SoHum Health

Southern Humboldt Community Healthcare District

MEETING NOTICE
Governing Board

A regular meeting of the Board of Directors of the Southern Humboldt Community Healthcare District will be held on September 30, 2025, at 1:30 p.m., by teleconference and in-person. Members of the public may participate virtually via Webex or telephone, or appear in person at the Sprowel Creek Campus at 286 Sprowel Creek Road, Garberville, California 95542.

Call-In Information: Join by phone +1-415-655-0001 US Toll

Webex Link:

https://shchd.webex.com/shchd/j.php?MTID=m65c1024281b4ef67076bbe032ec5f0d9

Written comments may also be sent to boardcomments@shchd.org. Comments received no later than two hours prior to the start of the meeting will be provided to the Board or may be read aloud or summarized during the meeting. Members of the public may also comment in real time during the meeting by attending in person or via Webex or phone.

Agenda

Page **Item**

A. Call to Order

B. Approval of the Teleconferencing of a Board Member

C. Approval of the Agendas

D. Public Comment on Non-Agendized Items
See below for Public Comment Guidelines

E. Board Member Comments
Board members are invited to address issues not on the agenda and to submit items within the subject jurisdiction of the Board for future consideration. Please limit individual comments to three minutes.

F. Announcements

G. Consent Agenda –

1. Approval of Previous Minutes

6-18 a. Governing Board Meeting, August 28, 2025

2. SHCHD New and Updated Policies

Patient Financial Services:

19-23 a. Registration Procedures
b. Debt Collection

Skilled Nursing:

24-29 c. Monthly Medication Regimen Review
d. Staffing and Coverage
e. Insulin Utilization

Obsolete Policies:

30-55 f. Death of a Resident
g. Discharge from Skilled Nursing
h. Pastoral Services
i. Resident Care Planning
j. Chaperones
k. Death of a Child in the Emergency Department
l. Care Planning for Inpatients
m. Fall Prevention Risk Assessment
n. Hourly rounding
o. Patient and Staff Safety Plan
p. Compassionate Access to Medical Cannabis

3. Quarterly Reports - (Feb, May, Aug, Nov) - None
   a. Human Resources – Season Bradley Koskinen, HR Manager
   b. Foundation – Chelsea Brown, Outreach Manager
   c. Operations – Kent Scown, Chief Operations Officer

Approval of Consent Agenda

H. Last Action Items for Discussion

1. Approval of the Peer Review Policy

I. Correspondence, Suggestions, or Written Comments to the Board

J. Administrator's Report – Matt Rees, CEO

1. Department Updates
   a. Milestones
   b. August Employee Anniversaries
      1 Year: Pharmacist Brian Winterburg, LVN Rhonda Wilhoit, Piper Keener, LVN Jenn Rose, LVN Larry Rose, Hether Johnson, and ED Tech Michael Carnahan

54-82 c. Approval of the August Financials - Paul Eves – See Report

83-85 d. CNO Report – Adela Yanez – See Report

e. Family Resource Center – Amy Terrones – Mar and Oct - None

K. Old Business - None

L. New Business - None

M. Parking Lot

1. Elm Street Parking Zoning

N. Meeting Evaluation

O. New Action Items

P. Next Meetings

1. Medical Staff Committee – Thursday, October 9, 2025, at 12:30 p.m
2. Medical Staff Policy Development Committee – Tuesday, October 14, 2025, 10:00 a.m
3. QAPI Meeting – Wednesday, October 8, 2025, at 10:00 a.m.
4. Finance Committee – October 24, 2025, at 10:00 a.m.
5. Governing Board Meeting – October 30, 2025, at 1:30 p.m.

Q. Adjourn to Closed Session

1. Closed Session
2. Update on Peer Review, Credentialing, and Appointment/Reappointments – Medstaff
3. Compliance, Risk, and Reports of Quality Assurance Committees **[H&S Code § 32155]** - Kristen Rees, CQCO
4. Quarterly Reports -
   a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec.
   b. Patient Safety – Mar., June, Sept., Dec.

c. Medication Error – Feb., May, Aug., Dec.

5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]

   a. Dr. Supriya Gupta, MD Reappointment as Active status for Teleradiology – Diagnostic Radiology privileges October 1, 2025 – September 30, 2025
   b. Dr. Arron Jun, MD Reappointment as Active status for Teleradiology – Diagnostic Radiology privileges October 1, 2025 – September 30, 2025
   c. Dr. Nicolaus Kuen, MD Reappointment as Active status for Teleradiology – Diagnostic Radiology privileges October 1, 2025 – September 30, 2025
   d. Dr. Joshua McCain, MD Reappointment as Active status for Teleradiology – Diagnostic Radiology privileges October 1, 2025 – September 30, 2025
   e. Dr. Paul Rupin, MD Reappointment as Active status for Teleradiology – Diagnostic Radiology privileges October 1, 2025 – September 30, 2025
   f. Dr. Carl Hsu, MD Reappointment as Active status for Emergency Medicine, Inpatient, and Clinic/Ambulatory privileges October 1, 2025 – September 30, 2025.

6. Personnel Matter –Evaluation § 54957
   a. CEO Matt Rees

R. Adjourn Closed Session; Report on Any Action Taken, If Needed

S. Resume Open Session

T. Adjourn

Abbreviations

ACHD	Association of California Healthcare Districts	*ACLS*	Advanced Cardiac Life Support Certification
AR	Accounts Receivable	*BLS*	Basic Life Support Certification
CAIR	California Immunization Registry	*CEO*	Chief Executive Officer
CFO	Chief Financial Officer	*CMS*	Centers for Medicare and Medicaid Services
CNO	Chief Nursing Officer	*COO*	Chief Operating Officer
CPHQ	Certified Professional in Healthcare Quality	*CQO*	Chief Quality and Compliance Officer
EMR	Electronic medical record	*ER*	Emergency Room
FTE	Full Time Equivalent/Full Time Employee	*HIM*	Health Information Management
HRG	Healthcare Resource Group	*HVAC*	Heating, Ventilation and Air Conditioning system
IGT	Intergovernmental transfer	*IT*	Information Technology
JPCH	Jerold Phelps Community Hospital	*LCSW*	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse	*MPH*	Master of Public Health
OBS	Observation	*PALS*	Pediatric Advanced Life Support Certification

PFS	Patient Financial Services	*QAPI*	Quality Assurance Performance Improvement
QIP	Quality Improvement Project/Program	*RN*	Registered Nurse
SHCC	Southern Humboldt Community Clinic	*SHCHD*	Southern Humboldt Community Healthcare District
SNF	Skilled Nursing Facility	*SWG*	Swing beds
DO	Doctor of Osteopathic Medicine		

PUBLIC COMMENT ON MATTERS NOT ON THE MEETING AGENDA: Members of the public are welcome to address the Board on items not listed on the agenda and within the jurisdiction of the Board of Directors. The Board is prohibited by law from taking action on matters not on the agenda, but may ask questions to clarify the speaker's comment and/or briefly answer questions. The Board limits testimony on matters not on the agenda to three minutes per person and not more than ten minutes for a particular subject, at the discretion of the Chair of the Board.

PUBLIC COMMENT ON MATTERS THAT ARE ON THE AGENDA: Individuals wishing to address the Board regarding items on the agenda may do so after the Board has completed their initial discussion of the item and before the matter is voted on, so that the Board may have the benefit of these comments before making their decision. Please remember that it is the Board's responsibility to discuss matters thoroughly amongst themselves and that, because of Brown Act constraints, the Board meeting is their only opportunity to do so. Comments are limited to three minutes per person per agenda item, at the discretion of the Chair of the Board.

OTHER OPPORTUNITIES FOR PUBLIC COMMENT: Members of the public are encouraged to submit written comments to the Board at any time by writing to SHCHD Board of Directors, 733 Cedar Street, Garberville, CA 95542. Writers who identify themselves may, at their discretion, ask that their comments be shared publicly. All other comments shall be kept confidential to the Board and appropriate staff.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, if you require special accommodations to participate in a District meeting, please contact the District Clerk at 707-923-3921, ext. 1276 at least 48 hours prior to the meeting."

**Times are estimated*

COPIES OF OPEN SESSION AGENDA ITEMS: Members of the public are welcome to see and obtain copies of the open session regular meeting documents by contacting SHCHD Administration at (707) 923-3921 ext. 1276 or stopping by 291 Sprowel Creek Rd, Garberville, CA 95542 during regular business hours. Copies may also be obtained on the District's website, sohumhealth.org.

Posted September 25, 2025

Governing Board

Date: August 28, 2025
Time: 1:30 p.m.
Location: Sprowel Creek Campus and Via Webex Conferencing
Facilitator: Board President, Kevin Church

Minutes

The following people attended at Sprowel Creek Campus and via Webex

The Governing Board consists of Corinne Stromstad, Kevin Church, Yvonne Hendrix, and Galen Latsko, all in person.

Not Present: Christopher Schille

Also in person: Administrative Assistant Darrin Guerra, Chief of Staff Joseph Rogers, CEO Matt Rees, CFO Paul Eves, CNO Adela Yanez, PFS Manager Marie Brown, CQCO Kristen Rees, HR Assistant Toni Genero, and HR Manager Season Bradley-Koskinen

Also via Webex: Vice Chief of Staff Carl Hsu, HIM Manager Remy Quinn, Grant Writer Nick Vogel, Quality Specialist Kana Voelckers, Heidi Hughes, Lab Manager Adam Summers, Business Development Director Ryan Staples, and COO Kent Scown

A. Call to Order – Board President Kevin Church called the meeting to order at 1:31 pm.

B. Approval of the Teleconferencing of a Board Member - None

C. Approval of the Agenda

Motion:	Galen Latsko motioned to approve the agenda.
Second:	Yvonne Hendrix
Ayes:	Corinne Stromstad, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

D. Public Comment on Non-Agendized Items

E. Board Member Comments - None

F. Announcements

1. Matt Rees shared that after over 50 years of serving the communities of Humboldt, Dr. Alan French OD has retired from Fortuna Optometry.

G. Approval of Consent Agenda

1. Approval of Previous Minutes
   a. Special Governing Board Meeting July 25, 2025
   b. Governing Board Meeting, July 31, 2025

2. SHCHD New and Updated Policies

   Clinic:
   a. Clinic Location &Hours of Operation
   Quality:
   b. Event Reporting
   c. Notary Services
   Skilled Nursing:
   d. Resident Elopement

3. Quarterly Reports - (Feb, May, Aug, Nov)
   a. Human Resources – Season Bradley Koskinen, HR Manager
   b. Foundation – Chelsea Brown, Outreach Manager
   c. Operations – Kent Scown, Chief Operations Officer

Kevin Church pulled G.1.A from the consent agenda.

Motion:	Galen Latsko motioned to approve the consent agenda.
Second:	Corinne Stromstad
Ayes:	Corinne Stromstad, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

Motion:	Galen Latsko motioned to approve agenda items G.1.A with corrections. Changed "Corinne Stromstad Adjourned Closed Session" to "Kevin Church Adjourned…" and "Corinne Stromstad Resumed Open Session" to "Kevin Church Resumed…"
Second:	Yvonne Hendrix
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

H. Last Action Items for Discussion

1. Sprowel Creek Parking Lot and Rejected Bids Update
   a. Due to the price of the current bids, Admin has decided to fill the Elm St parking lot with gravel and to return the Sprowel Creek plans to bid at a future date.
2. Med Staff Coordinator Update
   a. Numerous applications for the position have been received, but only two interviews have been completed. More information will follow in September.
3. Peer Review policy
   a. Dr. Rogers states that the policy is 90% complete and would like an additional extension to the September 30th Governing Board meeting.

I. Correspondence Suggestions or Written Comments to the Board - None

J. Administrator's Report – Matt Rees, CEO

Matt Rees presented the administrative report and updated the Board on some exciting news from the District this past month. We are happy to announce that the USDA Pre-Loan Application has been approved, and we expect to have the full application completed and submitted in the coming months. The Administrative Team is currently finalizing the contract with Elevate to outsource our ED providers and have agreed on a start date of November 3, 2025.

1. Department Updates
   a. Milestones
   b. August Employee Anniversaries
      1 Year: Infection Prevention, Ben Larkey
      5 Year: Ed tech, Katrina Rumley, Quality Specialist, Coral Cirabellini, and Dietary, Doris Sweeny
   c. Approval of the July Financials - Paul Eves – See Report
      i. Paul presented the July financials and answered corresponding questions.
   d. CNO Report – Adela Yanez – See Report
      i. Adela presented her staff report.

e. Family Resource Center – Amy Terrones – Mar and Oct - None

Motion:	Yvonne Hendrix motioned to approve the July 2025 Financials.
Second:	Galen Latsko
Ayes:	Corinne Stromstad, Galen Latsko, Yvonne Hendrix and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

K. Old Business - None

L. New Business

1. Annual Discussion and Approval of Employee Benefits: Resolution 25:04 Approval to Appoint Healthsure Insurance Services, Inc. as Broker of Record and Resolution 25:05 Electing Cease to be Subject to the Public Employees' Medical and Hospital Care Act.
   a. Toni Genero presented a report covering the Cost, Risk, and Benefits of keeping CalPers and moving to a new employee benefits program.
   b. The Board decided to return to this subject after the return to open session and voted as follows.

Motion:	Galen Latsko motioned to approve Resolution 25:04 Approval to Appoint Healthsure Insurance Services, Inc. as Broker of Record and Resolution
Second:	Corinne Stromstad
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

Motion:	Yvonne Hendrix motioned to approve Resolution 25:05 Electing Cease to be Subject to the Public Employees' Medical and Hospital Care Act
Second:	Galen Latsko
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

2. Resolution 25:03 Approval of a Loan from Umpqua Bank of up to $7.5 Million to Finance the Remodeling of Redwood Drive, Sprowel Creek housing unit, Sprowel Creek and Elm Street parking, and the Utility Upgrade Project

Motion:	Corinne Stromstad motioned to approve Resolution 25:03 Approval of a Loan from Umpqua Bank
Second:	Galen Latsko
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	Christopher Schille
Motion Carried	

M. Parking Lot - None

N. Meeting Evaluation

1. "It was an extensive surprise."

O. New Action Items

1. Approval of the Peer Review Policy

P. Next Meetings

1. Medical Staff Committee – Thursday, September 11, 2025, at 12:30 p.m
2. Medical Staff Policy Development Committee – Tuesday, September 16, 2025, 10:00 a.m
3. QAPI Meeting – Wednesday, September 10, 2025, at 10:00 a.m.
4. Finance Committee – Canceled
5. Special Governing Board Meeting – September 30, 2025, at 11:00 a.m.
6. Governing Board Meeting – September 30, 2025, at 1:30 p.m.

Q. Kevin Church Adjourn to Closed Session at 3:08 p.m.

1. Closed Session
2. Update on Peer Review, Credentialing, and Appointment/Reappointments – Medstaff
3. Compliance, Risk, and Reports of Quality Assurance Committees **[H&S Code § 32155]** - Kristen Rees, CQCO
4. Quarterly Reports -
   a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec.
   b. Patient Safety – Mar., June, Sept., Dec.

c. Medication Error – Feb., May, Aug., Dec.

5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]
   a. Dr. Lawrence Gettler**,** MD, recredentialing as Provisional status – Emergency Department privileges August 1, 2025 – December 31, 2025.
   b. Dr. Tiffany Ordonez, MD, Initial Appointment as a Medical Staff member, Provisional status in Clinic/Ambulatory and Inpatient, August 1, 2025, to July 31, 2026.
6. Personnel Matter –Evaluation § 54957
   a. CQCO Kristen Rees

R. Kevin Church Adjourned Closed Session

S. Kevin Church Resumed Open Session

1. Action Items to Report in Open Session

Motion:	Galen Latsko motioned to approve Dr. Lawrence Gettler**,** MD, recredentialing as Provisional status – Emergency Department privileges August 1, 2025 – December 31, 2025 and Dr. Tiffany Ordonez, MD, Initial Appointment as a Medical Staff member, Provisional status in Clinic/Ambulatory and Inpatient, August 1, 2025, to July 31, 2026.
Second:	Yvonne Hendrix
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	None
Motion Carried	

T. Kevin Church Adjourned Open Session

Submitted by Darrin Guerra

Abbreviations

ACHD	Association of California Healthcare Districts	*ACLS*	Advanced Cardiac Life Support Certification
AR	Accounts Receivable	*BLS*	Basic Life Support Certification
CAIR	California Immunization Registry	*CEO*	Chief Executive Officer
CFO	Chief Financial Officer	*CMS*	Centers for Medicare and Medicaid Services
CNO	Chief Nursing Officer	*COO*	Chief Operating Officer
CPHQ	Certified Professional in Healthcare Quality	*CQO*	Chief Quality Officer
EMR	Electronic medical record	*ER*	Emergency Room
FTE	Full-Time Equivalent/Full-Time Employee	*HIM*	Health Information Management
HRG	Healthcare Resource Group	*HVAC*	Heating, Ventilation and Air Conditioning system
IGT	Intergovernmental transfer	*IT*	Information Technology
JPCH	Jerold Phelps Community Hospital	*LCSW*	Licensed Clinical Social Worker

LVN	Licensed Vocational Nurse	*MPH*	Master of Public Health
OBS	Observation	*PALS*	Pediatric Advanced Life Support Certification
PFS	Patient Financial Services	*QAPI*	Quality Assurance Performance Improvement
QIP	Quality Improvement Project/Program	*RN*	Registered Nurse
SHCC	Southern Humboldt Community Clinic	*SHCHD*	Southern Humboldt Community Healthcare District
SNF	Skilled Nursing Facility	*SWG*	Swing beds
DO	Doctor of Osteopathic Medicine		

SoHum Health

733 Cedar Street
Garberville, CA 95542
(707) 923-3921
shchd.org

Southern Humboldt Community Healthcare District

GOVERNING BOARD RESOLUTION 25:03

APPROVAL OF A LOAN FROM UMPQUA BANK

A RESOLUTION OF SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT AUTHORIZING EXECUTION AND DELIVERY OF A LOAN AND SECURITY AGREEMENT, PROMISSORY NOTE, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR UPQUA BANK.

WHEREAS, **Southern Humboldt Community Healthcare District** (the "Borrower") has determined that it is in its best interest to borrow an aggregate amount not to exceed **$7,500,000.00** from Umpqua Bank (the "Lender"), and

WHEREAS, the Borrower intends to use the funds for the following: **Remodeling of the Redwood Drive Parcel, Remodeling of the Sprowel Creek housing Unit, Sprowel Creek and Elm Street Parking, and the Utility Upgrade Project**;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. **Matt Rees, Chief Executive Officer** (an "Authorized Officer"), is hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer deems necessary or advisable in order to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 2. The proposed Loan and Security Agreement (the "Agreement") dated as of August 28, 2025, which contains the terms of the loan, is hereby approved. The loan shall be in a principal amount not to exceed $7,500,000.00. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in a substantially said form that includes the Assignment of Anticipated Ad Valorem Operating Tax Assessment Collections in the event of default, with such changes therein as the Authorized Officer may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Section 3. The proposed form of Promissory Note (the "Note") dated as of **August 28, 2025**, as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with such changes therein as the Authorized Officer may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Environmental Compliance Certificate dated as of **August 28, 2025,** certifying for the benefit of the Lender to the best knowledge of Borrower with regard to any violations of or claims regarding environmental laws or conditions, is approved. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Environmental Compliance Certificate in substantially said form, with such changes therein s the Authorized Officer may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

PASSED AND ADOPTED by the Board of Directors of SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT, this 28th day of August 2025, by the following vote:

Ayes: Corinne Stromstad, Galen Latsko, Kevin Church, Yvonne Hendrix

Noes: _____

Abstain: _____

Absent: Chris Schilla

Witnessed by: Kevin Church, President

Witnessed by: Corinne Stromstad, Vice-President/Secretary

SECRETARY'S CERTIFICATE

I, Corinne Stromstad, Secretary of **Southern Humboldt Community Healthcare District**, hereby certify that the foregoing is a complete, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of **Southern Humboldt Community Healthcare District** duly and regularly held at the regular meeting place thereof on the 28th day of August, 2025 of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

Ayes: Kevin Church, Galen Latska, Corinne Stromstad, Yvonne Hendrix

Noes: _____

Absent: Chris Schille

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption, and is now in full force and effect.

Secretary

8/28/25
Date

SoHum Health

733 Cedar Street
Garberville, CA 95542
(707) 923-3921
shchd.org

Southern Humboldt Community Healthcare District

GOVERNING BOARD RESOLUTION 25:04

A RESOLUTION OF THE BOARD OF DIRECTORS OF SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT ELECTING TO APPOINT HEALTHSURE INSURANCE SERVICES, INC. AS BROKER OF RECORD AND TO PARTICIPATE IN THE COMMUNITY HOSPITAL INSURANCE COALITION EFFECTIVE JANUARY 1, 2026

WHEREAS,

1. The Southern Humboldt Community Healthcare District, a duly organized and existing hospital district under the California Health & Safety Code, is committed to prudent financial stewardship and the provision of accessible, high-quality healthcare services to its community; and
2. The Board of Directors recognizes the importance of comprehensive and cost-effective risk management and insurance solutions to support the District's operations; and
3. HealthSure Insurance Services, Inc. ("HealthSure") is an insurance brokerage firm specializing in risk management for community hospitals and public health entities, and serves as program administrator for the Community Hospital Insurance Coalition ("CHIC"), a group captive insurance program developed for the benefit of rural and community hospitals; and
4. The Board has reviewed and discussed the benefits of participation in CHIC, including potential cost savings, broader risk-sharing, access to specialized loss-control services, and enhanced long-term stability in insurance coverage; and
5. The Board has determined that appointing HealthSure as Broker of Record and joining the CHIC program is in the best interest of the District, its employees, and the community it serves;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Southern Humboldt Community Healthcare District as follows:

1. Broker of Record Appointment: Effective January 1, 2026, HealthSure Insurance Services, Inc. is hereby appointed as the exclusive Broker of Record for Medical/Health plan-related lines of insurance coverage for the District.

2. Participation in Coalition: The District hereby elects to participate in the Community Hospital Insurance Coalition (CHIC), effective January 1, 2026, and authorizes HealthSure, in its capacity as Broker of Record, to execute and administer all necessary documentation for such participation on behalf of the District.

3. Delegated Authority: The Chief Executive Officer (or General Manager) of the District is authorized and directed to take such actions, execute such agreements, and deliver such instruments as may be necessary or appropriate to effectuate the intent of this Resolution.

Effective Date: This Resolution shall take effect immediately upon its adoption

THE FOREGOING RESOLUTION WAS ADOPTED upon motion of Galen Latsko, Seconded by Corinne Stromstad of the Southern Humboldt Community Healthcare District Governing Board at a Board meeting held on the 28th day of August, 2025, by the following roll call vote:

Ayes: CorinneStromstad, Galen Latsko, Kevin Church, Yvonne Hendrix

Noes: _____

Abstain: _____

Absent: Chris Schille

_____
Witnessed by: Board President

_____
Witnessed by: Vice President/Secretary

RESOLUTION NO. 25:05
ELECTING CEASE TO BE SUBJECT TO
THE PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT

(700 Non-PERS All Employees)

WHEREAS, (1) Government Code Section 22938 provides that a contracting agency which has elected to be subject to the Public Employees' Medical and Hospital Care Act (the "Act") may cease to be so subject by proper application by the contracting agency; and

WHEREAS, (2) Southern Humboldt Community HealthCare District is a contracting agency under Government Code Section 22920 and subject to the Act; now, therefore be it

RESOLVED, (a) Southern Humboldt Community HealthCare District elects to cease to be subject to the Act; and be it further

RESOLVED, (b) That coverage under the Act cease on December 31, 2025.

Adopted at a regular meeting of the Governing Board at 286 Sprowel Creek RD, Garberville CA, 95542, this 28th day of August, 2025.

Signed: _____
President, Kevin Church

Attest: _____
Vice President, Corinne Stromstad

Subject:	Manual:
Registration Procedures	**Patient Financial Services**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to register patients accurately and completely, in accordance with appropriate medical records guidelines and insurance requirements.

PROCEDURE:

All procedures and processes for registration are contained in the electronic health record (EHR) system, using the F1 help key for work flows. These work flows are updated when new or revised processes and procedures are put in place. Patient financial services (PFS) staff are notified of the updates. They reference the current EHR hospital and clinic system.

The work flows include detailed instructions and visual aids when deemed helpful. They include, but are not limited to, information regarding insurance specifics; patient type specifics; patient paperwork and signature requirements;On the 'S' drive containsare other resourcesresourses including daily checklists; and many other detailed aspects of how, when, and why to register patients in different settings with different insurances.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Debt Collection	**Patient Financial Services**

POLICY

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure compliance with all federal and state debt collection regulations.

Definitions

Charity Care: Free care.

Discount Payment: Any charge for care that is reduced but not free.

High Medical Costs:

"A patient with high medical costs" means a person whose family income does not exceed 400 percent of the federal poverty level. For these purposes, "high medical costs" means any of the following:

- Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.
- Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months. Out-of-pocket expenses means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

PROCEDURE

(a) SHCHD shall not assign an account to collection or advance patient debt to a debt buyer, as defined in Section 1788.50 of the Civil Code, unless all of the following apply:

(1) SHCHD has found the patient ineligible for financial assistance, or the patient has not responded to any attempts to bill or offer financial assistance for 180 days.

(2) SHCHD includes contractual language in the sales agreement in which the debt buyer agrees to return, and SHCHD agrees to accept, any account in which the balance has been determined to be incorrect due to the availability of a third-party payer, including a health plan or government health coverage program, or the patient is eligible for charity care or financial assistance.

(3) The debt buyer agrees to not resell or otherwise transfer the patient debt, except to SHCHD or if the debt buyer is sold or merged with another entity.

(4) The debt buyer agrees not to charge interest or fees on the patient debt.

(5) The debt buyer is licensed as a debt collector by the Department of Financial Protection and Innovation.

(b) SHCHD shall be the only authority to assign an account to collection or advance patient debt to a debt buyer. A list of accounts may be prepared by SHCHD or an assigned third-party billing vendor once the accounts meet all needed criteria, but all balances shall be reviewed and approved for advance only by SHCHD.

(c) SHCHD has established standards and practices for the collection of debt and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to SHCHD's standards and scope of practices.

(1) This agreement shall require the affiliate, subsidiary, debt buyer, or external collection agency of SHCHD that collects the debt to comply with SHCHD's definition and application of a reasonable payment plan.

(2) This policy and any agreements shall not constitute a conflict with other applicable laws or regulations and shall not be construed to create a joint venture between SHCHD and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables.

(3) In determining the amount of a debt SHCHD may seek to recover from patients who are eligible under SHCHD's charity care policy or discount payment policy, SHCHD may consider only income and monetary assets as limited by California Code, Health and Safety Code - HSC § 127405.

(d) At the time of billing or assignment of an account to collections, SHCHD shall provide a written summary or applicable policy consistent with California Code, Health and Safety Code - HSC § 127410 and HSC § 127430 , which shall include information about the availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies.

(e) Before assigning an account to collections, or selling patient debt to a debt buyer, SHCHD shall send the patient account guarantor a notice with all of the following information:

(1) The date or dates of service of the account that is being assigned to collections or sold.

(2) The name of the entity the account is being assigned or sold to.

(3) A statement informing the patient how to obtain an itemized hospital bill from SHCHD.

(4) The name and plan type of the health coverage for the patient on record with SHCHD at the time of services or a statement that SHCHD does not have that information.

(5) An application for SHCHD's charity care and financial assistance.

(6) The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

(f) SHCHD, any assignee of SHCHD, or another owner of the patient debt, including a collection agency or debt buyer, shall not commence a civil action against the patient for nonpayment before 180 days after initial billing by SHCHD.

(g) SHCHD shall not use income tax returns or pay stubs for collections activities.

(h) If a patient is attempting to qualify for eligibility under SHCHD's charity care or discount payment policy and is attempting in good faith to settle an outstanding account with SHCHD by negotiating a reasonable payment plan, or by making regular partial payments of a reasonable amount, SHCHD shall not send the unpaid account to any collection agency, debt buyer, or other assignee.

(i) Extended payment plans offered by SHCHD to assist patients eligible under SHCHD's charity care policy, discount payment policy, or any other policy adopted by SHCHD for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest-free.

(1) SHCHD extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring SHCHD extended payment plan no longer operative, SHCHD, collection agency, debt buyer, or assignee shall make a reasonable attempt to contact the patient by telephone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. The notice and telephone call to the patient shall be made to the last known telephone number and address of the patient. Prior to SHCHD extended payment plan being declared inoperative, SHCHD, collection agency, debt buyer, or

assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient.

(2) SHCHD, collection agency, debt buyer, or assignee shall not commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative.

(3) If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this subdivision does not limit or alter the obligation of the patient to make payments on the obligation owing to SHCHD pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subdivision

(j) The period described in (a)(1) of this policy shall be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made, if the patient makes a reasonable effort to communicate with the hospital about the progress of any pending appeals.

(1) For purposes of this subsection, "pending appeal" includes any of the following:

(A) A grievance against a contracting health care service plan.

(B) An independent medical review.

(C) A fair hearing for a review of a Medi-Cal claim.

(D) An appeal regarding Medicare coverage consistent with federal law and regulations.

(k) For further information on provisions related to California Code, Health and Safety Code - HSC § 127405, please reference SHCHD's Charity Care, Financial Assistance, Payment Plans, and Discounted and Extended Payment Plans Policy.

(l) This policy does not diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law.

REVIEWED BY:

Revenue Cycle Manager
Health Information Management
Chief Quality and Compliance Officer

SoHum Health

Subject: Monthly Medication Regimen Review	Manual: Hospital Pharmacy

POLICY:

It is the policy oif the Southern Humboldt Community Healthcare District ("SoHum Health", "District", SHCHD")Skilled Nursing Facility to ensurehat a licensed pharmacist will reviews eachthe resident's drug regimen, including the resident's chart within seven (7) calender days of admission and at least once a month. The pharmacist may need to conduct the medication regimen review more frequently depending on the resident's condition(s), review of skilled -nursing resident's medication(s),s and risk of adverse consequences. The licensed pharmaciust will report in writing, any irregularities to the attending physician and the Ddirector of Nnursing to be acted upon. These reports will be maintained in the resident medical record.

PROCEDURE:

1. The cConsultant Pharmacist will perform a monthly drug regimen review on each resident at least monthly unless the resident condition/risk will indicates a more frequent schedule that is individualized and communicated between the facility clinical staff and the pharmacist.
2. This review shall be performed by evaluating the medical record of each resident, which contains the current mMedication rRegimen as documented on the most recent pPhysician's oOrder sSheets or electronic record of current orders.
3. Irregularities identified will be documented on a separate, written report known as the "Monthly Drug Regimen Review". This report is located in each resident binder, listing the resident name, relevant drug, and irregularity the pharmacist has identified. If an irregularity requires urgent action, the pharmacy consultant will immediately report the irregularity to the Director of Nursing and the attending physician by phone or Webex.
4. The attending physician will review the "Drug Regimen Review" sSheets at least monthly to ensure they are compliant with their review and documentation.
5. The attending physician shall act upon the "Drug Regimen Review" findings/recommendations in a timely manner of seven (7) 14 days or less. The physician shall document in the resident record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated.
6. Upon completion, the cConsultant Pharmacist shall provide written documentation of all recommendations and submit monthly to the facility for attending physician or designee's review and response. The written documentation and prescriber response shall be considered a permanent part of each resident's medical record.
7. If the review is off siteoffsite, the pharmacist will document findings and send the report electronically to the facility to include in the medical record.

DEFINITIONS:

Word: None

SoHum Health

Subject:	Manual:
~~SNF Quality Assurance Policy: Registered Nurse~~ Staffing and Coverage	Skilled Nursing Facility~~Quality~~

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure adequate and qualified Registered Nurse (RN) coverage at all times, consistent with federal and state regulations, to meet the complex medical needs of residents and promote their highest practicable physical, mental, and psychosocial well-being. This policy outlines the facility's commitment to quality assurance and continuous performance improvement related to nurse staffing.

PROCEDURE:

Minimum requirements

- **8-Hour Daily RN Coverage:** An RN must be on duty and physically present in the facility for at least eight consecutive hours per day, every day of the week.
- **24-Hour Licensed Nurse Coverage:** The facility will provide 24-hour licensed nursing services. During the 16 hours when an RN is not on duty, a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) will be on duty.
- **Director of Nursing (DON):** The facility must employ a full-time Director of Nursing who is a Registered Nurse.

Staffing M~~m~~anagement and Q~~q~~uality A~~a~~ssurance

- **Facility Assessment:** The Skilled Nursing Facility~~quality department~~ will ensure a comprehensive facility assessment is conducted and documented annually. This assessment determines the appropriate ~~mix and~~ level of staffing needed based on the resident population's acuity, diagnoses, and care needs.
- **Performance Improvement Projects (PIPs):** The Skilled Nursing Facility ~~quality department~~ will work in conjunction with the Quality Department to initiate and oversee Performance Improvement Projects, which could include ~~focused on~~ nursing coverage. These projects will use data to improve

processes and address quality deficiencies, such as preventing avoidable falls or pressure ulcers, which may be~~are~~ directly related to staffing levels.

- **Data Monitoring:** The Skilled Nursing Facility~~department~~ will continuously monitor and analyze staffing data, including hours per resident day (HPRD), staff turnover, and adverse event reporting, to ensure optimal staffing levels are maintained. This data will be used to track progress toward quality objectives.

- **Training and Competency:** The Skilled Nursing Facility~~quality department~~ will ensure nursing staff receive regular, comprehensive training to maintain and enhance their skills, particularly for high-acuity residents. New staff will be properly onboarded and trained on ~~all~~ facility policies.

- **Resident and Family Feedback:** Input from residents, families, and staff regarding nursing care quality and staffing will be regularly solicited and incorporated into QAPI initiatives as appropriate.

- **Emergency Contingency Planning:** A documented plan will be in place to address unexpected staffing shortages due to call-outs, severe weather, or other emergencies to ensure continuous, safe coverage.

Regulatory compliance and reporting

- **Daily Posting:** The total number of licensed and unlicensed nursing staff working each shift and the actual hours worked will be posted daily in a public area, as required by law.

- **Audits and Documentation:** The Skilled Nursing Facility~~quality department~~ will conduct regular, unannounced internal audits of staffing schedules and payroll-based journal (PBJ) data to verify compliance with staffing requirements. All staffing records will be ~~meticulously~~ documented for state surveys and audits.

- **Reporting:** Any failure to meet minimum staffing standards will be immediately investigated, corrected, and reported to the Quality Assessment and Assurance (QAA) committee. An action plan will be developed to prevent recurrence.

DEFINITIONS: NONE

Subject:	Manual:
Insulin Utilization	**Nursing**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SoHum Health", "District", "SHCHD") to detail the storage, handling, ordering, preparation, dispensing, administration, documentation, and disposal of all insulin products available at SoHum Health. In order to provide an environment conducive to pPatient safety, SoHum Health has implemented a protocol for the storage, dispensing, and oversight of all iInsulin products.

Insulin has been identified by the Institute of Safe Medication Practices (ISMP) at SoHum Health as a "High Alert" medication. Insulin products are capable of causing patient harm and must be ordered, stored, handled, prepared, dispensed, and administered with redundant medication safety measures in order to avert potential adverse events.

PROCEDURE:

Insulin Administration

Insulin Formulations Available:

- Approved insulin types (i.e. insulin lispro, insulin regular, and/or insulin glargine) mutli-dose vials may be available in secured Automated Dispensing Machines (ADMs) refrigerators on designated nursing units.
- At times insulin will be dispensed thru Garberville Pharmacy and labeled as patient specific.
- Insulin vials will be provided in the most appropriate dosage form/package size available from the manufacturer, in order to reduce the risk of patient harm and minimize waste.
- All insulin shall be drawn up within an insulin-syringe (or equivalent), following high risk/high alert and bar code medication administration procedures prior to administration.

Labeling of Insulin:

- Insulin vials will be labeled with a patient specific label with insulin formulation, dose, directions for use, and frequency.
- Insulin iInfusions will be labeled with a patient-specific label with iInsulin formulation, concentration, and bar code label.
- Insulin vials are given a 28-day expiration date once opened or stored at room temperature. These vials may be stored at room temperature or under refrigeration when dispensed to patient care areas.
- The open and expiration dates shall be written on the appropriate auxiliary label. For insulin pens, the auxiliary label shall be placed unto the pen itself, not the cap.

Double Verification upon Administration or Titration:

- Insulin represents a High Alert Medication class and requires additional safeguards to prevent patient harm. For this reason, SoHum Health requires that two independent clinicians verify insulin orders prior to administration for orders containing intravenousIV insulin, or subcutaneous insulin.

- Two licensed SoHum Health cClinicians will verify the following prior to administration: the licensed independent practitioner (LIP) order, type of insulin, dosage, route, time, and most recent blood glucose level.
- The double verification will be documented in the medication administration record (MAR).

Storage:

- Insulin vials are stored in a pharmaceutical grade refrigerators.
- Insulin vials are stored in patient-specific medication bins or designated refrigerators.
- Insulin vials stored within Pyxis will be visibly designated as High Alert Medications.
- All insulin formulations are stable in vial form at controlled room temperature for 28 days upon initial removal from refrigeration.

Disposal:

Following insulin order discontinuation and/or hospital patient discharge, all insulin vials stored in patient-specific bins will be discarded in designated universal pharmaceutical waste receptacles located by the nNurse's sStation and/or hospital pPharmacy.

Routes of Administration

Subcutaneous Insulin Injections

- Insulin injections will be administered subcutaneously in the abdomen whenever possible. If the patient has a contraindication to receiving an injection subcutaneously in the abdominal area, the subcutaneous tissue located in the back of the upper arm can be used as an alternative location. Subcutaneous insulin injections into the deltoid area should be avoided due to risk of inadvertent intramuscular injection.

RN Responsibilities

If an altered level of consciousness, cognitive capability, depression / suicidal tendencies or physical limitations are noted at any time, the RN is to do all of the following:

A. Notify the Attending Physician immediately
B. Request orders for alternative insulin delivery
C. Check bBlood gGlucose per the pPhysician's order.
D. Document the programmed basal rate(s) and any bolus doses, in the medical record.
E. Assess the infusion site every shift and document in the medical record.

~~Patient responsibilities~~

Intravenous Insulin Injections

Patients treated for emergent hHyperkalemia may utilize iInsulin rRegular & dDextrose 50% administered intravenously for the emergent treatment of hHyperkalemia.

Management of Hypoglycemia

Hypoglycemia will be managed as per the SoHum Health "Hypoglycemia Management Protocol" within EpicPIC.

Insulin dosage and/or dietary plan may be adjusted in response to hypoglycemic episodes.

DEFINITIONS:

Beyond Use Date - The date beyond which a compounded drug or preparation can no longer be safely used. It is established by the compounding pharmacy following United States Pharmacopeia (USP) guidelines.

Expiration Date - The date beyond which the manufacturer no longer guarantees the safety or potency of a drug. It is determined by the manufacturer and verified by the United States Food and Drug Administration (FDA).

~~**References**~~

~~California Board of Pharmacy Laws & Regulations, ISMP~~

~~Refer to the following policies: High Alert, Medication Administration, Patient Own Medication, Medication Formulary and Clinical Pharmacy Protocols, Patient Own Medical Equipment, Medication Labeling. Medication Monitoring and Storage, Prescribed Orders, Compounding of Sterile Preparations Outside Pharmacy Services, Compounding of Sterile Preparations~~

~~**Reviewed by**~~

~~Director of Pharmacy Services~~

~~Chief of Nursing~~

~~DON~~

SoHum Health

Subject:	Manual:
Death of a Resident	**Skilled Nursing Facility**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate postmortem care.

PURPOSE:

The purpose of this policy and procedure is to provide guidelines for the nursing staff to follow when a resident dies.

PROCEDURE:

The care given a body after death (postmortem care) must preserve the cultural expectations, rights, and dignity of the expired resident and his family during a traumatic event.

The procedure is designed to:

- Prepare the body for viewing by the family.
- Assemble possessions to be given to the family or sent with the body.
- Properly identify the body and transfer to the coroner OR MORTUARY.
- Systematically notify all necessary departments, family, etc.

The resident must be pronounced dead by a physician. The nurse on duty will call the ~~ED~~ on-call physician to pronounce the resident. If a physician is unable to come to the facility in a timely manner to pronounce the patient, the licensed nurse must record appropriate information to reflect that "no signs of life" are apparent. For example:

"No blood pressure or respirations are obtainable. No pulses felt and no apparent signs of life present."

- The family must be notified of the resident's death either by the physician or licensed nurse.
- Notify the coroner if death is a coroner's case; the body is released or held for autopsy on his order. (See criteria for coroner's case below.)
- Check with the physician before removing any drains or tubes from the body. They are left in place if an autopsy is to be performed.
- Notify appropriate religious representative, if any.
- Fill in discharge information on admission sheet.
- Notify appropriate departments, i.e. business office, dietary.
- Notify Mortuary of family's choice.
- Have family sign "Release of Body" form.

CARE OF THE BODY

EQUIPMENT:

- Basin of water
- Towels
- Laundry Bag
- Clean dressing, if needed
- Large bag or box for clothing and belongings
- Chux

1. Straighten the body and elevate head on one pillow this prevents post-mortem hypostasis which might discolor the face.
2. Insert dentures, upper set first, and close mouth. If unable to insert, place in labeled cup for mortician to take. Rigor mortis starts in the jaw and may not disappear for 6 days.
3. Close eyes by gently pulling down on lashes. Pressure on eyelids may give unnatural appearance and prevent closure.
4. Jewelry may be left with body if mortuary representative signs a release. Document any jewelry removed by family. If any other jewelry or valuables, place in valuables envelope and have person sign for it.
5. If an autopsy is ordered, leave any tubes in place. Tubes sutured in place must be removed by physician. If no autopsy is anticipated, remove all tubes after checking with the physician.
6. Bathe the body, if needed, and comb hair out of consideration for the mortician.
7. Change dressings if needed.
8. Place body in supine position. Sphincter relaxation is part of the death process. Place perineal pads over perineum.
9. Check wrist for identification bracelet. If band is missing, the nurse must replace it.
10. Extend the arms at sides. Cover body to neck with a sheet. Ask the physician if family wishes to see the body. If so, ask them to come in.
11. If an extended wait for family is expected, the body should be moved to a single room if it is not already in a private room.

Nursing Documentation Requirements:

- Resident's physical condition prior to death and any action taken.
- Administration of Last Rites of church or attendance of a Rabbi, Minister, or Priest.
- Time resident was pronounced dead and by whom, time and name of physician notified.
- Presence of family and/or notification to them of resident's death and by whom.
- Time body was released to and transferred by mortician, including signed release form from the mortician.
- In a coroner's case, record the date and time the coroner's office was notified, name of coroner's representative, and any instructions given.

CRITERIA FOR CORONER CASE

The coroner must be notified when a death has occurred under certain specific circumstance (Government Code sections 27491 and 27491.1; Health and Safety Code section 102850).

Health and Safety Code section 102850 provides that:
A physician and surgeon, physician assistant (in a skilled nursing facility or intermediate care facility), funeral director, or other person shall immediately notify the coroner when he or she has knowledge of a death that occurred under any of the following circumstances:

- Without medical attendance.
- During the continued absence of the attending physician and surgeon.
- Where the attending physician and surgeon or the physician assistant (in a skilled nursing facility or intermediate care facility) is unable to state the cause of death.
- Where suicide is suspected.
- Following an injury or accident.
- Under circumstances which raise a reasonable suspicion that the death was caused by the criminal act of another.

Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.

In a coroner's case the physician last in attendance does not complete the medical and health section data; does not sign the certificate; and does not solicit an autopsy permit or order an autopsy without the permission of the coroner.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Discharge from Skilled Nursing	**Skilled Nursing Facility**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to have a plan for each resident being discharged.

PURPOSE:

The purpose of this policy is to outline the process for discharging a resident.

PROCEDURE:

1. Set up a discharge appointment with the provider.
2. Inform resident and/or responsible party of discharge date and time of appointment and arrange for transportation.
3. Assess for any medical equipment that may be needed for discharge. Obtain order for any needed equipment and order from appropriate business. Confirm time of delivery.
4. Arrange for any assistance needed from outside agencies (Meals on Wheels, visiting nurse)
5. On day of discharge, after appointment with the provider, print out discharge instructions, print out medication reconciliation list, explain to resident and/or responsible party, and confirm clear comprehension.
6. Have resident or responsible party, sign discharge instructions and Medication Reconciliation, obtain a copy and place in Medical Records box at the nurses' station.
7. Only medications that resident has a current order for are to be discharged with the resident.
8. Any medications, including narcotics, that there aren't a current order for are to be destroyed. All narcotics sent with resident must be counted by two nurses before giving to resident and signed off on the narcotic log by two nurses stating that medication has been sent with resident.
9. Obtain any prescriptions or triplicates to be filled from the provider. Make a copy to be placed in medical records and send the original with the resident.
10. Inventory the resident's belongings, add to the discharge section of the inventory list, have resident/responsible party sign for belongings. Send belongings with resident. Check room to make sure no belongings are left behind.
11. Escort resident to mode of transportation and assist with transfer if needed.
12. Document in the Electronic Medical Record (EMR) in nurses' note: time of departure, explanation of medications and discharge instructions, current medications sent with resident, how resident transferred to vehicle, dietary notified, registration notified.
13. Give completed discharge slip to registration staff.
14. Give completed dietary slip to dietary to notify time of discharge.
15. Discontinue all care plans and Physician orders, except outstanding lab orders in EMR.

Inform housekeeping of resident discharge so room can be cleaned.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pastoral Services	**Skilled Nursing Facility**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure the religious needs of each resident are met.

PURPOSE:

The purpose of this policy is to ensure the religious and spiritual needs of each resident are met.

PROCEDURE:

1. The purpose of our pastoral policies is to establish a uniform set of procedures to follow in providing religious services to residents, staff, and family members.

2. The objectives of our pastoral services are:

    a. To meet the religious needs of residents;

    b. To enable residents to participate in their religious beliefs, worship, devotions, ritual observations, and sacramental ministrations;

    c. To provide assurance and support in times of uncertainty and crisis;

    d. To maintain a tie with the community when the resident is separated from his/her normal life setting because of illness or infirmities;

    e. To provide visitation for prayer and consultation; and

    f. To assist the resident and family when decline and death are inevitable.

3. In the absence of a pastoral department, pastoral services are under the general supervision of the activity director.

4. The activity director is responsible for assisting clergy in their activities when necessary or as requested.

5. SHCHD employees are also instructed to make and will call for a resident who requests that the clergy of his church be called and a visit requested.

6. A list of clergy will be kept at the nurses' station for reference.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Resident Care Planning	**Skilled Nursing Facility**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide all residents with an accurate and up-to-date plan of care.

PURPOSE:

The purpose of this policy and procedure is to delineate the process for care planning and documentation. The purpose of resident care planning is to develop a coordinated and comprehensive plan in order to meet the resident's individual needs. Resident care planning includes participation from all involved health care disciplines and initiated on admission with continual reassessment until resident discharge. The primary process utilized is the resident assessment instrument with the results of this process recorded in the resident care plan.

PROCEDURE:

Definition

The resident care plan is a current, written, and personalized plan for the individual resident indicating the care he/she needs, how it can best be accomplished and the goals the interdisciplinary team collectively hopes to help the resident achieve.

Upon admission the nurse gathers data and inputs it into the Electronic Medical Record (EMR) system. The nurse will complete weekly summaries which will then be used to gather data for the Minimum Data Set (MDS). The MDS coordinator will enter the data into the EPICjRAVEN system. The MDS system auto populates appropriate plans of care for each individual resident. The plans of care are found in paper form which are initiated and updated as needed by the MDS coordinator and the nursing staff and reviewed monthly by the Skilled Nursing Facility (SNF) Manager/Director of Nursing (DON).

Any change in a resident's condition requires notification to the provider, SNF Manager/DON, and a full care plan review and/or update.

The process of evaluation and re-assessment of the resident care plan will occur on a continuing basis as needed until the resident is discharged. However, each individual resident care plan will be reviewed and re-evaluated at least every month.

Guidelines

- The resident care plan is a permanent part of the resident's health record.
- The resident care plan shall be kept in the resident's health record and shall be readily available to all personnel providing resident care.
- The language shall be simple to ensure all levels of the interdisciplinary team can understand the plan of care.

Resident Care Plan Development

It is the responsibility of nursing services to develop and maintain resident care plans. However, all members of the interdisciplinary team shall participate in developing the plan of care, including their observations of the resident and recommendations.

Steps of Development:

- Gathering information
- Writing the plan
- Using the plan

- Evaluating the plan
-

Gathering Information

In order to develop a meaningful resident care plan, information shall be gathered as it relates to the following resident's needs or problems: (On admission utilize the information gathered from the Nursing Assessment.)

- Motor ability
- Elimination
- Sleep and rest
- Food and fluids
- Sensory
- Emotional
- Mental
- Personal, cultural and social
- Spiritual
- Physical factors
- Discharge plans

Sources of information

- Resident's health records
- Resident
- Family
- Physician
- Other health care personnel when applicable (physical therapist, social worker, occupational therapist, dietitian, activity director)
- Screening guide

Developing the plan of care

Upon initiating the resident care plan, all pertinent identifying information regarding the resident will be completed first. Information regarding the following components of the resident care plan will then be determined and recorded:

- The resident's problems, needs, and goals
- The interdisciplinary services plan of care
- The discharge plan

Resident PROBLEMS, NEEDS, GOALS

Identify the problems or needs. After the information has been gathered the data must be analyzed in order to determine what resident problems and needs exist. The following guidelines should be employed when identifying, selecting, and recording problems.

- The date the care plan was populated or initiated should reflect the date that the problem was identified.
- A resident's problem is a difficulty or concern experienced by the resident. Be sure to determine the resident's needs not your own.
- The resident's problems include currently existing difficulties as well as potential problems. (i.e. potential skin breakdown in a high-risk resident)
- Problem statements should be written so as to reflect physical, psychological, or social difficulties.
- Problem statements should be followed with a "due to" and or "related to" phrase relating the perception of the cause of the problem from a nursing standpoint.

Determine the resident's goals or expected outcomes. When determining expected outcomes or goals, the following should be kept in mind:

Short-term goals

A short-term goal is a quick resulting effort which can realistically be reached within the patient's abilities. Each problem should have a short-term goal. It should be simple, specific, measurable, and patient-oriented. It should indicate progress toward problem resolution.

Long-term goals

A long-term goal is the end result of short-term goals which leads to the highest obtainable level of independence for the resident. The long-term goal is stated in relation to the expected course of the resident's condition and is determined collectively by the health care team.

Sample explanation: Self-care may be a long-term goal, but for a resident who has had a radical mastectomy, this long-term goal is attained step-by-step through the achievement of short-term objectives such as self-feeding, combing hair, applying make-up, self-direction in doing prescribed exercises, and acceptance of the operation and its implication.

Changes: If any goal changes (long or short term), resolve it and initiate a new goal and current date.

Select the actions/approaches

When selecting appropriate actions or approaches toward resolving the resident's problems, the following must be remembered:

- Actions must clearly state and be specific as to the "how."
- Some actions or approaches may be more appropriate to defer or may be medically prescribed to defer until a later time (i.e. defer a bladder training program until the problem of anxiety is resolved).
- In some cases there are no immediate solutions, but the problem remains under consideration until actions or approaches can be determined. Although specific actions are performed according to the individual responsible discipline, the health care team's collective actions provide the most effective solution toward resolution of the resident's problem.

Document resolution of the problem

As a problem becomes resolved, the appropriate date will be indicated in the resident care plan.

Interdisciplinary Services

- All interdisciplinary services shall provide information regarding resident problems, goals, plan of care, treatment, etc. as appropriate. This information should then be recorded in the care plan.
- The Activity Plan shall be outlined, reviewed, and updated on the resident care plan on a quarterly basis and as needed.
- Dietary Services, Activity Services, etc., shall outline, review, and update the patient care plan as needed.

Using the Plan

In order to develop and maintain a complete resident care plan and promote continuity of care, input and involvement from nursing personnel from all three working shifts is necessary. Additionally, more information may be gathered or resident needs may change as a result of physiological, pathological, and psychological processes. As the plan is used and desired results are not achieved or as changes occur, the team action may need to be modified to meet the needs of the resident.

The mere development of the plan for each resident does not insure that it will be followed; this is accomplished through assignment of team members on the basis of their competence and the needs of the residents. In addition, it is necessary to make periodic observations and evaluations of each patient and determine that:

- The right person is caring for the resident
- The plan is being carried out
- The goals are being met

Evaluating the Plan

When evaluating and re-assessing the plan of care for the resident, the following shall be considered:

- Are the resident's problems still current? Are there new problems?
- Are the short-term goals realistic?
- Are the actions/approaches appropriate and effective?
- Are the health care disciplines involved in the plan of care as needed?
- Does the long-term goal remain appropriate?

Discharge Plan

Part of the resident care planning process includes an assessment of the resident in terms of planning for his/her discharge to a lower level of care whenever possible.

Initial Discharge Plan

In order to develop the initial discharge plan, the following information shall be determined and recorded on the resident care plan:

- Purpose of admission
- Rehabilitative potential
- Expected length of stay
    - Anticipated level of care needed
    - Need for continued skilled nursing care on a long-term basis
    - Possible transfer to lower level of care at intermediate care facility or residential care facility
    - Return to resident's own home
- Current or anticipated discharge needs if any
- When considering a return to a lower level of care, services which the resident is expected to need should be identified (i.e. Meals on Wheels, visiting nurse, medical equipment, etc.)

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Chaperones	**Emergency Department**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to preserve the dignity of all patients by providing chaperones during any, and all sensitive medical examinations and/or procedures involving opposite gender patient/provider interactions. A patient and/or a provider may at any time request a chaperone and that request will be honored. The job of the chaperone is to enhance the patient's and provider's comfort, safety, privacy, security and dignity during sensitive exams or procedures. It is understood by all parties involved that professional standard of privacy and confidentiality will be maintained.

PURPOSE:

The purpose of this policy is to ensure the dignity of all patients during sensitive medical examinations.

PROCEDURE:

- It is strongly recommended that all practitioners have an appropriate chaperone with them during physical examinations of breasts, vagina, penile, scrotal or rectum.
- The need for the presence of a chaperone may be waived by any patient; this must be documented in the medical record.
- A chaperone will be offered/provided whenever requested by a patient.
- Chaperones must be SHCHD employees and must be at least 18 years old. All chaperones be healthcare professionals.
- Family members may be present during exams and procedures if this is desired by the patient and is
- acceptable to the practitioner. However, the family member is not considered a chaperone. An SHCHD
- healthcare professional must also be in attendance.

DEFINITIONS:
NONE

SoHum Health

Subject:	Manual:
Death of a Child in the Emergency Department	**Emergency Department**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure all healthcare professionals who come in contact with the family and ill/injured child at the time of initial crisis adequately assess and respond to the emotional, cultural, and procedural issues required of caring for ill and injured children who die. This is most often a sudden, unexpected event and for many families the process of bereavement after the loss of a child begins in the ED.

PURPOSE:

The purpose of this policy and procedure is to best prepare healthcare professionals to provide effective communication, convey empathy and compassion and minimize misunderstanding during this uncommon event. Procedure must include support for the grieving family, notification of the child's primary care physician, and appropriate authorities. No single policy or plan can address all situations, but the following protocol can better prepare staff.

PROCEDURE:

Initial Care:

When an infant or young child presents in the emergency department of the hospital in a lifeless or near lifeless condition, the child is evaluated, and emergency resuscitative measures are instituted if necessary and appropriate. It is very reassuring for parents to know that everything possible is being done for their child.

Medical Evaluation and Diagnosis:
Before speaking with the family, the emergency personnel team should review information provided by parents, caretakers, police, and ambulance personnel. This review will assist the healthcare team in determining an appropriate and sensitive approach to discuss the child's death with family members.

In cases of sudden and unexpected infant or child death, causes, which should be considered, are:

- Infections: sepsis, meningitis, encephalitis, pneumonia, and botulism
- Cardiac disease: myocarditis, congenital heart disease, and sudden arrhythmia
- Aspiration or airway obstruction
- Injury
- Congenital anomalies
- Genetic disorders
- Seizure disorders
- Sudden Infant Death Syndrome (SIDS) or sudden unexpected death in childhood

Any diagnosis made in the emergency department is tentative pending an autopsy and death investigation unless there is a documented disease or obvious severe injury. The medical examiner, who must be notified regarding the infant's death, makes the final decision concerning the performance of the autopsy and determination of final cause of death.

SIDS is diagnosed based on the absence of diagnostic conditions plus autopsy findings consistent with the typical findings of SIDS (intrathoracic petechiae, mild pulmonary edema, and minor inflammatory changes in the airway.) SIDS is the final diagnosis in about 85% of sudden and unexplained infant deaths.

Additional pertinent information, which may be helpful in assisting the pathologist as well as those providing counseling, may be documented on the emergency room form. (See Appendix B)

Informing the Parents:

It is desirable that the doctor in charge of the resuscitative effort or the primary care physician (if present in the emergency department), and the emergency team member who has been assigned to the family be present when the family is informed of the child's death. The physician may tell the family: "We know your child died suddenly and unexpectedly; an autopsy must be performed to establish the cause of death."

If the family is resistant to the idea of autopsy, the physician or nurse may be able to alleviate anxiety associated with this procedure.

- It is helpful to explain to parents that an autopsy is a medical procedure like surgery or an "operation." A specialized physician or pathologist performs this operation in a respectful manner.
- Besides ruling out injury, an autopsy will eliminate or confirm any unsuspected illness or congenital anomaly as the cause of death.
- In almost all cases in which autopsies are NOT performed, the family may have lingering doubts as to the cause of death. It may be difficult or impossible for parents to assimilate information during the state of shock usually experienced at this time of crisis. It is important to provide adequate information to families, but only as much as they can handle at this time. Information about the cause of death will be repeated and discussed more thoroughly through counseling.

Parent Support:

Each person reacts differently to the sudden, unexpected death of a child. It is important for emergency personnel to respond to the needs of family members, keeping in mind individual differences and cultural patterns. A member of the emergency team should stay with the parents as much as possible to provide support and answer questions. In the event of complicated grief reactions, a social worker, psychiatric nurse, or chaplain may be contacted for immediate crisis intervention.

Be prepared for difficult situations, including extremes in behavior such as screaming, collapsing, or even expressing no emotion. Encourage the parents to talk about the child; use the child's name. Give permission for next of kin to grieve. Appropriate support during this time may set the tone for the entire process of grieving.

- Parents should be encouraged to see and hold their child. Spending time with the child assists parents in focusing on the reality of the death while providing an opportunity to say goodbye.
- Efforts should be made to contact absent family members or any individual whose presence is important to the family. The presence of a member of the clergy and/or performance of family rituals such as baptism should be discussed.
- Since many parents are unfamiliar with funeral arrangements, it may be helpful to inform the family of the necessity of contacting a funeral director and/or a member of the clergy for assistance. The funeral director will assume the responsibility for the infant's body after its release from the medical examiner or hospital.

Emergency room staff should:

- Listen
- Ask open-ended questions.
- Develop a rapport with the family that will allow free expression and facilitate a healthy grieving process.
- Direct family to services that offer support for the bereaved:
    - Bereavement counseling and information
    - Parent support group meetings
    - Peer support contacts

Follow-Up:

Before the family leaves the emergency room, inform them when and by whom they will be told of the autopsy results. Find out where they can be reached - frequently families do not return to their own homes.

- Give the family further information about the cause of death.
- Review the autopsy findings.
- Provide anticipatory guidance through the grief process.
- Assess the family for any pre-existing problems or potential problems initiated by the death. Respond to questions.
- Make available information about counseling, home visits, parent support groups, and parent-to-parent contacts and referral for mental health counseling.

Emergency Team Conference:

It may be helpful for the emergency room staff to meet for support to discuss feelings and concerns regarding unsuccessful resuscitation and the family's anguish. The emotional drain on the emergency room staff needs to be considered and addressed. It is also helpful to evaluate intervention strategies with families to gain a sense of competency. Was the family supported at the time of crisis and was provision made for follow-up care? Appropriate intervention in the emergency room sets the tone for how parents begin to cope with the impact of their child's death. Supportive care in the immediate crisis period in conjunction with long-term follow-up promotes mental health and reduces the incidence of psychiatric morbidity.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Care Planning for, Inpatients, Swing, and SNF	**Nursing**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide all inpatients, swing patients and SNF residents with an accurate and up-to-date plan of care.

PURPOSE:

The purpose of this policy and procedure is to delineate the process for care planning and documentation. The purpose of care planning is to develop a coordinated and comprehensive plan in order to meet the individual's needs. Care planning includes participation from all involved health care disciplines and is initiated on admission with continual reassessment until patient/resident discharge or death. The primary process utilized is the patient/resident assessment with the results of this process being used to develop care plans specific to each resident.

DEFINITIONS:

Inpatient
All inpatients will have at least **two computerized** care plans developed by the interdisciplinary team within 24 hours of admission. Inpatient care plans are found in the Electronic Medical Record under the care plans tab within Heathland, the hospital's current EMR system. *Nursing will review inpatient care plans each shift and will update and resolve care plans accordingly.*

Swing

All Swing patients will have paper care plans that are hand-written and stored in the patient's paper chart at the nursing station. These care plans are reviewed weekly by nursing and are updated or resolved accordingly by the interdisciplinary team. Every three months the MDS coordinator determines if the care plan is current and either discontinues it or updates it accordingly.

When paper care plans are removed from the patient chart at the nursing station, they are sent to Medical Records to be scanned under documents in the patient's electronic medical record in Heathland. Previously hand-written care plans can be found here.

Skilled Nursing Facility (SNF)

All SNF residents will have paper care plans that are hand-written and stored in the resident's paper chart at the nursing station. These care plans are reviewed weekly by nursing and are updated or resolved accordingly by the interdisciplinary team monthly. Every three months the MDS coordinator determines if the care plan is current and either discontinues it or updates it accordingly.

When paper care plans are removed from the resident chart at the nursing station, they are sent to Medical Records to be scanned under documents in the patient's electronic medical record in Heathland. Previously hand-written care plans can be found here.

PROCEDURE:

Definition

The care plan is a current, written, and personalized plan for each individual indicating the care he/she needs, how it can best be accomplished, and the goals the interdisciplinary team collectively hopes to help the person achieve.

Upon admission, the nurse gathers data and inputs it into the Electronic Medical Record (EMR) system for inpatients or writes paper care plans for Swing/SNF patients and residents. The nurse will complete weekly summaries which will then be used to gather data for the Minimum Data Set (MDS). The MDS coordinator will enter the data into the jRAVEN system. The MDS system auto-populates appropriate plans of care for each individual resident. The plans of care are found in paper form which are initiated and updated as needed by the MDS coordinator and the nursing staff and are reviewed by the Skilled Nursing Facility (SNF) Manager/Director of Nursing (DON) monthly for one quarter after admission than quarterly thereafter until resident discharge or death.

Any change in condition requires notification to the provider, Skilled Nursing Facility (SNF) Manager/Director of Nursing (DON), and a full care plan review and/or update.

The process of evaluation and re-assessment of the care plan will occur on a continuing basis as needed until discharged. However, each individual resident care plan will be reviewed and re-evaluated at least every month.

Guidelines

- The care plan is a permanent part of the health record.
- The care plan shall be kept in the health record and shall be readily available to all personnel providing patient care.
- The language shall be simple to ensure all levels of the interdisciplinary team can understand the plan of care.

Care Plan Development
It is the responsibility of nursing services to develop and maintain all patient and resident care plans. However, all members of the interdisciplinary team shall participate in developing the plan of care, including their observations of the resident and recommendations.

Steps of Development:
- Gathering information
- Writing the plan
- Using the plan
- Evaluating the plan

Gathering Information
In order to develop a meaningful care plan, information shall be gathered as it relates to the following needs or problems: (On admission utilize the information gathered from the Nursing Assessment.)

- Motor ability
- Elimination
- Sleep and rest
- Food and fluids
- Sensory
- Emotional
- Mental
- Personal, cultural and social
- Spiritual
- Physical factors
- Discharge plans

Sources of information

- Health records
- Patient/Resident
- Family
- Physician
- Other health care personnel when applicable (physical therapist, social worker, occupational therapist, dietitian, activity director)

- Screening guide

Developing the plan of care

Upon initiating the care plan, all pertinent identifying information regarding the patient/resident will be completed first. Information regarding the following components of the resident care plan will then be determined and recorded:

- The problems, needs, and goals
- The interdisciplinary services plan of care
- The discharge plan

PROBLEMS, NEEDS, GOALS

Identify the problems or needs of the patient/resident. After the information has been gathered the data must be analyzed in order to determine what resident problems and needs exist. The following guidelines should be employed when identifying, selecting, and recording problems.

- The date the care plan was populated or initiated should reflect the date that the problem was identified.
- A person's problem is a difficulty or concern experienced by only them. Be sure to determine the patient/resident's needs not your own.
- The resident's problems include currently existing difficulties as well as potential problems. (i.e., potential skin breakdown in a high-risk resident)
- Problem statements should be written so as to reflect physical, psychological, or social difficulties.
- Problem statements should be followed with a "due to" and or "related to" phrase relating the perception of the cause of the problem from a nursing standpoint.

Determine the goals or expected outcomes. When determining expected outcomes or goals, the following should be kept in mind:

Short-term goals

A short-term goal is a quick resulting effort which can realistically be reached within the patient's abilities. Each problem should have a short-term goal. It should be simple, specific, measurable, and patient-oriented. It should indicate progress toward problem resolution.

Long-term goals

A long-term goal is the end result of short-term goals which leads to the highest obtainable level of independence for the patient/resident. The long-term goal is stated in relation to the expected course of the resident's condition and is determined collectively by the health care team.

Sample explanation: Self-care may be a long-term goal, but for a person who has had a radical mastectomy, this long-term goal is attained step-by-step through the achievement of short-term objectives such as self-feeding, combing hair, applying make-up, self-direction in doing prescribed exercises, and acceptance of the operation and its implication.

Changes: If any goal changes (long or short term), nursing will resolve it and initiate a new goal and current date.

Select the actions/approaches

When selecting appropriate actions or approaches toward resolving problems, the following must be remembered:

- Actions must clearly state and be specific as to the "how."
- Some actions or approaches may be more appropriate to defer or may be medically prescribed to defer until a later time (i.e., defer a bladder training program until the problem of anxiety is resolved).
- In some cases, there are no immediate solutions, but the problem remains under consideration until actions or approaches can be determined. Although specific actions are performed according to the individual responsible discipline, the health care team's collective actions provide the most effective solution toward resolution of the resident's problem.

Document resolution of the problem

As a problem becomes resolved, the appropriate date will be indicated in the care plan.

Interdisciplinary Services

- All interdisciplinary services shall provide information regarding problems, goals, plan of care, treatment, etc. as appropriate. This information should then be recorded in the care plan. The interdisciplinary services will review and update the care plan as needed.
- The Activity Plan shall be outlined, reviewed, and updated on the resident care plan on a quarterly basis and as needed.

Using the Plan

In order to develop and maintain a complete resident care plan and promote continuity of care, input and involvement from nursing personnel from working shifts is necessary. Additionally, more information may be gathered, or resident needs may change as a result of physiological, pathological, and psychological processes. As the plan is used and desired results are not achieved or as changes occur, the team action may need to be modified to meet the needs of the resident.

The mere development of the plan for each person does not ensure that it will be followed; this is accomplished through assignment of team members on the basis of their competence and the needs of the patients. In addition, it is necessary to make periodic observations and evaluations of each patient and determine that:

- The right person is caring for the resident
- The plan is being carried out
- The goals are being met

Evaluating the Plan

When evaluating and re-assessing the plan of care for the resident, the following shall be considered:

- Are the patient/resident's problems still current? Are there new problems?
- Are the short-term goals realistic?
- Are the actions/approaches appropriate and effective?
- Are the health care disciplines involved in the plan of care as needed?
- Does the long-term goal remain appropriate?

Discharge Plan

Part of the resident care planning process includes an assessment of the resident in terms of planning for his/her discharge to a lower level of care whenever possible.

SoHum Health

Subject:	Manual:
Fall Prevention/Risk Assessment	**Nursing**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assess the fall risk for each inpatient, swing bed patient, and Skilled Nursing Facility resident upon admission.

PURPOSE:

The purpose of this policy and procedure is to ensure the safety of every inpatient, swing bed patient, and resident and that each inpatient, swing bed patient, and resident is assessed for their risk of a fall at the time of admission. Additionally, each resident in the Skilled Nursing Facility will be re-assessed quarterly with each review of the Minimum Data Set (MDS) and an update to the specific care plan for Fall Risk if applicable.

Recent studies have identified the following characteristics of the fall-prone patient:

1. Age 65 or older.
2. Poor general health.
3. Normal or abnormal mental status such as dementia.
4. A history of falls.
5. Decreased mobility.
6. Urinary frequency or diarrhea; and
7. Sensory deficit, particularly impaired vision.

Falls often occur:

1. In the early morning or evening.
2. After patients have received sedatives, tranquilizers, diuretics or antihypertensive.
3. Attempts to meet physical needs are often present.
4. Patients described themselves as independent but were preoccupied by life crises.
5. Patients believe falls were inevitable; and
6. Patients did not seek help prior to attempting activities that led to falling.

The following procedures will be implemented in order to assess patients for risk of falls.

All patients will be assessed upon admission and throughout the hospital stay for characteristics of the fall-prone patients:

1. Age.
2. State of health.
3. Mental status.
4. Mobility.
5. Elimination patterns.
6. Sensory deficits.
7. History of fall; and
8. Medications.

DEFINITIONS:
None

PROCEDURE:

All patients are assessed at the time of admission using the Morse Fall Scale. If the Morse Fall Scale is calculated as moderate or high a Fall Risk Assessment will be completed. Following the initial patient assessment, patients and residents will be re-assessed in the event any change in condition as noted in 2-8 of the above lists occurs. Any patient or resident experiencing a change in condition as noted from the above list will be re-assessed for Fall Risk and the individualized Falls Care Plan updated as appropriate. In the event of a fall, a new Fall Risk Assessment and Fall Risk Record will be completed and documentation of such in the EMR is completed, along with any updates and/or new interventions implemented and reflected on the individualized Care Plan.

Morse Fall Scale

If the Morse Fall Scale is calculated as moderate or high; initiate fall precautions and complete the Fall Risk Assessment. The computer automatically assigns risk levels according to categories checked for each individual patient and resident. The scale assesses the following:

1. Ambulatory status; use of safety devices
2. Integrity of gait; steady or unsteady
3. Previous history of falls
4. Medications; IV therapy/access
5. Secondary diagnoses, dementia, cognitive impairment
6. Mental status; orientation to person, place, and time

A. In order to reduce the risk of patient falls certain precautions will be taken for all patients regardless of their level of risk. Paying particular attention to the four "Ps"; Pain, Potty, Positioning, Possessions.

1. Assess the patient for pain level, the need for elimination, position of comfort and make sure that possessions are within reach.
2. Call bell within reach, bed in a low position, and lock the bed wheels.
3. Place bedside tables and over-bed tables close to the client.
4. Encourage the client to rise from the bed or chair slowly to prevent dizziness resulting from postural hypotension.
5. Remove clutter from bedside tables, hallways, and bathrooms.
6. Instruct all clients as to the location of emergency call bells in the bathrooms.
7. See that wheelchairs remain locked when transporting a client from the bed to a wheelchair or back to bed.
8. The use of side rails may be necessary to protect elderly clients from falling out of bed.
9. Place a pull tab alarm on high-risk patients when up in chairs and/or wheelchairs; use chair pad and bed pad alarm as indicated for high fall-risk patients/residents who have a diagnosis of dementia and/or the Minimum Data Set (MDS) reflective of cognitive impairment. The integrity of the alarms is to be checked during hourly rounding.
10. Use lift devices for those patients who have been identified as not being able to transfer safely otherwise.

B. If the Morse Fall Scale is calculated as moderate or high the following interventions and safety precautions are put in place and entered into the Falls Care Plan:

1. Patient care plan is based on the nursing diagnosis of potential for injury and falls.
2. Door frame outside the patient's room will be marked with a Fall Risk sign to alert healthcare workers that the patient is at risk for falls.
3. Patient's chart shall be identified with labels stating High Risk and/or Fall Precautions, and a fall precaution bracelet will be placed on their bed rail and their wheelchair for the Skilled Nursing Facility patients, and a Fall Risk bracelet placed on any inpatient or swing bed patient identified as a Fall Risk.
4. The patient/resident that has been assessed as a high risk for falls will be assessed every 1 hour and as necessary for the level of comfort, elimination needs, and other comfort measures.
5. Patients are informed to call a nurse for any ambulation assistance; hourly rounding occurs on

all Skilled Nursing residents and other patients deemed to be a high risk for falls.

6. Those patients or residents who have been diagnosed with dementia or identified through the MDS assessment with a cognitive impairment will not be left unassisted or unsupervised during transfers or activities of daily living (ADLS)

C In the event of a fall the following will be completed:

1. Call the provider/ stay with the patient.
2. Place patient back in bed, if not contraindicated
3. Assess for injury and complete a set of vital signs
4. Assess for mechanism of fall
5. Call the patient's family or advocate
6. Document circumstances
7. Complete a Fall Assessment and the Fall Risk Record

SoHum Health

Subject:	Manual:
Hourly Rounding	**Nursing**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to do hourly rounds on all in-patients, swing-bed patients, and skilled nursing facility residents.

PURPOSE:

The purpose of this policy and procedure is to decrease falls, decrease the need for patients/residents to press the call light for help, decrease hospital-acquired pressure ulcers, and increase patient and employee safety and satisfaction. This policy will help bring nurses back to the bedside and improve safety, clinical outcomes, and build trust with our patients.

DEFINITIONS:
None

PROCEDURE:

Rounds must be done on all patients and residents on an hourly basis. Rounds consist of an LVN, CNA, or RN walking into each room to visually check on each patient/resident. Rounds shall be tailored to the needs of the patient/resident using the FIVE P's of rounding, pain, positioning, potty, periphery i.e. call light, phone, TV remote, and water and pump.
For example, on each hourly round:

1. Patients who need assistance to the restroom shall be offered assisted toileting.
2. The patient's pain control shall be assessed if pain has been an issue.
3. The patient shall be assessed for comfort and positioning in bed if they appear uncomfortable or are unable to change position independently.
4. Patients with a peripheral intravenous catheter in place, shall have the IV site assessed, along with any continuous fluids/ IV antibiotics that may be running.
5. Monitor leads shall be checked for proper placement, on those with cardiac monitoring ordered.
6. The patient's wristbands shall be checked for placement and correctness.
7. The room shall be checked for safety hazards
8. It shall be checked that the patient has the call light within reach and other essentials such as the phone, tissue, and water.
9. If the patient/resident needs a bed alarm or any other type of alarm, it shall be checked to ensure it is activated.

Assessing the 5 P's:

The nurse will ask:

Pain: How is your pain?

Position: Are you comfortable? (Turn and Position patient)

Potty: Do you have bathroom needs?

Periphery: Do you need me to move the phone, call light, trash can, water cup or over bed table? (Move the phone,
fill the water cup). Ensure all equipment is plugged in. Eliminate unnecessary clutter.

Pump: Check the IV pump.

Nursing shall document in the Electronic Medical Record under chart notes that hourly rounds were done and what they did for the patients. There should be one note in the system with multiple time stamps or multiple entries per shift documenting the 5 P's.

SoHum Health

Subject:	Manual:
Patient and Staff Safety Plan	**Nursing**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a safe environment for patients, visitors, and staff.

PURPOSE:

The purpose of this policy and procedure is to provide general safety guidelines for the staff to follow. Safety is a very important part of the acute care unit as it concerns patients and employees. All nursing staff must be trained in their duties to assure safety in the acute care unit for the patients, the public, and employees. Be aware and know the risks involved in your job. Explain safety rules to patients and staff and set the example of safety awareness and practices for co-workers, patients, and visitors.

DEFINITIONS:
None

PROCEDURE:

Work Areas or Stations

- All drawers and doors closed when not in use.
- Electrical equipment is turned off when not in use.
- All needles, glass, and razor blades are placed in an appropriate biohazard container for disposal.
- Uniforms shall not restrict free movement or be designed to allow entanglement in equipment.
- All aisles and hallways are clear. Store all equipment in the proper area.
- All outside doors are to be kept closed and locked after 9 PM, outside doors are never to be left propped open under any circumstances.

Patient Safety

- All patients are instructed in the use of the call light at the time of admission.
- All patients are provided with identification bracelets at the time of admission:
  - A white bracelet with name, physician, date of admission, and hospital number
  - A red bracelet for allergy identification
  - A yellow bracelet if identified as a fall risk after assessment.
- All acute care beds are equipped with side rails* and shall be used when:
  - Patients are under sedation
  - Unconscious patients
  - Any patients when admitted are under the influence of alcohol or narcotics
  - Patients in a confused state of mind
  - When the patient is sleeping if the patient may be considered at high risk for falls

*Nurse's notes should indicate when side rails are in place. The bed is also to be in the lowest position.

- All patient bathing and toilet areas are equipped with grab bars.
- Automatic regulation of the temperature of the hot water supply is maintained in order that the temperature does not exceed 110° Fahrenheit.
- Use of portable electric heaters is prohibited**.**

Oxygen Safety

- Patients and visitors shall be instructed about oxygen hazards.
- No oil, alcohol, or any substance that may ignite readily will be used on the patient while oxygen is in use.

- Oxygen and other gas cylinders shall be transported on carriers.
- All cylinders shall be secured.
- Read the cylinder label carefully before administering oxygen to a patient.
- Any faulty regulators, valves, or oxygen leaks should be reported to the Maintenance department immediately.

Any equipment that malfunctions is to be taken out of service immediately and reported to Engineering and a work order is placed through email to group work orders.

Safety Rules Specific to the Acute Care Unit

- When restraints are required, a physician's order will be obtained prior to the use of the restraints. Use the pre-printed order set and restraint assessment flow sheet in EHR
- **NO SMOKING** in the building.
- The identification band is to be checked using two patient identifiers before the administration of medication, IV fluid, blood, or blood product and before any procedure invasive or otherwise.
- All electrical equipment brought into the acute care unit must have had an electrical safety check by engineering within an appropriate period of time, prior to use in the unit.
- No portable electric heaters or electric blankets may be used by any patient or resident.
- No electric shavers will be used on patients if the patient is on oxygen in the acute care unit.
- Visitors must check in at the nurse's station before entering the room.
- In an emergency or code blue scenario RN's may follow ACLS and PALS protocols until a physician arrives.
- When breaking ampules use a piece of gauze between your fingers and the ampules to keep from cutting yourself; always use a filter needle when removing medication from a glass ampule.
- Always use standard precautions for all patients and use personal protective equipment (PPE) in accordance with the situation, the patient's diagnosis, and hospital policy.
- If transmission-based precautions are in place for any patient or resident all visitors and staff must wear the appropriate personal protective equipment (PPE). The nursing staff is to teach and role model for the family/visitors.
- Clean medical devices and equipment between every patient and when visibly soiled per facility policy.
- Use an aseptic technique for the insertion and manipulation of invasive patient lines (e.g., Foley catheters, central lines, and peripheral IV catheters).

Any adverse event reportable or non-reportable (a patient safety event) will be documented by submitting the appropriate report to RL Solutions and will be reviewed by the Patient Safety Committee for quality assurance performance improvement measures.

A patient safety event is defined as the following, but not limited to:

- Healthcare-associated infections (HAI)
- Fall with or without injury
- Medication error

SoHum Health

Subject:	Manual:
Compassionate Access to Medical Cannabis	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to adhere to the legislative requirements set forth in the Compassionate Access to Medical Cannabis Act (Senate Bill 988). The District shall permit patient use of medicinal cannabis and shall carry out all of the following described in the corresponding procedure.

BACKGROUND:

Senate Bill (SB) 311 (Chapter 384, Statutes of 2021) established the Compassionate Access to Medical Cannabis Act requiring health care facilities to allow terminally ill patients to access medicinal cannabis under specified conditions.
SB 988 provides revisions to the Act.
Effective January 1st, 2023, SB 988 reiterates that for purposes of the Act the definition of a "health care facility" does NOT include, among other things, the emergency department of a General Acute Care Hospital. This means that the Act does NOT require the District's emergency department to permit terminally ill patients access to medicinal cannabis.

DEFINITIONS:

Patient – means an individual who is terminally ill, NOT an individual receiving emergency services and care.
Terminally ill – a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

PROCEDURE:

Per Senate Bill 988, the Skilled Nursing and Swing sections of SoHum Health District are in the scope of the Compassionate Access to Medical Cannabis Act. As such, they must follow the guidelines set forth by the Act:

- The patient or primary caregiver is explicitly responsible for acquiring, retrieving, and administering the medicinal cannabis.
- Healthcare professionals and facility staff are prohibited from administering medicinal cannabis or retrieving it from storage.
- Medicinal cannabis shall be securely stored at all times in a locked container in the patient's room, other designated area, or with the patient's primary caregiver.
- Smoking or vaping are not permittable methods of use.
- Upon discharge, patients or primary caregivers are responsible for the removal of the medicinal cannabis.
- If they are unable to remove the medicinal cannabis, it will be disposed of by a nurse and require a witnessing nurse or Pharmacist.
- Any warranted dispositions shall be documented in Pyxis in the electronic health record.

It must be stated that the Act does not require the facility to provide a patient with a recommendation to use medicinal cannabis or include medicinal cannabis in a patient's discharge plan.

Southern Humboldt Community Healthcare District

SoHum Balance Sheet

End of Aug 2025

Financial Row	Amount
Assets	
Current Assets	
Cash - Checking & Investments	$2,439,272
Patients Accounts Receivable Less Allowances	$6,602,732
Other Receivables	$7,432,869
Inventories	$622,620
Prepaid Expenses and Deposits	$1,265,451
Total Current Assets	$18,362,944
Property and Equipment	
Land	$1,193,526
Land Improvements	$553,251
Buildings	$5,720,831
Equipment	$8,409,815
Construction in progress	$15,862,475
Less: Accumulated Depreciation	($9,841,016)
Net Property and Equipment	$21,898,882
Total Assets	$40,261,826
Liabilities & Fund Balance	
Current Liabilities	
Accounts Payable	$1,646,640
Accrued Payroll & Related costs	$2,332,533
Other Current Liabilities	
Deferred Revenue IGT	$2,720
Loans & Current Portion of Lease Obligations	$122,529
Other	
Accrued Purchases	$4,936
Other Current Liabilities	$4,936
Total Other Current Liabilities	$130,185
Total Current Liabilities	$4,109,358
Long Term Debt, Less Current Portion	
Maple Lane Loan	$186,187
ELGA Lease Loan	
2250-030 - ELGA Lease Loan	$1,697,196
Total - ELGA Lease Loan	$1,697,196
CHFFA Help II Loan	$1,808,368
Lease Obligations	$236,003
Net Long Term Debt	$3,927,754
Equity	
Unrestricted Fund Balance - Prior Years	$2,830,961
Retained Earnings	$29,174,845
Net Income	$218,907
Total Fund Balance	$32,224,714
Total Liabilities & Fund Balance	$40,261,826

Southern Humboldt Community Healthcare District

SoHum Income Statement

Aug 2025

Financial Row	Amount
Revenue	
Gross Patient Revenue	
Inpatient	$308,032
Inpatient Ancillary	$71,719
Outpatient	$1,721,842
Outpatient Ancillary	$853,501
Total Patient Revenue	$2,955,094
Deductions from Revenue	
9060-913 - Supplemental Revenue	($891,164)
Contractual Allowances	$1,327,546
Provision for Bad Debts	$106,451
Other Allowances / Deductions	$35,388
Cost Of Sales	$365,500
Total Deductions	$943,721
Net Patient Revenue	$2,011,373
Other Operating Revenue	$545,492
Total Operating Revenue	$2,556,865
Expenses	
Salaries & Wages	$1,337,712
Employee Benefits	$508,405
Professional Fees	$320,537
Supplies	$91,385
Repairs & Maintenance	$17,666
Purchased Services	$245,710
Utilities	$29,399
Insurance	$22,865
Depreciation/ Amortization	$55,168
Other	$33,796
Total Operating Expenses	$2,662,643
Operating Profit (Loss)	($105,778)
Tax Revenue	$117,362
Other Non Operating Revenue (Expense)	$27,082
Interest Income	$1,519
Net Non Operating Revenue (Expense)	$145,963
Net Income (Loss)	$40,185

Revenue Cycle Dashboard

Southern Humboldt

August 2025

TruBridge

Monthly KPI Scorecard

Facility Name: Southern Humboldt
Month: August 2025

Aging Metrics	KPI Actual	KPI Goal	Goal Var +/-	LM Actual	% CHG LM
Facility A/R Days	59.9	55	4.9	60.2	-1%
Total Insurance A/R % >90 Days	29%	15%	14%	30%	-1%
BCBS A/R % >90 Days	30%	10%	20%	33%	-3%
Medicare A/R % >90 Days	29%	10%	19%	32%	-3%
Medicaid A/R % >90 Days	26%	15%	11%	27%	-1%
Commercial A/R % >90 Days	38%	15%	23%	32%	6%
Self-Pay >90 % of Total A/R	15%	35%	-20%	16%	-1%
Credit Balances A/R Days	-1.9	-2	0.1	-2.3	-18%
Cash Collection Metrics	**KPI Actual**	**KPI Goal**	**Goal Var +/-**	**LM Actual**	**% CHG LM**
POS Collections	17%	3%	14%	21%	13%
Billing Metrics	**KPI Actual**	**KPI Goal**	**Goal Var +/-**	**LM Actual**	**% CHG LM**
DNSP A/R Days (Discharged Not Submitted to Payer)	12.9	6	6.9	14.2	-9%
FBNS A/R Days (Final Bill Not Submitted)	0.0	3	-3.0	0.0	#DIV/0!
DNFB A/R Days (Discharged Not Final Billed)	12.9	3	9.9	14.2	-9%
% of Zero Pay Denials vs. Total Remitted	13%	4%	9%	8%	5%
RCM Imported Clean Claim % (If Available)	98%	75%	23%	97%	1%
Adjustment Metrics	**KPI Actual**	**KPI Goal**	**Goal Var +/-**	**LM Actual**	**% CHG LM**
Final Insurance Denial % of Gross Patient Revenue	2%	3%	-1%	1%	1%
B/D Recovery % of B/D Adjustments (Gross)	0%	10.0%	-10.0%	0%	0%

KPI Indicator Key	Indicator	Totals	% of Total Metrics
Goal Threshold - Pass		7	41%
Goal Threshold - Neutral		1	6%
Goal Threshold - Fail		9	53%
		17	100%

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Monthly KPI Metrics

KPI Metric	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Gross A/R Days	74.4	64.3	66.1	63.4	60.2	59.9
A/R Day (Goal - Short Term)	55.0	55.0	55.0	55.0	55.0	55.0
A/R Day (Goal Variance)	19.4	9.3	11.1	8.4	5.2	4.9
A/R Day (Goal - Long Term)	45.0	45.0	45.0	45.0	45.0	45.0
Total A/R Balance	$ 6,595,947.32	$ 5,866,388.04	$ 6,324,089.79	$ 6,383,237.16	$ 6,177,976.23	$ 6,455,281.29
Total Insurance A/R Balance (less Credits)	$ 5,188,401.49	$ 4,507,752.86	$ 4,967,903.33	$ 5,046,809.98	$ 4,773,357.09	$ 5,058,456.61
Total Self-Pay Balance	$ 1,407,545.83	$ 1,358,635.18	$ 1,356,186.46	$ 1,336,427.18	$ 1,404,619.14	$ 1,396,824.68
Average Daily Revenue (90 Day)	$ 88,711.20	$ 91,221.58	$ 95,647.09	$ 100,618.50	$ 102,655.91	$ 107,818.70
MTD Cash Collections	$ 1,664,074.67	$ 2,286,899.18	$ 1,478,249.46	$ 2,197,241.54	$ 1,895,063.73	$ 1,251,624.77
BCBS	$ 173,245.58	$ 269,176.67	$ 193,667.60	$ 216,359.35	$ 316,105.93	$ 195,525.89
Medicare	$ 745,626.92	$ 1,204,141.10	$ 880,241.02	$ 1,133,928.30	$ 932,390.37	$ 533,434.10
Medicaid	$ 535,357.19	$ 636,450.66	$ 267,421.94	$ 242,098.32	$ 359,148.53	$ 286,585.36
Commercial	$ 154,209.06	$ 121,223.82	$ 87,581.22	$ 561,407.35	$ 239,418.72	$ 200,215.65
Self-Pay	$ 55,635.92	$ 55,906.93	$ 49,337.68	$ 43,448.22	$ 48,000.18	$ 35,863.77
POS Collections ($) - (Within 7 Days of Dischg)	$ 15,193.31	$ 7,275.65	$ 9,177.79	$ 5,694.93	$ 10,205.51	$ 6,117.19
Collection Goal ($)	$ 19,472.57	$ 19,567.43	$ 17,268.19	$ 15,206.88	$ 16,800.06	$ 12,552.32
% of POS Collections	27%	13%	19%	13%	21%	17%
POS Collections (Goal) - 35% of Self-Pay Collections	35%	35%	35%	35%	35%	35%

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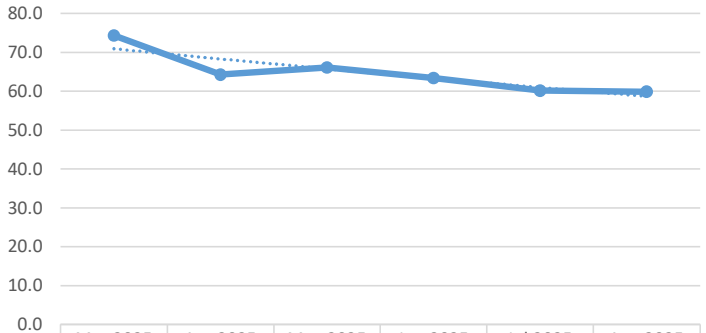
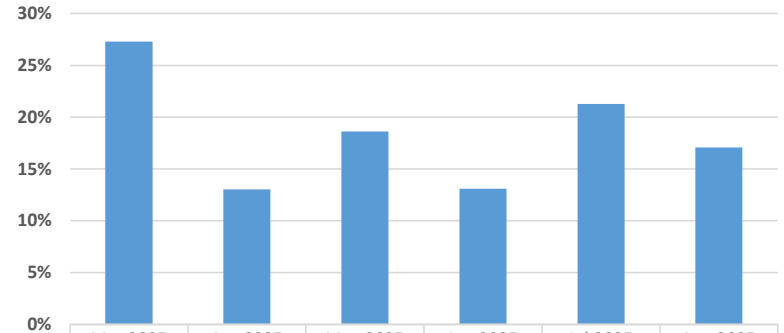
Gross A/R Days



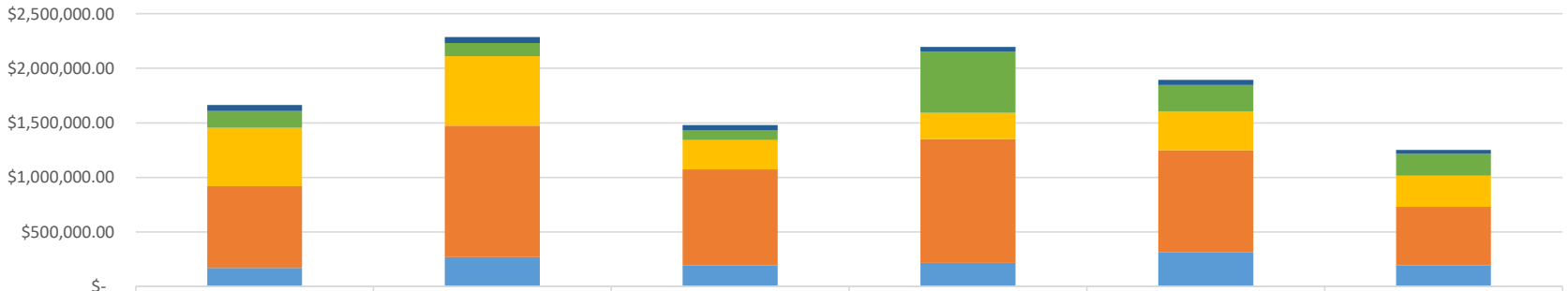
	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
A/R Days	74.4	64.3	66.1	63.4	60.2	59.9

POS Cash Collections



	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
POS	27%	13%	19%	13%	21%	17%

MTD Cash Collections



	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Self-Pay	$55,635.92	$55,906.93	$49,337.68	$43,448.22	$48,000.18	$35,863.77
Commercial	$154,209.06	$121,223.82	$87,581.22	$561,407.35	$239,418.72	$200,215.65
Medicaid	$535,357.19	$636,450.66	$267,421.94	$242,098.32	$359,148.53	$286,585.36
Medicare	$745,626.92	$1,204,141.10	$880,241.02	$1,133,928.30	$932,390.37	$533,434.10
BCBS	$173,245.58	$269,176.67	$193,667.60	$216,359.35	$316,105.93	$195,525.89

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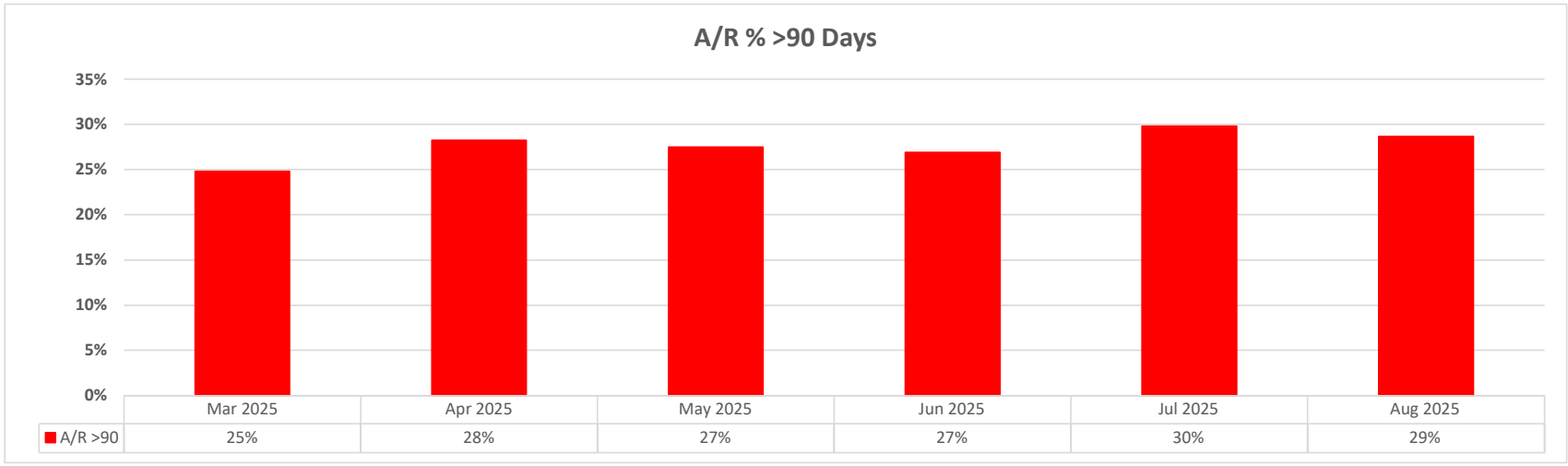
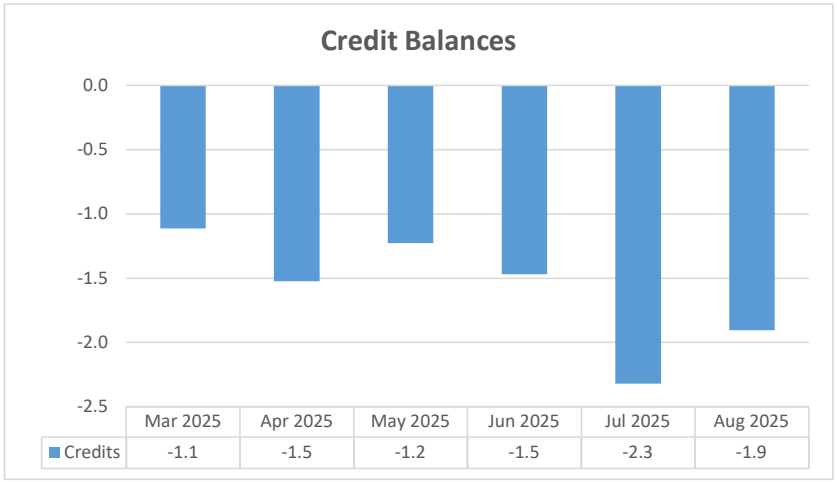
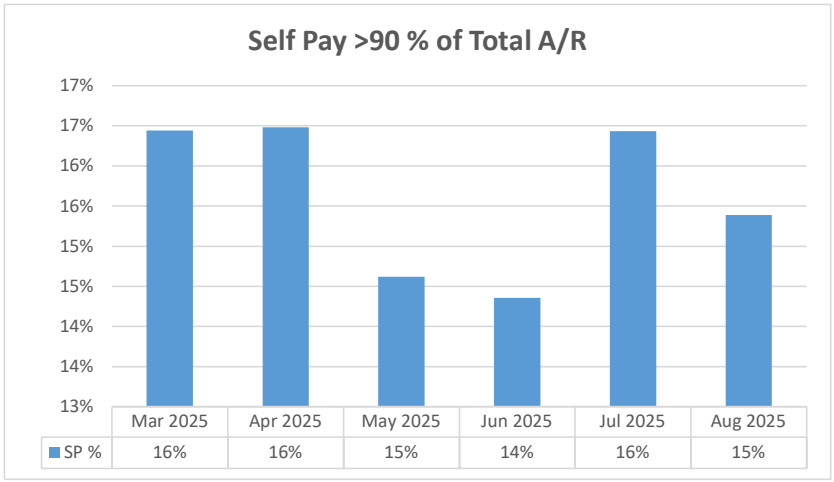
KPI Metric	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Total Insurance A/R Balance (>90 Days)	$ 1,287,353.48	$ 1,272,707.64	$ 1,364,294.90	$ 1,356,287.07	$ 1,421,919.43	$ 1,448,557.54
Total Insurance A/R Days (>90 Days)	14.5	14.0	14.3	13.5	13.9	13.4
Total Insurance A/R % (>90 Days)	25%	28%	27%	27%	30%	29%
Total Insurance A/R % (>90 Days Goal)	15%	15%	15%	15%	15%	15%
Total Insurance A/R % (Goal Variance)	10%	13%	12%	12%	15%	14%
BCBS A/R Balance (>90 Days)	$ 98,240.24	$ 67,350.37	$ 84,434.27	$ 106,745.16	$ 141,583.68	$ 142,188.85
BCBS A/R Days (>90 Days)	1.1	0.7	0.9	1.1	1.4	1.3
BCBS >90 - % of Total Ins A/R >90	8%	5%	6%	8%	10%	10%
BCBS >90 - % of Total Ins A/R	2%	1%	2%	2%	3%	3%
Medicare A/R Balance (>90 Days)	$ 266,684.78	$ 432,676.19	$ 552,286.69	$ 548,939.25	$ 585,213.38	$ 551,006.15
Medicare A/R Days (>90 Days)	3.0	4.7	5.8	5.5	5.7	5.1
Medicare >90 - % of Total Ins A/R >90	21%	34%	40%	40%	41%	38%
Medicare >90 - % of Total Ins A/R	5%	10%	11%	11%	12%	11%
Medicaid A/R Balance (>90 Days)	$ 823,273.49	$ 679,764.01	$ 647,176.16	$ 595,800.15	$ 531,564.81	$ 585,721.41
Medicaid A/R Days (>90 Days)	9.3	7.5	6.8	5.9	5.2	5.4
Medicaid >90 - % of Total Ins A/R >90	64%	53%	47%	44%	37%	40%
Medicaid >90 - % of Total Ins A/R	16%	15%	13%	12%	11%	12%
Commercial A/R Balance (>90 Days)	$ 99,154.97	$ 92,917.07	$ 80,397.78	$ 104,802.51	$ 163,557.56	$ 169,641.13
Commercial A/R Days (>90 Days)	1.1	1.0	0.8	1.0	1.6	1.6
Commercial >90 - % of Total Ins A/R >90	8%	7%	6%	8%	12%	12%
Commercial >90 - % of Total Ins A/R	2%	2%	2%	2%	3%	3%
Self-Pay A/R Balance (>90 Days)	$ 1,084,414.94	$ 966,690.02	$ 924,532.27	$ 916,345.32	$ 1,015,238.07	$ 993,352.09
Self-Pay A/R Days (>90 Days)	12.2	10.6	9.7	9.1	9.9	9.2
Self-Pay >90 % of Total A/R	16%	16%	15%	14%	16%	15%
Credit Balances ($)	$ (98,657.13)	$ (139,229.29)	$ (117,390.06)	$ (147,834.26)	$ (238,373.39)	$ (205,279.28)
Credit Balances A/R Days	-1.1	-1.5	-1.2	-1.5	-2.3	-1.9
Credit Balances A/R Day (Goal)	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0
Credit Balances A/R Day (Goal Variance)	0.9	0.5	0.8	0.5	-0.3	0.1


A/R % >90 Days
35%
30%
25%
20%
15%
10%
5%
0%
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
A/R >90
25%
28%
27%
27%
30%
29%


Credit Balances
0.0
-0.5
-1.0
-1.5
-2.0
-2.5
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
Credits
-1.1
-1.5
-1.2
-1.5
-2.3
-1.9


Self Pay >90 % of Total A/R
17%
17%
16%
16%
15%
15%
14%
14%
13%
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
SP %
16%
16%
15%
14%
16%
15%

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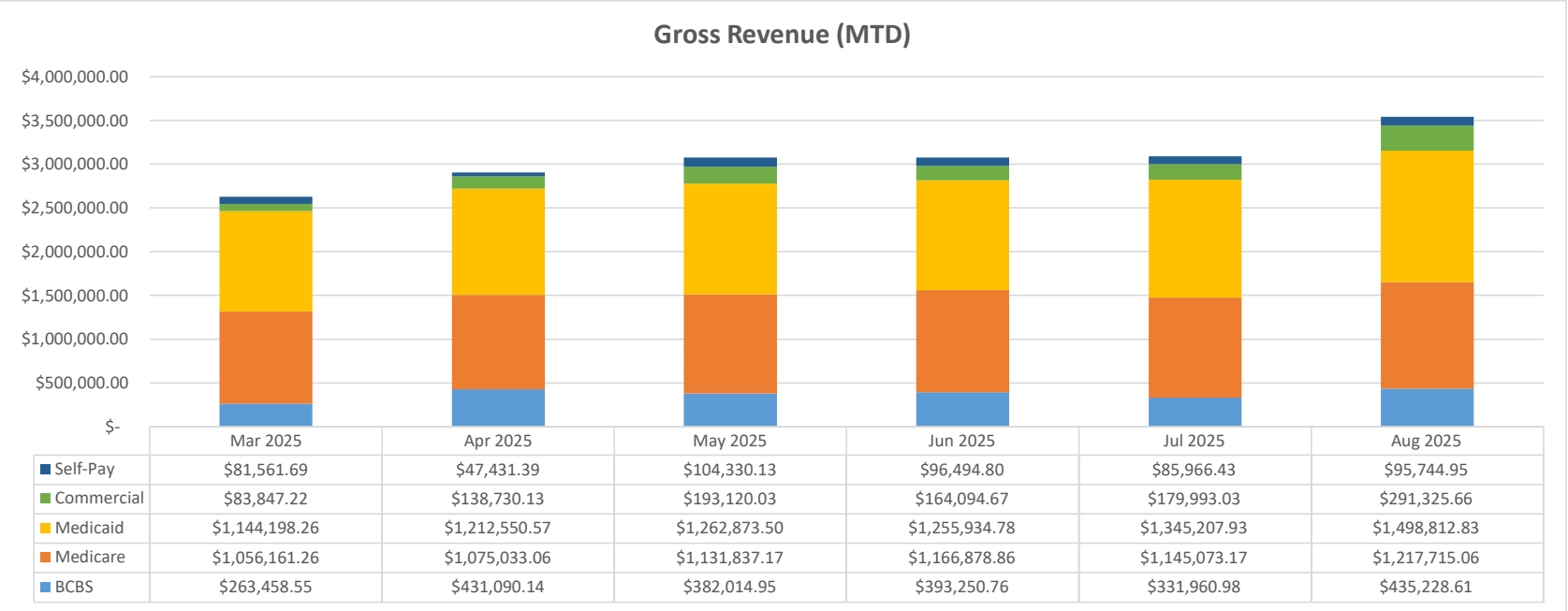
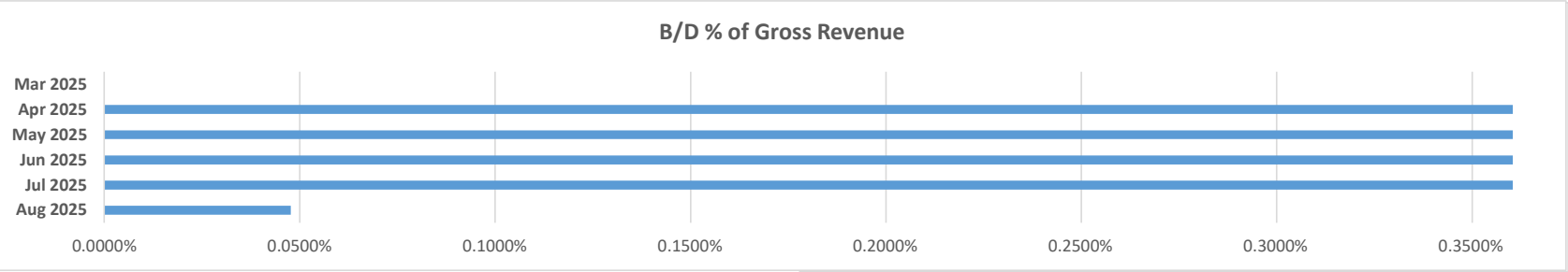
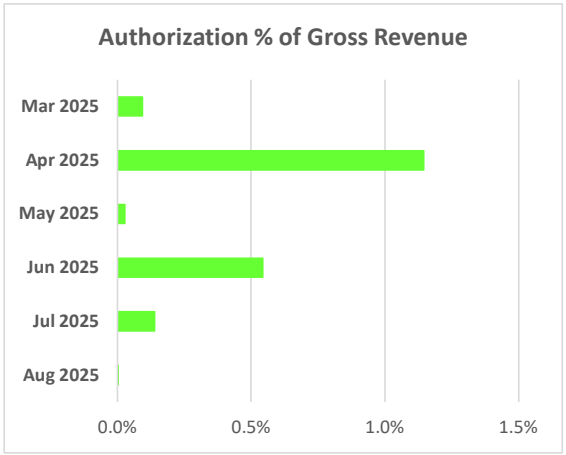
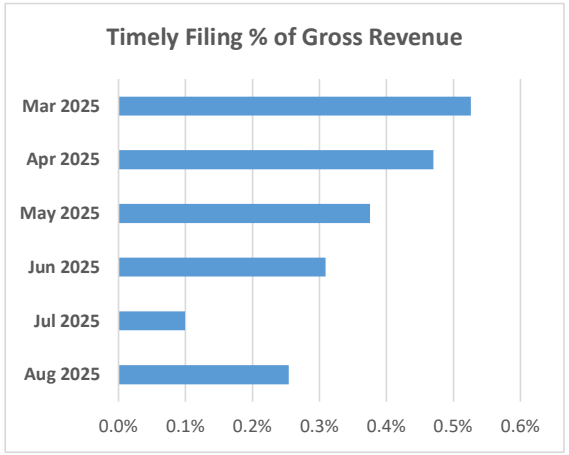
KPI Metric	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Gross Revenue ($)	$ 2,629,226.98	$ 2,904,835.29	$ 3,074,175.78	$ 3,076,653.87	$ 3,088,201.54	$ 3,538,827.11
BCBS	$ 263,458.55	$ 431,090.14	$ 382,014.95	$ 393,250.76	$ 331,960.98	$ 435,228.61
Medicare	$ 1,056,161.26	$ 1,075,033.06	$ 1,131,837.17	$ 1,166,878.86	$ 1,145,073.17	$ 1,217,715.06
Medicaid	$ 1,144,198.26	$ 1,212,550.57	$ 1,262,873.50	$ 1,255,934.78	$ 1,345,207.93	$ 1,498,812.83
Commercial	$ 83,847.22	$ 138,730.13	$ 193,120.03	$ 164,094.67	$ 179,993.03	$ 291,325.66
Self-Pay	$ 81,561.69	$ 47,431.39	$ 104,330.13	$ 96,494.80	$ 85,966.43	$ 95,744.95
B/D Write-Off Total ($)	$ -	$ 91,897.64	$ 107,225.00	$ 145,278.00	$ 39,017.00	$ 1,691.20
B/D % of Gross Revenue	0.0000%	3.1636%	3.4879%	4.7219%	1.2634%	0.0478%
Credentialing Denials Total ($)	$ 7,869.99	$ 4,820.15	$ 16,288.61	$ 615.03	$ 4,743.97	$ 3,553.13
Credentialing Denials % of Gross Revenue	0.3%	0.2%	0.5%	0.0%	0.2%	0.1%
Timely Filing Denials Total ($)	$ 13,827.05	$ 13,652.04	$ 11,544.01	$ 9,502.03	$ 3,069.12	$ 8,989.13
Timely Filing Denials % of Gross Revenue	0.5%	0.5%	0.4%	0.3%	0.1%	0.3%
Medical Necessity Denials Total ($)	$ 16,179.37	$ 9,687.09	$ 13,068.47	$ 14,887.12	$ 17,546.39	$ 37,860.77
Medical Necessity Denials % of Gross Revenue	0.6%	0.3%	0.4%	0.5%	0.6%	1.1%
Non-Covered Charges Total ($)	$ 23,235.84	$ 24,031.90	$ 39,147.30	$ 23,684.40	$ 19,068.18	$ 23,879.39
Non-Covered % of Gross Revenue	0.9%	0.8%	1.3%	0.8%	0.6%	0.7%
Authorization Denials Total ($)	$ 2,455.51	$ 33,278.19	$ 870.53	$ 16,697.91	$ 4,274.39	$ 74.62
Authorization Denials % of Gross Revenue	0.1%	1.1%	0.0%	0.5%	0.1%	0.0%
Insurance Denial Write-Off Amount	$ 55,697.77	$ 80,649.22	$ 64,630.31	$ 64,771.46	$ 43,958.08	$ 70,803.91
% of Gross Revenue	2.1%	2.8%	2.1%	2.1%	1.4%	2.0%
Target Goal %	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Target Variance %	-0.9%	-0.2%	-0.9%	-0.9%	-1.6%	-1.0%

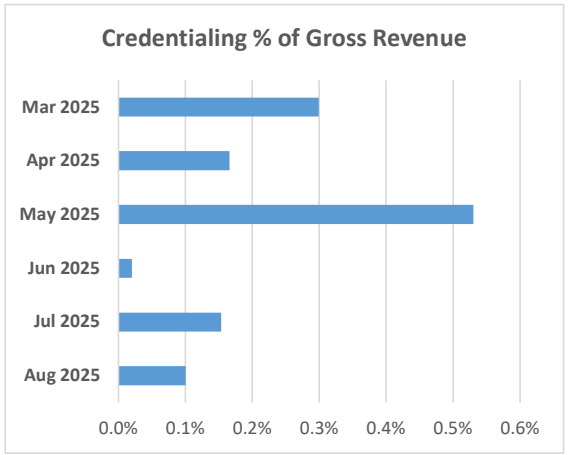


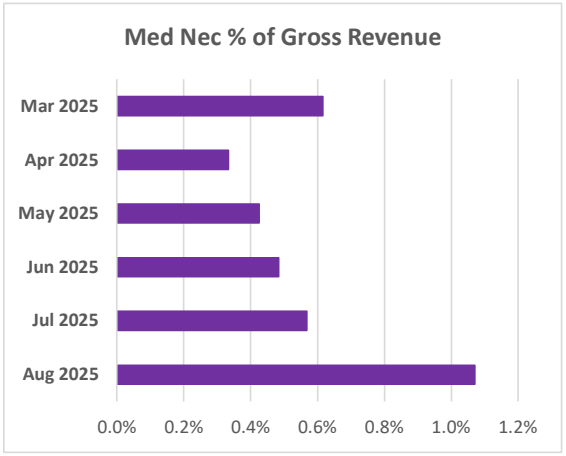
	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Self-Pay	$81,561.69	$47,431.39	$104,330.13	$96,494.80	$85,966.43	$95,744.95
Commercial	$83,847.22	$138,730.13	$193,120.03	$164,094.67	$179,993.03	$291,325.66
Medicaid	$1,144,198.26	$1,212,550.57	$1,262,873.50	$1,255,934.78	$1,345,207.93	$1,498,812.83
Medicare	$1,056,161.26	$1,075,033.06	$1,131,837.17	$1,166,878.86	$1,145,073.17	$1,217,715.06
BCBS	$263,458.55	$431,090.14	$382,014.95	$393,250.76	$331,960.98	$435,228.61

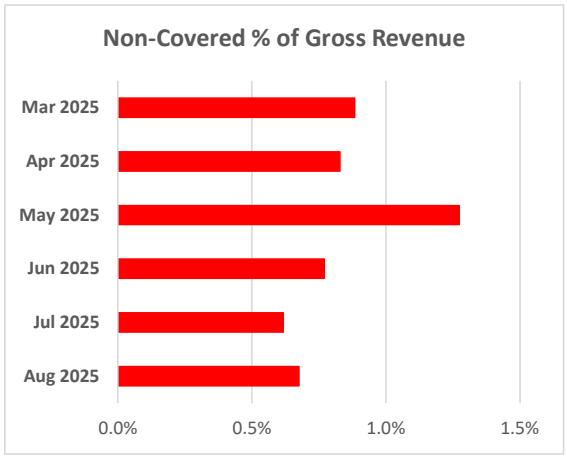


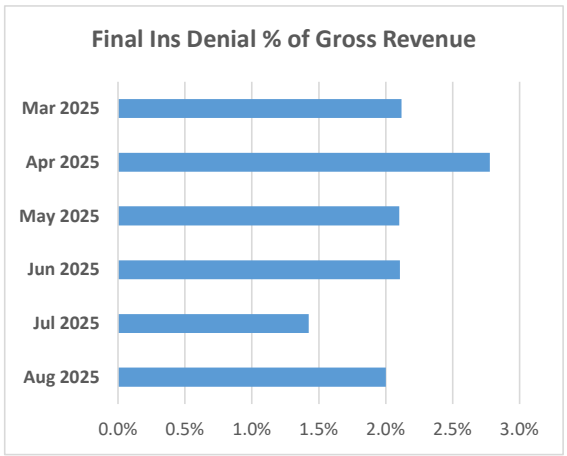

Authorization % of Gross Revenue
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0%
0.5%
1.0%
1.5%


Timely Filing % of Gross Revenue
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0%
0.1%
0.2%
0.3%
0.4%
0.5%
0.6%


Credentialing % of Gross Revenue
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0%
0.1%
0.2%
0.3%
0.4%
0.5%
0.6%

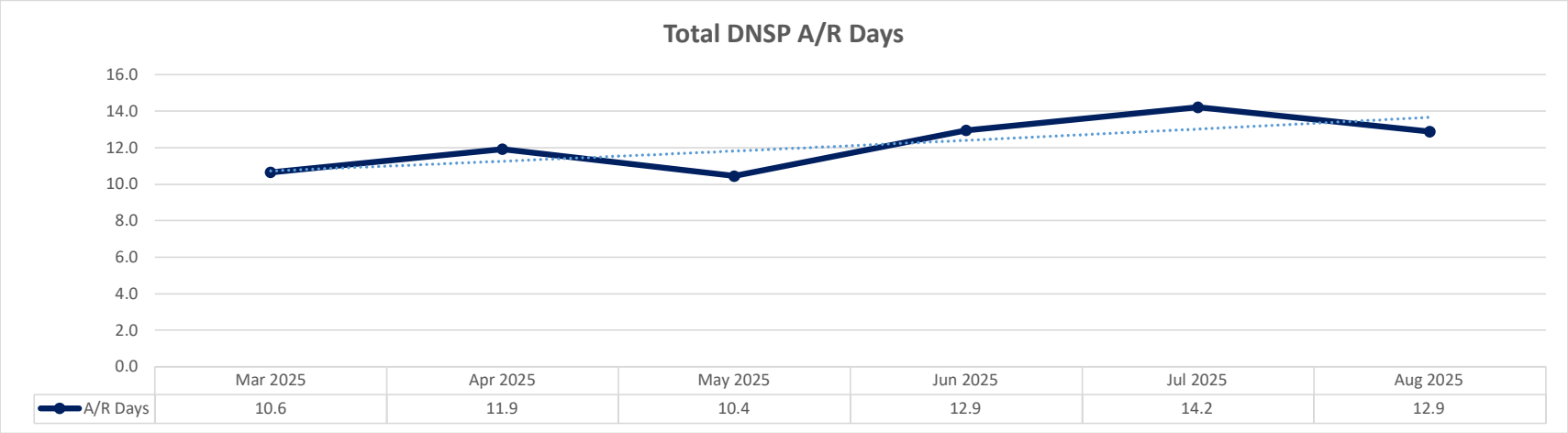

Med Nec % of Gross Revenue
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0%
0.2%
0.4%
0.6%
0.8%
1.0%
1.2%

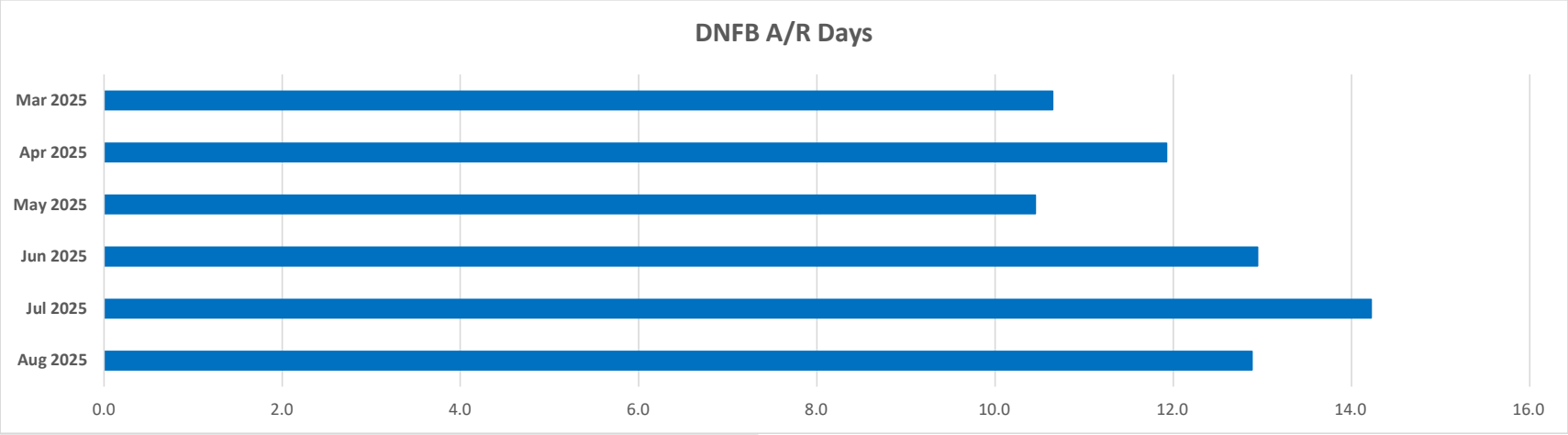

Non-Covered % of Gross Revenue
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0%
0.5%
1.0%
1.5%

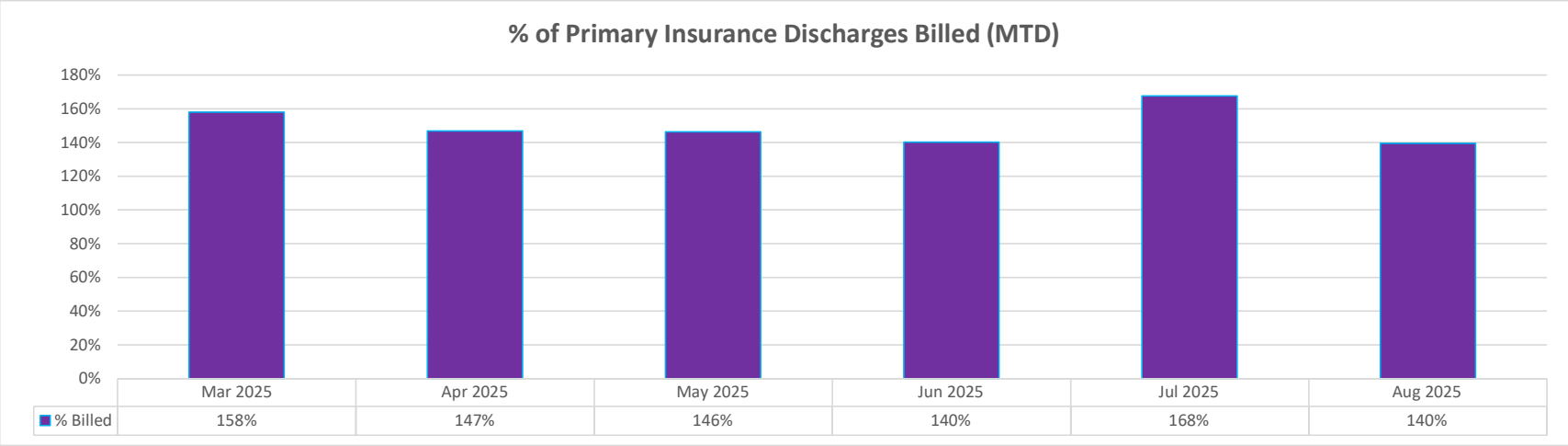

Final Ins Denial % of Gross Revenue
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0%
0.5%
1.0%
1.5%
2.0%
2.5%
3.0%

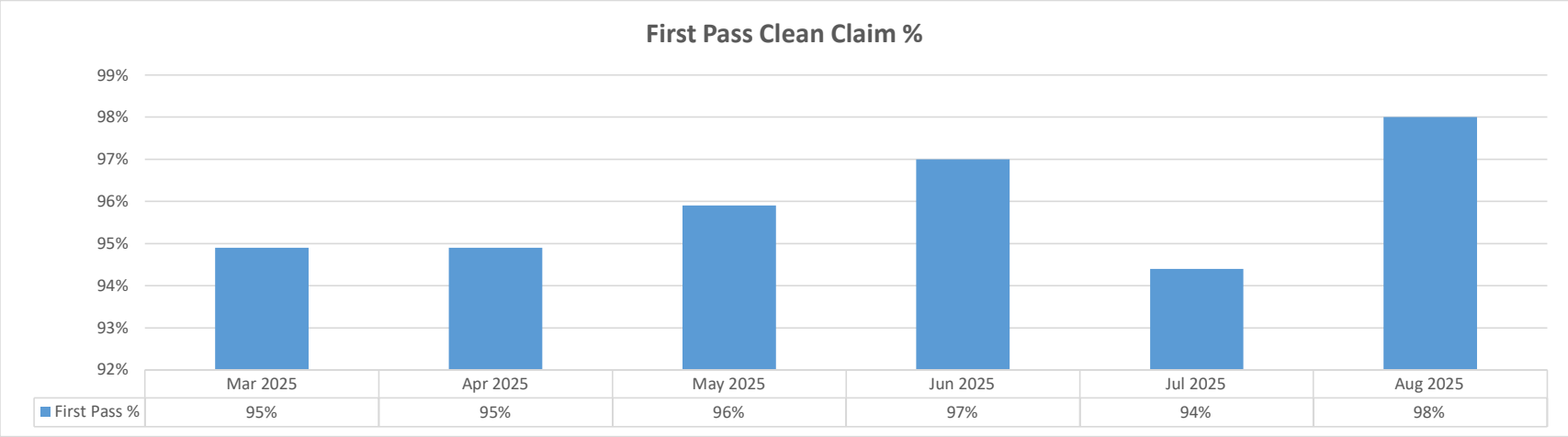
KPI Metric	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
DNSP $$ (Month End)	$ 944,626.00	$ 1,087,840.00	$ 999,484.00	$ 1,302,749.00	$ 1,459,615.00	$ 1,389,088.00
DNSP A/R Days (Month End)	10.6	11.9	10.4	12.9	14.2	12.9
DNSP A/R Days (Goal)	6.0	6.0	6.0	6.0	6.0	6.0
DNSP A/R Days (Goal Variance)	-4.6	-5.9	-4.4	-6.9	-8.2	-6.9
DNFB $$ (Month End)	$ 944,626.00	$ 1,087,840.00	$ 999,484.00	$ 1,302,749.00	$ 1,459,615.00	$ 1,389,088.00
DNFB A/R Days (Month End)	10.6	11.9	10.4	12.9	14.2	12.9
Total Insurance Discharges(Monthly Total)	1424	1481	1334	1664	1506	1481
**Total Insurance Discharges (Total Billed)*	2251	2174	1953	2334	2526	2066
Total Insurance Discharges - Goal 85%	85%	85%	85%	85%	85%	85%
**Total Insurances Discharges (% Billed)*	158%	147%	146%	140%	168%	140%
Total Count of Claims Remitted	1454	1713	1417	1453	1993	1494
**Total Zero Pay Denials in the Month (All DOS)*	108	135	100	89	163	191
% of Zero Pay vs. Total Remitted	7%	8%	7%	6%	8%	13%
% of Zero Pay vs. Total Remitted (Goal)	4%	4%	4%	4%	4%	4%
% of Zero Pay vs. Total Remitted (Variance)	3%	4%	3%	2%	4%	9%
First Pass Clean Claim % Rate	95%	95%	96%	97%	94%	98%
First Pass Clean Claim % Goal	95%	95%	95%	95%	95%	95%
First Pass Clean Claim % (Variance)	0%	0%	1%	2%	-1%	3%

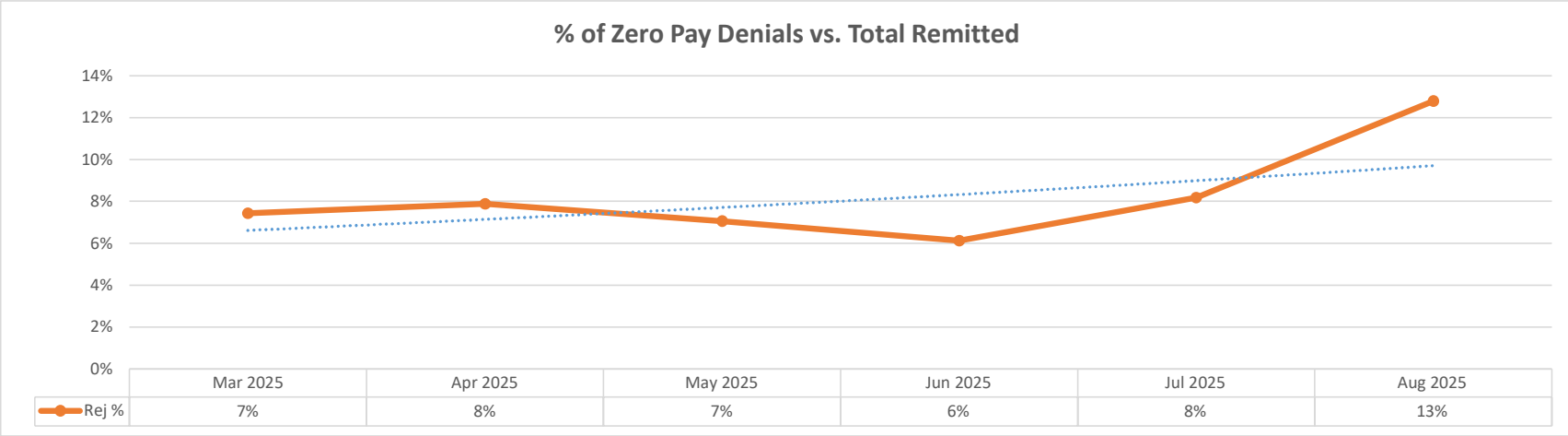
Billed Claims and Rejection Totals - Primary Claims Only

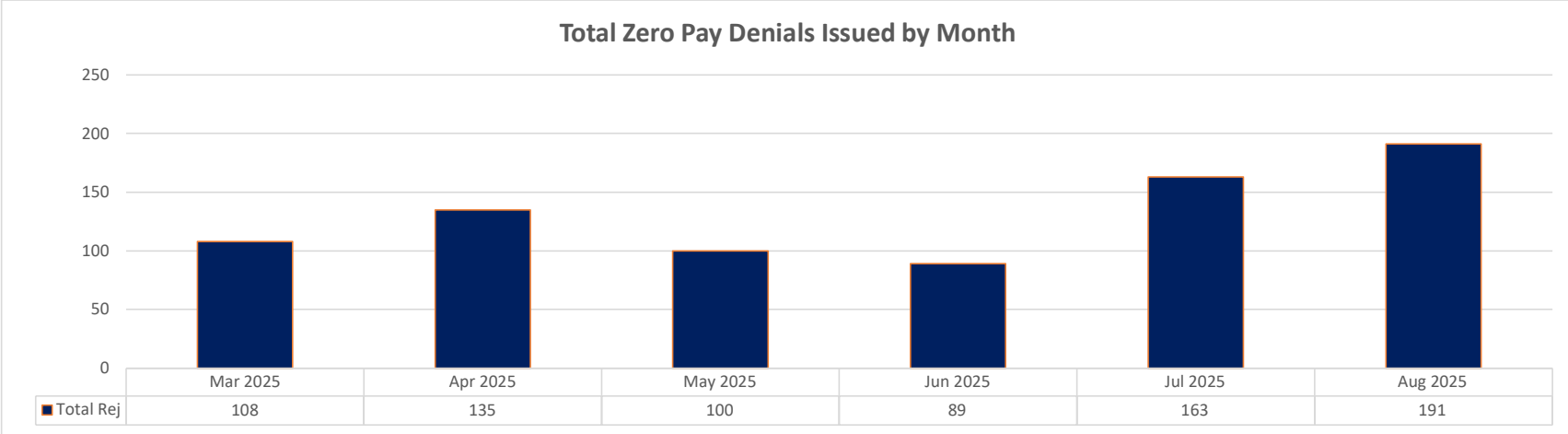

Total DNSP A/R Days
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
A/R Days
10.6
11.9
10.4
12.9
14.2
12.9


DNFB A/R Days
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
0.0
2.0
4.0
6.0
8.0
10.0
12.0
14.0
16.0


% of Primary Insurance Discharges Billed (MTD)
180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
% Billed
158%
147%
146%
140%
168%
140%


First Pass Clean Claim %
99%
98%
97%
96%
95%
94%
93%
92%
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
First Pass %
95%
95%
96%
97%
94%
98%

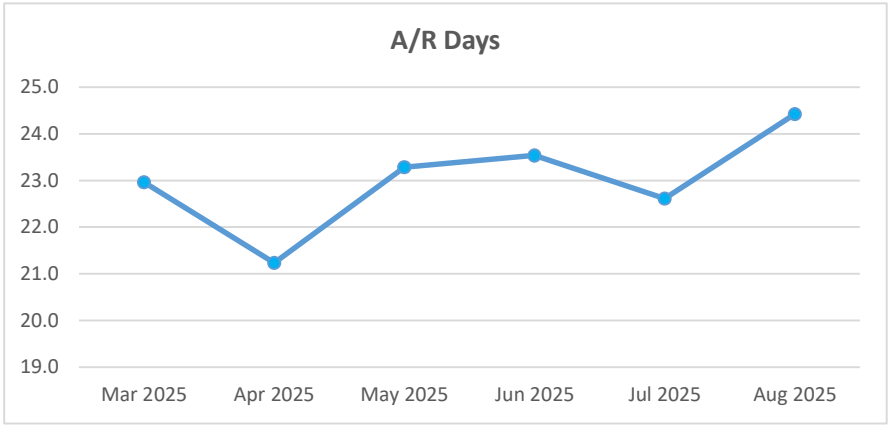

% of Zero Pay Denials vs. Total Remitted
14%
12%
10%
8%
6%
4%
2%
0%
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
Rej %
7%
8%
7%
6%
8%
13%

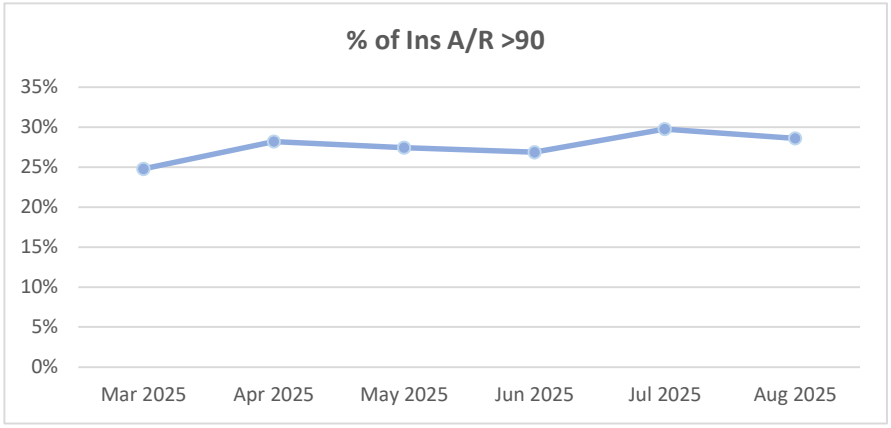

Total Zero Pay Denials Issued by Month
250
200
150
100
50
0
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
Total Rej
108
135
100
89
163
191

TruBridge

Aging Analysis - Summary of All Payers

	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
BCBS	$ 465,604.96	$ 362,269.15	$ 458,440.06	$ 456,968.90	$ 424,419.83	$ 469,564.96
Medicare	$ 1,813,883.20	$ 1,800,353.62	$ 2,208,138.22	$ 2,029,192.01	$ 1,839,440.14	$ 1,883,914.24
Medicaid	$ 2,679,845.60	$ 2,052,922.68	$ 1,953,557.92	$ 2,160,391.51	$ 2,005,251.44	$ 2,264,234.19
Commercial	$ 229,067.73	$ 292,207.41	$ 347,767.13	$ 400,257.56	$ 504,245.68	$ 440,743.22
Self-Pay	$ 1,407,545.83	$ 1,358,635.18	$ 1,356,186.46	$ 1,336,427.18	$ 1,404,619.14	$ 1,396,824.68
Total ATB Balance	**$ 6,595,947.32**	**$ 5,866,388.04**	**$ 6,324,089.79**	**$ 6,383,237.16**	**$ 6,177,976.23**	**$ 6,455,281.29**
Total A/R Days	23.0	21.2	23.3	23.5	22.6	24.4
ADR	$ 287,200.66	$ 276,265.75	$ 271,560.38	$ 271,222.54	$ 273,168.17	$ 264,296.42
Previous Mo. (Net Change %)	0%	-11%	8%	1%	-3%	4%
Total Ins A/R Balances >90	$ 1,287,353.48	$ 1,272,707.64	$ 1,364,294.90	$ 1,356,287.07	$ 1,421,919.43	$ 1,448,557.54
% of Ins A/R Balances >90	25%	28%	27%	27%	30%	29%





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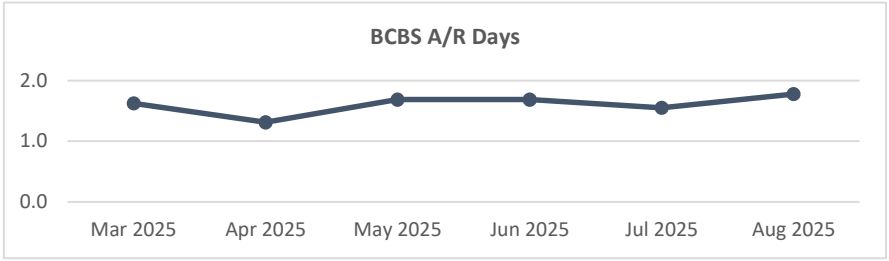
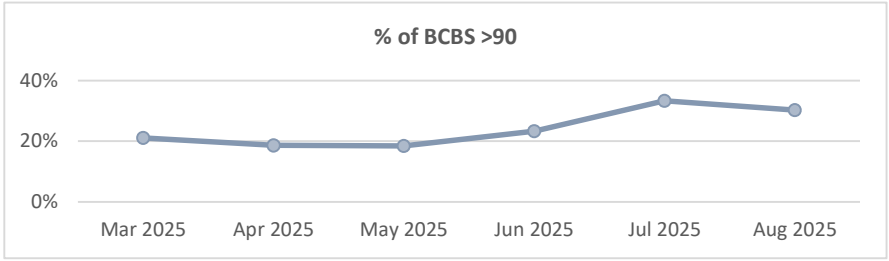
BCBS Aging Analysis

	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Credits	$ (13,937.44)	$ (33,214.15)	$ (11,702.34)	$ (20,154.32)	$ (18,590.64)	$ (24,441.15)
In-House	$ 6,780.23	$ 7,826.74	$ 9,296.86	$ 12,787.55	$ 2,820.00	$ 1,469.45
Current	$ 275,653.10	$ 234,751.66	$ 236,498.43	$ 232,408.28	$ 232,301.48	$ 208,655.28
>30 Days	$ 81,998.00	$ 43,722.56	$ 113,636.41	$ 64,340.26	$ 51,397.58	$ 87,524.62
>60 Days	$ 16,870.83	$ 41,831.97	$ 26,276.43	$ 60,841.97	$ 14,907.73	$ 54,167.91
>90 Days	$ 6,549.78	$ 14,009.00	$ 28,325.45	$ 16,011.27	$ 11,516.03	$ 5,321.39
>120 Days	$ 91,690.46	$ 53,341.37	$ 56,108.82	$ 90,733.89	$ 130,067.65	$ 136,867.46
BCBS Balance	**$ 465,604.96**	**$ 362,269.15**	**$ 458,440.06**	**$ 456,968.90**	**$ 424,419.83**	**$ 469,564.96**
BCBS Total A/R Days	1.6	1.3	1.7	1.7	1.6	1.8
Credit A/R Days	0.0	-0.1	0.0	-0.1	-0.1	-0.1
In-House A/R Days	0.0	0.0	0.0	0.0	0.0	0.0
Current A/R Days	1.0	0.8	0.9	0.9	0.9	0.8
>30 A/R Days	0.3	0.2	0.4	0.2	0.2	0.3
>60 A/R Days	0.1	0.2	0.1	0.2	0.1	0.2
>90 A/R Days	0.0	0.1	0.1	0.1	0.0	0.0
>120 A/R Days	0.3	0.2	0.2	0.3	0.5	0.5
BCBS % of Total A/R	7%	6%	7%	7%	7%	7%
Previous Mo. (Net Change %)	0%	-22%	27%	0%	-7%	11%
BCBS Balance >90	$ 98,240.24	$ 67,350.37	$ 84,434.27	$ 106,745.16	$ 141,583.68	$ 142,188.85
% of BCBS >90	21%	19%	18%	23%	33%	30%





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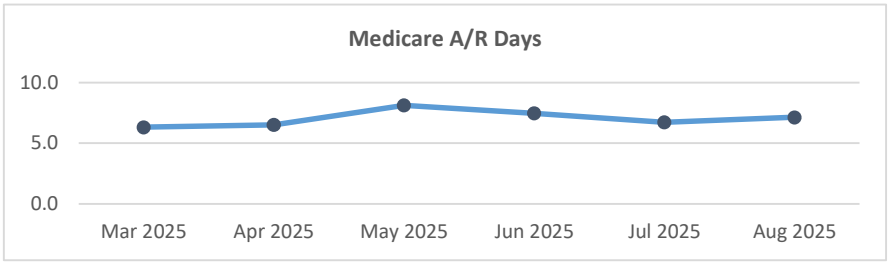
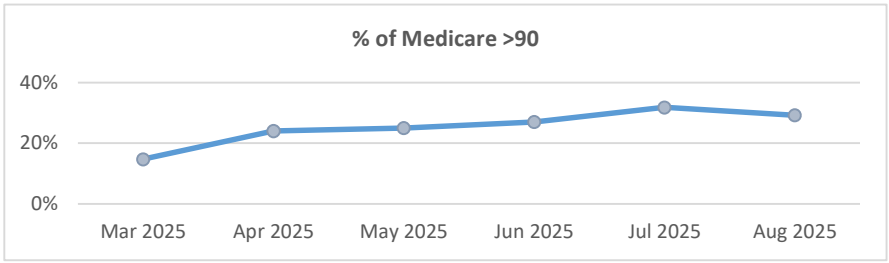
Medicare Aging Analysis

	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Credits	$ (19,242.32)	$ (16,981.82)	$ (15,588.86)	$ (42,068.73)	$ (122,736.63)	$ (86,710.46)
In-House	$ 20,513.36	$ 142,195.17	$ 30,295.79	$ 23,691.23	$ 96,088.48	$ 27,458.58
Current	$ 905,640.39	$ 822,439.94	$ 974,992.71	$ 953,448.96	$ 922,984.28	$ 710,170.33
>30 Days	$ 393,778.71	$ 228,816.63	$ 467,763.46	$ 305,190.11	$ 222,222.62	$ 523,733.66
>60 Days	$ 246,508.28	$ 191,207.51	$ 198,388.43	$ 239,991.19	$ 135,668.01	$ 158,255.98
>90 Days	$ 76,014.19	$ 107,850.09	$ 197,788.65	$ 141,329.30	$ 126,431.80	$ 119,586.15
>120 Days	$ 190,670.59	$ 324,826.10	$ 354,498.04	$ 407,609.95	$ 458,781.58	$ 431,420.00
Medicare Balance	**$ 1,813,883.20**	**$ 1,800,353.62**	**$ 2,208,138.22**	**$ 2,029,192.01**	**$ 1,839,440.14**	**$ 1,883,914.24**
Medicare Total A/R Days	6.3	6.5	8.1	7.5	6.7	7.1
Credit A/R Days	-0.1	-0.1	-0.1	-0.2	-0.4	-0.3
In-House A/R Days	0.1	0.5	0.1	0.1	0.4	0.1
Current A/R Days	3.2	3.0	3.6	3.5	3.4	2.7
>30 A/R Days	1.4	0.8	1.7	1.1	0.8	2.0
>60 A/R Days	0.9	0.7	0.7	0.9	0.5	0.6
>90 A/R Days	0.3	0.4	0.7	0.5	0.5	0.5
>120 A/R Days	0.7	1.2	1.3	1.5	1.7	1.6
Medicare % of Total A/R	27%	31%	35%	32%	30%	29%
Previous Mo. (Net Change %)	0%	-1%	23%	-8%	-9%	2%
Medicare Balance >90	$ 266,684.78	$ 432,676.19	$ 552,286.69	$ 548,939.25	$ 585,213.38	$ 551,006.15
% of Medicare >90	15%	24%	25%	27%	32%	29%





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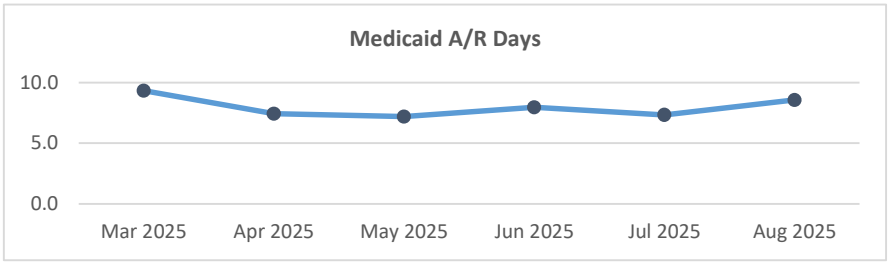
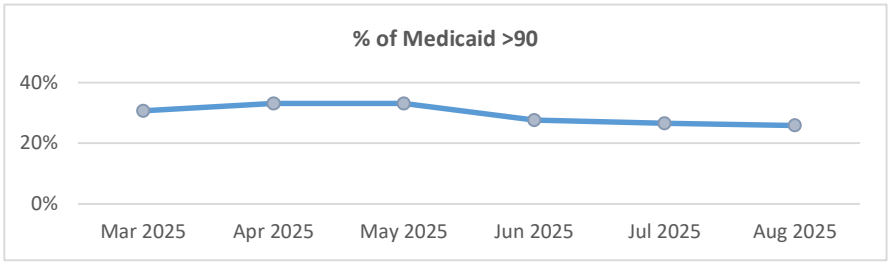
Medicaid Aging Analysis

	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Credits	$ (15,545.78)	$ (14,228.05)	$ (12,525.21)	$ (6,796.07)	$ 1,512.45	$ 480.20
In-House	$ 58,247.82	$ 50,438.15	$ 74,832.14	$ 174,065.76	$ 211,143.87	$ 129,231.52
Current	$ 1,061,829.08	$ 930,143.12	$ 842,880.49	$ 1,069,151.25	$ 872,333.40	$ 1,118,199.74
>30 Days	$ 539,812.08	$ 250,691.17	$ 284,360.07	$ 205,416.79	$ 272,774.92	$ 286,645.30
>60 Days	$ 212,228.91	$ 156,114.28	$ 116,834.27	$ 122,753.63	$ 115,921.99	$ 143,956.02
>90 Days	$ 135,903.53	$ 98,645.61	$ 62,839.09	$ 75,316.01	$ 84,436.46	$ 70,713.83
>120 Days	$ 687,369.96	$ 581,118.40	$ 584,337.07	$ 520,484.14	$ 447,128.35	$ 515,007.58
Medicaid Balance	**$ 2,679,845.60**	**$ 2,052,922.68**	**$ 1,953,557.92**	**$ 2,160,391.51**	**$ 2,005,251.44**	**$ 2,264,234.19**
Medicaid Total A/R Days	9.3	7.4	7.2	8.0	7.3	8.6
Credit A/R Days	-0.1	-0.1	0.0	0.0	0.0	0.0
In-House A/R Days	0.2	0.2	0.3	0.6	0.8	0.5
Current A/R Days	3.7	3.4	3.1	3.9	3.2	4.2
>30 A/R Days	1.9	0.9	1.0	0.8	1.0	1.1
>60 A/R Days	0.7	0.6	0.4	0.5	0.4	0.5
>90 A/R Days	0.5	0.4	0.2	0.3	0.3	0.3
>120 A/R Days	2.4	2.1	2.2	1.9	1.6	1.9
Medicaid % of Total A/R	41%	35%	31%	34%	32%	35%
Previous Mo. (Net Change %)	0%	-23%	-5%	11%	-7%	13%
Medicaid Balance >90	$ 823,273.49	$ 679,764.01	$ 647,176.16	$ 595,800.15	$ 531,564.81	$ 585,721.41
% of Medicaid >90	31%	33%	33%	28%	27%	26%

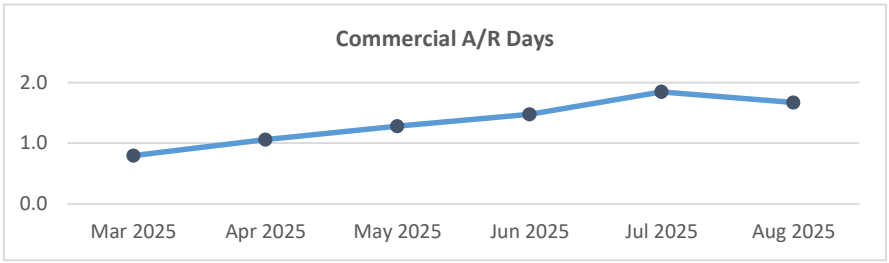


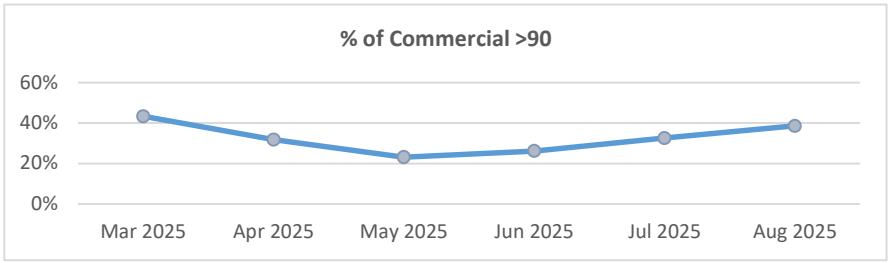


TruBridge

Commercial Aging Analysis

	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Credits	$ (22,139.33)	$ (41,591.12)	$ (38,716.99)	$ (43,064.21)	$ (49,288.91)	$ (54,169.73)
In-House	$ 1,078.36	$ -	$ -	$ 649.05	$ -	$ -
Current	$ 82,762.07	$ 155,894.88	$ 174,006.45	$ 157,218.10	$ 248,928.16	$ 186,345.82
>30 Days	$ 64,620.76	$ 56,743.73	$ 103,471.96	$ 91,970.83	$ 93,368.21	$ 91,644.48
>60 Days	$ 3,590.90	$ 28,242.85	$ 28,607.93	$ 88,681.28	$ 47,680.66	$ 47,281.52
>90 Days	$ 8,626.20	$ 2,274.65	$ 16,803.48	$ 24,952.33	$ 55,351.58	$ 27,676.77
>120 Days	$ 90,528.77	$ 90,642.42	$ 63,594.30	$ 79,850.18	$ 108,205.98	$ 141,964.36
Commercial Balance	**$ 229,067.73**	**$ 292,207.41**	**$ 347,767.13**	**$ 400,257.56**	**$ 504,245.68**	**$ 440,743.22**
Commercial Total A/R Days	0.8	1.1	1.3	1.5	1.8	1.7
Credit A/R Days	-0.1	-0.2	-0.1	-0.2	-0.2	-0.2
In-House A/R Days	0.0	0.0	0.0	0.0	0.0	0.0
Current A/R Days	0.3	0.6	0.6	0.6	0.9	0.7
>30 A/R Days	0.2	0.2	0.4	0.3	0.3	0.3
>60 A/R Days	0.0	0.1	0.1	0.3	0.2	0.2
>90 A/R Days	0.0	0.0	0.1	0.1	0.2	0.1
>120 A/R Days	0.3	0.3	0.2	0.3	0.4	0.5
Commercial % of Total A/R	3%	5%	5%	6%	8%	7%
Previous Mo. (Net Change %)	0%	28%	19%	15%	26%	-13%
Commercial Balance >90	$ 99,154.97	$ 92,917.07	$ 80,397.78	$ 104,802.51	$ 163,557.56	$ 169,641.13
% of Commercial >90	43%	32%	23%	26%	32%	38%

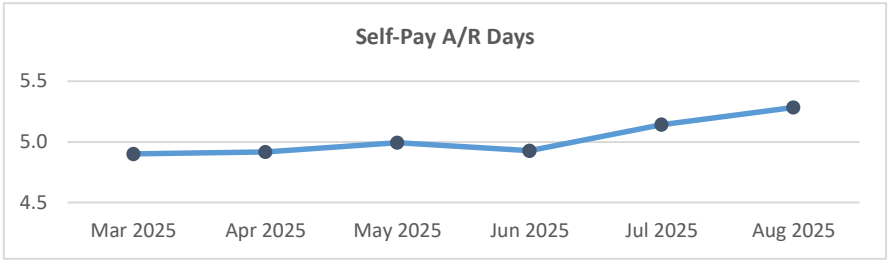


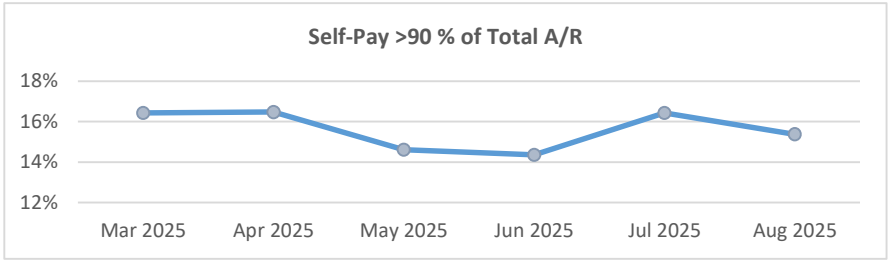


TruBridge

Self-Pay Aging Analysis

	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Credits	$ (27,792.26)	$ (33,214.15)	$ (38,856.66)	$ (35,750.93)	$ (49,269.66)	$ (40,438.14)
In-House	$ -	$ -	$ 40,832.86	$ 10,729.67	$ 9,785.66	$ 8,309.19
Current	$ 83,068.65	$ 190,221.49	$ 103,378.56	$ 122,511.27	$ 132,124.70	$ 148,260.96
>30 Days	$ 136,847.60	$ 121,212.90	$ 177,056.07	$ 129,255.06	$ 159,836.26	$ 119,946.42
>60 Days	$ 131,006.90	$ 113,724.92	$ 149,243.36	$ 193,336.79	$ 136,904.11	$ 167,394.16
>90 Days	$ 108,198.56	$ 107,123.28	$ 110,229.08	$ 146,756.07	$ 195,356.17	$ 127,347.26
>120 Days	$ 976,216.38	$ 859,566.74	$ 814,303.19	$ 769,589.25	$ 819,881.90	$ 866,004.83
Self-Pay Balance	**$ 1,407,545.83**	**$ 1,358,635.18**	**$ 1,356,186.46**	**$ 1,336,427.18**	**$ 1,404,619.14**	**$ 1,396,824.68**
Self-Pay Total A/R Days	4.9	4.9	5.0	4.9	5.1	5.3
Credit A/R Days	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
In-House A/R Days	0.0	0.0	0.2	0.0	0.0	0.0
Current A/R Days	0.3	0.7	0.4	0.5	0.5	0.6
>30 A/R Days	0.5	0.4	0.7	0.5	0.6	0.5
>60 A/R Days	0.5	0.4	0.5	0.7	0.5	0.6
>90 A/R Days	0.4	0.4	0.4	0.5	0.7	0.5
>120 A/R Days	3.4	3.1	3.0	2.8	3.0	3.3
Self-Pay % of Total A/R	21%	23%	21%	21%	23%	22%
Previous Mo. (Net Change %)	0%	-3%	0%	-1%	5%	-1%
Self-Pay Balance >90	$ 1,084,414.94	$ 966,690.02	$ 924,532.27	$ 916,345.32	$ 1,015,238.07	$ 993,352.09
Self-Pay >90 % of Total A/R	16%	16%	15%	14%	16%	15%





TruBridge

Monthly Denial Analysis

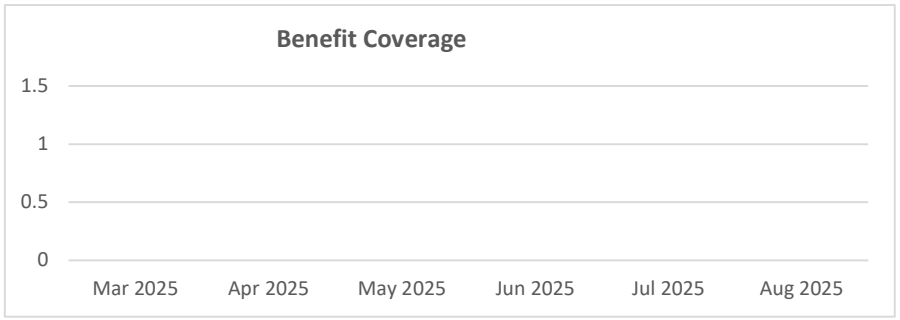
Denials by Category	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Benefit Coverage - $$	$ -	$ -	$ -	$ -	$ -	$ -
Benefit Coverage - % of ($$) Total	0%	0%	0%	0%	0%	0%
Benefit Coverage - Count						
Benefit Coverage - % of Total Count	0%	0%	0%	0%	0%	0%
Patient Registration - $$	$ 45,426.15	$ 39,689.71	$ 69,542.05	$ 37,901.41	$ 91,063.54	$ 51,944.74
Patient Registration - % of ($$) Total	20%	20%	28%	22%	33%	18%
Patient Registration - Count	58	28	46	24	55	36
Patient Registration - % of Total Count	14%	10%	17%	11%	14%	9%
Medical Necessity - $$	$ 16,179.37	$ 9,687.09	$ 13,068.47	$ 14,887.12	$ 17,546.39	$ 37,860.77
Medical Necessity - % of ($$) Total	7%	5%	5%	9%	6%	13%
Medical Necessity - Count	14	24	5	11	16	19
Medical Necessity - % of Total Count	3%	8%	2%	5%	4%	5%
Non-Covered Services - $$	$ 23,235.84	$ 24,031.90	$ 39,147.30	$ 23,684.40	$ 19,068.18	$ 28,643.59
Non-Covered Services- % of ($$) Total	10%	12%	16%	14%	7%	10%
Non-Covered Services - Count	101	50	82	43	92	63
Non-Covered Services - % of Total Count	25%	18%	31%	19%	23%	16%
Technical Billing - $$	$ 48,915.24	$ 27,233.58	$ 56,714.89	$ 34,738.64	$ 92,062.56	$ 105,010.11
Technical Billing - % of ($$) Total	21%	14%	23%	20%	34%	36%
Technical Billing - Count	154	114	79	76	158	203
Technical Billing - % of Total Count	37%	40%	30%	34%	40%	51%
Coding - $$	$ 9,561.08	$ 11,309.19	$ 1,092.17	$ 13,155.23	$ 4,028.30	$ 1,975.12
Coding - % of ($$) Total	4%	6%	0%	8%	1%	1%
Coding - Count	30	8	6	20	14	15
Coding - % of Total Count	7%	3%	2%	9%	4%	4%

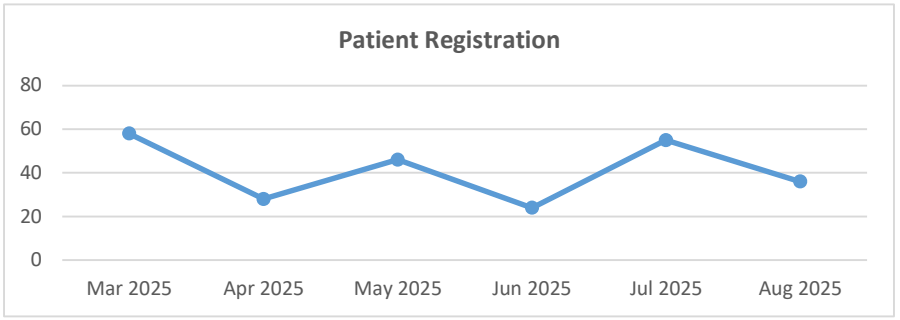
TruBridge

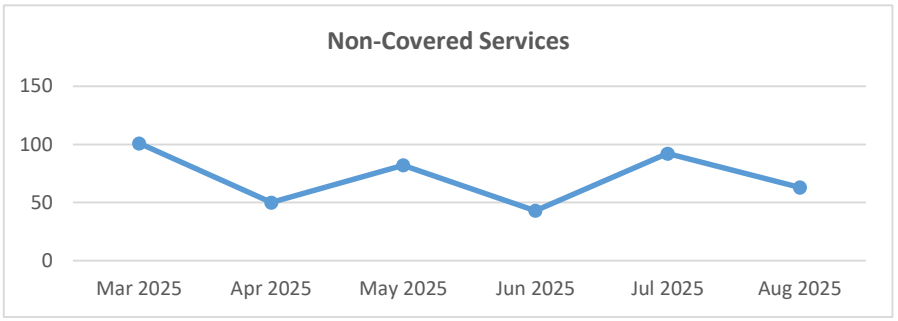
Denials by Category	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Prior Authorization - $$	$ 2,455.51	$ 33,278.19	$ 870.53	$ 16,697.91	$ 4,274.39	$ 74.62
Prior Authorization - % of ($$) Total	1%	17%	0%	10%	2%	0%
Prior Authorization - Count	3	7	4	8	5	2
Prior Authorization - % of Total Count	1%	2%	2%	4%	1%	1%
Workers Compensation - $$	$ -	$ -	$ -	$ -	$ -	$ -
Workers Compensation - % of ($$) Total	0%	0%	0%	0%	0%	0%
Workers Compensation - Count	0	0	0	0	0	0
Workers Compensation - % of Total Count	0%	0%	0%	0%	0%	0%
Duplicate Claim - $$	$ 54,311.98	$ 28,135.88	$ 46,698.89	$ 12,825.75	$ 15,293.59	$ 44,714.31
Duplicate Claim - % of ($$) Total	23%	14%	19%	7%	6%	15%
Duplicate Claim - Count	21	17	28	20	23	20
Duplicate Claim - % of Total Count	5%	6%	11%	9%	6%	5%
Other - $$	$ 17,866.07	$ 8,727.98	$ 13,215.06	$ 9,261.66	$ 25,562.68	$ 13,414.55
Other - % of ($$) Total	8%	4%	5%	5%	9%	5%
Other - Count	14	24	5	11	16	18
Other - % of Total Count	3%	8%	2%	5%	4%	5%
Timely Filing - $$	$ 13,827.05	$ 13,652.04	$ 11,544.01	$ 9,502.03	$ 3,069.12	$ 8,989.13
Timely Filing - % of ($$) Total	6%	7%	5%	6%	1%	3%
Timely Filing - Count	17	12	11	11	21	24
Timely Filing - % of Total Count	4%	4%	4%	5%	5%	6%
Total (All Categories) - $$	**$ 231,778.29**	**$ 195,745.56**	**$ 251,893.37**	**$ 172,654.15**	**$ 271,968.75**	**$ 292,626.94**
Total (All Categories) - Count	**412**	**284**	**266**	**224**	**400**	**400**

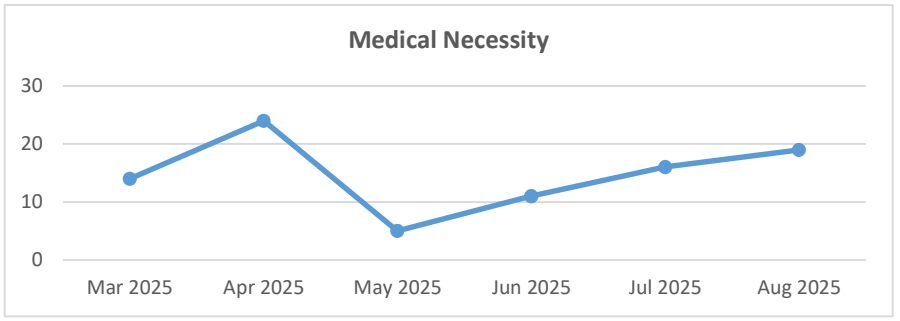
TruBridge

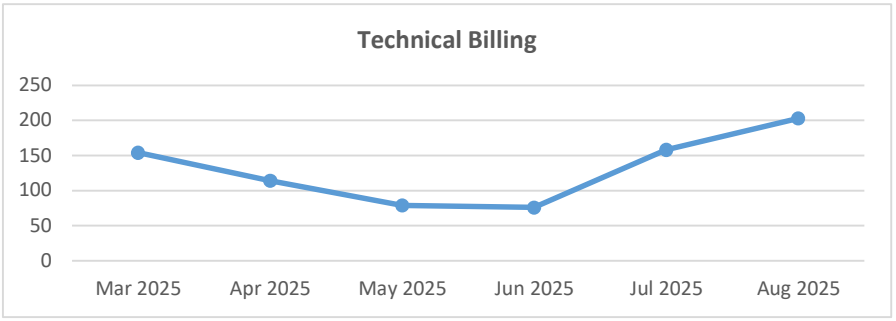
Category Trends by Count of Denial

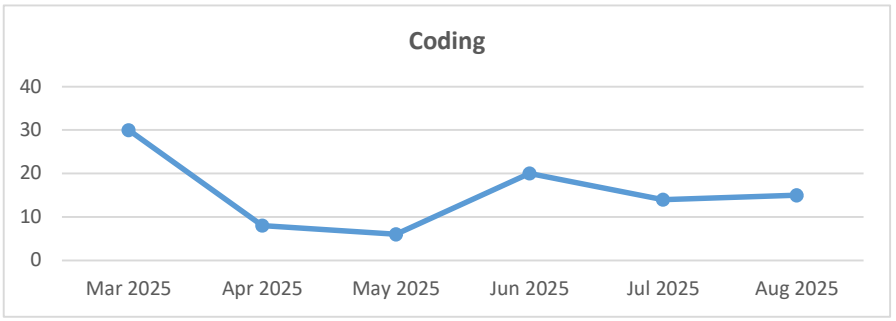






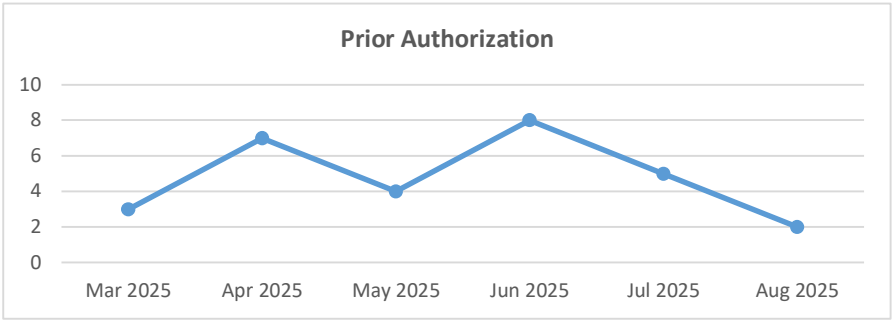


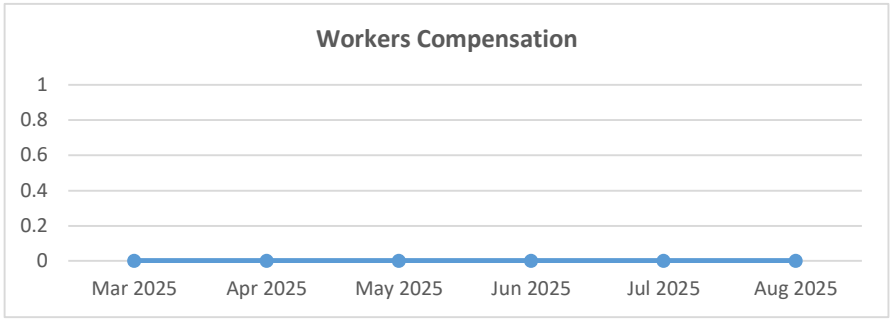


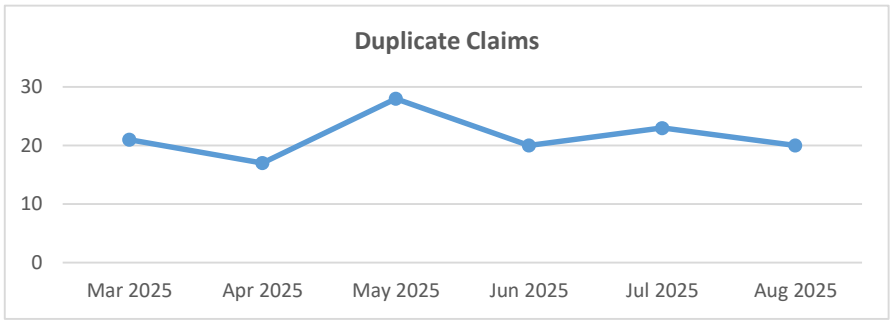


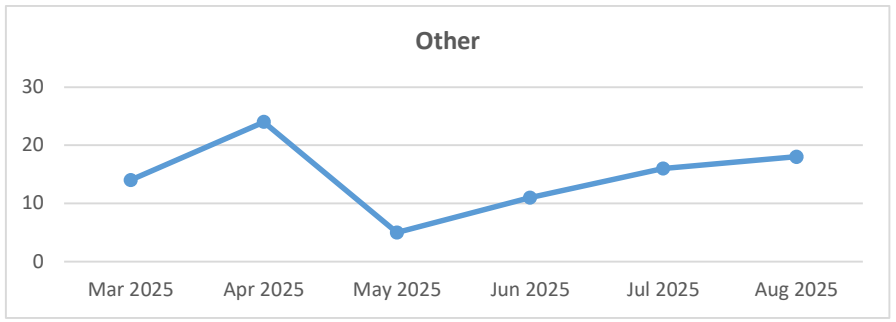
TruBridge

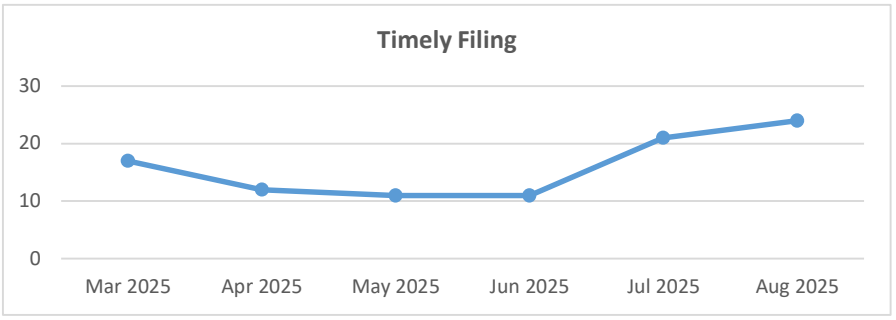
Category Trends by Count of Denial

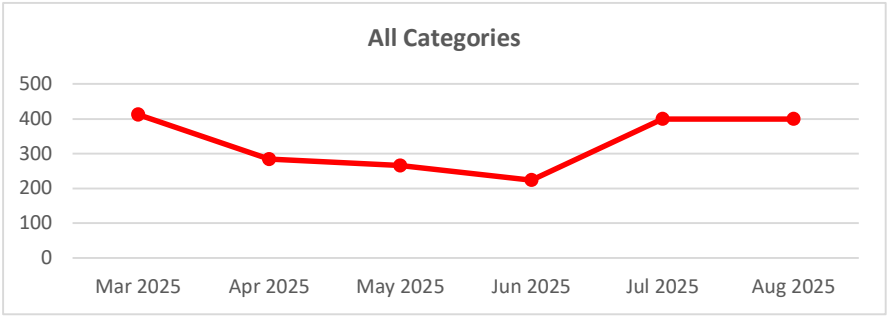












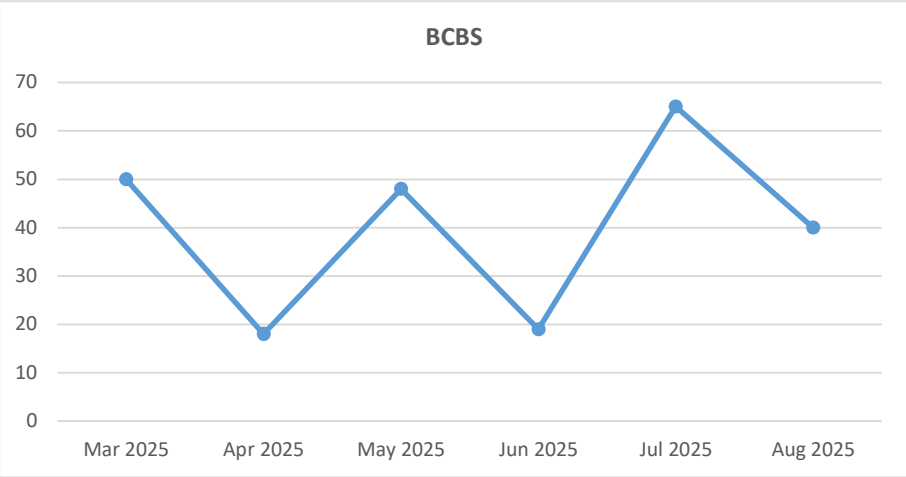
TruBridge

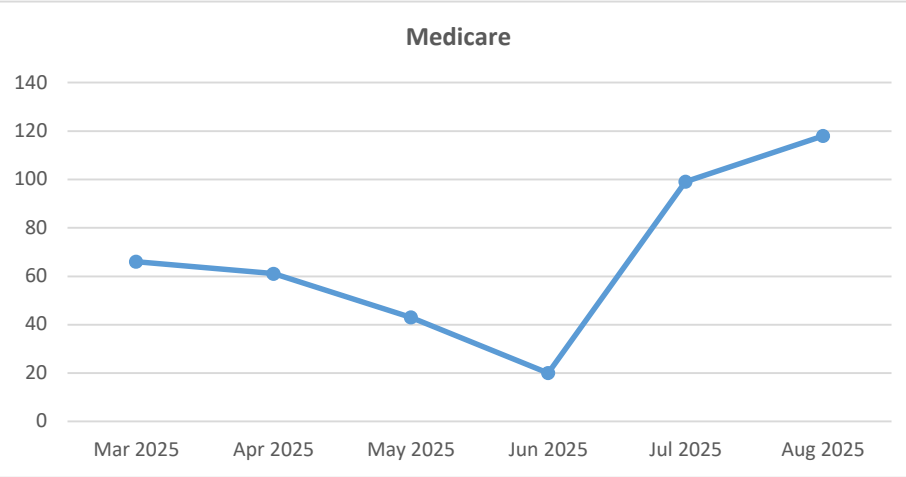
Category Trends by Count of Denial

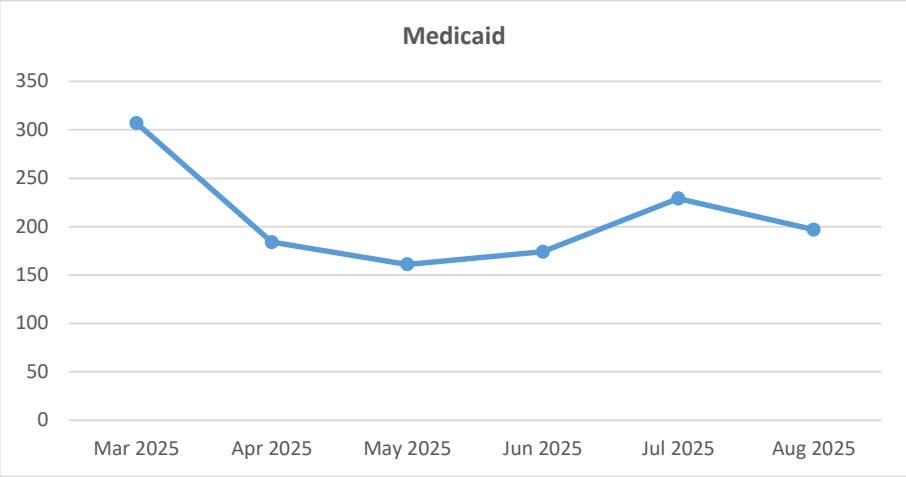
Denials by Payer Group	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
BCBS - $$	$ 27,592.42	$ 46,169.89	$ 48,119.33	$ 18,595.78	$ 38,416.08	$ 32,751.40
BCBS - % of ($$) Total	12%	24%	19%	11%	14%	11%
BCBS - Count	50	18	48	19	65	40
BCBS - % of Total Count	12%	6%	18%	8%	16%	10%
BCBS - Reimbursement Average	0%	0%	0%	0%	0%	0%
BCBS - ($$) Impact	$ -	$ -	$ -	$ -	$ -	$ -
Medicare - $$	$ 32,254.58	$ 32,139.16	$ 46,089.31	$ 16,758.57	$ 67,495.62	$ 85,595.32
Medicare - % of ($$) Total	14%	16%	18%	10%	25%	29%
Medicare - Count	66	61	43	20	99	118
Medicare - % of Total Count	16%	21%	16%	9%	25%	30%
Medicare - Reimbursement Average	0%	0%	0%	0%	0%	0%
Medicare - ($$) Impact	$ -	$ -	$ -	$ -	$ -	$ -
Medicaid - $$	$ 143,908.36	$ 82,268.32	$ 132,907.55	$ 85,154.19	$ 110,691.64	$ 89,663.10
Medicaid - % of ($$) Total	62%	42%	53%	49%	41%	31%
Medicaid - Count	307	184	161	174	229	197
Medicaid - % of Total Count	75%	65%	61%	78%	57%	49%
Medicaid - Reimbursement Average	0%	0%	0%	0%	0%	0%
Medicaid - ($$) Impact	$ -	$ -	$ -	$ -	$ -	$ -
Commercial - $$	$ 46,370.72	$ 40,379.83	$ 47,500.44	$ 56,851.07	$ 64,157.39	$ 88,170.25
Commercial - % of ($$) Total	20%	21%	19%	33%	24%	30%
Commercial - Count	56	36	58	40	46	53
Commercial - % of Total Count	14%	13%	22%	18%	12%	13%
Commercial - Reimbursement Average	0%	0%	0%	0%	0%	0%
Commercial - ($$) Impact	$ -	$ -	$ -	$ -	$ -	$ -

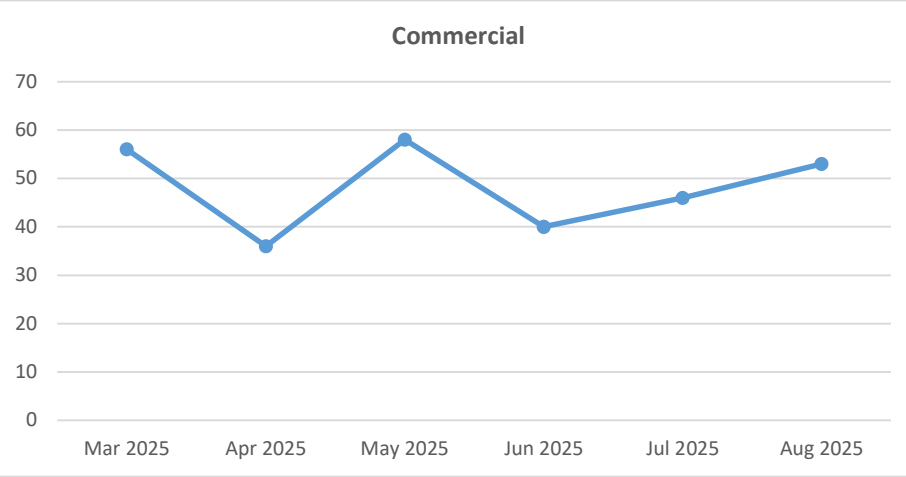
TruBridge

Payer Trends by Count of Denial









TruBridge

Final Denial Adjustment Totals (Current Month)

Payer Group	Timely Filing	Medical Necessity	Non-Covered	Authorization	Credentialing	Totals
BCBS	$ 823.71	$ -	$ 671.12	$ 34.60	$ -	$ 1,529.43
BCBS - Reimbursement Average	68.1%	68.1%	68.1%	68.1%	68.1%	68.1%
BCBS - Cash Lost	$ 560.95	$ -	$ 457.03	$ 23.56	$ -	$ 1,041.54
Medicare	$ -	$ 13,412.91	$ 5,252.20	$ -	$ -	$ 18,665.11
Medicare - Reimbursement Average	64.7%	64.7%	64.7%	64.7%	64.7%	64.7%
Medicare - Cash Lost	$ -	$ 8,678.15	$ 3,398.17	$ -	$ -	$ 12,076.33
Medicaid	$ 2,154.76	$ 4,316.08	$ 14,385.90	$ -	$ 2,169.94	$ 23,026.68
Medicaid - Reimbursement Average	25.5%	25.5%	25.5%	25.5%	25.5%	25.5%
Medicaid - Cash Lost	$ 549.46	$ 1,100.60	$ 3,668.40	$ -	$ 553.33	$ 5,871.80
Commercial	$ 6,010.66	$ 20,131.78	$ 8,334.37	$ 40.02	$ 1,383.19	$ 35,900.02
Commercial - Reimbursement Average	63.8%	63.8%	63.8%	63.8%	63.8%	63.8%
Commercial - Cash Lost	$ 3,834.80	$ 12,844.08	$ 5,317.33	$ 25.53	$ 882.48	$ 22,904.21
Cash Lost (All Payers)	**$ 4,945.21**	**$ 22,622.83**	**$ 12,840.94**	**$ 49.10**	**$ 1,435.81**	**$ 41,893.88**

APPENDIX (Key Fields)

Field Name	Field Description	Section
Gross A/R Days	Average days to collect based on gross charges and the 90-Day ADR	**KPI**
Total A/R Balance	Total A/R to include all oustanding insurance and self-pay balances. Includes credit balances	**KPI**
Total Insurance A/R Balance (less Credits)	Total A/R for all accounts with active insurance. Does not include accounts with credit balances	**KPI**
Total Self-Pay Balance	Total A/R for all accounts identifed as active self-pay balances. Does not include credit balances	**KPI**
MTD Cash Collections	Total A/R cash collections posted within the EHR for that month	**KPI**
POS Collections	Cash collections posted on, or before, or within 7 days of the discharge date	**KPI**
Total Insurance A/R Balance (>90 Days)	All active insurance balances >90 days from the patient discharge date. This is reported on a global level by the individual payer	**KPI**
Self-Pay >90 % of Total A/R	Self-Pay patient balances >90 days as a % of the total outstanding A/R	**KPI**
Credit Balances	The total of all active credit balances in the hospital A/R	**KPI**
Gross Revenue	Total gross revenue posted within the EHR for that month	**KPI**
B/D Write-Off Total	Total bad debt adjustments posted within the EHR for that month	**KPI**
B/D Recovery Total	Total bad debt recovery payments posted within the EHR for that month	**KPI**
Insurance Denial Write-Off Amount	The total adjustment amounts recorded for final denials in the following insurance categories: Credentialing, Timely Filing, Medical Necessity, Non-Covered Charges, and Authorization denials	**KPI**
DNSP Totals	Combination of the FBNS and the DNFB totals	**KPI**
FBNS Totals	The total dollar amount and A/R days associated with the claims that have reached the final billed status in the EHR, but have not been final submitted and forwarded to the payer	**KPI**
DNFB Totals	The total dollar amount and A/R days associated with the claims that have been discharged in the EHR, but have not been final billed	**KPI**
Total Insurance Discharges (% Billed)	% of current month discharges that were billed. Target is 85%	**KPI**
Total Zero Pay Denials MTD (All DOS)	Count and % of claims in which the denied charges were 100% of the submitted charges. This is based on remitted claims within the current month	**KPI**
First Pass Clean Claim % Rate	% of claims that passed through cleanly after manual intervention	**KPI**
Clean Claim % Rate	% of claims that passed through cleanly requiring no intervention	**KPI**
Previous Month (Net Change %)	% of change in A/R balances between the current month and the previous month	**Aging**
In-House A/R Days	The total number of A/R Days associated with patient accounts that have not been discharged	**Aging**
Final Denial Adjustment Totals	The total dollar of cash collections lost (based on reimbursement averages) for the following final denial categories: Credentialing, Timely Filing, Medical Necessity, Non-Covered Charges, and Authorization denials	**Denials**

SoHum Health

CNO Board Report – September 2025

Infection Prevention

In September 2025, the Infection Prevention manager provided significant updates regarding the upcoming flu season, which begins on October 1st. Preparations for a vaccination campaign are underway; however, uncertainty looms as the CDC has yet to issue official recommendations. The California Department of Public Health and the County of Humboldt await further guidance to finalize their recommendations and mandates for this year's flu season, ensuring decisions are based on the most current information.

Emergency Department/Acute Care Update

In August, the Emergency Department (ED) cared for 323 patients; the Acute Care side cared for 12 swing-bed patients and three inpatient admissions. With the recent addition of new nursing staff, the department can manage care for more than five acute patients simultaneously, adhering to the required nurse-to-patient ratios with a registered nurse and a licensed vocational nurse on each shift.

The EDAP Survey, which was conducted on September 3, 2025, yielded positive feedback, and the team is currently awaiting the official results. Looking ahead, six nurses are scheduled to attend CR Preceptor Training in October, and preparations are in motion for a Physician Orientation packet for new doctors. Discussions about acquiring a portable building for use as a triage, fast track, or isolation space are ongoing.

The hiring process is also active, with plans to bring on one new RN and potentially two more. One travel RN contract is set to conclude in October, and another LVN contract will end in early January. The department is also preparing for an upcoming survey for the Acute/Emergency Department while maintaining a strong commitment to providing exceptional care and fostering a supportive environment for patients in recovery.

Laboratory

The recent updates from our laboratory highlight significant achievements and ongoing improvements. Adam announced that the ACHC has completed their review and granted the laboratory a full two-year accreditation, the best possible outcome. They will not conduct another survey until the mandated review in Spring 2027. While the lab team needs to provide ongoing compliance evidence for four specific items by December, they have already begun addressing these issues, making the process straightforward. Adam praised the lab team for exceeding expectations during the review, showcasing the quality of their work and earning full accreditation, with special thanks extended to Dr. Fangluo and other supportive colleagues.

SoHum Health

Skilled Nursing Update

Katherine, our DON, is excited to share that our Skilled Nursing Facility (SNF) has reached a wonderful milestone with a total of 8 residents, reflecting a growing sense of community and companionship. The facility recently underwent a survey by the California Department of Public Health, where it performed admirably, with only minor deficiencies already corrected. We await the official report. The Activity Department has been proactive in providing enriching experiences for residents, including enjoyable outings to the local library and the Healy Senior Center. A recent reggae-themed ice cream and mocktail party brought residents and guests joy. Additionally, the beautifully maintained raised flower beds, cared for by one resident, enhance the welcoming atmosphere of our outdoor space.

Clinic Update

Our clinic had a busy month in August, serving 554 patients. We are thrilled to announce the expansion of our Visiting Nurse Program, which provides excellent care to 13 patients.

In provider updates, Dr. Raisoni has gained approval to enroll with Partnership and focus her efforts on our pediatric patients. Additionally, Dr. Whitney has joined the Mobile Optometry Unit, contributing two days a week, and his involvement has significantly enhanced our team dynamic.

Our clinic is dedicated to achieving key quality measures and fostering a friendly, competitive spirit among our providers. Last month, Dr. Murphy celebrated a notable victory, while Dr. Raisoni is gearing up to take on the challenge next month.

We are pleased to announce that Dr. Ordones will join our clinic team in October 2025. She will focus on patient care in the clinic, contribute to hospital care, and oversee patients in the skilled nursing facility.

Radiology Update

August was productive in our radiology department, with 179 X-ray exams, 114 CT scans, 47 ultrasounds, and 25 mammograms performed. We have extended our partnership with a traveling technician to ensure uninterrupted coverage as we approach the holiday season.

Pharmacy

The Pharmacy department is working diligently to enhance its policies and procedures, especially in navigating COVID-19 vaccine recommendations. We are collaborating with local clinics to provide immunizations to schools in Redway and ensuring precision in medication

orders for transfer patients in long-term care. Our team also monitors storage and inventory for the UCLA Buprenorphine Study/Grant.

Physical Therapy Update
We are committed to serving our community, with many patients in Physical Therapy. To better meet the increasing demand, we are in the process of hiring an additional team member. While we seek a larger dedicated space on Main Street, we are pleased to announce the opening of a second physical therapy room within the hospital to accommodate more patients.

We appreciate the community's patience during these transitions and assure everyone that our team is dedicated to finding practical solutions to enhance our service.

Thank you for your ongoing support.

Adela Yanez, RN, BSN, CNO