

Board Meeting

Board Meeting - October 21, 2026

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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

October 21, 2026, 8:30 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/j/86114057527>

Webinar ID: 861 1405 7527

Passcode: 898843

PHONE CONNECTION:

(669) 444-9171

(719) 359-4580

Webinar ID: 861 1405 7527

1. Call to order at 8:30am
2. Public comment on closed session items
3. Adjourn to closed session for:
 - a. Conference with legal counsel – Existing Litigation
Existing litigation pursuant to Government Code § 54956.9(d)(1)
Loy, M.D. v. Northern Inyo Hospital, et al.
 - b. 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. 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 September 16, 2026 Regular Board Meeting
 - b. Approval of Policies and Procedures
 - i. Medical Staff Department Policy - Emergency Medicine
 - ii. Mobile Intensive Care Nurse
 - iii. Newborn Blood Glucose Monitoring
 - iv. Reimbursement for Mileage, Meals and Incidentals, and Lodging for District Business
 - v. Pre-cleaning and Returning of Instruments to Sterile Processing
 - vi. Trauma Policy
8. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
 - a. Medical Staff Initial Appointments 2026-2027
 - b. Medical Staff Telemedicine Privileges 2026-2027
 - c. Additional Privileges
 - d. Medical Staff Reappointments 2027-2028
9. Chief of Staff Report
 - a. Infectious Disease Privilege Form – Action Item
10. Chief Executive Officer Report
 - a. Introduce Board Clerk – Information Item
 - b. Community Engagement – Information Item
 - c. Joint NIHD/Mammoth Hospital Update – Information Item
 - d. Renown Update – Information Item
 - e. HealthTrust Benchmarking Update – Information Item
 - f. Outpatient Clinic Operational Assessment – Action Item
11. Governance Committee
 - a. Advocacy Update – Information Item
 - b. Performance Evaluation Process – Information Item
12. Finance Committee
 - a. Grant Update – Action/Information Item

- i. Accelerator Partners Grant – Action Item
 - ii. Workforce Grant – Action Item
 - iii. HCAI Letter – Action Item
 - b. Capital Report – Action Item
 - c. Financial and Statistical Report – Action Item
13. Future Agenda Items
14. General Information from Board Members
15. Adjournment

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

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Vice-Chair Lent called the meeting to order at 9:05 am.
PRESENT	Melissa Best-Baker, Chair David Lent, Vice-Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large Adam Hawkins, Chief Medical Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
ABSENT	Recused from closed session: Melissa Best-Baker, Chair
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Vice-Chair Lent reported that at this time, audience members may speak only on closed session agenda items. Public Comment: None
ADJOURN TO CLOSED SESSION	Adjourn to closed session at 9:07 am.
RETURN TO OPEN SESSION	Return to open session at 10:00 am.
REPORT OUT FROM CLOSED SESSION	No reportable action.
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. Public Comment: None
CONSENT AGENDA	Public Comment: None Board Discussion: None Motion by Turner to approve the consent agenda. 2nd: Smith Pass: 5-0 The following items were approved:

1. Approval of minutes for August 19, 2026 Regular Board Meeting
2. Approval of minutes for August 19, 2026 Special Board Meeting
3. Approval of minutes for September 10, 2026 Special Board Meeting
4. Approval of Policies and Procedures
 - a. Emergency Management Plan
 - b. Water Management Plan (WMP) Prevention and Control Legionella and Other Waterborne Pathogens

CHIEF EXECUTIVE
OFFICER REPORT

Panther Clinic Update

Pediatric Nurse Practitioner McEvoy provided an update on NIHD's school-based health clinics and reported that the Panther Clinic at Palisade Glacier High School is anticipated to begin providing services on October 2. The clinic will provide services similar to the Bronco Clinic and serve students at Palisade Glacier High School and the alternative school, with staff also exploring options to improve access for Big Pine students. McEvoy reported that the school provided \$50,000 toward startup and remodeling costs and that an additional \$9,000 grant was received through the foster youth program to support setup and programming. The clinic is initially expected to operate on the first Friday of each month, with the schedule to be evaluated based on student needs and utilization. She also reported that the Bronco Clinic continues to experience strong utilization, particularly for mental health needs, physicals, vision care, and other routine healthcare services.

Public Comment: None

Board Discussion:

The Board discussed the value of NIHD's school-based clinics in improving access to care for local students, particularly in addressing mental health needs and barriers to routine healthcare services. Board members expressed support for expanding access to students throughout the District, including Big Pine, and recognized McEvoy and the staff and community partners supporting the program.

Communication Plan

Manager of Marketing, Communications and Strategy Laughon presented NIHD's FY2027 Communication Plan and reviewed communication results from FY2026. Laughon reported significant growth in NIHD's digital reach, including 2.57 million social media impressions, approximately 28,700 YouTube views, and approximately 127,000 website users, while noting that traditional media remains important in reaching the Eastern Sierra community. She reported that content featuring employees, providers, patient care services, new programs, and community events generated the strongest engagement and emphasized using trusted local voices to connect the community with care. The FY2027 plan focuses on making care easier to find, supporting the patient experience, strengthening community trust, highlighting NIHD's people and progress, keeping employees and medical staff informed, and measuring effectiveness. Planned initiatives include redesigning NIH.org, a quarterly printed newsletter, expanded service-line tracking, the "Making the Most of Your Visit" campaign, a "Behind Your Care" video series, CEO community

conversations, and communication support for major organizational projects. Laughon emphasized that communication resources will be prioritized based on organizational needs, with patient and public safety communications taking precedence when priorities compete.

Public Comment: None

Board Discussion:

The Board expressed support for the Communication Plan and highlighted the value of the “Making the Most of Your Visit” initiative in helping patients better prepare for appointments. Board members thanked Laughon and the communications team for their work.

Joint Board Meeting

Chief Executive Officer Wallis provided an update following the September joint meeting between the NIHD and Southern Mono Healthcare District Boards. He reported that the meeting demonstrated strong interest in continued regional collaboration and identified opportunities to build on existing partnerships between the two organizations. He recommended moving forward with planning the next joint Board meeting, anticipated for January 2027 in Bishop, with future meetings alternating between Bishop and Mammoth.

Public Comment: None

Board Discussion:

Board members expressed support for continuing the joint meetings and noted the positive tone, shared goals, and opportunities for greater regional collaboration. The Board also recognized that staff from the two organizations are already collaborating in several areas.

Motion by Egan to approve a joint board meeting with SMHD

2nd: Lent

Pass: 5-0

GOVERNANCE
COMMITTEE

Advocacy Update

Madden provided the following legislative and advocacy updates:

- **AB 1923 – Distressed Hospital Loan Program:** The original language related to funding the Distressed Hospital Loan Program was removed and replaced with unrelated legislation. The requested funding was instead included in the State budget, and the current bill is no longer relevant to NIHD.
- **AB 1607 – Maddy Emergency Medical Services Fund:** The bill would extend the sunset date of the Maddy Emergency Medical Services Fund, which provides reimbursement to hospitals and physicians for care provided to uninsured patients. The bill passed the Legislature and is awaiting action by the Governor.

- **HR 8209 – School-Based Health Centers:** The federal legislation would establish a competitive grant program supporting school-based health centers, with approximately \$55 million annually proposed for fiscal years 2027 through 2031. The bill remains in the House of Representatives awaiting further action.
- **AB 1882 – Labor and Delivery Services:** The bill would establish a pilot program providing funding to qualifying hospitals for maintaining labor and delivery services and has passed the Legislature and is awaiting action by the Governor. Implementation of the pilot program would require a separate State budget appropriation, which has not yet been provided. NIHD will continue monitoring the legislation and potential funding because the District may qualify for the program.
- **Office of Health Care Affordability (OHCA):** OHCA approved regulations establishing enforcement and penalty provisions associated with the statewide healthcare spending target. The statewide target is 3.5 percent, with potential penalties based on the amount by which an organization exceeds the target. Madden discussed the Performance Improvement Plan process and the potential delay between a spending-target year and assessment of penalties.

Public Comment: None

Board Discussion:

The Board expressed significant concern regarding OHCA's 3.5% spending target and the potential impact of the enforcement framework on rural hospitals. Discussion emphasized that rising labor costs, including wage increases necessary for recruitment and retention, and investments in facilities and services could cause NIHD to exceed the target despite being necessary to maintain and expand access to care. Board members also raised concerns regarding the Performance Improvement Plan process, potential penalties, and the administrative and financial burden the framework could place on the District.

Strategic Plan

Chief Executive Officer Wallis presented NIHD's 2025–2030 Strategic Plan, which establishes a five-year framework organized around the District's CARES values and strategic priorities. He explained that each priority is supported by goals, objectives, tactics, and specific actions to provide a structure for implementation and accountability. Key areas of focus include patient experience and access to care, sustainable service-line growth and community partnerships, employee and physician engagement, quality and care coordination, and long-term financial and operational stewardship. Progress will be monitored through a quarterly dashboard using status indicators to identify areas that are on track, require attention, or have not yet begun. He reported that the dashboard is expected to be presented to the Board beginning in December and ultimately made available to the public on the District's website.

Public Comment: None

Board Discussion:

The Board expressed strong support for the Strategic Plan and discussed the value of having a clear framework that connects the District's priorities to measurable goals and actions.

Motion by Egan to approve the Strategic Plan

2nd: Turner

Pass: 5-0

Compliance Report

Compliance Officer Dickson presented the Compliance Report and highlighted efforts to evolve Board reporting from a summary of compliance activities toward an assessment of program effectiveness. Dickson reported that future reports will incorporate additional Board education to support the Board's compliance oversight responsibilities. She also reported that the Compliance and Business Ethics Committee charter has been restructured and that the committee is expected to convene before the end of the year. The initial meeting will focus on educating participants about the committee's role, with a core group supported by subject-matter experts as needed. Updates from the committee will be incorporated into future Compliance Reports to the Board.

Public Comment: None

Board Discussion:

The Board discussed the status of the Compliance and Business Ethics Committee and questioned when committee meetings would resume. Dickson reported that the committee has not met for some time, but that the charter, agenda, and educational materials have been prepared and she expects to convene the committee before the end of the year.

Motion by Smith to accept the Compliance Report

2nd: Egan

Pass: 5-0

FINANCE COMMITTEE

Strategic Growth Wipfli Update

Chief Executive Officer Christian Wallis provided an update on the Strategic Growth Initiative, which integrates the District's market survey, master facility plan, and long-range financial plan to evaluate opportunities for expanding services and provider capacity. The market survey identifies provider needs, while the master facility plan evaluates the space necessary to accommodate existing and additional providers. The financial analysis will evaluate anticipated revenue from relocating existing specialists and recruiting new specialties against the costs associated with acquiring or financing a medical office building. Wallis reported that financing options will also be evaluated to determine how expanded services and associated revenue could support the cost of the facility, with a report anticipated for presentation at the October Board meeting.

Public Comment: None

Board Discussion: None

RHTP (Rural Health Transformation Project)

Chief Executive Officer Wallis provided an update on the Rural Health Transformation Program and reported that all grant applications have been submitted. Applications include the Eastern Sierra Women's Health collaborative, Epic electronic health record modernization, a chronic disease initiative, and a workforce recruitment and retention proposal. He highlighted the workforce application, which requests just under \$1 million to support recruitment and retention efforts in response to identified provider needs, including family practice, anesthesiology, hematology/oncology, cardiology, and gastroenterology. Applications will be reviewed through the State and federal process, with award decisions anticipated in October and approximately 12 months to implement funded projects. He recognized staff and the District's grant writer for their work developing and submitting the applications.

Public Comment: None

Board Discussion:

The Board expressed appreciation for the work completed to pursue the available funding opportunities.

Financial and Statistical Report

Chief Financial Officer Mossman presented the July Financial and Statistical Report and reported a strong start to the fiscal year, with income exceeding budget by approximately \$900,000. Higher patient volumes, particularly surgical and orthopedic volumes, contributed to net patient revenue exceeding budget by approximately \$1.3 million. Expenses exceeded budget by approximately \$338,000, primarily due to costs associated with increased volumes, contract labor, provider productivity payments, and billing fees. Collections exceeded \$11 million for the month, representing an all-time high, while accounts receivable days continued to improve. Mossman reported that the District remains in a strong cash position, with approximately 114 days cash on hand and a debt service coverage ratio of 6.0, both exceeding required financial covenants. She also discussed ongoing efforts to improve operational efficiency, align staffing with volumes, benchmark performance, and incorporate long-range financial planning into the District's strategic growth efforts.

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 Egan to accept the Financial and Statistical Report

2nd: Smith
Pass: 5-0

FUTURE AGENDA ITEMS None

GENERAL INFORMATION FROM BOARD MEMBERS Board members expressed appreciation for the opportunity to attend the recent Medical Executive Committee gathering and interact with medical staff and their families. A Board member also reported that a community member had expressed interest in helping close the funding gap for the purchase of two bedside inpatient nephrology machines.

ADJOURNMENT Adjournment at 11:28 am.

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: Medical Staff Department Policy - Emergency Medicine		
Owner: Medical Staff Director		Department: Medical Staff
Scope: Practitioners with Privileges in Emergency Medicine		
Date Last Modified: 10/07/2026	Last Review Date: No Last Periodic Review Date Set	Version: 2
Final Approval by: NIHD Board of Directors		Original Approval Date: 06/16/2022

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

POLICY: All practitioners (physicians and Advanced Practice Providers) granted privileges in the Department of Emergency Medicine will adhere to the following procedures. The procedures outlined in this document should reflect and be congruent with the agreements in the Emergency Room Physician Service Agreements provided by Eastern Sierra Emergency Physicians.

PROCEDURE:

1. Patient Care Responsibilities

- a. Practitioners will provide 24-hour basic emergency services for patients of all ages whose emergent medical needs can be met within the capabilities of the hospital staff and facilities.
- b. Practitioners are to be present and ready to see patients in the Emergency Department or take sign-out from the outgoing provider at the time of their scheduled shifts. Unexcused tardiness will result in disciplinary action.
- c. Practitioners performing Emergency Services are required to be in-house at all times while on shift. Practitioners are required to respond to all emergencies/codes as outlined in existing hospital policies. Practitioners first responsibility is to their patient's in the Emergency Department but every effort should be made to assist with emergencies/codes called outside of the Emergency Department but within the hospital.
- d. Practitioners will provide a medical screening exam on all patients, regardless of the ability to pay.
- e. Practitioners will be familiar with and abide by Emergency Medical Treatment and Labor Act (EMTALA) at all times and during all patient encounters.

2. Documentation:

- a. The practitioner shall be responsible for developing the ability to use the electronic health record of NIHD. It is expected that the practitioner will maintain their individual passwords and login information. It is expected that the practitioner will maintain a level of familiarity with the electronic health record that will allow them to safely and efficiently care for patients in the Emergency Department.
- b. Informed consent is to be obtained by the physician and properly documented for applicable procedures as described in the *Informed Consent – Practitioner's Responsibility* policy.
- c. Verbal and/or phone orders are to be authenticated within the timeframe specified as per the *Verbal and/or Phone Medical Staff Practitioner Orders* policy.

- d. It is a requirement for all practitioners to participate in any training provided by the District or recommend by the Emergency Department Medical Director that involves charting. This includes but is not limited to: billing, coding, electronic health record training.
 - e. All patient charts are to be completed in a timely manner with the goal for patient charts to be completed within 24 hours of the patient encounter.
- 3. Credentialing:
 - a. Physician practitioners in the Department of Emergency Medicine must be board certified or board eligible by the American Board of Emergency Medicine or the American Board of Family Medicine or AOA (American Osteopathic Association) equivalent.
- 4. Meeting Attendance:
 - a. Practitioners are to attend meetings of the Medical Staff per Medical Staff Bylaws requirements.
- 5. Focused Professional Practice Evaluation (FPPE):
 - a. Practitioners new to NIHD will be expected to complete FPPE as per policy and as delineated during the privileging process.
- 6. Ongoing Professional Practice Evaluation (OPPE):
 - a. Practitioners will be expected to participate in all requirements of OPPE as per Medical Staff policy.
- 7. Peer Review:
 - a. All charts identified by critical indicators will be peer reviewed by a physician with privileges in Emergency Medicine. Records are confidential and will be kept by the Medical Staff Office.
- 8. Re-Entry:
 - a. Applicants to the Department of Emergency Medicine are not eligible for Re-entry.

REFERENCES:

- 1. N/A

RECORD RETENTION AND DESTRUCTION:

- 1. Life of policy, plus 6 years

CROSS-REFERENCED POLICIES AND PROCEDURES:

- 1. [Northern Inyo Healthcare District Medical Staff Bylaws](#)
- 2. [Informed Consent Policy - Practitioner's Responsibility](#)
- 3. [Verbal and/or Phone Medical Staff Practitioner Orders](#)
- 4. [Medical Staff Peer Review and Professional Practice Evaluations](#)
- 5. [Practitioner Re-Entry Policy](#)

Supersedes: v.1 Medical Staff Department Policy - Emergency Medicine
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NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Mobile Intensive Care Nurse (MICN)		
Owner: Manager of ED and Disaster Planning		Department: Emergency Department
Scope: Emergency Department RNs		
Date Last Modified: 07/11/2024	Last Review Date: 10/07/2026	Version: 4
Final Approval by: NIHD Board of Directors		Original Approval Date: 02/1995

PURPOSE:

To allow the MICN to give immediate direction by radio to the Advanced Life Support (ALS) provider following the protocols as set forth by the California State Emergency Medical Authority (EMS), administered locally by the Inland Counties Emergency Medical Agency (ICEMA), and approved as described by ICEMA.

POLICY:

The ALS providers are responsible for giving a patient care report for any patient contact. The MICN on duty at Northern Inyo Hospital emergency department (ED) shall have the necessary authority to give direction to the ALS providers by radio as outlined in the protocols. This policy allows that the MICN at Northern Inyo Hospital will have the necessary authority to follow current protocols as outlined by this policy to give direction to the ALS providers by radio.

The emergency department nurse manager, pre-hospital liaison nurse (PLN) and the base station hospital director (BSD) or designee will review the protocols prior to being instituted. If the BSD, or ED physician has concern over a particular protocol that issue will be addressed in the Emergency Services Committee, and the committee's decision will be forwarded to ICEMA. If agreed upon, that concern will be noted as an exception to the protocols for the MICN to follow. This exception will be placed in the appropriate place in the protocol manual for direction in the ED, and all MICN's will be notified of the exception.

PROCEDURE:

MICN's will have current understanding of approved protocols and will refer to the protocol manual located in the ED when any question about protocol direction arises. All MICNs will complete the requirements for MICN certification or recertification. The protocol manual will be updated as new protocols are approved, and a copy of the current protocols will be available in the main ED, near the radio at all times. This book will be updated as protocols and exceptions to protocols are made.

DOCUMENTATION:

MICN shall document all ALS contacts on the MICN run sheet and pre-hospital log. The MICN shall also be responsible for any other pertinent paperwork relating to ICEMA policy.

REFERENCE:

1. LALS/ALS ICEMA (EMS Agency) Protocol, Base Hospital Designation, Health and Safety Code Division 2.5 1797.56

RECORD RETENTION AND DESTRUCTION: Record retention will be maintained for 6 years as per California Hospital Association recommendations.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pre-Hospital Care Policy
2. ICEMA Policy Procedure and Protocol Manual

Supersedes: v.3 MICN Guidelines



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Newborn Blood Glucose Monitoring		
Owner: PERINATAL NURSE MANAGER		Department: Perinatal
Scope: Perinatal LDRP Nurse		
Date Last Modified: 09/30/2026	Last Review Date: No Last Periodic Review Date Set	Version: 11
Final Approval by: NIHD Board of Directors		Original Approval Date: 12/17/15

PURPOSE: To provide guidelines for blood glucose monitoring, screening and treatment for neonates at risk of hypoglycemia.

DEFINITIONS:

Hypoglycemia: A condition in which blood sugar (glucose) level is lower than the standard range.

Point of Care Testing (POCT): clinical testing that occurs at the bedside or close to where treatment is provided.

Prematurity: Neonates born less than 37 weeks' gestation.

Euglycemic: A condition or state in which the blood glucose level is within normal range.

POLICY:

1. All newborns will be assessed for the need to monitor blood glucose levels.
2. All infants with risk factors for hypoglycemia (asymptomatic) will undergo routine glucose screening. All symptomatic newborns will be immediately screened and physician notified.
3. All Point of Care Testing (POCT) will be done by heel stick blood sugar (HSBS) unless otherwise indicated.

PROCEDURE:

1. For at risk infants establish regular feedings approximately every 2 to 3 hour. Breastfeeding support and assessment of milk supply and infant latch must occur.
2. **INITIAL** feed: All infants should be fed within the first hour of life and prior to the first blood glucose check, unless unstable. If the first feed is delayed, or the infant is ordered NPO, the initial screen should occur between 60-120 minutes of life.
3. Symptoms of newborn hypoglycemia may include irritability, exaggerated Moro reflex, high pitched cry, decreased suck, temperature instability, jitteriness, tachypnea, apnea, lethargy, decreased tone, or seizures. If there is concern for hypoglycemia based on these symptoms, screen immediately. If blood glucose level is outside of defined parameters, notify pediatrician. *If infant is ≥ 48 hours of age, notify provider if glucose is at any point < 60 .*
4. **Newborns with the following identified risk factors should be monitored for 24 hours:**
 - a) Prematurity
 - b) Small for Gestational Age (SGA) - consider antepartum diagnosis of IUGR when assessing for SGA.
5. Infants requiring **24 hours** of blood glucose monitoring require a minimum of 5 total checks within defined parameters to be considered euglycemic. These checks should occur at approximately the following intervals
 - a) Within 30-60 minutes after the first feed, or between 60-120 minutes of life if feeding is delayed.

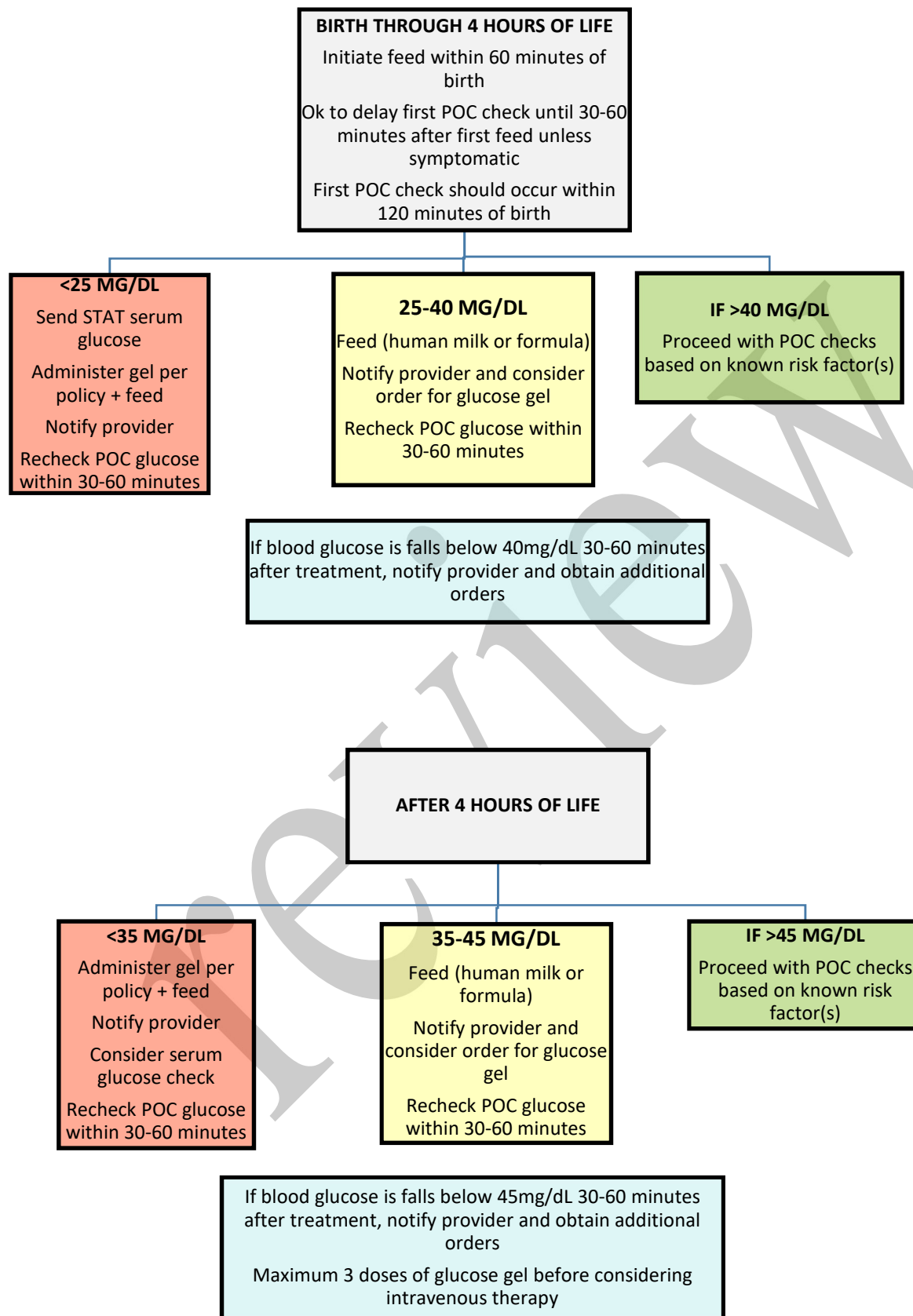
- b) The second check should occur *before* the second feeding, approximately 2-3 hours after the first feeding.
- c) The third check should occur *before* feeding, approximately between 9-12 hours of life.
- d) The fourth check should occur *before* feeding, approximately between 15-18 hours of life.
- e) The fifth check should occur at 24 hours of life.
- f) If any POCT result is below defined parameter or if newborn becomes symptomatic, follow pathway for treatment (Appendix A) and notify pediatrician. See order set for dosing guidelines.

6. Newborns with the following identified risk factors should be monitored for 12 hours:

- a) Infants born to mothers with gestational diabetes or diabetes mellitus
 - b) Large for Gestational Age (LGA)
 - c) Postdates (>42 weeks gestation)
 - d) Infants born to mothers who received beta blockers within 48 hours of birth
 - e) Perinatal stress, including infants who required resuscitation at birth, are on continuous oxygen supplementation, 5-minute APGAR <7, or cord pH <7.
- a) 7. Infants requiring **12 hours** of blood glucose monitoring require a minimum of 3 consecutive measurements above threshold in order to be considered euglycemic. These checks should occur at approximately the following intervals: Initiate monitoring within 30-60 minutes after the first feed, or between 60-120 minutes of life if feeding is delayed.
 - b) The second check should occur *before* the second feeding, approximately 2-3 hours after the first feeding.
 - c) The third check should occur *before* feeding, between approximately 9-12 hours of life.
 - d) If any POCT result is below defined parameter or if newborn becomes symptomatic, follow pathway for treatment (Appendix A) and notify pediatrician. See order set for dosing guidelines.

REFERENCES:

1. Hypoglycemia Clinical Guideline. Stanford Medicine Newborn Nursery.
<https://med.stanford.edu/newborns/clinical-guidelines/hypoglycemia.html>
2. Mandy, G. T. (2022, July 18). Infants with fetal (intrauterine) growth restriction. UpToDate.
https://www.uptodate.com/contents/infants-with-fetal-intrauterine-growth-restriction?search=SGA+newborn§ionRank=1&usage_type=default&anchor=H584200489&source=machineLearning&selectedTitle=1~150&display_rank=1#H584200489
3. Rozance, P. J. (2023, April 17). Pathogenesis, Screening, and Diagnosis of Neonatal Hypoglycemia. UpToDate.
https://www.uptodate.com/contents/pathogenesis-screening-and-diagnosis-of-neonatal-hypoglycemia?sectionName=SCREENING&search=overview+of+the+routine+management+of+healthy+newborn+infant&topicRef=5068&anchor=H16&source=see_link#H16
4. Simpson, K. R., Creehan, P. A., O'Brien-Abel, N., Roth, C. K., & Rohan, A. J. (2021). AWHONN Perinatal Nursing (5th ed.). Wolters Kluwer.
5. Wight, N. E. (2021). ABM Clinical protocol #1: Guidelines for glucose monitoring and treatment of hypoglycemia in term and late preterm neonates, revised 2021. Breastfeeding Medicine, 16(5), 353–365.
<https://doi.org/10.1089/bfm.2021.29178.new>



Gestational Age	Males	Females
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(weeks)	SGA	LGA	SGA	LGA
35	2070	3117	1990	3019
36	2307	3406	2212	3300
37	2522	3646	2415	3523
38	2754	3852	2644	3711
39	2952	4024	2841	3869
40	3068	4122	2958	3968
41	3168	4245	3056	4083
42	3225	4407	3080	4213

Adapted from "A 2017 US Reference for Singleton Birth Weight Percentiles Using Obstetric Estimates of Gestation" (Pediatrics, July 2019)

Recommended Feeding Volumes (human milk or formula)

Age/hrs	mL/Feed
0-24	2-10
24-48	5-15
48-72	15-30
72-96	30-60

RECORD RETENTION AND DESTRUCTION:

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

CROSS REFERENCED POLICIES AND PROCEDURES:



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: Reimbursement for Travel and Mileage for District Business		
Owner: Chief Financial Officer		Department: Fiscal Services
Scope: Districtwide		
Date Last Modified: 10/15/2026	Last Review Date: No Last Periodic Review Date Set	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: to establish reimbursement guidelines for mileage, meals and incidentals expenses, and lodging incurred while conducting District Business.

POLICY: Reimbursement for authorized District business expenses shall be as follows:

Mileage: Reimbursed at the applicable IRS standard business mileage rate.

Meals and Incidental Expenses (M&IE): Reimbursement shall be based on actual expenses incurred, supported by receipts or required documentation, and shall not exceed the highest daily M&IE rate established by the General Services Administration (GSA) for travel within the continental United States, regardless of travel destination. The daily M&IE rate shall serve as a combined maximum reimbursement amount, rather than separate limits for breakfast, lunch, dinner, or incidental expenses.

Lodging: Reimbursement shall be based on actual expenses incurred, supported by receipts.

REFERENCE:

Mileage Rate: <https://www.irs.gov/tax-professionals/standard-mileage-rates>

Meals and incidental expenses (M&IE) rates and breakdown:

<https://www.gsa.gov/travel/plan-a-trip/per-diem-rates/mie-breakdowns>

Supersedes: Not Set



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Precleaning and Returning of Instruments to Sterile Processing		
Owner: Perioperative Manager		Department: Sterile Processing
Scope: District Wide		
Date Last Modified: 03/15/2022	Last Review Date: 03/15/2022	Version: 4
Final Approval by: NIHD Board of Directors		Original Approval Date: 02/01/2001

PURPOSE: To identify the process for the immediate pre-cleaning of used instruments prior to transport to Sterile Processing.

POLICY:

- A. Each department/office will have a designated, rigid container with a lid to soak reusable instruments prior to return to Sterile Processing.
- B. PPE (Personal Protective Equipment) will be worn when pre-cleaning instruments.
- C. Instruments are to be soaked, cleaned, and free of debris prior to transport to Sterile Processing. Corrosion, rusting, and pitting occur when blood and debris are allowed to dry in or on surgical instruments. Cannulas or lumens can become obstructed with organic material.
- D. Each department/office is responsible for the cleaning of instruments used in the department and the removal/disposal of sharps prior to placing them in the transport containers.
- E. Transport of instrument to Sterile Processing will be in a designated container for transport.
- F. The Sterile Processing Department will be responsible for the final decontamination and terminal sterilization of reusable instruments and medical devices.

PROCEDURE:

Step 1: Pre-cleaning

Apply appropriate PPE for type of pre-cleaning

Step 2: Removing Sharps

All sharps must be removed and properly disposed of prior to handling / cleaning instruments.

Step 3: Cleaning, Soaking, and Washing

Remove visible gross debris from reusable instruments or medical devices at point of use with approved enzymatic cleaner per manufacturer's directions.

- A. Place manufacturer approved enzymatic detergent and water into appropriate empty container, verifying expiration date of enzymatic detergent.
- B. Place instruments in container.
- C. Leave hinged instruments in open position and disassemble those with removable parts
- D. Soak instrument per manufacturer's guidelines.
- E. Scrub all surfaces with scrub brush or other cleaning tools, paying special attention to serrated edges, box locks and other hard to reach places. Brush delicate instruments carefully and handle separate from general instruments.

- a. Instruments must be scrubbed while submerged in enzymatic cleaner to prevent aerosolization of blood borne pathogens.
- b. Discard one time use brushes and cleaning tools after use.
- c. Discard enzymatic detergent after use.

Step 4: Rinsing

Rinsing with water is part of the washing process so any sediment left on the washed items may be removed.

Step 5: Checking

Opening and closing instrument to ensure soil is not trapped in the box locks of the instrument. Observation also ensures the cleaning process is thorough and complete.

Step 6: Transport

Monday – Friday a courier will pick up and transport pre-cleaned reusable instrument or medical device in approved container to the Sterile Processing Department for completion of the terminal sterilization process. The transport container must be labeled to indicate bio-hazardous contents to communicate to others the items are potentially infectious. The transport container should be labeled with unit specific (colored) autoclave tape to ensure each department/ office receives the correct instruments after sterilization.

Step 7: Return / Pickup

Return of Sterile Instruments and Clean Transport Containers will be done Monday through Friday by courier (when the courier comes to pick up instruments, the sterilized instruments will be returned to the clinic/office or department). If after hours pick up is necessary, please contact the House Supervisor.

REFERENCES:

1. Association of Perioperative Registered Nurses (2013) Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Settings. AORN: Denver, CO.

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICY & PROCEDURE:

1. InQuiseek – Disinfection and Sterilization Policy

Supersedes: v.3 Precleaning and Returning of Instruments to Sterile Processing
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NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Trauma Policy		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: ED Registered Nurses, Ancillary Staff		
Date Last Modified: 05/17/2026	Last Review Date: 05/01/2024	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/2004	

PURPOSE:

To provide a standardized approach for the rapid identification, stabilization, and disposition of trauma patients presenting to or arriving at the Northern Inyo Healthcare District (NIHD) Emergency Department (ED). This policy ensures safe, efficient, and coordinated care in accordance with the Inland Counties Emergency Medical Agency (ICEMA) guidelines and applicable state and federal regulations for Critical Access Hospitals.

POLICY:

NIHD is an 8-bed Critical Access Hospital Emergency Department staffed and equipped to provide **initial resuscitation, stabilization, and transfer** of major trauma patients to higher levels of care when indicated. All trauma patients will be assessed, managed, and transferred according to established trauma triage criteria, ensuring timely communication, documentation, and collaboration with EMS and receiving trauma centers.

DEFINITIONS:

- **Trauma Patient:** Any individual sustaining physical injury resulting from an external source (blunt, penetrating, or thermal) that may require specialized trauma care.
- **Major Trauma:** Injuries meeting county or state trauma triage criteria requiring transfer to a designated trauma center.
- **Minor Trauma:** Stable patients with potentially significant mechanisms or isolated injuries requiring expedited evaluations and diagnostics but not full activation.
- **Trauma Team:** The multidisciplinary response group including the ED physician, RN(s), respiratory therapist, diagnostic imaging technician, and lab personnel responsible for responding to and managing trauma activations.

TRAUMA ACTIVATION LEVELS:

- **Code Trauma Major:** Requires overhead activation (“Code Trauma ED”) and multidisciplinary response.
- **Code Trauma Minor:** Requires an ED trauma response but does not require an overhead announcement.

TRAUMA ACTIVATION CRITERIA:

A trauma activation shall occur upon notification by EMS or identification in the ED of a patient meeting one or more of the following criteria:

Code Trauma Major

Triggered by **any** of the following:

A. Physiologic Indicators:

- Systolic BP < 90 mmHg (adult) or age-appropriate hypotension (pediatric)
- Respiratory rate < 10 or > 29 (adult)
- GCS $\leq$ 13 with suspected trauma
- Need for airway intervention

B. Anatomic Indicators:

- Penetrating injury to head, neck, torso, or extremities proximal to elbow/knee
- Flail chest
- Two or more proximal long bone fractures
- Suspected pelvic fracture
- Traumatic amputation proximal to wrist/ankle
- Spinal cord injury with neurologic deficit
- Burns > 10% TBSA or associated with other trauma

C. Mechanism of Injury (MOI) Considerations:

- Ejection from vehicle
- Death in same vehicle
- Fall > 15 feet (adult), > 10 feet (child)
- High-speed MVC (> 40 mph)
- Rollover, intrusion, or prolonged extrication
- Pedestrian or bicyclist struck by vehicle
- Blast or high-impact injury

D. Special Considerations:

- Age < 5 or > 55
- Known anticoagulant or bleeding disorder
- Pregnancy > 20 weeks
- EMS or physician judgment

Code Trauma Minor

Triggered by the following:

- Stable vital signs but moderate mechanism of injury
- MVC < 40 mph with potential chest/abdominal/pelvic or long bone trauma
- Falls < 15 feet with potential chest/abdominal/pelvic or long bone trauma
- Age > 65 fall with anticoagulation (excluding aspirin) with head strike or LOC
- Found down with traumatic mechanism or visible traumatic injury
- Helmet or helmet contact with neurological changes

- Long bone fractures with mechanism of ground level fall
- Discretion of the ED physician

PROCEDURE:

A. Upon Trauma Notification:

1. Activation:

- Any ED staff member, including EMS, may recommend trauma activation.
- The **ED physician** will determine the level of trauma activation (Code Trauma Major or Code Trauma Minor).
- Overhead announcements (***“Code Trauma ED”***) will be made for Code Trauma Major activations only.
- The ED tech or designee will be responsible for making the overhead announcement for Code Trauma Major activations.
- Assign trauma roles as appropriate (primary RN, documentation RN, airway, IV/meds, etc.).
- Ancillary departments (lab, radiology, RT) and House Supervisor respond immediately to the trauma bay to any “Code Trauma ED” activation.

2. Preparation:

- Trauma bed cleaned and bay prepped.
- Necessary equipment gathered (airway supplies, trauma cart, ultrasound, warm fluids, etc.).
- PPE donned by all staff.

3. Primary Survey (ABCDE):

- Led by ED Physician, assisted by RN and RT.
- Vital signs, airway control, immediate life-saving interventions.

4. Secondary Survey:

- Detailed head-to-toe assessment.
- FAST exam as indicated.
- DI tech will perform any portable imaging within the trauma bay as requested by the ED provider.
- Advanced imaging will be performed expeditiously at the discretion of the ED provider.
- Labs, medical interventions, and ongoing resuscitation.

5. Transfer:

- ED physician contacts appropriate receiving trauma center via direct line
- Include brief patient summary (mechanism, vitals, interventions, imaging).
- EMS Agency will be notified to coordinate ground/air transport.
- Send all records, labs, and imaging either electronically and/or copies with EMS crew.
- Transfer packet will include:
 - ✓ Patient demographics and injury summary
 - ✓ Vital signs and clinical course

- ✓ Diagnostic results (if completed)
- ✓ Interventions performed
- ✓ Medication reconciliation record (MAR)

6. Documentation:

- The primary RN or the House Supervisor will complete a trauma flowsheet.
- The ED physician will document the medical decision-making, transfer justification and trauma handoff details in the medical record.

7. Post-Event Debrief:

- Conducted immediately after patient disposition.
- Review teamwork, communication, and process improvement.

B. Team Compositions and Role

Role	Responsibilities
Emergency Physician (Team Leader)	Conducts the primary survey, directs the teams action, orders imaging/labs, determines airway needs and disposition (transfer vs. local management).
Primary RN	Obtains IV access, attaches monitors, administers meds, records vital signs, documents in trauma flowsheet.
Secondary RN	Assists with exposure, procedures, supplies, patient transfer, specimen labeling.
Respiratory Therapy	Prepares airway equipment, assists with intubation, manages oxygen and ventilator support, assists during RSI.
Diagnostic Imaging Technologist	Positions portable X-ray unit, obtains STAT chest/pelvis films immediately post-primary survey, assists/prepares for subsequent imaging.
Lab Personnel	Draws blood for trauma panel, type and screen/cross match, ensures STAT processing.
ED Clerk or Charge Nurse	Pages “ <i>Code Trauma ED</i> ” overhead for major trauma activations, calls for additional resources, contacts transfer center, documents keys times, facilitates communication.
House Supervisor	Documents in trauma flowsheet, EMS ground/flight crew coordination, resource allocation.

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT (PI)

- Trauma care will be monitored as part of the Emergency Department’s ongoing performance improvement activities.
- Selected trauma cases, including those with identified variances, delays, or adverse outcomes, will be reviewed by ED leadership and/or by the ED Medical Director.
- Opportunities for improvement will be addressed through existing PI and peer review processes, as applicable.

REFERENCES:

1. California Code of Regulations, Title 22, Division 5
2. American College of Surgeons (ACS) – Resources for Optimal Care of the Injured Patient
3. Inland Counties Emergency Medical Agency EMS Trauma Triage and Transfer Guidelines

RECORD RETENTION AND DESTRUCTION: N/A**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. EMTALA Policy
2. Standards of Care in the Emergency Department
3. Interfacility Transfer Guidelines

Supersedes: v.4 Trauma Patient Care in the Emergency Department



DATE: October 7, 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Anne Wakamiya, MD, Vice Chief of Staff
RE: Chief of Staff Report

MEMORANDUM

Recommendations

The Medical Executive Committee met on October 6, 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. Pamela Mundell, MD (*dermatology*) – Active Staff
2. Alexander Dunnum, DO (*anesthesiology*) – Courtesy Staff
3. Mandeep Sahani, MD (*nephrology*) – Telemedicine Staff
4. Melby Abraham, MD (*nephrology*) – Telemedicine Staff
5. Jamal Ksar, MD (*diagnostic radiology*) – Telemedicine Staff
6. Jamel Reid, MD (*diagnostic radiology*) – Telemedicine Staff

B. Medical Staff Telemedicine Privileges 2026-2027 – Proxy Credentialing (*action item*)

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

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

C. Additional Privileges (*action item*)

1. Benjamin Mundell, MD (*general surgery*) – recommendation to grant privileges for independent fluoroscopy performance as authorized by Dr. Mundell's valid California permit
2. 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

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

1. Steven Arbogast, DO (*neurology*) — Telehealth Staff
2. Nandini Bakshi, MD (*neurology*) — Telehealth Staff
3. Sierra Bourne, MD (*emergency Medicine*) — Active Staff
4. Timothy Crall, MD (*orthopedic Surgery*) — Active Staff
5. Lauren Crawford, MD (*neurology*) — Telehealth Staff
6. Amy Do-Nguyen, MD (*emergency medicine*) — Active Staff
7. James Eidel, MD (*anesthesiology*) — Active Staff
8. Jake Ichino, MD (*cardiology*) — Telehealth Staff
9. Samantha Jeppsen, MD (*emergency medicine*) — Active Staff
10. Kyle Minkel, DO (*orthopedic surgery*) — Courtesy Staff

E. Infectious Disease Privilege Form (*action item*)

1. The Medical Staff has recommended approval of an Infectious Disease telehealth service as outlined in the enclosed privilege form.



Infectious Disease

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the Request checkbox at the top of a group to request all privileges in that group.
2. Uncheck any privileges you do not want to request in that group.
3. Sign form electronically and submit with any required documentation.

Facilities

☒ **NIHD**

Required Qualifications

Education/Training	Completion of an ACGME or AOA accredited Residency training program in Internal Medicine. AND Completion of an ACGME or AOA accredited Fellowship training program in Infectious Disease.
Certification	Current certification or active participation in the examination process leading to certification in Infectious Disease by the American Board of Internal Medicine or AOA equivalent.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of infectious disease services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must have provided clinical services representative of the scope and complexity of privileges requested during the past 24 months.

Core Privileges in Infectious Disease

Description: Infectious Disease is the subspecialty of Internal Medicine that focuses on the prevention, evaluation, diagnosis, treatment and management of infections, including those caused by bacteria, viruses, fungi, and parasites.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Newly Requested privileges ☒ - Currently Granted privileges
	Evaluation and Management

Core Privileges in Infectious Disease

Description: Infectious Disease is the subspecialty of Internal Medicine that focuses on the prevention, evaluation, diagnosis, treatment and management of infections, including those caused by bacteria, viruses, fungi, and parasites.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Newly Requested privileges ☐ - Currently Granted privileges
	☐ Evaluate, diagnose, medically manage and provide treatment to patients presenting with acute and chronic infectious diseases, disorders and conditions of all types and in all organ systems, including underlying predisposing diseases. Privileges include medical management of general medical conditions which are encountered in the course of care for infectious disease patients. ☐ Perform discharge planning and discharge patients to home or appropriate transition of care ☐ Provide consultations specific to specialty

FPPE (Department Chief to select)

☐	Retrospective review of the evaluation and medical management of 5 patients admitted for the treatment of a variety of complex infectious disease conditions, disorders, or diseases. (Department Chair to determine the specific conditions, diseases, or disorders to be evaluated).
☐	Retrospective review and evaluation of the records of 5 patients requiring laboratory testing. Review should focus on the appropriate utilization of tests and interpretation of results.
☐	Interview with clinical leadership regarding the applicants timeliness, responsiveness, communication and ability to work with the healthcare team.
☐	Reference from a physician who consulted the Infectious Disease specialist concerning the timeliness of the consultation and documentation and the overall efficiency and effectiveness of the care, treatment or services provided.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, health status, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Northern Inyo Healthcare District and I understand that:

- A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

NIHD

Department Chief Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation
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DATE: October 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Christian Wallis, CEO
RE: HealthTrust Benchmarking Update

MEMORANDUM

Background

The District engaged HealthTrust to conduct a benchmarking assessment of staffing levels and operational efficiency. The assessment was intended to evaluate current staffing practices, compare departmental performance against industry benchmarks, and identify opportunities to improve operational efficiency and manage personnel costs.

Discussion

The HealthTrust benchmarking assessment identified three primary opportunities for improvement: reducing personnel costs through position vacancies and reductions, implementing staffing practices based on departmental productivity standards, and providing department-specific recommendations for operational improvements that leadership will evaluate and implement as appropriate for the District.

As a result of the assessment, the District identified six positions that will not be backfilled and one position eliminated through a reduction in force. These staffing changes represent an estimated savings of \$1,068,080.

The second initiative focuses on aligning staffing levels with patient volumes and departmental workloads. Implementation began approximately one month ago, with initial testing underway in the Medical-Surgical and Emergency Departments. Under this approach, staffing levels are evaluated based on patient census and units of service to better align staffing resources with operational demand. The District is also developing tools through ADP and its new payroll system to monitor staffing productivity and establish standards for variable and semi-variable staffing.

Variable staffing refers to positions where staffing needs fluctuate directly with patient volumes or services provided, such as nursing staff in patient care departments. Semi-variable staffing refers to positions that require a baseline level of staffing but may need additional personnel as workload or organizational demands increase, such as Information Technology support.

The third outcome of the assessment is a set of department-specific action plans containing recommendations for operational improvement. The District's chiefs and department leaders will review these recommendations and determine which are appropriate to implement based on the hospital's operational needs and available resources. Staff will continue evaluating the implementation of these measures and identifying additional opportunities for cost savings.



DATE: October 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Christian Wallis, CEO
RE: Outpatient Clinic Operational Assessment

MEMORANDUM

Background

Northern Inyo Healthcare District has been evaluating opportunities to improve operational efficiency, staffing, and productivity across the organization. While recent benchmarking initiatives have focused on hospital operations, the District's outpatient clinics were not included in those assessments.

To address this gap, the District is considering engaging Medical Group Management Association (MGMA) Consulting to conduct a comprehensive operational assessment of its outpatient clinics. The assessment would evaluate current operations, identify opportunities for improvement, and support the District's plans for physician recruitment and future growth.

Discussion

MGMA Consulting has submitted a proposal to conduct a comprehensive assessment of the District's outpatient clinic operations. The assessment would compare clinic performance against industry benchmarks and evaluate several key operational areas, including:

Staffing and Productivity: Evaluate staffing levels, staff responsibilities, and productivity to identify opportunities for improved efficiency.

Provider Scheduling and Patient Access: Review provider schedules, appointment availability, and patient flow to identify opportunities to improve access and maximize capacity.

Clinic Workflows: Assess operational processes to identify inefficiencies and opportunities for standardization across clinics.

Space Utilization: Evaluate the use of existing clinic space and examination rooms to support current operations and future provider growth.

Rural Health Clinic Operations: Identify opportunities to better align clinic operations with the District's long-term facility and reimbursement strategies.

Data and Reporting: Review the availability and reliability of operational data used to monitor performance and support management decisions.

Upon completion, MGMA would provide a comprehensive operational assessment, benchmarking analysis, summary of findings, and prioritized recommendations with an implementation roadmap. A final written report and presentation to physician leadership would also be provided.

The proposed cost of the engagement is \$102,000, excluding travel-related expenses, which would be billed separately. Any services requested outside the agreed-upon scope would be charged at \$500 per hour, subject to prior approval. Under the proposed payment terms, 50% of the professional fees would be invoiced upon execution of the agreement, with payment due within 30 days. Final pricing and payment terms would be established in the consulting agreement.

The assessment is intended to provide District leadership with recommendations to improve outpatient clinic efficiency, strengthen staffing and productivity practices, maximize existing resources, and support sustainable growth.

Recommendation

Staff recommends that the Board of Directors approve the engagement of MGMA Consulting to conduct a comprehensive outpatient clinic operational assessment at a proposed cost of \$102,000, plus applicable travel expenses, and authorize the Chief Executive Officer to execute the consulting agreement.

Advocacy Tracker

Priority	Legislation	Description	Status
Priority	Legislation	Description	Status
1	AB 1923 - Soria	~~Distressed Hospital Loan Program—\$250 million~~ ~~—Expands and funds California’s Distressed Hospital Loan Program to provide financial assistance to hospitals at risk of closure. The bill broadens eligibility and allows for loan forgiveness based on financial need, with the goal of stabilizing hospital operations. It is intended to preserve access to care, particularly in rural and underserved communities.~~ This was amended to change to an entirely different topic. This is called a gut and amend.	Introduced (2/12/26) Passed Assembly Health Committee (15-0 on 4/23/26) Passed Assembly Appropriations Committee (5/14/26) (Placed on Suspense) Passed the Assembly (78-0 on 5/27/26) Referred to the Senate Health Committee (6/10/26) Passed Senate Health Committee (7/1/26) Re-Referred to Senate Appropriations Committee
1	AB 1607 - M. Gonzalez	Extension of sunset for Maddy Emergency Medical Services Fund Removes the sunset on counties’ authority to levy penalties that fund the Maddy Emergency Medical Services (EMS) Fund, maintaining the funding mechanism for emergency medical and trauma services. By preserving this funding structure, the bill supports continued operation of EMS systems. These services are critical to maintaining access to emergency care, particularly in rural and underserved communities. Update: Extends funding for the Maddy EMS Fund and Richie’s Fund through January 1, 2037.	Passed Assembly Health Committee (16-0 on 3/24/26) Passed Assembly Public Safety Committee (9-0 on 4/14/26) Passed the Assembly (72-1 on 4/20/26) Passed Senate Health Committee (11-0 on 6/17/26) Re-referred to the Senate Public Safety Committee (6/18/26) Passed Senate Public Safety Committee (6-0 on 7/1/26) Passed Senate Floor (38-0) Signed by Governor
1	HR 8209 - Tonko	Bipartisan legislation introduced to extend School-Based Health Centers grant program through 2031 The SBHC grant program provides competitive funding to support the establishment and operation of school-based health centers. Grants can be used to acquire or lease equipment, support workforce training, pay staff salaries and cover operational and management costs. The program prioritizes communities facing significant barriers to care, including areas with high rates of uninsured children. Update: Awaits consideration by the full House of Representatives. It would authorize \$55 million annually for FY 2027–2031 to support School-Based Health Centers.	Introduced (4/6/26) Passed House Energy & Commerce Health Subcommittee (voice vote on 4/20/26) Passed House Energy & Commerce Committee (46-0 on 5/21/26) Awaiting consideration by the full House of Representatives
1	AB 1882 - Ellis	Payments For Standby Labor and Delivery Services The bill would create the Safe Delivery Fund Pilot Program, administered by the Department of Health Care Access and Information, to help hospitals cover uncompensated standby costs for obstetric and related inpatient specialty services in areas with limited access to maternity care. It would fund eligible hospitals that serve geographically isolated populations and would be harmed by losing obstetric services, with payments limited to \$5 million per hospital each year. Participating hospitals would have to report staffing and service data quarterly, use funds only for specified clinical capacity costs, and remain subject to audits and program reviews.	Passed Assembly Health 16-0 Passed Assembly Appropriations 15-0 Passed Assembly 77-0 Passed Senate Health 10-0 Passed Senate Appropriations 7-0 Passed Senate 39-0 Vetoed by Governor

Advocacy Tracker

Priority	Legislation	Description	Status
2	AB 2282 - Alanis	Free Standing Emergency Department for Del Puerto HCD Authorizes the establishment of a freestanding emergency department in the Del Puerto area to expand access to emergency medical services. The bill is intended to address gaps in emergency care availability in a rural and underserved region. It supports improved access to timely care where hospital-based emergency services are not readily available.	Passed Assembly Health Committee (16-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Passed the Assembly (76-0 on 5/29/26) Referred to the Senate Health Committee (6/11/26) Passed Senate Health Committee (7/1/26) In Senate Appropriations Committee - Placed on Suspense File Passed Senate Appropriations Committee Passed Senate Floor (37-2) Vetoed by Governor
2	AB 2311 - Schiavo	Healthcare Districts hiring physicians Expands the authority of healthcare districts to employ physicians and directly provide medical services. The bill is intended to improve access to care by allowing districts greater flexibility in staffing and service delivery. It supports rural and underserved communities where recruiting and retaining providers is a challenge.	Passed Assembly Health Committee (17-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Passed the Assembly (79-0 on 5/29/26) Referred to the Senate Health Committee (6/11/26) Passed Senate Health Committee (7/1/26) In Senate Appropriations Committee - Placed on Suspense File Passed Senate Appropriations Committee Passed Senate Floor (40-0) Signed by Governor
3	SB 1187 - Durazo	Brown Act - Relates to what makes majority for a legislative body This bill would repeal certain future Brown Act requirements for eligible local legislative bodies related to electronic access, agenda translation, and interpretation assistance, while declaring the measure an urgency statute. This bill was significantly amended to the changes above.	Passed Senate Local Government Committee (6-0 on 4/23/26) Passed Senate Judiciary Committee (12-0 on 5/6/26) Passed the Senate (39-0 on 5/29/26) Referred to the Assembly Local Government Committee (6/11/26) Passed Assembly Local Government Committee (8-0 on 7/1/26) Passed Assembly Floor (73-0) Signed by Governor
3	AB 1789 - Boerner	Campaign Finance and Ethics Training Requirements Requires most state and local candidates for elected office, as well as certain campaign treasurers, to complete FPPC-approved training on campaign finance and ethics laws. The bill is intended to improve compliance with the Political Reform Act, reduce reporting violations, and increase public confidence in elections. The requirements would likely apply to candidates for local special district boards, including healthcare districts, beginning January 1, 2029.	Passed the Assembly (78-0 on 5/26/26) Passed Senate Elections and Constitutional Amendments Committee (5-0 on 6/16/26) Re-referred to Senate Appropriations Committee (6/16/26) Senate Appropriations Committee - Placed on Suspense File Passed Senate Appropriations Committee Passed Senate Floor (39-0) Signed by Governor

Advocacy Tracker

Priority	Legislation	Description	Status
1	AB 2353 - Pacheco	Requires review of any new mandate for hospitals Requires an independent evaluation of legislation that imposes new requirements on hospitals to assess its cost and impact on healthcare affordability. The bill aims to provide lawmakers with better information on how proposed policies affect hospital operations and overall healthcare costs. It is intended to improve decision-making and prevent unintended financial strain on hospitals and the healthcare system. Update: The bill now establishes the Health Mandates Review Program and the Center for Health Provider Policy Impact to provide independent analyses of proposed hospital mandates and their impacts on hospital operations, healthcare affordability, workforce, and access to care before new requirements are enacted.	Passed Assembly Health Committee (11-0 on 4/21/26) Passed Assembly Appropriations Committee (12-0 on 5/14/26) Passed the Assembly (56-1 on 5/27/26) Referred to the Senate Health Committee (6/10/26) Senate Health Committee - Hearing cancelled
1	AB 2208 - Stefani	Maintains three month retroactive eligibility for Medi-Cal. Puts in place co pays for Medi-Cal as required by HR-1 maintains the current three-month retroactive eligibility period for Medi-Cal, allowing patients to receive coverage for services provided prior to enrollment. The bill also implements cost-sharing requirements, including co-pays, in alignment with federal policy changes under H.R. 1. It is intended to preserve access to coverage while aligning Medi-Cal policies with federal requirements.	Introduced (2/19/26) Passed Assembly Health Committee Passed Assembly Appropriations Committee Passed the Assembly Referred to the Senate Health Committee (6/10/26) Passed Senate Health Committee (7/1/26) Referred to Senate Appropriations Committee - Placed on the Suspense File Held on Suspense File
2	AB 1811 - Rogers	Health Professions Shortage Areas preservation These designations support recruitment and retention of healthcare providers by maintaining eligibility for existing federal and state incentive programs, such as loan repayment and grants. The bill is intended to preserve provider availability in underserved and rural communities. Update: The bill was amended to preserve Health Professional Shortage Area (HPSA) designations that existed on January 1, 2025, through January 1, 2035, ensuring affected communities remain eligible for state incentive programs despite changes to federal HPSA designations.	Passed Assembly Health Committee (16-0 on 3/24/26) Passed Assembly Appropriations Committee (15-0 on 5/6/26) Passed the Assembly (79-0 on 5/14/26) Referred to Senate Health Committee (Was not heard in committee)
2	AB 2386 - Alvarez	Licensed Physicians from Mexico Program Expands California's physician workforce pathways by allowing physicians from Mexico who complete a limited-term program to transition to full licensure and continue practicing in the state. The bill also creates a provisional licensing pathway for internationally trained physicians to practice under supervision and eventually obtain full licensure. It is intended to address physician shortages—particularly in underserved and rural areas—while maintaining oversight and training requirements. Update: The bill was amended to clarify eligibility, supervision, and licensure requirements for internationally trained physicians participating in the provisional licensing pathway.	Passed Assembly Business and Professions Committee (12-2 on 4/21/26) Passed Assembly Appropriations Committee (11-2 on 5/14/26) Passed the Assembly (54-9 on 5/26/26) Referred to Senate Business, Professions and Economic Development Committee (6/16/26) Amended in the Senate (6/16/26) Passed Senate Business, Professions and Economic Development Committee (12-2 on 6/22/26) Re-referred to Senate Appropriations Committee (6/22/26) Senate Appropriations Committee hearing scheduled - Placed on Suspense File Held on Suspense File

Advocacy Tracker

Priority	Legislation	Description	Status
2	AB 2497 - Johnson	Physical Therapy Scope of Practice Expansion Modernizes and expands the scope of practice for physical therapists in California. Authorizes physical therapists to perform additional services such as musculoskeletal ultrasound, broader direct access treatment, referrals for imaging, and certain tissue penetration procedures commonly referred to as dry needling. The bill is intended to improve access to musculoskeletal care and reduce administrative barriers, but has generated opposition from acupuncture groups and others concerned about training standards and patient safety. Update: The bill was amended to further define education, competency, and certification requirements for physical therapists performing dry needling and other newly authorized procedures.	Passed Assembly Business and Professions Committee (15-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Failed on Assembly Floor (26-19 on 5/28/26)
2	AB 1460 - Rogers	Pharmacy / 340B Program Prohibits pharmaceutical manufacturers from restricting qualifying nonhospital 340B clinics from using contract pharmacies to dispense discounted medications to eligible patients. The bill is intended to protect access to the federal 340B program and preserve pharmacy-related funding mechanisms used by safety-net and rural healthcare providers. Supporters state the bill protects patient access and operational sustainability, while opponents raise concerns regarding transparency and oversight of contract pharmacy arrangements. Update: Adds annual audit, recertification, and reporting requirements for participating 340B clinics while strengthening protections for the use of contract pharmacies.	Passed Assembly Health Committee (16-0 on 4/8/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Passed the Assembly (79-0 on 5/28/26) Referred to Senate Health Committee (6/10/26) Passed Senate Health Committee (11-0 on 6/25/26) Re-referred to Senate Judiciary Committee (6/25/26) Amended in the Senate (6/27/26) Was not heard in Senate Health Committee
3	AB 2729 - Bonta	Employer fee for employees on Medi-Cal Would impose a fee on large employers whose employees rely on Medi-Cal for health coverage. The bill is intended to shift some of the cost burden to employers whose workers depend on public health programs. It aims to support Medi-Cal funding but may increase costs for certain employers. Update: The bill now establishes a framework for implementing the employer fee through the state budget process.	Passed Assembly Health Committee (11-3 on 4/21/26) Re-referred to Assembly Appropriations Committee (4/22/26) Placed on the Assembly Appropriations Suspense File (5/6/26) Amended and re-referred to Assembly Appropriations Committee (5/19/26) Did not move any further. Dead for 2026.
3	AB 1900 - Kalra	Single payer health system Proposes the establishment of a statewide single-payer health care system in which the state would finance and oversee coverage for all Californians. The bill would significantly restructure how hospitals and providers are paid by replacing much of the current multi-payer system with a state-administered model. While intended to expand access and control costs, it would have major implications for hospital reimbursement, financial sustainability, and operations.	In Rules - Dead for 2026

Advocacy Tracker

Priority	Legislation	Description	Status
3	AB 1671 - Tangipa	Creates grant program for providers to serve in rural areas Establishes a grant program to support healthcare providers who commit to serving in rural and underserved areas. The bill is intended to improve workforce recruitment and retention by offering financial incentives to providers. It aims to expand access to care by increasing the availability of healthcare professionals in rural communities.	In Asm Appropriations -Held on Suspense File Dead for 2026
3	AB 2665 - Tangipa	Budget request for Northern and Southern Inyo HCDs a budget request that seeks state funding support specifically for the Northern and Southern Inyo Healthcare Districts. The bill is intended to provide financial resources to sustain operations, infrastructure, or services in these rural districts.	Pulled
3	SB 1422 - Durazo	Allows for individuals who are unsatisfactory immigration status to apply for full scope Medi-Cal Expands eligibility for full-scope Medi-Cal to individuals regardless of immigration status. The bill is intended to increase access to comprehensive health coverage for underserved populations. It would likely increase enrollment in Medi-Cal and expand access to care across the healthcare system.	Passed Senate Health Committee (11-0 on 4/9/26) Passed Senate Appropriations Committee (7-0 on 5/23/26) Placed on inactive file in Senate
3	AB 2131 - Rubio	Exclude freestanding structures like congregate living health facilities or hospices from seismic requirements. Exempts certain freestanding health care facilities, such as congregate living health facilities and hospices, from California's hospital seismic safety requirements. The bill is intended to reduce regulatory and financial burdens on these smaller or non-acute care facilities. It recognizes that these facilities may not require the same level of seismic compliance as full acute care hospitals.	In Asm Health - Dead for 2026
3	AB 1018 Bauer-Kahan	Automated Decision Systems Regulates the use of automated decision systems and artificial intelligence tools used in areas such as healthcare, employment, housing, insurance, and public services. The bill would require impact assessments, bias evaluations, transparency disclosures, and certain consumer protections related to AI-assisted decision making. It is intended to address concerns regarding discrimination, accountability, and oversight of AI systems, but may create additional compliance and operational requirements for healthcare organizations and public agencies.	Passed Assembly Privacy and Consumer Protection Committee (9-3 on 4/29/25) Passed Assembly Judiciary Committee (8-3 on 4/29/25) Passed Assembly Appropriations Committee (10-3 on 5/23/25) Passed the Assembly (50-16 on 6/2/25) Referred to the Senate Judiciary Committee (6/11/25) Passed Senate Judiciary Committee (7-2 on 6/26/26) Passed Senate Appropriations Committee (5-2 on 8/29/26) On Senate Floor. Did not pass. Dead for 2026.

Advocacy Tracker

Priority	Legislation	Description	Status
3	AB 225 Bonta	Facility Fees for Outpatient Services Prohibits hospitals from charging facility fees for telehealth visits, preventive services, and certain outpatient office visits that are commonly provided in hospital-owned clinics. Facility fees are additional charges billed by hospitals, separate from the provider's professional fee, and can represent a significant source of outpatient revenue. Recent amendments would also require hospitals to notify patients when facility fees may be charged and report facility fee revenue and utilization data to the state. The bill could reduce hospital revenue and increase reporting requirements for facilities that rely on outpatient clinic services. Update: The bill was amended to narrow the prohibition on facility fees by exempting certain outpatient services, including emergency, observation, surgery, and diagnostic services. It also clarifies hospital notice requirements and requires annual reporting of facility fee revenue, utilization, and payer information to the state.	Passed Assembly Health Committee (11-4 on 4/8/26) Passed Assembly Appropriations Committee (10-5 on 5/23/26) Passed the Assembly (51-17 on 6/2/26) Referred to the Senate Health Committee (6/16/26) Senate Health Committee hearing scheduled (bill pulled from hearing)

Ballot Initiatives of interest for November 2026

Proposition 3 - Make income taxes on higher earners permanent to fund education and healthcare

The tax, first enacted in 2012, is set to expire in 2031. Under the measure, income taxes for top earners range from 10.3% (for individual income over \$360,000) to 12.3% (for individual income over \$721,000), with graduated rates in between. Eighty-nine percent of the money goes to K-12 public schools and 11% goes to community colleges, with any excess going to public healthcare. The tax typically raises \$5 billion to \$15 billion a year.

Proposition 40 - Apply one-time tax to billionaires to fund healthcare and education

Proposition 40 would require the estimated 200 Californians whose net worth exceeded \$1 billion at the start of this year to pay a one-time 5% tax. Service Employees International Union-United Healthcare Workers West, the group sponsoring the measure, projects that it would raise roughly \$100 billion over five years. That money would be earmarked primarily for healthcare, with some reserved for food assistance and education. If [propositions 41](#) or [42](#) earn more votes than Proposition 40, this measure would be nullified.

Proposition 41 - Require audits of new tax programs

This proposition would make it harder to pass new special taxes by requiring the state auditor to review any special tax proposal before it goes to voters. The auditor would assess whether the program that would receive funding could cut spending by at least 10% annually. Any new special tax approved by voters would count toward California's spending limit, potentially triggering automatic refunds that reduce funding for other state programs. If this proposition receives more votes than [Proposition 40](#) (a wealth tax on billionaires), Proposition 40 is nullified, even if Proposition 40 also passes.

Proposition 42 - Ban new taxes on personal property

Proposition 42 is meant to make it much harder to create a wealth tax in California by prohibiting new taxes on the mere ownership of assets such as investment accounts, business interests and personal property — assets that are typically only taxed when they are sold or generate income. Like [Proposition 41](#), which also attempts to block [Proposition 40](#) (a wealth tax on billionaires), Proposition 42 would nullify Proposition 40 if it receives more votes, even if the billionaire tax also passes.

Proposition 43 - Raise vote threshold for special tax measures

This would make it harder to impose or increase local taxes by raising the threshold for local citizen-driven special tax ballot initiatives to pass from a simple majority to two-thirds. The two-

thirds threshold already applies to taxes proposed by local governments but not by individuals. The measure reflects a deal between state lawmakers and the anti-tax Howard Jarvis Taxpayers Association to keep a more restrictive tax proposal off the ballot.

Proposition 44 - Require more clinic spending on patient care

Proposition 44 would require community clinics that serve low-income patients to spend 90% of their annual revenue on patient care. The measure directs the attorney general to publish guidance on what spending qualifies and allows the state to fine clinics that don't spend the full 90%. The labor union SEIU-UHW pushed a similar bill last year, but it failed. Clinics failed to keep the measure off the ballot with a lawsuit earlier this year.



October 21, 2026

California Department of Health Care Access and Information

RE: California Rural Health Transformation (CalRHT) Accelerator Partners Grant – Board Authorization

To Whom It May Concern:

At a duly noticed meeting held on October 21, 2026, the Northern Inyo Healthcare District Board of Directors authorized the District to accept, receive, and expend grant funds awarded through the California Rural Health Transformation (CalRHT) Accelerator Partner Grant in an amount up to \$298,480 per applicable award funding cycle.

The Board further authorized the Chief Executive Officer, or designee, to execute the grant agreement with the California Department of Health Care Access and Information (HCAI) and related documents necessary to accept and administer the grant award.

The Board approved this authorization by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

Sincerely,

Melissa Best-Baker
Board Chair
Northern Inyo Healthcare District



October 21, 2026

California Department of Health Care Access and Information

RE: California Rural Health Transformation (CalRHT) Workforce Development: Recruitment & Retention Grant – Board Authorization

To Whom It May Concern:

At a duly noticed meeting held on October 21, 2026, the Northern Inyo Healthcare District Board of Directors authorized the District to accept, receive, and expend grant funds awarded through the California Rural Health Transformation (CalRHT) Workforce Development: Recruitment & Retention Grant in an amount up to \$332,030 per applicable award funding cycle.

The Board further authorized the Chief Executive Officer, or designee, to execute the grant agreement with the California Department of Health Care Access and Information (HCAI) and related documents necessary to accept and administer the grant award.

The Board approved this authorization by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

Sincerely,

Melissa Best-Baker
Board Chair
Northern Inyo Healthcare District



October 21, 2026

Department of Health Care Access and Information (HCAI)
Jennifer Hernandez, CalRHT Program Director
Elizabeth Landsberg, Director of HCAI
2020 West El Camino Avenue Ste. 800
Sacramento, CA 95833

RE: Disappointment Regarding Rural Health Transformation Grant Funding for Northern Inyo Healthcare District

Dear HCAI Leadership,

On behalf of the Northern Inyo Healthcare District (NIHD) Board of Directors, we are writing to express our profound disappointment and concern regarding the limited funding awarded to our hospital through the Rural Health Transformation Grant. While we appreciate the State's recognition of the challenges facing rural healthcare, the funding allocated to NIHD falls significantly short of addressing the critical needs of our hospital and the vast geographic region we serve.

Northern Inyo Healthcare District is not simply a small rural hospital. We are a frontier healthcare district and a vital healthcare lifeline for residents throughout the Eastern Sierra's, including Inyo and Mono Counties, portions of Kern County, and communities across the Nevada border. Our region is characterized by vast distances, widely dispersed communities, mountainous terrain, and limited access to alternative healthcare facilities. These conditions distinguish our frontier hospital from many other rural facilities, where alternative healthcare services may be more readily accessible. Our geographic isolation, limited healthcare resources, and the extraordinary distances patients must travel to access alternative services make our hospital essential to the health, safety, and well-being of thousands of individuals and families.

Of particular concern is the lack of meaningful funding to support our obstetrical (OB) program. NIHD provides essential maternity and delivery services to families throughout the Eastern Sierra region and beyond. As the only hospital providing labor and delivery services in Inyo and Mono Counties, NIHD serves a region spanning more than 13,000 square miles. Maintaining obstetrical services in a frontier community is not merely a matter of convenience; it is a matter of patient safety, timely access to care, and the ability of families to receive critical medical services close to home. Without these services, expectant mothers may be forced to travel approximately 135 miles south to Ridgecrest Regional Hospital or 200 miles north to Renown Regional Medical Center in Reno, Nevada, often across mountain passes and through unpredictable weather conditions, to receive prenatal care or deliver their babies. The consequences of losing or diminishing these services would be devastating to the communities we serve.

Beyond obstetrics, our hospital faces the same significant financial and operational pressures affecting rural hospitals across California, but with additional challenges created by our frontier location, limited patient volume, workforce shortages, and the high cost of maintaining essential services. These challenges are precisely why rural healthcare transformation funding is so desperately needed.

We had hoped the Rural Health Transformation Grant would provide a meaningful opportunity to stabilize and strengthen the healthcare infrastructure in communities like ours. Instead, the limited funding awarded raises serious questions about whether the unique circumstances and essential role of frontier hospitals were adequately considered in the allocation process.

For a small frontier hospital already working tirelessly to maintain critical healthcare services, the lack of substantial and meaningful funding is both disappointing and disheartening. It is difficult to reconcile the stated purpose of rural healthcare transformation with funding decisions that do not sufficiently support hospitals serving some of California's most geographically isolated populations.

Our Board recognizes that funding resources are limited and that many rural healthcare organizations face significant needs. However, equitable funding should not be based solely on population size, patient volume, or the ability of larger organizations to compete for resources. For frontier hospitals like NIHD, funding decisions must recognize the additional challenges created by extreme geographic isolation and the lack of nearby healthcare alternatives. It must also reflect the cost of maintaining essential services and the potentially life-threatening consequences when those services are no longer available.

We respectfully request that HCAI reconsider the funding allocated to Northern Inyo Healthcare District and explore opportunities to provide additional financial support, particularly for our obstetrical program and other essential hospital services. We also request greater transparency regarding how the needs of frontier hospitals were evaluated and weighted in the funding process.

The residents of the Eastern Sierra deserve access to safe, reliable, and sustainable healthcare, regardless of where they live. Our hospital and its dedicated staff continue to meet that responsibility despite extraordinary challenges. We had hoped this funding opportunity would demonstrate an equally strong commitment from the State to preserving healthcare in its most remote communities.

We urge HCAI to recognize that rural healthcare transformation cannot succeed if the hospitals serving California's most isolated communities are left without the resources necessary to survive, much less transform.

We welcome the opportunity to discuss our concerns and work collaboratively with HCAI to identify meaningful solutions that will protect and strengthen healthcare services throughout the Eastern Sierra.

Sincerely,

Melissa Best-Baker, NIHD Chair
David Lent, NIHD Vice-Chair

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514
Melissa.bestbaker@nih.org
David.lent@nih.org

cc: Christian Wallis, NIHD CEO
(760) 873-2109
Christian.wallis@nih.org

Capital Summary

So far, we are on track for capital spending for the year. Most of the quarter 1 projects are completed and pending final invoices. For contingency, we have spent \$101,895.53 out of the approved \$324,306.10.

Quarter 1 Current status and owner follow up

Quarter 1 includes \$969,656.86 in approved capital and \$101,895.53 in items marked contingent. Recorded invoices total \$300,166.10.

Items with invoices recorded

Capital item	Budget estimate	Invoiced to date	Status
Philips AvalonCL Fetal Monitor	\$7,091.06	\$7,573.92	Completed – over budget
Synergy Vision Connect and Arthroscope Accessories	\$189,778.61	\$176,872.62	Completed – under budget
Pavement Maintenance, Service, and Repair	\$125,000.00	\$90,500.00	Completed – Awaiting final invoices
Weapons Detection Equipment	\$114,525.00	\$13,408.07	In Progress – on target
PMA Remodel	\$300,000.00	\$11,811.49	In Progress – on target

Quarter 1 Items with no invoice amount recorded

Capital item	Budget estimate	Status
Fetal Monitor Work Station	\$9,703.34	In Progress – on target
Ultrasonic Instrument Cleaner	\$37,558.86	In Progress – on target
Dialysis System One S — contingent	\$91,240.13	In Progress – under budget due to grant
Alps Stucco and Eaves Repair, New Infusion Area	\$25,000.00	In Progress – on target
M365 Migration	\$161,000.00	In Progress – on target
Roche Navify POC Operations Middleware — contingent	\$10,655.40	In Progress – on target

Quarters 2–4 Scheduled capital and planning updates

The following items are separate from the Quarter 1 follow-up above. Please confirm whether each remains on schedule, any purchasing activity to date, and changes to scope, funding, or estimated cost.

Quarter 2

Capital item	Budget estimate	Status
GE Venue Go Refurbished Ultrasound	\$66,821.28	In Progress – on target
Myla to Maestria Middleware Upgrade	\$0.00	Not Started
Replace Three Aerco Boilers	\$400,000.00	Not Started

Quarter 3

Capital item	Budget estimate	Status
Centrella Smart Bed	\$10,311.03	Not Started
SIGNA Artist EVO MRI Upgrade	\$2,113,750.00	In Progress – on target
Concrete Repair and Replacement	\$35,000.00	Not Started
Parking Lot/Handicap Spot Upgrades	\$30,000.00	Not Started
T291 Walk-Behind Scrubber	\$9,660.00	Not Started

Quarter 4

Capital item	Budget estimate	Status
Centrella Smart Bed	\$10,311.03	Not Started
Server Upgrade/Update	\$49,986.30	Not Started
Datacenter Cooling	\$28,681.75	Not Started



Northern Inyo Healthcare District

Chief Financial Officer Report

Financial Summary and Operational Insights – August 2026

Date: October 2026

To: Board of Directors, Northern Inyo Healthcare District

From: Andrea Mossman, Chief Financial Officer

Executive Summary

Northern Inyo Healthcare District delivered an exceptionally strong financial performance in August 2026, with results significantly exceeding budget. The month benefited from strong patient volumes across several outpatient service areas, a favorable payer mix, continued improvement in revenue cycle performance, and strong non-operating income.

August net income was **\$709,095**, which was **\$487,316 favorable to budget**. The operating loss of **\$(426,146)** was **\$512,185 better than budget**, reflecting the strength of operating revenue despite higher expenses associated with increased patient activity.

Patient volumes remained strong in the Emergency Department, diagnostic imaging, and rehabilitation. Surgical volume was **12% below budget**, primarily due to physician time off.

Operating expenses were **3% above budget**. Professional fees were **\$80,553 above budget**, driven primarily by increased cash collection fees. Benefits were **\$167,359 higher than budget**, largely due to increased medical, dental, and vision utilization under the District's self-funded benefit plan. Labor management and expense discipline therefore remain important areas of focus as the organization continues to pursue growth.

Liquidity strengthened further during the month. Northern Inyo Healthcare District ended **August with 102 days of cash on hand and \$35.5 million in unrestricted cash**, approximately **\$9.9 million higher than the prior**

year. Improvements in accounts receivable, bad debt, and aged receivables also contributed to stronger cash flow.

Overall, August results demonstrate continued momentum in patient volumes, revenue cycle performance, and liquidity, while highlighting the continued need to manage labor and professional fees carefully.

Financial Performance

August closed with **net income of \$709,095**, exceeding budget by **\$487,316**. The operating loss was **\$(426,146)**, which was **\$512,185 favorable to budget**.

The favorable operating performance was primarily attributable to:

- Strong patient volumes across several key service lines.
- Continued growth in more complex orthopedic surgical activity.
- Higher-than-budgeted Emergency Department, rehabilitation, and diagnostic imaging volumes.
- A favorable payer mix, including a **2.8 percentage-point increase in Blue Cross & Commercial volume compared with budget**, resulting in a favorable reimbursement impact.
- Continued improvement in revenue cycle performance and collections.

These gains were partially offset by higher operating expenses associated with increased medical, dental, and vision utilization and higher cash collection fees.

Board takeaway: August results reflect broad-based operational strength and continued surgical growth. Management remains focused on converting volume growth into sustainable operating improvement while maintaining discipline over the associated cost structure.

Volume and Operational Performance

Patient activity remained strong throughout August, with most major service lines exceeding budget.

Service Metric	August Performance
Admissions	80; 7% below budget but 25% above August 2025

Service Metric	August Performance
Inpatient Days	4% below budget; 16% above prior year
Average Daily Census	18% below budget; 16% above prior year
Emergency Department Visits	9% above budget
Rehabilitation Visits	8% above budget
Rural Health Clinic Visits	395 visits below budget
Diagnostic Imaging	10% above budget
Surgical Cases	18 cases / 12% below budget

Clinic and surgical volumes were impacted by provider time off.

Board takeaway: Volume growth remains a significant strength, particularly in surgical services, the Emergency Department, diagnostic imaging, and rehabilitation. Management will continue to evaluate capacity, scheduling, staffing, and resource utilization to ensure that growth is financially sustainable.

Revenue Performance

August gross patient revenue exceeded budget by approximately **\$1.8 million**, primarily reflecting higher patient volumes in outpatient services.

Contractual allowances increased in line with gross revenue; however, **net patient revenue remained approximately 8% above budget** for the month.

The favorable payer mix, including higher Blue Cross & Commercial volume, further supported reimbursement performance.

Continued improvement in coding, collections, denials management, and overall revenue cycle performance remains a priority as the District works to sustain these gains.

Expense Performance

Operating expenses were **\$327,602, or 3%, above budget** in August.

Key expense variances included:

- **Salaries, wages, and benefits:** 5% above budget, primarily due to a higher average hourly rate and increased medical, dental, and vision (MDV) expenses.
- **Supplies:** \$38,593 above budget, largely consistent with the significant increase in orthopedic surgeries.
- **Professional fees:** \$80,553 above budget, driven primarily by higher-than-budgeted cash collection fees.

While increased expenses are expected as volumes grow, management will continue to monitor whether incremental revenue is generating an appropriate contribution margin. The focus will remain on improving productivity and identifying opportunities to reduce unnecessary cost growth.

Labor and Workforce

Labor management remains a key organizational priority.

August contract labor expense was **\$2,195 above budget**, with staffing challenges concentrated in several key areas, particularly Labor & Delivery. Contract staffing averaged approximately **0.8 FTE below budget** during the month.

Salaries, wages, and benefits represented approximately **52% of operating expenses**, compared with the District's long-term goal of maintaining labor expense at **50% or less**.

Management's focus will remain on reducing reliance on agency labor, improving workforce productivity, aligning staffing with patient volumes, and strengthening recruitment and retention in areas with persistent staffing needs.

Cash and Liquidity

Liquidity remained strong and continued to improve during August.

- **Days Cash on Hand:** 102 days
- **Unrestricted Cash:** \$35.5 million

- **Increase in unrestricted cash versus prior year:** Approximately \$9.8 million

Revenue cycle performance also continued to strengthen:

- Accounts receivable days improved by **5 days** compared with August 2025.
- Bad debt and write-offs improved by **\$549,049** compared with August 2025.
- Accounts receivable over 90 days decreased by **4.3%** compared with August 2025.

The combination of strong operating performance, improved collections, and disciplined cash management has materially strengthened the District's liquidity position.

Board takeaway: The District enters the remainder of FY2027 from a position of strong liquidity. Continued focus on revenue cycle performance and operating cash generation will be important to preserve this financial flexibility.

Strategic Priorities for Fiscal Year 2027

Management will continue to focus on the following priorities throughout FY2027:

- Grow strategic service lines, with continued expansion of orthopedic, urology, and general surgery programs.
- Optimize operating room utilization and improve clinic scheduling efficiency to maximize existing capacity.
- Strengthen revenue cycle performance through improved coding, denials management, collections, and cash conversion.
- Improve labor productivity and reduce reliance on contract and agency staffing.
- Reduce supply and operating room costs through supply chain management, standardization, and utilization initiatives.
- Maintain expense discipline while investing in service-line growth and other strategic priorities.
- Protect liquidity and financial flexibility through continued focus on operating performance and cash generation.

Conclusion

August 2026 was a strong month for Northern Inyo Healthcare District. Revenue and patient volumes significantly exceeded expectations, surgical growth continued, revenue cycle performance improved, and liquidity strengthened.

At the same time, management recognizes that sustained volume growth must be accompanied by disciplined management of labor, supplies, professional fees, and other variable costs. The FY2027 focus will therefore remain on achieving profitable growth, improving operational efficiency, and preserving the District's strong liquidity position.

Northern Inyo Healthcare District
August 2026 – Financial Summary

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
** Variances are B / (W)														
Net Income (Loss)	709,095	221,779	487,316	220%	(1,650,273)	2,359,368	143%	1,640,752	254,236	1,386,517	(545%)	(2,995,425)	4,636,177	(155%)
Operating Income (Loss)	(426,146)	(938,332)	512,185	(55%)	(2,029,125)	1,602,979	79%	(619,903)	(2,086,836)	1,466,933	70%	(3,800,618)	3,180,715	(84%)
EBIDA (Loss)	1,208,547	662,789	545,757	82%	(1,216,571)	2,425,118	199%	2,642,087	1,136,204	1,505,883	(133%)	(2,128,242)	4,770,330	(224%)
IP Gross Revenue	4,242,031	4,124,416	117,615	3%	3,568,998	673,033	19%	8,821,198	8,229,280	591,918	7%	6,927,249	1,893,949	27%
OP Gross Revenue	17,078,786	15,304,068	1,774,717	12%	13,040,013	4,038,772	31%	34,716,143	30,450,335	4,265,808	14%	27,103,982	7,612,161	28%
Clinic Gross Revenue	1,861,574	1,996,215	(134,642)	(7%)	1,925,757	(64,183)	(3%)	3,824,228	3,912,228	(88,000)	(2%)	3,731,920	92,307	2%
Total Gross Revenue	23,182,390	21,424,699	1,757,691	8%	18,534,768	4,647,622	25%	47,361,569	42,591,843	4,769,725	11%	37,763,151	9,598,418	25%
Net Patient Revenue	10,803,754	9,963,966	839,788	8%	7,960,546	2,843,208	36%	21,946,855	19,814,085	2,132,770	11%	16,042,034	5,904,821	37%
Cash Net Revenue % of Gross	47%	47%	0%	0%	43%	4%	9%	46%	47%	(0%)	(0%)	42%	4%	9%
Admits (excl. Nursery)	80	86	(6)	(7%)	64	16	25%	165	171	(6)	(4%)	128	37	29%
IP Days	239	240	(1)	(0%)	204	35	17%	508	491	16	3%	449	59	13%
IP Days (excl. Nursery)	196	204	(9)	(4%)	168	27	16%	426	424	2	1%	381	45	12%
Average Daily Census	6.3	8	(1.4)	(18%)	5.4	0.9	16%	6.9	16	(9.0)	(57%)	6.1	0.7	12%
ALOS	2.4	3	(0.3)	(12%)	2.6	(0.2)	(7%)	2.6	6	(3.2)	(55%)	3.0	(0.4)	(13%)
Deliveries	21	19	2	11%	19	2	11%	37	40	(3)	(8%)	40	(3)	(8%)
OP Visits	4,540	-	4,540	-%	4,155	385	9%	9,083	-	9,083	-%	8,273	810	10%
Rural Health Clinic Visits	1,953	2,371	(418)	(18%)	2,387	(434)	(18%)	4,203	4,596	(393)	(9%)	4,620	(417)	(9%)
Rural Health Women Visits	617	553	64	12%	553	64	12%	1,262	1,101	161	15%	1,101	161	15%
Rural Health Behavioral Visits	111	152	(41)	(27%)	152	(41)	(27%)	200	236	(36)	(15%)	258	(58)	(22%)
Total RHC Visits	2,681	3,076	(395)	(13%)	3,092	(411)	(13%)	5,665	5,933	(268)	(5%)	5,979	(314)	(5%)
Bronco Clinic Visits	-	-	-	-%	21	(21)	(100%)	-	-	-	-%	21	(21)	(100%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	291	323	(32)	(10%)	323	(32)	(10%)	657	644	13	2%	644	13	2%
Pediatric Clinic Visits	549	597	(48)	(8%)	597	(48)	(8%)	1,117	1,133	(16)	(1%)	1,133	(16)	(1%)
Specialty Clinic Visits	707	651	56	9%	638	69	11%	1,439	1,308	131	10%	1,282	157	12%
Surgery Clinic Visits	150	168	(18)	(11%)	170	(20)	(12%)	305	336	(31)	(9%)	308	(3)	(1%)
Virtual Care Clinic Visits	-	-	-	-%	42	(42)	(100%)	-	-	-	-%	83	(83)	(100%)
Total NIA Clinic Visits	1,697	1,739	(42)	(2%)	1,791	(94)	(5%)	3,518	3,421	97	3%	3,471	47	1%
IP Surgeries	13	17	(4)	(24%)	11	2	18%	25	30	(5)	(17%)	17	8	47%
OP Surgeries	123	137	(14)	(10%)	142	(19)	(13%)	246	244	2	1%	257	(11)	(4%)
Total Surgeries	136	154	(18)	(12%)	153	(17)	(11%)	271	274	(3)	(1%)	274	(3)	(1%)
Cardiology	1	4	(3)	(75%)	-	1	100%	7	7	-	-%	-	7	-%
General	66	90	(24)	(27%)	94	(28)	(30%)	136	161	(25)	(16%)	163	(27)	(17%)
Gynecology & Obstetrics	15	11	4	36%	9	6	67%	28	20	8	40%	20	8	40%
Ophthalmology	-	-	-	-%	21	(21)	(100%)	-	-	-	-%	38	(38)	(100%)
Orthopedic	31	33	(2)	(6%)	14	17	121%	69	58	11	19%	29	40	138%
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Podiatry	-	-	-	-%	1	(1)	(100%)	-	-	-	-%	1	(1)	(100%)
Urology	21	16	5	31%	14	7	50%	29	28	1	4%	23	6	26%
Diagnostic Image Exams	2,416	2,206	210	10%	2,190	226	10%	4,936	4,549	387	9%	4,516	420	9%
Emergency Visits	955	874	81	9%	865	90	10%	1,976	1,805	171	9%	1,787	189	11%
ED Admits	46	34	12	35%	34	12	35%	103	34	69	203%	71	32	45%
ED Admits % of ED Visits	5%	4%	1%	24%	4%	1%	23%	5%	4%	1%	34%	4%	1%	31%
Rehab Visits	921	853	68	8%	779	142	18%	1,891	1,716	175	10%	1,599	292	18%
OP Infusion/Wound Care Visits	1,104	722	382	53%	722	382	53%	1,884	1,257	627	50%	1,257	627	50%
Observation Hours	1,533	1,050	483	46%	1,050	483	46%	3,073	2,394	679	28%	2,394	679	28%

Northern Inyo Healthcare District

August 2026 – Financial Summary

** Variances are B / (W)

PAYOR MIX (Patient Days)

	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Blue Cross	27.1%	31.4%	(4.3%)	(13.7%)	31.4%	(4.3%)	(13.7%)	26.3%	23.9%	2.4%	9.9%	23.9%	2.4%	9.9%
Commercial	6.6%	9.8%	(3.1%)	(32.1%)	9.8%	(3.1%)	(32.1%)	5.7%	4.9%	0.8%	16.9%	4.9%	0.8%	16.9%
Medicaid	26.3%	15.9%	10.4%	65.5%	15.9%	10.4%	65.5%	28.0%	19.3%	8.7%	45.3%	19.3%	8.7%	45.3%
Medicare	39.9%	38.2%	1.8%	4.7%	38.2%	1.8%	4.7%	37.5%	46.0%	(8.6%)	(18.6%)	46.0%	(8.6%)	(18.6%)
Self-pay	-%	4.7%	(4.7%)	(100.0%)	4.7%	(4.7%)	(100.0%)	2.2%	5.9%	(3.7%)	(63.4%)	5.9%	(3.7%)	(63.4%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.4%	-%	0.4%	-%	-%	0.4%	-%
Other	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%

PAYOR MIX (Gross Revenue)

Blue Cross	29.2%	28.4%	0.8%	2.9%	28.4%	0.8%	2.9%	29.1%	27.3%	1.8%	6.4%	27.3%	1.8%	6.4%
Commercial	8.6%	6.6%	1.9%	29.2%	6.6%	1.9%	29.2%	7.5%	6.2%	1.2%	20.0%	6.2%	1.2%	20.0%
Medicaid	16.8%	14.7%	2.1%	14.0%	14.7%	2.1%	14.0%	18.1%	16.8%	1.3%	7.8%	16.8%	1.3%	7.8%
Medicare	42.5%	46.8%	(4.3%)	(9.2%)	46.8%	(4.3%)	(9.2%)	41.3%	46.0%	(4.7%)	(10.2%)	46.0%	(4.7%)	(10.2%)
Self-pay	1.7%	2.4%	(0.7%)	(28.1%)	2.4%	(0.7%)	(28.1%)	2.6%	2.6%	(0.0%)	(1.4%)	2.6%	(0.0%)	(1.4%)
Worker's Comp	0.8%	0.9%	(0.1%)	(12.3%)	0.9%	(0.1%)	(12.3%)	1.1%	0.8%	0.3%	40.5%	0.8%	0.3%	40.5%
Other	0.4%	0.1%	0.3%	210.3%	0.1%	0.3%	210.3%	0.3%	0.2%	0.1%	40.5%	0.2%	0.1%	40.5%

DEDUCTIONS

Contract Adjust	(12,294,395)	(10,741,542)	(1,552,853)	14%	(9,932,413)	(2,361,982)	24%	(25,339,548)	(21,348,395)	(3,991,153)	19%	(19,457,483)	(5,882,065)	30%
Bad Debt	294,778	(427,008)	721,786	(169%)	(288,924)	583,702	(202%)	600,164	(848,661)	1,448,826	(171%)	(1,553,158)	2,153,322	(139%)
Write-off	(387,538)	(440,290)	52,751	(12%)	(352,885)	(34,653)	10%	(684,059)	(875,058)	191,000	(22%)	(710,476)	26,418	(4%)

CENSUS

Patient Days	196	204	(9)	(4%)	168	27	16%	426	424	2	1%	381	45	12%
Adjusted ADC	35	42	(7)	(18%)	28	6	22%	37	82	(45)	(55%)	34	3	10%
Adjusted Days	1,069	1,246	(177)	(14%)	875	195	22%	2,288	2,544	(256)	(10%)	2,078	210	10%
Employed FTE	376.1	378.6	(2.5)	(1%)	378.6	(2.5)	(1%)	377.2	377.6	(0.3)	(0%)	377.6	(0.3)	(0%)
Contract Labor FTE	19.3	20.1	(0.8)	(4%)	20.1	(0.8)	(4%)	21.0	19.7	1.3	7%	19.7	1.3	7%
Total Paid FTE	395.4	398.7	(3.3)	(1%)	398.7	(3.3)	(1%)	398.3	397.3	1.0	0%	397.3	1.0	0%
EPOB (Employee per Occupied Bed)	2.0	2.4	(0.3)	(15%)	2.4	(0.3)	(15%)	1.9	2.4	(0.5)	(21%)	2.1	(0.2)	(10%)
EPOC (Employee per Occupied Case)	0.4	0.5	(0.1)	(19%)	0.5	(0.1)	(19%)	0.2	0.5	(0.3)	(62%)	0.2	(0.0)	(9%)
Adjusted EPOB	11.0	12.3	(1.2)	(10%)	12.3	(1.2)	(10%)	10.0	12.3	(2.3)	(18%)	11.4	(1.3)	(12%)
Adjusted EPOC	2.0	2.4	(0.3)	(15%)	2.4	(0.3)	(15%)	0.9	2.4	(1.4)	(60%)	1.0	(0.1)	(10%)

SALARIES

Per Adjust Bed Day	3,676	3,066	610	20%	4,268	(592)	(14%)	3,417	3,004	412	14%	3,541	(124)	(4%)
Total Salaries	3,931,653	3,820,883	110,769	3%	3,734,261	197,392	5%	7,817,531	7,643,563	173,968	2%	7,357,333	460,197	6%
Average Hourly Rate	59.01	56.97	2.05	4%	55.68	3.34	6%	58.49	57.14	1.35	2%	55.00	3.49	6%
Employed Paid FTEs	376.1	378.6	(2.5)	381.2	378.6	(2.5)	(1%)	377.2	377.6	(0.3)	(0%)	377.6	(0.3)	(0%)

BENEFITS

Per Adjust Bed Day	1,558	1,203	355	30%	1,391	167	12%	1,408	1,178	230	20%	1,289	120	9%
Total Benefits	1,665,884	1,498,525	167,359	11%	1,216,930	448,954	37%	3,221,984	2,997,224	224,760	7%	2,677,592	544,391	20%
Benefits % of Wages	42%	39%	3%	8%	33%	3%	30%	41%	39%	2%	5%	5%	5%	13%
Pension Expense	329,427	359,665	(30,239)	(8%)	350,232	(20,805)	(6%)	657,380	719,362	(61,982)	(9%)	698,763	(41,383)	(6%)
MDV Expense	1,069,047	782,746	286,301	37%	574,559	494,488	86%	2,010,801	1,565,493	445,308	28%	1,398,086	612,715	44%
Taxes, PTO accrued, Other	267,410	356,113	(88,703)	(25%)	292,139	(24,729)	(8%)	553,802	712,369	(158,567)	(22%)	580,743	(26,941)	(5%)

Contract Labor

Total Contract Labor	282,842	280,647	2,195	1%	436,656	(153,815)	(35%)	721,439	541,964	179,475	33%	722,192	(753)	(0%)
Contract AHR	82.67	78.86	3.82	5%	122.69	(40.02)	(33%)	96.83	77.55	19.28	25%	103.34	(6.51)	(6%)
Contract Paid FTEs	19.3	20.1	(0.8)	(4%)	20.1	(0.8)	(4%)	21.0	19.7	1.3	7%	19.7	1.3	7%

Salaries, Wages & Benefits

SWB/APD	5,498	4,494	1,004	22%	6,159	(660)	(11%)	5,140	4,395	745	17%	5,177	(37)	(1%)
SWB % of Total Expenses	52%	51%	1%	2%	54%	(2%)	(3%)	52%	51%	1%	2%	54%	(2%)	(4%)

Northern Inyo Healthcare District
August 2026 – Financial Summary

** Variances are B / (W)

Labor Cost per Adjusted Patient Day
Salary Expense / Net Patient Revenue
Agency/Contract Labor \$\$ %
Agency/Contract Labor FTE %

Current Month				Prior MTD			Year to Date				Prior YTD		
Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
3,941	3,292	649	20%	4,768	(827)	(17%)	3,732	3,217	515	16%	3,888	(156)	(4%)
39%	41%	(2%)	(5%)	52%	(13%)	(26%)	39%	41%	(2%)	(6%)	50%	(11%)	(23%)
7%	7%	(0%)	(2%)	10%	(4%)	(36%)	8%	7%	2%	28%	9%	(0%)	(5%)
5%	5%	(0%)	(3%)	5%	(0%)	(3%)	5%	5%	0%	6%	5%	0%	6%

Northern Inyo Healthcare District
August 2026 – Financial Summary

** Variances are B / (W)

PROFESSIONAL FEES

Per Adjust Bed Day
Total Physician Fee
Total Other Pro-Fees
Total Professional Fees
Physician Fee per Adjust Bed Day

PHARMACY

Per Adjust Bed Day
Total Rx Expense

MEDICAL SUPPLIES

Per Adjust Bed Day
Total Medical Supplies

EHR SYSTEM

Per Adjust Bed Day
Total EHR Expense

OTHER EXPENSE

Per Adjust Bed Day
Total Other

DEPRECIATION AND AMORTIZATION

Per Adjust Bed Day
Total Depreciation and Amortization

TOTAL EXPENSES

Per Adjust Bed Day
Per Calendar Day

Current Month				Prior MTD			Year to Date				Prior YTD		
Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
2,631	2,193	438	20%	2,705	(74)	(3%)	2,530	2,088	442	21%	2,175	354	16%
1,947,533	1,934,660	12,873	1%	1,664,607	282,926	17%	3,932,449	3,797,124	135,325	4%	3,173,933	758,516	24%
865,966	798,286	67,680	8%	701,734	164,232	23%	1,855,564	1,515,198	340,366	22%	1,346,027	509,537	38%
2,813,499	2,732,946	80,553	3%	2,366,341	447,158	19%	5,788,013	5,312,322	475,691	9%	4,519,960	1,268,053	28%
1,821	1,553	268	17%	1,903	(82)	(4%)	1,719	1,492	226	15%	1,528	191	13%
427	302	125	41%	475	(48)	(10%)	380	312	68	22%	414	(34)	(8%)
456,623	376,047	80,576	21%	415,938	40,685	10%	869,548	795,008	74,540	9%	860,405	9,142	1%
512	473	39	8%	593	(82)	(14%)	484	499	(15)	(3%)	437	47	11%
547,434	589,417	(41,983)	(7%)	519,164	28,270	5%	1,107,821	1,270,775	(162,954)	(13%)	907,497	200,324	22%
26	19	7	36%	27	(1)	(4%)	25	31	(6)	(18%)	38	(13)	(33%)
28,052	24,015	4,037	17%	24,015	4,037	17%	57,824	78,694	(20,871)	(27%)	78,694	(20,871)	(27%)
939	914	25	3%	963	(24)	(2%)	866	935	(69)	(7%)	891	(25)	(3%)
1,004,462	1,138,809	(134,346)	(12%)	842,665	161,797	19%	1,981,265	2,379,402	(398,138)	(17%)	1,851,795	129,470	7%
467	354	113	32%	496	(29)	(6%)	438	347	91	26%	417	20	5%
499,452	441,010	58,441	13%	433,701	65,750	15%	1,001,335	881,969	119,366	14%	867,183	134,152	15%
11,229,900	10,902,298	327,602	3%	9,989,672	1,240,229	12%	22,566,758	21,900,921	665,838	3%	19,842,652	2,724,107	14%
10,501	8,749	1,751	20%	11,419	(918)	(8%)	9,863	8,608	1,255	15%	9,550	313	3%
362,255	351,687	10,568	3%	322,247	40,007	12%	363,980	353,241	10,739	3%	320,043	43,937	14%

Key Financial Performance Indicators	Industry		FYE 2025		FYE 2026			Variance to	Variance to FYE											
	Benchmark	Aug-24	Average	Aug-25	Average	Jul-26	Aug-26	PM	2026 Average	Variance to PYM										
Volume																				
Admits		41	75	69	64	75	87	80	(7)	5	16									
Deliveries	n/a		19	17	19	16	16	21	5	5	2									
Adjusted Patient Days	n/a		1,362	977	875	1,098	1,217	1,069	(147)	(28)	195									
Total Surgeries		153	168	141	153	138	135	136	1	(2)	(17)									
ER Visits		659	905	837	865	849	1,021	955	(66)	106	90									
RHC and Clinic Visits	n/a		4,921	4,772	4,883	4,771	4,805	4,378	(427)	(393)	(505)									
Diagnostic Imaging Services	n/a		2,221	2,129	2,190	2,241	2,520	2,416	(104)	175	226									
Rehab Services	n/a		808	838	779	816	970	921	(49)	105	142									
AR & Income																				
Gross AR (Cerner only)	n/a	\$	57,648,281	\$	50,813,697	\$	43,163,140	\$	43,895,991	\$	48,479,909	\$	49,965,828	\$	1,485,919	\$	6,069,838	\$	6,802,689	
AR > 90 Days	\$	7,271,986.32	\$	24,824,364	\$	19,638,850	\$	17,125,397	\$	15,623,287	\$	17,133,809	\$	17,654,618	\$	520,809	\$	2,031,331	\$	529,221
AR % > 90 Days	15%		43.1%		38.6%		39.68%		35.8%		35.34%		35.3%		0.0%		-0.4%		-4.3%	
Gross AR Days (per financial statements)	60		84		80		72		63		62		67		5		4		(5)	
Net AR Days (per financial statements)	30		64		71		62		65		60		66		6		2		4	
Net AR	n/a	\$	20,277,373	\$	19,370,868	\$	16,007,125	\$	20,633,479	\$	21,593,930	\$	23,060,459	\$	1,466,529	\$	2,426,979	\$	7,053,334	
Net AR % of Gross	n/a		35.2%		38.5%		37.1%		46.4%		44.5%		46.2%		1.6%		-0.3%		9.1%	
Gross Patient Revenue/Calendar Day	n/a	\$	683,348	\$	634,418	\$	597,896	\$	694,615	\$	779,974	\$	747,819	\$	(32,154)	\$	53,204	\$	149,923	
Net Patient Revenue/Calendar Day	n/a	\$	315,574	\$	273,563	\$	256,792	\$	319,513	\$	359,455	\$	348,508	\$	(10,947)	\$	28,995	\$	91,716	
Net Patient Revenue/APD	n/a	\$	7,183	\$	8,088	\$	9,099	\$	8,978	\$	9,157	\$	10,102	\$	945	\$	1,124	\$	1,003	
Wages																				
Wages	n/a	\$	3,241,107	\$	3,661,965	\$	3,734,261	\$	3,705,110	\$	3,885,878	\$	3,931,653	\$	45,775	\$	226,543	\$	197,392	
Employed paid FTEs	n/a		372.26		370.77		378.62		379.65		378.36		376.09		(2.27)		(3.56)		(2.53)	
Employed Average Hourly Rate	\$55.50	\$	49.29	\$	56.78	\$	55.83	\$	56.30	\$	58.14	\$	59.18	\$	1.04	\$	2.87	\$	3.35	
Benefits	n/a	\$	1,478,605	\$	1,401,858	\$	1,216,930	\$	1,312,122	\$	1,556,100	\$	1,665,884	\$	109,784	\$	353,762	\$	448,954	
Benefits % of Wages	30%		45.6%		39.0%		32.6%		35.6%		40.0%		42.4%		2.3%		6.8%		9.8%	
Contract Labor	n/a	\$	829,876	\$	447,445	\$	436,656	\$	361,823	\$	438,597	\$	282,842	\$	(155,755)	\$	(78,982)	\$	(153,815)	
Contract Labor Paid FTEs	n/a		28.31		23.89		20.09		19.55		22.75		19.31		(3.43)		(0.23)		(0.78)	
Total Paid FTEs	n/a		400.57		394.65		398.71		399.20		401.11		395.40		(5.70)		(3.80)		(3.31)	
Contract Labor Average Hourly Rate	\$	81.04	\$	165.95	\$	117.91	\$	123.03	\$	106.68	\$	109.15	\$	82.90	\$	(26.25)	\$	(23.78)	\$	(40.13)
Total Salaries, Wages, & Benefits	n/a	\$	5,549,587	\$	5,511,268	\$	5,387,847	\$	5,379,055	\$	5,880,575	\$	5,880,378	\$	(197)	\$	501,323	\$	492,532	
SWB% of NR	50%		56.7%		70.3%		67.7%		56.0%		56.1%		54.4%		-1.7%		-1.6%		-13.3%	
SWB/APD	2,416	\$	4,075	\$	5,064	\$	6,159	\$	5,020	\$	4,833	\$	5,498	\$	666	\$	479	\$	(660)	
SWB % of total expenses	50%		56.3%		57.3%		53.9%		51.7%		51.9%		52.4%		0.5%		0.6%		-1.6%	

	Industry		FYE 2025		FYE 2026			Variance to	Variance to FYE	
	Benchmark	Aug-24	Average	Aug-25	Average	Jul-26	Aug-26	PM	2026 Average	Variance to PYM
Physician Spend										
Physician Expenses	n/a	\$ 1,536,032	\$ 1,507,510	\$ 1,664,607	\$ 1,811,516	\$ 1,984,916	\$ 1,947,533	\$ (37,383)	\$ 136,017	\$ 282,926
Physician expenses/APD	n/a	\$ 1,128	\$ 1,476	\$ 1,903	\$ 1,676	\$ 1,631	\$ 1,821	\$ 190	\$ 145	\$ (82)
Supplies										
Supply Expenses	n/a	\$ 1,264,257	\$ 776,504	\$ 935,102	\$ 967,638	\$ 973,312	\$ 1,004,057	\$ 30,744	\$ 36,419	\$ 68,954
Supply expenses/APD		\$ 928	\$ 744	\$ 1,069	\$ 892	\$ 800	\$ 939	\$ 139	\$ 47	\$ (130)
Other Expenses										
Other Expenses	n/a	\$ 1,432,005	\$ 1,824,207	\$ 2,002,116	\$ 2,214,853	\$ 2,498,056	\$ 2,397,932	\$ (100,123)	\$ 183,080	\$ 395,817
Other Expenses/APD	n/a	\$ 1,051	\$ 1,787	\$ 2,289	\$ 2,068	\$ 2,053	\$ 2,242	\$ 189	\$ 175	\$ (46)
Margin										
Net Income	n/a	\$ (149,542)	\$ 383,722	\$ (1,650,273)	\$ 877,257	\$ 931,657	\$ 709,095	\$ (222,562)	\$ (168,162)	\$ 2,359,368
Net Profit Margin	n/a	-1.6%	3.0%	-20.7%	7.0%	8.4%	6.6%	-1.8%	-0.4%	27.3%
Operating Income	n/a	\$ (544,049)	\$ (686,444)	\$ (2,029,125)	\$ (671,709)	\$ (193,757)	\$ (426,146)	\$ (232,389)	\$ 245,563	\$ 1,602,979
Operating Margin	2.9%	-5.9%	-9.9%	-25.5%	-9.9%	-1.7%	-3.9%	-2.2%	6.0%	21.5%
EBITDA	n/a	\$ 175,023	\$ 841,891	\$ (1,216,571)	\$ 1,346,683	\$ 1,433,540	\$ 1,208,547	\$ (224,994)	\$ (138,137)	\$ 2,425,118
EBITDA Margin	12.7%	1.9%	9.0%	-15.3%	11.9%	12.9%	11.2%	-1.7%	-0.7%	26.5%
Debt Service Coverage Ratio	3.70	130.0%	3.9	(5.2)	(0.1)	0.5	10.9	10.4	11.0	16.1
Cash										
Avg Daily Disbursements (excl. IGT)	n/a	\$ 426,350	\$ 355,328	\$ 379,493	\$ 430,840	\$ 376,919	\$ 422,830	\$ 45,911	\$ (8,011)	\$ 43,336
Average Daily Cash Collections (excl. IGT)	n/a	\$ 306,137	\$ 340,919	\$ 283,158	\$ 335,789	\$ 359,424	\$ 253,190	\$ (106,234)	\$ (82,599)	\$ (29,968)
Average Daily Net Cash		\$ (120,213)	\$ (14,409)	\$ (96,335)	\$ (95,051)	\$ (17,495)	\$ (169,640)	\$ (152,145)	\$ (74,588)	\$ (73,305)
Upfront Cash Collections		\$ 45,382	\$ 36,146	\$ 66,623	\$ 66,519	\$ 59,895	\$ 68,610	\$ 8,715	\$ 2,092	\$ 1,987
Upfront Cash % of Gross Charges	1%	\$ 0	0.2%	0.4%	0.3%	0.2%	0.3%	0.0%	0.0%	-0.1%
Unrestricted Funds	n/a	\$ 31,263,610	\$ 23,536,438	\$ 25,662,275	\$ 28,328,253	\$ 39,973,321	\$ 35,544,887	\$ (4,428,434)	\$ 7,216,634	\$ 9,882,612
Change of cash per balance sheet	n/a	\$ 1,108,081	\$ (321,485)	\$ (2,422,397)	\$ 1,204,912	\$ 375,558	\$ (4,428,434)	\$ (4,803,993)	\$ (5,633,347)	\$ (2,006,037)
Days Cash on Hand (assume no more cash is collected)	196	73	73	84	88	114	102	(12)	14	18
Estimated Days Until Depleted (operating cash only)		385	1,633	435	466	2,285	380	(1,905)	(86)	(55)
Years Until Cash Depletion (operating cash only)		1.06	4.48	1.19	1.28	6.26	1.04	(5.22)	(0.24)	(0.15)

NIHD Financial Update

Chief Financial Officer

August 2026 Results



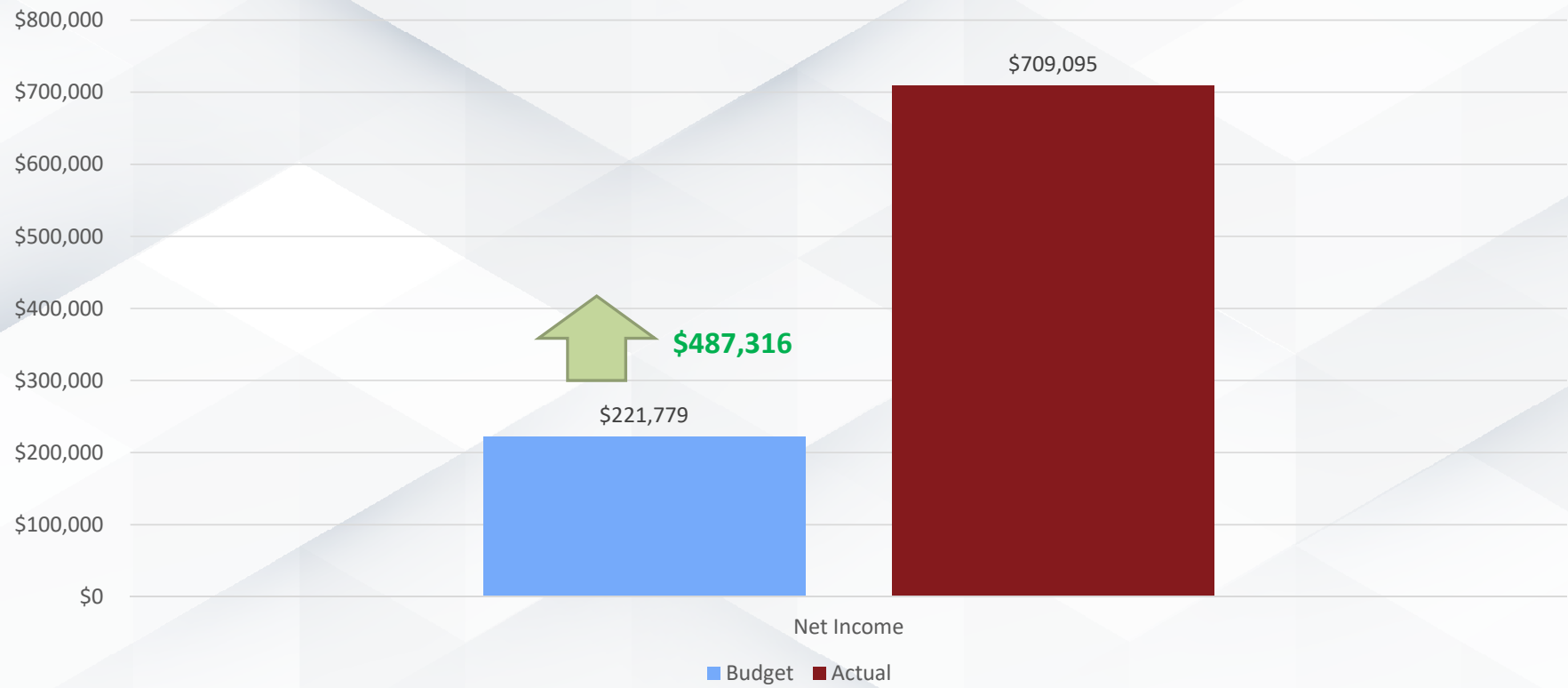
NORTHERN INYO HEALTHCARE DISTRICT

INCOME PERFORMANCE

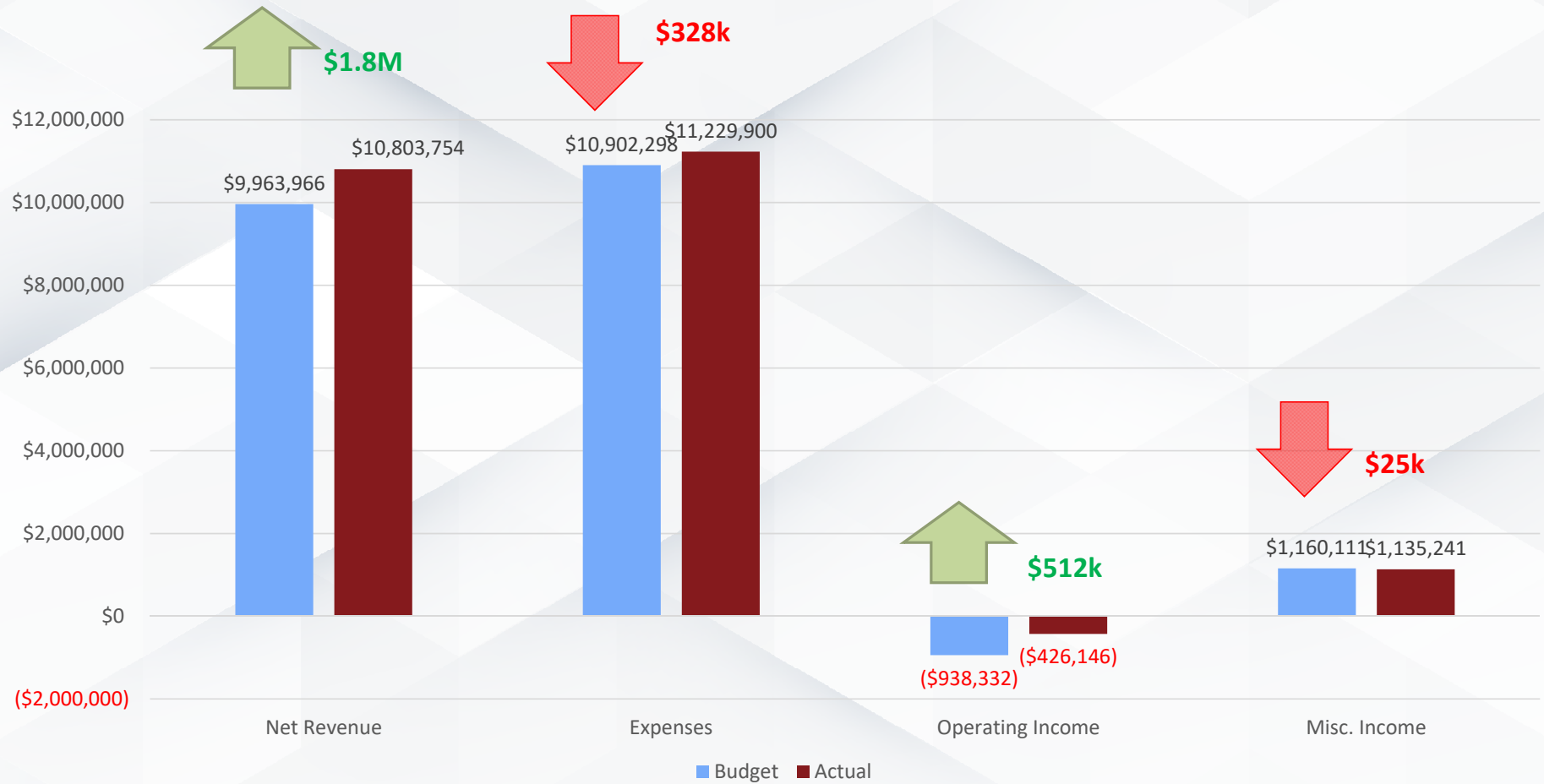


NORTHERN INYO HEALTHCARE DISTRICT

Net Income



Income to Budget



Volume & Income Action plan

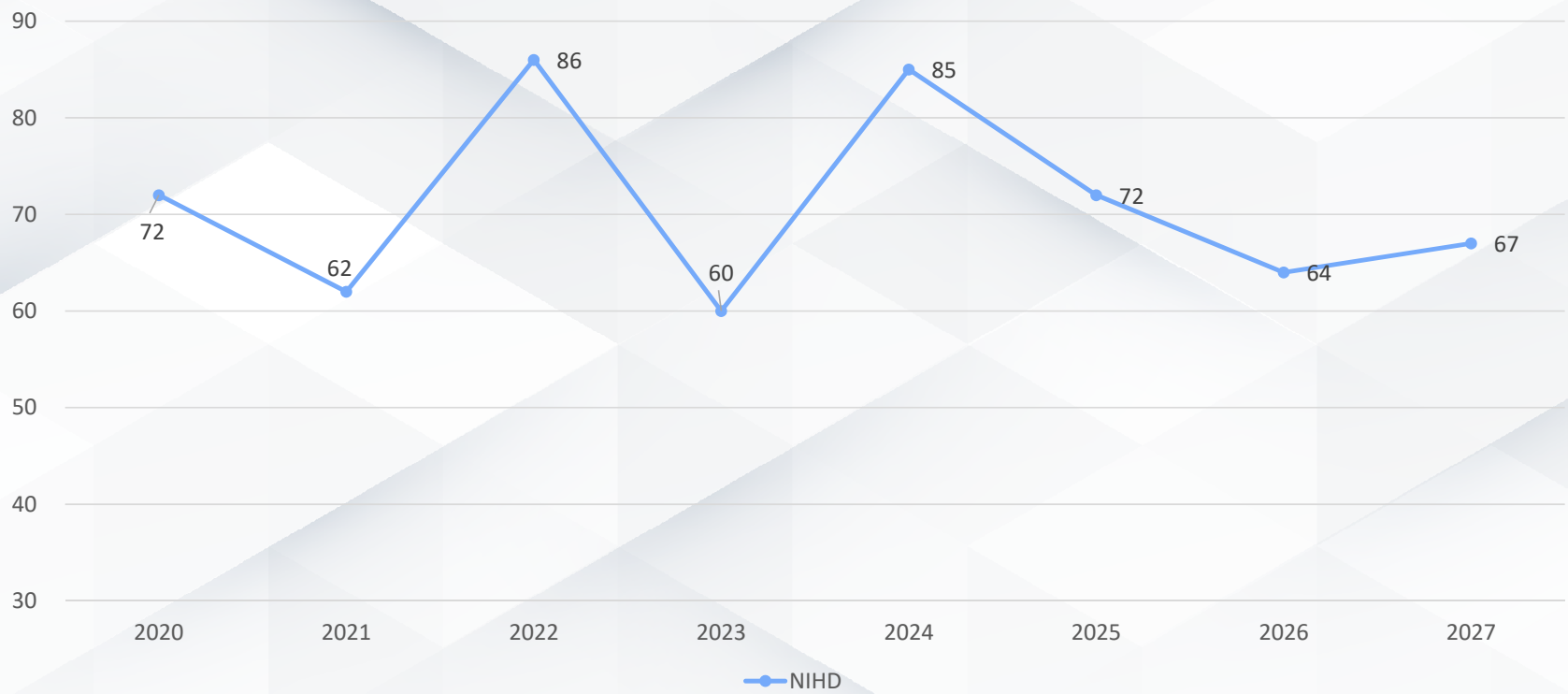
- We are working on reviewing operational efficiency including OR utilization and space utilization reviews to maximize patient flow and care.
- We are being more deliberate in our service line strategy.
- We are working on a staff benchmarking analysis to determine if we are appropriately staffing by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

Cash Performance

Income to Cash

	FYE 2026
Net Income (loss)	\$1,640,752
Principal Payments on Long-Term Debt (balance sheet only)	\$0
Other Debt (long-term leases & subscriptions – balance sheet only)	\$(224,211)
Capital purchases (balance sheet only)	\$(365,115)
IGT funding	\$ (1,745,242)
Timing of accruals vs cash (including IGT revenue)	\$(3,359,066)
Impact to Cash	\$(5,693,634)
Adjusted Net Income (cash basis)	\$(4,052,882)

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 are at a record low for the organization.

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2027

	7/31/2026	Jul Budget	7/31/2025	8/31/2026	Aug Budget	8/31/2025	2027 YTD	Budget Variance	PYM Change
Gross Patient Service Revenue									
Inpatient Patient Revenue	4,579,167	4,104,865	3,358,250	4,242,031	4,124,416	3,568,998	8,821,198	117,615	673,033
Outpatient Revenue	17,637,358	15,146,266	14,063,969	17,078,786	15,304,068	13,040,013	34,716,143	1,774,717	4,038,772
Clinic Revenue	1,962,654	1,916,013	1,806,164	1,861,574	1,996,215	1,925,757	3,824,228	(134,642)	(64,183)
Gross Patient Service Revenue	24,179,179	21,167,144	19,228,383	23,182,390	21,424,699	18,534,768	47,361,569	1,757,691	4,647,622
Deductions from Revenue									
Contractual Adjustments	(13,045,153)	(10,606,853)	(9,525,069)	(12,294,395)	(10,741,542)	(9,932,413)	(25,339,548)	(1,552,853)	(2,361,982)
Bad Debt	305,386	(421,653)	(1,264,234)	294,778	(427,008)	(288,924)	600,164	721,786	583,702
A/R Writeoffs	(296,521)	(434,769)	(357,591)	(387,538)	(440,290)	(352,885)	(684,059)	52,751	(34,653)
Other Deductions from Revenue	-	146,249	-	-	148,107	-	-	(148,107)	-
Deductions from Revenue	(13,036,287)	(11,317,026)	(11,146,895)	(12,387,155)	(11,460,733)	(10,574,222)	(25,423,442)	(926,422)	(1,812,933)
Other Patient Revenue									
Incentive Income	210	-	-	8,519	-	-	8,729	8,519	8,519
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-	-	-	-
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-
Other Patient Revenue	210	-	-	8,519	-	-	8,729	8,519	8,519
Net Patient Service Revenue	11,143,101	9,850,118	8,081,488	10,803,754	9,963,966	7,960,546	21,946,855	839,788	2,843,208
CNR%	46.1%	46.5%	42.0%	46.6%	46.5%	42.9%	46.3%	0.1%	3.7%
Cost of Services - Direct									
Salaries and Wages	3,290,203	3,822,680	3,094,605	3,326,885	3,233,154	3,175,377	6,617,088	93,731	151,507
Benefits	1,298,976	1,498,699	1,252,765	1,399,644	1,259,032	1,041,071	2,698,620	140,612	358,573
Professional Fees	2,260,084	2,579,376	1,650,515	2,146,712	2,085,250	1,873,583	4,406,797	61,462	273,129
Contract Labor	378,756	261,317	190,675	264,479	262,427	339,022	643,235	2,052	(74,543)
Pharmacy	412,925	418,961	444,467	456,623	376,047	415,938	869,548	80,576	40,685
Medical Supplies	560,387	681,358	388,333	547,434	589,417	519,164	1,107,821	(41,983)	28,270
Hospice Operations	-	-	-	-	-	-	-	-	-
EHR System Expense	29,771	54,679	54,679	28,052	24,015	24,015	57,824	4,037	4,037
Other Direct Expenses	716,136	1,240,594	785,085	775,327	879,026	601,687	1,491,463	(103,700)	173,639
Total Cost of Services - Direct	8,947,239	10,557,664	7,861,124	8,945,156	8,708,367	7,989,858	17,892,395	236,789	955,298
General and Administrative Overhead									
Salaries and Wages	595,675	-	528,468	604,768	587,729	558,883	1,200,443	17,039	45,885
Benefits	257,124	-	207,897	266,240	239,492	175,859	523,363	26,747	90,381
Professional Fees	714,430	-	503,103	666,786	647,696	492,758	1,381,217	19,091	174,028
Contract Labor	59,841	-	94,861	18,362	18,220	97,634	78,203	142	(79,272)
Depreciation and Amortization	501,883	440,958	433,481	499,452	441,010	433,701	1,001,335	58,441	65,750
Other Administrative Expenses	260,666	-	224,045	229,136	259,783	240,978	489,802	(30,647)	(11,842)
Total General and Administrative Overhead	2,389,619	440,958	1,991,856	2,284,744	2,193,931	1,999,814	4,674,363	90,814	284,930
Total Expenses	11,336,858	10,998,623	9,852,980	11,229,900	10,902,298	9,989,672	22,566,758	327,602	1,240,229
								-	-
Financing Expense	168,415	195,629	197,282	168,102	182,354	181,532	336,517	(14,252)	(13,430)
Financing Income	384,000	354,840	260,000	384,000	365,276	260,000	768,000	18,724	124,000
Investment Income	127,759	54,116	58,186	119,932	36,614	40,684	247,691	83,317	79,248
Miscellaneous Income	782,071	967,635	305,436	799,412	940,574	259,701	1,581,482	(141,162)	539,711
Net Income (Change in Financial Position)	931,657	32,456	(1,345,152)	709,095	221,779	(1,650,273)	1,640,752	487,316	2,359,368
Operating Income	(193,757)	(1,148,504)	(1,771,492)	(426,146)	(938,332)	(2,029,125)	(619,903)	512,185	1,602,979
EBIDA	1,433,540	473,415	(911,671)	1,208,547	662,789	(1,216,571)	2,642,087	545,757	2,425,118
Net Profit Margin	8.4%	0.3%	-16.6%	6.6%	2.2%	-20.7%	7.5%	4.3%	38.5%
Operating Margin	-1.7%	-11.7%	-21.9%	-3.9%	-9.4%	-25.5%	-2.8%	5.5%	29.1%
EBIDA Margin	12.9%	4.8%	-11.3%	11.2%	6.7%	-15.3%	12.0%	4.5%	37.1%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2027

	PY Balances	7/31/2026	7/31/2025	8/31/2026	8/31/2025	PM Change	PY Change
Assets							
Current Assets							
Cash and Liquid Capital	28,460,222	28,731,778	19,787,525	24,303,306	17,614,185	(4,428,472)	6,689,121
Short Term Investments	11,137,546	11,241,543	7,800,231	11,241,581	7,551,052	37	3,690,529
PMA Partnership	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	21,307,775	21,593,930	16,184,152	23,060,459	16,007,125	1,466,529	7,053,334
Other Receivables	2,954,416	3,796,999	10,594,449	8,350,721	10,876,532	4,553,722	(2,525,811)
Inventory	5,537,948	5,561,610	5,325,022	5,583,212	5,333,341	21,602	249,871
Prepaid Expenses	1,762,519	2,137,092	1,310,343	1,954,027	1,486,823	(183,065)	467,204
Total Current Assets	71,160,427	73,062,952	61,001,722	74,493,306	58,869,057	1,430,354	15,624,248
Assets Limited as to Use							
Internally Designated for Capital Acquisition:	-	-	-	-	-	-	-
Short Term - Restricted	1,470,800	1,470,928	1,469,420	1,471,056	1,469,548	128	1,508
Limited Use Assets	-	-	-	-	-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	3,743,510	3,743,510	9,393,030	3,743,510	9,393,030	-	(5,649,520)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	4,316,607	4,316,607	9,966,127	4,316,607	9,966,127	-	(5,649,520)
Revenue Bonds Held by a Trustee	230,052	224,574	291,637	219,097	285,893	(5,477)	(66,796)
Total Assets Limited as to Use	6,017,459	6,012,110	11,727,185	6,006,760	11,721,568	(5,349)	(5,714,808)
Long Term Assets							
Long Term Investment	-	-	496,916	-	497,038	-	(497,038)
Fixed Assets, Net of Depreciation	78,338,535	77,848,511	81,304,067	77,708,645	81,092,433	(139,865)	(3,383,787)
Total Long Term Assets	78,338,535	77,848,511	81,800,984	77,708,645	81,589,470	(139,865)	(3,880,825)
Total Assets	155,516,421	156,923,572	154,529,890	158,208,711	152,180,096	1,285,139	6,028,615
Liabilities							
Current Liabilities							
Current Maturities of Long-Term Debt	3,440,037	3,443,154	3,618,572	3,431,006	3,726,714	(12,148)	(295,709)
Accounts Payable	4,416,081	4,531,548	5,160,660	4,948,972	4,051,592	417,424	897,381
Accrued Payroll and Related	4,276,351	4,614,062	3,876,752	4,744,581	4,244,712	130,519	499,869
Accrued Interest and Sales Tax	76,902	140,328	149,575	204,346	217,529	64,018	(13,183)
Notes Payable	229,820	229,820	339,892	229,820	339,892	-	(110,072)
Unearned Revenue	-	-	-	-	-	-	-
Due to 3rd Party Payors	4,125,564	4,125,564	3,324,903	4,125,564	3,324,903	-	800,661
Due to Specific Purpose Funds	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	5,006,479	5,006,479	8,756,720	5,006,479	8,754,650	-	(3,748,171)
Total Current Liabilities	21,571,235	22,090,956	25,227,074	22,690,769	24,659,993	599,813	(1,969,225)
Long Term Liabilities							
Long Term Debt	30,065,301	29,955,981	33,237,566	29,851,904	33,246,456	(104,077)	(3,394,552)
Bond Premium	90,328	87,191	121,699	84,054	118,562	(3,137)	(34,508)
Accreted Interest	17,383,865	17,468,253	17,361,713	17,552,641	17,450,748	84,388	101,893
Other Non-Current Liability - Pension	28,132,971	28,132,971	31,874,258	28,132,971	31,874,258	-	(3,741,287)
Total Long Term Liabilities	75,672,466	75,644,396	82,595,236	75,621,570	82,690,024	(22,826)	(7,068,454)
Suspense Liabilities	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	134,005	134,005	54,922	134,005	54,922	-	79,083
Total Liabilities	97,377,707	97,869,357	107,877,232	98,446,344	107,404,939	576,987	(8,958,595)
Fund Balance							
Fund Balance	45,944,004	56,651,630	46,528,390	56,650,559	46,301,034	(1,071)	10,349,525
Temporarily Restricted	1,470,800	1,470,928	1,469,420	1,471,056	1,469,548	128	1,508
Net Income	10,723,910	931,657	(1,345,152)	1,640,752	(2,995,425)	709,095	4,636,177
Total Fund Balance	58,138,714	59,054,215	46,652,658	59,762,367	44,775,157	708,152	14,987,210
Liabilities + Fund Balance	155,516,421	156,923,572	154,529,890	158,208,711	152,180,096	1,285,139	6,028,615
(Decline)/Gain		1,407,151	(167,926)	1,285,139	(2,349,794)	(122,012)	3,634,933

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2027

Calculation method agrees to SECOND and THIRD
SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:

Excess of revenues over expense
+ Depreciation Expense
+ Interest Expense
Less GO Property Tax revenue
Less GO Interest Expense

HOSPITAL FUND ONLY

\$	1,640,752
	1,001,335
	336,517
	622,000
	75,679

"Income available for debt service"

\$	2,280,926
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Denominator:

Maximum "Annual Debt Service"

2021A Revenue Bonds
2021B Revenue Bonds
2009 GO Bonds (Fully Accreted Value)
2016 GO Bonds
Financed purchases and other loans

\$	112,700
	892,400
	1,506,725
\$	2,511,825

Total Maximum Annual Debt Service

Ratio: (numerator / denominator)

	5.45
--	------

Required Debt Service Coverage Ratio:

1.10

In Compliance? (Y/N)

Yes

Unrestricted Funds and Days Cash on Hand

HOSPITAL FUND ONLY

Cash and Investments-current
Cash and Investments-non current
Sub-total
Less - Restricted:
PRF and grants (Unearned Revenue)
Held with bond fiscal agent
Building and Nursing Fund

\$	35,544,887
	-
	35,544,887
	-
	-
	-
\$	35,544,887

Total Unrestricted Funds

Total Operating Expenses

\$	22,566,758
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Less Depreciation

	1,001,335
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Net Expenses

	21,565,423
--	------------

Average Daily Operating Expense

\$	347,829
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Days Cash on Hand

	102
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Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2027

CASH FLOWS FROM OPERATING ACTIVITIES

Receipts from and on Behalf of Patients	21,962,543
Payments to Suppliers and Contractors	(16,320,878)
Payments to and on Behalf of Employees	(11,760,953)
Other Receipts and Payments, Net	(157,492)
Net Cash Provided (Used) by Operating Activities	<u>(6,276,780)</u>

CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES

Noncapital Contributions and Grants	1,249,172
Property Taxes Received	146,000
Net Cash Provided (Used) by Noncapital Financing Activities	<u>1,395,172</u>

CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES

Principal Payments on Long-Term Debt	-
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defeasement Revenue Bonds	-
Interest Paid	(336,517)
Purchase and Construction of Capital Assets	365,115
Payments on Lease Liability	(17,244)
Payments on Subscription Liability	(206,967)
Property Taxes Received	768,000
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	<u>572,387</u>

CASH FLOWS FROM INVESTING ACTIVITIES

Investment Income	247,691
Rental Income	8,648
Net Cash Provided (Used) by Investing Activities	<u>256,339</u>

NET CHANGE IN CASH AND CASH EQUIVALENTS

(4,052,882)

Cash and Cash Equivalents - Beginning of Year

39,597,769

CASH AND CASH EQUIVALENTS - END OF YEAR

35,544,887