



**Board of Directors
Regular Meeting & Executive Session
March 26, 2026 6:00 p.m.
Southern Coos Hospital & Health Center Conference Room**

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-2-26-26	3
	b. Legal Counsel – Robert S. Miller - Invoice - # 1225.....	9
	2. Policy 500.022 Critical Staff Recruiting	10
	3. Policy 500.064 Health Savings Account (HSA) Employer Contributions.....	14
	Motion to Approve Consent Agenda.....	(action)
III.	New Business	
	1. Consideration of Liability Insurance Coverage Proposals/Coverage Year 2026-2027 Derek Grewatz, Chivaroli & Associates	(under separate cover) (action)
	2. Clinically Integrated Network (CIN) Information	15
IV.	Old Business	
	None.	
V.	Staff Reports-Discussion	
	1. CEO Report.....	22
	2. CMO Report.....	24
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	4. CNO Report	29
	5. CFO Report – See Financial Review Section	
	6. CIO Report.....	33
	7. Multi-Specialty Clinic Report	37
	8. HR Report	39
	9. SCHD Foundation Report	41
	10. Strategic Plan Update.....	(under separate cover)
VI.	Financial Review	
	1. Month-End CFO Report & Financial Statements for Period Ending March 31, 2026 ...	43
	2. February Revenue Cycle Report.....	57
	3. FY26 Monthly Mitigation Plan 3-Month Period Review.....	60

VII. Open Discussion

VIII. 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 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-2-26-26.....(action).
2. Motion to Approve Reports from Executive Session:
 - a. Quality & Patient Safety, Risk & Compliance Report.....(action)
 - c. Medical Staff Credentialing & Privileging Report.....(action)

X. Adjournment

**Southern Coos Health District
Board of Directors Meeting
Open Session Minutes
February 26, 2026
Adapt, LLC Conference Room**

I. Open Session Call to Order at 5:00 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. **Others present:** Robert S. Miller, Counsel.

At 5:01 p.m. the Board moved to Executive Session 1 of 2.

II. Executive Session 1 of 2 under ORS 162.660(2)(i) and 196.660(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.

III. At 6:00pm the Board Returned to Open Session. There were no decisions from Executive Session.

1. **Agenda - Corrections or Additions.** No motion at this time. Later in the meeting, a decision was made to move forward in the agenda, agenda item VIII. 4. FY26 Monthly Mitigation Plan 3-Month Period Review, to occur prior to monthly staff reports.

2. **Public Input – None.**

IV. Consent Agenda

1. **Regular Meeting Open Session Minutes – 1/22/26**

2. **Invoice for Legal Services – Robert S. Miller Invoice #1207**

Mary Schamehorn **moved** to accept the Consent Agenda as presented. Pam Hansen **seconded** the motion. **All in favor. Motion passed.**

V. New Business

1. **Consideration of Amendment to Medical Staff Rules and Regulations.**

Alden Forrester, MD, Chief Medical Officer, summarized the revision to the Peer Review section of the Medical Staff Rules and Regulations that had been revised and approved by the Board of Directors in July 2025. This amendment is intended to codify Peer Review practices already in place. A copy of proposed language was provided in the meeting packet for review.

Mary Schamehorn **moved** to accept the amendment to the Medical Staff Rules and Regulations as presented. **Discussion:** The practice of peer review is ongoing, with 3 charts reviewed per provider every 2 years, and by incident, with review performed by a impartial third party. Southern Coos is pleased to have a reciprocal peer review agreement with Lower Umpqua Hospital. Bob Pickel **seconded** the motion. **All in favor. Unanimous decision.**

2. Consideration of 2026 Quality Assurance & Performance Improvement Plan (QAPI)

Amanda Bemetz, Director of Quality, Risk and Compliance, presented the 2026 QAPI plan provided in the meeting packet with edits in redline for clarity. New CMS requirements have been added.

Mary Schamehorn **moved** to accept the 2026 QAPI as presented. Kay Hardin **seconded** the motion. **All in favor. Unanimous decision.**

3. Consideration of Interim Cost Report – Discussion

Cam Marlowe, Interim Chief Financial Officer, provided a verbal overview of the Cost Report process and benefits of performing an Interim Cost Report at approximately the 8th or 9th month of the fiscal year. An interim cost report assists with accuracy, thereby also often expediting reimbursement. The cost report and interim cost reports assist with budgeting and planning for the next fiscal year. The cost of performing an interim cost report is estimated to be \$10,000 to \$20,000. **Discussion:** Board approval not possible until the actual cost may be presented for consideration.

At this time a request was made to move forward agenda item VIII. #4, FY26 Monthly Mitigation Plan 3-Month Period Review, on the agenda, ahead of routine staff reporting, due to importance of topic and timely completion of the meeting.

Agenda Item VIII. Financial Review, 4. FY26 Monthly Mitigation Plan 3-Month Period Review

Thomas Bedell, Chairman, SCHD Board of Directors, provided a recap of the 3-month-period financial reporting created at the time of the FY26 budget, for quarterly review, to provide mitigation options available in response to budget shortfall. At the January meeting, it was decided to review monthly, rather than every 3 months as originally planned. In June 2025, trigger points were created and new strategic initiatives were separated due to anticipated ramp up time necessary for each service. The current income statement indicates a YTD loss of almost \$180,000. Without the new initiatives we would have a positive YTD bottom line of \$776,000. 340B Drug program savings assisted in bottom line support. Mr. Marlowe continued; as of January 31 we are trending positively. The hospital Executive Team has been focused on erasing the \$180,000 YTD deficit with non-replacement of several positions; the formerly outsourced HIM management has been returned to in-house management, and contract labor reductions have been realized. Mr. Marlowe shared a new plan to move to a preferred staffing agency allowing for more favorable rates

and other negotiated benefits such as ability to call off staff during periods of low census. **Discussion:** Mr. Bedell inquired about Medicare reimbursement impacted by increases and decreases in expenses due to the Cost to Charge Ratio. What we show as savings will ballpark at approximately 50% of that savings amount, based on our percentage of Medicare patients. Our current Medicare patient volume is approximately 64%. In surgical services, our percentage of Medicare utilization is approximately 70%. If revenue increases, but expenses do not we are paid based on the expenses. We benefit by providing more services in every department and reducing expenses. **Discussion:** Four contract positions have been replaced with Full Time Employees (FTE). Surgery and the Retail Pharmacy are trending positively. Census has been up. The Board thanked the Executive Team for this positive status report. No further action was requested at this time.

Return to published agenda sequence.

VI. Old Business

1. None.

VII. Staff Reports

1. CEO Report

Ray Hino, CEO, added information not all of which was included in the printed report. The Senior Life Solutions group therapy program is hosting group sessions two times per week. A special Master Facilities Planning presentation is scheduled to be held on March 19. This will not be a public meeting. Two board members will be invited to attend with a debriefing for the other 3 board members. From the written report, Mr. Hino wished to elaborate on the Rural Coordinating Committee, for which he is the Committee Chairman. Discussion by the committee includes consideration of formation of a clinically integrated network to leverage group purchasing. A Catalyst Grant of \$80.0 Million total is to be awarded in a competitive Request for Grant Proposal (RFGP) process. Awardees must implement their grant projects within the first 2 years with deadline of September 30, 2027. RFGP instructions are to be issued by the spring of 2026. Mr. Hino is proposing to apply for funding for Level IV Trauma designation under this category, with other potential opportunities also to be considered. **Discussion:** A “small” grant might be \$500,000, while a “large” grant could be in the range of \$5M.

2. CMO Report

Dr. Alden Forrester, Chief Medical Officer, provided highlights from his report, describing need to transition to new after hours reading radiology group due to changes in the business model of our current long-term group. Mr. Hino provided a description of the service which provides after-hours and emergency back-up radiology reading with credentialed radiologists for our regular contracted Radiologists, PJ Keizer, MD and Stephen Quinn, MD. We anticipate improved response times for ER reading with new group and estimated increase of \$1,000.00

per month. There were no questions.

3. SCHHC Retail Pharmacy Report

There were no questions for Dr. Forrester regarding the Retail Pharmacy report.

4. CNO Report

Cori Valet, Chief Nursing Officer, was asked if we are able to track individual department profit and loss reporting. Mr. Marlowe, CFO, responded that we are not able to do so at this time, though we are presently working in Sage to provide income statements for each department. Inpatient claims vs. actual payment processing described. Sage can show gross revenue but not the contractual allowance. Mr. Marlowe intends to create a report with meaningful statistics, or performance indicators, to gauge financial trends such as how many hours worked / units, and so forth. There were no further questions.

5. CFO Report

Mr. Cam Marlowe, Interim Chief Financial Officer, noted that there is no CFO Staff Report this month, having been combined with the Monthly Financial Review in section VIII. on the agenda.

6. CIO Report

Scott McEachern, Chief Information Officer, the 2025 HIPAA Security Risk Assessment has been completed, was included in the meeting packet, and will require acceptance by the Board of Directors at tonight's meeting, though not identified as such on the agenda. Security is again a concern for continued discussion. Board members would like a short report on the use of AI at SCHHC at a future Board meeting.

Mary Schamehorn **moved** to approve the 2025 HIPAA Security Risk Assessment as presented. Bob Pickel **seconded** the motion. **All in favor. Unanimous decision.**

7. Multi-Specialty Clinic Report

David Serle, Multi-Specialty Clinic Director, received kudos from Director Kay Hardin for his report this month. It was noted that the clinic loss YTD is (-\$259,000). Coordinated Care (CCM) income will continue to improve clinic bottom line.

8. Human Resources Report

Stacy Nelson, Director of Human Resources, touched on New Employee Turnover statistics and efforts for improvement including 30, 60, 90-day check-in with new employees. Ms. Bemetz added the new orientation process has been helpful and the "warm hand-off" to the respective department manager. Mr. Nelson noted that the demographic range of employees can also affect individual expectations.

9. SCHD Foundation Report

There were no questions for Alix McGinley, Health Foundation Executive Director, attending via remote link.

10. Strategic Plan

Discussion: As we near completion of the current Strategic Plan, Board Members inquired if it is time to consider development of a new Plan, to include the current new initiatives, and if this can be completed in-house (without using a consultant). No decision was made at this time.

VIII. Financial Review

1. Month-End Report & Statements for Period Ending January 31, 2026

Mr. Marlowe, Interim Chief Financial Officer, presented the monthly statements including a new format with monthly trends and Year to Date (YTD) averages, appreciated by Board Members.

2. Contractual Allowance Presentation/Overview

Mr. Marlowe included this section as an educational piece. In the financial reporting the contractual allowance (or adjustment) is the legally mandated difference between the billed charge for a service and the lower, pre-negotiated rate accepted from an insurance payer, representing a "write-off" of the uncollectible portion. Also may be referred to as a contractual adjustment, negotiated discount, or contractual write-off. Mr. Marlowe presented a overhead slide requested to be forwarded to Board members for reference and added to the meeting record, including a review of, 1) Actual contractual allowances for a specific reporting month; 2) Contractual allowance reserves calculation; and, 3) Medicare/Medicaid Estimated Payable/Receivable. Our contractual allowance calculations and processes are reviewed each year and have been found to be sound and acceptable.

3. January Revenue Cycle Report

Colene Hickman provided a high-level overview of the provided report, noting an increase in Accounts Receivables related to Medicare system and coding updates after the first of the calendar year. December is historically a lower billing month. Three inpatient VA accounts that required lengthy processing were paid in February, reducing outstanding Accounts Receivables by \$300,000. There were no questions.

4. Monthly Review of Mitigation Plan was moved to earlier in the agenda.

IX. Open Discussion

Cori Valet, CNO, noted that the Critical Staff Recruiting Policy in process is nearly ready for approval at the March regular meeting. Mr. Hino summarized, this is a bonus incentive for employees in support of recruitment and retention.

X. Executive Session

At 7:56 p.m. the Board moved to 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. 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; P.J. Keizer, Medical Staff Chief of Staff. **Others in attendance:** Robert S. Miller, Legal Counsel; Kim Russell, Executive Assistant. **Press:** None.

XI. Return to Open Session

At 8:18 p.m. the meeting returned to Open Session.

1. Consideration of Executive Session Minutes 1-26-26

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

2. Reports from Executive Session 2 of 2

- a. **Quality and Patient Safety Committee Report**
- b. **Medical Staff Credentialing Report**

Mary Schamehorn **moved** to accept the Quality & Patient Safety Report and Medical Staff Credentialing Report as presented. Pam Hansen **seconded** the motion. **All in favor. Motion passed.**

X. Adjournment

The meeting adjourned at 8:21 p.m. The next regular meeting will be held on March 26 at 6:00 p.m., location to be announced.

Thomas Bedell, Chairman 3-26-2026

Mary Schamehorn, Secretary 3-26-2026

INVOICE

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

Invoice details

Invoice no.: 1225
Terms: Net 30
Invoice date: 03/05/2026
Due date: 04/04/2026

#	Product or service	Description	Qty	Rate	Amount
1.	Attorney (\$300/hr)	March 26, 2026 Board Meeting & Executive Session	2.5	\$300.00	\$750.00

Total **\$750.00**

Ways to pay



[View and pay](#)



DEPARTMENT: Human Resources	NUMBER: 500.022
SUBJECT: Critical Staff Recruitment Incentives	PAGE: 1 of 4
EFFECTIVE DATE: TDB	REPLACES POLICY DATED: 07-01-2021, 07-26-2021, 05-04-2022, 06-01-2023
APPROVED BY: Executive team, Policy & Procedure Committee, Board of Directors	DISTRIBUTION: Organization Wide

Policy:

Southern Coos Hospital & Health Center (SCHHC) may provide financial incentives for the recruitment, and referral of critical staff positions. The Southern Coos Health District Board of Directors will approve the criteria for positions that meet the definition of Critical Staff Positions.

Human Resources Department will monitor the use of the recruitment and retention incentive program and will have final authority over all aspect of the program.

Purpose:

To enhance recruiting capabilities by increasing candidate selection pools and boosting employee morale. To establish the mutual and respective understandings, responsibilities, terms, and conditions under which recruitment and referral, incentives may be provided to staff members.

Eligibility and Participation:

Eligible positions are those open positions that meet the criteria for a critical staff position:

- A position that performs an essential function, critical to the operations of the hospital and requires the use of contract / registry labor when the position is vacated by a full-time employee.

This Policy applies to employees of the organization. Licensed Independent Practitioners are excluded from this Policy and are subject to the terms of their respective contractual agreements.

Referral Bonuses have specific limitations that do not extend to:

- Senior management (C-level executives and directors).
- Human Resources Department employees.
- Hiring manager, supervisor, or individual who would have a direct reporting relationship with the candidate.
- Employees who are on a performance improvement plan or have received a formal disciplinary action within the last six months.

All eligible candidates must meet the following criteria in order for the employee to be eligible for a referral bonus:

- Can not be a former employee within the last two years, contract temporary help, agency employee or student employee.
- Cannot be an immediate family member.
- Cannot have a third party fee or other agency fee required for hire.



DEPARTMENT: Human Resources	NUMBER: 500.022
SUBJECT: Critical Staff Recruitment Incentives	PAGE: 2 of 4
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APPROVED BY: Executive team, Policy & Procedure Committee, Board of Directors	DISTRIBUTION: Organization Wide

Recruitment “Sign-on” Incentive:

For vacant, full-time Critical Staff Positions that have remained open, without a qualified applicant for at least 10 regularly scheduled working days, sign-on incentive compensation of up to 12% of the Gross Annual Income of the position, not to exceed \$10,000.00, may be provided to the successful candidate. This incentive compensation will be contingent upon the employee’s full time employment at Southern Coos Hospital and Health Center for a period of 2 years in the agreed upon shift and department.

- Southern Coos Hospital & Health Center will pay one-half of the incentive compensation at the end of the recipient’s first pay period. Upon successful completion of a 2nd positive annual performance review, which normally occurs 2 years after the employee’s start date, the second half of the incentive compensation payment will be provided to the employee at the end of the next pay period.

Employee Referral Incentive:

When a regular full-time, part-time, or per diem employee recommends a qualified individual for a valid critical staff member opening, and the referral is hired as a regular full-time or regular part-time employee. This incentive compensation will be contingent upon the referred employee’s continued employment in the applicable full-time status for SCHHC for a period of 1 year in the agreed upon shift and department.

Referrals may be submitted by the following methods:

- The applicant may list the employee’s name as a referral source on the employment application or on the applicants resume.
- The SCHHC employee may complete and submit to Human Resources the referral form attached as Appendix A.

The Employee Referral Bonus amount is \$2,500 for the referral of a full-time critical staff member.

The referral bonus will be paid, in two installments. One-half of the referral compensation incentive will be paid on the first pay period after the successful completion of the referred employee’s 90-day introductory period. The second half of the referral incentive will be paid one year after the referred employees start date at the end of the next pay period. Applicable taxes will be deducted from each installment payment.

Both the employee who made the recommendation and the employee who was hired must be employees of Southern Coos Hospital & Health Center at the time the bonus payment is due. An employee who is on leave or temporary disability at the time the bonus payment is due will have any bonus payment deferred until the employee returns from the leave of absence.

If multiple employees refer the same candidate, only the first referral received will be eligible for the bonus. In the case of simultaneous submissions, the bonus will be split equally among the referring employees.



DEPARTMENT: Human Resources	NUMBER: 500.022
SUBJECT: Critical Staff Recruitment Incentives	PAGE: 3 of 4
EFFECTIVE DATE: TDB	REPLACES POLICY DATED: 07-01-2021, 07-26-2021, 05-04-2022, 06-01-2023
APPROVED BY: Executive team, Policy & Procedure Committee, Board of Directors	DISTRIBUTION: Organization Wide

Board Evaluation of Business Environment:

The Southern Coos Health District Board of Directors will review the business environment of the organization periodically to determine the ongoing need for recruitment, and referral incentives. The recruitment policy may be revised or eliminated at any time at the discretion of the Board of Directors. If the policy is revised or eliminated, any commitments made to an employee will be honored under the terms and conditions in place at the time those commitments were initiated.

An employee may appeal decisions made under this policy to the Chief Executive Office.



DEPARTMENT: Human Resources	NUMBER: 500.022
SUBJECT: Critical Staff Recruitment Incentives	PAGE: 4 of 4
EFFECTIVE DATE: TDB	REPLACES POLICY DATED: 07-01-2021, 07-26-2021, 05-04-2022, 06-01-2023
APPROVED BY: Executive team, Policy & Procedure Committee, Board of Directors	DISTRIBUTION: Organization Wide

Appendix A:

**Southern Coos Hospital & Health Center
New Employee Referral Form**

DIRECTIONS

Please either print this form, complete it by hand, and return it to your Department Manager or Human Resources (HR) representative; or complete it electronically and return it to your Department Manager or HR representative.

EMPLOYEE INFORMATION

Your name: _____ Employee ID: _____

Department: _____

REFERRED CANDIDATE INFORMATION

Candidate Name: _____

Position Candidate is Being Referred For: _____

Department that Open Position is Being Advertised In: _____

Candidate Email: _____

Candidate Phone: _____

FOR DEPARTMENT USE ONLY

Date and Time Initially Received: ____/____/____ at ____:____ AM/PM

Date Hired: ____/____/____

Date Employee Eligible for Bonus: ____/____/____

Date Bonus Paid to Employee: ____/____/____

DEPARTMENT:	Human Resources	NUMBER:	500.064
SUBJECT:	Health Savings Account (HSA) Employer Contributions	PAGE:	1 of 1
EFFECTIVE DATE:	TBD – After Policy Committee Approval	REPLACES POLICY DATED:	N/A
APPROVED BY:	Executive Team, Policy & Procedure Committee	DISTRIBUTION:	Organization wide

POLICY:

It is the policy of Southern Coos Hospital & Health Center (SCHHC) to make a one time annual lump sum employer contribution into the individually owned Health Savings Account (HSA) for benefit eligible employees who enroll in the HSA plan. The SCHHC provided HSA will be compliant with all Internal Revenue Service (IRS) regulations. The employer contribution amount will be determined by SCHHC management and its board of directors annually prior to open enrollment and will remain consistent for the entire benefit plan year. The employer contribution is subject to change at the start of each new plan year.

SCHHC will make a lump sum employer contribution into each qualified employee’s individual HSA account in the first pay period of the new plan year, for employees eligible and participating in the plan on the first day of the new plan year. For employees enrolling after the first day of the new plan year, the employer contribution will be made in the first pay period where they are benefit eligible. Employer contributions into HSAs are non-forfeitable. Lump sum contributions will remain in the employee’s individually owned HSA account regardless of whether the employee remains employed or eligible for the entire plan year.

SCHHC employees who qualify and enroll in the plan after the first day of the plan year, will receive a pro-rated employer HSA contribution based on when the employee becomes HSA eligible. The pro-rated formula will be as follows:

- The approved annual lump sum Employer contribution (paid to employees who are enrolled ~~start~~ on the first day of the plan year) will be reduced by a percentage of the year already completed using a formula of 2 pay periods per month (24 pay periods for the entire 12-month year).
- For example, if the approved lump sum Employer contribution is \$1,000 for employees who are participating on day 1 of the new plan year, and assuming that the new plan year begins on January 1, then a new employee who becomes eligible on June 10 would receive the following pro-rated lump sum, Employer paid, HSA contribution.
 - \$1000 divided by 24 pay periods (\$41.67) and multiplied by expired pay periods from the start of the year. In this case that would be 13 expired pay periods, for a total of \$541.71.
 - The expired plan year amount of \$541.71 would be subtracted from the full year approved amount of \$1,000.00.
 - The new employee, who became eligible for the HSA plan participation on June 13, would receive a pro-rated lump sum Employer contribution of \$458.29.



DATE: March 20, 2026
TO: Board of Directors
FROM: Raymond T. Hino, CEO *Raymond T. Hino*
SUBJECT: Clinically Integrated Networks

Executive Summary

A group of rural Oregon independent (not owned or affiliated by a Healthcare system) hospitals have been meeting for approximately ten (10) months to discuss the possibility of creating an Oregon Clinically Integrated Network (CIN), whose membership would be restricted to rural and independent hospitals. The majority, but not all of the hospitals are critical access hospitals. Bay Area Hospital is an example of a rural hospital that is independent, but not a CAH. The majority, but not all, of the hospitals are District Hospitals. An example of a non-district hospital is Grand Ronde Hospital in La Grande, Oregon, who is currently among the potential members of the new CIN.

I am attaching an informative article on rural CINs to this memo, and have placed this as an agenda item on tonight's agenda to educate the Board on the potential for membership in the Oregon CIN.

There is only minimal cost to joining the CIN at this time (less than \$10,000). Because the CIN has applied for start up expenses to be covered by the Rural Health Transformation Program. The primary benefit would be joint contract negotiations among the network members for payer contracts with commercial plans (e.g. Regence Blue Cross/ Blue Shield, Moda).

attachment



Introduction to Rural Clinically Integrated Networks

Rural Health Value

February 2025

What: Rural clinically integrated networks

Why: To deliver better care and participate in value-based care and payment opportunities

How: Maintain independence through interdependence

Summary

A collaboration of independent rural healthcare organizations (HCOs), incorporated as a clinically integrated network (CIN), can achieve the scale and develop the infrastructure necessary to successfully participate in value-based care and payment opportunities. Furthermore, CINs can be a powerful vehicle to deliver better rural health care, healthier rural people, and smarter spending. The purpose of this Rural Health Value topic brief is to define CINs, describe common CIN characteristics, and explore the unique value-based care advantages a rural CIN may bring to its members.

Clinically integrated networks (CINs) are neither new nor uncommon. Many vertically integrated and/or horizontally integrated health systems currently operate as CINs and have existed for decades. These health systems provide CIN organizational structure, own multiple healthcare organizations (HCOs), and employ a variety of clinical personnel. Additionally, many health system CINs also include affiliated (but not owned) HCOs with whom they share operational practices and accountabilities to varying degrees. As examples, Mayo Clinic, University of Pittsburgh Medical Center, and Kaiser Permanente operate as health system CINs. But CINs among *independent* rural HCOs are less common. The purpose of this Rural Health Value topic brief is to define CINs, describe common CIN characteristics, associate CINs and healthcare value, and explore the unique value-based care advantages a rural CIN may bring to its members.

Clinically Integrated Networks

CINs form a corporation of HCOs (generally hospitals and/or clinician practices) who join together to improve and coordinate clinical care and demonstrate market value (high quality and low cost) using proven clinical protocols and measures of quality processes and outcomes.^{1,2,3} Furthermore, CIN members collaborate to “actively assess and modify services to deliver efficient and affordable coordinated care to specific groups of patients. They share pertinent information and data, creating a high degree of interdependence and cooperation among the clinically integrated providers to control costs and ensure quality, usually via an electronic platform.”⁴ In 2009, Federal Trade Commission (FTC) Commissioner Pamela Jones Harbor provided this CIN description.

The essence of clinical integration is the creation of interdependence among health care providers. Put simply, each provider must have a vested interest in

the performance of the other providers, such that their financial and other incentives are closely aligned to meet common objectives. In addition, physicians are most likely to conform their behavior to network goals when their performance is judged by objective standards, in comparison to their peers.⁵

More recently in its 2018 Health IT Playbook Glossary, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) provided this CIN definition.

A clinically integrated network is a term used to describe a collection of clinicians from different specialties who create processes and systems for managing and coordinating the care they deliver to individual patients. If a clinically integrated network meets specific standards established by the Federal Trade Commission (FTC), the clinicians in the network can jointly negotiate with payers in ways that could otherwise be deemed to be a violation of anti-trust laws, even if they are not taking financial risk. The things that a network must do to show it is clinically integrated under FTC rules include developing and using detailed, evidence-based clinical practice guidelines; limiting participation in the network to clinicians who are committed to following the clinical practice guidelines measuring the participating clinicians' compliance with the guidelines; and enforcing use of the clinical guidelines.⁶

In summary, CINs are organizations composed of multiple healthcare clinicians and organizations that implement models of care integration intended to achieve higher quality at lower cost. They typically serve patients across broad geographies by integrating the roles of clinicians at various points of service. With their focus on care coordination and population health improvement they are well-positioned to realize the full potential of new value-based payment models as negotiated with third-party payers.

CIN Accreditation

URAC (previously Utilization Review Accreditation Commission) has an optional accreditation program for CINs. Although URAC accreditation does not guarantee FTC approval, the URAC program provides helpful guidance through key CIN characteristics and responsibilities in six categories.⁷

1. **Structure and Operations** – CINs should maintain policies regarding business agreements and documents, CIN organizational structure and governing body, staff and provider qualifications and training, consumer safety mechanisms, financial integration, and fiduciary responsibilities.
2. **Health Information Technology** – Collection, aggregation, analysis, and sharing of clinical and financial data is key to a high-functioning CIN. CINs should evaluate various technologies, validate data accuracy and completeness, and ensure information security.
3. **Clinical Management** – Delivering better care and promoting healthier people requires evidence-based clinical care protocols implemented across the CIN. CINs should select and use clinical protocols appropriately, coordinate care for patients with chronic conditions, and support patient self-management.
4. **Population Health** – In the interest of healthier people, CINs should manage population health improvement activities, health risk mitigation, and provider access programs.

5. **Care Coordination** – Care coordination deliberately organizes patient care activities and shares information among all the participants concerned with a patient's care to achieve safer and more effective care.⁸ CINs should support care coordination and transitions of care.
6. **Performance Measurement and Reporting** – Supported by health information technology, CINs should develop performance metrics (both clinical and financial), develop internal and external performance-sharing processes, and continuously improve performance.

Clinical Integration and Healthcare Value

Healthcare value is represented by the concurrent goals of better care, healthier people, and smarter spending.⁹ In the Innovation Center 2021 Strategy Refresh, the Centers for Medicare & Medicaid Services (CMS) stated that all Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.¹⁰ These two accountabilities, quality and cost, are fundamental to value-based care and are supported by value-based payment. Value-based care contracting is also becoming increasingly common in state-based healthcare programs (e.g., Medicaid) and commercial health insurance payer programs.

Research by the Rand Corporation in 2020 could find no studies that evaluated the clinical impacts of CINs.¹¹ However, a CIN focus on clinical performance improvement and operational efficiency suggests that CINs are well-positioned to be an effective vehicle for value-based care success.

Rural Perspective

Many rural HCOs participate in value-value-based plans and programs. But overall, rural healthcare organizations' participation in value-based care and payment plans has lagged urban participation. This is due to a variety of factors including low patient and service volumes (making it more difficult to achieve enrollment thresholds and leaving organizations at higher risk for loss due to statistical variation), less experience with managed care, fewer financial management and population health resources, and low financial risk tolerance due to thin operating margins.¹²

Rural HCO senior leadership teams and boards often remark that they wish to remain independent; that is, not owned by a larger and distant organization. In other words, rural HCO leadership and boards wish to retain local control of their community's healthcare future. As noted above, value-based care and payment contracts are rapidly expanding among all payers. But participation in value-based care contracts requires patient volumes and supporting infrastructures, often unavailable in rural areas. Historically, some rural HCOs have affiliated with, or sold to, larger and distant health systems to achieve the scale and resources necessary for value-based care program participation. But by doing so, rural HCO senior leadership teams and boards lose at least some, if not all, decision-making authority regarding their community's healthcare future.

Rural Clinically Integrated Networks

CINs composed of *independent* rural HCOs are an alternative to health system affiliation. Independent rural HCOs can legally incorporate as a CIN. By aggregating patients and service

volumes, sharing expertise and clinical protocols, and investing collaboratively in value-based care infrastructure (including clinical data aggregation and analysis systems), rural HCOs can achieve the scale and support necessary to participate in value-based care programs. Furthermore, rural CIN members share decision-making authority typically through a representative board governance, articles of incorporation outlining decision-making authorities, and physician (and/or other clinician) input regarding clinical issues. Thus, rural CIN members maintain independence through interdependence.

URAC provides the best guidance for CIN structure and function, but there are minimal prescriptive CIN roadmaps or checklists promulgated by the FTC, Department of Justice, or state attorneys general. In her 2009 remarks referenced above, FTC Commissioner Pamela Jones Harbour stated that the FTC will not issue regulatory guardrails and safe harbors for CINs. Rather, “based on what we know right now about the relative benefits and risks of clinical integration – a flexible, case-by-case approach may be best for market participants as well as consumers.”¹³

In the 1990s, few value-based care plans existed (except health maintenance organizations and isolated experiments with capitation), quality measures were underdeveloped, and clinical quality and cost data systems were rudimentary compared to current population health information technology platforms. And even since the 2009 FTC remarks, clinical performance analysis systems have become markedly more sophisticated. Considering new healthcare realities and absent clear regulatory guidance, it appears *reasonable* that rural CINs of independent rural HCOs should demonstrate interdependence through the following characteristics:¹⁴

- Clinical integration per URAC accreditation standards
- Distributed evidence-based clinical guidelines
- Physician (or other clinician) governance
- Use of a common population health information technology platform

Rural CIN Examples

Illinois Rural Community Care Organization – “The Illinois Rural Community Care Organization (IRCCO) is a group of physicians, hospitals, and clinics who voluntarily work together with Medicare to provide high-quality services and care through the Medicare Shared Savings Program. IRCCO is dedicated to quality, collaboration, excellence, and service. IRCCO strives to deliver the best healthcare possible to rural communities in Illinois. As a collaborative organization IRCCO believes primary care, chronic disease management, care coordination and social services are best delivered and supported on a local level. The IRCCO mission is to improve the health of the individual seeking care and services, improve the overall health of the rural population served, and reduce the individual healthcare beneficiary spend and reduce overall healthcare costs.” (<https://www.iruralhealth.org/>)

Rough Rider Network – “The network of 23 North Dakota hospitals and their associated clinics join forces on clinical and operational fronts, amplifying the accessibility, affordability, and quality of care in North Dakota’s rural communities. The network is a beacon for nearly 300,000 patients, ensuring they receive nothing but the best care. The Rough Rider Clinical Integration Network (CIN) was established to further enhance collaborative efforts. The CIN empowers member hospitals to offer continuous care to patients across the network, from surgery and ophthalmology to mental health and obstetrics. The CIN’s Clinical Integration Committee, comprising a practitioner from each member hospital, supervises all clinical and quality initiatives.” (<https://roughridernetwork.org/>)

Western Health Alliance – “The Western Healthcare Alliance (WHA) helps rural providers with collaborative solutions and resources focused on rural healthcare. WHA members have the independence and freedom to make decisions with confidence to ensure the best care in their communities. Hospitals and clinics alike receive the education and support needed to be able to manage day-to-day operations while planning for the future. WHA began in 1989 when a small group of rural Colorado hospitals decided that there was power in numbers. Today, WHA has over 30 healthcare members in Colorado, Utah, and Michigan. As members embark on the journey towards alternative payment models and population health, WHA formed the Community Care Alliance (CCA). The CCA is dedicated to creating solutions that ensure quality outcomes during the shift towards a reimbursement model focused on value. Members learn and work together to coordinate care and ensure success as their medical communities are rewarded for maintaining healthy populations through better care at lower costs.” (<https://www.wha1.org/>)

- Shared goals of improved quality, increased efficiency, and reduced inappropriate utilization
- Shared financial risk in value-based payment contracts between the CIN and payers.

As noted above, the ASTP/ONC Health IT Handbook stated that “the clinicians in the network can jointly negotiate with payers in ways that could otherwise be deemed to be a violation of anti-trust laws, even if they are not taking financial risk.”¹⁵ However, before proceeding with payer negotiations, CINs should obtain antitrust legal counsel to help ensure that their activities meet reasonable criteria for clinical integration.

Conclusion

A collaboration of independent rural HCOs, incorporated as a CIN, can achieve the scale and develop the infrastructure necessary to successfully participate in value-based care and payment opportunities. Furthermore, CINs can be a powerful vehicle to deliver better rural health care, healthier rural people, and smarter spending.

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¹³ FTC. Clinical Integration: The Changing Policy Climate And What It Means For Care Coordination.

¹⁴ Ridgley, MS et al. Consolidation by Any Other Name.

¹⁵ ASTP/ONC. Health IT Playbook.



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, March 26, 2026

Senior Life Solutions:

- Senior Life Solutions was successful in hiring a full-time employed Therapist this month. Her name is Kim Reilly. Kim is a licensed clinical therapist, who currently lives in Port Orford. She has over 20 years of experience in behavioral health, and most recently has been working in private practice. Her expected start date is in April.

Physical Plant Moves:

- Kendall Roberts, of our Health Information Management (HIM) department has been moved over to the SCHHC Business Services Center at the Ray's Shopping Center. That space now houses Colene Hickman and her entire Bandon-based team, including Revenue Cycle, SHEBA Counselors and HIM.
- The former Foundation/Business Office Building, which is now being referred to as the SCHHC Specialty Clinic continues to make progress towards completion. Two (2) inspections took place earlier this week, (1) Fire Alarm Permit Inspection and (2) Wall Permit Inspection. Both went well. Painting, electrical and plumbing work is scheduled for completion by next week, and equipment will begin to be installed next week. The final step will be Oregon Health Authority inspection, which will likely occur in April.

Master Facility Planning Process

- An on-site Master Facility Planning (MFP) meeting took place on March 19, with representation from Joe Kunkel, Project Manager and J.D. Dreyer, Principal with Davis Partnership Architects. During the 6-hour meeting, we were able to go through the different options that have been created by Davis Partnership for hospital expansion and possible replacement, and the positives and negatives of each option. This was a working session. Our plan is to come to the Board of Directors at our April Board meeting with a full report.

Federal/State Funding – Rural Health Transformation Program Funds

- The Oregon Rural Health Coordinating Council (RHCC), which I am the Chair of this year, met for the third time in 2026 on March 20. The Council has decided to meet monthly this year, instead of its normal quarterly schedule in prior years. In this month's meeting we learned more of the details on how the first-year allocation of \$197.3 million is planned to be spent. It will be split up into four (4) categories. The following is the latest information that we have:
 - Catalyst Awards (\$80.0 Million) to be awarded in a competitive Request for Grant Proposal (RFGP) process. We learned that grant proposals process will begin in early April, with a

deadline for submittal within 45 days. The announcement of awardees will occur in the summer months of July or August. 50 to 100 projects are expected to be funded, which means that awards, on average could be in the range of \$800,000 to \$1,600,00 per successful awardee, and the funds must be spent no later than September 30, 2027. Funds may be used to create regional partnerships, expansion of access points, physician residency training programs, and Information Technology. My proposal to apply for funding for Level IV Trauma designation could fit under Regional Partnerships and System Transformation.

- Immediate Impact Awards (\$40 Million) to be awarded in non-competitive direct awards. We learned that the Immediate Impact Awards are planned to be announce in April. Only 10 Immediate Impact Awards have been approved for the First “Wave.”
- Regional Planning and Innovation Awards (\$40 Million) to be awarded for regional convenings and technical assistance. The Oregon Office of Rural Health has proposed to create eight (8) regions for regional convenings. Southern Coos is proposed to be placed in Region 8, which will encompass the Curry, Coos and a portion of Douglas County (Reedsport) and Lane County (Florence). A first regional convening for each region is planned to occur in 2026.
- Tribal Initiatives (\$37.3 Million) to be allocated for Tribal projects.

Oregon Cascade Clinically Integrated Network

- Separate from the Rural Health Transformation Program (RHTP), but related, is an opportunity for SCHHC to become a part of a Clinically Integrated Network (CIN). Oregon hospitals are creating a CIN, which will be called the Cascade Clinically Integrated Network. The hospitals are also requesting Rural Health Transformation Program dollars to aid in the costs of creating the network. I am putting a separate agenda item on tonight’s Board agenda to educate our Board on what a Clinically Integrated Network is.

2026 Oregon (Short) Legislative Session:

- In this year’s short legislative session in Oregon there were two (2) bills that affect rural hospitals, that were approved by the legislature and are now moving to the Governor for signature.
 - HB 4040 included changes in the Oregon Hospital Financial Assistance law, also referred to as Oregon’s Presumptive Eligibility Law. Under this new law, presumptive eligibility does not apply to individuals with hospital bills under \$1500. The original law required eligibility for all bills above \$500.
 - HB 4047 creates a new hospital licensure category in Oregon, called the Rural Emergency Hospital (REH). The Rural Emergency Hospital model was created by the Federal Government and approved by CMS beginning on January 1, 2023. The difference between Rural Emergency Hospitals and Critical Access Hospitals is that REHs do not have any inpatient beds, including swing beds. They are restricted to free standing emergency departments and ancillary services only. The REHs are paid a set rate by CMS (\$285,626/month in 2025) plus the Outpatient Prospective Payment rate + 5% for ancillary services. This is a model that will apply to critical access hospitals that are unable to survive as CAHs. Although CMS has approved the model since January of 2023, it still required the State of Oregon to approve the model in Oregon. It has now been approved. According to the Rural Information Hub, there are currently 42 approved REHs in the United States.



Chief Medical Officer Report

To: Southern Coos Health District Board of Directors
From: Alden Forrester, MD, Chief Medical Officer
Re: CMO Report for SCHD Board of Directors, March 2026

Salem Radiology

Thanks to the hard work of Michele Winchell, our Credentials Committee, our Medical Staff, and staff at Salem Radiology, credentialing of providers for our new after-hours radiology service is going better than expected. You will find several of their providers who are providing coverage in April in this month's list of providers to be approved. We anticipate the rest of the Salem Radiology providers will be forwarded to you for approval over the coming two months.

General Surgery

We continue to interview candidates to replace Dr. Schulte when his time with us is up in late summer. Two of those candidates have had on-site interviews and both have expressed significant interest in working at Southern Coos. The goal is to decide on a replacement in time for the new surgeon to be credentialled by July.

South Coast Internal Medicine Residency

Our current Strategic Plan includes support for a new residency program to be developed on the southern Oregon coast. After a period of dormancy, this idea appears to be gaining momentum with strong support from other entities in the region, and we have met with representatives from one of the local entities and the medical school interested in supporting this project.

I am deliberately being vague on details at this time as I have not been authorized to release them, but there is now a real possibility of this residency program being established. I will provide more specific information as plans mature.

Medical Staff Application Fees

Currently we charge no fees to those wishing to apply for or renew medical staff membership at Southern Coos. There are several compelling reasons to charge such fees. First, credentialing costs money. Not only is there staff time, but there are fees to obtain background checks and other required information as well as fees for the software used to store and analyze the information. An application fee would help offset some of those costs.

Second, there are several members of the medical staff who continue to reapply for privileges every two years even though they have not treated any Southern Coos patients during that time. Not only does this cost us money (see point one above) but it creates a regulatory duty for us to monitor the quality of the clinician's work. Since they have not seen any patients here, we have no local data to

use for quality monitoring, making this process difficult if not impossible. A fee may discourage such providers from re-applying.

It should be noted that application fees are a standard part of the application and reapplication process at many hospitals.

I have been asked to provide several scenarios of how fees might be applied to the medical staff at next month's medical staff meeting. If a fee system is agreed to by the medical staff and hospital administration, it would necessitate a change to the Bylaws and/or Rules and Regulations that would require Board approval.



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, March 2026

Retail Pharmacy Volume

2397 prescriptions were filled by our retail pharmacy in the month of February, which is similar to January's total. About 1700 were new prescriptions and the rest refills of existing prescriptions.

Financial Statement for December

The net change in position for retail pharmacy for February 2026 was (\$24,375).

We continue to see adverse contractual terms negatively impacting our reimbursement from pharmacy benefit managers. Current state of addressing this issue is that we are working with our largest contract manager (Leadernet) to make sure we are on the most favorable contract tier to which we are entitled with each pharmacy benefit management organization.

Please see Retail Pharmacy Profit and Loss statement in Appendix A below for additional retail pharmacy information (Thank you, as always, to Jenny Percy for providing this data).

Initiatives to Reduce Cost

We are participating in an organization-wide effort led by our finance team to reduce overtime and associated overtime pay to the lowest possible level.

We have also renegotiated slightly lower rates with one of our service vendors.

We are implementing a program to optimize which specific manufactures we purchase from to optimize reimbursement.

Initiatives to Increase Revenue

We are moving forward with agreements for 340b contract pharmacy operations. This will allow us to capture revenue from prescriptions filled by our patients at Coos County Safeway and Fred Meyer pharmacies. Revenue from these agreements will begin showing up in July if we meet the April sign-on deadline.

Jeremy Brown identified an instance where we were charging a Pharmacy Benefit Manager (PBM) organization less than our contract allowed. That has been corrected.

We are moving forward with vaccination services through our pharmacy which will augment our clinic operations in providing vaccines for our community and add additional pharmacy revenue. Anticipated start date is mid-summer.

None of these initiatives are home runs that will wipe out our retail pharmacy operational deficit on their own, but we hope to hit enough singles to chip away at the deficit until we can achieve a positive net margin.

Non-retail pharmacy operations continue to show positive monthly changes in net position that significantly exceed budget.

Appendix A

Southern Coos Health District
PHARMACY-RETAIL (OP)

Southern Coos Hospital & Health Center Profit & Loss Statement As of February 28, 2026

	Month To Date 02/28/2026				07/01/2025 Through 02/28/2026			
	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	-	76,747	(76,747)	(100.0) %	-	356,648	(356,648)	(100.00) %
Outpatient Revenue	-	76,747	(76,747)	(100.0) %	-	356,648	(356,648)	(100.00) %
Retail Pharmacy Revenue								
3020 - RETAIL PHARMACY REVENUE	538,827	-	538,827	100.0 %	3,693,955	-	3,693,954	100.00 %
Retail Pharmacy Revenue	538,827	-	538,827	100.0 %	3,693,955	-	3,693,954	100.00 %
Total Patient Revenue	538,827	76,747	462,080	602.1 %	3,693,955	356,648	3,337,306	935.74 %
Total Deductions	403,342	-	403,342	100.0 %	2,685,367	-	2,685,367	100.00 %
Net Patient Revenue	135,485	76,747	58,739	76.5 %	1,008,587	356,648	651,939	182.79 %
Total Operating Revenue	135,485	76,747	58,739	76.5 %	1,008,587	356,648	651,939	182.79 %
Total Operating Expenses								
Total Labor Expenses								
Salaries & Wages	32,414	37,750	(5,335)	(14.1) %	272,647	320,592	(47,945)	(14.95) %
Benefits	6,696	7,442	(747)	(10.0) %	41,317	64,587	(23,271)	(36.03) %
Total Labor Expenses	39,110	45,192	(6,082)	(13.5) %	313,964	385,179	(71,216)	(18.48) %
Purchased Services								
4500 - PURCHASED SERVICES	459	-	459	100.0 %	16,408	-	16,409	100.00 %
Purchased Services	459	-	459	100.0 %	16,408	-	16,409	100.00 %
Drugs & Pharmaceuticals								
4204 - DRUGS	125,700	27,618	98,082	355.1 %	917,480	220,948	696,532	315.24 %
4206 - DRUGS - 340B SAVINGS	(15,040)	-	(15,040)	100.0 %	(100,671)	-	(100,671)	100.00 %
Drugs & Pharmaceuticals	110,660	27,618	83,042	300.7 %	816,809	220,948	595,861	269.68 %
Medical Supplies								
4202 - NONBILLABLE SUPPLIES - MEDICAL	484	-	484	100.0 %	5,647	-	5,647	100.00 %
Medical Supplies	484	-	484	100.0 %	5,647	-	5,647	100.00 %
Other Supplies								
4301 - OFFICE SUPPLIES	345	-	345	100.0 %	4,710	-	4,710	100.00 %
4398 - MINOR EQUIPMENT	-	-	-	-	2,145	-	2,145	100.00 %
Other Supplies	345	-	345	100.0 %	6,855	-	6,855	100.00 %
Other Expenses								
4302 - POSTAGE & FREIGHT	50	-	50	100.0 %	1,115	-	1,115	100.00 %
4501 - MARKETING - ALLOWABLE (MCR)	-	1,667	(1,667)	(100.0) %	-	13,333	(13,334)	(100.00) %
4502 - MARKETING - NON ALLOWABLE	5,202	-	5,202	100.0 %	11,793	-	11,794	100.00 %
4504 - PRINTING & COPYING	168	-	168	100.0 %	510	-	509	100.00 %
4702 - LICENSING & GOVERNMENT FEES	-	840	(840)	(100.0) %	555	6,720	(6,165)	(91.74) %
4703 - DUES & SUBSCRIPTIONS	885	-	885	100.0 %	8,077	-	8,078	100.00 %
4798 - BANK & COLLECTION FEES	762	-	762	100.0 %	4,430	-	4,429	100.00 %
Other Expenses	7,067	2,507	4,560	181.9 %	26,480	20,053	6,426	32.04 %
Utilities								
4404 - ELECTRICITY	-	3,773	(3,773)	(100.0) %	-	30,184	(30,184)	(100.00) %
Utilities	-	3,773	(3,773)	(100.0) %	-	30,184	(30,184)	(100.00) %
Depreciation & Amortization								
6162 - DEPRECIATION - MAJOR MOVABLE EQUIPMENT	410	-	410	100.0 %	3,279	-	3,279	100.00 %
6152 - DEPRECIATION - BUILDING - CLINIC	1,326	-	1,326	100.0 %	10,607	-	10,608	100.00 %
Depreciation & Amortization	1,736	-	1,736	100.0 %	13,886	-	13,887	100.00 %
Total Operating Expenses	159,861	79,090	80,771	102.1 %	1,200,049	656,364	543,685	82.83 %
Operating Income / (Loss)	(24,375)	(2,343)	(22,032)	940.2 %	(191,462)	(299,716)	108,254	(36.11) %
Change In Net Position	(24,375)	(2,343)	(22,032)	940.2 %	(191,462)	(299,716)	108,254	(36.11) %



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 – March 26, 2026

Clinical Department Staffing –

- Medical-Surgical department – Four full-time RNs and three full-time CNA positions vacant in February. Four contract RNs utilized.
 - FTE variance – Below expectations (-8.07)
 - 289.6 Stand-by hours replaced working hours due to flexing staff for low census days (equivalent of 24.13 – 12 hour shifts or 1.67 FTE).
 - No need to replace short notice vacancies related to FMLA or sick call due to low census (26 sick calls and 21 FLMA vacancies in the month of February)
 - The intentional delay of hiring of two tele-tech positions until trauma certification is imminent.
 - Positive news for March 2026 – Two full-time CNAs on-boarded and have begun orientation. Two per diem RNs have accepted part-time positions (2 days/week per nurse). Two full-time RNs and three full-time CNA positions have been filled, and orientation has begun.
- Emergency department – Fully staffed. One contract RNs utilized while 1 orienting nurse completes orientation.
 - FTE variance – Over by 0.51 due to new employee orienting on the unit.
- Laboratory department – One Medical Lab Technologist on-boarded and began orientation. This is the last full time position to be filled! Two contract MLS/MLTs utilized. One contract ended and will not be renewed.
 - FTE variance - Over by 2.55 due to new employee orientation and final contract period for two (2) Medical Lab Technologists.
 - Positive news for March 2026 – The final contracted MLS/MLT is no longer needed the department is fully staffed! Zero contracted staff utilized after the first week in March.
- Surgical department – Circulating nurse position has been filled! Surgical Department is now fully staffed for current volumes!
 - FTEs variance – Below expectations (-2.65 FTE) due to limited surgical volumes.
 - Staff being flexed to other departments and/or called off for low census.
 - Freeze on additional RN and surgical tech recruitment efforts until volumes indicate need.
- Medical Imaging – No changes from prior month. One full time CT/XR technologist positions remain open. One CT/XR technologist contract utilized.
 - FTE variance – Below expectations (-3.75) due to the delay in hiring an additional US technologist, Mammography technologist, and CT/XR technologist for surgical services until volumes indicate the need.
 - One contract cardiac sonographer started in March to cover expected maternity leave.

- Respiratory therapy – One full time respiratory therapist (RT) position vacant. Two FT therapists out on leave of absence. One (1) RT contract ended in February and will not need to be continued/replaced.
 - FTE variance – Below expectations (-2.78) due to leave of absences and scheduled vacation. Pulmonary function test scheduling limited to one day a week due to staff vacancies. Department manager flexed to cover shift needs.
- Case management – No changes from prior month, fully staffed.

	February 2026 FTE				
	SCH Actual	Contract Actual	Actual Total	Budget	Diff
Med Surg	20.34	3.54	23.88	31.95	-8.07
Manager	1	0	1	1	0
CH RN	2.74	0	2.74	3.85	-1.11
RN	7.56	3.54	11.1	12	-0.9
LPN	1.14	0	1.14	2.45	-1.31
CNA	6.56	0	6.56	8.65	-2.09
TeleTech	1.34	0	1.34	4	-2.66
Emergency Dept	14.17	1.52	15.69	15.18	0.51
Manager	1	0	1	1	0
RN	9.54	1.52	11.06	8.78	2.28
LPN	2.8	0	2.8	3.6	-0.8
CNA/US	0.83	0	0.83	1.8	-0.97
Laboratory	10.71	1.25	11.96	9.41	2.55
Manager	1	0	1	1	0
MLS	1.11	0	1.11	0.37	0.74
MLT	3.32	1.25	4.57	3.12	1.45
Lab Assist I	3.3	0	3.3	2.38	0.92
Lab Assist II	1.13	0	1.13	1.47	-0.34
Lab Assist III	0.85	0	0.85	1.07	-0.22
Surgical Dept	5.15	0	5.15	7.8	-2.65
Manager	1	0	1	1	0
Surgical RN	1.7	0	1.7	3	-1.3
Sterile processor	0.71	0	0.71	1	-0.29
Surgical Tech	0.94	0	0.94	2	-1.06
Housekeeper	0.8	0	0.8	0.8	0
Medical Imaging	9.72	0.92	10.64	14.39	-3.75
Manager	1	0	1	1	0
Radiology Tech	3.3	0.92	4.22	8.03	-3.81
Rad Tech I	2.89	0	2.89	0.7	2.19
Ultrasound	1.18	0	1.18	2.66	-1.48
MI Coordinator	0.88	0	0.88	1	-0.12
MI Admin Assist	0.47	0	0.47	1	-0.53
Respiratory Therapy	3.85	0.68	4.53	7.31	-2.78
Manager	1	0	1	1	0
RT	2.85	0.68	3.53	6.31	-2.78
Swing Bed	1.59	0	1.59	1.65	-0.06
Case manager	1.59	0	1.59	1.65	-0.06
Totals	65.53	7.91	73.44	87.69	-14.25
% of FTE	89%	11%			

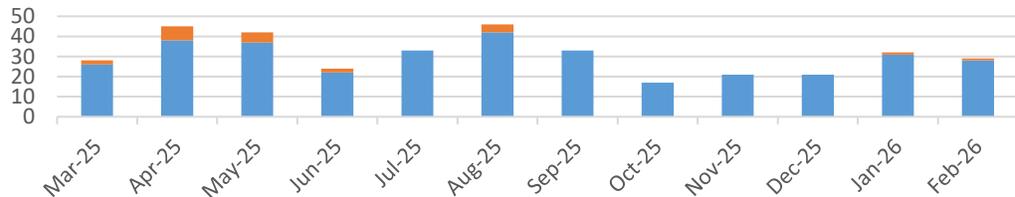
Medical Imaging –

- An MQSA certification inspection of mammography services, as well as a state inspection of all medical imaging modalities, was completed 3/17/2026. Inspections ensure that quality standards are met for personnel, equipment, maximum allowable radiation dose, quality assurance, medial audit and outcome analysis, medical recordkeeping and reporting requirements. Zero deficiencies were identified.

ED Transfer Statistics –

- February 2026 Transfers – Total Transfers = Twenty-nine (29). Twenty-eight (28) transfers required higher level of care and/or specialty services not offered at SCHHC. One (1) transfer was the result of no airborne precaution room/bed available at SCHHC.

ED Transfers



	Mar-25	Apr-25	May-25	Jun-25	Jul-25	25-Aug	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
■ No SCHHC Beds	2	7	5	2	0	4	0	0	0	0	1	1
■ Higher level of care required	26	38	37	22	33	42	33	17	21	21	31	28

Cumulative Transfer Needs June 2025 – Feb 2026	
<ul style="list-style-type: none"> ▪ Cardiology – 62 ▪ Surgical Services – 64 ▪ Intensive care – 56 ▪ Obstetrics - 4 ▪ Urology – 10 ▪ Psychiatric evaluation – 1 ▪ Ear/Nose/Throat – 1 ▪ Neurology – 15 ▪ Pulmonology - 1 ▪ Airborne precaution room - 1 	<ul style="list-style-type: none"> ▪ Dialysis - 1 ▪ Pediatric – 3 ▪ Orthopedics - 11 ▪ Hematology/Platelets – 1 ▪ Gastroenterology – 7 ▪ Interventional Radiology – 2 ▪ Ultrasound – 4 ▪ MRI – 3 ▪ Nuclear Medicine - 1 ▪ IMCU level of care > 5 days - 1

Growth opportunities within current scope of services offered at SCHHC: Increase ultrasound coverage to ensure technologist availability.

- Provide training to cardiac sonographer to become certified to perform general and vascular ultrasound so as not to be dependent on a single point of failure as currently only one technologist possesses the required skills/certification.

Efforts to Reduce Clinical Department Expenses –

- Medical Imaging – Hold put on hiring the additional mammographer and CT/XR technologist for surgical services until volumes indicate the need. Train up echo tech to perform general ultrasound to avoid needing to staff another position.
- Respiratory Therapy – Manager covering staff vacancy shifts to avoid use of contract therapist.
- Laboratory – Load leveling and staff reassignment to cover staffing needs to be able to end contract staff use. Reviewing alternative contracted services for better service/prices. Reviewing products used in lab to determine alternatives that meet our needs at lesser cost. Training up staff to perform additional responsibilities (more productivity, less need for additional staff).
- Med-Surg – Reduces use of Red star incentive pay, flexing staff to census need.
- Surgical Services – Flex circulating RN to Med-surg unit when no cases. Hold on recruitment of additional budgeted FTEs until volumes reflect the need.
- Emergency Dept – Staff orientation management to ensure reasonable orientation periods to reduce need for contract staff.



Chief Information Officer Report

To: Board of Directors and Southern Coos Management
From: Scott McEachern, CIO
Re: CIO Report for Board of Directors Meeting – March 26, 2026

CIO Report

In response to the board's request for a short report on SCHHC's use of artificial intelligence (AI) tools, I have crafted the following:

SCHHC's Data Governance Committee oversees SCHHC's use of AI tools. We have created an AI subcommittee to evaluate, track, and monitor AI tools deployed in the SCHHC environment. We have several active, sanctioned AI tools in use:

1. Main Hospital Phone Line Agent
2. Clinic Main Line Agent (see below for additional information)
3. Microsoft CoPilot

We are evaluating several other AI tools:

1. Ambient Note-Taking for Providers
2. Automated Incoming Fax Routing
3. AI phone communication with payors
4. OpenEvidence (via Providence); a clinical reference tool that will be embedded in the EHR
5. Doximity (via Providence); a clinical reference tool

Please reach out to me if you have any questions.

Projects Report

In response to the board's request at the February 2026 board meeting, I have included the budget and actuals for the five projects that have the greatest impact on the organization.

Multi-Specialty Clinic Space (previous Business Office)

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: mid-end of April 2026 (updated from December 5, 2025)
- Budget: \$150,000
- Current Spend as of Feb 28, 2026: \$61,327.37

Salem Radiology

SCHHC is working with Salem Radiology to replace Direct Radiology, which termed our contract effective April 8, 2026. SCHHC is working with the Salem Radiology technical team and the NovaRad team (our Picture Archiving Computer System, or PACS vendor) to work on interfacing our PACS system to Salem Radiology's.

- Estimated Completion Date: April 7, 2026
- Budget: \$8,500
- Spend as of February 28: \$0

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
- Budget: \$19,200
- Spend as of February 28: \$0

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
- Budget: \$40,000
- Spend: \$0

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: April 13, 2026 (updated from January 30, 2026)
- Budget: \$9,520
- Spend: \$0

Interface EKGs with Epic

SCH is working with Providence to connect EKGs with Epic through 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: July 1, 2026
- Budget: \$65,000
- Spend: \$0

Interface Telcor to Epic

SCH is implementing a middle-ware (a piece of software that sits between medical equipment and the EHR) called Telcor. The reason for this implementation is to connect point of care testing equipment such as an A1C Glucose analyzer to the EHR.

- Estimated completion date: August 1, 2026
- Budget: \$72,000
- Spend: \$0

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. Due to delays on the Providence side, the video roll-out has been pushed to end of April.

- Estimated completion date: April 30, 2026 (updated from February 2026)
- Budget: \$0
- Spend as of February 28, 2026: \$0

FY26 Completed Projects

Clinic Phone Agent

We built a new phone agent for the clinic to better manage incoming calls and after-hours transfers. We tested the agent March 9-13 for two hours per day. Our team met every day to debrief and review the incoming calls and the agent’s responses. On March 18, the agent is active 24/7.

Date Completed: March 20, 2026
Spend: \$1,500

SCHHC Business Center at the Bandon Shopping Center

Date Completed: March 11, 2026
Spend as of Feb 28, 2026: \$17,984

IS Remodel to HR/Quality Space

Date Completed: March 6, 2026
Spend as of Feb 28, 2026: \$10,942

Americollect Implementation

Date Completed: February 28, 2026
Spend: \$2,400

Clinical Informatics Report

CI Tickets Summary

2026	January	February	March	Count
Closed	139	93	33	265
On Hold	5	2	7	14

2026	January	February	March	Count
Open	2	0	5	7
Count	146	95	45	286

High Priority Projects

- ❖ SLS Documentation and Charge Capture
 - Optimize the SLS workflow for scheduling, documentation, and charge capture to improve efficiency, ensure accurate billing, and streamline clinical operations.

- ❖ Laboratory Test Validation Workflow:
 - Review and optimize workflow process steps for validation of new laboratory tests.



Multi-Specialty Clinic Report

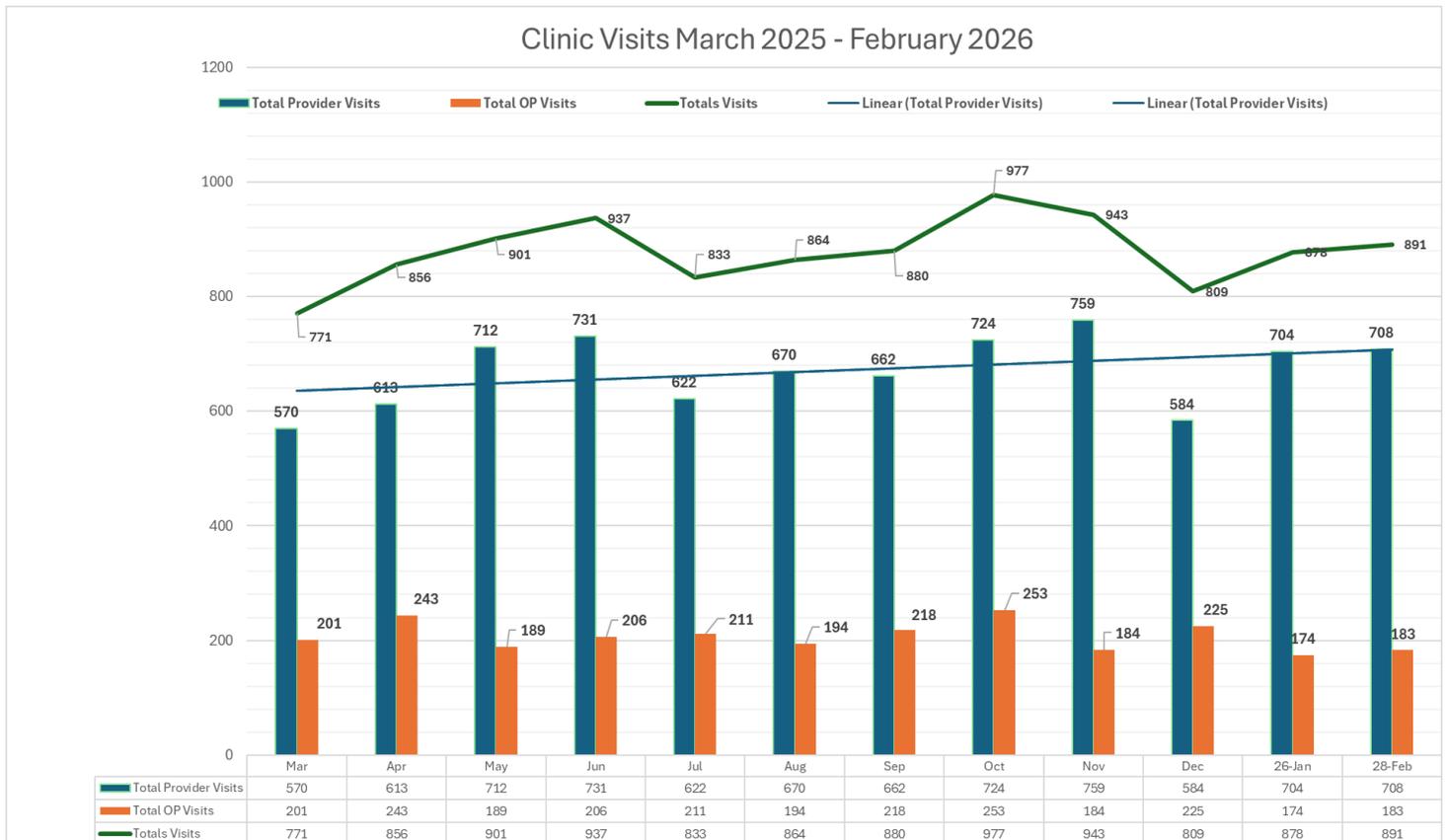
To: Southern Coos Health District Board of Directors and Southern Coos Management
 From: David M Serle – Director Medical Group Operations
 Re: Multi-Specialty Clinic Report for SCHD Board of Directors Meeting – March 2026

Clinic Operations - February 2026

Provider Recruiting/Onboarding: As of 3/20/26

- Interviewing Mathew Hiesterman, DO on Saturday 3/21/26. Schulte was hired to kickstart our General Surgery Program and was never intended to continue long term. Dr. Schulte’s final week is scheduled to be in July 2026. Volume is growing very quickly and starting the recruiting process now should position us for a transition to another surgeon if needed later this year starting in August 2026.
- New Hire: Natalie Speck, MD, started seeing patients Wednesday, March 4th.
 - As of March 20th has seen 71 patients.
 - Has presented at Bandon Fisheries and Adapt. Scheduled to present at the Rotary Club on the 27th of March.

Combined Clinic Volume March 2025 – February 2026



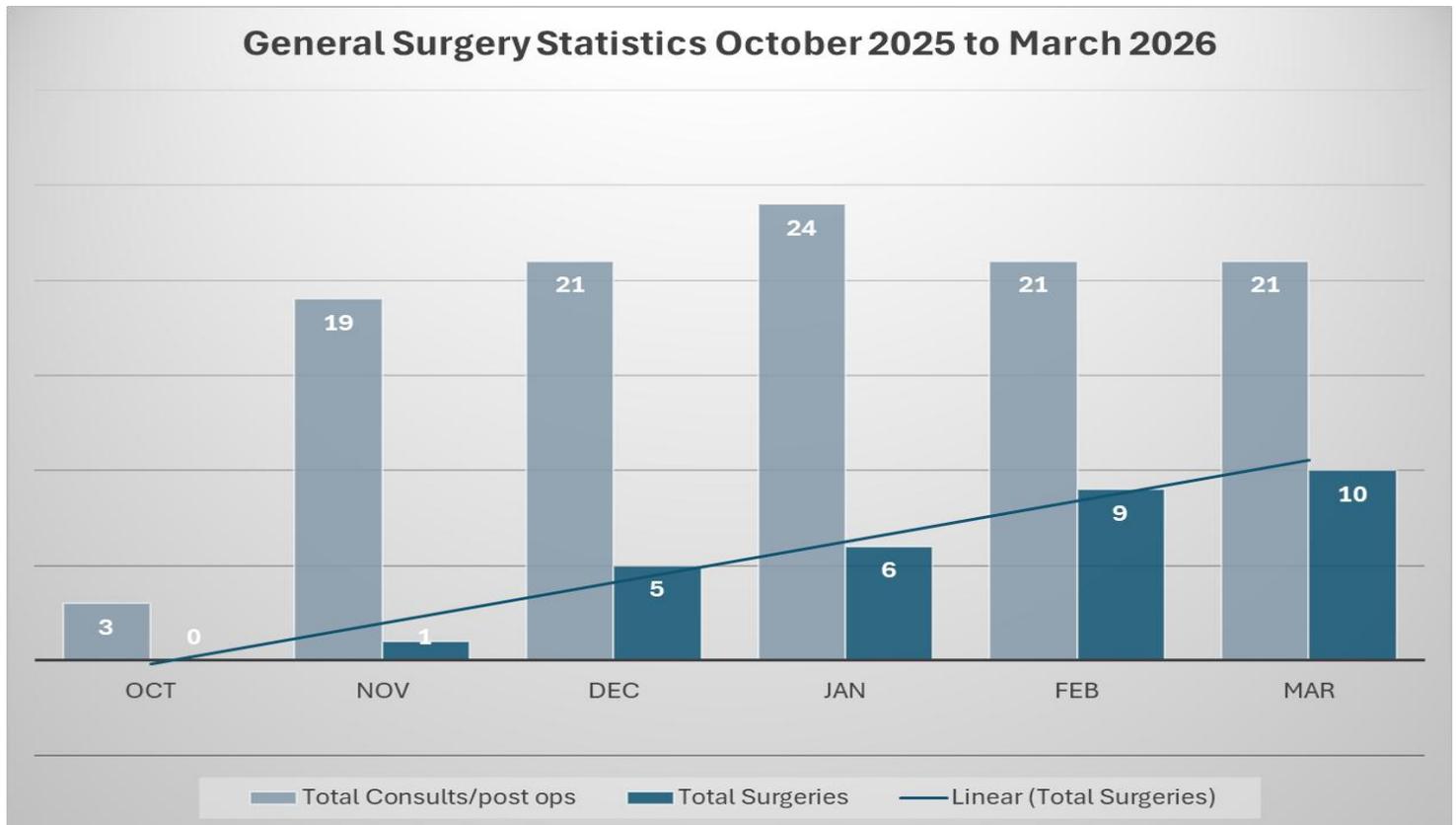
Clinic Volume By Provider October 2025 – February 2026

											Projected					
Year: 2026											October	November	December	January	February	March
Month: February	Clinic	PT's	No	Total	AVG	No	Cancel	Tele	New							
Provider	Days	Sched	Cancel	Show	Seen	Seen	Rate	Rate	HLTH	PT's						
Jennifer Webster, MD	14.0	187	17	8	162	11.6	4%	9%	3	0	159	123	129	93	162	146
Paul Preslar, DO	9.7	128	4	6	118	12.1	5%	3%	0	0	132	135	128	153	118	156
Natalie Speck, MD																94
Felisha Miller, FNP	11.4	83	8	2	73	6.4	2%	10%	0	24	107	92	103	79	73	114
Kim Bagby, FNP	15.0	120	14	3	103	6.9	3%	12%	0	0	130	154	26	124	103	
Shane Matsui, LCSW	19.0	89	9	2	78	4.1	2%	10%	3	4	87	74	80	79	78	85
Henry Holmes	7.0	70	4	0	66	9.4	0%	6%	1	0	37	61	62	48	66	57
Tami Marriott, MD	3.0	25	3	1	21	7.0	4%	12%	0	0	33	34	35	33	21	15
Victoria Schmelzer, CRNA	10.3	70	4	0	66	6.4	0%	6%	0	11	36	67	0	71	66	30
Brett Schulte, MD	2.5	25	3	1	21	8.4	4%	12%	0	16	3	19	21	24	21	21
Total Provider Visits	92	797	66	23	708	7.7	3%	8%	7	55	724	759	584	704	708	718
Total Outpatient Services	20	206	22	1	183	9.2	0%	11%	0	0	253	184	225	174	183	201
Total Visits	112	1003	88	24	891	8.0	2%	9%	7	55	977	943	809	878	891	919

Clinic Visit Highlights:

- Provider visits are up slightly from previous month (+4)
- Total visits are up slightly from previous month +1.4% (+13)
- Provider visits are projected to go up slightly +1.4% (+10) for March
- Total visits are projected to go up slightly +3.1% (+28) for March

General Surgery Volume October 2025 – March 2026





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, March 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/Staffing:

New Hires - February 2026

- Alyssa Ekblad - Registered Nurse - Med/Surg Department
- Lindsey May - Registered Nurse - Med/Surg Department
- Jessica Savage - Certified Nurse Assistant - Med/Surg Department
- Makayla Goble - Patient Access Services - Emergency Department
- Erin Boldt - Dietary Aid - Dietary Department

Open Positions Frozen - February 2026

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

Current Contract Staff - September 2025 vs. February 2026

- Laboratory Department:
 - September 2025 = 3 Travelers, Current 2026 = 0 Travelers
- Respiratory Department:
 - September 2025 = 1 Traveler, Current 2026 = 0 Travelers

- Medical/Surgical Department:
 - September 2025 = 6 Travelers, Current 2026 = 2 Travelers
- Multi-Specialty Clinic:
 - September 2025 = 1 Traveler, Current 2026 = 0 Travelers
- Medical Imaging:
 - September 2025 = 2 Travelers, Current 2026 = 2 Travelers

Activities/Events:

- 2026 Leadership Academy:

- March - Legal Red Flags	- August - Emotional Intelligence
- April - Timekeeping 101	- September - HR 101
- May - Clifton Strengths	- October - Work/Life Balance
- June - Professionalism at Work	- November - Hospital Finance 101
- July - Crucial Conversations	- December - End of Year Celebration

People:

Quote of the Month - February 2026

“I’ve been a traveling nurse for a while now, and there is a difference working at Southern Coos Hospital. This place is special.” - Staffing Agency RN

Employees of the Month - February 2026

- Clinical - Cheryl Johnson - Manager - Respiratory Therapy Department

“I would like to nominate this employee in recognition of their exceptional leadership & dedication to both their team & our patients. In our small hospital setting, teamwork & flexibility are essential, & they consistently go above and beyond to support their staff. They are always willing to step in & help when the department is short-staffed, ensuring patient care remains safe, efficient, & compassionate. Their hands-on approach shows that they are not only a leader but also a true team player. They take the time to show appreciation and ensure their team feels valued, which greatly contributes to morale & retention. Their kindness, professionalism, & approachable nature make their staff feel comfortable turning to them for guidance or support. For their dedication, compassion, and commitment to excellence, they are truly deserving of Employee of the Month recognition.”

- Non Clinical - Jeff Hamilton - Maintenance Supervisor - Engineering Department

“This person goes above and beyond in so many projects. From the build-out of several new offices recently to the countless behind-the-scenes efforts that keep everything running smoothly, they truly make a difference. What stands out just as much as the quality of their work is the positive attitude they bring to every task. No matter the challenge, they approach it with professionalism, teamwork, and a willingness to help. That kind of commitment and spirit strengthens our entire organization. I’m incredibly grateful for their hard work and the pride they take in what they do.”



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, March 13, 2025

Women's Health Day (WHD) / Bandon School Nurse (BSN) Program Updates

Our 23rd Annual Women's Health Day was another fantastic success, with 114 attendees and seven vendors, including our very own Hospital Gift Shop, which generated an impressive \$730.35 a tremendous win! Dr. Neil Nathan once again captivated the audience as our keynote speaker. Our Bandon School nurses, Liz Deters and Lena Hawthorne, completed our presentation tour (including at Rotary, 100 Strong Bandon, Meet & Greet, and WHD), and they were very well received.

Autumn Mercer brought great energy to her presentation, although some attendees felt it had a sales pitch tone. Special thanks go to our dedicated SCHHC employees Chris Cox, Andy Okey, Amy Moss Strong, Tina Gulseth and all the volunteers who helped make this event a success. Rita Hamilton, in particular, received the most positive survey responses this year. She prepared both breakfast and lunch as entirely gluten-free (and nearly dairy-free), which was a significant achievement! One attendee shared that last year was her first time attending WHD, and due to her Coeliac disease, she was unable to eat. She expressed her gratitude, sharing how seen she felt and how emotional it was for her. Rita truly excels in her role!

Overview of WHD Survey Results (Percentages reflect Above Average and Excellent scores):

- Dr. Neil Nathan, Keynote Speaker: 97%
- Bandon School Nurses' Presentation (Liz and Lena): 93%
- Autumn Mercer: 65%

*All survey results are attached for your review.

In terms of fundraising, we raised \$3,880.25 from sponsors and vendors, along with an additional \$925 from raffle baskets, a 50/50 draw, and donations at the event, bringing the total to \$4,805.25. After accounting for the event costs of \$2,851.45, we have a surplus of \$1,953.80. Adding the \$238 received from presentations and donations at registration means a total of \$2,191.80 will be allocated to our Bandon School Nurse program. Additionally, we anticipate a donation from 100 Strong Bandon later this month. Anne McCaleb, the incoming Rotary President, expressed interest in having our Bandon Rotary support the Bandon School Nurse program as well, which is an exciting development!

Volunteer Expansion

As we work on our exciting plan to expand our volunteer base and activities, Women's Health Day (WHD) provided the perfect forum to gauge community interest. During the event, I invited attendees to participate in a journal exercise focused on the needs of seniors in our community. I also encouraged anyone interested in participating in our program to provide their contact information in the survey, and I'm pleased to report we received nine leads!

To further engage the youth in our community, I will be meeting with the Leadership 101 group at Bandon High School and the school-based Rotary group to explore opportunities for them to volunteer as well.

Tina and I will begin developing this volunteer program, and we are planning a “Call to Volunteers” event in April. Training for volunteers will include essential topics such as HIPAA compliance, vaccination protocol, and more to prepare them to interact with patients, welcome visitors to Southern Coos Hospital, and assist with the upcoming TeleCare service. We are excited about the potential to enhance our volunteer efforts and to make a positive impact in the community. Stay tuned for more updates as we move forward!

Golf for Health Classic (GFHC)

Our first Golf for Health Classic meeting kicked off this year’s planning for our biggest fund raiser of the year. We welcomed new committee member Torrey Contreras (Bandon City Manager). We are working on enlisting a \$25k-\$50k major event sponsor thanks to Johnny Ohanesian. We submit this week and should hear back in the next few months. This year’s GFHC dates are Friday, September 18th for Bandon Dunes Reception and Saturday, September 19th for Bandon Crossings Tournament.



Chief Financial Officer Report & Financial Statements

To: Board of Directors and Southern Coos Management
From: Cameron Marlowe, Interim CFO
RE: February 2026 Month-End Financial Overview and Operational Report – March 26

1. Registration Observations/Trainings

Colene and Kianna will be sitting with registration/front-desk personnel at the primary care clinic to observe inbound/outbound phone calls, appointment setting procedures, phone call transfers and all other front desk responsibilities to identify appropriate staffing levels, busy/less busy times of the day, opportunities for customer satisfaction improvements, etc... Once these observations are documented, registration/revenue cycle management will work with clinic leadership, the quality department and me to identify ways to improve customer satisfaction, improve efficiencies, and collaborate better with clinical staff. When finished, the plan is to conduct similar reviews/observations at the hospital and ED front desks.

2. Supply Charge Capture

Chris, Colene and I are taking medical supply billing data and comparing that to supply purchase data to determine if we are accurately capturing purchased and used clinical supplies on the patient bill. If we identify supplies that are not set up to be billed in our electronic health record that should be or we identify supplies that are already set up to be billed in our EHR but are not loaded to applicable claims the team will make updates to our processes and EHR setup to ensure appropriate supply charge capture.

3. Leadership Training

With the financial assistance of some grants we obtained, Jason Cook (Engineering) and Rita Hamilton (Dietary) have been enrolled in a leadership training program. Both individuals have stated that they are learning valuable skills that are helpful in their everyday jobs.

4. Interim Clinical Travelers – Cost Reduction Project

I updated the board last month on the progress being made with staffing agencies. At that time there were only a couple positions left that had not been finalized as a result of those efforts. Here is a breakout of desirable changes to our staffing agency contractors:

2 contractor's contracts were terminated without being backfilled.

2 contractors were replaced with employees

2 contractors remained with our "preferred" staffing agency at much lower hourly costs

3 contractors transferred from other staffing agencies to our preferred staffing agency at much better rates.

An estimated annual savings of \$900,000 resulted from this work. Many thanks to Stacy in HR, several clinical department leaders and our CNO, Cori for making this happen.

5. **New Financials**

As part of a series of improvements to the financials that we provide the board each month, I shared a new income statement last month that showed a 6-month trend. This month I updated that same report to include 13 months' trend as well as a year-to-year, budget, and 3-month comparison. These improvements will greatly improve my ability to spot trends and focus on areas that need attention in a much more timely manner. You will note that I also made similar improvements to our balance sheet. In the near future, with Scott McEachern's and Sage Intacct's reporting expertise, we will continue to build a more robust set of reports, some of which will be included in the board packet.

6. **Group Purchasing Organization (GPO) Request For Proposal (RFP)**

Chris in supply chain and I are in the process of pulling med/surg and pharmacy spend data to determine if there would be significant savings if we were to switch GPOs or purchasing coalitions within our current GPO. This is the beginning phase to determine if the savings would be large enough to want to pursue, as switching GPOs is a very involved process that requires significant effort from many departments. I estimate that it will take a couple months to determine if the savings are substantial enough to pursue. While this opportunity should only be reviewed every several years or even once a decade, it could potentially provide our organization with substantial savings if pursued.

7. **February Financial Performance**

The month of February resulted in a gross profit margin of 3.4% or \$112,000. This is welcomed news when recognizing that we booked losses in four out of five previous months. I will share more details regarding my February financial highlights when I present the financials at board meeting.

Southern Coos Hospital & Health Center
Income Statement Trends

	FYTD24	FYTD25	Budget FYTD26	FYTD26	3 Month To 3 Month Compare	FYTD26 Average	Feb 2026	Jan 2026	Dec 2025	Nov 2025	Oct 2025	Sep 2025	Aug 2025	Jul 2025	Jun 2025	May 2025	Apr 2025	Mar 2025	Feb 2025	
Total Patient Revenue																				
Inpatient Revenue	6,130,878	6,656,762	7,854,774	7,235,611	-19.7%	904,451	936,964	850,911	782,878	802,131	867,194	809,703	1,286,279	899,551	571,557	1,011,490	836,483	881,295	654,691	
Outpatient Revenue	23,920,551	27,540,048	31,218,065	30,479,626	0.0%	3,809,953	3,618,235	3,420,630	3,694,473	3,378,933	4,319,262	3,850,184	3,895,084	4,302,825	3,639,510	3,703,644	3,778,884	3,681,985	3,528,544	
Swingbed Revenue	2,282,742	2,435,269	4,183,020	2,407,022	-10.8%	300,878	231,923	394,130	263,804	276,817	252,197	364,719	361,067	262,365	240,264	524,036	614,566	349,008	536,956	
Retail Pharmacy Revenue	-	-	-	3,693,955		461,744	538,827	527,035	610,819	476,226	494,630	368,618	351,114	326,686	-	-	-	-	-	
Total Patient Revenue	32,334,171	36,632,079	43,255,859	43,816,214	6.3%	5,477,027	5,325,949	5,192,706	5,351,974	4,934,107	5,933,283	5,393,224	5,893,544	5,791,427	4,451,331	5,239,170	5,229,933	4,912,288	4,720,191	
Total Deductions	11,522,133	14,202,794	16,457,529	17,683,428	1.3%	2,210,429	2,012,021	2,056,926	2,005,495	1,873,105	2,487,643	2,320,196	2,524,233	2,403,809	1,339,226	2,425,473	2,106,999	1,971,896	2,185,347	
Deductions/Patient Revenue	35.6%	38.8%	38.0%	40.4%	-5.2%	40.4%	37.8%	39.6%	37.5%	38.0%	41.9%	43.0%	42.8%	41.5%	30.1%	46.3%	40.3%	40.1%	46.3%	
Net Patient Revenue	20,812,038	22,429,285	26,798,329	26,132,786	9.7%	3,266,598	3,313,928	3,135,780	3,346,479	3,061,002	3,445,640	3,073,028	3,369,311	3,387,618	3,112,105	2,813,697	3,122,934	2,940,392	2,534,844	
Other Operating Revenue	54,838	27,010	26,240	220,005	17.5%	27,501	2,157	2,141	2,191	78,607	116,767	5,878	10,485	1,779	1,790	1,812	1,700	4,467	1,373	
Total Operating Revenue	20,866,876	22,456,295	26,824,569	26,352,791	9.7%	3,294,099	3,316,085	3,137,921	3,348,670	3,139,609	3,562,407	3,078,906	3,379,796	3,389,397	3,113,895	2,815,509	3,124,634	2,944,859	2,536,217	
Total Operating Expenses																				
Total Labor Expenses																				
Salaries & Wages	10,189,264	11,614,573	14,158,393	12,858,834	6.5%	1,607,354	1,456,158	1,682,236	1,721,461	1,579,262	1,681,154	1,587,425	1,594,488	1,556,650	1,579,329	1,492,606	1,590,167	1,499,277	1,388,656	
Contract Labor	3,882,025	3,611,504	3,209,974	4,303,972	29.2%	537,997	520,505	528,579	619,974	511,039	513,474	499,908	594,457	516,036	447,875	469,886	428,170	419,705	401,022	
Benefits	1,688,801	1,895,308	1,503,482	2,186,222	16.5%	273,278	338,082	219,731	279,776	292,866	300,310	284,199	170,970	300,288	279,731	288,436	269,483	242,288	284,131	
Total Labor Expenses	15,760,090	17,121,385	18,871,849	19,349,028	12.0%	2,418,629	2,314,745	2,430,546	2,621,211	2,383,167	2,494,938	2,371,532	2,359,915	2,372,974	2,306,935	2,250,928	2,287,820	2,161,270	2,073,809	
Total Labor/Net Revenue	75.7%	76.3%	70.4%	74.0%	0.7%	74.0%	69.8%	77.5%	78.3%	77.9%	72.4%	77.2%	70.0%	70.0%	74.1%	80.0%	73.3%	73.5%	81.8%	
Purchased Services	2,099,424	2,793,839	2,744,361	1,621,410	-57.2%	202,676	206,177	189,751	122,829	211,000	217,928	261,989	212,411	199,325	146,408	312,561	204,711	158,569	404,546	
Drugs & Pharmaceuticals	577,958	750,079	940,335	1,879,721	143.6%	234,965	250,141	163,288	321,958	240,301	253,227	210,050	220,212	220,544	111,626	116,447	124,807	125,488	97,095	
Medical Supplies	660,591	821,812	952,700	795,272	-17.7%	99,409	82,369	99,955	123,498	96,382	99,220	93,175	88,821	111,852	101,426	68,183	133,372	52,895	111,543	
Other Supplies	209,204	181,666	425,432	364,106	37.2%	45,513	55,031	62,876	34,837	44,338	49,997	41,318	24,464	51,245	48,467	35,993	63,081	86,462	24,955	
Lease & Rental Expense	(12,524)	(3,179)	19,095	25,480	335.1%	3,185	15,216	7,732	-	-	1,266	-	-	1,266	-	-	1,267	-	1,267	
Repairs & Maintenance	150,590	139,644	249,492	175,332	4.1%	21,917	18,221	15,601	18,126	14,541	48,332	25,696	20,246	14,569	10,544	21,155	14,485	26,692	20,545	
Other Expenses	716,843	1,102,236	1,095,390	1,424,499	-1.5%	178,062	121,641	169,814	195,997	168,250	189,010	192,710	194,568	192,509	173,658	211,496	174,097	161,059	203,159	
Utilities	210,649	231,678	253,971	230,790	-15.0%	28,849	24,188	32,932	29,122	31,945	19,761	38,373	22,414	32,055	26,661	28,305	27,271	31,009	27,960	
Insurance	164,939	175,589	167,632	190,504	7.0%	23,813	24,211	24,211	23,629	23,629	23,814	23,628	23,753	23,629	44,922	23,629	23,628	22,666	22,843	
Depreciation & Amortization	816,496	1,113,917	1,394,413	1,499,332	5.1%	187,417	217,403	179,650	225,510	179,511	186,412	221,822	128,091	160,933	478,545	176,802	166,780	183,747	190,617	
Total Operating Expenses	21,354,261	24,428,667	27,114,672	27,555,474	5.5%	3,444,434	3,329,343	3,376,356	3,716,717	3,393,064	3,583,905	3,480,293	3,294,895	3,380,901	3,449,192	3,245,499	3,221,319	3,009,857	3,178,339	
Op. Expenses/Op. Revenue	102.3%	108.8%	101.1%	104.6%	-4.8%	104.6%	100.4%	107.6%	111.0%	108.1%	100.6%	113.0%	97.5%	99.7%	110.8%	115.3%	103.1%	102.2%	125.3%	
Operating Income / (Loss)	(487,385)	(1,972,372)	(290,103)	(1,202,683)	-34.4%	(150,335)	(13,258)	(238,435)	(368,047)	(253,455)	(21,498)	(401,387)	84,901	8,496	(335,297)	(429,990)	(96,685)	(64,998)	(642,122)	
Operating Income/Loss	-2.3%	-8.8%	-1.1%	-4.6%	-45.9%	-4.6%	-0.4%	-7.6%	-11.0%	-8.1%	-0.6%	-13.0%	2.5%	0.3%	-10.8%	-15.3%	-3.1%	-2.2%	-25.3%	
Property Taxes	758,825	760,000	785,752	809,417	4.5%	101,177	101,177	101,177	101,177	101,177	114,333	96,792	96,792	96,792	122,115	96,792	96,792	96,792	96,792	
Non-Operating Revenue	153,620	104,473	75,376	343,828	354.4%	42,979	36,876	33,526	85,983	29,668	53,948	35,000	64,154	4,673	52,946	9,941	38,831	21,048	8,545	
Interest Expense	(198,862)	(265,669)	(267,488)	(307,896)	-27.1%	(38,487)	(30,888)	(31,724)	(47,441)	(43,326)	(33,930)	(36,569)	(33,934)	(50,084)	(44,153)	(33,801)	(43,963)	(77,820)	(41,537)	
Investment Income	342,400	349,480	310,368	291,595	-19.8%	36,449	18,480	52,664	24,716	24,826	58,581	25,596	27,072	59,660	42,870	23,930	66,429	23,845	22,067	
Gain / Loss on Asset Disposal	(13,036)	-	-	(1,685)	0.0%	(211)	-	-	-	-	-	(162)	162	(1,685)	-	-	-	-	-	
Net Non Operating Revenue	1,042,947	948,284	904,008	1,135,259	52.0%	141,907	125,645	155,643	164,435	112,345	192,932	120,657	154,246	109,356	173,778	96,862	158,089	63,865	85,867	
Change In Net Position	555,562	(1,024,088)	613,905	(67,424)	-73.3%	(8,428)	112,387	(82,792)	(203,612)	(141,110)	171,434	(280,730)	239,147	117,852	(161,519)	(333,128)	61,404	(1,133)	(556,255)	
Gross Margin	2.7%	-4.6%	2.3%	-0.3%	-79.1%	-0.3%	3.4%	-2.6%	-6.1%	-4.5%	4.8%	-9.1%	7.1%	3.5%	-5.2%	-11.8%	2.0%	0.0%	-21.9%	

Southern Coos Hospital & Health Center
Balance Sheet Trends

	FY24 Ending	FY25 Ending	Feb 2025	Jan 2026	Dec 2025	Nov 2025	Oct 2025	Sep 2025	Aug 2025	Jul 2025	Jun 2025	May 2025	Apr 2025	Mar 2025	Feb 2025
Total Assets															
Total Current Assets															
Cash - Operating	1,400,507	1,812,826	922,882	615,196	1,223,709	1,502,524	1,230,611	986,759	584,310	1,143,201	1,812,826	1,192,239	1,108,456	763,083	335,757
Investments - Unrestricted	4,076,428	3,984,313	3,430,442	3,411,971	4,138,430	4,113,714	4,088,888	4,062,503	4,036,909	4,010,560	3,984,313	3,415,326	3,391,397	3,368,326	3,344,402
Investments - Restricted	3,744,080	3,419,943	2,782,879	2,782,879	2,782,878	3,419,943	3,419,943	3,419,943	3,419,943	3,419,943	3,419,943	3,419,943	3,419,943	3,744,080	3,744,079
Investments - Board	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000
Cash & Cash Equivalents	11,721,015	11,717,082	9,636,203	9,310,046	10,645,017	11,536,181	11,239,442	10,969,205	10,541,162	11,073,704	11,717,082	10,527,508	10,419,796	10,375,489	9,924,238
Net Patient Accounts Rec.	3,907,633	3,536,706	4,099,430	4,169,365	3,733,449	3,798,199	3,693,145	3,921,150	4,418,059	4,429,256	3,536,706	5,145,137	5,324,870	4,857,810	5,303,996
Other Current Assets	798,202	990,065	668,527	636,044	437,674	682,871	1,407,460	1,332,374	1,234,575	1,155,670	990,065	721,582	770,895	379,660	426,338
Total Current Assets	16,426,850	16,243,853	14,404,160	14,115,455	14,816,140	16,017,251	16,340,047	16,222,729	16,193,796	16,658,630	16,243,853	16,394,227	16,515,561	15,612,959	15,654,572
Net Property/Plant/Equip.	6,423,952	8,243,887	7,611,661	7,748,861	7,861,243	7,966,794	8,085,587	8,112,749	8,170,108	8,150,845	8,243,887	8,882,362	8,968,493	9,001,710	9,130,591
Total Assets	22,850,802	24,487,740	22,015,821	21,864,316	22,677,383	23,984,045	24,425,634	24,335,478	24,363,904	24,809,475	24,487,740	25,276,589	25,484,054	24,614,669	24,785,163
Total Liabilities & Net Assets															
Total Current Liabilities															
Accounts Payable	1,344,652	1,551,870	1,401,677	1,328,946	1,360,904	1,432,300	1,544,686	1,575,424	1,418,887	1,664,885	1,551,870	1,430,749	1,625,409	1,133,479	1,664,216
Accrued Payroll & Benefits	1,411,152	1,741,066	1,331,300	1,284,800	1,979,388	1,712,202	1,608,783	1,363,640	1,265,920	1,915,918	1,741,066	1,605,262	1,497,624	1,334,559	1,191,668
Line of Credit Payable	0	3,139,376	2,511,501	2,511,501	2,511,501	3,139,376	3,139,376	3,139,377	3,139,377	3,139,377	3,139,376	3,139,376	3,139,377	3,139,376	3,139,376
Interest & Other Payable	100,992	268,479	181,362	196,194	98,694	114,295	120,694	260,973	266,112	280,805	268,479	272,070	274,214	94,555	81,782
Est. Payor Settlements	997,650	534,781	36,586	72,963	107,866	580,426	791,394	759,410	803,074	506,338	534,781	1,111,785	825,695	786,546	515,207
Cur. Portion Long-Term Debt	635,560	656,838	463,883	491,414	520,141	548,096	600,445	594,368	996,268	623,927	656,838	734,854	689,250	842,873	876,210
Total Current Liabilities	4,490,006	7,892,410	5,926,309	5,885,818	6,578,494	7,526,695	7,805,378	7,693,192	7,889,638	8,131,250	7,892,410	8,294,096	8,051,569	7,331,388	7,468,459
Total Long-Term Debt	4,535,131	4,228,131	3,789,740	3,791,112	3,828,711	3,983,560	4,005,355	4,198,818	3,750,068	4,193,175	4,228,131	4,453,775	4,570,638	4,482,837	4,515,126
Total Liabilities	9,025,137	12,120,541	9,716,049	9,676,930	10,407,205	11,510,255	11,810,733	11,892,010	11,639,706	12,324,425	12,120,541	12,747,871	12,622,207	11,814,225	11,983,585
Total Net Assets	13,825,665	12,367,199	12,299,772	12,187,386	12,270,178	12,473,790	12,614,901	12,443,468	12,724,198	12,485,050	12,367,199	12,528,718	12,861,847	12,800,444	12,801,578
Total Liabilities & Net Assets	22,850,802	24,487,740	22,015,821	21,864,316	22,677,383	23,984,045	24,425,634	24,335,478	24,363,904	24,809,475	24,487,740	25,276,589	25,484,054	24,614,669	24,785,163

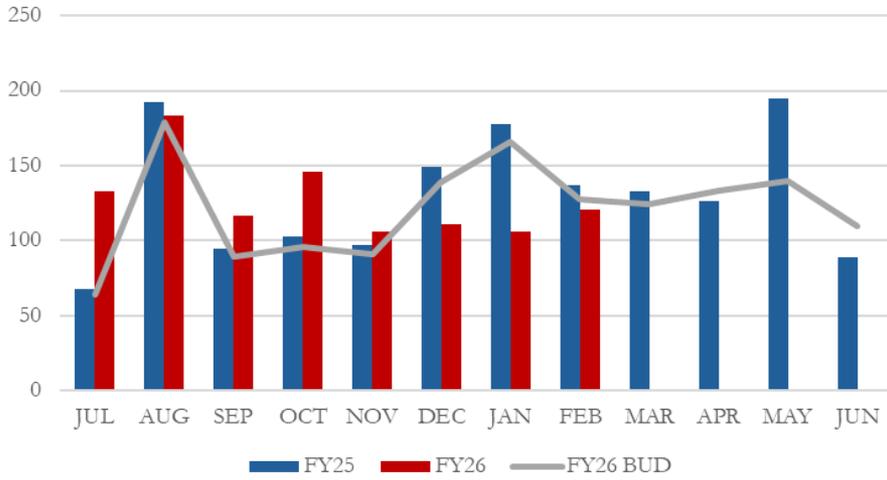
Southern Coos Hospital & Health Center

Balance Sheet Summary

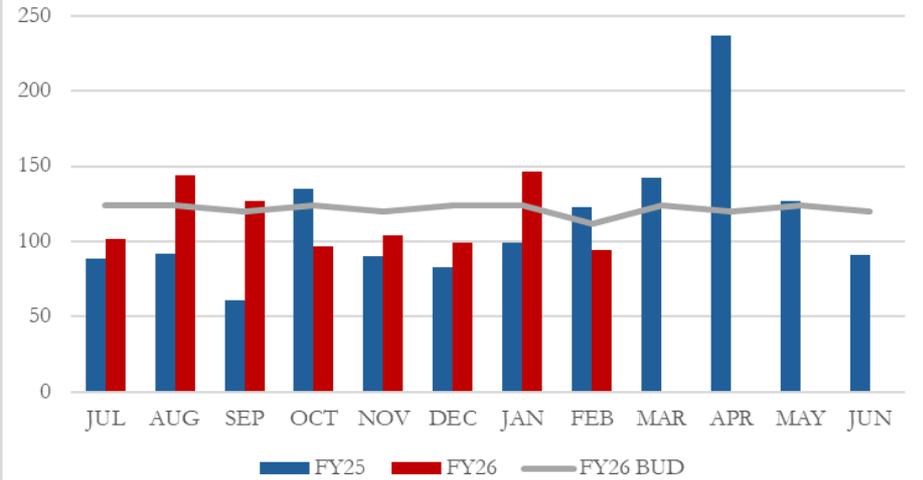
	Year To Date 02/28/2026	Year Ending 06/30/2025		Year Ending 06/30/2024
	Current Year Balance	Prior Year	Current vs. Prior	Actual
Total Assets				
Total Current Assets				
Cash and Cash Equivalents	9,636,203	11,717,082	(2,080,880)	11,721,015
Net Patient Accounts Receivable	4,099,430	3,536,706	562,725	3,907,633
Other Assets	668,527	990,065	(321,538)	798,202
Total Current Assets	14,404,160	16,243,853	(1,839,693)	16,426,850
Net PP&E	7,611,661	8,243,887	(632,226)	6,423,952
Total Assets	22,015,821	24,487,740	(2,471,919)	22,850,802
Total Liabilities & Net Assets				
Total Liabilities				
Current Liabilities	5,926,309	7,892,410	(1,966,101)	4,490,006
Total Long Term Debt, Net	3,789,740	4,228,131	(438,391)	4,535,131
Total Liabilities	9,716,049	12,120,541	(2,404,492)	9,025,137
Total Net Assets	12,299,772	12,367,199	(67,427)	13,825,665
Total Liabilities & Net Assets	22,015,821	24,487,740	(2,471,919)	22,850,802

Cash to Debt Ratio	0.99	0.97	0.02	1.30
Debt Ratio	0.44	0.49	(0.05)	0.39
Current Ratio	2.43	2.06	0.37	3.66
Debt to Capitalization Ratio	0.23	0.23	0.00	0.25

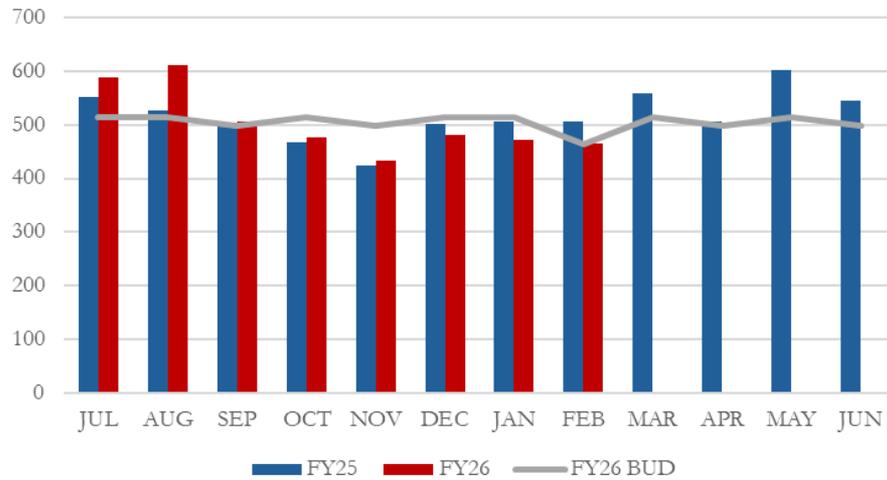
IP Days



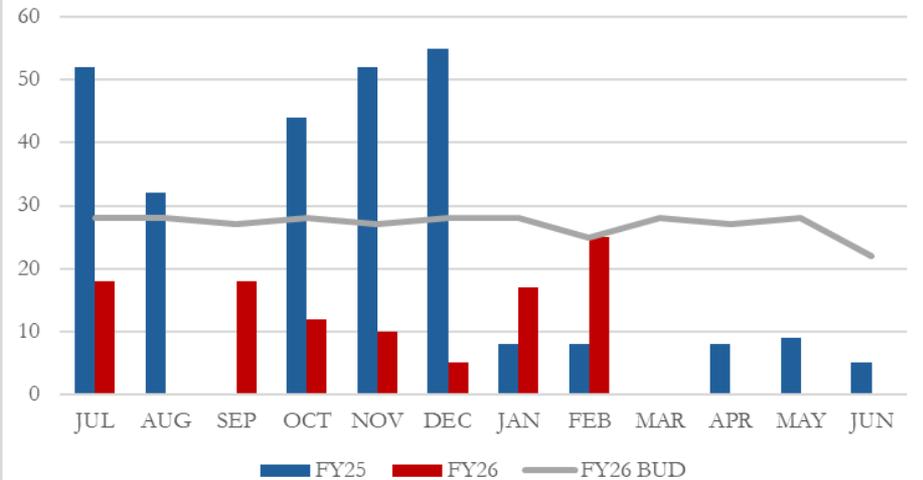
Swing Bed Days



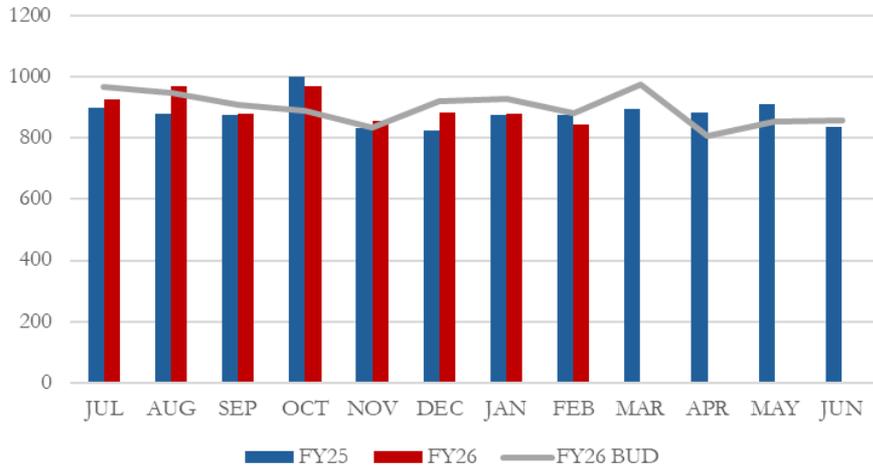
ER Visits



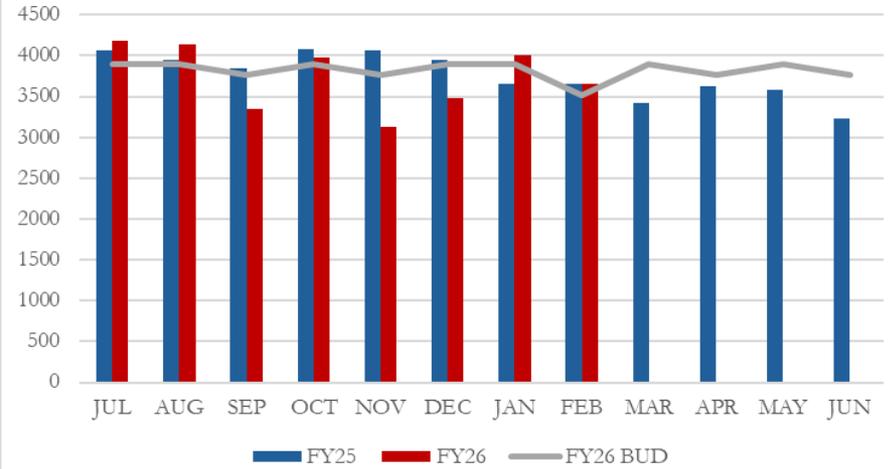
Surgery Patients



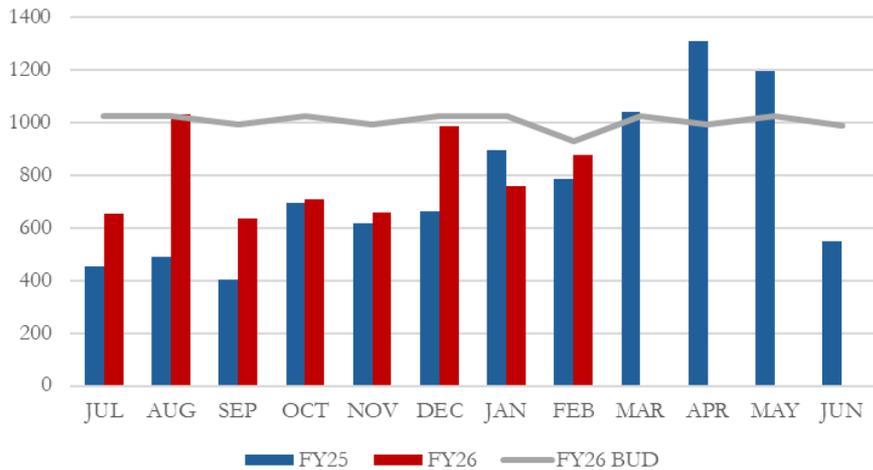
Imaging Visits



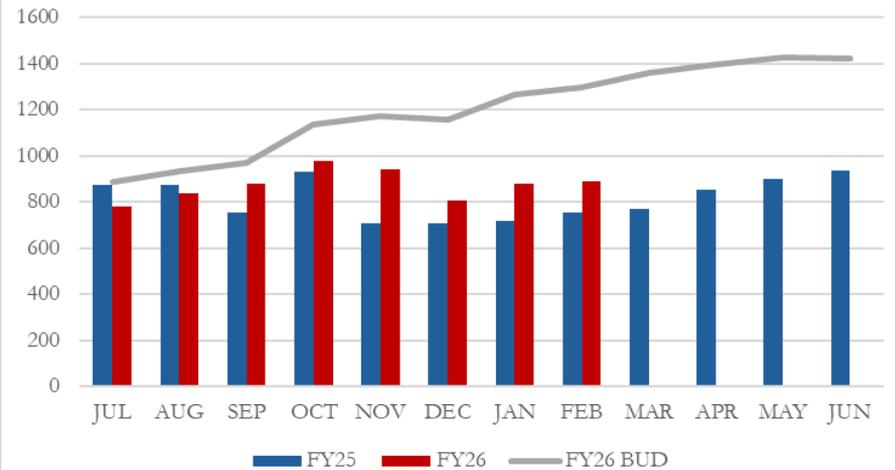
Lab Tests



RT Procedures



Clinic Visits



Southern Coos Hospital & Health Center

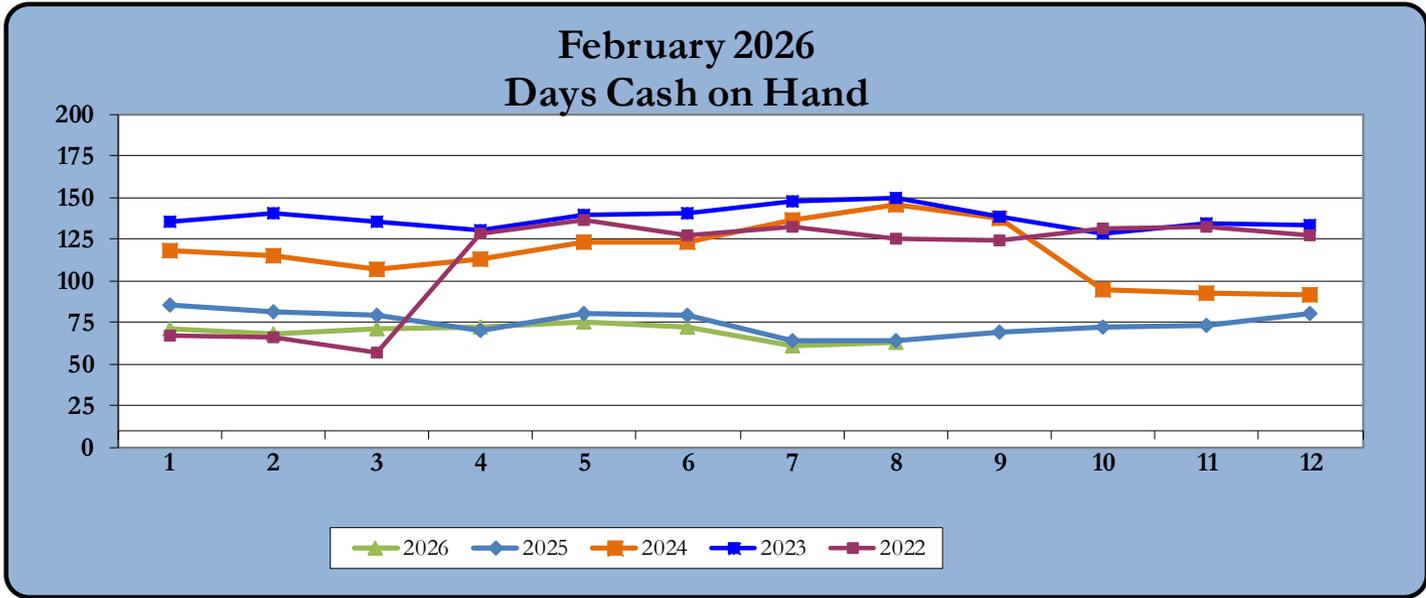
Volume and Key Performance Ratios
For The Period Ending February 2026

		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	121	128	137	-5.5%	-11.7%	1,023	952	1,019	7.4%	0.4%
	Swing Bed Days	94	168	123	-44.0%	-23.6%	913	1,458	772	-37.4%	18.3%
	Total Inpatient Days	215	296	260	-27.4%	-17.3%	1,936	2,410	1,791	-19.7%	8.1%
	Avg Daily Census	7.7	10.6	9.3	-27.4%	-17.3%	8.0	9.9	7.4	-19.7%	8.1%
	Avg Length of Stay - IP	3.0	3.0	2.4	0.8%	25.9%	3.5	3.0	3.8	17.6%	-7.6%
	Avg Length of Stay - SWB	15.7	8.8	8.8	77.2%	78.3%	11.1	8.9	11.5	25.2%	-3.4%
	ED Registrations	466	464	505	0.4%	-7.7%	4,033	4,028	3,984	0.1%	1.2%
	Clinic Registrations	708	300	796	136.0%	-11.1%	6,892	2,602	4,879	164.9%	41.3%
	Ancillary Registrations	1,566	555	1,468	182.2%	6.7%	9,609	4,820	9,609	99.4%	0.0%
	Total OP Registrations	2,740	1,319	2,769	107.7%	-1.0%	20,534	11,450	18,472	79.3%	11.2%
Key Income Statement Ratios	Gross IP Rev/IP Day	7,744	7,762	4,779	-0.2%	62.0%	7,073	7,073	6,533	0.0%	8.3%
	Gross SWB Rev/SWB Day	2,467	2,919	4,366	-15.5%	-43.5%	2,636	2,858	3,154	-7.7%	-16.4%
	Gross OP Rev/Total OP Registrations	1,321	3,380	1,274	-60.9%	3.6%	1,281	3,150	1,491	-59.3%	-14.1%
	Collection Rate	58.0%	62.0%	53.7%	-6.4%	7.9%	55.9%	62.0%	61.2%	-9.7%	-8.7%
	Compensation Ratio	69.8%	69.9%	81.8%	-0.2%	-14.6%	73.4%	71.5%	76.2%	2.7%	-3.7%
	OP EBIDA Margin \$	204,144	114,751	(451,504)	77.9%	-145.2%	296,645	637,051	(858,452)	-53.4%	-134.6%
	OP EBIDA Margin %	6.2%	3.5%	-17.8%	74.0%	-134.6%	1.1%	2.4%	-3.8%	-53.4%	-129.4%
	Total Margin	3.4%	1.6%	-21.9%	105.6%	-115.5%	-0.3%	0.6%	-4.6%	-145.7%	-94.4%
Key Liquidity Ratios	Days Cash on Hand	63.2	80.0	63.7	-21.0%	-0.8%					
	AR Days Outstanding	56.1	50.0	56.5	12.2%	-0.7%					

Southern Coos Hospital & Health Center

Data Dictionary

Volume Summary	<p>IP Days</p> <p>Swing Bed Days</p> <p>Total Bed Days</p> <p>Avg Daily Census</p> <p>Avg Length of Stay - IP</p> <p>Avg Length of Stay - SWB</p> <p>ED Registrations</p> <p>Clinic Registrations</p> <p>Ancillary Registrations</p> <p>Total OP Registrations</p>	<p>Total Inpatient Days Per Midnight Census</p> <p>Total Swing Bed Days per Midnight Census</p> <p>Total Days per Midnight Census</p> <p>Total Bed Days / # of Days in period (Mo or YTD)</p> <p>Total Inpatient Days / # of IP Discharges</p> <p>Total Swing Bed Days / # of SWB Discharges</p> <p>Number of ED patient visits</p> <p>Number of Clinic patient visits</p> <p>Total number of all other OP patient visits</p> <p>Total number of OP patient visits</p>
Key Income Statement Ratios	<p>Gross IP Rev/IP Day</p> <p>Gross SWB Rev/SWB Day</p> <p>Gross OP Rev/Total OP Registrations</p> <p>Collection Rate</p> <p>Compensation Ratio</p> <p>OP EBIDA Margin \$</p> <p>OP EBIDA Margin %</p> <p>Total Margin (%)</p>	<p>Avg. gross patient charges per IP patient day</p> <p>Avg. gross patient charges per SWB patient day</p> <p>Avg. gross patient charges per OP visit</p> <p>Net patient revenue / total patient charges</p> <p>Total Labor Expenses / Total Operating Revenues</p> <p>Operating Margin + Depreciation + Amortization</p> <p>Operating EBIDA / Total Operating Revenues</p> <p>Total Margin / Total Operating Revenues</p>
Key Liquidity Ratios	<p>Days Cash on Hand</p> <p>AR Days Outstanding</p>	<p>Total unrestricted cash / Daily OP Cash requirements</p> <p>Gross AR / Avg. Daily Revenues</p>



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	69.2
2025	74.8
2024	116.3
2023	137.8
2022	113.0

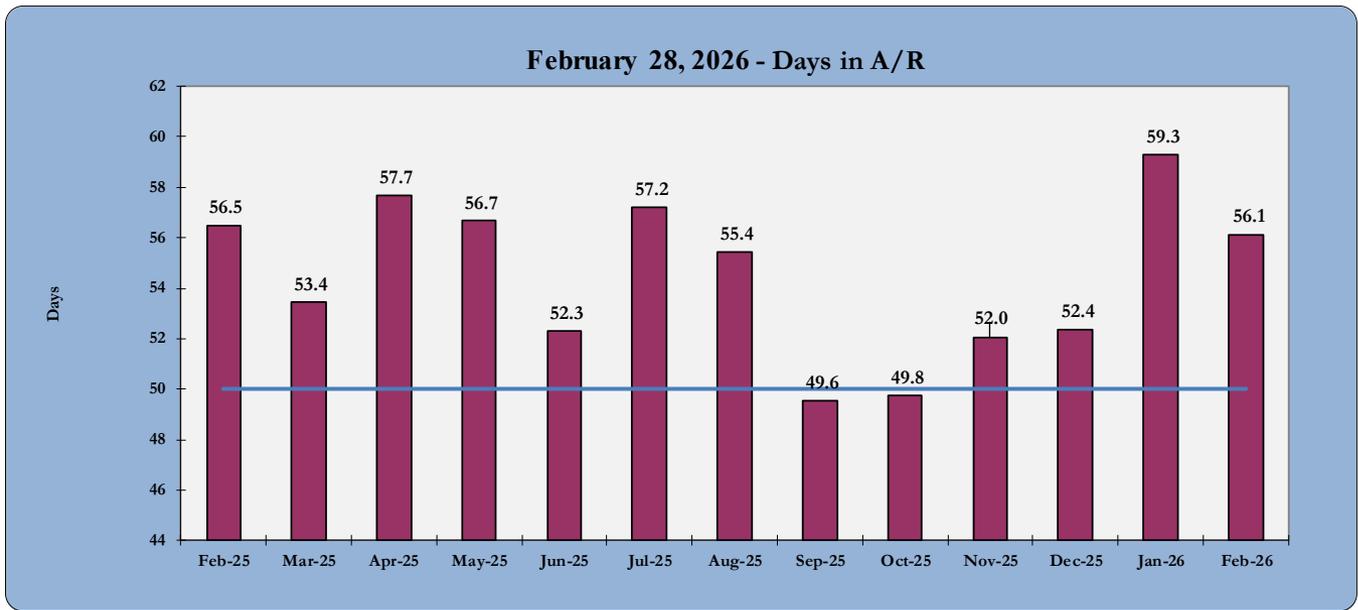
Benchmark

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	60.4	63.2				
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.

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
A/R (Gross)	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	8,934,107	8,853,251
Days in AR	56.5	53.4	57.7	56.7	52.3	57.2	55.4	49.6	49.8	52.0	52.4	59.3	56.1
Days in Month	28	31	30	31	30	31	31	30	31	30	31	31	28
Monthly Revenue	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	4,665,671	4,787,122
3 Mo Avg Daily Revenue	165,896	163,990	164,835	165,101	163,962	164,732	168,028	174,258	173,975	163,969	159,105	150,703	157,711
Days in AR	56.5	53.4	57.7	56.7	52.3	57.2	55.4	49.6	49.8	52.0	52.4	59.3	56.1

**SOUTHERN COOS HOSPITAL & HEALTH CENTER
CAPITAL PURCHASES SUMMARY FY2026**

FY26 Capital Budget - Projects under \$15,000

Total Budget	\$	186,000
Projects Completed / Capitalized	\$	9,245
Projects In Progress	\$	32,008
Remaining Budget	\$	144,747

FY26 Capital Budget - Projects over \$15,000

Total Budget	\$	3,114,000
Projects Completed / Capitalized	\$	453,625
Projects In Progress	\$	224,062
Remaining Budget	\$	2,436,314

FY26 Capital Budget - Grant Funded

Total Grant	\$	246,000
Projects Completed / Capitalized	\$	-
Projects In Progress	\$	150,583
Remaining Budget	\$	95,417

Clinic Provider Income Summary

All Providers Excluding Pain Clinic

For The Budget Year 2026

	ACT	BUD	ACT	BUD	Current Budget YTD														
	JUL	JUL	AUG	AUG	SEP	SEP	OCT	OCT	NOV	NOV	DEC	DEC	JAN	JAN	FEB	FEB	FYTD	FYTD26 Budget	Variance
Provider Productivity Metrics																			
Clinic Days	64	56	72	56	77	56	92	83	84	83	76	83	83	83	82	92	628	581	48
Total Visits	505	520	617	520	599	520	688	668	692	708	584	747	633	787	642	897	4,960	5,298	(338)
Visits/Day	8.0	9.3	8.6	9.3	7.8	9.3	7.5	8.1	8.3	8.6	7.7	9.1	7.6	9.5	7.9	9.7	7.9	9.1	(1.2)
Total RVU	1271	1078	1522	1078	1532	1078	1714	1386	1607	1467	1352	1548	1323	1629	1506	1710	11,828	10,975	853
RVU/Visit	2.52	2.07	2.47	2.07	2.56	2.07	2.49	2.08	2.32	2.07	2.31	2.07	2.09	2.07	2.35	1.91	2.38	2.07	0.31
RVU/Clinic Day	20.02	19.25	21.15	19.25	20.03	19.25	18.63	16.80	19.18	17.78	17.79	18.77	15.94	19.75	18.45	18.53	18.82	18.91	(0.08)
Gross Revenue/Visit	514	473	486	473	518	473	521	483	515	484	529	485	482	485	474	523	505	481	24
Gross Revenue/RVU	204	228	197	228	202	228	209	233	222	233	229	234	230	235	202	274	212	232	(21)
Net Rev/RVU	86	97	83	97	86	97	89	98	93	98	97	99	98	99	86	115	89	98	(9)
Expense/RVU	109	125	99	125	120	125	104	128	115	122	120	120	145	110	131	116	117.21	119	(1.59)
Diff	(22)	(27)	(15)	(27)	(34)	(27)	(16)	(30)	(22)	(24)	(23)	(22)	(48)	(11)	(45)	(1)	(28)	(21)	(7)
Net Rev/Day	1,724	1,871	1,764	1,871	1,719	1,871	1,649	1,651	1,789	1,750	1,724	1,849	1,556	1,947	1,579	2,126	1,685	1,855	(171)
Expense/Day	2,173	2,397	2,084	2,397	2,408	2,397	1,943	2,153	2,205	2,171	2,126	2,254	2,317	2,164	2,409	2,148	2,206	2,246	(40)
Diff	(449)	(526)	(321)	(526)	(689)	(526)	(294)	(503)	(415)	(422)	(402)	(405)	(761)	(216)	(831)	(22)	(522)	(391)	(131)
Patient Revenue																			
Outpatient																			
Total Patient Revenue	259,705	245,798	300,156	245,798	309,987	245,798	358,390	322,348	356,170	342,261	309,142	362,173	304,942	382,086	304,205	468,931	2,502,696	2,548,259	45,563
Deductions From Revenue																			
Total Deductions From Revenue (Note A)	150,232	141,008	173,167	141,008	178,490	141,008	206,680	186,173	206,255	197,921	178,117	209,669	175,810	221,418	175,388	272,657	1,444,139	1,471,371	27,231
Net Patient Revenue	109,473	104,790	126,989	104,790	131,496	104,790	151,710	136,176	149,915	144,340	131,025	152,504	129,132	160,668	128,817	196,275	1,058,557	1,076,889	(18,332)
Total Operating Revenue	109,473	104,790	126,989	104,790	131,496	104,790	151,710	136,176	149,915	144,340	131,025	152,504	129,132	160,668	128,817	196,275	1,058,557	1,076,889	(18,332)
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	121,433	102,460	126,714	109,270	861,465	724,018	137,447
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	3,767	5,834	7,005	7,361	31,106	34,921	(3,814)
Purchased Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Supplies	-	-	91	-	13	-	299	-	55	-	943	-	1,188	-	1,646	-	2,589	-	2,589
Other Supplies	-	-	9	-	-	-	-	-	-	-	-	-	295	-	-	-	304	-	304
Maintenance and Repairs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Expenses	5,339	-	1,659	-	8,104	-	3,657	378	6,151	378	4,250	378	3,353	378	2,544	378	35,057	1,891	33,166
Allocation Expense	47,224	61,676	48,828	61,676	51,053	61,676	62,881	69,228	55,615	70,448	67,558	77,254	62,276	69,832	60,351	79,661	455,785	542,977	(87,191)
Total Operating Expenses	137,966	134,248	150,069	134,248	184,241	134,248	178,792	177,651	184,700	179,120	161,613	185,926	192,312	178,504	196,614	198,317	1,386,307	1,303,806	82,500
Excess of Operating Rev Over Exp	(28,493)	(29,458)	(23,080)	(29,458)	(52,745)	(29,458)	(27,082)	(41,476)	(34,785)	(34,780)	(30,588)	(33,422)	(63,180)	(17,836)	(67,797)	(2,042)	(327,750)	(226,918)	(100,832)
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)	(27,082)	(41,476)	(34,785)	(34,780)	(30,588)	(33,422)	(63,180)	(17,836)	(67,797)	(2,042)	(327,750)	(226,918)	(100,832)

Clinic Income Statement - Excuding Pain Clinic

Southern Coos Hospital & Health Center

Statements of Revenues, Expenses, and Changes in Net Position

As of February 28, 2026

	Month Ending 2/28/2026			Year To Date 2/28/2026		
	Hospital Actual	Clinic Providers Actual	Actual	Hospital Actual	Clinic Providers Actual	Actual
Total Patient Revenue						
Inpatient Revenue	936,964	-	936,964	7,235,610	-	7,235,610
Outpatient Revenue	3,250,637	367,598	3,618,235	27,141,292	3,338,334	30,479,626
Swingbed Revenue	231,923	-	231,923	2,407,022	-	2,407,022
Retail Pharmacy Revenue	538,827	-	538,827	3,693,955	-	3,693,955
Total Patient Revenue	4,958,351	367,598	5,325,949	40,477,879	3,338,334	43,816,213
Total Deductions	1,799,231	212,790	2,012,021	15,746,262	1,937,166	17,683,428
Revenue Deductions %	36.3 %	57.9 %	37.8 %	38.9 %	58.0 %	40.4 %
Net Patient Revenue	3,159,120	154,808	3,313,928	24,731,617	1,401,168	26,132,785
Other Operating Revenue	2,157	-	2,157	220,004	-	220,004
Total Operating Revenue	3,161,276	154,808	3,316,084	24,951,621	1,401,168	26,352,789
Total Operating Expenses						
Total Labor Operating Expenses	2,173,151	141,594	2,314,745	18,398,149	950,879	19,349,028
Total Other Operating Expenses	942,355	72,243	1,014,598	7,674,536	531,912	8,206,448
Total Operating Expenses	3,115,506	213,837	3,329,343	26,072,686	1,482,790	27,555,476
Operating Income / (Loss)	45,772	(59,029)	(13,257)	(1,121,064)	(81,622)	(1,202,686)
Net Non Operating Revenue	125,645	-	125,645	1,135,259	-	1,135,259
Change In Net Position	171,417	(59,029)	112,388	14,195	(81,622)	(67,427)



Revenue Cycle Report

To: Board of Directors and Southern Coos Management
 From: Colene Hickman, Director Revenue Cycle
 Re: Report for Board of Directors Meeting – March 26, 2026

Executive Summary

February results reflect a strong recovery following timing-related challenges in December and January. Total AR decreased, AR Days improved to 54.1, and aged AR >90 days declined from 21.3% in December to 16.2%. Collections rebounded to \$3.2M with the highest average daily performance in the period, and billing remained strong. Reductions in Self-Pay and Government aging, along with resolution of high-dollar accounts, confirm stabilization. Commercial AR remains elevated but is stabilizing following resolution of prior staffing gaps.

Key Highlights

- AR Days improved (▼ 4.7 days)
- Aged AR >90 days reduced significantly
- Collections strongest in reporting period
- Billing sustained recovery
- Self-Pay aging declining with Americollect impact

Aged AR Over 120 Days by Financial Class

Class	Oct	Nov	Dec	Jan	Feb
Medicare	\$148,201	\$127,546 ▼ \$20,655	\$106,571 ▼ \$20,975	\$59,824 ▼ \$46,747	\$66,537 ▲ \$6,713
Commercial	\$433,980	\$425,551 ▼ \$8,429	\$437,265 ▲ \$11,714	\$462,521 ▲ \$25,256	\$430,565 ▼ \$31,956
Self-Pay	\$757,442	\$811,588 ▲ \$54,146	\$888,531 ▲ \$76,943	\$924,788 ▲ \$36,257	\$777,135 ▼ \$147,653
Medicare HMO	\$86,181	\$124,931 ▲ \$38,750	\$144,837 ▲ \$19,906	\$213,041 ▲ \$68,204	\$287,425 ▲ \$74,384
Medicaid HMO	\$69,806	\$85,578 ▲ \$15,772	\$153,758 ▲ \$68,180	\$172,040 ▲ \$18,282	\$144,422 ▼ \$27,618
Other Government	\$15,541	\$23,189 ▲ \$7,648	\$146,571 ▲ \$123,382	\$326,590 ▲ \$180,019	\$10,699 ▼ \$315,891
Medicaid	\$28,050	\$44,123 ▲ \$16,073	\$30,258 ▼ \$13,865	\$28,441 ▼ \$1,817	\$26,890 ▼ \$1,551
Worker's Comp	\$5,207	\$3,613 ▼ \$1,594	-\$1,616 ▼ \$5,229	-\$2,157 ▼ \$541	-\$1,700 ▲ \$457
Other	\$4,864	\$5,389 ▲ \$525	\$5,128 ▼ \$261	\$3,515 ▼ \$1,613	\$3,515 ▼ \$0
Undistributed	-\$10,719	\$5,230 ▲ \$15,949	-\$8,792 ▼ \$14,022	\$22,687 ▲ \$31,479	\$18,342 ▼ \$4,345

February shows improvement in Self-Pay and Government balances, while Medicare HMO and Commercial continue to be monitored.

AR Days Month over Month

Oct	Nov	Dec	Jan	Feb
47.6	50.7	54.4	58.8	54.1

AR Days peaked in January and improved in February, reflecting normalization of collections and aging.

AR Aging Distribution

Bucket	Oct	Nov	Dec	Jan	Feb
0-30	\$3.88M (47%)	\$4.06M (49%) ▲	\$4.06M (47%) ▼	\$4.01M (45%) ▼	\$4.35M (51%) ▲
>90 Days	\$1.49M (18%)	\$1.57M (19%) ▲	\$1.84M (21.3%) ▲	\$1.78M (~20%) ▼	\$1.38M (16.2%) ▼
121-180	\$578K (7%)	\$580K (7%)	\$776K (9%)	\$892K (10%)	\$519K (6%)
180+	\$908K (11%)	\$1.08M (13%)	\$1.12M (13%) ▲	\$1.34M (15%) ▲	\$1.24M (15%) ▼

The majority of Accounts Receivable remains concentrated in the lower aging buckets, with over half in the 0-30 day category, indicating a healthy and well-functioning revenue cycle. Aging trends in higher-risk categories have improved month over month, particularly in balances over 90 days, which have declined from peak levels. This shift toward more current receivables reflects stronger collections performance, improved workflow efficiency, and continued stabilization across revenue cycle operations.

Claims Billing Activity

Month	Total Billed
October	\$6,102,351
November	\$5,580,756 ▼ \$521,595
December	\$5,117,797 ▼ \$462,959
January	\$5,745,879 ▲ \$628,082
February	\$6,042,778 ▲ \$296,899

Billing increased in January and February, reflecting recovery from prior production declines.

Collections Performance

Month	Payments	Avg Daily
October	\$3,403,456	\$154,703
November	\$2,628,555 ▼ \$774,901	\$146,031 ▼ \$8,672
December	\$2,823,235 ▲ \$194,680	\$128,329 ▼ \$17,702
January	\$2,259,582 ▼ \$563,653	\$112,979 ▼ \$15,350
February	\$3,220,267 ▲ \$960,685	\$169,478 ▲ \$56,499

February collections significantly improved, representing the strongest performance in the reporting period.

Department Reports

Patient Access

Training for Patient Access staff on scanning and indexing is largely complete. Transitioning this function from Health Information Management has improved turnaround times. The team is also collaborating with other departments to streamline new patient workflows, including efforts to schedule ED patients without primary care providers directly into clinic services without unnecessary duplicate paperwork. These improvements support better continuity of care, ensure appropriate follow-up, and help reduce avoidable ED utilization.

Health Information Management

HIM continues to perform well following the transition away from Coding Concepts oversight. Improvements have been made in Release of Information workflows and deficiency management. The team is now focusing on optimizing Requests to Obtain records for primary care, including better utilization of Care Everywhere to reduce reliance on fax requests and associated scanning. Continued optimization of EPIC functionality remains a key priority.

Referrals & Authorizations

The referrals team continues to perform well while focusing on workflow optimization, particularly around closing the loop on outgoing referrals. These referrals require significant follow-up and cannot be closed until patients are seen and documentation is received from external providers. Challenges remain due to limited specialist availability, extended scheduling timelines, and some providers not accepting new patients. Despite increased workload from the addition of general surgery, the team has adapted effectively.

Billing

The billing team remains focused on reducing aging over 90 days through root cause analysis and identification of payer trends. Efforts are underway in collaboration with provider relations to address issues such as delayed processing and underpayments inconsistent with contract terms. The team is also targeting preventable denials, with feedback loops established to address common drivers such as medical necessity, missing authorizations, frequency limits, eligibility issues, and mismatches between authorized and billed services.

Patient Billing and Financial Counseling

Financial counselors have successfully transitioned to their new location at the Ray's Business Center, with positive feedback from patients. The team continues to balance patient engagement with timely placement of accounts to Americollect, ensuring all reasonable resolution efforts are made beforehand. With the transition to Americollect, bad debt placements now occur weekly and payments are received bi-weekly, improving cash flow and supporting long-term AR reduction.

Respectfully Submitted,

Colene Hickman
Revenue Cycle Director

FY26 Monthly Mitigation Plan 3-Month Period Review

SCHHC Monthly Review Dashboard						
Metric	Status (based on 3- Month Avg)	3-Month Average	As of December 31, 2025	As of January 31, 2026	As of February 28, 2026	Baseline
Contingency Plan Tracking Metric						
Operating Gain/Loss - Excluding New Initiatives	● \$	\$ (131,077)	\$ (119,020)	\$ (160,619)	\$ 96,141	3 month average, excluding FY26 new initiatives expense
Operating Gain/Loss - New Initiatives (SLS, Surgery, Retail RX)	⊗ \$	\$ (155,569)	\$ (249,027)	\$ (77,816)	\$ (109,400)	3 month average, FY26 new initiatives only
Organizational Rev/Expense Metrics						
Total Patient Revenue	● \$	\$ 4,621,569	\$ 4,741,155	\$ 4,665,671	\$ 4,787,122	Budgeted patient revenue
Total Retail Pharmacy Revenue	● \$	\$ 538,027	\$ 610,819	\$ 527,035	\$ 538,827	
% Total Deductions from Revenue	⊗ \$	42.80%	42.30%	44.09%	39.81%	Goal: 35% average
Total Operating Revenue	● \$	\$ 3,208,733	\$ 3,348,670	\$ 3,137,921	\$ 3,316,084	3 month average calculated on 10% variance over 3-month average budget
Revenue Actual v Budget Variance	● \$	\$ (176,749)	\$ (56,873)	\$ (528,906)	\$ 73,179	Positive variance
Total Operating Expenses	⊗ \$	\$ 3,495,379	\$ 3,716,717	\$ 3,376,356	\$ 3,329,343	Budgeted Operating Expenses
Expenses Actual v Budget Variance	● \$	\$ (17,619)	\$ (215,126)	\$ 160,176	\$ (26,888)	
Operating Gain/Loss	⊗ \$	\$ (286,646)	\$ (368,047)	\$ (238,435)	\$ (13,259)	Includes all expense, including FY26 new initiatives
Change in Net Position	● \$	\$ (142,505)	\$ (203,612)	\$ (82,792)	\$ 112,386	Budgeted Change in Net Position
% Margin	⊗	(4.40%)	(6.10%)	(2.60%)	3.40%	Positive >1.0
Financial Health Metrics						
A/R Days Outstanding	●	54.6	52.4	59.3	56.1	40-55 days
Days Cash on Hand	●	69.3	72.4	60.4	63.2	60-180 days
Cash to Debt Ratio	●	1.0	1.0	1.0	1.0	.20 - 1.00+
Debt Ratio	●	0.5	0.5	0.4	0.4	.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 Loss by Dept									Q1 2026	Q2 2026	Q3 2026	Rolling 3 month Ave
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Average	Average	Average	
SLS	\$ -	\$ (9,500)	\$ (9,500)	\$ (9,500)	\$ (8,235)	\$ (30,916)	\$ (37,419)	\$ (47,030)	\$ (6,333)	\$ (16,217)	\$ (42,225)	\$ (25,523)
Surgery	\$ (76,237)	\$ (70,922)	\$ (77,832)	\$ (114,173)	\$ (95,487)	\$ (176,669)	\$ (72,273)	\$ (37,995)	\$ (74,997)	\$ (128,776)	\$ (55,134)	\$ (114,810)
Retail Pharm	\$ (29,619)	\$ (17,896)	\$ (23,617)	\$ (50,246)	\$ (36,142)	\$ (41,442)	\$ 31,876	\$ (24,375)	\$ (23,711)	\$ (42,610)	\$ 3,751	\$ (15,236)
Total	\$ (105,856)	\$ (98,318)	\$ (110,949)	\$ (173,919)	\$ (139,864)	\$ (249,027)	\$ (77,816)	\$ (109,400)	\$ (105,041)	\$ (187,603)	\$ (93,608)	\$ (155,569)
Overall Operating Gain/(Loss)	\$ 8,495	\$ 84,901	\$ (401,387)	\$ (21,499)	\$ (253,455)	\$ (368,047)	\$ (238,435)	\$ (13,259)	\$ (102,664)	\$ (214,334)	\$ (125,847)	\$ (286,646)
Gain (Loss) Excluding Initiatives	\$ 114,351	\$ 183,219	\$ (290,438)	\$ 152,419	\$ (113,591)	\$ (119,020)	\$ (160,619)	\$ 96,141	\$ 2,377	\$ (26,731)	\$ (32,239)	\$ (131,077)