Board of Directors
Regular Meeting & Executive Session
January 22, 2026 6:00 p.m.

AGENDA

I. Regular Meeting Open Session Call to Order 6:00 p.m.

1. Agenda - Corrections or Additions (action)
2. Public Input

II. Consent Agenda

1. Meeting Minutes
   a. Regular Meeting-12-18-25 3
   b. Legal Counsel – Robert S. Miller - Invoice - #1187 10
2. **Motion to Approve Consent Agenda** (action)

III. New Business

1. Consideration of Dr. Monica Mehrens as Clinician Champion for Antimicrobial Stewardship (action)11
2. Consideration of Medical Staff Bylaws Revision (action)12

IV. Old Business

1. None.

V. Staff Reports-Discussion

1. CEO Report 13
2. CMO Report 15
3. Retail Pharmacy Report 17
4. CNO Report 19
5. CFO Report 23
6. CIO Report 24
7. Multi-Specialty Clinic Report 27
8. HR Report 29
9. SCHD Foundation Report 55
10. Strategic Plan Update (under separate cover)

VI. Financial Review

1. Month-End Report & Statements for Period Ending December 31, 2025 56
2. December Revenue Cycle Dashboard Report 75
3. FY26 Mitigation Plan Q2 Review 86

VII. Open Discussion

VIII. Executive Session

Executive Session Under 192.660(2)(c) to consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 Licensing of facilities and health maintenance organizations, and under ORS 162.660(2)(i) and 192.660(8) to review and evaluate the performance of an officer, employee or staff member if the person does not request an open meeting. This reason may not be used to do a general evaluation of an agency goal, objective or operation of any directive to personnel concerning these subjects. No decisions are made in Executive Session.

IX. Return to Open Session

Action from Executive Session

1. Motion to Approve Executive Session Minutes-12-18-25 (action)
2. Motion to Approve Reports from Executive Session: (action)
   a. Quality & Patient Safety, Risk & Compliance
   b. Medical Staff Credentialing Report

X. Adjournment

Southern Coos Health District
Board of Directors Meeting
Open Session Minutes
December 18, 2025
Adapt, LLC Conference Room

I. Open Session Call to Order at 6:00 p.m.

Roll Call – Quorum established; Thomas Bedell, Chairman; Mary Schamehorn, Secretary; Pamela Hansen, Treasurer/Foundation Liaison, Kay Hardin, Quality Liaison, and Robert Pickel, Director. **Administration:** Raymond Hino, CEO; Cameron Marlowe, Interim CFO; Alden Forrester, MD, CMO; Cori Valet, CNO; Scott McEachern, CIO; David Serle, Clinic Director; Stacy Nelson, HR Director; Amanda Bemetz, RN, Quality, Risk & Compliance Director; Colene Hickman, Revenue Cycle Director. **Absent:** Philip J. Keizer, MD, Chief of Staff. **Others present:** Robert S. Miller, Counsel; Brenda Sund, Controller; Kim Russell, Executive Assistant. **Via Remote Link:** James Mann, Clifton Larson Allen; Alix McGinley, SCH Foundation Executive Director. **Press:** None.

1. Agenda - Corrections or Additions

Bob Pickel **moved** to accept the agenda as presented. Mary Schamehorn **seconded** the motion. **All in favor. Motion passed.**

2. Public Input – None.

II. Consent Agenda

1. Open Session Meeting Minutes (Executive Session Minutes are Reviewed in Executive Session):

a. Regular Meeting-11/20/2025
b. Invoice for Legal Services - None

Mary Schamehorn **moved** to accept the Consent Agenda. Bob Pickel **seconded** the motion. **All in favor. Motion passed.**

III. New Business

1. Annual Audit Report FY25

Mr. Bedell welcomed James Mann from Clifton Larson Allen (CLA), the District audit firm, to present audit findings for fiscal year ending June 30, 2025, attending via remote link. Mr. Mann shared his presentation also included in the meeting packet. The presentation included an executive summary highlighting significant transactions during the year including the electronic health record conversion to EPIC, the related issuance of a promissory note; the single audit performed, as is required by our existing USDA loan and continuing compliance, with no noted subsequent events. Internal control results yielded no material weaknesses identified. Financial performance indicators were reviewed against various comparative data including CLA “medium” critical access hospital (CAH) clients,

over 300 additional medium facilities, and with Oregon CAH data extracted as part of the Clifton Larson Allen Gold Standard Study. Economic and healthcare industry drivers were reviewed including government changes in healthcare policy, technology advancements, and the Rural Health Transformation Fund, as well as state options to address funding cuts. The audit resulted in an unqualified (or unmodified), "clean" report. **Discussion:** Mr. Bedell noted significant changes since July with increased Medicare rebate but also increased expenses and apparent increase in depreciation, which Mr. Bedell will continue to review with the CEO and interim CFO in their weekly meetings and will keep the Board informed.

Mary Schamehorn **moved** to accept the audit report as presented. Bob Pickel **seconded** the motion. **All in favor. Unanimous decision.** Mr. Mann was excused at this time.

IV. Old Business

1. Master Facility Plan Financial Analysis

Raymond Hino, CEO, provided a review of the Master Facility Plan project to-date. It is now necessary to expend additional funds to complete the following four scopes of work; 1) Review SCHHC's existing financial position and estimate financial affordability for a major building project; 2) Complete an analysis of the current financial status of SCHHC and its capacity to fund a hospital expansion project, either through reserve funds, borrowing, or a combination of sources; 3) Complete an analysis of statutory bonding capacity, voter authorization, and debt thresholds; and 4) Complete an analysis of charitable giving opportunities. A competitive bid process resulted in receipt of 3 proposals, from Eide Bailey, Wipfli, and CLA. The recommendation of hospital Administration and the Project Manager, Joe Kunkel, is to award this next phase of work to Wipfli, LLC, whose total Bid was $80,000. When complete, Southern Coos Hospital & Health Center will apply for Federal funding support through the United States Department of Agriculture (USDA). Additional steps, later in the project, will include decisions on the Donor Capacity Analysis and Voted Bond Threshold Analysis, anticipated to cost an additional $38,000. Additionally, the Bandon Dunes Charitable Foundation has agreed to support this next phase of the project, by awarding an additional $150,000 for financial analysis and building up the infrastructure in our Foundation Offices to conduct a top tier capital campaign, grant writing and professional support for a potential public election. Thank you to the Bandon Dunes Charitable Foundation for this generous support. **Discussion:** Southern Coos will be responsible for travel expenses.

Bob Pickel **moved** to grant authority to the CEO to engage the services of Wipfli, LLC as proposed at $80,000 plus expenses. **Discussion:** The organization is located in Spokane, Washington. Pam Hansen **seconded** the motion. **All in favor. Unanimous decision.**

V. Staff Reports

1. CEO Report

Ray Hino, CEO, reviewed highlights from his written report. The Senior Life Solutions service line started this week with the first 2 patients, however, the new director recently resigned for personal reasons, with interviews scheduled for that position with support from PMC, the parent company. Kristin Crusoe, Director, and Raquel Peterson our SLS/PMC representative, visited Pacific View and Adapt, LLC and other local providers which was well received. Ms. Crusoe has been instrumental in our setup and we appreciate her contributions. We are pleased to report that we received notice of our mid-year distribution from Advanced Health of $74,506.65. The Rural Health Transformation Program survey has been submitted, requesting funds to support formation of a Southern Oregon Coast network to coordinate and collaborate on efforts to serve our communities, and also funding to support our strategic plan project to achieve Level IV Trauma Center designation in 2026. In November, Southern Coos Hospital & Health Center was awarded a 2025 Performance Leadership Award by the Chartis Center for Rural Health; one of 13 Oregon hospitals to be recognized. Mr. Hino closed with sharing the 2025 Employee of the Year awards, with congratulations to Brandie Guzman, Medical Lab Assistant III, Laboratory and Kassandra Keller, Assistant Manager, SCHHC Clinic.

2. CMO Report

Dr. Alden Forrester, Chief Medical Officer, referred to his printed report, requesting any questions. There is no Medical Staff meeting in December. There were no questions.

3. SCHHC Retail Pharmacy Report

Dr. Forrester provided a summary of the Retail Pharmacy Report. Over 1900 prescriptions were filled in November, down from October, but roughly 1400 were new prescriptions, indicating potential for growth. As of this date in December, we are averaging 70 prescriptions per day. The Pharmacy team is working to resolve several issues regarding contracting. At this time, the Retail Pharmacy financials are included in our mitigation dashboard under new strategic initiatives. **Discussion:** Board members inquired about the Medicare Advantage plan, WellCare. As of December 19, SCHHC Retail Pharmacy has been confirmed as “in network” with WellCare and additional Medicare Advantage plans.

4. CNO Report

Cori Valet, CNO, reviewed highlights from her written report for the month of November. **Staffing:** Six nursing positions are in recruitment, up by 1 from prior month. With lower census, staff has been “flexed down.” At present, there are four contract RNs. Night shift has been a challenge to fill. The new Laboratory Manager, Tonya Sotelo has joined us and is doing a great job. One per diem Respiratory Therapist will now be full time. **Discussion:** Kay Hardin, Board Member, inquired

about a referral program. Nurse Staffing requirements were discussed. Mr. Bedell, Chairman, noted that it would be unrealistic to anticipate not using contract staffing, due in part to our geographical location and availability of certain clinical specialties. Stacy Nelson, HR Director, added that contract usage has been reduced from prior year. A plus for Southern Coos in recruitment is our culture, but available housing remains a challenge. **Skills Days:** This expanded program extends to all staff, all departments, at SCHHC, previously dedicated to only nursing departments. In December, subjects were presented by Health Information Management, Clinical Informatics, Revenue Cycle, Patient Services, Quality, and Infection Prevention/Employee Health. There were no further questions. **Surgical Services:** Endoscopy services have resumed with positive feedback from patients and staff Dr. Schulte has been commended by staff for his exceptional communication, patience, and professionalism.

5. CFO Report

In the interest of time, Cam Marlowe, Interim Chief Financial Officer, offered to answer any questions regarding his report on operations for the month of November in the areas of Financial Accounting, Engineering, Materials Management, and Revenue Cycle. There were no questions.

6. CIO Report

Scott McEachern, Chief Information Officer, opened with an update on internal projects including the facility remodel in what has been the Information Technology (IT) and Health Information Management (HIM) department space and the Business Office move from 2nd Street to new leased space at the Ray's Market complex. There has been a pause in the conversion of the former business office space due to contractor scheduling. The hospital conference room has become transitional office space. The Information Technology team and Engineering team have been transitioning staff from the IT space to the conference room and other staff are remote. **Discussion:** The Interface with Motion MD for durable medical equipment ordering will allow ordering in Epic via the patient chart, moving way from a paper workflow, for traceable ordering within the system.

7. Clinic Report

David Serle, Multi-Specialty Clinic Director, provided a summary of Clinic activities from prior month. We are excited to welcome Natalie Speck, MD who be joining the Clinic staff in mid-February. Dr. Schulte, MD, General Surgeon, with us 5 days per month, has 21 consults in December. Dr. Schulte and Senior Life Solutions geriatric mental health counseling have both been well received. Holidays in November and December will impact the number of patient visits but visits are up 4.8% from prior month, however are expected to reduce in December. Mr. Serle will be adding a month-to-month data comparison to his monthly report. Patient surveys for the period October 19-December 12 resulted in a net score of 86.2 with 13 specific categories. We are pleased to see high scores in areas of "Care Provider Explains Things," "Staff Members are Courteous and Respectful," "Would Recommend," "Facility in Clean and Good Condition," and, "Received Wanted Info Regarding

Mental Health." One of the areas we would like to improve includes "Easy to Get Appointment." Mr. Serle was pleased to report that the Clinic Outpatient Services will be providing regular infusion treatments for 2 patients who have had kidney transplants, allowing them to avoid travel outside of our local area. The separate Provider Productivity Report is in development with assistance from the Financial Accounting team. The summary report will be included in the Board packet.

8. Human Resources Report

Stacy Nelson, Director of Human Resources, reviewed highlights from his written report, including tracking of employee turnover metrics, exit interviews and compensation surveys completed in 2025. **New Hires:** New employees in November include the new Lab Manager, 2 full-time Emergency Department RNs, A Per Diem ER RN, Per Diem Med/Surg CNA, and full-time Dietary Cook. Open positions frozen at this time include 2 FTE HIM Specialist IIs, 1 FTE Manager of Budgeting and Financial Analysis, and 1 FTE Clinical Informatics Specialist. In the previous month, Mr. Nelson had shared that a focus would be placed on reducing employee turnover. New employee onboarding has been revamped following industry leader resources, Quint Studer "Emotional Onboarding" and Jobvite "The Ultimate Employee Onboarding Experience." While technical onboarding covers logistics (parking, equipment, and job duties), Emotional Onboarding focuses on fostering a sense of belonging to reduce early turnover. **Employee Health Insurance Open Enrollment**: Open Enrollment with Regence Blue Cross Blue Shield has been going well, closing tomorrow, December 19. Once complete there will be a final audit before employee payroll deductions begin in the January. **Employees of the Month:** Our employees of the month in November were Ayu McKenzie, CNA in the Medical/Surgical Department and Kiz Noble, Patient Access Specialist. Ray Hino shared Employee of the Year awards announced at the employee end of year dinner. **Discussion:** Board members inquired further about Recruitment responsibility, if that falls under Human Resources. HR coordinates recruitment advertising and works with existing staffing contracts to fill full-time non-clinical and clinical positions as well as temporary or locums staffing. Board members also inquired about goals regarding employee turnover.

9. SCHD Foundation Report

Alix McGinley, Health Foundation Executive Director, attending via remote link, provided a review of her report for the month of November. The new donor software platform is working great and capturing monthly donations from the Giving Tuesday staff event. The annual year end giving campaign mailer event is underway. The gift shop is doing well after addressing a minor reporting issue, now resolved. We are excited to be expanding volunteer services to include greeting patients in the lobby and staffing a book cart for inpatients. **Discussion:** Kay Hardin noted that music in the lobby could be a welcome addition.

10. Strategic Plan

Raymond Hino, CEO, provided a high-level status report of initiatives included in the strategic plan. In the first 17 months since the new Strategic Plan was created,

we have completed 15 goals (at 100% each). That is an increase in 2 completed goals since our last Strategic Plan report, 1) Develop a Clinical Informatics Roadmap, and 2) Develop IS Strategy and Roadmap. We are currently at 77.06 completion and all 42 goals have now been activated. This is a 0.34% increase from the previous report. The last remaining goal that was previously not activated was the Elder Loneliness goal, however, with the addition of our new Senior Life Solutions program, which has resources to aid with Elder Loneliness, we are now showing 87.5% completion of that goal. The profitability plan improved from 68.85% up to 70.52% this month due to completion of Senior Life Solutions from 80% up to 100%. The major goal for the next several months will be continued focus on the profitability improvement plans included in the Finance and Self-Sustainability section, in particular, Revenue Cycle.

VI. Monthly Financial Statements Review & Discussion

1. Month End Financial Summary and Review of Statements Ending November 30, 2025

Cameron Marlowe, Interim Chief Financial Officer, shared highlights from the financial statements. Gross Revenue: $4.5M for November, fell short of the $5.0M budget, but exceeded the same month last year by $300K. Outpatient volumes fell short of budget by $290K and swing bed revenue fell $222K below budget. Fiscal Year-to-Date we are about even at $107K bottom line. Mr. Hino noted that new provider “ramp up” is accounted for in the budget, but we did not budget for ramp up on Surgery. The Medicare Cost Report Settlement for FY26 is estimated to be $100K at November 30, 2025. **Discussion:** Retail Pharmacy Reporting and Capital Purchases were discussed in further detail. Ms. Hardin expressed staff safety concerns regarding bariatric bed included in the Capital Purchases. It was noted that the Respiratory Pulmonary Function Testing available at Southern Coos is not available elsewhere, locally, serving the greater Coos and Curry communities.

2. November Revenue Cycle Dashboard

Cam Marlowe, Interim CFO, presented the revenue cycle dashboard as Colene Hickman, Revenue Cycle Manger is out of office. There were no questions.

3. November Budget Mitigation Dashboard

Scott McEachern, CIO, reviewed the monthly budget mitigation dashboard to be expanded upon every three months, with the next benchmark evaluation to be presented in January. New strategic initiatives were included in the November report with positive results in October, but down in November. The three-month average of ($84K) is under close watch. In January, we will review potential “trigger” actions as previously determined based on the defined benchmarks.

VII. Open Discussion

Mr. Bedell wished everyone a Merry Christmas and Happy New Year.

VIII. Executive Session

At 8:08 p.m. the Board moved into Executive Session Under 192.660(2)(c) to consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 Licensing of facilities and health maintenance organizations, and under ORS 192.660(2)(f) to consider information or records that are exempt from disclosure by law, including written advice from legal counsel. No decision will be made in Executive Session.

Others were excused at this time. **Remaining in attendance:** Thomas Bedell, Chairman; Mary Schamehorn, Secretary; Pamela Hansen, Treasurer/Foundation Liaison, Kay Hardin, Director/Quality Committee Liaison, and Robert Pickel, Director. **Administration:** Raymond Hino, CEO; Amanda Bemetz, Director Quality Risk & Compliance; Alden Forreser, MD, CMO. **Absent:** P.J. Keizer, Medical Staff Chief of Staff. **Others in attendance:** Robert S. Miller, Legal Counsel; Kim Russell, Executive Assistant. **Press:** None.

At 8:17pm Dr. Forrester and Amanda Bemetz were excused.

IX. Return to Open Session

At 8:40 p.m. the meeting returned to Open Session.

1. Consideration of Executive Session Minutes 11-18-25

Mary Schamehorn **moved** to accept Executive Session Minutes as presented. Bob Pickel **seconded** the motion. **All in favor. Motion passed.**

2. Reports from Executive Session

a. Quality and Patient Safety Committee Report

Mary Schamehorn **moved** to accept the Quality & Patient Safety Report as presented. Bob Pickel **seconded** the motion. **All in favor. Motion passed.**

X. Adjournment

The meeting adjourned at 9:42 p.m. The next regular meeting will be held on January 22 at 6:00 p.m. In January, the meeting may return to the Adapt, LLC building 2nd floor conference room, to be announced.

Thomas Bedell, Chairman 1-22-2026 Mary Schamehorn, Secretary 1-22-2026

INVOICE

Robert S. Miller III, Attorney
1010 1st St SE
Ste 210
Bandon, OR 97411-9309

rsmiii@aol.com
+1 (541) 347-6075

Bill to
Southern Coos Hospital & Health Center
900 11th Street SE
Bandon, OR 97411 USA

Ship to
Southern Coos Hospital & Health Center
900 11th Street SE
Bandon, OR 97411 USA

Invoice details
Invoice no.: 1187
Terms: Net 30
Invoice date: 12/29/2025
Due date: 01/28/2026

#	Product or service	Description	Qty	Rate	Amount
1.	**Attorney ($300/hr)**	General Board Meeting & Executive Session, December 18, 2025.	3	$300.00	$900.00

Total **$900.00**

Ways to pay

View and pay

DATE: January 16, 2026
TO: Board of Directors
FROM: Raymond T. Hino, CEO
SUBJECT: Appointment of Monika Mehrens, DO as Antibiotic Stewardship Champion

Recommended Action

Management is seeking Board approval to appoint Monika Mehrens, DO as our Qualified Antibiotic Stewardship Champion, effective immediately. Dr. Mehrens is qualified for this position, due to her background, expertise in antibiotic stewardship and her experience in similar roles in licensed hospitals, that are mandated to comply with CMS Conditions of Participation. As compensation for serving in this role, management recommends that Dr. Mehrens be offered a monthly stipend of $2,000.

Background

CMS Conditions of Participation §482.42 (b)(1) Standard: Antibiotic Stewardship Program Organization and Policies, requires the Critical Access Hospital Governing Board to appoint an individual or individual(s) who is qualified through education, training, and experience in antibiotic stewardship. The appointment of this individual must be based on recommendations of medical staff leadership and pharmacy leadership.

Dr. Mehrens' education, qualifications and experience have been examined by Medical Staff leadership (represented by Alden Forrester, MD, Chief Medical Officer) and Pharmacy leadership (represented by Jeremy Brown, Pharm.D, Director of Pharmacy), and both recommend Dr. Mehrens for approval and appointment by the Board of Directors.

The management and clinical leadership of Southern Coos Hospital are presenting Monika Mehrens, DO, for approval and appointment as the Antibiotic Stewardship Champion for SCHHC due to the fact that she meets all requirements.

3.1 MEDICAL STAFF MEETINGS

3.4-1 MEDICAL STAFF YEAR: The Medical Staff year will begin on July 1 of every odd-numbered year.

3.4-2 MEDICAL STAFF MEETINGS

A. REGULAR MEETINGS: Eleven (11) monthly regular Medical Staff meetings will be held per calendar year. The Medical Staff may authorize the holding of additional general Staff meetings by resolution.

B. SPECIAL MEETINGS: A special meeting of the Medical Staff may be called by the Chief of Staff of the Medical Staff and must be called by the Chief of Staff at the written request of the Board of Directors or two (2) members of the Active Medical Staff. A call of a special meeting shall require notice specifying the place, date, time and purpose of the meeting.

C. PEER REVIEW MEETINGS: Peer Review meetings shall be held ~~at~~ monthly (except December)~~least quarterly~~ to review the appropriateness and quality of care provided by members as part of the Continuous Peer Review Process. The Credentials Committee serves as the Peer Review Committee for Continuous Peer Review.

Meetings of the Incident-specific Peer Review Committee occur on an as-needed basis to perform reviews of episodes of care where a concern has been identified. The membership, duties, and procedures for the Incident-specific Peer Review Committee are defined in the Rules and Regulations of the SCHHC Medical Staff.

~~C.~~

Formatted: Font: 12 pt

Formatted: Indent: Left: 1.15", Hanging: 0.5", Right: 0", Space Before: 0 pt, Line spacing: single, No bullets or numbering, Tab stops: Not at 1.65"

Formatted: Indent: Left: 1.65"

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Chief Executive Officer Report

To: Southern Coos Health District Board of Directors
From: Raymond T. Hino, MPA, FACHE, CEO
Re: CEO Report for SCHD Board of Directors, January 2026

Senior Life Solutions:

- As reported last month, the new Senior Life Solutions (SLS) program did, in fact, begin providing services during the week of December 15, 2025. The first cohort includes 2 Medicare patients in the group.

- Previously, I reported that the Program Director for Senior Life Solutions was going to be Kristin Crusoe, RN from nearby Charleston. After performing much of the work to start the new program, Kristin has decided that, as much as she loves what SLS offers our patients, that the Program Director position is not a fit for what she wants to do professionally at this time in her career. We were sorry to lose Kristin, but completely understand her desires. Effective January 5, 2026, an Interim Program Director, hired by SLS has been working to keep the program going and moving forward. We have an interview with a qualified local health professional on Monday, January 19. We are hoping to have the position filled as soon as possible.

Physical Plant Moves:

- The former IS/HIM office space renovation is about 60% complete at this time. Office space has been completed for Dr. Forrester, Dr. Keizer, HR, Quality and Health Information Management (HIM). We are still waiting on the materials to complete the office space for Stacy Nelson and Amanda Bemetz. This office space should be completed before our February Board meeting.

- The new office space in the Ray's Shopping Center, which we now refer to as the SCHHC Business Services Center, is also nearing completion. Colene Hickman and the majority of the Revenue Cycle team have been moved into new office space in the Center. There are still 2 private offices that have not yet been conducted, that will be used for Senior Health Insurance Benefits Assistance (SHIBA) counselors for Medicare. Belle Rosander, who answers phones and accepts payments has also been moved into this new space. Our staff and patients like this new office for its convenience for our patients. It's located right next to Dollar Tree and has excellent parking accessibility.

- The former Foundation/Business Office Building is nearing completion as well. Nearly all construction is now completed. The last steps are installation of alarm systems and approval by the Oregon Health Authority as clinical space. These final steps are expected to take place by the end of this month or the first week in February. As a reminder, this space will be occupied by Senior Life Solutions, Pain Management and General Surgery (Dr. Schulte).

Master Facility Planning Process

- After the Board approval last month to engage with the Wipfli Financial Services organization to conduct a Financial Feasibility analysis, debt capacity study and funding options review for our Master Facility Planning process, we signed with Wipfli and have begun the process. We have begun the process of supplying financial information to Wipfli. We are on track to provide a Master Facility Plan and financial analysis for the next Finance Committee meeting in April, with the plan to have a final presentation for the Board of Directors at their meeting in April or May.

Federal/State Funding – Rural Health Transformation Program Funds

- The Oregon Rural Health Coordinating Council (RHCC), which I now Chair, met on Friday, January 16, 2026, for our first meeting of 2026. The RHCC is a State mandated body, working in conjunction with the Oregon Office of Rural Health and representing rural providers throughout the State (doctors, dentists, pharmacists, hospitals, clinics, mental health, etc.) All members of the RHCC are appointed by the Governor of the State. The RHCC was included in the State of Oregon's application for Rural Health Transformation Program (RHTP) funds, as an Advisor to the State in the administration of the RHTP funds. On December 29, 2025, it was announced by CMS that the State of Oregon will receive $197.3 million in 2026 of these funds. Those funds will be disbursed to health providers and programs using a grant application process. In total, Oregon expects to receive about $1.0 billion total in 5 years. The total amount to be awarded to all states over the 5-year life of the RHTP is $50.0 billion.

- During our January RHCC meeting (a public meeting with opportunities for public input and comment), we met with the Oregon Health Authority team responsible for administration of the RHTP funds, for 1.5 hours. The Council decided to begin meeting monthly, instead of our normal cadence of quarterly.

Toast of the South Coast Awards:

- On January 6, 2026, Southern Coos Hospital & Health Center was invited to attend the Awards Event for formal announcement of the winners of the 2025-2026 Bicoastal Media Toast of the South Coast Award winners. Once again, this year, SCHHC did very well. This year we brought home the following:

    - Medical Facility – Gold Medal Winner (3 years in a row – all Gold Medals)
    - Behavioral Health – Gold Medal Winner (3 years in a row with Silver Medals for the past 2 years)
    - Hospital - Silver Medal Winner (3 years in a row with Gold Medals for the past 2 years)
    -
    - Pharmacy - Silver Medal Winner (our first time winning in this category)
    - Pediatrician - Silver Medal Winner (our time winning in this category)
    - Place to Volunteer - Silver Medal Winner (our first time winning in this category)

- In 3 years of the Bicoastal Media Toast of the South Coast Awards (including businesses, restaurants, retail, professionals and more on the Oregon South Coast from Florence down to Langlois), Southern Coos Hospital & Health Center has won a total of 17 medals.

Chief Medical Officer Report

To: Southern Coos Health District Board of Directors

Re: CMO Report for SCHD Board of Directors, January 2026

Antimicrobial Stewardship

The appropriate use of antibiotics and other antimicrobial treatments is a critical part of patient care and safeguarding our community against the threat of antibiotic resistance. To that end, we are creating a more formal and robust antimicrobial stewardship program here at Southern Coos. One of the early steps of this process is appointing an individual to be the program's Clinician Champion.

Dr. Monica Mehrens, one of our new hospitalists, has overseen similar programs at other hospitals and has volunteered to serve as our Clinician Champion. Per CMS regulations, she will need approval from the Board to accept this position.

I have full confidence in Dr. Mehrens and, on the recommendation of the Southern Coos Medical Staff, ask for the Board's approval of her appointment to the position of Antimicrobial Stewardship Clinician Champion.

Medical Staff Bylaws Revisions

As part of the continuing effort to improve its bylaws, the medical staff recommends to the Board changes regarding the peer review process. Specifically, these changes provide clarity on the peer review committee processes for different types of peer review. Recommended text of changes to Bylaws section 3.4-2 approved by the medical staff are included in the Board packet for this month and require Board approval to become effective.

Direct Radiology

Direct Radiology, the group of radiologists that provide backup to Drs. Quinn and Keizer, informed us that they are terminating their contract with us as of April this year. No reason was given. As of this writing we are searching for a replacement group.

General Surgery

At the time of this writing, we have 5 general surgery cases scheduled for this month and 13 scheduled for February. The work Dr. Schulte, Danielle Wirt, David Serle, and everyone else involved has put in to restart general surgery at Southern Coos is greatly appreciated.

The next steps are to solidify what we have gained and consider when it might make sense to expand this program. This is an interesting time for surgeon recruitment with the recent or impending closure of hospitals with general surgery programs.

Dr. Speck

The appointment of Dr. Natalie Speck to our medical staff is on tonight's Board agenda. If approved, she will fill the last vacancy on our primary care team giving us four providers under contract and ending our reliance on locum coverage for primary care.

SCHHC Retail Pharmacy Report

To: Southern Coos Health District Board of Directors
From: Alden Forrester, MD, Executive for Pharmacy Services
Re: Retail Pharmacy Report for SCHD Board of Directors, January 2026

Retail Pharmacy Volume

2388 prescriptions were filled by our retail pharmacy in the month of December, which is up from 1943 in November (a 23% increase). We continue promotional efforts and evaluation of alternative revenue streams. I hope to have more concreate information for the Board regarding new revenue streams at the February meeting.

Financial Statement for December:

The Net Change in Position for December 2025 was negative $41,442. For comparison, the net change for November was negative $36,142. Unfortunately gains made in revenue were more than offset by increased expenses including increased labor expenses for the month of December.

Please see Profit and Loss statement in Appendix A below for additional information (Thank you again to Jenny Pearcy for providing this data).

(Continued next page.)

Appendix A

PHARMACY-RETAIL (OP)

Southern Coos Health District
Profit & Loss Statement
As of December 31, 2025

	Month To Date 12/31/2025				07/01/2025 Through 12/31/2025			
	Actual	Operating Budget	Actual minus budget	Budget variance	Actual	Operating Budget	Actual minus budget	Budget variance
Total Patient Revenue								
Outpatient Revenue								
3009 - OTHER PATIENT REVENUE	-	58,689	(58,689)	(100.0) %	-	212,184	(212,184)	(100.00)
Outpatient Revenue	-	58,689	(58,689)	(100.0) %	-	212,184	(212,184)	(100.00)
Total Patient Revenue	**-**	**58,689**	**(58,689)**	**(100.0) %**	**-**	**212,184**	**(212,184)**	**(100.00)**
Total Deductions	**429,817**	**-**	**429,817**	**100.0 %**	**1,885,632**	**-**	**1,885,632**	**100.00**
Net Patient Revenue	**(429,817)**	**58,689**	**(488,506)**	**(832.4) %**	**(1,885,632)**	**212,184**	**(2,097,816)**	**(988.67)**
Other Operating Revenue	**610,819**	**-**	**610,819**	**100.0 %**	**2,628,092**	**-**	**2,628,092**	**100.00**
Total Operating Revenue	**181,002**	**58,689**	**122,313**	**208.4 %**	**742,460**	**212,184**	**530,276**	**249.91**
Total Operating Expenses								
Total Labor Expenses								
Salaries & Wages	44,339	41,794	2,545	6.1 %	199,562	241,048	(41,486)	(17.21)
Benefits	6,311	8,240	(1,928)	(23.4) %	30,493	48,906	(18,412)	(37.64)
Total Labor Expenses	50,650	50,034	617	1.2 %	230,055	289,954	(59,898)	(20.65)
Purchased Services								
4500 - PURCHASED SERVICES	779	-	779	100.0 %	12,885	-	12,885	100.00
Purchased Services	779	-	779	100.0 %	12,885	-	12,885	100.00
Drugs & Pharmaceuticals								
4204 - DRUGS	164,084	27,618	136,465	494.1 %	662,994	165,711	497,282	300.09
Drugs & Pharmaceuticals	164,084	27,618	136,465	494.1 %	662,994	165,711	497,282	300.09
Medical Supplies								
4202 - NONBILLABLE SUPPLIES - MEDICAL	1,495	-	1,495	100.0 %	4,116	-	4,116	100.00
Medical Supplies	1,495	-	1,495	100.0 %	4,116	-	4,116	100.00
Other Supplies								
4301 - OFFICE SUPPLIES	15	-	15	100.0 %	2,759	-	2,760	100.00
4398 - MINOR EQUIPMENT	-	-	-	-	2,145	-	2,145	100.00
Other Supplies	15	-	15	100.0 %	4,904	-	4,905	100.00
Other Expenses								
4302 - POSTAGE & FREIGHT	163	-	162	100.0 %	1,009	-	1,008	100.00
4501 - MARKETING - ALLOWABLE (MCR)	-	1,667	(1,666)	(100.0) %	-	10,000	(10,000)	(100.00)
4502 - MARKETING - NON ALLOWABLE	1,900	-	1,900	100.0 %	4,684	-	4,684	100.00
4504 - PRINTING & COPYING	123	-	123	100.0 %	341	-	342	100.00
4702 - LICENSING & GOVERNMENT FEES	50	840	(790)	(94.0) %	100	5,040	(4,940)	(98.01)
4703 - DUES & SUBSCRIPTIONS	831	-	832	100.0 %	6,879	-	6,879	100.00
4798 - BANK & COLLECTION FEES	618	-	618	100.0 %	3,040	-	3,040	100.00
Other Expenses	3,685	2,507	1,179	47.0 %	16,053	15,040	1,013	6.73
Utilities								
4404 - ELECTRICITY	-	3,773	(3,773)	(100.0) %	-	22,638	(22,638)	(100.00)
Utilities	-	3,773	(3,773)	(100.0) %	-	22,638	(22,638)	(100.00)
Depreciation & Amortization								
6162 - DEPRECIATION - MAJOR MOVABLE EQUIPMENT	410	-	409	100.0 %	2,460	-	2,459	100.00
6152 - DEPRECIATION - BUILDING - CLINIC	1,326	-	1,326	100.0 %	7,955	-	7,956	100.00
Depreciation & Amortization	1,736	-	1,735	100.0 %	10,415	-	10,415	100.00
Total Operating Expenses	**222,444**	**83,932**	**138,512**	**165.0 %**	**941,422**	**493,343**	**448,080**	**90.82**
Operating Income / (Loss)	**(41,442)**	**(25,243)**	**(16,199)**	**64.2 %**	**(198,962)**	**(281,159)**	**82,196**	**(29.23)**
Change In Net Position	**(41,442)**	**(25,243)**	**(16,199)**	**64.2 %**	**(198,962)**	**(281,159)**	**82,196**	**(29.23)**

Chief Nursing Officer Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Cori Valet, RN, BSN, Chief Nursing Officer
Re: CNO Report for SCHD Board of Directors Meeting – January 22, 2026

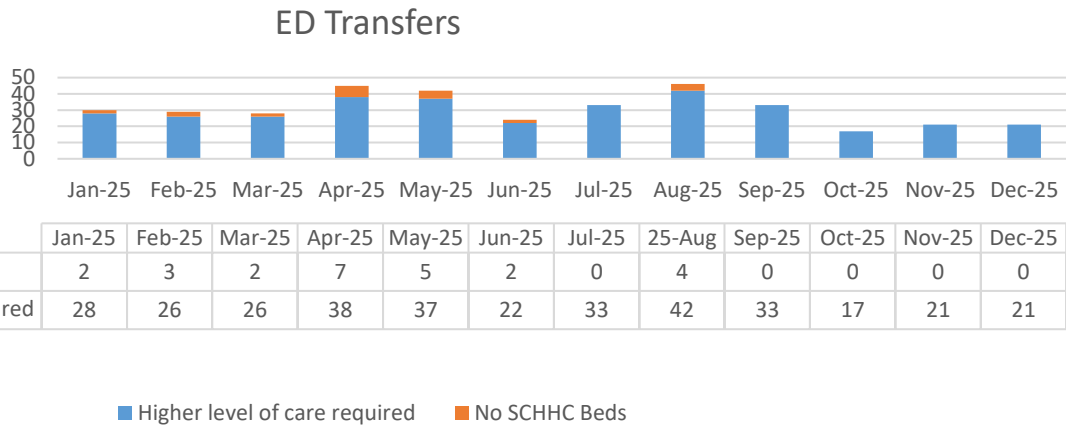
Clinical Department Staffing –

Medical-Surgical department – No changes from prior month.
- December stand-by time = 326.61 hours (equal to 27.22 shifts), which would have been hours worked if census required it.

- Emergency department – One full-time night shift RN submitted resignation (relocating). One full-time night shift RN expressed intention to transition to a per diem position in January, 2026. Recruitment efforts initiated with good results. Three full-time night shift RNs were recruited and began orientation. No further vacancies to fill. One contract RN utilized in December.
- Laboratory department – One Medical Lab Assistant position vacant. Two full time Medical Lab Scientist(MLS)/Medical Lab Technologist(MLT) positions vacant. One MLT submitted resignation (last day to be 01/15/2026). Two contract MLS/MLTs in place in December. Positive news for January 2026 – One MLS, One MLT, and One MLA have been recruited and will begin orientation 01/20/2026.
    - The variance of 2.3 FTE shown in the FTE grid is expected and welcomed with the orientation of our new manager.
- Surgical department – No changes from prior month. One circulating registered nurse position remains vacant. Recruitment efforts will be extended when surgical volumes indicate need.
    - FTEs below expectations (-2.79 FTE) due to limited surgical volumes.
- Medical Imaging – No changes from prior month. One full time CT/XR technologist positions remain open. One technologist contract utilized in November.
    - Deficiency of 2.64 shown in the FTE table was due to the delay in hiring an additional US technologist, Mammography technologist, and CT/XR technologist for surgical services until volumes indicate the need.
- Respiratory therapy – Two full time respiratory therapist (RT) positions vacant in December. One (1) contract RT utilized. One per diem RT transitioned into full-time mid-December.
    - Deficiency of 2.95 FTE shown in the FTE table due to leave of absence and scheduled vacation.
- Case management – No changes from prior month, fully staffed.

	December 2025 FTE				
	SCH Actual	Contract Actual	Actual Total	Budget	Diff
Med Surg	**25.75**	**4.11**	**29.86**	**31.95**	**-2.09**
Manager	1	0	1	1	0
CH RN	3.35	0	3.35	3.85	-0.5
RN	9.58	4.11	13.69	12	1.69
LPN	1.25	0	1.25	2.45	-1.2
CNA	8.98	0	8.98	8.65	0.33
TeleTech	1.59	0	1.59	4	-2.41
Emergency Dept	**14.12**	**1.18**	**15.3**	**15.18**	**0.12**
Manager	1	0	1	1	0
RN	9.06	1.18	10.24	8.78	1.46
LPN	3.31	0	3.31	3.6	-0.29
CNA/US	0.75	0	0.75	1.8	-1.05
Laboratory	**9.68**	**2.05**	**11.73**	**9.41**	**2.32**
Manager	0.5	0	0.5	1	-0.5
MLS	2.34	0	2.34	0.37	1.97
MLT	1.81	2.05	3.86	3.12	0.74
Lab Assist I	2.75	0	2.75	2.38	0.37
Lab Assist II	1.31	0	1.31	1.47	-0.16
Lab Assist III	0.97	0	0.97	1.07	-0.1
Surgical Dept	**5.01**	**0**	**5.01**	**7.8**	**-2.79**
Manager	1	0	1	1	0
Surgical RN	0.77	0	0.77	3	-2.23
Sterile processor	0.56	0	0.56	1	-0.44
Surgical Tech	1.66	0	1.66	2	-0.34
Housekeeper	1.02	0	1.02	0.8	0.22
Medical Imaging	**10.73**	**1.02**	**11.75**	**14.39**	**-2.64**
Manager	1	0	1	1	0
Radiology Tech	3.88	1.02	4.9	8.03	-3.13
Rad Tech I	2.92	0	2.92	0.7	2.22
Ultrasound	1.72	0	1.72	2.66	-0.94
MI Coordinator	0.69	0	0.69	1	-0.31
MI Admin Assist	0.52	0	0.52	1	-0.48
Respiratory Therapy	**3.75**	**0.61**	**4.36**	**7.31**	**-2.95**
Manager	1	0	1	**1**	**0**
RT	2.75	0.61	3.36	6.31	-2.95
Swing Bed	**1.54**	0	**1.54**	**1.65**	**-0.11**
Case manager	1.54	0	1.54	1.65	-0.11
Totals	**70.58**	**8.97**	**79.55**	**87.69**	**-8.14**
% of FTE	89%	11%			

ED Transfer Statistics –



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	25-Aug	Sep-25	Oct-25	Nov-25	Dec-25
No SCHHC Beds	2	3	2	7	5	2	0	4	0	0	0	0
Higher level of care required	28	26	26	38	37	22	33	42	33	17	21	21

- December 2025 Transfers – Total Transfers = 21. All transfers required higher level of care and/or services not offered at SCHHC.
  -
  - Pulmonology - 0
  - Surgical Services – 5
  - Obstetrical – 0
  - Intensive care – 5
  - Urology – 1
  - Psychiatric evaluation - 0
  - Dialysis - 0
  - Pediatric – 0
  - Orthopedics - 2
  - Hematology/Platelets – 0
  - Gastroenterology – 1
  - Interventional Radiology - 0

Specialized Clinical Positions and Estimated Financial Impact –

Within the Respiratory and Medical Imaging Departments, there are a few positions that require specialized training and/or certification where in there are only one or two staff members employed at SCHHC who poses the skills/certifications to perform specific procedures. Below is a list of the procedures and the estimated financial impact that we would suffer if an individual with those skills were not available, or the position were to remain vacant.

Procedure	Estimate/Month	Estimate/Year
Pulmonary Function Testing	$13,499.36	$161,992.32
MRI	$148,718.12	$1,784,617.44
Ultrasound	$131,584.00	$1,579,008.00

Data for X-Ray and CT are not included as we have multiple employees who possess training/certification to perform these skills and it is highly unlikely we would suffer incidents where in these services are unavailable related to staffing.

The above totals are estimates based on the average cost per modality and an average procedure volume based on historical data.

Employee Referral Bonus –

Efforts have been initiated to initiate an employee referral bonus for employees of Southern Coos Hospital & Health Center to receive an incentive bonus for a successful referral of a full-time critical staff member. At this time the policy is in the draft stage and is being reviewed by all interested parties and applicable department heads for suggestion or editing. The goal is to implement a fully approved policy by the end of February 2026.

Chief Financial Officer Report

To: **Board of Directors and Southern Coos Management**
From: **Cameron Marlowe, Interim CFO**
Re: **CFO Report for Board of Directors Meeting – January 22, 2026**

December 2025 Department Achievements/Activities

Finance & Accounting Update:

- We recently contracted with a placement firm out of California to help us find an interim controller.

Engineering / EVS Update:

- No updates at this time.

Materials Management / Supply Chain Update:

- We are looking into a couple group purchasing/purchasing coalition options that may be able to provide us with widespread savings across departments. These savings will pertain to supplies (medical and non-medical), purchased service expenditures, as well as some capital purchases. This process does take several months to complete, but when done appropriately, and with the support of administration and department heads, it can result in significant hospital-wide savings.

Revenue Cycle Update:

- No updates above and beyond what was included in Colene's report.

Other Items:

- I am currently working with other team members on several initiatives that will improve our bottom line. Specifically, I spoke with and shared with the executive team our list of highest paid vendors and discussed the opportunities that we have to reduce costs with many of those vendors by eliminating their services, reducing their services, improving our payment terms with them, etc… Our next steps are as follows:
    1. Continue working on the projects we have already started.
    2. Set up meetings between myself and each member of the executive team to discuss vendors that service their areas of responsibility and brainstorm on ways we can reduce our expenses with these vendors through collaboration between the CFO, one or more departments, the proper executive team members, etc...
    3. Identify any vendors that we cannot/should not pursue and state the reason for not pursuing them.
    4. Develop a comprehensive game plan for those vendors we are not already working on to address and pursue possible cost reductions.
    5. Create and update the list of vendors that we are pursuing and make regular updates to that list.
    6. As an FYI, some of these vendor efforts/opportunities will only take a matter of weeks while others may take several months to complete.

Chief Information Officer Report

To: Board of Directors and Southern Coos Management
From: Scott McEachern, CIO
Re: CIO Report for Board of Directors Meeting – January 2026

CIO Report

We have incorporated the AI Council and Forms Committee into the Data Governance committee, in an effort to reduce the number of meetings for our staff.

Our IS staff have spent a large amount of time in December implementing the necessary infrastructure for the staff space planning moves.

We are planning to migrate the remainder of our on-premise data to Microsoft Azure (a cloud-based system that provides greater security for our digital assets and PHI).

We completed the 2025 HIPAA Security Risk Assessment. I will present our findings to the board at your February meeting.

Projects Report

Business Office Conversion to Clinic Space

Completion of the project continues to move forward. We have completed the fire safety equipment installation, framed new doors and a wall for a new public bathroom, completed wiring. Contractors have finished drywalling. As of this writing, we are planning for staff to begin installing sinks, cabinets, mirrors, doors, and associated equipment in rooms.

Estimated date for occupancy: First week of February, 2026 (updated from December 5, 2025)

Bandon Shopping Center office space

As of this writing, Friday, January 16, the majority of the revenue cycle staff has moved to the space in the Bandon Shopping Center. The address is 120 Suite C, Michigan Avenue, SE. Business office mail will continue to be delivered to 900 11th Street (the main hospital) and then distributed to the clinic, 2nd street, and Business Center locations by materials management staff.

We are working on some final items, including installing the modular walls for the financial counselors. These may be installed by the date of the board meeting.

Final occupancy date: January 16, 2026 (updated from the week of December 29, 2025)

IS Remodel to HR/Quality Space

Flooring will be installed the week of December 15th. All staff have been moved back into the IS space, with the exception of the Directors of HR and Quality. We ran into an issue with the modular walls that has been fixed but it was necessary to order additional parts from the the manufacturer.

Estimated completion date: First week of February 2026 (updated from December 31st)

EHR Projects with Providence

Interface EKGs with Epic

SCH is working with Providence to connect EKGs with Epic through a software called MUSE. This software is a GE product that is used by Providence to integrate EKGs and other biomedical devices with Epic.

Estimated completion date: February 28, 2026

Radiology Data Conversion

SCH is working with Providence to connect radiology reports from studies conducted prior to the December 7, 2024 go-live with Epic. This project will link the prior studies to the patient chart in Epic, eliminating the need for providers to check two systems for past patient information.

Estimated completion date: June 1, 2026 (updated from April 30, 2026)

Epic Video Client Roll-out

Providence is rolling out a new video client that is native to Epic. The new video system will be embedded in the Epic software program.

Estimated completion date: February 2026

Interface with Motion MD

This interface will allow SCHHC nursing staff to order durable medical equipment within the patient chart or through Epic. The current workflow is manual.

Estimated completion date: January 30, 2026

Americollect Implementation

SCHHC is switching debt collection services to AmeriCollect. Our former agency proved difficult to work with and had long lapses in communication.

Estimated Completion Date: February 28, 2026

Credit Card Framework

This project is meant to implement a Providence-based point of sale solution. The new point of sale solution will integrate with Epic and eliminate the need for third-party point of sale software.

Estimated completion date: March 30, 2027 (updated by Providence from March 30, 2026)

Echo Interface with NovaPacs

In an effort to streamline the Echo results directly into the patient chart in Epic, we are working with Providence to build an interface between the Echo modality and Epic.

Estimated completion date: May 2, 2026

Clinical Informatics Report

CI Tickets Summary

2025	Totals		January 2026	Count
Closed	653	Closed	35	35
On Hold	1	On Hold	7	7
Open	0	Open	5	5
Count	654	Count	47	47

High Priority Projects

- Departmental Charge Capture Process:
  - Analyzing departmental charge capture workflows to standardize processes and improve charge entry efficiency.

- Anesthesia Workflow/Charging:
  - Reviewing and personalizing anesthesia workflows to optimize perioperative efficiency, accuracy, and patient safety.

- Laboratory Orders and Charge Configuration:
  - Evaluating charge routing errors within the laboratory workflow to prevent lost or incorrect charges, strengthen revenue integrity, and ensure accurate, compliant billing for lab services.

Multi-Specialty Clinic Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: David M Serle – Director Medical Group Operations
Re: Multi-Specialty Clinic Report for SCHD Board of Directors Meeting – January 2026

Clinic Operations - December 2025

Provider Recruiting/Onboarding: As of 1/15/26

- New Hire: Natalie Speck, MD, From Hood River Oregon
  - 3-year contract (working 3 days/wk.)
  - Start Date – February 16, 2026
  -

- Dr. Brett Schulte (Volume October - December)
  - Through December (41-Consults, 2-Post Ops, and 5 surgical procedures)
  - January 2026 scheduled (22-Consults, 2-Post Ops, 6-procedures)
  - February 2026 scheduled (1-Consult, 7-Procedures)
  - March, 2026 scheduled (0-Consults, 2-Procedures)
  -

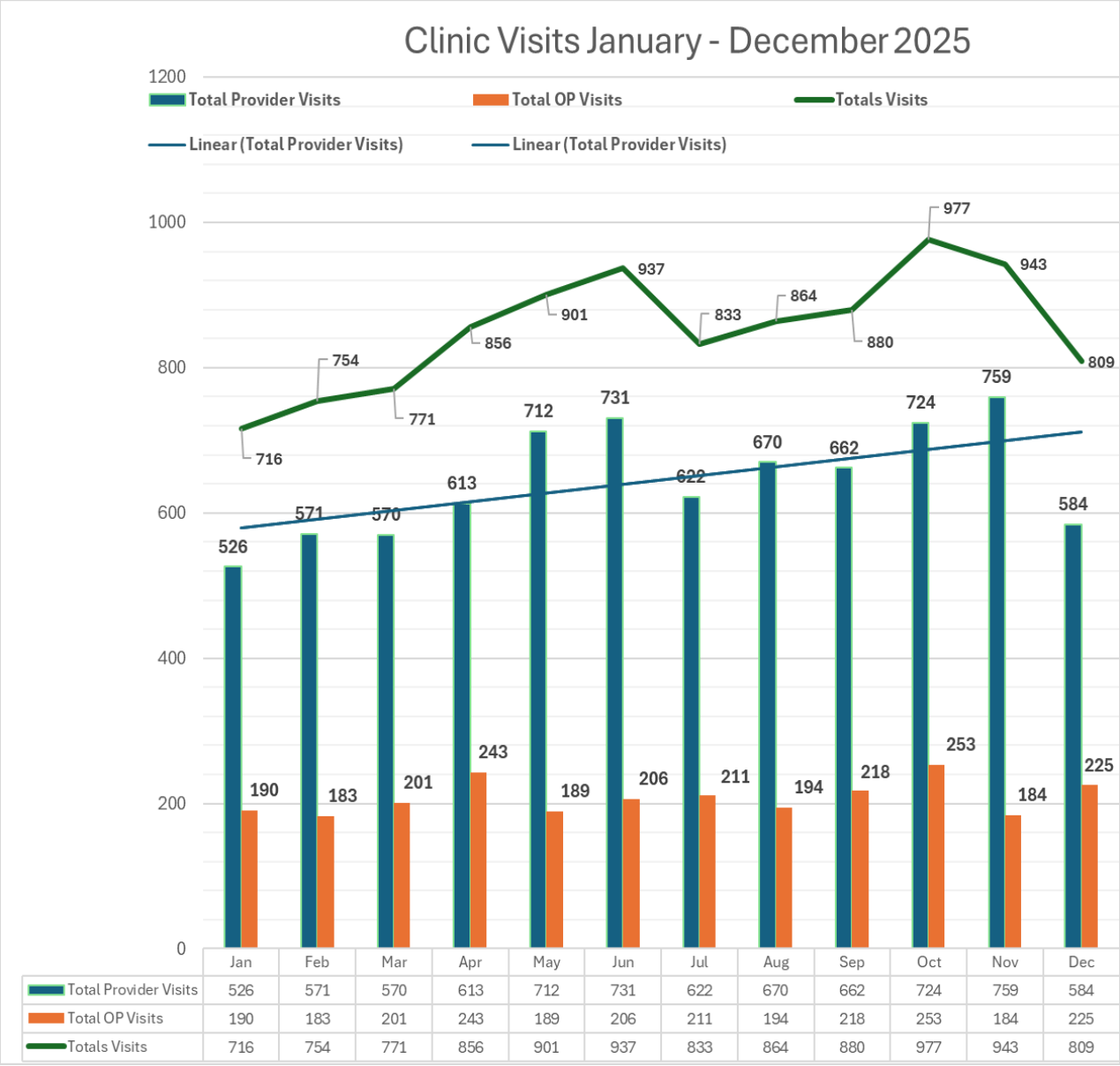
Clinic Visit Highlights:

- Provider visits are down 11% (-67) from the previous month
- Total visits are down 3% (-26) from the previous month
- Provider visits projected to go up 26% (+149) for December
- Total visits projected to go up 12% (+96) for the month of December

Clinic Visits By Provider

											Previous Months					Projected
Year: 2025							No									
Month: December	Clinic	PT's		No	Total	AVG	Show	Cancel	Tele	New	August	September	Ocober	November	December	January
Provider	Days	Sched	Cancel	Show	Seen	Seen	Rate	Rate	HLTH	PT's						
Paul Preslar, DO	10.00	140	7	5	128	12.8	4%	5%	0	3	111	133	132	128	128	156
Shane Matsui, LCSW	18.00	89	7	2	80	4.4	2%	8%	9	2	78	84	87	80	80	71
Victoria Schmelzer, CRNA											29	63	36	67	0	48
Tami Marriott, MD	5.25	40	5	0	35	6.7	0%	13%	0	0	85	44	33	35	35	48
Jennifer Webster, MD	11.14	148	11	8	129	11.6	5%	7%	5	1	162	127	159	129	129	108
Henry Holmes	7.00	71	7	2	62	8.9	3%	10%	0	0	43	56	37	62	62	58
Veronica Simmonds, MD											24					
Kim Bagby, FNP	4.00	29	2	1	26	6.5	3%	7%	0	1	138	86	130	26	26	133
Felisha Miller, FNP	16.50	120	10	7	103	6.2	6%	8%	1	30		69	107	103	103	91
Brett Schulte	4.00	22	0	1	21	5.3	5%	0%	0	20			3	21	21	20
Total Provider Visits	***76***	***659***	***49***	***26***	***584***	***7.7***	***4%***	***7%***	***15***	***57***	***670***	***662***	***724***	***651***	***584***	***733***
Total Outpatient Services	20.5	283	56	2	225	*11.0*	*1%*	*20%*	*0*	*0*	*194*	*218*	*253*	*184*	*225*	*172*
Total Visits	***96***	***942***	***105***	***28***	***809***	***8.4***	***3%***	***11%***	***15***	***57***	***864***	***880***	***977***	***835***	***809***	***905***

Clinic Volume YTD 2025



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Provider Visits	526	571	570	613	712	731	622	670	662	724	759	584
Total OP Visits	190	183	201	243	189	206	211	194	218	253	184	225
Totals Visits	716	754	771	856	901	937	833	864	880	977	943	809

Chronic Care Management (CCM)

Much of our chronic care services had to be put on hold due concerns about insufficient documentation within the patient chart to have a billiable service. After an extensive audit and review of patient charts by Colene Hickman, Director of Revenue Cycle, Amanda Bemetz, Director of Quality, Risck & Compliance, Kelli Cotton, and Chandra Donnell, Independent Contractors, they were able to determine that an estimated $75,000 - $85,000 should be billable. These 4 individuals worked tirelessly because they believed there was an opportunity to collect more and I want to recognize them for their painstaking and tedious efforts to realize these dollars that were not part of our budget for 2025/2026.

Did You Know?

Colposcopies are performed in the clinic. They are a procedure where a doctor uses a lighted , magnified instument (colposcope) to closely examine the cervix, vagina, and vulva for abnormal or precancerous cells, often after an abnormal pap smear or positive HPV test. This test is also used for diagnosing causes of abnormal bleeding or pain and monitoring changes from HPV.

Human Resources Report

To: Southern Coos Health District Board of Directors
From: Stacy Nelson II, Director, Human Resources
Re: Report for SCHD Board of Directors, January 2026

Metrics

Employee Turnover:

- FY 2024 = 12.21%
- FY 2025 = 9.31%
- FY 2026 YTD
  - 9/30/2025 = 8.21%
  - 12/31/2025 = 7.85%
- FY 2026 New Employee Turnover YTD
  - 9/30/2025 = 17.80%
  - 12/31/2025 = 14.53%

Recruitment

- SCHHC - Employee Recruitment and Retention Policy
- SCHHC - Turnover Metrics

New Hires - December 2025:

- Pamela Furness - Registered Nurse - Full Time - Emergency Department
- Leah Bindra - Cook - Full Time - Dietary Department

Open Positions Frozen - December 2025:

- 1.0 FTE - Manager of Budgeting & Financial Analysis
- 1.0 FTE - IT Clinical Informatics Specialist

Activities/Events

- Employee Benefits
  - Open Enrollment - 12/4/25 to 12/19/25 - Total 174 Employees
    - Base Plan - 113 Employees
    - Buy Up Plan - 43 Employees
    - HSA Plan - 18 Employees

- December 2025 - SCHHC Skills Day - "Crucial Conversations"

    - How to Have a Crucial Conversation
    - Style Under Stress Survey
    - Silence Kills Study

- 2025 Christmas Dinner - Day/Night Shift - SCHHC Employees

People

Quote of the Month - December 2025:

"I was planning to leave the healthcare industry. There's too much stress, and I'm burned out. However, in coming to Southern Coos, I've learned what a supportive workplace looks like, and I'm so grateful to be here. I've rediscovered my passion for patient care." - New Employee at Southern Coos Hospital and Health Center.

Employees of the Year - 2025

- Clinical - Brandie Guzman - Assistant Supervisor - Laboratory Department

This employee has really stepped up and filled some big shoes during a sad time. They have taken to a leadership role with compassion, patience, and dedication. Nobody wants to be the boss, manage schedules, hire new department staff, or answer tough questions, BUT they saw a need for the department and conquered it. They also bake the BEST desserts in the world and always share with their coworkers and other departments. I am so grateful for this employee; without them, I don't think I could have handled the workload. In all seriousness, even if they don't win employee of the month, I hope they read this and know how much I, and our department, appreciate them so much.

- Non Clinical Kassandra Keller - Assistant Manager - Multi-Specialties Clinic

This employee is an incredibly kind, compassionate, and dedicated team member who has
I would like to nominate an extraordinary non-clinical employee who consistently goes above and beyond for their department. They are a true leader, respected and appreciated by department leaders, office staff, medical assistants, and even our patients. This past month, they personally assisted a patient with a conversation that was both highly professional and deeply compassionate. It was a shining example of the care and dedication this employee brings to their role every day, and I feel truly blessed to work alongside them. Beyond patient interactions, they work tirelessly to streamline processes and workflows across multiple departments, improving efficiency and making our workplace a better environment for everyone. Their dedication, leadership, and commitment to excellence are inspiring, and I am honored to have the opportunity to collaborate with them.

crucial conversations®

How to Have a Crucial Conversation

A crucial conversation is any conversation where the stakes are high, opinions differ, and emotions run strong. We often fear them because our past experience has taught us that if we're both emotional and honest, bad things are likely to happen. However, if we have the skills to speak up both candidly and honestly, we can actually strengthen relationships while solving problems. Follow these steps to help you succeed in your next crucial conversation.

BEFORE THE CONVERSATION

1. **Start with Heart:** Before you begin, examine your motives. Ask yourself what you really want for you, for the other person, and for the relationship? This question activates your brain and diffuses your strong emotions.
2. **Prepare to STATE Your Path**—STATE stands for Share your facts, Tell your story, Ask for others' paths, Talk tentatively, and Encourage testing. Make sure you identify only the facts of the situation and the story you have drawn as a result of those facts.
3. **Identify a Mutual Purpose and Desired Outcome:** Identify goals both you and the other person care about. Clearly outline the actions or outcomes you'd like to see. If you can't identify these beforehand, ask the other person how you can solve the issue together.
4. **Practice:** Practice these skills ahead of time to prepare for your meeting.

AT THE BEGINNING OF THE CONVERSATION

1. **Get Buy-In:** Begin by getting agreement from the other person to have the conversation. If he or she wants to discuss something else or isn't prepared, schedule another time to meet.
2. **Clarify and Agree:** Reach agreement with the other person that there is an issue, identify what the issue is, and clearly articulate what a successful resolution would look like for both parties.

DURING THE CONVERSATION

1. **Make It Safe:** The antidote to defensiveness in crucial conversations is to make it safe. To create safety, help others understand that you respect them and care about their interests as much as you care about your own. When they believe this, they open up to your views. When they don't, they shut down. After you create a safe environment, confidently share your facts and your story.
2. **Invite Dialogue & Listen:** Once you've safely stated your path, invite differing opinions. Encourage the other person to disagree with you and then listen. Those who are best at crucial conversations want to learn. If your goal is just to dump on others, they'll resist you. If you are open to hearing others' points of view, they'll be more open to yours.

AT THE END OF THE MEETING

1. **Move to Action:** It's easy to let assignments fall through the cracks. When ending a crucial conversation, document WHO does WHAT by WHEN, and how you will FOLLOW UP. This will help you turn a conversation into real action and results.

To learn more, visit www.crucialskills.com

VitalSmarts®

SILENCE KILLS

The Seven Crucial Conversations® for Healthcare

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

VitalSmarts™

crucial conversations®

Silence Kills

The Seven Crucial Conversations for Healthcare

David Maxfield, Joseph Grenny, Ron McMillan, Kerry Patterson, Al Switzler

NASA employs some of the smartest and most dedicated professionals in the world. Individually they are the cream of the crop in their various science, engineering, and administrative disciplines. Their collective achievements have dramatically expanded the boundaries of our knowledge of both our universe and our world. And yet in spite of their individual dedication and collective brilliance, on February 1, 2003, seven astronauts died—perhaps unnecessarily—when the *Columbia* Shuttle Mission STS-107 incinerated on reentry into the earth's atmosphere. The reason? A key contributor to the tragedy was a culture that "prevented effective communication of critical safety information and stifled professional differences of opinion."[1] People's inability to confront risky topics allowed risks to go unaddressed—contributing to the loss of seven lives.

Those who serve daily in U.S. hospitals could be described as similarly intelligent and dedicated. In the aptly titled report *To Err is Human*[2], the Institute of Medicine acknowledges both the individual dedication and collective contributions of those who give their all to improve and save the lives of patients in our healthcare institutions. And yet, as the report points out, each year hundreds of thousands of patients are brought to harm in the course of their healing because of fundamental problems in the collective behavior of these caring professionals. These problems are not unlike those that contributed to the loss of *Columbia*. For example, each year one in twenty in-patients at hospitals will be given a wrong medication, 3.5 million will get an infection from someone who didn't wash his or her hands or take other appropriate precautions[3], and 195,000 will die because of mistakes made while they're in the hospital.[4]

Hospitals are responding aggressively to this crisis with new technologies, quality-improvement systems, and methods of organizing. However, though the healthcare community is taking needed action on a number of fronts, there is a deeper problem that must be resolved before acceptable levels of improvement will be attainable.

As with NASA personnel, key problems that contribute to these tragic errors are often known far in advance. And yet few people talk about them. Every day, many healthcare workers stand next to colleagues and see them cut corners, make mistakes, or demonstrate serious incompetence. But only a small percentage speak up and discuss what they have seen—even though they're standing only a few feet away. As a result, problems go on for years—contributing to avoidable errors, high turnover, decreased morale, and reduced productivity. Just as the unwitting behavior of well-intended NASA personnel served to suppress key information that might have escalated risks, many healthcare workers tend to act in ways that allow risks and problems to remain unaddressed—sometimes for years.

> *A group of eight anesthesiologists agree a peer is dangerously incompetent, but they don't confront him. Instead, they go to great efforts to schedule surgeries for the sickest babies at times when he is not on duty. This problem has persisted for over five years.* (Focus Group of Physicians)

> *A group of nurses describe a peer as careless and inattentive. Instead of confronting her, they double check her work—sometimes running in to patient rooms to retake a blood pressure or redo a safety check. They've "worked around" this nurse's weaknesses for over a year. The nurses resent her, but never talk to her about their concerns. Nor do any of the doctors who also avoid and compensate for her.* (Focus Group of Nurses)

Past studies have indicated that more than 60 percent of medication errors are caused by mistakes in interpersonal communication. The Joint Commission on Accreditation of Healthcare Organizations suggests that communication is a top contributor to sentinel events.[5] This study builds on these findings by exploring the specific concerns people have a hard time communicating that may contribute to avoidable errors and other chronic problems in healthcare.

The study we report here suggests that there are seven *crucial conversations* that people in healthcare frequently fail to hold that likely add to unacceptable error rates. The nationwide study was conducted by VitalSmarts in partnership with the American Association of Critical-Care Nurses. This study suggests that improvement in these seven crucial conversations could not only contribute to significant reductions in errors, but also to improvements in quality of care, reduction in nursing turnover, and marked improvement in productivity.

In addition, we will offer healthcare leaders a simple method for measuring their current performance in these seven crucial conversations, as well as an action plan for making measurable improvement in this key competency.

The Study

Researchers conducted dozens of focus groups, interviews, and workplace observations, and then collected survey data from more than 1,700 respondents, including 1,143 nurses, 106 physicians, 266 clinical-care staff, and 175 administrators during 2004. Their research sites included thirteen urban, suburban, and rural hospitals from across the U.S. These included a mix of teaching, general, and pediatric hospitals. Although this is a modest sample, the findings fit together in a significant and compelling way.

The study identified the categories of conversations that are especially difficult and, at the same time, especially essential for people in healthcare to master. The study showed that the quality of these crucial conversations relates strongly with medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover. We grouped these concerns into seven areas: Broken Rules, Mistakes, Lack of Support, Incompetence, Poor Teamwork, Disrespect, and Micromanagement.

More than half of the healthcare workers surveyed in this study had occasionally witnessed broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement. Many had seen some of their colleagues cutting corners, making mistakes, and demonstrating serious incompetence. However, even though they had these concerns, fewer than one in ten fully discussed their concerns with the coworker. Furthermore, most healthcare workers neither believe it's possible nor even their responsibility to call attention to these issues.

About half of respondents say the concerns have persisted for a year or more. And a significant number of those who have witnessed these persistent problems report injurious consequences. For example, one in five physicians say they have seen harm come to patients as a result of these concerns, and 23 percent of nurses say they are considering leaving their units because of these concerns.

On the positive side, this study shows that healthcare workers who are confident in their ability to raise these crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying. About 10 percent of the healthcare workers surveyed fall into this category. While additional confirming research is needed, the implication is that if more healthcare workers could learn to do what this influential 10 percent seem to be able to do systematically, the result would be significantly fewer errors, higher productivity, and lower turnover.

Prevalence of the Seven Most Crucial Concerns

Participants were asked to indicate the percentage of their coworkers with whom they had each of the seven crucial concerns. They had to indicate that at least 10 percent of their coworkers were in violation to be categorized as "seeing the concern." It is important to point out that respondents consistently report that the vast majority of healthcare workers *do not* exhibit the problems described below. And yet the vast majority of healthcare workers *do* see some number who not only exhibit the problems, but also continue to do so for long periods of time without being held accountable.

1. **Broken Rules:** 84 percent of physicians and 62 percent of nurses and other clinical-care providers see some number of their coworkers taking shortcuts that could be dangerous to patients. This concern was focused on a relatively small number of their colleagues. The median was 10 percent, meaning that they were comfortable with 90 percent of their colleagues' ability.

   "A phlebotomist in a neonatal unit would slip on her gloves and immediately tear the tip of the index finger off her glove, so she could feel the baby's vein better and wouldn't miss. I talked to her about it twice. Finally I said, 'If I ever see you tear the finger out of another glove I will write you up for a willful violation.' Now she follows the rules." (Nurse Manager)

2. **Mistakes:** 92 percent of physicians and 65 percent of nurses and other clinical-care providers work with some people who have trouble following directions; 88 percent of physicians and 48 percent of nurses and other clinical-care providers see some colleagues show poor clinical judgment when making assessments, doing triage, diagnosing, suggesting treatment, or getting help. Again, these respondents are pointing to a relatively small minority of their colleagues—the median was again just 10 percent.

   "Some docs can make incorrect orders. We let it slide—especially if it is a jerk . . . For example, one physician prescribed a drug that you should give three times a day, but he said to give it twice a day. I let it go, because it was just a pain pill. It wasn't going to make the child any sicker." (Pharmacist.)

3. **Lack of Support:** 53 percent of nurses and other clinical-care providers report that 10 percent or more of their colleagues are reluctant to help, impatient, or refuse to answer their questions. 83 percent have a teammate who complains when asked to pitch in and help. On the positive side, 76 percent say that half or more of their colleagues give them emotional support when they are down, and 64 percent say that half or more of their colleagues pick up a share of their work when they need help. It's clear that most people provide support. The problem is with a small minority who don't.

   "Some people here are burnt out. They've lost the excitement or have some personal issue in their life . . . People have to cover for them, pick up their slack. People get mad at them, isolate them, don't offer to help them, shy away from them. If they need extra help, they don't get it. They don't call or ask for it." (Nurse)

4. **Incompetence:** 81 percent of physicians and 53 percent of nurses and other clinical-care providers have concerns about the competency of some nurse or other clinical-care provider they work with; 68 percent of physicians and 34 percent of nurses and other clinical-care providers have concerns about the competency of at least one physician they work with.

   "There is a cardiologist who everybody feels is incompetent. He makes himself very accessible to general practitioners, so he gets a lot of referrals, but those of us who have to work with him—the thoracic surgeons, the anesthesiologists, the other cardiologists—would never put someone under his care." (Physician)

5. **Poor Teamwork:** 88 percent of nurses and other clinical-care providers have one or more teammate who gossips or is part of a clique that divides the team. 55 percent have a teammate who tries to look good at others' expense.

   "We have a nurse who is like your eccentric aunt—she's a bully. She makes unreasonable demands like, 'I won't take any more patients today.' She gets away with it. She's a very good nurse, but she's ornery and a bully. She doesn't do her fair share. It ticks all of us off. We've lost a couple of good nurses here because they were sick of putting up with her and our supervisor won't deal with her." (Nurse)

6. **Disrespect:** 77 percent of nurses and other clinical-care providers work with some who are condescending, insulting, or rude. 33 percent work with a few who are verbally abusive—yell, shout, swear, or name call.

   "A group of physicians went right into the patient's room without gowns or masks or gloves. This was a patient who was supposed to be in isolation. We didn't confront them because that cardio surgeon has a reputation. He belittles nurses by saying things like, 'Do they have any nurses on this unit who aren't stupid?' If you question him, he starts yelling, and turns it into a war." (Nurse)

7. **Micromanagement:** 52 percent of nurses and other clinical-care providers work with some number of people who abuse their authority—pull rank, bully, threaten, or force their point of view on them.

   "We have a charge nurse who . . . pages us to come to the desk so she can tell us what to do . . . She will come into the room where we have a sick patient and she'll take over . . . She'll say, 'Do it because I say so.' Sometimes when she bosses me around I feel less inclined to correct her when she's wrong about how to treat the child. I'm sure I've gone along with something I shouldn't have because I resent her. But basically, I've started looking at other hospitals for a job." (Nurse)

The Impact of these Crucial Conversations

Most healthcare respondents are happy in their careers and believe their organizations do good work. And yet most respondents report that a number of their colleagues create problems that are common, frequent, persistent, and dangerous. And, most important, the data show these problems are rarely addressed.

The study focused in detail on three of the seven crucial conversations: incompetence, poor teamwork, and disrespect. In these three areas the study mapped the frequency, duration, and impacts of people's concerns. It also measured whether and how these concerns were addressed.

Incompetence

The survey asked about a variety of competency issues, ranging from "poor clinical judgment" to "making decisions beyond their competency level" to "missing basic skills." Respondents indicated whether they had coworkers who are incompetent in these areas. Next, respondents were asked to think of the coworker with the worst competency problem, and to rate how often this person does something dangerous, how long the problem has gone on, and how the person's competency has impacted patient health and safety.

The data in tables 1-a and 1-b reveal the scope of the problem. Most healthcare workers have serious concerns about the competence of some of their coworkers. In fairness, a person's perceptions of another's competence can sometimes be just a difference of judgment—and nowhere more than in a field as complex and often ambiguous as healthcare. And yet the prevalence of the perceptions, along with strong anecdotal data from focus group interviews, suggest that real problems exist. Many cite a coworker who does something dangerous as often as every month. Nearly half report the problem has continued for a year or more. Some have witnessed the person causing harm to patients. And yet only a small percentage discuss their concerns with the person.

The data show it is much tougher to confront a physician than to confront a nurse or other clinical-care provider. Interestingly, the data also show physicians are about as unlikely to confront nurses and other clinical-care providers as they are to confront physicians, even though their clinical authority would seem to make it an easier discussion.

Nurses and Other Clinical Care Providers' Concerns about Incompetence		
53% are concerned about a peer's competence. 12% have spoken with this peer and shared their full concerns.	This peer does something dangerous at least once a month.	27%
	The problem with this peer has gone on for a year or more.	48%
	A patient has been harmed by this person's actions during the last year.	7%
34% are concerned about a physician's competence. Less than 1% have spoken with this physician and shared their full concerns.	This physician does something dangerous at least once a month.	19%
	The problem with this physician has gone on for a year or more.	54%
	A patient has been harmed by this physician's actions during the last year.	8%

Table 1-a

Physicians' Concerns about Incompetence		
81% are concerned about a nurse's or other clinical-care provider's competence. 8% have spoken with this person and shared their full concerns.	This person does something dangerous at least once a month.	15%
	The problem with this person has gone on for a year or more.	46%
	A patient has been harmed by this person's actions during the last year.	9%
68% are concerned about a physician's competence. Less than 1% have spoken with this physician and shared their full concerns.	This physician does something dangerous at least once a month.	21%
	The problem with this physician has gone on for a year or more.	66%
	A patient has been harmed by this physician's actions during the last year.	19%

Table 1-b

Poor Teamwork

The survey examined a variety of teamwork concerns, ranging from "gossiping" to "making themselves look good at your expense" to "not doing their fair share of the work." Respondents indicated whether they had coworkers who demonstrated poor teamwork in these areas. Next, respondents were asked to think of the coworker whose poor teamwork has the most negative impact, and to rate how often this person does something that undermines the team, how long the problem has gone on, and how the person's poor teamwork has impacted patient care and employee morale.

The data in Table 2 show a widespread problem. Three-quarters of the healthcare workers surveyed are concerned about a teamwork issue, and more than two-thirds say this problem has gone on for over a year. A smaller—yet significant—number (one-fifth) say the teamwork issue is so severe they can't trust that patients are getting the right level of care, and even more are seriously considering leaving their jobs because of the teamwork issue. And yet relatively few ever discuss their concerns with the person involved.

Nurses and Other Clinical Care Providers' Concerns about Poor Teamwork		
75% are concerned about a peer's poor teamwork.	This peer does something that undercuts the team at least once a month.	61%
	The problem with this peer has gone on for a year or more.	69%
16% have spoken with this peer and shared their full concerns.	Because of this teamwork issue, the respondent can't trust that patients in their area are receiving the right level of care.	22%
	Because of this teamwork issue, the respondent is seriously considering leaving the unit or the hospital.	23%

Table 2

Disrespect

The survey asked about disrespectful and abusive behavior, ranging from "verbal abuse" to "condescending, insulting, or rude" to "bullying and threatening." Respondents indicated whether they worked with people who were abusive toward them in these ways. Next, respondents were asked to think of the person whose abuse has the most negative impact, and to rate how often this person is disrespectful or abusive toward them, and how long the problem has gone on.

The data in Table 3 show that three-quarters of the healthcare workers surveyed experience some level of disrespect. For many, the treatment is frequent and long-standing. The correlations show that the more frequent the behavior and the longer it has gone on, the greater the workers' intent to quit their jobs. In fact, these correlations are so strong (correlations where r>.1 are meaningful—here we find r=.424, which is impressive) that disrespectful behavior is suggested to be a primary cause of people's desire to quit. Discussing their concerns with the person who is responsible for the abuse is almost out of the question.

Nurses and Other Clinical Care Providers' Concerns about Disrespect and Abuse		
77% are concerned about disrespect they experience.	This person is disrespectful or abusive toward them in at least a quarter of their interactions.	28%
	The behavior has gone on for a year or more.	44%
7% have spoken with this peer and shared their full concerns.	Correlation between the frequency of mistreatment and intent to quit their job.	$r = .424$, $p < .001$
	Correlation between the duration of abuse and intent to quit their job.	$r = .190$, $p < .001$

Why Don't People Speak Up and Share Their Full Concerns?

The obvious reason is that confronting people is difficult. In fact, most respondents to the survey indicated it was between difficult and impossible to confront people in these crucial situations. People's lack of ability, belief that it is "not their job," and low confidence that it will do any good to have the conversation are the three primary obstacles to direct communication.

When the Concern Is…	Percentage Saying It Is Difficult to Impossible to Confront the Person
Incompetence	56% of Physicians 72% of Nurses and other Clinical-Care Providers
Poor Teamwork	78% of Nurses and other Clinical-Care Providers
Disrespect or Abuse	59% of Nurses and other Clinical-Care Providers

Table 4

Other obstacles include time and fear of retaliation. The survey asked respondents to indicate the reasons they didn't confront people when they had these important concerns. The reasons they selected were similar for each concern, with the most common reasons being: "There wasn't a time or opportunity," "It's not my role," "I've seen them get angry," and "I thought they would retaliate." People don't want to make others angry or undercut their working relationships, so they leave difficult discussions to others or to another time, and never get back to the person.

However, some people don't remain silent about the problems they see. They talk about them with others. Depending on the nature of the problem, a quarter to half of the respondents discussed the problem with coworkers or with the person's manager. In interviews, participants suggested that the purpose for discussing these problems with coworkers is not to solve problems. Instead, it's to work around them, warn others about them, and blow off steam. The comments below, taken from focus groups, illustrate these workarounds, warnings, and venting sessions.

> *"We all know who I'm talking about. She has bad habits, or is missing good ones. She gets busy and leaves the rails down on an infant bed or the door open on an incubator. We all check on her patients just to make sure about things."* (Nurse)

> *"People give you the word. A nurse will call from surgery and say, 'He's in a mood.' If something goes wrong in surgery, he'll come in yelling at people. You are just waiting for your turn."* (Nurse)

> *"She can't be trusted with cases. She can give meds, but she won't ever get it. She's been there for seven months. This nurse would do fine in a doctor's office, but won't make it in the hospital. The other nurses all agree."* (Nurse)

Most respondents also say going to the person's manager creates problems.

> *"I'm embarrassed. I saw a nurse cutting corners and instead of talking to her I talked to her boss. Here's the situation. I used to be this nurse's boss, but now she's training me and we are peers. I should have gone to her, but I was concerned about our relationship and I went to her boss instead. It was a bad move."* (Nurse Practitioner)

The data suggest that going to the person's manager is, indeed, a bad move. Although managers are somewhat more likely than employees to confront the person and fully discuss the problem, they are still very unlikely to do so. Taking a concern to a manager was often a dead end.

When the Concern Is	Percentage of Non-Supervisory Employees Who Confront the Person	Percentage of Supervisors Who Confront the Person
Competence of a Nurse or other Clinical-Care Provider	3%	16%
Competence of a Physician	Less than 1%	Less than 1%
Poor Teamwork	5%	9%
Disrespect or Abuse	2%	5%

Table 5

People Who Do Step Up to these Crucial Conversations

Within each hospital there is a fascinating minority, 5–15 percent of healthcare workers, depending on the issue, who step up to these crucial conversations. They work in the same units or departments as the 85–95 percent of their coworkers who don't feel able to speak up. Are they crazy? Are they destroyed by the unsafe environment? No; these people prove that it's possible to discuss serious concerns in almost any environment and succeed.

The significant correlations in Table 6 show that people who are confident in their ability to have crucial conversations achieve positive outcomes for their patients, for the hospital, and for themselves. This is counterintuitive. Most of those who don't speak up believe that to do so would lead to disaster. The opposite seems to be the case for this critical minority of interpersonally skilled individuals. Again, the correlations of from .2 up to .465 suggest that these peoples' ability to deal with tough interpersonal challenges is highly related to all of the outcomes described. The "p<.001" means that the odds that this strong relationship is due to chance is less than 1 in 1000.

Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is Incompetence	Observe better patient outcomes (Spearman correlation = -.336, p < .001)
	Are more satisfied with their workplace (Spearman correlation = -.267, p < .001)
	Exhibit more discretionary effort[6]—work beyond the minimum required (Spearman correlation = -.240, p < .001)
	Intend to stay in their unit and hospital (Spearman correlation = -.335, p < .001)
Physicians who are confident in their ability to confront people when the concern is Incompetence	Observe better patient outcomes (Spearman correlation = -.307, p < .001)
	Are more satisfied with their workplace (Spearman correlation = -.309, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.263, p < .001)
Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is Poor Teamwork	Observe better patient care (Spearman correlation = -.310, p < .001)
	Have higher morale (Spearman correlation = -.465, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.297, p < .001)
	Intend to stay in their unit and hospital (Spearman correlation = -.460, p < .001)
Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is disrespect or abuse	Are more satisfied with their workplace (Spearman correlation = -.271, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.203, p < .001)
	Intend to keep their job (Spearman correlation = -.258, p < .001)

Table 6

These correlations make sense. People who feel able to confront and resolve the problems they see, take action, and improve the environment for everyone. Consider the two examples below. The first involves a physician who wasn't able to confront a peer.

> *"One surgeon actually left because of another's lousy work ethic. You'd call him at one in the morning, and he'd say, 'It can wait till morning.' The best member of his practice quit over it. No one ever made him shape up or confronted him over it. Docs would talk about it, but not to him."* (Physician)

When problems are allowed to fester, morale and productivity suffer, and patients are put at risk. Below is a contrasting example from a physician who is comfortable confronting his peer.

> *"I have a guy in my practice who is (acting in an inappropriate way) . . . It meant that his other partners and I would have to work more nights. I spoke to him. It wasn't easy but he agreed to change."* (Physician)

People who are able to speak up and address the problems they see make a positive difference. This finding isn't a big surprise. The surprise is how few healthcare workers speak up. The confident physician in the example above represents less than one in a hundred of the physicians in our sample. The other 99 percent live with their concerns and the bad outcomes they see around them.

Conclusions

The majority of the healthcare workers in this study have serious concerns about someone they work next to. Some share these concerns with coworkers and managers, but rarely speak directly to the people they are concerned about. Few of their coworkers and managers approach these people either, so the problems continue with a high frequency and for a long time.

It is critical for hospitals to create cultures of safety, where healthcare workers are able to candidly approach each other about their concerns. The added benefits in productivity improvement, reduction in nursing turnover and physician cooperation make improvement in this core competence an overwhelmingly high-leverage objective. However, it would be dangerous to conclude that the responsibility for breaking this pervasive culture of silence depends solely on making it *safer* to speak up. There are those in every hospital who are *already* speaking up, and they are not suffering for their outspokenness. Although they are only 5–15 percent of the total, they are the most effective, satisfied, and committed in the organization.

Hospitals need to learn from this skilled minority. VitalSmarts has spent 10,000 hours observing these *opinion leaders* and can recommend a series of steps for spreading their capabilities across a hospital.

Recommendations

The medical and business leaders of a hospital need to make improving crucial conversations one of their top two or three priorities for at least a year. The reluctance to confront is so deeply rooted in the healthcare culture that it will take this level of attention to create lasting improvements. The American Association of Critical-Care Nurses points out that lasting change in challenging interpersonal communication practices like these will require the combined commitment of nurses and healthcare professionals as well as healthcare organizations.[7]

Enabling crucial conversations may involve a variety of interventions, depending on the obstacles and inertia present in a hospital. Here we will focus on four steps that have provided rapid payoffs in many organizations.

Establish a Baseline and a Target for Improvement

The fundamental principle of organizational attention is: If you don't measure it you don't care about it. Survey the hospital to establish a baseline measure of the seven crucial conversations, and set a clear target for improvement.[8] A public goal for 25 percent improvement in a one-year period is achievable, and will concentrate attention on the issue. Update the baseline at least four times a year so people can be rewarded and held accountable for progress.

Conduct Focus-Group Interviews

Form interview teams that include top administrators and key physicians, and have these interview teams lead focus groups. It is important to have leaders, not staff, conduct these interviews. Leaders need to hear about the problems and their causes directly, and they need to demonstrate their willingness to listen.

The purpose of these interviews is to learn about the obstacles preventing crucial conversations. The most common obstacle you will hear is "safety;" people feel it is unsafe to confront.[9] Leaders need to take this safety concern to heart, because it is a criticism aimed at them. The interviews should solicit specific feedback about the kinds of behaviors and experiences people have that lead them to conclude they should *not* step up to these crucial conversations—or vice versa in areas where the conversations are happening.

> *"Everybody knows the cardiac surgeons can do whatever they want because they bring in a lot of dollars. I was warned not to confront them."* (Nurse)

If a cardiac surgeon is preventing nurses from confronting him or her, it is only because a manager or another physician is permitting it. These focus groups are an opportunity for leaders to learn about their role in allowing problems to continue.

Focus on Problem Areas

Use the baseline survey to focus your efforts. The survey will show you where conversations aren't happening or aren't happening well. Often, these are high-stress, high-impact areas such as the emergency room, operating rooms, and intensive care units. Focus on the intersection of "poor conversations" and "high impact."

Form teams within these problem areas, and have medical and administrative leaders participate. These teams should identify key obstacles and develop solutions to test.

Implement Training

A handful of the people in your hospital are already speaking up and resolving the problems they see around them. Training can be a powerful way to help others speak up, but its success is far from guaranteed. Below are the most critical elements in determining whether training will result in significant improvements.

- **Leaders teach.** Leaders need to conduct the training. Research shows that line managers, even those selected for their *poor* teaching abilities, achieve greater improvements than highly rated professional trainers.[10] In addition, having a leader teach a set of skills guarantees he or she will master them, and goes a long way toward ensuring he or she will "walk the talk" and model the skills.

- **Quality Materials.** The training must employ an effective instructional design. Participants need to be able to understand the concepts and master the behaviors. The skills taught should be valid in the highly emotional and risky confrontations we're asking people to step up to. Generic "communication" training will not suffice as the rules and challenges change when these seven emotionally and politically risky topics emerge. In addition, the training activities need to include emotionally compelling experiences that cause participants to examine themselves and recognize the need to change.[11]

- **Spaced learning.** Smaller chunks spaced a week or two apart are far better than longer, more intensive chunks. Two-hour or four-hour workshops avoid the cognitive overload so common in many training programs, and spaced learning allows people to apply and test the skills between sessions.

- **Sustained attention.** Some training interventions seem like a race to the finish—as if the goal were to get everyone through the course as quickly as possible. In fact, sustaining a skill-building effort over time is more important than "finishing" it on deadline. Unless people stay in the learning process for four to six months, it won't penetrate to their daily experience.

- **Relevant.** Obviously the content of the training must relate directly to risky situations people need to confront. Generic training in listening and feedback won't help participants handle the tough situations measured in our

study. Practices built into the training should focus on the specific crucial conversations the individuals involved need to master.

The problem described in this study is severe. 1) People see others make mistakes, violate rules, or demonstrate dangerous levels of incompetence 2) repeatedly 3) over long periods of time 4) in ways that hurt patient safety and employee morale 5) but they don't speak up and 6) the critical variable that determines whether they break this chain by speaking up is their confidence in their ability to confront.

These results give hospitals a powerful tool for improving patient safety and employee performance. The inability to speak up is an information bottleneck. Finding and removing the bottlenecks will release a cascade of benefits. Leaders can begin this process immediately, and achieve rapid and substantial progress.

About the Sponsors

VitalSmarts

A global leader in organizational performance and leadership, VitalSmarts provides training and consulting services to thousands of organizations, including more than 300 of the Fortune 500. For more than twenty-five years, the company principals have researched methods for bringing about systematic and lasting change. *Crucial Conversations*®, (including *The New York Times* bestselling book of the same title—McGraw-Hill 2002) delivers a set of influence tools that vitalize companies, strengthen teams, improve communities, and enrich relationships. Borrowing from more than twenty-five years of research, VitalSmarts introduces its newest *Wall Street Journal* and *New York Times* bestselling title, *Crucial Confrontations* (McGraw-Hill 2004), as well as a new set of training tools that teach organizations, teams, and individuals to effectively deal with violated expectations in a way that solves the problem at hand and strengthens the relationship in the process. VitalSmarts also offers other services including keynote speaking, on-site consulting, customized development, and executive mastery retreats.

AACN

The American Association of Critical-Care Nurses (AACN) is the world's largest specialty nursing organization. Representing the interests of more than 400,000 nurses who care for critically ill patients, AACN is dedicated to creating a healthcare system driven by the needs of patients and their families, where critical-care nurses make their optimal contribution.

AACN defines critical-care nursing as that specialty within nursing that deals with human responses to life-threatening health problems. The purpose of AACN is to promote the health and welfare of those experiencing critical illness or injury by advancing the art and science of critical care nursing and promoting environments that facilitate comprehensive professional nursing practice.

Endnotes

[1] Columbia Accident Investigation Board Report Volume 1 (August 2003) 9.

[2] L. Kohn, J. Corrigan, M. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000) 127.

[3] Richard P. Wenzel and Michael B. Edmond, "The Impact of Hospital-Acquired Bloodstream Infections," Emerging Infectious Diseases 7, no. 2 (March–April 2001)

[4] HealthGrades Quality Study: *Patient Safety in American Hospitals*, (HealthGrades, Inc., July, 2004).

[5] Joint Commission on Accreditation of Healthcare Organizations, *Root Causes of Medication Errors 1995-2003.* http://www.jcaho.org/accredited+organizations/ambulatory+care/sentinel+events/rc+of+medication+errors.htm

[6] "Discretionary effort" is a concept first introduced by Daniel Yankelovich in 1983 (Yankelovich and Immerwahr, *Putting the Work Ethic to Work,* Public Agenda Foundation). It is the engine of productivity in any knowledge-intensive organization. Discretionary effort is the gap between the least amount a worker can put in without being sanctioned or fired and the most they could put in if they chose to. In many professions this "discretionary effort" can account for productivity improvements of 100–500 percent when an employee chooses to offer it.

[7] *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* (American Association of Critical Care Nurses: 2005) 40.

[8] A downloadable survey of these seven crucial conversations is available at www.silencekills.com along with usage requirements.

[9] A downloadable script and suggested structure for these interviews is available at www.silencekills.com.

[10] VitalSmarts research on using leaders as teachers.

[11] For information on VitalSmarts' approach to Crucial Conversations, www.silencekills.com.

crucial conversations®

WHAT IS YOUR STYLE UNDER STRESS™?

From the *New York Times* bestseller
Crucial Conversations:
Tools for Talking
When Stakes are High

"When we use crucial conversations skills, we can influence decisions, improve relationships, and speak our minds in a way that gets heard."

- Joseph Grenny

How do you react when conversations suddenly move from smooth and easygoing to tense or awkward? Do you retreat into silence? Do you go on the attack? Or do you do your best to keep the conversation calm and focused on the issues at hand?

Crucial conversations take place when the stakes are high, opinions differ, and emotions run strong. Handling crucial conversations well can dramatically improve your personal relationships, your career progress, and your work team's performance.

Take this 33-question test to explore how you typically respond when you're in the middle of a stressful situation. Have your friends, colleagues, or family members take the test as well. The answers may surprise you.

A self-scoring version of this test is available online at www.vitalsmarts.com/styleunderstress. Information on what your score means can be found on pages 68-69 of the *New York Times* bestseller *Crucial Conversations: Tools for Talking When Stakes are High*.

Instructions

Before you start, read through the following points:

- **RELATIONSHIP**
  Think about the relationship you want to improve—with your boss, coworker, direct report, friend, or family member—and keep this relationship in mind.

- **CIRCUMSTANCE**
  Next, think of a tough situation—one you might have handled poorly or avoided altogether.

- **APPLY**
  Now, with that situation in mind, respond to the statements on the following pages as either true or false.

VitalSmarts®

Style Under Stress™ Test

T F 1. At times I avoid situations that might bring me into contact with people I'm having problems with.

T F 2. I have put off returning phone calls or e-mails because I simply didn't want to deal with the person who sent them.

T F 3. Sometimes when people bring up a touchy or awkward issue I try to change the subject.

T F 4. When it comes to dealing with awkward or stressful subjects, sometimes I hold back rather than give my full and candid opinion.

T F 5. Rather than tell people exactly what I think, sometimes I rely on jokes, sarcasm, or snide remarks to let them know I'm frustrated.

T F 6. When I've got something tough to bring up, sometimes I offer weak or insincere compliments to soften the blow.

T F 7. In order to get my point across, I sometimes exaggerate my side of the argument.

T F 8. If I seem to be losing control of a conversation, I might cut people off or change the subject in order to bring it back to where I think it should be.

T F 9. When others make points that seem stupid to me, I sometimes let them know it without holding back at all.

T F 10. When I'm stunned by a comment, sometimes I say things that others might take as forceful or attacking—terms such as "Give me a break!" or "That's ridiculous!"

T F 11. Sometimes when things get a bit heated I move from arguing against others' points to saying things that might hurt them personally.

T F 12. If I really get into a heated discussion, I've been known to be tough on the other person. In fact, they might even feel a bit insulted or hurt.

T F 13. When I'm discussing an important topic with others, sometimes I move from trying to make my point to trying to win the battle.

T F 14. In the middle of a tough conversation, I often get so caught up in arguments that I don't see how I'm coming across to others.

T F 15. When talking gets tough and I do something hurtful, I'm quick to apologize for my mistakes.

T F 16. When I think about a conversation that took a bad turn, I tend to focus first on what I did that was wrong rather than focus on others' mistakes.

T F 17. When I've got something to say that others might not want to hear, I avoid starting out with tough conclusions, and instead start with facts that help them understand where I'm coming from.

T F 18. I can tell very quickly when others are holding back or feeling defensive in a conversation.

T F 19. Sometimes I decide it's better not to give harsh feedback because I know it's bound to cause problems.

T F 20. When conversations aren't working, I step back from the fray, think about what's happening, and take steps to make it better.

T F 21. When others get defensive because they misunderstand me, I immediately get us back on track by clarifying what I do and don't mean.

T F 22. There are some people I'm rough on because, to be honest, they need or deserve what I give them.

T F 23. I sometimes make absolute statements like "The fact is…" or "It's obvious that…" to be sure my point gets across.

T F 24. If others hesitate to share their views, I sincerely invite them to say what's on their mind, no matter what it is.

T F 25. At times I argue hard for my view hoping to keep others from bringing up opinions that would be a waste of energy to discuss anyway.

T F 26. Even when things get tense, I adapt quickly to how others are responding to me and try a new strategy.

T F 27. When I find that I'm at cross purposes with someone, I often keep trying to win my way rather than looking for common ground.

T F 28. When things don't go well, I'm more inclined to see the mistakes others made than notice my own role.

T F 29. After I share strong opinions, I go out of my way to invite others to share their views, particularly opposing ones.

T F 30. When others hesitate to share their views, I do whatever I can to make it safe for them to speak thonestly.

T F 31. Sometimes I have to discuss things I thought had been settled because I don't keep track of what was discussed before.

T F 32. I find myself in situations where people get their feelings hurt because they thought they would have more of a say in final decisions than they end up having.

T F 33. I get frustrated sometimes at how long it takes some groups to make decisions because too many people are involved.

Scoring

Fill out the following score sheets. Each domain contains two to three questions. Next to the question number is either a (T) or (F). For example, under "Masking," question 5, you'll find a (T). If you answered question 5 true, check the box. With question 13, on the other hand, you'll find an (F). Only check that box if you answered the question false—and so on. Finally, add the number of checks in each column to determine your total score.

Your Style Under Stress score will show you which forms of silence or violence you turn to most often. Your Crucial Conversations Skills score is organized by concept and chapter from the book *Crucial Conversations: Tools for Talking When Stakes are High* so that you can decide which chapters will benefit you the most. Again, a self-scoring version of this test is available at www.vitalsmarts.com/styleunderstress. This test is also duplicated on pages 63-69 of *Crucial Conversations.*

Style Under Stress

Your silence and violence scores give you a measure of how frequently you fall into these less-than-perfect strategies. It's actually possible to score high in both. A high score (one or two checked boxes per domain) means you use this technique fairly often. It also means you're human. Most people toggle between holding back and becoming too forceful.

Masking

☐ 5 (T)

☐ 6 (T)

Avoiding

☐ 3 (T)

☐ 4 (T)

Withdrawing

☐ 1 (T)

☐ 2 (T)

Silence Total _____

Controlling

☐ 7 (T)

☐ 8 (T)

Labeling

☐ 9 (T)

☐ 10 (T)

Attacking

☐ 11 (T)

☐ 12 (T)

Violence Total _____

Crucial Conversations Skills

The seven domains below reflect your skills in each of the corresponding seven skill chapters found in *Crucial Conversations: Tools for Talking When Stakes are High*. If you score high (two or three boxes) in one of these domains, you're already quite skilled in this area. If you score low (zero or one), you may want to pay special attention to these chapters.

Start with Heart
(chapter 3)

- ☐ 13 (F)
- ☐ 19 (F)
- ☐ 25 (F)

Total _____

STATE My Path
(chapter 7)

- ☐ 17 (T)
- ☐ 23 (F)
- ☐ 29 (T)

Total _____

Learn to Look
(chapter 4)

- ☐ 14 (F)
- ☐ 20 (T)
- ☐ 26 (T)

Total _____

Explore Others' Paths
(chapter 8)

- ☐ 18 (T)
- ☐ 24 (T)
- ☐ 30 (T)

Total _____

Make It Safe
(chapter 5)

- ☐ 15 (T)
- ☐ 21 (T)
- ☐ 27 (F)

Total _____

Move to Action
(chapter 9)

- ☐ 31 (F)
- ☐ 32 (F)
- ☐ 33 (F)

Total _____

Master My Stories
(chapter 6)

- ☐ 16 (T)
- ☐ 22 (F)
- ☐ 28 (F)

Total _____

Conclusion

Since these scores represent how you typically behave during stressful or crucial conversations, they can change. Your score doesn't represent an inalterable character trait or a genetic propensity. It's merely a measure of your behavior—and you can change that.

Here are two ways to improve your skills:

- **ATTEND TRAINING**
  Crucial Conversations is an award-winning, two-day course that teaches skills for fostering open dialogue around high-stakes, emotional, or risky topics.
  www.vitalsmarts.com/crucialconversationstraining

- **FREE NEWSLETTER**
  One of our best learning resources is our free, weekly e-newsletter. Subscribers of the *Crucial Skills Newsletter* receive expert instruction from our bestselling authors on handling real-life crucial conversations.
  www.crucialskills.com

VitalSmarts®

Southern Coos Health Foundation Report

To: Southern Coos Health District Board of Directors and Southern Coos Health Foundation
From: Alix McGinley, Executive Director, SCHF
Re: SCH Foundation Report for SCHD/SCHF Board of Directors, January 2025

Campaign Updates

Giving Tuesday SCHHC Family Edition

On December 2nd, the Southern Coos Health Foundation (SCHF) launched our inaugural employee giving campaign with a kickoff event. The gathering was well-received and enjoyed by all attendees. This campaign serves as a catalyst for Employee Giving, and we successfully raised nearly $4,000 in contributions and pledges, including seven monthly gifts, facilitated by our new donor database, DonorPerfect.

2025 End-of-Year/Annual Giving

Our end-of-year campaign generated $16,400 this year. We welcomed numerous new donors and have improved our ability to track all contacts, gifts, and interactions effectively.

Upcoming for 2026

Our 23rd annual Women's Health Day is scheduled for Saturday, March 7th at The Barn (Bandon Community Center). We have secured $1,000 in sponsorships thus far. Alix will present at the 100 Strong Bandon event in February in hopes of securing additional funding along with other sponsorships. Beginning last year, all proceeds exceeding event costs were allocated to support the Bandon School Nurse program, and we plan to continue this practice for all future Women's Health Day events. Additionally, we will "tease" the Bandon School District "Giving Garden" initiative to address the needs of Bandon children. We will also begin conversations around expansion of our SCHF Volunteer program.

Capital Campaign Readiness

We are currently in the process of preparing for the Capital Campaign, leveraging resources from the Association for Healthcare Philanthropy (AHP) and any other available avenues.

Grant Submissions

Additionally, we have submitted a grant application for the Spring 2026 cycle of the Oregon Community Foundation for General Operating Support.

Monthly Finance Report

To: **Board of Directors and Southern Coos Management**
From: **Cameron Marlowe, Interim CFO**
RE: **December 2025 Month End Financial Results - January 22, 2026**

Revenue Performance:

- **Gross Revenue:** $4.7M for December, falling short of the $5.5M budget, and falling short of the same month last year by $151k. Inpatient volumes fell short of budget by $303K and swing bed revenue fell $278K below budget.

Revenue Deductions:

- **Total Deductions:** $2.0M (42.3 % of gross), up from 42.0% in November.
- **Patient A/R:** Decreased slightly to $8.3M, with $2.4M over 120 days. This includes $555K in legacy CPSI balances, which is fully reserved.
- **Contractuals:** Actual contractual deductions were 42.4% of revenue (vs. 32.6% in November). Charity care totaled $40K, with $3K recovered from prior bad debts.
- **Discounts:** $116K (2.4% of gross)

Medicare Cost Report Settlement:

- **FY26:** Estimated receivable increased to $600K at December 31, 2025 – driven by an updated tool based on FY25 filing.
- **FY25:** As filed 11/30/2025, actual receivable of $867K improving FY2025 Net Position (as reported in July 2025 for fiscal year end) by $516K.

Operating Revenues:

- **Total Operating Revenues:** December totaled $3.35M, which was just slightly below a budget of $3.41M and $408K higher than December last year. ($3.4M higher than Prior Year to Date.)

Operating Expenses:

- **Labor:** December's $2.6M was higher than a budget of $2.5M
- **Total Operating Expenses:** $3.7M – over budget $200k
    - Driven by higher costs of drugs issued

Operating Income/Loss:

- **December:** Operating loss of ($368K), $272k more than the budgeted loss of ($96K).
- **YTD:** Operating loss of ($951K), $123K more than budgeted loss of ($828k), but $284K better than Prior Year to Date.

Change in Net Position:

- **December:** Loss of $(204K), $220k more than the budgeted gain of $17K.
- **YTD:** Loss of $(97K), $53k better than budget expectations of a ($150K) loss.

Financial Health Indicators:

- **Days Cash on Hand:** Decreased to 72.4 in December from 75.1 in November
- **A/R Days Outstanding:** Increased to 52.4 from 52
- **Debt Ratio:** Remains steady at 0.46 roughly 50% of our assets are financed with liabilities – a balanced use of debt.
- **Cash to Liabilities Ratio:** 1.02 in December – almost exactly enough cash to cover every dollar of liabilities.

Southern Coos Health District

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses, and Changes in Net Position
As of December 31, 2025

	Month Ending 12/31/2025				Month Ending 12/31/2024	Year To Date 12/31/2025				Prior Year To Date 12/31/2024
	Actual	Operating Budget	Actual minus budget	Budget variance	Actual	Actual	Operating Budget	Actual minus budget	Budget variance	Actual
Total Patient Revenue										
Inpatient Revenue	782,878	1,085,822	(302,944)	(27.9) %	1,276,458	5,447,736	5,505,760	(58,024)	(1.1) %	4,730,819
Outpatient Revenue	3,694,473	3,864,406	(169,933)	(4.4) %	3,307,249	23,440,761	22,425,058	1,015,703	4.5 %	20,116,395
Swingbed Revenue	263,804	541,450	(277,646)	(51.3) %	308,012	1,780,969	3,119,795	(1,338,826)	(42.9) %	1,745,961
Total Patient Revenue	**4,741,155**	**5,491,678**	**(750,523)**	**(13.7) %**	**4,891,719**	**30,669,466**	**31,050,613**	**(381,147)**	**(1.2) %**	**26,593,175**
Total Deductions	**2,005,495**	**2,089,415**	**(83,921)**	**(4.0) %**	**1,953,365**	**13,614,481**	**11,813,808**	**1,800,673**	**15.2 %**	**10,157,448**
Revenue Deductions %	**42.3 %**	**38.0 %**	**4.3 %**	**11.2 %**	**39.9 %**	**44.4 %**	**38.0 %**	**6.4 %**	**16.7 %**	**38.2 %**
Net Patient Revenue	**2,735,660**	**3,402,263**	**(666,603)**	**(19.6) %**	**2,938,354**	**17,054,986**	**19,236,806**	**(2,181,820)**	**(11.3) %**	**16,435,727**
Other Operating Revenue	**613,010**	**3,280**	**609,730**	**18,588.9 %**	**2,735**	**2,843,798**	**19,680**	**2,824,118**	**14,349.8 %**	**24,225**
Total Operating Revenue	**3,348,670**	**3,405,543**	**(56,873)**	**(1.7) %**	**2,941,089**	**19,898,784**	**19,256,486**	**642,297**	**3.3 %**	**16,459,952**
Total Operating Expenses										
Total Labor Operating Expenses	2,621,211	2,459,223	161,988	6.6 %	2,366,921	14,603,738	13,946,865	656,872	4.7 %	12,912,925
Total Other Operating Expenses	1,095,506	1,042,368	53,138	5.1 %	781,799	6,246,038	6,137,729	108,310	1.8 %	4,782,172
Total Operating Expenses	**3,716,717**	**3,501,591**	**215,126**	**6.1 %**	**3,148,720**	**20,849,776**	**20,084,594**	**765,182**	**3.8 %**	**17,695,097**
Operating Income / (Loss)	**(368,047)**	**(96,048)**	**(271,999)**	**283.2 %**	**(207,632)**	**(950,992)**	**(828,108)**	**(122,885)**	**14.8 %**	**(1,235,146)**
Net Non Operating Revenue	**164,435**	**113,001**	**51,435**	**45.5 %**	**57,400**	**853,971**	**678,005**	**175,966**	**26.0 %**	**712,412**
Change In Net Position	**(203,612)**	**16,952**	**(220,564)**	**(1,301.1) %**	**(150,232)**	**(97,021)**	**(150,102)**	**53,081**	**(35.4) %**	**(522,733)**

-
    - $2.647M YTD for Retail Pharmacy
    - $95k – CPH
    - $15k – ACO
    - $75k – Risk Share
    - $2k -- PCPCH
- Revenue Deductions
    - $1.880M YTD for Retail Pharmacy

Fiscal Year 2026	July	August	September	October	November	December	Average	YTD
Income Statement								
Average Daily Revenues	176,282	178,788	167,487	175,440	148,596	152,940	166,589	166,682
Average Daily Actual Contractuals	55,093	60,284	73,038	60,661	48,402	64,897	60,396	60,392
% of Actual Contractuals of Total Payment	37.35%	36.62%	36.74%	34.53%	30.65%	38.68%	35.76%	35.82%
Revenues	5,464,741	5,542,430	5,024,606	5,438,653	4,457,881	4,741,155	5,111,578	30,669,466
Actual Contractual Adjustments	1,707,877	1,868,812	2,191,142	1,880,492	1,452,046	2,011,806	1,852,029	11,112,175
Actual Discount Adjustments	41,014	113,606	102,102	157,121	343,966	116,293	145,684	874,102
Estimated Contractuals Patient AR	454,703	6,912	(180,352)	91,519	(40,447)	(62,844)	44,915	269,490
Estimated Contractuals Retail Pharmacy	245,325	254,834	267,635	342,494	345,527	429,817	314,272	1,885,632
Medicare Tool Adjustment	(45,110)	280,069	(60,331)	16,017	(227,986)	(489,577)	(87,820)	(526,918)
Total Deductions	2,403,809	2,524,233	2,320,196	2,487,643	1,873,105	2,005,495	2,269,080	13,614,481
Actual Contractuals % of Revenues	31.25%	33.72%	43.61%	34.58%	32.57%	42.43%	36.36%	36.23%
Discount Adjustments % of Revenues	0.75%	2.05%	2.03%	2.89%	7.72%	2.45%	2.98%	2.85%
Estimated Contractuals Patient AR % of Revenues	8.32%	0.12%	-3.59%	1.68%	-0.91%	-1.33%	0.72%	0.88%
Estimated Contractuals Retail Pharm % of Revenues	4.49%	4.60%	5.33%	6.30%	7.75%	9.07%	6.25%	6.15%
Medicare Tool Adjustment % of Revenues	-0.83%	5.05%	-1.20%	0.29%	-5.11%	-10.33%	-2.02%	-1.72%
Total Deductions % of Revenues	43.99%	45.54%	46.18%	45.74%	42.02%	42.30%	44.29%	44.39%
Balance Sheet								
CPSI Patient Cash Posted	19,363	25,091	13,726	4,445	10,381	6,057	13,177	79,063
EPIC Patient Cash Posted	2,804,008	3,095,411	3,656,281	3,403,456	2,931,618	3,066,816	3,159,598	18,957,590
Total Cash Posted	2,823,371	3,120,502	3,670,007	3,407,901	2,941,999	3,072,873	3,172,775	19,036,653
Average Daily Cash	91,076	100,661	122,334	109,932	98,067	99,125		
Total Patient AR Over 120 Days	2,083,375	1,925,399	2,133,515	2,093,660	2,207,083	2,369,541	2,135,429	2,369,541
Total Patient AR	9,425,337	9,315,988	8,636,662	8,487,865	8,532,097	8,333,957	8,788,651	8,333,957
AR Allowance for Uncollectables	5,036,189	4,954,420	4,775,504	4,867,573	4,829,241	4,748,831	4,868,626	4,748,831
Net Patient AR	4,389,148	4,361,568	3,861,158	3,620,292	3,702,856	3,585,126	3,920,025	3,585,126
% Allowance for Oustanding AR	53.43%	53.18%	55.29%	57.35%	56.60%	56.98%	55.47%	56.98%
% Change in Allowance from Prior Month	9.96%	-1.62%	-3.61%	1.93%	-0.79%	-1.67%	0.70%	
Increase of AR Over 120 from Prior Month	160,853	(157,976)	208,116	(39,856)	113,423	162,458	74,503	
Increase (Decrease) of Total AR from Prior Month	850,701	(109,349)	(679,326)	(148,797)	44,232	(198,140)	(40,113)	

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses & Changes in Net Position
As of December 31, 2025

	Month Ending 12/31/2025				Month Ending 12/31/2024
	Actual	Operating Budget	Actual minus budget	Budget variance	Actual
Total Patient Revenue					
Inpatient Revenue	782,878	1,085,822	(302,944)	(27.9) %	1,276,458
Outpatient Revenue	3,694,473	3,864,406	(169,933)	(4.4) %	3,307,249
Swingbed Revenue	263,804	541,450	(277,646)	(51.3) %	308,012
Total Patient Revenue	**4,741,155**	**5,491,678**	**(750,523)**	**(13.7) %**	**4,891,719**
Total Deductions	**2,005,495**	**2,089,415**	**(83,921)**	**(4.0) %**	**1,953,365**
Net Patient Revenue	**2,735,660**	**3,402,263**	**(666,603)**	**(19.6) %**	**2,938,354**
Other Operating Revenue	**613,010**	**3,280**	**609,730**	**18,588.9 %**	**2,735**
Total Operating Revenue	**3,348,670**	**3,405,543**	**(56,873)**	**(1.7) %**	**2,941,089**
Total Operating Expenses					
Total Labor Expenses					
Salaries & Wages	1,721,461	1,868,049	(146,588)	(7.8) %	1,698,052
Contract Labor	619,974	399,462	220,512	55.2 %	414,069
Benefits	279,776	191,712	88,064	45.9 %	254,800
Total Labor Expenses	2,621,211	2,459,223	161,988	6.6 %	2,366,921
Purchased Services	122,829	343,045	(220,216)	(64.2) %	342,392
Drugs & Pharmaceuticals	321,958	119,267	202,692	169.9 %	98,246
Medical Supplies	123,498	128,212	(4,716)	(3.7) %	89,467
Other Supplies					
4300 - OTHER NON-MEDICAL SUPPLIES	-	6,520	(6,519)	(100.0) %	6,704
4301 - OFFICE SUPPLIES	8,061	4,291	3,770	87.9 %	3,261
4304 - LAUNDRY & LINENS / NONFOOD SUPPLIES	13,029	2,615	10,414	398.2 %	1,514
4398 - MINOR EQUIPMENT	5,195	28,992	(23,797)	(82.1) %	6,738
4399 - INVENTORY ADJUSTMENT	(161)	-	(161)	100.0 %	-
4505 - CATERING & FOOD	8,713	10,761	(2,048)	(19.0) %	8,025
Other Supplies	34,837	53,179	(18,341)	(34.5) %	26,242
Lease & Rental Expense	-	2,387	(2,387)	(100.0) %	1,073
Repairs & Maintenance	18,126	31,187	(13,060)	(41.9) %	702
Other Expenses					
4302 - POSTAGE & FREIGHT	10,421	5,350	5,070	94.8 %	2,627
4303 - COMPUTER & IT EQUIPMENT	807	-	807	100.0 %	10,131
4501 - MARKETING - ALLOWABLE (MCR)	9,773	8,564	1,209	14.1 %	(621)
4502 - MARKETING - NON ALLOWABLE	4,925	8,502	(3,578)	(42.1) %	12,911
4504 - PRINTING & COPYING	4,372	-	4,373	100.0 %	4,719
4700 - OTHER EXPENSES	(14)	(1,601)	1,586	(99.1) %	-
4701 - OREGON PROVIDER TAX	11,081	-	11,081	100.0 %	(69,794)
4702 - LICENSING & GOVERNMENT FEES	20,994	20,903	92	0.4 %	16,689
4703 - DUES & SUBSCRIPTIONS	87,880	64,190	23,690	36.9 %	7,994
4704 - EMPLOYEE RELATIONS ACTIVITIES - MEETINGS	8,673	7,503	1,169	15.6 %	3,044
4705 - TRAINING / CONFERENCE FEES	1,395	19,703	(18,307)	(92.9) %	2,317
4706 - TRAVEL & LODGING	24,877	8,186	16,691	203.9 %	739
4710 - OCCUPANCY / RENT EXPENSE	-	-	-	0.0 %	-
4711 - EQUIPMENT RENTAL	-	834	(833)	(100.0) %	-
4720 - DONATIONS / GRANTED FUNDS	-	-	-	0.0 %	-
4797 - MISC TAX (A/P)	1,910	-	1,909	100.0 %	-
4798 - BANK & COLLECTION FEES	13,637	5,618	8,019	142.7 %	12,222
4799 - MISCELLANEOUS EXPENSE	(4,734)	(9,663)	4,929	(51.0) %	(521)
Other Expenses	195,997	138,089	57,907	41.9 %	2,457
Utilities	29,122	31,747	(2,625)	(8.3) %	33,842
Insurance	23,629	20,954	2,675	12.8 %	21,508
Depreciation & Amortization	225,510	174,301	51,209	29.4 %	165,870
Total Operating Expenses	**3,716,717**	**3,501,591**	**215,126**	**6.1 %**	**3,148,720**
Operating Income / (Loss)	**(368,047)**	**(96,048)**	**(271,999)**	**283.2 %**	**(207,632)**
Net Non Operating Revenue					
Property Taxes	101,177	98,219	2,958	3.0 %	96,792
Non-Operating Revenue	85,983	9,422	76,561	812.6 %	2,515
Interest Expense	(47,441)	(33,436)	(14,005)	41.9 %	(68,805)
Investment Income	24,716	38,796	(14,079)	(36.3) %	26,898
Gain / Loss on Asset Disposal	-	-	-	0.0 %	-
Net Non Operating Revenue	**164,435**	**113,001**	**51,435**	**45.5 %**	**57,400**
Change In Net Position	**(203,612)**	**16,952**	**(220,564)**	**(1,301.1) %**	**(150,232)**

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses & Changes in Net Position
As of December 31, 2025

	Year To Date 12/31/2025				Prior Year To Dat 12/31/202
	Actual	Operating Budget	Actual minus budget	Budget variance	Actu
Total Patient Revenue					
Inpatient Revenue	5,447,736	5,505,760	(58,024)	(1.1) %	4,730,81
Outpatient Revenue	23,440,761	22,425,058	1,015,703	4.5 %	20,116,39
Swingbed Revenue	1,780,969	3,119,795	(1,338,826)	(42.9) %	1,745,96
Total Patient Revenue	**30,669,466**	**31,050,613**	**(381,147)**	**(1.2) %**	**26,593,17**
Total Deductions	**13,614,481**	**11,813,808**	**1,800,673**	**15.2 %**	**10,157,44**
Net Patient Revenue	**17,054,986**	**19,236,806**	**(2,181,820)**	**(11.3) %**	**16,435,72**
Other Operating Revenue	**2,843,798**	**19,680**	**2,824,118**	**14,350.2 %**	**24,22**
Total Operating Revenue	**19,898,784**	**19,256,486**	**642,297**	**3.3 %**	**16,459,95**
Total Operating Expenses					
Total Labor Expenses					
Salaries & Wages	9,720,439	10,466,826	(746,387)	(7.1) %	8,748,30
Contract Labor	3,254,890	2,345,493	909,397	38.8 %	2,733,25
Benefits	1,628,409	1,134,546	493,862	43.5 %	1,431,36
Total Labor Expenses	14,603,738	13,946,865	656,872	4.7 %	12,912,92
Purchased Services	1,225,481	2,058,271	(832,789)	(40.5) %	1,925,43
Drugs & Pharmaceuticals	1,466,291	709,686	756,605	106.6 %	546,47
Medical Supplies	612,948	682,810	(69,862)	(10.2) %	539,71
Other Supplies					
4300 - OTHER NON-MEDICAL SUPPLIES	11,301	39,117	(27,816)	(71.1) %	28,54
4301 - OFFICE SUPPLIES	34,081	25,745	8,336	32.4 %	21,07
4304 - LAUNDRY & LINENS / NONFOOD SUPPLIES	73,985	15,693	58,292	371.5 %	12,77
4398 - MINOR EQUIPMENT	72,940	173,952	(101,012)	(58.1) %	37,84
4399 - INVENTORY ADJUSTMENT	(1,102)	-	(1,102)	#DIV/0!	(54,07
4505 - CATERING & FOOD	54,995	64,567	(9,572)	(14.8) %	50,49
Other Supplies	246,200	319,074	(72,874)	(22.8) %	96,59
Lease & Rental Expense	2,532	14,321	(11,789)	(82.3) %	(7,37
Repairs & Maintenance	141,511	187,120	(45,608)	(24.4) %	90,46
Other Expenses					
4302 - POSTAGE & FREIGHT	46,448	32,101	14,346	44.7 %	26,46
4303 - COMPUTER & IT EQUIPMENT	15,543	-	15,543	#DIV/0!	10,34
4501 - MARKETING - ALLOWABLE (MCR)	65,363	51,383	13,979	27.2 %	29,67
4502 - MARKETING - NON ALLOWABLE	26,017	51,014	(24,995)	(49.0) %	60,27
4504 - PRINTING & COPYING	16,152	-	16,151	#DIV/0!	10,07
4700 - OTHER EXPENSES	(4)	(16,208)	16,204	(100.0) %	-
4701 - OREGON PROVIDER TAX	13,208	-	13,208	#DIV/0!	(68,67
4702 - LICENSING & GOVERNMENT FEES	136,597	120,418	16,179	13.4 %	93,29
4703 - DUES & SUBSCRIPTIONS	605,986	385,138	220,848	57.3 %	270,56
4704 - EMPLOYEE RELATIONS ACTIVITIES - MEETINGS	27,208	45,019	(17,811)	(39.6) %	17,09
4705 - TRAINING / CONFERENCE FEES	3,350	118,218	(114,868)	(97.2) %	64,28
4706 - TRAVEL & LODGING	82,275	49,118	33,157	67.5 %	46,54
4710 - OCCUPANCY / RENT EXPENSE	510	-	510	#DIV/0!	-
4711 - EQUIPMENT RENTAL	-	5,000	(5,000)	(100.0) %	-
4720 - DONATIONS / GRANTED FUNDS	2,486	-	2,486	#DIV/0!	-
4797 - MISC TAX (A/P)	2,594	-	2,594	#DIV/0!	
4798 - BANK & COLLECTION FEES	89,670	33,707	55,963	166.0 %	46,73
4799 - MISCELLANEOUS EXPENSE	(360)	(70,473)	70,113	(99.5) %	3,15
Other Expenses	1,133,043	804,435	328,607	40.8 %	609,73
Utilities	173,670	190,477	(16,807)	(8.8) %	164,04
Insurance	142,083	125,725	16,358	13.0 %	129,75
Depreciation & Amortization	1,102,279	1,045,810	56,469	5.4 %	687,35
Total Operating Expenses	**20,849,776**	**20,084,594**	**765,182**	**3.8 %**	**17,695,09**
Operating Income / (Loss)	**(950,992)**	**(828,108)**	**(122,885)**	**14.8 %**	**(1,235,14**
Net Non Operating Revenue					
Property Taxes	607,062	589,313	17,749	3.0 %	566,41
Non-Operating Revenue	273,426	56,532	216,894	383.7 %	72,57
Interest Expense	(245,283)	(200,613)	(44,670)	22.3 %	(183,43
Investment Income	220,451	232,773	(12,322)	(5.3) %	256,86
Gain / Loss on Asset Disposal	(1,685)	-	(1,685)	#DIV/0!	-
Net Non Operating Revenue	**853,971**	**678,005**	**175,966**	**26.0 %**	**712,41**
Change In Net Position	**(97,021)**	**(150,102)**	**53,081**	**(35.4) %**	**(522,73**

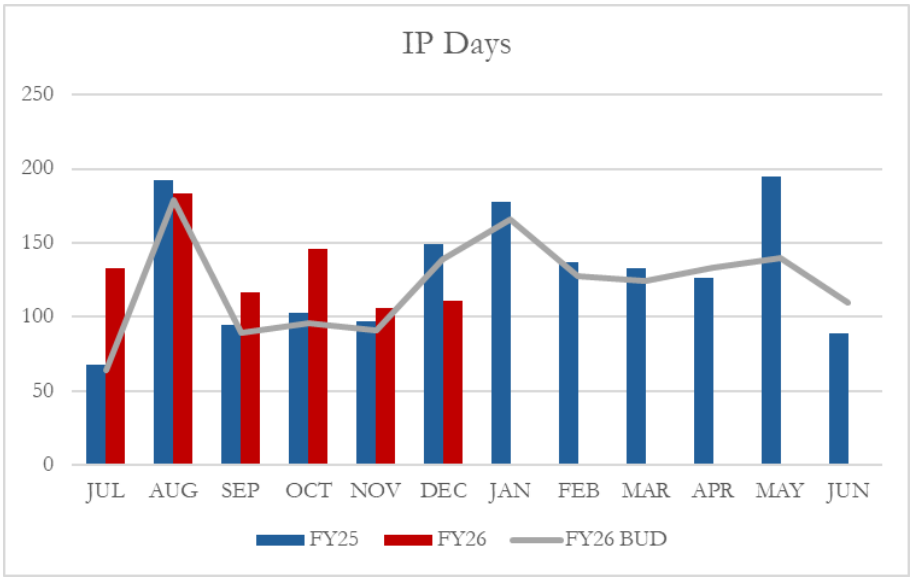
Southern Coos Hospital & Health Center
Balance Sheet Summary

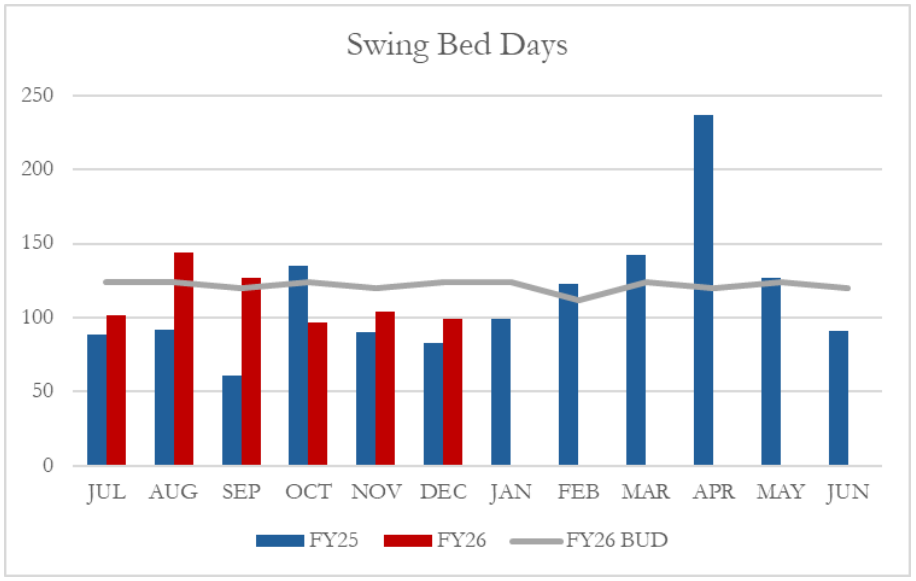
	Year To Date 12/31/2025 Current Year Balance	Year Ending 06/30/2025 Prior Year	Current vs. Prior	Year Ending 06/30/2024 Actual
Total Assets				
Total Current Assets				
Cash and Cash Equivalents	10,645,017	11,717,082	(1,072,065)	11,721,015
Net Patient Accounts Receivable	3,733,449	3,536,706	196,743	3,907,633
Other Assets	437,674	990,065	(552,390)	798,202
Total Current Assets	14,816,140	16,243,853	(1,427,712)	16,426,850
Net PP&E	7,861,243	8,243,887	(382,645)	6,423,952
Total Assets	**22,677,383**	**24,487,740**	**(1,810,357)**	**22,850,802**
Total Liabilities & Net Assets				
Total Liabilities				
Current Liabilities	6,578,494	7,892,410	(1,313,916)	4,490,006
Total Long Term Debt, Net	3,828,711	4,228,131	(399,420)	4,535,131
Total Liabilities	10,407,205	12,120,541	(1,713,336)	9,025,137
Total Net Assets	12,270,178	12,367,199	(97,021)	13,825,665
Total Liabilities & Net Assets	**22,677,383**	**24,487,740**	**(1,810,357)**	**22,850,802**

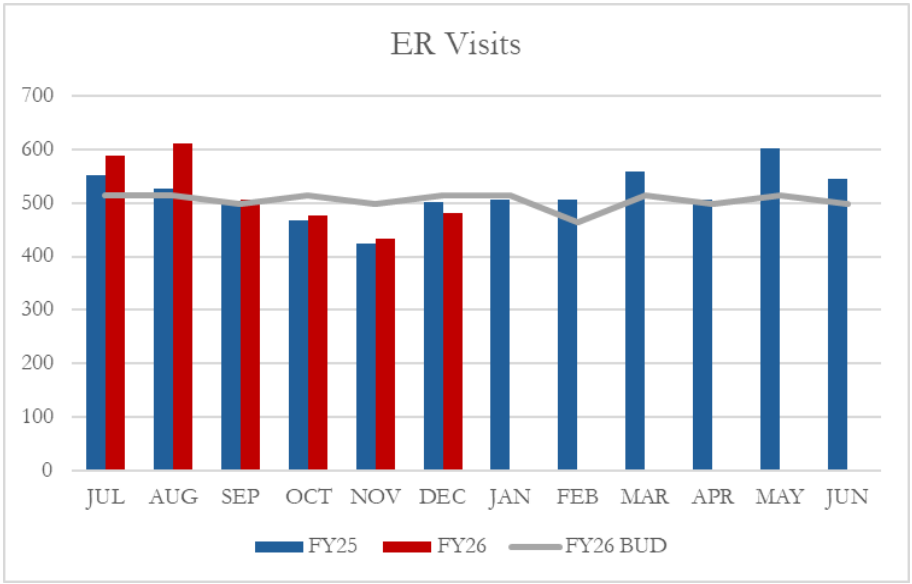
Cash to Debt Ratio	**1.02**	**0.97**	**0.05**	**1.30**
Debt Ratio	**0.46**	**0.49**	**(0.03)**	**0.39**
Current Ratio	**2.25**	**2.06**	**0.19**	**3.66**
Debt to Capitalization Ratio	**0.24**	**0.23**	**0.01**	**0.25**

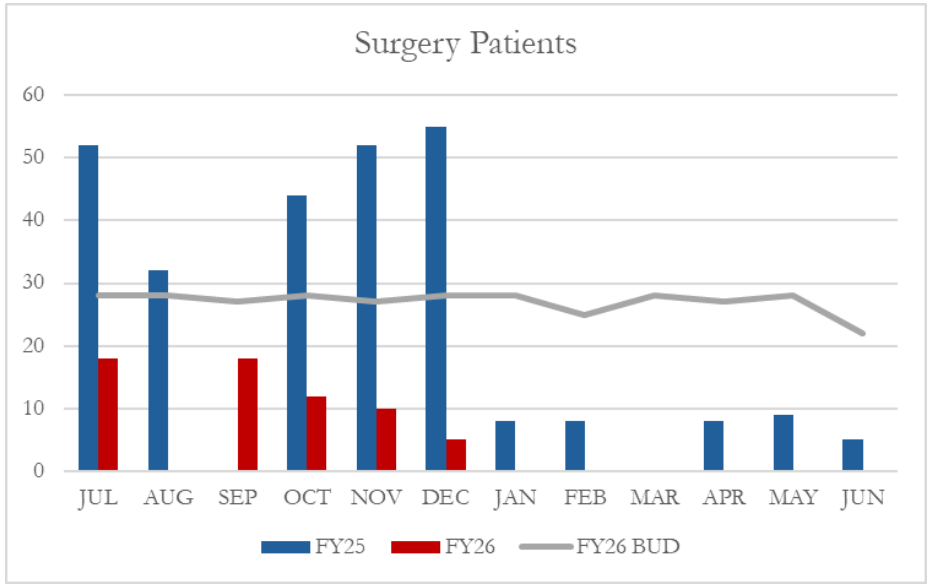
Southern Coos Hospital & Health Center
Balance Sheet

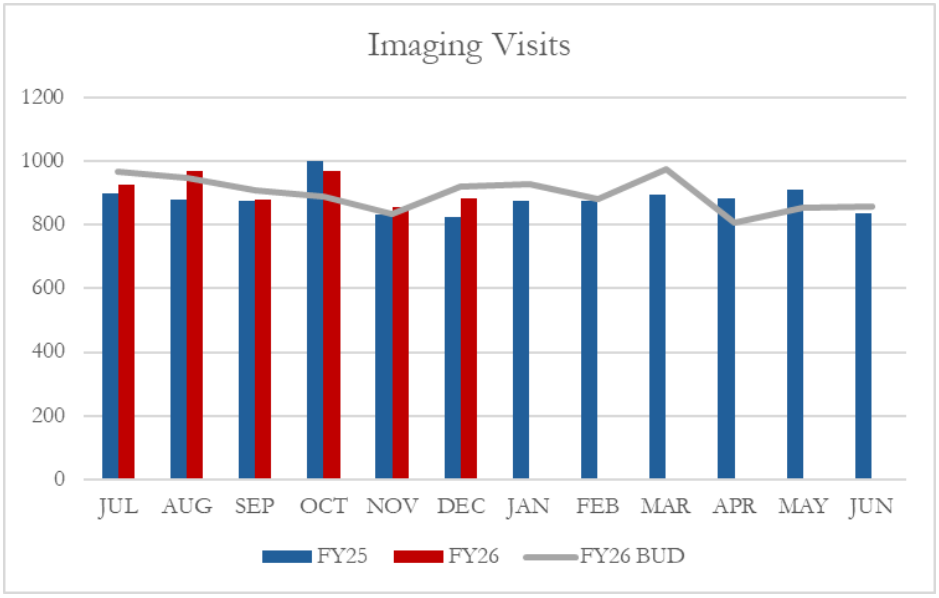
	Year To Date 12/31/2025	Year Ending 06/30/2025		Year Ending 06/30/2024
	Current Year Balance	Prior Year	Change	Actual
Total Assets				
Total Current Assets				
Cash and Cash Equivalents				
Cash Operating	**1,223,709**	**1,812,826**	**(589,117)**	**1,400,507**
Investments - Unrestricted	**4,138,430**	**3,984,313**	**154,116**	**4,076,428**
Investments - Reserved Certificate of Deposit	**2,549,174**	**3,186,239**	**(637,064)**	**3,510,375**
Investment - USDA Restricted	**233,704**	**233,704**	**-**	**233,705**
Investment - Board Designated	**2,500,000**	**2,500,000**	**-**	**2,500,000**
Cash and Cash Equivalents	**10,645,017**	**11,717,082**	**(1,072,065)**	**11,721,015**
Net Patient Accounts Receivable				
Patient Accounts Receivable				
1101 - A/R PATIENT - EPIC	7,918,283	7,850,956	67,327	-
1102 - A/R PATIENT - CPSI / EVIDENT	555,771	723,680	(167,910)	7,228,690
1103 - A/R - PHARMACY RETAIL OP	148,323	-	148,324	-
1109 - A/R - SUSPENSE ACCOUNT - UNAPPLIED CASH (cash-in-transit)	(140,792)	-	(140,792)	-
1110 - A/R - SUSPENSE ACCOUNT - UNRECEIVED CASH (remittance-in-transit)	-	(457,716)	457,716	-
2003 - REFUNDS - PATIENT / INSURANCE	695	-	695	(192)
Patient Accounts Receivable	**8,482,280**	**8,116,920**	**365,360**	**7,228,499**
Allowance for Uncollectibles				
1121 - ALLOW FOR UNCOLL - EPIC	(4,992,695)	(4,598,461)	(394,235)	-
1122 - ALLOW FOR UNCOLL - CPSI	(555,771)	(723,679)	167,910	(3,840,559)
1130 - WRITE OFF RECOVERY	(772,846)	(723,288)	(49,559)	(554,030)
1132 - BAD DEBT W/O - NON-MEDICARE	1,572,481	1,465,214	107,267	1,073,723
Allowance for Uncollectibles	**(4,748,831)**	**(4,580,214)**	**(168,617)**	**(3,320,866)**
Net Patient Accounts Receivable	**3,733,449**	**3,536,706**	**196,743**	**3,907,633**
Other Assets				
Other Receivables	**565**	**29,598**	**(29,033)**	**21,045**
Inventory	**336,646**	**346,070**	**(9,423)**	**230,930**
Prepaid Expense	**487,157**	**530,442**	**(43,286)**	**465,262**
Property Tax Receivable	**(386,694)**	**83,955**	**(470,648)**	**80,965**
Other Assets	**437,674**	**990,065**	**(552,390)**	**798,202**
Total Current Assets	**14,816,140**	**16,243,853**	**(1,427,712)**	**16,426,850**
Net PP&E				
Land	**461,528**	**461,527**	**-**	**461,527**
Property and Equipment	**23,690,940**	**23,375,034**	**315,906**	**20,435,404**
Accumulated Depreciation	**(16,636,777)**	**(15,682,145)**	**(954,632)**	**(15,194,163)**
Construction In Progress	**345,552**	**89,471**	**256,081**	**721,184**
Net PP&E	**7,861,243**	**8,243,887**	**(382,645)**	**6,423,952**
Total Assets	**22,677,383**	**24,487,740**	**(1,810,357)**	**22,850,802**
Total Liabilities & Net Assets				
Total Liabilities				
Current Liabilities				
Accounts Payable	**1,360,904**	**1,551,870**	**(190,966)**	**1,344,652**
Accrued Payroll and Benefits	**1,979,388**	**1,741,066**	**238,322**	**1,411,152**
Line of Credit Payable	**2,511,501**	**3,139,376**	**(627,875)**	**-**
Interest and Other Payable	**98,694**	**268,479**	**(169,784)**	**100,992**
Estimated Third Party Payor Settlements	**107,866**	**534,781**	**(426,916)**	**997,650**
Current Portion of Long Term Debt	**520,141**	**656,838**	**(136,697)**	**635,560**
Current Liabilities	**6,578,494**	**7,892,410**	**(1,313,916)**	**4,490,006**
Total Long Term Debt, Net				
Long Term Debt	**3,828,711**	**4,228,131**	**(399,420)**	**4,535,131**
Total Long Term Debt, Net	**3,828,711**	**4,228,131**	**(399,420)**	**4,535,131**
Total Liabilities	**10,407,205**	**12,120,541**	**(1,713,336)**	**9,025,137**
Total Net Assets	**12,270,178**	**12,367,199**	**(97,168)**	**13,825,665**
Total Liabilities & Net Assets	**22,677,383**	**24,487,740**	**(1,810,504)**	**22,850,802**

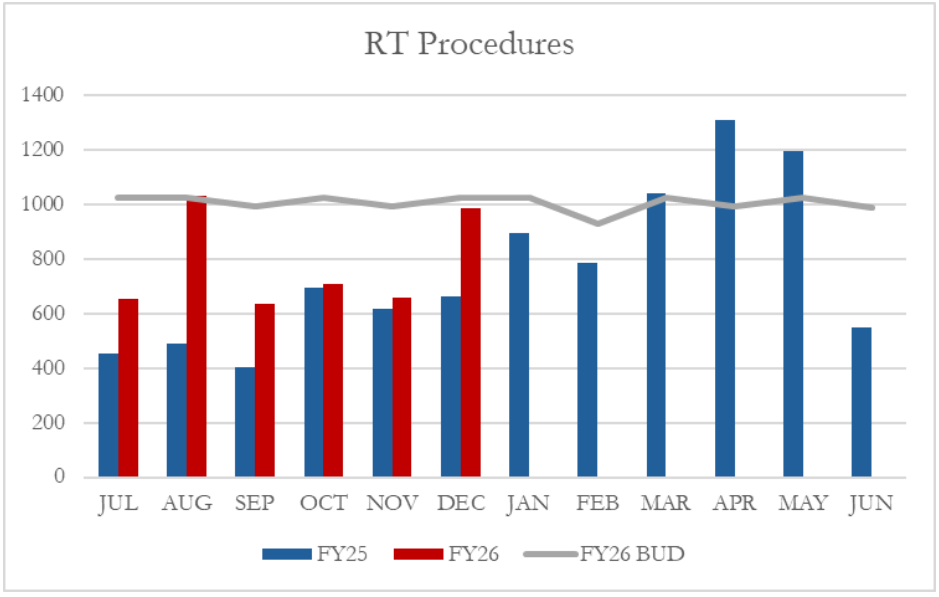

IP Days
250
200
150
100
50
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD

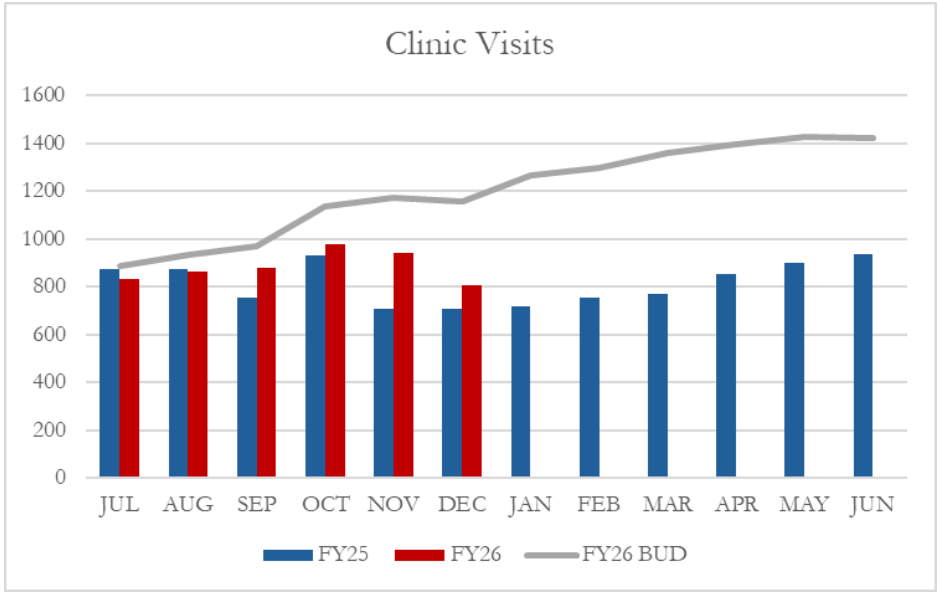

Swing Bed Days
250
200
150
100
50
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD


ER Visits
700
600
500
400
300
200
100
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD


Surgery Patients
60
50
40
30
20
10
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD


Imaging Visits
1200
1000
800
600
400
200
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD


RT Procedures
1400
1200
1000
800
600
400
200
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD


Clinic Visits
1600
1400
1200
1000
800
600
400
200
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY25 FY26 FY26 BUD

Southern Coos Hospital & Health Center

Volume and Key Performance Ratios
For The Period Ending December 2025

		Month						Year to Date				
		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior Year		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior Year
Volume Summary	IP Days	111	139	149	-20.3%	-25.5%		796	658	704	21.0%	13.1%
	Swing Bed Days	99	186	83	-46.8%	19.3%		673	1,104	550	-39.0%	22.4%
	Total Inpatient Days	210	325	232	-35.4%	-9.5%		1,469	1,762	1,254	-16.6%	17.1%
	Avg Daily Census	6.8	10.5	7.5	-35.4%	-9.5%		8.0	9.6	6.8	-16.6%	17.1%
	Avg Length of Stay - IP	3.6	3.0	6.0	19.4%	-39.9%		3.6	3.0	4.7	19.0%	-24.5%
	Avg Length of Stay - SWB	11.0	8.9	10.4	24.2%	6.0%		10.4	8.9	12.0	16.3%	-13.4%
	ED Registrations	482	514	501	-6.2%	-3.8%		3,096	3,050	2,974	1.5%	4.1%
	Clinic Registrations	809	332	380	143.7%	112.9%		5,306	1,970	3,315	169.3%	60.1%
	Ancillary Registrations	1,602	615	1,226	160.5%	30.7%		6,661	3,650	6,661	82.5%	0.0%
	Total OP Registrations	2,893	1,461	2,107	98.0%	37.3%		15,063	8,670	12,950	73.7%	16.3%
Key Income Statement Ratios	Gross IP Rev/IP Day	7,053	7,797	8,567	-9.5%	-17.7%		6,844	6,844	6,720	0.0%	1.8%
	Gross SWB Rev/SWB Day	2,665	2,911	3,711	-8.5%	-28.2%		2,646	2,826	3,174	-6.4%	-16.6%
	Gross OP Rev/Total OP Registrations	1,277	3,149	1,570	-59.5%	-18.6%		1,292	3,080	1,553	-58.0%	-16.8%
	Collection Rate	57.7%	62.0%	60.1%	-6.9%	-3.9%		55.6%	62.0%	61.8%	-10.2%	-10.0%
	Compensation Ratio	78.3%	72.2%	80.5%	8.4%	-2.7%		73.4%	72.4%	78.5%	1.3%	-6.5%
	OP EBIDA Margin $	(142,537)	78,253	(41,761)	-282.1%	241.3%		151,286	217,703	(547,787)	-30.5%	-127.6%
	OP EBIDA Margin %	-4.3%	2.3%	-1.4%	-285.2%	199.8%		0.8%	1.1%	-3.3%	-30.5%	-122.8%
	Total Margin	-6.1%	0.5%	-5.1%	-1321.5%	19.0%		-0.5%	-0.8%	-3.2%	-37.4%	-84.6%
Key Liquidity Ratios	Days Cash on Hand	72.4	80.0	79.7	-9.5%	-9.2%						
	AR Days Outstanding	52.4	50.0	51.9	4.8%	1.0%						

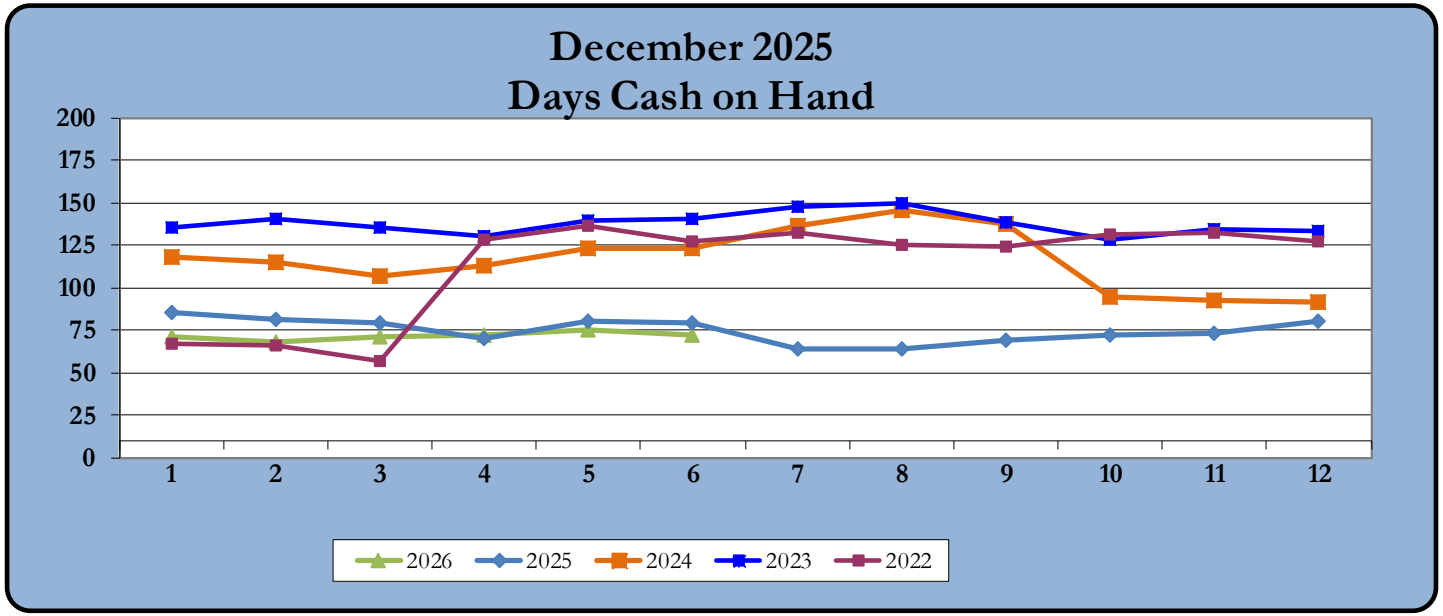
Southern Coos Hospital & Health Center

Data Dictionary

Volume Summary	IP Days	Total Inpatient Days Per Midnight Census
	Swing Bed Days	Total Swing Bed Days per Midnight Census
	Total Bed Days	Total Days per Midnight Census
	Avg Daily Census	Total Bed Days / # of Days in period (Mo or YTD)
	Avg Length of Stay - IP	Total Inpatient Days / # of IP Discharges
	Avg Length of Stay - SWB	Total Swing Bed Days / # of SWB Discharges
	ED Registrations	Number of ED patient visits
	Clinic Registrations	Number of Clinic patient visits
	Ancillary Registrations	Total number of all other OP patient visits
	Total OP Registrations	Total number of OP patient visits

Key Income Statement Ratios	Gross IP Rev/IP Day	Avg. gross patient charges per IP patient day
	Gross SWB Rev/SWB Day	Avg. gross patient charges per SWB patient day
	Gross OP Rev/Total OP Registrations	Avg. gross patient charges per OP visit
	Collection Rate	Net patient revenue / total patient charges
	Compensation Ratio	Total Labor Expenses / Total Operating Revenues
	OP EBIDA Margin $	Operating Margin + Depreciation + Amortization
	OP EBIDA Margin %	Operating EBIDA / Total Operating Revenues
	Total Margin (%)	Total Margin / Total Operating Revenues

Key Liquidity Ratios	Days Cash on Hand	Total unrestricted cash / Daily OP Cash requirements
	AR Days Outstanding	Gross AR / Avg. Daily Revenues



Calculation: Total Unrestricted Cash on Hand / Daily Operating Cash Needs

Definition: This ratio quantifies the amount of cash on hand in terms of how many "days" an organization can survive with existing cash reserves.

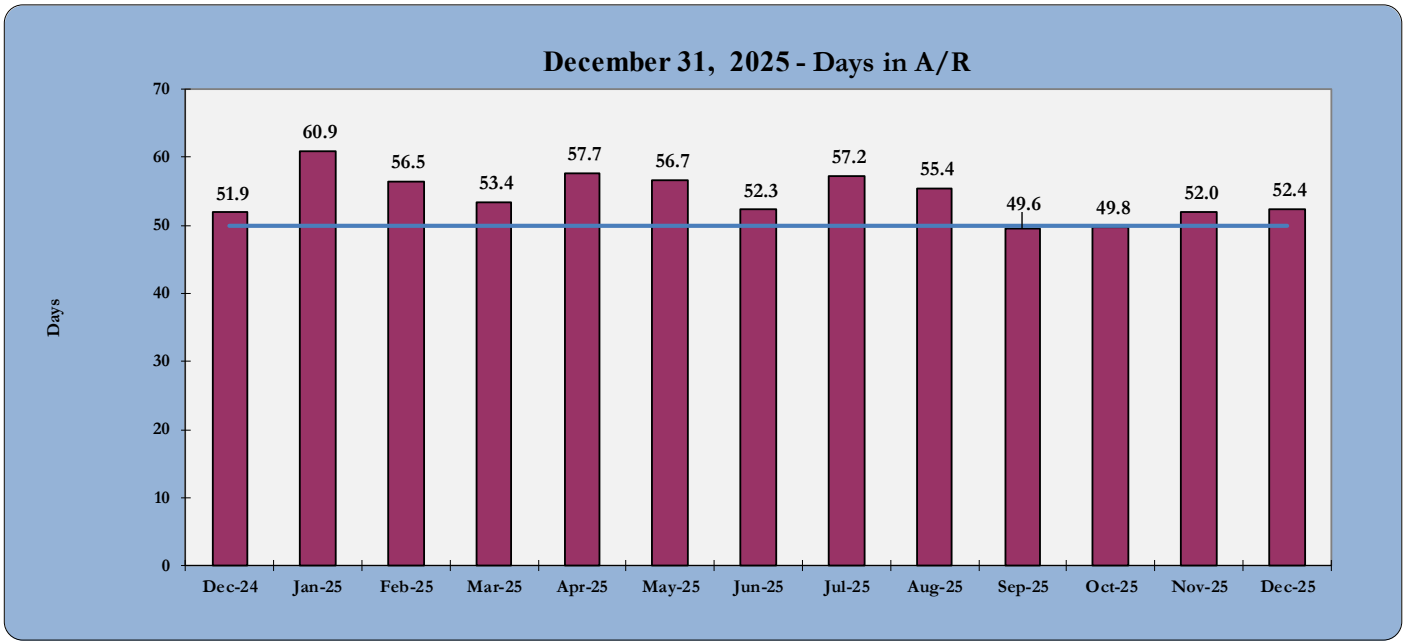
Desired Position: Upward trend, above the median

Year	Average
2026	71.6
2025	74.8
2024	116.3
2023	137.8
2022	113.0

Benchmark **80 Days**

How ratio is used: This ratio is frequently used by bankers, bondholders and analysts to gauge an organization's liquidity--and ability to meet short term obligations as they mature.

Fiscal	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2026	71.6	67.6	70.7	72.5	75.1	72.4						
2025	85.4	81.4	79.0	70.5	79.9	79.7	64.2	63.7	68.6	71.9	72.8	80.1
2024	117.7	114.5	106.8	113.1	123.1	123.3	136.1	145.3	137.0	94.5	92.8	91.4
2023	135.9	140.8	135.2	130.5	139.4	140.7	147.8	149.7	138.9	127.8	134.2	133.3
2022	67.2	66.2	56.6	128.6	136.1	127.4	132.1	125.1	124.6	131.5	132.8	127.5



Calculation: Gross Accounts Receivable / Average Daily Revenue

Definition: Considered a key "liquidity ratio" that calculates how quickly accounts are being paid.

Desired Position: Downward trend below the median, and below average.

Benchmark ***50***

How ratio is used: Used to determine timing required to collect accounts. Usually, organizations below the average Days in AR are likely to have higher levels of Days Cash on Hand.

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
A/R (Gross)	7,761,771	9,505,725	9,372,293	8,762,600	9,509,727	9,356,665	8,574,636	9,425,337	9,315,989	8,636,661	8,656,663	8,532,097	8,333,957
Days in AR	**51.9**	**60.9**	**56.5**	**53.4**	**57.7**	**56.7**	**52.3**	**57.2**	**55.4**	**49.6**	**49.8**	**52.0**	**52.4**
``	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**
A/R (Gross)	7,761,771	9,505,725	9,372,293	8,762,600	9,509,727	9,356,665	8,574,636	9,425,337	9,315,989	8,636,661	8,656,663	8,532,097	8,333,957
Days in Month	31	31	28	31	30	31	30	31	31	30	31	30	31
Monthly Revenue	4,891,719	5,318,712	4,720,191	4,720,191	5,229,933	5,239,205	4,451,443	5,464,741	5,542,430	5,024,606	5,438,653	4,457,881	4,741,155
3 Mo Avg Daily Revenue	149,578	155,993	165,896	163,990	164,835	165,101	163,962	164,732	168,028	174,258	173,975	163,969	159,105
Days in AR	**51.9**	**60.9**	**56.5**	**53.4**	**57.7**	**56.7**	**52.3**	**57.2**	**55.4**	**49.6**	**49.8**	**52.0**	**52.4**

SOUTHERN COOS HOSPITAL & HEALTH CENTER
CAPITAL PURCHASES SUMMARY FY2026

Approved Projects:

Budgeted Threshold Projects (>$15,000)

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Status	Notes
Transport Vehicle	Admin	65,000		65,000		
Heated Chilled Meal Cart	Dietary	20,000	19,875	125	Complete	Capitalized 12.31.25
Mindray US Machine	ED	70,000	64,625	5,375	Complete	Capitalized 08.31.25
ED room 3 safety renovation project	ED	40,000		40,000		
Level 1 rapid infuser fluid warmer	ED	30,000		30,000		
New desk/workspace in ER	ED	15,000		15,000		
Midmark EKGs (MAC VU360)	EKG	15,000	23,000	(8,000)	In Progress	
Business Office Remodel	Engineering	600,000	34,016	565,984	In Progress	
MM Expansion	Engineering	600,000		600,000		
Lab Expansion	Engineering	600,000		600,000		
Air Handler repairs and upgrade	Engineering	150,000		150,000		
Building Automation (HVAC)	Engineering	120,000		120,000		
Parking Lot Resurface	Engineering	50,000	28,270	21,730	Complete	Capitalized 10.31.25
Floor Replacement for Various Departments	Engineering	36,000		36,000		
Trailers	Engineering	30,000		30,000		
Rain Gutters for Hospital (Commercial Grade)	Engineering	22,000		22,000		
Primary Firewall Replacement	Information Systems	27,000		27,000		
Conference Room Upgrade	Information Systems	20,000		20,000		
DataCenter Battery Backup Replacement	Information Systems	19,000		19,000		
Storage Server Replacement	Information Systems	15,000		15,000		
Biosafety Cabinet Type II Class 2B (Hood)	Lab	25,000		25,000		
Blood Culture Incubator w/ Synapsys (BD FX 40)	Lab	21,000	13,995	7,005	Complete	Capitalized 08.31.25
Backup Troponin System	Lab	20,000		20,000		
Louvered panel wall hanging bin storage system.	Materials	20,000		20,000		

Unit Room Remodels	Med Surg	50,000		50,000		
Cardiac Monitors	Med Surg	29,000		29,000		
Ultrasound	Pain Management	55,000		55,000		
Pyxis Anesthesia System	Pharmacy	130,000		130,000		
Hamilton C1 X4 Invasive/NON-invasive/High flow	Respiratory	74,000		74,000		
Vapotherm High Flow X2	Respiratory	27,000	12,184	14,816	Complete	Capitalized 11.2025
ConMed Insuflation (Working on Quote)	Surgery	35,000		35,000		
Avantos RFA machine (Meeting with Rep on 4/7)	Surgery	29,000	28,003	997	In Progress	
Sonosite Ultrasound Machine	Surgery	25,000		25,000		
Camera Control Unit	Surgery	15,000		15,000		
Instrumentation/Sets for Simmonds	Surgery	15,000		15,000		

Un-Budgeted Threshold Projects (>$15,000)

Building Improvements 2nd Street	Administration	-	84,245	(84,245)	Complete	Capitalized 07.31.25
IS Equipment 2nd Street	Information Systems	-	13,873	(13,873)	Complete	Capitalized 07.31.25
Bariatric Bed	Med Surg	-	41,118	(41,118)	Complete	Capitalized 11.30.25
ER Stretchers (3)	ER	-	42,954	(42,954)	Complete	Capitalized 08.31.25
Teladoc Telehealth Units (3)	ER/ MS / Clinic	-	49,781	(49,781)	Complete	Capitalized 10.31.25 - USDA Grant Matching
Hospital Admin Space Remodel	Administration	-	15,663	(15,663)	In Progress	
Business Building Remodel	Administration	-	104,831	(104,831)	In Progress	
MAC 7 ECG	Clinic	-	15,203	(15,203)	In Progress	
		-		-		
Totals - Threshold Projects		**3,114,000**	**591,635**	**2,522,365**		
Grand Total		**3,300,000**	**612,567**	**2,687,433**		

Grant Funded Projects:

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Date Completed	Grant Funding Source
Master Facilities Plan	Administration	171,000	130,666	40,334		
				-		
Totals - Grant Funded		**171,000**	**130,666**	**40,334**		

Clinic Provider Income Summary

All Providers

For The Budget Year 2026

	ACT JUL	BUD JUL	ACT AUG	BUD AUG	ACT SEP	BUD SEP	ACT OCT	BUD OCT	ACT NOV	BUD NOV	ACT DEC	BUD DEC	ACT FYTD	Current Budget YTD FYTD26 Budget	Variance
Provider Productivity Metrics															
Clinic Days	64	56	72	56	77	56	91	83	81	83	72	83	456	416	41
Total Visits	505	520	686	520	599	520	685	668	673	708	563	747	3,711	3,684	27
Visits/Day	8.0	9.3	9.5	9.3	7.8	9.3	7.5	8.1	8.3	8.6	7.8	9.1	8.1	8.9	(0.7)
Total RVU	1,264	1,078	912	1,078	1,111	1,078	1,263	1,386	1,079	1,467	1,071	1,548	6,700	7,635	(936)
RVU/Visit	2.50	2.07	1.33	2.07	1.85	2.07	1.84	2.08	1.60	2.07	1.90	2.07	1.81	2.07	(0.27)
RVU/Clinic Day	19.90	19.25	12.67	19.25	14.52	19.25	13.88	16.80	13.24	17.78	14.87	18.77	14.68	18.38	(3.70)
Gross Revenue/Visit	514	473	438	473	518	473	523	483	519	484	525	485	505	479	26
Gross Revenue/RVU	205	228	329	228	279	228	284	233	324	233	276	234	280	231	48
Net Rev/RVU	87	97	139	97	118	97	120	122	136	98	117	99	118	98	20
Expense/RVU	109	125	164	125	166	125	141	128	170	122	146	120	147.70	124	23.88
Diff	(23)	(27)	(25)	(27)	(47)	(27)	(21)	(7)	(33)	(24)	(29)	(22)	(29)	(26)	(4)
Net Rev/Day	1,724	1,871	1,764	1,871	1,719	1,871	1,667	2,043	1,804	1,750	1,742	1,849	1,735	1,799	(64)
Expense/Day	2,173	2,397	2,084	2,397	2,408	2,397	1,954	2,153	2,244	2,171	2,175	2,254	2,168	2,275	(108)
Diff	(449)	(526)	(321)	(526)	(689)	(526)	(287)	(110)	(441)	(422)	(433)	(405)	(433)	(477)	44
Patient Revenue															
Outpatient															
Total Patient Revenue	259,705	245,798	300,156	245,798	309,987	245,798	358,390	322,348	349,043	342,261	295,440	362,173	1,872,720	1,764,175	(108,545)
Deductions From Revenue															
Total Deductions From Revenue (Note A)	150,232	141,008	173,167	141,008	178,490	141,008	206,680	153,808	202,050	197,921	170,033	209,669	1,080,652	1,016,787	(63,865)
Net Patient Revenue	**109,473**	**104,790**	**126,989**	**104,790**	**131,496**	**104,790**	**151,710**	**168,540**	**146,993**	**144,340**	**125,407**	**152,504**	**792,069**	**747,389**	**44,680**
Total Operating Revenue	**109,473**	**104,790**	**126,989**	**104,790**	**131,496**	**104,790**	**151,710**	**168,540**	**146,993**	**144,340**	**125,407**	**152,504**	**792,069**	**747,389**	**44,680**
Operating Expenses															
Salaries & Wages	83,598	70,656	98,070	70,656	120,403	70,656	107,783	102,211	118,844	102,460	84,620	102,460	613,318	519,099	94,219
Benefits	1,805	1,916	1,412	1,916	4,668	1,916	4,172	5,834	4,034	5,834	4,243	5,834	20,334	23,252	(2,918)
Purchased Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Supplies	-	-	91	-	13	-	101	-	-	-	-	-	205	-	205
Other Supplies	-	-	9	-	-	-	-	-	-	-	-	-	9	-	9
Maintenance and Repairs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Expenses	5,339	-	1,659	-	8,104	-	3,657	378	6,092	378	4,152	378	29,003	1,134	27,869
Allocation Expense	47,224	61,676	48,828	61,676	51,053	61,676	62,111	69,228	53,920	70,448	63,561	77,254	326,697	401,957	(75,259)
Total Operating Expenses	137,966	134,248	150,069	134,248	184,241	134,248	177,824	177,651	182,890	179,120	156,576	185,926	989,566	945,442	44,124
Excess of Operating Rev Over Exp	**(28,493)**	**(29,458)**	**(23,080)**	**(29,458)**	**(52,745)**	**(29,458)**	**(26,114)**	**(9,111)**	**(35,897)**	**(34,780)**	**(31,169)**	**(33,422)**	**(197,498)**	**(198,053)**	**555**
Non-Operating Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non Operating Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Non-Operating Income	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Excess of Revenue Over Expenses	**(28,493)**	**(29,458)**	**(23,080)**	**(29,458)**	**(52,745)**	**(29,458)**	**(26,114)**	**(9,111)**	**(35,897)**	**(34,780)**	**(31,169)**	**(33,422)**	**(197,498)**	**(198,053)**	**555**

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses, and Changes in Net Position
As of December 31, 2025

	Month Ending 12/31/2025			Year To Date 12/31/2025		
	Hospital Actual	Clinic Providers Actual	Actual	Hospital Actual	Clinic Providers Actual	Actual
Total Patient Revenue						
Inpatient Revenue	782,878	-	782,878	5,447,736	-	5,447,736
Outpatient Revenue	3,399,033	295,440	3,694,473	21,568,041	1,872,720	23,440,761
Swingbed Revenue	263,804	-	263,804	1,780,969	-	1,780,969
Total Patient Revenue	**4,445,715**	**295,440**	**4,741,155**	**28,796,746**	**1,872,720**	**30,669,466**
Total Deductions	**1,835,462**	**170,033**	**2,005,495**	**12,533,829**	**1,080,652**	**13,614,481**
Revenue Deductions %	**41.3 %**	**57.6 %**	**42.3 %**	**43.5 %**	**57.7 %**	**44.4 %**
Net Patient Revenue	**2,610,253**	**125,407**	**2,735,660**	**16,262,917**	**792,069**	**17,054,986**
Other Operating Revenue	**613,010**	**-**	**613,010**	**2,843,798**	**-**	**2,843,798**
Total Operating Revenue	**3,223,263**	**125,407**	**3,348,670**	**19,106,715**	**792,069**	**19,898,784**
Total Operating Expenses						
Total Labor Operating Expenses	2,532,348	88,863	2,621,211	13,970,086	633,652	14,603,738
Total Other Operating Expenses	1,027,793	67,713	1,095,506	5,890,124	355,914	6,246,038
Total Operating Expenses	**3,560,141**	**156,576**	**3,716,717**	**19,860,210**	**989,566**	**20,849,776**
Operating Income / (Loss)	**(336,877)**	**(31,169)**	**(368,046)**	**(753,494)**	**(197,498)**	**(950,992)**
Net Non Operating Revenue	**164,435**	**-**	**164,435**	**853,971**	**-**	**853,971**
Change In Net Position	**(172,442)**	**(31,169)**	**(203,611)**	**100,477**	**(197,498)**	**(97,021)**

Revenue Cycle Board Finance Report
December 2025

Key Highlights

TOTAL AR INCREASED SLIGHTLY WITH GROWTH CONCENTRATED IN CURRENT AND 0-30 BALANCES, INDICATING HEALTHY BILLING ACTIVITY RATHER THAN ACCOUNTS AGING

LEGACY AR DECLINED AND CONTINUED CLEAN UP OF CREDITS OVERALL AR DOWN ONLY $27K, BUT PROGRESS IS BEING MADE IN LEGACY BALANCE RESOLUTION

APPROXIMATELY $800K IN SELF-PAY AR AGED OVER 120 DAYS EARMARKED FOR COLLECTIONS PLACEMENT WILL MOVE UPON COMPLETION OF COLLECTIONS IMPLEMENTATION

COLLECTIONS IMPROVED MONTH OVER MONTH TOTALING $3.07M, AND INCREASE OF $127K COMPARED TO NOVEMBER

SELF-PAY AR IN EPIC REMAINS ELEVATED OVER $10K IN POINT OF SERVICE COLLECTIONS DRIVEN BY INCREASED PATIENT ESTIMATES BEFORE AND AT THE TIME OF SERVICE

Post-Go-Live Monitoring Transition

Organization is now one year post–Epic go-live.

Post-stabilization dashboards are no longer in use.

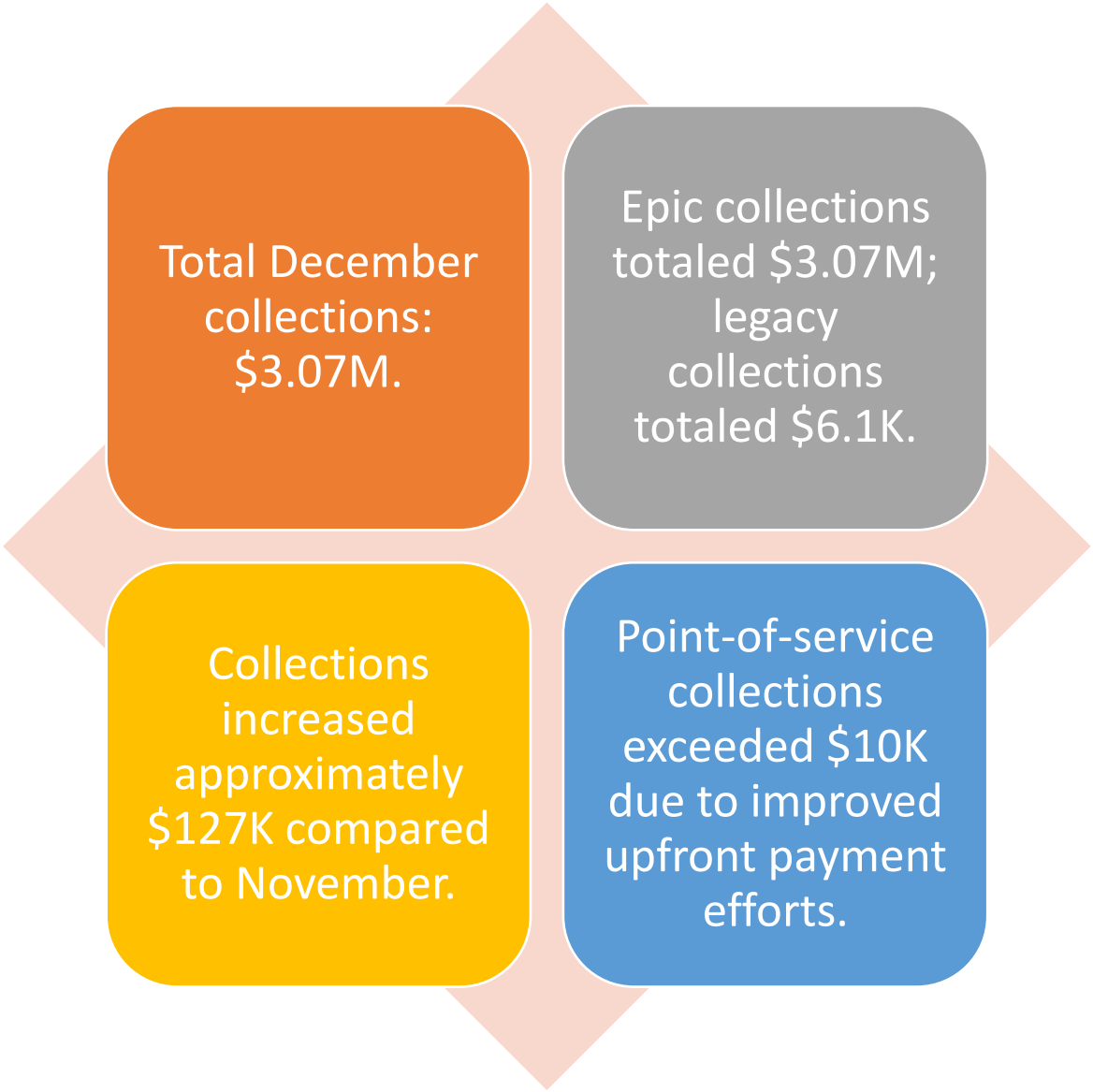
Revenue cycle performance is monitored through standard operational reporting.

KPIs continue to be reviewed and monitored through reports available through EPIC.

Accounts Receivable Overview

- Total Epic AR ended December at $8.63M.
- AR growth driven primarily by current and early aging buckets.
- No material deterioration observed in collectability.
-
- Total AR Days in EPIC & Legacy: 57.89, EPIC at 54.4 just slightly above the top 25% (51).

Cash Collections Performance



Self-Pay AR and Collections Strategy

- $888K in self-pay AR aged over 120 days.
- Represents approximately 5.6 days of total AR. Once moved, gross AR will decrease to below 50 days.
- Balances earmarked for placement with a third-party collections agency.
- Americollect implementation is underway.

- Net legacy AR totaled $555.8K.
- Decreased approximately $27K from November.
- Reductions driven by private pay collections and payment plan activity.
- Credit balance cleanup related to historical posting issues continues.

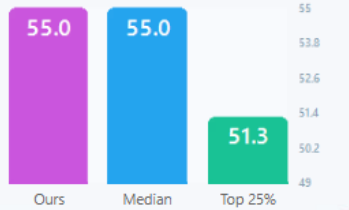
financial pulse
HOSPITAL BILLING

CC OCO SOUTHERN COOS HOSPITAL AND HEALTH CENTER SA

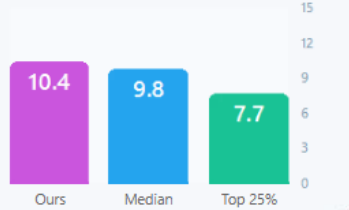
Service Area

0 0 2 1

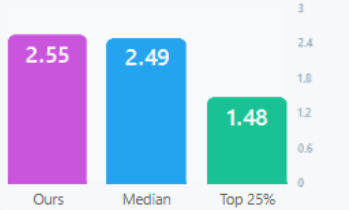
AR Days



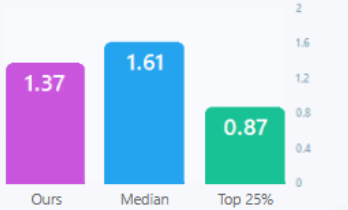
DNFB Days



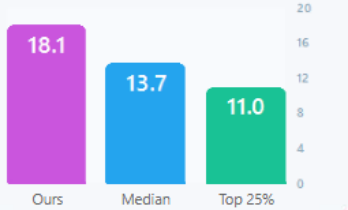
Coding Days



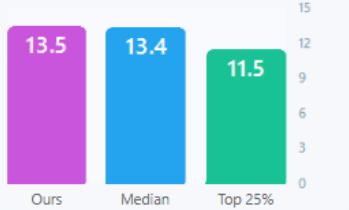
Claim Error Days



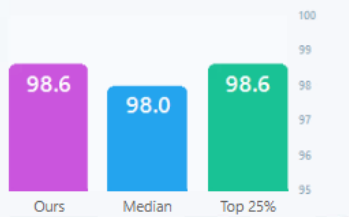
Overall Denial Rate



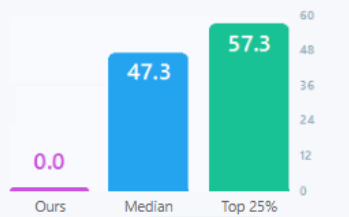
Primary Denial Rate



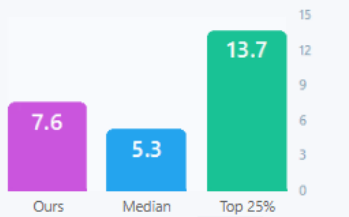
Correct Coverage Rate



Clean Paid Claims %



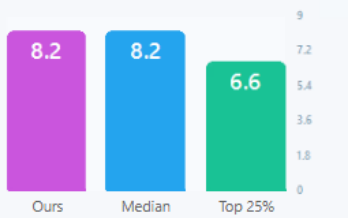
Pre-Service Collection %



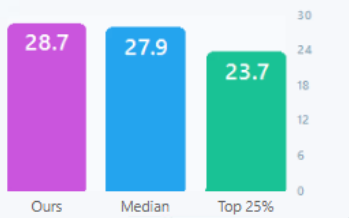
Estimate Accuracy %

The sample size is too small for accurate benchmarking.

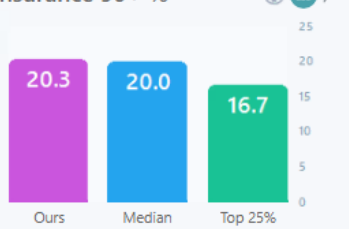
Self-Pay Days



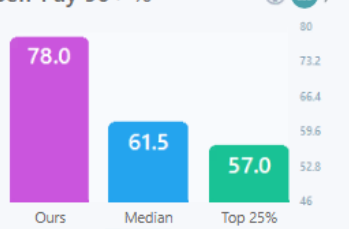
Aged 90+ %



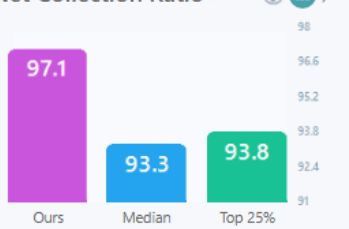
Insurance 90+ %



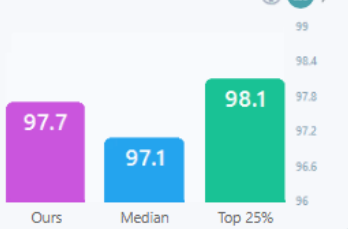
Self-Pay 90+ %



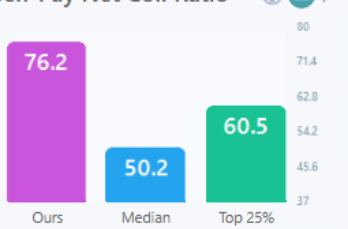
Net Collection Ratio



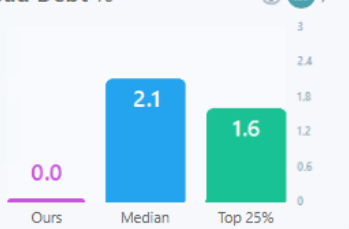
Insurance Net Coll Ratio



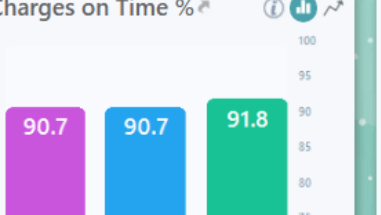
Self-Pay Net Coll Ratio



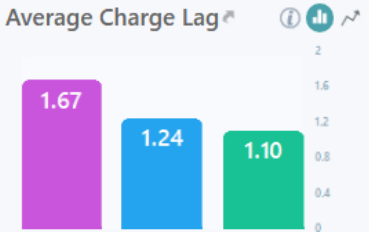
Bad Debt %



Charges on Time %



Average Charge Lag



Active Accounts Receivable – Aging Summary

Payer	Current / Open	0–30 Days	31–60 Days	61–90 Days	91–120 Days	121–180 Days	Over 180 Days	Total AR ($)	% of Total
Medicare	338,668	2,117,809	308,442	62,335	22,650	44,104	62,467	2,956,474	34%
Commercial	24,877	389,228	250,975	126,791	85,542	168,494	268,771	1,314,677	15%
Self-Pay	4,266	57,944	112,931	117,028	103,686	219,857	668,674	1,284,387	15%
Medicare HMO	62,436	594,763	175,343	116,607	141,258	70,980	73,857	1,235,244	14%
Medicaid HMO	48,923	684,023	158,860	61,537	42,083	101,099	52,659	1,149,184	13%
Other Government	515	184,353	14,141	27,666	189,646	134,712	11,859	562,891	7%
Medicaid (FFS)	4,877	28,745	10,548	20,461	731	6,380	23,978	95,720	1%
Worker's Comp	0	5,733	44,945	4,850	0	(935)	(681)	53,912	1%
Other	0	0	0	1,447	662	411	4,717	7,236	0%
Undistributed	(5,052)	0	(6,889)	(8,425)	(2,348)	(3,602)	(5,190)	(31,506)	0%
Active AR Totals	479,510	4,062,598	1,069,296	530,295	583,909	741,500	1,161,112	8,628,220	100%

Legacy Accounts Receivable Summary (All over 180 Days)

Category	Amount ($)
Private Pay – Payment Arrangements	25,698.87
Insurance	311,162.44
Private Pay	327,787.37
Subtotal (Gross Legacy AR)	
Credit Balances	(108,894.99)
Total Legacy AR (Net of Credits)	555,753.69

Aged AR – Work and Priorities

- **Medicare >120 days:** A portion of aged AR relates to Chronic Care Management services pending medical record validation. A plan of correction is in place and claims remain within timely filing limits.

  Commercial claims: Multiple team members are actively working aged balances, including Medicare secondary claims with delayed payer responses.

- **High-dollar accounts:** Some commercial claims are under payer medical record review, which can extend processing beyond 90 days.
- **Escalation efforts:** A detailed list of delayed accounts is being prepared for escalation through Provider Relations to support timely payment.

Questions

FY26 Mitigation Plan 2nd Quarter Review

DATE: January 22, 2026
TO: SCHD Board of Directors
FROM: SCHHC Executive Team
SUBJECT: Second Quarter Review FY26 Contingency Plan

Purpose

The purpose of this Q2 review is twofold: 1. Review progress on the FY26 mitigation plan through the second quarter of the fiscal year; and 2. Perform a review of Q2 gain/loss and determine actions for the rest of the fiscal year.

Progress Review: FY26 Mitigation Plan

After six months of FY26, the FY26 Mitigation Plan remains consistent with the plan management presented to the SCHD Board of Directors in July 2025:

1. Stabilize operating performance,
2. Reduce controllable expenditures,
3. Tighten revenue-cycle execution, and,
4. Grow clinical operations while major enterprise initiatives from last fiscal year (Epic, Sage Intacct) continue to create downstream efficiencies and positive impacts.

Q2 Operating Gain/Loss Review

As of December 31, 2025, the 3-month average Operating Gain/Loss — excluding the three new initiatives Surgery, Senior Life Solutions, and Retail Pharmacy—sits at a **($26,731) loss**.

As management analyzed Q2's performance, we also considered the overall **Operating Gain/Loss, which for December 2025 sits at ($368,047)** — including the revenues/expenses of the three new initiatives Surgery, Senior Life Solutions, and Retail Pharmacy. Our recommendation that follows is based on the dual strategy of optimizing revenue cycles and clinical workflows while aggressively managing the ramp-up phase of new FY26 service line initiatives.

Management Recommendation

Per the matrix presented in the original mitigation plan, management recommends the following:

1. Continue the hiring freeze of non-clinical staff positions;
2. Focus tightly on cost-reduction and expansion of revenue-generating initiatives;
3. Begin preparations for possibility of more aggressive actions in Q3 and Q4.
    a. Look to Drastic Measures in the FY26 Mitigation Plan

Key Points

See Appendix for the following documents:

1. Full FY26 Mitigation Dashboard
2. High-Level P&L for the FY26 New Initiatives of Surgery, Senior Life Solutions, and Retail Pharmacy

FY26 Initiatives in Detail

In the following section, we will summarize progress on FY26 New initiatives; progress on initiatives from the FY26 mitigation plan; and describe the expense reduction and revenue-generating efforts that SCH Management has made and is the process of making for FY26 Q3 and Q4.

What We Have Done (first 6 months of FY26)

- Re-launched the Surgery Department and surgical operations continue to show steady performance
- Senior Life Solutions began seeing patients on-time and is growing incrementally
- Retail Pharmacy: increased volume of prescriptions and revenue of goods sold
- Implemented tighter approval thresholds and reduced participation to essential, role-critical employee conference and travel
- Performed the annual HIPAA Security Risk Assessment in-house: savings $30,000
- Launched 340b program and realized $70,834 in savings to date (as of January 12, 2026)
- Increased point-of-service co-pays
- SCHHC continues to out-perform peers in Epic revenue capture, especially for Critical Access Hospitals after an EHR implementation
- Invested in staff space planning: moved Revenue Cycle team to the space between Ray's Grocery and Dollar General in the Bandon Shopping Center; remodeled the IS space to create new space for the HR and Quality team; and continue to convert the business building to speciality clinic space

Current Initiatives In-Flight (expected future expense reductions)

1. **Contract Staff Reduction**
    a. **HIM department restructure**
        i. Eliminated ~2.25 FTE in HIM contract services
        ii. Therefore, significantly reduced spend on ROI employees
        iii. Brought all request of medical record (ROI) functions in-house
        Trained front desk staff on document scanning and indexing in the medical record
        v. See CFO's report for additional information

    b. Reduced **Clinical Informatics** backfill
        i. Reduced Clinical Informatics consultant to .125 FTE from 1.0 FTE
        ii. Expected reduction of $44,000 in FY26

    c. Plan to reduce the **staffing agency clinical staff** (nurses, techs, etc)
        i. See CFO and CNO's reports for more information

    d. **Eliminated Red Star pay for Per Diem staff:** resulting in some employees moving from Per Diem to PT/FT
        i. See CNO's report for more details

2. **Focus on Growth Initiatives in Existing Service Lines**
    a.
        i. The Chronic Care Management (CCM) program has undergone major updates due to recent changes in CMS compliance guidelines
        ii. Please see Clinic Manager's report for additional information

    b. **Pain Management**
        i. See Clinic Manager's report for more information

    c. **Clinic Productivity:** onboarding Dr. Natalie Speck in February 2026
        i. See Clinic Manager's report for more information

3. **Launch Vendor and Application Rationalization**
    a. Reviewing all vendors for potential cost savings and contract leverage
    b. Reviewing all medical equipment, software applications and programs for duplication and/or lower-cost solutions
        i. See CFO's report for additional information

4. **Enhance SCHHC's Staff experience**
    a. In HR, we are working with ADP (our human resources information system, or HRIS, vendor) to **streamline our on- and off-boarding processes.**
    b. HR is leading an initiative to refine the offerings of SCHHC's **learning management system** to make the training modules more responsive to employees' specific roles and responsibilities.

SCHHC Monthly Review Dashboard

Metric	Status (based on 3-Month Avg)	3-Month Average	As of October 31, 2025	As of November 30, 2025	As of December 31, 2025	3-Month Trend	Baseline
Contigency Plan Tracking Metric							
Operating Gain/Loss - Excluding New Initiatives	🟡	$ (26,731)	$ 152,419	$ (113,591)	$ (119,020)	↘	3 month average, excluding FY26 new initiatives expense
Operating Gain/Loss - New Initiatives (SLS, Surgery, Retail RX)	❌	$ (187,603)	$ (173,919)	$ (139,864)	$ (249,027)	↘	3 month average, FY26 new initiatives only
Organizational Rev/Expense Metrics							
Total Patient Revenue	🟢	$ 4,879,230	$ 5,438,653	$ 4,457,881	$ 4,741,155	↘	Budgeted patient revenue
Total Retail Pharmacy Revenue	🟢	$ 527,225	$ 494,629	$ 476,226	$ 610,819	↘	
% Total Deductions from Revenue	❌	43.35%	45.74%	42.02%	42.30%	↘	Goal: 35% average
Total Operating Revenue	🟢	$ 3,350,228	$ 3,562,406	$ 3,139,609	$ 3,348,670	↘	3 month average calculated on 10% variance over 3-month average budget
Revenue Actual v Budget Variance	🟢	$ 110,649	$ 333,289	$ 55,531	$ (56,873)	↘	Positive variance
Total Operating Expenses	❌	$ 3,564,562	$ 3,583,905	$ 3,393,064	$ 3,716,717	↘	Budgeted Operating Expenses
Expenses Actual v Budget Variance	❌	$ (84,178)	$ (39,499)	$ 2,092	$ (215,126)	↘	
Operating Gain/Loss	❌	$ (214,334)	$ (21,499)	$ (253,455)	$ (368,047)	↘	Includes all expense, including FY26 new initiatives
Change in Net Position	🟡	$ (57,763)	$ 171,433	$ (141,111)	$ (203,612)	↘	Budgeted Change in Net Position
% Margin	❌	(2.10%)	4.30%	(4.50%)	(6.10%)	↘	Positive >1.0
Financial Health Metrics							
A/R Days Outstanding	🟢	51.4	49.8	52.0	52.4	↘	40-55 days
Days Cash on Hand	🟢	73.3	72.4	75.1	72.4	↘	60-180 days
Cash to Debt Ratio	🟢	1.0	1.0	1.0	1.0	↘	.20 - 1.00+
Debt Ratio	🟡	0.5	0.5	0.5	0.5	—	.30 - .60

Status Light Key

🟢	(10%) above or below baseline
🟡	between 10.1% and 20% below baseline
🟠	between 20.1% to 30% below baseline
❌	anything 30% or more below baseline

Operating Gain/Loss for FY26 New Initiatives

Operating Loss by Dept	July	Aug	Sept	Oct	Nov	Dec	Q1 2026 Average	Q2 2026 Average	Sage Dept
SLS	$ -	$ (9,500)	$ (9,500)	$ (9,500)	$ (8,235)	$ (30,916)	$ (6,333)	$ (48,651)	D182
Surgery	$ (76,237)	$ (70,922)	$ (77,832)	$ (114,173)	$ (95,487)	$ (176,669)	$ (74,997)	$ (386,329)	D010
Retail Pharm	$ (29,619)	$ (17,896)	$ (23,617)	$ (50,246)	$ (36,142)	$ (41,442)	$ (23,711)	$ (127,830)	D041
Total	**$ (105,856)**	**$ (98,318)**	**$ (110,949)**	**$ (173,919)**	**$ (139,864)**	**$ (249,027)**	**$ (105,041)**	**$ (562,810)**	
Overall Operating Gain/(Loss)	$ 8,495	$ 84,901	$ (401,387)	$ (21,499)	$ (253,455)	$ (368,047)	$ (102,664)	$ (643,002)	
Gain (Loss) Exculding Initiatives	**$ 114,351**	**$ 183,219**	**$ (290,438)**	**$ 152,419**	**$ (113,591)**	**$ (119,020)**	**$ 2,377**	**$ (26,731)**	
				Updated by JP 1.12.26					