired infections identifies the presence of pathogenic biological agents in water systems, our contracted vendor along with the Infection Preventionist Manager and the Maintenance Manager collaborate to identify an effective treatment and future growth prevention program. When an outbreak of an infectious, waterborne disease (e. g., Legionella) is identified, our contracted vendor notifies the Maintenance Department staff and the Infection Preventionist Manager. The Maintenance Department staff along with direction from our vendor would then treat the affected domestic water system to eliminate the hazard.

Maintenance of Air Pressurization, Filtration, & Filter Efficiency
The organization designs, installs, and maintains ventilation equipment to provide appropriate pressure relationships, air-exchange rates, and filtration efficiencies, temperature and humidity for ventilation systems in critical care areas specially designed to control air-borne contaminants (e. g., biological agents, gases, fumes, dust). The basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).

The air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by the Maintenance Department. The schedule of regular inspection of filter performance monitoring equipment, air pressure sensing equipment, and air-flow rate sensors is managed by the Maintenance Department.

A qualified service provider is engaged to verify volume flow rates (air exchange rates, and positive or negative pressure rates) and pressure relationships as part of the commissioning of all new building projects and major space renovations. In addition, the air volume flow rates and pressure relationships are tested periodically throughout the hospital including investigation of complaints related to indoor air quality. The results of testing are used to adjust the performance of air handling systems by changing control software parameters and mechanical or electrical controls.

If system performance cannot be adjusted to meet code requirements or occupant needs, the Maintenance Department works with the Infection Preventionist Manager and clinical staff to develop temporary management practices to mitigate issues. In addition, a recommendation for upgrading or replacing the equipment involved is prepared and submitted to the CEO and Governing Board as appropriate.

Maintenance of Air Pressurization, Filtration, & Filter Efficiency (Non-Critical)
The organization designs, installs, and maintains ventilation equipment in non–critical care areas to provide appropriate pressure relationships, temperature, and humidity. The non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.

Mapping distribution of Utility Systems
The Maintenance Department is responsible for managing the process for documenting the layout of utility systems and the locations of critical or emergency controls for a partial or complete shut-down of the system. This includes maintaining a variety of historical documents that graphically illustrate each of the utility systems. Historical documents will be converted, as time and money allow, to computerized drawings. New utility systems and major updates to existing utility systems are required to be developed by the architect or engineer and provided as computerized drawings.

Day-to-day use of historical documents and computerized drawings includes additions, deletions, and other changes to the layout of utility systems to be documented in a timely manner. This ongoing process of making changes allows the overall accuracy of the utility system layout to be maintained at a very high

level at all times. Critical or emergency operating components of utility systems are identified on historical documents or computerized drawings.

Medical Gas
Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7.

Emergency Power Supply
The emergency power supply system's equipment and environment are maintained per manufacturers' recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust.

Operating Rooms as Wet Procedure Locations
Operating rooms are considered wet locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters.

Electrical Distribution
Electrical distribution in the hospital is based on the following categories:

1. **Category 1:** Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where essential life support equipment is required.
2. **Category 2:** General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients.
3. **Category 3**: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours.

Hospital-Grade
Hospital-grade receptacles at patient locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, playrooms, and activity rooms are listed tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.

Relocatable Power Taps (RPTs)
Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards.

Extension Cords
Extension cords are not used as a substitute for fixed wiring in a building. Extension cords which have been approved for temporary use are removed immediately upon completion of the intended purpose.

Areas Designated for Administration of General Anesthesia

Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with applicable sections of the National Fire Protection Association (NFPA) Life Safety Code NFPA-2012 and NFPA 99-2012.

- Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others.
- Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV.
- Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone valve box assemblies.
- The essential electrical systems (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES equipment system supplies power to the ventilation system.

Managing Emergency Electrical Power Systems

The Maintenance Department provides reliable emergency power systems. For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the hospital has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch.

The hospital provides emergency power within 10 seconds for the following:

1. Alarm systems, as required by the Life Safety Code.
2. Exit route and exit sign illumination, as required by the Life Safety Code.
3. Emergency communication systems, as required by the Life Safety Code.
4. Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems.
5. Areas in which loss of power could result in patient harm, including intensive care, emergency rooms, operating rooms, recovery rooms, obstetrical delivery rooms, nurseries, and urgent care areas.
6. Emergency lighting at emergency generator locations. The hospital’s emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location.

Equipment Designated for EPS

Equipment designated to be powered by emergency power supply are energized by the hospital’s design. Staging of equipment start up is permissible.

Emergency Power for Elevators
The District provides emergency power for elevators selected to provide service to patients during interruption of normal power (at least one for non-ambulatory patients).

Emergency Backup for Essential Medication Dispensing Equipment
The District has a policy to provide emergency backup for essential medication dispensing equipment.

Emergency Backup for Essential Refrigeration/Freezers
The District has a policy to provide emergency backup for essential refrigeration/freezing for medications, (any clinical refrigerators or freezers that house medications are collected and stored in the Lab or Pharmacy).

Areas Not Serviced by the Emergency Power Source
Battery lamps and flashlights are available in areas not serviced by the emergency supply source.

Managing Risks
When performing repairs or maintenance activities, the hospital has a process to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors.

Inspecting, Maintaining, & Testing of Utility Systems
The Maintenance Department will test all utility systems on the inventory before initial use and after major repairs or upgrades. This includes safety, operational, and functional checks. The inventory is maintained by addition of new equipment and, as appropriate, replacement components; and removal of equipment no longer in use. These inspection, testing and maintenance documents are maintained in the Maintenance Department for review. The Maintenance Manager manages the program of planned inspection and maintenance. The completion date and the results of the tests are documented.

Testing of High-Risk Utility System Equipment
The Maintenance Manager assures that inspecting, testing and maintaining of all high-risk utility system components is performed in a timely manner. The completion date and the results of the tests are documented. Reports of the completion rate of scheduled inspection and maintenance are documented and presented to the Safety Committee. Required activities and associated frequencies for maintaining, inspecting and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate.

Testing of Infection Control Utility System Equipment
The Maintenance Manager assures that inspecting, testing and maintaining of all infection control utility system components is performed in a timely manner. The completion date and the results of the tests are documented. Reports of the completion rate of scheduled inspection and maintenance are documented and presented to the Safety Committee. Required activities and associated frequencies for maintaining, inspecting and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate.

Testing of Non-High-Risk Utility System Equipment
The Maintenance Manager assures that that inspecting, testing and maintaining of all non-high-risk (life support) utility system components is performed in a timely manner. The completion date and the results of the tests are documented. Reports of the completion rate of scheduled inspection and maintenance are documented and presented to the Safety Committee.

Line Isolation Monitors *(Not Applicable at this time)*
Line isolation monitors (LIM), if installed are tested at least monthly. At least annually, LIM circuits with automated self-testing are manually tested. LIM monitors and circuits are tested per applicable sections of NFPA 99-2012.

Electrical and HVAC
The District meets all other HealthCare Facilities Code requirements for electrical systems related to heating, ventilation, and air conditioning (HVAC), as related to NFPA 99-2012: Chapters 6 and 9.
The District meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3.

Managing Emergency Power Systems
The Maintenance Manager is responsible for managing a program of inspection, maintenance, and testing of the essential electrical systems.

Battery-Powered Exit Lights
The Maintenance Department is responsible for identifying all emergency lighting systems and EXIT signs required for egress and task lighting for a minimum duration of 30 seconds at least monthly. A visual inspection of other EXIT signs is conducted at least monthly. The completion dates and test results are documented.

Each battery-powered lights on the inventory required for egress and exit signs are tested for 1-1/2 hours every 12 months. The annual test meets the requirements of applicable codes and standards and manufacturer recommendations. The completion date and the results of the tests are documented

For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. The completion date and results of the tests are documented.

Stored Emergency Power Supply Systems (SEPSS) *(Not Applicable at this time)*
The Maintenance Department and vendor are responsible for performing a functional test of Level 1 Stored Emergency Power Supply Systems (SEPSS) on a monthly basis and performs a test of Level 2 SEPSS on a quarterly basis. The test duration is for 5 minutes or as specified for its class (whichever is less). SEPSS includes any system that is intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Including are systems that supply emergency power for such function as illumination for safe exiting, ventilation where it is essential to maintain fire, fire detection and alarms systems, public safety communication systems, and process where the current interruption would produce serious life safety or health hazards to patients, the public or staff. The completion date and the results of the tests are documented.

The Maintenance Department and vendor perform an annual test at full load for 60% duration of it class. The class defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged. The completion date and the results of the tests are documented.

Non-SEPSS battery back-up power systems that a hospital has determined to be critical for operation during a power failure should be properly tested and maintained in accordance with the manufacturer's recommendations. This includes such as laboratory equipment or electronic medical records. The completion date and the results of the tests are documented.

Emergency Power Supply Systems (EPSS)
At least weekly, Maintenance inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented.

Emergency Generators
The Maintenance Department will test each emergency generator at least monthly under load for at least 40 continuous minutes. The cool-down period is not part of the 40 continuous minutes. The monthly tests for diesel-powered generators are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. The completion date and the results of the tests are documented.

Appropriate notice of each test run is forwarded to departments throughout the hospital. Tests will be delayed if a critical medical procedure is underway and unanticipated failure of the essential electrical system would result in immediate life-threatening conditions, but testing is conducted within the defined time frames.

If any diesel-powered emergency generator is not loaded to 30% or more of its nameplate capacity during connected load tests, temperature measurements are made to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. If the hospital does not meet either the 30% nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07EP5, then it must test the loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1-1/2 continuous hours.

Automatic Transfer Switches
All automatic and manual transfer switches are tested at least monthly with the generator load test. The completion date and the results of the tests are documented. Their performance is generally verified during generator testing, as well as annual maintenance of each switch.

Fuel Quality Test
At least annually, the Maintenance tests the fuel quality to ASTM standards. The test results and completion dates are documented.

Four-hour Generator Test
Additionally, all diesel-powered generators are tested for four (4) hours at least once every thirty-six (36) months. The tests are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. The completion date and the results of the tests are documented.

Category Designation
Medical gas, medical air, surgical vacuum, waste anesthetic gas disposal (WAGD), and air supply systems in which failure is likely to cause major injury or death are designated as follows:

1. **Category 1**: Systems in which failure is likely to cause minor injury to patients
2. **Category 2:** Systems in which failure is not likely to cause injury, but can cause discomfort to patients
3. **Category 3:** Deep sedation and general anesthesia are not administered when using Category 3 medical gas system

Warning System Requirements
All master, zones, and local alarm systems used for medical gas and vacuum systems comply with category 1-3 warning system requirements.

Containers, Cylinders, Tanks
Containers, cylinders, and tanks are designed, fabricated, tested and marked in accordance with NFPA 99-2012: 5.1.3.1.1-5.1.3.1.7.

Door Labeling O_2/Med Air/Other
Locations containing only oxygen or medical air have doors labeled "Medical Gases: NO Smoking or Open Flame." Locations containing other gases have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening.”

Precautionary Signage
A precautionary sign readable from 5 feet away is on each door or gate of a cylinder storage room, where the sign, at a minimum, includes the wording "CAUTION: OXIDIZING GAS(ES) STORED WITHIN. NO SMOKING.” Storage is planned so cylinders are used in the order they are received from the supplier. Only gas cylinders and reusable shipping containers and their accessories are permitted to be stored in rooms containing central supply systems or gas cylinders.

Cylinders with Integral Pressure Gauge

When the hospital uses cylinders with an integral pressure gauge, a threshold pressure considered empty is established when the volume of stored gases is as follows:

- When more than 300 but less than 3,000 cubic feet, the storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinkler) or enclosed in a cabinet of noncombustible construction having a minimum 1/2-hour fire protection rating.
- When less than 301 cubic feet in a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in NFPA 99-2012: 11.6.2.

Inspecting, Maintaining & Testing Medical Gas & Vacuum System
The Maintenance Manager and Certified Medical Testing are responsible for the inspection, maintenance, and testing of the piped medical gas and vacuum systems.

Certified Medical Testing in collaboration with the Maintenance Department conducts PM on an annual basis. This includes inspecting, testing, and maintaining the critical components of the piped medical gas systems and vacuum systems; waste anesthetic gas disposal (WAGD); and support systems.

The PM activity is conducted by Certified Medical Testing. Persons that maintain the systems are qualified by training and certification to the requirements of the American Society of Sanitary Engineers (ASSE) 6030 or 6040. Documentation of the testing and results are maintained by the Maintenance Department.

Bulk Oxygen Systems
The bulk oxygen system above ground, is located in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating “OXYGEN – NO SMOKING – NO OPEN FLAMES.”

The emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it.

Testing Installed, Modified, or Repaired Systems
Certified contractors or specially-trained staff will test and certify piped medical gas and vacuum systems when the systems are initially installed, modified, or invasively repaired. Testing includes verification that there is no cross-connection of piping and outlets; testing the piping for content purity and particulates, and verification that the pipes maintain pressure. Testing is completed to demonstrate the system meets at least NFPA 99 and CGA 1 requirements. The completion date and the results of the tests are documented and maintained in the Maintenance Department.

Labeling Main Supply Valves
The main supply valve and the area shut-off valves of each piped medical gas and vacuum system are clearly labeled with the type of gas and the areas the valve is to be accessible. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum systems, including the name of system or chemical symbol, color code, and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in an emergency.

Ongoing environmental rounds and observation are used to assure the valves are maintained clear of obstructions. In addition, staff is trained about the locations of the applicable medical gas zone valves, which might be needed during emergencies.

Labeling Main Supply Valves

The hospital policy on all cylinders within the hospital includes the following:

1. Labeling, handling and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2
2. Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder
3. Adaptors or conversion fittings are prohibited
4. Oxygen cylinders, containers and associated equipment are protected from contamination, damage, and contact with oil and grease
5. Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F.
6. Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacture recommendations or -20°F
7. Valve protection caps (if supplied) are secured in place when cylinder is not in use
8. Labeling empty cylinders
9. Prohibiting transfilling in any compartment with patient care rooms.

~~**Transfilling in any Patient Care Room**~~

~~Transfilling is not conducted at NIHD.~~

G. COMPLIANCE

NIHD meets all other HealthCare Facilities Code requirements, gas and vacuum systems, and gas equipment, as related to NFPA 99-2012:

REFERENCES:

1. California Department of Public Health (CDPH). (2024). Medical Waste Management Program. Retrieved from https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx
2. Centers for Medicare & Medicaid Services (CMS). (2024). Life Safety Code & Health Care Facilities Code Requirements
3. Facility Guidelines Institute (FGI). (2025). Guideline's for Design and Construction of Hospitals. Retrieved from https://fgiguidelines.org/
4. National Fire Protection Association (NFPA). (2025). NFPA 101 Code Development: The Life Safety Code. Retrieved from https://www.nfpa.org/codes-and-standards/nfpa-101-standard-development/101
5. The Joint Commission. (2024). E-dition-Standards & Eps. Critical Access Hospital. Environment of Care Chapter. Retrieved from https://edition.jcrinc.com/

CROSS REFERENCE~~D~~ POLICIES AND PROCEDURES:

1. Disposal of Hazardous Medications
2. Hazardous Materials & Waste Inventory
3. Formalin Use and Spill Management in Surgery
4. Diagnostic Imaging-Radioactive Waste Storage and Disposal
5. Medical Waste Management Plan
6. InQuiseek-#530 Risk Management Policy~~InQuiseek - #530 Risk Management Policy~~
7. Conducting Hot Work
8. Fire Drills
9. Fire Safety- Fire Hazards During Surgical Procedures
10. Fire Safety Equipment Inspection
11. Fire Safety in Surgery
12. Policy of Transfilling of Medical Gas Cylinders
13. Fire Safety Equipment Inspection
14. Emergency Management Plan
15. Evacuation
16. Building and Fire Protection Features
17. Fire Watch
18. Interim Life Safety Measures
19. Refer to Environment of Care policies

RECORD RETENTION AND DESTRUCTION:

Per Regulatory Guidelines for each Management Plan

Supersedes:

1. Access to Security Sensitive Areas EC.02.01.01 EP 8
2. Action to Safety & Security Risks EC.02.01.01 EP 3
3. Assessment of Responsibility for LS Activities LS01.01.01 EP 1
4. Building and Fire Protection Feature LS 02.01.10 EP 1-15

5. Criteria for Alternate Operations of Medical Equipment
6. Disposal of trash EC 02.02.01 EP 9
7. Electrical Equipment
8. Ethylene oxide EC.02.02.01 EP 9
9. Exits in Business Occupancy
10. Fire Alarm Systems LS 02.01.34 EP 1-10
11. Fire and Smoke Protection LS .02.01.30 EP 1-26
12. Fire Drill Safety
13. Fire Drills EC.02.03.03 EP1-5
14. Fire Response Plan-Code Red EC.02.03.01 EP9
15. Fire Safety Compliance with NFPA-99-2012 Chapter 15 EC.02.03.01 EP 13
16. Fire Safety EC.02.03.01 EP 1 a
17. Fire Safety Management Plan (FSMP) EC.01.01.01 EP 7
18. Fire Safety: Compliance with NFPA 99-2012: Chapter 15 EC.02.03.01 EP 13
19. Fire Safety-Fire Hazards During Surgical Procedures EC02.03.01 EP 11-12
20. Formaldehyde EC 02.02.01 EP
21. Glutaraldehyde EC 02.02.01 EP 9
22. Hazardous Materials & Waste Management Plan
23. Hazardous Spills and Exposures
24. Identifying the Fire Control Agencies LS.01.01.01 EP 5
25. Information Collection & Monitoring EC.04.01.01 EP 1
26. Initial Testing & Installation
27. Inspection, Testing, & Maintenance of Medical Equipment, Sterilizers, & Hemodialysis
28. Inspection, Testing, & Maintenance of New Medical Equipment
29. Library of EOC information EC.01.01.01 EP3
30. Maintaining, Testing, & Inspecting Med Equipment
31. Management of Gas Storage Locations EC.02.05.09 EP 1-6
32. Management of Hazardous Chemicals EC 02.02.01 EP 5
33. Managing Hazardous Wastes Gases and Vapors
34. Managing Risks-Library of EOC Information EC.01.01.01 EP 3
35. Medical Equipment Failure & Emergency Response
36. Medical Equipment Inventory
37. Medical Equipment Management Plan version 1
38. Medical Equipment Medical Plan
39. Performance Improvement Activity EC.04.01.03 EP 3
40. Providing a Safe Environment EC.02.06.01 EP 1-26
41. Reporting Fire Safety Incident EC04.01.01 EP 9
42. Reporting Hazardous Materials & Waste Incident EC.04.01.01 EP 8
43. Reporting Property Damage EC.04.01.01 EP 5
44. Reporting Security Incident EC.04.01.01 EP 6
45. Reporting Utility System Incident EC.04.01.01 EP 11
46. Safety Committee EC.04.01.03 EP 1-2
47. Safety Management Plan
48. Security Management Plan
49. Utilities System Management Plan

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: NIHD Wireless Connectivity		
Owner: Director of IT	Department: Information Technology	
Scope: Districtwide		
Date Last Modified: 02/02/2026	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/30/2010	

PURPOSE:
This policy establishes appropriate use of the wireless data communications of Northern Inyo Hospital.

POLICY:
Northern Inyo Hospital hosts four wireless networks with the following requirements:

- NIHD-General
  - May only be used for connecting NIHD equipment to the NIHD network.
  - May only be used only by those users with individual network accounts.

- PACS (Picture Archiving and Communication System)
  - May only be used for connecting PACS stations to the NIH network

- NIHD-Guest
  - May only be used for connecting non-NIHD equipment to the internet via the NIHD network.
  - May not be used with NIHD-owned equipment.
  - May only be used for internet browsing (ports 80 and 443)
  - May not be used for applications other than internet browsers

Supersedes: v.1 NIH Wireless Connectivity

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

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

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

TO: NIHD Board of Directors
FROM: Samantha Jeppsen, MD, Chief of Medical Staff
DATE: February 3, 2026
RE: Medical Executive Committee Report

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

A. Medical Staff Reappointments 2026-2027 (action item)
    1. James Haug, DO (diagnostic radiology) – Telehealth (Direct Radiology)

B. Medical Staff Initial Appointments 2026-2027 (action item)
    1. Benjamin Mundell, MD (general surgery) – Active Staff
    2. Aleksandra Kozlova, MD (internal medicine/hospitalist) – Active Staff
    3. Christopher Hampson, MD (diagnostic radiology) – Telehealth (Tahoe Carson Radiology)

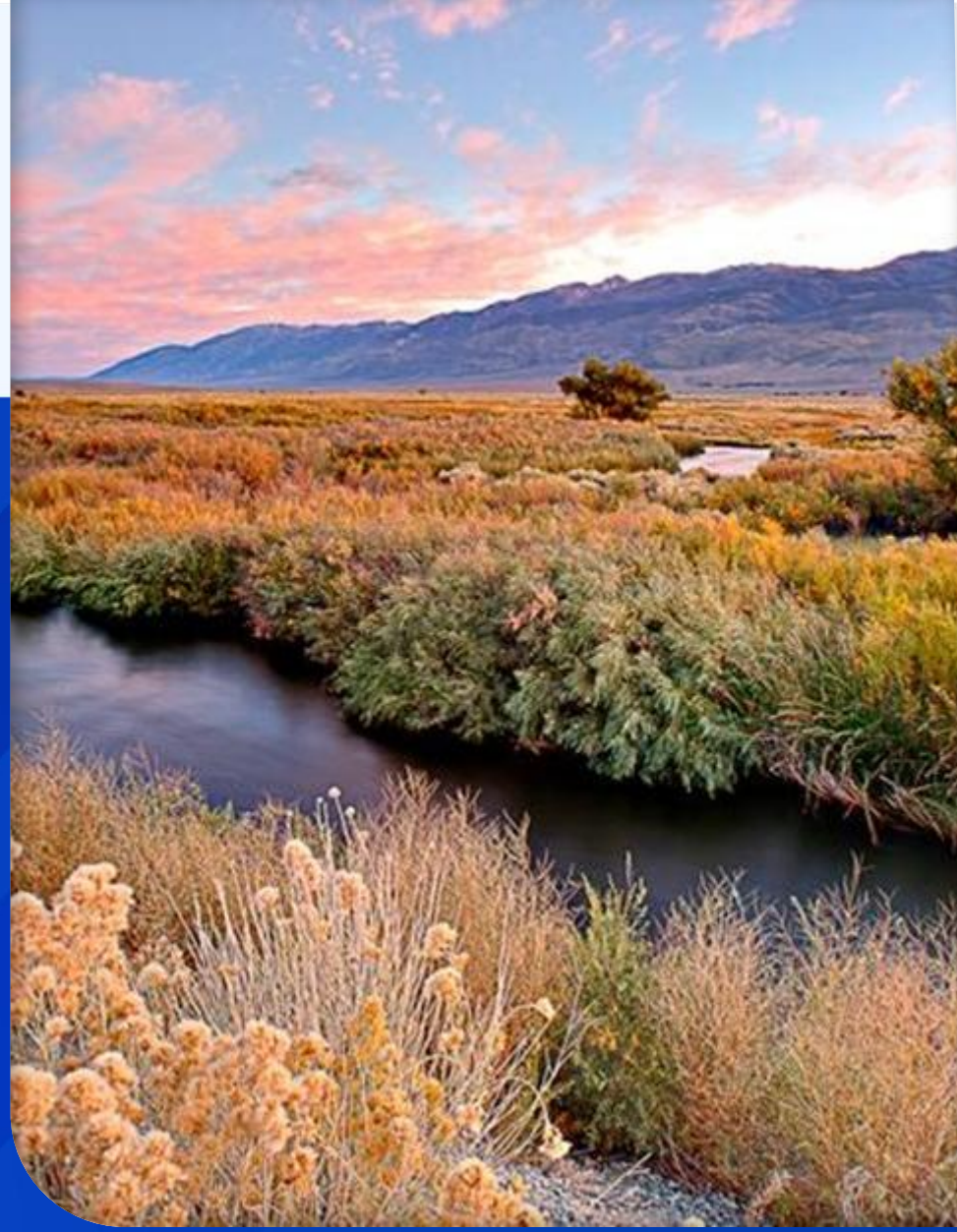
C. Medical Staff Initial Appointments 2026-2027 – Proxy Credentialing (action item)
    As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon the Distant-Site entity's credentialing and privileging decisions.
    1. Jeremy Tomcho, MD (cardiovascular disease) – Telehealth (Renown)
    2. Suzanne Aquino, MD (diagnostic radiology) – Telehealth (Direct Radiology)
    3. Stephen DeFreiz, DO (diagnostic radiology) – Telehealth (Direct Radiology)
    4. James Le, MD (diagnostic radiology) – Telehealth (Direct Radiology)

Ovation Healthcare

Northern Inyo Healthcare District

2025 Community Health Needs Assessment

Board Summary



February 10th, 2026

Community Health Needs Assessment (CHNA): Overview

CHNA Purpose:

A CHNA is a required assessment for many health organizations to be completed every 3 years. It provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas.

Key Outputs of a CHNA:

- ✓ Identification of health disparities and social determinants to inform future outreach strategies
- ✓ Awareness of key service delivery gaps
- ✓ Deeper understanding of the communities' perceptions of healthcare in the region
- ✓ Collaboration with community organizations to better serve the community

CHNA Process

Kick Off & Information Gathering

Determine project scope, outline timeline, and gather data for input

Data Analysis & Discovery

Analyze population health data and gather community input through survey distribution

Health Need Prioritization & Planning

Identify key priorities and develop a plan to reach collective community goals

Final Review & Approval

Present assessment to required entities for final review and approval

Service Area Demographics

	Inyo County	California
Population	18,527	38,965,193
Under 18	20%	22%
65+	26%	16%
Rural	42.1%	5.8%
Median HHI	$71,656	$95,473

Race/ Ethnicity	Inyo County	California
Non-Hispanic White	59.0%	34.3%
Non-Hispanic Black	1.0%	5.6%
American Indian or Alaska Native	14.0%	1.7%
Asian	1.9%	16.5%
Native Hawaiian or Pacific Islander	0.2%	0.5%
Hispanic	24.6%	40.4%

Top Health Priority Data: Perspectives from the Community

NIHD & SIHD 2025 (n=381)		
	Top 15 Health Priorities	Rank
↑	Healthcare: Affordability	*4.58*
↑	Access to Specialty Care	*4.56*
↓	Mental Health	*4.54*
↑	Geriatric / Elder Care	*4.50*
↑	Cost of Health Insurance	*4.50*
↓	Cancer	*4.45*
↓	Affordable Housing	*4.41*
↑	Access to Primary Care	*4.38*
–	Senior Services / Elder Care	*4.36*
↑	Women's Health	*4.29*
↓	Healthcare: Location of Services	*4.29*
↑	Access to Affordable Food	*4.24*
↑	Heart Disease	*4.21*
–	Healthcare: Prevention Services	*4.19*
↓	Substance Use Disorder	*4.14*

NIHD 2022 (n=643)	
Top 15 Health Priorities	Rank
Mental Health	*4.53*
Affordable Housing	*4.46*
Healthcare Services: Affordability	*4.41*
Physical Presence	*4.38*
Cancer	*4.37*
Drug/Substance Abuse	*4.30*
Access to Childcare	*4.27*
Diabetes	*4.24*
Access to Senior Services	*4.21*
Livable Wage	*4.21*
Heart Disease	*4.20*
Women's Health	*4.17*
Education System	*4.15*
Healthcare Services: Prevention	*4.15*
Employment and Income	*4.10*

National CHNAs (n=10,654)	
Top 15 Health Priorities	Rank
Cost of Health Insurance	*4.57*
Healthcare Affordability	*4.56*
Cancer	*4.47*
Mental Health	*4.47*
Affordable Housing	*4.34*
Drug/Substance Use	*4.34*
Heart Disease	*4.32*
Women's Health	*4.26*
Access to Healthcare	*4.25*
Diabetes	*4.25*
Access to Senior Services	*4.23*
Employment and Income	*4.21*
Alzheimer's and Dementia	*4.19*
Obesity	*4.17*
Access to Healthy Food	*4.16*

Note: *Arrows indicate a change in ranking from previous CHNA survey*

Top Health Priorities: Implementation Strategy

Care Coordination and Disease Management

Relevant Needs Addressed: Geriatric/Elder Care, Cancer, Women's Health

Goal: Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.

Access to Healthcare Services

Relevant Needs Addressed: Access to Specialty Care, Access to Primary Care, Senior Services/Elder Care, Healthcare: Affordability

Goal: Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.

Mental Health

Relevant Needs Addressed: Mental Health

Goal: Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.

Top Health Priorities: Implementation Strategy

Healthcare Access

Future Actions to Address Need:

- Align future strategic planning and master facility planning with key service line and outpatient expansion opportunities to better meet community needs and support future provider recruitment and retention.
- Leverage Patient Throughput Committee to improve patient flow and throughput, increasing appointment availability and timely access to care.
- Develop and deliver community education on navigating the healthcare system, including understanding appropriate levels of care, referral pathways, and available local/regional services.
- Implement financial counseling and patient navigation to support awareness of financial assistance, insurance options, and affordability resources, with targeted education for seniors and other high-need populations.

Mental Health

Future Actions to Address Need:

- Define a sustainable, community-based mental health care model that clarifies NIHD's role within a broader network of providers.
- Strengthen partnerships with community mental health organizations to improve continuity of care following screening or crisis events.
- Improve access to prescriber-level mental health services to address medication management needs.
- Increase coordination and awareness of available mental health and substance use resources across the community.

Care Coordination and Disease Management

Future Actions to Address Need:

- Prioritize patient navigation as the core care coordination function across specialty service lines, supporting continuity from initial patient access through referrals, diagnostics, treatment, and follow-up care.
- Improve utilization of cancer care navigation services by increasing awareness and integration with clinical workflows.
- Partner with senior centers and community organizations to provide education on the healthcare journey, chronic disease management, and preventive care.
- Strengthen coordinated care for seniors by improving continuity in internal medicine and primary care, enhancing navigation of specialty services (including out-of-area care), and supporting care transitions across care settings.

THANK YOU

1573 Mallory Lane Suite 200, Brentwood, TN 37027

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

Northern Inyo Healthcare District

2025

Community Health Needs Assessment – *Executive Summary*

Ovation Healthcare

Community Health Needs Assessment
Overview

CHNA Purpose

A CHNA is part of the required documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals and fulfills requirements for accreditation for many health and public health entities. However, regardless of status, a CHNA provides many benefits to an organization. This assessment provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Organizational Benefits

- Identify health disparities and social drivers to inform future outreach strategies
- Identify key service delivery gaps
- Develop an understanding of community members' perceptions of healthcare in the region
- Support community organizations for collaborations

CHNA Process

Survey the Community

Develop a CHNA survey to be deployed to the broad community in order to assess significant health priorities.

Data Analysis

Review survey data and relevant data resources to provide qualitative and quantitative feedback on the local community and market.

Determine Top Health & Social Needs

Prioritize community health and social needs based on the community survey, data from secondary sources, and facility input.

Implementation Planning

Build an implementation plan to address identified needs with actions, goals, and intended impacts on significant health needs.

Demographics and Health Indicators

Inyo County Demographics

	Inyo Co.	CA
Total Population	18,527	38,965,193
65+ Pop. %	25.6%	16.2%
Female Pop. %	49.4%	50.1%
White Pop. %	59.0%	34.3%
Hispanic Pop. %	24.6%	40.4%
Median HH Income	$71,656	$95,473

Leading Causes of Death

- ***Heart Disease***
- ***Cancer***
- ***Accidents***
- ***Chronic Lower Respiratory Disease***
- ***Stroke***

Healthcare Access

1,459:1
Population per 1 Primary Care Physician

1,248:1
Population per 1 Dentist

183:1
Population per 1 Mental Health Provider

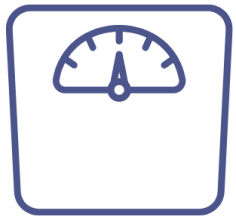
9%
Uninsured Population

Health Behaviors

Adult Smoking
Inyo: **14%**
CA: 10%

Excessive Drinking
Inyo: **23%**
CA: 20%

Physical Inactivity
Inyo: **20%**
CA: 22%

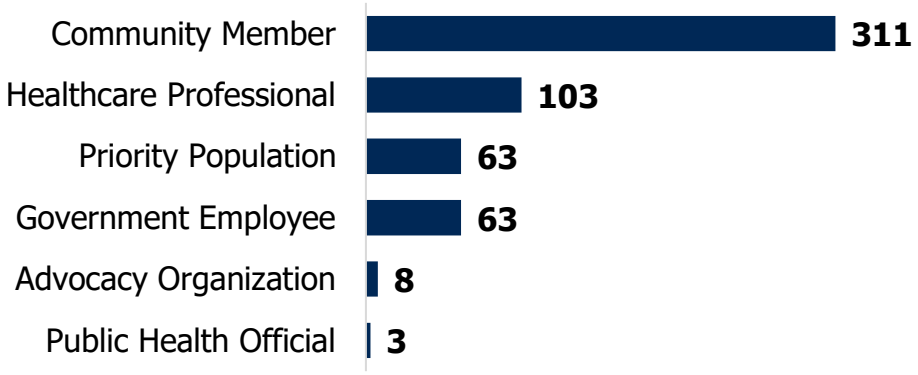


Adult Obesity
Inyo: **30%**
CA: 28%

Community Survey Data

381 *survey respondents from Nov. – Dec. 2025*

Survey Respondents & Local Expert Make Up:



Ranked Health Priorities

Survey respondents were asked to rank the importance of top health needs on a scale of 1 (not at all) to 5 (extremely). The results of that ranking are displayed below. In 2025, healthcare affordability was the top response, and other highly ranked responses included cost of health insurance, affordable housing, and access to care, suggesting growing financial pressures and perceived barriers to healthcare access.

2025 NIHD and SIHD Survey (n=381)	
Top 10 Health Priorities	Rank
Healthcare: Affordability	*4.58*
Access to Specialty Care	*4.56*
Mental Health	*4.54*
Geriatric / Elder Care	*4.50*
Cost of Health Insurance	*4.50*
Cancer	*4.45*
Affordable Housing	*4.41*
Access to Primary Care	*4.38*
Senior Services / Elder Care	*4.36*
Women's Health	*4.29*

2022 NIHD Survey (n=643)	
Top 10 Health Priorities	Rank
Mental Health	*4.53*
Affordable Housing	*4.46*
Healthcare Services: Affordability	*4.41*
Physical Presence	*4.38*
Cancer	*4.37*
Drug/Substance Abuse	*4.30*
Access to Childcare	*4.27*
Diabetes	*4.24*
Access to Senior Services	*4.21*
Livable Wage	*4.21*

Input on the Actions Taken Since the 2022 CHNA

NIHD considered written comments received on the prior CHNA and Implementation Strategy as a component of the development of the 2025 CHNA and Implementation Strategy. Comments were solicited from community members to provide feedback on any efforts and actions taken by NIHD since the 2022 CHNA and Implementation Plan were conducted. These comments informed the development of the 2025 CHNA and Implementation Plan and are presented in full in the appendix of this report. The health priorities identified in the 2022 CHNA are listed below with a selection of survey responses.

- Behavioral Health
- Access to Healthcare
- Chronic Disease Management

Implementation Strategy

Health Priority Selection Process

To determine the top health priorities for the community, a structured evaluation and selection process was conducted, where Hospital leaders reviewed both community survey findings and key secondary data indicators, comparing local health outcomes to state benchmarks to identify areas of concern. Each potential priority was assessed based on several criteria: the level of community concern (as reflected in survey responses), whether the issue showed worse-than-average performance compared to the state, the Hospital's capacity and resources to meaningfully address the need, and the alignment with the Hospital's strategic goals.

The top 3 health priorities identified by NIHD for the development of implementation strategies are:

Healthcare Access: Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.

Relevant Health Needs: Access to Specialty Care, Access to Primary Care, Senior Services/Elder Care, Healthcare: Affordability

Mental Health: Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.

Relevant Health Needs: Mental Health

Care Coordination and Disease Management: Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.

Relevant Health Needs: Geriatric/Elder Care, Cancer, Women's Health

Health Needs Not Addressed

NIHD acknowledges the significance of all health priorities identified through the community survey and overall assessment. While many of these needs are currently being addressed through existing programs, resources, and strategies led by other community organizations and the Hospital, NIHD has chosen to focus its future efforts on three top-priority areas where it can make the most meaningful impact in line with its strategic goals. By concentrating attention and resources on these key issues, the Hospital aims to strengthen outcomes through targeted programming and strategic collaboration with local partners.

DRAFT

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

Northern Inyo Healthcare District

2025

Community Health Needs Assessment

Approved by Board: TBD

Ovation Healthcare

Table of Contents

Executive Summary

Northern Inyo Health District (NIHD) performed a Community Health Needs Assessment (CHNA) in partnership with Ovation Healthcare ("Ovation") to assist in determining the health needs of the local community and an accompanying implementation plan to address the identified health needs. This CHNA report consists of the following information:

1) a definition of the community served by the Hospital and a description of how the community was determined;

2) a description of the process and methods used to conduct the CHNA;

3) a description of how the Hospital solicited and considered input received from persons who represent the broad interests of the community it serves;

4) commentary on the 2022 CHNA Assessment and Implementation Strategy efforts;

5) a prioritized description of the significant health needs of the community identified through the CHNA along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

6) a description of resources potentially available to address the significant health needs identified through the CHNA.

Data was gathered from multiple well-respected secondary sources to help build an accurate picture of the current community and its health needs. A broad community survey was performed in conjunction with Southern Inyo Healthcare District (SIHD) to review and provide feedback on the prior CHNA and to support the determination of the Significant Health Needs of the community in 2025.

The health priorities identified by NIHD from this assessment are:

Healthcare Access

Mental Health

Care Coordination and Disease Management

In the Implementation Strategy section of the report, the Hospital addresses these areas through identified programs and resources with intended impacts included for each health need to track progress towards improved community health outcomes.

Community Health Needs Assessment
Overview

CHNA Purpose

A CHNA is part of the required documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals and fulfills requirements for accreditation for many health and public health entities. However, regardless of status, a CHNA provides many benefits to an organization. This assessment provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Organizational Benefits

- Identify health disparities and social drivers to inform future outreach strategies
- Identify key service delivery gaps
- Develop an understanding of community members' perceptions of healthcare in the region
- Support community organizations for collaborations

CHNA Process

Survey the Community

Develop a CHNA survey to be deployed to the broad community in order to assess significant health priorities.

Data Analysis

Review survey data and relevant data resources to provide qualitative and quantitative feedback on the local community and market.

Determine Top Health & Social Needs

Prioritize community health and social needs based on the community survey, data from secondary sources, and facility input.

Implementation Planning

Build an implementation plan to address identified needs with actions, goals, and intended impacts on significant health needs.

Process & Methods

This assessment takes a comprehensive approach to determining community health needs and includes the following methodology:

- Several independent data analyses based on secondary source data
- Augmentation of data with community opinions through a community-wide survey
- Resolution of any data inconsistency or discrepancies by reviewing the combined opinions formed by local expert advisors and community members

Data Collection and Analysis

This assessment relies on secondary source data, which primarily uses the county as the smallest unit of analysis. Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the community members cooperating in this study are displayed in the CHNA report appendix.

All data sources are detailed in the appendix of this report, with the majority of the data used in this assessment coming from:

- County Health Rankings 2025 Report
- Centers for Medicare & Medicaid Services – CMS
- Centers for Disease Control and Prevention – CDC

A standard process of gathering community input was utilized. In addition to gathering data from the above sources, a CHNA survey was deployed to local expert advisors and the general public to gain input on local health needs and the needs of priority populations. Local expert advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's economic, racial, and geographically diverse population. Nine hundred forty-five (945) survey responses from community members were gathered in October 2025.

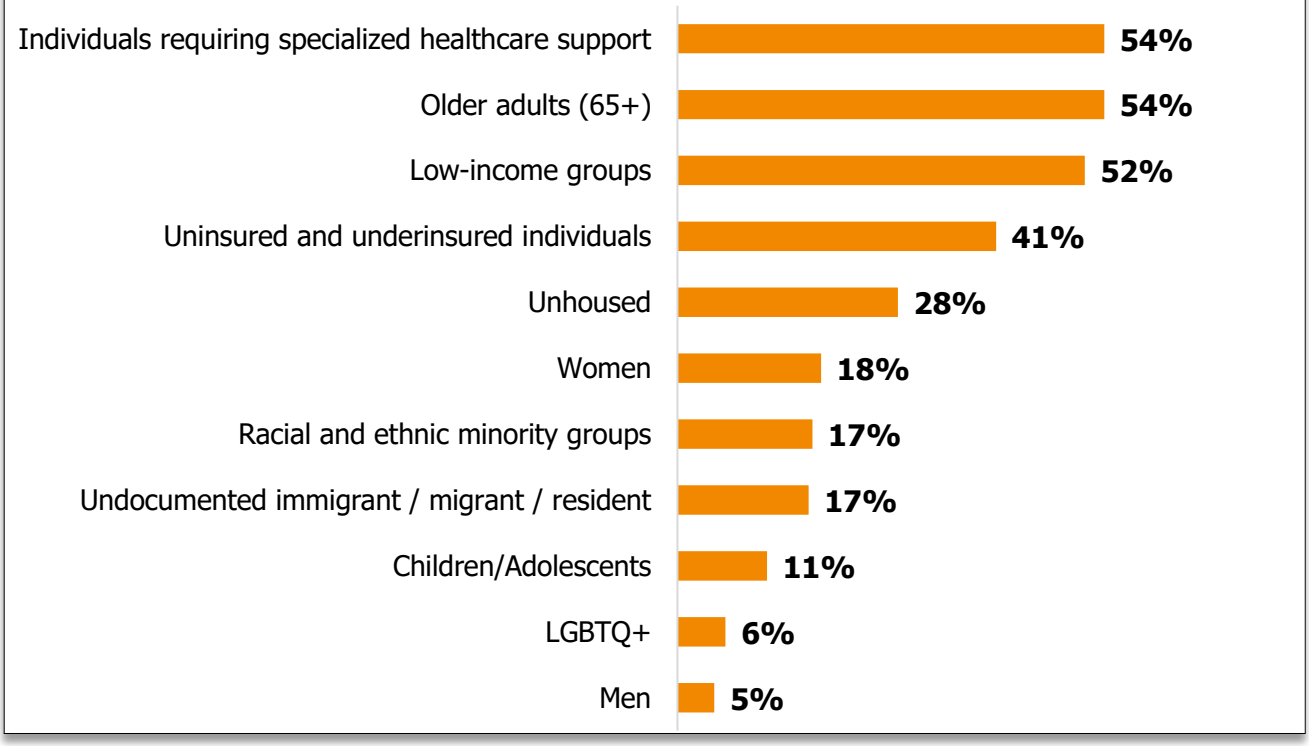
Community Input

Input was obtained from the required three minimum federally required sources and expanded to include other representative groups. The Hospital asked all those participating in the written comment solicitation process to self-identify into any of the following representative classifications, which are detailed in the appendix to this report. Additionally, survey respondents were asked to identify their age, race/ethnicity, and income level to ensure a diverse range of responses were collected.

Priority Populations

Medically underserved populations are those who experience health disparities or face barriers to receiving adequate medical care because of income, geography, language, etc. The Hospital assessed what population groups in the community ("Priority Populations") would benefit from additional focus and asked survey respondents to elaborate on the key health challenges these groups face.

Survey Question: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community?



Local opinions of the needs of Priority Populations, while presented in their entirety in the appendix, were abstracted into the following key themes:

- The top three priority populations identified were older adults (65+), low-income groups, and un/underinsured individuals.
- Summary of unique or pressing needs of the priority groups identified by the respondents:

Access to Specialty Care | Financial Barriers | Care Coordination | Behavioral Health

Input on the Actions Taken Since the 2022 CHNA

NIHD considered written comments received on the prior CHNA and Implementation Strategy as a component of the development of the 2025 CHNA and Implementation Strategy. Comments were solicited from community members to provide feedback on any efforts and actions taken by NIHD since the 2022 CHNA and Implementation Plan were conducted. These comments informed the development of the 2025 CHNA and Implementation Plan and are presented in full in the appendix of this report. The health priorities identified in the 2022 CHNA are listed below with a selection of survey responses.

- Behavioral Health
- Access to Healthcare
- Chronic Disease Management

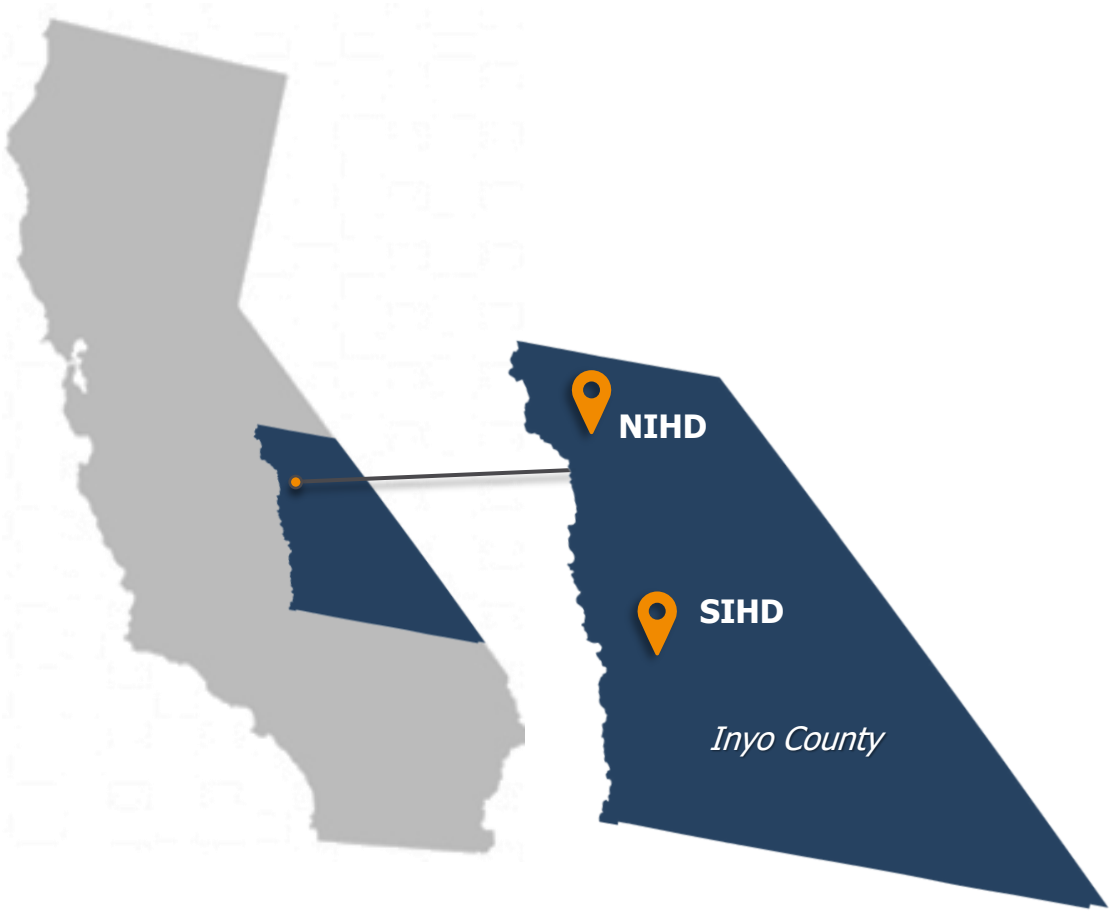
Community Served

For the purpose of this study, the service area is defined as Inyo County in California. The data presented in this report is based on this county-level service area and compared to state averages. Geographically, NIHD is located in northeast Inyo County. There is one other critical access hospital, Southern Inyo Healthcare District, located at the southern end of the county.

Service Area

Inyo County

Total Population: **18,527**



Source: County Health Rankings 2025 Report, ArcGIS

Service Area Demographics

	Inyo	California
Demographics		
Total Population	18,527	38,965,193
Age		
Below 18 Years of Age	19.8%	21.7%
Ages 19 to 64	54.6%	62.1%
65 and Older	25.6%	16.2%
Race & Ethnicity		
Non-Hispanic White	59.0%	34.3%
Non-Hispanic Black	1.0%	5.6%
American Indian or Alaska Native	14.0%	1.7%
Asian	1.9%	16.5%
Native Hawaiian or Other Pacific Islander	0.2%	0.5%
Hispanic	24.6%	40.4%
Gender		
Female	49.4%	50.1%
Male	50.6%	49.9%
Geography		
Rural	42.1%	5.8%
Urban*	57.9%	94.2%
Income		
Median Household Income	$71,656	$95,473

*Notes: *Urban is defined by the US Census Bureau as census blocks that encompass at least 5,000 people or at least 2,000 housing units*
Source: County Health Rankings 2025 Report

Methods of Identifying Health Needs

Collect & Analyze

Analyze existing data and collect new data

737 indicators collected from data sources

381 surveys completed by community members

Evaluate

Evaluate indicators based on the following factors:

- Worse than benchmark
- Identified by the community
- Impact on health disparities
- Feasibility of being addressed

Select

Select priority health needs for implementation plan

Prioritizing Significant Health Needs

The survey respondents participated in a structured communication technique called the "Wisdom of Crowds" method. This approach relies on the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the Hospital's process, each survey respondent had the opportunity to prioritize community health needs. The survey respondents then ranked the importance of addressing each health need on a scale of 1 (not at all) to 5 (extremely), including the opportunity to list additional needs that were not identified.

The ranked needs were divided into "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable breakpoint in rank order occurred. The Hospital analyzed the health issues that received the most responses and established a plan for addressing them.

Ranked Health Priorities

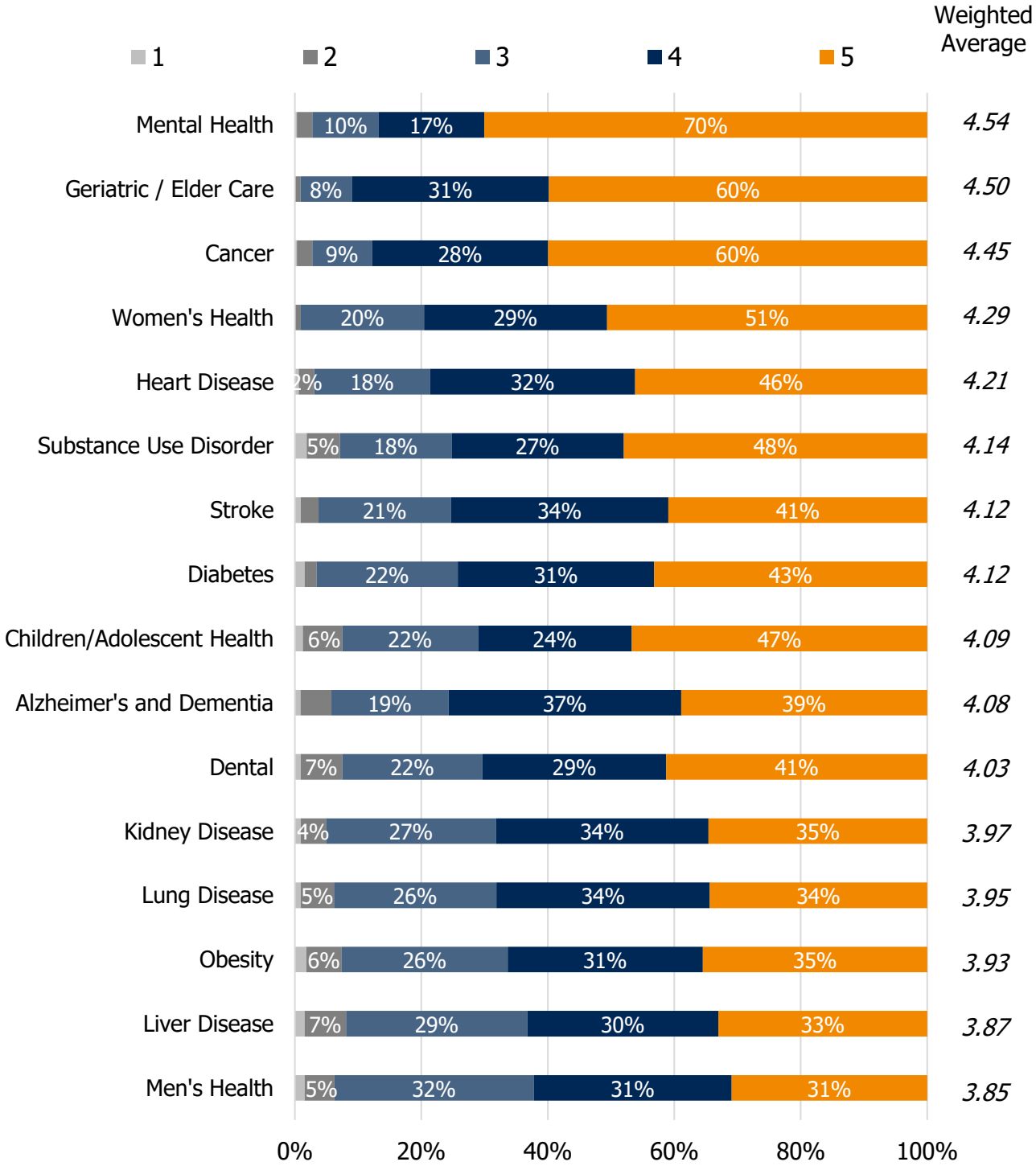
The health priority ranking process included an evaluation of health factors, community factors, and personal factors, given that they each uniquely impact the overall health and health outcomes of a community:

- Health factors include chronic diseases, health conditions, and the physical health of the population.
- Community factors are the social drivers that influence community health and health equity.
- Behavioral factors are the individual actions that affect health outcomes.

In our community survey, each broad factor was broken out into more detailed components, and respondents rated the importance of addressing each component in the community on a scale from 1 to 5. The results of the health priority rankings are outlined below:

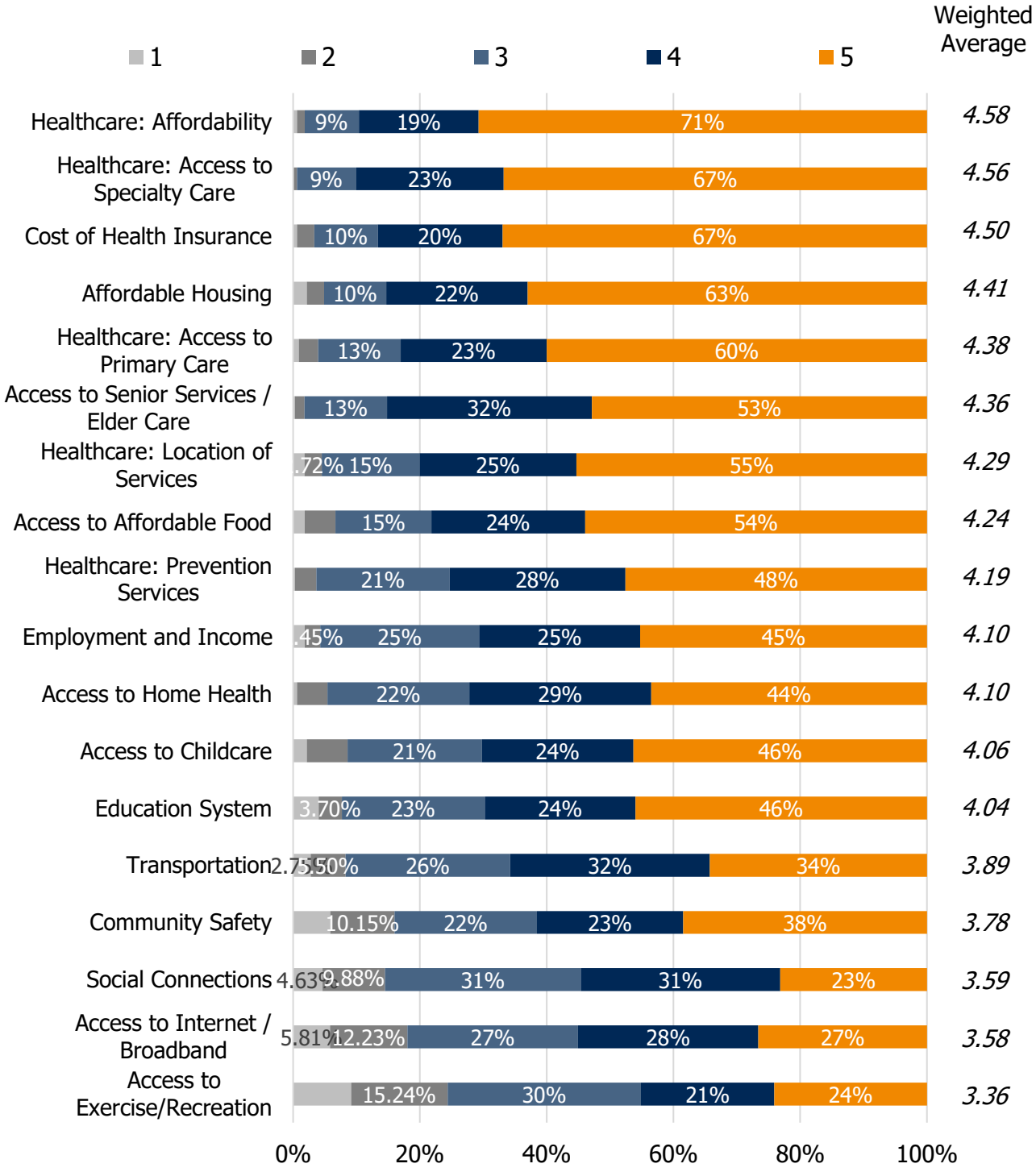
Health Factors

Survey Question: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely).



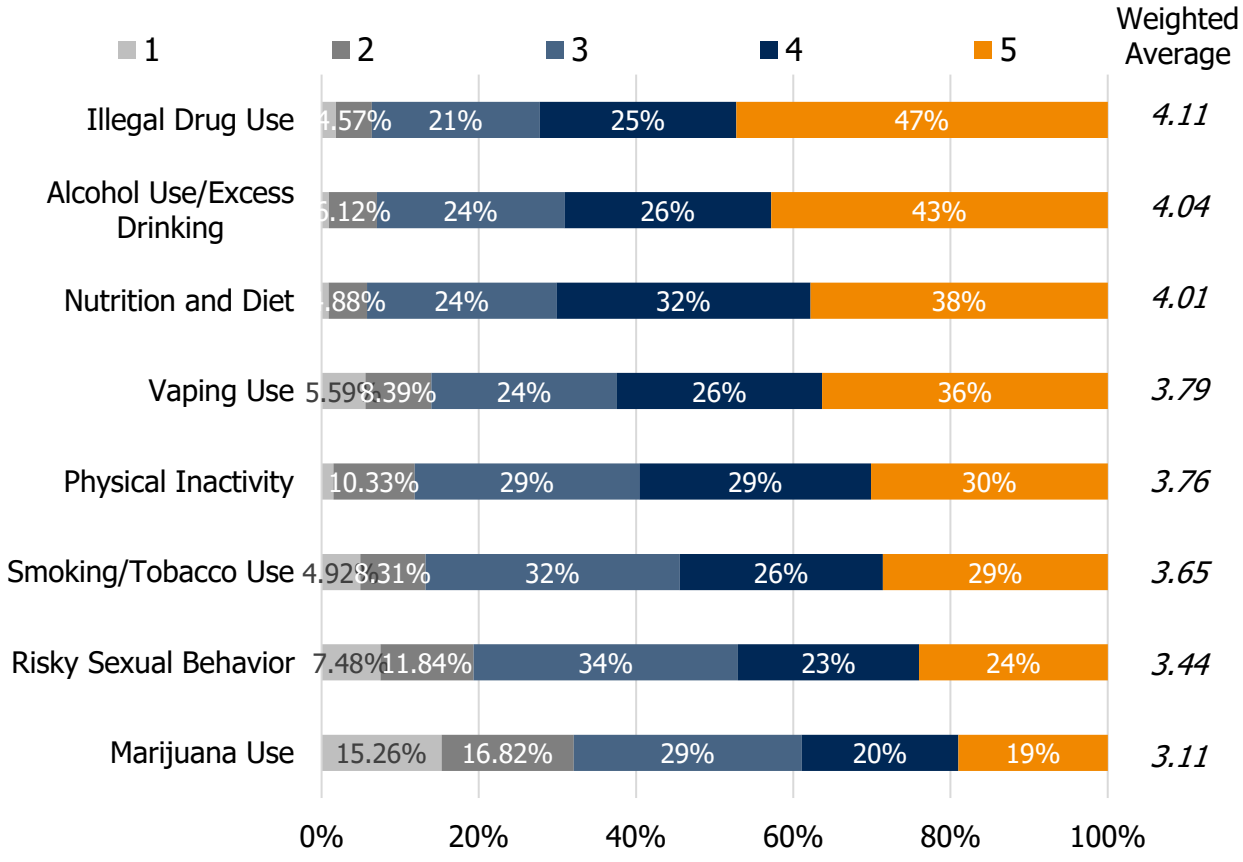
Community Factors

Survey Question: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely).



Behavioral Factors

Survey Question: Please rate the importance of addressing each behavioral factor in your community on a scale of 1 (Not at all) to 5 (Extremely).



Overall Health Priority Ranking (Top 10 Highlighted)

Health Issue	Weighted Average (out of 5)	Combined 4 (Important) and 5 (Extremely Important) Rating
Healthcare: Affordability	4.58	89.6%
Healthcare: Access to Specialty Care	4.56	90.0%
Mental Health	4.54	86.7%
Geriatric / Elder Care	4.50	90.9%
Cost of Health Insurance	4.50	86.7%
Cancer	4.45	87.8%
Affordable Housing	4.41	85.3%
Healthcare: Access to Primary Care	4.38	83.0%
Access to Senior Services / Elder Care	4.36	85.2%
Women's Health	4.29	79.6%
Healthcare: Location of Services	4.29	80.1%
Access to Affordable Food	4.24	78.2%
Heart Disease	4.21	78.6%
Healthcare: Prevention Services	4.19	75.3%
Substance Use Disorder	4.14	75.2%
Diabetes	4.12	74.2%
Stroke	4.12	75.3%
Illegal Drug Use	4.11	72.3%
Access to Home Health	4.10	72.2%
Employment and Income	4.10	70.6%
Children/Adolescent Health	4.09	71.0%
Alzheimer's and Dementia	4.08	75.7%
Access to Childcare	4.06	70.3%
Education System	4.04	69.8%
Alcohol Use/Excess Drinking	4.04	69.1%
Dental	4.03	70.3%
Nutrition and Diet	4.01	70.1%
Kidney Disease	3.97	68.2%
Lung Disease	3.95	68.1%
Obesity	3.93	66.4%
Transportation	3.89	65.8%
Liver Disease	3.87	63.2%
Men's Health	3.85	62.2%
Vaping Use	3.79	62.4%
Community Safety	3.78	61.5%
Physical Inactivity	3.76	59.6%
Smoking/Tobacco Use	3.65	54.5%
Social Connections	3.59	54.6%
Access to Internet / Broadband	3.58	55.1%
Risky Sexual Behavior	3.44	47.0%
Access to Exercise/Recreation	3.36	45.1%
Marijuana Use	3.11	38.9%

Survey Ranking Comparison from 2022 to 2025

The 2025 survey highlights consistent concern around healthcare affordability and mental health, but with some notable shifts in priority emphasis from the 2022 survey results. In 2025, healthcare affordability was the top response, and other highly ranked responses included cost of health insurance, affordable housing, and access to care, suggesting growing financial pressures and perceived barriers to healthcare access. Mental health remains a top concern, reflecting continued community focus on behavioral health needs. Newer or elevated priorities include, geriatric/elder care and women's health, indicating increased attention to chronic disease management and priority populations.

2025 NIHD and SIHD Survey (n=381)	
Top 10 Health Priorities	Rank
Healthcare: Affordability	*4.58*
Access to Specialty Care	*4.56*
Mental Health	*4.54*
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2022 NIHD Survey (n=643)	
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Mental Health	*4.53*
Affordable Housing	*4.46*
Healthcare Services: Affordability	*4.41*
Physical Presence	*4.38*
Cancer	*4.37*
Drug/Substance Abuse	*4.30*
Access to Childcare	*4.27*
Diabetes	*4.24*
Access to Senior Services	*4.21*
Livable Wage	*4.21*

Community Health Characteristics

This section highlights health status indicators, outcomes, and relevant data on the health needs in Inyo County. The data at the county level is supplemented with benchmark comparisons to the state data. The most recently available data is used throughout this report with trended data included where available. A scorecard that compares the population health data of the service area county to that of California can be found in the report appendix.

Behavioral Health

Mental Health

Mental health was the #3 community-identified health priority, with 87% of respondents rating it as important to be addressed in the community (important is categorized as a 4 or 5 rating on the community survey). The suicide mortality rate in Inyo County is 16.2, which is higher than the California average.

Inyo County has better access to mental health providers compared to the state, where there is 1 provider for every 183 county residents. Additionally, the county has higher rates of frequent mental distress compared to the state.

	Inyo	California
Suicide Mortality Rate per 100,000 (2019-2023)	16.2	10.3
Poor Mental Health Days past 30 days (2022)	5.7	4.7
Population per 1 Mental Health Provider (2024)	183:1	213:1
Frequent Mental Distress (2022)	17%	15%

Note: "Frequent Mental Distress" indicates percentage of adults reporting 14 or more days of poor mental health per month
Source: NIH: HDPulse, County Health Rankings 2025 Report, PLACES: Local Data for Better Health

Drug, Substance, and Alcohol Use

Inyo County has a higher drug-related overdose death rate compared to California (50 compared to 26 per 100,000 population, respectively). The prevalence of excessive drinking and alcohol-impaired driving deaths is higher in Inyo County compared to the state. Additionally, the adult smoking rate is higher in Inyo county than the state of California as a whole.

	Inyo	California
Drug-Related Overdose Deaths per 100,000 (2021-2023)	50.2	26.1
Excessive Drinking (2022)	23.3%	19.9%
Alcohol-Impaired Driving Deaths (2018-2022)	28.2%	25.6%
Adult Smoking (2022)	13.8%	9.9%

Source: CDC National Vital Statistics System, County Health Rankings 2025 Report

Chronic Diseases

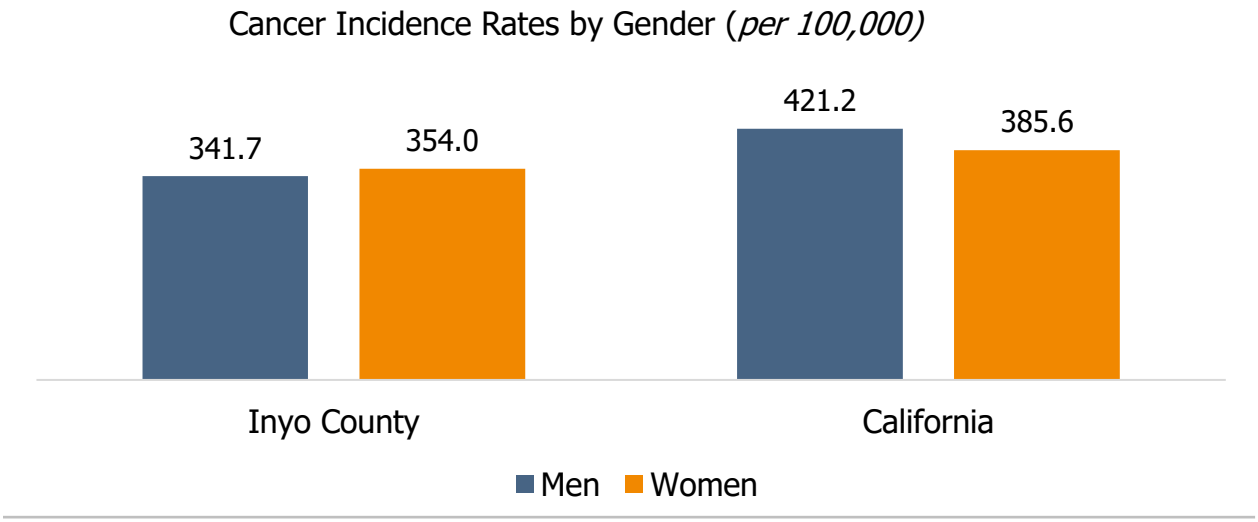
Cancer

Cancer was identified as the #6 community health issue with 88% of survey respondents rating it as important to address in the community. Cancer is the 2nd leading cause of death in Inyo County. Additionally, 53% of survey respondents said they would like to see additional access to cancer care in Inyo County. Inyo County has both a lower cancer incidence rate and mortality rate compared to California cancer rates.

Inyo County exhibits a slightly higher cancer incidence rate among women than men, a pattern that contrasts with statewide trends and may reflect population size, cancer type distribution, and screening-related factors rather than a true gender-based disparity.

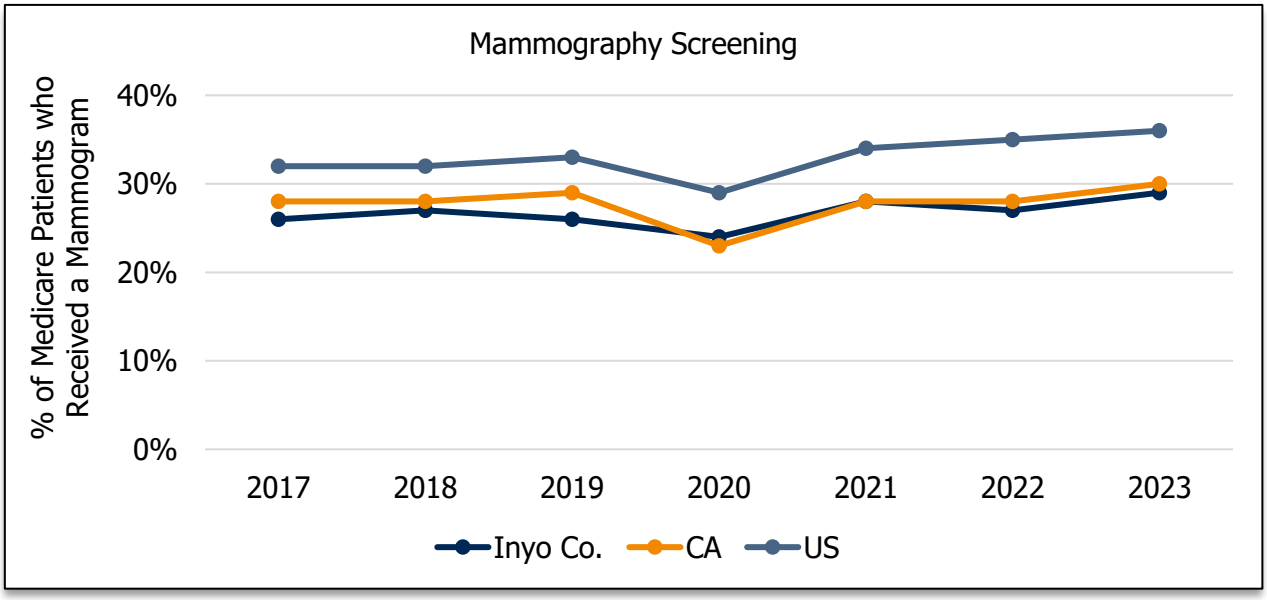
	Inyo	California
Cancer Incidence Rate Age-Adjusted per 100,000 (2017-2021)	345.4	397.4
Cancer Mortality Rate per 100,000 (2019-2023)	130.1	131.9

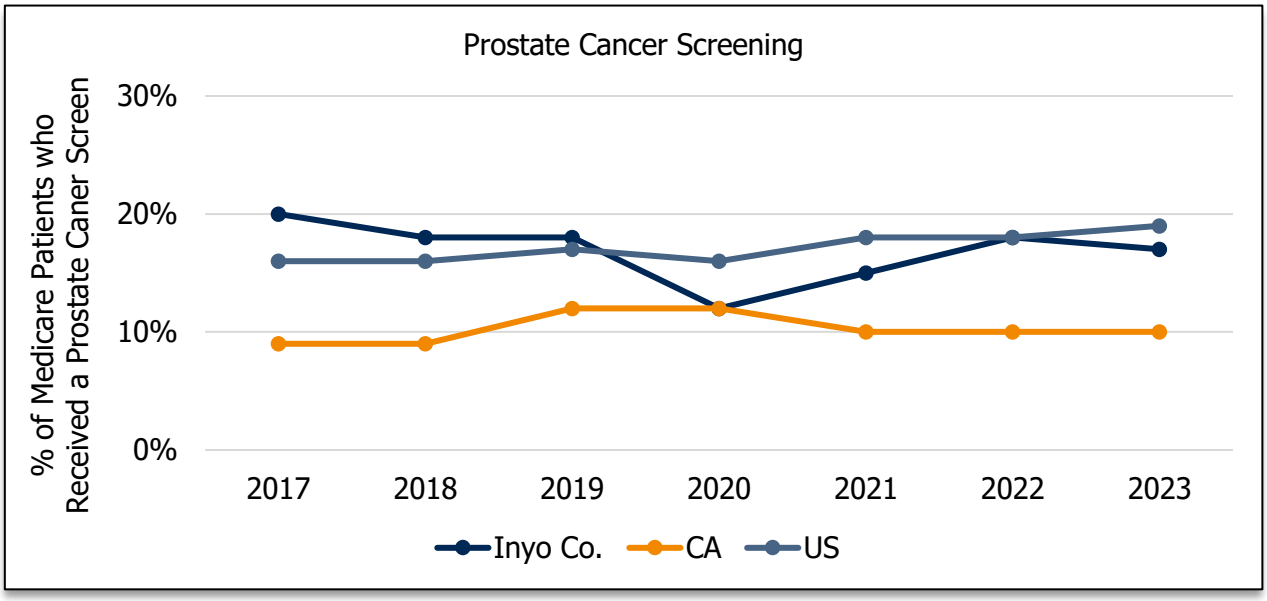
Source: NIH: HDPulse, National Cancer Institute



Source: National Cancer Institute

The rate of Medicare enrollees (women age 65+) who have received a mammogram in the past year is comparable between Inyo County and the state (29% and 30%, respectively). These rates have increased in recent years following a dip downward in 2020 during the COVID-19 pandemic. Among Medicare enrollees (men age 65+), Inyo County has a higher rate of prostate cancer screening compared to the state (17% compared to 10%, respectively).





Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

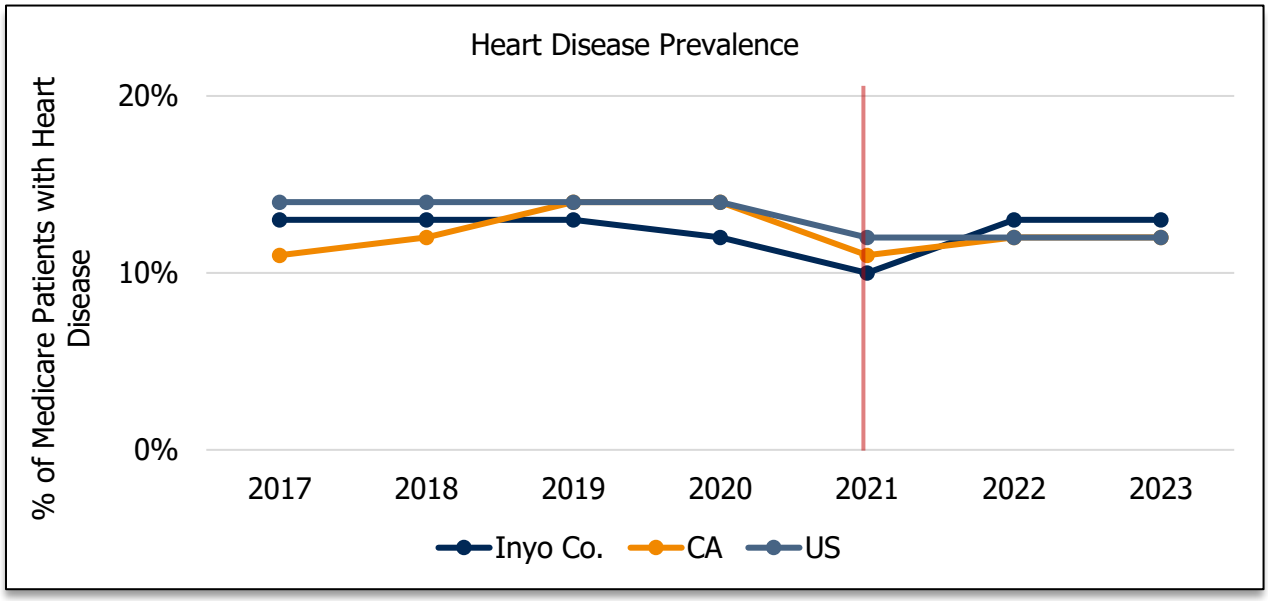
Cardiovascular Health

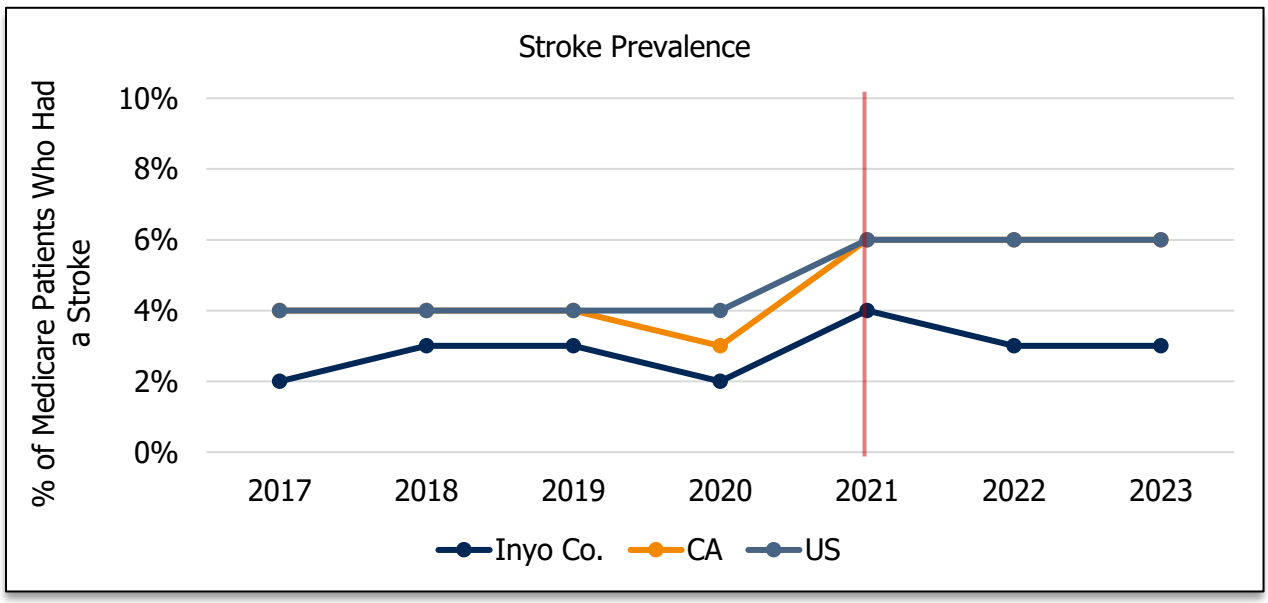
Heart disease is the leading cause of death in Inyo County though the county has a lower mortality rate for both heart disease and stroke compared to state averages. Looking at risk factors for negative cardiovascular health, Inyo County has a slightly lower prevalence of high blood pressure compared to the California average.

	Inyo	California
Heart Disease Mortality Rate per 100,000 (2019-2023)	137.5	143.6
Stroke Mortality Rate per 100,000 (2019-2023)	32.3	40.1
High Blood Pressure (2021-2023)	35.1%	37.1%

Source: NIH: HDPulse, PLACES: Local Data for Better Health, America's Health Rankings

In the Medicare population, Inyo County has a slightly higher prevalence of heart disease compared to the state (13% compared to 12% respectively), and the prevalence of stroke is the lower than the state (3% and 6%, respectively).





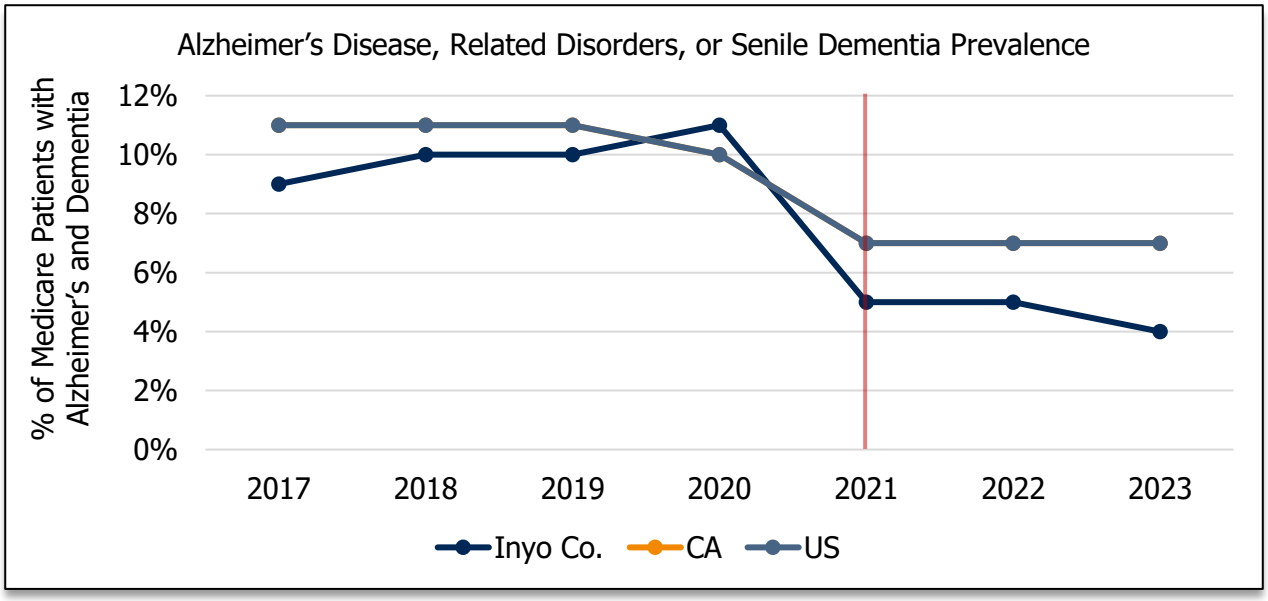
Note: There was a change in the algorithm of reported data in 2021 noted by a red bar. Between 2017 to 2019 and 2021 to 2023, the State and National data overlap
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Alzheimer's and Dementia

Inyo County has a lower mortality rate for Alzheimer's compared to the state on average. Additionally, in the Medicare population, the prevalence of Alzheimer's, related disorders, or senile dementia is 4% which is lower than state and national averages of 7%.

	Inyo	California
Alzheimer's Mortality Rate per 100,000 (2019-2023)	10.2	38.8

Source: NIH: HDPulse



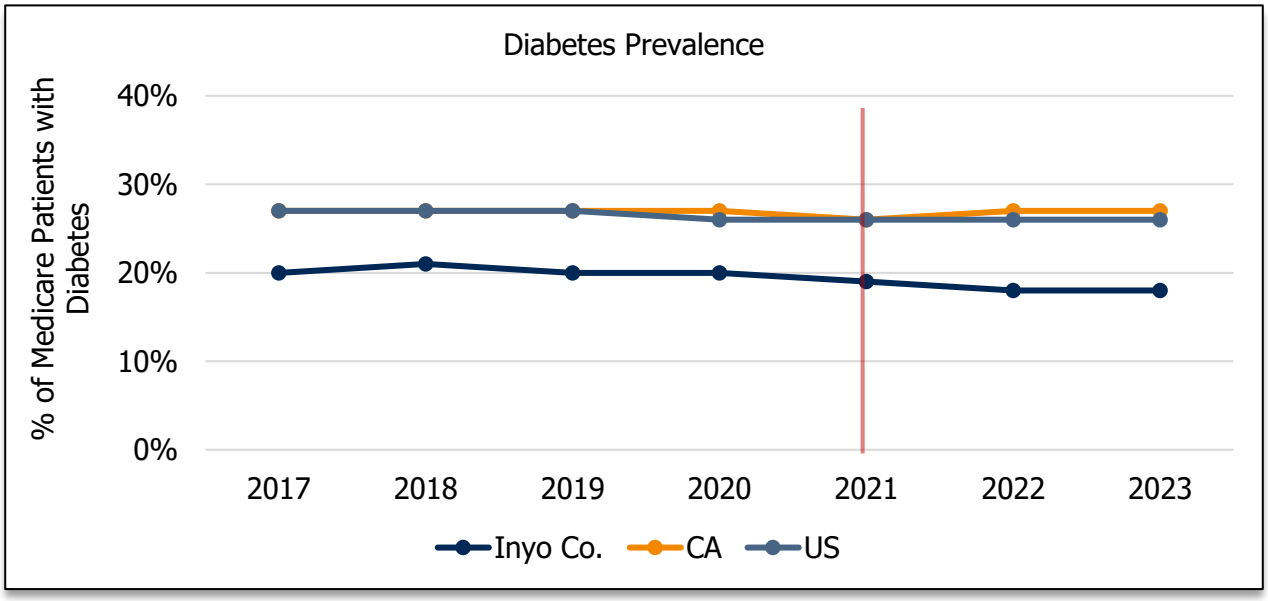
Note: There was a change in algorithm in 2021, marked by the vertical red line representing a break in trend lines
Between 2017 to 2023, the State and National data overlap
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Diabetes

The prevalence of diabetes in Inyo County is the slightly lower than the California average, and the county sees a diabetes mortality rate lower than the state's. When evaluating the Medicare population, Inyo County has a lower prevalence of diabetes compared to the state (18% and 27% respectively), though rates have remained relatively stable over the past several years.

	Inyo	California
Diabetes Mortality Rate per 100,000 (2019-2023)	18.5	24.6
Diabetes Prevalence (2023)	9.3%	10.6%

Source: NIH: HDPulse, County Health Rankings 2025 Report



Note: There was a change in the algorithm of reported data in 2021 noted by a red bar. Between 2017 to 2019 and in 2021, the State and National data overlap
Sources: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Obesity and Unhealthy Eating

In Inyo County, adults have slightly higher rates of obesity than in California on average. Additionally, the county sees lower access to both healthy foods and exercise opportunities (proximity to a park or recreation facility). This combination contributes to an increased risk of chronic diseases and further exacerbates health disparities, especially in low-income and rural communities. Additionally, obesity, physical inactivity, and diet are well-established risk factors for type 2 diabetes development (American Diabetes Association).

	Inyo	California
Adult Obesity (2022)	29.9%	28.3%
Limited Access to Healthy Foods (2019)	7.8%	3.2%
Physical Inactivity (2022)	19.7%	21.6%
Access to Exercise Opportunities (2020-2024)	86.9%	94.3%

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

Healthcare Access

Access & Affordability

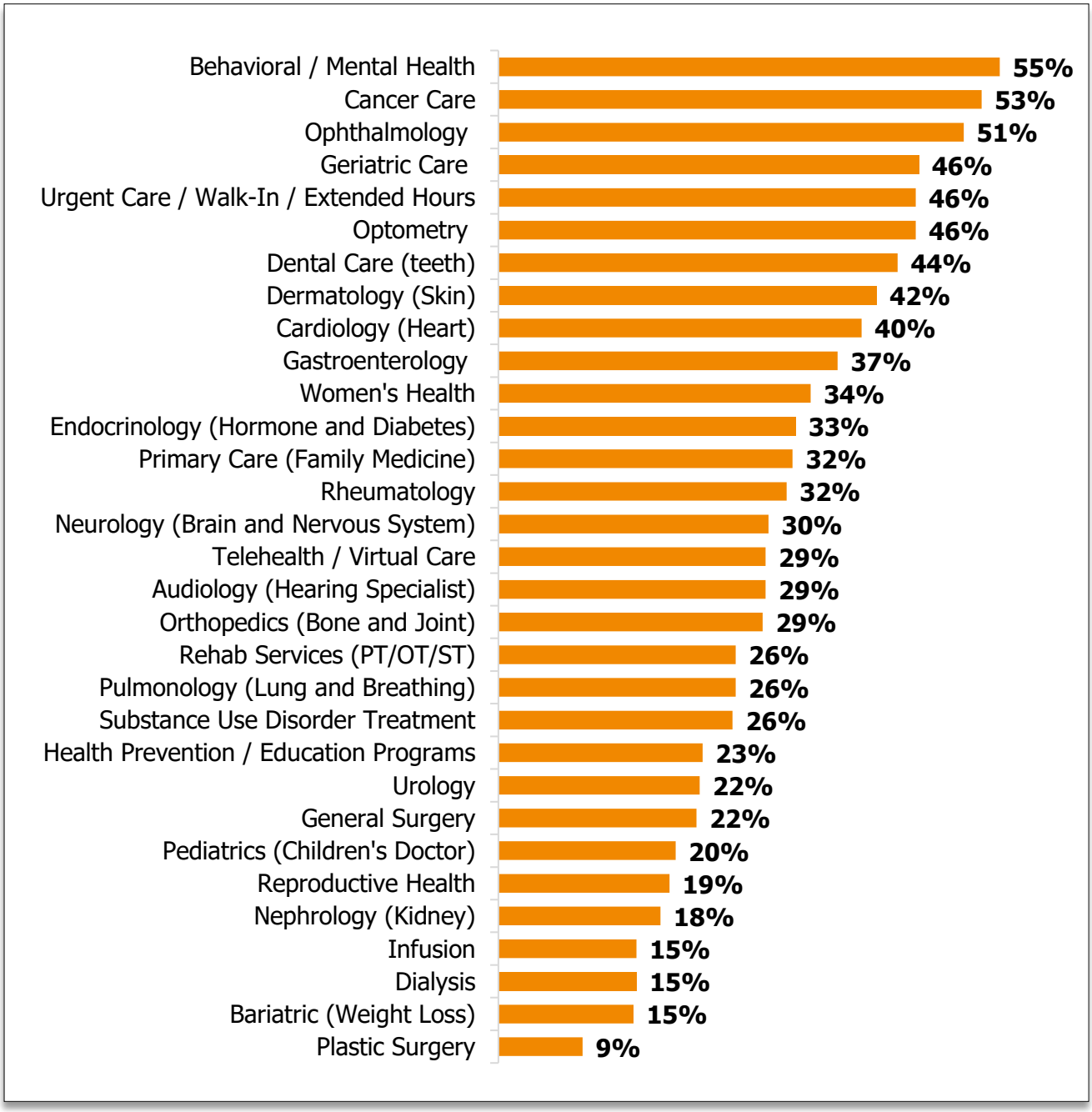
Access to affordable and quality healthcare services is a key driver of improved health outcomes, economic stability, and health equity. In the community survey, 32% of respondents said they would like to see additional primary care availability in the county. Inyo County has a lower household income than the California average and has a comparable uninsured population relative to state rates. Inyo County has 1 primary care physician (MD, DO) for every 1,459 residents, which indicates less access to primary care than the state average (1 physician for every 1,233 residents). Similarly, Inyo County has less access to dental providers compared to California on average.

	Inyo	California
Uninsured Population (2022)	9.0%	9.1%
Population per 1 Primary Care Physician (2021)	1,459:1	1,233:1
Population per 1 Primary Care Provider (APP) (2021)	842:1	1,062:1
Population per 1 Dentist (2022)	1,248:1	1,076:1

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

In the community survey, respondents were asked to identify what healthcare services and programs they would like to see available in their community. Mental Health was the top identified service need, with 55% of respondents saying they would like to see it available in their community, followed by Cancer Care (53%), and Ophthalmology (51%).

Survey Question: What additional services/offerings would you like to see available locally? (select all that apply)



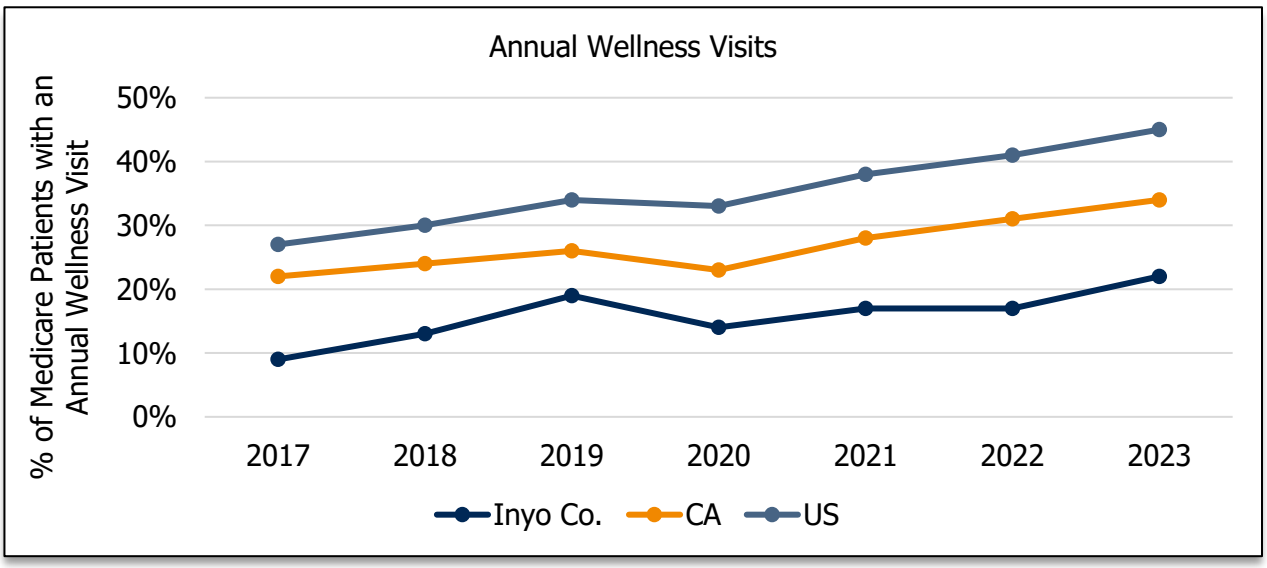
Prevention Services

Prevention services, including routine check-ups, health screenings, and education, can help prevent or detect diseases early when they are easier to treat. Preventive care reduces the burden on healthcare systems by preventing unnecessary hospital stays and costly care. In the community survey, 23% of respondents said they would like to see additional health prevention and education programs available in the community.

Inyo County has lower flu vaccine adherence rates and a lower rate of preventable hospital stays (hospital stays for ambulatory-care sensitive conditions) than the state. This rate represents the effectiveness of preventive care in a community, reflecting how well primary care services manage chronic conditions and prevent avoidable hospital admissions. Additionally, the rate of annual wellness visits in the Medicare population is lower in Inyo County than the California average, with rates increasing in recent years.

	Inyo	California
Preventable Hospital Stays per 100,000 (2022)	1,198	2,257
Flu Vaccination (2022)	39.0%	44.0%

Source: County Health Rankings 2025 Report



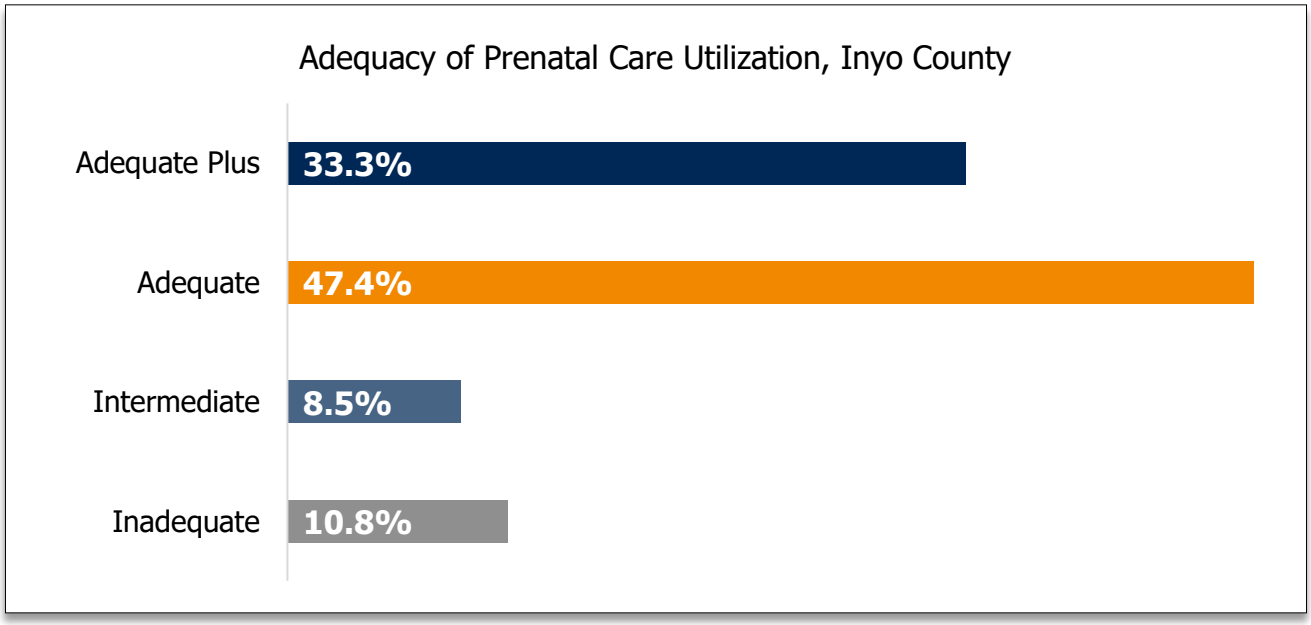
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Women's Health

Rural communities face significant barriers to women's health, including provider shortages, long travel distances, and financial constraints, which limit access to preventive care, maternity services, and chronic disease management. This lack of access contributes to poorer health outcomes, such as higher rates of late-stage cancer diagnoses, maternal complications, and untreated chronic conditions. Strengthening women's health services improves maternal and infant health while also supporting the local workforce and promoting long-term community sustainability.

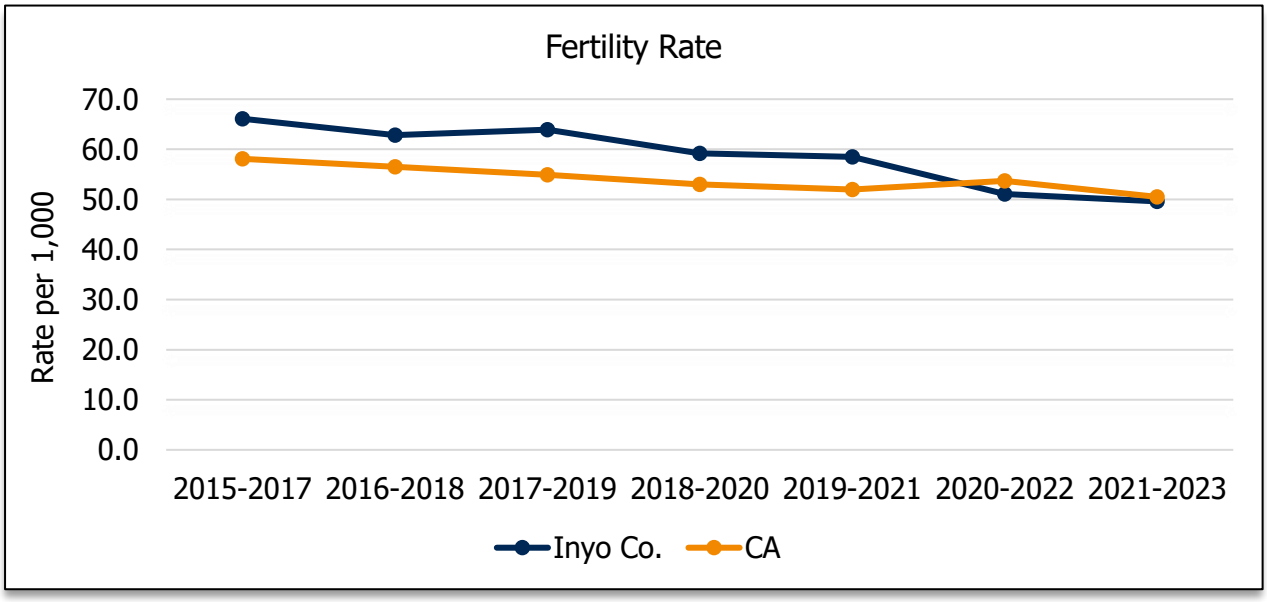
	Inyo	California
Female Population	49.4%	50.1%
Female Population of Reproductive Age (15-44)	32.7%	40.4%
Mammography Screening (2022)	33.0%	36.0%
Adequate Prenatal Care (2021-2023)	80.7%	73.7%

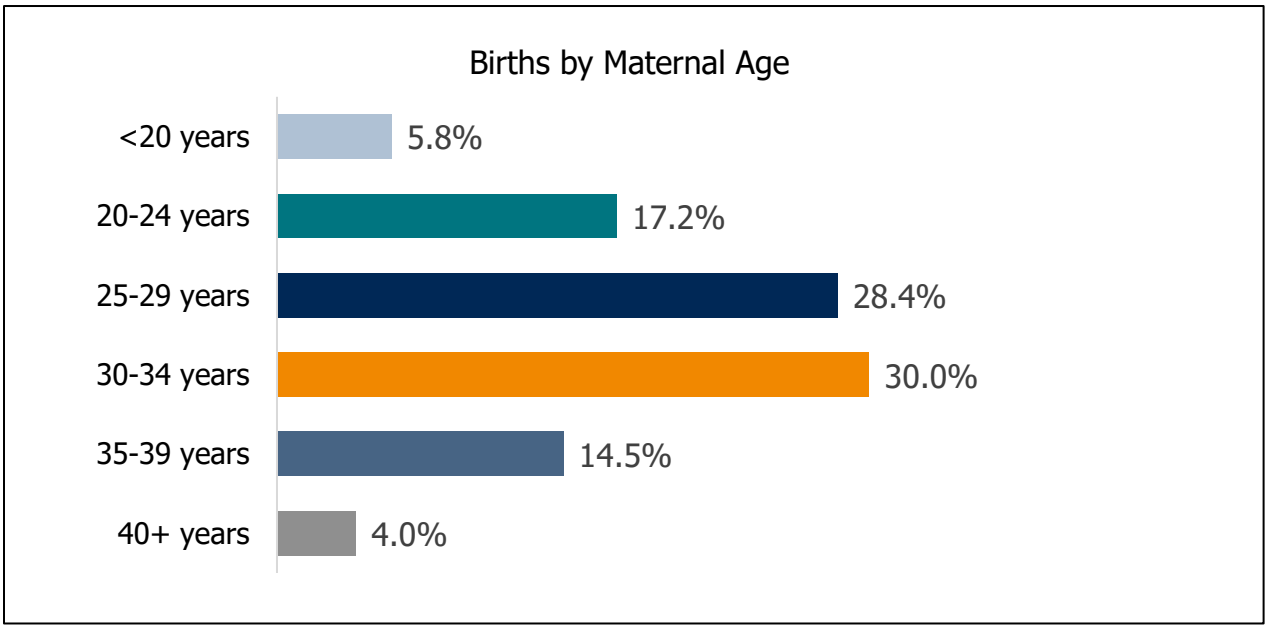
Source: County Health Rankings 2024 Report, ESRI, CDPH



Source: CDPH (2021-2023)

Historically, Inyo County has had a higher fertility rate relative to the state, however the most recent data shows a slight decline, with Inyo County at 49.6 and California at 50.5. Births in Inyo County are now most concentrated among women ages 30–34, surpassing the 25–29 age group that has historically represented the largest share of births. While birth rates remain highest within the 25–29 and 30–34 age bands, these cohorts tend to be more cost-sensitive, focused on convenient access points, and may increased interest in alternative care models, including midwifery, doula services, and birth centers.





Note: Fertility Rate represents number of births per 1,000 females age 15-44
Source: CDPH (2021-2023)

Access to Senior Services

Geriatric/Elder Care and access to senior services were identified as the #4 and #9 survey priorities, respectively. Older adults were identified as the top priority population in the community making access to senior services an important need. Additionally, the population of people 65+ is projected to grow by over 3% in Inyo county over the next five years.

	Inyo	California
Population 65+ (2025)	25.6%	16.2%
5-Year Projected Increase in 65+ Population (2025)	+3.5%	+9.5%

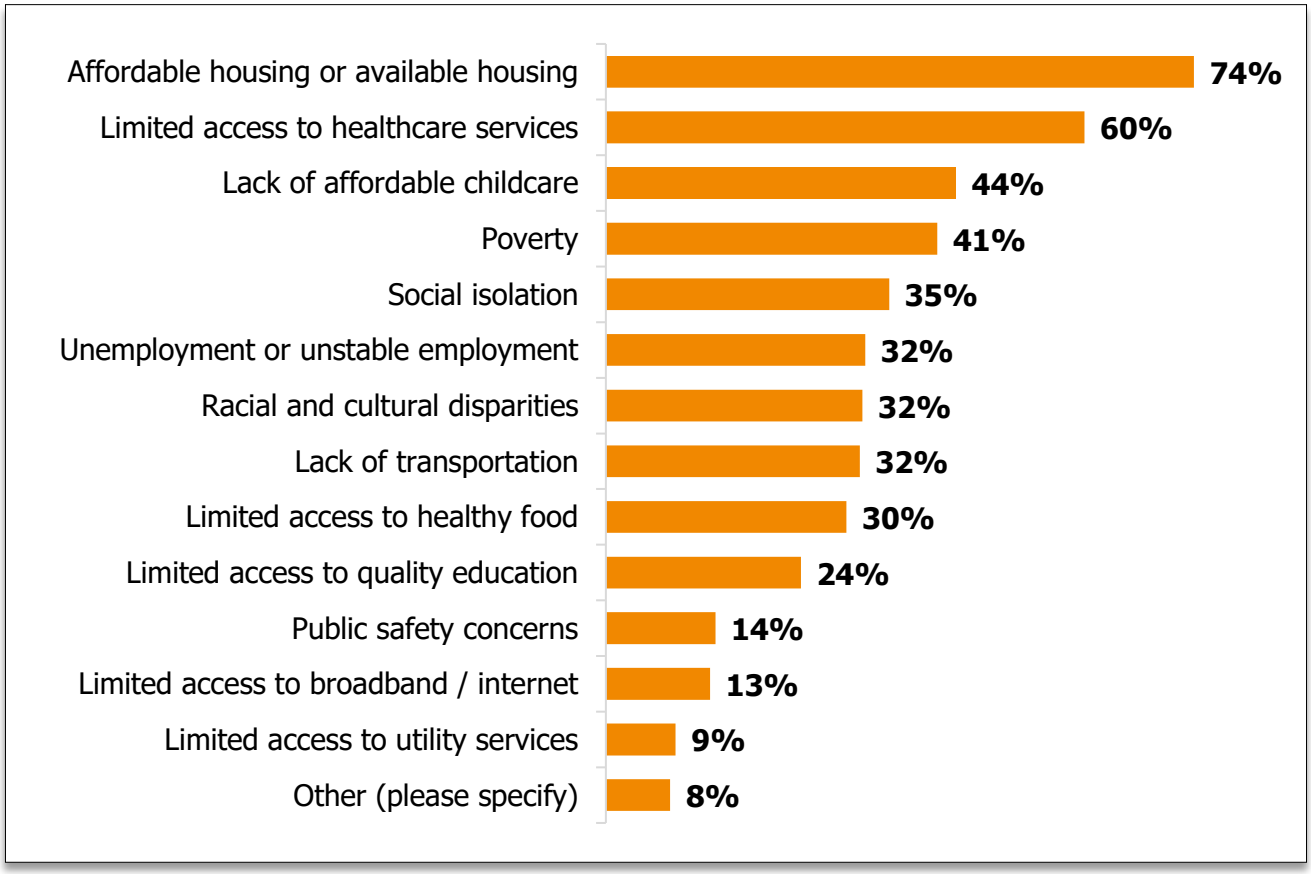
Source: County Health Rankings 2025 Report, ESRI

Social Determinants of Health

Social determinants of health, such as economic stability, education, and access to healthcare, significantly influence health outcomes by shaping individuals' living conditions, behaviors, and access to resources necessary for maintaining good health. These factors can lead to health disparities, with marginalized groups often experiencing worse health outcomes due to these determinants (Healthy People 2030).

Survey respondents were asked to identify the key social conditions that negatively impact the community. The top social condition identified was housing affordability/availability, with 74% of survey respondents reporting it as negatively affecting the community's health, followed by limited access to healthcare services and lack of affordable childcare.

Survey Question: Please select the key social determinants that negatively impact the health of you or your community (select all that apply):



Housing

Access to affordable and safe housing influences a wide range of factors that contribute to physical and mental well-being. There is evidence that a lack of access to affordable and stable housing can lead to negative health outcomes such as mental illnesses and stress, exposure to environmental hazards, and financial instability (Center for Housing Policy). Less Inyo County residents experience severe housing problems (overcrowding, high housing costs, lack of plumbing) than the state average. Additionally, 11% of Inyo County residents spend 50% or more of their household income on housing.

	Inyo	California
Severe Housing Problems (2017-2021)	16.9%	25.8%
Severe Housing Cost Burden (2019-2023)	11.4%	20.0%
Broadband Access (2019-2023)	82.7%	92.5%

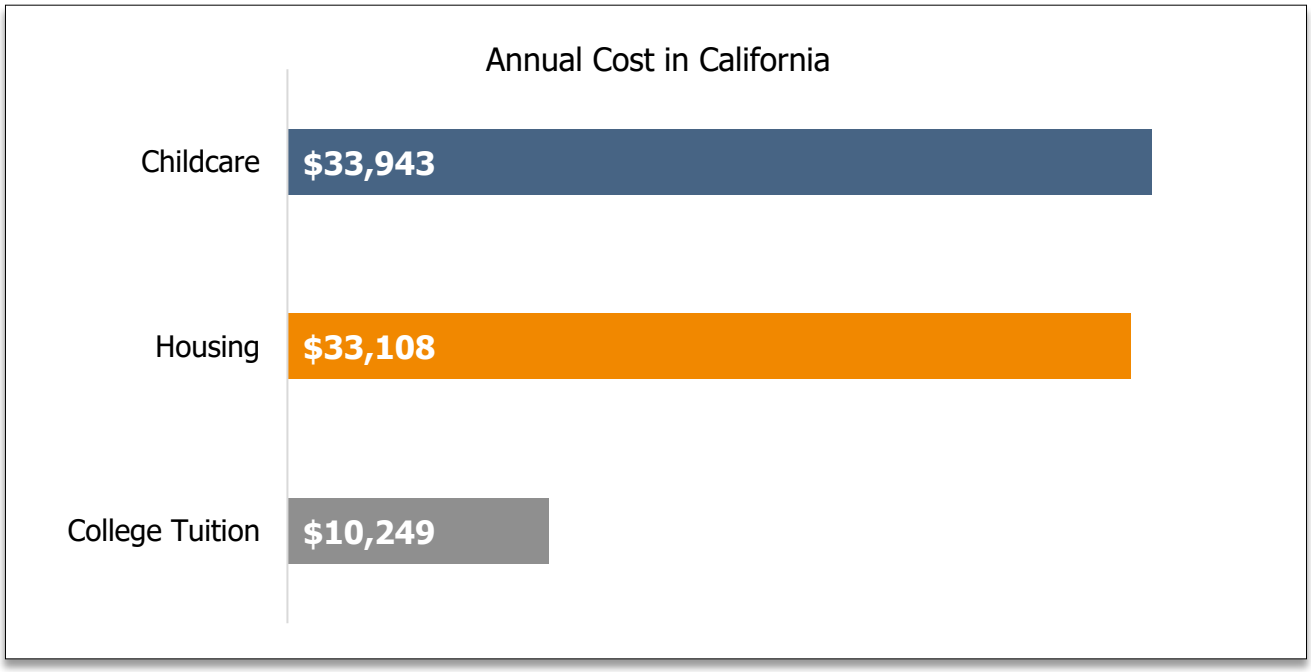
Source: County Health Rankings 2025 Report

Access to Childcare

The average yearly cost of infant care in California is $19,547. The U.S. Department of Health and Human Services defines affordable childcare as being no more than 7% of a family's income (Economic Policy Institute). In Inyo County, nearly 31% of household income is required for childcare expenses, and there are approximately 13 childcare centers for every 1,000 children under age 5 in the county, compared to 8 in the state.

	Inyo	California
Children in Single-Parent Households (2019-2023)	29.8%	22.5%
Child Care Cost Burden - % of HHI used for childcare (2023-2024)	30.9%	29.7%
Child Care Centers per 1,000 Under Age 5 (2010-2022)	13	8

Source: County Health Rankings 2025 Report



Note: Annual childcare price for 2 children (an infant and 4-year-old) in a center
Source: Child Care Aware (2023)

Income, Employment, and Education

Income, employment, and education play a role in the community's ability to afford healthcare and impact health outcomes through health literacy and access to health insurance. Educational attainment and employment impact mental health through poverty and unstable work environments, health behaviors like smoking, diet, and exercise, and access to health insurance (HealthAffairs). Additionally, these factors impact people's ability to afford services to live healthy and happy lives like safe housing, transportation, childcare, and healthy food.

	Inyo	California
Median Household Income (2023)	$71,656	$95,473
High School Completion (2021-2022)	92.8%	84.6%
Some College – Includes Those Who Had and Had Not Attained Degrees (2019-2023)	68.3%	68.0%
Unemployment (2023)	3.8%	4.8%
Children in Poverty (2019-2023)	14.2%	15.0%

Source: County Health Rankings 2025 Report

Evaluation Process

Worse than Benchmark Measure

Health needs were deemed "worse than the benchmark" if the supported county data was worse than the state and/or U.S. averages

Identified by the Community

Health needs expressed in the online survey and/or mentioned frequently by community members

Feasibility of Being Addressed

Growing health needs where interventions are feasible, and the Hospital could make an impact

Impact on Health Equity

Health needs that disproportionately affect vulnerable populations and can impact health equity if addressed

Health Need Evaluation	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Equity
Healthcare: Affordability	✓	✓		✓
Healthcare: Access to Specialty Care	✓	✓	✓	✓
Mental Health	✓	✓	✓	✓
Geriatric / Elder Care	✓	✓	✓	✓
Cost of Health Insurance	✓	✓		✓
Cancer		✓	✓	✓
Affordable Housing		✓		✓
Healthcare: Access to Primary Care	✓	✓	✓	✓
Access to Senior Services / Elder Care	✓	✓	✓	✓
Women's Health	✓	✓	✓	✓

Implementation Strategy

Health Priority Selection Process

To determine the top health priorities for the community, a structured evaluation and selection process was conducted, where Hospital leaders reviewed both community survey findings and key secondary data indicators, comparing local health outcomes to state benchmarks to identify areas of concern. Each potential priority was assessed based on several criteria: the level of community concern (as reflected in survey responses), whether the issue showed worse-than-average performance compared to the state, the Hospital's capacity and resources to meaningfully address the need, and the alignment with the Hospital's strategic goals.

The top 3 health priorities identified by NIHD for the development of implementation strategies are:

Healthcare Access: Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.

Relevant Health Needs: Access to Specialty Care, Access to Primary Care, Senior Services/Elder Care, Healthcare: Affordability

Mental Health: Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.

Relevant Health Needs: Mental Health

Care Coordination and Disease Management: Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.

Relevant Health Needs: Geriatric/Elder Care, Cancer, Women's Health

Health Needs Not Addressed

NIHD acknowledges the significance of all health priorities identified through the community survey and overall assessment. While many of these needs are currently being addressed through existing programs, resources, and strategies led by other community organizations and the Hospital, NIHD has chosen to focus its future efforts on three top-priority areas where it can make the most meaningful impact in line with its strategic goals. By concentrating attention and resources on these key issues, the Hospital aims to strengthen outcomes through targeted programming and strategic collaboration with local partners.

Healthcare Access

NIHD Services and Programs Committed to Respond to This Need

- NIHD provides healthcare across a variety of settings including:
    - 24-hour emergency care.
    - Swing bed care.
    - The Rural Health Clinic (RHC) provides primary healthcare services, with same-day and Saturday clinic appointments available.
    - A variety of specialty care services are offered including Women's Health, Orthopedics, Urology, Plastic Surgery, Allergy, Breast Health, and Cardiology.
    - Telehealth services are available for multiple service lines.
- The CAREShuttle is available to provide non-emergency medical transportation services for patients. An additional shuttle was added to meet growing demand.
- A collaboration is in place with Mammoth Hospital to grow local access to specialties, while reducing redundancy of services.
- A Patient Throughput Committee has been developed to address patient throughput opportunities and barriers in key areas (primary care, specialty care, hospital-based care).
- NIHD has a financial assistance program available for patients based on need.
- NIHD posts their chargemaster for IP and OP services on their website and offers customized estimates of care costs.
- A Language Access Services Program is in place, offering interpretation services for patients.
- Clinic providers specialize in caring for seniors.

Goals and Future Actions to Address this Significant Health Need

Goal: *Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.*

- Align future strategic planning and master facility planning with key service line and outpatient expansion opportunities to better meet community needs and support future provider recruitment and retention.
- Leverage Patient Throughput Committee to improve patient flow and throughput, increasing appointment availability and timely access to care.
- Develop and deliver community education on navigating the healthcare system, including understanding appropriate levels of care, referral pathways, and available local/regional services.
- Implement financial counseling and patient navigation to support awareness of financial assistance, insurance options, and affordability resources, with targeted education for seniors and other high-need populations.

Healthcare Access

Impact of Actions and Access to Resources

- Improved access to primary and specialty care:
  - 3rd next available appointment rates
  - Future service line plans developed
- Reduced barriers to care, including transportation and financial barriers:
  - CAREShuttle utilization rates
  - Improved awareness and use of financial assistance programs

Other local organizations available to respond to this need

- Inyo County: https://www.inyocounty.us/
- Inyo County Aging Services: https://www.inyocounty.us/services/health-human-services/aging-social-services/aging-services
- Mammoth Hospital: https://mammothhospital.org/
- Southern Inyo Healthcare District: https://www.sihd.org/
- Renown Healthcare (Telehealth): https://www.renown.org/Health-Services/Telehealth
- Toiyabe Indian Health Project: https://www.toiyabe.us/

Mental Health

NIHD Services and Programs Committed to Respond to This Need

- NIHD conducts near-universal screening for prenatal and postnatal depression, with identified opportunities to strengthen follow-up care.
- NIHD Mental Health services include a licensed clinical social worker (LCSW) who provides psychotherapy remotely through the RHC.
- Primary care providers are skilled in addressing basic mental health needs and medication management.
- NIHD offers a Medication Assisted Treatment (MAT) program to address substance use disorder, supported by:
    - Substance use disorder (SUD) physicians
    - SUD nurse practitioner
    - SUD care coordinators
- Mental health crisis response is supported through a partnership with county mental health services.

Goals and Future Actions to Address this Significant Health Need

Goal: *Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.*

- Define a sustainable, community-based mental health care model that clarifies NIHD's role within a broader network of providers.
- Strengthen partnerships with community mental health organizations to improve continuity of care following screening or crisis events.
- Improve access to prescriber-level mental health services to address medication management needs.
- Increase coordination and awareness of available mental health and substance use resources across the community.

Impact of Actions and Access to Resources

- Partnerships and collaborations coordinated to increase access to mental healthcare
- Reduced suicide mortality rate in Inyo County

Mental Health

Other local organizations available to respond to this need

- Eastern Sierra Counseling: https://www.easternsierracounseling.com/
- Inyo County: https://www.inyocounty.us/
- Inyo County Sheriff: https://www.inyocounty.us/services/sheriff
- Mammoth Hospital: https://mammothhospital.org/
- Toiyabe Indian Health Project: https://www.toiyabe.us/
- Wild Iris Family Counseling & Crisis Center: https://wild-iris.org/

Care Coordination and Disease Management

NIHD Services and Programs Committed to Respond to This Need

- The Rural Health Clinic (RHC) provides primary healthcare services, including chronic disease management.
- Healthy Lifestyle Talks are conducted every month with speakers covering a variety of healthcare topics.
- NIHD participates in community events and provides education to raise awareness of chronic diseases.
- NIHD offers a variety of screening services, including cancer risk assessments, Breast MRI, mammography, and more.
- The dedicated Women's Health RHC offers comprehensive obstetrics and gynecology care across the lifespan, including prenatal and high-risk pregnancy care, family planning and contraceptive services, well-woman exams and preventive screenings, menopause support, and a full range of gynecologic surgical services.
- NIHD offers comprehensive maternity care, including prenatal care, childbirth education, labor and delivery services, and postpartum support.
- The Breast Health Center provides comprehensive services (prevention, detection, surgery, infusion, rehabilitation, nutrition services). NIHD offers a patient-centered 3D mammography system designed with women's comfort and imaging accuracy in mind, with features that reduce discomfort and improve early detection; evening "Moonlight Mammogram" appointments are also available to increase convenience and access.
- NIHD provides an Oncology Patient Navigator to help patients understand their care options, access available services, coordinate appointments, and connect with community resources.
- A partnership is in place with City of Hope to ensure local access to chemotherapy – initial visit at City of Hope followed by chemotherapy at NIHD.

Goals and Future Actions to Address this Significant Health Need

Goal: *Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.*

- Prioritize patient navigation as the core care coordination function across specialty service lines, supporting continuity from initial patient access through referrals, diagnostics, treatment, and follow-up care.
- Improve utilization of cancer care navigation services by increasing awareness and integration with clinical workflows.
- Partner with senior centers and community organizations to provide education on the healthcare journey, chronic disease management, and preventive care.
- Strengthen coordinated care for seniors by improving continuity in internal medicine and primary care, enhancing navigation of specialty services (including out-of-area care), and supporting care transitions across care settings.

Care Coordination and Disease Management

Impact of Actions and Access to Resources

- Increased number of preventative screenings (Cancer, Women's Health, etc.)
- Improved community education and awareness of prevention/wellness resources offered
- Enhanced support for seniors navigating multiple providers and services

Other local organizations available to respond to this need

- City of Hope (Partnership for Chemotherapy): https://www.cityofhope.org/
- Eastern Sierra Cancer Alliance (Financial Assistance for Cancer Patients Traveling for Care): https://escanceralliance.org/
- Inyo County Aging Services: https://www.inyocounty.us/services/health-human-services/aging-social-services/aging-services
- Inyo County: https://www.inyocounty.us/
- Inyo County Office of Education: https://www.inyocoe.org/
- Local Senior Centers

Appendix

Community Data Tables

Leading Cause of Death

The Leading Causes of Death are determined by the official Centers for Disease Control and Prevention (CDC) final death total. The Leading Causes of Death are listed in the tables below in U.S. rank order. Inyo County's mortality rates are compared to the California state average, and whether the death rate was notably higher (red), or lower (green) compared to the state average.

	Inyo	California	U.S.
Heart Disease	137.5	143.6	168.9
Cancer	130.1	131.9	145.4
Accidents	75.7	46.5	59.7
Chronic Lower Respiratory Disease	46.4	27.4	35.9
Cerebrovascular Diseases (Stroke)	32.3	40.1	39.8
Liver	28.2	14.3	13.1
Diabetes	18.5	24.6	23.9
Suicide	16.2	10.3	13.9
Pneumonia	11.2	11.1	10.7
Alzheimer's	10.2	38.8	30.8
Blood Poisoning (Septicemia)	10.1	4.0	10.0
Homicide	N/A	5.8	7.6
Kidney	N/A	10.3	13.4

Source: NIH: HDPulse, CDC (2019-2023)

County Health Rankings

	Inyo	California	US Overall
Length of Life			
Premature Death*	**10,431**	6,744	8,400
Life Expectancy*	**77**	78	77
Quality of Life			
Poor or Fair Health	**17%**	18%	17%
Poor Physical Health Days	**4.6**	3.9	3.9
Poor Mental Health Days	**5.7**	4.7	5.1
Low Birthweight*	**8%**	7%	8%
Health Behaviors			
Adult Smoking	**14%**	10%	13%
Adult Obesity	**30%**	28%	34%
Limited Access to Healthy Foods	**8%**	3%	6%
Physical Inactivity	**20%**	22%	23%
Access to Exercise Opportunities	**87%**	94%	84%
Excessive Drinking	**23%**	20%	19%
Alcohol-Impaired Driving Deaths	**28%**	26%	26%
Drug Overdose Deaths*	**50**	26	31
Sexually Transmitted Infections*	**262**	494	495
Teen Births *(per 1,000 females ages 15-19)*	**21**	12	16
Clinical Care			
Uninsured	**9%**	9%	10%
Primary Care Physicians (MDs & DOs)	**1459:1**	1233:1	1,330:1
Other Primary Care Providers (APPs)	**842:1**	1062:1	710:1
Dentists	**1248:1**	1076:1	1,360:1
Mental Health Providers	**183:1**	213:1	300:1
Preventable Hospital Stays*	**1,198**	2,257	2,666
Mammography Screening	**33%**	36%	44%
Flu Vaccinations	**39%**	44%	48%
Social & Economic Factors			
High School Completion	**93%**	85%	89%
Some College	**68%**	68%	68%
Unemployment	**4%**	5%	3.6%
Children in Poverty	**14%**	15%	16%
Children in Single-Parent Households	**30%**	22%	25%
Injury Deaths*	**99.2**	62.9	84
Child Care Cost Burden *(% of HHI used for childcare)*	**31%**	30%	28%
Child Care Centers *(per 1,000 under age 5)*	**13**	8	7
Physical Environment			
Severe Housing Problems	**17%**	26%	17%
Long Commute - Driving Alone *(> 30 min. commute)*	**19%**	41%	37%
Severe Housing Cost Burden *(50% or more of HHI)*	**11%**	20%	15%
Broadband Access	**83%**	93%	90%
Per 100,000 Population			

Key (Legend)
Better than CA Same as CA Worse than CA

Source: County Health Rankings 2025 Report

Data and Inputs

Data Limitations

Rural communities and those with low population sizes face several data limitations including but not limited to:

- Small sample sizes: small populations reduce the statistical power and do not capture the full diversity of the community
- Data privacy: to ensure the confidentiality of individuals in small communities, data may be aggregated or withheld
- Data gaps: some events may happen less frequently in small populations leading to limited data and gaps in time
- Resource constraints: rural areas often have less funding for data collection and access to data collection technologies
- Underrepresentation in national surveys: many national level data sources focus on urban areas due to the higher population making access to data in small communities more limited

This assessment is meant to capture the health status of the service area at a specific point in time, combining both qualitative data from the local community through survey collection and quantitative data from multiple sources where the county is available as the smallest unit of analysis.

Local Expert Groups

Survey Respondents self-identify themselves into any of the following representative classifications:

1) Public Health Official – Persons with special knowledge of or expertise in public health
2) Government Employee or Representative – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the Hospital
3) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
4) Community Resident – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations
5) Priority Population – Persons who identify as medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+
6) Healthcare Professional – Individuals who provide healthcare services or work in the healthcare field with an understanding / education on health services and needs.
7) Other (please specify)

Data Sources

Source	Data Element	Date Accessed	Data Date
County Health Rankings 2025 Report	Assessment of health needs of the county compared to all counties in the state; County demographic data	December 2025	2014-2023
NIH: HDPulse – CDC	Leading causes of death, median household income	December 2025	2019-2023
PLACES: Local Data for Better Health	County level health, socioeconomic, and environmental data	December 2025	2024
America's Health Rankings	National and State level data for health, environmental, and socioeconomic measures	January 2026	2022
American Community Survey, US Census Bureau	Social, economic, housing, and demographic information for States	December 2025	2024
NIH National Cancer Institute	State cancer profiles; incidence rates	December 2025	2017-2021
Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population	Health outcome measures and disparities in chronic diseases	January 2026	2022
American Diabetes Association	Type 2 diabetes risk factors	January 2026	2005
Centers for Disease Control and Prevention – CDC	Racial and ethnic disparities in heart disease	December 2025	2019
Healthy People 2030 – OASH	Social Determinants of Health	December 2025	n.d.
Center for Housing Policy	Impacts of affordable housing on health	December 2025	2015
Child Care Aware	Childcare costs	January 2026	2023
Health Affairs: Leigh, Du	Effects of low wages on health	December 2025	2022

Survey Results

Based on 381 survey responses gathered from Nov – Dec 2025.

Due to a high volume of survey responses, not all comments are provided in this report. All included comments are unedited and are contained in this report in the format they were received.

Q1: Your role in the community (select all that apply)

Answer Choices	Responses	
Community Member	82.06%	311
Healthcare Professional	27.18%	103
Government Employee or Representative	16.62%	63
Priority Population (medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+)	16.62%	63
Representative of Chronic Disease Group or Advocacy Organization	2.11%	8
Public Health Official	0.79%	3
	Answered	379
	Skipped	2

Q2: Race/ethnicity (select all that apply)

Answer Choices	Responses	
White or Caucasian	81.55%	305
Hispanic or Latino	9.63%	36
American Indian or Alaska Native	4.81%	18
Prefer not to answer	4.81%	18
Asian or Asian American	2.94%	11
Other (please specify)	0.80%	3
Black or African American	0.53%	2
Native Hawaiian or other Pacific Islander	0.53%	2
	Answered	374
	Skipped	7

Q3: Age group

Answer Choices	Responses	
65+	32.98%	125
55-64	18.73%	71
35-44	17.68%	67
45-54	16.36%	62
25-34	8.97%	34
18-24	2.64%	10
Prefer not to answer	2.64%	10
	Answered	379
	Skipped	2

Q4: What is your gender?

Answer Choices	Responses	
Woman	74.01%	279
Man	22.55%	85
Prefer not to say	2.65%	10
Non-binary / Gender non-conforming	0.53%	2
Prefer to self-describe:	0.27%	1
	Answered	377
	Skipped	4

Q5: Which town do you primarily live in?

Answer Choices	Responses	
Bishop	48.3%	184
West Bishop	15.7%	60
Big Pine	8.7%	33
Lone Pine	5.8%	22
Chalfant	3.7%	14
Independence	2.9%	11
Wilkerson	2.1%	8
Tecopa	2.1%	8
Olancha	1.6%	6
Mesa	1.3%	5
Mammoth Lakes	1.3%	5
Other (Less Than 5 Each)	6.6%	25
	Answered	379
	Skipped	2

Q6: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community? (please select your top 3 responses)

Answer Choices	Responses	
Older adults (65+)	54.44%	196
Individuals requiring specialized healthcare support	54.44%	196
Low-income groups	51.94%	187
Uninsured and underinsured individuals	40.56%	146
Unhoused	28.06%	101
Women	18.33%	66
Racial and ethnic minority groups	17.22%	62
Undocumented immigrant / migrant / resident	16.67%	60
Children/Adolescents	11.39%	41
LGBTQ+	6.11%	22
Men	4.72%	17
	Answered	360
	Skipped	21

What do you believe to be some of the specific needs of the groups selected above?

- Transportation
- More specialist for the area, older patients can not travel out of town.
- Food insecurity for children
- Dental care for low income
- Drug/mental health interventions
- Transportation fear of doctors health care cost
- Long term care , to many have to go out of town for medical
- Access to specialties, such as neurology, dermatology and gastrointestinal specialists. Without those travel of between 150 and 200 miles is required to get the healthcare.
- Mental health care access.
- Local access to specialty providers, fewer wait times to get a specialty appointment, and access to low/no cost routine care for the uninsured and underinsured.
- Telehealth and support for those that need specialized healthcare. Billing and financial help.
- Poor health due to poor nutrition and access to care.
- Aging, women's health, diabetes, heart disease, mobility issues and nutrition issues.
- Being able to afford healthcare-doctor visits, medications, insurance premiums, etc
- Age related illnesses and problems.
- Racially I am worried about stigma towards Latino and Native folks in town, and biases towards them.
- Options for elder care.

- Access to specialists for specific issues such as heart, rehab,cancer.
- Costs of Healthcare here, cash-pay, are very high. Creates a barrier for patients.
- Avoiding care because of cost, financially burdened by medical bills
- Access to care, learning how to apply for insurance, navigating insurance and out of town appointments, transportation to appts in Bishop and out of town, inability to pay for medications. Very limited mental health care that is affordable- both counseling and psychiatry.
- Either home hospice support or a hospice facility. Home support would allow old folks to die in their home with a little help from other community members.
- Lack of specialists, lack of senior care, poor home health services
- Low understanding of available resources
- In some cases fear of official contact for the Migrant community
- Transportation for areas without public transit options (Thank goodness for Care shuttle!!!)
- Gerontology, home health care and assisted living health care (that's not a nursing home!)"
- Affordable care. Easier access to specialists.
- In general, there are no programs targeted towards men. This should be changed.
- Cardiology, oncology, dermatology, and orthopedic localized help is needed as long distance travel, particularly finding driving help, is very difficult for elderly population.
- Not having much specialty care- oncology, cardiology, dermatology.
- ACCESS! Medi-Cal patients have to drive 3-4 hours each way to get health care in Bishop or Ridgecrest. Specialized care is only available across state lines (Las Vegas) or out of the county.
- Undocumented are cash clients which serves as a barrier unless there are specific programs targeting the population. Fear factor. Lack of outreach to population to inform of services and payment options. At one time there was an outreach program helping the uninsured and/or underinsured to enroll in a health plan. It is all on-line now which can function as a barrier.
- Transportation is important. The Care Shuttle isn't enough.
- Residents here who rely on state insurance (Medical) cannot access health care unless they drive at least two hours to Barstow, in another county, or four or five hours to Lone Pine or Bishop.
- More providers who partner with the VA so that local veterans can utilize a wider network of healthcare providers and have options to receive more specialized care.
- Healthcare in general for the unhoused and uninsured, specialized healthcare access for the elderly.
- Language barrier, lack of cultural competency amongst providers, lack of diversity within providers to reflect the population you serve, lack of support with applying for health insurance, specialized care not being available in the area.
- Lack of specialty medicine and lack of low income services. Also, the wait time to get appointments at Rural Health.

- Lack of access to care, long wait times to even get in to see a Dr. waiting months for an initial appointment.
- Specialized care out of our area, cost of transport, overnight stays.
- Access to primary doctor's is limited because there are not enough of them
- No insurance, no regular access to health care providers, difficult social circumstances such as substance use disorders, lack of family/community support, geographical isolation, lack of transportation
- Permanent, on-staff healthcare specialists (doctors and RNs) needed. Home healthcare. Long-term healthcare. Affordable medications. Healthcare history data sharing with other out-of-the-area hospitals and specialists.
- Mental health, general elder care, obesity, diabetes, overall wellness
- Older adults may need more specialty doctors. Uninsured may not have the money to cover the bill.
- Technologically challenged people such as the elderly or people who cannot afford iPhones or other smart phones
- Specialists - Gastroenterologists, Cardiologists, Optometrists, Periodontists
- Money and time off work for healthcare and wellness
- Our Native American population seem to have inconsistent follow up despite Toiyabe being present
- More robust access to specialty clinics; more providers to select from.
- No urgent care in northern inyo
- Limited options for treatment- long waiting periods for preventive care
- Options for elder care.
- PPOs also are an issue. Limited providers if any
- Lack of specialized care or any care for low incomes, elderly. Lack of mental health care.
- Access to affordable healthcare
- Primary care, regular check ups, medications
- People without insurance don't get preventative care
- Better prevention and education. Especially from a young age.
- Not enough Women's clinic providers for the region.
- People living in rural areas self-pay. Health costs are expensive.
- Limited providers for marketplace insurance plans. Still necessary to travel for most specialty procedures, diagnostics, etc
- Having the means to make appointments, access transportation, have a call back number, access the patient portal, pay for care
- Chronic health conditions
- Abortion care and specialized care as well as bias in medicine.
- Lack of Affordable housing
- Lack of Spanish language providers

Q7: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Mental Health	1	8	34	54	227	324	4.54
Geriatric / Elder Care	0	3	27	103	198	331	4.50
Cancer	1	8	31	91	196	327	4.45
Women's Health	0	3	62	92	161	318	4.29
Heart Disease	2	8	60	106	151	327	4.21
Substance Use Disorder	6	17	57	88	155	323	4.14
Diabetes	5	6	72	100	139	322	4.12
Stroke	3	9	67	110	131	320	4.12
Children/Adolescent Health	4	20	69	78	150	321	4.09
Alzheimer's and Dementia	3	16	61	121	128	329	4.08
Dental	3	21	71	93	132	320	4.03
Kidney Disease	3	13	87	109	112	324	3.97
Lung Disease	3	17	83	109	111	323	3.95
Obesity	6	18	85	100	115	324	3.93
Liver Disease	5	21	92	97	106	321	3.87
Men's Health	5	15	101	100	99	320	3.85
Other (please specify)						20	
						Answered	331
						Skipped	50

Other:

- Gun safety , suicide prevention
- Eye care (Opthalmology), Neurology, Gastrointestinal
- Gender-affirming care
- No psychiatrist in the area at all
- Ophthalmology
- Lack of access to medical and surgical abortions for women which is a shame.
- The heat here is dangerous 4 months every year. We need a 24 hour place of refuge with generator and cots. Some of us need to get horizontal a lot. And we need to do it where we can get cooled off. Closing the cooling center at 4pm, the hottest time, is no good.

- Every health factor would be improved if people knew about the newer nutrition research.
- Wound Care
- Wound care
- LBGTQ+, Native and cultural emphasis
- Eye care
- What do you need to provide is readily accessible, affordable General health and or preventive healthcare, which is primarily advice and may involve specific treatment. You can head off 80 to 85% of high cost chronic disease through timely education and prevention.
- Eye health
- All of these are important
- Optometry
- Menopausal health very important.
- Hearing aids
- Internal Medicine

Q8: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Healthcare: Affordability	2	4	28	62	232	328	4.58
Healthcare: Access to Specialty Care	0	2	31	77	221	331	4.56
Cost of Health Insurance	2	9	33	65	221	330	4.50
Affordable Housing	7	9	32	73	206	327	4.41
Healthcare: Access to Primary Care	3	10	43	76	198	330	4.38
Access to Senior Services / Elder Care	1	5	43	107	175	331	4.36
Healthcare: Location of Services	6	9	51	82	183	331	4.29
Access to Affordable Food	6	16	50	80	178	330	4.24
Healthcare: Prevention Services	1	11	69	91	156	328	4.19
Access to Home Health	2	16	74	95	144	331	4.10
Employment and Income	6	8	82	83	148	327	4.10
Access to Childcare	7	21	69	78	151	326	4.06
Education System	13	12	73	77	149	324	4.04
Transportation	9	18	85	103	112	327	3.89
Community Safety	19	33	73	75	125	325	3.78
Social Connections	15	32	100	102	75	324	3.59
Access to Internet / Broadband	19	40	88	93	87	327	3.58
Access to Exercise/Recreation	30	50	100	69	79	328	3.36
Other (please specify)						17	
						Answered	332
						Skipped	49

Other:

- Low barrier care
- Sense of committee. Music, parades, plays, environmental awareness
- Transportation is low as I know there are vans and volunteer drivers moving people around already, which is good.
- Hospice program.

- Please continue food assistance. Access to telephone-There is no cellular connection here and pay phones often are not working! A simple fall outside wifi can be deadly!
- Re healthcare: Scarcely any healthcare professionals know about the nutrition research of the past 50 years. They all make money from people being sick. They'd make less money if people had the knowledge to eat healthfully.
- Trilingual services
- If you do not want to go outside and exercise that is your decision. No one can force you, and we don't need money going towards persuading people to get outside. Affordable food should also actually be healthy. Access to childcare is important, but providing better support through employers to allow parents to spend more time with their kids and maintain a career is more important. More time allowance for paternity and maternity leave would make a huge difference.
- Cardiology is essential
- Until you have completely fulfilled, the needs for basic routine and or preventative healthcare you have no business spending money on specialist or high cost healthcare professionals, and expensive testing. The vast majority of a community healthcare needs require easy access whether that involves brick and mortar or telehealth, Followed by consistent provider messaging, and affordability of treatment options.
- Access to transportation is hard to find
- I have concerns about seniors who no longer have a license and little support getting food and medical care
- All issues are important
- Access to & *Consistency of* Mental Health Providers
- Access to pet boarding for single individuals who must travel for healthcare services. Providing chemotherapy for cancer patients.

Q9: Please rate the importance of addressing each behavioral factor in your community on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Illegal Drug Use	6	15	70	82	155	328	4.11
Alcohol Use/Excess Drinking	3	20	78	86	140	327	4.04
Nutrition and Diet	3	16	79	106	124	328	4.01
Vaping Use	18	27	76	84	117	322	3.79
Physical Inactivity	5	34	94	97	99	329	3.76
Smoking/Tobacco Use	16	27	105	84	93	325	3.65
Risky Sexual Behavior	24	38	108	74	77	321	3.44
Marijuana Use	49	54	93	64	61	321	3.11
Other (please specify)						8	
						Answered Skipped	331 50

Other:

- Environmental appreciation and stewardship
- Teen sexual behavior. Drug and alcohol use during pregnancy. Child sexual abuse.
- Judicial reform
- These are active choices made by individuals. You can try to educate, but you cannot force someone to change their lifestyle choices. Proper parenting is what our society needs to address these issues.
- You can provide a vast array of less expensive care if it is mobile, telehealth, nurse practitioner, or PA based, and focuses on basic healthcare needs rather than high cost specialist options for small number of people with specialty needs. A tremendous amount of basic healthcare can be provided by low cost, but highly motivated healthcare professionals and does not require direct MD evaluation every single time. High cost medications, high cost, testing, and high cost specialist evaluation is appropriate sometimes, but not at the cost of providing basic broad spectrum easily accessible low cost options.

- I would say most of these services should be targeted for our youth as preventive care - addressing these issues for adults should involve a component of individual responsibility
- Many of these subjects are already targeted through PH or tribal resources. Will you partner with their existing programs? How?
- NIHD needs to update their website

Q10: Please provide feedback on any actions you've seen taken by NIHD and SIHD Community Hospital to address the significant health needs in your community and what additional actions you would like to see.

- Additional needs include reducing the cost to individuals to receive services. Cost continue to rise at a rate far above the cost of living even with health insurance.
- Potentially provide more options for payment plans as people do want to pay their bills.
- We need a psychiatrist and mental health access priority number one
- There is no Nutrition education for diabetic patients, and no Endocrinologist here in Inyo or Mono County.
- Chronic disease management needs are more in outreach and making sure patients are getting the maintenance they need.
- Monthly blood pressure checks or other health monitoring services might benefit the community.
- Patients don't follow up as they should and could benefit from 'nagging.
- I would like to hear that the primary care providers are being more assertive/aggressive about follow-up and multi-system care for patients with diabetes and other chronic diseases.
- The hospital shuttle service is a life saver too bad they don't go to Lone Pine any more.
- They should have a person to teach diabetes classes.
- The addition of a robust cardiology program has been well received and very impactful for our community. The telehealth neurology services are also incredible, but outpatient options are still lacking. Full time urology service is incredible.
- Better transportation options for community's far from Bishop
- We travel to Bishop at least one time a week for medical services and this is becoming more challenging as we age
- The mental health options are lacking greatly. Far too many patient per mental health worker.
- We still don't have sufficient mental health services, and the hospital doesn't have a single Psychiatrist that sees patients in our community
- Affordable healthcare is a national issue… the system will remain broken and unaffordable for many classes of people.
- Behavioral health is still lacking severely in our community and is made up with patchwork that is mostly missing
- I would like to see a bed for people experiencing a mental health or substance abuse crisis
- On the topic of behavioral health, please make your psychiatric nurse available without a referral
- I LOVE the women's clinic
- Work with healthcare providers to ensure more in-network providers are available locally, within Inyo County.

- Moonlight mammograms are great - I appreciate the emphasis on women's healthcare
- Need: Neurologist, Ophthalmologist, Gastroenterologist if we don't have a visiting one
- I really appreciate that NIHD provides the Care Shuttle
- Better specialty needs available locally. Bishop or Mammoth, instead of Gardnerville to Sparks
- Having health specialists locally is a must. Having to drive to Reno or Southern California to see a specialist
- More specialized services available at certain times. Need more availability than 1x per month
- Please get a good endocrinologist. Virtual care just lost theirs
- Need a local cardiologist and other specialties. Need gynecologist to replace dr. Arndal since she left
- Thanks for brining cardiology, urology, breast surgeon, continued ortho care. Need dermatology and ENT
- I think access to chronic heart disease management is better with the Cardiology Tream from Reno (Dr. Rowan, Natalie).
- Memory care services for those with Alzheimer's and other mental illnesses that prevent self care
- It would help with making it more manageable to pay bills if they were more timely.
- The hospital needs to get their billing in check. Wrong billing double billing. It's out of control.
- Not consistent enough, too many providers coming and going
- Medical needs of all vary, not all care is available in this community. The cost of healthcare at Northern Inyo is extremely high and unaffordable.
- Tele-health options help a lot and are a lifeline in our remote area
- We have lost an OB so women's health and maternal/fetal health is less well-served now
- The OB/GYN clinic is in a trailer and is the only OB in Bishop available
- Home health care is very limited
- There needs to be more DO/MDs at the RHC for our patients that have complex health issues
- Senior living that is NOT BCC
- As we age, access to local care becomes more critical
- A new building for all the clinics at the hospital
- I have not seen any action by NIHD
- We need ophthalmology!
- There needs to be better outreach to the community
- The efforts to recruit new providers have definitely been noticed, but we need to RETAIN them as well.
- Desperately need a nurse practitioner that can prescribe meds for mentally ill people.

- There are many specialists now available through Northern Inyo without having to travel out of the area. This is way better than it used to be.
- Mental health is chronically underfunded and overwhelmed. NIHD should try for more providers and creative ways to pay/reimburse for services.
- Transportation to and from appointments and home from ER visit, helpful
- I appreciate the expanded lab services at Southern Inyo, although it seems to be shrinking again. Can't get an echo cardio gram in lone pine like we could 6 months ago.
- NIHD continually works toward improving access to healthcare for everyone.More assistance with mental health. I believe a lot of people are depressed and need help, especially since Covid.
- I would like to see more focus on chronic and invisible illnesses in our community.
- I would like to see SIH, NIH, and Mammoth Hospital team up as one entity to help with flow and care throughout of valley
- I like the service that the Rural Clinic provides.
- Veterans need more local options in healthcare providers who partner with the VA.
- Improve strategic communications and marketing so that the community is aware of actions taken and resources/services available
- I'd suggest health education classes, programs, etc. Would be nice to see real community classes. The one's I've seen seem scripted, lacking knowledge and not always a topic of interest for our population.
- Neither Inyo nor Mono County have been able to provide consistent access to local on-site chemotherapy and chronic disease management
- Good efforts on MAT, would like to see that work continue with supportive counseling services.
- The access to orthopedic services was a critical step forward, one which helps many elderly patients in the area and helped cover a critical need for the southern county patients. Access to nephrology could be a progressive step also with the number of diabetic patients in the area, understanding that preventing CKD from progressing to ESRD.
- Care Shuttle, Urgent Care at Rural Health clinic, NIH education/lectures & podcasts
- I've seen breast cancer screening.I would like to see periodic community health screenings for various health issues (blood pressure, stoke, etc.) like we've had in the past
- It would greatly benefit our community to have access to all healthcare needs and all specialized services. The lack of local access to such a wide range of services is extremely disappointing.
- I would like an urgent care or a way to get care without a pcp
- Team with local libraries, schools, pharmacies, and other local health and well being providers to have more community education/outreach events
- Senior care, eye care, dental care, overall care to not travel out of town more than an hour for care
- Improve access to surgical services

Q11: Social drivers of health (SDoH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social drivers that negatively impact the health of you or your community (select all that apply):

Answer Choices	Responses	
Affordable housing or available housing	73.58%	220
Limited access to healthcare services	59.87%	179
Lack of affordable childcare	43.81%	131
Poverty	41.47%	124
Social isolation	35.45%	106
Unemployment or unstable employment	32.44%	97
Racial and cultural disparities	32.11%	96
Lack of transportation	31.77%	95
Limited access to healthy food	30.10%	90
Limited access to quality education	24.41%	73
Public safety concerns	13.71%	41
Limited access to broadband / internet	13.04%	39
Limited access to utility services	8.70%	26
Other (please specify)	8.03%	24
	Answered	299
	Skipped	82

Comments:

- Extremely poor access to BH care
- Many live in rv or trailers. Rent in many places are going out of range.
- Open and supportive Cooperation verses territorial boundaries
- High cost of living
- None of these personally affect me but I think all of them affect the community
- Lack of knowledge about nutrition.
- Lack of self preservation
- Unacceptable High costs of health care in our area
- Specialized healthcare for elders is lacking
- Lack of medical specialist

- Even those who have stable careers can't afford the rent here. Landlords seem to want to charge top dollar for properties that have questionable conditions. Prices of homes are not reflective of what average annual incomes are.
- Limited access to affordable shopping, food and other necessities.
- Lack of women's healthcare services
- None of the above
- Extreme negativity on Facebook accounts from local community
- Today's world is extremely hard for elderly especially in rural areas.mosr can navigate modern technology which further hinders access to many things including shopping and Healthcare communication.until Marshall's recent opening, I have had to assist elderly order online for many basic needs.
- My Mother is 75 and never learned how to use a computer or had a smart phone. It would be nice if there were classes to help people learn those skills.
- "Party culture"/multi-generational substance availability and use
- Small gene pool that is disassociated from real world environments.
- LGBTQIA equality
- Lack of help and care for elderly, especially families with Alzheimer’s patients. Medicare doesn’t cover home health and families are worn out even with some home health care which is expensive.
- All of the above affect negatively, but many drivers are due to making poor personal choices in life, ie becoming addicted to drugs/alcohol.
- Low wages

Q12: What barriers keep you or anyone in your household from receiving local healthcare services? (select all that apply)

Answer Choices	Responses	
Limited availability of services or specialties	71.63%	207
Difficulty getting an appointment (long wait times)	49.48%	143
High cost of services	42.21%	122
Billing issues or lack of clarity in billing statements	31.14%	90
Unhappy with previous experience with providers or staff	26.64%	77
Out-of-network for insurance plans	24.57%	71
Poor communication from providers or staff	20.42%	59
Facilities are too far from home	20.42%	59
Perception of low-quality care	19.72%	57
Limited access to telehealth options	19.72%	57
Limited facility hours (inconvenient for working individuals)	17.65%	51
Underinsured/no insurance	15.22%	44
Not aware of the local healthcare services or programs	13.15%	38
Other (please specify)	9.34%	27
Language or cultural barriers	5.19%	15
	Answered	289
	Skipped	92

Comments

- Out of area providers getting current medical records
- Mammoth Hospital is close, easier to deal with and much less drama, staff seems happier there and less stressed
- Lack of ophthalmology, lack of orthopedic care, lack of psychological/psychiatric care
- "Circuit" doctors have always brought their specialty services to the valley, but sometimes one day a month isn't enough. That's improving, though.
- There are no local health care services.
- It's impossible to get a healthful meal in any local restaurant.
- High deductible insurance and high out of pocket cost
- I receive all my healthcare locally.
- Gastroenterology, specifically safe, well done surgery, is an ongoing concern
- Needing to travel several hours away for health care requiring one or more nights in a hotel.

- Transportation
- Specialists are out of the area - I realize that this is part of the nature of living in remote areas and I try to explain this to patients.
- I had ONE bad experience with a local specialist and have decided to go out of town for that issue alone, I will never try again here even if he were to be replaced. However, that one experience counts for a small percentage of my overall health picture; "the rest" I do handle locally and have been VERY happy with the generalists who have chosen long-term practice here!!!
- None
- No barriers
- It's impossible to predict how much I'll owe before going to an appointment. Foe a pcp they say 0-550$… and I can't take the risk
- No barriers
- No barriers for us.
- Limited availability of healthcare for Alzheimer's patients and lack of insurance coverage specifically for that.
- No long Covid clinic
- No money no healthcare
- No significant barriers for my household
- Privacy - employees discuss patient information outside of work
- Specialty care

Q13: What additional services / offerings would you like to see available locally? (select all that apply)

Answer Choices	Responses	
Behavioral / Mental Health	55.30%	167
Cancer Care	53.31%	161
Ophthalmology (Eye - Medical Treatment / Surgery)	51.32%	155
Geriatric Care (Elder Care, Home Health, Hospice)	46.36%	140
Optometry (Eye - Vision Screening)	46.03%	139
Urgent Care / Walk-In / Extended Hours	46.03%	139
Dental Care (teeth)	44.04%	133
Dermatology (Skin)	41.72%	126
Cardiology (Heart)	40.07%	121
Gastroenterology (Digestive System/Stomach)	37.42%	113
Women's Health	34.44%	104
Endocrinology (Hormone and Diabetes)	32.78%	99
Primary Care (Family Medicine)	32.45%	98
Rheumatology (Arthritis and Autoimmune Disease)	31.79%	96
Neurology (Brain and Nervous System)	29.80%	90
Audiology (Hearing Specialist)	29.47%	89
Telehealth / Virtual Care	29.47%	89
Orthopedics (Bone and Joint)	29.14%	88
Pulmonology (Lung and Breathing)	26.16%	79
Rehab Services (Physical Therapy, Occupational Therapy, Speech Therapy)	26.16%	79
Substance Use Disorder Treatment	25.83%	78
Health Prevention / Education Programs	22.52%	68
Urology (Urinary System and Male Reproductive)	22.19%	67
General Surgery	21.85%	66
Pediatrics (Children's Doctor)	19.54%	59
Reproductive Health	18.87%	57
Nephrology (Kidney)	17.88%	54
Dialysis	15.23%	46
Infusion	15.23%	46
Bariatric (Weight Loss)	14.90%	45
Other (please specify)	9.60%	29
Plastic Surgery (Reparative/Reconstructive)	9.27%	28
	Answered	302
	Skipped	79

Comments

- Geriatric specialist
- Ear, Nose & Throat specialist. Doctor of Dermatology.
- Inpatient detox for substance abuse

- Access to abortions.
- Most of us get healthcare in Pahrump NV and even there we have a shortage of doctors and most kinds of specialty offices. Hospice home care is most needed. Someone visiting maybe weekly with support from locals as caregivers.
- It seems to me that all of those specialties are available locally, if only on a limited basis.
- Mental health
- Healthful food served in the Senior Center. Honest up-to-date nutrition available to everyone.
- In home support for elders who have private insurance and/or Medicare parts A and B but who cannot afford it
- It seems like there are no Residential Communities For the Elderly (RCFE) in Bishop. Which also means there is very little to now options for Veterans who need assisted living. Why does our community not have group homes for the elderly?
- Pain Management
- Most needed is Urgent Care. There is nothing between the clinic and the emergency room
- Local services need to partner together better! The community needs to get senior living facility (assisted living). Inyo is regressing in resources instead of progressing! We can do better!
- Pain management
- I think the recent loss of local Ortho at NIH with dedicated providers at NIh is a huge loss. I do love Mammoth Ortho and certainly hope this works for the health financially of NIH. Last time this was tried, it did not work well for the NIH health district.
- I forgot to say on a previous question that NIH's addition of Sevaro neurology evaluations seems great!
- Pediatric specialists
- A lab
- ENT, Functional Medicine with IV therapy, Accupuncture
- Massage therapist that takes insurance - to go along with physical therapy treatments
- ENT
- Is it possible for patients with orthopedic issues to be sent to Mammoth rather than flown to Reno? Or possible to be flown south instead of to Reno? Expensive for family and lots of red tape if patient dies in Nevada.
- Menopausal health
- Orthopedic surgeon using robotics

Q14: Where do you typically get most of your health information (advice about managing health conditions, wellness tips, information about treatment options, recommendations for preventive care)? (select all that apply)

Answer Choices	Responses	
Doctor/Healthcare Provider	80.46%	243
Websites/Internet (Google, WebMD, Mayo Clinic)	57.95%	175
Hospital or Clinic	42.05%	127
Family or Friends	28.81%	87
Public Health Agencies (Local Health Department, CDC, etc.)	22.19%	67
Word of Mouth	16.56%	50
Social Media (Facebook, Twitter / X, Instagram, TikTok)	12.25%	37
Newspaper/Magazine (Online Publications)	11.59%	35
Workplace	10.93%	33
Podcasts/YouTube Videos	10.60%	32
AI Platform (ChatGPT)	8.61%	26
Other (please specify)	6.29%	19
School/College	5.63%	17
Newspaper/Magazine (Print Publications)	3.64%	11
Television	2.32%	7
Radio	1.66%	5
	Answered	302
	Skipped	79

Comments:

- Workplace sponsored health programs
- Pharmacist, including the info that comes on the bottle.
- Vetted Substack blogs
- I am a nurse
- Cleveland clinic
- Books
- Integrative nutritionists, specialists who do not follow the mainstream healthcare recommendations. i.e. who use alternative methods for treatment that have been proven successful for many generations.

- Healthcare training, physician resources, and scientific studies
- UpToDate
- Independent research
- I am a provider so I have a bit more expertise in finding out answers
- Due to multiple past incidents, I admit to having developed a considerable amount of suspicion around the "usual sources" of information (especially government, inept/inadequately informed providers, and those whose attitudes are not conducive to an acceptable level of patient "care".
- CME
- I am a healthcare provider
- Medical journals

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Quality Committee Charter		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 02/02/2026	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

Board of Directors Bylaws: Quality Committee

1. The Quality Committee shall consist of two members of the Board of Directors and one alternate, appointed yearly by the Board Chair.
2. The function of the Quality Committee is to advise the Board of Directors on quality-related governance matters.
3. The Quality Committee shall meet quarterly or as needed.
4. Quality Committee meetings shall be conducted according to the Brown Act. The general public, patients, their families and friends, Medical Staff, and District staff are always welcome to attend and provide input.

COMMITTEE PURPOSE

The purpose of the Quality Committee is to guide and assist the Governing Board in its responsibility to provide oversight of quality care and patient safety. The Committee supports the Board by reviewing quality-related performance information and standards and by making recommendations to ensure alignment with applicable healthcare quality and safety requirements.

COMMITTEE RESPONSIBILITIES

The Quality Committee is responsible for providing Board-level oversight of quality of care and patient safety. In support of this role, the Committee shall:

1. Review quality and patient safety performance reports, trends, and key indicators
2. Review quality improvement initiatives and outcomes
3. Review patient safety events and improvement actions at a summary level
4. Review quality-related plans, programs, and policies requiring governing body oversight
5. Review quality dashboards and performance metrics
6. Make recommendations to the Board regarding quality priorities and performance improvement focus areas

FREQUENCY REVIEW/REVISION

1. The Quality Committee shall review the Charter biennially, or more often if required. If revisions are needed, they will be taken to the Board for action.

Supersedes: v.1 Compliance, Quality, Safety, and Risk Committee Charter

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Quality Committee Charter		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 02/02/2026	Last Review Date: No Review Date	Version: 2
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4. Quality Committee meetings shall be conducted according to the Brown Act. The general public, patients, their families and friends, Medical Staff, and District staff are always welcome to attend and provide input.

COMMITTEE PURPOSE

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

The purpose of the Quality Committee is to guide and assist the Governing Board in its responsibility to provide oversight of quality care and patient safety. The Committee supports the Board by reviewing quality-related performance information and standards and by making recommendations to ensure alignment with applicable healthcare quality and safety requirements.

COMMITTEE RESPONSIBILITIES

The Quality Committee is responsible for providing Board-level oversight of quality of care and patient safety. In support of this role, the Committee shall:

1. Review quality and patient safety performance reports, trends, and key indicators
2. Review quality improvement initiatives and outcomes
3. Review patient safety events and improvement actions at a summary level
4. Review quality-related plans, programs, and policies requiring governing body oversight
5. Review quality dashboards and performance metrics
6. Make recommendations to the Board regarding quality priorities and performance improvement focus areas

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

~~COMMITTEE GOALS~~

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

~~COMMITTEE MEMBERSHIP~~

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

~~FREQUENCY OF MEETINGS~~

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

~~PUBLIC PARTICIPATION~~

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

FREQUENCY REVIEW/REVISION

1. The Quality Committee shall review the Charter biennially, or more often if required. If revisions are needed, they will be taken to the Board for action.

1. ~~The CQSRC shall review the Charter biennially and as needed.~~

2. Revisions will be reviewed at CQSRC and a recommendation will be presented to the full Northern Inyo Healthcare District Board of Directors for approval.

RETENTION AND DESTRUCTION OF RECORDS

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

REFERENCES

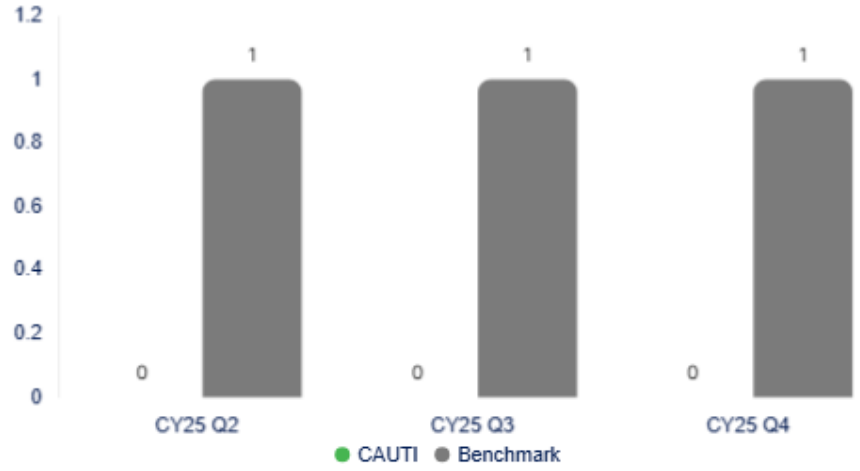
1. The Joint Commission 2025. Critical Access Hospital. MS.07.01.01.
2. The Joint Commission (2024), IC.04.01.01.
3. The Joint Commission (2024) IC .06.01.01
4. The Joint Commission. (2024). MM.09.01.01
5. Centers for Medicare & Medicaid Services. (2022). Infection Prevention and Control and Antibiotic Stewardship Program Interpretive Guidance Update. Retrieved from
6. California Department of Public Health (CDPH). (2024). Healthcare-Associated Infections HAI Program: Antimicrobial Resistance (AR). Retrieved from
7. California Department of Public Health (CDPH). (2020). Healthcare-Associated Infections HAI Program. HAI Reporting Guidance for California Hospitals. Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CA_SpecificReportingGuidelines.aspx
8. General Compliance Program Guidance 2023. Retrieved from
9. The Joint Commission 2025. Critical Access Hospital. IM.02.01.03.
10. The Joint Commission 2025. Critical Access Hospital. LD.01.03.01
11. The Joint Commission 2025. Critical Access Hospital. LD.07.01.01.
12. The Joint Commission 2025. Critical Access Hospital. LD.03.01.01.
13. The Joint Commission 2025. Critical Access Hospital. LD.04.01.01.
14. The Joint Commission 2025. Critical Access Hospital. EC.01.01.01.

Supersedes: v.1 Compliance, Quality, Safety, and Risk Committee Charter

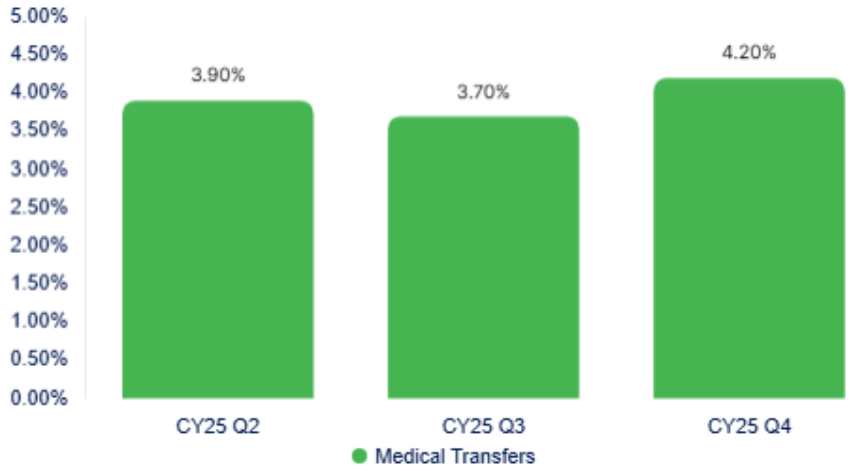
NIHD Quality Committee Dashboard

Central Line-Associated Bloodstream Infect <

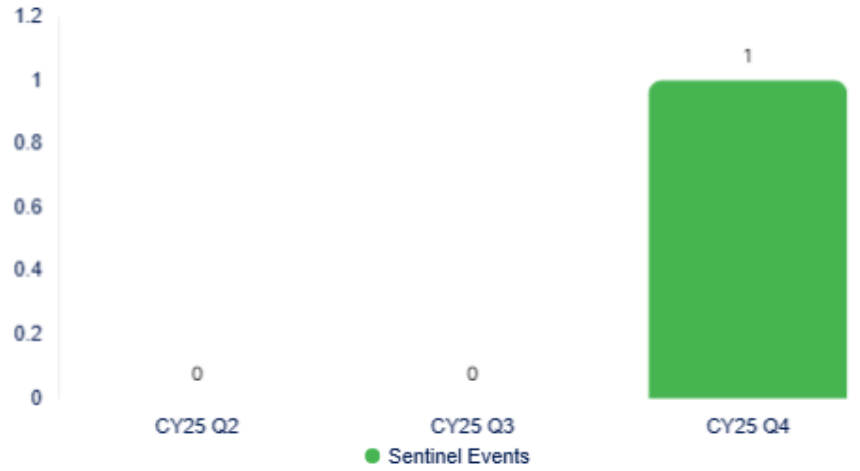
Catheter-Associated Urinary Tract Infection <



Medical Transfer Rate

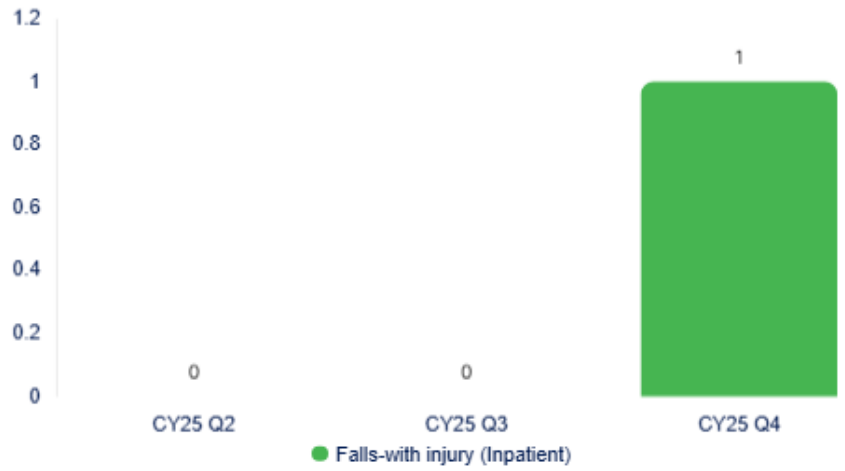


Sentinel Events <

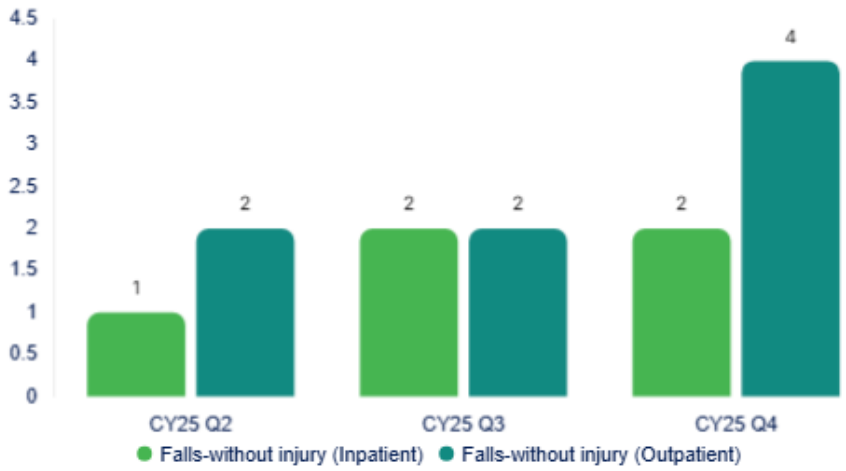


"<" means lower is better

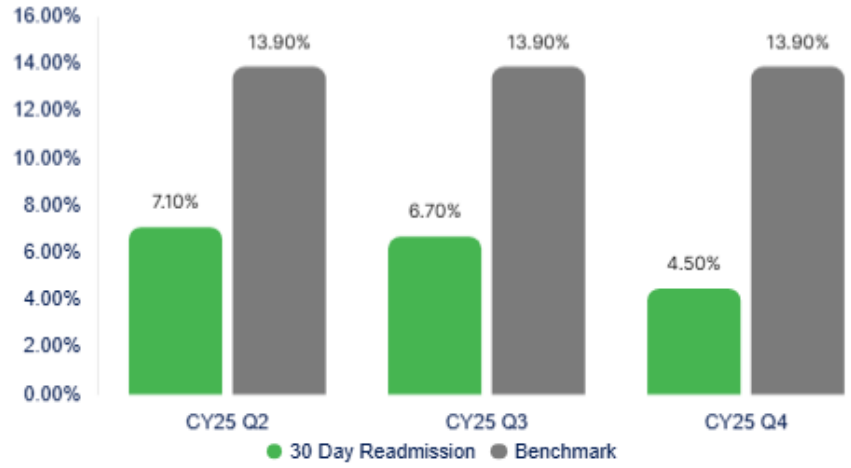
Patient Falls- With Injury <



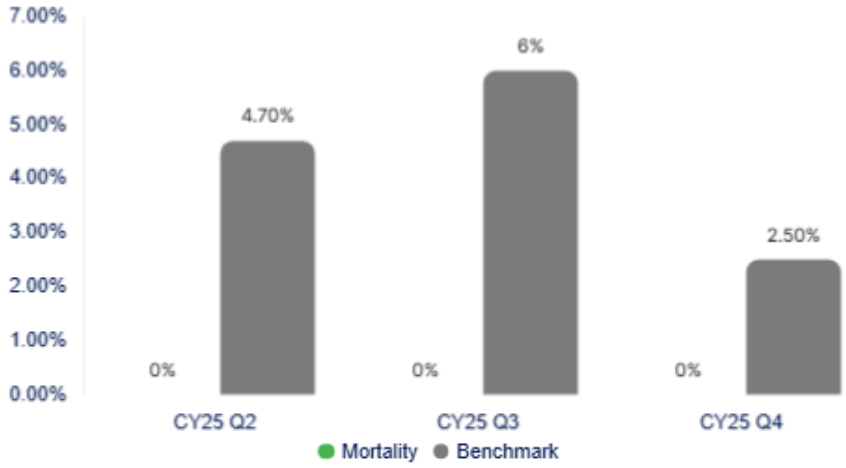
Patient Falls- Without Injury <



30 Day Readmission <

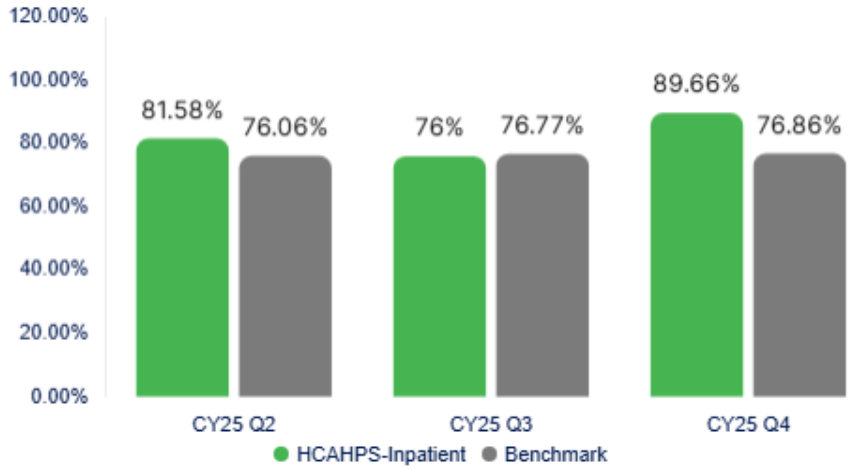


Mortality <

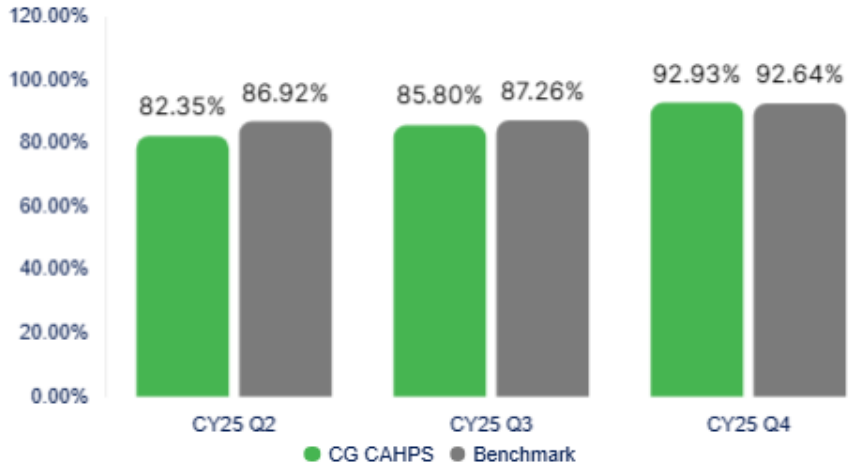


"<" means lower is better

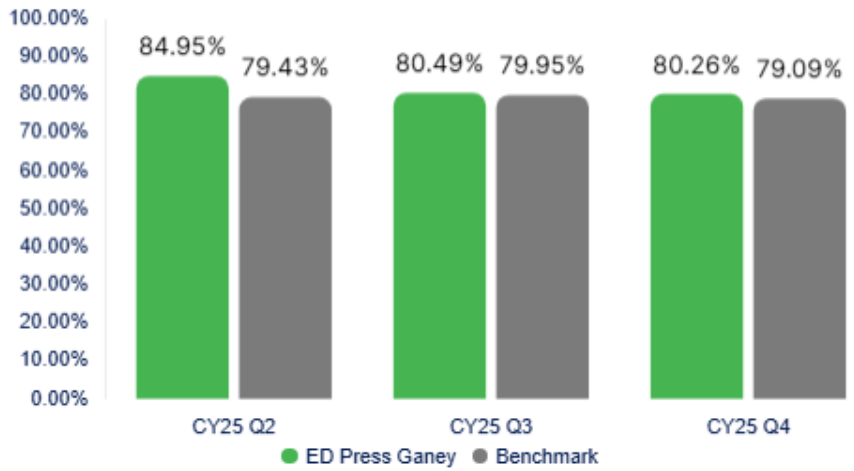
Likelihood to Recommend Top Box Score (Inpatient)



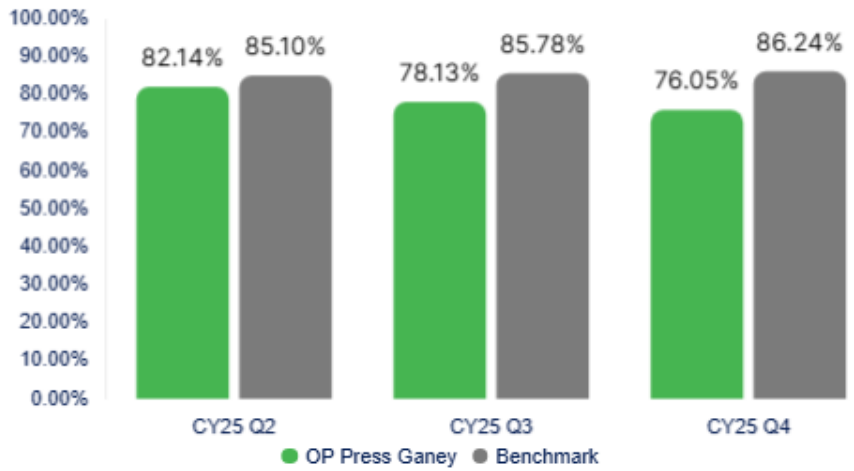
Likelihood to Recommend Top Box Score (Clinic)



Likelihood to Recommend Top Box Score (ED)

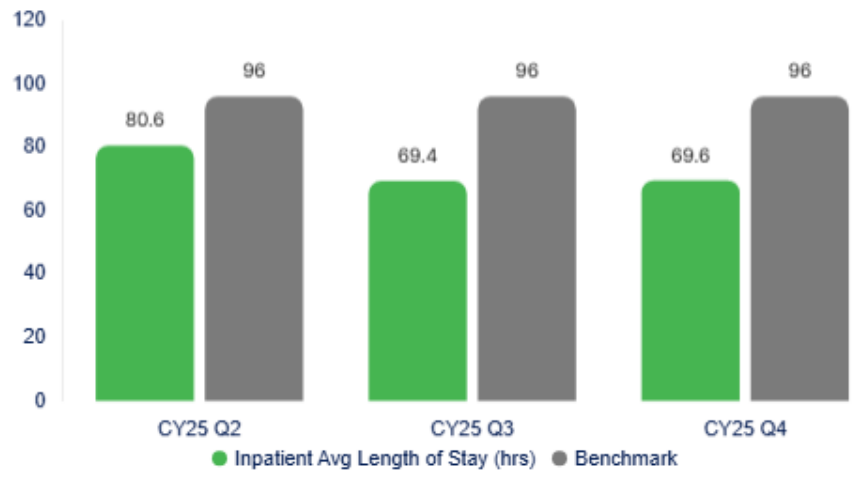


Likelihood to Recommend Top Box Score (OP)

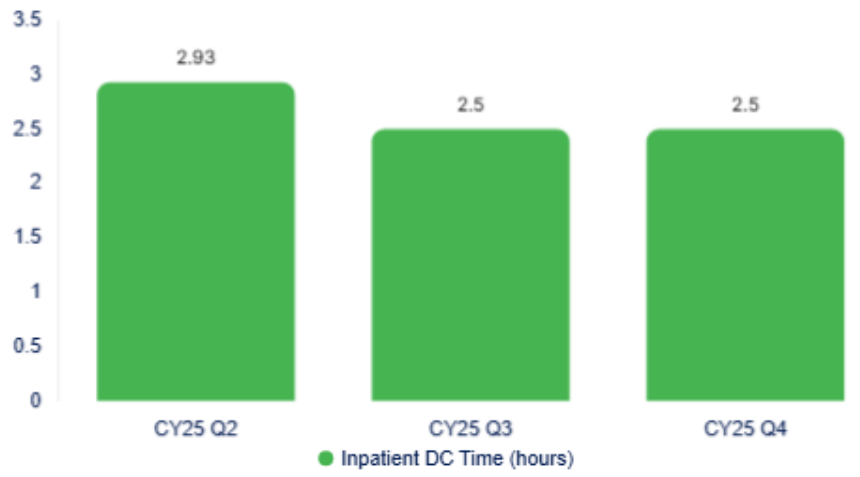


"<" means lower is better

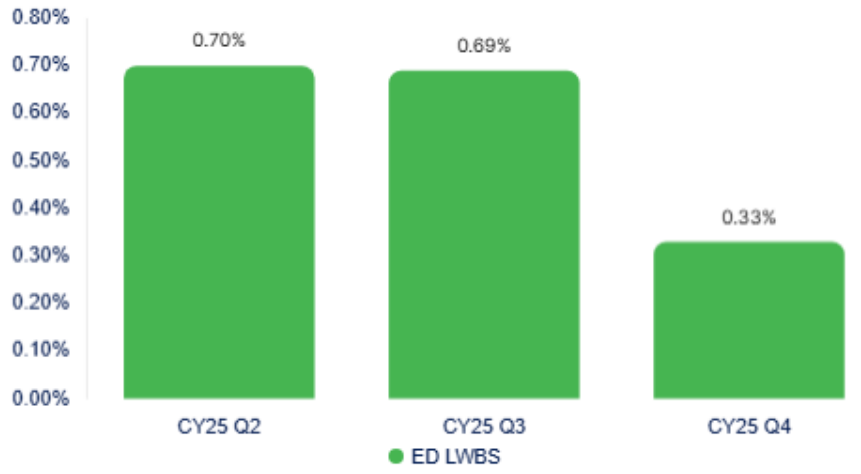
Inpatient Average Length of Stay (hours) <



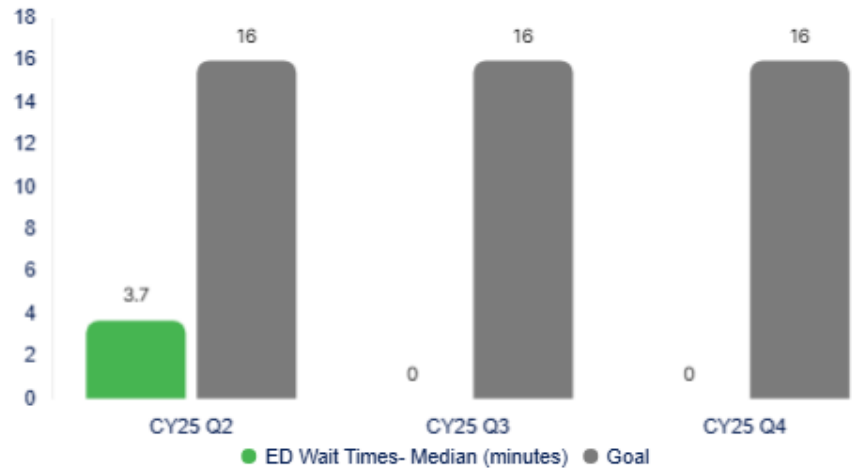
Inpatient Discharge Time (hours) <



ED Left Without Being Seen <



ED Wait Times- Median (minutes) <

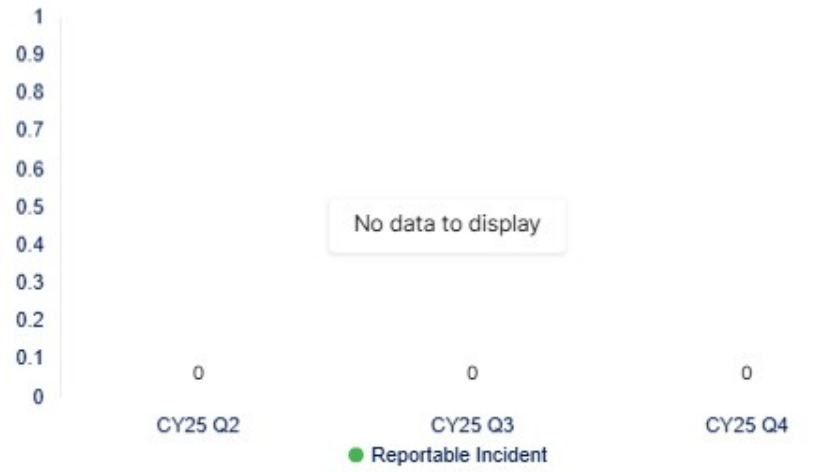


"<" means lower is better

Employee Engagement

Employee Turnover

Reportable Incidents- Employees



Workers Comp Claims

"<" means lower is better

NORTHERN INYO HEALTHCARE DISTRICT

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEAR ENDED JUNE 30, 2025

CPAs | CONSULTANTS | WEALTH ADVISORS

CLAconnect.com

NORTHERN INYO HEALTHCARE DISTRICT
TABLE OF CONTENTS
YEAR ENDED JUNE 30, 2025

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Northern Inyo Healthcare District
Bishop, California

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the business-type activities and fiduciary activities of the Northern Inyo Healthcare District (District), as of and for the year then ended June 30, 2025, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and fiduciary activities the District, as of June 30, 2025, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

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

Required Supplementary Information

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

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

Supplementary Information

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

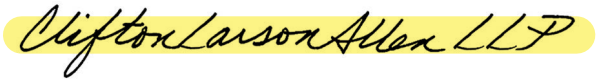
Other Information

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

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

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated December 15, 2025 on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering District's internal control over financial reporting and compliance.



CliftonLarsonAllen LLP

Roseville, California
December 15, 2025

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF NET POSITION
JUNE 30, 2025

ASSETS

CURRENT ASSETS	
Cash and Investments	$ 28,597,729
Receivables:	
Patient, Net of Estimated Uncollectibles	16,694,500
Leases Receivable	19,414
Other Receivables	5,144,059
Estimated Third-Party Payor Settlements	841,312
Inventory	5,334,240
Prepaid Expenses and Other Assets	1,153,602
Total Current Assets	57,784,856

Added

Assets increased by estimated 3rd party settlements above

NONCURRENT CASH AND INVESTMENTS	
Restricted for Specific Operating Purposes and Capital Improvements	1,469,292
Long-Term Investments	735,988
Total Noncurrent Cash and Investments	2,205,280

CAPITAL ASSETS	
Capital Assets not Being Depreciated/Amortized	12,442,254
Capital Assets Being Depreciated/Amortized, Net	69,178,864
Total Capital Assets	81,621,118
Total Assets	141,611,254

Assets increased by estimated 3rd party settlements above

DEFERRED OUTFLOWS OF RESOURCES	
Deferred Outflows Related to Pensions	9,393,030
Deferred Outflows Related to Refunding	297,382
Deferred Outflows Related to Acquisition	469,940
Total Deferred Outflows of Resources	10,160,352
Total Assets and Deferred Outflows of Resources	$ 151,771,606

Assets increased by estimated 3rd party settlements above

See accompanying Notes to Financial Statements.

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF NET POSITION (CONTINUED)
JUNE 30, 2025

LIABILITIES

CURRENT LIABILITIES	
Current Maturities of Long-Term Debt	$ 1,991,714
Current Maturities Related to Leases	186,100
Current Maturities Related to SBITA's	1,238,931
Other Liabilities	341,930
Removed estimated 3rd party settlement of $(841,312)	
Accounts Payable:	
Trade	4,793,082
Accrued Expenses:	
Salaries and Wages	2,810,076
Interest and Sales Taxes	89,554
Self-Insurance Claims	1,062,590
Unearned Revenue	35,314
Total Current Liabilities Liabilities reduced by $841,312 mentioned above	12,549,291
LEASE LIABILITY, Less Current Maturities	242,733
SBITA LIABILITY, Less Current Maturities	4,996,188
LONG-TERM DEBT, Less Current Maturities	45,871,672
NET PENSION LIABILITY	31,874,258
Total Liabilities Liabilities reduced by $841,312 mentioned above	95,534,142
DEFERRED INFLOWS OF RESOURCES	
Deferred Inflows Related to Pensions	8,740,164
Deferred Inflows Related to Lease Receivables	18,626
Total Deferred Inflows of Resources	8,758,790
NET POSITION	
Net Investment in Capital Assets	27,093,780
Restricted:	
Programs	25,142
Capital Improvements	1,444,150
Unrestricted	18,915,602
Total Net Position	47,478,674
Total Liabilities, Deferred Inflows of Resources, and Net Position	$ 151,771,606

Liabilities reduced by $841,312 mentioned above

See accompanying Notes to Financial Statements.

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
YEAR ENDED JUNE 30, 2025

OPERATING REVENUES	
Net Patient Service Revenue	$ 99,493,670
Other Revenue	2,585,894
Total Operating Revenues	102,079,564
OPERATING EXPENSES	
Salaries and Wages	46,908,256
Employee Benefits	17,221,022
Professional Fees and Purchased Services	19,695,452
Supplies	12,812,432
Purchased Services	6,929,502
Depreciation and Amortization	5,187,694
Other	8,387,850
Total Operating Expenses	117,142,208
OPERATING LOSS	(15,062,644)
NONOPERATING REVENUES (EXPENSES)	
Property Tax for Operations	987,050
Property Tax for Debt Service	2,170,208
Investment Income	16,110
Interest Expenses	(1,753,903)
Gain (Loss) on Sale of Assets	4,598
Noncapital Contributions and Grants	14,645,324
Rental Income	24,836
Miscellaneous Income (Expense)	3,970,263
Net Nonoperating Revenues (Expenses)	20,064,486
CHANGE IN NET POSITION	5,001,842
Net Position - Beginning of Year	42,476,832
NET POSITION - END OF YEAR	$ 47,478,674

Increased by $341,570

Decreased by $341,570

See accompanying Notes to Financial Statements.

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF CASH FLOWS
YEAR ENDED JUNE 30, 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	$ 98,272,460
Payments to Suppliers and Contractors	(36,622,859)
Payments to and on Behalf of Employees	(67,022,135)
Other Receipts and Payments, Net	(7,802,569)
Net Cash Used by Operating Activities	(13,175,103)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	14,645,324
Property Taxes Received	987,050
Net Cash Provided by Noncapital Financing Activities	19,531,023
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(3,832,965)
Interest Paid	461,409
Purchase and Construction of Capital Assets	(1,711,304)
Payments on Lease Liability	(269,021)
Payments on Subscription Liability	(1,199,596)
Property Taxes Received	2,170,208
Net Cash Used by Capital and Capital Related Financing Activities	(4,381,269)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	16,110
Rental Income	49,892
Net Cash Provided by Investing Activities	66,002
NET CHANGE IN CASH AND CASH EQUIVALENTS	2,040,653
Cash and Cash Equivalents - Beginning of Year	28,762,356
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 30,803,009
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION	
Cash and Cash Equivalents in Current Assets	$ 28,597,729
Cash and Cash Equivalents in Noncurrent Cash and Investments	2,205,280
Total Cash and Cash Equivalents	$ 30,803,009

See accompanying Notes to Financial Statements.

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF CASH FLOWS (CONTINUED)
DECEMBER 31, 2024

RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION	
Cash and Cash Equivalents in Current Assets	$ 28,597,729
Cash and Cash Equivalents in Noncurrent Cash and Investments	2,205,280
Total Cash and Cash Equivalents	$ 30,803,009
RECONCILIATION OF OPERATING LOSS TO NET CASH USED BY OPERATING ACTIVITIES	
Operating Loss	$ (15,062,644)
Adjustments to Reconcile Operating Income to Net Cash Used by Operating Activities:	
Depreciation and Amortization	5,187,694
Pension Expense	3,621,047
Provision for Bad Debts	15,447,684
(Increase) Decrease in Assets:	
Patient Receivables	(14,189,898)
Other Receivables	(2,028,087)
Inventory	1,679,927
Prepaid Expenses	(39,498)
Deferred Outflow of Resources	4,489,427
Increase (Decrease) in Liabilities:	
Accounts Payable	1,216,998
Estimated Third-Party Payor Settlements	(2,478,996)
Accrued Expenses	(2,460,479)
Other Liabilities	(48,937)
Net Pension Liability	(4,693,144)
Deferred Inflow of Resources	(3,816,197)
Net Cash Used by Operating Activities	$ (13,175,103)
SUPPLEMENTAL DISCLOSURES OF NONCASH CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Gain on Extinguishment of Debt	$ 71,614
Lease Assets Received in Exchange for Lease Liability	$ 186,488

See accompanying Notes to Financial Statements.

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF FIDUCIARY NET POSITION
DECEMBER 31, 2024

ASSETS	
INVESTMENTS AT FAIR VALUE	
Cash and Cash Equivalents	$ 2,110,453
Mutual Funds	15,286,722
Total Assets	$ 17,397,175
NET POSITION	
Restricted for Pensions	$ 17,397,175
Total Net Position	$ 17,397,175

See accompanying Notes to Financial Statements.

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF CHANGES IN FIDUCIARY NET POSITION – PENSION TRUST FUND
YEAR ENDED DECEMBER 31, 2024

ADDITIONS	
Contributions:	
Employer	$ 5,120,561
Employee	472,648
Total Contributions	5,593,209
INVESTMENT EARNINGS	
Interest, Dividends, and Other	1,507,690
Total Investment Earnings	1,507,690
Total Additions	7,100,899
DEDUCTIONS	
Benefits Paid to Participants or Beneficiaries	(1,849,968)
Administrative Expenses	(5,758)
Total Deductions	(1,855,726)
CHANGE IN NET POSITION	5,245,173
Net Position - Beginning of Year	12,152,002
NET POSITION - END OF YEAR	$ 17,397,175

See accompanying Notes to Financial Statements.

NOTE 1 REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Reporting Entity

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

Blended Component Units

Northern Inyo Hospital Foundation, Inc. (the Foundation) is a legally separate 501(c)(3) tax-exempt nonprofit public benefit corporation. The Foundation acts primarily as a fundraising organization to supplement the resources that are available to the District. Although the District does not control the timing or amount of receipts from the Foundation, the majority of the resources, or income thereon that the Foundation holds and invests are restricted to the activities of the District by the Foundation's bylaws. The Foundation's board of directors may also restrict the use of such funds for capital asset replacement, expansion, or other specific purposes. The District shall appoint the board of directors for the Foundation per the Foundation's bylaws, and for this reason it is a blended component unit of the District. No separate financial report is prepared for the Foundation.

Northern Inyo Hospital Auxiliary, Inc. (the Auxiliary) is also a legally separate 501(c)(3) tax-exempt public benefit corporation. The Auxiliary's actions are subject to the approval of the District and for this reason it is a blended component unit of the District. The Auxiliary's fiscal year end is May 31, 2024. No separate financial report is prepared for the Auxiliary.

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

Fiduciary Component Unit

Northern Inyo Local Hospital District Retirement Plan (the Plan) is a single employer defined benefit retirement plan organized under Internal Revenue Code (IRC) Section 415 for District employees who meet certain eligibility criteria. The Pension Trust Fund Plan is reported in the accompanying financial statements in separate statements of fiduciary net position and changes in fiduciary net position to emphasize that it is legally separate from the District. The Plan's fiscal year end is December 31, 2024. Separate financial statements for the fiduciary component unit are not available.

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

Measurement Focus and Basis of Accounting

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

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

Basis of Presentation

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

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

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

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

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

Use of Estimates

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

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

Cash and Cash Equivalents

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

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

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

Restricted Cash and Investments

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

Patient Receivables

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

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

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

Patient Receivables (Continued)

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

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

Inventories

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

Fair Value Measurement

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

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

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

Level 2 – Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets.
- Quoted prices for identical or similar assets or liabilities in inactive markets.

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

Fair Value Measurement (Continued)

- Inputs, other than quoted prices, those are observable for the asset or liability.
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

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

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

Investment Income

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

Capital Assets

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

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

Accreted Interest

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

Bond Premiums

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

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

Compensated Absences

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

Estimated Health Claims Payable

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

Unemployment Compensation

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

Retirement Plan

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

Deferred Outflows/Inflows of Resources

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

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

Deferred Outflows/Inflows of Resources (Continued)

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

Property Tax

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

Operating Revenues and Expenses

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

Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as final settlements are determined.

Charity Care

The District provides healthcare services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the District does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was $117,200 for the year ended June 30, 2025, calculated by multiplying the ratio of cost to gross charges for the District by the gross uncompensated charges associated with providing charity care to its patients.

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

Grants and Contributions

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

Employee Retention Credit

The District filed amended Form 941-X's (Amended Returns) for the Employee Retention Credit (ERC) for the first and second quarters of 2021. The Amended Returns are subject an IRS cursory review and the result of such potential review is uncertain. Management has recorded an estimated other receivable and miscellaneous income in financial statements as of and for the year ending June 30, 2025 of approximately $4 million dollars.

Right-of-Use Lease Asset and Liability

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

Subscription-Based Information Technology Arrangements (SBITA)

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

NOTE 2 NET PATIENT SERVICE REVENUE

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

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

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

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

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

Patient revenue from the Medicare and Medi-Cal programs accounted for approximately 22% and 10% of the District's net patient service revenue for the year ended June 30, 2025.

Laws and regulations governing the Medicare, Medi-Cal, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The net patient service revenue for the year ended June 30, 2025 decreased by $-0- due to removal of allowances previously estimated that are no longer necessary as a result of final settlements, adjustments to amounts previously estimated and years that are no longer likely subject to audits, reviews, and investigations.

NOTE 2 NET PATIENT SERVICE REVENUE

Medi-Cal Payments

California legislation (AB-915) provides for a Medi-Cal supplemental payment for Medi-Cal outpatient hospital services. As a result of this program, payments received were $1,296,165 in the year ended June 30, 2025.

The California Department of Healthcare Services (DHCS) implemented The Hospital Quality Assurance Fee (HQAF) program in 2010. The program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The District received $990,578 in the year ended June 30, 2025, under this program.

California legislation also provides for a Nondesignated Public Hospital Intergovernmental Transfer Program (IGT) for additional payments for outpatient managed care hospital services. As a result of this program, net payments recognized were $13,185,042 in the year ended June 30, 2025. Amounts due under this program total $-0- as of June 30, 2025 and are reported as other receivables on the statement of net position.

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

NOTE 3 DEPOSITS AND INVESTMENTS

The carrying amounts of deposits and investments as of June 30, 2025 are as follows:

Carrying Amount:	
Petty Cash	$ 1,998
Cash and Deposits	22,381,376
Investments	8,419,635
Total	$ 30,803,009

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

Cash and Investments	$ 29,333,717
Restricted for Specific Operating Purposes and Capital Improvements	1,469,292
Total	$ 30,803,009

NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

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

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

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

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

Investments Authorized by Debt Agreements

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

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

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

NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. One of the ways that the District manages its exposure to interest rate risk is by purchasing a combination of shorter term and longer term investments and by timing cash flows from maturities so that a portion of the portfolio is maturing or coming close to maturity evenly over time as necessary to provide the cash flow and liquidity needed for operations. Information about the sensitivity of the fair values of the District's investments (including investments held by bond trustee) to market interest rate fluctuation is provided by the following table that shows the distribution of the District's investments by maturity at June 30, 2025:

	Carrying		Investment Maturities (in Years)		
Investment Type	Amount	Rating	Less Than 1	1-5	6-10
Certificates of Deposits	$ 2,836,508	P-1/Aa1	$ 2,100,520	$ 735,988	$ -
Mutual Funds	98,199	AAAm	98,199	-	-
Equities	82,751	AAAm	82,751	-	-
Local Agency Investment Fund	5,402,176	Not Rated	5,402,176	-	-
Total	$ 8,419,634		$ 7,683,646	$ 735,988	$ -

Credit Risk

Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. The CGC limits the minimum rating required for each investment type. The LAIF is not rated.

Custodial Credit Risk

Custodial credit risk for *deposits* is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for *investments* is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code and the District's investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits or investments, other than the following provision for deposits: The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure the District's deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits.

As of June 30, 2025, $26,352,527 of the District's deposits with financial institutions in excess of federal depository insurance limits were held in uncollateralized accounts.

NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

Investment in State Investment Pool

The District is a voluntary participant in the Local Agency Investment Fund (LAIF) that is regulated by the California Government Code under the oversight of the treasurer of the state of California. The fair value of the District's investment in this pool is reported in the accompanying financial statements at amounts based upon the District's pro-rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis.

Fair Value Measurements

Assets measured at fair value on a recurring basis and the related fair value of these assets as of June 30, 2025 are as follows:

Investments by Fair Value	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level I)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
District Investments:				
Certificates of Deposit	$ 2,836,508	$ -	$ 2,836,508	$ -
Mutual Funds	98,199	98,199	-	-
Equities	82,751	82,751	-	-
Total District Investments Measured at Fair Value	3,017,458	$ 180,950	$ 2,836,508	$ -
Investments not Measured at Fair Value or Subject to Fair Value Hierarchy:				
Local Agency Investment Fund	5,402,176			
Total District Investments	$ 8,419,634			

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

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

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

NOTE 3 DEPOSITS AND INVESTMENTS (CONTINUED)

Employees' Retirement System

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

Pension Plan Investment Policy

The Plan's investment policy authorizes the Plan to invest in all investments allowed by state statue. These include deposits/investments in insured commercial banks, savings and loan institutions, interest-bearing obligations of the U.S. Treasury and U.S. agencies, interest-bearing bonds of the state of California or any county, township, or municipal corporation of the state of California, money market mutual funds whose investments consist of obligations of the U.S. Treasury or U.S. agencies, separate accounts managed by life insurance companies, mutual funds, and California Funds (created by the State Legislature under the control of the State Treasurer that maintains a $1 per share value, which is equal to the participant's fair value). During the year ended June 30, 2025, there were no changes to the investment policy.

Pension Plan Credit Risk

Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by assignment of a rating by a nationally recognized statistical rating organization. The Plan has and investment policy that limit investment choices by credit rating.

	Carrying		Investment Maturities (in Years)		
Investment Type	Amount	Rating	Less Than 1	1-5	6-10
Mutual Funds	$ 15,286,722	AA+	$ 15,286,722	$ -	$ -
Total	$ 15,286,722		$ 15,286,722	$ -	$ -

Pension Plan Custodial Credit Risk

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

Pension Plan Fair Value Measurements

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

NOTE 4 PATIENT RECEIVABLES, NET

Patient receivables - net for the District consisted of the following at June 30, 2025:

Gross Accounts Receivable	$ 45,275,220
Less:	
Contractual Adjustments	(18,854,656)
Provision for Uncollectible Accounts	(9,726,064)
Patient Receivables, Net	$ 16,694,500

NOTE 5 NET PATIENT SERVICE REVENUE

Net patient service revenue for the District consisted of the following for the year ended June 30, 2025:

Gross Patient Service Revenue	$ 231,667,372
Less:	
Contractual Adjustments	(116,726,018)
Provision for Uncollectible Accounts	(15,447,684)
Net Patient Service Revenue	$ 99,493,670

NOTE 6 CAPITAL ASSETS

Capital assets additions, retirements, transfers and balances for the year ended June 30, 2025 are as follows:

	Balance July 1, 2024	Additions	Transfers and Retirements	Balance June 30, 2025
Capital Assets not Being Depreciated:				
Land	$ 1,353,966	$ -	$ -	$ 1,353,966
Construction in Progress	10,521,159	792,082	(224,953)	11,088,288
Total Capital Assets not Being Depreciated	10,293,090	792,082	(224,953)	12,442,254
Capital Assets Being Depreciated:				
Land Improvements	867,086	-	-	867,086
Buildings and Improvements	92,501,922	229,738	(1,298)	92,730,362
Equipment	40,181,100	752,720	183,890	41,117,710
Total Capital Assets Being Depreciated	131,174,600	982,458	182,592	134,715,158
Lease Assets Being Amortized:				
Equipment	638,292	186,488	(22,052)	802,728
SBITAs	9,689,467	-	(72,556)	9,616,911
Total Lease Assets Being Amortized	10,925,304	186,488	(94,608)	10,419,639
Less Accumulated Depreciation for:				
Land Improvements	787,269	4,249	-	791,518
Buildings and Improvements	33,063,258	2,546,158	-	35,609,416
Equipment	34,450,858	1,108,799	(15,625)	35,544,032
Total Accumulated Depreciation	64,718,509	3,659,206	(15,625)	71,944,966
Net Capital Assets Being Depreciated	66,456,091	(2,676,748)	198,217	62,770,192
Less Lease Asset Accumulated Amortization for:				
Equipment	144,737	274,342	(22,052)	397,027
SBITAs	2,423,371	1,265,193	(74,624)	3,613,940
Total Accumulated Amortization	2,538,562	1,539,535	(96,676)	4,010,967
Net Lease Assets Being Amortized	8,386,742	(1,353,047)	2,068	6,408,672
Capital Assets, Net	$ 85,135,923	$ (3,237,713)	$ (24,668)	$ 81,621,118

Depreciation expense for the year ended June 30, 2025 was $3,922,501 and is reported with depreciation and amortization expense on the statement of revenues, expenses and changes in net position.

Construction in progress at June 30, 2025 represents the ICU Building Retrofit, Chiller/Condenser Replacement and Pharmacy Building Constructions. The estimated cost to complete this project is $350 thousand with construction commitments of $350 thousand as of June 30, 2025, which will be financed with District funds.

NOTE 7 LONG-TERM DEBT

Long-term debt consists of the following at June 30, 2025:

	Balance July 1, 2024	Additions	Deletions	Debt Forgiveness	Balance June 30, 2025	Due Within One Year
General Obligation Bonds:						
Direct Placement - 2016 General Obligation Refunding Bonds	$ 14,598,000	$ -	$ (761,000)	$ -	$ 13,837,000	$ 817,000
2009 General Obligation Bonds	6,578,060	1,150,000	(1,496,293)	-	6,231,767	354,947
Revenue Bonds:						
Direct Placement - Refunding Revenue Bonds, Series 2021A	3,220,000	-	-	-	3,220,000	-
Direct Placement - Refunding Revenue Bonds, Series 2021B	7,340,000	-	(670,000)	-	6,670,000	690,000
Subtotal Bonds Payable	31,736,060	1,150,000	(2,927,293)	-	29,958,767	1,861,947
Bond Premiums:						
2009 General Obligation Bonds	165,619	-	(37,644)	-	127,975	-
Total Bonds Payable	31,901,679	1,150,000	(2,964,937)	-	30,086,742	1,861,947
Accreted Interest - 2009 General: Obligation Bonds	16,991,065	1,085,705	(804,092)	-	17,272,678	-
Financed Purchases - Direct Borrowings:						
Equipment Purchase	531,894	-	(13,420)	(71,614)	446,860	106,968
Alcon	80,556	-	(23,450)	-	57,106	22,799
7 Medical	27,066	-	(27,066)	-	-	-
Total Financed Purchase Obligations	639,516	-	(63,936)	(71,614)	503,966	129,767
Total Long-Term Debt	49,532,260	2,235,705	(3,832,965)	(71,614)	47,863,386	1,991,714

The terms and due dates of the District's general obligation bonds at June 30, 2025 are as follows:

General Obligation Bonds, 2009 Series

On April 21, 2009, the District issued $14,464,947 in General Obligation Bonds, 2005 Election, 2009 Series to finance the construction and equipping of an expansion and renovation of the Hospital. The 2009 Bonds consist of two types of bonds, Current Interest Bonds and Capital Appreciation Bonds, issued in the amounts of $6,320,000 and $8,144,947, respectively. The Current Interest Bonds maturing through November 1, 2019 have been fully paid. The Term Bond maturing November 1, 2038 was partially extinguished in 2016 using proceeds from the issuance of the 2016 General Obligation Refunding Bond.

Interest on the Capital Appreciation Bonds is accreted annually and paid at maturity. The Capital Appreciation Bonds mature annually commencing on November 1, 2020, through November 1, 2038, in amounts ranging from $1,020,000 to $3,420,000, including interest accreted through such maturity dates. The Capital Appreciation Bonds are not subject to redemption prior to their fixed maturity dates.

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

NOTE 7 LONG-TERM DEBT (CONTINUED)

General Obligation Bonds, 2009 Series (Continued)

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

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

Direct Placements

2016 General Obligation Refunding Bond

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

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

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

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

Refunding Revenue Bonds, Series 2021A

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

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

NOTE 7 LONG-TERM DEBT (CONTINUED)

Direct Placements (Continued)

Refunding Revenue Bonds, Series 2021A (Continued)

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

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

Taxable Refunding Revenue Bonds, Series 2021B

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

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

NOTE 7 LONG-TERM DEBT (CONTINUED)

Direct Placements (Continued)

Taxable Refunding Revenue Bonds, Series 2021B (Continued)

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

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

Defeased Debt

At June 30, 2025, $9,890,000 of the Series 2021 defeased revenue bonds remain outstanding.

Direct Borrowings

Financed Purchases

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

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

Purchase Agreement

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

NOTE 7 LONG-TERM DEBT (CONTINUED)

Direct Borrowings (Continued)

Purchase Agreement (Continued)

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

	General Obligation Bonds		Revenue Bonds		Direct Borrowings		Totals	
Year Ending June 30,	Principal	Interest	Principal	Interest	Principal	Interest	Principal	Interest
2026	$ 1,171,947	$ 1,397,429	$ 690,000	$ 315,100	$ 129,767	$ 15,306	$ 1,991,714	$ 1,727,835
2027	1,232,891	1,503,299	710,000	292,700	134,037	11,036	2,076,928	1,807,035
2028	1,328,490	1,576,789	735,000	269,580	126,508	6,800	2,189,998	1,853,169
2029	1,363,759	1,730,192	755,000	245,740	113,654	3,383	2,232,413	1,979,315
2030	1,545,676	1,742,362	780,000	221,180	-	-	2,325,676	1,963,542
2031-2035	9,682,353	10,153,621	4,295,000	705,618	-	-	13,977,353	10,859,239
2036-2040	3,743,651	10,455,003	1,925,000	67,988	-	-	5,668,651	10,522,991
2041-2045	-	-	-	-	-	-	-	-
Subtotal	$20,068,767	$28,558,695	$ 9,890,000	$ 2,117,906	$ 503,966	$ 36,525	30,462,733	$30,713,126
					Premium on Bonds		127,975	
					Accreted Interest		17,272,678	
					Total		$47,863,386	

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

NOTE 8 LEASES AND SBITAS

Lease obligations and receivables consist of the following for the year ended June 30, 2025:

	Balance July 1, 2024	Additions	Deletions	Balance June 30, 2025	Due Within One Year
Lease Liabilities	$ 511,366	$ 186,488	$ (269,021)	$ 428,833	$ 186,100
Lease Receivables	$ 44,470	$ -	$ (25,056)	$ 19,414	$ 19,414

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

Year Ending June 30,	Principal	Interest	Total
2026	$ 186,100	$ 17,815	$ 203,915
2027	118,815	8,975	127,790
2028	107,521	2,979	110,500
2029	16,397	130	16,527
Total Minimum Lease Payments	$ 428,833	$ 29,899	$ 458,732

SBITA obligations consist of the following for the year ended June 30, 2025:

	Balance July 1, 2024	Additions	Deletions	Balance June 30, 2025	Due Within One Year
SBITA Liabilities	$ 7,434,715	$ -	$ (1,199,596)	$ 6,235,119	$ 1,238,931

NOTE 8 LEASES AND SBITAS (CONTINUED)

Total future minimum payments under SBITA agreements are as follows:

Year Ending June 30,	Principal	Interest	Total
2026	$ 1,238,931	$ 164,366	$ 1,403,297
2027	1,224,690	128,134	1,352,824
2028	1,248,637	91,427	1,340,064
2029	1,269,312	53,920	1,323,232
2030	1,224,526	17,558	1,242,084
Thereafter	29,023	649	29,672
Total Minimum Lease Payments	$ 6,235,119	$ 456,054	$ 6,691,173

NOTE 9 RETIREMENT PLANS

Defined Benefit Plan - Plan Description

The District sponsors a single-employer defined benefit pension plan for employees over age 21 with at least one year of service. The plan is governed by the District's board of directors, which may amend benefits and other plan provisions, and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels. A separate financial report is not prepared for the plan.

Benefits Provided

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full- time employment. Members with five years of total service are eligible to retire at age 55 with statutorily reduced benefits. All members are eligible for pre-retirement death benefits after five years of service. The benefit vesting schedule is 50% vesting after five years, increasing 10% per year to 100% vested after 10 years of service. The Plan was closed to new entrants effective January 1, 2013.

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

The Plan's provisions and benefits in effect at June 30, 2025 are summarized as follows:

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

NOTE 9 RETIREMENT PLANS (CONTINUED)

Benefits Provided (Continued)

Employees covered at December 31, 2024, by the benefit terms for the Plan are as follows:

Inactive Employees or Beneficiaries Currently Receiving Benefits	21
Inactive Employees Entitled to but Not Yet Receiving Benefits	64
Active Employees	71
Total	156

Contributions

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the Plan are determined annually on an actuarial basis as of January 1 by the Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. For the year ended June 30, 2025, the employer contribution was $5,120,561.

Rate of Return

For the year ended December 31, 2024, the annual money-weighted rate of return on pension plan investments, net of pension plan investment expense, was 10.48%. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

Concentration of Credit Risk

The Plan's policy does not limit the percentage of any asset in the Plan portfolio. The composition of plan assets consisted of the following at December 31, 2024:

Asset Allocation	Percent of Total Plan Assets
Cash and Cash Equivalents	28.0 %
Mutual Funds	72.0
Total	100.0 %

NOTE 9 RETIREMENT PLANS (CONTINUED)

Net Pension Liability

The District's net pension liability was measured as of December 31, 2024, and the total pension liability used to calculate the net pension liability was determined by an actuarial as of December 31, 2024.

Actuarial Assumptions - The total pension liability in the January 1, 2024 actuarial valuation were determined using the following actuarial assumptions:

Valuation Date	January 1, 2024
Measurement Date	December 31, 2024
Actuarial Cost Method	Entry-Age Normal Cost Method
Actuarial Assumptions:	
Discount Rate	6.25%
Projected Salary Increase	5.25%
Investment Rate of Return	6.25%

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

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

Asset Class	Asset Allocation	Long-Term Expected Real Rate of Return
Large Cap	41.00 %	4.52 %
Mid/Small Cap	30.00	2.52
International	22.00	5.44
Specialty/Alts	7.00	3.12
Total	100.00 %	

NOTE 9 RETIREMENT PLANS (CONTINUED)

Net Pension Liability (Continued)

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

Changes in the Net Pension Liability

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

	Increase (Decrease)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability(Asset)
Balance at June 30, 2024	$ 45,098,357	$ 12,152,002	$ 32,946,355
Changes in the Year:			
Service Cost	979,570	-	979,570
Interest on Total Pension Liability	2,822,935	-	2,822,935
Differences between Expected and Actual Experience	2,220,539	-	2,220,539
Change of Assumptions	-	-	-
Contribution - Employer	-	5,120,561	(5,120,561)
Contribution - Member	-	472,648	(472,648)
Net Investment Income	-	1,507,690	(1,507,690)
Benefit Payments Including Refunds of Member Contributions	(1,849,968)	(1,849,968)	-
Administrative Expense	-	(5,758)	5,758
Net Changes	4,173,076	5,245,173	(1,072,097)
Balance at June 30, 2025	$ 49,271,433	$ 17,397,175	$ 31,874,258

Sensitivity of the Net Pension Liability to Changes in the Discount Rate – The following presents the net pension liability of the District calculated using the discount rate of 6.25%, as well as what the District's net pension liability would be if it were calculated using a discount rate that is 1 percentage-point lower or 1 percentage-point higher than the current rate.

	1% Decrease (5.25%)	Current Discount Rate (6.25%)	1% Increase (7.25%)
District Net Pension Liability	$ 38,463,231	$ 31,874,258	$ 26,395,675

NOTE 9 RETIREMENT PLANS (CONTINUED)

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

For the fiscal year ended June 30, 2025, the District recognized pension expense of $3,292,750. At June 30, 2025, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflow of Resources
Differences Between Expected and Actual Experience	$ 4,834,774	$ -
Changes of Assumptions	2,578,617	(8,740,164)
Net Differences Between Projected and Actual Earnings on Plan Investments	59,639	-
Contributions Made Subsequent to the Measurement Date	1,920,000	-
Total	$ 9,393,030	$ (8,740,164)

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

Year Ending June 30,	Amount
2026	$ (196,546)
2027	(752,355)
2028	(86,180)
2029	(62,772)
Total	$ (1,097,853)

Defined Contribution Plan – Plan Description

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

Benefit terms, including contribution requirements, for NICLHD are established and may be amended by the District's board of directors. Beginning August 1, 2023 for each employee in the pension plan, the District is required to match up to 3.5% of contributions elected by employees who are allowed to contribute to the plan. Employees are not permitted to make contributions to the pension plan. The District does not contribute to this plan if an employee does not elect to contribute. For the year ended June 30, 2025, the District made employer contributions in the amount of $762,142.

NOTE 9 RETIREMENT PLANS (CONTINUED)

Defined Contribution Plan – Plan Description (Continued)

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

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

NOTE 10 RISK MANAGEMENT

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

The District's comprehensive general liability insurance covers losses of up to $20,000,000 per claim with $30,000,000 annual aggregate for occurrence basis during a policy year regardless of when the claim was filed (occurrence-based coverage).

The District's professional liability insurance covers losses up to $3,000,000 per claim with $3,000,000 annual aggregate for claims reported during a policy year (claims-made coverage). Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District.

Although there exists the possibility of claims arising from services provided to patients through June 30, 2025, which have not yet been asserted, the District is unable to determine the ultimate cost, if any, of such possible claims, and accordingly no provision has been made for them. Settled claims have not exceeded commercial coverage in any of the three preceding years.

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

NOTE 11 SELF-INSURED HEALTHCARE PLAN

The District has a self-funded health care plan that provides medical and dental benefits to employees and their dependents. Employees share in the cost of health benefits. Health care expense is based on actual claims paid, reinsurance premiums, administration fees, and unpaid claims at year-end. The District buys reinsurance to cover catastrophic individual claims over $215,000. The District records a liability for claims incurred but not reported that is recorded in accrued payroll and related liabilities in the accompanying statements of net position.

Year	Beginning Liability	Current Year Claims and Changes in Estimates	Claim Payments	Ending Liability
2024	$ (749,280)	$ (12,777,176)	$ 12,679,129	$ (847,327)
2025	(847,327)	(10,170,404)	10,296,711	(721,020)

NOTE 12 CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at June 30, 2025 was as follows:

Medicare	21.6 %
MediCal	9.6
Other Third-Party Payors	48.4
Patients	20.4
Total	100.0 %

NOTE 13 CONTINGENCIES

Malpractice Insurance

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

Litigation, Claims, and Disputes

The Organization is subject to various legal proceedings and claims which arise in the ordinary course of operations. In the opinion of management, the amount of any liability, if any, with respect to these actions would not materially affect the financial position or results of operations of the Organization.

NOTE 13 CONTINGENCIES (CONTINUED)

Litigation, Claims, and Disputes (Continued)

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Department of Health and Human Services (HHS) and the Medicare and Medi-Cal programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

NOTE 14 CONDENSED COMBINING INFORMATION

Statement of net position as of June 30, 2025:

	Hospital	Foundation	Auxiliary	Total
Assets and Deferred Outflows of Resources				
Assets:				
Current Assets	$ 57,447,777	$ 246,406	$ 90,673	$ 57,784,856
Capital Assets, Net	81,621,118	-	-	81,621,118
Other Assets	2,205,280	-	-	2,205,280
Total Assets	141,274,175	246,406	90,673	141,611,254
Deferred Outflows of Resources:	10,160,352	-	-	10,160,352
Total Assets and Deferred Outflows of Resources	151,434,527	246,406	90,673	151,771,606
Liabilities, Deferred Inflows of Resources, and Net Position				
Liabilities:				
Current Liabilities	12,549,291	-	-	12,549,291
Long-Term Liabilities	82,984,851	-	-	82,984,851
Total Liabilities	95,534,142	-	-	95,534,142
Deferred Inflows of Resources	8,758,790	-	-	8,758,790
Net Position:				
Net Investment in Capital Assets	27,093,780	-	-	27,093,780
Restricted	1,469,292	-	-	1,469,292
Unrestricted	18,578,523	246,406	90,673	18,915,602
Total Net Position	47,141,595	246,406	90,673	47,478,674
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 151,434,527	$ 246,406	$ 90,673	$ 151,771,606

Hospital changed (assets & liabilities for 3rd party settlement)

NOTE 14 CONDENSED COMBINING INFORMATION (CONTINUED)

Operating results and changes in net position for the year ended June 30, 2025:

	Hospital	Foundation	Auxiliary	Total
OPERATING REVENUES				
Net Patient Service Revenue	$ 99,493,670	$ -	$ -	$ 99,493,670
Other Operating Revenue	2,519,454	26	66,414	2,585,894
Total Operating Revenues	102,013,124	26	66,414	102,079,564
OPERATING EXPENSES				
Depreciation and Amortization	5,187,694	-	-	5,187,694
Other Operating Expenses	111,896,473	5,146	52,895	111,954,514
Total Operating Expenses	117,084,167	5,146	52,895	117,142,208
OPERATING INCOME (LOSS)	(15,071,043)	(5,120)	13,519	(15,062,644)
NET NONOPERATING REVENUES	20,022,022	42,464	-	20,064,486
Revenues in Excess of (Less Than) Expenses and Change in Net Position	4,950,979	37,344	13,519	5,001,842
Net Position - Beginning of Year	42,190,616	209,062	77,154	42,476,832
NET POSITION - END OF YEAR	$ 47,141,595	$ 246,406	$ 90,673	$ 47,478,674

Statement of cash flows as of June 30, 2025:

	Hospital	Foundation	Auxiliary	Total
Net Cash Provided (Used) by Operating Activities	$ (13,183,502)	$ (5,120)	$ 13,519	$ (13,175,103)
Net Cash Provided (Used) by Noncapital Financing Activities	19,509,559	21,464	-	19,531,023
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(4,381,269)	-	-	(4,381,269)
Net Cash Provided (Used) by Investing Activities	45,002	21,000	-	66,002
NET CHANGE IN CASH AND CASH EQUIVALENTS	1,989,790	37,344	13,519	2,040,653
Cash and Cash Equivalents - Beginning of Year	28,476,140	209,062	77,154	28,762,356
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 30,465,930	$ 246,406	$ 90,673	$ 30,803,009

NOTE 15 RELATED PARTY TRANSACTIONS

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

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

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Total Pension Liability:										
Service Cost	$ 979,570	$ 1,240,702	$ 1,376,714	$ 1,706,921	$ 1,951,401	$ 1,781,772	$ 2,121,997	$ 2,281,116	$ 2,812,178	$ 2,219,985
Interest on the Total Pension Liability	2,822,935	2,346,115	2,183,032	2,179,367	2,298,637	2,694,973	2,726,359	2,805,649	3,053,437	3,047,939
Differences Between Expected and Actual Experience	2,220,539	1,766,631	3,910,725	769,805	880,397	2,640,361	3,016,650	1,343,607	(3,295,677)	1,385,608
Changes in Assumptions	-	(15,685,950)	-	96,057	1,737,567	6,850,017	(84,200)	(185,137)	(417,283)	12,966,856
Benefit Payments	(1,849,968)	(3,924,140)	(2,603,583)	(6,023,511)	(13,117,516)	(8,053,422)	(8,082,821)	(5,554,354)	(7,575,753)	(8,213,871)
Net Change in Total Pension Liability	4,173,076	(14,256,642)	4,866,888	(1,271,361)	(6,249,514)	5,913,701	(302,015)	690,881	(5,423,098)	11,406,517
Total Pension Liability - Beginning	45,098,357	59,354,999	54,488,111	55,759,472	62,008,986	56,095,285	56,397,300	56,575,151	61,998,249	50,591,732
Total Pension Liability - Ending (a)	$ 49,271,433	$ 45,098,357	$ 59,354,999	$ 54,488,111	$ 55,759,472	$ 62,008,986	$ 56,095,285	$ 57,266,032	$ 56,575,151	$ 61,998,249
Plan Fiduciary Net Position:										
Contributions - Employer	$ 5,120,561	$ 5,331,816	$ 7,403,934	$ 347,300	$ 3,000,000	$ 5,242,000	$ 6,300,000	$ 5,340,000	$ 5,340,000	$ 3,900,000
Contributions - Member	472,648	-	-	-	-	-	-	-	-	-
Net Investment Income (Loss)	1,507,690	(1,336,658)	817,781	2,082,706	(746,702)	1,893,587	(116,063)	(292,381)	(126,769)	880,376
Benefit Payments	(1,849,968)	(3,924,140)	(2,603,583)	(6,023,511)	(13,117,516)	(8,053,422)	(8,082,821)	(5,554,354)	(7,575,753)	(8,213,871)
Administrative Expense	(5,758)	(16,352)	(58,167)	(57,983)	(54,472)	(58,625)	(64,562)	(88,502)	(55,640)	(51,336)
Net Change in Plan Fiduciary Net Position	5,245,173	54,666	5,559,965	(3,651,488)	(10,918,690)	(976,460)	(1,963,446)	(595,237)	(2,418,162)	(3,484,831)
Plan Fiduciary Net Position - Beginning	12,152,002	12,097,336	6,537,371	10,188,859	21,107,549	22,084,009	24,047,455	26,087,619	28,505,781	31,990,612
Plan Fiduciary Net Position - Ending (b)	17,397,175	12,152,002	12,097,336	6,537,371	10,188,859	21,107,549	22,084,009	25,492,382	26,087,619	28,505,781
Net Pension Liability - Ending (a)-(b)	$ 31,874,258	$ 32,946,355	$ 47,257,663	$ 47,950,740	$ 45,570,613	$ 40,901,437	$ 34,011,276	$ 31,773,650	$ 30,487,532	$ 33,492,468
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability										
Covered Payroll	$ 8,545,281	$ 8,563,359	$ 8,609,073	$ 9,243,630	$ 9,302,388	$ 10,780,522	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425
Net Pension Liability as Percentage of Covered Payroll	373.00 %	384.74 %	548.93 %	518.74 %	489.88 %	379.40 %	294.79 %	245.01 %	225.34 %	210.74 %
Measurement Date	December 31, 2024	December 31, 2023	December 30, 2022	December 30, 2021	December 31, 2020	December 31, 2019	December 31, 2018	December 31, 2017	December 31, 2016	December 31, 2015

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

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Actuarially Determined Contribution	$ 3,504,078	$ 4,730,922	$ 4,960,082	$ 9,056,000	$ 7,752,000	$ 6,072,000	$ 5,484,000	$ 4,716,000	$ 5,340,000	$ 3,900,000
Contributions in Relation to the Actuarily Determined Contributions	3,650,635	4,743,446	5,973,722	5,599,234	3,000,000	5,500,000	6,060,000	5,340,000	5,340,000	3,900,000
Contribution Deficiency (Excess)	$ (146,557)	$ (12,524)	$ (1,013,640)	$ 3,456,766	$ 4,752,000	$ 572,000	$ (576,000)	$ (624,000)	$ -	$ -
Covered Payroll	$ 8,545,281	$ 8,563,359	$ 8,609,073	$ 9,243,630	$ 9,302,388	$ 10,780,522	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425
Contributions as a Percentage of Covered Payroll	42.72 %	55.39 %	69.39 %	60.57 %	32.25 %	51.02 %	52.53 %	41.18 %	39.47 %	24.54 %

Notes to Schedule:

Valuation Date: January 1, 2025

Methods and Assumptions Used to Determine Contribution Rates

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

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

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Annual Money-Weighted Rate of Return, Net of Investment Expense	10.48%	(10.45)%	9.33 %	36.17 %	(4.36)%	8.74 %	(0.47)%	(1.16)%	(0.48)%	3.11 %

NORTHERN INYO HEALTHCARE DISTRICT
COMBINING STATEMENT OF NET POSITION
JUNE 30, 2025

Assets and Deferred Outflows of Resources	Hospital	Foundation	Auxiliary	Total
Current Assets:				
Cash and Investments	$ 28,260,650	$ 246,406	$ 90,673	$ 28,597,729
Receivables:				
Patient, Net of Estimated Uncollectibles	16,694,500	-	-	16,694,500
Leases Receivable	19,414			19,414
Other Receivables	5,144,059	-	-	5,144,059
Estimated Third-Party Payor Settlements	841,312	Moved this from liabilities to assets	-	841,312
Inventory	5,334,240	-	-	5,334,240
Prepaid Expenses and Other Assets	1,153,602	-	-	1,153,602
Total Current Assets	57,447,777	246,406	90,673	57,784,856
Noncurrent Cash and Investments:				
Restricted for Specific Operating Purposes and Capital Improvements	1,469,292	-	-	1,469,292
Long-Term Investments	735,988	-	-	735,988
Total Noncurrent Cash and Investments	2,205,280	-	-	2,205,280
Capital Assets:				
Capital Assets not Being Depreciated/Amortized	12,442,254	-	-	12,442,254
Capital Assets Being Depreciated/Amortized, Net	69,178,864	-	-	69,178,864
Total Capital Assets	81,621,118	-	-	81,621,118
Total Assets	141,274,175	246,406	90,673	141,611,254
Deferred Outflows of Resources:				
Deferred Outflows Related to Pensions	9,393,030	-	-	9,393,030
Deferred Outflows Related to Refunding	297,382	-	-	297,382
Deferred Outflows Related to Acquisition	469,940	-	-	469,940
Total Deferred Outflows of Resources	10,160,352	-	-	10,160,352
Total Assets and Deferred Outflows of Resources	$ 151,434,527	$ 246,406	$ 90,673	$ 151,771,606

NORTHERN INYO HEALTHCARE DISTRICT
COMBINING STATEMENT OF NET POSITION (CONTINUED)
JUNE 30, 2025

Liabilities, Deferred Inflows of Resources, and Net Position	Hospital	Foundation	Auxiliary	Total
Current Liabilities:				
Current Maturities of Long-Term Debt	$ 1,991,714	$ -	$ -	$ 1,991,714
Current Maturities Related to Leases	186,100	-	-	186,100
Current Maturities Related to SBITA's	1,238,931	-	-	1,238,931
Other Liabilities	341,930	-	-	341,930
Accounts Payable:				
Trade	4,793,082	-	-	4,793,082
Accrued Expenses:	Removed estimated 3rd party settlement of $(841,312)			
Salaries and Wages	2,810,076	-	-	2,810,076
Interest and Sales Taxes	89,554	-	-	89,554
Self-Insurance Claims	1,062,590	-	-	1,062,590
Unearned Revenue	35,314	-	-	35,314
Total Current Liabilities	12,549,291	-	-	12,549,291
Lease Liability, Less Current Maturities	242,733	-	-	242,733
SBITA Liability, Less Current Maturities	4,996,188	-	-	4,996,188
Long-Term Debt, Less Current Maturities	45,871,672	-	-	45,871,672
Net Pension Liability	31,874,258	-	-	31,874,258
Total Liabilities	95,534,142	-	-	95,534,142
Deferred Inflows of Resources:				
Deferred Inflows Related to Pensions	8,740,164	-	-	8,740,164
Deferred Inflows Related to Lease Receivables	18,626	-	-	18,626
Total Deferred Inflows of Resources	8,758,790	-	-	8,758,790
Net Position:				
Net Investment in Capital Assets	27,093,780	-	-	27,093,780
Restricted:				
Programs	25,142	-	-	25,142
Capital Improvements	1,444,150	-	-	1,444,150
Unrestricted:	18,578,523	246,406	90,673	18,915,602
Total Net Position	47,141,595	246,406	90,673	47,478,674
Total Liabilities, Deferred Inflows of Resources, and Net Pension	$ 151,434,527	$ 246,406	$ 90,673	$ 151,771,606

NORTHERN INYO HEALTHCARE DISTRICT
COMBINING STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
YEAR ENDED JUNE 30, 2025

	Hospital	Foundation	Auxiliary	Total
Operating Revenues:				
Net Patient Service Revenue	$ 99,493,670	$ -	$ -	$ 99,493,670
Other Revenue	2,519,454	26	66,414	2,585,894
Total Operating Revenues	102,013,124	26	66,414	102,079,564
Operating Expenses:				
Salaries and Wages	46,893,192	15,064	-	46,908,256
Employee Benefits	17,209,980	11,042	-	17,221,022
Professional Fees and Purchased Services	19,694,702	750	-	19,695,452
Supplies	12,811,274	1,158	-	12,812,432
Purchased Services	6,929,502	-	-	6,929,502
Depreciation and Amortization	5,187,694	-	-	5,187,694
Other	8,357,823	(22,868)	52,895	8,387,850
Total Operating Expenses	117,084,167	5,146	52,895	117,142,208
OPERATING INCOME (LOSS)	(15,071,043)	(5,120)	13,519	(15,062,644)
Nonoperating Revenues (Expenses):				
Property Tax for Operations	987,050	-	-	987,050
Property Tax for Debt Service	2,170,208	-	-	2,170,208
Investment Income	(4,890)	21,000	-	16,110
Interest Expense	(1,753,903)	-	-	(1,753,903)
Gain (Loss) on Sale of Assets	4,598	-	-	4,598
Noncapital Contributions and Grants	14,623,860	21,464	-	14,645,324
Rental Income	24,836	-	-	24,836
Miscellaneous Income (Expense)	3,970,263	-	-	3,970,263
Net Nonoperating Revenues	20,022,022	42,464	-	20,064,486
CHANGE IN NET POSITION	4,950,979	37,344	13,519	5,001,842
Net Position - Beginning of Year	42,190,616	209,062	77,154	42,476,832
NET POSITION - END OF YEAR	$ 47,141,595	$ 246,406	$ 90,673	$ 47,478,674

Expenses of $341,570 reclassed from other to benefits

NORTHERN INYO HEALTHCARE DISTRICT
COMBINING STATEMENT OF CASH FLOWS
YEAR ENDED JUNE 30, 2025

	Hospital	Foundation	Auxiliary	Total
CASH FLOWS FROM OPERATING ACTIVITIES				
Receipts from and on Behalf of Patients	$ 98,272,460	$ -	$ -	$ 98,272,460
Payments to Suppliers and Contractors	(36,591,674)	21,710	(52,895)	(36,622,859)
Payments to and on Behalf of Employees	(66,996,029)	(26,106)	-	(67,022,135)
Other Receipts and Payments, Net	(7,868,259)	(724)	66,414	(7,802,569)
Net Cash Provided (Used) by Operating Activities	(13,183,502)	(5,120)	13,519	(13,175,103)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES				
Noncapital Contributions and Grants	14,623,860	21,464	-	14,645,324
Property Taxes Received	987,050		-	987,050
Other	3,898,649	-	-	3,898,649
Net Cash Provided by Noncapital Financing Activities	19,509,559	21,464	-	19,531,023
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES				
Principal Payments on Long-Term Debt	(3,832,965)	-	-	(3,832,965)
Interest Paid	461,409	-	-	461,409
Purchase and Construction of Capital Assets	(1,711,304)	-	-	(1,711,304)
Payments on Lease Liability	(269,021)	-	-	(269,021)
Payments on Subscription Liability	(1,199,596)	-	-	(1,199,596)
Property Taxes Received	2,170,208	-	-	2,170,208
Net Cash Used by Capital and Capital Related Financing Activities	(4,381,269)	-	-	(4,381,269)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Income	(4,890)	21,000	-	16,110
Rental Income	49,892	-	-	49,892
Net Cash Provided by Investing Activities	45,002	21,000	-	66,002
NET CHANGE IN CASH AND CASH EQUIVALENTS	1,989,790	37,344	13,519	2,040,653
Cash and Cash Equivalents - Beginning of Year	28,476,140	209,062	77,154	28,762,356
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 30,465,930	$ 246,406	$ 90,673	$ 30,803,009

NORTHERN INYO HEALTHCARE DISTRICT
COMBINING STATEMENT OF CASH FLOWS (CONTINUED)
YEAR ENDED JUNE 30, 2025

	Hospital	Foundation	Auxiliary	Total
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION				
Cash and Investments in Current Assets	$ 28,260,650	$ 246,406	$ 90,673	$ 28,597,729
Cash and Investments in Noncurrent Cash and Investments	2,205,280	-	-	2,205,280
Total Cash and Cash Equivalents	30,465,930	246,406	90,673	30,803,009
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES				
Operating Loss	(15,071,043)	(5,120)	13,519	(15,062,644)
Adjustments to Reconcile Operating Income to Net Cash Provided (Used) by Operating Activities				
Depreciation and Amortization	5,187,694	-	-	5,187,694
Pension Expense	3,621,047	-	-	3,621,047
Provision for Bad Debts	15,447,684	-	-	15,447,684
(Increase) Decrease in Assets:				
Patient Receivables	(14,189,898)	-	-	(14,189,898)
Other Receivables	(2,028,087)	-	-	(2,028,087)
Inventory	1,679,927	-	-	1,679,927
Prepaid Expenses	(39,498)	-	-	(39,498)
Deferred Outflow of Resources	4,489,427	-	-	4,489,427
Increase (Decrease) in Liabilities:				
Accounts Payable	1,216,998	-	-	1,216,998
Estimated Third-Party Payor Settlements	(2,478,996)	-	-	(2,478,996)
Accrued Expenses	(2,460,479)	-	-	(2,460,479)
Other Liabilites	(48,937)	-	-	(48,937)
Net Pension Liability	(4,693,144)	-	-	(4,693,144)
Deferred Inflow of Resources	(3,816,197)	-	-	(3,816,197)
Net Cash Provided (Used) by Operating Activities	$ (13,183,502)	$ (5,120)	$ 13,519	$ (13,175,103)
SUPPLEMENTAL DISCLOSURES OF NONCASH CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES				
Gain on Extinguishment of Debt	$ 71,614	$ -	$ -	$ 71,614
Lease Assets Received in Exchange for Lease Liability	$ 186,488	$ -	$ -	$ 186,488

NORTHERN INYO HEALTHCARE DISTRICT
STATISTICAL INFORMATION
LAST EIGHT YEARS

	2025	2024	2023	2022	2021	2020	2019	2018
Bed Complement								
Medical/Surgical	12	12	11	11	11	11	11	11
Prenatal/Obstetrics	5	5	6	6	6	6	6	6
Pediatric	4	4	4	4	4	4	4	4
Intensive Care	4	4	4	4	4	4	4	4
Total Licensed Bed Capacity	25	25	25	25	25	25	25	25
Utilization								
License Beds	25	25	25	25	25	25	25	25
Patient Days	2,887	2,562	2,458	2,646	2,931	2,968	3,257	3,474
Discharges	1,076	1,048	1,019	993	1,050	1,104	1,037	1,106
Occupancy Percentage	32%	28%	27%	29%	32%	33%	36%	38%
Average Stay (Days)	3	2	2	3	3	3	3	3
Emergency Room Visits	10,219	10,080	9,866	8,730	7,066	8,262	9,153	8,798
Outpatient Visits	47,767	42,374	43,678	44,067	48,938	40,472	38,960	38,651
Medical Staff								
Active	53	51	50	49	50	54	50	53
Consulting	50	33	26	21	25	19	17	17
Honorary	2	2	2	2	2	11	11	11
AHP	14	14	16	16	18	18	12	10
Other - Telemedicine	60	34	38	32	30	33	27	-
Total Practitioners	179	134	132	120	125	135	117	91
Employees								
Full-Time	334	332	329	350	370	361	362	330
Part-Time and Per Diem	125	94	112	104	113	124	131	126
Total Employees	459	426	441	454	483	485	493	456
Full-Time Equivalents	371	356	384	348	349	374	375	393

NORTHERN INYO HEALTHCARE DISTRICT
STATISTICAL INFORMATION (CONTINUED)
LAST EIGHT YEARS

Bond Debt Service Cover (Thousands)	2025	2024	2023	2022	2021	2020	2019	2018
Excess (Deficit) of Revenue Over Expenses	$ 5,002	$ 5,749	$ (11,414)	$ (842)	$ 8,650	$ (2,641)	$ 1,725	$ 1,696
Add:								
Depreciation Expense	5,188	5,210	5,221	4,161	4,170	4,302	4,267	4,457
Interest Expense	1,754	2,782	2,611	2,616	3,890	2,377	2,912	2,893
Available to Meet Debt Service	$ 11,943	$ 13,741	$ (3,582)	$ 5,935	$ 16,710	$ 4,038	$ 8,904	$ 9,046
Actual Debt Service (Principal and Interest):								
2009 General Obligation Bonds	$ 1,150	$ 1,015	$ 1,145	$ 1,100	$ 1,020	$ 860	$ 1,364	$ 955
2016 General Obligation Bonds	1,252	1,254	981	1,317	865	1,242	1,178	1,179
2010 Revenue Bonds	1,211	1,211	1,211	1,209	1,204	1,179	765	769
2013 Revenue Bonds	765	765	765	765	769	762	864	814
2021 A Refunding Revenue Bonds	113	113	113	48	-	-	-	-
2021 B Refunding Revenue Bonds	894	905	864	84	-	-	-	-
Financed Purchases	1,547	1,578	20	394	382	-	-	-
Totals	$ 6,932	$ 6,841	$ 5,099	$ 4,917	$ 4,240	$ 4,043	$ 4,171	$ 3,717
Historical Debt Service Coverage Ratio	1.72	2.01	(1.15)	1.21	3.94	1.00	2.13	2.43

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

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

DATE: February 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights December 2025

Financial Summary

1. Net Income (loss): December's net loss was $(633k) which was worse than budget by $(8.2M) and worse than prior year by $(6.5M). This was due to timing of IGT, which was budgeted this month in the year but recognized last month in other income. Net patient revenue was better than budget by 22% or $1.8M and better than prior year by $3.4M due to higher volumes in most areas. Expenses were over budget by $565k and over prior year by $459k due to higher physician fees and professional services. For the year, net loss is $(3.2M) which is a miss of budget by $(10.3M). This is due to lower net revenue, higher expenses, and lower than planned supplemental income.
2. Operating Income (loss): December's operating loss was $(451k) which was better than budget by $1.2M due to higher than budgeted volumes and revenue.

   Action Plan: Volumes were strong in December and continued into the New Year. We also raised our prices since it had been over a year and we were eligible. This helps offset rising expenses. We continue to work on scheduling efficiency and ensuring we are managing expenses to get back to profitable.

Stats Summary

1. Admits (excluding Nursery): Admits were over budget by 11 admits due to higher ER volume and medical admits. For the year, admits are under budget by (26) admits due to surgeries and medical admits.
2. Inpatient Days (excluding Nursery): Inpatient days were over budget by 34 days due to more admissions. For the year, inpatient days were under budget by (224) days due to lower admits.
3. Average Daily Census: Census was over budget by 1 patient. For the year, census was lower by (1) patient.

4. Average Length of Stay (ALOS): Length of stay was at budget for December and lower than budget for the year.
5. Deliveries: For December, deliveries were (4) under budget. For the year, deliveries were (1) under budget.
6. Surgical Procedures: For December, surgeries were over budget by 9 cases with increases in general, orthopedics, and urology. For the year, surgeries were under budget by (35) cases with declines in ophthalmology due to Dr. Reid retiring and orthopedics due to transition in providers.
7. Emergency Department (ED) Visits: For December, ED visits were 97 visits over budget. For the year, ED visits were (134) under budget.
8. Diagnostic Imaging (DI) Exams: For December, exams were 202 over budget. For the year, exams were 643 (+5%) over budget.
9. Rehab Visits: For December, rehab visits were under budget by (37) visits. For the year, rehab visits were (625) under budget.
10. Outpatient Infusion / Injections / Wound Care Visits: For December, these visits were (107) under budget. For the year, these visits were over budget by 45%.
11. Observation Hours: Observations hours were down (12%) for December and (31%) for the year due to change in processes to meet regulatory requirements.
12. Rural Health Clinic (RHC) Visits: For December, RHC was 7% or 195 visits higher than budget. For the year, RHC visits were flat to budget.
13. Other Clinics: For December, other clinics were 337 visits over budget with most clinics exceeding budget. For the year, other clinics were 278 visits over budget due to specialty clinic, with budget misses in all other clinics.

Action Plan: Volumes were higher due to the start of flu and respiratory illness season. We are working on projects to improve scheduling efficiency in both the clinics and operating room. We are marketing the new orthopedics group including in Ridgecrest.

Revenue Summary

1. For December, gross revenue was over budget by $4.1M due to higher than budgeted volumes in most areas along with a 5% charge increase in most areas. For the year, gross revenue was under budget by $(766k) due to lower than budgeted volumes.

   Action Plan: We will continue to work on efficiency in schedules and increasing surgical volume.

Deductions Summary

1. Deductions were higher than budget by $2.5M due to higher than budgeted revenue. NR% of gross charges is consistent with budget at 43%.

Action Plan: We will continue to work on cash flow actions to reduce write-offs and increase cash. We will continue to work on increasing surgical volumes, which reimburse at a higher rate than a medical admit.

Salaries

1. Total Salaries: For December, salaries were over budget by 19% for December due to MOU implementation and retro pay occurring this month. For the year, salaries were over $2M (10%) due to an aggressive budget that did not include MOU changes. Full-time equivalents were also over by 5.1 FTEs. This was partially offset by lower than budgeted contract labor expense and benefits.
2. Average Hourly Rate: For December, average hourly rate was 12% higher than budget but only 4% higher than last December. For the year, average hourly rate was 7% over budget due to unbudgeted MOU changes.

Action Plan: We have developed reports to monitor our largest expense better including overtime, missed meal and rest breaks, and call pay to ensure we are staffing effectively. Additionally, we are reviewing where the increase of 5 FTEs occurred to determine if that was due to rising volumes.

Benefits

1. Total Benefits: For December, benefits were under budget by $(417k). For the year, benefits were under budget by $(490k).
2. Benefits % of Wages: We were 27% for December and 39% for the year.

Action Plan: We will continue to review opportunities with our benefits broker to save money while still offering quality benefits to our employees.

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For December, the unbudgeted MOU raises increased SWB per patient causing it to be 20% over budget. For the year, higher than budgeted wages along with lower than budgeted volumes caused this to be 27% over budget.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For December, this was at 49% which is close to industry standard. Including contract labor, this was at 50%, which is our goal. However, for the year, this was 53% including contract labor.

Contract Labor

1. Contract Labor Expense: For December, contract labor was lower by $(290k) due to YTD accounting corrects. For the year, contract labor was $(341k) under budget due to better recruiting and retention in a lot of areas.
2. Contract Labor Rates: Rates were 13% over budget due to women's services.
3. Contract Labor Full-Time Equivalents (FTEs): We used (24%) less than budgeted for contract labor FTEs.

   Action Plan: We are retaining employees and using less contract workers. However, we do anticipate staffing challenges and more contract labor in order to support labor & delivery services.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For December, physician expenses were 13% over budget. For the year, physician expenses were flat to budget.
2. Other Professional Fees: For December, other professional fees were over 30%. For the year, these were 25% over budget due to billing/collection fees and consulting.
3. Supplies: For December, supplies were over budget by $276k due to volumes. For the year, supplies were over budget $201k due to rising costs.
4. Total Expenses: For December, total expenses were $565k over budget due to MOU raises and higher supplies due to volume. For the year, total expenses were $2.8M over budget due to higher than budgeted wages due to MOU changes, higher professional services for billing/collections and rising inflation.

   Action Plan: We are educating leaders to be the "CEO of their own cost center" and manage their expenses to budgets FYE 2026. We will continue to monitor spend and find opportunities to save.

Cash Summary

1. Days Cash on Hand: Days cash on hand was 65 due to funding several large IGTs this month that will be recouped in early 2026. Our bond requirement is 75 days if we are profitable and 100 if we are not profitable.
2. Estimated Days until Depletion (excluding supplement/IGT): This month we collected less than we spent. We have 389 days excluding IGT.
3. Unrestricted Cash: Unrestricted cash balance is now $21M. This is $124k higher than last December.

   Action Plan: The cash flow action team continues to work on projects to decrease billing delays and improve cash. Our AR days has improved by 30 days or 1 month meaning we get cash in the door quicker. Jorie AI billing is helping us improve AR and cash flow.

Northern Inyo Healthcare District

December 2025 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Net Income (Loss)	(632,700)	7,559,289	(8,191,989)	(108%)	5,868,407	(6,501,107)	111%	(3,223,152)	7,088,489	(10,311,641)	145%	8,961,180	(12,184,332)	(136%)
Operating Income (Loss)	(450,779)	(1,688,355)	1,237,576	(73%)	(3,344,121)	2,893,341	87%	(10,863,331)	(4,721,464)	(6,141,867)	(130%)	(2,059,936)	(8,803,395)	427%
EBIDA (Loss)	(197,022)	7,976,443	(8,173,465)	(102%)	6,277,571	(6,474,593)	103%	(640,530)	9,591,412	(10,231,942)	107%	11,512,043	(12,152,573)	(106%)
IP Gross Revenue	4,837,635	3,265,690	1,571,945	48%	2,658,147	2,179,488	82%	21,611,487	22,127,437	(515,950)	(2%)	21,371,274	240,213	1%
OP Gross Revenue	16,353,865	14,301,930	2,051,935	14%	12,983,214	3,370,650	26%	85,515,860	87,030,314	(1,514,454)	(2%)	85,995,521	(479,662)	(1%)
Clinic Gross Revenue	2,150,379	1,649,095	501,284	30%	1,632,767	517,611	32%	11,781,239	10,517,121	1,264,119	12%	10,450,186	1,331,053	13%
Total Gross Revenue	**23,341,878**	**19,216,715**	**4,125,163**	**21%**	**17,274,128**	**6,067,750**	**35%**	**118,908,586**	**119,674,871**	**(766,285)**	**(1%)**	**117,816,981**	**1,091,605**	**1%**
Net Patient Revenue	**10,045,276**	**8,242,864**	**1,802,412**	**22%**	**6,693,130**	**3,352,145**	**50%**	**51,184,695**	**54,539,752**	**(3,355,057)**	**(6%)**	**54,112,572**	**(2,927,877)**	**(5%)**
Cash Net Revenue % of Gross	*43%*	*43%*	*0%*	*0%*	*39%*	*4%*	*11%*	*43%*	*46%*	*(3%)*	*(6%)*	*46%*	*(3%)*	*(6%)*
Admits (excl. Nursery)	73	62	11	18%	62	11	18%	409	435	(26)	(6%)	435	(26)	(6%)
IP Days	246	212	34	16%	212	34	16%	1,328	1,552	(224)	(14%)	1,552	(224)	(14%)
IP Days (excl. Nursery)	212	180	32	18%	180	32	18%	1,115	1,344	(228)	(17%)	1,344	(228)	(17%)
Average Daily Census	6.8	5.8	1.0	18%	5.8	1.0	18%	6.1	7.3	(1.2)	(17%)	7.3	(1.2)	(17%)
ALOS	2.9	2.9	0.0	0%	2.9	0.0	0%	2.7	3.1	(0.4)	(12%)	3.1	(0.4)	(12%)
Deliveries	17	21	(4)	(19%)	21	(4)	(19%)	110	111	(1)	(1%)	111	(1)	(1%)
OP Visits	3,852	3,887	(35)	(1%)	3,887	(35)	(1%)	24,289	23,117	1,172	5%	23,117	1,172	5%
Rural Health Clinic Visits	2,484	2,233	251	11%	2,233	251	11%	14,008	13,709	299	2%	13,709	299	2%
Rural Health Women Visits	544	505	39	8%	505	39	8%	3,211	3,116	95	3%	3,116	95	3%
Rural Health Behavioral Visits	107	202	(95)	(47%)	202	(95)	(47%)	751	1,144	(393)	(34%)	1,144	(393)	(34%)
Total RHC Visits	**3,135**	**2,940**	**195**	**7%**	**2,940**	**195**	**7%**	**17,970**	**17,969**	**1**	**0%**	**17,969**	**1**	**0%**
Bronco Clinic Visits	27	38	(11)	(29%)	38	(11)	(29%)	199	213	(14)	(7%)	213	(14)	(7%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	373	265	108	41%	265	108	41%	1,949	2,139	(190)	(9%)	2,139	(190)	(9%)
Pediatric Clinic Visits	560	505	55	11%	505	55	11%	3,408	3,546	(138)	(4%)	3,546	(138)	(4%)
Specialty Clinic Visits	714	513	201	39%	513	201	39%	4,100	3,274	826	25%	3,274	826	25%
Surgery Clinic Visits	124	133	(9)	(7%)	133	(9)	(7%)	807	931	(124)	(13%)	931	(124)	(13%)
Virtual Care Clinic Visits	43	50	(7)	(14%)	50	(7)	(14%)	269	351	(82)	(23%)	351	(82)	(23%)
Total NIA Clinic Visits	**1,841**	**1,504**	**337**	**22%**	**1,504**	**337**	**22%**	**10,732**	**10,454**	**278**	**3%**	**10,454**	**278**	**3%**
IP Surgeries	10	5	5	100%	5	5	100%	51	71	(20)	(28%)	71	(20)	(28%)
OP Surgeries	121	117	4	3%	117	4	3%	776	791	(15)	(2%)	791	(15)	(2%)
Total Surgeries	**131**	**122**	**9**	**7%**	**122**	**9**	**7%**	**827**	**862**	**(35)**	**(4%)**	**862**	**(35)**	**(4%)**
Cardiology	1	1	-	-%	1	-	-%	13	4	9	225%	4	9	225%
General	73	58	15	26%	58	15	26%	475	425	50	12%	425	50	12%
Gynecology & Obstetrics	8	13	(5)	(38%)	13	(5)	(38%)	65	71	(6)	(8%)	71	(6)	(8%)
Ophthalmology	-	28	(28)	(100%)	28	(28)	(100%)	68	134	(66)	(49%)	134	(66)	(49%)
Orthopedic	28	9	19	211%	9	19	211%	109	145	(36)	(25%)	145	(36)	(25%)
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	1	-	1	-%	-	1	100%	1	1	-	-%	1	-	-%
Podiatry	-	1	(1)	(100%)	1	(1)	(100%)	2	3	(1)	(33%)	3	(1)	(33%)
Urology	20	12	8	67%	12	8	67%	94	78	16	21%	78	16	21%
Diagnostic Image Exams	2,157	1,955	202	10%	1,955	202	10%	13,175	12,532	643	5%	12,532	643	5%
Emergency Visits	886	789	97	12%	789	97	12%	5,058	5,192	(134)	(3%)	5,192	(134)	(3%)
ED Admits	46	36	10	28%	36	10	28%	248	253	(5)	(2%)	253	(5)	(2%)
ED Admits % of ED Visits	5%	5%	1%	14%	5%	1%	14%	5%	5%	0%	1%	5%	0%	1%
Rehab Visits	703	740	(37)	(5%)	740	(37)	(5%)	4,574	5,199	(625)	(12%)	5,199	(625)	(12%)
OP Infusion/Wound Care Visits	625	732	(107)	(15%)	732	(107)	(15%)	3,957	2,725	1,232	45%	2,725	1,232	45%
Observation Hours	1,089	1,239	(150)	(12%)	1,239	(150)	(12%)	6,548	9,536	(2,988)	(31%)	9,536	(2,988)	(31%)

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

Northern Inyo Healthcare District
December 2025 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PAYOR MIX (Patient Days)														
Blue Cross	23.1%	20.6%	2.4%	11.9%	20.6%	2.4%	11.9%	24.9%	25.1%	(0.2%)	(0.9%)	25.1%	(0.2%)	(0.9%)
Commercial	6.0%	10.0%	(4.0%)	(39.8%)	10.0%	(4.0%)	(39.8%)	6.1%	7.0%	(0.9%)	(13.5%)	7.0%	(0.9%)	(13.5%)
Medicaid	19.2%	34.2%	(15.0%)	(43.7%)	34.2%	(15.0%)	(43.7%)	23.1%	26.7%	(3.6%)	(13.6%)	26.7%	(3.6%)	(13.6%)
Medicare	51.7%	34.2%	17.5%	51.0%	34.2%	17.5%	51.0%	43.6%	38.7%	5.0%	12.9%	38.7%	5.0%	12.9%
Self-pay	-%	1.0%	(1.0%)	(100.0%)	1.0%	(1.0%)	(100.0%)	2.4%	1.8%	0.5%	29.5%	1.8%	0.5%	29.5%
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	-%	0.6%	(0.6%)	(100.0%)	0.6%	(0.6%)	(100.0%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)
PAYOR MIX (Gross Revenue)														
Blue Cross	25.9%	26.4%	(0.5%)	(1.9%)	26.4%	(0.5%)	(1.9%)	27.7%	27.1%	0.6%	2.1%	27.1%	0.6%	2.1%
Commercial	6.7%	6.4%	0.3%	5.2%	6.4%	0.3%	5.2%	5.9%	6.3%	(0.4%)	(5.6%)	6.3%	(0.4%)	(5.6%)
Medicaid	17.5%	20.0%	(2.5%)	(12.6%)	20.0%	(2.5%)	(12.6%)	18.3%	19.9%	(1.5%)	(7.8%)	19.9%	(1.5%)	(7.8%)
Medicare	47.5%	42.8%	4.7%	11.0%	42.8%	4.7%	11.0%	45.2%	42.9%	2.3%	5.4%	42.9%	2.3%	5.4%
Self-pay	1.6%	3.4%	(1.8%)	(53.0%)	3.4%	(1.8%)	(53.0%)	2.1%	2.6%	(0.5%)	(18.7%)	2.6%	(0.5%)	(18.7%)
Worker's Comp	0.7%	0.9%	(0.2%)	(22.1%)	0.9%	(0.2%)	(22.1%)	0.8%	1.2%	(0.4%)	(36.1%)	1.2%	(0.4%)	(36.1%)
Other	0.1%	0.1%	(0.0%)	(35.6%)	0.1%	(0.0%)	(35.6%)	0.1%	0.2%	(0.1%)	(44.3%)	0.2%	(0.1%)	(44.3%)
DEDUCTIONS														
Contract Adjust	(11,815,242)	(9,943,164)	(1,872,078)	19%	(8,575,086)	(3,240,156)	38%	(62,427,688)	(59,017,489)	(3,410,198)	6%	(57,189,971)	(5,237,717)	9%
Bad Debt	(1,124,188)	(119,730)	(1,004,458)	839%	(526,905)	(597,283)	113%	(2,461,732)	(710,657)	(1,751,075)	246%	(1,180,267)	(1,281,465)	109%
Write-off	(357,172)	(731,396)	374,223	(51%)	(1,479,007)	1,121,835	(76%)	(2,834,471)	(4,341,186)	1,506,715	(35%)	(5,185,989)	2,351,517	(45%)
CENSUS														
Patient Days	212	180	32	18%	180	32	18%	1,115	1,344	(228)	(17%)	1,344	(228)	(17%)
Adjusted ADC	33	38	(5)	(13%)	38	(5)	(13%)	34	40	(7)	(17%)	40	(7)	(17%)
Adjusted Days	1,022	1,169	(147)	(13%)	1,169	(147)	(13%)	6,137	7,407	(1,271)	(17%)	7,407	(1,271)	(17%)
Employed FTE	386.3	364.6	21.7	6%	364.6	21.7	6%	378.9	367.7	11.2	3%	367.7	11.2	3%
Contract Labor FTE	18.9	26.2	(7.3)	(28%)	26.2	(7.3)	(28%)	19.7	25.8	(6.1)	(24%)	25.8	(6.1)	(24%)
Total Paid FTE	405.2	390.8	14.4	4%	390.8	14.4	4%	398.5	393.4	5.1	1%	393.4	5.1	1%
EPOB (Employee per Occupied Bed)	1.9	2.2	(0.3)	(12%)	2.2	(0.3)	(12%)	2.1	1.7	0.4	22%	1.7	0.4	22%
EPOC (Employee per Occupied Case)	0.4	0.3	0.1	19%	0.3	0.1	19%	0.1	0.1	0.0	21%	0.1	0.0	21%
Adjusted EPOB	9.2	14.1	(4.9)	(35%)	14.1	(4.9)	(35%)	11.7	9.6	2.1	22%	9.6	2.1	22%
Adjusted EPOC	1.9	2.2	(0.3)	(12%)	2.2	(0.3)	(12%)	0.4	0.3	0.1	21%	0.3	0.1	21%
SALARIES														
Per Adjust Bed Day	3,952	2,905	1,047	36%	3,132	820	26%	3,612	2,719	893	33%	2,529	1,083	43%
Total Salaries	4,037,755	3,394,919	642,836	19%	3,659,647	378,108	10%	22,164,953	20,139,151	2,025,802	10%	18,734,437	3,430,516	18%
Average Hourly Rate	59.00	52.57	6.44	12%	56.67	2.34	4%	55.64	52.10	3.54	7%	48.46	7.18	15%
Employed Paid FTEs	386.3	364.6	21.7	342.8	364.6	21.7	6%	378.9	367.7	11.2	3%	367.7	11.2	3%
BENEFITS														
Per Adjust Bed Day	1,072	1,293	(222)	(17%)	1,437	(365)	(25%)	1,409	1,234	176	14%	1,203	206	17%
Total Benefits	1,094,758	1,511,602	(416,845)	(28%)	1,678,868	(584,110)	(35%)	8,648,329	9,138,163	(489,835)	(5%)	8,910,177	(261,849)	(3%)
Benefits % of Wages	27%	45%	(17%)	(39%)	46%	-19%	(41%)	39%	45%	(6%)	(14%)	48%	(9%)	(18%)
Pension Expense	359,116	372,656	(13,539)	(4%)	380,455	(21,339)	(6%)	2,143,818	2,374,224	(230,407)	(10%)	2,425,606	(281,788)	(12%)
MDV Expense	441,559	782,153	(340,594)	(44%)	1,018,880	(577,321)	(57%)	4,614,318	4,642,457	(28,139)	(1%)	4,661,954	(47,635)	(1%)
Taxes, PTO accrued, Other	294,083	356,793	(62,711)	(18%)	279,532	14,550	5%	1,890,192	2,121,482	(231,289)	(11%)	1,822,617	67,575	4%
Salaries, Wages & Benefits	5,132,512	4,906,521	225,991	5%	5,338,515	(206,002)	(4%)	30,813,282	29,277,314	1,535,968	5%	27,644,614	3,168,668	11%
SWB/APD	5,024	4,199	825	20%	4,568	455	10%	5,021	3,953	1,069	27%	3,732	1,289	35%
SWB % of Total Expenses	49%	49%	(1%)	(1%)	53%	(4%)	(8%)	50%	49%	0%	1%	49%	0%	1%

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

Northern Inyo Healthcare District
December 2025 – Financial Summary

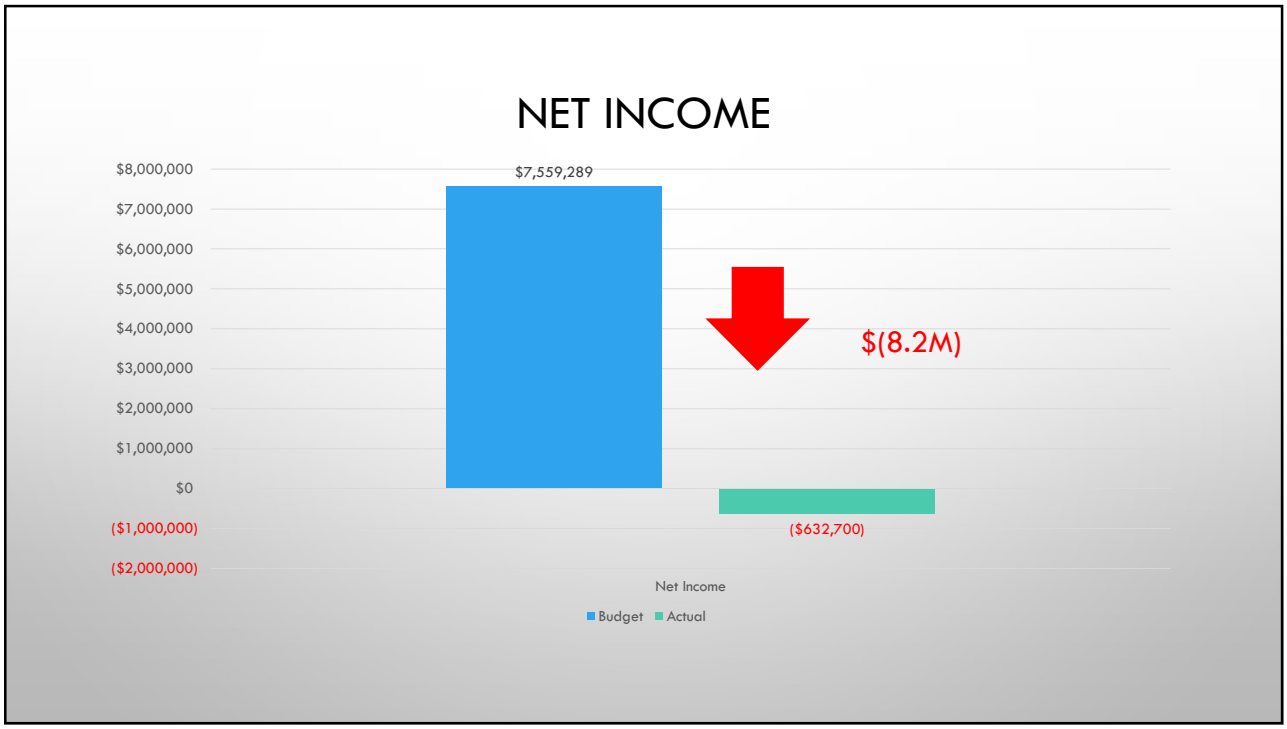
** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,872	2,400	472	20%	2,281	591	26%	2,824	2,261	564	25%	2,037	788	39%
Total Physician Fee	1,946,664	1,721,844	224,820	13%	1,498,281	448,382	30%	10,296,337	10,273,062	23,275	0%	9,280,455	1,015,882	11%
Total Contract Labor	131,351	421,796	(290,445)	(69%)	672,468	(541,117)	(80%)	2,172,563	2,513,310	(340,746)	(14%)	3,024,285	(851,722)	(28%)
Total Other Pro-Fees	856,304	661,164	195,140	30%	495,336	360,968	73%	4,863,916	3,959,030	904,886	23%	2,780,577	2,083,339	75%
Total Professional Fees	2,934,318	2,804,804	129,515	5%	2,666,085	268,233	10%	17,332,816	16,745,401	587,415	4%	15,085,317	2,247,499	15%
Contract AHR	39.26	90.84	(51.59)	(57%)	144.83	(105.57)	(73%)	105.10	92.78	12.32	13%	111.64	(6.54)	(6%)
Contract Paid FTEs	18.9	26.2	(7.3)	(28%)	26.2	(7.3)	(28%)	19.7	25.8	(6.1)	(24%)	25.8	(6.1)	(24%)
Physician Fee per Adjust Bed Day	1,905	1,473	432	29%	1,282	623	49%	1,678	1,387	291	21%	1,253	425	34%
PHARMACY														
Per Adjust Bed Day	481	386	94	24%	382	99	26%	401	362	39	11%	286	114	40%
Total Rx Expense	491,024	451,577	39,447	9%	446,090	44,933	10%	2,459,893	2,680,327	(220,434)	(8%)	2,121,627	338,265	16%
MEDICAL SUPPLIES														
Per Adjust Bed Day	664	378	286	76%	299	365	122%	496	354	142	40%	426	70	17%
Total Medical Supplies	678,410	442,141	236,269	53%	348,884	329,526	94%	3,044,872	2,623,836	421,036	16%	3,153,684	(108,813)	(3%)
EHR SYSTEM														
Per Adjust Bed Day	35	27	8	28%	10	25	234%	38	26	12	47%	27	11	41%
Total EHR Expense	35,831	32,115	3,716	12%	12,263	23,569	192%	234,202	192,689	41,513	22%	200,001	34,200	17%
OTHER EXPENSE														
Per Adjust Bed Day	772	750	21	3%	698	73	10%	909	707	202	29%	731	178	24%
Total Other	788,282	876,908	(88,626)	(10%)	816,251	(27,969)	(3%)	5,580,340	5,238,726	341,614	7%	5,416,400	163,940	3%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	426	357	69	19%	350	76	22%	421	338	83	25%	344	76	22%
Total Depreciation and Amortization	435,678	417,154	18,524	4%	409,164	26,514	6%	2,582,622	2,502,923	79,699	3%	2,550,863	31,759	1%
TOTAL EXPENSES	10,496,055	9,931,219	564,836	6%	10,037,251	458,804	5%	62,048,026	59,261,216	2,786,810	5%	56,172,508	5,875,518	10%
Per Adjust Bed Day	10,273	8,498	1,775	21%	8,589	1,684	20%	10,111	8,001	2,111	26%	7,584	2,528	33%
Per Calendar Day	338,582	320,362	18,221	6%	323,782	14,800	5%	337,218	322,072	15,146	5%	305,285	31,932	10%

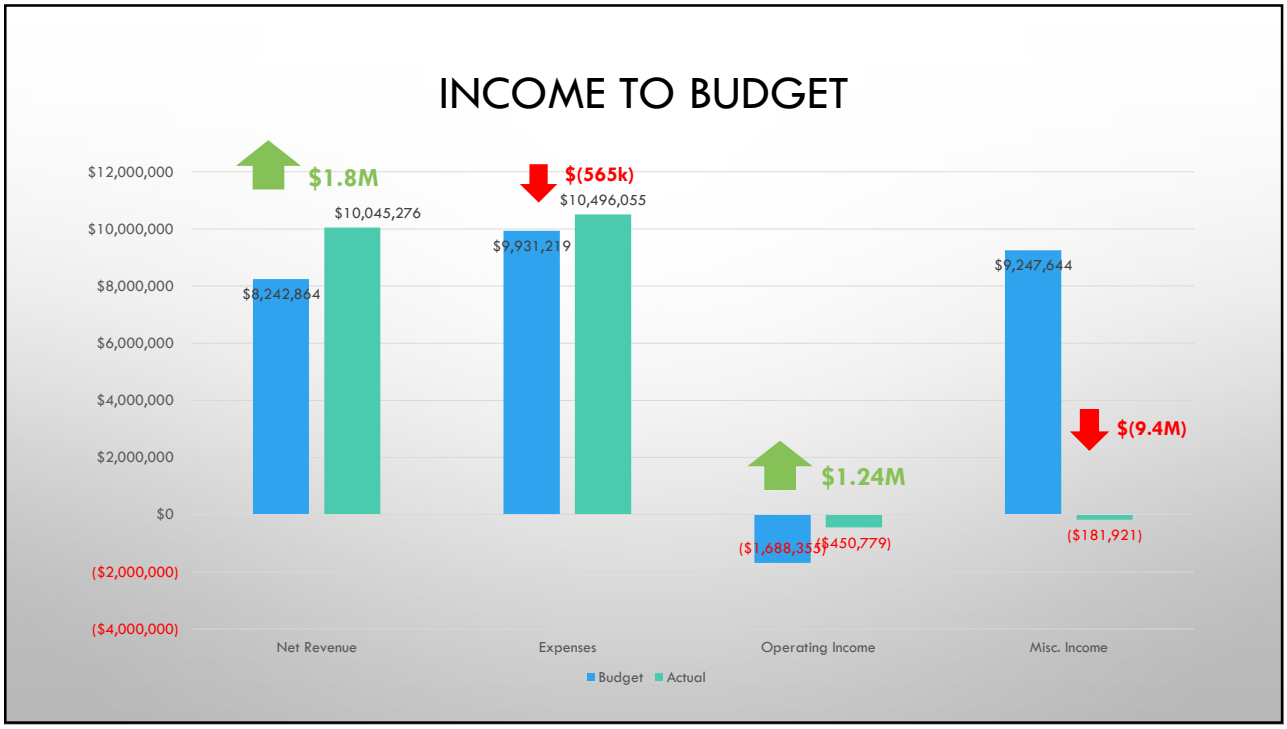
Provided by: Chief Financial Officer
Report Name: November 2025 Financial Summary

Key Financial Performance Indicators	Industry Benchmark	Dec-23	FYE 2024 Average	Dec-24	FYE 2025 Average	Sep-25	Oct-25	Nov-25	Dec-25	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Volume												
Admits	41	68	69	62	71	65	76	67	73	6	2	11
Deliveries	n/a	18	17	21	17	20	15	18	17	(1)	-	(4)
Adjusted Patient Days	n/a	971	977	1,169	1,125	1,023	1,161	880	1,022	142	(103)	(147)
Total Surgeries	153	143	146	122	140	163	147	112	131	19	(9)	9
ER Visits	659	833	826	789	852	840	819	726	886	160	34	97
RHC and Clinic Visits	n/a	4,576	4,607	4,444	4,772	4,738	5,154	4,384	4,976	592	204	532
Diagnostic Imaging Services	n/a	1,899	2,069	1,955	2,129	2,271	2,274	1,957	2,157	200	28	202
Rehab Services	n/a	547	662	740	838	739	764	769	703	(66)	(135)	(37)
AR & Income												
Gross AR (Cerner only)	n/a	$ 53,913,830	$ 52,823,707	$ 46,678,451	$ 50,813,697	$ 40,875,951	$ 38,777,469	$ 37,941,078	$ 40,266,148	$ 2,325,070	$ (10,547,549)	$ (6,412,303)
AR > 90 Days	$ 6,599,901.18	$ 26,961,876	$ 23,112,391	$ 19,761,172	$ 20,669,422	$ 16,330,677	$ 14,855,434	$ 14,887,324	$ 14,240,093	$ (647,231)	$ (6,429,329)	$ (5,521,079)
AR % > 90 Days	15%	50.8%	44.2%	42.33%	40.6%	40.0%	38.3%	39.2%	35.4%	-3.9%	-5.2%	-7.0%
Gross AR Days (per financial statements)	60	89	85	84	80	62	58	66	53	(13)	(27)	(30)
Net AR Days (per financial statements)	30	66	58	84	71	54	36	55	67	13	(3)	(16)
Net AR	n/a	$ 20,452,310	$ 16,938,200	$ 18,106,671	$ 19,370,868	$ 14,268,379	$ 11,138,154	$ 13,862,975	$ 21,831,732	$ 7,968,757	$ 2,460,865	$ 3,725,061
Net AR % of Gross	n/a	37.9%	31.9%	38.8%	38.5%	34.9%	28.7%	36.5%	54.2%	17.7%	15.7%	15.4%
Gross Patient Revenue/Calendar Day	n/a	$ 604,887	$ 619,457	$ 557,230	$ 634,418	$ 661,191	$ 671,419	$ 571,795	$ 752,964	$ 181,169	$ 118,545	$ 195,734
Net Patient Revenue/Calendar Day	n/a	$ 308,700	$ 292,759	$ 215,907	$ 273,563	$ 264,312	$ 308,780	$ 253,195	$ 324,041	$ 70,846	$ 50,478	$ 108,134
Net Patient Revenue/APD	n/a	$ 9,855	$ 8,757	$ 5,727	$ 8,088	$ 7,749	$ 8,246	$ 8,631	$ 9,832	$ 1,201	$ 1,744	$ 4,105
Wages												
Wages	n/a	$ 3,303,307	$ 3,285,431	$ 3,659,647	$ 3,661,965	$ 3,512,638	$ 3,694,416	$ 3,562,811	$ 4,037,755	$ 474,943	$ 375,789	$ 378,108
Employed paid FTEs	n/a	346.65	353.69	364.57	370.77	375.49	377.37	378.81	386.31	7.50	15.54	21.74
Employed Average Hourly Rate	$55.50	$ 53.79	$ 53.49	$ 56.82	$ 56.89	$ 54.72	$ 55.42	$ 55.02	$ 59.17	$ 4.15	$ 2.28	$ 2.34
Benefits	n/a	$ 1,251,579	$ 1,640,216	$ 1,678,868	$ 1,401,858	$ 1,502,338	$ 1,826,000	$ 1,547,641	$ 1,094,758	$ (452,884)	$ (307,100)	$ (584,110)
Benefits % of Wages	30%	37.9%	48.8%	45.9%	39.8%	42.8%	49.4%	43.4%	27.1%	-16.3%	-12.7%	-18.8%
Contract Labor	n/a	$ 508,486	$ 518,351	$ 672,468	$ 447,445	$ 455,774	$ 358,976	$ 504,270	$ 131,351	$ (372,919)	$ (316,094)	$ (541,117)
Contract Labor Paid FTEs	n/a	22.52	23.49	26.21	23.89	20.69	19.09	19.88	18.89	(0.99)	(5.00)	(7.32)
Total Paid FTEs	n/a	369.17	377.18	390.78	394.65	396.18	396.46	398.69	405.19	6.51	10.54	14.41
Contract Labor Average Hourly Rate	$ 81.04	$ 127.46	$ 123.22	$ 145.23	$ 120.98	$ 128.84	$ 106.43	$ 148.37	$ 39.36	$ (109.01)	$ (81.62)	$ (105.87)
Total Salaries, Wages, & Benefits	n/a	$ 5,063,372	$ 5,443,998	$ 6,010,983	$ 5,511,268	$ 5,470,750	$ 5,879,392	$ 5,614,723	$ 5,263,863	$ (350,859)	$ (247,405)	$ (747,120)
SWB% of NR	50%	61.0%	62.1%	89.8%	72.0%	69.0%	61.4%	73.9%	52.4%	-21.5%	-19.6%	-37.4%
SWB/APD	2,204	$ 5,215	$ 5,104	$ 5,144	$ 5,284	$ 5,347	$ 5,065	$ 6,380	$ 5,152	$ (1,228)	$ (132)	$ 9
SWB % of total expenses	50%	56.8%	55.4%	59.9%	55.6%	54.5%	52.5%	53.5%	50.2%	-3.4%	-5.5%	-9.7%

Physician Spend	Industry Benchmark	Dec-23	FYE 2024 Average	Dec-24	FYE 2025 Average	Sep-25	Oct-25	Nov-25	Dec-25	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Physician Expenses	n/a	$ 1,498,281	$ 1,613,172	$ 1,416,488	$ 1,507,510	$ 1,645,840	$ 1,932,281	$ 1,597,620	$ 1,946,664	$ 349,044	$ 439,153	$ 530,176
Physician expenses/APD	n/a	$ 1,282	$ 1,565	$ 1,212	$ 1,476	$ 1,608	$ 1,664	$ 1,815	$ 1,905	$ 90	$ 429	$ 693
Supplies												
Supply Expenses	n/a	$ 794,786	$ 832,644	$ 809,100	$ 776,504	$ 727,501	$ 1,004,885	$ 835,043	$ 1,169,433	$ 334,390	$ 392,930	$ 360,333
Supply expenses/APD		$ 680	$ 822	$ 692	$ 744	$ 711	$ 866	$ 949	$ 1,145	$ 196	$ 400	$ 452
Other Expenses												
Other Expenses	n/a	$ 1,733,013	$ 1,939,040	$ 678,357	$ 1,824,207	$ 2,186,236	$ 2,376,590	$ 2,440,391	$ 2,116,095	$ (324,296)	$ 291,888	$ 1,437,738
Other Expenses/APD	n/a	$ 1,483	$ 1,861	$ 580	$ 1,787	$ 2,137	$ 2,047	$ 2,773	$ 2,071	$ (702)	$ 284	$ 1,491
Margin												
Net Income	n/a	$ 5,868,595	$ 253,100	$ 1,000,942	$ 383,722	$ (1,640,281)	$ (1,132,695)	$ 3,176,018	$ (632,700)	$ (3,808,718)	$ (1,016,422)	$ (1,633,642)
Net Profit Margin	n/a	87.7%	3.7%	10.5%	3.0%	-20.7%	-11.8%	41.8%	-6.3%	-48.1%	-9.3%	-16.8%
Operating Income	n/a	$ (3,343,933)	$ (1,557,761)	$ 654,759	$ (686,444)	$ (2,100,965)	$ (1,620,972)	$ (2,891,928)	$ (450,779)	$ 2,441,149	$ 235,665	$ (1,105,538)
Operating Margin	2.9%	-50.0%	-26.1%	6.8%	-10.9%	-26.5%	-16.9%	-38.1%	-4.5%	33.6%	6.4%	-11.3%
EBITDA	n/a	$ 6,277,759	$ 676,999	$ 1,345,271	$ 841,891	$ (1,213,453)	$ (697,302)	$ 3,593,558	$ (197,022)	$ (3,790,580)	$ (1,038,913)	$ (1,542,294)
EBITDA Margin	12.7%	93.8%	9.4%	14.1%	8.7%	-15.3%	-7.3%	47.3%	-2.0%	-49.3%	-10.7%	-16.1%
Debt Service Coverage Ratio	3.70	774.1%	3.9	2.3	3.3	(5.5)	(5.0)	(0.6)	(0.7)	(0.1)	(4.0)	(3.0)
Cash												
Avg Daily Disbursements (excl. IGT)	n/a	$ 367,542	$ 350,828	$ 264,416	$ 355,328	$ 325,126	$ 416,814	$ 388,940	$ 380,372	$ (8,569)	$ 25,043	$ 115,955
Average Daily Cash Collections (excl. IGT)	n/a	$ 273,563	$ 340,919	$ 316,748	$ 299,110	$ 348,085	$ 388,454	$ 278,666	$ 325,614	$ 46,948	$ 26,503	$ 8,865
Average Daily Net Cash		$ (93,979)	$ (9,908)	$ 52,332	$ (56,218)	$ 22,959	$ (28,360)	$ (110,274)	$ (54,758)	$ 55,516	$ 1,460	$ (107,090)
Upfront Cash Collections		$ 22,508	$ 54,286	$ 22,671	$ 36,146	$ 63,634	$ 77,539	$ 43,734	$ 42,688	$ (1,046)	$ 6,542	$ 20,017
Upfront Cash % of Gross Charges	1%	0.1%	0.3%	0.1%	0.2%	0.3%	0.4%	0.3%	0.2%	-0.1%	0.0%	0.1%
Unrestricted Funds	n/a	$ 15,074,303	$ 23,774,285	$ 20,904,990	$ 23,536,438	$ 26,418,948	$ 26,719,622	$ 21,356,431	$ 21,028,877	$ (327,554)	$ (2,507,561)	$ 123,887
Change of cash per balance sheet	n/a	$ (1,025,067)	$ 321,485	$ (163,212)	$ (321,485)	$ 756,674	$ 300,674	$ (5,363,191)	$ (327,554)	$ 5,035,638	$ (6,068)	$ (164,342)
Days Cash on Hand (assume no more cash is collected)	196	50	73	79	72	85	84	66	65	(1)	(7)	(14)
Estimated Days Until Depleted (operating cash only)		292	2,399	486	406	491	671	396	389	(7)	(17)	(97)
Years Until Cash Depletion (operating cash only)		0.80	6.57	1.33	1.11	1.34	1.84	1.09	1.07	(0.02)	(0.05)	(0.26)

VOLUME & INCOME


NET INCOME
$8,000,000
$7,000,000
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
($1,000,000)
($2,000,000)
$7,559,289
$(8.2M)
($632,700)
Net Income
Budget
Actual


INCOME TO BUDGET
$12,000,000
$10,000,000
$8,000,000
$6,000,000
$4,000,000
$2,000,000
$0
($2,000,000)
($4,000,000)
$1.8M
$10,045,276
$8,242,864
$(565k)
$10,496,055
$9,931,219
$1.24M
($1,688,355)
($450,779)
$9,247,644
$(9.4M)
($181,921)
Net Revenue
Expenses
Operating Income
Misc. Income
Budget
Actual

VOLUME & INCOME ACTION PLAN

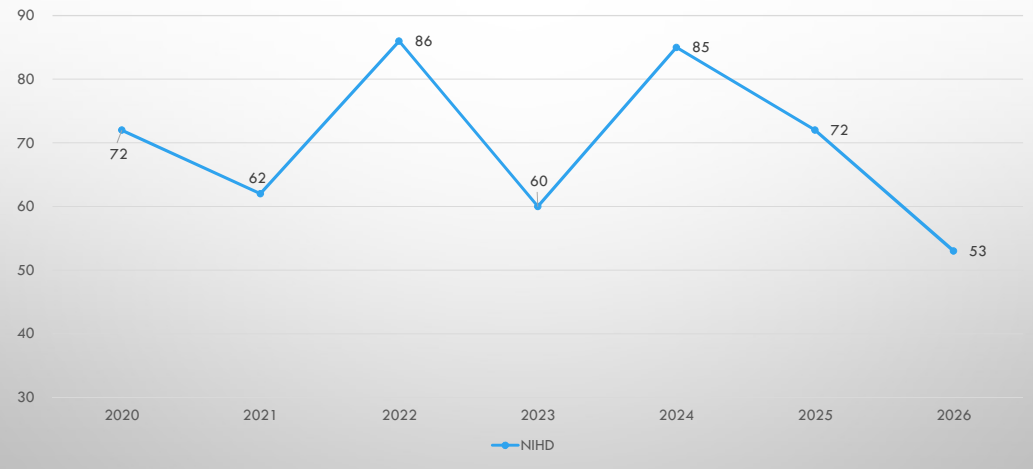
- THE MAMMOTH ORTHOPEDIC INSTITUTE BEGAN ORTHOPEDIC SURGERIES IN JULY. THEIR SURGICAL VOLUME HAS STEADILY INCREASED THE PAST FEW MONTH. THE ORTHO CLINIC EXCEEDED THEIR BUDGET FOR DECEMBER AND ORTHOPEDICS SURGERIES ALSO WERE ABOVE BUDGET.
- WE ARE WORKING ON REVIEWING OPERATIONAL EFFICIENCY INCLUDING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

CASH PERFORMANCE

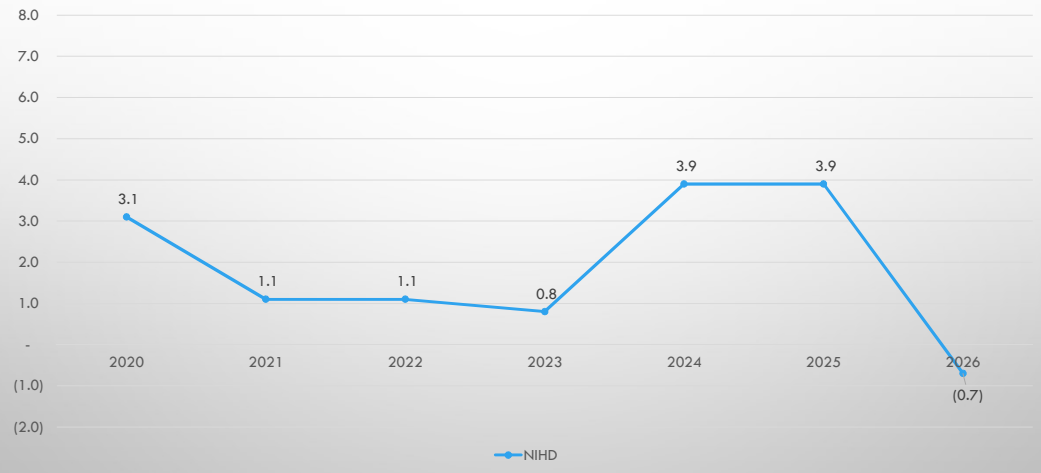
INCOME TO CASH

	FYE 2026
Net Income (loss)	**$(3,223,152)**
Principal Payments on Long-Term Debt (balance sheet only)	$(1,861,947)
Other Debt (long-term leases & subscriptions – balance sheet only)	$(455,983)
Capital purchases (balance sheet only)	$(568,351)
Timing of Accruals vs Disbursements (cash vs accruals)	$2,208,076
IGT Revenue Recognized but Cash Not Received (cash vs. accruals)	$(3,569,320)
Impact to Cash	**$(4,247,525)**
Adjusted Net Income (cash basis)	**$(7,470,677)**

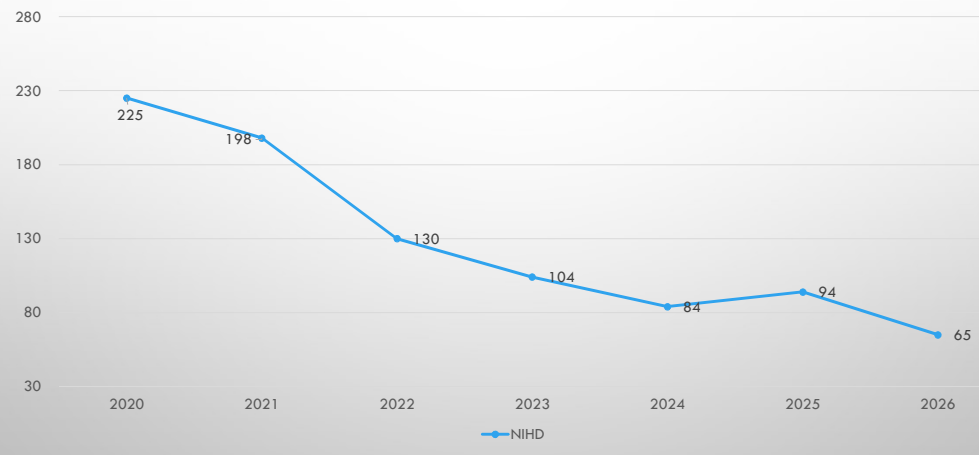
GROSS AR DAYS



DEBT SERVICE COVERAGE RATIO



DAYS CASH ON HAND



UNRESTRICTED FUNDS

CASH ACTION PLAN

- THE CASH FLOW ACTION TEAM IS WORKING TO IMPROVE PROCESSES IN ALL ASPECTS OF BILLING AND COLLECTIONS.
- WE HAVE HIRED A NEW AI-BASED BILLING COMPANY, JORIE, AND HAVE HIT RECORD CASH COLLECTIONS THE PAST FEW MONTHS. THE AUTOMATION IS NOW LIVE IN SEVERAL AREAS.
- WE HAVE MOVED $11M IN CASH TO FIVE STAR BANK TO EARN BETTER RETURNS ON OUR CASH.
- WE HAVE ANOTHER $5.5M IN THE LAIF EARNING OVER 4% INTEREST.
- WE COLLECTED $220K MORE IN CY 2025 UPFRONT THAN WE DID IN EITHER CY 2023 OR CY 2024.
- AR DAYS ARE AT A RECORD LOW FOR THE ORGANIZATION.
- WE HAVE SWITCHED OUR MEDI-CAL BILLING TO JORIE AS OF DECEMBER TO IMPROVE COLLECTIONS EVEN FURTHER.
- WE HAVE RECEIVED A NET OF $500K FROM UNDERPAYMENTS ON CLAIMS

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2026

	9/30/2025	Sept Budget	9/30/2024	10/31/2025	Oct Budget	10/31/2024	11/30/2025	Nov Budget	11/30/2024	12/31/2025	Dec Budget	12/31/2024	2026 YTD	Budget Variance	PYM Change
Gross Patient Service Revenue															
Inpatient Patient Revenue	3,114,655	4,078,963	4,039,585	3,663,512	3,432,674	3,316,543	3,068,437	3,683,029	3,654,138	4,837,635	3,265,690	2,658,147	21,611,487	1,571,945	2,179,488
Outpatient Revenue	14,794,416	15,235,114	15,293,444	15,012,546	16,276,892	16,328,013	12,251,051	12,068,831	12,133,332	16,353,865	14,301,930	12,983,214	85,515,860	2,051,935	3,370,650
Clinic Revenue	1,926,649	1,774,172	1,756,606	2,137,938	2,016,861	2,003,181	1,834,353	1,712,532	1,695,930	2,150,379	1,649,095	1,632,767	11,781,239	501,284	517,611
Gross Patient Service Revenue	19,835,720	21,088,249	21,089,635	20,813,996	21,726,427	21,647,737	17,153,841	17,464,392	17,483,401	23,341,878	19,216,715	17,274,128	118,908,586	4,125,163	6,067,750
Deductions from Revenue															
Contractual Adjustments	(11,079,353)	(9,622,417)	(10,744,619)	(10,574,256)	(9,943,164)	(10,328,421)	(9,501,354)	(9,622,417)	(9,645,351)	(11,815,242)	(9,943,164)	(8,575,086)	(62,427,688)	(1,872,078)	(3,240,156)
Bad Debt	(253,457)	(115,868)	(1,378,285)	242,346	(119,730)	(302,126)	226,725	(115,868)	2,304,836	(1,124,188)	(119,730)	(526,905)	(2,461,732)	(1,004,458)	(597,283)
A/R Writeoffs	(573,549)	(707,802)	(394,591)	(909,911)	(731,396)	(1,472,830)	(283,363)	(707,802)	(1,097,867)	(357,172)	(731,396)	(1,479,007)	(2,834,471)	374,223	1,121,835
Other Deductions from Revenue	-	(173,770)	-	-	(179,562)	-	-	(173,770)	-	-	(179,562)	-	-	179,562	-
Deductions from Revenue	(11,906,359)	(10,619,856)	(12,517,495)	(11,241,821)	(10,973,852)	(12,103,377)	(9,557,992)	(10,619,856)	(8,438,382)	(13,296,602)	(10,973,852)	(10,580,998)	(67,723,891)	(2,322,751)	(2,715,604)
Other Patient Revenue															
Incentive Income	-	-	2,000	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	2,000	-	-	-	-	-	-	-	-	-	-	-	-
Net Patient Service Revenue	**7,929,361**	**10,468,392**	**8,574,140**	**9,572,175**	**10,752,575**	**9,544,361**	**7,595,849**	**6,844,535**	**9,045,019**	**10,045,276**	**8,242,864**	**6,693,130**	**51,184,695**	**1,802,412**	**3,352,145**
CNR%	**40.0%**	**49.6%**	**40.7%**	**46.0%**	**49.5%**	**44.1%**	**44.3%**	**39.2%**	**51.7%**	**43.0%**	**42.9%**	**38.7%**	**43.0%**	**0.1%**	**4.3%**
Cost of Services - Direct															
Salaries and Wages	2,998,160	2,804,210	2,855,425	3,155,300	2,899,508	3,033,243	3,026,638	2,790,979	2,944,227	3,435,111	2,888,220	3,119,241	18,885,190	546,891	315,870
Benefits	1,280,717	1,254,242	1,387,677	1,561,958	1,289,162	1,587,436	1,252,353	1,191,782	616,715	933,385	1,288,785	1,445,404	7,322,249	(355,400)	(512,019)
Professional Fees	1,853,649	1,745,359	1,865,737	2,141,550	1,828,541	1,956,752	1,817,462	1,683,241	1,765,895	2,193,430	1,864,795	1,757,982	11,530,188	328,635	435,448
Contract Labor	376,610	341,317	(172,022)	257,899	303,030	466,567	423,986	347,300	495,129	84,298	270,699	366,331	1,672,491	(186,401)	(282,033)
Pharmacy	367,511	437,010	432,361	432,888	451,577	363,699	308,065	437,010	628,990	491,024	451,577	446,090	2,459,893	39,447	44,933
Medical Supplies	359,990	427,637	353,623	571,996	442,141	496,964	526,979	427,637	406,800	678,410	442,141	348,884	3,044,872	236,269	329,526
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	31,736	32,115	26,143	42,185	32,115	25,930	45,755	32,115	47,276	35,831	32,115	12,263	234,202	3,716	23,569
Other Direct Expenses	635,834	632,889	452,410	829,934	699,541	687,481	787,124	660,753	854,548	566,683	630,395	554,226	4,206,347	(63,712)	12,457
Total Cost of Services - Direct	7,904,208	7,674,778	7,201,353	8,993,710	7,945,613	8,618,072	8,188,360	7,570,816	7,759,581	8,418,171	7,868,725	8,050,420	49,355,431	549,446	367,751
General and Administrative Overhead															
Salaries and Wages	514,477	481,196	516,811	539,116	495,411	588,796	536,174	494,427	519,714	602,644	506,699	540,406	3,279,763	95,945	62,238
Benefits	221,621	217,039	246,360	264,041	217,926	308,829	295,289	281,007	96,641	161,373	222,818	233,464	1,326,080	(61,445)	(72,091)
Professional Fees	648,703	610,805	226,058	649,380	554,467	294,687	726,582	672,923	231,039	609,538	518,213	235,635	3,630,064	91,325	373,903
Contract Labor	79,164	71,745	59,381	101,078	118,766	77,262	80,283	65,763	88,238	47,053	151,097	306,137	500,073	(104,044)	(259,084)
Depreciation and Amortization	426,828	417,154	440,195	435,393	417,154	409,531	417,540	417,154	409,531	435,678	417,154	409,164	2,582,622	18,524	26,514
Other Administative Expenses	233,393	232,312	186,912	210,428	177,367	149,642	243,549	204,448	481,883	221,599	246,514	262,025	1,373,993	(24,914)	(40,426)
Total General and Administrative Overhead	2,124,186	2,030,252	1,675,716	2,199,437	1,981,092	1,828,748	2,299,417	2,135,721	1,827,047	2,077,884	2,062,494	1,986,831	12,692,595	15,390	91,053
Total Expenses	**10,028,394**	**9,705,029**	**8,877,070**	**11,193,147**	**9,926,705**	**10,446,820**	**10,487,777**	**9,706,537**	**9,586,628**	**10,496,055**	**9,931,219**	**10,037,251**	**62,048,026**	**564,836**	**458,804**
Financing Expense	178,823	196,180	192,696	181,041	196,180	215,407	171,993	196,180	206,574	174,430	196,180	201,339	1,085,101	(21,750)	(26,909)
Financing Income	260,000	286,867	286,867	260,000	181,031	181,031	260,000	181,031	181,031	260,000	181,031	181,031	1,560,000	78,969	78,969
Investment Income	43,082	47,322	50,746	73,728	47,322	40,963	66,342	47,322	56,648	347,664	47,322	45,165	629,685	300,341	302,498
Miscellaneous Income	336,425	236,765	177,134	335,591	1,214,625	293,111	5,913,597	217,829	248,404	(615,154)	9,215,471	9,187,671	6,535,595	(9,830,625)	(9,802,825)
Net Income (Change in Financial Position)	**(1,638,349)**	**1,138,137**	**19,121**	**(1,132,695)**	**2,072,668**	**(602,761)**	**3,176,018**	**(2,611,999)**	**(262,101)**	**(632,700)**	**7,559,289**	**5,868,407**	**(3,223,152)**	**(8,191,989)**	**(6,501,107)**
Operating Income	(2,099,033)	763,363	(302,930)	(1,620,972)	825,870	(902,460)	(2,891,928)	(2,862,001)	(541,610)	(450,779)	(1,688,355)	(3,344,121)	(10,863,331)	1,237,576	2,893,341
EBIDA	(1,211,521)	1,555,291	459,316	(697,302)	2,489,822	(193,230)	3,593,558	(2,194,845)	147,431	(197,022)	7,976,443	6,277,571	(640,530)	(8,173,465)	(6,474,593)
Net Profit Margin	-20.7%	10.9%	0.2%	-11.8%	19.3%	-6.3%	41.8%	-38.2%	-2.9%	-6.3%	91.7%	87.7%	-6.3%	-98.0%	-94.0%
Operating Margin	-26.5%	7.3%	-3.5%	-16.9%		-9.5%	-38.1%	-41.8%	-6.0%	-4.5%	-20.5%	-50.0%	-21.2%	16.0%	45.5%
EBIDA Margin	-15.3%	14.9%	5.4%	-7.3%		-2.0%	47.3%	-32.1%	1.6%	-2.0%	96.8%	93.8%	-1.3%	-98.7%	-95.8%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2026

	PY Balances	9/30/2025	9/30/2024	10/31/2025	10/31/2024	11/30/2025	11/30/2024	12/31/2025	12/31/2024	PM Change	PY Change
Assets											
Current Assets											
Cash and Liquid Capital	20,757,956	18,620,647	17,374,679	19,711,431	16,909,058	14,348,583	10,295,002	14,510,441	9,262,111	161,858	5,248,330
Short Term Investments	7,741,599	7,301,260	7,574,716	6,511,054	6,876,555	6,271,772	6,872,978	6,021,285	6,873,880	(250,487)	(852,595)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	16,645,748	14,268,379	19,842,483	11,138,154	19,252,585	13,862,975	20,054,289	21,831,732	18,106,671	7,968,757	3,725,061
Other Receivables	9,238,007	11,053,197	4,823,782	12,675,718	4,771,477	18,836,206	9,458,105	13,490,140	18,665,903	(5,346,066)	(5,175,763)
Inventory	5,334,241	5,327,510	6,112,780	5,325,812	6,079,443	5,329,753	6,117,401	5,368,712	6,141,928	38,959	(773,216)
Prepaid Expenses	1,106,127	1,913,942	1,933,935	1,495,596	1,353,383	1,423,818	1,091,960	1,500,971	852,094	77,153	648,877
Total Current Assets	**60,823,678**	**58,484,936**	**57,662,375**	**56,857,764**	**55,242,502**	**60,073,106**	**53,889,735**	**62,723,281**	**59,902,587**	**2,650,176**	**2,820,694**
Assets Limited as to Use											
Internally Designated for Capital Acquisitio	-	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,469,292	1,469,672	1,468,166	1,469,800	1,468,293	1,469,924	1,468,417	(711,423)	1,468,545	(2,181,347)	(2,179,968)
Limited Use Assets			-		-		-		-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	9,393,030	9,393,030	10,346,490	9,393,030	10,346,490	9,393,030	10,346,490	9,393,030	10,346,490	-	(953,460)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisitio	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	9,966,127	9,966,127	10,919,587	9,966,127	10,919,587	9,966,127	10,919,587	9,966,127	10,919,587	-	(953,460)
Revenue Bonds Held by a Trustee	297,382	280,149	359,303	274,405	353,592	268,661	347,848	262,916	342,104	(5,744)	(79,188)
Total Assets Limited as to Use	**11,732,801**	**11,715,948**	**12,747,056**	**11,710,332**	**12,741,473**	**11,704,712**	**12,735,852**	**9,517,621**	**12,730,236**	**(2,187,091)**	**(3,212,616)**
Long Term Assets											
Long Term Investment	497,086	497,041	755,869	497,137	999,950	736,076	747,654	497,152	748,961	(238,925)	(251,809)
Fixed Assets, Net of Depreciation	81,644,252	81,093,361	84,066,999	80,788,073	83,828,939	80,414,574	83,555,961	80,152,672	83,368,289	(261,902)	(3,215,617)
Total Long Term Assets	**82,141,338**	**81,590,401**	**84,822,868**	**81,285,210**	**84,828,890**	**81,150,650**	**84,303,615**	**80,649,823**	**84,117,250**	**(500,826)**	**(3,467,427)**
Total Assets	**154,697,817**	**151,791,285**	**155,232,299**	**149,853,306**	**152,812,864**	**152,928,467**	**150,929,203**	**152,890,725**	**156,750,074**	**(37,742)**	**(3,859,348)**
Liabilities											
Current Liabilities											
Current Maturities of Long-Term Debt	3,599,764	3,720,584	4,771,637	3,733,143	4,780,264	3,746,074	4,742,849	3,734,182	4,616,414	(11,892)	(882,231)
Accounts Payable	4,413,297	4,983,412	4,443,274	5,934,043	3,949,738	5,086,695	4,337,497	4,804,574	4,496,145	(282,121)	308,430
Accrued Payroll and Related	3,525,333	4,532,241	2,931,730	5,038,910	3,453,920	3,953,250	1,532,265	4,825,174	2,073,837	871,924	2,751,337
Accrued Interest and Sales Tax	83,538	282,515	78,276	109,061	166,600	10,834	192,433	80,904	275,828	70,070	(194,924)
Notes Payable	339,892	339,892	446,860	339,892	446,860	339,892	446,860	339,892	446,860	-	(106,968)
Unearned Revenue	-	-	(4,542)	-	(4,542)	-	(4,542)	-	(4,542)	-	4,542
Due to 3rd Party Payors	3,324,903	3,324,903	693,247	3,324,903	693,247	4,331,882	693,247	4,331,882	693,247	-	3,638,635
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	8,758,790	8,752,581	12,593,614	8,750,511	12,591,545	8,748,442	12,589,475	8,746,372	12,589,475	(2,070)	(3,843,103)
Total Current Liabilities	**24,045,518**	**25,936,127**	**25,954,096**	**27,230,464**	**26,077,633**	**26,217,069**	**24,530,084**	**26,862,981**	**25,187,264**	**645,912**	**1,675,717**
Long Term Liabilities											
Long Term Debt	33,367,666	33,132,389	36,004,290	31,853,055	34,797,823	30,916,770	34,698,029	30,808,805	33,927,979	(107,965)	(3,119,174)
Bond Premium	127,973	115,425	156,207	115,425	153,070	112,288	149,933	109,151	146,796	(3,137)	(37,645)
Accreted Interest	17,272,679	17,539,782	17,271,137	16,708,764	16,560,403	16,793,152	16,653,761	16,877,539	16,742,795	84,388	134,744
Other Non-Current Liability - Pension	31,874,258	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	-	(1,072,097)
Total Long Term Liabilities	**82,642,576**	**82,661,854**	**86,377,989**	**80,551,502**	**84,457,651**	**79,696,468**	**84,448,078**	**79,669,753**	**83,763,925**	**(26,715)**	**(4,094,172)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	61,310	54,922	147,821	54,957	127,821	34,957	127,821	34,957	127,821	-	(92,864)
Total Liabilities	**106,749,404**	**108,652,903**	**112,479,907**	**107,836,923**	**110,663,105**	**105,948,494**	**109,105,983**	**106,567,691**	**109,079,010**	**619,197**	**(2,511,319)**
Fund Balance											
Fund Balance	40,722,935	46,302,484	37,326,592	46,313,053	37,326,592	48,100,501	37,262,030	48,076,134	37,241,338	(24,367)	10,834,796
Temporarily Restricted	1,469,292	1,469,672	1,468,166	1,469,800	1,468,293	1,469,924	1,468,417	1,470,052	1,468,545	128	1,507
Net Income	5,756,186	(4,633,774)	3,957,635	(5,766,469)	3,354,874	(2,590,452)	3,092,773	(3,223,152)	8,961,180	(632,700)	(12,184,332)
Total Fund Balance	**47,948,412**	**43,138,382**	**42,752,392**	**42,016,384**	**42,149,759**	**46,979,974**	**41,823,220**	**46,323,034**	**47,671,064**	**(656,939)**	**(1,348,029)**
Liabilities + Fund Balance	**154,697,817**	**151,791,285**	**155,232,299**	**149,853,306**	**152,812,864**	**152,928,467**	**150,929,203**	**152,890,725**	**156,750,074**	**(37,742)**	**(3,859,348)**
(Decline)/Gain		(388,811)	(90,686)	(1,937,979)	(2,419,435)	3,075,161	(1,883,661)	(37,742)	5,820,871	(3,112,903)	(5,858,613)

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

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

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ (3,223,152)
+ Depreciation Expense	2,582,622
+ Interest Expense	1,085,101
Less GO Property Tax revenue	1,092,000
Less GO Interest Expense	235,250
"Income available for debt service"	**$ (882,679)**
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**
	1,255,912
Ratio: (numerator / denominator)	**(0.70)**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**No**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 20,531,726
Cash and Investments-non current	497,152
Sub-total	21,028,877
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 21,028,877**
Total Operating Expenses	$ 62,048,026
Less Depreciation	2,582,622
Net Expenses	59,465,404
Average Daily Operating Expense	$ 323,182
Days Cash on Hand	**65**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2026

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	51,210,806
Payments to Suppliers and Contractors	(31,143,798)
Payments to and on Behalf of Employees	(32,985,845)
Other Receipts and Payments, Net	481,842
Net Cash Provided (Used) by Operating Activities	(12,436,995)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	4,679,760
Property Taxes Received	468,000
Other	1,560,000
Net Cash Provided (Used) by Noncapital Financing Activities	6,707,760
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,861,947)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,085,101)
Purchase and Construction of Capital Assets	(568,351)
Payments on Lease Liability	(44,582)
Payments on Subscription Liability	(411,401)
Property Taxes Received	1,560,000
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(2,411,382)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	629,685
Rental Income	40,254
Net Cash Provided (Used) by Investing Activities	669,939
NET CHANGE IN CASH AND CASH EQUIVALENTS	(7,470,677)
Cash and Cash Equivalents - Beginning of Year	28,499,555
CASH AND CASH EQUIVALENTS - END OF YEAR	21,028,877

	Final FYE 2022	Final FYE 2023	Final FYE 2024	Final FYE 2025	2026 YTD Dec Actual	Annualized FYE 2026	Adjustment	FYE 2026 Projection	Budget FYE 2026	Variance to Budget	Variance to PYTD	Variance to FYE 2022 (5 year % change)	Comment
Revenue													
Inpatient Patient Revenue	$ 38,128,566	$ 36,784,193	$ 41,350,077	$ 41,966,661	$ 21,600,780	$ 43,201,559.82	$ 448,208	$ 43,649,768	$ 43,755,410	0%	4%	14%	Using last year's month with 5% increase for chargemaster
Outpatient Revenue	$ 129,358,154	$ 145,867,603	$ 166,037,287	$ 168,619,604	$ 85,526,567	$ 171,053,133.14	$ 3,385,877	$ 174,439,010	$ 172,755,934	1%	3%	35%	Using last year's month + 11% growth (YOY growth)
Clinic Revenue	$ 14,406,706	$ 16,953,471	$ 19,388,997	$ 21,078,588	$ 11,781,239	$ 23,562,478	$ (451,554)	$ 23,110,925	$ 21,078,640	10%	10%	60%	Using last year's month with 5% increase for chargemaster
Cerner Unaliased	$ -	$ -	$ -	$ -	$ -	$ -		$ -					
Gross Patient Service Revenue	**$ 181,893,426**	**$ 199,605,267**	**$ 226,776,361**	**$ 231,664,853**	**$ 118,908,586**	**$ 237,817,171**	**$ 3,382,531**	**$ 241,199,703**	**$ 237,589,984**	**2%**	**4%**	**33%**	
Deductions from Revenue	$ (90,037,467)	$ (110,649,262)	$ (122,164,272)	$ (132,174,148)	$ (67,723,891)	$ (135,447,782)	$ (1,987,715)	$ (137,435,498)	$ (129,208,253)		4%	53%	Using 57% (YTD)
Other Revenue	$ 150,603	$ 45,144	$ 6,979	$ 6,738	$ 0	$ 1		$ 1					
Net Patient Service Revenue	**$ 92,006,562**	**$ 89,001,149**	**$ 104,619,068**	**$ 99,497,443**	**$ 51,184,695**	**$ 102,369,390**	**$ 1,394,816**	**$ 103,764,206**	**$ 108,381,731**	**-4%**	**4%**	**13%**	
Net Revenue % of Gross Revenue	50.6%	44.6%	46.1%	42.9%	43.0%	43.0%	41.2%	43.0%	45.6%	-6%	0%	-8%	
Expense													
Salaries and Wages	$ 31,036,457	$ 35,444,756	$ 38,674,815	$ 41,959,974	$ 22,164,953	$ 44,329,906	$ (469,406)	$ 43,860,501	$ 40,209,209	9%	5%	41%	Using January per day for remainder of year
Benefits	$ 24,525,410	$ 25,880,261	$ 19,010,904	$ 17,187,726	$ 8,648,329	$ 17,296,657	$ (232,482)	$ 17,064,175	$ 18,087,699	-6%	-1%	-30%	Using YTD average
Contract Labor	$ 10,082,428	$ 9,178,958	$ 6,024,606	$ 5,390,001	$ 2,172,563	$ 4,345,127	$ (58,402)	$ 4,286,724	$ 4,640,419	-8%	-20%	-57%	Using YTD average
Professional Fees	$ 21,318,573	$ 24,332,779	$ 24,587,956	$ 26,571,060	$ 15,160,252	$ 30,320,505	$ (407,534)	$ 29,912,971	$ 28,415,333	5%	13%	40%	Using YTD average
Pharmacy	$ 4,291,460	$ 3,820,099	$ 5,046,317	$ 4,569,649	$ 2,459,893	$ 4,919,785	$ (66,126)	$ 4,853,659	$ 5,316,953	-9%	6%	13%	Using YTD average
Medical Supplies	$ 4,379,917	$ 2,667,099	$ 3,640,448	$ 5,708,135	$ 3,044,872	$ 6,089,744	$ (81,851)	$ 6,007,892	$ 3,383,654	78%	5%	37%	Using YTD average
Other Expenses	$ 11,862,684	$ 7,927,432	$ 9,833,942	$ 10,445,932	$ 5,814,542	$ 11,629,083	$ (156,305)	$ 11,472,778	$ 10,830,269	6%	10%	-3%	Using YTD average
Depreciation and Amortization	$ 4,134,640	$ 5,212,693	$ 5,209,726	$ 5,187,698	$ 2,582,622	$ 5,165,244	$ (69,425)	$ 5,095,819	$ 5,005,847	2%	-2%	23%	Using YTD average
Total Expenses	**$ 111,631,569**	**$ 114,464,077**	**$ 112,028,714**	**$ 117,020,175**	**$ 62,048,026**	**$ 124,096,051**	**$ (1,541,531)**	**$ 122,554,520**	**$ 115,889,383**	**6%**	**5%**	**10%**	
Cost to charge ratio (Medicare reimbursement)	61%	57%	49%	51%	52%	52%		51%	49%	4%	1%	-17%	
Financing Expense	$ 2,602,830	$ 2,606,512	$ 3,216,949	$ 2,273,560	$ 1,085,101	$ 2,170,202	$ (29,169)	$ 2,141,033	$ 2,354,160	-9%	-6%	-18%	
Financing Income	$ 3,199,828	$ 3,005,872	$ 3,155,532	$ 3,157,257	$ 1,560,000	$ 3,120,000	$ (41,935)	$ 3,078,065	$ 2,321,468	33%	-3%	-4%	
Investment Income	$ 185,770	$ 727,121	$ 644,248	$ 491,666	$ 629,685	$ 1,259,370	$ (242,331)	$ 1,017,039	$ 567,870	79%	107%	447%	December was high - using November average
Total Grant Revenue	$ 10,612	$ 950,520											
Miscellaneous Income	$ 17,881,591	$ 12,883,484	$ 12,537,333	$ 21,161,899	$ 6,535,595	$ 13,071,190	$ (900,000)	$ 12,171,190	$ 13,951,448	-13%	-42%	-32%	Using last year less $3M ERC (one-time) less $6M rate range
Net Income/(Loss)	**$ (950,036)**	**$ (10,502,443)**	**$ 5,710,518**	**$ 5,014,529**	**$ (3,223,152)**	**$ (6,446,303)**	**$ 1,781,250**	**$ (4,665,053)**	**$ 6,978,974**	-167%	-193%	391%	
Net Profit Margin %	**-1.0%**	**-11.8%**	**5.5%**	**5.0%**	**-6.3%**	**-6.3%**		**-4.5%**	**6.4%**	-170%	-189%	335%	
Operating Income/(Loss)	**$ (19,625,007)**	**$ (25,462,928)**	**$ (7,409,646)**	**$ (17,522,732)**	**$ (10,863,331)**	**$ (21,726,661)**	**$ 2,936,347**	**$ (18,790,314)**	**$ (7,507,652)**	150%	7%	-4%	
Operating Margin %	**-21.3%**	**-28.6%**	**-7.1%**	**-17.6%**	**-21.2%**	**-21.2%**		**-18.1%**	**-6.9%**	161%	3%	-15%	
SWB including contract labor	$ 65,644,295	$ 70,503,975	$ 63,710,325	$ 64,537,702	$ 32,985,845	$ 65,971,690		$ 65,211,400	$ 62,937,327	4%	1%	-1%	
SWB % of total expenses	59%	62%	57%	55%	53%	53%		53%	54%	-2%	-4%	-10%	
Total Supplies	$ 8,671,377	$ 6,487,198	$ 8,686,765	$ 10,277,784	$ 5,504,765	$ 11,009,529		$ 10,861,551	$ 8,700,607	25%	6%	25%	

NIHD FYE 2026 Cash Projection

		FYE 2026	Comment
YTD Cash Collections (January 2026)	$	73,996,773	
One time items:			
Grants	$	-	
IGT	$	2,746,567	
Tax Appropriations	$	2,692,898	
Other	$	858,282	Voya Stoploss (medical benefits) & Verity (bad debt collect
Total non-recurring cash	$	6,297,747	
Expected one-time items:			
Grants	$	13,312	SHIP Grant (using last year)
IGT	$	5,253,433	DHDP, AB 915, AB 113, and QIP - should be recouped by June
Tax Appropriations	$	1,308,157	Based on prior year - receipt in June
ERC	$	3,500,000	IRS Covid employee retention credit - IRS is slow to processing ~$5M. It is questionable whether we will get approved
Other	$	69,170	Voya Stoploss (medical benefits) & Verity (bad debt)
Other			Adjust for annual run rate
Total expected one-time items	$	10,144,072	
Projected FYE 2026 cash intake	**$**	**130,697,936**	Prior year was $133.9M, FYE 2023 was $124.4M
YTD Disbursements	$	(79,879,397)	Lower than prior year by $1.5M
One time items:			
Bond payments	$	(2,129,115)	
Capital	$	(568,351)	per balance sheet activity
IGT	$	(4,518,915)	Rate range, directed payments, HQAF
Total non-recurring disbursements	$	(7,216,381)	
Expected one-time items:			
Bond payments	$	(1,599,987)	
Capital	$	(1,431,649)	Q2 - Q4 approved budget
IGT	$	(1,500,000)	
Other	$	(3,000,000)	Adjustment for monthly average increasing
Total expected one-time items	$	(7,531,636)	
Projected FYE 2025 disbursements	**$**	**(137,251,364)**	Prior year was $132.3M
Projected 2025 Net Cash	**$**	**(6,553,428)**	
Daily Deficit	**$**	**(17,955)**	

Available Balances at 1/31/26		
ESBC General Checking	$	4,837,882
US Bank Checking	$	555,224
US Bank RHC	$	3,827
US Bank Athena	$	384
Petty Cash	$	1,650
Five Star	$	11,115,780
LAIF	$	5,521,022
CDs maturing within 3 months	$	500,263
Cash or cash equivalents	**$**	**22,536,033**
CD - not available as cash equivalent	$	397,152
Total with investments	$	22,933,185
June 2025 cash balances	$	28,499,555
January 2025 cash balances	$	22,536,033
Depletion	$	(5,963,522)
Average Monthly Depletion	$	(851,932)
Average Daily Depletion		(31,700)
Days until depleted		710.92
Years until depleted		**1.9**
Estimated Ending Cash Balances	**$**	**17,781,065**
Days cash on hand		**53**

Using projected daily deficit		
	$	(17,955)
		1,255
		3.4