Northern Inyo Healthcare District

Board Meeting

Board Meeting - November 18, 2026

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

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

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

November 18, 2026, 9:00 am
Open Session scheduled to begin at 10:00 am

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 9:00am
2. Public comment on closed session items
3. Adjourn to closed session for:
    a. Public Employee Performance Evaluation

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

       Chief Executive Officer: Christian Wallis

    Open Session Scheduled to begin at 10:00 am
4. Return to open session and report on any actions taken in closed session.
5. Pledge of Allegiance
6. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the

agenda. Public comments on agenda items should be made at the time each item is considered.

7. Oath of Office – Action Item
    a. Melissa Best-Baker
    b. Maggie Egan
    c. Laura Smith
    d. Jean Turner
8. 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 October 20, 2026 Special Board Meeting
    b. Approval of Minutes for October 21, 2026 Regular Board Meeting
    c. Approval of Policies and Procedures
        i. Inter-facility Transfer Guidelines
        ii. Patient's Rights and Responsibilities
        iii. Standby/Callback
9. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
    a. Medical Staff Initial Appointments 2026-2027
    b. Additional Privileges
    c. Medical Staff Reappointments 2027-2028
10. Chief Executive Officer Amendment to Employment Agreement for Christian Wallis - Action Item
11. Chief Executive Officer Report
    a. Foundation Report – Information Item
    b. Auxiliary Report – Information Item
    c. Mammoth Hospital – Information Item
    d. Community Update – Information Item
    e. Beta Award – Information Item
12. Governance Committee
    a. Advocacy Update – Information Item
    b. Quarterly Compliance Report – Action Item
13. Finance Committee
    a. Grant Update – Information Item
    b. Appointment of New Bond Trustee and Paying Agent – Action Item
    c. Service Line Update
        i. Psychological Services Consultation Agreement – Action Item

ii. Radiology Services Agreement - Bristlecone Pine Radiology - Action Item

iii. Women's Health Collaboration Agreement between Northern Inyo Healthcare District and Mammoth – Action Item

d. Investment Report – Action Item

e. Financial and Statistical Report – Action Item

14. Quality Committee

    a. Quality Dashboard – Information Item

    b. Emergency Department Transfer Project – Information Item

    c. Grievance Committee – Information Item

    d. Patient Safety Committee Structure – Information Item

    e. Unusual Occurrence Report (UOR) – Action Item

15. Future Agenda Items

16. General Information from Board Members

17. 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 Best-Baker called the meeting to order at 10:20 pm.
PRESENT	Melissa Best-Baker, Chair David Lent, Vice-Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Chair Best-Baker reported that at this time, audience members may speak only on closed session agenda items. **Public Comment:** None
ADJOURN TO CLOSED SESSION	Adjourn to closed session at 10:20 pm.
RETURN TO OPEN SESSION	Return to open session at 12:14 pm.
REPORT OUT FROM CLOSED SESSION	No reportable action.
ADJOURNMENT	Adjournment at 12:15 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Best-Baker called the meeting to order at 8:38 am.
PRESENT	Melissa Best-Baker, Chair David Lent, Vice-Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer Anne Wakamiya, MD, Vice Chief of Staff
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Chair Best-Baker reported that at this time, audience members may speak only on closed session agenda items. **Public Comment:** None
ADJOURN TO CLOSED SESSION	Adjourn to closed session at 8:39 am.
RETURN TO OPEN SESSION	Return to open session at 10:20 am.
REPORT OUT FROM CLOSED SESSION	The Board of Directors authorized payment of any judgment for punitive or exemplary damages as to Christian Wallis, conditioned upon all acts being in scope and acted in good faith, and that payment would be within the best interest of the District. The Board of Directors authorized payment of any judgment for punitive or exemplary damages as to Sierra Borne, conditioned upon all acts being in scope and acted in good faith, and that payment would be within the best interest of the District. The Board of Directors authorized payment of any judgment for punitive or exemplary damages as to the medical staff, conditioned upon all acts being in scope and acted in good faith, and that payment would be within the best interest of the District.

The Board approved moving Christian Wallis to Paid Time Off (PTO) Level 3 and changing his contract immediately.

PUBLIC COMMENT

Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board.

Public Comment: None

CONSENT AGENDA

Public Comment: None

Board Discussion: None

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

The following items were approved:
1. Approval of minutes for September 16, 2026 Regular Board Meeting
2. Approval of Policies and Procedures
    a. Medical Staff Department Policy - Emergency Medicine
    b. Mobile Intensive Care Nurse
    c. Newborn Blood Glucose Monitoring
    d. Reimbursement for Mileage, Meals and Incidentals, and Lodging for District Business
    e. Pre-cleaning and Returning of Instruments to Sterile Processing
    f. Trauma Policy

CONSIDERATION OF CREDENTIALING ACTIONS RECOMMENDED BY THE MEDICAL EXECUTIVE COMMITTEE

Public Comment: None

Board Discussion:
The Board requested clarification regarding the distinction between telehealth and telemedicine privileges. Chief Medical Officer Hawkins confirmed that the terms are used interchangeably and do not represent different credentialing categories. The board also shared positive community feedback regarding the District's dermatology services.

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

The following credentials were approved:
Medical Staff Initial Appointments 2026-2027
Pamela Mundell, MD (*dermatology*) – Active Staff
Alexander Dunnum, DO (*anesthesiology*) – Courtesy Staff
Mandeep Sahani, MD (*nephrology*) – Telemedicine Staff
Melby Abraham, MD (*nephrology*) – Telemedicine Staff
Jamal Ksar, MD (*diagnostic radiology*) – Telemedicine Staff

Jamel Reid, MD (*diagnostic radiology*) – Telemedicine Staff

Medical Staff Telemedicine Privileges 2026-2027 – Proxy Credentialing

Siddharth Dalal, MD (*teleneurology*) – Telemedicine Staff (Distant Site: Sevaro)

Additional Privileges

Benjamin Mundell, MD (*general surgery*) – recommendation to grant privileges for independent fluoroscopy performance as authorized by Dr. Mundell's valid California permit

Jack Kornfeld, MD (*emergency medicine*) – recommendation to grant privileges for patient care in the Medication Assisted Treatment program as qualified by Dr. Kornfeld's training and participation in the examination process for board certification in Addiction Medicine

Medical Staff Reappointments 2027-2028

Steven Arbogast, DO *(neurology)* — Telehealth Staff
Nandini Bakshi, MD *(neurology)* — Telehealth Staff
Sierra Bourne, MD *(emergency Medicine)* — Active Staff
Timothy Crall, MD *(orthopedic Surgery)* — Active Staff
Lauren Crawford, MD *(neurology)* — Telehealth Staff
Amy Do-Nguyen, MD *(emergency medicine)* — Active Staff
James Eidel, MD *(anesthesiology)* — Active Staff
Jake Ichino, MD *(cardiology)* — Telehealth Staff
Samantha Jeppsen, MD *(emergency medicine)* — Active Staff
Kyle Minkel, DO *(orthopedic surgery)* — Courtesy Staff

CHIEF OF STAFF

Infectious Disease Privilege Form

The Board reviewed the Infectious Disease Privilege Form, which will be used to credential providers for the District's new inpatient infectious disease consultation services.

Public Comment: None

Board Discussion: None

Motion by Egan to approve the Infectious Disease Privilege Form
2nd: Smith
Pass: 5-0

CHIEF EXECUTIVE REPORT

Introduce Board Clerk

Chief Executive Officer Wallis introduced Brynn Norman as the District's new Board Clerk. He highlighted her previous experience with Kern Regional Center and the Inyo County Office of Education, including her work with public agencies and boards. Norman expressed her appreciation and enthusiasm for joining the District.

Public Comment: None

Board Discussion:
The Board welcomed Brynn Norman to the District.

Community Engagement
Chief Executive Officer Wallis reported that he provided an update to the Bishop City Council regarding the District's growth strategy, including market surveys, the long-range financial plan, and the master facility plan. He also discussed service line developments involving behavioral health, dermatology, and women's health, as well as progress following the September joint Board meeting with Mammoth Hospital. CEO Wallis reported that the City Council was receptive to the presentation and raised no significant concerns. He noted that updates to the City Council will now occur semiannually rather than quarterly and that a similar presentation to the Inyo County Board of Supervisors is planned for early November.

Public Comment: None

Board Discussion: None

Joint NIHD/Mammoth Hospital Update
Chief Executive Officer Wallis provided an update on progress following the September joint Board meeting with Mammoth Hospital. The approximately 60 ideas identified during the meeting have been consolidated into broader priorities and specific initiatives, with anticipated implementation timelines. Leadership from both organizations is working to develop a more structured joint strategic plan for presentation at the January meeting, with facilitator Karma assisting in the process. CEO Wallis also reported that Mammoth Hospital is developing its own strategic plan with support from Virginia Mason and that both organizations have exchanged departmental contact lists to encourage direct communication and collaboration.

Public Comment: None

Board Discussion: The Board asked whether departments were already communicating regularly. CEO Wallis explained that collaboration varies by department, with some having established relationships and others only recently beginning to communicate. He emphasized that ongoing coordination between corresponding departments is now an expectation. The Board also expressed appreciation for the joint press release outlining the purpose and scope of the collaboration.

Renown Update
Chief Executive Officer Wallis reported that NIHD participated in a regional collaboration meeting hosted by Renown Health, attended by representatives from 22 hospitals that refer patients to the Reno area. Renown engaged a consultant to survey participating hospitals regarding their existing relationships, communication, and opportunities for increased collaboration.

CEO Wallis noted that discussions focused on shared challenges, including patient transportation, emergency department capacity, and opportunities to keep patients closer to home. Individual hospital survey results are expected to be distributed, and participants expressed interest in reconvening during the winter or spring to identify specific opportunities for collaboration.

Public Comment: None

Board Discussion: None

HealthTrust Benchmarking Update
Chief Executive Officer Wallis provided an update on the HealthTrust staffing and productivity benchmarking assessment, which compared District departments with similar rural critical access hospitals. The assessment resulted in the elimination of six positions, five through vacancies that were not filled and one through a reduction in force, generating approximately $1 million in savings. To support continued improvements, the District established a Position Management Committee to evaluate staffing requests and determine whether vacancies need to be filled. CEO Wallis reported that the Emergency Department and Medical-Surgical Unit have begun implementing more structured daily productivity monitoring to align staffing with patient volumes, with plans to expand the approach to other departments. Department leaders have also received HealthTrust recommendations and will be responsible for evaluating and reporting progress on applicable improvements, with an emphasis on reducing costs through operational efficiencies and attrition rather than additional layoffs.

Public Comment: None

Board Discussion:
The Board asked how the revised staffing practices would affect employees and whether voluntary reductions in scheduled hours would be offered. Chief Operating Officer Partridge explained that adjusting staffing to patient volumes is an established practice, but the District is implementing a more consistent and intentional approach, with voluntary reductions offered before mandatory adjustments. Regarding the effectiveness of benchmarking, Partridge acknowledged that adapting to data-driven staffing decisions has required adjustments but reported that department leaders are working to understand and implement the recommendations. The Board expressed support for management's approach to improving productivity while minimizing involuntary staff reductions.

Outpatient Clinic Operational Assessment
Chief Executive Officer Wallis presented a proposal to engage the Medical Group Management Association (MGMA) to conduct a comprehensive operational assessment of the District’s outpatient clinics, which were not included in the HealthTrust benchmarking assessment. The review would evaluate staffing levels, provider productivity, scheduling practices, workflows,

and space utilization to identify opportunities for improved efficiency and patient access. He explained that MGMA specializes in outpatient clinic operations and offered a proposal at less than half the cost of another consulting firm considered. Chief Medical Officer Dr. Adam Hawkins supported the assessment, emphasizing the need for reliable benchmarking data to guide staffing decisions, standardize clinic operations, and improve scheduling and access to care.

Public Comment: None

Board Discussion: The Board expressed concern regarding the longstanding lack of reliable operational data to support decision-making and acknowledged the challenges this creates for staff and leadership. Members expressed support for the assessment as an investment in improving clinic operations.

Motion by Turner to approve the MGMA contact
2nd: Smith
Pass: 5-0

GOVERNANCE COMMITTEE

Advocacy Update:
Nicole Quinonez partner of Tim Madden presented the legislative update on behalf of Tim Madden, joined by Sarah Bridge of the Association of California Healthcare Districts (ACHD), who provided additional information regarding ACHD's positions on ballot initiatives. Quinonez reported that the Governor signed approximately 1,400 bills during the 2026 legislative session. The presenters reviewed the following legislation and ballot propositions:

- **AB 1923 – Distressed Hospital Loan Program:** The proposed $250 million in funding was secured through the state budget rather than the legislation, which was subsequently amended to address an unrelated issue.
- **AB 1607 – Maddy Emergency Medical Services Fund:** Signed into law, extending the program for an additional 10 years.
- **HR 8209 – Federal Legislation:** No additional activity since the previous update.
- **AB 1882 – Safe Delivery Fund:** Vetoed by the Governor due to state budget constraints and administrative concerns. The proposal would have provided financial assistance to hospitals serving geographically isolated populations at risk of losing obstetric services.

Ballot Proposition Updates

- **Proposition 3 – High-Income Tax Extension:** Would make existing income taxes on high earners permanent, primarily supporting education, with potential funding for healthcare programs.
- **Proposition 40 – One-Time Billionaire Tax:** Would impose a one-time 5% tax on California residents with a net worth exceeding $1

billion, with approximately 90% of proceeds designated for healthcare. ACHD has adopted a watch position due to concerns regarding revenue stability and reliance on one-time funding.

- **Proposition 41 – Special Tax Oversight:** Would require additional review of proposed special taxes by the State Auditor and impose additional fiscal requirements. If approved with more votes than Proposition 40, it could supersede that measure.
- **Proposition 42 – Restrictions on Wealth Taxes:** Would prohibit certain taxes on asset ownership and could supersede Proposition 40 if approved with more votes.
- **Proposition 43 – Local Special Tax Approval:** Would increase the voter approval threshold for citizen-initiated local special taxes from a simple majority to two-thirds.
- **Proposition 44 – Community Clinic Spending Requirements:** Would require certain community clinics to spend at least 90% of annual revenue on patient care. ACHD opposes the measure due to potential financial and administrative impacts on healthcare districts and the absence of an exemption for public healthcare providers.
- **Proposition 45 – CEQA Reform:** Would streamline environmental review requirements for certain projects, including healthcare facilities. ACHD is monitoring the measure but has not adopted a formal position.

Public Comment: None

Board Discussion: None

Performance Evaluation Process
Chief Executive Officer Wallis provided an update on revisions to the District's employee performance evaluation process. The revised process will align employee performance goals with the District's strategic plan and the Board-approved CEO goals and objectives. Goals will cascade from the CEO to the executive leadership team, department directors, managers, and ultimately employees to ensure organizational alignment and accountability.

Public Comment: None

Board Discussion: None

FINANCE COMMITTEE

Grant Update

Chief Executive Officer Wallis provided an update on recent grant applications and awards.

USDA Telemedicine Grant: The District's application for funding to purchase four telemedicine units was denied because the community's income levels exceeded the grant's eligibility threshold.

Rural Health Transformation Program (RHTP): The District submitted four grant applications:

- **Electronic Health Record (EHR) Transition:** The application for funding to transition to Epic was not approved. The District intends to pursue funding in the next grant cycle.
- **Chronic Disease Management:** The collaborative application with Southern Humboldt and other healthcare organizations was not approved.
- **Eastern Sierra Women's Health Program/Accelerator Partners Grant:** Of the $1.8 million requested, approximately $280,000–$290,000 was awarded for telemedicine equipment and a program manager. Funding for recruitment and retention of clinical staff was not approved.
- **Workforce Grant:** Of the $996,000 requested, approximately $320,000 was awarded for pediatric and family practice physician recruitment. CEO Wallis reported that the District worked with the state to redirect the family practice funding toward obstetrics and gynecology recruitment to support the regional women's health program.

Board Discussion: Members discussed the limited grant awards and expressed disappointment that funding for essential clinical staffing was not approved, despite the District's efforts to develop a sustainable regional women's health program. Chief Executive Officer Wallis explained that funding for a program manager and telemedicine equipment, without sufficient funding for the providers needed to deliver services, presented challenges to implementing the program as originally proposed. Members acknowledged management's efforts to redirect available workforce funding to support the recruitment of an obstetrician-gynecologist and pediatrician.

The Board discussed grant reporting requirements, the one-year funding period, and the importance of understanding which organizations received funding and for what purposes. CEO Wallis reported that statewide award information was expected to be released and could help inform future grant applications.

Members expressed concern that the awards did not adequately reflect the healthcare challenges facing the Eastern Sierra, including geographic isolation, limited healthcare resources, and the need to develop regional partnerships. Members noted the substantial work undertaken to coordinate with neighboring healthcare organizations and HCAI representatives to develop proposals that aligned with the program's objectives.

The Board expressed support for the letter drafted by Chair Best-Baker to HCAI communicating the District's concerns regarding the grant awards and explaining the unique challenges of providing healthcare in the Eastern Sierra. Members emphasized the importance of HCAI hearing directly from the Board and requested an update at a future meeting regarding any response to the letter, as well as information on statewide grant recipients, award amounts, and

funded programs.

Accelerator Partners Grant:

Motion by Lent to approve the execution of the Accelerator Partners Grant
2nd: Turner
Pass: 5-0

Workforce Grant:

Public Comment: None

Board Discussion: None

Motion by Egan to approve the execution of the Workforce Grant
2nd: Smith
Pass: 5-0

HCAI Letter

Public Comment: None

Board Discussion: None

Motion by Turner to approve the letter to HCAI and its submission
2nd: Egan
Pass: 5-0

Capital Report
CFO Mossman presented the first-quarter capital expenditure report, noting that approximately $970,000 in capital expenditures had been approved, with roughly one-third invoiced. Approximately $220,000 remained available in the capital contingency budget. Several projects were completed or nearing completion, including fetal monitoring equipment, pavement improvements, and arthroscopic accessories. Updates were provided on the inpatient dialysis machine, Microsoft 365 migration, laboratory equipment and software, and MRI project.

COO/CNO Partridge discussed the proposed purchase of a tractor with snow removal attachments for approximately $31,005, funded through capital contingency, to improve winter maintenance, campus safety, and facility access.

Public Comment: None.

Board Discussion: The Board expressed appreciation for the quarterly report and supported the proposed snow removal equipment purchase. No formal action was taken.

Motion by Turner to accept the Capital Report
2nd: Lent
Pass: 5-0

Financial and statistical Report
CFO Mossman presented the August financial and statistical reports, noting that the District continued to perform favorably compared to budget despite lower-than-anticipated patient volumes in several service areas. Net revenue exceeded budget by approximately $1.8 million, while operating expenses were approximately $328,000 above budget, primarily due to increased employee benefit claims. The operating loss was approximately $426,000, compared to a budgeted loss of nearly $1 million, and year-to-date net income was approximately $1.64 million. Higher emergency department, diagnostic imaging, and rehabilitation volumes, along with a favorable payer mix, contributed to revenue performance. She also discussed staffing expenses, ongoing departmental budget reviews, and accounts receivable of 67 days, which remained above the target range of 45–60 days.

Public Comment: None

Board Discussion:
The Board discussed the positive financial results and recognized the continued improvement in collections and the District's cash position.

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

FUTURE AGENDA ITEMS — None

GENERAL INFORMATION FROM BOARD MEMBERS — Board members shared highlights from the Association of California Healthcare Districts (ACHD) Conference in Monterey, including presentations on healthcare literacy, employee happiness and customer service, healthcare policy and propositions, hospital construction, and community cardiac emergency preparedness. Members also noted the value of networking and educational opportunities. Additional updates included attendance at the Palisades Panther Clinic ribbon-cutting ceremony, recognition of CEO Wallis for his healthcare advocacy efforts, and participation in ACHD education and governance activities.

ADJOURNMENT — Adjournment at 11:45 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Interfacility Transfer Guidelines		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Hospital		
Date Last Modified: 07/22/2026	Last Review Date: 08/20/2023	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/01/1995	

approval

PURPOSE:
To establish standardized guidelines and responsibilities for Registered Nurses (RNs) who accompany patients during interfacility transport on behalf of Northern Inyo Healthcare District (NIHD). This policy is intended to promote safe and consistent patient care during transport, ensure continuity of care between facilities, clearly define the roles and responsibilities of the accompanying RN and Emergency Medical Services (EMS) personnel, and ensure compliance with applicable federal and state regulations, the Emergency Medical Treatment and Labor Act (EMTALA), California law, and Inland Counties Emergency Medical Agency (ICEMA) policies and protocols.

POLICY:
NIHD may provide a RN escort during an interfacility transfer when ordered by the transferring physician and the patient's clinical condition requires nursing assessment, monitoring, or interventions beyond the scope of practice of the transporting Emergency Medical Services (EMS) personnel.

The transferring physician is responsible for determining the medical necessity of an RN escort.

The Emergency Department Charge Nurse and/or House Supervisor shall coordinate staffing to ensure adequate patient care resources remain available within the hospital during the RN's absence.

The accompanying RN shall practice within the California Nursing Practice Act, physician orders, current hospital policies, and the RN scope of practice.

All interfacility transfers shall comply with:

- Emergency Medical Treatment and Labor Act (EMTALA) requirements
- Current Inland Counties Emergency Medical Agency (ICEMA) policies and protocols
- Applicable NIHD policies governing patient transfers

The transporting EMS personnel remain responsible for ambulance operations and patient care provided within the EMS scope of practice. The accompanying RN is responsible for nursing care and physician-ordered interventions provided within the RN scope of practice.

PROCEDURE:

I. Qualifications

- Current California RN license

- Current Mobile Intensive Care Nurse (MICN) certification (preferred but not required for transport)
- Current ACLS certification
- Demonstrated competency caring for critically ill patients
- Familiarity with ICEMA transport protocols for non-MICN RN's

II. Prior to Transport

- Receive report from transferring provider and primary nurse
- Verify receiving facility and physician acceptance
- Review patient's condition
- Review physician orders
- Ensure transfer packet is complete
- Verify medications accompanying the patient
- Verify transport equipment
- Coordinate transport plan with EMS personnel

III. Responsibilities During Transport

- Perform ongoing patient assessments
- Monitor vital signs
- Administer medications
- Manage IV infusions
- Document significant events
- Communicate change in condition to EMS personnel
- Assist with ACLs interventions if necessary
- Carry out physician orders within scope of practice

EMS personnel will be responsible for ambulance operations, contact of Base Station as required, and document care in the ePCR.

IV. Arrival at Receiving Facility

- Accompany the patient into the receiving unit
- Give bedside handoff
- Give transfer documentation packet
- Confirm transfer of responsibility

V. Return to NIHD

- Notify House Supervisor of return
- Complete required documentation
- Complete payroll documentation

VI. Documentation

- Departure time
- Arrival time
- Assessments
- Vital signs
- Medications
- Physician communication

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- Significant changes
- Nursing interventions

VII. Limitations

An RN escort shall not be utilized when the patient's anticipated care needs exceed the capabilities of the transporting ambulance or available personnel. Patients requiring physician-level interventions or specialized critical care transport resources should be transported by the most appropriate critical care transport team whenever available.

REFERENCES:

1. Inland Counties Emergency Medical Agency (ICEMA) (2025). Policy, Procedure and Protocol Manual, Reference #8010.
2. California Code of Regulations. Title 22, Division 5- Article 6, s 70451 (2014). Retrieved from http://nursealliancecа.org/files/2012/06/Title-22-Chapter-5.pdf
3. Emergency Medical Treatment and Labor Act (EMTALA), 42 CFR §489.24.
4. Centers for Medicare & Medicaid Services (CMS). *State Operations Manual*, Appendix V – Responsibilities of Medicare Participating Hospitals in Emergency Cases (EMTALA).

CROSS REFERENCE POLICY & PROCEDURES:

1. EMTALA Policy

Supersedes: v.2 Interfacility Transfer Guidelines

approval

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Patient's Rights and Responsibilities		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 05/07/2026	Last Review Date: No Last Periodic Review Date Set	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/2001	

approval

PURPOSE:

To inform all patients and workforce of the rights and responsibilities of all patients while undergoing treatment in our District facilities.

POLICY:

1. Northern Inyo Healthcare District shall comply with the California statutes regarding patient rights and responsibilities.
2. A list of patients' rights shall be posted in both English and Spanish in appropriate areas within the District, making them available to all patients.
3. Patients shall receive written 'Patient Rights and Responsibilities' as part of the admission packet.
4. All District workforce performing patient care shall observe these patient rights.

PATIENT RIGHTS - As a patient of Northern Inyo Healthcare District (NIHD), you have the right to:

1. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, marital status, or the source of payment for care.
2. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences.
3. Know the name of the licensed health care provider acting within the scope of his or her professional licensure, who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery, and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care during hospitalization and for discharge planning, to meet your medical and psychological needs. You have the right to participate in the ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment, or to request an Ethics Consult.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or

non-treatment including the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.

6. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment. However, the patient does not have the right to demand treatment or services deemed medically unnecessary or inappropriate.
7. Full consideration of privacy concerning medical care will be maintained. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence and consent to the presence of any individual.
    a. Patient has the right to have visitors leave prior to an examination and/or prior to discussion about treatment.
    b. Privacy curtains will be used in non-private patient care areas.
8. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Basic information may be released to the public, unless specifically prohibited in writing by the patient. Written permission must be obtained before medical records can be made available to anyone not directly concerned with the care of the patient except as may otherwise be required or permitted by law.
9. Reasonable responses to any reasonable requests he or she may make for service.
10. Leave the hospital even against the advice of physicians, to the extent permitted by law.
11. Reasonable continuity of care, to know in advance the time and location of appointments, as well as the identity of persons providing the care.
12. Be advised if hospital/personal physician proposes to engage in or perform research, investigational treatment, or clinical trial participation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed of continuing health care requirements following discharge from the hospital.
14. Examine and receive and explanation of the bill regardless of source of payment.
15. Know which District rules and policies apply to the patient's conduct while a patient.
16. Have all of his or her rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Designate visitors of his or her choosing, if the patient has decision making capacity, whether or not the visitor is related by blood or marriage, unless:
    a. No visitors are allowed.
    b. The Healthcare District reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the Healthcare District workforce, or other visitor to the Healthcare District campus, or would significantly disrupt the operations of the District.
    c. The patient has indicated to the District workforce that the patient no longer wants this person to visit.
18. Have his or her wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the Healthcare District policy on visitation. At a minimum, the Healthcare District shall include any person living in the household. Verbally designate a support person, who may exercise the patient's visitation rights if the patient is unable.
19. Right to know the identity of persons caring for you, including your caregivers. Workforce is required to wear name badge with name and job title.
20. Right to be informed of continuing care requirements after discharge. If the patient authorizes, a friend or family member maybe given information on continuing care requirements after discharge.

approval

21. Formulate advance directives for healthcare and have hospital staff and practitioners who provide care in the hospital comply with these directives. This includes the designation of a decision maker if he or she becomes incapable of understanding a proposed treatment or becomes unable to communicate his or her wishes regarding care. The patient has the right to have a family member (or representative of the patient's choice) and the patient's own physician notified promptly of the patient's admission to the hospital.
22. The patient has the right to appropriate assessment and management of his or her pain, information about pain, pain relief measures, and to participate in pain management decisions. If the patient suffers from severe chronic intractable pain, the patient has the option to request or reject the use of any or all modalities to relieve pain, including opiate medication. The patient's doctor may refuse to prescribe opiate medication, but if so, must inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
23. Right to have family member and personal physician notified within 24 hours of admission, should you be incapable of communication. Reasonable efforts to reach the person with authority to make health care decisions for the patient will be made by NIHD workforce.
24. Have District documents communicated/printed to make them readable/understandable. NIHD provides these documents in English and Spanish. Other language needs are met via the 'Language Access Services Procedure.' Qualified interpreter services, auxiliary aids, and accessible communication services will be provided at no cost to the patient, to assist in effective communication for those with disabilities or limited English proficiency. Patients may also file discrimination complaints with the U.S. Department of Health and Human Services Office for Civil Rights (OCR).
25. Receive care in a safe setting. Be free from physical or mental abuse, corporal punishment, restraint or seclusion, or any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restrain or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
26. Access, request amendment to, and obtain information on disclosures of your health information (medical records) in a reasonable amount of time.
27. Examine and receive an explanation of District's bill regardless of source of payment.
28. These patient rights may not be construed to prohibit the Healthcare District from otherwise establishing restrictions on visitation, including restrictions upon the hours of visitations and number of visitors.

PATIENT RESPONSIBILITIES – As a patient of Northern Inyo Healthcare District (NIHD), you have the responsibility to:

1. Provide complete and accurate information regarding his or her medical history to those involved with his or her care.
2. Inform the physician or nurse of any changes in his or her health.
3. Inform the provider and the nurse of any pain he or she has and results of pain control measures.
4. Make it known whether he or she clearly understands the course of action and expectations set by NIHD.
5. Make it known to appropriate Healthcare District staff and/or his or her provider that he or she is in need of interpreter services or other assistance because of language or communication barriers.
6. Work with your provider and the District's patient care staff in developing and carrying out agreed upon treatment plans.
7. The patient shall follow Healthcare District rules and regulations affecting patient care and conduct.
8. Fulfill the financial rules and obligations of his or her health care as promptly as possible.
9. Be considerate of the rights or other patients and Healthcare District personnel.

approval

10. The patient shall take responsibility for maximizing health habits, such as exercising, not smoking, and eating a healthy diet.
11. Avoid knowingly spreading disease.
12. Recognize the reality of risks and limits of the science of medical care, and the human fallibility of the health care professional.
13. Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
14. Report wrongdoing and fraud to appropriate resources or legal authorities.

Grievance Instructions for Patients:

Should there be a conflict between the care expectations of the patient (or the care expectations of the parents and/or guardians of neonate, child or adolescent patients); the patient (or patient's representative) should request a care conference by speaking to the physician or NIHD Leader of the department. The conference should involve the patient (and/or the patient's representative) and District staff members involved in the conflict, and should be conducted within 24 hours of the request for the conference.

If those attending the patient care conference cannot resolve the conflict, the patient or the representative should file a grievance verbally or in writing. Presentation of a grievance or complaint will not compromise a patient's access to care. File a grievance in writing or via phone.

To report a grievance, call the Northern Inyo Healthcare District Compliance Department @ (760) 873-2083 or send a written correspondence to NIHD Compliance Officer, 150 Pioneer Lane, Bishop, CA 93514.

The District Compliance and Quality staff will review each grievance and provide the patient with a response in accordance with the Grievance Policy. The written response will contain the name of a person to contact at the Healthcare District, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Refer concerns regarding quality of care or premature discharge to the appropriate utilization review leadership and Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO).

The patient has the right to file a complaint with the California Department of Public Health regardless of whether the Healthcare District's grievance process is used or not.

The State Department of Health Service's phone number and address is **California Department of Health Services, Licensing and Certification**, San Bernardino District Office, 464 West 4th Street, Suite 529, San Bernardino, Ca 92401, phone 909-383-4777 or 800-344-2896.

REFERENCES:

1. 42 CFR §482.13 Patient Rights; 42 CFR §485.608 Conditions of Participation for Critical Access Hospitals.
2. 22 CCR §§70707, 70707.1, 70707.5, and applicable California Health and Safety Code provisions.
3. UNRUH Civil Rights Act – Civil Code Sections 51-53.
4. U.S. Department of Health and Human Services, Office for Civil Rights: Patient Protection and Affordable Care Act (ACA), Section 1557.

approval

5. California Hospital Association Consent Manual, 2026.

CROSS-REFERENCE POLICIES AND PROCEDURES:

1. Management of Discharge Disputes from Medicare Patients
2. Patient Visitation Rights Complaint or Grievance Process for Reporting, Tracking, Investigating and Resolution Discharge Planning for the Hospitalized Patient
3. Advance Directives
4. Service and Therapy Animals and Pets in District Buildings

RECORD RETENTION AND DESTRUCTION:

Maintain all unusual occurrence reports (UOR) at NIHD for 10 years.

Supersedes: v.3 Patient's Rights and Responsibilities

approval

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Standby/Callback		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/10/2026	Last Review Date: No Last Periodic Review Date Set	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/20/2002	

PURPOSE:
To clarify standby/callback pay process.

POLICY:

1. An employee is on standby call whenever the employee is not working his or her regular shift, but is available to be called back to the hospital on an emergency basis.
2. Standby is when an employee is available to her/his department, and when contacted, reports to work per department response time Policy and Procedure. Response time for Standby/Callback for all departments is 30 minutes or the usual commute time of the employee (not to exceed an hour).
3. The hourly Standby rate is paid at $10.00 per hour for each hour the employee is required to be on Standby.
    a. An employee shall not receive Standby pay during time she/he is called back for duty.
    b. When an employee is called upon to report to work during the period of such standby service, she/he shall be guaranteed a minimum of two (2) hours of work for each occasion for which she/he is called in not to exceed the total hours of the standby period.
    c. If the employee is scheduled and still on the clock when the employee is to be on Standby, this will be deemed holdover and no Standby pay shall be paid. Instead, the employee shall be paid standby pay upon clocking out of the holdover.
    d. When standby employees are called back to the hospital to work between 7:00 A.M. and 3:00 P.M., they will be paid at time-and-one-half their hourly "shift 1" pay rate, for each time they are called back.
    e. When standby employees are called back to the hospital to work between 3:00 P.M. and 11:00 P.M., they will be paid at time-and-one-half their hourly "shift 1" pay rate when they clock in at or after 3:00 P.M. and clock out not later than 6:30 P.M. Standby employees are paid a minimum of two hours, at time-and-one-half their hourly "shift 2" rate when they clock in after 3:00 P.M. and clock out after 6:30 P.M.
    f. When standby employees are called back to the hospital to work between 11:00 P.M. and 7:00 A.M., they will be paid at double their hourly "shift 3" rate, for each time they are called back. Because of the shift differential window, standby employees are paid at time-and-one-half their "shift 1" rate when they clock in at, or any time after, 6:00 A.M.
    g. Time worked beyond the two-hour minimum by standby employees during standby time will be paid at the appropriate aforementioned time-and-one-half or double-time rates. Standby employees are expected to swipe out immediately upon the completion of their work.

approval

h. A new standby call period begins when the employee swipes out with the expectation of not immediately returning to work.

4. An employee who is not on Standby and is called in to work will receive One Time Callback pay in the amount of $27.50 in lieu of Standby pay.
5. All non-exempt employees who are on Standby or receive One Time Callback and are called into work shall receive Call-back pay.
    a. Call back pay begins at the time the employee arrives at work and swipes into timeclock.
    b. When the employee is called back to the hospital to work between 7:00 A.M. and 3:00 P.M., the employee will be paid a minimum of two hours, at time-and-one-half his or her hourly "shift 1" pay rate, for each call back.
    c. When the employee is called back to the hospital to work between 3:00 P.M. and 11:00 P.M., the employee will be paid a minimum of two hours, at time-and-one-half his or her hourly "shift 1" rate when the employee clocks in at or after 3:00 P.M. and clocks out not later than 6:30 P.M. The employee will be paid a minimum of two hours, at time-and-one-half his or her hourly "shift 2" rate when the employee clocks in after 3:00 P.M. and clocks out after 6:30 P.M.
    d. When the employee is called back to the hospital to work between 11:00 P.M. and 7:00 A.M., the employee will be paid a minimum of two hours, at double his or her hourly "shift 3" rate, for each call back. Because of the shift differential window, the called back employee is paid a minimum of two hours, at time-and-one half his or her hourly "shift 1" rate when the employee clocks in at, or any time after, 6:00 A.M.
    e. Time worked beyond the two hours minimum by these called back employees will be paid at the appropriate aforementioned time-and-one-half or double-time rates.

REFERENCE:

1. Fair Labor Standards Act (FLSA) https://www.dol.gov/agencies/whd/flsa#:~:text=The%20Fair%20Labor%20Standards%20Act%20(FLSA)%20establishes%20minimum%20wage%2C,%2C%20State%2C%20and%20local%20governments.
2. Memorandum of Understanding Northern Inyo Healthcare District and District Council 57, American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO.

RECORD RETENTION AND DESTRUCTION:

Human Resource records are maintained life of employment plus six years
Payroll records maintained: Employees not entitled to pension: 15 years Employees entitled to pension: life of employment plus six years

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Personnel Classifications
2. Payroll Policies and Guidelines

Supersedes: v.2 Standby/Callback

approval

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

DATE: November 3, 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Anne Wakamiya, MD, Vice Chief of Staff

RE: Consideration of Credentialing Actions recommended by the Medical Executive Committee

MEMORANDUM

Recommendations

The Medical Executive Committee met on November 3, 2026 and recommended that the Board of Directors approve the following Medical Staff Appointments and Privileges:

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

1. Giorgi Berulava, MD (*pathology*) – Active Staff
2. Quintin Fender, MD (*diagnostic radiology*) - Telemedicine Staff (GTR)

B. Additional Privileges (*action item*)

1. Stacey Brown, MD (*family medicine*) – recommendation to grant privilege for Botox for migraines
2. Adam Jesionek, MD (*internal medicine*) – recommendation to grant privileges for patient care in the Medication Assisted Treatment program

C. Medical Staff Reappointments 2027-2028 (*action item*)

1. Abhilash Akinapelli, MD (*cardiovascular disease*) — Telehealth Staff
2. Robbin Cromer-Tyler, MD (*general surgery*) — Active Staff
3. Allison Robinson, MD (*general surgery*) — Active Staff
4. Stefan Schunk, MD (*internal medicine*) — Active Staff
5. Michael Karch, MD (*orthopaedic surgery*) — Active Staff
6. Tyler Williamson, MD (*orthopaedic surgery*) — Active Staff
7. Stephen Knecht, MD (*orthopaedic surgery*) — Active Staff
8. David Hackley, MD (*orthopaedic surgery*) — Courtesy Staff
9. Anne Gasior, MD (*family medicine*) — Active Staff
10. Mike Khieu, MD (*cardiovascular disease*) — Telehealth Staff
11. Anita Kedia, MD (*cardiovascular disease*) — Telehealth Staff
12. Katrinka Kip, MD (*pediatric cardiology*) — Telehealth Staff
13. Heather Lee, DO (*pediatrics*) — Courtesy Staff
14. Michael Doyle, MD (*pediatrics*) — Courtesy Staff
15. Grace Kim, MD (*pediatrics*) — Courtesy Staff

AMENDMENT NO. 1 TO EMPLOYMENT AGREEMENT FOR

CHIEF EXECUTIVE OFFICER

This Amendment No. 1 to EMPLOYMENT AGREEMENT is made as of this 18th day of November 2026, by and between CHRISTIAN T. WALLIS ("WALLIS") and NORTHERN INYO HEALTHCARE DISTRICT ("DISTRICT").

RECITALS

A. DISTRICT is a Local Healthcare District duly organized and existing under the laws of the State of California and more specifically pursuant to the provision of Health and Safety Code *§§ 32000*, et seq. known as the Local Healthcare District Law.

B. DISTRICT owns and operates NORTHERN INYO HOSPITAL ("HOSPITAL"), an acute care licensed hospital facility, a Rural Health Clinic (1206(d)), and multiple 1206(b) clinics, all located in Bishop, California.

C. The DISTRICT desires to amend the October 2025 Employment Agreement between WALLIS and the DISTRICT pursuant to the terms and provisions of this Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL COVENANTS AND CONDITIONS CONTAINED HEREIN, THE PARTIES AGREE AS FOLLOWS:

AMENDMENT NO. 1 TO EMPLOYMENT AGREEMENT

Except as specifically provided below, all provisions of the October 2025 Employment Agreement remain unchanged.

Section 3 of the October 2025 Employment Agreement shall be replaced as follows

3. Place of Employment

Performance of services under this Agreement shall be rendered in the City of Bishop and the County of Inyo and within the boundaries of the DISTRICT (including satellite offices and facilities), subject to necessary travel requirements for the position and duties described herein. Notwithstanding this expectation, WALLIS shall use his best judgment and retains discretion to perform his duties remotely so long as the best interests of the District are not compromised.

Section 6.3 of the October 2025 Employment Agreement shall be replaced with the following:

6.3 Paid Time Off/Holidays/Additional Leave Time. WALLIS shall be entitled to Paid Time Off ("PTO") as described in DISTRICTS's PTO policy at Level 3. This new PTO accrual rate shall be effective August 9, 2026.

IN WITNESS WHEREOF, this Agreement is executed as of the day and year first above written.

NORTHERN INYO HEALTHCARE DISTRICT

By _____
Melissa Best-Baker, Board Chair
Board of Directors

CHRISTIAN WALLIS

_____
CHRISTIAN WALLIS, DHA, MBA, FACHE

NORTHERN INYO HEALTHCARE DISTRICT

Quarterly Compliance Report

NOVEMBER 2026 | BOARD OF DIRECTORS

Presented to the Governance Committee for review and recommendation to the full Board of Directors.

BOARD EDUCATION | HOW EFFECTIVE OVERSIGHT WORKS

Identifying a Risk Is Only the Beginning

Compliance independently identifies and assesses risks. Operational leaders own improvements. The Board oversees whether risks are being reduced and corrective actions work.

RESPONSIBILITY AT EACH STEP Compliance Operations Shared

Color bands and right-hand labels show who is responsible for each action.

1 Identify and Monitor — COMPLIANCE

Audits, investigations, and regulatory developments reveal emerging risks.

2 Assess and Communicate — COMPLIANCE

Compliance evaluates findings and informs leaders of significant risks.

3 Implement Improvements — OPERATIONS

Operational leaders own the response, resources, and corrective action.

4 Independently Validate — COMPLIANCE

Compliance independently tests whether corrective actions are effective.

5 Resolve or Follow Up — OPERATIONS / COMPLIANCE

Operations sustain improvements; Compliance verifies results and escalates.

WHY IT MATTERS

A completed task does not establish effective risk reduction. Meaningful Board oversight focuses on results, unresolved exposure, and whether improvements remain effective over time.

Reference: U.S. Department of Health and Human Services, Office of Inspector General, General Compliance Program Guidance (2023).

NORTHERN INYO HEALTHCARE DISTRICT

2026 Compliance Workplan Progress

FIVE ORGANIZATIONAL IMPROVEMENT PRIORITIES

The Board approved five Compliance Workplan priorities in September 2026. This update highlights progress, remaining barriers, and validation of those priorities.

Completed | In Progress | Barrier | Not Started

1 Restore Formal Compliance Oversight

The Compliance and Business Ethics Committee reconvened October 15, 2026. Establishing a consistent cadence and follow-up remains the next step.

2 Strengthen Corrective Action Accountability

Centralized tracking is operational and reviewed at least monthly. Independent validation of completed actions remains an ongoing focus.

3 Reduce Vendor and Patient Information Risks

Reviews of vendor privacy agreements, high-risk contracts, release-of-information processes, and access permissions continue.

4 Prepare Policies Before Changing Systems

The formal system evaluation is proposed for 2027 because of operational capacity. Leaders are updating policy consistency and regulatory accuracy now.

5 Formalize Risk-Based Compliance Monitoring

Targeted audits continue, but the consolidated 2026 compliance risk assessment has not been completed. Security assessment information is outstanding.

Corrective Action Monitoring

IMPLEMENTATION, VALIDATION, AND ACCOUNTABILITY

Corrective Action Plans (CAPs) identify the response, responsible owner, and evidence needed to resolve identified concerns. Compliance reviews the centralized tracker at least monthly. Selected plans are shown by tracker number.

Closed Pending Validation In Progress

Pending Validation: Testing whether implemented corrections work and are sustainable.

Restore Formal Compliance Committee Oversight — 01

The committee reconvened in October; ongoing governance processes await validation.

Centralized Corrective Action Tracking — 02

Centralized monitoring is operational and reviewed at least monthly.

Information Security Risk Assessment Follow-Up — 05

Cybersecurity documentation remains outstanding; Information Technology is following up.

Vendor Privacy and Security Safeguards — 08

Review of vendor agreements, privacy safeguards, and access relationships continues.

Public Access to Hospital Pricing Information — 09

Website corrections were implemented; external validation remains pending.

Patient Financial Assistance and Fair Billing — 10

Policies and patient-facing materials are being updated for regulatory requirements.

Allergy Clinic Billing and Coding Accuracy — 11

Claims review and corrective work continue following identified coding concerns.

Timely Initial Complaint Response Letters — 13

Compliance is monitoring whether improved response timeliness is sustained.

Secure File Sharing and Account Access — 23

Account authorization, former-user access, and safeguards remain under review.

Regulatory and Compliance Developments

SIGNIFICANT OBLIGATIONS AND EMERGING ISSUES

These updates describe material requirements and emerging exposure, rather than repeating corrective-action counts.

Progressing Pending Validation External Dependency

Patient Financial Assistance and Fair Billing

California patient financial assistance and fair billing obligations affect eligibility, required patient notices, and collection practices. Policies and patient-facing materials are being updated, including preparation for additional 2027 requirements.

Public Availability of Hospital Pricing

Federal price transparency requirements call for accessible and accurate pricing information. Corrections to the online estimator and machine-readable file are implemented; regulatory confirmation remains outstanding.

Annual Information Security Risk Analysis

The 2026 assessment is due in November. CyberMaxx documentation remains outstanding despite requests; Information Technology follow-up is underway. Recent vulnerability findings also inform risk evaluation.

Public Records and Language Access

Compliance continues coordinating California Public Records Act (CPRA) requests and monitoring interpreter services. These ongoing public-access and patient-rights obligations require sustained attention, not a separate workplan completion claim.

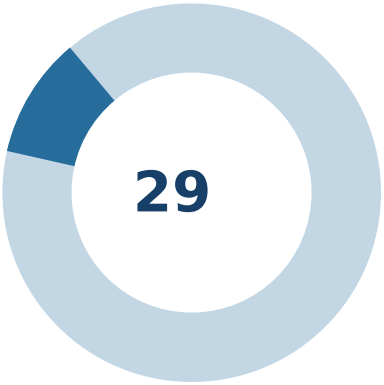
NORTHERN INYO HEALTHCARE DISTRICT

Privacy Investigations

2026 INTERNAL DETERMINATIONS | HISTORICAL REGULATORY OVERSIGHT

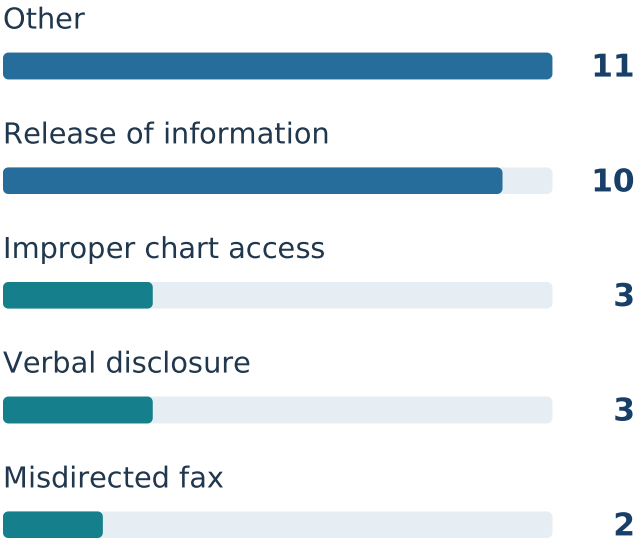
District investigations determine whether notification is required. California Department of Public Health (CDPH) review status is presented separately.

Regulatory Reporting Determinations | 2026



- Reportable: 3 (10.3%)
- Not reportable: 26 (89.7%)

Types of Privacy Concerns



HISTORICAL EXTERNAL REGULATORY OVERSIGHT | 2023–2026

17 privacy-related reports to the California Department of Public Health (CDPH) across 2023–2026; these are not 17 new reports in 2026.



12 closed **5 in progress**

Five previously reported cases remain under CDPH review, with potential regulatory exposure. These are CDPH review statuses, not unresolved internal investigations.

Source: CDPH CalHEART

Recent CDPH determination

CDPH closed the Release of Information investigation involving multiple privacy breaches. The breaches were substantiated, but CDPH cited no deficiencies.

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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: Appointment of New Bond Trustee and Paying Agent

MEMORANDUM

Background

The District currently has four outstanding series of bonds for which Bank of New York Mellon Corporation (BNY) is serving as Trustee and/or Paying Agent. These include the 2009 General Obligation Bonds, and 2016 General Obligation Refunding Bonds for which it serves as Paying Agent and the 2021 Series A and Series B Revenue Refunding Bonds for which it serves as Trustee. The Trustee/Paying Agent is appointed by the District and serves as a fiduciary to bond holders, ensuring compliance with Districts fiduciary duties and bond covenants, managing bond registration and managing debt service payments. The Trustee/Paying Agent can be replaced at the election of the District.

District staff have experienced difficulties during the last few years with BNY and sought a proposal from US Bank to provide the services. There are very limited options for banks that are qualified and eligible to provide these services and US Bank provides the service to many hospital districts throughout California.

Some of the key steps in the process to replace the Trustee/Paying agent are as follows:

- The District must send a removal notification letter no later than 30 days prior to the desired effective date of the transfer to the new Trustee/Paying Agent and copy the bondholders for the private placement debts which include the 2021 Bonds and the 2016 Bonds;
- The 2009 Bonds are publicly issued bonds held through DTC FAST, BNY and US Bank will need to notify DTC no later than 10 days prior to the effective date (10 day prior rule per SEC Rule 17ad-16). This is referred to as the CUSIP “swing” notification.
- It is anticipated that BNY will require the District and US Bank to execute a Tri-Party Agreement(s) to document the effective date transfer. There is typically one agreement for the bond issues for which they serve as Trustee and one agreement for the issues for which they serve as Paying Agent.
- US Bank will assist with the preparation of the notification letter and the Tri-Party Agreements to facilitate the change.

To serve as Trustee for the 2021 Bonds US Bank would charge a flat fee of $2,500 per year, per indenture. There is one indenture for the two series of 2021 Bonds so the total would be $2,500 per year.

To serve as Paying Agent for the 2009 Bonds and 2016 Bonds, US Bank would charge a flat fee of $800 per year per issue, for a total of $1,600 per year.

If approved, it is anticipated that the transition would take approximately two months to implement after notification letters are sent. If notices are sent in December, completion could occur in February. This timeframe would work well with the debt service schedules for the existing bonds which have payments due on the first of June and December for the 2021 Bonds and the first of May and November for the 2009 Bonds and 2016 Bonds.

Fiscal Impact
There would be an annual cost of $4,100 for all four bond issues payable in advance. All initial set up fees would be waived.

Recommendation
Staff recommends that the Board of Directors approve and authorize the Chief Executive Officer to proceed with the process of appointing US Bank Trust Company, N.A. as Trustee for the Districts existing general obligation and revenue bonds, replacing the existing Trustee, the Bank of New York Mellon Corporation.

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

DATE: November 2026

TO: Finance Committee, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: Psychological Services Consultation Agreement

MEMORANDUM

Background

The proposed agreement engages Action Potential Psychological Services, Inc., through Jacob Eide, Psy.D., to evaluate NIHD's existing behavioral health services, recommend program improvements, and develop a long-term strategy for integrated behavioral health care.

Discussion

The proposed services include three phases:

1. **Program Evaluation:** Assess existing behavioral health services, regulatory considerations, treatment practices, outcomes, and the Medication-Assisted Treatment (MAT) program. A written report will provide findings and recommendations.
2. **Implementation Support:** Provide consultation, staff training, workflow development, and recommendations for program improvement.
3. **Strategic Development:** Develop a multiyear plan for integrated behavioral health, including Primary Care Behavioral Health, Collaborative Care, outpatient therapy, and proposed staffing expansion.

Recommendation

It is recommended that the board consider approval of the Consulting Services Agreement with Action Potential Psychological Services, Inc. for behavioral health program evaluation, implementation support, and strategic development. The proposed agreement would be for a one-year term at a rate of $175/hour, not to exceed $175,000, subject to confirmation of the effective date and expense limitations.

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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, CEO

RE: Proposed Radiology Services Agreement – Bristlecone Pine Radiology

MEMORANDUM

Background
Northern Inyo Healthcare District is pursuing a new radiology services agreement with Bristlecone Pine Radiology P.C. (BCPR) to replace its current radiology services provider. The proposed agreement is intended to provide continued radiology coverage, including on-site and remote interpretation services, while establishing defined service expectations and performance standards.

Discussion
The proposed agreement would engage BCPR to provide radiology coverage and administrative services for an initial three-year term, with an option to renew for one additional year upon mutual written agreement. The anticipated start date is May 2027, subject to completion of the contract and transition requirements.

Under the proposed agreement, BCPR would provide on-site radiologist coverage for 26 weeks annually, and remote radiology interpretation services 24 hours per day, seven days per week. Services would include diagnostic imaging interpretations, designated radiology procedures, physician consultations, and radiology medical leadership responsibilities. The agreement would also establish performance standards for report turnaround times, quality assurance, and subspecialty interpretations.

The proposed agreement also includes a $100,000 advance payment to BCPR to assist with upfront implementation expenses, including physician licensing, hospital credentialing, legal and insurance expenses, technology setup, and travel. The advance would be paid within 10 business days following execution of the definitive agreement and recovered through deductions from BCPR's monthly compensation payments after services commence. The advance would not increase the total annual guaranteed compensation of $2,400,000.

Recommendation
Staff recommends that the Board of Directors approve the transition of radiology services to Bristlecone Pine Radiology P.C. and authorize the District to enter into a three-year agreement with an annual guaranteed compensation of $2,400,000, for a total guaranteed contract amount of $7,200,000 over the initial term, including a $100,000 advance against the guaranteed compensation for implementation expenses, subject to final contract negotiations and required approvals.

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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, Chief Executive Officer

RE: Women's Health Collaboration Agreement between Northern Inyo Healthcare District and Mammoth Hospital

MEMORANDUM

RECCOMENDATION
We formally request that the Board of Directors of Northern Inyo Healthcare District approve the proposed Women's Health Collaboration Agreement between Northern Inyo Healthcare District (NIHD) and Mammoth Hospital, effective immediately.

BACKGROUND & CLINICAL NEED
Both Mammoth Hospital and Northern Inyo Hospital operate as Critical Access Hospitals in geographically isolated, mountainous regions. Delivering comprehensive women's healthcare, particularly inpatient obstetric (OB) and labor and delivery (L&D) services, is increasingly challenging for rural facilities nationwide due to workforce shortages, low patient volumes, and the high fixed costs of maintaining 24/7 OB readiness.

Currently, Mammoth Hospital does not have the patient volume required to sustain an independent inpatient OB unit or L&D services. Consequently, expectant mothers in Mono County rely heavily on NIHD for obstetric delivery and inpatient care. While NIHD maintains a robust inpatient OB program, a newborn nursery, and 24/7 on-call OB coverage, operating these services requires a substantial financial commitment that NIHD currently sustains at a loss to protect regional access.

THE COLLABORATIVE SOLUTION
To ensure safe, continuous, and high-quality care for expectant mothers across the Eastern Sierra, our organizations have developed an integrated regional women's health service line. It is neither practical nor fiscally responsible for each District to independently recruit and duplicate expensive 24/7 OB resources. Instead, this agreement allows us to share the incremental costs of sustaining a single, robust regional OB program.

Key Components of the Agreement:

1. Regional Obstetric Readiness: NIHD commits to maintaining inpatient L&D services, a newborn nursery, 24/7 on-call OB provider coverage, and necessary anesthesia and pediatric support. These services will be available to Mammoth's service area residents on the exact same basis as NIHD's local patients.
   2. Financial Cost-Sharing: In consideration of the services and readiness provided by NIHD, Mammoth Hospital will pay an annual compensation of $356,000 (paid in quarterly installments of

$89,000). This figure is based on fair market value and NIHD's documented Medicare cost report data for maintaining OB readiness.

(Note: Outpatient women's health provider coverage at Mammoth is handled under separate Clinic Agreements, ensuring complete continuity of care from outpatient prenatal visits in Mammoth to inpatient delivery in Bishop).

CONCLUSION

This collaboration represents a forward-thinking, fiscally responsible approach to rural healthcare. By pooling our limited resources and integrating our clinical workflows, we can secure the future of obstetric care in the Eastern Sierra. We are proud to present this joint initiative and strongly recommend the Board's approval of the Women's Health Collaboration Agreement to ensure the mothers and families of Mono and Inyo counties continue to receive the exceptional care they deserve.

Northern Inyo Healthcare District

Chief Financial Officer Report

FY 2027 First-Quarter Financial and Operational Report

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

Executive Summary

Northern Inyo Healthcare District completed the first quarter of FY2027 with net income approximately $171,000 favorable to budget, demonstrating financial resilience despite significant expense pressures and an unfavorable Medi-Cal reimbursement adjustment in September.

For the first quarter, net revenue was $1.9 million, or 6%, above budget, reflecting continued strength in patient volumes and strategic service-line growth. Operating expenses were $1.7 million, or 5%, above budget, primarily driven by increased medical, dental, and vision (MDV) claims under the District's self-funded benefit plan, higher professional fees, and increased supply costs. Despite these expense pressures, the District reported an operating loss of approximately $2.5 million, which was $186,000 favorable to budget.

Compared with the first quarter of FY 2026, net income improved by approximately $5.6 million, while operating performance improved by approximately $3.4 million. Net revenue increased by approximately $335,000 compared with the prior year, while expenses increased 15%.

September presented a significant financial challenge, with a net loss of approximately $653,000 and an unfavorable variance of approximately $1.2 million compared with budget. The primary driver was a Medi-Cal rate adjustment, including approximately $600,000 associated with prior-month accounts receivable. The adjustment resulted in net revenue finishing $241,000, or 2%, below budget for the month. An unfavorable payer mix, including a 3.7 percentage-point decline in Blue Cross & Commercial volume, further affected reimbursement performance, partially offset by increased Medicare volume.

Operationally, patient activity remained encouraging. First-quarter volumes exceeded budget in inpatient days, NIA clinics, diagnostic imaging, Emergency Department visits, rehabilitation, and outpatient infusions and wound care. Surgical volume remained below budget, primarily due to general surgery, while Rural Health Clinic visits continued to be affected by provider turnover in primary care.

The District ended the quarter with 97 days cash on hand, a cash balance of $34.6 million, and a debt service coverage ratio of 3.08. Cash decreased approximately $5 million during the quarter, primarily due to timing differences associated with Intergovernmental Transfers (IGT), accrued expenses, and the timing of cash receipts compared with cash disbursements.

Overall, the District enters the remainder of FY 2027 with favorable cumulative financial performance compared with budget, strong patient demand across several strategic service lines, and a solid liquidity position. Management's focus will be on sustaining revenue growth, managing self-funded benefit costs, improving labor productivity, controlling professional and supply expenses, and maintaining disciplined cash management.

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1. First-Quarter Financial Performance

The District finished Q1 FY 2027 approximately $171,000 favorable to budget on net income.

Financial Measure	Q1 FY2027 Performance
Net Income	$171,000 favorable to budget
Operating Income (Loss)	$(2.5) million
Operating Income Variance	$186,000 favorable to budget
Net Revenue vs. Budget	$1.9 million favorable / 6%
Expenses vs. Budget	$1.7 million unfavorable / 5%
Net Income Improvement vs. Prior Year	$5.6 million
Operating Improvement vs. Prior Year	$3.4 million
Net Revenue vs. Prior Year	Approximately $335,000 higher
Expenses vs. Prior Year	15% higher

The District's favorable net income performance reflects strong revenue generation and continued improvement in operating results, despite expenses exceeding budget.

Net revenue exceeded budget by $1.9 million, or 6%, reflecting favorable patient volumes and service-line activity. This revenue growth was partially offset by operating expenses exceeding budget by $1.7 million, or 5%.

Compared with the prior year, operating performance improved substantially, with operating results approximately $3.4 million better than the first quarter of FY 2026.

Board takeaway: The District remains slightly ahead of its FY 2027 net income budget, with meaningful improvement over the prior year. Maintaining this favorable position will require

continued revenue growth and a stronger focus on managing the expense pressures associated with increased patient activity and employee benefit costs.

2. September Financial Performance

September was a challenging month financially, with results significantly impacted by a Medi-Cal reimbursement adjustment.

The District experienced an unfavorable financial variance of approximately $1.2 million compared with budget, with a net loss of approximately $653,000.

The primary driver was a Medi-Cal rate adjustment, including approximately $600,000 related to prior-month accounts receivable. Net revenue finished $241,000, or 2%, below budget as a result of the reimbursement true-up.

Payer mix was also unfavorable, with Blue Cross & Commercial volume 3.7 percentage points below budget, partially offset by increased Medicare volume.

Expense pressures further contributed to the unfavorable monthly results, particularly medical, dental, and vision claims and supply costs.

September operating expenses were approximately $1 million, or 10%, above budget. The largest unfavorable expense variances included:

- **Medical, Dental, and Vision:** $669,000 above budget, contributing to salary, wages, and benefits finishing $585,000 above budget.
- **Supplies:** $548,000 above budget, primarily due to pharmacy supplies, which also contributed to higher-than-budgeted revenue.

Despite September's unfavorable results, the District maintained a favorable cumulative net income position for the first quarter.

3. Revenue and Payer Mix Performance

Revenue performance for the first quarter remained strong overall.

Q1 net revenue exceeded budget by approximately $1.9 million, or 6%, supported by increased patient activity across several key service lines.

Payer mix was favorable for the quarter, with Blue Cross & Commercial volume 1.5 percentage points above budget, offset by a decrease in Medicare volume.

September experienced a reversal in this trend, with Blue Cross & Commercial volume 3.7 percentage points below budget, partially offset by Medicare.

The Medi-Cal rate adjustment also created a significant reimbursement impact in September, including approximately $600,000 associated with prior-month accounts receivable.

Management will continue monitoring payer mix, reimbursement trends, contractual allowances, coding, denials, and collections to ensure that volume growth translates into sustainable net revenue improvement.

Quarterly Revenue Priorities:

- Maintain growth in strategic service lines.
- Monitor reimbursement changes and payer mix trends.
- Strengthen coding and documentation accuracy.
- Improve denial prevention and collections.
- Monitor Medi-Cal reimbursement and rate adjustments.
- Improve cash conversion and revenue cycle performance.

4. Volume and Operational Performance

Patient volumes remained strong throughout the first quarter, with several key service lines exceeding budget.

Q1 FY 2027 Volume Performance

Service Metric	Q1 Performance vs. Budget
Admissions	8 admissions / 3% below budget
Inpatient Days	60 days above budget
Rural Health Clinic Visits	320 visits / 4% below budget
NIA Clinic Visits	222 visits / 4% above budget
Surgical Cases	40 cases / 9% below budget
Diagnostic Imaging Exams	7% above budget
Emergency Department Visits	11% above budget
Rehabilitation Visits	11% above budget
Outpatient Infusions and Wound Care	42% above budget

Operational performance reflects continued strength in outpatient services and increased utilization across several strategic service lines.

Inpatient admissions were slightly below budget, while inpatient days exceeded budget, suggesting increased utilization among admitted patients.

NIA clinic volumes exceeded budget, primarily due to growth in specialty and orthopedic services. Rural Health Clinic volumes remained below budget as a result of provider turnover in primary care.

Surgical volume remained below budget, primarily due to general surgery. Management will continue evaluating provider availability, scheduling, and opportunities to improve operating room utilization.

Diagnostic imaging, Emergency Department, rehabilitation, and outpatient infusion and wound care volumes continued to demonstrate favorable growth.

Board takeaway: Patient demand remains a significant strength for the District. Growth in outpatient services, specialty clinics, diagnostic imaging, Emergency Department, rehabilitation, and infusion services provides opportunities to improve financial performance. Continued attention to primary care provider recruitment and surgical capacity will be important to realizing additional growth.

September Operational Performance

September volumes reflected a mixed performance across service lines.

Service Metric	September Performance
Admissions	2 admissions / 2% below budget
Inpatient Days	57 days / 31% above budget
Rural Health Clinic Visits	59 visits / 2% below budget
NIA Clinic Visits	125 visits / 7% above budget
Surgical Cases	37 cases / 23% below budget
Diagnostic Imaging Exams	4% above budget
Emergency Department Visits	14% above budget
Rehabilitation Visits	135 visits above budget
Outpatient Infusions and Wound Care	29% above budget

NIA clinic growth was driven by orthopedic, pediatric, and specialty services. Rural Health Clinic volumes continued to be impacted by primary care provider availability.

Surgical cases were below budget, primarily due to lower general surgery and orthopedic volumes.

Emergency Department, diagnostic imaging, rehabilitation, and outpatient infusions and wound care continued to demonstrate favorable patient activity.

5. Expense Performance

Expense management remains one of the District's most significant challenges entering the remainder of FY 2027.

For the first quarter, operating expenses were approximately $1.7 million, or 5%, above budget.

The primary driver was increased medical, dental, and vision claims under the District's self-funded employee benefit plan.

Q1 Expense Variances

- **Medical, Dental, and Vision:** Claims were approximately $1.2 million above budget, contributing significantly to the unfavorable salary, wages, and benefits variance.
- **Salaries, Wages, and Benefits:** 7% above budget, primarily driven by increased employee benefit claims.
- **Professional Fees:** Approximately $325,000 above budget, primarily due to higher legal expenses and consulting costs.
- **Supplies:** Approximately $460,000 above budget, largely driven by pharmacy expenses, partially offset by higher associated patient revenue.

While increased supplies and pharmacy costs are associated with higher patient activity and revenue, management will continue evaluating utilization, purchasing practices, and contribution margins.

September Expense Performance

September operating expenses were approximately $1 million, or 10%, above budget.

The largest unfavorable expense variances included:

- **Medical, Dental, and Vision:** $669,000 above budget, contributing to salary, wages, and benefits finishing $585,000 above budget.
- **Supplies:** $548,000 above budget, primarily due to pharmacy supplies, which also contributed to higher-than-budgeted revenue.

The increase in benefit claims continues to be a significant financial pressure for the District.

Board takeaway: The District's primary expense challenge is the volatility of self-funded employee benefit claims. Management will continue monitoring claims trends, evaluating benefit plan performance, and identifying opportunities to improve expense predictability. Additional attention will be directed toward professional fees, consulting, legal expenses, and pharmacy utilization.

6. Labor and Workforce Management

Labor and benefit costs remain a key focus for FY 2027.

Salary, wages, and benefits were 7% above budget for the first quarter, primarily due to $1.2 million in unfavorable medical, dental, and vision claims.

Although these benefit costs are a significant component of the District's labor expense, management must continue to balance workforce needs, employee retention, and appropriate staffing levels with the District's financial objectives.

The District's priorities include:

- Monitoring self-funded medical, dental, and vision claims.
- Improving workforce productivity and staffing efficiency.
- Reducing reliance on contract and agency labor.
- Aligning staffing with patient volumes and operational demand.
- Strengthening recruitment and retention in areas with persistent staffing needs.
- Monitoring overtime, premium pay, and departmental labor utilization.

Management will continue to evaluate both direct labor costs and employee benefit expenses to identify sustainable opportunities for improvement.

7. Cash, Liquidity, and Debt Service Coverage

The District ended the first quarter of FY 2027 with a cash balance of $34.6 million, 97 days cash on hand, and a debt service coverage ratio of 3.08.

Cash decreased approximately $5 million during the quarter. The decline was primarily driven by timing differences associated with Intergovernmental Transfers (IGT), accrued expenses, and the timing of cash receipts compared with cash disbursements.

While the reduction in cash is an important trend to monitor, the primary drivers reflect timing differences between recognized expenses and actual cash inflows and outflows. Management will continue monitoring these fluctuations closely, particularly as IGT receipts and other cash collections are realized.

Quarter-End Liquidity Indicators

Measure	September 30, 2026
Days Cash on Hand	97 days
Cash Balance	$34.6 million
Change in Cash During Quarter	$(5.0) million
Debt Service Coverage Ratio	3.08

The District continues to maintain a meaningful liquidity position, although the decline in cash reinforces the importance of maintaining disciplined cash management and closely monitoring the timing of IGT receipts, accrued liabilities, and operating cash flows.

Revenue cycle performance also demonstrated continued improvement during the quarter:

- Accounts receivable days increased by 5 days compared with September 2025.

- Bad debt and write-offs improved by $$3.6M compared with September 2025.
- Accounts receivable over 90 days increased by $3.5M compared with September 2025.

Board takeaway: The District ended Q1 with 97 days cash on hand, $34.6 million in cash, and a debt service coverage ratio of 3.08. Although cash declined by approximately $5 million during the quarter, the decrease was primarily attributable to timing differences involving IGT and accrued expenses compared with cash receipts. Management will continue to prioritize cash flow forecasting, timely collections, and liquidity management to preserve the District's financial flexibility.

8. Strategic Priorities for the Remainder of FY 2027

Management will maintain focus on the following priorities:

1. **Strategic Service-Line Growth:** Continue expanding orthopedic, urology, and general surgery programs while supporting growth in specialty clinics, rehabilitation, diagnostic imaging, and outpatient services.
2. **Operational Efficiency:** Optimize operating room utilization, improve clinic scheduling, and maximize existing capacity.
3. **Revenue Cycle Improvement:** Strengthen coding, denials management, collections, and reimbursement accuracy.
4. **Workforce Productivity:** Improve labor efficiency, reduce reliance on contract staffing, and align staffing with patient demand.
5. **Employee Benefit Cost Management:** Monitor self-funded MDV claims, evaluate utilization trends, and identify opportunities to improve benefit cost predictability.
6. **Supply Chain Management:** Address supply cost increases through standardization, utilization management, and purchasing initiatives.
7. **Professional Fee Management:** Review legal, consulting, and other professional service expenses to ensure appropriate utilization and accountability.
8. **Financial Sustainability:** Maintain expense discipline while supporting strategic investments and service-line growth.
9. **Liquidity Preservation:** Protect the District's financial flexibility through improved operating performance and continued cash generation.

9. Management Outlook

The first quarter of FY 2027 demonstrates that Northern Inyo Healthcare District continues to make progress toward improved financial performance.

Net income finished approximately $171,000 favorable to budget, and operating results were $186,000 better than budget. Net revenue growth of 6% reflects continued strength in patient demand and strategic service-line activity.

However, the District continues to face meaningful expense pressures. Self-funded medical, dental, and vision claims represent the largest unfavorable expense variance, while professional fees and supplies also remain areas requiring attention.

The September Medi-Cal rate adjustment highlights the importance of monitoring reimbursement changes and maintaining appropriate revenue recognition and accounts receivable processes.

The $5 million reduction in cash during the first quarter also reinforces the importance of closely monitoring operating cash flow and the timing of IGT receipts and accrued expenditures. Although the District maintains 97 days cash on hand and a debt service coverage ratio of 3.08, continued attention to liquidity will remain important.

For the remainder of FY 2027, management will focus on sustaining revenue growth while improving expense performance, strengthening operational productivity, and maintaining financial flexibility.

Conclusion

Northern Inyo Healthcare District completed the first quarter of FY 2027 slightly ahead of its net income budget, with operating results also favorable to budget and significant improvement compared with the prior year.

Strong patient volumes across outpatient services, diagnostic imaging, Emergency Department, rehabilitation, and specialty clinics continue to provide opportunities for sustainable growth. At the same time, the District must address ongoing challenges in surgical volumes, primary care provider availability, self-funded employee benefit costs, professional fees, and pharmacy expenses.

The District's financial position remains encouraging, supported by favorable revenue performance, improved operating results, 97 days cash on hand, and a debt service coverage ratio of 3.08.

Management's focus for the remainder of FY 2027 will be on converting patient volume growth into sustainable financial improvement, managing expense pressures, improving operational efficiency, and preserving the financial resources necessary to support the District's mission of providing high-quality healthcare services to the communities it serves.

Northern Inyo Healthcare District

September 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Net Income (Loss)	(652,782)	562,871	(1,215,653)	(216%)	(1,638,349)	985,567	60%	987,970	817,106	170,864	(21%)	(4,633,774)	5,621,744	(121%)
Operating Income (Loss)	(1,846,475)	(565,885)	(1,280,589)	226%	(2,099,033)	252,558	12%	(2,466,378)	(2,652,721)	186,343	7%	(5,899,651)	3,433,273	(58%)
EBIDA (Loss)	(165,606)	996,476	(1,162,082)	(117%)	(1,211,521)	1,045,915	86%	2,476,481	2,132,680	343,801	(16%)	(3,339,764)	5,816,245	(174%)
IP Gross Revenue	4,851,961	4,138,097	713,864	17%	3,114,655	1,737,307	56%	13,673,159	12,367,377	1,305,782	11%	10,041,903	3,631,256	36%
OP Gross Revenue	16,308,661	15,788,588	520,073	3%	14,794,416	1,514,245	10%	51,024,804	46,238,923	4,785,881	10%	41,898,398	9,126,406	22%
Clinic Gross Revenue	2,208,042	1,949,481	258,560	13%	1,926,649	281,392	15%	6,032,269	5,861,709	170,560	3%	5,658,569	373,700	7%
Total Gross Revenue	**23,368,664**	**21,876,166**	**1,492,498**	**7%**	**19,835,720**	**3,532,944**	**18%**	**70,730,232**	**64,468,010**	**6,262,223**	**10%**	**57,598,871**	**13,131,361**	**23%**
Net Patient Revenue	**9,935,277**	**10,176,304**	**(241,027)**	**(2%)**	**7,929,361**	**2,005,916**	**25%**	**31,882,132**	**29,990,389**	**1,891,743**	**6%**	**23,971,395**	**7,910,738**	**33%**
Cash Net Revenue % of Gross	*43%*	*47%*	*(4%)*	*(9%)*	*40%*	*3%*	*6%*	*45%*	*47%*	*(1%)*	*(3%)*	*42%*	*3%*	*8%*
Admits (excl. Nursery)	85	87	(2)	(2%)	65	20	31%	250	258	(8)	(3%)	193	57	30%
IP Days	280	223	57	25%	201	80	40%	788	715	73	10%	650	138	21%
IP Days (excl. Nursery)	241	183	57	31%	161	80	50%	667	607	60	10%	542	125	23%
Average Daily Census	8.0	7	0.6	8%	5.4	2.7	50%	7.2	23	(16.1)	(69%)	5.9	1.4	23%
ALOS	2.8	3	0.3	10%	2.5	0.4	14%	2.7	8	(5.7)	(68%)	2.8	(0.1)	(5%)
Deliveries	18	20	(2)	(10%)	20	(2)	(10%)	55	60	(5)	(8%)	60	(5)	(8%)
OP Visits	4,569	-	4,569	-%	4,121	448	11%	13,652	-	13,652	-%	12,394	1,258	10%
Rural Health Clinic Visits	2,141	2,299	(158)	(7%)	2,311	(170)	(7%)	6,344	6,895	(551)	(8%)	6,931	(587)	(8%)
Rural Health Women Visits	624	485	139	29%	485	139	29%	1,886	1,586	300	19%	1,586	300	19%
Rural Health Behavioral Visits	85	125	(40)	(32%)	125	(40)	(32%)	285	354	(69)	(19%)	383	(98)	(26%)
Total RHC Visits	**2,850**	**2,909**	**(59)**	**(2%)**	**2,921**	**(71)**	**(2%)**	**8,515**	**8,835**	**(320)**	**(4%)**	**8,900**	**(385)**	**(4%)**
Bronco Clinic Visits	-	-	-	-%	57	(57)	(100%)	-	-	-	-%	78	(78)	(100%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	346	301	45	15%	301	45	15%	1,003	945	58	6%	945	58	6%
Pediatric Clinic Visits	578	562	16	3%	562	16	3%	1,695	1,695	-	-%	1,695	-	-%
Specialty Clinic Visits	793	727	66	9%	714	79	11%	2,232	2,035	197	10%	1,996	236	12%
Surgery Clinic Visits	166	168	(2)	(1%)	142	24	17%	471	504	(33)	(7%)	450	21	5%
Virtual Care Clinic Visits	-	-	-	-%	41	(41)	(100%)	-	-	-	-%	124	(124)	(100%)
Total NIA Clinic Visits	**1,883**	**1,758**	**125**	**7%**	**1,817**	**66**	**4%**	**5,401**	**5,179**	**222**	**4%**	**5,288**	**113**	**2%**
IP Surgeries	16	18	(2)	(11%)	12	4	33%	41	48	(7)	(15%)	29	12	41%
OP Surgeries	111	146	(35)	(24%)	151	(40)	(26%)	357	390	(33)	(8%)	408	(51)	(13%)
Total Surgeries	**127**	**164**	**(37)**	**(23%)**	**163**	**(36)**	**(22%)**	**398**	**438**	**(40)**	**(9%)**	**437**	**(39)**	**(9%)**
Cardiology	1	4	(3)	(75%)	2	(1)	(50%)	8	11	(3)	(27%)	2	6	300%
General	67	96	(29)	(30%)	99	(32)	(32%)	203	257	(54)	(21%)	262	(59)	(23%)
Gynecology & Obstetrics	12	12	-	-%	8	4	50%	40	32	8	25%	28	12	43%
Ophthalmology	-	-	-	-%	20	(20)	(100%)	-	-	-	-%	58	(58)	(100%)
Orthopedic	26	35	(9)	(26%)	17	9	53%	95	93	2	2%	46	49	107%
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Podiatry	-	-	-	-%	-	-	-%	-	-	-	-%	1	(1)	(100%)
Urology	21	17	4	24%	17	4	24%	50	45	5	11%	40	10	25%
Diagnostic Image Exams	2,373	2,288	85	4%	2,271	102	4%	7,309	6,837	472	7%	6,787	522	8%
Emergency Visits	971	849	122	14%	840	131	16%	2,947	2,654	293	11%	2,627	320	12%
ED Admits	51	33	18	55%	33	18	55%	154	33	121	367%	104	50	48%
ED Admits % of ED Visits	5%	4%	1%	35%	4%	1%	34%	5%	4%	1%	34%	4%	1%	32%
Rehab Visits	984	867	117	13%	739	245	33%	2,875	2,583	292	11%	2,338	537	23%
OP Infusion/Wound Care Visits	946	736	210	29%	736	210	29%	2,830	1,993	837	42%	1,993	837	42%
Observation Hours	1,229	1,141	87	8%	1,141	87	8%	4,302	3,535	767	22%	3,535	767	22%

Provided by: Chief Financial Officer
Report Name: September 2026 Financial Summary

Northern Inyo Healthcare District

September 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PAYOR MIX (Patient Days)														
Blue Cross	24.0%	30.4%	(6.4%)	(21.2%)	30.4%	(6.4%)	(21.2%)	25.5%	26.1%	(0.6%)	(2.2%)	26.1%	(0.6%)	(2.2%)
Commercial	7.1%	7.3%	(0.2%)	(2.6%)	7.3%	(0.2%)	(2.6%)	6.2%	5.7%	0.5%	8.6%	5.7%	0.5%	8.6%
Medicaid	17.3%	24.4%	(7.2%)	(29.3%)	24.4%	(7.2%)	(29.3%)	24.4%	21.0%	3.4%	16.3%	21.0%	3.4%	16.3%
Medicare	51.6%	37.8%	13.8%	36.5%	37.8%	13.8%	36.5%	42.2%	43.3%	(1.1%)	(2.6%)	43.3%	(1.1%)	(2.6%)
Self-pay	-%	-%	-%	-%	-%	-%	-%	1.4%	3.9%	(2.5%)	(63.4%)	3.9%	(2.5%)	(63.4%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.2%	-%	0.2%	-%	-%	0.2%	-%
Other	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%
PAYOR MIX (Gross Revenue)														
Blue Cross	26.2%	29.9%	(3.7%)	(12.4%)	29.9%	(3.7%)	(12.4%)	28.1%	28.2%	(0.1%)	(0.2%)	28.2%	(0.1%)	(0.2%)
Commercial	7.4%	5.4%	2.1%	38.2%	5.4%	2.1%	38.2%	7.5%	6.0%	1.5%	25.5%	6.0%	1.5%	25.5%
Medicaid	15.0%	18.2%	(3.1%)	(17.3%)	18.2%	(3.1%)	(17.3%)	17.1%	17.3%	(0.2%)	(1.0%)	17.3%	(0.2%)	(1.0%)
Medicare	47.9%	43.5%	4.4%	10.0%	43.5%	4.4%	10.0%	43.5%	45.2%	(1.7%)	(3.7%)	45.2%	(1.7%)	(3.7%)
Self-pay	2.2%	1.8%	0.4%	22.3%	1.8%	0.4%	22.3%	2.5%	2.3%	0.1%	4.6%	2.3%	0.1%	4.6%
Worker's Comp	1.1%	1.1%	(0.1%)	(6.6%)	1.1%	(0.1%)	(6.6%)	1.1%	0.9%	0.2%	20.9%	0.9%	0.2%	20.9%
Other	0.2%	0.1%	0.1%	84.0%	0.1%	0.1%	84.0%	0.2%	0.2%	0.1%	49.6%	0.2%	0.1%	49.6%
DEDUCTIONS														
Contract Adjust	(14,078,308)	(10,965,665)	(3,112,643)	28%	(11,079,353)	(2,998,955)	27%	(39,417,856)	(32,314,060)	(7,103,796)	22%	(30,536,836)	(8,881,020)	29%
Bad Debt	951,747	(435,917)	1,387,665	(318%)	(253,457)	1,205,204	(476%)	1,551,912	(1,284,579)	2,836,490	(221%)	(1,806,615)	3,358,526	(186%)
Write-off	(363,125)	(449,476)	86,351	(19%)	(573,549)	210,424	(37%)	(1,047,184)	(1,324,534)	277,351	(21%)	(1,284,026)	236,842	(18%)
CENSUS														
Patient Days	241	183	57	31%	161	80	50%	667	607	60	10%	542	125	23%
Adjusted ADC	39	42	(3)	(8%)	35	4	11%	37	122	(84)	(69%)	34	4	11%
Adjusted Days	1,159	1,184	(25)	(2%)	1,023	135	13%	3,449	3,728	(279)	(7%)	3,108	341	11%
Employed FTE	368.7	375.5	(6.8)	(2%)	375.5	(6.8)	(2%)	374.5	376.9	(2.4)	(1%)	376.9	(2.4)	(1%)
Contract Labor FTE	20.8	20.7	0.1	0%	20.7	0.1	0%	20.9	20.0	0.9	4%	20.0	0.9	4%
Total Paid FTE	389.5	396.2	(6.7)	(2%)	396.2	(6.7)	(2%)	395.4	396.9	(1.5)	(0%)	396.9	(1.5)	(0%)
EPOB (Employee per Occupied Bed)	1.6	2.5	(0.8)	(34%)	2.5	(0.8)	(34%)	1.8	2.5	(0.6)	(26%)	2.2	(0.4)	(19%)
EPOC (Employee per Occupied Case)	0.3	0.4	(0.0)	(12%)	0.4	(0.0)	(12%)	0.1	0.4	(0.3)	(70%)	0.1	(0.0)	(10%)
Adjusted EPOB	7.8	15.7	(7.9)	(50%)	15.7	(7.9)	(50%)	9.4	15.7	(6.3)	(40%)	12.9	(3.5)	(27%)
Adjusted EPOC	1.6	2.4	(0.8)	(33%)	2.4	(0.8)	(33%)	0.6	2.4	(1.8)	(76%)	0.7	(0.1)	(19%)
SALARIES														
Per Adjust Bed Day	3,167	3,128	39	1%	3,433	(266)	(8%)	3,331	3,044	287	9%	3,498	(167)	(5%)
Total Salaries	3,669,501	3,702,654	(33,153)	(1%)	3,512,638	156,864	4%	11,487,032	11,346,217	140,815	1%	10,869,971	617,061	6%
Average Hourly Rate	58.05	57.52	0.53	1%	54.57	3.48	6%	58.35	57.27	1.09	2%	54.86	3.49	6%
Employed Paid FTEs	368.7	375.5	(6.8)	382.3	375.5	(6.8)	(2%)	374.5	376.9	(2.4)	(1%)	376.9	(2.4)	(1%)
BENEFITS														
Per Adjust Bed Day	1,746	1,256	490	39%	1,468	278	19%	1,521	1,203	318	26%	1,345	176	13%
Total Benefits	2,022,646	1,487,015	535,631	36%	1,502,338	520,308	35%	5,244,629	4,484,239	760,390	17%	4,179,930	1,064,699	25%
Benefits % of Wages	55%	40%	15%	37%	43%	12%	29%	46%	40%	6%	16%	38%	7%	19%
Pension Expense	327,304	357,589	(30,285)	(8%)	349,086	(21,781)	(6%)	984,684	1,076,952	(92,267)	(9%)	1,047,848	(63,164)	(6%)
MDV Expense	1,451,252	782,746	668,505	85%	794,959	656,293	83%	3,462,053	2,348,239	1,113,814	47%	2,193,045	1,269,008	58%
Taxes, PTO accrued, Other	244,090	346,679	(102,590)	(30%)	358,293	(114,203)	(32%)	797,892	1,059,048	(261,156)	(25%)	939,036	(141,144)	(15%)
Contract Labor														
Total Contract Labor	383,983	301,916	82,067	27%	455,774	(71,791)	(16%)	1,105,422	843,880	261,542	31%	1,177,966	(72,544)	(6%)
Contract AHR	107.92	85.11	22.81	27%	128.48	(20.57)	(16%)	100.41	80.10	20.32	25%	111.81	(11.39)	(10%)
Contract Paid FTEs	20.8	20.7	0.1	0%	20.7	0.1	0%	20.9	20.0	0.9	4%	20.0	0.9	4%
Salaries, Wages & Benefits	6,076,130	5,491,585	584,545	11%	5,470,750	605,381	11%	17,837,083	16,674,336	1,162,747	7%	16,227,867	1,609,216	10%
SWB/APD	5,245	4,639	605	13%	5,347	(102)	(2%)	5,172	4,473	699	16%	5,222	(50)	(1%)
SWB % of Total Expenses	52%	51%	0%	1%	55%	(3%)	(5%)	52%	51%	1%	2%	54%	(2%)	(4%)

Provided by: Chief Financial Officer
Report Name: September 2026 Financial Summary

Northern Inyo Healthcare District

September 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**	**Actual**	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**
Labor Cost per Adjusted Patient Day	3,499	3,383	116	3%	3,878	(380)	(10%)	3,651	3,270	381	12%	3,877	(225)	(6%)
Salary Expense / Net Patient Revenue	41%	39%	1%	4%	50%	(9%)	(18%)	39%	41%	(1%)	(3%)	50%	(11%)	(21%)
Agency/Contract Labor $$ %	9%	8%	2%	26%	11%	(2%)	(18%)	9%	7%	2%	27%	10%	(1%)	(10%)
Agency/Contract Labor FTE %	5%	5%	0%	2%	5%	0%	2%	5%	5%	0%	5%	5%	0%	5%

Provided by: Chief Financial Officer
Report Name: September 2026 Financial Summary

Northern Inyo Healthcare District

September 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,270	2,303	(33)	(1%)	2,446	(176)	(7%)	2,441	2,156	284	13%	2,260	181	8%
Total Physician Fee	1,828,755	1,909,624	(80,869)	(4%)	1,645,840	182,915	11%	5,761,204	5,706,748	54,456	1%	4,819,773	941,431	20%
Total Other Pro-Fees	800,793	816,591	(15,798)	(2%)	856,512	(55,719)	(7%)	2,656,358	2,331,789	324,569	14%	2,202,539	453,819	21%
Total Professional Fees	2,629,548	2,726,215	(96,667)	(4%)	2,502,352	127,197	5%	8,417,562	8,038,537	379,025	5%	7,022,312	1,395,250	20%
Physician Fee per Adjust Bed Day	1,578	1,613	(35)	(2%)	1,608	(30)	(2%)	1,671	1,531	140	9%	1,551	120	8%
PHARMACY														
Per Adjust Bed Day	632	270	363	134%	359	273	76%	465	299	166	55%	395	69	18%
Total Rx Expense	732,617	319,424	413,193	129%	367,511	365,107	99%	1,602,165	1,114,432	487,733	44%	1,227,916	374,249	30%
MEDICAL SUPPLIES														
Per Adjust Bed Day	605	479	126	26%	352	253	72%	524	493	32	6%	408	117	29%
Total Medical Supplies	701,031	566,598	134,433	24%	359,990	341,041	95%	1,808,852	1,837,373	(28,520)	(2%)	1,267,487	541,365	43%
EHR SYSTEM														
Per Adjust Bed Day	11	27	(16)	(58%)	31	(20)	(64%)	21	30	(9)	(31%)	36	(15)	(42%)
Total EHR Expense	13,077	31,736	(18,660)	(59%)	31,736	(18,660)	(59%)	70,900	110,430	(39,530)	(36%)	110,430	(39,530)	(36%)
OTHER EXPENSE														
Per Adjust Bed Day	986	991	(5)	(1%)	849	136	16%	906	953	(47)	(5%)	876	30	3%
Total Other	1,142,172	1,173,026	(30,853)	(3%)	869,228	272,945	31%	3,123,437	3,552,428	(428,991)	(12%)	2,721,023	402,414	15%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	421	366	54	15%	417	3	1%	432	353	79	22%	416	15	4%
Total Depreciation and Amortization	487,176	433,605	53,571	12%	426,828	60,348	14%	1,488,511	1,315,574	172,937	13%	1,294,011	194,500	15%
TOTAL EXPENSES	11,781,752	10,742,190	1,039,562	10%	10,028,394	1,753,358	17%	34,348,510	32,643,111	1,705,400	5%	29,871,046	4,477,465	15%
Per Adjust Bed Day	10,169	9,075	1,094	12%	9,801	369	4%	9,960	8,756	1,203	14%	9,612	348	4%
Per Calendar Day	392,725	358,073	34,652	10%	334,280	58,445	17%	373,353	354,816	18,537	5%	324,685	48,668	15%

Provided by: Chief Financial Officer
Report Name: September 2026 Financial Summary

Key Financial Performance Indicators	Industry Benchmark	Sep-24	FYE 2025 Average	Sep-25	FYE 2026 Average	Jul-26	Aug-26	Sep-26	Variance to PM	Variance to FYE 2026 Average	Variance to PYM
Volume											
Admits	41	83	69	65	75	87	80	85	5	10	20
Deliveries	n/a	17	17	20	16	16	21	18	(3)	2	(2)
Adjusted Patient Days	n/a	1,312	977	1,023	1,098	1,217	1,069	1,159	89	61	135
Total Surgeries	153	133	141	163	138	135	136	127	(9)	(11)	(36)
ER Visits	659	947	837	840	849	1,021	955	971	16	122	131
RHC and Clinic Visits	n/a	4,808	4,772	4,738	4,771	4,805	4,378	4,733	355	(38)	(5)
Diagnostic Imaging Services	n/a	2,194	2,129	2,271	2,241	2,520	2,416	2,373	(43)	132	102
Rehab Services	n/a	887	838	739	816	970	921	984	63	168	245
AR & Income											
Gross AR (Cerner only)	n/a	$ 58,109,192	$ 50,813,697	$ 40,875,951	$ 43,895,991	$ 48,479,909	$ 49,965,828	$ 52,204,876	$ 2,239,048	$ 8,308,885	$ 11,328,925
AR > 90 Days	$ 7,271,986.32	$ 26,062,067	$ 19,638,850	$ 16,330,677	$ 15,623,287	$ 17,133,809	$ 17,654,618	$ 19,786,831	$ 2,132,214	$ 4,163,545	$ 3,456,155
AR % > 90 Days	15%	44.9%	38.6%	39.95%	35.8%	35.34%	35.33%	37.9%	2.6%	2.1%	-2.0%
Gross AR Days (per financial statements)	60	83	80	62	63	62	67	67	0	4	5
Net AR Days (per financial statements)	30	69	71	54	65	60	66	69	3	4	15
Net AR	n/a	$ 19,842,483	$ 19,370,868	$ 14,268,379	$ 20,633,479	$ 21,593,930	$ 23,060,459	$ 22,875,561	$ (184,897)	$ 2,242,082	$ 8,607,182
Net AR % of Gross	n/a	34.1%	38.5%	34.9%	46.4%	44.5%	46.2%	43.8%	-2.3%	-2.6%	8.9%
Gross Patient Revenue/Calendar Day	n/a	$ 702,988	$ 634,418	$ 661,191	$ 694,615	$ 779,974	$ 747,819	$ 778,955	$ 31,136	$ 84,341	$ 117,765
Net Patient Revenue/Calendar Day	n/a	$ 285,805	$ 273,563	$ 264,312	$ 319,513	$ 359,455	$ 348,508	$ 331,176	$ (17,332)	$ 11,663	$ 66,864
Net Patient Revenue/APD	n/a	$ 6,537	$ 8,088	$ 7,749	$ 8,978	$ 9,157	$ 10,102	$ 8,576	$ (1,527)	$ (403)	$ 826
Wages											
Wages	n/a	$ 3,372,236	$ 3,661,965	$ 3,512,638	$ 3,705,110	$ 3,885,878	$ 3,931,653	$ 3,669,501	$ (262,151)	$ (35,608)	$ 156,864
Employed paid FTEs	n/a	363.12	370.77	375.49	379.65	378.36	376.09	368.73	(7.36)	(10.93)	(6.76)
Employed Average Hourly Rate	$55.50	$ 54.32	$ 56.78	$ 54.72	$ 56.30	$ 58.14	$ 59.18	$ 58.21	$ (0.97)	$ 1.91	$ 3.49
Benefits	n/a	$ 1,634,036	$ 1,401,858	$ 1,502,338	$ 1,312,122	$ 1,556,100	$ 1,665,884	$ 2,022,646	$ 356,762	$ 710,524	$ 520,308
Benefits % of Wages	30%	48.5%	39.0%	42.8%	35.6%	40.0%	42.4%	55.1%	12.7%	19.5%	12.4%
Contract Labor	n/a	$ (112,642)	$ 447,445	$ 455,774	$ 361,823	$ 438,597	$ 282,842	$ 383,983	$ 101,142	$ 22,160	$ (71,791)
Contract Labor Paid FTEs	n/a	27.17	23.89	20.69	19.55	22.75	19.31	20.76	1.44	1.21	0.06
Total Paid FTEs	n/a	390.28	394.65	396.18	399.20	401.11	395.40	389.48	(5.92)	(9.72)	(6.70)
Contract Labor Average Hourly Rate	$ 81.04	$ 118.60	$ 117.91	$ 128.84	$ 106.68	$ 109.15	$ 82.90	$ 108.21	$ 25.31	$ 1.53	$ (20.62)
Total Salaries, Wages, & Benefits	n/a	$ 4,893,631	$ 5,511,268	$ 5,470,750	$ 5,379,055	$ 5,880,575	$ 5,880,378	$ 6,076,130	$ 195,752	$ 697,075	$ 605,381
SWB% of NR	50%	57.1%	70.3%	69.0%	56.0%	56.1%	54.4%	61.2%	6.7%	5.1%	-7.8%
SWB/APD	2,416	$ 3,731	$ 5,064	$ 5,347	$ 5,020	$ 4,833	$ 5,498	$ 5,245	$ (254)	$ 225	$ (102)
SWB % of total expenses	50%	55.1%	57.3%	54.5%	51.7%	51.9%	52.4%	51.6%	-0.8%	-0.1%	-3.0%

	Industry		FYE 2025		FYE 2026					Variance to	Variance to FYE	
Physician Spend	**Benchmark**	**Sep-24**	**Average**	**Sep-25**	**Average**	**Jul-26**	**Aug-26**	**Sep-26**		**PM**	**2026 Average**	**Variance to PYM**
Physician Expenses	n/a	$ 1,424,804	$ 1,507,510	$ 1,645,840	$ 1,811,516	$ 1,984,916	$ 1,947,533	$ 1,828,755		$ (118,778)	$ 17,240	$ 182,915
Physician expenses/APD	n/a	$ 1,086	$ 1,476	$ 1,608	$ 1,676	$ 1,631	$ 1,821	$ 1,578		$ (243)	$ (98)	$ (30)
Supplies												
Supply Expenses	n/a	$ 754,993	$ 776,504	$ 727,501	$ 967,638	$ 973,312	$ 1,004,057	$ 1,433,649		$ 429,592	$ 466,010	$ 706,148
Supply expenses/APD		$ 576	$ 744	$ 711	$ 892	$ 800	$ 939	$ 1,237		$ 299	$ 346	$ 526
Other Expenses												
Other Expenses	n/a	$ 3,472,628	$ 1,824,207	$ 2,186,236	$ 2,214,853	$ 2,498,056	$ 2,397,932	$ 2,443,218		$ 45,286	$ 228,365	$ 256,982
Other Expenses/APD	n/a	$ 2,648	$ 1,787	$ 2,137	$ 2,068	$ 2,053	$ 2,242	$ 2,109		$ (133)	$ 41	$ (28)
Margin												
Net Income	n/a	$ 1,355,571	$ 383,722	$ (1,640,281)	$ 877,257	$ 931,657	$ 709,095	$ (652,782)		$ (1,361,877)	$ (1,530,040)	$ 987,499
Net Profit Margin	n/a	11.6%	3.0%	-20.7%	7.0%	8.4%	6.6%	-6.6%		-13.1%	-13.6%	14.1%
Operating Income	n/a	$ 1,170,684	$ (686,444)	$ (2,100,965)	$ (671,709)	$ (193,757)	$ (426,146)	$ (1,846,475)		$ (1,420,329)	$ (1,174,766)	$ 254,490
Operating Margin	2.9%	10.0%	-9.9%	-26.5%	-9.9%	-1.7%	-3.9%	-18.6%		-14.6%	-8.7%	7.9%
EBITDA	n/a	$ 1,682,046	$ 841,891	$ (1,213,453)	$ 1,346,683	$ 1,433,540	$ 1,208,547	$ (165,606)		$ (1,374,153)	$ (1,512,290)	$ 1,047,847
EBITDA Margin	12.7%	14.4%	9.0%	-15.3%	11.9%	12.9%	11.2%	-1.7%		-12.9%	-13.6%	13.6%
Debt Service Coverage Ratio	3.70	370.0%	3.9	(5.5)	(0.1)	0.5	10.9	3.1		(7.8)	3.1	8.6
Cash												
Avg Daily Disbursements (excl. IGT)	n/a	$ 321,703	$ 355,328	$ 325,126	$ 430,840	$ 376,919	$ 422,830	$ 355,735		$ (67,095)	$ (75,106)	$ 30,609
Average Daily Cash Collections (excl. IGT)	n/a	$ 255,132	$ 340,919	$ 348,085	$ 335,789	$ 359,424	$ 253,190	$ 340,354		$ 87,164	$ 4,565	$ (7,731)
Average Daily Net Cash		$ (66,571)	$ (14,409)	$ 22,959	$ (95,051)	$ (17,495)	$ (169,640)	$ (15,381)		$ 154,259	$ 79,671	$ (38,340)
Upfront Cash Collections		$ 37,564	$ 36,146	$ 63,634	$ 66,519	$ 59,895	$ 68,610	$ 64,900		$ (3,710)	$ (1,619)	$ 1,267
Upfront Cash % of Gross Charges	1%	$ 0	0.2%	0.3%	0.3%	0.2%	0.3%	0.3%		0.0%	0.0%	0.0%
Unrestricted Funds	n/a	$ 32,193,415	$ 23,536,438	$ 26,418,948	$ 28,328,253	$ 39,973,321	$ 35,544,887	$ 34,612,369		$ (932,518)	$ 6,284,116	$ 8,193,420
Change of cash per balance sheet	n/a	$ 929,805	$ (321,485)	$ 756,674	$ 1,204,912	$ 375,558	$ (4,428,434)	$ (932,518)		$ 3,495,916	$ (2,137,431)	$ (1,689,192)
Days Cash on Hand (assume no more cash is collected)	196	100	73	85	88	114	102	97		(5)	9	12
Estimated Days Until Depleted (operating cash only)		422	1,633	491	466	2,285	380	513		133	47	22
Years Until Cash Depletion (operating cash only)		1.16	4.48	1.34	1.28	6.26	1.04	1.40		0.36	0.13	0.06

NIHD Financial Update

Chief Financial Officer

Q1 2027 Results

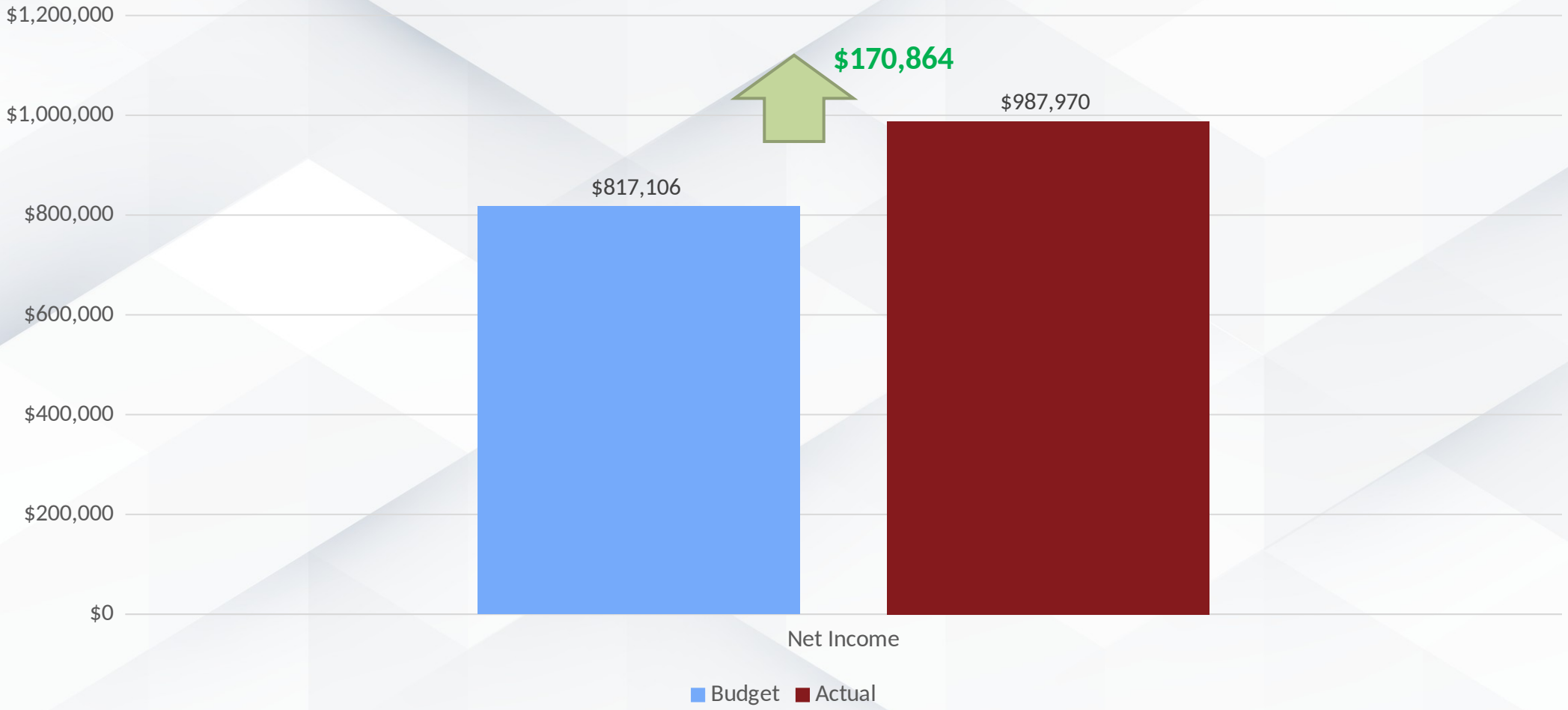


Northern Inyo Healthcare District

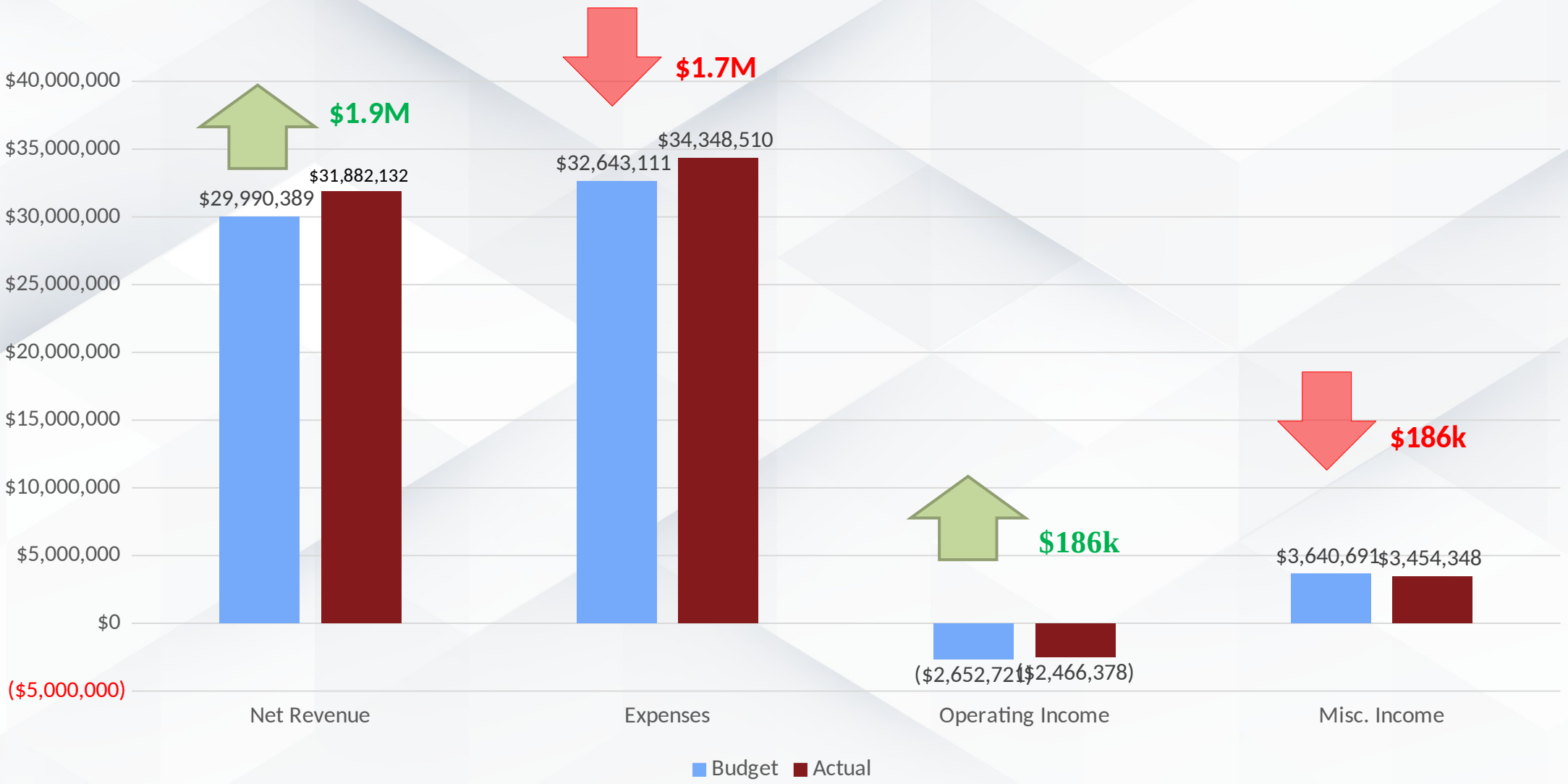
INCOME PERFORMANCE

NORTHERN INYO HEALTHCARE DISTRICT

Net Income


$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
$170,864
$987,970
$817,106
Net Income
Budget
Actual

Income to Budget



Volume & Income Action plan

- We are working on reviewing operational efficiency including OR utilization and space utilization reviews to maximize patient flow and care.
- We are being more deliberate in our service line strategy.
- We are working on a staff benchmarking analysis to determine if we are appropriately staffing by skill mix in all departments.
- Leaders are doing a great job of managing their expenses and helping build budgets for the next fiscal year.
- We will be working closely with our insurance broker to find opportunities to save on medical, dental and vision.

Cash Performance

NORTHERN INYO HEALTHCARE DISTRICT

Income to Cash

	FYE 2027
Net Income (loss)	**$987,970**
Principal Payments on Long-Term Debt (balance sheet only)	$0
Other Debt (long-term leases & subscriptions – balance sheet only)	$(351,857)
Capital purchases (balance sheet only)	$(524,884)
IGT funding	$ (1,745,242)
Timing of accruals vs cash (including IGT revenue)	$(3,351,387)
Impact to Cash	**$(5,973,370)**
Adjusted Net Income (cash basis)	$(4,985,400)

Gross AR Days



Debt Service Coverage Ratio



Days Cash on Hand



Unrestricted Funds



Cash action plan

- The cash flow action team is working to improve processes in all aspects of billing and collections.
- We have hired a new AI-based billing company, Jorie, and have hit record cash collections. The automation is working well and we continue to meet with them to find more opportunities to automate and improve cash.
- We have moved $20M in cash to Five Star Bank to earn better returns on our cash.
- We have another $11M in the LAIF Earning over 4% interest.
- AR days still trending favorable compared to historical numbers.

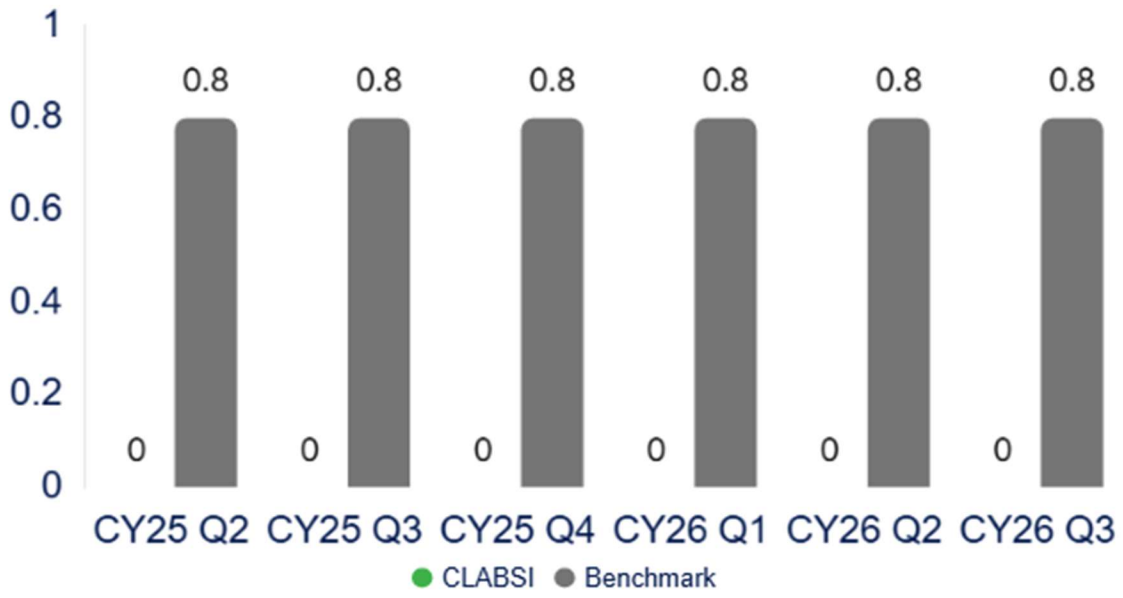
Key Financial Performance Indicators	Industry Benchmark	Sep-24	FYE 2025 Average	Sep-25	FYE 2026 Average	Jul-26	Aug-26	Sep-26	Variance to PM	Variance to FYE 2026 Average	Variance to PYM
Volume											
Admits	41	83	69	65	75	87	80	85	5	10	20
Deliveries	n/a	17	17	20	16	16	21	18	(3)	2	(2)
Adjusted Patient Days	n/a	1,312	977	1,023	1,098	1,217	1,069	1,159	89	61	135
Total Surgeries	153	133	141	163	138	135	136	127	(9)	(11)	(36)
ER Visits	659	947	837	840	849	1,021	955	971	16	122	131
RHC and Clinic Visits	n/a	4,808	4,772	4,738	4,771	4,805	4,378	4,733	355	(38)	(5)
Diagnostic Imaging Services	n/a	2,194	2,129	2,271	2,241	2,520	2,416	2,373	(43)	132	102
Rehab Services	n/a	887	838	739	816	970	921	984	63	168	245
AR & Income											
Gross AR (Cerner only)	n/a	$ 58,109,192	$ 50,813,697	$ 40,875,951	$ 43,895,991	$ 48,479,909	$ 49,965,828	$ 52,204,876	$ 2,239,048	$ 8,308,885	$ 11,328,925
AR > 90 Days	$ 7,271,986.32	$ 26,062,067	$ 19,638,850	$ 16,330,677	$ 15,623,287	$ 17,133,809	$ 17,654,618	$ 19,786,831	$ 2,132,214	$ 4,163,545	$ 3,456,155
AR % > 90 Days	15%	44.9%	38.6%	39.95%	35.8%	35.34%	35.33%	37.9%	2.6%	2.1%	-2.0%
Gross AR Days (per financial statements)	60	83	80	62	63	62	67	67	0	4	5
Net AR Days (per financial statements)	30	69	71	54	65	60	66	69	3	4	15
Net AR	n/a	$ 19,842,483	$ 19,370,868	$ 14,268,379	$ 20,633,479	$ 21,593,930	$ 23,060,459	$ 22,875,561	$ (184,897)	$ 2,242,082	$ 8,607,182
Net AR % of Gross	n/a	34.1%	38.5%	34.9%	46.4%	44.5%	46.2%	43.8%	-2.3%	-2.6%	8.9%
Gross Patient Revenue/Calendar Day	n/a	$ 702,988	$ 634,418	$ 661,191	$ 694,615	$ 779,974	$ 747,819	$ 778,955	$ 31,136	$ 84,341	$ 117,765
Net Patient Revenue/Calendar Day	n/a	$ 285,805	$ 273,563	$ 264,312	$ 319,513	$ 359,455	$ 348,508	$ 331,176	$ (17,332)	$ 11,663	$ 66,864
Net Patient Revenue/APD	n/a	$ 6,537	$ 8,088	$ 7,749	$ 8,978	$ 9,157	$ 10,102	$ 8,576	$ (1,527)	$ (403)	$ 826
Wages											
Wages	n/a	$ 3,372,236	$ 3,661,965	$ 3,512,638	$ 3,705,110	$ 3,885,878	$ 3,931,653	$ 3,669,501	$ (262,151)	$ (35,608)	$ 156,864
Employed paid FTEs	n/a	363.12	370.77	375.49	379.65	378.36	376.09	368.73	(7.36)	(10.93)	(6.76)
Employed Average Hourly Rate	$55.50	$ 54.32	$ 56.78	$ 54.72	$ 56.30	$ 58.14	$ 59.18	$ 58.21	$ (0.97)	$ 1.91	$ 3.49
Benefits	n/a	$ 1,634,036	$ 1,401,858	$ 1,502,338	$ 1,312,122	$ 1,556,100	$ 1,665,884	$ 2,022,646	$ 356,762	$ 710,524	$ 520,308
Benefits % of Wages	30%	48.5%	39.0%	42.8%	35.6%	40.0%	42.4%	55.1%	12.7%	19.5%	12.4%
Contract Labor	n/a	$ (112,642)	$ 447,445	$ 455,774	$ 361,823	$ 438,597	$ 282,842	$ 383,983	$ 101,142	$ 22,160	$ (71,791)
Contract Labor Paid FTEs	n/a	27.17	23.89	20.69	19.55	22.75	19.31	20.76	1.44	1.21	0.06
Total Paid FTEs	n/a	390.28	394.65	396.18	399.20	401.11	395.40	389.48	(5.92)	(9.72)	(6.70)
Contract Labor Average Hourly Rate	$ 81.04	$ 118.60	$ 117.91	$ 128.84	$ 106.68	$ 109.15	$ 82.90	$ 108.21	$ 25.31	$ 1.53	$ (20.62)
Total Salaries, Wages, & Benefits	n/a	$ 4,893,631	$ 5,511,268	$ 5,470,750	$ 5,379,055	$ 5,880,575	$ 5,880,378	$ 6,076,130	$ 195,752	$ 697,075	$ 605,381
SWB% of NR	50%	57.1%	70.3%	69.0%	56.0%	56.1%	54.4%	61.2%	6.7%	5.1%	-7.8%
SWB/APD	2,416	$ 3,731	$ 5,064	$ 5,347	$ 5,020	$ 4,833	$ 5,498	$ 5,245	$ (254)	$ 225	$ (102)
SWB % of total expenses	50%	55.1%	57.3%	54.5%	51.7%	51.9%	52.4%	51.6%	-0.8%	-0.1%	-3.0%

	Industry		FYE 2025		FYE 2026					Variance to	Variance to FYE	
Physician Spend	**Benchmark**	**Sep-24**	**Average**	**Sep-25**	**Average**	**Jul-26**	**Aug-26**	**Sep-26**		**PM**	**2026 Average**	**Variance to PYM**
Physician Expenses	n/a	$ 1,424,804	$ 1,507,510	$ 1,645,840	$ 1,811,516	$ 1,984,916	$ 1,947,533	$ 1,828,755		$ (118,778)	$ 17,240	$ 182,915
Physician expenses/APD	n/a	$ 1,086	$ 1,476	$ 1,608	$ 1,676	$ 1,631	$ 1,821	$ 1,578		$ (243)	$ (98)	$ (30)
Supplies												
Supply Expenses	n/a	$ 754,993	$ 776,504	$ 727,501	$ 967,638	$ 973,312	$ 1,004,057	$ 1,433,649		$ 429,592	$ 466,010	$ 706,148
Supply expenses/APD		$ 576	$ 744	$ 711	$ 892	$ 800	$ 939	$ 1,237		$ 299	$ 346	$ 526
Other Expenses												
Other Expenses	n/a	$ 3,472,628	$ 1,824,207	$ 2,186,236	$ 2,214,853	$ 2,498,056	$ 2,397,932	$ 2,443,218		$ 45,286	$ 228,365	$ 256,982
Other Expenses/APD	n/a	$ 2,648	$ 1,787	$ 2,137	$ 2,068	$ 2,053	$ 2,242	$ 2,109		$ (133)	$ 41	$ (28)
Margin												
Net Income	n/a	$ 1,355,571	$ 383,722	$ (1,640,281)	$ 877,257	$ 931,657	$ 709,095	$ (652,782)		$ (1,361,877)	$ (1,530,040)	$ 987,499
Net Profit Margin	n/a	11.6%	3.0%	-20.7%	7.0%	8.4%	6.6%	-6.6%		-13.1%	-13.6%	14.1%
Operating Income	n/a	$ 1,170,684	$ (686,444)	$ (2,100,965)	$ (671,709)	$ (193,757)	$ (426,146)	$ (1,846,475)		$ (1,420,329)	$ (1,174,766)	$ 254,490
Operating Margin	2.9%	10.0%	-9.9%	-26.5%	-9.9%	-1.7%	-3.9%	-18.6%		-14.6%	-8.7%	7.9%
EBITDA	n/a	$ 1,682,046	$ 841,891	$ (1,213,453)	$ 1,346,683	$ 1,433,540	$ 1,208,547	$ (165,606)		$ (1,374,153)	$ (1,512,290)	$ 1,047,847
EBITDA Margin	12.7%	14.4%	9.0%	-15.3%	11.9%	12.9%	11.2%	-1.7%		-12.9%	-13.6%	13.6%
Debt Service Coverage Ratio	3.70	370.0%	3.9	(5.5)	(0.1)	0.5	10.9	3.1		(7.8)	3.1	8.6
Cash												
Avg Daily Disbursements (excl. IGT)	n/a	$ 321,703	$ 355,328	$ 325,126	$ 430,840	$ 376,919	$ 422,830	$ 355,735		$ (67,095)	$ (75,106)	$ 30,609
Average Daily Cash Collections (excl. IGT)	n/a	$ 255,132	$ 340,919	$ 348,085	$ 335,789	$ 359,424	$ 253,190	$ 340,354		$ 87,164	$ 4,565	$ (7,731)
Average Daily Net Cash		$ (66,571)	$ (14,409)	$ 22,959	$ (95,051)	$ (17,495)	$ (169,640)	$ (15,381)		$ 154,259	$ 79,671	$ (38,340)
Upfront Cash Collections		$ 37,564	$ 36,146	$ 63,634	$ 66,519	$ 59,895	$ 68,610	$ 64,900		$ (3,710)	$ (1,619)	$ 1,267
Upfront Cash % of Gross Charges	1%	$ 0	0.2%	0.3%	0.3%	0.2%	0.3%	0.3%		0.0%	0.0%	0.0%
Unrestricted Funds	n/a	$ 32,193,415	$ 23,536,438	$ 26,418,948	$ 28,328,253	$ 39,973,321	$ 35,544,887	$ 34,612,369		$ (932,518)	$ 6,284,116	$ 8,193,420
Change of cash per balance sheet	n/a	$ 929,805	$ (321,485)	$ 756,674	$ 1,204,912	$ 375,558	$ (4,428,434)	$ (932,518)		$ 3,495,916	$ (2,137,431)	$ (1,689,192)
Days Cash on Hand (assume no more cash is collected)	196	100	73	85	88	114	102	97		(5)	9	12
Estimated Days Until Depleted (operating cash only)		422	1,633	491	466	2,285	380	513		133	47	22
Years Until Cash Depletion (operating cash only)		1.16	4.48	1.34	1.28	6.26	1.04	1.40		0.36	0.13	0.06

NIHD Quality Committee Dashboard

"<" means lower is better

Central Line-Associated Bloodstream Infect <



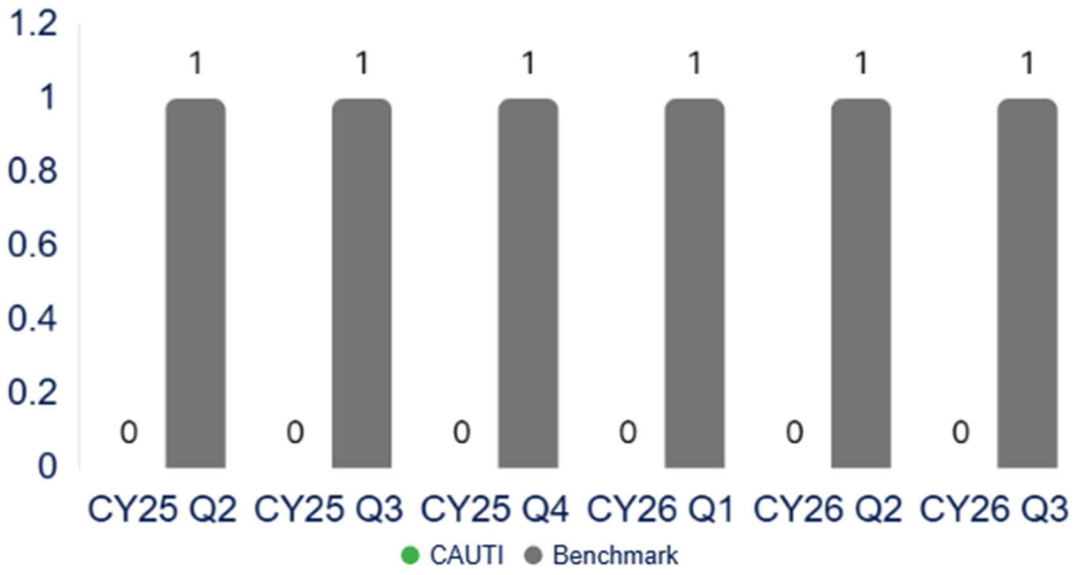
Central Line-Associated Bloodstream Infections

Infections caused by central line catheters

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Catheter-Associated Urinary Tract Infection <



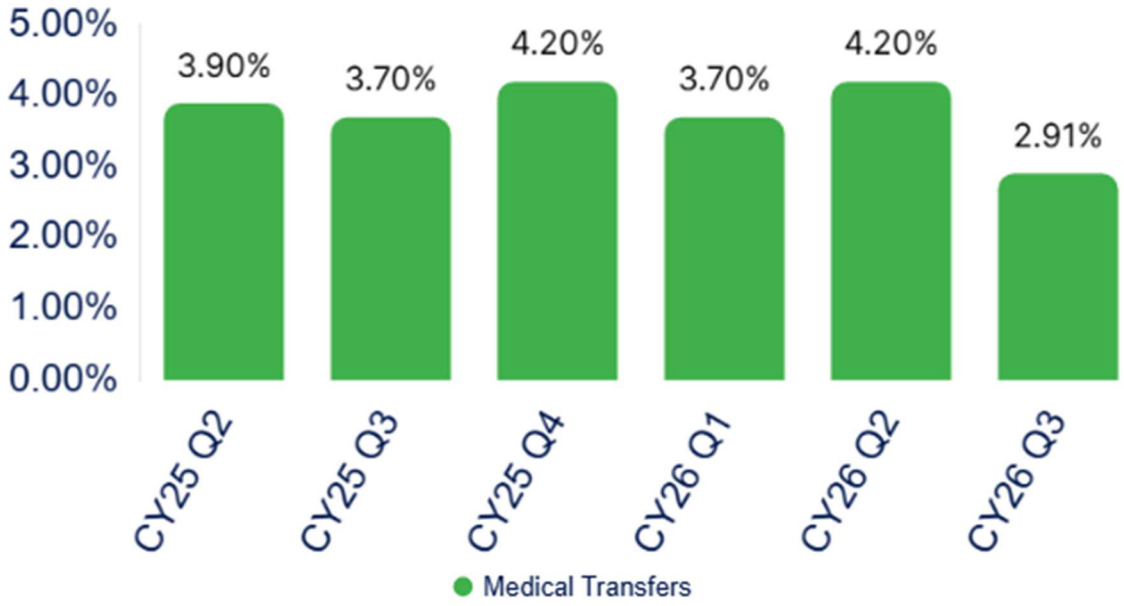
Catheter-Associated Urinary Tract Infection <

Infections caused by indwelling urinary catheters

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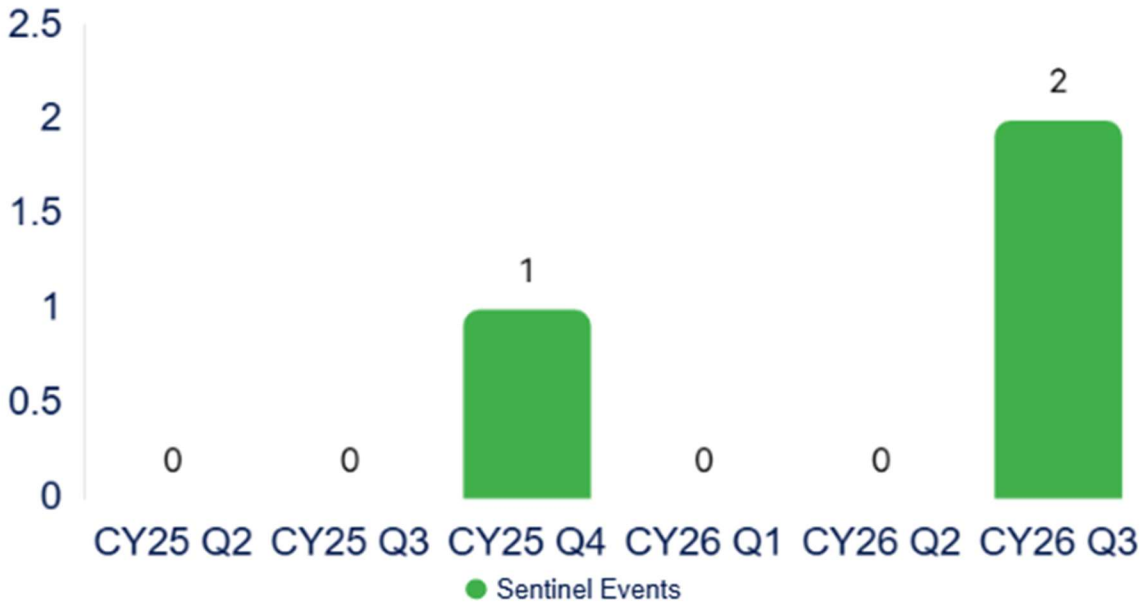
Medical Transfer Rate from ED



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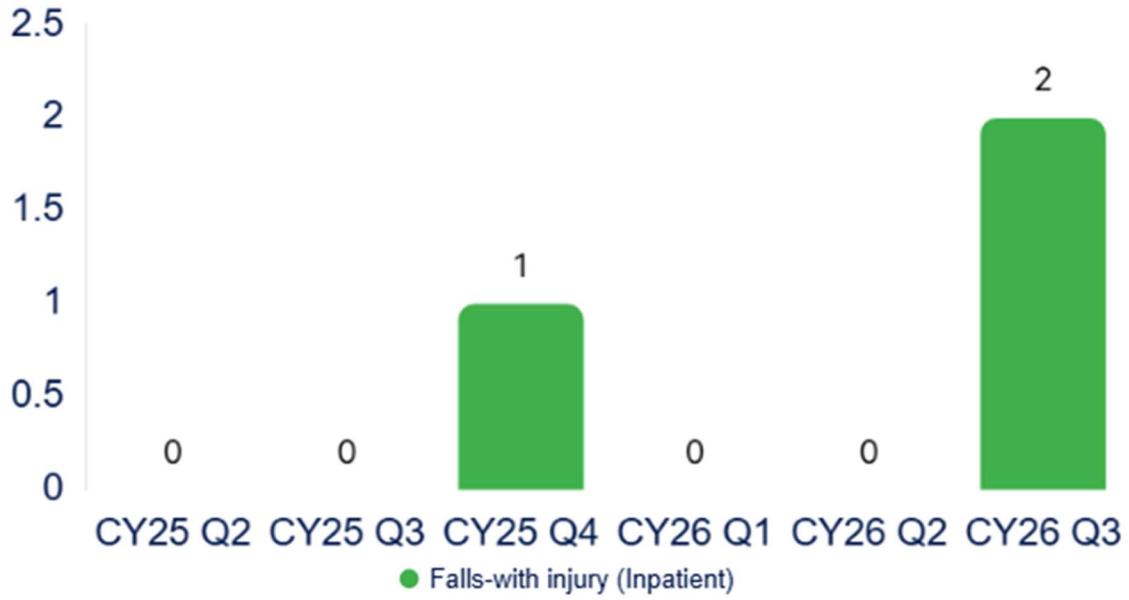
Sentinel Events <



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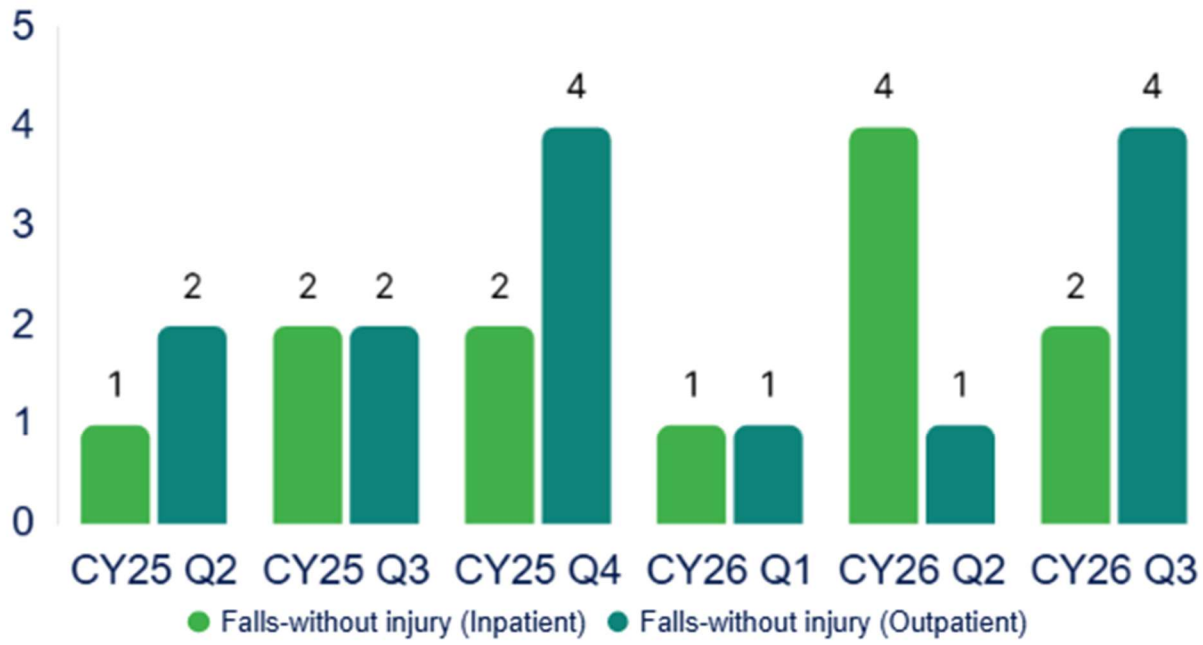
Patient Falls- With Injury <



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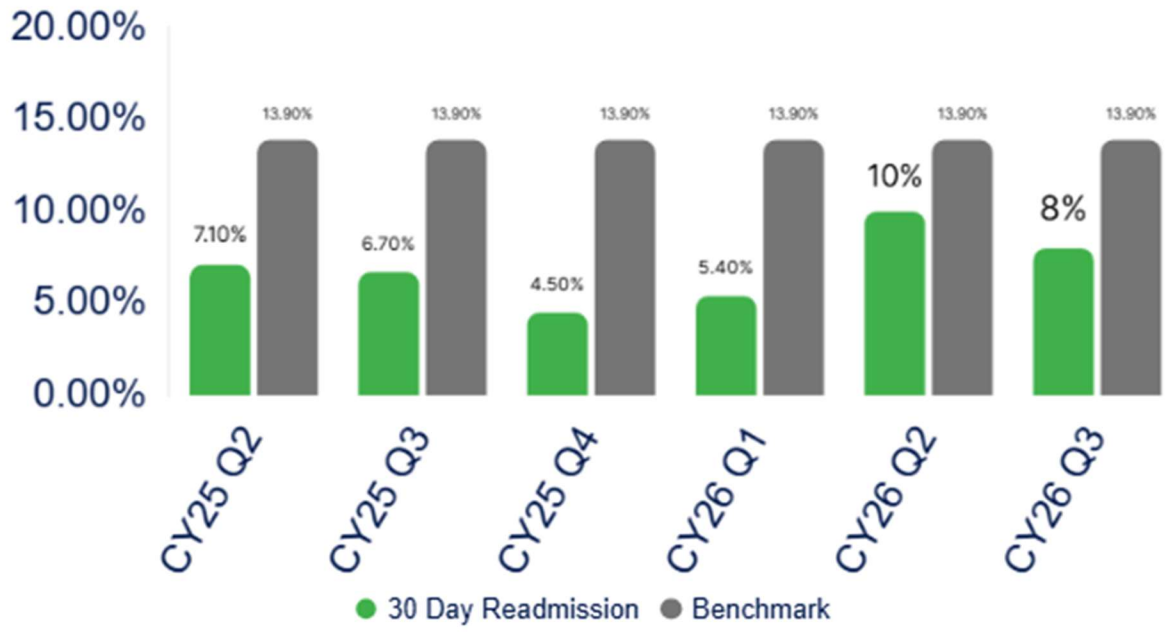
Patient Falls- Without Injury <



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30 Day Readmission <



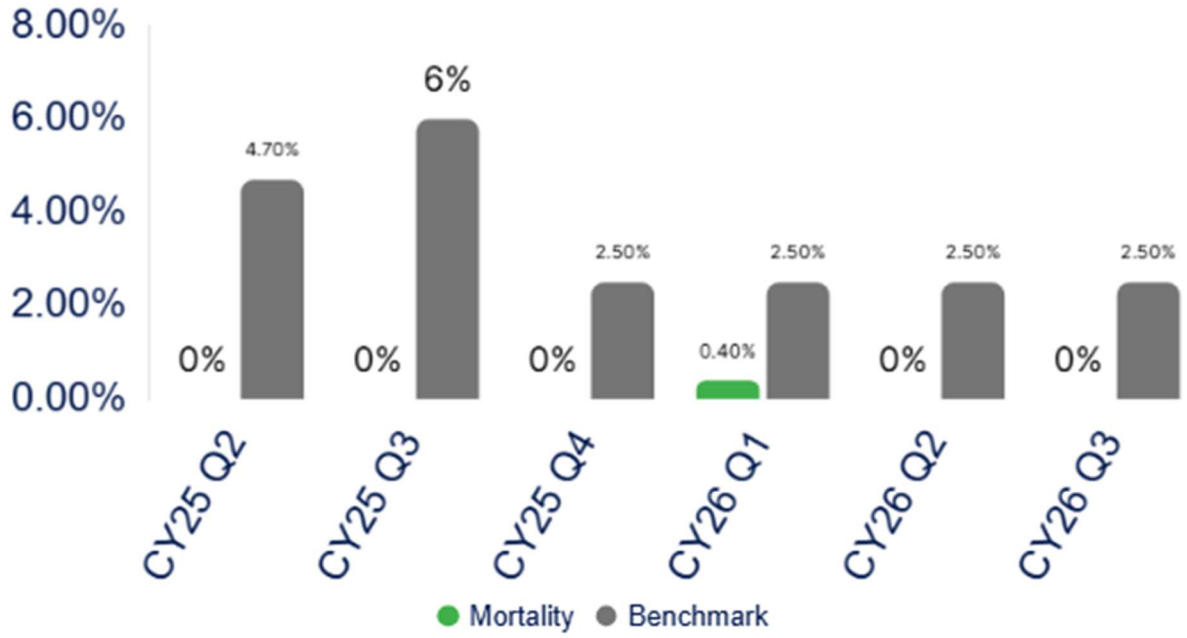
30 Day Readmission

Percentage of patient who, within 30 days of discharge from an inpatient stay, are re-admitted for any reason.

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Mortality <



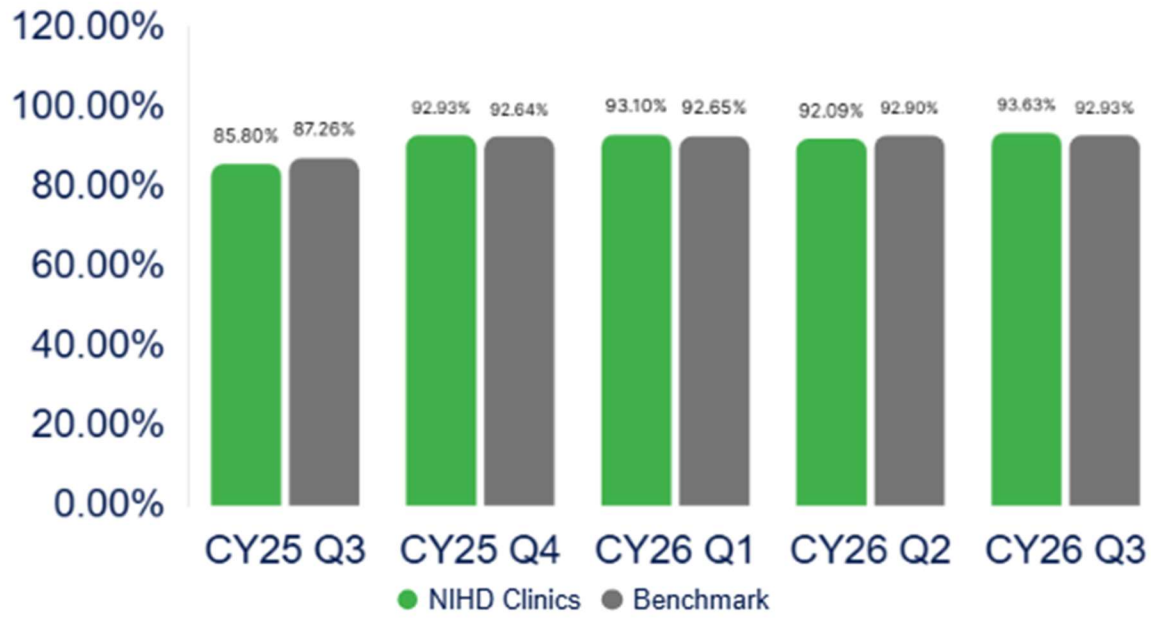
Mortality

Percentage of patient who die as inpatients, exclusive of those on comfort or palliative care.

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Likelihood to Recommend Top Box Score (Clinic)



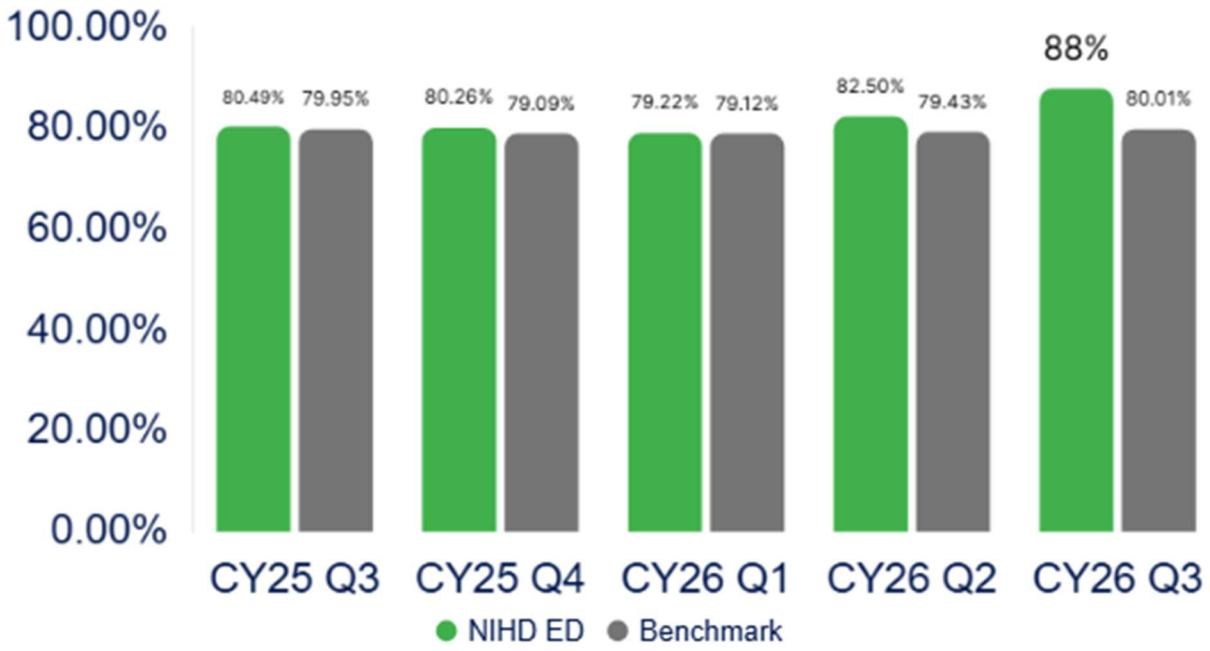
Likelihood to Recommend

Based on patient surveys, the likelihood that the patient would recommend the service area to others. This is measured as a "top box" score, or the portion of patients who gave the highest possible rating.

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Likelihood to Recommend Top Box Score (ED)



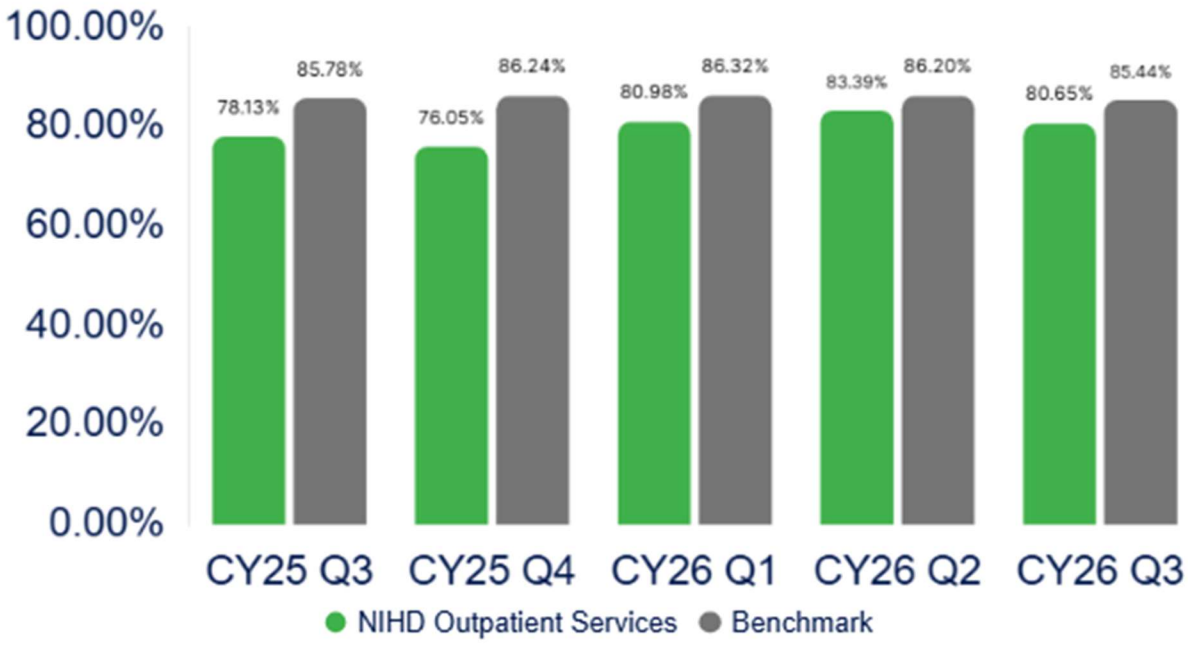
Likelihood to Recommend

Based on patient surveys, the likelihood that the patient would recommend the service area to others. This is measured as a "top box" score, or the portion of patients who gave the highest possible rating.

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Likelihood to Recommend Top Box Score (OP)

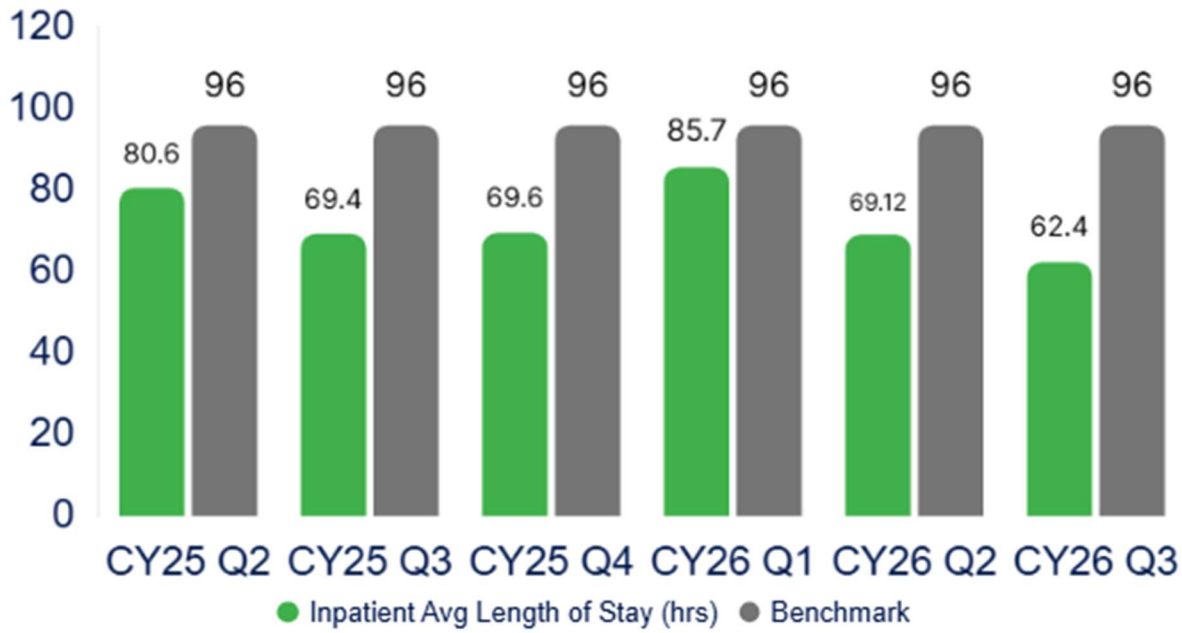


Likelihood to Recommend

Based on patient surveys, the likelihood that the patient would recommend the service area to others. This is measured as a "top box" score, or the portion of patients who gave the highest possible rating.

"<" means lower is better

Inpatient Average Length of Stay (hours) <



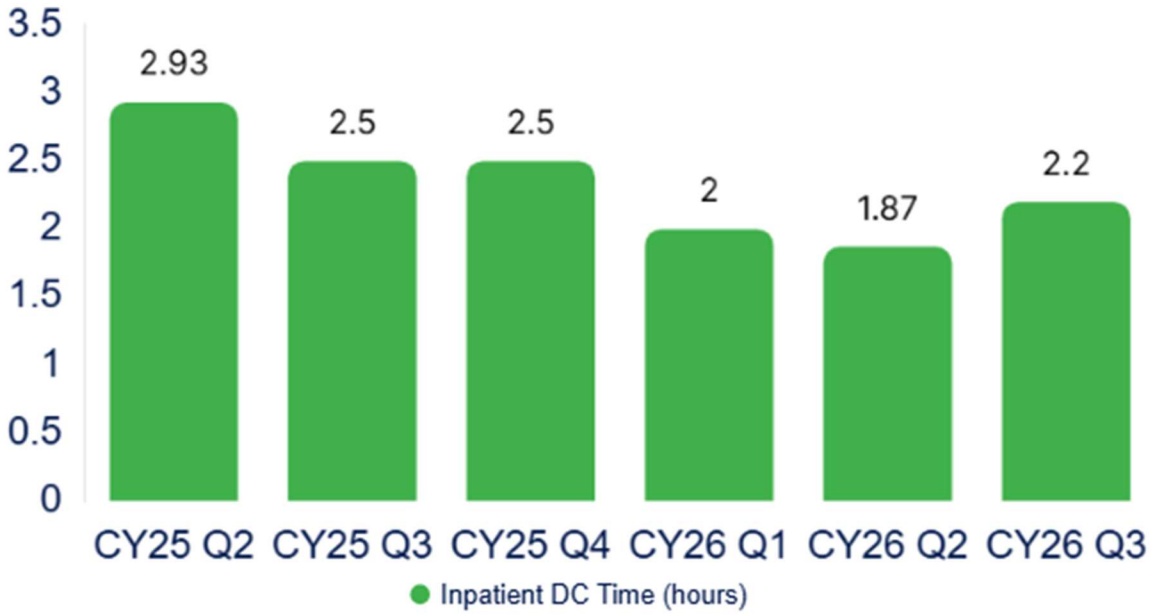
Inpatient Average Length of Stay

Average length of inpatient hospital stays. Annual average must remain below 96 hours to maintain Critical Access Hospital status.

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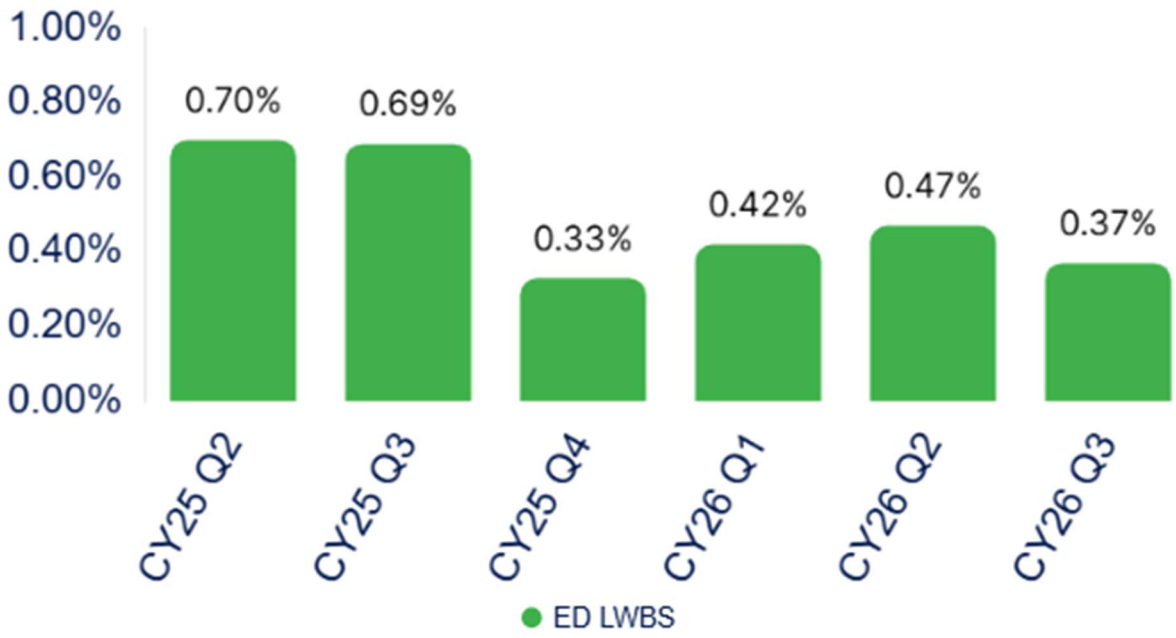
Inpatient Discharge Time (hours) <



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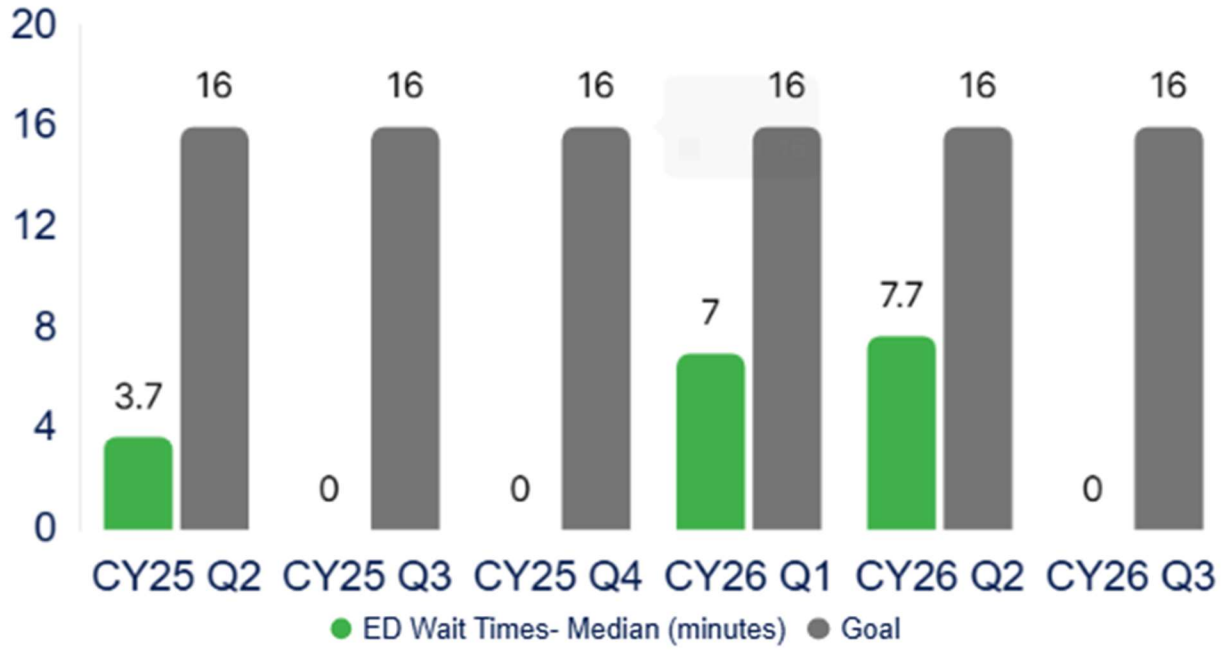
ED Left Without Being Seen <



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ED Wait Times- Median (minutes) <



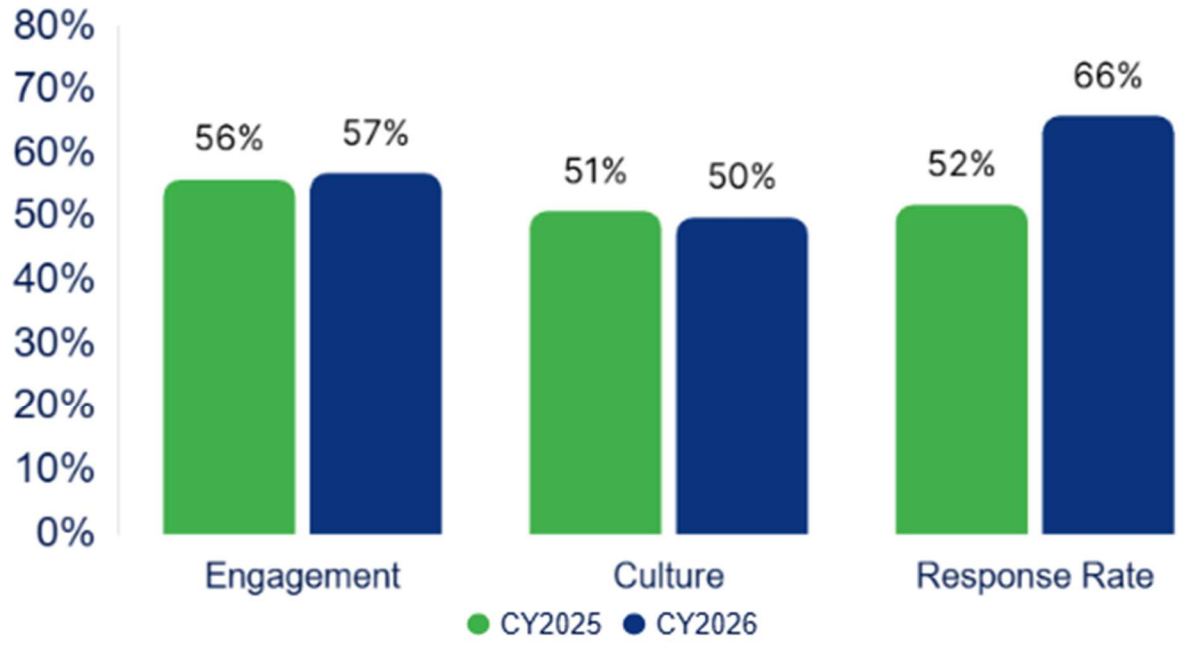
ED Wait Times

Median time from triage to when patient is seen by a provider.

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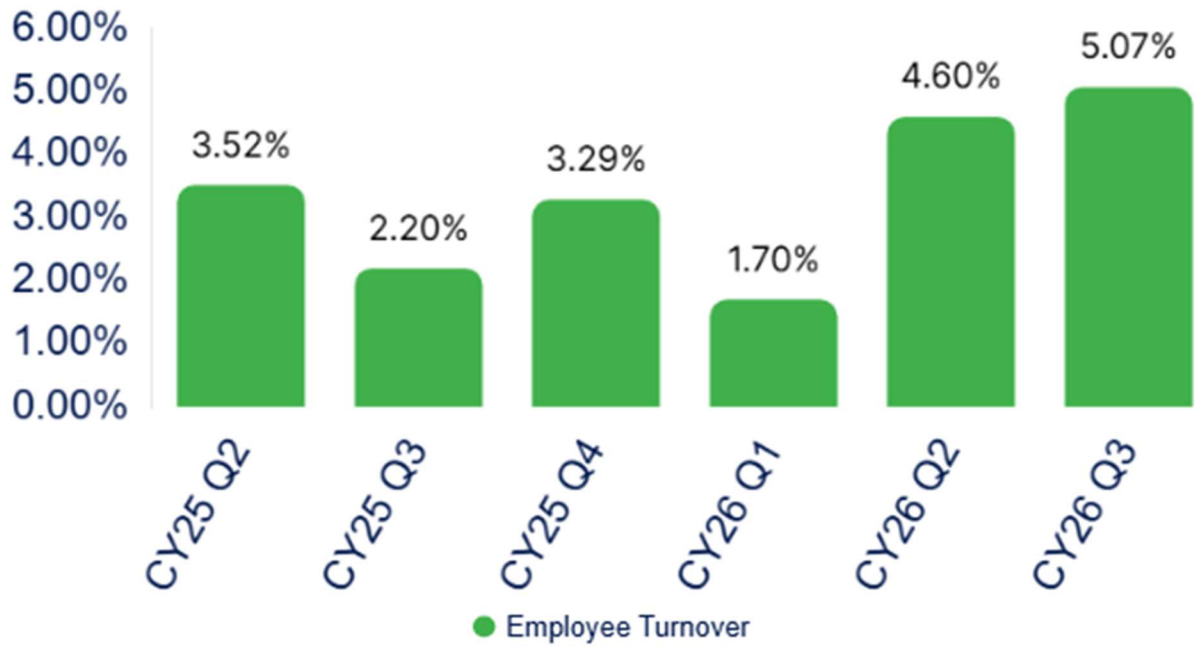
Employee SCORE Survey Results



NIHD Quality Committee Dashboard

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Employee Turnover



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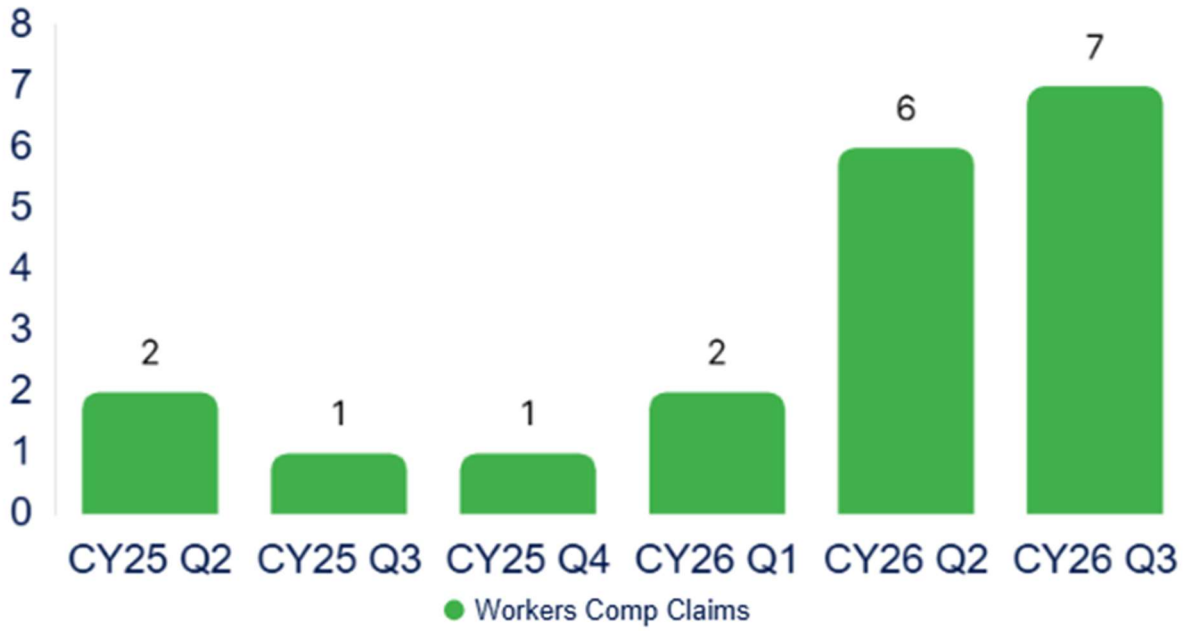
Reportable Incidents- Employees



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Workers Comp Claims



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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Adam Hawkins, DO, Chief Medical Officer

RE: Grievance Resolution Committee Structure and Process

MEMORANDUM

Committee Structure

The Grievance Resolution Committee (GRC) is a multidisciplinary committee established under Northern Inyo Healthcare District's Patient Safety Program and reports to the Patient Safety Committee. Its primary responsibility is to ensure patient and family grievances are reviewed thoroughly, consistently, and timely, with a focus on appropriate resolution, patient communication, and organizational improvement.

The committee functions in a multidisciplinary structure and evaluates concerns from clinical, operational, financial, and patient experience perspectives. A collaborative environment is approaches with other committees and department. For example, if events require a process improvement change or additional operation improvement, the GRC will connect with the Clinical Events Committee.

Ultimately, the Patient Safety Committee serves as a central forum for bringing together findings from different areas of the organization and the GRC supports this philosophy by determining appropriate grievance resolutions, and ensuring identified concerns are communicated to the appropriate leadership or committee for follow-up.

Grievance Process

NIHD has an established grievance resolution process designed to ensure patient and family concerns are acknowledged, appropriately investigated, and resolved in a timely and consistent manner.

Receipt and Initial Review

Patient and family grievances are documented in the Unusual Occurrence Reporting (UOR) system. The Compliance Department reviews the report, identifies whether it meets the definition of a grievance, and assigns it to the Grievance Resolution Committee and other appropriate stakeholders.

The Quality Department contacts the patient to better understand their concerns, identify their desired outcome, and coordinate the review process.

Investigation and Committee Review

Depending on the nature of the grievance, additional reviews may be initiated, including clinical or Medical Staff peer review, departmental operational review, and financial review.

The GRC meets weekly or as needed to review grievances. During these meetings, the committee evaluates:

- The patient's concerns and desired resolution.
- Clinical and operational findings, including communication gaps, delays, or process failures.
- Billing concerns and potential financial adjustments.
- Opportunities for service recovery, corrective action, and process improvement.

The committee determines whether sufficient information is available to reach a resolution or whether additional investigation is necessary. Significant patient harm events are escalated through the appropriate patient safety and BETA HEART processes.

Resolution and Follow-Up

Once the committee reaches a determination, the Quality Department or designee communicates the outcome to the patient through direct follow-up and a written resolution letter.

Resolution may include clarification of care, an apology, service recovery, financial adjustments when appropriate, or identification of operational and clinical improvements.

The Quality Department coordinates follow-up on identified actions. Beyond resolving individual concerns, the committee uses patient feedback to identify recurring trends, recommend improvements, and support organizational learning and accountability.

Case Volume

During CY 26 Q3, the committee averaged approximately 7 grievances per month, with 6 HEART events identified during the quarter.


Board of Directors
Quality Committee
MAIC
Patient Safety Committee
Peer Review
Falls Committee
Safe Patient Handling
Grievance Resolution Committee (GRC)
Environment of Care Committee (formerly Safety)
Clinical Events Review Committee
Infection Prevention Committee (IP)
Alarm Fatigue Committee
Grievances, HEART Events
Clinical Errors and Near Misses
Antibiotic Stewardship
Sharps Committee

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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Adam Hawkins, DO, Chief Medical Officer

RE: Patient Safety Committee

MEMORANDUM

Overview

Over the past year, & in conjunction with the work we have pursued through BETA HEART, we have been working to strengthen how Northern Inyo Healthcare District identifies, responds to, and learns from patient safety events. One of our primary goals has been to develop a more coordinated and consistent approach to patient safety across the District.
Historically, much of this work has occurred through individual departments, committees, and processes. While each serves an important purpose, we believe there is an opportunity to better connect these efforts and develop a more comprehensive Patient Safety Program.

Proposed Program Structure

- District-wide coordination: We are developing a Patient Safety Program to coordinate an organized and rapid response to any patient safety event on our campus.
- Clear accountability: Defining responsibility for reviewing safety concerns, coordinating follow-up, and ensuring issues are addressed.
- Consistent response: Developing a more standardized approach to evaluating events, investigating significant concerns, and implementing corrective actions.
- A culture of safety: Encouraging staff to report concerns, near misses, and errors without fear of inappropriate blame or retaliation, with a focus on improving systems.
- Proactive improvement: Identifying high-risk processes and opportunities to prevent harm before an adverse event occurs.

Moving Forward

Ultimately, we want to move beyond simply identifying and documenting patient safety concerns. We want to build a program that ensures concerns are appropriately investigated, assigned to the right teams, and translated into meaningful improvements. This work is ongoing, and we look forward to sharing more as the program develops.

NORTHERN INYO HEALTHCARE DISTRICT

Quality Committee

Unusual Occurrence Report (UOR) Overview

January 1 · September 30, 2026

PURPOSE OF SUBMISSION

Submitted to the Quality Committee for review and recommendation to the full Board of Directors.

Report scope

Occurrence reporting volume, categories, trends, aging, response timeliness, and selected reporting details.

Unusual occurrence

An unanticipated occurrence that deviates from regular District operations, whether or not injury occurs. A UOR supports investigation, tracking, trending, and identifying opportunities for performance improvement.

Prepared by Patty Dickson, Compliance Officer

Northern Inyo Healthcare District | November 2026

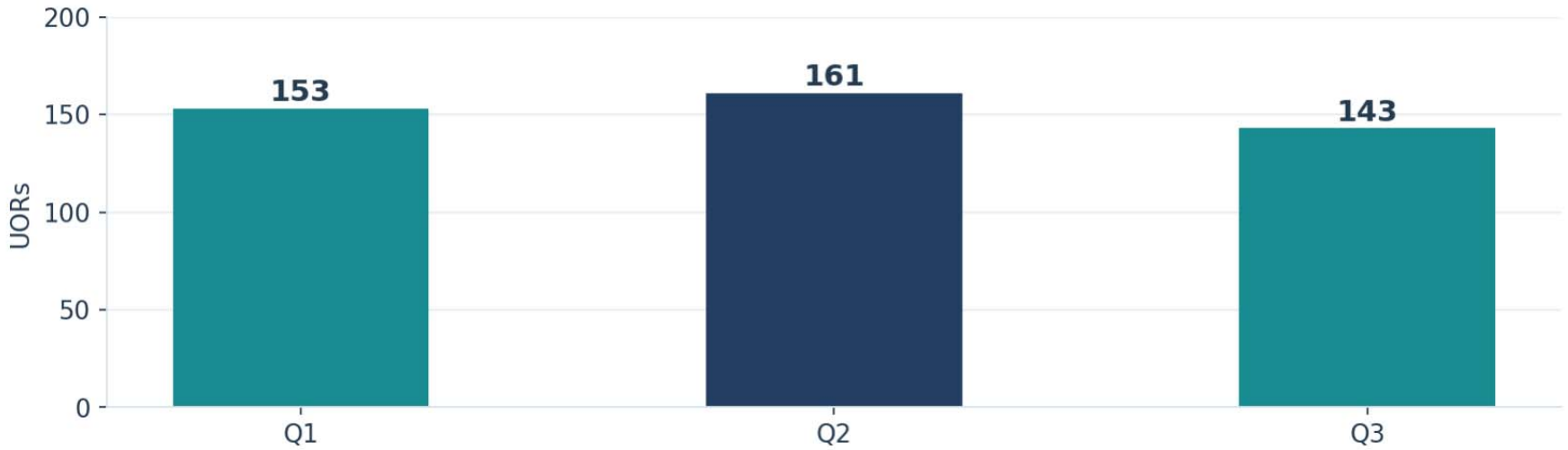
Unusual Occurrence Report (UOR) Overview | January·September 2026

All reported incident categories included

457

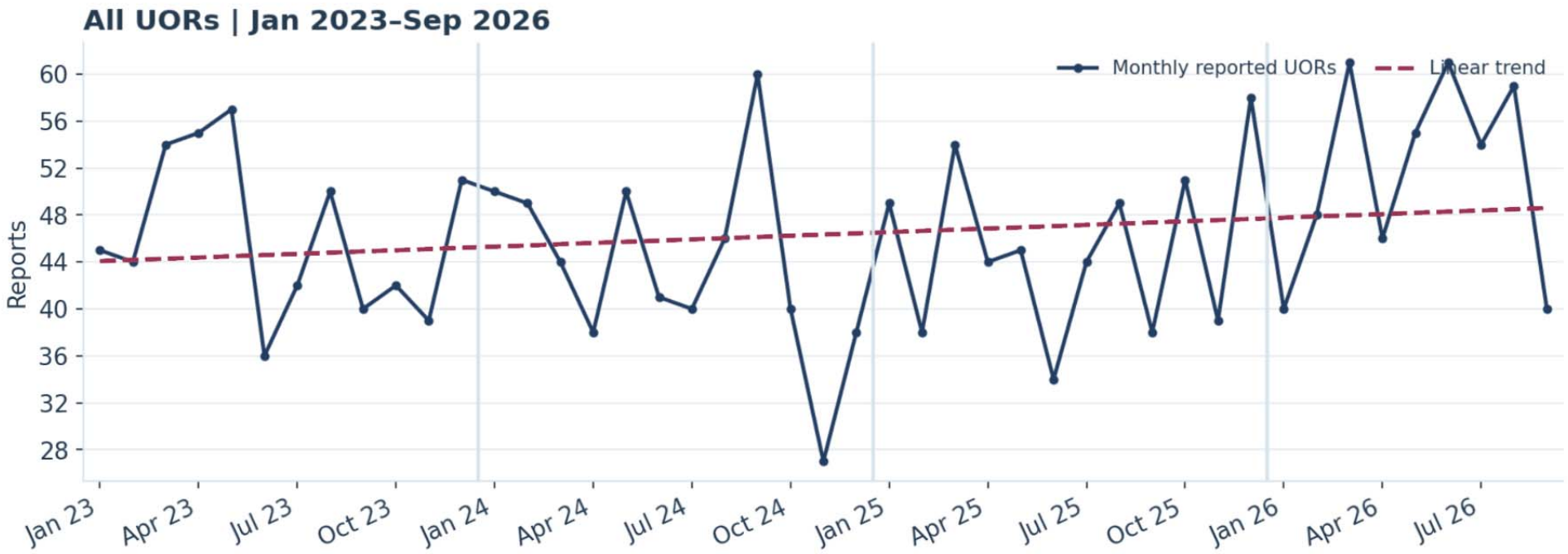
Total reported UORs

January 1–September 30, 2026



Historical Reporting Volume | 2023–2026

Monthly UOR counts and trend line | Through September 30, 2026

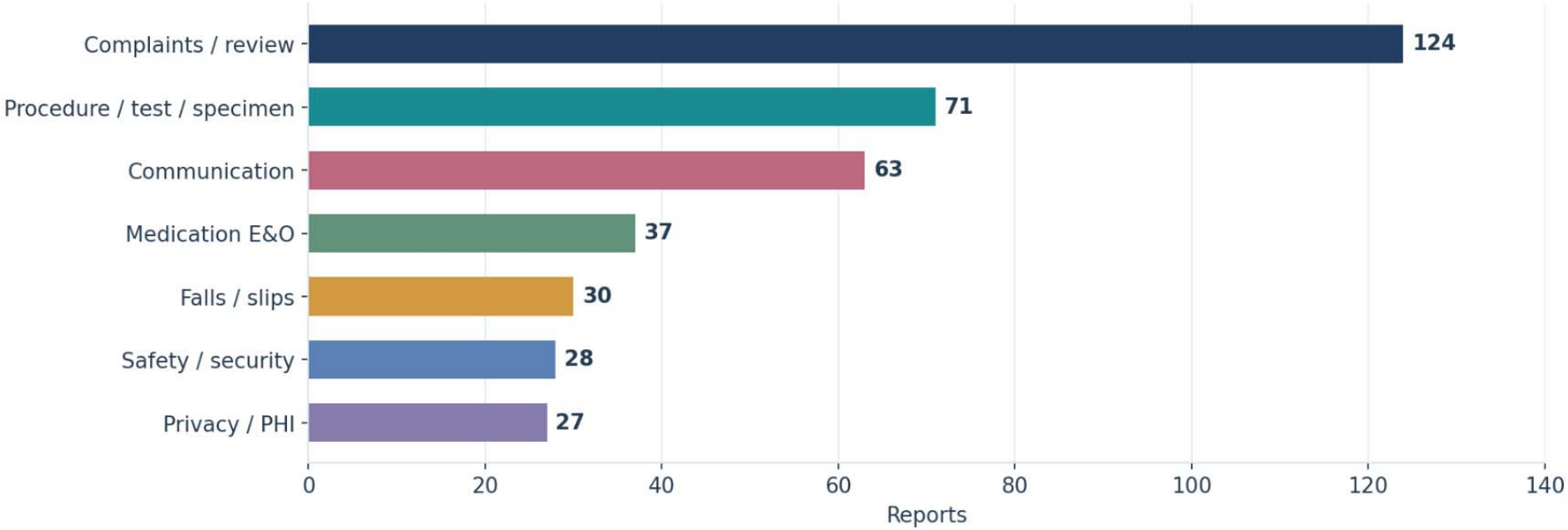


Reporting timing consideration

Some laboratory quality variance reports may be entered in batches rather than at the time of the event. This may contribute to month-to-month fluctuations in recorded UOR volume; the extent has not been quantified.

Top Seven Reported Incident Categories

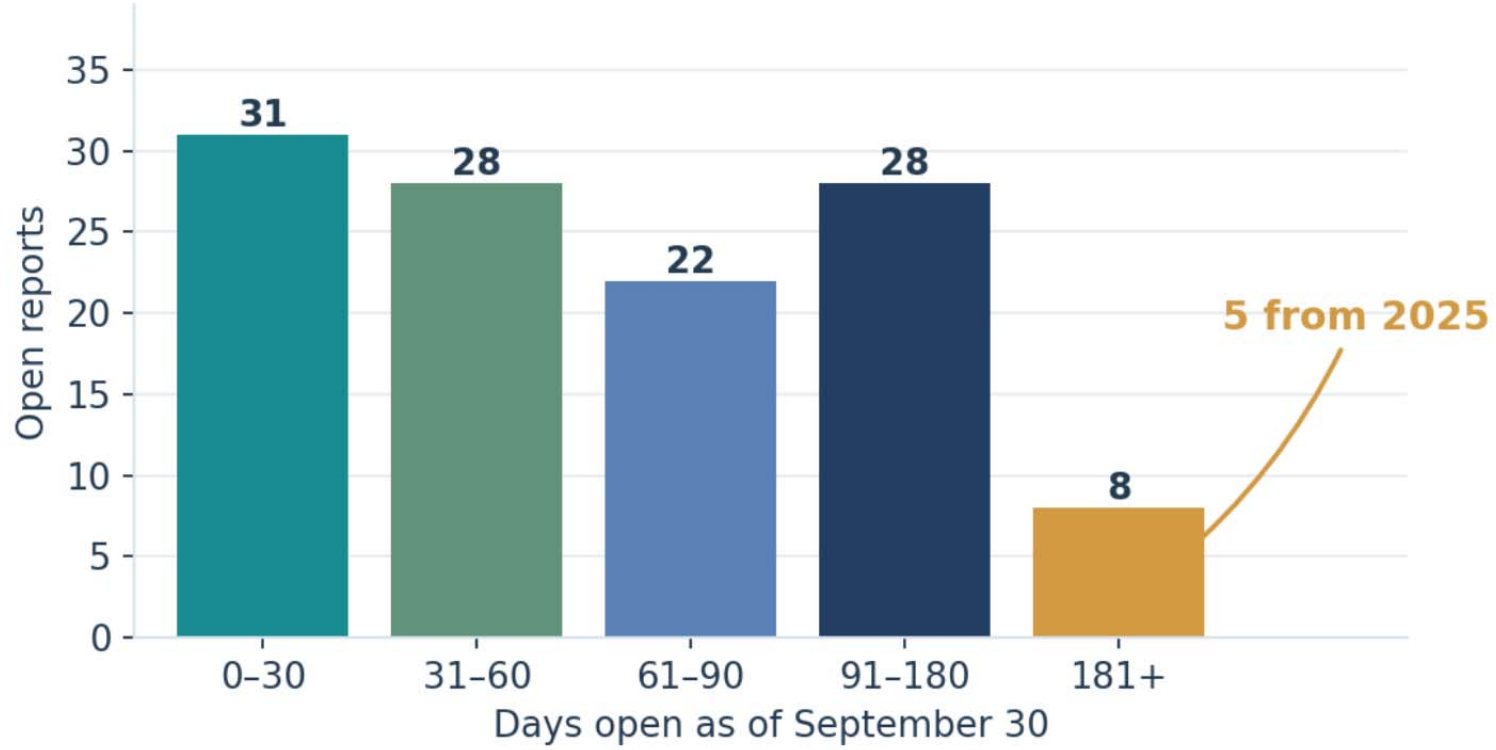
January 1–September 30, 2026 | Includes Medication Errors and Occurrences (E&O) and privacy reports



UOR Aging Report | September 30, 2026

UORs Excluding Medication and Privacy Reports | Creation and closure dates

117 **UORs open on September 30**

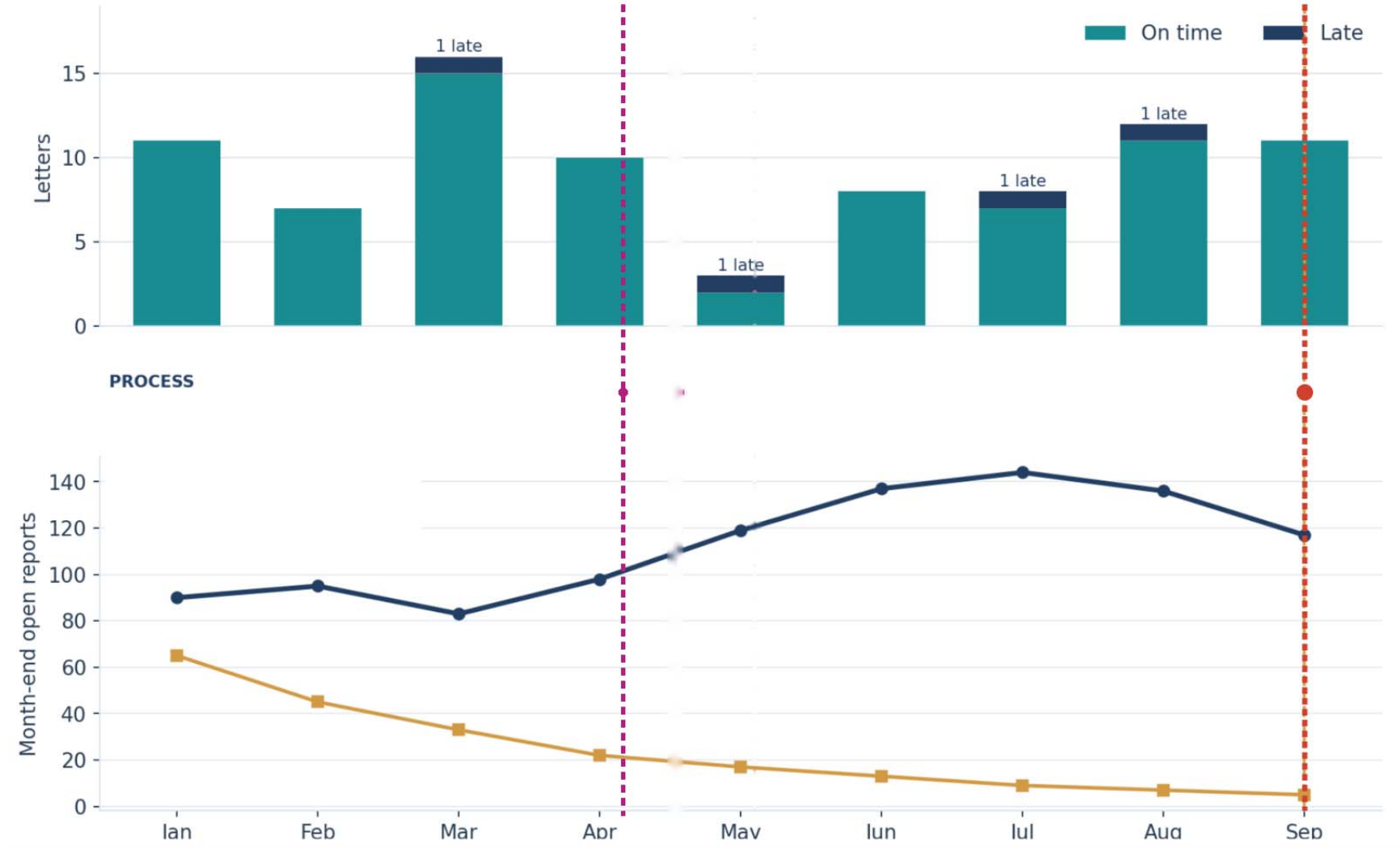


Scope: Medication error and privacy reports are excluded from these aging counts.

An open report does not necessarily represent an unresolved safety concern.

UOR Resolution and Process Improvement

January·September 2026 | Complaint letters, UOR backlog, and workflow milestones



Scope: Open-report trends exclude medication and privacy reports; milestones mark process start dates.

Initial Complaint Response Letter Timeliness

Initial response letters sent within 7 days | 2019-2026

2019

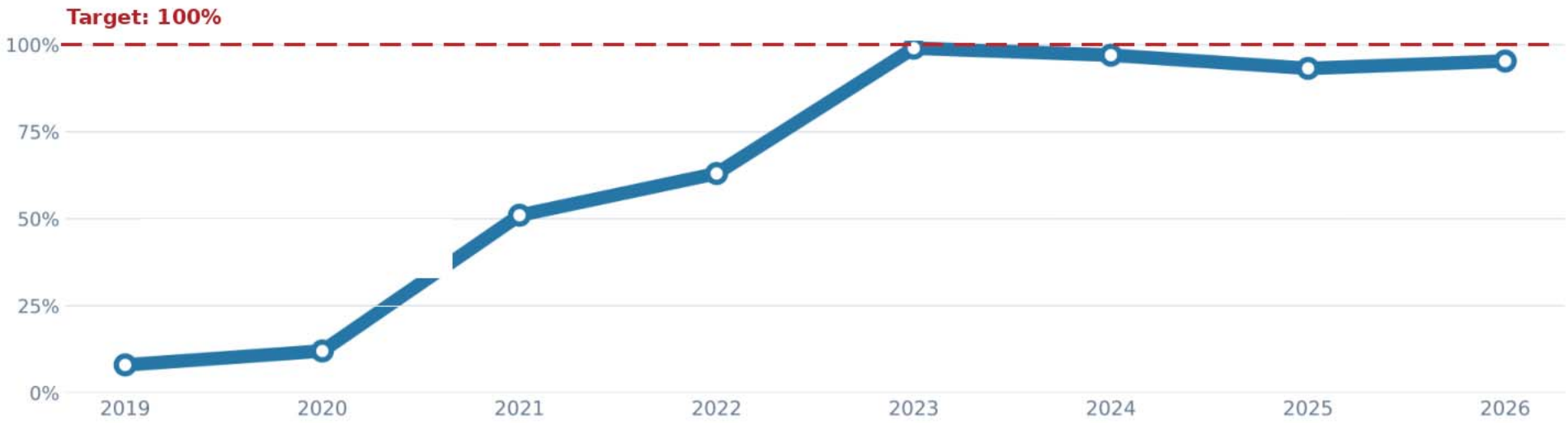
8%

ON TIME

2026

95.3%

ON TIME



2026 data through September 30. Target: 100% of initial letters within 7 days.

Historical Trend | Complaints and Review Requests

January 2023·September 2026



Privacy-Related UORs | Historical Reporting Trend

January 2023–September 2026

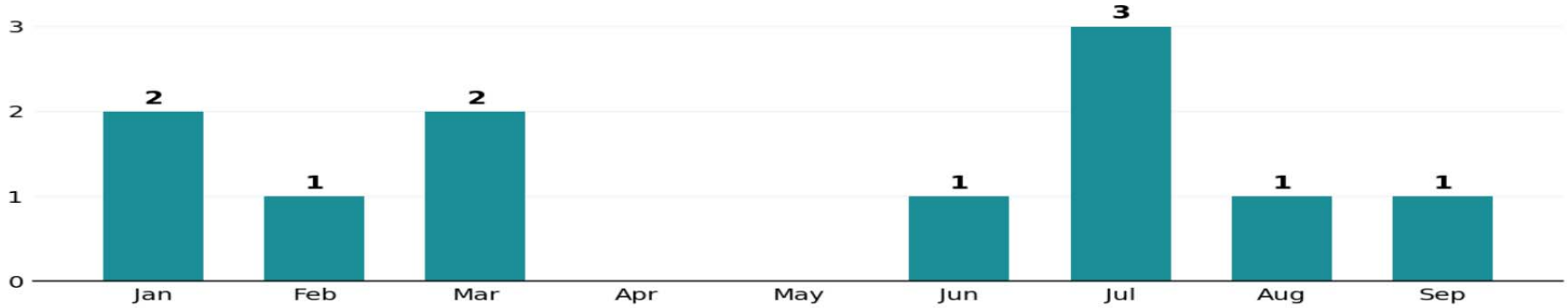


Workplace Violence | Reporting Overview

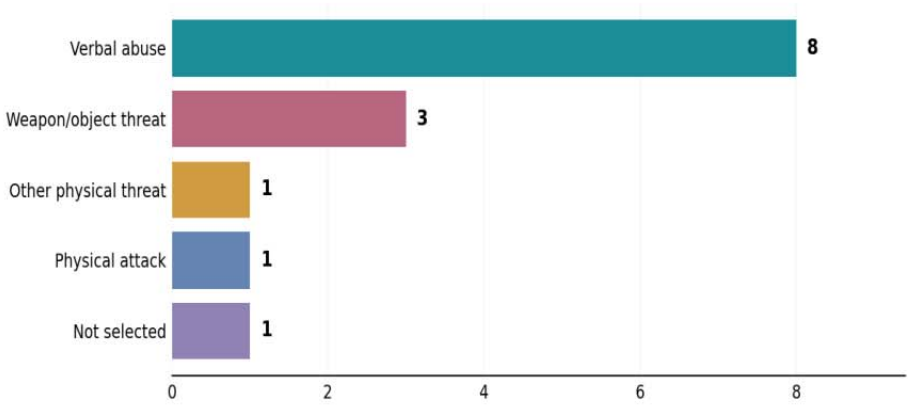
January–September 2026 | Unusual Occurrence Reports (UOR)

11 Workplace violence reports

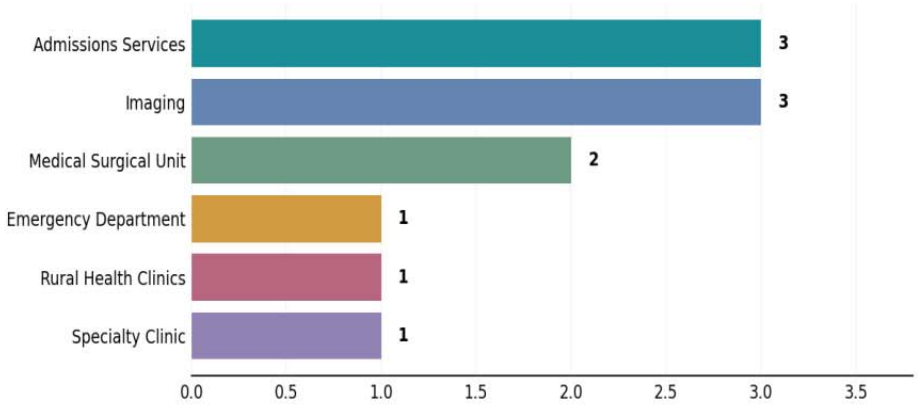
Reports by Month



Reported Aggression Types



Incident Locations

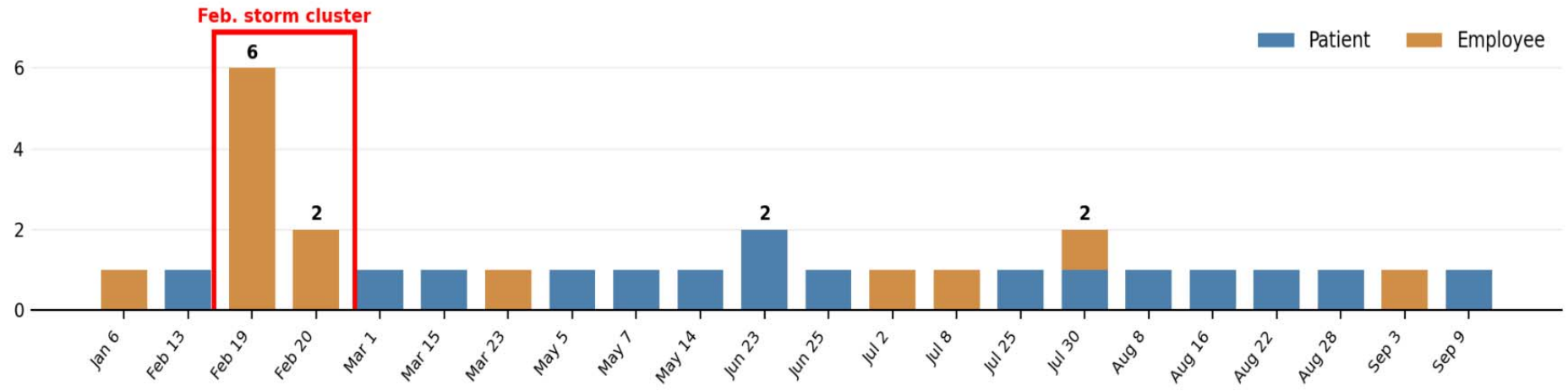


Aggression is a multi-select field; selections may exceed the 11 reported incidents.

Falls and Slips | Reporting and Risk Assessment

January 1·September 30, 2026 | Unusual Occurrence Reports (UOR)

30	14	8
TOTAL FALLS/SLIPS	EMPLOYEE FALLS	STORM CLUSTER



Bars are stacked by patient and employee classification. Red outline highlights the February 19–20 storm-related employee cluster.

Winter Storm | Trend and Corrective Action

Finding: 8 employee falls during February 19·20 storm (57% of employee falls).

Cause: Snow and ice accumulation exceeded manual removal capacity despite extensive Facilities response.

Corrective action: Snow-removal tractor and appropriately sized equipment ordered.

Status: Equipment delivery, winter readiness, and effectiveness to be verified.

Medication Errors and Occurrences | 2026

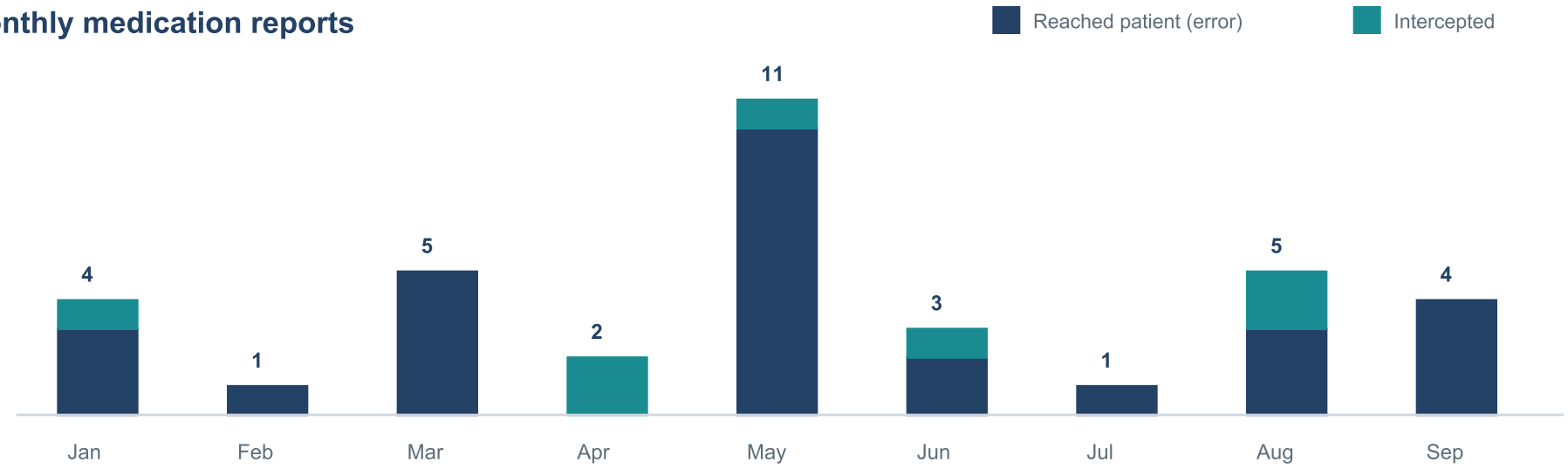
January 1-September 30, 2026 | Medication reporting and MERP indicators

36
Medication-specific reports

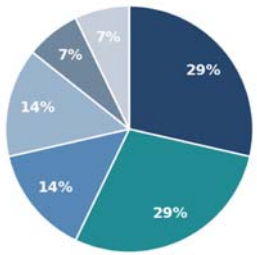
29
Errors reaching the patient

7
Occurrences intercepted

Monthly medication reports



July-September 2026: MERP indicator selections



Administration	**4 (29%)**
Order communication	**4 (29%)**
Labeling	**2 (14%)**
Prescribing	**2 (14%)**
Distribution	**1 (7%)**
Not selected	**1 (7%)**

14 indicator selections across 10 July-September reports

Source: Medication Errors and Occurrences reports, January-September 2026. Of 37 medication-related UORs, 36 have medication-specific classification fields. One was filed through the regular UOR workflow and reviewed by MAIC; its classification fields were not captured.