AGENDA

Board of Directors Meeting

6:30 PM - Wednesday, February 25, 2026

Click link to join Zoom meeting

SPH Conference Rooms 1&2

Meeting ID: 878 0782 1015 Pwd: 931197

Phone Line: 669-900-9128 or 301-715-8592

Aaron Weisser, President		Jim Anderson		Matthew Bullard	
Preston Simmons Vice President		Ken Ciccoli		Kim Frost	
Mary E. "Beth" Wythe, Secretary		Edson Knapp, MD		Christopher Landess, MD	
Michael Dye, Treasurer		Bernadette Wilson			

Board Master Reports List

Mission: South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare.

Vision: South Peninsula Hospital is the provider of choice with a dynamic team committed to service excellence.

Values: Compassion, Respect, Trust, Teamwork and Commitment

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4 — 4.1. Rules for Participating in a Public Meeting

Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

5 - 12 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for January 28, 2026
Board of Directors - Jan 28 2026 - Minutes - DRAFT

13 - 15 7.2. Consideration to Approve January FY2026 Financials
Balance Sheet January FY26
Income Statement January FY26
Cash Flow January FY26

16 - 30 7.3. Consideration to Approve HW-269, South Peninsula Hospital's Infection Prevention Plan and the Infection Prevention Risk Assessments for the Hospital and Long Term Care Facility
HW-269
Infection Prevention Risk Assessment - Hospital
Infection Prevention Risk Assessment - LTC

8. PRESENTATIONS

9. UNFINISHED BUSINESS

10. NEW BUSINESS

11. REPORTS

31 - 37 11.1. Chief Executive Officer
Q2-FY26 Scorecard

11.2. BOD Committee: Finance & Pension

11.3. BOD Committee: Strategic Planning & Communication

38 - 42 11.4. BOD Committee: Governance
REPORTS MASTER LIST 26 01 26 UPDATES, clean
EMP-01, revised

11.5. BOD Committee: Quality - **no meeting this month**

11.6. Chief of Staff

11.7. Board President Report (Executive Committee, Education Sessions & Generative Discussions)

11.8. Service Area Board Representative

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

16. ACTION ITEMS

17. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

18. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

18.1. Consideration to Approve Resolution 2026-05, Approving the Medical Staff Credentialing February 2026

19. ADJOURNMENT

South Peninsula Hospital

MEMO

Administration
4300 Bartlett Street
Homer, AK 99603
907-235-0325 ~ 907-235-0253, fax

To: Public Participants

From: Operating Board of Directors – South Peninsula Hospital

Re: Rules for Participating in a Public Meeting

The following has been adapted from the "Rules for Participating in a Public Meeting" used by Kenai Peninsula SAB of SPHI and reflects language from the Operating Agreement with the Kenai Peninsula Borough.

Each member of the public desiring to comment upon policies or proposed actions of the SPH Operating Board of Directors at tonight's meeting will be given an opportunity to speak within the following guidelines:

- *Comments are restricted to policies or proposed actions of the SPH Operating Board of Directors.*
- *Those who wish to speak will need to sign in on the sign in sheet being circulated. When the chair recognizes you to speak, you need to clearly give your name and the policy or proposed action you wish to address.*
- *Please be concise and courteous. There is a limit of 3 minutes per speaker; total time allotted for public comment is at the discretion of the chair.*
- *Please observe normal rules of decorum and avoid disparaging by name the reputation or character of any member of the Operating Board of directors, the administration or personnel of SPHI, or the public. You cannot mention or use names of individuals.*
- *The Operating Board Directors may ask you to respond to their questions following your comments. You could be asked to give further testimony in "Executive Session" if your comments are directly related to a member of personnel, or management of SPHI, or dealing with specific financial matters, either of which could be damaging to the character of an individual or the financial health of SPHI, however, you are under no obligation to answer any question put to you by the Operating Board Directors.*
- *If you have questions, you may direct them to the chair. Questions will not be addressed by the board during the public comment period, but may be addressed at a later time.*

These rules for participating in a public meeting were discussed and approved at the Board of Directors meeting on September 25, 2024.

MINUTES

Board of Directors Meeting

6:30 PM - Wednesday, January 28, 2026

Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, January 28, 2026, at 6:30 PM, in the Conference Rooms 1&2 and Zoom.

1. CALL TO ORDER

The board went into Executive Session to discuss personnel and financial matters prior to the start of the regular meeting. The board when into Executive Session at 5:30pm. President Aaron Weisser called the regular meeting to order at 6:30pm.

2. ROLL CALL

BOARD PRESENT: **Aaron Weisser, Edson Knapp, Michael Dye, Bernadette Wilson, Beth Wythe, Preston Simmons, Matthew Bullard, Christopher Landess, Kim Frost, Jim Anderson, and Ken Ciccoli**

BOARD EXCUSED:

ALSO PRESENT: **Ryan Smith (CEO), Rachael Kincaid (COO), Anna Hermanson (CFO), Amber Gall (CNO), Miranda Weiss (Director of Philanthropy) and Maura Gibson (Exec Asst)**

Only meeting participants who comment, report or give presentations are noted in the minutes. Others may be present on the room or on the virtual meeting.

A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Amber Gall, CNO shared a patient case from December involving a severe intestinal problem requiring surgery. The surgery was successful, and the patient recovered efficiently, with Nurse Jordan Lugo being highlighted for exceptional care.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

Aaron Weisser welcomed new board members Jim Anderson and Ken Ciccoli.

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

Michael Dye made a motion to approve the agenda as presented. Beth Wythe seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Beth Wythe read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for December 17, 2025

7.2. Consideration to Approve the November FY2026 and December FY2026 Financials

7.3. Consideration to Approve the South Peninsula Hospital Corporate Compliance and Ethics Program and HW-101, Corporate Compliance and Ethics Policy

7.4. Consideration to Approve a Retirement Proclamation for Julie McCarron after 26 Years of Service to South Peninsula Hospital

7.5. Consideration to Approve the 2026 Long Term Care Performance Improvement Project

7.6. Consideration to Approve the Revised Committee Charters for 2026

7.7. Consideration to Approve the Revised Board of Directors Bylaws

Beth Wythe made a motion to approve the consent calendar as read. Michael Dye seconded the motion. Motion Carried.

8. PRESENTATIONS

8.1. Presentation of Julie McCarron's Retirement Proclamation

Aaron Weisser read the retirement proclamation for Julie McCarron, recognizing her 26 years of service. Julie McCarron thanked the board and expressed her gratitude for the care she was able to provide to families.

8.2. Introduction of Miranda Weiss, Director of Philanthropy

Miranda Weiss introduced herself and her role as Director of Philanthropy. She shared her background, including her children born at the hospital and her previous work with the hospital. Miranda discussed her responsibilities, including grant writing, donor development, and partnerships with senior leadership. Success stories include securing grants for a new mammography machine and a travel lift for Long-Term Care.

8.3. Presentation of the FY2025 Financial Audit

Joy Merriner from BDO presented the financial audit results, highlighting no findings and no journal entries identified. Joy discusses the audit process, internal controls, and the importance of 100% board giving for grant success. The financial statements show significant increases in assets, liabilities, and net position, with a focus on capital investments and patient receivables.

9. UNFINISHED BUSINESS

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10. NEW BUSINESS

10.1. Consideration to Accept the Financial Audit for FY2025

Preston Simmons made a motion to approve the financial audit for FY2025. Michael Dye seconded the motion. A roll call vote was held. Those board members who were non-independent, either hospital employees or have family members that are hospital employees) recused themselves and left the room for the vote.

Jim Anderson	*Yes*
Matthew Bullard	*Yes*
Ken Ciccoli	*Yes*
Mike Dye	*Yes*
Kim Frost	*Yes*
Edson Knapp	*Recused (employee)*
Christopher Landess	*Recused (employee)*
Preston Simmons	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Recused (employed family member)*
Aaron Weisser	*Recused (employed family member)*

Motion Carried.

10.2. Consideration to Approve SPH Resolution 2026-01, A Resolution of the South Peninsula Hospital Board of Directors Approving the Capital Budget for FY2027

Anna Hermanson, CFO presents the capital budget for FY 2027, requesting $2.772 million for various equipment and infrastructure updates. The budget includes items like a staff duress and precision locating system, replacement equipment, and updates to floors and infrastructure. The Finance Committee reviewed and approved this in their meeting.

Beth Wythe made a motion to approve SPH Resolution 2026-01, A Resolution of the South Peninsula Hospital Board of Directors Approving the Capital Budget for FY2027 Michael Dye seconded the motion. A roll call vote was held:

Jim Anderson	*Yes*
Matthew Bullard	*Yes*
Ken Ciccoli	*Yes*
Mike Dye	*Yes*
Kim Frost	*Yes*
Edson Knapp	*Yes*
Christopher Landess	*Yes*
Preston Simmons	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*

Aaron Weisser Yes

10.3. Consideration to Approve SPH Resolution 2026-02, A Resolution of the South Peninsula Hospital Board of Directors Approving a Plan Amendment for the 457 Plan to Adhere to the Requirements of the Secure 2.0 Act of 2022

Ms. Hermanson reported on Resolution 2026-02, a resolution to amend the 457 plan to comply with the SECURE Act 2022.

Beth Wythe made a motion to approve SPH Resolution 2026-02, A Resolution of the South Peninsula Hospital Board of Directors Approving a Plan Amendment for the 457 Plan to Adhere to the Requirements of the Secure 2.0 Act of 2022 Michael Dye seconded the motion. Motion Carried.

10.4. Consideration to Approve SPH Resolution 2026-03, A Resolution of the South Peninsula Hospital Board of Directors Approving the 2025 Discretionary Contribution for the Non-Union 403b Plan

Ms. Hermanson explains the non-union 403(b) plan and the proposed 2% annual discretionary contribution. The contribution schedule for union employees is built into the collective bargaining agreement, so no resolution is needed.

Beth Wythe made a motion to approve SPH Resolution 2026-03, A Resolution of the South Peninsula Hospital Board of Directors Approving the 2025 Discretionary Contribution for the Non-Union 403b Plan Kim Frost seconded the motion. Motion Carried.

10.5. Consideration to Approve the Revised Peer Review Policy , as Recommended by the Medical Staff

Dr. Sarah Roberts, Chief of Staff, presented the revised peer review policy, recommended by the medical staff. The policy aims to provide clear guidelines and procedures for peer review processes.

Beth Wythe made a motion to approve the Revised Peer Review Policy, as Recommended by the Medical Staff Michael Dye seconded the motion. Motion Carried.

11. REPORTS

11.1. Chief Executive Officer

Ryan Smith, CEO, and the executive team reviewed the new balanced scorecard data. Key metrics include patient experience, sepsis care, stroke care, and emergency room admission rates. The board discusses the importance of these metrics and the need for continuous improvement. Amber Gall discusses patient and resident satisfaction surveys, including inpatient,

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outpatient, and home health. The board discusses the importance of tracking and improving various quality metrics. Anna Hermanson emphasizes the importance of completing security awareness training, currently at 83% completion. Financial health indicators are reviewed, with strong revenue growth and a negative 4% surgical case growth for the quarter. Anna Hermanson explains the revenue growth due to high volumes and specific surgery types. Aaron Weisser inquires about cash on hand, with Anna explaining the impact of AR and the hiring of an interim revenue cycle director. The new director will help improve workflows, coding, billing, and prevent denials.

11.2. BOD Committee: Finance & Pension

Mike Dye, committee chair, reported. The Finance & Pension committee met last week and reviewed the November and December financials. He encouraged everyone to read the audit documents.

11.3. BOD Committee: Strategic Planning & Communication

Aaron Weisser, committee chair, updated on strategic planning and communication efforts, including targeted outreach plans for board members.

11.4. BOD Committee: Governance

Beth Wythe, committee chair, reported on their meeting. The Governance Committee did a lot of work in 2025. The revised bylaws were approved today, which concludes the committee's 2025 work list. The 2026 training schedule has been submitted as a plan, but will remain flexible.

11.5. BOD Committee: Quality

Preston Simmons, committee chair, reported. The Quality Committee had a presentation by the Acute Care and OB Directors, highlighting professional development initiatives for ICU nurses and labor and delivery quality metrics, interdisciplinary collaboration and proposed goals for 2026, including neonatal resuscitations and postpartum hemorrhage prevention.

11.6. Chief of Staff

Dr. Sarah Roberts shared that the General Med Staff is going to be at the beginning of February. The medical staff is restructuring our committees to align better with Board deadlines. They have completed a full review of their bylaws and rules and regulations, and will be moving their focus to physician education, DAX copilot, and integrating some new AI advancements into our diagnostic use in the hospital.

11.7. Board President Report (Executive Committee, Education Sessions & Generative Discussions)

Aaron Weisser shared that the board had their pre-meeting education on Medicare Inducement to Use Services - a self-pay and regulatory overview. He expressed appreciation for the informative education sessions the leadership team has been providing.

11.8. Service Area Board Representative

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Tamara Fletcher gave a short report on behalf of the Service Area Board (SAB). The SAB had an detailed, in-person presentation by Brandi Harbaugh from the Kenai Peninsula Borough on the budget, which was helpful for new members.

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Ryan Smith welcomed new members Jim and Ken. He thanked Dr. Roberts for the work on peer review. He thanked Miranda Weiss, Katie Martin and Rachael Kincaid for their work on the Gold Award application for Long Term Care. He thanked Anna Hermanson for her work on the financial audit.

14.2. Board Members

Mike Dye shared he was just started the NRHA Board Certification program and was already finding it to be very informative. One takeaway so far is having a visual reminder of strategies/visions at meetings to keep them at front-of-mind. Kim Frost thanked the team working on the Gold Award application. Jim Anderson was honored to be included on the board, and shared that both he and his wife were born in the hospital. He felt healthcare and the perception of the hospital in the community are both important. Preston Simmons welcomed the new board members. Bernadette Wilson also welcomed the new members and congratulated Julie McCarron on her retirement. She gave kudos to Anna on the clean financial audit and thanked Miranda for the presentation. Ken Ciccoli thanked the board for the opportunity to serve, and looks forward to learning a lot. Edson Knapp welcomed the new members, and thanked Miranda Weiss for her grant work, which has had a positive impact on the Imaging Department. Beth Wythe congratulated Anna on the clean audit, and welcomed new members. Aaron Weisser welcomed the new members. He expressed the privilege he feels in being part of an organization that he can support and recommend to others without regret or caveat.

15. INFORMATIONAL ITEMS

15.1. Board Committee Assignments for 2026

President Aaron Weisser set committee assignments for 2026.

Finance & Pension Committee: Mike Dye (Chair), Christopher Landess, and Edson Knapp

Strategic Planning & Community Relations Committee: Kim Frost (Chair), Aaron Weisser, Christopher Landess, Mike Dye and Matt Bullard

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Governance Committee: Beth Wythe (Chair), Matt Bullard, Bernadette Wilson, Preston Simmons and Aaron Weisser

Quality-of-Care Committee: Preston Simmons (Chair), Bernadette Wilson, Edson Knapp, Kim Frost and Beth Wythe

Executive Committee: Aaron Weisser (Chair), Preston Simmons, Beth Wythe and Mike Dye

Credentials Committee: Bernadette Wilson
SPH Foundation: Beth Wythe
Medical Executive Committee: Dr. Edson Knapp & Dr. Christopher Landess

15.2. Board Agenda Calendar for 2026

A calendar of agenda items for 2026 was provided. It is a living document that will be updated as the year progresses.

15.3. Board Representatives to Service Area Board Meetings for 2026

The list of board representatives to SAB meetings for 2026 was provided.

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

No additional executive session was needed.

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Consideration to Approve SPH Resolution 2026-04, Approving the Medical Staff Credentialing for January 2026

to approve SPH Resolution 2026-04, Approving the Medical Staff Credentialing for January 2026, to include:

The reappointment of:

Katelynn Bailey, DO	Emergency Medicine	Active
Jessica Jule, CNRA	Anesthesia	Active
Nathan Kincaid, MD	General Surgery	Active
Seth Krauss, MD	Cardiology	Part-Time Active
Kim Madden, DO	Neurology	Part-Time Active
William Mayer, MD	Cardiology	Part-Time Active
Suneet Purohit, MC	Cardiology	Part-Time Active
Tamara Shrader, ANP	Adult/Geriatric Medicine	Active
John Stephens, MD	Cardiology	Part-Time Active
Mohammad Hirzallah, MD	Neurology	TeleStroke
Helen Zhang, MD	Psychiatry	TelePsych
Nausheen Naveed, MD	Radiology	TeleRad
Christopher Rickman, MD	Radiology	TeleRad
Stephanie Runyan, DO	Radiology	TeleRad

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And the initial appointment of:

Ian Dobbe, MD	Family Medicine	Active
Phani Kantamneni, MD	Internal Med	TeleCritical Care

18. ADJOURNMENT

The meeting adjourned at 8:26pm.

Respectfully Submitted,

Accepted:

Maura Gibson, Executive Assistant

Aaron Weisser, President

Minutes Approved:

Mary E. Wythe, Secretary

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DRAFT-UNAUDITED

BALANCE SHEET
As of January 31, 2026

		Month Ending 01/31/2026	Month Ending 01/31/2025	Month Ending 12/31/2025	Change From Prior Year
	ASSETS				
	CURRENT ASSETS				
	CASH				
1	CASH AND CASH EQUIVALENTS	26,412,964	24,526,061	28,241,902	5,445,736.00
2	EQUITY IN CENTRAL TREASURY	10,933,588	9,580,437	8,802,480	1,353,151.00
3	TOTAL CASH	37,346,552	34,106,498	37,044,382	6,798,887.00
	NET PATIENT ACCOUNTS RECEIVABLE				
4	PATIENT RECEIVABLES	67,517,075	42,356,663	72,052,173	21,601,579.00
5	LESS ALLOWANCES AND ADJUSTMENTS	(33,160,304)	(20,222,821)	(38,968,686)	(12,937,483.00)
6	TOTAL NET PATIENT ACCOUNTS RECEIVABLE	34,356,771	22,133,842	33,083,487	8,664,096.00
	NET PROPERTY TAXES RECEIVABLE - KPB				
7	PROPERTY TAX RECEIVABLE	296,520	202,387	357,676	94,133.00
8	LESS ALLOWANCE PROPERTY TAX - KPB	4,166	4,165	4,165	0.00
9	TOTAL NET PROPERTY TAXES RECEIVABLE - KPB	292,354	198,222	353,511	94,133.00
10	OTHER RECEIVABLES	486,596	213,725	401,577	272,869.00
11	INVENTORY	2,897,761	3,388,808	2,806,317	(491,047.00)
12	NET PENSION ASSET	534,985	3,225,068	534,985	(2,690,083.00)
13	PREPAID EXPENSE	1,852,926	1,478,689	1,719,277	374,238.00
14	TOTAL CURRENT ASSETS	77,767,945	64,744,852	75,943,536	13,023,093.00
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	4,636,536	7,116,007	4,591,638	(2,479,471.00)
16	PREF OBLIGATED	364,478	1,162,592	2,606,772	(798,114.00)
17	OTHER RESTRICTED FUNDS	40,523	1,079,424	40,422	(1,038,901.00)
	TOTAL ASSETS WHOSE USE IS LIMITED	5,041,537	9,358,023	7,238,832	(4,316,486.00)
18	PROPERTY AND EQUIPMENT				
19	LAND AND IMPROVEMENTS	4,943,992	4,330,766	6,604,217	613,226.00
20	BUILDING	71,027,135	66,786,775	69,366,909	4,240,360.00
21	EQUIPMENT	34,584,807	27,734,737	34,584,808	6,850,071.00
22	BUILDINGS INTANGIBLE ASSETS	4,257,906	4,016,799	4,257,906	241,106.00
23	EQUIPMENT INTANGIBLE ASSETS	1,750,896	1,119,432	1,750,895	631,463.00
24	SOFTWARE INTANGIBLE ASSETS	3,277,656	1,046,832	3,031,996	2,230,825.00
25	IMPROVEMENTS OTHER THAN BUILDINGS	1,544,013	1,449,244	1,544,012	94,769.00
26	CONSTRUCTION IN PROGRESS	3,681,907	4,311,218	2,911,125	(629,311.00)
27	LESS ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(64,790,160)	(60,550,030)	(64,201,363)	(4,240,130.00)
28	LESS ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(3,992,439)	(2,506,012)	(3,815,282)	(1,486,427.00)
	NET CAPITAL ASSETS	56,285,713	47,739,761	56,035,223	8,545,952.00
29	GOODWILL	0	0	0	0.00
30	**TOTAL ASSETS**	**139,095,195**	**121,842,636**	**139,217,591**	**17,252,559.00**
	DEFERRED OUTFLOW OF RESOURCES				
31	PENSION RELATED (GASB 68)	4,127,265	4,233,392	4,364,862	(106,126.00)
32	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	127,180	188,225	132,267	(61,046.00)
33	TOTAL DEFERRED OUTFLOW OF RESOURCES	4,254,445	4,421,617	4,497,129	(167,172.00)
34	**TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES**	**143,349,640**	**126,264,253**	**143,714,720**	**17,085,387.00**
	LIABILITIES AND FUND BALANCE				
	CURRENT LIABILITIES				
35	ACCOUNTS AND CONTRACTS PAYABLE	3,114,545	1,791,682	1,828,910	1,322,863.00
36	ACCRUED LIABILITIES	6,503,853	4,960,002	8,343,824	1,543,850.00
37	DEFERRED CREDITS	623,768	1,118,131	219,378	(494,362.00)
38	CURRENT PORTION OF LEASE PAYABLE	1,014,012	880,505	995,801	133,508.00
39	CURRENT PORTION OF SOFTWARE INTANGIBLE PAYABLE	1,054,519	235,718	1,006,648	818,800.00
40	CURRENT PORTION OF NOTES DUE	874,094	10,587	874,094	863,507.00
41	CURRENT PORTION OF BOND PAYABLE	1,250,000	1,195,000	1,250,000	55,000.00
42	BOND INTEREST PAYABLE	119,042	96,442	94,236	22,601.00
43	DUE TO/FROM THIRD PARTY PAYERS	1,076,863	876,864	1,076,864	199,999.00
44	COMPENSATED ABSENCES CURRENT	6,855,722	4,933,326	6,651,173	1,922,395.00
45	TOTAL CURRENT LIABILITIES	22,486,418	16,098,257	22,340,928	6,388,161.00
	LONG-TERM LIABILITIES				
46	NOTES PAYABLE	3,302,695	921,144	3,279,495	2,381,551.00
47	COMPENSATED ABSENCES, NET OF CURRENT	3,540,224	0	3,019,555	3,540,224.00
48	BONDS PAYABLE, NET OF CURRENT PORTION	4,170,000	5,420,000	4,170,000	(1,250,000.00)
49	PREMIUM ON BONDS PAYABLE	139,200	218,879	145,178	(79,679.00)
50	CAPITAL LEASE, NET OF CURRENT PORTION	3,334,697	3,538,333	3,418,094	(203,636.00)
51	SOFTWARE INTANGIBLE LEASE, NET OF CURRENT PORTION	1,033,441	116,462	935,250	916,979.00
	TOTAL NONCURRENT LIABILITIES	15,520,257	10,214,818	14,967,572	5,305,439.00
51	TOTAL LIABILITIES	38,006,675	26,313,075	37,308,500	11,693,600.00
	DEFERRED INFLOW OF RESOURCES	0	0	0	0.00
	PROPERTY TAXES RECEIVED IN ADVANCE	0	5	0	(5.00)
54	INVESTED IN CAPITAL ASSETS	56,412,893	47,927,986	56,167,490	0.00
55	RESTRICTED	575,508	4,304,492	575,407	0.00
56	UNRESTRICTED FUND BALANCE SPH	52,976,652	48,541,348	49,834,404	5,632,398.00
57	CHANGE IN FUND BALANCE	(1,063,255)	(822,648)	(171,081)	(240,606.00)
58	TOTAL NET POSITION	108,901,798	99,951,178	106,406,220	5,391,792.00
59	**TOTAL LIABILITIES AND FUND BALANCE**	**143,349,640**	**126,264,253**	**143,714,720**	**17,085,387.00**

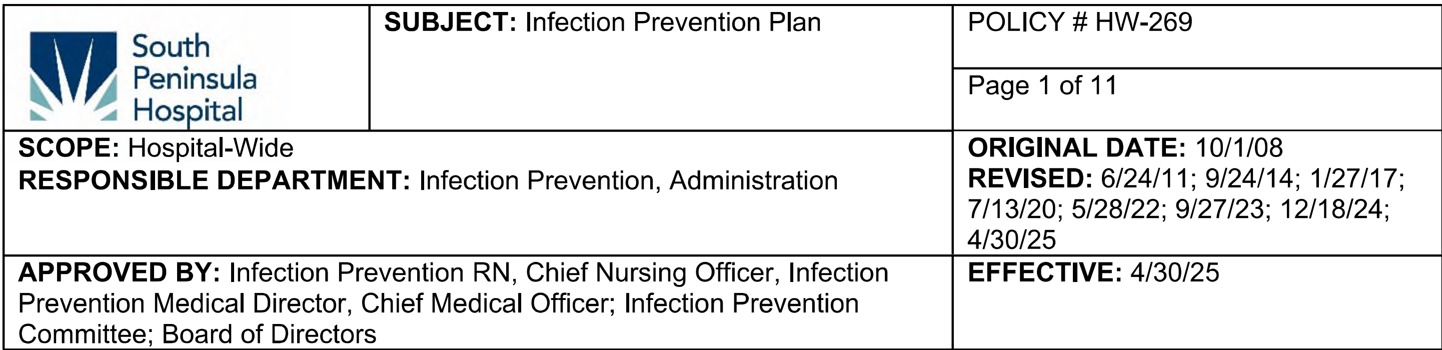
INCOME STATEMENT
As of January 31, 2026
DRAFT-UNAUDITED

		Month Ending 01/31/2026 Actual	Budget FY26	Var B (W)	Month Ending 01/31/2025 Actual	Year To Date 01/31/2026 Actual	Budget FY26	Var B (W)	Prior Year To Date 01/31/2025 Actual
	PATIENT SERVICE REVENUE								
1	INPATIENT REVENUE	3,068,272	3,498,028	(12.29) %	3,310,772	23,911,904	23,320,190	2.54 %	21,030,806
2	OUTPATIENT REVENUE	20,732,778	18,804,951	10.25 %	17,471,628	144,088,330	133,985,272	7.54 %	127,190,061
3	LONG TERM CARE	1,494,885	1,491,919	0.20 %	1,383,219	10,373,963	10,443,433	(0.67) %	9,074,143
4	TOTAL PATIENT SERVICE REVENUE	25,295,935	23,794,898	6.31 %	22,165,619	178,374,197	167,748,895	6.33 %	157,295,010
	DEDUCTIONS FROM REVENUE								
5	MEDICARE	5,861,561	5,026,867	16.60 %	5,427,698	39,844,484	35,712,718	11.57 %	38,330,061
6	MEDICAID	2,318,650	2,773,559	(16.40) %	3,076,031	19,858,310	19,704,389	0.78 %	16,990,511
7	CHARITY CARE	98,692	238,677	(58.65) %	66,623	2,820,539	1,695,645	66.34 %	1,496,500
8	COMMERICAL AND ADMIN	2,513,858	2,439,016	3.07 %	1,894,675	18,246,960	17,327,672	5.31 %	15,790,316
9	BAD DEBT	520,131	312,317	66.54 %	290,019	2,891,298	2,218,814	30.31 %	2,311,355
10	TOTAL DEDUCTIONS	11,312,892	10,790,436	4.84 %	10,755,046	83,661,591	76,659,238	9.13 %	74,918,743
11	NET PATIENT SERVICES	13,983,043	13,004,462	7.52 %	11,410,573	94,712,606	91,089,657	3.98 %	82,376,267
12	USAC AND OTHER REVENUE	117,624	131,067	(10.26) %	80,651	797,396	917,468	(13.09) %	489,329
13	TOTAL OPERATING REVENUE	14,100,667	13,135,529	7.35 %	11,491,224	95,510,002	92,007,125	3.81 %	82,865,596
	TOTAL OPERATING EXPENSES								
14	SALARIES AND WAGES	7,238,268	6,809,228	6.30 %	6,385,338	43,630,839	43,881,689	(0.57) %	39,809,241
15	EMPLOYEE BENEFITS	3,757,164	3,345,498	12.31 %	2,574,137	20,376,091	21,589,691	(5.62) %	17,362,093
16	SUPPLIES AND DRUGS	1,525,759	1,657,457	(7.95) %	1,262,492	11,589,539	12,221,707	(5.17) %	9,928,276
17	CONTRACT STAFFING	326,570	132,069	147.27 %	178,546	2,833,191	807,310	250.94 %	1,390,304
18	PROFESSIONAL FEES	639,971	585,677	9.27 %	449,940	5,096,119	3,509,766	45.20 %	3,635,795
19	UTILITIES AND TELEPHONE	204,136	226,805	(10.00) %	193,452	1,377,784	1,461,630	(5.74) %	1,290,812
20	INSURANCE	79,080	111,593	(29.14) %	101,797	677,270	756,353	(10.46) %	665,293
21	DUES, BOOKS, AND SUBSCRIPTIONS	24,756	38,920	(36.39) %	42,062	148,390	198,137	(25.11) %	187,516
22	SOFTWARE MAINT/SUPPORT	192,393	217,796	(11.66) %	203,112	1,378,615	1,307,194	5.46 %	1,134,152
23	TRAVEL, MEETINGS AND EDUCATION	125,240	122,050	2.61 %	87,577	445,565	696,649	(36.04) %	437,236
24	REPAIRS AND MAINTENANCE	123,687	207,493	(40.39) %	229,411	1,150,999	1,478,387	(22.14) %	1,406,365
25	LEASES AND RENTALS	92,888	62,576	48.44 %	48,550	319,991	409,165	(21.79) %	312,931
26	OTHER (RECRUIT, ADVERT, ETC.)	170,526	214,901	(20.65) %	217,410	1,336,761	1,504,311	(11.14) %	1,255,118
27	DEPRECIATION AND AMORTIZATION	765,955	565,765	35.38 %	580,933	4,073,612	3,960,357	2.86 %	3,463,441
28	TOTAL OPERATING EXPENSES	15,266,393	14,297,828	6.77 %	12,554,757	94,434,766	93,782,346	0.70 %	82,278,573
29	**GAIN (LOSS) FROM OPERATIONS**	**(1,165,726)**	**(1,162,299)**	**0.29 %**	**(1,063,533)**	**1,075,236**	**(1,775,221)**	**(160.57) %**	**587,023**
	NON-OPERATING REVENUE								
30	GENERAL PROPERTY TAXES	68,903	43,980	56.67 %	53,291	4,123,514	4,222,112	(2.34) %	3,836,249
31	INVESTMENT INCOME	135,071	132,515	1.93 %	187,783	821,573	927,607	(11.43) %	1,043,178
32	GOVERNMENTAL SUBSIDIES	0	0	0.00 %	0	0	0	0.00 %	0
33	OTHER NON-OPERATING REVENUE	0	217	(100.00) %	0	2,043	1,516	34.74 %	1,300
34	GIFTS AND CONTRIBUTIONS	0	0	0.00 %	0	0	0	0.00 %	0
35	GAIN LOSS ON DISPOSAL	0	0	0.00 %	(35,273)	(457,203)	0	0.00 %	(35,173)
36	SPH AUXILIARY	1,454	793	83.37 %	441	5,504	5,554	(0.88) %	5,205
37	TOTAL NON-OPERATING REVENUE	205,428	177,505	15.73 %	206,242	4,495,431	5,156,789	(12.82) %	4,850,759
	NON-OPERATING EXPENSES								
38	INSURANCE								
39	SERVICE AREA BOARD	0	0	0.00 %	0	0	0	0.00 %	0
40	OTHER DIRECT EXPENSE	40,947	9,500	331.02 %	13,997	76,887	66,500	15.62 %	77,876
41	ADMINISTRATIVE NON-RECURRING	0	0	0.00 %	0	0	0	0.00 %	0
42	INTEREST EXPENSE	62,010	60,786	2.01 %	46,964	507,687	425,501	19.32 %	348,648
43	TOTAL NON-OPERATING EXPENSES	102,957	70,286	46.48 %	60,961	584,574	492,001	18.82 %	426,524
	GRANTS								
44	GRANT REVENUE	0	139,880	(100.00) %	99,419	1,006,897	979,160	2.83 %	576,622
45	GRANT EXPENSE	0	15,985	(100.00) %	3,816	18,830	111,901	(83.17) %	99,731
46	TOTAL NON-OPERATING GRANTS, NET	0	123,895	(100.00) %	95,603	988,067	867,259	13.93 %	476,891
47	TOTAL INCOME (LOSS) BEFORE TRANSFERS	(1,063,255)	(931,185)	14.18 %	(822,649)	5,974,160	3,756,826	59.02 %	5,488,149
48	OPERATING TRANSFERS	0	0	0.00 %	0	0	0	0.00 %	0
49	**NET INCOME**	**(1,063,255)**	**(931,185)**	**14.18 %**	**(822,649)**	**5,974,160**	**3,756,826**	**59.02 %**	**5,488,149**

DRAFT-UNAUDITED

Statement of Cash Flows
As of January 31, 2026

	Cash Flow from Operations:	
1	YTD Net Income	5,974,160
2	Add: Depreciation & Pension Expense	5,282,973
3	Adj: Inventory (increase) / decrease	(234,398)
4	Patient Receivable (increase) / decrease	(10,162,611)
5	Prepaid Expenses (increase) / decrease	(683,468)
6	Other Current assets (increase) / decrease	(432,523)
7	Accounts payable increase / (decrease)	963,515
8	Accrued Salaries increase / (decrease)	(600,749)
9	Net Pension Asset (increase) / decrease	-
10	Other current liability increase / (decrease)	(222,702)
11	Net Cash Flow from Operations	(115,803)
	Cash Flow from Investing:	
12	Cash paid for the purchase of property/equip	(1,360,534)
13	Cash transferred to plant replacement fund	
14	Proceeds from disposal of equipment	(457,203)
15	Net Cash Flow from Investing	(1,817,737)
	Cash Flow from Financing	
16	Cash (paid) / received for Lease Payable	(1,325,962)
17	Cash paid for Debt Service	(118,959)
18	Net Cash from Financing	(1,444,921)
19	Net increase (decrease) in Cash	$ (3,378,461)
20	Beginning Cash as of July 1, 2025	$ 45,726,027
21	Ending Cash as of Jan 31, 2025	$ 42,347,566



	SUBJECT: Infection Prevention Plan	POLICY # HW-269
		Page 1 of 11
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Infection Prevention, Administration		**ORIGINAL DATE:** 10/1/08 **REVISED:** 6/24/11; 9/24/14; 1/27/17; 7/13/20; 5/28/22; 9/27/23; 12/18/24; 4/30/25
APPROVED BY: Infection Prevention RN, Chief Nursing Officer, Infection Prevention Medical Director, Chief Medical Officer; Infection Prevention Committee; Board of Directors		**EFFECTIVE:** 4/30/25

Table of Contents

I. Missions, Vision, Values: 1
II. Background: 2
III. Goals: 2
IV. Program Objectives: 3
V. Program Authority and Responsibility 3
VI. Infection Prevention Committee (IPC) 4
VII. Scope and Description of Services 6
VIII. Organization and Staffing of the Infection Prevention Program (IPP) 6
IX. Resources 7
X. Infection Prevention Surveillance Activities 7
XI. Recording and Reporting Infections 8
XII. Evaluation of Data 8
XIII. Confidentiality 9
XIV. Infection Prevention Policies and Procedures 9
XV. Annual Reappraisal 9

PURPOSE:

Program components and outline for the South Peninsula Hospital (SPH) Infection Prevention Plan in accordance with federal, state, and local regulatory guidelines and requirements, including:

- Defining the Infection Prevention Program, its goals, objectives, authority, and responsibilities
- Outlining the processes used to determine and evaluate Healthcare-Associated Infections (HAIs)
- Determination of HAIs, type of surveillance used, data source, patient sources, and reporting of analysis
- Identification of process improvement opportunities, plan intervention activities, implementation of action plans, and evaluation of plans for effectiveness.
- Integration of the Infection Prevention Program into all disciplines, services, and settings throughout the South Peninsula Hospital organization and Long Term Care. (See Long Term Care Infection Prevention Plan for more details).

DEFINITION(S):

N/A

POLICY:

I. Missions, Vision, Values:

The foundation of the SPH Infection Prevention Plan is the organization's mission, vision, values, and associated behaviors:

Mission: SPH promote community health and wellness by providing personalized, high quality, locally coordinated healthcare.

Vision: SPH is the healthcare provider of choice with a dynamic and dedicated team committed to service excellence and safety.
Values & associated behaviors**:** (See Attachment A – 'Our Values in Action' for additional details)
Compassion**:** We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.
Respect**:** We show respect for the dignity, beliefs, perspectives, and abilities of everyone.
Trust**:** We are open, honest, fair, and trustworthy.
Teamwork**:** We work together as a dynamic, collaborative team, embracing change, and speaking as one.
Commitment**:** We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.

II. Background:

- The Infection Prevention Program provides a plan of action designed to identify infections that occur in patients, residents, healthcare workers, visitors, and others in the healthcare environment in coordination with Employee Health (EH) that have the potential for disease transmission and recommends risk reduction practices by integrating principles of infection prevention into all direct and indirect standards of practice.
- Infection Prevention services are provided by Infection Prevention/Employee Health/Quality Director/Chief Nursing Officer 8 hours a day, 5 days per week, with phone access to the Infection Prevention Physician 24/7, in accordance with our Values and Behaviors.
- The Infection Prevention Program has been established to define a realistic framework that contributes to organizational effectiveness through the identification of risk and risk reduction methods. This support will influence and improve the quality of healthcare in the facility by preventing disease transmission using evidence-based, cost-effective, epidemiological approach to patient care.
- The SPH Organization is committed to preventing adverse outcomes such as HAIs and their sequelae, to improve patient care by supporting the staff in all areas of the facility when appropriate, to minimize occupational hazards associated with the delivery of healthcare, and to foster scientifically based decision making.
- The Infection Prevention Program is a multidisciplinary, systematic approach to quality patient care that emphasizes risk reduction of disease transmission of the hospital environment by using sound epidemiological principles. This Infection Prevention Plan is a plan of action to prevent disease transmission when possible, monitor its occurrence, and initiate measures to minimize the impact in those cases that cannot be prevented.
- The goals are accomplished by setting preventions or standards that have proven effective in decreasing infections that cannot be prevented, preventing those that can be, and providing early diagnosis and appropriate treatment of all infections. These Preventions include hospital policies and procedures and departmental protocols. The effectiveness is achieved by integrating principles of infection prevention within each of the hospital's department's standards.
- As standards are reviewed, measures are taken to identify practices that follow infection prevention standards and evaluate them for effectiveness.
- The Infection Prevention Program at the SPH Organization is coordinated by the Infection Prevention Committee and is in compliance with all regulatory agencies.

III. Goals:

The primary goal of the Infection Prevention Program (IPP) is to reduce the risk of acquisition and transmission of HAIs at the SPH Organization. In order to accomplish this goal, the hospital will:

- Incorporate the Infection Prevention Program as a major component of its safety and performance improvement programs
- Perform ongoing assessments to identify its risks for the acquisition and transmission of infectious

agents

- Use an epidemiological approach that consists of surveillance, data collection, and trend identification
- Effectively implement infection prevention/control processes
- Educate and collaborate with organization-wide leaders to effectively participate in design and implementation of the IPP
- Integrate its infection prevention efforts with healthcare and community leaders to the extent practical, recognizing that infection prevention and control is a community wide effort
- Plan for its response to infections that could potentially overwhelm its resources
- Communicate to physicians, employees, students, trainees, volunteers, subcontractors, construction workers, and as appropriate, visitors, residents, and patients about infection prevention and control issues, including their responsibilities in preventing the spread of infection within the hospital
- In the event of an infectious disease outbreak, provide liaison activities with facility management in order that decisions may be made regarding temporary halting of services, to limiting visitors within the facility, to fully activate the organization's Emergency Operations Plan
- Provide documentation of recognition and compliance with appropriate regulatory and accrediting agencies
- Report appropriate information to the organization and public health agencies

IV. Program Objectives:

1. To prevent or limit unprotected exposure to pathogens organization wide.~~within the hospital.~~
2. To recommend methods for early identification and appropriate therapy when infections are considered inevitable.
3. To recommend practice oriented towards preventing introduction of infection into the facility and/or containing the spread of infection if it is introduced.
4. To mitigate the unintended consequences of antimicrobial use (resistance, morbidity & mortality, cost).
5. To systematically identify and minimize the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
6. To incorporate the CDC Recommendations for Prevention of HAIs into policy and practice within the facility as they relate to:
   - Ventilator Associated Pneumonia
   - Central Line Associated Bloodstream Infections
   - Catheter Associated Urinary Tract Infections
   - Surgical Site Infections (Inpatient)
     - To implement practices that decrease the risk of transmission of microorganisms within the organization, such as ensuring effective hand hygiene practices throughout the facility.
7. To support EH, quality improvement, risk management, safety, and utilization management efforts, using epidemiological and scientific methodologies.
8. To facilitate compliance with reporting requirements in coordination with EH of the hospital to the various public health officials/agencies via SPH Laboratory Department.

V. Program Authority and Responsibility

A. The IPP receives dual authority and responsibility based on function and anticipated outcome.
B. The Infection Prevention Physician Liaison is responsible for the medical direction and decisions as indicated. Their credentials will show evidence of knowledge and special interest in Infection Prevention. They serve as an advisor and consultant to the Infection Prevention Nurse and Employee Health Nurse. They are also responsible for the review, analysis, and presentation of infection reports and policies to the Medical Staff. They provide guidance, clinical expertise in the assessment and evaluation of the infection prevention measures and activities throughout the health system.
C. The Infection Prevention Nurse (IP RN) is a registered nurse who has documented evidence of

education, training, and experience related to surveillance, prevention, and control of infections and is responsible for:

1. Coordinating all infection prevention and control within the SPH Organization. Facilitating ongoing monitoring and the effectiveness of prevention and/or control activities and interventions.
2. Implementing policies governing asepsis and infection prevention.
3. Developing a system for identifying, investigating, reporting, and preventing the spread of infections and communicable diseases among patients and healthcare workers.
4. Identifying, investigating, and reporting infection and outbreak of communicable diseases among patients, residents, and patient care staff in coordination with EH.
5. Preventing and controlling the spread of infections and communicable diseases among patients, residents, and staff.
6. Cooperating with hospital-wide orientation and in-service education programs.
7. Cooperating with other departments and services in the performance of quality assurance activities.
8. Cooperating with disease prevention activities of the local health authority.
9. Maintaining a log of incidents related to infections and communicable diseases for patients.
10. Collaborating and investigating information from the log of incidents related to infections and communicable diseases for employees, contract workers, and volunteers received from EH.
11. Preparing budget proposal to support general program activities that support data collection, evaluation, reporting, and follow-up as directed annually by the IPC.

D. Statement of Authority

The Infection Prevention Committee (IPC) shall be responsible for developing and monitoring the hospital Infection Prevention Program for the SPH Organization. The Physician Liaison of the IPC or their designee* is authorized by the Governing Board and Medical Staff to institute any surveillance, prevention, and appropriate prevention measures or studies, and to recommend corrective action organization wide~~within any department~~, when there is a reason to believe that any patient, personnel, resident, or visitor may be in danger. When any of these actions are taken the patient's attending physician will be notified.

The IPC has the ultimate authority in the event that there is a question or disagreement in relation to Infection Prevention policy or procedure.

**The designee is defined as the Infection Prevention Nurse (IP RN). In the absence of the IP RN, the IP RN, with the approval of the Infection Prevention Physician and Chief Nursing Officer, will appoint a representative from the Nursing Department.*

VI. Infection Prevention Committee (IPC)

A. The IPC reports to the Quality Management committee, and the Governing Body. It is a multidisciplinary committee from all relevant departments and services. The composition of the committee shall be as follows:

- Infection Prevention Physician
- Infection Prevention Nurse
- Medical Staff Representation
- Senior Administration as needed
- Nursing Administration
- Employee Health Nurse
- Acute Care Nurse/Manager
- Emergency Department Manager
- Laboratory (Microbiology)
- Environmental Services (EVS~~, Laundry~~)
- Pharmacy
- Surgical Services
- Engineering/Safety
- ~~Food~~ Nutrition Services

- Long Term Care
- Home Health
- Outpatient Clinics
- Imaging
- Education
- Quality Management
- Risk Managment
- Childcare Center
- Any clinical area on an as-needed liaison basis

B. The IPC is responsible to:

1. Establish guidelines/policies for the function and scope of the prevention, control, and surveillance of infection.

~~2.~~

~~3.~~2. Integrate findings with the Quality Management Department to collate, trend, analyze, and disseminate data to departments/areas of concern or interest.

~~4.~~3. Assess the overall success or failure of key processes for preventing and controlling infection.

~~5.~~4. Assess the adequacy of the human, information, physical, and financial resources allocated to support the IPP.

~~6.~~5. Review and revise the IPP at least annually and as needed based upon identified risks.

~~7.~~6. Facilitate annual education/training of Infection Prevention/Employee Health to all staff.

C. The IPC shall meet quarterly or as necessary to conduct business and shall review the following data in assessing the effectiveness of the IPP:

1. Surveillance and Infection Prevention Data
    - Policies governing asepsis and Infection Prevention
    - QI reports
    - Outbreak investigations
    - Results of environmental tours
    - Employee vaccination rates
    - Preventing and controlling the spread of infection and communicable diseases among patients and staff, in coordination with EH.
2. Patient Safety
    - Compliance with Hand Hygiene Guidelines
    - Identification and reporting of any deaths due to HAIs
3. Coordination with Other Programs, Services, Agencies
    - Cooperating with hospital-wide orientation and in-service education programs
    - Environmental Services
    - Microbiology
    - Sterile Processing Department
    - Pharmacy Intervention
    - City/County Health Notifiable Conditions
    - Emergency Preparedness
4. Management of the Environment of Care
    - Maintenance reports of ventilation equipment to provide appropriate air exchanges.
5. Evaluate all new or proposed disinfecting and sterilization materials and procedures.

D. The IPC shall report its findings and recommendations to the Board of Directors and Medical Staff through the Chief Nursing Officer. Written minutes of all committee meetings will be maintained and be made available upon request. Pertinent findings of the IPC shall be a part of the hospital's continuing education program, including the New Employee Orientation Program, which is reviewed/updated annually.

E. Dissemination of Infection Prevention information is crucial. Both surveillance data and policy decisions will be communicated throughout the organization. This is accomplished through routine QI reports to

specific department directors for review. This information is then communicated to the appropriate staff members. Routine reports to specific departments will be presented to the department manager for their review and communicated as appropriate to staff members.

F. In the event that an issue should arise that requires decision and action between meetings, the IP RN will communicate with the Infection Prevention Physician. Any action required will be under the authority of the Infection Prevention Physician and implemented by the IP RN.

VII. Scope and Description of Services

A. The design and scope of the IPP will be based on the level of risk identified by the SPH Organization and are appropriate to the geographic location, the volume of patients encountered, the patients populations served, the clinical focus, and number of employees and residents.

B. SPH is a 22-bed Critical Access Hospital, and 28 bed Long Term Care Facility providing both inpatient and outpatient health services and Skilled Nursing services to the South Peninsula area. The hospital is a full service hospital that services adult and pediatric patients. The hospital offers many specialized services in addition to 24-hour emergency services, intensive care (ICU), medical & surgical services, maternal-child services, and rehabilitation and Skilled Nursing Facility services. Ambulatory clinics/services include:

- South Peninsula's Physical and Occupational Therapy Centers
- Emergency Services
- Home Health Program
- Laboratory
- Imaging
- Infusion Clinic
- Homer Medical Center
- Family Care Clinic
- Specialty/Surgical Clinic
- Plastic Surgery Clinic
- Daycare
- Long Term Care

C. The Infection Prevention Nurse (IP RN), Employee Health Nurse (EH RN), Quality Director, Chief Nursing Officer (CNO) have responsibility for the implementation of this Plan in all listed areas as deemed appropriate and epidemiologically significant.

VIII. Organization and Staffing of the Infection Prevention Program (IPP)

A. The Infection Prevention Department is under the supervision of the Infection Prevention Committee, Chief Nursing Officer, and Infection Prevention Physician.

B. Based on the needs of the facility and related services, 1.0 FTE has been allotted to coordinate the Infection Prevention. The number of FTEs allotted to each program is related to the needs of the patients/employees and not solely on the bed size or number of patients served. During off hours, the Nursing Supervisor/Charge RN are available for consult in the absence of the IP RN N

POSITION	HOURS	CODE
Infection Prevention RN	flexible	1.0 Full Time

C. The IP RN participates on the following committees and task forces:

i. SPH
  - Infection Prevention Committee
  - Product Review Committee (including Sharps)
  - Patient Centered Care Quality Committee
  - Hospital Incident Management Team
  - LTC Quality Assurance and Performance Improvement (QAPI)

ii. Community
  - Disaster Plan Committee

- MAPP (Mobilizing for Action through Planning and Partnerships)

IX. Resources

A. Information Management Systems available include:
- Laboratory Data Bank
- Personal Computers with Internet Access
- List Servers from CDC, APIC (Association for Professionals in Infection Control and Epidemiology), Joint Commission, Alaska Department of Health and Social Services, AOHP (Association of Occupational Health Professionals in Healthcare)

B. Support Services include:
- Laboratory support to provide reports for surveillance and employee exposures.
- Pharmacy support in review of data for trending, assessment, intervention, and evaluation of action plans.
- Data collection support from other department managers.
- Public Health Department and the Alaska Department of State Health Services provide consultative services.
- Environmental Services will recommend the specific solutions for organization-wide cleaning and disinfection purposes. It will be supplied by the department with specific instructions for its use, as well as stated in the department policy.

X. Infection Prevention Surveillance Activities

A. Utilizing a targeted methodology, the SPH Organization's surveillance measures include the following indicators:
1. Outbreak Investigations
2. Prevalence surveillance with multidrug resistant or especially virulent organisms and coordinates with Pharmacy Antibiotic Stewardship.
3. Identification and reporting of diseases/infections designated as reportable by the CDC, Alaska Department of Health and other regulatory agencies.
4. Surgical Site Infections –
   - Outpatient / inpatient – Surgical patients readmitted for infection within 30 days or 90 days diagnosis specific per CDC of a surgical procedure via post op SSI (surgical site surveillance) letters to surgeons
   - Surgical staff performs post-op follow up calls and reports to Infection Prevention (IP) any signs or symptoms of infection for further investigation
5. Acid-Fast Bacillus/Tuberculosis (AFB/TB) Isolation Protocols
6. Employee Health (EH) to report to Infection Prevention:
   - Employee tuberculosis (TB) exposures, evaluation and follow up
   - Employee blood borne pathogen exposures
7. Selected Healthcare-Associated Infections (HAI)
   - Central Line Associated Blood Stream Infection (CLABSI)
   - Ventilator-Associated Pneumonias (VAP) – ICU
   - Catheter-Associated Urinary Tract Infection (CAUTI)
8. Environmental Surveillance
   - Construction Compliance Rounds in coordination with Support Services
   - Ventilation air quality report from Support Services and Surgery Department Log
   - Terminal cleaning procedures in coordination with Environmental Services
9. Patient Safety
   - Sterilization processes in coordination with Surgical Services
     - Positive biological indicators

        - Flash sterilization usage
    - Refrigerator/freezer quality control
    - Hand hygiene compliance
10. Healthcare-Associated Infections related to unexpected death or permanent loss of function (Sentinel Events)

XI. Recording and Reporting Infections

A. Data Collection Methods
1. Retrospective data – Review of patient records to determine healthcare-acquired vs. community-acquired infections.
2. Prospective data – Review of patient records from onset to discharge.
3. Surveillance rounds – Rounds of various areas to monitor selected quality prevention issues, procedural implementation, and employee knowledge of processes.
4. Quality Prevention data – Reports from other departments relating to Infection Prevention issues.

B. Sources of Data
1. Daily census reports
2. Emergency Department records
3. Microbiological reports
4. Serological reports
5. Isolation Reports
6. Occurrence reports
7. Pharmacy reports
8. Initial Tuberculosis (TB) assessment reports
9. Multidrug resistant organism (MDRO) surveillance admission reports
10. Mortality reviews
11. Chart reviews
12. Surveillance round reports on the patient care units to identify problems
13. Employee Health alerts and reports related to increased call-ins for infectious conditions
14. Reports from support departments regarding suspicious signs and symptoms of infection
15. Nursing staff reports
16. Physician consultations
17. Physician/Surgeon feedback

XII. Evaluation of Data

A. The Infection Prevention Nurse will be responsible for trending the data collected and presenting such to the Infection Prevention Physician and Infection Prevention Committee for further evaluation of findings that exceed the threshold.

B. If at any point in the evaluation process a problem has been identified, the Infection Prevention Nurse will consult with the Infection Prevention Physician to develop a plan of action. Action plans will include recommendations, actions taken, and conclusions, with follow-up and re-evaluation noted. Assessment of all corrective actions will be conducted continuously following implementation. Conclusions will be developed after corrective actions have been in place long enough to result change. Follow-up will continue for a sufficient period of time to ensure resolution. Plans, updates, and results will be reported to the Infection Prevention Committee.

C. The hospital Performance Improvement Model is utilized for monitoring and evaluation of the program. The following ten steps are utilized in the Quality Improvement Program for Infection Prevention:
1. Assign responsibility
2. Delineate scope of care
3. Identify important aspects of care
4. Identify indicators
5. Establish thresholds for evaluation
6. Collect and organize data

7. Evaluate care
8. Take actions to solve identified problems
9. Assess actions and document improvement
10. Communicate relevant information to organization-wide quality improvement

XIII. Confidentiality

All activities including minutes, reports, and worksheets shall be held in strictest confidences and safeguarded against unauthorized disclosure.

XIV. Infection Prevention Policies and Procedures

A. There are written policies and procedures for infection surveillance, prevention, and control for all patient care departments/services, which include but are not limited to the following:
- Nursing units
- Central Sterile Processing
- Food Services
- Laundry
- Pharmacy
- Physical Therapy
- Imaging
- Surgical Services
- Employee health
- Environmental Services
- Long Term Care Facility

B. The written policies and procedures are made known to employees performing patient care procedures that are associated with the potential for infection. The Infection Prevention and/or Employee Health Nurse introduces general orientation to new employees at New Employee Orientation. Each Manager is responsible for department specific training of their staff to pertinent Infection Prevention Policies and Procedures in collaboration with the Infection Prevention Nurse. Infection Prevention Policies will be reviewed and/or revised and approved by the Infection Prevention Committee at least annually.

XV. Annual Reappraisal

A. The Infection Prevention Program will be evaluated at least annually to determine the effectiveness of prevention and control intervention strategies in reducing healthcare–acquired infection risk. The goals will be revised at least annually to reflect the type and scope of surveillance activities based on data analysis, services/procedures added, and/or problems identified during the last year. The evaluation will include at least the following elements:
- Changes in the scope of services
- Changes in the results of the Infection Prevention risk analysis
- Emerging and reemerging problems in the healthcare community that potentially affect the hospital
- An assessment of the success or failure of interventions for preventing and controlling infections
- Responses to concerns raised by leadership and others within the hospital
- The evolution of relevant infection prevention and control guidelines that are based on evidence, or in the absence of evidence, expert consensus

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):

1. South Peninsula Hospital Long Term Care Facility Infection Prevention Plan

CONTRIBUTOR(S):
Infection Prevention RN; Employee Health RN; Chief Nursing Officer; Infection Prevention Medical Director; Infection Prevention Committee

Attachment A:

Our Values in Action

COMPASSION IS:

- I place patient and resident needs first.
- I use safe work practices.
- I am willing to help all individuals.
- I have time for you.
- I show empathy.
- I behave in a caring manner.

COMPASSION IS NOT:

- I treat you as a burden.
- I look the other way.
- I am too busy.
- I act as if I don't care.
- I can't help you.

RESPECT IS:

- I respect diversity and individual beliefs.
- I am kind and polite.
- I am considerate of your needs.
- I value your input.
- I treat you as an equal.
- I respect privacy and confidentiality.

RESPECT IS NOT:

- I bully and intimidate.
- I raise my voice and curse.
- I shame and embarrass others.
- I am divisive and judgmental.
- I manipulate and undermine.
- I ignore you.

TRUST IS:

- I build trust with what I say and do.
- I communicate in an open and timely manner.
- I listen to what you say and ensure that I understand.
- I am fair and consistent in the actions I take.
- I follow up and provide feedback.
- I act with integrity.
- I responsibly report risks, hazards and errors.
- I apologize and admit when I am wrong.

TRUST IS NOT:

- I say one thing and do another.
- I gossip and spread rumors.
- I withhold information and conceal mistakes.
- I undermine the chain of command.
- I discuss issues outside appropriate channels.
- I draw conclusions before facts are known.
- I cause or tolerate retribution to the reporting of harm or near misses.

TEAMWORK IS:

- I embrace change and engage in process improvement.
- I adapt to changing circumstances.
- I actively participate in teamwork and seek out ways to help the team.
- I support the team's decisions.
- I recognize and acknowledge contributions and achievements.
- I invite and accept constructive feedback.

TEAMWORK IS NOT:

- I exclude others.
- "It's not my job/responsibility."
- I resist change.
- I disregard team decisions.
- I do not follow established processes.
- I am not cooperative.
- I complain without offering a solution or recommendation.

COMMITMENT IS:

- I represent my organization's best interests with a positive attitude.
- I exemplify expected behaviors.
- I am responsible and accountable.
- I hold others accountable in a fair and consistent manner.
- I adhere to the organization's policies and best practices.
- I prioritize and accomplish my work with a sense of urgency.
- I am a good steward of resources.

COMMITMENT IS NOT:

- I compromise the quality, safety and reputation of my organization.
- I act inappropriately.
- I delay or fail to hold myself or others accountable.
- I avoid review of my performance.
- I am defensive and make excuses.
- I blame others.
- I disregard policies and procedures.

South Peninsula Hospital

2026 Infection Prevention Risk Assessment

INFECTION EVENT	PROBABILITY OF OCCURRENCE (How likely is this to occur?)				LEVEL OF HARM FROM EVENT (What would be the most likely?)				IMPACT ON CARE (Will new treatment/care be needed for patient/staff?)				READINESS TO PREVENT (Are processes/resources in place to identify/address this event?)			RISK LEVEL (Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	High	Med.	Low	None	Serious Harm	Moderate Harm	Temp. Harm	None	High	Med.	Low	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
Device- or care-related																
Catheter-associated urinary tract infection (CAUTI)		2				2			3						1	8
Ventilator associated pneumonia			1		3				3						1	8
Vascular catheter-related infection (CLABSI)			1		3				3						1	8
Surgical site infection (SSI)			1		3				3						1	8
Equipment-related infections			1			2			3						1	7
Patient-related																
Hospital-aquired pneumonia			1			2			3						1	7
Clostridioides difficile infection (C.Diff)			1			2			3						1	7
Tuberculosis*			1			2			3						1	7
VRE			1				1		3						1	6
MRSA			1				1		3						1	6
Outbreak-related																
Influenza*			1			2					1					4
Other viral respiratory pathogens* (RSV, COVID-19)			1			2					1				1	5
Norovirus gastroenteritis*			1			2					1				1	5
Bacterial gastroenteritis (e.g.,*Salmonella, Shigella*)			1			2					1				1	5
GAS & GBS invasive disease			1			2					1				1	5
MDRO			1			2			3						1	7
Bioterrisom Agents			1		3				3				3			10
Community Infectious Diseases			1			2					1				1	5
Other: ___________																0

* Risk assessment should take into account the frequency of this disease in the community as part of determining probability of occurrence. Data from State/local health department may be informative.

South Peninsula Hospital

2026 Infection Prevention Risk Assessment

IPC PRACTICE FAILURES	PROBABILITY OF OCCURRENCE (How likely is this to occur?)				IMPACT ON PATIENT/STAFF SAFETY (Will this failure directly impact safety?)				CAPACITY TO DETECT (Are processes in place to identify this failure?)			READINESS TO PREVENT (Are policies, procedures, and resources available to address this failure?)			RISK LEVEL (Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	High	Med.	Low	None	High	Med.	Low	None	Poor	Fair	Good	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	3	2	1	
Care activity															
Lack of accessible alcohol-based hand rub			1		3						1			1	6
Lack of accessible personal protective equipment (PPE)			1		3						1			1	6
Inappropriate selection and use of PPE			1		3						1			1	6
Inadequate staff adherence to hand hygiene			1		3					2				1	7
Lack of appropriate Isolation Precautions			1		3					2				1	7
Non-compliance with sharps safety			1		3						1			1	6
Occupational health															
Low influenza immunization rates among staff		2				2					1			1	6
Lack of notification of employee illness		2				2					1			1	6
Lack of annual employee Fit Testing (N95)			1		3						1			1	6
Low compliance with tuberculosis (TB) screening among staff (when required)			1			2					1			1	5
Lack of compliance with Bloodborne Pathogen Exposure Plan			1				1				1			1	4
Patient/visitor health															
Low rate of patient acceptance of influenza immunization		2				2					1			1	6
Visitors entering facility when ill		2			3						1			1	7
Environment															
Lack of access to EPA-registered products for routine cleaning and disinfection			1			2					1			1	5
Inadequate cleaning and disinfection of high touch surfaces and terminal cleaning			1			2					1			1	5
Infection from inadequate air handling or related to construction/renovation			1		3						1			1	6
Medical Devices and Equipment															
Inappropriate sharing of devices labeled for single-patient use			1		3					2				1	7
Improper handling of medications and injection equipment (e.g., reuse of syringes)			1		3					2				1	7
Improper cleaning and disinfection of point-of-care devices and shared equipment			1		3					2				1	7
Antibiotic Stewardship															
Lack of leadership support for antibiotic stewardship			1			2					1			1	5
Inadequate written policies guiding antibiotic use			1			2					1			1	5
Unable to obtain report summarizing antibiotic resistance patterns (e.g., antibiogram)			1			2					1			1	5
Other (specify):______________															0

IPC PRACTICE FAILURES	PROBABILITY OF OCCURRENCE				IMPACT ON RESIDENT/STAFF SAFETY				CAPACITY TO DETECT			READINESS TO PREVENT			RISK LEVEL
	(How likely is this to occur?)				(Will this failure directly impact safety?)				(Are processes in place to identify this failure?)			(Are policies, procedures, and resources available to address this failure?)			(Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	High	Med.	Low	None	High	Med.	Low	None	Poor	Fair	Good	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	3	2	1	
Care activity															
Lack of accessible alcohol-based hand rub			1		3						1			1	6
Lack of accessible personal protective equipment (PPE)			1		3						1			1	6
Inappropriate selection and use of PPE			1		3						1			1	6
Inadequate staff adherence to hand hygiene			1		3						1			1	6
Inadequate staff adherence to glove and gown use when resident in Contact Precautions			1		3						1			1	6
Inadequate staff adherence to facemask use when resident in Droplet Precautions			1			2					1			1	5
Other (specify): Inadequate staff adherence to glove and gown use when resident in Enhanced Barrier Precautions		~~2~~	1			2					1			1	~~6~~5
Other (specify):________________															
Occupational health															
Low influenza immunization rates among staff		2			3						1			1	7
Lack of notification of employee illness or working sick			1		3						1			1	6
Low compliance with ~~annual~~ tuberculosis (TB) screening among staff			1			2					1			1	5
Other (specify):________________															
Resident/visitor health															
Low rates of TB screening among new resident admissions			1			2					1			1	5
Low rate of resident acceptance of influenza immunization			1		3						1			1	6
Low rate of resident acceptance of pneumococcal			1		3						1			1	6
Visitors entering facility when ill			1		3						1			1	6
Lack of notification to visitors during facility outbreaks			1				1				1			1	4
Inadequate resident/visitor education on facility hand hygiene policies			1		3						1			1	6
Inadequate resident/visitor education on facility respiratory etiquette			1			2					1			1	5
Other (specify):________________															
Environment															
Lack of access to U.S. Environmental Protection Agency (EPA)-registered products for routine cleaning and disinfection			1		3						1			1	6
Lack of access to EPA-registered products with sporicidal activity for cleaning and disinfection (e.g., for *C. difficile)*			1		3						1			1	6
Inadequate cleaning and disinfection of high touch surfaces in resident room			1			2					1			1	5
Inadequate terminal cleaning and disinfection of resident rooms			1			2					1			1	5
Inadequate cleaning and disinfection of resident common areas			1		3						1			1	6
Other (specify):________________															
Medical Devices and Equipment															
Improper handling of medications and injection equipment (e.g., reuse of syringes)			1			2					1			1	5
Lack of access to single- use, auto-disabling fingerstick devices			1			2					1			1	5
Inappropriate sharing of devices labeled for single-patient use			1			2					1			1	5

Improper cleaning and disinfection of point-of-care devices (e.g., blood glucose meter) between residents			1			2					1			1	5
Improper cleaning and disinfection of shared equipment (e.g., blood pressure cuff) between residents			1			2					1			1	5
Lack of separation between clean supplies and dirty/contaminated medical supplies			1			2					1			1	5
Improper storage and/or transport of linen			1				1				1			1	4
Other (specify):________________															
Antibiotic Stewardship															
Lack of leadership support for antibiotic stewardship			1				1				1			1	4
Inadequate written policies guiding antibiotic use			1				1				1			1	4
Unable to obtain antibiotic usage report from pharmacy			1				1				1			1	4
Unable to obtain report summarizing antibiotic resistance patterns (e.g., antibiogram)			1				1				1			1	4
Other (specify):________________															

Approved by BOD: 4/30/25

Adapted from https://spice.unc.edu/resources/template-risk-assessment-for-ltc/

South Peninsula Hospital
Hospital Board of Directors Balanced Scorecard Report
2nd Quarter FY 2026 *(October, November, December)*

Overall Indicators	Q2 FY26	Target	Note
Care Compare Overall Hospital Star Rating	N/A	5	Mortality, Safety of Care, Readmission, Patient Experience, Timely & Effective Care
Care Compare Overall Nursing Home Star Rating	5	5	Staffing, Health Inspections, Quality Measures
Care Compare Home Health Quality Rating	3	5	Activities of Daily Living, Symptoms, Harm, Hospitalization, Value of Care

Clinical & Service Excellence

Using evidence-based practices, South Peninsula Hospital is dedicated to achieving consistent and demonstrated excellence in clinical quality and safety.

Quality of Care / Patient Safety	Q2 FY26	Target	Note
Severe Sepsis & Septic Shock Care	100%	> 75%	*CMS Hospital Compare: 70%*
Percentage *of patients who received appropriate care for sepsis and/or septic shock.*			Passed 7 of 7 cases
Stroke Care	100%	> 75%	*CMS Hospital Compare: Not Available*
Percentage of patients who receive CT/MRI within 45 minutes of arrival to ED w/stroke symptoms.			1 CMS reportable stroke; 4 Excluded cases
Median Emergency Room Time	133	< 180min	*CMS Hospital Compare: 134 min*
Average minutes spent in department before leaving the Emergency Department.			Average throughput time of ED visits (CMS allows for certain exclusions).
ER Admission Rate	7.81%		
Measures the percentage of ER patients admitted.			1292 visits, 101 admits
Colonoscopy Follow-up	100%	> 75%	*CMS Hospital Compare: 100%*
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy.			
Patient Fall Rate (AC)	3.04	< 5	**# of patient falls / # patient days x 1000**
Measures the number of patient falls per 1,000 patient days.			3 falls, none with injury
Medication Errors	0	0	
Number of patient medication errors that cause harm. *(Level E on the NCC MERP Index)*			*(Tracking through occurrence reporting system.)*
Never Events	0	0	
Unexpected occurrence involving serious injury or death.			

Independent Ambulation (HH)	**77%**	**> 75%**	
Percentage of home health patients demonstrating improvement with ability to ambulate more independently.			*(Tracked through OASIS Reporting.) No patients worsened.*
Independent Oral Medication (HH)	**67%**	**> 75%**	
Percentage of home health patients demonstrating improvement with ability to take oral medications more independently.			*(Tracked through OASIS Reporting.)* 100% improved or unchanged
Pressure Ulcers (LTC)	**0**	**< 3**	
Number of residents who develop pressure ulcers after admission.			*(Tracked through Minimum Data Set Reporting.)*
Primary Care MIPS Pathways	**TBD**	**> 75%**	**Working to merge CPSI and Epic data and finalize. Scoring tabulated as a running, annual score.**
CMS Merit-Based Incentive Payment System *(MIPS)* for outpatient clinics.			Special focuses: cervical cancer screening, specialist referrals, high blood pressure, hemoglobin A1c, medication reconciliation, fall risk

Patient & Resident Experience

Patient Satisfaction Through Press Ganey (PG)	Q2 FY26	Target	
Inpatient Percentile	**99th**	**75th**	9 or 10 best hospital/definitely recommend; Survey Responses: 33
Measures the overall satisfaction of inpatient pts. respondents.			Q1 FY26 94th: Q4 FY25 63rd: Q3 FY25 90th: Q2 FY25 69th
Outpatient Percentile	**27th**	**75th**	Mean Score: 94.34 Survey Responses: 489
Measures the overall satisfaction of outpatient pts. respondents.			Q1 FY26 7th: Q4 FY25 34th: Q3 FY25 31st: Q2 FY25 39th
Emergency Department Percentile	**86th**	**75th**	Mean Score: 92.46 Survey Responses: 98
Measures the overall satisfaction of emergency pts. respondents.			Q1 FY26 79th: Q4 FY25 92nd: Q3 FY25 71st: Q2 FY25 80th
Medical Practice Percentile	**37th**	**75th**	Mean Score: 93.68 Survey Responses: 330
Measures the overall satisfaction of pts. respondents at SPH Clinics.			Q1 FY26 51st: Q4 FY25 59th: Q3 FY25 55th: Q2 FY25 71st
Ambulatory Surgery (AS) Percentile	**10th**	**75th**	9 or 10 best hospital/definitely recommend; Survey Responses: 59
Measures the overall satisfaction of AS pts. respondents.			Q1 FY26 94th: Q4 FY25 25th: Q3 FY25 87th: Q2 FY25 29th
Home Health (HH) Percentile	**67th**	**75th**	9 or 10 best hospital/definitely recommend; Survey Responses: 50
Measures the overall satisfaction of HH pts. respondents.			Q1 FY26 64th: Q4 FY25 43rd: Q3 FY25 60th: Q2 FY25 25th

Medical Staff Alignment

South Peninsula Hospital desires to be an employer and/or provider of choice for medical staff practitioners by fostering an atmosphere of continuous collaboration.

Provider Alignment	2024	Target	Note
Provider Satisfaction Percentile	85th	75th	
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.			Result of provider survey 2024

Employee Engagement

South Peninsula Hospital desires to be an employer of choice that offers our staff an opportunity to make positive impact in our community.

Staff Alignment	2024	Target	Note
Employee Satisfaction Percentile	60th	75th	
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.			Result of employee survey 2024

Workforce	Q2 FY26	Target	Note
Turnover: All Employees	3.20%	< 5%	
Percentage of all employees separated from the hospital for any reason			37 Terminations / 651 Total Employees
Turnover: Voluntary All Employees	2.00%	< 4.75%	
Measures the percentage of voluntary staff separations from the hospital			30 Voluntary Terminations / 651 Total Employees
First Year Total Turnover	2.40%	< 7%	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.			8 New Staff Terminated 115 Total New Hires from 09/01/2024-09/30/2025
Contract Utilization	20	< 20	
Measure average number of contract staff utilized.			RN, CST, MLT, MRI, OT, RT

Information System Solutions	Q2 FY26	Target	Note
IT Security Awareness Training Complete Rate	**83%**	**> 95%**	
% of employees who have completed assigned security training			2053 Training videos sent; 1700 were completed.
Phishing Test Pass Rate	**94%**	**> 95%**	
% of Phishing test emails that were not failed.			3494 Test phishing emails sent; 227 links were clicked.

Financial Health

SPH is financially positioned to support our dedication to the Mission, Vision and Values, and our continued investment in our employees, medical staff, physical plant and equipment.

Financial Health	Q2 FY26	Target	Note
Operating Margin	**0%**	**-13%**	
Measures the surplus (deficit) of operating income over operating expenses as a percentage of net patient service revenue for the quarter.			Target is based on budgeted operating margin for the period.
Adjusted Patient Discharges	**872**	**841**	**Total Discharges: # 181 *(Acute, OB, Swing, ICU)***
Measures the number of patient discharges adjusted by inpatient revenues for the quarter.			Adjusted Patient Days = [Inpatient Days(Excludes Nursery)] X [Gross Patient Revenue/Gross Inpatient Revenue] Target Discharges 115
Net Revenue Growth	**14%**	**5%**	
Measures the percentage increase *(decrease)* in net patient revenue for the quarter compared to the same period in the prior year.			Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior yr.
FTE vs Budget	**596.0**	**620.98**	
FTE is calculated based on hours paid + Contract FTE			Target is based on budget
Overtime as a Percentage of Hours Worked	**3%**	**<5%**	
Measures overtime hours as a percentage of regular hours worked indicative of understaffing or schedulig inefficiencies			Target is based on industry standard

Net Days in Accounts Receivable	77	55	
Measures the rate of speed with which the hospital is paid for health care services.			Target is based on industry standard
Cash on Hand	**70**	**90**	**81 Total Days Cash on Hand, Operating +Unobligated PREF**
Measure the actual unrestricted cash on hand (excluding PREF and Service Area) that the hospital has to meet daily operating expenses.			Cash available for operations based average daily operating expenses during the quarter less depreciation for the quarter.
Uncompensated Care as a Percentage of Gross Revenue	**3%**	**2-3%**	
Measures bad debt & charity write offs as a percentage of gross patient service revenue			Target is based on industry standards & SPH Payer Mix Budgeted total is 2.4% Expected range of 2-3%
Average Age of Plant	**10.2**	**10**	
Average age of assets used to provide services			Target is based on hospital optimal age of plant for a critical access hospital
Intense Market Focus to Expand Market Share	**Q2 FY26**	**Target**	**Note**
Outpatient Revenue Growth	**17%**	**4%**	
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.			Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period prior yr.
Surgical Case Growth	**-4%**	**5%**	
Measures the increase *(decrease)* in surgical cases for the quarter compared to the same period in the prior year.			Target is based on budgeted surgeries above actual from same quarter prior yr.

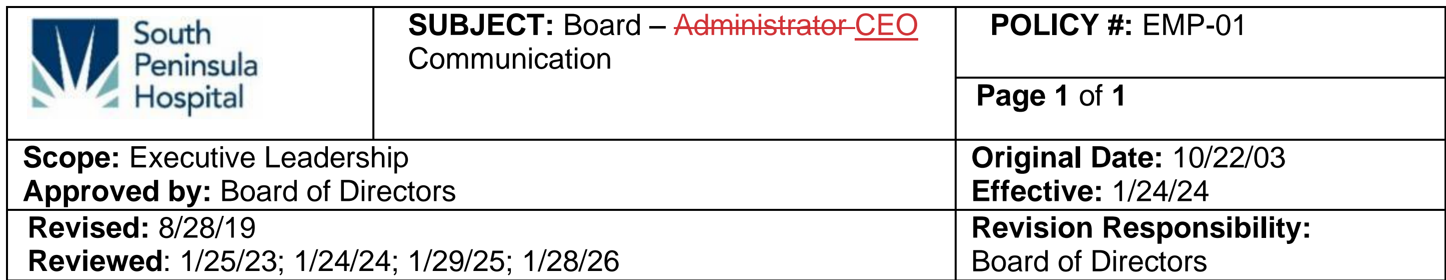
REPORTS MASTER LIST

POLICY	REPORT	METHOD	FREQUENCY	COMMENTS	TIMELINE
MS-02	"The MEC is responsible for reporting the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges to the Board of Directors."	Credentialing Reports (from Medical Staff/MSO)	Monthly	Monthly Credentialing Reports provided in Executive Session. Each provider is reviewed every 2 years upon reappointment, and as needed as issues are identified, per Medical Staff Bylaws.	Every Month
Q-02	"On a quarterly basis, the Board will monitor and assess the Hospital Board of Trustees Balanced Scorecard (BSC) report and associated Plan-Do-Study-Act (PDSA) reports, and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) as appropriate to the operation of the facility."	Report	Quarterly	The Balanced Scorecard including HCAHPS reports are provided to the Board Quality Committee quarterly. BSC is also included in Open Session under CEO Report. PDSAs are discussed monthly in CNO updates, as well as addressed in Executive Session as needed.	January April July October
Q-06	"The Board will review and approve the Quality Plan on an annual basis."	Board Agenda Item	Annually	Quality Plans for the hospital, LTC and Home Health are reviewed by the Quality-of-Care Committee and submitted to the BOD for approval. Annual	December (Policy/Plan) January (Annual Projects)

				QAPI projects are also submitted to the board for approval.	
EMP-02	"The CEO will prepare an annual Corporate Compliance report for the Board of Directors."	CEO Report	Annually	Prepared by the Corporate Compliance Officer on behalf of the CEO. Submitted as part of the Annual Report to the Contract Admin.	February
F-03	"If funds are maintained separately from the Kenai Peninsula Borough funds, the CEO shall submit annually to the Hospital Finance Committee an investment report that summarizes the portfolio in terms of investment securities, maturities, risk categories, returns, and other features."	CEO Report	Annually	Do not have any such funds, so there is no report to give. Will report annually to Finance Committee if this has/not changed.	January (Finance Committee)
F-07	"A report of (pension) fund activity will be made to the Board no later than the end of the first quarter of each calendar year."	Finance/Pension Committee Report	Annually	Provided by the Finance/Pension Committee via memo to the Board.	February
F-07	"The (Pension) Plan will be audited annually, and a report of the audit results will be made to the Board."	Audit Report	Annually	Audit report included in Board packet as soon as it is completed.	~ November (varies)
F-10	"Each month the Board will monitor and assess performance in the following areas with the established budget: 1. Patient Services Revenue 2. Deductions from Revenue 3. Other Revenue 4. Total Operating Revenue 5.	CFO Report	Monthly	CFO's monthly report to the Finance Committee Included in Executive Session packet under CFO Report.	Monthly

	Total Operating Expense 6. Operating Gain or Loss 7. Non-Operating Revenue 8. Net Revenue (Including Borough Funds) 9. Operating Margin 10. Total Margin”				
F-10	“In addition, the Board will monitor: • Acute Care occupancy • Long Term Care occupancy • Contractual % by payer”	CFO Report	Monthly	Same as above.	Monthly
F-10	In addition, the Board will establish performance objectives for: 1. Days of Cash on Hand 2. Accounts Receivable 3. Bad Debt & Charity Care (% of Gross Charges) 4. FTE’s Per (adjusted) Occupied Bed	Balanced Scorecard	Quarterly	Financial indicators on the Balanced Scorecard, which is included in the board packet each month, updated quarterly.	Quarterly: January April July October
F-13	“Board Approved monthly financial reports will be provided to the KPB Finance Director within 14 days of approval. C. These reports, the Balance Sheet, Income Statement, and Cash Flow Statement, will be sent via email to the KPB Finance Director in accordance with the 2020 Operating Agreement.”	Report	Monthly	Provided to Board on consent agenda. Emailed to KPB Finance Director monthly by the CFO after Board approval.	Monthly
F-14	“A quarterly report will be provided to the Board of Directors of grants that are being pursued, conditions and terms of grant, and any assistance needed by the Board to pursue applicable grants.”	Report	Quarterly	Quarterly report provided to Finance Committee	March June September December

F-15	"The financial performance of new services will be reviewed quarterly for the first two years, in comparison with the original business plan and proforma."	Report	Quarterly	Quarterly, when new service lines	Put on calendar when new service line instituted
F-16	"The Board will receive a list of all capital asset purchases including all unbudgeted capital, on a monthly basis."	Report	Monthly	Report is included in the Finance Committee packet monthly, and in the Executive Session packet under CFO report, monthly.	Monthly



South Peninsula Hospital	**SUBJECT:** Board – ~~Administrator~~ CEO Communication	**POLICY #:** EMP-01 **Page 1 of 1**
Scope: Executive Leadership **Approved by:** Board of Directors		**Original Date:** 10/22/03 **Effective:** 1/24/24
Revised: 8/28/19 **Reviewed**: 1/25/23; 1/24/24; 1/29/25; 1/28/26		**Revision Responsibility:** Board of Directors

PURPOSE:
Expectations regarding communication between the Chief Executive Officer and the Board of Directors.

DEFINITION(S):
N/A

POLICY:

A. The CEO and Board shall promote and demonstrate open and honest communication in all hospital business.
B. The CEO and Board will protect the privacy of patient information, financial information, strategic information and sensitive risk management information. Such information will be divulged only on a "need to know" basis in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and other legal and regulatory guidelines.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
N/A

CONTRIBUTORS:
Board of Directors