Northern Inyo County Local Hospital District

Board of Directors Regular Meeting

Wednesday June 16, 2010; 5:30pm

Board Room
Northern Inyo Hospital

DRAFT AGENDA

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING

June 16, 2010 at 5:30 P.M.

In the Board Room at Northern Inyo Hospital

1. Call to Order (at 5:30 P.M.).
2. Opportunity for members of the public to comment on any items on this Agenda.
3. Interviews, District Zone II Board vacancy (*action item*).
4. Approval of minutes of the May 19 2010 regular meeting.
5. Financial and Statistical Reports for the month of April 2010; John Halfen.
6. Administrator's Report; John Halfen.
   A. Building Update (cash flow)
   B. Security Report
   C. MRI software upgrade
   D. Other
7. Chief of Staff Report; Charlotte Helvie, M.D.
   A. Policy and Procedure approvals (*action items*):
      1. *NIH 2010 Surge Plan*
      2. *Multidrug Resistant Organism (MDRO) Control Plan*
      3. *Respiratory Care Infection Control General Policies*
      4. *Respiratory Care – Infection Control; Personal Protection*
   B. Staff Advancement, Thomas J. Boo, M.D. (*action item*).
   C. Medical Staff Elections (*information item*).
   D. Performance Improvement Plan (*action item*).
   E.. Other
8. Old Business
   - None -
9. New Business
   A. Request to Start Community Outreach Program (*Jillene Freis*).
   B. Resolution 10-01, Consolidation of November Elections (*action item*).
   C. Approval of appropriations limit for fiscal year 2010-2011 fiscal year, Board Resolution 10-02 (*action item*).
   D. Milliman Actuarial Valuation as of January 1, 2010 (*action item*).
   E. M.R.I. upgrade, $299,320.00 (*possible action item*).

F. VOIP system purchase (*possible action item*).

10. Reports from Board members on items of interest.
11. Opportunity for members of the public to comment on any items on this Agenda, and/or on any Items of interest.
12. Adjournment to closed session to:
    A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962).
    B. Confer with legal counsel regarding action filed by John Nesson M.D. against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).
    C. Confer with legal counsel regarding action filed by Stephen Johnson and Elizabeth Manahan-Johnson against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).
13. Return to open session, and report of any action taken in closed session.
14. Opportunity for members of the public to address the Board of Directors on items of interest.
15. Adjournment.

THIS SHEET

INTENTIONALLY

LEFT BLANK

CALL TO ORDER	The meeting was called to order at 5:34 p.m. by John Ungersma, M.D., Vice President.
PRESENT	John Ungersma, M.D., Vice President M.C. Hubbard, Secretary D. Scott Clark, M.D., Director Charlotte Helvie, M.D., Chief of Staff
ALSO PRESENT	John Halfen, Administrator Douglas Buchanan, Esq., Hospital District Legal Counsel Sandy Blumberg, Administration Secretary
ABSENT	Peter Watercott, President
ALSO PRESENT FOR RELEVANT PORTION(S)	Dianne Shirley, R.N. Performance Improvement Coordinator
PUBLIC COMMENTS ON AGENDA	Doctor Ungersma asked if any members of the public wished to address the Board on any items listed on the agenda for this meeting. No comments were heard.
MINUTES	The minutes of the April 21 2010 regular meeting were approved.
FINANCIAL AND STATISTICAL REPORTS	Mr. Halfen called attention to the financial and statistical reports for the month of March 2010. He noted the statement of operations shows a bottom line excess of revenues over expenses of $718,140. Mr. Halfen additionally called attention to the following: - *Inpatient and outpatient service revenue were both over budget* - *Total expenses were over budget* - *Salaries and wages and employee benefits expense were over budget* - *Professional fees expense was over budget* - *The Balance Sheet showed no significant change* - *Year-to-date net revenue totals $1,891,044* Mr. Halfen noted cash and cash equivalents and short term investments fluctuated during the month in order to help provide funding for the hospital rebuild project. He additionally noted total assets continue to grow and he reviewed the status of the hospital's investments which remain stable at this time. He noted surgery and outpatient revenue have both helped to keep the hospital in positive numbers for the year, and bad debt expense and employee benefits expense both continue to rise. Professional fees expense is high due to an increase in legal fees incurred in recent months. Mr. Halfen additionally mentioned he will review third party liability figures at the next regular meeting. It was moved by M.C. Hubbard, seconded by D. Scott Clark, M.D., and passed to approve the financial and statistical reports for the month of March 2010 as presented.
ADMINISTRATOR'S REPORT	

BUILDING UPDATE

John Hawes, Project Manager with Turner Construction Company reported structural steel work is progressing and steel welding is now 80% complete. Workers are currently installing the deck for the 2nd floor of the new building and work will begin soon on the roof and 1st floor slab. Mr. Hawes also noted construction of the exterior frame of the building will begin soon, and the review of the plumbing plans for the new building was positive. Kathy Sherry, also with Turner Construction additionally reported when the user group meetings being conducted this week are concluded, the design for the new building will essentially be complete.

SECURITY REPORT

Mr. Halfen called attention to the monthly security report which revealed no significant security issues.

RAMADAN CLINIC STATUS

Mr. Halfen reported that Amr Ramadan M.D.'s Women & Family practice recently received rural health clinic designation, thanks in part to the efforts of Practice Management Supervisor Lisa Harmon, and Rural Health Clinic nurse manager Tracy Aspel, R.N.. Mr. Halfen additionally noted that 60% of Dr. Ramadan's patients are Medi-Cal patients.

STANDARD & POORS GLOBAL CREDIT PORTAL

Mr. Halfen called attention to a report from Standard & Poor's which explains why the credit impact of Healthcare Reform will take hold slowly, and which also illustrates some of the reasons Northern Inyo Hospital (NIH's) bond rating went down as a result of the negative status associated with conducting business within the State of California.

CHIEF OF STAFF REPORT

POLICY AND PROCEDURE APPROVALS

Chief of Staff Charlotte Helvie, M.D. reported following careful review and consideration the Medical Executive Committee recommends approval of the hospital-wide policy and procedure titled *Warfarin Monitoring Protocol*. It was moved by Doctor Clark, seconded by Ms. Hubbard, and passed to approve the *Warfarin Monitoring Protocol* policy and procedure as presented.

Doctor Helvie also reported the Medical Executive Committee recommends approval of a second hospital-wide policy and procedure titled *Annual Clinic Evaluation; RHC*. It was moved by Ms. Hubbard, seconded by Doctor Clark, and passed to approve the hospital-wide policy and procedure titled *Annual Clinic Evaluation; RHC* as recommended.

Doctor Helvie additionally noted the Medical Staff and appropriate Committees recommend approval of the following standardized procedures submitted for Board review and re-approval:

1. *General Policy for Rural Health Clinic Nurse Practitioner*
2. *Adult Health Maintenance*
3. *Obstetric Care*
4. *Pre-Employment Physical Exams*
5. *Medical Screening Examination for the Obstetrical Patient Performed by Registered Nurse*

Following review of the policies presented it was moved by Ms. Hubbard, seconded by Doctor Clark and passed to approve all five standardized policies and procedures as recommended.

Doctor Helvie additionally reported the Medical Executive Committee recommends approval of the following two policies and procedures which have been re-worded in response to the findings of the Joint Commission during their recently conducted survey:

1. *Credentialing Health Care Practitioners in the Event of a Disaster*
2. *Medical Staff Peer Review*

It was moved by Ms. Hubbard, seconded by Doctor Clark, and passed to approve the changes to both policies and procedures as recommended.

Doctor Helvie also noted (as an informational item) that Donna McAuley FNP, CNM will be taking a leave of absence for a period of at least three months.

OLD BUSINESS

There was no Old Business scheduled for discussion at this meeting.

NEW BUSINESS

BETA HEALTHCARE RATES & DIVIDENDS

Mr. Halfen called attention to a letter received from Beta Healthcare Group informing the hospital of its' annual liability insurance claims audit, which shows a surplus (credit) from the prior fiscal year. The surplus can be returned to the hospital in the form of an approximate 5% premium reduction for the upcoming year; or the hospital may receive a cash refund. Following brief discussion it was moved by Ms. Hubbard, seconded by Doctor Clark, and passed to apply the surplus to the hospital's liability insurance premium for the upcoming fiscal year.

JACK BURROUGHS; ACHD

Jack Burroughs, Director of Executive Services for the Association of California Healthcare Districts (ACHD) was present to compliment Northern Inyo Hospital on being fiscally sound during difficult economic times, and on management's understanding of the importance of having a net income from hospital operations. Mr. Burroughs distributed a comparison of California Healthcare Districts which shows Northern Inyo Hospital as having the third highest income from operations in the State in spite of its small size, and stated he considers NIH to be a "shining example" of fiscally responsible Health Care Districts, which he often refers to as a hospital that other Districts should attempt to emulate.

DISTRICT BOARD VACANCY

Mr. Halfen noted that following the resignation of Board Treasurer Michael Phillips, M.D., the Board has until June 20 2010 to fill the vacancy for Zone II of the District. Mr. Halfen stated that to date three residents have shown an interest in representing Zone II, and one of those persons, Ms. Denise Hayden, was present at this meeting. Dr. Ungersma welcomed Ms. Hayden on behalf of the Board, and noted that Mr. Halfen

will first meet with each of the interested parties, then appointments will be set up for the candidates to be interviewed by the District Board.

OMNICELL BAR CODE SYSTEM

Pharmacy Director Jillene Freis, RPH called attention to a proposal to purchase a medication bar-coding system for the Pharmacy Department at a cost of $40,725. Ms. Freis noted the importance of a bar-coding system in the prevention of patient medication errors, and noted pharmacy and nursing committees both recommend the purchase in the interest of patient safety. Following review of the proposal (which also involves an additional $12,600 cost for annual maintenance and service fees) it was moved by Doctor Clark, seconded by Ms. Hubbard, and passed to approve the purchase of the Omnicell bar-coding system as requested.

2010-2011 FISCAL YEAR BUDGET

Mr. Halfen called attention to the following eleven Budget Assumptions for the 2010-2011 fiscal year:

1. No change in patient activity will be budgeted for FY 2011. The current YTD Average Daily Census is 9.63 patients.
2. There will be no budget change in the payer mix or services from current operations.
3. Other Operating Revenue will include $786,490 from the District for Debt Service payments on the 2005 General Obligation Bond.
4. The cost of supplies, purchased services, and miscellaneous expenses will increase at a 5.5% inflation rate.
5. Wages and salaries will increase by 1.0% for a cost of living adjustment effective with the first payroll in July 2010. Total wages will increase an additional 3.8% for anniversary (step) increases and wage adjustments.
6. It is expected that employee benefits will run about 58% of Wages and Salaries.
7. The hospital's operating reserves (not including the building fund(s)) will decline to about $10,000,000, producing a budgeted interest income of $200,000 (average 2% yields.)
8. Capital expenditures will be budgeted at $.5M excluding the building project and related capital purchases.
9. A 6.0% across-the-board rate increase (effective 7-01-2010) and other focused rate adjustments that would net another 1.0% in net increases.
10. This budget includes the lease expense of the temporary buildings (modulars) of $502,713.
11. This budget includes the added depreciation of the two new permanent buildings of $430,890.

Mr. Halfen reviewed each of the budget assumptions and noted the budget has basically remained the same for the last nine years. He noted a sizeable expenditure for a new MRI coil should be expected, and information on that expenditure will be presented to the Board at a future meeting. Following review of the information provided it was moved by Doctor Clark, seconded by Ms. Hubbard, and passed to approve the

	proposed budget and assumptions for fiscal year 2010-2011 as presented.
SENDING PROTECTEDHEALTH INFORMATION BY FAX	Leo Fries, Compliance Officer and Administrative Support Services referred to a proposed policy and procedure titled *Sending Protected Health Information by Fax*, which allows for safeguards being put in place to ensure the privacy of faxed medical information. Following review of the proposed policy it was moved by Ms. Hubbard, seconded by Doctor Clark, and passed to approve the proposed policy and procedure titled *Sending Protected Health Information by Fax* as requested.
BOARD MEMBERREPORTS	Doctor Ungersma reported he recently attended the annual meeting of the Association of California Healthcare Districts (ACHD), and that pertinent information on current healthcare issues was discussed including the effects of healthcare reform and the impact it will have on the available supply of healthcare professionals. No other reports were heard.
OPPORTUNITY FOR PUBLIC COMMENT	In keeping with the Brown Act Doctor Ungersma again asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. No comments were heard.
CLOSED SESSION	At 7:01 p.m. Dr. Ungersma announced the meeting was being adjourned to closed session to allow the Board of Directors to: A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962). B. Confer with legal counsel regarding action filed by John Nesson M.D. against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)). C. Confer with legal counsel regarding action filed by Stephen Johnson and Elizabeth Manahan-Johnson against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 7:13 p.m. the meeting returned to open session. Dr. Ungersma reported the Board took no reportable action.
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma again asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. No comments were heard.
ADJOURNMENT	The meeting was adjourned at 7:14 p.m..

____
John Ungersma, Vice President

Attest:______________________________
M.C. Hubbard, Secretary

THIS SHEET

INTENTIONALLY

LEFT BLANK

BUDGET VARIANCE ANALYSIS

Apr-10 PERIOD ENDING After Audit

In the month, NIH was

		-13%	under budget in IP days;
	(	-0.18%)	under in IP Revenue and
	(	2.0%)	over in OP Revenue resulting in
$	(402,500) (	-5.6%)	under in gross patient revenue from budget &
$	545,914 (	12.7%)	over in net patient revenue from budget

Total Expenses were:

$	241,424 (	5.8%)	over budget. Wages and Salaries were
$	19,228 (	1.3%)	over budget and Employee Benefits
$	(124,147) (	-13.5%)	under budget.
$	171,687		of other income resulted in a net income of
$	669,228	$ 398,463	over budget.

The following expense areas were over budget for the month:

$	19,228	1%	Salaries and Wages
			Professional Fees; Physicians, Registry Staff &
$	206,736	61%	Legal Fees
$	50,354	10%	Supplies
$	91,358	41%	Purchased Services
$	3,715	4%	Interest Expense
$	37,224	26%	Bad Debt

Other Information:

31.26%	Contractual Percentages for month
40.59%	Contractual Percentages for Year
$ 2,560,271	Year-to-date Net Revenue

Special Notes:

Prior Year Adjustments were $1,376,451 for tentative settlements for FY08 & FY09 Medicare Cost Report receipts for underpayments from Medicare in Prior Years.

NORTHERN INYO HOSPITAL

Balance Sheet

April 30, 2010

	Current Month	*Prior Month*	*FYE 2009*
Current assets:			
Cash and cash equivalents	1,171,324	2,714,167	881,651
Short-term investments	18,229,559	16,328,704	29,519,296
Assets limited as to use	2,819,358	2,119,958	738,740
Plant Expansion and Replacement Cash	2,099,869	2,099,852	10,439,607
Other Investments (Partnership)	961,824	961,824	961,824
Patient receivable, less allowance for doubtful accounts $593.137	7,469,156	8,514,228	7,591,694
Other receivables (Includes GE Financing Funds)	1,067,067	1,123,996	867,584
Inventories	2,495,613	2,482,251	2,456,265
Prepaid expenses	1,179,664	1,221,105	1,057,280
Total current assets	37,493,433	37,566,085	54,513,940
Assets limited as to use:			
Internally designated for capital acquisitions	744,694	658,341	657,814
Specific purpose assets	417,867	803,612	564,033
	1,162,561	1,461,953	1,221,847
Revenue bond construction funds held by trustee	12,130,807	845,373	788,610
Less amounts required to meet current obligations	2,819,358	2,119,958	738,740
Net Assets limited as to use:	10,474,009	187,368	1,271,716
Long-term investments	11,751,227	11,751,227	100,000
Property and equipment, net of accumulated depreciation and amortization	44,990,073	44,376,390	35,316,271
Unamortized bond costs	1,021,841	664,425	687,964
Total assets	105,730,583	94,545,495	91,889,892

NORTHERN INYO HOSPITAL

Balance Sheet

April 30, 2010

Liabilities and net assets	*Current Month*	*Prior Month*	*FYE 2009*
Current liabilities:			
Current maturities of long-term debt	122,713	183,547	1,103,540
Accounts payable	1,354,312	1,671,469	1,523,288
Accrued salaries, wages and benefits	2,958,347	3,343,960	2,807,675
Accrued interest and sales tax	388,897	599,298	247,663
Deferred income	136,413	180,124	48,991
Due to third-party payors	2,616,664	2,678,771	2,940,964
Due to specific purpose funds	-	-	-
Total current liabilities	7,577,346	8,657,169	8,672,120
Long-term debt, less current maturities	50,209,004	38,609,004	38,624,386
Bond Premium	1,438,160	1,442,503	1,481,587
Total long-term debt	51,647,164	40,051,507	40,105,973
Net assets:			
Unrestricted	46,088,207	45,033,207	42,547,767
Temporarily restricted	417,867	803,612	564,033
Total net assets	46,506,073	45,836,819	43,111,799
Total liabilities and net assets	105,730,583	94,545,495	91,889,892

NORTHERN INYO HOSPITAL

Statement of Operations

As of April 30, 2010

	MTD Actual	MTD Budget	MTD Variance $	MTD Variance %	YTD Actual	YTD Budget	YTD Variance $	YTD Variance %	Prior YTD
Unrestricted revenues, gains and other support:									
In-patient service revenue:									
Routine	494,763	658,264	(163,501)	(24.8)	5,748,072	6,582,725	(834,653)	(12.7)	5,996,938
Ancillary	1,786,438	2,114,459	(328,021)	(15.5)	19,637,754	21,145,093	(1,507,339)	(7.1)	18,802,510
Total in-patient service revenue	2,281,202	2,772,723	(491,521)	(0.18)	25,385,826	27,727,818	(2,341,992)	-8.4%	24,799,448
Out-patient service revenue	4,483,755	4,394,733	89,022	2.0	48,272,558	43,947,965	4,324,593	9.8	41,098,215
Gross patient service revenue	6,764,956	7,167,456	(402,500)	(5.60)	73,658,384	71,675,783	1,982,601	2.8	65,897,663
Less deductions from patient service revenue:									
Patient service revenue adjustments	272,347	233,195	(39,152)	(16.8)	1,427,301	2,331,979	904,678	38.8	2,061,197
Contractual adjustments	3,035,812	2,688,593	(347,219)	(12.9)	29,343,754	26,885,959	(2,457,795)	(9.1)	25,092,739
Prior Period Adjustments	(1,376,451)	(41,667)	1,334,784	100.0	(2,801,202)	(416,667)	2,384,535	100.0	(1,635,264)
Total deductions from patient service revenue	1,931,707	2,880,121	948,414	32.9	27,969,853	28,801,271	831,418	2.9	25,518,673
Net patient service revenue	4,833,249	4,287,335	545,914	13%	45,688,531	42,874,512	2,814,019	7%	40,378,990
Other revenue	21,265	40,111	(18,846)	(47.0)	288,537	401,166	(112,629)	(28.1)	370,055
Transfers from Restricted Funds for Other Operating Expenses	64,666	64,666	-	-	646,660	646,658	2	0.0	655,410
Total Other revenue	85,931	104,777	(18,846)	(18.0)	935,197	1,047,824	(112,627)	(10.8)	1,025,465
Total revenue, gains and other support	4,919,180	4,392,112	527,068	(17.9)	46,623,728	43,922,336	2,701,392	(10.7)	41,404,455
Expenses:									
Salaries and wages	1,525,602	1,506,374	(19,228)	(1.3)	15,040,648	15,063,903	23,255	0.2	13,977,049
Employee benefits	794,167	918,314	124,147	13.5	9,839,173	9,183,258	(655,915)	(7.1)	8,261,790
Professional fees	545,958	339,222	(206,736)	(60.9)	4,542,410	3,392,275	(1,150,135)	(33.9)	3,657,771
Supplies	557,429	507,075	(50,354)	(9.9)	5,186,355	5,070,913	(115,442)	(2.3)	4,803,069
Purchased services	314,599	223,241	(91,358)	(40.9)	2,646,112	2,232,539	(413,573)	(18.5)	2,068,786
Depreciation	230,691	230,397	(294)	(0.1)	2,248,308	2,303,981	55,673	2.4	2,182,363
Interest	109,372	105,657	(3,715)	(3.5)	1,083,219	1,056,580	(26,639)	(2.5)	1,099,079
Bad debts	182,731	145,507	(37,224)	(25.6)	1,928,688	1,455,068	(473,620)	(32.6)	1,286,088
Other	161,089	204,428	43,339	21.2	1,926,609	2,044,476	117,867	5.8	2,021,847
Total expenses	4,421,639	4,180,215	(241,424)	(5.8)	44,441,522	41,802,993	(2,638,529)	(6.3)	39,357,842
Operating income (loss)	497,541	211,897	285,644	(12.1)	2,182,206	2,119,343	62,863	(4.4)	2,046,613
Other income:									
District tax receipts	43,711	47,650	(3,939)	(8.3)	437,111	476,500	(39,389)	(8.3)	476,500
Interest	42,374	43,338	(964)	(2.2)	156,624	433,383	(276,759)	(63.9)	807,799
Other	4,000	-	4,000	N/A	50,181	-	50,181	N/A	37,931
Grants and Other Non-Restricted Contributions	86,326	1,223	85,103	6,958.6	123,289	12,235	111,054	907.7	118,098
Partnership Investment Income	51,855	-	51,855	N/A	51,855	-	51,855	-	-
Net Medical Office Activity	(56,580)	(33,343)	(23,237)	191.7	(440,995)	(333,479)	(107,516)	(32.2)	30,376
Total other income, net	171,687	58,868	112,819	192	378,065	588,639	(210,574)	(35.8)	1,470,704
Excess (deficiency) of revenues over expenses	669,228	270,765	398,463	147	2,560,271	2,707,982	(147,711)	(6)	3,517,317

NORTHERN INYO HOSPITAL

Statement of Operations--Statistics

As of April 30, 2010

	Month Actual	Month Budget	Month Variance	Variance Percentage	YTD Actual	YTD Budget	Year Variance	Year Percentage
Operating statistics:								
Beds	25	25	N/A	N/A	25	25	N/A	N/A
Patient days	231	264	(33)	0.88	2,525	2,646	(121)	0.95
Maximum days per bed capacity	750	750	N/A	N/A	7,600	7,600	N/A	N/A
Percentage of occupancy	30.80	35.20	(4.40)	0.88	33.22	34.82	(1.60)	0.95
Average daily census	7.70	8.80	(1.10)	0.88	8.31	8.70	(0.40)	0.95
Average length of stay	3.16	3.00	0.16	1.05	3.08	3.01	0.08	1.03
Discharges	73	88	(15)	0.83	819	880	(61)	1
Admissions	69	87	(18)	0.79	820	874	(54)	1
Gross profit-revenue depts.	4,198,204	4,741,397	(543,193)	0.89	48,175,974	47,414,758	761,216	1.02
Percent to gross patient service revenue:								
Deductions from patient service revenue and bad debts	31.26	42.21	(10.95)	0.74	40.59	42.21	(1.62)	0.96
Salaries and employee benefits	33.97	33.81	0.16	1.00	33.50	33.81	(0.31)	0.99
Occupancy expenses	5.53	5.10	0.43	1.08	4.93	5.10	(0.17)	0.97
General service departments	5.50	5.90	(0.40)	0.93	5.79	5.90	(0.11)	0.98
Fiscal services department	6.11	5.13	0.98	1.19	5.15	5.13	0.02	1.00
Administrative departments	5.48	5.23	0.25	1.05	5.01	5.23	(0.22)	0.96
Operating income (loss)	7.79	1.41	6.38	5.52	1.62	1.41	0.21	1.15
Excess (deficiency) of revenues over expenses	9.89	3.78	6.11	2.62	3.48	3.78	(0.30)	0.92
Payroll statistics:								
Average hourly rate (salaries and benefits)	41.48	44.47	(3.00)	0.93	43.50	44.47	(0.98)	0.98
Worked hours	48,261.11	46,826.00	1,435.11	1.03	485,770.76	468,381.00	17,389.76	1.04
Paid hours	55,403.43	54,496.00	907.43	1.02	567,358.06	544,960.00	22,398.06	1.04
Full time equivalents (worked)	280.59	270.67	9.92	1.04	280.47	270.27	10.20	1.04
Full time equivalents (paid)	322.11	315.01	7.11	1.02	327.57	314.46	13.11	1.04

NORTHERN INYO HOSPITAL

Statements of Changes in Net Assets

As of April 30, 2010

	Month-to-date	Year-to-date
Unrestricted net assets:		
Excess (deficiency) of revenues over expenses	669,227.73	2,560,271.30
Net Assets due/to transferred from unrestricted	(86,326.17)	(86,326.17)
Interest posted twice to Bond & Interest	-	(47.40)
Net assets released from restrictions used for operations	385,745.00	979,615.00
Net assets released from restrictions used for payment of long-term debt	(64,666.00)	(646,660.00)
Contributions and interest income	86,352.59	86,879.83
Increase in unrestricted net assets	990,333.15	2,893,732.56
Temporarily restricted net assets:		
District tax allocation	-	817,828.71
Net assets released from restrictions	(385,745.00)	(979,615.00)
Restricted contributions	-	15,450.00
Interest income	-	217.94
Net Assets for Long-Term Debt due from County	64,666.00	646,660.00
Increase (decrease) in temporarily restricted net assets	(321,079.00)	500,541.65
Increase (decrease) in net assets	669,254.15	3,394,274.21
Net assets, beginning of period	45,836,819.18	43,111,799.12
Net assets, end of period	46,506,073.33	46,506,073.33

NORTHERN INYO HOSPITAL

Statements of Cash Flows

As of April 30, 2010

	Month-to-date	Year-to-date
Cash flows from operating activities:		
Increase (decrease) in net assets	669,254.15	3,394,274.21
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities: (correcting fund deposit)		47.40
Depreciation	230,690.58	2,248,308.22
Provision for bad debts	182,731.35	1,928,688.22
Loss (gain) on disposal of equipment	-	4,137.56
(Increase) decrease in:		
Patient and other receivables	919,269.22	(2,005,634.45)
Other current assets	28,079.79	(161,731.78)
Plant Expansion and Replacement Cash	(17.75)	8,339,737.42
Increase (decrease) in:		
Accounts payable and accrued expenses	(956,881.80)	210,353.14
Third-party payors	(62,107.07)	(324,299.52)
Net cash provided (used) by operating activities	1,011,018.47	13,633,880.42
Cash flows from investing activities:		
Purchase of property and equipment	(844,373.08)	(11,930,840.06)
Purchase of investments	(1,900,855.18)	(361,489.38)
Proceeds from disposal of equipment	-	4,592.31
Net cash provided (used) in investing activities	(2,745,228.26)	(12,287,737.13)
Cash flows from financing activities:		
Long-term debt	11,534,823.19	10,560,363.94
Issuance of revenue bonds	(11,285,433.94)	(11,342,197.04)
Unamortized bond costs	(357,415.12)	(333,876.25)
Increase (decrease) in donor-restricted funds, net	299,392.41	59,238.52
Net cash provided by (used in) financing activities	191,366.54	(1,056,470.83)
Increase (decrease) in cash and cash equivalents	(1,542,843.25)	289,672.46
Cash and cash equivalents, beginning of period	2,714,167.12	881,651.41
Cash and cash equivalents, end of period	1,171,323.87	1,171,323.87

Northern Inyo Hospital
Summary of Cash and Investment Balances
Calendar Year 2010

Month	Balance at Beginning of Month	Deposits	Disbursements	Balance at End of Month	Investment Operations Fund	Bond and Interest Fund	Equipment Donations Fund	Childrens Fund	Scholarship Fund	Tobacco Settlement Fund	* Total Revenue Bond Fund	General Obligation Bond Fund
	Operations Checking Account					Time Deposit Month-End Balances						
January	4,462,389	6,137,876	6,469,248	4,131,017	27,112,118	796,335	26,233	2,640	17,472	632,052	750,421	2,793,443
February	4,131,017	5,265,638	6,258,389	3,138,266	27,557,615	796,335	26,233	2,640	4,472	632,076	797,897	1,941,057
March	3,138,266	6,113,051	6,461,223	2,790,095	28,079,592	796,335	26,236	2,640	4,474	718,431	806,520	1,941,078
April	2,790,095	7,447,491	9,025,365	1,212,221	29,980,448	410,678	26,236	2,640	4,474	718,458	10,978,230	1,941,094
Prior Year May	2,315,128	3,264,722	4,556,036	1,023,814	28,168,905	552,617	26,218	3,138	8,016	631,411	934,534	11,007,929
June	1,023,814	3,947,195	3,990,630	980,379	29,618,958	552,753	26,225	3,184	8,018	631,589	788,610	10,122,651
July	980,379	7,052,713	7,416,364	616,727	30,121,668	574,431	26,225	2,639	18,468	631,762	836,048	9,398,497
August	616,727	6,367,182	5,462,850	1,521,059	29,615,171	574,431	26,225	2,639	18,468	631,852	883,487	8,652,655
September	1,521,059	4,571,506	4,221,577	1,870,988	29,609,631	574,537	26,230	2,639	17,470	631,900	930,926	8,074,645
October	1,870,988	6,700,748	6,690,198	1,881,538	29,097,832	34,292	26,230	2,639	17,470	631,949	978,365	8,074,772
November	1,881,538	14,574,637	14,781,591	1,674,584	28,603,006	34,292	26,230	2,639	17,470	631,999	1,045,102	6,395,453
December	1,674,584	9,083,464	6,295,659	4,462,389	26,778,789	34,310	26,233	2,640	17,472	632,026	702,945	4,657,307

Notes: Revenue Bond Fund includes 2010 Revenue Bond

Investments as of April 30, 2010

Institution	Certificate ID	Purchase Dt	Maturity Dt	Principal	YTM	Broker
LAIF (Walker Fund)	20-14-002	15-Apr-10	01-May-10	$317,923	0.59%	Northern Inyo Hospital
Union Bank-Money Market	2740028807	30-Apr-10	01-May-10	$17,407,392	0.10%	Union Bank
American General Finance Corp Note	02635PSV6	24-Apr-08	15-May-10	$503,905	4.47%	Multi-Bank Service
Total Short Term Investments				**$18,229,221**		
Federal Home Loan Mtg Corp-MBS	313397L82	10-Nov-09	25-Oct-10	$3,988,333	0.31%	Multi-Bank Service
United States Treasure Note-FNC	912828JS0	10-Nov-09	30-Nov-10	$4,038,750	0.33%	Financial Northeaster Corp.
Worlds Foremost Bank (FNC CD)	5X42688	18-Dec-08	18-Dec-10	$100,000	4.40%	Financial Northeaster Corp.
Santander Financial Issuances LTD	802813AE5	01-Mar-10	15-Feb-11	$1,049,310	1.17%	Multi-Bank Service
National Rural Utilites Corp Bond-FNC	63743FLH7	13-Aug-09	15-Aug-11	$250,000	2.35%	Financial Northeaster Corp.
Union National Bank & Trust CO-FNC	5L27278	19-Oct-09	19-Oct-11	$250,000	2.00%	Financial Northeaster Corp.
Credit Suisse 1st	22541LAB9	02-Feb-10	15-Nov-11	$541,865	1.36%	Multi-Bank Service
HSBC Financial Corp	40429XWB8	15-Sep-09	15-Sep-12	$250,000	3.85%	Financial Northeaster Corp.
Citigroup Inc	125581FT0	10-Dec-09	01-May-13	$46,122	7.00%	Multi-Bank Service
Citigroup Inc	125588FU7	10-Dec-09	01-May-14	$66,903	7.00%	Multi-Bank Service
United States Treasure Note-FNC	912828LK4	31-Aug-09	31-Aug-14	$995,933	2.46%	Financial Northeaster Corp.
Citigroup Inc	125588FV5	10-Dec-09	01-May-15	$66,181	7.00%	Multi-Bank Service
Citigroup Inc	125581FW3	10-Dec-09	01-May-16	$107,830	7.00%	Multi-Bank Service
Total Long Term Investments				**$11,751,227**		
Grand Total Investments				**$29,980,448**		

Financial Indicators

	Target	Apr-10	Mar-10	Feb-10	Jan-10	Dec-10	Nov-09	Oct-09	Sep-09	Aug-09	Jul-09	Jun-09	May-09	Apr-09	Mar-09
Current Ratio	>1.5-2.0	4.95	4.34	5.42	5.65	6.01	5.99	6.10	5.81	6.05	6.39	6.29	6.56	7.53	4.20
Quick Ratio	>1.33-1.5	4.32	3.78	4.87	5.09	5.45	5.41	5.53	5.27	5.51	5.85	5.78	6.04	6.96	3.74
Days Cash on Hand	>75	230.21	217.46	322.93	293.20	315.81	306.58	307.60	364.93	344.81	349.84	388.66	289.03	337.98	227.43

THIS SHEET

INTENTIONALLY

LEFT BLANK

NORTHERN INYO HOSPITAL

SECURITY REPORT

04/25/10 THRU 05/24/10

FACILITY SECURITY

Access security during this period revealed five occasions of open or unsecured exterior doors being located during those hours when doors were to be secured. Seven interior doors were located during this same period.

Main building roof access was found unsecure on one occasion.

Construction gate was found open on one occasion.

Pioneer Medical Building was found unsecure on thirteen occasions.

HUMAN SECURITY

On April 25th a disruptive, belligerent discharge was located in the Main Lobby complaining about poor service. This subject was borderline combative and very profane. Further investigation revealed that he was treated in the ED and drugs were not prescribed. He left Campus upon request of Security Staff.

On April 25th an ED patient became combative. Security was called and the subject calmed down upon the arrival of Security Staff.

On April 26th Security received a report of a child crying near the southwest corner of Campus. The area was checked with negative results.

On May 2nd an uncooperative visitor was reported to Security by Medical Staff. The visitor was located and counseled by Security whereupon he agreed to cooperate.

On May 2nd an intoxicated, subject presented in the ED. Security assisted with management of the patient until the patient was treated and discharged to a family member.

On May 7th Sheriff's personnel arrived with a combative, in-custody for medical clearance. Security assisted with the patient until cleared.

On May 7th an intoxicated ED patient became disruptive and profane. The patient was counseled by Security Staff and agreed to comply with treatment in lieu of jail.

On May 15th the Hospital experienced a power failure as the result of a MVA in west Bishop. CHP presented with the intoxicated driver for medical clearance. Security stood-by until the arrestee was transported to jail.

On may 17th Police personnel arrived with a disruptive, in-custody for medical clearance. Security assisted with the patient until cleared.

On May 21st an intoxicated, combative, patient was brought by EMS to the ED. The patient was counseled and remained manageable throughout treatment.

Security Staff had six contacts with Mr. Santa during this period. He was well behaved on five of the six contacts. However, on one of the contacts he was found loitering about the cafeteria alone. When contacted by Security he was told to leave the cafeteria at which time he became argumentative and belligerent. He initially refused to leave and recited his apparent understanding of the rules for which he was expected to comply with while on Campus. Security Staff has been well briefed on this matter and once again clarified the rules and advised him to leave the cafeteria or face the possibility of arrest. Mr. Santa reluctantly complied and left Campus.

Law Enforcement assistance was provided ten times during this period. Four cases were for Lab BAC's and one potential 5150.

Security Staff provided patient assistance on thirty-six occasions during this period.

THIS SHEET

INTENTIONALLY

LEFT BLANK

Northern Inyo Hospital 2010 Surge Plan

Definition of Surge. As defined by the State in consultation with healthcare providers throughout the state, a working definition of a Surge Event is:A Surge Event is a significant event or circumstances that impact the healthcare delivery system resulting in excess demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services.This definition does not take into consideration the scope of the event or the time between the onset of surge and a local or statewide proclamation of an emergency and/or issuance of gubernatorial executive orders waiving specific licensing and scope of practice requirements. Therefore, hospital planners need to consider the following in surge plan activation:

Local/Regional Surge: No gubernatorial waiver of existing regulations. Local or regional event that may require mutual aid from outside the region. Hospital activates plans to create and expand capacity within existing licensing and other regulatory requirements (e.g., discharge or transfer patients, cancel or delay admissions), or, seeks approval for short-term expansion of capacity through State agencies (e.g., surge tents, ED beds,

Regional/Statewide Surge: Waiver of existing regulations. Multi-area or statewide event(s) that requires mutual aid from outside the region. Hospital activates plans to create and expand capacity and capability using alternative treatment areas, modified/expanded use of licensed facilities, and waiver of selected regulatory requirements (e.g., altered/expanded use of inpatient facilities, nursing ratios, isolation areas, surge tents, clinics, cafeterias,

Surge Plan: NIH's Surge Plan is incorporated into its Emergency Operations Plan (EOP) and does include a series of policies, procedures and protocols referenced in the EOP. Many of the elements that should be addressed in the Surge Plans are included in the EOP or other hospital plans, policies, procedures or protocols.
This Surge Plan (and policies and procedures) addresses internal and external communication regarding current emergency status for surge levels, regulatory status, the type, scope and expected duration of an event, and escalation and de-escalation as new information is received. Job action sheets, task checklists and other tools for activating and operationalizing the surge plan will be utilized for this purpose.

1. COMMAND AND MANAGEMENT

Plan identifies triggers and decision-making processes for activating the Emergency Operations Plan (EOP) and surge plan in response to a surge event. Initial assessment of the event type, scope and magnitude, estimated influx of patients, real or potential impact on the hospital, and special response needs (e.g., infectious disease,

Activation of the Incident Command System (e.g., Hospital Incident Command System) and determination of appropriate ICS positions to be activated. Activation of the Hospital Command Center (HCC)
Notification to appropriate local governmental point of contact (e.g., local health department, local emergency medical services agency, Medical and Health Operational Area Coordinator) of the surge status and activation of the EOP and surge plan.1 The EOP identifies the local government points of contacts and 24/7 contact numbers, alternate contacts and appropriate notification priorities and processes.
Establish ongoing communications with local governmental point of contact to report patient census, bed capacity, using standardized reporting terminology with the HAVBed system hospital status, critical issues and resource requests.Activation of resource management system including inventory, tracking, prioritizing, procuring and allocating of resources.

2. CREATING SURGE CAPACITY

Triage: Plan to activate and operate additional/alternate triage area(s) during a surge event. Activation triggers for establishing alternate/additional triage areas are defined. Triage protocols for internal and external patient disposition (e.g., minor care, delayed care, holding, ACS, etc.).

Northern Inyo Hospital 2010 Surge Plan

Alternate Triage Areas: Identifies primary and alternate triage areas (consider external triage areas, event type, and facility damage). Responsibility and processes for set-up and operation of triage area(s) are defined. Communications plan for communications between triage areas, Emergency Department, other key departments and the HCC (e.g., landlines, handi-talkies, radios). Staffing of the alternate triage sites. Provision of supplies and equipment for the triage area (consider scope and type of event, based on the facility HVA).

Local government point of contact is used in this document to represent the local health department, local emergency medical services agency, Medical Health Operational Area Coordinator (MHOAC) or other local contact responsible for coordinating disaster medical response in hospital's operational area. In the absence of gubernatorial orders waiving specific licensing and regulatory requirements, use of facilities outside of existing licensure should trigger notification/requests to appropriate State licensing and regulatory agencies.

Infectious and/or exposed patient triage area(s) and protocols (universal precautions, staff PPE, ventilation, infection control protocols for staff and patients)
Flow of patients to and from the triage area. Signage for directing patients to triage area(s).

Decontamination: Plan to activate and perform decontamination, as necessary. Plan for set-up (checklist) and operation of holding and decontamination area(s) (list individuals responsible). Plan for segregation and prioritization of contaminated individuals for decontamination. Methods for directing patients to decontamination area(s) (e.g., signage, stations, cones, etc.). Primary and alternative decontamination areas (consider external areas, event/agent, and facility damage potential). Communications protocols within the decontamination area(s)

Holding Areas: Plan for activation and operation of holding areas for patients awaiting triage, decontamination, treatment, admission, discharge, or transport to lower levels of care. Responsibility for set-up and operation of holding area(s) (identify by area). Map and signage for directing staff/family and patients to holding area(s)

Primary and alternate holding area(s) (consider event type, capacity, level of care, infectious disease, facility status). Communications (between treatment areas, with HCC).

Treatment Areas: Plan for activation and operation of additional treatment areas (to include identification of sites, signage, capacity, responsibility, communications, staffing, equipment and supplies, patient tracking/medical records, etc.) to allow the emergency department to focus on higher acuity patients.

Infectious disease care area (specific to type of contagion)
Security – Facility Access: Plan(s) for securing and limiting facility access during a surge event. Security assessment with plans to address vulnerabilities. Training for staff who may be utilized in security roles (including protocols, handling abusive behavior, etc.). Plan and mutual aid agreements for assistance with hospital security (hospital staffing pool, local law enforcement, outside agencies).

Plan for activating traffic control measures for access to facility (pre-planned traffic control measures, tools, etc). Road map outlining ingress, egress and traffic controls during surge event (coordinated with law enforcement). Specific staffing assignments and instructions for traffic control (who, what, how) during surge event.

Plan for initiating facility(ies) lock-down and/or limited access and entry. Identification/diagram of all access points in facility(ies). Identification of limited access points for entry and procedures for monitoring/managing (staff).

Criteria and protocols for facilities entry and exit, including staff, volunteers, patients, family and other individuals (e.g., who, identification requirements). Staffing plan for manning closed entrances (which will only be locked for external entry). Communication (between lead security, manned areas and HCC).

Special considerations following a terrorist attack (e.g. creating a secure perimeter, restricting access to adjacent parking areas, etc.)

Specific protocols for creating surge capacity to care for a significant surge of both ambulatory care and inpatient disaster patients.

Agreements with area hospitals, long term care facilities and other health providers to accept or receive patients and share resources as appropriate and possible. Plan for immediate cancellation/delay of scheduled/non-emergent admissions, procedures and diagnostic testing. Inpatient admissions (scheduled surgeries/procedures).

Protocols for rapid and periodic review of patients for admission, discharge or transfer by teams of physicians, nurses and discharge planners for: For potential/actual terrorist or criminal event, chain-of-evidence for law

Communication and coordination with HCC regarding activated and available community resources to triage, discharge or transfer to (plan should include checklist with location, level or care and contact information). Specific protocols for expanding ambulatory and inpatient capacity beyond licensed capacity. Identify how ED, inpatient units, clinics, clinical areas and other hospital areas (e.g., cafeteria, auditorium, conference rooms, open spaces, etc.), will be utilized to expand surge capacity.

Capacity and use, considering cohorting of patients (e.g., Inpatient, minor care, holding)

Management and operation of the area (describe responsibilities and procedures)

Management of special needs patients (hearing impaired, blind, wheelchair dependent, other)

Inpatient Capacity: Specific plans for increase bed capacity to care for surge of inpatients, including expanding beyond licensed capacity on inpatient units and use of alternative care areas (dialysis, outpatient surgery, recovery, etc.) while maintaining continuity of operations and care for current patients who cannot be discharged or

Trauma (assume all hospitals will receive trauma cases when trauma center capabilities exceeded)

Critical Care (expand bed capacity in existing units, use of other areas/units)

Burn (assume all hospitals will receive burn patients when burn center capabilities exceeded)

Isolation (identify specific hospital unit(s) or areas for negative pressure or isolation through independent ventilation if event involves contagious/infectious disease)

Pediatric (assume all hospitals will be receive pediatric cases when pediatric center capabilities exceeded)

Maternity (assume continuity of operations)

Ambulatory Care Capacity: Specific plans for expanding capacity to care for surge of emergency/ambulatory patients, including use of ambulatory care centers, and opening Alternative Treatment Areas (e.g., surge tents, clinics, other hospital areas and facilities).2

Ancillary Services: Specific plans have been established for increasing capacity and capability for ancillary/diagnostic services during a surge event. Laboratory services, including communication and reporting to and from County Laboratory. Imaging services (including MRI, CT, Ultrasound, etc).

Fatality Management: Plans have been established for management and disposition of deceased patients. Plans are consistent and coordinated with Operational Area Fatality Management plan (ME/Coroner Plans). Includes mortality estimates by type of event to anticipate and secure supply needs (e.g., body bags, shroud packs). Plan for expanding morgue capacity, including alternative areas (identify capacity). Agreements with external agencies for refrigerated trucks or mortuary support (contacts and capacity).

surge event.

3. PERSONNEL

Northern Inyo Hospital 2010 Surge Plan

Staffing: Specific plans for staffing during a significant surge event using hospital staff, contracted pools, and mutual aid resources taking into consideration type and scope of event. Identification of staffing needs by staff type, service area, and status of regulatory waivers regarding staffing ratios, licensure and scope of practice. Contingency staffing plan identifies minimum staffing needs and prioritizes critical and non-essential services. Staff contact information (updated) available to HCC and individuals responsible for contacts (redundant).

Staff disaster response assignments/roles (labor pool, specific units/areas, etc considering event type). Staff notification and call-back protocols, including responsibility(ies) (multiple methods, automated if possible).

Agreements with staffing agencies (assume multiple organizations have agreement with the same agencies). Protocols for requesting and for receiving staff resources (volunteers, special needs/teams, etc.) through HCC to local government point of contact).

Consider movement of select critical care patients to step-down areas, high/low rate alarms on pulse oximitry in lieu of cardiac monitors, increased reliance on ventilator alarms for ventilated patients and portable monitors in ward rooms to upgrade capability. Consider and plan for conversion of single rooms to double, double to triple, etc. Consider use of corridors, classrooms, open space, etc. Cross-training, and reassignment, of staff to support

Establish Just In Time (JIT) training for key areas to allow staff to be assigned where most needed (e.g., Pediatrics, Burns, Respiratory, security, critical care).

Protocols for shift changes and rotation of staff (consider type of event)
Specific areas designated for staff respite and sleeping (identify areas, responsibilities)
Supplies to ensure food and water for staff and volunteers (for a minimum of 96 hours self-sufficiency)
Volunteers: Plan includes utilization of non-facility volunteers including policies and procedures for accepting, credentialing, orienting, training and using volunteers during a surge event.
Volunteer check-in protocols including staffing of check-in location (single entry)
Registration, Credentialing and Privileging protocols, including use of local MRC and ESAR-VHP
Systems to collect and maintain volunteer information
Issuance of identification badge and other means of identification (e.g., colored/printed armband)
Protocols for assignments and roles by type of volunteer (consider buddy systems as appropriate)
Just-in-Time (JIT) training as appropriate to volunteer role(s)
Staff/Family Needs: Specific plans for addressing staff needs, family and domestic concerns during a surge event
Internal or external arrangements for dependent care to include, if necessary, boarding, food, and special needs to remove barriers that may prevent staff from coming to work (encourage staff to have family disaster plan and to pre-arrange, if possible)
Internal or external arrangements for pet care (encourage staff to pre-arrange)
Protocols and specific assignment of appropriately trained professionals to monitor and assess staff for both stress related and physical health concerns
Plan for providing staff and family with psychological support and resources

4. SUPPLIES, PHARMACEUTICALS AND EQUIPMENT

The Northern Inyo Surge Plan addresses supplies, pharmaceuticals and equipment (SPE) for patients and staff for a 96 hour period of self-sufficiency for a significant surge event. This includes Personal Protective Equipment(PPE), equipment and furnishments (Beds, Vetilators, IV pumps, etc),Phyarmaceuticals including prophylaxis for in-patients, staff and staff families, and supplies required to run the facility on a daily basis such as food, paper supplies, etc. Northern Inyou hospital will use its existing Emergency Management plan to ensure the there are sufficient supplies and that the required paperwork and agreements are met to accomplish this. All hospital Disaster/cashed items will be used as deemed required by the Incident command per EOP. The current EOP includes a process to report real time information regarding status of resorces to the local government and county

5. COMMUNICATION

Northern Inyo Hospital 2010 Surge Plan

The Northern Inyo Hospital Surge Plan describes primary and back up internal and external communication systems, assigned frequencies and uses, maintenance and equipment locations (e.g., internet, telephone, cell, satellite, EM System, WebEOC, CAHAN). It includes media communication using the current EOP,(an EOP spokes person will be identified), communication with other county agencies, as well as other area hospitals will be the decision of the incident command.

6. DOCUMENTATION – The Northern Ino Hospital Plan includes patient documentation requirements for use during a surge event and protocols for patient tracking and reporting to appropriate agencies per our EOP.

7. **ALTERED STANDARDS OF CARE** The hospital will continue to provide critiacal/essential services, non-essential services and protocals for staff assignments during the surge. The hospital does have a disaster back up system if unable to use electronic ordering. Protocols for transfer of patient to a facility with appropriate capabilities, when available. Prophylaxis/Vaccination Plan. Hospital has plan and, as available, pharmaceutical and other resources to prophylax or vaccinate staff, staff family members, volunteers, and patients.

8. **TOOLS AND RESOURCES**
See EOP for tools

8. **RESOURSES**
HICS Guidebooks, tools and website, including Hospital Overload Incident Planning and Response Guides (www.emsa.ca.gov/hics/hics.asp www.hicscenter.org)
Operational Area Medical-Health Emergency Management/Surge Plan
The Joint Commission, Environment of Care Standards, June 2007
Academic Emergency Medicine 13 (11), pages 1087 - 1253.
Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employees (OSHA 2007)
Standing Together: An Emergency Planning Guide for America's Communities (The Joint Commission 2005)
Surge Hospitals: Providing Safe Care in Emergencies (The Joint Commission 2006)
Healthcare at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems (The Joint Commission 2003)
CDHS Surge Standards and Guidelines www.bepreparedcalifornia.ca.gov/EPO/surge
Psychological First Aid www.ncptsd.va.gov

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Multidrug Resistant Organism (MDRO) Control Plan	
Departments/Scope: Infection Control	
Source: Infection Prevention	Effective Date: January 2009

PURPOSE:
To identify and isolate patients infected or colonized with multi-drug resistant organisms (MDRO) and prevent the spread of MDRO infection within the hospital.

LEGAL BASIS:
California Senate Bill No. 1058, an act to add Sections 1255.8 and 1288.55 to the Health and Safety Code, relating to Health.

DEFINED POPULATION:

I. At-risk populations:
   A. Patients with a known history of MDRO.
   B. Patients with chronic, poorly healing or non-healing wounds.
   C. Dialysis patients.
   D. Patients with long-term urinary catheters, or other long-term invasive devices.
   E. Residents of long-term care facilities.
   F. Immunosuppressed (e.g.; steroid use, cachexia)

POLICY:

I. Any patient known or suspected to be infected, or known to be colonized with a MDRO shall be placed in Contact Precautions and remain in isolation for the duration of their hospital admission, or until the patient has had three successive negative screening cultures taken at least one week apart. Screening cultures must not be obtained within three weeks of antimicrobial therapy.

II. **Active Surveillance Culturing (ASC)**: Each inpatient admitted to NIH shall be tested for methicillin-resistant staph aureus (MRSA) within 24 hours of admission, in the following cases:
   A. The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection.
   B. It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.
   C. The patient will be admitted to the intensive care unit.
   D. The patient is being transferred from a skilled nursing facility.
   E. Any other patient meeting the definition of at-risk populations as defined above.

PROCEDURE:

I. Patients will be screened for indications requiring ASC (See Section II of POLICY) during the admission assessment, and placed into the appropriate transmission-based isolation if the results of the screening under the above criteria are resulted as positive.

II. If a patient tests positive for any MDRO, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible.

III. Any patient who has tested NEGATIVE and later develops risks during hospitalization (i.e.; indwelling urinary catheter, central line; see defined at-risk populations) shall again be tested for MRSA immediately prior to discharge from the facility. This requirement does not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility.

IV. A patient who tests positive for any MDRO infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

V. An active surveillance culture for MRSA screening shall consist of a nasal swab culture, and/or site specific culture as ordered by the physician.

Committee Approval	**Date**
Infection Control Committee	01/07/09
Compliance Committee	
Policy and Procedure Committee	
Medical Executive Committee	
Administration	
Board of Directors	

References:

California Senate Bill No. 1058; http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_1051-1100/sb_1058_bill_20080831_enrolled.pdf

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title Respiratory Care Infection Control General Policies	
Scope: Departmental	Department: Respiratory Care
Source: Respiratory Care Manager	Effective Date: 9-2009

PURPOSE:

The Respiratory Care Department provides diagnostic and therapeutic services to monitor and support the respiratory system. Respiratory Care activities include emergency resuscitation, the administration of medical gases and aerosolized medications, bronchial hygiene and airway management procedures, lung expansion therapies, mechanical ventilation and blood gas sampling. Each of these is a potential source of infection for the patient or the practitioner. The purpose of this policy is to prevent such infections. Personal hygiene is critical to infection control in general. Specific to respiratory care are issues involving proper equipment handling, cleaning, disinfection, and storage and protecting patients, clinicians, and equipment from contamination while providing care and disposing expendables.

KEY CONCEPTS

- Patients at highest risk for respiratory infections include those with extremes of age, severe underlying disease, depressed sensorium, enteral feeding, and thoracoabdominal surgery.
- Intubation and mechanical ventilation alter and bypass first-line airway defense mechanisms and increase the risk of aspiration and subsequent infection of the lungs.
- Routes of transmission of pathogens most commonly associated with respiratory care are airborne-droplet nuclei and direct contact with contaminated fluids, hands, and equipment. Routes of transmission may be from practitioner or device to patient, from one patient to another.
- Sterilization or high-level disinfection can eliminate vegetative bacteria from device reservoirs, making them safe for patient use.
- Standard precautions are required when coming into contact with blood and body fluid is anticipated, including gowns, masks, gloves and eye ware.
- Northern Inyo Hospital Respiratory Care Department will attempt to carry disposable, single patient use supplies.

Committee Approval	**Date**
Respiratory Care	9-2009
Infection Control	
Compliance	
Policy and Procedure	

Revised 9-2009
Reviewed
Supercedes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title Respiratory Care-- Infection Control; Personal Protection	
Scope: Departmental	Department: Respiratory Care
Source: Respiratory Care Manager	Effective Date: 9-2009

POLICY:

Various types of masks, goggles, and face shields are worn alone or in combination to provide barrier protection. A mask that covers both the nose and mouth, and goggles or a face shield are worn by hospital personnel during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions to provide protection of the mucous membranes of the eyes, nose and mouth from contact transmission of pathogens. OSHA mandates the wearing of masks, eye protection, and face shields in specified circumstances to reduce the risk of exposures to blood borne pathogens. A surgical mask generally is worn by hospital personnel to provide protection against spread of infectious large-particle droplets that are transmitted by close contact and generally travel only short distances (up to 3 ft) from infected patients who are coughing or sneezing.

FACE PROTECTION IS REQUIRED WHEN INVOLVED IN THE FOLLOWING PROCEDURES:

1. Intubation
2. Suction without closed system
3. Sputum induction
4. Disconnecting vent tubing (if ~~spaying~~ spraying is likely)
5. Cleaning equipment (if using brush and spraying is likely, hold brush below water level to minimize spraying)
6. Bag mask, or bag to endo-tracheal tube ventilation

Committee Approval	Date
Respiratory Care	9-2009
Infection Control	
Compliance	
Policy and Procedure	

Revised 9-2009
Reviewed
Supercedes

NORTHERN INYO HOSPITAL
PERFORMANCE IMPROVEMENT PLAN

PURPOSE

The Performance Improvement Plan establishes a hospital wide program and interdisciplinary approach to improve patient care and services at Northern Inyo Hospital; and to meet the requirements established by outside agencies.

SCOPE AND AUTHORITY

The scope of this plan will include all patient care and support services throughout the hospital and will encompass all ancillary care facilities.

The Northern Inyo County Local Hospital District (NICLHD) Board of Directors establishes these policies supporting the mission of Northern Inyo Hospital and is ultimately responsible for the quality of patient care and services provided. The NICLHD Board of Directors delegates the development, implementation and evaluation of the performance improvement policy and related plan to the Medical Staff and Hospital Administrator.

The Northern Inyo Hospital Administrator delegates performance improvement activities to the Performance Improvement Committee.

The Northern Inyo Hospital Medical Staff is charged with participating in the Performance Improvement Plan to achieve quality patient care and compliance with all regulatory agencies. Medical Staff members will contribute to all quality improvement activities through participation in Medical Staff service committees and by assuming leadership roles, as necessary, in the performance improvement process.

OBJECTIVES

1. To establish quality standards for patient care and services; and, to measure performance against accepted standards.
2. To improve patient care and services by directing the performance assessment and corrective actions for all hospital staff and associated services.
3. To accurately collect and organize data to identify areas for improvement; and, to seek resolution of identified concerns and support future improvement.
4. To communicate important findings and corrections to the Medical Staff Quality Improvement Committee and the NICLHD Board of Directors.

PERFORMANCE AND QUALITY MEASURES

Northern Inyo Hospital has established measurements to assess performance. The scope of these measurements will be consistent with the care and services provided, as well as the mission and goals of Northern Inyo Hospital.

Quality performance criteria will address, but is not limited to, the following:

1. Safety of the environment of care
2. Safety of the providers and recipients of care
3. The mission and objectives of Northern Inyo Hospital
4. Compliance with the regulatory, licensing, and accreditation requirements
5. The effectiveness, timeliness and stability of processes that are high risk, high volume or problem prone
6. Desirable outcomes of care for at-risk populations
7. The effectiveness of the design of new or modified services.

NORTHERN INYO HOSPITAL
PERFORMANCE IMPROVEMENT PLAN

The criteria below will be the basis for ongoing evaluation of Northern Inyo Hospital functions, care, and services:

1. Operative and other invasive procedures
2. Medication use, including review of all medication errors and adverse drug reactions
3. Use of blood and blood components and transfusion reactions
4. Restraint use
5. Resuscitation outcomes
6. Infection prevention and control
7. Customer satisfaction
8. Pain management
9. Critical Indicators as established by NIH Medical Staff service committees
10. Quality of care and safety concerns identified by employees and staff
11. Utilization management
12. Falls reduction and patient safety
13. Outcomes related to use of anesthesia and procedural sedation
14. All sentinel events
15. Effectiveness of response to change or deterioration in patient's' condition.

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments or services, or focused on selected populations. These measurements may be ongoing, time limited, intensive or recurring. The duration, intensity, and frequency of monitoring are based on the needs of the organization, external requirements, and the results of data analysis.

DATA ANALYSIS

Data collected from performance measures will be reviewed and analyzed in order to identify patterns, trends and variations that might demonstrate opportunities for improvement. Analysis may include a continuous monitoring program or an intensive focused assessment appropriate to the situation or issue.

Data will be intensively assessed when a significant undesirable performance or variation is noted. Intense analysis may also be necessary when levels of performance or variation indicate a potential problem or concern such as the following:

1. Performance varies significantly from that of other organizations or recognized standards
2. A sentinel event has occurred, triggering a root cause analysis
3. There is a confirmed hemolytic reaction
4. There is a significant medication error or adverse drug reaction
5. There is a major discrepancy between preoperative and post-operative diagnosis including those identified during pathologic review
6. There is a significant adverse event associated with anesthesia or procedural sedation.

PERFORMANCE IMPROVEMENT EVALUATION AND REVIEW

Northern Inyo Hospital will undertake to improve existing processes and outcomes, and then institute policies and practices in order to sustain improved performance. Northern Inyo Hospital utilizes the PDCA model to institute practices to improve care: P (plan), D (do, implement the plan), C (check on results), and A (act on findings). This process may be used formally or informally in organizational improvement processes. In order for performance improvement to be sustained at Northern Inyo Hospital, staff must be educated in the key processes. Education and participation of staff at all levels is essential. Information available about sentinel events from either The Joint Commission (TJC) or from healthcare organizations that provide similar care and services will be analyzed for

opportunities to improve Northern Inyo Hospital's internal process and to prevent the event from occurring at Northern Inyo Hospital.

The Performance Improvement Coordinator will be responsible for reviewing, organizing and processing risk management incidents. The Performance Improvement department will collect and compile the data identified in this Plan for analysis and presentation to the Medical Staff Quality Improvement Committee. Data or information regarding individual physicians, independent licensed practitioners, and others granted clinical privileges at Northern Inyo Hospital or appointed to the Northern Inyo Hospital Medical Staff will be forwarded to the Medical Staff Coordinator for appropriate action and secure storage in the Medical Staff office.

MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

The Medical Staff Quality Improvement Committee is composed of the members of the Medical Executive Committee, the Hospital Administrator, the Director of Nurses and the Performance Improvement Coordinator. The Quality Improvement Committee meets at least ten (10) times a year. The Quality Improvement Committee shall be responsible for overall supervision of patient care services, quality monitoring, and hospital assessment and improvement activities. Accordingly, the Quality Improvement Committee shall:

1. Oversee the implementation of the Performance Improvement Plan to improve the quality of care and services which affect patient health and safety;
2. Revise the Performance Improvement Plan as necessary to set forth specific mechanisms for reviewing, evaluating, and maintaining the quality, appropriateness, and efficiency of patient care within the hospital;
3. Evaluate reports and review data regarding the quality and appropriateness of the diagnosis and treatment furnished by all health care providers.
4. Take appropriate remedial actions to address deficiencies found through the quality assurance programs and document the outcomes of all remedial actions.
5. Assess corrective actions when indicated by the findings and recommendations generated by the peer review process or the quality improvement organization, BETA Healthcare Group. The outcomes of all remedial actions will be documented.
6. Support continuing healthcare education and the development of appropriate educational programs for physicians and hospital staff.
7. Annually review, and report to the NICLHD Board of Directors, all patient care services and other services which affect patient health and safety.

PERFORMANCE IMPROVEMENT COMMITTEE

The Performance Improvement Committee will consist of all Hospital department heads, supervisors and managers, the Performance Improvement Coordinator, the Compliance Officer, the Medical Staff Coordinator, and the Hospital Administrator. The Performance Improvement Committee will meet at least quarterly. The Committee will review the performance improvement activities of hospital departments and patient care services and all other services that affect patient health and safety, excluding Medical Staff and peer review reports and activities, as directed by the Medical Staff Quality Improvement Committee. Patient safety studies will be reported to the Performance Improvement Committee at least quarterly. The Performance Improvement Committee will also recommend remedial actions to address deficiencies found through the quality assurance programs.

The Northern Inyo Hospital Performance Improvement Committee and the Medical Staff Quality Improvement Committee will review this Performance Improvement Plan and any associated plans at least annually.

THIS SHEET

INTENTIONALLY

LEFT BLANK

We Care! Early Breast Cancer Detection Program

Executive Summary

Prepared for the Northern Inyo County Local Hospital District Board of Directors
June 2010

The state funded Every Woman Counts program, which provided financial support for screening, diagnostic mammograms and follow up radiology studies, was drastically cut in January. As of now, only women over 50 who were enrolled in the program prior to January 2010 are eligible to receive services from Every Woman Counts, which excludes hundreds of women in our service area. Over six months ago, NIH exhausted the one time grant of $25,000 that was obtained through the Sierra Sistas and the National Breast Cancer Foundation, which provided screening and diagnostic mammograms for a $5 copay to encourage timely screenings in our community. Now that neither funding source is available, NIH administration, the Inyo County Health & Human Services- Public Health Division, the Rural Health Clinic, and the Eastern Sierra Breast Cancer Alliance (ESBCA) have serious concerns that the needs of the women in our service area are not being met. The ESBCA has aided a few women by covering the costs of their screenings and diagnostic mammograms, however the ESBCAs function is to help patients already diagnosed with the auxiliary costs associated with having cancer (i.e. travel, copays, bills, etc...), and simply does not have the funding to continue to cover the cost screenings and follow up diagnostics indefinitely.

We Care! Early Breast Cancer Detection Program is a program designed to encourage screenings as recommended by the American Cancer Society, for women who are uninsured or under insured, and would cover the cost of services up to an actual diagnosis of cancer. The mission of We Care! Early Breast Cancer Detection Program is to reduce breast cancer mortality rates in our community. Not only will this program save countless lives, but it will help reduce the health care costs associated with treating cancer for those who can least afford it, and thus reduce the projected burden on NIH's charity care funding and/or bad debt write offs.

This program, upon Board approval, would receive its funding from an alliance between the ESBCA and the Northern Inyo County Local Hospital District (NICLHD). Professional fees associated with screening and diagnoses typically range between $40-$153 per visit. The ESBCA has pledged $10,000 to cover the professional fees associated with screenings and diagnostic tests. The costs for professional fees at this stage can range between $40-$153 dollars, however this funding provided by ESBCA should cover the professional fees for several hundred women, lasting over 5 years, at the current service rate. NICHLD is being asked to cover the costs of baseline and annual screenings, as well as diagnostic mammograms, radiology studies and biopsies as needed. In response to the request to fulfill this need in our community, NIH's administration has proposed that the hospital absorb all facility fees associated with the professional fees covered by the ESBCA's $10,000 contribution.

We Care! Early Breast Cancer Detection Program

Eligibility

1. Any uninsured or under insured person who is considered to have high risk factors for breast cancer, as defined by the American Cancer Society
   a. Covers individuals up to age 65 (until Medicare begins coverage)
2. A physician must refer patient to program via the application brochure or standard referral form. A referral from any licensed physician will suffice.

Out of Pocket Cost

The cost to qualified individuals shall be $10 per visit, due at the time of each visit.

Program Services

1. Initial Base Line Screening
2. Annual Screenings as recommended by the ACS
3. Diagnostic Mammograms
4. Ultrasounds
5. Biopsies
6. All fees and services up to a diagnosis of cancer

Community Outreach Program-

Strong emphasis, June through October (National Breast Cancer Month).

- Approximately 7 Radio Ads (KIBS/KBOV, KMMT/KRHV, KSRW)
  - Several spots in Spanish for the Spanish Show on Sundays on the Wave
- Display ads in Inyo Register, Mammoth Times, The Sheet, Sierra Magazine, The Reader, El Sol
  - In Spanish in El Sol
- Informational Brochure with Referral to all physician offices, health departments, etc...
  - In Spanish as well
- 2 Flyers posted around community
- Internet advertising on KMMT/KRHV, KSRW, and NIH's web sites

THIS SHEET

INTENTIONALLY

LEFT BLANK

RESOLUTION NO. 10-01

RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT REQUESTING CONSOLIDATION OF ELECTION

WHERAS, it is necessary that three (3) directors be elected to the Board of Directors of Northern Inyo County Local Hospital District, one each from Zones II, III, and V of said District; and

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Northern Inyo County Local Hospital District that it request that the Board of Supervisors of the County of Inyo, State of California, consolidate said election of directors with the statewide election to be held on November 2, 2010; and,

BE IT FURTHER RESOLVED THAT THE Hospital Administrator be, and he is hereby directed to file copies of this Resolution with said Board of Supervisors of the County of Inyo, State of California, and the County Clerk-Recorder, Registrar of Voters of said County.

Adopted, signed and approved this 16th day of June, 2010.

____
Peter J. Watercott, President

Attest: ______________________________
M.C. Hubbard, Secretary

THIS SHEET

INTENTIONALLY

LEFT BLANK

RESOLUTION NO. 10-2
OF THE
NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS

WHEREAS, the Northern Inyo County Local Hospital District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, on May, 2009, the Board of Directors of Northern Inyo Hospital established an appropriations limit of $573,523.66 for the July 1, 2009 to June 30, 2010 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance, an appropriations limit of $559,073.79 has been calculated for the July 1, 2010 to June 30, 2011 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo County Local Hospital District, meeting in regular session this 16th day of June, 2010 that an appropriations limit of $559,073.79 be established for the Northern Inyo County Local Hospital District for the 2010-2011 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

Peter J. Watercott, President

Attest:

M. C. Hubbard, Secretary

APPROPRIATIONS LIMIT CALCULATIONS
FISCAL YEAR 2011

Per capita change multiplied by the population change yields a calculation factor.

For the district this is:

.9746 X 1.0002 = .9748

.9748 x $573,526.66=$559,073.79

New Limit is $559,073.79

ARNOLD SCHWARZENEGGER, GOVERNOR
915 L STREET ■ SACRAMENTO CA ■ 95814-3706 ■ WWW.DOF.CA.GOV

May 2010

Dear Fiscal Officer:

Subject: Price and Population Information

Appropriations Limit
The California Revenue and Taxation Code, Section 2227, mandates the Department of Finance (Finance) to transmit an estimate of the percentage change in population to local governments. Each local jurisdiction must use their percentage change in population factor for January 1, 2010, in conjunction with a change in the cost of living, or price factor, to calculate their appropriations limit for fiscal year 2010-2011. Enclosure I provides the change in California's per capita personal income and an example for utilizing the price factor and population percentage change factor to calculate the 2010-2011 appropriations limit. Enclosure II provides city and unincorporated county population percentage changes, and Enclosure IIA provides county's and incorporated area's summed population percentage changes. The population percentage change data excludes federal and state institutionalized populations and military populations.

Population Percent Change for Special Districts
Some special districts must establish an annual appropriations limit. Consult the Revenue and Taxation Code, Section 2228 for further information regarding the appropriation limit. You can access the Code from the following website: "http://www.leginfo.ca.gov/calaw.html" check box: "Revenue and Taxation Code" and enter 2228 for the search term to learn more about the various population change factors available to special districts to calculate their appropriations limit. Article XIII B, Section 9(C), of the State Constitution exempts certain special districts from the appropriations limit calculation mandate. Consult the following website: "http://www.leginfo.ca.gov/.const/.article_13B" for additional information. Special districts required by law to calculate their appropriations limit must present the calculation as part of their annual audit. Any questions special districts have on this issue should be referred to their respective county for clarification, or to their legal representation, or to the law itself. No State agency reviews the local appropriations limits.

Population Certification
The population certification program applies only to cities and counties. Revenue and Taxation Code Section 11005.6 mandates Finance to automatically certify any population estimate that exceeds the current certified population with the State Controller's Office. **Finance will certify the higher estimate to the State Controller by June 1, 2010**.

Please Note: Prior year's city population estimates may be revised.

If you have any questions regarding this data, please contact the Demographic Research Unit at (916) 323-4086.

Enclosure II
Annual Percent Change in Population Minus Exclusions
January 1, 2009 to January 1, 2010 and Total Population, January 1, 2010

County City	Percent Change 2009-2010	--- Population Minus Exclusions --- 1-1-09	 1-1-10	Total Population 1-1-2010
Inyo				
Bishop	-0.08	3,546	3,543	3,543
Unincorporated	0.05	14,434	14,441	14,567
County Total	0.02	17,980	17,984	18,110

(*) Exclusions include residents on federal military installations and group quarters residents in state mental institutions, state and federal correctional institutions and veteran homes.

A. **Price Factor**: Article XIII B specifies that local jurisdictions select their cost-of-living factor to compute their appropriation limit by a vote of their governing body. The cost-of-living factor provided here is per capita personal income. If the percentage change in per capita personal income is selected, the percentage change to be used in setting the 2010-2011 appropriation limit is:

Per Capita Personal Income

Fiscal Year (FY)	Percentage change over prior year
2010-2011	-2.54

B. Following is an example using sample population change and the change in California per capita personal income as growth factors in computing a 2010-2011 appropriation limit.

2010-2011:

Per Capita Cost of Living Change = -2.54 percent
Population Change = 1.03 percent

Per Capita Cost of Living converted to a ratio: $\frac{-2.54 + 100}{100}$ = .9746

+.02 = 1.0002

Population converted to a ratio: $\frac{1.03 + 100}{100}$ = ~~1.0103~~

Calculation of factor for FY 2010-2011: .9746 x 1.~~0103~~ = ~~.9846~~

1.0002 = .9748

THIS SHEET

INTENTIONALLY

LEFT BLANK

650 California Street, 17th Floor
San Francisco, CA 94108-2702
USA

Tel +1 415 403 1333
Fax +1 415 403 1334

milliman.com

May 21, 2010

Mr. John Halfen
Chief Financial Officer
Northern Inyo Hospital
150 Pioneer Lane
Bishop, California 93514-2599

Northern Inyo County Local Hospital District Retirement Plan
Actuarial Valuation as of January 1, 2010

Dear John:

Enclosed are two copies of the Actuarial Valuation as of January 1, 2010.

We are recommending an annual contribution of $2,964,000. This means the current monthly contribution rate of $254,000 should be decreased to $247,000, effective July 1, 2010. The contribution decrease is due primarily to a smaller increase in the average salary over the past year than our assumed salary scale of 6%.

If you have any questions or would like to review the report with me, please give me a call at (415) 394-3716.

Sincerely,

Rich Wright

RAW:km
enc.
n:\nih\corr\2010\nih2010v-e.doc

Northern Inyo County
Local Hospital District Retirement Plan

Actuarial Valuation as of January 1, 2010

Prepared by:

Richard A. Wright
FSA, MAAA

Milliman, Inc.
650 California Street, 17th Floor
San Francisco, California 94108
Tel 415 403 1333 Fax 415 403 1334
milliman.com

May 21, 2010

650 California Street, 17th Floor
San Francisco, CA 94108-2702
USA

Tel +1 415 403 1333
Fax +1 415 403 1334

milliman.com

May 21, 2010

Northern Inyo Hospital
150 Pioneer Lane
Bishop, California 93514-2599

Northern Inyo County Local Hospital District Retirement Plan
Actuarial Valuation as of January 1, 2010

At the request of the Hospital, we have made an actuarial valuation of the Northern Inyo County Local Hospital District Retirement Plan for the plan year beginning January 1, 2010.

In preparing our report, we relied on financial information provided by New York Life Insurance Company and employee data furnished to us by the Hospital. While Milliman has not audited the financial and census data, they have been reviewed for reasonableness and are, in our opinion, sufficient and reliable for the purposes of our calculations. If any of this information as summarized in this report is inaccurate or incomplete, the results shown could be materially affected and this report may need to be revised.

The actuarial cost method and assumptions used as well as the supporting data and principal plan provisions upon which the valuation is based are set forth in the following report. In our opinion, each actuarial assumption, method, and technique used is reasonable taking into account the experience of the Plan and reasonable expectations. Nevertheless, the emerging costs will vary from those presented in this report to the extent actual experience differs from that projected by the actuarial assumptions.

The calculations reported herein have been made in accordance with the applicable provisions of the Internal Revenue Code. The results of this valuation are applicable only for the current year and are intended to be used only by the plan sponsor for the specific purposes described herein. Accordingly, this report may not be distributed to any third party without Milliman's written consent. Reliance on information contained in this report by anyone for anything other than the intended purpose puts the relying entity at risk of being misled.

Milliman's work is prepared solely for the internal business use of the Hospital. To the extent that Milliman's work is not subject to disclosure under applicable public records laws, Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work product. Milliman's consent to release its work product to any third party may be conditioned on the third party signing a Release, subject to the following exception(s):

(a) The Hospital may provide a copy of Milliman's work, in its entirety, to the Hospital's professional service advisors who are subject to a duty of confidentiality and who agree to not use Milliman's work for any purpose other than to benefit the Hospital.

(b) The Hospital may provide a copy of Milliman's work, in its entirety, to other governmental entities, as required by law.

No third party recipient of Milliman's work product should rely upon Milliman's work product. Such recipients should engage qualified professionals for advice appropriate to their own specific needs.

On the basis of the foregoing, we hereby certify that, to the best of our knowledge and belief, all costs, liabilities, and other factors under the Plan were determined in accordance with generally accepted actuarial principles and practices which are consistent with the applicable Actuarial Standards of Practice of the American Academy of Actuaries. We further certify that, to the best of our knowledge, the report is complete and accurate and the information presented herein, in our opinion, fully and fairly discloses the actuarial position of the Plan.

The undersigned is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Sincerely,

Richard A. Wright, FSA, MAAA
Consulting Actuary

RAW:km
n:\nih\corr\2010\nih2010v-e.doc

TABLE OF CONTENTS

Section **Page**

I VALUATION SUMMARY

Introduction 1
Highlights 1
Results of Valuation 3
Monthly Contributions 4

II FINANCIAL EXHIBITS

Exhibit 1. Summary of Plan Assets 5
Exhibit 2. Summary of Changes in Plan Assets 6
Exhibit 3. Historical Returns on Plan Assets 7
Exhibit 4. Present Value of Accumulated Plan Benefits 8
Exhibit 5. Changes in Accumulated Plan Benefits 9

III DETERMINATION OF CONTRIBUTION

Exhibit 6. Development of Normal Cost 10
Exhibit 7. Actuarial Liability 11
Exhibit 8. Full Funding Limitation 12
Exhibit 9. Recommended Contribution 13

IV APPENDICES

Appendix A. Summary of Pension Plan 14
Appendix B. Actuarial Cost Method and Assumptions 15
Appendix C. Summary of Participant Data 16

Introduction

This report sets forth the results of our valuation of the Northern Inyo County Local Hospital District Retirement Plan, as of January 1, 2010. In Section II we furnish certain financial statements and actuarial exhibits of the Fund for the 2009 plan year. Section III presents the determination of the contribution requirement for the 2010 plan year.

A summary of the Plan is set forth in Appendix A, and the actuarial assumptions and cost method used in determining the costs and liabilities are described in Appendix B. The membership data is shown in Appendix C.

Highlights

For this valuation, we have kept the pre-retirement interest assumption at 6.75%. We have incorporated a different post-retirement interest assumption, 6.5%, for participants joining the Plan on and after July 1, 2009, to be in line with the Plan's new actuarial basis for determining lump sums that is applicable for those participants. For all others, we have maintained the 8.0% post-retirement interest assumption. For our actuarial valuation, we have based the post-retirement interest assumption on the Plan's interest rate for determining lump sums since most participants elect to receive their benefits in that form.

Similarly, we have incorporated a different mortality assumption for participants joining the Plan on and after July 1, 2009. The assumption for them is the RP-2000 Mortality Table for Males, set back 4 years, which corresponds to the Plan's mortality table for determining lump sum benefits for such participants.

The new assumptions for mortality and post-retirement interest for participants joining the Plan on and after July 1, 2009, had a relatively small impact on this year's valuation results. Among the 298 active participants as of January 1, 2010, there are only 26 participants that joined on and after July 1, 2009. Since they have very little credited service at the present time, and are also relatively young, the new assumptions had a negligible impact on the accrued liability and the present value of accumulated plan benefits as of January 1, 2010 (an increase of less than 0.1%). The effect of the new assumptions on the normal cost was an increase of $27,822, as the normal cost would have been $2,386,324, rather than $2,414,146, if the new assumptions had not been implemented.

The normal cost increased from $2,325,750 in last year's valuation to $2,414,146 this year, due to the increase in total payroll and the above-mentioned assumption changes. The normal cost as a percentage of payroll decreased slightly from 14.4% in last year's valuation to 14.2% this year.

The investment performance of the fund showed a return of 6.0% for 2009 in comparison with 6.5% for 2008.

The Full Funding Limitation is a measure of the funding status of the plan as of the valuation date. It is normally used to determine minimum required contributions and the maximum tax-deductible limit for taxable entities. For the 2010 Plan Year, the Full Funding Limitation would limit contributions to the Plan to $10,812,795 for the year.

The recommended contribution is based on a target funding level of 125% of the Accumulated Benefit Obligation (ABO). The plan's current funding level is 115.2% of ABO, compared with 118.8% as of

January 1, 2009. The excess over 125% (or deficit, in the case of this year's valuation) is being amortized over a 25-year period beginning on January 1, 2002. The applicable amortization amount for the year is added to the current year's ABO normal cost to determine the recommended contribution for the year. The recommended contribution for the 2010 Plan Year is $2,964,000, or $247,000 per month if paid in 12 monthly installments during the 7/1/2010-6/30/2011 fiscal year. The recommended contribution decreased from last year's $3,048,000 due to the smaller ABO normal cost this year, which resulted primarily from a smaller increase in the average salary over the past year than our assumed salary scale of 6%.

Results of Valuation

The following table summarizes the principal valuation results and compares them with the prior plan year.

		January 1, 2010	January 1, 2009
Number of Participants			
Active	– Fully vested	131	127
	– Partially vested	81	74
	– Nonvested	86	80
	– Total	298	281
Part-time employees with accrued benefits		10	21
Disabled employees with accrued benefits		1	1
Terminated vested		48	46
Retired		0	0
Total participants		357	349
Participant Payroll		$ 17,029,679	$ 16,144,532
Actuarial Liability (PBO)		$ 39,008,886	$ 36,810,886
Funding Target – 125% of Accumulated Benefit Obligation (ABO)		$ 33,952,810	$ 31,476,244
Actuarial Assets		$ 31,293,950	$ 29,912,439
Normal Cost at Beginning of Year		$ 2,414,146	$ 2,325,750
As a percentage of applicable payroll		14.2%	14.4%
Full Funding Limitation		$ 10,812,795	$ 9,846,830
Recommended Contribution		$ 2,964,000	$ 3,048,000
As a percentage of applicable payroll		17.4%	18.9%
Investment Return			
Current annual yield		6.0%	6.5%
Average annual yield for last 5 years		6.0%	6.0%

Monthly Contributions

To satisfy the funding requirement for the 2010 plan year, we recommend the schedule of contributions shown below. Contributions for a fiscal year (July 1 to June 30) are being applied to the plan year (January 1 to December 31) ending within the fiscal year.

Approximate Date of Contribution	Contributions for the 2010 Plan Year
07/15/2010	$ 247,000
08/15/2010	247,000
09/15/2010	247,000
10/15/2010	247,000
11/15/2010	247,000
12/15/2010	247,000
01/15/2011	247,000
02/15/2011	247,000
03/15/2011	247,000
04/15/2011	247,000
05/15/2011	247,000
06/15/2011	247,000
Total	$ 2,964,000

Exhibit 1. Summary of Plan Assets

The valuation assets as of January 1, 2010, are the sum of the accrued balances in the contractual Fixed Dollar Account (GA-928) and the Indexed Bond Fund (account #11344) as of December 31, 2009, maintained by New York Life, plus any accrued but unpaid contributions and minus any distributions payable. The balance in the contractual Pension Account is allocated to retired participants and beneficiaries and is excluded from the valuation. Development of the assets is as follows:

	January 1, 2010	January 1, 2009
Plan Assets		
Fixed Dollar Account (GA-928)	$ 21,122,635	$ 20,390,583
Indexed Bond Fund (Acc. #11344)	8,647,315	8,195,856
Total	$ 29,769,950	$ 28,586,439
Accrued Contributions	1,524,000	1,326,000
Actuarial Assets	$ 31,293,950	$ 29,912,439
Asset Allocation		
Fixed Dollar Account	67.5%	68.2%
Indexed Bond Fund	27.6%	27.4%
Accrued Contributions	4.9%	4.4%
Total	100.0%	100.0%

Note: We have not audited the fund's assets shown above. We have relied on the information furnished by New York Life Insurance Company.

Exhibit 2. Summary of Changes in Plan Assets

Plan assets increase or decrease each year due to employer contributions, investment income, benefit payments to retiring participants, plan expenses paid by the trust fund, and any realized and unrealized gains and losses from investments.

	PLAN YEAR ENDING	
	December 31, 2009	December 31, 2008
Beginning Balance	$ 28,586,439	$ 25,403,931
Additions:		
Employer contributions	2,850,000	2,382,000
Investment income	1,716,971	1,739,681
Experience adjustment	0	0
Total	4,566,971	4,121,681
Subtractions:		
Benefit payments	(3,292,132)	(826,276)
Expenses & related charges	(41,077)	(36,563)
Experience adjustment	(50,251)	(76,334)
Total	(3,383,460)	(939,173)
Ending Balance	$ 29,769,950	$ 28,586,439

Exhibit 3. Historical Returns on Plan Assets

The following table shows the historical return on plan assets since 1993:

Plan Year	Return
2009	5.97%
2008	6.53%
2007	6.71%
2006	5.57%
2005	5.32%
2004	5.84%
2003	5.41%
2002	8.18%
2001	7.33%
2000	8.48%
1999	4.42%
1998	7.90%
1997	8.64%
1996	5.70%
1995	12.16%
1994	2.89%
1993	8.89%
Average for last 5 years	6.02%
Average for last 10 years	6.53%

The actuarial valuation rate for the 2010 plan year is 6.75%.

Exhibit 4. Present Value of Accumulated Plan Benefits (ABO)

The present value of accumulated plan benefits (also known as the Accumulated Benefit Obligation or ABO) is the value of benefits that have been accrued to date.

	As of January 1, 2010	As of January 1, 2009
Vested Benefits		
Active participants	$ 23,095,541	$ 20,602,278
Part-time participants with accrued benefits	320,692	451,210
Terminated vested participants	2,436,431	2,921,251
Disabled participants	15,188	13,577
Participants currently receiving payments	0	0
Total	$ 25,867,852	$ 23,988,316
Nonvested Benefits	1,294,396	1,192,679
Total	$ 27,162,248	$ 25,180,995
Valuation Assets	$ 31,293,950	$ 29,912,439
Funding Ratio	115.2%	118.8%

Exhibit 5. Changes in Accumulated Plan Benefits

The changes in the present value of accumulated plan benefits for the last two plan years are summarized below.

	PLAN YEAR ENDING	
	December 31, 2009	December 31, 2008
Beginning of Year	$ 25,180,995	$ 21,569,003
Benefits accumulated and actuarial experience	3,567,106	2,982,360
Increase for interest due to the decrease in the discount period	1,699,717	1,455,908
Plan amendment	0	0
Change in actuarial assumptions	6,562	0
Benefits paid	(3,292,132)	(826,276)
End of Year	$ 27,162,248	$ 25,180,995

Exhibit 6. Development of Normal Cost

The normal cost is calculated according to the actuarial cost method. Under the projected unit credit cost method, the normal cost is equal to the value of the benefits accrued during the year based on compensation projected to retirement. The normal cost is as follows:

	PLAN YEAR BEGINNING	
	January 1, 2010	January 1, 2009
Normal cost as of beginning of plan year	$ 2,414,146	$ 2,325,750
Estimated payroll for plan participants	17,029,679	16,144,532
Normal Cost as % of payroll	14.2%	14.4%
Normal cost as of end of plan year	2,577,101	2,482,738

Exhibit 7. Actuarial Liability (PBO)

In the Projected Unit Credit method, the actuarial liability is equal to that portion of an employee's projected benefit that is allocated to past service periods and includes the value of assumed future compensation increases. This is also known as the Projected Benefit Obligation or PBO. Any actuarial liability in excess of the plan's assets is called an unfunded liability.

	As of January 1, 2010	As of January 1, 2009
Actuarial Liability (PBO)		
Active participants	$ 36,236,575	$ 33,424,848
Part-time participants with accrued benefits	320,692	451,210
Terminated vested participants	2,436,431	2,921,251
Disabled participants	15,188	13,577
Participants currently receiving payments	0	0
Total	$ 39,008,886	$ 36,810,886
Actuarial Assets	$ 31,293,950	$ 29,912,439
Unfunded Actuarial Liability	$ 7,714,936	$ 6,898,447

Exhibit 8. Full Funding Limitation

The full funding limitation is defined by the Internal Revenue Code and limits minimum required and maximum deductible contributions of well-funded retirement plans.

	PLAN YEAR ENDING	
	December 31, 2010	December 31, 2009
Actuarial Liability	$ 39,008,886	$ 36,810,886
Normal Cost	2,414,146	2,325,750
Total	$ 41,423,032	$ 39,136,636
Actuarial assets	$ 31,293,950	$ 29,912,439
Full Funding Limitation, beginning of year	$ 10,129,082	$ 9,224,197
Interest	683,713	622,633
Full Funding Limitation, end of year	$ 10,812,795	$ 9,846,830

Exhibit 9. Recommended Contribution

The recommended contribution targets a funding level of 125% of the Accumulated Benefit Obligation (ABO). Since the plan is currently funded less than 125% of ABO, the deficit is amortized over the 25 years starting from January 1, 2002. The recommended contribution is reduced, if necessary, to the Full Funding Limitation.

	PLAN YEAR ENDING	
	December 31, 2010	December 31, 2009
Target Surplus		
Accumulated Benefit Obligation (ABO)	$ 27,162,248	$ 25,180,995
Funding Target %	x 125%	x 125%
Funding Target (125% of ABO)	$ 33,952,810	$ 31,476,244
Actuarial Assets	31,293,950	29,912,439
Excess / (deficit)	$ (2,658,860)	$ (1,563,805)
Recommended Contribution		
ABO Normal Cost	$ 2,523,110	$ 2,711,907
Amortization of (Excess) / Deficit	250,714	143,015
Total as of beginning of year	$ 2,773,824	$ 2,854,922
Interest	187,233	192,707
Total as of end of year	$ 2,961,057	$ 3,047,629
Full Funding Limitation, end of year	$ 10,812,795	$ 9,846,830
Recommended Contribution	$ 2,961,057	$ 3,047,629

Appendix A. Summary of Pension Plan

The following paragraphs are only a brief summary of the more important provisions of the plan. In the event there are any inconsistencies between statements contained in this Appendix and the plan document, the provisions of the plan document shall control.

Effective Date: March 1, 1975; last restatement January 1, 2009.

Plan Eligibility: An employee becomes a participant of the plan on the earliest January 1 or July 1 following the later of attainment of age 21 and completion of 1 year of service.

Vesting: 50% vesting after 5 years of Credited Service increasing 10% per year until 100% vested after 10 years of service. Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

Normal Retirement Date: The first day of the month coinciding with or following the later of Participant's attainment of age 65 or completion of 5 years of plan participation. However, the Normal Retirement Date shall not be later than age 70.

Normal Retirement Benefit: 2.50% of Average Annual Compensation multiplied by years of Credited Service, but not less than $600.

Average Annual Compensation: Average of annual compensation for the highest consecutive 36-month period preceding the determination date. Compensation includes wages, shift differential, standby pay, and 50% of the value of any unused and unpaid sick leave existing at the time of termination of employment, and accrued after April 26, 1997.

Accrued Benefit: Normal Retirement Benefit prorated on credited service.

Normal Form of Retirement Benefit: Life Annuity.

Early Retirement: The first day of the month coinciding with or following the Participant's attainment of age 55 and completion of at least 5 years of credited service. Then the normal retirement benefit will be reduced by 5/9% for each of the first 60 months and 5/18% for each additional month that payment starts before normal retirement age.

Pre-Retirement Death Benefit: If a vested participant dies prior to retirement, his or her beneficiary will receive the actuarially determined present value of his or her accrued benefit.

Appendix B. Actuarial Cost Method and Assumptions

The following cost method and assumptions were used in valuing the benefits of all participants.

	January 1, 2010	January 1, 2009
Actuarial Cost Method	Projected Unit Credit	Projected Unit Credit
Funding Interest Rate		
Pre-retirement	6.75%	6.75%
Post-retirement	Based on Date of Participation DOP Before 7/1/2009: 8.00% DOP On/After 7/1/2009: 6.50%	8.00%
Salary Scale	6.00%	6.00%
Administrative Expenses	None.	None.
Mortality	Based on Date of Participation DOP Before 7/1/2009: 1984 UP Mortality Table set back 4 years. DOP On/After 7/1/2009: RP-2000 Table for Males set back 4 years.	1984 UP Mortality Table set back 4 years.
Disability		
Disablement Rate	None.	None.
Disabled Annuitants Mortality	None.	None.
Withdrawal Rates	Table T-8, The Actuary's Pension Handbook, Crocker-Sarason-Straight.	Table T-8, The Actuary's Pension Handbook, Crocker-Sarason-Straight.
Retirement Age	The later of age 65 or the 5th anniversary of date of participation; or age 70, if earlier.	The later of age 65 or the 5th anniversary of date of participation; or age 70, if earlier.
Asset Valuation Method	Market value	Market value

Appendix C. Summary of Participant Data

Active Participants

Age	NUMBER OF PARTICIPANTS Males	Females	Total	ANNUAL SALARIES Males	Females	Total
Under 25	0	4	4	$ 0	$ 102,616	$ 102,616
25 - 29	1	13	14	26,953	594,206	621,159
30 - 34	7	17	24	557,365	757,315	1,314,680
35 - 39	5	13	18	295,894	560,046	855,940
40 - 44	5	18	23	429,223	979,785	1,409,008
45 - 49	13	38	51	828,149	2,073,316	2,901,465
50 - 54	11	49	60	757,787	2,791,108	3,548,895
55 - 59	9	52	61	518,751	3,244,935	3,763,686
60 - 64	6	25	31	465,298	1,564,964	2,030,262
65 - 69	3	8	11	489,800	484,791	974,591
70 & Over	0	1	1	0	58,815	58,815
Total	60	238	298	$ 4,369,220	$ 13,211,897	$ 17,581,117

Other Participants

Participant Status	NUMBER OF PARTICIPANTS Males	Females	Total	ANNUAL BENEFITS Males	Females	Total
Part-time	0	10	10	$ 0	$ 59,556	$ 59,556
Disabled	0	1	1	0	1,551	1,551
Terminated Vested	9	39	48	85,438	348,824	434,262
Retired	0	0	0	0	0	0
Total	9	50	59	$ 85,438	$ 409,931	$ 495,369

THIS SHEET

INTENTIONALLY

LEFT BLANK

MRI Upgrade

Current MRI scanner was last upgraded in 2003.

This upgrade will include:

- New operator console, monitors and computer processors
  - Will increase image resolution and quality
  - Will provide a 350% increase in scan/processing speed (less time in the scanner per patient)
- Upgrade for a 12x to 15x platform
- Ability to move from 8 to 16 channel coils
- Software upgrades
  - COSMIC – improved visualization of the cervical nerve roots and intervertebral disks
  - LAVA – increased resolution of abdominal scans, ability to reconstruct 3D volume images from a single scan, completed in a single breath decreasing motion on images
  - IDEAL – can generate multiple tissue contrast data sets from a single series. Improved quality and speed for brachial plexus, neck, spine, chest, foot and ankle imaging.
  - CUBE – single series acquisition allows for multiple plane reconstruction with increased resolution. Improves neuro and musculoskeletal imaging
  - SWAN – Increases resolution and decreases time for angiography studies
  - INHANCE – allows for angiography studies in patients who cannot tolerate contrast. Allows for "contrast-like" studies of lower extremities vessels and renal arteries without using contrast.
  - BREASE – Optimizes breast scanning and allows for spectroscopy of tissues
- 5 Days of On-site applications training
- Decrease in the service contract fees by up to $14,871/year (if we approve a 7-yr contract)
  - Current service contract is $142,364 annually
  - 7 year contract after upgrade would be $127,493

GE Healthcare

QUOTATION

Quotation Number: P8-C83190 V 2

Northern Inyo Hospital 150 Pioneer Ln Bishop CA 93514	Attn: Patty Dickson 150 Pioneer Ln Bishop CA 93514	Date: 04-09-2010

Qty	Catalog No.	Description
1		**Signa HD to HDxt 1.5T Upgrade**
1	S7505BZ	Signa HDxt 1.5T 16 Channel Upgrade for HD CXK4 Magnet with Wide Open Covers

Signa HDxt 1.5T 16 Channel Upgrade for HD CXK4 Magnet with Wide Open Covers

Upgraded system level is a 16 Channel HDxt.

The GE SIGNA Continuum is the industry's best and leading obsolescence and investment protection program. When a customer buys a GE SIGNA MRI, GE customers have the competitive advantage of reinvesting in their existing technology to ensure state of the art clinical and operational performance without ever having to replace the magnet. It's about leadership MRI performance when you need it, how you need it with rich standard configurations at prices with the shortest payback period in the industry. When you buy GE SIGNA, you have a platform for life.

In addition to the industry's leading operating system and user-interface, this upgrade package includes GE proprietary software, normally available for purchase optionally. GE SIGNAture software included in this upgrade package is 3D-COSMIC and LAVA-XV.

COSMIC (Coherent Oscillatory State acquisition for Manipulation if Image Contrast.) COSMIC is a 3D imaging technique specifically tailored to C-spine studies. Its unique fluid-weighted contrast yields improved visualization of the cervical nerve roots and intervertebral disks.

LAVA (Liver Acquisition with Volume, Acceleration)-XV. Compared to conventional, techniques, LAVA-XV is a more reliable and, robust approach to high-resolution liver imaging, providing more extensive coverage without time, penalty. By employing multi-dimensional parallel, imaging and GEM reconstruction, LAVA-XV produces, 3D image volumes extending from liver dome to pelvis in a single breath-hold. By over-sampling, the center of k-space, this acquisition, technique embeds the calibration data within the image data, ensuring robust parallel imaging and reconstruction free of breathing artifacts. Its unique variable density sampling approach is what eliminates time penalties for the self-calibrated acquisition. The clinical result: Outstanding, high-resolution imaging, patient after patient.

The user interface is upgraded to HDxt levels including an LCD wide-screen monitor and keyboard. This flat-panel Liquid Crystal Display (LCD) monitor delivers 1920 x 1200 dot resolution at a refresh rate of 85Hz and an excellent 500:1 contrast ratio using a digital DVI interface -all significant improvements over conventional designs.

To improve the look and feel of each upgraded system, the GE SIGNA Continuum includes a number of patient comfort, positioning and safety items worth several thousand dollars at no additional charge. Included items are E8802MC - Wide Security Straps, E8802MD Narrow

PO Box 414, Milwaukee, WI 53201-0404
General Electric Company
General Electric Company, GE Medical Systems

Qty	Catalog No.	Description
		Security Straps E8802AE - Extremity Pad Set, E8802MH - Table Pad, E8823A - MR Patient Positioning Kit, E8801BA - Aearo Earplugs. This MR upgrade is covered by a six month GE Healthcare warranty, in accordance with GE Healthcare's standard product warranty statement. As noted in the warranty statement, for partial system equipment upgrades, the warranty applies only to the upgraded components. The upgrade may affect Service contract rates.
1	M3335PL	1.5T EXCITE Upgraded HD to HDx/t Cabinet Upgrade Components Collector 1.5T EXCITE Upgraded HD to HDx/t Cabinet Upgrade Components Collector
1	S7503LP	4-Channel to 8-Channel Upgrade 4-Channel to 8-Channel Upgrade
1	M3335EW	1.5T Unified Coil Phantom Kit 1.5T Unified Coil Phantom Kit Set of phantoms for the 1.5T system that is used on various surface coils to conduct quality assurance testing.
1	M3340AC	IDEAL Fat/Water Imaging Package IDEAL Fat/Water Imaging Package Generate consistent tissue contrast and reduce the number of series in an exam with IDEAL. The IDEAL acquisition and reconstruction methods can generate a water-only, fat-only, in-phase and out-of-phase data sets for clear tissue differentiation in a single series. In addition, susceptibility artifacts common to MR imaging such as incomplete or inaccurate fat saturation, and chemical shift can be significantly reduced. The IDEAL application acquires multiple echoes and uses unique reconstruction routines to generate the four image contrasts and correct for errors due to tissue susceptibility. IDEAL is ideally suited for imaging anatomical regions such as the brachial plexus, neck, spine, chest, foot, ankle, and axilla where inhomogeneous magnetic fields may yield failures with traditional fat saturation techniques. IDEAL is compatible with Fast Spin Echo, 3D Gradient Echo and parallel imaging. The IDEAL method is compatible with ASSET parallel imaging and is optimized based on the anatomy of interest.
1	M3090PL	ConnectPro ConnectPro ConnectPro is the software that enables the DICOM worklist server class for the Signa operators' console, making it possible for the console to query your HIS/RIS by name, modality, or

Qty	Catalog No.	Description
		scheduled date, and to download patient demographics directly to the scanner. This may require separate gateway hardware to connect non DICOM-compatible HIS/RIS systems to the MR system.
1	M3033PJ	Performed Procedure Step Performed Procedure Step Performed Procedure Step (PPS) is an important automated connectivity capability - and a key step towards a film-less and paperless environment. Used in conjunction with the GE PACS broker, it automatically notifies the HIS/RIS and PACS systems of procedure status - in effect, closing the loop on the information gathered from patient arrival through billing. The results: Improved patient care and enhanced productivity.
1	W0108MR	TiP MR System Upgrade Training 4 Days Onsite 10 Hours TVA TiP MR System Upgrade Training 4 Days Onsite 10 Hours TVA 4 Consecutive Days plus 10 Hours TVA training for MR System Upgrade Training. Onsite training is delivered Monday through Friday between 8AM and 5PM. T&L expenses are included. This training program must be scheduled and completed within 36 months after the date of product delivery.
1	W0001MR	1 Day MR TiP Onsite Training 1 Day MR TiP Onsite Training One Day MR Onsite Training provided from 8AM to 5PM, Monday through Friday. Includes T&L expenses. This training program must be scheduled and completed within 12 months after the date of product delivery.

Quote Summary:

Total Quote Net Selling Price **$299,320.00**

(Quoted prices do not reflect state and local taxes if applicable)

If you would like to place an order for this equipment, a formal contract document will be prepared for your consideration. This quote is for budgetary use only; only a GE contract can become a binding order.

Options

(These items are not included in the total quotation amount)

PO Box 414, Milwaukee, WI 53201-0404
General Electric Company
General Electric Company, GE Medical Systems

Quotation Number: P8-C83190 V 2

Qty	Catalog No.	Description
1	M3340AA	Cube Volumetric Imaging Package Cube Volumetric Imaging Package Exclusive to GE, the Cube technology can eliminate multiple independent two-dimensional datasets with a single three-dimensional volume (or cube) of high resolution data to provide better image quality in shorter exam times. Compared to traditional 3D fast spin echo acquisitions, Cube uses a combination of optimized echo train pulses to: reduce SAR, extend the duration of the acquisition echo train, and reduce the echo spacing. The system automatically adjusts the echo train flip angle amplitude to provide optimal tissue contrast based on the specific tissue T1 and T2 characteristics and prescription parameters. To further reduce exam time and improve image quality, Cube relies on ARC self-calibrating parallel imaging. Isotropic Cube datasets are easily reformatted from a single acquisition into any plane, without gaps, and with the same resolution as the original plane for improved anatomical review and tissue visualization. High resolution Cube data can be acquired with T2, T2 FLAIR, or Proton density weighted tissue contrasts for neuro and musculoskeletal imaging.
1	M3340AG	SWAN T2 Star-Weighted ANgiography SWAN T2 Star-Weighted ANgiography SWAN is a volumetric 3D acquisition technique that is sensitive to differences in susceptibility between different tissues. This technique acquires multiple-echoes at different echo times to highlight regions with increased T2* (susceptibility-induced) decay. Utilizing multiple-echoes, SWAN generates images with higher SNR when compared with similar techniques that rely on a single echo.
1	M3340AJ	Inhance (Inherent Enhancement) Non-Contrast MRA Inhance (Inherent Enhancement) Non-Contrast MRA The Inhance application suite consists of several new sequences designed to provide high-resolution images of the vasculature with short-acquisition times and excellent vessel detail. These new sequences include: Inhance 3D Velocity: Inhance 3D Velocity is designed to acquire angiography images in brain and renal arteries with excellent background suppression in a short scan time. By combining a volumetric 3D phase contrast acquisition with parallel imaging, efficient k-space traversal, and pulse sequence optimization, Inhance 3D Velocity is faster than previous generations and is capable of obtaining complete neurovascular imaging in 5-6 minutes. Furthermore, background suppression is improved by the optimized pulse sequence design, resulting in better visualization of small branches. Respiratory trigger is also compatible with 3D Velocity to enable abdominal angiography, especially renal arteries. The result is the Inhance 3D Velocity technique offers

PO Box 414, Milwaukee, WI 53201-0404
General Electric Company
General Electric Company, GE Medical Systems

Qty	Catalog No.	Description
		improved productivity and image quality.

Inhance 2D Inflow: The Inhance 2D Inflow pulse sequence is designed to acquire angiography images of arteries, which follow almost a straight path, i.e. femoral, poplitial, carotid arteries, etc. Arterial blood flow is faster during systolic phase and slows down during diastolic phase. Inhance 2D Inflow is designed to acquire data during systolic phase and offers the following:

- Optimized spatial saturation gap to improve fat suppression and background suppression. With this saturation gap optimization, higher views per segment (vps up to 48) could be used, resulting in significant scan time reduction.
- Peripheral Gating that minimizes the pulsatile artifacts.
- Optimized View Ordering to improve arterial signal.
- ASSET acceleration compatibility to reduce scan time.

Inhance Inflow IR: Inhance Inflow IR is a new angiographic method, which has been developed to image renal arteries with ability to suppress static background tissue and venous flow. This sequence is based on 3D FIESTA, which improves SNR, as well as produce bright blood images. A selective inversion pulse is applied over the region of interest, which inverts arterial, venous, and static tissue. At the null point of the venous blood, an excitation pulse is applied to generate signal. The net result is an angiographic image with excellent background suppression and without venous contamination. Uniform fat suppression is achieved using a spectrally selective chemical saturation (SPECIAL) technique to provide uniform fat suppression, while respiratory gating compatibility reduces respiratory motion artifacts during free-breathing renal exams.

Qty	Catalog No.	Description
1	M3335KK	BREASE Breast Spectroscopy

BREASE Breast Spectroscopy

BREASE is a single-voxel TE-averaged PRESS sequence that is optimized for mapping the bio-chemical information within a voxel. The TE averaging eliminates unwanted information from side-bands to ensure clean and simple spectra and streamline interpretation. Optimized Prescan and Reconstruction algorithms are employed to accurately characterize spectra in the presence of breast tissue that is normally dominated by lipid signal.

(Quoted prices do not reflect state and local taxes if applicable)

PO Box 414, Milwaukee, WI 53201-0404
General Electric Company
General Electric Company, GE Medical Systems

Northern Inyo - MR Upgrd

Quote expires on 6/12/2010

GE Healthcare is excited about partnering with you for all of your Diagnostic Imaging service needs. The following is a preliminary quote for your imaging equipment. The quote is for budgetary purposes and contains only a general description of the proposed Service offerings. Final pricing and terms will be solely those contained in an executed Agreement.

Equipment Identifiers	Equipment	Effective Date	Offering	Options	Features	5year Term Annual Amount	7year Term Annual Amount
System ID: 760873MRHD Billing Acct: 670633475	GE MR 1.5T HD TO HDXT UPGRADE (MSU111)	End of Warranty	AssurePoint Rapid	INCLUDED: ☐ Coldhead Chiller Coverage ☐ GE Supplied Coils ☐ iLinq Diagnostic ☐ iLinq Response Time: 5 Mins ☐ InSite OnWatch ☐ Spectroscopy EXCLUDED: ☐ 32 Channel ☐ Printers	☐ TVA on Demand ☐ FE Cov. Weekdays: Mon-Fri, 8AM-9PM ☐ FE Onsite Response Time: 2 Hour ☐ iCenter Maintenance Reports: Silver ☐ InSite / Tech. Phone Support ☐ No SPH parts fee for Hard Down ☐ Parts Delivery: Priority ☐ PM Cov.: Mon-Fri, 8AM-9PM ☐ Software Updates: Safety & Quality Updates ☐ TiP Answer Line ☐ Uptime Commitment: 98%	$103,610	$98,828

Equipment Identifiers	Equipment	Effective Date	Offering	Options	Features	5year Term Annual Amount	7year Term Annual Amount
System ID: 760873MRHDCRYO Billing Acct: 670633475	GE MR SIGNA CRYOGENS (MSC28Z)	End of Warranty	Magnet Maintenance and Cryogen	INCLUDED: ☐ Magnet Type: [MA1] MMC Coverage for .5T, 1.0T, 1.5T Non-Twin	☐ FE Cov. Weekdays: Mon-Fri, 8AM-9PM ☐ InSite / Tech. Phone Support ☐ InSite OnWatch	$30,030	$28,665

TOTAL:	$133,640	$127,493

Please call me with any questions:
310.697.6407

Respectfully,

Daniel Mills
Healthcare Services Account Manager

THIS SHEET

INTENTIONALLY

LEFT BLANK

N . I . H . MEMORANDUM

DATE: 6/10/2010

TO: Mr. Halfen

FROM: Scott Hooker

RE: Communication Network

John,

With the help of Kathy and Adam, we have put together the information on the Communication Network. The Communication Network consists of:

- Overhead Paging
- Patient TV's
- Infant Security
- Security System
- Access Control
- Video Intercom (this is a part of Access Control)
- ED Radio System (base station)
- Phone System
- Wireless Access Points
- Computers and Printers
- Server Room Equipment

The attached information includes the above items, GMP, Rexmoore, Current Forecast, and Variance numbers. Also, the projected Total Cost of Ownership Model for Voice and Data.

Scott

Description	Sub -Tiers	GMP	Rex Moore's	Current Forecast	Variance	Remarks
Structured Cabling		**$322,202**	**$310,700**	**$310,700**	**($11,502)**	Bid Amount
Low Voltage						
	Overhead Paging		$43,241	$72,077		Bid Amount
	CATV (TV's)		$139,065	$139,065		Budget
	Infant Security		$71,259	$165,792		Bid Amount: Includes pediatric and geriatric security. Ref. COR 35
	CCTV (security)		$40,084	$135,000		Budget: Increased security scope. Pending approval of IB 151, in production
	Access Control		$79,763	$200,000		Budget: Increased access control. Pending approval of IB 12 at OSHPD
	Video Intercom		$5,815	$50,000		Budget
	Radio System		$31,395	$31,395		Bid Amount
	Subtotal	**$377,798**	**$410,622**	**$793,329**	**$415,531**	
Costs not included in GMP						
	VOIP	$0	$0	$958,766	$958,766	Bid Amount
	WAPs	$0	$0	$36,000	$36,000	Budget
	Computer/Printers	$0	$0	$130,000	$130,000	Budget
	Server Room Equipment	$0	$0	$100,000	$100,000	Budget
TOTALS		**$700,000**	**$721,322**	**$2,328,795**	**$1,628,795**	

Northern Inyo Hospital

Projected Total Cost of Ownership (TCO) Model for

Voice & Data Systems

Developed for Budgetary & Planning Purposes Only

Notice: This document and its contents are intended for use only by Northern Inyo Hospital. All information contained in or disclosed by this document is considered CONFIDENTIAL and PROPRIETARY.

Growth Factor for Years 2-10: 2% | Upgrade Factor: 10% | Inflation Factor: 3%

Item	DESCRIPTION	Total Cost Year 1	Total Cost Year 2	Total Cost Year 3	Total Cost Year 4	Total Cost Year 5	Total Cost Year 6	Total Cost Year 7	Total Cost Year 8	Total Cost Year 9	Total Cost Year 10	Total Years 1-10
	VoIP Phone System				UPGRADE YEAR				UPGRADE YEAR			
1	IP Communication System Call Control / Gateway Hardware	$ 28,154	$ -	$ -	$ 2,816	$ -	$ -	$ -	$ 3,098	$ -	$ -	$ 34,078
2	IP Communication System Call Control / Gateway Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	IP Communication System Licensing Costs	$ 62,568	$ 1,251	$ 1,251	$ 1,251	$ 1,276	$ 1,276	$ 1,276	$ 1,276	$ 1,276	$ 1,276	$ 73,980
4	Basic IP Phones	$ 5,880	$ 118	$ 118	$ 118	$ 120	$ 120	$ 120	$ 120	$ 120	$ 120	$ 6,953
5	Standard IP phones	$ 73,320	$ 1,466	$ 1,466	$ 1,466	$ 1,496	$ 1,496	$ 1,496	$ 1,496	$ 1,496	$ 1,496	$ 86,694
6	Advanced IP phones	$ 4,497	$ 90	$ 90	$ 90	$ 92	$ 92	$ 92	$ 92	$ 92	$ 92	$ 5,317
7	ACD Agent IP Phone	$ 3,384	$ 68	$ 60	$ 352	$ 75	$ 75	$ 75	$ 634	$ 75	$ 75	$ 4,879
8	Analog Conference Phone (i.e., Polycom)	$ 441	$ 9	$ 9	$ 46	$ 10	$ 10	$ 10	$ 83	$ 10	$ 10	$ 536
9	IP Conference Phone (i.e., Polycom)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	Attendant Console Hardware/Software	$ 48,829	$ -	$ -	$ 4,883	$ -	$ -	$ -	$ 5,371	$ 1,074	$ 1,074	$ 61,231
11	Messaging Systems/Hardware	$ 4,320	$ -	$ -	$ 432	$ -	$ -	$ -	$ 475	$ -	$ -	$ 5,227
12	Messaging Systems/Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	Messaging System Licensing Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14	Systems Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Advanced Automatic Call Distribution (ACD)/Call Management System Hardware/Software	$ 1,920	$ -	$ -	$ 192	$ -	$ -	$ -	$ 211	$ -	$ -	$ 2,323
16	Advanced Automatic Call Distribution (ACD)/Call Management System Licensing Costs	$ 8,880	$ 178	$ 178	$ 178	$ 181	$ 181	$ 181	$ 181	$ 181	$ 181	$ 10,500
17	Call Recording / Quality Monitoring	$ 56,436	$ -	$ -	$ 11,287	$ -	$ -	$ -	$ 13,545	$ -	$ -	$ 81,268
18	Mobility/Fixed-Mobile Covergence Solution (Include all hardware, and software (associated with PBX integration))	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19	Network Monitoring, Analysis, and Reporting Tools Hardware/Software	$ 36,385	$ -	$ -	$ 3,639	$ -	$ -	$ -	$ 4,002	$ -	$ -	$ 44,026
	Services and Support				UPGRADE YEAR				UPGRADE YEAR			
20	Training (End User, Advanced User, Operator & Sys Admin)	$ -	$ -	$ -	$ 1,500	$ -	$ -	$ -	$ 1,500	$ -	$ -	$ 3,000
21	Vendor provided System Administration Certification Training	$ 11,297	$ -	$ -	$ 3,000	$ -	$ -	$ -	$ 3,000	$ -	$ -	$ 17,297
22	Project Management Fees	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	Installation and Professional Services (Phase 1 & 2)	$ 103,599	$ -	$ -	$ 8,827	$ -	$ -	$ -	$ 10,093	$ -	$ -	$ 122,519
24	LAN/WAN Network Readiness Assessment	$ 9,643	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,120	$ -	$ -	$ 17,763
25	Year One Maintenance (8x5 Response)	$ 46,859	$ 46,859	$ 46,859	$ 47,796	$ 47,796	$ 47,796	$ 47,796	$ 48,752	$ 48,752	$ 48,752	$ 478,018
26	Subscription Service (3-year pre-paid)	$ 23,409	$ -	$ -	$ 28,091	$ -	$ -	$ 28,091	$ -	$ -	$ 28,091	$ 107,682
27	Miscellaneous	$ 13,204	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,204
28	Shipping	$ 6,384	$ 32	$ 32	$ 267	$ 32	$ 32	$ 32	$ 306	$ 43	$ 43	$ 7,205
29	Applicable Taxes	$ 32,478	$ 278	$ 278	$ 2,341	$ 284	$ 284	$ 284	$ 2,676	$ 378	$ 378	$ 39,661
30	Other	$ 357	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 357
	SUBTOTAL 1 PROJECTED COSTS	$ 582,253	$ 51,659	$ 53,369	$ 129,244	$ 57,526	$ 59,067	$ 93,755	$ 127,067	$ 66,337	$ 103,617	$ 1,324,113
	Network / LAN Electronics Remediation				UPGRADE YEAR				UPGRADE YEAR			
31	Network / LAN Electronics Hardware	$ 231,547	$ 4,631	$ 4,631	$ 24,081	$ 5,113	$ 5,113	$ 5,113	$ 43,360	$ 5,113	$ 5,113	$ 333,813
32	Installation and Professional Services (Phase 1 & 2)	$ 13,595	$ -	$ -	$ 7,947	$ -	$ -	$ -	$ 14,309	$ -	$ -	$ 35,851
33	Year One Maintenance	$ 28,621	$ 28,621	$ 28,621	$ 29,193	$ 29,193	$ 29,193	$ 29,193	$ 29,777	$ 29,777	$ 29,777	$ 291,968
34	Shipping	$ 4,149	$ 46	$ 46	$ 241	$ 51	$ 51	$ 51	$ 434	$ 51	$ 51	$ 5,171
35	Applicable Taxes	$ 20,260	$ 405	$ 405	$ 2,107	$ 447	$ 447	$ 447	$ 3,794	$ 447	$ 447	$ 29,209
	SUBTOTAL 2 PROJECTED COSTS:	$ 298,172	$ 34,714	$ 35,726	$ 69,290	$ 38,981	$ 40,025	$ 41,069	$ 110,926	$ 43,881	$ 44,943	$ 757,728
	SUBTOTAL PROJECTED COSTS:	**$ 880,425**	**$ 86,573**	**$ 89,095**	**$ 198,534**	**$ 96,507**	**$ 99,092**	**$ 134,824**	**$ 238,013**	**$ 110,218**	**$ 148,560**	**$ 2,081,841**
	Contingency Costs	$ 88,043			$ 19,853				$ 23,801			$ 131,697
	GRAND TOTAL PROJECTED COSTS:	**$ 968,468**	**$ 86,573**	**$ 89,095**	**$ 218,387**	**$ 96,507**	**$ 99,092**	**$ 134,824**	**$ 261,814**	**$ 110,218**	**$ 148,560**	**$ 2,213,538**

END