Kaweah Delta Health Care District
Board of Directors Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Kaweah Health
MORE THAN MEDICINE. LIFE.

DATE POSTED: October 23, 2026

NOTICE

Date: Wednesday, October 28, 2026
Location: City of Visalia – City Council Chambers
Address: 707 W. Acequia Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.
https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeeti
You can also dial in using your phone.
Access Code: 460-561-181
United States: +1 (646) 749-3122

SCHEDULE:

- **3:30 PM** – Open Session (to approve the Closed Session agenda)
- **4:15 PM** – Closed Session
  Pursuant to:
  - Government Code §54956.9(d)(1) (Existing Litigation)
  - Government Code §54956.9(d)(2) (Anticipated Litigation – Significant Exposure)
  - Health & Safety Code §§1461 and 32155 (Confidential Quality Assurance/Medical Staff Matters)
- **5:15 PM** – Open Session

AMERICANS WITH DISABILITIES ACT (ADA) NOTICE:
In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Board Clerk at (559) 624-2330. Notification at least 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the meeting.

POSTING NOTICE:
All Kaweah Delta Health Care District regular Board and committee meeting notices and agendas are posted at least **72 hours** prior to the meeting (and **24 hours** prior to special meetings) in the Kaweah Health Medical Center, Mineral King Wing, near the Mineral King entrance, in accordance with Government Code §54954.2(a)(1).

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

PUBLIC RECORDS:
Disclosable public records related to this agenda are available for public inspection at:
Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)
400 West Mineral King Avenue, Visalia, CA 93291
You may also request records by contacting the Board Clerk at (559) 624-2330 or **kedavis@kaweahhealth.org**, or by visiting the District's website at **www.kaweahhealth.org**.

KAWEAH DELTA HEALTH CARE DISTRICT
Dean Levitan, M.D, Secretary/Treasurer

Prepared by:

Kelsie K. Davis
Board Clerk / Executive Assistant to the CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff, **www.kaweahhealth.org**

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This agenda is posted in compliance with the Ralph M. Brown Act, including amendments enacted under Senate Bill 707.

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS MEETING

City of Visalia – City Council Chambers
707 W. Acequia, Visalia, CA

Wednesday October 28, 2026 {Regular Meeting}

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OPEN SESSION – 3:30 PM

1. **CALL TO ORDER**
2. **PUBLIC COMMENT –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.
3. **BOARD EDUCATIONAL STUDY SESSION** - The Board of Directors will receive an educational presentation regarding national and local Medicare and Medicare Advantage enrollment trends. The presentation will address strategic considerations related to reimbursement, financial sustainability, physician alignment, and the health system's long-term positioning in a changing healthcare payment environment.
4. **ADJOURN TO CLOSED SESSION**

CLOSED SESSION – 4:15 PM

1. **CALL TO ORDER**

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

2. **CEO EVALUATION** – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuit to Government Code 54957(B)(1)

3. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION AND RISK MANAGEMENT** –Semi Annual Claims Discussion with legal counsel regarding ongoing litigation matters involving risk management, patient safety, or related claims. (Pursuant to Government Code 549 56.9(d)(1))

A. BURNS-NUNEZ V KDHCD	G. MARTINEZ-LUNA V. KDHCD
B. M. VASQUEZ V. KDHCD	H. MORENO V KDHCD
C. OLVERA V KDHCD	I. TINOCO V KDHCD
D. LARUMBLE-TORRES V KDHCD	J. MACKEY V KDHCD
E. SMITHSON V KDHCD	K. MEDINA V KDHCD
F. VELASEQUEZ V KDHCD	L. JOHNSON V KDHCD

Action Requested – Settlement Approval of one case.

4. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION / QUALITY OF CARE RISK EXPOSURE –** Conference with legal counsel regarding potential exposure to litigation involving adverse patient outcomes, risk management review, and related quality assurance matters. Pursuant to Government Code 54956.9(d)(2); Three potential cases.
Possible reportable action

5. **MEDICAL STAFF CREDENTIALING AND PRIVILEGING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Government Code 54957.

Action Requested – Approval of Medical Staff Credentialing and Privileging

6. **MEDICAL STAFF QUALITY ASSURANCE/PEER REVIEW** discussion and evaluation of medical staff quality assurance matters, including peer review findings, performance assessments, and related compliance activities. This session is closed pursuant to Government Code 54957 & Evid. Code 1157.

7. **APPROVAL OF THE CLOSED MEETING MINUTES** – September 23, 2026.

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

Action Requested – Approval of all Closed Meeting Minutes from September.

8. ADJOURN CLOSED SESSION

OPEN SESSION – 5:15 PM (OR IMMEDIATELY FOLLOWING CLOSED SESSION)

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1. CALL TO ORDER

2. ROLL CALL

3. FLAG SALUTE

4. PUBLIC PARTICIPATION

Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five (5) minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.

5. CLOSED SESSION ACTION TAKEN

Report on action(s) taken in closed session.

6. BOARD MEMBER REPORT OUTS

Board members may provide brief reports on attendance at conferences, educational programs, meetings with external organizations, community events, or other activities related to District business. No action will be taken on matters not otherwise listed on the agenda. Matters requiring further discussion or Board action may be referred to staff for follow-up or placed on a future agenda in accordance with applicable open meeting laws.

7. RECOGNITIONS

7.1. Presentation of Resolution 2300 to Ariadna Liz Hernandez in recognition as the Kaweah Health World Class Employee of the month – October 2026.

7.2. Team of the Month – October 4N Dialysis Team

8. CONSENT CALENDAR

All items listed under the Consent Calendar are considered routine and non-controversial by District staff and will be approved by one motion, unless a Board member, staff, or member of the public requests that an items be removed for separate discussion and action.

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

Public Participation

Members of the public may comment on agenda item before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of all items on the October 28, 2026, Consent Calendar.
[Consent Calendar Items 9.1 – 9.5 as presented]

Section	Item	Description	Type
9.1. REPORTS	A	Physician Recruitment	Receive and File
	B	Overall Strategic Plan	Receive and File
	C	Emergency Services	Receive and File
	D	Quail Park	Receive and File
9.2. MINUTES			
	A	Patient Experience Committee – July 8, 2026	Approve Minutes
	B	Finance Property Services Acquisition Committee- September 16, 2026	Approve Minutes
	C	Quality Council Committee – September 17, 2026	Approve Minutes
	D	Population Health Committee – July 20, 2026	Approve Minutes
	E	Regular Open Board Meeting – September 23, 2026	Approve Minutes
9.3. POLICIES			
		Administrative Policies	
	A	AP186 Kaweah Health External Event Planning Services	New Policy
	B	AP187 Kaweah Health Physician Retirement Celebrations Policy	New Policy
	C	AP114 Census Saturation Plan	Approve Revisions
	D	AP153 Annual Budget	Approve Revisions
	E	AP 179 Bridge Policy	Approve Revisions
9.4. MEC			
	A	MS60 EHR Onboarding Medical Staff	New Policy
	B	Privileging form for Podiatry	Revised
9.5 DISTRICT			
	A	2nd Amendment to CEO Agreement, Market Adjustment	Approve

9. ANNUAL AUDITED FINANCIAL STATEMENT – FISCAL YEAR 2026

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

The Board will receive presentation from Baker Tilly regarding Kaweah Health's annual audited financial statements for fiscal year 2026 and approve the audited financial states as presented.
Action Requested: Approve the Annual Audited Financial Statements for Fiscal Year 2026 as presented by Baker Tilly

10. STRATEGIC OVERSIGHT (MONTHLY REPORT) – OUTSTANDING HEALTH OUTCOMES

Strategic Oversight discussion regarding organizational priorities, long-term planning initiatives, strategic objectives, operational alignment, community health needs, workforce considerations, and progress toward Board-approved strategic goals. The Board may provide direction to staff regarding strategic priorities and future planning efforts.

11. EMPLOYEE ENGAGEMENT SURVEY

HR presentation and discussion regarding the results of the Employee Engagement Survey, including overall engagement trends, key findings, areas of strength, opportunities for improvement, and organizational initiatives focused on employee engagement, culture, retention, and workforce experience.

12. PATIENT EXPERIENCE AND SATISFACTION UPDATE

Staff presentation and discussion regarding aggregated and de-identified patient experience data, including trends, themes, and opportunities for improvement. No individual patient information will be disclosed.

13. FINANCIAL STEWARDSHIP

Financial Stewardship report and discussion regarding the financial status of the district, including budget performance, revenue and expense trends, financial sustainability initiatives, capital planning, operational efficiencies, compliance considerations, and fiscal oversight responsibilities of the Board. The Board may provide direction to staff regarding financial priorities and oversight activities.
Action Requested – Approval September's Financials.

14. FUTURE GOVERNANCE TOPICS

Discussion regarding future governance topics, Board education opportunities, governance priorities, committee work planning, policy development, regulatory updates, and potential future agenda items to support effective governance and Board oversight responsibilities. The Board may provide direction to staff regarding future governance planning and educational priorities.

15. REPORTS

15.1. Chief of Staff Report- Report relating to current medical staff events and issues.

15.2. Chief Executive Officer Report - Report on current events and issues.

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Jonna Schengel • Zone 2 Board Member
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15.3. Board President - Report on current events and issues.

16. ADJOURNMENT

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BOARD EDUCATIONAL STUDY SESSION

Medicare

vs

Medicare Advantage



Content Outline

- Medicare vs Medicare Advantage (MA) Overview
- Medicare vs Medicare Advantage: Macro-Trends
- Medicare Enrollment – National and County trends
- Kaweah Health Overall Payor Mix Trends: Medicare vs Medicare Advantage
- Kaweah Health Medicare & MA partnerships/payment models
- Key Factors to consider for Health systems
- Balancing short term and long-term financial sustainability

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Original Medicare vs. Medicare Advantage

Original Medicare	*vs.*	Medicare Advantage
Part A and Part B	**Also known as**	Part C
Federal government	**Who offers the coverage**	Medicare-approved private insurance companies
Part A – Inpatient care Part B – Outpatient care	**What it covers**	Combines Parts A and B into one plan, often including Part D prescription drugs and extra benefits such as hearing, vision, and dental care
Part A is free for most people Part B has an average premium of around $205	**What it costs**	Each plan sets its own premium, with many offering $0 or low-cost premiums
No	**Annual cap on out-of-pocket costs**	Yes

Traditional Medicare vs. Medicare Advantage (MA): Macro-Trends

Challenged Federal Budgets due to unsustainable health spending trends driving payment & care delivery reform in Medicare/MA

1. Medicare Trust Fund Insolvent by 2032

"Largest driver of Medicare spending growth during next decade expected to be higher volume and intensity of health care services"

Medicare insolvency date creeps forward thanks to 'Big Beautiful Bill,' trustees find

The trust fund underpinning Medicare's hospital benefit is set to run out of money one quarter earlier than previously expected due to tax cuts in the GOP's reconciliation legislation.

Published June 11, 2026

Likely Impact:

- Strained Federal Budgets (CMS)
- Payment updates < Inflation
- Policies to curb payment & use + "de-risking" through Medicare Advantage

2. Aging Population: The "Silver Tsunami"

By 2030, over 1 in 5 people in U.S. will be Age 65+

Population count by age range	<=17	18-34	35-44	45-64	65+
2025 (%)	21.0	22.8	13.2	24.4	18.6
2030 projection (%)	20.2	22.1	13.2	23.9	20.7

Likely Impact:

- Healthcare use ↑ w/sicker patients
- Federal Budgets (CMS) strained
- ↑ Payor Shift mix to Govt. based

3. MA Growth: Medicare Age-Ins continue to choose MA

55% of Medicare beneficiaries are now enrolled in MA Plans.

Forbes

Despite Scrutiny, Medicare Advantage Enrollment Poised To Rise As Premiums Fall 16%

Likely Impact:

- Tighter utilization controls
- Lower payment yield/unit
- Value: Network exclusion

4. No Outcomes, No Income

Traditional Medicare mandating new payment models, placing providers at downside risk.

CMS innovation center remains focused on mandatory models, officials say

CMMI Director Abe Sutton and CMS Administrator Dr. Mehmet Oz outlined how the administration aims to get more providers, especially poor-performing ones, into value-based models.

Published March 4, 2026

Likely Impact:

- "Death by a Thousand Cuts" for poor performers
- Population Health & care coordination competencies

[1] https://www.healthcaredive.com/news/medicare-insolvency-date-hi-fund-obbb-trustees-report/822499/

[2] https://www.spglobal.com/market-intelligence/en/news-insights/articles/2024/11/1-in-5-americans-to-be-65-years-old-or-older-by-2030-86270288

[3] https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/

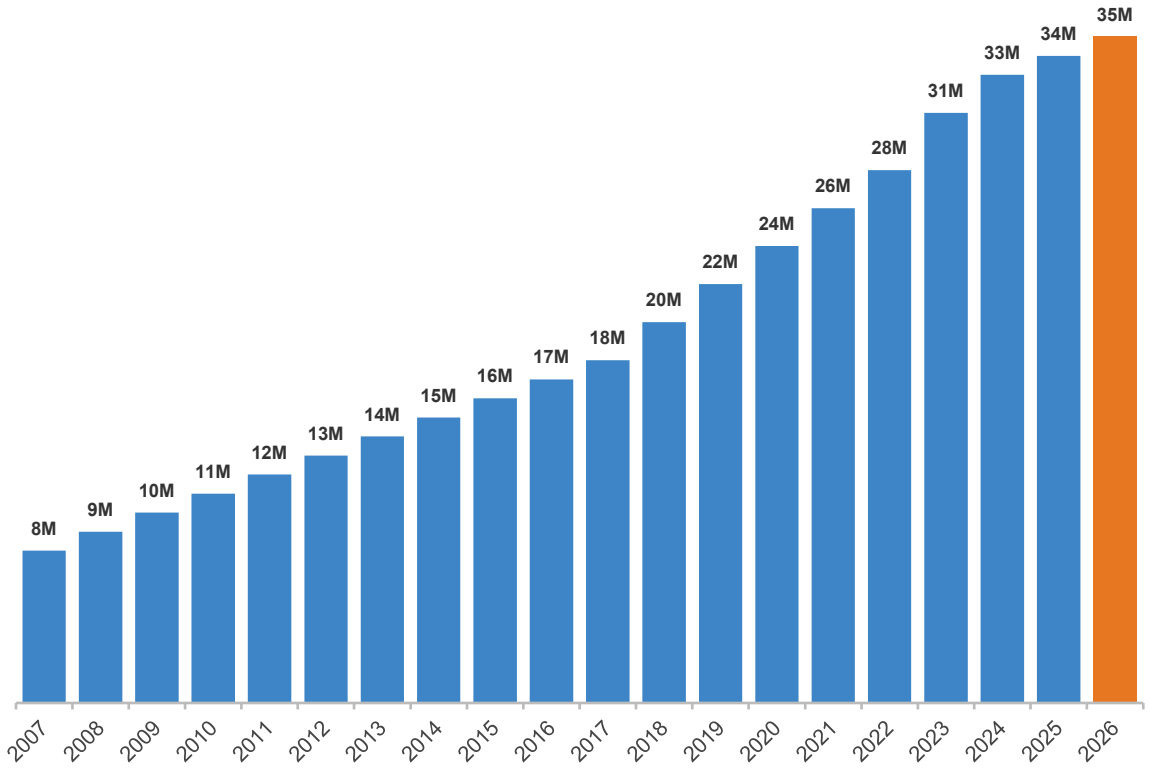
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Medicare Advantage National Trends

2026 Highlights

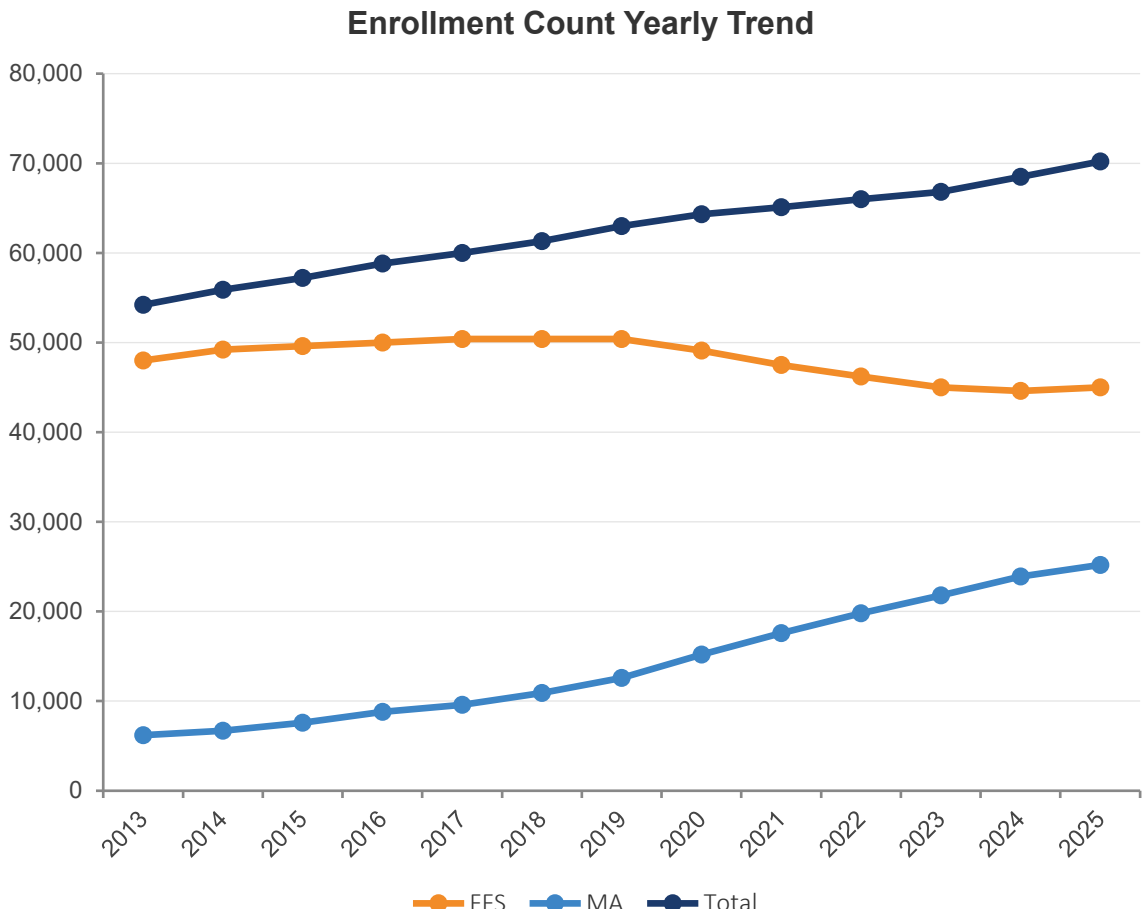
- Medicare Advantage enrollment has grown nationwide every year since 2007
- More than half of eligible Medicare beneficiaries are enrolled in a Medicare Advantage plan
- Roughly 23% of Medicare Advantage enrollees are in a Special Needs Plan (SNP) in 2026
- 78% of SNP enrollment is in plans for people eligible for both Medicare and Medi-Cal
- Enrollment growth slowed to roughly 3% in 2026, lower than in prior years

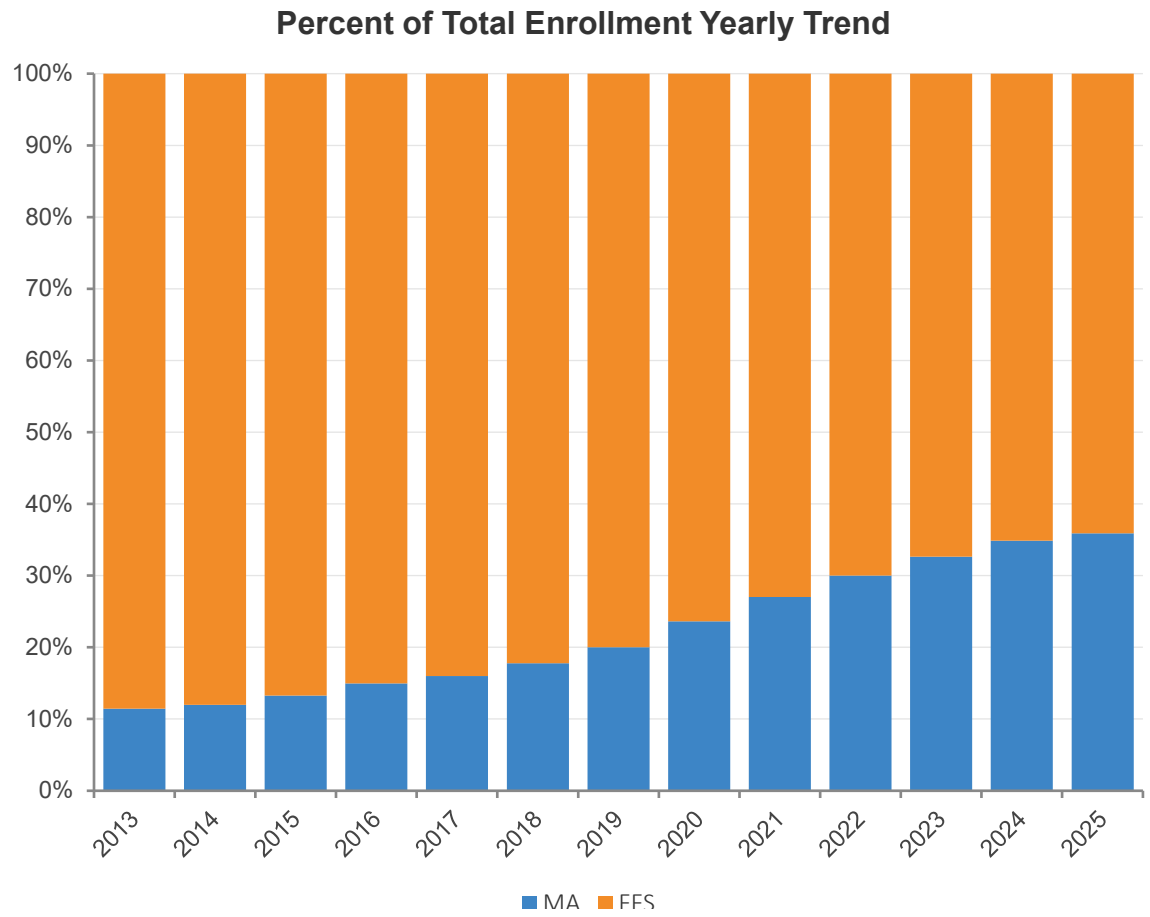
Medicare Advantage Enrollment, 2007–2026



Medicare Enrollment Trends: Tulare County

Tulare County's Total Medicare population growing rapidly with increasing enrollment in MA. Kings has similar trends.

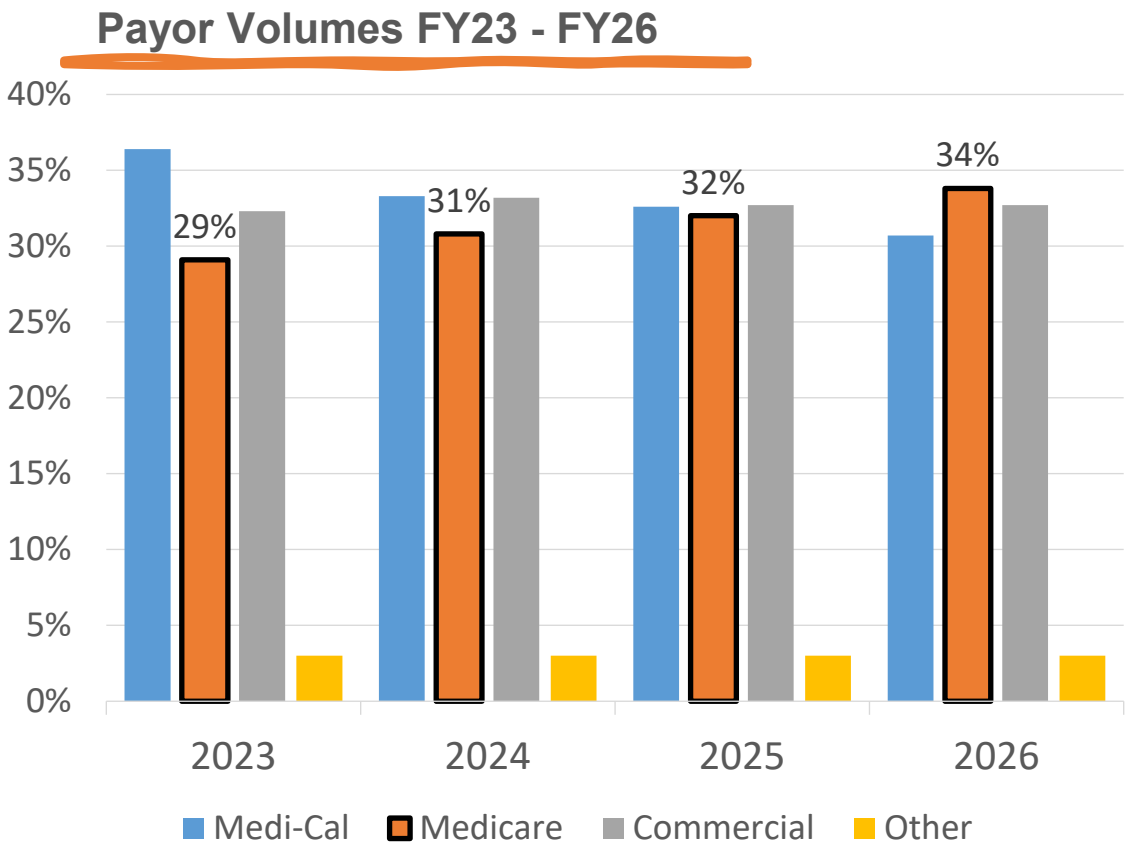




Kaweah Health Payor Mix Trends (FY 2023 to FY 2026)

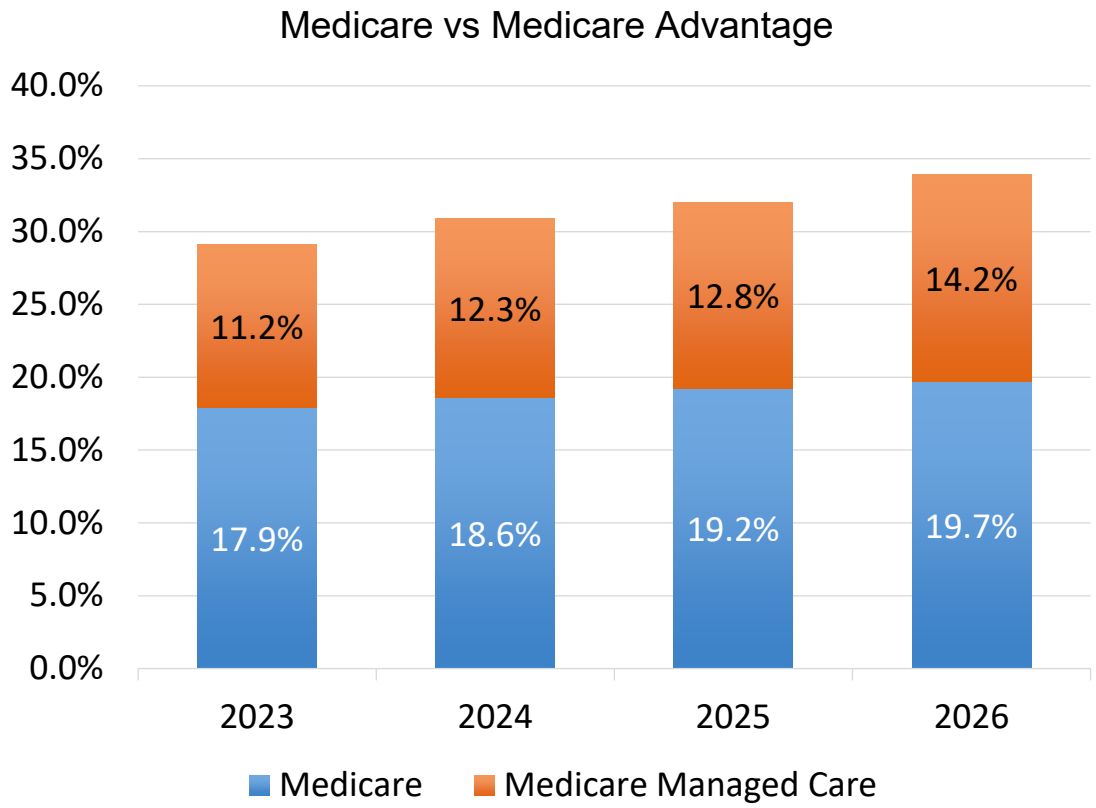
1) Growth in Medicare Mix % reflects Aging Population

- Medicare eligible (includes Traditional Medicare and MA) patients represent 34% of our total volume in FY26
- Up 5% from FY23 (29% to 34%)



2) Medicare Mgd Care (MA) growing faster than Traditional Medicare

- MA growth from 11.2% to 14.2% (27% ↑ since FY 2023)
- Traditional Medicare growth from 17.9% to 19.7% (10% ↑ since FY 2023)
- Reflect National and Regional Trend of growing MA Penetration



Current Kaweah Health Payment Portfolio

Traditional Medicare Value Based Care Payment Programs



HOSPITAL VALUE BASED PURCHASING

HOSPITAL READMISSION REDUCTION PROGRAM

HOSPITAL ACQUIRED CONDITION REDUCTION PROGRAM

QUALITY PAYMENT PROGRAM

MEDICARE SHARED SAVINGS PROGRAM

Medicare Advantage Health Plan Partnerships



PART A CAPITATION AGREEMENT

DUAL RISK AGREEMENT

FEE FOR SERVICE

HEALTH PLAN PARTNERSHIP

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Strategic Partnerships at Kaweah Health

2015 1st Capitation/Risk Bearing Contract with a Medicare Advantage plan

2017 - Partnered with Key Medical Group to develop Sequoia Health Plan and Sequoia Integrated Health

2024 - Joined Traditional Medicare ACO (MSSP) through our partnership with Aledade, earning gainshare payout (settled / received in CY 2025).

2026 –Currently partnered with 4 health plans for Medicare Advantage members in both Value Based Care and FFS models

2027 – Adding 2 additional Medicare Advantage plans

The "Whys": History & Strategic Intent

Kaweah Health has been part of the Sequoia Health Plan (SHP) Partnership since 2017

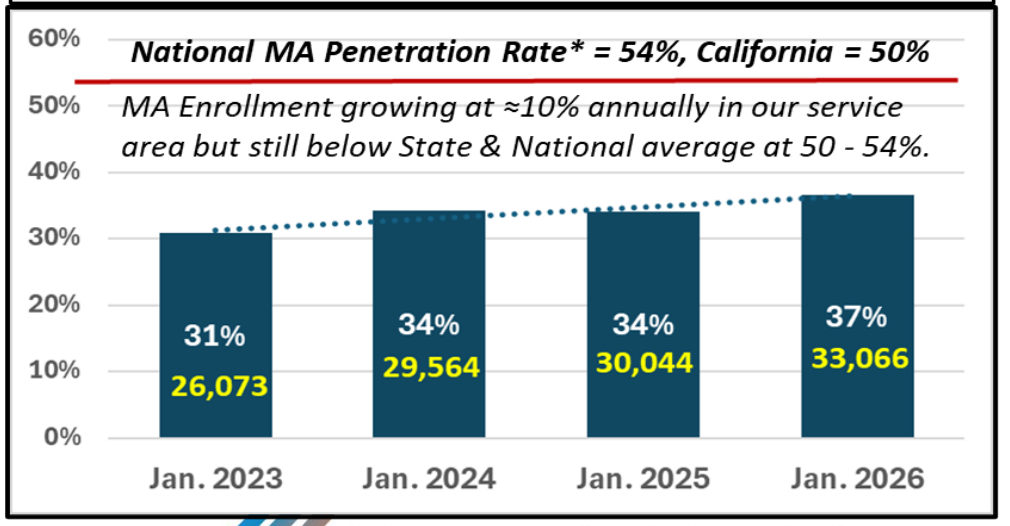
Strategic Intent:

- **Strengthen Physician Alignment**, Clinical / Financial Integration & Partnerships
- **Revenue Diversification + De-risking** as CMS Payment Updates to MA Plans increase faster than Hospital Rates.
- **Growth Opportunity** as Medicare Age-ins increasingly select enrollment in MA Plan
- **Access to Claims Data** for insights to referral patterns, market opportunities & care quality.
- **Payment Reform Drives Care Delivery Reform** = Better Patient Outcomes

CMS Annual Payment Update Increases:
MA Plans 5.06% ↑ vs. Hospital Inpatient 2.2% ↑

Feature	Medicare Advantage (MA) Plans	Hospital Inpatient (IPPS)
Annual Update Metric	Effective growth rate & benchmarks	Hospital market basket
Typical 2025–2026 Adjustments	~5.06% payment increase	~2.4% to 2.6% increase

Tulare & Kings County Service Area
Medicare Advantage (MA) Enrollees & Penetration Rate*



Medicare Advantage (MA) Penetration Rate: MA Enrolees / Total CMS Eligible Beneficiaries

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Why Health Systems Stay Entrenched in Fee-for-Service

Barriers to adopting value-based care models

1	**Cash-flow predictability & timing**	Fee-for-service pays per unit of service, so revenue tracks volume and is easy to forecast. Health systems can use historical and payment data to predict future volume and revenue.
2	**Infrastructure & incentive alignment**	Physician compensation models, EHR billing workflows, and capital planning (bed capacity, specialty service lines) are all built around volume. Undoing this is expensive and organizationally painful.
3	**Actuarial, scale & risk expertise**	Value-based care, especially full-risk capitation, requires taking on insurance-like risk. Many health systems lack the actuarial expertise, scale or data sophistication to manage these arrangements.
4	**Fragmented, siloed data**	Population health management requires longitudinal patient data across care settings, but most systems' EHR and claims data remain siloed, making it hard to manage total cost of care proactively absent aggregation of claims and clinical data.
5	**Weak downside-risk contracts**	Many value-based arrangements (e.g., MSSP ACOs) are upside-only or have short performance periods, giving systems little reason to fully commit organizational and capital resources.

Health System Considerations

Forces pushing the shift toward value-based care

Payer mix shift toward Medicare Advantage

Health plans increasingly use risk-based and quality-linked payment structures (e.g., Star Ratings, HEDIS-linked bonuses) rather than pure FFS. Health systems must invest to build and manage these arrangements to ensure continued network participation.

CMS policy direction

CMS aims to move all Medicare and most Medicaid beneficiaries into accountable-care relationships, putting a policy floor under the transition even as absolute FFS volume continues to grow. In addition, it is implementing more mandatory models that penalize low performers.

Rising chronic disease burden

Growing total-cost-of-care pressure means value-based arrangements can put unforeseen strain on health systems when costs outpace the payment model.

Growing data & analytics maturity

Advances in analytics are gradually making risk stratification, care management and prospective risk pricing more feasible for systems that invest in them.

Key Terms

Medicare Program - A federal health insurance program for people aged 65 and older as well as younger individuals with specific disabilities or permanent kidney failure

Traditional Medicare Members – A qualifying eligible Medicare beneficiary whose benefits are managed by the federal government through the Part A benefit or hospital coverage, Part B benefit or physicians services and Part D benefit or pharmacy benefit.

Medicare Advantage Member – A Medicare beneficiary who has opted out of the federal government managing their benefits and opted to have a health plan managed those same benefits. This would include their Part A, Part B and Part D benefits and is often referred to as Part C.

Value Based Care Model - Value-based care (VBC) focuses on improving health outcomes and patient experiences while controlling costs. Unlike traditional fee-for-service models, where providers are paid for each service delivered, VBC ties payment to the results achieved, such as quality, equity, and efficiency of care

Risk Based Model/ Contract - Risk-based contracting is a type of arrangement between healthcare providers and health plans or government programs (together "plans") whereby financial responsibilities for the cost of care shifts between the plan to the provider.

Fee for Service Model/Contract - A fee-for-service (FFS) contract in healthcare is an agreement where providers are paid separately for each service—such as visits, tests, or procedures—rather than receiving a bundled or fixed payment.

Two-Sided Risk Agreement - A two-sided risk agreement in healthcare is a payment arrangement where the provider (such as a hospital, physician group, or accountable care organization) is financially responsible for both the cost and quality of care for a defined group of patients.

Upside Risk - If the provider delivers care that meets or exceeds quality targets and keeps costs below a pre-set benchmark, the provider can share in the savings

Downside Risk - If costs exceed the benchmark or quality targets are missed, the provider must repay the payer (insurer, Medicare, Medicaid, etc.) for the excess.

Risk Adjustment or RAF score- A method of assigning a member a score which identifies how complex or medical needy is the patient. The higher the RAF score the more funding provided to care for that member.

Agenda item intentionally omitted

Resolution 2300

RESOLUTION 2300

Board Resolution Honoring
Ariadna Liz Hernandez as World Class Employee of the Month of October

WHEREAS, Kaweah Health recognizes outstanding performance, dedication, and excellence among its staff through the Employee of the Month program;

WHEREAS, Ariadna Liz Hernandez, of the Youth Crisis Stabilization Unit, has consistently demonstrated exceptional commitment to their responsibilities, a strong work ethic, and a positive attitude that uplifts their team;

WHEREAS, She has made significant contributions during the month of October 2026, including but not limited to providing seamless support and maintaining unshakable professionalism while juggling the chaos that only an exemplary employee can make;

WHEREAS, Ariadna's professionalism, integrity, and enthusiasm embody the core values of Kaweah Health, setting a high standard for colleagues and exemplifying what it means to go above and beyond in the workplace;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors formally recognizes and congratulates Ariadna Liz Hernandez as **Employee of the Month** for Octoebr 2026, and expresses its sincere appreciation for her outstanding contributions;

BE IT FURTHER RESOLVED, that this resolution be entered into the official records of Kaweah Health and that a copy be presented to Ariadna Liz Hernandez as a token of recognition and gratitude.

PASSED AND ADOPTED this 28th of October, 2026, by the Board of Directors of Kaweah Health.

David Francis
President
Kaweah Health Board of Directors

Dean Levitan, MD
Secretary/Treasurer
Kaweah Health Board of Directors

Kaweah Delta Healthcare District

2026 Audit Results

Discussion with Management and the Board of Directors

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Agenda

1. Your Service Team
2. Auditor Opinion and Report
3. Scope of Services
4. Significant Risks Identified
5. Matters Required to be Communicated with Those Charged with Governance
6. Financial Ratios and Metrics
   - Statement of Financial Position
   - Operations

Your Service Team



Brian Conner
Principal, Engagement Reviewer



Joelle Pulver
Principal, Concurring Reviewer



Laura Kennedy
Senior Manager, Engagement Manager



Todd Schroeder
Director, Third-Party Reimbursement Practice

Auditor Opinion and Report

Unmodified Opinion

- Consolidated financial statements as of and for the year ended June 30, 2026, are presented fairly and in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).
- We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We performed our audit in accordance with generally accepted auditing standards issued by the AICPA and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements for California Special Districts*, and designed the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

Scope of Services

We have performed the following services for Kaweah Delta Healthcare District:

Annual Audit

- Annual consolidated financial statement audit for the year ended June 30, 2026

Non-Attest Services

- Assisted management with drafting the consolidated financial statements as of and for the year ended June 30, 2026
- Assisted management with the preparation of cost reports and various reimbursement consultation.

Significant Risks Identified

During the planning of the audit, we have identified the following significant risks:

Significant Risks	Procedures
Valuation of Patient Accounts Receivable and Patient Service Revenue	We performed a lookback analysis to determine if management's estimate was materially correct at June 30, 2025, based upon cash collections. We also analyzed subsequent cash collections on June 30, 2026, accounts receivable as well as performed analytical procedures on June 30, 2026, accounts receivable and net patient service revenue. Finally, we performed test procedures on management's patient accounts receivable allowance model.
IBNR Liabilities	We evaluated how the District estimates the IBNR accruals to ensure that the estimate is reasonable as compared to actuarial estimates.
Management Override of Controls	We performed inquiries of accounting and operational personnel, performed risk assessment procedures, and tested risk-based manual journal entry selections.

Matters Required to be Communicated with Those Charged with Governance

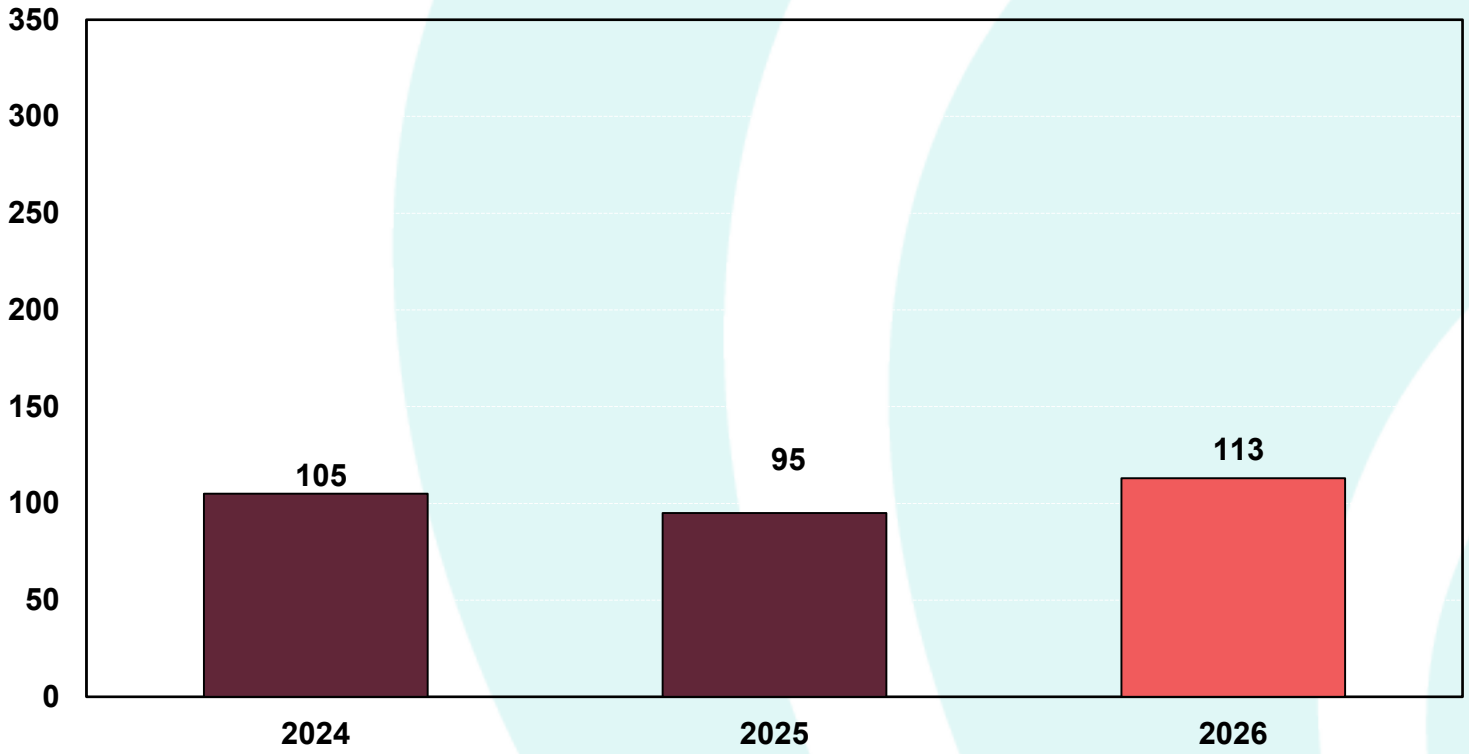
- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- Corrected and uncorrected misstatements
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No consultation with other accountants
- No awareness of material instances of fraud or noncompliance with laws and regulations

Financial Ratios and Metrics

Cash on Hand (days)

- Liquidity indicator
- Measures the ability of the hospital to sustain operations with existing cash
- The higher the number, the more cash reserves available
- (Unrestricted cash and investments plus funds designated for capital improvements x 365)/(total operating expenses – depreciation and amortization expenses)

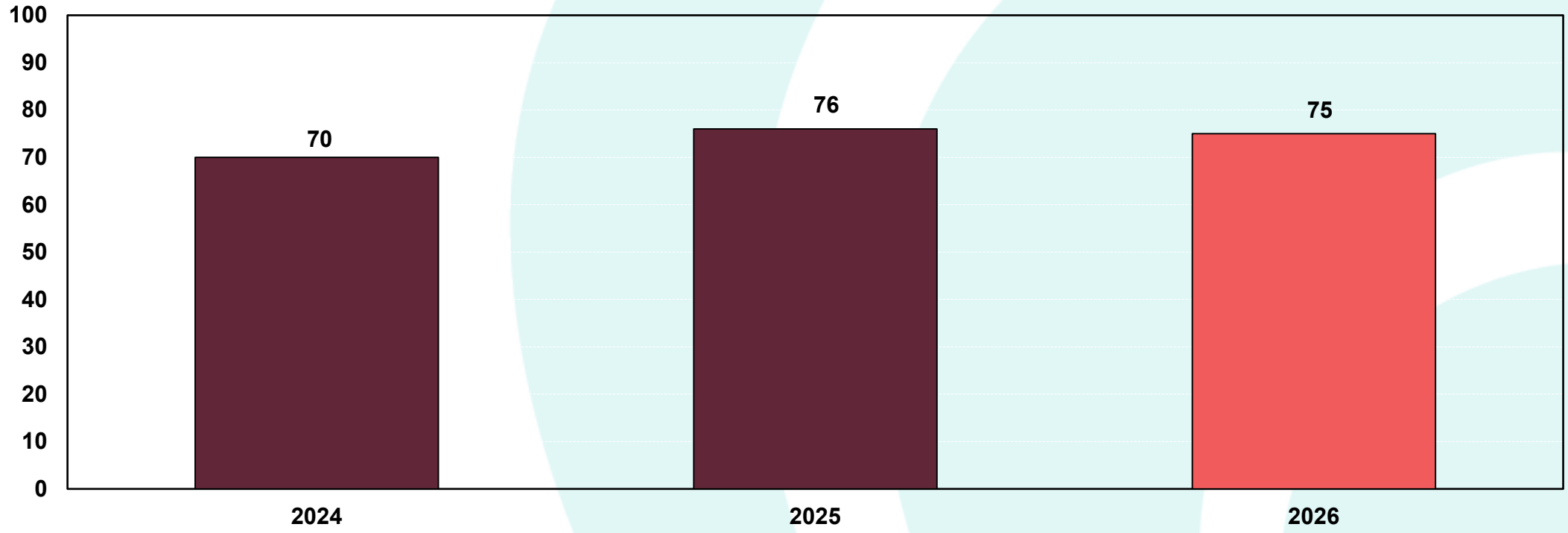
Cash on Hand (days)



Days in Accounts Receivable

- Liquidity indicator
- Measures the average number of days that accounts receivable are outstanding
- Lower number indicates that outstanding balances are being collected within a shorter duration
- (Net accounts receivable)/(net patient revenue/365)

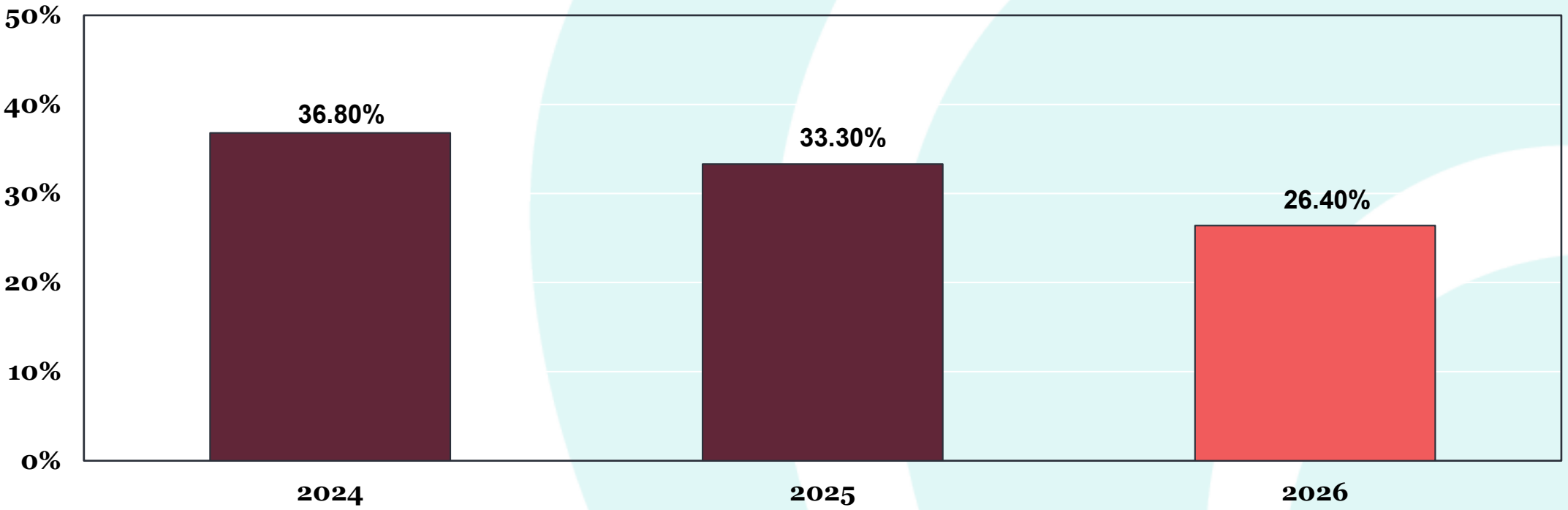
Days in Accounts Receivable



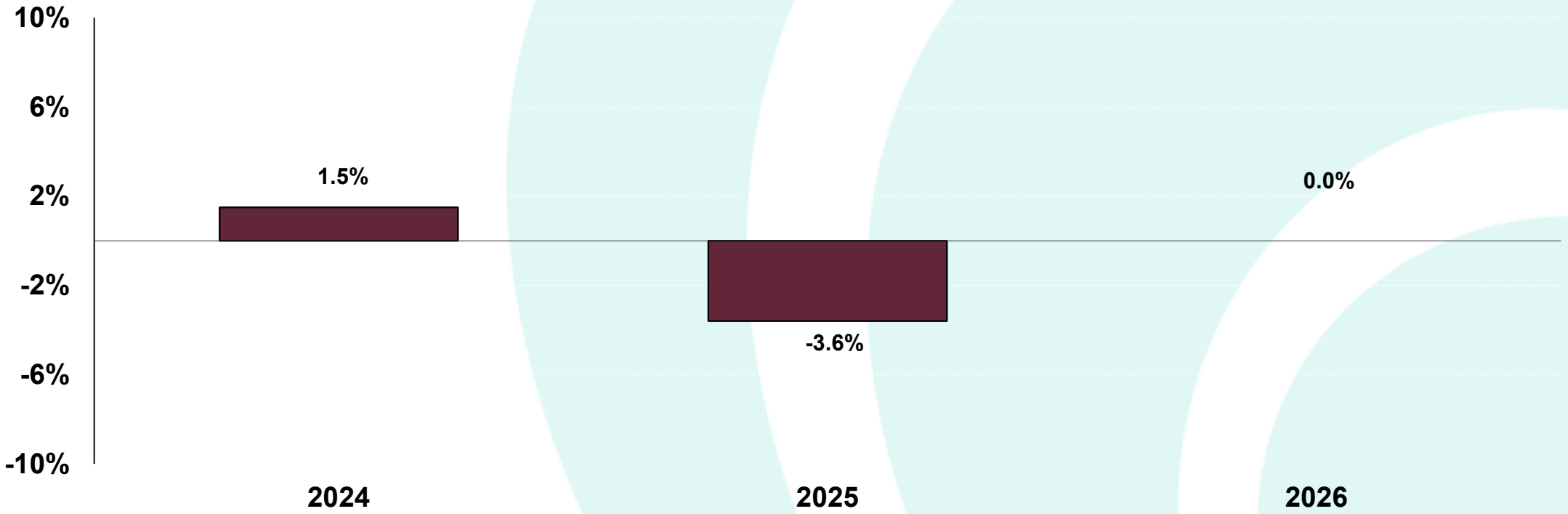
Debt to Capitalization

- Leverage indicator
- Indicates extent assets are financed with debt as opposed to paid for with cash
- Lower number indicates assets are “bought and paid for”
- (Long-term and current portion of debt)/(long-term and current portion of debt plus net assets)

Debt to Capitalization



Operating Margin (Unadjusted) (Operating (Loss) Income/Total Revenue)



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Report of Independent Auditors and
Consolidated Financial Statements with
Required Supplementary Information

Kaweah Delta Health Care District

June 30, 2026 and 2025

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Management's Discussion and Analysis

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Overview of the Financial Statements

The Management Discussion and Analysis (MD&A) of Kaweah Delta Health Care District (the "District") provides management's perspective on the financial position and results of operations for the year ended June 30, 2026, with comparative information for the year ended June 30, 2025. The MD&A should be read in conjunction with the consolidated financial statements in this report.

The consolidated financial statements of the District include: (a) a consolidated statement of net position, (b) a consolidated statement of revenues, expenses, and changes in net position, and (c) a consolidated statement of cash flows. The consolidated statement of net position includes information about the nature of the District's assets and liabilities and classifies them as current or noncurrent. It also provides the basis for evaluation of the capital structure of the District and for assessing the liquidity and financial flexibility of the District. The District's revenues and expenses are accounted for in the consolidated statement of revenues, expenses, and changes in net position. This statement measures the District's operations and can be used to determine whether the District has been able to recover all of its operating costs from patient services and other operating revenue sources. The primary purpose of the consolidated statement of cash flows is to provide information about the District's cash from operating, noncapital financing, capital and related financing, and investing activities. It provides answers to such questions as, what were the District's sources of cash, what was cash used for, and what was the change in cash balances during the reporting period.

Effective July 1, 2025, the District implemented GASB Statement No. 103, *Financial Reporting and Model Improvements*, which updated the structure and content of the MD &A and certain financial reporting presentation.

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TABLE 1
Financial Summary
Condensed Consolidated Statements of Net Position
(in Thousands)

A summary of the District's consolidated statements of net position is presented in Table 1 below:

	June 30, 2026	June 30, 2025	*pre-Gasb 103** June 30, 2024	2026/2025 Change
Current and other assets	$ 652,922	$ 627,167	$ 575,652	$ 25,755
Capital assets	266,388	272,441	290,676	(6,053)
Total assets	919,310	899,608	866,328	19,702
Deferred outflows	11,984	13,308	15,283	(1,324)
Total assets and deferred outflows	$ 931,294	$ 912,916	$ 881,611	$ 18,378
Current and other liabilities	$ 211,931	$ 218,263	$ 204,111	$ (6,332)
Long-term debt outstanding	207,606	222,369	235,463	(14,763)
Total liabilities	419,537	440,632	439,574	(21,095)
Deferred inflows	27,763	175	-	27,588
Net investment in capital assets	63,683	60,147	66,112	3,536
Restricted	42,495	58,979	52,733	(16,484)
Unrestricted	377,816	352,983	323,192	24,833
Total net position	483,994	472,109	442,037	11,885
Total liabilities, deferred inflows, and net position	$ 931,294	$ 912,916	$ 881,611	$ 18,378

**Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications may not be directly comparable to fiscal years 2025 and 2026*

As reflected in Table 1, total assets increased by $19.7 million. Cash and investments also increased by $36.8 million due to the receipt of $48 million in FEMA funds in early fiscal 2026 which were included in other accounts receivable at June 30, 2025. Total liabilities decreased by $21.1 million due to principal payments on debt, and the decrease of the net pension liability. Net position increased $11.9 million to $484.0 million for the year ended June 30, 2026, primarily attributable to the District's $9.3 million income before contributions.

TABLE 2
Financial Summary (Continued)
Condensed Consolidated Statements of Revenues, Expenses, and Changes in Net Position
(in Thousands)

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The following table presents a summary of the District's revenues, expenses, and changes in net position:

	Years Ended			
	June 30, 2026	June 30, 2025	*pre-GASB 103** June 30, 2024	2026/2025 Change
Net patient services revenue	$ 820,734	$ 743,868	$ 699,851	$ 76,866
Premium revenue	91,244	85,931	88,414	5,313
Management services revenue	-	-	37,519	-
Other operating revenue	70,254	63,699	44,299	6,555
Total operating revenues	982,232	893,498	870,083	88,734
Salaries and benefits	504,232	466,246	426,992	37,986
Medical and other supplies	179,768	165,851	163,147	13,917
Medical and other fees and services	196,275	189,762	174,700	6,513
Maintenance, utilities, and rent	38,536	37,725	35,901	811
Depreciation and amortization	40,296	39,870	38,511	426
Other	23,239	26,633	18,060	(3,394)
Total operating expenses	982,346	926,087	857,311	56,259
Operating (loss) income	(114)	(32,589)	12,772	32,475
Nonoperating revenues, net of nonoperating expenses	9,391	60,246	8,586	(50,855)
Income before capital contributions	9,277	27,657	21,358	(18,380)
Capital contributions	2,608	2,415	632	193
Changes in net position	11,885	30,072	21,990	(18,187)
Net position, beginning of year	472,109	442,037	420,047	30,072
Net position, end of year	$ 483,994	$ 472,109	$ 442,037	$ 11,885

**Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications may not be directly comparable to fiscal years 2025 and 2026*

Detailed Analysis

Operating revenues – For fiscal year 2026, the District derived 98.2% of its total revenues from operations. Operating revenues include, among other items, patient care revenue from Medicare, Medi-Cal, and other federal, state, and local government programs, and commercial insurance payers and patients; premium revenue associated with a capitated Medicare Advantage contract; retail pharmacy revenue; cafeteria sales; Quality Incentive Pool (QIP) program revenue; and membership sales and dues from a District-owned health and fitness center.

Nonoperating revenues – For fiscal year 2026, the District derived 1.8% of its total revenues from nonoperating revenues. Nonoperating revenues include investment income, stimulus funds, gain on the sale of capital assets and property tax revenue including that associated with the general obligation bonds as well as an allocation of general property taxes assessed by the County of Tulare, California, on properties residing within the District's geographical boundaries.

The following summarizes the District's consolidated statements of revenues, expenses, and changes in net position between 2026 and 2025:

Net patient services revenue increased $76.9 million, or 10.3%, in 2026. This increase can be attributed to an increase in supplemental program revenues, an increase in case mix, and increases in inpatient and outpatient volumes.

Both acute admissions and acute patient days remained fairly flat at 23,567 and 126,391 in 2026, respectively. Skilled nursing and long-term subacute patient days increased by 4.4% to 15,712 days. Outpatient equivalent patient days, a measure of overall outpatient activity, increased by 3.0% from 2025 levels. The overall increase in outpatient activity was mainly driven by emergency department and clinic visits, surgeries, cardiac catheterization procedures, and medical oncology and clinical laboratory volumes.

The District participates in various supplemental payment programs administered by the State of California as discussed in detail in the notes to the consolidated financial statements. In fiscal year 2026, net patient services revenue includes $2.5 million related to the Hospital Qualified Assurance Fee (HQAF) Managed Care Medi-Cal program; $7.0 million related to the AB113 Intergovernmental Transfer (IGT) Fee-for-Service (FFS) Medi-Cal Inpatient program; $79.8 million related to the District Hospital Directed Payment (DHDP) Medi-Cal program; and $35.0 million related to the Rate Range IGT Managed Medi-Cal program.

Premium revenue associated with a capitated Medicare managed care contract increased by $5.3 million, or 6.2%, from 2025, due to an increase in the number of covered lives, and the amount paid per member per month.

Other operating revenue increased by $6.6 million, or 10.3%. This increase is primarily related to an increase in retail pharmacy revenue.

Salaries and benefits expense increased $38.0 million, or 8.1%. Salaries and wages increased $22.3 million, or 5.8%, and employee benefits expense increased $15.7 million, or 19.4%, from 2025. The increase in salaries and wages was mainly attributable to increases in the number of employees and wage rate increases driven by market factors. The increase in benefits was related to an increase in defined benefit pension cost.

Medical and other supplies expense increased $13.9 million, or 8.4%, from 2025. The increase was the result of the increase in patient activity noted above. Pharmaceutical cost had the largest increase, driven by increases in medical oncology and retail pharmacy volumes.

Medical and other fees and services increased $6.5 million, or 3.4%. This increase was primarily due to a $9.9 million increase in physician fees, offset by a $2.3 million decrease in nursing contract labor, and a $2.9 million decrease in third party payments paid for the capitated Medicare managed care plan.

Maintenance, utilities, and rent expense increased $811,000, or 2.1%, due mainly to increases in IT service contract costs.

Depreciation and amortization expense increased $426,000, or 1.1%, from the increase in amortization of leased assets.

Other expenses decreased $3.4 million, or 12.7%, resulting mainly from a decrease in professional liability expense.

Nonoperating revenues as described above decreased by $50.9 million as no stimulus funding was recognized in fiscal year 2026.

Nonoperating expenses represent interest on the District's short-term and long-term debt consisting of revenue and general obligation bonds, loss on disposal of capital assets, and bond issuance expense. Total interest expense decreased by $255,000, or 3.0%, from 2025.

Significant Capital Asset and Long-Term Financing Activity

Capital assets decreased $6.1 million to $266.4 million. Net additions to building, equipment, and construction in progress of $17.0 million was outpaced by a $23.1 million net increase in accumulated depreciation.

During the fiscal year, the District made the following significant capital expenditures:

- Construction costs for many facility improvement projects including the CT suite remodel and the Crisis Stabilization Unit remodel.
- Data storage equipment and network hardware
- Pyxis medication dispensing equipment
- Fetal monitoring equipment
- Ultrasound equipment

The source of funding for these projects, as well as other capital expenditures, was derived from operations, capital contributions, grant funds, and funds reserved for capital acquisition.

Capital contributions to the District and to Kaweah Delta Hospital Foundation (the "Foundation") were $2.6 million in fiscal year 2026, an increase of $193,000 compared to fiscal year 2025.

At June 30, 2026, the District had approximately $227.9 million of long-term debt, lease liabilities, and subscription liabilities, compared with $239.2 million at June 30, 2025.

The long-term debt includes revenue and general obligation bonds outstanding as described in Note 9 to the consolidated financial statements. The general obligation bonds represent the general obligation of the District. The District has the power and is obligated to cause annual ad valorem taxes to be levied upon all property within the District, subject to taxation by the District, and collected by the County of Tulare for payment, when due, of the principal and interest on the bonds. The bond indenture agreements contain various restrictive covenants that include, among other things, minimum debt service coverage, maintenance of minimum liquidity, restrictions on certain additional indebtedness, and requirements to maintain certain financial ratios.

The District made $13.0 million of principal payments on existing revenue and general obligation bonds during 2026. The District also entered into a $3.5 million equipment financing lease and renewed or added several building leases and subscription-based information technology arrangements during the year which resulted in approximately $4.3 million of additional lease and subscription liabilities.

Currently Known Facts, Decisions, or Conditions

In developing its fiscal year 2027 budget, management considered several factors, including state and federal fiscal policies, labor affordability, rising health care costs, and regional competition for health care services. Based on these factors, management anticipates the following financial impacts for fiscal year 2027, which have been incorporated into the budget, including:

- Inpatient utilization is projected to increase by 6.6% from 2026 levels reflecting an average daily patient census of 431, driven mainly by expected increases in acute psychiatric and sub-acute volumes. Outpatient activity expressed in equivalent inpatient days is projected to increase 12.1% from 2025 with the addition of several new clinics, and additional radiology and laboratory volumes.

- A 4.5% increase in gross patient services revenue due to changes in patient care volume and mix of services.

- A Medicare general acute care rate increase of approximately 3.0%, an increase of 2.6% for outpatient services, an increase of 2.4% for skilled nursing and for subacute services, a decrease of 1.3% for home health services, an increase of 2.8% for rural health clinic services, an increase of 1.5% for acute rehabilitation, and a 2.3% increase for acute psychiatric services.

- No change in reimbursement anticipated for Medi-Cal fee-for-service acute medical/surgical, rehabilitation services, skilled nursing, subacute, psychiatric, home health, and outpatient fee-for-service reimbursement. Includes $4.7 million in anticipated fee-for-service intergovernmental transfer revenues and $6.7 million in provider fee intergovernmental transfer and grant revenue.

- Medi-Cal managed care reimbursement rate increases of approximately 1.9% based on scheduled rate increases included in multi-year contracts. Includes $27.6 million of Medi-Cal managed care rate range program and $73.5 million of District Hospital Directed Payment program intergovernmental transfer revenue.

- Annual scheduled rate increases for nongovernment managed care payers for contracts negotiated in prior years as well as expected new negotiated increases with managed care plans averaging 3.7%.

- Overall expense per adjusted patient day is projected to decrease by 7.4% from the prior year as the utilization increases described above will outpace total expense increases of 1.7% due to a shift from contracted to employed labor and a decrease in pension cost.

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Consolidated Financial Statements

Kaweah Delta Health Care District
Consolidated Statements of Net Position
(in Thousands)
June 30, 2026 and 2025

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	2026	2025
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
CURRENT ASSETS		
Cash and cash equivalents	$ 12,466	$ 6,595
Board-designated and trustee assets, current portion	18,698	17,533
Accounts receivable		
Patient accounts receivable, net	167,825	154,634
Other	24,789	70,335
Total accounts receivable	192,614	224,969
Inventories	15,342	13,871
Medicare and Medi-Cal settlements	70,424	62,463
Prepaid expenses	8,633	8,234
Total current assets	318,177	333,665
NONCURRENT CASH AND INVESTMENTS		
Board-designated assets	271,267	218,025
Bond assets held by trustee	-	22,950
Assets in self-insurance trust fund	73	626
Total noncurrent cash and investments	271,340	241,601
RIGHT-TO-USE LEASE ASSETS, net of accumulated amortization	18,682	15,613
SUBSCRIPTION ASSETS, net of accumulated amortization	10,459	8,062
CAPITAL ASSETS		
Land	17,542	17,542
Buildings and improvements	447,821	437,184
Equipment	348,824	340,593
Construction in progress	16,909	18,729
	831,096	814,048
Less accumulated depreciation	(564,708)	(541,607)
Total capital assets, net	266,388	272,441
OTHER ASSETS		
Property not used in operations	5,115	5,155
Health-related investments	2,308	2,147
Net pension asset	4,590	-
Other	22,251	20,924
Total other assets	34,264	28,226
Total assets	919,310	899,608
DEFERRED OUTFLOW OF RESOURCES		
Unamortized loss on defeasance of debt	1,945	2,339
Unamortized goodwill	10,039	10,969
Total deferred outflows of resources	11,984	13,308
Total assets and deferred outflows of resources	$ 931,294	$ 912,916

See accompanying notes.

Kaweah Delta Health Care District
Consolidated Statements of Net Position
(in Thousands)
June 30, 2026 and 2025

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	2026	2025
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 37,231	$ 43,962
Accrued payroll and related liabilities	73,947	71,620
Subscription liabilities, current portion	3,298	3,031
Lease liabilities, current portion	3,727	3,204
Bonds payable, current portion	13,454	13,014
Financing leases, current portion	499	-
Notes payable, current portion	3,841	-
Total current liabilities	135,997	134,831
LEASE LIABILITIES, net of current portion	15,671	12,850
SUBSCRIPTION LIABILITIES, net of current portion	4,639	3,941
LONG-TERM DEBT, net of current portion		
Bonds payable	188,085	201,619
Financing lease payable	2,614	-
Notes payable	16,907	20,750
Total long-term debt	207,606	222,369
NET PENSION LIABILITY	-	16,169
OTHER LONG-TERM LIABILITIES	55,624	50,472
Total liabilities	419,537	440,632
DEFERRED INFLOWS OF RESOURCES		
Deferred inflows - actuarial	27,763	175
NET POSITION		
Invested in capital assets, net of related debt	63,683	60,147
Restricted		
Expendable	18,383	40,711
Nonexpendable - minority interest	3,246	1,530
Nonexpendable - permanent endowments	20,866	16,738
Unrestricted	377,816	352,983
Total net position	483,994	472,109
Total liabilities, deferred inflows of resources, and net position	$ 931,294	$ 912,916

See accompanying notes.

Kaweah Delta Health Care District
Consolidated Statements Revenues, Expenses, and Changes in Net Position
(in Thousands)
Years Ended June 30, 2026 and 2025

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	2026	2025
OPERATING REVENUES		
Net patient services revenue	$ 820,734	$ 743,868
Premium revenue	91,244	85,931
Other revenues		
Other	70,254	63,699
Total other revenues	70,254	63,699
Total operating revenues	982,232	893,498
OPERATING EXPENSES		
Salaries and wages	407,553	385,298
Employee benefits	96,679	80,948
Total employment expenses	504,232	466,246
Medical and other supplies	179,768	165,851
Medical and other fees	126,107	120,264
Purchased services	70,168	69,498
Repairs and maintenance	26,116	25,463
Utilities	10,435	10,556
Rents and leases	1,985	1,706
Depreciation and amortization	40,296	39,870
Other	23,239	26,633
Total operating expenses	982,346	926,087
Operating loss	(114)	(32,589)
NONOPERATING REVENUES (EXPENSES)		
Property tax revenue	5,703	5,882
Stimulus funds	-	48,412
Investment returns, net	12,341	14,634
Interest expense	(8,316)	(8,571)
Loss on disposal of capital assets	(337)	(111)
Total nonoperating revenues, net	9,391	60,246
INCOME BEFORE CAPITAL CONTRIBUTIONS	9,277	27,657
CAPITAL CONTRIBUTIONS	2,608	2,415
CHANGES IN NET POSITION	11,885	30,072
NET POSITION, beginning of year	472,109	442,037
NET POSITION, end of year	$ 483,994	$ 472,109

See accompanying notes.

Kaweah Delta Health Care District
Consolidated Statements of Cash Flows
(in Thousands)
Years Ended June 30, 2026 and 2025

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	2026	2025
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from net patient services revenue	$ 800,061	$ 742,725
Cash received from management services and other operating revenues	153,988	148,042
Cash payments for salaries, wages, and related benefits	(501,905)	(457,006)
Cash payments for other operating expenses	(430,094)	(407,245)
Net cash from operating activities	22,050	26,516
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Property tax revenue	2,240	2,086
Federal stimulus funds	45,546	666
Net cash from noncapital financing activities	47,786	2,752
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Interest payments on bonds payable	(7,400)	(7,755)
Principal payments on bonds payable	(13,014)	(12,585)
Interest payments on lease and subscription liabilities	(662)	(558)
Principal payments on lease and subscription liabilities	(9,505)	(6,441)
Principal payments on notes payable	-	(9,850)
Contributions received for capital expenditures	2,608	2,415
Tax revenue related to general obligation bonds	3,464	3,796
Purchase of capital assets	(22,587)	(13,715)
Proceeds from disposal of capital assets	527	10
Net cash from capital and related financing activities	(46,569)	(44,683)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest income on investments	10,394	8,582
Purchase of investments	(100,866)	(57,371)
Net health-related investment distributions	1,168	1,487
Proceeds from sales and maturities of investments	93,887	56,550
Net cash from investing activities	4,583	9,248
NET CHANGES IN CASH AND CASH EQUIVALENTS	27,850	(6,167)
CASH AND CASH EQUIVALENTS, beginning of year	109,950	116,117
CASH AND CASH EQUIVALENTS, end of year	$ 137,800	$ 109,950

See accompanying notes.

Kaweah Delta Health Care District
Consolidated Statements of Cash Flows
(in Thousands)
Years Ended June 30, 2026 and 2025

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	2026	2025
RECONCILIATION OF OPERATING LOSS TO NET CASH FROM OPERATING ACTIVITIES		
Operating loss	$ (114)	$ (32,589)
Adjustments to reconcile operating loss to net cash from operating activities		
Depreciation and amortization	40,296	39,870
Provision for bad debts	24,365	18,826
Changes in operating assets and liabilities		
Accounts receivable	(37,556)	(37,220)
Inventories, prepaid expenses, and other assets	(17,341)	16,306
Accounts payable and accrued expenses, accrued payroll related liabilities, lease liabilities, SBITA liabilities, and other long-term liabilities	12,400	21,323
Net cash from operating activities	$ 22,050	$ 26,516
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENTS OF NET POSITION		
Cash and cash equivalents in current assets	12,466	$ 6,595
Cash and cash equivalents in noncurrent cash and investments		
Board-designated cash and investments	116,131	92,623
Bond assets held by trustee	7,836	10,453
Assets in self-insurance trust fund	1,367	279
	$ 137,800	$ 109,950
NONCASH FINANCING, CAPITAL, AND INVESTING ACTIVITY		
Right-of-use assets obtained and lease obligations incurred	$ 6,989	$ 8,454
SBITA assets obtained and subscription obligations incurred	$ 6,821	$ 295

See accompanying notes.

Kaweah Delta Health Care District
Statements of Fiduciary Net Position
(in Thousands)
June 30, 2026 and 2025

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	KAWEAH DELTA HEALTH CARE DISTRICT EMPLOYEES' RETIREMENT PLAN	
	2026	2025
ASSETS		
Receivables		
Employer contribution receivable	$ -	$ 2,321
Accrued interest and dividends receivable	342	309
Total receivables	342	2,630
Investments, at fair value		
Cash and cash equivalents	5,732	2,653
Fixed income investments	82,950	63,541
Equities	231,650	224,718
Total investments	320,332	290,912
Total assets and net position restricted for pensions	$ 320,674	$ 293,542

See accompanying notes.

Kaweah Delta Health Care District
Statements of Changes in Fiduciary Net Position
(in Thousands)
Years Ended June 30, 2026 and 2025

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	KAWEAH DELTA HEALTH CARE DISTRICT EMPLOYEES' RETIREMENT PLAN	
	2026	2025
ADDITIONS		
Contributions		
Employer contributions	$ 4,500	$ 2,321
Investments income		
Net increase in fair value of investments	33,164	17,825
Interest and dividend income	11,373	8,442
Investment expense	(596)	(716)
Net income from investing	43,941	25,551
Total additions, net	48,441	27,872
DEDUCTIONS		
Benefit payments	20,781	20,026
Administrative expenses	528	555
Total deductions	21,309	20,581
INCREASE IN NET POSITION	27,132	7,291
NET POSITION RESTRICTED FOR PENSIONS		
Beginning of year	293,542	286,251
End of year	$ 320,674	$ 293,542

See accompanying notes.

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Note 1 – Basis of Presentation and Accounting Policies

A summary of significant accounting policies applied in the preparation of the accompanying consolidated financial statements follows:

Reporting entity – Kaweah Delta Health Care District (the "District") is a political subdivision of the state of California, organized and existing under the State of California Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The District is governed by a separately elected Board of Directors (the "Board").

The accounting policies of the District conform to those recommended by the Health Care Committee of the American Institute of Certified Public Accountants. The District's consolidated financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB), and the Financial Accounting Standards Board (FASB), when applicable. The District is not generally subject to state and federal income taxes. The District provides health care services to individuals who reside primarily in the local geographic area.

Principles of consolidation – The consolidated financial statements of the District include the accounts of the District; Kaweah Delta Hospital Foundation (the "Foundation"); Sequoia Regional Cancer Center, LLC (SRCC); Sequoia Regional Cancer Center – Medical Oncology, LLC (SRCC-MO); and TKC Development, LLC (TKC). SRCC, SRCC-MO, TKC, and the Foundation are component units that have been blended for presentation purposes. The District has a 75% interest in TKC, which leases real estate and equipment from the District and then subleases the real estate and equipment to SRCC and SRCC-MO. The District has a 75% interest in SRCC and an 85% interest in SRCC-MO, management services organizations providing staff, facilities, and administration services to the radiation oncology department of the District and the medical oncology department of the District. The District provides key management, administrative, and support services to SRCC and SRCC-MO, including all of their employees, leased buildings and equipment, accounting, human resources, information technology, housekeeping, risk management, and maintenance services.

The Foundation was established in March 1980, as an exempt organization under Internal Revenue Code (IRC) Section 501(c)(3) to raise funds to support the operation of the District. The Foundation's bylaws provide that all funds raised be distributed to or be held for the benefit of the District. The Foundation's general funds, which represent the Foundation's unrestricted resources, will be distributed to the District in amounts and in periods determined by the Foundation's Board of Trustees.

All intercompany transactions have been eliminated in the District's consolidated financial statements.

Proprietary fund accounting – The District utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and consolidated financial statements are prepared using the economic resources measurement focus.

Fiduciary fund accounting – Fiduciary funds for which the District acts only as an agent or trust are not included in the business-type activities of the District. These funds are reported in the statements of fiduciary net position and statements of change in fiduciary net position at the fund financial statement level.

Kaweah Delta Health Care District Employees' Retirement Plan – The "Retirement Plan" was originally adopted as a defined benefit plan effective July 1, 1984. Effective June 30, 2011, the Retirement Plan was restated and amended (see Note 11). The Retirement Plan is administered by the sponsor, the District, and Retirement Plan assets are held by the custodian of the Retirement Plan, First State Trust Company. The Retirement Committee (the "Committee") of the District retains the responsibility to oversee the management of the Retirement Plan, including the requirement that investments and assets held within the Retirement Plan continually adhere to the requirements of the California Government Code which specifies that the trustee's primary role is to preserve capital, then maintain investment liquidity and thirdly, to protect investment yield. As such, the District acts as the fiduciary of the Retirement Plan.

Use of estimates – The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP), requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Accounting standards – Pursuant to GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989, Financial Accounting Standards Board (FASB) and American Institute of Certified Public Accountants (AICPA) Pronouncements*, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

Net patient services revenue and patient accounts receivable – Net patient services revenue is reported at the estimated net realizable amount from patients, governmental programs, health maintenance and preferred provider organizations, and insurance contracts under applicable laws, regulations, and program instructions. Net realizable amounts are generally less than the District's established rates. Final determination of certain amounts payable is subject to review by appropriate third-party representatives. Subsequent adjustments, if any, arising from such reviews are recorded in the year final settlement becomes known. Significant concentrations of net patient accounts receivable at June 30, 2026 and 2025, include Medicare, 41.5% and 33.5%, respectively, and Medi-Cal, 20.5% and 24.7%, respectively. The District provides for estimated losses on amounts receivable directly from patients based on historical bad debt experience. Past due status is based on the date the account is determined to be payable directly from the patient. When the account is deemed uncollectible in accordance with District policy, it is written off to bad debt expense. Recoveries from previously written-off accounts are recorded when received. At June 30, 2026 and 2025, the District provided allowances for losses on amounts receivable directly from patients totaling $48.8 million and $47.6 million, respectively. Amounts written off to bad debt expense included in net patient services revenue totaled approximately $24.4 million and $18.8 million for 2026 and 2025, respectively.

The District renders service to patients under contractual arrangements with the Medicare and Medi-Cal programs. Medicare payments are primarily prospective for inpatients, while Medicare payments for outpatients are based on a combination of a fee-for-service schedule and prospective reimbursement. Medi-Cal inpatient payments are subject to the state's prospective payment system. Medi-Cal outpatient services are reimbursed on a fee-for-service schedule. The programs' administrative procedures preclude final determination of amounts due for services to program patients until after the cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. Medicare cost reports for 2019 through 2025 are subject to audit and possible adjustment. Medi-Cal cost reports for 2025 and 2024 are subject to audit and possible adjustment. Net Medicare and Medi-Cal program patient services revenue amounted to approximately $477.4 million and $443.5 million in 2026 and 2025, respectively. The District recognized in the consolidated statements of revenues, expenses, and changes in net position a decrease of approximately $3.4 million in 2026 and an increase of $8.7 million in 2025, respectively, in net patient services revenue pertaining to the settlement of previous years' cost reports.

Cash and cash equivalents – Cash and cash equivalents include cash in bank checking, savings, and time deposit accounts, money market funds, and investments in highly liquid debt instruments with a maturity of three months or less when purchased.

Charity care – The District provides care without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policy. The District accepts all patients regardless of their ability to pay. Partial payments, to which the District is entitled from public assistance programs on behalf of patients that meet the District's charity care criteria, are reported as net patient services revenue. Charity care, which is excluded from recognition as receivables or revenue in the consolidated financial statements, provided in 2026 and 2025, measured on the basis of uncompensated cost, was $5.6 million and $5.1 million, respectively.

Inventories – Inventories are reported at cost (determined by the first-in, first-out method), which is not in excess of market value.

Prepaid expenses – Certain payments to vendors reflect costs applicable to future accounting periods and are recorded as prepaid expenses.

Investments – Investments are reported at fair value, based on quoted market prices when applicable, and realized and unrealized gains and losses are included in nonoperating revenues as investment income. The fair market value of money market funds, guaranteed investment contracts, and investments in the Local Agency Investment Funds (LAIF), an external investment pool for government agencies administered by the state of California, approximates cost due to the liquid nature of these investments.

Noncurrent cash and investments – Noncurrent cash and investments include unrestricted cash and investments designated by the Board for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes, cash, and investments held by trustees under bond indentures, and cash and investments held in the District's self-insurance trust fund.

Intangible asset – The District contributed $2.0 million of the 2004 general obligation bond proceeds to the city of Visalia (the "City") for the construction of a parking garage in exchange for 84 parking spaces for District use (see Note 9). The District's use of the parking spaces is indefinite, and the District is amortizing the asset over the estimated 25-year useful life of the parking garage. Amortization began in 2007 when the parking garage was completed and placed into service by the City.

Capital assets – Property, plant, and equipment are reported on the basis of cost or, in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities, or extend useful lives are capitalized.

Depreciation expense and amortization of capital assets are combined in the consolidated statements of revenues, expenses, and changes in net position and are computed by the straight-line method for financial reporting purposes over the estimated useful lives of the assets or the life of the lease, whichever is less, which range from 5 to 40 years for buildings and improvements, and 3 to 25 years for equipment and leasehold improvements.

At times, the District may dispose of capital assets prior to the end of the assets' projected useful life. In cases when an associated gain or loss is recognized due to the disposal, the related gain or loss is shown as a nonoperating revenue or expenditure in the consolidated statements of revenue, expenses, and changes in net position.

Right-to-use lease assets and lease liabilities – The District has recorded intangible right-to-use assets as a result of implementing GASB Statement No. 87, *Leases* (GASB No. 87). The right-to-use lease assets are initially measured at an amount equal to the initial measurement of the related lease liability plus any lease payments made prior to the lease term, less lease incentives, and plus ancillary charges necessary to place the lease into service. The right-to-use lease assets are amortized on a straight-line basis over the life of the related lease. The District recognizes lease contracts or equivalents that have a term exceeding one year and that meet the definition of an other than short-term lease. The District uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the District's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Subscription assets and subscription liabilities – The District has recorded subscription assets as a result of implementing GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* (GASB No. 96). The subscription assets are initially measured at an amount equal to the initial measurement of the related to subscription-based information technology arrangements (SBITA). The subscription assets are amortized on a straight-line basis over the life of the related lease. The District recognizes SBITA contracts or equivalents that have a term exceeding one year and that meet the definition of an other than short-term contract. The District uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the District's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Consolidated statements of revenues, expenses, and changes in net position – All revenues and expenses directly related to the delivery of health care services are included in operating revenues and expenses in the consolidated statements of revenues, expenses, and changes in net position. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or investment income.

Medical malpractice and general liability self-insurance – The District maintains a self-insurance policy against malpractice and comprehensive general liability loss with supplemental coverage for losses in excess of $4.0 million per incident and $6.0 million in aggregate with a coverage limit of $20.0 million per incident and in aggregate. The current portion of the related liability is reported in accounts payable and accrued expenses on the consolidated statements of net position, while the long-term portion is included in other long-term liabilities. The District has established an irrevocable trust for the purpose of appropriating assets to cover such losses. Under the trust agreement, the trust assets can only be used for payment of malpractice losses, general liability losses, related expenses, and the cost of administering the trust. The assets of the trust and related liabilities are reported on the consolidated statements of net position. Income from the trust assets, estimated losses from claims, and administrative costs are reported in the consolidated statements of revenues, expenses, and changes in net position.

Losses from asserted and unasserted claims identified under the District's incident reporting system are accrued based on estimates that incorporate the District's past experience as well as other considerations, including the nature of each claim or incident and relevant trend factors. The District's accrued malpractice losses also include an estimate of possible losses attributable to incidents that may have occurred, but have not been identified under the incident reporting system. The District has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Estimated future payments relating to malpractice losses have been discounted at a 3.0% rate.

Workers' compensation self-insurance – The District maintains a self-insurance policy against workers' compensation losses with supplemental coverage for losses in excess of $1.5 million. The Board has designated funds for the payment of workers' compensation claims. The current portion of the related liability is reported in accrued payroll and related liabilities on the consolidated statements of net position, while the long-term portion is included in other long-term liabilities. Losses from asserted and unasserted claims identified under the District's incident reporting system are accrued based on estimates that incorporate the District's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. The District's accrued workers' compensation losses also include an estimate of possible losses attributable to incidents that may have occurred, but have not been identified under the incident reporting system. The District has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Estimated future payments relating to workers' compensation losses have been discounted at a 4.0% rate.

Medical benefits self-insurance – The District maintains a policy of self-insuring medical costs up to $850,000 per employee. The related liability is reported in accrued payroll and related liabilities on the consolidated statements of net position. Losses from asserted and unasserted claims identified under the District's reporting system are accrued based on estimates that incorporate the District's past experience and relevant trend factors. The District's accrued medical insurance liability also includes an estimate of possible losses attributable to incidents that may have occurred, but have not been reported.

Compensated absences – The District's benefits-eligible employees earn vacation, short-term illness, and holiday leave, referred to as Paid Time Off (PTO), at varying rates based upon qualifying service hours. Employees may accumulate PTO up to a specified maximum. Accrued PTO is paid to the employee upon termination of employment or upon conversion to nonbenefits-eligible status. The estimated amount of PTO payable to employees is reported as a current liability as of June 30, 2026 and 2025. Extended Illness Bank (EIB) time is also earned at a specific rate per qualified service hour. Employees who were vested in the District's defined benefit retirement plan as of June 30, 2011 (the effective date it was "frozen"), were offered a one-time opportunity to have their accrued EIB time applied to length of service up to a maximum of one-year service credit. However, no payment is made for accrued EIB time when employment is terminated.

Premium revenue and health care services cost recognition – The District contracts with a Medicare Advantage company (Humana) to provide health care services for certain members for which it receives revenue on a capitated basis. Under this agreement, the District receives monthly capitation payments based upon the number of participants covered under the agreements, regardless of services actually performed by the District or others under the agreements. Revenue is recognized during the period in which the District is obligated to provide services to the participants. The agreement for which the District is compensated on a capitated basis requires that the District provide or arrange for certain covered health care services to all members covered under the contract, which results in the District compensating other providers on a fee-for-services basis for the services. The cost of these services is accrued in the period the services are provided to the members, based in part on estimates by management. The accrual of expense for such services provided includes an estimate of services provided but not reported to the District as of the fiscal year end.

Net position – Net position is divided into three components: net investment in capital assets, restricted, and unrestricted.

These classifications are defined as follows:

Net investment in capital assets – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of restricted expendable net position, the use of which is restricted through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, laws or regulations of other governments, or constraints imposed by law through constitutional provisions or enabling legislation and includes assets in self-insurance trust funds, revenue bond reserve fund assets, and net position restricted to use by donors. Restricted nonexpendable net position equals the principal portion of permanent endowments as well as minority interest.

Unrestricted – This component of net position consists of net position that does not meet the definition of "restricted" or "invested in capital assets, net of related debt."

New accounting pronouncements – In April 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements* (GASB 103). The objective of GASB 103 is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability. The financial statement improvements resulting from GASB 103 include changes to management's discussion and analysis, presentation of major discretely presented component units, reporting extraordinary and special items as unusual or infrequent items, changes to the proprietary statement of revenues, expenses, and changes in fund net position, definitions of operating and nonoperating revenues and expenses, and the presentation of budgetary comparison information. GASB 103 is effective for fiscal years beginning after June 15, 2025. The District implemented GASB 103 in 2026, the implementation of which did not have a material impact on the District's consolidated financial statements.

In September 2024, the GASB issued Statement No. 104, *Disclosure of Certain Capital Assets*. This Statement requires separate disclosure of certain capital assets in the notes, such as lease, intangible right-to-use (ROU), and subscription assets, each by major class. It also establishes new disclosure requirements for capital assets that a government has decided to sell and for which a sale is probable within one year. The District implemented GASB 104 in 2026, the implementation of which did not have a material impact on the District's consolidated financial statements.

Reclassifications – Certain reclassifications have been made to prior period financial statements to conform to the current period presentation. These reclassifications had no impact on net assets for the year ended June 30, 2026.

Note 2 – Noncurrent Cash and Investments

Cash and investments required for obligations classified as current liabilities are reported as current assets. The composition of noncurrent cash and investments at June 30 were as follows (in thousands):

	2026	2025
Board-designated assets		
Cash and cash equivalents	$ 116,131	$ 92,623
U.S. Treasury obligations	72,367	48,570
Federal agency obligations	11,036	4,329
Municipal obligations	5,895	6,047
Corporate obligations	40,880	31,473
Equity securities	14,827	12,958
Mutual funds	1,496	1,254
Asset and mortgage-backed securities	16,270	27,967
Alternative investments	287	333
Interest receivable	1,646	1,081
Current portion	(9,568)	(8,610)
	$ 271,267	$ 218,025

	2026	2025
Bond assets held in trust		
Cash and cash equivalents	$ 7,836	$ 10,453
Federal agency obligations	-	519
U.S. Treasury obligations	-	19,772
Interest receivable	-	42
Current portion	(7,836)	(7,836)
	$ -	$ 22,950

	2026	2025
Assets in self-insurance trust fund		
Cash and cash equivalents	$ 1,367	$ 279
U.S. Treasury obligations	-	1,429
Interest receivable	-	6
Current portion	(1,294)	(1,088)
	$ 73	$ 626

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Note 3 – Fair Value of Assets and Liabilities

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The three levels of inputs that may be used to measure fair value within the fair value hierarchy are:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

The following tables present the fair value measurements of assets recognized in the accompanying consolidated statements of net position reported at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall (in thousands):

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	June 30, 2026				
	Level 1	Level 2	Level 3	Investments Held at Net Asset Value	Balance
Cash and cash equivalents	$ 113,638	$ -	$ -	$ -	$ 113,638
U.S. Treasury obligations	72,367	-	-	-	72,367
Federal agency obligations	-	11,036	-	-	11,036
Municipal obligations	-	5,895	-	-	5,895
Corporate obligations	-	40,880	-	-	40,880
Asset and mortgage-backed securities	-	16,270	-	-	16,270
Other Foundation assets	16,323	-	-	287	16,610
	$ 202,328	$ 74,081	$ -	$ 287	$ 276,696

	June 30, 2025				
	Level 1	Level 2	Level 3	Investments Held at Net Asset Value	Balance
Cash and cash equivalents	$ 94,381	$ -	$ -	$ -	$ 94,381
U.S. Treasury obligations	69,770	-	-	-	69,770
Federal agency obligations	-	4,848	-	-	4,848
Municipal obligations	-	6,048	-	-	6,048
Corporate obligations	-	31,474	-	-	31,474
Asset and mortgage-backed securities	-	27,968	-	-	27,968
Other Foundation assets	14,212	-	-	333	14,545
	$ 178,363	$ 70,338	$ -	$ 333	$ 249,034

Note 4 – Bank Deposits

At June 30, 2026 and 2025, the District had bank balances totaling $25.2 million and $15.5 million, respectively, which approximate book balances. Of these balances, $3.8 million and $4.0 million were insured by the Federal Deposit Insurance Corporation at June 30, 2026 and 2025, respectively, and the remainder was collateralized. The California Government Code (the Code) requires financial institutions to secure the District's deposits, in excess of insured amounts, by pledging government securities as collateral. The fair value of pledged securities must equal at least 110% of the District's deposits.

Note 5 – Investments

GASB Statement No. 40, *Deposit and Investment Risk Disclosures—An Amendment of GASB Statement No. 3*, requires the District to disclose its deposit and investment policies related to investments with credit risk or deposits with custodial credit risk, the credit ratings and maturities of its investments (other than U.S. government obligations or obligations guaranteed by the U.S. government), and additional disclosures related to uninsured deposits. A summary of scheduled maturities by investment type at June 30, 2026, is as follows (in thousands):

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		Investment Maturities (in Years)		
	Fair Value	Less than 1	1–5	More than 5
U.S. Treasury obligations	$ 72,368	$ 10,638	$ 61,267	$ 463
Federal agency obligations	11,036	-	10,982	54
Corporate obligations	40,880	1,480	39,262	138
Municipal obligations	5,895	1,395	4,500	-
Asset and mortgage-backed securities	16,269	13	16,256	-
LAIF	63,361	63,361	-	-
CAMP	45,527	45,527	-	-
Money market funds	4,750	4,750	-	-
	260,086	$ 127,164	$ 132,267	$ 655
Equity securities	14,827			
Alternative investments	287			
Mutual funds	1,496			
	$ 276,696			

A summary of scheduled maturities by investment type at June 30, 2025, is as follows (in thousands):

		Investment Maturities (in Years)		
	Fair Value	Less than 1	1–5	More than 5
U.S. Treasury obligations	$ 69,770	$ 16,143	$ 53,288	$ 339
Federal agency obligations	4,848	4,780	17	51
Corporate obligations	31,474	4,607	26,774	93
Municipal obligations	6,048	589	5,459	-
Asset and mortgage-backed securities	27,968	162	27,806	-
LAIF	48,594	48,594	-	-
CAMP	36,717	36,717	-	-
Money market funds	9,070	9,070	-	-
	234,489	$ 120,662	$ 113,344	$ 483
Equity securities	12,958			
Alternative investments	333			
Mutual funds	1,254			
	$ 249,034			

Investment activities of the District are governed by sections of the Code, which specify the authorized investments that may be made by the District. The District's investment policy (the "Policy") requires that all investing activities of the District comply with the Code and also sets forth certain additional restrictions that exceed those imposed by the Code. The Foundation is governed by the IRC; therefore, its investment activities are not subject to the same requirements as the District.

Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Investments held for longer periods are subject to increased risk of adverse interest rate changes. The District's investment policy provides that no investment shall be made in any security having a term remaining to maturity exceeding five years at the time of investment. The Foundation's Policy allows for longer-term investments.

Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Policy requires that, to be eligible for investment, corporate notes shall be rated "A," or its equivalent, or better by a nationally recognized rating service at the time of purchase. The Policy also limits investment in collateralized mortgage obligations to obligations rated "AA," or its equivalent, or better. All of the District's investments in corporate obligations and collateralized mortgage obligations met these requirements as of June 30, 2026 and 2025. The Policy allows for investments in LAIF up to the maximum amount allowed by the State of California. The investment in LAIF is sufficiently liquid to permit withdrawal of cash at any time without prior notice or penalty. The State of California Treasurer's office has regulatory oversight of LAIF. The Policy includes no limitations or restrictions related to investments in United States Treasury or federal agency obligations. The Policy also allows for investment in shares of beneficial interest issued by a joint power authority (JPA) organized pursuant to the Code that invests in the securities and obligations authorized under the Code. The Code requires that the JPA issuing the shares shall have retained an investment adviser with appropriate size and experience as outlined in the Code. The District is a participant in a JPA program, the California Asset Management Program, commonly known as "CAMP," for the purpose of pooling local agency assets for investing. Participation in the JPA program is open to any public agency in California. The JPA program is governed by a Board of Trustees (Trustees), all of whom are experienced investment officers or employees of the public agency members. The Trustees are responsible for setting the overall policies and procedures for and for overall administration of the JPA. The CAMP pool is managed to maintain a dollar-weighted portfolio maturity of 60 days or less and seeks to maintain a constant net asset value (NAV) of one dollar per share.

Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The market value of LAIF investments represented 22.9% and 19.5% of the District's total investment market value at June 30, 2026 and 2025, respectively. The market value of CAMP investments represented 16.5% and 14.7% at June 30, 2026 and 2025, respectively.

Note 6 – Capital Assets

A summary of changes in capital assets during 2026 is as follows (in thousands):

	Beginning Balance 2025	Additions	Deletions	Transfers	Ending Balance 2026
Land	$ 17,542	$ -	$ -	$ -	$ 17,542
Buildings and improvements	437,184	490	-	10,147	447,821
Equipment	340,593	16,353	(8,651)	529	348,824
Construction in progress	18,729	8,856	-	(10,676)	16,909
	814,048	25,699	(8,651)	-	831,096
Less accumulated depreciation and amortization	541,607	30,894	(7,793)	-	564,708
	$ 272,441	$ (5,195)	$ (858)	$ -	$ 266,388

A summary of changes in capital assets during 2025 is as follows (in thousands):

	Beginning Balance 2024	Additions	Deletions	Transfers	Ending Balance 2025
Land	$ 17,542	$ -	$ -	$ -	$ 17,542
Buildings and improvements	428,209	11	-	8,964	437,184
Equipment	334,316	6,642	(1,782)	1,417	340,593
Construction in progress	22,757	7,061	-	(11,089)	18,729
	802,824	13,714	(1,782)	(708)	814,048
Less accumulated depreciation and amortization	512,148	31,120	(1,661)	-	541,607
	$ 290,676	$ (17,406)	$ (121)	$ (708)	$ 272,441

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Note 7 – Health-Related Investments

The following table summarizes the District's health-related investments recorded on the equity method at June 30 (in thousands):

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	2026	2025
Cypress Company, LLC	$ 757	$ 750
Sequoia Surgery Center, LLC	194	400
Sequoia Integrated Health Plan, LLC	1,238	920
Visalia Kidney Center	119	77
	$ 2,308	$ 2,147

Investment in Cypress Company, LLC (CyCo) – In August 2010, Cypress Surgery Center formed CyCo, a real estate holding company organized as a California limited liability company, and transferred all of its real property and associated real estate debt, along with certain other assets and liabilities, to CyCo. The District holds a 40% investment in CyCo.

Investment in Sequoia Surgery Center, LLC (formerly Cypress Surgery Center) – At June 30, 2017, the District held a 31% investment in a free-standing ambulatory surgery center located within the District. In August 2010, Cypress Surgery Center completed a "merger" with the Center for Ambulatory Medicine and Surgery (CAMS), a local ambulatory surgery center, and changed its legal name to Sequoia Surgery Center, LLC, as well as its organizational structure from a California limited partnership to a California limited liability company. To effect the merger, Cypress Surgery Center acquired 100% of the assets and outstanding ownership interests of CAMS in exchange for approximately 52% ownership in Cypress Surgery Center (now Sequoia Surgery Center, LLC). As a result of this acquisition, the District's ownership interest in Sequoia Surgery Center, LLC, was diluted from 64.9% to approximately 31%. Sequoia Surgery Center, LLC, leases its ambulatory surgery center facility from CyCo.

Investment in Northwest Visalia Senior Housing, LLC – In January 2017, the District made its initial capital contribution to establish its investment in a joint venture company. Northwest Visalia Senior Housing, LLC, was formed in furtherance of the members' elder care mission and to put into practice innovative approaches to care of the elderly, simultaneously addressing the housing and health care needs of the elderly. This will be accomplished in part by constructing, developing, owning, maintaining, and operating a full service assisted living retirement facility in Visalia, California. Northwest Visalia Senior Housing, LLC, is owned 33.33% by the District; 33.33% by Shannon Senior Care, LLC; 20% by BTV Senior Housing, LLC; and 13.34% by Millennium Advisors, Inc. Net loss allocations have exceeded initial capital contributions resulting in a deficit equity position for Northwest Visalia Senior Housing, LLC. The District has recorded its interest in the joint venture company at $0 in accordance with GAAP as the District is not liable for obligations of the joint venture company.

Investment in Sequoia Integrated Health, LLC – In August 2016, the District made its initial capital contribution to establish its investment in a joint venture company formed in furtherance of the members' common purpose to better serve and coordinate health care services for the communities of Tulare and Kings Counties, and to own and operate an integrated delivery network in California and activities incident thereto. Sequoia Integrated Health, LLC, is owned 40% by the District; 10% by Sierra View Local Health Care District; 25% by Key Medical Group, Inc.; and 25% by Foundation for Medical Care of Tulare and Kings Counties, Inc. The District has recorded its interest in the joint venture based upon its initial capital contributions.

Investment in Quail Park Retirement Village, LLC – The District holds an investment in a joint venture company that operates an assisted living facility in Visalia, California. The joint venture company, Quail Park Retirement Village, LLC, is owned 44% by the District and 56% by Living Care Visalia, LLC, and its affiliated investors. Under the terms of the joint venture agreement, the District has an option to purchase an additional 5% of Living Care Visalia, LLC's equity interest at fair market value determined at the time of sale. Distributions have exceeded initial capital contributions resulting in a deficit equity position for Quail Park Retirement Village, LLC. The District has recorded its interest in the joint venture company at $0 in accordance with GAAP, as the District is not liable for obligations of the joint venture company.

Investment in Laurel Court at Quail Park, LLC – In June 2011, the District made its initial capital contribution to establish its investment in a joint venture company formed to construct, develop, own, maintain, and operate a full service memory care retirement facility in Visalia, California. The joint venture company, Laurel Court at Quail Park, LLC, is owned 44% by the District and 56% by Living Care Visalia, LLC. Distributions have exceeded initial capital contributions resulting in a deficit equity position for Laurel Court at Quail Park, LLC. The District has recorded its interest in the joint venture company at $0 in accordance with GAAP, as the District is not liable for obligations of the joint venture company.

Income or loss from equity method investments is included in other revenues in the corresponding consolidated statements of revenues, expenses, and changes in net position.

Note 8 – Right-to-Use Lease Assets and Lease Liabilities and Subscription Assets and Subscription Liabilities

Right-to-use lease assets and lease liabilities – The District is a lessee for noncancelable leases of buildings with lease terms through 2036. There are no residual value guarantees included in the measurement of the District's lease liabilities nor recognized as an expense for the years ended June 30, 2026 and 2025. The District does not have any commitments that were incurred at the commencement of the leases. The District is subject to variable equipment usage payments that are expensed when incurred. There were no amounts recognized as variable lease payments as lease expense on the consolidated statements of revenues, expenses, and changes in net position for the years ended June 30, 2026 and 2025. No termination penalties were incurred during the fiscal year.

The following table summarizes the District's right-to-use lease assets at June 30 (in thousands):

	Balance as of June 30, 2025	Increases	Decreases	Balance as of June 30, 2026
Right-to-use lease assets	$ 28,176	$ 6,989	$ (1,067)	$ 34,098
Less accumulated amortization	(12,563)	(3,920)	1,067	(15,416)
Right-to-use lease assets, net	$ 15,613	$ 3,069	$ -	$ 18,682

	Balance as of June 30, 2024	Increases	Decreases	Balance as of June 30, 2025
Right-to-use lease assets	$ 19,722	$ 8,454		$ 28,176
Less accumulated amortization	(9,258)	(3,305)	-	(12,563)
Right-to-use lease assets, net	$ 10,464	$ 5,149	$ -	$ 15,613

The following table summarizes the District's lease liabilities at June 30 (in thousands):

	Balance as of June 30, 2025	Increases	Decreases	Balance as of June 30, 2026
Lease liabilities	$ 16,054	$ 6,992	$ (3,648)	$ 19,398

	Balance as of June 30, 2024	Increases	Decreases	Balance as of June 30, 2025
Lease liabilities	$ 10,725	$ 8,454	$ (3,125)	$ 16,054

The future lease liability principal and interest lease payments as of June 30, 2026, were as follows (in thousands):

	Principal Payments	Interest Payments	Total
Years Ending June 30,			
2027	$ 3,727	$ 517	$ 4,244
2028	3,416	438	3,854
2029	2,929	364	3,293
2030	2,102	296	2,398
2031	1,671	238	1,909
2032–2036	5,553	396	5,949
	$ 19,398	$ 2,249	$ 21,647

The District evaluated the right-to-use lease assets for impairment and determined there was no impairment for the years ended June 30, 2026 and 2025.

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Subscription assets and subscription liabilities – The District entered into various agreements for information technology subscriptions. These agreements range in terms through 2030. Variable payments based upon the use of the underlying subscription assets are not included in the subscription liabilities because they are not fixed in substance; therefore, these payments are not included in subscription assets or subscription liabilities. There were no variable subscription expenses or payments in the fiscal years ended June 30, 2026 and 2025.

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The following tables summarize the District's subscription assets at June 30 (in thousands):

	Balance as of June 30, 2025	Increases	Decreases	Balance as of June 30, 2026
Subscription assets	$ 21,499	$ 6,821	$ (6,131)	$ 22,189
Less accumulated amortization	(13,437)	(4,424)	6,131	(11,730)
Subscription assets, net	$ 8,062	$ 2,397	$ -	$ 10,459

	Balance as of June 30, 2024	Increases	Decreases	Balance as of June 30, 2025
Subscription assets	$ 21,204	$ 295	$ -	$ 21,499
Less accumulated amortization	(9,051)	(4,386)	-	(13,437)
Subscription assets, net	$ 12,153	$ (4,091)	$ -	$ 8,062

The following table summarizes the District's subscription liabilities at June 30 (in thousands):

	Balance as of June 30, 2025	Increases	Decreases	Balance as of June 30, 2026
Subscription liabilities	$ 6,972	$ 6,821	$ (5,856)	$ 7,937

	Balance as of June 30, 2024	Increases	Decreases	Balance as of June 30, 2025
Subscription liabilities	$ 9,992	$ 295	$ (3,316)	$ 6,972

The future subscription liability principal and interest lease payments as of June 30, 2026, were as follows (in thousands):

Years Ending June 30,	Principal Payments	Interest Payments	Total
2027	$ 3,298	$ 205	$ 3,503
2028	2,952	118	3,070
2029	897	39	936
2030	790	18	808
	$ 7,937	$ 380	$ 8,317

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The District evaluated the subscription assets for impairment and determined there was no impairment for the years ended June 30, 2026 and 2025.

Note 9 – Bonds and Note Payable

Bonds payable – During January 2014, the District issued $48.9 million of Kaweah Delta Health Care District General Obligation Refunding Bonds, Series 2014, at rates of 3.6% to 4.1%, solely to advance refund $47.3 million of the outstanding 2004 General Obligation bonds, bearing interest rates of 5.0% to 5.5%. Mandatory sinking fund redemption payments on the bonds began on August 1, 2015. The final maturity of the bonds is August 1, 2034. The advance refunding of the 2004 bonds resulted in decreased debt service payments of approximately $6.3 million over the next 21 years, and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $4.3 million.

The general obligation bonds represent the general obligation of the District. The District has the power and is obligated to cause annual *ad valorem* taxes to be levied upon all property within the District, subject to taxation by the District, and collected by the County for payment, when due, of the principal and interest on the bonds.

During October 2015, the District issued $19.4 million of Kaweah Delta Health Care District Revenue Bonds, Series 2015A. The 2015A revenue bonds bear interest at a rate of 2.975%. The net proceeds were used to prepay existing debt, including a portion of the 2006 and 2011B revenue bonds as well as the outstanding amount of the 2003A and 2011A revenue bonds. The 2015A revenue bonds maturing on or after June 1, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium. The current refunding of the 2003A and 2006 bonds and the advanced refunding of the 2011A and 2011B bonds resulted in decreased debt service payments of approximately $3.9 million over the next 18 years, and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $3.0 million.

During December 2015, the District issued $98.4 million of Kaweah Delta Health Care District Revenue Bonds, Series 2015B. The 2015B revenue bonds bear interest rates of 3.25% to 5.0%. The net proceeds were for the acquisition, construction, installation, and equipping of the second, fifth, and sixth floors of the Kaweah Delta Medical Center's Acequia Wing, expansion and improvement of the emergency department, expansion of outpatient endoscopy services, acquisition and implementation of a new information technology platform (Cerner), acquisition and construction of a new urgent care center, improvements to the Exeter Health Clinic campus, and other projects. The 2015B revenue bonds, maturing on or after June 1, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium.

During December 2017, the District issued $59.5 million Series 2017C of Kaweah Delta Health Care District Revenue Bonds. The 2017C revenue bonds bear interest at a rate of 2.71%. The net proceeds were used to refund $46.0 million of the 2012 revenue bonds and to prepay the remaining 2011 Siemens lease obligation. The 2017C revenue bonds maturing on or after June 1, 2028, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium. The advance refunding of the 2012 revenue bonds and lease obligations resulted in decreased debt service payments of approximately $8.6 million over the next 24 years and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $5.9 million.

During January 2020, the District issued $6.8 million Series 2020A and $8.2 million Series 2020B of Kaweah Delta Health Care District Revenue Bonds. Both the 2020A and the 2020B revenue bonds bear interest at a rate of 2.37%. The net proceeds were used to fund capital projects and equipment. The 2020A and 2020B revenue bonds, maturing on or after June 1, 2020, to May 31, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 102% of the principal amount of the bonds. The 2020A and 2020B revenue bonds, maturing on or after June 1, 2025, to May 31, 2030, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 101% of the principal amount of the bonds. The 2020A and 2020B revenue bonds, maturing on or after June 1, 2030, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium.

During April 2022, the District issued $32.0 million Series 2022 Kaweah Delta Health Care District Revenue Refunding Bonds. The revenue bonds bear interest at a rate of 2.0%. The net proceeds were used to prepay existing debt, including the remaining 2017A and 2017B bonds. The 2022 revenue bonds, maturing on or after June 1, 2022, to May 31, 2023, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 102% of the principal amount of the bonds. The 2022 revenue bonds, maturing on or after June 1, 2023, to May 31, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 101% of the principal amount of the bonds. The 2022 revenue bonds, maturing on or after June 1, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium. The current refunding of the 2017A and 2017B bonds resulted in decreased debt service payments of approximately $1.3 million over the next nine years and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $1.2 million.

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Principal and interest payments due on the revenue and general obligation bonds over the next five years, and in five-year increments, thereafter, calculated at the interest rate in effect at June 30, 2026, are as follows (in thousands):

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Years Ending June 30,	Principal	Interest
2027	$ 13,454	$ 7,035
2028	13,919	6,649
2029	14,413	6,245
2030	14,883	5,849
2031	15,349	5,463
2032–2036	45,796	21,976
2037–2041	39,535	14,143
2042–2046	42,665	4,433
	200,014	$ 71,793
Unamortized premium	1,525	
	201,539	
Less current portion	13,454	
	$ 188,085	

The bond indenture agreements contain various restrictive covenants that include, among other things, minimum debt service coverage, maintenance of minimum liquidity, restrictions on certain additional indebtedness, and requirements to maintain certain financial ratios. Management believes the District's days cash on hand and debt service coverage ratios met required levels as of June 30, 2026.

The District paid approximately $8.1 million and $8.3 million in interest in 2026 and 2025, respectively, on all debt, including revenue and general obligation bonds, and notes payable.

A summary of changes in bonds payable for the years ended June 30 is as follows (in thousands):

	Beginning Balance	Additions	Payments	Ending Balance
2026	$ 213,028	$ -	$ 13,014	$ 200,014
2025	$ 225,613	$ -	$ 12,585	$ 213,028

Notes payable – To offset the delay and assist with the cash flow issues caused by the change from PRIME to QIP, the State legislature authorized the California Health Facilities Financing Authority (CHFFA) to provide low-cost working capital loans to eligible nondesignated public hospitals to assist with their operations. This program is referred to as the CHFFA Bridge Loan Program. The District received loans in phase one of the program totaling $7.9 million and totaling $9.8 million in phase two. The loans mature 24 months from loan execution and the proceeds were to be used for working capital expenditures. The loans had no interest but were offset by a 1% loan fee at distribution. The loans were subordinate to the revenue bonds but are secured by an interest in future Medi-Cal payments. The phase one loans were repaid in fiscal year 2024 and phase two loans were repaid in fiscal year 2025.

The Distressed Hospital Loan Program (DHLP) was established through legislation to offer interest-free, working capital loans to non-profit and publicly operated, financially distressed hospitals, while they implement turnaround strategies to regain financial viability. The District received a DHLP loan of $20.8 million in 2025. Payments are deferred for the first 18 months and then equal installments are required until the loan is repaid over the remaining 54 months. The loan is on parity with the revenue bonds and secured by an interest in future Medi-Cal payments. During fiscal year 2025, the District applied for and was granted a loan modification that extended the payment deferral period an additional 12 months. In fiscal year 2026, the District also applied for a loan modification to forgive the first 12 months payments. This modification was approved subsequent to June 30, 2026.

A summary of changes in noninterest-bearing notes payable for the years ended June 30 is as follows (in thousands):

	Beginning Balance	Additions	Payments	Ending Balance
2026	$ 20,750	$ -	$ -	$ 20,750
2025	$ 30,600	$ -	$ 9,850	$ 20,750

Principal payments due on notes payable over the next five years, and thereafter for the years ended June 30 are as follows (in thousands):

	Principal
Years Ending June 30,	
2027	$ 3,843
2028	4,611
2029	4,611
2030	4,611
2031	3,074
2032	-
	$ 20,750

Note 10 – Self-Insured Claims

As discussed in Note 1, the District is self-insured for medical malpractice and general comprehensive liability, medical benefits, and workers' compensation, and discounts the medical malpractice and general comprehensive and workers' compensation liabilities using a 3.0% and 4.0% discount rate, respectively. The following is a summary of the changes in the self-insured plan liabilities, included in accounts payable and accrued expenses, accrued payroll and related liabilities, and other long-term liabilities on the consolidated statements of net position for the years ended June 30 (in thousands):

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	Beginning Balance	Additions	Payments	Ending Balance	Current Portion
2026	$ 41,300	$ 44,784	$ 39,419	$ 46,665	$ 13,561
2025	$ 32,310	$ 47,740	$ 38,750	$ 41,300	$ 12,526

Note 11 – Employees' Retirement Plan

The Kaweah Delta Health Care District's Employees' Retirement Plan (the "Retirement Plan") is a single-employer defined benefit pension plan established to provide retirement benefits for District employees based on length of service and the average of the highest consecutive three years of earnings. The Retirement Plan is administered by a retirement plan committee appointed by the Board of the District. The Retirement Plan issues a separate financial report that includes financial statements and required supplemental information.

Employees were eligible to participate on the first day of a pay period following six months of service if hired prior to January 1, 2003, and elected not to participate in the salary deferral plan's matching contribution component. Employees hired on or after January 1, 2003, were not eligible to participate in the Retirement Plan. Employees' retirement benefits vested 100% after five years of completed service.

Effective June 30, 2011, the Retirement Plan was amended to suspend all accruals and otherwise freeze benefits under the plan.

The Retirement Plan complies with the IRC and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). As a government plan, the Retirement Plan is exempt from the annual minimum funding requirements of ERISA. The Retirement Plan's funding policy is to contribute an annual amount necessary to amortize any unfunded net pension liability over a 15-year period. The District made $4.5 million in contributions to the plan in 2026 and $2.3 million in contributions to the plan in 2025.

Investment activities of the Retirement Plan are governed by sections of the California Government Code, which allow any type of prudent investment. The Plan's investment policy is intended to assist the Retirement Committee (the "Committee") in prudently evaluating investment options and establishing an allocation strategy for the assets of the Plan. The objective of the Committee is to ensure the security of all accrued benefits. The Committee's asset allocation strategy is predicated on meeting its objective with a desire to effectively manage funded status volatility and mitigate undue risk exposure, taking into consideration performance expectations, risk tolerance and volatility, liquidity, and the Plan's time horizon. An analysis of Plan liabilities, projected liquidity needs and assets is used to determine the Plan's long-term investment strategy. The Committee intends to utilize a range of investment alternatives to achieve the return and risk objectives of the Plan.

Concentration of credit risk is the risk of loss attributed to the magnitude of the Retirement Plan's investment in a single issuer. As of June 30, 2026 and 2025, there were no investments exceeding 5% of the Plan's total investments. There were no investments held with a single corporate or government agency issuer that exceeded 5% of the Plan's total investments (excluding investments issued by the U.S. government and mutual funds that are exempt from reporting).

There were no other concentrations of investments at or exceeding 5% of the Retirement Plan's fiduciary net position (excluding investments issued by the U.S. government and mutual funds that are exempt from reporting).

Investments are measured at fair value on a recurring basis. Recurring fair value measurements are those that GASB require or permit in the statement of net position at the end of each reporting period. Fair value measurements are categorized based on the valuation inputs used to measure an asset's fair value: Level 1 inputs are quoted prices in active markets for identical assets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs. The mutual funds are priced using a NAV. The mutual funds may include several different underlying investments, including equities, bonds, real estate, and global securities. The NAV price is derived from the value of these investments, accrued income, anticipated cash flows (maturities), management fees, and other fund expenses. Certain investments within the fund may be deemed unobservable and not considered to be in an active market.

The following tables present the fair value measurements of financial instruments recognized by the Retirement Plan in the accompanying fiduciary statements of net position measured at fair value on a recurring basis and the level within the GASB Statement No. 72, *Fair Value Measurement and Application,* fair value hierarchy in which the fair value measurements fall at June 30 (in thousands):

	Fair Value Measurements at June 30, 2026			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 5,732	$ -	$ -	$ 5,732
Fixed income investments	73,775	9,175	-	82,950
Equity securities	231,650	-	-	231,650
Total assets in the fair value hierarchy	$ 311,157	$ 9,175	$ -	$ 320,332

	Fair Value Measurements at June 30, 2025			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,653	$ -	$ -	$ 2,653
Fixed income investments	51,393	12,148	-	63,541
Equity securities	224,718	-	-	224,718
Total assets in the fair value hierarchy	$ 278,764	$ 12,148	$ -	$ 290,912

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The District uses a measurement date of June 30 for each year presented. The actuarial valuation for fiscal years 2026 and 2025 is based on participant data as of June 30, 2025 and 2024. Update procedures were used to roll forward the total pension liability to the measurement date.

Components of pension cost and deferred outflows and deferred inflows of resources under the requirements of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—An Amendment of GASB Statement No. 27,* are as follows for the years ended June 30 (in thousands):

	2026	2025
PENSION COST		
Administrative expense	$ 528	$ 554
Interest	22,449	22,310
Expected return on assets, net of investment expenses	(21,385)	(20,784)
Recognition of deferred outflows	9,543	(2,996)
Recognition of deferred inflows	194	(996)
Total pension cost	$ 11,329	$ (1,912)
DEFERRED INFLOWS OF RESOURCES		
Established July 1		
Difference between expected and actual experience	$ 4,698	$ (2,541)
Net difference in expected and actual earnings	(22,723)	(1,626)
Deferred inflows of resources, beginning of year	(18,025)	(4,167)
AMOUNT RECOGNIZED IN CURRENT YEAR PENSION COST		
Established July 1		
Difference between expected and actual experience	4,698	(2,533)
Net difference in expected and actual earnings	5,040	(1,459)
Amount recognized in current year	9,738	(3,992)
Deferred inflows of resources, end of year	$ (27,763)	$ (175)

Amounts reported as deferred inflows of resources to be recognized in pension cost for future years (in thousands):

Years Ending June 30,	
2027	$ (9,525)
2028	(8,263)
2029	(5,464)
2030	(4,511)
	$ (27,763)

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Participant data for the plan is as follows for June 30:

	2026	2025
Active employees	405	434
Terminated vested	919	957
Retirees receiving benefits	1,022	977
Total participants	2,346	2,368

The following table summarizes changes in net pension liability for the years ended June 30 (in thousands):

	2026	2025
TOTAL PENSION LIABILITY		
Interest	$ 22,449	$ 22,310
Differences between expected and actual experience	4,705	(50)
Benefit payments	(20,781)	(20,026)
NET CHANGES IN TOTAL PENSION LIABILITY	6,373	2,234
TOTAL PENSION LIABILITY, beginning of year	309,711	307,477
TOTAL PENSION LIABILITY, end of year	316,084	309,711
PLAN FIDUCIARY NET POSITION		
Employer contributions	4,500	2,321
Net investment gain	43,941	25,550
Benefit payments	(20,781)	(20,026)
Administrative expenses	(528)	(554)
NET CHANGES IN PLAN FIDUCIARY NET POSITION	27,132	7,291
PLAN FIDUCIARY NET POSITION, beginning of year	293,542	286,251
PLAN FIDUCIARY NET POSITION, end of year	320,674	293,542
NET PENSION (ASSET) LIABILITY, end of year	$ (4,590)	$ 16,169
Plan fiduciary net position as percentage of total pension liability	101.45%	94.78%
Covered employee payroll	N/A	N/A
Net pension liability as percent of covered payroll	N/A	N/A

The pension liability is based on actuarial calculations applied to census data and the Retirement Plan provisions. Certain estimates in the data were updated in the current year, resulting in a reduction in the total pension liability as reflected in the above differences between expected and actual experience.

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The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of June 30, 2026:

Valuation date	June 30, 2025
Actuarial cost method	Entry Age Normal
Amortization method	Level Dollar
Asset valuation method	Fair Value
Actuarial assumptions (including 2% inflation)	
Discount Rate	7.5%
Mortality	RP-2014 table, projected using MP-2021
Projected Salary Increases	N/A

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The mortality assumptions are updated annually with the most recent tables published by the Society of Actuaries, if any.

Sensitivity of Net Pension Asset at June 30, 2026, to changes in the Discount Rate (in thousands)	
1% Decrease (6.5%)	$ (24,070)
Current Discount Rate (7.5%)	$ 4,590
1% Increase (8.5%)	$ 29,170

The District also administers a salary deferral plan (the “Salary Plan”) available to substantially all full-time employees meeting certain service requirements. The Salary Plan qualifies under the IRC Section 401(k) and was established to provide supplemental retirement income for employees of the District. Under the Salary Plan, the District makes matching contributions to participants in accordance with an established schedule based upon each participant’s years of service with the District. The District made matching contributions of $9.2 million and $0 million in 2026 and 2025, respectively. The District recognized pension expense of $9.8 million and $9.3 million related to the Salary Plan in 2026 and 2025, respectively. The liability related to the Salary Plan was $15.3 million and $14.7 million at June 30, 2026 and 2025, respectively. The Salary Plan does not meet the definition of a blended component unit or a fiduciary activity.

Employees are immediately vested in their own contributions and earnings on those contributions. Employees become vested in the District contributions and earnings on District contributions after completion of five years of service. Nonvested contributions are forfeited upon termination of employment and such forfeitures are used to offset future District contributions. For the years ended June 30, 2026 and 2025, forfeitures reduced the District’s pension expense by $173,000 and $114,000, respectively.

The District offers its employees a deferred compensation plan (the “457 Plan”) created in accordance with IRC Section 457. The 457 Plan, available to all District employees with at least one year of service, permits them to defer a portion of their salary until future years. The deferred compensation is not available to employees until termination, retirement, death, or certain emergency situations. The 457 Plan does not meet the definition of a blended component unit or a fiduciary activity.

Note 12 – Commitments

At June 30, 2026, the District has projects in progress to construct, improve, and equip various routine, ancillary, and support services. Major projects in progress include the expansion of the existing mental health facility, operating room improvements, and various other improvement projects to existing facilities. Total costs expended as of June 30, 2026, related to these projects and others are approximately $16.9 million. The total estimated cost of these projects at completion is approximately $26.8 million, of which approximately $20.6 million has been expended or contractually obligated. Funding for the projects is expected to include a combination of grant funds, operating cash flows, community donations, and funded reserves.

The District has entered into various physician income guarantees whereby, pursuant to the terms in the agreement, the District has extended income guarantees to certain doctors in exchange for the doctors maintaining a medical practice in the District's service area. Payments under the guarantees are expected to be forgiven over a two to three-year period, should the physician remain in practice in the community. If a doctor terminates his medical practice in the community prior to the completion of the term, the remaining balance under the guarantee is immediately due and payable. The District records expenses under these guarantees as payments are made to physicians. Accounts receivable are recorded when defaults under the agreements occur and are evaluated for collectability.

Note 13 – Contingencies

Malpractice, workers' compensation, and comprehensive general liability claims have been asserted against the District by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. There are also known incidents that have occurred through June 30, 2026, that may result in the assertion of additional claims. District management has accrued their best estimate of these contingent losses.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Over the last several years, government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in the imposition of significant fines and penalties as well as significant repayment of previously billed and collected revenue for patient services. Management believes that the District is in substantial compliance with current laws and regulations and that any potential liability arising from compliance issues have been properly reflected in the District's consolidated financial statements or are not considered to be material to the District's financial position and results of operations as of and for the years ended June 30, 2026 and 2025.

As disclosed in Note 1, the Medicare and Medi-Cal government reimbursement programs account for a substantial amount of the District's net patient services revenue. Expenditure reduction efforts and budget concerns within the United States, and California legislature continue to create uncertainty over the volume of future health care funding. It is at least reasonably possible that future reimbursements for patient services under these programs could be negatively impacted.

Note 14 – Intergovernmental and Direct Grant Supplemental Payment Programs

The District participates in various supplemental payment programs administered by the state of California including intergovernmental transfer and direct grant funding mechanisms. A summary of these programs is as follows:

Hospital Quality Assurance Fee Managed Care Medi-Cal Payment Program – The District receives supplemental Medi-Cal payments under California's Hospital Quality Assurance Fee (HQAF) Program. The program is administered by the California Department of Health Care Services (DHCS) and is subject to federal approval by the Centers for Medicare & Medicaid Services (CMS). Under the HQAF Program, qualifying hospitals and other participating entities are subject to hospital quality assurance fees or related funding mechanisms. The resulting revenues, together with available federal financial participation, are used to support supplemental Medi-Cal payments to eligible hospitals through various payment methodologies, including fee-for-service and managed care payments.

As a nondesignated public hospital (NDPH), the District participates in applicable supplemental payment programs established under the HQAF framework. Payments to the District are dependent upon applicable state legislation, federal approvals, and the availability of program funding. The HQAF Program has been extended through successive program periods and remains in effect. The current program is subject to ongoing federal and state approvals and modifications, including changes to payment methodologies and funding arrangements. In fiscal years 2026 and 2025, the District recognized HQAF program-related net patient services revenue of $2.5 million and $18.5 million, respectively.

NDPH IGT Program – The District also receives supplemental Medi-Cal inpatient payments under the Non-Designated Public Hospital (NDPH) Intergovernmental Transfer (IGT) Program established under Assembly Bill 113 (AB 113). The program allows eligible NDPHs to use IGTs as the non-federal share of Medi-Cal payments, enabling the State to obtain corresponding federal financial participation. The amount and timing of payments are subject to applicable federal and state requirements, including federal approval of the payment methodology and available funding. The AB 113 NDPH supplemental payment program remains in effect, with DHCS currently projecting payments through fiscal year 2025–26. The District recognized net patient services revenue of $7.0 million and $5.2 million related to this program for the years ended June 30, 2026 and 2025, respectively.

Rate Range IGT Program – The District receives "Rate Range" IGT-managed Medi-Cal payments. Federal rules allow that NDPH facilities may access managed care rate range room as determined by negotiations with Medi-Cal managed care plans. As defined by law, rate range room is the difference between the amount that the State pays the managed care plans, referred to as a "lower bound" rate, and the maximum allowed, or the "upper bound" rate. This difference, or rate range, is then available through supplemental IGT payments to public entities that participate in the program in each county. The District recognized net patient services revenue of $35.0 million and $48.0 million related to this program in fiscal years 2026 and 2025, respectively.

District Hospital Directed Payment Program – On June 13, 2023, CMS approved the California Department of Health Care Services' District Hospital Directed Payment (DHDP) program for the calendar year 2023 rating period, starting January 1, 2023. The DHDP program provides supplemental payments in the form of uniform dollar increases for inpatient, outpatient, and nursing facility contracted services provided by District Hospitals (also known as nondesignated public hospitals) to Medi-Cal managed care beneficiaries. The District recognized net patient service revenue of $79.8 million and $46.5 million for this program for the years 2026 and 2025, respectively.

Quality Incentive Pool Program – The District participates in the Quality Incentive Pool (QIP) Program, which provides supplemental Medi-Cal managed care payments to eligible public hospitals based on performance against specified quality and delivery-system measures. The QIP Program was established following the conclusion of the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program on December 31, 2020. QIP payments are directed through Medi-Cal managed care plans and are based on the District's achievement of applicable performance measures and targets. Funding for the program is subject to applicable federal and state requirements, including approval by the Centers for Medicare & Medicaid Services (CMS), and the amount and timing of payments may vary based on program performance and available funding. The District recognized other operating revenue of $12.6 million and $14.0 million related to the QIP program in fiscal years 2026 and 2025, respectively.

Note 15 – Subsequent Events

Subsequent events are events or transactions that occur after the consolidated statement of net position date, but before the consolidated financial statements are issued. The District recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated statement of net position, including the estimates inherent in the process of preparing the consolidated financial statements. The District's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated statement of net position, but arose after the consolidated statement of net position date and before the consolidated financial statements are issued.

Distressed Hospital Loan Program – Subsequent to June 30, 2026, the District received approval of its request to modify the terms of its Distressed Hospital Loan Program loan. Under the approved modification, the District received forgiveness of the first 12 months of scheduled principal payments under the loan agreement. The loan forgiveness represents a nonrecognized subsequent event and, accordingly, no adjustment has been made to the amounts reported in the consolidated financial statements as of June 30, 2026.

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Required Supplementary Information

Kaweah Delta Health Care District
Supplemental Pension Information (Unaudited)
June 30, 2026 and 2025

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The following table summarizes the number of total plan participants at June 30:

	2026	2025
Active employees	405	434
Terminated vested	919	957
Retirees receiving benefits	1,022	977
Total participants	2,346	2,368

The following table summarizes changes in net pension liability for the years ended June 30 (in thousands):

	2026	2025
TOTAL PENSION LIABILITY		
Interest	$ 22,449	$ 22,310
Differences between expected and actual experience	4,705	(50)
Benefit payments	(20,781)	(20,026)
NET CHANGES IN TOTAL PENSION LIABILITY	6,373	2,234
TOTAL PENSION LIABILITY, beginning of year	309,711	307,477
TOTAL PENSION LIABILITY, end of year	316,084	309,711
PLAN FIDUCIARY NET POSITION		
Employer contributions	4,500	2,321
Net investment gain	43,941	25,550
Benefit payments	(20,781)	(20,026)
Administrative expenses	(528)	(554)
NET CHANGES IN PLAN FIDUCIARY NET POSITION	27,132	7,291
PLAN FIDUCIARY NET POSITION, beginning of year	293,542	286,251
PLAN FIDUCIARY NET POSITION, end of year	320,674	293,542
NET PENSION (ASSET) LIABILITY, end of year	$ (4,590)	$ 16,169
Plan fiduciary net position as percentage of total pension liability	101.45%	94.78%
Covered employee payroll	N/A	N/A
Net pension liability as percent of covered payroll	N/A	N/A

Kaweah Delta Health Care District
Supplemental Pension Information (Continued)
Years Ended June 30, 2026 and 2025

The District's actuarially determined contribution and actual contributions, since 2017, are presented in the following table (in thousands):

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Fiscal Year Ended	Actuarially Determined Contribution	Actual Contribution	Contribution Excess (Shortage)	Covered Payroll	Actual Contribution as a Percentage of Covered Payroll
2017	$ 6,879	$ 9,000	$ 2,121	N/A	N/A
2018	5,818	11,400	5,582	N/A	N/A
2019	4,533	11,400	6,867	N/A	N/A
2020	3,466	11,400	7,934	N/A	N/A
2021	4,414	11,400	6,986	N/A	N/A
2022	-	11,400	11,400	N/A	N/A
2023	4,350	-	(4,350)	N/A	N/A
2024	4,697	-	(4,697)	N/A	N/A
2025	2,321	2,321	-	N/A	N/A
2026	1,768	4,500	2,732	N/A	N/A
	$ 38,246	$ 72,821	$ 34,575		

Physician Recruitment

Physician Recruitment Board Report

October 2026

64	10	4	9	17
ACTIVE CANDIDATES	FY27 COMMITMENTS	CURRENT OFFERS EXTENDED	PENDING SITE VISITS	CURRENTLY IN SCREENING

PHYSICIAN GROUP TARGETS

Key Medical Associates

- Pulmonology x1
- Psychiatry x1

Oak Creek Anesthesia

- Anesthesia - Cardiac x1
- Anesthesia - General x2
- Anesthesia - Regional x1

Valley Children's

- Maternal Fetal Medicine x2
- Neonatology x1
- Pediatric Cardiology x1
- Pediatric Hospitalist x1

Orthopaedics Associates

- Ortho Joint x1
- Ortho Trauma / General x1
- Ortho Surgery (General) x1

Other Recruitment / Group TBD

- Cardiology General / HF x1
- Cardiology Interventional x1
- CT Surgery x1
- Family Medicine x5
- Gastroenterology x2
- Infectious Disease x1
- Neurology IP/OP x1
- OB/GYN x4
- Pulmonology OP x1
- Radiation Oncology x1
- Rheumatology x1
- Urology x2
- Vascular Surgery x1

FY27 YEAR-TO-DATE SUMMARY

71	10	14%
FY27 CANDIDATES PURSUED	FY27 COMMITMENTS July - October 2026	FY27 CONVERSION RATE 10 of 71 committed

BOARD NARRATIVE | SEPTEMBER 2026

During the month of September, the Physician Recruitment Team secured new commitments in several priority specialties while continuing to expand the candidate pipeline through national recruitment events.

Signed letters of intent were received from a Urologist with a May 2027 start date and a Family Medicine physician with a January 2027 start date. In early October, a second Neurologist signed a letter of intent with a January 2027 start date, marking the second Neurology commitment of the fiscal year.

OB/GYN recruitment continues to advance. Following a September site visit, an offer has been extended to an OB/GYN candidate, and work continues with Key Medical Associates to establish visa sponsorship for an additional OB/GYN candidate.

The Physician Recruitment Team recently participated in national physician career fairs in Cleveland and Los Angeles. Pipeline activity has also expanded in Vascular Surgery, Colorectal Surgery, and Vascular Neurology, with candidates in each specialty now at the site visit stage.

The recruitment of additional OB/GYN, Family Medicine, Urology, and Neurology physicians remains a top priority for the Kaweah Health Physician Recruitment team.

Active Physician Pipeline

October 2026

Kaweah Health

Phase Key:	Site Visit	Screening	Offer Extended	Offer Accepted	Leadership Call	Applied

#	Specialty	Group	Phase	Start Date
1	Colorectal Surgery	TBD	Site Visit	
2	OB/GYN	Key Medical Associates	Site Visit	08/01/27
3	Orth Surgeon (General)	Orthopedic Assoc	Site Visit	01/04/27
4	PM&R	TBD	Site Visit	
5	Ped Hospitalist	Valley Children's	Site Visit	
6	Pulmonology	TBD	Site Visit	
7	Vascular Neurology	TBD	Site Visit	
8	Vascular Surgery	TBD	Site Visit	
9	Vascular Surgery	TBD	Site Visit	02/01/27
10	Anesthesia	Oak Creek	Screening	
11	Anesthesia	Oak Creek	Screening	
12	Anesthesia (Cardiac)	Oak Creek	Screening	
13	Cardiology (EP)	TBD	Screening	
14	Cardiology (Interventional)	KH Sequoia Cardiology	Screening	
15	Cardiothoracic Surgery	TBD	Screening	
16	Colorectal Surgery	TBD	Screening	
17	Diagnostic Radiology	Mineral King Radiology	Screening	
18	Family Medicine	1099 - TBD	Screening	
19	Family Medicine	TBD	Screening	
20	Internal Medicine (Outpatient)	TBD	Screening	
21	OB/GYN	TBD	Screening	
22	Radiation Oncology	SRCC	Screening	
23	Radiation Oncology	Sequoia Regional Cancer Center	Screening	
24	Vascular Surgery	TBD	Screening	
25	Vascular Surgery	TBD	Screening	
26	Vascular Surgery	TBD	Screening	
27	Heart Failure	1099 - KH Direct	Offer Extended	08/01/27
28	OB/GYN	TBD	Offer Extended	08/01/27
29	Pulmonology	TBD	Offer Extended	09/01/27
30	Rad Oncology	Sequoia Radiation Oncology	Offer Extended	08/01/27
31	Cardiology (EP)	1099 - KH Direct	Offer Accepted	11/01/26
32	ENT	Valley ENT	Offer Accepted	09/01/27
33	Endocrinology	1099 - KH Direct	Offer Accepted	TBD
34	Family Medicine	1099 - KH Direct	Offer Accepted	11/01/26
35	Family Medicine	1099 - KH Direct	Offer Accepted	01/01/27
36	Family Medicine	Venice Hills Medical Associates	Offer Accepted	11/01/26
37	Nephrology	Dr. Javed's Group	Offer Accepted	

#	Specialty	Group	Phase	Start Date
38	Neurology	1099 - KH Direct	Offer Accepted	11/04/26
39	Neurology	TBD	Offer Accepted	01/01/27
40	Neurology	TBD	Offer Accepted	09/01/27
41	Nurse Practitioner	Mineral King Radiology	Offer Accepted	07/06/26
42	Nurse Practitioner	Oak Stone Medical Group	Offer Accepted	09/30/26
43	Orth Surgeon (Hand)	Orthopedic Assoc	Offer Accepted	12/01/26
44	PM&R	Dr. Sorenson's Practice	Offer Accepted	05/01/27
45	Pediatrics	1099 - KH Direct	Offer Accepted	12/01/26
46	Pediatrics	Venice Hills Medical Associates	Offer Accepted	11/01/26
47	Psychiatry	Oak Stone Psychiatry	Offer Accepted	07/01/27
48	Urology	1099 - KH Direct	Offer Accepted	05/01/27
49	Colorectal Surgery	TBD	Leadership Call	
50	Family Medicine	TBD	Leadership Call	
51	Infectious Disease	TBD	Leadership Call	08/01/27
52	OB/GYN	TBD	Leadership Call	
53	Pulmonology	TBD	Leadership Call	
54	Pulmonology	TBD	Leadership Call	08/01/27
55	Vascular Surgery	TBD	Leadership Call	
56	Anesthesia	Oak Creek	Applied	
57	Gastroenterology	TBD	Applied	
58	Internal Medicine/Outpatient	TBD	Applied	
59	OB/GYN	TBD	Applied	
60	Orth Surgeon (General)	Orthopedic Assoc	Applied	
61	PM&R (Interventional Pain)	TBD	Applied	
62	Ped Hospitalist	TBD	Applied	
63	Tele-Endocrinology	TBD	Applied	
64	Urology	TBD	Applied	

Overall Strategic Plan

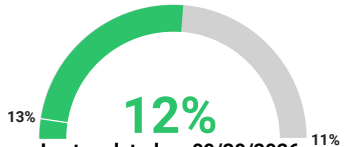
FY2027 Strategic Plan
Monthly Performance

Board of Directors
October 28, 2026



Kaweah Health
MORE THAN MEDICINE. LIFE.

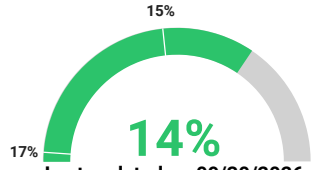
Decrease Overall Turnover Rate to less than equal to 11% (FYE-26)



Last updated on 09/30/2026

Move from baseline of 13% to target of 11%

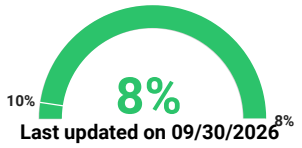
Decrease New Hire Turnover Rate (leaving within 6 months) to less than or equal to 15% (FYE-26)



Last updated on 09/30/2026

Move from baseline of 17% to target of 15%

Decrease RN New Hire Turnover Rate (leaving within 6 months) to less than or equal to 8% (FYE-26)



Last updated on 09/30/2026

Move from baseline of 10% to target of 8%

Strategy Summary - Ideal Environment

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Employee Engagement and Retention	On Track	07/01/2026	06/30/2027	Hannah Mitchell	Current Month * Ideal Environment Strategic Plan presented to the Board of Directors. * Employee Engagement Survey Action Plan Roadmap drafted. * Market adjustments under way for selected positions to remain competitive with local pay rates. * 401k step-vesting communicated September 2026 for December 31, 2026 effective date. * Multidisciplinary task force formed to collaborate on potential TeamSTEPPs training rollout. * Introduced 7 new KHU Scholars Programs focused on IT certification prep. Next Steps * Present on the Ideal Environment Strategic Plan and New Hire Turnover Project at the October Leadership Team Meeting. * Introduce new interview guides to leaders. * NRC to present the Employee Engagement and Patient Experience Crosswalk to the Executive Team, Patient Experience, and Organizational Development in October onsite. * CNO/NRC/Organizational Development meeting to review Employee Engagement Survey results, key takeaways, and nursing action plan ideas scheduled in October. * Present the Employee Engagement Survey Action Plan Roadmap to the Executive Team and finalize tactics and communication plan. * Present Employee Engagement Survey Results to the Board of Directors in October. * Multidisciplinary task force to present TeamSTEPPS rollout plan to CEO and Chief of Staff, followed by the Executive Team and MEC if supported. * New Mandatory AI Training for all staff and Positive Employee Relations Knowledge Check for leaders rolling out 10/1.
School Partnerships and Volunteer Programs	On Track	07/01/2026	06/30/2027	Jaime Morales	Current Month *In September, we hired 12 external RN New Grads and had 0 Internal RN New Grad transfers, for a total of 12 New Grad RNs joining Kaweah Health. *60 New Grad RNs graduated from Kaweah Health's Licensed Nurse Residency Program (LNRP). *25 employees graduated from the Unitek Nursing Program on September 24, 2026. *Welcomed Unitek Cohort #6 into Year Two of the three-year program, beginning the Nursing Core. *Employee Educational Sponsorship interviews underway for Unitek January 2027 cohort, with selections to be made by Unitek in October. Interviews were also conducted for the Carrington September 2026 ADN cohort, with three Kaweah Health employees selected for the cohort. *Hosted Unitek and COS on-site visits and nursing program information sessions. Shared COS TEAS preparation course with employees to support successful program applications. * In September, 216 individuals volunteered more than 3623 hours. *Working to secure volunteer coverage for the new Discharge Lounge. Next Steps *Conduct a Kaweah Health employee survey to determine how many employees qualify for the COS RN program with completion of all required pre-requisite courses. The goal is to better prepare qualified employees for the TEAS exam and applications to the Summer 2027 Year-Round Program. *Continue recruitment and hiring of RN New Grads, with a focus on candidates interested in building a long-term career with Kaweah Health and who are familiar with our organization, culture, and patient population. *Development of an internal employee webpage dedicated to Career Pathways and educational and sponsorship opportunities.
Resident Engagement and Retention	On Track	07/01/2026	06/30/2027	Angel Smith	Fellowship match closes in October and I will be following up with residents about opportunities to return to KH after fellowship.
Physician and Provider	On Track	07/01/2026	06/30/2027	Teresa Boyce	Revision of governing documents complete. CME Coordinator in training; Mentoring program development in process.

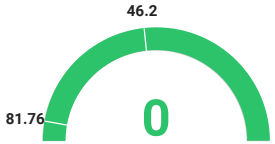
Reduce Serious Safety Event Occurrences by 10% to 2.88 (FYE-26)



Last updated on 09/30/2026

Move from baseline of 3.2 to target of 2.88

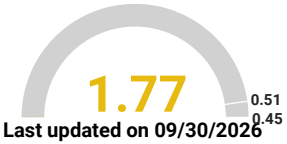
CMS thirty-day death rate among surgical inpatients with complications less than or equal to 46.20 (CMS 50th percentile) (FYE-26)



Last updated on 09/30/2026

Move from baseline of 81.76 to target of 46.2

Hospital Acquired Pressure Injuries, Stage 2 and above, <0.46 (World Health Organization pooled incidence rate) (FYE-26)



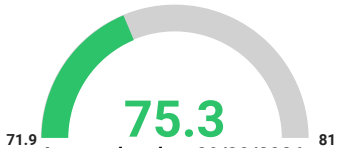
Last updated on 09/30/2026

Move from baseline of 0.51 to target of 0.45

Strategy Summary - Outstanding Health Outcomes

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Safety Program Optimization	On Track	07/01/2026	06/30/2027	Cindy Vander Schuur	YTD Update: *Current process for handoff and escalation reviewed/mapped with process improvement engineer and clinical directors *Updated draft of standard safety rounding board Next Steps *Executive approval of the Safety Rounding board *Finalize the rounding structure with executive team. * Identify any gaps, strategize and implement a handoff and escalation process that will negate any gaps in processes, if identified *Planned presentations to PPC and LNR
Reduce Hospital Acquired Infections (HAI)	On Track	07/01/2026	06/30/2027	Shawn Elkin	YTD Update: * We project November outcomes to trend down based on several interventions that are underway or planned Next Steps: * CLABSI – Nursing, CLIP form and presence at all central line insertion. Physicians, resident education and practicum, only 2 physicians present at insertion * Critical Care multidisciplinary rounds review central lines * IV Safety Team/PICC nurses evaluating vascular devices
Surgical Safety Program	On Track	07/01/2026	06/30/2027	Chris Patty	YTD Update: * Significant elevation (undesirable) in the PSI-12 (postoperative DVT/PE) metric remains * First meetings held with intraoperative stakeholder team to develop action plan for improving mechanical VTE prophylaxis Next Steps: * Will meet in early October with Pharmacy and Trauma teams to evaluate workflows related to PSI fallouts
Safety in Nursing Practice	On Track	07/01/2026	06/30/2027	Mara Lawson	YTD Update: *Overall, we are making progress. HAPI rates increased related to new repositioning protocol. Wound RN informed team at deployment that heightened awareness initially leads to increased reporting. Numbers are already trending down from most current reported data. Next Steps: *HAPI Action Plan being finalized and implemented *Preparing to re-implement Post Falls Huddle

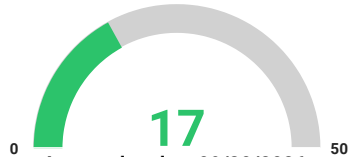
HCAHPS "Would Recommend Hospital" is 72.3 (FY2027)



Last updated on 09/30/2026

Move from baseline of 71.9 to target of 81

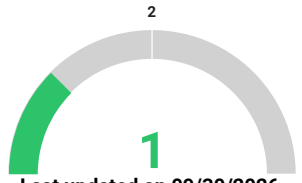
50 community outreach events FYTD-27



Last updated on 09/30/2026

Move from baseline of 0 to target of 50

Two or more Cuadrilla events in FYTD-27



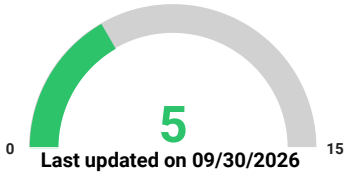
Last updated on 09/30/2026

Stay above baseline of 2

Strategy Summary - Patient and Community Experience

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Promote a Patient-Centric Culture	On Track	07/01/2026	06/30/2027	Deborah Volosin	YTD Update: * Compassionate Communication Trainings continued throughout the month of September and into October.
Improve the hospital's physical spaces.	On Track	07/01/2026	06/30/2027	Deborah Volosin	YTD Update * PX rounded with Facilities, Maintenance, and CEO.
Strengthen Community Engagement	On Track	07/01/2026	06/30/2027	Deborah Volosin	YTD Update: * In September, CE met with CAC groups, had employees at the Tulare County Fair, hosted a NICU reunion, sponsored community events, and attended Visalia and Tulare City luncheons.

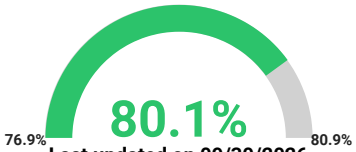
Recruit 15 Specialty Providers



Last updated on 09/30/2026

Move from baseline of 0 to target of 15

NPS "Likelihood to Recommend: Medical Practices" at 80.9 or greater



Last updated on 09/30/2026

Move from baseline of 76.9% to target of 80.9%

Perform on Seven or more QIP measures for calendar year 2026



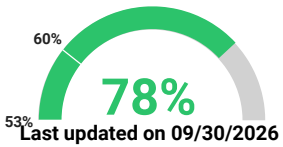
Last updated on 09/30/2026

Stay above baseline of 0

Strategy Summary - Physician Alignment

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Recruit Physicians and Advanced Practice Providers	On Track	07/01/2026	06/30/2027	JC Palermo	YTD Update: *Continued outreach to UCSF Fresno and Dignity Health to build early-career FM pipelines, including participation in the upcoming UCSF Fresno career fair. *Continued visa sponsorship discussions with Key Medical Group for an OB/GYN candidate and support of Key's Plastic Surgeon search; ongoing acquisition conversations with two local physicians. *Recruited to date: 5 of 15 Specialty Providers, 2 of 5 Primary Care Physicians. *No changes to the recruitment and onboarding process this period; prior refinements remain in place. Next Steps: *Participate in the UCSF Fresno career fair, hold the FM coordinator meeting, and work to secure face time with Dignity Health. *Continue active specialty and PCP searches, including Family Medicine, Acute Heart Failure, and Radiation Oncology. *Advance OB/GYN visa sponsorship and acquisition conversations.
Mature Value Based Care Capabilities to position Kaweah Health as the Must Have Network	On Track	07/01/2026	06/30/2027	Tom Boggs	YTD Update: * Workgroup teams progressing on Annual Wellness Visits and Quality (Gaps in Care / Stars) execution. *Execute on AWVs - Trend improving YOY Next Steps: *Chronic Care Management team to support ER "Super Users" and ASM model *Execute contract for Implementation of Oracle tools to support accurate documentation, patient orchestration
Journey to Top Decile Ambulatory Clinic Performance	On Track	07/01/2026	06/30/2027	Tom Boggs	YTD Update: *Initial Benchmarking of Practice Operations for baseline underway - starting with Physician Productivity Next Steps: *Complete Physician Productivity Benchmarks *Internal development of reporting for Access (Third Next Available) in progress. Focus on Patient Experience *Reformat Internal Financial Statements to reflect Physician Practices

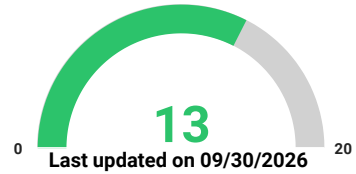
Through the work of the OR Optimization Committee, increase overall block usage to 60% in FY2027 (12% increase)



Last updated on 09/30/2026

Move from baseline of 53% to target of 60%

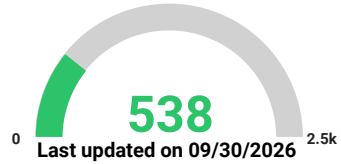
Complete 20 Mitra Clip Procedures in FY2027



Last updated on 09/30/2026

Stay between baseline of 0 and target of 20

2,500 new patient PCP visits in the rural health clinics for FY2027 (39% increase)



Last updated on 09/30/2026

Move from baseline of 0 to target of 2.5k

Strategy Summary - Strategic Growth and Innovation

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Grow Targeted Service Line Volumes	On Track	07/01/2026	06/30/2027	Kevin Bartel	YTD Update: *Volume goals met in many areas -- TAVR, mitral clip & EP procedures, endoscopy, Urology, general surgery *9 beds opened in SNF, with phase 2 & 3 in planning Next Steps: *Physician liaison support enlisted with identified elective practices to promote more known referral patter pipelines with local providers to drive clinic volume, including Ortho as volumes were below budget *Recruitment of EP cardiologist with identified candidate, potential start date may fall into early FY28
Enhance Medical Center Capacity and Efficiency	On Track	07/01/2026	06/30/2027	Kevin Bartel	YTD Update: *Continue OR Optimization committee -- had a large Add-on volume bringing the total OR utilization up to 78% -- KH leaders are in dept during first case starts to encourage staff and MDs to be accountable *Expansion of CV PACU and construction of two OP procedure rooms on track to be completed in FY2027 Next Steps: *Focus of OR Optimization committee will be on addressing first case start times and OR turnaround time, as not all metrics did not meet established goals in September *While construction of two OR procedure rooms is on track for completion in FY27, licensing delays may ultimately push clinical use of this space into FY28
Expand access for patients though Clinic Network Development	On Track	07/01/2026	06/30/2027	Ivan Jara	YTD Update: * Outpatient clinic access continues to grow through the development of new locations, new specialties, and the expansion of current services. * Current efforts include physician recruitment for Primary and Specialty Care and advanced practice provider recruitment Continued efforts to identify new clinic locations (Specialty, Rural, and Commercial) * Ongoing review and application for federal/state programs and grants
Innovation	On Track	07/01/2026	06/30/2027	Kevin Bartel	YTD Update: *Hospitalist pilot of AI ambient listening is complete *Workday demo for HR, Finance, Supply Chain & Payroll *RHTP grant submission -- informed that KH's proposal was not selected for funding *Care at Home program -- Straw Model developed for workflows, etc Next Steps: *Broad rollout of AI ambient listening for Hospitalists and APPs, with nursing pilot scheduled for Q2 2027 *Internal meetings to decide whether to move forward with AI agents in Workday *TMaH -- meetings with partner health plans along with non-binding application of interest *Scoping of $ risk exposure in Ambulatory Medical Specialty (ASM) Model *Care at Home program -- Review with clinic Medical Director Leadership for feedback
Enhance Health Plan Programs	On Track	07/01/2026	06/30/2027	Sonia Duran-Aguilar	YTD Update: * Evaluate CHW Medi-Cal Benefit application and submit to MCPs for CHW reimbursement contracting.

Emergency Services

SERVICE LINE BOARD REPORT



Kaweah Health Emergency Dept.
Cameron Beatty DNP, MBA, NEA-BC
559.624.2410

Executive Summary

Executive narrative

Top Three Wins

- Participation in the employee engagement survey was the highest it has been in over 10 year (190 respondents). Engagement scores for the ED were significantly higher year-over-year, 3.9 to 4.10
- Travel nurse footprint has been reduced from 45+ to 25. We have replaced these with full-time FTEs.
- Volumes continue to grow (on pace for 104,000 CY 26' visits)

Top Three Risks

- Admission holds and hallway beds: undermine quality, safety, length of stay, travel nurse reliance
- Employee turnover at 21% represents approximately 52 colleagues in a 250 FTE department
- Patients and the community losing coverage may increase volumes even further

Goals for the next year

- Pursue and achieve Lantern Award Recognition from the Emergency Nurses Association (ENA)
- Increase the patient experience, reflected by increasing Net Promoter Scores
- Continue reduction of travel nurse footprint
- Keep job vacancy rates below 10%, reduce voluntary turnover

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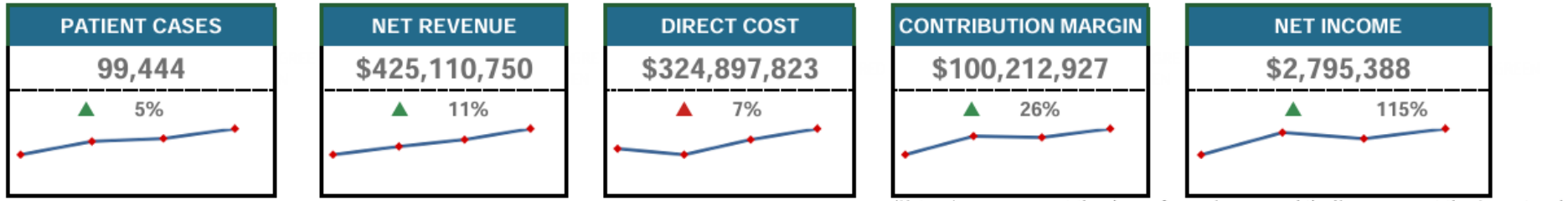
Financials

Emergency Services

- Operating Margin
  - Net Revenue $425,110,750 **(Higher than FY 25')**
  - Direct Cost $324,897,823 **(Higher than FY 25')**
  - Contribution Margin $100,212,927 **(Much higher than FY 25')**
- Budget Variance
  - Increase in COGs, equipment, staffing
- Productivity
  - Increased volume and admission holds, productivity continues to be an opportunity
- Provided by Finance
  - See attached finance report

Financials

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026



*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	87,968	93,806	95,062	99,444 ▲	5%	
Net Revenue	$324,763,264	$355,979,759	$382,787,969	$425,110,750 ▲	11%	
Direct Cost	$285,292,186	$273,357,606	$303,152,542	$324,897,823 ▲	7%	
Additional Reimb	$45,753,752	$43,002,392	$56,410,868	$69,083,957 ▲	22%	
Contribution Margin	$39,471,078	$82,622,153	$79,635,426	$100,212,927 ▲	26%	
Indirect Cost	$92,434,552	$87,990,417	$97,985,319	$97,417,539 ▼	-1%	
Net Income	($52,963,475)	($5,368,264)	($18,349,892)	$2,795,388 ▲	115%	

Dashboard

Service Line Metrics

- Quality
  - 36.9 NPS score annualized
  - 1.2% LWBS rate
  - >86% sepsis compliance 4 months in a row
- Employee
  - 22% turnover
  - 13 open positions, <6% vacancy
  - Moderately Engaged. Jump from 3.9 to 4.1 raw engagement score



Growth & Access

GENERAL METRICS	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
ED Volume	8577	8023	9049	8413	8926	8607	8735	8876	8753			
% pts Left Without Being Seen	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.4%	1.8%			
Benchmark LWBS	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
% of Pts Admitted	22.0%	22.0%	22.0%	22.0%	21.0%	22.0%	22.0%	22.0%	22.0%			
% of Pts Discharged	68.0%	68.0%	67.0%	68.0%	69.0%	69.0%	67.0%	68.0%	68.0%			
% of Pts Left During Treatment	4.5%	4.4%	5.1%	4.6%	4.3%	3.7%	4.3%	4.3%	4.6%			
% of Pts. Transferred	1.3%	1.0%	1.1%	1.2%	1.2%	1.3%	1.1%	0.9%	0.9%			
% of Pts Left AMA	1.0%	1.0%	0.8%	0.9%	0.8%	0.9%	0.9%	1.1%	1.1%			

ED THROUGHPUT METRICS	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Median Length of Stay (LOS) for Admitted Inpatients	862	841	815	718	669	636	657	769	767			
LOS-A Benchmark	500	500	500	500	500	500	500	500	500	500	500	500
Median LOS in Min for Discharged Pts	282	283	290	288	273	268	265	275	278			
LOS-D Benchmark	240	240	240	240	240	240	240	240	240	240	240	240
Median LOS in Min for Admit Order to ED Depart (Inpt Status)	566	544	524	429	400	363	373	494	472			
LOS Admit to Depart Benchmark	287	287	287	287	287	287	287	287	287	287	287	287
Average LOS in Minutes for Admitted Mental Health Pts	1373	1441	1372	1360	1706	1800	1498	1413	1310			
(Vit. Analystics) LOS ESI 4s	198	190	191	189	173	156	155	183	187			
ESI 4s Benchmark	100	100	100	100	100	100	100	100	100	100	100	100
900	80	90	109	97	83	92	94	100	146			
ESI 5s Benchmark	100	100	100	100	100	100	100	100	100	100	100	100

Patient Experience & Quality

PATIENT EXPERIENCE	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
NRC Net Promoter Score	34.7	34.3	32.9	36.8	35.6	38.3	35.8	38.7	31.3			
Net Promotor Score Benchmark	43.0	43.0	43.0	43.0	43.0	43.0	43.0	43.0	43.0	43.0	43.0	43.0
Time Spent with Provider	38.3	37.5	36.6	38.7	38.3	39.7	38.4	40.2	40.0			
Time Spent with Provider Benchmark	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0
Trust in Provider	47.1	48.6	44.8	47.3	47.4	49.3	47.0	48.0	46.7			
Trust in Provider Benchmark	53.0	53.0	53.0	53.0	53.0	53.0	53.0	53.0	53.0	53.0	53.0	53.0

SEPSIS	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
% of ED Sepsis Order Set Compliance	92%	67%	97%	100%	100%	100%	100%	100%	100%			
Order Set Benchmark	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
CMS % Sepsis Bundle Compliance	57%	30%	78%	81%	82%	94%	95%	85%	86%			
Sepsis Bundle Benchmark	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%

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SERVICE LINE BOARD REPORT

Kaweah Health Trauma Department
Cameron Beatty DNP, MBA, NEA-BC
559.624.2410



Executive Summary

- Kaweah Health Trauma Department is a dedicated department that is vital to achieving and maintaining trauma center verification. We are committed to patient safety and ensure we have resources (such as equipment, personnel, and support) through our continuous focus on high-quality performance improvement reviews.

- Our Trauma program/Emergency Department saw 3,544 trauma registry patients, including 2,462 activations, for the calendar year 2025. This is an overall increase of 2% from the previous year. The trauma registrar abstracts over 50 charts per month, and Performance improvement nurses review over 100 charts monthly to improve our performance and outcomes.

- The Kaweah Health Trauma program is currently preparing for our reverification in April of 2027.

- The Trauma Department has a Community Outreach/Prevention program that participates in events in Tulare County. We teach Stop the Bleed throughout the year and have trained over 200 community members. Our classes have been taught at schools in our area, and quarterly training with The County of Tulare.

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Executive Summary (Cont.)

Top Three Wins

- Increase of 2% in trauma activations over prior year
- 100% participation in the employee engagement survey
- Stable leadership and workforce

Top Three Risks

- Change over in trauma physician group.
- Change in trauma department medical director
- Currently preparing for reverification in Apr. 2027

Goals for the next year

- Achieve three-year reverification
- Maintain and enhance community outreach (EMS week BBQ, seek out grants, helmet + water safety)
- Improve trauma charting and increase trauma quality metrics through partnership

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Financials

Inpatient Trauma Activations admitted through the ED

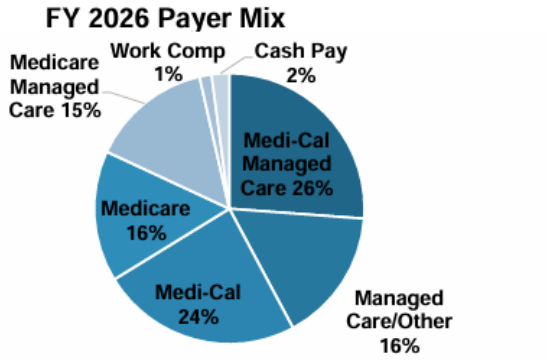
KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
491	$18,863,967	$13,682,318	$5,181,649	$1,269,682
-6%	-18%	-14%	-26%	-43%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	40%	29%	38%	26%
Managed Care/Other	15%	17%	17%	16%
Medi-Cal	12%	15%	16%	24%
Medicare	19%	19%	14%	16%
Medicare Managed Care	10%	11%	9%	15%
Work Comp	2%	4%	3%	1%
Cash Pay	2%	4%	2%	2%



Financials Outpatient ED Trauma Activations

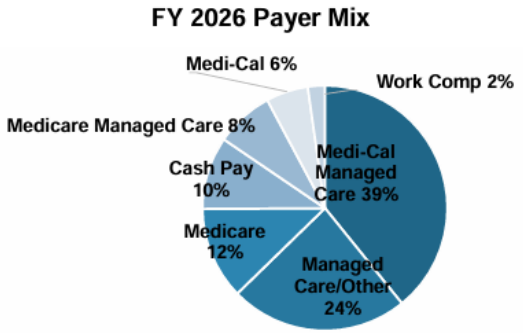
KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
771	$2,882,062	$2,809,899	$72,163	($970,149)
▲ 10%	▲ 17%	▲ 1%	▲ 643%	▲ 58%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

PAYER MIX - 4 YEAR TREND (Patient Visits)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	42%	42%	40%	39%
Managed Care/Other	24%	21%	21%	24%
Medicare	10%	10%	11%	12%
Cash Pay	8%	11%	10%	10%
Medicare Managed Care	7%	7%	8%	8%
Medi-Cal	7%	7%	8%	6%
Work Comp	2%	3%	2%	2%



Dashboard

Service Line Metrics

Registry Cases		Apr	May	Jun	Jul	Aug
Activations		176	237	210	178	246
Non Activations		91	79	94	95	94
Total		267	316	304	273	340
2026	**Benchmark**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Surgeon Response - Level 1	80%	88%	100%	92%	94%	92%
Ortho Response	80%	n/a	n/a	n/a	n/a	n/a
Neuro Response	80%	100%	100%	n/a	n/a	n/a
Femur Fixation <24 hr (avg)	24 hr.	32:49:00	20:53:00	25:03:00	16:26:00	26:44:00
Hip Fx < 24 hr	24 hr.	27:13:00	18:34:00	24:07:00	22:09:00	24:09:00
Open tib/fib <24 hr	24 hr.	13:03:00	14:35:00	16:29:00	12:54:00	5:35:00
Temps in the OR	80%	88%	67%	80.00%	100%	100%
SBIRT - Screening	80%	82%	81%	81%	89%	80%
SBIRT - Intervention	80%	83%	80%	82%	92%	75%
Trauma Registry < 60 days	80%	99%	98%	99%	98%	97%
Temps in the ED	90%	94%	90%	97%	100%	98%

	Odds Ratio									
Cohort	Spring 2022	Fall 2022	Spring 2023	Fall 2023	Spring 2024	Fall 2024	Spring 2025	Fall 2025	Spring 2026	Fall 2026
All Patients*	1.54	2.08	1.36	1.24	1.63	1.86	1.49	0.85	1.30	1.12



Growth & Access

Department Focuses/Projects

Documentation – Physician response times

Assist providers with attestation note creation so they may be reminded to document their response times.

Continue to follow up with staff and providers as we audit monthly for fallouts.

Orthopedic surgical procedures

We are emailing our liaisons to follow up on our fallouts monthly. Work with OR leadership to expedite cases reaching the 24-hour mark when it's safe to do so. As we have kept more patients since the addition of Dr. Dean this has contributed to some delays in fixation. OR leadership is consistently working on this area as we continue to grow as a facility to increase the room availability rates to help with compliance.

Community Outreach

We continue to find new opportunities for our program. Recently completed a choking hazard and car seat safety event at our NICU graduation.

The pursuit of healthiness



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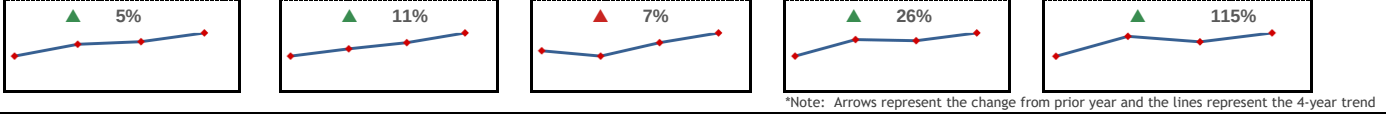
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Emergency Services - Summary

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
99,444	$425,110,750	$324,897,823	$100,212,927	$2,795,388
▲ 5%	▲ 11%	▲ 7%	▲ 26%	▲ 115%



*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS BY SERVICE LINE - FY 2026

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
ED Inpatient	15,080	$316,751,283	$231,236,316	$85,514,967	$18,444,141
Outpatient Emergency Department	81,604	$78,169,907	$63,802,705	$14,367,202	($6,756,437)
ED Trauma Inpatient	491	$18,863,967	$13,682,318	$5,181,649	$1,269,682
ED Trauma Outpatient	845	$3,378,530	$2,842,161	$536,369	($409,492)
ED Inpatient Mental Health Hospital	162	$2,460,826	$2,623,607	($162,781)	($1,140,682)
Outpatient ED Surgery	1,262	$5,486,236	$10,710,715	($5,224,480)	($8,611,823)
Emergency Services Totals	99,444	$425,110,750	$324,897,823	$100,212,927	$2,795,388

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	87,968	93,806	95,062	99,444 ▲	5%	
Net Revenue	$324,763,264	$355,979,759	$382,787,969	$425,110,750 ▲	11%	
Direct Cost	$285,292,186	$273,357,606	$303,152,542	$324,897,823 ▲	7%	
Additional Reimb	$45,753,752	$43,002,392	$56,410,868	$69,083,957 ▲	22%	
Contribution Margin	$39,471,078	$82,622,153	$79,635,426	$100,212,927 ▲	26%	
Indirect Cost	$92,434,552	$87,990,417	$97,985,319	$97,417,539 ▼	-1%	
Net Income	($52,963,475)	($5,368,264)	($18,349,892)	$2,795,388 ▲	115%	
Net Revenue Per Case	$3,692	$3,795	$4,027	$4,275 ▲	6%	
Net Rev w/o Add Reimb Per Case	$3,172	$3,336	$3,433	$3,580 ▲	4%	
Add Reimb Per Case	$520	$458	$593	$695 ▲	17%	
Direct Cost Per Case	$3,243	$2,914	$3,189	$3,267 ▲	2%	
Contrb Margin Per Case	$449	$881	$838	$1,008 ▲	20%	
CM w/o Add Reimb Per Case	($71)	$422	$244	$313 ▲	28%	
% of Add Reimb per Case/CM per Case	116%	52%	71%	69%		

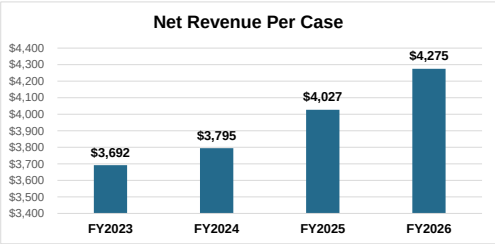
KAWEAH HEALTH ANNUAL BOARD REPORT

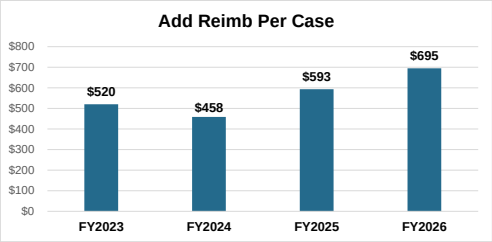
FY2026

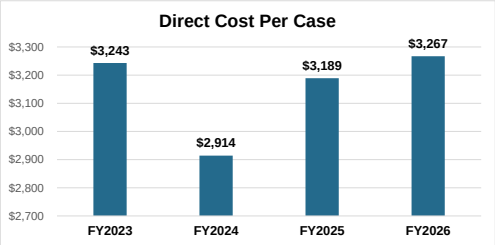
Emergency Services - Summary

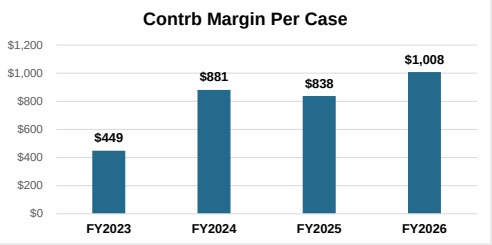
KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

GRAPHS









Note:
Source: Inpatient and Outpatient Service Line Reports
Criteria: Inpatient Service Line
Trauma - Inpatient KDMC patients with Trauma Flag valued at 1.
ED - Inpatient KDMC patients with ED Flag valued at 1.
Criteria: Outpatient Service Line
Trauma - Outpatient KDMC patients with Trauma Flag valued at 1.
ED - Outpatients in the Emergency Department Service Line, excluding Sugeries, Cath Lab and Trauma Activations
Patients in the O/P Surgery Service Line, with the ED Flag valued at 1, excludes Trauma Activations

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Emergency Services - Inpatients Admitted through the ED

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

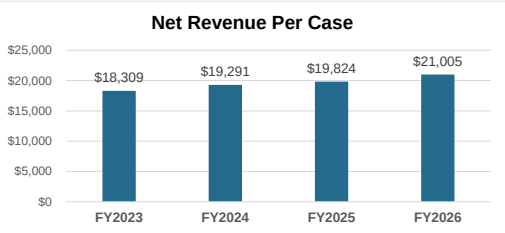
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
15,080	$316,751,283	$231,236,316	$85,514,967	$18,444,141
▲ 5%	▲ 11%	▲ 8%	▲ 21%	▲ 326%

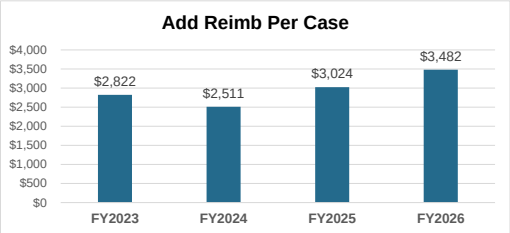
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

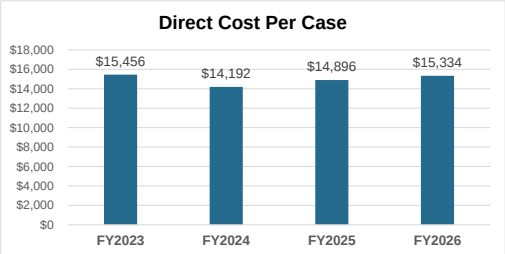
METRICS SUMMARY - 4 YEAR TREND

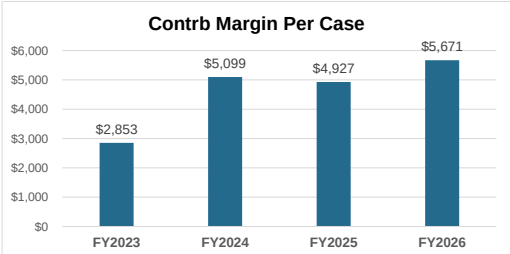
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	13,443	13,943	14,343	15,080	▲ 5%	
Patient Days	82,041	80,738	80,157	80,327	▶ 0%	
ALOS	6.10	5.79	5.59	5.33	▼ -5%	
GM LOS	4.02	3.99	3.91	3.80	▼ -3%	
Opportunity Days	2.09	1.80	1.68	1.52	▼ -9%	
Net Revenue	$246,133,217	$268,975,261	$284,332,215	$316,751,283	▲ 11%	
Additional Reimb	$37,934,596	$35,009,788	$43,370,301	$52,501,711	▲ 21%	
Direct Cost	$207,780,796	$197,876,596	$213,657,610	$231,236,316	▲ 8%	
Contribution Margin	$38,352,421	$71,098,665	$70,674,605	$85,514,967	▲ 21%	
Indirect Cost	$63,407,724	$59,244,563	$66,342,509	$67,070,827	▲ 1%	
Net Income	($25,055,303)	$11,854,102	$4,332,096	$18,444,141	▲ 326%	
Net Revenue Per Case	$18,309	$19,291	$19,824	$21,005	▲ 6%	
Net Rev w/o Add Reimb Per Case	$15,488	$16,780	$16,800	$17,523	▲ 4%	
Add Reimb Per Case	$2,822	$2,511	$3,024	$3,482	▲ 15%	
Direct Cost Per Case	$15,456	$14,192	$14,896	$15,334	▲ 3%	
Contrb Margin Per Case	$2,853	$5,099	$4,927	$5,671	▲ 15%	
CM w/o Add Reimb Per Case	$31	$2,588	$1,904	$2,189	▲ 15%	
% of Add Reimb per Case/CM per Cas	99%	49%	61%	61%		

PER CASE TRENDED GRAPHS









KAWEAH HEALTH ANNUAL BOARD REPORT

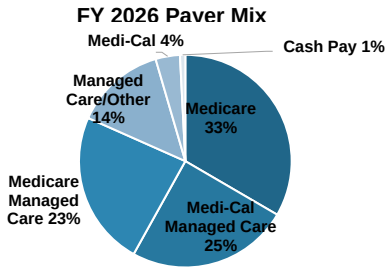
FY2026

Emergency Services - Inpatients Admitted through the ED

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	36%	35%	34%	33%
Medi-Cal Managed Care	24%	24%	25%	25%
Medicare Managed Care	19%	21%	23%	23%
Managed Care/Other	15%	14%	13%	14%
Medi-Cal	5%	5%	4%	4%
Cash Pay	1%	1%	1%	1%



Notes:
Source: Inpatient Service Line Report
Selection Criteria: Inpatient KDMC patients with ED Flag valued at 1, Trauma Flag valued at 0.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Emergency Services - Mental Health Hospital Inpatients Admitted through the ED

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

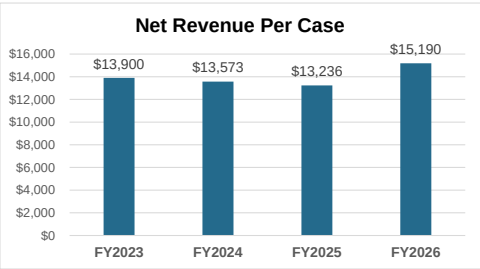
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
162	$2,460,826	$2,623,607	($162,781)	($1,140,682)
▲ 7%	▲ 23%	▲ 3%	▲ 71%	▲ 25%

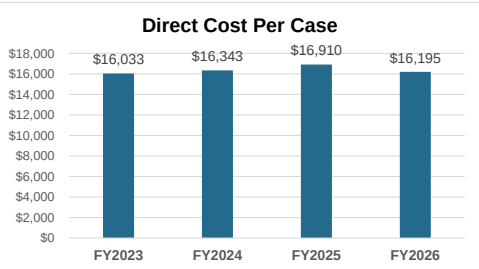
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

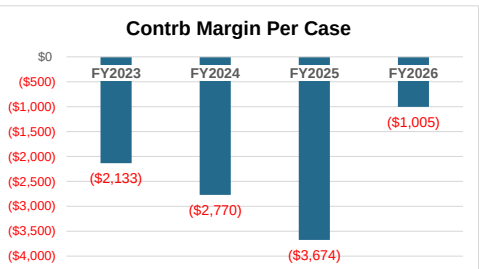
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	161	159	151	162 ▲	7%	
Patient Days	2,448	2,387	2,147	2,162 ▲	1%	
ALOS	15.20	15.01	14.22	13.35 ▼	-6%	
Net Revenue	$2,237,877	$2,158,172	$1,998,585	$2,460,826 ▲	23%	
Direct Cost	$2,581,344	$2,598,614	$2,553,402	$2,623,607 ▲	3%	
Contribution Margin	($343,467)	($440,442)	($554,817)	($162,781) ▲	71%	
Indirect Cost	$896,758	$958,704	$975,258	$977,902 ▶	0%	
Net Income	($1,240,225)	($1,399,146)	($1,530,075)	($1,140,682) ▲	25%	
Net Revenue Per Case	$13,900	$13,573	$13,236	$15,190 ▲	15%	
Direct Cost Per Case	$16,033	$16,343	$16,910	$16,195 ▼	-4%	
Contrb Margin Per Case	($2,133)	($2,770)	($3,674)	($1,005) ▲	73%	

PER CASE TRENDED GRAPHS

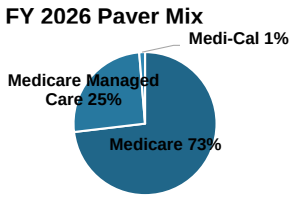






PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	83%	71%	64%	73%
Medicare Managed Care	15%	28%	31%	25%
Medi-Cal	1%	0%	2%	1%



Notes:
Source: Inpatient Service Line Report
Selection Criteria: Inpatient KDMH patients with ED Flag valued at 1.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Emergency Services - Inpatient Trauma Activations admitted through the ED

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

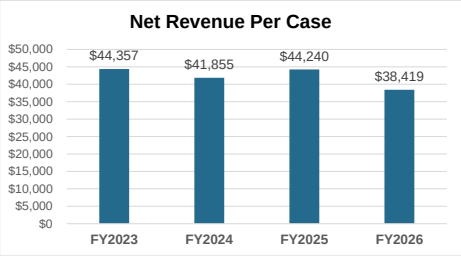
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
491	$18,863,967	$13,682,318	$5,181,649	$1,269,682
▼ -6%	▼ -18%	▼ -14%	▼ -26%	▼ -43%

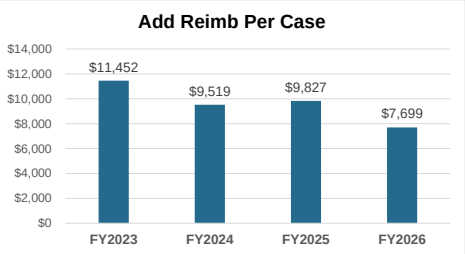
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

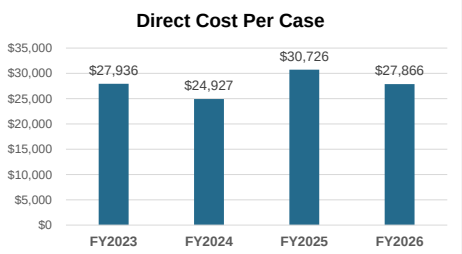
METRICS SUMMARY - 4 YEAR TREND

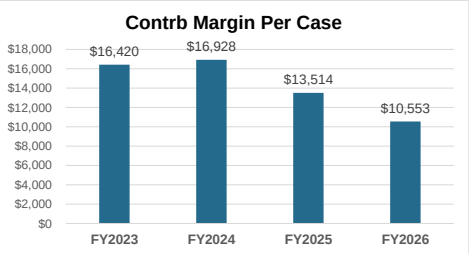
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	486	486	520	491 ▼	-6%	
Patient Days	3,663	3,887	4,571	3,803 ▼	-17%	
ALOS	7.54	8.00	8.79	7.75 ▼	-12%	
GM LOS	5.01	4.90	5.11	4.83 ▼	-5%	
Net Revenue	$21,557,324	$20,341,574	$23,004,688	$18,863,967 ▼	-18%	
Direct Cost	$13,577,079	$12,114,416	$15,977,463	$13,682,318 ▼	-14%	
Additional Reimb	$5,565,501	$4,626,215	$5,110,300	$3,780,059 ▼	-26%	
Contribution Margin	$7,980,245	$8,227,157	$7,027,225	$5,181,649 ▼	-26%	
Indirect Cost	$4,045,991	$3,743,190	$4,815,048	$3,911,967 ▼	-19%	
Net Income	$3,934,255	$4,483,968	$2,212,177	$1,269,682 ▼	-43%	
Net Revenue Per Case	$44,357	$41,855	$44,240	$38,419 ▼	-13%	
Net Rev w/o Add Reimb Per Case	$32,905	$32,336	$34,412	$30,721 ▼	-11%	
Add Reimb Per Case	$11,452	$9,519	$9,827	$7,699 ▼	-22%	
Direct Cost Per Case	$27,936	$24,927	$30,726	$27,866 ▼	-9%	
Contrb Margin Per Case	$16,420	$16,928	$13,514	$10,553 ▼	-22%	
CM w/o Add Reimb Per Case	$4,969	$7,409	$3,686	$2,855 ▼	-23%	
% of Add Reimb per Case/CM per Cas	70%	56%	73%	73%		

PER CASE TRENDED GRAPHS









KAWEAH HEALTH ANNUAL BOARD REPORT

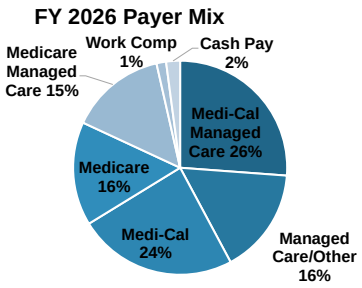
FY2026

Emergency Services - Inpatient Trauma Activations admitted through the ED

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	40%	29%	38%	26%
Managed Care/Other	15%	17%	17%	16%
Medi-Cal	12%	15%	16%	24%
Medicare	19%	19%	14%	16%
Medicare Managed Care	10%	11%	9%	15%
Work Comp	2%	4%	3%	1%
Cash Pay	2%	4%	2%	2%



Notes:
Source: Inpatient Service Line Reports
Criteria: Inpatient KDMC patients with Trauma Flag valued at 1.

KAWEAH HEALTH ANNUAL BOARD REPORT

Emergency Services - Outpatient Emergency Department

FY2026

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

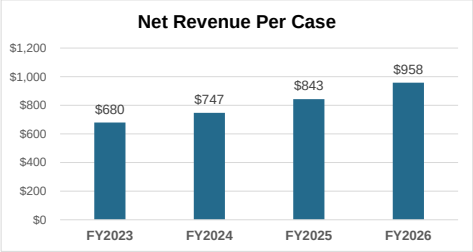
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
81,604	$78,169,907	$63,802,705	$14,367,202	($6,756,437)
▲ 4%	▲ 19%	▲ 10%	▲ 87%	▲ 51%

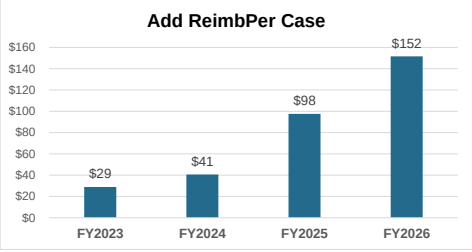
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

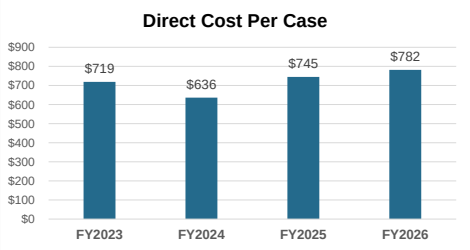
METRICS SUMMARY - 4 YEAR TREND

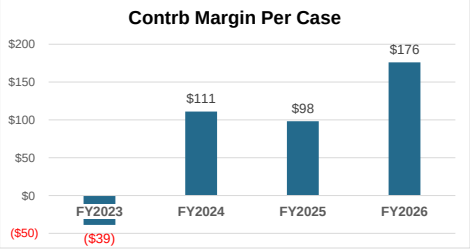
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	72,231	77,332	78,175	81,604	▲ 4%	
Net Revenue	$49,108,541	$57,792,530	$65,885,979	$78,169,907	▲ 19%	
Direct Cost	$51,913,728	$49,205,800	$58,209,714	$63,802,705	▲ 10%	
Additional Reimb	$2,085,246	$3,140,272	$7,625,369	$12,370,561	▲ 62%	
Contribution Margin	($2,805,187)	$8,586,730	$7,676,265	$14,367,202	▲ 87%	
Indirect Cost	$20,722,731	$20,162,934	$21,574,766	$21,123,639	▼ -2%	
Net Income	($23,527,917)	($11,576,204)	($13,898,501)	($6,756,437)	▲ 51%	
Net Revenue Per Case	$680	$747	$843	$958	▲ 14%	
Net Rev w/o Add Reimb Per Case	$651	$707	$745	$806	▲ 8%	
Add Reimb Per Case	$29	$41	$98	$152	▲ 55%	
Direct Cost Per Case	$719	$636	$745	$782	▲ 5%	
Contrb Margin Per Case	($39)	$111	$98	$176	▲ 79%	
CM w/o Add Reimb Per Case	($68)	$70	$1	$24	▲ 3658%	
% of Add Reimb per Case/CM per Case	-74%	37%	99%	86%		

PER CASE TRENDED GRAPHS









KAWEAH HEALTH ANNUAL BOARD REPORT

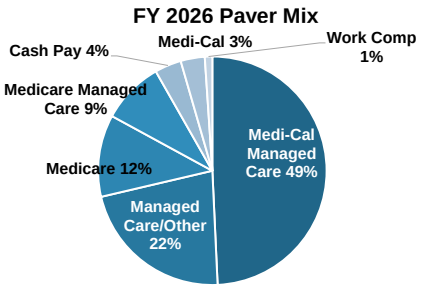
Emergency Services - Outpatient Emergency Department

FY2026

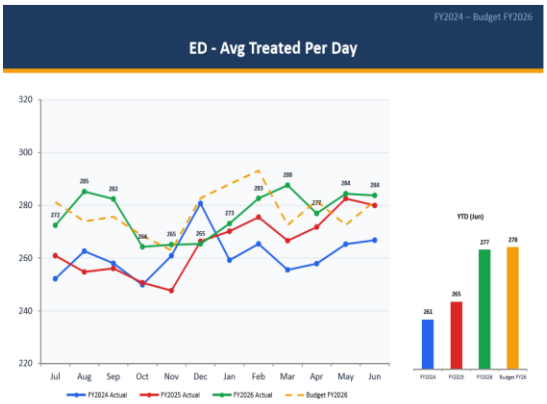
KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PAYER MIX - 4 YEAR TREND (Patient Visits)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	50%	50%	50%	49%
Managed Care/Other	21%	21%	22%	22%
Medicare	12%	12%	11%	12%
Medicare Managed Care	7%	8%	8%	9%
Cash Pay	4%	4%	4%	4%
Medi-Cal	5%	5%	4%	3%
Work Comp	1%	1%	1%	1%



Level Of Care	FY2023	FY2024	FY2025	FY2026
Level I	0%	0%	1%	1%
Level II	5%	5%	3%	3%
Level III	27%	26%	25%	23%
Level IV	39%	39%	41%	40%
Level V	22%	22%	23%	23%
Level VI	2%	2%	2%	3%
No Level	6%	6%	6%	6%



Notes:
Source: Outpatient Service Line Report
Selection Criteria: Outpatients in the Emergency Department Service Line, excluding Sugeries, Cath Lab and Trauma Activations

KAWEAH HEALTH ANNUAL BOARD REPORT

Emergency Services - Outpatient ED Trauma Activations

FY2026

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

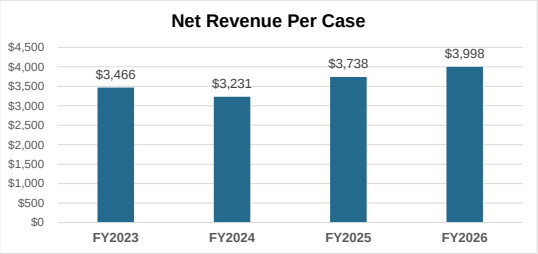
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
771	$2,882,062	$2,809,899	$72,163	($970,149)
▲ 10%	▲ 17%	▲ 1%	▲ 643%	▲ 58%

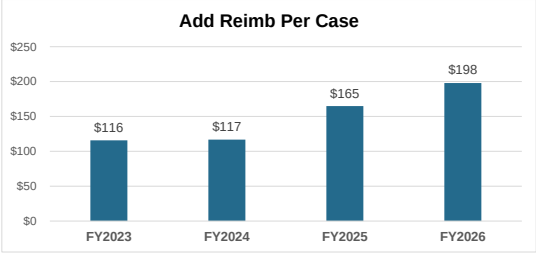
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

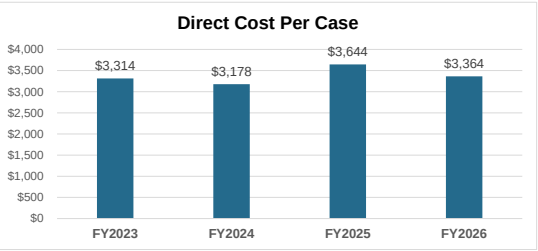
METRICS SUMMARY - 4 YEAR TREND

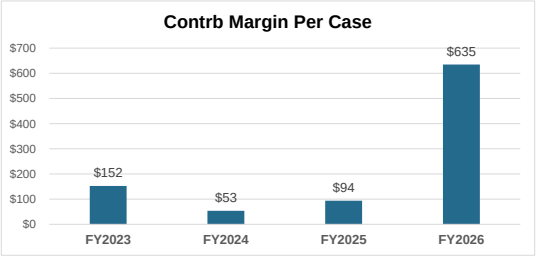
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	812	893	771	845 ▲	10%	
Net Revenue	$2,814,586	$2,885,674	$2,882,062	$3,378,530 ▲	17%	
Direct Cost	$2,690,921	$2,837,900	$2,809,899	$2,842,161 ▲	1%	
Additional Reimb	$93,938	$104,242	$127,107	$167,204 ▲	32%	
Contribution Margin	$123,665	$47,774	$72,163	$536,369 ▲	643%	
Indirect Cost	$1,107,167	$1,139,628	$1,042,312	$945,861 ▼	-9%	
Net Income	($983,502)	($1,091,854)	($970,149)	($409,492) ▲	58%	
Net Revenue Per Case	$3,466	$3,231	$3,738	$3,998 ▲	7%	
Net Rev w/o Add Reimb Per Case	$3,351	$3,115	$3,573	$3,800 ▲	6%	
Add Reimb Per Case	$116	$117	$165	$198 ▲	20%	
Direct Cost Per Case	$3,314	$3,178	$3,644	$3,364 ▼	-8%	
Contrb Margin Per Case	$152	$53	$94	$635 ▲	578%	
CM w/o Add Reimb Per Case	$37	($63)	($71)	$437 ▲	713%	
% of Add Reimb per Case/CM per Case	76%	218%	176%	31%		

PER CASE TRENDED GRAPHS









KAWEAH HEALTH ANNUAL BOARD REPORT

Emergency Services - Outpatient ED Trauma Activations

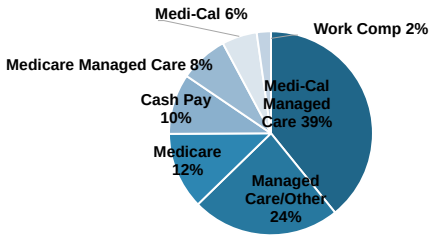
FY2026

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PAYER MIX - 4 YEAR TREND (Patient Visits)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	42%	42%	40%	39%
Managed Care/Other	24%	21%	21%	24%
Medicare	10%	10%	11%	12%
Cash Pay	8%	11%	10%	10%
Medicare Managed Care	7%	7%	8%	8%
Medi-Cal	7%	7%	8%	6%
Work Comp	2%	3%	2%	2%

FY 2026 Payer Mix



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient KDMC patients with Trauma Flag valued at 1.

KAWEAH HEALTH ANNUAL BOARD REPORT

Emergency Services - OP Surgeries Admitted through the ED

FY2026

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

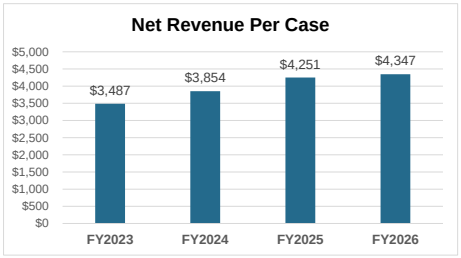
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,262	$5,486,236	$10,710,715	($5,224,480)	($8,611,823)
▲ 15%	▲ 17%	▲ 8%	▲ 1%	▼ -1%

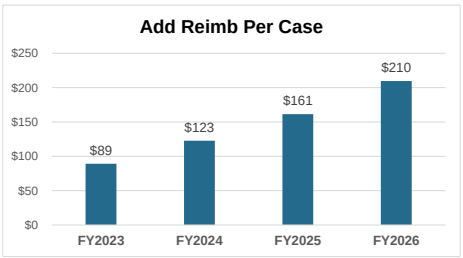
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

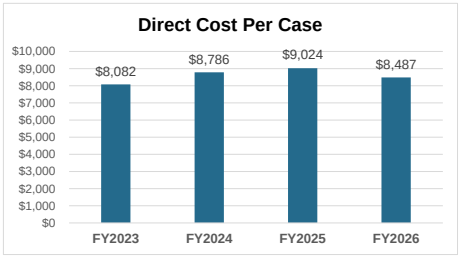
METRICS SUMMARY - 4 YEAR TREND

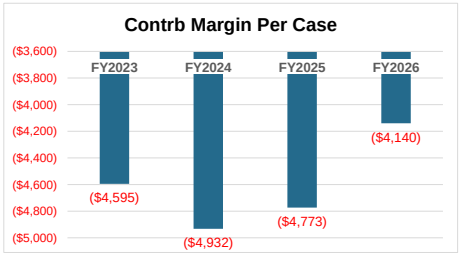
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	835	993	1,102	1,262	▲ 15%	
Net Revenue	$2,911,718	$3,826,548	$4,684,440	$5,486,236	▲ 17%	
Direct Cost	$6,748,319	$8,724,280	$9,944,455	$10,710,715	▲ 8%	
Additional Reimb	$74,472	$121,875	$177,791	$264,421	▲ 49%	
Contribution Margin	($3,836,601)	($4,897,733)	($5,260,015)	($5,224,480)	▲ 1%	
Indirect Cost	$2,254,181	$2,741,397	$3,235,426	$3,387,343	▲ 5%	
Net Income	($6,090,782)	($7,639,129)	($8,495,441)	($8,611,823)	▼ -1%	
Net Revenue Per Case	$3,487	$3,854	$4,251	$4,347	▲ 2%	
Net Rev w/o Add Reimb Per Case	$3,398	$3,731	$4,090	$4,138	▲ 1%	
Add Reimb Per Case	$89	$123	$161	$210	▲ 30%	
Direct Cost Per Case	$8,082	$8,786	$9,024	$8,487	▼ -6%	
Contrb Margin Per Case	($4,595)	($4,932)	($4,773)	($4,140)	▲ 13%	
CM w/o Add Reimb Per Case	($4,684)	($5,055)	($4,934)	($4,349)	▲ 12%	
% of Add Reimb per Case/CM per Case	-2%	-2%	-2%	-5%		

PER CASE TRENDED GRAPHS









KAWEAH HEALTH ANNUAL BOARD REPORT

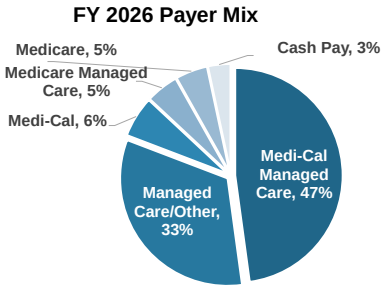
Emergency Services - OP Surgeries Admitted through the ED

FY2026

KEY METRICS - FY 2026 Twelve Months Ended June 30, 2026

PAYER MIX - 4 YEAR TREND (Patient Visits)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	41%	45%	47%	47%
Managed Care/Other	36%	32%	34%	33%
Medi-Cal	7%	8%	6%	6%
Medicare Managed Care	5%	5%	4%	5%
Medicare	7%	6%	6%	5%
Cash Pay	3%	3%	2%	3%
Work Comp	1%	1%	0%	1%



Notes:
Source: Outpatient Service Line Reports
Criteria: Patients in the O/P Surgery Service Line, with the ED Flag valued at 1, excludes Trauma Activations

Quail Park

Quail Park Senior Housing

Jag Batth

FY2026 Update

Board of Directors Committee Meeting

Finance, Property, Services & Acquisition Committee

Quail Park at Cypress Laurel Court Memory Care Quail Park at Shannon Ranch



FY2026 UPDATE

Portfolio at a glance

Quail Park at Cypress

127 units | Independent & assisted

81%

24 of 127 units available

Kaweah Health owns 44%

Laurel Court Memory Care

40 units | Memory care only

82.5%

7 of 40 units available

Kaweah Health owns 44%

Quail Park at Shannon Ranch

120 units | Assisted + memory care

80%

24 of 120 units available

Kaweah Health owns 33⅓%

National benchmark: 87.4% senior housing occupancy (NIC, end of Q2 2025)

This year: we lent $289,080 to cover shortfalls; our share of losses was $1.32M

THE FINANCIAL PICTURE, IN PLAIN TERMS

FY2026: smaller losses, fewer loans

Our share of the properties' losses this year

$1.32M

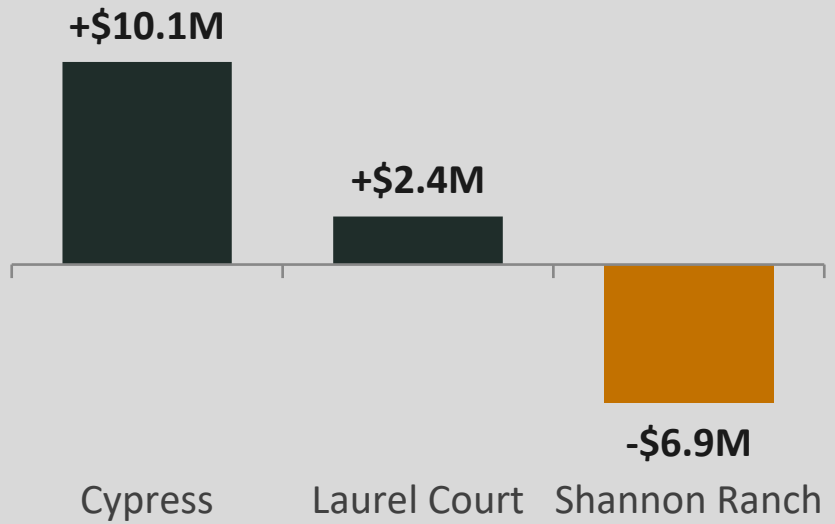
Down from $1.92M last year (31% less)

Money we lent to cover shortfalls (repayable)

$289K

Down from $985K last year (71% less)

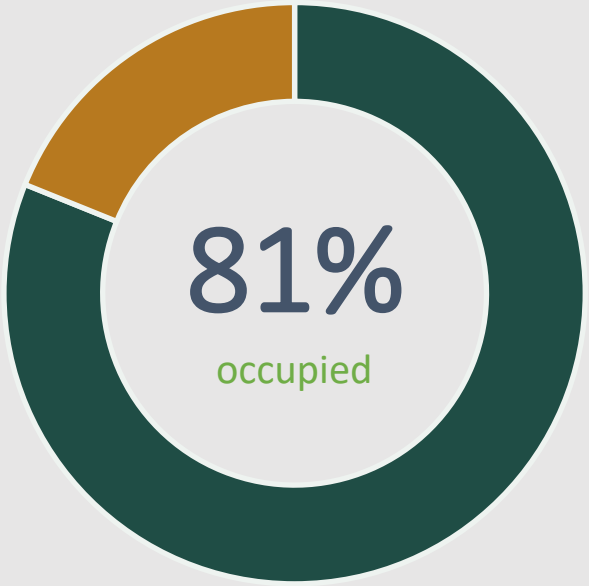
Since opening: cash received minus cash put in



+$5.6M overall: more cash received than put in

QUAIL PARK AT CYPRESS

81% occupied, 24 units open



103 occupied

24 available

18

open in The Lodge (assisted living)

6

open in Enhanced Assisted Living

4250 W. Cypress Ave., Visalia

Owned 44% Kaweah Health / 56% Living Care

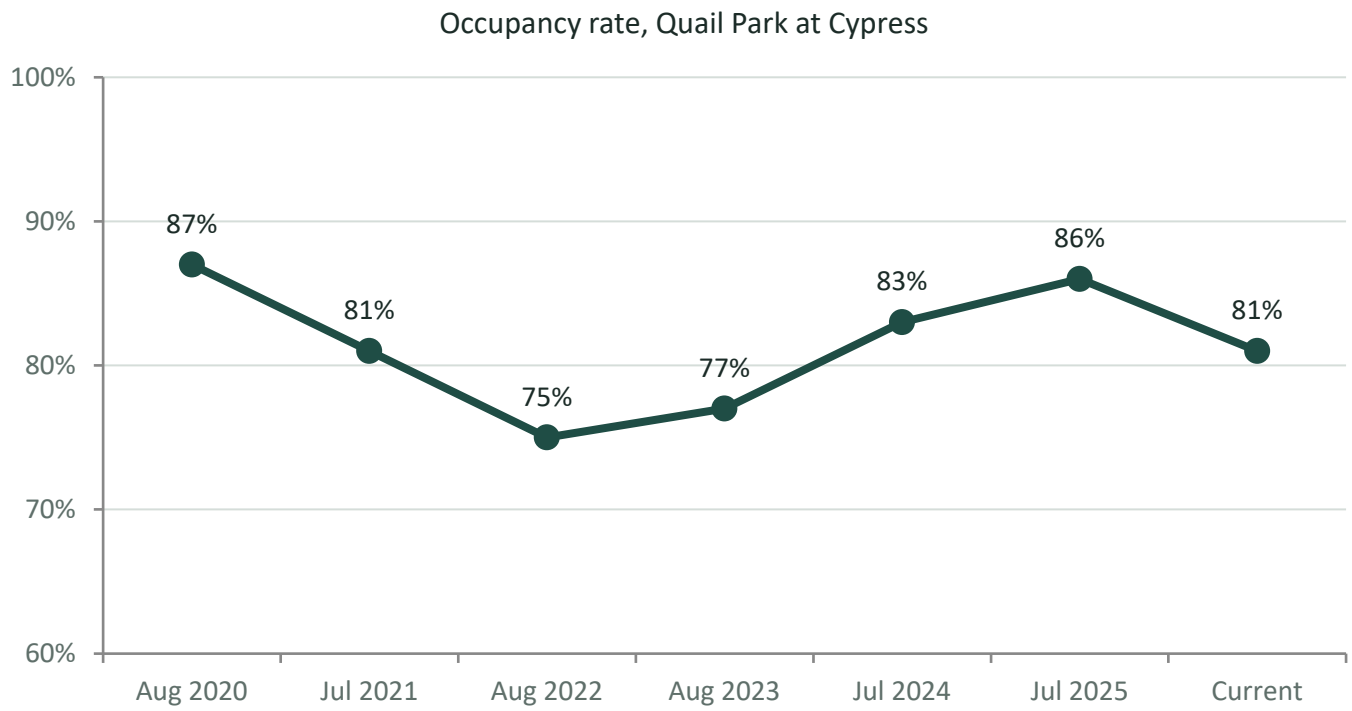
Opened 2002 | 127 total units

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MORE THAN MEDICINE. LIFE.

QUAIL PARK AT CYPRESS

Recovering, but down from 86%



Before COVID, Cypress ran near capacity with a 28-unit waiting list (June 2019).

75% Low point in 2022, after COVID and new local competition

86% July 2025, just under the 87.4% national rate

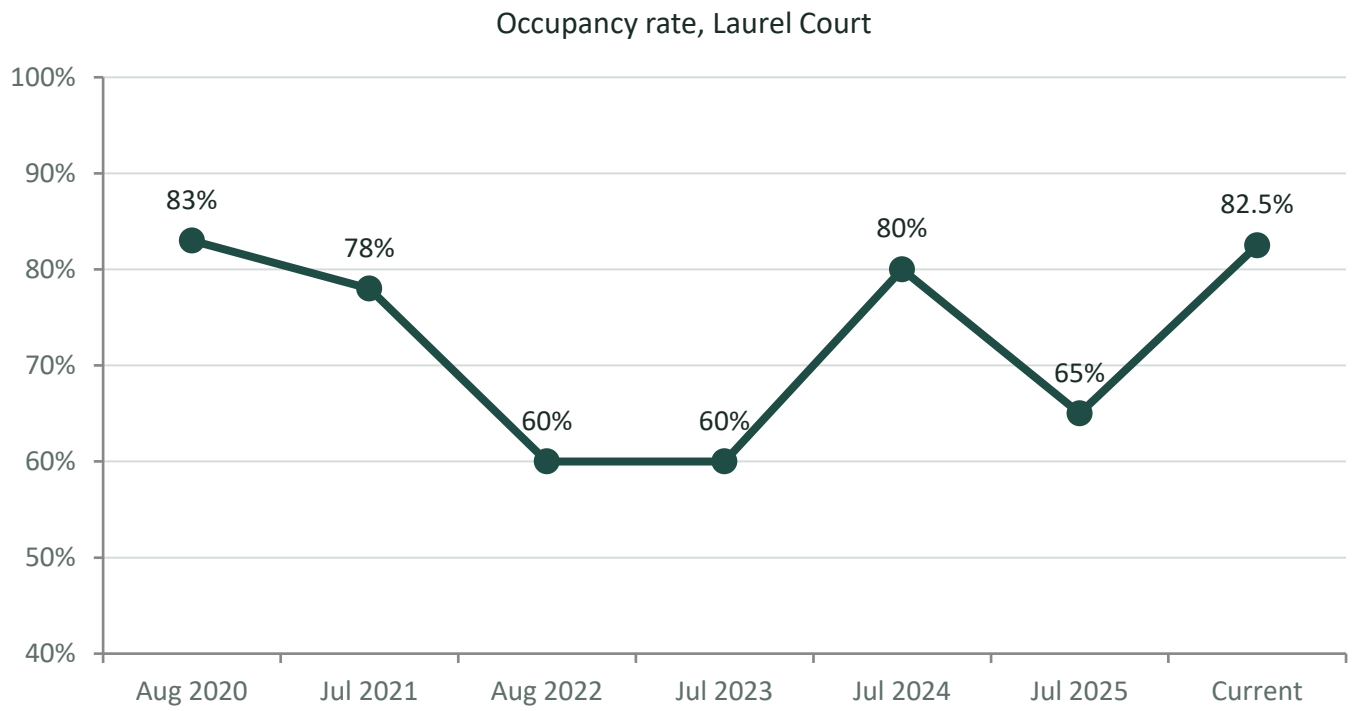
81% Today. Last year's outlook was 90% by early 2026 (about 12 more units)

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LAUREL COURT MEMORY CARE

Memory care rebounds to 82.5%



Before COVID, Laurel Court ran near 100% with a waiting list. National: 87% (NIC, Q2 2025).

60% Low in 2022–2023, when families paused move-ins

65% July 2025, down from 80% a year earlier

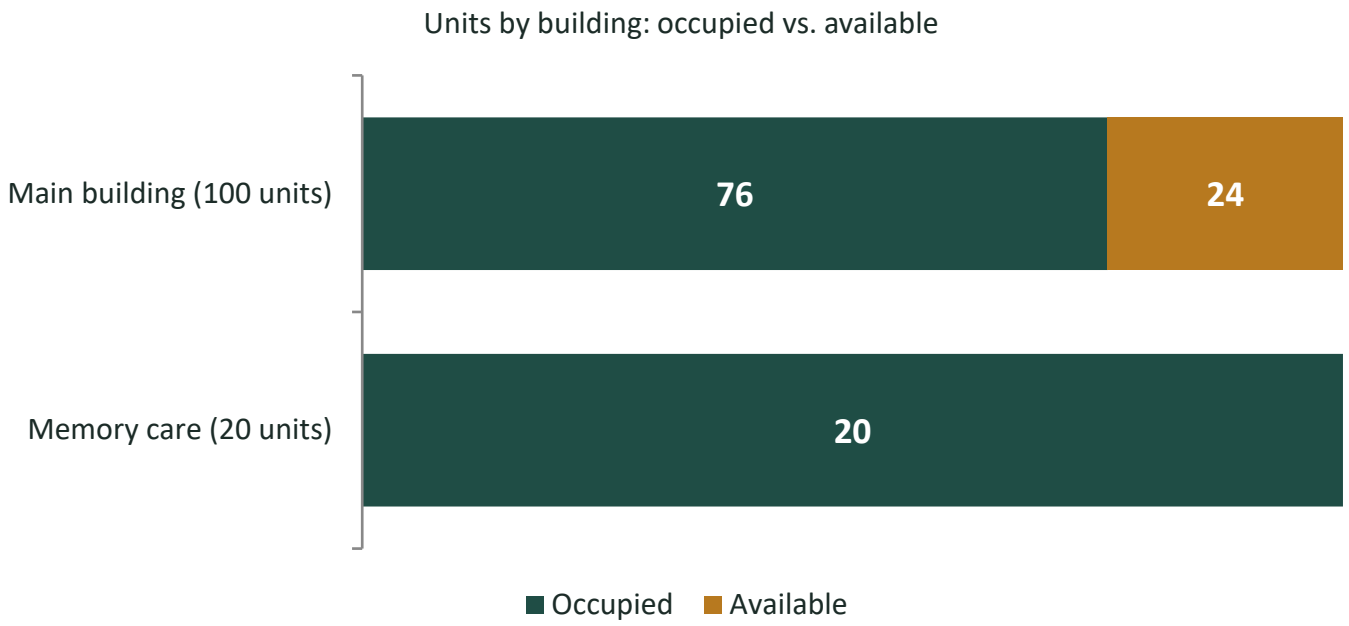
82.5% Today: 33 of 40 units occupied, 7 available

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QUAIL PARK AT SHANNON RANCH

80% occupied; memory care is full



80%

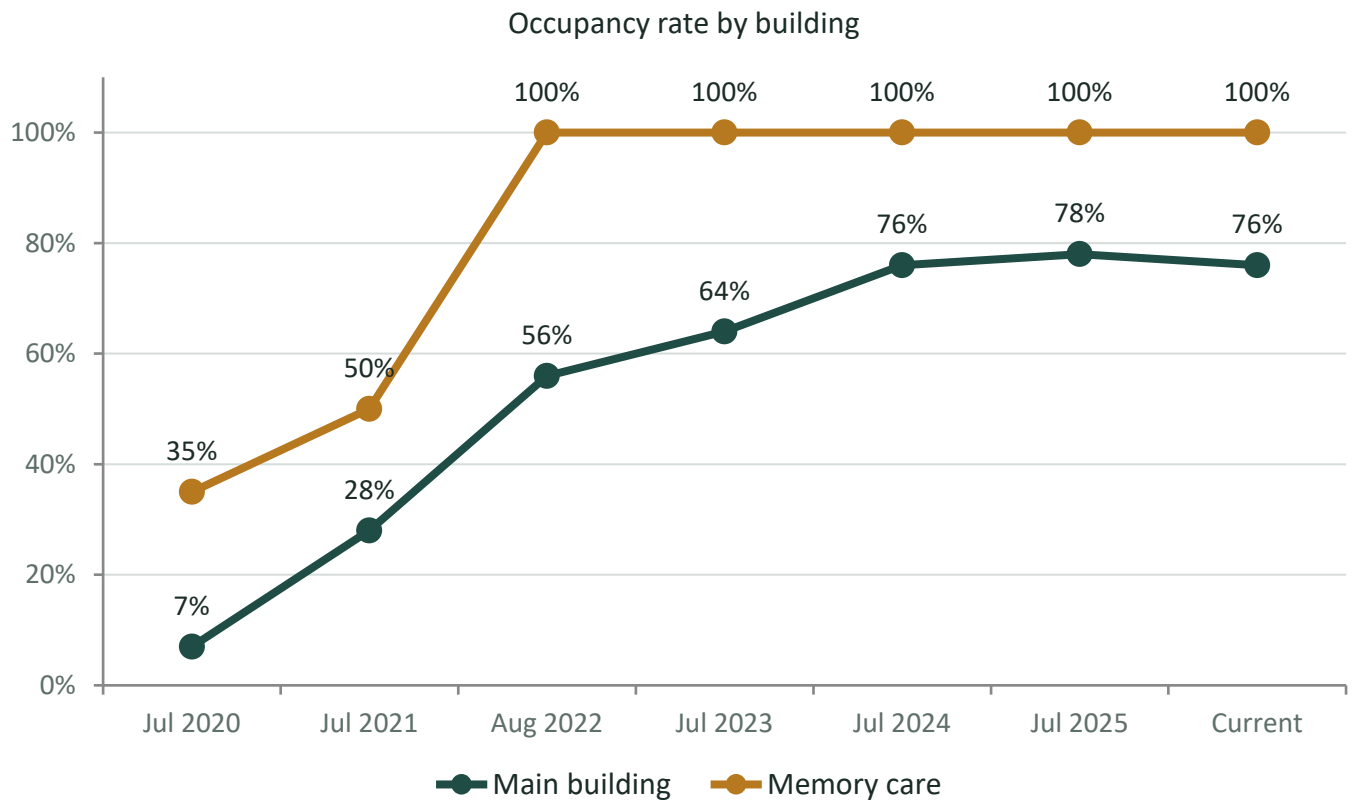
overall occupancy

96 of 120 units occupied. All 24 open units are in the licensed assisted living building.

3440 W. Flagstaff Ave. | Opened early 2020 | ~$40M project | Kaweah Health owns 33⅓%

QUAIL PARK AT SHANNON RANCH

From 7% at opening to 76% today



Current main-building figure is derived: 24 open units out of 100.

To break even, occupancy needs to be 80–85%

Today: 80%

60% 100%

Break-even range

In FY2025 the property's loan was refinanced at a lower rate, with a period of interest-only payments.

QUAIL PARK AT SHANNON RANCH

No new loans needed in FY2026

Dollar figures are for the fiscal year July 1, 2025, to June 30, 2026, unless noted.

$0

lent to cover shortfalls this year, vs. $603,929 last year

Total lent since 2020 is $2,906,087, to be paid back.

$815,220

Our share of this year's loss, down 20% from last year

$3,997,054

What we invested, all from the Betty Quilla Fund

$0

Cash paid back to us so far; the property is still filling up

kaweahhealth.org

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RECOMMENDATIONS

Stay the course, press for results

Cypress

81% occupied

Keep operating as a high-level senior retirement center. Work with management on attractive, safe facilities and excellent service. Market aggressively.

Laurel Court

82.5% occupied

Keep operating as a high-level dementia care center. Increase pressure on Living Care leadership to improve operations and occupancy.

Shannon Ranch

80% occupied

Keep supporting the facility and push Living Care leadership for better performance. To break even we need 80–85% occupancy; we are at the low end.

The pursuit of healthiness



Kaweah Health
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Patient Experience Committee – July 8, 2026

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Patient Experience Committee – OPEN MEETING
Wednesday, July 8, 2026
Kaweah Health Medical Center – Executive Office Conference Room

Present: Director: Mike Olmos (Chair); Max Heckhausen, VP of Strategy; Jag Batth, Chief Operations Officer; Scott Baker, Chief Nursing Officer; Cameron Beatty, Director of Emergency and Trauma Services; Deborah Volosin, Director of Patient & Community Experience; Sintayehu Yirgu, Patient Experience Advocate; Teresa Bobadilla, Patient Experience Data Analyst; Marlo Montejano, Patient Experience Liaison; and Lisette Mariscal, Recording

CALL TO ORDER – This meeting was called to order at 4:04 PM by Mike Olmos.

PUBLIC/MEDICAL PARTICIPATION – There was no public or medical participation.

MINUTES – The minutes from the May 13, 2026 meeting were reviewed.

PATIENT EXPERIENCE –
4.1 Teresa Bobadilla reviewed the June 2026 Patient Experience Dashboard. (see Attachment 4.1. of the agenda)
4.2 Teresa presented trends from July 2025 through May 2026 across inpatient, emergency department, and medical practice. (see Attachment 4.2. of the agenda)
4.3 – 4.5. The team presented a graph comparing goals to current scores in various facilities for the period of July 2025 through May 2026. (see Attachment 4.3. – 4.5. of the agenda)
4.6 – 4.9 Sintayehu and Marlo reviewed data related to patient experience, including MIDAS, rounding, and lost belongings for the month of June. (see Attachment 4.6. – 4.9. of the agenda)
4.10. Discussion of this agenda item deferred.

Adjourned at 4:50 PM

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

Mike Olmos • Zone 1 Board Member | **Jonna Schengel • Zone 2** Board Member | **Dean Levitan, MD • Zone 3** Secretary/Treasurer | **David Francis • Zone 4** President | **Armando Murrieta • Zone 5** Vice President

Finance Property Services Acquisition Committee- September 16, 2026

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS FINANCE, PROPERTY, SERVICES & ACQUISITION COMMITTEE MINUTES

Kaweah Health Medical Center
305 W. Acequia Avenue, Executive Office Conference Room (1st Floor)

Wednesday September 16, 2025

Present: Directors: David Francis (Chair) & Dean Levitan; Marc Mertz, Chief Executive Officer. Malinda Tupper, Chief Financial Officer; Jennifer Stockton, Director of Finance; Jag Batth, Chief Operating Officer; Kevin Morrison, VP Support Services; Max Heckhausen, VP Strategy; Tom Boggs, Chief Ambulatory Officer; Kelsie Davis, Board Clerk Recording

OPEN MEETING – Called to order at 10:01 AM

PUBLIC PARTICIPATION –None
MINUTES- Reviewed and forward to the Board for approval.
FINANCIALS- Discussion ensued on the most current fiscal year financial results and proposed FY27 budget. The presentation is attached hereto the minutes.

ADJOURN – 11:10am *David Francis, President*

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

Quality Council Committee – September 17, 2026

OPEN Quality Council Committee
Thursday, September 17, 2026
The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; Dave Francis, Board Member; Marc Mertz, CEO; Kevin Morrison, VP of Support Services; Jag Batth, Chief Operation Officer; Dr. Micheal Tedaldi, Vice Chief of Staff; Ben Cripps, Chief of Compliance; Max Heckhausen, VP of Strategy; Jewel Crisan Calub, Chief Nursing Officer; Dr. Paul Stefanacci, CMO/CQO; Farid Sheikh, Director of Quality and Patient Safety; Luke Schneider, VP of Information Systems and Services; Shawn Elkin, Infection Prevention Manager; Randy Kokka, Director of Laboratory Services; Lawrence Headley, Director of Food Nutritional Services; Roxanna Mendez, Senior Quality and Patient Safety Project Manager; Chris Patty, Clinical Practice Guidelines Program Manager; Kyndra Licon, Quality Project Manager

Closed Session:

Dr. Dean Levitan called to order at 8:00 AM.

Review of Closed Session Agenda: Dr. Dean Levitan made a motion to approve the closed agenda, there were no objections.

Dr. Dean Levitan adjourned the meeting at 8:20 AM.

Open Session:

Public Participation – None.

Dr. Dean Levitan called to order at 8:30 AM.

4. **Review of August Quality Council Open Session Minutes –** Dr. Dean Levitan, Chair Board Member
    - Reviewed and acknowledged the August Quality Council Open Session Minutes by Dr. Dean Levitan.

5. **Laboratory Quality Report –** A review of current performance and actions focused on the clinical goals for Laboratory Services. *Randy Kokka, Director of Laboratory.* No further actions.

6. **Food and Nutrition Services Quality Report -** A review of current performance, quality outcomes, and improvement initiatives focused on food and nutrition services. *Lawerence Headley, Director of Food & Nutrition Services.* No further actions.

7. **Clinical Quality Report –** A review of outstanding health outcomes initiatives for Surgical Safety Program. *Chris Patty, Clinical Practice Guidelines Program Manager.* No further actions.

Adjourn Open Meeting – *Dr. Dean Levitan*
Dean Levitan adjourned the meeting at 9:30 AM.

Population Health Committee – July 20, 2026

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS

POPULATION HEALTH COMMITTEE- MINUTES

Monday July 20, 2026

Kaweah Health Medical Center

305 W. Acequia Avenue, Executive Office Conference Room (1st Floor)

ATTENDING: Dean Levitan (Chair), Armando Murrieta; Marc Mertz, Tom Boggs, Max Heckhausen, Luke Schneider, Sonia Duran-Aguilar, Chelsea Stafford- Recording

CALLED TO ORDER AT 12:00 – Dean Levitan, Secretary/Treasurer

Dr. Dean Levitan called the meeting to order at 12:00PM and welcomed the group. He gave an overview of the meeting purpose as this was the first meeting. The committee was established from the desire to bring Population Health activities to the attention of the board as it is on the strategic plan. This is a formal way to capture reviews, ask questions, and ensure project goals are achieved. Dr. Levitant thanked Sonia, Tom and Chelsea for their time putting the agenda together and organizing the meeting.

MEETING CADENCE- The committee agreed to a bi-monthly cadence.

CHARTER- FOR REVIEW ONLY- Tom shared the charter was drafted from best practices and describes how this committee will support the board, what the authority structure and scope of responsibilities are. The membership list was reviewed and discussed. The group agreed with the charter. The charter was made available in the packet. It was asked that a Population Health org chart be provided at the next meeting.

COMMITTEE OVERVIEW & PATIENT STORY-Tom welcomed the committee and suggested meetings should start with a patient success story. Sonia shared a patient story. The story was available in the packet and did not include any patient information. Chelsea and Sonia introduced themselves upon Dr. Levitan's request and shared backgrounds.

CURRENT STATE- Tom provided an overview of the current state of the Population Health Division including contracts, grants, and quality. Tom asked that the group join in for questions as they come up. Tom spoke to the difficulties that are driving the need for payment reform and how that effects care. Tom discussed the effects of HR1 and the impact in terms of Medi-cal redetermination. The group discussed what the projects of patients falling off Medi-cal may be. The committee discussed various strategies for

continuing to meet the needs of the community. More information was available in the packet.

QUALITY INCENTIVE PROGRAM (QIP)- Sonia shared a slide with the measures that the organization monitors. She noted that for 2026 there will be 7 measures reported on. She added that there are strong workflows in place in the clinics and a dedicated Gaps in Care team and Annual Wellness Visits team. Sonia described the process for closing gaps and shared some of the tools used. Marc added that Kaweah Health has been recognized at a state level for work in this program.

SEQUOIA HEALTH PLAN (SHP)- Tom shared information on the partnership. Information was available in the packet. He noted that there has been a lot of improvement in a short period of time. There are action plans and focus aeras in place. Tom shared that our challenges here align with other challenges across the country.

TRADITIONAL MEDICARE-MSSP (ALEDADE)- Tom described the relationship with Aledade. Detailed information was made available in the packet. There was discussion on the savings and payment structure.

QUALITY METRIC INDICATORS- Information was provided in the packet. Tom shared that the next step is developing an enterprise quality score card.

COMMUNITY PARTNERSHIPS/ OUTREACH- Information regarding community outreach efforts was briefly discussed with information available in the packet. Armando asked about incorporating residents into community outreach events like street medicine and Cuadrilla events.

GRANT REVIEW- The committee reviewed and discussed the current grants and grant opportunities. This information was included in the packet. Dr. Levitan asked what the grant seeking and writing process is. Sonia described the current collaboration between the foundation grant coordinator and the population health division.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)- Sonia shared what Kaweah's role is in developing the CHNA as part of the regional collaborative. Sonia will bring details when the next cycle begins.

ENHANCED CARE MANAGEMENT (ECM) & COMMUNITY SUPPORTS (CS)- Enrollment information and tracking was available in the packet. The Community Supports program has enrolled 142 members to date.

ADJOURN – The meeting was adjourned at 1:03pm

Regular Open Board Meeting – September 23, 2026

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY SEPTEMBER 23, 2026, AT 3:30PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan & Murrieta; M. Mertz, CEO; R. Berglund, Legal Counsel; B. Cripps, and K. Davis, recording

The meeting was called to order at 3:30 PM by Director Francis.

PUBLIC PARTICIPATION –None.

BOARD EDUCATIONAL STUDY SESSION- The board received an educational presentation regarding board fiduciary responsibilities on the STARK Law and governance principles.

ADJOURN - Meeting was adjourned at 4:14PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Dean Levitan, MD, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY SEPTEMBER 23, 2026, AT 4:30PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan & Murrieta; M. Mertz, CEO; J. Randolph, Chief of Staff; D. Cox, Chief Human Resource Officer; B. Cripps, CCO; J. Batth, COO; K. Morrison, VP Support Services; J. Calub, CNO; M. Heckhausen; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:30 PM by Director Francis.

ROLL CALL- Directors Olmos, Levitan, Francis, and Murrieta were present in person. Schengel was absent.

FLAG SALUTE- Director Francis lead the flag salute.

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: In closed session the board approved the Medical Executive Committee's credentialing recommendations for September 2026. The board approved the closed meeting minutes of August 26, 2026, and the Board also approved rejection of a claim.

BOARD MEMBER REPORT OUTS- Discussion ensued.

RECOGNITIONS- Resolution 2299

CONSENT CALENDAR – Director Francis entertained a motion to approve the September 23, 2026, consent calendar.

PUBLIC PARTICIPATION – None.

MMSC (Olmos/Murrieta) to approve the September 23, 2026, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta and Francis.

DISTRICT HOSPITAL LEADERSHIP FORUM– Ryan Witz, executive director presented an overview on DHLF Matters. Copy of presentation attached to the original of the minutes and to be considered a part thereof.

CNO MISSION & VISION– Jewel Calub, CNO, presented her vision for the nursing of Kaweah Health. Copy of presentation attached to the original of the minutes and to be considered a part thereof.

QUALITY REPORT - HANDHYGIENE– Shawn Elkin presented an overview on hand hygiene quality compliance matters. Copy of presentation attached to the original of the minutes and to be considered a part thereof.

LABORATORY QUALITY– Randy Kokka, lab director presented an overview on lab quality. Copy of presentation attached to the original of the minutes and to be considered a part thereof.

STRATEGIC OVERSIGHT (MONTHLY REPORT) – IDEAL ENVIRONMENT– Dianne, Hannah, Jaime, Angel, Teresa, all provided their strategic oversight discussion regarding organizational priorities, long-term planning initiatives, strategic objectives, operational alignment, community health needs, workforce considerations, and progress toward Board-approved strategic goals.

PATIENT EXPERIENCE AND SATISFACTION UPDATE- Max presented September's overview of patient experience. Copy attached hereto the original of the minutes.

FINANCIAL STEWARDSHIP – A presentation and discussion of current financial statements, budget performance, revenue, and expense trends, and year-to-date comparisons for the District. Presented by Jennifer Stockton. Copy attached to the original of the minutes and to be considered a part thereof.

MMSC (Murrieta/Levitan) to approve July's Financials. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta and Francis.

REPORTS

Chief Executive Officer Report –Report relative to current CEO activities. – *Marc Mertz, CEO*
Board President- None. – *David Francis, Board President*
Chief of Staff Report – Report relative to current Medical Staff events and issues – Julianne Randolph, DO, *Chief of Staff.*

ADJOURN - Meeting was adjourned at 6:48PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Dean Levitan, MD, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

AP186 Kaweah Health External Event Planning Services

Policy Number: AP 186	**Date Created: 9/23/2026**
Document Owner: Jenn Cooper	**Date Approved: 10/28/2026**
Approvers: Board of Directors (Administration)	

External Event Planning Services

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: This policy establishes the District's requirements for the use of external event-planning services in connection with events hosted, sponsored, funded, or otherwise supported by Kaweah Health. As a public hospital district, Kaweah Health is committed to the responsible stewardship of its resource and to keep event planning capabilities within its internal teams.

POLICY: This policy applies to all events hosted, sponsored, funded or otherwise supported in whole or in part by Kaweah Health, including activities conducted by any of its departments, service lines, and affiliated entities and to the use of Kaweah Health funds, facilities, equipment, staff time, or other District resources for such events. Application to affiliated entities is limited to circumstances in which Kaweah Health has authority to establish or enforce the requirements of this policy.

Kaweah Health shall not use District funds or other District resources to procure an external event planner or event planning services company to design, coordinate, manage, or execute an event on behalf of Kaweah Health. This restriction is an additional requirement and does not replace or supersede applicable District procurement, contracting, conflict of interest, compliance code of conduct or other policies.

For the purposes of this policy, an "external event planner" or "event planning services company" means an external individual or firm engaged primarily to design, coordinate, manage, or execute an event on behalf of Kaweah Health. The definition does not include vendors that provide ordinary event-related goods or services, such as catering, food service, audiovisual services, equipment rental, printing, signagee, or venue/facility rental, when those vendors are not engaged to plan, coordinate, or manage the event.

All Kaweah Health events shall be planned and organized by Kaweah Health internal teams. Internal teams are responsible for coordinating event logistics, scheduling, communications, and on-site management using existing organizational resources, consistent with applicable District policies and established departmental processes.

PERMITTED VENDORS

This policy does not prohibit the routine procurement of standard goods and services that support an event, provided the vendor is engaged in accordance with applicable District procurement, contracting, conflict of interest, compliance and code of conduct requirements. Such permitted goods and services may include:

- Catering and food service;
- Venue or facility rental;
- Audiovisual, equipment, or rental services;
- Printing and signage.

The engagement of such vendors must not amount to contracting an external party to plan, coordinate, or manage the event. Any vendor selection, contracting, or payment must also comply with applicable District policies and approval requirements.

RESPONSIBILITIES

- Department leaders and managers are responsible for ensuring compliance with this policy and applicable procurement, contracting, compliance, conflict of interest, and code of conduct requirements before committing District funds or resources.
- Internal teams are responsible for planning and organizing Kaweah Health events using internal resources and established departmental processes, including any processes maintained by designated event planning stakeholders.
- Finance and procurement staff are responsible for applying applicable payment, reimbursement, and procurement requirements and for referring questions about this policy to the appropriate operational or policy owner.

ENFORCEMENT

Failure to comply with this policy may result in the payment or reimbursement being denied and may be subject to appropriate corrective action. Nothing in this policy is intended to automatically invalidate an otherwise executed contract; contract related remedies and obligations will be addressed in accordance with the applicable contract and District contracting requirements.

RESOURCES

AP40 – Vendor Relationships, as applicable to the selection, engagement, management, and conduct of relationships with event-related vendors and contractors.

AP134 – Expenses Reimbursable by Foundation/District Funds, as applicable to the funding, reimbursement, or payment of event-related expenses by the District or an affiliated Foundation.

AP156 – Standard Procurement Practices.
AP166 – Competitive Bidding of Contracts.
AP167 – Quote and Proposal Guidelines.

Policy Review

This policy shall be reviewed at least every two (2) years by the designated Policy Owner to ensure that it remains current, accurate, effective, and consistent with applicable laws, regulations, organizational practices, and related policies. The policy may be reviewed and revised earlier when warranted by changes in law, regulation, organizational structure, operations, or other circumstances. The completion of a scheduled review shall be documented, including whether revisions are necessary.

AP187 Kaweah Health Physician Retirement Celebrations Policy

Policy Number: AP 187	**Date Created: 9/23/2026**
Document Owner: Jenn Cooper	**Date Approved: 10/28/2026**
Approvers: Board of Directors (Administration)	

Kaweah Health Physician Retirement Celebrations Policy

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: This policy establishes clear and consistent expectations for physician and provider retirement recognition activities hosted, sponsored, funded, or otherwise supported by Kaweah Health. Kaweah Health values the contributions of its physicians and providers and remains committed to honoring their service in a manner that is respectful, meaningful, and a responsible use of District resources.

POLICY: This policy applies to retirement recognition activities for physicians and providers that are hosted, sponsored, funded or otherwise supported in whole or in part by Kaweah Health, including activities conducted by its departments and service lines. It governs the use of Kaweah Health funds, facilities, equipment, paid staff time, or other District resources for such activities. Application to affiliated entities is limited to circumstances in which Kaweah Health has authority to establish or enforce the requirements of this policy.

Kaweah Health may host, sponsor, or fund a modest retirement recognition activity that meets the requirements of this policy. This policy does not regulate a privately organized retirement celebration that does not use Kaweah Health funds, facilities equipment, paid staff time, or other district resources.

A permitted District retirement recognition is a small, on-site event that allows colleagues to recognize the retiring physician or provider within the workplace. A permitted event is characterized by the following:

- A catered on-site lunch or light reception held on Kaweah Health premises, consistent with applicable District purchasing and event practices;
- Attendance generally limited to the retiring physician's or provider's colleagues, care team, Medical Staff colleagues, and Kaweah Health staff, with outside guests limited as appropriate to the District sponsored recognition activity;
- Modest recognition items (e.g., a card, plaque, or certificate of service), consistent with applicable District policies and spending limits.

District sponsored retirement recognition activities that exceed the parameters of a permitted event described above require review by the appropriate policy owner and stakeholders before District resources are committed. This policy does not authorize an

exception to other applicable District policies, procurement or contracting requirements, Medical Staff requirements, Compliance requirements, or spending/approval limits. Privately organized retirement celebrations that do not use District resources are outside the scope of this policy.

RESPONSIBILITIES

- Department leaders and managers are responsible for ensuring that any District sponsored retirement recognition complies with this policy and applicable procurement, contracting, compliance, conflict of interest, code of conduct, and medical staff requirements before committing funds or resources.
- Internal teams are responsible for planning and organizing permitted District retirement recognition activities using established organizational resources and processes.
- Finance and procurement staff are responsible for applying applicable payment, reimbursement, and procurement requirements and for referring questions about whether an expenditure is permitted to the appropriate policy owner and stakeholders. When vendors or contractors are involved, individuals selecting, approving or managing those vendors must comply with applicable conflict of interest, related party, procurement, contracting, compliance and code of conduct requirements.

ENFORCEMENT

Failure to comply with this policy may result in the payment or reimbursement being denied and may be subject to appropriate corrective action. Nothing in this policy is intended to automatically invalidate an otherwise executed contract; contract related remedies and obligations will be addressed in accordance with applicable contract and District contracting requirements. Questions regarding the application of this policy should be directed to the policy owner or the Office of the Chief Executive Officer, as appropriate.

REFERENCE

AP40 – Vendor Relationships, as applicable to the selection, engagement, management, and conduct of relationships with vendors or contractors supporting a District-sponsored recognition activity.
AP134 – Expenses Reimbursable by Foundation/District Funds, as applicable to the funding, reimbursement, or payment of retirement-recognition expenses by the District or an affiliated Foundation.
AP156 – Standard Procurement Practices.
AP166 – Competitive Bidding of Contracts.
AP167 – Quote and Proposal Guidelines.
AP186 – External Event Planning

POLICY REVIEW

This policy shall be reviewed at least every two (2) years by the designated Policy Owner to ensure that it remains current, accurate, effective, and consistent with applicable laws, regulations, organizational practices, and related policies. The policy may be reviewed and revised earlier when warranted by changes in law, regulation, organizational structure, operations, or other circumstances. The completion of a scheduled review shall be documented, including whether revisions are necessary.

AP114 Census Saturation Plan

Policy Number: AP114	Date Created: No Original Creation Date Set
Document Owner: Jenn Cooper (Executive Assistant)	Date Approved: 07/26/2024
Approvers: Board of Directors (Administration)	

Census Saturation Plan

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the plan for:

Routine assessment and management of hospital census status.

Patient placement and resource/staff deployment at peak census times.

Alternatives for patient placement during census saturation in patient care areas

A. Acute Adult Inpatient
B. Maternal Child Health Departments
C. Emergency Department {ED)

This procedure assumes:

Aggressive management of the patient's care, focusing on discharge preparation, is occurring in all service settings, and patients are appropriate as defined in the utilization management plan.

Aggressive activation of staffing resources to meet the needs of presenting patients.

Use as a guideline to help shift leaders make determinations on deployment of resources and decisions on how to support patient volumes. Census designations may vary based on situations not captured. The Hospital Surge Matrix is the primary working tool for these determinations.

GOAL: To meet essential patient needs with coordination of resources; and to define measures to be taken when needs exceed routine resources.
The responsibility for determining the census saturation level includes input from all units/departments. Generally, each department's representing lead nurse will report the unit census and anticipated activity which collectively helps determine the corresponding census level. This reporting process occurs within the Bed Meetings and through unit rounding. Reporting the identified census level is the responsibility of the House Supervisor.

Definitions:

1. Level 1 - Green - Go
2. Level 2 - Yellow - Early Caution/Surge
3. Level 3 - Red - Census Crisis
4. Level 4 - Black - Disaster
5. Boarding - Patient holding in a level of care awaiting transfer for 4 hours or more.
6. Hosp

7. Hospital Surge Matrix – A living operational document that outlines unit-level actions, staffing and resource strategies, and patient placement options for each census level. It is maintained separately from this policy, is not an attachment to it, and may be updated as operational needs change without revision of this policy.

Inpatient and Emergency Department Capacity and Census

Definition/Criteria: Level 1 - Green - Go

Criteria Guidelines

- Please refer to Hospital Surge Matrix for criteria for both staffing and physical capacity.

Level 2 - Yellow- Early to Late Caution/Surge

Criteria Guidelines

Please refer to Hospital Surge Matrix for criteria for both staffing and physical capacity..Level 3: - Red - Census Crisis

Criteria Guidelines

- Please refer to Hospital Surge Matrix for criteria for both staffing and physical capacity.

Level 4: Black - Disaster

Criteria Guidelines

Please refer to Hospital Surge Matrix for criteria for both staffing and physical capacity.

Maternal Child Health Census Saturation

- Please refer to Hospital Surge Matrix for criteria for both staffing and physical capacity.

Census Level Responses:

Inpatient and Emergency Department

Reference: Hospital Surge Matrix – Inpatient and Emergency Department (current version at [insert intranet/SharePoint location])

- The Hospital Surge Matrix is used to provide recommendations, guidance, and instructions on options to respond to census saturation and changes.
- The Hospital Surge Matrix is a supplement to the critical thinking and planning of the leaders involved in the census saturation response.
- Plans made to respond to census saturation may not be listed in the matrix. They should be decided upon by the house or throughput supervisor (or designee) with support from Directors and Administrators.

Maternal Child Health

Reference: Hospital Surge Matrix – Maternal Child Health (current version at [insert intranet/SharePoint location])

- The Hospital Surge Matrix is used to provide recommendations, guidance, and instructions on options to respond to census saturation and changes.
- The Hospital Surge Matrix is a supplement to the critical thinking and planning of the leaders involved in the census saturation response.
- Plans made to respond to census saturation may not be listed in the matrix.

They should be decided upon by the house or throughput supervisor (or designee) with support from Directors and Administrators.

Hospital Surge Matrix Governance

- The Hospital Surge Matrix is a living operational document. It is not part of, or attached to, this policy.
- Owner: CNO.
- Review: at least [annually] and after any Level 3 or Level 4 activation.
- Updates: made with input from unit lead nurses, House Supervisors, and Emergency Management, and approved by Nursing Leadership / Bed Flow Committee. Board of Directors approval and policy revision are not required for matrix updates.
- Version control: each version carries a revision date and approver. The current version is stored at [insert intranet/SharePoint location] and is accessible to all House Supervisors and department leaders. Only the current electronic version is valid; printed copies are for reference only.
- Changes to the census level definitions or responsibilities in this policy require policy revision. Changes to matrix content (actions, staffing, supplies, placement options) do not.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: AP153	Date Created: No Original Creation Date Set
Document Owner: Jenn Cooper (Assistant Board Clerk/Executive Assistant to COO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Annual Operating and Capital Budget Development and Monitoring

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: To meet its clinical, service, technology and physical capacity objectives, the District must consistently generate sufficient profitability and cash liquidity to support the operating and capital needs of the organization and provide it with ready and affordable access to the capital markets. To ensure the accomplishment of these objectives, management will prepare an annual operating and capital budget that provides the financial plan for the fiscal year and complies with ~~the 10-Year Financial Forecast and~~ the budget guidelines established by the Board and senior management. The annual operating and capital budget will be approved by the Board in June of each year and will provide the basis for evaluation of the District's collective and cost center level financial performance.

PROCEDURE:

Budget Development

1) By March of each year, budget guidelines for the new budget year will be established by senior management. These guidelines will be reviewed with the District's Board of Directors and Finance Committee in late May/early June. These guidelines will outline specific minimum performance objectives needed to be met by every department and by the District as a whole to ensure the District can meet its patient care, financial and strategic objectives. Senior management will also prepare a projection of inpatient census by unit to provide the framework from which departmental managers can establish their estimates of projected activity and necessary resources.

~~2)~~ Operating and capital budget packages will be prepared by Finance for each District cost center for use by managers in preparing their budget estimates. The operating budget packages will include detailed information relative to the current year performance for each cost center and will be provided to the managers in ~~early~~ March. Managers will have approximately three to four weeks to complete their estimates and return their completed packages to Finance, after approved by the appropriate Executive Team member. Completed operating budget packages should include detailed base and budget year information regarding total paid manhours by ~~OSHPD~~ HCAI job category, operating expenses by natural classification, and units of service where applicable. Finance staff, using the Adaptive budget model, will compute patient revenue based on the units of service information provided. Any sources of nonpatient revenue should be

estimated and provided by the department manager. Finance staff, using the Adaptive budget model, will also calculate salaries (from submitted manhours), equipment depreciation and allocated employee benefits. Completed capital budget packages will include specific identification of all proposed capital expenditures in excess of the District's capitalization threshold. The completed capital budget package should include a Captial Interest form for each item that includes a description of the item, the financial and operational justification for the purchase, and other pertinent information. All interest forms for each cost center should be summarized on the Capital Equipment form. The appropriate Executive Team member must approve the capital budget package prior to submission to Finance.classified into the following categories:

a. Nonnegotiable: Patient care cannot be delivered without the expenditure, or the expenditure is so strategically important that to not make the expenditure would place the District at risk

b. Mission critical: Critical to District's mission, and patient care may be compromised/limited without the expenditure in the near term

c. Mission essential: Essential to District's mission, but patient care is not compromised/limited without the expenditure in the near term

d. Covered by new revenue: Expenditure would be fully paid back by new revenue sources within one year.

All capital expenditure costs should also reflect applicable taxes and shipping charges as well as implementation and installation costs, including any related construction to be performed by outside entities. Capital budgets should also include estimates for the succeeding two fiscal years for the purpose of capital and cash flow planning. Managers will be provided with standard cost amounts for certain fixtures and furnishings and information technology expenditures.

3)2) Total paid manhours figures should include all productive and nonproductive time. Productive manhours should include student nurse interns/aides, replacement time for staff replaced when on nonproductive time, training/orientation time and all overtime and premium time hours. Nonproductive hours should include all time related to combo, sick,PTO, EIB, leaves and stand-by time (stand-by should be budgeted at one-third of the actual hours spent on stand-by).

4)3) Detailed descriptions ("zero-based" budgeting) will be given by management for all budgeted expenses as stipulated in the annual budget instructions.

5)4) Managers will consult all appropriate parties regarding annual operating and capital budget development, including District medical staff, to ensure that submitted estimates have collective support.

6) Vice President approval will be required for budgets not complying with established budget guidelines.

7)5) Once operating budget packages are returned to Finance the results will be compiled and overall and departmental results will be analytically reviewed to determine adherence to budget guidelines and achievement of budget objectives. The results of this analytical review will be discussed with senior management to ensure that all variances from budget guidelines have senior

management approval. Based on this analytical review, management may be required to reexamine departmental estimates and make adjustments necessary to achieve acceptable overall budget results. Such adjustments will be effectively communicated between all levels of management with budgetary responsibility.

~~8)~~6) Once capital budget packages are returned to Finance the results will be compiled and reviewed to determine adherence to budget guidelines and achievement of budget objectives. If the total compiled capital expenditures exceed the amount prescribed in the budget guidelines ~~the Leadership Team~~Senior management will meet as needed to reduce total proposed capital expenditures to achieve the guideline amount.

~~9)~~7) Once the annual operating and capital budget is determined to meet budget guidelines and objectives by senior management, it will be submitted to the Board for approval prior to the commencement of the new fiscal year.

~~10)~~8) ~~The annual operating and capital budget presented to the Board will include a ten-year financial forecast projecting the financial results necessary to accomplish operating, capital and strategic objectives.~~ The annual budget will be reviewed by Finance and senior management to ensure resources related to all initiatives and projects identified in the District's Strategic Plan are appropriately incorporated.

Budget Monitoring

1. Once the District's annual operating and capital budget is approved by the Board, departmental budgets will be distributed to management. Management will receive monthly operating budget performance reports (and supporting detail) comparing monthly and year-to-date actual results to budget. These reports will include both fixed budget and flexed (adjusted for volume variations) budget measurements. For those departments not having a unit of service, the fixed and flexed budget amounts will be the same.
2. Managers and directors are expected to ensure their departments operate within the flexed budget amounts (or fixed budget amounts for departments not having a unit of service). Any amounts expended in excess of applicable departmental budget totals will require ~~Vice President~~Executive approval or submission of a plan to the ~~Vice President~~appropriate Executive describing the measures to be taken to ensure that year-end results are within budgeted resources. Department managers and directors will be expected to meet with their respective ~~Vice Presidents~~Executives when monthly and/or year-to-date results are not within the applicable budget amounts and initiate plans for corrective action. ~~Vice Presidents~~Executives will perform monthly reviews of the operating results of their respective areas and follow up with department managers and directors as appropriate. ~~The Executive Team will conduct a quarterly review of the top 25 departmental variances and others as necessary and may require the department managers and directors to attend an Executive Team meeting to discuss their plan for bringing their results back into budget adherence~~.

Adherence to budget will be a material consideration in evaluating each manager's performance.

3. ~~Finance staff will provide a "Monthly Expense Variance Report" to management summarizing the budget-to-actual results for all cost centers. This report contains separate worksheets delineating the top 25 variances from budget and those cost centers having negative budget-to-actual variances of 5% or greater~~After financial results are final each month, Finance staff will send out a notification to leaders that the performance reports in Adaptive/Workday are ready for review. Leaders are required to review the reports for the cost centers that they are responsible for and provide written variance explanations for amounts exceeding budget that are determined to be material and are highlighted for explanation. The leaders must return these reports, with explanations, to Finance with a copy to the appropriate Executive.

4. Finance will also produce and distribute on a periodic basis a report depicting all expenditures made against the approved capital budget, including amounts committed but not yet disbursed. Please refer to Administrative Policy No. 135, "Capital Budget Purchases" for further discussion regarding the management of capital expenditures.

~~5.~~ Various reporting tools are made available by Finance to assist managers in assessing and analyzing their departmental performance, particularly with regard to labor productivity. The tools are reports will change from time but currently include a detailed expense listing and salary and hours detail in Workday/Adaptive. Monthly trended statistical reports and graphs are also provided. For labor management, several Excel based tools are provided including daily and bi-weekly productivity reports, daily punch reports from timekeeping, and bi-weekly payroll data by cost center. A summary of payroll trends and variances will also be provided to the Executive Team on a bi-weekly basis. ~~Descriptions of these reporting tools are as follows:~~

~~b. Labor Cost Performance Per Unit of Service: This monthly report measures the amount of labor cost incurred per unit of service by cost center and compares totals to budget. For those departments not having a unit of service, the report assigns adjusted patient days as the statistic. While those departments might not be expected to adjust their resources in the near term when adjusted patient days fall short of budget, protracted periods of below-budget statistical performance may necessitate such adjustments.~~

~~c. Departments With FTEs Exceeding Budget: This pay period based report compares actual paid full-time employees (FTEs) to the applicable fixed budget amounts (does not consider variations in units of service) by cost center. The report shows results for the individual pay periods as well as year-to-date results. An FTE is defined as the equivalent of a 2,080 hours per year employee. Any negative variances from budget not already approved by senior management should be the result of increased units of service.~~

~~d. Total Hours Per Unit of Service: This pay period based report compares total paid manhours per unit of service to budget for each cost center. The report shows results for the individual pay periods as well as year-to-date results. For those departments not having a unit of service, the report assigns adjusted patient days as the statistic.~~

e. Statistics Summary: This monthly report compares key monthly and year-to-date patient care statistics to budget and to the amounts generated in the prior fiscal year. The report includes both a tabular and graphical presentation of statistical performance.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: AP179	Date Created: No Original Creation Date Set
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Approvers:Board of Directors (Administration)	

Bridge Policy for Federal Grants and Awards Management

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: Kaweah Delta Health Care District may receive Federal Grant Awards. Therefore, the District's accounting system shall operate in accordance with OMB Uniform Guidance when applicable to grant funded programs supported by Federal Awards. The Director of ~~Development~~Foundation, the Grants Coordinator and the Director/and or Manager responsible for the department operating the Federal Grant are responsible for the education of, the monitoring of, and compliance with this policy.

The District's Administrative and Department Policy manuals contain various policies relating to internal controls. The policy and procedures outlined below are intended to supplement those policies, and will override as to Federal Awards should there be a conflict.

Administrative Policy **AP.148** *Grants* outlines the overall process for applying for, administering and managing grants in general.

In addition, Grants involving Federal Awards are subject to the following financial management policies and procedures:

1. **Cash Management**

   Kaweah Delta requests funds on a reimbursement basis from the Payment Management System (PMS). This ensures that funds requested are the minimum amounts necessary to cover allowable project costs, that they are in alignment with actual cash expenditures related to the project and that they do not cover future expenses. The following process should be followed when requesting fund drawdowns:

   a. Using the departmental performance report for the grant cost center, the ~~Development~~ Foundation Coordinator will compile all invoices and receipts that support the draw down request into a packet.
   b. Submit the packet and the draw down request form to the Department Director and/or Manager operating the grant cost center, the Director of ~~Development~~ Foundation and the Grants Coordinator for approval.
   c. Once approved the packet will be provided to the Finance Department to initiate the draw down request. Allow 3-4 days for the draw down to be processed.
   d. All supporting documentation related to draw downs will be maintained in the Grant Department and the Finance Department.

2. Annual Audits

A financial statement audit is conducted by independent external auditors annually for Kaweah Delta Health Care District. As part of the annual audit process, the Schedule of Expenditures of Federal Awards (SEFA) is prepared to determine whether a Single Audit is triggered, based on expenditures of federal awards in the amount of $~~750,000~~1 million or more. The results of the Annual Financial Statement audit and any triggered Single Audits are presented to and reviewed by the Audit Committee and the Board of Kaweah Delta Health Care District.

Selection of the independent external auditors is completed by the Audit and Compliance Committee of the Board of Directors and is governed by Administrative Policy **AP.~~167~~ 69** *~~Quote and Proposal Guidelines~~Requirements for Contracting with Service providers* which governs the ~~selection~~ contracts for ~~of~~ service providers.
If a Single Audit is required, the audit package and the data collection form shall be submitted to the Federal Audit Clearinghouse 30 days after receipt of the auditor's report, or 9 months after the fiscal year end, whichever comes first.

3. Accounting System

Grant funding is accounted for in the District's financial records by assigning a separate cost center~~, referred to as an accounting unit in the accounting software system,~~ to the grant to account for all incoming funding and outgoing expenditures. Monthly financial performance reports are generated that are provided to the Grant ~~Manager~~ Coordinator for review. These processes are further outlined in Administrative Policy **AP.153** *Annual Operating and Capital Budget Development and Monitoring* .
Finance Department Policies **FDP.21** *General Ledger Chart of Accounts* and **FPD.41** *Guidelines for Natural Classification of Expense* govern the maintenance of the chart of accounts. Each ~~accounting unit (~~cost center~~)~~ in the accounting system has designated posting accounts. Each grant award will be designated a specific accounting unit number in the chart and will be assigned posting accounts and natural classes of expenditures, based upon the types of expenditures that are allowed by the grant. Any payment related to the grant will be coded to this accounting unit and correct account, or natural classification.

Source documents are retained electronically in most cases in accordance with Finance Department Policy **FDP.39** *Record Retention* . This policy applies to grant source document for paid expenditures including authorization, bank statements and financial statements. These documents are housed in the ~~Finance scanning~~Workday accounts payable system (as attachments) as well as in the Finance G: drive. Draw down reimbursement packages including authorization and all source documentation for expenditures, copies of federal awards, and copies of financial reports ~~such as the SF 425 and FFR reports~~ are retained electronically in the G: drive Grant folder online. In addition, the ~~Development~~ Foundation Department retains a complete grant file for each

award including the electronic tracking of project budgets and comparison to actual expenditures, awards, obligations and unobligated balances.

4. Bank Statements

Finance Department Policy **FDP.25** *Account Reconciliation Procedure* requires all general ledger balances, including bank account balances, to be reconciled within a timely manner. A timely manner is considered to be within 30 days of month end. Administrative Policy **AP.146** *Cash Control* Also requires bank reconciliation and audit as applicable.

The ~~Sr. Financial Analyst~~Finance staff member assigned to Treasury functions completes the monthly reconciliation process and reviews the statements. Monthly reconciliations, along with statements, are to be reviewed by the Finance ~~GL~~ Treasury Manager. In addition, the Finance Director completes a ~~quarterly~~ periodic review and approval of all cash and investments reconciliations, including a review of statements. The Director of Finance does not process AP payments; they are released by the Finance AP Manager and processed by AP staff.

Bank Statements are obtained electronically from the Commercial Banking Online Portal. The Chief Executive Officer, Chief Financial Officer and Board ~~treasurer~~ Treasurer are the only individuals listed as authorized signers on bank accounts and are authorized to approve the system administrator, the Director of Finance, of the Online Portal. The authorized signers are not users of the Online portal.

The ~~Sr. Analyst~~Finance staff member assigned to Treasury who performs the bank account reconciliation does not have authority to process payments and is not an authorized bank signer. All checks are signed electronically and include the signature of the CEO and Board Treasurer. Only Accounts Payable staff authorized to process checks in the AP system are allowed access to the ~~MHC~~ Workday functions ~~system~~ that generates ~~checks~~payments including electronic payments or check payments.

5. Disbursements/Procurement

Kaweah Delta maintains all documentation related to expenditures of grant funds as outlined above in Cash Management. The following process should be followed when requesting fund drawdowns:

a. Using the departmental performance report for the grant cost center, the ~~Development~~ Foundation Coordinator will compile all invoices and receipts that support the draw down request into a packet.
b. Submit the packet and the draw down request form to the Department Director and/or Manager operating the grant cost center, the Director of ~~Development~~ Foundation and the Grants Coordinator for approval.
c. Once approved the packet will be provided to the Finance Department to initiate the draw down request. Allow 3-4 days for the draw down to be processed.

d. **All supporting documentation** related to draw downs will be maintained in the Grant Department and the Finance Department.

Grant expenditures adhere to Kaweah Delta's Administrative Policies, **AP.156** *Standard Procurement Practices* , **AP.166** Competitive Bidding on Contracts and **AP.167** *Quote and Proposal Guidelines* to ensure appropriate and reasonable use of grant funds.

Expenditures area also in accordance with Kaweah Delta's purchase authorization process, whereby purchasing authority is granted by Directors and ~~Vice Presidents~~Executives related to both the types of purchases allowed, as well as the purchasing limits. These authorization forms are kept on file in the Finance Department as required by ~~Materials Management~~Finance Policy ~~**MM.12**~~**FDP.50** *Purchase Authorization* . Purchase orders and non PO invoices require pre-approval by those with purchasing authority as outlined in Finance Department Policy **FDP.09** *Accounts Payable Invoice Processing* and **FDP.50** *Purchase Authorization* as well as Materials Management Policy ~~Policies **MM.12** Purchase Authorization and~~ **MM.17** *Non-Stock Item Purchase* .

All checks are processed electronically and therefore there are no blank checks. Checks are also signed electronically as outlined above. Invoices are released for payment in Workday once the appropriate authorized signer has electronically approved them. Invoices above a certain dollar limit are also reviewed and approved by the Accounts Payable Supervisor or ~~T~~he Accounts Payable Manager~~ reviews and electronically releases all invoice batches and reviews supporting documents prior to the processing of checks~~. The settlement run, which creates payments using electronic, check or virtual card processing, is generated by the Accounts Payable Supervisor on a weekly basis. Only the Accounts Payable Supervisor or the Accounts Payable Manager can create a settlement run in Workday. The settlement run is then reviewed and approved by the designated Accounts payable staff member (Settlement Specialist in Workday) and then it is released for payment by designated method. ~~SettlThe batch release process is required by the AP system for payment of an invoice by check or ACH.~~ Those authorized to enter Purchase Orders ~~and Invoices~~ are not authorized to release ~~invoice batches for payment~~payments. Invoices will only be processed if applicable purchase authorization is ~~verified upon invoice or PO entry~~completed as described above.

FDP.44 *Accounts Payable Trade Vendor Maintenan*ce outlines the process for setting up new vendors in the ~~AP~~ Workday system. ~~The Finance AP Manager reviews all vendor setup and the Administrative Assistant enters new vendor~~

~~information into the system~~The Materials Management/Procurement staff process new vendor packages to ensure appropriate setup information and enter new vendors into the Workday system. Those who process payments (AP Staff) do not have the authority to setup new vendors in the system. ~~The Finance AP Manager reviews the AP vendor maintenance forms and releases batches, but now have system authority to enter invoices and does not process checks and ACH payments. The Administrative Assistant enters the vendors into the system~~. New vendor entry is controlled by a separate team then the AP team that processes payments.

FDP .47 *Accounts Payable Check Runs* outlines the process for processing check and ~~ACH~~ electronic payments. Invoices ~~batches~~ are entered by AP staff, administrative staff or are electronically uploaded to the Workday system (then reviewed by AP staff). Only the ~~Finance~~ AP Supervisor and/or Manager can ~~release batches~~generate a settlement run for invoices to be paid. ~~Once they are released, the AP staff authorized can generate the check or ACH file. The Administrative Assistant assures check or ACH copies are matched to invoice documentation and scans into the electronic filing system~~When invoices are entered, the Workday system requires that an image of the actual invoice be attached to the invoice record. Wire transfer templates can only be approved by the CEO system administrator.

6. Matching or Cost Sharing

For all Federal awards, any shared costs or matching funds and all contributions, including cash and third party in-kind contributions, are accepted as part of Kaweah Delta's Cost Sharing or Matching when the following criteria are met:

a. The costs are verifiable from Kaweah Delta's records;

b. The costs are not included as contributions for any other Federally assisted project or program;

c. The costs are necessary and reasonable for proper and efficient accomplishment of project or program objectives;

d. The costs are not paid by the Federal Government under another award, except where the Federal statute authorizing a program specifically provides that Federal funds made available for such program can be applied to matching or cost sharing requirements of other Federal programs; and

e. The costs are allowable and provided for in the approved budget.

7. Consultants and Contractors

Kaweah Delta's Administrative Policies, **AP.69** *Contracting with Outside Service Providers*, **AP.166**, *Competitive Bidding on Contract*s and **AP.167**, *Quote and Proposal Guidelines* should be followed related to the hiring or engagement of consultants and contractors. Further requirements must be satisfied related to Federal Awards*:*

a. Internal capabilities must be assessed related to the proposed consultant or contractor work to be performed prior to obtaining this assistance outside of Kaweah Delta. This assessment will be documented by the Grants ~~Manager~~ Coordinater and retained in the Grant File.

b. To avoid unfair advantages, contractors who provide services to develop or draft grant applications, contract specifications, requirements, statements of work, invitations for bids and/or requests for proposal are excluded from competing for such opportunities.

c. Prior to selecting a new consultant or contractor, the Excluded Parties List System, within the System for Award Management at https://www.sam~~lgove/portal/public/SAM~~.gov/searh (select Entity Information and Exclusion) should be reviewed to ensure that the party is not excluded from receiving federal funds.

8. Expenditure Analysis

Grant funding is accounted for in the District's financial records by assigning a cost center (department), called an accounting unit, to the grant to account for all incoming funding and outgoing expenditures. Monthly financial performance reports including budgeted and actual expenditures are generated that are provided to the ~~Development~~ Foundation Coordinator and Grant Coordinator for review. These budget monitoring processes are further outlined in Administrative Policy **AP.153** *Annual Operating and Capital Budget Development and Monitoring*. This policy requires those responsible to perform the analysis, understand reason for variance and make a plan for correction if applicable. **AP.148** *Grants* outlines this process as well.
Specific to federal grant funds, the Department Director responsible for the grant, the Grant Coordinator and the ~~Development~~ Foundation Coordinator monitor variances between budget estimates and actual expenditures in a separate spreadsheet in addition to departmental performance reports. These spreadsheets, that track budget, expenses and remaining balances are also submitted as support to the reimbursement package.

9. Indirect Costs

For Federal grants, the only current indirect cost rate being utilized is the fixed 8% rate allowed for training grants.
The indirect rate is applied to applicable expenditures and included in the draw down package submitted to be reimbursed. The Grants Coordinator, ~~Development~~ Foundation Coordinator, Department Director responsible for the Grant operation approve the package for reimbursement.

Applicable support for the indirect rate calculation is to be retained with the Grant file.

10. Credit Cards

Federal Awards will follow Kaweah Delta's Administrative Policy, **AP.46**, *Commercial Card Expense Reporting Program* which governs the controls related to District issued credit cards through the CCER program.

11. Timekeeping

Kaweah Delta's Human Resources Policy **HR. 63** *Timekeeping of Payroll Hours*, should be followed related to Timekeeping controls and practices. In addition, Federal Awards must adhere to the following practices:

a. The Grants ~~Manager~~ Coordinaor and Department Director must monitor the hours and dollars charged to the grant on a regular basis to ensure that the amounts allocated to and supported by the grant are in accordance with the federal award. This will ensure that the hours and dollars charged to the grant are based on actual recorded and approved hours and include the total activity for which employees were compensated. Salaries and wages will not be based on budget estimates, but on actual hours recorded and approved in the timekeeping system.

12. Travel

Kaweah Delta's Administrative Policies, **AP.19** *Travel, Per Diem and Other Employee Reimbursements* and **AP.84** *Mileage Reimbursement* should be followed related to travel expenses reimbursed by Federal Award dollars.

In addition, any travel related to federal awards should be budgeted and monitored and any specific restrictions of the award shall apply. There are to be no exceptions to rates published in the Federal Travel Regulations, unless otherwise justified.

13. Not applicable

14. Conflict of Interest

Administrative Policy **AP.23** *Conflict of Interest* covers certain District employees that are required to file a Statement of Economic Interest on an annual Basis. In addition, those administering Federal Grant Awards will adhere to the following conflict of Interest procedures:

Conflict of Interest: Any official action or any decision or recommendation

by an individual acting in a capacity related to a grant-funded project, the effect of which would appear to or actually result in financial benefit to that individual or a member of the individual's household or a business with which the individual or a member of the individual's household is associated.

Family Member: The following relationships to an individual affiliated with a grant-funded project are defined as a family member: spouse or domestic partner, spouse's and domestic partner's parents, children, children's spouses or domestic partners, parents, parent's spouses or domestic partners, siblings, siblings spouses or domestic partners, grandparents, grandparent's spouses or domestic partners, grandchildren, grandchildren's spouses or domestic partners

Financial Interest: Anything of monetary value received or held by any member of Kaweah Delta Health Care District or Kaweah Delta Hospital Foundation or a member of his/her family, whether or not the value is readily ascertainable, including, but not limited to: salary or other payments for services (e.g., consulting fees, honoraria, or paid authorships for other than scholarly works); any equity interests (e.g., stocks, stock options, or other ownership interests); and the value of intellectual property rights and interests (e.g., patents, trademarks, service marks, and copyrights) and royalties or other income received from any such intellectual property.

Kaweah Delta Health Care District and Kaweah Delta Hospital Foundation ("The Organizations") encourage and support outside interactions of its staff with federal, state, and local governments, community organizations, non-profit groups, and business and industry as important parts of their daily work and community engagement activities. However, maintenance of the public’s trust is critical to the mission and reputation of The Organizations. As such, it is critical that all members of The Organizations demonstrate that they hold themselves to the highest ethical standards, including the disclosure of their participation in any activity that will result in financial, professional, or personal benefit and that results in, or gives the appearance of, a Conflict of Interest.

The Organization's approach to identifying, evaluating and managing potential Conflicts of Interest, does not attempt to illustrate all possible situations that require disclosure. All persons related to grant funded projects are expected to be vigilant and ethical in all dealings in order to ensure any potential conflicts are addressed quickly and appropriately.

A Conflict of Interest would arise when an employee, Board Member,

agent, or any member of his or her immediate family, has a financial or other interest in or may receive a tangible personal benefit from a firm considered for a contract. The standard against which this should be measured is whether a reasonable person with knowledge of the situation would question the impartiality of those involved. As such the following are restrictions apply:

- No employee, Board Member, or agent of The Organizations may participate in the selection, award, or administration of a contract supported by a federal award if he or she has a real or apparent Conflict of Interest.
- No employee, Board Member, agent or any member of his or her immediate family may solicit or accept gratuities, favors or anything of monetary value from contractors or parties to subcontracts.

Employees are expected to comply with any applicable requirements pertaining to Conflicts of Interest in their grant funded activities.
In cases where grant funding is given to sub recipients to conduct grant activities, including sub awards ~~under 45 CFR §75.351~~, the sub recipient will be required to adhere to this Conflict of Interest Policy in its entirety and this requirement will be included in any agreements or contracts. When actual or perceived conflicts of interest are identified by the sub recipient, Kaweah Delta, the grant recipient, must be notified immediately upon identification.

Those participating in grant funded activities are required to certify that they have appropriately disclosed any Conflict of Interest related to the grant, which would reasonably appear to create a conflict. This certification is required by all grant participants on the attached Conflict of Interest Disclosure Form.
The Grant ~~Manager~~ Coordinator will report the existence of any Conflict of Interest, financial or other, to the granting agency contact prior to the expenditure of any sponsor funds, and provide assurance that the conflict has been managed, reduced or eliminated within 30 days of discovery. If a conflict is identified after this initial report, another disclosure must be made to the Grant ~~Manager~~ Coordinator within thirty (30) days of that identification, and such conflict must also be managed, reduced or eliminated within thirty (30) days of that identification. If required by the granting agency, a supplemental report detailing this conflict and its management will be provided.
If it is determined that a Conflict of Interest, financial or other, cannot be satisfactorily managed, the Grant ~~Manager~~ Coordinator will notify in writing the appropriate granting agency contact.
Any disclosed grant-related Conflict of Interest, financial or other, will be reviewed promptly by the Grants Committee for a determination of whether it constitutes a Conflict of Interest. Notification will be provided to the sponsor of identified conflicts, including action taken to manage the Conflict, including the reduction or elimination of the conflict, as appropriate. ~~This will be reported in accordance with 42 CFR § 75.112.~~

In addition, if it is determined that a Conflict of Interest was not identified or managed in a timely manner, a retrospective review of the activities funded by the grant will be conducted to determine if activities were impacted. This will be completed by the Grant ~~Manager~~Coordinator. Notification will be provided to the granting agency within 30 days of discovery, including how the conflict was managed.

The Grant ~~Manager~~ Coordinator will administer this policy to the extent that a Conflict of Interest, financial or other, is grant- related, and maintain records of all filed disclosure forms and associated documents, including, but not limited to, documentation of actions taken by The Organizations to eliminate, reduce and/or manage Conflicts of Interest. All such records will be retained for a period of three years following completion of the grant.

Failure to comply with this policy may subject an Employee to corrective action up to and including dismissal. Violations of this policy must be reported to the Grants ~~Manager~~ Coordinator and the Compliance and Privacy Officer.

Conflict of Interest Disclosure Form

Conflict of Interest: Any official action or any decision or recommendation by an individual acting in a capacity related to a grant-funded project, the effect of which would appear to or actually result in financial benefit to that individual or a member of the individual's household or a business with which the individual or a member of the individual's household is associated.

Family Member: The following relationships to an individual affiliated with a grant-funded project are defined as a family member: spouse or domestic partner, spouse's and domestic partner's parents, children, children's spouses or domestic partners, parents, parent's spouses or domestic partners, siblings, siblings spouses or domestic partners, grandparents, grandparent's spouses or domestic partners, grandchildren, grandchildren's spouses or domestic partners

Financial Interest: Anything of monetary value received or held by any member of Kaweah Delta Health Care District or Kaweah Delta Hospital Foundation or a member of his/her family, whether or not the value is readily ascertainable, including, but not limited to: salary or other payments for services (e.g., consulting fees, honoraria, or paid authorships for other than scholarly works); any equity interests (e.g., stocks, stock options, or other ownership interests); and the value of intellectual property rights and interests (e.g., patents, trademarks, service marks, and copyrights) and royalties or other income received from any such intellectual property.

A potential or actual conflict of interest exists when commitments and obligations are likely to be compromised by the nominator(s)'other material interests, or relationships (especially economic), particularly if those interests or commitments are not disclosed.

This Conflict of Interest Form should indicate whether the individual participating in grant activities, funded by federal award dollars, has an economic interest in, or acts as an officer or a director of, any outside entity whose financial interests would reasonably appear to be affected by participation in grant activities. The individual participating should also disclose any personal, business, or volunteer affiliations that may give rise to a real or apparent conflict of interest. Relevant Federally and organizationally established regulations and guidelines in financial conflicts must be abided by. Conflicts should be disclosed and actions taken to manage or eliminate the real or apparent conflict.

Name: _____ Date: _____

Position: _____

Grant/Federal Award to which this disclosure applies:
_____

Please describe below any relationships, transactions, positions you hold (volunteer or otherwise), or circumstances that you believe could contribute to a conflict of interest:

_____ I have no conflict of interest to report.

_____ I have the following conflict of interest to report (please specify other nonprofit and for-profit boards you (and your spouse) sit on, any for-profit businesses for which you or an immediate family member are an officer or director, or a majority shareholder, and the name of your employer and any businesses you or a family member own:

1. _____

2._____

3._____

I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature: _____

Date: _____

15. Mandatory Disclosures

Kaweah Delta will timely disclose, in writing to the granting agency, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the award.

~~See **Appendix A** of this policy for other Standard Terms of the NOA that are incorporated into this policy.~~

Administrative Policy **AP.53** *Patients' Rights and Responsibilities, and Non-Discrimination* purpose is to comply with applicable State and Federal civil rights laws regarding non-discrimination and ensure patients' rights regardless of race,

color, national origin, age, disability, religion, or sex. The policy outlines the process to file an internal grievance and to file an external complaint. It also provides for free language services to people whose primary language is not English.

As related to Federal awards, under terms of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended by (22 USC 7104):

Trafficking in persons.

1. As a recipient, Kaweah Delta, its employees, sub recipients of federal awards, and sub recipients' employees may not –

a. Engage in severe forms of trafficking in persons during the period of time the award is in effect;

b. Procure a commercial sex act during the period of time that the federal award is in effect; or

c. Use forced labor in the performance of the award or sub awards under the award.

Kaweah Delta will inform HRSA immediately of any information we receive from any source alleging a violation of a prohibition of 1 a, b and c above of this award term.

Kaweah Delta will include the requirements in 1 a, b and c above of this award term related to Trafficking in any sub award made to a private entity.

~~See **Appendix C** for full text of this award term.~~

16. Legislative Mandates

Kaweah Delta will adhere to all HRSA grant Legislative Mandates that could impact or limit the use of federal award dollars and include those as updates to these procedures. ~~See **Appendix B** of this policy for the~~The most current Grants Policy Bulletin related to Legislative Mandates is HRSA Grants Policy Bulletin 2026-02E.

In addition, on an annual basis, the Legislative Mandates for the coming year will be reviewed, assessed and incorporated into the policies and practices as appropriate.

17. Allowability of costs

There are two types of costs related to grants: direct cost and indirect costs. Direct costs are expenses that are specifically associated with a particular sponsored project and can be directly assigned to such activities easily with a high degree of accuracy. Indirect costs are expenses that cannot be identified specifically with a particular project of activity. They are expenses that benefit more than one activity.

To be considered an allowable cost, the following criteria must be met:

- The cost must be reasonable. The cost is determined to be reasonable if a normal person, aware of the facts, would be willing to spend the same amount in similar circumstances.
- The cost must be allocable to the project and must benefit the grant programs or projects.
- The cost must be properly documented within the accounting system with source documentation as support.
- The costs must conform to all limitations and exclusions as set forth in the Notice of Award
- The costs must be treated consistently. A cost may not be attributed to one Federal Award as a direct cost when the same cost is attributed to another Federal Award as an indirect cost.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

MS60 EHR Onboarding Medical Staff

Subcategories of District Manuals not selecte

Policy Number: MS 60	Date Created: No Original Creation Date Set
Document Owner: Belen Contreras (Executive Assistant)	Date Approved: Not Approved Yet
Approvers: Leah Daugherty, Director ISS Clinical Informatics, Teresa Boyce, Director of Medical Staff Services & Medical Executive Committee	

EHR Onboarding Medical Staff

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: EHR (Electronic Health Record) onboarding for credentialed Medical Staff members is a critical step in the integration of a new physician or advanced practice provider to Kaweah Health. Onboarding involves an introduction to the EHR workflows and functionality as well as orientation and set up for clinical applications such as dictation assistant applications, secure messaging applications, and any other patient care related technology. A robust EHR and patient care technology onboarding and support is imperative for success in accurate documentation and safe care of the patient.

Purpose: The purpose of this policy is to ensure a robust professional EHR, and technology onboarding is completed before the credentialed physician, advanced practice provider, or GME (Graduate Medical Education) Resident, Visiting Fellow, or other Student is completed successfully prior to working their first shift or clinic day. Exceptions may be allowed for locum physicians or any emergency circumstances requiring access before onboarding can occur. These will be evaluated on a case-by-case basis by the Director of Medical Staff and the Director of Clinical Informatics.

Scope: To outline the process for scheduling onboarding and follow up support for new members of the Medical Staff as outlined in the Purpose section above.

Procedure:

1. Once a member of the Medical Staff is credentialed an EMR onboarding session will be scheduled with the Informatics Team, once scheduled EMR access will be granted.
2. Sessions must be in person except for telehealth providers.
3. Any on-line learning modules assigned must be completed before the in-person session occurs.
4. Onboarding will be tailored to meet each person's learning needs, consideration to prior EHR experience and documentation style will be factored in.
5. Tip sheets, support contact information, and tools will be shared with the learner during the onboarding session.
6. At the elbow support will be coordinated and scheduled by the Medical Informatics Educator or team member providing the initial onboarding. At the elbow support will vary depending on the service line of the Medical Staff member.

References:

American Medical Association, 2025. Onboarding Optimization: Pave the Way for New Physician Success and Satisfaction | AMA STEPS Forward | AMA Ed Hub, https://edhub.ama-assn.org/steps-forward/module/2832726

"These guidelines, procedures, or policies herein do not represent only medically or legally acceptable approach but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Privileging form for Podiatry

Privileges in Podiatry

Name: _____

Please Print

PODIATRY PRIVILEGES – Criteria

Education: DPM; **AND** successful completion of a podiatric medicine residency program from an accredited American College of Podiatric Medicine **AND** Current certification or active participation in the examination process leading to certification within 5 years by the American Board of Podiatric Medicine, ~~American Board of Podiatric Surgery~~ or American Board of Foot and Ankle Surgery (applicants completing training prior to 1968 will be grandfathered in)

Initial Clinical Experience: Documentation of at least 50 podiatric procedures in the past 2 years or successful completion of a podiatric medicine residency program in the past 12 months

Renewal Criteria: A minimum of 50 podiatric procedures in the last 2 years AND Maintain current certification or active participation in the examination process leading to Certification by the ~~American Board of Podiatric Surgery.~~ American Board of Foot and Ankle Surgery OR the American Board of Podiatric Medicine.

FPPE Requirements: Direct observation of five (5) procedures with concurrent chart review (may include advanced procedures – excluding hyperbaric)

PODIATRY CORE PRIVILEGES

Request	Procedure	Approve
☐	**Core Privileges include:** • Evaluate, diagnose, consult (may include telehealth), perform H&P and provide surgical and non-surgical treatment/care to patients of all ages presenting with illnesses, injuries and disorders of the foot, and ankle, including basic fore foot and rear foot procedures and tendon repair and transfer. • Amputations: to all joints of the foot and ankle of the lower extremity. • Wound Care: Surgical debridement of wounds, transcutaneous oximetry interpretation, complicated wound management, local and regional anesthesia, wound biopsy and preparation of wound bed and application of skin substitute.	☐
☐	Admitting Privileges (must request Active staff status)	☐

ADVANCED PROCEDURES

(Must meet Core Privileges Criteria and Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship, or other acceptable experience.)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE Requirements	Approve
☐	Ankle Arthroscopy	Documentation of training and a minimum of 2 procedures in the last 2 years.	Documentation of a minimum of 2 procedures in the last 2 years.	Direct observation of first case with concurrent chart review	☐
☐	Complex Rear Foot/Ankle	Documentation of training and a minimum of 5 procedures in the last 2 years.	Documentation of a minimum of 5 procedures in the last 2 years.	Direct observation of first case with concurrent chart review	☐
☐	Complex External Fix	Documentation of training and a minimum of 2 procedures in the last 2 years.	Documentation of a minimum of2 procedures in the last 2 years.	Direct observation of first case with concurrent chart review	☐
☐	Hyperbarics Supervision (limited to wounds below the knee). Treatment of conditions requiring hyperbaric oxygen delivery at the Kaweah Health wound center.	Completion of 40 hour Hyperbaric Course approved by the Undersea and Hyperbaric Medical Society (UHMS) or the American College of Hyperbaric Medicine (ACHM) and 10 procedures in the last two years.	20 procedures in the last 2years.	Direct observation of the first two cases with concurrent chart review	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE Requirements	Approve
☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__ Dinuba __Exeter __Lindsay __Tulare __Valencia __Woodlake __KHMC – Akers __KHMC – Willow Specialty 202__KHMC – Willow 502 __Specialty Clinic __Tulare Cardiology Clinic**	Initial Core Criteria AND Contract for Outpatient Clinical services with Kaweah Delta Health Care District.	Maintain initial criteria	None	☐

☐	Administration of Procedural Sedation	Must successfully pass Kaweah Health Sedation/Analgesia (Procedural Sedation) Exam	Must successfully pass Kaweah Health Sedation/Analgesia (Procedural Sedation) Exam	None	☐
☐	Supervision of a technologist using fluoroscopy equipment	Meet Initial Criteria AND Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and; I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) I may participate in the Kaweah Health Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.

(c) **Emergency Privileges –** In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

Name: _____
Print

Signature: _____ _____
Applicant *Date*

Signature: _____ _____
Department of Surgery Chair *Date*

SECOND AMENDMENT TO CHIEF EXECUTIVE OFFICER AGREEMENT

This is a Second Amendment to the Chief Executive Officer Agreement, which became effective December 22, 2025 as amended effective July 1, 2026 ("Agreement"), between Kaweah Delta Health Care District ("KDHCD") and Marc Mertz ("Mr. Mertz").

WHEREAS, as stated in section D of the Agreement, the market for healthcare CEOs is national and highly competitive with significant demand for qualified candidates. The retention of a highly-qualified CEO inures to the benefit of the organization by maintaining consistent and orderly economic and organizational direction and growth. Compensation of the CEO at competitive and equitable rates based on national rates is therefore necessary;

WHEREAS, the Board most recently revised its Executive Compensation Policy (BOD4) ("Policy") on June 27, 2025 and such Policy recognizes competition for quality executives in the healthcare industry is very high while the years of continuous employment of healthcare executives at a specific institution is surprisingly low;

WHEREAS, under the Local Health Care District Law the Board is vested with authority to appoint the Chief Executive Officer and to fix the CEO's compensation (California Health and Safety Code section 32121(h)), and any written employment agreement with the CEO must set forth the material terms of that compensation (California Health and Safety Code section 32121.6);

WHEREAS, it is the position of the Board, in order to maintain appropriate continuity in the CEO, while at the same time continuing as good stewards of KDHCD's funds, the CEO should receive total compensation that is at or near the median for CEOs at comparable institutions;

WHEREAS, the appropriateness of the CEO's compensation is confirmed through the use of an outside and independent consulting firm with nationwide expertise in healthcare executive compensation;

WHEREAS, to assist the Board in this process, it engaged the Human Resources & Compensation consulting practice of national consulting firm Arthur J. Gallagher & Company ("Gallagher"). Gallagher possesses one of the nation's largest and most complete healthcare compensation databases. Its proprietary database contains current total compensation data on more than 550 health systems and over 3,000 hospitals. Gallagher has drawn upon this data to develop a custom peer group of comparable health systems and has used that peer group to evaluate the total compensation for KDHCD's CEO against the market median;

WHEREAS, the Board determined at a duly noticed open meeting on October 28, 2026 that Mr. Mertz's Base Salary was below the competitive market rate and approved a market adjustment increasing his Base Salary to $1,223,640.00, effective December 1, 2026, an amount that is at or near the median for comparable healthcare CEOs as identified by the Gallagher data and is consistent with the Policy; and

WHEREAS, the Board determined at the same duly noticed open meeting on October 28, 2026 that Mr. Mertz's Incentive Compensation was below the competitive market rate and approved a market adjustment increasing his Incentive Compensation to $305,910.00, effective December 1, 2026, an amount that is at or near the median for comparable healthcare CEOs as identified by the Gallagher data and is consistent with the Policy; and

WHEREAS, the Board finds that providing the CEO total compensation at or near the market median serves the substantial public purpose of recruiting and retaining a qualified and competent Chief Executive Officer in a highly competitive national market, that the approved compensation is fair and reasonable consideration for the services to be rendered, and that it therefore does not constitute a gift of public funds;

WHEREAS, consistent with the Ralph M. Brown Act, the Board, before taking final action, orally summarized in open session the recommendation for the CEO's salary and compensation, took no action by secret ballot, and approved and reported the compensation set forth herein in open session on October 28, 2026;

WHEREAS, the Policy, the Gallagher compensation study, and this Second Amendment are maintained as public records of KDHCD and are available to members of the public upon request;

WHEREAS, the KDHCD Board, by action on October 28, 2026 authorized the Agreement to be modified as set forth below to be more consistent with Gallagher data and Board Policy.

NOW, THEREFORE, KDHCD and Mr. Mertz agree that the Agreement is hereby amended as follows:

1. Mr. Mertz's Base Salary is adjusted to $1,223,640.00, effective December 1, 2026 on a prospective basis. KDHCD personnel are authorized to implement this adjusted Base Salary prospectively and, solely to the extent payroll is not updated as of the December 1, 2026 effective date, to make a one-time catch-up payment equal to the difference between the amount actually paid to Mr. Mertz for the period on and after December 1, 2026 and the adjusted Base Salary for that same period. For the avoidance of doubt, no payment under this Second Amendment is made as compensation for services rendered before December 1, 2026.

2. Mr. Mertz's potential Incentive Compensation is adjusted to $305,910.00, effective December 1, 2026 on a prospective basis.

The remaining terms and conditions of the Agreement shall remain the same.

KAWEAH DELTA HEALTH CARE DISTRICT

By_____
David Francis, Board President

By_____
Marc Mertz, CEO

OUTSTANDING HEALTH OUTCOMES

Outstanding Health Outcomes FY2027
October 2026

Kaweah Health

MORE THAN MEDICINE. LIFE.

OHO FY2027

Safety Program Optimization / Champion: Cindy Vander Schuur

Metric Description	Baseline	July 2026	August 2026	FYTD 2027	FY2027 Goal
Serious Safety Event Rate	3.2 (5/25–4/26)	1.61	2.40	2.01	2.88 (10% Reduction from Baseline)

Quality Initiatives:

1. Ensure consistent execution of core safety behaviors at the bedside
- Implement structured Hand-off process
- Establish real-time escalation of Change in Patient Condition

2. Promote safer care through leadership and engagement
- Conduct daily executive safety rounds with frontline staff
- Implement a Physician-Nurse Collaboration Council

Safety Program Optimization Initiatives

Goal: Ensure consistent execution of core safety behaviors at the bedside

Initiative 1a

Implement structured hand-off process

Complete

Current state mapped

Hand-off practice mapped with clinical directors; opportunities identified to formalize a standard process and policy

Next steps

Identify best practices

Review evidence-based hand-off practices

Standardize hand-off

Implement a standardized hand-off process to close gaps

Gather frontline input

Professional Practice Council (November) and Licensed Nurse Residency groups (October and November)

Initiative 1b

Establish real-time escalation of change in patient condition

Complete

Policy and process reviewed

Reviewed with clinical directors and gaps identified; policy in place, but escalation opportunities persist

Next steps

Identify best practices

Review evidence-based escalation practices

Complete gap analysis

With subject matter experts and the Process Improvement Engineer

Close gaps

Implement changes to close gaps

Gather frontline input

Professional Practice Council (November) and Licensed Nurse Residency groups (October and November)

Safety Program Optimization Initiatives

Goal: Promote safer care through leadership and engagement

Initiative 2a

Conduct daily executive safety rounds with frontline staff

In progress

Unit Quality and Safety Board drafted
Standard board developed for every unit; ready for executive team review

Partnering with executive leadership
Quality partnering with the executive team to plan rollout

Next steps

Set the rounding structure
Executive team to determine who rounds, how often, and on which units

Build a follow-up process
Log concerns, assign an owner, and track each item to closure

Close the loop
Report outcomes back to frontline staff

Initiative 2b

Implement a Physician-Nurse Collaboration Council

Planned

Council leadership identified

Next steps

Set expectations
Define the council's purpose and expected outcomes

Set the structure
Determine membership, meeting cadence, and reporting

Establish a charter
Formalize the council's scope, roles, and responsibilities

OHO FY2027

Reduce Hospital Acquired Infections / Champion: Shawn Elkin

Metric Description	Baseline	FYTD27	FY27 Goal
CLABSI SIR	FY 2026 – 1.64	1.43 (2 cases)	≤0.486 (NHSN 30th Percentile 2022)
C. diff SIR	FY 2026 – 1.34	0.564 (5 cases)	≤0.170 (NHSN 30th Percentile 2024)

Quality Initiatives:

1. CLABSI: Ensure Appropriate Use and Management of Central Lines

- Align insertion & maintenance bundles with evidence-based practices
- Embed daily interdisciplinary line necessity assessments into workflow
- Implement strict criteria limiting femoral access to emergent or last-resort

2. C. diff: Strengthen Commitment to Infection Prevention Practices

- Implement a Structured Culture Optimization Protocol
- Optimize Antibiotic Stewardship
- Embed all infection prevention protocols into the EHR with real-time alerts, order sets, and decision pathways

CLABSI and C. diff: FY2027 Key Actions

Central line-associated bloodstream infections (CLABSI) and Clostridioides difficile infections (C. diff)

Initiative 1

Reduce CLABSI

Complete

Review line necessity
IP reviews every central line twice weekly for appropriateness; above-median use flagged at the daily Safety Huddle

Limit femoral lines
Tracked daily until removal; units prompted to remove or replace for quicker transition to a safer access site

Standardize insertion
Residents trained on the insertion bundle in July; checklists tracked monthly and reviewed for every infection

Dedicated line care
IV Safety Team for dressing changes, PICCs, midlines and removal of unneeded lines; closed blood sampling in critical care

In progress

ICU trial of the CLIP form
Developing a Central Line Insertion Practices (CLIP) form to ensure standardized adherence to best-practice insertion techniques

Initiative 2

Reduce C. diff

Complete

Test early
Cultures and C. diff testing encouraged before hospital day 3, while infection still counts as present on admission

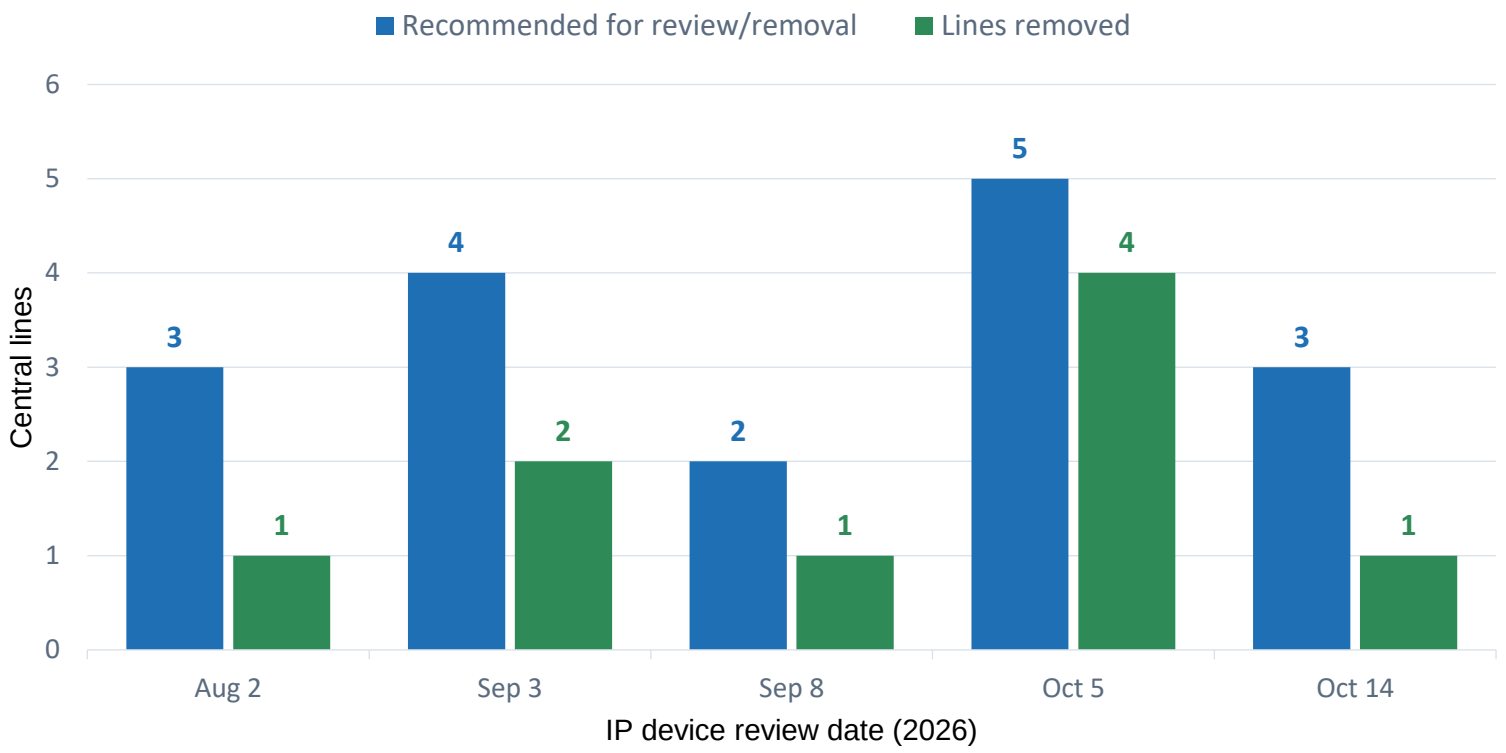
In progress

Test the right patients
Developing a workflow to require an Infectious Disease consult for C. diff testing on hospital day 4 or later

Two-step testing
Evaluating NAAT first, then toxin, to separate colonization from true infection

Antibiotic stewardship
Infection Prevention working with the ID physician and ID pharmacist on culturing and testing practices

CENTRAL LINE DEVICE REVIEW: Lines Recommended vs. Removed



17

Lines recommended for removal

Identified through Infection Prevention device review, Aug 2 to Oct 14, 2026

53%

Removed (9 of 17 lines)

Lines removed after Infection Prevention recommended review or removal

IP review drives line removal

Fewer line days, lower CLABSI risk

OHO FY2027

Surgical Safety Program / Champion: Chris Patty

Metric Description	Baseline	July 2026	August 2026	FY27 Goal
CMS Thirty-day Death Rate Among Surgical Inpatients with Complications (ISCMR/FTR)	FY 2026 – 75.2	40 (2 cases)	0.00 (0 cases)	46.20 (CMS 50th Percentile)
PSI-90 CMS Composite Score	FY 2026 - 1.46	1.47	1.21	1.01 (Midas 50th Percentile)
PSI 11 Postoperative Respiratory Failure **PSI-12 Perioperative PE or DVT**	FY 2026 – 10.3 FY 2026 – 4.04	0 7.66 (2 cases)	0 3.27 (1 case)	6.16 (Midas 50th Percentile) 2.67 (Midas 50th Percentile)

Quality Initiatives:

1. Reduce Surgical Mortality by Improving Failure-to-Rescue
2. Reliable Execution of Harm-Prevention Bundles

Failure to Rescue: Reducing Surgical Mortality

Shift Left: recognize postoperative deterioration earlier and act before it becomes a crisis

Initiative 1a

Standardize early detection and rapid escalation of postoperative deterioration

Complete

- Quality team joined the Surgical Quality Improvement (SQIP) and Critical Care Committees

In progress

- Proactive rapid response team rounding with an oxygen escalation protocol
- Early shock patients moved to the ICU by intensivists
- Evaluating the National Early Warning Score 2 (NEWS-2) as our early warning tool

Initiative 1b

Strengthen rapid response systems

Complete

- Rapid response scorecard re-analyzed; new Proactive and Reactive Intervention Indexes created

In progress

- Additional critical care and rapid response positions approved
- Rapid response staff interviewed on barriers to timely intervention and escalation

Reliable Execution of Harm-Prevention Bundles

Prevent postoperative VTE and respiratory failure through consistent, evidence-based care

Initiative 2a

VTE prevention bundles (PSI-12)

Complete

- Quality team joined SQIP (July 2026) and the Patient Mobility task force
- HSAG bundle assessment and gap analysis completed (August 2026)

In progress

- Every postoperative chemoprophylaxis fallout reviewed by surgical leadership and SQIP
- Closing gaps in how prophylaxis is ordered, given, and communicated

Initiative 2b

Respiratory care bundles (PSI-11)

Complete

- Quality team joined the Patient Mobility task force, supporting early postoperative mobilization

In progress

- Proactive rapid response rounding with an updated oxygen escalation protocol
- Implementing a BiPAP (non-invasive ventilation) protocol

Initiative 2c

Documentation and coding accuracy

Complete

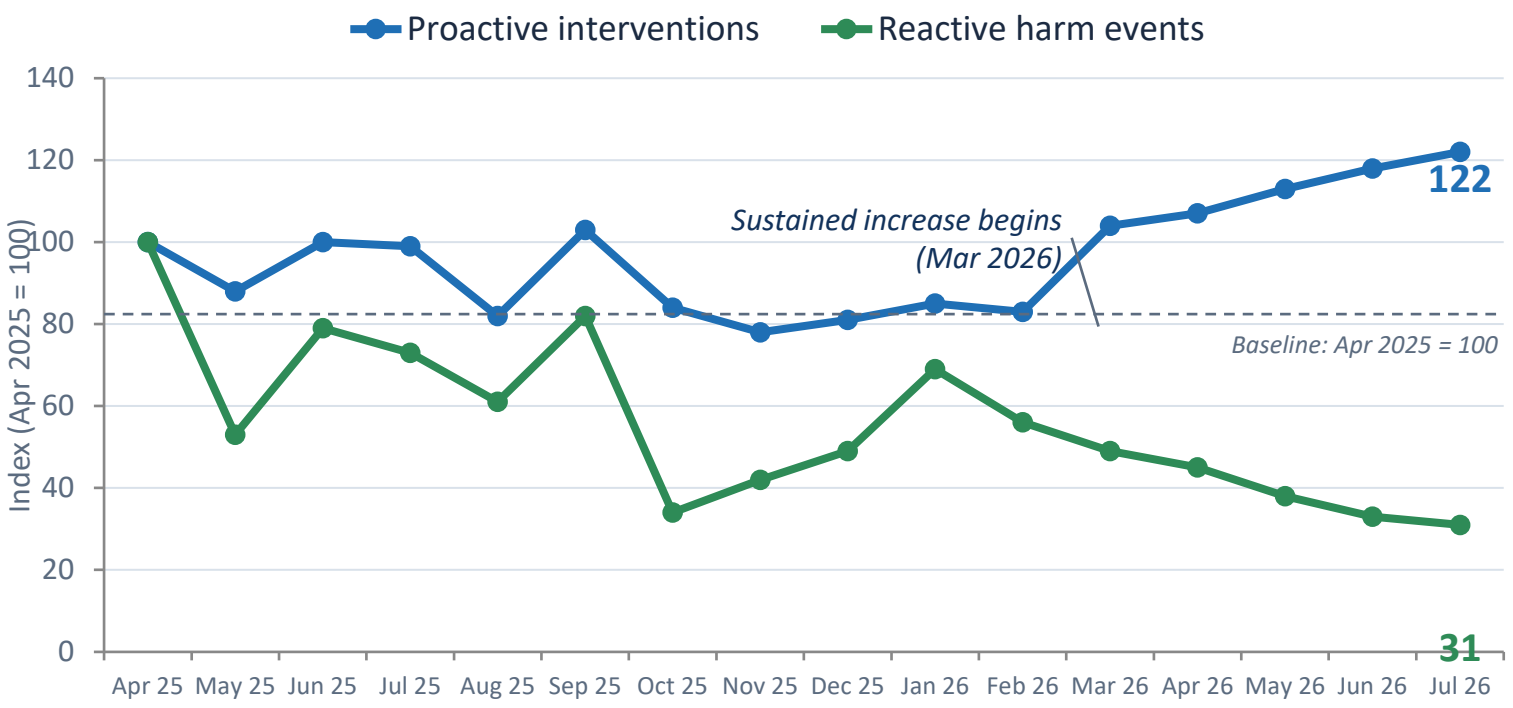
- September 2025 PCI/CABG coding events reviewed; staff education provided
- No similar events since September 2025

Ongoing

- Proactive record review for coding mismatches

PSIs are calculated from coded data, so accurate documentation ensures our rates reflect true patient harm, not coding errors.

CLINICAL DETERIORATION MANAGEMENT: Earlier Intervention Impact



+22%

Proactive interventions

RRTs, ICCU/ICU transfers, and codes in critical care

–69%

Reactive harm events

Code Blues, deaths during arrest, RRT mortality, RRTs within 24 hrs of admission

More proactive care delivered earlier
Results in fewer downstream harm events

OHO FY2027

Safety in Nursing Practice/ Champion: Mara Lawson

Metric Description	Baseline	July 2026	Aug 2026	FY2027 Goal
Falls with Injury	0.33	0.19	0.27	<0.30
Hospital Acquired Pressure Injuries (Stage 2 and above)	0.51	0.76	1.39	<0.46

Quality Initiatives:

1. Risk Stratification & Prevention

2. Implementation of Evidence-Based Prevention & Management Bundles

Objectives:

Quality Initiative #1

a) Implement standardized fall-risk assessments

b) Ensure effective use of skin assessment tools

Quality Initiative #2

a) Hourly rounding focused on identified patient needs

b) Repositioning schedules and pressure-relieving surfaces

Falls: Quality Initiatives

Outstanding Health Outcomes (OHO) priority: reduce patient falls with injury

Initiative 1

In progress

Risk Stratification and Prevention

Standardized fall-risk assessment that links why each patient is at risk to targeted interventions.

99.7%

of patients screened every shift (July)

96.2%

initial screen completed timely on admission

Next steps

- Unit leaders rounding on at-risk and missed patients where compliance is below 100%

Initiative 2

In progress

Evidence-Based Prevention Bundles

Purposeful hourly rounding based on patient needs (toileting, mobility) and an immediate post-fall huddle using a standardized tool.

Areas of focus

- Use fall causes to target hourly rounding
- Address barriers that stopped prior post-fall huddles
- Adopt a standardized post-fall huddle tool

Falls: Action Plan

Initiatives 1 and 2: risk stratification and prevention bundles, led by champion Mara Lawson

Leadership accountability and data

- Unit leaders round on at-risk and missed patients where screening is below 100%
- Monthly falls with injury rate vs goal of <0.30
- Screening compliance tracked by unit

Outcome: Faster trend identification

Risk-targeted prevention

- Hourly rounding built around toileting and mobility
- Toileting drives about 30% of falls (FY2026 data)
- Focus on peak times: late morning and 2000 hours

Outcome: Fewer toileting-related falls

Fall-risk screening

- Standardized assessment links why each patient is at risk to targeted interventions
- Screen every shift: 99.7% (July)
- Admission screen on time: 96.2% (about 89% in Feb)

Outcome: Every patient's risk identified early

Post-fall huddles

- Immediate post-fall huddle reinstated
- Standardized post-fall huddle tool adopted
- Barriers that stopped prior huddles addressed

Outcome: Cause found and acted on after every fall

Pressure Injuries: Quality Initiatives

Outstanding Health Outcomes (OHO) priority: prevent hospital-acquired pressure injuries

Initiative 1

In progress

Risk Stratification and Prevention

Effective use of skin assessment (Braden subscales) to target interventions to each patient's specific risk.

Opportunities

- Update outdated support surface algorithm
- Improve proper offloading
- Strengthen documentation of interventions

Initiative 2

In progress

Evidence-Based Prevention Bundles

Draft 120-day action plan (next slide) developed by a certified wound care nurse on a national wound nursing education committee.

Progress

- Approved by the HAPI Prevention Committee and executive leadership.
- Reviewed with Patient Care Directors. Barriers addressed

Pressure Injuries: 120-Day Action Plan

Draft

Initiative 2: evidence-based prevention bundles, led by the Hospital-Acquired Pressure Injury Committee

30 days: Launch → **60 days:** Standardize → **90 days:** Sustain and spread → **120 days:** Evaluate

Leadership accountability and data

- Daily leader rounds on all units with a standardized tool
- Unit scorecards and a monthly committee dashboard
- Streamlined event reporting; less duplicate work

Outcome: Standardized daily rounding; faster trend identification

Risk-targeted prevention

- Braden subscale interventions built into the health record
- Updated support surface algorithm; unit-specific fixes (turning wedges on 2N and 4N)
- Mobility program Phase 2 live since August 4

Outcome: Fewer sacrum, coccyx and heel injuries

Admission skin assessment

- Two-person skin check on every admission and transfer
- Admission skin photography for at-risk patients

Outcome: Accurate present-on-admission capture

Staff and provider education

- Wound classes re-established, taught by a certified wound nurse
- Education extended to residents and medical staff

Outcome: Bedside staff confident in prevention interventions

EMPLOYEE ENGAGEMENT SURVEY

Kaweah Health

2026 Employee Engagement Survey Results



nrc HEALTH

Kaweah Health
MORE THAN MEDICINE. LIFE.

Engagement Impact

Why Engagement Matters

Employee engagement is a strategic lever, not just an HR metric, that drives patient trust, culture, retention, and performance.

Motivation and Satisfaction

A positive employee experience raises day-to-day motivation, morale, and satisfaction.

Retention and Attraction

Strong experiences attract top talent and reduce costly turnover.

Performance and Patient Care

Engaged teams deliver higher productivity, innovation, and better patient outcomes.

Well-being and Teamwork

Support for mental health and collaboration builds a healthier, more resilient workforce.

Participation Rate



Survey period:
June 1 – June 19

- 4,694 Invitations sent
- 3,953 Responses
- 64% Industry average response rate
- 2% NRC average abandonment rate

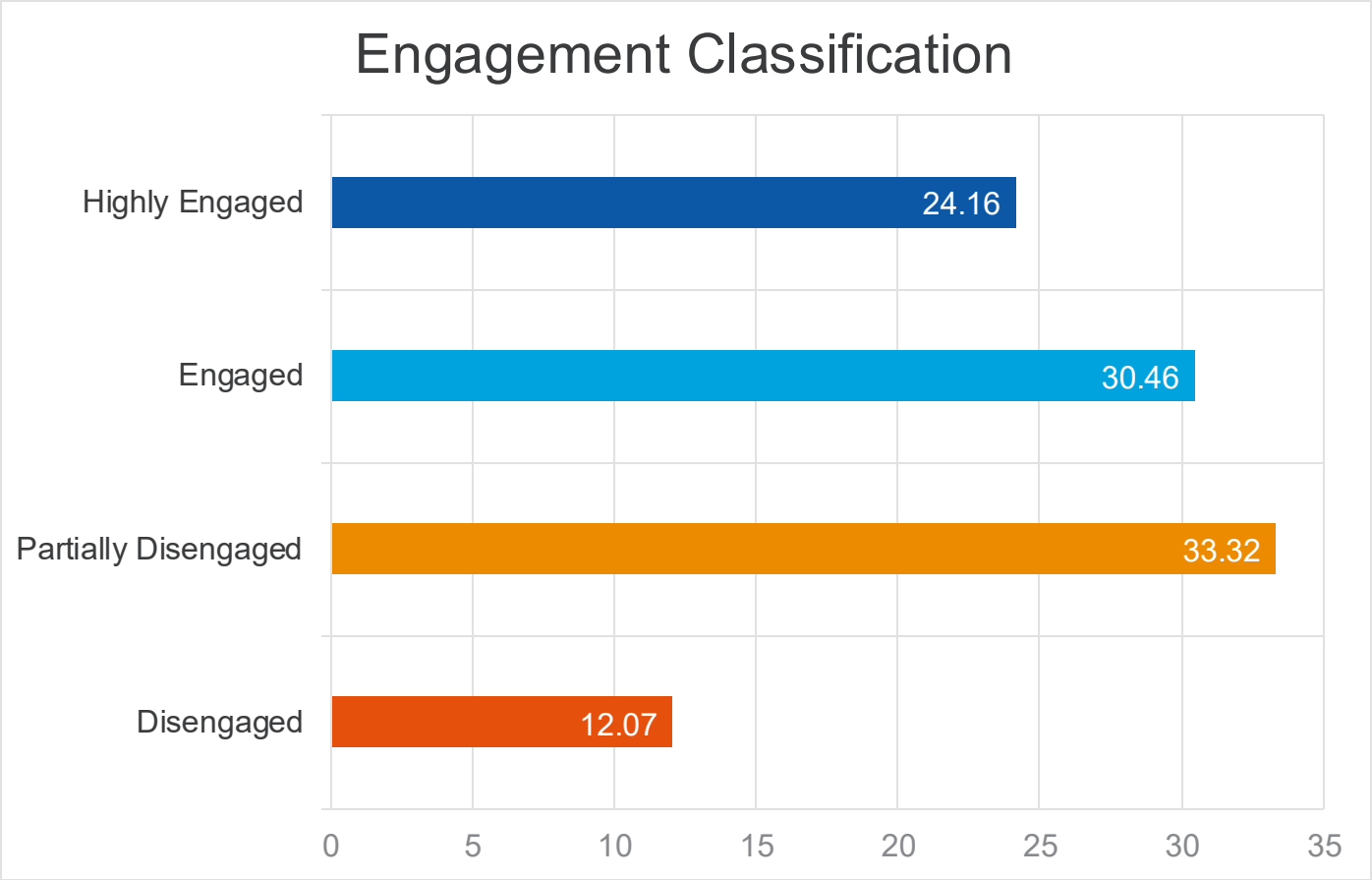
Comparison to Past Performance (2024)

	% Favorable		
	2026	**2024**	**Change**
Response Rate	84	74	+10
Overall, I am a satisfied employee	79	77	+2
I would recommend *this organization to family and friends who need care	78	79	-1

*2024 survey used *Kaweah Health

© NRC Health

Engagement Landscape

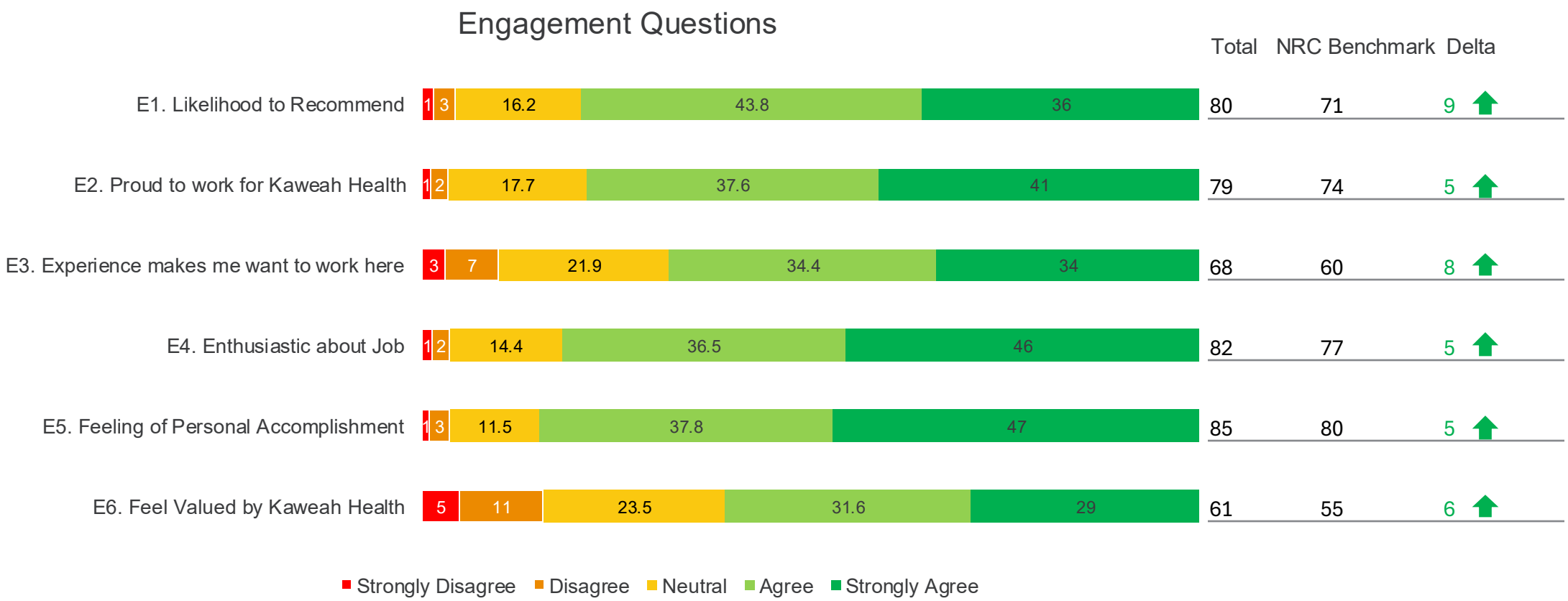


Engagement Classifications

- Highly Engaged: Strongly Agreed (5) with all Engagement items
- Engaged: A combination of Strongly Agreed (5) and Agree (4) with all Engagement items
- Partially Disengaged: A combination of agreement, neutral (3), or limited disagreement
- Disengaged: Strongly Disagree (1) with one or Disagree (2) with two or more Engagement items

Engagement Items

People are committed advocates but don't always feel valued





What we heard

Drivers of Engagement: Strengths and Opportunities

Areas of Strength

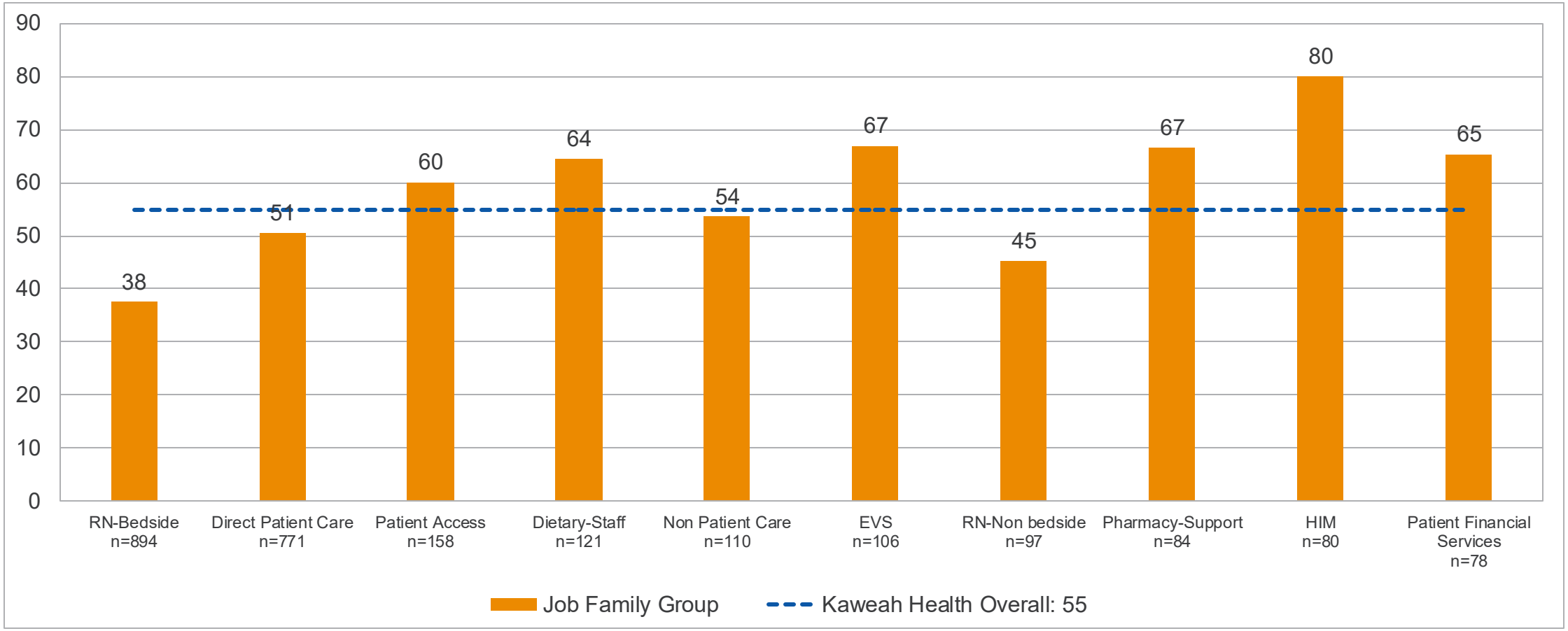
1. I know the Mission Statement of Kaweah Health
2. I like the work I do
3. I have the tools and resources I need to do my job well

Opportunities to Address

1. My input is considered in decisions that affect my work
2. My manager takes action based on employee feedback
3. My manager holds employees accountable for their performance

Engagement by Job Family Groups – Top 10 Volume

Nursing and Direct Patient Care are largest opportunity areas



What Employees Are Saying



65.3% Positive
519 records

49.2% Negative
391 records

16.6% Neutral

1,134 total comments

What Employees Value Most

- Supportive managers and direct leaders
- Teamwork and collaboration
- Meaningful patient care and community impact
- Opportunity to learn, grow, and advance
- Pride in Kaweah Health and its mission

Greatest Opportunities for Improvement

- Compensation, benefits, and retention
- Staffing levels and workload
- Leadership communication, transparency, and involvement
- Leadership stability, accountability, and consistency
- Resources, equipment, and operational support

Strong Foundation, Clear Opportunities

Employee Engagement Insights and Strategic Priorities

01

Response Rate

Response rates indicate a workforce that is connected and willing to provide feedback.

02

Engagement 55

Performing above the benchmark with overall High Engagement, but one-third are “on the fence.”

03

Strengths

Advocacy & Commitment: Employees show strong pride, mission connection, and enthusiasm for their work.

04

Opportunities

Feedback to Action: Employees are looking for clearer evidence that their feedback informs decisions, drives improvement priorities, and results in visible action through communication, accountability, and closed-loop follow-up.

05

Top Drivers of Engagement

- Input in Decision Making
- Leader Accountability and Communication

Theme 1: Leader Visibility

Leader Visibility Shapes Trust in Decisions

Employees are seeking a stronger connection to the senior leaders

68

Experience makes me want to work here

- 58 for Nursing/Direct Patient Care

Leader Visibility

Employees want more direct engagement from leaders through executive and director rounding, presence during change, and a stronger grasp of frontline realities. Many view visibility as a key driver of trust and confidence in decisions.

Employee Perceptions

Leaders seen as less present on units and in clinics, with limited rounding and reach.

Theme 2: Input Into Decisions

Employees Want a Voice Before Decisions Are Final

Employees want to feel valued and considered

61

Feel valued by Kaweah Health

- 51 for Nursing/Direct Patient Care

70

My input is considered in decisions

- 65 for Nursing/Direct Patient Care

Input in Decision Making

Employees want a stronger voice in decisions that affect their work. Changes are often perceived as made for employees rather than with them. Teams are seeking earlier involvement, clearer rationale, and visible evidence that feedback influences action.

Employee Perceptions

Workflow and scheduling changes announced after decisions were already final.

© NRC Health

Theme 3: Accountability

Consistent Accountability Builds Trust and Morale

Employees are seeking consistency and ownership

74

Manager holds employees accountable

- 71 for Nursing/Direct Patient Care

73

Manager takes action on feedback

- 69 for Nursing/Direct Patient Care

Accountability

Accountability emerged as a trust-building opportunity. Employees want greater consistency in how expectations, policies, and behavioral standards are applied, with stronger follow-through on concerns and visible ownership at all levels.

Employee Perceptions

Concerns raised repeatedly to leadership with limited follow-through or ownership. Uneven policy enforcement, workload, and professionalism.

Actions

Recommended enterprise priorities

Priority	Owner group	Leadership behavior
Increase visible leadership listening	Executive team, Senior leaders	Be present where work happens and listen. Weekly executive rounding.
Close the loop on employee voice	Executive team, HR and Organizational Development	Visibly connect decisions and actions back to employee feedback. Enterprise message, then leader cascade.
Strengthen manager follow-through	Senior leaders, directors, managers	Ask, listen, act, follow up. Monthly review of workgroup actions. Share insights at staff meetings.
Focus frontline voice where care happens	Operations, nursing, patient experience, HR and OD	Use frontline input to remove barriers affecting the care experience. Targeted rounding and escalation.

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient & Community Experience

Board of Directors
October 2026



kaweahhealth.org

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PX

Patient Experience Matters

Opportunities and insights to increase patient satisfaction.

Kaweah Health

September 2026

Fiscal Year Data	NRC survey results reflect July 2026 – August 2026	Operational data (Midas, Rounding) reflect September 2026

Survey Scores

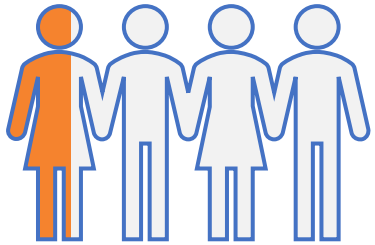


HCAHPS:

Would Recommend Hospital

75.3

65th Percentile



Overall Organization NPS:

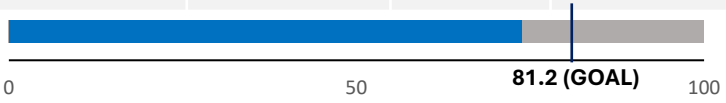
Would Recommend Facility

73.7

17th Percentile

FY27 Organizational Goal Status

Goal Measure	Current Score (Percentile)	FY27 Goal	Status
NPS: Would Recommend	73.7 (26th Percentile)	81.2	↓ 7.5 points below goal



September 2026 Operational Data

Midas Opened	Inpatient Rounds	ED Rounds	Leader Rounds
59	250	464	849

Service Alerts

Closed	Open
117	230

Human Understanding

76.6

12th Percentile

Priority

Safety Was a Priority

Make safety visible. Explain safety precautions, respond promptly to concerns, and reassure patients that their well-being is priority throughout their care.

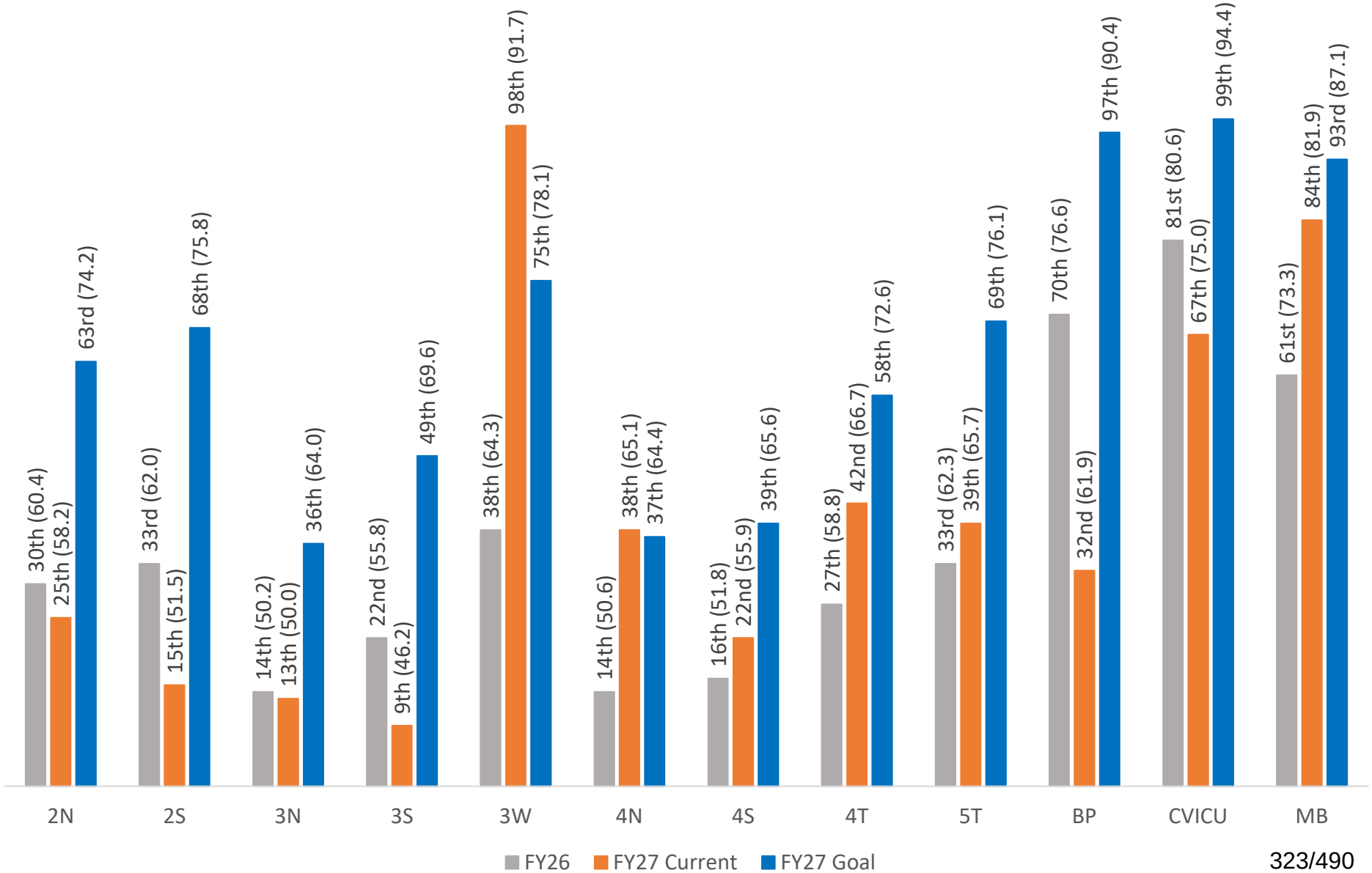
Trust Providers With Care

Build trust through follow-through. Listen to concerns, communicate clearly, and follow through on commitments so patients feel confident in their care team.

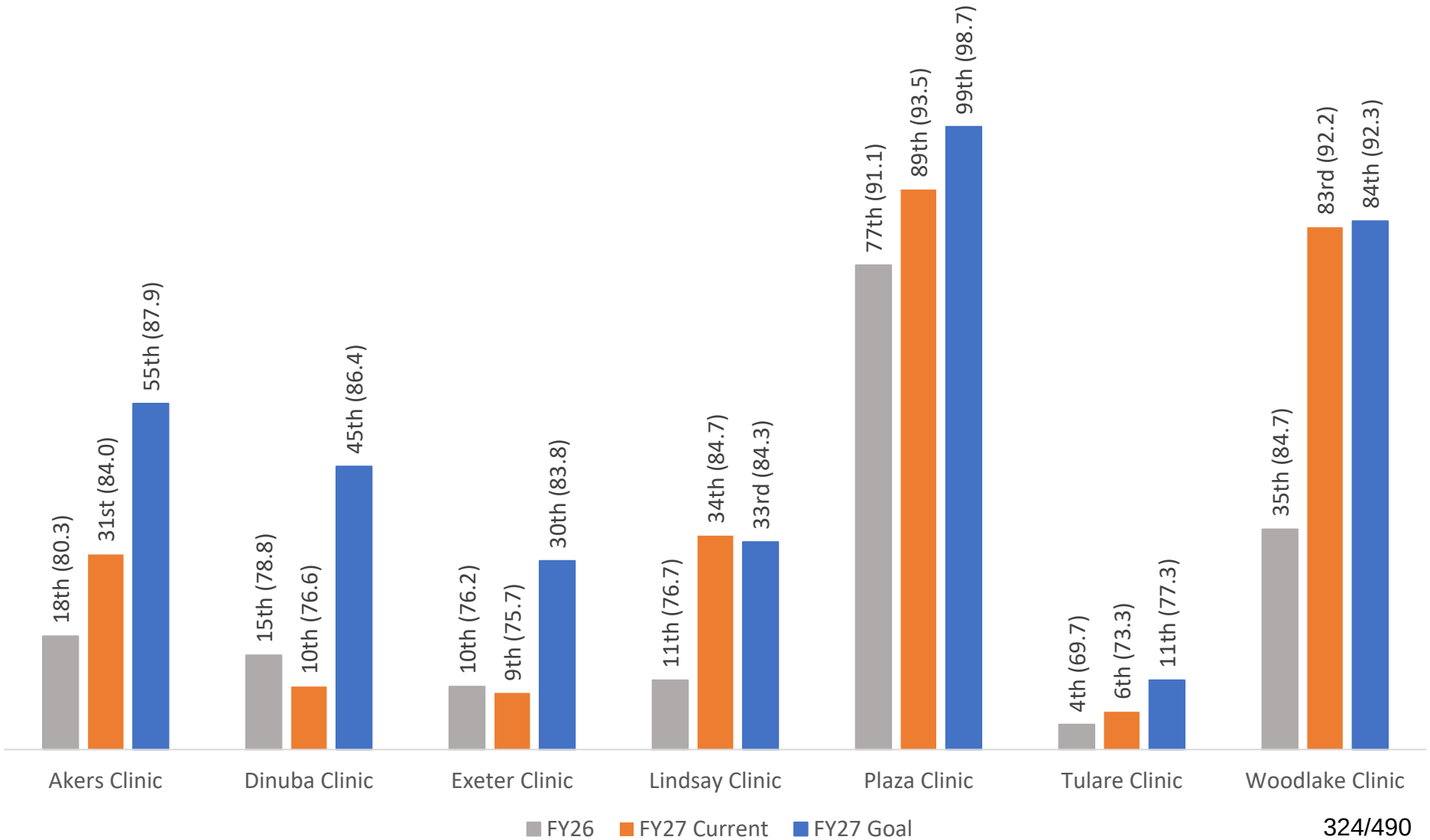
Spent Enough Time With Patient

Commit to Sit. When appropriate, sit at eye level, give patients your full attention, and allow time for questions so they feel heard rather than rushed.

Inpatient Unit's Current Score: July 2026 - August 2026

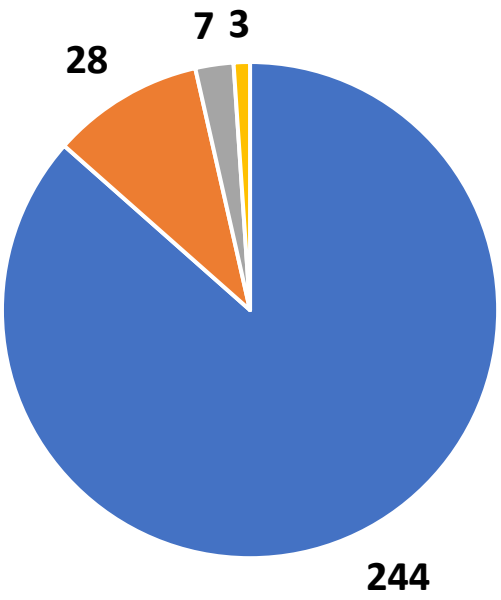


Outpatient Medical Practice Current Score: July 2026 - August 2026



PX Rounding: September

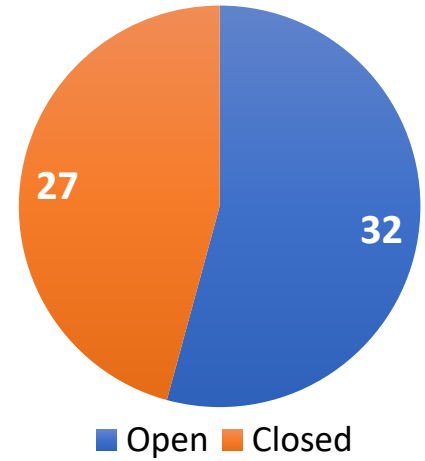
250 Rounds

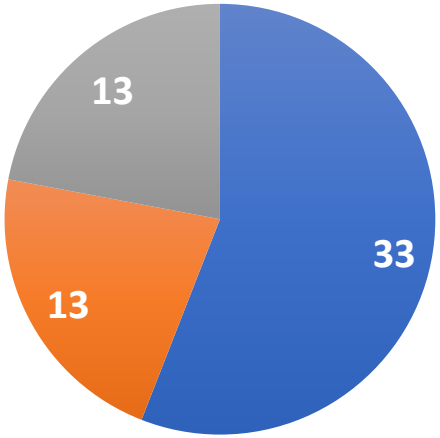




MIDAS: September

59 Opened

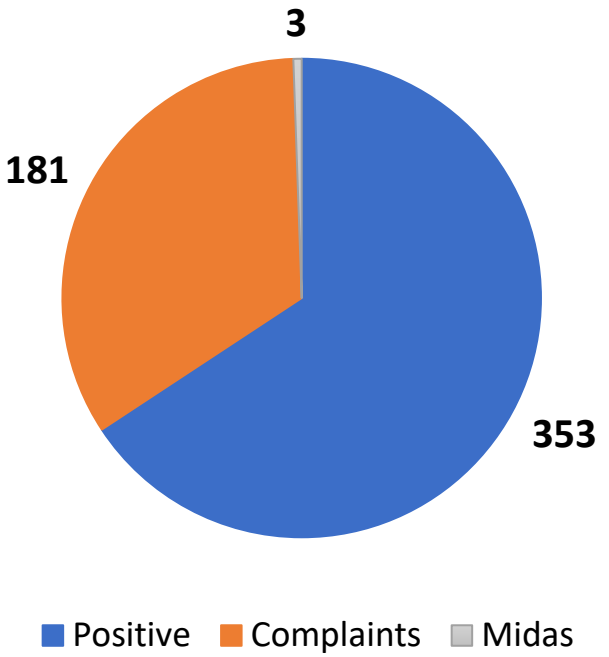






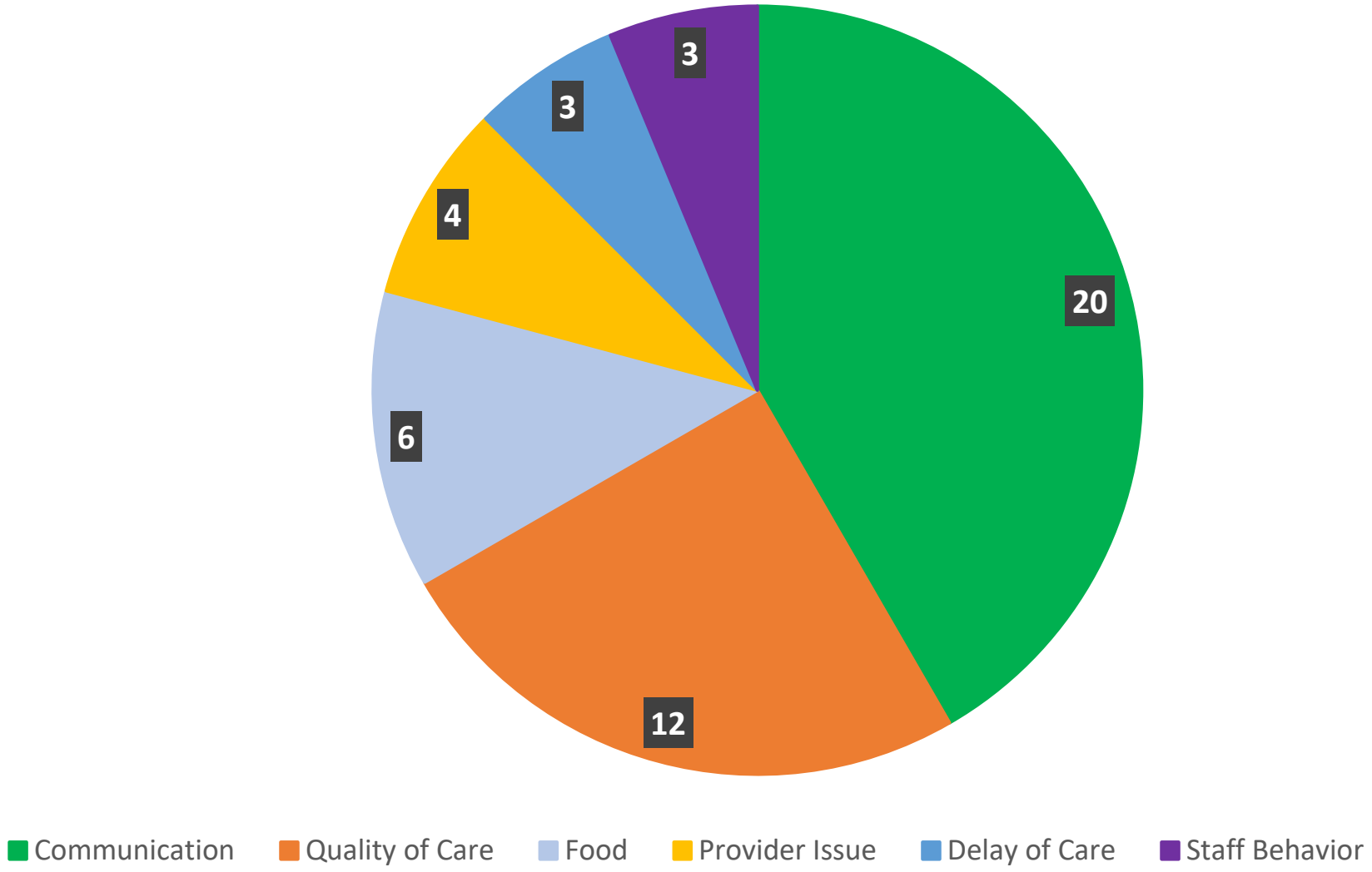
ED Rounding: September

464 Rounds

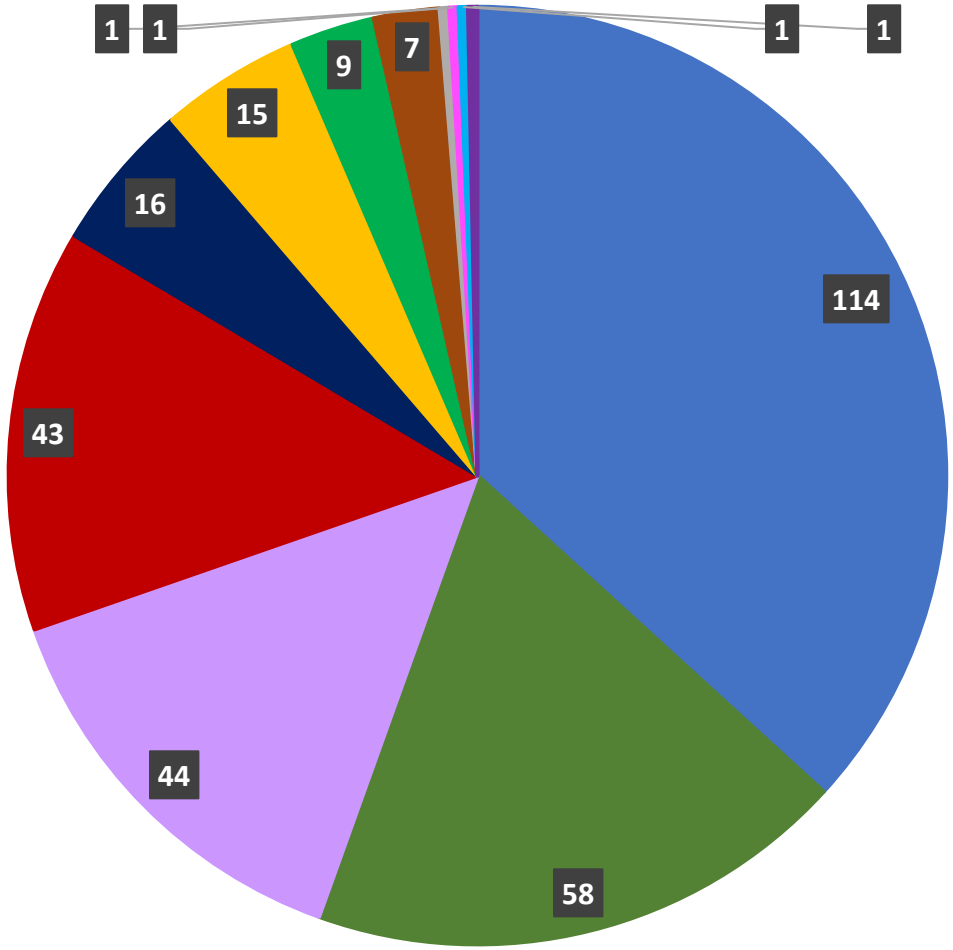




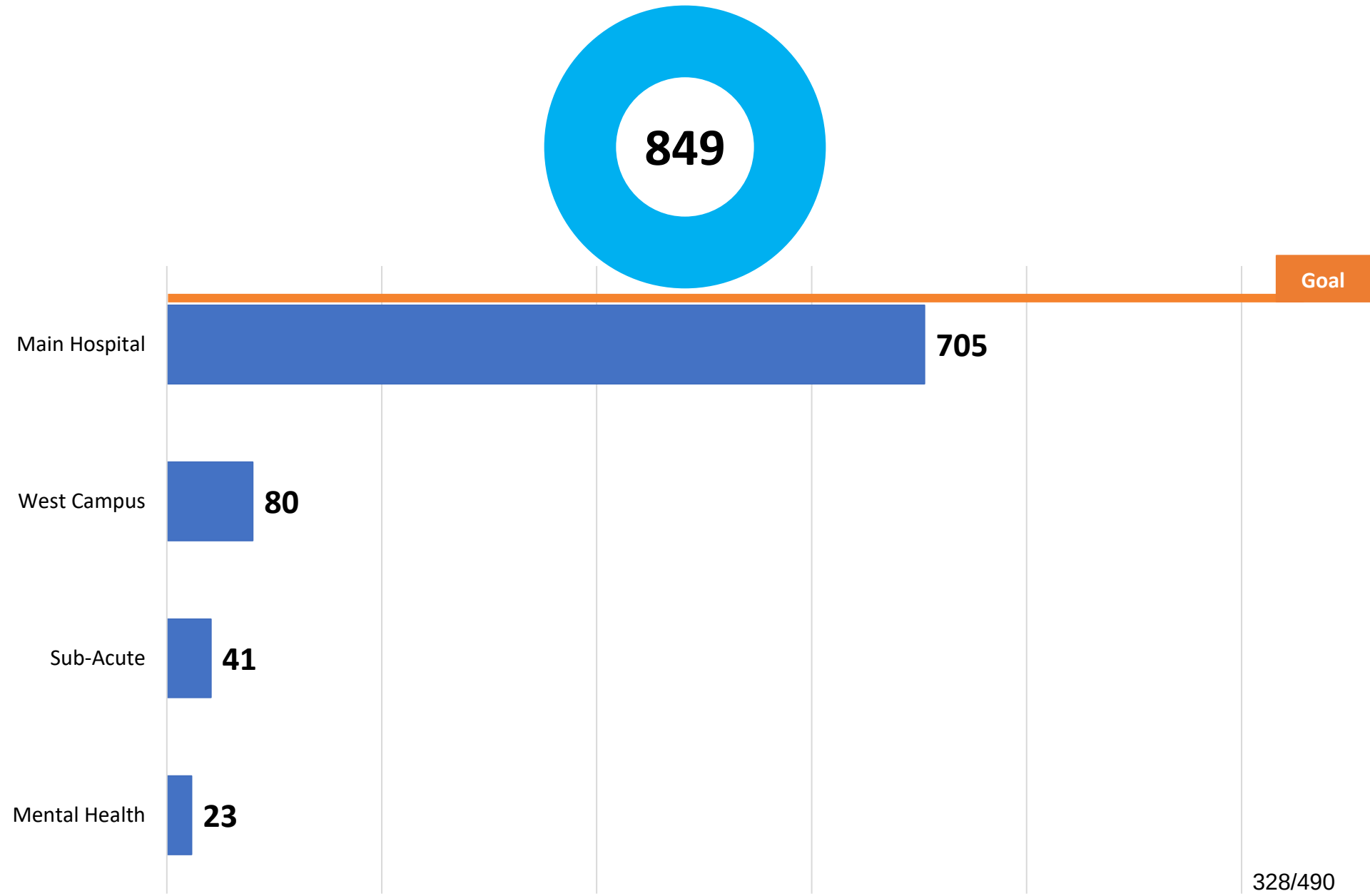
PX Patient Rounding Complaints Breakdown: September 2026



ED Patient Rounding Complaints Breakdown: September 2026



Leader Rounds: September 2026



Executive Rounding - August

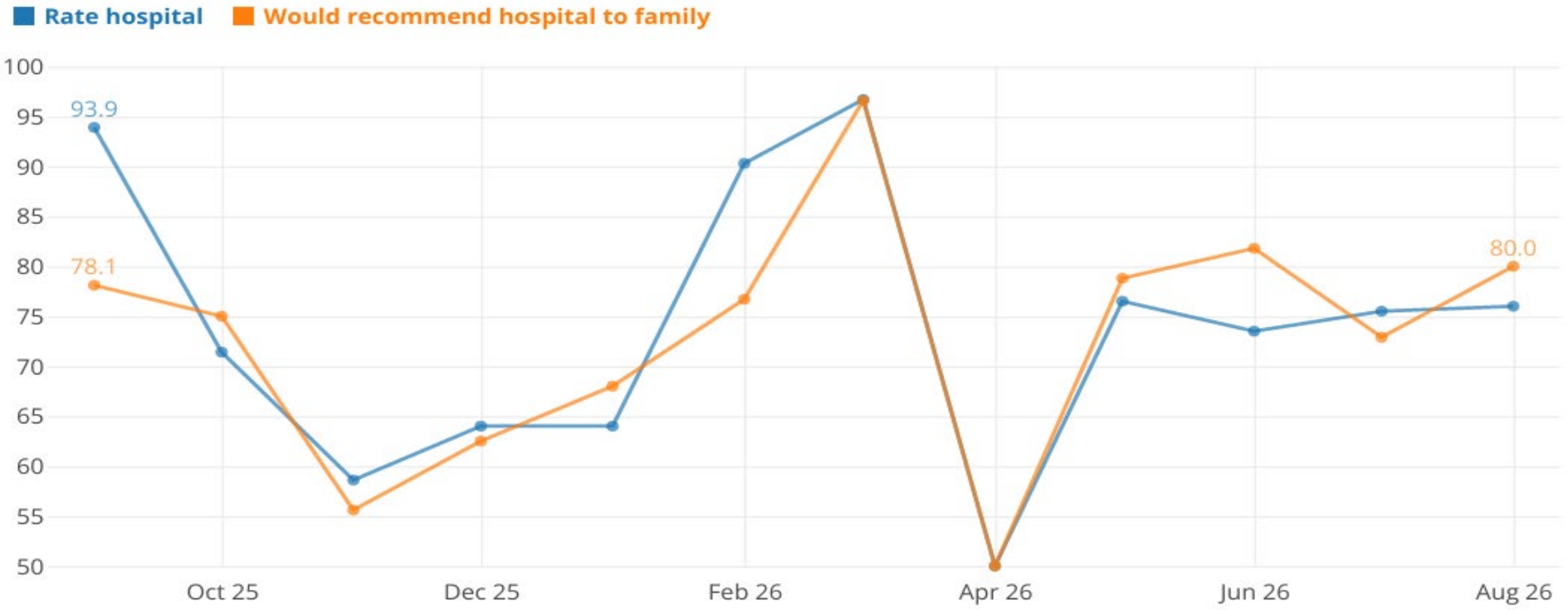
Executive Team Rounds = 11 executive rounds

Executive	NOV	DEC	JAN	FEB	MAR	APR	May	June	July	AUG	SEP
CEO/Marc Mertz.	11/4, 11/20	12/3, 12/23	1/12	Cancelled JC	3/25	4/23	5/11	6/23	7/28	8/27	9/10, 9/30
Jag B.	11/12	12/10	1/13	Cancelled JC	3/19	4/8	5/7	Cancelled	7/14	8/28	9/22
Dianne C.	11/11	12/15	1/8	2/4	3/5	4/22	5/28	6/25		8/26	9/29
Jewel C.										8/25	
Ben C.	11/24	12/18	1/22	Cancelled JC	Cancelled by PX	4/22	5/21	6/16	7/23	8/11	9/24
Paul S.		12/2	1/28	18-Feb	3-Mar	4/15	5/19	6/11	7/22	8/17	9/3
Kevin Morrison						4/30	5/29	6/15	7/1	8/4	9/15
Board of Directors				2/9 (MO)	3/2 (AM)	4/16 (DF)	5/11 (MO)	6/4 (DL)	N/A	N/A	9/21 (AM)
Luke Schneider							5/4	6/24	7/15	8/12	9/9
Max Heckhausen							5/5	6/2	7/8	8/19	9/23
Tom Boggs							5/20	6/29		8/18	9/17

Appendix: Supporting Materials

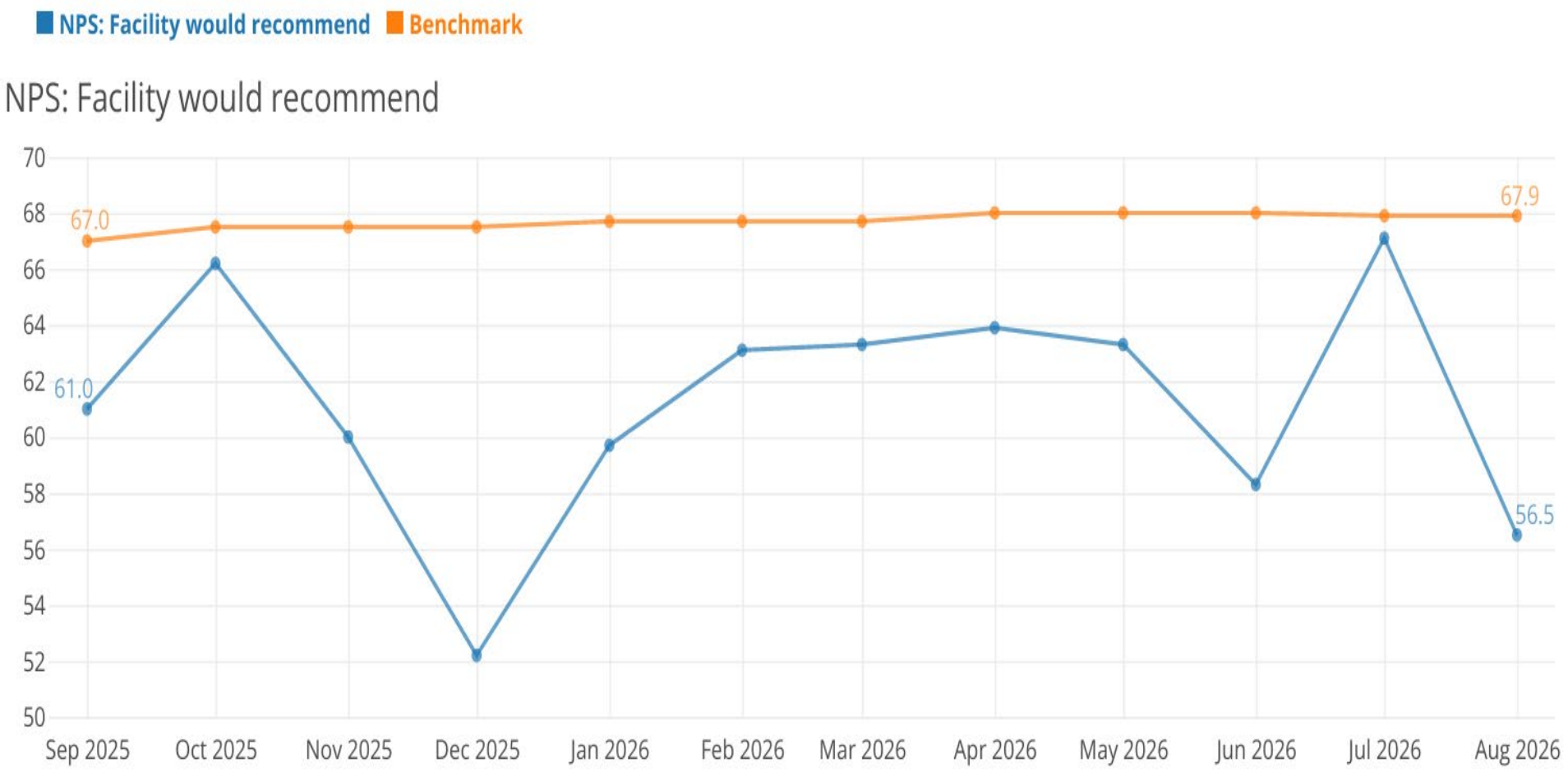
- Trend Lines
  - Appendix A: HCAHPS
  - Appendix B: Inpatient NPS
  - Appendix C: Emergency Department
  - Appendix D: Medical Practice
  - Appendix E: Human Understanding
- Scores
  - Outpatient Services
    - Appendix F: Center for Mental Wellness, Urgent Care, Specialty Outpatient Infusion
    - Appendix G: Imaging Center, Radiation Oncology, Diagnostic Center, Inpatient Rehab
- Appendix H: Midas / Lost Belongings
- Appendix I: Lost Belongings FY26 Totals

HCAHPS Trend: Last 12 Months



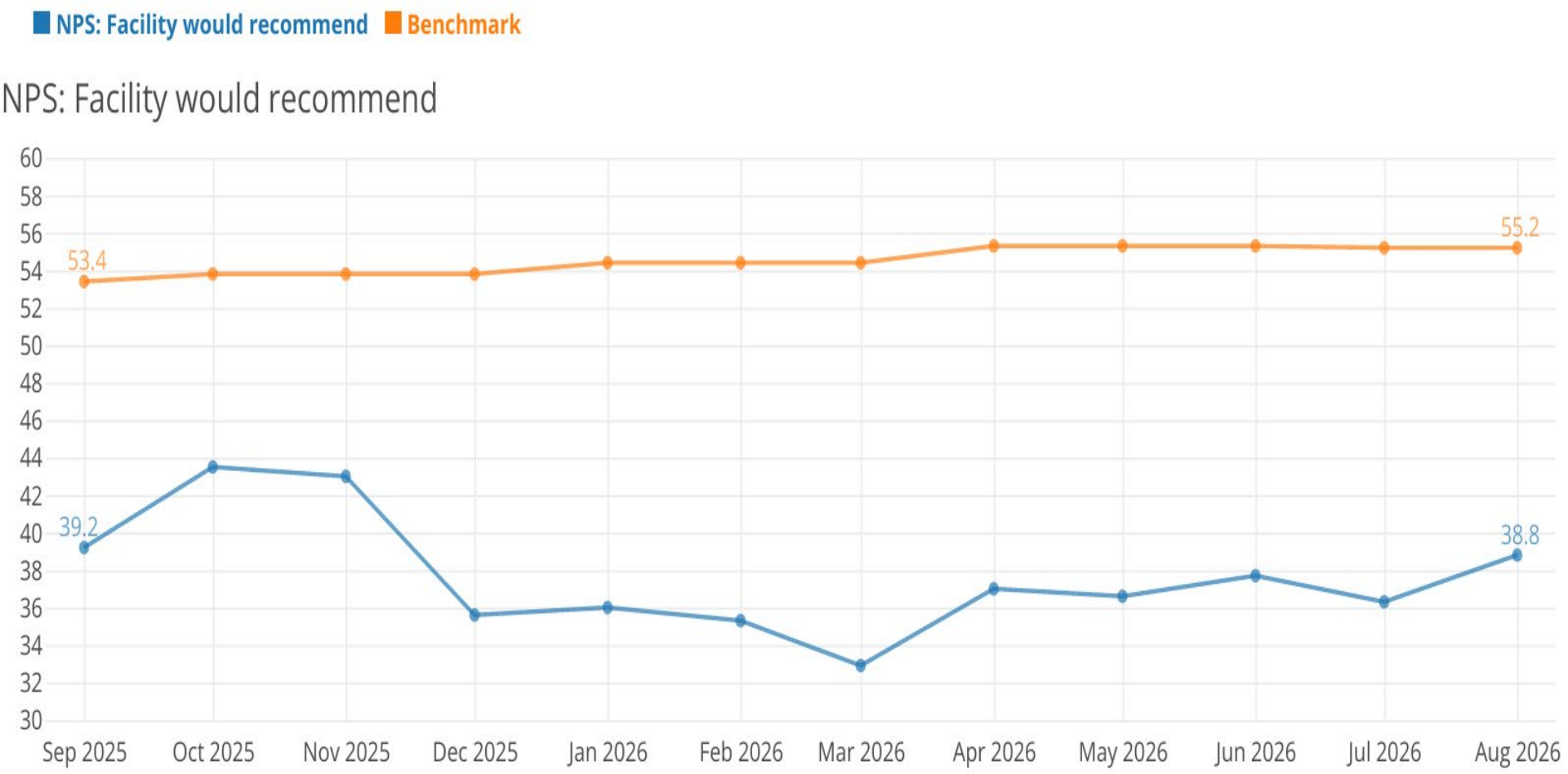
Question	Benchmark	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26
Rate hospital	71.6	93.9 n = 33	71.4 n = 28	58.6 n = 29	64.0 n = 25	64.0 n = 25	90.3 n = 31	96.7 n = 30	50.0 n = 24	76.5 n = 34	73.5 n = 34	75.5 n = 49	76.0 n = 25
Would recommend hospital to family	73.3	78.1 n = 32	75.0 n = 28	55.6 n = 27	62.5 n = 24	68.0 n = 25	76.7 n = 30	96.6 n = 29	50.0 n = 24	78.8 n = 33	81.8 n = 33	72.9 n = 48	80.0 n = 25

Inpatient: Last 12 Months



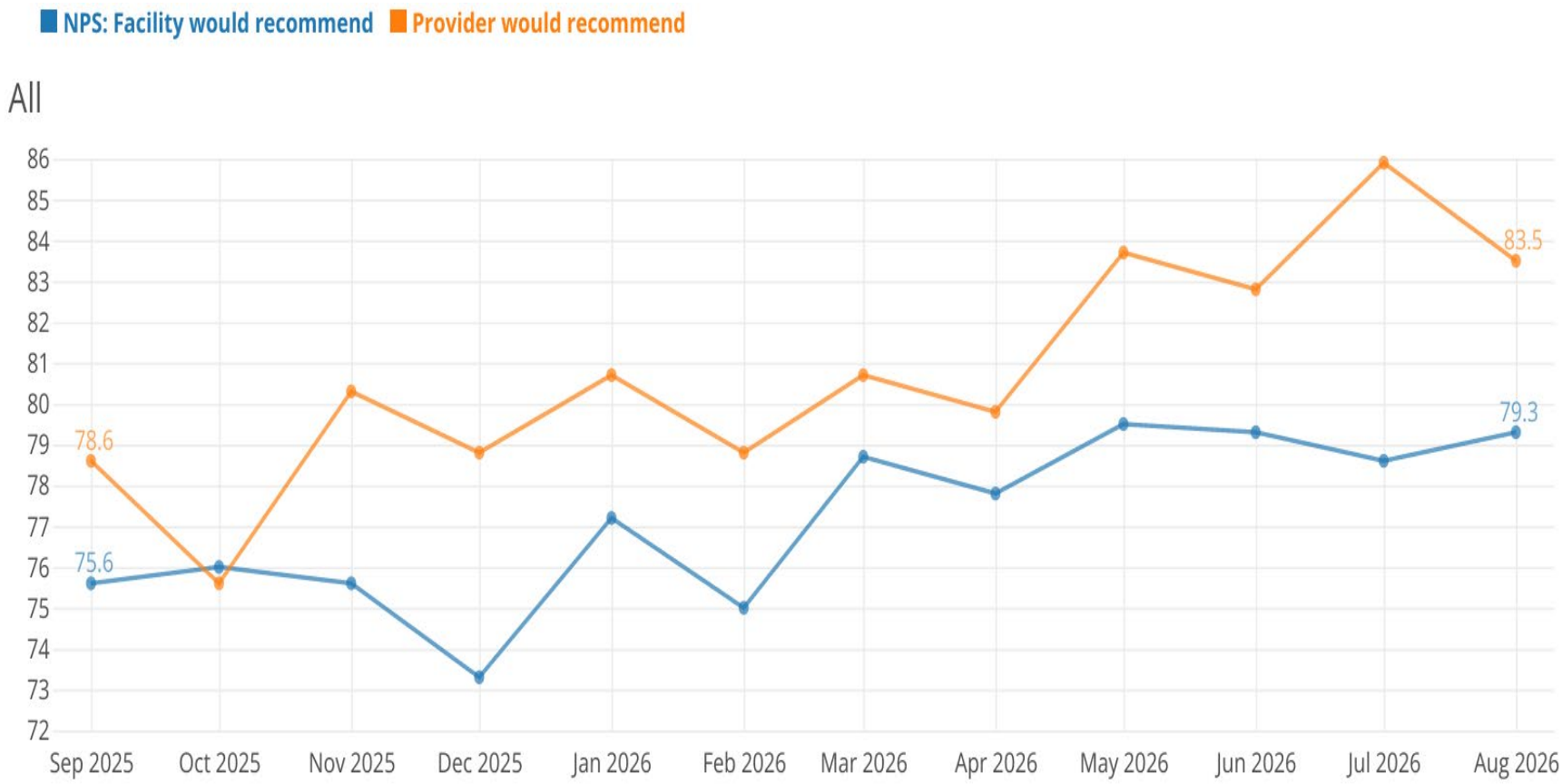
	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
uld	61.0	66.2	60.0	52.2	59.7	63.1	63.3	63.9	63.3	58.3	67.1	56.5
	n = 187	n = 198	n = 220	n = 230	n = 233	n = 198	n = 221	n = 219	n = 245	n = 218	n = 237	n = 237

Emergency Department: Last 12 Months



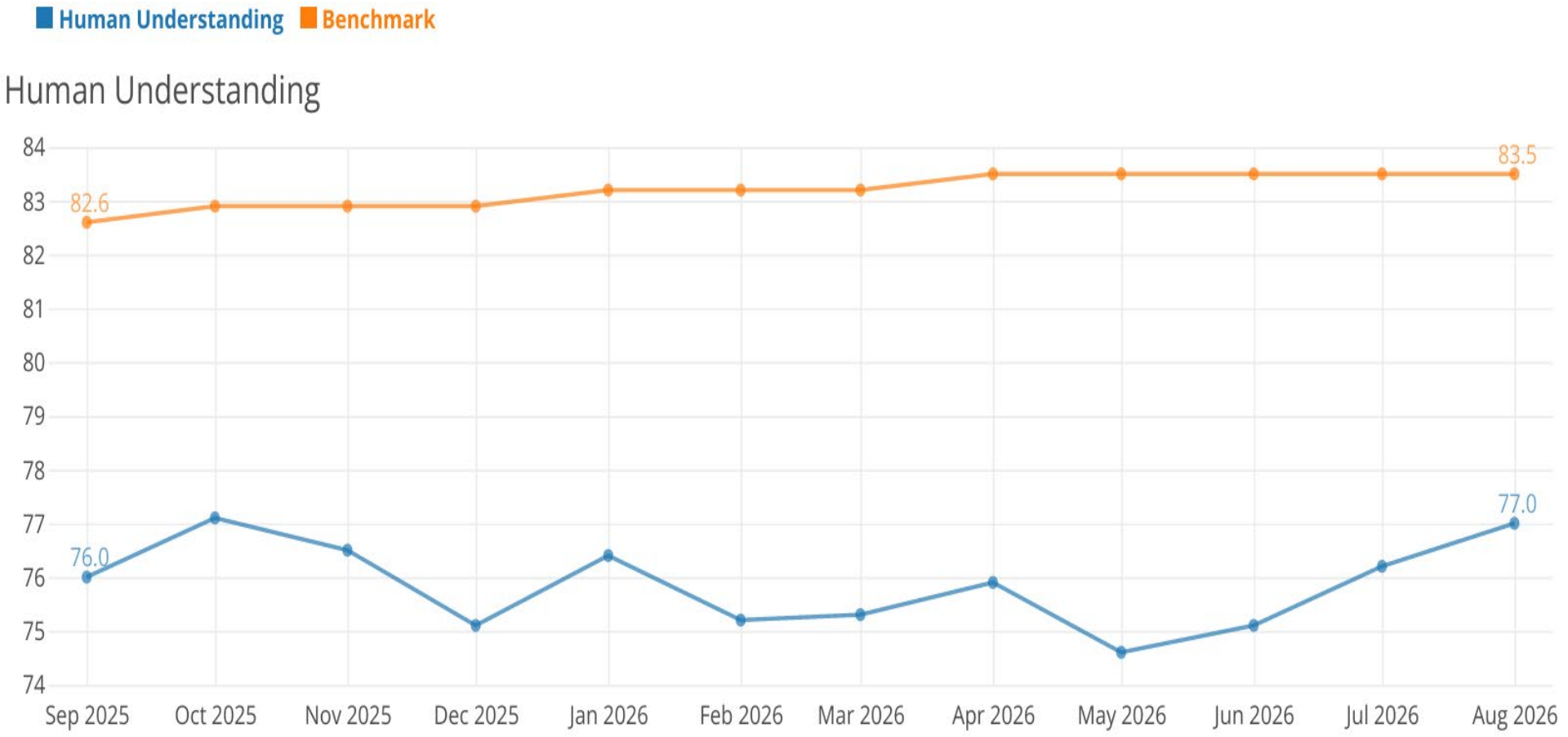
	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
ld	39.2	43.5	43.0	35.6	36.0	35.3	32.9	37.0	36.6	37.7	36.3	38.8
	n = 793	n = 710	n = 698	n = 758	n = 801	n = 750	n = 832	n = 789	n = 837	n = 803	n = 742	n = 882

Outpatient Medical Practice: Last 12 Months



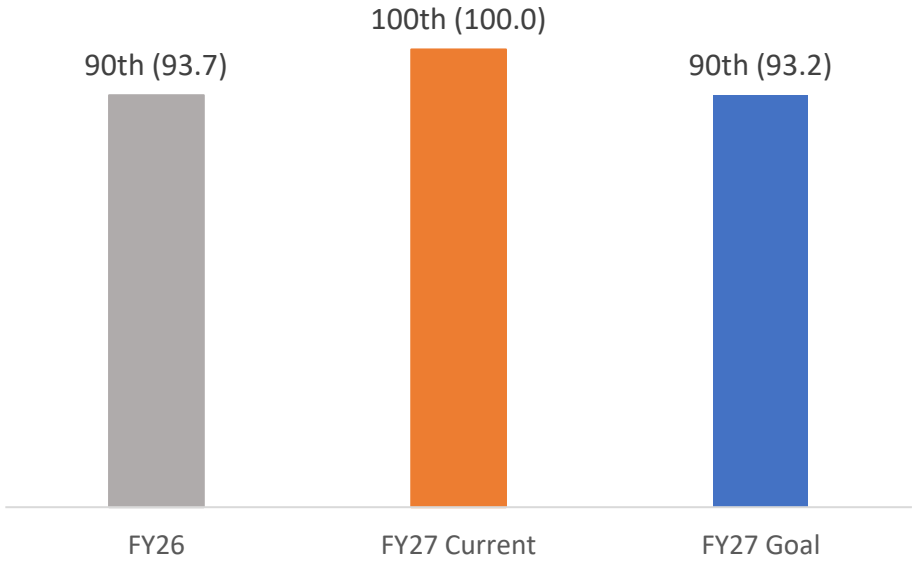
	Benchmark	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
NPS: Facility would recommend	86.5	75.6 n = 717	76.0 n = 637	75.6 n = 537	73.3 n = 565	77.2 n = 689	75.0 n = 627	78.7 n = 609	77.8 n = 686	79.5 n = 657	79.3 n = 656	78.6 n = 524	79.3 n = 695
Provider would recommend	88.1	78.6 n = 695	75.6 n = 620	80.3 n = 529	78.8 n = 556	80.7 n = 673	78.8 n = 609	80.7 n = 596	79.8 n = 664	83.7 n = 645	82.8 n = 639	85.9 n = 510	83.5 n = 680

Human Understanding: Organization
Last 12 Months

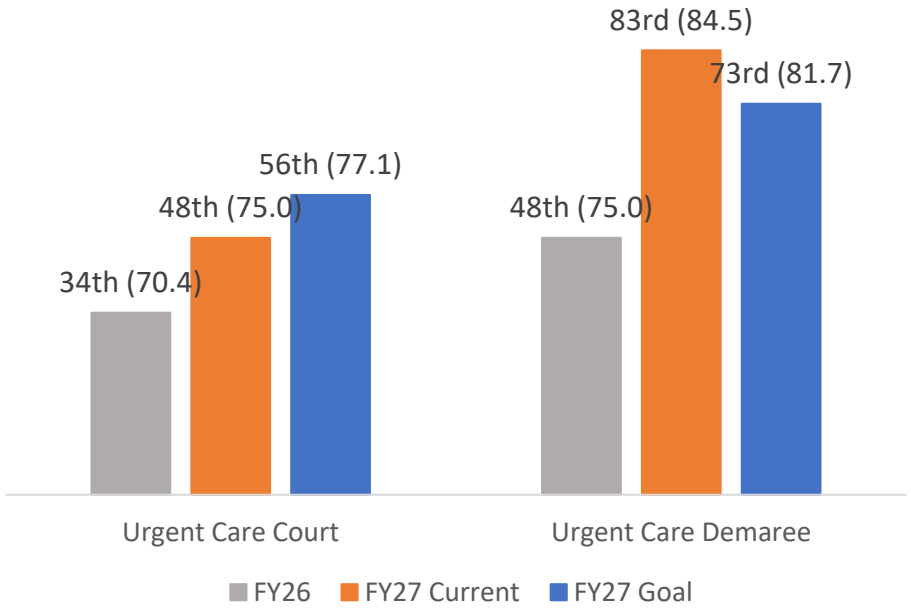


anding	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
	76.0	77.1	76.5	75.1	76.4	75.2	75.3	75.9	74.6	75.1	76.2	77.0
	n = 3,836	n = 3,949	n = 3,380	n = 3,813	n = 4,188	n = 3,854	n = 4,208	n = 4,081	n = 4,066	n = 4,008	n = 3,948	n = 4,041

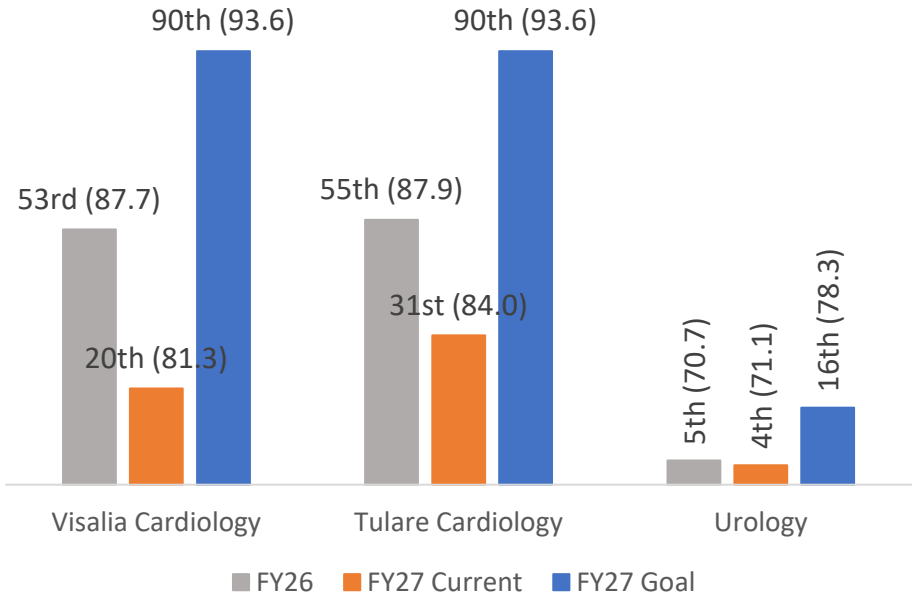
Center for Mental Wellness



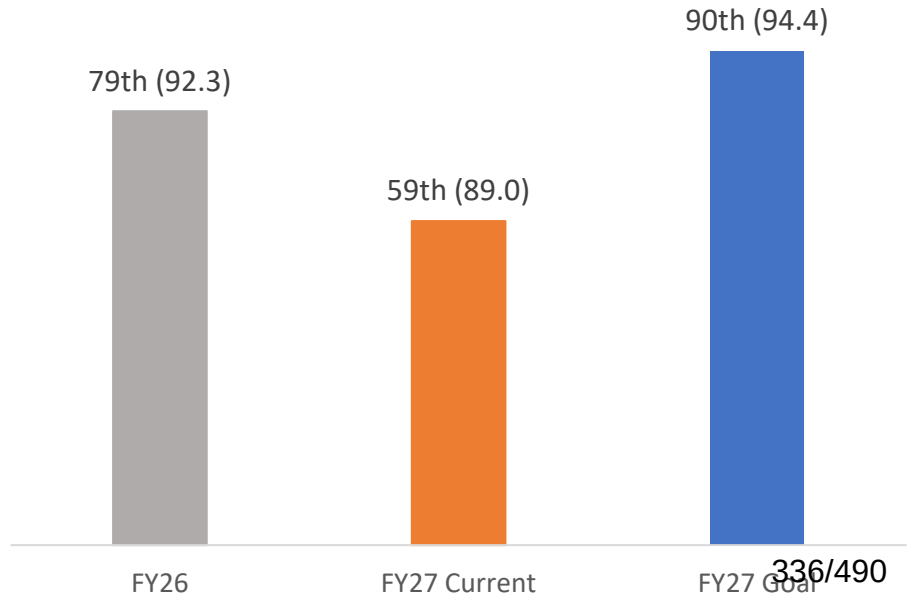
Urgent Care



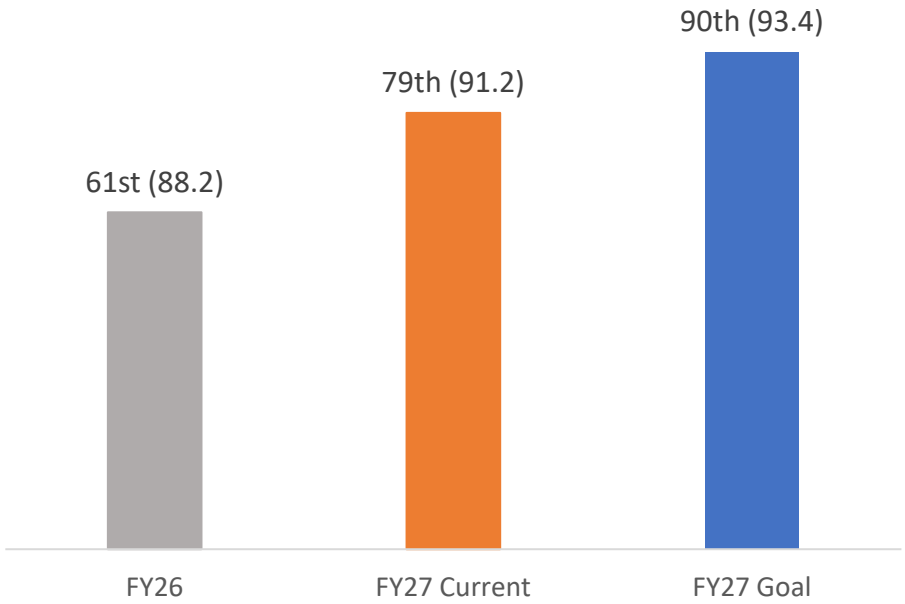
Specialty Clinics



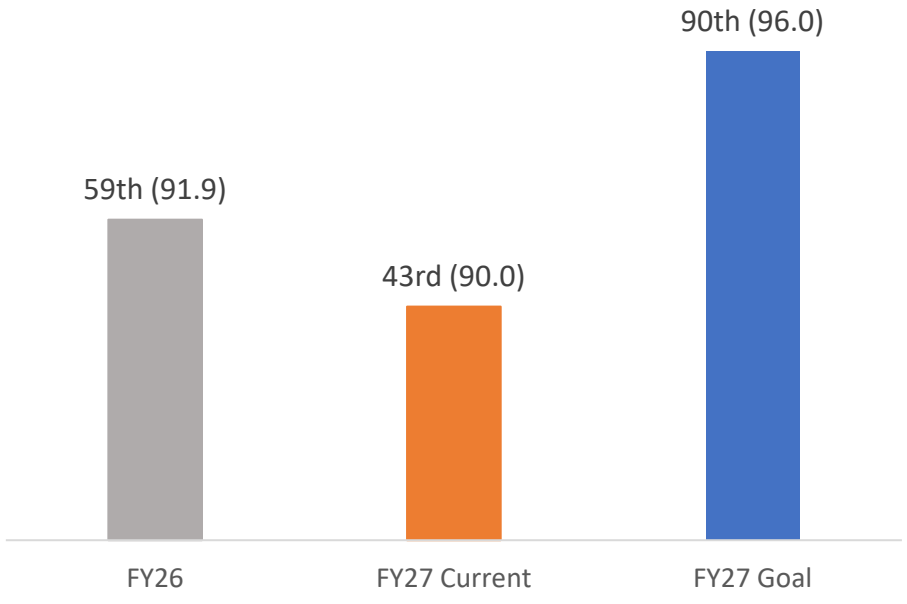
Outpatient Infusion



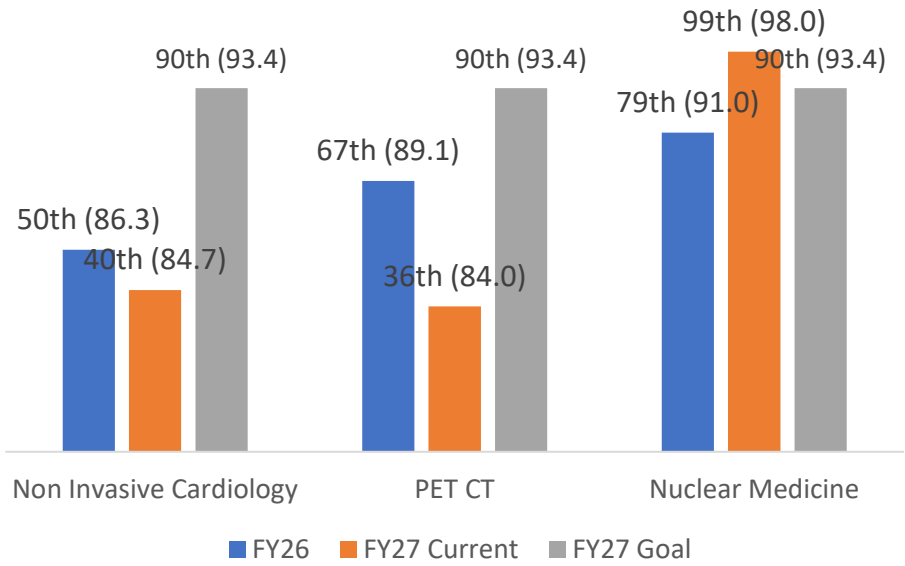
Imaging Center



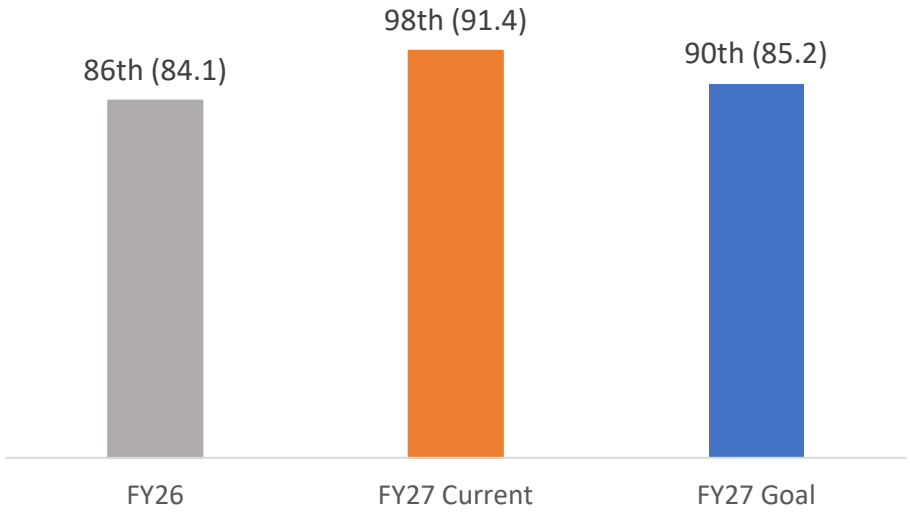
Radiation Oncology



Diagnostic Center



Inpatient Rehab

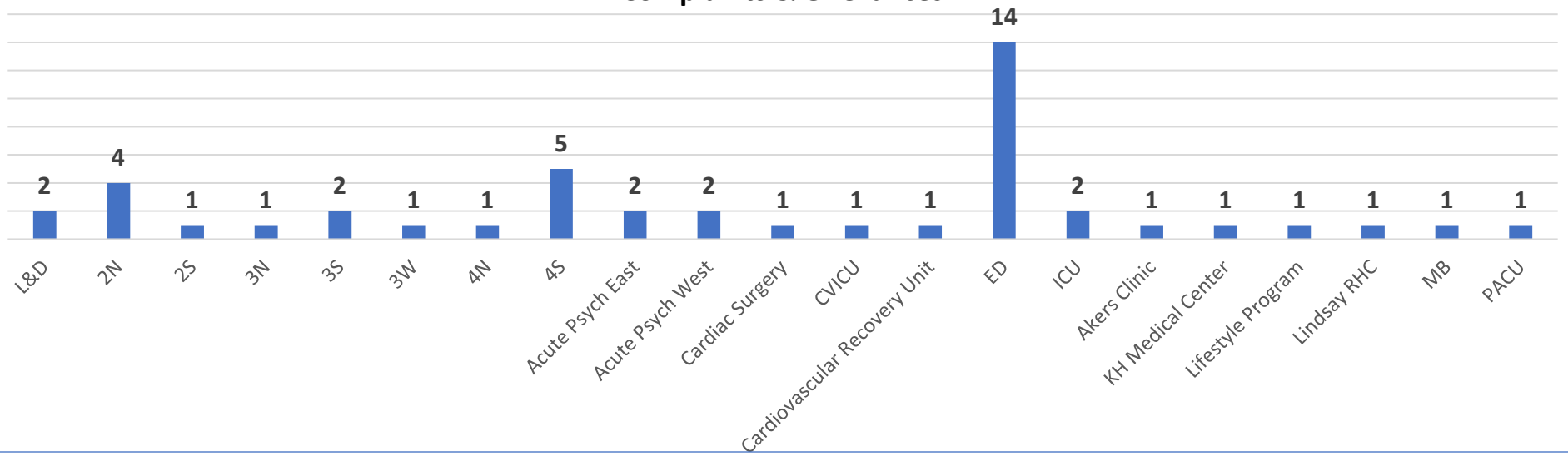


Appendix H

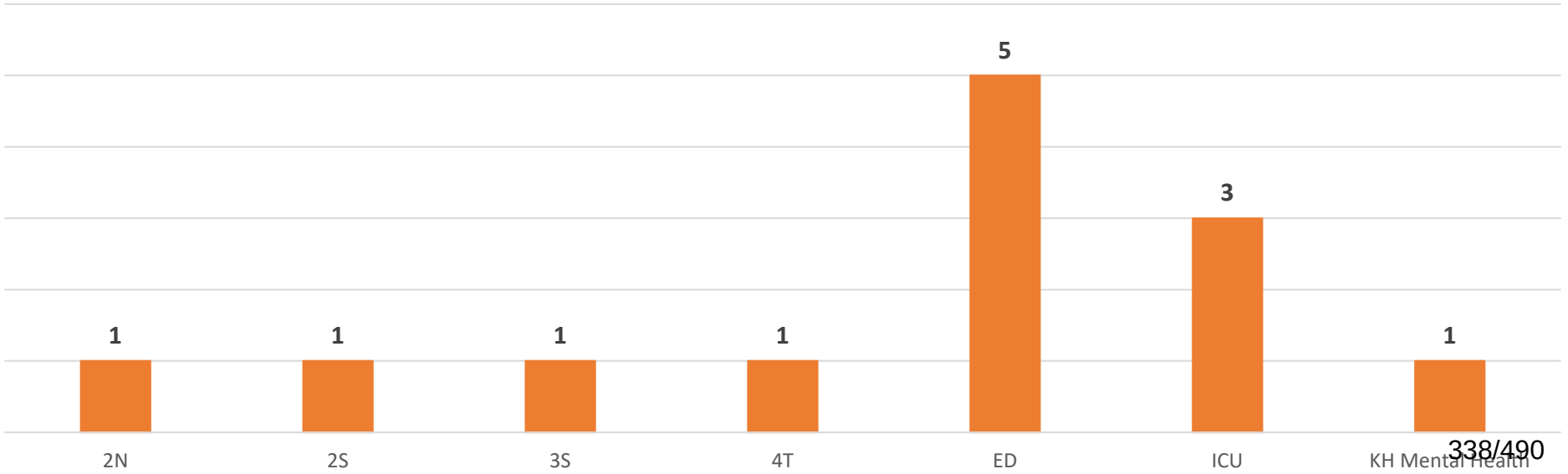
MIDAS: September 2026

59 Opened

Complaints & Grievances



Lost Belongings



Lost Belongings

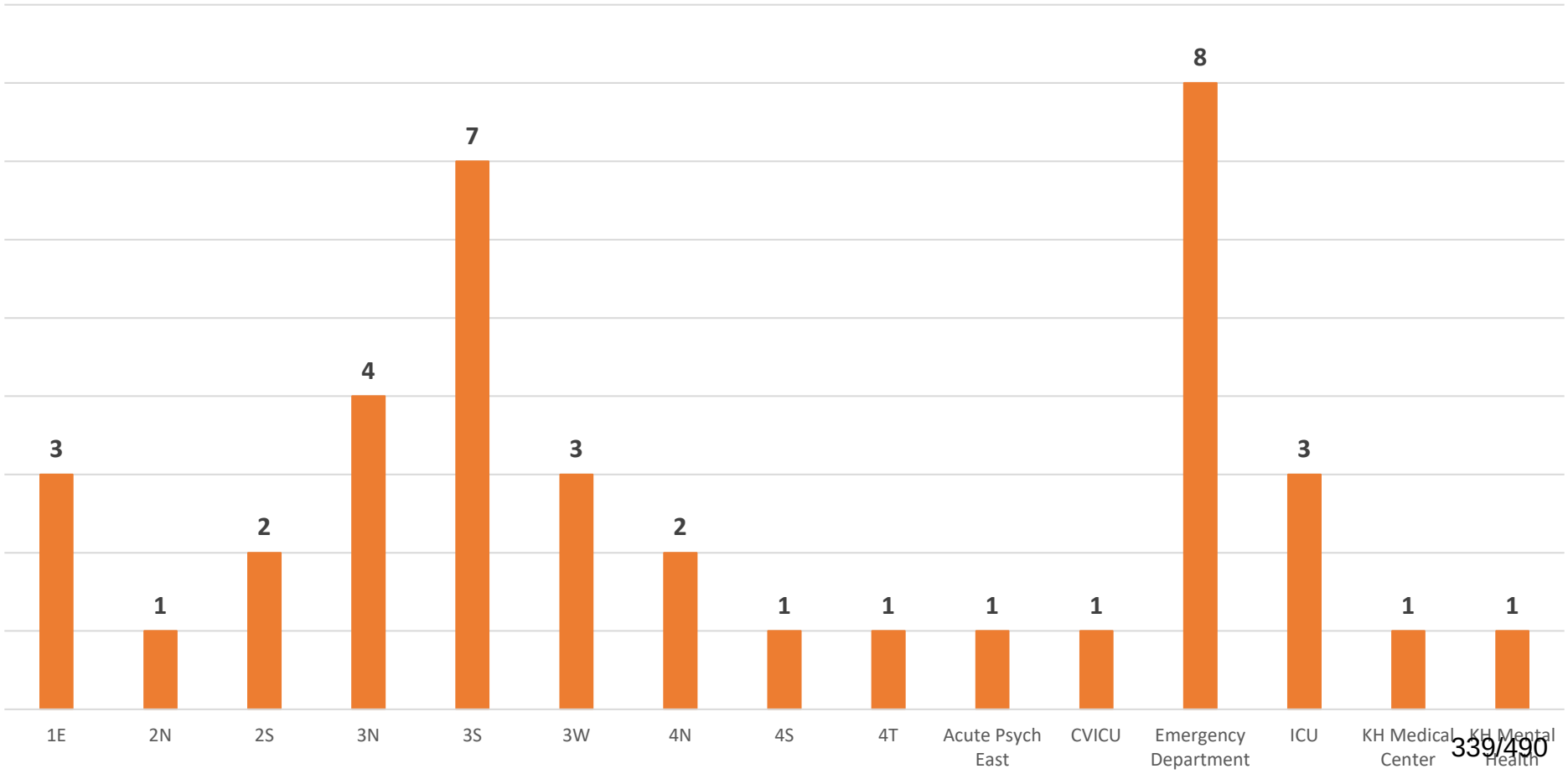
FY27: 7/1/2026 – 9/30/2026

Total Reported in Midas: 39

39
Total Cases

20
Closed

19
Remain Open



FINANCIAL STEWARDSHIP

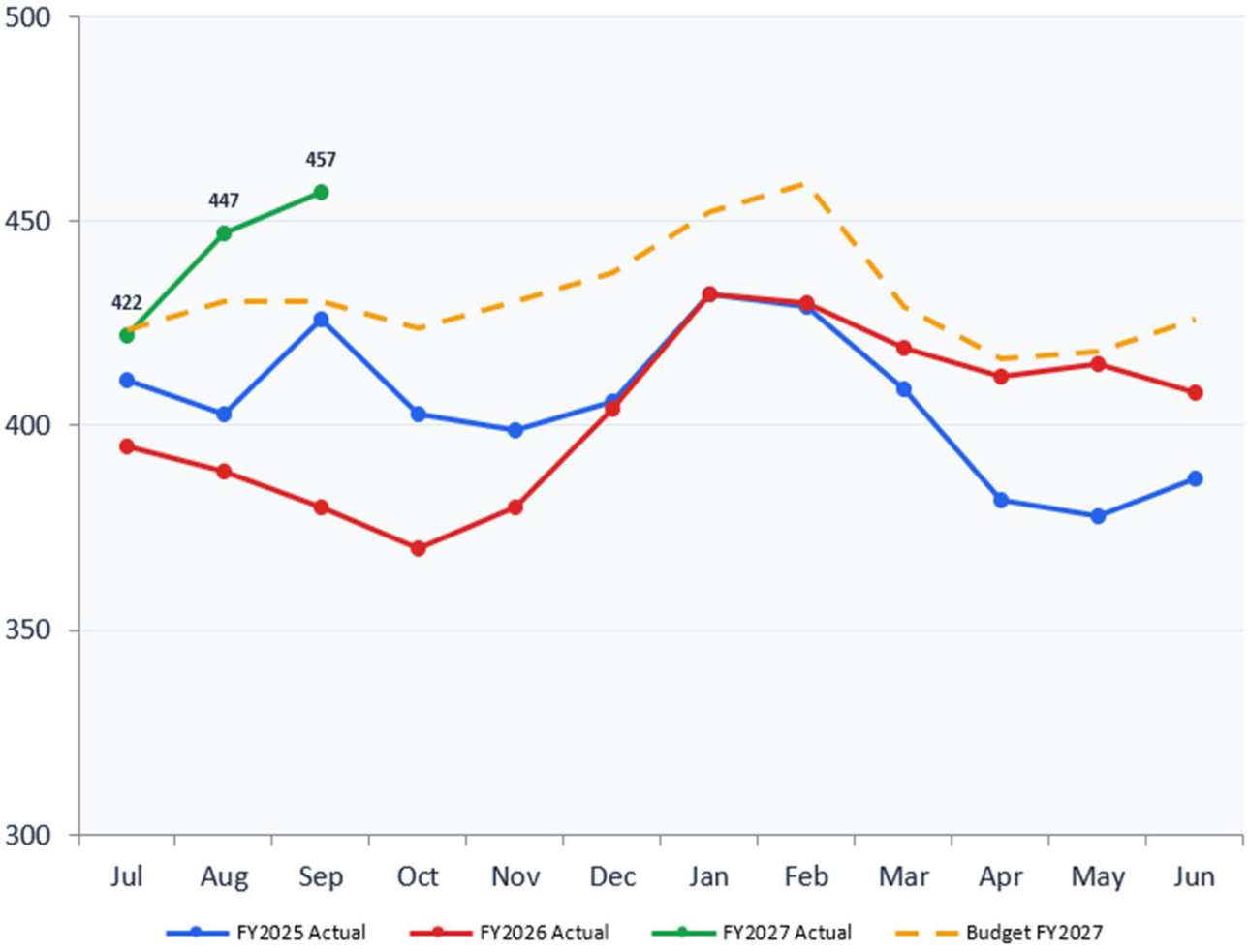
CFO Financial Report

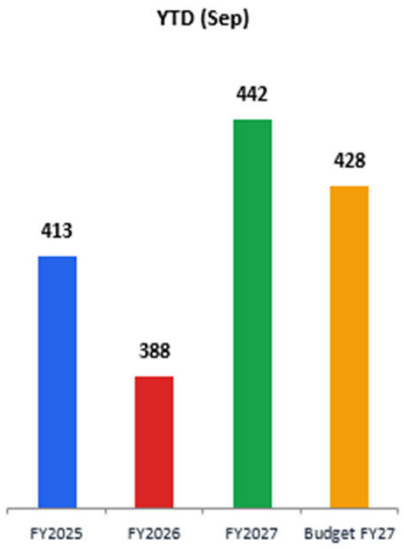
Month Ending September 2026

kaweahhealth.org

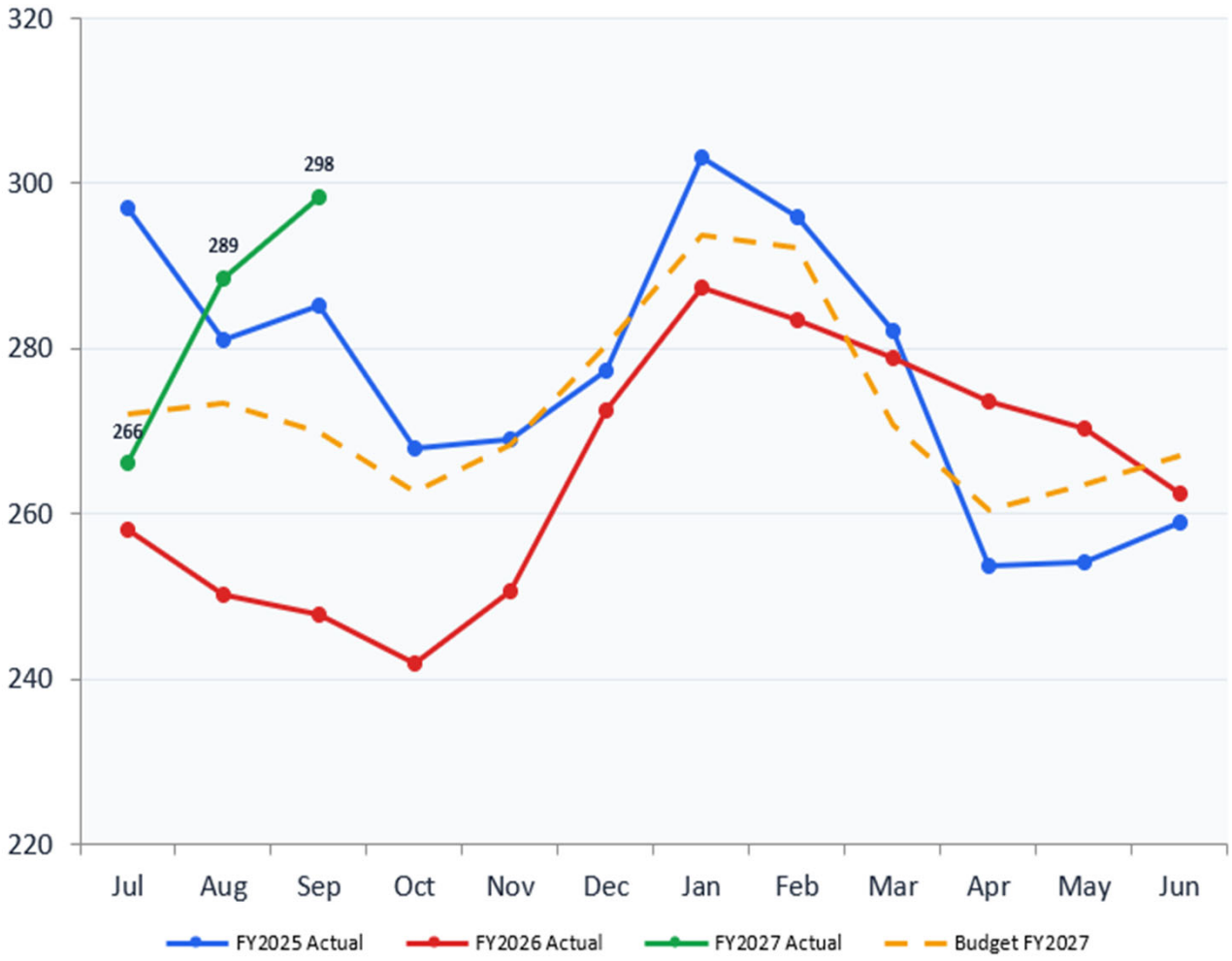
Kaweah Health
MORE THAN MEDICINE. LIFE.

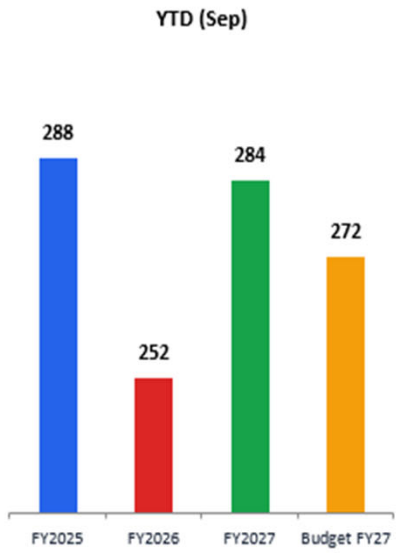
Average Daily Census



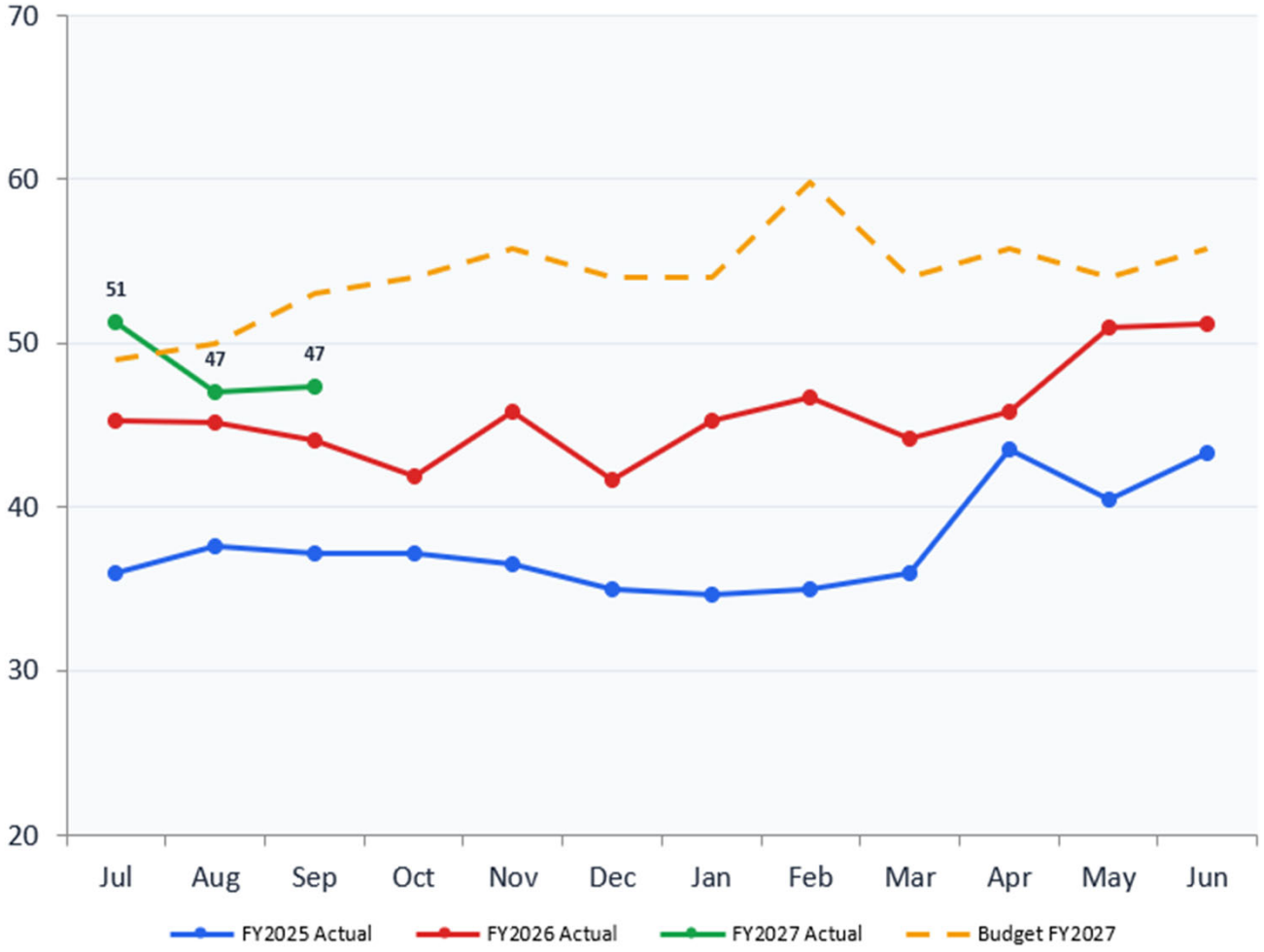


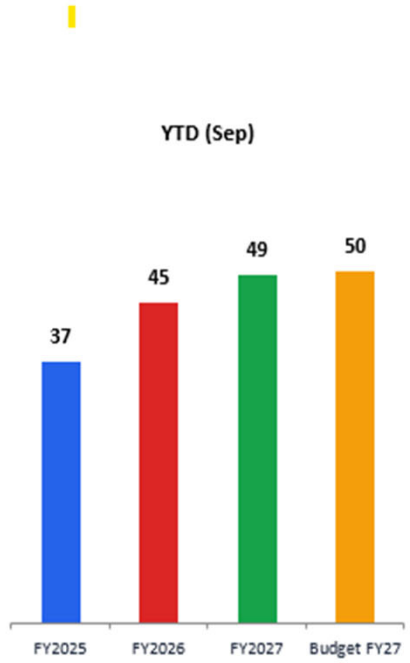
Medical Center (Avg Patients Per Day)



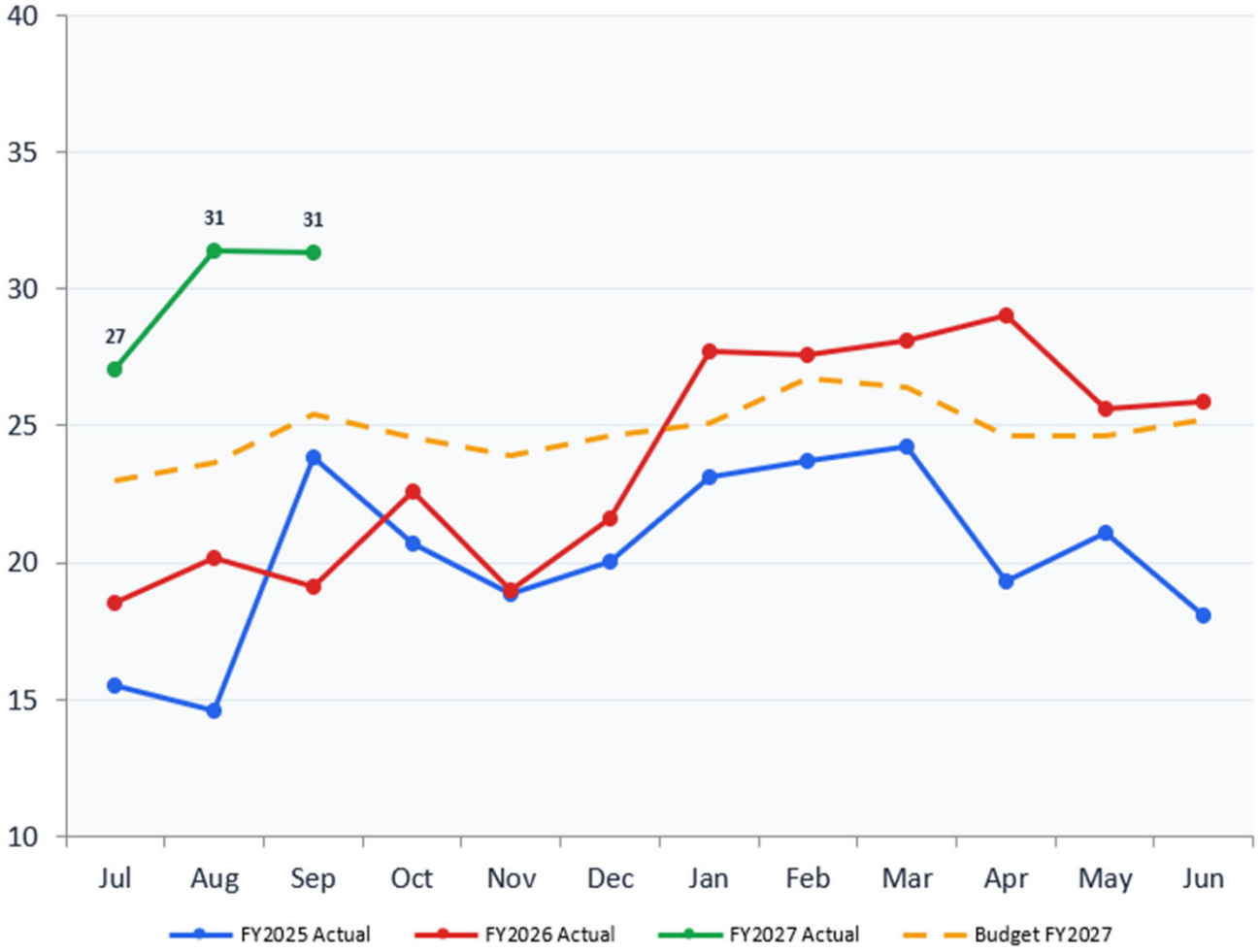


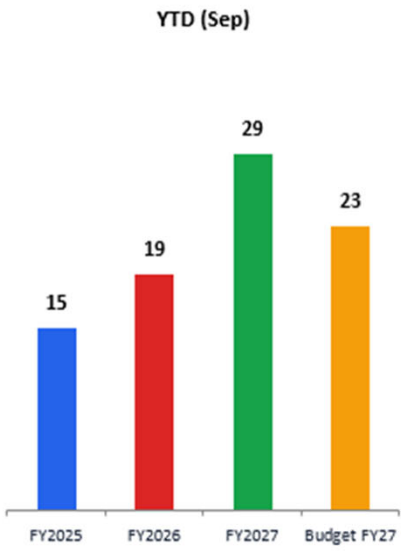
Acute I/P Psych (Avg Patients Per Day)



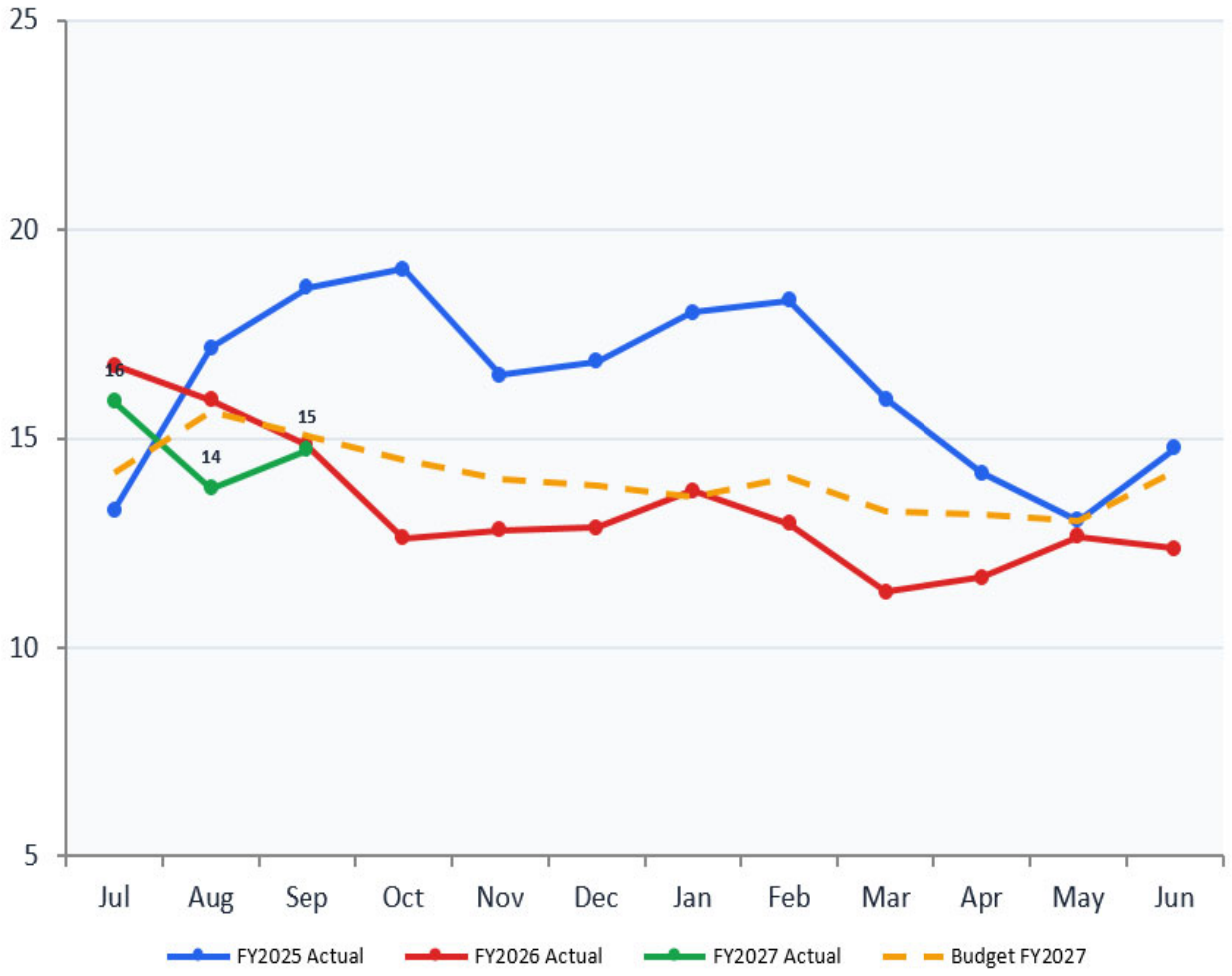


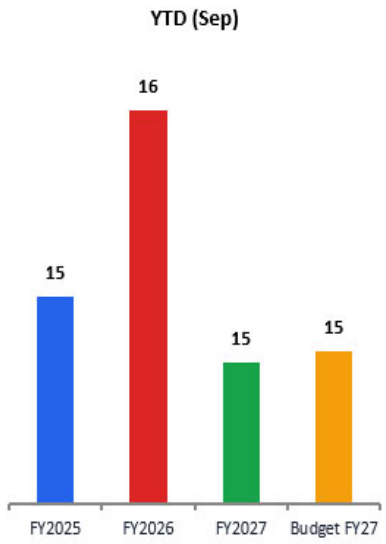
Rehabilitation Hospital (Avg Patients Per Day)





Nursery (Avg Patients Per Day)



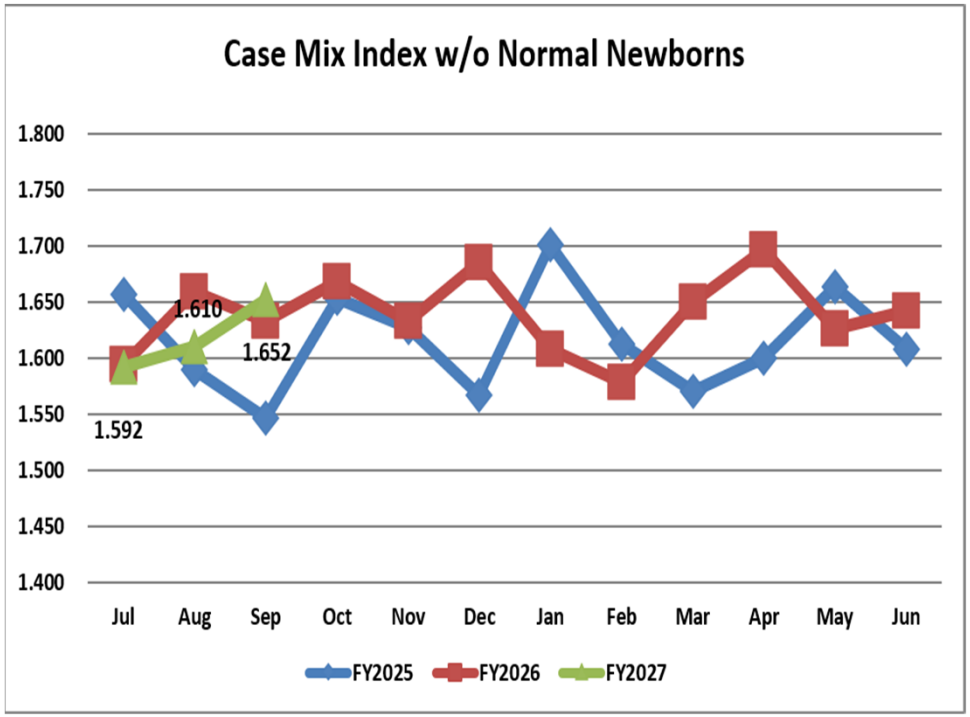


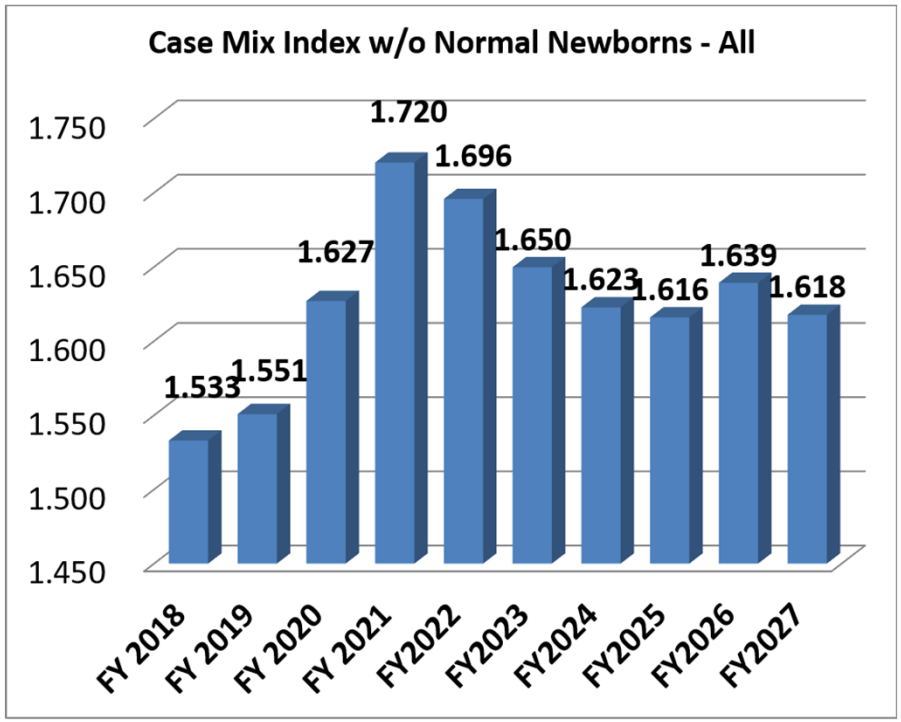
Statistical Results – Fiscal Year Comparison (Sep)

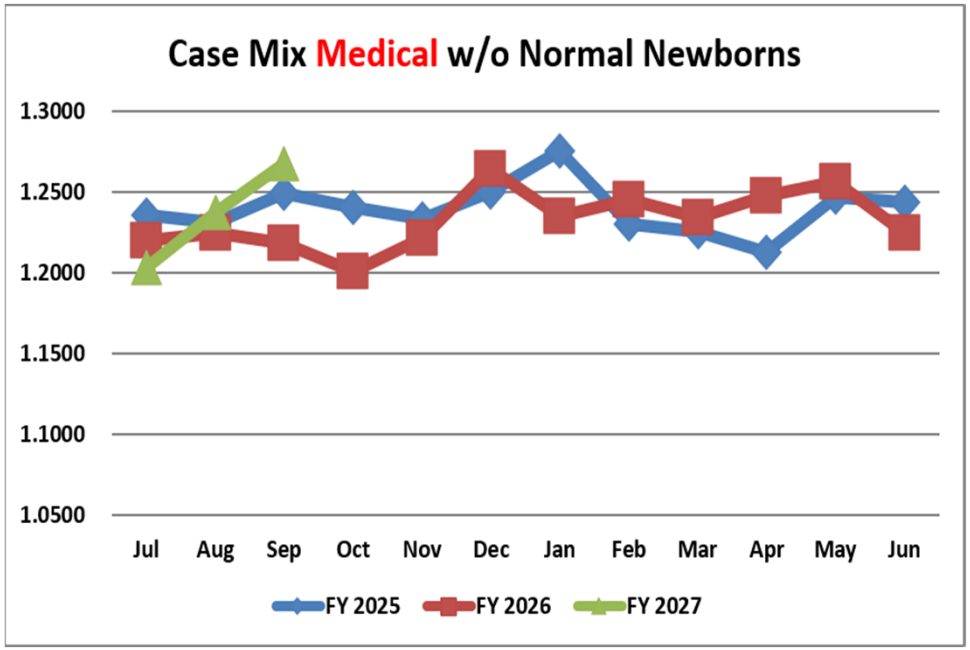
	Actual Results			Budget	Budget Variance	
	Sep 2025	Sep 2026	% Change	Sep 2026	Change	% Change
Average Daily Census	**380**	**457**	**20.2%**	**430**	**26**	**6.1%**
KDHCD Patient Days:						
Medical Center	7,433	8,950	20.4%	8,095	855	10.6%
Acute I/P Psych	1,321	1,422	7.6%	1,590	(168)	(10.6%)
Sub-Acute	863	1,141	32.2%	1,235	(94)	(7.6%)
Rehab	573	940	64.0%	763	177	23.2%
TCS-Ortho (Short Stay Rehab)	409	382	(6.6%)	395	(13)	(3.3%)
NICU	343	430	25.4%	384	46	12.0%
Nursery	445	442	(0.7%)	452	(10)	(2.2%)
Total KDHCD Patient Days	**11,387**	**13,707**	**20.2%**	**12,914**	**793**	**6.1%**
Total Outpatient Volume	**64,080**	**66,300**	**3.5%**	**65,422**	**878**	**1.3%**

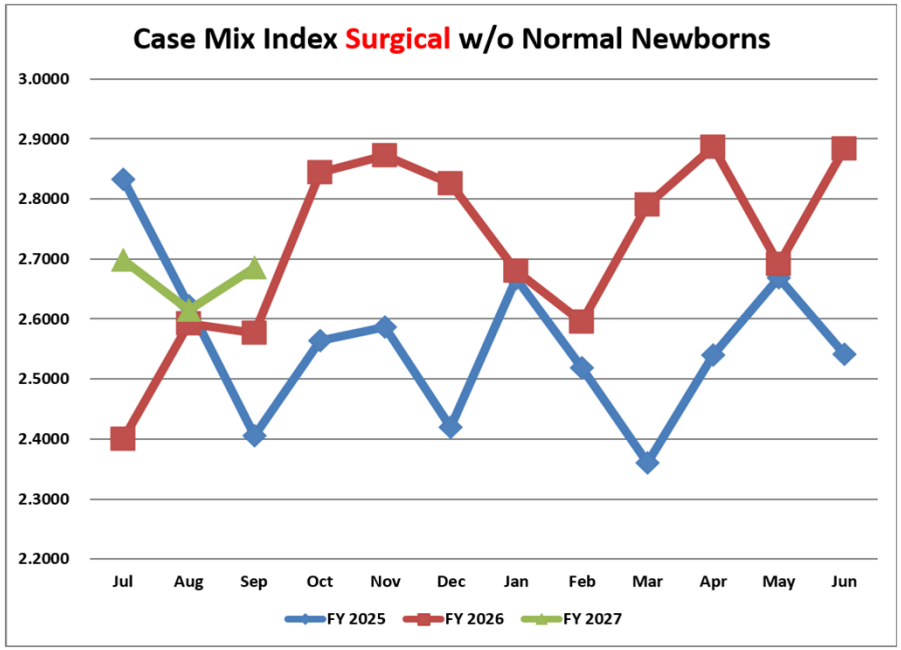
Statistical Results – Fiscal Year Comparison (Jul-Sep)

	Actual Results			Budget	Budget Variance	
	FYTD 2026	FYTD 2027	% Change	FYTD 2027	Change	% Change
Average Daily Census	**388**	**442**	**13.9%**	**427**	**15**	**3.5%**
KDHCD Patient Days:						
Medical Center	23,185	26,143	12.8%	24,903	1,240	5.0%
Acute I/P Psych	4,122	4,470	8.4%	4,659	(189)	(4.1%)
Sub-Acute	2,616	3,490	33.4%	3,637	(147)	(4.0%)
Rehab	1,774	2,753	55.2%	2,208	545	24.7%
TCS-Ortho (Short Stay Rehab)	1,292	1,143	(11.5%)	1,249	(106)	(8.5%)
NICU	1,231	1,298	5.4%	1,255	43	3.4%
Nursery	1,457	1,362	(6.5%)	1,376	(14)	(1.0%)
Total KDHCD Patient Days	**35,677**	**40,659**	**13.9%**	**39,287**	**1,372**	**3.5%**
Total Outpatient Volume	**190,901**	**197,492**	**3.5%**	**200,628**	**(3,136)**	**(1.6%)**

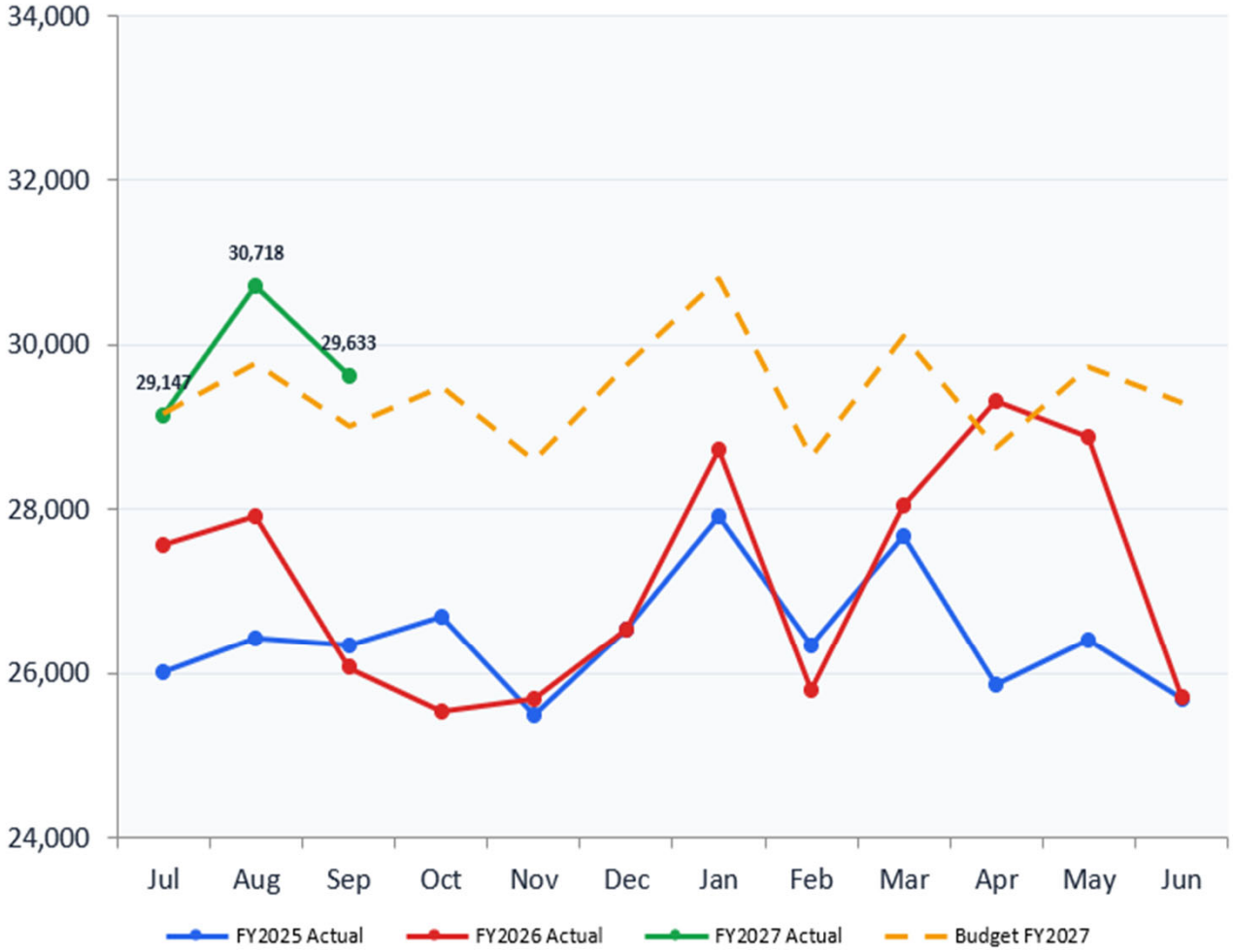

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.610
1.652
1.592
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2025
FY2026
FY2027

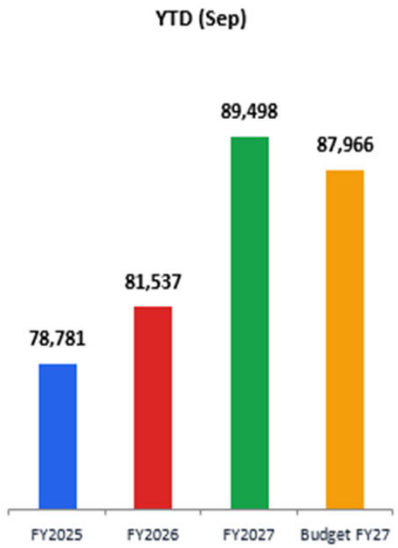

Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.533
1.551
1.627
1.720
1.696
1.650
1.623
1.616
1.639
1.618
FY 2018
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024
FY2025
FY2026
FY2027


Case Mix Medical w/o Normal Newborns
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2025
FY 2026
FY 2027

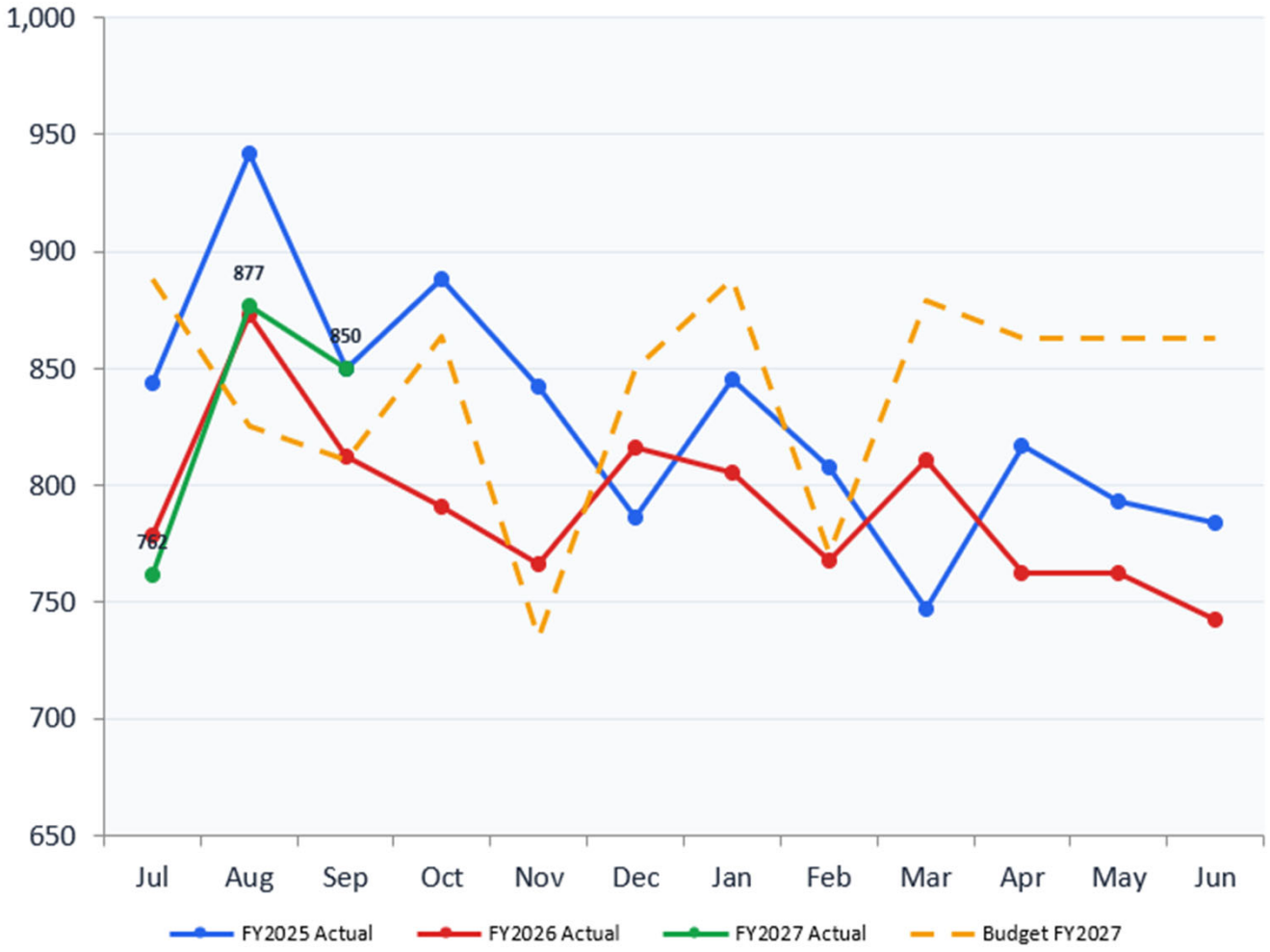

Case Mix Index Surgical w/o Normal Newborns
3.0000
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2025
FY 2026
FY 2027

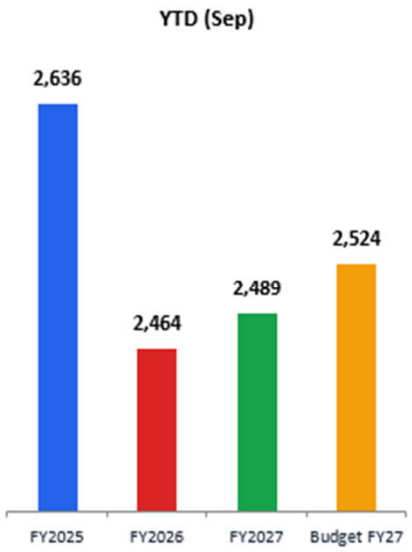
Adjusted Patient Days



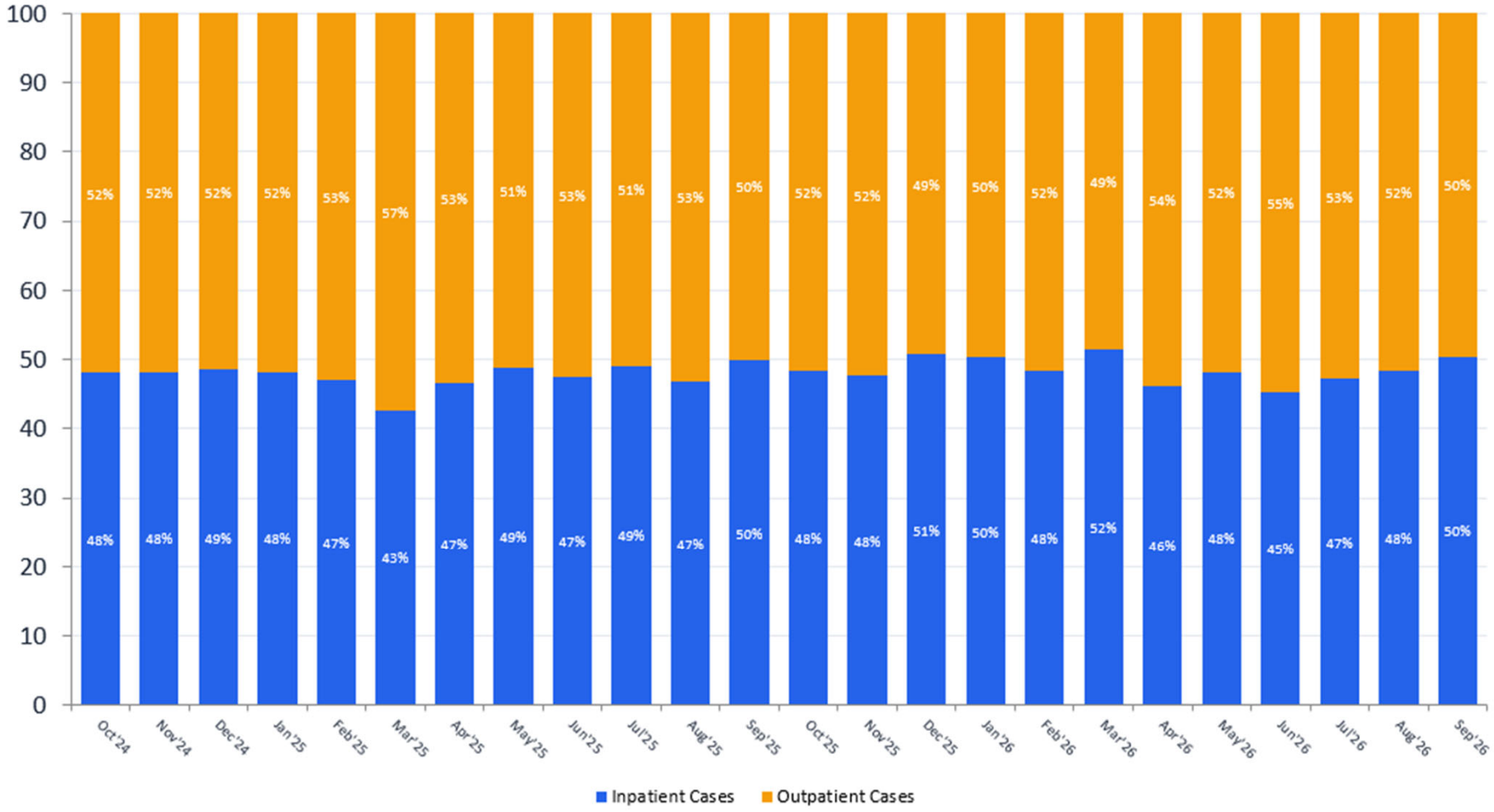


Surgery (IP & OP) – 100 Min Units

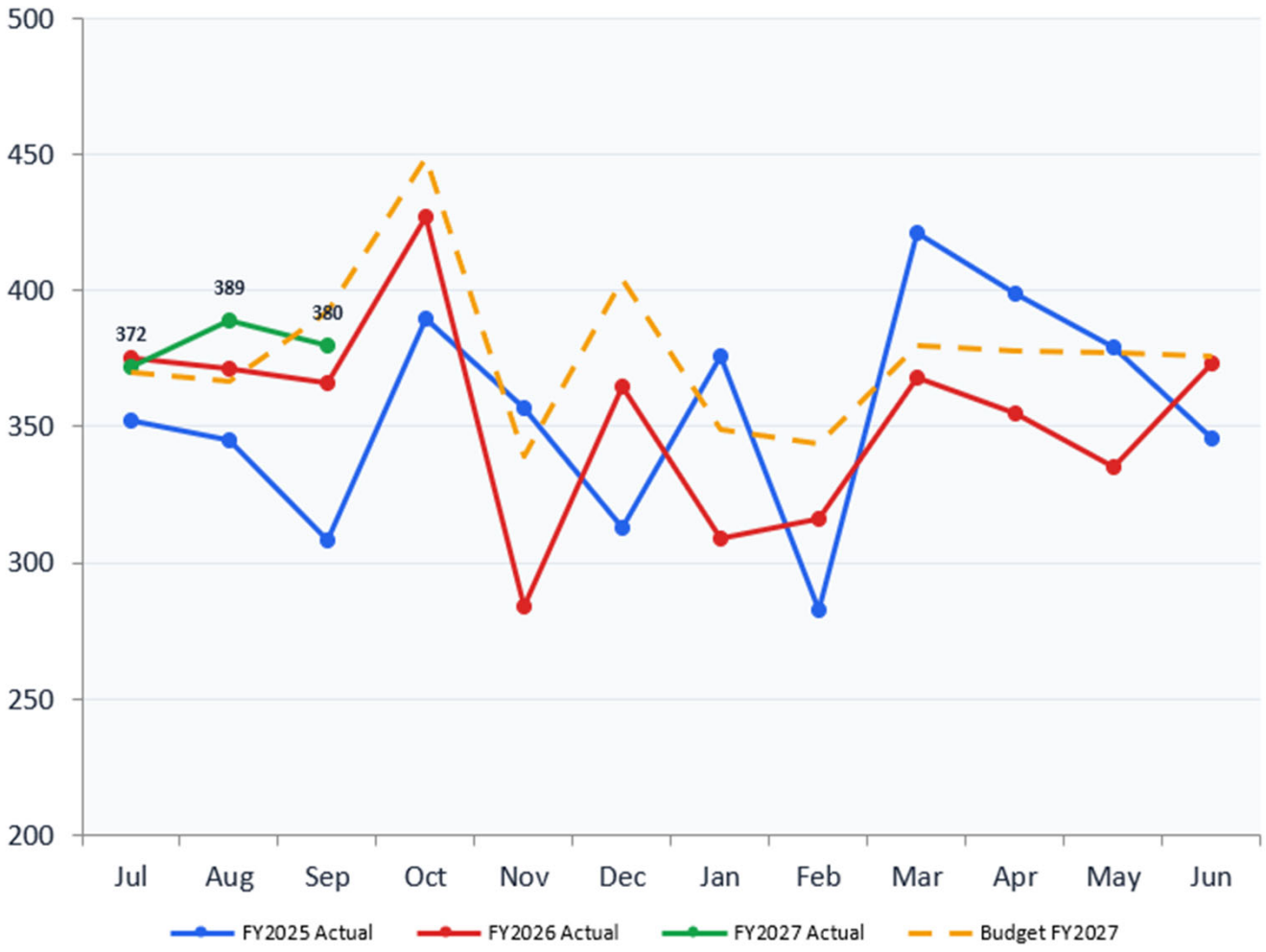


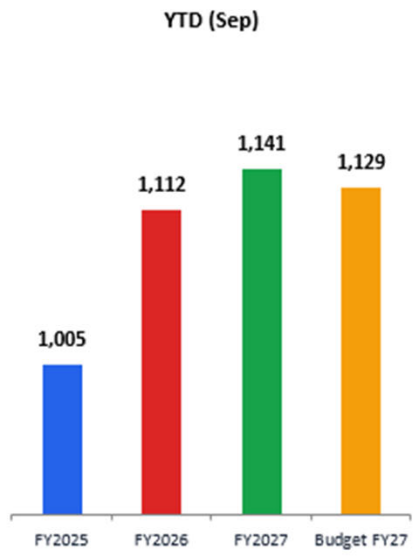


Surgery Cases (IP & OP)

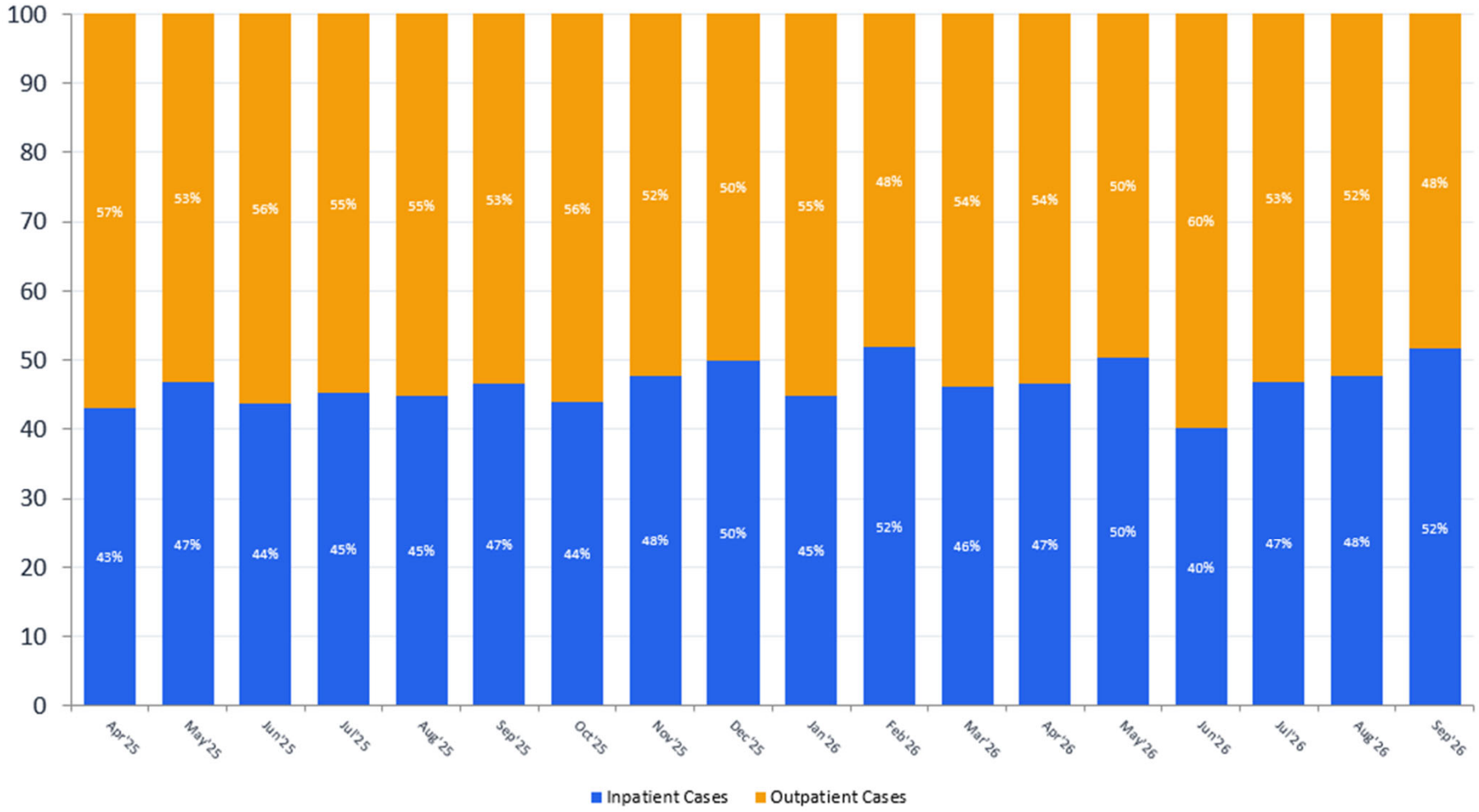


Cath Lab (IP & OP) – 100 Min Units





Cath Lab Patients (IP & OP)



Other Statistical Results – Prior Year/Budget Comparison (Sep)

	Actual Results				Budget	Budget Variance	
	Sep25	Sep26	Change	% Change	Sep26	Change	% Change
ED - Avg Treated Per Day	282	286	4	1.4%	276	11	3.9%
Surgery (IP & OP) – 100 Min Units	812	850	38	4.7%	811	39	4.8%
Endoscopy Procedures	612	543	(69)	(11.3%)	566	(23)	(4.1%)
Cath Lab (IP & OP) - 100 Min Units	366	380	14	3.7%	392	(12)	(3.1%)
Cardiac Surgery Cases	29	24	(5)	(17.2%)	36	(12)	(33.3%)
Deliveries	345	355	10	2.9%	342	13	3.7%
Clinical Lab	258,892	276,864	17,972	6.9%	294,699	(17,835)	(6.1%)
Reference Lab	7,754	8,186	432	5.6%	6,970	1,216	17.4%
Dialysis Center - Visalia Visits	1,582	1,249	(333)	(21.0%)	1,463	(214)	(14.6%)
Infusion Center - Units of Service	614	532	(82)	(13.4%)	589	(57)	(9.7%)
Hospice Days	4,147	3,961	(186)	(4.5%)	4,175	(214)	(5.1%)
Home Health Visits	3,189	2,638	(551)	(17.3%)	2,700	(62)	(2.3%)
Home Infusion Days	23,489	23,294	(195)	(0.8%)	22,350	944	4.2%

Other Statistical Results – Fiscal Year Comparison (Jul-Sep)

	YTD Actual Results				Budget	Budget Variance	
	YTD Sep25	YTD Sep26	Change	% Change	YTD Sep26	Change	% Change
ED - Avg Treated Per Day	280	282	2	0.7%	278	4	1.4%
Surgery (IP & OP) – 100 Min Units	2,464	2,489	25	1.0%	2,524	(35)	(1.4%)
Endoscopy Procedures	1,873	1,648	(225)	(12.0%)	1,624	24	1.5%
Cath Lab (IP & OP) - 100 Min Units	1,112	1,141	29	2.6%	1,129	12	1.1%
Cardiac Surgery Cases	87	66	(21)	(24.1%)	100	(34)	(34.0%)
Deliveries	1,097	1,045	(52)	(4.7%)	1,049	(4)	(0.4%)
Clinical Lab	775,827	845,589	69,763	9.0%	866,731	(21,142)	(2.4%)
Reference Lab	24,089	23,585	(504)	(2.1%)	22,925	660	2.9%
Dialysis Center - Visalia Visits	4,394	3,938	(456)	(10.4%)	4,463	(525)	(11.8%)
Infusion Center - Units of Service	1,937	1,633	(304)	(15.7%)	1,814	(181)	(10.0%)
Hospice Days	11,995	11,711	(284)	(2.4%)	12,698	(987)	(7.8%)
Home Health Visits	9,249	7,855	(1,394)	(15.1%)	8,100	(245)	(3.0%)
Home Infusion Days	73,647	68,360	(5,287)	(7.2%)	71,521	(3,161)	(4.4%)

Other Statistical Results – Prior Year/Budget Comparison (Sep)

	Actual Results				Budget	Budget Variance	
	Sep25	Sep26	Change	% Change	Sep26	Change	% Change
All O/P Rehab Svcs Across District	21,038	22,172	1,134	5.4%	19,693	2,479	12.6%
Physical & Other Therapy Units (I/P & O/P	18,191	22,237	4,046	22.2%	20,289	1,948	9.6%
Radiology - CT - All Areas	5,259	5,549	290	5.5%	5,384	165	3.1%
Radiology - MRI - All Areas	944	997	53	5.6%	966	31	3.2%
Radiology - Ultrasound - All Areas	2,976	3,767	791	26.6%	3,580	187	5.2%
Radiology - Diagnostic Radiology	10,036	10,041	5	0.0%	9,360	681	7.3%
Radiology – Main Campus	16,210	16,619	409	2.5%	16,011	608	3.8%
Radiology - Ultrasound - Main Campus	2,276	2,741	465	20.4%	2,565	176	6.9%
West Campus - Diagnostic Radiology	1,298	1,550	252	19.4%	1,292	258	19.9%
West Campus - CT Scan	573	663	90	15.7%	526	137	26.0%
West Campus - MRI	434	496	62	14.3%	446	50	11.3%
West Campus - Ultrasound	700	1,026	326	46.6%	1,015	11	1.1%
West Campus - Breast Center	1,361	1,768	407	29.9%	1,725	43	2.5%
Med Onc Visalia Treatments	1,151	1,365	214	18.6%	1,207	158	13.1%
Rad Onc Visalia Treatments	1,671	2,666	995	59.5%	1,663	1,003	60.3%
Rad Onc Hanford Treatments	306	269	(37)	(12.1%)	242	27	11.2%

Other Statistical Results – Fiscal Year Comparison (Jul-Sep)

	YTD Actual Results				Budget	Budget Variance	
	YTD Sep25	YTD Sep26	Change	% Change	YTD Sep26	Change	% Change
All O/P Rehab Svcs Across District	62,338	63,759	1,421	2.3%	60,525	3,234	5.3%
Physical & Other Therapy Units (I/P & O/P	55,835	66,609	10,774	19.3%	62,589	4,020	6.4%
Radiology - CT - All Areas	15,479	17,496	2,017	13.0%	16,151	1,345	8.3%
Radiology - MRI - All Areas	2,805	3,011	206	7.3%	2,930	81	2.8%
Radiology - Ultrasound - All Areas	9,238	10,688	1,450	15.7%	11,052	(364)	(3.3%)
Radiology - Diagnostic Radiology	28,902	30,273	1,371	4.7%	28,355	1,918	6.8%
Radiology – Main Campus	47,454	50,250	2,796	5.9%	48,506	1,744	3.6%
Radiology - Ultrasound - Main Campus	7,066	7,518	452	6.4%	7,996	(478)	(6.0%)
West Campus - Diagnostic Radiology	3,896	4,600	704	18.1%	3,888	712	18.3%
West Campus - CT Scan	1,614	2,007	393	24.3%	1,655	352	21.3%
West Campus - MRI	1,288	1,441	153	11.9%	1,383	58	4.2%
West Campus - Ultrasound	2,172	3,170	998	45.9%	3,056	114	3.7%
West Campus - Breast Center	4,179	5,888	1,709	40.9%	5,451	437	8.0%
Med Onc Visalia Treatments	3,494	3,867	373	10.7%	3,620	247	6.8%
Rad Onc Visalia Treatments	5,007	6,572	1,565	31.3%	5,249	1,323	25.2%
Rad Onc Hanford Treatments	875	674	(201)	(23.0%)	746	(72)	(9.7%)

Other Statistical Results – Prior Year/Budget Comparison (Sep)

	Actual Results				Budget	Budget Variance	
	Sep25	Sep26	Change	% Change	Sep26	Change	% Change
Rural Health Clinics Visits	13,013	12,866	(147)	(1.1%)	12,037	829	6.9%
RHC Exeter - Visits	6,219	6,194	(25)	(0.4%)	6,144	50	0.8%
RHC Lindsay - Visits	1,809	1,688	(121)	(6.7%)	1,795	(107)	(6.0%)
RHC Woodlake - Visits	687	581	(106)	(15.4%)	630	(49)	(7.8%)
RHC Woodlake Valencia - Visits	696	808	112	16.1%	912	(104)	(11.4%)
RHC Dinuba - Visits	1,353	1,376	23	1.7%	1,274	102	8.0%
RHC Tulare - Visits	2,249	2,219	(30)	(1.3%)	2,193	26	1.2%
Urgent Care – Court Total Visits	2,456	2,371	(85)	(3.5%)	2,685	(314)	(11.7%)
Urgent Care – Demaree Total Visits	1,812	2,177	365	20.1%	1,997	180	9.0%
KH Medical Clinic - Plaza Visits	229	300	71	31.0%	306	(6)	(2.0%)
KH Medical Clinic - Akers Visits	0	1,527	1,527	0.0%	1,848	(321)	(17.4%)
KH Willow Specialty Clinic	0	302	302	0.0%	249	53	21.3%
KH Cardiology Center Visalia Registrations	1,461	1,501	40	2.7%	1,941	(440)	(22.7%)
KH Mental Wellness Clinic Visits	299	367	68	22.7%	418	(51)	(12.2%)
Urology Clinic Visits	323	239	(84)	(26.0%)	349	(110)	(31.5%)
Therapy-Wound Care Svcs Encounters	370	372	2	0.5%	347	25	7.2%

Other Statistical Results – Fiscal Year Comparison (Jul-Sep)

	YTD Actual Results				Budget	Budget Variance	
	YTD Sep25	YTD Sep26	Change	% Change	YTD Sep26	Change	% Change
Rural Health Clinics Visits	38,060	38,005	(55)	(0.1%)	35,961	2,044	5.7%
RHC Exeter - Visits	18,117	18,442	325	1.8%	18,535	(93)	(0.5%)
RHC Lindsay - Visits	5,394	5,296	(98)	(1.8%)	5,313	(17)	(0.3%)
RHC Woodlake - Visits	1,889	1,730	(159)	(8.4%)	1,891	(161)	(8.5%)
RHC Woodlake Valencia - Visits	1,960	2,329	369	18.8%	2,736	(407)	(14.9%)
RHC Dinuba - Visits	4,127	3,828	(299)	(7.2%)	3,796	32	0.8%
RHC Tulare - Visits	6,573	6,380	(193)	(2.9%)	6,426	(46)	(0.7%)
Urgent Care – Court Total Visits	7,358	6,907	(451)	(6.1%)	8,026	(1,119)	(13.9%)
Urgent Care – Demaree Total Visits	5,184	6,014	830	16.0%	5,915	99	1.7%
KH Medical Clinic - Plaza Visits	839	988	149	17.8%	969	19	2.0%
KH Medical Clinic - Akers Visits	0	4,459	4,459	0.0%	5,422	(963)	(17.8%)
KH Willow Specialty Clinic	0	1,037	1,037	0.0%	758	279	36.8%
KH Cardiology Center Visalia Registrations	4,349	4,391	42	1.0%	5,951	(1,560)	(26.2%)
KH Mental Wellness Clinic Visits	1,022	1,015	(7)	(0.7%)	1,330	(315)	(23.7%)
Urology Clinic Visits	977	750	(227)	(23.2%)	1,083	(333)	(30.8%)
Therapy-Wound Care Svcs Encounters	1,088	1,065	(23)	(2.1%)	1,065	0	0.0%

Sep Financial Summary (000's) Budget Comparison

	Comparison to Budget - Month of September			
	Budget Sep-2026	Actual Sep-2026	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$60,638	$64,082	$3,444	5.4%
Other Operating Revenue	$23,059	$24,075	$1,016	4.2%
Total Operating Revenue	**$83,697**	**$88,157**	**$4,460**	**5.1%**
Operating Expenses				
Employment Expenses	$41,720	$42,950	$1,230	2.9%
Other Expenses	$40,906	$41,528	$622	1.5%
Total Operating Expenses	**$82,626**	**$84,478**	**$1,852**	**2.2%**
Operating Margin	**$1,070**	**$3,678**	**$2,608**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**$1,070**	**$3,678**	**$2,608**	
Nonoperating Revenue (Loss)	$1,174	($2,380)	($3,554)	
Excess Margin	**$2,244**	**$1,298**	**($947)**	

Sep Financial Summary (000's) Prior Year Comparison

	Comparison to Prior Year - Month of September			
	Actual Sep-2025	Actual Sep-2026	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$56,822	$64,082	$7,260	11.3%
Other Operating Revenue	$22,899	$24,075	$1,176	4.9%
Total Operating Revenue	**$79,720**	**$88,157**	**$8,436**	**9.6%**
Operating Expenses				
Employment Expenses	$42,190	$42,950	$760	1.8%
Other Expenses	$38,038	$41,528	$3,491	8.4%
Total Operating Expenses	**$80,228**	**$84,478**	**$4,251**	**5.0%**
Operating Margin	**($507)**	**$3,678**	**$4,185**	
Stimulus/FEMA	($0)	$0	$0	
Operating Margin after Stimulus/FEMA	**($507)**	**$3,678**	**$4,185**	
Nonoperating Revenue (Loss)	$1,968	($2,380)	($4,348)	
Excess Margin	**$1,461**	**$1,298**	**($163)**	

Year to Date Financial Summary (000's)

	Comparison to Budget - YTD September			
	Budget YTD Sep-2026	Actual YTD Sep-2026	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$183,320	$186,374	$3,054	1.6%
Other Operating Revenue	$69,397	$71,063	$1,666	2.3%
Total Operating Revenue	**$252,717**	**$257,437**	**$4,720**	**1.8%**
Operating Expenses				
Employment Expenses	$126,863	$130,729	$3,866	3.0%
Other Expenses	$123,549	$123,828	$279	0.2%
Total Operating Expenses	**$250,412**	**$254,557**	**$4,145**	**1.6%**
Operating Margin	**$2,305**	**$2,880**	**$575**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**$2,305**	**$2,880**	**$575**	
Nonoperating Revenue (Loss)	$3,575	$4,861	$1,286	
Excess Margin	**$5,880**	**$7,741**	**$1,861**	

Sep Financial Comparison (000's)

	Comparison to Budget - Month of September				Comparison to Prior Year - Month of September			
	Budget Sep-2026	Actual Sep-2026	$ Change	% Change	Actual Sep-2025	Actual Sep-2026	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$60,638**	**$64,082**	**$3,444**	**5.4%**	**$56,822**	**$64,082**	**$7,260**	**11.3%**
Supplemental Gov't Programs	$9,369	$9,369	($0)	0.0%	$10,083	$9,369	($714)	-7.6%
Prime Program	$1,064	$1,064	$0	0.0%	$631	$1,064	$434	40.7%
Premium Revenue	$7,631	$7,352	($279)	-3.8%	$7,126	$7,352	$227	3.1%
Other Revenue	$4,994	$6,289	$1,295	20.6%	$5,059	$6,289	$1,230	19.6%
Other Operating Revenue	$23,059	$24,075	$1,016	4.2%	$22,899	$24,075	$1,176	4.9%
Total Operating Revenue	**$83,697**	**$88,157**	**$4,460**	**5.1%**	**$79,720**	**$88,157**	**$8,436**	**9.6%**
Operating Expenses								
Salaries & Wages	$34,143	$35,512	$1,369	3.9%	$33,046	$35,512	$2,466	6.9%
Contract Labor	$1,305	$1,405	$100	7.1%	$1,376	$1,405	$28	2.0%
Employee Benefits	$6,272	$6,034	($238)	-3.9%	$7,768	$6,034	($1,734)	-28.7%
Total Employment Expenses	**$41,720**	**$42,950**	**$1,230**	**2.9%**	**$42,190**	**$42,950**	**$760**	**1.8%**
Medical & Other Supplies	$15,953	$17,509	$1,557	8.9%	$14,494	$17,509	$3,016	17.2%
Physician Fees	$9,080	$9,280	$200	2.2%	$7,632	$9,280	$1,648	17.8%
Purchased Services	$2,100	$2,005	($95)	-4.7%	$2,109	$2,005	($104)	-5.2%
Repairs & Maintenance	$2,675	$2,697	$22	0.8%	$2,205	$2,697	$491	18.2%
Utilities	$1,025	$927	($97)	-10.5%	$1,069	$927	($141)	-15.3%
Rents & Leases	$212	$178	($34)	-19.3%	$196	$178	($19)	-10.5%
Depreciation & Amortization	$3,174	$2,884	($290)	-10.0%	$3,473	$2,884	($589)	-20.4%
Interest Expense	$561	$558	($3)	-0.6%	$568	$558	($10)	-1.7%
Other Expense	$2,529	$2,420	($109)	-4.5%	$2,172	$2,420	$248	10.2%
Humana Cap Plan Expenses	$3,598	$3,070	($528)	-17.2%	$4,120	$3,070	($1,050)	-34.2%
Total Other Expenses	**$40,906**	**$41,528**	**$622**	**1.5%**	**$38,038**	**$41,528**	**$3,491**	**8.4%**
Total Operating Expenses	**$82,626**	**$84,478**	**$1,852**	**2.2%**	**$80,228**	**$84,478**	**$4,251**	**5.0%**
Operating Margin	**$1,070**	**$3,678**	**$2,608**		**($507)**	**$3,678**	**$4,185**	
Stimulus/FEMA	**$0**	**$0**	**$0**		**($0)**	**$0**	**$0**	
Operating Margin after Stimulus/FEMA	**$1,070**	**$3,678**	**$2,608**		**($507)**	**$3,678**	**$4,185**	
Nonoperating Revenue (Loss)	$1,174	($2,380)	($3,554)		$1,968	($2,380)	($4,348)	
Excess Margin	**$2,244**	**$1,298**	**($947)**		**$1,461**	**$1,298**	**($163)**	

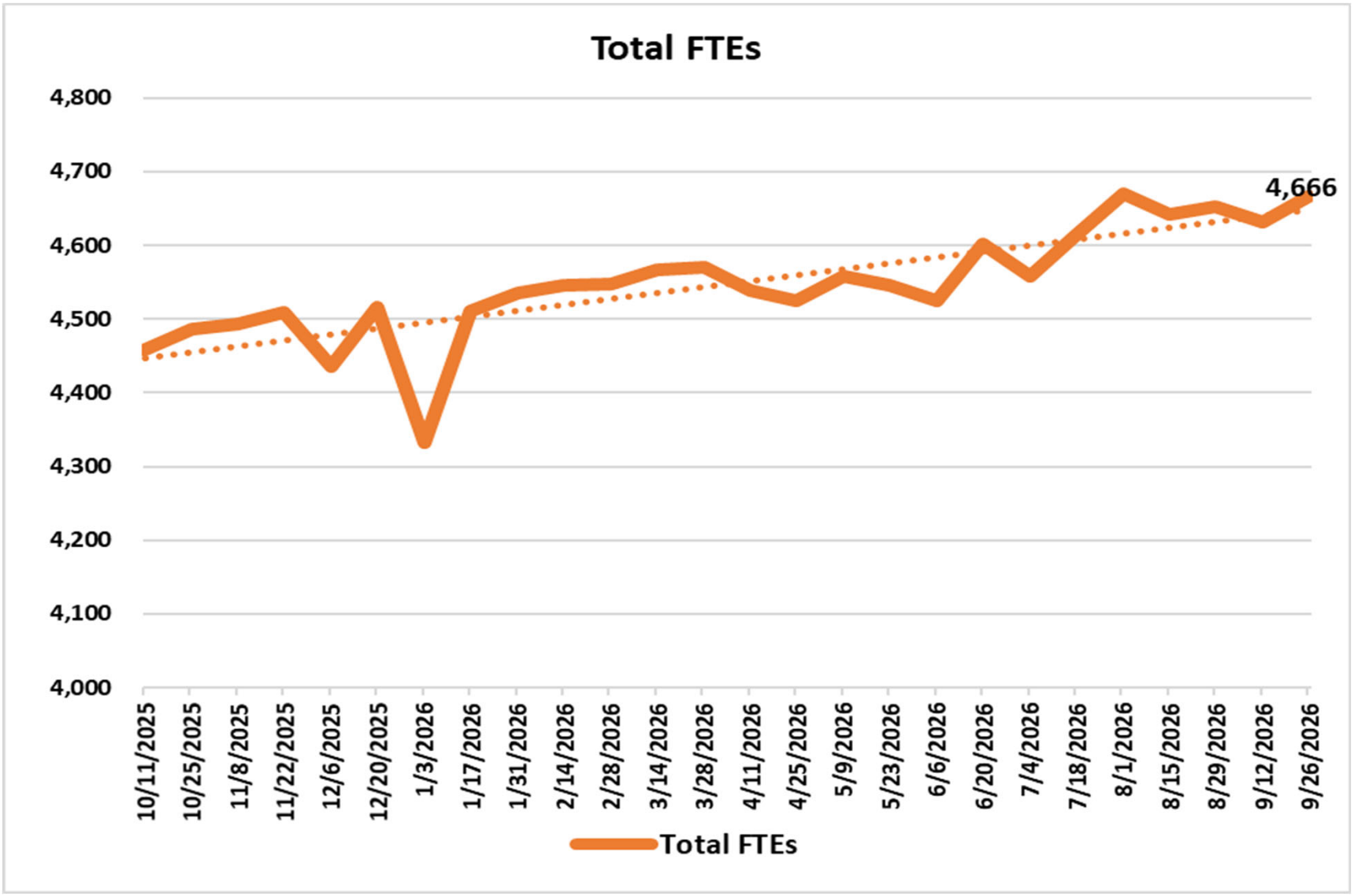
Year to Date: July through Sep Financial Comparison (000's)

	Comparison to Budget - YTD September				Comparison to Prior Year - YTD September			
	Budget YTD Sep-2026	Actual YTD Sep-2026	$ Change	% Change	Actual YTD Sep-2025	Actual YTD Sep-2026	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$183,320**	**$186,374**	**$3,054**	**1.6%**	**$166,612**	**$186,374**	**$19,762**	**10.6%**
Supplemental Gov't Programs	$28,108	$28,108	($0)	0.0%	$29,522	$28,108	($1,414)	-5.0%
Prime Program	$3,193	$3,193	$0	0.0%	$1,892	$3,193	$1,301	40.7%
Premium Revenue	$22,893	$22,086	($807)	-3.7%	$22,160	$22,086	($75)	-0.3%
Other Revenue	$15,203	$17,676	$2,473	14.0%	$15,076	$17,676	$2,600	14.7%
Other Operating Revenue	$69,397	$71,063	$1,666	2.3%	$68,651	$71,063	$2,412	3.4%
Total Operating Revenue	**$252,717**	**$257,437**	**$4,720**	**1.8%**	**$235,263**	**$257,437**	**$22,174**	**8.6%**
Operating Expenses								
Salaries & Wages	$103,827	$107,447	$3,620	3.4%	$100,552	$107,447	$6,895	6.4%
Contract Labor	$3,999	$4,762	$763	16.0%	$6,333	$4,762	($1,571)	-33.0%
Employee Benefits	$19,037	$18,520	($517)	-2.8%	$21,599	$18,520	($3,079)	-16.6%
Total Employment Expenses	**$126,863**	**$130,729**	**$3,866**	**3.0%**	**$128,483**	**$130,729**	**$2,246**	**1.7%**
Medical & Other Supplies	$48,285	$50,035	$1,750	3.5%	$43,751	$50,035	$6,284	12.6%
Physician Fees	$27,084	$27,781	$697	2.5%	$23,729	$27,781	$4,052	14.6%
Purchased Services	$6,433	$6,053	($379)	-6.3%	$5,829	$6,053	$224	3.7%
Repairs & Maintenance	$8,205	$7,255	($950)	-13.1%	$6,615	$7,255	$640	8.8%
Utilities	$3,120	$2,777	($343)	-12.3%	$2,946	$2,777	($169)	-6.1%
Rents & Leases	$661	$565	($95)	-16.8%	$407	$565	$158	28.0%
Depreciation & Amortization	$9,521	$9,694	$173	1.8%	$9,859	$9,694	($165)	-1.7%
Interest Expense	$1,719	$1,703	($16)	-0.9%	$1,707	$1,703	($4)	-0.3%
Other Expense	$7,727	$6,877	($849)	-12.4%	$6,159	$6,877	$718	10.4%
Humana Cap Plan Expenses	$10,794	$11,087	$293	2.6%	$12,505	$11,087	($1,418)	-12.8%
Total Other Expenses	**$123,549**	**$123,828**	**$279**	**0.2%**	**$113,508**	**$123,828**	**$10,320**	**8.3%**
Total Operating Expenses	**$250,412**	**$254,557**	**$4,145**	**1.6%**	**$241,992**	**$254,557**	**$12,565**	**4.9%**
Operating Margin	**$2,305**	**$2,880**	**$575**		**($6,729)**	**$2,880**	**$9,609**	
Stimulus/FEMA	**$0**	**$0**	**$0**		**($0)**	**$0**	**$0**	
Operating Margin after Stimulus/FEM	**$2,305**	**$2,880**	**$575**		**($6,729)**	**$2,880**	**$9,609**	
Nonoperating Revenue (Loss)	**$3,575**	**$4,861**	**$1,286**		**$4,270**	**$4,861**	**$591**	
Excess Margin	**$5,880**	**$7,741**	**$1,861**		**($2,459)**	**$7,741**	**$10,200**	

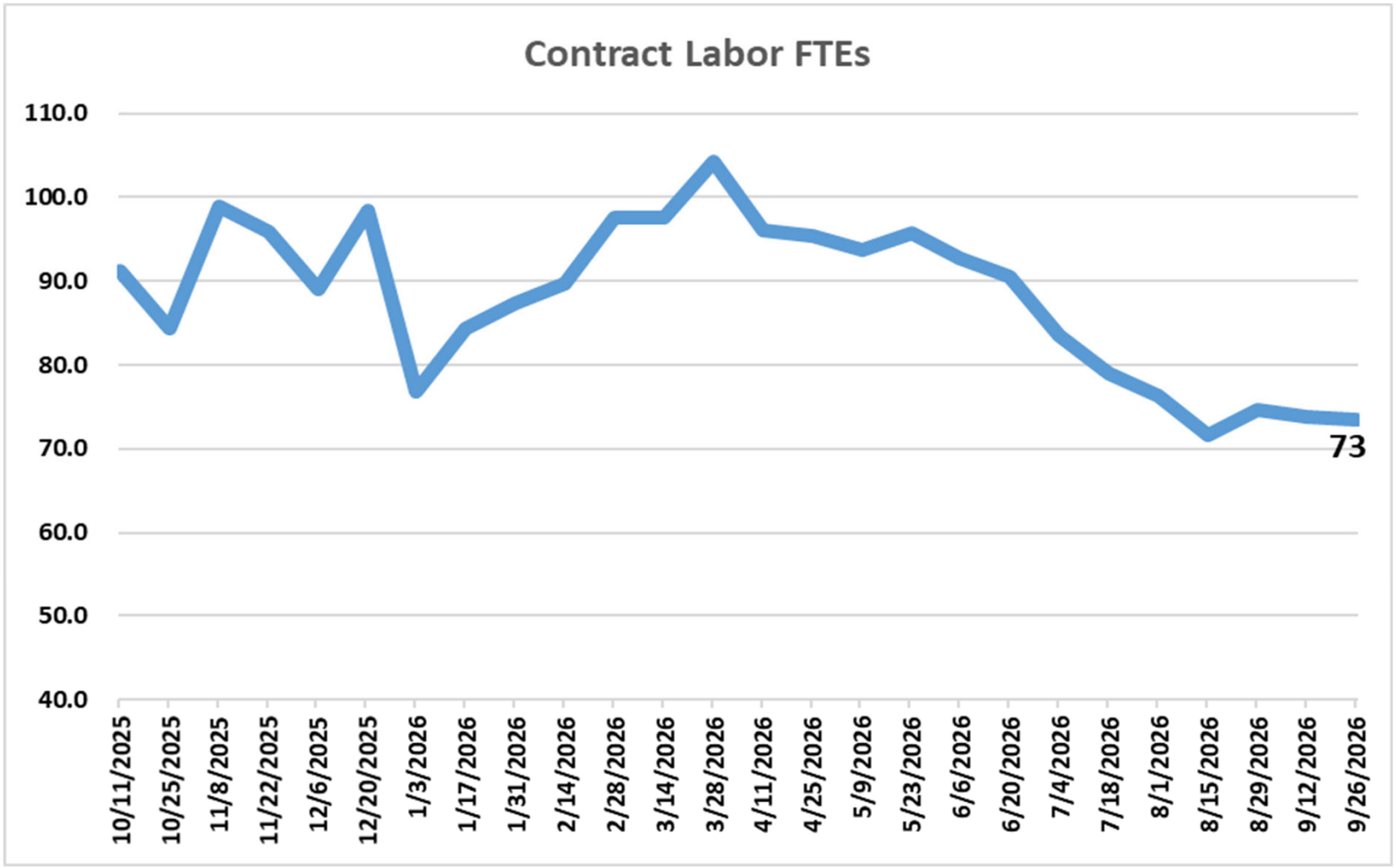
Month of September - Budget Variances

- **Net Patient Service Revenue:** The favorable budget variance of $3.4M, or 5.4%, is due to higher than expected patient volumes in the month of September.
- **Other Revenue:** Other revenue exceeded budget by $1.3M mainly due to positive variances in retail and other pharmacy revenues.
- **Salaries and Wages:** The unfavorable variance of $1.4M, or 3.9%, in salaries and wages in September is partially due to increases in volumes and the related need for staffing in the nursing areas as well as the emergency department.
- **Medical & Other Supplies:** The $1.6M overage is due to increases in pharmaceutical expense related to medical oncology, as well as retail and other pharmacy volume.
- **Non-Operating Revenue:** The $3.6M unfavorable variance is due to the recognition of $3.9M of unrealized losses as the District's and Foundation's investment portfolio are adjusted for market value changes each quarter.

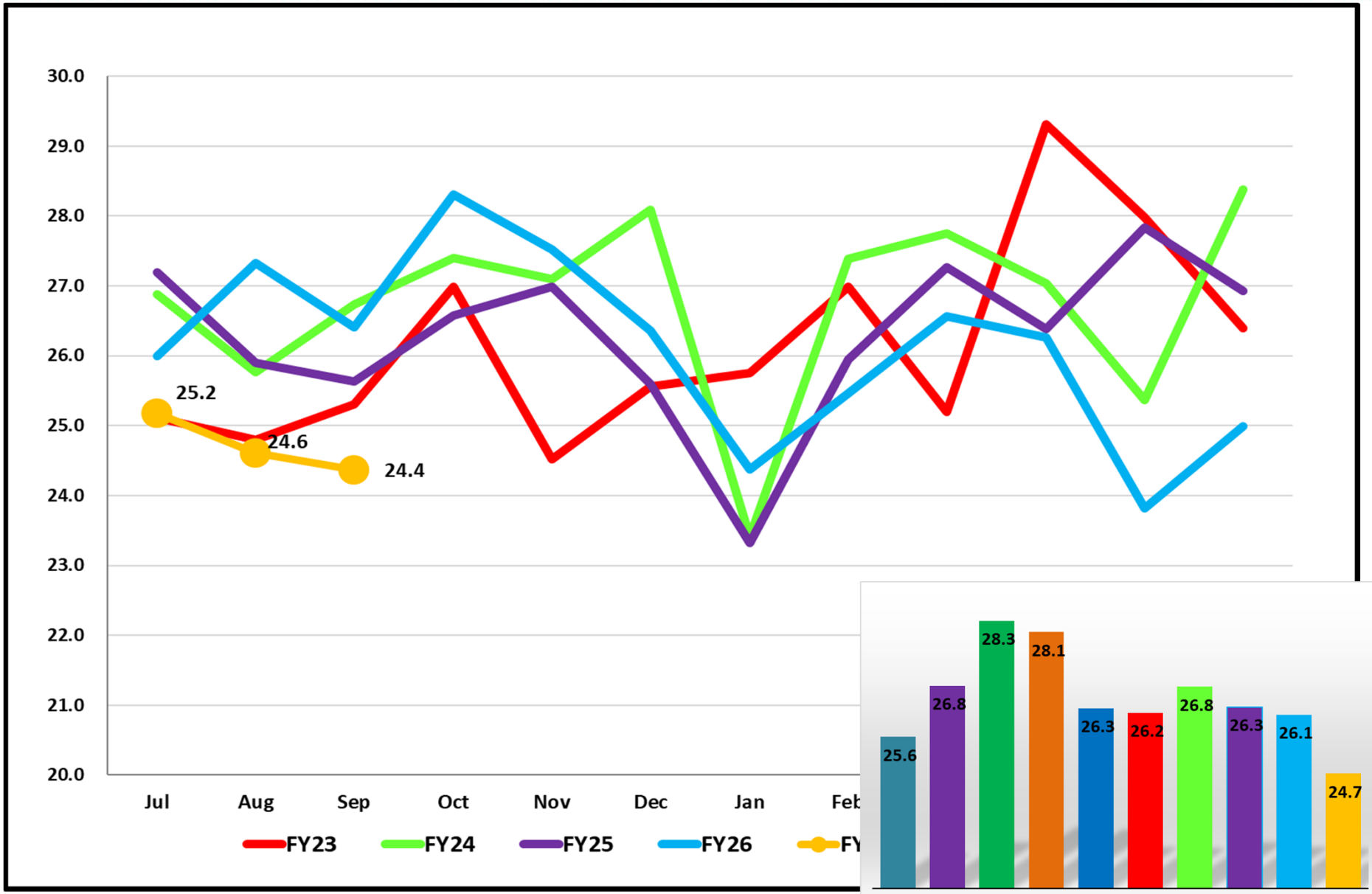
Total FTEs (includes Contract Labor)



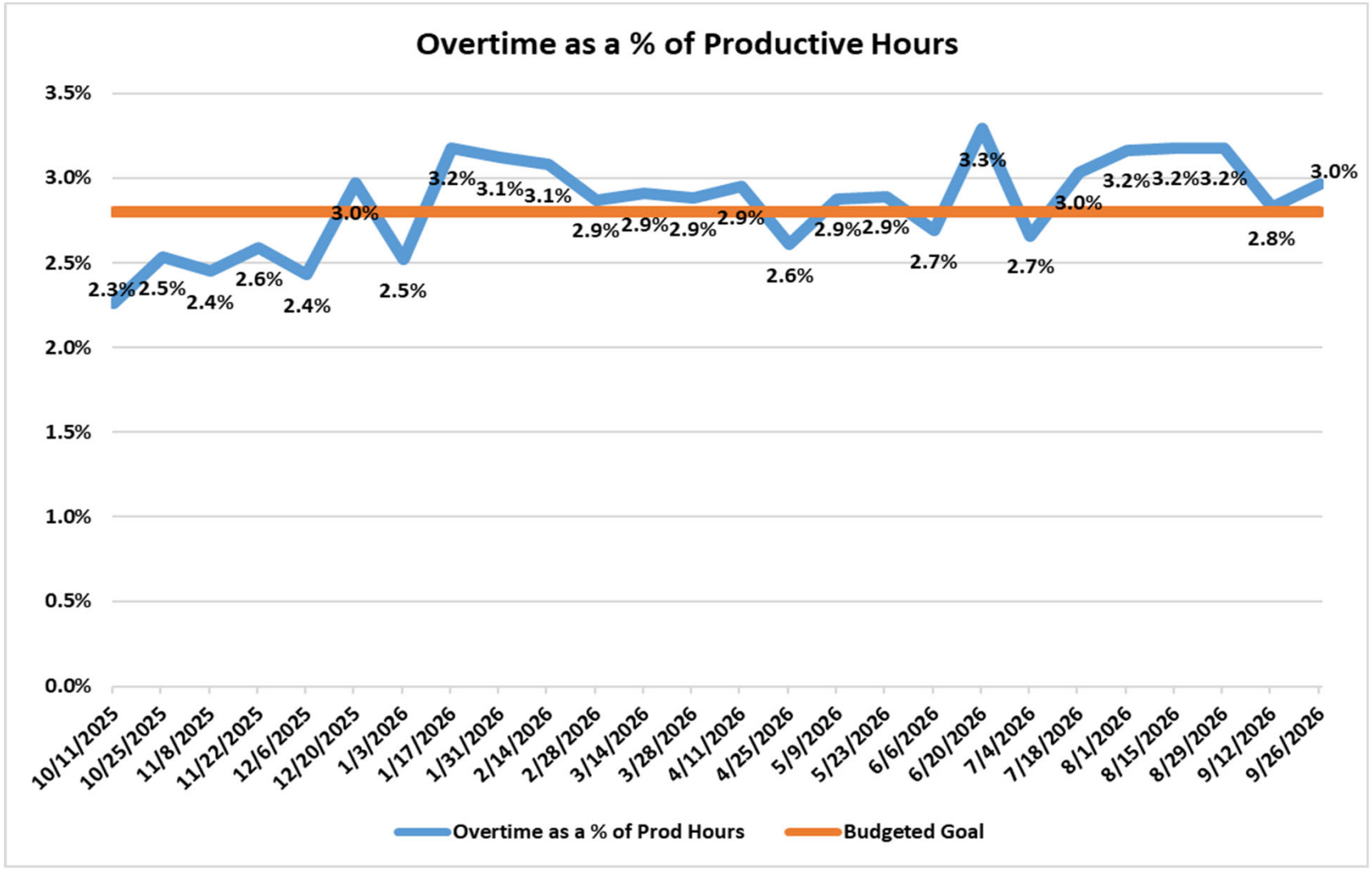
Contract Labor Full Time Equivalents (FTEs)



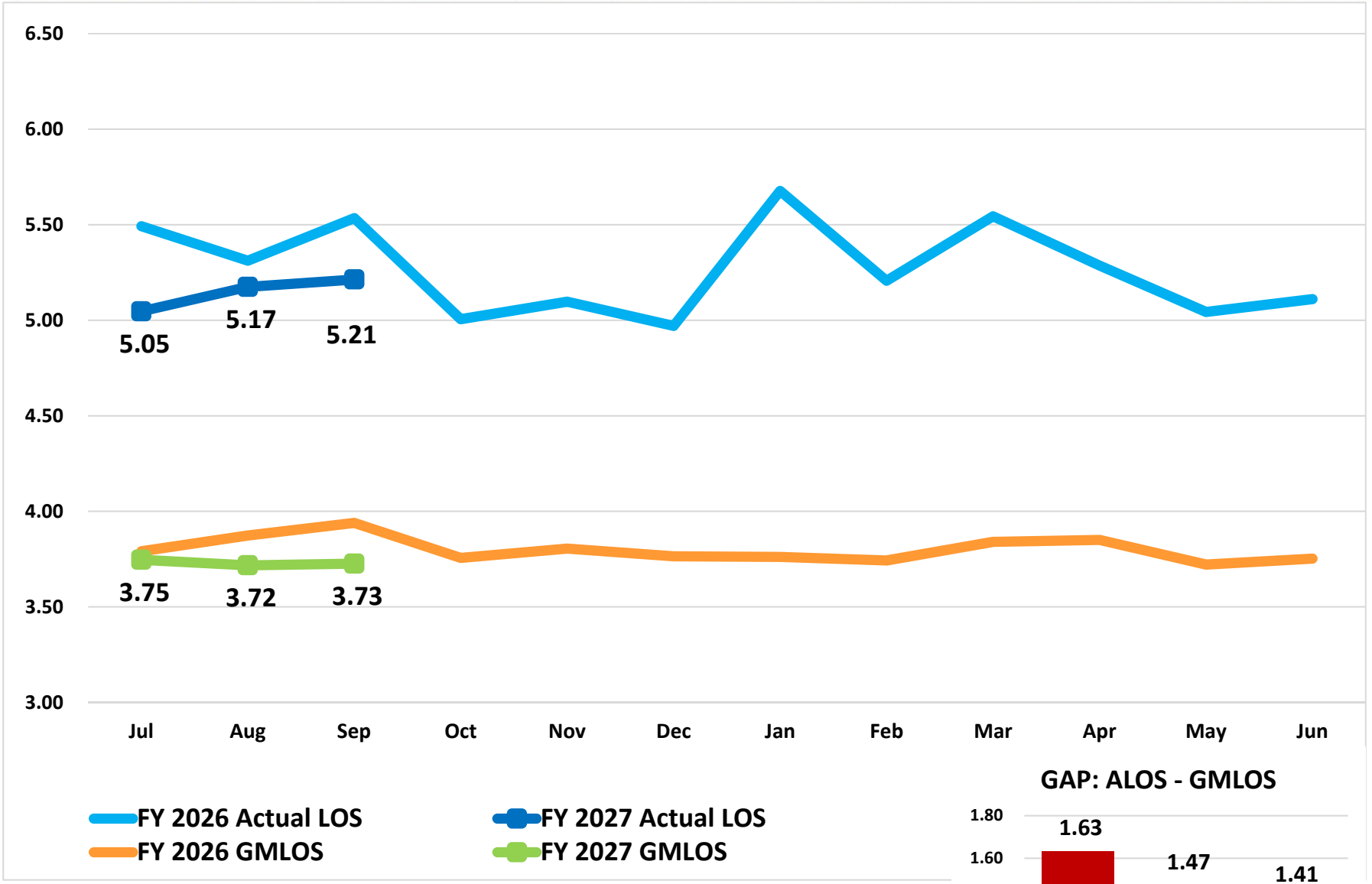
Productivity Measure : Worked Hours/ Adj. Patient Days



Overtime as a % of Productive Hours



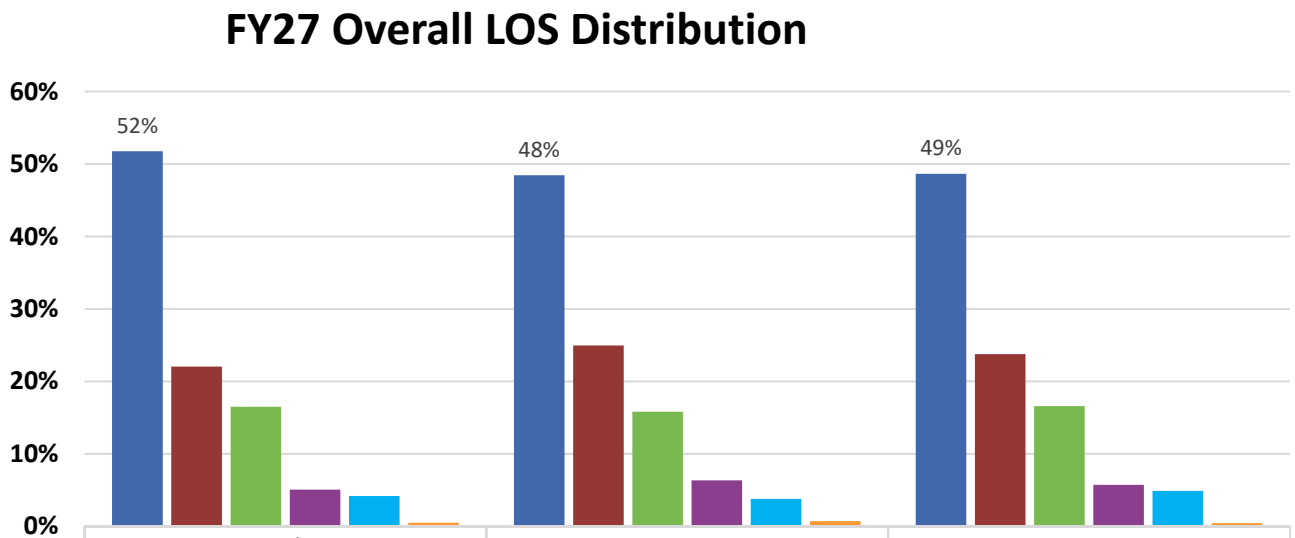
Average Length of Stay versus National Average (GMLOS)



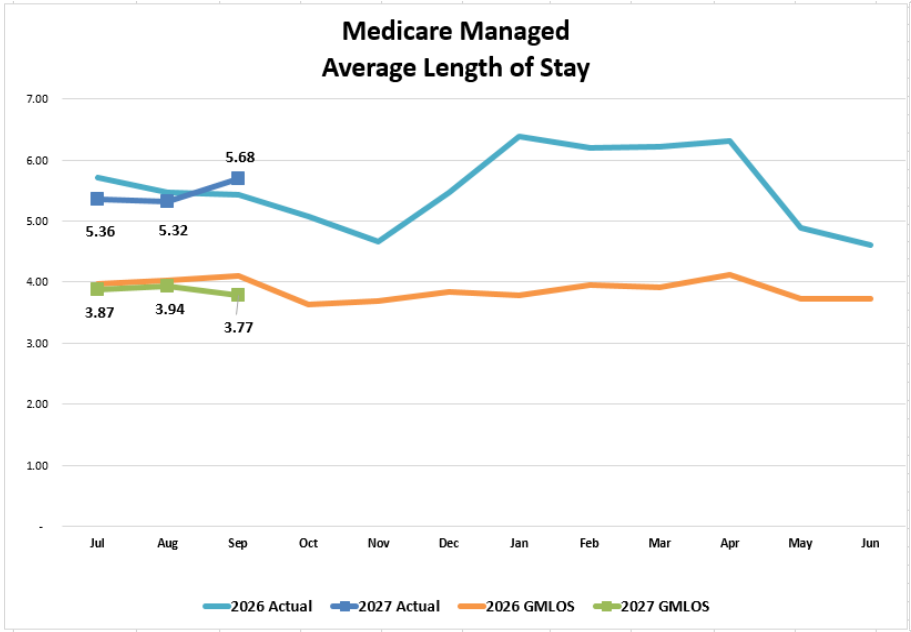
Average Length of Stay versus National Average (GMLOS)

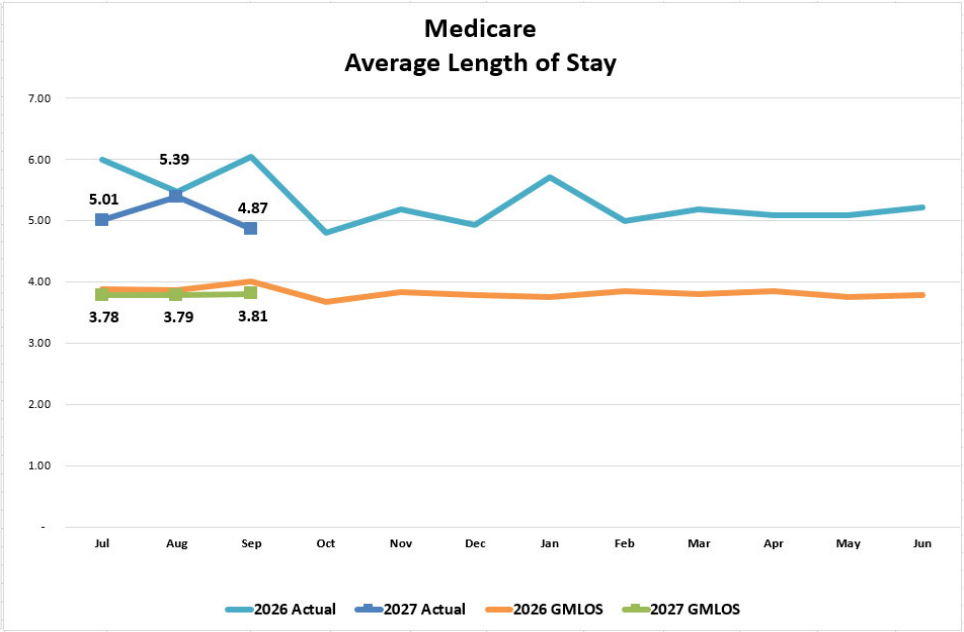
	ALOS	GMLOS	GAP
Jul-24	5.77	4.02	1.75
Aug-24	5.74	3.95	1.79
Sep-24	5.39	3.88	1.51
Oct-24	5.72	4.01	1.71
Nov-24	5.23	3.87	1.37
Dec-24	5.68	3.94	1.74
Jan-25	6.16	4.04	2.12
Feb-25	5.36	3.92	1.43
Mar-25	5.46	3.80	1.66
Apr-25	5.68	3.80	1.89
May-25	5.15	3.78	1.37
Jun-25	5.14	3.85	1.29
Jul-25	5.49	3.79	1.70
Aug-25	5.31	3.87	1.44
Sep-25	5.53	3.94	1.59
Oct-25	5.01	3.76	1.25
Nov-25	5.10	3.80	1.29
Dec-25	4.97	3.76	1.21
Jan-26	5.68	3.76	1.92
Feb-26	5.21	3.74	1.46
Mar-26	5.54	3.84	1.70
Apr-26	5.29	3.85	1.44
May-26	5.04	3.72	1.32
Jun-26	5.11	3.75	1.36
Jul-26	5.05	3.75	1.30
Aug-26	5.17	3.72	1.46
Sep-26	5.21	3.73	1.49

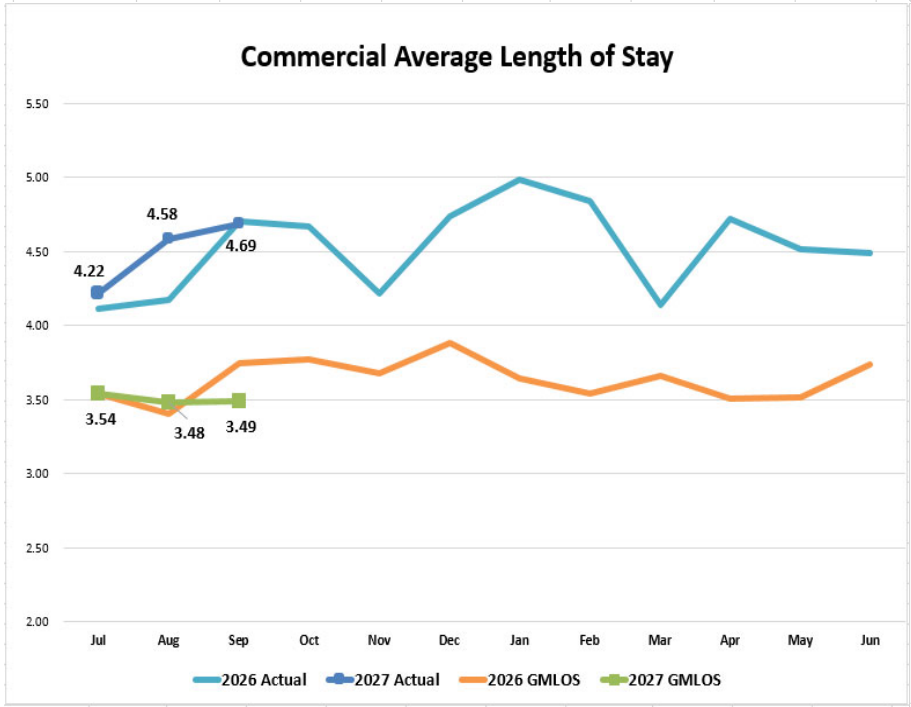
Average Length of Stay Distribution

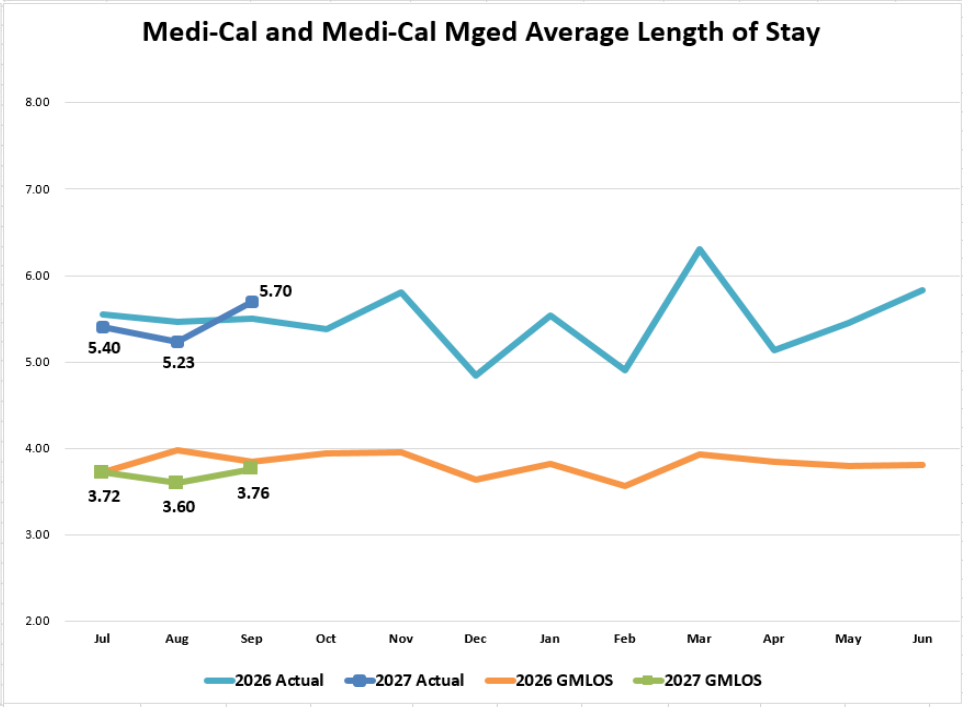


	Jul	Aug	Sep
at GMLOS or Better	52%	48%	49%
1-2 days over GMLOS	22%	25%	24%
2-6 days over GMLOS	16%	16%	17%
6-10 days over GMLOS	5%	6%	6%
10-30 days over GMLOS	4%	4%	5%
30+ days over GMLOS	0.5%	0.7%	0.4%

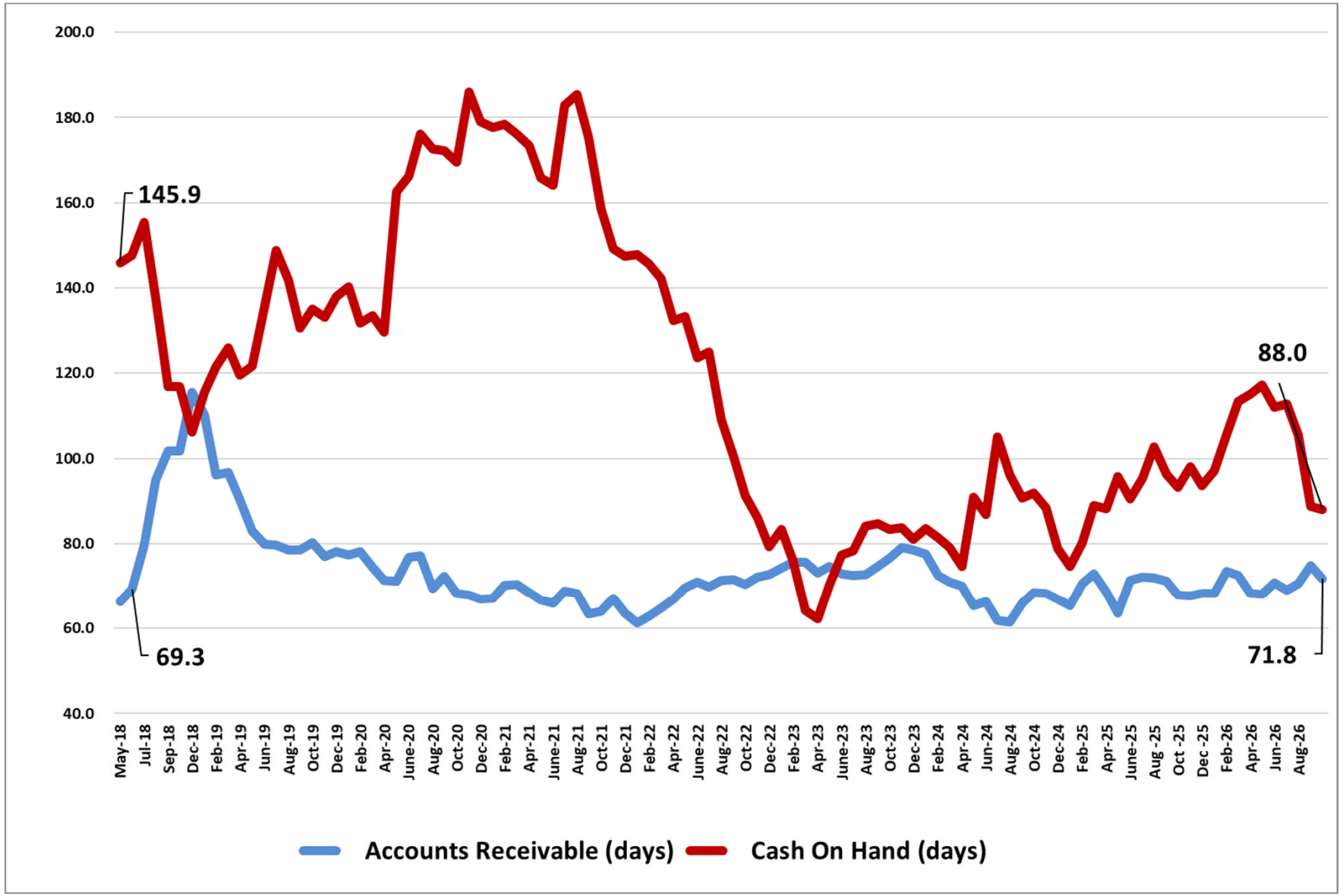

Medicare Managed
Average Length of Stay
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.68
5.36
5.32
3.87
3.94
3.77
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2026 Actual
2027 Actual
2026 GMLOS
2027 GMLOS


Medicare
Average Length of Stay
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.39
5.01
4.87
3.78
3.79
3.81
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2026 Actual
2027 Actual
2026 GMLOS
2027 GMLOS


Commercial Average Length of Stay
5.50
5.00
4.50
4.00
3.50
3.00
2.50
2.00
4.58
4.69
4.22
3.54
3.48
3.49
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2026 Actual
2027 Actual
2026 GMLOS
2027 GMLOS


Medi-Cal and Medi-Cal Mged Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
5.70
5.40
5.23
3.72
3.60
3.76
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2026 Actual
2027 Actual
2026 GMLOS
2027 GMLOS

Trended Liquidity Ratios



Ratio Analysis Report

SEPTEMBER 30, 2026

	Current Month Value	Prior Month Value	June 30, 2026 Unaudited Value	2025 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.9	2.9	2.3	1.5	**1.9**	1.7
Accounts Receivable (days)	71.8	74.8	69.0	45.1	**46.3**	45.1
Cash On Hand (days)	88.0	88.9	112.8	280.4	**190.7**	116.9
Cushion Ratio (x)	10.7	10.7	13.4	46.6	**26.1**	15.9
Average Payment Period (days)	50.1	49.2	52.3	72.7	**61.4**	60.3
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	123.0%	122.8%	150.2%	307.7%	**188.7%**	112.8%
Debt-To-Capitalization	28.6%	28.4%	29.3%	19.7%	**28.5%**	37.9%
Debt-to-Cash Flow (x)	2.6	2.3	3.6	1.9	**3.1**	5.2
Debt Service Coverage	3.7	4.2	2.6	8.8	**5.4**	3.0
Maximum Annual Debt Service Coverage (x)	2.9	3.3	2.1	7.8	**4.7**	2.8
Age Of Plant (years)	14.9	14.2	14.0	10.9	**13.2**	15.2
PROFITABILITY RATIOS						
Operating Margin	1.1%	(.5%)	(.5%)	3.6%	**1.6%**	0.1%
Excess Margin	3.0%	3.7%	0.9%	7.1%	**4.0%**	1.5%
Operating Cash Flow Margin	5.5%	4.2%	4.3%	8.0%	**6.1%**	4.1%
Return on Assets	3.3%	4.1%	1.0%	5.4%	**3.8%**	1.5%

Consolidated Statements of Net Position (000's)

	Sep-26	Jun-26 (Pre-audited)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 16,011	$ 12,466
Current Portion of Board designated and trusted assets	22,266	$ 18,698
Accounts receivable:		
Net patient accounts	167,437	$ 167,825
Other receivables	53,900	$ 24,789
	221,337	192,614
Inventories	15,717	$ 15,342
Medicare and Medi-Cal settlements	97,829	$ 70,424
Prepaid expenses	12,975	$ 8,633
Total current assets	386,136	318,177
NON-CURRENT CASH AND INVESTMENTS - less current portion		
Board designated cash and assets	207,647	$ 271,267
Assets in self-insurance trust fund	-	$ 73
Total non-current cash and investments	207,647	271,340
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	17,627	$ 18,682
INTANGIBLE RIGHT TO USE SBITA, net of accumulated amortization	9,271	$ 10,459
CAPITAL ASSETS		
Land	17,542	$ 17,542
Buildings and improvements	449,891	$ 447,821
Equipment	349,428	$ 348,824
Construction in progress	19,572	$ 16,909
	836,433	831,096
Less accumulated depreciation	571,839	$ 564,708
	264,594	266,388
OTHER ASSETS		
Property not used in operations	5,105	$ 5,115
Health-related investments	1,972	$ 2,308
Net Pension Asset	6,700	$ 4,590
Other	22,394	$ 22,251
Total other assets	36,171	34,264
Total assets	921,446	919,310
DEFERRED OUTFLOWS	11,653	$ 11,984
Total assets and deferred outflows	**$ 933,099**	**$ 931,294**

Consolidated Statements of Net Position (000's)

	Sep-26	Jun-26
LIABILITIES AND NET ASSETS		**(Pre-audited)**
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 34,381	$ 37,231
Accrued payroll and related liabilities	77,538	$ 73,947
SBITA liability, current portion	3,298	$ 3,298
Lease liabiilty, current portion	3,727	$ 3,727
Bonds payable, current portion	13,629	$ 13,454
Notes payable, current portion	384	$ 3,841
Financing Lease Liability, current portion	499	$ 499
Total current liabilities	133,456	135,997
LEASE LIABILITY, net of current portion	14,658	$ 15,671
SBITA LIABILITY, net of current portion	4,098	$ 4,639
LONG-TERM DEBT, less current portion		
Bonds payable	185,340	$ 188,085
Financing Lease payable	2,528	$ 2,614
Notes payable	15,755	$ 16,907
Total long-term debt	203,622	207,606
OTHER LONG-TERM LIABILITIES	57,560	$ 55,624
Total liabilities	413,394	419,537
DEFERRED INFLOW OF RESOURCES	27,763	27,763
NET ASSETS		
Invested in capital assets, net of related debt	64,446	$ 63,683
Restricted	44,640	$ 42,496
Unrestricted	382,857	$ 377,816
Total net position	491,944	$ 483,994
Total liabilities, deferred inflows, and net position	**$ 933,099**	**$ 931,294**

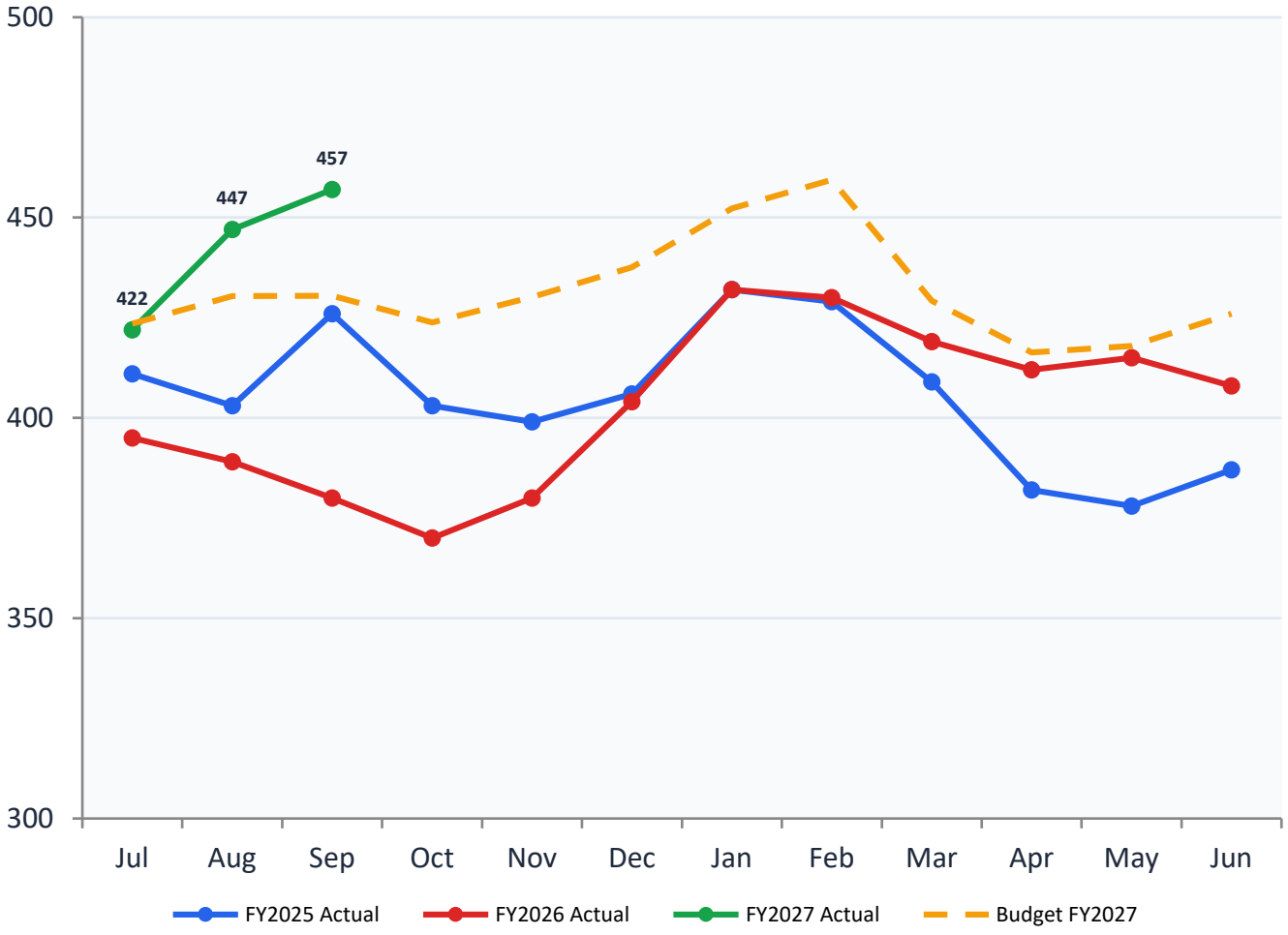
Monthly Statistics Report

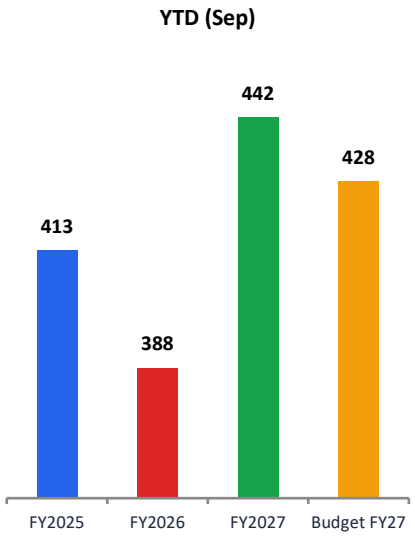
FY2025 – FY2027 Actuals | Budget FY2027

Kaweah Health

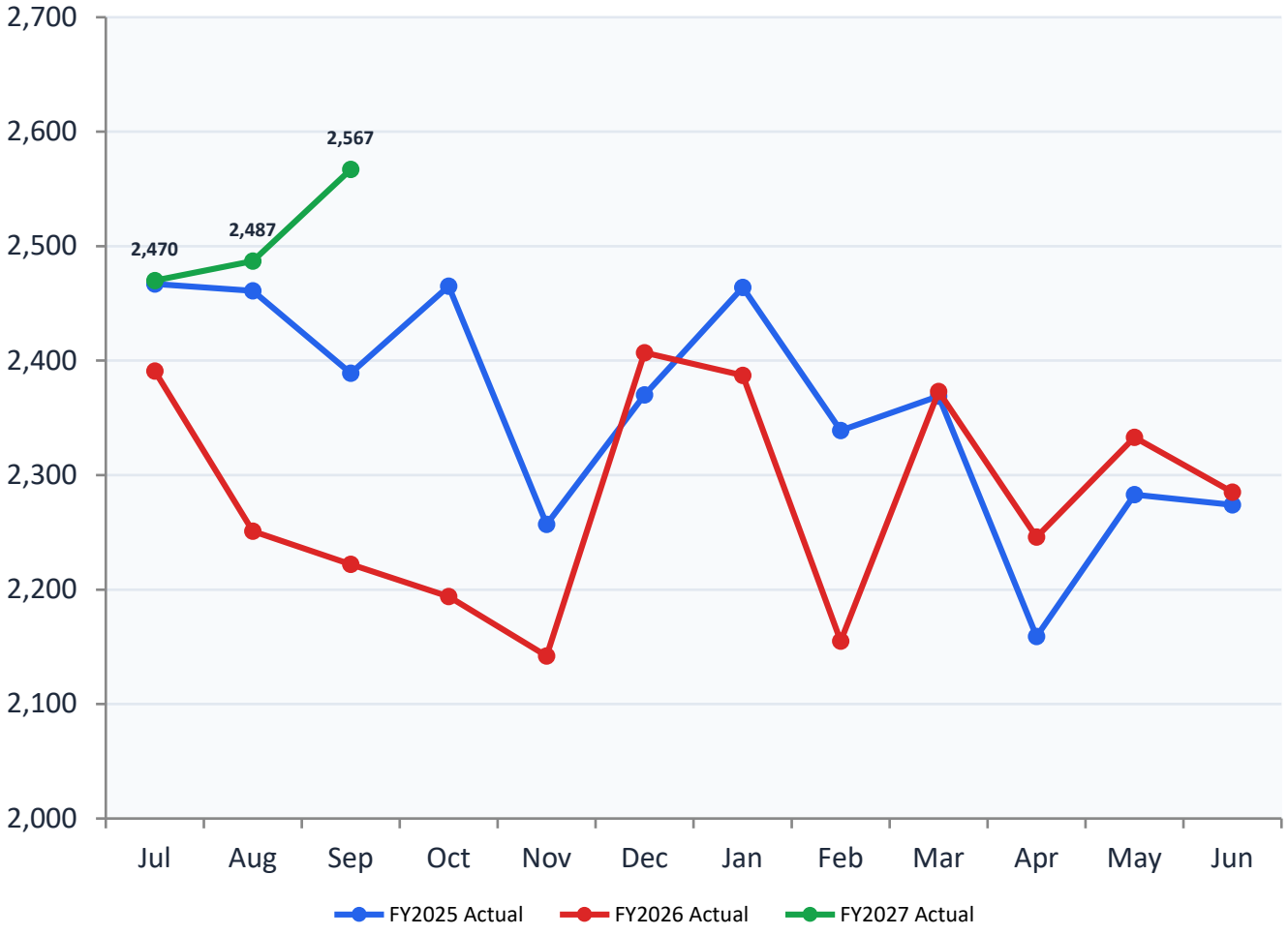
September 2026

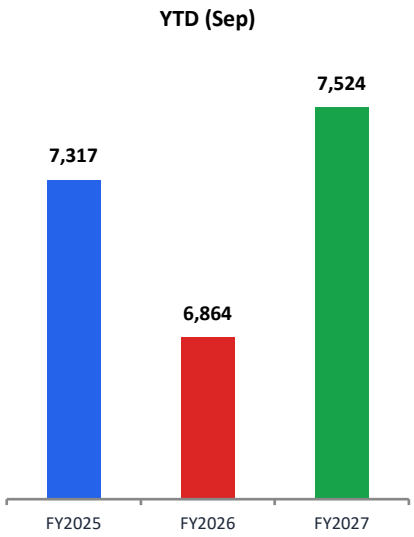
Average Daily Census



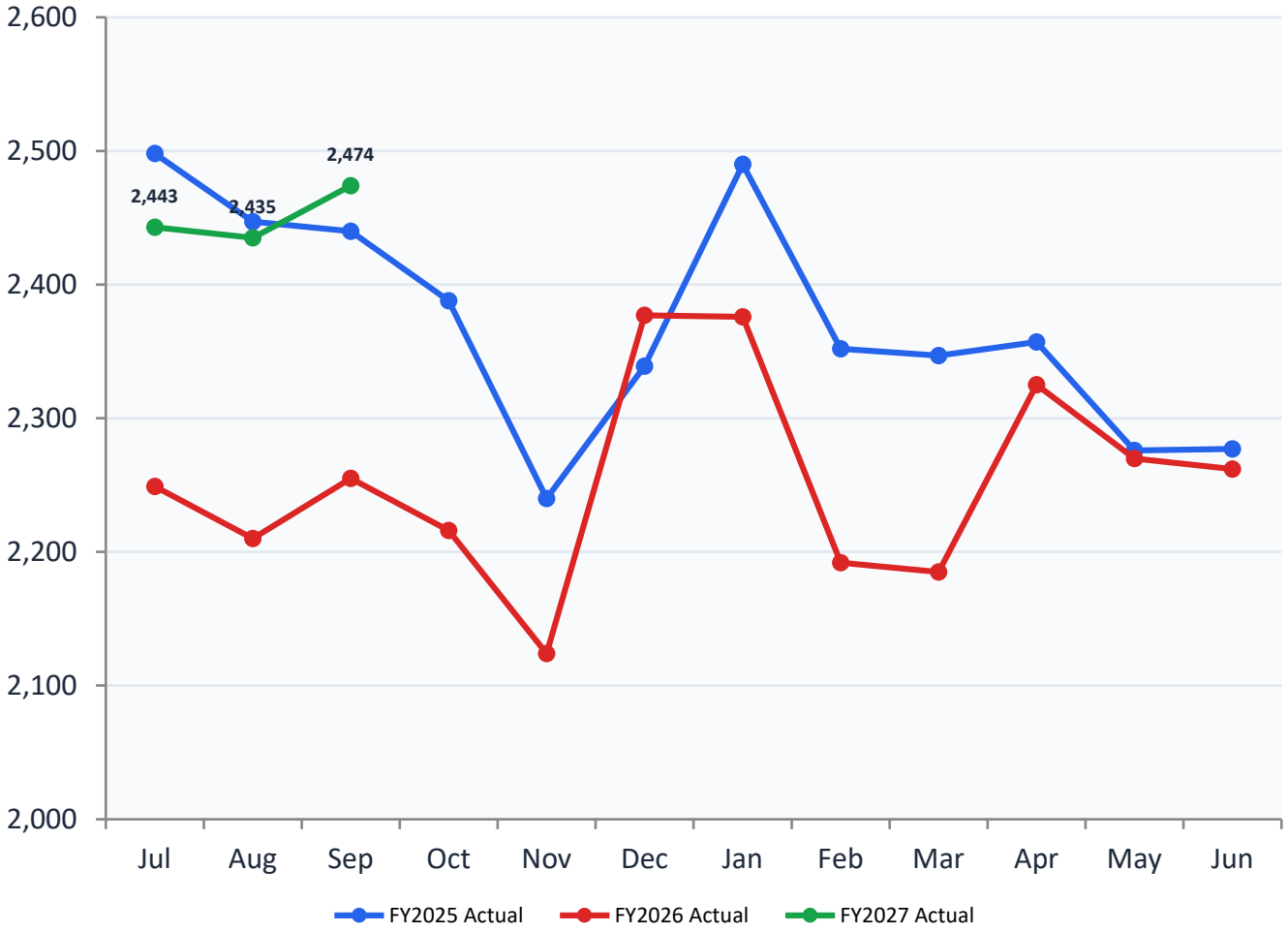


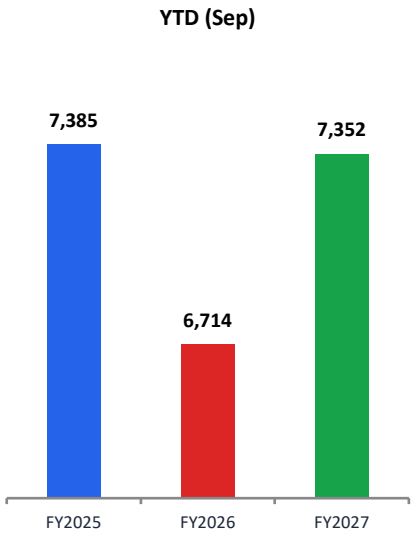
Admissions


2,700
2,600
2,500
2,400
2,300
2,200
2,100
2,000
2,470
2,487
2,567
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2025 Actual
FY2026 Actual
FY2027 Actual

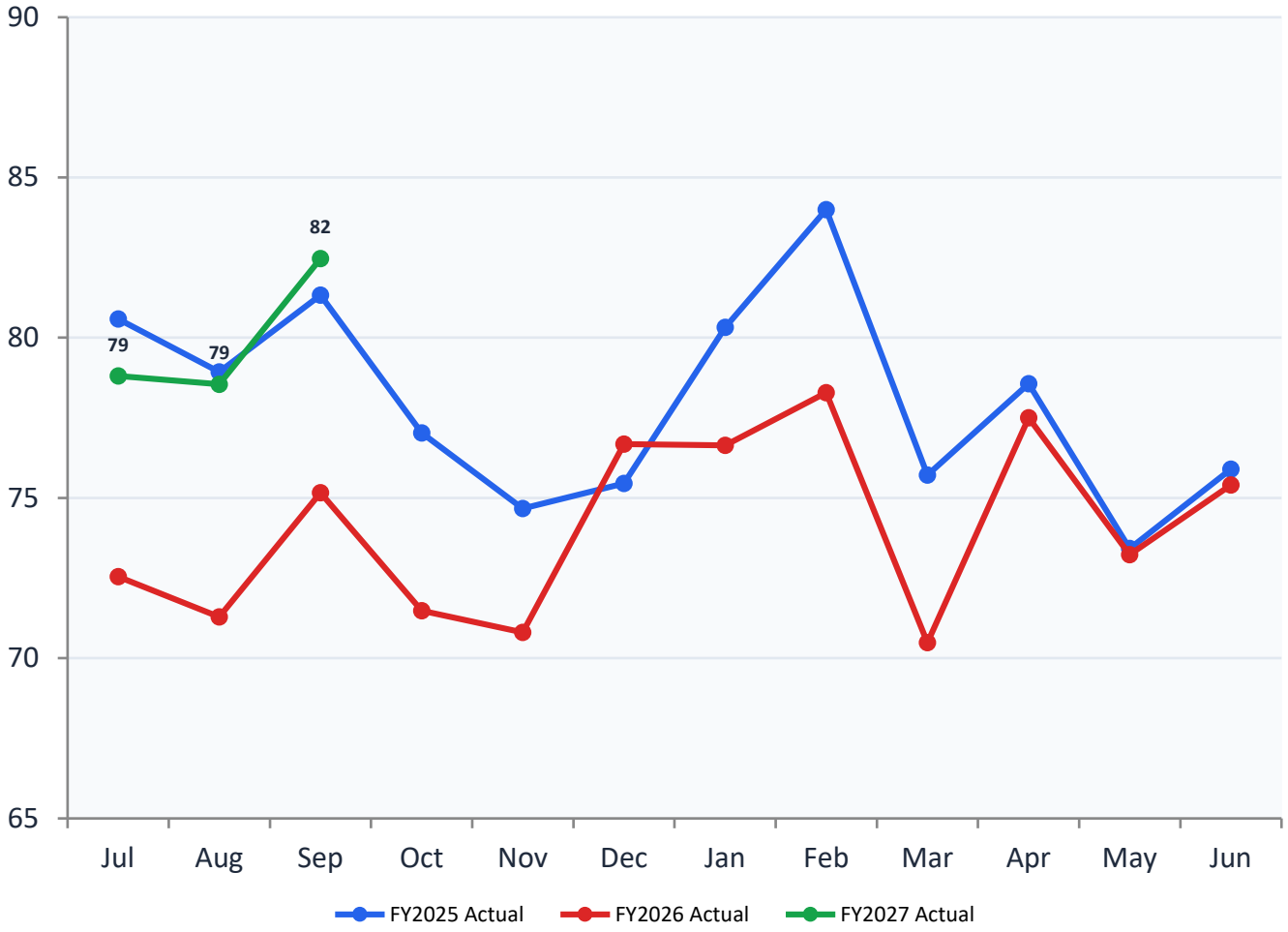

YTD (Sep)
7,317
6,864
7,524
FY2025
FY2026
FY2027

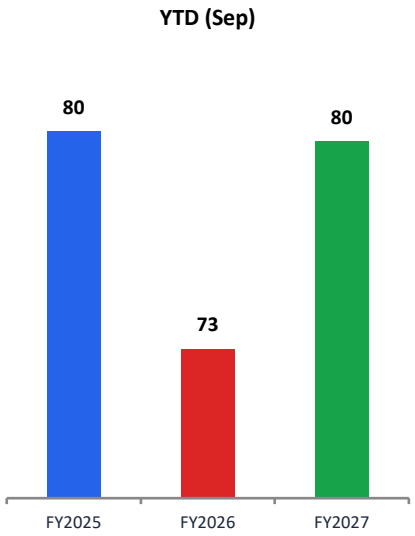
Discharges


2,600
2,500
2,400
2,300
2,200
2,100
2,000
2,443
2,435
2,474
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2025 Actual
FY2026 Actual
FY2027 Actual

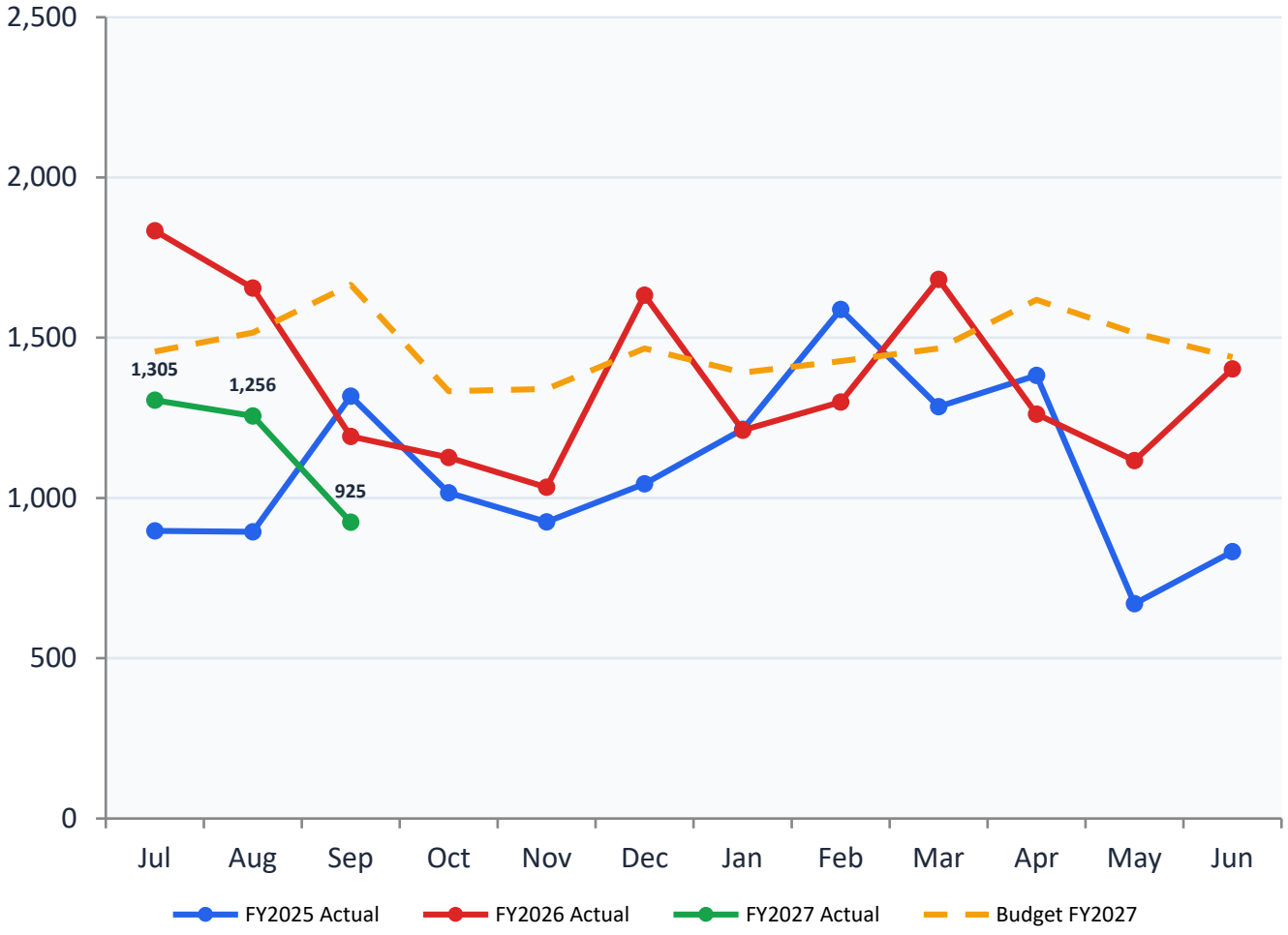

YTD (Sep)
7,385
6,714
7,352
FY2025
FY2026
FY2027

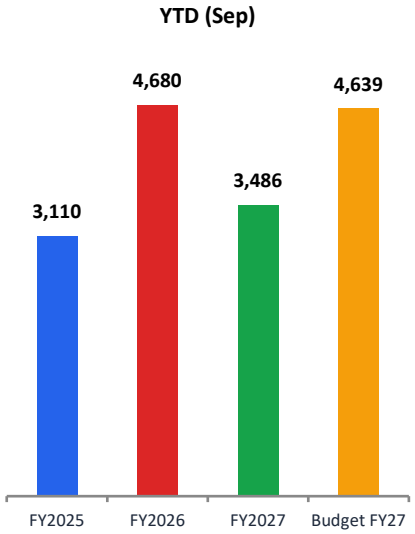
Avg Discharges per day



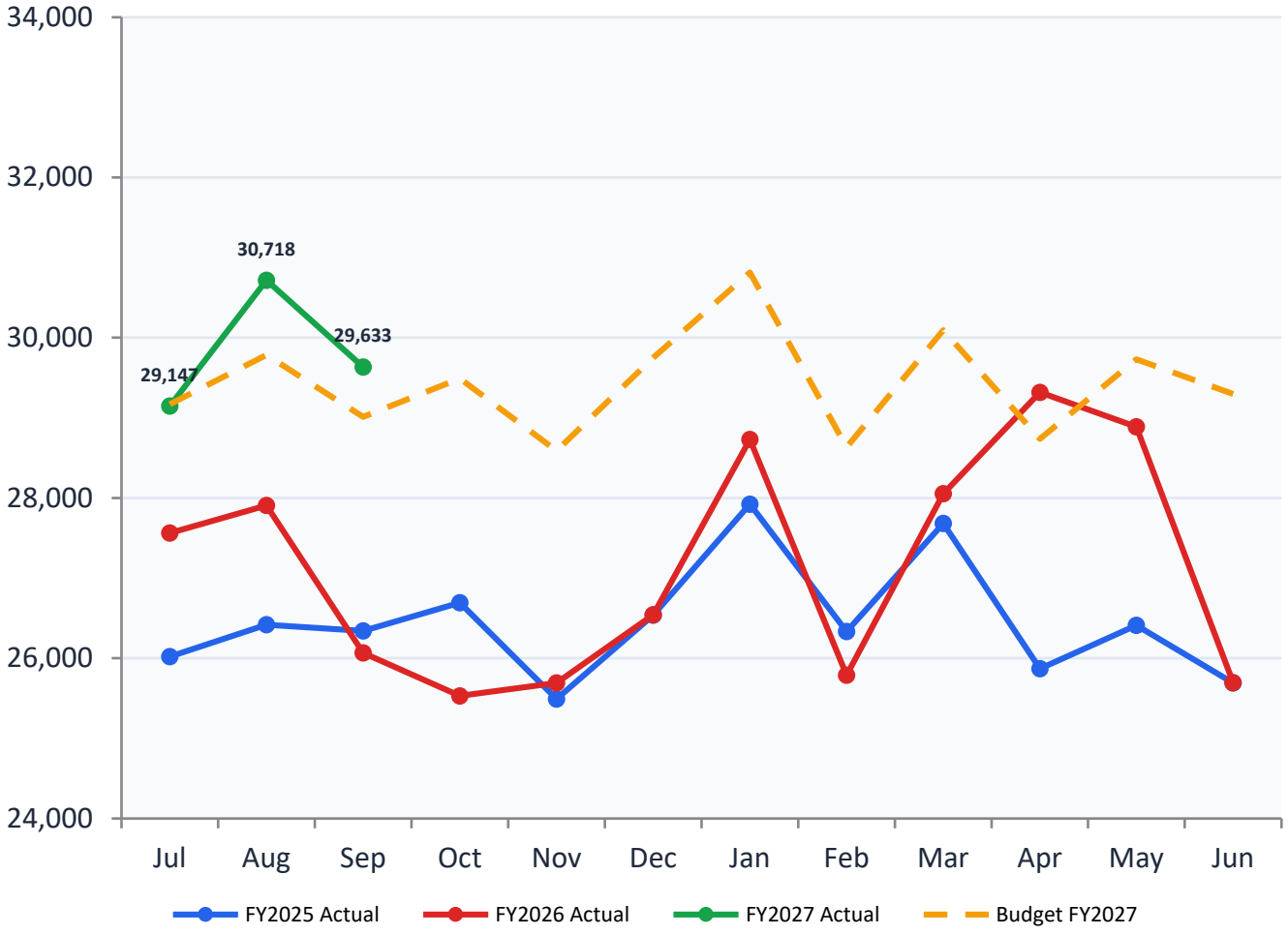


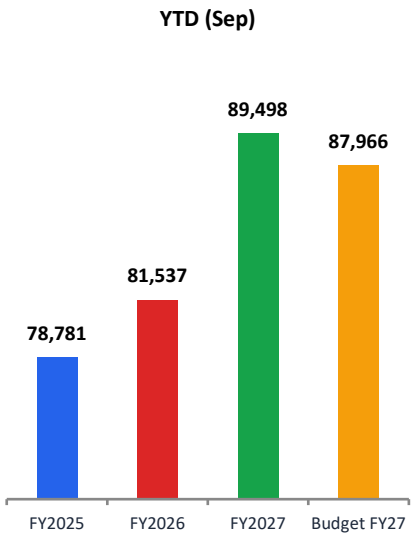
Observation Days



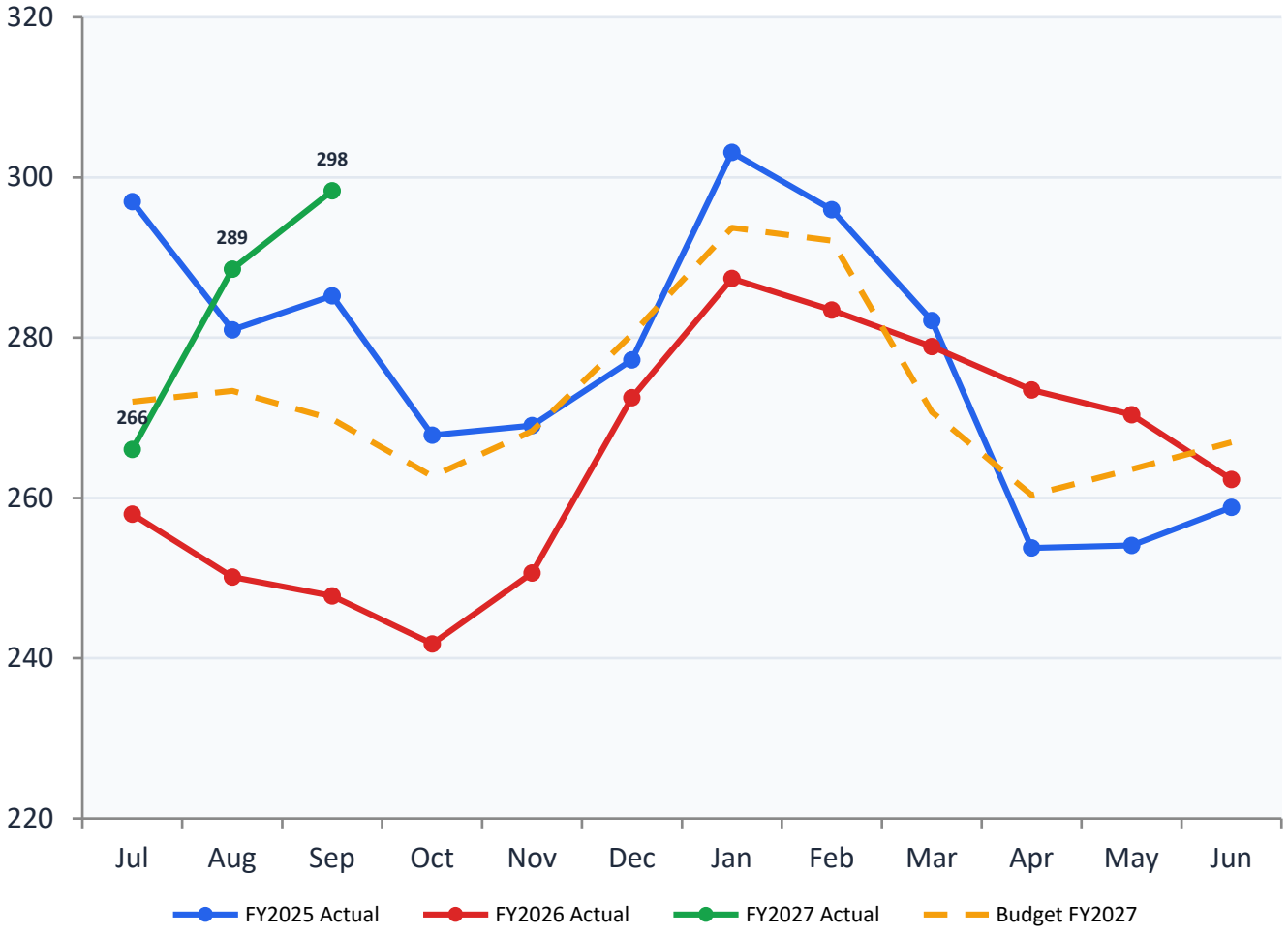


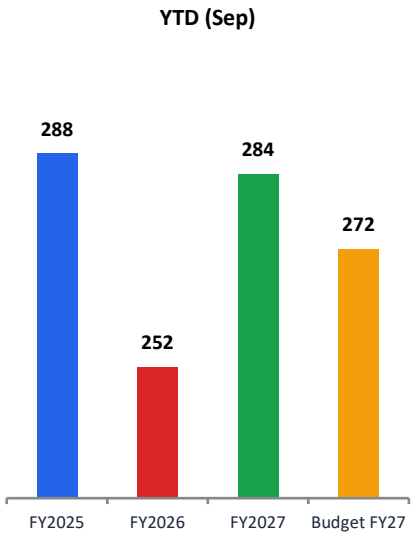
Adjusted Patient Days



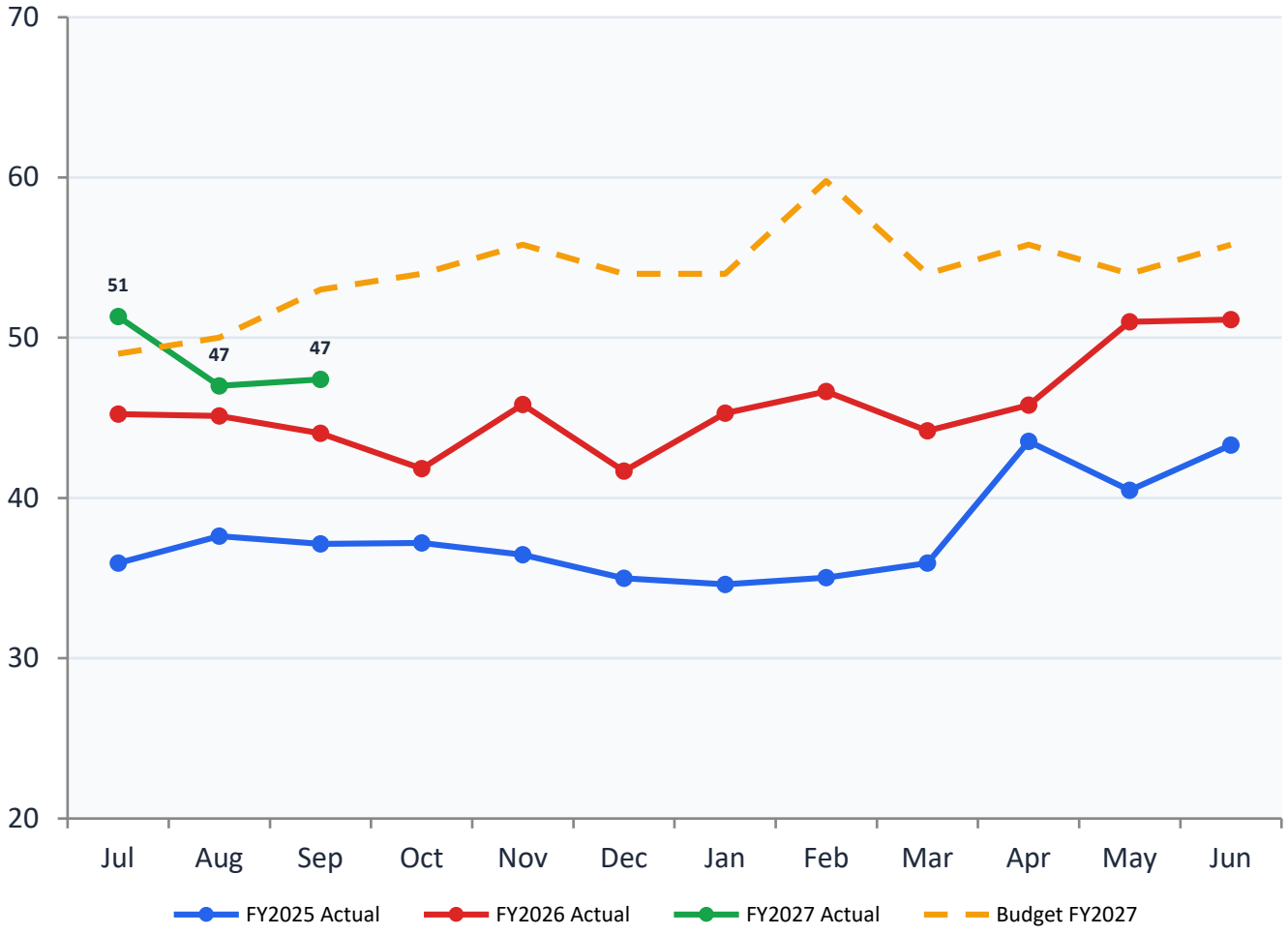


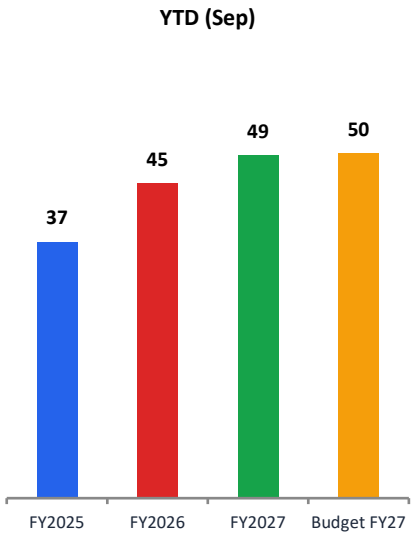
Medical Center (Avg Patients Per Day)



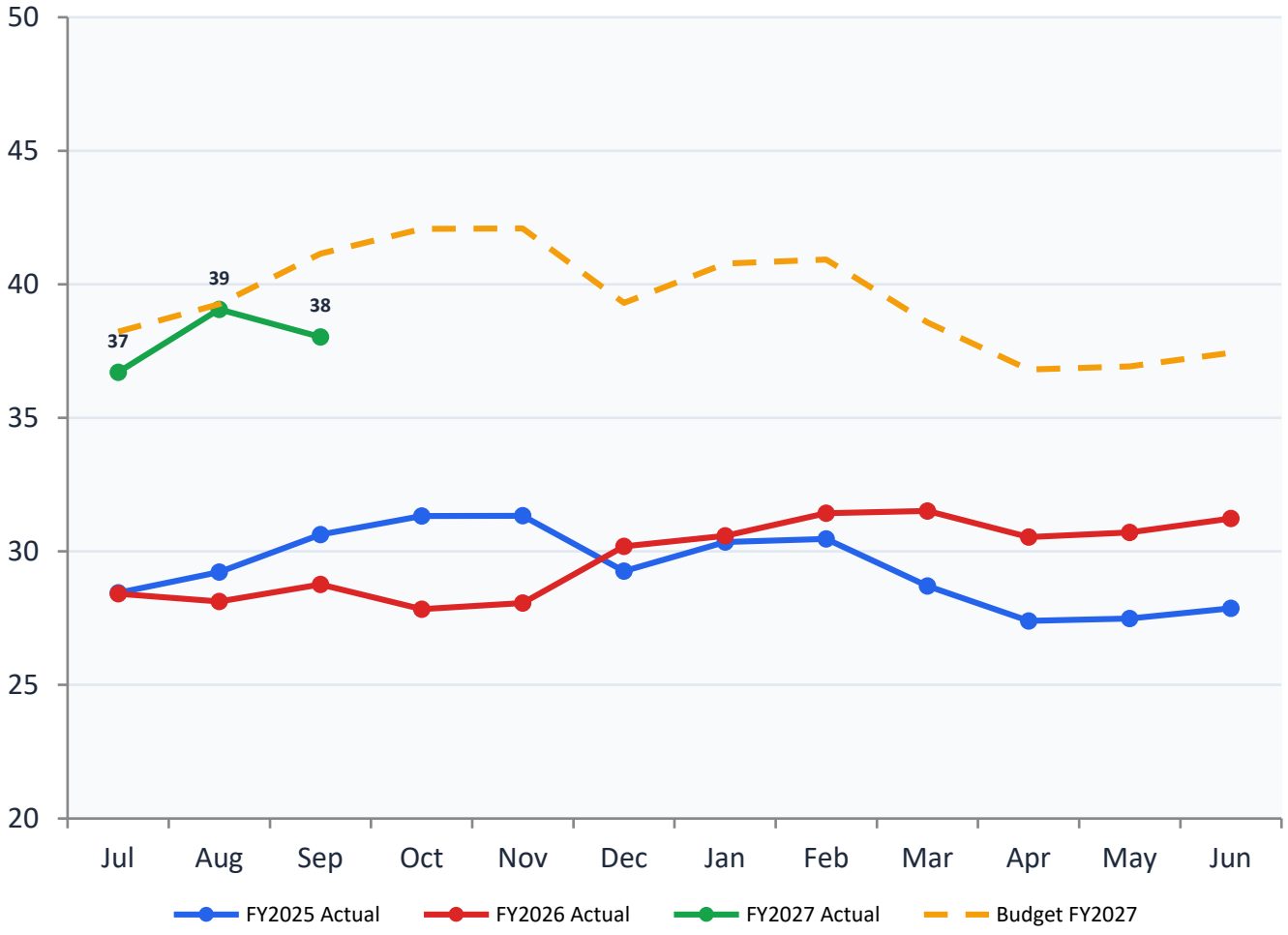


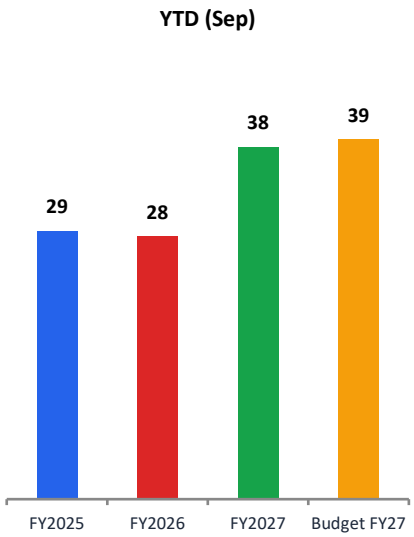
Acute I/P Psych (Avg Patients Per Day)



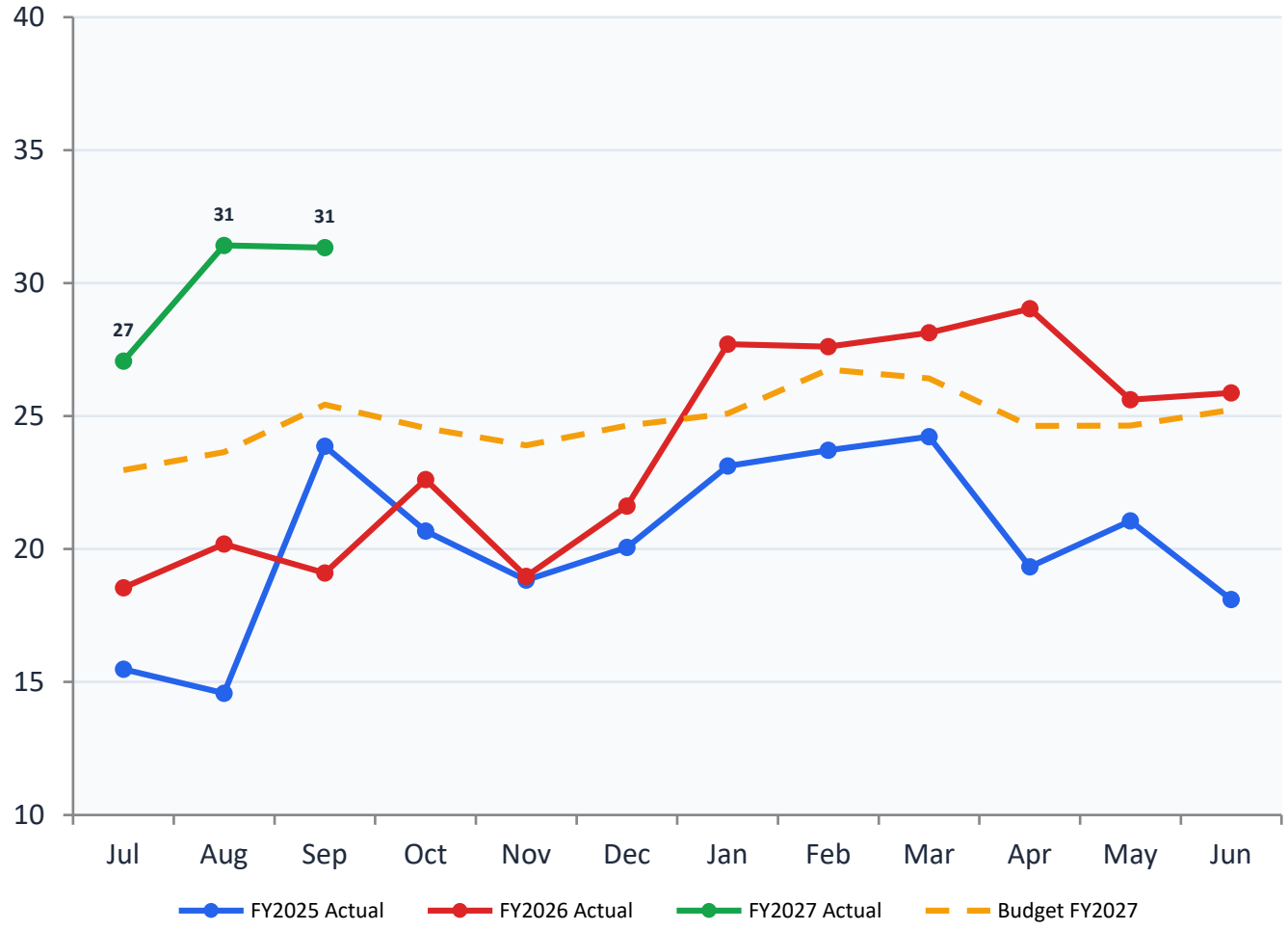


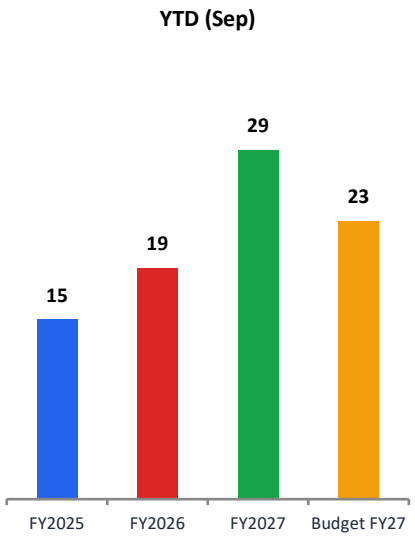
Sub-Acute - (Avg Patients Per Day)



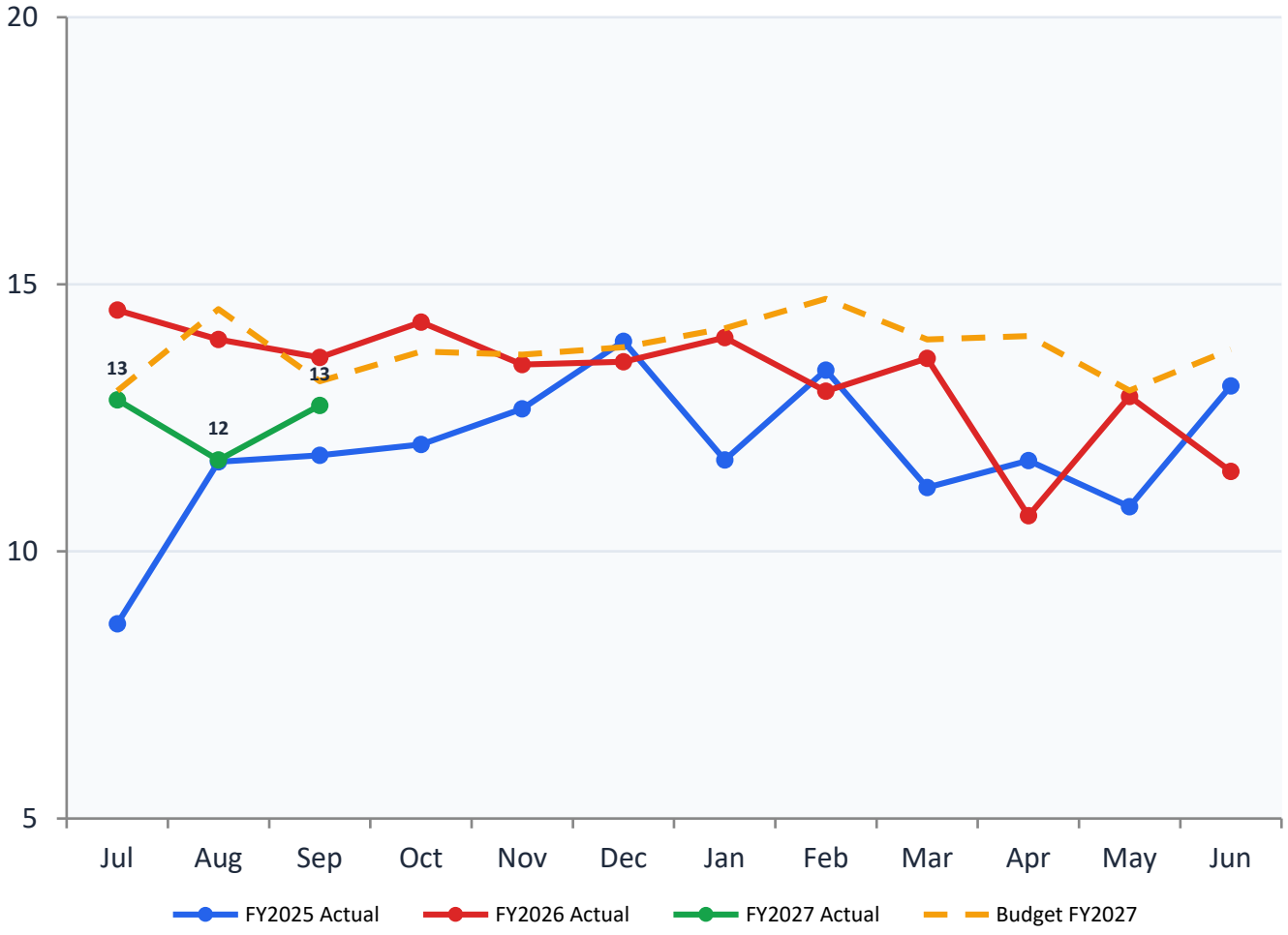


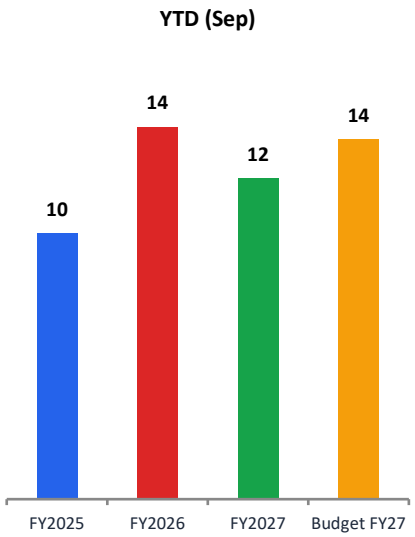
Rehabilitation Hospital - (Avg Patients Per Day)



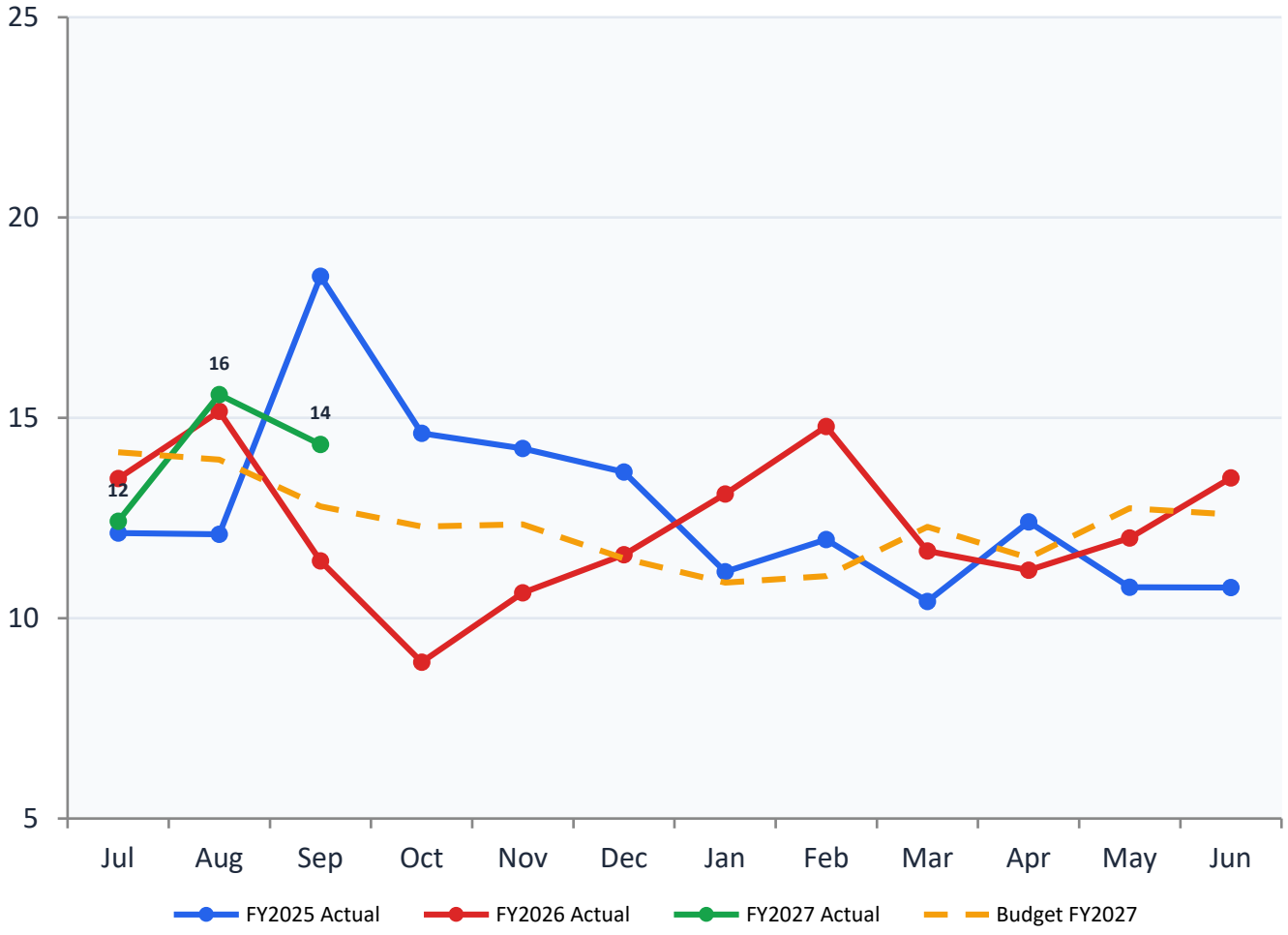


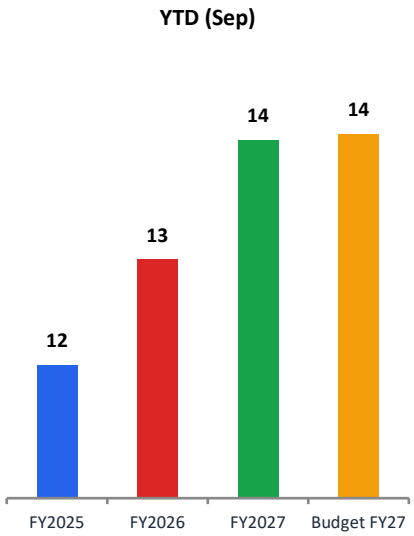
TCS Ortho - (Avg Patients Per Day)



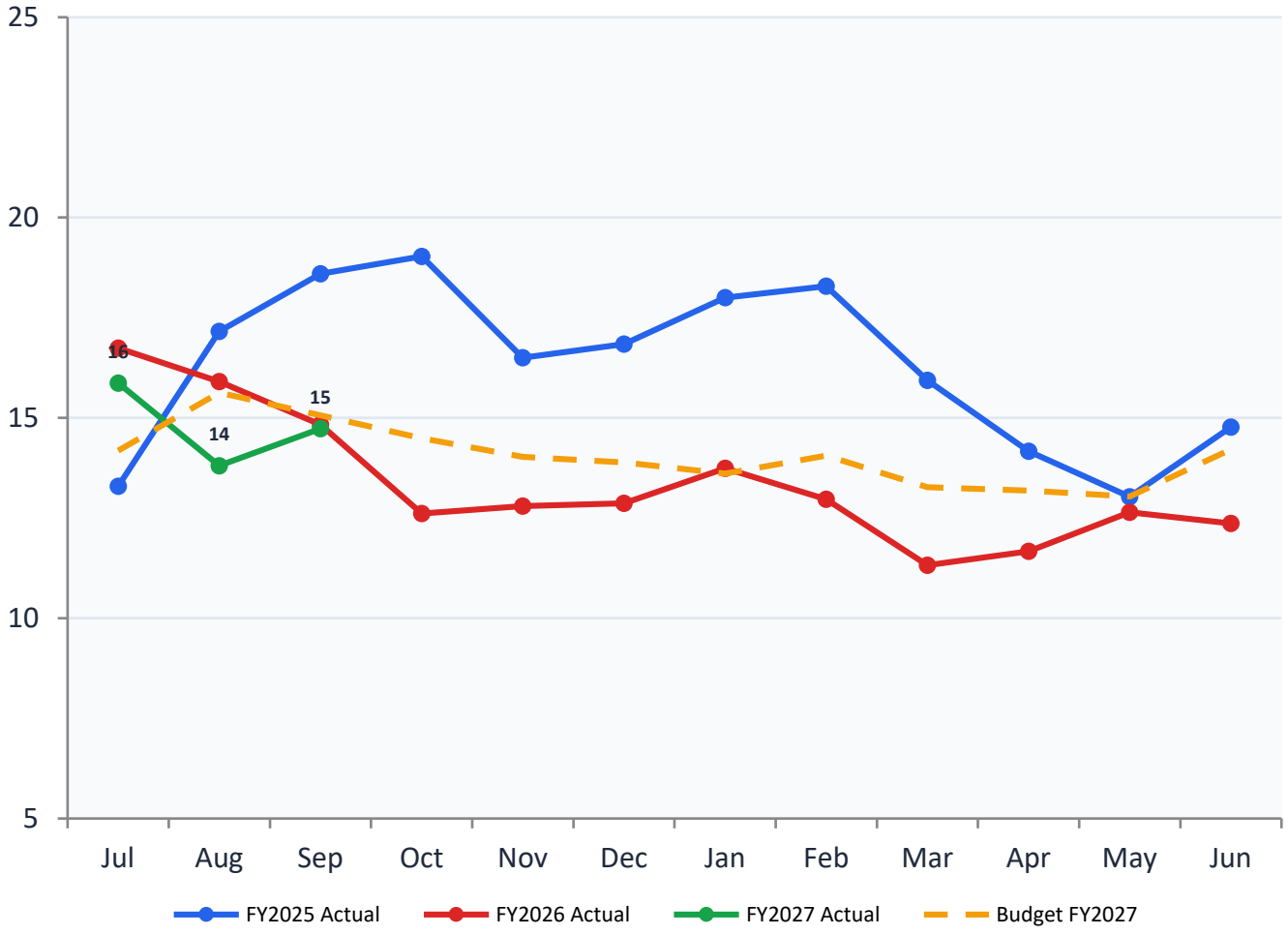


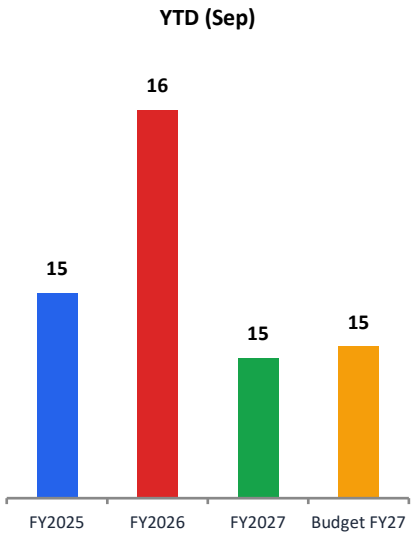
NICU - (Avg Patients Per Day)



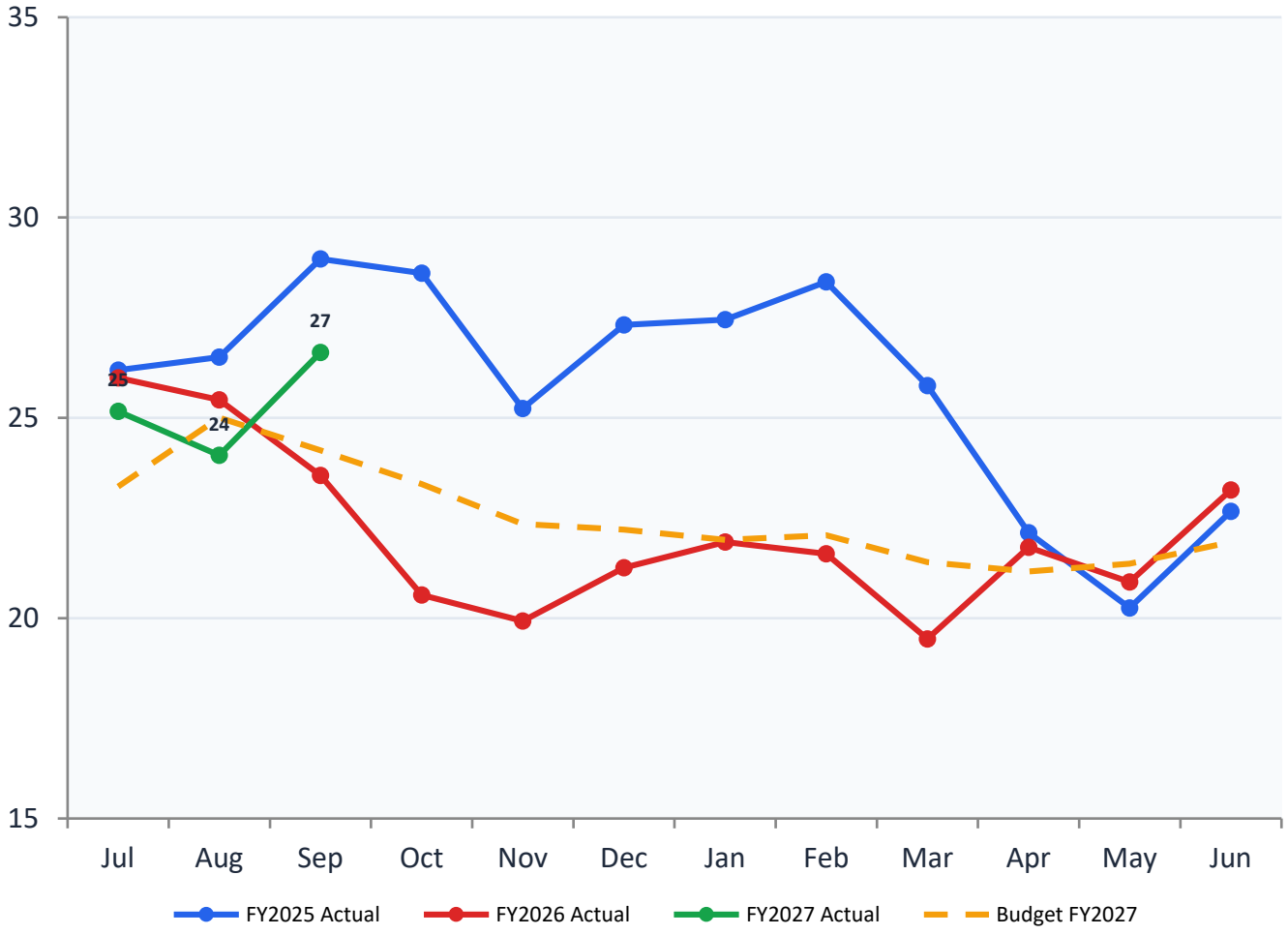


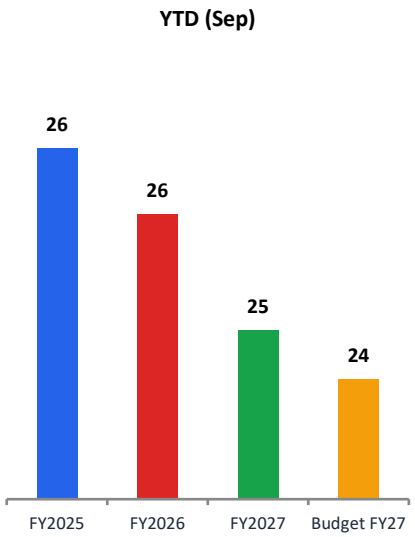
Nursery - (Avg Patients Per Day)



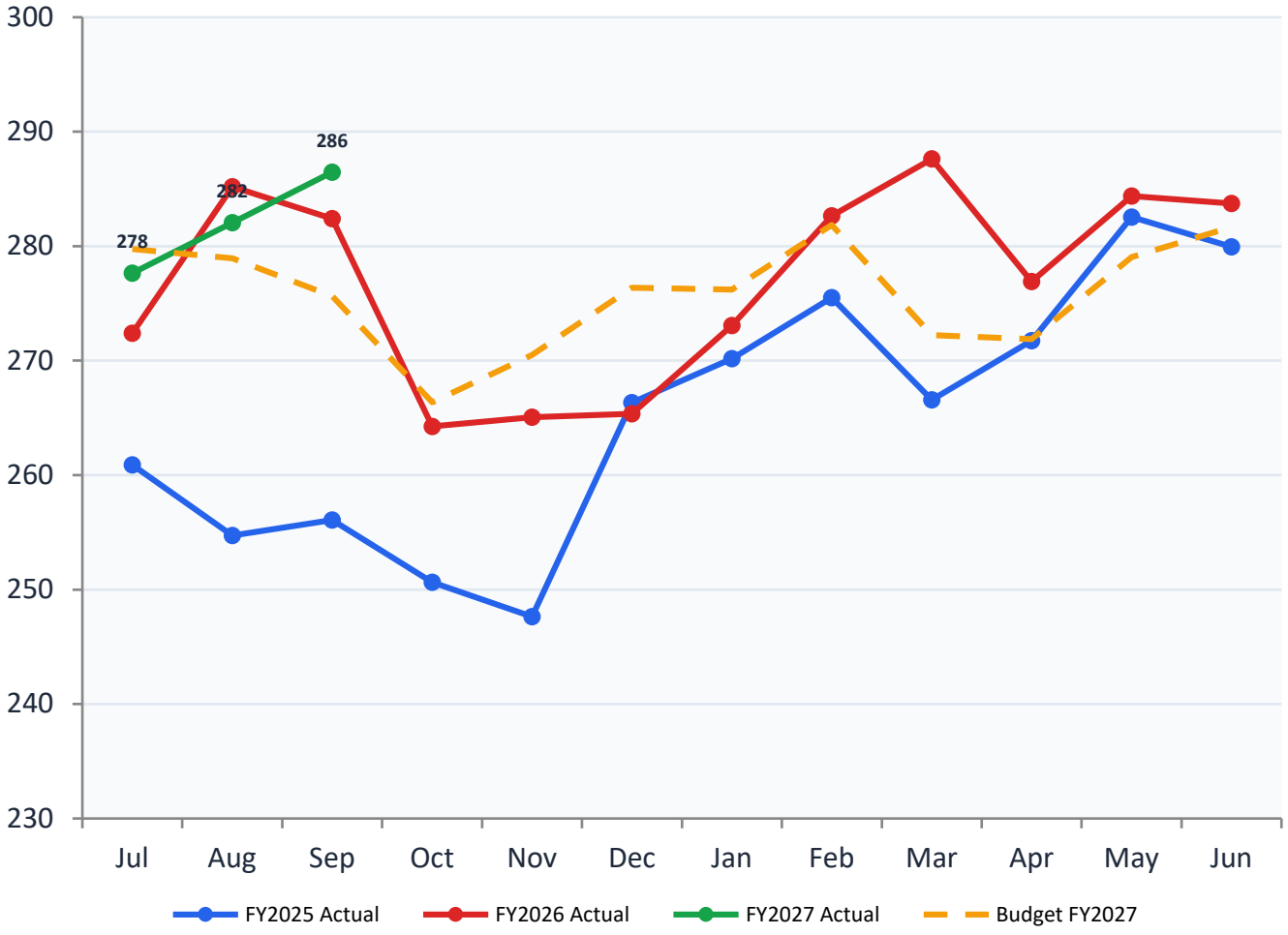


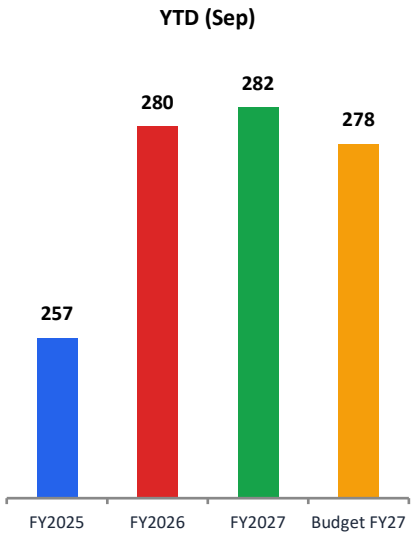
Obstetrics - (Avg Patients Per Day)



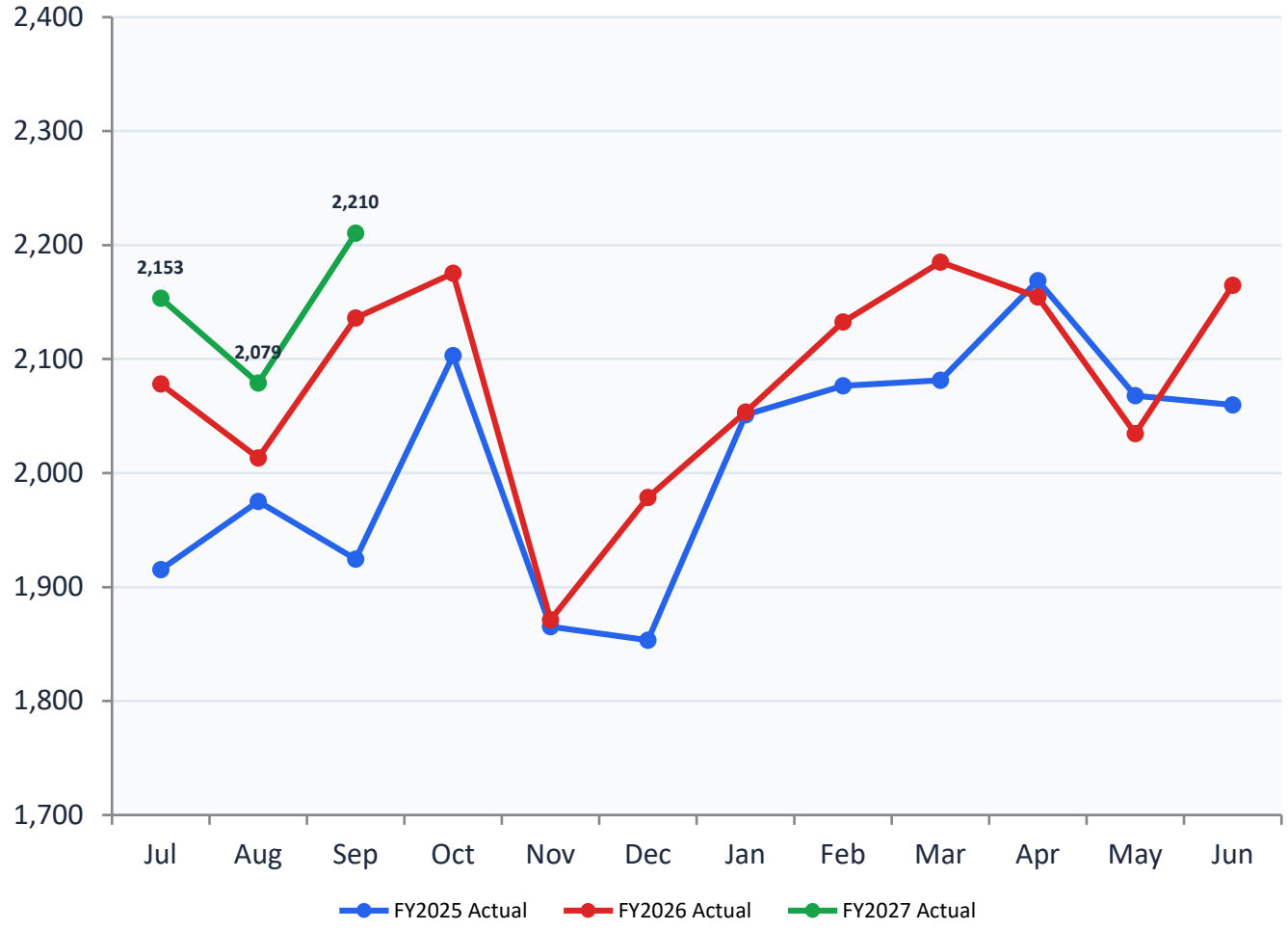


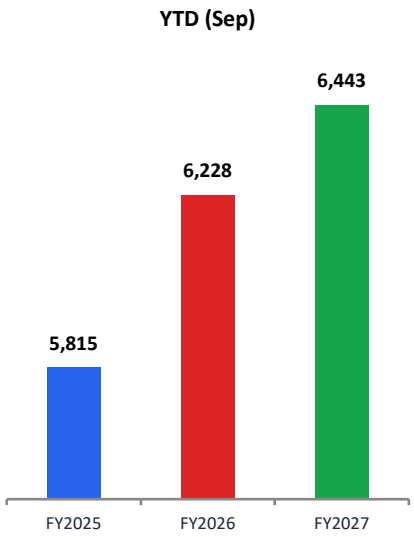
ED - (Avg Treated Per Day)



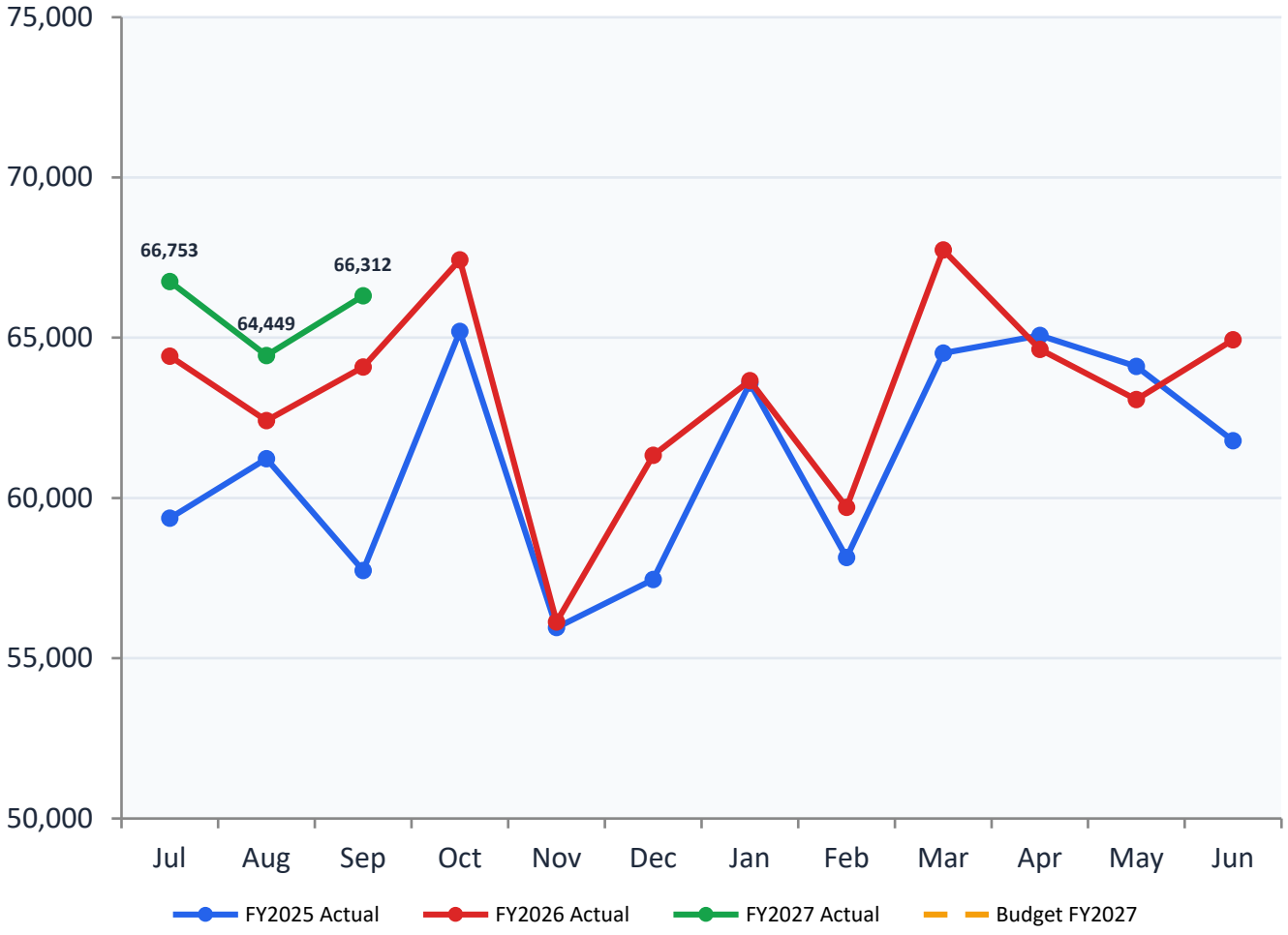


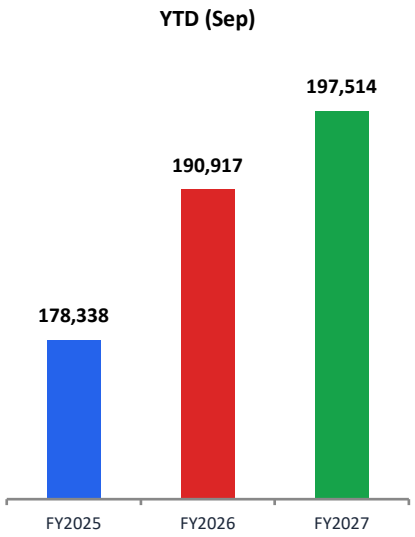
Outpatient Registrations Per Day



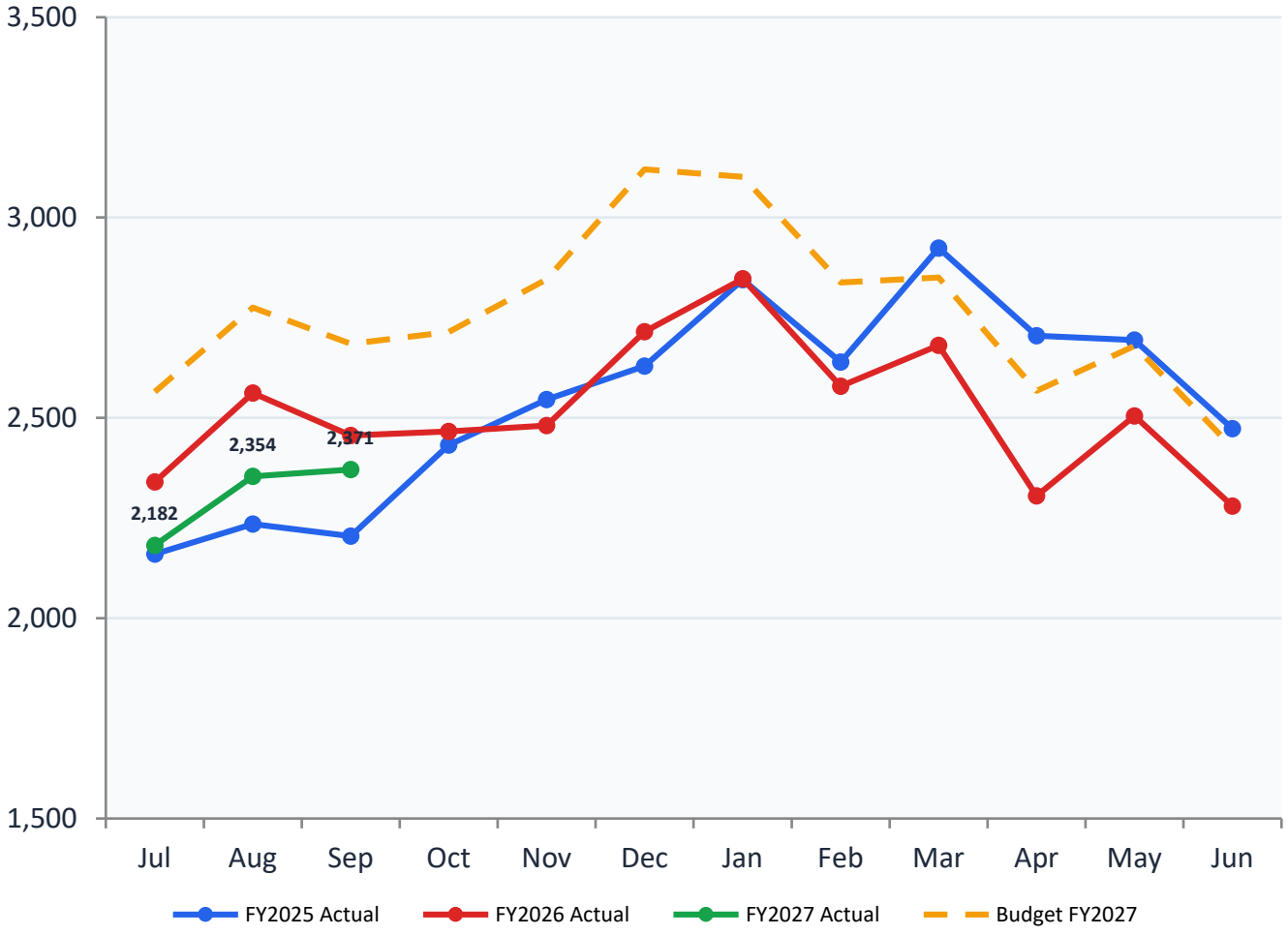


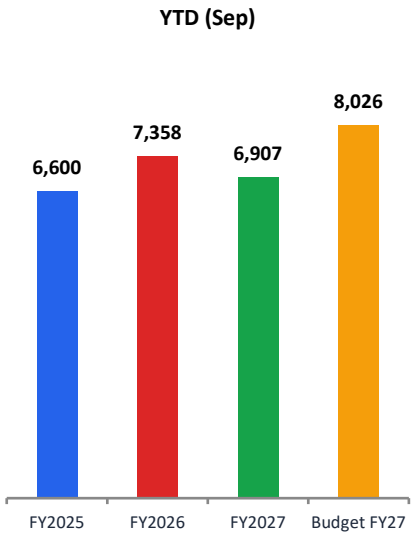
Outpatient Registrations



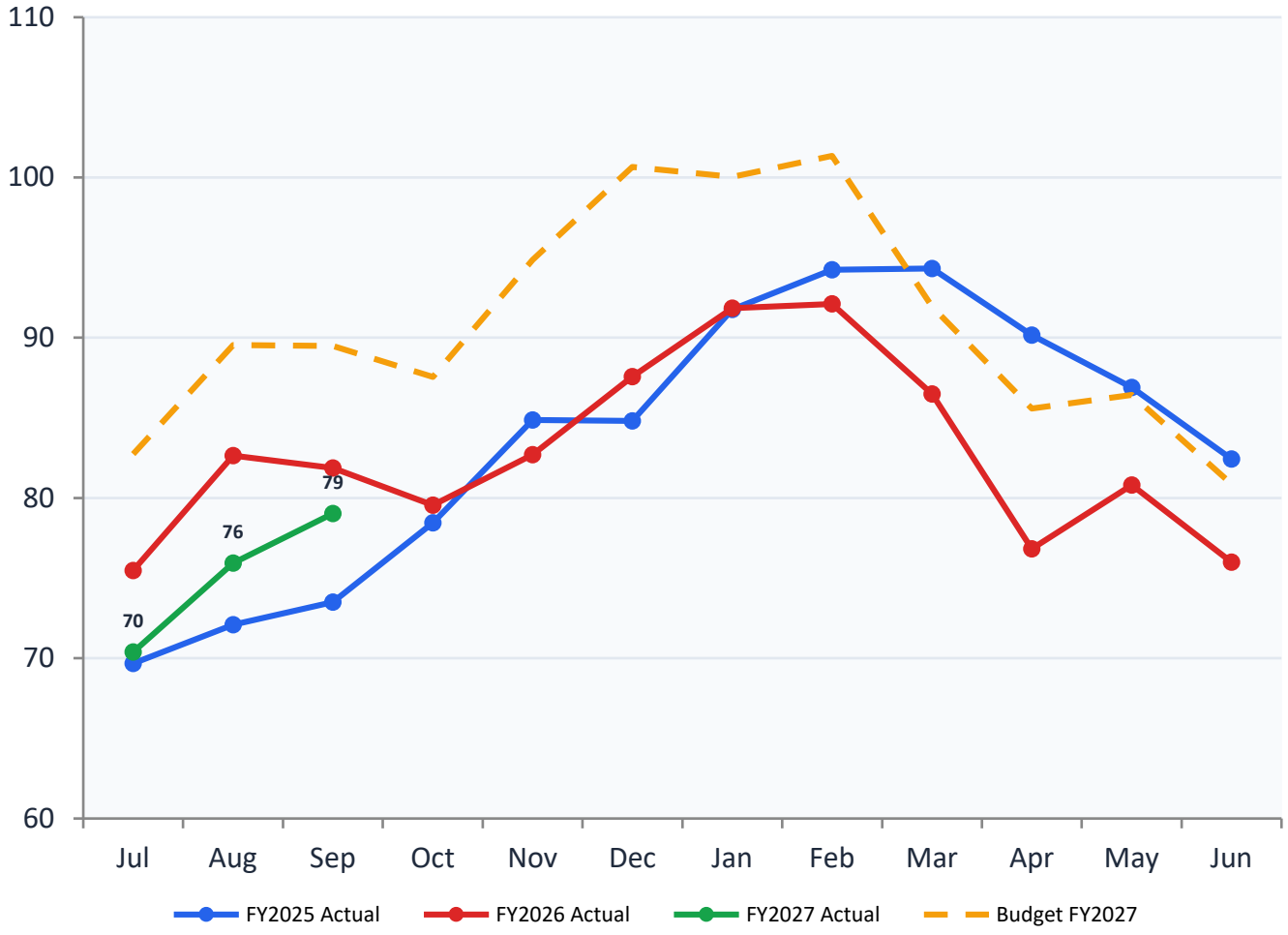


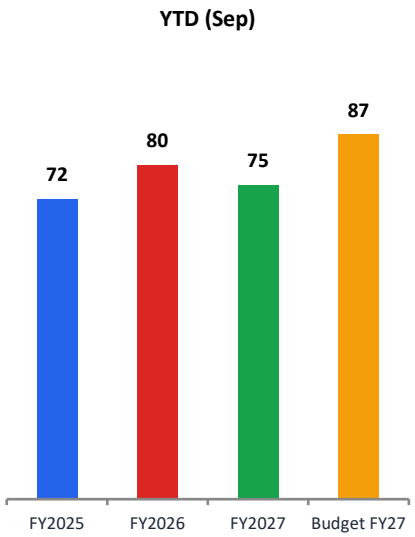
Urgent Care – Court Total Visits



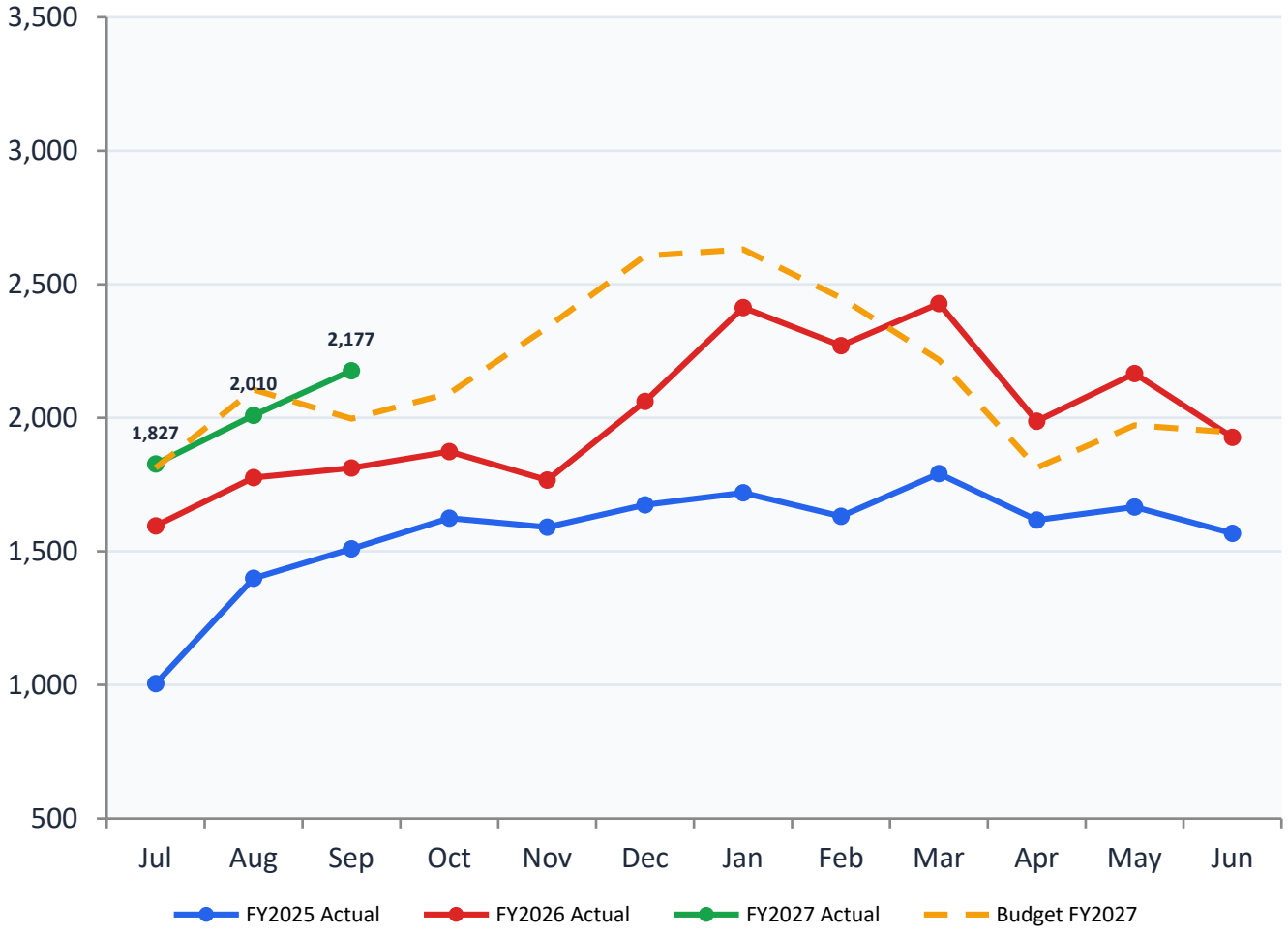


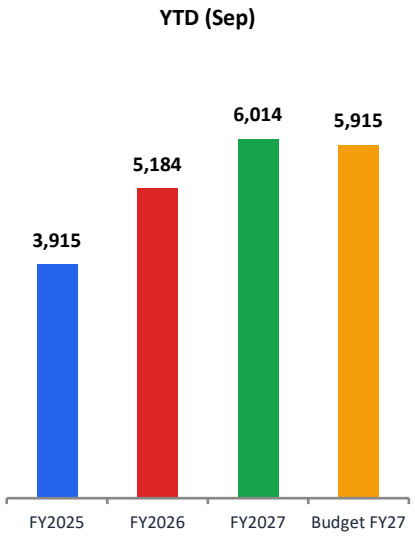
Urgent Care – Court (Avg Visits Per Day)



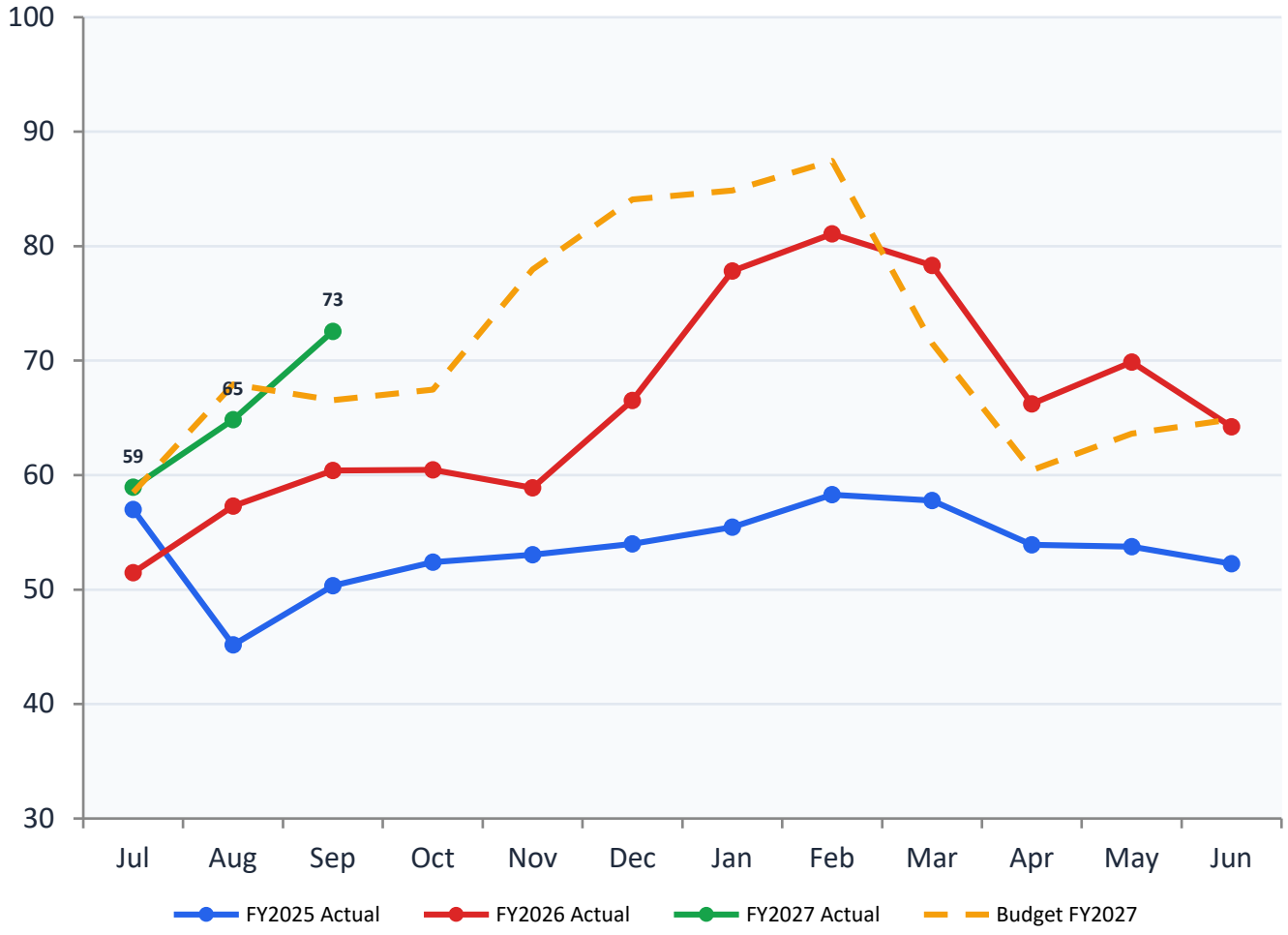


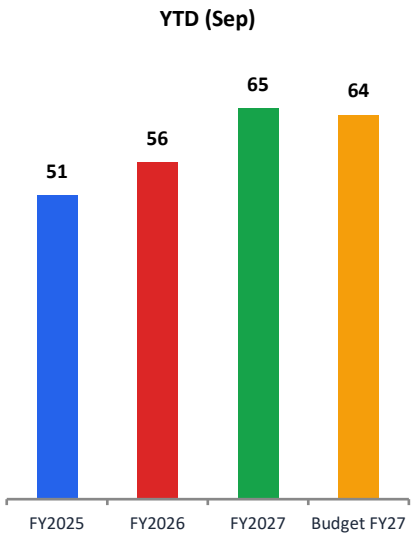
Urgent Care – Demaree Total Visits



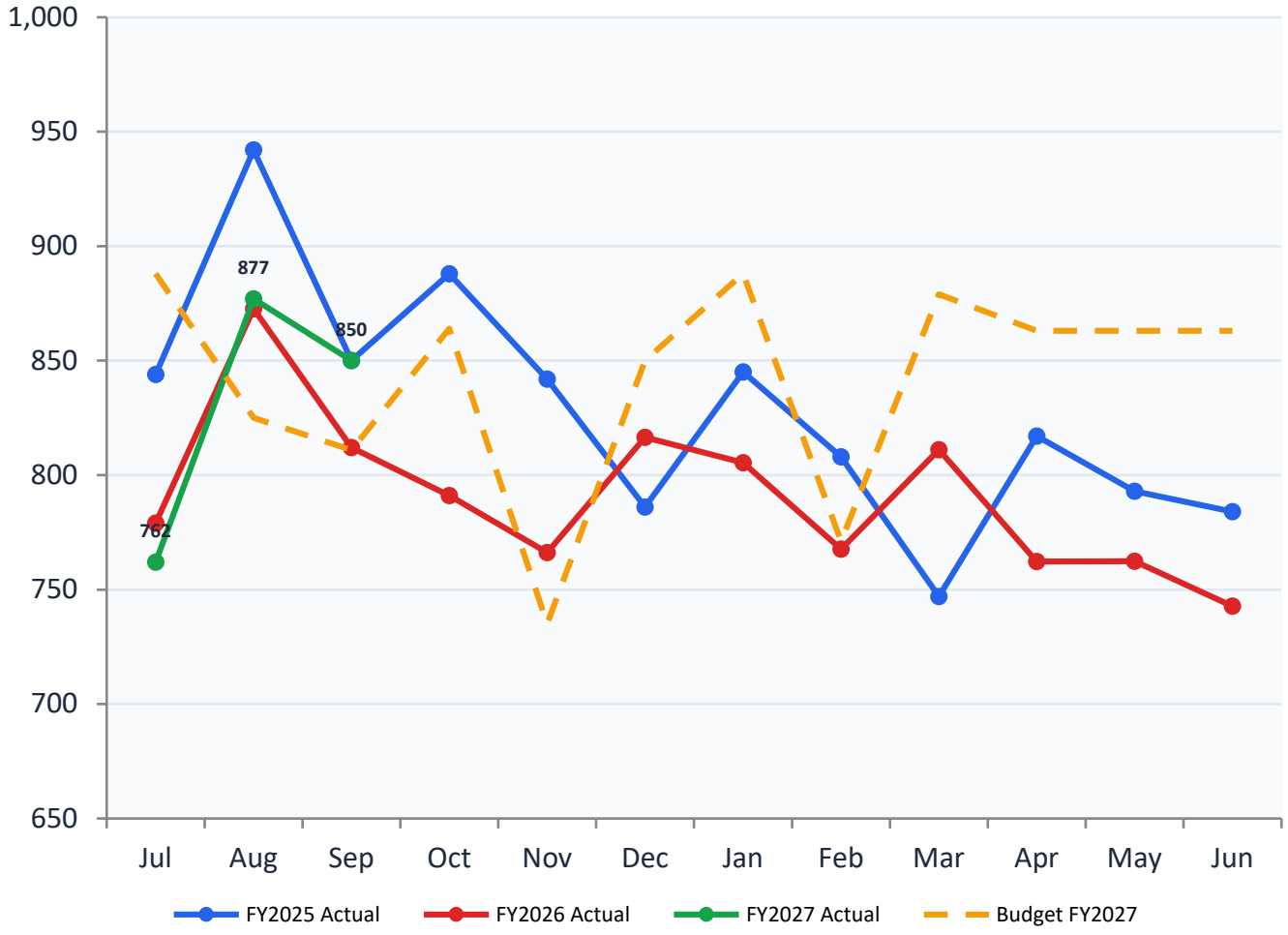


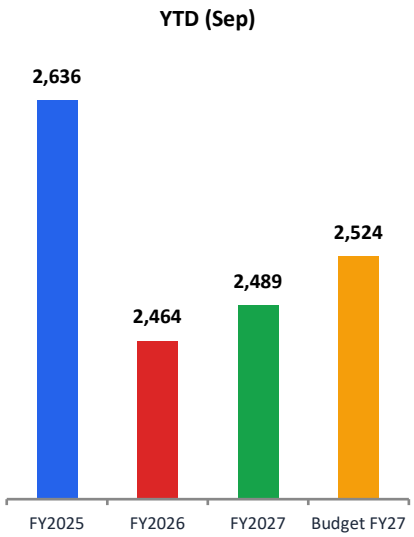
Urgent Care – Demaree (Avg Visits Per Day)



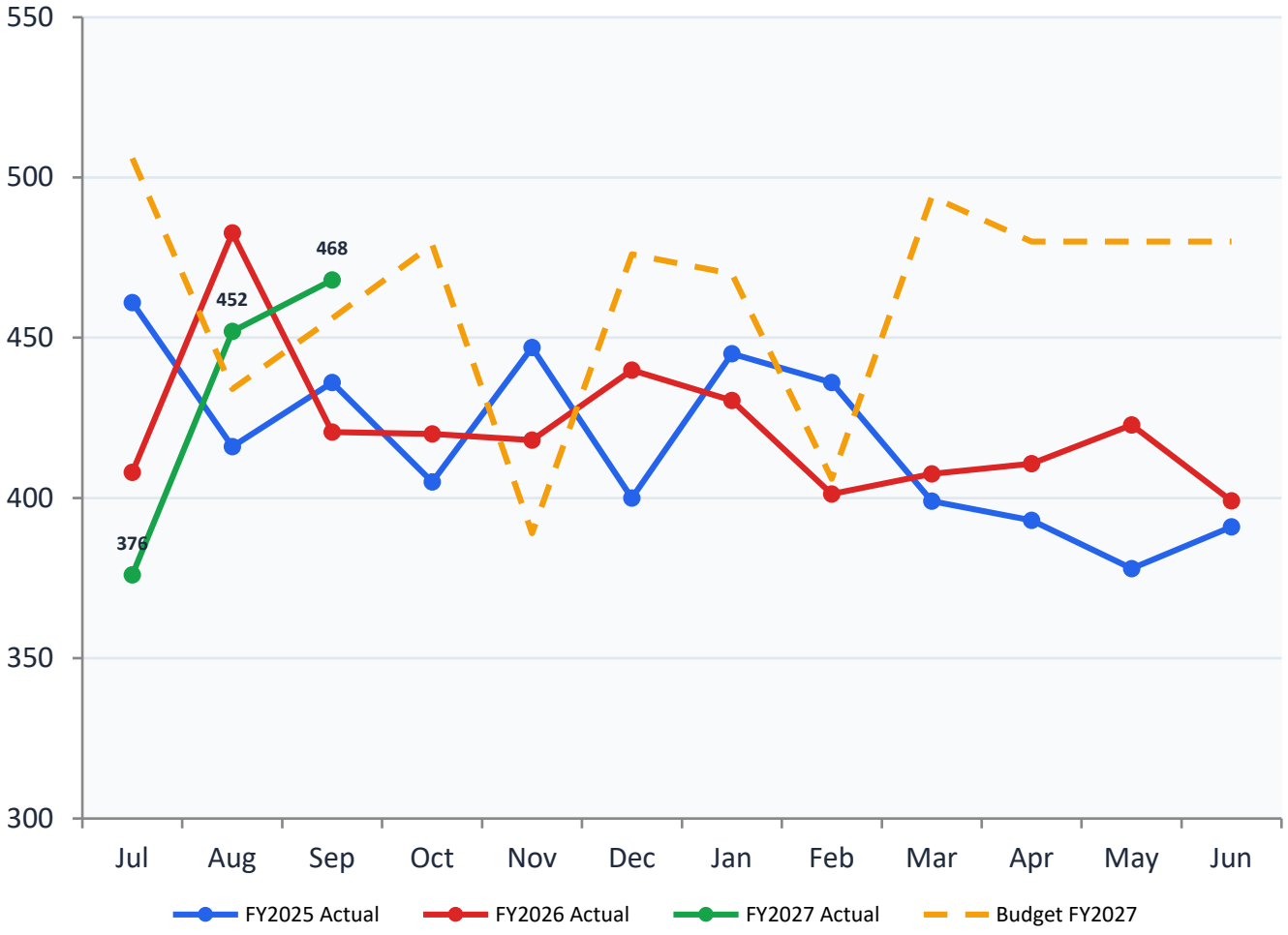


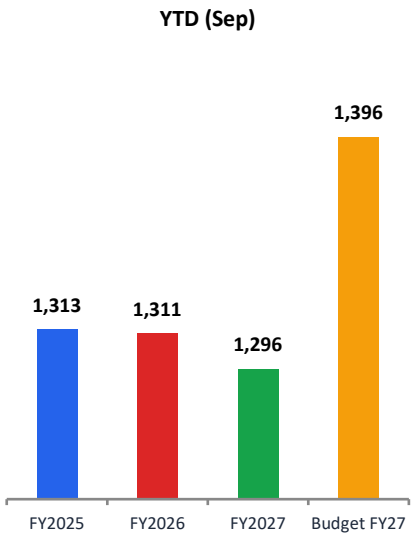
Surgery (IP & OP) – 100 Min Units



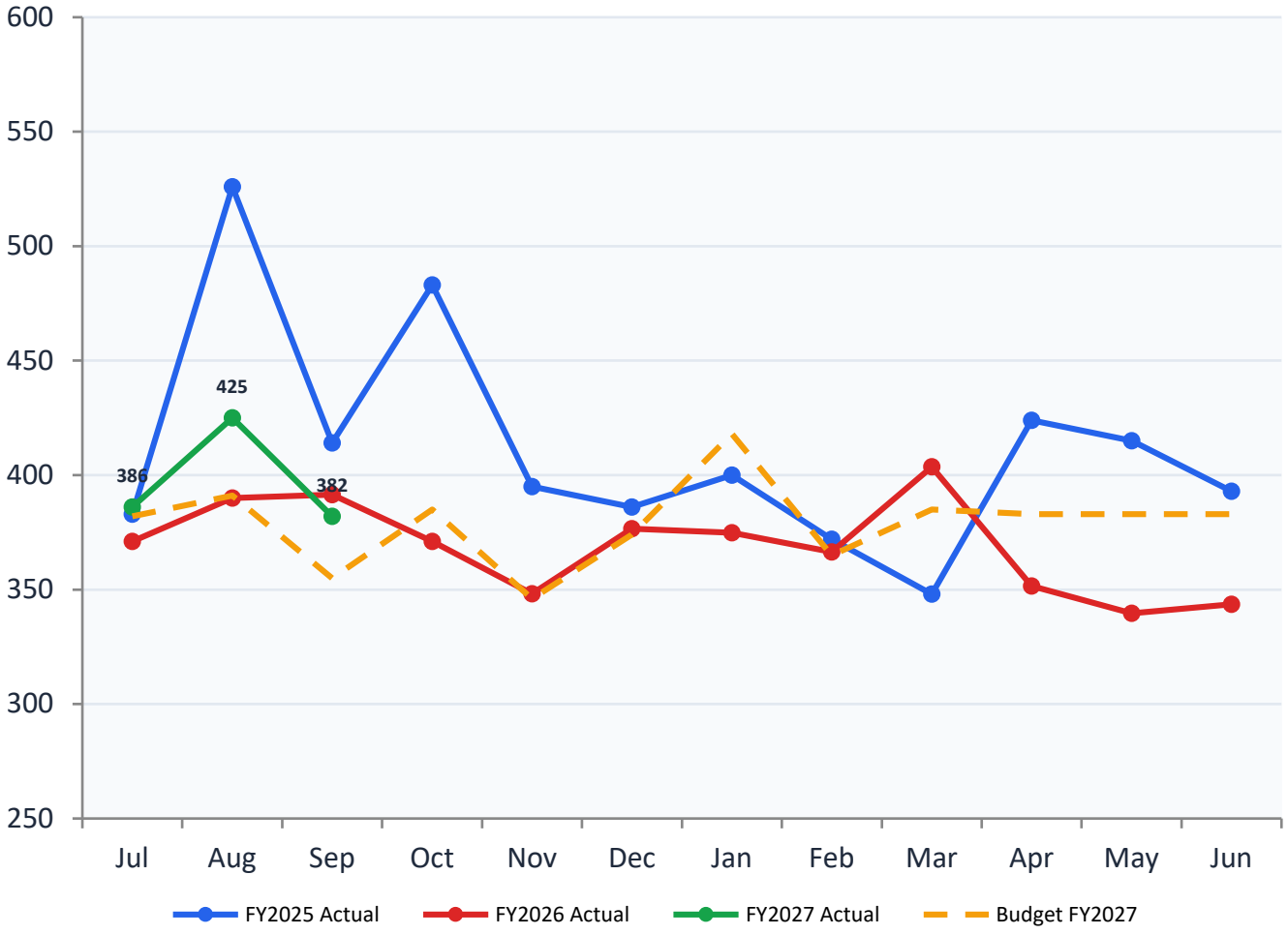


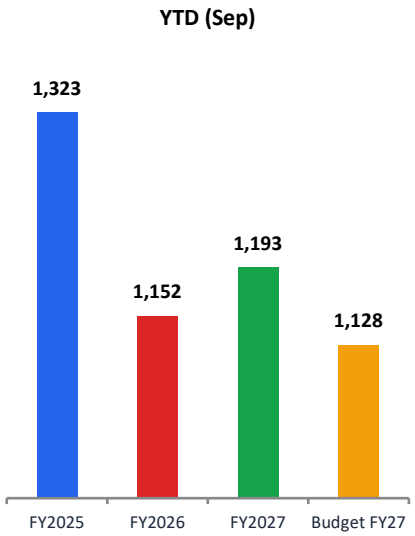
Surgery (IP Only) - 100 Min Unit



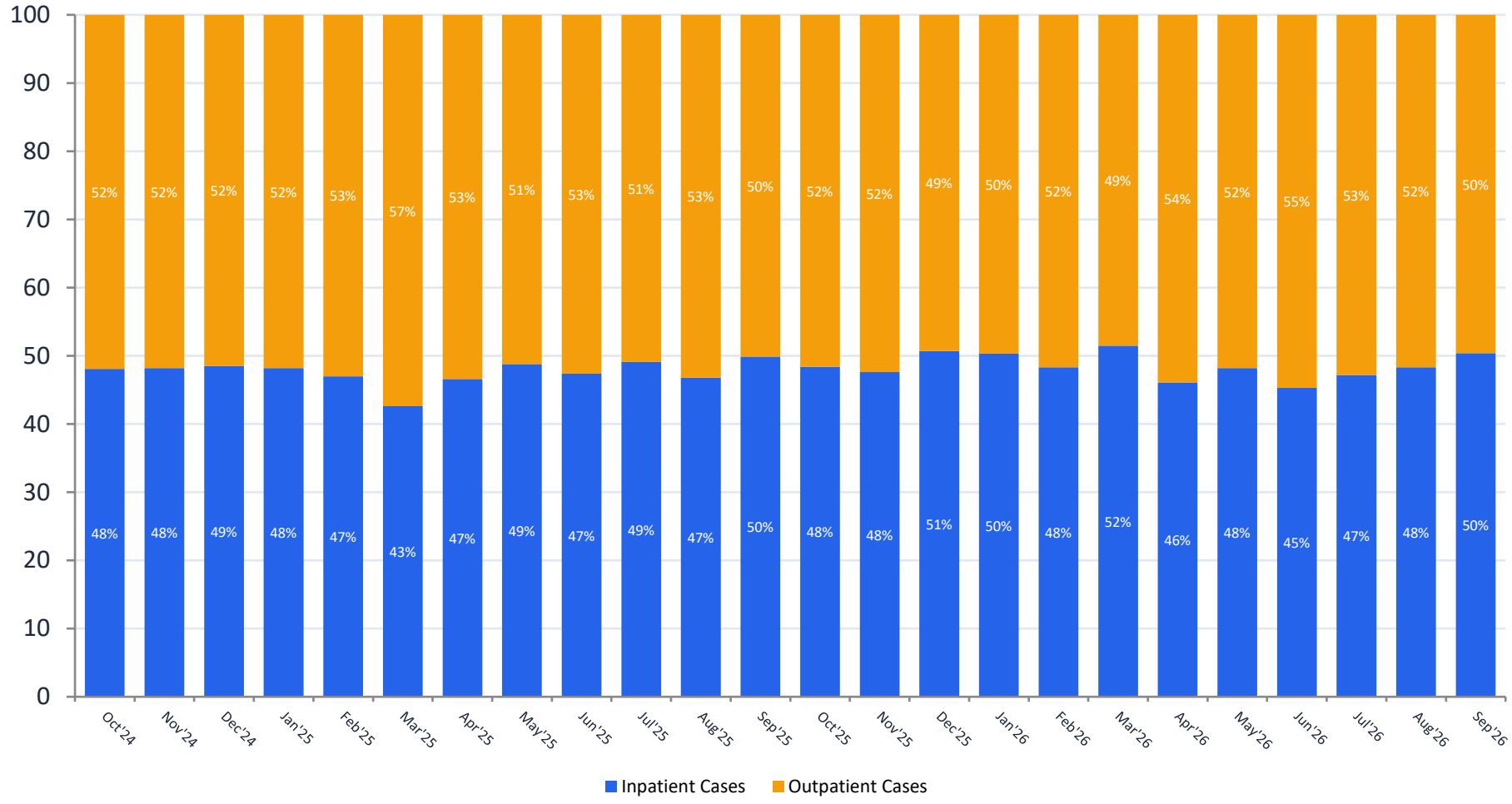


Surgery (OP Only) - 100 Min Units

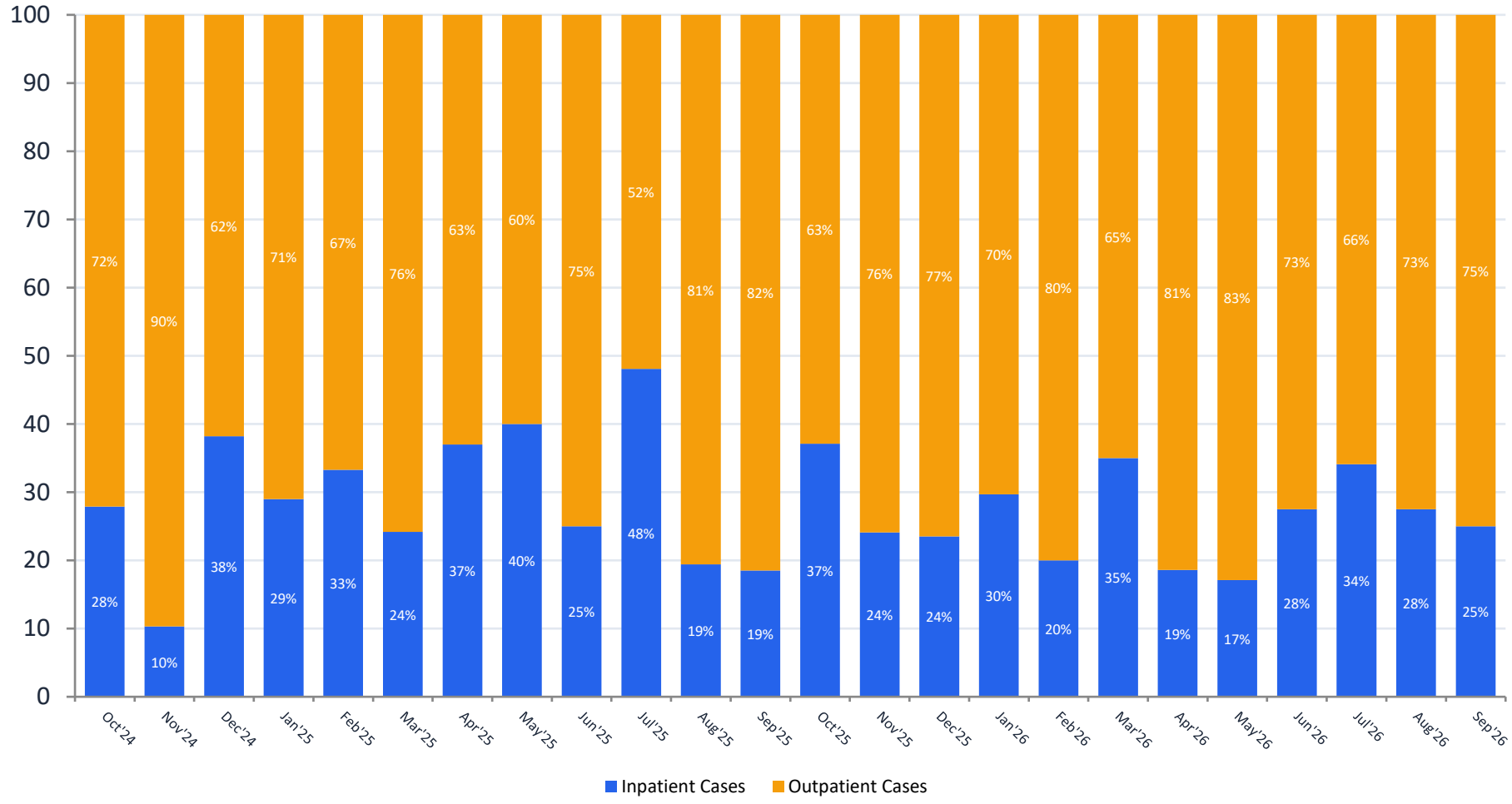




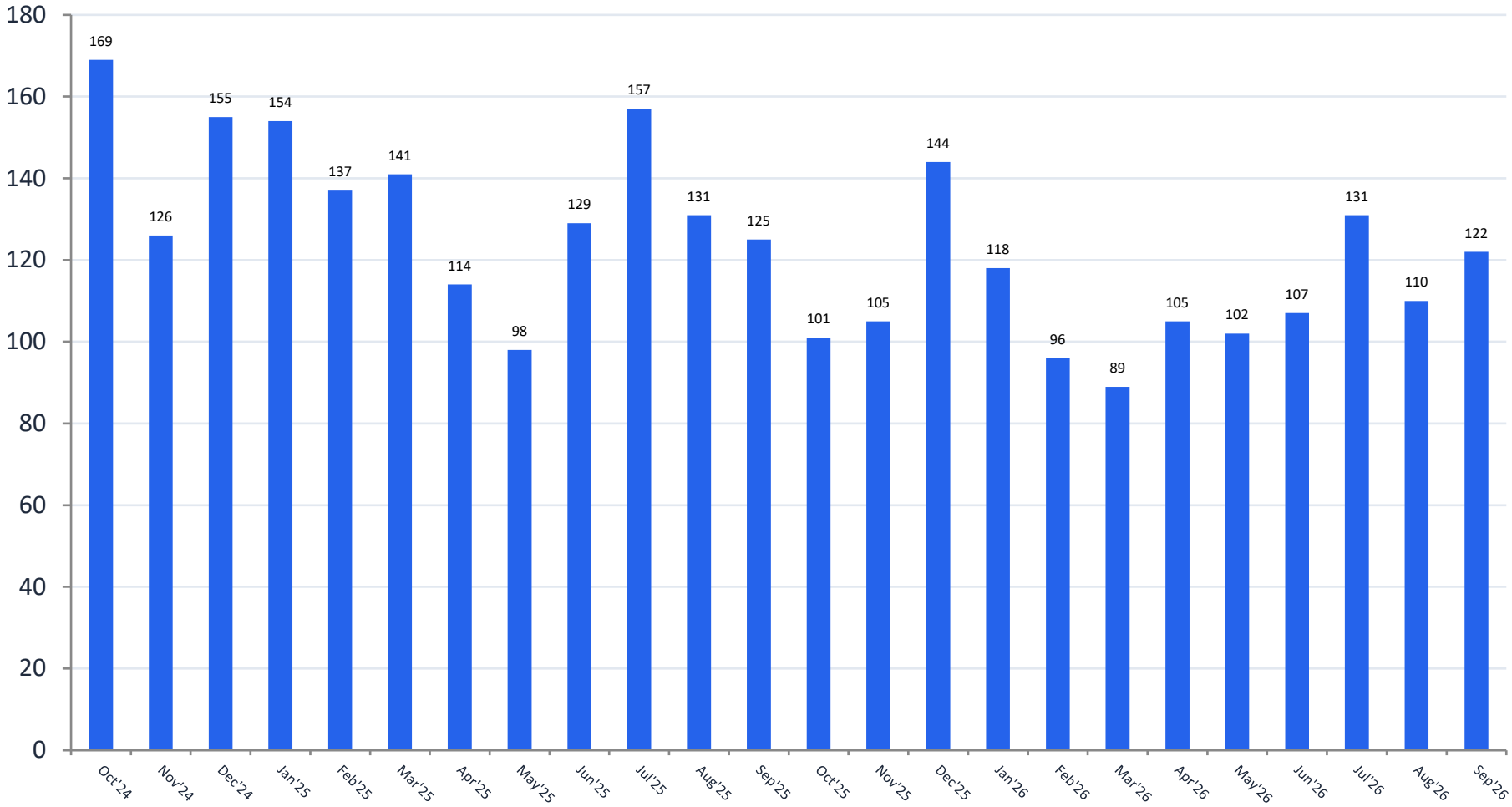
Surgery Cases (IP & OP)



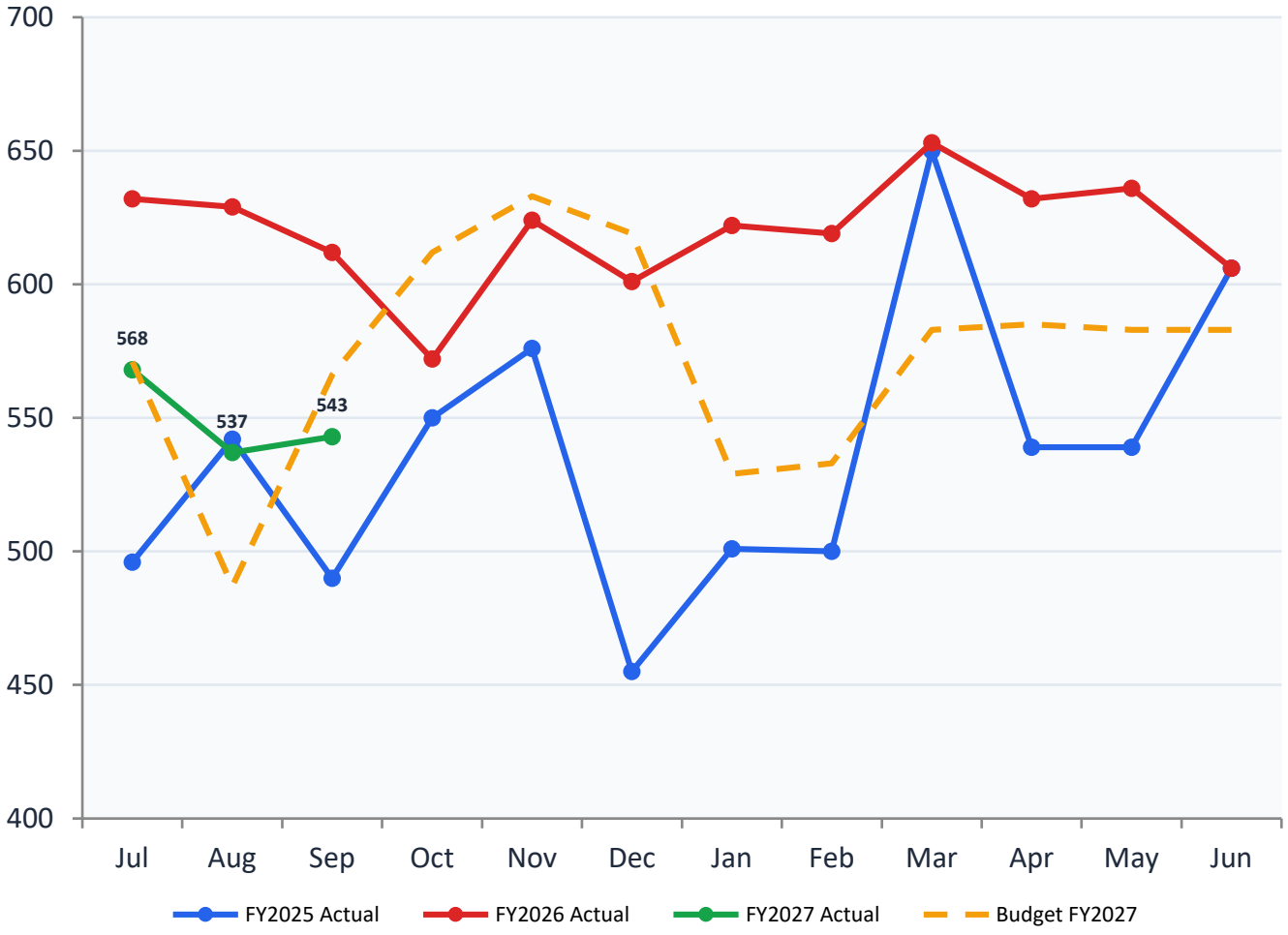
Robotic Cases (IP & OP)

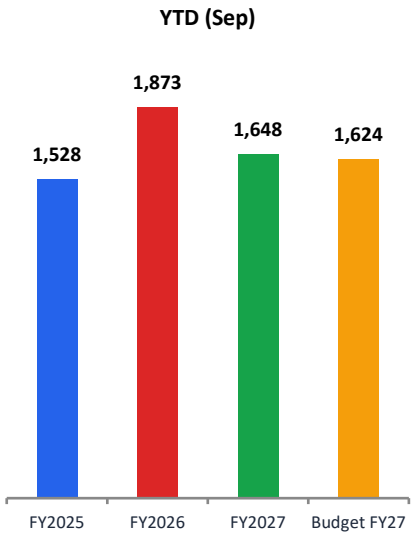


OB Cases

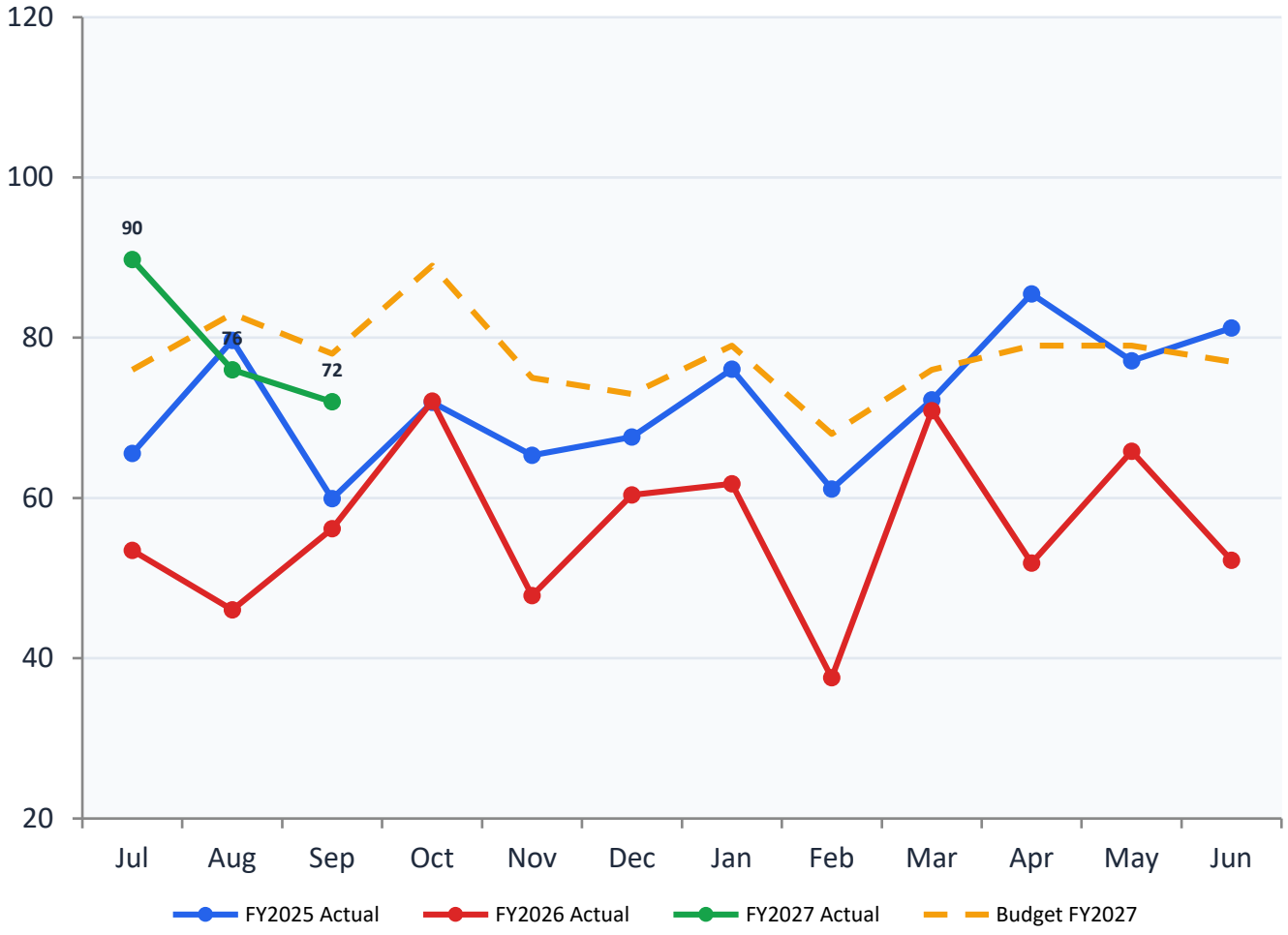

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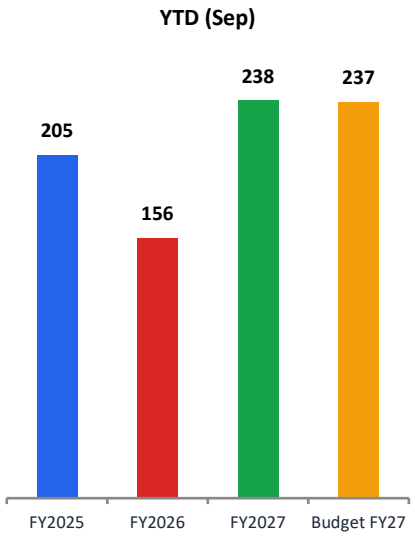
Endoscopy Procedures



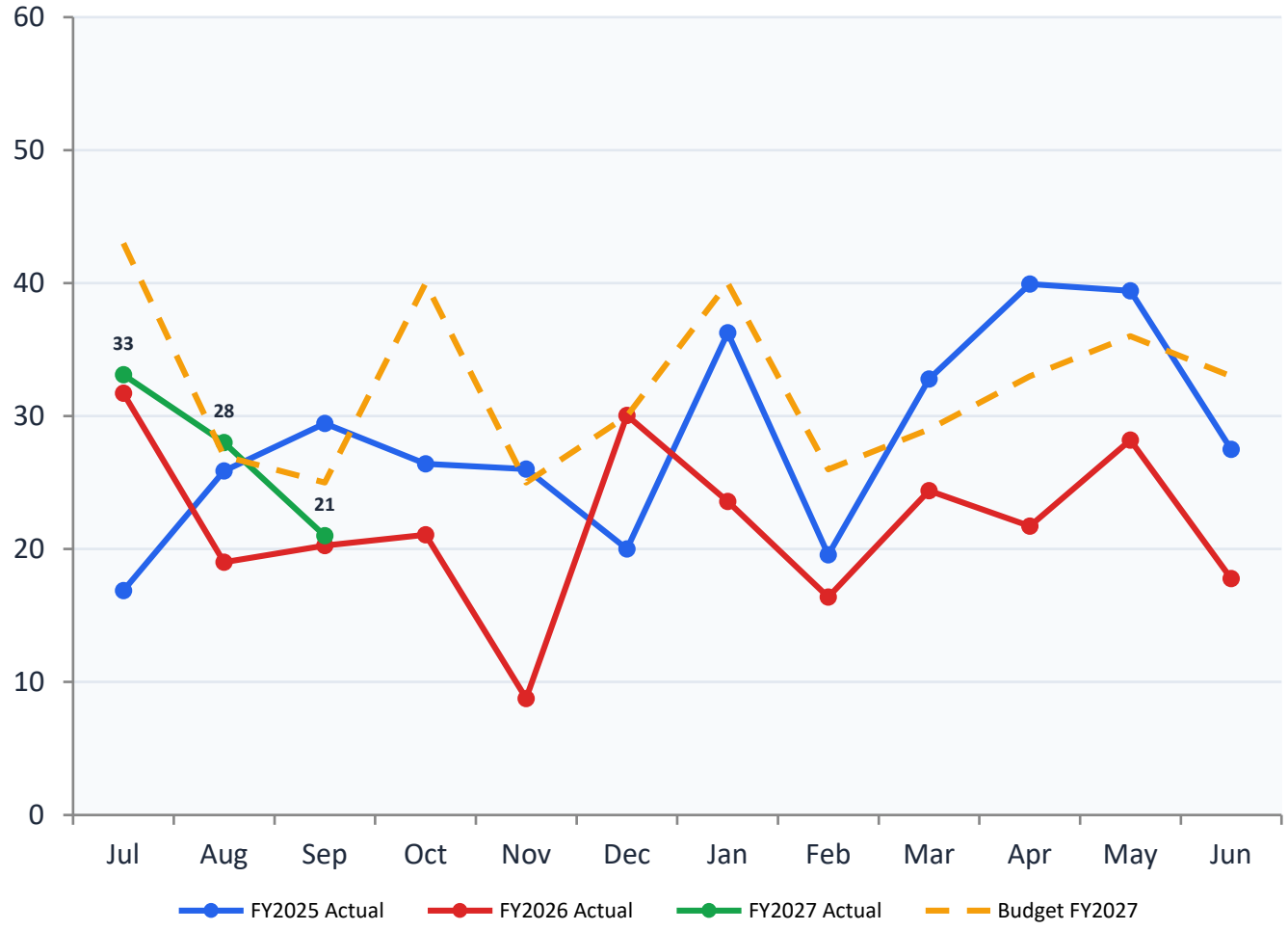


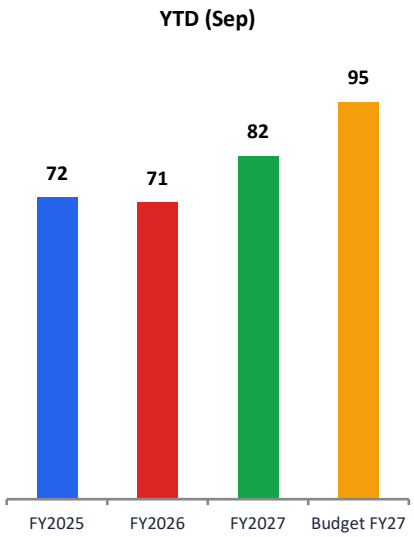
Robotic Surgery (IP & OP) - 100 Min Units



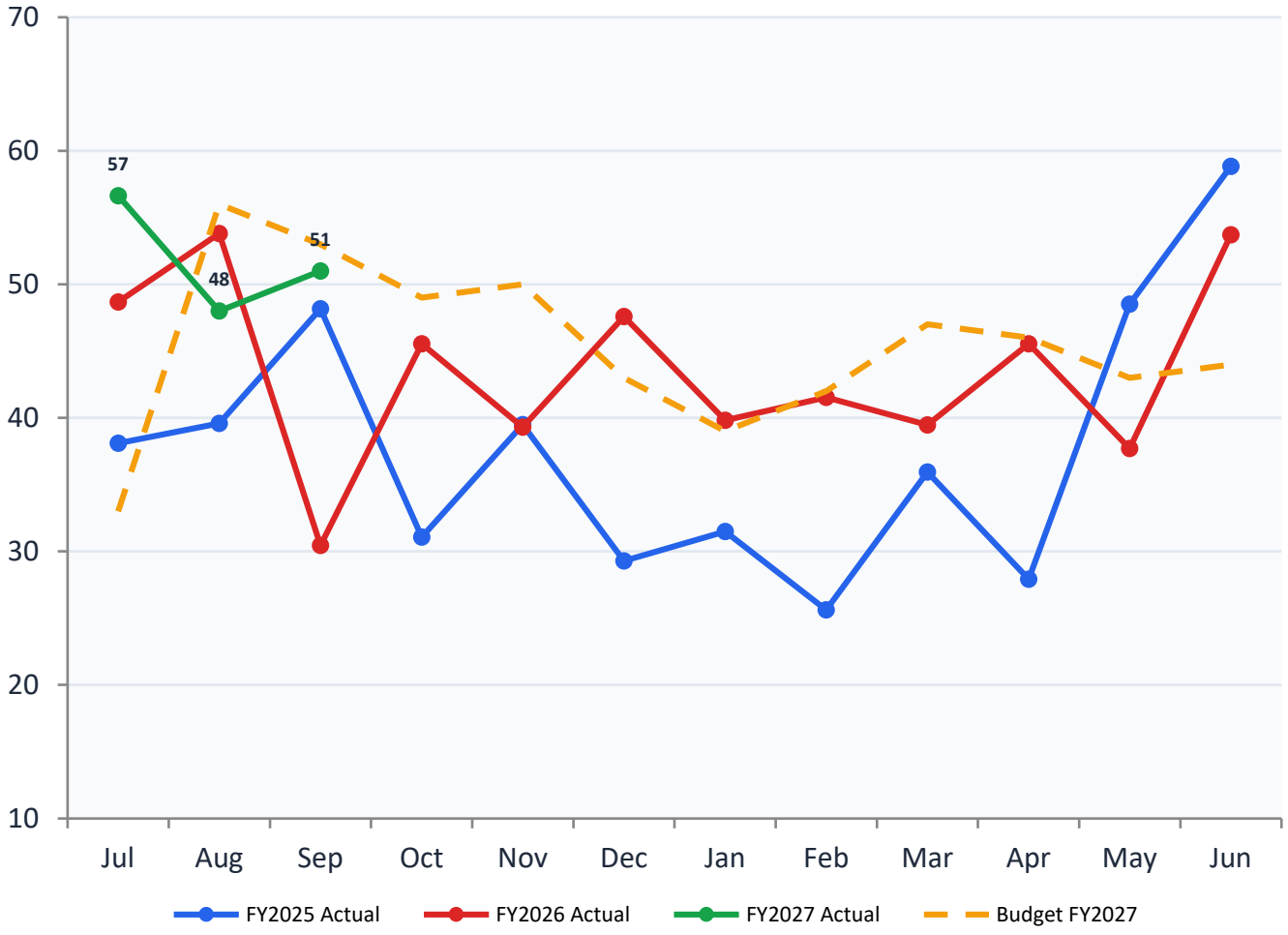


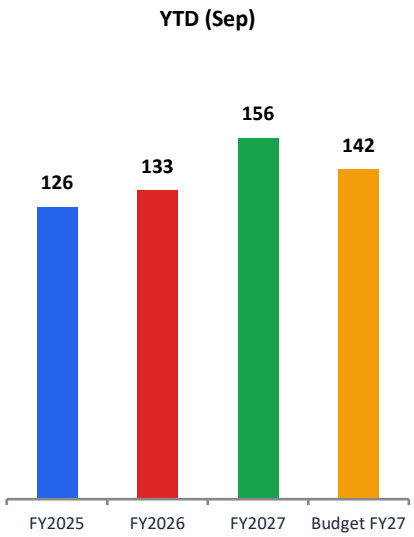
Robotic Surgery Minutes (IP Only)



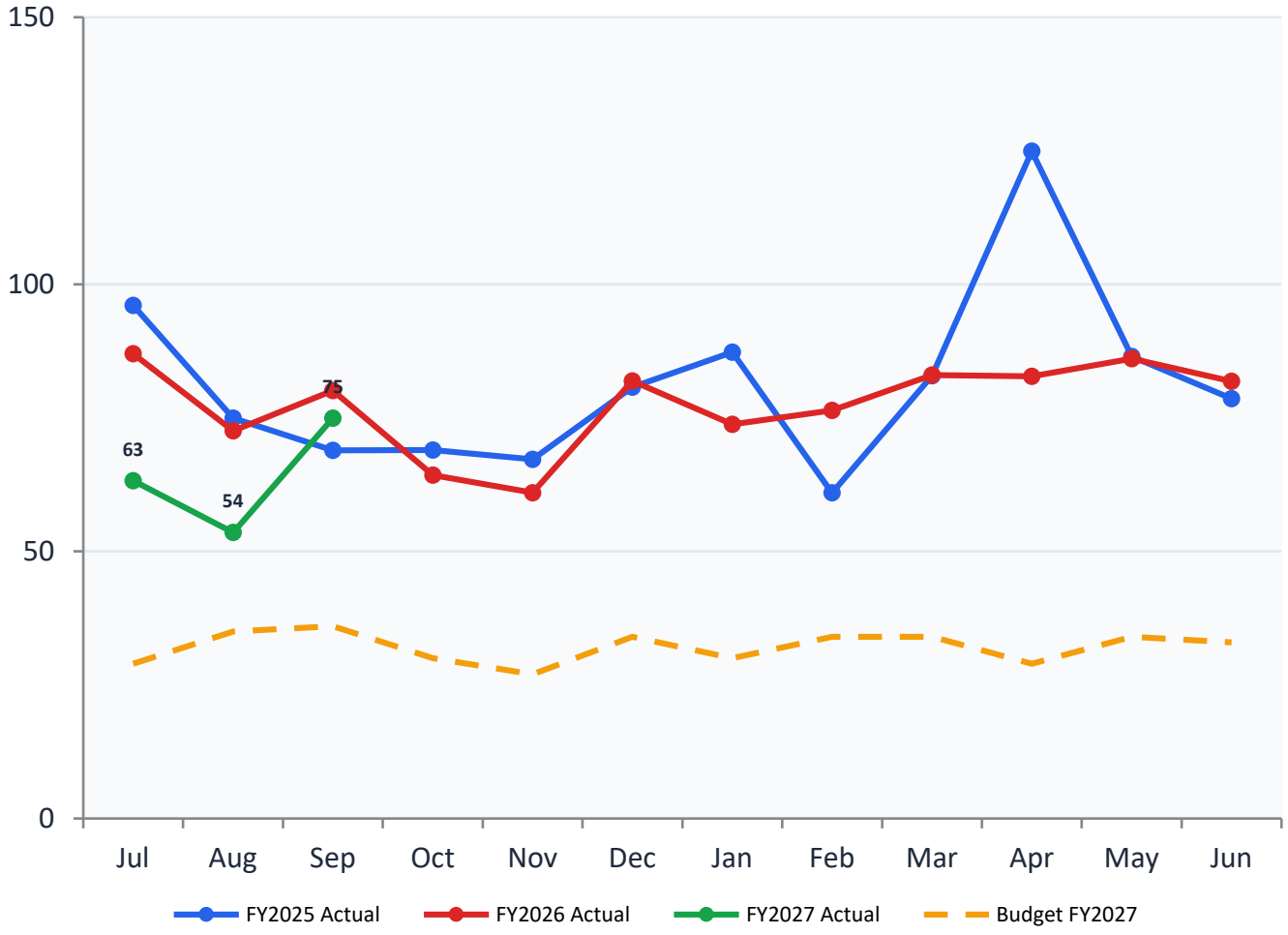


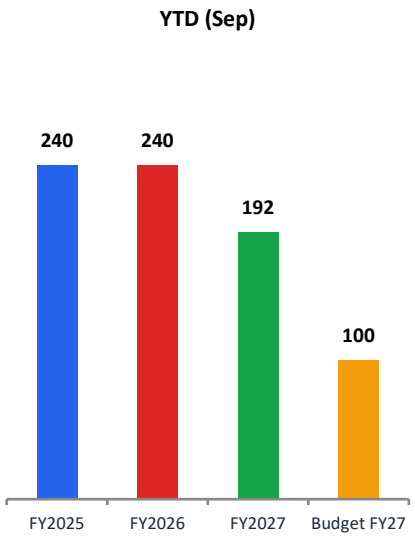
Robotic Surgery Minutes (OP Only)



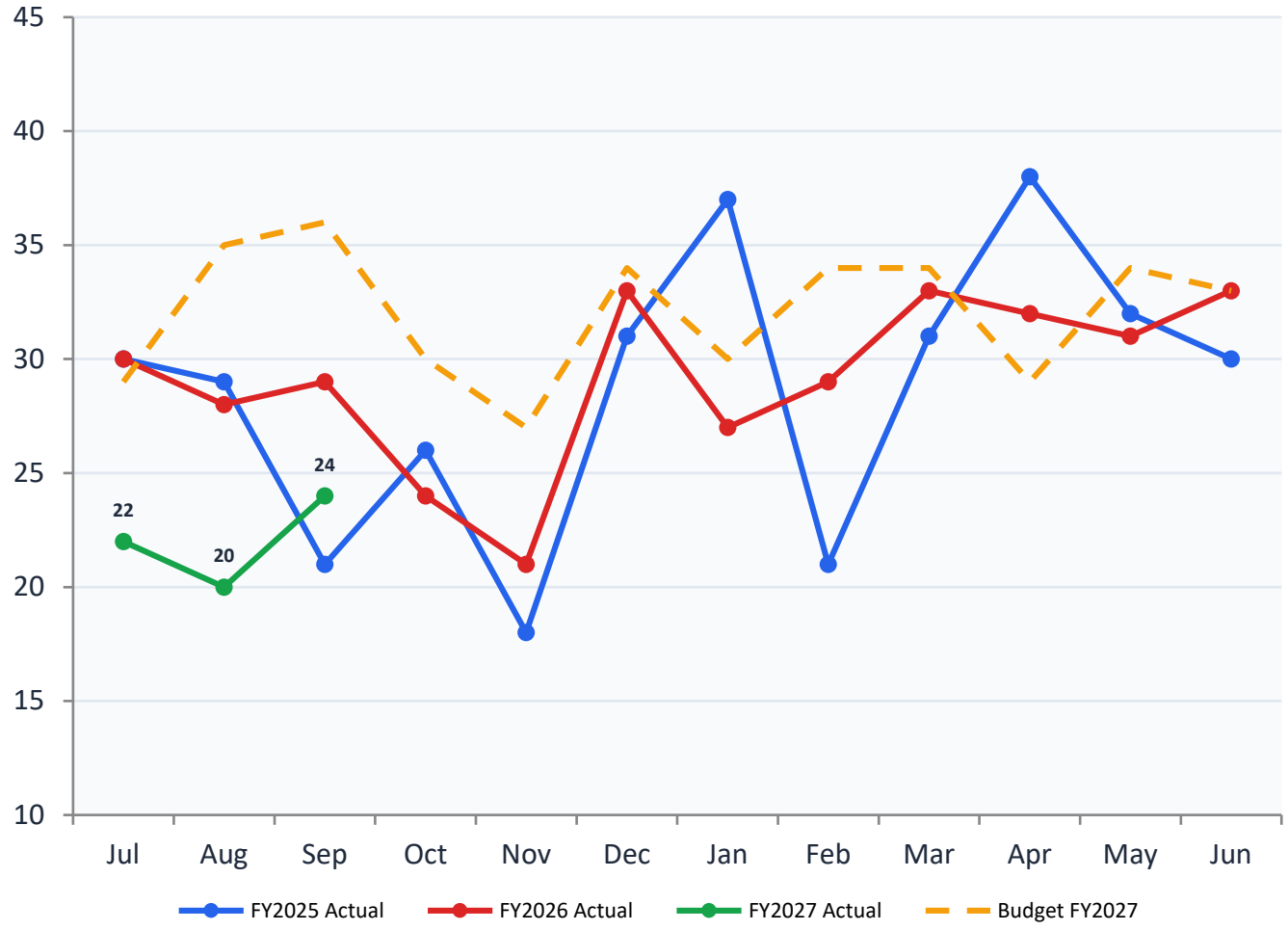


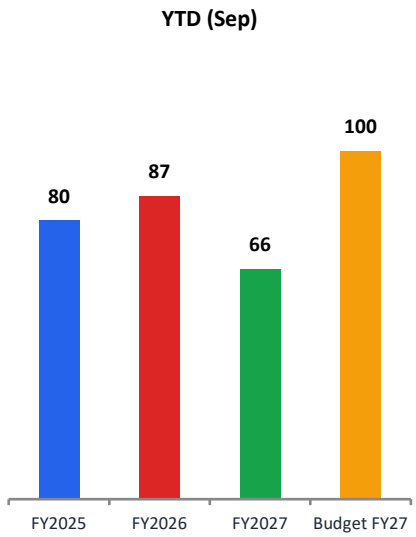
Cardiac Surgery - 100 Min Units



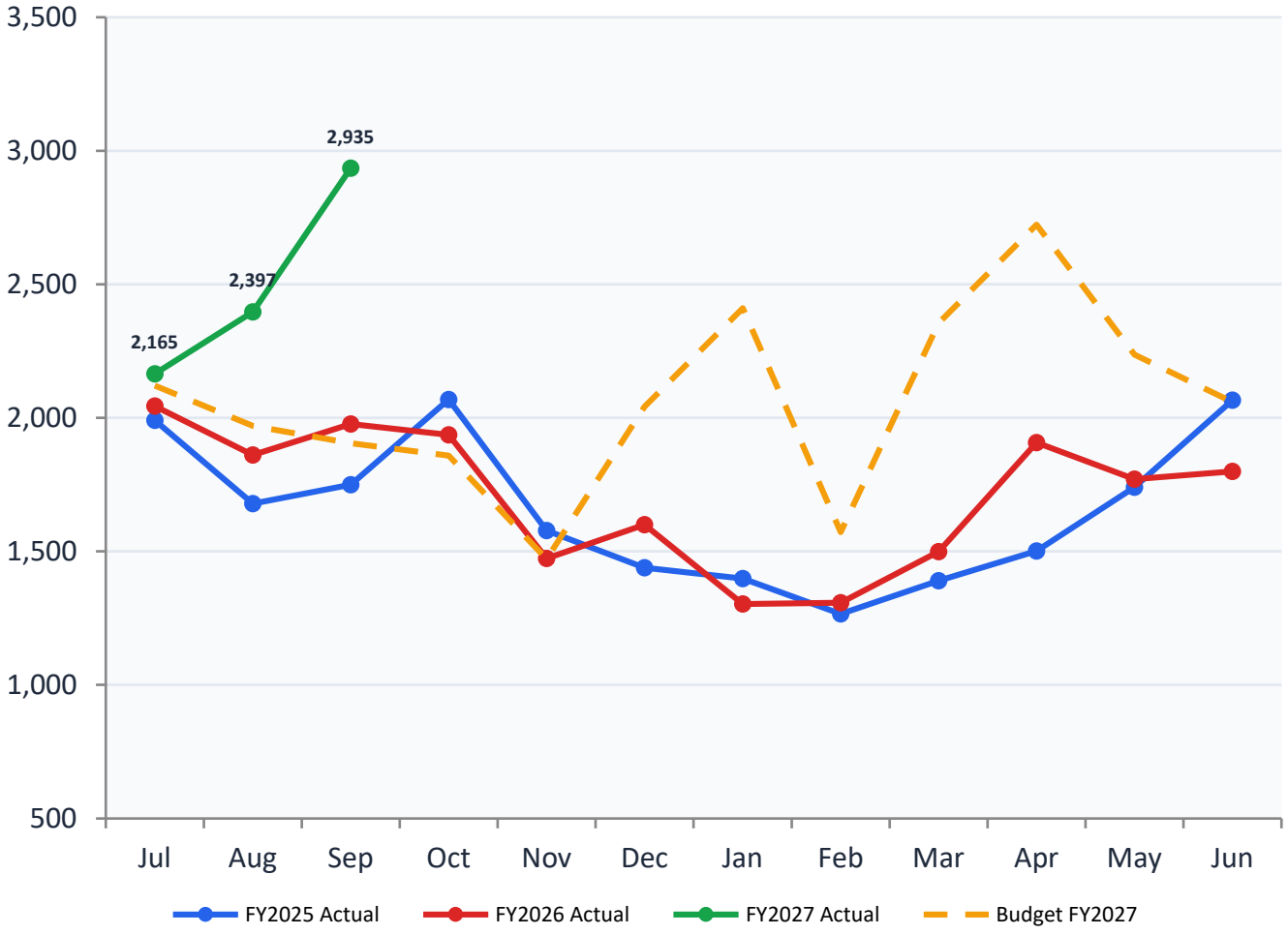


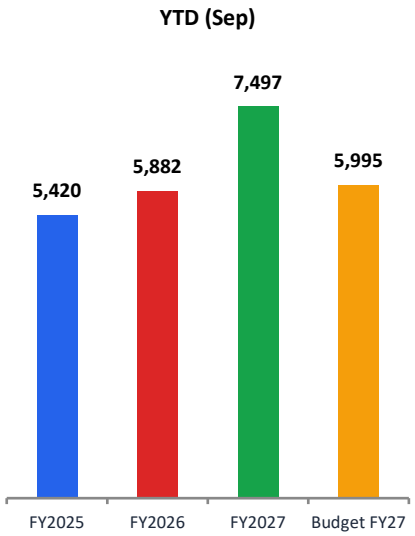
Cardiac Surgery Cases



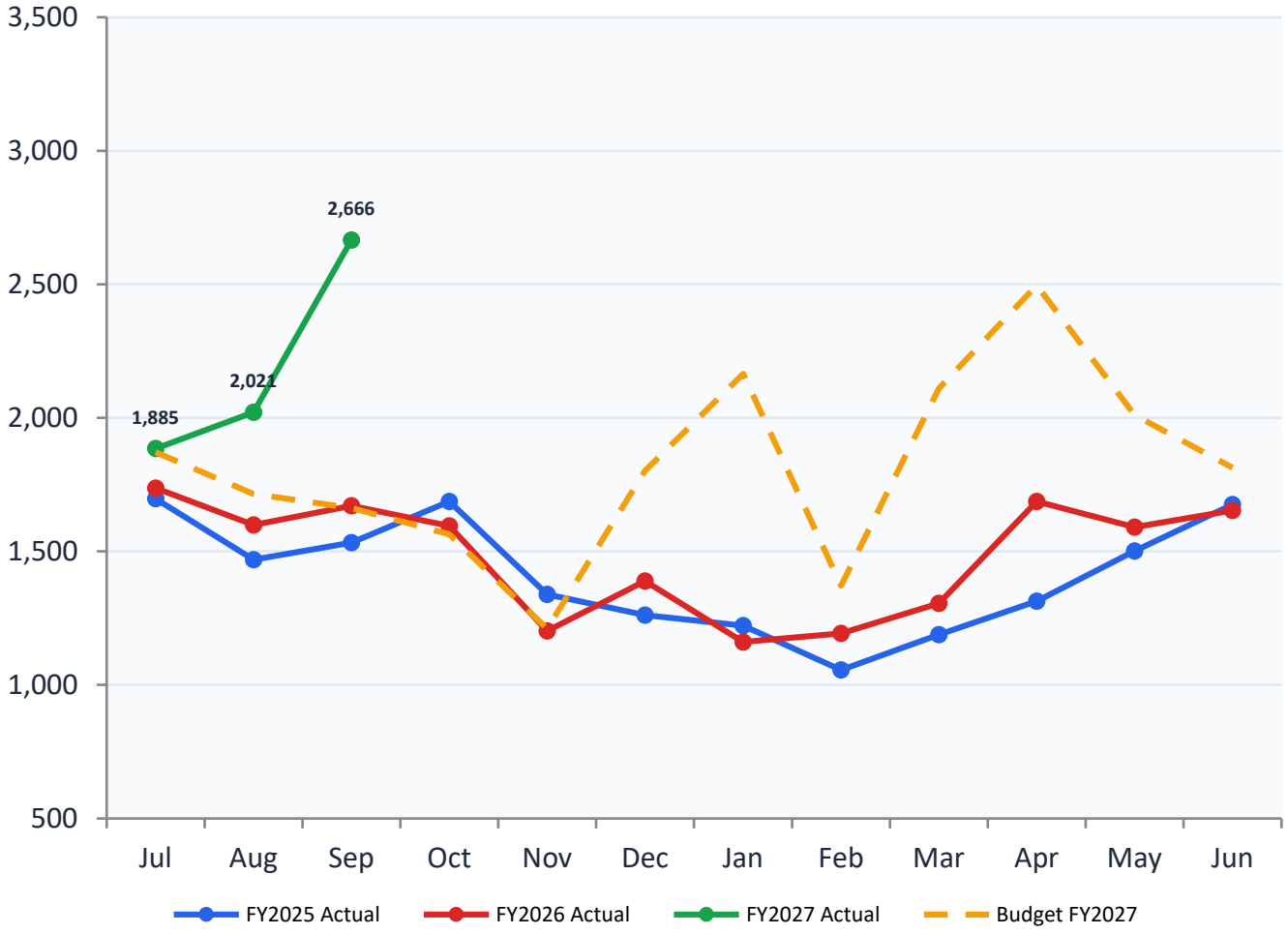


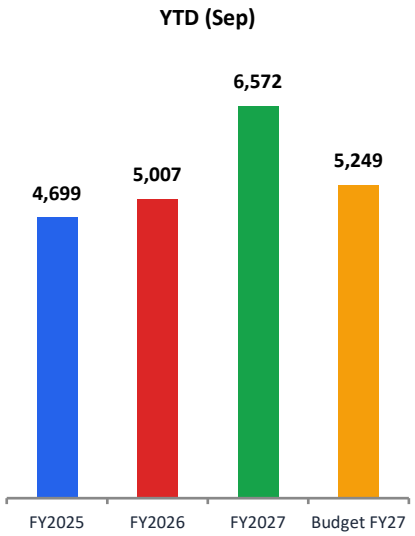
Rad Onc Treatments (Vis. & Hanf.)



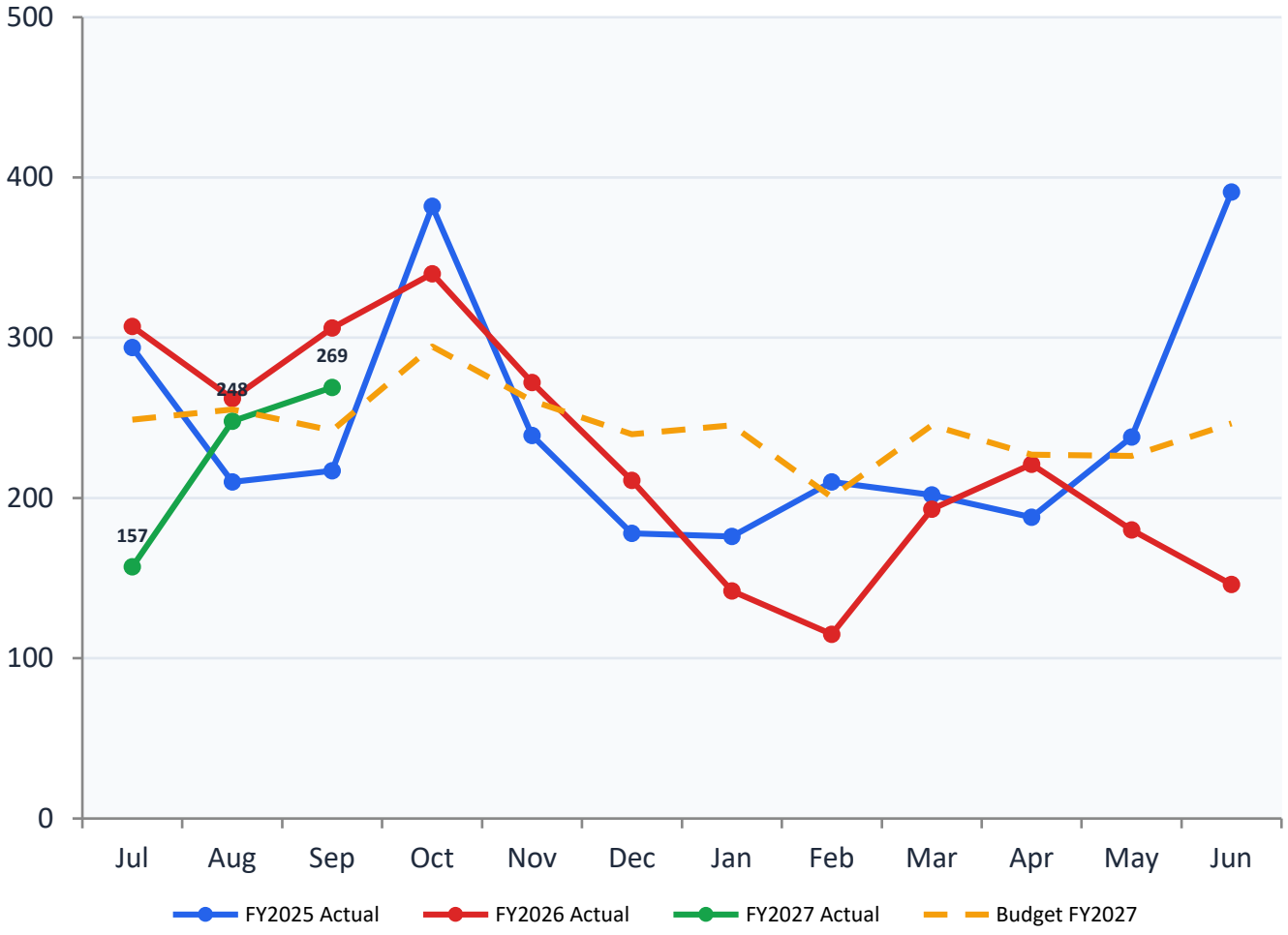


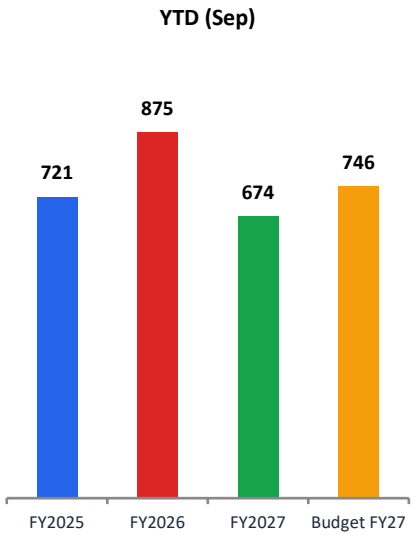
Rad Onc Visalia



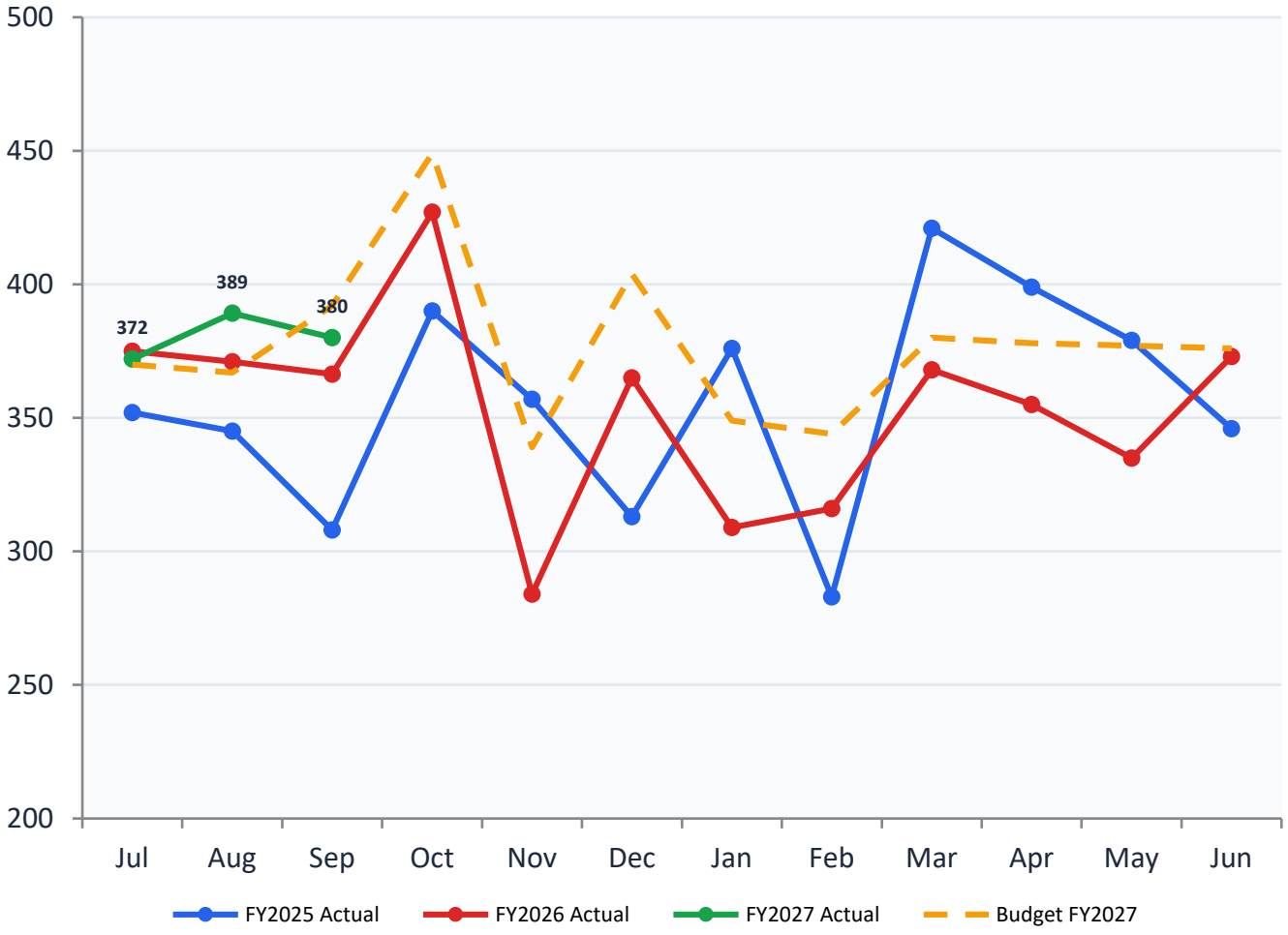


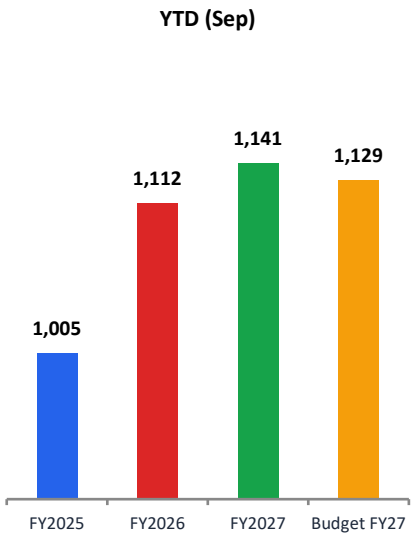
Rad Onc Hanford



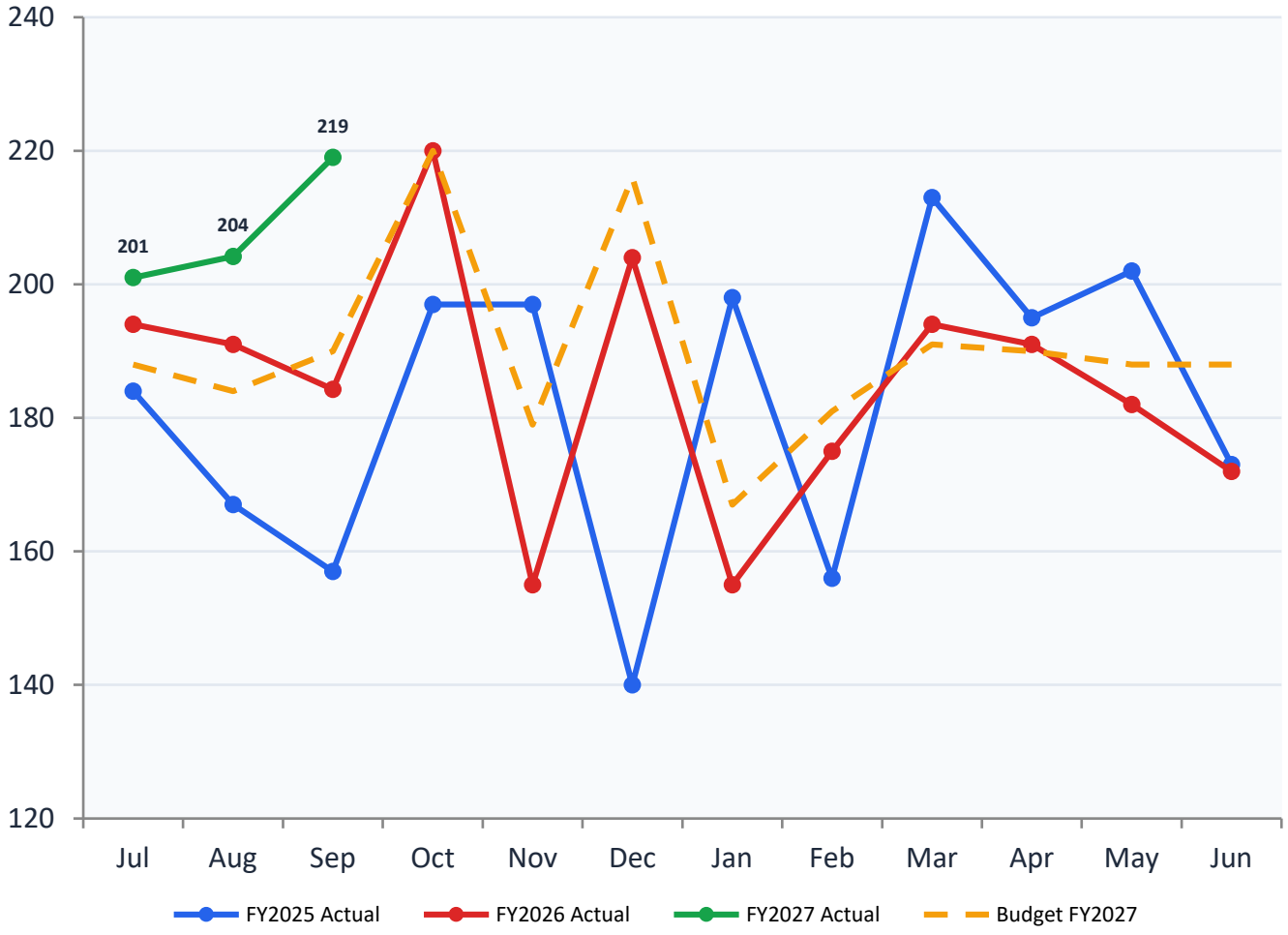


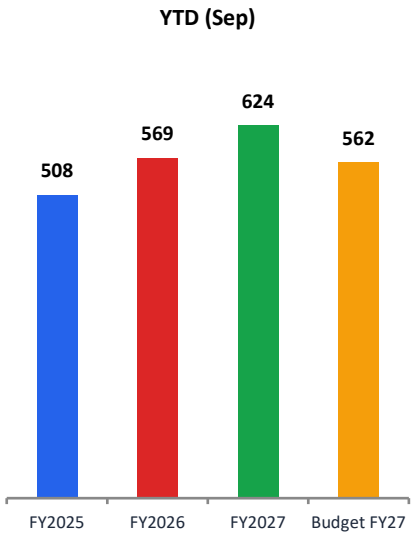
Cath Lab (IP & OP) - 100 Min Units



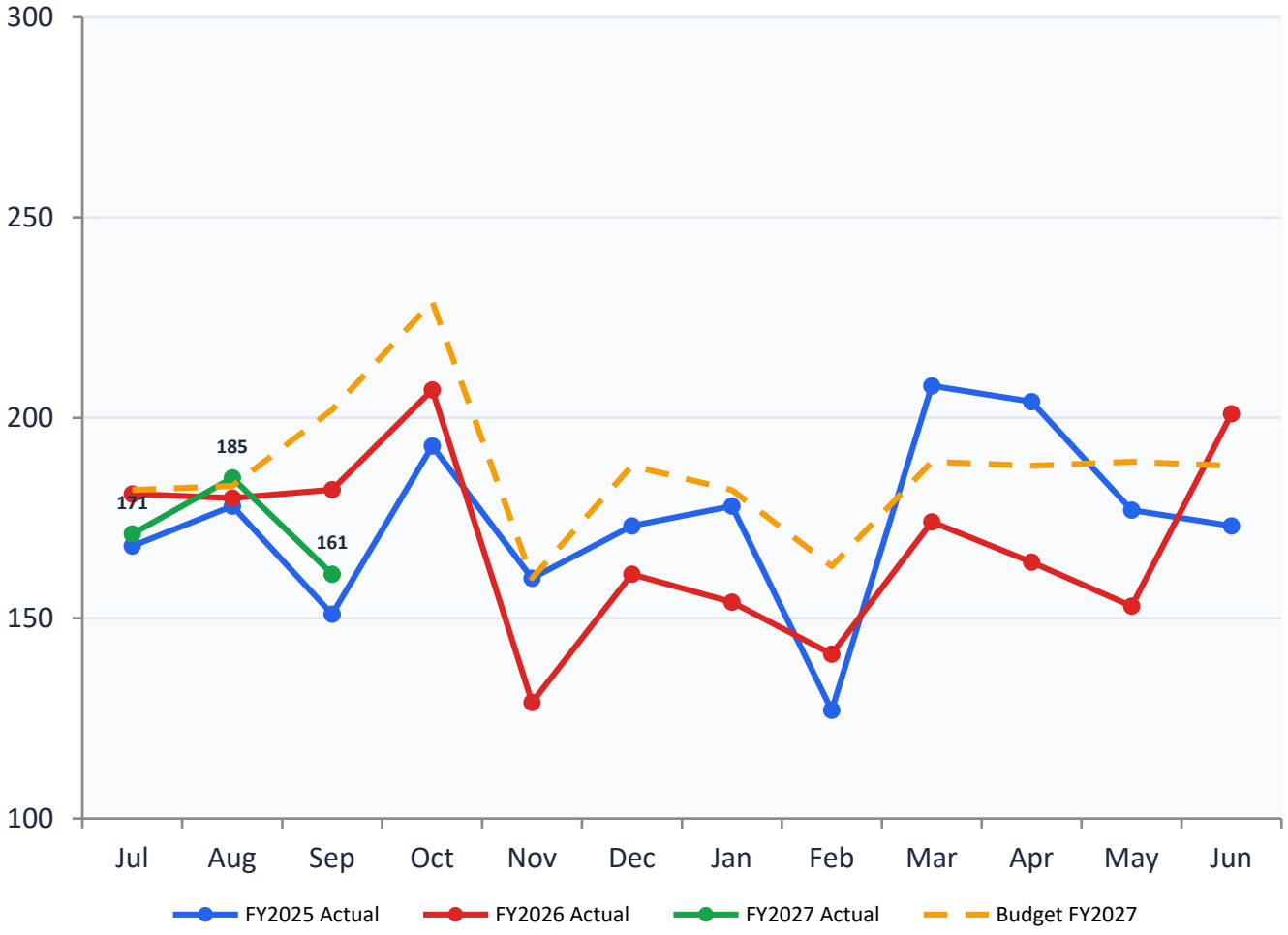


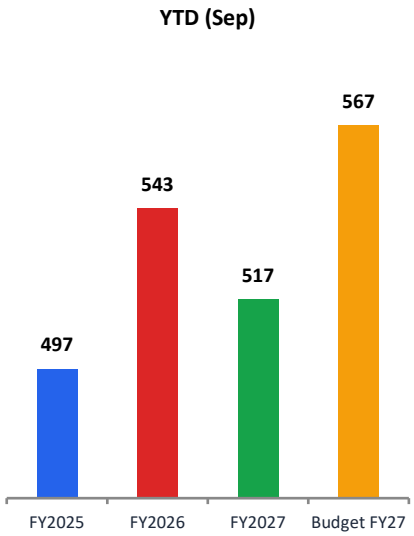
Cath Lab (IP Only) – 100 Min Units



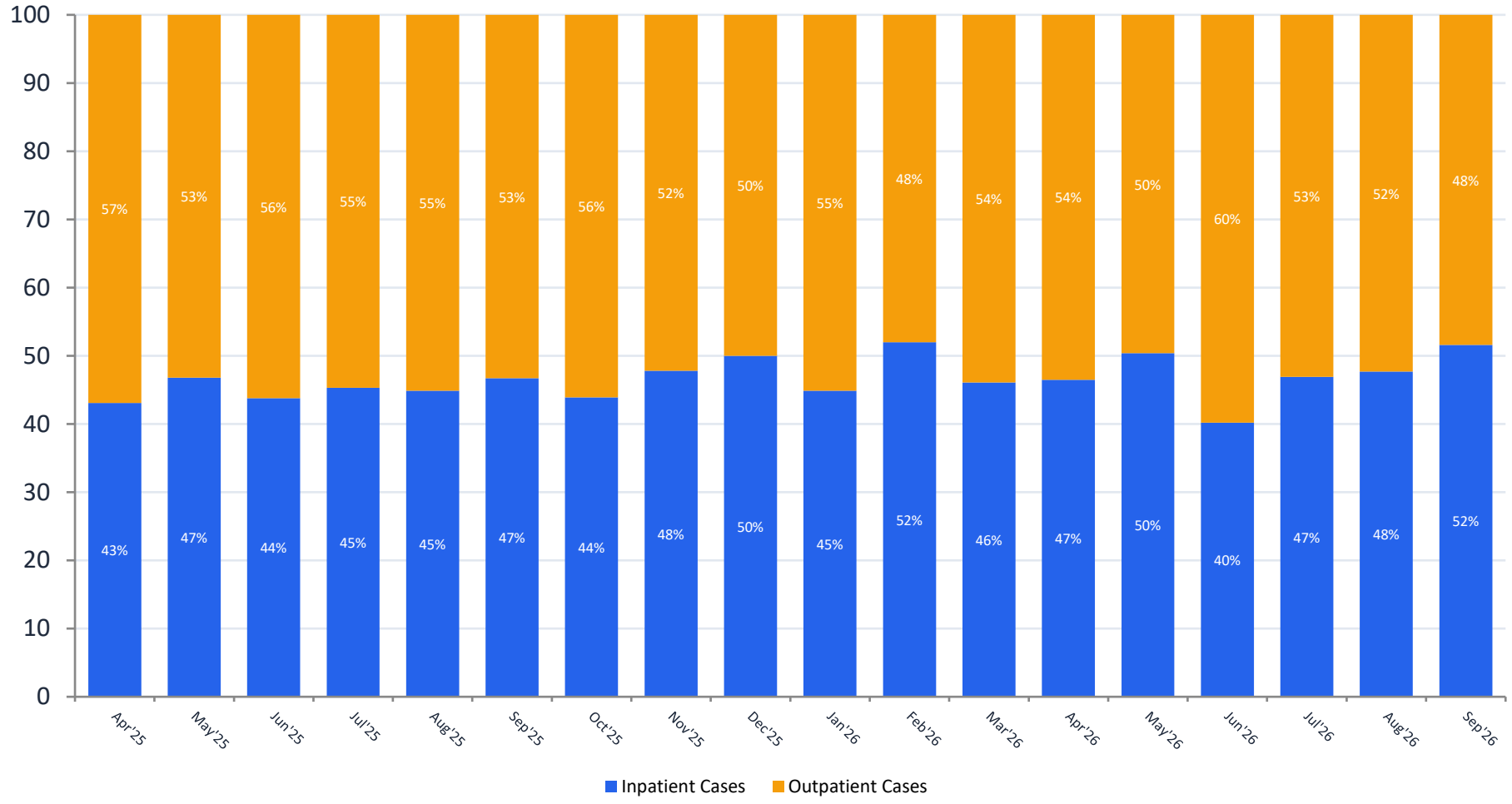


Cath Lab (OP Only) – 100 Min Units

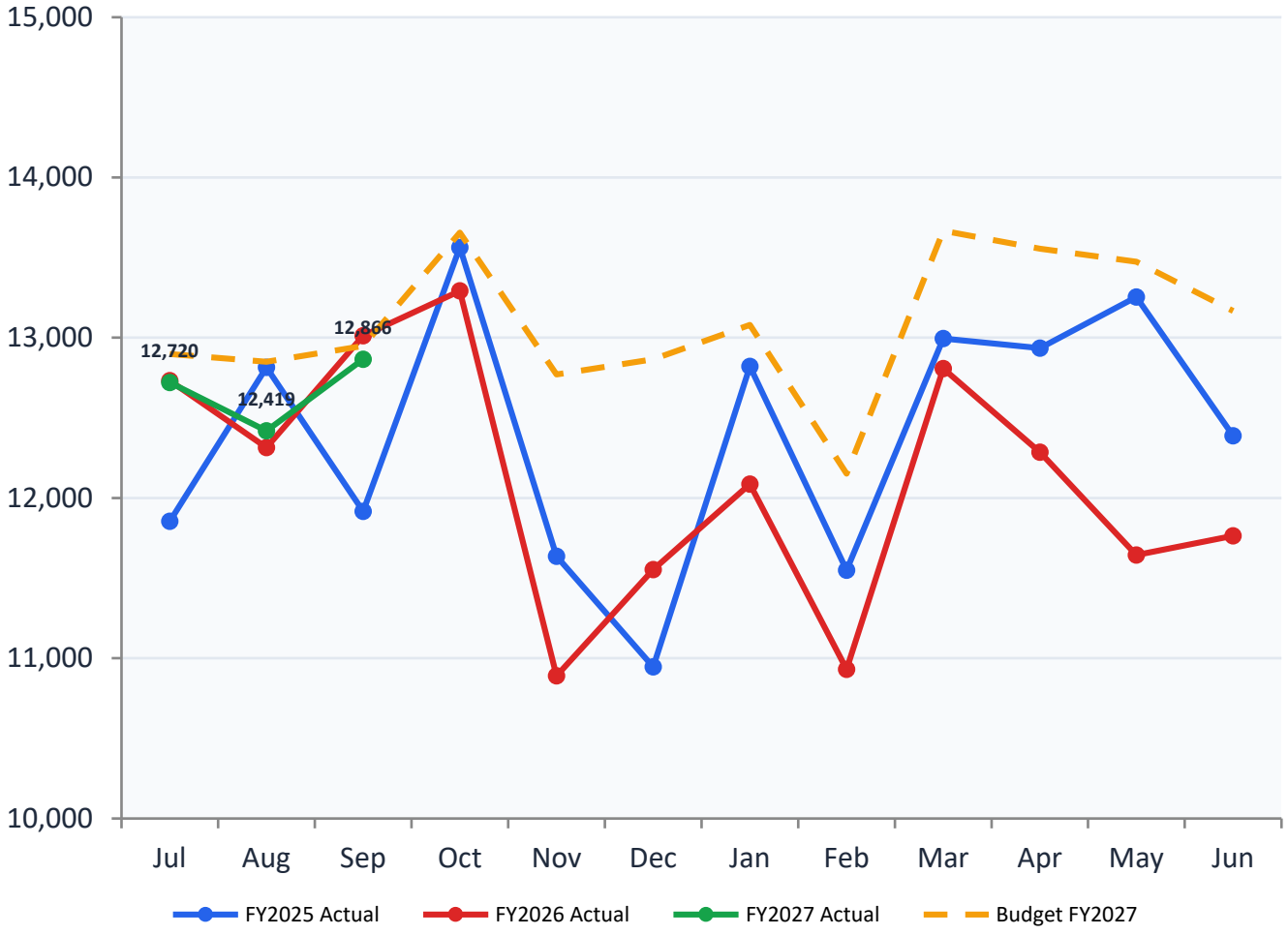


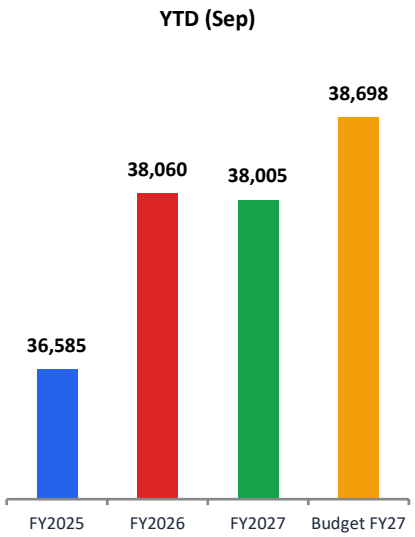


Cath Lab Patients (IP & OP)

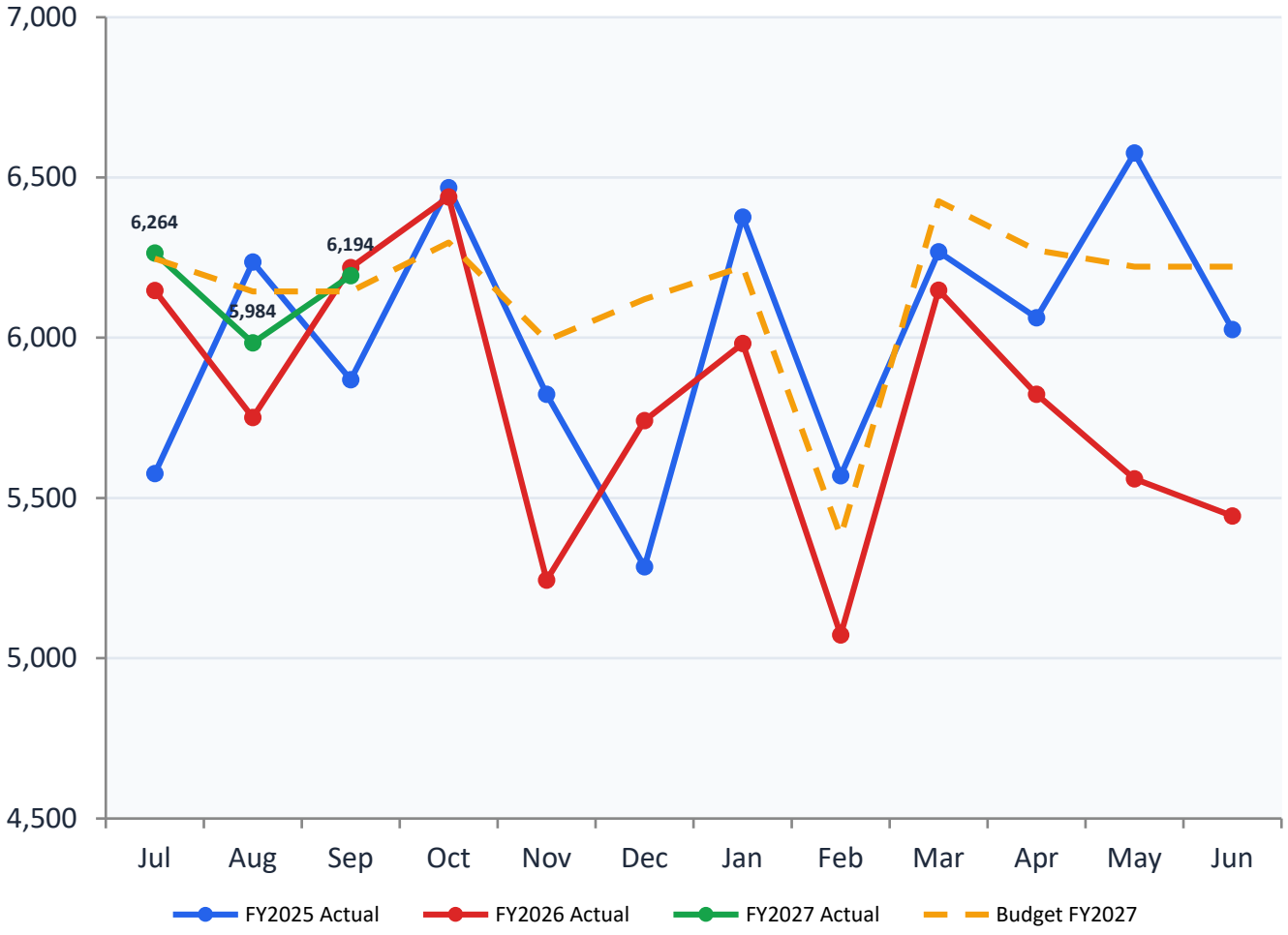


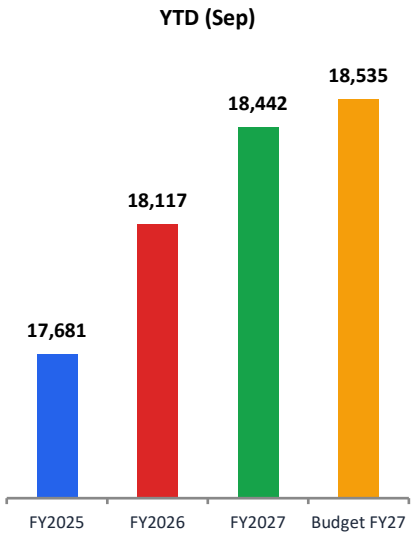
Rural Health Clinics Visits



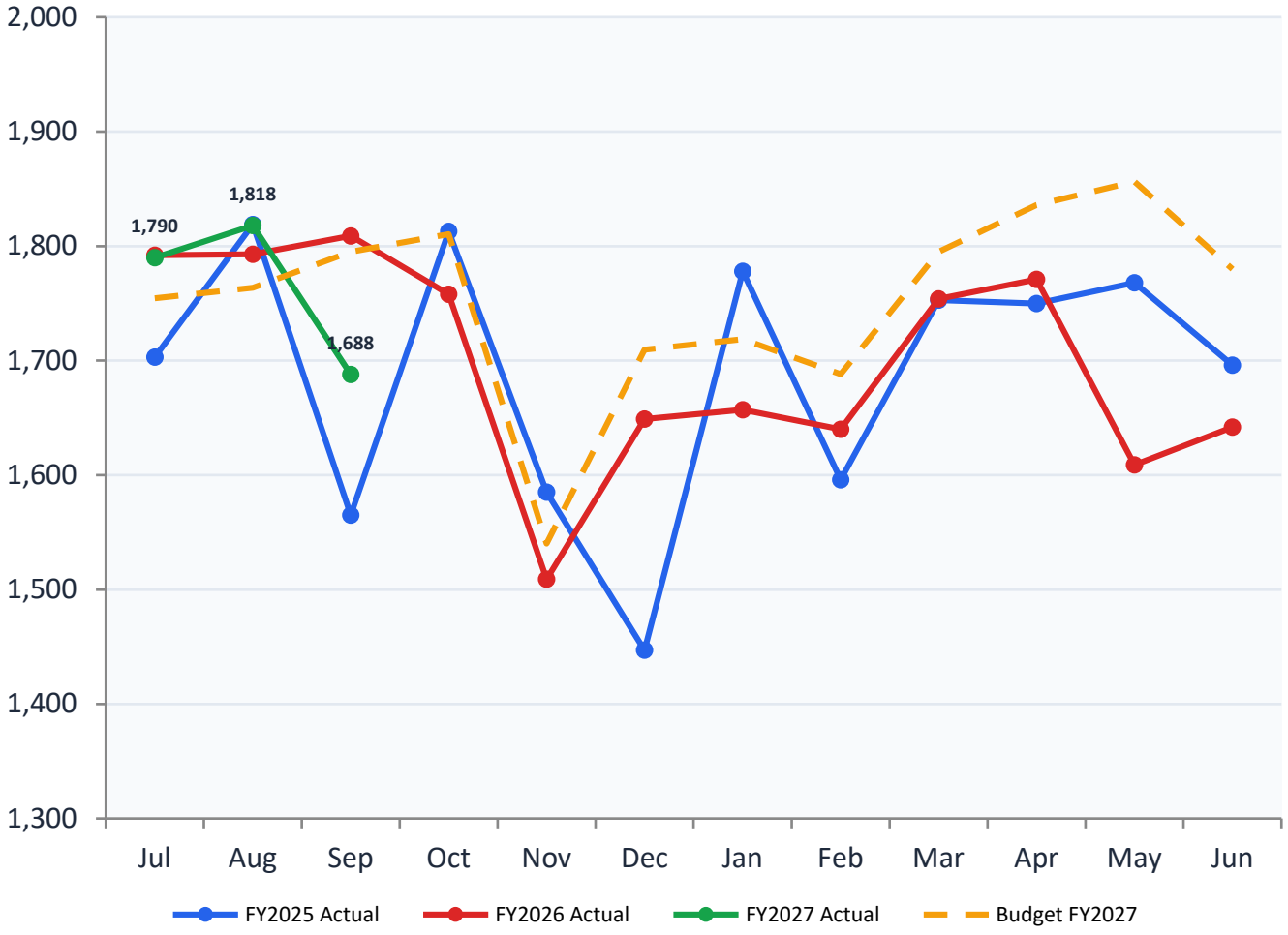


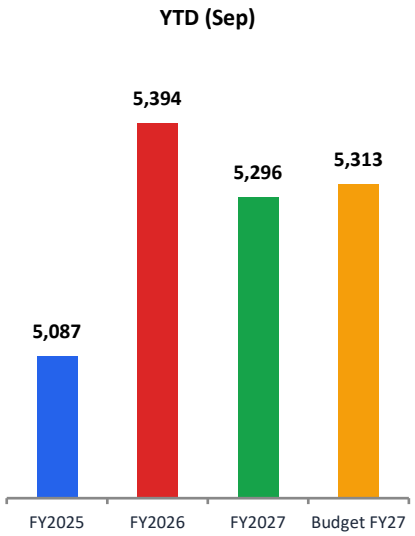
RHC Exeter - Visits



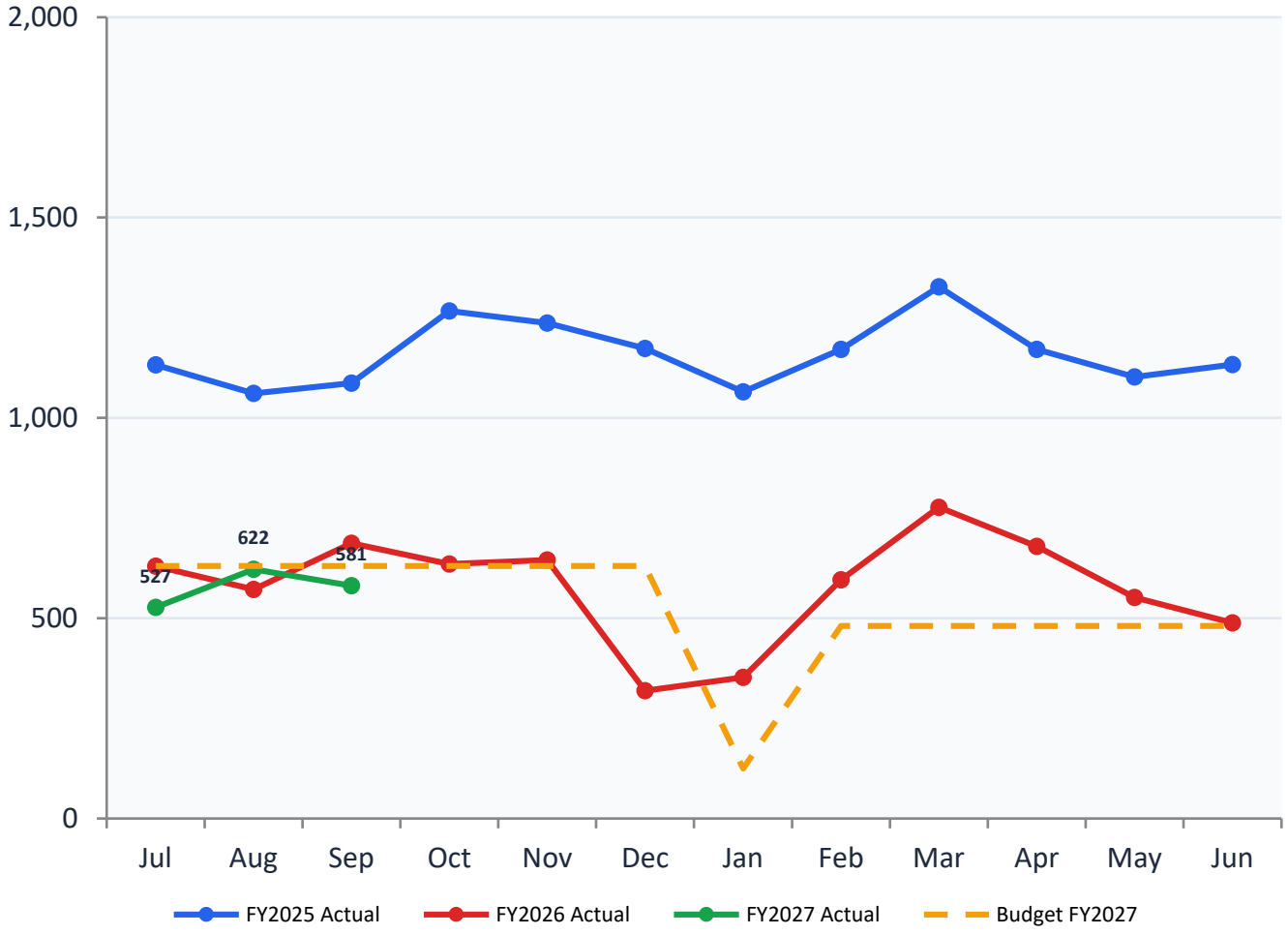


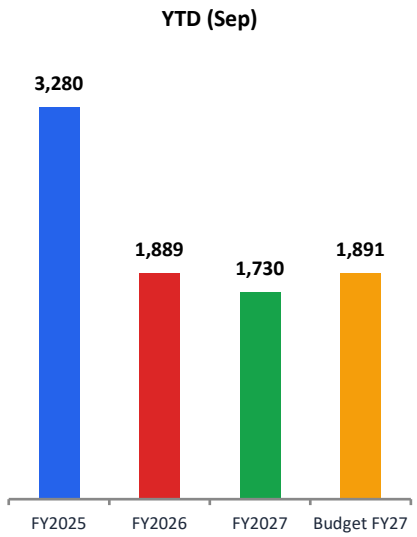
RHC Lindsay - Visits



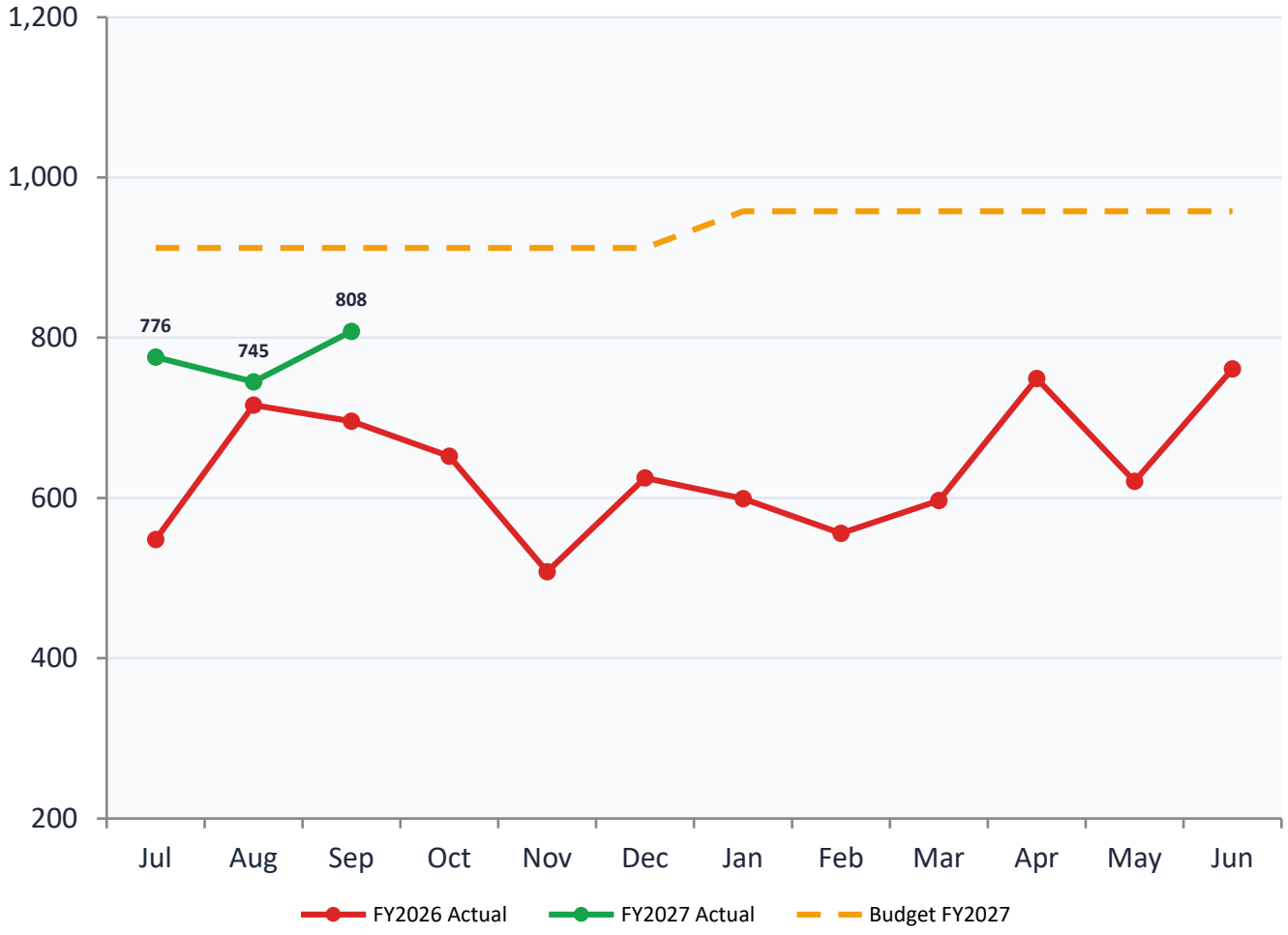


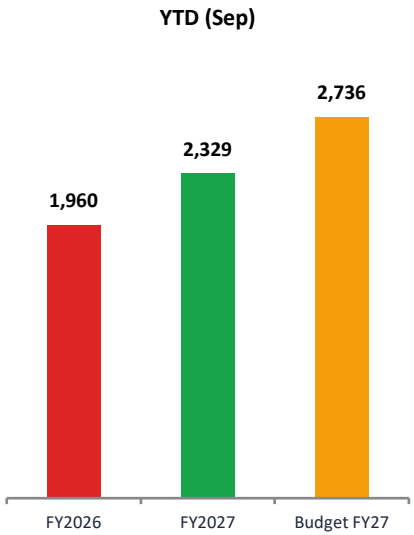
RHC Woodlake - Visits



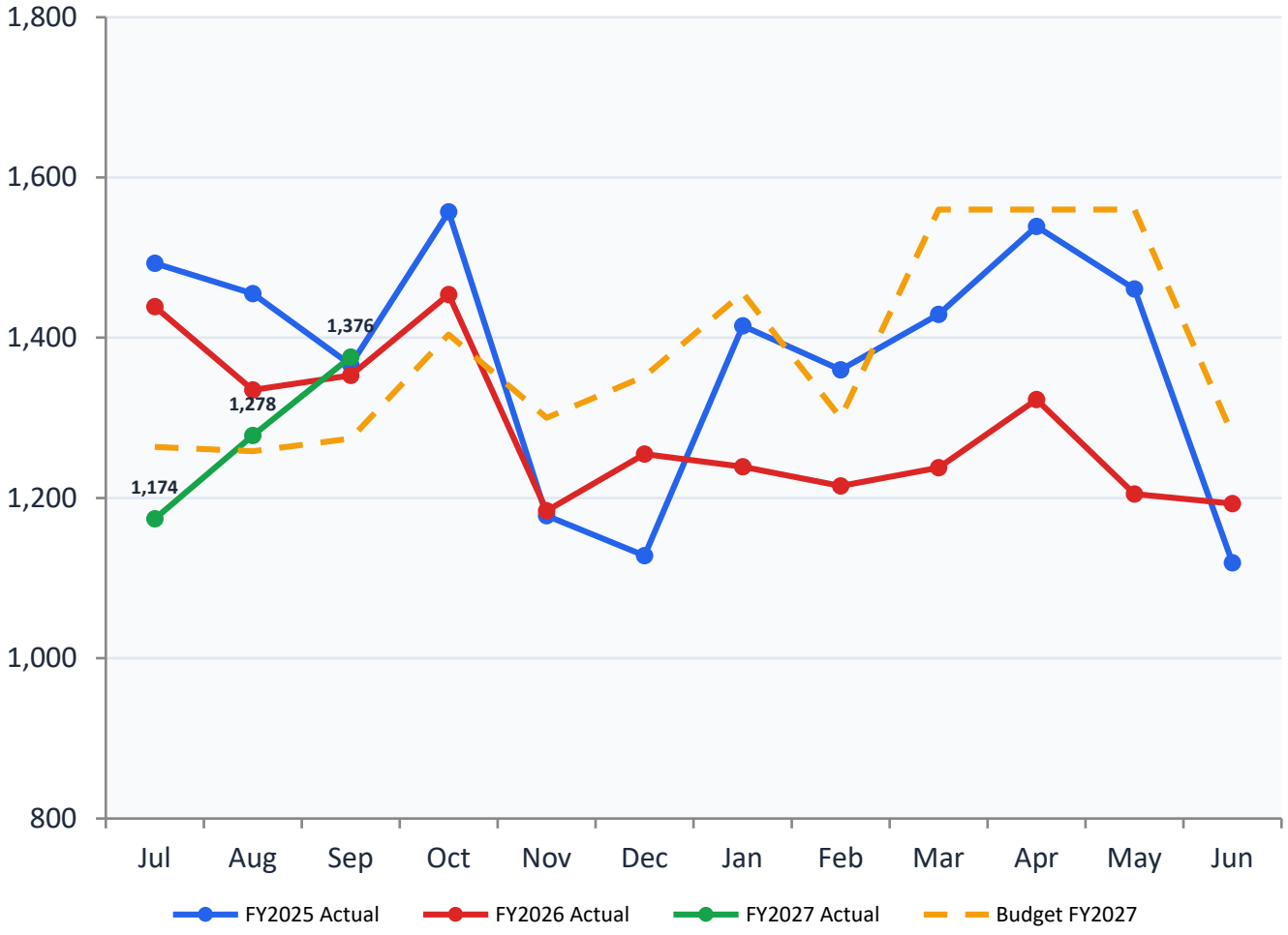


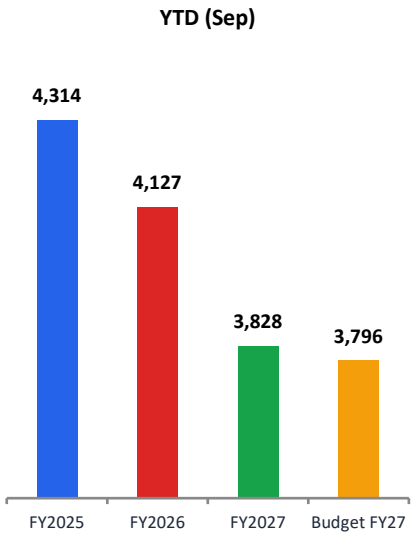
RHC Woodlake Valencia - Visits



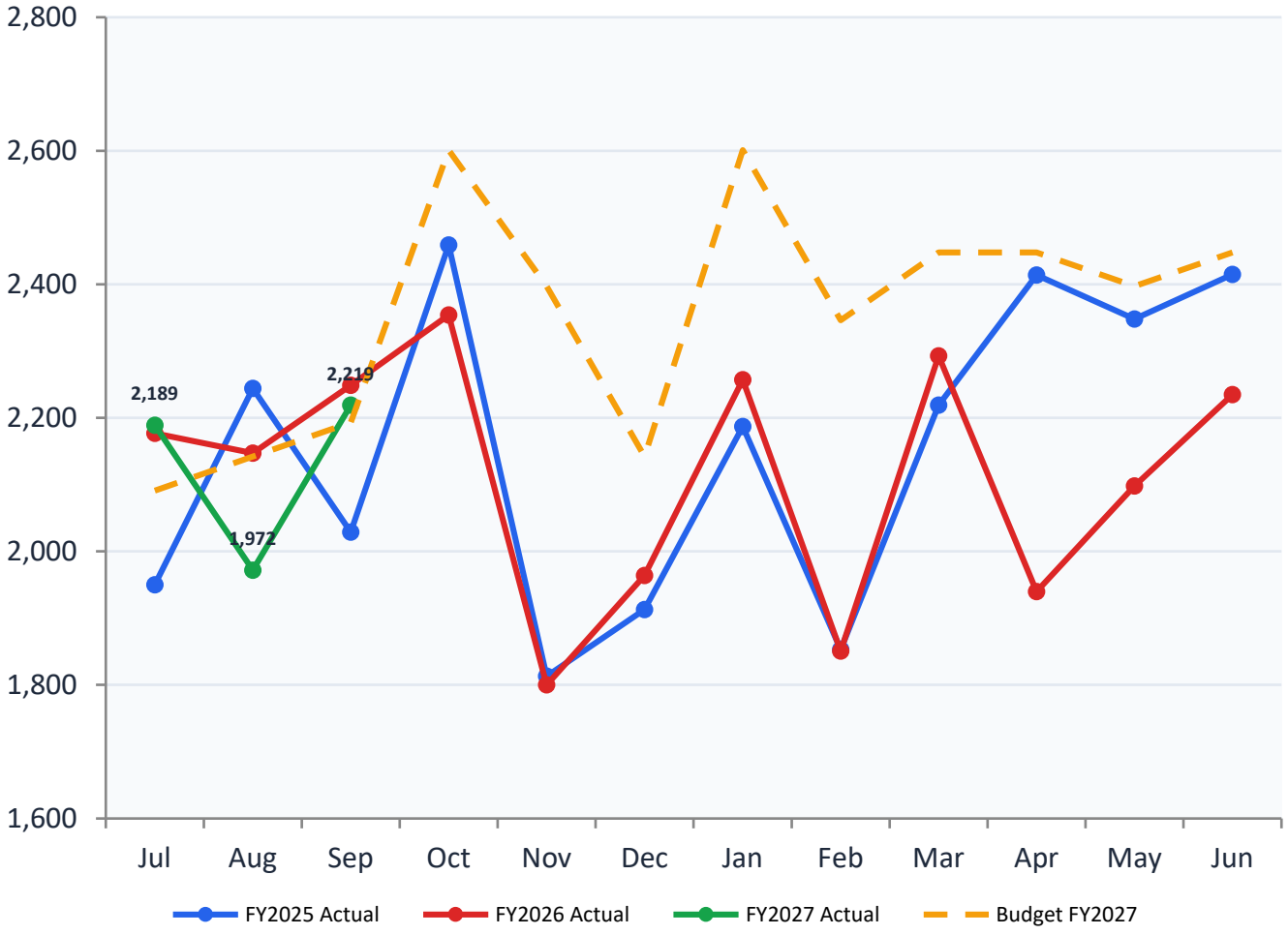


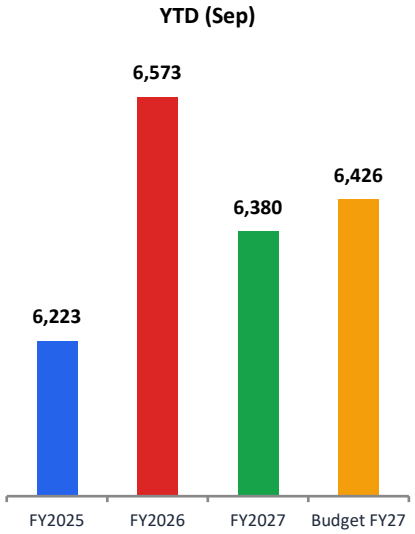
RHC Dinuba - Visits



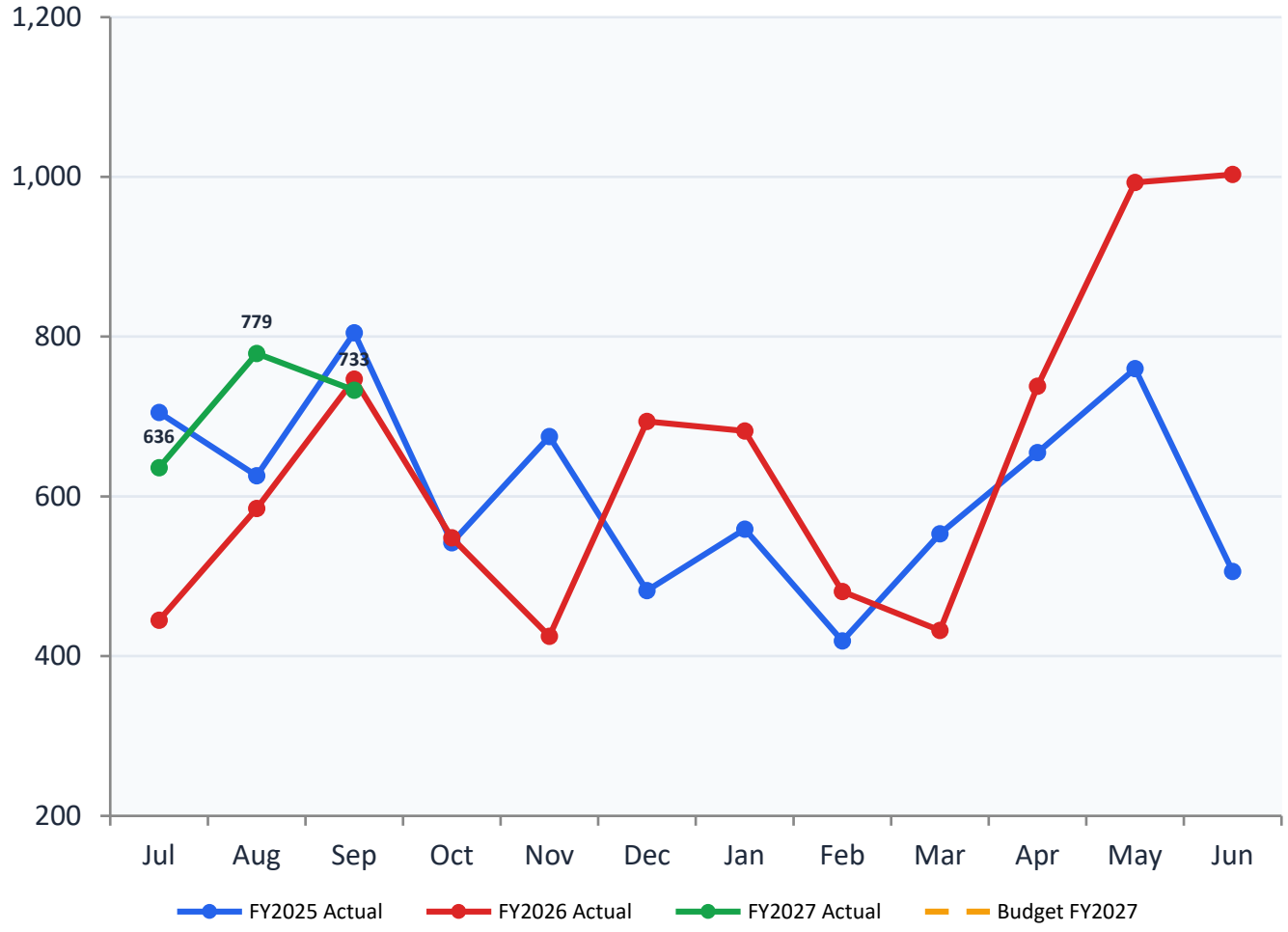


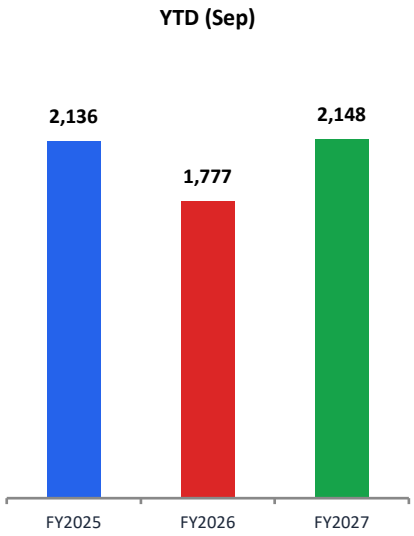
RHC Tulare - Visits



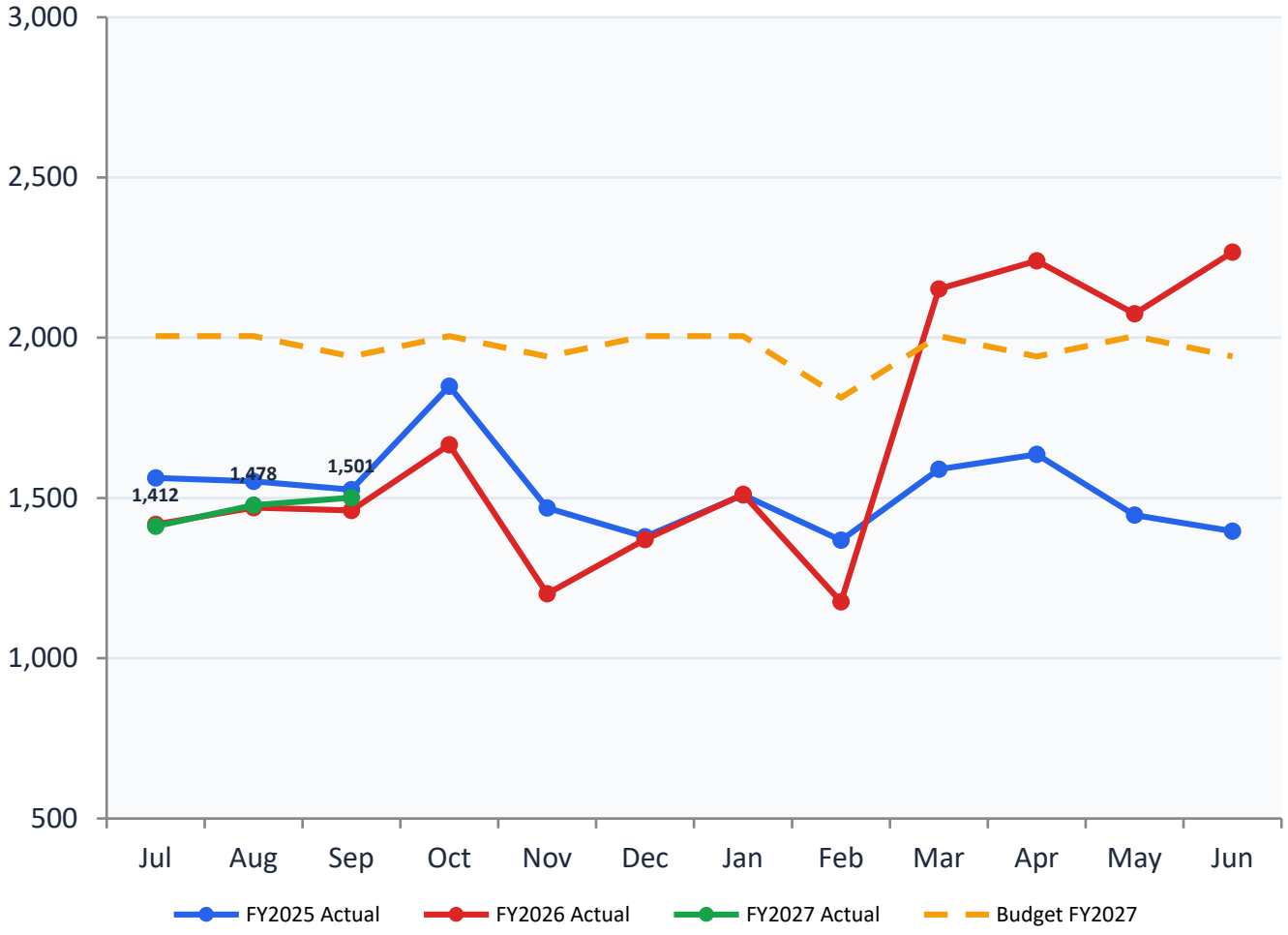


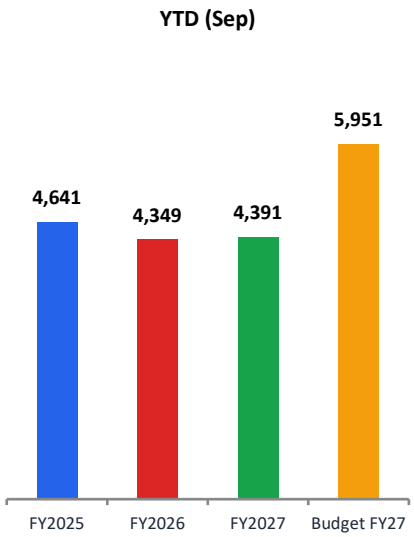
Neurosurgery Clinic - wRVU's



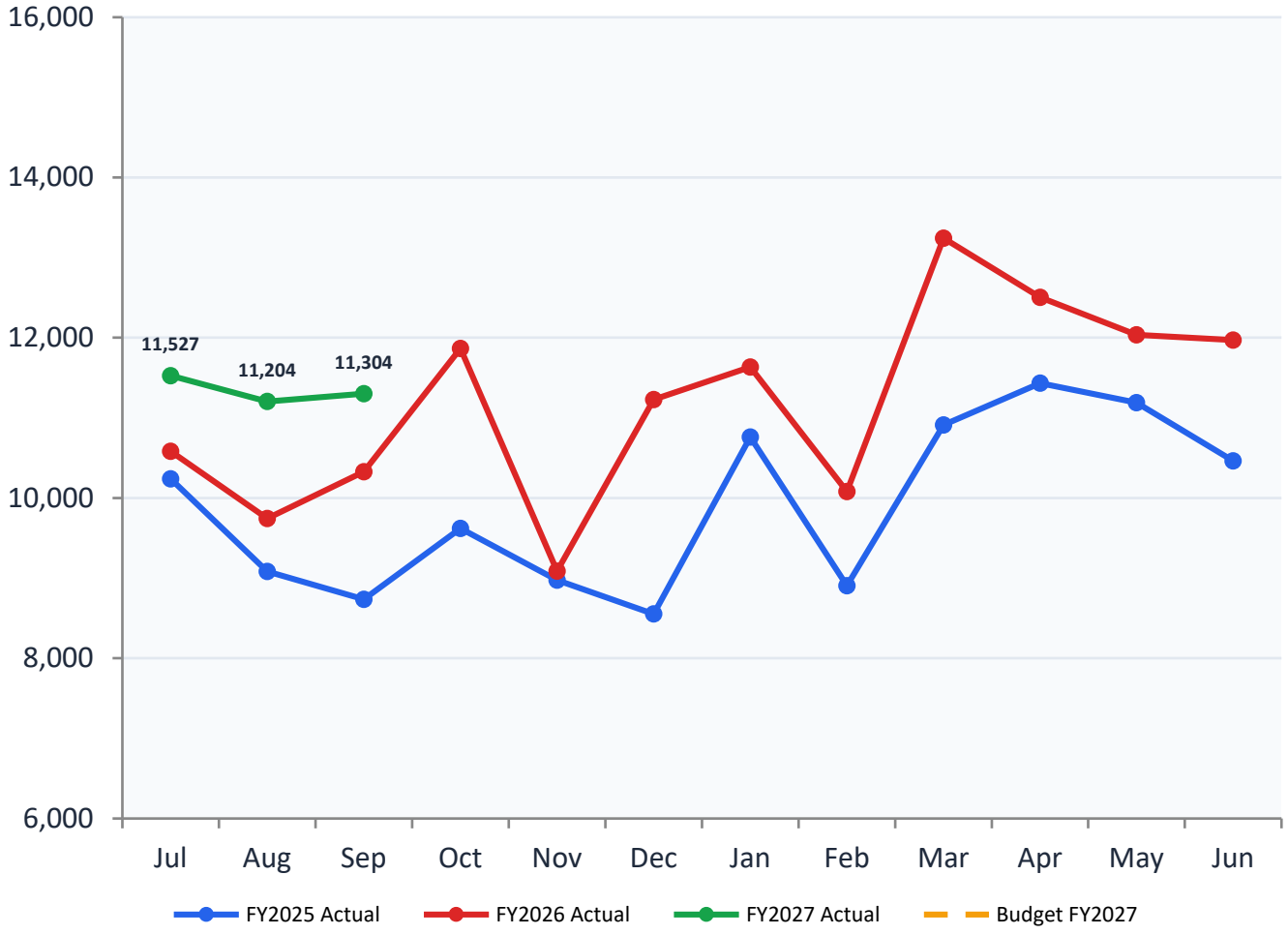


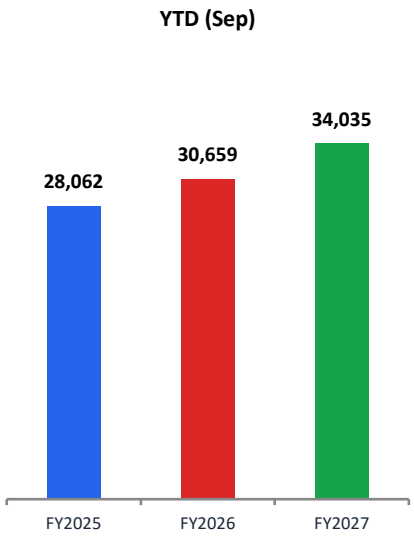
KH Cardiology Center Registrations



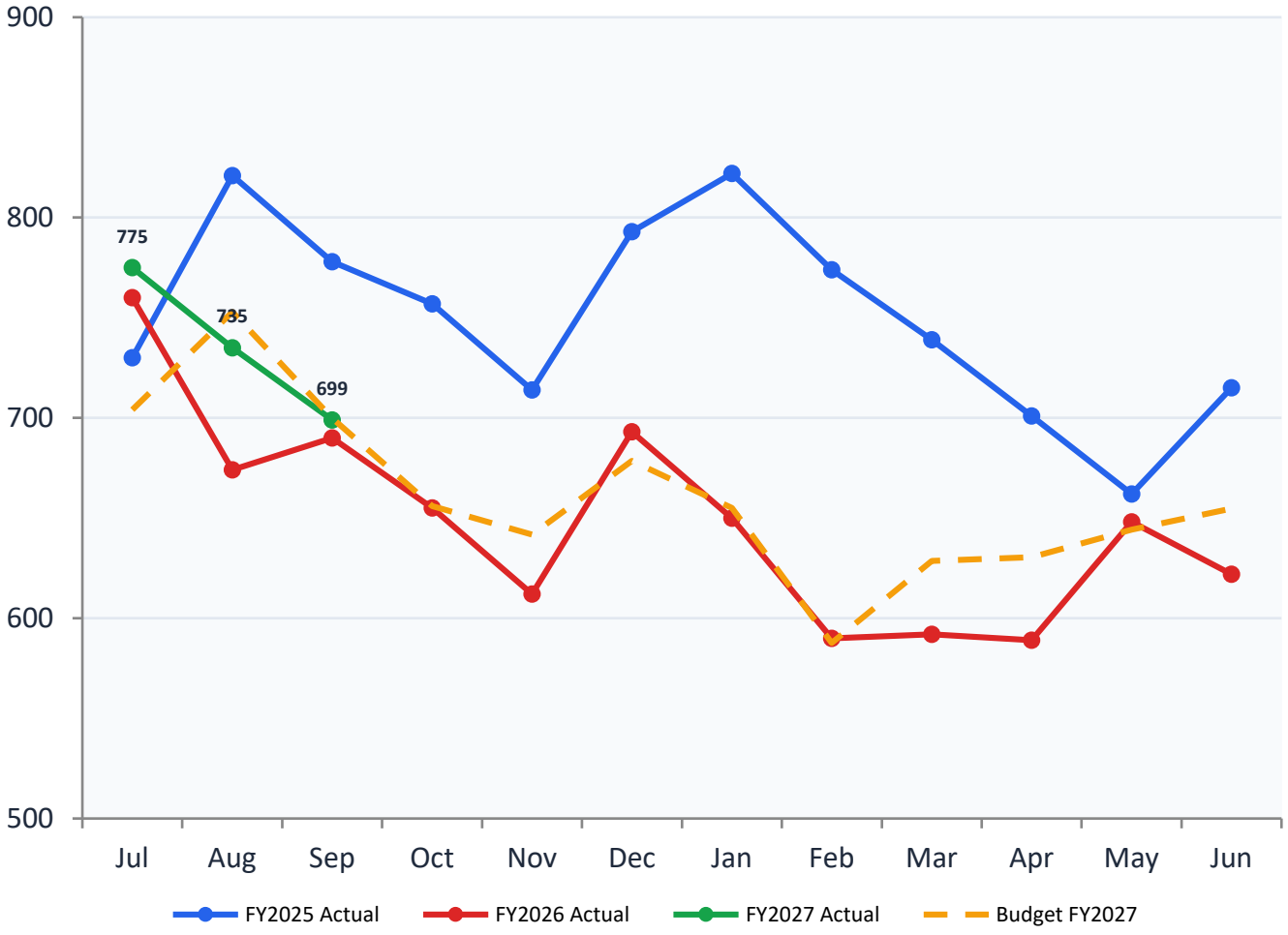


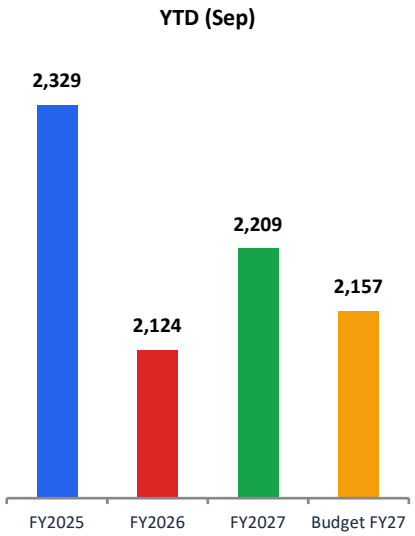
KH Cardiology Center - wRVU's



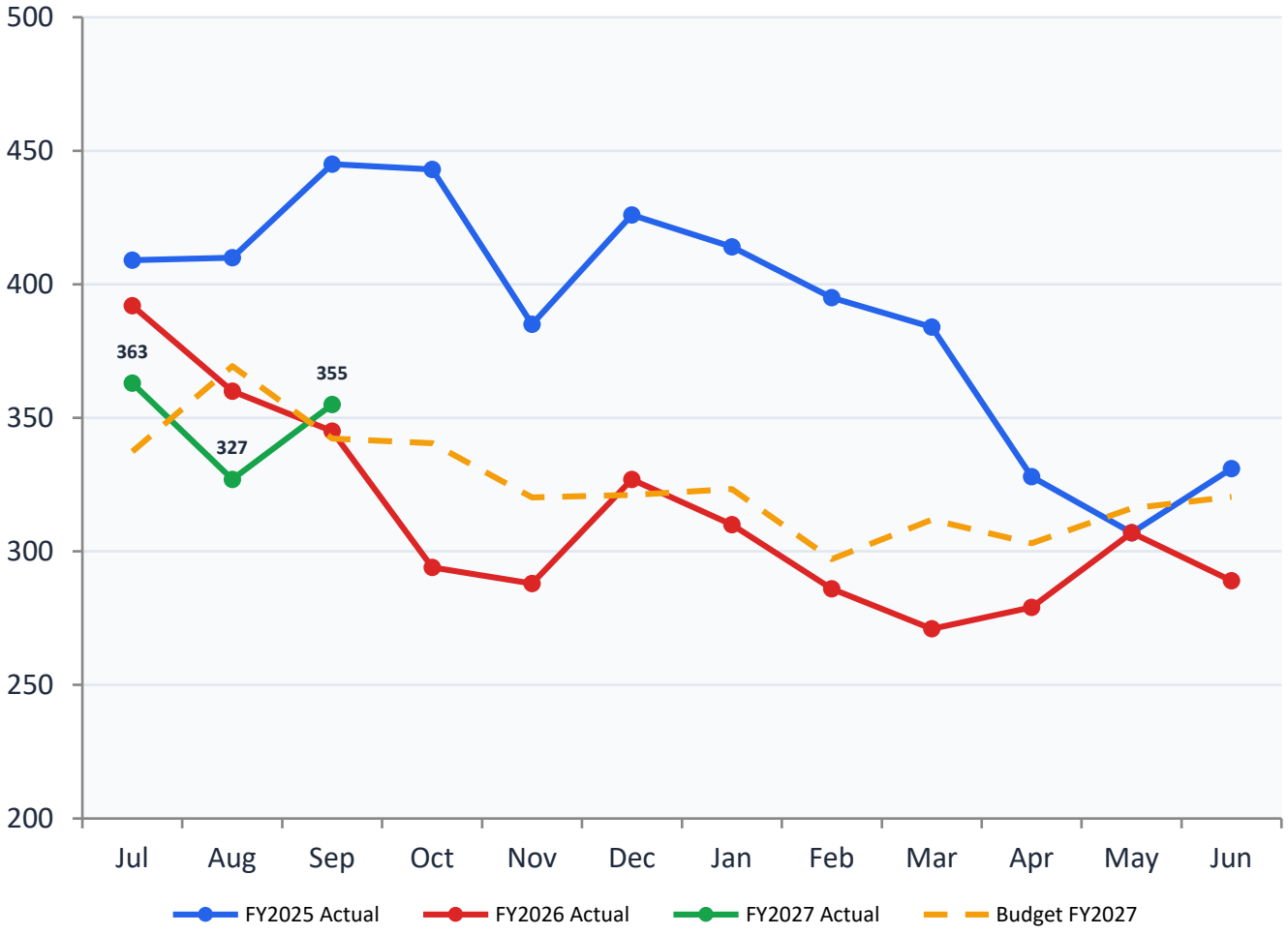


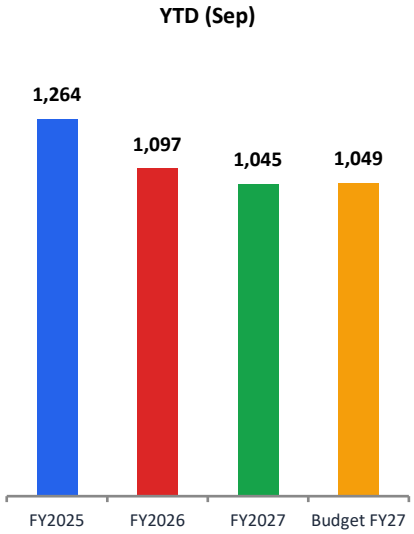
Labor Triage Registrations



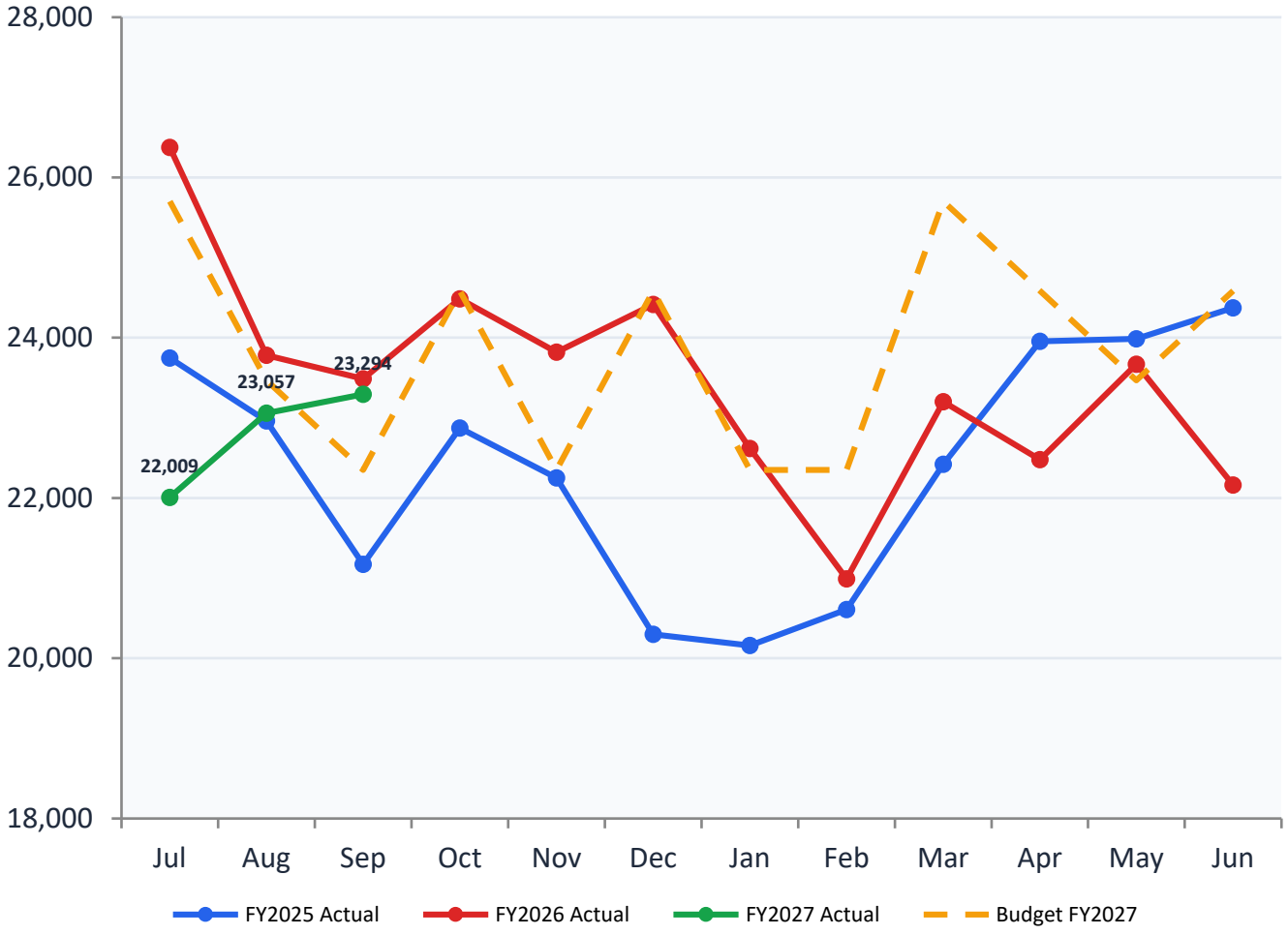


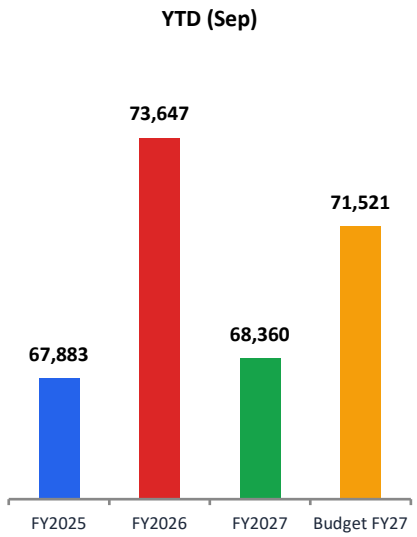
Deliveries


500
450
400
350
300
250
200
363
355
327
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2025 Actual
FY2026 Actual
FY2027 Actual
Budget FY2027

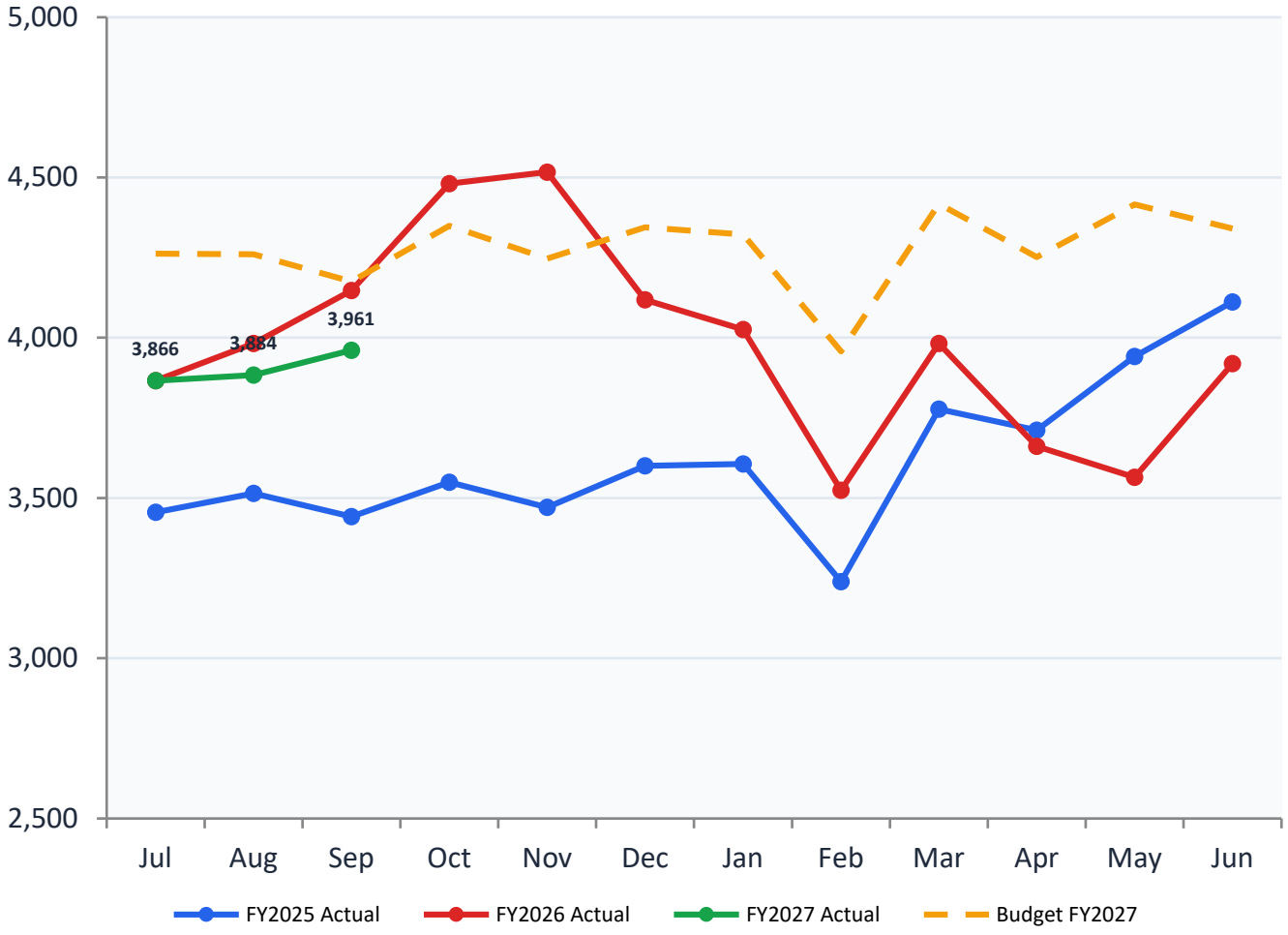

YTD (Sep)
1,264
1,097
1,045
1,049
FY2025
FY2026
FY2027
Budget FY27

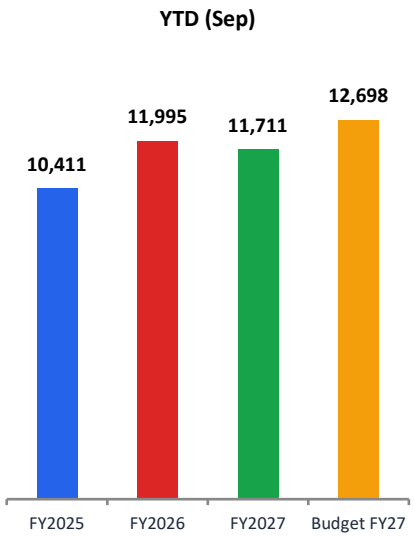
Home Infusion Days



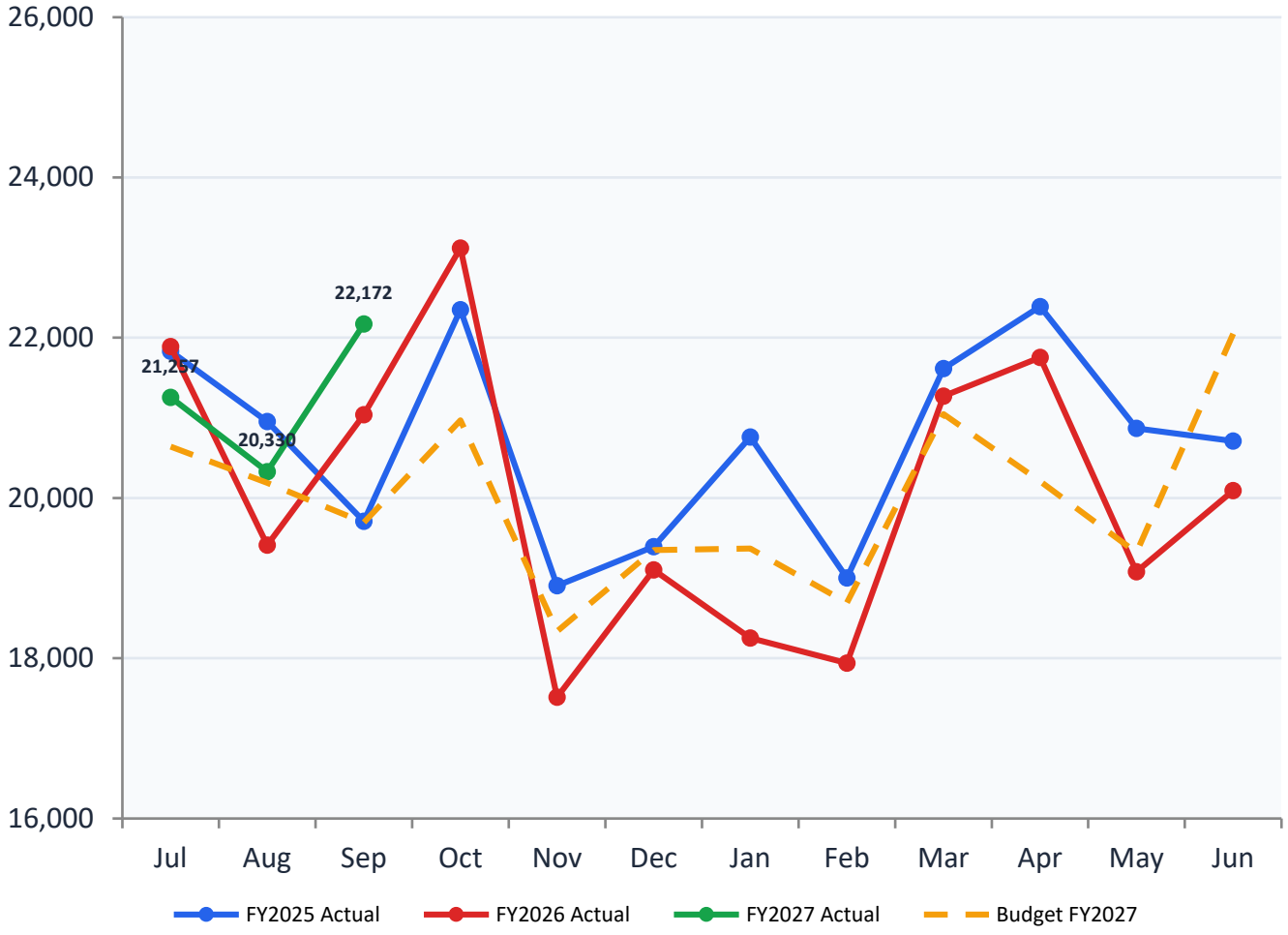


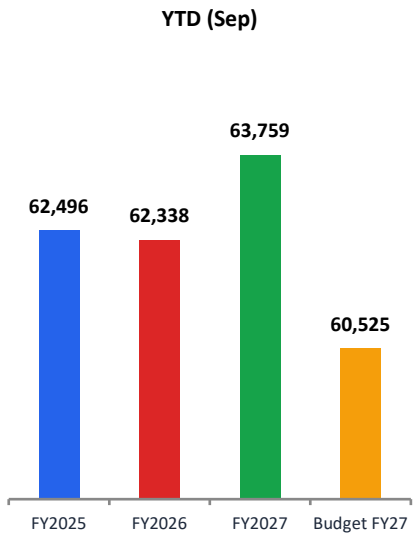
Hospice Days



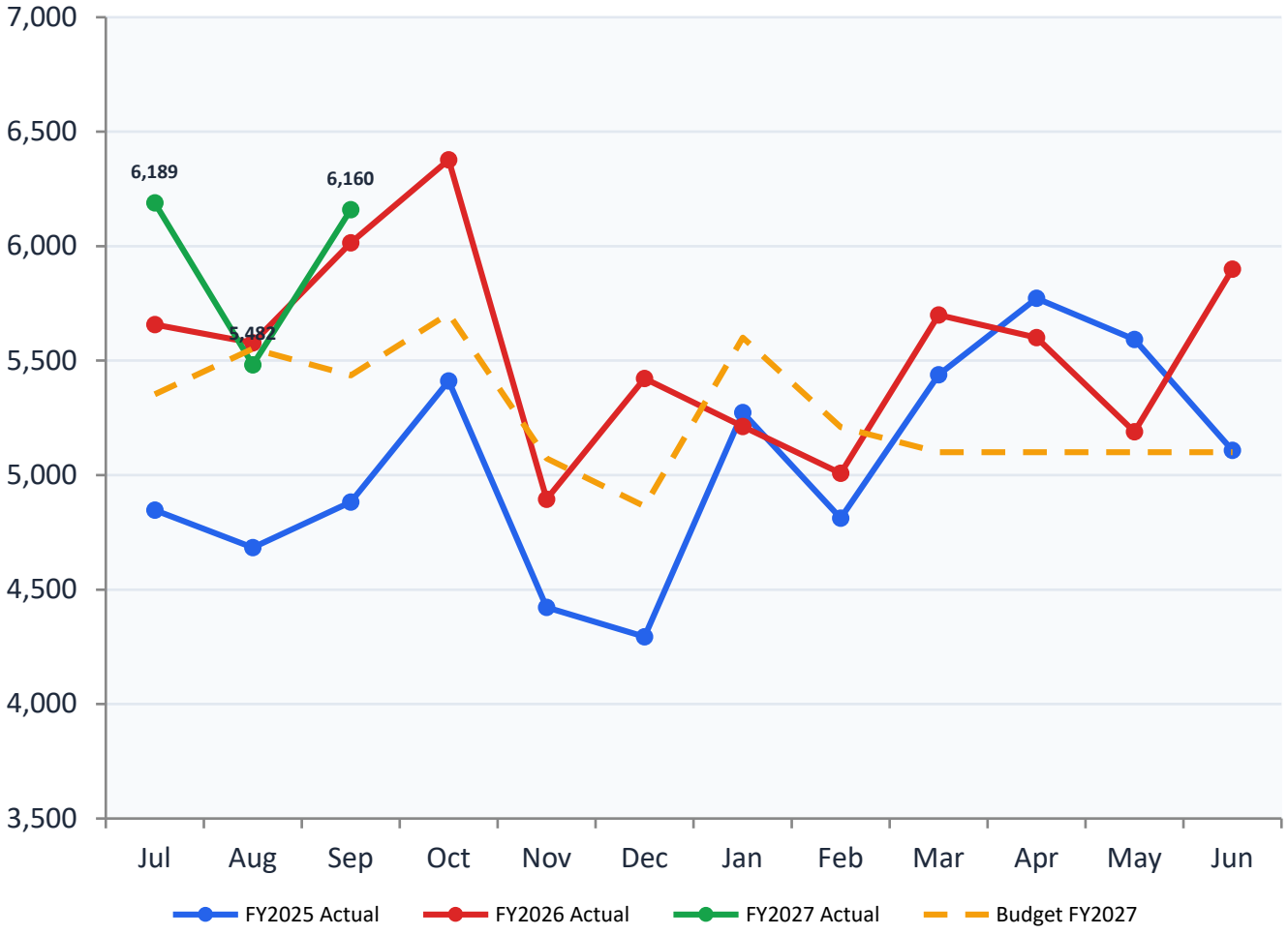


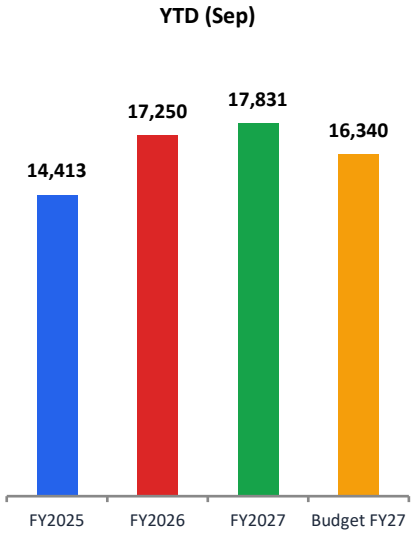
All O/P Rehab Svcs Across District



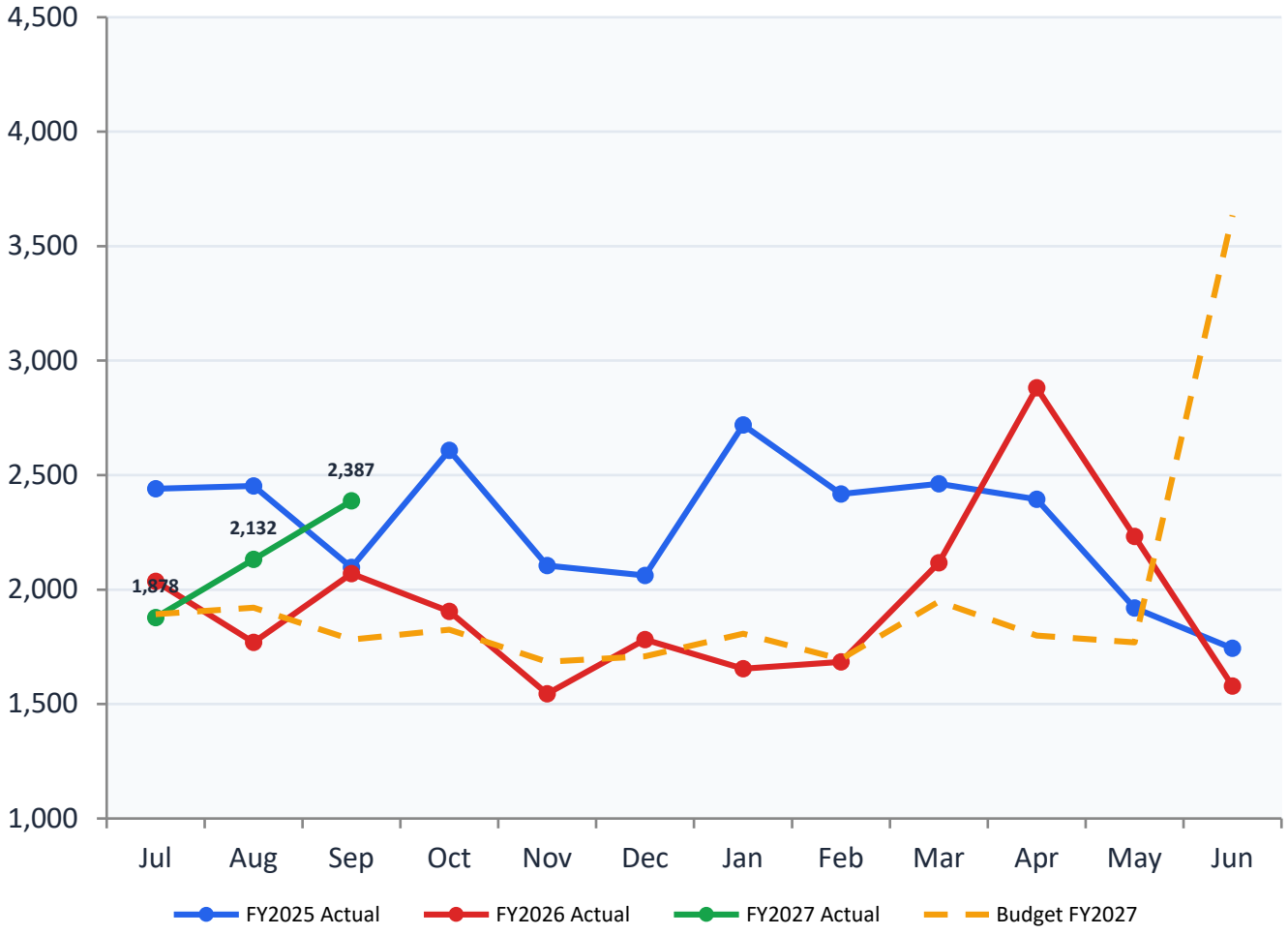


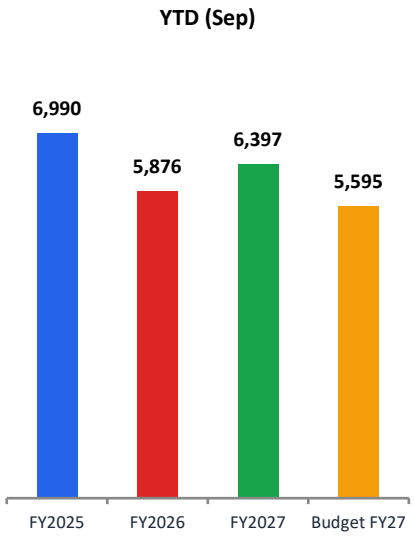
O/P Rehab Services



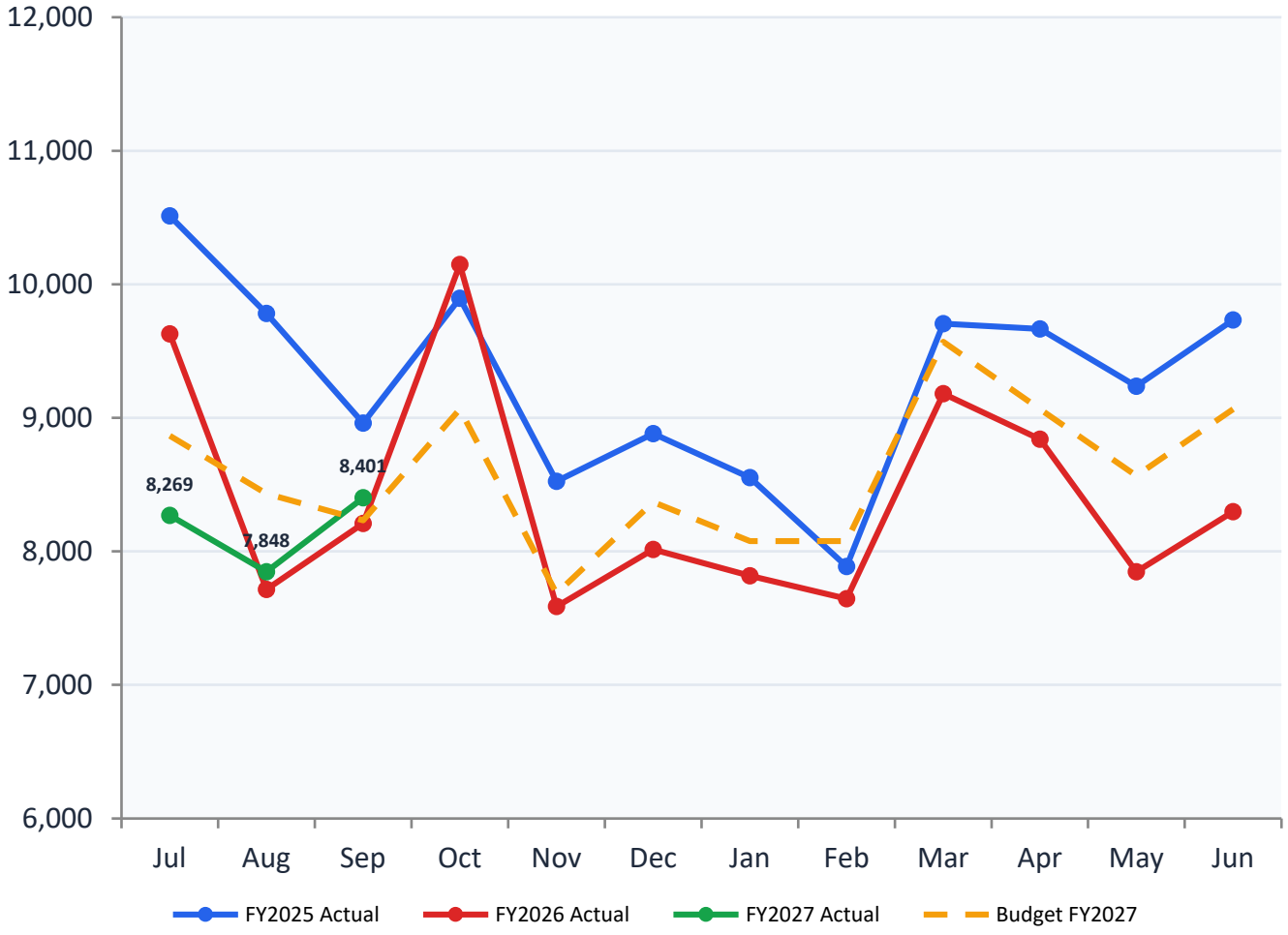


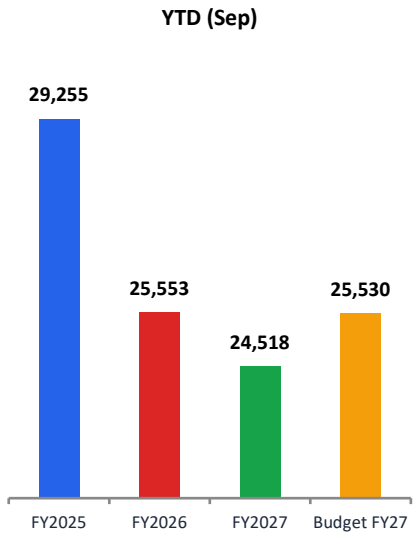
O/P Rehab - Exeter



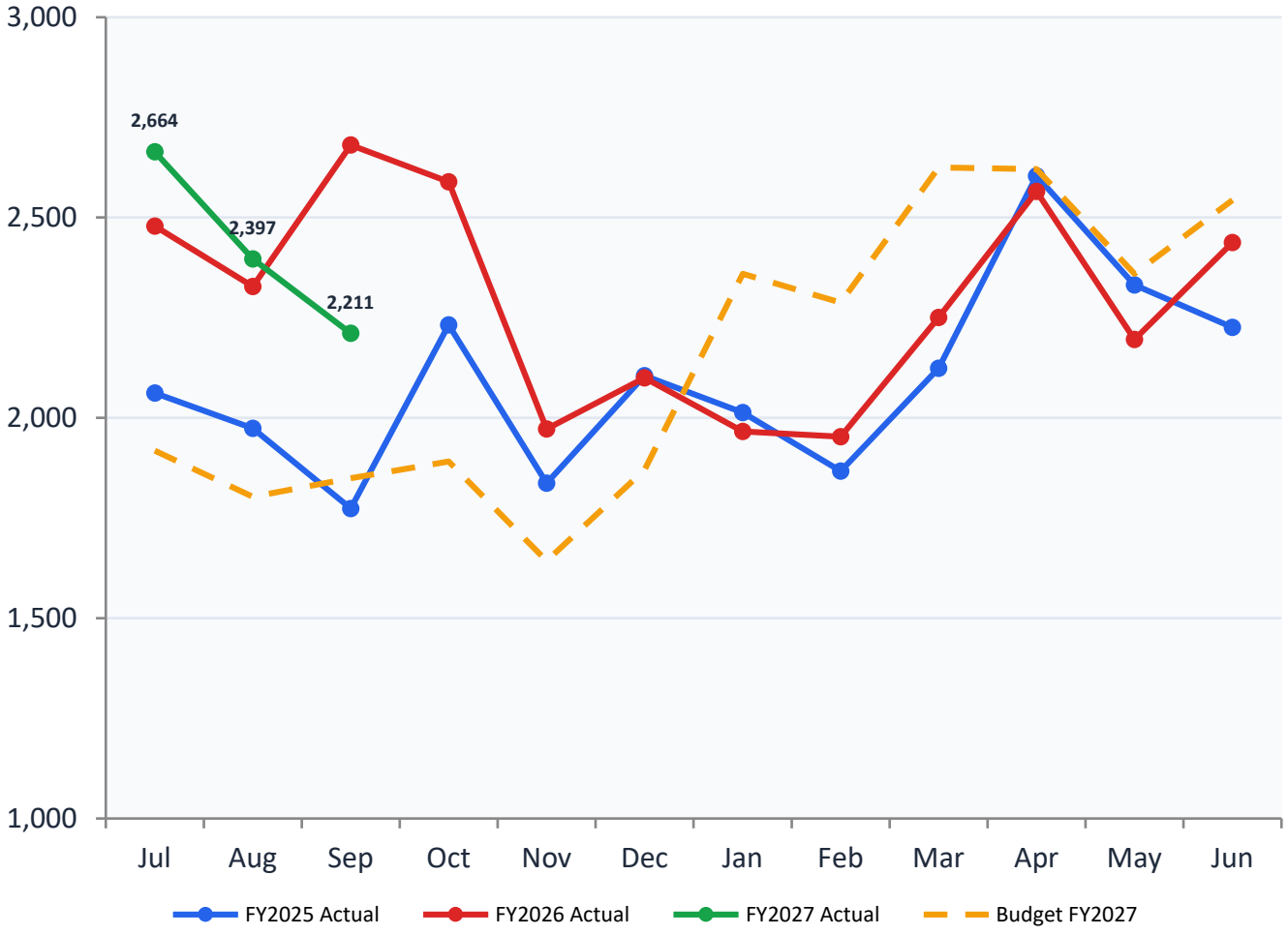


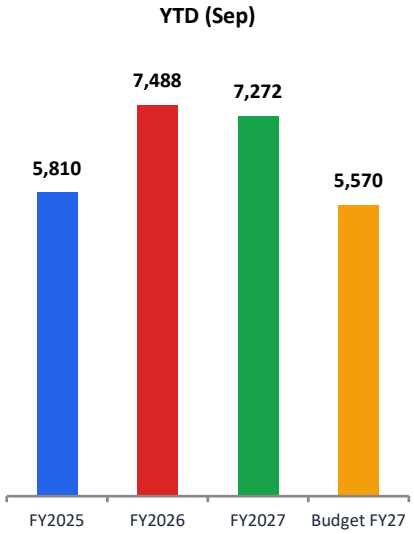
O/P Rehab - Akers



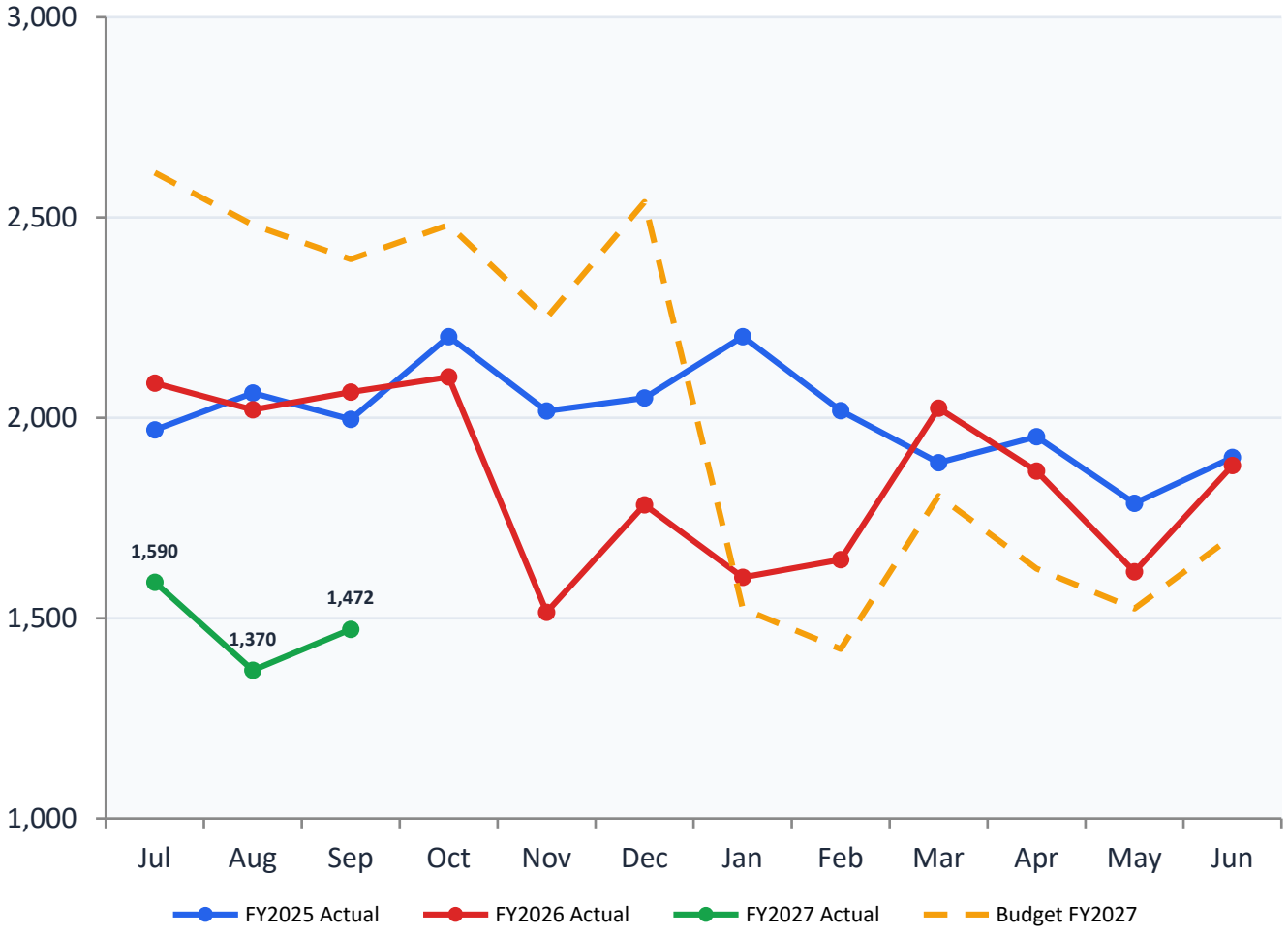


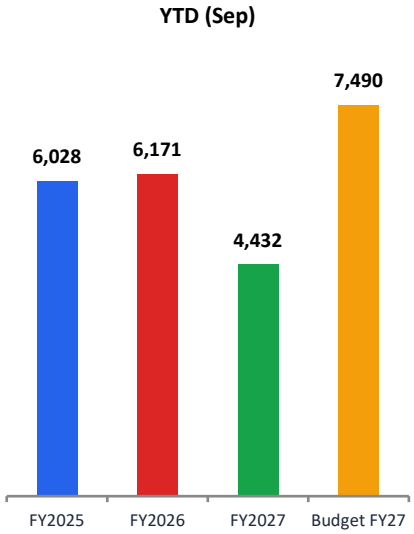
O/P Rehab - LLOPT



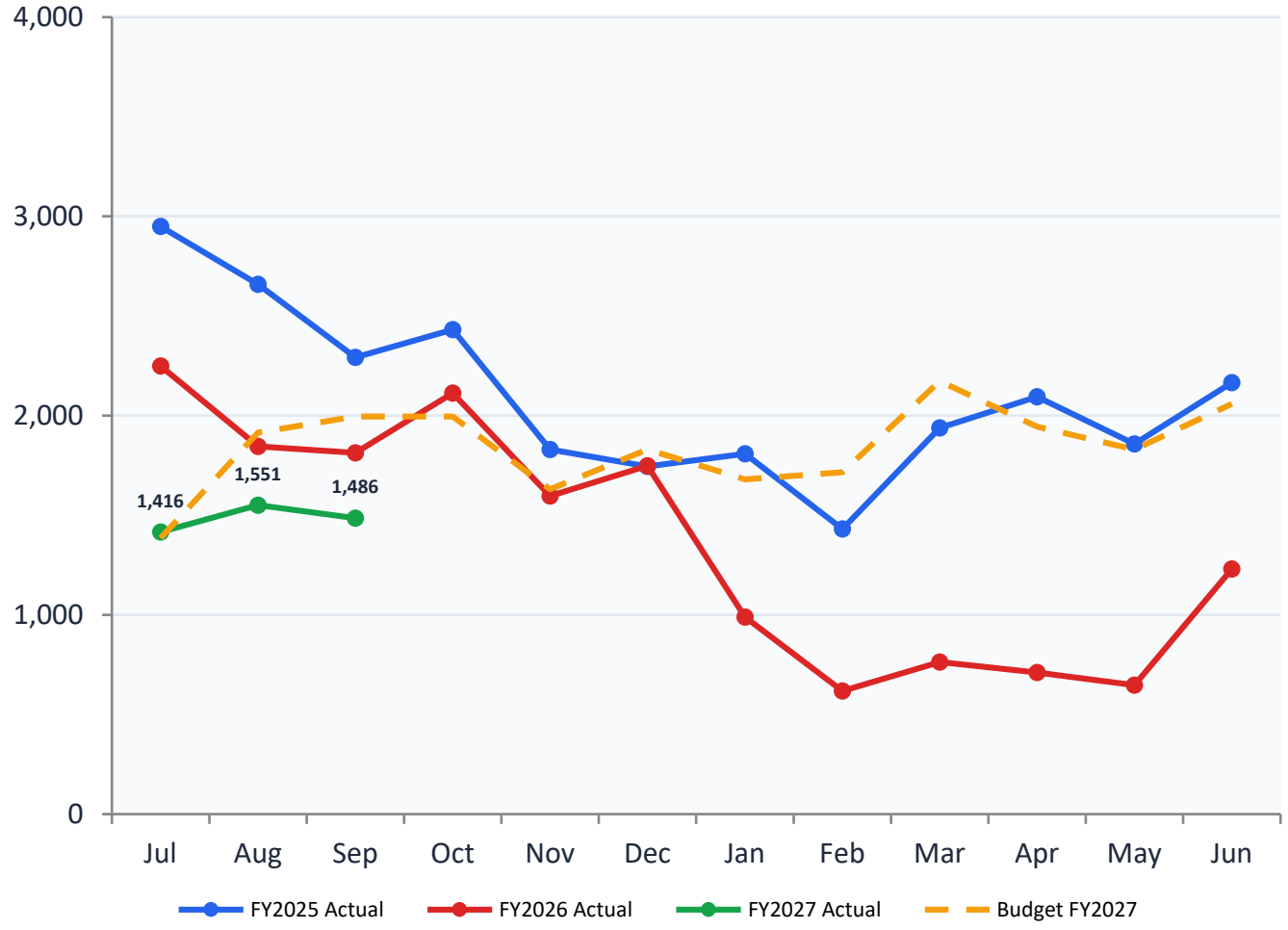


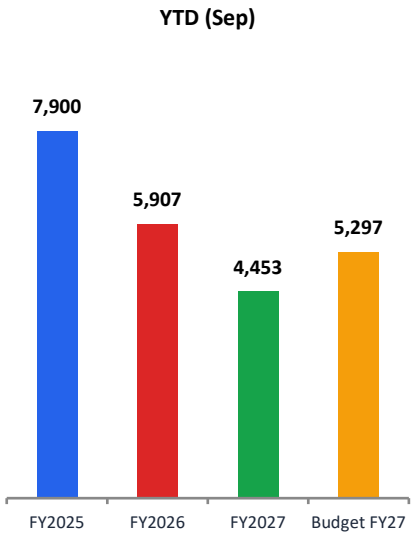
O/P Rehab - Dinuba



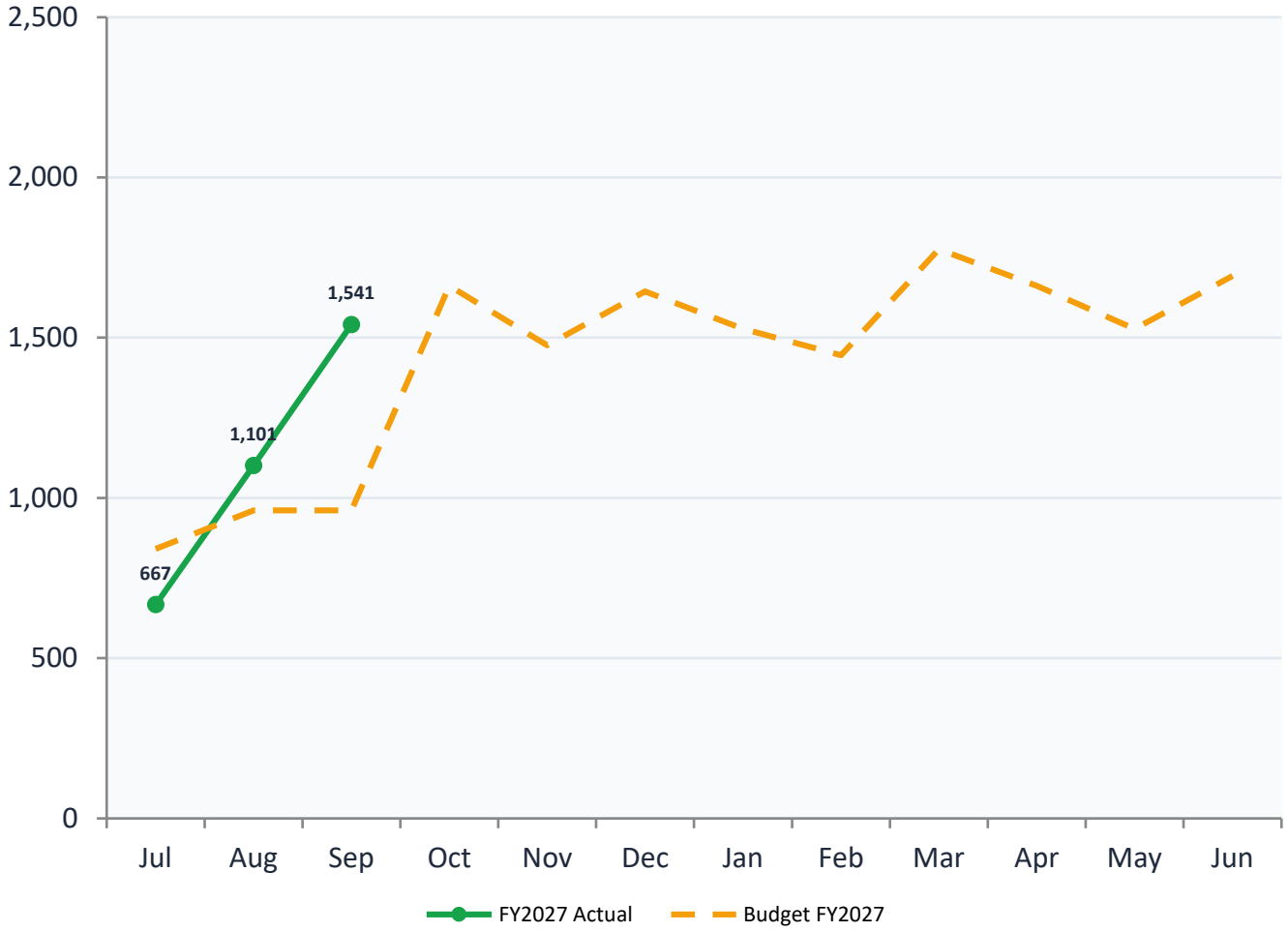


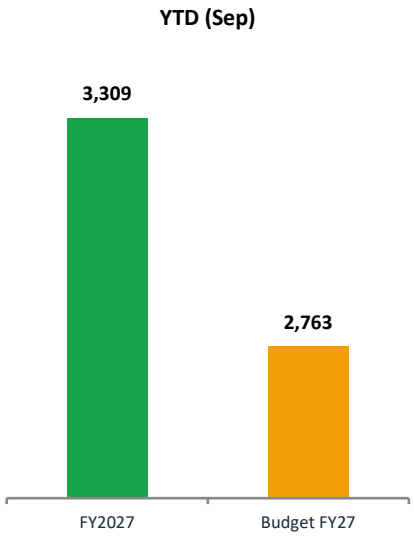
Therapy - Cypress Hand Center



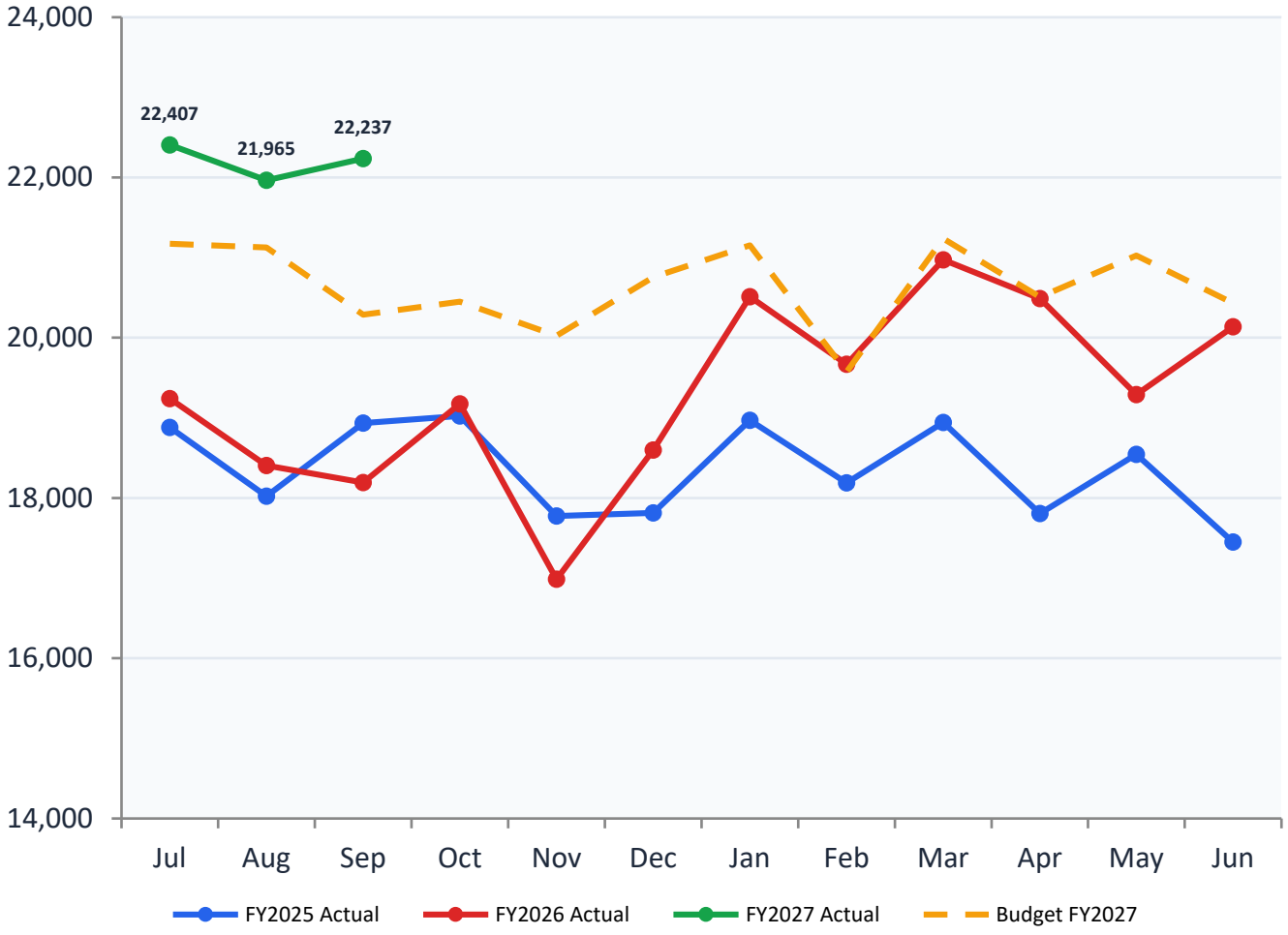


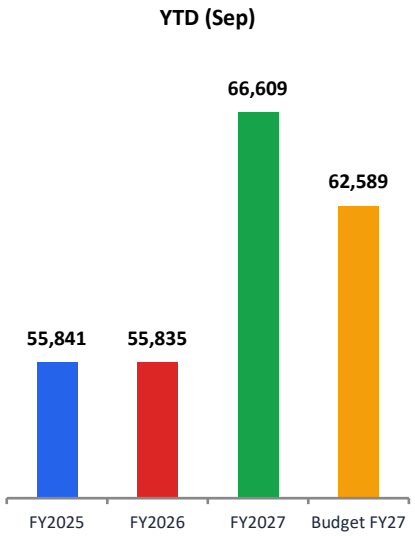
O/P Rehab - Tulare



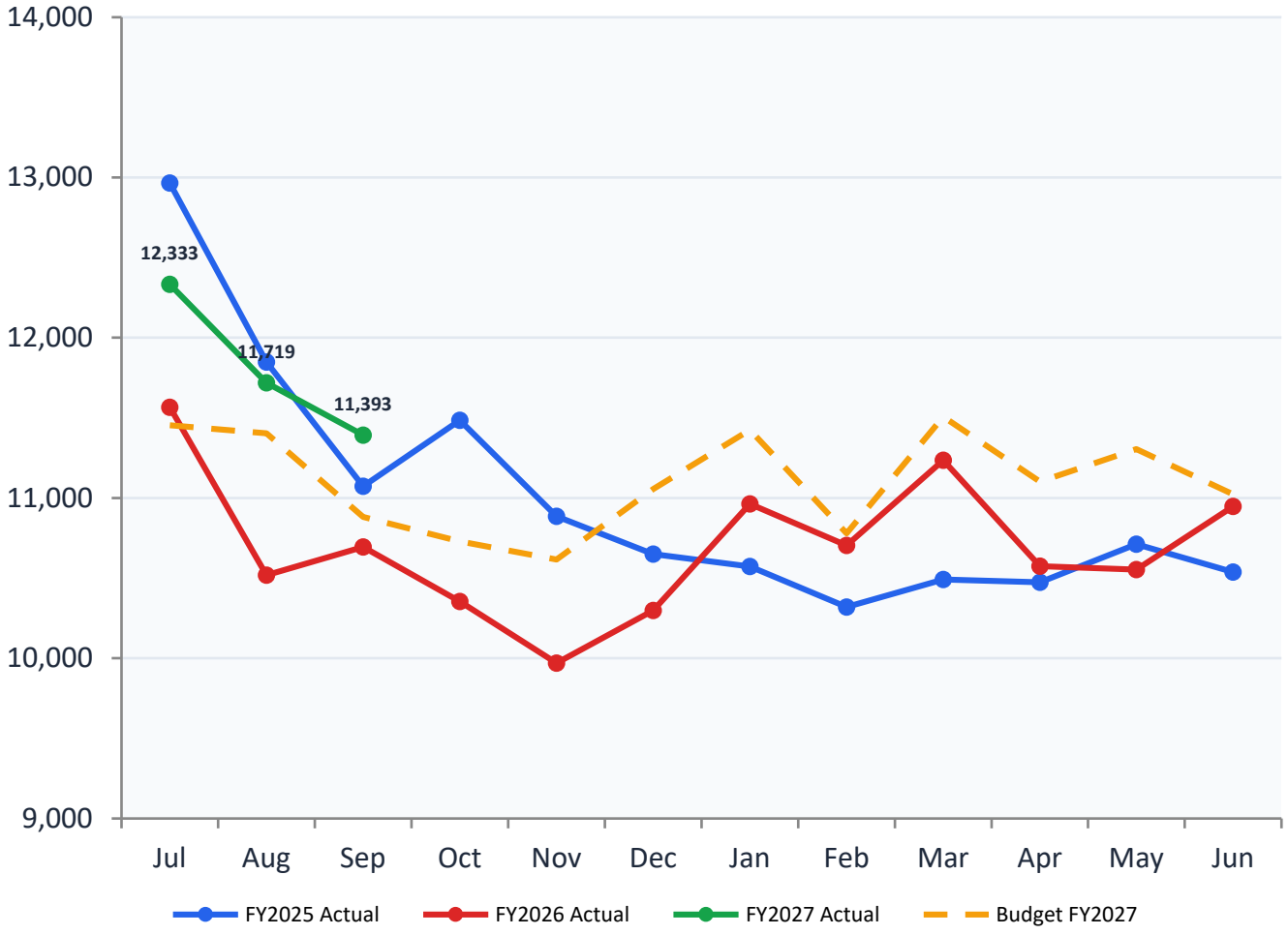


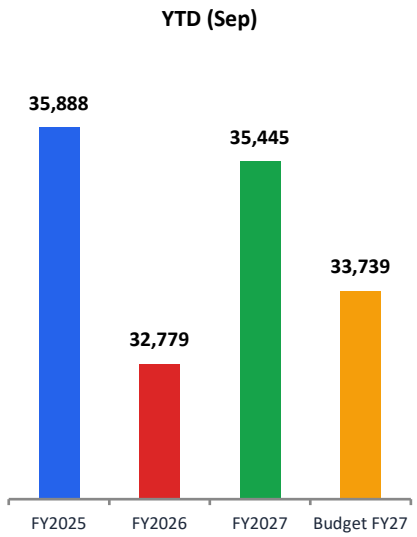
Physical & Other Therapy Units (I/P & O/P)



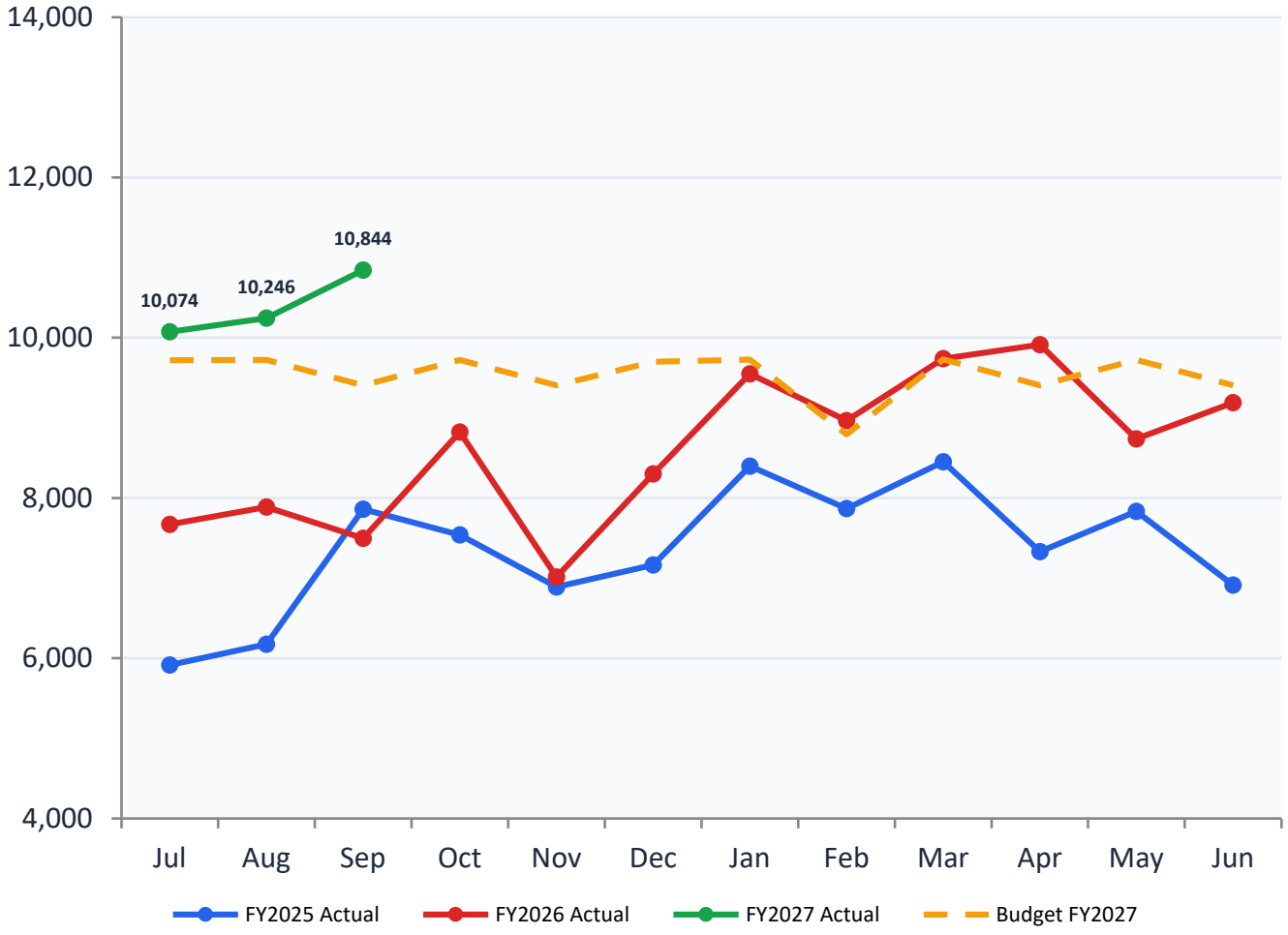


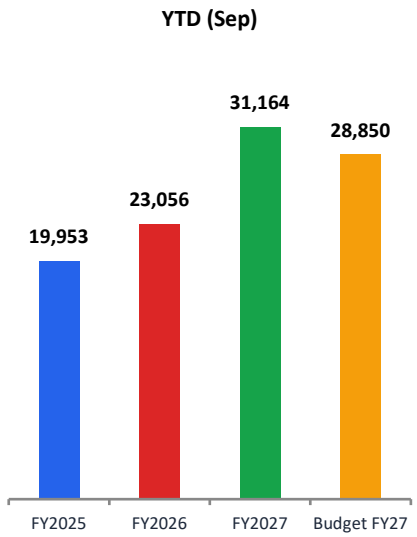
Physical & Other Therapy Units (I/P & O/P)-Main Campus



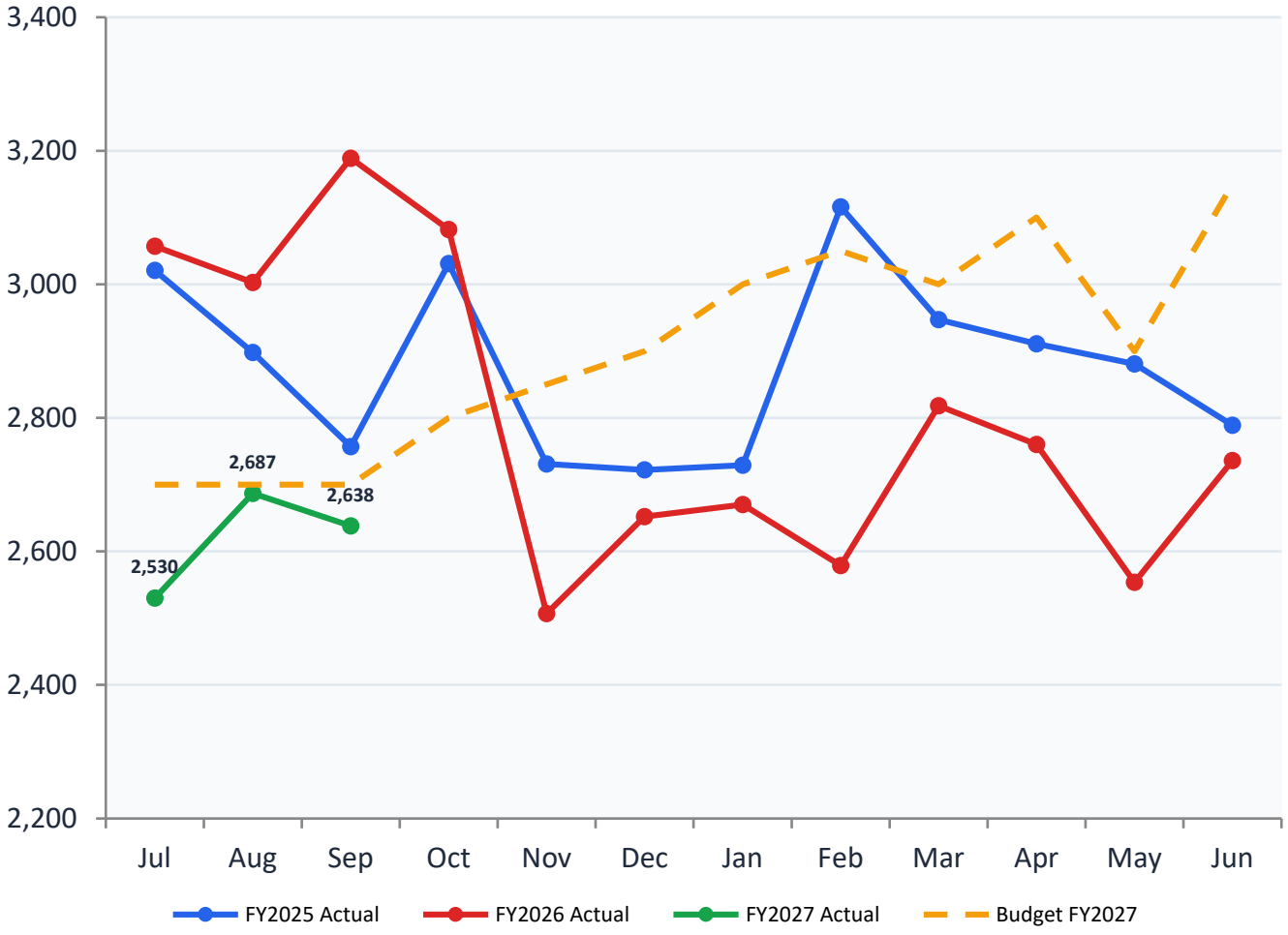


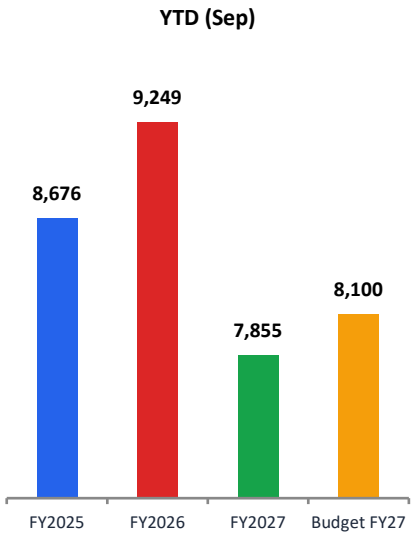
Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus



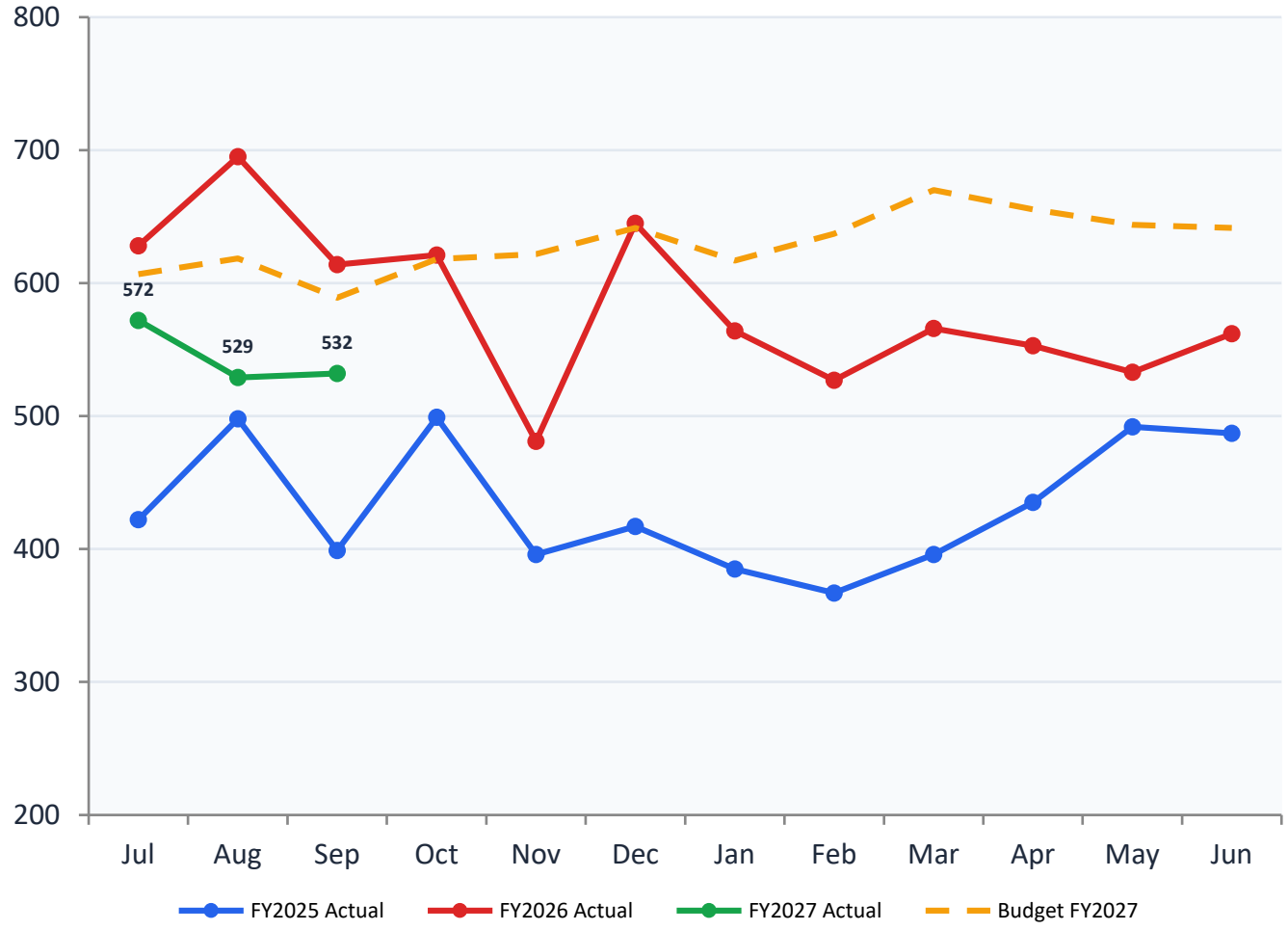


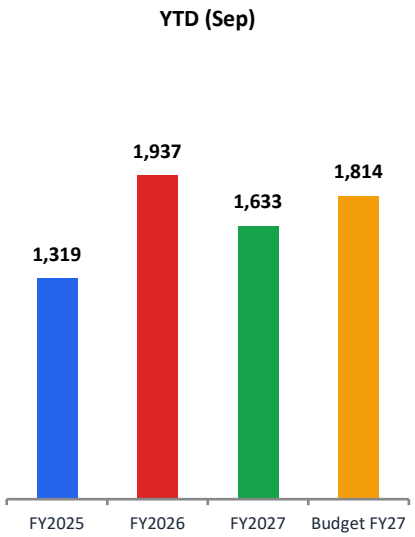
Home Health Visits



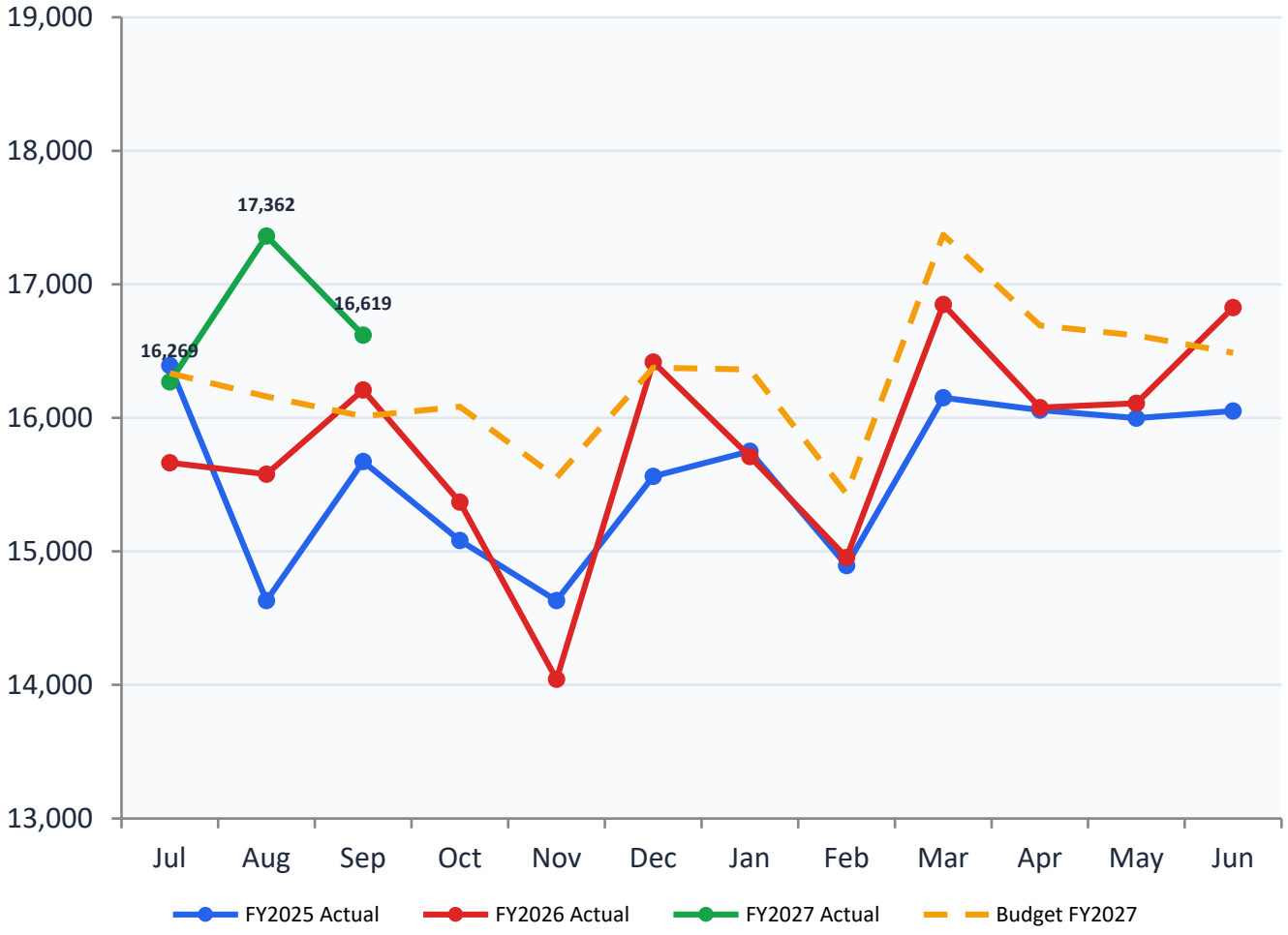


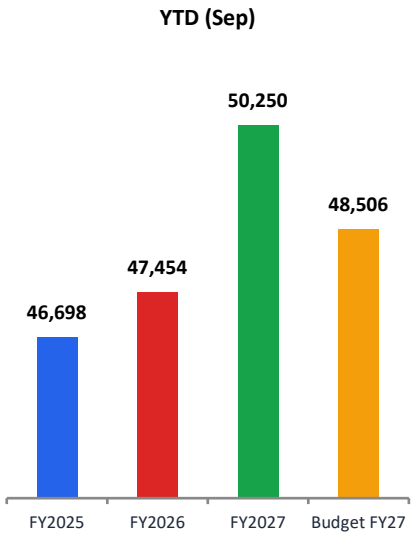
Infusion Center - Units of Service



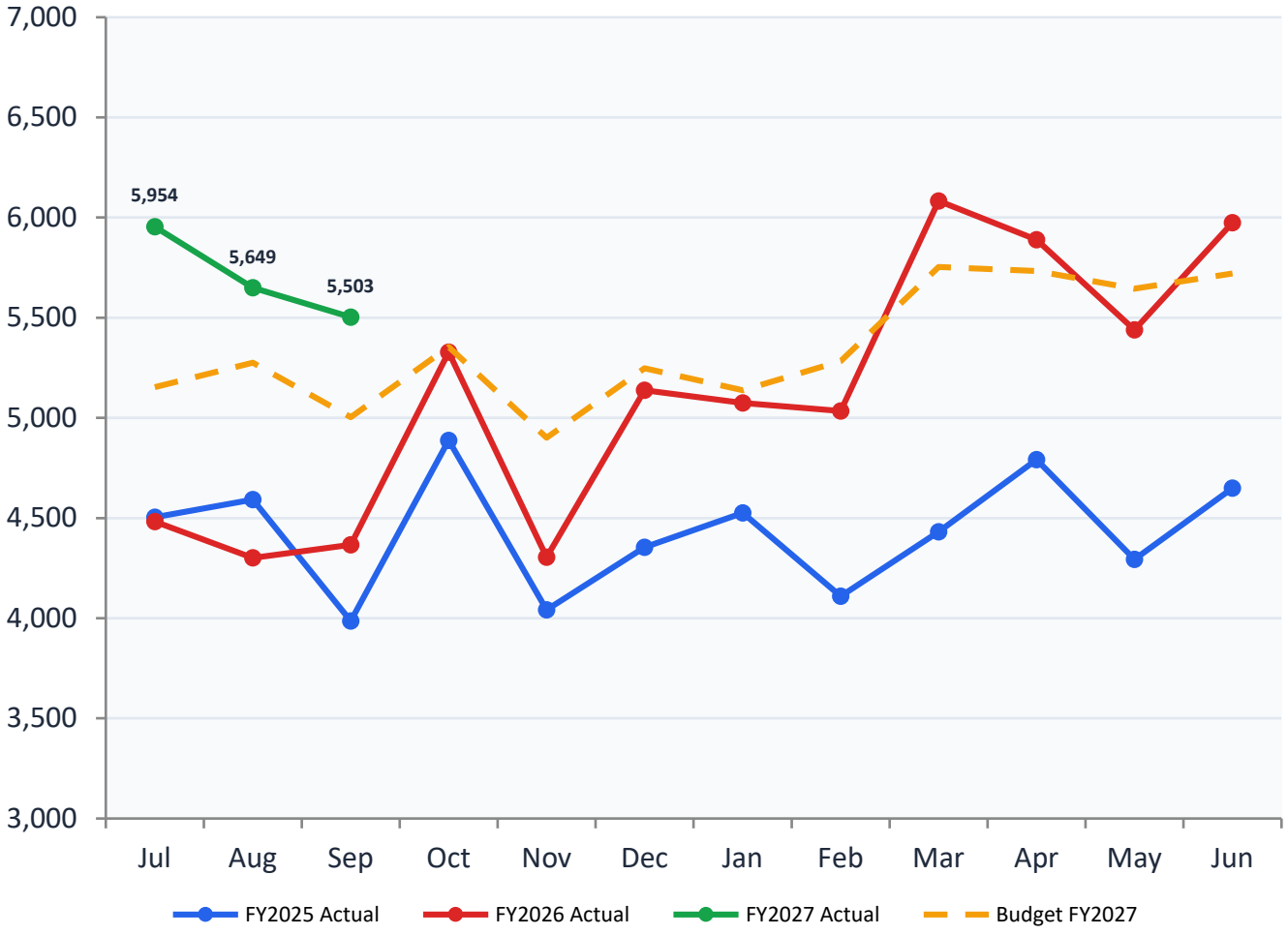


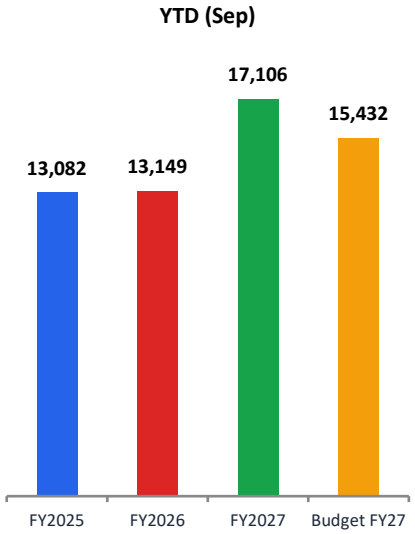
Radiology – Main Campus



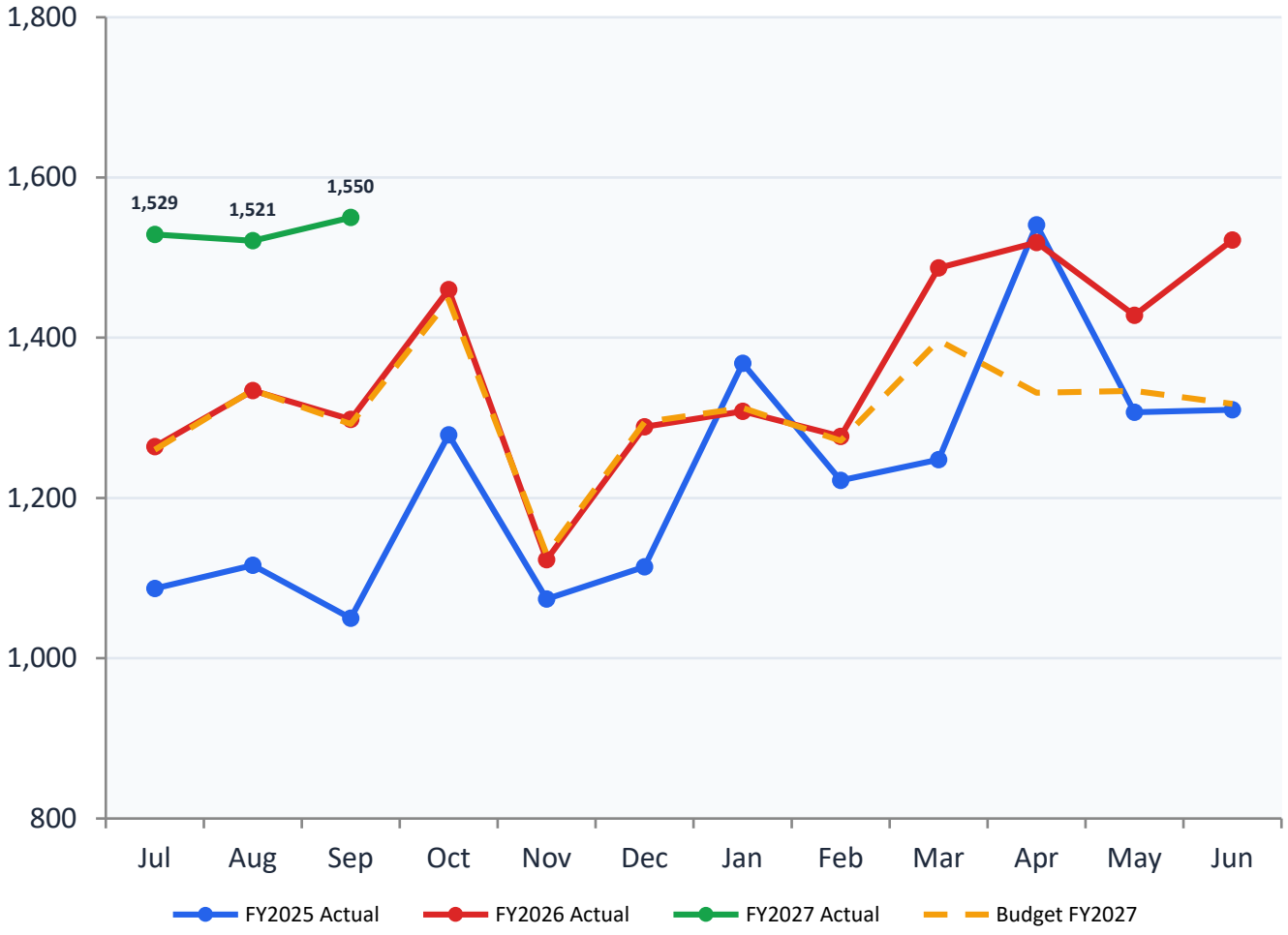


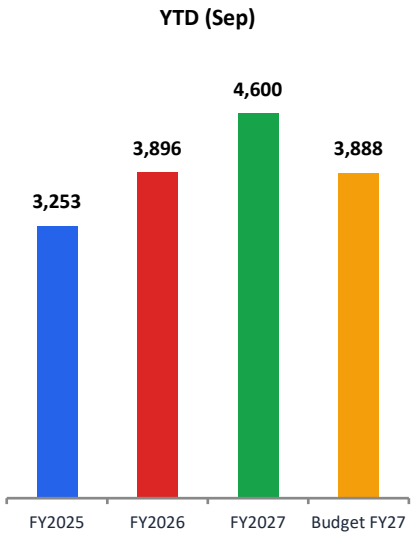
Radiology - West Campus Imaging



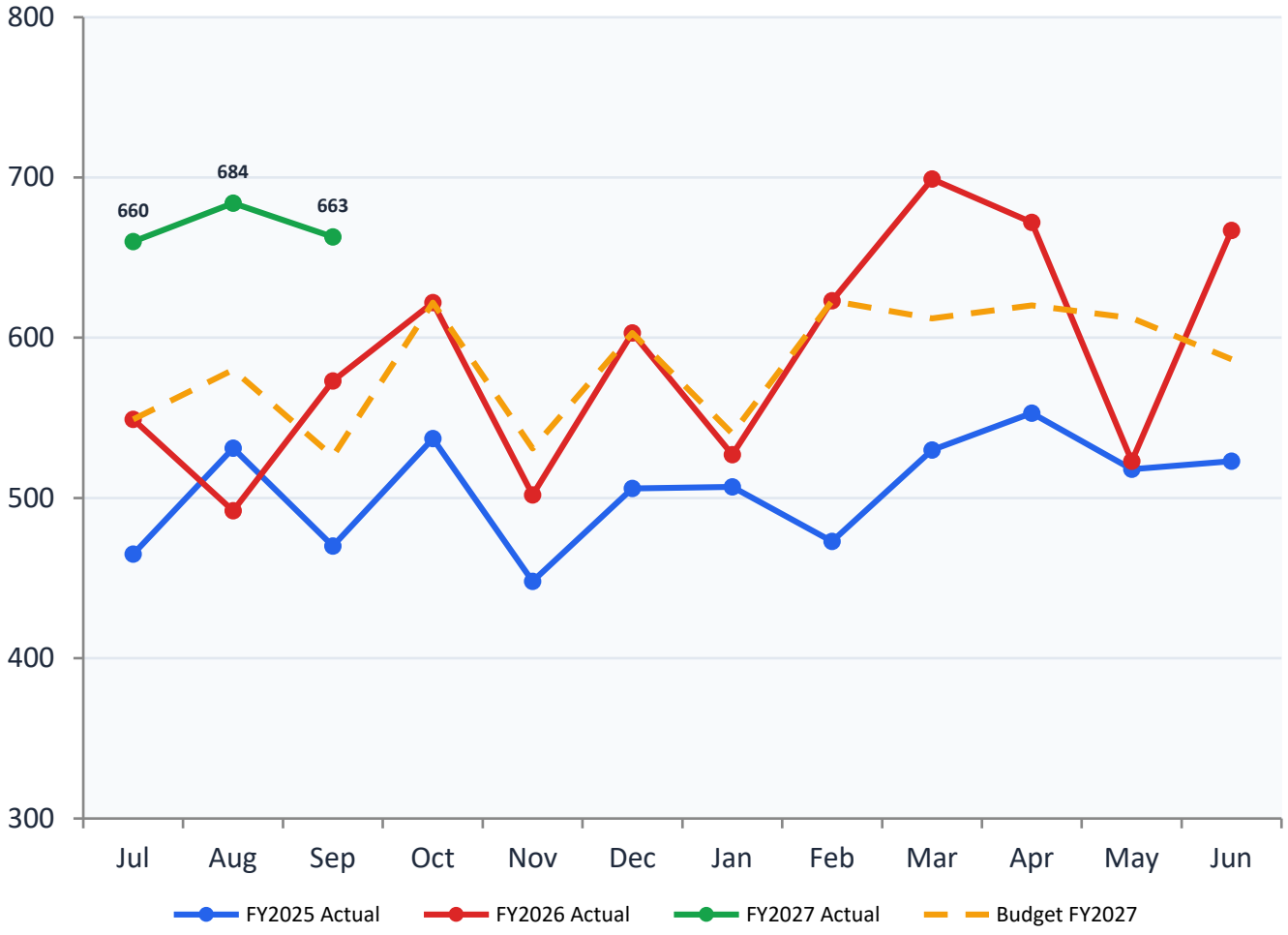


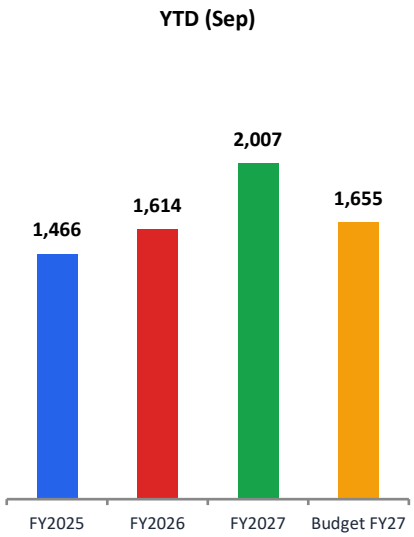
West Campus - Diagnostic Radiology



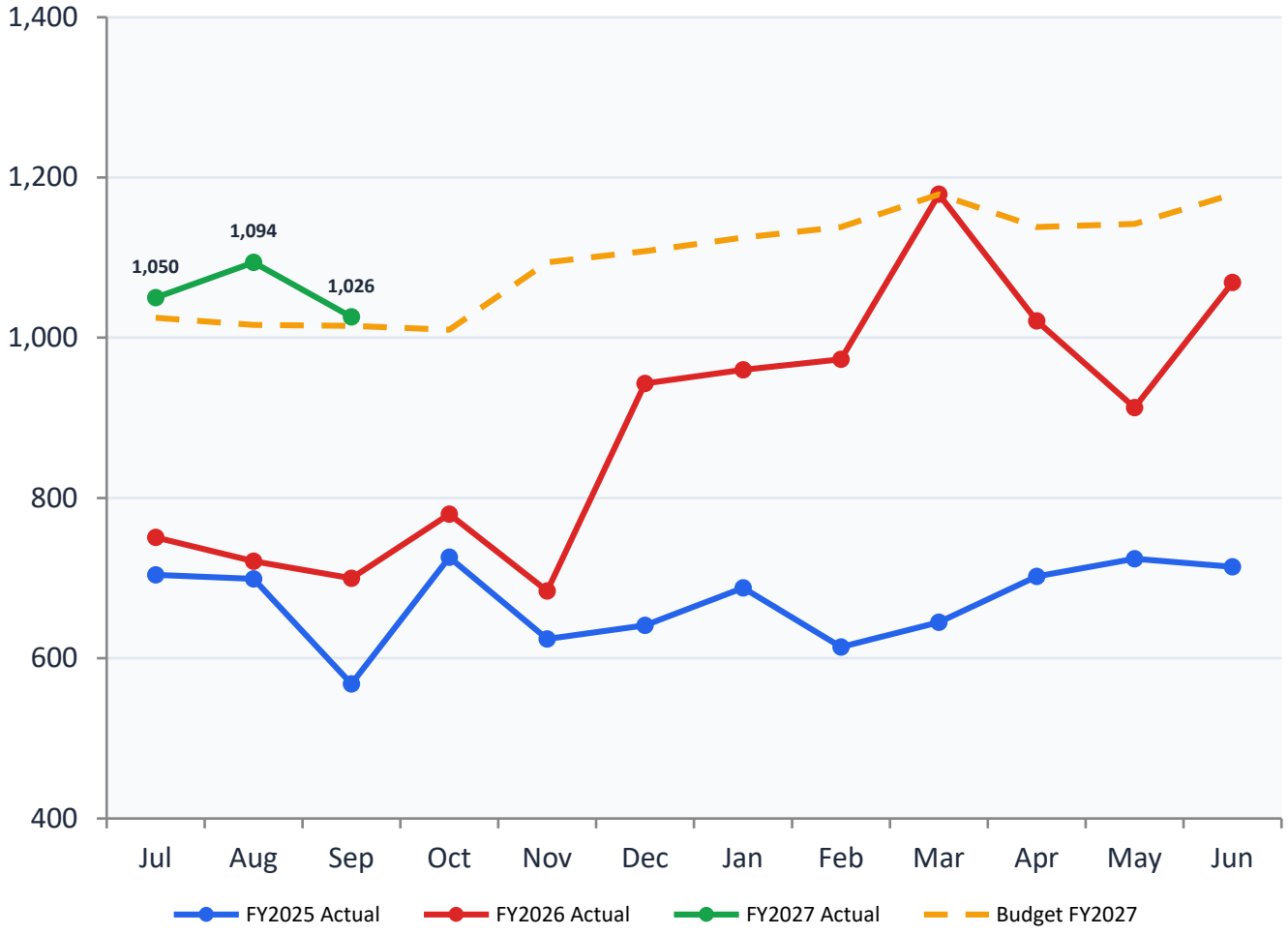


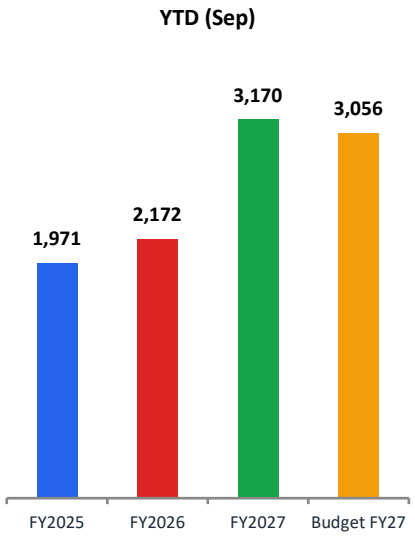
West Campus - CT Scan



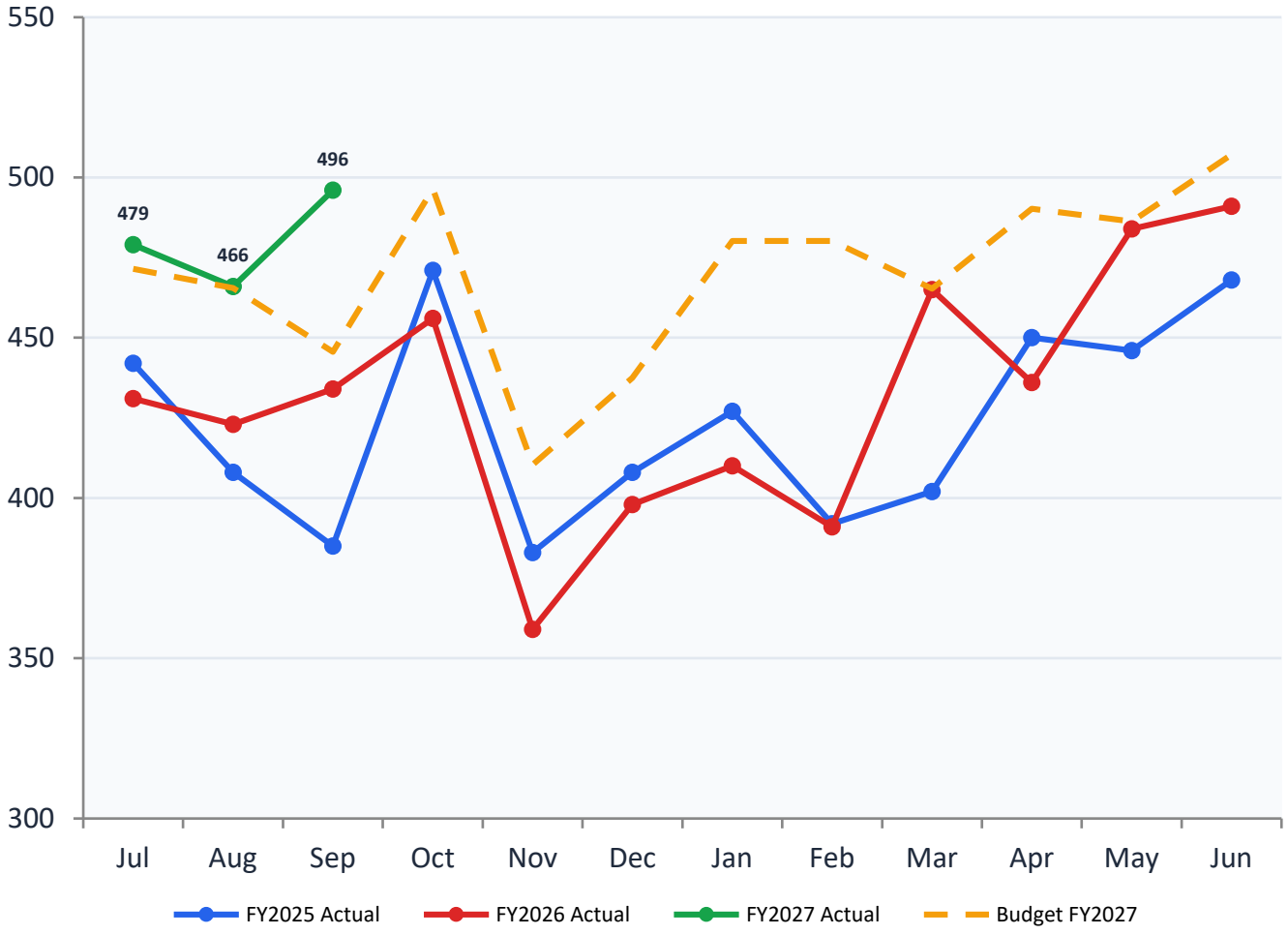


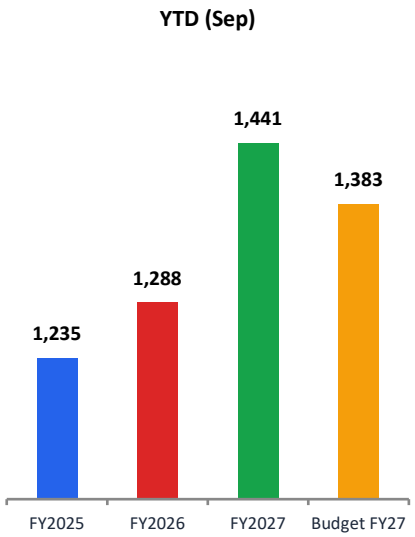
West Campus - Ultrasound



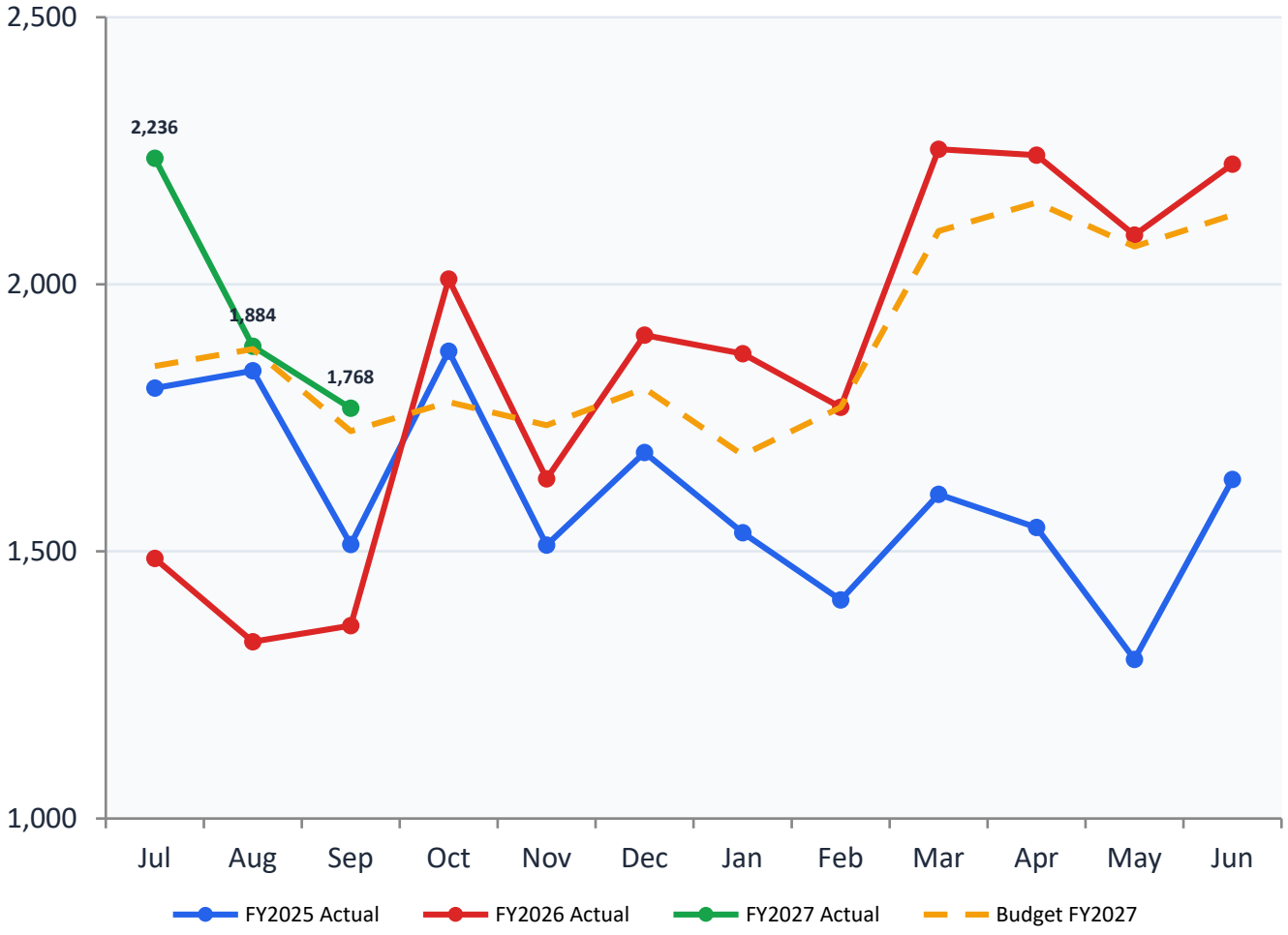


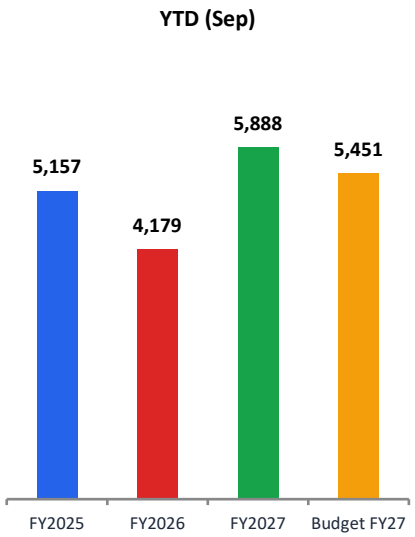
West Campus - MRI



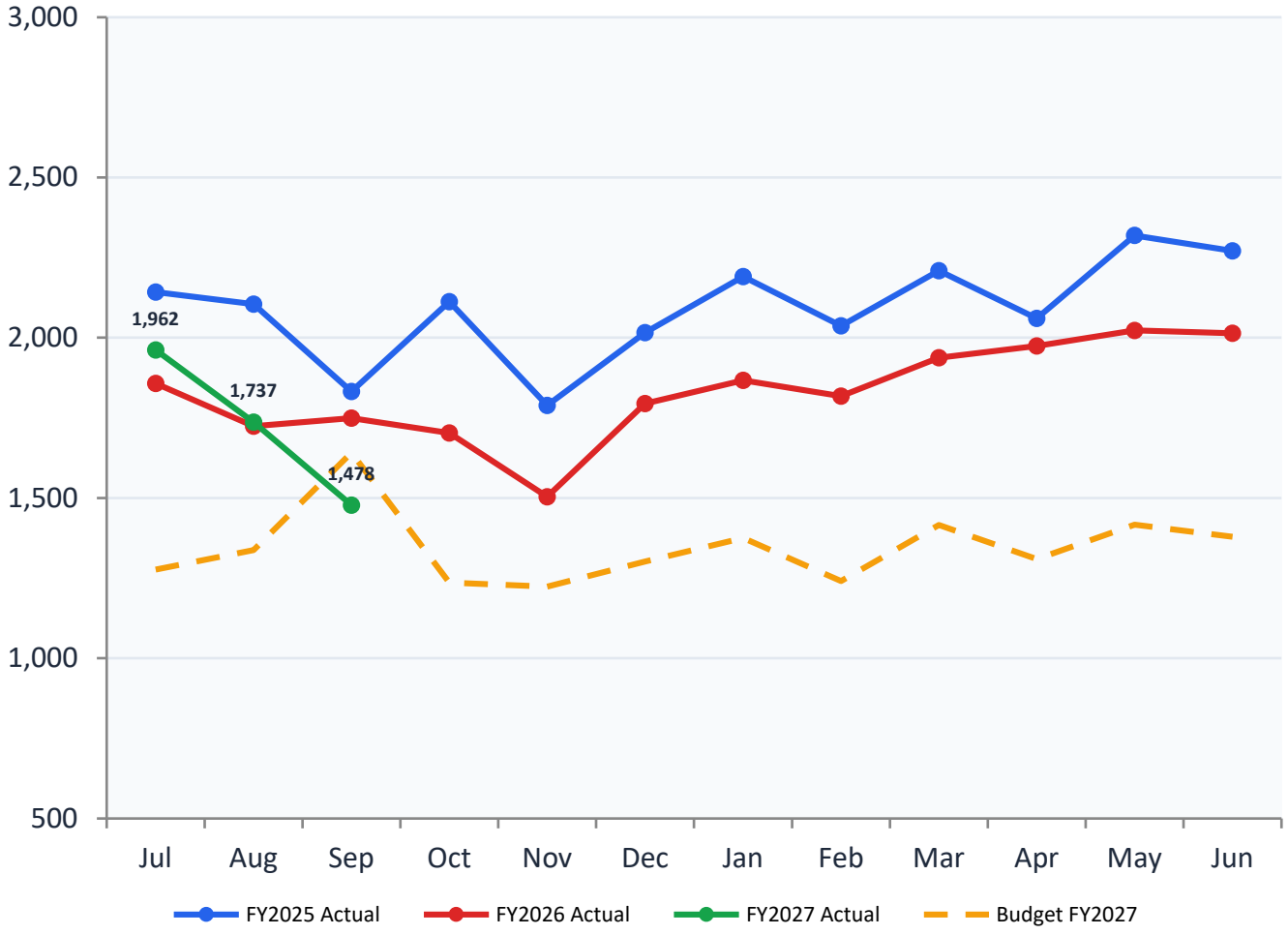


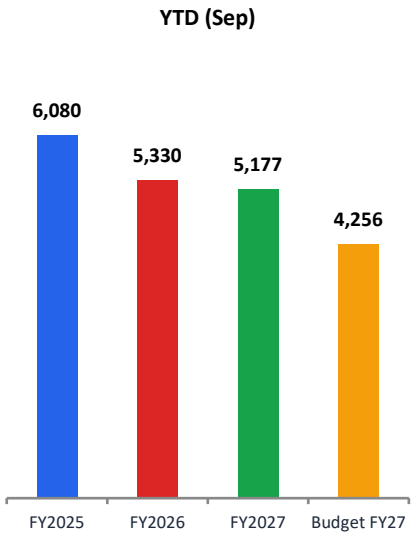
West Campus - Breast Center



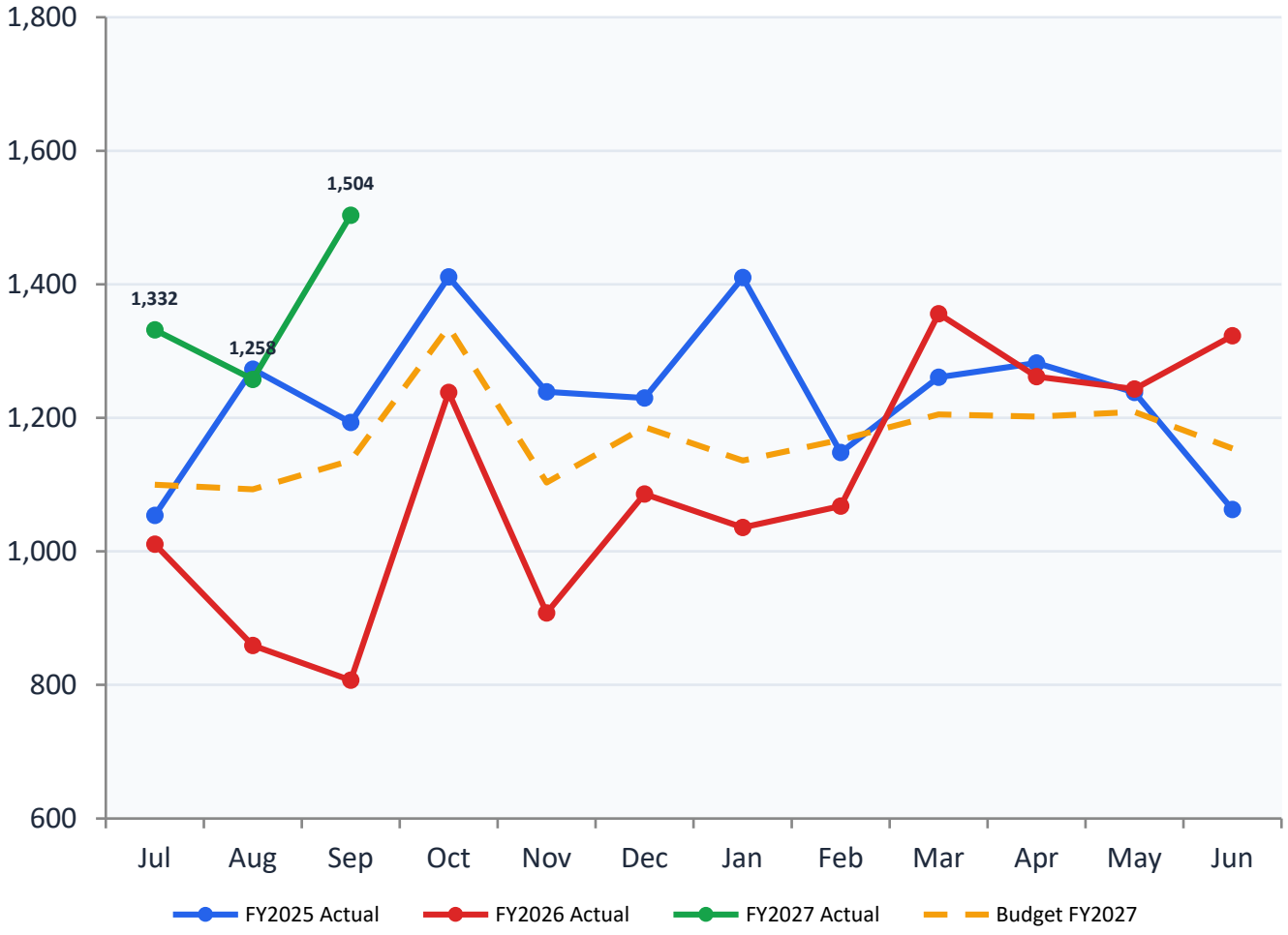


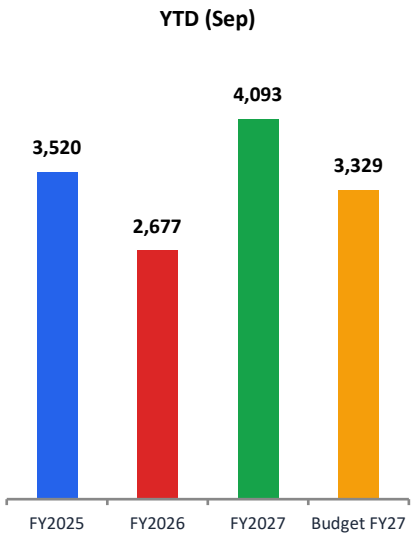
Noninvasive Cardiology-KHMC



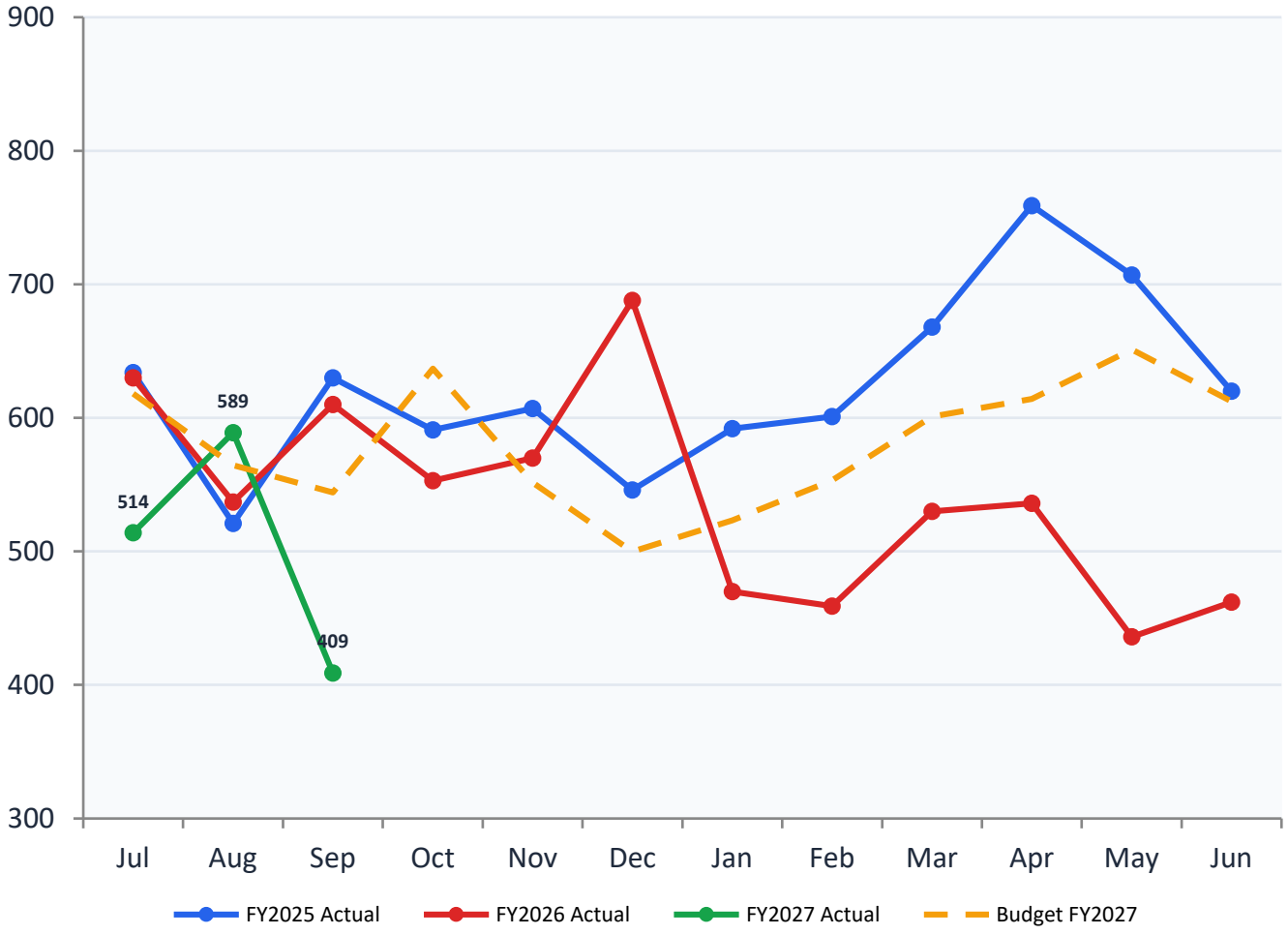


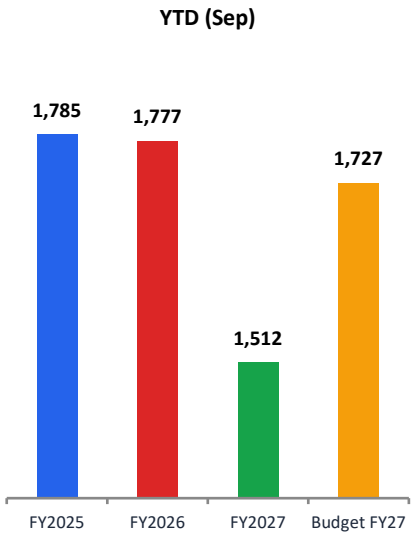
Noninvasive Cardiology-KHDC



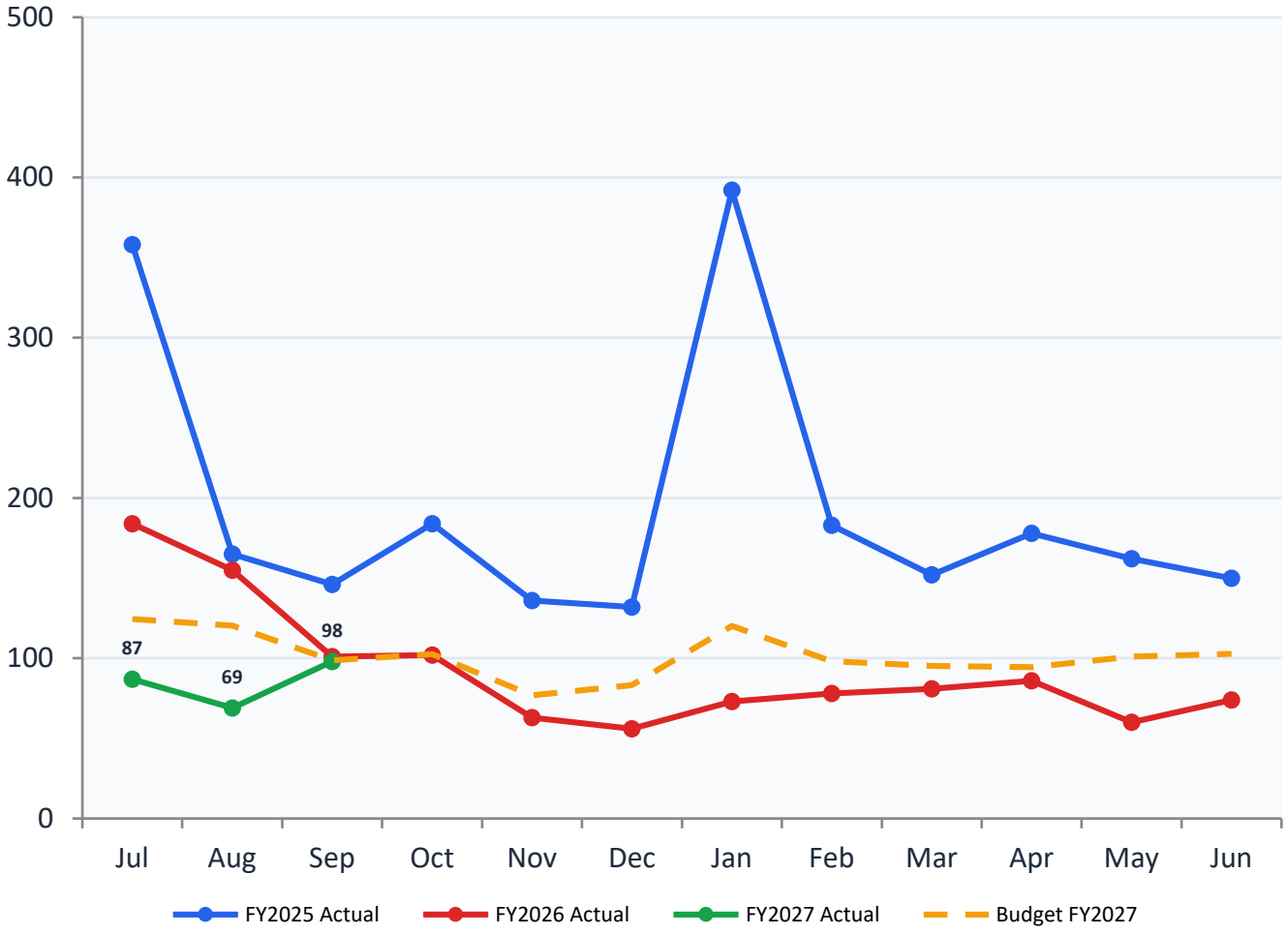


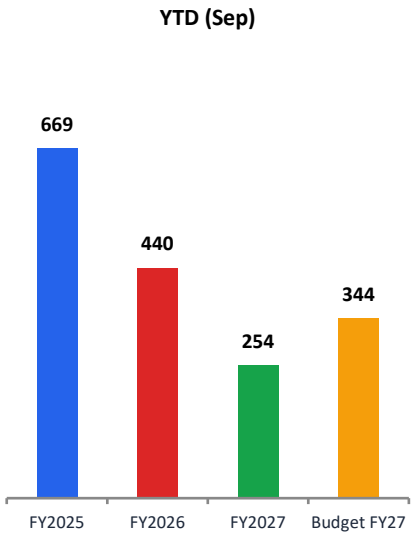
Nuclear Medicine-KHMC



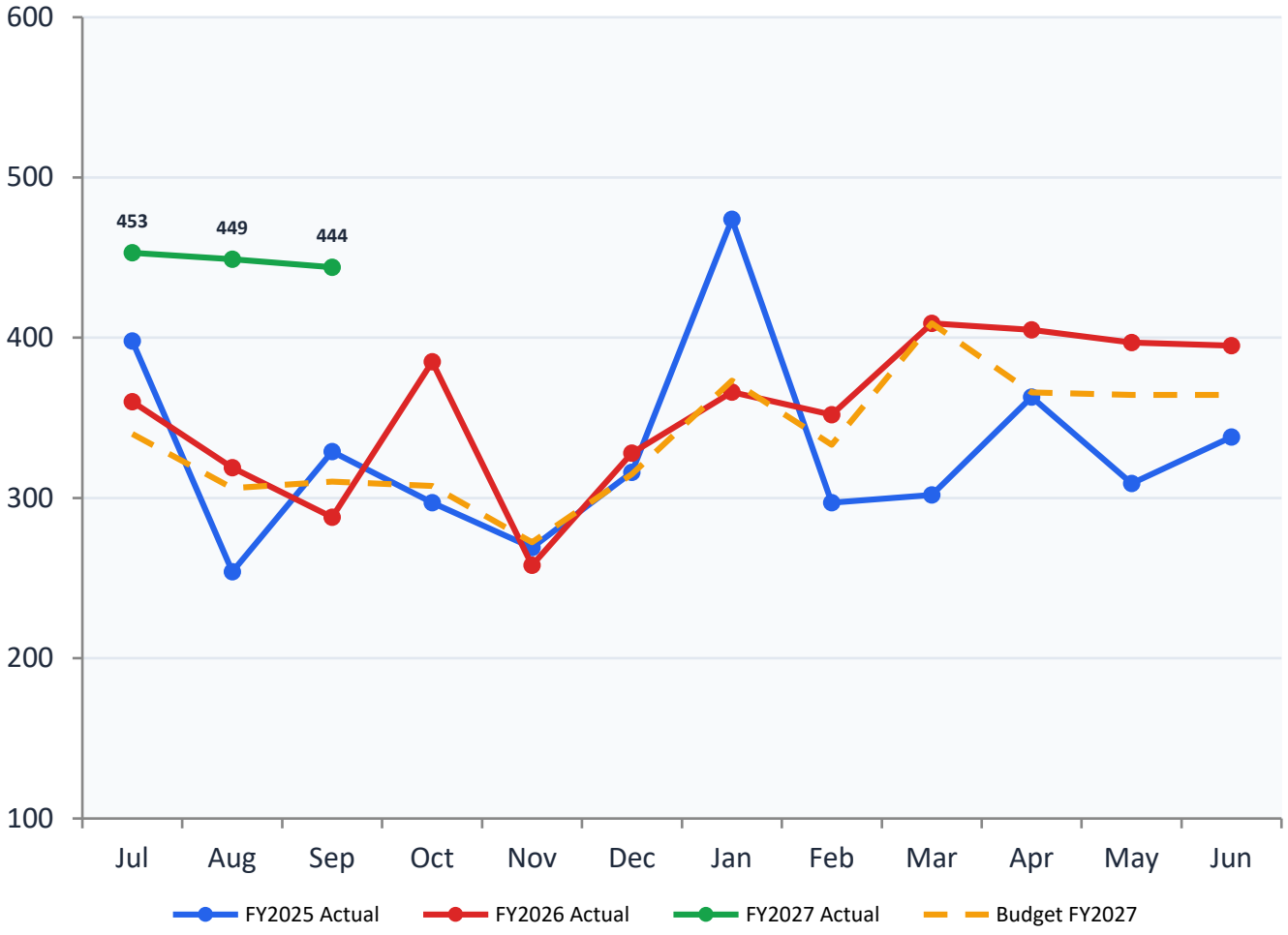


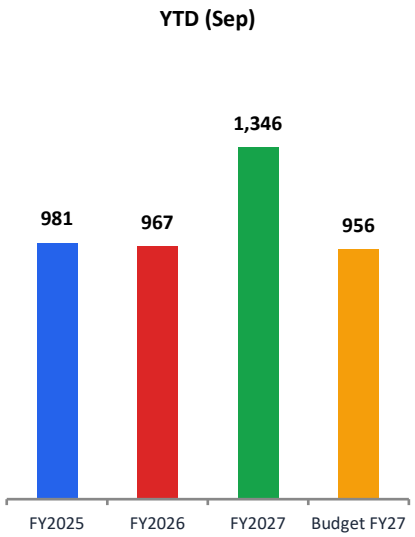
Nuclear Medicine-KHDC



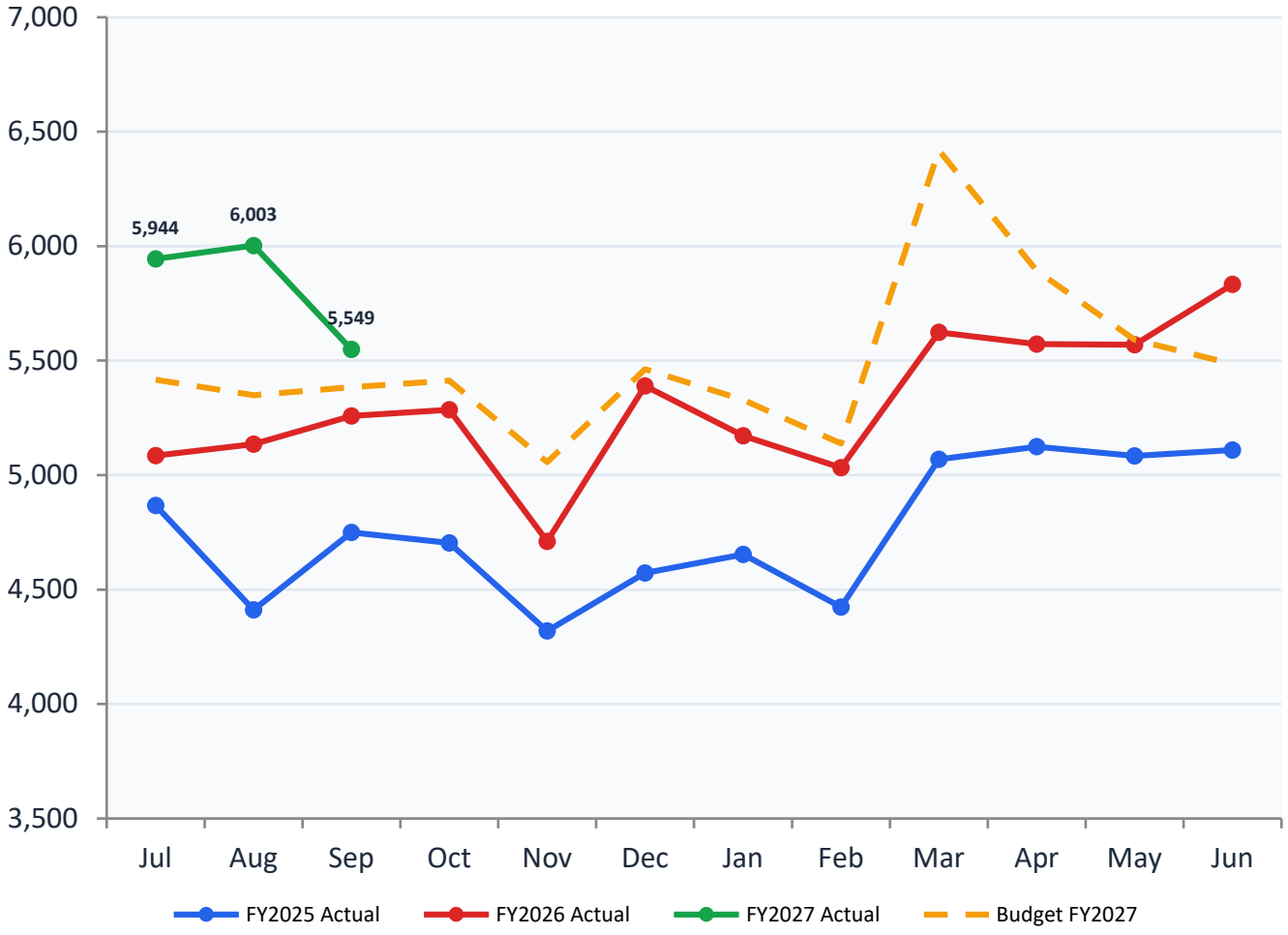


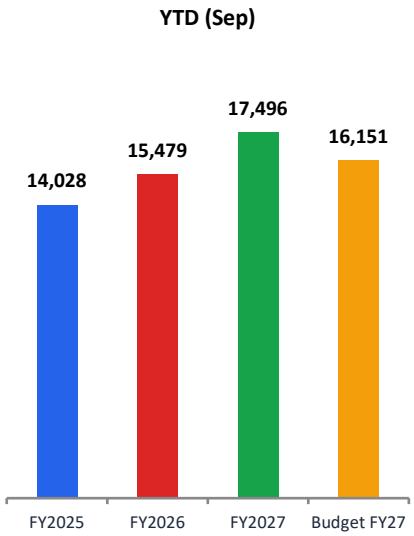
PET/CT-KHDC


600
500
400
300
200
100
453
449
444
Jul
Aug
Sep
Oct
Nov
Dec
Jan
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FY2027 Actual
Budget FY2027

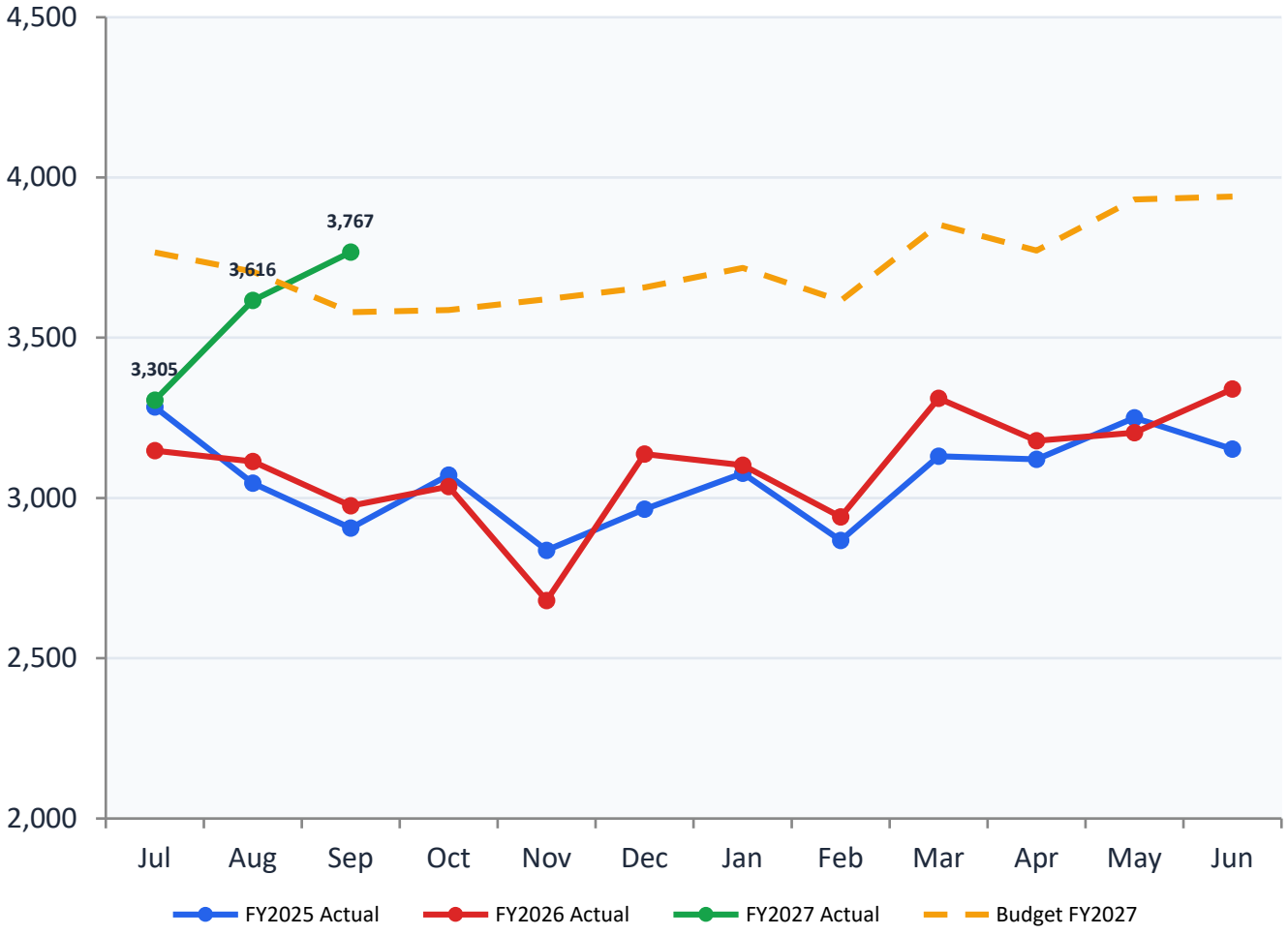

YTD (Sep)
981
967
1,346
956
FY2025
FY2026
FY2027
Budget FY27

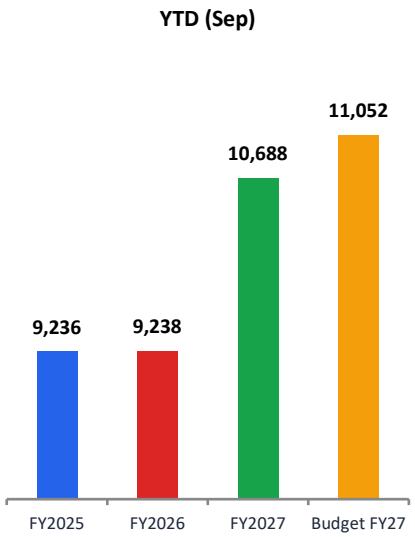
Radiology - CT - All Areas



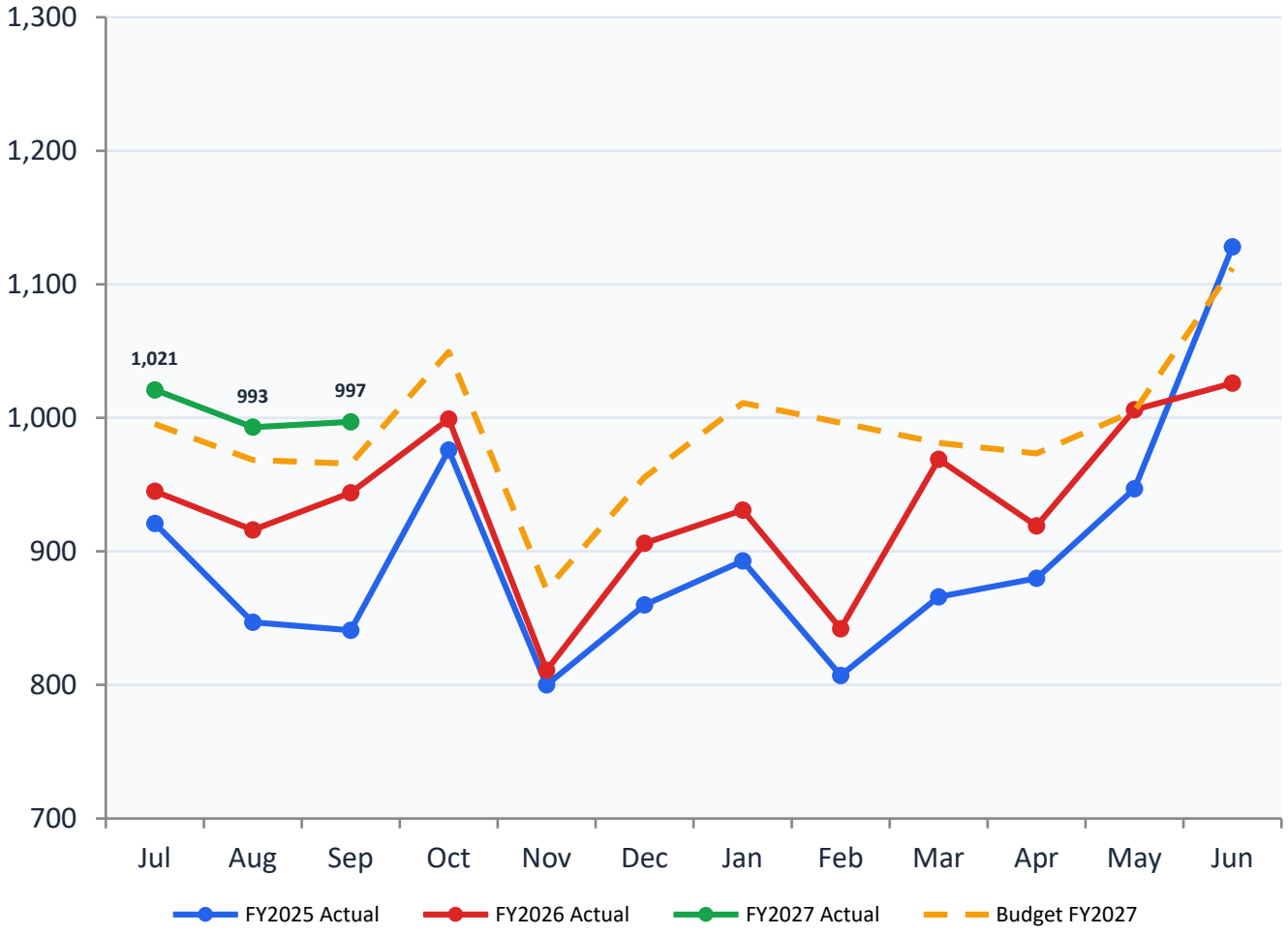


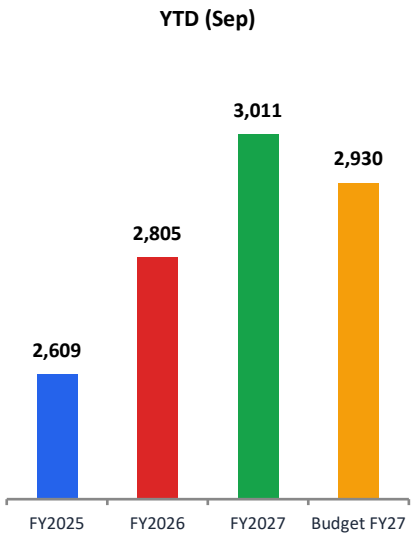
Radiology - Ultrasound - All Areas



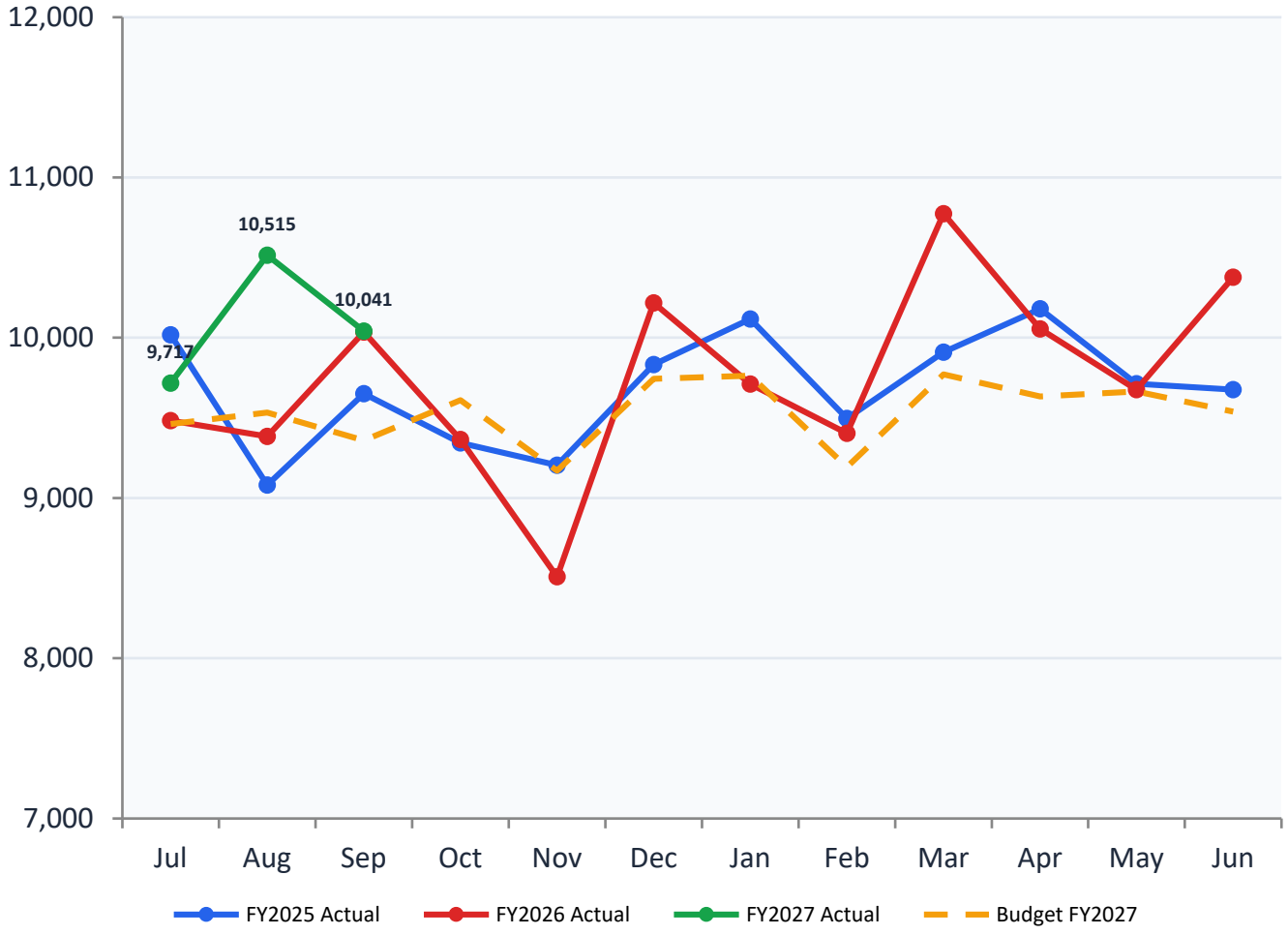


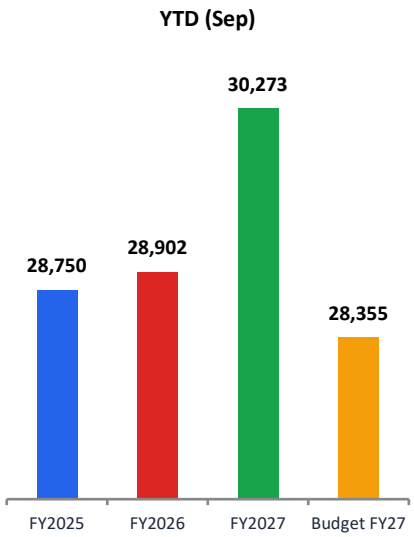
Radiology - MRI - All Areas



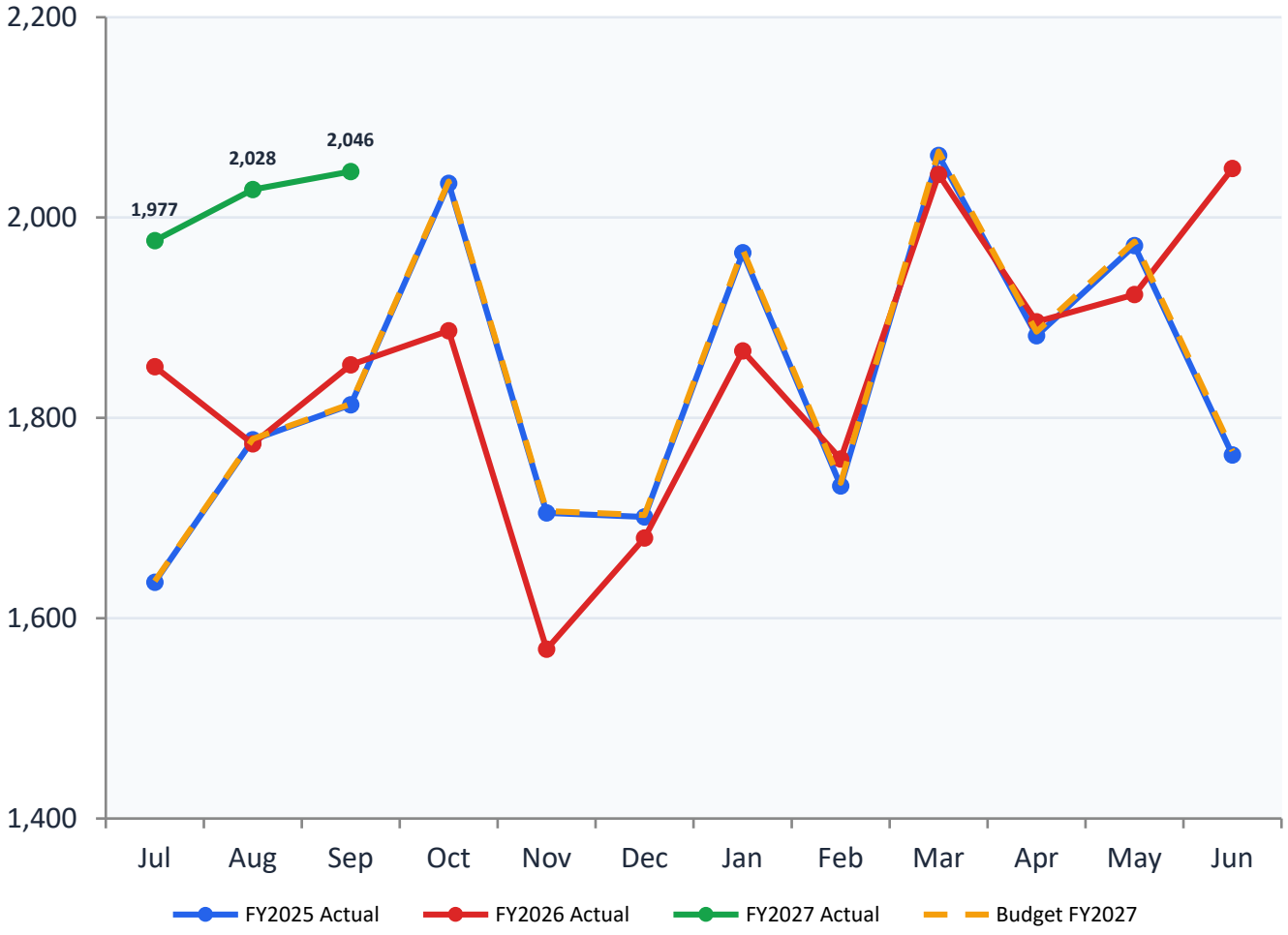


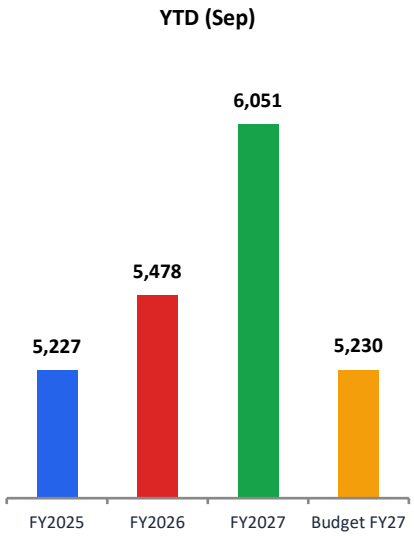
Radiology Modality - Diagnostic Radiology



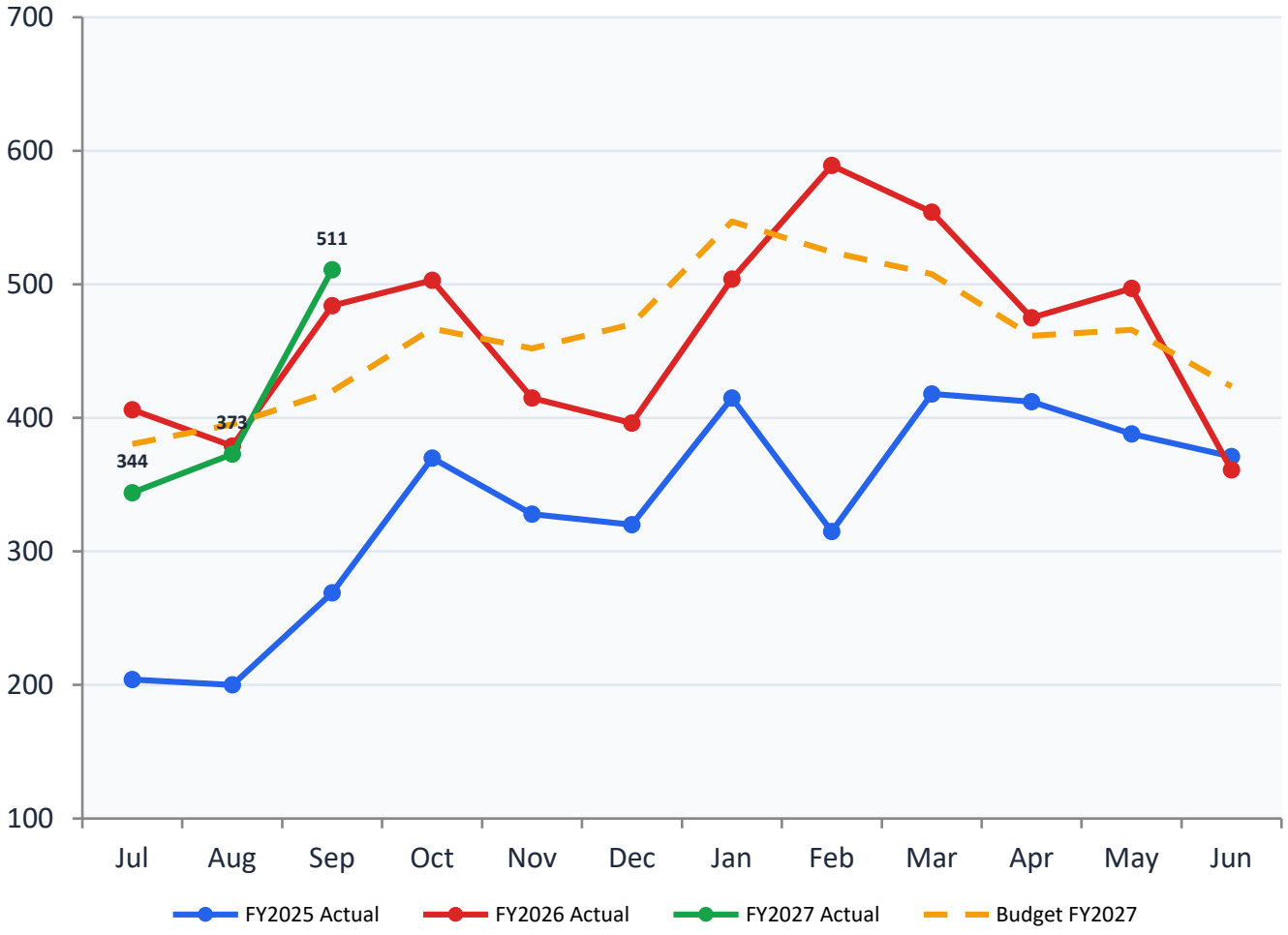


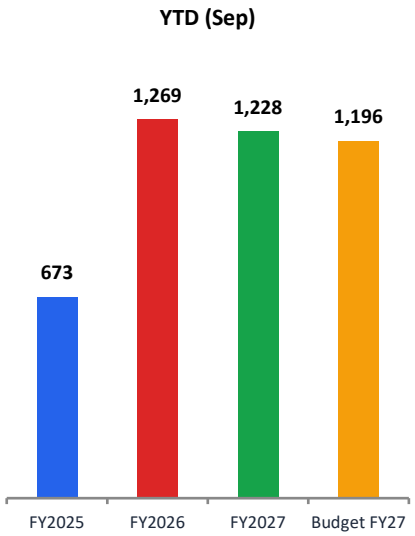
Radiology - UC Court/South Campus



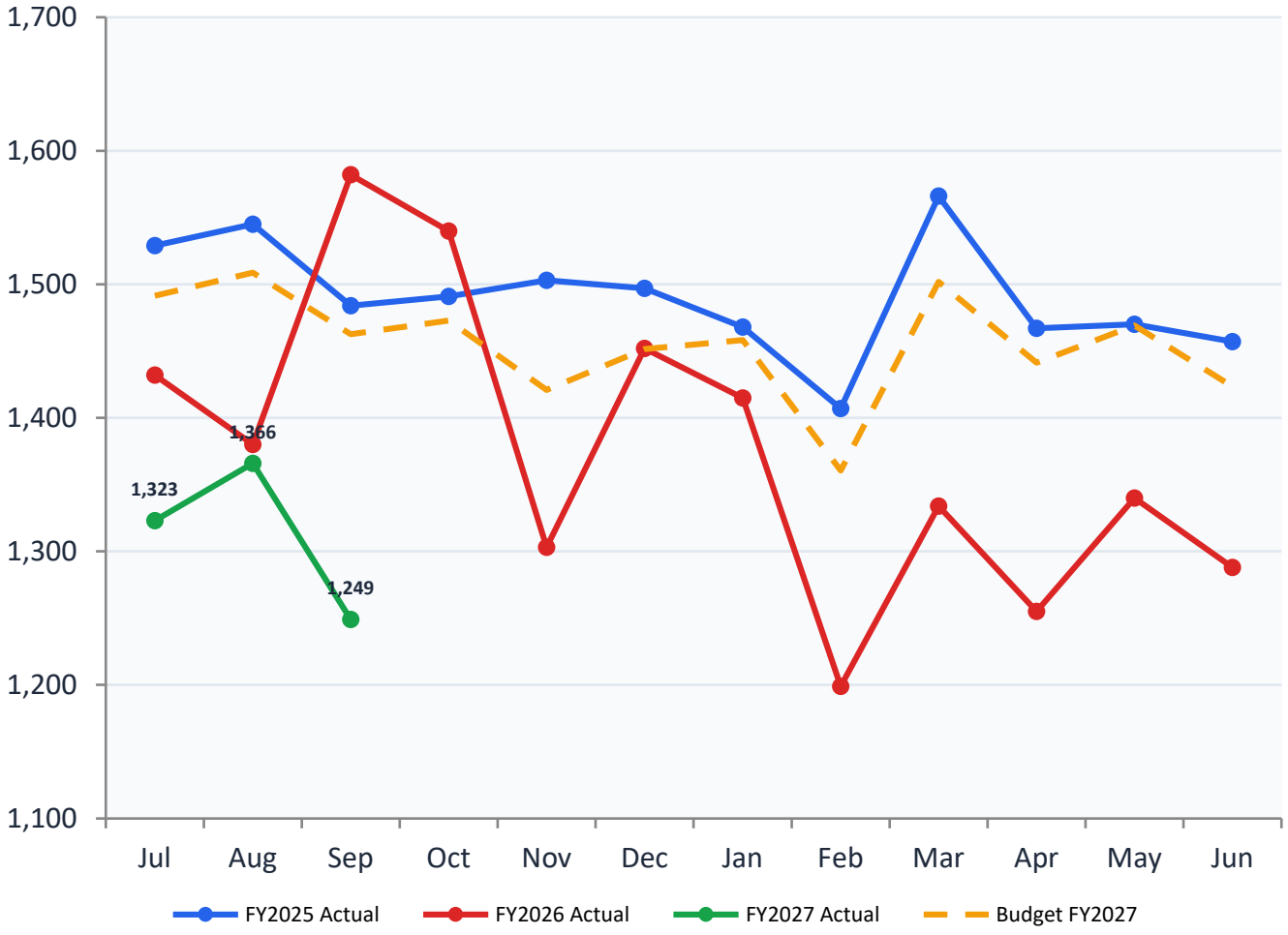


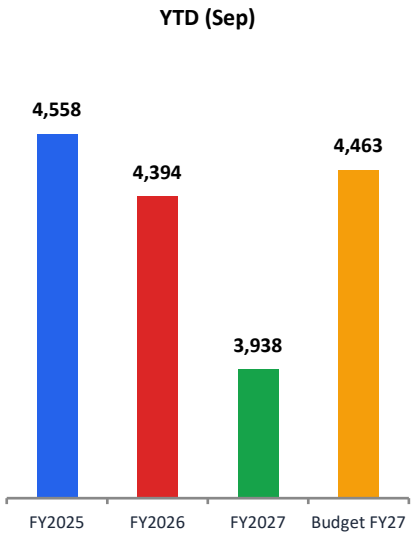
Radiology - UC Demaree/North Campus



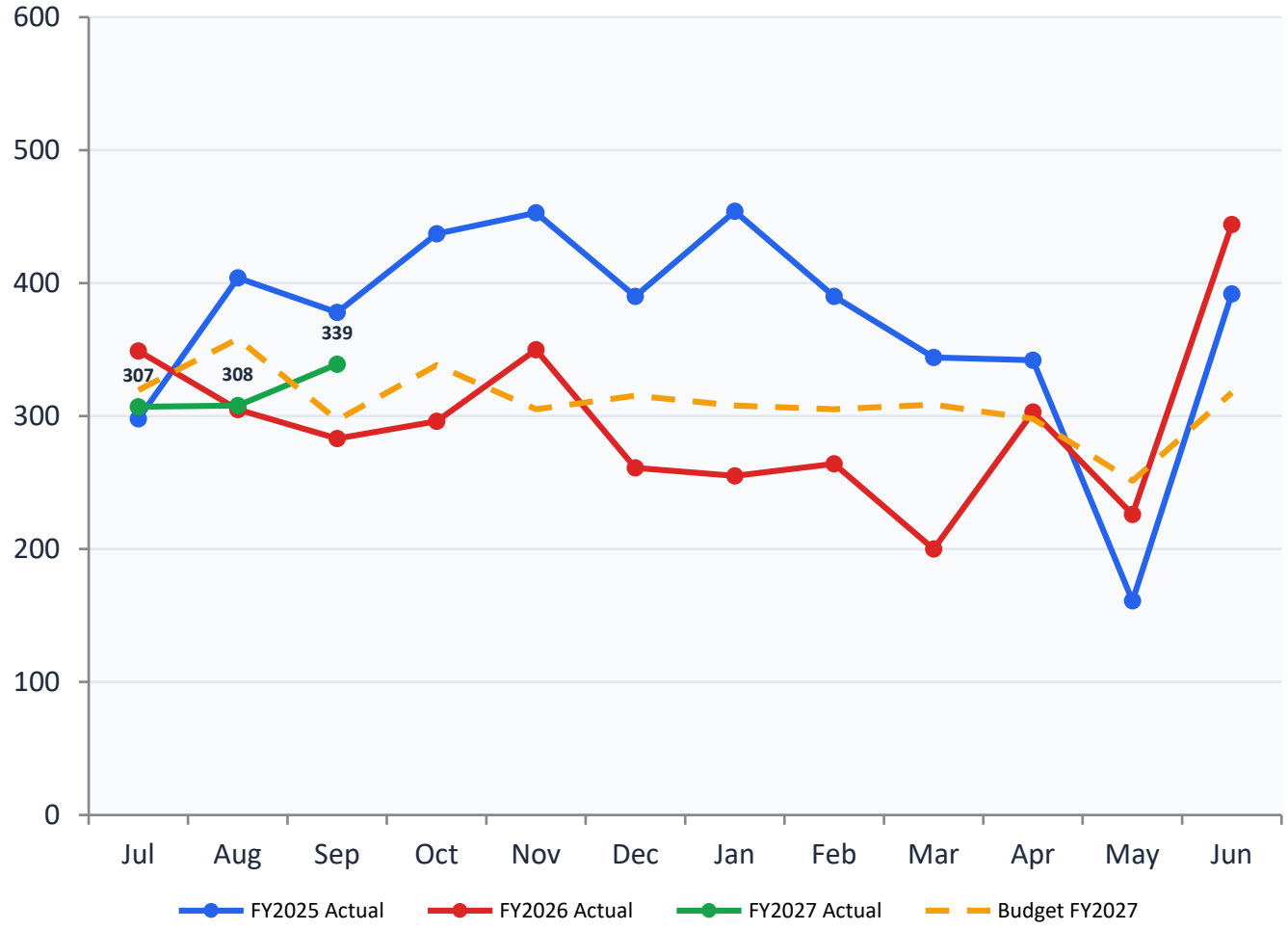


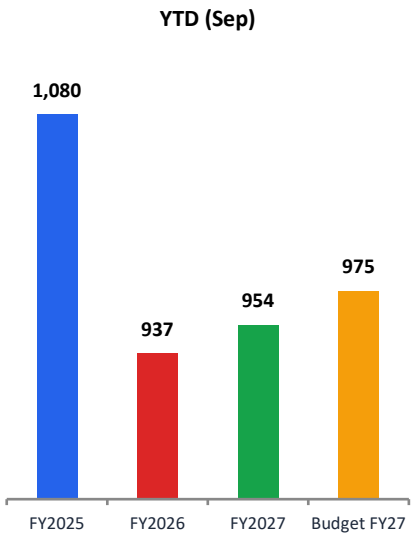
Chronic Dialysis - Visalia



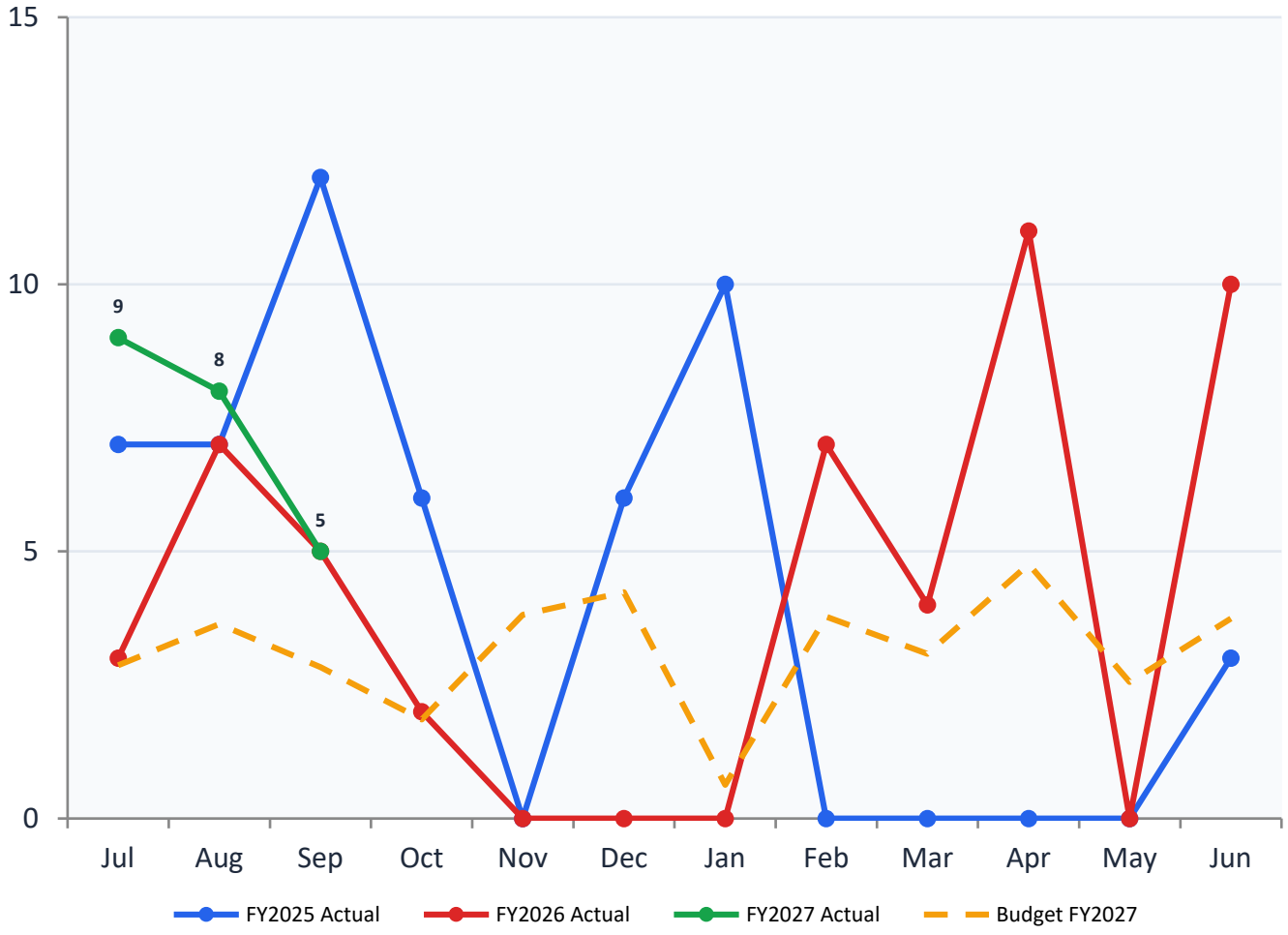


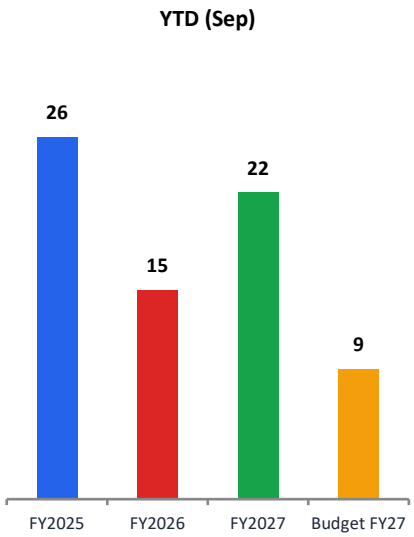
CAPD/CCPD - Maintenance Sessions



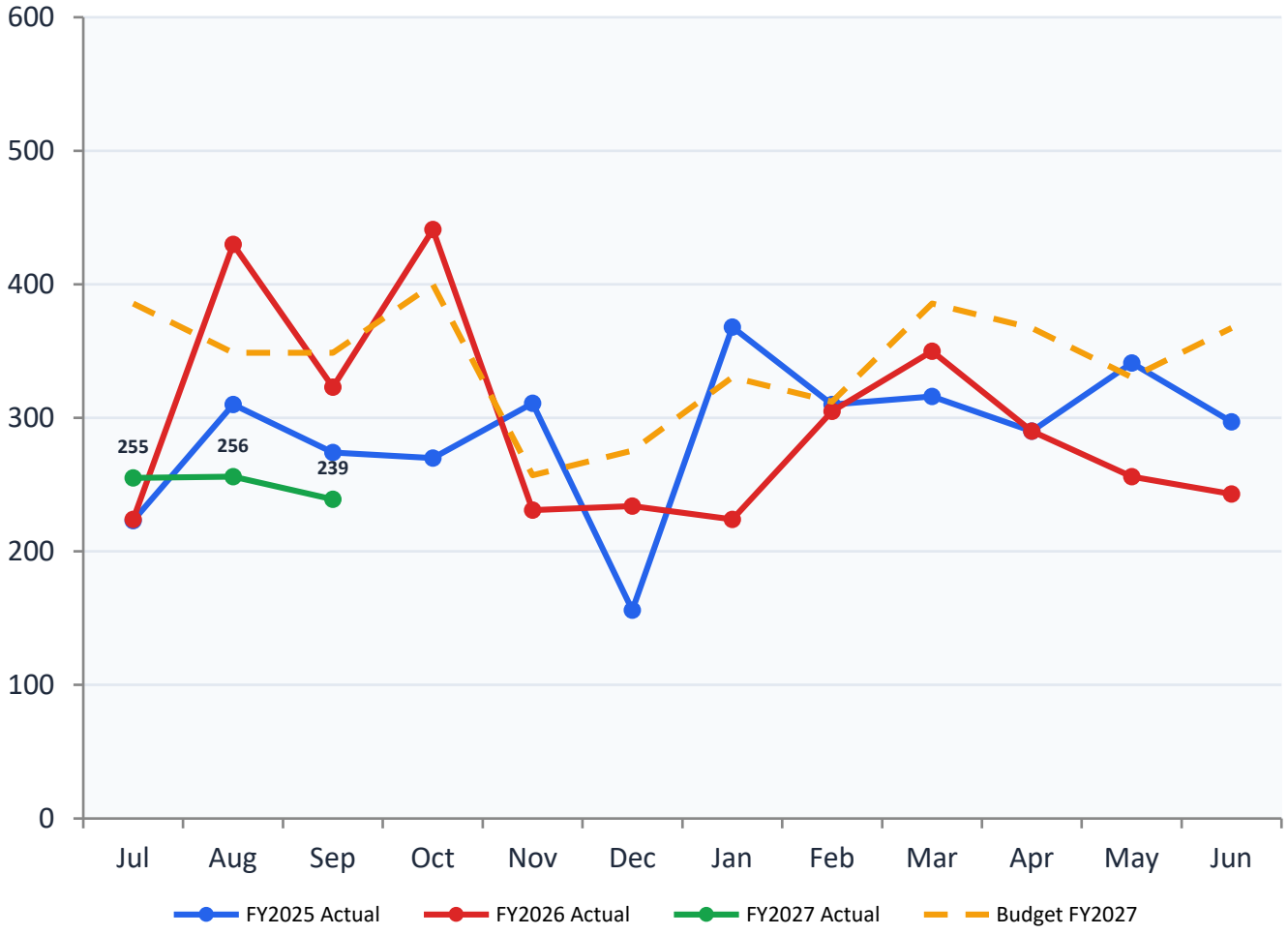


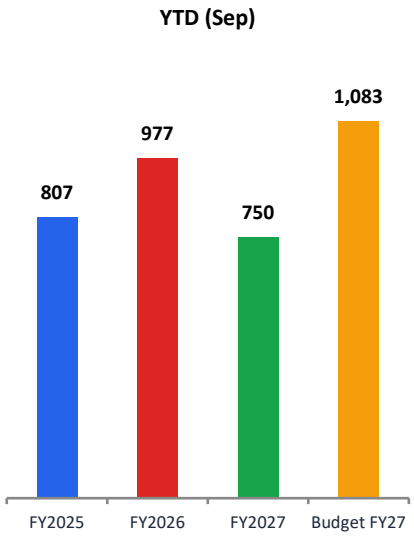
CAPD/CCPD - Training Sessions



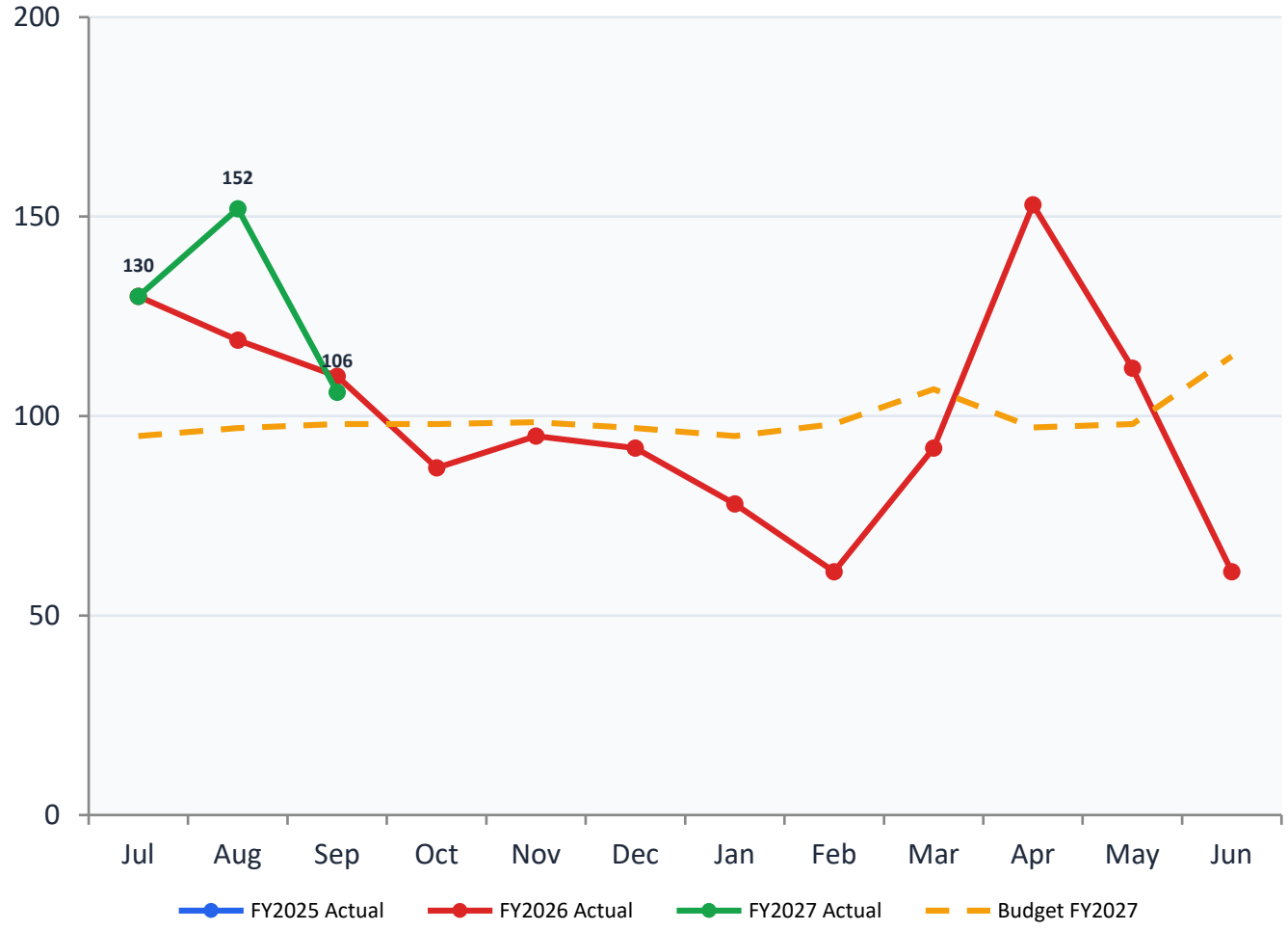


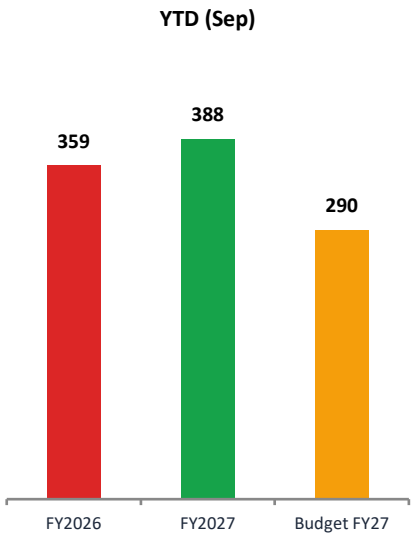
Urology Clinic Visits



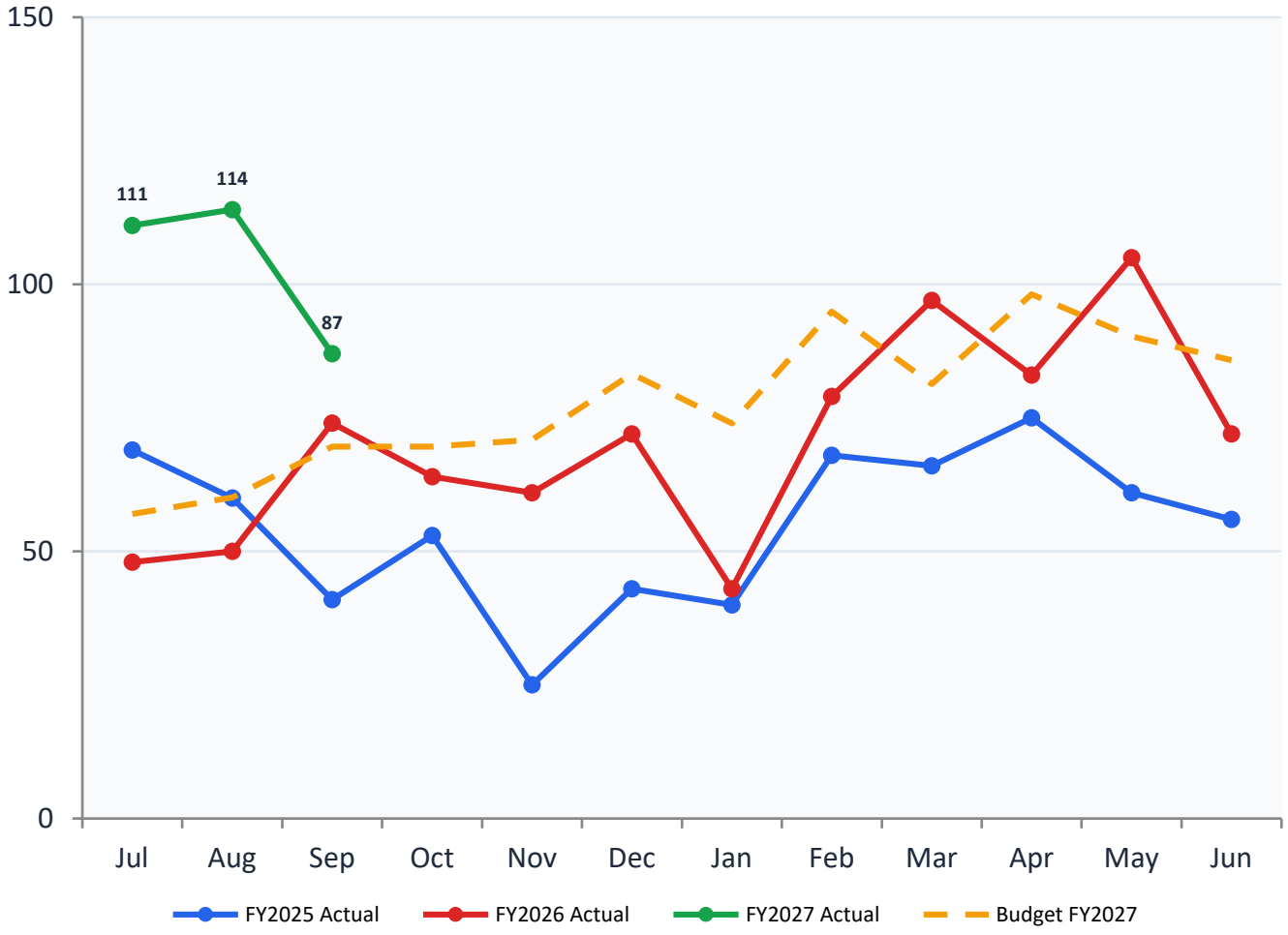


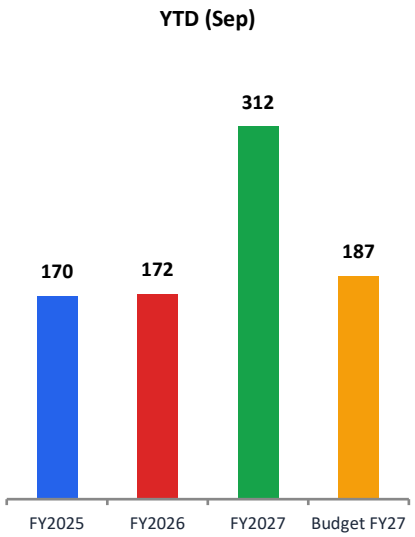
Open Arms House - Patient Days



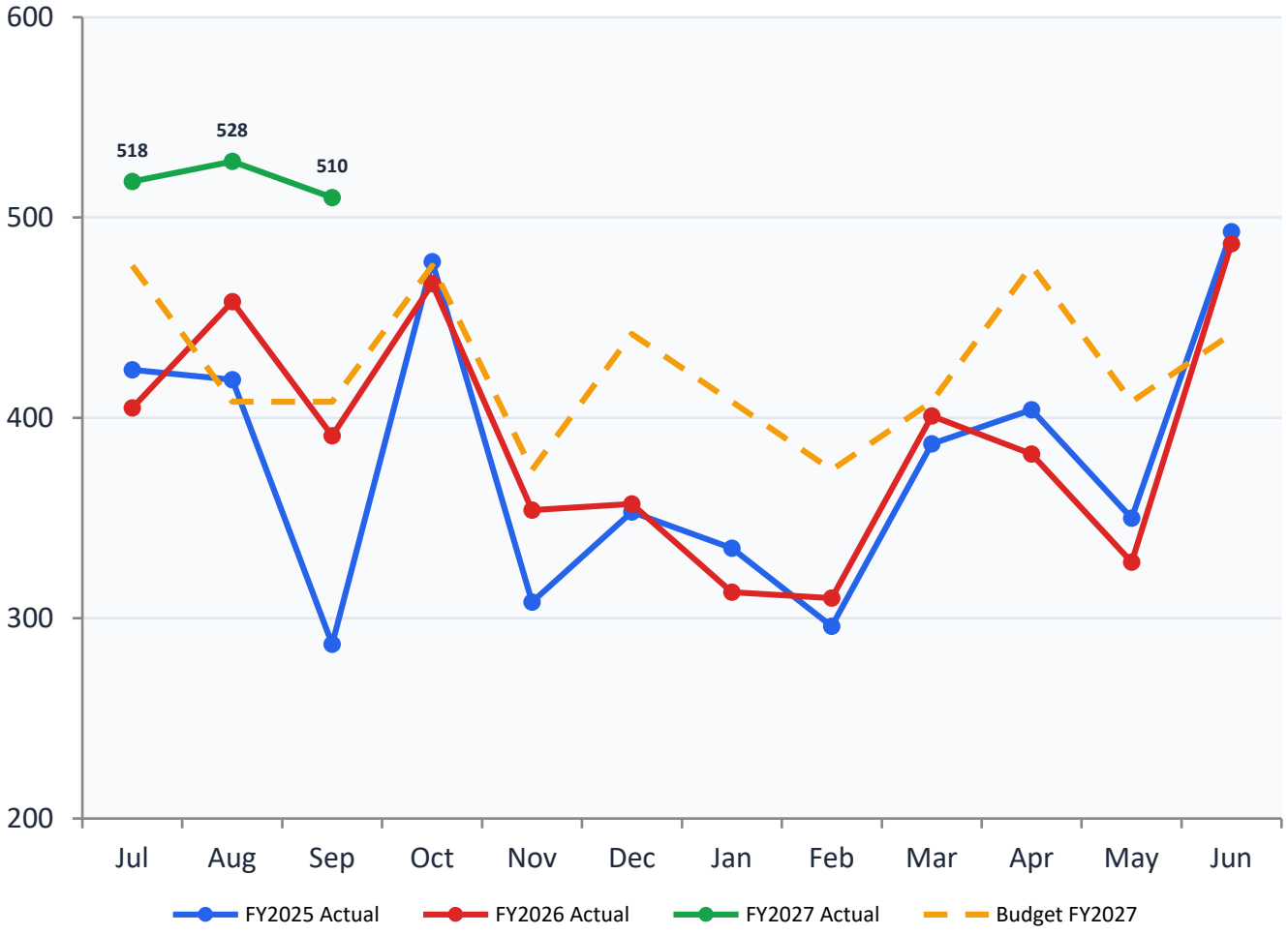


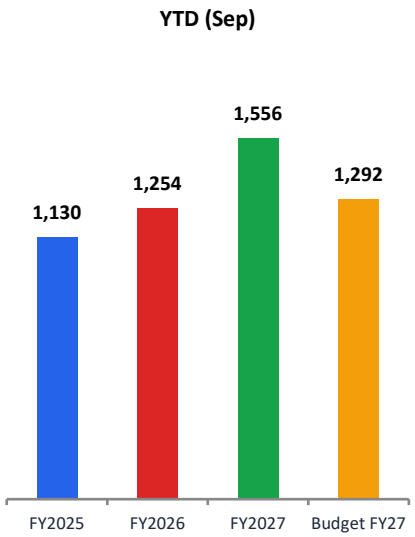
Cardiothoracic Surgery Clinic - Visits



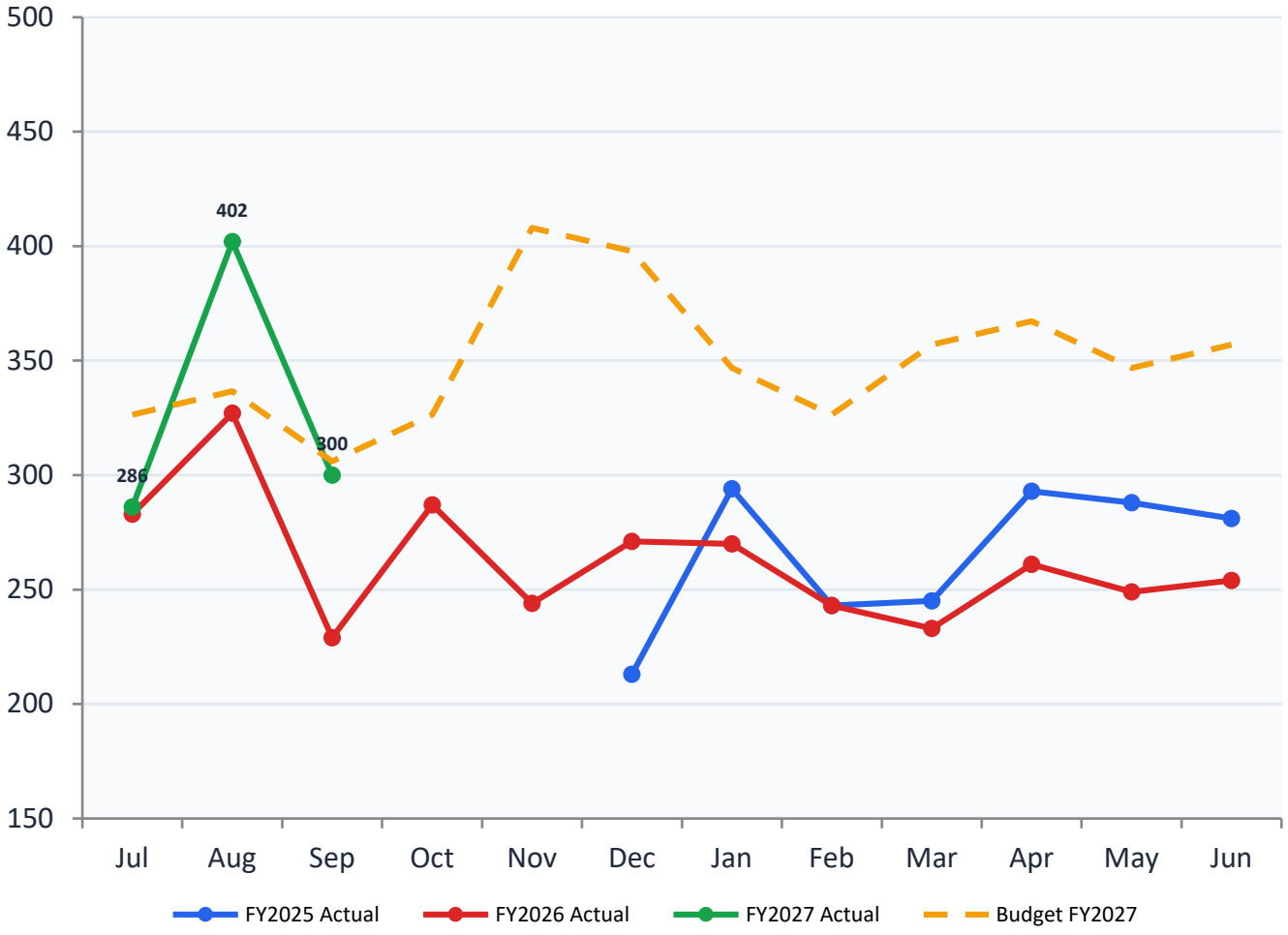


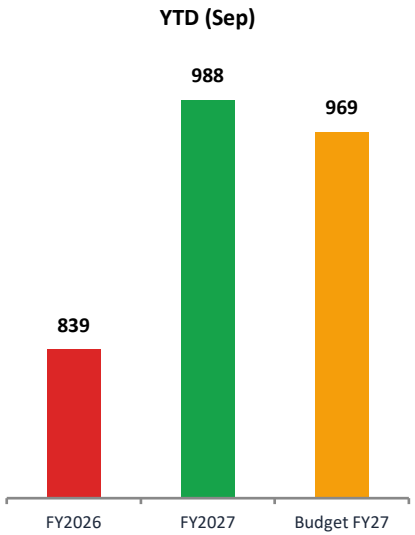
Cardiac Rehabilitation



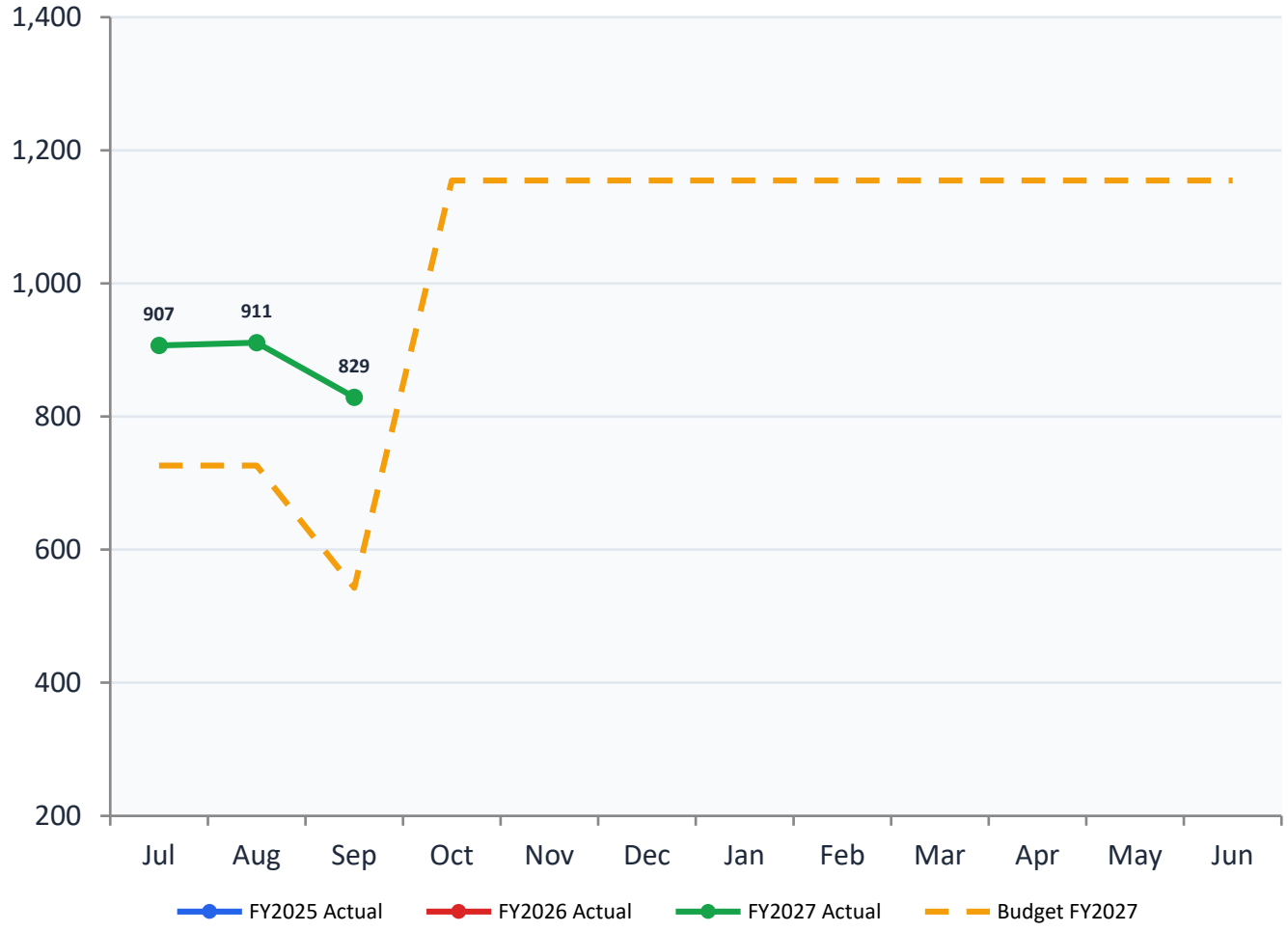


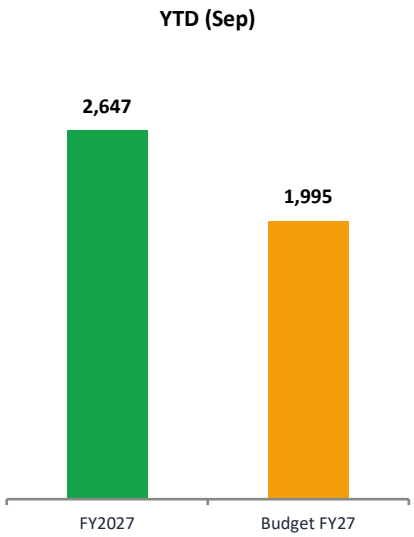
KH Medical Clinic - Plaza



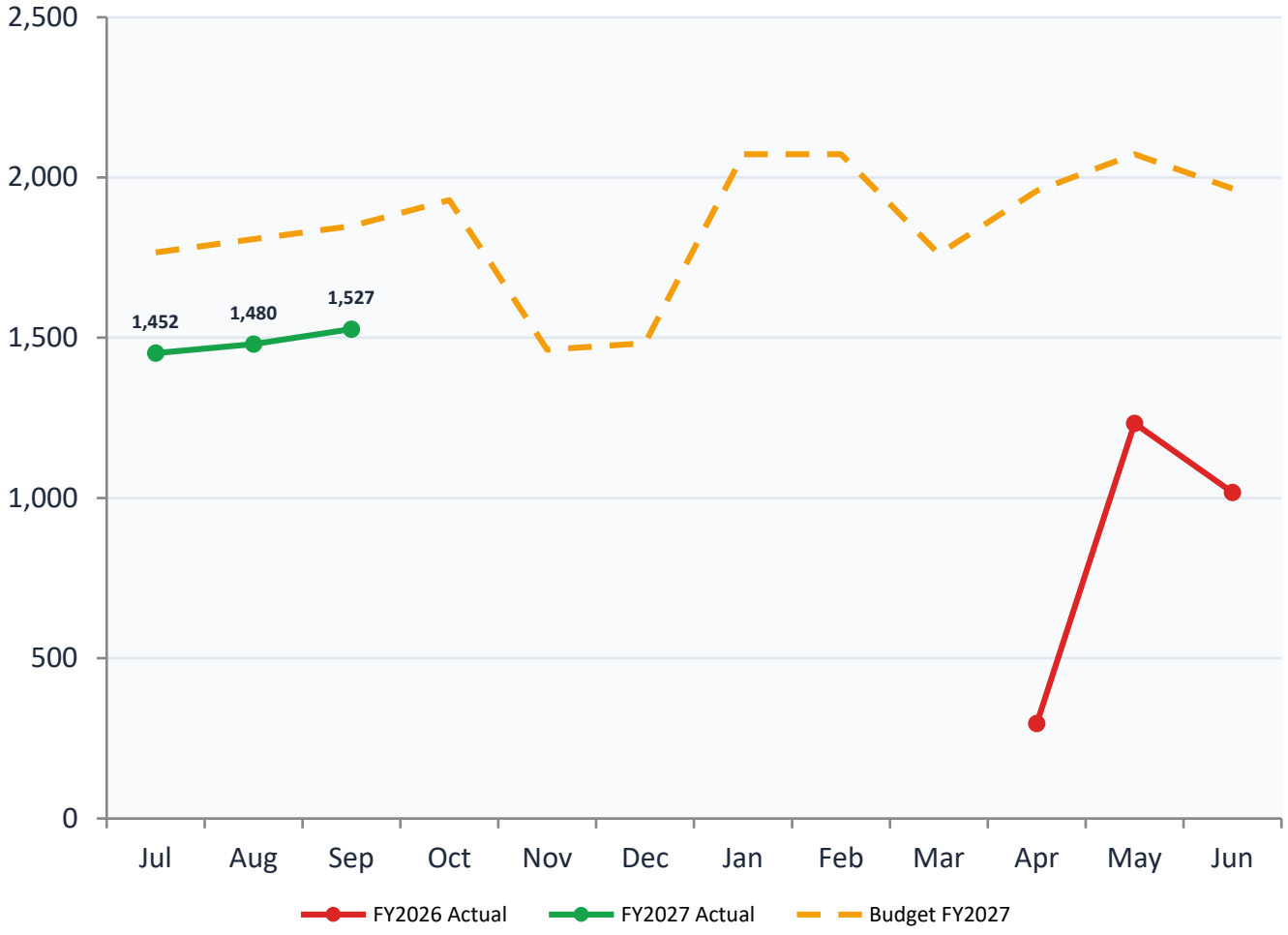


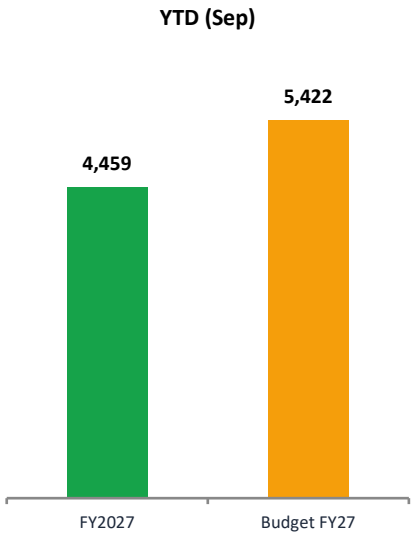
KH Willow Clinic-Women's Health



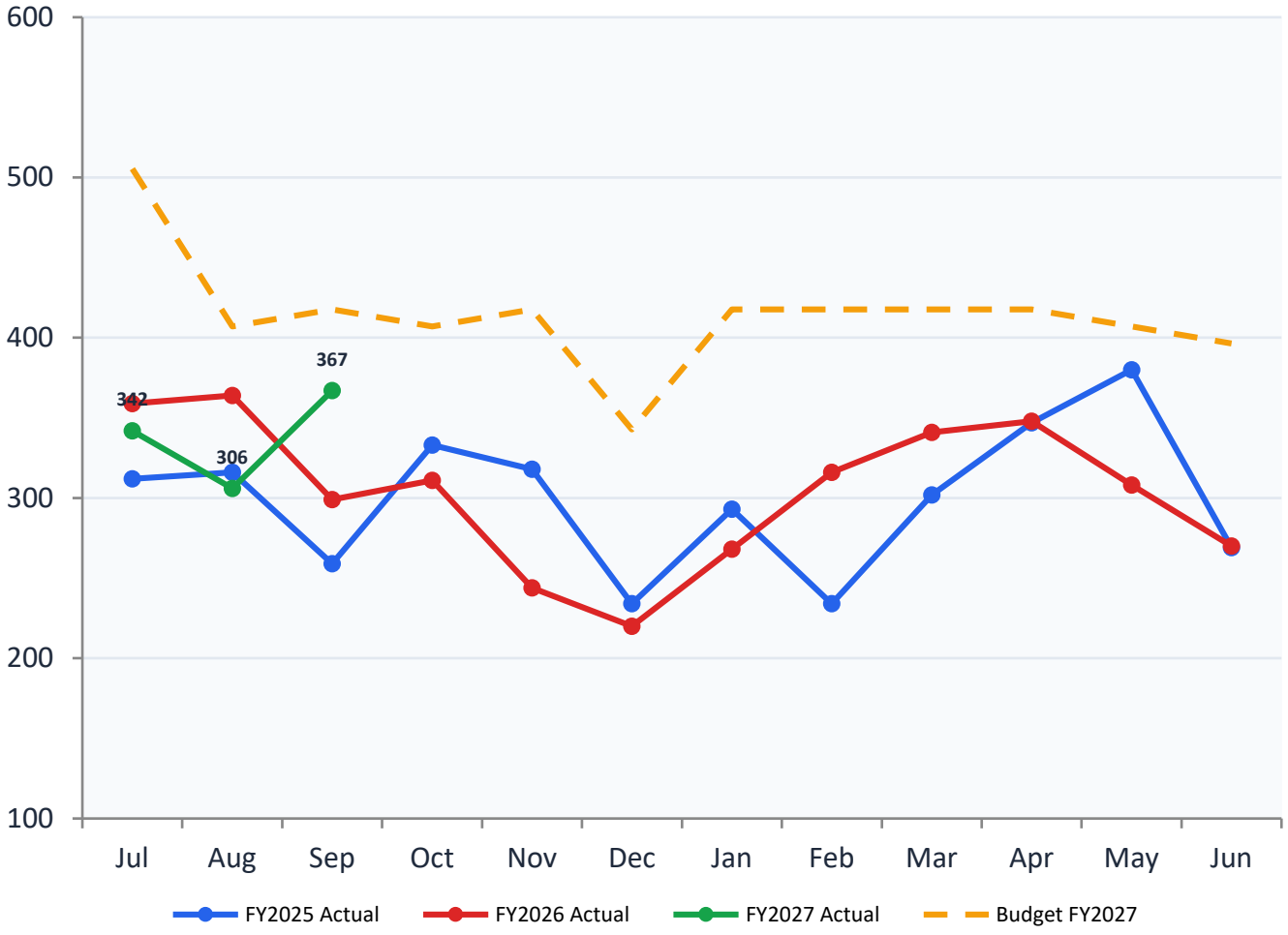


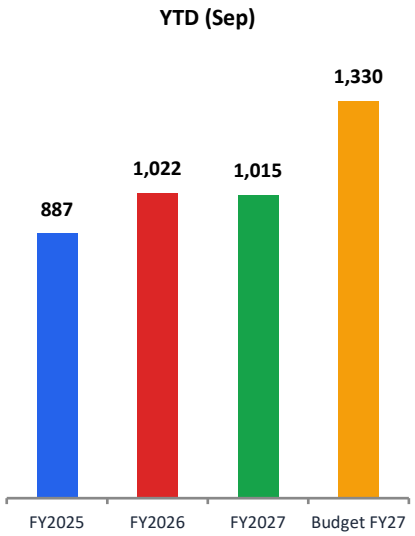
KH Medical Clinic - Akers



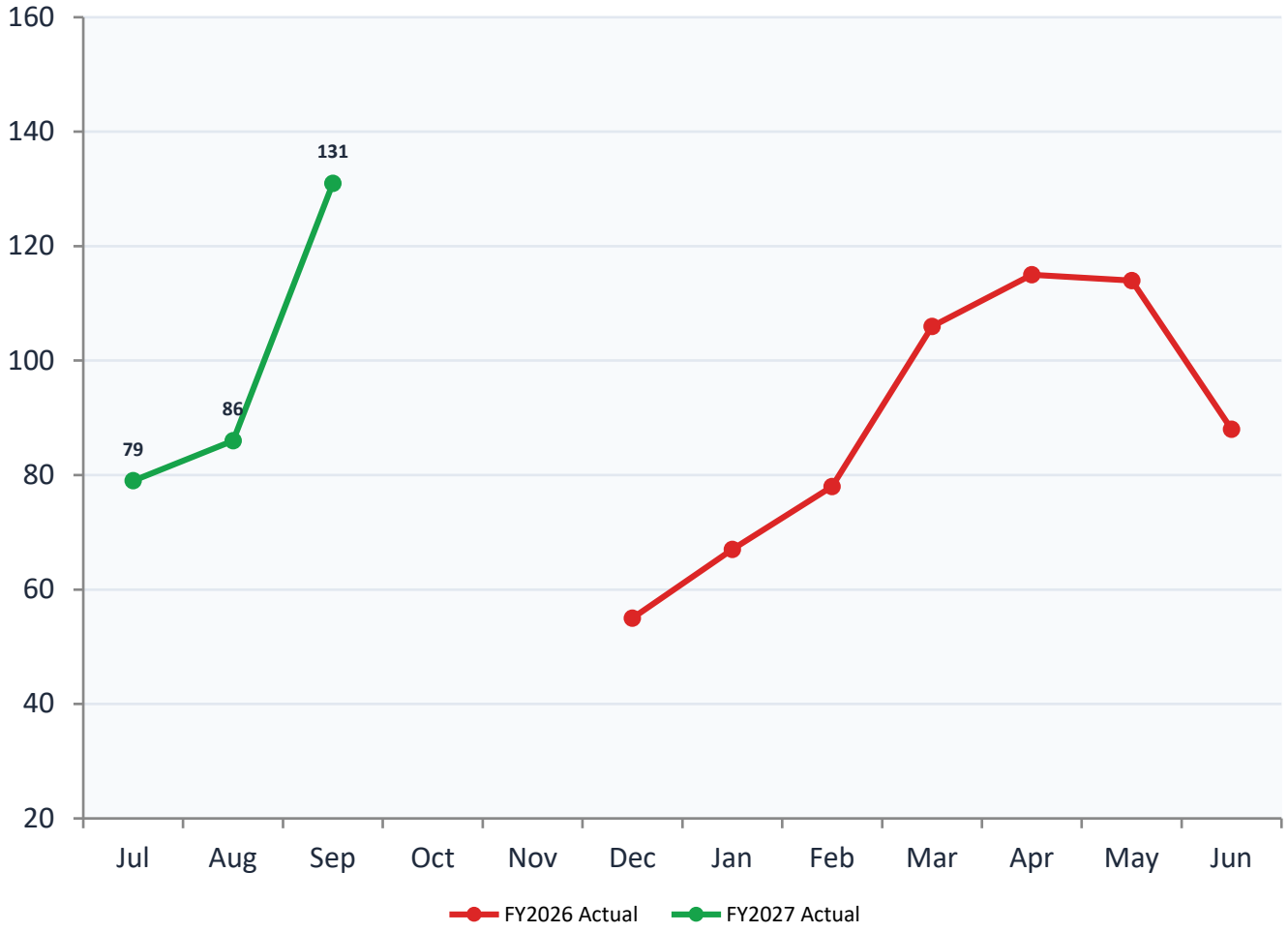


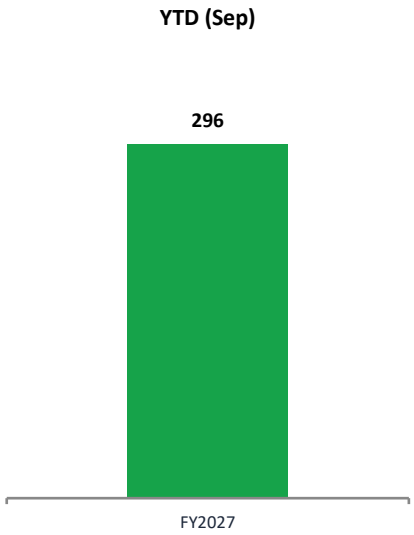
Mental Wellness Clinic - Visits



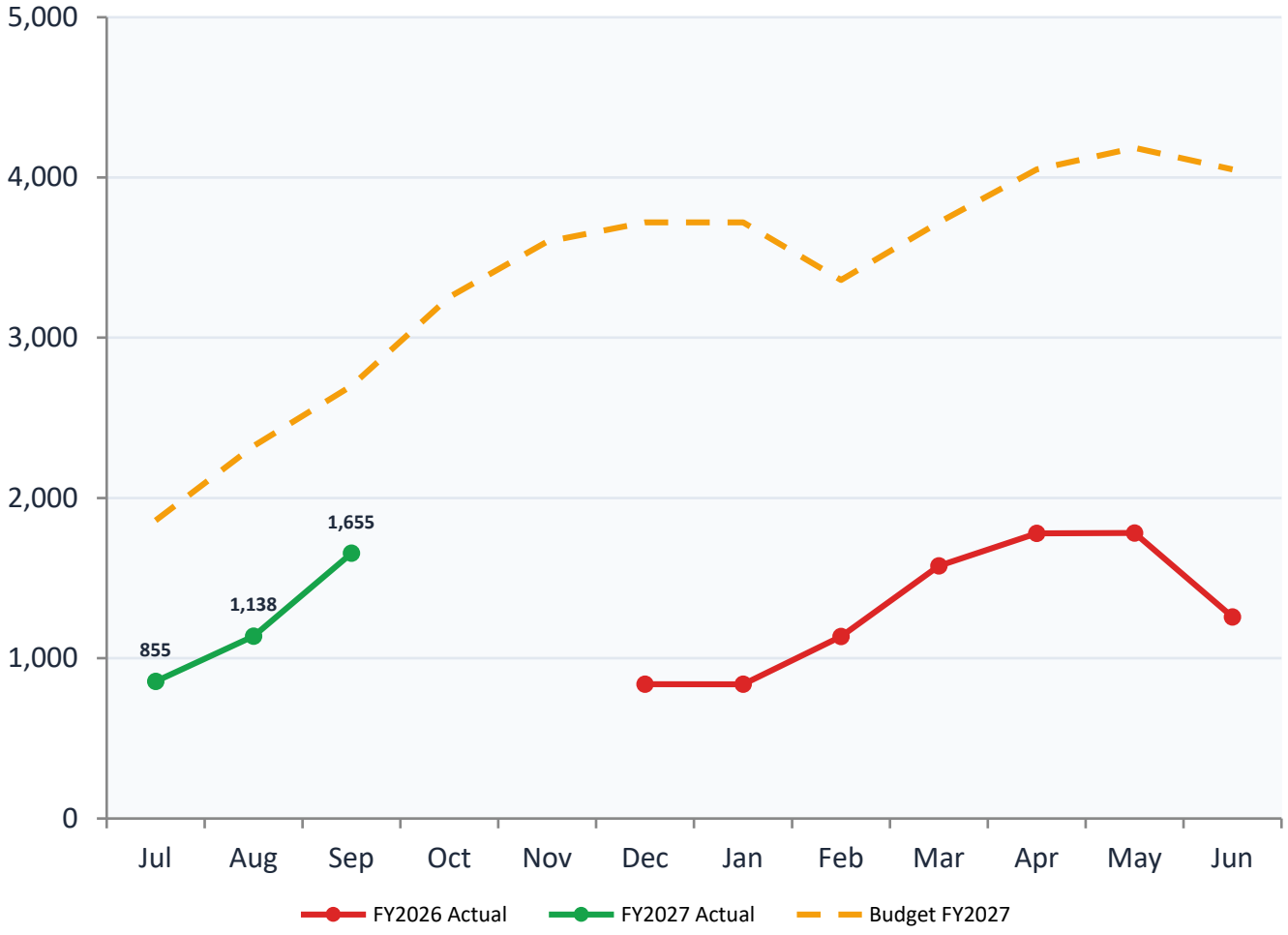


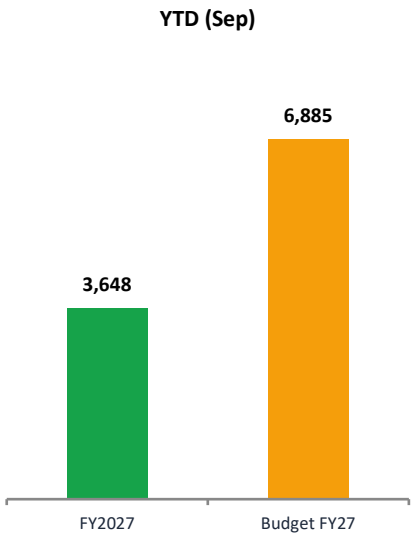
Crisis Stabilization Unit - Visits



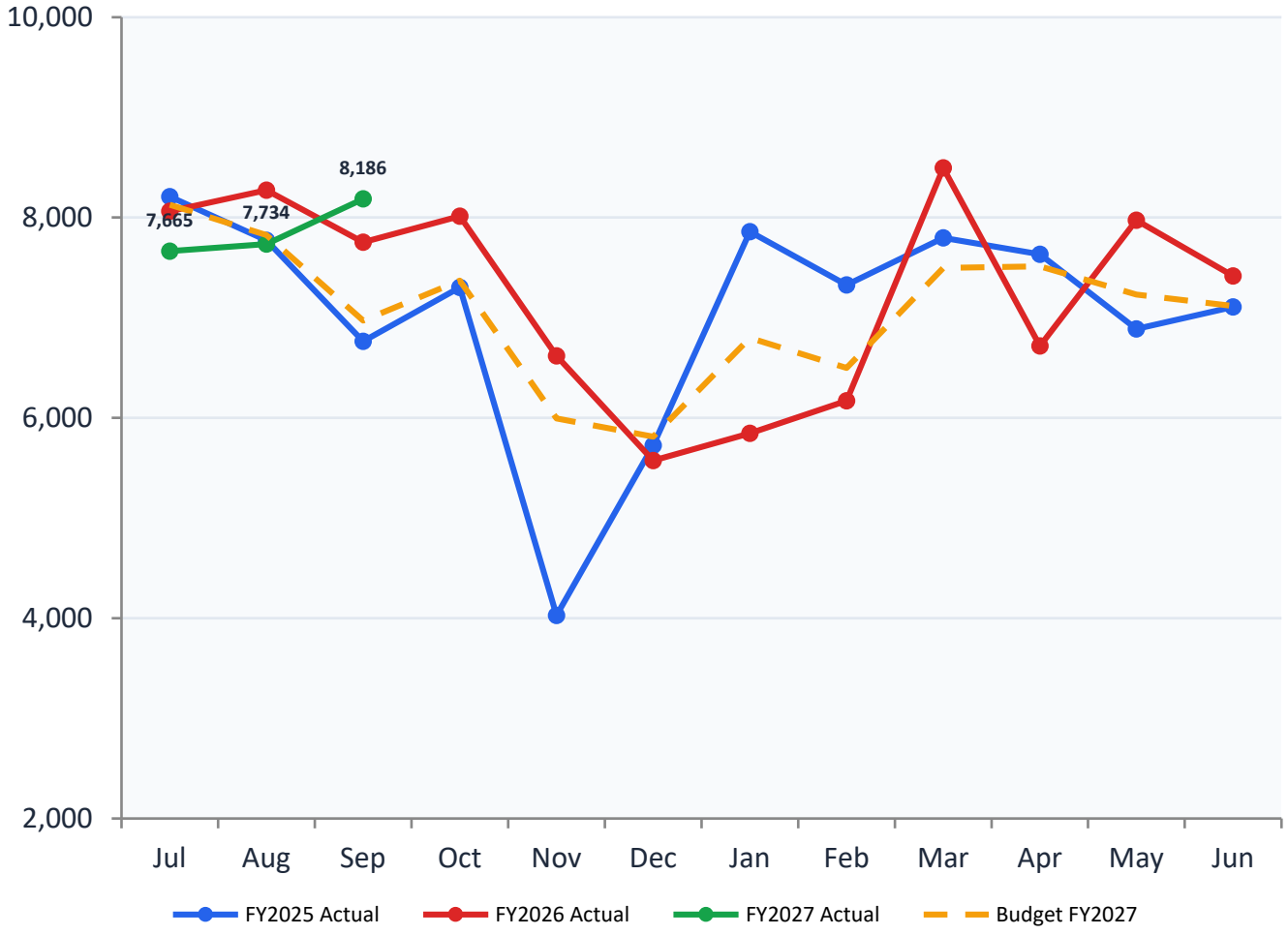


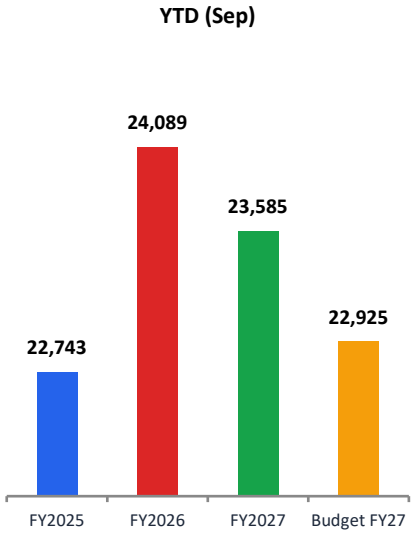
Crisis Stabilization Unit - Hours





Reference Lab





Other Statistical Results – Prior Year/Budget Comparison (Sep)

	Actual Results				Budget	Budget Variance	
	Sep25	Sep26	Change	% Change	Sep26	Change	% Change
ED - Avg Treated Per Day	282	286	4	1.4%	276	11	3.9%
Surgery (IP & OP) – 100 Min Units	812	850	38	4.7%	811	39	4.8%
Endoscopy Procedures	612	543	(69)	(11.3%)	566	(23)	(4.1%)
Cath Lab (IP & OP) - 100 Min Units	366	380	14	3.7%	392	(12)	(3.1%)
Cardiac Surgery Cases	29	24	(5)	(17.2%)	36	(12)	(33.3%)
Deliveries	345	355	10	2.9%	342	13	3.7%
Clinical Lab	258,892	276,864	17,972	6.9%	294,699	(17,835)	(6.1%)
Reference Lab	7,754	8,186	432	5.6%	6,970	1,216	17.4%
Dialysis Center - Visalia Visits	1,582	1,249	(333)	(21.0%)	1,463	(214)	(14.6%)
Infusion Center - Units of Service	614	532	(82)	(13.4%)	589	(57)	(9.7%)
Hospice Days	4,147	3,961	(186)	(4.5%)	4,175	(214)	(5.1%)
Home Health Visits	3,189	2,638	(551)	(17.3%)	2,700	(62)	(2.3%)
Home Infusion Days	23,489	23,294	(195)	(0.8%)	22,350	944	4.2%

Other Statistical Results – Fiscal Year Comparison (Sep)

	YTD Actual Results				Budget	Budget Variance	
	YTD Sep25	YTD Sep26	Change	% Change	YTD Sep26	Change	% Change
ED - Avg Treated Per Day	280	282	2	0.7%	278	4	1.4%
Surgery (IP & OP) – 100 Min Units	2,464	2,489	25	1.0%	2,524	(35)	(1.4%)
Endoscopy Procedures	1,873	1,648	(225)	(12.0%)	1,624	24	1.5%
Cath Lab (IP & OP) - 100 Min Units	1,112	1,141	29	2.6%	1,129	12	1.1%
Cardiac Surgery Cases	87	66	(21)	(24.1%)	100	(34)	(34.0%)
Deliveries	1,097	1,045	(52)	(4.7%)	1,049	(4)	(0.4%)
Clinical Lab	775,827	845,589	69,763	9.0%	866,731	(21,142)	(2.4%)
Reference Lab	24,089	23,585	(504)	(2.1%)	22,925	660	2.9%
Dialysis Center - Visalia Visits	4,394	3,938	(456)	(10.4%)	4,463	(525)	(11.8%)
Infusion Center - Units of Service	1,937	1,633	(304)	(15.7%)	1,814	(181)	(10.0%)
Hospice Days	11,995	11,711	(284)	(2.4%)	12,698	(987)	(7.8%)
Home Health Visits	9,249	7,855	(1,394)	(15.1%)	8,100	(245)	(3.0%)
Home Infusion Days	73,647	68,360	(5,287)	(7.2%)	71,521	(3,161)	(4.4%)

Other Statistical Results – Prior Year/Budget Comparison (Sep)

	Actual Results				Budget	Budget Variance	
	Sep25	Sep26	Change	% Change	Sep26	Change	% Change
All O/P Rehab Svcs Across District	21,038	22,172	1,134	5.4%	19,693	2,479	12.6%
Physical & Other Therapy Units (I/P & O/P	18,191	22,237	4,046	22.2%	20,289	1,948	9.6%
Radiology - CT - All Areas	5,259	5,549	290	5.5%	5,384	165	3.1%
Radiology - MRI - All Areas	944	997	53	5.6%	966	31	3.2%
Radiology - Ultrasound - All Areas	2,976	3,767	791	26.6%	3,580	187	5.2%
Radiology - Diagnostic Radiology	10,036	10,041	5	0.0%	9,360	681	7.3%
Radiology – Main Campus	16,210	16,619	409	2.5%	16,011	608	3.8%
Radiology - Ultrasound - Main Campus	2,276	2,741	465	20.4%	2,565	176	6.9%
West Campus - Diagnostic Radiology	1,298	1,550	252	19.4%	1,292	258	19.9%
West Campus - CT Scan	573	663	90	15.7%	526	137	26.0%
West Campus - MRI	434	496	62	14.3%	446	50	11.3%
West Campus - Ultrasound	700	1,026	326	46.6%	1,015	11	1.1%
West Campus - Breast Center	1,361	1,768	407	29.9%	1,725	43	2.5%
Med Onc Visalia Treatments	1,151	1,365	214	18.6%	1,207	158	13.1%
Rad Onc Visalia Treatments	1,671	2,666	995	59.5%	1,663	1,003	60.3%
Rad Onc Hanford Treatments	306	269	(37)	(12.1%)	242	27	11.2%

Other Statistical Results – Fiscal Year Comparison (Sep)

	YTD Actual Results				Budget	Budget Variance	
	YTD Sep25	YTD Sep26	Change	% Change	YTD Sep26	Change	% Change
All O/P Rehab Svcs Across District	62,338	63,759	1,421	2.3%	60,525	3,234	5.3%
Physical & Other Therapy Units (I/P & O/P	55,835	66,609	10,774	19.3%	62,589	4,020	6.4%
Radiology - CT - All Areas	15,479	17,496	2,017	13.0%	16,151	1,345	8.3%
Radiology - MRI - All Areas	2,805	3,011	206	7.3%	2,930	81	2.8%
Radiology - Ultrasound - All Areas	9,238	10,688	1,450	15.7%	11,052	(364)	(3.3%)
Radiology - Diagnostic Radiology	28,902	30,273	1,371	4.7%	28,355	1,918	6.8%
Radiology – Main Campus	47,454	50,250	2,796	5.9%	48,506	1,744	3.6%
Radiology - Ultrasound - Main Campus	7,066	7,518	452	6.4%	7,996	(478)	(6.0%)
West Campus - Diagnostic Radiology	3,896	4,600	704	18.1%	3,888	712	18.3%
West Campus - CT Scan	1,614	2,007	393	24.3%	1,655	352	21.3%
West Campus - MRI	1,288	1,441	153	11.9%	1,383	58	4.2%
West Campus - Ultrasound	2,172	3,170	998	45.9%	3,056	114	3.7%
West Campus - Breast Center	4,179	5,888	1,709	40.9%	5,451	437	8.0%
Med Onc Visalia Treatments	3,494	3,867	373	10.7%	3,620	247	6.8%
Rad Onc Visalia Treatments	5,007	6,572	1,565	31.3%	5,249	1,323	25.2%
Rad Onc Hanford Treatments	875	674	(201)	(23.0%)	746	(72)	(9.7%)

Other Statistical Results – Prior Year/Budget Comparison (Sep)

	Actual Results				Budget	Budget Variance	
	Sep25	Sep26	Change	% Change	Sep26	Change	% Change
Rural Health Clinics Visits	13,013	12,866	(147)	(1.1%)	12,037	829	6.9%
RHC Exeter - Visits	6,219	6,194	(25)	(0.4%)	6,144	50	0.8%
RHC Lindsay - Visits	1,809	1,688	(121)	(6.7%)	1,795	(107)	(6.0%)
RHC Woodlake - Visits	687	581	(106)	(15.4%)	630	(49)	(7.8%)
RHC Woodlake Valencia - Visits	696	808	112	16.1%	912	(104)	(11.4%)
RHC Dinuba - Visits	1,353	1,376	23	1.7%	1,274	102	8.0%
RHC Tulare - Visits	2,249	2,219	(30)	(1.3%)	2,193	26	1.2%
Urgent Care – Court Total Visits	2,456	2,371	(85)	(3.5%)	2,685	(314)	(11.7%)
Urgent Care – Demaree Total Visits	1,812	2,177	365	20.1%	1,997	180	9.0%
KH Medical Clinic - Plaza Visits	229	300	71	31.0%	306	(6)	(2.0%)
KH Medical Clinic - Akers Visits	0	1,527	1,527	0.0%	1,848	(321)	(17.4%)
KH Willow Specialty Clinic	0	302	302	0.0%	249	53	21.3%
KH Cardiology Center Visalia Registrations	1,461	1,501	40	2.7%	1,941	(440)	(22.7%)
KH Mental Wellness Clinic Visits	299	367	68	22.7%	418	(51)	(12.2%)
Urology Clinic Visits	323	239	(84)	(26.0%)	349	(110)	(31.5%)
Therapy-Wound Care Svcs Encounters	370	372	2	0.5%	347	25	7.2%

Other Statistical Results – Fiscal Year Comparison (Sep)

	YTD Actual Results				Budget	Budget Variance	
	YTD Sep25	YTD Sep26	Change	% Change	YTD Sep26	Change	% Change
Rural Health Clinics Visits	38,060	38,005	(55)	(0.1%)	35,961	2,044	5.7%
RHC Exeter - Visits	18,117	18,442	325	1.8%	18,535	(93)	(0.5%)
RHC Lindsay - Visits	5,394	5,296	(98)	(1.8%)	5,313	(17)	(0.3%)
RHC Woodlake - Visits	1,889	1,730	(159)	(8.4%)	1,891	(161)	(8.5%)
RHC Woodlake Valencia - Visits	1,960	2,329	369	18.8%	2,736	(407)	(14.9%)
RHC Dinuba - Visits	4,127	3,828	(299)	(7.2%)	3,796	32	0.8%
RHC Tulare - Visits	6,573	6,380	(193)	(2.9%)	6,426	(46)	(0.7%)
Urgent Care – Court Total Visits	7,358	6,907	(451)	(6.1%)	8,026	(1,119)	(13.9%)
Urgent Care – Demaree Total Visits	5,184	6,014	830	16.0%	5,915	99	1.7%
KH Medical Clinic - Plaza Visits	839	988	149	17.8%	969	19	2.0%
KH Medical Clinic - Akers Visits	0	4,459	4,459	0.0%	5,422	(963)	(17.8%)
KH Willow Specialty Clinic	0	1,037	1,037	0.0%	758	279	36.8%
KH Cardiology Center Visalia Registrations	4,349	4,391	42	1.0%	5,951	(1,560)	(26.2%)
KH Mental Wellness Clinic Visits	1,022	1,015	(7)	(0.7%)	1,330	(315)	(23.7%)
Urology Clinic Visits	977	750	(227)	(23.2%)	1,083	(333)	(30.8%)
Therapy-Wound Care Svcs Encounters	1,088	1,065	(23)	(2.1%)	1,065	0	0.0%

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Sep 30, 2026

Board designated funds	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
LAIF		3.82	Various			22,588,794	
CAMP		3.87	CAMP			19,946,899	
Allspring		3.45	Money market			68,262	
PFM		3.45	Money market			167,252	
Western Alliance		0.25	Money market			29,716	
PFM	11-Aug-26	0.00	U.S. Govt Agency	FHLMC		450,000	
PFM	1-Nov-26	4.76	Municipal	California St Univ		125,000	
PFM	4-Nov-26	1.65	MTN-C	American Express Co		445,000	
Allspring	30-Nov-26	1.25	U.S. Govt Agency	US Treasury Bill		1,500,000	
Allspring	15-Jan-27	1.95	MTN-C	Target Corp		900,000	
Allspring	31-Jan-27	1.50	U.S. Govt Agency	US Treasury Bill		325,000	
Allspring	31-Mar-27	2.50	U.S. Govt Agency	US Treasury Bill		3,320,000	
Allspring	30-Apr-27	2.75	U.S. Govt Agency	US Treasury Bill		970,000	
Western Alliance - CDARS	10-Jun-27	3.20	CD	Banc of California		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	Beneficial State Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	Blue Sky Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	BOKF, National Association		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	Commerce Bank & Trust		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	DNB National Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	East West Bank		79,861	
Western Alliance - CDARS	10-Jun-27	3.20	CD	First Liberty Bank		82,139	
Western Alliance - CDARS	10-Jun-27	3.20	CD	FirstOak Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	Live Oak Banking Company		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	Meridian Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	OMB Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	OneUnited Bank		236,500	
Western Alliance - CDARS	10-Jun-27	3.20	CD	West Texas State Bank		236,500	
Allspring	15-Jul-27	3.68	Municipal	Massachusetts St		1,000,000	
Allspring	1-Aug-27	3.46	Municipal	Alameda Cnty Ca		500,000	
Allspring	1-Aug-27	3.23	Municipal	San Jose Ca Redev		400,000	
Allspring	1-Oct-27	4.66	Municipal	San Francisco Ca		1,000,000	
Allspring	22-Oct-27	4.33	MTN-C	State Street Corp		400,000	
Allspring	22-Oct-27	4.33	MTN-C	State Street Corp		1,000,000	
Allspring	15-Nov-27	4.60	MTN-C	Caterpillar Finl Mtn		1,000,000	
PFM	30-Nov-27	3.50	U.S. Govt Agency	US Treasury Bill		1,475,000	
PFM	31-Dec-27	3.38	U.S. Govt Agency	US Treasury Bill		1,500,000	
PFM	15-Jan-28	4.10	MTN-C	Mastercard		130,000	
PFM	24-Jan-28	4.90	MTN-C	Wells Fargo MTN		145,000	
Allspring	12-Feb-28	4.55	MTN-C	Eli Lilly Co		300,000	
PFM	15-Feb-28	4.25	U.S. Govt Agency	US Treasury Bill		80,000	
PFM	18-Feb-28	5.41	ABS	Honda Auto		49,703	
PFM	25-Feb-28	5.47	ABS	BMW Vehicle Owner		7,062	
PFM	26-Feb-28	4.48	MTN-C	Chevron USA Inc		340,000	
PFM	29-Feb-28	1.13	U.S. Govt Agency	US Treasury Bill		1,500,000	
PFM	17-Apr-28	5.48	ABS	Hyundai Auto		14,356	
Allspring	22-Apr-28	5.57	MTN-C	JP Morgan		300,000	
Allspring	22-Apr-28	5.57	MTN-C	JP Morgan		1,100,000	
PFM	23-Apr-28	4.89	MTN-C	Goldman Sachs		155,000	
PFM	30-Apr-28	1.25	U.S. Govt Agency	US Treasury Bill		600,000	
PFM	30-Apr-28	3.50	U.S. Govt Agency	US Treasury Bill		750,000	
PFM	15-May-28	5.46	ABS	Ally Auto Rec		33,656	
PFM	15-May-28	4.25	MTN-C	Servicenow Inc		60,000	
PFM	15-May-28	5.23	ABS	Ford CR Auto Owner		27,865	
PFM	16-Jun-28	5.45	ABS	GM Finl con Auto Rec		19,119	
PFM	25-Jun-28	4.78	U.S. Govt Agency	FHLMC		271,837	
PFM	25-Jun-28	4.82	U.S. Govt Agency	FHLMC		528,096	
Allspring	30-Jun-28	4.00	U.S. Govt Agency	US Treasury Bill		500,000	
PFM	30-Jun-28	4.00	U.S. Govt Agency	US Treasury Bill		1,300,000	
PFM	1-Jul-28	4.42	Municipal	Los Angeles Ca		140,000	
PFM	6-Jul-28	4.66	MTN-C	Morgan Stanley		250,000	
Allspring	14-Jul-28	4.95	MTN-C	John Deere Mtn		700,000	
PFM	14-Jul-28	4.95	MTN-C	John Deere Mtn		120,000	
PFM	24-Jul-28	4.42	MTN-C	Truist Bk Sr Nt		275,000	
PFM	25-Jul-28	4.18	U.S. Govt Agency	FNMA		482,083	
Allspring	1-Aug-28	5.75	Municipal	San Diego County		1,000,000	
PFM	25-Aug-28	4.74	U.S. Govt Agency	FHLMC		545,000	
PFM	25-Aug-28	4.65	U.S. Govt Agency	FHLMC		545,000	
PFM	25-Sep-28	4.85	U.S. Govt Agency	FHLMC		410,000	
PFM	25-Sep-28	4.80	U.S. Govt Agency	FHLMC		535,000	
PFM	30-Sep-28	4.63	U.S. Govt Agency	US Treasury Bill		500,000	
PFM	15-Oct-28	3.50	U.S. Govt Agency	US Treasury Bill		560,000	
Allspring	25-Oct-28	5.80	MTN-C	Bank New York Mtn		375,000	
Allspring	25-Oct-28	5.80	MTN-C	Bank New York Mtn		1,000,000	
PFM	25-Oct-28	5.07	U.S. Govt Agency	FHLMC		200,000	
PFM	25-Oct-28	4.86	U.S. Govt Agency	FHLMC		300,000	
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill		775,000	
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill		1,500,000	
PFM	25-Nov-28	5.00	U.S. Govt Agency	FHLMC		257,781	
PFM	25-Dec-28	4.72	U.S. Govt Agency	FHLMC		315,000	
PFM	25-Dec-28	4.57	U.S. Govt Agency	FHLMC		325,000	
PFM	31-Dec-28	1.38	U.S. Govt Agency	US Treasury Bill		500,000	
PFM	31-Dec-28	3.75	U.S. Govt Agency	US Treasury Bill		1,200,000	
PFM	12-Jan-29	5.02	MTN-C	Morgan Stanley		250,000	
PFM	24-Jan-29	4.92	MTN-C	JP Morgan		140,000	
PFM	26-Jan-29	4.08	MTN-C	PNC Finl Svcs Group INC		290,000	
PFM	31-Jan-29	4.00	U.S. Govt Agency	US Treasury Bill		700,000	
PFM	8-Feb-29	4.60	MTN-C	Air products		295,000	
PFM	8-Feb-29	4.60	MTN-C	Texas Instrs		370,000	
PFM	9-Feb-29	4.01	MTN-C	American Express Co		400,000	
PFM	15-Feb-29	3.50	U.S. Govt Agency	US Treasury Bill		160,000	
PFM	20-Feb-29	4.90	MTN-C	Cummins INC		195,000	
PFM	23-Feb-29	3.75	MTN-C	Caterpillar Finl Mtn		355,000	
PFM	26-Feb-29	4.85	MTN-C	Astrazeneca		165,000	
PFM	26-Feb-29	4.85	MTN-C	Cisco Sys Inc		225,000	
PFM	28-Feb-29	4.25	U.S. Govt Agency	US Treasury Bill		750,000	
PFM	14-Mar-29	3.75	MTN-C	Disney Walt co		730,000	
Allspring	15-Mar-29	5.38	ABS	Hyundai Auto Rec		649,533	
PFM	15-Mar-29	4.65	MTN-C	Salesforce Inc		725,000	
PFM	25-Mar-29	5.18	U.S. Govt Agency	FHLMC		315,000	

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
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Allspring	31-Mar-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-Mar-29	4.13	U.S. Govt Agency	US Treasury Bill	225,000
PFM	4-Apr-29	4.80	MTN-C	Adobe Inc	225,000
Allspring	15-Apr-29	3.75	U.S. Govt Agency	US Treasury Bill	2,000,000
Allspring	16-Apr-29	3.88	ABS	Mercedes Benz Auto Leas	1,400,000
PFM	23-Apr-29	4.91	MTN-C	Wells Fargo co	205,000
PFM	25-Apr-29	4.73	MTN-C	American Express	245,000
Allspring	30-Apr-29	4.63	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	9-May-29	4.62	MTN-C	Bank America Mtn	290,000
PFM	15-May-29	4.42	ABS	Hyundai Auto Rec	161,794
PFM	25-May-29	4.72	U.S. Govt Agency	FHLMC	460,000
Allspring	31-May-29	4.50	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	15-Jun-29	5.15	MTN-C	National Rural Mtn	850,000
Allspring	15-Jun-29	4.13	U.S. Govt Agency	US Treasury Bill	1,400,000
Allspring	25-Jun-29	4.75	MTN-C	Home Depot Inc	500,000
PFM	25-Jun-29	4.75	MTN-C	Home Depot Inc	95,000
PFM	25-Jun-29	4.64	U.S. Govt Agency	FHLMC	200,000
PFM	30-Jun-29	3.25	U.S. Govt Agency	US Treasury Bill	1,930,000
PFM	15-Jul-29	4.76	ABS	Ford CR Auto Owner	300,818
Allspring	16-Jul-29	4.65	ABS	American Express	1,025,000
PFM	25-Jul-29	4.62	U.S. Govt Agency	FHLMC	410,000
PFM	25-Jul-29	4.54	U.S. Govt Agency	FHLMC	515,000
Allspring	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	500,000
PFM	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	530,000
PFM	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	260,000
PFM	9-Aug-29	4.55	MTN-C	Toyota Motor	195,000
Allspring	13-Aug-29	4.65	MTN-C	Illinois Tool Wks	525,000
PFM	16-Aug-29	4.27	ABS	GM Finl con Auto Rec	112,422
PFM	18-Aug-29	4.64	ABS	Toyota Auto	239,596
PFM	20-Aug-29	4.92	ABS	Volkswagen Auto Ln	365,000
PFM	31-Aug-29	3.63	U.S. Govt Agency	US Treasury Bill	750,000
PFM	18-Sep-29	3.80	MTN-C	Novartis Capital	365,000
PFM	21-Sep-29	4.57	ABS	Honda Auto	192,148
PFM	25-Sep-29	4.85	ABS	BMW Vehicle Owner	121,616
PFM	25-Sep-29	4.79	U.S. Govt Agency	FHLMC	345,000
Allspring	30-Sep-29	3.50	U.S. Govt Agency	US Treasury Bill	950,000
Allspring	1-Oct-29	4.35	Municipal	Los Angeles Ca	250,000
PFM	4-Oct-29	4.05	MTN-C	Accenture Capital	195,000
PFM	15-Oct-29	4.45	ABS	Ford Credit Auto	445,000
PFM	15-Oct-29	4.15	ABS	Honda Auto	125,000
PFM	21-Oct-29	4.15	MTN-C	Goldman Sachs	580,000
Allspring	31-Oct-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-Oct-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	15-Nov-29	4.77	ABS	Toyota Auto	220,000
Allspring	30-Nov-29	4.13	U.S. Govt Agency	US Treasury Bill	1,700,000
Allspring	15-Dec-29	4.49	ABS	Nissan Auto Rec	500,000
Allspring	17-Dec-29	4.98	ABS	GM Finl Consumer	425,487
PFM	17-Dec-29	4.78	ABS	Mercedes Benz Auto	228,392
Allspring	31-Dec-29	4.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	31-Dec-29	4.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	9-Jan-30	4.24	MTN-C	Morgan Stanley	1,450,000
Allspring	17-Jan-30	4.95	MTN-C	Adobe Inc	900,000
PFM	17-Jan-30	4.95	MTN-C	Adobe Inc	285,000
Allspring	23-Jan-30	5.20	MTN-C	Wells Fargo co	500,000
PFM	23-Jan-30	4.82	MTN-C	Wells Fargo co	240,000
PFM	25-Jan-30	4.41	U.S. Govt Agency	FHLMC	205,000
Allspring	31-Jan-30	4.00	U.S. Govt Agency	US Treasury Bill	1,125,000
Allspring	31-Jan-30	3.50	U.S. Govt Agency	US Treasury Bill	800,000
PFM	31-Jan-30	4.25	U.S. Govt Agency	US Treasury Bill	295,000
PFM	8-Feb-30	4.21	MTN-C	Morgan Stanley	385,000
Allspring	12-Feb-30	4.75	MTN-C	Eli Lilly Co	600,000
PFM	24-Feb-30	4.75	MTN-C	Cisco Sys Inc	290,000
PFM	28-Feb-30	4.00	U.S. Govt Agency	US Treasury Bill	160,000
PFM	28-Feb-30	4.00	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	20-Mar-30	4.51	ABS	Verizon Master Trust	440,000
PFM	20-Mar-30	3.92	ABS	Volkswagen Auto Least TR	215,000
PFM	31-Mar-30	3.63	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	31-Mar-30	4.00	U.S. Govt Agency	US Treasury Bill	700,000
Allspring	1-Apr-30	3.38	MTN-C	Toyota Motor	1,100,000
PFM	15-Apr-30	4.28	ABS	American Express	410,000
PFM	16-Apr-30	4.66	ABS	GM Finl Consumer	95,000
Allspring	20-Apr-30	4.59	MTN-C	Goldman Sachs	700,000
PFM	23-Apr-30	4.41	MTN-C	JP Morgan	570,000
PFM	24-Apr-30	4.76	MTN-C	State Street Corp	140,000
Allspring	28-Apr-30	4.35	MTN-C	Walmart Inc	500,000
Allspring	30-Apr-30	3.88	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	30-Apr-30	3.88	U.S. Govt Agency	US Treasury Bill	160,000
PFM	15-May-30	4.31	ABS	Bank of America	265,000
PFM	15-May-30	4.80	MTN-C	Toyota Motor	200,000
PFM	15-May-30	4.34	ABS	WF Card Issuance	515,000
Allspring	20-May-30	4.91	MTN-C	Citibank N A	500,000
Allspring	20-May-30	4.91	MTN-C	Citibank N A	900,000
PFM	21-May-30	4.74	MTN-C	Schwab Charles Corp	175,000
PFM	25-May-30	4.36	U.S. Govt Agency	FHLMC	375,000
PFM	25-May-30	4.35	U.S. Govt Agency	FHLMC	575,000
PFM	29-May-30	4.91	MTN-C	Citibank N A	250,000
Allspring	31-May-30	4.00	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	5-Jun-30	4.55	MTN-C	John Deere Mtn	285,000
PFM	15-Jun-30	4.19	ABS	Ford CR Auto Owner	235,000
PFM	15-Jun-30	4.50	MTN-C	Analog Devices	435,000
PFM	21-Jun-30	4.30	ABS	Citibank Credit	580,000
PFM	25-Jun-30	4.33	U.S. Govt Agency	FHLMC	575,000
PFM	25-Jun-30	4.27	U.S. Govt Agency	FHLMC	590,000
Allspring	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	540,000
PFM	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	2,000,000
PFM	15-Jul-30	4.30	ABS	American Express	330,000
PFM	15-Jul-30	3.85	ABS	Capital One Prime	135,000
Allspring	15-Jul-30	4.16	ABS	Chase Issuance Trust	1,000,000
PFM	25-Jul-30	4.29	U.S. Govt Agency	FHLMC	460,000
PFM	29-Jul-30	4.30	MTN-C	GE Aerospace	65,000
Allspring	31-Jul-30	3.88	U.S. Govt Agency	US Treasury Bill	500,000
Allspring	31-Jul-30	4.00	U.S. Govt Agency	US Treasury Bill	1,575,000
PFM	31-Jul-30	3.88	U.S. Govt Agency	US Treasury Bill	500,000
Allspring	31-Aug-30	3.63	U.S. Govt Agency	US Treasury Bill	600,000
Allspring	31-Aug-30	3.75	U.S. Govt Agency	US Treasury Bill	800,000
PFM	31-Aug-30	3.75	U.S. Govt Agency	US Treasury Bill	950,000
PFM	1-Sep-30	4.20	ABS	Honda AR Owner Tr	185,000
Allspring	15-Sep-30	4.15	MTN-C	Merck Co inc	900,000
PFM	15-Sep-30	3.95	MTN-C	Home Depot Inc	65,000
PFM	16-Sep-30	3.82	ABS	Capital one Mtn	360,000
PFM	16-Sep-30	3.86	ABS	Toyota Auto	170,000
Allspring	30-Sep-30	3.63	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	15-Oct-30	4.05	ABS	Ford CR Auto Owner	295,000
Allspring	15-Oct-30	4.09	ABS	Ally Auto Rec	1,400,000
Allspring	15-Oct-30	4.30	MTN-C	Chevron USA Inc	500,000
PFM	15-Oct-30	4.55	ABS	Mercedes Benz Ar	505,000
Allspring	31-Oct-30	3.63	U.S. Govt Agency	US Treasury Bill	500,000
PFM	5-Nov-30	4.10	MTN-C	Novartis Capital	540,000
PFM	6-Nov-30	4.13	MTN-C	Shell Fin US INC	130,000
PFM	15-Nov-30	4.30	ABS	Honda Auto Rec Own	480,000
Allspring	15-Nov-30	4.20	MTN-C	Meta Platforms INC	550,000
PFM	15-Nov-30	0.88	U.S. Govt Agency	US Treasury Bill	465,000
PFM	19-Nov-30	4.15	MTN-C	Northern TR Corp	120,000
PFM	25-Nov-30	4.09	U.S. Govt Agency	FHLMC	335,000
PFM	25-Nov-30	4.17	U.S. Govt Agency	FHLMC	390,000
Allspring	30-Nov-30	3.63	U.S. Govt Agency	US Treasury Bill	1,000,000

KAWEAH DELTA HEALTH CARE DISTRICT
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PFM	30-Nov-30	3.63	U.S. Govt Agency	US Treasury Bill	900,000	
PFM	15-Dec-30	4.50	ABS	Nissan Auto Rec	505,000	
Allspring	31-Dec-30	3.63	U.S. Govt Agency	US Treasury Bill	200,000	
PFM	31-Dec-30	3.63	U.S. Govt Agency	US Treasury Bill	2,000,000	
PFM	8-Jan-31	4.15	MTN-C	Caterpillar Finl Mtn	95,000	
PFM	13-Jan-31	4.25	MTN-C	Totalenergies Cap USA LLC	290,000	
Allspring	24-Jan-31	5.16	MTN-C	Bank of America	275,000	
PFM	31-Jan-31	4.00	U.S. Govt Agency	US Treasury Bill	1,790,000	
PFM	31-Jan-31	3.75	U.S. Govt Agency	US Treasury Bill	45,000	
PFM	15-Feb-31	4.65	ABS	Ford CR Auto Owner	365,000	
PFM	18-Feb-31	3.79	ABS	Hyundai Auto	210,000	
PFM	18-Feb-31	4.81	ABS	Hyundai Auto	350,000	
Allspring	28-Feb-31	3.50	U.S. Govt Agency	US Treasury Bill	1,600,000	
PFM	2-Mar-31	4.00	MTN-C	Astrazeneca	345,000	
PFM	13-Mar-31	4.25	MTN-C	Amazon Com Inc	410,000	
PFM	15-Mar-31	4.00	MTN-C	Abbott Laboratories	500,000	
PFM	15-Mar-31	1.38	MTN-C	Home Depot Inc	835,000	
PFM	25-Mar-31	4.23	U.S. Govt Agency	FHLMC	360,000	
Allspring	31-Mar-31	3.88	U.S. Govt Agency	US Treasury Bill	250,000	
Allspring	31-Mar-31	3.88	U.S. Govt Agency	US Treasury Bill	750,000	
PFM	1-Apr-31	4.21	Municipal	Hawaii St	190,000	
Allspring	30-Apr-31	3.88	U.S. Govt Agency	US Treasury Bill	3,500,000	
Allspring	15-May-31	5.08	MTN-C	US Bancorp	500,000	
Allspring	15-May-31	5.08	MTN-C	US Bancorp	600,000	
PFM	15-May-31	4.55	MTN-C	Meta Platforms Inc	370,000	
PFM	20-May-31	4.60	MTN-C	Gilead Sciences Inc	195,000	
PFM	22-May-31	4.65	MTN-C	Merck Co inc	340,000	
Allspring	31-May-31	4.13	U.S. Govt Agency	US Treasury Bill	1,500,000	
PFM	8-Jun-31	4.60	MTN-C	Mastercard	440,000	
PFM	15-Jun-31	4.50	MTN-C	Nvidia Corporation	185,000	
PFM	15-Jun-31	4.95	MTN-C	Intuit	365,000	
PFM	15-Jun-31	4.50	MTN-C	Nvidia Corporation	500,000	
PFM	16-Jun-31	4.83	ABS	Hyundai Auto Rec	290,000	
PFM	10-Jul-31	5.00	MTN-C	Accenture Capital	345,000	
PFM	15-Jul-31	4.77	ABS	Capital One Prime	240,000	
PFM	31-Jul-31	4.38	U.S. Govt Agency	US Treasury Bill	1,500,000	
PFM	15-Aug-31	4.88	MTN-C	Alphabet Inc Sr	365,000	
PFM	17-Aug-31	5.00	MTN-C	Advanced Micro	370,000	
PFM	25-Aug-31	4.40	U.S. Govt Agency	FHLMC	545,000	
PFM	15-Sep-31	4.99	ABS	American Express	645,000	
Allspring		3.75	U.S. Govt Agency	US Treasury Bill	875,000	
Allspring		5.10	MTN-C	Analog Devices	1,375,000	
Allspring		5.08	ABS	Ford CR Auto Owner	1,175,000	
Allspring		5.07	ABS	Nissan Auto Rec	1,000,000	
Allspring		1.74	Municipal	California St	1,000,000	
						$ 194,454,286

	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
2015A revenue bonds							
US Bank			Principal/Interest payment fund		142110	2,811,318	
							2,811,318
2015B revenue bonds							
US Bank			Principal/Interest payment fund		142110	1,390,258	
							1,390,258
2017C revenue bonds							
US Bank			Principal/Interest payment fund		142110	3,570,681	
							3,570,681
2020 revenue bonds							
US Bank			Principal/Interest payment fund		142110	730,399	
							730,399
2022 revenue bonds							
US Bank			Principal/Interest payment fund		142110	818,437	
							818,437
2014 general obligation bonds							
CAMP			Interest Payment fund		152440	2,289,417	
							2,289,417
Operations							
Wells Fargo Bank		0.38	Checking	100100	100100	(3,544,093)	
Wells Fargo Bank		0.38	Checking	100500	100500	6,957,475	
						3,413,382	
Payroll							
Wells Fargo Bank		0.38	Checking		100200	10,904,688	
Wells Fargo Bank		0.38	Checking	Flexible Spending	100300	654,884	
Wells Fargo Bank		0.38	Checking	Benefits	100300	434,032	
Wells Fargo Bank		0.38	Checking	HSA	100300	27,332	
						12,020,937	
							15,434,318
					Total investments		**$ 221,499,114**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Sep 30, 2026

Kaweah Delta Hospital Foundation

Central Valley Community Checking	Investments	100100	463,862		
Various	S/T Investments	142200	6,278,399		
Various	L/T Investments	142300	13,581,135		
Various	Unrealized G/L	142400	3,215,051		
				$	**23,538,447**

Summary of board designated funds:

Plant fund:				
Uncommitted plant funds	$ 121,275,620	142100		
Committed for capital	15,772,805	142100		
	137,048,425			
GO Bond reserve - L/T	1,992,658	142100		
401k Matching	8,881,174	142100		
Cost report settlement - current	2,135,384	142104		
Cost report settlement - L/T	1,312,727	142100		
	3,448,111			
Development fund/Memorial fund	104,184	112300		
Workers compensation - current	7,433,000	112900		
Workers compensation - L/T	17,304,000	113900		
	24,737,000			
Professional Liability - current	1,087,518	112901		
Professional Liability - L/T	17,155,216	113901		
	18,242,735			
	$ 194,454,286			

Investment summary by institution:	**Total Investments**	**%**	**Trust Accounts**	**Surplus Funds**	**%**
Bancorp	$ -	0.0%		-	0.0%
Cal Trust	-	0.0%		-	0.0%
CAMP	19,946,899	9.0%		19,946,899	9.5%
Local Agency Investment Fund (LAIF)	22,588,794	10.2%		22,588,794	10.8%
CAMP - GOB Tax Rev	2,289,417	1.0%	2,289,417	-	0.0%
Allspring	74,333,281	33.6%	-	74,333,281	35.4%
PFM	74,555,596	33.7%		74,555,596	35.5%
Western Alliance - CDARS	3,000,000			3,000,000	1.4%
Western Alliance	29,716			29,716	0.0%
Wells Fargo Bank	15,434,318	7.0%		15,434,318	7.4%
Signature Bank	-	0.0%	-	-	0.0%
US Bank	9,321,092	4.2%	9,321,092	-	0.0%
Total investments	$ 221,499,114	100.0%	$ 11,610,509	209,888,604	100.0%

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Sep 30, 2026

Investment summary of surplus funds by type:			**Investment Limitations**	
Negotiable and other certificates of deposit	$	3,000,000	62,967,000	(30%)
Checking accounts		15,434,318		
Local Agency Investment Fund (LAIF)		22,588,794	75,000,000	
Cal Trust		-		
CAMP		19,946,899		
Medium-term notes (corporate) (MTN-C)		39,380,000	62,967,000	(30%)
U.S. government agency		84,609,797		
Municipal securities		5,605,000		
Money market accounts		265,230	41,978,000	(20%)
Commercial paper		-	52,472,000	(25%)
Asset Backed Securties		19,058,566	41,978,000	(20%)
Supra-National Agency		-	62,967,000	(30%)
	$	209,888,604		

Return on investment:	
Current month	**4.45%**
Year-to-date	**4.25%**
Prospective	**3.65%**
LAIF (year-to-date)	**3.84%**
Budget	**3.68%**

Fair market value disclosure for the quarter ended September 30, 2026 (District only):	**Quarter-to-date**	**Year-to-date**
Difference between fair value of investments and amortized cost (balance sheet effect)	N/A	(3,351,416)
Change in unrealized gain (loss) on investments (income statement effect)	$ (2,672,644)	(2,672,644)

Investment summary of CDs:		
Banc of California	$	236,500
Beneficial State Bank		236,500
Blue Sky Bank		236,500
BOKF, National Association		236,500
Commerce Bank & Trust		236,500
DNB National Bank		236,500
East West Bank		79,861
First Liberty Bank		82,139
FirstOak Bank		236,500
Live Oak Banking Company		236,500
Meridian Bank		236,500
OneUnited Bank		236,500
OMB Bank		236,500
West Texas State Bank		236,500
	$	3,000,000

Investment summary of asset backed securities:		
Ally Auto Rec	$	1,433,656
American Express		2,410,000
Bank of America		265,000
BMW Vehicle Owner		128,678
Capital One Prime		375,000
Capital one Mtn		360,000
Chase Issuance Trust		1,000,000
Citibank Credit		580,000
Ford CR Auto Owner		2,398,683
Ford Credit Auto		445,000
GM Finl con Auto Rec		131,541
GM Finl Consumer		520,487
Honda Auto		366,851
Honda AR Owner Tr		185,000
Honda Auto Rec Own		480,000
Hyundai Auto		574,356
Hyundai Auto Rec		1,101,327
Mercedes Benz Ar		505,000
Mercedes Benz Auto		228,392
Mercedes Benz Auto Leas		1,400,000
Nissan Auto Rec		2,005,000
Toyota Auto		629,596
Verizon Master Trust		440,000
WF Card Issuance		515,000
Volkswagen Auto Least TR		215,000
Volkswagen Auto Ln		365,000
	$	19,058,566

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Sep 30, 2026

Investment summary of medium-term notes (corporate):		
Accenture Capital	$	540,000
Abbott Laboratories		500,000
Adobe Inc		1,410,000
Air products		295,000
Alphabet Inc Sr		365,000
Advanced Micro		370,000
Amazon Com Inc		410,000
American Express		245,000
American Express Co		845,000
Analog Devices		1,810,000
Astrazeneca		510,000
Bank America Mtn		290,000
Bank New York Mtn		1,375,000
Bank of America		275,000
Caterpillar Finl Mtn		1,450,000
Chevron USA Inc		840,000
Cisco Sys Inc		515,000
Citibank N A		1,650,000
Cummins INC		195,000
Disney Walt co		730,000
Eli Lilly Co		900,000
GE Aerospace		65,000
Gilead Sciences Inc		195,000
Goldman Sachs		1,435,000
Home Depot Inc		1,495,000
Intuit		365,000
John Deere Mtn		1,105,000
JP Morgan		2,110,000
Mastercard		570,000
Merck Co Inc		1,240,000
Meta Platforms Inc		920,000
Morgan Stanley		2,335,000
National Rural Mtn		850,000
Northern TR Corp		120,000
Novartis Capital		905,000
Nvidia Corporation		685,000
PNC Finl Svcs Group INC		290,000
Salesforce Inc		725,000
Schwab Charles Corp		175,000
Servicenow Inc		60,000
Shell Fin US INC		130,000
Illinois Tool Wks		525,000
State Street Corp		1,540,000
Target Corp		900,000
Texas Instrs		370,000
Truist Bk Sr Nt		275,000
Totalenergies Cap USA LLC		290,000
Toyota Motor		1,495,000
US Bancorp		1,100,000
Walmart Inc		500,000
Wells Fargo Mtn		145,000
Wells Fargo co		945,000
	$	39,380,000
Investment summary of U.S. government agency:		
Federal National Mortgage Association (FNMA)	$	482,083
Federal Home Loan Mortgage Corp (FHLMC)		11,337,715
US Treasury Bill		72,790,000
	$	84,609,797
Investment summary of municipal securities:		
Alameda Cnty Ca	$	500,000
California St	$	1,000,000
California St Univ		125,000
Hawaii St		190,000
Los Angeles Ca		390,000
Massachusetts St		1,000,000
San Diego County		1,000,000
San Francisco Ca		1,000,000
San Jose Ca Redev		400,000
	$	5,605,000