Northern Inyo Healthcare District

Board Meeting

Board Meeting - January 21, 2026

Chief of Staff Report

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

January 21, 2026, 5:00 pm

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

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

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

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

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3. Consent Agenda – All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.
    a. Approval of minutes for December 17, 2025, Regular Board Meeting
    b. Approval of Policies and Procedures

i. Statement of Leadership and Financial Commitment for Antibiotic Stewardship
ii. Resolution for Appointment of Infection Preventionist
iii. Automatic and Manual Transfer Switch Testing
iv. Bloodborne Pathogen Exposure Control Plan
v. Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room) and Segregated Radiopharmaceutical Processing Area (SRPA)
vi. Fire Response Plan-Code Red
vii. Hospital-Grade Receptacles
viii. Lockdown

4. Chief Executive Officer Report
    a. Jacob Green and Associates – Action Item
    b. Rural Transformation – Information Item
    c. Update to City Council – Information Item
5. Finance Committee
    a. Finance Committee Charter – Action Item
    b. Bond Update – Information Item
    c. 2026 Budget – Information Item
    d. Financial & Statistical Reports – Action Item
6. Governance Committee
    a. Advocacy Platform – Action Item
    b. Civility and Code of Conduct Policy – Action Item
    c. Governance Committee Charter – Action Item
    d. Onboarding and Continuing Education of Board Members Policy – Action Item
    e. Purchasing and Signature Authority – Action Item
7. Chief of Staff Report, Sam Jeppsen, MD
    a. Medical Staff Reappointments 01/01/2026 – 12/31/2027 – Action Item
8. General Information from Board Members

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9. Adjournment

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

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary Maggie Egan, Treasurer Laura Smith, Member at Large Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer Sam Jeppsen, MD, Chief of Staff
TELECONFERENCING	Notice has been posted and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. **Public Comment:** A community member addressed the Board and requested that a community petition in support of Dr. Loy be entered into the public record. The petition was added to the meeting as supplemental material and can be found on the NIHD website. The Board acknowledged the request and accepted the petition as part of the official record for the meeting. The speaker also expressed appreciation for the care her husband recently received at the District's Emergency Department and inpatient units.
CONSENT AGENDA	**Public Comment**: None **Motion by Lent**: to approve the Consent Agenda **2nd:** Best-Baker **Pass:** 5-0
Approval of Tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) Technical Unit	Administration stated that the Tentative Agreement between the District and AFSCME represents the successful conclusion of collective bargaining and positions the organization to move into 2026 with greater stability and collaboration. The agreement reflects a shared commitment to workforce partnership, recruitment, and retention, while supporting uninterrupted operations and patient care. Administration expressed appreciation for all parties involved in the bargaining process and recommended approval of the agreement.

Public Comment: None

Board Discussion:
Board members expressed appreciation for the collaborative bargaining process and commended staff and management for their work in reaching an agreement. Directors noted that the Tentative Agreement supports workforce stability and allows the District to move forward without the risk of labor disruption.

Motion by Smith: to approve tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) Technical Unit
2nd: Egan
Pass: 5-0

Approval of District Board Resolution 25-04

Public Comment: None

Motion by Lent: to approve District Board Resolution 25-04
2nd: Best-Baker
Pass: 5-0

Approval of Tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) RN Unit

Public Comment: None

Motion by Smith: to approve tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) RN Unit
2nd: Best-Baker
Pass: 5-0

Approval of District Board Resolution 25-05

Public Comment: None

Motion by Best-Baker: to approve District Board Resolution 25-05
2nd: Egan
Pass: 5-0

SLATE OF OFFICERS

Proposed slate of officers by the Chair:

- **Chair:** Melissa Best-Baker
- **Vice Chair:** David Lent
- **Secretary:** Maggie Egan
- **Treasurer:** Laura Smith
- **Member-at-Large:** Jean Turner

Public Comment: None

Board Discussion:
Directors discussed the proposed slate of officers and a prior deviation from the standard rotation, with questions raised regarding David Barrett's role and the change made the previous year. Best-Baker explained that the adjustment was

based on discussions with Mr. Barrett about his work schedule and availability to fulfill officer responsibilities at that time.

Motion by Lent: to approve the recommended slate of officers
2nd: Egan
Pass: 4-1
No: Smith

CHIEF EXECUTIVE OFFICER REPORT

Holiday Parade

CEO Wallis reported on NIHD's participation in the Bishop Holiday Parade, thanking the Chamber of Commerce and staff who represented the District. He noted strong community turnout and positive engagement, describing the event as a meaningful opportunity to connect with the community and highlight NIHD's presence.

Board Discussion:
Directors expressed appreciation for staff participation in the parade and noted the positive community response to NIHD's involvement.

Ophthalmology Update

CEO Wallis reported that ophthalmology services continue without interruption following a transfer of ownership from Dr. Reid to Dr. Tawansy. He noted that Dr. Tawansy, who operates multiple practices in Central and Southern California, has begun transitioning the practice, and that Dr. Reid is expected to continue practicing alongside him for a period during the transition.

CHNA Update

CEO Wallis reported that the Community Health Needs Assessment survey period has closed, with a total of 357 surveys received, including 324 from Northern Inyo and 33 from Southern Inyo. He noted that the survey responses are sufficient to complete the assessment and that the contractor, Ovation, is currently analyzing the data and preparing a comprehensive report. A detailed report-out will be scheduled to review community priorities and inform future planning efforts.

The Joint Commission Final Report Out

CEO Wallis reported that the District received the final results from the Joint Commission survey conducted in September, which identified 19 findings. He noted that all findings were successfully addressed and accepted by The Joint Commission on the first submission, crediting staff for their preparation and follow-through. He emphasized the importance of maintaining continuous Joint Commission readiness as part of daily operations rather than preparing only in advance of future surveys.

Public Comment: None

FINANCE COMMITTEE

NIH Financial Audit

Dan Frein of Clifton Larson Allen LLP (CLA) presented the results of the District's fiscal year ended June 30, 2025 audit. He reported that CLA issued a clean, unmodified audit opinion, the highest level of assurance available, with no audit adjustments, no passed adjustments, and no identified internal control deficiencies or material weaknesses. Significant audit areas included construction in progress, Medi-Cal and Medicare settlement estimates, and the Employee Retention Credit, approximately $4 million, all of which were reviewed and reported appropriately.

Chief Financial Officer Andrea Mossman reported that the audit was completed earlier than in prior years and met all bond covenant requirements, including debt service coverage ratio and days cash on hand. She noted that for the first time in many years, the District had no audit findings and that all balance sheet accounts were fully reconciled. Ms. Mossman also reported that Medicare underpayments resulted in an estimated $4 million receivable, expected to be received in spring 2026, and that timely completion of the audit supported on-time filing of the Medicare cost report.

Public Comment: None

Board Discussion:
Board members expressed strong appreciation for the timely completion of the audit and the significant progress made in financial reporting and internal controls. Directors noted that long-standing audit issues from prior years had been resolved and emphasized the importance of maintaining these practices going forward.

Motion by Best-Baker: to accept the Audit
2nd: Smith
Pass: 5-0

WAYPOINT CONTRACT FOR SNF PARTNERSHIP

Tim Cooley from Waypoint presented an overview of the Distinct Part Skilled Nursing Facility (DPSNF) program and the proposed consulting engagement with Waypoint. He explained the reimbursement challenges faced by skilled nursing facilities serving long-term Medi-Cal patients and described how hospital-affiliated distinct part SNF beds receive significantly higher Medi-Cal reimbursement rates. Mr. Cooley outlined that the initial phase of the engagement is exploratory and preparatory, focused on financial modeling, regulatory analysis, and feasibility determination, with no obligation for the District or Bishop Care Center to proceed to implementation. He noted that Waypoint's fees are contingent upon completion of a transaction and are reimbursed through increased facility revenues.

Bryce Lindsey stated that Bishop Care Center leadership is aware of and supportive of exploring the DPSNF opportunity. He indicated that the program has worked successfully in other California communities and expressed interest

in pursuing the analysis to improve continuity of care, access for long-term care patients, and alignment between the hospital and skilled nursing facility. Lindsey noted that increased reimbursement could allow for expanded services and capacity at Bishop Care Center.

Motion by Lent: to approve the consulting agreement in concept and authorize management to negotiate and finalize non-substantive provisions
2nd: Egan
Pass: 5-0

RCTMD CONTRACT

CEO Wallis provided an overview of the RCTMD contract, explaining that it governs a medical group structure allowing physicians to be employed as W-2 employees rather than independent contractors. He noted that the existing contract, originally developed around 2015, no longer aligned with current operations or leadership transitions within the group, including the assumption of operational responsibility by Dr. Loy. CEO Wallis reported that the prior contract was properly terminated and that negotiations have been underway to modernize the agreement to reflect current practices. He advised that the revised contract is substantially complete, with remaining items primarily related to benefits and other non-salary terms.

Public Comment: None

Board Discussion:
The Board discussed the need to finalize the agreement in a timely manner given contract expiration dates and Board meeting schedules. Clarification was provided that any remaining adjustments would be limited in scope and remain within ten percent of the approved terms, allowing execution without further delay.

Motion to Best-Baker: to approve the RCTMD contract as presented and authorized the CEO to finalize and execute the agreement, including adjustments within ten percent of the approved terms.
2nd: Lent
Pass: 5-0

FINANCIAL AND STATISTICAL REPORTS

CFO Mossman presented the October Financial and Statistical Reports, highlighting a $3.2 million unfavorable budget variance primarily attributable to lower patient volumes across clinics, surgeries, emergency department visits, and deliveries. Although admissions increased, reduced elective activity and changes in post-surgical observation practices negatively impacted revenue. Expense variances were driven largely by wages, benefits, and fixed staffing costs that could not be flexed downward during low-volume periods. CFO Mossman reported improvements in cash performance, including accounts receivable days reduced to 58 and increased monthly collections following billing process changes. Additional cost savings were noted from terminating a higher-cost Medi-Cal billing vendor and recouping underpayments through a contract review initiative.

Public Comment: None

Board Discussion: None

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

GOVERNANCE COMMITTEE

Board Committee Restructure

CEO Wallis presented an overview of the proposed board committee restructure, explaining that the goal was to improve effectiveness, allow for more substantive discussion at the committee level, and streamline the flow of action items to the full Board. He described a revised meeting cadence in which committees meet earlier in the month, allowing action items to be fully developed before Board meetings. The proposal also included strengthening committee roles, adding alternate committee members for continuity, and formalizing the structure through a pilot program prior to amending the bylaws.

Public Comment: None

Board Discussion
Board members expressed support for the revised committee structure, noting improved meeting flow, more substantive committee discussions, and better alignment with Board schedules. Members discussed maintaining flexibility by allowing meetings to occur at least monthly or quarterly, with the ability to add meetings as needed without requiring bylaw amendments or emergency actions. Directors noted that the pilot approach had addressed prior frustrations with committee timing and generally agreed the structure was working well. The Board approved the recommendation and directed that the bylaw language be updated accordingly.

Motion by Lent: to approve to board committee restructure
2nd: Egan
Pass: 5-0

CHIEF OF STAFF REPORT

Motion by Best-Baker: to approve Medical Staff Initial Appointments 12/17/2025 – 12/31/2026
2nd: Smith
Pass: 5-0

Motion by Smith: to approve Medical Staff Initial Appointments 12/17/2025 – 12/31/2026 – Proxy Credentialing
2nd: Best-Baker
Pass: 5-0

Motion by Lent: to approve Additional Privileges 12/17/2025 – 12/31/2026
2nd: Smith
Pass: 5-0

Motion by Best-Baker: to approve Medical Staff Reappointments 01/01/2026 – 12/31/2027
2nd: Smith
Pass: 5-0

Motion by Best-Baker: Medical Staff Reappointments 01/01/2026 – 07/01/2026
2nd: Egan
Pass: 5-0

Medical Executive Committee Meeting Report

The Medical Executive Committee reported that its members recently participated in a leadership retreat focused on strengthening leadership skills and improving internal processes. The retreat was described as beneficial in helping members develop tools and approaches to support their roles as clinical leaders. In addition, the Committee reported ongoing efforts in the Emergency Department to bolster trauma care and protocols, recognizing that while the District is not a designated trauma center, it frequently treats trauma patients and continues to focus on delivering high-quality care.

Public Comment: None

Board Discussion: None

CHIEF MEDICAL OFFICER REPORT

RHC Biennial Report
Rural Health Clinic leadership presented the Biennial Report covering the most recent two-year reporting period, fulfilling a regulatory requirement. The presentation included an overview of clinic operations, visit volume, staffing, payer mix, and quality oversight activities, noting a 14 percent increase in total visits from fiscal year 2023 to 2025. Quality assurance processes were reviewed, including chart audits, advanced practice provider oversight, and participation in Quality Improvement Program initiatives. Goals for the upcoming fiscal year included improved use of space, scheduling standardization, enhanced data collection, and continued participation in patient throughput efforts. The report also highlighted the clinic's teaching program, which hosted 26 students, along with a summary of service lines and provider staffing.

Public Comment: None

Board Discussion:
Board members expressed appreciation for the Rural Health Clinic's services, same-day access, and role in meeting rural community needs, and voiced support for continued improvements in data collection and operational planning.

CHIEF FINANCIAL OFFICER REPORT

Department Update
Information Technology Services Update

IT Director Henderson provided an overview of the District's current information technology environment, focusing on core systems, infrastructure, and governance. He identified priority areas for improvement including replacement of the IT ticketing system, consolidation of multiple software platforms to reduce duplication and cost, enhancements to Cerner training for providers and staff, modernization of phone and email systems, and addressing the lack of internet and phone redundancy. Additional focus areas included improving asset management and lifecycle planning, pursuing grant funding opportunities, and developing a phased roadmap to modernize IT systems and support more proactive planning.

Public Comment: None

Board Discussion: Board members expressed appreciation for the assessment and discussed the importance of stabilizing core systems and improving data reliability to support informed decision-making across the organization.

Revenue Cycle Update
Revenue Cycle Director Lind provided a brief update focused on revenue cycle performance and improvement efforts. She reported that a denial workgroup will be a primary focus in the upcoming quarter, with efforts directed toward improving denial prevention and resolution processes, supported by continued collaboration with Jory to increase efficiency and consistency. Lind also reported positive performance trends, including a reduction in discharged not final billed (DNFB) days from 13 to 9 and a decrease in accounts receivable days from 70 to 58 since the start of the fiscal year. Additionally, she noted that while average charges remain below the prior year, payments have increased, reflecting faster processing, improved reimbursement, and stronger overall revenue cycle performance. She also reported the receipt of quarterly Medicare bonus payments related to the District's designation as a health professional shortage area.

Public Comment: None

Board Discussion:
Board members acknowledged the progress reported and expressed appreciation for the improvements and positive momentum in revenue cycle performance.

GENERAL INFORMATION FROM BOARD MEMBERS

A Board member shared positive reflections on recent community events, including participation in the Shop with a Cop program, noting the impact and value of the program for local children and families. Appreciation was expressed for staff support and coordination of Board materials and onboarding activities, with comments noting the thoroughness of the Board packet and the value of the onboarding process for new Directors. It was also reported that the Association of California Healthcare Districts (ACHD) unanimously approved

the Chief Executive Officer's appointment to its Board of Directors, with Board members expressing appreciation for the CEO's willingness to serve during a critical time for healthcare leadership.

ADJOURNMENT — Adjournment at 7:06 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
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Statement of Leadership and Financial Commitment for Antibiotic Stewardship

Purpose

This Statement documents Northern Inyo Healthcare District's (NIHD) leadership accountability and financial support for an effective Antibiotic Stewardship Program (ASP) and is intended to demonstrate compliance with CMS Conditions of Participation (CoPs) for Critical Access Hospitals (42 CFR §485.640), the CDC Core Elements of Hospital Antibiotic Stewardship Programs, and applicable California requirements. This Statement is maintained as survey-ready documentation and is available upon request to regulatory and accreditation surveyors.

Scope

This Statement applies to all inpatient and outpatient clinical services, medical staff, advanced practice providers, pharmacists, nursing staff, ancillary departments, and contracted services involved in prescribing, dispensing, administering, monitoring, or evaluating antimicrobial therapy.

Leadership Commitment

The Governing Body, Chief Executive Officer, and Chief of Medical Staff formally commit to the following actions, consistent with CMS surveyor expectations:

1. **Governing Body Accountability**
    - The Governing Body assumes ultimate responsibility for the Antibiotic Stewardship Program and ensures the program is implemented, maintained, and evaluated.
    - The Governing Body receives regular reports on ASP activities, outcomes, and improvement actions, and documents oversight through meeting minutes or committee reports.
2. **Designated Qualified Leadership**
    - NIHD designates a physician or advanced practice provider leader and a pharmacist leader responsible for day-to-day stewardship activities.
    - Designated leaders possess appropriate training or experience in antimicrobial stewardship and are granted authority to implement interventions.
3. **Medical Staff Engagement and Authority**
    - Medical Staff bylaws, rules, or policies support compliance with antimicrobial stewardship policies and evidence-based prescribing practices.
    - Prescribers cooperate with stewardship reviews, recommendations, and data requests.
4. **Integration With Quality and Patient Safety**
    - The ASP is integrated into NIHD's Quality Assessment and Performance Improvement (QAPI) program.

- Stewardship metrics and action plans are incorporated into quality improvement activities when opportunities for improvement are identified.

5. **Education and Culture of Safety**
    - Leadership ensures initial and ongoing education for prescribers and clinical staff regarding antimicrobial resistance, appropriate use, and facility-specific guidelines.
    - Leadership promotes a non-punitive culture that supports evidence-based prescribing and continuous improvement.

Financial and Resource Commitment

Leadership commits to providing sufficient financial and operational resources to ensure the ASP is effective and sustainable, as evidenced by:

1. **Staffing and Protected Time**
    - Allocation of protected time for the ASP physician/APP and pharmacist leaders to conduct core stewardship activities, including review of antimicrobial use, feedback to prescribers, policy development, and reporting.
    - Access to infection prevention, laboratory, nursing, and quality staff to support stewardship initiatives.
2. **Data, Tracking, and Reporting Capabilities**
    - Resources to track antimicrobial prescribing, utilization, and resistance patterns using available electronic health record (EHR) functionality or alternative methods appropriate for a CAH.
    - Ability to generate stewardship reports for internal review and surveyor validation.
3. **Education and Competency Support**
    - Funding for continuing education, training, and competency development for ASP leaders and involved staff.
4. **Operational and Laboratory Support**
    - Support for development and maintenance of facility-specific treatment guidelines, order sets, and diagnostic stewardship practices.
    - Collaboration with laboratory services to ensure appropriate culture, susceptibility testing, and reporting practices.

Regulatory and Standards Alignment

NIHD commits to maintaining ASP practices consistent with:

- CMS Conditions of Participation applicable to Critical Access Hospitals;
- CDC Core Elements of Hospital Antibiotic Stewardship Programs;
- Applicable California laws and regulations (including Title 22, California Code of Regulations): and,
- Joint Commission accreditation standards, as applicable.

Measurement, Reporting, and Improvement

To meet CMS and accreditation survey expectations, leadership supports:

- Routine monitoring of antimicrobial use, resistance trends, and selected process or outcome measures appropriate to NIHD's size and services;
- Documentation of stewardship interventions and prescriber feedback;

- Regular reporting of ASP activities and findings to the Governing Body, Medical Staff leadership, and QAPI committees;
- Implementation and documentation of corrective actions and performance improvement activities when deficiencies or trends are identified.

Accountability and Review

This Statement will be reviewed at least annually, or more frequently as required by regulatory changes or organizational needs. Continued leadership and financial support will be reaffirmed through the budgeting and governance processes.

Approved By:
Chairperson
NIHD Board of Directors

Authorized Executive:
Chief Executive Officer

Medical Staff Leader:
Chief of Staff

CMS Survey Tag Crosswalk (Critical Access Hospital)

The following crosswalk links this Statement to applicable CMS Conditions of Participation survey expectations for CAHs. This table is intended as a survey-preparation aid and does not replace regulatory text.

CMS Regulation / Survey Focus	Surveyor Expectation	Where Addressed in This Statement
42 CFR §485.640(a)		
Antibiotic stewardship program	Hospital has an active ASP that promotes appropriate antibiotic use and patient safety	Purpose; Leadership Commitment; Financial and Resource Commitment
§485.640(a)(1)		
Leadership accountability	Governing Body and executive leadership are responsible for implementation and oversight of the ASP	Leadership Commitment – Governing Body Accountability
§485.640(a)(2)		
Qualified leadership	Hospital designates qualified individual(s) responsible for ASP activities	Leadership Commitment – Designated Qualified Leadership
§485.640(a)(3)		
Medical staff involvement	Medical staff are engaged and comply with stewardship policies and interventions	Leadership Commitment – Medical Staff Engagement and Authority
§485.640(a)(4)		
Education	Hospital provides education on antimicrobial stewardship to prescribers and staff	Leadership Commitment – Education and Culture of Safety; Financial Commitment – Education and Training
§485.640(b)		
Policies and procedures	ASP includes evidence-based policies, guidelines, and interventions	Leadership Commitment – Clinical Integration and Authority; Operational Support
§485.640(c)		
Tracking and monitoring	Hospital tracks antibiotic use and resistance, using methods appropriate to size and services	Financial Commitment – Data, Tracking, and Reporting Capabilities; Measurement, Reporting, and Improvement
§485.640(d)		

CMS Regulation / Survey Focus	Surveyor Expectation	Where Addressed in This Statement
Reporting **§485.640(e)**	ASP information is reported to leadership and medical staff	Measurement, Reporting, and Improvement
Program evaluation	Hospital evaluates the effectiveness of the ASP and takes improvement actions	Measurement, Reporting, and Improvement; Accountability and Review
QAPI Integration (42 CFR §485.641)	ASP activities are integrated into the QAPI program with documented PI actions	Leadership Commitment – Integration With Quality and Patient Safety; Measurement, Reporting, and Improvement

Surveyors commonly request evidence such as Governing Body minutes reflecting ASP oversight, stewardship reports, documentation of prescriber feedback, education records, and proof of protected time or resources for ASP leaders.

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Infection Preventionist Appointment & Qualification Record

Infection Preventionist Name: Robin Christensen, BSRN, HIC
Title: Manager of Infection Prevention and Employee Health
Renewal Appointment Date: January 1, 2026

Qualifications (See Competency Notebook for specific documentation)

Ms. Christensen brings specialized education, training, and experience to NIHD's Infection Prevention and Control Program. She has demonstrated dedication and expertise in infection prevention and control since 2006 and has held a leadership role in Infection Prevention since 2016.

Ms. Christensen's education and training in the field of Infection Prevention and Control include significant involvement with the following organizations and institutions:

- The Association for Professionals in Infection Control and Epidemiology (APIC)
- California Department of Public Health (CDPH)
- The Centers for Disease Control and Prevention (CDC)
- The California Hospital Association (CHA)
- National Healthcare Safety Network (NHSN)
- Hospital Quality Institute
- The Joint Commission
- Sepsis Alliance
- National Emerging Special Pathogens Training & Education Center (NETEC).

Ms. Christensen's commitment to ongoing professional development is evident in her attendance at the APIC national conference and training sessions, as well as the NHSN annual training, which keep her abreast of the latest advancements and best practices in infection prevention and control. Her continuous engagement with these professional bodies and educational opportunities, and the resulting improvement in our infection prevention strategies, ensures that our hospital remains at the forefront of infection prevention strategies and maintains compliance with the highest standards.

Leadership Recommendation

Medical Staff Leadership Recommendation: ☑ Yes ☐ No

Chief of Staff: Samantha Jeppsen
Samantha Jeppsen (Jan 8, 2026 15:32:26 PST)

Chief Medical Officer : J. Adam Hawkins
J. Adam Hawkins (Jan 8, 2026 08:26:02 PST)

Medical Director of Infection Prevention

Nursing Leadership Recommendation: ☑ Yes ☐ No

Chief Operating Officer/Chief Nursing Officer: Allison Partridge
Allison Partridge (Jan 8, 2026 08:29:28 PST)

Annual Review

Reviewed By: Christian Wallis
Christian Wallis (Jan 8, 2026 08:33:53 PST)

Title: Chief Executive Officer

Northern Inyo Healthcare District

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Northern Inyo Healthcare District Board of Directors' Resolution for Appointment of Infection Preventionist 26-01

WHEREAS, Northern Inyo Healthcare District (NIHD) is a Medicare-certified Critical Access Hospital subject to 42 CFR §485.640 and California Title 22, CCR §70739, requiring an Infection Prevention and Control Program;

WHEREAS, the Medical Staff and nursing leadership have recommended Robin Christensen, BSRN, HIC, for the role of Infection Preventionist;

WHEREAS, the Governing Body is responsible for the appointment of a qualified Infection Preventionist and adoption and oversight of infection prevention and control policies under federal and California law;

NOW, THEREFORE, BE IT RESOLVED that the Governing Body appoints the following individual as Infection Preventionist for Northern Inyo Healthcare District:

Robin Christensen, BSRN, HIC
Manager of Infection Prevention/Employee Health

Allison Partridge
Allison Partridge (Jan 8, 2026 08:29:28 PST)
Chief Operating Officer/Chief Nursing Officer

J. Adam Hawkins
J. Adam Hawkins (Jan 8, 2026 08:26:02 PST)
Chief Medical Officer

Samantha Jeppsen
Samantha Jeppsen (Jan 8, 2026 15:32:26 PST)
Chief of Staff

Chairperson
NIHD Board of Directors

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Automatic and Manual Transfer Switch Testing		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Maintenance		
Date Last Modified: 12/02/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE:
To ensure all automatic and manual transfer switches (ATS/MTS) connected to the Emergency Power Supply System (EPSS) are tested in accordance with NFPA 110-2010, CMS Conditions of Participation, and Joint Commission EC.02.05.07 EP 7. Testing ensures reliable operation during loss of normal power.

POLICY:
Northern Inyo Healthcare District (NIHD) will perform and document required operational testing of all automatic and manual transfer switches serving the emergency power system in compliance with NFPA 110-2010, NFPA 99-2012, CMS, and Joint Commission standards.

PROCEDURE:
1. **Each automatic and manual transfer switch (ATS/MTS) shall be tested at least monthly**, in accordance with NFPA 110-2010 (8.4.6).
2. Testing must include:
   - Normal → Emergency transfer
   - Emergency → Normal retransfer
   - Verification of correct time delay operation
   - Confirmation that Level 1 ATS restore power to essential loads **within 10 seconds**, per NFPA 110-2010 (6.1.6.1).
3. If load banks are used to maintain ≥30% load during generator testing, NIHD will maintain a method to ensure essential loads can be automatically restored in the event of actual normal power failure.
4. ATS shall be electrically operated to transfer to the emergency source and back to the normal source.
5. When appropriate, a **different ATS** may be used to initiate the monthly generator test rotating among switches feeding different EPSS branches.
6. **Documentation** shall include:
   - ATS identification/location
   - Date and time of test
   - Transfer time and retransfer time
   - Pass/fail results
   - Technician performing test
   - Deficiencies identified
   - Corrective actions taken

   Records shall be kept electronically.

REFERENCES:

1. NFPA 110-2010: Sections 6.1.6.1, 8.4.6
2. NFPA 99-2012
3. Joint Commission CAMCAH EC.02.05.07 EP 7
4. CMS K-Tags: K918, K919

RECORD RETENTION AND DESTRUCTION:

Records will be maintained for **at least 36 months** in compliance with NFPA 110.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Automatic and Manual Transfer Switch Testing

Supersedes: v.2 Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Bloodborne Pathogen Exposure Control Plan		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope:		
Date Last Modified: 12/30/2025	Last Review Date: No Review Date 10/17/2024	Version: 10
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The goal is of this plan is to minimize or eliminate health care worker exposure to bloodborne pathogens. This plan focuses on safer work practices, personal protective equipment, and engineering and administrative controls. Adhering to this plan ensures compliance with all applicable laws and regulations relating to bloodborne pathogens exposure, and is in accordance with The Division of Occupational Safety and Health (DOSH), better known as Cal/OSHA Bloodborne Pathogens Standard (Title 8, California Code of Regulations, and Section 5193). This plan continues our commitment to providing a safe and healthy environment in which to deliver patient care.

POLICY

Northern Inyo Healthcare District is committed to providing a safe and healthy environment for its entire staff. All employees and physicians working within this facility who may be potentially exposed will follow this policy and procedure to bloodborne pathogens. Failure to follow this policy and procedure may result in disciplinary actions. Bloodborne Pathogen exposure/injuries will be reviewed at Safety Committee, Infection Prevention, and Sharps Committee for any percutaneous injuries.

DEFINITIONS

Administrative controls- Eliminating or reducing an opportunity for an exposure by modifying procedures, policies, or workflows.

Bloodborne pathogens – Pathogenic microorganisms that may be present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

Contaminated – The presence or the reasonably anticipated presence of blood or other potentially infectious materials on a surface or in or on an item.

Decontamination – The use of physical or chemical means to remove, inactivate or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

Engineering controls – Controls such as sharps disposal containers, needleless systems and sharps with engineered sharps injury protection that isolate or remove the bloodborne pathogens hazard from the workplace.

Engineered sharps injury protection – A physical attribute built into a needle device used for withdrawing other potentially infectious materials accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal or other effective mechanisms; or a physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

Exposure incident – A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Healthcare Worker (HCW) - Refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Needleless system: A device that does not use a needle and is used to withdraw body fluids after initial venous or arterial access is established; to administer medication or fluids; or for any other procedure involving the potential for an exposure incident

Occupational exposure – A job category where skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials could be reasonably anticipated.

Other potentially infectious materials (OPIM) –

- Human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response
- Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
- Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV or HCV:
    - Cell, tissue, or organ cultures from humans or experimental animals
    - Blood, organs or other tissues from experimental animals
    - Culture medium or other solutions

Passive safety: A feature that requires no action by the user.

Personal Protective Equipment (PPE): PPE is specialized clothing or equipment worn by an employee to minimize exposure to a variety of hazards.

Safety Engineered Devices: A device that has a built in sharps injury protection mechanism such as an attached sheath covering the needle or scalpel after use or needles that retract.

Sharps: Devices or objects capable of cutting or piercing. Examples include scalpels, razor blades, broken glass, microscope slides, and needles.

Sharps container: Rigid puncture resistant container with a secure lid that can safely store sharps waste.

Source individual – Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients, clients in institutions for the developmentally disabled, trauma victims, clients of drug and alcohol treatment facilities, residents of hospices and nursing homes, human remains, and individuals who donate or sell blood or blood components.

Standard precautions – An approach to infection control. Standard precautions expand the universal precautions concept *(see below)* to include all other potentially infectious materials with the intent of protecting employees from any disease process that can be spread by contact with a moist body substance. This isolation technique includes substances such as feces, urine, saliva and sputum that were not included in Standard universal precautions unless they contained visible blood.

Universal precautions – Is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other bloodborne pathogens. Universal Precautions emphasizes the use of Personal Protective Equipment (PPE) barrier to prevent contact with blood and other potentially infectious materials Precautions apply to blood, semen, and vaginal secretions; amniotic, cerebrospinal, pericardial, peritoneal, pleural, and synovial fluids; and any other body fluid visibly contaminated with blood.

Work Practice Controls: Are controls that reduce the likelihood of exposure be altering the in manner in which a task is performed.

EXPOSURE DETERMINATION

The exposure determination looks at all job classifications to determine the potential for occupational exposure to blood or other potentially infectious materials. Health care worker (HCW) job classifications listed below have been determined to be at risk for occupational exposure. This list includes those job classifications in which only some employees have occupational exposure. All elements of this exposure control plan apply to all employees in these jobs.

- Activities Director
- Biomedical engineers
- Central Sterile Processing
- Diagnostic Imaging Technologists
- EKG technicians
- Environmental Services
- Laboratory employees
- Language Services
- Laundry
- Maintenance/Plant Operations
- Nursing- All
- Patient Access
- Pharmacy
- Physicians
- Rehab Department
- Cardiopulmonary Department
- Security
- Social Services
- Surgical Technicians
- Dietary

- Medical Records
- Any additional roles that require a worker to enter patient rooms

METHODS OF COMPLIANCE

This section reviews the numerous work practices and procedures necessary to minimize or eliminate un-protected exposure to bloodborne pathogens. Compliance with these practices and procedures is MANDATORY and is a condition of employment.

Standard Precautions

Refer to Lippincott Procedures Standard Precautions.

Use standard precautions in all patient care to prevent contact with blood and OPIM. Always treat the following body fluids as if infectious for HBV, HCV or HIV:

- * Human blood, blood components and products made from human blood
- * **Other potentially infectious materials (OPIM)**
  - semen
  - vaginal secretions
  - cerebrospinal fluid
  - synovial fluid
  - pleural fluid
  - pericardial fluid
  - peritoneal fluid
  - amniotic fluid
  - any other body fluid contaminated with blood such as saliva or vomitus
  - any unfixed tissue or organ from a human

In circumstances where it is difficult or impossible to differentiate between body fluid types, those fluids are assumed to be potentially infectious.

The Infection Preventionist of Northern Inyo Healthcare District (NIHD) and leadership is responsible for overseeing the use of standard precautions by all NIHD workforce members.

Engineering Controls:

Engineering controls are used to minimize or eliminate HCW occupational exposures to bloodborne pathogens. These controls include, but are not limited to:

- Devices with engineered sharps injury protection
- Needleless systems
- Safety design devices
- Hand washing facilities
- Sharps containers
- Laboratory safety hoods where appropriate

- Pneumatic Tube Safety
- Specimen containers
- Protective shields

Use of Needleless Systems, Needle Devices, Non-needle Sharps

When feasible, needless system(s) will be used for:

- Withdrawing OPIM after initial venous or arterial access is established.
- Administering medications or fluids
- Any other procedure involving the potential exposure incident for which a needle device with engineered sharps injury protection is available

When feasible, devices with engineered sharp injury protection will be used for:

- Withdrawing OPIM
- Accessing a vein or artery
- Administering medication or fluid
- Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.

Non-needle sharps (e.g., scalpels, lancets) shall have engineered sharps injury protection mechanisms

Employees with potential occupational exposure to blood and OPIM will be trained in the use of engineering controls provided for their use. Additional training will be provided as necessary when new engineering controls are adopted.

NIHD Sharps Protection Injury Committee evaluates engineering control on an as needed basis and determines which ones provide the best protection without compromising patient care.

Engineered sharps injury protection devices are not required in the following situations only:

- An engineering control is not available in the marketplace during a pandemic or during a national shortage.
- A licensed health care professional, directly involved in a patient's care, determines in the reasonable exercise of clinical judgment, that the use of the engineering control will jeopardize the patient's safety or the success of a medical or nursing procedure involving the patient. In such cases, the use of this exception shall be investigated and documented by the Infection Preventionist or designee, and must be approved by the NIHD Infection Committee.
- The employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing incidents than the alternative used by the employer.
- There is no reliable or specific safety performance information available on the safety performance of the safety control for this facility's procedures. NIHD actively determines whether the use of engineering controls lacking reliable or specific safety performance information will reduce the risk of exposure incidents occurring in this facility.

The use of engineering controls will be re-evaluated annually during the yearly review of this exposure control plan. Additions or deletions will be made at that time or as indicated by ongoing monitoring activities.

Work Practice Controls:

The use of standard precautions is an integral part of this exposure control plan and of NIHD infection prevention program. Standard precautions will be practiced whenever exposure to blood or OPIM is anticipated. When differentiation between body fluid types is difficult or impossible, all other potentially infectious materials will be considered potentially infectious materials.

Work practice controls/procedures have been implemented to minimize exposure to bloodborne pathogens. Each department manager/supervisor is responsible for implementing, evaluating and monitoring compliance with these work practices. Infection Preventionist, department designee, and Department Safety Officers will monitor work practices as part of routine rounds through each area.

Specific infection control policies and procedures are in place to address work practices and procedures centered on the concept of standard precautions. The minimization and elimination of exposure to blood and OPIM is the primary goal.

The following is a summary of work practice controls:

- Hands will be washed with soap and water or alcohol based hand rub (ABHR) before patient contact, after the removal of gloves or other personal protective equipment and immediately following contact or exposure to blood or Other potentially infectious materials before clean/aseptic procedure, and after touching patient surroundings. *Wash hands with soap and water if there is any visible contamination with blood or other fluids.*
- Mucous membranes and eyes will be immediately flushed with water following exposure to blood or other potentially infectious materials.
- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure (e.g., nurses' station).
- Food, drink and oral medications will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials may be present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets.
- Specimens of blood or other potentially infectious materials will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping. Syringes containing blood or other potentially infectious materials will not be transported with needles attached unless an engineered safety device is in place permanently shielding the needle.
- The container for storage, transport or shipping to outside of the facility will be labeled or color-coded with the legend "biohazard." These labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color. The surgery department labels are blue for specimens.
- If outside contamination of the primary container occurs, the primary container will be placed within a second container that prevents leakage during handling, processing, storage, transport or shipping and is properly labeled. If specimen could puncture the primary container, the primary container will be placed within the secondary container that is also puncture-resistant.
- Equipment that may be contaminated with blood or other potentially infectious materials will be decontaminated prior to servicing or shipping. If decontamination is not feasible, a biohazard-warning label (that meets the Cal/OSHA requirements) will be attached to the equipment identifying the contaminated portions. Information will be conveyed to all affected employees, servicing people and/or the manufacturer prior to handling to ensure that appropriate precautions are taken.

- Pneumatic Tube System: In case of a biohazard spill in the system:
- On control panel of the pneumatic tube system, the employee should immediately push“911 and hit the “Special Function” key. This disables the system and prevents other tubes from becoming contaminated.
- During the day notify maintenance and during off hours notify the Nursing Supervisor.
- To prevent this problem, all employees who may place either blood or urine in the tube, need to remember how important it is to carefully seal every biohazard bag.
- To prevent possible hand contamination, open all tubes slowly and carefully.

Pneumatic Tube educational video available on NIHD Intranet

Managing Blood/OPIM Spills.

- Basic principles
    - Standard precautions apply, including use off PPE as applicable
    - Spills should be cleaned before the area is cleaned (adding liquid to spills increase the size of the spill and should be avoided)
- Management small spill < 10cm
    - Secure the spill area notify appropriate personnel
    - Wipe the area immediately with paper toweling
    - Clean with approved hospital disinfectant
    - Management of large spill > 10cm
    - Secure the spill area and notify appropriate personnel
    - Contain the spill using spill kit
    - Remove absorbed material with a scraper and pan and place in a biohazard bag
- Clean with approved hospital disinfectant

Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care will be performed using the following effective patient-handling techniques and other methods designed to minimize risk of a sharps injury:

- Contaminated needles and syringes, and other sharps will not be bent, broken, recapped or otherwise manipulated and will be disposed of in rigid-walled disposable sharps containers. ***Exception***: Syringes that contain radioactive pharmaceuticals that must be returned to the pharmaceutical company for disposal may be recapped using a safety device designed for this purpose or by the “one-handed” method.
- Reusable sharps will be placed in labeled, puncture resistant, leak-proof containers for appropriate cleaning and sterilization. Cleaning of such sharps will not require employees to reach their hands into sharps containers.
- Do not reuse disposable sharps under any circumstances.

- Contaminated sharps will be immediately, or as soon as possible after use, disposed of in rigid, puncture-resistant, leak proof containers that are labeled "Sharps Waste" or with the international biohazard symbol and the word "Biohazard."
- Sharps container seals must be leak resistant and difficult to reopen.
- Sharps containers will be readily available and easily accessible for all situations in which sharps are used or can be anticipated to be found, including dietary trays and laundry, if applicable.
- Sharps containers will be maintained in the upright position and will be replaced when reaches the fill line (2/3 full) to avoid overfilling.
- Broken glassware or sharps located on floor or other item that may be contaminated staff will not pick up by hand, but by mechanical means such as a brush and dustpan, tongs or forceps.
- No items shall be placed on top of the sharps container (e.g. germicidal wipes, Kleenex boxes
- Staff must ensure that no items are sticking out and/or stuck in the opening of sharps containers
- A safety device will be used (ex-point lock) if there is no engineered safety device.
- The employee or physician performing the procedure **SHOULD** dispose of his/her own sharps except in the Operating room.
- Always dispose of needles into sharps box with one-handed technique; do not open lid with second hand.

Personal Protective Equipment:

Personal protective equipment is an essential component of a plan to reduce or eliminate exposure to bloodborne pathogens. The following policies and procedures will be adhered to:

- Personal protective equipment will be used in conjunction with engineered controls and work practice controls.
- Where the potential for occupational exposure exists, staff will be provided, at no cost to the employee, appropriate personal protective equipment such as gloves, gowns, aprons, laboratory coats, splash goggles, glasses, face shields, masks, mouthpieces, resuscitation bags, pocket masks, hoods, shoe covers, etc.
- Appropriate personal protective equipment will not permit blood or other potentially infectious materials to pass through (e.g., impervious gowns) or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucus membranes under normal conditions of use.
- Hypoallergenic gloves, glove liners, powderless gloves, and other similar alternatives will be readily available to those employees who experience allergenic problems with the standard gloves.
- Department managers will insure that personal protective equipment in the appropriate size is readily available and utilized when necessary to provide the needed level of protection from anticipated exposure.
- The Infection Preventionist will monitor compliance by checking use of personal protective equipment as part of the environmental rounds, and department managers will monitor compliance on a day-to-day basis.
- Employees will be provided training on the appropriate use of personal protective equipment. Training will be completed at the time of initial assignment to a job classification or task/procedure that presents the potential for blood, body fluid or other potentially infectious material exposure.

- A staff member may temporarily and briefly decline to use personal protective equipment only under rare and extraordinary circumstances. If he/she believes, based on their own professional judgment, that its use would prevent the delivery of health care or public safety services or would pose an increased hazard to worker safety, then they may decline to use the personal protective equipment. If this occurs, the Infection Preventionist will investigate and document the circumstances to determine whether changes should be implemented to prevent a similar occurrence in the future. NIHD encourages employees to report all such instances.
- NIHD will be responsible for the cleaning, laundering, repairing, replacing and disposing of personal protective equipment as needed to maintain effectiveness at no cost to the employee.
- Any garment(s) penetrated by blood or other potentially infectious materials will be removed immediately or as soon as feasible, and placed in the designated area or container for storage until washed or disposed of by the facility.
- All personal protective equipment will be removed prior to leaving the work area and patients room
- Employees are responsible for placing their personal protective equipment, after removal, in a designated area or container for storage, washing, decontamination or disposal.
- Employees will wear gloves when it is reasonably anticipated that they will have hand contact with blood or other potentially infectious materials, mucous membranes and non-intact skin when performing vascular access procedures, and when handling or coming into contact with contaminated items or surfaces.
- Disposable gloves will be replaced, as soon as practical when contaminated, torn or punctured or when their ability to function as a barrier has been compromised.
- Disposable gloves will not be washed or decontaminated for reuse.
- Heavy duty, utility gloves may be decontaminated for reuse; however, they must be discarded if cracked, peeling, torn or exhibit any signs of deterioration that would compromise their barrier protection.
- Employees will wear masks in combination with eye protective devices such as glasses with solid sidepieces, goggles or face shields whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.
- Gowns, aprons, lab coats or similar outer garments will be worn whenever the potential for exposure to blood or other potentially infectious materials is likely.
- Surgical caps or hoods, and impermeable shoe covers or boots will be worn in instances where “gross contamination” is anticipated (e.g., autopsies, orthopedic surgery, labor and delivery).

Cleaning and Decontaminating the Work Site:

Listed below are cleaning and decontaminating policies and procedures that must be followed:

- Environmental Services is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning is scheduled appropriately and proper methods for cleaning and decontaminating are followed. A written schedule for cleaning and decontaminating the worksite has been developed and is posted in Environmental Services work stations and in the Environmental Services manual

- All dirty linen is handled in compliance with standard precautions. All appropriate steps are taken to minimize or eliminate potential exposures. If the soiled linen is wet and presents the likelihood of causing exposure, a plastic bag will be used to prevent leakage or exposure.
- Linen will be bagged or containerized at the point of use and will not be sorted or rinsed in this location.
- The Infection Control Committee is responsible for reviewing and approving policies and procedures that address proper cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated.

A summary of cleaning requirements follows:

- All equipment and environmental and work surfaces will be cleaned and decontaminated as soon as possible after contact with blood or other potentially infectious materials.
- Contaminated work surfaces, or surfaces that come into contact with the hands, will be cleaned and decontaminated immediately or as soon as feasible in the event they become overtly contaminated, when blood or other potentially infectious materials fluid spills occur, or when procedures are completed, using a disinfectant with a hepatitis B or tuberculocidal claim.
- All bins, pails, cans and similar receptacles that become contaminated with blood or other potentially infectious materials will be cleaned and decontaminated immediately or as soon as feasible, no later than at the end of the work shift.
- Protective coverings such as plastic wrap, aluminum foil, or imperviously backed absorbent paper used to cover equipment or environmental surfaces will be removed, replaced and appropriately disposed of at the end of each work shift. If such covering becomes overtly contaminated, it will be removed and disposed of immediately or as soon as feasible.

Waste Disposal:

The California Medical Waste Management Act, in conjunction with this plan, will provide direction on the proper disposal of biohazardous waste to include sharps waste and wastes contaminated with blood or OPIM. The following will be placed in red plastic bags marked with the word and symbol for "biohazard" and disposed of using the biohazard waste pathway:

- Liquid or semi-liquid blood or other potentially infectious materials
- Contaminated items that contain liquid or semi-liquid blood or are caked with dried blood and are capable of releasing these materials when handled or compressed
- Contaminated sharps
- Pathological and microbiological wastes containing blood or other potentially infectious materials

Accepting Community Needles:

- NIHD will accept contaminated needles from the community for disposal
- Refer questions from persons with needles to infection control or maintenance.
- A sharps disposal unit is at the front of the hospital and all community sharps may be placed in this unit.
- Sharps containers may not be sold or given to patients or other individuals for home use.
- Sharps disposal located at NIHD front entrance (large **red** receptacle with the wording "sharps")
- Must be in a rigid hard plastic bottle or container with screw lids.
- Sharp boxes designed for sharps. Will not be accepted otherwise.

- Any ambulance service may dispose of their needles/infectious waste at NIHD, at any time, but must dispose of it themselves in appropriate infectious waste containers.

Hepatitis B Vaccination Program:

In an effort to provide maximum protection from hepatitis B infection, NIHD offers a vaccination program, at no employee cost, to all staff that has potential occupational exposure to bloodborne pathogens. Components of the program are outlined below:

- The vaccination program will be discussed with applicable staff following the training outlined in this plan and within 10 days of initial assignment and annually during the bloodborne pathogens training program. The safety of the vaccine and the advantages of receiving the vaccine will be reviewed with all applicable staff. Details for receiving the vaccine also will be included.
- Vaccine will be provided when indicated by Employee Health as part of the initial employment physical for all new employees with potential exposure to blood or other potentially infectious materials. Employee Health follows up with each employee until the vaccination series is complete.
- Current employees also will be offered the HBV vaccine free of charge from Employee Health. The vaccine is offered to physicians and non-licensed contracted employees with potential exposure to blood free of charge.
- All employees have the right to decline immunization and are required to complete and sign the declination statement. If the employee subsequently changes his/her mind and requests the vaccine, it will be provided at no cost to the employee.

Post-Exposure Evaluation and Follow-Up: Follow P&P Exposure Evaluation-Blood Borne Pathogen

NOTE: Refer to - Initial Evaluation of NIHD HCW

A bloodborne pathogen exposure prophylaxis protocol has been implemented to provide an immediate, confidential medical evaluation and follow-up of employees exposed to blood or other potentially infectious materials. This protocol is in accordance with the most recent recommendations of the U.S. Public Health Service.

Note: *The Standard requires providers to follow procedures as recommended by the U.S. Public Health Service. The Centers for Disease Control and Prevention periodically issue new recommendations. Providers, and in particular, medical professionals who conduct post-exposure evaluations, need to keep updated on the CDC's recommendations.* Current recommendations and checklists are incorporated into packets and outlined below to ensure comprehensive and appropriate treatment.

- The protocol and information packets are available from the Employee Health policies and procedures manual. Detailed instructions and all necessary forms are included in the packet for the employee, supervisor and physician, to ensure the evaluation is comprehensive and thorough.
- The Emergency Department Physician conducts initial Medical Evaluation of the exposed healthcare worker. The initial workflow is conducted by Nursing Supervisor, Emergency Department Nurses, Infection Prevention Nurse, or Employee Health Nurse Specialist. Follow up labs are conducted by Employee Health Nurse Specialist or Infection Prevention Nurse. A primary care physician conducts follow up medical care.

- If the healthcare worker refuses post-exposure medical evaluation and laboratory testing, "refusal of care document" will be signed, and healthcare worker is encouraged to follow up with their primary care as soon as possible.
- Medical evaluation and laboratory tests will be provided at no cost to the employee.
- All medical records will be maintained in the patient's confidential employee health file.

Reporting and Documenting Sharps Injuries:

All sharps related injuries will be reported as an occupational injury following the facility's Occupational Injury and Illness Reporting procedure. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury. A report denoting the frequency of use of the types and brands of sharps involved in exposure incidents will be generated and reported to the Safety and Infection Control Committees annually. Frequency of use will be approximated by product ordering trends. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury.

In addition, all sharps injuries will be recorded on the sharps injury log within 14 working days of the date the incident was reported. The log will be maintained for a minimum of five years by Employee Health.

The log will include the following information

- Job classification of the exposed employee.
- Date and time of the exposure incident.
- Type and brand of the sharp involved, if known.
- A description of the exposure incident which must include:
    - Job classification of the exposed employee.
    - Department or work area where the exposure incident occurred.
    - The procedure the exposed employee was performing at the time of the incident.
    - How the incident occurred.
    - The body part involved in the exposure incident.
    - If the sharp had engineered sharps injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation, or after activation.
    - If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury.
    - The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury.

Communicating Hazards to Employees:

In addition to the provisions of standard precautions, the following hazard communication provisions are implemented as part of the exposure control plan:

- Biohazardous waste will be collected in red bags pre-printed with both the word **BIOHAZARD** and the biohazard symbol.

- Warning labels with the legend **BIOHAZARD** will be affixed to refrigerators and freezers containing blood or other potentially infectious materials-and all other containers used to store, transport or ship blood or other potentially infectious materials.
- Biohazardous wastes will be labeled with the legend **BIOHAZARDOUS WASTE** or **SHARPS WASTE** as appropriate. Labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.

The following items *do not* require hazard labels/signs:

- Containers of blood or blood products already labeled as to their contents and released for transfusion or other clinical use.
- Individual containers, tubes and specimen cups of blood or other potentially infectious materials placed in biohazard labeled bags or containers for storage, transport, shipment or disposal.
- Primary specimen containers, as all staff are trained to use standard precautions when handling patient specimens.
- Laundry bags and containers, as both staff and laundry workers are trained in standard precautions.
- Biohazardous (regulated) waste which has been decontaminated (e.g., processed in a sterilizer) prior to disposal.

Note: *The California Medical Waste Management Act also requires hazard-warning signs/labels of biohazardous waste. The requirements of this exposure plan are not intended to supersede these requirements but augment them.*

Information and Training:

All employees and physicians covered by this plan will be provided training at the time of initial assignment to an at-risk job classification.

Training will be provided by the Infection Preventionist, or designee, or assigned training. Training will be provided in the language and vocabulary appropriate to the employee's education, literacy and language background.

Training will occur:

- At the time of initial assignment to an at-risk job classification.
- Annually, within 12 months of the previous training.
- When changes affect the employee's occupational exposure, such as new engineering, administrative or work practice controls, modifications of tasks/procedures or institution of new tasks/procedures. This training may be limited to these changes.

The training program will contain, at a minimum, the following elements:

- Copy and explanation of the Standard – A copy of Cal/OSHA's Bloodborne Pathogens Standard is available for review in the Infection Prevention department and this plan.
- Epidemiology and symptoms – A general explanation of the epidemiology and symptoms of bloodborne pathogens.
- Modes of transmission – A general explanation of the modes of transmission of bloodborne pathogens.

- Employer's exposure control plan – An explanation of the plan and how an employee can obtain a copy.
- Risk identification – An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- Methods of compliance – An explanation of the use and limitations of methods to prevent or reduce exposure, including appropriate engineering controls, administrative or work practice controls, and personal protective equipment.
- Personal protective equipment – Information on the types, proper use, location, removal and an explanation of the basis for selecting personal protective equipment.
- Decontamination and disposal – Information on handling and the decontamination and disposal of personal protective equipment.
- Hepatitis B vaccination – Information on the hepatitis B vaccine, including its efficacy, safety, method of administration, the benefits of being vaccinated, and that it will be offered free of charge.
- Emergencies – Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- Exposure incident – An explanation of the procedure to follow if an exposure incident occurs, including how the incident should be reported, the medical follow-up available and the procedure for recording the incident on the sharps injury log.
- Post-exposure evaluation and follow-up – Information on the post-exposure evaluation and follow-up that will be provided to the employee after an exposure incident.
- Signs and labels – An explanation of the signs, labels and/or color-coding used to identify hazards.
- Interactive questions and answers – An opportunity for interactive questions and answers with the trainer.

Recordkeeping:

Records covered in this section are available through Human Resources, Employee Health, and Infection Prevention. Records must be made available under these circumstances:

- All records (training records, medical records and sharps injury log) will be provided upon request to Cal/OSHA and NIOSH for examination and copying.
- Employee training records will be provided upon request to employees and employee representatives.
- Employee medical records will be provided to the subject employee upon request for examination and photocopying. Anyone with written consent from this employee may also request the employee health and medical records.
- The sharps injury log is available upon request to examine and photocopy, and will be made available to employees and to employee representatives upon request.

Medical Records

Employee Health will maintain a medical record for each employee who performs duties that may result in an exposure incident. These records will include the following information:

- The name and social security number of the affected employee.
- A copy of the employee's hepatitis B vaccination status including the dates of all hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination.
- A copy of all examination and medical testing results, and follow-up procedures.
- The employer's copy of the health care professional's written opinion.
- A copy of the information provided to the health care professional.
- These records will be kept confidential and will not be disclosed or reported without the employee's expressed written consent except as required by Title 8, California Code of Regulations, Section 3204, and other applicable laws. These records will be maintained within the above listed departments for at least the duration of employment plus 30 years.

Training Records

Full documentation of training must be completed for all employees trained. Documentation will be maintained by, and be the responsibility of, department managers, within Learning Management System, and the Infection Preventionist or Employee Health Nurse.

- Training records must include, at a minimum, the following:
- Date of training session
- Summary of content
- Names and job titles of attendees
- Names and qualifications of trainers

Annual Review:

A review of this plan is conducted each year. The Infection Preventionist and Sharps Injury Prevention Committee members, and Safety Committee will conduct this review. Frontline health care workers—those who have contact with patients and use sharps frequently—will be included in this review. As part of the review process, the committee will consider the effectiveness of the program in preventing "exposure incidents" and will include a review of current engineering controls and work practice. The Infection Preventionist Manager is responsible for reviewing and updating the Bloodborne Pathogen Exposure Control Plan annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure. The annual review process will include soliciting input from frontline healthcare workers who have contact with patients and use sharps frequently.

REFERENCES:

1. The Joint Commission (2025) Infection Prevention and Control IC.06.01.01 EP 5. Retrieved from https://edition.jcrinc.com/
2. California Code of Regulations. Site Accessed 6/19/25. Subchapter 7. General Industry Safety Orders §5193. Bloodborne Pathogens. Retrieved from

https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/BloodbornePathogensStd.pdf
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6. Centers for Disease Control and Prevention. (2014). (Site Accessed 07/02/2024) Bloodborne Pathogen Exposure. Retrieved from https://www.cdc.gov/niosh/docs/2007-157/default.html
7. Centers for Disease Control and Prevention. (2015). Workbook for Designing, Implementing and Evaluating a Sharps Injury Prevention Program. Retrieved from https://www.cdc.gov/infection-control/hcp/sharps-safety/program-workbook.html
8. Centers for Disease Control and Prevention. (2024). Sharps Safety Program Resources. Retrieved from https://www.cdc.gov/infection-control/hcp/sharps-safety/index.html.
9. California Hospital Record and Data Retention Schedule. (2018). Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf

CROSS-REFERENCE P&P:

1. Handling of Soiled Linen
2. Bloodborne Pathogen Exposure-Initial Evaluation of NIHD HCW
3. Infectious/Non-Infectious Waste Disposal Procedure Infectious/Non-Infectious Waste Disposal Procedure
4. Injury and Illness Prevention Program
5. Lippincott Standard Precautions
6. Personal Protective Equipment (PPE's) Putting On
7. Personal Protective Equipment (PPE's) Removing with critical notes
8. Personal Protective Equipment (PPE's) and Supplies
9. Pneumatic Tube Use
10. Infection Prevention Plan (IPP)
11. Medical Waste Management Plan
12. Sharps Committee Charter
13. Designated Areas for Food and Drink Near Patient Care Areas
14. InQuiseek – Blood Borne Pathogens: Exposure Control
15. InQuiseek – Infection Control Policy

RECORD RETENTION AND DESTRUCTION:

See medical records and training records section of this annual plan.

Sharps injury training records will be kept for at least six years.

Sharps Injury log will be kept for 10 years

Supersedes: v.9 Bloodborne Pathogen Exposure Control Plan

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room) and Segregated Radiopharmaceutical Processing Area (SRPA)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Pharmacy, Environmental Services, Infection Prevention, Nuclear Medicine		
Date Last Modified: 12/30/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/21/2018	

PURPOSE:

To give Environmental Services (EVS), pharmacy personnel, and the Nuclear Medicine Technician the proper guidelines and training to ensure proper cleaning and disinfecting of the Pharmacy Sterile IV Preparation area and Segregated Radiopharmaceutical Processing Area (SRPA) respectively. The EVS team is not be responsible for cleaning and disinfecting Primary Engineering Control areas (PEC).

POLICY:

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

15. Documentation of each occurrence with cleaning and sanitizing of the compounding areas shall include a record of the identity of the person completing the cleaning and sanitizing as well as the product name of the cleaning and sanitizing agent.
16. Nuclear Medicine will follow the below polices for area survey, wipe tests related to monitoring of radiation exposure levels, and radioactive material spills procedure.
    - DI-NM P&P- Daily Area Surveys
    - DI-NM P&P Area Surveys and Wipe Tests.
    - Diagnostic Imaging-Radioactive Material Spills Procedure

DEFINITIONS:

1. Anteroom: An International Organization for Standardization (ISO) Class 8 or cleaner room with fixed walls and doors where personnel hand hygiene, garbing procedures, and other activities that generate high particulate levels may be performed. The anteroom is the transition room between the unclassified area of the facility and the buffer room
2. Primary Engineering Control (PEC): A device or zone that provides an International Organization for Standardization (ISO) Class 5 air quality environment for sterile compounding
   Secondary Engineering Control (SEC): The area where the PEC is placed (e.g., a cleanroom suite or an Segregated Compounding Area (SCA)). It incorporates specific design and operation parameters to minimize the risk of contamination within the compounding area.

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

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

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

Site	Cleaning	Disinfecting	Sporicidal Disinfectant
Pass-through chamber	**Daily** on days compounding occurs	**Daily** on days compounding occurs	**Monthly** areas excluding the PEC by EVS team
PEC, work surfaces, and equipment inside PEC & SEC	**Daily** on days compounding occurs	**Daily** on days compounding occurs	**Monthly** using Sterile Sporicidal by trained pharmacy staff
Work surfaces outside	**Daily** on days compounding occurs	**Daily** on days compounding occurs	**Monthly** areas excluding the PEC by EVS team
Floors	**Daily** on days compounding occurs	**Daily** on days compounding occurs	**Monthly** areas excluding the PEC by EVS team
Walls, doors, and door frames	**Monthly**	**Monthly**	**Monthly** excluding the PEC by EVS team
Ceilings			
Storage shelving and bins			
PEC and Equipment outside PEC			

PROCEDURE:

1. Perform Hand Hygiene
2. Don first pair booties
3. Don remaining Personal Protective Equipment (PPE) after crossing demarcation line:
    - Pharmacy area: Hospital launder scrubs or bunny suit.
    - Nuclear Medicine area: Low lint gown
    - All areas mask, gloves, beard cover if applicable, hairnet, 2nd pair booties, and eye protection
    - Remove and discard PPE when exiting.
4. Disposable soap containers must be replaced they are not to be refilled or topped off.
5. Daily: clean- wipe all horizontal surfaces; mop the floor with a designated mop.
6. Monthly cleaning: Walls, doorframes, ceilings, storage shelving, tables, stools, and all other items and surfaces in the Pharmacy Compounding area and SRPA using approved sporicidal/germicidal product.
7. No sweeping or dry dusting. No spraying of cleaning and disinfecting products inside the PEC areas.
8. Daily: Empty all trash containers. The outside of the waste containers shall be wiped with the approved germicidal cleaning and disinfecting solutions.
9. Monthly: Cleaning of the inside and outside of trash containers with approved sporicidal agent.
10. All waste containers will be properly disposed of when at fill line. Replacements must be wiped down with sporicidal disinfectant, EPA-registered disinfectant or 70% sterile alcohol before placed in sterile compounding areas.
11. Complete daily and monthly log.

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). August 2023. Ten Key Points the Infection Preventionist Needs to Know about (USP) >797>: Pharmaceutical Compounding-Sterile Preparations. Retrieved from https://apic.org/wp-content/uploads/2023/08/APIC_PGC_Ten-Key-Points-the-Infection-Preventionist-Needs-to-Know.pdf
2. California Hospital Association. (2018). Record and Data Retention Schedule. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf
3. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
4. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
5. The Joint Commission Medication Management MM.05.01.07 The Critical Access Hospital safely prepares medications. Retrieved from https://e-dition.jcrinc.com/ASearch.aspx
6. United States Pharmacopeia (USP). 11/1/23. <797> Faqs. Retrieved from https://go.usp.org/USP_GC_797_FAQs
7. United States Pharmacopeia (USP). 11/22. <797> Pharmaceutical Compounding-Sterile Preparations. Retrieved from https://online.uspnf.com/uspnf/document/1_GUID-A4CAAA8B-6F02-4AB8-8628-09E102CBD703_7_en-US
8. United States Pharmacopeia (USP). 2017. USP General Chapter <800> Hazardous Drugs-Handling in Healthcare Settings. Retrieved from www.usp.org

RECORD RETENTION AND DESTRUCTION:

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

CROSS-REFERENCE P&P:

1. Medical Waste Management Plan
2. Pharmacy Sterile Products: Compounding Quality Assurance Program Plan
3. Pharmacy Sterile Compounding Training Requirements, General Conduct, and Aseptic Compounding
4. DI-NM P&P- Daily Area Surveys
5. DI-NM P&P-Area Survey and Wipe Tests
6. Diagnostic Imaging-Radioactive Material Spills Procedure

Supersedes: v.4 Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Fire Response Plan-Code Red		
Owner: Maintenance Manager	Department: Maintenance	
Scope: NIHD		
Date Last Modified: 12/02/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To establish a standardized and compliant response to fire, suspected fire, or fire alarm activation in order to protect the safety of patients, staff, visitors, and licensed independent practitioners. This plan ensures compliance with **NFPA 101 (Life Safety Code), NFPA 99 (Health Care Facilities Code), NFPA 10 (Portable Fire Extinguishers), CMS CAH Conditions of Participation, California Title 22**, and **Joint Commission EC/LS/EM standards**.

POLICY:
All NIHD staff and licensed independent practitioners shall follow the R.A.C.E. fire response procedure and the requirements of this policy. Staff shall respond the same way during drills as during actual events. Fire drills, fire alarm activations, and fire events will be managed in accordance with Joint Commission standards, NFPA codes, and internal NIHD procedures.
All staff must know:

- The location of the nearest fire alarm pull station
- The location of fire extinguishers
- The location of fire doors and smoke barriers
- The closest evacuation routes and areas of refuge

Fire response actions must prioritize life safety, containment, and communication.

DEFINITIONS:
- **R.A.C.E.** – Rescue, Alarm, Confine, Extinguish/Evacuate
- **PASS** – Pull, Aim, Squeeze, Sweep
- **Smoke Compartment** – A fire-rated area defined by smoke barriers per NFPA 101
- **Incident Commander** – The House Supervisor until relieved by Administration or the Fire Department
- **Area of Refuge** – A protected location for temporary patient shelter-in-place

PROCEDURE:

1. **CODE RED – Fire in Your Immediate Area**
   Upon discovering fire, smoke, burning odor, or when the fire alarm activates in your work area, perform **R.A.C.E.**:

   R – RESCUE
   - Remove anyone in immediate danger (patients, visitors, staff).
   - Move them to a safe location within the smoke compartment.
   - **Do NOT use elevators.**

A – ALARM

- **Activate** the nearest fire alarm pull station.
- **Report** the location by calling **2400** and stating, "Code Red at [location]."
- The operator will announce:
  "CODE RED, [location]" (three times).
- Alarms between 9:00 PM – 6:00 AM may use modified audible notifications per drill protocol, but **actual fire events always use full audible/visual notification**.

C – CONFINE

- Close **all** patient room doors, fire doors, smoke barrier doors, and office doors.
- Ensure fire doors latch fully.
- Maintain corridors free of obstruction.
- Do **not** attempt to relocate corridor equipment during an active fire unless directed and safe to do so.
- Oxygen shutdown:
  - Respiratory Therapy evaluates oxygen shutdown needs.
  - Only Respiratory Therapy, Maintenance, or House Supervisor may close zone valves.
  - **Exception:** In surgical areas, anesthesia staff may shut off oxygen first.

E – EXTINGUISH / EVACUATE

- Use a fire extinguisher **only if safe** and you are trained.
- Use PASS method (Pull, Aim, Squeeze, Sweep).
- If the fire cannot be controlled, close doors, retreat, and await the Fire Department.
- Evacuate only if ordered or if life safety demands immediate relocation.

CODE RED SECURED

The Bishop Fire Department and Incident Commander confirm the area is safe.
The operator announces:
"CODE RED, SECURED."
Only authorized personnel may reset the Fire Alarm Control Panel.

2. RESPONSE IN AREAS ABOVE, BELOW, OR ADJACENT TO THE FIRE

- Close all doors.
- Keep corridors clear.
- Have patients return to rooms.
- Remind visitors not to use elevators.
- Listen for further overhead announcements.

3. RESPONSE REMOTE FROM THE FIRE AREA

- Prepare to receive relocated patients if needed.
- Avoid elevators.
- Monitor overhead announcements for status updates.

4. DEFEND/PROTECT IN PLACE

NIHD prioritizes **horizontal shelter-in-place** when safest for patients.
Protect-in-place is used when:

- Fire is contained
- Smoke compartment barriers remain intact
- Evacuation creates greater clinical risk

Evacuation is only ordered by the **Incident Commander** or **Bishop Fire Department**, unless immediate danger exists.

5. EVACUATION

Evacuation may be:

Stage I – Horizontal Evacuation

Move patients to an adjacent smoke compartment.

Stage II – Vertical Evacuation

Move one level down via stairwell.

(Performed **only when horizontal evacuation is insufficient**.)

Stage III – Total Building Evacuation

Move all occupants outside to designated assembly areas.

Designated Assembly Area:

- **NIHD Main Parking Lot (All Zones – Entire Lot Functions as Assembly Area)**
  (No Secondary Area needed; the entire contiguous lot is the primary evacuation zone.)

The Incident Commander and Bishop Fire Department determine the need for evacuation beyond horizontal movement.

Refer to the Emergency Operations Plan, Appendix 1 (Evacuation Plan).

6. FIRE RESPONSE TEAM

Includes:

- Maintenance
- Security
- Respiratory Therapy
- House Supervisor (Incident Commander)
  This team assists the Fire Department and supports containment, utilities shutdown, investigation, and safety control.

7. CODE RED IN BUSINESS OCCUPANCIES

Freestanding or attached outpatient/business-use facilities use the same R.A.C.E. procedure, with mandatory total evacuation.

Required actions:

- Activate nearest pull station
- Call **2400** and, if needed, **911**
- Announce building evacuation
- Evacuate immediately to the designated assembly area
- Do not use elevators

The Fire Department determines when reentry is safe.

8. FIRE EXTINGUISHERS

Location

- All staff are oriented to extinguisher locations.
- Extinguishers must never be blocked.
- Maintenance inspects all extinguishers monthly per **NFPA 10**.

Use (PASS)

- **Pull** the pin
- **Aim** at base of fire
- **Squeeze** handle
- **Sweep** side to side

Staff must only attempt extinguishment if safe.

9. FIRE DRILLS

Fire drills will:

- Occur **quarterly on each shift** (per NFPA 101/TJC)
- Be unannounced
- Simulate realistic scenarios
- Be conducted annually in business occupancies
- Be observed on multiple units
- Include evaluation of:
  - RACE
  - PASS
  - Containment
  - Areas of refuge
  - Horizontal/vertical evacuation
  - Alarm response
  - Staff knowledge

Documentation will include:

- Time, date, shift
- Scenario
- Staff response
- Fire safety equipment performance
- Opportunities for improvement
- Corrective actions

Drill performance is reviewed by the Safety Committee.

10. STAFF TRAINING AND COMPETENCY

All staff receive:

- Annual fire safety training
- Competency validation in RACE, PASS, and smoke compartmentation
- Orientation to areas of refuge, fire doors, pull stations, and evacuation routes

Staff unable to self-evacuate will be identified and assisted appropriately.

REFERENCES:

- NFPA 101: Life Safety Code (2012)
- NFPA 99: Health Care Facilities Code (2012)
- NFPA 10: Portable Fire Extinguishers (2010)
- CMS Conditions of Participation – Fire Safety Final Rule
- California Title 22 – Fire & Life Safety
- TJC EC.02.03.01 – Response to Fire
- TJC EC.02.03.03 – Fire Drills
- TJC EC.02.05.01 – Utility Shutdown
- TJC LS.02.01.30 – Fire Response Plan
- TJC EM.02.02.05 – Evacuation Procedures
- NIHD Emergency Operations Plan – Appendix 1 (Evacuation Plan)

RECORD RETENTION AND DESTRUCTION:

NIHD will maintain all fire safety documentation, including fire drills, Code Red after-action reports, fire alarm testing records, sprinkler inspections, fire extinguisher inspections, fire door inspections, and training records for a minimum of **three (3) years** in accordance with **NFPA 101 (2012), NFPA 99 (2012), NFPA 25, NFPA 72, Joint Commission EC.02.03.03, and CMS Conditions of Participation**.

Records containing staff names or operational data are stored securely and destroyed using approved methods such as shredding, pulping, or HIPAA-compliant electronic deletion. A destruction log will be maintained showing the date, record type, method of destruction, and authorized individual. Records subject to litigation, audit, or regulatory review are not destroyed until the hold is lifted.

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.2 Fire Response Plan-Code Red EC.02.03.01 EP9

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Hospital-Grade Receptacles		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Maintenance		
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 ensure that all hospital-grade electrical receptacles used at Northern Inyo Healthcare District (NIHD) meet the requirements of NFPA 99-2012 and The Joint Commission (CAMCAH) standards for safety, reliability, and performance in patient care areas. This policy establishes requirements for installation, testing, labeling, and maintenance of electrical receptacles in patient bed locations, anesthetizing locations, and pediatric care spaces.

POLICY:
1. **Hospital-grade receptacles** shall be installed and used in all patient bed locations and in all areas where deep sedation or general anesthesia is administered, in accordance with NFPA 99-2012 (6.3.2.2.6).
2. All electrical receptacles in these locations shall be **tested after initial installation, replacement, or servicing** to verify proper polarity, grounding integrity, retention force, and physical condition, in accordance with NFPA 99-2012 Chapter 6. Testing shall be performed by **qualified personnel**.
3. **Pediatric Locations:** In patient rooms (excluding nurseries), bathrooms, playrooms, and activity rooms, receptacles shall be **tamper-resistant** or equipped with a **listed tamper-resistant cover**, as required by NFPA 99-2012 (6.3.2.2.6.3).
4. Electrical receptacles or cover plates that are supplied from the **Life Safety Branch** or **Critical Branch** of the Essential Electrical System (EES) shall have a **distinctive color or permanent marking** to clearly identify the branch source, in accordance with NFPA 99-2012 (6.3.2.2.6.2).
5. Any receptacle that fails visual inspection or electrical testing shall be **removed from service** and replaced or repaired immediately.
6. Documentation of all receptacle testing performed under this policy shall be maintained and made available for review during Joint Commission surveys, in accordance with EC.02.05.01 EP22.

REFERENCES:
1. The Joint Commission CAMCAH Manual (Jan 2021), EC.02.05.01 EP22
2. NFPA 99-2012, Health Care Facilities Code (Sections 3.3, 6.3.2.2.6, 6.3.4)

RECORD RETENTION AND DESTRUCTION: N/A

CROSS-REFERENCED POLICIES AND PROCEDURE: N/A

Supersedes: v.1 Hospital-Grade Receptacles EC.02.05.01 EP22

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Lockdown		
Owner: Director of Facilities	Department: Plant Services	
Scope: Districtwide		
Date Last Modified: 12/17/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/19/2016	

PURPOSE

To provide assistance to staff members and/or visitors, who are confronted by a credible threat, such as an individual brandishing or claiming to possess a weapon, or one who has taken hostages within the healthcare facility or within its property or for other occasions for lockdown. To ensure a safe and secure environment for patients, visitors, and staff. This type of situation must be approached calmly, carefully, and thoughtfully to reduce danger to patients, staff, and visitors.

POLICY

The ability to lockdown the hospital is of primary importance in an emergency situation. Establishing a secure perimeter and the routing of foot and vehicular traffic to controlled entry/exit points that are staffed by hospital personnel are key elements in controlling and maintaining the integrity of the facility and its surrounding perimeter. Situations calling for lockdowns and/or high level controlled access within the facility include, but are not limited to, infant abductions, kidnappings, bio/chemical incidents requiring partial or total quarantine, and/or a civil disturbance occurring within the Hospital's immediate surrounding perimeter, a credible threat against the hospital, staff, patients or visitors. The House Supervisor, Administrator on Call and/or Incident Commander can perform a lockdown by assessing the level of threat and initializing the appropriate level of lockdown.

Occasions for lockdown

Event	Prevent Entry	Prevent Exit	
Bomb threat	X		
External Contamination	X	X	
Civil disturbance	X	X	
Hostage event	X		
Active Shooter	X		
Infant abduction	X	X	
Child Abduction	X	X	
Combative Employee	X		

DEFINITIONS

I. Levels of Lockdown

A. <u>Total Lockdown</u>

This is the highest level of facility and perimeter security. During a total lockdown, **all** perimeter doors and exterior barriers are secured and no one is allowed to enter or exit the facility. Security personnel or designees will be deployed to key entry/exit point areas.

B. <u>Controlled Lockdown</u>

1. **Type I - Controlled Lockdown/Exit Only**
   During a controlled lockdown/exit only, all perimeter doors are secured. Security personnel/designees are deployed to public entrances/exits. Each person attempting to leave would be screened, as defined by this policy. There is no entry allowed during this lockdown level.

2. **Type 2 – Controlled Lockdown/Entry Only**
   During a controlled lockdown/entry only, all perimeter doors and exterior barriers are secured and security personnel/designees are deployed to public entrance/exit points. Each person attempting to enter would be screened, as defined by this policy.

3. **Type 3 – Controlled Lockdown with Entry/Exit**
   During a controlled lockdown with entry/exit, all perimeter doors are secured and security personnel/designees are deployed to all public entrances, exits, and external barriers. Each person attempting to enter or leave would be screened in accordance to this policy.

4. **Type 4 – Partial Lockdown**
   During a partial lockdown, all foot traffic is directed towards designated controlled entrances/exits (main lobby doors, emergency doors, etc.). Security officers or designees will maintain control in both of these areas as required and/or mandated. Surveillance and/or screening will be conducted as directed.

5. **Type 5 – Emergency Room Lockdown**
   This type of lockdown is used to regulate entry/exit of the emergency room only. All magnetic and/or other access controlled doors, as well as all elevators leading to and from the ED will be secured. Security personnel/designees will be stationed at all doors and elevators (interior/exterior depending on situation) that are not mechanically controlled.

6. **Type 6 – Clinic and other out buildings**
   This type of lockdown is used to regulate entry/exit to clinics and other out buildings. All doors leading to and from the clinics and out buildings will be secured. Security personnel and/or designees will be assigned to these areas. The Department Director or Designee, Administrator on Call, or the Incident Commander would make the decision to lockdown the Clinics or other out buildings.

II. Screening: Defined

At all control points during lockdown (with the exception of Type 4), individuals should be appropriately screened, depending on the circumstances of the situation. Individuals should be screened upon exit and/or entry. Screening Techniques will be at the discretion of the Security Officer or Law Enforcement.

EQUIPMENT:

1. Keys
2. Radios (Located in Maintenance Shop) if appropriate

PROCEDURE:

Initiation of Lockdown Procedures:

Local law enforcement will be contacted for assistance by dialing 911. Control of driveways onto/exiting the property as needed.

The determination to declare and/or initiate total or controlled lockdown will be at the discretion of the House Supervisor, Administrator on Call and/or Incident Commander.
All hospital personnel will report to their respective units/departments to await further instructions from their respective managers. During a lockdown additional hospital personnel may be needed as well as adjustments to normal shift hours. These adjustments will be at the discretion of the House Supervisor, Administrator on Call or Incident Commander.

In the event of a lockdown (with the exception of type 4 lockdown unless otherwise directed) hospital personnel should be in a state of high alert and question any suspicious or incident related circumstances, appearance, and/or condition, until explained, proven and verified to their satisfaction. Documentation of the contact, with basic information, should be maintained while lockdown status is in effect.

LOCKDOWN

Switchboard Operator:
Upon notification from the House Supervisor, Administrator on Call or Incident Commander the switchboard operator will announce the level of lockdown three (3) times via overhead page with one of the following:

"A Total Hospital Lockdown is now in effect"; or
"A Controlled Lockdown Entry Only is now in effect"; or
"A Controlled Lockdown Entry/Exit is now in effect"

Environmental Services:
If onsite or on arrival environmental staff will work together with the House Supervisor and available staff as a team to secure and place signs on the doors stating that we are in lockdown.

Maintenance:
If onsite or upon arrival, Maintenance will assist in securing the Hospital doors.

Safety Officer
On notification of the total hospital lockdown, the safety officer will assess the impact and work with the House Supervisor, Administrator on Call and/or Incident Commander.

EMERGENCY DEPARTMENT LOCKDOWN

Environmental Services:
If onsite or on arrival environmental staff will work together with the House Supervisor and available staff as a team to secure and place signs on the doors stating that we are in lockdown.

Maintenance:
If onsite or upon arrival, Maintenance will assist in securing the Hospital doors.

Safety Officer:

On notification of the emergency department lockdown, the safety officer will assess the impact and work with the House Supervisor, Administrator on Call and/or Incident Commander.

RETURN TO NORMAL OPERATIONS

The determination to terminate or discontinue a total, controlled or emergency department lockdown will be at the direction of the House Supervisor, Administrator on Call and/or Incident Commander.

Switchboard Operator:

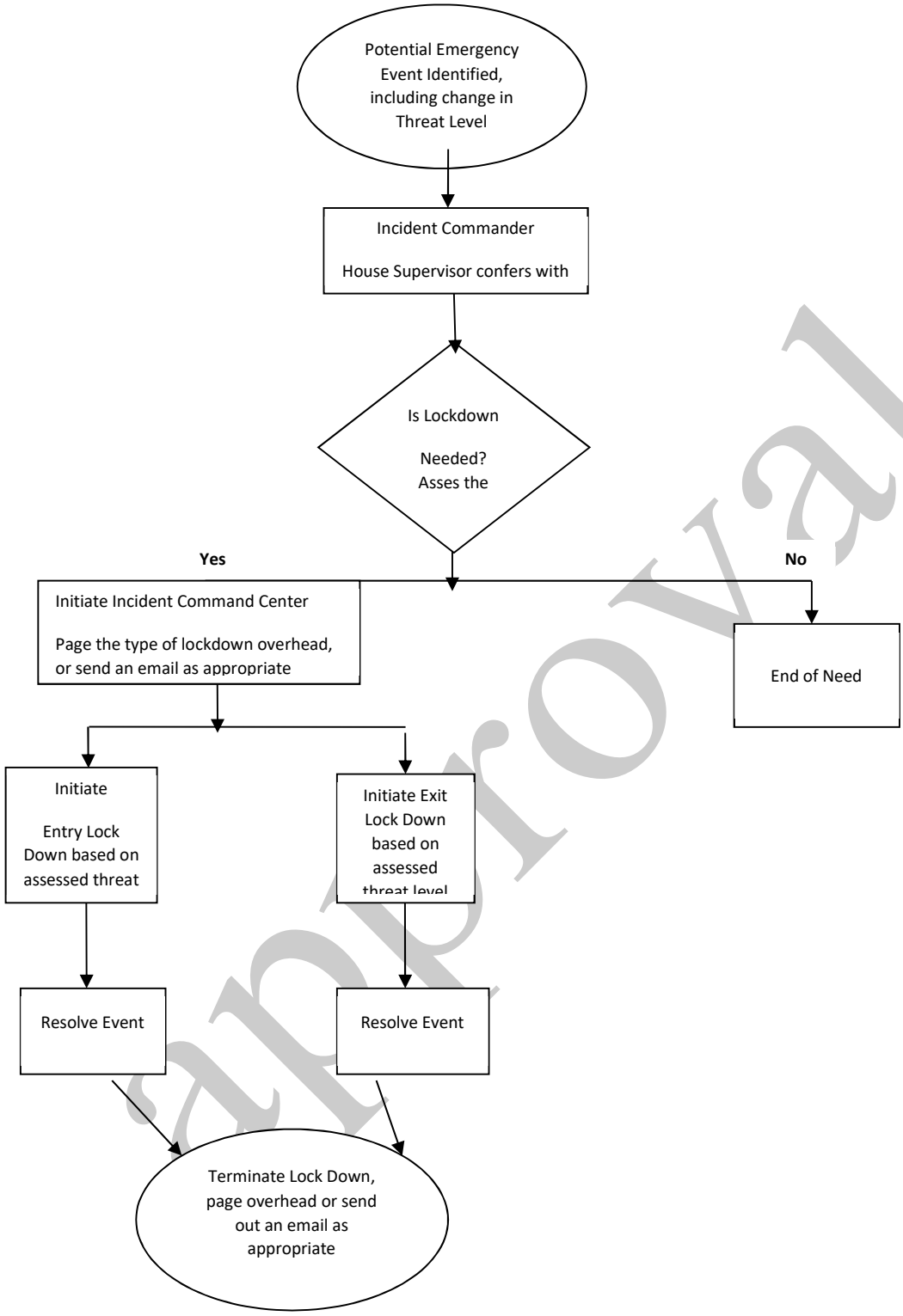
The switchboard operator will announce 3 times via overhead page "*Emergency lockdown all clear*".

Key personnel will assembly in the command center for debriefing.

REFERENCES:

CROSS REFERENCE P&P

1. EOP Plan
2. HICS Plan
3. EC.01.01.01EP2 a Appointment for Immediate Threat to Life


Potential Emergency Event Identified, including change in Threat Level
Incident Commander
House Supervisor confers with
Is Lockdown
Needed?
Asses the
Yes
No
Initiate Incident Command Center
Page the type of lockdown overhead, or send an email as appropriate
End of Need
Initiate
Entry Lock Down based on assessed threat
Initiate Exit Lock Down based on assessed
Resolve Event
Resolve Event
Terminate Lock Down, page overhead or send out an email as appropriate

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

DATE: January 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Governance Committee

RE: Jacob Green and Associates Contract

MEMORANDUM

Purpose

This memo provides an overview of the proposed engagement with Jacob Green & Associates (JGA) to support Board alignment and goal-setting.

Summary of Proposal

Jacob Green & Associates proposes a structured facilitation process designed to help the Board clarify priorities, strengthen communication, and establish clear, measurable goals for the coming year. The process begins with one-on-one interviews with each Board member to understand their perspectives on vision and strategic priorities. JGA then facilitates a workshop focused on governance alignment, Mission, Vision, and Values, as well as CEO performance evaluation and foundational goal-setting concepts. This phased approach is designed to yield a well-defined set of organizational goals grounded in the District's mission, strategic direction, and long-term priorities.

Cost

- Consultant Fee: **$24,000**
- Travel: **Invoiced at cost**
- Materials: **Invoiced at cost**

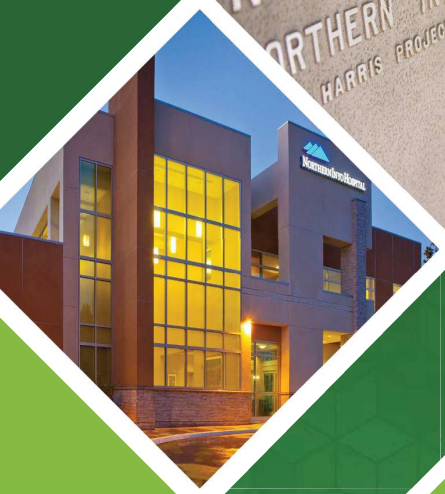
Anticipated Benefits

The engagement is intended to support the Board in establishing a unified direction, improving communication, and creating a clear framework for organizational goals. These goals can be referenced throughout the year and inform future planning cycles to support consistent leadership and well-aligned governance practices.

Recommendation

Approve the contract with Jacob Green & Associates.

PROPOSAL FOR GOAL SETTING SERVICES



NIHD

JACOB GREEN & ASSOCIATES

NOVEMBER 2025

13217 Jamboree Rd., #248
Tustin, CA 92782
888.4.JGA.1ST
JacobGreenAndAssociates.com

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NORTHERN INYO HEALTHCARE DISTRICT

November 4, 2025

Christian Wallis, Chief Executive Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

Dear Chief Executive Officer Wallis,

Thank you for the opportunity to support the Northern Inyo Healthcare District as it continues its journey toward organizational stability, cohesive governance, and shared purpose. At Jacob Green & Associates (JGA), we specialize in helping Special District boards navigate periods of transition through the foundational work of creating strategic alignment; including the development of Mission, Vision, Goals, and future performance expectations for the CEO that truly reflect the Board's aspirations.

Our team brings over 600 combined years of local government experience, and we recognize that successful governance requires more than just policy; it demands unity, purpose, and empowerment. We also recognize that the Northern Inyo Healthcare District is prioritizing the development of a clear and constructive framework for CEO performance evaluation. This includes establishing goals that reflect the District's strategic priorities while laying the groundwork for a transparent and meaningful evaluation process in the year ahead.

Our Goal Setting services are designed to deliver lasting value and measurable progress. Through a collaborative and tailored approach, our work will result in the following key outcomes:

1. **Board cohesion –** Strengthened collaboration, communication, and alignment among board members.
2. **Organizational alignment –** Clear connection between vision, goals, and day-to-day operations across all levels.
3. **Stakeholder investment and trust –** Increased confidence and engagement from internal and external stakeholders.
4. **Legacy and impact –** A forward-looking strategy that ensures long-term relevance, value, and influence.

Through thoughtful facilitation and targeted governance training, JGA will assist the Board in clarifying roles, strengthening collaboration with the CEO, and achieving alignment on expectations and outcomes. Our approach emphasizes trust-building, transparency, and the translation of dialogue into actionable strategies that enhance organizational cohesion, accountability, and long-term success.

We look forward to partnering with the Northern Inyo Healthcare District to support its leadership and governance goals.

Sincerely,

Jacob Green
President & CEO

SCOPE OF SERVICES

SECTION A

GOAL SETTING FACILITATION

Goal setting plays a pivotal role in shaping the future of the Northern Inyo Healthcare District. It provides a clear framework for the Board and CEO to align priorities, make informed decisions, and ensure accountability to the organization and the community it serves. By establishing clear, measurable objectives, the District can strengthen communication between governance and executive leadership, promote transparency, and guide performance in a way that supports both immediate organizational needs and long-term strategic goals. Well-defined CEO goals not only enhance clarity and trust but also serve as a foundation for next year's formal performance evaluation, helping the District sustain stability.

STEP 1: ONE-ON-ONE INTERVIEWS WITH BOARD MEMBERS

Our team will conduct one-on-one interviews with the Board in advance of the Workshop in Step 2. The purpose of these one-hour conversations will be to build rapport and ensure that JGA creates a customized experience to meet the Board's individual and collective interests. These sessions will focus on gathering the individual Board members' Vision, Strategic Priorities, and expectations for the CEO's future performance.

STEP 2: OPEN SESSION WORKSHOP

JGA will provide an open session training to include, but not limited to, the following topics:

- Role of Cognitive Diversity in Team Cohesion
- Building a Highly Effective Team
- Roles and Responsibilities in a Municipal Organization
- Vision, Mission, Goals/Objectives, Values

STEP 3: CLOSED SESSION FACILITATION

In closed session (under the Appointee Performance Evaluation – Closed Session item), the Board will discuss its priorities and expectations for the CEO's future performance evaluation. This confidential setting provides an opportunity for the Board and CEO to engage in a candid dialogue to ensure alignment around goals, performance criteria, and organizational priorities. The intent of this discussion is to establish clear, agreed-upon evaluation criteria in advance so that future assessments are objective, transparent, and directly connected to the Board's expectations and the agency's strategic direction.

Northern Inyo Healthcare District Project Commitment

Successful project outcomes rely on a strong partnership between our team and yours. To ensure the best results, we've outlined key client responsibilities that foster effective collaboration and project efficiency. By fulfilling these roles, you actively contribute to the project's success, helping us deliver high-quality work on time and within scope. This mutual commitment not only improves project outcomes but also maximizes the value and impact of our combined efforts.

- **Clear Objectives:** Define and communicate project goals, expectations, and deliverables clearly at the project's outset.
- **Active Participation:** Engage in regular meetings and provide necessary feedback to ensure the project stays on track and aligns with expectations.
- **Resource Allocation:** Ensure the availability of internal resources, including key personnel, data, and tools, required for the project.
- **Open Communication:** Maintain open and honest communication with the Consultant, addressing any concerns or changes in scope as soon as they arise.
- **Decision-Making:** Facilitate timely decision-making processes to avoid delays and ensure project progress.
- **Access Provision:** Provide the Consultant with necessary access to relevant systems, documentation, and facilities.
- **Respect Timelines:** Adhere to agreed-upon timelines for reviews, approvals, and information requests to maintain project momentum.
- **Change Management:** Collaborate on managing any changes in project scope, requirements, or timelines, ensuring mutual agreement on modifications.
- **Partnership Approach:** Foster a collaborative and respectful working relationship, recognizing that successful outcomes depend on both parties' commitment and cooperation.
- **Timely Payment**: Pay invoices pursuant to contract terms and communicate any payment issues promptly with the Consultant.

YOUR TEAM

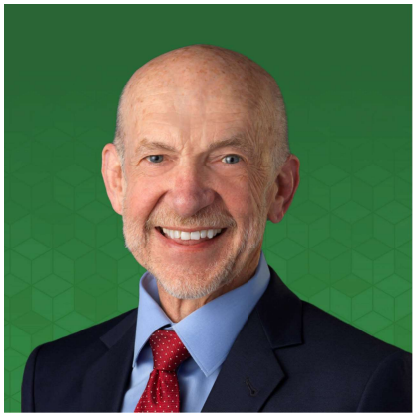
SECTION B

JGA's Team Video Link: Jacob Green and Associates - JGA - Your First Call

JACOB GREEN, MPA

Founder & CEO / Senior Facilitator

Jacob is a nationally recognized local government expert in organization and leadership development. As an Assistant City Manager for the City of San Juan Capistrano and the City of Ontario, he has managed hundreds of employees and numerous government departments. As a trainer, keynote speaker, facilitator and coach, Jacob has worked with municipal clients, as well as commercial clients such as Mattel, FedEx, Hyundai Capital, ADP, and many others. In 2019, Jacob distilled his personal and professional experiences into an Amazon best-selling book: See Change Clearly: Leveraging Adversity to Sharpen Your Vision and Build Resilient Teams. Jacob has received numerous awards for his leadership, including the National Caring Award, the Orange County Human Relations Award, the Most Inspiring Student at UC Irvine, and is the youngest recipient of the Gene Lentzner Humanitarian Award. Jacob has his Bachelor of Arts in Social Sciences with a Minor in Management from the University of California, Irvine, his Master of Public Administration (MPA) degree from California State University, Long Beach, and was recently awarded an honorary doctorate from Western University School of Health Sciences.



GREGORY C. DEVEREAUX, JD

Senior Facilitator

Greg Devereaux served in state and local government for 40 years, holding a variety of leadership positions including City Manager of both Fontana and Ontario, and Chief Executive Officer of San Bernardino County. In each of these roles, he partnered with elected officials to implement fiscal discipline, improve operational outcomes, and align organizational direction with community goals. While serving as CEO, he supported the Board of Supervisors in launching a countywide transformation built on teamwork and long-term planning. He also led the County's development of the Countywide Vision in collaboration with the San Bernardino Associated Governments. Greg is a Past President of the California Redevelopment Association and has served on numerous committees with the League of California Cities and the California State Association of Counties. In 2015 he became a Fellow of the Congressionally chartered National Academy of Public Administration. At Jacob Green and Associates, Greg applies his high-level public sector leadership experience to support local governments with executive strategy, governance training, and long-range visioning. He brings valuable insight to agencies navigating complex organizational challenges and seeking clear, actionable frameworks for policy implementation and fiscal responsibility.

NICOLE BEACH, PMP

Director of Strategic Initiatives

Nicole Beach is a project management and strategy delivery leader who specializes in assisting organizations in realizing value by aligning strategy with execution. Nicole collaborates closely with our clients to develop work plans that ensure their success in executing strategic goals and provides project management oversight across all projects. Before joining JGA, Nicole amassed a wealth of experience leading complex technology, organizational, and strategic projects, including M&A integrations, ERP implementations, and process improvement initiatives. Most recently, she oversaw Project Management Offices and Strategic Portfolio Management for SAFEbuilt, Citrix, and Sport Clips. Nicole holds certifications as a Certified Change Management Professional (CCMP), Project Management Professional (PMP), and Lean Six Sigma Green Belt. She also earned an MBA with a concentration in Process Improvement from Nova Southeastern University.

DAVE BROWN

Leadership Development Partner

Chief Dave Brown (ret.) is passionate about helping public sector executives and organizations succeed in a dynamic and challenging environment, especially when facing leadership, political, or personnel challenges. Chief Brown has held command positions in every division of law enforcement, including many years as a Chief of Police. He has also served as Director of Public Safety, Assistant City Manager, and held several stints as Interim City Manager. In 2017, Chief Brown was recruited by the City of Menifee, California, to spearhead the creation of the Menifee Police Department. Over the next three years, Brown created and implemented a robust, data-driven strategy, successfully launching the new Menifee Police Department on July 1, 2020. More recently, Dave served as the Executive Director of the Riverside Sheriffs Association (RSA), one of the largest law enforcement labor organizations in the country.

KATIE DISTELRATH

Training and Development Manager

Katie Distelrath is a seasoned Community Services and Leadership Development professional who helps public sector teams and emerging leaders grow with clarity, confidence, and purpose. Her greatest strengths lie in fostering inclusive, people-centered environments that build resilience, emotional intelligence, and authentic leadership. Over the past 15+ years, Katie has led community engagement initiatives, overseen large-scale programs, and developed high-performing teams across three California municipalities. Her work has included strategic planning, staff development, and innovative service delivery that meets the evolving needs of diverse communities. Katie holds a BA in Psychology from the University of Southern California and a master's in Marriage and Family Therapy from the University of La Verne.

ALBERT RIVAS, MA

Project Manager

Albert Rivas is a government consultant and public service leader with over 20 years of experience advancing local, state, and community-based initiatives through strategic planning, organizational development, and operational leadership. He has served as a trusted advisor to the Governor's Office, state departments, counties, and municipal executives, including City Managers and Deputy City Managers. In these roles, he has provided high-level strategic coordination, organizational planning, and support for priority-setting efforts across diverse public agencies. Albert also leads the design and execution of enterprise resource planning and change management strategies, improving operational transparency, performance, and accountability across government systems. Appointed by the Governor of California, Albert served as Chief of External Affairs for the California Department of Corrections and Rehabilitation. He has also held roles as a Commissioner for First 5 Sacramento, Commissioner for the Human Rights and Fair Housing Commission, and Senior District Representative in the California State Senate. He is ProSci and DEI Certified. Albert holds a Master of Arts in Education and a Bachelor of Arts in Political Science from the University of California, Davis, as well as a Certificate in Local Governance from Stanford University.

JESSICA MCLIN

Project Manager

Jessica is a project management professional with a knack for blending strategy, creativity, and a sense of humor to deliver exceptional results. Passionate about both achieving organizational goals and providing top-notch customer service, she is skilled at developing and executing innovative programming that engages and delights every step of the way. What sets Jessica apart is her unique ability to combine strong project management skills with a coaching mindset. She's not just about hitting milestones; she's committed to guiding her client's growth, helping them to thrive. Her proactive approach helps to early identify potential roadblocks, leverage strengths, and navigate challenges, leading to both personal and project success. Jessica wears many hats with ease, whether it's coaching, process improvements, or managing complex projects. She's focused on driving results, and knows how to rein in the chaos along the way. With her expertise in leadership development and project management, Jessica is dedicated to helping teams optimize their performance, streamline processes, and better understand their individual and collective contributions. Whether leading a project or mentoring an individual or team, Jessica ensures everyone has the support they need to reach their goals, while having a little fun in the process.

COST PROPOSAL

SECTION C

The costs outlined in this proposal are considered valid and binding for a period of 90 days, commencing from the date of the proposal's issuance. During this timeframe, the provided pricing and estimates for products, services, and associated expenses will remain unchanged, subject to the terms and conditions specified in the proposal document. Any modifications or alterations to the proposal, as well as adjustments to the costs, will require mutual agreement between the involved parties.

COST PROPOSAL

Description	Cost
Goal Setting Facilitation	$24,000
Travel	Invoiced at Cost
Materials	Invoiced at Cost

EXCLUSIONS:

The following program expenses are not included in consultant fees and are the responsibility of the Northern Inyo Healthcare District, if necessary.

- Venue rental fees for events
- Food and beverages for events
- Materials/supplies for workshops
- Translation services, if needed

LATE PAYMENT FEE:

All invoices are due and payable within 30 days of the invoice date. Any invoice not paid within 30 days will be subject to a late payment fee. A fee of 1.5% per month will be added to the outstanding balance until the invoice is paid in full.

The prices, specifications, and conditions covered within this proposal are satisfactory and hereby accepted. JGA is authorized to do the work as specified.

Signature:_____

Name/Title:_____

Date:_____

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Finance Committee Charter		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 01/09/2026	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

Board of Directors Bylaws: Finance Committee:

1. The Finance Committee shall consist of two members of the Board of Directors and one alternate.
2. The function of the Finance Committee is to provide Board-level oversight of the District's financial condition and performance and to advise the Board of Directors on financial matters.
3. The Finance Committee shall meet quarterly or as needed.
4. Finance 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 Finance Committee oversees the hospital's financial management to support long-term financial sustainability, fiscal accountability, and sound financial decision-making. The Committee reviews financial statements and key financial performance information and makes recommendations to the Board on quarterly financial reports (at a minimum, with more frequent monthly review as appropriate), the annual operating budget, annual capital requests, and the annual audit. The Committee also reviews and makes recommendations on significant unbudgeted expenditures, including purchase requests exceeding $40,000

COMMITTEE RESPONSIBILITIES

1. Analyze financial and audit reports
2. Review capital equipment, construction, and IT project status
3. Review Operational and Capital Budget
4. Review audit results and mitigation plan
5. Review Financial Policies
6. Review Investment status
7. Review cash position
8. Review Bond Covenant and Relationship
9. Review Pension Fund
10. Review approval limitations and signers

FREQUENCY REVIEW/REVISION

1. The Finance 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 Finance and Audit Committee Charter

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Finance Committee Charter		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 01/09/2026	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

Board of Directors Bylaws: Finance Committee:

1. The Finance Committee shall consist of two members of the Board of Directors and one alternate. ~~Members of this standing committee shall include a committee of the whole of the Board of Directors, the Chief Financial Officer, the Chief Executive Officer, and others as requested. The Directors shall be the only members of the Committee with voting privileges.~~

2. ~~The~~ The function of the Finance Committee is to provide Board-level oversight of the District's financial condition and performance and to advise the Board of Directors on financial matters.~~The Finance Committee, in consultation with the Chief Executive Officer and Chief Financial Officer, shall be responsible for reviewing and monitoring the annual budget and, as appropriate, its long-term capital expenditure plan. The Finance Committee shall make recommendations to the Board on retention of auditors and approve audits, and business plans pursuant to subsidiary organizations.~~
3. ~~The~~ The Finance Committee shall meet quarterly or as needed.
4.
5. ~~The Finance and Audit Committee shall meet no less than three times per year~~
6. Finance 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

1. ~~The Finance and Audit Committee will oversee the management of finances and audit process to ensure that the hospital is financially sustainable, operating within budgetary guidelines, and audit findings are addressed.~~ The Finance Committee oversees the hospital's financial management to support long-term financial sustainability, fiscal accountability, and sound financial decision-making. The Committee reviews financial statements and key financial performance information and makes recommendations to the Board on quarterly financial reports (at a minimum, with more frequent monthly review as appropriate), the annual operating budget, annual capital requests, and the annual audit. The Committee also reviews and makes recommendations on significant unbudgeted expenditures, including purchase requests exceeding $40,000

~~COMMITTEE MEMBERSHIP~~

~~1. The Finance and Audit Committee shall include a committee of the whole of the Board of Directors, the Chief Executive Officer, the Chief Financial Officer, and others as requested. The Directors shall be the only members of the committee with voting privileges.~~
~~2. All Finance and Audit Committee 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 OF MEETINGS**~~

~~1. The Finance and Audit Committee shall meet in January, May, and August at a minimum unless there is a need for additional meetings. Meetings may be held at irregular intervals.~~

COMMITTEE RESPONSIBILITIES

1. Analyze financial and audit reports
2. Review capital equipment, construction, and IT project status
3. Review Operational and Capital Budget
4. Review audit results and mitigation plan
5. Review Financial Policies
6. Review Investment status
7. Review cash position
8. Review Bond Covenant and Relationship
9. Review Pension Fund
10. Review approval limitations and signers

FREQUENCY REVIEW/REVISION

1. The Finance ~~and Audit~~ 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 Finance and Audit Committee Charter

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

DATE: January 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: Department-Led Budget Development Process

MEMORANDUM

Background

Over the past year, the District implemented an initial shift toward a department-led budgeting approach to strengthen directors' and managers' understanding of their financial responsibilities and the relationship between operational decisions and financial outcomes. This approach increased accountability by giving directors and managers greater ownership over their areas of responsibility and expanded spending authority consistent with that responsibility, reinforcing early departmental involvement, shared understanding of budget assumptions, and stronger ownership of budget targets.

This approach builds on the past year's budgeting experience by strengthening alignment between operational decision-making and financial accountability, ensuring that those responsible for managing resources have meaningful input into how budgets are developed. By increasing transparency and shared understanding, the process promotes organizational alignment and collective responsibility toward common financial goals.

Information

Beginning with the upcoming fiscal year, the District will implement a department-led budget development process.

Expectations for Directors and Managers

Directors and managers will be responsible for developing budgets for their respective cost centers. This includes identifying operational priorities, anticipated revenues, and expected expenses aligned with District goals and approved strategic direction. Directors and managers are accountable for managing performance within their approved budgets once adopted.

Tools and Support Provided

The goal of this approach is to ensure that directors and managers have the appropriate tools, information, and guidance needed to develop realistic, accountable budgets and effectively manage their cost centers.

Throughout the past year, directors and managers have been provided tools and information to support budget understanding and ownership, including hands-on practice, discussion, and review of financial information.

To support the current budget development process, directors and managers have been provided with historical information and current data to inform assumptions, identify trends, and support realistic budget development, along with a detailed budget development schedule outlining milestones and due dates to ensure consistency across departments.

As the new budget is developed and implemented, directors and managers will continue to receive approximately six months of structured financial and budget-related training and support from executive leadership and the finance team. This ongoing support will focus on strengthening budgeting skills, improving forecasting, and reinforcing consistent cost-center management.

Executive Team and CEO Oversight

This process aligns with the Board's governance structure, with accountability flowing from the Board to the CEO and cascading through the executive team, directors, and managers, and with the CEO ultimately accountable to the Board for meeting the District's budgetary goals.

Board Review and Approval

The proposed budget will be presented to the Finance Committee and the Board of Directors at their respective May 2026 meetings. If additional review or revisions are needed, the budget will be brought forward to the Finance Committee and the Board of Directors again in June 2026 for final consideration and approval.

Operational Objective

The District's operational objective is to improve financial sustainability by reducing recurring operating losses and progressing toward balanced operations over time. This budgeting process is a key tool to support that objective.

This approach increases transparency, strengthens accountability, and allows directors and managers to meaningfully participate in financial planning while maintaining executive oversight and Board governance. It supports informed decision-making, aligns operational priorities with financial realities, and advances the District's goal of achieving break-even operations.

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

DATE: January 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights November 2025

Financial Summary

1. Net Income (loss): November's net income was $3.2M which was better than budget by $5.8M and better than prior year by $3.4M. This was due to timing of IGT which was budgeted later in the year but recognized this month in other income. Net patient revenue was better than budget by 11% or $751k due to a low budgeted net this month. However, net patient revenue was lower than prior year by 16% or $(1.45M) due to lower volumes in several areas including surgeries, RHC clinics, and ER visits. Expenses were over budget by $781k and over prior year by $901k due to wages, professional fees, and other expenses.
2. Operating Income (loss): November's operating loss was $(2.9M) which was relatively close to budget yet worse than last year by $(2.4M). This was due to a combination of lower net patient revenue along with increased expenses as mentioned above.

   Action Plan: We are working on multiple projects to increase the scheduling efficiency in the clinics and operating room. Additionally, we are working with Mammoth Orthopedic Institute to increase volume including marketing in Ridgecrest.

Stats Summary

1. Admits (excluding Nursery): Admits were under budget by (10) admits (-13%) due to surgeries.
2. Inpatient Days (excluding Nursery): Inpatient days were under budget by (52) days due to lower admits.
3. Average Daily Census: Census was also under budget.
4. Average Length of Stay (ALOS): Length of stay was also under budget by (-13%).
5. Deliveries: Deliveries were +4 over budget.
6. Surgical Procedures: For November, surgeries were -17 or (13%) under budget due to ophthalmology (Dr. Reid retired).

7. Emergency Department (ED) Visits: ED visits were -8% under budget.
8. Diagnostic Imaging (DI) Exams: Exams were +4% over budget.
9. Rehab Visits: Rehab visits were -15% under budget.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were 2% higher than budget.
11. Observation Hours: Observations hours were down (15%) due to change in processes to meet regulatory requirements.
12. Rural Health Clinic (RHC) Visits: RHC was -5% or -141 visits lower than budget.
13. Other Clinics: Other clinics were relatively flat to budget (+10 visits) with orthopedics up 12%.

Action Plan: Volumes were low due to the holiday and a later start to flu and cold season. However, orthopedics is improving and hit budget for both the clinic visits and surgical cases. 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 November, gross revenue was under budget by $(311k) yet net revenue was over budget by $751k. This was due to lower volumes in ER, rehab, surgeries, and admissions. Net revenue was better than budget due to a low budget month.

Action Plan: We will continue to work on efficiency in schedules and increasing surgical volume.

Deductions Summary

1. Deductions were better than budget by $888k due to budget spread being light in November.

Action Plan: Our AR days have decreased by -17 days from last November, meaning we are collecting payments sooner. Aged AR > 90 days has decreased $(6.3M) from last November. Jorie AI is taking over all billing except for self-pay which will further improve out cash.

Salaries

1. Total Salaries: Salaries were over budget by 8% for the month but only 3% higher than last November (attributed to annual merits). This was due to higher than budgeted FTEs.
2. Average Hourly Rate: Average hourly rate was 6% higher than budget but only 1% higher than last November.

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 8 FTEs occurred to determine if that was due to rising volumes.

Benefits

1. Total Benefits: Benefits were over budget by $75k. This was due to higher medical claims.
2. Benefits % of Wages: We were 43% for November which was 2% better than budget.

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: Because volume was under budget, SWB/ adjusted patient day was over budget by 21%.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For the month, we were at 54% of total expenses when including contract labor. Our goal is 50% or less.

Contract Labor

1. Contract Labor Expense: Contract labor was $91k over budget due to higher than budgeted rates in labor & delivery.
2. Contract Labor Rates: Rates were 40% over budget due to women's services.
3. Contract Labor Full-Time Equivalents (FTEs): We used -13% 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: Physician expenses were -6% under budget.
2. Other Professional Fees: Other professional fees are 44% over budget due to Jorie billing and collection fees. However, we are also seeing improved cash due to Jorie. Additionally, we terminated our Medi-Cal biller contract which will save an average of $78k monthly starting in January.
3. Supplies: Supplies were under budget by $(30k).
4. Total Expenses: Total expenses were over budget by $781k due to higher wages, higher medical claims, higher collection fees, higher repairs, and higher utilities.

   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 66 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 more than we spent. We have 396 days excluding IGT.
3. Unrestricted Cash: Unrestricted cash balance is now $21.4M. This is $288k higher than last November.

   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 17 days or 2 weeks meaning we get cash in the door quicker. Jorie AI billing is helping us improve AR and cash flow.

Northern Inyo Healthcare District

November 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)	3,176,018	(2,611,999)	5,788,017	(222%)	(262,101)	3,438,118	1,312%	(2,590,452)	(470,800)	(2,119,652)	(450%)	3,092,773	(5,683,225)	(184%)
Operating Income (Loss)	(2,891,928)	(2,862,001)	(29,927)	1%	(541,610)	(2,350,319)	(434%)	(10,412,552)	(3,033,109)	(7,379,443)	(243%)	1,284,185	(11,696,737)	(911%)
EBIDA (Loss)	3,593,558	(2,194,845)	5,788,403	(264%)	147,431	3,446,127	(2,337%)	(443,508)	1,614,970	(2,058,477)	127%	5,234,472	(5,677,980)	(108%)
IP Gross Revenue	3,068,437	3,683,029	(614,592)	(17%)	3,654,138	(585,701)	(16%)	16,773,852	18,861,747	(2,087,894)	(11%)	18,713,127	(1,939,275)	(10%)
OP Gross Revenue	12,251,051	12,068,831	182,221	2%	12,133,332	117,719	1%	69,161,995	72,728,384	(3,566,389)	(5%)	73,012,307	(3,850,312)	(5%)
Clinic Gross Revenue	1,834,353	1,712,532	121,820	7%	1,695,930	138,423	8%	9,630,860	8,868,026	762,835	9%	8,817,418	813,442	9%
Total Gross Revenue	**17,153,841**	**17,464,392**	**(310,551)**	**(2%)**	**17,483,401**	**(329,560)**	**(2%)**	**95,566,708**	**100,458,156**	**(4,891,448)**	**(5%)**	**100,542,853**	**(4,976,145)**	**(5%)**
Net Patient Revenue	**7,595,849**	**6,844,535**	**751,314**	**11%**	**9,045,019**	**(1,449,170)**	**(16%)**	**41,139,419**	**46,296,888**	**(5,157,469)**	**(11%)**	**47,419,442**	**(6,280,023)**	**(13%)**
Cash Net Revenue % of Gross	*44%*	*39%*	*5%*	*13%*	*52%*	*(7%)*	*(14%)*	*43%*	*46%*	*(3%)*	*(7%)*	*47%*	*(4%)*	*(9%)*
Admits (excl. Nursery)	67	77	(10)	(13%)	77	(10)	(13%)	336	373	(37)	(10%)	373	(37)	(10%)
IP Days	193	245	(52)	(21%)	245	(52)	(21%)	1,082	1,340	(257)	(19%)	1,340	(257)	(19%)
IP Days (excl. Nursery)	157	207	(50)	(24%)	207	(50)	(24%)	904	1,164	(260)	(22%)	1,164	(260)	(22%)
Average Daily Census	5.2	6.9	(1.7)	(24%)	6.9	(1.7)	(24%)	5.9	7.6	(1.7)	(22%)	7.6	(1.7)	(22%)
ALOS	2.3	2.7	(0.3)	(13%)	2.7	(0.3)	(13%)	2.7	3.1	(0.4)	(14%)	3.1	(0.4)	(14%)
Deliveries	18	14	4	29%	14	4	29%	93	90	3	3%	90	3	3%
OP Visits	3,638	3,847	(209)	(5%)	3,847	(209)	(5%)	20,437	19,230	1,207	6%	19,230	1,207	6%
Rural Health Clinic Visits	2,121	2,203	(82)	(4%)	2,203	(82)	(4%)	11,524	11,476	48	0%	11,476	48	0%
Rural Health Women Visits	528	497	31	6%	497	31	6%	2,667	2,611	56	2%	2,611	56	2%
Rural Health Behavioral Visits	102	192	(90)	(47%)	192	(90)	(47%)	644	942	(298)	(32%)	942	(298)	(32%)
Total RHC Visits	**2,751**	**2,892**	**(141)**	**(5%)**	**2,892**	**(141)**	**(5%)**	**14,835**	**15,029**	**(194)**	**(1%)**	**15,029**	**(194)**	**(1%)**
Bronco Clinic Visits	44	43	1	2%	43	1	2%	172	175	(3)	(2%)	175	(3)	(2%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	276	247	29	12%	247	29	12%	1,576	1,874	(298)	(16%)	1,874	(298)	(16%)
Pediatric Clinic Visits	502	644	(142)	(22%)	644	(142)	(22%)	2,848	3,041	(193)	(6%)	3,041	(193)	(6%)
Specialty Clinic Visits	642	509	133	26%	509	133	26%	3,386	2,761	625	23%	2,761	625	23%
Surgery Clinic Visits	129	127	2	2%	127	2	2%	683	798	(115)	(14%)	798	(115)	(14%)
Virtual Care Clinic Visits	40	53	(13)	(25%)	53	(13)	(25%)	226	301	(75)	(25%)	301	(75)	(25%)
Total NIA Clinic Visits	**1,633**	**1,623**	**10**	**1%**	**1,623**	**10**	**1%**	**8,891**	**8,950**	**(59)**	**(1%)**	**8,950**	**(59)**	**(1%)**
IP Surgeries	2	14	(12)	(86%)	14	(12)	(86%)	41	66	(25)	(38%)	66	(25)	(38%)
OP Surgeries	110	115	(5)	(4%)	115	(5)	(4%)	655	674	(19)	(3%)	674	(19)	(3%)
Total Surgeries	**112**	**129**	**(17)**	**(13%)**	**129**	**(17)**	**(13%)**	**696**	**740**	**(44)**	**(6%)**	**740**	**(44)**	**(6%)**
Cardiology	5	-	5	-%	-	5	100%	12	3	9	300%	3	9	300%
General	66	70	(4)	(6%)	70	(4)	(6%)	402	367	35	10%	367	35	10%
Gynecology & Obstetrics	11	10	1	10%	10	1	10%	57	58	(1)	(2%)	58	(1)	(2%)
Ophthalmology	-	25	(25)	(100%)	25	(25)	(100%)	68	106	(38)	(36%)	106	(38)	(36%)
Orthopedic	14	13	1	8%	13	1	8%	81	136	(55)	(40%)	136	(55)	(40%)
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	-	1	(1)	(100%)	1	(1)	(100%)
Podiatry	-	-	-	-%	-	-	-%	2	2	-	-%	2	-	-%
Urology	16	11	5	45%	11	5	45%	74	66	8	12%	66	8	12%
Diagnostic Image Exams	1,957	1,880	77	4%	1,880	77	4%	11,018	10,577	441	4%	10,577	441	4%
Emergency Visits	726	789	(63)	(8%)	789	(63)	(8%)	4,172	4,403	(231)	(5%)	4,403	(231)	(5%)
ED Admits	47	49	(2)	(4%)	49	(2)	(4%)	202	217	(15)	(7%)	217	(15)	(7%)
ED Admits % of ED Visits	6%	6%	0%	4%	6%	0%	4%	5%	5%	0%	(2%)	5%	0%	(2%)
Rehab Visits	769	903	(134)	(15%)	903	(134)	(15%)	3,871	4,459	(588)	(13%)	4,459	(588)	(13%)
OP Infusion/Wound Care Visits	614	600	14	2%	600	14	2%	3,332	1,993	1,339	67%	1,993	1,339	67%
Observation Hours	867	1,017	(150)	(15%)	1,017	(150)	(15%)	5,459	8,297	(2,838)	(34%)	8,297	(2,838)	(34%)

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** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PAYOR MIX (Patient Days)														
Blue Cross	29.0%	27.7%	1.3%	4.7%	27.7%	1.3%	4.7%	25.2%	26.0%	(0.8%)	(3.0%)	26.0%	(0.8%)	(3.0%)
Commercial	6.0%	8.4%	(2.4%)	(28.5%)	8.4%	(2.4%)	(28.5%)	6.1%	6.4%	(0.3%)	(5.3%)	6.4%	(0.3%)	(5.3%)
Medicaid	37.2%	22.3%	14.9%	66.8%	22.3%	14.9%	66.8%	23.8%	25.2%	(1.4%)	(5.4%)	25.2%	(1.4%)	(5.4%)
Medicare	27.2%	40.4%	(13.2%)	(32.7%)	40.4%	(13.2%)	(32.7%)	42.0%	39.5%	2.5%	6.3%	39.5%	2.5%	6.3%
Self-pay	0.5%	0.6%	(0.1%)	(16.7%)	0.6%	(0.1%)	(16.7%)	2.9%	2.0%	0.9%	42.5%	2.0%	0.9%	42.5%
Worker's Comp	-%	0.5%	(0.5%)	(100.0%)	0.5%	(0.5%)	(100.0%)	-%	0.8%	(0.8%)	(100.0%)	0.8%	(0.8%)	(100.0%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)
PAYOR MIX (Gross Revenue)														
Blue Cross	27.1%	27.8%	(0.8%)	(2.7%)	27.8%	(0.8%)	(2.7%)	28.0%	27.2%	0.8%	2.9%	27.2%	0.8%	2.9%
Commercial	4.9%	6.4%	(1.4%)	(22.1%)	6.4%	(1.4%)	(22.1%)	5.7%	6.2%	(0.5%)	(7.9%)	6.2%	(0.5%)	(7.9%)
Medicaid	22.2%	19.5%	2.6%	13.3%	19.5%	2.6%	13.3%	18.5%	19.8%	(1.4%)	(6.8%)	19.8%	(1.4%)	(6.8%)
Medicare	43.5%	42.0%	1.5%	3.6%	42.0%	1.5%	3.6%	44.7%	42.9%	1.8%	4.3%	42.9%	1.8%	4.3%
Self-pay	1.8%	2.3%	(0.5%)	(22.6%)	2.3%	(0.5%)	(22.6%)	2.2%	2.4%	(0.2%)	(9.1%)	2.4%	(0.2%)	(9.1%)
Worker's Comp	0.5%	1.8%	(1.3%)	(72.1%)	1.8%	(1.3%)	(72.1%)	0.8%	1.3%	(0.5%)	(38.0%)	1.3%	(0.5%)	(38.0%)
Other	0.0%	0.2%	(0.2%)	(79.4%)	0.2%	(0.2%)	(79.4%)	0.1%	0.2%	(0.1%)	(45.3%)	0.2%	(0.1%)	(45.3%)
DEDUCTIONS														
Contract Adjust	(9,501,354)	(9,622,417)	121,062	(1%)	(9,645,351)	143,996	(1%)	(50,612,446)	(49,074,325)	(1,538,120)	3%	(48,614,884)	(1,997,562)	4%
Bad Debt	226,725	(115,868)	342,593	(296%)	2,304,836	(2,078,111)	(90%)	(1,337,544)	(590,927)	(746,617)	126%	(653,362)	(684,182)	105%
Write-off	(283,363)	(707,802)	424,440	(60%)	(1,097,867)	814,505	(74%)	(2,477,299)	(3,609,791)	1,132,492	(31%)	(3,706,982)	1,229,683	(33%)
CENSUS														
Patient Days	157	207	(50)	(24%)	207	(50)	(24%)	904	1,164	(260)	(22%)	1,164	(260)	(22%)
Adjusted ADC	29	33	(4)	(11%)	33	(4)	(11%)	34	41	(7)	(18%)	41	(7)	(18%)
Adjusted Days	880	990	(110)	(11%)	990	(110)	(11%)	5,148	6,253	(1,105)	(18%)	6,253	(1,105)	(18%)
Employed FTE	378.8	370.8	8.0	2%	370.8	8.0	2%	377.4	368.3	9.1	2%	368.3	9.1	2%
Contract Labor FTE	20.6	23.6	(3.0)	(13%)	23.6	(3.0)	(13%)	20.3	25.7	(5.4)	(21%)	25.7	(5.4)	(21%)
Total Paid FTE	399.5	394.4	5.0	1%	394.4	5.0	1%	397.6	394.0	3.7	1%	394.0	3.7	1%
EPOB (Employee per Occupied Bed)	2.5	1.9	0.6	33%	1.9	0.6	33%	2.2	1.7	0.5	30%	1.7	0.5	30%
EPOC (Employee per Occupied Case)	0.5	0.4	0.1	14%	0.4	0.1	14%	0.1	0.1	0.0	22%	0.1	0.0	22%
Adjusted EPOB	14.2	9.1	5.1	56%	9.1	5.1	56%	12.8	9.3	3.5	38%	9.3	3.5	38%
Adjusted EPOC	2.5	1.9	0.6	33%	1.9	0.6	33%	0.4	0.3	0.1	30%	0.3	0.1	30%
SALARIES														
Per Adjust Bed Day	4,048	3,318	731	22%	3,498	550	16%	3,521	2,678	843	31%	2,411	1,110	46%
Total Salaries	3,562,811	3,285,406	277,406	8%	3,463,941	98,871	3%	18,127,198	16,744,232	1,382,967	8%	15,074,790	3,052,409	20%
Average Hourly Rate	54.86	51.68	3.18	6%	54.49	0.37	1%	54.94	52.00	2.94	6%	46.82	8.13	17%
Employed Paid FTEs	378.8	370.8	8.0	362.8	370.8	8.0	2%	377.4	368.3	9.1	2%	368.3	9.1	2%
BENEFITS														
Per Adjust Bed Day	1,759	1,487	271	18%	720	1,038	144%	1,467	1,220	248	20%	1,156	311	27%
Total Benefits	1,547,641	1,472,789	74,853	5%	713,356	834,285	117%	7,553,571	7,626,561	(72,990)	(1%)	7,231,310	322,261	4%
Benefits % of Wages	43%	45%	(1%)	(3%)	21%	23%	111%	42%	46%	(4%)	(9%)	48%	(6%)	(13%)
Pension Expense	384,795	368,720	16,075	4%	376,674	8,121	2%	1,784,702	2,001,569	(216,867)	(11%)	2,045,151	(260,449)	(13%)
MDV Expense	857,240	756,922	100,317	13%	184,740	672,500	364%	4,172,760	3,860,304	312,456	8%	3,643,074	529,686	15%
Taxes, PTO accrued, Other	305,606	347,146	(41,540)	(12%)	151,942	153,664	101%	1,596,110	1,764,688	(168,578)	(10%)	1,543,085	53,025	3%
Salaries, Wages & Benefits	5,110,453	4,758,194	352,259	7%	4,177,297	933,156	22%	25,680,769	24,370,793	1,309,977	5%	22,306,099	3,374,670	15%
SWB/APD	5,807	4,805	1,002	21%	4,218	1,589	38%	4,988	3,898	1,091	28%	3,567	1,421	40%
SWB % of Total Expenses	49%	49%	(0%)	(1%)	44%	5%	12%	50%	49%	0%	1%	48%	1%	3%

Provided by: Chief Financial Officer
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** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	3,464	2,796	667	24%	2,606	858	33%	2,797	2,229	567	25%	1,986	811	41%
Total Physician Fee	1,597,620	1,698,925	(101,305)	(6%)	1,508,531	89,090	6%	8,349,673	8,551,218	(201,545)	(2%)	7,782,174	567,499	7%
Total Contract Labor	504,270	413,063	91,207	22%	583,367	(79,097)	(14%)	2,041,213	2,091,513	(50,301)	(2%)	2,351,817	(310,604)	(13%)
Total Other Pro-Fees	946,424	657,239	289,185	44%	488,404	458,020	94%	4,007,612	3,297,866	709,746	22%	2,285,241	1,722,371	75%
Total Professional Fees	3,048,313	2,769,226	279,087	10%	2,580,301	468,012	18%	14,398,498	13,940,598	457,900	3%	12,419,232	1,979,266	16%
Contract AHR	142.48	101.96	40.52	40%	144.00	(1.52)	(1%)	115.14	93.18	21.96	24%	104.77	10.37	10%
Contract Paid FTEs	20.6	23.6	(3.0)	(13%)	23.6	(3.0)	(13%)	20.3	25.7	(5.4)	(21%)	25.7	(5.4)	(21%)
Physician Fee per Adjust Bed Day	1,815	1,716	100	6%	1,523	292	19%	1,622	1,368	254	19%	1,245	377	30%
PHARMACY														
Per Adjust Bed Day	350	441	(91)	(21%)	635	(285)	(45%)	382	356	26	7%	268	114	43%
Total Rx Expense	308,065	437,010	(128,945)	(30%)	628,990	(320,925)	(51%)	1,968,869	2,228,750	(259,881)	(12%)	1,675,537	293,332	18%
MEDICAL SUPPLIES														
Per Adjust Bed Day	599	432	167	39%	411	188	46%	460	349	111	32%	449	11	2%
Total Medical Supplies	526,979	427,637	99,342	23%	406,800	120,179	30%	2,366,462	2,181,696	184,767	8%	2,804,801	(438,339)	(16%)
EHR SYSTEM														
Per Adjust Bed Day	52	32	20	60%	48	4	9%	39	26	13	50%	30	9	28%
Total EHR Expense	45,755	32,115	13,640	42%	47,276	(1,522)	(3%)	198,371	160,574	37,797	24%	187,739	10,632	6%
OTHER EXPENSE														
Per Adjust Bed Day	1,171	874	297	34%	1,350	(178)	(13%)	931	698	233	33%	736	195	27%
Total Other	1,030,673	865,201	165,472	19%	1,336,432	(305,759)	(23%)	4,792,058	4,361,818	430,240	10%	4,600,149	191,908	4%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	474	421	53	13%	414	61	15%	417	334	83	25%	343	75	22%
Total Depreciation and Amortization	417,540	417,154	386	0%	409,531	8,009	2%	2,146,944	2,085,769	61,175	3%	2,141,699	5,245	0%
TOTAL EXPENSES	10,487,777	9,706,537	781,241	8%	9,586,628	901,149	9%	51,551,970	49,329,997	2,221,973	5%	46,135,256	5,416,714	12%
Per Adjust Bed Day	11,917	9,802	2,115	22%	9,681	2,236	23%	10,014	7,889	2,125	27%	7,378	2,636	36%
Per Calendar Day	349,593	323,551	26,041	8%	319,554	30,038	9%	336,941	322,418	14,523	5%	301,538	35,403	12%

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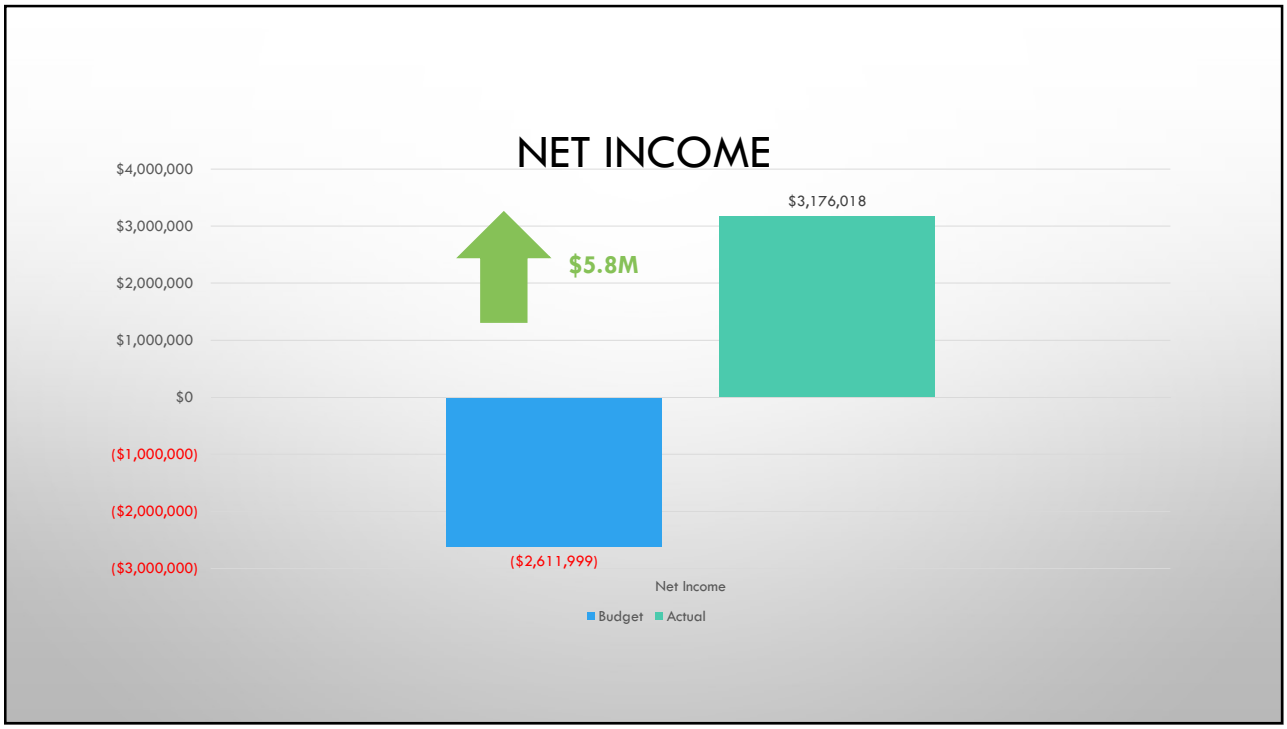
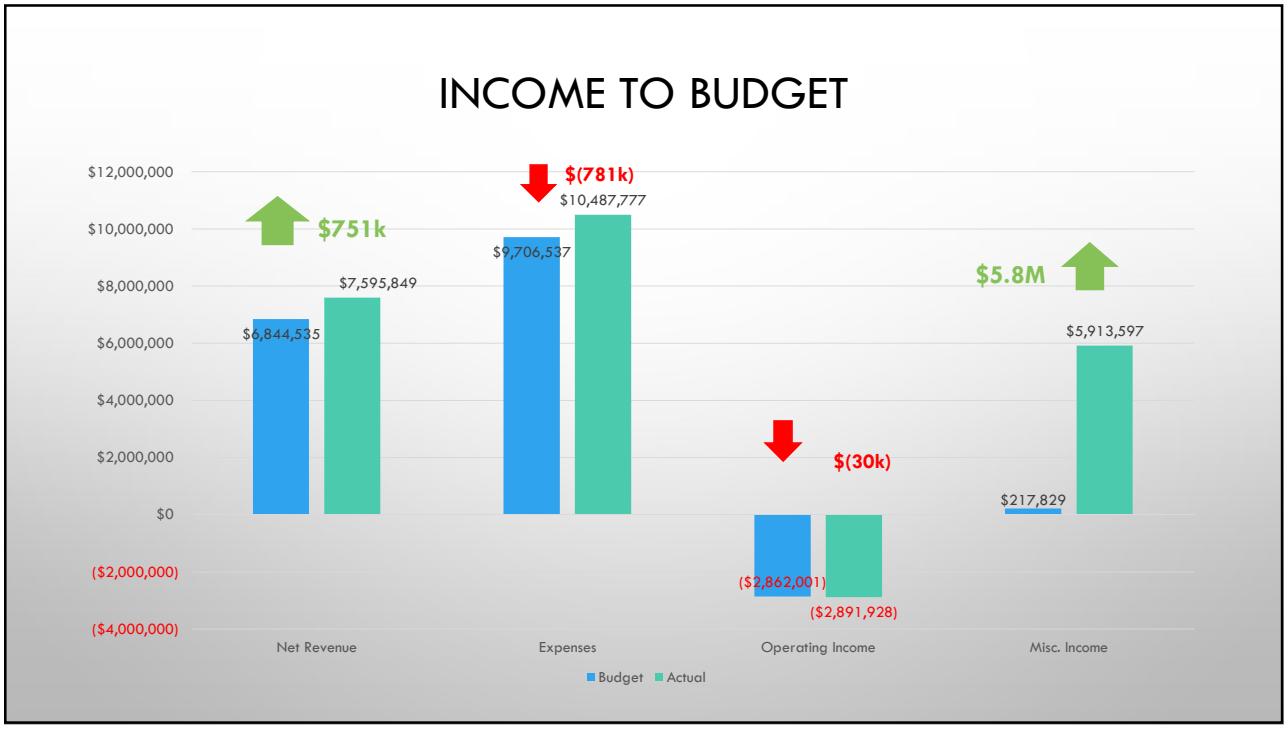
Key Financial Performance Indicators	Industry Benchmark	Nov-23	FYE 2024 Average	Nov-24	FYE 2025 Average	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Volume													
Admits	41	75	69	77	71	64	64	65	76	67	(9)	(4)	(10)
Deliveries	n/a	16	17	14	17	21	19	20	15	18	3	1	4
Adjusted Patient Days	n/a	940	977	970	1,125	1,218	875	1,023	1,161	880	(281)	(245)	(90)
Total Surgeries	153	149	146	129	140	121	153	163	147	112	(35)	(28)	(17)
ER Visits	659	750	826	789	852	922	865	840	819	726	(93)	(126)	(63)
RHC and Clinic Visits	n/a	4,768	4,607	4,515	4,772	4,567	4,883	4,738	5,154	4,384	(770)	(388)	(131)
Diagnostic Imaging Services	n/a	1,897	2,069	1,880	2,129	2,326	2,190	2,271	2,274	1,957	(317)	(172)	77
Rehab Services	n/a	614	662	903	838	820	779	739	764	769	5	(69)	(134)
AR & Income													
Gross AR (Cerner only)	n/a	$ 52,529,762	$ 52,823,707	$ 48,660,966	$ 50,813,697	$ 43,999,341	$ 43,163,140	$ 40,875,951	$ 38,777,469	$ 37,941,078	$ (836,390)	$ (12,872,619)	$ (10,719,888)
AR > 90 Days	$ 6,599,901.18	$ 26,596,663	$ 23,112,391	$ 21,134,023	$ 20,669,422	$ 17,867,182	$ 17,125,397	$ 16,330,677	$ 14,855,434	$ 14,887,324	$ 31,890	$ (5,782,098)	$ (6,246,699)
AR % > 90 Days	15%	50.2%	44.2%	43.43%	40.6%	40.6%	39.7%	40.0%	38.3%	39.2%	0.9%	-1.4%	-4.2%
Gross AR Days (per financial statements)	60	88	85	83	80	71	72	62	58	66	9	(14)	(17)
Net AR Days (per financial statements)	30	74	58	67	71	62	62	54	36	55	19	(16)	(12)
Net AR	n/a	$ 20,460,545	$ 16,938,200	$ 20,054,289	$ 19,370,868	$ 16,184,152	$ 16,007,125	$ 14,268,379	$ 11,138,154	$ 13,862,975	$ 2,724,821	$ (5,507,893)	$ (6,191,314)
Net AR % of Gross	n/a	39.0%	31.9%	41.2%	38.5%	36.8%	37.1%	34.9%	28.7%	36.5%	7.8%	-2.0%	-4.7%
Gross Patient Revenue/Calendar Day	n/a	$ 599,349	$ 619,457	$ 582,780	$ 634,418	$ 620,270	$ 597,896	$ 661,191	$ 671,419	$ 571,795	$ (99,625)	$ (62,624)	$ (10,985)
Net Patient Revenue/Calendar Day	n/a	$ 276,478	$ 292,759	$ 301,501	$ 273,563	$ 260,693	$ 256,792	$ 264,312	$ 308,780	$ 253,195	$ (55,585)	$ (20,368)	$ (48,306)
Net Patient Revenue/APD	n/a	$ 8,824	$ 8,757	$ 9,321	$ 8,088	$ 6,636	$ 9,099	$ 7,749	$ 8,246	$ 8,631	$ 385	$ 543	$ (690)
Wages													
Wages	n/a	$ 3,126,785	$ 3,285,431	$ 3,463,941	$ 3,661,965	$ 3,623,073	$ 3,734,261	$ 3,512,638	$ 3,694,416	$ 3,562,811	$ (131,605)	$ (99,154)	$ 98,871
Employed paid FTEs	n/a	350.57	353.69	370.82	370.77	376.49	378.62	375.49	377.37	378.81	1.44	8.04	7.99
Employed Average Hourly Rate	$55.50	$ 52.03	$ 53.49	$ 54.64	$ 56.89	$ 54.47	$ 55.83	$ 54.72	$ 55.42	$ 55.02	$ (0.40)	$ (1.87)	$ 0.37
Benefits	n/a	$ 1,804,521	$ 1,640,216	$ 713,356	$ 1,401,858	$ 1,460,662	$ 1,216,930	$ 1,502,338	$ 1,826,000	$ 1,547,641	$ (278,358)	$ 145,783	$ 834,285
Benefits % of Wages	30%	57.7%	48.8%	20.6%	39.8%	40.3%	32.6%	42.8%	49.4%	43.4%	-6.0%	3.7%	22.8%
Contract Labor	n/a	$ 211,163	$ 518,351	$ 583,367	$ 447,445	$ 285,536	$ 436,656	$ 455,774	$ 358,976	$ 504,270	$ 145,294	$ 56,825	$ (79,097)
Contract Labor Paid FTEs	n/a	21.61	23.49	23.63	23.89	19.36	20.09	21.46	19.88	20.65	0.76	(3.24)	(2.99)
Total Paid FTEs	n/a	372.18	377.18	394.45	394.65	395.85	398.71	396.95	397.25	399.45	2.20	4.80	5.01
Contract Labor Average Hourly Rate	$ 81.04	$ 57.00	$ 123.22	$ 144.39	$ 120.98	$ 83.49	$ 123.03	$ 124.24	$ 102.21	$ 142.87	$ 40.66	$ 21.89	$ (1.52)
Total Salaries, Wages, & Benefits	n/a	$ 5,142,469	$ 5,443,998	$ 4,760,664	$ 5,511,268	$ 5,369,271	$ 5,387,847	$ 5,470,750	$ 5,879,392	$ 5,614,723	$ (264,670)	$ 103,455	$ 854,059
SWB% of NR	50%	62.0%	62.1%	52.6%	72.0%	51.3%	67.7%	69.0%	61.4%	73.9%	12.5%	1.9%	21.3%
SWB/APD	2,204	$ 5,471	$ 5,104	$ 4,906	$ 5,284	$ 4,409	$ 6,159	$ 5,347	$ 5,065	$ 6,380	$ 1,315	$ 1,096	$ 1,474
SWB % of total expenses	50%	55.4%	55.4%	49.7%	55.6%	54.5%	53.9%	54.5%	52.5%	53.5%	1.0%	-2.1%	3.8%

Physician Spend	Industry Benchmark	Nov-23	FYE 2024 Average	Nov-24	FYE 2025 Average	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
Physician Expenses	n/a	$ 1,508,531	$ 1,613,172	$ 1,713,978	$ 1,507,510	$ 1,509,326	$ 1,664,607	$ 1,645,840	$ 1,932,281	$ 1,597,620	$ (334,661)	$ 90,110	$ (116,358)
Physician expenses/APD	n/a	$ 1,555	$ 1,565	$ 1,766	$ 1,476	$ 1,239	$ 1,903	$ 1,608	$ 1,664	$ 1,815	$ 151	$ 339	$ 49
Supplies													
Supply Expenses	n/a	$ 1,034,853	$ 832,644	$ 856,240	$ 776,504	$ 832,800	$ 935,102	$ 727,501	$ 1,004,885	$ 835,043	$ (169,841)	$ 58,540	$ (21,197)
Supply expenses/APD		$ 1,066	$ 822	$ 882	$ 744	$ 684	$ 1,069	$ 711	$ 866	$ 949	$ 83	$ 205	$ 66
Other Expenses													
Other Expenses	n/a	$ 2,271,303	$ 1,939,040	$ 1,950,680	$ 1,824,207	$ 2,141,584	$ 2,002,116	$ 2,186,236	$ 2,376,590	$ 2,440,391	$ 63,801	$ 616,184	$ 489,711
Other Expenses/APD	n/a	$ 2,341	$ 1,861	$ 2,010	$ 1,787	$ 1,758	$ 2,289	$ 2,137	$ 2,047	$ 2,773	$ 726	$ 986	$ 763
Margin													
Net Income	n/a	$ (250,823)	$ 253,100	$ (236,090)	$ 383,722	$ (1,345,152)	$ (1,650,273)	$ (1,640,281)	$ (1,132,695)	$ 3,176,018	$ 4,308,713	$ 2,792,296	$ 3,412,108
Net Profit Margin	n/a	-2.8%	3.7%	-2.8%	3.0%	-16.6%	-20.7%	-20.7%	-11.8%	41.8%	53.6%	38.8%	44.6%
Operating Income	n/a	$ (530,332)	$ (1,557,761)	$ (987,232)	$ (686,444)	$ (1,771,492)	$ (2,029,125)	$ (2,100,965)	$ (1,620,972)	$ (2,891,928)	$ (1,270,956)	$ (2,205,484)	$ (1,904,696)
Operating Margin	2.9%	-5.9%	-26.1%	-11.9%	-10.9%	-21.9%	-25.5%	-26.5%	-16.9%	-38.1%	-21.1%	-27.1%	-26.2%
EBITDA	n/a	$ 158,708	$ 676,999	$ 120,086	$ 841,891	$ (911,671)	$ (1,216,571)	$ (1,213,453)	$ (697,302)	$ 3,593,558	$ 4,290,859	$ 2,751,667	$ 3,473,472
EBITDA Margin	12.7%	1.8%	9.4%	1.4%	8.7%	-11.3%	-15.3%	-15.3%	-7.3%	47.3%	54.6%	38.6%	45.9%
Debt Service Coverage Ratio	3.70	336.0%	3.9	4.4	3.3	(4.5)	(5.2)	(5.5)	(5.0)	(0.6)	4.4	(3.9)	(5.0)
Cash													
Avg Daily Disbursements (excl. IGT)	n/a	$ 296,503	$ 350,828	$ 379,443	$ 355,328	$ 347,474	$ 379,493	$ 325,126	$ 416,814	$ 388,940	$ (27,874)	$ 33,612	$ 9,497
Average Daily Cash Collections (excl. IGT)	n/a	$ 288,101	$ 340,919	$ 306,475	$ 299,110	$ 289,930	$ 283,158	$ 348,085	$ 388,454	$ 278,666	$ (109,788)	$ (20,444)	$ (27,809)
Average Daily Net Cash		$ (8,402)	$ (9,908)	$ (72,968)	$ (56,218)	$ (57,544)	$ (96,335)	$ 22,959	$ (28,360)	$ (110,274)	$ (81,914)	$ (54,057)	$ (37,306)
Upfront Cash Collections		$ 26,687	$ 54,286	$ 45,246	$ 36,146	$ 77,997	$ 66,623	$ 63,634	$ 77,539	$ 43,734	$ (33,805)	$ 7,588	$ (1,512)
Upfront Cash % of Gross Charges	1%	$ 0	0.3%	0.3%	0.2%	0.4%	0.4%	0.3%	0.4%	0.3%	-0.1%	0.1%	0.0%
Unrestricted Funds	n/a	$ 16,099,369	$ 23,774,285	$ 21,068,202	$ 23,536,438	$ 28,084,672	$ 25,662,275	$ 26,418,948	$ 26,719,622	$ 21,356,431	$ (5,363,191)	$ (2,180,007)	$ 288,229
Change of cash per balance sheet	n/a	$ (6,864,309)	$ 321,485	$ (5,304,581)	$ (321,485)	$ 2,945,857	$ (2,422,397)	$ 756,674	$ 300,674	$ (5,363,191)	$ (5,663,865)	$ (5,041,706)	$ (58,610)
Days Cash on Hand (assume no more cash is collected)	196	43	73	56	72	92	84	85	84	66	(18)	(6)	10
Estimated Days Until Depleted (operating cash only)		372	2,399	339	406	499	435	491	671	396	(275)	(9)	57
Years Until Cash Depletion (operating cash only)		1.02	6.57	0.93	1.11	1.37	1.19	1.34	1.84	1.09	(0.75)	(0.03)	0.16

VOLUME & INCOME


NET INCOME
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
($1,000,000)
($2,000,000)
($3,000,000)
$5.8M
$3,176,018
($2,611,999)
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)
$751k
$6,844,535
$7,595,849
$(781k)
$9,706,537
$10,487,777
$(30k)
($2,862,001)
($2,891,928)
$5.8M
$217,829
$5,913,597
Net Revenue
Expenses
Operating Income
Misc. Income
Budget
Actual

VOLUME & INCOME ACTION PLAN

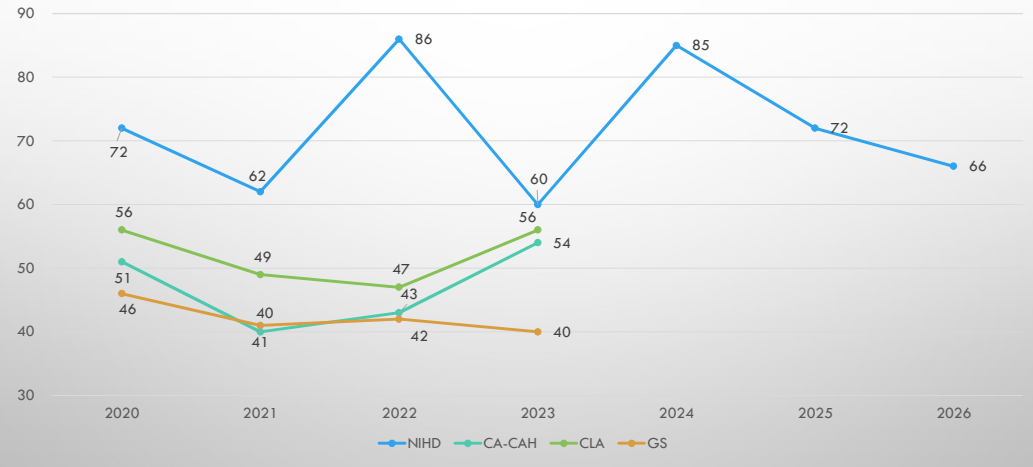
- THE MAMMOTH ORTHOPEDIC INSTITUTE BEGAN ORTHOPEDIC SURGERIES IN JULY. THEIR SURGICAL VOLUME HAS STEADILY INCREASED THE PAST FEW MONTH. THE ORTHO CLINIC HIT THEIR BUDGET FOR NOVEMBER AND ORTHOPEDICS SURGERIES ALSO WERE ABOVE BUDGET.
- WE ARE WORKING ON REVIEWING OPERATIONAL EFFICIENCY INCLUDING OR UTILIZATION 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

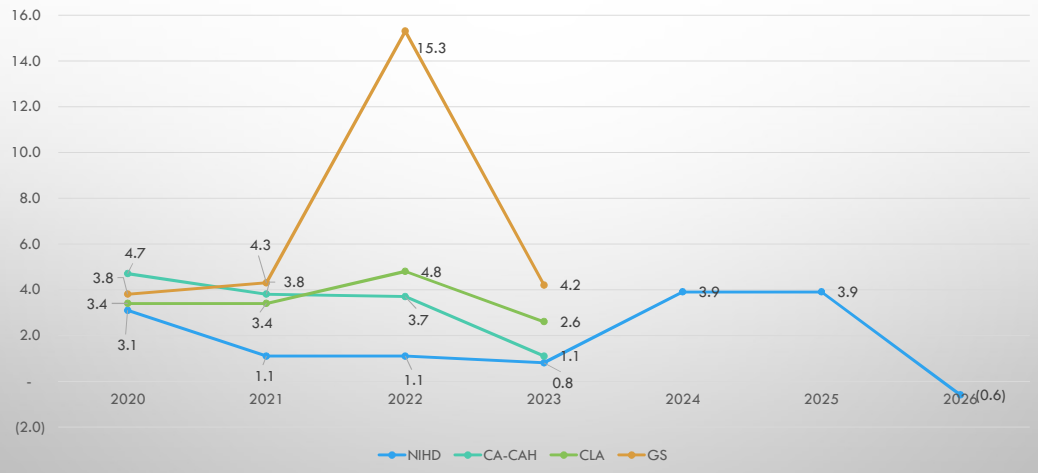
INCOME TO CASH

	FYE 2026
Net Income (loss)	**$(2,590,452)**
Principal Payments on Long-Term Debt	$(1,171,947)
Other Debt (long-term leases & subscriptions)	$(320,095)
Capital purchases	$(382,023)
Timing of Accruals vs Disbursements	$890,713
IGT Revenue Recognized but Cash Not Received	$(3,569,320)
Impact to Cash	**$(4,552,672)**
Adjusted Net Income (cash basis)	**$(7,143,124)**

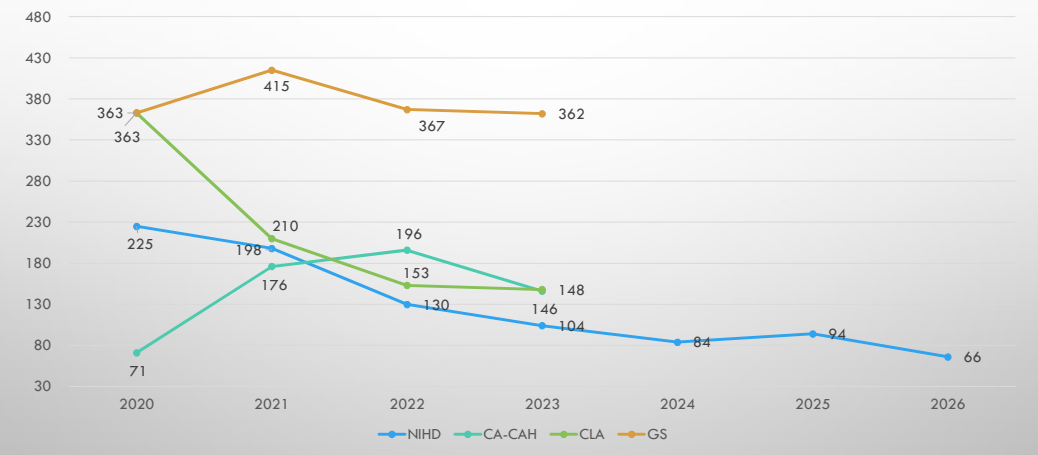
GROSS AR DAYS



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 $10M 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 2025.
- 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 FUTHER.
- 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	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	16,773,852	(614,592)	(585,701)
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	69,161,995	182,221	117,719
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	9,630,860	121,820	138,423
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	95,566,708	(310,551)	(329,560)
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)	(50,612,446)	121,062	143,996
Bad Debt	(253,457)	(115,868)	(1,378,285)	242,346	(119,730)	(302,126)	226,725	(115,868)	2,304,836	(1,337,544)	342,593	(2,078,111)
A/R Writeoffs	(573,549)	(707,802)	(394,591)	(909,911)	(731,396)	(1,472,830)	(283,363)	(707,802)	(1,097,867)	(2,477,299)	424,440	814,505
Other Deductions from Revenue	-	(173,770)	-	-	(179,562)	-	-	(173,770)	-	-	173,770	-
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)	(54,427,289)	1,061,865	(1,119,610)
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**	**41,139,419**	**751,314**	**(1,449,170)**
CNR%	**40.0%**	**49.6%**	**40.7%**	**46.0%**	**49.5%**	**44.1%**	**44.3%**	**39.2%**	**51.7%**	**43.0%**	**5.1%**	**-7.5%**
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	15,450,079	235,659	82,411
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	6,388,864	60,571	635,637
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	9,336,759	134,221	51,566
Contract Labor	376,610	341,317	(172,022)	257,899	303,030	466,567	423,986	347,300	495,129	1,588,193	76,686	(71,142)
Pharmacy	367,511	437,010	432,361	432,888	451,577	363,699	308,065	437,010	628,990	1,968,869	(128,945)	(320,925)
Medical Supplies	359,990	427,637	353,623	571,996	442,141	496,964	526,979	427,637	406,800	2,366,462	99,342	120,179
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	31,736	32,115	26,143	42,185	32,115	25,930	45,755	32,115	47,276	198,371	13,640	(1,522)
Other Direct Expenses	635,834	632,889	452,410	829,934	699,541	687,481	787,124	660,753	854,548	3,639,664	126,371	(67,424)
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	40,937,260	617,545	428,780
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	2,677,119	41,747	16,460
Benefits	221,621	217,039	246,360	264,041	217,926	308,829	295,289	281,007	96,641	1,164,707	14,282	198,648
Professional Fees	648,703	610,805	226,058	649,380	554,467	294,687	726,582	672,923	231,039	3,020,526	53,659	495,543
Contract Labor	79,164	71,745	59,381	101,078	118,766	77,262	80,283	65,763	88,238	453,020	14,521	(7,955)
Depreciation and Amortization	426,828	417,154	440,195	435,393	417,154	409,531	417,540	417,154	409,531	2,146,944	386	8,009
Other Administative Expenses	233,393	232,312	186,912	210,428	177,367	149,642	243,549	204,448	481,883	1,152,394	39,101	(238,334)
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	10,614,710	163,696	472,370
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**	**51,551,970**	**781,241**	**901,149**
Financing Expense	178,823	196,180	192,696	181,041	196,180	215,407	171,993	196,180	206,574	910,671	(24,187)	(34,581)
Financing Income	260,000	286,867	286,867	260,000	181,031	181,031	260,000	181,031	181,031	1,300,000	78,969	78,969
Investment Income	43,082	47,322	50,746	73,728	47,322	40,963	66,342	47,322	56,648	282,022	19,020	9,694
Miscellaneous Income	336,425	236,765	177,134	335,591	1,214,625	293,111	5,913,597	217,829	248,404	7,150,749	5,695,768	5,665,193
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)**	**(2,590,452)**	**5,788,017**	**3,438,118**
Operating Income	(2,099,033)	763,363	(302,930)	(1,620,972)	825,870	(902,460)	(2,891,928)	(2,862,001)	(541,610)	(10,412,552)	(29,927)	(2,350,319)
EBIDA	(1,211,521)	1,555,291	459,316	(697,302)	2,489,822	(193,230)	3,593,558	(2,194,845)	147,431	(443,508)	5,788,403	3,446,127
Net Profit Margin	-20.7%	10.9%	0.2%	-11.8%	19.3%	-6.3%	41.8%	-38.2%	-2.9%	-6.3%	80.0%	44.7%
Operating Margin	-26.5%	7.3%	-3.5%	-16.9%		-9.5%	-38.1%	-41.8%	-6.0%	-25.3%	3.7%	-32.1%
EBIDA Margin	-15.3%	14.9%	5.4%	-7.3%		-2.0%	47.3%	-32.1%	1.6%	-1.1%	79.4%	45.7%

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	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	(5,362,849)	4,053,580
Short Term Investments	7,741,599	7,301,260	7,574,716	6,511,054	6,876,555	6,271,772	6,872,978	(239,282)	(601,206)
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	2,724,821	(6,191,314)
Other Receivables	9,238,007	11,053,197	4,823,782	12,675,718	4,771,477	18,836,206	9,458,105	6,160,488	9,378,101
Inventory	5,334,241	5,327,510	6,112,780	5,325,812	6,079,443	5,329,753	6,117,401	3,941	(787,648)
Prepaid Expenses	1,106,127	1,913,942	1,933,935	1,495,596	1,353,383	1,423,818	1,091,960	(71,778)	331,858
Total Current Assets	**60,823,678**	**58,484,936**	**57,662,375**	**56,857,764**	**55,242,502**	**60,073,106**	**53,889,735**	**3,215,342**	**6,183,371**
Assets Limited as to Use									
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,469,292	1,469,672	1,468,166	1,469,800	1,468,293	1,469,924	1,468,417	124	1,507
Limited Use Assets			-		-		-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	9,393,030	9,393,030	10,346,490	9,393,030	10,346,490	9,393,030	10,346,490	-	(953,460)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	9,966,127	9,966,127	10,919,587	9,966,127	10,919,587	9,966,127	10,919,587	-	(953,460)
Revenue Bonds Held by a Trustee	297,382	280,149	359,303	274,405	353,592	268,661	347,848	(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**	**(5,620)**	**(1,031,141)**
Long Term Assets									
Long Term Investment	497,086	497,041	755,869	497,137	999,950	736,076	747,654	238,940	(11,578)
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	(373,500)	(3,141,387)
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**	**(134,560)**	**(3,152,965)**
Total Assets	**154,697,817**	**151,791,285**	**155,232,299**	**149,853,306**	**152,812,864**	**152,928,467**	**150,929,203**	**3,075,161**	**1,999,265**
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	12,931	(996,775)
Accounts Payable	4,413,297	4,983,412	4,443,274	5,934,043	3,949,738	5,086,695	4,337,497	(847,348)	749,198
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	(1,085,660)	2,420,985
Accrued Interest and Sales Tax	83,538	282,515	78,276	109,061	166,600	10,834	192,433	(98,227)	(181,599)
Notes Payable	339,892	339,892	446,860	339,892	446,860	339,892	446,860	-	(106,968)
Unearned Revenue	-	-	(4,542)	-	(4,542)	-	(4,542)	-	4,542
Due to 3rd Party Payors	3,324,903	3,324,903	693,247	3,324,903	693,247	4,331,882	693,247	1,006,979	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	(2,070)	(3,841,033)
Total Current Liabilities	**24,045,518**	**25,936,127**	**25,954,096**	**27,230,464**	**26,077,633**	**26,217,069**	**24,530,084**	**(1,013,395)**	**1,686,985**
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	(936,285)	(3,781,259)
Bond Premium	127,973	115,425	156,207	115,425	153,070	112,288	149,933	(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	84,388	139,391
Other Non-Current Liability - Pension	31,874,258	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	-	(1,072,097)
Total Long Term Liabilities	**82,642,576**	**82,661,854**	**86,377,989**	**80,551,502**	**84,457,651**	**79,696,468**	**84,448,078**	**(855,034)**	**(4,751,610)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	61,310	54,922	147,821	54,957	127,821	34,957	127,821	(20,000)	(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**	**(1,888,429)**	**(3,157,489)**
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	1,787,448	10,838,471
Temporarily Restricted	1,469,292	1,469,672	1,468,166	1,469,800	1,468,293	1,469,924	1,468,417	124	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	3,176,018	(5,683,225)
Total Fund Balance	**47,948,412**	**43,138,382**	**42,752,392**	**42,016,384**	**42,149,759**	**46,979,974**	**41,823,220**	**4,963,590**	**5,156,754**
Liabilities + Fund Balance	**154,697,817**	**151,791,285**	**155,232,299**	**149,853,306**	**152,812,864**	**152,928,467**	**150,929,203**	**3,075,161**	**1,999,265**
(Decline)/Gain		(388,811)	(90,686)	(1,937,979)	(2,419,435)	3,075,161	(1,883,661)	5,013,140	4,958,822

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	$ (2,590,452)
+ Depreciation Expense	2,146,944
+ Interest Expense	910,671
Less GO Property Tax revenue	910,000
Less GO Interest Expense	196,784
"Income available for debt service"	**$ (639,620)**
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**
	1,046,594
Ratio: (numerator / denominator)	**(0.61)**
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	$ 20,620,355
Cash and Investments-non current	736,076
Sub-total	21,356,431
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 21,356,431**
Total Operating Expenses	$ 51,551,970
Less Depreciation	2,146,944
Net Expenses	49,405,026
Average Daily Operating Expense	$ 322,909
Days Cash on Hand	**66**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2026

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	41,157,251
Payments to Suppliers and Contractors	(27,059,486)
Payments to and on Behalf of Employees	(27,721,982)
Other Receipts and Payments, Net	369,515
Net Cash Provided (Used) by Operating Activities	(13,254,702)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	5,628,840
Property Taxes Received	390,000
Other	1,300,000
Net Cash Provided (Used) by Noncapital Financing Activities	7,318,840
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,171,947)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(910,671)
Purchase and Construction of Capital Assets	(382,023)
Payments on Lease Liability	(36,331)
Payments on Subscription Liability	(320,095)
Property Taxes Received	1,300,000
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(1,521,068)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	282,022
Rental Income	31,784
Net Cash Provided (Used) by Investing Activities	313,805
NET CHANGE IN CASH AND CASH EQUIVALENTS	(7,143,124)
Cash and Cash Equivalents - Beginning of Year	28,499,555
CASH AND CASH EQUIVALENTS - END OF YEAR	21,356,431

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Advocacy Platform		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 11/05/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Purpose

To adopt the District's Advocacy Platform yearly, establishing the policy direction that will guide NIHD's participation in legislative, regulatory, and associated activities supporting rural healthcare and good governance.

Proposed Priority Areas for the Advocacy Platform:

1. **Critical Access Hospital (CAH) Priorities** – financial sustainability, workforce development, access to care, and other issues central to rural hospital operations.
2. **Health in Rural Communities** – transportation, broadband, telehealth, chronic disease, behavioral health, and social determinants aligned with CHNA findings.
3. **Special District Governance** – district authority, independence, protecting local revenue and control, access to state and federal infrastructure funding opportunities, and Brown Act or governance-related statutory changes.
4. **General Healthcare Issues** – statewide and federal policy impacts, including reimbursement challenges, ACA subsidy implications, and major statewide initiatives.

The priorities serve as NIHD's guiding principles for annual advocacy. They reflect the areas where the Board places the highest emphasis that support NIHD's mission, values, and long-term rural healthcare sustainability. These priorities guide NIHD's advocacy direction without limiting the District's ability to act on related or emerging issues consistent with the Advocacy Policy.

Implementation and Reporting

Staff will monitor legislative and regulatory developments in partnership with Association of California Healthcare Districts (ACHD), District Hospital Leadership Forum (DHLF), California Hospital Association (CHA), and California Special District Association (CSDA).
A minimum of Quarterly updates will be provided to the Governance Committee.

If necessary, the CEO has the authority to take action on legislative issues with the concurrence of the Chair of the Governance Committee and consistent with the Advocacy Policy. The CEO will report all advocacy actions taken at the next regular meeting of the Board of Directors.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Board Civility and Code of Conduct Policy		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 01/08/2026	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

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

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

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

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

STANDARDS OF CIVILITY AND CODE OF CONDUCT

Respectful Communication

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

Equal Participation

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

Preparedness

- Members are expected to come prepared, having reviewed agenda packets and materials in advance.
- Meetings are most effective when discussion builds on the background information already provided, rather than revisiting it.

Respect for Public Comment

- Public comment is a valued opportunity for community input. Board members listen respectfully, and responses—when appropriate—may be provided at a later time through staff or subject-matter experts, or during an agendized discussion.
- The Chair may adjust speaking time limits for all speakers equally, consistent with the Brown Act (Gov. Code §54954.3).

Cell Phones & Technology

- During public comment, members are encouraged to give their full attention to speakers without using devices.
- Limited use is appropriate only for emergencies, agenda materials, or urgent District business.

Confidentiality & Closed Session

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

Board–Staff Interaction

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

Board Member Communications Outside of Meetings

- Board members should avoid email, text, or phone chains to engage in "serial meetings" or reach a consensus outside of publicly noticed meetings, in compliance with the Brown Act (Gov. Code §54952.2).
- Board communications should be respectful and focused on logistics or information, with discussion of District business reserved for public meetings.
- Written communications between members should remain professional and respectful, recognizing they may become part of the public record.

Out-of-Meeting Conduct

- Civility standards apply outside the boardroom, including in emails, public events, and on social media.
- Board members model professionalism by speaking respectfully about the District, staff, and fellow directors in public settings.
- Concerns about civility violations outside of meetings may be reported in writing to the Board Chair and Governance Committee for review.

Board Member Media and Public Communications

• Board members serve as visible representatives of the District and must exercise care when communicating publicly to preserve public trust, comply with law, and avoid confusion regarding the District's official positions.

• Individual Board members may express personal views in public settings; however, they shall not speak on behalf of the District, the Board as a body, or District staff unless specifically authorized to do so by the Board Chair or the Chief Executive Officer.

• All media inquiries, interview requests, filming requests, or requests for comment regarding District operations, incidents, patients, personnel, or Board actions must be referred promptly to the Chief Executive Officer or the Manager of Marketing, Communications, and Strategy, consistent with the District's Media Policy.

• Board members shall not provide off-the-record statements, background information, or informal commentary to members of the media regarding District matters.

• Board members shall not disclose confidential information, including closed session discussions, protected health information, personnel matters, attorney-client communications, or other non-public District information, in any public forum, including interviews, social media, or public meetings.

• When communicating publicly, including on personal social media platforms, Board members shall take reasonable steps to avoid statements that could reasonably be interpreted as representing official District policy, direction, or decisions, unless such statements have been formally adopted by the Board.

• Board members shall respect the role of designated spokespersons and avoid actions that could undermine coordinated public messaging during emergencies, incidents, or matters of heightened public interest.

Code of Conduct Commitments

I will:

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

I will not:

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

Meeting Procedures: Order of Discussion for Each Agenda Item

1. **Chair Introduces the Item**
2. **Presentation of Item**
3. **Public Comment** – 3 minutes per speaker; 30 minutes total unless extended by the Chair
4. **Board Discussion**
    - **Step 1 – Round-Robin Discussion**: Each Board member is called on in turn; Board members may speak or "pass." No interruptions.
    - **Step 2 – Clarification and Responses**: Staff or other Board members may clarify, directed through the Chair.
    - **Step 3 – Open Floor Discussion**: Board members may request recognition; repetition should be avoided.
    - **Step 4 – Summarizing Key Points**: Chair summarizes the discussion.
    - **Step 5 – Final Comments**: Chair invites final remarks.
    - **Step 6 – Transition to Action**: Chair calls for a motion.
5. **Motion and Vote** – Motion made and seconded, restated by the Chair, then voted on. Roll call required if remote participation.

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

Agenda Management

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

Public Disruptions

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

Enforcement & Consequences

General

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

If a Board Member Violates Civility or Meeting Procedure

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

1. **Reminder/Redirection** – The Chair provides a reminder or may call a brief recess to redirect discussion privately.
2. **Call to Order** – If needed, the Chair formally calls the Board member to order.
3. **Referral** – Repeated or disruptive violations are documented and referred to the Governance Committee, which may recommend corrective action or training and report findings to the full Board.
4. **Board Action** – If necessary, the full Board may take corrective action, such as:
    - Issuing a private or public warning.
    - Requiring additional training (such as governance, civility, or Brown Act training offered by CSDA or another recognized provider).

If the Chair Violates this Policy

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

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

Removal from Office

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

Definitions

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

Annual Acknowledgement

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

_____ _____

Signature Date

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

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Governance Committee Charter		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 01/09/2026	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

Board of Directors Bylaws: Governance Committee

1. The Governance Committee shall consist of two members of the Board of Directors and one alternate.
2. The function of the Governance Committee is to review and recommend amendments to the District's Bylaws and Board policies and to advise the Board of Directors on matters of Board governance.
3. The Governance Committee Shall meet quarterly or as needed.
4. Governance 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 Committee reviews Board governance structure and policies, oversees Board development practices and committee charters, and oversees the District's Board advocacy platform, including legislative and regulatory matters affecting the District, and makes recommendations to the Board of Directors on governance-related matters**.**

COMMITTEE RESPONSIBILIES

1. Review and recommend amendments to the District's Bylaws
2. Review and recommend Board governance policies
3. Review and recommend Board committee structure and committee charters
4. Oversee Board orientation and onboarding processes
5. Recommend Board education and governance training priorities
6. Monitor governance-related statutory training requirements applicable to Board members
7. Ensure an annual Board self-assessment is conducted and review results to recommend governance improvements
8. Maintain and implement a governance policy review schedule
9. Review and recommend the District's Board advocacy platform

10. Review legislative and regulatory issues affecting the District and recommend advocacy priorities and legislative representation to the Board

11. Serve as the forum for governance matters not assigned to another standing committee

12. Perform other governance-related duties as assigned by the Board

FREQUENCY OF REVIEW/REVISION

The Governance 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 Governance Committee Charter

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Governance Committee Charter		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 01/09/2026	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

Board of Directors Bylaws: Governance Committee

1. The Governance Committee shall consist of two members of the Board of Directors and one alternate.
2. The function of the Governance Committee is to review and recommend amendments to the District's Bylaws and Board policies and to advise the Board of Directors on matters of Board governance.
3. The Governance Committee Shall meet quarterly or as needed.
4. Governance 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 Committee reviews Board governance structure and policies, oversees Board development practices and committee charters, and oversees the District's Board advocacy platform, including legislative and regulatory matters affecting the District, and makes recommendations to the Board of Directors on governance-related matters.

~~Consistent with the Mission of the District the Governance Committee (GC) assists the Board to improve its functioning, structure, and infrastructure, while the Board serves as the steward of the District. The Board serves as the representative of the residents of the Northern Inyo Healthcare District (NIHD) by protecting and enhancing their investment in the NIHD in ways that improve the health of the community collectively and individually. The Board formulates policies, makes decisions, and engages in oversight regarding matters dealing with business performance trends, CEO performance, quality of care, and finances. The Board must ensure that it possesses the necessary capacities, competencies, structure, systems, and resources to fulfill these responsibilities and execute these roles. In this regard, it is the Board's duty to ensure that:~~

- ~~Its configuration is appropriate;~~
- ~~Necessary evaluation and Board development and education processes are in place;~~
- ~~Its meetings are conducted in a productive manner;~~
- ~~Its fiduciary obligations are fulfilled.~~

~~The GC shall assist the Board in its responsibility to ensure that the Board functions effectively. To this end the GC shall:~~

- ~~Formulate policy to convey Board expectations and directives for Board action;~~
- ~~Make recommendations to the Board among alternative courses of action;~~
- ~~Provide oversight, monitoring, and assessment of key organizational processes and outcomes.~~

~~The Board shall use the GC to address these duties and shall refer all matters brought to it by any party regarding Board governance to the GC for review, assessment, and recommended Board action, unless that issue is the specific charge of another Board Standing Committee. The GC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District, except for legislative issues requiring prompt action.~~

~~**Policy:**~~

~~**SCOPE AND APPLICABILITY**~~

~~This is a NIHD Board Policy, and it specifically applies to the Board, the Governance Committee and all other Standing Committees, the CEO, and the Compliance Officer.~~

COMMITTEE RESPONSIBILIES~~TY~~

1. Review and recommend amendments to the District's Bylaws
2. Review and recommend Board governance policies
3. Review and recommend Board committee structure and committee charters
4. Oversee Board orientation and onboarding processes
5. Recommend Board education and governance training priorities
6. Monitor governance-related statutory training requirements applicable to Board members
7. Ensure an annual Board self-assessment is conducted and review results to recommend governance improvements
8. Maintain and implement a governance policy review schedule
9. Review and recommend the District's Board advocacy platform
10. Review legislative and regulatory issues affecting the District and recommend advocacy priorities and legislative representation to the Board
11. Serve as the forum for governance matters not assigned to another standing committee
12. Perform other governance-related duties as assigned by the Board

~~**Committee Structure and Membership**~~

- ~~The GC, with input from the Standing Committees, shall review the composition of the Standing Committees annually for vacancies, including an assessment of the desired homogeneous and heterogeneous traits necessary for the Board to work together effectively. Examples of desired homogeneous traits include integrity, interest in, and commitment to the District, interpersonal maturity, and willingness to devote the necessary time and effort, and the ability get along and work effectively with others; and heterogeneous traits include their relationship to the District, experience, gender,~~

ethnicity, and expertise. The GC may have one member from the community, subject to approval by the Board of Directors.

Board Development

- **New Member Orientation**
  - Design our Board's new-member orientation process and reassess it periodically including Human Resources and the Board Clerk.
- **Continuing Education of the Board**
  - Plan annual board special sessions in concert with the Board Chair to identify an annual training program addressing current issues of importance to the Board to be presented for the Board, possibly including Standing Committee members, Medical Staff, selected hospital leaders, and others as deemed appropriate by the Board.
  - Direct and oversee our Board's continuing education and development activities for both the Board and its Standing Committees.
- **Board Self-Assessment**
  - Ensure, with the Chair of the Board, that an annual Board self-assessment is completed.

Develop Policies and Recommend Decisions

- Draft policies and decisions regarding governance performance and submit them to the Board for deliberation and action.

Oversight

- **Compliance**
  - Conduct a review and revision of all Board policies as dictated by the policy schedule.

Legislation

- Review, draft, and/or recommend legislative proposals to the Board for deliberation and action in concert with the CEO.
- At its discretion and in concert with the CEO, the Governance committee, or Board, can deliberate and take action on legislation or regulatory issue. The CEO may commit the District to support or oppose legislative initiatives, provide the CEO and the Board Chair are in agreement.
- Perform other tasks related to governance as assigned by the Board.

Annual GC Calendar

- Scheduled review and assessment of all board policies regarding governance, specifically including the GC and all other Standing Committee Charters and make recommendations to the Board for action per the schedule.
- The GC shall create an annual work plan.
- The GC shall report on the results of its prior year's work plan accomplishments by November.

- ~~The GC annual work plan shall be updated and submitted to the Board no later than December for approval.~~
- ~~The GC shall establish the next calendar meeting schedule at the last meeting of the year.~~
- ~~Ensure that the CEO develops and provides a 12-month calendar of all scheduled Regular Board Meetings and post on the NIHD website at the beginning of the calendar year. It shall be kept updated.~~
- ~~The GC shall annually review the District's Code of Conduct and NIHD Compliance Program and report to the Board for its action no later than December, for presentation to the Board in January.~~

~~**GC Membership**~~

~~The GC shall have 2 members, normally the elected officers in the Chair & Secretary positon, and the CEO, unless the Board acts specifically to make an exception.~~

~~**Staff to the GC**~~

~~The GC shall be staffed by the District's CEO and/or Administrative Representative. At the request of the GC Chair, the Compliance Officer shall attend GC meetings.~~

~~**Frequency of GC Meetings**~~

~~The GC shall meet quarterly at minimum unless there is a need for additional meetings. Meetings may be held at irregular intervals.~~

~~**Public Participation**~~

~~All GC meetings shall be announced and conducted pursuant to the Brown Act. The general public, patients, and their families and friends, Medical Staff, and District staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.~~

FREQUENCY OF REVIEW/REVISION

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

~~The GC 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 Governance Committee Charter

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Onboarding and Continuing Education of Board Members		
Owner: Chief Executive Officer	Department: Administration	
Scope: Board of Directors		
Date Last Modified: 01/08/2026	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Purpose/Policy

This document outlines the onboarding and orientation process for newly elected or appointed Board Members of the Northern Inyo Healthcare District (NIHD). The process ensures each Director receives the information, access, and introductions necessary to begin performing governance responsibilities.

Board Chair

- Meeting norms
- Roles and Communication
- Committees
- Board Culture

Chief Executive Officer (CEO): provides a general orientation that includes:

- Orientation to Special Districts and Healthcare Districts
- Introduction to NIHD's history and structure
- Mission, Vision, and Values
- Organizational Chart
- Strategic Plan
- Update on current events and issues.

General Counsel: reviews the Board Member's legal and statutory responsibilities:

- Brown Act requirements
- Public meeting procedures
- Overview of District authorities and limits

Executive Team: the new Board Member meet individually with:

- Chief Business Development Officer
- Chief Financial Officer
- Chief Human Resources Officer
- Chief Medical Officer
- Chief Nursing Officer
- Chief Operating Officer
- Chief of Staff

Compliance Officer:

- NIHD's Compliance Program
- Compliance & Business Ethics Committee
- Board Reference Binder
- How Compliance supports Board operations

Clerk of the Board: supports the Board Member through the following onboarding activities:

1. Provide initial access and materials:
    - Issue District identification badge
    - Initiate IT access and email credential setup
2. Support completion of required regulatory filings and trainings:
    - Form 700
    - AB 1234 Ethics Training
    - Sexual Harassment Prevention Training
    - Board Civility and Code of Conduct acknowledgment
    - Stipend Payment
3. Coordinate meetings and orientation activities:
    - Introduction to the Executive Team
    - Meeting with the Compliance Officer
    - Hospital campus tour
    - Photography appointment with Marketing/Communications
4. Collect Information:
    - Biography Information

Continuing Education

The District will provide information on Board development trainings, conferences, webinars, and other continuing education opportunities and will encourage Board members to participate. Board members may also independently pursue relevant continuing education. Educational resources may include organizations such as the California Special Districts Association (CSDA), League of California Cities, Association of California Healthcare Districts (ACHD), and similar governance or healthcare-focused organizations. Reimbursement for approved education shall be in accordance with District policy.

~~**PURPOSE:**~~

~~The purpose of the onboarding and orientation process is to provide a new Northern Inyo Healthcare District (NIHD) board member the information necessary to begin the governing work of the Board of Directors. Further development as a board member is through continuing education.~~

~~**POLICY:**~~

~~NIHD will provide essential knowledge of the District to all incoming board members within thirty (30) days of election or appointment.~~

~~Board members will be provided opportunities for continuing education to expand their knowledge on key healthcare issues and governance.~~

~~**PROCEDURE:**~~

~~When onboarding, new board members complete the following steps:~~

~~Human Resources~~
~~Complete and sign necessary paperwork with Human Resources.~~
~~Introduction to NIHD Workforce: a review of NIHD benefits, special events, community involvement.~~
~~Arrange District campus tour.~~

~~Clerk of the Board~~
~~Receives tablet, user ID and email~~
~~Completes FPPC Statement of Economic Interest From 700~~
~~Initiates required regulatory training (i.e. AB1234 Ethics training, Sexual Harassment Prevention training).~~
~~Discuss cost-effectiveness and efficiency of direct deposit reimbursement of expenses and stipends versus paper check process. Recommend and complete as appropriate.~~
~~Provides overview of Board Meeting structure.~~
~~Arrange District leadership introductions, department tours, and services line overview.~~

~~Chief Executive Officer (CEO)~~
~~Meets with CEO to review the Mission, Vision, Values, Organizational Chart, and Strategic Plan of the District.~~
~~Reviews patient grievance process.~~
~~Reviews Board policies.~~
~~Facilities meet-and-greet with Executive Team.~~

~~General Counsel~~
~~Meets with General Counsel to review Brown Act, public meeting procedures, etc.~~

~~Compliance Officer~~
~~Reviews District's Compliance Program and Work Plan.~~
~~Completes NIHD Conflicts of Interest form.~~
~~Review Compliance and Ethics Committee structure, role and duties.~~

~~NIHD Board Chair and/or Vice Chair~~
~~Reviews Order & Decorum, board policies, etc.~~

~~Chief Financial Officer~~
~~Reviews most recent audited financials, budget and 10 year forecast.~~
~~Reviews monthly financials report and package.~~
~~Reviews Finance Committee role and duties.~~

~~Director of Quality~~
~~Reviews Quality Assurance Performance Improvement Plan (QA/PI).~~
~~Reviews Quality Dashboard.~~
~~Reviews Patient Satisfaction platform.~~
~~Reviews Quality and Safety Committee role and duties.~~

~~Director of Medical Staff Services~~
~~Reviews structure and duties of Medical Executive Committee.~~

~~Reviews current process for Medical Staff credentialing.~~
~~Reviews Medical Staff Peer Review process.~~
~~Reviews Medical Staff Bylaws.~~

~~Manager of Marketing, Communication & Strategy~~
~~Reviews District's website.~~

~~Additional materials on governance, quality and finance topics will be distributed electronically.~~

~~Appropriate external continuing education and conference will be suggested by Administration. Outside education costs will be paid in accordance with District policy.~~

~~**REFERENCES:**~~

~~**RECORD RETENTION AND DESTRUCTION:**~~

~~**CROSS REFERENCED POLICIES AND PROCEDURES:**~~

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Purchasing and Signature Authority		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: District Leadership		
Date Last Modified: 01/09/2026	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2016	

PURPOSE:
To control the commitment of healthcare District funds, including purchasing and signing activities. Goods and services purchased with District funds must be necessary and relevant to the District's business and the advancement of its mission. District funds include Local District Taxing Authority revenues and carry with them fiduciary responsibilities. Proper stewardship of District funds is the responsibility of all employees involved in procurement transactions.

POLICY:
1. Established purchase levels are tiered in low, mid, and high value purchasing authority. All purchases including purchase orders and check requests will follow these guidelines as outlined in the procedure below. The only exception made is for emergency purchases as outlined in the Emergency Purchases Policy.
2. The Board of Directors delegates and approves authority for purchases to the Chief Executive Officer (CEO).
3. The CEO delegates purchasing authority to the Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Operating Officer (COO), Chief Human Resource Officer (CHRO), Administrator on Call (AOC), directors (and equivalent level positions), and managers at the approval levels defined in the procedure below.
4. Only those employees given explicit written authority by the Northern Inyo Healthcare District (NIHD) Board of Directors, currently the Chief Executive Officer (CEO) or CEO's designee may execute the procurement agreements.
5. Group Purchasing Organization (GPO) contracts, approved by the CEO, allow Directors to work within the terms stipulated. Various departments utilize GPO contracts without requiring new signatures per the established purchasing levels.

PROCEDURE:
1. District leadership may authorize purchases at the levels defined below for cost centers associated with their leadership position.
2. Purchase authorization and approval levels are established in the following manner:
   i. Manager – up to $3,000
   ii. Director or equivalent position – up to $10,000
   iii. Chief - up to $25,000
   iv. CEO - up to $40,000
   v. All purchase requests above $40,000 require the approval of the NIHD Board of Directors with the exception of Capital Approved purchases that were part of the NIHD Board Budget approval

process and purchases authorized in the approved District operational budget. See Capitalization of Asset policy for specific information on capital purchase limits.

3. Check signing
    i. All checks will be electronically signed by a chief who has a signature card on file with the appropriate financial institution.
    ii. Printed checks over $10,000 will be hand-signed by a second chief who has a signature card on file with the appropriate financial institution.
4. Materials Management via Purchasing Department with Predetermined Catalog items
    i. Board of Directors approves the annual District budget, which includes materials supplied via the Purchasing Department.
    ii. Pre-established Periodic Automated Replenishing (PAR) levels based on department needs are built into the District's information system.
    iii. Upon documented use of items, District Information System reorders the items necessary to maintain PAR stock.
    iv. Items reordered within the PAR do not fall into the need for purchase orders or signature requirements listed within procedure #1.
    v. Special order items, not routinely requested or on the PAR, do fall under the purchase signature requirements listed within procedure #1.
5. Emergency Purchasing Authorization
    i. **Authority to Approve Emergency Purchases**
    With prior approval from the Board Chair or the next Director in the chain of command, the CEO may authorize an unbudgeted purchase of up to **$100,000** during a declared emergent operational situation when failure to act would be detrimental to District operations.
    ii. **Board Notification Requirement**
    If this emergency authority is exercised, the full Board must be notified and provided with the expenditure details and a summary of the circumstances at the earliest available Board meeting, for retroactive approval.
        1. If the expenditure is not approved by the full Board, the Board, in consultation with General Counsel, will determine whether any further review is conducted in open session (e.g., policy or procedural compliance) or in closed session in accordance with the Brown Act's personnel provisions (e.g., matters involving CEO performance).
    iii. **Limitation of Emergency Authority**
    This emergency authorization is limited to true emergency conditions and may not be used to circumvent the normal budgeting process or standard purchasing thresholds.
6. Reporting violations for complaints or concerns regarding compliance with the above, please contact the Chief Finance Officer (CFO) or the Compliance Officer.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) January 2022. Standard LD.01.04.01 EP 1.

RECORD RETENTION AND DESTRUCTION:

Maintenance of Fiscal records, including documents associated with procurement contracts and purchase orders is for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Capitalization of Assets
2. Emergency Purchases

Supersedes: v.5 Purchasing and Signature Authority

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: January 6, 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 01/01/2026 – 12/31/2027 (*action item*)
As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon the Distant-Site entity's credentialing and privileging decisions.

1. Jeffrey Grossman, MD (*diagnostic radiology*) – Telehealth

B. Medical Executive Committee Meeting Report (*information item*)