

Board Meetings

Board Meeting - March 19, 2025

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS - REGULAR MEETING

March 19, 2025, 5:00 pm

Northern Inyo Healthcare District invites you to join this meeting

Connect via Zoom: *(A link is also available on the NIHD Website)*

<https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09>

Meeting ID: 213 497 015

Password: 608092

Phone Connection:

888 475 4499 US Toll-free

877 853 5257 US Toll-free

Meeting ID: 213 497 015

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

Board Member, David McCoy Barrett, will attend from 401 Mercer Street, Seattle, WA 98109, via Zoom.

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

- a. Discuss trade secrets (Health & Safety. Code § 32106 and Civ. Code 3426.1). The discussion will concern a new service line. The estimated date of public disclosure is September 2025.
 5. Return to open session and report on any actions taken in closed session
-
6. Consent Agenda – *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*
 - a. Approval of minutes for the February 19, 2025, Regular Board Meeting
 - b. Approval of minutes for the March 10, 2025, Special Board Meeting
 - c. CEO Credit Card Statements
 - d. Approval of Policies and Procedures
 - i. 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedures
 - ii. Airborne Infection Isolation Rooms (AIIR)
 - iii. Billing Write Off
 - iv. Employee Dissatisfaction
 - v. HVAC Pressure Relations in Critical Areas
 - vi. Purchasing and Signature Authority
 - vii. Quality Assurance and Performance Improvement (QAPI) Plan
 - viii. Travel Between Hospital Locations
 - ix. Weapons Policy
-
7. New Business:
 - a. Chief of Staff Report, Sierra Bourne, MD
 - i. Dr. Wiles – *Information Item*
 - ii. Medical Executive Committee Meeting Report – *Information Item*
 - b. Chief Executive Officer Report (*Board will receive this report*)
 - i. CEO Report
 1. BETA Heart Conference – *Information Item*
 - ii. Chief Human Resources / Chief Business Development Officer Report
 1. CBDO – CHRO Report – *Information Item*
 - iii. Chief Nursing Officer / Chief Operating Officer Report

1. CNO – COO Report – *Information Item*
 - iv. Chief Financial Officer Report
 1. Financial & Statistical Reports (*The Board will consider the approval of these reports*)
-

8. General Information from Board Members (*Board will provide this information*)

9. Adjournment

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

CALL TO ORDER Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm.

PRESENT Jean Turner, Chair
Melissa Best-Baker, Vice Chair
David Lent, Secretary
David McCoy Barrett, Treasurer
Laura Smith, Member at Large

Stephen DelRossi, Chief Executive Officer
Allison Partridge, Chief Operations Officer / Chief Nursing Officer
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, Chief Human Resources Officer, Chief Business Development Officer
Andrea Mossman, Chief Financial Officer
Sierra Bourne, MD, Chief of Staff

TELECONFERENCING Notice has been posted, and a quorum participated from locations within the jurisdiction.

PUBLIC COMMENT Chair Turner reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board.

There were no comments from the public.

EMERGENCY AGENDA ITEM ADDED Toy Cleaning Policy

Under Code § 54954.2(b)(2), the Board of Directors voted to add the 'Toy Cleaning' policy to the agenda.

Motion to add the Toy Cleaning policy on an emergency basis: Lent
2nd: Best-Baker
Roll Call Vote
Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass
Pass 5-0

PUBLIC COMMENT ON CLOSED SESSION ITEMS There were no comments from the public.

ADJOURNMENT TO CLOSED SESSION Adjournment to closed session at 5:07 pm

RETURN TO OPEN SESSION Called back to order at 6:15 pm

Chair Turner stated there were no reportable actions from the closed session.

CONSENT AGENDA

Chair Turner called attention to the consent agenda.

1. The following policies were removed from the consent agenda:
 - a. Billing and Collections
 - b. Billing Write Off
 - c. Finance and Audit Committee Charter
 - d. Financial Assistance and Charity Care Policy
2. Motion to approve remaining items with corrections: Smith
3. 2nd: Best Baker
 - a. Approved with corrections to phone numbers and addresses, grammatical errors:
 - i. Mandated Reporting Child Abuse/Neglect: Dependent Adult/Elder Abuse: Injury by Firearm by Assault/Abuse

Roll Call Vote

Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass

Pass 5-0

NEW BUSINESS

TOY CLEANING POLICY

Motion to approve the “Toy Cleaning Policy”: Lent
2nd: Smith

Roll Call Vote

Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass

Pass 5-0

CHIEF OF STAFF REPORT

Medical Staff Reappointments
Motion to approve Medical Staff Reappointments: Best-Baker
2nd: Lent

Roll Call Vote

Barrett - Pass
Smith - Pass
Lent - Pass

Best-Baker - Pass
Turner - Pass
Pass 5-0

Request for Additional Privileges
Motion Request for Additional Privileges: Best-Baker
2nd: Smith

Roll Call Vote
Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass
Pass 5-0

Medical Staff Initial Appointments
Motion Medical Staff Initial Appointments: Smith
2nd: Best-Baker

Roll Call Vote
Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass
Pass 5-0

Medical Staff Initial Appointments – Proxy Credentialing
Motion to approve Medical Staff Initial Appointments – Proxy Credentialing
: Best-Baker
2nd: Lent

Roll Call Vote
Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass
Pass 5-0

COMPLIANCE OFFICER
REPORT

Chair Turner called attention to the Compliance Officer Report

Motion to approve the 2024 Compliance Officer Report: Best-Baker
2nd: Lent

Roll Call Vote
Barrett - Pass
Smith - Pass

Lent - Pass
Best-Baker - Pass
Turner - Pass

Pass 5-0

Interpreter Services – We now have HIPAA-compliant Pocket Talk device for language interpreter services.

CHIEF EXECUTIVE
OFFICER REPORT

Chair Turner called attention to the CEO Report.

1. Customer Service Training - In February 2025, Partridge and Murray attended a Disney University Institute, where they learned about purpose-driven leadership.
2. Jorie/AI – we continue to work to implement Jorie and its ability to help with efficiency in billing and insurance.
3. Bishop City Council and Townhall Community meeting – NIHD urged community members to attend the monthly Board meetings

CHIEF MEDICAL OFFICER
REPORT

Chair Turner called attention to the CMO Report.

1. In January 2025, we met with Beta Heart to discuss fostering a culture of safety. Staff and providers are excited about this initiative, and safety remains our highest priority.
2. Healthy lifestyle talks – we have strong physician participation.
3. Recruitment – We continue to recruit to expand service lines.

CHIEF FINANCIAL
OFFICER REPORT

Financial and Statistical Reports

Motion to approve Financial and Statistical Report: Smith
2nd: Best-Baker

Roll Call Vote

Barrett - Pass
Smith - Pass
Lent - Pass
Best-Baker - Pass
Turner - Pass

Pass 5-0

Chair Turner called attention to the CFO Quarterly Report.
Discussion ensued.

GENERAL INFORMATION

Chair Turner called attention to General Information.

Director Barrett discussed his recent encounter at the hospital.

Director Lent commented on the potential of Jorie.

Director Turner asked the Executive Team to consider presenting at the annual ACHD conference.

ADJOURNMENT

Adjournment at 7:31 pm.

Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
Laura Smith
Northern Inyo Healthcare District Chair
Secretary

CALL TO ORDER Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm.

PRESENT Jean Turner, Chair
Melissa Best-Baker, Vice Chair
David Lent, Secretary
Laura Smith, Member at Large

Adam Hawkins, DO, Chief Medical Officer
Allison Partridge, Chief Operations Officer / Chief Nursing Officer
Alison Murray, Chief Human Resources Officer, Chief Business Development Officer
Andrea Mossman, Chief Financial Officer
Stephen DelRossi, Chief Executive Officer

ABSENT David McCoy Barrett, Treasurer

PUBLIC COMMENT No public comments were made

NEW BUSINESS Financial Assistance and Charity Care Policy
Bad Debt Policy

Motion to approve policy with corrections: Best-Baker
2nd: Smith
Passed: 4-0

ADJOURNMENT Adjournment at 5:08 pm.

Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
Laura Smith
Northern Inyo Healthcare District Chair
Secretary



March 2025 Statement

Open Date: 02/06/2025 Closing Date: 03/05/2025

Account: [REDACTED]

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [REDACTED]

Cardmember Service [REDACTED]
BUS 30 USB 1 3

New Balance	\$1,152.96
Minimum Payment Due	\$12.00
Payment Due Date	04/01/2025

Activity Summary		
Previous Balance	+	\$5,773.99
Payments	-	\$5,773.99 ^{CR}
Other Credits		\$0.00
Purchases	+	\$1,152.96
Balance Transfers		\$0.00
Advances		\$0.00
Other Debits		\$0.00
Fees Charged		\$0.00
Interest Charged		\$0.00
New Balance	=	\$1,152.96
Past Due		\$0.00
Minimum Payment Due		\$12.00
Credit Line		\$37,500.00
Available Credit		\$36,347.04
Days in Billing Period		28

Payment Options:



Please detach and send coupon with check payable to: U.S. Bank [REDACTED]



24-Hour Cardmember Service: [REDACTED]

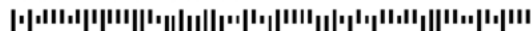
- [REDACTED] . to pay by phone
- [REDACTED] . to change your address

Account Number	[REDACTED]
Payment Due Date	4/01/2025
New Balance	\$1,152.96
Minimum Payment Due	\$12.00

Amount Enclosed \$ _____

NORTHERN INYO HOSPITA
STEPHEN DELROSSI
150 PIONEER LN
BISHOP CA 93514-2556

U.S. Bank
P.O. Box 790408
St. Louis, MO 63179-0408



What To Do If You Think You Find A Mistake On Your Statement

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at: Cardmember Service, P.O. Box 6335, Fargo, ND 58125-6335.

In your letter or call, give us the following information:

- ▶ **Account information:** Your name and account number.
- ▶ **Dollar amount:** The dollar amount of the suspected error.
- ▶ **Description of Problem:** If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake. You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:
 - ▶ We cannot try to collect the amount in question, or report you as delinquent on that amount.
 - ▶ The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
 - ▶ While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
 - ▶ We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than \$50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service, P.O. Box 6335, Fargo, ND 58125-6335

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

Important Information Regarding Your Account

1. INTEREST CHARGE: Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate ("**DPR**") by the Average Daily Balance ("**ADB**") (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you. To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the **ADB** calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.

2. Payment Information: We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, P.O. Box 790408, St. Louis, MO 63179-0408 or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.

3. Credit Reporting: We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.



March 2025 Statement 02/06/2025 - 03/05/2025

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NORTHERN INYO HOSPITA
STEPHEN DELROSSI

Cardmember Service

Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at usbank.com/lcgin.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
02/25	02/25	0000	INTERNET PAYMENT THANK YOU	\$5,773.99CR	
TOTAL THIS PERIOD				\$5,773.99CR	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
02/06	02/05	7841	TST* WHISKEY CREEK BISHOP CA	\$69.30	<u>Recruiting</u>
02/14	02/12	1043	VONS #1753 BISHOP CA	\$113.05	<u>Accounting</u>
02/14	02/12	5448	CREEKSIDE INN 760-8723044 CA FOLIO: 34679	\$123.21	<u>Rev Cycle</u>
02/28	02/27	5645	AMAZON MKTPL*ZV8GU1E2 Amzn.com/bill WA	\$66.83	<u>Employee Recog.</u>
02/28	02/28	4031	FACEBK *STFNLLKU2 650-5434800 CA	\$400.00	<u>Marketing</u>
03/03	02/28	5519	NPDB NPDB.HRSA.GOV 800-767-6732 VA	\$2.50	<u>Credential</u>
03/03	02/28	5691	NPDB NPDB.HRSA.GOV 800-767-6732 VA	\$2.50	<u>Credential</u>
03/03	02/28	5774	NPDB NPDB.HRSA.GOV 800-767-6732 VA	\$2.50	<u>Credential</u>
03/03	02/28	5857	NPDB NPDB.HRSA.GOV 800-767-6732 VA	\$2.50	<u>Credential</u>
03/03	02/28	5931	NPDB NPDB.HRSA.GOV 800-767-6732 VA	\$2.50	<u>Credential</u>
03/03	02/28	4021	FACEBK *P8PJ9K4LU2 650-5434800 CA	\$7.23	<u>Marketing</u>
03/05	03/04	7351	NPDB NPDB.HRSA.GOV 800-767-6732 VA	\$2.50	<u>Credential</u>
03/05	03/04	1169	TST*MAMMOTH ROCK N BOW Mammoth Lakes CA	\$358.34	<u>Recruiting</u>
TOTAL THIS PERIOD				\$1,152.96	

2025 Totals Year-to-Date	
Total Fees Charged in 2025	\$0.00
Total Interest Charged in 2025	\$0.00

Company Approval

(This area for use by your company)

Signature/Approval: _____

Accounting Code: _____

Continued on Next Page



March 2025 Statement 02/06/2025 - 03/05/2025

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NORTHERN INYO HOSPITA
STEPHEN DELROSSI

Cardmember Service



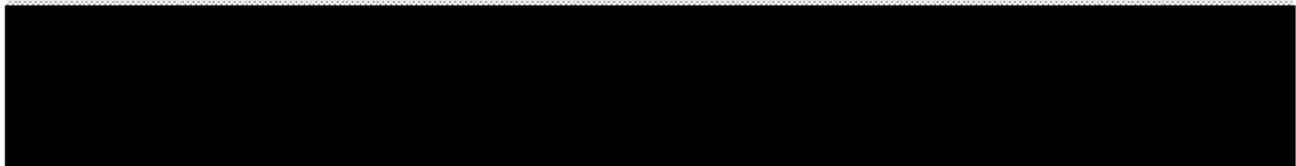
Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

**APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	\$0.00	\$0.00	YES	\$0.00	23.24%	
**PURCHASES	\$1,152.96	\$0.00	YES	\$0.00	23.24%	
**ADVANCES	\$0.00	\$0.00	YES	\$0.00	29.99%	

Contact Us



End of Statement

NORTHERN INYO HOSPITA

Time to update your email? Check your usbank.com profile

Dont miss out on exclusive offers and important updates.
Simply provide your current email address and opt into marketing,
then enjoy all the benefits of your U.S. Bank account.

You may change your email marketing preferences at any time in the Privacy section of usbank.com. Note that confidential, personal or financial information will never be sent or requested in an email from U.S. Bank.



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedure		
Owner: PHARMACY DIRECTOR	Department: Pharmacy	
Scope: Pharmacy, Compliance, Fiscal		
Date Last Modified: 02/10/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/19/2016	

PURPOSE:

This policy and procedure is intended to ensure that Northern Inyo Healthcare District (NIHD), which participates in the HRSA 340B Drug Pricing Program, remains compliant with all applicable 340B federal laws and regulations. As such, this policy and procedure should not be interpreted or implemented in a manner that would contradict any such law. Furthermore, the purpose is to define a systematic approach to protect the integrity of and adherence to the rules and regulations of the Health Resources and Services Administration (HRSA) 340B Drug Pricing Program (340B Program).

SCOPE:

This policy and procedure is applicable to Northern Inyo Healthcare District's participation in the 340B drug pricing program, which provides 340B covered outpatient drugs to its outpatients. This document includes guidelines for managing 340B drug purchasing and compliance at NIHD.

DEFINITIONS:

340B Drug Pricing Program: The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. Participation in the Program can result in significant savings on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients, and providing more comprehensive services.

340B Eligible Patient: A patient of a covered entity that meets HRSA's definition of a patient. A 340B Eligible Patient may receive 340B purchased covered outpatient drugs while admitted as an outpatient of a covered entity and/or after receiving treatment and being discharged from the covered entity.

HRSA's definition of a patient requires that (1) the hospital establishes a relationship with the individual, such that the covered entity maintains records of the individual's healthcare; and (2) the individual receives healthcare services from a healthcare professional who is either employed by the covered entity or provides healthcare under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the hospital.

340B Price: The maximum price for a covered outpatient drug that manufacturers can charge covered entities participating in the 340B drug pricing program.

340B Eligible Provider: A Healthcare Professional who is either employed by the covered entity or provides healthcare under contractual or other arrangement, such as a referral for consultation for instance (e.g., a physician specialty practice).

340B Purchased Drugs: Covered outpatient drugs purchased by a covered entity under the 340B Drug Pricing Program.

340B Eligible Location: An onsite or offsite service area or facility (location) that is an integral part of a 340B hospital covered entity, as evidenced by the fact that it has reimbursable outpatient revenue and expense allocated to the hospital's Medicare Cost report.

- Offsite 340B Eligible Locations shall be registered with OPA as soon as possible once listed on the hospital's MCR. All clinics/services of an offsite 340B Eligible Location must be registered as a child site, regardless of whether they are in the same offsite building.
- Expanded care delivery location at same physical address of CE's registered location (parent hospital) will be considered 340B eligible. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion of emergency departments into parking lots.
- Expanded care delivery location of a hospital child-site location of CE will be considered 340B eligible if the care delivered represents an expansion of the currently registered services, falling on the same Medicare Cost Report Line and Trial Balance department code. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion of emergency departments into parking lots.
- An expanded care delivery location might also include mobile delivery care units which have cost and revenue on a reimbursable line of the cost report.

Contract Pharmacy: A pharmacy that is not owned by the covered entity with which the covered entity has a written contract to provide services to the covered entity's patients, including the service of dispensing covered entity-owned 340B drugs.

Contract Pharmacy Arrangement: An arrangement in which a 340B covered entity signs a contract with a contract pharmacy to provide pharmacy services.

Covered Entity: A hospital or other facility enrolled in the 340B Drug Pricing Program and eligible to purchase covered outpatient drugs for 340B eligible patients through the program at 340B prices.

Covered Outpatient Drug: A drug defined in Section 1927(k) of the Social Security Act (42 USC § 1396r-8(k)) that may be purchased, with certain possible exceptions, by covered entities under the 340B Drug Pricing Program.

Diversion Prohibition: The prohibition against the resale or transfer of covered outpatient drugs purchased under the 340B Pricing Program to anyone other than a 340B eligible patient of a Covered Entity.

Duplicate Discount Prohibition: The prohibition against subjecting a manufacturer to providing both a drug at a discounted price under the 340B Pricing Program and also to providing a rebate for the drug under Title XIX of the Social Security Act (Medicaid).

Healthcare Professional: Physician, Nurse Practitioner, Physician assistant, Registered Nurse, Pharmacist, Respiratory Therapists and other licensed professionals who are trained to provide healthcare to patients.

Group Purchasing Organization (GPO): An organization that represents and organizes a group of hospitals to evaluate and select pharmaceutical products. Using the purchasing power of the entire group, the GPO negotiates contracts that are more favorable than a single organization could achieve.

Health Resources Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services that is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated or medically vulnerable.

Medicaid Exclusion File: Covered entities are required to designate in the application process whether 340B drugs will be utilized for Medicaid patients. HRSA maintains this information in the Medicaid Exclusion File which is available to state Medicaid programs. The purpose of this file is to exclude 340B drugs from Medicaid rebate requests. This prevents drug manufacturers from providing duplicate discounts – upfront as the 340B drug price and then later as the Medicaid rebate.

Office of Pharmacy Affairs (OPA): The component within HRSA that administers the 340B Drug Pricing Program. The Office of Pharmacy Affairs is located within HRSA's Special Programs Bureau.

Orphan Drug: Those drugs granted a designation by the Food and Drug Administration (FDA) to treat a rare disease or condition, which the law defines as any disease or condition that affects fewer than 200,000 people in the United States or affects more than 200,000 people but drug sales would not cover the costs of developing the drug.

POLICY:

1. Northern Inyo Healthcare District, which is participating in the 340B Drug Pricing Program as a covered entity, will adhere to all applicable 340B federal laws and regulations.
2. Northern Inyo Healthcare District will be responsible for implementing a procedure to ensure compliance with all applicable federal 340B laws and regulations and to ensure that at least the following requirements are met:
 - 2.1. Annual 340B recertification by Northern Inyo Healthcare District is kept current.
 - 2.2. Only 340B Eligible Patients receive 340B purchased drugs to avoid diversion.
 - 2.3. Manufacturers are not subjected to duplicate discounts for 340B drugs purchased by Northern Inyo Healthcare District under the 340B Drug Pricing Program.
 - 2.4. Any drug purchasing restrictions applicable to Northern Inyo Healthcare District are followed. These purchasing restrictions may vary depending on which 340B pricing program Northern Inyo Healthcare District is enrolled under.
 - 2.5. Northern Inyo Healthcare District uses any savings generated from 340B in accordance with 340B Program intent.
 - 2.6. Northern Inyo Healthcare District has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.
 - 2.7. Northern Inyo Healthcare District maintains auditable records demonstrating compliance with the 340B Program.
 - 2.7.1. 340B Program related records and transactions are maintained for a period of three years in a readily retrievable and auditable format.
 - 2.7.2. These records are reviewed monthly as part of its 340B oversight and compliance program.
 - 2.7.3. Northern Inyo Healthcare District engages an independent organization to perform audits of its contract pharmacies. Efforts are made to schedule such audits annually, or as close to annually as is reasonably possible.
 - 2.7.4. The 340B Specialist will be responsible for ensuring compliance with the 340B program. Periodic audits of 340B transactions will be conducted by NIHD.
 - 2.8. Northern Inyo Healthcare District will implement a 340B Oversight Team, for oversight and audit response. The Oversight Team will meet on a quarterly basis to assess the covered entity's overall compliance, address and resolve any lapses in compliance, and otherwise oversee the covered entity's participation in the 340B program.
 - 2.8.1. The 340B Oversight Team will include those staff listed in the procedure below.
 - 2.8.2. The team will also include, either as regularly scheduled participants or ad hoc participants, other employees that are identified as being available to respond to a 340B audit from HRSA/OPA or a drug manufacturer (e.g., compliance staff, legal staff, information technology staff).

PROCEDURE:

1. **340B Eligibility:** Northern Inyo Healthcare District is eligible to participate in the 340B Drug Purchasing Program by meeting the following three criteria for inclusion:
 - 1.1.1. Private non-profit corporation which maintains contract(s) with state or local government for provision of patient services.
 - 1.1.2. Sole Community Hospital (SCH), Critical Access Hospital (CAH), and Rural Referral Center (RRC) must meet eligibility requirements under 42 USC 256b(a)(4)(L)(i). SCHs and RRCs must

also have a disproportionate share adjustment percentage equal to or greater than 8% on the most-recently filed Medicare cost report.

- 1.2. 340B eligible clinic/departments of NIHD have cost and revenue allocated to a reimbursable line of the Medicare cost report, to be eligible for 340B purchasing.
- 1.3. Orphan Drugs: Certain hospitals, including SCHs, CAHs, and RRCs cannot purchase orphan drugs at a 340B price. However, manufacturers may voluntarily provide discounted pricing for their orphan drugs to SCHs, CAHs, and RRCs.
- 1.4. Northern Inyo Healthcare District complies with the following process to review or add new 340B services areas or facilities (locations) in the 340B Drug Purchasing Program:
 - 1.4.1. Northern Inyo Healthcare District's 340B Authorizing Official evaluates a new service area or facility (location) to determine if the location is 340B eligible. If cost and revenue are allocated to a reimbursable line of the cost report 340B drug may begin to be used at the new hospital outpatient department. Once the Authorizing Official or Primary Contact validates that the location appears as reimbursable on NIHD's most recent Medicare Cost Report, the location will be registered on OPAIS.
 - 1.4.2. Northern Inyo Healthcare District location eligibility is validated annually with collaboration of Legal, Finance, and Pharmacy. This is accomplished at the time the Medicare Cost Report is finalized and filed.
 - 1.4.3. The registration of Northern Inyo Healthcare District and its child site locations on the 340B Office of Pharmacy Affairs Information System (OPAIS) is reviewed annually in conjunction with the facility eligibility review. All data on OPAIS is reviewed for accuracy and compliance with guidelines for registration.
 - 1.4.4. Northern Inyo Healthcare District's Authorizing Official and Primary Contact are responsible for completing the OPAIS online registration during open registration periods only.
2. **Recertification:** Annual 340B recertification by Northern Inyo Healthcare District is kept current.
 - 2.1. Northern Inyo Healthcare District's Authorizing Official completes the annual recertification by following the directions in the recertification email sent from HRSA to the Authorizing Official prior to the stated deadline.
 - 2.2. Northern Inyo Healthcare District submits specific recertification questions to 340b.recertification@hrsa.gov.
3. **Patient/Prescriber Eligibility Compliance:**
 - 3.1. An individual is considered a 340B Eligible Patient of Northern Inyo Healthcare District if:
 - 3.1.1. NIHD has established a relationship with the individual, which includes maintaining records of the individual's healthcare.
 - 3.1.2. The individual receives healthcare services from a healthcare professional that is either employed by NIHD or provides healthcare under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the individual's care remains with NIHD.
 - 3.2. An individual is not considered a 340B Eligible Patient of NIHD if the sole healthcare service rendered is the dispensing or prescribing of a drug for self-administration.
 - 3.3. NIHD establishes such relationships with 340B Eligible Patients and provides healthcare services by healthcare professionals (e.g., while onsite and/or remotely via telemedicine services) such that it remains responsible for their care during patient encounters (e.g., in-person and/or remotely via telemedicine services) at a NIHD 340B eligible location(s).
 - 3.4. A 340B Eligible Patient of NIHD is considered qualified for a 340B drug in the following cases:
 - 3.4.1. The patient is a 340B Eligible Patient treated at a 340B Eligible Location and has a legal drug order written by a prescriber employed by, under contract or referral relationship (e.g., physician specialty practice) with NIHD.
 - 3.4.2. The patient is an outpatient at the date/time the drug is administered. Observation patients are classified as outpatients of NIHD.

- 3.4.3. When a patient's status changes to inpatient, then drugs are not accumulated to the 340B account and are then accumulated to the GPO account.
- 3.4.4. Retrospective changes to patient status are not taken into account in either direction (i.e., outpatient to inpatient OR inpatient to outpatient).
4. **Compliance with Duplicate Discount Prohibition:**
- 4.1. NIHD has mechanisms in place to prevent duplicate discounts by ensuring manufacturers are not subjected to Medicaid rebates for 340B purchased drugs.
- 4.2. NIHD ensures that its information on OPAIS and the HRSA Medicaid Exclusion File (MEF) is consistent with actual practice. NIHD informs OPA immediately of any changes to its information on OPAIS/MEF.
- 4.3. **Carve-In:** NIHD does bill Medicaid payers for 340B purchased drugs.
- 4.3.1. NIHD has answered "yes" to the question, "At this site, will the covered entity bill Medicaid fee-for-service for drugs purchased at 340B prices" on the HRSA 340B Database.
5. **Inventory and Procurement:**
- 5.1. **Neutral Inventory:**
- 5.1.1. A virtual GPO-based mixed-use drug inventory is maintained by the hospital pharmacy. Inventory is replenished based on 340B or GPO accumulations processed by NIHD's automated split-billing software system. In operation, patient-specific administered drug charges are sent to the software system daily to be processed. The neutral inventory is replenished on an 11-digit NDC basis with drug order purchases made based on available 340B or GPO accumulations.
- 5.1.2. Once individual accumulations are used, they are decremented from the bank of available accumulations.
- 5.1.3. In exceptional circumstances when 11-digit NDC replenishment is not possible (e.g., NDC availability, inner vs. outer NDC packaging), 9-digit NDC level replenishment may be used.
- 5.1.4. Dispensing staff are not required to make any determinations regarding the drug inventory stock to be utilized when dispensing.
- 5.2. **Direct Purchases:**
- 5.2.1. Covered outpatient drugs not available from the pharmacy wholesaler may be purchased from the manufacturer using a direct account.
- 5.2.2. Separate 340B accounts can be maintained with each manufacturer to purchase 340B drugs.
- 5.2.3. For mixed use areas, a GPO account and 340B account (when possible) is established with each source.
- 5.2.4. Direct purchases will be decremented from the accumulator.
- 5.3. **Crediting and Rebilling:**
- 5.3.1. Credits of purchased drugs and subsequent rebills may be processed in the event a 340B account is utilized for a drug purchase that should have been purchased on a non-340B purchasing account.
- 5.3.2. NIHD may petition the manufacturer, via the distributor, to credit the non-340B purchasing account and rebill the 340B account. The manufacturer may or may not accept NIHD's request.
- 5.4. **Borrow/Lend:**
- 5.4.1. To minimize complexity and compliance risk, NIHD follows a process of borrowing/lending 340B purchased drugs only in emergent situations and not as part of its normal process for inventory replenishment.
- 5.4.2. NIHD may borrow from or loan medications to nearby facilities in emergent situations. The transaction will be logged and the same product NDC will be returned by the borrower.
- 5.5. **Returns/Waste:**
- 5.5.1. **Patient-Specific Waste:** Waste associated with a dosage form of a drug provided (e.g., dispensed, administered) to a patient may be documented and allocated for accumulation and/or purchase based on the patient's eligibility status.
- 5.5.2. **Inventory Waste:** Drug inventory which is wasted/disposed may be documented and allocated for re-accumulation and/or purchased based on applicable pricing and purchase history.

6. 340B Oversight:

6.1. The oversight of the 340B Drug Pricing Program is the responsibility of the 340B Oversight Team, which is comprised of the following individuals:

6.1.1. Pharmacy Director

6.1.2. Authorizing Official

6.1.3. Additional staff: Compliance Officer, Executive Team, and 340B Analyst

6.2. The 340B Oversight Group has the following responsibilities:

6.2.1. Setting the general direction and policy for 340B drug purchasing and compliance.

6.2.2. Establishing a 340B program audit plan for NIHD.

6.2.2.1. Ensure that internal and external self-audits are conducted on a regular basis in accordance with the 340B program audit plan.

6.2.3. Meets on a quarterly to review reports, trends and audit results.

6.2.4. Maintaining information on current best practices by sending key NIHD personnel to related conferences and/or training programs (e.g., webinars, teleconferences).

6.2.5. Providing compliance and oversight direction.

6.2.6. Providing appropriate resources.

6.2.7. Determining needed modifications or expansion.

6.2.8. Communication to hospital leadership of potential changes/trends to the 340B program that will impact the institution.

6.2.9. Assessing discrepancy response, including determining whether or not a material breach has occurred.

6.3. Discrepancies:

6.3.1. NIHD acknowledges that it may be liable to an individual manufacturer of a covered outpatient drug that is the subject of a discrepancy, and depending upon the circumstances, may be subject to repayment.

6.3.1.1. **Material Breach:** Discrepancies that are considered material are self-reported to HRSA as a material breach. A material breach is defined as a discrepancy that results in an impact of more than 5% of the total pharmacy spend in a fiscal year and does not self-correct within six (6) months.

7. Competency:

7.1. Pharmacy staff with 340B procurement responsibilities are provided comprehensive training on the 340B Program and the compliance requirements of this program. This training is completed by pharmacy procurement staff initially upon hire and competency is also verified annually.

REFERENCES:

1. Apexus: <https://www.apexus.com/home/>

2. Section 340B of the Public Health Service Act ("PHSA"), Section 602 of the Veterans Health Care Act of 1992

3. Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, Office of Pharmacy Affairs (OPA): <http://www.hrsa.gov/opa/index.html>

4. HRSA's Final Notice Regarding Manufacturer Audit Guideline and Dispute Resolution Process, 61 Fed. Reg. (Dec. 12, 1996), page 65407:

<https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/disputeresolutionprocess121296.pdf>

CROSS REFERENCED POLICIES AND PROCEDURES:

1. 340B Contract Pharmacy Policy and Procedure

RECORD RETENTION AND DESTRUCTION:

340B records must be maintained for a minimum of three (3) years.

Supersedes: v.4 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedure

Approval



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Airborne Infection Isolation Rooms (AIIR)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Hospital Inpatient		
Date Last Modified: 07-04-2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2017	

PURPOSE:

To provide a negative pressure required for airborne precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei.

POLICY:

1. Airborne Isolation Infection Rooms (AIIR’s) are available:
 - a. Acute-Subacute unit room 5, (this room has an ante chamber, new construction)
 - b. Intensive care unit room 1, (this room has an ante chamber, new construction)
2. All patients with known or suspected serious illnesses transmitted by airborne droplet nuclei will be placed in (AIIR) Rooms if available. If AIIR not available, follow procedure below.
3. Staff to use the below references to determine if infection is airborne, or notify Infection Prevention.
 - a. CDC Appendix A located on Nursing and Physician desktop for duration of needed precautions.
 - b. Lippincott Procedures Airborne Precautions
4. Each AIIR will have a room pressure controller. This controller is designed to maintain a constant pressure differential. The controller has audible and visual alarms. The negative pressure is always on. The door to the room must closed as much as possible.
5. Sputum Inductions will be performed in the Airborne Infection Isolation Room (AIIR) located in ICU room 1 or Acute-Subacute room 5; attempt to use ICU room1 first.

Procedure If NIHD Has Insufficient Isolation Rooms:

If the patient needs an airborne isolation room and there is not one available, place patient in room with door closed and the patient should be a transfer to another facility in a timely manner.

1. Transfers to other facilities: Transfer should occur within 5 hours of identification, unless the initial encounter with patient occurs between 3:30pm and 7:00 am, in which case the patient must be transferred by 11:00 am. If the provider contacts the local health officer and determines that no facility is available to provide Airborne Infection Isolation (AII), then the patient may remain at NIHD, the provider must continue to contact the local health officer and other facilities every 24 hours to attempt the transfer, and at least every 24 hours thereafter, one of the following:
 - a. There is no room or area available within that jurisdiction.
 - b. Reasonable efforts have been made to contact establishments outside of that jurisdiction.
 - c. Applicable measures recommended by the local health officer and the Physician or other licensed health care professional

- d. Patients exhibiting flu like symptoms during flu season or suspected or confirmed COVID-19 do not require referral and transfer.

Exception to above:

1. The patient need not be transferred if the treating physician determines that the transfer would be detrimental to the patient's condition. In that case, the HCW will use all necessary respiratory protection when entering the patient's room. The patient's condition has to be reviewed at least every 24 hours. Once transfer is safe, then it should still occur in the timeframe above.
2. Where it is not feasible to provide Airborne Infection isolation rooms or areas to individuals suspected or confirmed to be infected with or carriers of novel (ex: Flu, COVID-19) or unknown ATPs, the employer shall provide other effective control measures to reduce the risk of transmission to HCWs, which shall include the use of respiratory protection in accordance with subsection (g) and Section 5144, Respiratory Protection of these orders.

DEFINITION:

- **Airborne Infection Isolation Room (AIIR)** - Formerly, negative pressure isolation room
 - An AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids.
 - AIIRs should provide negative pressure in the room (so that air flows under the door gap into the room); and an air flow rate of 6-12 ACH (6 ACH for existing structures, 12 ACH for new construction or renovation); and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter before returning to circulation.
- **Wall panel:** A panel located outside the ante chamber room that includes an audible and visual alarm to warn staff when pressurization is lost or drifts past the preset pressure value.

PROCEDURE:

- Ensure negative pressure setting light is green and there are no alarms in Acute-Subacute room 5 and ICU room 1.
- Don appropriate PPE for type of precautions while in the antechamber prior to entering the room with the patient. All staff must wear properly fitted N95 mask or Purified Air Powered Respirator (PAPR) before entering room
- Patient must have a surgical mask on when they are admitted to the room, or if they leave the room for a procedure
- Keep door closed between room and antechamber as well as between ante chamber and the hallway.
- Post airborne precautions signs on the anti-chamber door as well as the door to the room itself.
- All Donning and Doffing of PPE should be done in the antechamber.
- When the patient is discharged the room should be cleaned per type of organism.
- If the Airborne Isolation Rooms loses pressurization and does not correct itself by closing the doors, the Maintenance Department must be contacted immediately.

Monitoring AIIRs

- The AIIR is monitored and documented Bi-monthly by the Maintenance Department for the Acute-Subacute room 5 and ICU room 1
- Nursing staff will complete daily verification when a patient in Airborne Isolation is placed in Acute-Subacute room 5 and ICU 1. This is confirmed by ensuring that the green light located on the wall panel is on.

Documentation:

- The date and time the patient was placed in airborne precautions, including confirmation of negative pressure functionality.
- Each shift that the patient remains in airborne precautions with negative pressure operational.
- That correct isolation signage is in place.
- The date and time when the patient is removed from precautions.

REFERENCES:

1. Lippincott Procedures: Airborne Precautions. (Reviewed August 2024). <https://procedures.lww.com/lnp/view.do?pId=3261141&hits=airborne&a=false&ad=false&q=airborne>
2. Centers for Disease Control and Prevention. (2024) Guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings 2007. Retrieved from http://www.cdc.gov/hicpac/2007IP/2007ip_appendA.html
3. Centers for Disease Control and Prevention. (2024) Transmission based precautions. Retrieved from <https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html>
4. Centers for Disease Control and Precautions (2023). III Precautions to Prevent Transmission of Infectious Agents. Retrieved from <https://www.cdc.gov/infection-control/hcp/isolation-precautions/precautions.html>
5. Centers for Disease Control and Prevention. (2024) Appendix B. Air. Retrieved from <https://www.cdc.gov/infection-control/hcp/environmental-control/appendix-b-air.html>
6. Centers for Disease Control and Prevention. (2024). Appendix A Type and Duration of Infections Recommended for Selected Infections and Conditions. Retrieved from <https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html>

CROSS REFERENCES:

1. Airborne Precautions in Lippincott Procedure
2. Aerosolized Transmissible Disease Plan
3. Tuberculosis Exposure Control Plan

RECORD RETENTION AND DISTRUCTION:

Medical records are retained and destroyed per the NIHD Medical Records Department policy and procedure.

Supersedes: v.3 Airborne Infection Isolation Rooms (AIIR)



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: Billing Write Off		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: Revenue Cycle		
Date Last Modified: 01/05/2023	Last Review Date: 01/27/2025	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To ensure compliant coding and billing practices. Maintain and assure the integrity of the hospital’s Accounts Receivable activity. Set forth and define protocol and authority for billing adjustments and or write-off activity.

POLICY: Defined Write-Offs are not permitted by any staff other than those provided the authority by this policy. No Write-Off activity is permitted outside the defined Write-Offs listed in this policy unless directed and approved by the Chief Financial Officer or the Chief Executive Officer.

PROCEDURE:

- **Non-Billable Item**
Items charged to a patient account listed as “non-billable” per Hospital payor contract will be system flagged for Biller to write-off the patient account as claim final bills. Payor Non-Covered items are not submitted to the payor or patient.
- **Non-Covered Services - Payor Contract**
Non-covered services performed outside payor contract are not billed to patient if District did not inform patient of non-covered service prior to service. Charges are written off by billing staff using the Non-Covered Write-Off code.
- **Denials - Payor Contract**
Unresolvable account denials for unforeseen non-covered service will be written off by the business office to the code Insurance Contractual. Items above \$1,000.00 will be submitted to the business office manager for review and approval. Items above \$2,500.00 will be submitted to the Chief Financial Officer for review and approval. Sufficient documentation is required to review and approve the write off.
- **Billing Process Related Denials**
Unresolvable denials related to “Billing Process” activities for covered services are written off by the business office using the Administrative Write-Off code. Items above \$1,000.00 will be submitted to the business office manager for review and approval. Items above \$2,500.00 will be submitted to the Chief Financial Officer for review and approval. Sufficient documentation is required to review and approve the write off.
- **Administrative Adjustment Write-Off (Discretionary)**
When it is determined that reimbursable services should be written off based on factors of unfavorable business outcomes, or other discretionary purposes, balances are adjusted using the administrative

adjustment code. Such discretion may be out of concern for patient relation purposes; billing or clerical error/oversight affecting reimbursement not related to activities covered in other policies.

- **Small Balance Write-Off**

Small balance write-offs are patient account balances that do not merit the time and cost of sending a bill to the patient. The threshold for small balance write-offs is \$9.99 or less.

Monitor all write off activity for unusual activity, trends, accuracy, and adherence to policy.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:

Maintain records for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Charge Reduction or Removal at Department Level

Supersedes: Not Set



NORTHERN INYO HEALTHCARE DISTRICT EMPLOYEE HANDBOOK

Title: Employee Dissatisfaction		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 02/10/2025	Last Review Date: 08/19/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY:

If you have a complaint about your job, you should discuss it with your supervisor or department head. If an agreeable solution is not reached, you may take your complaint to a member of the Executive Leadership team. It is the responsibility of the immediate supervisor to offer suggestions, make recommendations, and provide the necessary guidance regarding employees' performance or conduct on the job. If you have a problem that you feel you cannot discuss with your supervisor or department head, you may contact the Administrator. Despite our sincere desire to provide all employees with pleasant and satisfying employment, it is possible that disagreements and misunderstandings will arise. Remember, we cannot help you solve problems that we don't know exist. If you have a problem, we want to know it. We want it resolved as much as you do, so let us know.

~~Remember, we cannot help you solve problems that we don't know exist. If you have a problem, we want to know it. We want it resolved as much as you do, so let us know.~~

RECORD RETENTION AND DESTRUCTION:

Human Resources records are kept for the duration of employment, plus 10 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Employee Complaints and the Grievance Process
- ~~2. Conferences with Supervisors~~
- ~~3.2.~~InQuiseek – #400 General Employment Policies
- ~~4.3.~~InQuiseek - #520 Grievance Policy

Supersedes: v.2 Employee Dissatisfaction, <u>v.2 Conferences with Supervisors</u>
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: HVAC Pressure Relations in Critical Areas		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Hospital Wide		
Date Last Modified: 02/10/2025	Last Review Date: No Review	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

In critical care areas designed to control airborne contaminants, the ventilation system provides appropriate pressure relationships, air exchange rates, filtration efficiencies, temperature, and humidity. This policy ensures compliance with applicable California regulations and The Joint Commission standards.

POLICY

It is the policy of the Northern Inyo Healthcare District (NIHD) that all ventilation systems shall be installed and maintained in a manner that will ensure that the appropriate pressure relationships, air exchange rates, and filter efficiencies are in place for ventilation systems serving areas specifically designed to control contaminants (e.g., biological agents, gases, fumes) in compliance with applicable California and federal regulations, including The Joint Commission standards.

PROCEDURE

1. General Compliance and Guidelines

1.1. The Maintenance Department Director will ensure all specially designed ventilation areas requiring pressure relationships, air exchange rates, filter efficiencies, temperature, and humidity comply with:

- California Building Standards Code (Title 24, CCR, Part 4).
- Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines).
- The Joint Commission Standards (EC.02.05.01 EP15).
- CDC Guidelines for Environmental Infection Control in Health-Care Facilities.

1.2. Critical areas and their criteria for design and updates will align with the latest California and federal standards.

2. Monitoring and Testing

2.1. The following areas require regular monitoring and testing:

- **Operating Rooms (ORs):** Positive pressure with air exchange rates of 20 ACH minimum.
- **Isolation Rooms:** Negative pressure with a minimum differential of -0.01-inch water column.
- **Special Procedure Rooms:** Positive pressure with appropriate air exchanges and filtration.
- **Sterile Processing Departments (SPD):** Positive pressure in clean areas and negative pressure in decontamination areas.
- **Pharmacy Cleanrooms:** Positive or negative pressure based on compounding requirements under USP 797/800.

2.2. Pressure, temperature, and humidity are monitored through the Building Automation System (BAS).

3. Scheduled Maintenance and Testing Frequency

3.1. Regular maintenance includes:

- Semi-annual particulate and air exchange rate testing for ORs and procedure suites.
- Semi-annual testing and filter replacement for isolation and reverse isolation rooms.
- Daily testing of isolation rooms while in use.
- Semi-annual testing of Biological Safety Cabinets (BSCs) and Chemical Fume Hoods (CFHs).
- Quarterly verification of pressure relationships in critical areas.

3.2. Construction sites are maintained with negative air machines and tested daily to prevent dust transmission.

3.3. All testing is documented and retained in the Maintenance Department. Active construction documentation is maintained by the Project Manager until project completion and then turned over to Facilities Management.

4. Temperature and Humidity Management

4.1. Operating room temperatures shall range from 64° to 73°F with a relative humidity of 30% to 60% (or CMS waiver-approved range of 20% to 60%). Any changes to these ranges must be approved by the Infection Preventionist Manager, Maintenance Manager, and Surgery staff.

4.2. Out-of-range conditions trigger alerts monitored by Maintenance. If sustained beyond 4 hours, corrective actions are implemented, including:

- System adjustments and inspection of Air Handling Units (AHUs).
- Notification of the Infection Preventionist Manager, Facilities Director, and Surgery DON if unresolved within 28 hours.

5. Documentation and Reporting

5.1. Documentation of pressure testing, temperature, and humidity monitoring is maintained in the Maintenance Department for a minimum of three years.

5.2. Any deficiencies and corrective actions are reported to the Safety Committee.

6. Verification and Commissioning

6.1. Qualified service providers verify volume flow rates, pressure relationships, and air exchange rates during commissioning of new projects and major renovations.

6.2. Periodic testing throughout the hospital investigates complaints related to indoor air quality and adjusts HVAC systems as needed.

7. Temporary Mitigation Measures

7.1. When systems cannot meet code requirements, the Maintenance Department collaborates with the Infection Preventionist Manager to implement temporary measures, such as portable HEPA filtration units, until permanent solutions are in place.

7.2. Recommendations for upgrades or replacements are submitted to the CEO and Board as needed.

8. Special Considerations for Critical Areas

8.1. Areas included in this program are:

- Operating rooms (all classes).
- Procedure rooms (e.g., bronchoscopy, endoscopy).
- Isolation rooms (airborne infection isolation and reverse isolation).
- Protective environments (e.g., bone marrow transplant units).
- Pharmacies and sterile processing rooms.
- Laboratories and sterile spaces with specific pressure requirements.

REFERENCES:

1. California Building Standards Code (Title 24, CCR, Part 4).
2. The Joint Commission CAMCAH Manual (EC.02.05.01 EP15).
3. FGI Guidelines for Design and Construction of Health Care Facilities.
4. CDC Guidelines for Environmental Infection Control in Health-Care Facilities.
5. USP 797 and USP 800 Standards.
6. CMS Memorandum (S&C: 13-25-LSC & ASC, April 19, 2013).

RECORD RETENTION AND DESTRUCTION: N/A

CROSS-REFERENCED POLICIES AND PROCEDURES:

Supersedes: v.1 Installing & Maintaining Appropriate Pressure Relations in Critical Areas EC.02.05.01 EP 15

Approved



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: Purchasing and Signature Authority		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: District Leadership		
Date Last Modified: 03/09/2023	Last Review Date: 01/27/2025	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2016	

PURPOSE:

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

POLICY:

1. Established purchase levels are tiered in low, mid and high value purchasing authority. All purchases including purchase orders and check requests will follow these guidelines as outlined in the procedure below. The only exception made is for emergency purchases as outlined in the Emergency Purchases Policy.
2. Only those employees given explicit written authority by the Northern Inyo Healthcare District (NIHD) Board of Directors, currently the Chief Executive Officer (CEO) or designee may execute the procurement agreements. (Written procurement agreements contractually bind the District and a supplier to a purchasing obligation.) Such written authority includes terms and conditions, typically including a review by the Compliance Officer and all such terms and conditions are legally binding.
3. Group Purchasing Organization (GPO) contracts, approved by the CEO, allow Directors to work within the terms stipulated. Various departments utilize GPO contracts without requiring new signatures per the established purchasing levels.

PROCEDURE:

1. Purchase Levels are established in the following manner:
 - i. Authorization of Purchases up to \$1,000 require the signature of manager level (or higher) associated with the cost center.
 - ii. Purchase requests over \$1,000 and below \$2,500 require the signature of a director level (or higher) member of the NIHD Management team associated with the cost center.
 - iii. Purchase requests above \$2,500 and below \$5,000 require the signature of an executive level member of the NIHD team.
 - iv. Over \$5,000 and below \$40,000 require the signature of the CEO or in his/her absence the Administrator-On-Call (AOC) for emergency purchases.
 - v. All purchase requests above \$40,000 require the approval of the NIHD Board of Directors with the exception of Capital Approved purchases that were part of the NIHD Board Budget approval process. See Capitalization of Asset policy for specific information on capital purchase limits.

- vi. All checks for payments based on any paid invoices are subject the Check Signing Policy regardless of purchase approval level.
2. Materials Management via Purchasing Department with Predetermined Catalog items
 - i. Board of Directors approves the annual District budget, which includes materials supplied via the Purchasing Department.
 - ii. Pre-established Periodic Automated Replenishing (PAR) levels based on department needs are built into the District's information system.
 - iii. Upon documented use of items, District Information System reorders the items necessary to maintain PAR stock.
 - iv. Items reordered within the PAR do not fall into the need for purchase orders or signature requirements listed within procedure #1.
 - v. Special order items, not routinely requested or on the PAR, do fall under the purchase signature requirements listed within procedure #1.
3. Reporting violations for complaints or concerns regarding compliance with the above, please contact the Chief Finance Officer (CFO) or the Compliance Officer.

REFERENCES:

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

RECORD RETENTION AND DESTRUCTION:

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

CROSS REFERENCE POLICIES AND PROCEDURES:

1. [Capitalization of Assets](#)
2. [Check Signing](#)
3. [Emergency Purchases](#)

Supersedes: v.3 Purchasing and Signature Authority*



**NORTHERN INYO HEALTHCARE DISTRICT
ANNUAL PLAN**

Title: Quality Assurance & Performance Improvement (QAPI) Plan		
Owner: Manager of Quality and Survey Readiness		Department: Quality
Scope: District Wide		
Date Last Modified: 02/10/2025	Last Review Date: No Review Date	Version: 7
Final Approval by: NIHD Board of Directors		Original Approval Date: 2016

Northern Inyo Healthcare District
**QUALITY ASSURANCE AND
PERFORMANCE IMPROVEMENT (QAPI)
PLAN**

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Approval

SECTION 1: INTRODUCTION

PURPOSE

The Quality Assurance and Performance Improvement (QAPI) Plan establishes a district-wide program for an interdisciplinary and ongoing approach to monitor, assess, and improve patient care and services at Northern Inyo Healthcare District (NIHD). The QAPI Plan is designed to support the Mission and Values of the District and collectively drive the safety and quality of patient care services provided.

MISSION AND VALUES

The Northern Inyo Healthcare District mission statement is as follows:

Our purpose is your health; our passion is your well-being.

VALUES: RESPECT, COMPASSION, STEWARDSHIP, EXCELLENCE, ACCOUNTABILITY

This set of values are the foundation on which all actions and decisions of the District are based.

SCOPE OF SERVICE AND AUTHORITY

The scope of this plan will include all patient care and support services throughout the District. The plan will measure, analyze, and track performance improvement indicators and other aspects of the quality of care. The plan reviews the District's operating systems and processes of care to identify and implement opportunities to provide high quality and safe care, focusing on improving health outcomes as well as preventing and reducing medical errors.

NIHD's Board of Directors is responsible for this plan, which supports the mission, vision, and values of the District and is ultimately responsible for ensuring that the QAPI Plan activities are met. The Board of Directors delegates the development, implementation, and sustainability of the plan to the Quality Department and Executive Team.

NIHD's Executive Team delegates the implementation of the QAPI Plan to the Quality Department. The Executive Team ensures resources are available for the implementation of quality and performance improvement activities.

NIHD's medical staff is responsible for participating in the QAPI Plan to achieve quality and safe patient care. Medical staff members contribute to the QAPI Plan through involvement in performance improvement activities, serving on committees, working on project teams, and through taking on leadership roles.

DEFINITIONS AND PRINCIPLES

QUALITY SERVICES

Quality services are services that are provided in a safe, effective, patient-centered, timely, efficient, and equitable fashion.

- **SAFE:** Avoiding injuries to patients from the care that is intended to help them.
- **EFFECTIVE:** Providing services based on scientific knowledge to those who would benefit, and refraining from providing services from those not likely to benefit.
- **PATIENT-CENTERED:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values.
- **TIMELY:** Reducing delays in providing and receiving healthcare.
- **EFFICIENT:** Avoiding waste, including waste of equipment, supplies, and energy.

- **EQUITABLE:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

ADVERSE EVENT

Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.

ERROR

Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.

MEDICAL ERROR

Medical error means an error that occurs in the delivery of healthcare services.

HEALTH EQUITY

The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

SOCIAL DETERMINANTS OF HEALTH (SDOH)

The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

PERFORMANCE IMPROVEMENT PRINCIPLES

Performance improvement is a systematic approach of assessing services and improving them on a priority basis. The District's approach to performance improvement is based on the following principles:

- **Patient Focused.** Every level of service shall be viewed from the perspective of the patient. With this frame of mind the District will focus on the patient experience and how best to adopt changes that enhance the experience.
- **Workforce Engagement.** All NIHD workforce members shall participate in ongoing quality improvement. Workforce members shall understand that along with ownership of how they engage those who contact or present to the District they are also empowered to identify issues, bring those issues to the attention of others, and participate in processes intended to prevent or improve the issue.
- **Leadership Involvement.** District leadership along with medical staff will serve as 'champions' of initiatives. As champions, they will support, promote, and provide necessary intervention when needed to achieve goals. Additionally, District leadership will ensure that the employees engaged in any given quality initiative have the tools, support, and resources needed to achieve the defined goals.
- **Data Informed Practice.** The District utilizes data to identify opportunities, determine priorities, and evaluate the effectiveness of quality projects.
- **Statistical Tools.** The District will apply standard statistical tools to the data collected in order to generate information that is both informative and actionable.
- **Prevention over Correction.** Although this QAPI Plan will provide for the identification of existing issues/concerns and correcting them, the goal of this QAPI Plan is to emphasize the identification of potential areas of concern to prevent quality of care issues from arising.
- **Continuous Improvement.** The District will commonly use Plan-Do-Study-Act method of continuous improvement.

- Equitable. Health care will be delivered in a manner where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

SECTION 2: PROGRAM STRUCTURE

LEADERSHIP

The key to the success of performance improvement is leadership. Leadership fosters teamwork and provides support to the quality improvement goals, objectives, and activities.

Leadership utilizes performance improvement methodology to identify opportunities for improvement and to monitor the effectiveness, safety, and quality of services provided. They accomplish this by:

- Implementing quality and performance activities that align and support the QAPI Plan.
- Reporting and monitoring indicators on departmental pillars/scorecards.
- Communicating and sharing results of measurement activities and overall performance.

The Quality Department provide ongoing operational oversight of the quality and performance improvement activities at the District.

The Quality Department drives the development of quality and performance improvement activities at the District and participates in committees and project teams related to improving quality of care. The department assists the District in fulfilling its responsibilities to assure patients receive quality care which also complies with regulatory and accreditation organizations. It does this by:

- Developing the annual QAPI Work Plan.
- Establishing measurable objectives based upon identified priorities for improving quality and safety of services.
- Continuously monitoring regulatory standards and District performance.
- Supporting quality improvement activities.
- Monitoring progress until goals have been met and maintained.
- Standardizing processes to achieve quality improvement in patient care services.
- Evaluating and making recommendations for improvement to the QAPI Plan.
- Reviewing and assessing feasibility of requests for quality related projects.
- Appointing subcommittees or teams to work on specific quality projects as necessary.
- High level trending of data to identify opportunities for improvement.
- Prioritizing QAPI projects and making recommendations to the Executive Team.
- Overseeing the progress of quality projects to assure timely implementation.
- Utilizing regulatory requirements to identify opportunities for improvement.

WORKFORCE MEMBERS

The Northern Inyo Healthcare District Workforce, including the medical staff, play a vital role in the QAPI Plan. The workforce participates and contributes to the Plan through their delivery of quality of care. Workforce members may be asked to participate in committees, project teams and other initiatives.

Workforce members, including individual members of the medical staff, are invited to bring forth ideas and suggestions for performance improvement activities to their department leaders, chairs or directly to the Quality department.

GOALS & OBJECTIVES

The goals of the QAPI Plan are to ensure that quality and safe care is provided to all patients throughout the District. The plan sets forth the manner in which the District identifies quality and performance opportunities, implements improvement activities, and ensures monitoring and sustainability of activities. The QAPI Plan takes a pro-active approach at identifying priorities and aligns with the District Strategic Plan on quality improvement and safety.

The following objectives have been established as long-term goals of the QAPI Plan.

- To evaluate and improve performance measurement systems to assess key processes or outcomes.
- To bring leaders, clinicians, and staff together to review data and clinical adverse occurrences to identify opportunities for improvement.
- To carefully prioritize identified opportunities or desired projects and set goals for their resolution.
- To achieve measurable improvement in highest priority areas for the selected goals.
- To meet internal and external reporting requirements.

Annually, a Work Plan (Attachment) is established to address the goals and objectives that have been identified as high priority, high volume, or high risk areas. NIHD also prioritizes activities related to improved health outcomes and the prevention and reduction of medical errors, adverse events, acquired conditions and infections; to promote health equity; and improve transition of care.

SECTION 3: PERFORMANCE IMPROVEMENT METHODOLOGY

PERFORMANCE MEASUREMENT

Performance measurement is the process of regularly assessing the results produced by the District. It involves identifying and selecting indicators of processes, systems, and outcomes that are integral to the performance of the service delivery system, and analyzing information related to these indicators on a regular basis. Performance improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance improvement they identify.

The purpose of the measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems of a process or outcome.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involves:

- Selection of a process or outcome to be measured.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators show that a process is not stable, is not performing at an expected level or represents an opportunity for improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

PERFORMANCE INDICATORS

A performance indicator, otherwise known as a metric or measure, is a quantitative tool that provides information about the performance of a department's process, services, functions, or outcomes.

Selection of a Performance Indicator is based on the following considerations:

- Alignment with and support of NIHD's mission, vision, and/or values
- Regulatory/accreditation requirement
- Clinical Importance that involves areas or processes that are problem prone, high risk, and/or high volume
- Scientific foundation: Relationship between the indicator and the process, system or clinical outcome.
- Validity: Whether the indicator assesses what it purports to assess
- Meaningfulness: Whether the results of the indicator can be understood, the indicator measures a variable over which NIHD has control, and the variable is possible to change by reasonable performance improvement efforts.
- Availability of industry benchmarks

For the purpose of this plan, performance indicators are tracked and monitored by individual departments, the Medical Staff Office, or the Quality department. Measurement of the metrics may be District-wide in scope, targeted to specific areas, departments, services, or selected populations.

The measurements may be ongoing, time limited, intensive, or recurring. The duration and frequency of monitoring are based on the need of the organization, external requirements, and based on the results of the data analysis.

DATA ANALYSIS & ASSESSMENT

Data analysis is completed through the collection and compilation of information. Internal and external collection is used for monitoring performance and ultimately guide the QAPI Plan in data informed decision making.

Assessment is accomplished by comparing actual performance on an indicator with:

- Trends over time.
- Pre-established standards, goals, benchmarks, or expected levels of performance.
- Evidence-based practices.
- Other hospitals, clinics, or similar service providers.

Data will be assessed for patterns, trends, and/or variations that may identify opportunities for improvement. Data analysis may also be necessary when performance levels or variation indicate a serious event, such as the following:

1. A sentinel event has occurred, triggering a root cause analysis.
2. Performance varies significantly from that of other organizations or recognized standards.

SECTION 4: PERFORMANCE IMPROVEMENT INITIATIVES

The purpose of an initiative is to improve the performance of existing services, quality of care, or to design a new service.

Opportunities for improvement (OFI) may be identified and prioritized through several means, including:

- Results, actions, or recommendation from internal reporting of events (i.e. Unusual Occurrence Reports).
- Results, responses, and status of regulatory and accreditation surveys or District tracer activities.

- Results of operational or process audits.
- Actions and improvements of Root Cause Analyses and/or Failure Modes Effects (and Criticality) Analyses (FMEAs/FMECAs).

SECTION 5: QAPI PLAN EVALUATION

A review of the QAPI plan will occur on an annual basis by the Quality Department and CMO.

REFERENCES:

1. Center for Medicare & Medicaid Services. Conditions of Participation: Quality Assessment and Performance Improvement Program, §485.641.
2. Dixon, L. (2021, March 23) *CMS Hospital Conditions of Participation (CoP) QAPI Standards and Worksheet* [Webinar]. Healthcare Risk Education and Consulting, LLC.
3. The Joint Commission. *Comprehensive Accreditation Manual for Critical Access Hospitals* (2022). LD.01.03.01, PI.01.01.01, PI.02.01.01, PI.03.01.01, PI.04.01.01.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. InQuiseek - #500 Program Evaluation Policy
2. InQuiseek - #510 Quality Assurance and Utilization Review
3. InQuiseek – 530 Risk Management Policy

RECORD RETENTION AND DESTRUCTION:

Maintain quality assurance reviews, investigations and analysis of medication occurrences for ten (10) years.

Maintain quality assurance reviews of mammography until the next inspection, plus six (6) years.

Maintain unusual occurrences reports (UOR), root cause analysis (RCA) records, and laboratory quality data for six (6) years.

Maintain quality data for twenty (20) years.

Supersedes: v.6 Quality Assurance & Performance Improvement (QAPI) Plan



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: Travel Between Hospital Locations		
Owner: Chief Executive Officer		Department: Administration
Scope:		
Date Last Modified: 02/13/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors		Original Approval Date:

PURPOSE:

To define the circumstances under which payment may be made for travel between hospital locations

POLICY:

1. The hospital will compensate employees for travel between hospital facilities under the terms and conditions set forth in this policy.
2. Hospital facilities for which travel compensation is available will be listed on the hospital intranet under Information>Hospital Locations. Any other travel compensation will be in accordance with the Travel Policy.
3. The hospital facility which is the employee’s primary work station will be the “from site” for purposes of this policy.
4. The hospital facility to which an employee travels from the “from site”, when assigned to do so by the employee’s manager, will be the “to site”.
5. Compensation under this policy will only be paid to employees using their own automobiles. Any other method of travel, i.e. foot, bicycle, hospital vehicle, will not be compensated.
6. Employees traveling between facilities will only be compensated for mileage logged on a form provided by the hospital called the “Mileage Log.” The Mileage Log may be paper or electronic at the option of the hospital. The distance for compensation between “from sites” and “to sites” will be predetermined and published by the hospital on the intranet under Information>Hospital Locations.
7. Compensation for travel between hospital facilities will be paid at the current IRS mileage amount times the distance travelled by the employee as documented on the Mileage Log which must be signed by both the employee and the employee’s manager.
8. Applicable taxes will be withheld from the compensation paid pursuant to this policy if such withholding is required by the IRS.
9. The frequency of compensation for travel between hospital facilities will be paid on a schedule determined by the hospital from time to time, but not less than each month.

Approval	Date
Administrator	
Board of Directors	

Responsibility for review and maintenance: Compliance

Index Listings: Travel

Initiated: 8-24-11

Revised/Reviewed:

Approval



**NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY**

Title: Weapons Policy		
Owner: Chief Executive Officer		Department: Administration
Scope: District Wide		
Date Last Modified: 03/09/2023	Last Review Date: 01/27/2025	Version: 2
Final Approval by: NIHD Board of Directors		Original Approval Date: 07/21/2006

PURPOSE:

To set a standard for Northern Inyo Healthcare District workforce related to carrying weapons on District property.

DEFINITIONS:

Pocket Knife: Under California Penal Code Section 17235, all folding knives are legal in the state and can be concealed if they are in the folded position. There is no restriction on the blade length when it comes to owning or possessing a folded knife.

Weapon: An instrument or device designed or used for inflicting bodily harm or physical damage. For example, weapons may include while not being limited to the following: guns, stun guns, knives, swords, pepper or mace spray, etc.

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD’s patients.

POLICY:

NIHD Workforce (excluding NIHD Security Staff), patients, and visitors shall not bring weapons (other than ordinary pocketknives) onto the District premises.

Law Enforcement Officers may carry weapons in the line of duty while on the District Premises.

The District has a zero tolerance for violent acts or threats of violence against employees, or non-employees with whom the District has a business, service, or professional relationship. No employee may commit or threaten to commit any violent act against a co-worker or other individual. This includes, but is not limited to, discussing the use of weapons or bringing weapons onto District property, even in a joking manner. Any employee who is subjected to or threatened with violence by a co-worker or another individual, or is aware of another individual who has been subjected to or threatened with violence, must immediately report this information to Human Resources. When an investigation discloses a violation of this policy, appropriate

disciplinary action may be taken up to and including termination. There will be no retaliation against any workforce member who, in good faith, files such a complaint.

REFERENCE:

1. California Penal Code Section 17235; December 2021.

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES:

1. [Workplace Violence Prevention Plan](#)
2. [NIHD Code of Business Ethics and Conduct](#)
3. [Patients Under Legal or Correctional Restriction](#)
4. [EOP Emergency Response Plan- Active Shooter EM.02.01.01EP2 & SS-EC.02.01.01EP9](#)
5. [Employee Conduct -Performance Improvement and Progressive Discipline](#)

Supersedes: v.1 Weapons Policy



DATE: March 2025
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Alison Murray – CBDO/CHRO
RE: District Updates

REPORT DETAIL

The Department Leaders have contributed to this report with an overview of the ongoing work in their areas of oversight.

Human Resources Highlights

As of March 2025, Northern Inyo Healthcare District (NIHD) employs 421 staff members and 26 contractors/travelers. The department has experienced significant activity in recruitment and staffing this year.

Recruitment

- Recent onboarding included two Surgery RNs, the conversion of a Perinatal Traveler to a permanent staff member, and the addition of an Interim Perinatal Manager.
- Recruitment efforts are focused on sourcing permanent staff for high-demand positions such as Perinatal RN and Physical Therapists.
- Housing remains a challenge for new hires, with the HR Recruitment and Relocation team working closely with travel companies and new hires to secure housing solutions.
- HR also updated recruitment policies and procedures, providing enhanced guidance to department leadership.

Employee of the Month (First Quarter 2025)

- January: Sierra Merchant, Environmental Services Attendant
- February: Elizabeth Kliks, RHC Women’s Health LVN
- March: Leroy Charley, Maintenance Worker 1

Annual Regulatory Assignments for 2025

- Training topics: HIPAA, Patient Rights, Workplace Safety, Infection Control, Diversity, and Cultural Competence.
- Workplace Violence Prevention (WPV): Regular training is provided twice a month, with successful engagement from both new hires and current staff.

Training Compliance for 2024

- Overall Compliance Rate: 75.73% on-time training completion; 97.71% overall training completion.
- Departments with 100% Compliance: Bio Medical Engineering, Central Supply, Compliance, Environmental Services, HR, Infection Control, Kitchen/Dietary, Laundry, Med Staff Office, Medical Records, Pediatric Office, Project Management, Purchasing, Quality, RHC OB GYN Specialty Services, Strategic Communications/Marketing.

New Hire Orientation

- Bi-weekly orientations for up to eight new hires.
- Positive feedback indicating orientations set a strong foundation for integration into the District.

Benefits/LOA

- An increase in Leave of Absence (LOA) requests with 16 active intermittent FMLA cases.
- Completed annual plan review for Defined Benefits and Defined Contribution eligibility and Roth 457(b) retirement setup.

Labor Relations

- Ongoing preparation for union negotiations.

Marketing/Strategic Communications Highlights

Marketing Campaigns

- Commercial Content Production: Featured interviews with Drs. Bo Nasmyth Loy and Christopher Rowan, CMO Adam Hawkins, CEO Stephen DelRossi, and community member Penny McCoy.
- Direct Marketing Postcard Campaign: Reached 7,500 households, promoting pre-pay information and sustaining engagement.
- Expanded Mobile Ad Campaign: Orthopedics featured on shopping carts at Bishop and Mammoth Lakes VONS stores.
- Publications Coverage: Campaigns in The Inyo Register, Sierra Reader, El Sol de la Sierra, and The SHEET.
 - Notable features: Babies on Parade, Breast Cancer Surgery, Community Town Hall, and Holiday Closure Hours.

Social Media Engagement

- Brand Exposure: Increased by 25%, 10% growth in audience, and 33% boost in engagement.
- Highlighted posts: Cervical Health Awareness (37,620 views) and Employee of the Month spotlights (27,000+ views).

Internal and External Communications

- Colleen McEvoy UCSF Honor: Coordinated filming for an honor video, released through media channels.
- Community Engagement: Successful participation in various community events, including Eastern Sierra Cancer Alliance Blue Ribbon Walk and Vitalant Blood Drives.

Event Support

- Employee & Community Events: Supported CASA Wish Tree, Shop with a Cop, and a Food Drive for local pantries.
- Holiday Engagement: Assisted with Holiday Parades and Employee Gift Drives.

Business Development/Grant Writing Highlights

Grant Activities

- Applications Submitted:
 - Flex Care and Flex Care Training through California Hospital Association.
 - SHIP and Rural Health Care Services Outreach Program.
- Awards Received:
 - Flex Care - \$10,000
 - Flex Care Training - \$1,500

Strategic Plan Update

- Community Engagement: Increased involvement with local partners and groups.
- BETA HEART Training: Surveys were completed for staff participation and baseline measurements.
- Union Negotiations: Preparation for the Successor Agreement 2025, set to begin in May.

Government Relations

- Legislation and Federal Tracking: Ongoing monitoring of relevant legislation impacting healthcare services and funding.

Foundation Highlights

Fundraising Goals and Strategy

- Annual Fundraising Goal: \$25,000-\$50,000 with four annual fundraisers.
- Next Fundraiser: Bunco Besties at Whiskey Creek on April 24.
- Review of Financial Investments: Ongoing review of investments with Orion Capital – LPL Financial.

Conclusion

Northern Inyo Healthcare District has made significant strides in recruitment, compliance, and community engagement efforts. As we move through 2025, HR continues to adapt to new challenges, marketing efforts increase outreach, and business development efforts push forward to secure additional funding and strengthen strategic partnerships. We look forward to continuing to serve our community with excellence.



NORTHERN INYO HEALTHCARE DISTRICT

*improving our communities, one life at a time.
One Team. One Goal. Your Health.*

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: March 2025
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Allison Partridge COO-CNO
RE: District Updates

REPORT DETAIL

The Department Leaders have contributed to this report with an overview of the ongoing work in their areas of oversight.

Acute/Subacute and ICU Updates

1. Acute/Subacute and ICU leadership is collaborating with the Rural Health Clinic Care Coordination Team to implement new workflows that ensure inpatients are scheduled for their follow-up appointments seamlessly and efficiently.
2. Acute/Subacute and ICU leadership is developing and implementing a new in-person telemetry-monitoring course focused on the monitoring, care, and management of cardiac/telemetry patients.
3. ICU leadership is collaborating with our cardiopulmonary team to develop and deploy a comprehensive ventilator training course for our ICU RNs.

Perinatal Updates

1. Perinatal leadership has implemented a submersion bathing procedure for newborns, which includes the use of a turtle tub. The specialized tub provides a controlled water temperature for bathing and is an evidence-based method for bathing babies that decreases stress on the newborn (79% less crying) and decreases the time between bathing and the next successful breastfeeding.
2. Perinatal leadership has entered into an agreement with Beta, NIHD's liability insurance provider, to provide Team STEPPS training and follow-up for 2 years. Team STEPPS provides evidence-based methods to improve communication and decrease errors.
3. The Perinatal team is continuing its work with Beta by participating in their Quest for Zero. It focuses on implementing evidence-based policy and practice changes to improve patient care and outcomes.

Emergency Department

1. The Emergency Department team is working on Beta Quest for Zero, Tiers 1 and 2. This year's participation includes both Emergency Department RNs and Physicians. The Emergency Department Physicians are focusing on sepsis, and the RNs are focusing on triage and sepsis.
2. Emergency Department leadership is collaborating with Inyo County in preparation for our annual full-scale County disaster exercise, which will take place on May 3, 2025.

Perioperative

Outpatient/Infusion

1. The Department is currently participating in weekly meetings to prepare for the transition to the new infusion center.
2. The Department is collaborating with our rehabilitation department to optimize the total joint classes.
3. The Department is fully staffed with no travelers.

Surgery

1. Our new Orthopedic Surgeon, Dr. Jeb Reid, has begun doing procedures in the OR.
2. The OR team is excited to share that Dr. Conner Wiles is now doing robotic hiatal hernia surgeries.
3. The OR team is preparing for Dr. Conner Wiles to begin AV fistula procedures for dialysis patients. These procedures will allow patients to avoid traveling out of the area for the procedure, which will be a great benefit to our community.
4. The OR will be fully staffed in April. This will be the first time in 8 years that we have not utilized Travel RNs in the OR.

Infection Prevention

1. The CMS/NHSN Annual Patient Safety Survey for 2024 was completed: Each year, all facilities enrolled in the NHSN Patient Safety Component must complete a survey covering key areas such as laboratory practices, infection control, newborn care, antibiotic stewardship, sepsis management, and water safety. The facility's Infection Preventionist (IP) is typically responsible for completing the survey. At NIHD, we include key stakeholders to ensure comprehensive input. This year, there was also a focus on Hospital-Acquired Infection (HAI) prevention and Venous Thromboembolism (VTE) practices and monitoring. The data collected from this survey plays a vital role in helping NHSN complete a risk adjustment model to predict Standardized Infection Ratios (SIR) for NIHD compared to national benchmarks.
2. In June, Robin Christensen will attend the 2025 APIC National Conference virtually.
3. LVN students are shadowing the Infection Prevention (IP) and Employee Health (EH) teams to enhance their understanding of infection control practices and employee health protocols. This experience provides them with valuable hands-on exposure to essential healthcare practices. We are grateful for this opportunity to contribute to their education and look forward to helping shape and grow the next generation of skilled nurses.
4. NIHD is collaborating with the Mono and Inyo County Coalition on HIPSTER (Highly Infectious Pathogenic, SME, Training, Emerging, & Response.) The goal is to enhance

collaboration among healthcare providers, public health agencies, and community partners to develop and implement strategies that mitigate the risks associated with highly infectious pathogens. This initiative promotes preparedness and coordinating effective response efforts to protect public health. Meetings will be quarterly.

5. The Infection Control Department is collaborating with the Emergency Department OB clinical teams and the Purchasing Department on the new Joint Commission Requirements for High Consequence Infectious Diseases (HCID) (e.g., Ebola, Marburg, and Measles.) This collaboration ensures that NIHD is prepared to care for patients with HCID while safeguarding the care team. The HIPSTER meetings will also provide valuable information and resources to support the hospital's preparedness efforts.

Employee Health

1. The NIHD Flu Vaccination. Goal >/ 72%. As of 2/21/25, we are at 80%.
2. The Employee Health team continues to scan all paper Employee Health records into the electronic health database called Agility. Once the information is uploaded and vaccines and titers are updated, the team will begin implementing a portal allowing employees to access their EH health information directly. It is exciting to transition all records into the electronic system, considering that some employees have been with the organization for 35-40 years. The District implemented the electronic database in August 2022, marking a significant step toward streamlining access to and management of employee health records.
3. Safe Patient Handling (SPH) Training for Clinical Staff Educators (CSEs) and Department Clinical Leads was completed on 2/19/25. Instructors included Marcia Male, RN, Employee Health Specialist, Joanne Henze, Director of Rehab, and Marjorie Routt, Manager of HR. The training intent is to decrease employee and patient injuries with a focus on:
 - a. Risk Factors
 - b. Physical Dependency of the Patient
 - c. Pieces of SPH Equipment
 - d. Patient Handling Episodes
 - e. Demonstration of Body Mechanics
 - f. Injury Prevention
 - g. Muscle Groups for Back Stabilization
 - h. Movements and Positions using Neutral Spine
 - i. Procedures to safely perform manual patient handling when necessary

Facilities Department Update

Environmental Services

1. The Environmental Services Department has 25 full-time employees, with no open positions—an uncommon but positive situation.
2. The Department has welcomed a new Floor Technician. This position focuses on cleaning, maintaining, and improving the hospital flooring.

Laundry Services

1. The Laundry Services Department has four full-time employees and one part-time employee, with no open positions.

2. The Laundry Team has undertaken a special project in collaboration with the Perioperative Team focusing on OR scrub utilization.

Maintenance Department

1. Medical Air Compressor Replacement
 - a. The engineering design is complete, and submission has occurred to the state for permitting.
 - b. Installation is scheduled for April, with a detailed coordination schedule forthcoming.
2. Generator 3 Radiator Replacement
 - a. A new radiator will be installed in the coming months.
 - b. A temporary backup generator will be in place to maintain power.
 - c. The process will take approximately one week with no impact on services.
3. Equipment Repairs & Maintenance
 - a. Laundry Dryer Repair – Repairs are in progress.
 - b. Two-Story Hospital Air Handling Unit -2 – Significant progress has been made in restoring full functionality to this unit.
4. Vendor Evaluations & Cost Optimization
 - a. Actively reviewing vendor partnerships to improve service quality and reduce costs.
 - b. Transitioning away from vendors that fail to meet service expectations or provide adequate value.
5. Roof Leak Repairs
 - a. Assessing costs and developing plans to address roof leaks across the District.

Pharmacy/Infusion Project

1. We received the substantial completion certification from the Department of Healthcare Access and Information (HCAI).
2. Fire Marshal Approval: The local fire marshal completed the site survey, approved fire life safety, and issued Form 850, a requirement for our CDPH certification.
3. USP 797 and 800 Compounding Hoods were certified Thursday, 2/21/25.
4. Flooring Replacement: The Infusion area flooring will be replaced due to moisture-related air bubbles.
5. NIHD is currently in the process of collating the necessary information for submission to CDPH.

Cardiopulmonary (CP)

Echocardiography

1. With Dr. Rowan's arrival, the Cardiopulmonary department has experienced a notable increase in patient volume and service orders. Echo-specific volume has risen by 34% compared to the previous year, with 1219 echocardiograms completed in 2024. The Department continues to monitor capacity across all cardiopulmonary services in response to this growing demand and is expanding resources as necessary to ensure timely appointment scheduling.
2. Echocardiographer Training and Development, we are pleased to announce that Adam Wills, our Echocardiographer trainee, successfully achieved his Registered Diagnostic Medical Sonographer (RDMS) certification in December 2024. A Neonatal Echo Training

Program has been implemented at NIHD to enhance his expertise further, allowing Adam to gain specialized experience in neonatal echo sonography.

3. New Echocardiography Equipment Demonstration: A demonstration of potential new echocardiogram equipment is scheduled for March 2025.

Electrocardiogram (EKG) and Stress Test Volumes

1. The Department has maintained steady volumes of stress tests and EKGs. Additionally, the Department has acquired a fourth pacemaker interrogator from Biotronik, complementing the existing St. Jude, Medtronic, and Boston Scientific pacemakers. This acquisition enhances the variety of services available to the community.

Pulmonary Function Tests (PFTs)

1. PFT's are conducted every Tuesday, with volumes remaining steady.

Respiratory Department

1. The Respiratory Department is fully staffed and is currently completing its yearly competencies.

Fit Testing Workflow Implementation

1. Implementing the new fit testing workflow, where each Department manages its fit testing procedures, is progressing smoothly. Additionally, a new workflow utilizing Smartsheet for conducting monthly checks on Powered Air Purifying Respirator (PAPR) units across the District is being implemented. This will enhance compliance and organizational efficiency.

Diagnostic Imaging (DI)

1. The Diagnostic Imaging Department successfully installed our new Mammography/Stereotactic unit this month and has applied for California state licensing. Our anticipated go-live date is April 1.
2. The Department is evaluating and planning to replace our primary X-ray room, which reached the end of life on 12/31/23.
3. The support structure in Diagnostic Imaging has expanded to include three Lead technologists. Natalie Santana has transitioned to the role of Radiology Information System/ Picture Archiving and Communication System (RIS/PACS) Lead. Natalie joins our lead team, which also includes Talicia Rico, our X-ray/Mammography Lead, and Evan Higginbotham, our CT/MRI lead.

Project Management

1. Our high-priority project with Jorie Revenue AI is progressing to improve key performance indicators. Two of the five areas are live, and several opportunities for efficiency have been identified. The Bots will be rolled out next month after their training is completed.
2. The Cerner Clinical AI Agent (aka CDA) project has its first provider live, completing the pilot testing in the RHC. This implementation supports our providers in having an efficient documentation process to reduce administrative burdens in their clinic days. By the end of next month, we expect to have those providers who wish to use this in the RHC and the Surgery Clinic live, and have a plan for the rollout to other clinics.
3. The Cerner Hub Connection with Toiyabe and Valley Health is making significant progress in connecting our separate systems to receive and send orders and results. This

collaboration will support the continuity of care for our patients in our community. We expect the functionality to be live at Valley Health by the beginning of May and at Toiyabe by the end of May.

4. The move in planning for the new Outpatient Nursing and Pharmacy areas is beginning to ramp up. Exciting milestones have been met in the last couple of weeks, propelling us towards completion. Our teams are working on completing items so we can move into our new spaces this summer.



DATE: March 2025
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Andrea Mossman, Chief Financial Officer
RE: Financial Summary and Operation Insights as of January 2025

Financial Summary

1. Net Income: January's net income was \$173k, which was \$496k higher than last January. This was due to higher volume contributing to higher revenue. For the year, net income was at \$6.2M due to favorable IGT compared to this time last year due to timing of IGT payments being moved to earlier in the year.
2. Operating Income: January's operating loss was \$(50k), which was better than last year due to volume increasing. For the year, operating loss was higher than last year by \$(2.7M) due to higher write-off rates, primarily Medicare and Medicare Advantage along with higher expenses.
3. EBIDA: January's EBIDA was favorable by \$582k due to timing of IGT. For the year, EBIDA was favorable by \$10.5M.
4. Revenue Breakdown: January's gross revenue was down \$(1M) due to 20 less inpatient surgeries compared to last January. However, total admissions and patient days were higher due to medical admissions. For the year, gross revenue was higher by 4% due to increased volumes in most areas but net revenue is lower due to higher write-off rates, primarily in Medicare and Medicare Advantage.

Deductions Summary

1. Contractual Adjustments: Contractual discounts were lower for the month due to better write-off rates compared to last January. For the year, deductions as a % of gross revenue is in line with budget at 47% but slightly lower than prior year.
2. Bad Debt: For January, bad debt declined due to AR >270 days declining significantly.
3. Write-offs: Other write-offs were higher than prior year and budget due to aged AR cleanup.

Salaries

1. Per Adjusted Patient Day / Adjusted Employee per Occupied Bed (Adjusted EPOB): For January and year-to-date, wages per patient were lower than last year due to higher volume in the outpatient and clinic settings.
2. Total Salaries: For January and year-to-date, wages were higher due to higher pay rates and increase employed FTEs.
3. Average Hourly Rate: For the year, average hourly rate was lower than budget yet up 6% compare to last year due to merits.

Benefits

1. Total Benefits: For January and year-to-date, benefits were lower due to reduced medical, dental vision, and federal taxes.
2. Benefits % of Wages: For the year, we were at 43% of wages, which was lower than prior year by (13%).

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For the year, we were (28%) under budget and (18%) under prior year-to-date. This was due to higher volume meaning we were more productive.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For January, we were flat to budget. For the year, we were lower than budget but 3% higher than prior year. This was due to merit increases in wages. For the year, we were at 52% of total expenses and our goal was 50%.

Contract Labor

1. Contract Labor Expense: For the year, contract labor was 8% higher than prior year due to staffing challenges and rates higher than planned.
2. Contract Labor Rates: Rates are higher than budgeted by 32%. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalent (FTEs): For the year, contract labor was 3% higher than prior year.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were (10%) under budget and (17%) under prior year-to-date.

2. Supplies: For the year, supplies were lower than prior year-to-date due to lower pharmacy costs and less surgical supply costs.
3. Total Expenses: For the year, expenses were under budget by (3%) yet 2% higher than prior year. This was due to higher wage costs for increase FTEs and wage rates along with increased utilities.

Stats Summary

1. Admits (excluding Nursery): For January, admits were 14% higher due to medical admits from the ER. For the year, admits were 8% higher due to higher deliveries and medical admits.
2. Inpatient Days (excluding Nursery): For January, inpatient days increased 24%. For the year, inpatient days increased 25%.
3. Average Daily Census: Average census increased 20% compared to last year-to-date.
4. Average Length of Stay (ALOS): Average length of stay increased 11% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 24% higher than last year-to-date.
6. Surgical Procedures: For January, surgeries were (22%) under prior year due to general, ophthalmology and orthopedics. For the year, surgical procedures were (4%) lower with increases in general and urology offsetting with decreases in orthopedics, ophthalmology, and gynecology.
7. Emergency Department (ED) Visits: Emergency visits were higher by 2% compared to last January and year-to-date leading to higher medical admits.
8. Diagnostic Imaging (DI) Exams: For the month and the year-to-date, DI exams were higher by 2%.
9. Rehab Visits: Rehab visits were up 45% compared to last year-to-date due to better staffing and corrected billing issues.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were up 73% compared to last year-to-date.
11. Observation Hours: Observations hours were down (21%) compared to last year-to-date due to change in observation methodology in the women and surgical service lines.
12. Rural Health Clinic (RHC) Visits: For January and year-to-date, RHC was down (2%).
13. Other Clinics: For the year, all clinics increased 13% due to new providers.

Northern Inyo Healthcare District January 2025 – Financial Summary

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
** Variances are B / (W)														
Net Income (Loss)	173,184	(506,953)	680,137	(134%)	(322,849)	496,033	154%	7,492,318	(5,820,545)	13,312,863	229%	1,317,891	6,174,427	469%
Operating Income (Loss)	(50,046)	(784,885)	734,840	(94%)	(404,286)	354,240	88%	(3,749,909)	(7,863,823)	4,113,914	52%	(1,081,864)	(2,668,045)	247%
EBIDA (Loss)	582,348	(143,375)	725,723	(506%)	197,779	384,569	(194%)	10,452,345	(3,275,499)	13,727,844	419%	3,839,194	6,613,150	172%
IP Gross Revenue	3,280,133	3,845,128	(564,995)	(15%)	4,415,671	(1,135,538)	(26%)	24,651,407	25,302,628	(651,222)	(3%)	24,888,321	(236,914)	(1%)
OP Gross Revenue	14,664,711	14,602,264	62,447	0%	14,723,154	(58,443)	(0%)	100,660,232	101,102,195	(441,963)	(0%)	97,002,080	3,658,152	4%
Clinic Gross Revenue	1,862,148	1,720,837	141,312	8%	1,668,331	193,817	12%	12,312,334	11,706,823	605,511	5%	11,034,750	1,277,584	12%
Total Gross Revenue	19,806,992	20,168,228	(361,236)	(2%)	20,807,156	(1,000,164)	(5%)	137,623,973	138,111,646	(487,673)	(0%)	132,925,151	4,698,822	4%
Net Patient Revenue	10,518,255	9,358,079	1,160,176	12%	9,375,055	1,143,201	12%	64,630,827	62,723,238	1,907,590	3%	65,968,710	(1,337,882)	(2%)
<i>Cash Net Revenue % of Gross</i>	53%	46%	7%	14%	45%	8%	18%	47%	45%	2%	3%	50%	(3%)	(5%)
Admits (excl. Nursery)	90	79	11	14%	79	11	14%	524	485	39	8%	485	39	8%
IP Days	282	227	55	24%	227	55	24%	1,818	1,457	361	25%	1,457	361	25%
IP Days (excl. Nursery)	237	216	21	10%	216	21	10%	1,551	1,296	255	20%	1,296	255	20%
Average Daily Census	7.6	7.0	0.7	10%	7.0	0.7	10%	7.2	6.0	1.2	20%	6.0	1.2	20%
ALOS	2.6	2.7	(0.1)	(4%)	2.7	(0.1)	(4%)	3.0	2.7	0.3	11%	2.7	0.3	11%
Deliveries	20	8	12	150%	8	12	150%	131	106	25	24%	106	25	24%
OP Visits	4,193	3,819	374	10%	3,819	374	10%	27,310	24,175	3,135	13%	24,175	3,135	13%
Rural Health Clinic Visits	2,355	2,489	(134)	(5%)	2,489	(134)	(5%)	16,064	16,824	(760)	(5%)	16,824	(760)	(5%)
Rural Health Women Visits	511	448	63	14%	448	63	14%	3,627	3,200	427	13%	3,200	427	13%
Rural Health Behavioral Visits	216	206	10	5%	206	10	5%	1,360	1,185	175	15%	1,185	175	15%
Total RHC Visits	3,082	3,143	(61)	(2%)	3,143	(61)	(2%)	21,051	21,209	(158)	(1%)	21,209	(158)	(1%)
Bronco Clinic Visits	52	48	4	8%	48	4	8%	265	189	76	40%	189	76	40%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	377	351	26	7%	351	26	7%	2,516	2,423	93	4%	2,423	93	4%
Pediatric Clinic Visits	687	663	24	4%	663	24	4%	4,233	4,361	(128)	(3%)	4,361	(128)	(3%)
Specialty Clinic Visits	520	459	61	13%	459	61	13%	3,794	2,534	1,260	50%	2,534	1,260	50%
Surgery Clinic Visits	170	139	31	22%	139	31	22%	1,101	883	218	25%	883	218	25%
Virtual Care Clinic Visits	55	56	(1)	(2%)	56	(1)	(2%)	406	310	96	31%	310	96	31%
Total NIA Clinic Visits	1,861	1,716	145	8%	1,716	145	8%	12,315	10,901	1,414	13%	10,901	1,414	13%
IP Surgeries	7	27	(20)	(74%)	27	(20)	(74%)	78	158	(80)	(51%)	158	(80)	(51%)
OP Surgeries	130	148	(18)	(12%)	148	(18)	(12%)	921	878	43	5%	878	43	5%
Total Surgeries	137	175	(38)	(22%)	175	(38)	(22%)	999	1,036	(37)	(4%)	1,036	(37)	(4%)
Cardiology	-	-	-	-%	-	-	-%	4	1	3	300%	1	3	300%
General	76	92	(16)	(17%)	92	(16)	(17%)	501	474	27	6%	474	27	6%
Gynecology & Obstetrics	10	12	(2)	(17%)	12	(2)	(17%)	81	109	(28)	(26%)	109	(28)	(26%)
Ophthalmology	20	28	(8)	(29%)	28	(8)	(29%)	154	177	(23)	(13%)	177	(23)	(13%)
Orthopedic	15	30	(15)	(50%)	30	(15)	(50%)	160	200	(40)	(20%)	200	(40)	(20%)
Pediatric	1	-	1	-%	-	1	100%	1	-	1	-%	-	1	-%
Plastics	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Podiatry	1	-	1	-%	-	1	-%	4	1	3	300%	1	3	300%
Urology	13	13	-	-%	13	-	-%	91	74	17	23%	74	17	23%
Diagnostic Image Exams	2,283	2,262	21	1%	2,262	21	1%	14,815	14,477	338	2%	14,477	338	2%
Emergency Visits	833	818	15	2%	818	15	2%	6,025	5,916	109	2%	5,916	109	2%
ED Admits	63	44	19	43%	44	19	43%	315	221	94	43%	221	94	43%
ED Admits % of ED Visits	8%	5%	2%	41%	5%	2%	41%	5%	4%	1%	40%	4%	1%	40%
Rehab Visits	725	743	(18)	(2%)	743	(18)	(2%)	5,924	4,077	1,847	45%	4,077	1,847	45%
OP Infusion/Wound Care Visits	796	284	512	180%	284	512	180%	3,521	2,040	1,481	73%	2,040	1,481	73%
Observation Hours	1,781	2,726	(945)	(35%)	2,726	(945)	(35%)	11,317	14,412	(3,095)	(21%)	14,412	(3,095)	(21%)

Northern Inyo Healthcare District January 2025 – Financial Summary

** Variances are B / (W)

PAYOR MIX

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Blue Cross	20.7%	15.9%	4.9%	30.6%	15.9%	4.9%	30.6%	24.8%	18.1%	6.7%	36.9%	18.1%	6.7%	36.9%
Commercial	8.2%	3.5%	4.7%	133.6%	3.5%	4.7%	133.6%	6.5%	3.3%	3.2%	96.1%	3.3%	3.2%	96.1%
Medicaid	29.5%	20.3%	9.2%	45.5%	20.3%	9.2%	45.5%	27.3%	24.8%	2.4%	9.8%	24.8%	2.4%	9.8%
Medicare	40.3%	55.5%	(15.2%)	(27.5%)	55.5%	(15.2%)	(27.5%)	39.2%	49.9%	(10.7%)	(21.4%)	49.9%	(10.7%)	(21.4%)
Self-pay	1.3%	4.8%	(3.5%)	(73.0%)	4.8%	(3.5%)	(73.0%)	1.8%	3.4%	(1.7%)	(48.6%)	3.4%	(1.7%)	(48.6%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.6%	0.4%	0.2%	45.9%	0.4%	0.2%	45.9%
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)

DEDUCTIONS

Contract Adjust	(8,951,555)	(9,517,222)	565,667	(6%)	(9,802,285)	850,730	(9%)	(66,141,525)	(66,420,785)	279,259	(0%)	(58,578,040)	(7,563,485)	13%
Bad Debt	1,386,194	(639,422)	2,025,616	(317%)	(1,227,065)	2,613,259	(213%)	205,927	(4,803,892)	5,009,819	(104%)	(5,210,207)	5,416,134	(104%)
Write-off	(1,723,376)	(653,505)	(1,069,871)	164%	(402,752)	(1,320,624)	328%	(6,909,364)	(4,163,732)	(2,745,633)	66%	(3,171,149)	(3,738,216)	118%

CENSUS

Patient Days	237	216	21	10%	216	21	10%	1,551	1,296	255	20%	1,296	255	20%
Adjusted ADC	45	33	12	38%	33	12	38%	40	32	8	25%	32	8	25%
Adjusted Days	1,432	1,018	414	41%	1,018	414	41%	8,660	6,922	1,738	25%	6,922	1,738	25%
Employed FTE	369.5	346.5	22.9	7%	346.5	22.9	7%	357.9	353.0	4.9	1%	353.0	4.9	1%
Contract Labor FTE	25.7	27.8	(2.1)	(8%)	27.8	(2.1)	(8%)	26.5	25.7	0.8	3%	25.7	0.8	3%
Total Paid FTE	395.2	374.4	20.8	6%	374.4	20.8	6%	384.4	378.8	5.7	1%	378.8	5.7	1%
EPOB (Employee per Occupied Bed)	1.7	1.7	(0.1)	(4%)	1.7	(0.1)	(4%)	1.7	2.0	(0.3)	(15%)	2.0	(0.3)	(15%)
EPOC (Employee per Occupied Case)	0.3	0.4	(0.1)	(23%)	0.4	(0.1)	(23%)	0.0	0.1	(0.0)	(19%)	0.1	(0.0)	(19%)
Adjusted EPOB	10.1	8.2	1.9	23%	8.2	1.9	23%	9.6	10.8	(1.2)	(11%)	10.8	(1.2)	(11%)
Adjusted EPOC	1.7	1.7	(0.0)	(2%)	1.7	(0.0)	(2%)	0.2	0.3	(0.0)	(15%)	0.3	(0.0)	(15%)

SALARIES

Per Adjust Bed Day	2,770	3,491	(720)	(21%)	3,195	(425)	(13%)	2,850	3,562	(711)	(20%)	3,305	(454)	(14%)
Total Salaries	3,966,354	3,552,696	413,658	12%	3,251,713	714,640	22%	24,684,398	24,652,835	31,564	0%	22,873,063	1,811,335	8%
Average Hourly Rate	60.60	57.87	2.73	5%	52.97	7.63	14%	56.14	56.84	(0.70)	(1%)	52.74	3.40	6%
Employed Paid FTEs	369.5	346.5	22.9	323.6	346.5	22.9	7%	357.9	353.0	4.9	1%	353.0	4.9	1%

BENEFITS

Per Adjust Bed Day	1,169	2,050	(881)	(43%)	1,227	(58)	(5%)	1,222	2,097	(875)	(42%)	1,631	(409)	(25%)
Total Benefits	1,674,059	2,086,552	(412,493)	(20%)	1,248,638	425,422	34%	10,584,237	14,515,655	(3,931,418)	(27%)	11,290,561	(706,324)	(6%)
Benefits % of Wages	42%	59%	(17%)	(28%)	38%	4%	10%	43%	59%	(16%)	(27%)	49%	(6%)	(13%)
Pension Expense	379,316	498,151	(118,835)	(24%)	542,170	(162,854)	(30%)	2,804,922	3,486,119	(681,197)	(20%)	3,162,882	(357,960)	(11%)
MDV Expense	895,963	748,612	147,351	20%	279,164	616,799	221%	5,557,917	5,240,284	317,633	6%	6,007,599	(449,682)	(7%)
Taxes, PTO accrued, Other	398,780	839,789	(441,009)	(53%)	427,304	(28,524)	(7%)	2,221,398	5,789,252	(3,567,854)	(62%)	2,120,080	101,317	5%
Salaries, Wages & Benefits	5,640,413	5,639,248	1,165	0%	4,500,351	1,140,062	25%	35,268,635	39,168,490	(3,899,854)	(10%)	34,163,624	1,105,011	3%
SWB/APD	3,939	5,541	(1,601)	(29%)	4,422	(482)	(11%)	4,072	5,659	(1,586)	(28%)	4,936	(863)	(17%)
SWB % of Total Expenses	53%	56%	(2%)	(4%)	46%	7%	16%	52%	55%	(4%)	(7%)	51%	1%	1%

Northern Inyo Healthcare District
January 2025 – Financial Summary

** Variances are B / (W)

PROFESSIONAL FEES

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Per Adjust Bed Day	1,793	2,207	(413)	(19%)	2,404	(611)	(25%)	2,038	2,257	(219)	(10%)	2,461	(423)	(17%)
Total Physician Fee	1,586,690	1,463,822	122,867	8%	1,545,167	41,523	3%	10,867,145	10,245,156	621,989	6%	10,438,557	428,588	4%
Total Contract Labor	312,240	349,333	(37,093)	(11%)	383,806	(71,566)	(19%)	3,336,525	2,445,686	890,839	36%	3,103,380	233,145	8%
Total Other Pro-Fees	668,438	432,691	235,747	54%	517,947	150,491	29%	3,445,837	2,933,425	512,412	17%	3,490,055	(44,218)	(1%)
Total Professional Fees	2,567,367	2,245,846	321,521	14%	2,446,920	120,447	5%	17,649,507	15,624,267	2,025,240	13%	17,031,992	617,515	4%
Contract AHR	68.61	70.85	(2.24)	(3%)	77.84	(9.23)	(12%)	102.36	77.34	25.02	32%	98.14	4.22	4%
Contract Paid FTEs	25.7	27.8	(2.1)	(8%)	27.8	(2.1)	(8%)	26.5	25.7	0.8	3%	25.7	0.8	3%
Physician Fee per Adjust Bed Day	1,108	1,438	(330)	(23%)	1,518	(410)	(27%)	1,255	1,480	(225)	(15%)	1,508	(253)	(17%)

PHARMACY

Per Adjust Bed Day	330	453	(123)	(27%)	367	(37)	(10%)	299	467	(168)	(36%)	432	(133)	(31%)
Total Rx Expense	473,056	461,460	11,597	3%	373,723	99,333	27%	2,588,193	3,230,217	(642,025)	(20%)	2,988,912	(400,719)	(13%)

MEDICAL SUPPLIES

Per Adjust Bed Day	299	420	(121)	(29%)	772	(473)	(61%)	376	434	(58)	(13%)	522	(147)	(28%)
Total Medical Supplies	427,905	427,618	287	0%	785,869	(357,964)	(46%)	3,254,740	3,001,517	253,224	8%	3,615,518	(360,777)	(10%)

EHR SYSTEM

Per Adjust Bed Day	29	133	(104)	(78%)	148	(119)	(81%)	28	137	(109)	(80%)	125	(97)	(78%)
Total EHR Expense	41,264	135,000	(93,736)	(69%)	150,509	(109,245)	(73%)	241,265	945,000	(703,735)	(74%)	866,385	(625,120)	(72%)

OTHER EXPENSE

Per Adjust Bed Day	705	855	(150)	(18%)	984	(279)	(28%)	741	877	(136)	(16%)	847	(106)	(13%)
Total Other	1,009,132	870,214	138,918	16%	1,001,340	7,791	1%	6,418,369	6,072,524	345,845	6%	5,862,839	555,530	9%

DEPRECIATION AND AMORTIZATION

Per Adjust Bed Day	286	357	(71)	(20%)	512	(226)	(44%)	342	368	(26)	(7%)	364	(22)	(6%)
Total Depreciation and Amortization	409,164	363,578	45,586	13%	520,628	(111,464)	(21%)	2,960,027	2,545,046	414,981	16%	2,521,304	438,723	17%

TOTAL EXPENSES

Per Adjust Bed Day	7,381	9,965	(2,584)	(26%)	9,608	(2,227)	(23%)	7,896	10,198	(2,302)	(23%)	9,687	(1,791)	(18%)
Per Calendar Day	340,913	327,192	13,721	4%	315,463	25,450	8%	318,050	328,312	(10,262)	(3%)	311,863	6,187	2%

**Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025**

	12/31/2024	Dec Budget	12/31/2023	1/31/2025	Jan Budget	1/31/2024	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue											
Inpatient Patient Revenue	2,658,147	3,508,170	3,205,729	3,280,133	3,845,128	4,415,671	24,651,407	24,888,321	(564,995)	(1,135,538)	(236,914)
Outpatient Revenue	12,983,214	14,511,663	13,872,841	14,664,711	14,602,264	14,723,154	100,660,232	97,002,080	62,447	(58,443)	3,658,152
Clinic Revenue	1,632,767	1,737,292	1,672,912	1,862,148	1,720,837	1,668,331	12,312,334	11,034,750	141,312	193,817	1,277,584
Gross Patient Service Revenue	17,274,128	19,757,125	18,751,482	19,806,992	20,168,228	20,807,156	137,623,973	132,925,151	(361,236)	(1,000,164)	4,698,822
Deductions from Revenue											
Contractual Adjustments	(8,575,086)	(9,512,631)	(8,812,993)	(8,951,555)	(9,517,222)	(9,802,285)	(66,141,525)	(58,578,040)	565,667	850,730	(7,563,485)
Bad Debt	(526,905)	(656,523)	(20,311)	1,386,194	(639,422)	(1,227,065)	205,927	(5,210,207)	2,025,616	2,613,259	5,416,134
A/R Writeoffs	(1,479,007)	(586,809)	(350,060)	(1,723,376)	(653,505)	(402,752)	(6,909,364)	(3,171,149)	(1,069,871)	(1,320,624)	(3,738,216)
Other Deductions from Revenue	-	-	-	-	-	53	(152,618)	53	-	(53)	(152,671)
Deductions from Revenue	(10,580,998)	(10,755,962)	(9,183,363)	(9,288,737)	(10,810,149)	(11,432,048)	(72,997,580)	(66,959,343)	1,521,412	2,143,311	(6,038,238)
Other Patient Revenue											
Incentive Income	-	-	-	-	-	-	2,000	-	-	-	2,000
Other Oper Rev - Rehab Thera Serv	-	-	1,568	-	-	-	2,435	2,955	-	-	(520)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	1,568	-	-	-	4,435	2,955	-	-	1,480
Net Patient Service Revenue	6,693,130	9,001,163	9,569,687	10,518,255	9,358,079	9,375,108	64,630,827	65,968,763	1,160,176	1,143,147	(1,337,936)
CNR%	38.7%	45.6%	51.0%	53.1%	46.4%	45.1%	47.0%	49.6%	6.7%	8.0%	-2.7%
Cost of Services - Direct											
Salaries and Wages	3,119,241	3,018,714	2,811,390	3,402,211	3,047,389	2,783,144	20,907,775	19,632,682	354,822	619,067	1,275,093
Benefits	1,445,404	1,787,968	1,069,389	1,412,693	1,760,785	1,093,886	9,028,474	9,685,285	(348,092)	318,807	(656,811)
Professional Fees	1,757,982	1,657,078	1,648,663	1,776,917	1,494,349	1,923,668	12,492,215	12,386,755	282,568	(146,750)	105,460
Contract Labor	366,331	163,390	422,431	373,323	417,673	379,756	2,771,134	2,799,710	(44,350)	(6,433)	(28,576)
Pharmacy	446,090	461,460	468,935	473,056	461,460	373,723	2,588,193	2,988,912	11,597	99,333	(400,719)
Medical Supplies	348,696	427,743	340,164	427,905	427,618	785,869	3,254,740	3,615,518	287	(357,964)	(360,777)
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	12,263	135,000	168,118	41,264	135,000	150,509	241,265	866,385	(93,736)	(109,245)	(625,120)
Other Direct Expenses	554,226	601,886	585,553	764,432	659,199	839,875	4,732,677	4,635,130	105,232	(75,443)	97,546
Total Cost of Services - Direct	8,050,233	8,253,239	7,514,645	8,671,801	8,403,473	8,330,430	56,016,472	56,610,377	268,329	341,371	(593,905)
General and Administrative Overhead											
Salaries and Wages	540,406	522,990	491,917	564,143	505,307	468,569	3,776,624	3,240,381	58,835	95,573	536,243
Benefits	233,464	288,796	182,190	261,366	325,767	154,751	1,555,762	1,605,276	(64,401)	106,614	(49,514)
Professional Fees	235,635	222,110	139,099	478,210	402,164	139,446	1,820,767	1,541,857	76,046	338,764	278,910
Contract Labor	306,137	136,543	86,055	(61,083)	(68,340)	4,050	565,391	303,670	7,257	(65,133)	261,721
Depreciation and Amortization	409,164	363,578	344,330	409,164	363,578	520,628	2,960,027	2,521,304	45,586	(111,464)	438,723
Other Administrative Expenses	262,025	284,558	156,693	244,700	211,015	161,466	1,685,693	1,227,708	33,686	83,235	457,984
Total General and Administrative Overhead	1,986,831	1,818,574	1,400,284	1,896,500	1,739,492	1,448,910	12,364,264	10,440,197	157,008	447,590	1,924,068
Total Expenses	10,037,064	10,071,813	8,914,928	10,568,301	10,142,964	9,779,340	68,380,736	67,050,574	425,336	788,960	1,330,163
Financing Expense	201,339	180,831	180,113	205,348	181,544	180,628	1,410,617	1,259,024	23,804	24,720	151,593
Financing Income	181,031	238,960	228,125	181,031	238,960	228,125	1,584,723	1,596,872	(57,930)	(47,094)	(12,149)
Investment Income	45,165	46,181	59,633	46,487	46,181	(186,959)	331,737	530,832	306	233,446	(199,095)
Miscellaneous Income	9,187,671	177,659	238,538	201,059	174,335	220,899	10,736,384	1,531,075	26,724	(19,840)	9,205,309
Net Income (Change in Financial Position)	5,868,595	(788,680)	1,000,942	173,184	(506,953)	(322,796)	7,492,318	1,317,944	680,137	495,980	6,174,374
Operating Income	(3,343,933)	(1,070,650)	654,759	(50,046)	(784,885)	(404,232)	(3,749,909)	(1,081,811)	734,840	354,187	(2,668,098)
EBIDA	6,277,759	(425,102)	1,345,271	582,348	(143,375)	197,832	10,452,345	3,839,248	725,723	384,516	6,613,097
Net Profit Margin	87.7%	-8.8%	10.5%	1.6%	-5.4%	-3.4%	11.6%	2.0%	7.1%	5.1%	9.6%
Operating Margin	-50.0%	-11.9%	6.8%	-0.5%	-8.4%	-4.3%	-5.8%	-1.6%	7.9%	3.8%	-4.2%
EBIDA Margin	93.8%	-4.7%	14.1%	5.5%	-1.5%	2.1%	16.2%	5.8%	7.1%	3.4%	10.4%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	9/30/2024	9/30/2023	10/31/2024	10/31/2023	11/30/2024	11/30/2023	12/31/2024	12/31/2023	1/31/2025	1/31/2024	PM Change	PY Change
Assets													
Current Assets													
Cash and Liquid Capital	18,718,414	17,374,679	18,771,541	16,909,058	15,130,616	10,295,002	9,784,681	9,262,111	9,536,326	16,381,395	8,555,307	7,119,284	7,826,088
Short Term Investments	6,418,451	7,574,716	10,555,533	6,876,555	10,658,191	6,872,978	8,158,191	6,873,880	10,810,616	7,420,527	10,332,998	546,647	(2,912,471)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,924,674	19,842,483	15,119,591	18,705,429	18,412,645	20,054,289	20,460,545	18,106,671	20,452,310	25,749,510	20,997,993	7,642,839	4,751,517
Other Receivables	4,754,052	4,823,782	794,581	4,771,477	1,149,410	9,458,105	2,837,260	18,665,903	3,258,427	3,755,159	6,140,920	(14,910,744)	(2,385,761)
Inventory	6,103,723	6,112,780	5,155,489	6,079,443	5,210,947	6,117,401	5,211,962	6,141,928	5,159,051	6,129,163	5,161,688	(12,765)	967,476
Prepaid Expenses	1,119,559	1,933,935	2,326,052	1,353,383	2,377,751	1,102,300	2,269,168	852,094	1,773,403	1,483,581	1,707,730	631,487	(224,150)
Total Current Assets	55,038,873	57,662,375	52,722,787	54,695,345	52,939,560	53,900,075	48,721,807	59,902,587	50,990,133	60,919,335	52,896,636	1,016,747	8,022,699
Assets Limited as to Use													
Internally Designated for Capital Acquisition	-	-	-	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,467,786	1,468,166	1,466,663	1,468,293	1,466,789	1,468,417	1,466,910	1,468,545	1,467,036	1,468,673	1,467,164	128	1,510
Limited Use Assets													
LAIF - DC Pension Board Restricted	-	-	828,419	-	828,417	-	828,417	-	175,992	-	-	-	-
LAIF - DB Pension Board Restricted	10,346,490	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	15,684,846	-	(5,338,356)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	10,919,587	10,919,587	14,478,346	10,919,587	13,905,247	10,919,587	14,478,344	10,919,587	13,825,919	10,919,587	16,257,943	-	(5,338,356)
Revenue Bonds Held by a Trustee	376,411	359,303	752,501	353,592	746,796	347,848	760,392	342,104	754,688	336,360	1,057,556	(5,744)	(721,196)
Total Assets Limited as to Use	12,763,784	12,747,056	16,697,511	12,741,473	16,118,832	12,735,852	16,705,646	12,730,236	16,047,643	12,724,620	18,782,662	(5,616)	(6,058,042)
Long Term Assets													
Long Term Investment	1,846,138	755,869	2,790,423	999,950	2,797,561	747,654	3,057,305	748,961	1,318,315	747,838	1,831,405	(1,123)	(1,083,568)
Fixed Assets, Net of Depreciation	84,474,743	84,066,999	76,854,908	83,828,939	77,676,251	83,555,961	77,109,988	83,235,289	76,904,399	83,392,600	85,031,471	157,311	(1,638,871)
Total Long Term Assets	86,320,881	84,822,868	79,645,331	84,828,890	80,473,812	84,303,615	80,167,293	83,984,250	78,222,714	84,140,438	86,862,876	156,188	(2,722,438)
Total Assets	154,123,537	155,232,299	149,065,629	152,265,708	149,532,205	150,939,543	145,594,746	156,617,074	145,260,490	157,784,393	158,542,174	1,167,319	(757,782)
Liabilities													
Current Liabilities													
Current Maturities of Long-Term Debt	4,146,183	4,771,637	190,197	4,782,382	655,101	4,744,967	676,353	4,616,414	1,339,056	4,601,872	11,675,726	(14,542)	(7,073,854)
Accounts Payable	5,010,089	4,443,274	6,935,344	3,949,738	6,819,778	4,337,497	5,370,018	4,496,145	6,383,025	4,559,038	4,881,333	62,893	(322,296)
Accrued Payroll and Related	6,224,657	4,915,339	12,664,513	5,437,529	12,669,463	3,515,873	8,534,376	2,073,837	6,924,804	2,929,795	6,556,620	855,957	(3,626,825)
Accrued Interest and Sales Tax	109,159	78,276	96,606	166,600	166,957	192,433	240,254	275,828	94,216	358,675	164,562	82,847	194,113
Notes Payable	446,860	446,860	1,633,708	446,860	1,633,708	446,860	1,633,708	446,860	1,633,708	446,860	1,532,689	-	(1,085,828)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	-	-
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	12,599,823	12,593,614	1,873,995	12,591,545	1,873,995	12,589,475	1,873,995	12,589,475	1,861,577	12,585,336	1,927,805	(4,139)	10,657,531
Total Current Liabilities	29,225,475	27,937,705	24,083,068	28,063,360	24,507,707	26,515,810	19,017,409	25,187,264	18,925,091	26,170,281	27,427,440	983,017	(1,257,160)
Long Term Liabilities													
Long Term Debt	36,301,355	36,004,290	33,341,647	34,797,823	32,730,530	34,698,029	31,715,530	33,927,979	30,380,530	33,830,169	28,565,060	(97,810)	5,265,109
Bond Premium	165,618	156,207	193,852	153,070	190,715	149,933	187,578	146,796	184,441	143,659	181,303	(3,137)	(37,645)
Accreted Interest	16,991,065	17,271,137	17,409,141	16,560,403	17,504,273	16,653,761	17,599,405	16,742,795	17,694,537	16,831,830	17,206,094	89,034	(374,264)
Other Non-Current Liability - Pension	32,946,355	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	-	(14,311,308)
Total Long Term Liabilities	86,404,394	86,377,989	98,202,303	84,457,651	97,683,181	84,448,078	96,760,176	83,763,925	95,517,170	83,752,012	93,210,120	(11,913)	(9,458,108)
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	31,506	147,821	36,944	127,821	68,644	127,821	107,118	127,821	107,118	87,821	106,018	(40,000)	(18,197)
Total Liabilities	115,661,375	114,463,515	122,322,315	112,648,832	122,259,532	111,091,709	115,884,703	109,079,010	114,549,379	110,010,114	120,743,579	931,104	(10,733,465)
Fund Balance													
Fund Balance	31,992,031	36,994,377	23,268,194	36,447,220	23,786,064	36,928,877	26,459,404	38,750,385	26,459,404	38,813,288	35,013,048	62,903	3,800,240
Temporarily Restricted	1,467,786	1,468,166	2,610,594	1,468,293	2,610,720	1,468,417	2,610,841	1,468,545	2,610,967	1,468,673	1,467,163	128	1,511
Net Income	5,002,346	2,306,242	864,526	1,701,362	875,889	1,450,539	639,798	7,319,134	1,640,740	7,492,318	1,318,385	173,184	6,173,932
Total Fund Balance	38,462,163	40,768,784	26,743,313	39,616,876	27,272,672	39,847,834	29,710,043	47,538,064	30,711,111	47,774,279	37,798,596	236,215	9,975,683
Liabilities + Fund Balance	154,123,537	155,232,299	149,065,629	152,265,708	149,532,205	150,939,543	145,594,746	156,617,074	145,260,490	157,784,393	158,542,174	1,167,319	(757,782)
(Decline)/Gain		(90,686)	1,771,115	(2,966,591)	466,576	(1,326,165)	(3,937,458)	5,677,531	(334,256)	1,167,319	13,281,684	(4,510,212)	(12,114,365)

Northern Inyo Healthcare District
 Long-Term Debt Service Coverage Ratio
 FYE 2025

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

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	\$ 7,492,318
+ Depreciation Expense	2,960,027
+ Interest Expense	1,410,617
Less GO Property Tax revenue	1,069,433
Less GO Interest Expense	289,655
"Income available for debt service"	\$ 10,503,873

Denominator:	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	\$ 112,700
2021B Revenue Bonds	894,160
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,546,875
Total Maximum Annual Debt Service	\$ 2,553,735
	1,489,679
Ratio: (numerator / denominator)	7.05

Required Debt Service Coverage Ratio: 1.10

In Compliance? (Y/N) **No**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	\$ 23,801,922
Cash and Investments-non current	747,838
Sub-total	24,549,759
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(336,360)
Building and Nursing Fund	(1,468,673)
Total Unrestricted Funds	\$ 22,744,726

Total Operating Expenses	\$ 68,380,736
Less Depreciation	2,960,027
Net Expenses	65,420,709
Average Daily Operating Expense	\$ 305,704

Days Cash on Hand **74**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES

Receipts from and on Behalf of Patients	64,660,671
Payments to Suppliers and Contractors	(41,676,610)
Payments to and on Behalf of Employees	(38,605,160)
Other Receipts and Payments, Net	8,988,442
Net Cash Provided (Used) by Operating Activities	<u>(6,632,658)</u>

CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES

Noncapital Contributions and Grants	62,250
Property Taxes Received	515,290
Other	1,584,723
Net Cash Provided (Used) by Noncapital Financing Activities	<u>2,162,263</u>

CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES

Principal Payments on Long-Term Debt	(1,776,909)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,410,617)
Purchase and Construction of Capital Assets	(644,220)
Payments on Lease Liability	(181,984)
Payments on Subscription Liability	(533,535)
Property Taxes Received	(358,124)
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	<u>(4,905,389)</u>

CASH FLOWS FROM INVESTING ACTIVITIES

Investment Income	331,737
Rental Income	43,173
Net Cash Provided (Used) by Investing Activities	<u>374,910</u>

NET CHANGE IN CASH AND CASH EQUIVALENTS

(9,000,874)

Cash and Cash Equivalents - Beginning of Year

25,136,864

CASH AND CASH EQUIVALENTS - END OF YEAR

16,135,990

Key Financial Performance Indicators	Industry Benchmark	FYE 2024										Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month		
		Jan-23	Jan-24	Average	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25					
Volume																
Admits	41	74	79	71	75	75	83	68	77	62	90	28	19	11		
Deliveries	n/a	20	8	17	18	19	17	21	14	21	20	(1)	3	12		
Adjusted Patient Days	n/a	1,102	1,009	1,035	1,164	1,362	1,312	1,335	970	1,169	1,432	263	397	423		
Total Surgeries	153	127	175	146	134	168	133	176	129	122	137	15	(9)	(38)		
ER Visits	659	753	818	840	903	905	947	859	789	789	833	44	(7)	15		
RHC and Clinic Visits	n/a	4,572	4,859	4,607	4,252	4,921	4,808	5,479	4,515	4,444	4,943	499	336	84		
Diagnostic Imaging Services	n/a	1,999	2,262	2,069	2,274	2,221	2,344	2,194	1,880	1,955	2,283	328	214	21		
Rehab Services	n/a	748	743	662	719	808	887	1,142	903	740	725	(15)	63	(18)		
AR & Income																
Gross AR (Cerner only)	n/a	\$ 52,158,604	\$ 56,381,675	\$ 52,823,707	\$ 56,859,164	\$ 57,648,281	\$ 58,109,192	\$ 51,585,302	\$ 48,660,966	\$ 46,678,451	\$ 45,458,077	\$ (1,220,374)	\$ (7,365,630)	\$ (10,923,598)		
AR > 90 Days	\$ 7,001,767.65	\$ 25,648,706	\$ 27,771,536	\$ 24,488,432	\$ 24,988,857	\$ 24,824,364	\$ 26,062,067	\$ 22,515,618	\$ 21,134,023	\$ 19,761,172	\$ 17,533,888	\$ (2,227,284)	\$ (6,954,544)	\$ (10,237,648)		
AR % > 90 Days	15%	51.15%	50.04%	46.7%	44.5%	43.1%	44.9%	43.6%	43.4%	42.3%	38.6%	-3.8%	-8.1%	-11.5%		
Gross AR Days (per financial statements)	60	93	84	85	92	84	83	74	83	84	71.15	(13)	(14)	(13)		
Net AR Days (per financial statements)	30	52	69	58	54	64	69	64	67	84	76	(8)	18	6		
Net AR	n/a	\$ 14,758,093	\$ 20,997,993	\$ 16,938,200	\$ 18,219,994	\$ 20,277,373	\$ 19,842,483	\$ 18,705,429	\$ 20,054,289	\$ 18,106,671	\$ 25,749,510	\$ 7,642,839	\$ 8,811,310	\$ 4,751,517		
Net AR % of Gross	n/a	28.3%	37.2%	31.9%	32.0%	35.2%	34.1%	36.3%	41.2%	38.8%	56.6%	17.9%	24.7%	19.4%		
Gross Patient Revenue/Calendar Day	n/a	\$ 561,125	\$ 671,199	\$ 619,457	\$ 617,364	\$ 683,348	\$ 702,988	\$ 698,314	\$ 582,780	\$ 557,230	\$ 638,935	\$ 81,705	\$ 19,478	\$ (32,263)		
Net Patient Revenue/Calendar Day	n/a	\$ 283,616	\$ 302,421	\$ 292,759	\$ 337,843	\$ 315,574	\$ 285,805	\$ 290,232	\$ 301,501	\$ 215,907	\$ 339,299	\$ 123,391	\$ 46,540	\$ 36,877		
Net Patient Revenue/APD	n/a	\$ 7,978	\$ 9,291	\$ 8,757	\$ 8,998	\$ 7,183	\$ 6,537	\$ 6,740	\$ 9,321	\$ 5,727	\$ 7,346	\$ 1,619	\$ (1,411)	\$ (1,945)		
Wages																
Wages	n/a	\$ 2,946,758	\$ 3,251,713	\$ 3,285,431	\$ 3,359,076	\$ 3,241,107	\$ 3,372,236	\$ 3,622,038	\$ 3,463,941	\$ 3,659,647	\$ 3,966,354	\$ 306,706	\$ 680,923	\$ 714,641		
Employed paid FTEs	n/a	385.06	346.54	353.69	366.38	366.24	391.40	369.11	364.72	367.90	369.48	1.58	15.79	22.94		
Employed Average Hourly Rate	\$55.50	\$ 43.20	\$ 52.97	\$ 53.32	\$ 51.76	\$ 49.96	\$ 50.26	\$ 55.40	\$ 55.40	\$ 56.15	\$ 60.60	\$ 4.45	\$ 7.28	\$ 7.63		
Benefits	n/a	\$ 1,924,062	\$ 1,248,638	\$ 1,640,216	\$ 1,509,407	\$ 1,478,605	\$ 1,634,036	\$ 1,896,266	\$ 713,356	\$ 1,678,868	\$ 1,674,059	\$ (4,808)	\$ 33,843	\$ 425,421		
Benefits % of Wages	30%	65.3%	38.4%	50.3%	44.9%	45.6%	48.5%	52.4%	20.6%	45.9%	42.2%	-3.7%	-8.1%	3.8%		
Contract Labor	n/a	\$ 975,969	\$ 383,806	\$ 518,351	\$ 507,387	\$ 829,876	\$ (112,642)	\$ 543,829	\$ 583,367	\$ 672,468	\$ 312,240	\$ (360,228)	\$ (206,111)	\$ (71,566)		
Contract Labor Paid FTEs	n/a	36.45	21.60	23.49	29.45	32.19	24.84	21.32	23.57	26.14	25.69	(0.45)	2.20	4.09		
Total Paid FTEs	n/a	421.51	368.14	377.18	395.83	398.43	416.25	390.44	388.29	394.04	395.17	1.13	17.99	27.03		
Contract Labor Average Hourly Rate	\$ 81.04	\$ 151.15	\$ 100.31	\$ 126.74	\$ 97.26	\$ 145.55	\$ 118.60	\$ 143.96	\$ 144.39	\$ 145.23	\$ 68.61	\$ (76.62)	\$ (58.13)	\$ (31.70)		
Total Salaries, Wages, & Benefits	n/a	\$ 5,846,788	\$ 4,884,157	\$ 5,443,998	\$ 5,375,870	\$ 5,549,587	\$ 4,893,631	\$ 6,062,133	\$ 4,760,664	\$ 6,010,983	\$ 5,952,653	\$ (58,330)	\$ 508,655	\$ 1,068,496		
SWB% of NR	50%	66.5%	52.1%	63.2%	51.3%	56.7%	57.1%	67.4%	52.6%	89.8%	56.6%	-33.2%	-6.6%	4.5%		
SWB/APD	2,572	\$ 5,306	\$ 4,841	\$ 5,346	\$ 4,618	\$ 4,075	\$ 3,731	\$ 4,541	\$ 4,906	\$ 5,144	\$ 4,157	\$ (986)	\$ (1,188)	\$ (683)		
SWB % of total expenses	50%	64.4%	49.9%	56.7%	59.6%	56.3%	55.1%	58.0%	49.7%	59.9%	56.3%	-3.6%	-0.4%	6.4%		

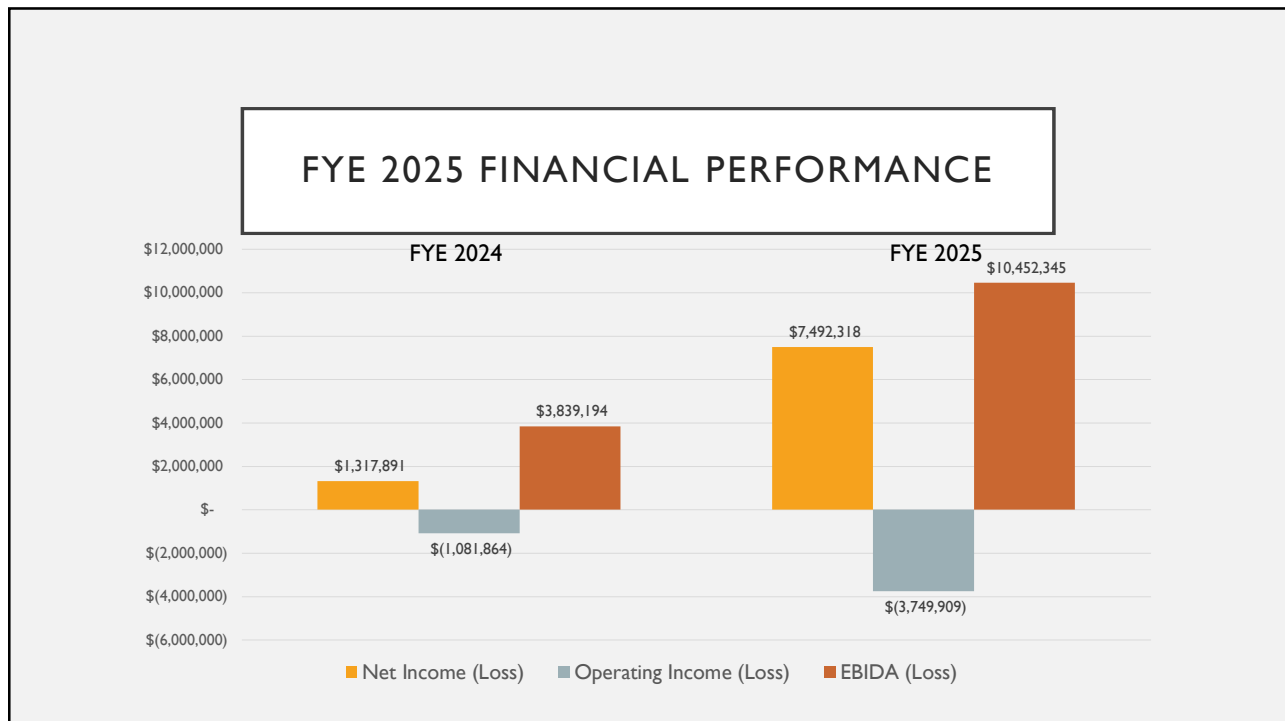
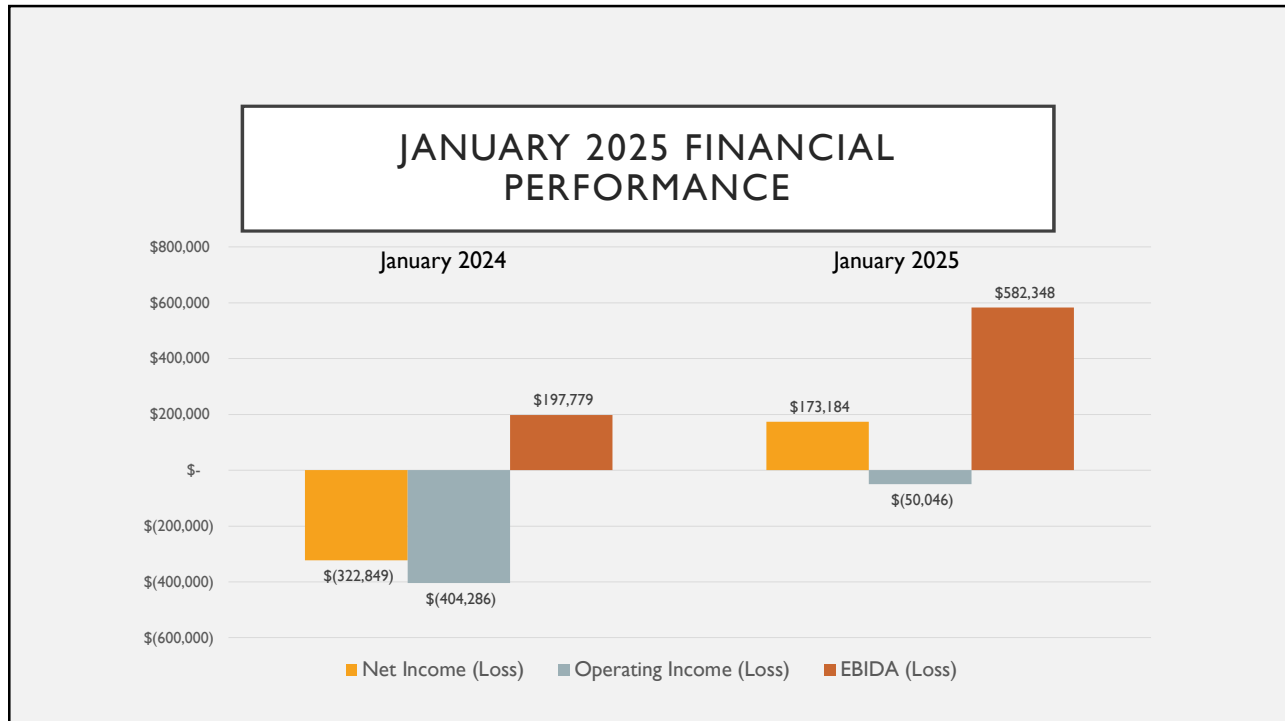
Industry	Benchmark	FYE 2024										Variance to FYE 2024		Variance to Prior Year	
		Jan-23	Jan-24	Average	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Average	Month		
Physician Spend															
Physician Expenses	n/a	\$ 1,366,533	\$ 1,099,861	\$ 1,507,510	\$ 1,553,004	\$ 1,399,376	\$ 1,621,308	\$ 1,699,955	\$ 1,508,531	\$ 1,498,281	\$ 1,586,690	\$	\$ 88,408	\$ 79,179	\$ 486,829
Physician expenses/APD	n/a	\$ 1,240	\$ 1,090	\$ 1,478	\$ 1,334	\$ 1,028	\$ 1,236	\$ 1,273	\$ 1,555	\$ 1,282	\$ 1,108	\$	\$ (174)	\$ (370)	\$ 18
Supplies															
Supply Expenses	n/a	\$ 837,141	\$ 1,159,592	\$ 776,504	\$ 387,610	\$ 1,078,077	\$ 785,983	\$ 860,663	\$ 1,034,853	\$ 794,786	\$ 900,961	\$	\$ 106,175	\$ 124,458	\$ (258,631)
Supply expenses/APD	n/a	\$ 760	\$ 1,149	\$ 780	\$ 333	\$ 792	\$ 599	\$ 645	\$ 1,066	\$ 680	\$ 629	\$	\$ (51)	\$ (151)	\$ (520)
Other Expenses															
Other Expenses	n/a	\$ 1,029,983	\$ 2,635,236	\$ 1,891,477	\$ 1,696,938	\$ 1,833,270	\$ 1,576,147	\$ 1,824,069	\$ 2,271,303	\$ 1,733,013	\$ 2,127,997	\$	\$ 394,984	\$ 236,520	\$ (507,239)
Other Expenses/APD	n/a	\$ 935	\$ 2,612	\$ 1,878	\$ 1,458	\$ 1,346	\$ 1,202	\$ 1,366	\$ 2,341	\$ 1,483	\$ 1,486	\$	\$ 3	\$ (392)	\$ (1,125)
Margin															
Net Income	n/a	\$ (418,086)	\$ (322,849)	\$ 383,722	\$ 2,041,456	\$ 248,064	\$ 19,121	\$ (1,152,036)	\$ (250,823)	\$ 5,868,595	\$ 173,184	\$	\$ (5,695,411)	\$ (210,538)	\$ 496,033
Net Profit Margin	n/a	-4.8%	-3.4%	3.0%	19.5%	2.5%	0.2%	-12.8%	-2.8%	87.7%	1.6%	\$	\$ -86.0%	\$ -1.3%	\$ 5.0%
Operating Income	n/a	\$ (1,095,469)	\$ (404,286)	\$ (686,444)	\$ 1,459,716	\$ (77,526)	\$ (302,930)	\$ (1,449,616)	\$ (530,332)	\$ (3,343,933)	\$ (50,046)	\$	\$ 3,293,888	\$ 636,399	\$ 354,240
Operating Margin	2.9%	-12.5%	-4.3%	-10.9%	13.9%	-0.8%	-3.1%	-16.1%	-5.9%	-50.0%	-0.5%	\$	\$ 49.5%	\$ 10.4%	\$ 3.8%
EBITDA	n/a	\$ (760,538)	\$ 197,779	\$ 841,891	\$ 2,482,790	\$ 689,172	\$ 459,316	\$ (742,505)	\$ 158,708	\$ 6,277,759	\$ 582,348	\$	\$ (5,695,411)	\$ (259,543)	\$ 384,569
EBITDA Margin	12.7%	-8.7%	2.1%	8.7%	23.7%	7.0%	4.7%	-8.3%	1.8%	93.8%	5.5%	\$	\$ -88.3%	\$ -3.2%	\$ 3.4%
Debt Service Coverage Ratio	3.70	(5.8)	2.4	3.3	0.8	7.3	5.5	3.3	3.4	7.7	7.1	\$	\$ (0.7)	\$ 3.7	\$ 4.7
Cash															
Avg Daily Disbursements (excl. IGT)	n/a	\$ 318,010	\$ 424,036	\$ 355,328	\$ 367,107	\$ 398,922	\$ 315,796	\$ 399,234	\$ 296,503	\$ 367,542	\$ 359,843	\$	\$ (7,699)	\$ 4,515	\$ (64,193)
Average Daily Cash Collections (excl. IGT)	n/a	\$ 438,340	\$ 289,440	\$ 299,110	\$ 349,783	\$ 262,199	\$ 302,042	\$ 359,292	\$ 288,101	\$ 273,563	\$ 239,449	\$	\$ (34,114)	\$ (59,661)	\$ (49,991)
Average Daily Net Cash	n/a	\$ 120,330	\$ (134,596)	\$ (56,218)	\$ (17,324)	\$ (136,723)	\$ (13,754)	\$ (39,942)	\$ (8,402)	\$ (93,979)	\$ (120,394)	\$	\$ (26,415)	\$ (64,176)	\$ 14,202
Upfront Cash Collections	n/a	\$	\$ 34,946	\$ 36,146	\$ 32,509	\$ 37,333	\$ 36,220	\$ 57,023	\$ 26,687	\$ 22,508	\$ 60,336	\$	\$ 37,828	\$ 24,190	\$ 25,390
Upfront Cash % of Gross Charges	1%	0.0%	0.2%	0.2%	0.2%	0.2%	0.2%	0.3%	0.2%	0.1%	0.3%	\$	\$ 0	\$ 0	\$ 0
Unrestricted Funds	n/a	\$ 24,110,443	\$ 18,888,305	\$ 23,536,438	\$ 27,015,779	\$ 24,366,780	\$ 24,708,310	\$ 22,963,678	\$ 16,099,369	\$ 15,074,303	\$ 22,744,726	\$	\$ 7,670,424	\$ (791,712)	\$ 3,856,421
Change of cash per balance sheet	n/a	\$ 1,424,767	\$ (2,016,685)	\$ (541,459)	\$ 1,876,964	\$ (2,648,999)	\$ 341,530	\$ (1,744,632)	\$ (6,864,309)	\$ (1,025,067)	\$ 7,670,424	\$	\$ 8,695,490	\$ 8,211,882	\$ 9,687,109
Days Cash on Hand (assume no more cash is collected)	196	82	45	72	98	84	58	77	43	50	74	\$	\$ 24	\$ 2	\$ 29
Estimated Days Until Depleted (operating cash only)		-	337	406	506	413	440	442	372	292	370	\$	\$ 78	\$ (36)	\$ 33
Years Until Cash Depletion (operating cash only)		-	0.92	1.11	1.39	1.13	1.21	1.21	1.02	0.80	1.01	\$	\$ 0.21	\$ (0.10)	\$ 0.09



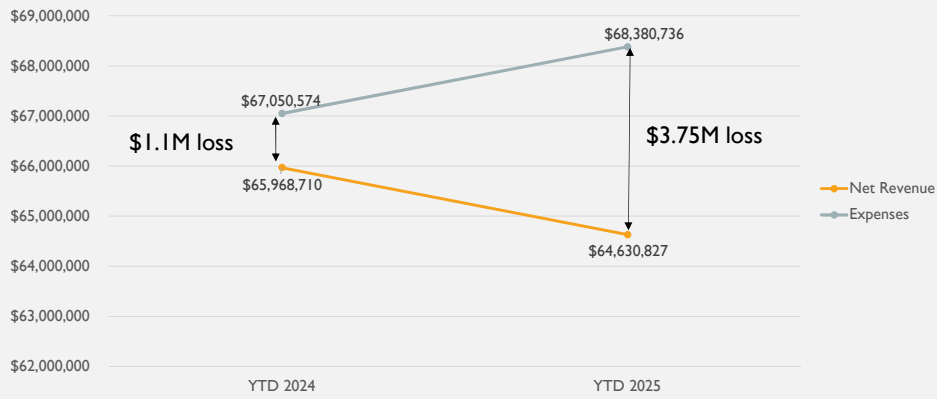
NIHD FINANCIAL UPDATE

January 2025

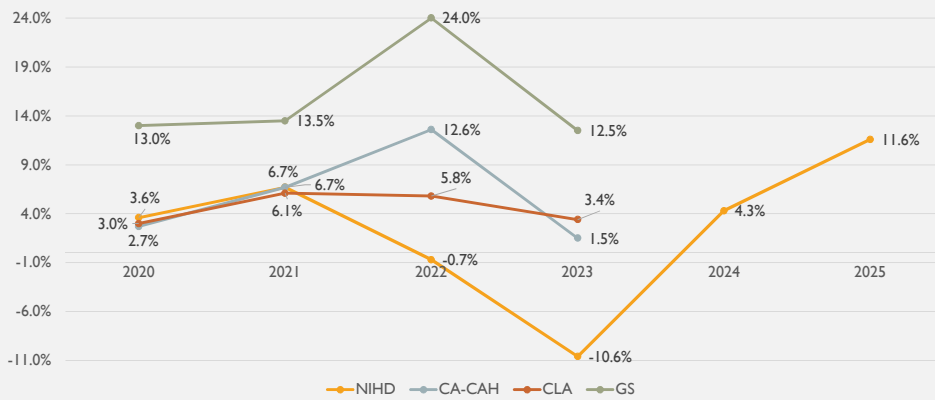
INCOME



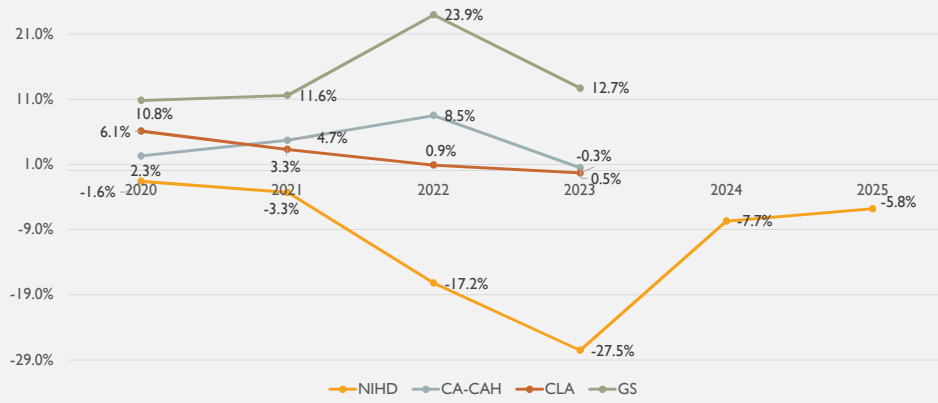
YTD OPERATING INCOME (LOSS) PERFORMANCE



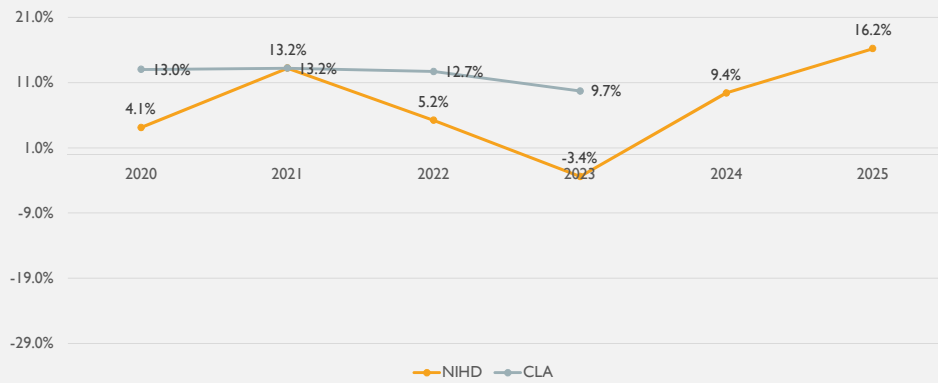
NET PROFIT MARGIN



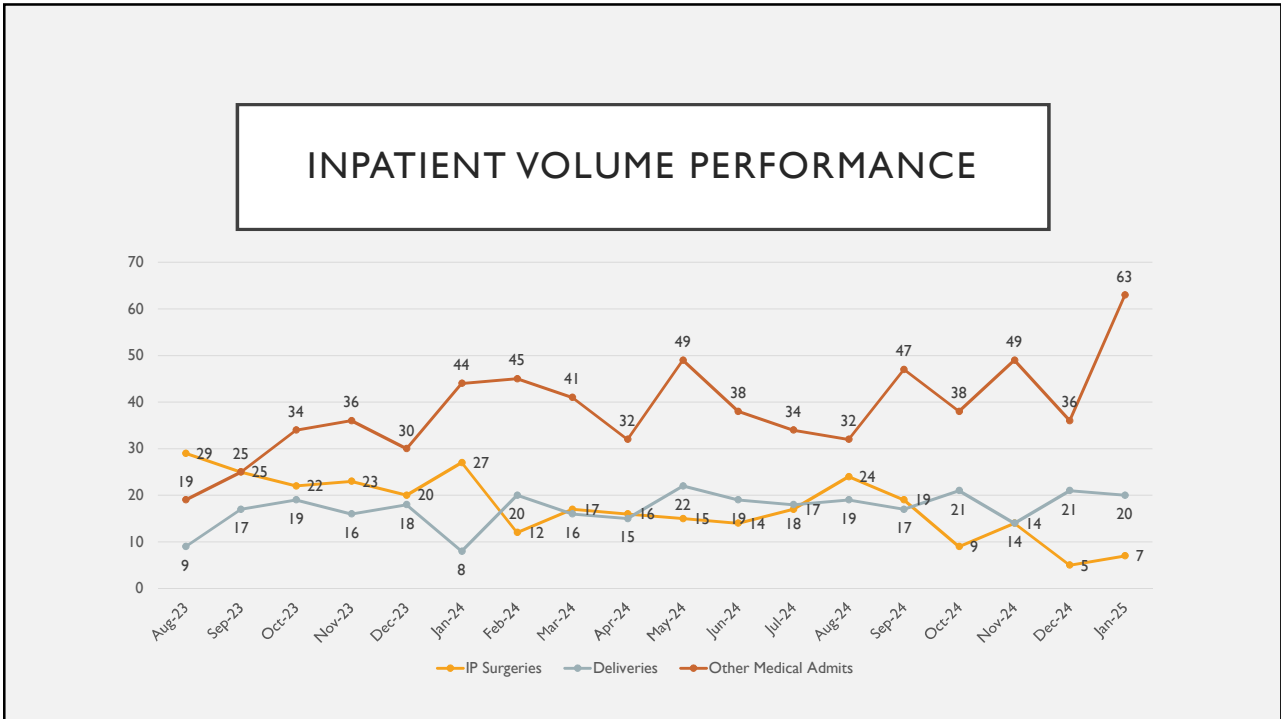
OPERATING MARGIN



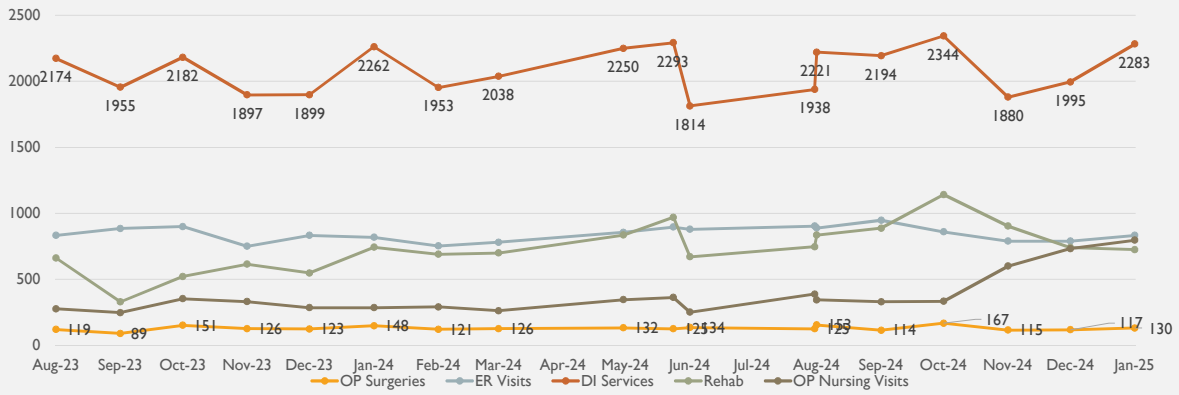
EBIDA MARGIN



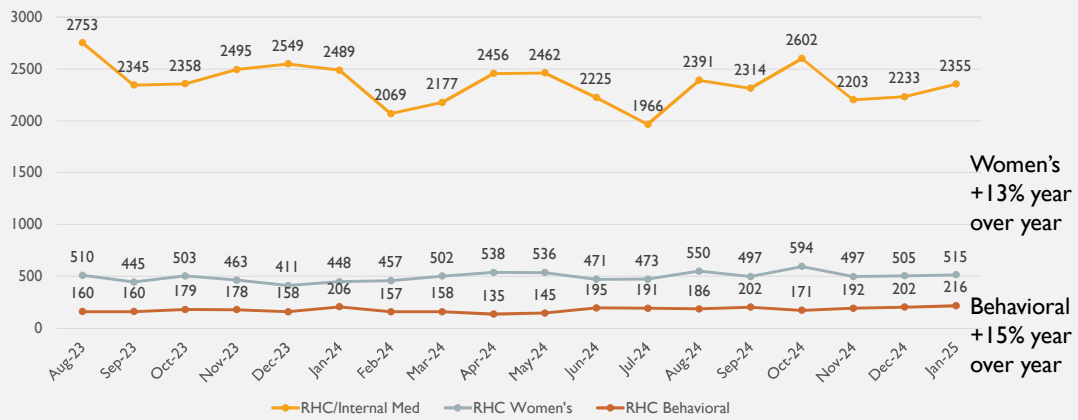
VOLUMES



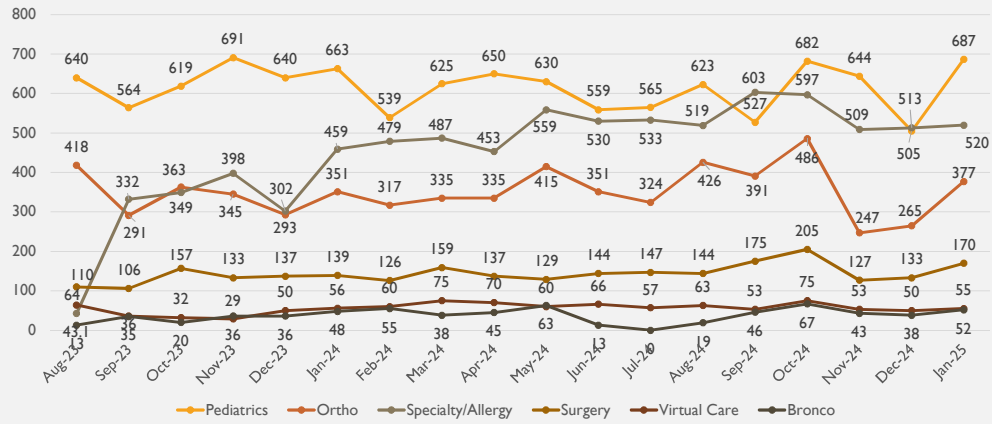
OUTPATIENT VOLUME PERFORMANCE



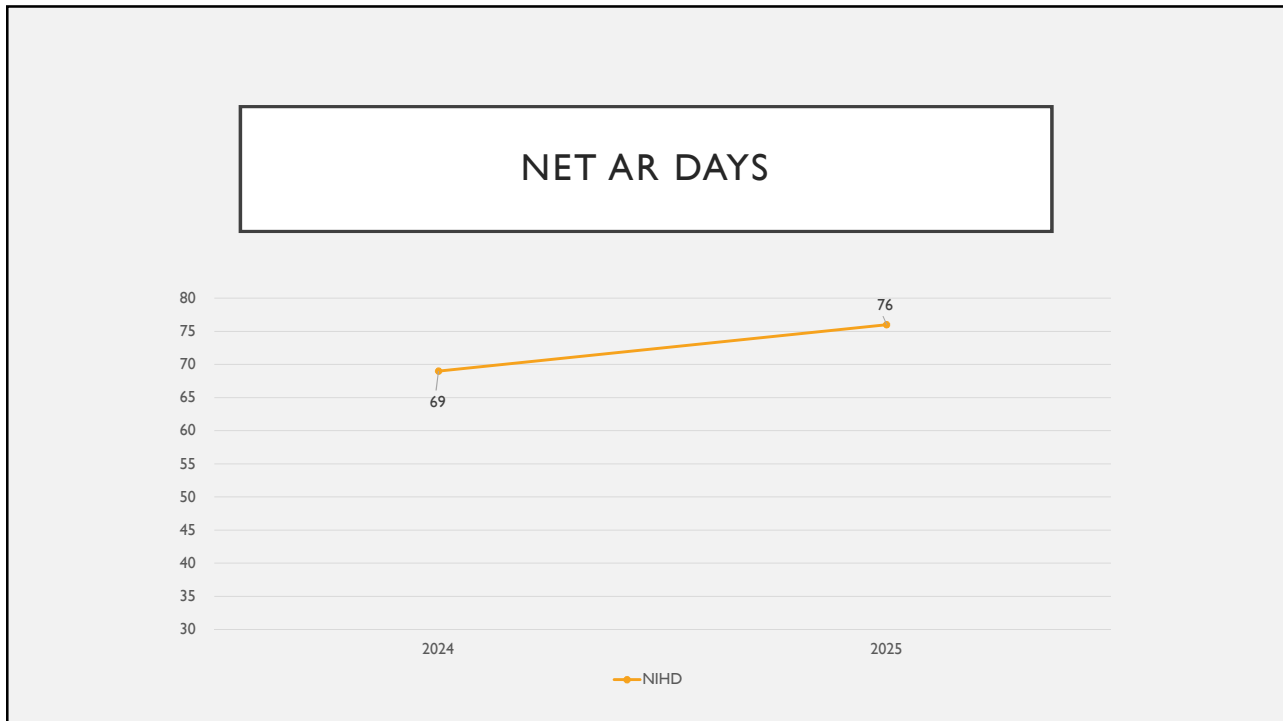
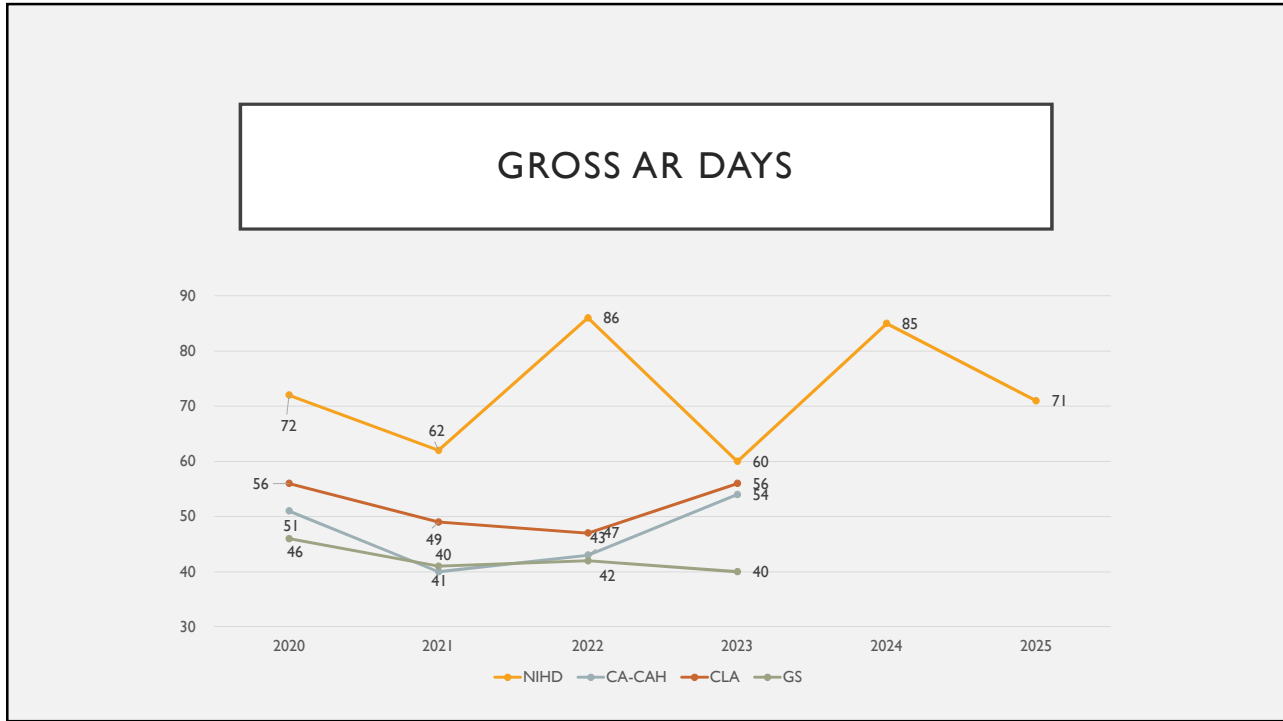
RHC VOLUME PERFORMANCE



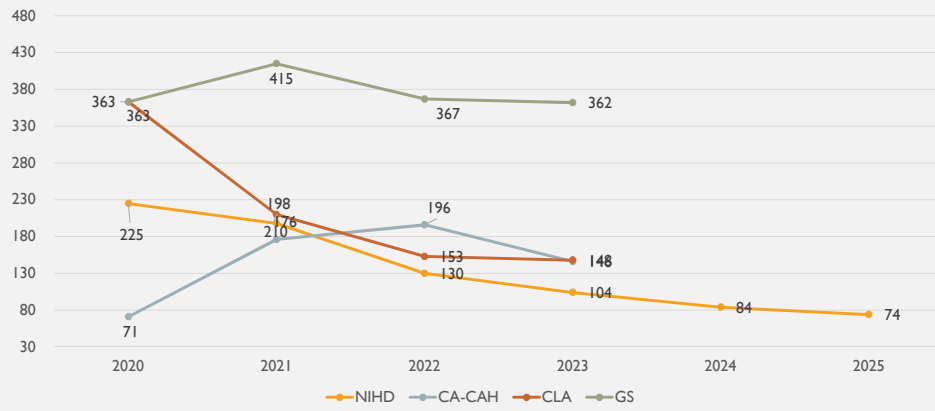
CLINIC VOLUME PERFORMANCE



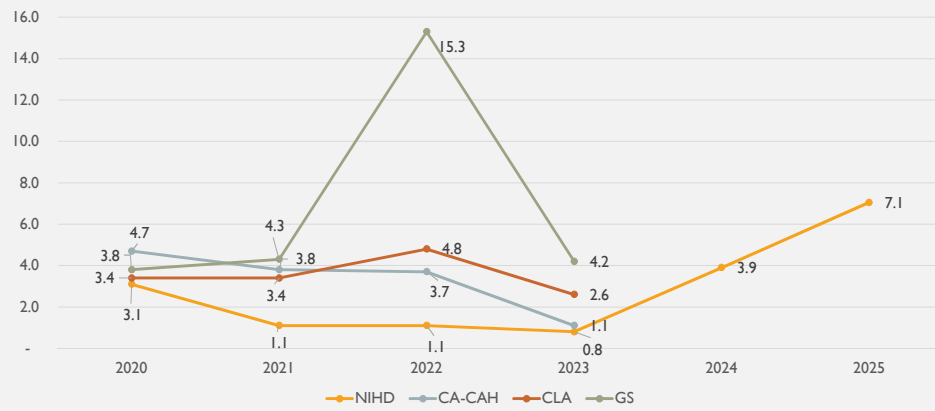
KEY PERFORMANCE INDICATORS



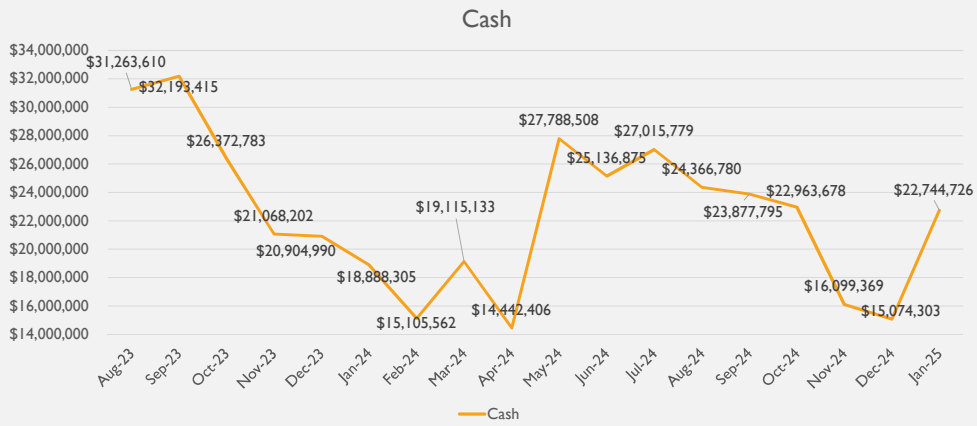
DAYS CASH ON HAND



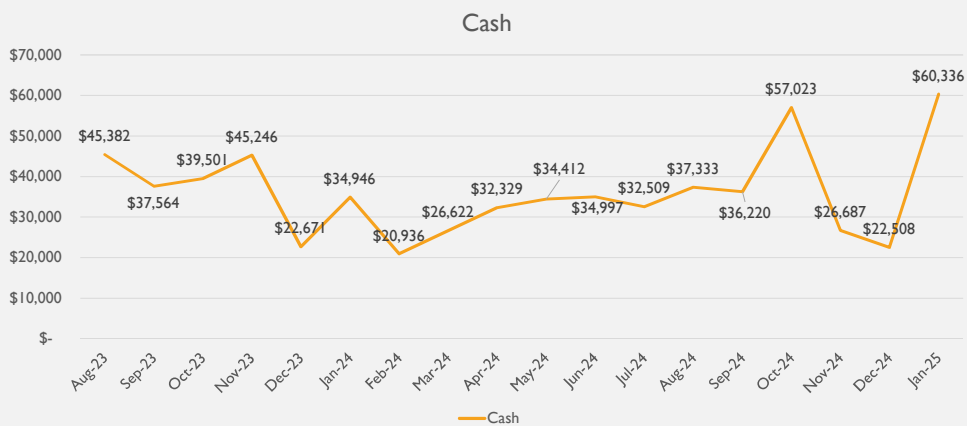
DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



UPFRONT CASH COLLECTIONS



WAGE COSTS

	January 2024	January 2025
Total Paid FTEs	368	395
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	\$4,884,157	\$5,952,653
SWB % of total expenses (including contract labor)	50%	56%
Employed Average Hourly Rate	\$52.97	\$60.60
Benefits % of Wages	38%	42%