IMPERIAL VALLEY
HEALTHCARE DISTRICT

**BOARD OF DIRECTORS**
*Katherine Burnworth, President | Laura Goodsell, Vice-President | James Garcia, Treasurer | Enola Berker, Secretary | Rodolfo Valdez, Director | Felipe Irigoyen, Director*

# AGENDA
# REGULAR MEETING OF THE BOARD OF DIRECTORS
# THURSDAY, MARCH 26, 2026, 6:00 P.M.

**El Centro Regional Medical Center | MOB Conference Room 1&2**
**1271 Ross Avenue, El Centro, CA. 92243**

**Join Microsoft Teams**
Meeting ID: 259 664 276 834 74
Passcode: MR2VY2g9

**~ CLOSED SESSION ~ 6:00 p.m.**

a. CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: El Centro Regional Medical Center, 1415 Ross Avenue El Centro, CA 92243 and related healthcare facilities
Agency negotiators: IVHD Ad Hoc (Katherine Burnworth, James Garcia, Laura Goodsell), Legal Counsel (Adriana Ochoa), IVHD CEO Christopher Bjornberg
Negotiating parties: Pablo Velez, ECRMC, City of El Centro
Under negotiation: Closing conditions related to Asset Transfer Agreement

1. **Call to Order – 6:30**

2. **Roll Call**

3. **Pledge of Allegiance**

4. **Approval of Request for Remote Appearance by Board Member(s)**, *if Applicable*

5. **Consider Approval of Agenda**
In the case of an emergency, items may be added to the agenda by a majority vote of the Board of Directors. An emergency is defined as a work stoppage, a crippling disaster, or other activity that severely imperils public health, safety,

or both. Items on the agenda may be taken out of sequential order as their priority is determined by the Board of Directors. The Board may take action on any item appearing on the agenda.

6. **Public Comments**
   At this time the Board will hear comments on any agenda item. If any person wishes to be heard, they shall stand; address the president, identify themself, and state the subject for comment. Time limit for each speaker is 3 minutes individually per item to address the Board. Individuals who wish to speak on multiple items will be allowed four (4) minutes in total. A total of 15 minutes shall be allocated for each item for all members of the public. The board may find it necessary to limit the total time allowable for all public comments on items not appearing on the agenda at anyone one meeting to one hour.

7. **Board Comments**
   Reports on meetings and events attended by Directors; Authorization for Director(s) attendance at upcoming meetings and/or events; Board of Directors comments.
   a. Brief reports by Directors on meetings and events attended
   b. Schedule of upcoming Board meetings and/or events
   c. Report by Merger Strategic Planning Ad-Hoc Committee
   d. Finance Committee Update

8. **Consent Calendar**
   Any member of the Board may request that items for the Consent Calendar be removed for discussion. Items so removed shall be acted upon separately immediately following approval of items remaining on the Consent Calendar.

   a. Approve minutes for meetings of March 12, 2026
   b. Approval and file PMH Expenses/Financial Report February 2026

9. **Items for Discussion and/or Board Action:**
   a. MEDICAL STAFF REPORT – Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/ procedures/forms, or other related recommendations.

   b. Staff Recommends Action to Authorize: Authorization to approve Medical Directorship Agreement for Rami Jirjis Urology P.C.
      Presented by: Carly Zamora/Christopher R. Bjornberg
      Contract Value: not to exceed $18,000 annually
      Contract Term: 3 years
      Budgeted: Yes
      Budgeted Classification: Directorship

   c. Action Item: Policy and Procedures: California Sick Leave

d. Staff Recommends Action to Authorize: Premier – Acute Care Membership Application.
Presented by: Carly Loper
Contract Value: $15,000,000/yr
Contract Term: 5 years
Budgeted: Yes
Budgeted Classification: Medical Supplies

e. Staff Recommends Action to Authorize: Sixth Amendment to IVHD-BRG Professional Services Agreement
Presented by: Christoper R. Bjornberg, CEO
Contract Increase Value: $225,954.27

f. PRESENTATION: Debt Capacity Analysis by WipFli Advisory, LLC
Summary: The goal of this analysis is to provide the IVHD Board with a general range of tax obligation support needed to support the IVHD healthcare facilities. This analysis will inform the Board regarding the range of tax obligation needed by the funding mechanism that the Board will put on the ballot for voter approval in November 2026, pursuant to SB 1070 (2024).
Presented by: Christoper R. Bjornberg, CEO, and WipFli Advisory LLC

g. Information, Discussion and Possible Action Regarding AB 2311
Presented by: Christoper R. Bjornberg, CEO and Adriana R. Ochoa, Legal Counsel

**10. Management Reports**

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer
b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer
c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations
d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918
e. Executive: Christopher R. Bjornberg – Chief Executive Officer
f. Legal: Adriana Ochoa – General Counsel

**11. Items for Future Agenda**

This item is placed on the agenda to enable the Board to identify and schedule future items for discussion at upcoming meetings and/or identify press release opportunities.

**12. Adjournment**

a. The next regular meeting of the Board will be held on April 9, 2026, at 6:00 p.m. at Calexico Location, 601 Heber Ave. Calexico, Ca. 92231

**POSTING STATEMENT**

A copy of the agenda was posted March 20, 2026, at 1271 Ross Avenue, El Centro, CA. 92243 at 9:30 p.m. and other locations throughout the IVHD pursuant to CA Government code 54957.5. Disclosable public records and writings related to an agenda item distributed to all or a majority of the Board,

including such records and written distributed less than 72 hours prior to this meeting are available for public inspection at the District Administrative Office where the IVHD meeting will take place. The agenda package and material related to an agenda item submitted after the packets distribution to the Board is available for public review in the lobby of the office where the Board meeting will take place.

*In compliance with the Americans with Disabilities Act, if any individuals request special accommodations to attend and/or participate in District Board meetings please contact the District at (760)970- 6046. Notification of 48 hours prior to the meeting will enable the District to make reasonable accommodation to ensure accessibility to this meeting [28 CFR 35.102-35.104 ADA title II].*

**MEETING MINUTES**
**MARCH 12, 2026**
**REGULAR BOARD MEETING**

**THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 12TH OF MARCH AT 207 W. LEGION ROAD CITY OF BRAWLEY, CA. ON THE DATE, HOUR AND PLACE DULY ESTABLISHED OR THE HOLDING OF SAID MEETING.**

**CLOSED SESSION – 6:03 p.m.**

a. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov. Code 54956.9(d)(1))**
**Case Name: Amy Rye v. Pioneers Memorial Healthcare District, et. al.**
**Imperial County Superior Court No. ECU00038**

b. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Gov. Code 54956.9(d)(1))**
**Case Name: Xitlalic Bucio v. Imperial Valley Healthcare District et al.**
**Imperial County Superior Court Case No: ECU004556)**

c. **CONFERENCE WITH REAL PROPERTY NEGOTIATORS**
**Property: El Centro Regional Medical Center, 1415 Ross Avenue El Centro, CA 92243 and related healthcare facilities**
**Agency negotiators: IVHD Ad Hoc (Katherine Burnworth, James Garcia, Laura Goodsell), Legal Counsel (Adriana Ochoa), IVHD CEO Christopher Bjornberg**
**Negotiating parties: Pablo Velez, ECRMC, City of El Centro**
**Under negotiation: Closing conditions related to Asset Transfer Agreement**

**Director Burnworth exited the meeting during closed session at 7:13pm.**

**BOARD RECONVENED INTO OPEN SESSION AT 7:40PM**

a. **No reportable action taken in closed session.**

1. **TO CALL ORDER:**
The regular meeting was called to order in open session at 7:40 pm by Laura Goodsell.

2. **ROLL CALL-DETERMINATION OF QUORUM:**

| | |
|---|---|
| President | Kathie Burnworth |
| Vice-President | Laura Goodsell |
| Treasurer | James Garcia |
| Trustee | Enola Berker |
| Trustee | Rodolfo Valdez |
| Trustee | Felipe Irigoyen |
| Trustee | Arturo Proctor |

**GUESTS:**
Adriana Ochoa – Legal/Snell & Wilmer
Christopher R. Bjornberg - Chief Executive Officer

Tomas Virgen - Support for IVHD (AB 918)

3. **PLEDGE OF ALLEGIANCE WAS LED BY DIRECTOR BURNWORTH.**

4. **APPROVAL OF REQUEST FOR REMOTE APPEARANCE BY BOARD MEMBER(S)**
   None

5. **CONSIDER APPROVAL OF AGENDA:**
   Motion was made by Director Garcia and second by Director Proctor to approve the agenda for March 12, 2026. Motion passed by the following vote wit:

   AYES: Goodsell, Garcia, Berker, Valdez, Irigoyen, Proctor
   NOES: None

6. **PUBLIC COMMENT TIME:**
   Ron Rubin noted that e has not seen any information regarding AB2311 in the board packets and stated that he believes it is a very important document being considered for a vote. He also expressed his concerns about El Centro Regional Hospital having a tax lean by the IRS.

7. **BOARD COMMENTS:**
   a. Brief reports by Directors on meetings and events attended.

      Director Berker reported that she attended the Robotic presentation and it was very positive and interesting. She also attended the Women's Auxiliary meeting.

   b. Schedule of upcoming Board meetings and events.

      None

   c. Report by Merger Strategic Planning Ad-Hoc Committee

      Attorney Adriana reported that the Strategi Planning and Ad-Hoc Committee continues to meet at least once or twice a week to discuss the outstanding issue of bondholder consent which remains the loan, one of the loan items that we are working towards to achieve closing.

   d. Finance Committee Update.

      None

8. **CONSENT CALENDAR:**
   Motion was made by Director Proctor and second by Director Garcia to approve the consent calendar items. Motion passed by the following vote wit:

   a. Minutes for February 26, 2026

AYES: Goodsell, Garcia, Berker, Valdez, Irigoyen, Proctor
NOES: None

**9. ACTION ITEMS:**

a. Staff Recommends Action to Authorize: Authorize the execution of the Resolution No. 2026-0312 of the Imperial Valley Healthcare District ("IVHD") to effectuate the Standard Agreement package for Sexual Assault Forensic Examination services for the California Department of Corrections and Rehabilitation ("CDCR").
Presented by: Carly Loper, CFO
Contract Value: *CDCR will compensate IVHD for services rendered
Contract Term: Three Year term (July 1, 2026 – June 30, 2029)
Budgeted: Yes
Budgeted Classification: Revenue

Motion was made by Director Garcia and second by Director Berker to approve Authorize the execution of the Resolution No. 2026-0312 of the Imperial Valley Healthcare District ("IVHD") to effectuate the Standard Agreement package for Sexual Assault Forensic Examination services for the California Department of Corrections and Rehabilitation ("CDCR"). Motion passed by the following vote wit:

AYES: Goodsell, Garcia, Berker, Valdez, Irigoyen, Proctor
NOES: None

b. Action Item: Intermediate NICU Social Work Services

Motion was made by Director Berker and second by Director Proctor to approve Intermediate NICU Social Work Services. Motion passed by the following vote wit:

AYES: Goodsell, Garcia, Berker, Valdez, Irigoyen. Proctor
NOES: None

c. Staff Recommends Action to Authorize: Authorize the execution of the Resolution No. 2026-0312A, Resolution of the Imperial Valley Healthcare District Authorizing Investment of Monies in the Local Agency Investment Fund ("LAIF")
Presented by: Carly Loper, CFO

Motion was made by Director Irigoyen and second by Director Garcia to approve Authorize the execution of the Resolution No. 2026-0312A, Resolution of the Imperial Valley Healthcare District Authorizing Investment of Monies in the Local Agency Investment Fund ("LAIF"). Motion passed by the following vote wit:

AYES: Goodsell, Garcia, Berker, Valdez, Irigoyen, Proctor
NOES: None

d. Action Item: Revised Second Amendment to Standard Industrial/Commercial Single-Tenant

Lease – Net with Tyson Medical Inc.
Presented by: Christoper R. Bjornberg – Chief Executive Officer

Motion was made by Director Proctor and second by Director Irigoyen to approve Revised Second Amendment to Standard Industrial/Commercial Single-Tenant Lease – Net with Tyson Medical Inc. Motion passed by the following vote wit:

AYES: Goodsell, Garcia, Berker, Valdez, Irigoyen, Proctor
NOES: None

**10. MANAGEMENT REPORTS:**

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer

Carly reported that they started receiving payments this week and they will get some more on the innovation side next week. It seems that it is settled. She also reported that they are working for the Medical State Insurance approval. She also reported that they did submit the department penal and consolidated penal for El Centro and Pioneers.

b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer

None

c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations

Carol went over the Clinic Operation report. She also reported that next month she will be submitting her report the second meeting of the month.

d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918

Tomas reported that Urgent Care saw 820 patients this month, which is about 40 patients a day.

e. Executive: Christopher R. Bjornberg – Chief Executive Officer

Chris reported that he had mentioned before that they had picked up a new broker for their health insurance and they met with the team this past week and they had an opportunity to sit with them and talk about a few things. They are planning on having everything all wrapped up and put together on the 26th of April. That would be for the last board meeting in April, and they will either present in person or online whatever the board prefers. The board preferred them to present in person.

Chris also reported that AB2311 is something that he has been champion for a long time and has been doing this before we were IVHD. They are very much aware of it and very much have pushed for it to have happen and it is something that they are going to be supporting as it goes through and as they go through that process, they will keep the board posted on how that plays out.

f. Legal: Adriana Ochoa – General Counsel

None

**11. ITEMS FOR FUTURE AGENDA:**

Update on AB2311
Presentation by Whitly regarding the debt capacity analysis

**12. ADJOURNMENT:**

With no future business to discuss, Motion was made unanimously to adjourn meeting at 8:15 p.m.

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

**To: Board of Directors**

**Katherine Burnworth, President**

**Laura Goodsell, Vice President**

**Arturo Proctor, Secretary**

**James Garcia, Treasurer**

**Enola Berker, Trustee**

**Rodolfo Valdez, Trustee**

**Felipe Irigoyen, Trustee**

**Additional Distribution:**

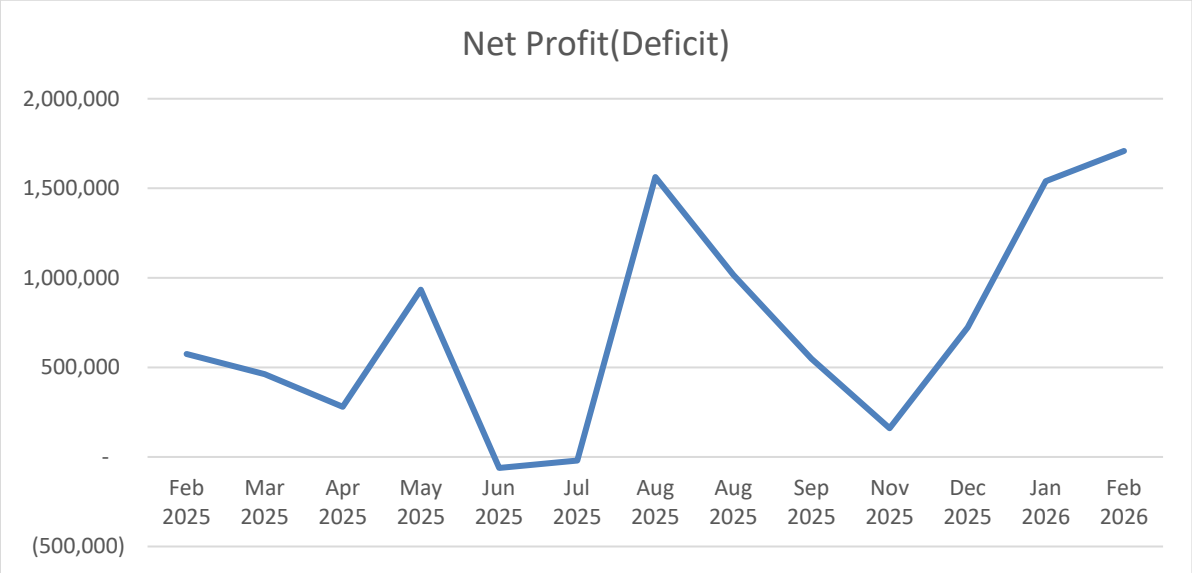
**Christopher R. Bjornberg, Chief Executive Officer**

**From: Carly Loper, Chief Financial Officer**

**Financial Report – February 2026**

## Overview:

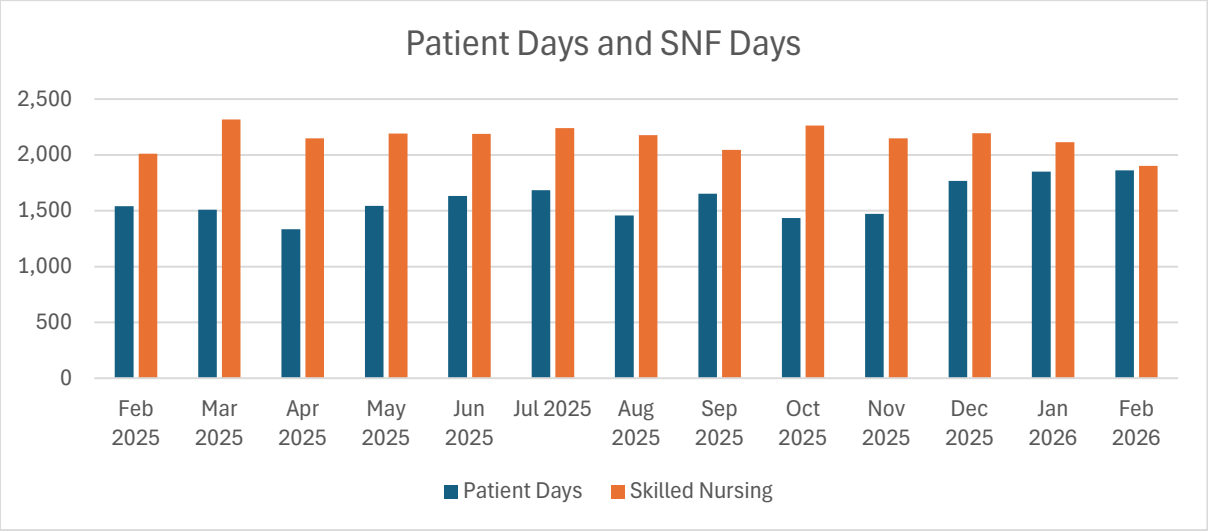
**Financial operations for the month of February resulted in a profit of $1,708,344 against a budgeted loss of ($732,993).**



## Patient Volumes:

**In February, inpatient days exceeded budget by 20.9% and exceeded the prior month volumes by 0.7%. For the year-to-date period, inpatient days were under budget and prior year volumes by (0.9%).**

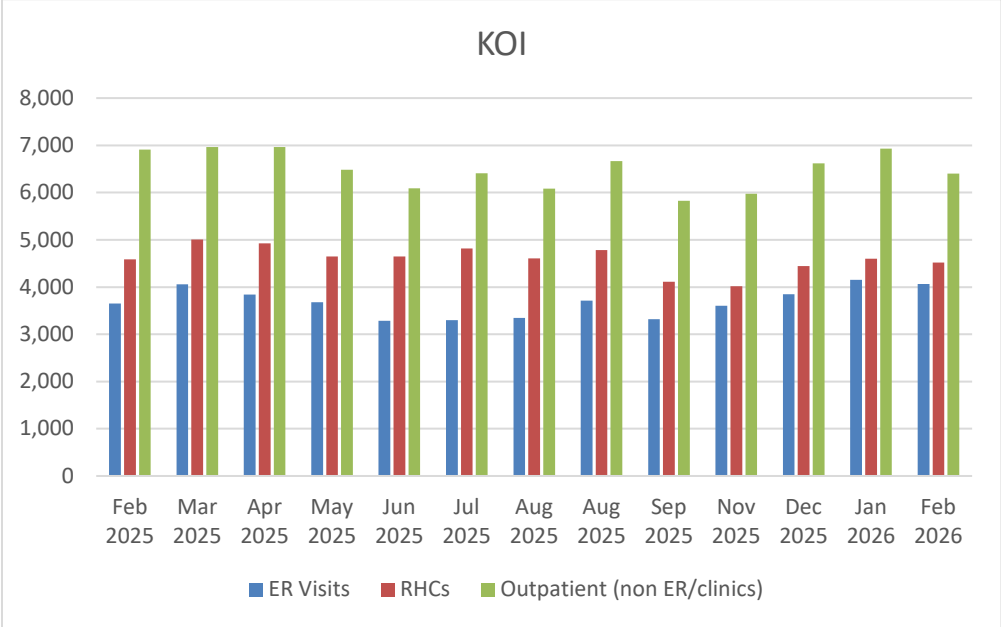
**February inpatient days for Pioneers Memorial Skilled Nursing Center (PMSNC) were 1,901 compared to 2,113 inpatient days in January. PMSNC had an average daily census (ADC) of 67.9 for the month of February.**

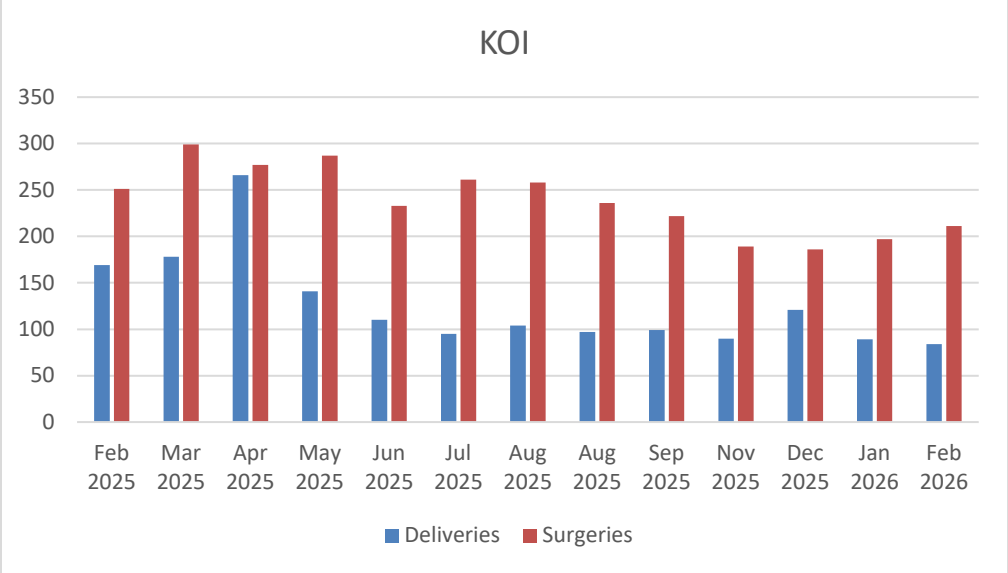



**For the month of February, Deliveries fell below the prior month volumes by (5.6%) and fell below the monthly budget by (46.2%). Emergency Room visits fell below the prior month volumes by (2.2%) but exceeded the monthly budget by 18.0%. Surgeries for the month of February exceeded the volumes of the prior month by 7.1% but fell below the monthly budget by (3.7%). Calexico Health Center visits for February exceeded the prior month visits while Pioneers Health Center visits, Pioneers Children Health Center visits and Outpatient (non-ER) visits/volumes all fell below the prior month visits/volumes. All fiscal year-to-date volumes, except for the Calexico Health Center, are lower than prior year volumes. For actual compared to budget fiscal year-to-date, the visits/volumes for Pioneers Children Health Center and Outpatient (non-ER) fell below budget while Pioneers Health Center and Calexico Health Center visits exceeded budget.**

**See Exhibit A (Key Volume Stats – Trend Analysis) for additional detail.**

| | Current Period | | | Year To Date | | |
|---|---|---|---|---|---|---|
| | Act. | Bud | Prior Yr. | Act. | Bud | Prior Yr. |
| Deliveries | 84 | 156 | 169 | 779 | 1,414 | 1,316 |
| E/R Visits | 4,062 | 3,442 | 3,654 | 29,341 | 29,217 | 30,812 |
| Surgeries | 211 | 219 | 251 | 1,760 | 2,377 | 2,780 |
| GI Scopes | 43 | 92 | 43 | 290 | 902 | 253 |
| Calexico RHC | 986 | 944 | 948 | 7,819 | 6,787 | 7,351 |
| Pioneer Health | 2,506 | 2,483 | 2,580 | 19,886 | 19,554 | 21,453 |




## Gross Patient Revenues:

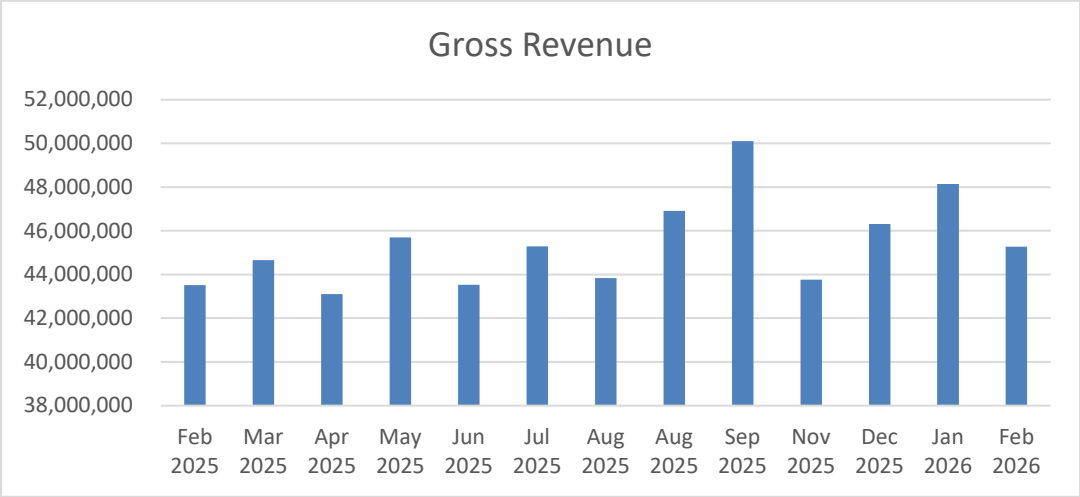
**In February, gross revenues exceeded budget by $1,767,550 or 4.1% but fell below the prior month's revenues by ($2,860,751) or (5.9%).**

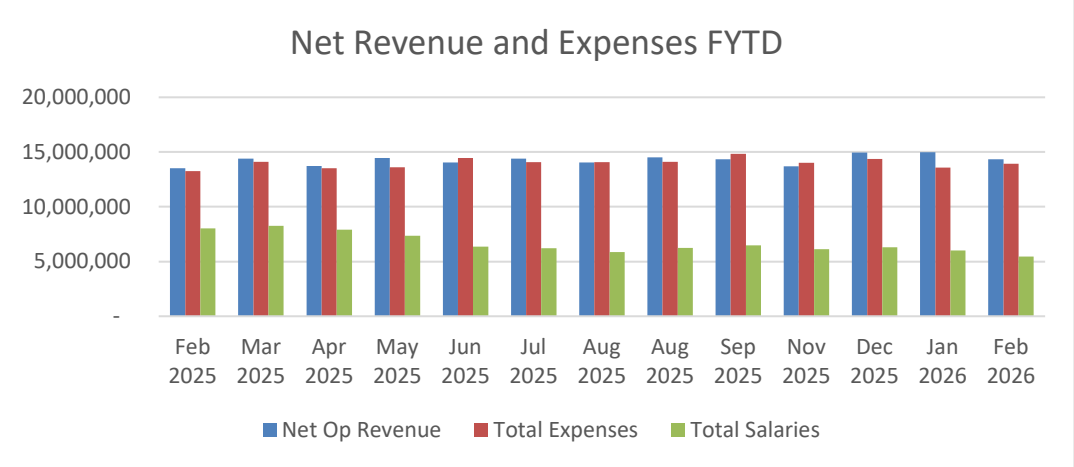
| | Monthly Gross Revenue | Daily Gross Revenue |
|---|---|---|
| January | $48,136,281 | $1,552,783 |
| February | $45,275,530 | $1,616,983 |

## Operating Expenses:

**In total, February operating expenses were over budget by ($163,129) or (1.2%). February's daily expenses were $497,062 per day, which exceeded February's budgeted expenses at $491,236 per day. Total staffing expenses for February were under budget by 12.1% while Repair & Maintenance expenses were over budget by (120.2%). Total expenses for February exceeded the prior month expenses by ($350,480) or (2.6%).**

| | Monthly Expenses | Daily Expenses |
|---|---|---|
| January | $13,567,246 | $437,653 |
| February | $13,917,726 | $497,062 |



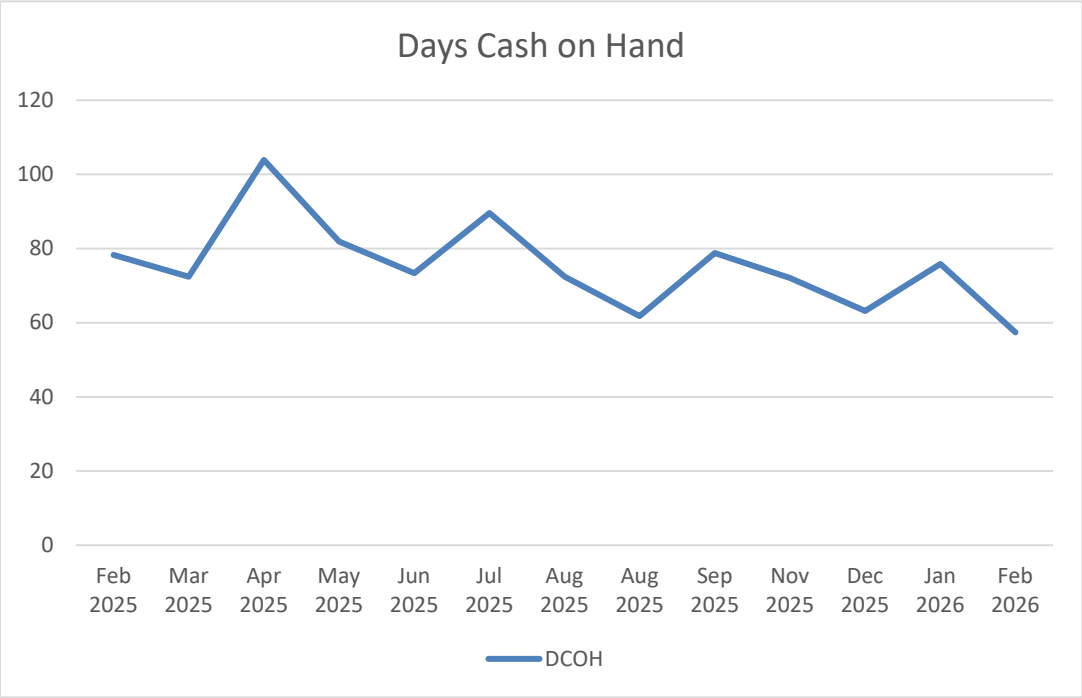



## Bond Covenants:

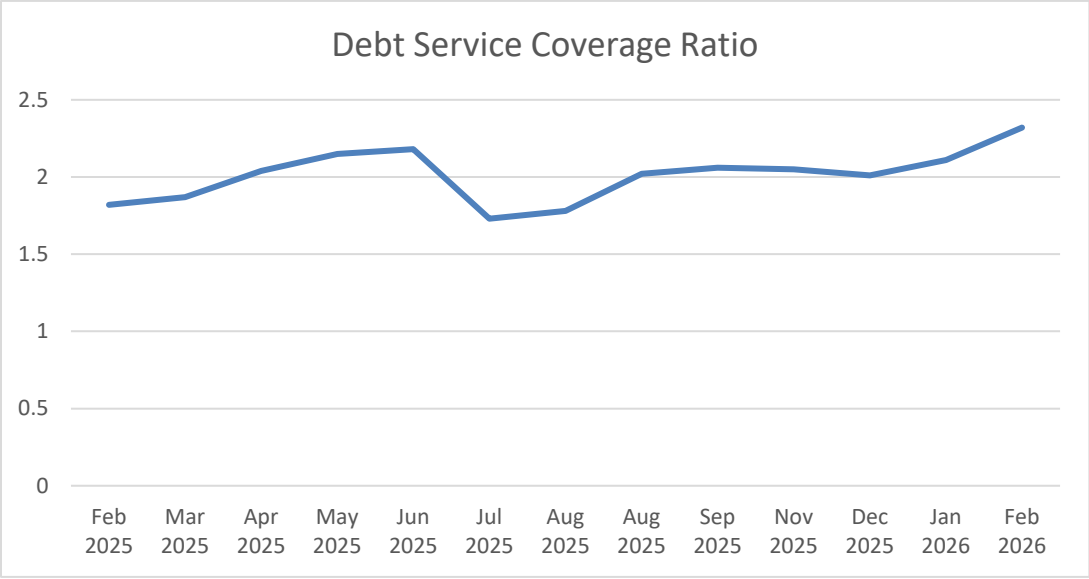
**As part of the Series 2017 Bond issue, the District is required to maintain certain covenants or "promises" to maintain liquidity (days cash on hand of 50 days) and profitability (debt service coverage ratio of 1.20). A violation of either will allow the Bond Trustee (U.S. Bank) authorization to take certain steps to protect the interest of the individual Bond Holders.**

**The District's days cash on hand decreased from the prior month with the following results:**

| | |
|---|---|
| **end of January 2026:** | **75.9 days cash on hand** |
| **end of February 2026:** | **57.4 days cash on hand** |

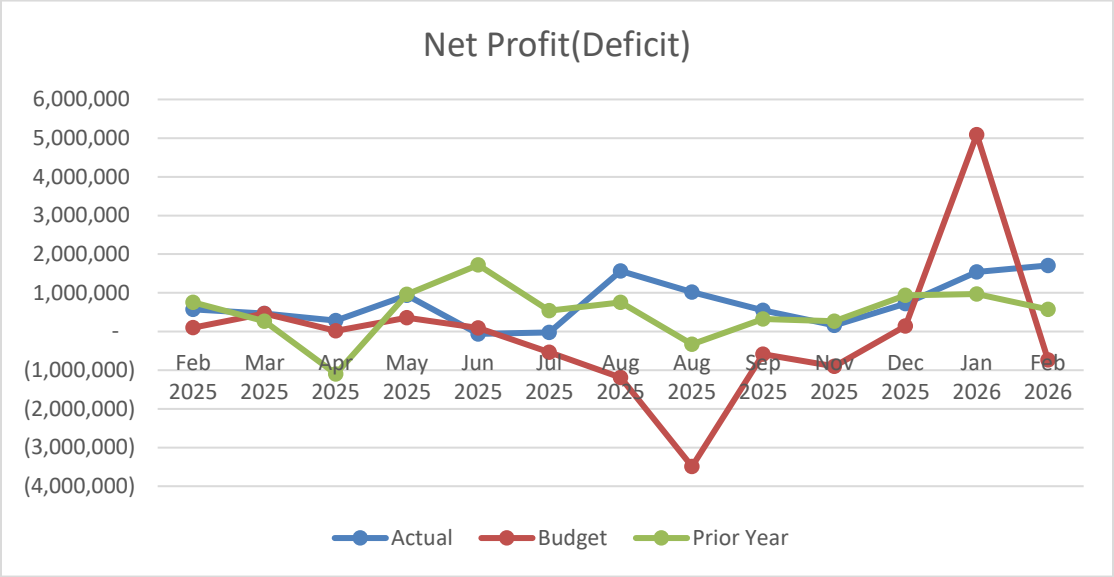



**The District's debt service coverage ratio for January 2026 was 2.11 while the debt service coverage ratio for February 2026 was 2.32.**



## Net Excess/(Deficit):

**Fiscal year-to-date, District operations have resulted in a profit of $7,237,196 against a budgeted profit of $538,253, which is ahead of the prior year-to-date profit of $4,025,118.**




# END OF REPORT

# IMPERIAL VALLEY HEALTHCARE DISTRICT
## STATEMENT OF REVENUE AND EXPENSE
### FOR THE PERIOD ENDING FEBRUARY 28, 2026

| LAST MONTH ACTUAL JANUARY | LAST YEAR ACTUAL FEBRUARY | THIS MONTH ACTUAL FEBRUARY | THIS MONTH BUDGET FEBRUARY | % VAR | | FYTD ACTUAL FEBRUARY | FYTD BUDGET FEBRUARY | % VAR | FYTD PRIOR YEAR FEBRUARY | % VAR |
|---|---|---|---|---|---|---|---|---|---|---|
| 5,099 | 2,876 | 5,048 | 3,474 | 45.34% | ADJ PATIENT DAYS | 35,509 | 30,699 | 15.67% | 30,699 | 15.67% |
| 1,849 | 1,275 | 1,862 | 1,540 | 20.91% | INPATIENT DAYS | 13,177 | 13,293 | -0.87% | 13,293 | -0.87% |
| 544 | 488 | 535 | 524 | 2.10% | IP ADMISSIONS | 4,248 | 4,384 | -3.10% | 4,112 | 3.31% |
| 60 | 46 | 67 | 55 | 20.91% | IP AVERAGE DAILY CENSUS | 54 | 55 | -0.87% | 55 | -0.87% |
| | | | | | GROSS PATIENT REVENUES | | | | | |
| 17,454,567 | 19,289,412 | 16,698,885 | 19,289,412 | -13.43% | INPATIENT REVENUE | 136,950,828 | 156,497,766 | -12.49% | 156,497,765 | -12.49% |
| 30,681,714 | 24,218,568 | 28,576,645 | 24,218,568 | 17.99% | OUTPATIENT REVENUE | 232,102,892 | 204,918,191 | 13.27% | 204,918,191 | 13.27% |
| 48,136,281 | 43,507,980 | 45,275,530 | 43,507,980 | 4.06% | TOTAL PATIENT REVENUES | 369,053,720 | 361,415,957 | 2.11% | 361,415,956 | 2.11% |
| | | | | | REVENUE DEDUCTIONS | | | | | |
| 11,459,208 | 11,368,853 | 12,701,740 | 12,779,537 | 0.61% | MEDICARE CONTRACTUAL | 96,065,866 | 102,236,297 | 6.04% | 86,029,555 | -11.67% |
| 14,173,721 | 12,813,377 | 12,526,206 | 13,214,896 | 5.21% | MEDICAL CONTRACTUAL | 110,950,842 | 105,719,172 | -4.95% | 110,037,350 | -0.83% |
| -1,559,145 | -1,378,326 | -1,558,849 | -1,518,546 | -2.65% | SUPPLEMENTAL PAYMENTS | -13,682,597 | -12,148,372 | -12.63% | -10,963,846 | -24.80% |
| 0 | -15,505 | 0 | 0 | 100.00% | PRIOR YEAR RECOVERIES | -243,579 | 0 | 100.00% | -1,941,145 | |
| 8,483,492 | 6,597,941 | 6,762,298 | 5,408,650 | -25.03% | OTHER DEDUCTIONS | 54,955,767 | 43,269,200 | -27.01% | 59,178,134 | 7.14% |
| | 7,162 | 0 | 0 | 0.00% | CHARITY WRITE OFFS | 1,775,956 | 0 | #DIV/0! | 289,127 | -514.25% |
| 939,836 | 950,000 | 833,587 | 1,365,442 | 38.95% | BAD DEBT PROVISION | 6,389,947 | 10,923,536 | 41.50% | 7,698,743 | 17.00% |
| -4,167 | 0 | -4,167 | -4,167 | 0.00% | INDIGENT CARE WRITE OFFS | -29,169 | -33,336 | 12.50% | -29,169 | 0.00% |
| 33,492,946 | 30,343,502 | 31,260,815 | 31,245,812 | -0.05% | TOTAL REVENUE DEDUCTIONS | 256,183,030 | 249,966,495 | -2.49% | 250,298,750 | -2.35% |
| 14,643,335 | 13,164,478 | 14,014,715 | 12,262,168 | 14.29% | NET PATIENT REVENUES | 112,870,690 | 111,449,462 | 1.28% | 111,117,206 | -1.58% |
| 69.6% | 69.7% | 69.0% | 71.8% | | | 69.4% | 69.2% | | 69.3% | |
| | | | | | OTHER OPERATING REVENUE | | | | | |
| 32,748 | 0 | | 4,167 | | GRANT REVENUES | 32,748 | 33,334 | | 0 | #DIV/0! |
| 311,078 | 362,386 | 315,660 | 461,008 | -31.53% | OTHER | 3,699,336 | 3,688,063 | 0.31% | 3,613,184 | 2.38% |
| 343,826 | 362,386 | 315,660 | 465,175 | -32.14% | TOTAL OTHER REVENUE | 3,732,084 | 3,721,397 | 0.29% | 3,613,184 | 3.29% |
| 14,987,161 | 13,526,864 | 14,330,375 | 12,727,343 | 12.60% | TOTAL OPERATING REVENUE | 116,602,774 | 115,170,859 | 1.24% | 114,730,390 | 1.63% |
| | | | | | OPERATING EXPENSES | | | | | |
| 6,000,604 | 6,039,904 | 5,464,696 | 6,334,303 | 13.73% | SALARIES AND WAGES | 48,991,168 | 53,352,421 | 8.17% | 50,878,119 | 3.71% |
| 1,494,165 | 1,691,888 | 1,678,127 | 1,761,447 | 4.73% | BENEFITS | 12,360,931 | 13,732,868 | 9.99% | 13,186,846 | 6.26% |
| 205,392 | 291,516 | 232,175 | 293,376 | 20.86% | REGISTRY & CONTRACT | 1,452,419 | 1,695,813 | 14.35% | 1,602,926 | 9.39% |
| 7,700,161 | 8,023,308 | 7,374,998 | 8,389,126 | 12.09% | TOTAL STAFFING EXPENSE | 62,804,517 | 68,781,103 | 8.69% | 65,667,891 | 4.36% |
| 1,665,655 | 1,142,132 | 1,722,820 | 1,169,216 | -47.35% | PROFESSIONAL FEES | 12,916,173 | 10,694,814 | -20.77% | 10,478,132 | -23.27% |
| 1,452,740 | 1,545,327 | 1,942,921 | 1,581,894 | -22.82% | SUPPLIES | 13,268,852 | 13,844,223 | 4.16% | 13,463,668 | 1.45% |
| 644,794 | 618,846 | 593,279 | 628,250 | 5.57% | PURCHASED SERVICES | 5,347,509 | 5,162,187 | -3.59% | 5,034,500 | -6.22% |
| 655,292 | 266,691 | 621,776 | 282,344 | -120.22% | REPAIR & MAINTENANCE | 5,024,241 | 5,108,326 | 1.65% | 4,981,400 | -0.86% |
| 371,466 | 282,356 | 371,466 | 263,311 | -41.07% | DEPRECIATION & AMORT | 2,600,276 | 2,352,659 | -10.53% | 2,413,978 | -7.72% |
| 207,264 | 239,646 | 227,964 | 255,506 | 10.78% | INSURANCE | 2,083,496 | 2,000,635 | -4.14% | 1,873,762 | -11.19% |
| 253,111 | 167,004 | 222,178 | 167,004 | -33.04% | HOSPITALIST PROGRAM | 1,689,473 | 1,817,384 | 7.04% | 1,572,065 | -7.47% |
| 616,764 | 977,589 | 840,324 | 1,017,945 | 17.45% | OTHER | 7,203,196 | 7,225,363 | 0.31% | 6,769,628 | -6.40% |
| 13,567,246 | 13,262,899 | 13,917,726 | 13,754,597 | -1.19% | TOTAL OPERATING EXPENSES | 112,937,733 | 116,986,693 | 3.46% | 112,255,024 | -0.61% |
| 1,419,914 | 263,965 | 412,649 | -1,027,254 | 140.17% | TOTAL OPERATING MARGIN | 3,665,040 | -1,815,833 | -301.84% | 2,475,366 | -48.06% |
| | | | | | NON OPER REVENUE(EXPENSE) | | | | | |
| 53,158 | 245,308 | 194,298 | 121,307 | 60.17% | OTHER NON-OP REV (EXP) | -73,105 | 970,455 | -107.53% | 974,210 | -107.50% |
| 0 | 0 | 0 | 0 | 0.00% | FEMA FUNDS | 2,078,448 | 0 | 100.00% | 0 | 0.00% |
| 117,632 | 117,632 | 1,152,541 | 225,987 | 410.00% | DISTRICT TAX REVENUES | 1,975,965 | 1,807,897 | 9.30% | 996,153 | 98.36% |
| -51,144 | -51,299 | -51,144 | -53,033 | 3.56% | INTEREST EXPENSE | -409,152 | -424,265 | 3.56% | -420,611 | 2.72% |
| 119,646 | 311,641 | 1,295,695 | 294,260 | 340.32% | TOTAL NON-OP REV (EXPENSE) | 3,572,156 | 2,354,087 | 51.74% | 1,549,751 | 130.50% |
| 1,539,560 | 575,605 | 1,708,344 | -732,993 | 333.06% | NET EXCESS / ( DEFICIT) | 7,237,196 | 538,253 | -1244.57% | 4,025,118 | -79.80% |
| 1,290.19 | 1,116.10 | 1,359.90 | 1,463.30 | 7.07% | TOTAL PAID FTE'S (Inc Reg & Cont.) | 1,173.21 | 1,382.40 | 15.13% | 1,268.30 | 7.50% |
| 1,098.47 | 948.70 | 1,218.48 | 1,137.77 | -7.09% | TOTAL WORKED FTE'S | 1,034.26 | 1,094.21 | 5.48% | 1,035.19 | 0.09% |
| 19.23 | 16.29 | 22.88 | 32.89 | 30.43% | TOTAL CONTRACT FTE'S | 18.45 | 21.90 | 15.76% | 20.84 | 11.48% |

**IMPERIAL VALLEY HEALTHCARE DISTRICT**
**BALANCE SHEET AS OF FEBRUARY 28, 2026**

| | JANUARY 2026 | FEBRUARY 2026 | FEBRUARY 2025 |
|---|---|---|---|
| **ASSETS** | | | |
| **CURRENT ASSETS** | | | |
| CASH | $34,516,657 | $26,279,893 | $35,009,315 |
| CASH - PEER ACCT | $0 | $0 | $0 |
| CASH - NORIDIAN AAP FUNDS | $0 | $0 | $0 |
| CASH - 3RD PRTY REPAYMENTS | -$435,703 | -$435,703 | $0 |
| CDs - LAIF & CVB | $66,244 | $66,244 | $66,244 |
| ACCOUNTS RECEIVABLE - PATIENTS | $110,755,408 | $107,651,920 | $94,182,720 |
| LESS: ALLOWANCE FOR BAD DEBTS | $1,088,668 | $1,357,424 | -$3,439,039 |
| LESS: ALLOWANCE FOR CONTRACTUALS | -$75,290,605 | -$69,461,001 | -$72,193,959 |
| NET ACCTS RECEIVABLE | $36,553,471 | $39,548,343 | $18,549,722 |
| | 33.00% | 36.74% | 19.70% |
| ACCOUNTS RECEIVABLE - OTHER | $26,815,074 | $28,265,887 | $34,096,916 |
| COST REPORT RECEIVABLES | $59,499 | $59,499 | $1,206,822 |
| INVENTORIES - SUPPLIES | $3,574,905 | $3,558,926 | $2,941,216 |
| PREPAID EXPENSES | $1,807,997 | $2,331,638 | $3,831,089 |
| TOTAL CURRENT ASSETS | $102,958,144 | $99,674,728 | $95,701,324 |
| **OTHER ASSETS** | | | |
| PROJECT FUND 2017 BONDS | $783,840 | $1,109,107 | $507,369 |
| BOND RESERVE FUND 2017 BONDS | $968,373 | $968,373 | $968,353 |
| LIMITED USE ASSETS | -$17,167 | $103,614 | $166,083 |
| NORIDIAN AAP FUNDS | $0 | $0 | $0 |
| GASB87 LEASES | $60,529,359 | $60,529,359 | $64,931,450 |
| OTHER ASSETS PROPERTY TAX PROCEEDS | $269,688 | $269,688 | $269,688 |
| OTHER INVESTMENTS | $420,000 | $420,000 | $420,000 |
| UNAMORTIZED BOND ISSUE COSTS | | | |
| TOTAL OTHER ASSETS | $62,954,093 | $63,400,141 | $67,262,944 |
| **PROPERTY, PLANT AND EQUIPMENT** | | | |
| LAND | $6,883,276 | $6,883,276 | $2,633,026 |
| BUILDINGS & IMPROVEMENTS | $63,870,530 | $63,870,530 | $63,001,597 |
| EQUIPMENT | $68,646,859 | $68,736,772 | $65,294,641 |
| CONSTRUCTION IN PROGRESS | $6,012,356 | $6,022,182 | $81,976 |
| LESS: ACCUMULATED DEPRECIATION | -$105,779,339 | -$106,150,805 | -$102,162,971 |
| NET PROPERY, PLANT, AND EQUIPMENT | $39,633,682 | $39,361,956 | $28,848,269 |
| TOTAL ASSETS | $205,545,919 | $202,436,824 | $191,812,537 |

**IMPERIAL VALLEY HEALTHCARE DISTRICT**
**BALANCE SHEET AS OF FEBRUARY 28, 2026**

| | JANUARY 2026 | FEBRUARY 2026 | FEBRUARY 2025 |
|---|---|---|---|
| **LIABILITIES AND FUND BALANCES** | | | |
| **CURRENT LIABILITIES** | | | |
| ACCOUNTS PAYABLE - CASH REQUIREMENTS | $3,730,844 | $4,195,628 | $3,366,375 |
| ACCOUNTS PAYABLE - ACCRUALS | $6,765,905 | $3,515,241 | $10,817,084 |
| PAYROLL & BENEFITS PAYABLE - ACCRUALS | $6,835,192 | $6,398,312 | $8,166,792 |
| COST REPORT PAYABLES & RESERVES | -$435,703 | -$435,703 | $0 |
| NORIDIAN AAP FUNDS | $0 | $0 | $0 |
| CURR PORTION- GO BONDS PAYABLE | $0 | $0 | $0 |
| CURR PORTION- 2017 REVENUE BONDS PAYABLE | $335,000 | $335,000 | $0 |
| INTEREST PAYABLE- GO BONDS | $1,917 | $1,917 | $1,917 |
| INTEREST PAYABLE- 2017 REVENUE BONDS | $533,771 | $586,900 | $268,125 |
| OTHER - TAX ADVANCE IMPERIAL COUNTY | $0 | $0 | $0 |
| DEFERRED HHS CARES RELIEF FUNDS | $0 | $0 | $0 |
| CURR PORTION- LEASE LIABILITIES(GASB 87) | $4,071,774 | $4,071,774 | $3,756,205 |
| SKILLED NURSING OVER COLLECTIONS | $3,923,705 | $3,392,861 | $1,632,566 |
| CURR PORTION- SKILLED NURSING CTR ADVANCE | $0 | $0 | $0 |
| CURRENT PORTION OF LONG-TERM DEBT | $1,037,037 | $1,037,037 | $1,075,791 |
| TOTAL CURRENT LIABILITIES | $26,799,442 | $23,098,968 | $29,084,855 |
| **LONG TERM DEBT AND OTHER LIABILITIES** | | | |
| PMH RETIREMENT FUND - ACCRUAL | $873,179 | -$241,801 | $721,305 |
| NOTES PAYABLE - EQUIPMENT PURCHASES | $0 | $0 | $0 |
| LOANS PAYABLE - DISTRESSED HOSP. LOAN | $26,962,963 | $26,962,963 | $26,962,963 |
| LOANS PAYABLE - CHFFA NDPH | $0 | $0 | $0 |
| BONDS PAYABLE G.O BONDS | $0 | $0 | $0 |
| BONDS PAYABLE 2017 SERIES | $14,115,136 | $14,113,151 | $14,471,974 |
| LONG TERM LEASE LIABILITIES (GASB 87) | $58,207,090 | $58,207,090 | $62,267,845 |
| DEFERRED REVENUE -CHW | $0 | $0 | $0 |
| DEFERRED PROPERTY TAX REVENUE | $275,438 | $275,438 | $275,438 |
| TOTAL LONG TERM DEBT | $100,433,806 | $99,316,841 | $104,699,525 |
| FUND BALANCE AND DONATED CAPITAL | $72,783,818 | $72,783,818 | $54,003,028 |
| NET SURPLUS (DEFICIT) CURRENT YEAR | $5,528,853 | $7,237,198 | $4,025,129 |
| TOTAL FUND BALANCE | $78,312,671 | $80,021,016 | $58,028,157 |
| TOTAL LIABILITIES AND FUND BALANCE | $205,545,919 | $202,436,825 | $191,812,537 |

**IMPERIAL VALLEY HEALTHCARE DISTRICT**
**STATEMENT OF REVENUE AND EXPENSE - 12 Month Trend**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Feb-26 |
| ADJ PATIENT DAYS | 3,264 | 2,707 | 3,686 | 3,714 | 4,647 | 4,044 | 4,407 | 3,843 | 3,835 | 4,616 | 5,099 | 5,013 | 46,933 |
| INPATIENT DAYS | 1,350 | 1,110 | 1,542 | 1,632 | 1,684 | 1,458 | 1,651 | 1,435 | 1,472 | 1,766 | 1,849 | 1,849 | 18,224 |
| IP ADMISSIONS | 511 | 462 | 551 | 538 | 555 | 500 | 518 | 486 | 519 | 591 | 544 | 544 | 6,263 |
| IP AVERAGE DAILY CENSUS | 44 | 46 | 50 | 54 | 54 | 47 | 55 | 48 | 49 | 57 | 60 | 60 | 609 |
| GROSS PATIENT REVENUES | | | | | | | | | | | | | |
| INPATIENT REVENUE | 18,471,097 | 17,673,179 | 19,122,305 | 19,132,498 | 16,407,174 | 15,807,716 | 17,579,003 | 18,708,455 | 16,577,828 | 17,717,202 | 17,454,567 | 16,698,885 | 211,349,909 |
| OUTPATIENT ANCILLARY | 26,191,988 | 25,433,294 | 26,581,622 | 24,402,953 | 28,872,822 | 28,033,507 | 29,339,945 | 31,397,710 | 26,610,818 | 28,589,731 | 30,681,714 | 28,576,645 | 334,712,750 |
| TOTAL PATIENT REVENUES | 44,663,085 | 43,106,473 | 45,703,927 | 43,535,451 | 45,279,996 | 43,841,223 | 46,918,948 | 50,106,165 | 43,188,646 | 46,306,933 | 48,136,281 | 45,275,530 | 544,295,109 |
| REVENUE DEDUCTIONS | | | | | | | | | | | | | |
| MEDICARE CONTRACTUAL | 11,713,712 | 10,228,981 | 10,173,409 | 10,067,042 | 10,914,920 | 9,513,796 | 13,253,122 | 12,400,237 | 12,107,072 | 10,865,907 | 11,459,208 | 12,701,740 | 135,399,146 |
| MEDICAL CONTRACTUAL | 12,785,203 | 13,643,163 | 13,219,010 | 13,232,031 | 13,887,933 | 12,434,283 | 13,701,424 | 15,868,842 | 14,854,153 | 13,155,413 | 14,173,721 | 12,526,206 | 163,481,382 |
| SUPPLEMENTAL PAYMENTS | -1,184,154 | -1,378,326 | -1,453,003 | -1,378,326 | -1,322,496 | 8,526,807 | -1,574,256 | -1,573,242 | -3,053,795 | -1,558,849 | -1,559,145 | -1,558,849 | -9,067,634 |
| PRIOR YEAR RECOVERIES | -88,856 | -467,741 | 0 | 0 | 0 | 994,668 | 0 | -243,579 | 0 | 0 | 0 | 0 | 194,492 |
| OTHER DEDUCTIONS | 6,978,258 | 6,797,466 | 8,500,637 | 6,238,570 | 6,876,265 | -4,235 | 5,605,549 | 7,821,997 | 4,893,665 | 9,044,769 | 8,483,492 | 6,762,298 | 77,998,731 |
| CHARITY WRITE OFFS | 0 | 8,600 | 188,266 | 1,012,366 | 2,926 | 159,173 | 1,375,831 | 390,992 | 0 | 0 | 0 | 0 | 3,138,154 |
| BAD DEBT PROVISION | 600,000 | 920,000 | 920,000 | 882,258 | 872,185 | -1,396,479 | 38,784 | 1,106,077 | 1,006,077 | 500,000 | 939,836 | 833,587 | 7,222,325 |
| INDIGENT CARE WRITE OFFS | 0 | 0 | 0 | 0 | 0 | 0 | -4,167 | -4,167 | -4,167 | -4,167 | -4,167 | -4,167 | -25,002 |
| TOTAL REVENUE DEDUCTIONS | 30,804,163 | 29,752,143 | 31,548,319 | 30,053,941 | 31,231,733 | 30,228,014 | 32,396,287 | 35,767,157 | 29,803,005 | 32,003,073 | 33,492,945 | 31,260,815 | 378,341,595 |
| NET PATIENT REVENUES | 13,858,922 | 13,354,330 | 14,155,608 | 13,481,510 | 14,048,263 | 13,613,209 | 14,522,661 | 14,339,008 | 13,385,641 | 14,303,860 | 14,643,336 | 14,014,715 | 165,953,514 |
| | 68.97% | 69.02% | 69.03% | 69.03% | 68.97% | 68.95% | 69.05% | 71.38% | 69.01% | 69.11% | 69.58% | 69.05% | 69.51% |
| OTHER OPERATING REVENUE | | | | | | | | | | | | | |
| GRANT REVENUES | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| OTHER | 535,886 | 372,539 | 311,185 | 571,500 | 339,253 | 424,312 | 457,484 | 887,444 | 322,016 | 642,090 | 343,826 | 315,660 | 5,523,195 |
| TOTAL OTHER REVENUE | 535,886 | 372,539 | 311,185 | 571,500 | 339,253 | 424,312 | 457,484 | 887,444 | 322,016 | 642,090 | 343,826 | 315,660 | 5,523,195 |
| TOTAL OPERATING REVENUE | 14,394,808 | 13,726,869 | 14,466,793 | 14,053,010 | 14,387,516 | 14,037,521 | 14,980,145 | 15,226,452 | 13,707,657 | 14,945,950 | 14,987,162 | 14,330,375 | 171,476,709 |
| OPERATING EXPENSES | | | | | | | | | | | | | |
| SALARIES AND WAGES | 6,268,879 | 6,237,213 | 6,278,514 | 6,359,473 | 6,223,056 | 6,189,444 | 6,240,870 | 6,463,090 | 6,119,637 | 6,289,771 | 6,000,604 | 5,464,696 | 74,135,247 |
| BENEFITS | 1,816,690 | 1,462,931 | 844,172 | 1,474,386 | 1,346,466 | 1,436,464 | 1,241,463 | 1,598,931 | 1,838,087 | 1,727,228 | 1,494,165 | 1,678,127 | 17,959,110 |
| REGISTRY & CONTRACT | 180,983 | 210,277 | 233,655 | 120,425 | 191,671 | 114,483 | 157,463 | 183,055 | 183,990 | 184,189 | 205,392 | 232,175 | 2,197,759 |
| TOTAL STAFFING EXPENSE | 8,266,552 | 7,910,421 | 7,356,341 | 7,954,285 | 7,761,193 | 7,740,391 | 7,639,796 | 8,245,076 | 8,141,714 | 8,201,188 | 7,700,161 | 7,374,998 | 94,292,116 |
| PROFESSIONAL FEES | 1,463,172 | 1,490,185 | 1,435,269 | 2,217,574 | 1,562,084 | 1,733,156 | 1,691,793 | 1,474,067 | 1,353,338 | 1,713,260 | 1,665,655 | 1,722,820 | 19,522,373 |
| SUPPLIES | 1,454,101 | 1,405,314 | 1,678,334 | 1,501,610 | 1,711,274 | 1,555,753 | 1,562,601 | 1,893,608 | 1,529,212 | 1,620,743 | 1,452,740 | 1,942,921 | 19,308,211 |
| PURCHASED SERVICES | 684,894 | 459,333 | 667,131 | 548,591 | 601,430 | 680,238 | 693,069 | 730,849 | 728,043 | 675,807 | 644,794 | 593,279 | 7,707,458 |
| REPAIR & MAINTENANCE | 723,397 | 662,344 | 733,946 | 591,319 | 713,336 | 617,305 | 666,485 | 471,500 | 603,894 | 674,653 | 655,292 | 621,776 | 7,735,247 |
| PHYSICIAN GUARANTEES | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | | | 0 |
| DEPRECIATION & AMORT | 282,356 | 331,604 | 305,281 | 299,579 | 309,556 | 309,566 | 309,556 | 309,556 | 309,555 | 309,555 | 371,466 | 371,466 | 3,819,096 |
| INSURANCE | 204,757 | 224,447 | 222,120 | 40,139 | 246,647 | 286,130 | 292,266 | 273,371 | 326,217 | 223,636 | 207,264 | 227,964 | 2,774,958 |
| HOSPITALIST PROGRAM | 249,017 | 244,297 | 207,916 | 292,881 | 295,732 | 244,175 | 253,042 | 256,382 | 164,853 | 0 | 253,111 | 222,178 | 2,683,584 |
| OTHER | 786,002 | 784,904 | 1,008,868 | 1,021,103 | 879,760 | 908,378 | 989,919 | 1,170,707 | 849,319 | 948,025 | 616,764 | 840,324 | 10,804,073 |
| TOTAL OPERATING EXPENSES | 14,114,248 | 13,512,849 | 13,615,206 | 14,467,081 | 14,081,012 | 14,075,092 | 14,098,527 | 14,825,116 | 14,006,145 | 14,366,867 | 13,567,247 | 13,917,726 | 168,647,116 |
| TOTAL OPERATING MARGIN | 280,560 | 214,020 | 851,587 | -414,071 | 306,504 | -37,571 | 881,618 | 401,336 | -298,488 | 579,083 | 1,419,915 | 412,649 | 2,829,592 |
| NON OPER REVENUE(EXPENSE) | | | | | | | | | | | | | |
| OTHER NON-OPS REVENUE | 114,595 | 344 | 16,003 | 286,161 | -1,109,043 | 171,783 | 68,041 | 79,378 | 391,419 | 77,861 | 53,158 | 194,298 | 343,998 |
| FEMA FUNDS | 0 | 0 | 0 | 0 | 715,753 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 715,753 |
| DISTRICT TAX REVENUES | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 117,632 | 1,152,541 | 2,446,493 |
| INTEREST EXPENSE | -51,247 | -51,196 | -51,144 | -51,144 | -51,144 | -51,144 | -51,144 | -51,144 | -51,144 | -51,144 | -51,144 | -51,144 | -613,883 |
| CARES HHS/ FEMA RELIEF FUNDING | 0 | 0 | 0 | 0 | 0 | 1,362,695 | 0 | 0 | 0 | 0 | 0 | 0 | 1,362,695 |
| TOTAL NON-OPS REVENUE(EXPENSE) | 180,980 | 66,780 | 82,491 | 352,649 | -326,802 | 1,600,966 | 134,529 | 145,866 | 457,907 | 144,349 | 119,646 | 1,295,695 | 4,255,056 |
| NET EXCESS / ( DEFICIT) | 461,540 | 280,800 | 934,078 | -61,422 | -20,298 | 1,563,395 | 1,016,147 | 547,202 | 159,419 | 723,432 | 1,539,561 | 1,708,344 | 7,084,648 |
| TOTAL PAID FTE'S (Inc Reg & Cont.) | 1,106.21 | 964.28 | 1,011.14 | 1,129.64 | 1,191.95 | 1,276.95 | 954.26 | 1,017.98 | 1,107.43 | 1,195.88 | 1,290.19 | 1,359.90 | 1,133.82 |
| TOTAL WORKED FTE'S | 981.75 | 837.21 | 915.77 | 991.52 | 1,049.86 | 1,137.05 | 853.38 | 922.31 | 987.18 | 1,017.82 | 1,098.47 | 1,218.48 | 1,000.90 |
| TOTAL CONTRACT FTE'S | 20.84 | 21.15 | 21.06 | 15.28 | 19.86 | 14.68 | 16.53 | 17.51 | 18.53 | 18.77 | 19.23 | 22.88 | 18.86 |
| PAID FTE'S - HOSPITAL | 914.42 | 803.19 | 860.70 | 1,024.79 | 1,089.84 | 1,124.91 | 850.19 | 913.90 | 999.88 | 1,085.17 | 1,139.27 | 1,252.57 | 1,004.90 |
| WKD FTE'S - HOSPITAL | 798.47 | 697.31 | 785.41 | 900.06 | 960.18 | 1,003.78 | 762.67 | 831.61 | 896.47 | 933.80 | 975.26 | 1,127.18 | 889.35 |

**Imperial Valley Healthcare District - Financial Indicators Report**
**(Based on Prior 12 Months Activities)**
**For The 12 Months Ending: February 28, 2026**
**excludes: GO bonds tax revenue, int exp and debt,**

## 1. Debt Service Coverage Ratio

This ratio compares the total funds available to service debt compared to the debt plus interest due in a given year.

$$\text{Formula:} \quad \frac{\text{Cash Flow + Interest Expense}}{\text{Principal Payments Due + Interest}}$$

$$\text{DSCR} = \frac{\$13,285,164}{\$5,722,694} = \mathbf{2.32}$$

Recommendation: To maintain a debt service coverage of at least 1.20% x aggregate debt service per the 2017 Revenue Bonds covenant.

## 2. Days Cash on Hand Ratio

This ratio measures the number of days of average cash expenses that the hospital maintains in cash and marketable investments. (Note: The proformas ratios include long-term investments in this calculation:)

$$\text{Formula:} \quad \frac{\text{Cash + Marketable Securities}}{\dfrac{\text{Operating Expenses, Less Depreciation}}{365 \text{ Days}}}$$

$$\text{DCOHR} = \frac{\$25,910,434}{\dfrac{\$164,828,031}{365}} = \mathbf{57.4}$$

Recommendation: To maintain a days cash on hand ratio of at least 50 days per the 2017 Revenue Bonds covenant.

## 3. Long-Term Debt to Capitalization Ratio

This ratio compares long-term debt to the Hospital's long-term debt plus fund balances.

$$\text{Formula:} \quad \frac{\text{Long-term Debt}}{\text{Long-term Debt + Fund Balance (Total Capital)}}$$

$$\text{L.T.D.-C.R.} = \frac{\$104,392,015}{\$182,704,686} = \mathbf{57.1}$$

Recommendation: To maintain a long-term debt to capitalization ratio not to exceed 60.0%.

| | Current Month 2/28/2026 | Year-To-Date 7 Month 2/28/2026 |
|---|---|---|
| CASH FLOWS FROM OPERATING ACTIVITIES: | | |
| Net Income (Loss) | 1,708,345 | 7,237,198 |
| Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities: | | |
| Depreciation | $371,466 | $2,600,278 |
| (Increase)/Decrease in Net Patient Accounts Receivable | ($2,994,872) | ($10,484,403) |
| (Increase)/Decrease in Other Receivables | ($1,450,813) | $1,583,667 |
| (Increase)/Decrease in Inventories | $15,979 | ($510,090) |
| (Increase)/Decrease in Pre-Paid Expenses | ($523,641) | ($224,861) |
| (Increase)/Decrease in Other Current Assets | $0 | $3,233,154 |
| Increase/(Decrease) in Accounts Payable | $464,784 | $530,501 |
| Increase/(Decrease) in Notes and Loans Payable | ($3,250,664) | ($6,404,400) |
| Increase/(Decrease) in Accrued Payroll and Benefits | ($436,880) | ($1,019,643) |
| Increase/(Decrease) in Accrued Expenses | $0 | $0 |
| Increase/(Decrease) in Patient Refunds Payable | $0 | $0 |
| Increase/(Decrease) in Third Party Advances/Liabilities | $0 | $0 |
| Increase/(Decrease) in Other Current Liabilities | $53,129 | ($10,670) |
| **Net Cash Provided by Operating Activities:** | **(6,043,167)** | **($3,469,269)** |
| CASH FLOWS FROM INVESTING ACTIVITIES: | | |
| Purchase of property, plant and equipment | ($99,740) | ($6,269,298) |
| (Increase)/Decrease in Limited Use Cash and Investments | ($120,781) | ($101,827) |
| (Increase)/Decrease in Other Limited Use Assets | ($325,267) | ($649,450) |
| (Increase)/Decrease in Other Assets | $0 | $0 |
| **Net Cash Used by Investing Activities** | **($545,788)** | **($7,020,575)** |
| CASH FLOWS FROM FINANCING ACTIVITIES: | | |
| Increase/(Decrease) in Bond/Mortgage Debt | ($1,985) | ($15,882) |
| Increase/(Decrease) in Capital Lease Debt | $0 | $0 |
| Increase/(Decrease) in Other Long Term Liabilities | ($1,645,825) | $2,171 |
| **Net Cash Used for Financing Activities** | **($1,647,810)** | **($13,710)** |
| (INCREASE)/DECREASE IN RESTRICTED ASSETS | **$0** | **$0** |
| **Net Increase/(Decrease) in Cash** | **($8,236,764)** | **($10,503,554)** |
| Cash, Beginning of Period | $34,147,198 | $36,413,989 |
| **Cash, End of Period** | **$25,910,435** | **$25,910,435** |

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

# Key Operating Indicators
## February 2026

| | Month | | | YTD | | |
|---|---|---|---|---|---|---|
| | ACTUAL | BUDGET | PRIOR YR | ACTUAL | BUDGET | PRIOR YR |
| **Volumes** | | | | | | |
| Admits | 535 | 524 | 488 | 4,248 | 4,384 | 4,112 |
| ICU | 114 | 110 | 110 | 829 | 948 | 948 |
| Med/Surgical | 1,315 | 922 | 922 | 8,604 | 7,935 | 7,935 |
| Newborn ICU | 107 | 94 | 94 | 795 | 894 | 894 |
| Pediatrics | 69 | 106 | 106 | 497 | 518 | 518 |
| Obstetrics | 257 | 308 | 308 | 2,452 | 2,998 | 2,998 |
| Total Patient Days | 1,862 | 1,540 | 1,540 | 13,177 | 13,293 | 13,293 |
| Adjusted Patient Days | 5,048 | 3,474 | 3,474 | 35,509 | 30,699 | 30,699 |
| Average Daily Census | 67 | 55 | 55 | 54 | 55 | 55 |
| Average Length of Stay | 2.68 | 2.94 | 3.31 | 1.50 | 3.03 | 2.85 |
| Deliveries | 84 | 156 | 169 | 779 | 1,414 | 1,316 |
| E/R Visits | 4,062 | 3,442 | 3,654 | 29,341 | 29,217 | 30,812 |
| Surgeries | 211 | 219 | 251 | 1,760 | 2,377 | 2,780 |
| Wound Care | 303 | 112 | 304 | 2,265 | 1,131 | 2,361 |
| Pioneers Health Center | 2,506 | 2,483 | 2,580 | 19,886 | 19,554 | 21,453 |
| Calexico Visits | 986 | 944 | 948 | 7,819 | 6,787 | 7,351 |
| Pioneers Children | 748 | 798 | 734 | 5,530 | 6,716 | 5,945 |
| Outpatients (non-ER/Clinics) | 6,399 | 7,663 | 6,911 | 51,050 | 57,416 | 54,274 |
| Surgical Health | 51 | 47 | 60 | 461 | 505 | 434 |
| Urology | 227 | 285 | 419 | 2,009 | 2,733 | 2,839 |
| WHAP | 281 | 320 | 325 | 2,663 | 3,213 | 3,377 |
| C-WHAP | 383 | 379 | 441 | 4,032 | 4,221 | 2,812 |
| CDLD | 185 | 111 | 162 | 1,244 | 450 | 544 |
| Skilled Nursing | 1,901 | 2,435 | 2,011 | 17,082 | 19,479 | 17,485 |
| **FTE's** | | | | | | |
| Worked | 1,218.48 | 1,137.77 | 1,051.28 | 1,034.26 | 1,094.21 | 1,035.19 |
| Paid | 1,359.90 | 1,463.30 | 1,172.24 | 1,173.21 | 1,382.40 | 1,268.30 |
| Contract FTE's | 22.88 | 32.89 | 24.10 | 18.45 | 21.90 | 20.84 |
| FTE's APD (Worked) | 6.76 | 9.17 | 8.47 | 7.08 | 8.66 | 8.19 |
| FTE's APD (Paid) | 7.54 | 11.80 | 9.45 | 8.03 | 10.94 | 10.04 |
| **Net Income** | | | | | | |
| Operating Revenues | 14,330,375 | 12,727,343 | 13,526,864 | $116,602,774 | $115,170,859 | $114,730,390 |
| Operating Margin | 412,651 | (1,027,254) | 263,965 | $3,665,043 | -$1,815,833 | $2,475,366 |
| Operating Margin % | 2.9% | -8.1% | 2.0% | 3.1% | -1.6% | 2.2% |
| Total Margin | 1,708,345 | (732,993) | 575,606 | $7,237,198 | $538,253 | $4,025,118 |
| Total Margin % | 11.9% | -5.8% | 4.3% | 6.2% | 0.5% | 3.5% |

*Exhibit A - February 2026*

**Key Volume Stats -Trend Analysis**

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Total | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Deliveries** | | | | | | | | | | | | | | |
| Actual | 95 | 104 | 97 | 99 | 90 | 121 | 89 | 84 | 0 | 0 | 0 | 0 | 779 | 779 |
| Budget | 162 | 181 | 195 | 171 | 187 | 200 | 162 | 156 | 178 | 177 | 177 | 177 | 2,123 | 1,414 |
| Prior FY 2025 | 152 | 167 | 184 | 159 | 167 | 170 | 148 | 169 | 178 | 266 | 141 | 110 | 2,201 | 1,316 |
| **E/R Visits** | | | | | | | | | | | | | | |
| Actual | 3,297 | 3,346 | 3,710 | 3,318 | 3,605 | 3,849 | 4,154 | 4,062 | 0 | 0 | 0 | 0 | 29,341 | 29,341 |
| Budget | 3,509 | 3,338 | 3,463 | 3,408 | 3,629 | 4,624 | 3,804 | 3,442 | 3,794 | 3,668 | 3,668 | 3,668 | 44,015 | 29,217 |
| Prior FY 2025 | 3,728 | 3,498 | 3,597 | 3,590 | 3,817 | 4,803 | 4,125 | 3,654 | 4,055 | 3,839 | 3,678 | 3,285 | 43,064 | 30,812 |
| **Surgeries** | | | | | | | | | | | | | | |
| Total Actual | 261 | 258 | 236 | 222 | 189 | 186 | 197 | 211 | 0 | 0 | 0 | 0 | 1,760 | 1,760 |
| Total Budget | 335 | 309 | 275 | 295 | 301 | 331 | 312 | 219 | 275 | 295 | 295 | 295 | 3,537 | 2,377 |
| Prior FY 2025 | 312 | 403 | 369 | 452 | 323 | 304 | 366 | 251 | 299 | 277 | 287 | 233 | 3,510 | 2,780 |
| **Calexico** | | | | | | | | | | | | | | |
| Actual | 1,124 | 961 | 1,002 | 914 | 900 | 958 | 974 | 986 | 0 | 0 | 0 | 0 | 7,819 | 7,819 |
| Budget | 722 | 760 | 831 | 906 | 776 | 891 | 957 | 944 | 1,074 | 873 | 873 | 873 | 10,480 | 6,787 |
| Prior FY 2025 | 621 | 675 | 829 | 915 | 1,119 | 1,232 | 1,012 | 948 | 1,074 | 1,174 | 923 | 1,034 | 11,556 | 7,351 |
| **Pioneers Health Center** | | | | | | | | | | | | | | |
| Actual | 2,654 | 2,539 | 2,630 | 2,251 | 2,269 | 2,485 | 2,552 | 2,506 | 0 | 0 | 0 | 0 | 19,886 | 19,886 |
| Budget | 2,186 | 2,396 | 2,320 | 2,678 | 2,377 | 2,305 | 2,809 | 2,483 | 2,594 | 2,461 | 2,461 | 2,461 | 29,531 | 19,554 |
| Prior FY 2025 | 1,937 | 2,115 | 2,308 | 2,688 | 3,473 | 3,496 | 2,856 | 2,580 | 2,744 | 2,655 | 2,599 | 2,584 | 32,035 | 21,453 |
| **Pioneers Children** | | | | | | | | | | | | | | |
| Actual | 660 | 734 | 766 | 622 | 573 | 673 | 754 | 748 | 0 | 0 | 0 | 0 | 5,530 | 5,530 |
| Budget | 723 | 799 | 846 | 906 | 858 | 881 | 905 | 798 | 839 | 839 | 839 | 839 | 10,072 | 6,716 |
| Prior FY 2025 | 358 | 376 | 765 | 841 | 1,009 | 984 | 878 | 734 | 845 | 728 | 749 | 659 | 8,926 | 5,945 |
| **Outpatients** | | | | | | | | | | | | | | |
| Actual | 6,548 | 6,085 | 6,669 | 5,825 | 5,974 | 6,617 | 6,933 | 6,399 | 0 | 0 | 0 | 0 | 51,050 | 51,050 |
| Budget | 7,094 | 6,949 | 7,889 | 7,775 | 5,951 | 6,154 | 7,941 | 7,663 | 6,516 | 7,104 | 7,104 | 7,104 | 85,244 | 57,416 |
| Prior FY 2025 | 6,314 | 6,270 | 6,378 | 6,780 | 6,531 | 7,619 | 7,471 | 6,911 | 6,961 | 6,966 | 6,484 | 6,092 | 80,777 | 54,274 |
| **Wound Care** | | | | | | | | | | | | | | |
| Actual | 297 | 281 | 272 | 323 | 237 | 272 | 280 | 303 | 0 | 0 | 0 | 0 | 2,265 | 2,265 |
| Budget | 197 | 160 | 118 | 122 | 119 | 136 | 167 | 112 | 104 | 137 | 137 | 137 | 1,646 | 1,131 |
| Prior FY 2025 | 270 | 327 | 332 | 326 | 251 | 258 | 293 | 304 | 287 | 292 | 242 | 270 | 3,452 | 2,361 |
| **WHAP** | | | | | | | | | | | | | | |
| Actual | 378 | 373 | 383 | 324 | 276 | 327 | 321 | 281 | 0 | 0 | 0 | 0 | 2,663 | 2,663 |
| Budget | 378 | 513 | 392 | 415 | 391 | 379 | 425 | 320 | 336 | 394 | 394 | 394 | 4,731 | 3,213 |
| Prior FY 2025 | 330 | 443 | 388 | 414 | 688 | 362 | 427 | 325 | 342 | 367 | 375 | 369 | 4,830 | 3,377 |
| **C-WHAP** | | | | | | | | | | | | | | |
| Actual | 738 | 657 | 651 | 424 | 403 | 414 | 362 | 383 | 0 | 0 | 0 | 0 | 4,032 | 4,032 |
| Budget | 465 | 457 | 588 | 610 | 558 | 583 | 581 | 379 | 445 | 518 | 518 | 518 | 6,220 | 4,221 |
| Prior FY 2025 | 131 | 95 | 365 | 403 | 552 | 400 | 425 | 441 | 432 | 419 | 599 | 588 | 4,850 | 2,812 |

# IMPERIAL VALLEY HEALTHCARE DISTRICT
## STATEMENT OF REVENUE AND EXPENSE
## FOR THE PERIOD ENDING FEBRUARY 28, 2026

| ECRMC ACTUAL FEBRUARY | IVHD ACTUAL FEBRUARY | Consolidated ACTUAL FEBRUARY | | ECRMC ACTUAL FEBRUARY | IVHD ACTUAL FEBRUARY | Consolidated ACTUAL FEBRUARY |
|---|---|---|---|---|---|---|
| | | | GROSS PATIENT REVENUES | | | |
| 14,131,378 | 16,698,885 | 30,830,263 | INPATIENT REVENUE | 122,386,783 | 136,950,828 | 259,337,611 |
| 0 | 1,812,095 | 1,812,095 | DAILY HOSPITAL SERVICES | 0 | 15,307,718 | 15,307,718 |
| 0 | 14,886,790 | 14,886,790 | INPATIENT ANCILLARY | 0 | 121,643,110 | 121,643,110 |
| 42,085,566 | 28,576,645 | 70,662,211 | OUTPATIENT REVENUE | 340,578,536 | 232,102,892 | 572,681,427 |
| 56,216,944 | 45,275,530 | 101,492,474 | TOTAL PATIENT REVENUES | 462,965,318 | 369,053,720 | 832,019,038 |
| | | | REVENUE DEDUCTIONS | | | |
| 13,248,673 | 12,701,740 | 25,950,413 | MEDICARE CONTRACTUAL | 126,949,608 | 96,065,866 | 223,015,474 |
| 2,078,355 | 12,526,206 | 14,604,561 | MEDICAL CONTRACTUAL | 15,542,201 | 110,950,842 | 126,493,043 |
| -2,028,937 | -1,558,849 | -3,587,786 | SUPPLEMENTAL PAYMENTS | -14,785,843 | -13,682,597 | -28,468,440 |
| 0 | 0 | 0 | PRIOR YEAR RECOVERIES | 0 | -243,579 | -243,579 |
| 30,766,027 | 6,762,298 | 37,528,325 | OTHER DEDUCTIONS | 232,966,567 | 54,955,767 | 287,922,333 |
| 119,787 | 0 | 119,787 | CHARITY WRITE OFFS | 356,805 | 1,775,956 | 2,132,761 |
| 444,748 | 833,587 | 1,278,335 | BAD DEBT PROVISION | 4,897,594 | 6,389,947 | 11,287,541 |
| 322 | -4,167 | -3,845 | INDIGENT CARE WRITE OFFS | -955 | -29,169 | -30,124 |
| 44,628,975 | 31,260,815 | 75,889,790 | TOTAL REVENUE DEDUCTIONS | 365,925,978 | 256,183,030 | 622,109,008 |
| 11,587,969 | 14,014,715 | 25,602,684 | NET PATIENT REVENUES | 97,039,340 | 112,870,690 | 209,910,030 |
| 79.4% | 69.0% | | | 79.0% | 69.4% | |
| | | | OTHER OPERATING REVENUE | | | |
| 0 | | 0 | GRANT REVENUES | 0 | 32,748 | 32,748 |
| 304,673 | 315,660 | 620,333 | OTHER | 2,681,966 | 3,699,336 | 6,381,302 |
| 304,673 | 315,660 | 620,333 | TOTAL OTHER REVENUE | 2,681,966 | 3,732,084 | 6,414,050 |
| 11,892,641 | 14,330,375 | 26,223,016 | TOTAL OPERATING REVENUE | 99,721,306 | 116,602,774 | 216,324,080 |
| | | | OPERATING EXPENSES | | | |
| 4,743,734 | 5,464,696 | 10,208,430 | SALARIES AND WAGES | 41,660,768 | 48,991,168 | 90,651,936 |
| 1,357,210 | 1,678,127 | 3,035,337 | BENEFITS | 11,868,890 | 12,360,931 | 24,229,821 |
| 9,931 | 232,175 | 242,106 | REGISTRY & CONTRACT | 174,293 | 1,452,419 | 1,626,712 |
| 6,110,875 | 7,374,998 | 13,485,873 | TOTAL STAFFING EXPENSE | 53,703,952 | 62,804,517 | 116,508,469 |
| 1,571,385 | 1,722,820 | 3,294,205 | PROFESSIONAL FEES | 11,341,583 | 12,916,173 | 24,257,756 |
| 2,586,686 | 1,942,921 | 4,529,607 | SUPPLIES | 21,018,730 | 13,268,852 | 34,287,582 |
| 168,008 | 593,279 | 761,287 | PURCHASED SERVICES | 1,545,530 | 5,347,509 | 6,893,039 |
| 655,267 | 621,776 | 1,277,043 | REPAIR & MAINTENANCE | 4,900,508 | 5,024,241 | 9,924,749 |
| 464,626 | 371,466 | 836,092 | DEPRECIATION & AMORT | 3,967,363 | 2,600,276 | 6,567,639 |
| 179,202 | 227,964 | 407,166 | INSURANCE | 1,446,074 | 2,083,496 | 3,529,569 |
| 0 | 222,178 | 222,178 | HOSPITALIST PROGRAM | 0 | 1,689,473 | 1,689,473 |
| 1,046,443 | 840,324 | 1,886,767 | OTHER | 7,782,410 | 7,203,196 | 14,985,606 |
| 12,782,492 | 13,917,726 | 26,700,218 | TOTAL OPERATING EXPENSES | 105,706,149 | 112,937,733 | 218,643,883 |
| -889,851 | 412,649 | -477,202 | TOTAL OPERATING MARGIN | -5,984,843 | 3,665,040 | -2,319,803 |
| | | | NON OPER REVENUE(EXPENSE) | | | |
| 0 | 194,298 | 194,298 | OTHER NON-OP REV (EXP) | 0 | -73,105 | -73,105 |
| 0 | 0 | 0 | FEMA FUNDS | 0 | 2,078,448 | 2,078,448 |
| 0 | 1,152,541 | 1,152,541 | DISTRICT TAX REVENUES | 0 | 1,975,965 | 1,975,965 |
| 558,020 | -51,144 | 506,876 | INTEREST EXPENSE | -4,145,465 | -409,152 | -4,554,617 |
| 558,020 | 1,295,695 | 1,853,715 | TOTAL NON-OP REV (EXPENSE) | 4,145,465 | 3,572,156 | -573,309 |
| -1,447,870 | 1,708,344 | 260,474 | NET EXCESS / ( DEFICIT) | -10,130,308 | 7,237,196 | -2,893,112 |

IMPERIAL VALLEY HEALTHCARE DISTRICT
BALANCE SHEET AS OF FEBRUARY 28, 2026

| | ECRMC | IVHD | Consolidated | ECRMC | IVHD | Consolidated |
|---|---|---|---|---|---|---|
| | FEBRUARY 2026 | FEBRUARY 2026 | FEBRUARY 2026 | FEBRUARY 2025 | FEBRUARY 2025 | FEBRUARY 2025 |
| ASSETS | | | | | | |
| CURRENT ASSETS | | | | | | |
| CASH | $3,284,381 | $26,279,893 | $29,564,274 | $8,643,238 | $35,009,315 | $43,652,553 |
| CASH - PEER ACCT | | $0 | $0 | $0 | $0 | $0 |
| CASH - NORIDIAN AAP FUNDS | $0 | $0 | $0 | $0 | $0 | $0 |
| CASH - 3RD PRTY REPAYMENTS | $0 | -$435,703 | -$435,703 | $0 | $0 | $0 |
| CDs - LAIF & CVB | $0 | $66,244 | $66,244 | $0 | $66,244 | $66,244 |
| ACCOUNTS RECEIVABLE - PATIENTS | $16,279,625 | $107,651,920 | $123,931,546 | $23,035,101 | $94,182,720 | $117,217,821 |
| LESS: ALLOWANCE FOR BAD DEBTS | $0 | $1,357,424 | $1,357,424 | $0 | -$3,439,039 | -$3,439,039 |
| LESS: ALLOWANCE FOR CONTRACTUALS | $0 | -$69,461,001 | -$69,461,001 | $0 | -$72,193,959 | -$72,193,959 |
| NET ACCTS RECEIVABLE | $16,279,625 | $39,548,343 | $55,827,968 | $23,035,101 | $18,549,722 | $41,584,823 |
| | 0.00% | 36.74% | $0 | 100.00% | 19.70% | $1 |
| ACCOUNTS RECEIVABLE - OTHER | $24,681,609 | $28,265,887 | $52,947,496 | $8,564,129 | $34,096,916 | $42,661,045 |
| COST REPORT RECEIVABLES | $0 | $59,499 | $59,499 | $0 | $1,206,822 | $1,206,822 |
| INVENTORIES - SUPPLIES | $2,951,771 | $3,558,926 | $6,510,697 | $2,964,165 | $2,941,216 | $5,905,381 |
| PREPAID EXPENSES | $2,826,574 | $2,331,638 | $5,158,213 | $2,507,050 | $3,831,089 | $6,338,139 |
| TOTAL CURRENT ASSETS | $50,023,961 | $99,674,728 | $149,698,689 | $45,713,683 | $95,701,324 | $141,415,007 |
| OTHER ASSETS | | | | | | |
| PROJECT FUND 2017 BONDS | $0 | $1,109,107 | $1,109,107 | $0 | $507,369 | $507,369 |
| BOND RESERVE FUND 2017 BONDS | $0 | $968,373 | $968,373 | $0 | $968,353 | $968,353 |
| LIMITED USE ASSETS | $11,694,984 | $103,614 | $11,798,597 | $11,492,118 | $166,083 | $11,658,201 |
| NORIDIAN AAP FUNDS | $0 | $0 | $0 | $0 | $0 | $0 |
| GASB87 LEASES | $0 | $60,529,359 | $60,529,359 | $0 | $64,931,450 | $64,931,450 |
| OTHER ASSETS PROPERTY TAX PROCEEDS | $0 | $269,688 | $269,688 | $0 | $269,688 | $269,688 |
| OTHER INVESTMENTS | $748,741 | $420,000 | $1,168,741 | $826,218 | $420,000 | $1,246,218 |
| UNAMORTIZED BOND ISSUE COSTS | $0 | | $0 | $0 | | $0 |
| TOTAL OTHER ASSETS | $12,443,725 | $63,400,141 | $75,843,865 | $12,318,336 | $67,262,944 | $79,581,280 |
| PROPERTY, PLANT AND EQUIPMENT | | | | | | |
| LAND | $1,773,456 | $6,883,276 | $8,656,732 | $0 | $2,633,026 | $2,633,026 |
| BUILDINGS & IMPROVEMENTS | $189,964,485 | $63,870,530 | $253,835,015 | $0 | $63,001,597 | $63,001,597 |
| EQUIPMENT | $84,539,290 | $68,736,772 | $153,276,063 | $0 | $65,294,641 | $65,294,641 |
| CONSTRUCTION IN PROGRESS | $25,475,871 | $6,022,182 | $31,498,053 | $0 | $81,976 | $81,976 |
| LESS: ACCUMULATED DEPRECIATION | -$144,229,843 | -$106,150,805 | -$250,380,647 | $0 | -$102,162,971 | -$102,162,971 |
| NET PROPERY, PLANT, AND EQUIPMENT | $157,523,260 | $39,361,956 | $196,885,216 | $155,914,867 | $28,848,269 | $184,763,136 |
| TOTAL ASSETS | $219,990,946 | $202,436,824 | $422,427,770 | $213,946,886 | $191,812,537 | $405,759,423 |

IMPERIAL VALLEY HEALTHCARE DISTRICT
BALANCE SHEET AS OF FEBRUARY 28, 2026

| | ECRMC | IVHD | Consolidated | ECRMC | IVHD | Consolidated |
|---|---|---|---|---|---|---|
| | FEBRUARY 2026 | FEBRUARY 2026 | FEBRUARY 2026 | FEBRUARY 2025 | FEBRUARY 2025 | FEBRUARY 2025 |
| LIABILITIES AND FUND BALANCES | | | | | | |
| CURRENT LIABILITIES | | | | | | |
| ACCOUNTS PAYABLE - CASH REQUIREMENTS | $0 | $4,195,628 | $4,195,628 | $0 | $3,366,375 | $3,366,375 |
| ACCOUNTS PAYABLE - ACCRUALS | $28,158,188 | $3,515,241 | $31,673,429 | $22,244,854 | $10,817,084 | $33,061,938 |
| PAYROLL & BENEFITS PAYABLE - ACCRUALS | $3,649,418 | $6,398,312 | $10,047,731 | $9,609,401 | $8,166,792 | $17,776,193 |
| COST REPORT PAYABLES & RESERVES | $0 | -$435,703 | -$435,703 | $0 | $0 | $0 |
| NORIDIAN AAP FUNDS | $0 | $0 | $0 | $0 | $0 | $0 |
| CURR PORTION- GO BONDS PAYABLE | $0 | $0 | $0 | $0 | $0 | $0 |
| CURR PORTION- 2017 REVENUE BONDS PAYABLE | $0 | $335,000 | $335,000 | $0 | $0 | $0 |
| INTEREST PAYABLE- GO BONDS | $0 | $1,917 | $1,917 | $0 | $1,917 | $1,917 |
| INTEREST PAYABLE- 2017 REVENUE BONDS | $0 | $586,900 | $586,900 | $0 | $268,125 | $268,125 |
| OTHER - TAX ADVANCE IMPERIAL COUNTY | $0 | $0 | $0 | $0 | $0 | $0 |
| DEFERRED HHS CARES RELIEF FUNDS | $0 | $0 | $0 | $0 | $0 | $0 |
| CURR PORTION- LEASE LIABILITIES(GASB 87) | $0 | $4,071,774 | $4,071,774 | $0 | $3,756,205 | $3,756,205 |
| SKILLED NURSING OVER COLLECTIONS | $0 | $3,392,861 | $3,392,861 | $0 | $1,632,566 | $1,632,566 |
| CURR PORTION- SKILLED NURSING CTR ADVANCE | $0 | $0 | $0 | $0 | $0 | $0 |
| CURRENT PORTION OF LONG-TERM DEBT | $0 | $1,037,037 | $1,037,037 | $24,370,370 | $1,075,791 | $25,446,161 |
| TOTAL CURRENT LIABILITIES | $31,807,607 | $23,098,968 | $54,906,574 | $56,224,625 | $29,084,855 | $85,309,480 |
| LONG TERM DEBT AND OTHER LIABILITIES | | | | | | |
| PMH RETIREMENT FUND - ACCRUAL | $0 | -$241,801 | -$241,801 | $0 | $721,305 | $721,305 |
| NOTES PAYABLE - EQUIPMENT PURCHASES | $0 | $26,962,963 | $0 | $0 | $0 | $0 |
| LOANS PAYABLE - DISTRESSED HOSP. LOAN | $0 | $0 | $26,962,963 | $0 | $26,962,963 | $26,962,963 |
| LOANS PAYABLE - CHFFA NDPH | $0 | $0 | $0 | $0 | $0 | $0 |
| BONDS PAYABLE G.O BONDS | $0 | $0 | $0 | $0 | $0 | $0 |
| BONDS PAYABLE 2017 SERIES | $112,415,866 | $14,113,151 | $126,529,016 | $113,491,075 | $14,471,974 | $127,963,049 |
| LONG TERM LEASE LIABILITIES (GASB 87) | $4,567,217 | $58,207,090 | $62,774,307 | $7,320,167 | $62,267,845 | $69,588,012 |
| DEFERRED REVENUE -CHW | $63,729,153 | $0 | $63,729,153 | $56,562,632 | $0 | $56,562,632 |
| DEFERRED PROPERTY TAX REVENUE | $0 | $275,438 | $275,438 | $0 | $275,438 | $275,438 |
| TOTAL LONG TERM DEBT | $180,712,235 | $99,316,841 | $280,029,076 | $177,373,874 | $104,699,525 | $282,073,399 |
| FUND BALANCE AND DONATED CAPITAL | $17,601,412 | $72,783,818 | $90,385,230 | -$19,651,613 | $54,003,028 | $34,351,415 |
| NET SURPLUS (DEFICIT) CURRENT YEAR | -$10,130,308 | $7,237,198 | -$2,893,110 | $0 | $4,025,129 | $4,025,129 |
| TOTAL FUND BALANCE | $7,471,104 | $80,021,016 | $87,492,120 | -$19,651,613 | $58,028,157 | $38,376,544 |
| TOTAL LIABILITIES AND FUND BALANCE | $219,990,946 | $202,436,825 | $422,427,770 | $213,946,886 | $191,812,537 | $405,759,423 |

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

DATE: March 18, 2026

TO: Imperial Valley Healthcare District Board of Directors

FROM: Ramaiah Indudhara, M.D; Chief of Staff, Pioneers Memorial Hospital
George Rapp, M.D, Chairman, Clinical Service of Medical Imaging, Pioneers Memorial Hospital

SUBJ: PMH Medical Staff Recommendations for Approval

**ITEMS FOR CONSIDERATION:** Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/procedures/forms or other related recommendations.

**SUMMARY AND BACKGROUND**: The Medical Executive Committee, upon the recommendations of the Credentials Committee and the respective clinical services and/or chiefs and based on the completed credential files, policies and procedures, recommends that medical staff membership and/or clinical privileges be granted as outlined below:

1. Recommendation for **Initial Appointment** to the **Provisional Staff effective April 1, 2026,** for the following:
   - Marangola, Renee, MD Emergency Medicine
   - Rao, Rajath, MD Teleradiology

2. Recommend **Reappointment** effective **May 1, 2026** for the following:
   - Drake, Macarthur, MD Teleradiology
   - Giudici, Mario, MD Teleradiology
   - Le, Charles, MD Nephrology
   - Singh, Ajay, MD Teleradiology
   - Tran, Tony, MD Internal Medicine
   - Campos Cuevas, Lisette, FNP Family Nurse Practitioner
   - Ramirez, Adriana, FNP Family Nurse Practitioner

3. Recommend Acceptance of Resignation effective March 30, 2026 (unless otherwise noted) as follows:
   - Seare, Tsehaye, MD Internal Medicine (Effective 3/5/2026)
   - Shafter, Ahmed, MD Internal Medicine (Effective 3/5/2026)
   - Tahvilian, Shahrouz, MD Teleradiology
   - Collins, Kelsey, CRNA, DNAP Nurse Anesthetist

4. Recommend Release from Proctoring and Advancement effective April 1, 2026, for the following:
   - Aasar, Abdul, MD Teleradiology
   - Anderson, Jon, MD Teleradiology
   - El-Akkad, Samih, MD Teleradiology
   - Fife, William, MD Teleradiology
   - Gujrathi, Sunil, MD Teleradiology
   - Hedayati, Amir, MD Teleradiology
   - Hwang, Janice, MD Teleradiology
   - Olsen, Erik, MD Teleradiology
   - Patel, Tejal, MD Teleradiology
   - Su, Hsiu, MD Teleradiology
   - Surapaneni, Bharath, MD Teleradiology
   - Williams, Danielle, MD Teleradiology

5. Recommend **Change/Addition Privileges** effective April 1, 2026**:**
   - Ramnath, Venktesh, MD Critical Care & Pulmonary Disease Privileges
   - Ramones, Maria Theresa, MD General Surgery (Major/Minor Amputations)

6. Recommend Acceptance of Privilege Form:
   - Pain Management

7. Recommend acceptance of the following policies/forms:
    - *Chaperone Care* (ADM-00083)
    - Pain Assessment and Management in the Neonate N-PASS (CLN-00223)
    - Patient Consent for HIV Test (CLN-00011)
    - Perinatal Epidural (CLN-01285)
    - *Pharmaceutical Services for Neonates in the NICU* (CLN-00295)
    - *Postpartum Hemorrhage* (CLN-02531)
    - Recovering Obstetrical Patients WI (CLN-01379)

    ***Note: not all of these policies require Board approval. Only those requiring this approval (in italics) will be forwarded to the Governing Body.***

8. Respiratory Mask Fit Testing compliance is at 69%. Notification has been sent to those who are not in compliance at this time, lists were sent to department chairs.

9. Mr. Bjornberg stated that we continue to work towards the merger but no new date has been set at this time. We are also in discussion with Cerner regarding the merge of medical records for both facilities. Seismic considerations are being reviewed and we are in process of requesting an extension to be in compliance.

10. Financial reports for January show a profit of $3.5M, not including money from FEMA which is around $2M. It appears we will have a profit in February as well but those numbers are not yet ready. For January, our days cash on hand is at 75.9 days. We had a dip in February. A letter was sent out to the providers with the new NPI number for IVHD.

11. We are transitioning from DNV to Joint Commission for our accreditation. They will be here after March 30th for a three day survey. A report was presented and discussed which reflects the Quality Data for both facilities.

12. Clinical Service and Committee Reports:
    - Hospitalists – No report.
    - Medicine – Dr. Krutzik reports no updates at this time.
    - Pathology – No report
    - Emergency Medicine – No report.
    - Surgery– Dr. Whyte had no report.
    - Anesthesia - Dr. Larra is working with Dr. Gwon and ECRMC for Anesthesia Services.
    - OB/GYN – Dr. Bean stated she had no updates to report.
    - Pediatrics –No report.
    - Medical Imaging – Dr. Rapp had no report for the department. The Nuc Med tech is transitioning from Yuma to work at PMH
    - Ambulatory Services –.No report
    - Credentials & Bylaws – Approved information above.
    - MSQC – approved policies as listed above.
    - Utilization Management – Reported was that the PMH Average Length of Stay is 4.12. Acute Case Mix Index is 1.520 and Medicare CMI is1.541 for the first quarter.

**RECOMMENDATION: That** Imperial Valley Healthcare District Board of Directors approves each of the recommendations of the Medical Executive Committee for medical staff membership and clinical privileges as outlined above, policies and procedures as noted and authorize the chief executive officer to sign any documents to implement the same.

Respectfully submitted,

George Rapp, M.D.
Chairman, Bylaws/Credentials
Chairman, Clinical Service of Medical Imaging
Pioneers Memorial Hospital
GR/cb

# POLICIES FOR APPROVAL AT BOARD

| | Policy | Policy No. | Page # | Revisions (see policy for full description) |
|---|---|---|---|---|
| 1. | ***Chaperone Care*** | ADM-00083 | • 1-5 | • Changed PMHD to IVHD |
| 2. | ***Pharmaceutical Services for Neonates in the NICU*** | CLN-00295 | • 6-7 | • Updated name of organization<br>• Added 5.1 competency validation reference to CLN-02867; updated References to<br>• include CLN-02867, CLN-02866, and CLN-02951 (added on 09/26/2025) |
| 3. | ***Postpartum Hemorrhage*** | CLN-02531 | • 8-21 | • Definitions updated per ACOG 2022.<br>• Added medications and contraindications<br>• Included mechanical interventions<br>• Added Attachment C and D |

**Imperial Valley Healthcare District**

| Title: **Chaperone Care** | Policy No. ADM-00083 |
|---|---|
| | Page 1 of 4 |
| Current Author: Merlina Esparza | Effective: |
| Latest Review/Revision Date: 01/30/2026 | Manual: Administration/Quality |

| Collaborating Departments: Nursing, Legal, Compliance, Quality/Risk | | Keywords: sensitive examination, physical examination; sensitive procedure | | |
|---|---|---|---|---|
| **Approval Route: List all required approval** | | | | |
| MARCC X | PSQC | Other: | | |
| Clinical Service _____ | | MSQC X | MEC X | BOD X |

**Note:** *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

## 1.0 Purpose:

1.1 The purpose of this policy is to provide guidelines on the provision of chaperones for patients during physical examinations, sensitive examination and/or procedures that involve physical inspection or palpation of anorectal, genital, and/or the female breast areas. The use of chaperones is part of the district's efforts to provide safe and responsible care by maintaining and fostering a culture of responsibility, mutual accountability, and appropriate response to suspected unprofessional or unsafe behavior.

## 2.0 Scope: District wide

## 3.0 Policy:

3.1 Imperial Valley Healthcare District (IVHD) through its corresponding hospital and clinical facilities, will work to make chaperones available to patients during physical examinations, sensitive examination and/or procedures that require physical inspection or palpation of anorectal, genital, and/or the female breast areas to foster a comfortable and considerate patient atmosphere.

## 4.0 Definitions:

4.1 Chaperone: A health care worker whose role is to independently observe an examination by a provider and/or health care worker to ensure appropriate patient interaction. A chaperone can be another nurse, nursing assistant, therapist, physician, and licensed independent practitioner, nursing student, department aide/assistant or a trained licensed or unlicensed staff member.

4.2 Sensitive examination: The physical examination of or, a procedure involving the genitalia, rectum (regardless of gender) or female breast or the breast of a patient who identifies as female.

4.3 Sensitive procedure: Nursing care or procedures that involve placement of finger(s), swabs, or medications/medical equipment on or into the vagina, penis, urethra or rectum.

## 5.0 Procedure:

5.1 Chaperones are entrusted with the duty of ensuring patient/employee and provider safety and privacy during Sensitive examinations and Sensitive procedures, and will be responsible for following IVHD Chaperone Care guidelines with the exception of daily

personal hygiene and/or nursing care that includes perineal cleansing and personal hygiene assistance (diaper changes, incontinence care, and bathing or perineal checks/care that do not involve cervical assessment for dilation (with the exception of laboring women).

5.2 Chaperone availability:

5.2.1 Chaperones will be offered prior to all genitourinary, rectal, and female breast examinations no matter the identified gender of the employee or patient.

5.2.2 A patient has the right to request a chaperone at any time throughout a consultation and/or examination.

5.2.3 A chaperone will be offered even if the patient has a trusted companion or family member present.

5.2.4 Special considerations for a chaperone may include patients with severe anxiety, religious/cultural needs, or mental health needs or developmental disorders

5.2.5 Chaperone documentation in the patient's medical record will include the chaperone's name, title and the portion of the examination which the chaperone was present.

5.3 In rare circumstances, when a chaperone may not be available:

5.3.1 The patient may decline the examination; the employee will document the examination delay due to unavailability of a chaperone in the patient's medical record. The nurse and/or physician must decide if they will proceed with the examination without a chaperone present, such as if the examination is urgent based on clinical history and presentation. The patient must agree to continue the examination without a chaperone. The employee will document the lack of a chaperone along with the rationale of proceeding without a chaperone and the patient’s consent in the medical record.

5.3.2 All patients will be provided with the highest level of privacy and dignity. The patient will be provided with a private room for dressing, appropriate gowns and drapes for the patient's body habitus, a private area to discuss concerns with their provider and/or employee, and any request for a chaperone will be honored.

5.3.3 The employee should explain what is involved with the examination or procedure, and that a chaperone will be present unless the patient prefers not to have one. This will minimize the chance of misunderstanding.

5.3.4 Whenever practical, but not required, the chaperone should be the gender that the patient feels most comfortable with.

5.3.5 Chaperones can assist the health care professional or provide support to the patient with personal hygiene, toileting or undressing/dressing if needed.

5.3.6 The employee should ensure that the chaperone is present prior to the commencement of the covered examination or procedure and remains present until the end of the examination or procedure.

5.3.7 If the patient declines a chaperone, document the declination of a chaperone in the medical record.

5.3.8 A chaperone has the right to stop a sensitive procedure/examination or care if they feel the employee’s behavior is inappropriate or unacceptable.

5.3.9 A chaperone who witnesses inappropriate/unacceptable behavior by an employee or provider will immediately stop the action and report this to their manager or another senior manager even if they did not stop the procedure while it was ongoing.

5.3.10 A relative or friend of the patient is not an impartial observer and cannot be a chaperone unless they are a parent or guardian of an infant or child (see Section 5.3.11 – Minors below). Even though they cannot be a chaperone, if the patient would like a relative or friend to stay with them, it should be allowed when reasonable and permissible. Clinical staff should always work to explain the examination or procedure to the patient and/or their representative to minimize the potential for any misunderstandings.

5.3.11 Minors – The following steps should be taken prior to the commencement of a physical examination or procedure that involves inspection or palpation of anorectal, genital, and/or the female breast areas of minor patients:

5.3.11.1 The physical examination of an infant or child under 12 years old should always be performed in the presence of a parent or guardian. If a parent or guardian is unavailable or the parent's presence will interfere with the physical examination, such as in a possible case of abuse or parental mental health issues, a chaperone must be present during any sensitive physical examination.

5.3.11.2 If the patient is an adolescent of 12 years or above and the examination requires inspection or palpation of anorectal or genital areas and/or the female breast, a chaperone must be present. An adolescent cannot refuse a chaperone.

5.3.12 Procedures deemed to be lifesaving or emergent should not be delayed. (i.e. removal of blouse to perform CPR).

5.3.13 For the following exams a chaperone can be offered but is not required unless requested by the patient:

5.3.13.1 Exam of the urethra in both males and females

5.3.13.2 Breast radiology including mammography, ultrasound, interventional, and MRI

5.3.13.3 Echocardiograms

5.3.13.4 Standard patient care such as listening to the heart or lungs or placing EKG leads

5.3.13.5 In all the above instances the patient should be appropriately draped and the drape utilized as a barrier between the patient and the healthcare professional

5.3.14 For the following exams a chaperone must be present unless declined by the patient:

5.3.14.1 Breast examination of a female patient or a patient that identifies as a female.

5.3.14.2 Palpation of the external genitalia.

5.3.14.3 Placement of fingers, speculum, swabs or any other instrument into

the vagina or rectum. Exception for women being evaluated for labor and delivery.

**6.0 References:**

6.1 The American College of Obstetricians and Gynecologists, Committee on Ethics, Opinion Number 373 (August 2007), Sexual Misconduct

6.2 American Medical Association, Opinion 8.21 - Use of Chaperones during Physical Exams

6.3 AMA Principles of Medical Ethics: I, IV. Use of Chaperones. American Medical Association (AMA) Code of Medical Ethics Opinion 1.2.4, *www.ama-assn.org/delivering-care/use-chaperones*

6.4 Medical Protection. Chaperones. April 12, 2016, *www.medicalprotection.org*

6.5 *University of Michigan Health System Executive Committee, The Use of Chaperones During Sensative Examinations and Procedures (June 2019) http://www. uofmhealth.org*

**7.0 Attachment List**

7.1 Attachment A – Chaperone Care Guideline

**8.0 Summary of Revisions:**

8.1 changed PMHD to IVHD

# Imperial Valley Healthcare District Chaperone Care

**What is a Chaperone:** a chaperone is a person who acts as a witness for a patient and/or health professional during sensitive examinations or procedures. Chaperones should place themselves in a location where they are able to assist as needed and observe the care being provided.

**What is a sensitive exam:** A sensitive exam is a physical examination or procedure/care involving the genitalia, rectum (regardless of gender) or female breast or the breast of a patient who identifies as female. EXCEPTION: Nursing care that includes perineal cleansing and care as a part of everyday personal hygiene assistance (e.g. Diaper changes, incontinence care, bathing)

- Chaperones are provided to help protect and enhance the patient's comfort, safety, privacy, security and dignity during sensitive examinations or procedures.
- Having a chaperone also provides protection for health care professionals against unfounded allegations of improper behavior.
- For patients with mental health needs or developmental disorders a chaperone should be provided because sensitive examinations or procedures can be confusing or threatening.
- A chaperone can be another nurse, nursing assistant, therapists, physician, licensed independent practitioner or nursing student.
- Whenever possible, but not required, the chaperone should be the gender that the patient feels most comfortable with.
- Chaperones can assist the health care professional or provide support to the patient with personal hygiene, toileting or undressing/dressing if needed.
- Family members or friends of the patient should never be utilized as a chaperone.
- In some cases a patient's personal and cultural preferences may broaden their own definition of a sensitive examination, chaperones will always be provided for other examinations if requested by a patient, parent or legal guardian.
- A patient can decline a chaperone. If they decline the chaperone, you must document in the medical record. Preferred documentation would be: "A chaperone was offered for this sensitive examination, but the patient requested that a chaperone not be present"
- When a chaperone is present for care you need to document the chaperones name in the electronic medical record.

**For the following exams a chaperone can be offered but is not required unless requested by the patient:**

- Exam of the urethra in both males and females
- Breast radiology including mammography, ultrasound, interventional, and MRI
- Echocardiograms
- Standard patient care such as listening to the heart or lungs or placing EKG leads
- In all the above instances the patient should be appropriately draped and the drape utilized as a barrier between the patient and the healthcare professional

**For the following exams a chaperone must be present unless declined by the patient:**

- Breast examination of a female patient or a patient that identifies as a female
- Palpation of the external genitalia
- Placement of fingers, speculum, swabs or any other instrument into the vagina or rectum

**Emergency care should never be impeded**

**A chaperone has the right to stop a sensitive procedure, examination or care if they feel that the health professional's behavior is inappropriate or unacceptable. A chaperone who witnesses inappropriate or unacceptable behavior on the part of the health professional will immediately report this to their manager or another administrator, even if they did not stop the procedure while it was ongoing.**

**Imperial Valley Healthcare District**

| Title: **Pharmaceutical Services for Neonates in the NICU** | Policy No. CLN-00295 |
|---|---|
| | Page 1 of 2 |
| Current Author: Sandra Taylor, RNC-NIC, BSN | Effective: |
| Latest Review/Revision Date: 09/15/2025 | Manual: Clinical / NICU |

| Collaborating Departments: Pharmacy, NICU Medical Director, NICU Manager | | Keywords: Medications/Neonate | |
|---|---|---|---|
| **Approval Route: List all required approval** | | | |
| MARCC 09/2025 | PSQC | Other: P&T Subcommittee | |
| Clinical Service Peds 10/2025 | | MSQC 10/2025 | MEC 10/2025 | BOD 10/2025 |

**Note:** *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

## 1.0 Purpose:

1.1 To provide neonatal appropriate medications

## 2.0 Scope: Pharmacy

## 3.0 Policy:

3.1 There shall be at least one licensed pharmacist holding a doctoral degree in pharmacy (PharmD) with neonatal expertise available for consultation to the PMH Intermediate NICU staff.

3.1.1 Pharmacists that hold PharmDs with neonatal expertise are available for consultation at Rady's Main through the Regional Cooperation agreement which provides services to the PMH Intermediate NICU and PMH pharmacy staff

3.2 Pharmacy staff and pharmaceutical services shall be available on a 24-hour basis to the PMH Intermediate NICU.

3.3 Pharmacy staff shall provide neonatal unit doses including individual neonatal intravenous and parenteral nutrition solutions, and neonatal nutritional products, in clearly marked containers, and shall also provide continuous drug surveillance.

3.4 Through the Regional Cooperation agreement, the PMH Intermediate NICU and PMH pharmacy staff will have access to pharmaceutical resources and expertise from Rady's Main for consultation, education, and training needs.

## 4.0 Definitions:

4.1 Neonatal Nutritional Products – Parenteral Nutrition Solutions

4.2 PMH – Pioneers Memorial Hospital

4.3 NICU – Neonatal Intensive Care Unit

## 5.0 Procedure:

5.1 Pharmacy staff who prepare and/or dispense medications for neonatal patients must maintain current, role-based competencies as defined in Pharmacy Competency Assessment (CLN-02867). Competency elements include knowledge and skills for neonatal dosing, preparation/labeling, independent double-check processes, and safe handling of neonatal nutritional products. Related requirements are addressed in Pediatric Medication Use (CLN02866) and Scope of Pharmacy Services & Staffing Guidelines (CLN-02951).

**6.0 References:**

6.1 CCS Manual of Procedures, Issued: 1/1/2021 Chapter 3.25.2-16

**7.0 Attachment List:** Not applicable

**8.0 Summary of Revisions:**

8.1 Updated name of organization
8.2 Added 5.1 competency validation reference to CLN-02867; updated References to
8.3 include CLN-02867, CLN-02866, and CLN-02951 (added on 09/26/2025).

**Imperial Valley Healthcare District**

| Title: Postpartum Hemorrhage | Policy No. CLN-02531 |
|---|---|
| | Page 1 of 5 |
| Current Author: Patricia Robles Martinez; Alexis Garcia | Effective: 1/2021 |
| Latest Review/Revision Date: 10/2025 | Manual: Clinical/OB |

| Collaborating Departments: Emergency Departme Operating Room, Blood Bank, Intensive Care Unit, Post-Anesthesia Care Unit, Dr. Zadeh | Keywords: hemorrhage, postpartum |
|---|---|

| **Approval Route: List all required approval** | | | | |
|---|---|---|---|---|
| MARCC x | PSQC | Other: | | |
| Clinical Service OB x | | MSQC x | MEC x | BOD x |

**Note:** *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

## 1.0 Purpose:

1.1 The purpose of this protocol is to provide guidelines for the optimal response of the multidisciplinary team in the event of obstetric hemorrhage. This protocol will also aid in recognizing patients at risk for hemorrhage and identifying stages of hemorrhage and primary treatment goals.

## 2.0 Scope:

2.1 Perinatal
2.2 OR Nursing Staff
2.3 LIP
2.4 Blood Bank

## 3.0 Policy

3.1 Optimal response to obstetric hemorrhage requires the coordination of effort of team members from multiple disciplines and departments.

3.1.1 Obstetric (OB) unit, anesthesia department, blood bank, operating room, and other appropriate services work together to identify necessary system supports and processes for mounting an efficient and coordinated response to obstetric hemorrhage.

3.1.2 Obstetric physicians, obstetric RNs, anesthesiologists, and other appropriately qualified clinicians are authorized to mobilize the team to respond to an obstetric hemorrhage.

3.1.3 The OB hemorrhage instrument trays and cart are always kept stocked, not expired, and available for an OB hemorrhage in the perinatal unit. The instrument trays and cart are checked monthly, expired items in the cart are restocked by the charge RN.

## 4.0 Definitions:

4.1 Postpartum Hemorrhage: cumulative blood loss≥ 1000 ml or blood loss with signs/symptoms of hypovolemia, within 24 hours of birth

4.2 Massive Hemorrhage: ≥1500 ml blood loss or ≥ 4 units PRBCs transfused within 2 hours.

4.3 DIC – Disseminated Intravascular Coagulation

4.4 Active Management of third stage of labor: Administration of uterotonic, controlled cord traction, and uterine massage.

**5.0 Procedure:**

5.1 Prenatal, Admission and Ongoing Risk Assessment Identify and prepare for patients with special considerations: Placenta Previa/Accreta, Bleeding Disorder, or those who decline blood products Screen and aggressively treat severe anemia: if oral iron fails, initiate IV Iron Sucrose Protocol (Iron Infusion Pre-printed Order set OB-NEW) to reach desired Hgb/Hct, especially for at-risk mothers

5.2 Admission Assessment and Planning

5.2.1 Verify Type & Antibody Screen from prenatal record; If not available:

5.2.1.1 Order Type & Screen (lab will notify if 2nd clot needed for confirmation)

5.2.1.2 If prenatal or current antibody screen positive, (if not low-level anti-D from Rho-GAM),

5.2.1.3 Type and crossmatch 2 units PRBCs

5.2.1.4 All other patients, send clot to blood bank

5.2.2 Evaluate for Risk Factors (see Attachment B)

5.2.2.1 If medium risk:

5.2.2.1.1 Order Type & Screen

5.2.2.1.2 Review Hemorrhage Protocol

5.2.2.2 If high risk:

5.2.2.2.1 Order Type & Crossmatch 2 units PRBCs

5.2.2.2.2 Review Hemorrhage Protocol

5.2.2.2.3 Notify OB Anesthesia

5.2.2.3 Identify women who may decline transfusion

5.2.2.3.1 Notify OB provider for plan of care

5.2.2.3.2 Early consult with OB anesthesia

5.2.2.3.3 Review Consent Form

5.3 Ongoing Risk Assessment

5.3.1 Evaluate for development of additional risk factors in labor:

5.3.1.1 Prolonged 2nd Stage labor

5.3.1.2 Prolonged oxytocin use

5.3.1.3 Active bleeding

5.3.1.4 Chorioamnionitis

5.3.1.5 Magnesium sulfate treatment

5.3.2 Increase Risk Level (see below) and convert to Type & Screen or

5.3.2.1 Type and Crossmatch

5.3.3 Treat multiple risk factors as High Risk

5.4 Admission Hemorrhage Risk Factor Evaluation

| Low (Clot only) | Medium (Type and Screen) | High (Type and Cross) |
|---|---|---|
| No previous uterine incision | Prior cesarean birth(s) or uterine surgery | Placenta previa, low lying placenta, |
| Singleton pregnancy | Multiple gestation | Suspected placenta accreta or |

| | | |
|---|---|---|
| | | percreta |
| ≤4 previous vaginal births | >4 previous vaginal births | Abruption or active bleeding (> than show) |
| No known bleeding disorder | Chorioamnionitis | Known Coagulopathy |
| No history of PPH | History of previous PPH | History of >1 postpartum Hemorrhage |
| | Large uterine fibroids | HELLP Syndrome |
| | Platelets 50, 000- 100, 000 | Platelets < 50, 000 |
| | Hematocrit < 30% (Hgb <10) | Hematocrit < 24% (Hgb <8) |
| | Polyhydramnios | Fetal Demise |
| | Gestational age <37 weeks or >41 weeks | 2 or more medium risk factors |
| | Preeclampsia | |
| | Prolonged labor/Induction | |

5.4.1 *If admitted patients are started on magnesium sulfate they are at higher risk of postpartum hemorrhage**.**

5.5 Immediate Emergency Release:

5.5.1 If type and screen has not been done and blood is needed immediately, O –Neg blood is available while awaiting the completion of the Type and Cross Match.

5.5.2 If the Antibody (Ab) screen is negative and blood needed immediately, type-specific blood may be used; crossmatch

5.5.3 If antibody screen positive, patient may only receive cross-matched blood. It should be recognized that it may take additional time to find cross-matched blood.

5.5.4 STAGE 0

5.5.4.1 Follow Obstetric hemorrhage care guidelines checklist (Attachment B) to mobilize response, act to mitigate bleeding, and move sequentially through treatment.

5.6 Prevention & Recognition of Hemorrhage during all births

5.6.1 Active Management of Third Stage of Labor

5.6.1.1 Administer Oxytocin infusion as per LIP order

5.6.1.1.1 Oxytocin 10 units IM

5.6.1.1.2 Do not give oxytocin as IV push

5.6.1.1.3 Precaution and monitoring for acute pulmonary edema following Oxytocin bolus shall be initiated

5.6.1.2 Provide vigorous fundal massage for at least 15 seconds

5.7 Ongoing Quantitative Measurement of Blood Loss at all Births

5.7.1 Assess blood loss at birth, prior to delivery of the placenta whenever possible.

5.7.2 Reassess cumulative blood loss after delivery of the placenta

5.7.3 Use formal methods to assess blood loss:

5.7.3.1 Use graduated under-buttock drapes

5.7.3.2 Weigh blood-soaked materials on gram scale (1 gm = 1ml)

5.7.3.2.1 Subtract known dry weight of materials

5.7.3.2.2 *NOTE: if a dry chux is used to protect scale from blood-soaked material, ZERO the scale after placing dry chux and prior to placing saturated item(s).

5.8 Ongoing Evaluation of Vital Signs and Clinical Triggers

5.8.1 STAGE 1

5.8.1.1 Cumulative Blood Loss ≥1000 ml vaginal birth or ≥1000 ml cesarean birth –OR Vital Signs abnormal HR ≥110, BP ≤85/45, O2 sat <95% - OR Confusion

5.8.1.2 Interventions:

5.8.1.2.1 Follow Obstetric hemorrhage care guidelines checklist (Attachment B) to mobilize response, act to mitigate bleeding, and move sequentially through treatment.

5.8.1.2.2 Activate Code MOM

5.8.1.2.3 Evaluate Uterus (tone, trauma, tissue, thrombin)

5.8.1.2.4 Administer sequential uterotonics:

5.8.1.2.4.1 Oxytocin (if not already given)

5.8.1.2.4.2 Methergine 0.2mg IM q2-hrs- contraindicated in Hypertension

5.8.1.2.4.3 Hemabate 250 mcg IM q 15-90 min, max 2mg)- contraindicated in Asthma

5.8.1.2.4.4 Cytotec 800mcg PR or SL as ordered

5.8.1.2.4.5 Continue uterine massage, monitor vitals q5 min

5.8.1.2.4.6 Reassess after each intervention and document QBL cumulatively.

5.8.2 STAGE 2

5.8.2.1 Proceed to STAGE 2 for any of the following when cumulative blood loss is <1500 mL or vitals remain abnormal

5.8.2.2 Interventions

5.8.2.2.1 Follow Obstetric hemorrhage care guidelines checklist (Attachment B) to mobilize response, act to mitigate bleeding, and move sequentially through treatment.

5.8.2.2.2 Establish two large bore IV lines.

5.8.2.2.3 Type and Cross addition 2 units PRBCs.

5.8.2.2.4 Initiate infusion if not already started

5.8.2.2.5 Consider mechanical intervention (uterine tamponade or uterine packing)

5.8.3 STAGE 3

5.8.3.1 Cumulative blood loss > 1500ml, > 4 units PRBCs given, DIC suspected, continued instability.

5.8.3.2 Interventions

5.8.3.2.1 Follow Obstetric hemorrhage care guidelines checklist (Attachment B) to mobilize response, act to mitigate bleeding, and move sequentially through treatment.

5.8.3.2.2 Massive transfusion Protocol
5.8.3.2.3 Transfuse PRBC:FFP:Platelets 1:1:1 ratio.
5.8.3.2.4 Consider Cryoprecipitate fibrinogen< 200mg/dl.
5.8.3.2.5 Do not delay for lab results- treat clinically.
5.8.3.2.6 Continue uterotonics and mechanical compression.
5.8.3.2.7 If unresponsive, proceed to surgical interventions.
5.8.3.2.8 Consult Anesthesia, IR for embolization if stable for transport

5.8.3.3 Post Event Surveillance and communication
5.8.3.3.1 Continue close monitoring of vitals, urine output, and QBL for ≥ 24 hours

5.8.3.4 Communication and Documentation
5.8.3.4.1 Verbally acknowledge actions you will take and orders received.
5.8.3.4.2 Provide ongoing updates about patient's status with other departments.
5.8.3.4.3 Record intake and output records.

## 6.0 References:

6.1 CMQCC Quality Improvement *Toolkit Improving Health Care Response to Obstetrics Hemorrhage* v3.0; 2022.
6.2 ACOG Practice Bulletin Number 183 *Postpartum Hemorrhage*, (October 2017, reaffirmed 2022)
*6.3* ACOG Clinical Practice update 2025*: Nonsurgical Hemorrhage Control devices in Obstetric care.*
*6.4* Calfornia Department of Public Health*: Perinatal Quality Measures for Obstetric Hemorrhage, 2024.*

## 7.0 Attachment List

7.1 Attachment A Obstetric hemorrhage care guidelines checklist
7.2 Attachment B Medications for Postpartum Hemorrhage
7.3 Attachment C OB OB Hemorrhage Report
7.4 Attachment D Appendix D: Obstetric Hemorrhage Care Guidelines:Flowchart Format ERRATA 7.18.22

## 8.0 Summary of Revisions:

8.1 Definitions updated per ACOG 2022.
8.2 Added medications and contraindications
8.3 Included mechanical interventions
8.4 Added Attachment C and D

# Iron Sucrose Protocol

## Obstetric Care for Women who Decline Transfusions (Jehovah's Witnesses and others)

Elliott Main, MD, Department of Obstetrics and Gynecology, California Pacific Medical Center, Sutter Health

Iron Sucrose (Venofer ®) is a safe intravenous preparation of iron for those who need iron and do not respond or cannot take oral iron.

**Side Effects**

Iron sucrose has not been associated with anaphylaxis, which makes it the preferred drug for parenteral iron supplementation. No serious adverse effects have been seen, including no hypotension. Occasionally, patients (5-10%) may have a transient metallic taste and hot flashes. [1, 2]

**Indications**

Selected patients with the following:

1. Severe antepartum iron deficient anemia non-responsive (or intolerant) to oral iron replacement
2. Anemia in a high-risk setting requiring quick replacement of iron stores:
   a) placenta previa/accreta
   b) Jehovah's Witness or other decliners of blood transfusions
3. Severe anemia from obstetric hemorrhage
4. Post autologous donation with need for rapid replenishment

In indications 2-4, there is additional consideration for recombinant human erythropoietin (EPO) (300 units/kg SQ, once), which combined with iron sucrose gives the most rapid response.

**Administration**

**Option 1:**

500 mg Iron Sucrose in NS 250 ml administered over three (3) hours; repeat in 3-7 days to reach 1 gm.

**Option 2:**

200 mg in NS 100 ml administered over 20-30 minutes; may repeat every other day to reach target.
**Fe need;** see below.

**Calculate Fe (Iron sucrose) need:**

**Fe need = wt (kg) x 0.24 x △Hgb (gm/L) + 500mg**

**= target - current**

Example: 70 kg woman with Hgb of 7.0 gm/dL and a target of 11 gm/L

**=** 70 kg **x** 0.24 **x** (target: 110 gm/L **—** actual: 70 gm/L) **+** 500 mg

Remember: 7 gm/dL = 70 gm/L
Remember: Use **pre-pregnancy** weight (kg)

**=** 672 mg **+** 500 mg **=** 1172 mg (This is usually rounded off to 100 or 200 mg increments)

## References

1. Breymann C, Visca E, Huch R, Huch A. Efficacy and safety of intravenously administered iron sucrose with and without adjuvant recombinant human erythropoietin for the treatment of resistant iron-deficiency anemia during pregnancy. Am J Obstet Gynecol 2001;184(4):662-7.
2. Al R, Unlubilgin E, Kandemir O, Yalvac S, Cakir L, Haberal A. Intravenous versus oral iron for treatment of anemia in pregnancy: a randomized trial. Obstet Gynecol 2005 Dec;106(6):1335-40.

CMQCC

# Obstetric Hemorrhage Emergency Management Plan: Checklist Format

Revision 9/10/14

## Stage 0: All Births – Prevention & Recognition of OB Hemorrhage
## Prenatal Assessment & Planning

☐ **Identify and prepare for patients with special considerations:** Placenta Previa/Accreta, Bleeding Disorder, or those who Decline Blood Products

☐ **Screen and aggressively treat severe anemia:** if oral iron fails, initiate IV Iron Sucrose Protocol to reach desired Hgb/Hct, especially for at risk mothers.

## Admission Assessment & Planning

**Verify Type & Antibody Screen** from prenatal record

***If not available***,

☐ Order Type & Screen (lab will notify if 2nd specimen needed for confirmation)

***If prenatal or current antibody screen positive (if not low level anti-D from Rho-GAM)***,

☐ Type & Crossmatch 2 units PRBCs

***All other patients***,

☐ Send specimen to blood bank

☐ Evaluate for ***Risk Factors*** on admission, throughout labor, and postpartum. (At every handoff)

***If medium risk***:

☐ Order Type & Screen

☐ Review Hemorrhage Protocol

***If high risk:***

☐ Order Type & Crossmatch 2 units PRBCs

☐ Review Hemorrhage Protocol

☐ Notify OB Anesthesia

***Identify*** women who may decline transfusion

☐ Notify OB provider for plan of care

☐ Early consult with OB anesthesia

☐ Review Consent Form

## Ongoing Risk Assessment

☐ **Evaluate for development of additional risk factors in labor**:

- Prolonged 2nd Stage labor
- Prolonged oxytocin use
- Active bleeding
- Chorioamnionitis
- Magnesium sulfate treatment

☐ **Increase Risk level** (see below) **and convert to Type & Screen or Type & Crossmatch**

☐ **Treat multiple risk factors as High Risk**

☐ **Monitor women postpartum for increased bleeding**

## Admission Hemorrhage Risk Factor Evaluation

| **Low** (Clot only) | **Medium** (Type and Screen) | **High** (Type and Crossmatch) |
|---|---|---|
| No previous uterine incision | Prior cesarean birth(s) or uterine surgery | Placenta previa, low lying placenta |
| Singleton pregnancy | Multiple gestation | Suspected Placenta accreta or percreta |
| ≤ 4 previous vaginal births | > 4 previous vaginal births | Hematocrit < 30 AND other risk factors |
| No known bleeding disorder | Chorioamnionitis | Platelets < 100,000 |
| No history of PPH | History of previous PPH | Active bleeding (greater than show) on admit |
| | Large uterine fibroids | Known coagulopathy |

## All Births – Prophylactic Oxytocin, Quantitative Evaluation of Blood Loss, & Close Monitoring

**Active Management of Third Stage**

☐ Oxytocin infusion: 10-40 units oxytocin/1000 ml solution titrate infusion rate to uterine tone; or 10 units IM; do not give oxytocin as IV push

**Ongoing Quantitative Evaluation of Blood Loss**

☐ Using formal methods, such as graduated containers, visual comparisons and weight of blood soaked materials (**1gm = 1ml**)

**Ongoing Evaluation of Vital Signs**

**If: Cumulative Blood Loss > 500ml vaginal birth or > 1000ml C/S with continued bleeding -OR-**
**Vital signs > 15% change or HR ≥ 110, BP ≤ 85/45, O2 sat < 95% -OR- Increased bleeding during recovery or postpartum,**
**proceed to STAGE 1**

# STAGE 1: OB Hemorrhage

**Cumulative Blood Loss >500ml vaginal birth or >1000ml C/S with continued bleeding -OR-**
**Vital signs >15% change or HR ≥110, BP ≤85/45, O2 sat <95% -OR-**
**Increased bleeding during recovery or postpartum**

## MOBILIZE

**Primary nurse**, **Physician or Midwife** to:

- ☐ Activate OB Hemorrhage Protocol and Checklist

**Primary nurse** to:

- ☐ Notify obstetrician or midwife (in-house and attending)
- ☐ Notify charge nurse
- ☐ Notify anesthesiologist

**Charge nurse:**

- ☐ Assist primary nurse as needed or assign staff member(s) to help

## ACT

**Primary nurse or designee**:

- ☐ Establish IV access if not present, at least 18 gauge
  Increase IV Oxytocin rate, 500 mL/hour of 10-40 units/500-1000 mL solution; Titrate infusion rate to uterine tone
- ☐ Apply vigorous fundal massage
- ☐ Administer Methergine 0.2 mg IM per protocol (if not hypertensive); give once, if no response, move to alternate agent; if good response, may give additional doses q 2 hr (If Misoprostol standard, misoprostol 800 mcg SL per protocol)
- ☐ Vital Signs, including O2 sat & level of consciousness (LOC) q 5 minutes
- ☐ Weigh materials, calculate and **record** cumulative blood loss q 5-15 minutes
- ☐ Administer oxygen to maintain O2 sats at >95%
- ☐ Empty bladder: straight cath or place Foley with urimeter
- ☐ Type and Crossmatch for 2 units Red Blood Cells STAT (if not already done)
- ☐ Keep patient warm

**Physician or midwife:**

- ☐ Rule out retained Products of Conception, laceration, hematoma

**Surgeon (if cesarean birth and still open)**

- ☐ Inspect for uncontrolled bleeding at all levels, esp. broad ligament, posterior uterus, and retained placenta

## THINK

Consider potential etiology:

- Uterine atony
- Trauma/Laceration
- Retained placenta
- Amniotic Fluid Embolism
- Uterine Inversion
- Coagulopathy
- Placenta Accreta

**Once stabilized:** Modified Postpartum management with increased surveillance

**If: Continued bleeding or Continued Vital Sign instability, and < 1500 mL cumulative blood loss**
**proceed to STAGE 2**

# STAGE 2: OB Hemorrhage

**Continued bleeding or Vital Sign instability, and < 1500 mL cumulative blood loss**

## MOBILIZE

**Primary nurse (or charge nurse):**

- ☐ Call obstetrician or midwife to bedside
- ☐ Call Anesthesiologist
- ☐ Activate Response Team:

**PHONE #:**_____

- ☐ Notify Blood bank of hemorrhage; order products as directed

**Charge nurse:**

- ☐ Notify Obstetrician/midwife or 2nd OB
- ☐ Bring hemorrhage cart to the patient's location
- ☐ Initiate OB Hemorrhage Record
- ☐ If considering selective embolization, call-in Interventional Radiology Team and second anesthesiologist
- ☐ Notify nursing supervisor
- ☐ Assign single person to communicate with blood bank
- ☐ Assign hospitalist/LIP or clinical nurse specialist as family support person or call medical social worker

## ACT

**Team leader** (OB physician or midwife):

- ☐ Additional uterotonic medication: Hemabate 250 mcg IM [if not contraindicated] **OR** Misoprostol 800 mcg SL
  - Can repeat Hemabate up to 3 times every 20 min; (note-75% respond to first dose)
- ☐ Continue IV oxytocin and provide additional IV crystalloid solution

**Do not delay other interventions (see right column) while waiting for response to medications**

- ☐ Bimanual uterine massage
- ☐ Move to OR (if on postpartum unit, move to L&D or OR)
- ☐ Order 2 units PRBCs and bring to the bedside
- ☐ Order labs STAT (CBC/PLTS, Chem 12 panel, Coag Panel II, ABG)
- ☐ **Transfuse PRBCs based on clinical signs** and response, **do not wait** for lab results; consider emergency O-negative transfusion

**Primary nurse (or designee)**:

- ☐ Establish 2nd large bore IV, at least 18 gauge
- ☐ Assess and announce Vital Signs and cumulative blood loss q 5-10 minutes
- ☐ Set up blood administration set and blood warmer for transfusion
- ☐ Administer meds, blood products and draw labs, as ordered
- ☐ Keep patient warm

**Second nurse** (or charge nurse):

- ☐ Place Foley with urimeter (if not already done)
- ☐ Obtain portable light and OB procedure tray or Hemorrhage cart
- ☐ Obtain blood products from the Blood Bank (or send designee)
- ☐ Assist with move to OR (if indicated)

**Blood Bank:**

- ☐ Determine availability of thawed plasma, fresh frozen plasma, and platelets; initiate delivery of platelets if not present on-site
- ☐ Consider thawing 2-4 FFP (takes 30 min), use if transfusing > 2 units PRBCs
- ☐ Prepare for possibility of massive hemorrhage

## THINK

**Sequentially advance through procedures** and other interventions based on etiology:

**Vaginal birth**

If **trauma (vaginal, cervical or uterine):**

- Visualize and repair

If **retained placenta**:

- D&C

If **uterine atony** or lower uterine segment bleeding:

- Intrauterine Balloon

If **above measures unproductive:**

- Selective embolization (Interventional Radiology if available)

**C-section**:

- B-Lynch Suture
- Intrauterine Balloon

If **Uterine Inversion**:

- Anesthesia and uterine relaxation drugs for manual reduction

If **Amniotic Fluid Embolism**:

- Maximally aggressive respiratory, vasopressor and blood product support

If **vital signs are worse than estimated or measured blood loss**: possible uterine rupture or broad ligament tear with internal bleeding; **move to laparotomy**

**Once stabilized:** Modified Postpartum management with increased surveillance

**Re-Evaluate Bleeding and Vital Signs**
**If cumulative blood loss > 1500ml, > 2 units PRBCs given, VS unstable or suspicion for DIC, proceed to STAGE 3**

# STAGE 3: OB Hemorrhage

**Cumulative blood loss > 1500ml, > 2 units PRBCs given, VS unstable or suspicion for DIC**

## MOBILIZE

**Nurse or Physician:**

☐ Activate Massive Hemorrhage Protocol

**PHONE #:**_____

**Charge Nurse or designee:**

☐ Notify advanced Gyn surgeon
☐ Notify adult hospitalist or intensivist
☐ Call-in second anesthesiologist
☐ Call-in OR staff
☐ Ensure hemorrhage cart available at the patient's location
☐ Reassign staff as needed
☐ Call house supervisor and Department Manager
☐ Continue OB Hemorrhage Record (In OR, anesthesiologist will assess and document VS)
☐ If transfer considered, notify House Supervisor and ICU

**Blood Bank:**

☐ Prepare to issue additional blood products as needed – **stay ahead**

## ACT

**Establish team leadership and assign roles**

**Team leader** (OB physician + OB anesthesiologist, anesthesiologist and/or perinatologist and/or intensivist):

☐ **Order Massive Hemorrhage Pack** (RBCs + FFP + 1 apheresis pack PLTS—see note in right column
☐ **Move to OR** if not already there
☐ Repeat CBC/PLTS, Coag Panel II STAT and Chem 12 panel q 30-60 min

**Anesthesiologist** (as indicated):

☐ Arterial blood gases
☐ Central hemodynamic monitoring
☐ CVP or PA line
☐ Arterial line
☐ Vasopressor support
☐ Intubation
☐ Calcium replacement
☐ Electrolyte monitoring

**Primary nurse:**

☐ Announce VS and cumulative measured blood loss q 5-10 minutes
☐ Apply upper body warming blanket if feasible
☐ Use fluid warmer and/or rapid infuser for fluid & blood product administration
☐ Apply sequential compression stockings to lower extremities
☐ Circulate in OR

**Second nurse and/or anesthesiologist:**

☐ Continue to administer meds, blood products and draw labs, as ordered

**Third Nurse (or charge nurse):**

☐ Recorder

## THINK

**Selective Embolization (IR)**

**Interventions based on etiology not yet completed**

**Prevent hypothermia, academia**

**Conservative or Definitive Surgery:**

- Uterine Artery Ligation
- Hysterectomy

**For Resuscitation:**

**Aggressively Transfuse**

**Based on Vital Signs, Blood Loss**

**After the first 2 units of PRBCs use**

**Near equal FFP and RBC for massive hemorrhage:**

**4-6 PRBCs: 4 FFP: 1 apheresis Platelets**

**Unresponsive Coagulopathy:**

- Role of rFactor VIIa is very controversial. After 8-10 units PRBCs and coagulation factor replacement with ongoing hemorrhage, may consider risk/benefit of rFactor VIIa in consultation with hematologist or trauma surgeon

**Once Stabilized:** Modified Postpartum Management with increased surveillance; consider ICU

## UTEROTONIC AGENTS for POSTPARTUM HEMORRHAGE

| Drug | Dose | Route | Frequency | Side Effects | Contraindications | Storage |
|---|---|---|---|---|---|---|
| Pitocin® (Oxytocin) 10 units/ml | 10-40 units per 500-1000 ml, rate titrated to uterine tone | IV infusion | Continuous | Usually none<br>Nausea, vomiting, hyponatremia ("water intoxication") with prolonged IV admin.<br>↓ BP and ↑ HR with high doses, esp IV push | Hypersensitivity to drug | Room temp |
| Methergine® (Methylergonivine) 0.2 mg/ml | 0.2 mg | IM (**not** given IV) | -Q 2-4 hours<br>-If no response after first dose, it is unlikely that additional doses will be of benefit | Nausea, vomiting<br>Severe hypertension, esp. if given IV, which is not recommended | Hypertension, Preeclampsia, Cardiovascular disease<br>Hypersensitivity to drug<br>**Caution** if multiple doses of ephedrine have been used, may exaggerate hypertensive response w/possible cerebral hemorrhage | Refrigerate<br>Protect from light |
| Hemabate® (15-methyl PG F2a) 250 mcg/ml | 250 mcg | IM or intra-myometrial (**not** given IV) | -Q 15-90 min<br>-Not to exceed 8 doses/24 hrs<br>-If no response after several doses, it is unlikely that additional doses will be of benefit. | Nausea, vomiting, Diarrhea<br>Fever (transient), Headache<br>Chills, shivering<br>Hypertension<br>Bronchospasm | Caution in women with hepatic disease, asthma, hypertension, active cardiac or pulmonary disease<br>Hypersensitivity to drug | Refrigerate |
| Cytotec® (Misoprostol) 100 or 200 mcg tablets | 600-800 mcg | Sublingual or oral | One time | Nausea, vomiting, diarrhea<br>Shivering, Fever (transient)<br>Headache | Rare<br>Known allergy to prostaglandin<br>Hypersensitivity to drug | Room temp |

## BLOOD PRODUCTS

| | |
|---|---|
| **Packed Red Blood Cells (PRBC)**<br>(approx. 35-40 min. for crossmatch—once sample is in the lab and assuming no antibodies present) | Best first-line product for blood loss<br>1 unit = 200 ml volume<br>If antibody positive, may take hours to days. for crossmatch, in some cases, such as autoantibody crossmatch compatible may not be possible; use "least incompatible" in urgent situations |
| **Fresh Frozen Plasma (FFP)**<br>(approx. 35-45 min. to thaw for release) | Highly desired if > 2 units PRBCs given, or for prolonged PT, PTT<br>1 unit = 180 ml volume |
| **Platelets (PLTS)**<br>Local variation in time to release (may need to come from regional blood bank) | Priority for women with Platelets < 50,000<br>Single-donor Apheresis unit (= 6 units of platelet concentrates) provides 40-50 k transient increase in platelets |
| **Cryoprecipitate (CRYO)**<br>(approx. 35-45 min. to thaw for release) | Priority for women with Fibrinogen levels < 80<br>10 unit pack (or 1 adult dose) raises Fibrinogen 80-100 mg/dl<br>Best for DIC with low fibrinogen and don't need volume replacement<br>Caution: 10 units come from 10 different donors, so infection risk is proportionate. |

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# OB HEMORRHAGE REPORT

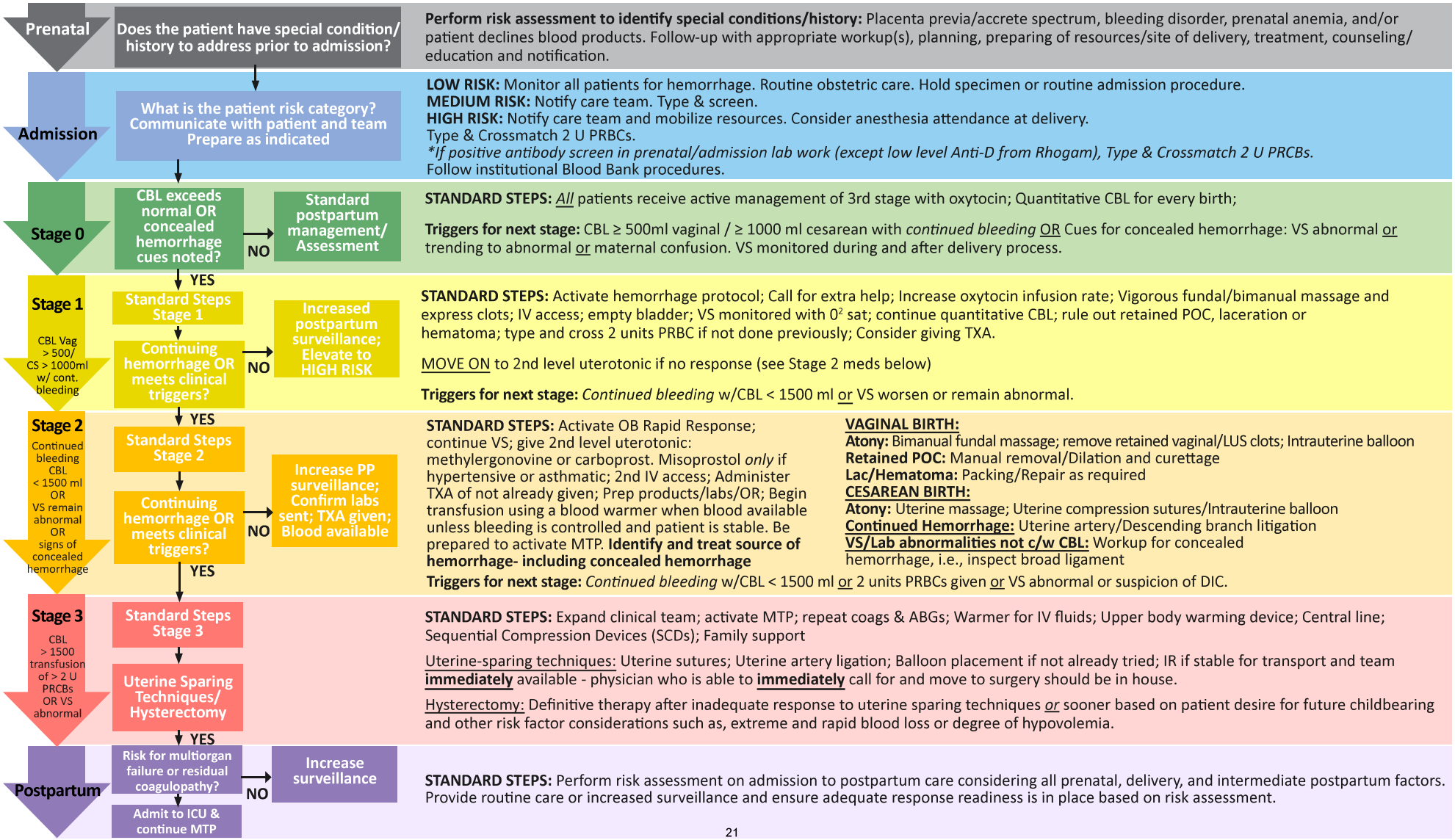
**Initiate at Stage 1:**
Blood loss >500 ml vaginal, 1000 ml cesarean OB
Vital Signs > 15% change or HR ≥110, BP ≤85/45. O2 Sat ≤95% OR
Increased bleeding during recovery, postpartum

Patient Addressograph

| MD Team Names | | | | Notified Time | Arrival Time | Date | | | Unit | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | History: | | | | | |
| | | | | | | | | | | | |
| | Time | | | | | | | | | | |
| Vital Signs | HR | | | | | | | | | | |
| | BP | | | | | | | | | | |
| | RR | | | | | | | | | | |
| | O2 sat | | | | | | | | | | |
| | EBL | | | | | | | | | | |
| | Mental Status | | | | | | | | | | |
| | Urine output | | | | | | | | | | |
| | Pain | | | | | | | | | | |
| MEDICATIO | Methergine | | | | | | | | | | |
| | Hemabate | | | | | | | | | | |
| | Misoprostol | | | | | | | | | | |
| | Pain Meds | | | | | | | | | | |
| | | | | | | | | | | | |
| IV & BLOOD PRODUCTS | LR | | | | | | | | | | |
| | NS | | | | | | | | | | |
| | Oxytocin IV drip | | | | | | | | | | |
| | RBCs | | | | | | | | | | |
| | FFP | | | | | | | | | | |
| | PLTS | | | | | | | | | | |
| | CRYO | | | | | | | | | | |
| | | | | | | | | | | | |
| LABS (note time drawn & results times) | Hemacue | | | | | | | | | | |
| | Hct/Hgb | | | | | | | | | | |
| | Platelets | | | | | | | | | | |
| | PT/PTT | | | | | | | | | | |
| | Fibrinogen | | | | | | | | | | |
| | ABG | | | | | | | | | | |
| PROCEDURE | Uterine balloon , Embolization, X-ray, Ultrasound, etc. | | | | | | | | | | |
| Outcome | | | | | | Disposition | | | | | |
| Primary nurse | | | | | R.N. | Other nurses | | | | | |
| Team Leader (MD) note: | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | MD Signature |

White copy – Chart
Yellow copy – Nurse Manager

# Appendix D: Obstetric Hemorrhage Care Guidelines: Flowchart Format **ERRATA 7.18.22**






*This figure was adapted from the Improving Health Care Response to Obstetric Hemorrhage: A California Quality Improvement Toolkit, funded by the California Department of Public Health, 2015; supported by Title V funds.*

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# Pain Medicine

Delineation of Privileges

Applicant's Name:

## Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group
3. Check off any special privileges you want to request
4. Sign form electronically and submit with any required documentation.

| Facilities |
|---|
| ☑ **PMH** |

| Required Qualifications | |
|---|---|
| **Membership** | Meet all requirements for medical staff membership |
| **Education/Training** | Completion of an ACGME or AOA accredited Residency training program in anesthesiology, neurology, child neurology or physical medicine and rehabilitation. |
| | **AND** Completion of an ACGME or AOA accredited Fellowship training program in Pain Medicine |
| **Continuing Education** | Applicant must have CME credits as required for licensure by the State of California directly related to the practice of Anesthesiology (waived for applicants who have completed residency training during the previous 24 months). |
| **Certification** | **OR** Applicant must be active in the MOC (maintenance of certification) program in pain medicine |
| | Current certification in Anesthesiology, Neurology, Child Neurology or Physical Medicine and Rehabilitation from the an American Board of Medical Specialties or American Osteopathic Association board. |
| | **AND** Current certification in Pain Medicine from an American Board of Medical Specialties or American Osteopathic Association board. |
| **Clinical Experience (Initial)** | Applicant must provide documentation of provision of pain medicine services (100 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year). |
| **Clinical Experience (Reappointment)** | Applicant must provide documentation of provision of clinical services (50 cases) representative of the scope and complexity of privileges requested during the past 24 months |
| **Additional Qualifications** | Current certification in ACLS PALS, etc. |

| Primary Privileges | |
|---|---|
| Evaluation, treatment, and rehabilitation of patients with non-procedural pain (i.e., chronic and cancer pain). | |
| | |
| **Request** | Click shaded blue check box to Request all privileges.<br>Uncheck any privileges you do not want to requests.<br><br>☐ - Currently Granted privileges |

| | |
|---|---|
| ☐ | Admit to inpatient or appropriate level of care |
| ☐ | Perform history and physical examination (for inpatient admission) |
| ☐ | Evaluate, diagnose, provide treatment, consultation and medically manage patients with non-procedural pain complaints (i.e., chronic and cancer pain). |
| | **Procedures** |
| ☐ | Discography |
| ☐ | Differential spinals and epidurals |
| ☐ | Facet injections |
| ☐ | Cervical nerve root injections |
| ☐ | Lumbar and thoracic nerve root injections |
| ☐ | Epidural and intrathecal injections |
| ☐ | Arthrocentesis and joint/bursae injection |
| ☐ | Chemoneurolysis |
| ☐ | Neuroablation -- all modes |
| ☐ | Peripheral nerve block |
| ☐ | Percutaneous therapeutic discal injections |
| ☐ | Percutaneous discectomy |
| ☐ | Trigger point injections |
| ☐ | Sympathetic ganglion blocks |
| ☐ | Use of botox |

| **FPPE** | |
|---|---|
| ☐ | Concurrent observation of one complex interventional pain management procedure |
| ☐ | Retrospective evaluation to include work-up, pain management plan and post-procedure course of events of 5 pain management procedures |
| ☐ | Evaluation of OPPE data collected for review of competency/performance |

| **Vertebroplasty and Kyphoplasty** |
|---|
| Vertebroplasty and kyphoplasty are minimally invasive procedures for the treatment of vertebral compression fractures (VCF), which are fractures involving the vertebral bodies that make up the spinal column. |
| |

## Qualifications

| | |
|---|---|
| **Education/Training** | Confirmation from pain medicine fellowship program director that applicant successfully completed training in the privileges requested including supervised experience on human subjects.<br>**OR** Confirmation that the applicant completed manufacturer designated training in the specific procedure requested with human subjects experience under the supervision of a qualified physician preceptor |
| **Clinical Experience (Initial)** | Applicant must provide documentation of provision of clinical services(5 cases) representative of the privileges requested during the previous year (waived for applicants who completed training during the previous year). |
| **Clinical Experience (Reappointment)** | Applicant must provide documentation of provision of clinical services (5 cases) representative of the privileges requested during the past 24 months. |

| Request | Click shaded blue check box to Request all privileges.<br>Uncheck any privileges you do not want to requests. |
|---|---|
| ☐ - Currently Granted privileges | |
| ☐ | Vertebroplasty |
| ☐ | Kyphoplasty |

| FPPE | |
|---|---|
| ☐ | Concurrent observation of one kyphoplasty procedure |
| ☐ | Concurrent observation of one vertebroplasty procedure |

## Pain Medicine Device Implantation

A specialized device which delivers medication directly to the area where pain can be managed. Patients who suffer from neuropathic pain, especially in the limbs, failed back surgery syndrome, complex regional pain syndrome, and sometimes chronic back pain, refractory angina pectoris, peripheral vascular disease may be candidates for spinal cord stimulation therapy. Patients with severe pain related to malignancy and patients with spascity as a result of multiple sclerosis, spinal cord injury, cerebral palsy and other neurologic disorders are candidates for intrathecal infusion pumps.

## Qualifications

| | |
|---|---|
| **Education/Training** | Confirmation from pain medicine fellowship program director that applicant successfully completed training in the privileges requested including supervised experience on human subjects.<br>**OR** Confirmation that the applicant completed manufacturer designated training in the specific procedure requested with human subjects experience under the supervision of a qualified physician preceptor |
| **Clinical Experience (Initial)** | Applicant must provide documentation of provision of clinical services (5 cases) representative of the privileges requested during the previous year (waived for applicants who completed training during the previous year). |
| **Clinical Experience (Reappointment)** | Applicant must provide documentation of provision of clinical services (5 cases) representative of the privileges requested during the past 24 months. |

| Request | Click shaded blue check box to Request all privileges.<br>Uncheck any privileges you do not want to requests.<br><br>☐ - Currently Granted privileges |
|---|---|
| ☐ | Spinal cord stimulator |
| ☐ | Peripheral stimulator |
| ☐ | Intrathecal infusion pump |
| ☐ | Analysis, reprogramming and refilling of implanted devices |

| FPPE | |
|---|---|
| ☐ | Concurrent observation of two procedures representative of the complexity of privileges requested. |

## Fluoroscopy

**Description:** Default to organization policy and definition. The following definition is provided as an example: Fluoroscopy is an imaging technique that uses X-rays to obtain real-time moving images of the interior of an object. In its primary application of medical imaging, a fluoroscope allows a physician to see the internal structure and function of a patient, so that the pumping action of the heart or the motion of swallowing, for example, can be watched.

### Qualifications

| | |
|---|---|
| **Education/Training** | The applicant must provide evidence of training and supervised experience during residency and/or fellowship OR if training occurred greater than 1 year ago the applicant must provide evidence of ongoing clinical practice. |
| **Clinical Experience (Initial)** | Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year). |
| **Clinical Experience (Reappointment)** | Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months. |
| **Additional Qualifications** | Current ACLS certification (will skills demonstration). |
| **Certification** | Requires certification by the California Department of Health. |

| Request | Click shaded blue check box to Request all privileges.<br>Uncheck any privileges you do not want to requests.<br><br>☐ - Currently Granted privileges |
|---|---|
| ☐ | Fluoroscopy |

## Applicant Acknowledgment

I have requested only those privileges for which, by education, training, current experience and demonstrated competency I am entitled to perform and that I wish to exercise at Pioneers Memorial Hospital.

I also understand that by making this request, I am bound by the applicable Medical Staff Bylaws and/or policies of Pioneers Memorial Hospital Services. I also attest that my professional liability insurance covers the privileges I have requested.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Applicant Signature PMH

| **Department Chair Recommendation - Privileges** | |
|---|---|
| I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): | |
| Privilege | Condition/Modification/Deletion/Explanation |

**Imperial Valley Healthcare District**

**BOARD MEETING DATE:** March 23rd, 2026

**SUBJECT:** Authorization to approve Medical Directorship Agreement for Rami Jirjis Urology P.C.

**BACKGROUND:** This agreement is for directorship services for the RHC's Urology health care activities

**KEY ISSUES:** Physician will be compensated at a base compensation of $1,500 per month with a maximum of 10 hours per month.

**CONTRACT VALUE:** not to exceed $18,000 annually.

**CONTRACT TERM:** 3 years

**BUDGETED:** Yes

**BUDGET CLASSIFICATION:** Directorship

**RESPONSIBLE ADMINISTRATOR:** Carly Zamora/Christopher R. Bjornberg

**DATE SUBMITTED TO LEGAL:** _____ **REVIEWED BY LEGAL:** [X] Yes [ ] No

**FIRST OR SECOND SUBMITTAL:** [X] 1st [ ] 2nd

**RECOMMENDED ACTION:** Authorization to approve Medical Directorship Agreement for Rami Jirjis Urology P.C.

# MEDICAL DIRECTOR AGREEMENT

THIS MEDICAL DIRECTOR AGREEMENT (the "**Agreement**") is entered into and executed as of March 1st ,2026 (the "**Effective Date**"), by and between Imperial Valley Healthcare District, dba Pioneers Memorial Hospital, a Local Healthcare District, organized and existing in the State of California pursuant to the California Health and Safety Code, § 32000 *et seq.* ("**Hospital**"), "), and Jirjis Urology P.C., a California Professional Corporation, which provides the services of Rami Jirjis, M.D., an individual licensed to practice medicine in the State of California ("**Director**"). Director and Hospital are sometimes individually referred to hereafter as a "Party," and collectively as "Parties." Services are expected to begin on March 1st, 2026 (the "**Service Start Date**").

## RECITALS

A. Hospital owns and operates a general acute care hospital located in Brawley, California and owns and operates various rural health clinics ("**RHCs**"), in Calexico, California and Brawley, California. By the Service Start Date, Hospital may also own and operate a second general acute hospital located in El Centro, California

B. The RHCs currently provide primary and specialty healthcare services through California-licensed Nurse Practitioners ("**NPs**"), Physician Assistants ("**PAs**"), and Physicians, who are independent contracts of Hospital.

C. The NPs and PAs serving in the RHCs require the oversight and assistance of a medical doctor licensed to practice medicine in the State of California, who can direct and oversee the medical operations of the RHCs.

D. Director is a Urologist, duly licensed to practice medicine in the State of California and is experienced and qualified to provide professional medical services at the RHCs.

E. Hospital desires to engage the Director to provide medical directors services for Urology components of the RHCs.

F. Director, having the requisite skills and background to provide the services sought herein, desires to enter into this Agreement with Hospital.

## AGREEMENT

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and for such other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged it is mutually agreed as follows:

1. Medical Director Services. Medical Director shall act as medical director of the Urology components of the RHCs and shall provide other professional services in accordance with the terms of this Agreement, and the RHCs' bylaws, policies, and procedures. Directorship services provided herein shall include the following:

a. Supervision and Oversight. Director will supervise and oversee the health services provided at the RHCs as outlined in ***Exhibit A*** ("**Medical Director Duties**") of this agreement. To facilitate the proper administration of this section and to assure the parties compliance with applicable state and federal law, Director shall complete and submit to Hospitals administrator on a monthly basis for the term of this Agreement, a time sheet (a copy of which is affixed to this Agreement as ***Exhibit B*** ("**Time and Activity Log**") and is incorporated herein by this reference) by the 10th day of the month after services describing the services performed and the amount of time expended in the prior month.

b. Development of New Services. Director will assist Hospital in developing and implementing new services for RHCs as appropriate for the changing needs of the community it serves.

c. Accreditation. Director shall meet with Hospital and RHCs personnel to assure that the RHCs' practices meet or exceed current Hospital and RHC accreditation guidelines as related to the operation of the Urology program at RHCs. Director shall further assist RHC personnel in preparing for accreditation surveys.

2. Director Availability and Reporting. Hospital hereby contracts with Director to act as its medical director of the Urology components of the RHCs, in connection with the services furnished by Director hereunder. Should Director be unavailable due to vacation plans, continuing medical education, or for any other reason for a period of two (2) or more weeks during the term of this Agreement, Director shall assist the Hospital in finding an appropriate physician to assume the Director's responsibilities set forth by this Agreement. This alternate physician shall be approved in writing, in advance, by the Hospital Administrator. To facilitate the proper administration of this section and to assure the parties compliance with applicable state and federal law, Director shall complete and submit to Hospitals administrator on a monthly basis for the term of this Agreement, a time sheet (a copy of which is affixed to this Agreement as ***Exhibit A*** ("**Time and Activity Log**") and is incorporated herein by this reference) by the 10th day of the month after services describing the services performed and the amount of time expended in the prior month.

. 3. No Personal Use of RHCs. Unless otherwise expressly agreed to in writing by Hospital, no part of the RHCs' premises shall be used at any time by Director as an office for personal use or for the private practice of medicine.

4. No Unauthorized Disclosure of Records. Director and Hospital agree to keep confidential and take all reasonable precautions to prevent the disclosure of records required to be prepared and/or maintained pursuant to this Agreement, unless such disclosure is authorized by patient or by law; provided, however, that to the extent required by 42 U.S.C.A. section 1395x(v)(1)(I) of Title II and any amendment thereto, revision or subsequent legislative enactment pertaining to the subject matter of said section, the parties agree to retain such records, and make them available for the appropriate governmental agencies, for a period of ten (10) years after the expiration of the termination of this agreement.

5. Establishment of Fees. The Hospital is solely responsible for establishing the fees for medical services.

6. Medical Director Compensation. Hospital shall pay Director according to the compensation schedule set forth in ***Exhibit C*** ("**Hours & Compensation**"). Hospital shall pay the compensation owed on or before the fifteenth (15th) day of each calendar month, for services provided by Practitioner during the immediately preceding calendar month; provided that Practitioner has delivered a visit record to Hospital in the form attached hereto as ***Exhibit B*** ("**Time Log**") on or before the fifth (5th) day of each calendar month for the immediately preceding calendar month.

7. Independent Contractor. Director is engaged as an independent contractor with Hospital in performing all work, duties, and obligations hereunder. Hospital shall not exercise any control or direction over the methods by which Director performs his work and functions, except that Director shall perform at all times in strict accordance with then currently approved methods and practices in Directors specialty. The Hospital's sole interest is to ensure that Director performs and renders services in a competent manner in accordance with medical and administrative standards. The parties expressly agree that no work, act, commission or omission of Director pursuant to the terms and conditions of this Agreement shall be construed to make or render Director an agent or servant of Hospital. Director shall not be entitled to receive vacation pay, sick leave, retirement benefits, Social Security, workers compensation, disability or unemployment insurance, or any other employee or pension benefit of any kind.

8. Insurance. Director shall provide and maintain current for the term of this Agreement, medical malpractice insurance as required by the Hospital Bylaws governing Hospital medical staff physicians in a minimum amount of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate. If the insurance coverage is "claims-made" rather than "occurrence-based", such coverage must be continued in the same amounts. However, if such coverage is terminated, Director shall at his expense provide Hospital with an extended reporting endorsement ("tail insurance") upon termination of this Agreement.

9. Term and Termination. The term of this Agreement shall be for three (3) years commencing on the Effective Date, unless terminated earlier as provided herein. This Agreement will automatically expire at the end of its current term unless extended in writing by mutual agreement of the parties neither party has any obligation to extend this Agreement beyond its current term.

a. Termination for Cause. Either Party may, for cause ("cause" being defined herein as a material breach of an obligation contained or set forth in this Agreement) terminate this Agreement, provided, however, that the breaching party has been provided with notice of the breach and has failed to cure said breach within fourteen (14) days of such notice.

b. Immediate Termination. The Hospital may terminate this Agreement immediately for the following reasons:

1. The revocation, restriction, suspension or termination of Director's license to practice medicine in the State of California.

2. Medical Director's malpractice insurance is cancelled, decreased or not renewed for any reason.

3. The attempted assignment or other unauthorized delegation of any of Director's duties or obligations hereunder.

4. The election of Director to file bankruptcy.

5. The revocation or suspension of Medical Staff privileges.

6. The failure of Director to provide the Directorship services.

7. The failure of Director to document his services in a form substantially similar to that in Exhibit B.

8. Medical Director's conviction of a felony crime or exclusion from participation in any state or federal health care program, including but not limited to Medicare or Medicaid.

9. Any material breach of this Agreement.

c. Early Termination Without Cause. Notwithstanding any other provisions of this Agreement, either party may terminate this Agreement for any reason with thirty (30) days advance written notice to the other party.

10. No Assignment by Director. Director shall not assign, sell, or transfer any rights conferred by this Agreement, without the prior written consent of Hospital.

11. Attorneys' Fees. The prevailing party in any legal action to enforce this Agreement shall be entitled to recover its costs and reasonable attorneys' fees in addition to any other relief granted.

12. No Waiver. Failure by either party to enforce any provision of this Agreement shall not constitute a waiver of such provision.

13. Severability. If any provision of this Agreement or the application thereof to any person or circumstance shall, at any time or to any extent, be invalid or unenforceable, the remainder of this Agreement shall not be affected thereby, and each such provision shall be valid and enforceable to the fullest extent permitted by law. However, if either party in good faith determines that the finding of illegality or unenforceability adversely affects the material consideration for its performance under this Agreement, such party at its sole option may, by giving written notice to the other party, terminate this Agreement.

14. Entire Agreement. This Agreement embodies the entire agreement between the parties hereto and supersedes all other previous agreements and understandings, written or oral, between the parties hereto. There are no other Agreements between the parties hereto as to the subject matter hereof other than those set forth in this Agreement.

15. Applicable Law and Venue. This Agreement shall be governed by and construed interpreted and enforced in accordance with the laws of the State of California. The venue for any legal proceeding relating to, or arising out of, this Agreement shall be in the County of Imperial, State of California.

16. Access to Records. Hospital agrees that during normal business hours in accordance with state and federal law, and only to the extent required by state and federal law, Director shall have access to and the right to examine records which relate to any services provided under this Agreement for a period of not less than two (2) years following the termination or expiration of this agreement. Upon written request of Director, such access shall be extended with respect to any records which Director identifies as the actual or potential matter of investigation or litigation.

17. Headings. Headings have been included solely as a convenience to the reader and are not intended nor shall they be construed in the interpretation of this Agreement.

18. Compliance with Non-Discrimination Laws.

a. Non-Discrimination. During the performance of this Agreement, Director and his subcontractors shall not unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Director and his subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. Director and his subcontractors

shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Division 4, Subchapter 1, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990(a-f), set forth in California Code of Regulations, Title 2, Division 4, Chapter 5, are incorporated into this contract by reference as if duly set forth herein. Director and his subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Director shall include the nondiscrimination and compliance provisions of this Agreement in all subcontracts to perform work under this Agreement.

b. Access to Determine Compliance. Director shall permit access by the representatives of the Department of Fair Employment and Housing and the Department of Corrections, upon reasonable notice at any time during normal business hours, but in no case less than twenty-four (24) hours notice, to such of its books, records, accounts, other sources of information and its facilities as such agencies shall require to ascertain compliance with this clause.

19. Access to Books and Records. Until the expiration of ten (10) years after the furnishing of any services pursuant to this Agreement, Director shall make available upon written request of the Secretary of the United States Department of Health and Human Departments or of the United States Comptroller General, or of any of their duly authorized representatives, this Agreement and such books, documents, and records of the Department as are necessary to certify the nature and the reasonable cost of services of the Hospital. If Director enters into an agreement with any related organization to provide services pursuant to this Agreement with a value or cost of ten thousand dollars ($10,000) or more over a twelve (12) month period, such agreement shall contain a clause to the effect that until expiration of ten (10) years after the furnishing of services pursuant to such agreement, the related organization shall make available, upon written request, of the Secretary or to the Comptroller General, or of any of their duly authorized representatives, the agreement and any books, documents, and records of such organization that are necessary to verify the nature and extent of such costs. This Section shall be of no force and effect if it is not required by law. Ownership of all records, books, and documents remains with the Hospital.

20. Notices.

Any notice to be given to any party hereunder shall be deposited in the United States Mail, duly registered or certified, with return receipt requested, with postage thereon paid, and addressed to the party for which intended, at the following addresses, or to such other address or addresses as the parties may hereafter designate in writing to each other.

Hospital: Chief Executive Office
Pioneers Memorial Hospital
207 Legion Road
Brawley, CA 92227

Director: Rami Jirjis M.D.

21. Confidentiality; HIPAA.

a. All records, files, proceedings and related information of Medical Director, Facility, and their providers pertaining to the evaluation and improvements of the quality of patient care at Facility shall be kept strictly confidential by Medical Director. Medical Director shall not voluntarily disclose such confidential information, either orally or in writing, except as expressly required by law or pursuant to written authorization by Facility. This provision shall survive the expiration and termination of this Agreement.

b. Except as otherwise provided herein, any and all records relating to the Administrative Services and produced as a result of either party's performance under this Agreement shall be and remain the property of Facility.

c. HIPAA.Director will comply with all confidentiality laws and requirements including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and California Civil Code Section 56.10 *et. seq*. as applicable.

22. Offset. In the event Director is indebted or financially obligated to Hospital for any reason and has failed to repay as required any such debt or obligation for 60 days or more, then Hospital in its sole discretion may offset the amount of such unpaid debt or obligation owed by Director from any compensation due and payable under this agreement to Director. Hospital shall provide Director written notice of the exercise of its offset rights under this paragraph at any time before, or at the time of exercise of the offset. Any offset(s) exercised by the Hospital shall not affect or change any other conditions or provisions of contracts or agreements between Hospital and Director. Further, Hospital's exercise of any offset shall not be considered a waiver of any interest or penalty amount due and payable to the Hospital from Director.

23. General Interpretation. The terms of this Agreement have been negotiated by the parties hereto and the language used in this Agreement shall be the language chosen by the parties hereto to express their mutual intent. This Agreement shall be construed without regard to any proscription or rule requiring construction against the party causing such instrument or any portion thereof to be drafted. No rule of strict construction will be applied against any person.

24. Retention of Professional and Administrative Responsibility. Hospital shall retain professional and administrative responsibility for the services rendered as outlined in this Agreement.

25. Compliance with Disclosure Requirements of Hospital's Conflict of Interest Code. In accordance with the California Political Reform Act, the Hospital has promulgated its Conflict of Interest Code ("Code"). By executing this Agreement, Director is a contract physician for purposes of the Code and is required by law to make certain disclosures each year of the term of this Agreement on Form 700 Statement of Economic Interests ("Form"). Hospital will provide Director with this Form annually. Director agrees to complete and return this Form timely each year as required by law. (Additional information can be obtained from the California Fair Political Practices Commission at (866) 275-3772 and www.fppc.ca.gov.)

26. Other Agreements between Director and Hospital. Hospital and Director may enter, or may have entered, into other agreements for services such as On-Call or Coverage Services Agreements. Such agreements are maintained in a contracts management system, and will be made available to any State or Federal entities that require access.

27. Compliance with Laws. Director shall comply with the policies and procedures of Hospital and the RHCs as may be in effect from time to time in his/her performance of the Medical Director Services. Director shall comply with all applicable laws, rules and regulations of all governmental authorities and accrediting agencies having jurisdiction over Facility, physicians, and/or this Agreement including all professional licensure and reimbursement laws, regulations and policies in his performance of the Medical Director Services.

28. Anti-Referral Laws. Nothing in this Agreement, or any other written or oral agreement, or any consideration in connection with this Agreement contemplates or requires the admission or referral of any patient to the RHCs. This Agreement is not intended to influence Director's judgment in choosing the proper care and treatment of patients.

IN WITNESS WHEREOF, the parties have fully executed this Agreement effective on the date first written above.

PIONEERS MEMORIAL HEALTHCARE DISTRICT:

By_____ Date_____
Christopher R. Bjornberg

DIRECTOR:

_____ Date_____
Rami Jirjis, M.D.

CORPORATION:

_____ Date_____

Jirjis Urology P.C.,
Owner

## EXHIBIT A

## MEDICAL DIRECTOR SERVICES

Director shall provide the following services, which include, but are not limited to, the following:

1) Supervision and oversight of health services provided by the health care staff
2) Provide medical direction and oversight of the Urology mid-level providers by being present in the RHC's at minimum every week for a minimum of 4 hours.
3) Ensures the annual review of practice guidelines/protocols designed to promote quality, safe and appropriate Urology patient care.
4) Leads the process to ensure provider quality via review of medical records, peer review, evaluation of operations and co-signing of medical records, if required, in accordance with California State regulations.
5) Is actively involved with department leadership in resolving patient grievances and complaints within the scope of the Urology services.
6) Is actively involved in the continuous development of the program's EHR (electronic health record) system and the functionality available to improve patient outcomes.
7) Supports department leadership in ensuring proper use of the EHR by Urology providers including the provider's compliance with documentation and billing standards/timelines.
8) Assists department leadership as needed with medical staff scheduling for the program
9) Oversees, recommends, and approves ongoing education for program providers.
10) Director shall be available to department providers and department leadership for consultation, assistance with urgent issues and other instances where program operation warrants the Director's intervention/participation.
11) Participate in meetings with department leadership to review operational considerations such as productivity, strategic initiatives, financial performance and staff development/concerns.
12) Be available (in person or by telephone) to prepare necessary medical orders and give emergency advice and assistance when needed.

**EXHIBIT B**

Imperial Valley Healthcare District
207 West Legion Road
Brawley, California 92227

**PHYSICIAN - TIME AND ACTIVITY LOG**

Physician's Name: _____

Hospital Department: _____

Month: _____

| Date | Services Performed | Time |
|---|---|---|
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I certify that I have performed the services set forth above and understand that this Time and Activity Log may be made available to law enforcement or other regulatory agencies to confirm compliance with applicable state and federal law if so requested.

Physician's Signature:_____ Date: _____

EXHIBIT C

**Hours & Compensation**

Hospital shall pay the Director an annual salary of eighteen thousand dollars ($18,000) which shall be paid in monthly installments of $1,500 per month.

Hospital anticipates that Director shall work, on average, ten (10) hours per month providing directorship duties pursuant to this agreement.

**Imperial Valley Healthcare District**

| Title:<br>**California Sick Leave** | Policy No. HRD-01398 |
|---|---|
| | Page 1 of 2 |
| Current Author: Estella Chavarin | Effective: 1/1/2024 |
| Latest Review/Revision Date: 3/2026 | Manual: Human Resources/Benefits |

| Collaborating Departments: Administration | | Keywords: Sick Leave, Benefits | |
|---|---|---|---|
| **Approval Route: List all required approval** | | | |
| MARCC x | PSQC | Other: | |
| Clinical Service _____ | MSQC | MEC | BOD x |

**Note:** *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

## 1.0 Purpose:

1.1 Imperial Valley Healthcare District provides paid California Sick leave to employees who have worked 30 or more days in California within a year of their employment with the company.

## 2.0 Scope: Full-Time, Part-Time, Per Diem employees.

## 3.0 Policy:

3.1 Eligibility:

3.1.1 An employee becomes eligible for paid sick leave by working in California for at least 30 days within a year. Before an employee can take any sick leave, he or she must satisfy a 90-day employment period at IVHD.

3.1.2 CA sick leave hours may be used at the employee's discretion.

3.1.3 Current employees and newly hired employees will receive a lump-sum grant of 40 hours or 5 days on 4/1. This CA Sick bank will then be repopulated into the employees' CA sick bank on April 1st of each subsequent year if the employee remains eligible.

3.1.4 Paid sick leave may be used after an employee has worked for the district for at least 90 days. Unused sick leave granted under this policy does not carry over from one year to the following year and will not be paid upon status change or termination.

3.1.5 As of 12/31 of each year or upon hire, whatever work schedule is assigned whether classified as an 8-, 10- or 12-hour employee will determine their CA sick leave allocation for the next year.

3.1.6 Leave under this policy may run concurrently with leave taken under other applicable policies as well as under local, state or federal law, including leave taken pursuant to the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

## 4.0 Definitions:

4.1 An immediate family member includes:

4.1.1 Spouses registered domestic partners, children (regardless of age), parents (including step-parents and parents-in-law), grandparents, grandchildren, siblings or a designated person.

**5.0 Procedure:**

5.1 After successfully completing 90 days of employment at IVHD, eligible employees may begin to request time off under CA sick leave in increments of no less than two hours, up to a maximum of 40 hours or 5 days per calendar year.

5.2 If the need for paid sick leave is foreseeable, the employee shall provide reasonable advance notification to their supervisor. If the need for paid sick leave is unforeseeable, the employee shall provide notice of the need for the leave as soon as practicable.

5.3 Employees will not be requested to provide a physician's note in support of the leave taken.

5.4 Unused time under this policy is not paid out at the time of separation from employment.

5.5 Sick leave balances are available for viewing on the employee's pay stub and in the human resources self-service information systems.

**6.0 References:**

6.1 Healthy Workplace Healthy Family Act (AB 1522)

**7.0 Attachment List:** Not applicable

**8.0 Summary of Revisions:**

8.1 Updated 3.1.3 to April 1 from January 1

8.2 Updated PMHD to IVHD

**IMPERIAL VALLEY HEALTHCARE DISTRICT**

**BOARD MEETING DATE:** March 26, 2026

**SUBJECT: Premier – Acute Care Membership Application**

**BACKGROUND: IVHD's current GPO is HealthTrust Purchasing Group, while ECRMC utilizes Premier as its GPO. A market basket analysis was conducted to compare pricing between the two organizations and support the selection of a new GPO for IVHD. Based on this evaluation, Premier was chosen due to its highly competitive pricing and strong customer support.**

**KEY ISSUES:**

1. **Cost Savings Opportunities: Transitioning to Premier offers access to more competitive pricing identified through the market basket analysis, creating potential for meaningful cost reductions.**

2. **Enhanced Customer Support: Premier is recognized for strong customer service, which can improve issue resolution times and overall support for procurement operations.**

3. **Contract Optimization: The transition allows IVHD to align with more favorable contracts, potentially expanding access to high-quality products at better value.**

4. **Standardization Across Facilities: Aligning with ECRMC's existing GPO, Premier, creates opportunities for greater standardization of supplies and processes across both organizations.**

5. **Improved Vendor Relationships: Leveraging Premier's network may strengthen vendor partnerships and improve service levels.**

6. **Data & Analytics Access: Enhanced reporting and analytics tools can support better purchasing decisions and identify additional cost-saving opportunities over time.**

7. **Operational Efficiencies: Streamlining procurement processes under a single GPO can reduce administrative burden and improve overall efficiency.**

8. **Scalability & Future Growth: Partnering with Premier positions IVHD to scale purchasing strategies effectively as organizational needs evolve.**

**CONTRACT VALUE: $15,000,000/yr**

**CONTRACT TERM: Five Years**

**BUDGETED: Yes**

**BUDGET CLASSIFICATION: Medical Supplies**

**RESPONSIBLE ADMINISTRATOR: Carly Loper**

**DATE SUBMITTED TO LEGAL:** 3/11/2026 **REVIEWED BY LEGAL:** [X] Yes [ ] No

**FIRST OR SECOND SUBMITTAL:** [X] 1st [ ] 2nd

**RECOMMENDED ACTION:** **Approve:** Premier – Acute Care Membership Application

# ACUTE CARE MEMBERSHIP APPLICATION

## Section I - Participating Member Information: *(All Fields In This Section Are Required)*

| | | | |
|---|---|---|---|
| Participating Member Facility Name: IMPERIAL VALLEY HEALTH CARE DISTRICT | | | Primary Contact Name: CARLY LOPER |
| Street Address *(No P.O. Boxes Please)*: 207 W LEGION ROAD | | Ste.: | Primary Contact Title: CFO |
| City: BRAWLEY | State: CA | Zip code: 92227 | Primary Contact Phone Number: 7603513594 |
| Member Phone Number: 7603513333 | | | Primary Contact Email: cloper@iv-hd.org |
| Website: https://pmhd.org/ | | | |

Agreement Effective Date ("Start Date"): _____

Go Live Date: _____

## Section II - Member Primary Service: Please choose one below *(Required)*

| | | |
|---|---|---|
| ☒ Children's Medical | ☐ Healthcare Corporate Office | ☐ Orthopedic Hospital |
| ☒ Critical Access | ☐ Healthcare Management Svc Org | ☐ Psych/Mental Health Hospital |
| ☐ Eye, Ear, Nose and Throat | ☒ Long Term Acute Care | ☐ Other (Specify): _____ |
| ☒ General Medical and Surgical | ☒ Maternity Hospital | **Total # Acute Staffed Beds**: 107 |

## Section III - Sponsor/Parent Information:

| | |
|---|---|
| Sponsor Name: | Direct Parent Name (parent company, if different from Sponsor): |
| Sponsor Entity Code: | Direct Parent Entity Code: |

**Participating Member's Relation to Direct Parent[1]** ***(If No Direct Parent, Indicate Participating Member Relation to Sponsor):***

☐ Owned ☐ Leased ☐ Managed ☒ Affiliated (Not Owned, Leased or Managed)

***Required to be completed by Sponsor:*** **Sponsor has reviewed the governmental exclusionary lists as required by Premier's policies and Participating Member does not appear on any such list:** ☐ **Agree** ☐ **Disagree**

## Section IV – Additional Information

| | |
|---|---|
| Estimated Annual Supply Spend: $ 15000000 | Current/Previous GPO: HPG |

**[1]Definitions for the types of member facilities relationships (collectively, the "Child Sites"):**

**OWNED:** A facility is considered to be owned if the Sponsor or Parent directly or indirectly holds (1) a majority of the equity or corporate membership interests in the facility or the power to appoint a majority of such facility's governing board or (2) a significant interest (which may be less than a majority of the total equity) sufficient to enable operational control and such facility is willing to designate Premier Healthcare Alliance, L.P. as its primary group purchasing organization.

**LEASED:** A facility is considered to be leased if it is leased and operated by its Sponsor or Parent.

**MANAGED:** A facility is considered to be managed if the Sponsor or Parent manages such facility in whole or in part (including at a minimum, the supplies purchasing function).

**AFFILIATED:** A facility is considered to be affiliated if the Sponsor or Parent formally sponsors the facility for participation in Premier's group purchasing organization, but does not own, lease or manage it.

## TERMS CONDITIONS AND SIGNATURES (THE "AGREEMENT")

**By signing below, Participating Member agrees that:**

A. Participating Member hereby designates Premier Healthcare Alliance, L.P. ("Premier") to act as Participating Member's group purchasing agent for the products and services (collectively, "Products") purchased by Participating Member through the Premier group purchasing program ("Program").

B. Participating Member will use Premier as its primary group purchasing organization.

C. Participating Member will use all Products it purchases under group purchasing contracts of Premier and, if applicable, the sponsor named on the first page of this Agreement ("Sponsor") solely for its own operations and will not re-sell any such Products (except to the extent Participating Member is a DME provider or retail pharmacy that is purchasing from Program vendors ("Vendors") who offer pricing to DME providers and/or retail pharmacies with the expectation that Products will be re-sold).

D. Participating Member (and Participating Member's agents, employees and representatives) shall keep confidential Premier's and Sponsor's proprietary and confidential information and shall not disclose such information to any third parties other than Premier's affiliates, Sponsor or Participating Member's employees with a need to know (who have been made aware of this provision by Participating Member and agree to comply with it). Such confidential information includes without limitation Premier's and Sponsor's plans, reports, proposals, agreements, organizational documents, clinical studies, software, pricing information, and contract catalogs (printed and electronic). Participating Member's obligation to maintain the confidentiality of such information shall remain in effect continuously throughout the period of Participating Member's membership in Premier and for a period of five (5) years thereafter.

E. Participating Member will sign the Facility Authorization and Vendor Fee Agreement attached as Exhibit A. The signed original of the Facility Authorization and Vendor Fee Agreement should be returned to Premier as soon as possible and a copy retained by Participating Member for its records. Notwithstanding approval of Participating Member's application to become a member in Premier, Participating Member will not have the right to participate in Premier's Program and Sponsor's group purchasing program until the Facility Authorization and Vendor Fee Agreement has been signed and returned to Premier. Execution of the Facility Authorization and Vendor Fee Agreement is required for compliance with the regulatory safe harbor for group purchasing organizations under the Federal Medicare Anti-Fraud and Abuse Statute, codified at 42 C.F.R. § 1001.952(j).

F. In the event Participating Member is subject to applicable open records laws (such as a federal, state or municipal agency) which may require Participating Member to release confidential or proprietary information of Premier or Sponsor, Participating Member agrees to promptly notify Premier and/or Sponsor, as applicable, of any request under such laws for the release of such information. Further, Participating Member shall cooperate in good faith with Premier and Sponsor and use its best efforts to assist Premier and Sponsor in preventing the release of such information to the extent consistent with applicable law.

G. Participating Member hereby acknowledges that the discounts available under Premier Vendor contracts in the Program may be exclusive and that its access to, or acceptance of, any incentives or rebates under separate programs may impact the discounts available to it under Premier Program contracts.

H. Participating Member represents and warrants that it (and its officers, directors and employees) are not listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in any federal and/or state programs. Premier and/or Sponsor may terminate Participating Member from participation in the Program immediately in the event at any point Participating Member is not in compliance with this representation and warranty. Termination is in addition to any other rights or remedies Premier and Sponsor may have at law or in equity.

I. Participating Member acknowledges that rebates or discounts it may receive from Vendors as part of its participation in the Program are, for purposes of 42 C.F.R. Section 1001.952(h), "discounts or other reductions in price" and Participating Member is required to disclose the specified dollar value of any such discounts or reductions in price under any state or federal program which provides cost or charge-based reimbursement to such Participating Members.

J. Participating Member acknowledges and agrees that by entering into this Agreement, the parties have not established, and do not intend to establish, a "business associate" relationship, as such term is defined under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA"). Under no circumstances will Premier request from Participating Member, nor will Participating Member provide to Premier, "protected health information," as such term is defined in HIPAA. For the avoidance of doubt, Participating Member agrees that Premier is not engaging any supplier as its downstream business associate.

K. Participating Member represents and warrants that its execution and performance of this Agreement does not conflict with or violate any other agreement or obligation to which Participating Member is subject or by which it is bound.

L. Participating Member acknowledges and agrees that Premier, its affiliates and their respective directors, officers, employees and agents will not be liable for the acts or omissions of Premier's contracted Vendors, or for any representations or warranties made by such Vendors.

M. Participating Member confirms that all information supplied by Participating Member to Premier and Sponsor is complete and accurate.

N. Participating Member authorizes Premier and Sponsor to individually activate group purchasing contracts in the Program on its behalf.

O. If Participating Member is a Multi-Facility System, Participating Member will list on Exhibit D attached to this Agreement the facilities that it intends to serve as Child Sites subject to the terms of this Agreement. Participating Member may update the Child Site list upon written notice to Premier consistent with the terms of this Agreement. Participating Member represents that it has authority over all purchases, including liability for payment of invoices, for each Child Site listed and that it has the authority to sign and bind each Child Site to the terms of this Agreement. In such case, Participating Member and each such Child Site shall be bound by the terms of this Agreement.

P. In addition to compliance with the terms and conditions contained in this Agreement, Participating Member shall comply with all Premier policies pertinent to the Program.

Q. If Participating Member wishes to participate in the Premier foodservice Program, the terms and conditions of Exhibit E shall apply.

R. Participating Member will receive any applicable Vendor rebates that are earned from purchases through the Premier Program via Electronic Funds Transfer (EFT). Please complete the Direct Deposit Via ACH Form and IRS Form W-9.

| | |
|---|---|
| Signature of Participating Member | Signature of Sponsor |
| CARLY LOPER | |
| Printed Name of Participating Member | Printed Name of Sponsor |
| CFO | |
| Title | Title |
| Date | Date |

**Email the completed application and exhibits to Rosters@PremierInc.com.**

**COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE ACCEPTANCE BY PREMIER.**

## EXHIBIT A – FACILITY AUTHORIZATION & VENDOR FEE AGREEMENT

### Participating Member Information:

| |
|---|
| Participating Member Facility Name ("Participating Member"):<br>IMPERIAL VALLEY HEALTH CARE DISTRICT |
| Street Address *(No P.O. Boxes Please)*:<br>207 W LEGION ROAD |
| City:<br>BRAWLEY |
| State:<br>CA |
| Zip code *(+4 if available)*:<br>92227 |

Participating Member and Premier Healthcare Alliance, L.P. ("Premier") hereby agree as follows:

**PURCHASING AGENT FOR PURPOSES OF PARTICIPATING IN GROUP PURCHASING PROGRAMS**
Premier and Sponsor, if applicable, are each authorized to act as a purchasing agent for Participating Member and any Child Sites that are added to Exhibit D as it may be amended from time to time.

**ADMINISTRATIVE FEE**
Participating Member is hereby notified that Vendors pay to Premier an administrative fee, which is a percentage of the purchase price of Products that Participating Member purchases from such Vendors, which may be apportioned between Premier and Sponsor pursuant to a separate agreement. Administrative fees will be noted in a report located in Premier's online member portal.

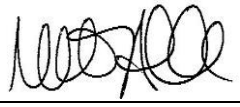
**ANNUAL DISCLOSURE OF ADMINISTRATIVE FEES**
Except as otherwise directed, Premier shall provide written notice on at least an annual basis to Participating Members that are healthcare providers of service[1] of the amount of administrative fees that Premier has received from Vendors with respect to purchases made by or on behalf of such Participating Member.

Signature of Participating Member

CARLY LOPER
Printed Name Date

CFO
Title

**ACKNOWLEGED BY PREMIER HEALTHCARE ALLIANCE, L.P.**
**By: Premier Healthcare Solutions, Inc.,**
**Its: General Partner**



Premier Authorized Signature

**Michael Alkire, President and CEO**
Printed Name, Title

[1] As defined in Section 1861(u) of the Social Security Act.

## EXHIBIT B – PHARMACY PROGRAM REQUIREMENTS - ACUTE AND HEALTH SYSTEM

| IVHD | AP9188651 | DSH050342 | 1100094257409 |
|---|---|---|---|
| Facility Name | DEA # | HIN # | GLN # |

PLEASE INCLUDE COPY OF DEA CERTIFICATE WHEN SUBMITTING APPLICATION

**PHARMACY START DATE*:** _____ *(*If there is an existing contract with another service provider, the start date may be delayed until after the expiration of the existing contract.)*

**Please check one which applies:**

| | | |
|---|---|---|
| ☒ Acute | ☐ Long Term Care | ☐ Prison / Correctional Provider |
| ☐ Government | ☐ LTC Closed Door Provider with Specialty | ☐ Retail |
| ☐ Infusion Closed Door | ☐ LTC Combo Provider | ☐ Retail Closed Door |
| ☐ Infusion Closed Door with Specialty | ☐ LTC Combo Provider with Specialty | ☐ Retail with Specialty |
| ☐ Infusion Combo | ☐ Mail Order | ☒ Specialty Pharmacy |
| ☐ Infusion Combo with Specialty | ☐ Non Acute Non Retail | |
| ☐ Infusion Suite | ☐ Physician Practice | |

- Participating Member agrees that it shall not purchase pharmaceutical Products through any other group purchasing organization during the term of this Agreement. In cases where Premier has not contracted for certain items required by Participating Member, Participating Member is encouraged to contact Premier so that those items may be added to the Premier portfolio of contracted Products.
- Participating Member designates the below listed wholesaler to be its prime vendor for purchasing pharmaceuticals Products under the Pharmacy Program. Participating Member further authorizes the below listed wholesaler to release total purchase data to Premier. Nothing contained in this Agreement shall prohibit Participating Member from purchasing Products through any wholesaler's or distributor's house contracts or source programs for non-injectable generic products.
- Participating Member represents that all pharmaceutical Products purchased under Premier group purchasing contracts are for Participating Member's own operations, excluding operations which compete with retail trade. If Participating Member is a Multi-Facility System, Participating Member also represents that all pharmaceutical Products purchased under Premier group purchasing contracts by Child Sites in Participating Member's system are for each such Child Site's own operations, excluding operations which compete with retail trade. If Participating Member competes with retail trade, Participating Member acknowledges that it will be eligible to purchase pharmaceutical Products through the Program only from Premier Vendors that offer pricing to the Participating Member with the expectation and understanding that such Products will be re-sold.
- Participating Member understands that each Vendor contract and each wholesaler contract in the Program has individual terms and conditions.

Former Purchasing Group: HPG Termination Date: MARCH 6, 2026

**Primary Designated Wholesaler**

Name

**Secondary Designated Wholesaler**

Name

**Signature of Member's Pharmacy Director or Other Authorized Person**

CARLY LOPER
Printed Name

| Pharmacy Service Provider Classification | Description |
|---|---|
| ACUTE | Acute care hospitals (including both acute and sub-acute beds) that use pharmaceuticals for their own operations, excluding operations which compete with retail trade. |
| NON ACUTE NON RETAIL | Health facilities that have no (or few) acute care beds and use pharmaceuticals for their own operations, excluding operations which compete with retail trade. Such facilities include, but are not limited to ambulatory surgery centers, diagnostic imaging centers, rehabilitation facilities, clinics, and hospices. |
| Long Term Care | A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living. |
| Prison/Correctional Provider | Provides pharmaceuticals to inmates in a correctional facility. A “Closed Door” pharmacy has no sales to the general public |
| LTC Closed Door Provider with Specialty | Provides pharmaceuticals to nursing homes, hospices, skilled nursing facilities, assisted living facilities, sub-acute facilities, group homes and/or other facilities that are sold and billed to end users or their agent. A “Closed Door” pharmacy has no sales to the general public. Provider also dispenses specialty drugs (high cost and/or high maintenance infusion, injectable, oral or inhaled therapies that require complex care on an ongoing basis.) |
| LTC Combo Provider | Provides pharmaceuticals to nursing homes, hospices, skilled nursing facilities, assisted living facilities, sub-acute facilities, group homes and/or other facilities that are sold and billed to end users or their agent. Provider also services retail patients. |
| LTC Combo Provider with Specialty | Provides pharmaceuticals to nursing homes, hospices, skilled nursing facilities, assisted living facilities, sub-acute facilities, group homes and/or other facilities that are sold and billed to end users or their agent. Provider also services retail patients and dispenses specialty drugs (high cost and/or high maintenance infusion, injectable, oral or inhaled therapies that require complex care on an ongoing basis.) |
| Infusion Closed Door | Provides infusion therapy services, which are administered in a home setting, at the provider's premises or at a physician's office. Infusion Therapy is defined as the way that liquid solutions or liquid medications are administered directly into the blood stream through an intravenous catheter inserted in a vein in the body. Infusion therapies can include total parenteral nutrition, antibiotics or other drugs, blood, and chemotherapy. Must have a valid DEA certificate and pharmacy license. A "Closed Door" pharmacy has no sales to the general public. |
| Infusion Closed Door with Specialty | Provides infusion therapy services, which are administered in a home setting, at the provider's premises or at a physician's office. Infusion Therapy is defined as the way that liquid solutions or liquid medications are administered directly into the blood stream through an intravenous catheter inserted in a vein in the body. Infusion therapies can include total parenteral nutrition, antibiotics or other drugs, blood, and chemotherapy. Must have a valid DEA certificate and pharmacy license. A "Closed Door" pharmacy has no sales to the general public. Provider also dispenses specialty drugs (high cost and/or high maintenance infusion, injectable, oral or inhaled therapies that require complex care on an ongoing basis.) |
| Infusion Combo | Provides infusion therapy services, which are administered in a home setting, at the provider's premises or at a physician's office. Infusion Therapy is defined as the way that liquid solutions or liquid medications are administered directly into the blood stream through an intravenous catheter inserted in a vein in the body. Infusion therapies can include total parenteral nutrition, antibiotics or other drugs, blood, and chemotherapy. Must have a valid DEA certificate and pharmacy license. Provider also services retail patients. |
| Infusion Combo with Specialty | Provides infusion therapy services, which are administered in a home, at the provider's premises or at a physician's office. Infusion Therapy is defined as the way that liquid solutions or liquid medications are administered directly into the blood stream through an intravenous catheter inserted in a vein in the body. Infusion therapies can include total parenteral nutrition, antibiotics or other drugs, blood, and chemotherapy. Must have a valid DEA certificate and pharmacy license. Provider also serves retail patients and dispenses specialty drugs (high cost and/or high maintenance infusion, injectable, oral or inhaled therapies that require complex care on an ongoing basis.) |
| Infusion Suite | Provides infusion therapy services, in an outpatient infusion suite setting. Infusion Therapy is defined as the way that liquid solutions or liquid medications are administered directly into the blood stream through an intravenous catheter inserted in a vein in the body. Infusion therapies can include total parenteral nutrition, antibiotics or other drugs, blood, and chemotherapy. Must have a valid DEA certificate and pharmacy license. |
| Mail Order | A closed door pharmacy that provides home delivery of prescriptions for patients with chronic conditions. Provider also dispenses specialty drugs (high cost and/or high maintenance infusion, injectable, oral or inhaled therapies that require complex care on an ongoing basis.) |
| Physician Practice | A certified and licensed physician office and business unit that engages in the diagnosis and /or management of patients, including but not limited to, oncology, pediatrics, immunology, neurology related diseases, purchase, preparation, dispensing, administration, management, and billing of diagnostics and therapy. |
| Retail | Provides prescription and over the counter drugs as well as other health related items to patients discharged from the hospital and to the general public. |
| Retail Closed Door | Provides prescription and over the counter drugs as well as other health related items to patients discharged from the hospital, employees and their covered entities. |
| Retail with Specialty | Provides prescription and over the counter drugs as well as other health related items to patients discharged from the hospital and to the general public. Provider also dispenses specialty drugs (high cost and/or high maintenance infusion, injectable, oral or inhaled therapies that require complex care on an ongoing basis.) |
| Specialty Pharmacy | Specialty pharmacies dispense and deliver specialty drugs to patients. They may also perform services for patients. Such services include, but not limited to managing reimbursement, performing case management and providing patient education. |
| GOVERNMENT | 1. Non-federal government entities or agencies providing health benefits (drug) to state/county/municipal employees on a self-insured or self-funded basis.<br>2. Entities that meet the definition of non-profit as defined by Internal Revenue Service code 501(c)(9) that provide health benefits on a self-insure or self-funded basis via Taft-Hartley Trust Funds and is tax exempt. |

## EXHIBIT C – CONTACT PROFILE

Please provide contact information in the table below (or in the attached Excel file) for anyone within your facility(s) interested in receiving communications from Premier. If left blank, the default contact will be the Primary Contact listed on Page 1.

Exhibit C - Contact Profile

| **Contact 1** | **Contact 2** | **Contact 3** |
|---|---|---|
| Full Name<br>DAVID MOMBERG | Full Name<br>Yvette Lewis | Full Name<br>KENNETH LE |
| Title<br>CFO | Title<br>Director of Materials Management | Title<br>DIRECTOR OF PHARMACY |
| Organization Name<br>ECRMC | Organization Name<br>IVHD | Organization Name<br>ECRMC AND IVHD |
| Address<br>1415 ROSS AVENUE | Address<br>207 W LEGION ROAD | Address<br>1415 ROSS AVENUE |
| City, State, and Zip<br>EL CENTRO, CA 92243 | City, State, and Zip<br>BRAWLEY, CA 92227 | City, State, and Zip<br>EL CENTRO, CA 92243 |
| Phone<br>760-339-7124 | Phone<br>760-351-4656 | Phone<br>7603397180 |
| Fax | Fax | Fax |
| Email<br>david.momberg@ecrmc.org | Email<br>ylewis@iv-hd.org | Email<br>Kenneth.Le@ecrmc.org |
| **Contact 4** | **Contact 5** | **Contact 6** |
| Full Name<br>JENNA MIDDLETON | Full Name<br>ANNABEL C. LIMENTANG | Full Name |
| Title<br>DIETARY DIRECTOR | Title<br>DIRECTOR LAB SERVICES | Title |
| Organization Name<br>IVHD | Organization Name<br>IVHD | Organization Name |
| Address<br>207 W LEGION ROAD | Address<br>207 W LEGION ROAD | Address |
| City, State, and Zip<br>BRAWLEY, CA 92227 | City, State, and Zip<br>BRAWLEY, CA 92227 | City, State, and Zip |
| Phone<br>7603513268 | Phone<br>760 351 3274 | Phone |
| Fax | Fax | Fax |
| Email<br>jmiddleton@iv-hd.org | Email<br>alimentang@iv-hd.org | Email |
| **Contact 7** | **Contact 8** | **Contact 9** |
| Full Name | Full Name | Full Name |
| Title | Title | Title |
| Organization Name | Organization Name | Organization Name |
| Address | Address | Address |
| City, State, and Zip | City, State, and Zip | City, State, and Zip |
| Phone | Phone | Phone |
| Fax | Fax | Fax |
| Email | Email | Email |

## EXHIBIT D – LIST OF CHILD SITES

Please use the form attached below to list all Child Sites that will be receiving Products through the Premier Program that meet the following requirements below:

1. **The Participating Member has legal authority to sign and bind the Child Site to Program contracts, including the terms of this Agreement.**

2. **The Participating Member has control over all supply chain and purchased services for the Child Site.**

If either of the requirements above are not met, the Child Site must complete its own, separate Membership Application.

Exh D - Sch 1 List of Child Sites_11-10-23.x

By submitting Exhibit D to Premier, Participating Member certifies that the responses listed on Exhibit D are true and accurate.

Participating Member authorizes and designates its Sponsor, distributor/wholesaler or other agent to add new Child Sites by submitting to Premier a list of new Child Sites on the attached form or by other written communication for the same purpose. Participating Member acknowledges and agrees that by making or authorizing any such future submissions of Child Site(s), unless expressly stated otherwise in the applicable submission, Participating Member certifies that it (1) has legal authority to sign and bind the Child Site(s) to contracts, including the terms of this Agreement, and (2) has control over all supply chain and purchased services for the Child Site(s).

Signature of Participating Member

CARLY LOPER

Printed Name Date

CFO

Title

## EXHIBIT E – FOODSERVICE PROGRAM REQUIREMENTS

If participating in the Foodservice Program, Participating Member agrees to the following Foodservice Program terms and conditions:

A. Participating Member agrees to utilize the Program's authorized foodservice distributor (the "Authorized Distributor") as its prime Vendor for foodservice distribution, with the intent to purchase a minimum of eighty percent (80%) of its annual food requirements for the Products(s) available from Premier's Authorized Distributor (as measured in dollars). Participating Member authorizes Premier to disclose this Agreement to the Authorized Distributor as part of the Program.

B. Participating Member agrees to comply with the participation requirements of the Premier foodservice distribution Program and Vendor programs.

C. Participating Member agrees, upon termination of its participation in the Program, to promptly purchase or cause a third party to promptly purchase any remaining inventory of specially ordered and/or proprietary Products stocked exclusively for the Participating Member.

D. Participating Member will receive applicable Vendor rebates that are earned from purchases through Vendors participating in the Program via Electronic Funds Transfer (EFT). Participating Member agrees to complete Premier's Rebate ACH Direct Deposit Enrollment Form. Participating Member is advised that Premier and its affiliates do not retain any portion of the Vendor rebates (excluding the administrative fee) generated by Participating Member purchases through the Program.

E. Participating Member hereby acknowledges that the discounts available under Program contracts are exclusive of any additional incentives or rebates that may be offered by contracted Vendors under separate programs. Participating Member hereby agrees not to attempt to access such other incentives or rebates to the extent the applicable Products purchased by Participating Member are purchased under Program contracts.

**SIXTH AMENDMENT TO PROFESSIONAL SERVICES AGREEMENT BETWEEN IMPERIAL VALLEY HEALTHCARE DISTRICT AND BERKELEY RESEARCH GROUP, LLP FOR FINANCIAL STRATEGIST SERVICES**

**THIS SIXTH AMENDMENT TO PROFESSIONAL SERVICES AGREEMENT** (this "**Sixth Amendment**") is entered into by and between **IMPERIAL VALLEY HEALTHCARE DISTRICT** ("**IVHD**"), and **BERKELEY RESEARCH GROUP, LLC** ("**CONTRACTOR**"), an independent contractor, collectively referred to herein as "**parties**" or individually as "**party**," dated effective as of March 26, 2026.

**RECITALS**

A. IVHD and Contractor are parties to that certain Professional Services Agreement having an Effective Date of September 10, 2024 (the "**Professional Services Agreement**").

B. IVHD and Contractor executed an Amendment to this Professional Services Agreement on December 12, 2024, to increase the Payment Cap in the Professional Services Agreement to Three Hundred Fifty Thousand Dollars ($350,000.00).

C. IVHD and Contractor executed a Second Amendment to this Professional Services Agreement on February 21, 2025, to increase the Payment Cap in the Professional Services Agreement to Five Hundred Fifty Thousand Dollars ($550,000.00).

D. IVHD and Contractor executed a Third Amendment to this Professional Services Agreement on June 12, 2025, to increase the Payment Cap in the Professional Services Agreement to Eight Hundred Thousand Dollars ($800,000.00).

E. IVHD authorized a Fourth Amendment to this Professional Services Agreement on August 28, 2025, to increase the Payment Cap by $250,000 in the Professional Services Agreement to One Million Fifty Thousand Dollars ($1,050,000.00).

F. IVHD and Contractor executed a Fifth Amendment to this Professional Services Agreement on November 13, 2025, to increase the Payment Cap by $305,000 in the Professional Services Agreement to One Million Three Hundred Fifty-Five Thousand Dollars ($1,355,000.00).

G. IVHD and Contractor desire to amend the Professional Services Agreement in accordance with the terms and provisions of this Sixth Amendment to increase the Payment Cap by two hundred twenty-five thousand nine hundred fifty-four dollars and twenty-seven cents ($225,954.27) in order to close out the financial consulting and modeling services relating to the ongoing merger between IVHD and El Centro Regional Medical Center ("ECRMC").

## AGREEMENT

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound, IVHD and Contractor agree as follows:

1. Amendment to Payment Cap. **Article 3** of the Professional Services Agreement is hereby amended so that all references to the total amount of the "Payment Cap" shall be increased by **Two Hundred Twenty-Five Thousand Nine Hundred Fifty-Four Dollars And Twenty-Seven Cents ($225,954.27)** in order to finalize and close out CONTRACTOR's provision of financial consulting services. The Professional Services Agreement's prior references to the Payment Cap, as amended, are hereby modified accordingly. Hereinafter, the relevant amended portions of Article 3 of the Professional Services Agreement, and the associated calculations related to the Payment Cap, shall be amended as follows:

a. Compensation paid for Services performed pursuant to this Agreement shall not exceed **One Million Five Hundred Eighty Thousand Nine Hundred Fifty-Four Dollars And Twenty-Seven Cents ($1,580,954.27),** in the aggregate (the "**Payment Cap**").

b. All previous contractual provisions regarding emergency or contingency spending are hereby deleted. In no event shall Contractor be entitled to compensation in excess of the Payment Cap without IVHD Board authorization.

c. As consideration for the Payment Cap increase, Contractor has delivered to IVHD the financial model relating to the ongoing merger between IVHD and El Centro Regional Medical Center, with a presentation of the model to the IVHD Board of Directors at the public board meeting of December 11, 2025, and has performed ongoing financial consultant services including financial analysis with bondholders and bondholders' consultants related to the ongoing merger between IVHD and ECRMC.

2. Other than as amended by this Sixth Amendment, all other terms of the Professional Services Agreement shall remain in full force and effect. The provisions in this Sixth Amendment shall control over all other provisions in the Professional Services Agreement, as amended.

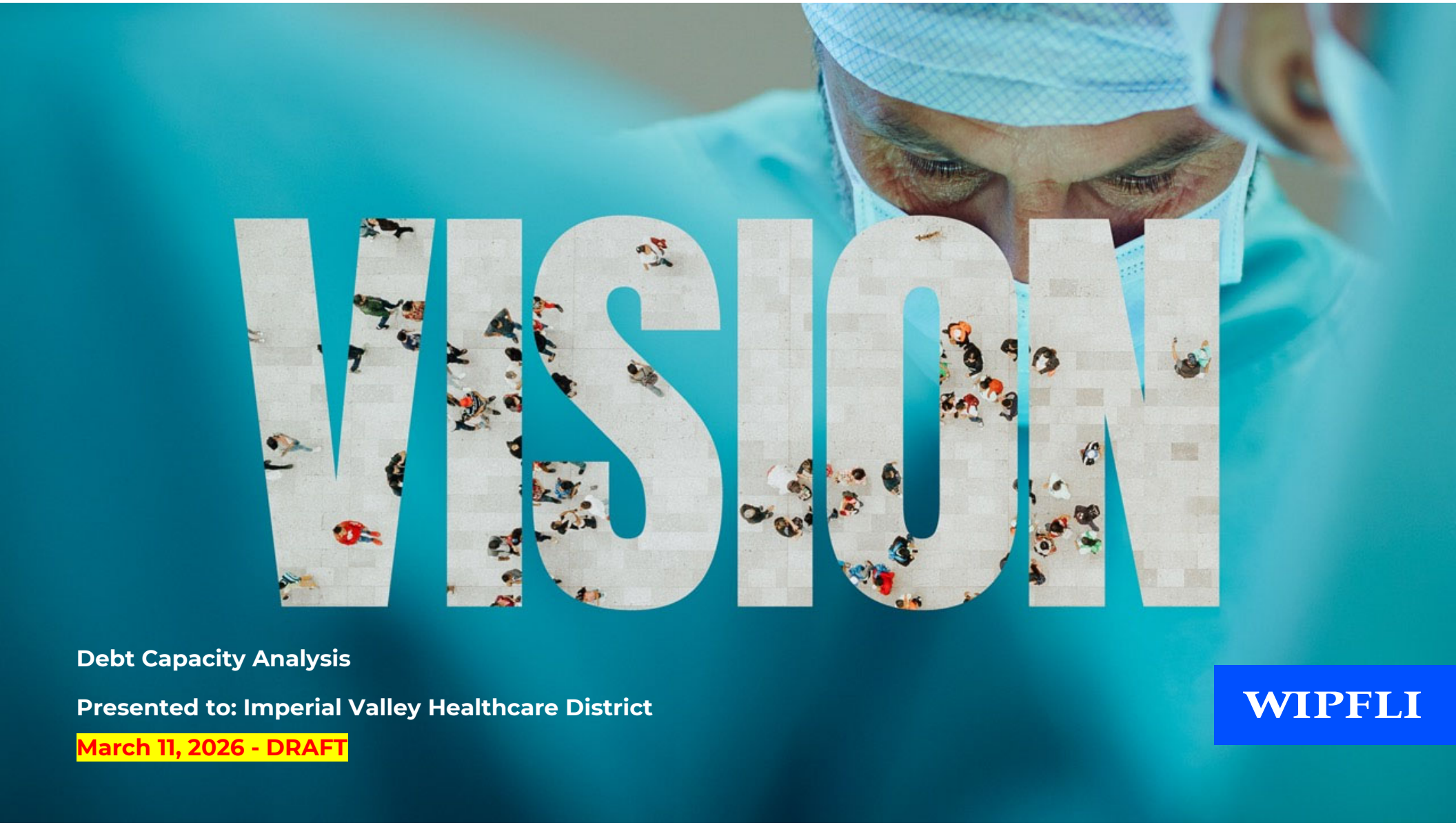
3. This Amendment is hereby incorporated into the terms of the Professional Services Agreement as though set forth fully therein. Capitalized terms not otherwise defined in this Sixth Amendment shall have the definitions and meanings provided in the Professional Services Agreement.

4. This Sixth Amendment may be executed in one or more counterparts, each of which shall be deemed an original and when taken together will constitute one instrument.

IN WITNESS WHEREOF, this Sixth Amendment has been executed as of the date set forth above.

| **IMPERIAL VALLEY HEALTHCARE DISTRICT:** | **CONTRACTOR:** |
|---|---|
| **Signature** | **Signature** |
| **Name** | **Name** |
| **Title** | **Title** |
| **Date** | **Date** |

DRAFT
03.11.26




# Debt Capacity Analysis

**Presented to: Imperial Valley Healthcare District**

**March 11, 2026 - DRAFT**

WIPFLI

## Scope of Services

Imperial Valley Healthcare District ("IVHD") engaged Wipfli Advisory LLC to perform a high-level debt capacity analysis. The goal of the analysis is to provide IVHD with a general range of tax obligation support needed to support the IVHD healthcare facilities.

Wipfli's work effort and is based upon the BRG Corporate Finance ("BRG") IVHD Model Overview that was presented to IVHD on December 8, 2025 ("IVHD December 8 Presentation") and the scope of services is as follows:

- 1. Read and comment (at a high-level) on the "IVHD Merger" financial projections that BRG prepared based on information provided by IVHD hospitals' respective management teams inclusive of strategic synergies and initiatives.
- 2. Prepare key financial ratios based upon the results of the financial projections presented on pages 22 to 25 of the IVHD December 8 Presentation.
- 3. Layer on various debt service amounts to those financial projections presented on pages 22 to 25 of the IVHD December 8 Presentation and calculate key ratios.
- 4. Provide a range of tax obligations needed to support the merged entity under various debt service scenarios in order to maintain days cash on hand of no less than 60 days.

## ➢ 1. Observations from "Read and Comment" on the "IVHD Merger" financial projections that BRG prepared based on information provided by IVHD hospitals' respective management teams inclusive of strategic synergies and initiatives.

*Wipfli read the projections and noted the following key assumptions and impacts to consider in future projection iterations.*

Revenue:

- Minimal growth in net patient service revenue
  - ➢ *Consider potential market capture as a part of the combined entity*
- Contractual adjustments as a percent of gross revenue is not changing
  - ➢ *Consider modeling gross and net revenue by payor and consider changes in reimbursement rates by payor*

Expenses:

- Staffing expenses increasing 2% annually, no significant changes in FTEs
  - ➢ *Consider how staffing might change with any changes in volumes*
  - ➢ *Consider if a 2% cost of living adjustment consistent with historical experience and market trends*
- Most expense lines generally increasing ~2% annually
  - ➢ *Consider a higher inflationary adjustment for supplies based on historical experience and impacts from tariffs*

## ➢ 1. Continued.

### Balance Sheet Observations

- Patient accounts receivable is assumed to be <50 days of net patient service revenue
  - ➢ *Consider current experience - 2025 calculation was more than 60 days; Consider reasonableness of the reduction in days over the projection period*
- Property and equipment and leased assets are increasing throughout the projection period
  - ➢ *Further analysis needs to done to understand what, if any, capital projects are in the projections*
- Accounts payable and accrued expenses is assumed to be > 100 days of operating expenses (excluding staffing costs and depreciation)
  - ➢ *Consider current experience - 2025 calculation was less than 100 days; Consider why an increase in days in these liabilities is assumed and impact on projected cash balances*

## ➢ 1. Continued.

### Cash Flow Observations

- Projected Cash Flow Statement
  - ➢ *Consider preparing a new cash flow statement that is in the format of a cash flow prepared in accordance with generally accepted accounting principles with components in appropriate sections (operating, investing, financing, etc.)*

## ➢ 2. Prepare key financial ratios based upon the results of the financial projections presented on pages 22 to 25 of the IVHD December 8 Presentation.

**Debt capacity is evaluated primarily through two key financial metrics: the debt service coverage ratio (DSCR) and the days cash on hand (DCOH). Together, these metrics offer a comprehensive assessment of debt capacity by balancing both the ability to service debt and maintain adequate liquidity.**

### Debt Service Coverage Ratio

- The debt service coverage ratio serves as a critical indicator of the organization's ability to meet its debt obligations.
- A constraint has been established for DSCR at 1.5x to ensure sufficient coverage.

### Days Cash on Hand

- Days cash on hand measures the liquidity position by indicating how many days the organization can continue to pay its operating expenses using only its available cash reserves.
- A constraint has been established to maintain at least 60 days of cash on hand, ensuring operational continuity and financial flexibility in times of unexpected cash flow disruptions.

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## ➢ 2. Continued.

### Debt Service Coverage Ratio

### ($ in Thousands)

- *Calculated based on the IVHD December 8 Presentation, adjusted to exclude the increase in tax revenue beginning in 2028*
- *Includes existing debt of $183M and finance leases of $69M*

| | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|
| Funds available for debt service: | | | | | |
| Change in net position | $ 6,438 | $ 28,671 | $ 28,611 | $ 21,031 | $ 18,536 |
| Plus: | | | | | |
| Depreciation and amortization | 10,734 | 11,092 | 11,414 | 11,976 | 12,838 |
| Interest expense | 7,774 | 7,241 | 7,149 | 7,061 | 6,968 |
| Pension GASB-68 | 7,251 | 8,044 | 8,425 | 8,591 | 8,759 |
| Total funds available for debt service (1) | 32,196 | 55,048 | 55,599 | 48,658 | 47,102 |
| Total annual debt service (2)[(a)] | $ 15,934 | $ 25,276 | $ 25,265 | $ 25,268 | $ 25,273 |
| **Annual debt service coverage [(1)/(2)]** | **2.02** | **2.18** | **2.20** | **1.93** | **1.86** |

[(a)] Annual Debt Service

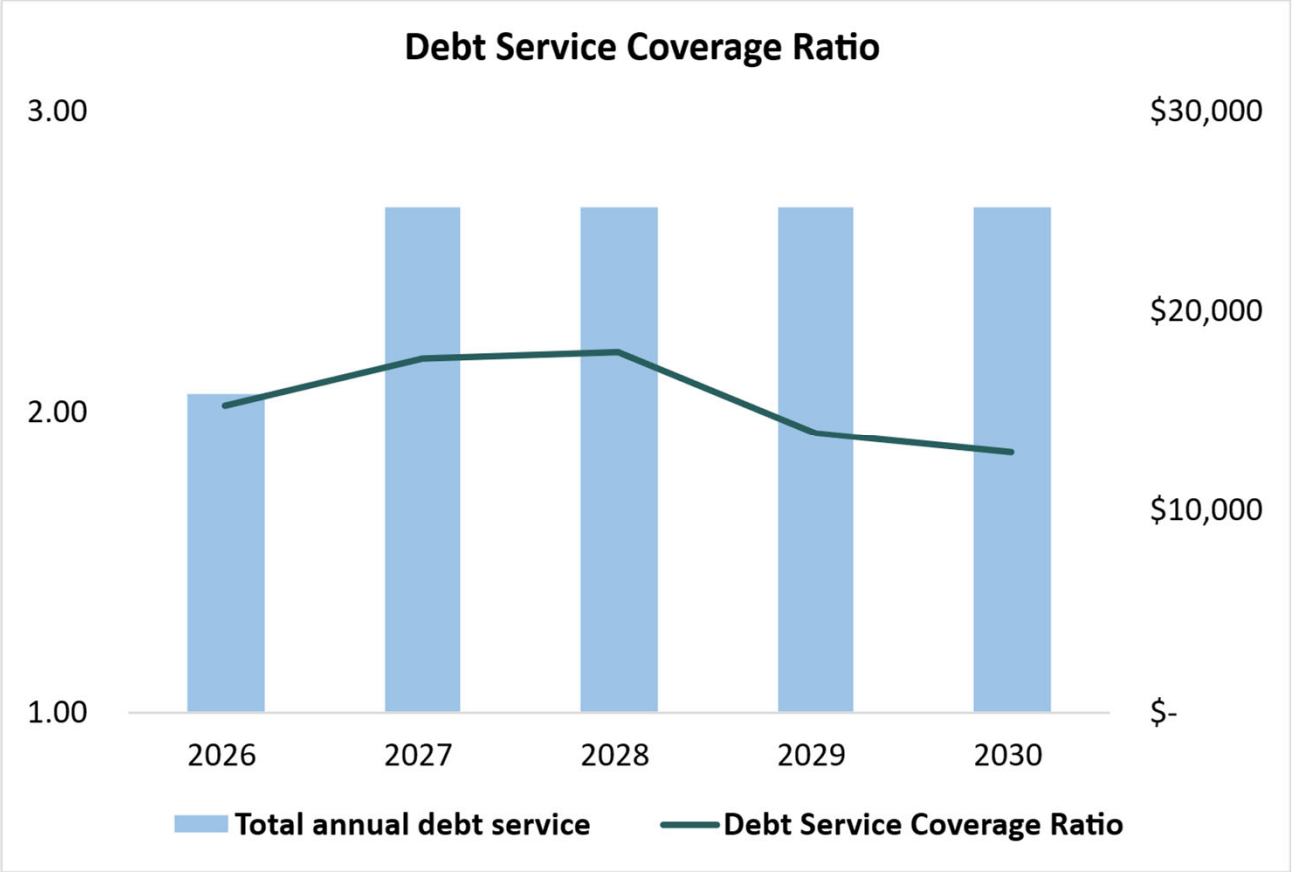
| | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|
| Principal payments: | | | | | |
| Bond Payable | $ 1,514 | $ 1,594 | $ 1,674 | $ 1,764 | $ 1,859 |
| Finance Leases | 3,960 | 3,960 | 3,960 | 3,960 | 3,960 |
| Notes Payable | 2,074 | 12,444 | 12,444 | 12,444 | 12,444 |
| Total principal payments | $ 7,548 | $ 17,998 | $ 18,078 | $ 18,168 | $ 18,263 |
| Interest payments: | | | | | |
| Interest expense | $ 7,774 | $ 7,241 | $ 7,149 | $ 7,061 | $ 6,968 |
| Plus: Interest payable for prior year | 3,598 | 2,987 | 2,951 | 2,913 | 2,874 |
| Less: Interest payable for current year | (2,987) | (2,951) | (2,913) | (2,874) | (2,833) |
| Total interest payments | $ 8,385 | $ 7,277 | $ 7,186 | $ 7,100 | $ 7,010 |
| Total annual debt service | $ 15,934 | $ 25,276 | $ 25,265 | $ 25,268 | $ 25,273 |

## ➢ 2. Continued.

### Debt Service Coverage Ratio, continued

*Observations:*

- *Debt service coverage ratio is strong but is declining due to shrinking margins and minimal change in tax revenue*
- *The income available for debt service indicates capacity for additional debt*



## ➢ 2. Continued.

### Days Cash on Hand

### ($ in Thousands)

- *Calculated based on the IVHD December 8 Presentation, adjusted to remove $100M in capital additions and the increase in tax revenue beginning in 2028*
- *Includes only the cash and cash equivalents line (assets limited as to use are excluded)*

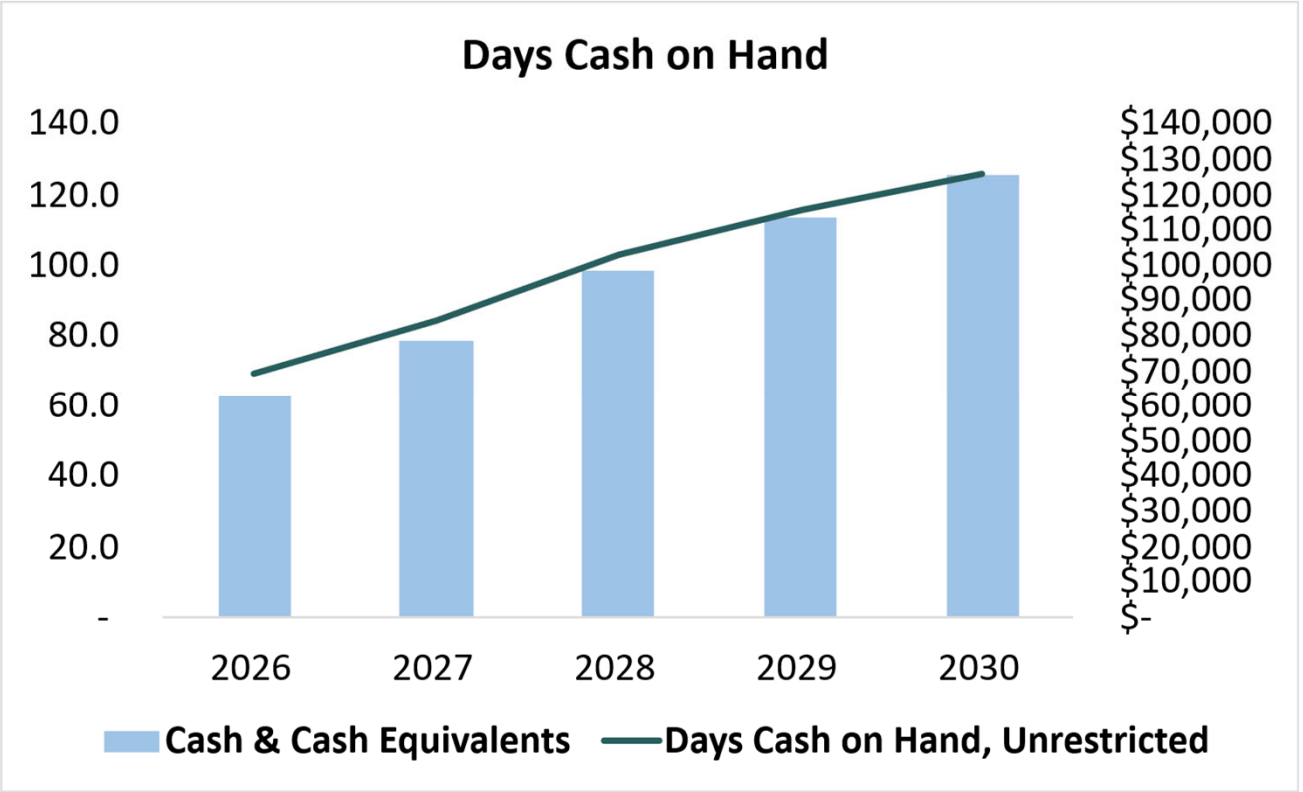
| | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|
| Cash and cash equivalents (1) | $ 62,584 | $ 78,551 | $ 98,632 | $ 113,414 | $ 125,619 |
| Total operating expenses | 333,751 | 343,939 | 355,084 | 362,858 | 371,065 |
| Plus: | | | | | |
| Interest expense | 7,774 | 7,241 | 7,149 | 7,061 | 6,968 |
| Less: | | | | | |
| Depreciation and amortization | 10,734 | 11,092 | 11,414 | 11,976 | 12,838 |
| Adjusted operating expenses (2) | $ 330,791 | $ 340,088 | $ 350,819 | $ 357,942 | $ 365,196 |
| Days in year (3) | 365 | 365 | 366 | 365 | 365 |
| Days cash on hand [(1) / ((2)/(3))] | 69.1 | 84.3 | 102.9 | 115.7 | 125.6 |

## ➢ 2. Continued.

### Days Cash on Hand, continued

*Observations:*

- *Cash is increasing during the projection period despite shrinking margins*
- *The increase in cash indicates potential capacity for additional debt*



➢ 3. Layer on various debt service amounts to those financial projections presented on pages 22 to 25 of the IVHD December 8 Presentation and calculate key ratios.

## Debt Capacity Assumptions:

- Borrowing occurs July 2027; principal and interest payments beginning August 2027
- 100% of amount financed is to be spent on capital additions, in addition to the capital additions already included in the projection model
- No reserve accounts or debt issuance costs are being projected as a part of the financing
- Existing debt is not refinanced
- Current facilities are not sold
- Terms of new debt:
  - ➢ Interest rate: 6%
  - ➢ Term: 30 years

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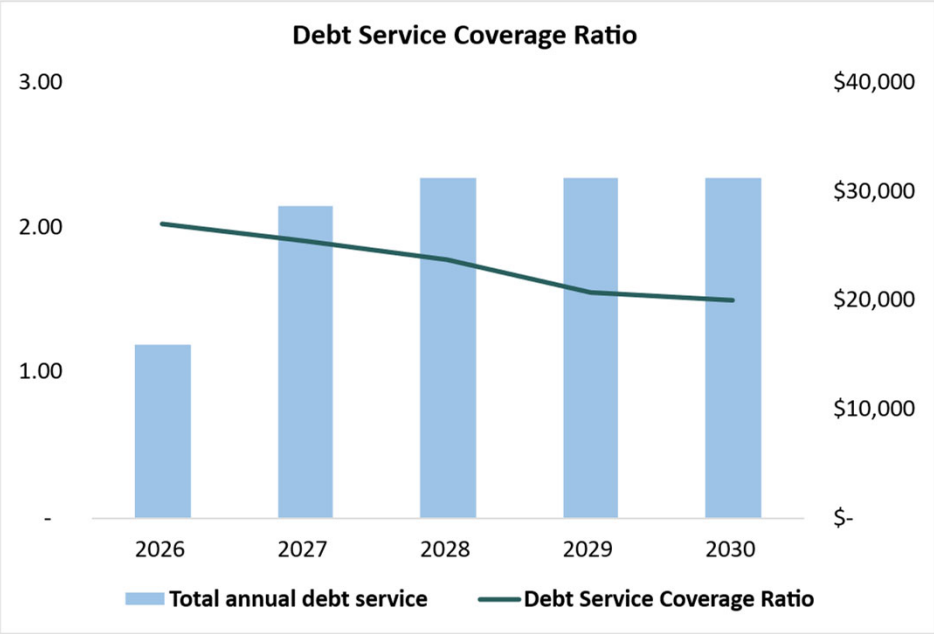
## ➢ 3. Continued.

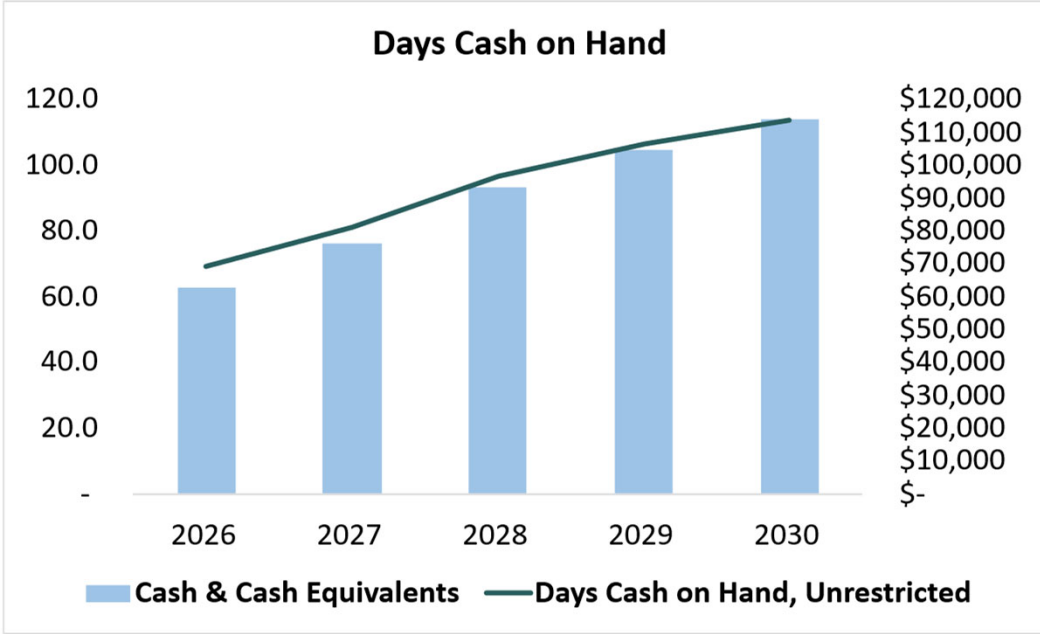
**Affordability to get to 1.5x Debt Service Coverage Ratio, assuming no additional tax revenue:**

**Up to $42,000,000**

### Debt Service Coverage




### Days Cash on Hand




*Observations: With no changes to tax revenue other than a small inflationary increase, IVHD has the capacity to maintain a 1.5x debt service coverage ratio and maintain 60+ days of cash while borrowing up to $42,000,000.*



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➢ 4. Provide a range of tax obligations needed to support the merged entity under various debt service scenarios in order to maintain days cash on hand of no less than 60 days.

## Scenario Assumptions and Results

Tax obligation requirement to meet debt service and days cash requirements:

**Project Size: $75,000,000**

| | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|
| Existing tax revenue | $ 2,712 | $ 2,249 | $ 2,295 | $ 2,306 | $ 2,318 |
| Additional tax revenue needed | - | - | - | 5,600 | 7,000 |
| Total tax revenue | $ 2,712 | $ 2,249 | $ 2,295 | $ 7,906 | $ 9,318 |

**Project Size: $100,000,000**

| | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|
| Existing tax revenue | $ 2,712 | $ 2,249 | $ 2,295 | $ 2,306 | $ 2,318 |
| Additional tax revenue needed | - | - | 4,000 | 11,000 | 12,500 |
| Total tax revenue | $ 2,712 | $ 2,249 | $ 6,295 | $ 13,306 | $ 14,818 |

## Summary

- The **costs** of updates required to meet seismic requirements are expected to be **$75M-$100M**
- Based on the current financial information, IVHD has **debt capacity** of up to **$42M**
- **Additional annual revenue** of the following will be required in order to borrow the funds required for the full construction/renovation, and meet the debt service coverage and days cash requirements:

| | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|
| $75M Project | $ - | $ - | $ - | $ 5,600 | $ 7,000 |
| $100M Projct | $ - | $ - | $ 4,000 | $ 11,000 | $ 12,500 |

# Additional Considerations

## Strategic Initiatives

- The Strategic Plan Document and Presentation includes operational and clinical changes that could impact the projection:
  - Service and utilization growth
  - Operational efficiency
  - Cost management
  - Expense reduction
  - Consolidating contracts and purchasing agreements
  - Staffing
    - Filling hard-to-fill positions
    - Removing duplicative roles

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## *Regarding this engagement and the use of this presentation*

- For the purpose of debt capacity analysis, Wipfli is not acting as a Municipal Financial Advisor and is not registered in that capacity with the IVHD. Our role is as an independent consultant to assist the management team in their planning process in the design, analysis, and facilitation of their capital projects. The information provided by us is not intended to be and should not be construed as "advice" within the meaning of Section 15B of the Securities Exchange Act of 1934.

- The results of this analysis will be for IVHD's internal use only and to guide the consultants and/or registered financial advisors engaged to assist in guiding the District in the tax levy process.

- Wipfli did not perform a preparation, compilation, or examination of the projections as a part of this engagement and, as such, does not provide any assurance on the financial information presented herein.

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WIPFLI

# ASSEMBLY BILL No. 2311

**Introduced by Assembly Member Schiavo**
**(Coauthors: Assembly Members Ortega and Pellerin)**
(Coauthor: Senator Becker)

February 19, 2026

An act to amend Section 2401 of the Business and Professions Code, relating to healing arts.

## LEGISLATIVE COUNSEL'S DIGEST

AB 2311, as introduced, Schiavo. Health care districts: employment.

Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons or doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. Existing law, the Local Health Care District Law, regulates the organization and management of health care districts. Existing law establishes the Department of Health Care Access and Information and charges it with various duties related to health planning and research development.

This bill would create an exemption to the general prohibition described above by authorizing health care districts and nonprofit corporations with a health care district as its sole corporate member that own or control a general acute care hospital to employ physicians and surgeons and charge for professional services. The bill would prohibit the health care district from interfering with, controlling, or otherwise directing the professional judgment of a physician or surgeon.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

SECTION 1. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, before January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of the patient's ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(e) Notwithstanding Section 2400, a federally certified critical access hospital may employ licensees and charge for professional services rendered by those licensees to patients, provided both of the following conditions are met:

(1) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(2) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

*(f) Notwithstanding Section 2400, a health care district, organized and governed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or a nonprofit corporation with a health care district as its sole corporate member, as described in subparagraph (B) of paragraph (1) of subdivision (h) of Section 14169.31 of the Welfare and Institutions Code, that owns or controls a general acute care hospital may employ licensees and charge for professional services rendered by those licensees. However, the health care district shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon.*

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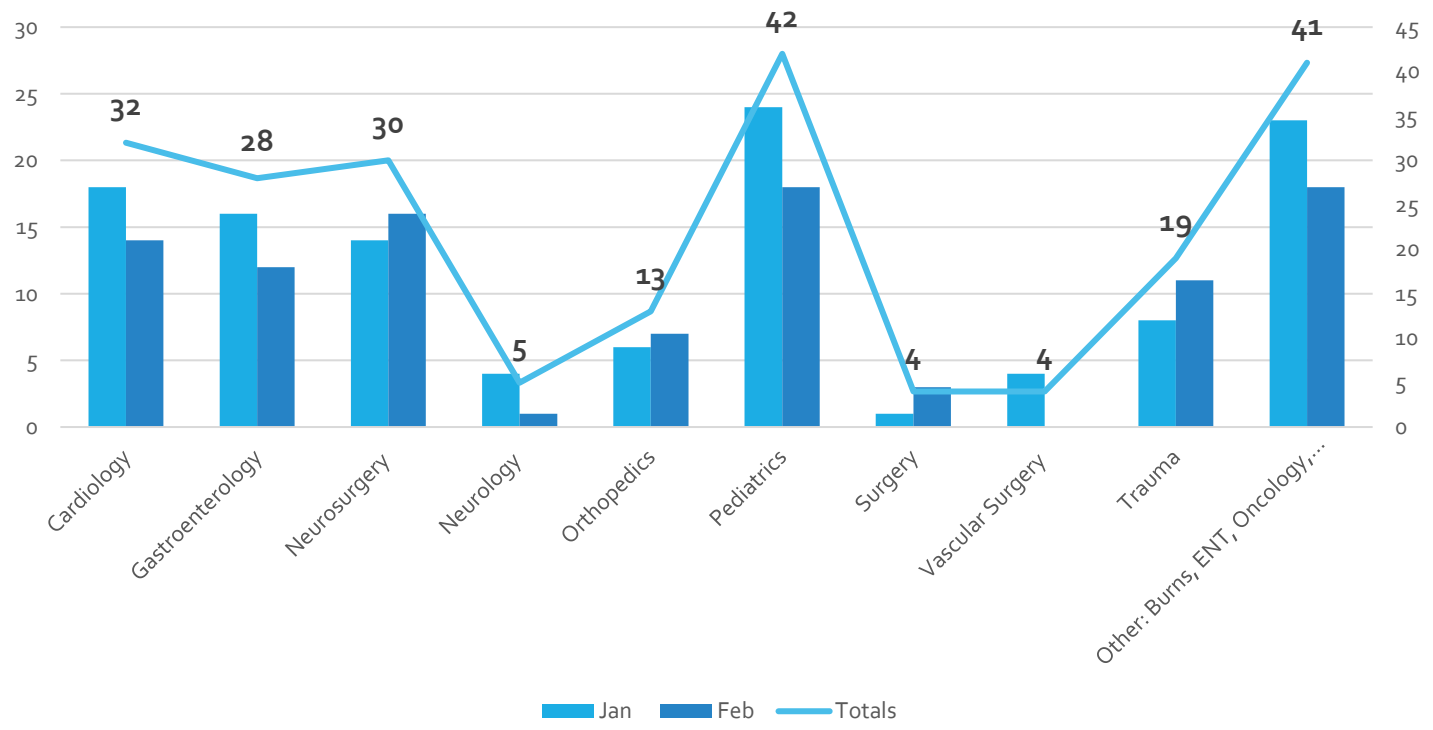
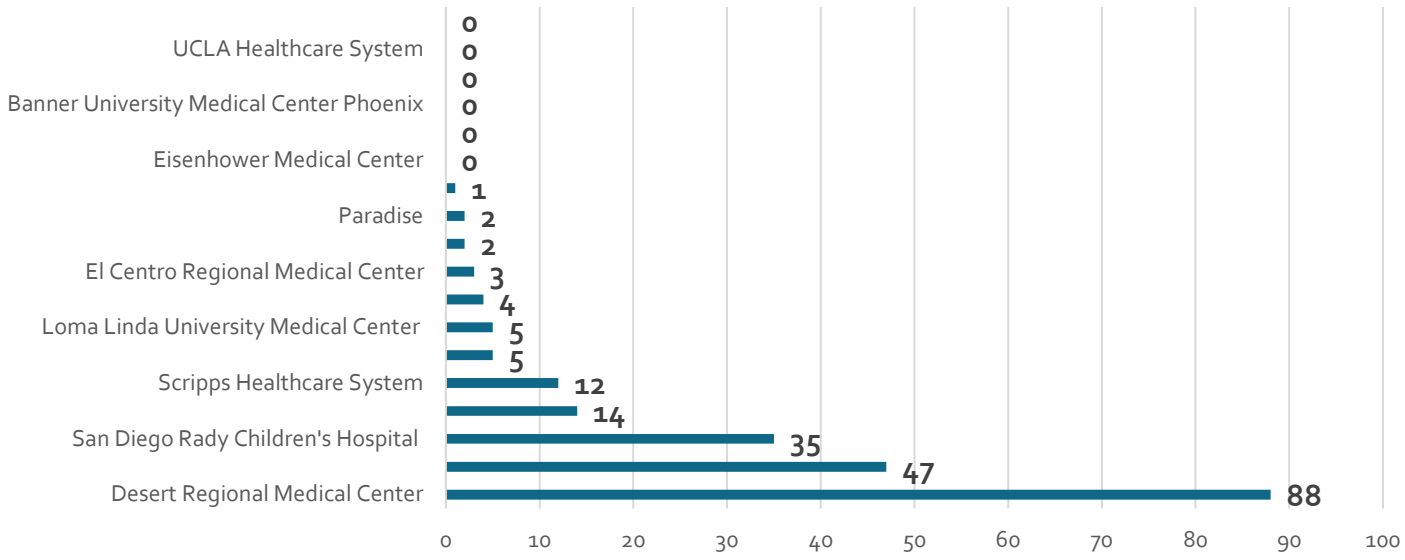
PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

# Board of Directors Meeting – Chief Nursing Officer Report

**March 2026**




| Specialty | 1Q2025 | 2Q2025 | 3Q2025 | 4Q2025 | January 2026 | February 2026 | Totals |
|---|---|---|---|---|---|---|---|
| Cardiology | 48 | 36 | 51 | 45 | 18 | 14 | 32 |
| Gastroenterology | 55 | 64 | 62 | 42 | 16 | 12 | 28 |
| Neurosurgery | 50 | 30 | 52 | 43 | 15 | 16 | 31 |
| Neurology | 12 | 7 | 14 | 13 | 4 | 1 | 5 |
| Orthopedic | 12 | 13 | 15 | 41 | 6 | 7 | 13 |
| Pediatrics | 51 | 43 | 44 | 70 | 24 | 18 | 42 |
| Surgery | 12 | 4 | 16 | 10 | 1 | 3 | 4 |
| Vascular Surgery | 6 | 9 | 9 | 5 | 4 | 0 | 4 |
| Trauma | 29 | 21 | 12 | 34 | 8 | 11 | 19 |
| Other: Burns, ENT, Oncology, Ophthalmology, Podiatry, Urology | 60 | 78 | 84 | 74 | 22 | 18 | 40 |
| **2025 Totals** | **335** | **305** | **359** | **377** | **118** | **100** | **218** |

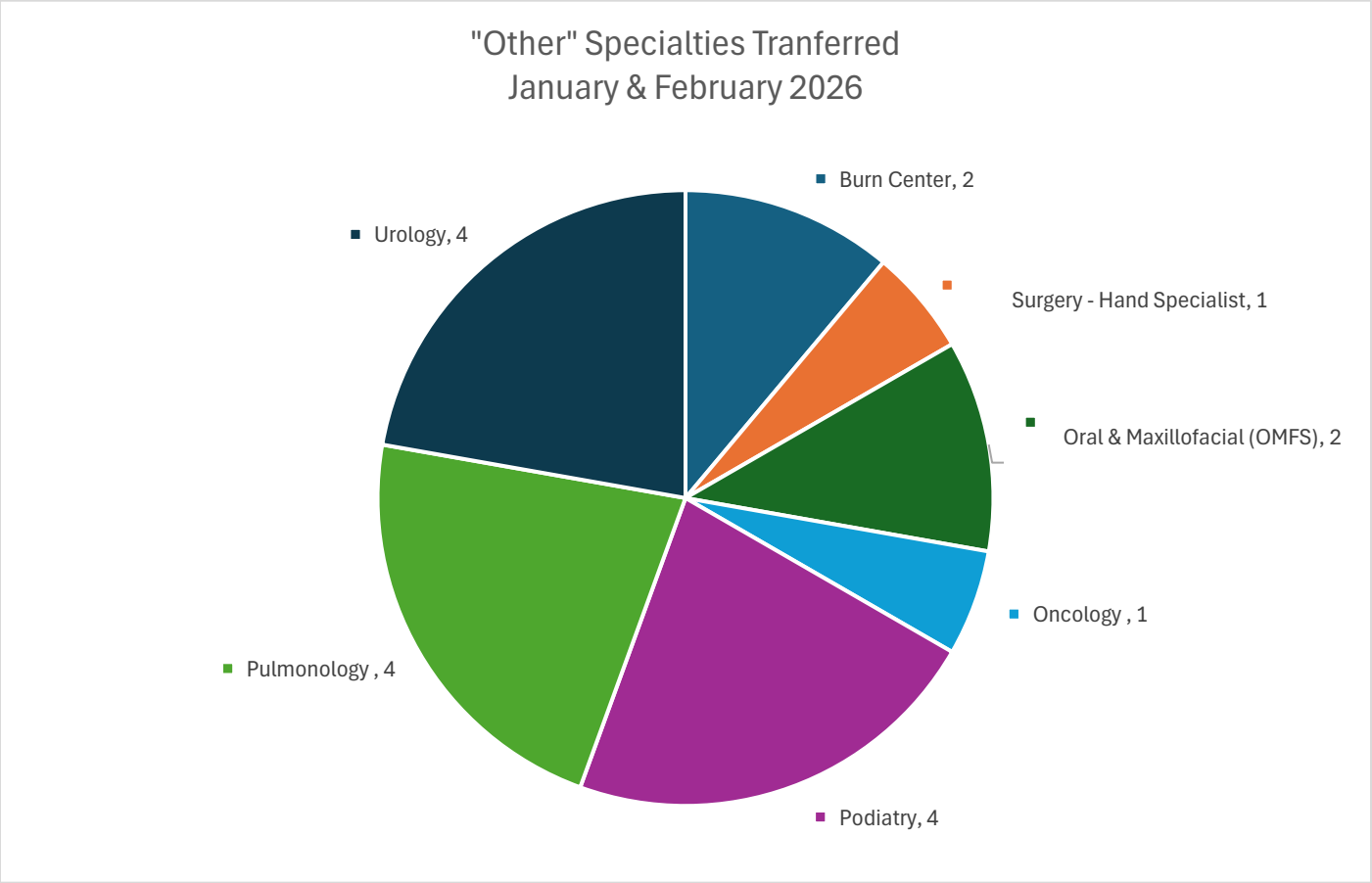



| Accepting Facility | 1Q2025 | 2Q2025 | 3Q2025 | 4Q2025 | JANUARY 2026 | FEBRUARY 2026 | Total |
|---|---|---|---|---|---|---|---|
| Scripps Healthcare System | 119 | 140 | 65 | 27 | 7 | 5 | 12 |
| Desert Regional Medical Center | 116 | 89 | 152 | 169 | 46 | 42 | 88 |
| San Diego Rady Children's Hospital | 47 | 41 | 44 | 64 | 20 | 15 | 35 |
| UCSD Healthcare System | 15 | 22 | 67 | 73 | 27 | 20 | 47 |
| Tri-City Medical Center | 10 | 3 | 2 | 10 | 2 | 3 | 5 |
| John F. Kennedy Memorial Hospital | 7 | 4 | 5 | 14 | 7 | 7 | 14 |
| Loma Linda University Medical Center | 5 | 1 | 0 | 7 | 3 | 2 | 5 |
| El Centro Regional Medical Center | 5 | 1 | 9 | 5 | 2 | 1 | 3 |
| Sharps Healthcare System | 4 | 0 | 10 | 3 | 2 | 2 | 4 |
| Eisenhower Medical Center | 3 | 1 | 2 | 2 | 0 | 0 | 0 |
| Riverside Medical Center | 3 | 0 | 1 | 2 | 0 | 0 | 0 |
| Banner University Medical Center Phoenix | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hospital Americano | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| UCLA Healthcare System | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Children's Hospital Los Angeles | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Kaiser Permanente Healthcare System | 0 | 0 | 1 | 1 | 1 | 1 | 2 |
| San Diego Navy Medical | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Paradise | 0 | 0 | 0 | 0 | 1 | 1 | 2 |
| **Total** | **335** | **305** | **359** | **377** | **118** | **100** | **218** |

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

# Board of Directors Meeting – Chief Nursing Officer Report

**March 2026**




From January through February of 2026, the Emergency Department recorded 8,825 visits. Of these, 218 (2.47%) resulted in transfers to other facilities. The most frequently transferred specialties included Neurology/Neurosurgery, Gastroenterology, Cardiology, and Pediatrics. There were 18 cases transferred categorized as “Other:” Urology 4, Burn Center 2, Hand Specialist 1, OMFS 2, Oncology 1, Podiatry 4, and Pulmonology 4.

In February 2026, ECRMC submitted 6 transfer requests: 2 pediatric, 2 gastroenterology (GI), 2 Interventional Radiology (IR). All requests were accepted except for one GI due to No GI services being available and no available beds.

During the same month, 20 inpatient cases were transferred out of our facility.

## Staffing:

| | New Hires | In Orientation | FT to PD status | Resignation | Open Positions |
|---|---|---|---|---|---|
| **Medical Surgical** | 0 | 4 | 0 | 1 | 1 |
| **Intensive Care Unit** | 0 | 2 | 0 | 0 | 1 |
| **Pediatrics** | 0 | 0 | 0 | 0 | 0 |
| **Emergency Department** | 0 | 6 RN's<br>1 ED Technicians | 0 | 0 | 0 |
| **Perioperative Services** | 2<br>1 Circulator, 1 supply chain clerk | 2 Circulators RNs<br>1 PACU RN<br>2 ENDO RN | 0 | 0 | 4 circulator RNs<br>(2 FT/ 2 PD) |
| **Perinatal Services** | 2 | 2 | 0 | 0 | 0 |
| **NICU** | 1 | 0 | 1<br>(starting 3/31) | 0 | 1 |
| **Cardiopulmonary** | 0 | 0 | 0 | 0 | 0 |
| **Case Management** | 0 | 0 | 0 | 1 | 1 Case Manager Assistant<br>1 Social Worker |
| **Total** | 5 | 20 | 1 | 2 | 9 |

## Travelers:

- (1) Labor and Delivery Nurses – Day Shift
- (3) Neonatal Intensive Care Unit – 1 Day shift, 2 Night shift
- (1) Respiratory Therapist – Night shift

## Notable Updates:

### Nursing Administration:

#### ECRMC/IVHD Nursing Services

- The Joint Commission Accreditation application was accepted. TJC surveyors are expected in April 2026.
- Employee and Patient Safety Survey (SCORE survey) ends March 23, 2026, ECRMC preparing to administer same survey in April.
- Counterparts continue to work together to reconcile policies, contracts, and delivery of care.
- National Nurse Week will be celebrated from May 6th to May 12th, May 6th being National Nurses Day.

#### Nurse Residency Program:

- Total: 16 Residents at PMH
- All schools of nursing resume clinicals for Spring this month

#### Barcode Medication Administration:

| BCMA | | | | |
|---|---|---|---|---|
| **2025 Average** | **3Q2025** | **4Q2025** | **January 2026** | **February 2026** |
| **91.55%** | **92.56%** | **94.30%** | **95.37%** | **91.15%** |

#### Patient Experience – Month of October 2025

| HCAHPS | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Score Goal** | **Percentile Rank Goal** | **2025 Average** | **3Q2025** | **4Q2025** | **JAN 2026** | **FEB 2026** |
| Likelihood to Recommend | 78.54% | 76 | 76.57% | 75.57% | 78.21% | 66% | 94.59% |
| Overall | | | 66.90% | 69.26% | 68.83% | 65.56% | 77.07% |
| Communication With Nurses | | | 81% | 77.13% | 83.31 | 73.97% | 90% |
| Communication With Doctors | | | 83% | 80.87% | 86.05% | 75.96% | 87.50% |

- In process of developing, one integrated Customer Service Experience – "Moments that matter."
- Developing goals for the upcoming year for the above metrics

PIONEERS
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HEALTHCARE DISTRICT

# Board of Directors Meeting – Chief Nursing Officer Report

**March 2026**

## Emergency Department:

| 2025 ED Throughput Metrics | | | | | | |
|---|---|---|---|---|---|---|
| INDICATOR | GOAL | 2025 Total | 3rd QUARTER | 4th QUARTER | JAN 2026 | FEB 2026 |
| Average Daily Visits | >125 Patients | 131 Patients | 124 Patients | 133 Patients | 147 Patients | 155 Patients |
| Median Time to Triage | <10 minutes | 8 minutes | 8 minutes | 7 minutes | 8 minutes | 10 minutes |
| Average Length of Stay for Discharged Patients | <180 minutes | 182 minutes | 182 minutes | 174 minutes | 183 minutes | 182 minutes |
| Average Length of Stay for all Patients | <160 minutes | 196 minutes | 199 minutes | 187 minutes | 191 minutes | 194 minutes |
| Average Length of Stay for all Transfers | <160 minutes | 474 minutes | 461 minutes | 412 minutes | 413 minutes | 493 minutes |
| Average Left Against Medical Advice (AMA) | | | | | 41(0.0090) | 51(0.011) |
| Left without Being Seen (LWBS) | | | | | 0.5 | 0.017 |

## Medical Surgical Department:

| Inpatient Throughput | | | | | | |
|---|---|---|---|---|---|---|
| INDICATOR | GOAL | 2025 Average Total | 3Q2025 | 4Q2025 | JAN 2026 | FEB 2026 |
| Time of Orders Written to Head in Bed | 120 min | 164 min | 142 min | 151 min | 244 | 323 |

| | Goal | 2025 Totals | 3Q 2025 | 4Q 2025 | JAN 2026 | FEB 2026 |
|---|---|---|---|---|---|---|
| Case Volumes Including Robotics | 90% | 4,729 | 393 | 374 | 356 | 256 |
| Robotics | N/A | 233 | 27.33 | 19 | 14 | 18 |

*NA= not available*

## Case Management:

| Indicator | | Goal | 2025 AVG Total | 3Q2025 | 4Q2025 | JAN 2026 | FEB 2026 |
|---|---|---|---|---|---|---|---|
| | Average Daily Census | | 51 | 51 | 51 | 60 | 72 |
| **Acute LOS** | ALOS (Actual) | <4.0 | 3.30 | 3.85 | 3.42 | 4.15 | 4.09 |
| **Case Mix Index** | Acute: Case Mix Index (CMI) | >1.40 | 1.47 | 1.69 | 1.48 | 1.47 | 1.56 |
| | Acute: Medicare CMI | >1.50 | 1.59 | 1.72 | 1.64 | 1.53 | 1.55 |
| **Medicare** | Medicare One-Day Stay Count | | 13.5 | 18 | 13 | 18 | 24 |
| | % Medicare 1-day Stays | | 13 | 17 | 12 | 18 | 23 |
| **Observation** | Total Observation Cases-DC | | 28.66 | 25 | 27 | 26 | 28 |
| | Observation Days-DC | | 31.5 | 30 | 33 | 26 | 33 |
| **Readmissions** | All-Cause Hospital-Wide Readmissions (HWR) | <10 | 4.57 | 4.13 | 5.53 | 4.47 | 5.10 |

## Perinatal Department:

- February Deliveries: 128 (83 vaginal, 19 primary C-Section, 26 secondary C-Section)
- February Non-Stress Tests conducted: 204
- February OB checks: 239

### Medical Surgical Unit/ICU:

- Ultrasound guided intravenous lines; we have trained a total of 7 RN's to be able to insert PowerGlide.

### Pediatrics:

- Asthma Prevention & Management Program Project
    - The unit has begun collecting data and submitting referrals to the ECRMC Asthma Wellness Program.
    - Asthma-related supplies are currently being purchased to support patients and sustain the program.

### NICU:

- Neonatal Stabilization Project:
    - GE vendor completed assembly of the Panda Beds; educator provided initial staff training on 3/2/26.
    - Additional staff education is ongoing before implementation.
    - One bed will be placed in the Emergency Department (ED) as the portal of entry to ensure immediate access to neonatal resuscitation equipment.
    - A second bed will be placed in OB-OR 7, where most cesarean sections are performed.
- Neonatal Crash Cart Standardization Project:
    - Awaiting Pharmacy to finalize medication boxes.
    - Once completed, neonatal crash carts will be distributed to OB-OR, Labor & Delivery/Postpartum, ED, Materials Management (for exchange), and NICU with complete supplies.