ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
MARCH 3, 2026 – 5:30 p.m.
MEDICAL CENTER HOSPITAL BOARD ROOM (2ND FLOOR)
500 W 4TH STREET, ODESSA, TEXAS

AGENDA (p.1-2)

I. CALL TO ORDER .....David Dunn, President

II. ROLL CALL AND VOTE ON ECHD BOARD MEMBER EXCUSED/UNEXCUSED ABSENCES (if needed) .....David Dunn

III. INVOCATION.....Chaplain Doug Herget

IV. PLEDGE OF ALLEGIANCE.....David Dunn

V. MISSION / VISION / VALUES OF MEDICAL CENTER HEALTH SYSTEM .....
.....Don Hallmark (p.3)

VI. AWARDS AND RECOGNITION

A. Associates of the Month.....Russell Tippin
- Nurse - Francis Dapanas
- Clinical – Rosa Weishaar
- Non-Clinical – Martha McKown

B. Net Promoter Score Recognition.....Russell Tippin
- Dr. Saima Mahmood
- Dr. Gia Marotta

VII. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

VIII. PUBLIC COMMENTS ON AGENDA ITEMS

IX. CONSENT AGENDA .....David Dunn (p.4-73)
(These items are considered to be routine or have been previously discussed, and can be approved in one motion, unless a Director asks for separate consideration of an item.)

A. Consider Approval of Regular Meeting Minutes, February 3, 2026
B. Consider Approval of Joint Conference, February 24, 2026
C. Consider Approval of Federally Qualified Health Center Monthly Report, January 2026
D. Consider Approval of Compliance Program Manual – 2026 Review

X. COMMITTEE REPORTS

A. Finance Committee .....Bryn Dodd (p.74-91)
1. Financial Report for Month Ended January 31, 2026
2. Consent Agenda
   a. Consider Approval of Oracle Remote Hosting Scope-of-Use True Up

B. Executive Policy Committee .....Don Hallmark (p.92-93)

C. Audit Committee.....Bryn Dodd (p.94-124)
1. Presentation of FY26 Audited Financial Statements
2. Report to Management

XI. TTUHSC AT THE PERMIAN BASIN REPORT

XII. PATIENT SAFETY AND WORKFORCE SAFETY UPDATE.....Courtney Look-Davis

XIII. CONSIDER APPROVAL OF 2026 EOC MANAGEMENT PLANS .....
.....Amanda Everett (p.125-221)

XIV. PRESIDENT/CHIEF EXECUTIVE OFFICER'S REPORT AND ACTIONS
.....Russell Tippin

A. Consider Moving the April Board Meeting to Monday, April 6, 2026
B. Ad hoc Report(s)

XV. EXECUTIVE SESSION

Meeting held in closed session involving any of the following: (1) Consultation with attorney regarding legal matters and legal issues pursuant to Section 551.071 of the Texas Government Code;(2) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; and (3) Deliberation Regarding Real Property pursuant to Section 551.072 of the Texas Government Code.

XVI. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements
B. Consider Approval of Medical Director Agreement
C. Consider Bids to Purchase 1940 E. 42nd Street Clinic
D. Consider Short Term Financing to Permian Basin Behavioral Health Center

XVII. ADJOURNMENT .....David Dunn

If during the course of the meeting covered by this notice, the Board of Directors needs to meet in executive session, then such closed or executive meeting or session, pursuant to Chapter 551, Texas Government Code, will be held by the Board of Directors on the date, hour and place given in this notice or as soon after the commencement of the meeting covered by this notice as the Board of Directors may conveniently meet concerning any and all subjects and for any and all purposes permitted by Chapter 551 of said Government Code.

MISSION

Medical Center Health System is a community-based teaching organization dedicated to providing high quality and affordable healthcare to improve the health and wellness of all residents of the Permian Basin.

VISION

MCHS will be the premier source for health and wellness.

VALUES

I-ntegrity
C-ustomer centered
A-ccountability
R-espect
E-xcellence

Medical Center Health System
Your One Source for Health

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS
REGULAR BOARD MEETING
FEBRUARY 3, 2026 – 5:30 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT:
David Dunn, President
Bryn Dodd, Vice President
Will Kappauf
Sylvia Rodriguez-Sanchez
Don Hallmark
Wallace Dunn
Kathy Rhodes

OTHERS PRESENT:
Russell Tippin, Chief Executive Officer
Kim Leftwich, Chief Nursing Officer
Dr. Timothy Benton, Chief Medical Officer
Steve Steen, Chief Legal Counsel
Matt Collins, Chief Operating Officer
Sharon Clark, Chief Financial Officer
Grant Trollope, Assistant Chief Financial Officer
Dr. Nimat Alam, Chief of Staff
Dr. Vijay Borra, Vice Chief of Staff
Kerstin Connolly, Paralegal
Lisa Russell, Executive Assistant to the CEO
Various other interested members of the Medical Staff, employees, and citizens

I. CALL TO ORDER

David Dunn, President, called the meeting to order at 5:30 p.m. in the Ector County Hospital District Board Room at Medical Center Hospital. Notice of the meeting was properly posted as required by the Open Meetings Act.

II. ROLL CALL AND ECHD BOARD MEMBER ATTENDANCE/ABSENCES

David Dunn called roll of the ECHD Board Members. All members were present.

III. INVOCATION

Chaplain Doug Herget offered the invocation.

IV. PLEDGE OF ALLEGIANCE

David Dunn led the Pledge of Allegiance to the United States and Texas flags.

V. MISSION/VISION OF MEDICAL CENTER HEALTH SYSTEM

Sylvia Rodriguez-Sanchez presented the Mission, Vision and Values of Medical Center Health System.

VI. AWARDS AND RECOGNITION

A. February 2026 Associates of the Month

Russell Tippin, Chief Executive Officer, introduced the February 2026 Associates of the Month as follows:

- Clinical – Araceli Guzman
- Non-Clinical – Veronica Molinar
- Nurse – Yeethir Adam Cherid

B. Net Promoter Score Recognition

Russell Tippin, Chief Executive Officer, introduced the Net Promoter Score High Performer(s).

- Dr. Santiago Giraldo
- Dr. Mavis Twum-Barimah

VII. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

No conflicts were disclosed.

VIII. PUBLIC COMMENTS ON AGENDA ITEMS

No comments from the public were received.

IX. CONSENT AGENDA

A. Consider Approval of Regular Meeting Minutes, January 6, 2026
B. Consider Approval of Joint Conference Committee, January 27, 2026
C. Consider Approval of Federally Qualified Health Center Monthly Report, December 2025

Kathy Rhodes moved, and Sylvia Rodriguez-Sanchez seconded the motion to approve the items listed on the Consent Agenda as presented. The motion carried.

X. COMMITTEE REPORTS

A. Finance Committee

1. Quarterly Investment Report – Quarter 1, FY 2026
2. Quarterly Investment Officer's Certification
3. Financial Report for Month Ended December 31, 2025.
4. Consent Agenda
   a. Consider Approval of Stryker Master Service Agreement Amendment/Renewal.
   b. Consider Approval of Abbott iSTAT Pricing Amendment.
   c. Consider Approval of Fresenius Inpatient Dialysis Contract Renewal.

Bryn Dodd moved, and Kathy Rhodes seconded the motion to approve the Finance Committee report as presented. The motion carried.

B. Executive Policy Committee

The Executive Policy Committee met on Thursday, January 29, 2026 at Noon to review and approve five (5) MCH policies meeting the committee guidelines. The committee recommends approval of five (5) policies as presented.

Don Hallmark moved, and Will Kappauf seconded the motion to approve the Executive Policy Committee report as presented. The motion carried.

C. Bylaws Committee

The Bylaws Committee met on Tuesday, January 20, 2026 to review and modify Article 5.01 and 5.02. The suggested language change to 5.01 and 5.02 is as follows:

ARTICLE V.
OFFICERS OF THE BOARD OF DIRECTORS

5.01 The officers of the Board of Directors shall be a President, a Vice-President and a Secretary. The President and Vice-President shall be elected by the Board of Directors from among its members at the first regular meeting of the Board held in June of each odd year. The Board shall also appoint a Secretary. The Secretary need not, but may be a Director. Nominations for officers of the Board will be made from the floor at the meeting at which officers are to be elected.

5.02 Each officer shall hold office for a period of two (2) years or until his/her successor shall have been duly elected and qualified. The Board shall fill a vacancy in a Board office for the unexpired term.

Don Hallmark moved and Bryn Dodd seconded the motion to approve the revised language as presented. Will Kappauf voted to oppose the change, the motion carried.

XI. TTUHSC AT THE PERMIAN BASIN REPORT

No report was given.

XII. CONSIDER APPROVAL OF SANE RESOLUTION

Alison Pradon, Vice President of Development, presented the following resolution for approval:

WHEREAS, The Ector County Hospital District Board of Directors finds it in the best interest of the citizens of Ector County that the Maintaining Status of a SAFE Ready Facility be operated as early as the year 2026; and

WHEREAS, The Ector County Hospital District Board of Directors agrees to provide support for the said project as required by the SE-SAFE Ready Facilities Program grant application; and

WHEREAS, The Ector County Hospital District Board of Directors agrees that in the event of loss or misuse of the Office of the Governor funds, The Ector County Hospital District Board of Directors assures that the funds will be returned to the Office of the Governor in full.

WHEREAS, The Ector County Hospital District Board of Directors designates the President and Chief Executive Officer of Medical Center Health System as the grantee's authorized official. The authorized official is given the power to apply for, accept, reject, alter, or terminate the grant on behalf of the applicant agency.

WHEREAS, The Ector County Hospital District Board of Directors designates the Chief Financial Officer as the grantee's financial officer. The financial officer is given the power to submit financial and/or programmatic reports or alter a grant on behalf of the applicant agency.

NOW THEREFORE, BE IT RESOLVED that The Ector County Hospital District Board of Directors approves submission of the grant application for the Maintaining Status of a SAFE Ready Facility to the Office of the Governor.

Passed and Approved by the Ector County Hospital District Board of Directors this 3rd of February, 2026.

David Dunn, President	Bryn Dodd, Vice President
Will Kappauf, Member	Sylvia Rodriguez-Sanchez, Member
Don Hallmark, Member	Wallace Dunn, Member
Kathryn "Kathy" Rhodes, Member	

Grant Number: 5722101

Don Hallmark moved, and Kathy Rhodes seconded the motion to approve the resolution as presented. The motion carried.

XIII. CONSIDER APPROVAL OF SIGNING AUTHORITY RESOLUTION

Steve Steen, Chief Legal Counsel, presented the following resolution for approval:

THE BOARD OF DIRECTORS OF THE
ECTOR COUNTY HOSPITAL DISTRICT

A RESOLUTION
Clarifying Signatory and Binding Authority

WHEREAS, the Board of Directors and ECHD Executive Team deem it beneficial to clarify which individuals are authorized to legally obligate ECHD and/or its affiliated entities;

WHEREAS, on February 13, 2019 the Board of Directors of ProCare designated that the individual serving as President of ProCare, Vice President Physician Enterprise or equivalent authority shall have the authority to sign all MCH ProCare documents in an effort to maintain the corporate identity of ProCare.

WHEREAS, the Board of Directors desires to grant signing and authority to certain person(s) described hereunder. Signatory authority relates to the ability to obligate an ECHD entity or affiliated entity to a binding contract, not a check request.

WHEREAS, the foregoing signing and authority granted shall include, but shall not be limited to, powers of attorney, transfers, assignments, contracts, obligations, certificates, and other instruments of whatever nature entered into by ECHD and/or its affiliated entities.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF THE ECTOR COUNTY HOSPITAL DISTRICT:

That the Board of Directors of Ector County Hospital District acknowledge the ProCare Board's designation of President of ProCare, Vice President Physician Enterprise as the authorized individual, capable of entering into employment and related documents on behalf of ProCare. Such documents shall continue to be reviewed by both the ProCare Board of Directors and the ECHD Board of Directors through the PTRC and related governance review processes.

That the Board deems it appropriate for certain designated ECHD executive employees to have authority to bind ECHD d/b/a MCH System and/or its affiliates in certain designated agreements, as long as such agreements are in the best interest of MCH System and/or its affiliates and otherwise in compliance with applicable laws, rules, and regulations.

We, the Board of Directors of the Ector County Hospital District, resolve that the CEO of the System and/or his designee are hereby authorized to take all actions necessary to effectuate this resolution.

RESOLVED, that the Board of Directors hereby authorizes and approves signing authority to conduct business to the following identified positions under the conditions described below:

Title	Approval	Signatory Authority	Entity
CEO/President	Agreements for goods, items, and services necessary for daily operations of the Hospital and/or Health System	Up to $250,000	MCH System, MCH, MCH affiliates
CEO/President	Emergency agreements for goods, items, and services necessary for urgent needs/operations of the Hospital and/or Health System	Exceeding $250,000 - As required for emergency response, upon telephonic communication with the ECHD Executive Committee least 2 Board members and full review at next regularly scheduled Board meeting	MCH System, MCH, MCH affiliates
CEO/President	Agreements for goods, items, and services previously approved by the Board	Exceeding $250,000	MCH System, MCH, MCH affiliates
VP, Physician Enterprise; President ProCare	Board approval, ProCare Board approval	All provider employment and related contracts; any contract up to $50,000	ProCare
In the absence of the CEO/President CFO, with one other Executive Team Member	Agreements for goods, items, and services necessary for daily operations	Up to $250,000, unless an emergency	MCH System, MCH, MCH affiliates
In the absence of the CEO/President CFO, with one other Executive Team Member	Agreements for goods, items, and services that the Board approved through budget process/approval	Exceeding $250,000	MCH System, MCH, MCH affiliates
CFO, CLO, COO	CNDAs	Non-Monetary	MCH System, MCH, MCH affiliates
CLO	Legal issues and agreement regarding the same	Up to $100,000	MCH, MCH System, MCH affiliates, ProCare

PASSED AND APPROVED by the Board of Directors of the Ector County Hospital District this the 3rd day of February, 2026.

David Dunn, Chairperson
Ector County Hospital District

Bryn Dodd, Vice President
Ector County Hospital District

Don Hallmark, Member
Ector County Hospital District

Sylvia Rodriguez-Sanchez, Member
Ector County Hospital District

Will Kappauf, Member
Ector County Hospital District

Wallace Dunn, Member
Ector County Hospital District

Kathryn "Kathy" Rhodes, Member
Ector County Hospital District

Kathy Rhodes moved, and Wallace Dunn seconded the motion to approve the resolution as presented. The motion carried.

XIV. PRESIDENT/CHIEF EXECUTIVE OFFICER'S REPORT AND ACTIONS

A. PBBHC Update

No update was provided.

B. Ad hoc Reports

Included in the packet was the Communications and Marketing Report.

These reports were informational only. No action was taken.

XV. EXECUTIVE SESSION

David Dunn stated that the Board would go into Executive Session for the meeting held in closed session involving any of the following: (1) Consultation with attorney regarding legal matters and legal issues pursuant to Section 551.071 of the Texas Government Code;(2) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; and (3) Deliberation regarding Real Property pursuant to Section 551.072 of the Texas Government Code.

ATTENDEES for the entire Executive Session: ECHD Board members, Bryn Dodd, Will Kappauf, Sylvia Rodriguez-Sanchez, David Dunn, Don Hallmark, Wallace Dunn, Kathy Rhodes and Russell Tippin, President/CEO, Steve Steen, Chief Legal Counsel, Matt Collins, Chief Operating Officer, Sharon Clark, Chief Financial Officer, Adiel Alvarado, President of MCH ProCare, and Kerstin Connolly, Paralegal.

Kelly Cecil, Chief of ECHD Police, presented the Annual Racial Profiling Report during Executive Session. He was excused from the remainder of Executive Session.

Adiel Alvarado, President of MCH ProCare, presented the ProCare provider agreement to the ECHD Board of Directors during Executive Session.

Steve Steen, Chief Legal Counsel, presented the Annual Litigation update to the ECHD Board of Directors during Executive Session.

Don Hallmark, Board Member, led the board in discussion about selling the property at 1940 E. 42nd Street, which is currently being used for the Free Community Diabetes Clinic.

Executive Session began at 5:57 p.m.
Executive Session ended at 7:42 p.m.

No action was taken during Executive Session.

XVI. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements.

David Dunn presented the following renewal contract:

- Genevieve Okafor, M.D. – This is a three (3) year renewal of a Family Medicine Contract.
- Ellen Novicio, N.P. – This is a three (3) year renewal of a Cardiology Contract.
- Samsadeen Issah, CRNA – This is a three (3) year renewal of a Anesthesia Contract.

David Dunn presented the following new contract:

- Kiana Ortiz, N.P. – This is a new three (3) year Cardiology Contract.
- Crystal Lewis, N.P. – This is a new three (3) year Urgent Care Contract.
- Amarachi Eke-Okoro, N.P. – This is a new three (3) year Urgent Care Contract.

Will Kappauf moved, and Wallace Don Hallmark seconded the motion to approve the MCH ProCare Provider Agreements as presented. The motion carried.

B. Consider Approval to Sell 1940 E. 42nd Street Clinic.

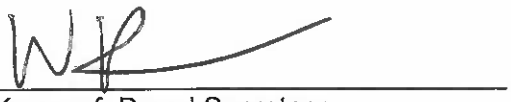
David Dunn presented the option to sell and accept bids to purchase the 42nd Street Clinic.
Don Hallmark moved, and Wallace Dunn seconded the motion to sell the 1940 E. 42nd Street Clinic and accept bids to purchase the property.

Will Kappauf and Kathy Rhodes voted to oppose the motion. The motion carried.

XVII. ADJOURNMENT

There being no further business to come before the Board, David Dunn adjourned the meeting at 7:43 p.m.

Respectfully submitted,



Will Kappauf, Board Secretary
Ector County Hospital District Board of Directors

Medical Center Hospital
A Member of Medical Center Health System

March 3,2026

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Medical Staff and Allied Health Professional Staff Applicants

Statement of Pertinent Facts:
Pursuant to Article 7 of the Medical Staff By laws, the application process for the following Medical Staff and Allied Health Professional applicants is complete. The Joint Conference Committee and the Medical Executive Committee recommend approval of privileges or scope of practice and membership to the Medical Staff Allied Health Professionals Staff for the following applicants, effective upon Board Approval.

Medical Staff:

Applicant	Department	Specialty/Privileges	Group	Dates
Aaron Laviana, MD	Surgery	Urology	Curative	03/03/2026-03/02/2027
**Sagar Patel, MD	Surgery	Urology		03/03/2026-03/02/2027
Alexandre Sintow, MD	Medicine	Infectious Disease	Eagle Telemedicine	03/03/2026-03/02/2027
Justin Taylor, MD	Radiology	Telemedicine	VRAD	03/03/2026-03/02/2028
Jelix Thomas, MD	Radiology	Telemedicine	American Radiology	03/03/2026-03/02/2027

Allied Health:

Applicant	Department	AHP Category	Specialty/ Privileges	Group	Sponsoring Physician(s)	Dates
Amara Eke-Okoro, NP	Family Medicine	AHP	Nurse Practitioner	ProCare	Dr. Aberra	03/03/2026-03/02/2028
Kiana Ortiz, NP	Cardiology	AHP	Nurse Practitione r	ProCare OHI	Dr. Farber, Dr. Patel, Dr. Boccalandro, Dr.	03/03/2026-03/02/2028

*Please grant temporary Privileges

Medical Center Hospital
A Member of Medical Center Health System

Advice, Opinions, Recommendations and Motions:

If the Hospital District Board of Directors concurs, the following motion is in order: Accept the recommendation of the Medical Executive Committee and the Joint Conference Committee and approve privileges and membership to the Medical Staff as well as scope of practice and Allied Health Professional Staff membership for the above listed applicants.

Nimat Alam, Chief of Staff
Executive Committee Chair
/MM

Medical Center Hospital
A Member of Medical Center Health System

March 3, 2026

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Reappointment of the Medical Staff and/or Allied Health Professional Staff

Statement of Pertinent Facts:
Medical Executive Committee and the Joint Conference Committee recommends. approval of the following reappointments of the Medical Staff and Allied Health Professional Staffa's submitted. These reappointment recommendations are made pursuant to and in accordance with Article 5 of the Medical Staff Bylaws.

Medical Staff:

Applicant	Department	Status Criteria Met	Staff Category	Specialty / Privilege	Group	Changes to Privileges	Dates
Ogechika Alozie, MD	Medicine	Yes	Associate	Infectious Disease		Updated Privilege Form	03/01/2026-02/28/2027
Varunsiri Atti, MD	Cardiology	Yes	Associate to Active	Cardiology	ProCare	Updated Privilege Form	05/01/2026-04/30/2028
Daniel Babbel, MD	Surgery	Yes	Active	Orthopedic	ProCare	Updated Privilege Form	04/01/2026-03/31/2028
Amy Childs, MD	Radiology	Yes	Telemedicine	Radiology	American Radiology	Updated Privilege Form	04/01/2026-03/31/2028
Timothy Donovan, MD	Radi ology	Yes	Telemedicine	Radiology	VRAD	None	04/01/2026-03/31/2028
Nkechi Ezirim, MD	OB/GYN	Yes	Associate	OB/GYN		Updated Privilege Form	04/01/2026-03/31/2027
Joseph Ifokwe, MD	Radiology	Yes	Telemedicine	Radiology	VRAD	None	04/01/2026-03/31/2028
Madhuri Jakkam-Setty, MD	Medicine	Yes	Associate to Active	Psychiatry	TTUHSC	Updated Privilege Form	04/01/2026-03/31/2028
Lawrence Kaler, MD	Radiology	Yes	Telemedicine	Radiology	VRAD	None	04/01/2026-03/31/2028
Ramcharitha Kandikatla, MD	Hospitalist	Yes	Active	Hospitalist	ProCare	Updated Privilege Form	04/01/2026-03/31/2028
Sudhakar Konda, MD	Family Medicine	Yes	Associate to Active	Family Medicine	TTUHSC	Updated Privilege Form	04/01/2026-03/31/2028
Robert Montana, MD	Emergency Medicine	Yes	Active	Emergency Medicine	BEPO	Updated Privilege Form	04/01/2026-03/31/2028
Lawrence Ngo, MD	Radiology	Yes	Telemedicine	Radiology	VRAD	None	04/01/2026-03/31/2028
Maria Nguyen, MD	Medicine	Yes	Active	Infectious Disease	Eagle Telemedicine	Updated Privilege Form	04/01/2026-03/31/2028
Darrell Parsons, MD	Medicine	Yes	Associate to Affiliate	Internal Medicine	First Physicians	Updated Privilege Form	04/01/2026-03/31/2028
Vikram Rao, MD	Radiology	Yes	Telemedicine	Radiology	VRAD	None	04/01/2026-03/31/2028
Dwan Turner, MD	OB/GYN	Yes	Associate to Active Full staff	OB/GYN		Updated Privilege Form	04/01/2026-03/31/2028
Wendy Wong, MD	Radiology	Yes	Telemedicine	Radiology	American Radiology	Updated Privilege Form	04/01/2026-03/31/2028

March 3, 2026

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Allied Health

Applicant	Department	AHP Category	Specialty / Privileges	Group	Sponsoring Physician(s)	Changes to Privileges	Dates
Benjamin Aguilar, NP	Cardiology	AHP	Nurse Practitioner	ProCare	Dr. Farber, Dr. Patel, Dr. Boccalandro, Dr.	Updated Privilege Form	04/01/2026-03/31/2028
Cynthia Chavez, NP	Pediatrics	AHP	Nurse Practitioner	TTUHSC	Dr. Visalakshi Sethuraman	Updated Privilege Form	04/01/2026-03/31/2028
Alma Hernandez , NP	Family Medicine	AHP	Nurse Practitioner	ProCare	Dr. Okafor	Updated Privilege Form	03/01/2026-02/28/2028
Ngan Hill, NP	Cardiology	AHP	Nurse Practitioner	ProCare	Dr. Farber, Dr. Patel, Dr.	Updated Privilege Form	04/01/2026-03/31/2028
Marivic Salarda, CRNA	Anesthesia	AHP	CRNA	ProCare	Dr. Putta Shankar Bangalore,	Updated Privilege Form	04/01/2026-03/31/2028
Regina Sledge, NP	Surgery	AHP	Nurse Practitioner	MCH Trauma Care	Dr. Gregory York, Dr. Peter Wiltse,	Updated Privilege Form	04/01/2026-03/31/2028
Chasity Young, SAC	Surgery	SFA	Surgical First Assist		Dr. Matthew Brown, Dr. Bradley	None	04/01/2026-03/31/2028

Advice, Opinions, Recommendations and Motions:

If the Hospital District Board of Directors concurs, the following motion is in order Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee relating to the reappointment of the Medical Staff and/or Allied Health Professional Staff.

Nimat Alam, MD Chief of Staff
Executive Committee Chair
/MM

March 3, 2026

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Change in Clinical Privileges

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommends the request below on change in clinical privileges. These clinical changes in privileges are recommendations made pursuant to and in accordance with Article 4 of the Medical Staff Bylaws.

Additional Privileges:

Staff Member	Department	Privilege
None		

Advice, Opinions, Recommendations and Motions:

If the Hospital District Board of Directors concurs, the following motion is in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee relating to the change in clinical privileges of the Allied Health Professional Staff.

Nimat Alam, MD Chief of Staff
Executive Committee Chair
/MM

March 3, 2026

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Change in Medical Staff or AHP Staff Status–Resignations/Lapse of Privileges

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommends approval of the following changes in staff status. These resignations/lapses of privileges are recommendations made pursuant to and in accordance with Article 4 of the Medical Staff Bylaws.

Resignation/Lapse of Privileges:

Staff Member	Staff Category	Department	Effective Date	Action
None				

Advice, Opinions, Recommendations and Motion:

If the Hospital District Board of Directors concurs, the following motion is in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee to approve the Resignation/Lapse of Privileges.

Nimat Alam, MD, Chief of Staff
Executive Committee Chair
/MM

March 3, 2026

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Change in Medical Staff or AHP Staff Category

Statement of pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommend approval of the following changes in staff status category. The respective departments determined that the practitioners have complied with all Bylaws requirements and are eligible for the changes noted below.

Staff Category Change:

Staff Member	Department	Category
Varunsiri Atti, MD	Cardiology	Associate to Active
Madhuri Jakkam-Setty, MD	Medicine	Associate to Active
Sudhakar Konda, MD	Family Medicine	Associate to Active
Darrell Parsons, MD	Medicine	Associate to Affiliate
Dwan Turner, MD	OB/GYN	Associate to Active Full staff Locum

Changes to Credentialing Dates:

Staff Member	Staff Category	Department	Dates
None			

Changes of Supervising Physician(s):

Staff Member	Group	Department
None		

Leave of Absence:

Staff Member	Staff Category	Department	Effective Date	Action
None				

March 3, 2026
ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Removal of I-FPPE

Staff Member	Department	Removal/Extension
None		

Change in Privileges

Staff Member	Department	Privilege
None		

Proctoring Request(s)/Removal(s)

Staff Member	Department	Privilege(s)
None		

Advice, Opinions, Recommendations and Motion:

If the Hospital District Board of Directors concurs, the following motions in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee to approve the staff category changes, changes to the credentialing dates, changes of supervising physicians, leave of absence, removal of-FPPE, proctoring requests/removals, and change in privileges.

Nimat Alam, MD Chief of Staff
Executive Committee Chair
/MM

March 3, 2026
ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Statement of Pertinent Facts:

The Medical Executive Committee recommends approval of the following:

- Cardiology Department Chairman
- Utilization Review Plan

Advice, Opinions, Recommendations and Motion:

- Cardiology Department Chairman
- Utilization Review Plan

Advice, Opinions, Recommendations and Motion:

- If the Joint Conference Committee concurs, the following motion is in order: Accept the recommendation of the Medical Executive Committee to approve the Cardiology Department Chairman and Utilization Review Plan
  Forward this recommendation to the Ector County Hospital District Board of Directors.
  .

Nimat Alam, MD, Chief of Staff
Executive Committee Chair
/MM

Medical Center Health System
Your One Source for Health

Utilization Review Plan

I. Definitions:

Utilization Review Plan – the hospital-wide plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the hospital and medical staff.

Physician Advisor or "PA" – a physician working under contract with Medical Center Hospital or in a medical staff position with the authority delegated by the Utilization Review Committee for the review of cases for clinical appropriateness and medical necessity of admissions, continued stays and services provided by the hospital.

Secondary Physician Review – a clinical review performed by a physician on the Utilization Review Committee other than the ordering physician when Cortex or other Medical Center Hospital approved clinical screening criteria guidelines suggest a different Patient Status of Level of Care than that ordered.

Cortex – clinical decision support guidelines that use an evidence-based clinical decision support tool approved for use by the Medical Executive Committee, to assist in clinically appropriate medical utilization decisions regarding patient status and level of care determinations. This decision support tool serves as guideline to prompt feedback and discussion. The physician order determines Patient Status and Level of Care determinations.

II. Purpose (42 CFR § 456.105)

The general aim of this plan is to codify the obligations of the utilization review (UR) committee, the hospital, its medical staff, and its associates to advance evidence-based, high-quality, cost effective, and safe care to our patients and our community.
The Utilization Review Plan is reviewed annually and revised as appropriate.

III. Scope

Utilization management is realized through the use of processes and procedures that assess, analyze, and evaluate medical necessity and appropriateness of the services provided. Recognized clinically applicable review criteria, trended patient population clinical care data, patterns of hospital resource utilization and clinical areas of the plan's scope include, but are not limited to:

- Delineation of the responsibilities and authority of personnel for conducting internal utilization review, conducting delegated review under managed care contracts, and facilitating external review under managed care and other payer contracts
- Establishes the protocols for the review of medical necessity of admissions, extended stays, professional services, and appropriateness of setting
- Outlines processes to review outlier cases based on extended length of stay and/or extraordinarily high costs
- Defines processes to review potential over-utilization, under-utilization, and inefficient utilization of resources
- Defines processes for coverage determination(s) denials, appeals and peer review within the organization
- Identifies the framework for reporting corrective action and documentation requirements for the utilization management process
- Establishes processes to identify patients with discharge planning needs or requests for discharge planning with timely evaluation of post-acute care services and availability of services to allow appropriate arrangements to be completed
- Optimizing efficient resource utilization through integration and coordination within the multi-interdisciplinary health care teams while maintaining optimal patient outcomes
- Reporting the results of resource management opportunities and efficiencies, patient clinical outcome data collection and reporting to the Utilization Review Committee, Medical Executive Committee, Quality Monitoring Committee, and Quality Assurance Performance Improvement Committee.

Objectives

- Review hospital inpatient admissions, observation stays, direct admissions and post-operative ambulatory procedure patients with a request for inpatient admission or observation, regardless of payer source.
- Conduct initial and concurrent medical record reviews to determine the medical necessity of the hospital stay and ensure the appropriate level of care is provided.
- Conduct individualized discharge planning screens to ensure early and timely identification of post-acute services required.
- Initiate and monitor any revisions in policies and procedures based on the Utilization Review's Plan scope, objectives and recommendations of the Utilization Review Committee.
- Professional and therapeutic services reviews are carried out to ensure availability, timeliness of delivery and medical necessity.

IV. Authority, Leadership and Accountability (42 CFR § 456.106 and 482.30(b))

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The Utilization Review Committee
The Board of Directors of Medical Center Hospital recognizes its authority and responsibility for the delivery of effective and efficient medical care in keeping with professionally recognized standards and available resources. The Board has delegated the responsibility for monitoring the appropriate use of hospital resources to the Utilization Review Committee.

The UR committee has the authority to perform prospective, concurrent, or retrospective review of the medical record of any patient admitted to the hospital or treated on an outpatient basis; to review documents certifying medical necessity for acute care admission; to review resource utilization data to evaluate service line and/or physician performance; and to discuss findings with the physician or physicians concerned but does not have the authority to take disciplinary action.

Findings and recommendations of the UR committee are reported to the president of the medical staff, board of directors, and chief executive officer, who have the authority and responsibility for considering and acting on them.

- The Utilization Review Committee is a standing committee of the Medical Center Hospital Medical Staff (Medical Staff Bylaws, Article 3.R. Utilization Review Committee, 1 and 2) and must comprise three or more active physician (MD/DO) members of the medical staff, and other practitioners to perform the utilization management function as well as administrative and departmental representatives of the hospital.
- The Medical Director of Utilization and Outcomes Management will serve as chairperson of the committee (Medical Staff Bylaws, Article 3.R.(c))
- A copy of the Conflict-of-Interest Statement is to be completed by Utilization Review committee members. A conflict of interest (aside from ownership in the hospital) does not automatically disqualify a member from participating in any given review. Rather, the conflict is a factor for the UR Committee Chairperson to evaluate when weighing decisions about specific member recusals.
- No person on the committee (or on a committee performing functions delegated by the UR committee) may have a financial interest in the hospital
- No person may participate in the case review of any care in which he or she was professionally involved in providing care. (42 CFR § 456.106 (d)(2) and 42 CFR § 482.30 (b)(3))
- Conflict of Interest Statements are completed annually.

Utilization Review Committee Functions

- Advance the practice of evidence-based care. Promote cost-effective utilization of hospital resources and services in accordance with the patient's acute medical needs and preferences
- Provide educational opportunities to engage the medical staff and hospital associates
- Identify and correct patterns of care and situational factors that may contribute to under-, over-, and/or inappropriate utilization of hospital resources and services

- Use objective data to assess physician practice trends and patterns regarding length of stay and resource utilization for the purpose of improving quality of care and service delivery
- Recommend and/or take corrective actions to improve resource utilization and the quality of care
- Performs focused reviews with accompanying action plan and reports results.
- Monitors the implementation of corrective action to achieve improvement
- Establishes procedures for external utilization management representatives who perform on site reviews.
- Reports at least semi-annually to the Medical Executive Committee, Quality Assurance Performance Improvement Committee, Quality Monitoring Committee and the Governing Board.
- Reports findings from the QIO to the Medical Staff.
- Delegates to case management staff, any UM subcommittee(s), a physician member of the Utilization Review Committee, and/or the Physician Advisor the authority to act on a day-to-day utilization management matters including, but not limited to, using screening criteria to evaluate the appropriateness of stay and level of care, making determinations regarding the medical necessity / appropriateness of an admission/continued stay, and issuing notices of non-coverage or causing the admission category to be revised in accordance with CMS guidelines.

Committee Membership

- At least two physicians who broadly represent the composition of the medical staff.
- Three physicians of the committee will be appointed by the Utilization Review Director, Inpatient Operations Medical Director, in consultation with the Vice Chief of Staff and the Chief Medical Officer.
- Administrative and clinical members of the committee are appointed by the Chief Executive Officer, and service as ex officio, without vote. (Article 3.R.(b))
    - Additional members may include the following: Physician Advisor, medical department chairpersons, the Chief Operating Officer, and Chief Nursing Officer.
    - Representatives of the following departments: Quality Improvement, Patient Care Services/Nursing, Emergency Department, Health Information Management Services, Case Management Services, Compliance, Utilization Review, Denial Management, pharmacy, laboratory, diagnostic imaging, respiratory, behavioral health, revenue integrity.

Utilization Review Committee Meeting

- The committee will meet four times per year.
- Changes to the meeting schedule are made at the discretion of the chairperson.
- Additional meetings may be prompted as needed, at the call of its chair to manage the utilization management process.

- Review of individual cases may occur between the regular meeting with findings presented to the full committee.

Informational Requirements (42 CFR § 456.111)
Any information required for review by the Utilization Review Committee will be maintained in the patient's medical record. Information may include:

- Patient identification, physician name and date of admission
- Dates of application for and authorization of Medicaid benefits if application is made after admission
- The plan of care, initial and subsequent continued stay review dates
- Date of surgical and/or diagnostic procedures
- Justification of the ED admission, if applicable
- Reasons and plan for continued stay if the attending believes continued stay is necessary
- Other supporting material that the committee believes appropriate to be included in the record.

Records and Reports (42 CFR § 456.112)

- The Utilization Review Committee will submit a written report after each meeting to the Medical Executive Committee and the Governing Board by chair/member of the UR Committee.
- Standard reports presented at Committee meetings may include the following information:
  - Avoidable days, trending, and analysis
  - Length of Stay (LOS) – Medical, Surgical, Observation
  - Excess days by payer
  - Disputes
  - Appeal Outcomes
  - Condition Code 44
  - Inpatient only procedure performed as outpatient
  - Medicare Spend Per Beneficiary (MSPB), reported annually
  - Cortex - Medical Center Hospital approved clinical screening criteria or other preadmission review results (cases or number of days that do not satisfy criteria for admission, continued stay and /or level of care and secondary review(s) results)
  - Number of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued
  - Number of Hospital Requested Reviews (HRR or HINN-10) for admission medical necessity
  - Observation information, including LOS in hours (observation unit and dispersed patients), number of observation stays converted to inpatient, the number of observation stays exceeding 24 and 48 hours
  - Summary report of the result of all cases reviewed by the Physician Advisor, including the number of cases converted from inpatient to outpatient observation or outpatient in

accordance with CMS guidelines (Condition Code 44) for Medicare and non-contracted MA plans
  - Percentage of medical necessity screening performed within 24 hours of admission
  - Readmission Review of cases readmitted within 30 days of pervious inpatient admission
  - Discharge Disposition reporting
  - Cortex report data
  - Reports of denials from KEPRO-Quality Improvement Organization (QIO) reviews (Medicare)
  - Reports of denials from commercial insurance companies, Medicare Recovery Audit, Medicare Claims Processor Administrator
  - Review of medical services by the appropriate peer review committee member as identified by the Utilization Review Committee
  - High Length of Stay (LOS) of 10 days or greater that is reviewed weekly
  - Provider Liable
- The Utilization Review Committee will formulate a written utilization review plan for the Hospital, to be approved by the Medical Executive Committee, the Chief Executive Officer, and the Board. (Medical Staff Bylaws, Article 3.R.2. (b))

V. Confidentiality (42 CFR § 456.113)

The proceedings of the UR committee, any sub committees, and all derivative documents and minutes are confidential and protected from discoverability under section 160.007 of the Texas Occupations Code § 160.007 (a) and the Peer Review Statute § 161.032 of the Texas Health and Safety Code.
During the utilization review process, the identities of individuals in all utilization records are kept confidential. Provides for confidentiality of the peer review process and findings.

VI. Types of Reviews

Prospective Pre-admission Reviews (42 CFR § 482.30 (c) (2), § 456.121 - § 456.123 n(a) - (g)

Transfers
- Agreement to accept a patient transfer from another facility requires the approval of a hospital physician in advance of the transfer.
- Following transferring hospital physician to accepting hospital physician communication regarding patient status and medical necessity, the accepting physician will confirm that the patient requires care that is not available at the transferring facility, and that the accepting hospital has the capability and capacity to provide necessary care.

Precertification for Elective Services
- Precertification completed by the physician office.

Medicare Inpatient-Only List

- Inpatient only procedures are verified at time of admission.

Admission Review Requirements (42 CFR § 456.121, § 456.122) – UR.2

- An admission review is completed on all patient admissions, observation, and post-operative ambulatory surgery patients with request for bed placement. Reviews are completed on all patients regardless of payer source.
- Admission reviews are completed using the clinical decision support tool or other Medical Center Hospital approved clinical screening criteria as soon as possible after admission or after the hospital is notified of the application for Medicaid.
- For payers with no authorization process: (sub-categorized the following)
    - If Cortex guidelines criteria are met on the initial review, the admission will be deemed appropriate.
    - If admission criteria are not satisfied, the reviewer must contact the attending physician for additional information. If additional information satisfies the admission criteria, the admission will be deemed appropriate.
    - If additional information is not provided or provided and still fails to satisfy admission criteria, the case must be referred for Secondary Review.

Concurrent/Continued Stay Review (42 CFR § 456.128, § 456.129, § 456.131 and § 456.132)

- Continued Stay Review (CSR) for medical necessity, must be performed for payers with no authorization process.
- Initial CSR date is determined at the time of the admission review by criteria, diagnosis, and any other pertinent factors for each patient.
- CSR for medical necessity are conducted as feasible based on prior Cortex screening results and anticipated date of discharge. The reviews are dependent upon available staff and census. All Medicare and Medicaid concurrent stays that may be reasonably assumed to qualify for an outlier payment are reviewed in the weekly outlier meeting with a member of the Utilization Committee or designee. (The weekly outlier meeting may be canceled due to certain circumstances such as holidays or throughput).,
- For payers with an authorization process, Medical Center Hospital will follow the specified language in the contract.
- The practitioner(s) responsible for a patient's care is/are consulted and afforded the opportunity to present his/her view before a determination is made that a hospitalization is not medically necessary.
- If the committee determines that an admission or continued stay is not medically necessary, written notification is given within two days to the hospital, the patient and the practitioner(s) responsible for the patient's care. (All federal guidelines will be strictly followed).

Continued Stay Review and Outlier Certification (42 CFR § 424.13)

- Inpatient continued-stay certification is required for patients who remain in the hospital more than 20 days.
- Prior to the 20th day and no later than the 20th day, the physician documents in the medical record justification of why the patient continues to require care in the hospital
- Documentation includes:
    - The reason for either:
        - Continued hospitalization of the patient for medical treatment of medically required diagnostic study
        - Special or unusual services for cost outlier cases such as participation in clinical trials or testing of new technologies
        - If the patient still requires care that could be provided in a sub-acute facility, such as a SNF, but there is not accepting facility in the area, the continuing stay can be certified but the physician note should indicate that a search for and accepting SNF is ongoing
    - Documentation includes the estimated time that the patient will need to spend in the hospital, such as an estimated LOS
    - The plans for post-hospital care, if appropriate.

Discharge Review (42 CFR § 482.43)

- Discharge review(s) (Named "Final Status" reviews in Cortex) must be performed when criteria for continued stay is not satisfied, or when help is needed in determining the next appropriate level of care within the facility or the appropriateness of discharge from the facility.
- If the case does not meet continued stay criteria, but the case is falling outside of the clinical stability parameters, the case manager must send the next review date and remove the barriers to discharge.
- If discharge indicators are met, the case manager will contact the physician to facilitate discharge or transfer to the next appropriate level of care.
- If the discharge indicators are met and the physician disagrees with the discharge, the case must be referred for secondary review.

Secondary Review Process

- When an admission or continued stay case is referred by the case manager/utilization review manager to the Physician Advisor or member of the UR Committee for secondary review, the secondary reviewer must review the case based on documentation in the medical record and discussions with the attending medical practitioner and make a determination using his/her medical judgment.
- Secondary review determination must be documented and supported with clinical rationale.
- Before determining that an admission or continued stay is not medically necessary, the Physician Advisor (PA) or physician member of the UR committee must consult with the

attending physician or the practitioner(s) responsible for the care of the patient and afford the attending and/or practitioner(s) the opportunity to present their views.

Adverse Decisions (42 CFR §456.124, 42 CFR § 456.126)

- If the Physician Advisor or member of the UR Committee determines that an admission or continued stay is not medically necessary and the attending physician or practitioner(s) responsible for the care of the patient agrees or fails(s) to present views regarding the case when afforded the opportunity, the case manager must facilitate discharge, transfer, or referral to the appropriate level of care.
- If the attending physician or practitioner(s) responsible for the care of the patient does not agree with the PA's determination, another physician member of the Utilization Review Committee must be consulted, and a further determination made.
- If the Utilization Review Committee or two physician members decide that the admission to, or continued stay in the hospital is not medically necessary, the Utilization Review Committee or designee must give written notification to:
    - the hospital
    - the patient
    - the Medicaid Intermediary (if Medicaid is the payer)
    - the attending physician or practitioner(s) responsible for the care of the patient.
- Notice is provided no later than (2) days after the determination
- In the case of Managed Care patients, the case manager must notify the Managed Care case manager regarding the medical necessity determination, pursuant to the Managed Care contract.

VII. Case Management Relationship with Third Party Payer Organizations

- The Director of Utilization Review must work to establish and maintain an effective and professional working relationship with third party payers, including managed care and external review organizations.
- Hospital policies regarding information privacy and security govern the processes for disclosure of protected health information.
- The case manager must provide clinical information as required by third-party payer contracts.
- The case manager must facilitate physician-to-physician communication when appropriate regarding adverse determinations by third party payers or external utilization review organization.
- Access to medical record and supervision of medical record review at the hospital by third party payer(s) and external review organization must be facilitated by the Director of HIM to

assure compliance with third party contracts and with procedures established by the Utilization Review Committee.

VIII. Medical Care Evaluation Studies (42 CFR § 456.141- 42 CFR § 456.145)

- Medical Care Evaluation Studies (MCES) are designed to promote both effective and efficient use of the facility that are consistent with patient needs and professionally recognized standards of care. MCES provide:
    - Emphasis on identification and analysis of patterns of patient care
    - Suggestions of appropriate changes needed to maintain high quality patient care
    - Suggestions for effective and efficient use of resources
- The Utilization Review Committee will select and conduct medical care evaluation studies.
    - The Utilization Review committee will determine study(s) utilizing the following methods: peer referral, review of records and reports, or in response to regulatory findings, external review bodies, or at the request of MEC and/or governing body.
    - MCES documentation will detail study findings, analysis, corrective action if indicated and specify how results are used to improve quality of care, efficiency, or improved resource utilization.
- The Utilization Review Committee will select appropriate subjects for study by identifying and analyzing factors related to patient care delivery where opportunities for improvement exist.
- Studies will include analysis of admissions, duration of stay, use of ancillary services and review of professional services.
- Findings will include any recommendations for change to improve quality of care, efficiency, or resource utilization.
- Appropriate data sources for MCES include, but is not limited to, medical records, statistics or profiles from external sources, information from the QIO, regulatory agencies, and fiscal agencies as appropriate.
- The Utilization Review Committee must, at least, have one study in progress at any time and complete one study per each calendar year.

IX. Information Management/Data

- Utilization management data is collected, analyzed and maintained to address issues of over-utilization, appropriateness of resource use, medical necessity of services and appropriate level of care assignment, and compliance with applicable federal and state regulations.
- Relevant utilization management data is collected and aggregated for tracking and trending reports using automated information systems wherever possible to optimize efficiency.
- Utilization management files must be maintained separate from individual patient medical records.

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X. Utilization Review Plan, Evaluation Amendment and Revisions

- The UR Plan is reviewed and updated or modified as necessary based on the ongoing annual evaluation of utilization review activities.
- The reviewed and/or revised plan should be submitted for review annually.
- An evaluation of the entire utilization review program and its effectiveness in allocating resources must be documented and reported to the board of directors annually.

Approval	Date
Approved by UR Committee	December 31st, 2025
Approved by Medical Quality Committee	January 20th, 2026
Approved by Medical Executive Committee	
Approved by Board of Directors	

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CONFLICT OF INTEREST STATEMENT

Effective UR is dependent upon a multidisciplinary team working together to ensure appropriate utilization of resources, while providing quality care to patients. To that end, and in order to avoid the appearance of any conflicts of interest between [hospital] and any member of Medical Center Hospital UR Committee and in accordance with Medicare Conditions of Participation set forth at 42 CFR § 482.30, no UM Committee member ("Member") may have a direct financial interest in Medical Center Hospital. Direct financial interest is defined as an ownership interest in the hospital through stock or otherwise. In addition, no Member may participate in the review and/or authorization of clinical cases in which he or she is the primary care giver, is a participant in a specific situation under review, or has any involvement either in the case or with the practitioner that impact him or her personally, professionally, or financially.
By signing below, Member acknowledges that no current conflict of interest or potential conflict of interest exists and agrees to notify the Chairperson of the UR Committee of any actual or potential conflict shall arise and agrees to abide by the decision of the Chairperson, including a request that the Member recuse himself or herself from the review of the clinical case in question.

Name

Signature

Date

Examples of potential conflicts of interest that should be reported to the UR Committee Chairperson:
· Member is related to the treating or consulting practitioner on the clinical case
· Member is in a group practice with the treating or consulting practitioner on the clinical case
· Member is related to the patient who is the subject of the clinical case
· Member is a competitor of the treating or consulting practitioner on the clinical case
This list is not exhaustive, nor does the inclusion of any relationship listed below necessarily constitute a conflict. The idea is to disclose matter which may raise a conflict so that they may be evaluated.

References

Medical Staff Bylaws: 3.A. Medical Staff Committees and Functions

Medical Staff Bylaws: 3.R. Utilization Review Committee

Title 42 Chapter IV-Centers for Medicare and Medicaid Services, Department of Health and Human Services, Subchapter G – Standards and Certification Part 482 – Conditions of Participation for Hospitals Subpart C – Basic Hospital Functions Section 482.30 – Condition of Participation: Utilization Review

Title 42 Chapter IV. Centers for Medicare and Medicaid Services, Department of Health and Human Services Sub Chapter C. Medical Assistance Programs, Part 456. Utilization Review

NIAHO Accreditation Standard Utilization Review (UR) UR.1 Documented Plan, UR.2 Sampling, UR.3 Medical Necessity Determination, UR.4 Extended Stay Review

Family Health Clinic
March 2026
ECHD Board Update

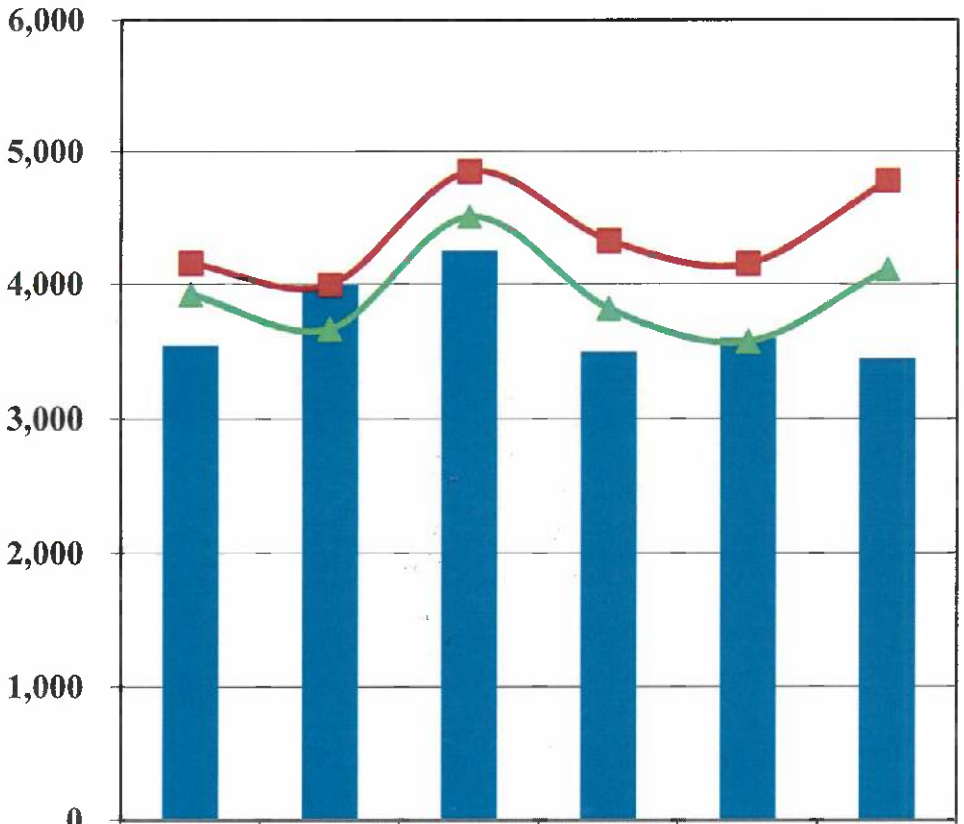
mch
Family Health Clinic
A Member of Medical Center Health System

Financial Presentation

For the Month Ended

January 31, 2026

Family Health Clinic Total Visits

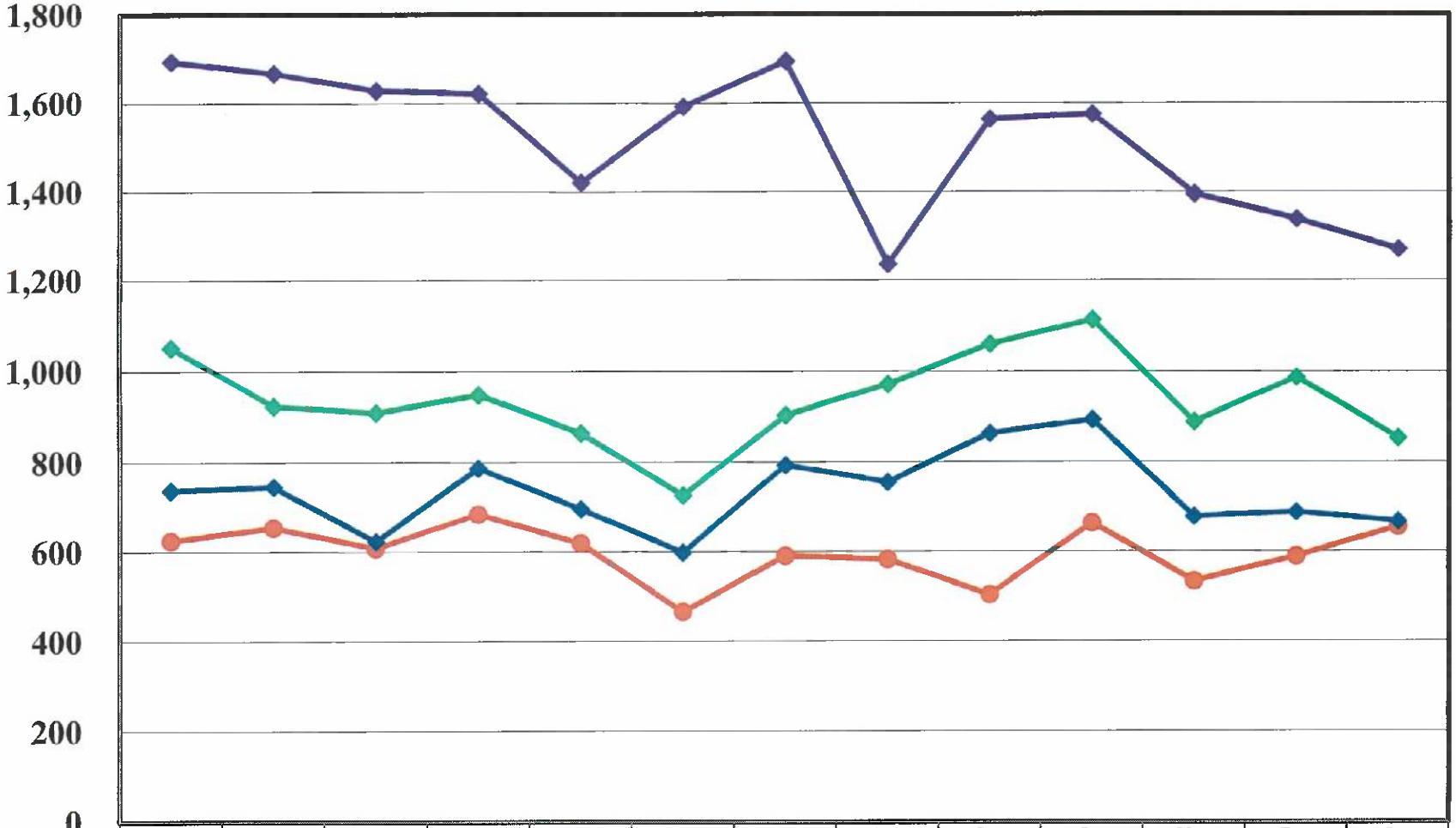


	Aug	Sep	Oct	Nov	Dec	Jan
Act	3,545	3,990	4,245	3,495	3,602	3,445
Bud	4,159	3,996	4,851	4,327	4,154	4,783
Prior	3,921	3,667	4,504	3,817	3,576	4,108

	Actual	Budget	Prior Year
Month	3,445	4,783	4,108
Var %		-28.0%	-16.1%
Year-To-Date	14,787	18,115	16,005
Var %		-18.4%	-7.6%
Rolling 12 Mo.	45,090	50,039	46,528
Var %		-9.9%	-3.1%

Family Health Center Visits

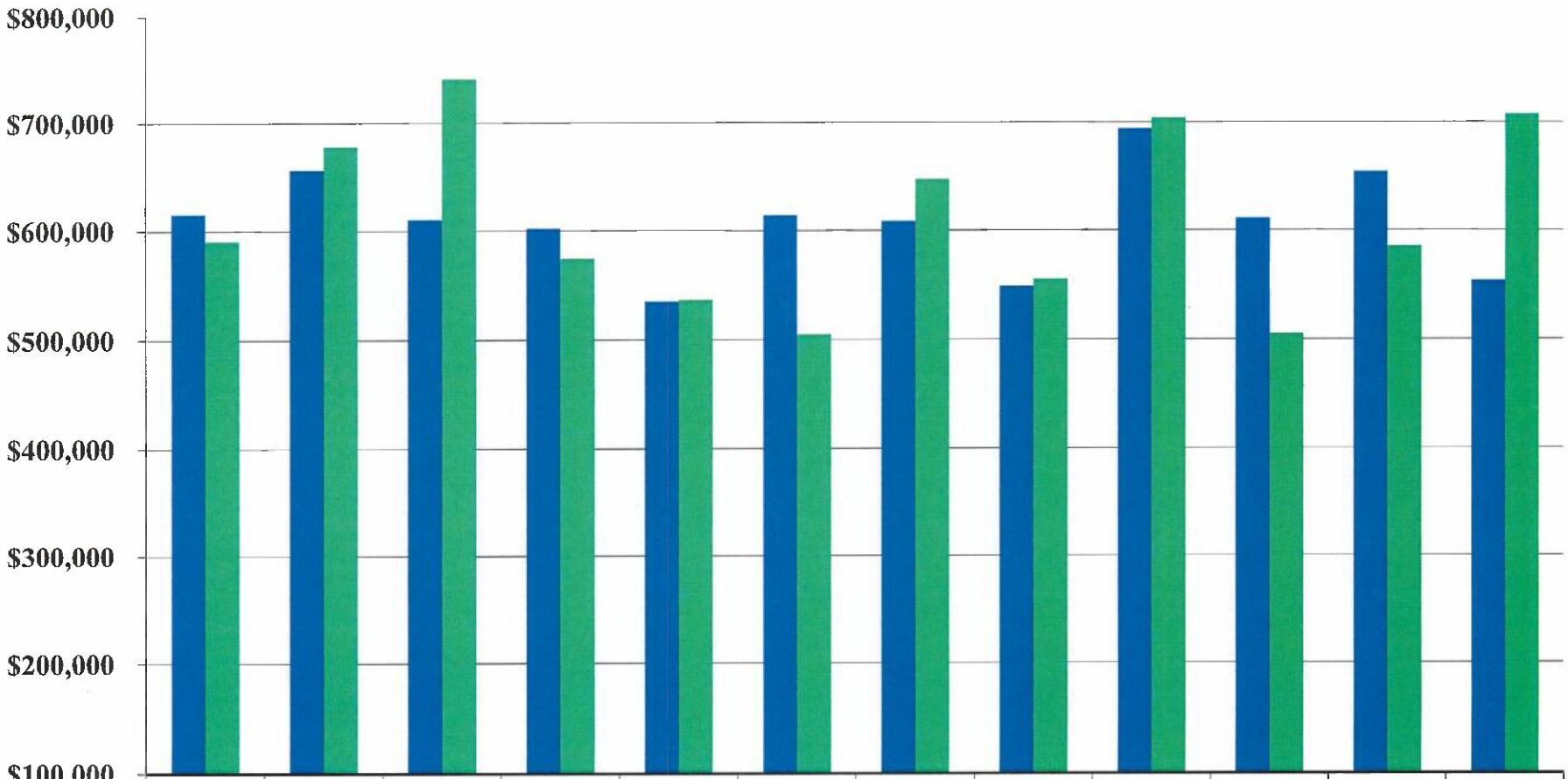
Thirteen Month Trending



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Clements Medical	626	655	609	685	620	466	591	583	504	665	534	590	656
W. University Medical	737	746	623	787	696	598	793	755	863	893	678	688	667
JBS	1,051	923	909	948	864	726	903	971	1,059	1,112	888	986	852
Womens Clinic	1,694	1,668	1,629	1,622	1,420	1,592	1,695	1,236	1,564	1,575	1,395	1,338	1,270

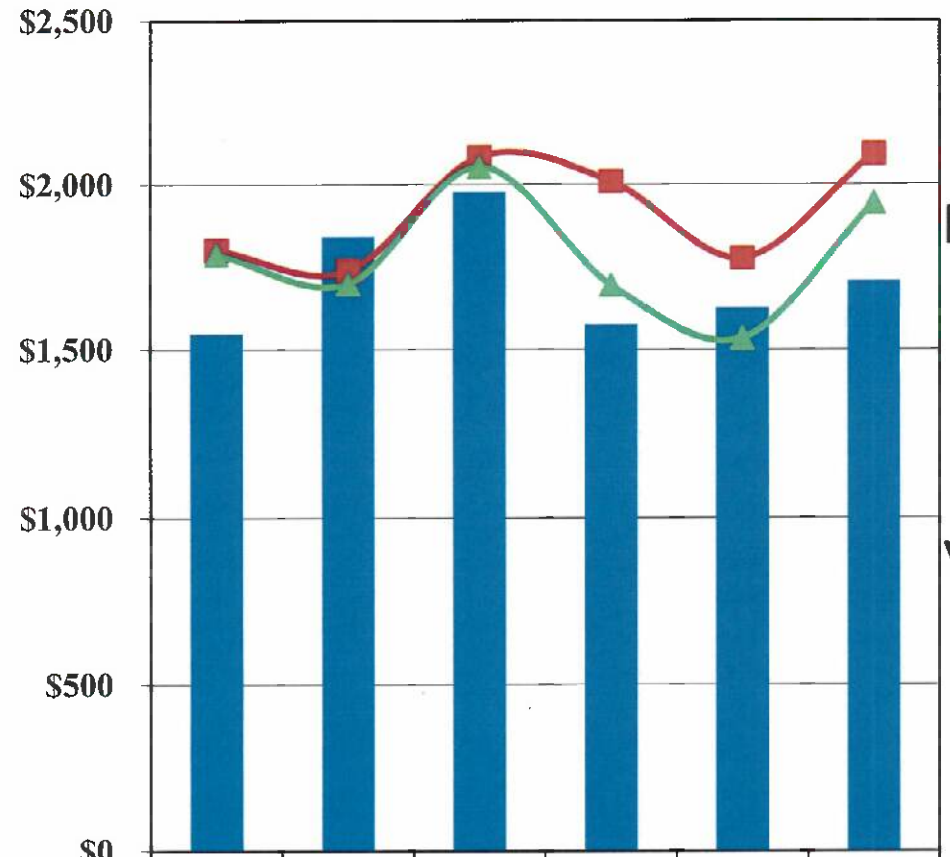
Total AR Cash Receipts

Compared to Prior Twelve Months



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
CY	614,244	655,662	609,861	601,616	535,020	613,280	608,166	548,572	693,234	610,288	653,333	553,219
PY	589,853	677,909	741,306	574,208	536,166	504,690	646,407	555,606	703,952	505,103	585,042	707,124

Total Patient Revenues



	Aug	Sep	Oct	Nov	Dec	Jan
Act	1,547.0	1,840.9	1,976.9	1,574.3	1,624.8	1,707.4
Bud	1,801.8	1,737.4	2,084.6	2,010.2	1,776.0	2,094.5
Prior	1,787.3	1,699.1	2,053.1	1,693.8	1,535.5	1,943.2

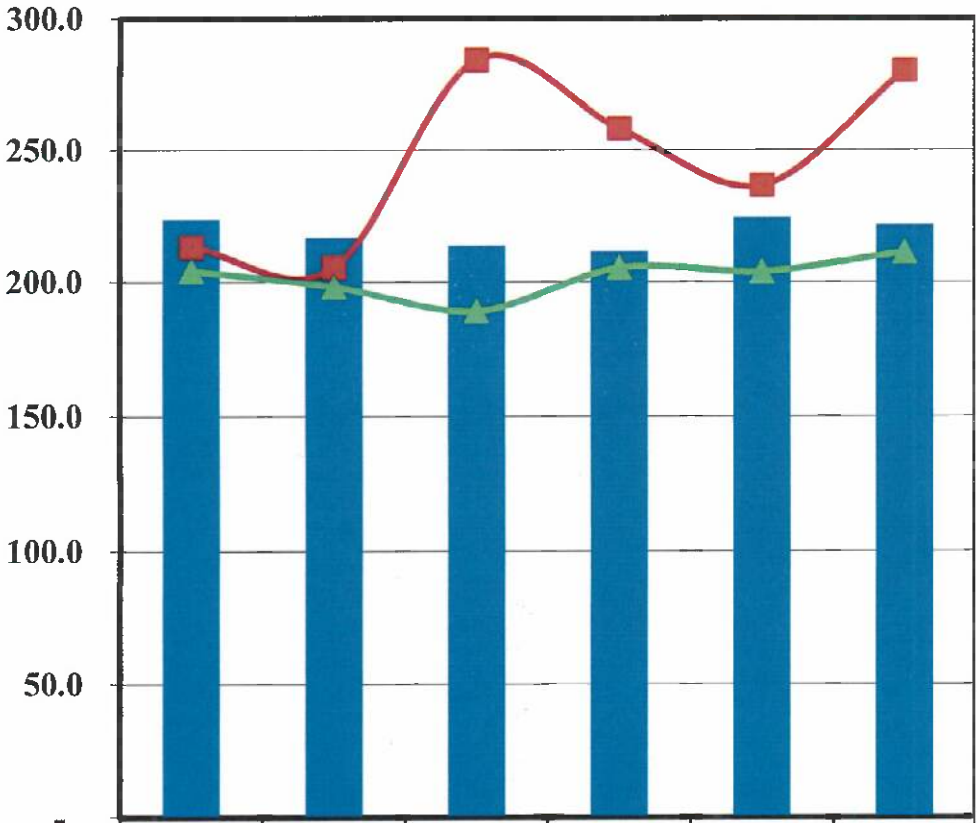
	Actual	Budget	Prior Year
Month	1,707.4	2,094.5	1,943.2
Var %		-18.5%	-12.1%
Year-To-Date	6,883.4	7,996.3	7,225.6
Var %		-13.9%	-4.7%
Rolling 12 Mo	20,890.7	21,837.8	20,867.9
Var %		-4.3%	0.1%

Net Patient Revenues

	Aug	Sep	Oct	Nov	Dec	Jan
Act	580.8	837.0	704.7	614.0	622.5	660.8
Bud	809.1	779.6	853.2	821.6	723.8	856.7
Prior	790.9	811.9	852.0	801.7	612.6	810.6

	Actual	Budget	Prior Year
Month	660.8	856.7	810.6
Var %		-22.9%	-18.5%
Year-To-Date	2,602.0	3,255.3	3,076.9
Var %		-20.1%	-15.4%
Rolling 12 Mo	8,222.6	9,487.9	9,324.6
Var %		-13.3%	-11.8%

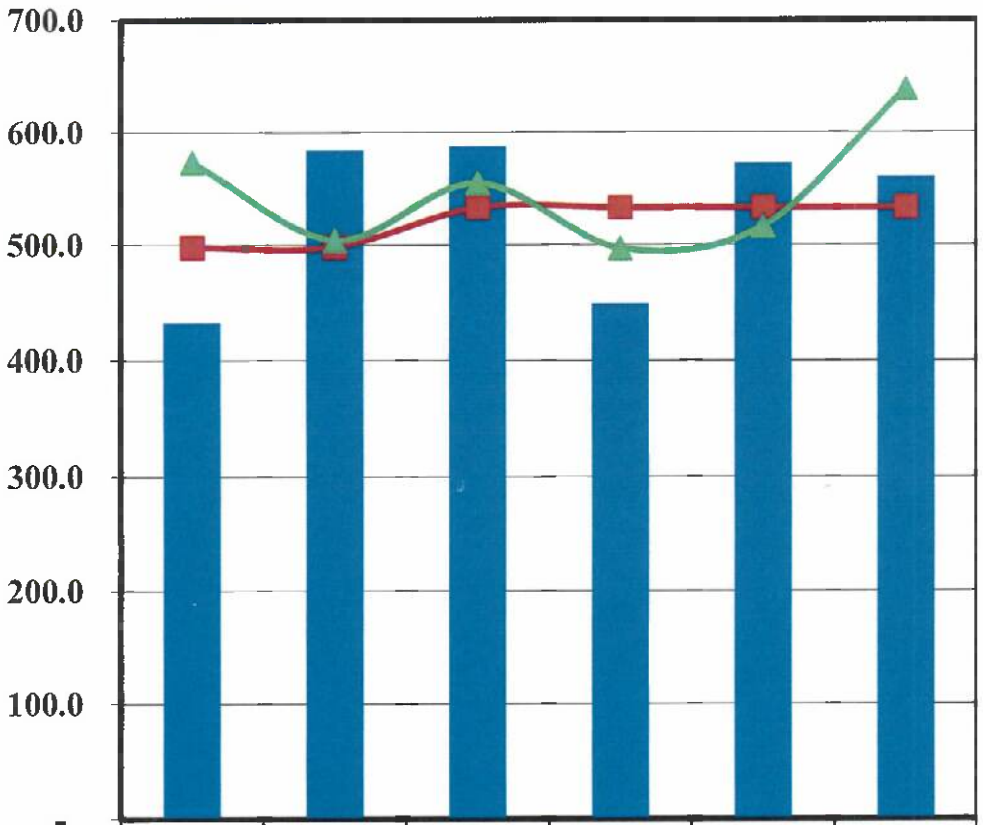
Salaries, Wages & Contract Labor



	Aug	Sep	Oct	Nov	Dec	Jan
Act	223.6	216.8	213.7	211.4	224.4	221.5
Bud	213.1	205.3	284.5	258.3	236.6	280.5
Prior	204.1	198.0	188.8	205.2	203.8	211.2

	Actual	Budget	Prior Year
Month	221.5	280.5	211.2
Var %		-21.0%	4.9%
Year-To-Date	871.0	1,059.9	809.1
Var %		-17.8%	7.7%
Rolling 12 Mo	2,591.4	2,677.2	2,335.9
Var %		-3.2%	10.9%

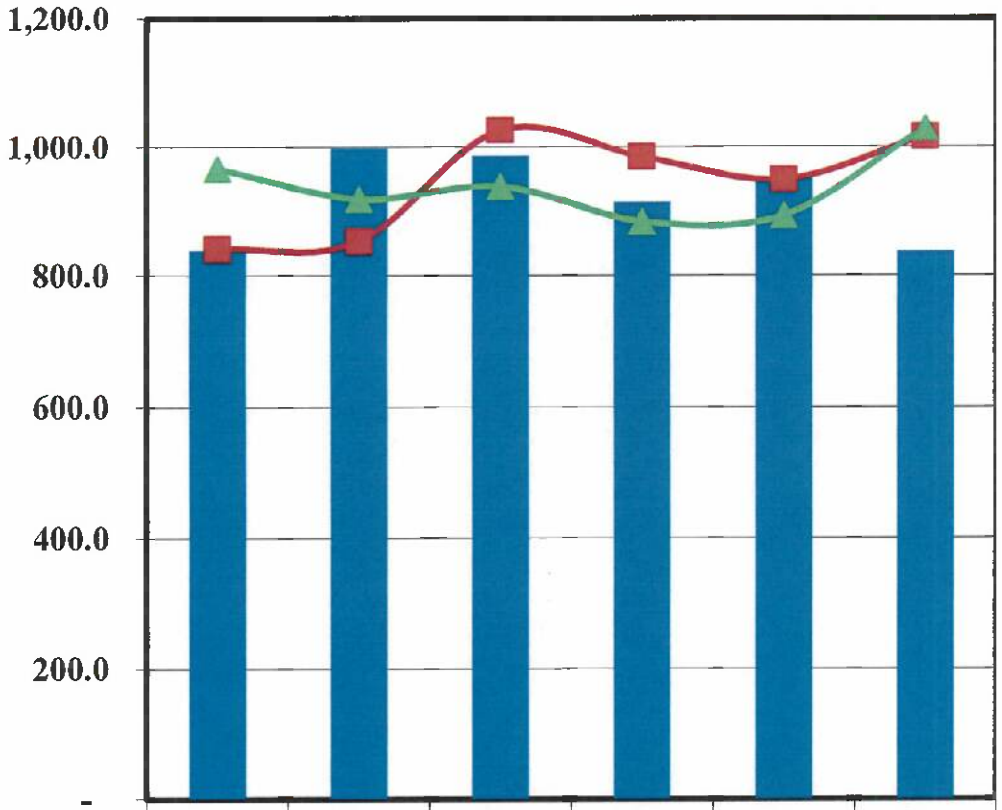
Physician Services



	Aug	Sep	Oct	Nov	Dec	Jan
Act	432.5	583.6	587.1	448.9	572.1	560.4
Bud	498.2	498.2	533.0	533.0	533.0	533.0
Prior	572.9	504.2	554.6	496.8	516.6	638.6

	Actual	Budget	Prior Year
Month	560.4	533.0	638.6
Var %		5.1%	-12.2%
Year-To-Date	2,168.5	2,132.0	2,206.6
Var %		1.7%	-1.7%
Rolling 12 Mo	6,023.6	6,117.6	6,086.8
Var %		-1.5%	-1.0%

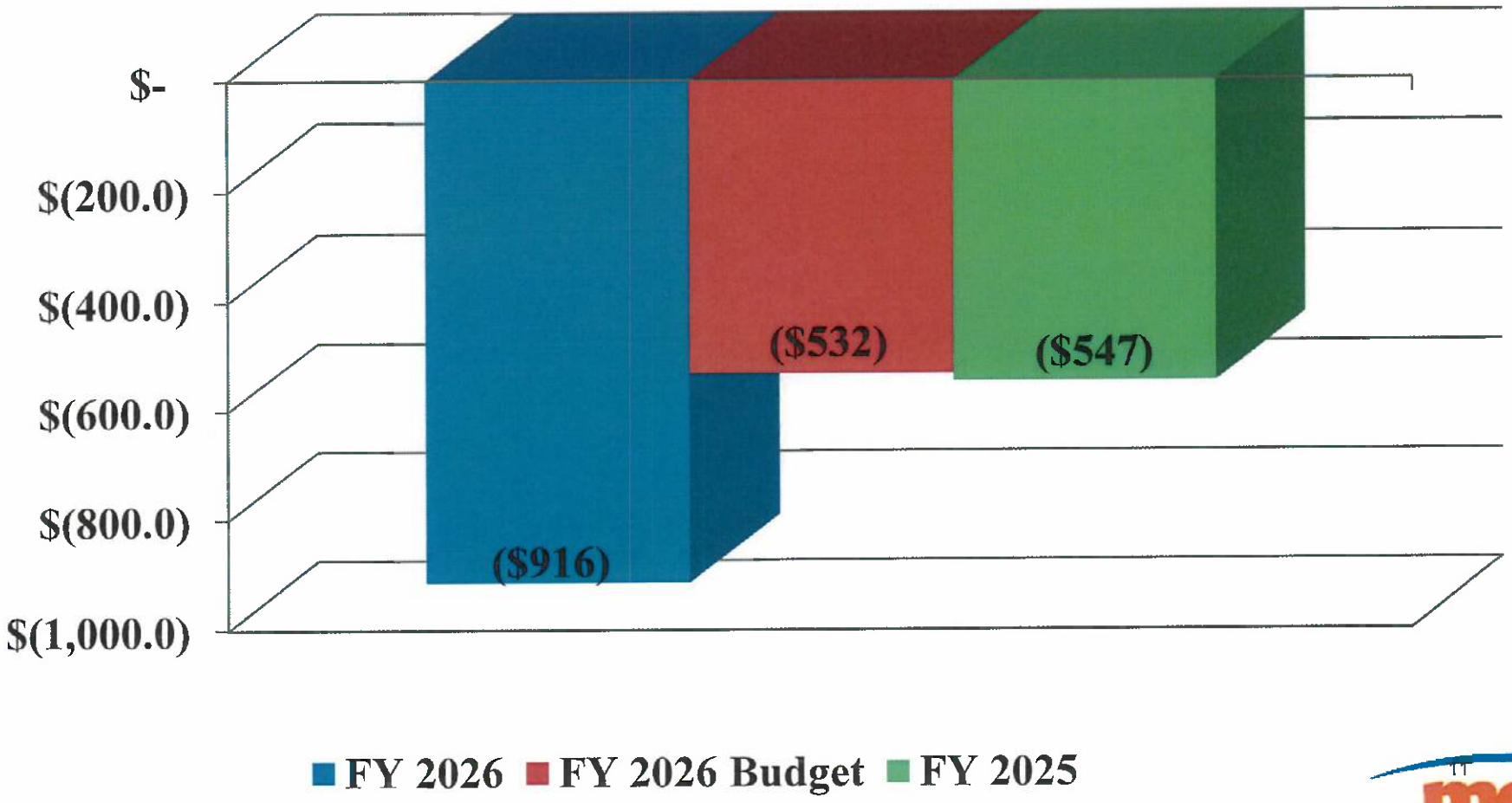
Total Operating Cost



	Aug	Sep	Oct	Nov	Dec	Jan
Act	838.7	998.3	985.8	913.8	951.0	836.3
Bud	841.3	852.6	1,027.2	984.8	949.3	1,017.1
Prior	966.0	918.6	938.2	883.1	893.2	1,029.8

	Actual	Budget	Prior Year
Month	836.3	1,017.1	1,029.8
Var %		-17.8%	-18.8%
Year-To-Date	3,686.6	3,978.6	3,744.5
Var %		-7.3%	-1.5%
Rolling 12 Mo	10,488.5	10,730.1	10,316.7
Var %		-2.3%	1.7%

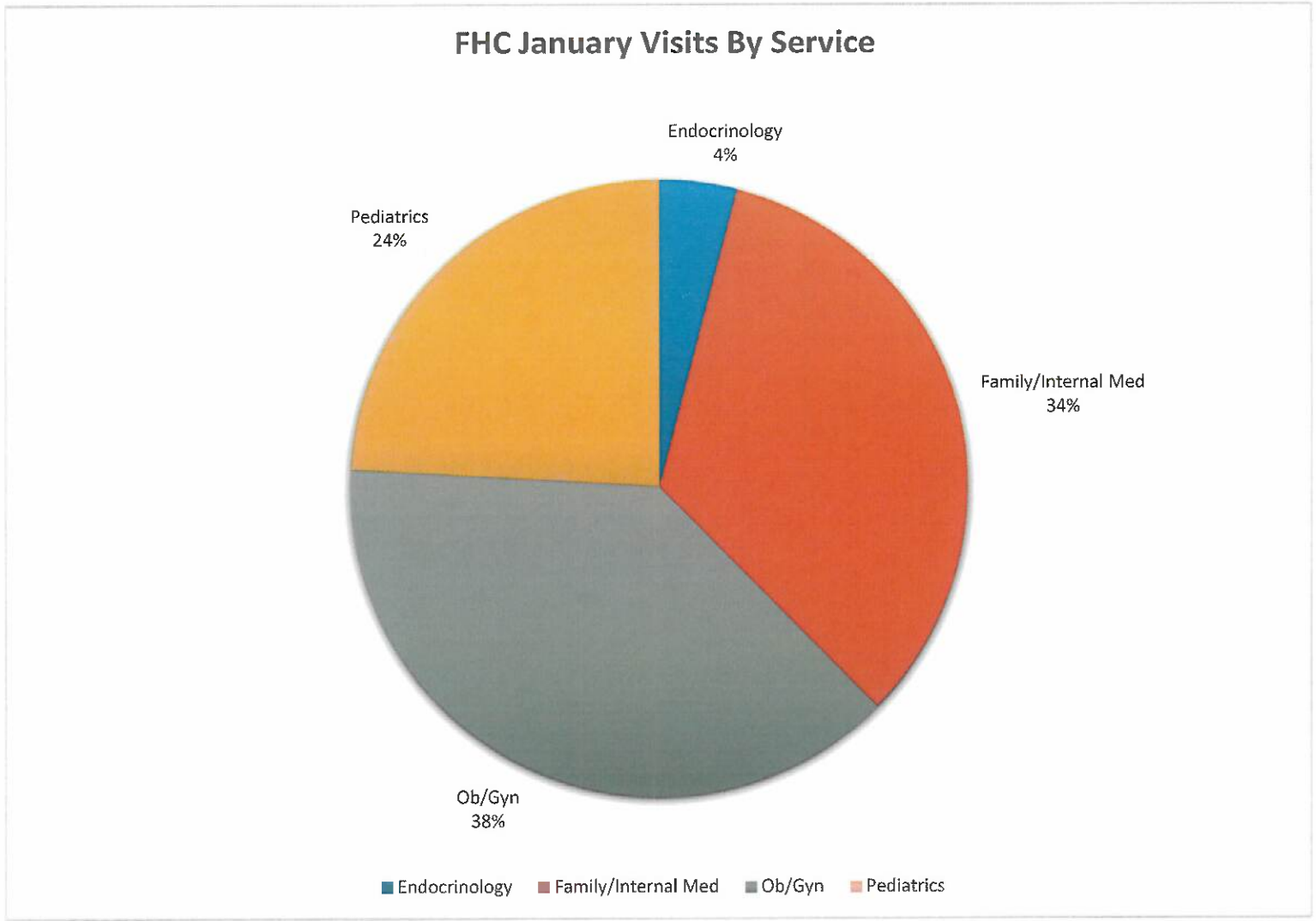
Net Gain (Loss) From Operations - YTD

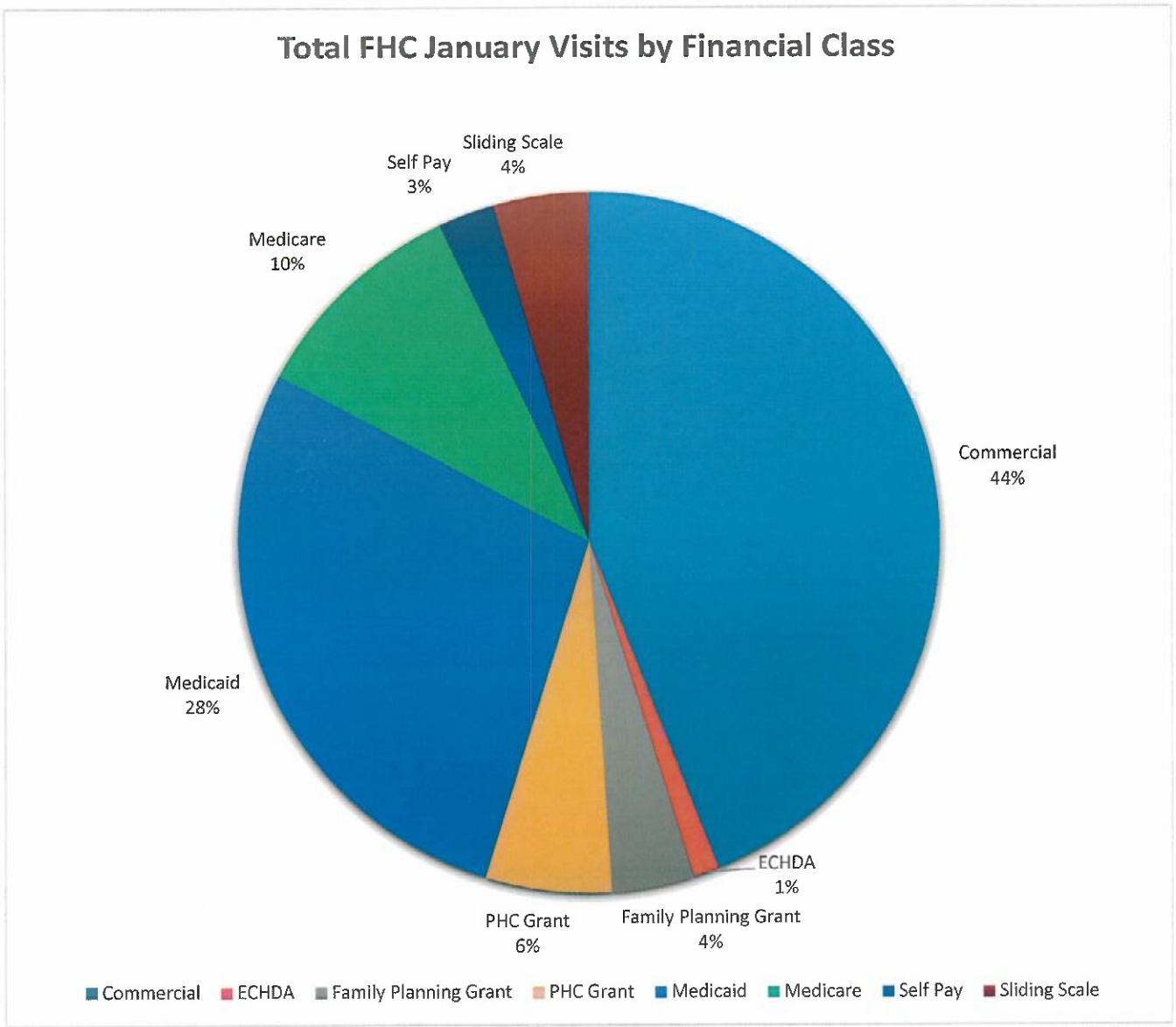


ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CENTERS COMBINED - OPERATIONS SUMMARY
JANUARY 2026

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 1,707,381	$ 2,094,454	-18.5%	$ 1,943,218	-12.1%	$ 6,883,357	$ 7,965,279	-13.6%	$ 7,225,623	-4.7%
TOTAL PATIENT REVENUE	$ 1,707,381	$ 2,094,454	-18.5%	$ 1,943,218	-12.1%	$ 6,883,357	$ 7,965,279	-13.6%	$ 7,225,623	-4.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 797,695	$ 1,016,080	-21.5%	$ 932,219	-14.4%	$ 3,347,910	$ 3,865,637	-13.4%	$ 3,538,030	-5.4%
Self Pay Adjustments	246,443	230,951	6.7%	191,930	28.4%	1,006,371	880,098	14.3%	583,653	72.4%
Bad Debts	2,489	(9,270)	-126.8%	8,483	-70.7%	(72,943)	(35,738)	104.1%	27,049	-369.7%
TOTAL REVENUE DEDUCTIONS	$ 1,046,626	$ 1,237,761	-15.4%	$ 1,132,632	-7.6%	$ 4,281,338	$ 4,709,997	-9.1%	$ 4,148,733	3.2%
	61.30%	59.10%		58.29%		62.20%	59.13%		57.42%	
NET PATIENT REVENUE	$ 660,755	$ 856,693	-22.9%	$ 810,587	-18.5%	$ 2,602,018	$ 3,255,282	-20.1%	$ 3,076,890	-15.4%
OTHER REVENUE										
FHC Other Revenue	$ 31,770	$ 47,777	-33.5%	$ 26,367	20.5%	$ 168,910	$ 191,108	-11.6%	$ 120,359	40.3%
TOTAL OTHER REVENUE	$ 31,770	$ 47,777	-33.5%	$ 26,367	20.5%	$ 168,910	$ 191,108	-11.6%	$ 120,359	40.3%
NET OPERATING REVENUE	$ 692,525	$ 904,470	-23.4%	$ 836,953	-17.3%	$ 2,770,928	$ 3,446,390	-19.6%	$ 3,197,249	-13.3%
OPERATING EXPENSE										
Salaries and Wages	$ 221,524	$ 280,490	-21.0%	$ 211,205	4.9%	$ 870,973	$ 1,059,946	-17.8%	$ 809,072	7.7%
Benefits	20,688	44,422	-53.4%	33,504	-38.3%	127,525	174,151	-26.8%	137,961	-7.6%
Physician Services	560,412	533,005	5.1%	638,562	-12.2%	2,168,538	2,132,020	1.7%	2,206,569	-1.7%
Cost of Drugs Sold	(22,609)	106,093	-121.3%	99,171	-122.8%	317,665	402,068	-21.0%	394,512	-19.5%
Supplies	23,768	23,497	1.2%	17,301	37.4%	79,898	88,627	-9.8%	73,927	8.1%
Utilities	6,421	3,698	73.6%	4,320	48.6%	21,496	18,534	16.0%	19,762	8.8%
Repairs and Maintenance	2,560	1,875	36.5%	2,494	2.6%	6,501	7,500	-13.3%	6,730	-3.4%
Leases and Rentals	1,129	1,058	6.7%	727	55.3%	4,329	4,232	2.3%	4,328	0.0%
Other Expense	1,000	1,135	-11.9%	1,000	0.0%	4,000	4,540	-11.9%	5,219	-23.3%
TOTAL OPERATING EXPENSES	$ 814,893	$ 995,273	-18.1%	$ 1,008,284	-19.2%	$ 3,600,925	$ 3,891,618	-7.5%	$ 3,658,079	-1.6%
Depreciation/Amortization	$ 21,358	$ 21,871	-2.3%	$ 21,510	-0.7%	$ 85,654	$ 86,938	-1.5%	$ 86,401	-0.9%
TOTAL OPERATING COSTS	$ 836,250	$ 1,017,144	-17.8%	$ 1,029,794	-18.8%	$ 3,686,579	$ 3,978,556	-7.3%	$ 3,744,480	-1.5%
NET GAIN (LOSS) FROM OPERATIONS	**$ (143,726)**	**$ (112,674)**	**27.6%**	**$ (192,841)**	**-25.5%**	**$ (915,651)**	**$ (532,166)**	**72.1%**	**$ (547,231)**	**67.3%**
Operating Margin	-20.75%	-12.46%	66.6%	-23.04%	-9.9%	-33.04%	-15.44%	114.0%	-17.12%	93.1%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	3,445	4,783	-28.0%	4,108	-16.1%	14,787	18,115	-18.4%	16,005	-7.6%
Average Revenue per Office Visit	495.61	437.90	13.2%	473.03	4.8%	465.50	439.71	5.9%	451.46	3.1%
Hospital FTE's (Salaries and Wages)	49.5	63.8	-22.3%	47.8	3.6%	49.6	60.6	-18.2%	46.6	6.3%


FHC January Visits By Service
Endocrinology
4%
Family/Internal Med
34%
Ob/Gyn
38%
Pediatrics
24%
Endocrinology
Family/Internal Med
Ob/Gyn
Pediatrics


Total FHC January Visits by Financial Class
Sliding Scale 4%
Self Pay 3%
Medicare 10%
Commercial 44%
Medicaid 28%
ECHDA 1%
PHC Grant 6%
Family Planning Grant 4%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale

Executive Director's Report-March 2026

- **Staffing Update**:
  - **Women's Clinic**: The Women's Clinic is currently searching for a full-time Medical Assistant and full-time Front Desk position.
  - **Healthy Kids Clinic**: The Healthy Kids Clinic currently has vacancies for a full-time LVN, and a full-time Medical Assistant.
  - **Family Health Clinic**: West University is currently in search of a part-time Medical Assistant.

- **Provider Update:**
  - **West University**: We are currently searching for a pediatrician and nurse practitioner/physician assistant for our West University location.
  - **Women's Clinic**: The Women's Clinic is currently searching for an additional OB/Gyn. Dr. Lyons has a new anticipated start of July 1, 2026.

- **Community Events**
  - MCH Employee Resource Fair: February 24, 2026
  - Odessa College Wellness Fair: March 27, 2026

MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE PROGRAM MANUAL 2026

CREATED: AUGUST 1998

REVIEWED AND/OR REVISED:
OCTOBER 2001
DECEMBER 2002
APRIL 2004
OCTOBER 2005
DECEMBER 2007
NOVEMBER 2010
DECEMBER 2011
JANUARY 2013
SEPTEMBER 2014
JANUARY 2016
FEBRUARY 2017
APRIL 2018
SEPTEMBER 2024
FEBRUARY 2026

MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE PROGRAM

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MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE PROGRAM

Introduction

Agencies and departments of the U.S. Government have publicized a number of instances of fraud, abuse and waste in federally funded health care programs including Medicare and Medicaid. The Board of Directors of the Ector County Hospital District and the Executive Team of Medical Center Health System recognize the seriousness of the issues raised by the Government and recognize that failure to comply with applicable laws and regulations could threaten MCHS's continuing participation in these health care programs.

The Ector County Hospital District (ECHD) Board, therefore, has directed that Medical Center Health System undertake an integrity program to continue MCHS's commitment to high standards of conduct, honesty and reliability in its business practices. This integrity program is called a Compliance Program. The purpose of the Compliance Program is to promote understanding of and adherence to applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse, or waste in Medical Center Health System in connection with federally funded health care programs and private health plans. There are several parts to the Compliance Program, each of which is important. The Program applies to all employees, medical staff, contractors, vendors, and volunteers.

I.

CHIEF COMPLIANCE & PRIVACY OFFICER AND COMPLIANCE COMMITTEE

A. **Officer.** The President/Chief Executive Officer (CEO) shall appoint a high-level employee as Chief Compliance & Privacy Officer. Chief Financial Officer (CFO) or Chief Legal Officer (CLO) shall not be appointed.

B. **Duties.** The Chief Compliance & Privacy Officer and the Compliance Committee shall prepare, and revise as necessary, a job description for the Chief Compliance & Privacy Officer. The Chief Compliance & Privacy Officer's primary responsibilities set out in the job description shall include:

1. Overseeing and monitoring the implementation of the Compliance Program for the Health System;

2. Reporting on a regular basis to the Health System's Boards of Directors, the President/CEO, and the Compliance Committee on the progress of implementation, and assisting the Boards, the President/CEO and the committee in establishing methods to improve MCHS's efficiency and quality of services, and to reduce the Health System's vulnerability to fraud, abuse and waste;

3. Periodically revising the Compliance Program as required by changes in the law and policies and procedures of government and private payor health plans;

4. Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program for the Health System, and seeks to ensure that all appropriate employees, medical staff, vendors and volunteers are knowledgeable of, and comply with, pertinent federal and state standards;

5. Ensuring that independent contractors and agents who furnish medical services to the Health System are aware of the requirements of the Health System's Compliance Program with respect to coding, billing, and marketing, among other things;

6. Coordinating personnel issues with the Chief Human Resources Officer, through IT Support, Volunteer Services Manager, Assistant Chief Financial Officer or designees and the Medical Staff Office to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, volunteers, medical staff and independent contractors;

7. Assisting in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments and audits;

8. Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all MCHS departments, Clinics, providers and sub-providers, agents and, if

appropriate, independent contractors; and

9. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

C. **Authority.** The Chief Compliance & Privacy Officer shall have direct access to the President/CEO and to the Health System's Boards of Directors. The Chief Compliance & Privacy Officer shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records, contracts and written arrangements or agreements with others. The Chief Compliance & Privacy Officer may seek advice from legal counsel and may retain necessary consultants or experts.

D. **Reports.** The Chief Compliance & Privacy Officer shall report to the Health System's Boards at least annually on the status of compliance in the Health System. Such reports may be written or oral.

E. **Compliance Committee.**

The Compliance Committee **is continuously composed of representatives from multiple disciplines**. At a minimum, the Compliance Committee will include the Chief Compliance and Privacy Officer, President and Chief Executive Officer (Pres./CEO), Chief Legal Counsel, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Chief Information Officer and two Ector County Hospital District Board Members. The Pres./CEO shall also appoint such ex officio members of the Compliance Committee as he or she deems necessary or advisable to assist the committee in the performance of its duties. Ex-officio members of the committee may not vote on matters before the committee.

The Compliance Committee will receive reports from ad-hoc guests which will be related to Human Resources, Information Technology/Security, Revenue Cycle/Integrity, or others as deemed necessary.

F. **Duties.** The duties of the Compliance Committee shall include:

1. Advising the Chief Compliance & Privacy Officer and assisting in the implementation and maintenance of the Health System's Compliance Program;

2. Working with appropriate departments of the Health System to develop policies and procedures to promote adherence to laws and regulations;

3. Recommending and monitoring, in conjunction with the relevant departments & Clinics, the development of internal systems and controls to carry out MCHS's standards, policies and procedures;

4. Determining the appropriate strategy and/or approach to promote adherence to the Health System's Compliance Program and the detection of potential violations;

5. Developing a system to solicit, evaluate and respond to complaints and problems;

6. Overseeing the education and training of employees and systems for communication with and by employees;

7. Analyzing the legal requirements with which MCHS must comply and locating and analyzing specific risk areas within the Health System; and

8. Establishing confidentiality standards and requirements for committee members and those people requested to provide assistance to the committee.

G. **Guidelines.** The Compliance Committee may adopt written guidelines for holding meetings and conducting the activities and operations of the committee.

II.
TRAINING AND EDUCATION

A. **Necessity.** It is imperative that coding and billing of federal health care claims be truthful and accurate and within appropriate guidelines. Not only are there severe penalties payable to the government for improper coding and billing, but honesty and integrity, in MCHS's operations, are the right and proper thing to do. Sometimes conduct undertaken without wrongful intent but with inadequate knowledge may violate applicable laws and regulations. Proper and continuing training and education of employees at all levels is, therefore, a significant element of an effective compliance program.

B. **Initial Education.** Mandatory Compliance, HIPAA Privacy and HIPAA Security education for all new employees, physicians, vendors and volunteers and the employee handbook will provide an overview of fraud and abuse laws, a copy of MCHS Compliance Standards of Conduct, and an explanation of the elements of the Compliance Program, including the reporting process and highlight the Health System's commitment to integrity in its business operations and compliance

with applicable laws and regulations. Annual Compliance, HIPAA Privacy and HIPAA Security education is also required for all employees, vendors as applicable, and volunteers. Physicians receive Compliance, HIPAA Privacy and HIPAA Security education at credentialing and re-credentialing.

C. **General Rules**. Periodically, as necessary, appropriate employees & volunteers will be retrained (i) in the Health System's Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and MCHS's business relationships; (iii) relevant Medicare and other federal and state requirements; and (iv) the consequences both to MCHS and individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the Health System's commitment to honesty and integrity in its business dealings.

D. **Substantive Rules**. Involved employees will be trained and retrained in the specific federal health care program rules (e.g., Medicare) that relate to their job function. By way of example:

1. Admitting personnel will receive training to ensure they are asking the necessary questions and obtaining the necessary information to comply with Medicare and Medicaid requirements.

2. Coding personnel will be taught current reimbursement principles, proper coding, the impact of coding on the DRG, and how to avoid the areas of concern applicable to the coding process described in Section II.

3. Patient care personnel will be instructed in charge entry and coding, and the importance of documenting services and supplies which will later be billed to Medicare or Medicaid.

4. Billing personnel will be instructed in Medicare requirements applicable to the preparation of claims for services, the distinction between covered and non-covered services and the importance of listing those services in the proper section of the claim forms and how to avoid the areas of concern applicable to the billing process described in Section II.

Such employees may be trained individually or as a group.

E. **Department Training and Education.** Department directors or managers shall periodically identify and advise the Chief Compliance & Privacy Officer of training and education necessary or advisable for all or any employees of his or her department. The Chief Compliance & Privacy Officer and the director or manager shall promptly arrange for such training and education.

F. **Types.** Training and education may occur in sessions with individual employees, in mandatory

in-service meetings or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external workshops and seminars.

G. **Amount of Training.** All employees need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all employees. Targeted training and education will be provided to employees whose actions may affect the accuracy of claims submitted to the government. The actual amount of training should reflect necessity, an analysis of risk areas or areas of concern identified by the Health System or the Office of the Inspector General, the Health System's compliance experience and the results of periodic audits or monitoring.

H. **Documentation.** The training provided to each employee shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program. Documentation is important.

I. **Failure to Attend.** Failure to comply with training requirements or to attend scheduled training sessions of the Health System or of each department may result in disciplinary action.

J. **Evaluation.** There should be periodic evaluations of training and education programs to determine, and if necessary, improve, the value, effectiveness, and appropriateness of any such program.

III.
COMMUNICATION

A. **Reason.** Open communications between employees and the Chief Compliance & Privacy Officer or the Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse, and waste. Without help from employees it may be difficult to learn of possible compliance problems and make necessary corrections.

B. **Questions.** At any time, any employee or physician may seek clarification or advice from the Chief Compliance & Privacy Officer or members of the Compliance Committee in the event of any confusion or question regarding this Program or any element of this Program or any MCHS policy or

procedure related to this Program. Questions and responses should be documented and, if appropriate, shared with other employees for informational and educational purposes. Employees should be encouraged to contact the Chief Compliance & Privacy Officer and any member of the committee and for this purpose the Chief Compliance & Privacy Officer will develop or cause to be developed publicity and notices regarding his or her name, location and e-mail address and the names of members of the committee and their location.

C. **Reporting.** Employees or physicians who are aware of or suspect acts of fraud, abuse or waste or violations of MCHS Compliance Standards of Conduct should report such acts or violations. Several independent reporting paths are available:

1. Employees may report concerns/violations directly to their supervisor or department director or manager. Supervisors and managers will thereafter promptly pass on the report to the Chief Compliance & Privacy Officer or member of the committee.

2. An employee or physician may report directly to the Chief Compliance & Privacy Officer or to a member of the compliance committee. The Compliance Office Hotline can be reached at 432-640-1900 during normal business hours.

3. MCHS has contracted with Navex/Ethics Point to operate a 24-hour, 365-day hotline known as the “Compliance Line” (1-800-805-1642). Employees and physicians may use this line anonymously at any time, day, or night. The phone number of the Compliance Line has been posted at various places throughout the Health System and employees will be reminded of the number and of their duty to report actual or suspected wrongdoing through the Health System newsletter, MCHS Intranet, unit meetings and other methods. Employees should be encouraged to use this line.

4. On each floor/unit in the Health System, in many cases next to a time clock, is a Hotline Poster with a QR Code that can be scanned into phones or other smart devices to take you directly to an online reporting form. Additionally, there are “Integrity Boxes” with blank forms and a pen located at key locations on the main hospital campus. The forms may be completed anonymously and dropped in the box. The Integrity Boxes are located on the first floor of the main building in the central hallway at the main entrance and the far West hallway near the basement elevator, and in the Annex building main entrance outside of Human Resources. These boxes are checked each week by the Compliance Office.

5. Concerns may also be placed online from the MCHS Intranet under the Employee Links section labeled Compliance Hotline.

D. **Confidentiality.** Reports received will be treated confidentially to the extent possible under applicable law. However, there may be a time when an individual’s identity may become known or must be revealed if governmental authorities become involved or in response to subpoena or other

legal proceeding.

E. **Non-Retaliation.** There will be no retaliation against any employee who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of MCHS Compliance Standards of Conduct or other wrongdoing or misconduct. However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action.

F. **Documentation.** Reports that suggest substantial violation of this Program, violation of MCHS's Compliance Standards of Conduct or violation of relevant law or regulation should be documented by the Chief Compliance & Privacy Officer. Information about such reports should be furnished periodically to the Board and the President/CEO and to the Compliance Committee at its regular meetings.

IV.
INVESTIGATION

A. **Requirement and Purpose.** Reports or reasonable indications of fraud, abuse or waste, violations of the MCHS Compliance Program and/or violations of MCHS's Compliance Standards of Conduct, violations of MCHS's policy or procedure or violations of applicable law or regulation will be promptly investigated. The purpose of the investigation shall be to identify those situations involving fraud, abuse or waste or relevant violations or unacceptable conduct; to identify individuals who may have knowingly or inadvertently caused or participated in such situations or may need further training and education; to facilitate corrective action; and to implement procedures necessary to ensure future compliance.

B. **Control of Investigation.** The Chief Compliance & Privacy Officer shall be responsible for directing the investigation of the alleged situation or problem. In undertaking investigations, the Chief Compliance & Privacy Officer may utilize other MCHS employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

C. **Process.** Because of the many situations or problems which are possible, the process and method of investigation is left to the sound judgment and discretion of the Chief Compliance & Privacy Officer, including when appropriate, pursuant to the advice of legal counsel. The Chief

Compliance & Privacy Officer or his or her designee, may conduct interviews with any MCHS employee and with other persons and may review any MCHS document including but not limited to those related to the claim development and submission process, patient records, e-mail and the contents of computers.

D. **Documentation.** The Chief Compliance & Privacy Officer shall include in his or her investigation event files, as applicable, the following types of information: (i) define the nature of the situation or problem (ii) summarize the investigation process (iii) identifies any person whom the investigator believes may have violated MCHS's Compliance Standards of Conduct, MCHS's policy or procedure or violations of applicable law or regulation and (iv) if possible, as applicable, estimate the nature and extent of any resulting overpayments.

E. **Response.**

The following actions may be taken as a result of an investigation:

1. Billing involved in the situation or problem may be discontinued until such time as appropriate corrections are made.

2. If duplicate or improper payments have been paid by Medicare/Medicaid or other health care program or excessive payments made because of coding or other MCHS errors or mistakes (i) the defective practice or procedure will be corrected; (ii) the duplicate or improper payments will be calculated and repaid to the appropriate payor; and (iii) a program of education will be undertaken with appropriate employees to prevent future similar problems.

3. A summary of the results of the investigation may be sent for appropriate disciplinary action to the department director or manager (or the appropriate executive staff member if the director or manager is implicated). Pending disciplinary action, any such employee may be removed from any position with oversight of or impact upon the claim's development and submission process.

4. State and federal agencies will be notified as deemed appropriate by the Chief Compliance & Privacy Officer in coordination with legal counsel, the President/CEO, and the ECHD Board.

   Voluntary Disclosures. Any voluntary self-disclosures may be guided by the OIG's Health Care Fraud Self-Disclosure Protocol 63 Fed. Reg. 58399 (October 21, 1998); (updated April 17, 2013: FR Doc.2013.11050, and amended November 8, 2021, updates and renames the Provider Self-Disclosure Protocol).

F. **Reports by Chief Compliance & Privacy Officer.** The Chief Compliance & Privacy Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the Board and the President & CEO and to the Compliance Committee at its

regular meetings.

V.

AUDITS

A. **Process.** Periodic audits will be undertaken to identify deficiencies in the claim development and submission process. MCHS will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by people with appropriate knowledge and experience.

B. **Time.** The Compliance Committee shall designate the time for audits and the departments and functions to be audited.

C. **New Employees.** It is the responsibility of each department manager to ensure that employees who are new to a position, which have a direct impact on the claim development and submission process, are provided adequate and appropriate training and education. To verify that each new employee understands the essential elements of his or her job function, the work of such new employees should be audited or reviewed until the director or manager is satisfied that the accuracy of the employee's work is adequate to justify cessation of the audit or review. Directors or managers may rely on other competent and experienced employees to assist in such reviews. New employees whose work does not meet the necessary quality or standard within a reasonable time after employment may be transferred to another job in or out of the department and such transfer shall not be considered disciplinary action for any purpose or reason.

D. **Periodic Tests and Audits.** MCHS, under the direction of the Chief Compliance & Privacy Officer, will conduct periodic tests of claims submitted to Medicare, Medicaid and other federal health care plan and audits of the claim's development and submission process. The audits shall include reviewing the work of coders, billers, admitting and registration clerks, patient care providers (including physicians where reasonably possible) ancillary departments such as laboratory and diagnostic imaging and risk areas identified by the OIG or fiscal intermediaries. Audits shall also cover MCHS's relationship with third party contractors, including physicians on its medical staff, and compliance with laws governing kickback arrangements. The Compliance Office may request that the director or manager of each affected department prepare and submit testing, audit, and

monitoring plans for his or her department.

E. **Access.** Auditors and reviewers shall have access to all necessary documents including those related to claim development and submission, patient records, e-mail and the contents of computers. Auditors and reviewers shall always bear in mind confidentiality requirements.

F. **Action.** The Chief Compliance & Privacy Officer will be notified of the results of all audits. Further action, if any, by the Chief Compliance & Privacy Officer with respect to any deviation or discrepancy revealed by an audit will be taken under the provisions of Section VI.

G. **Documents.** All audits shall be thoroughly documented. Such documents shall be maintained in the permanent files of the Chief Compliance & Privacy Officer and adequately secured.

VI.
SCREENING

A. **New Employees.** MCHS will conduct a reasonable background investigation of all new employees, or applicants for employment, who have or will have discretionary authority to make decisions that, or whose job function may, materially impact the Medicare/Medicaid claim development and submission process or MCHS's relationship with physicians on its medical staff. The purpose of the background investigation is to determine whether any such employee or applicant has been (i) convicted of a criminal offense related to health care or (ii) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation. All employees and volunteers will be screened monthly.

B. **Providers.** A similar reasonable background investigation will be undertaken for providers who do or will possess an individual Medicare or Medicaid provider number. Such providers will be screened monthly.

C. **Vendors and Contractors.** Reasonable background investigations will be conducted for vendors and contractors to determine if any such vendor or contractor has a criminal conviction related to health care or has been disbarred or excluded by a federal agency. For the vendors we contract with Vendor Credentialing Service to perform this function.

D. **Process.** The Chief Compliance & Privacy Officer, in consultation as necessary with the Chief

Human Resources Officer, The ECHD Police Dept., the Director of Medical Staff Services, MCH ProCare Administrative Staff and other employees, will implement and maintain policies and procedures for developing relevant applications for employment and for conducting such background investigations. The application for employment should require the applicant to disclose any criminal conviction related to health care programs or exclusion action. The background investigations should utilize the OIG Cumulative Sanction Report, the General Services Administration list of debarred contractors of, the Specially Designated Nationals (SDN) and the National Practitioner Data Bank.

E. **Prohibition.** MCHS will not hire or retain an employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicare/Medicaid claim development and submission process or MCHS's relations with its staff physicians if such prospect or employee has been convicted of a crime related to health care or has been excluded or debarred. MCHS will not contract with any person or entity which has been so convicted, excluded, or debarred and will attempt to terminate its contract arrangements with any such person or entity, subject to legal constraints such as damages for breach of contract. MCHS will make reasonable and prudent effort not to submit any claim for service ordered or furnished by any person or entity, including physicians, excluded from participation.

VII.
EVALUATIONS

Adherence to and promotion of this Program will be a factor in evaluating the performance of employees, including supervisory, managerial, and administrative personnel.

VIII.
REPORTS

The Chief Compliance & Privacy Officer shall make written evaluation reports on compliance activities including reports or complaints received from employees, investigations, auditing, and monitoring, to the system's Boards of Directors, the President/CEO, and members of the Compliance Committee on a regular basis. Reports to the Health System's Boards shall be at least

annually or more often as necessary or advisable.

IX.
RESPONSE TO GOVERNMENTAL INQUIRIES

A. **Cooperation.** Federal agencies have available several investigation tools including search warrants, subpoenas and civil investigation demands. Actions also may be brought against MCHS to exclude it from participating in Medicare/Medicaid if MCHS fails to grant immediate access to agencies conducting surveys or reviews. It is, therefore, the policy of Medical Center Health System to cooperate with and properly respond to all governmental inquiries and investigations.

B. **Process.** Employees who receive a search warrant, subpoena or other demand or request for investigation, or if approached by a federal agency, should attempt to identify the investigator, if any, and immediately notify the Chief Compliance & Privacy Officer or, in that Officer's absence, a member of the Compliance Committee or the employee's supervisor. Employees should request the government representative to wait until the Chief Compliance & Privacy Officer or his or her designee arrives before conducting any interview or reviewing documents. The Chief Compliance & Privacy Officer in consultation with outside legal counsel is responsible for coordinating MCHS's response to warrants, subpoenas, inquiries, and investigations by federal agencies. If appropriate, MCHS also may provide legal counsel to employees.

C. **Documents.** MCHS's response to any warrant, subpoena, investigation, or inquiry must be complete and accurate. No employee shall alter or destroy any document or record or alter, delete, or download any material from any computer. Documents and records must be preserved in their original form.

X.
DISCIPLINE AND DISCLAIMER

A. **Other Reasons:** In addition to possible disciplinary action mentioned elsewhere in this Program, employees may be subject to disciplinary action for:

1. Failure to perform any obligation or duty required of employees relating to compliance with this Program or applicable laws or regulations.

2. Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Program where reasonable

diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.

B. **Procedure**. Possible disciplinary action will follow MCHS's existing disciplinary policies and procedures. Progressive discipline is not required.

C. **Disclaimer.** Nothing in this Program shall (i) constitute a contract of or agreement for employment; or (ii) modify or alter in any manner any employee's at-will employment status. Any part of this Program may be changed or amended at any time without notice to any employee.

XI.
Employee Guidelines

All Medical Center Health System's business affairs must be conducted in accordance with federal, state, and local laws, professional standards, applicable federally funded health care program regulations and policies and with honesty, fairness, and integrity. Employees should perform their duties in good faith, in a manner that he or she reasonably believes to be in the best interest of Medical Center Health System and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances. To further these overall goals, several policies or Compliance Standards of Conduct have been adopted by MCHS.

A. **EMPLOYEE HANDBOOK.** The handbook given to each employee sets out several types of conduct, which are unacceptable. These include:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other MCHS records.
2. Dishonesty.
3. Unauthorized alteration or destruction of MCHS records including patients' charts.
4. Coding or billing which violates Medicare or Medicaid rules or regulations or other federal rules or regulations.
5. Behavior detrimental to the operation of MCHS.

Other unacceptable conduct may be found in the handbook.

B. **CONFLICT OF INTEREST.** To perform their duties with honesty and fairness and in the best interest of the Ector County Hospital District and Medical Center Health System, employees must avoid conflicts of interest in their employment. Conflicts of interest may arise from having a position

or interest in or furnishing managerial or consultative services to any concern or business from which MCHS obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the Health System and from using MCHS property for personal or private purposes. Conflicts also may arise in other ways. If an employee has any doubt or any question about any of his or her proposed activities, guidance or advice should be obtained from the Chief Compliance & Privacy Officer, Chief Human Resource Officer, or the employee's manager. MCHS's policy on and prohibiting conflicts of interest may be found in Policy Number MCH-3016. A copy may be obtained from MCHS Intranet under the MCH policies.

C. **HIPAA / CONFIDENTIALITY OF INFORMATION.** A patient's health record is the property of Medical Center Health System and shall be maintained to serve the patient, necessary health care providers, the institution and third-party payors such as Medicare in accordance with legal, accrediting, and regulatory agency requirements. The information contained in the health care record belongs to the patient and the patient is entitled to the protection of that information as mandated under the Health Insurance Portability and Accountability Act also known as HIPAA. All patient care information is regarded as confidential and available only to authorized users such as treating or consulting physicians, employees who may be providing patient care and to third party payors to facilitate reimbursement. The operations, activities, business affairs and finances of the Health System should also be kept confidential and discussed or made available only to authorized users.

D. **WORKPLACE ADMINISTRATIVE SEARCHES.** To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing employees with a safe working environment, to assist in the effective operation of the Compliance Program and to supplement the Drug and Alcohol Policy, MCH-3033, supervisors may conduct unannounced administrative searches of Health System premises, offices, work areas, property and equipment and the contents of such property and equipment. No employee should have any expectation of privacy on MCHS property or in their offices or work areas including lockers, desks, cabinets, drawers, shelves, or trash cans or in folders, envelopes or packages located on MCHS premises.

Any data on any MCHS device or in any of MCHS' systems is property of the hospital and subject to search/review. Personal possessions or materials should not be brought to work if they are of a sensitive or confidential nature. MCHS's policy on Workplace Administrative Searches is Policy Number MCH-3043. MCH-1046 Computer Security Policy also states that the use of computer systems at MCHS signifies consent to monitoring and monitoring does occur. A copy may be obtained from the MCHS Intranet under the MCH policies. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

E. **FRAUD AND ABUSE.** Employees shall refrain from conduct, which may violate the fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment or excessive payment for any service.

F. **BUSINESS ETHICS.** Employees must accurately and honestly represent MCHS and should not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

G**. FINANCIAL REPORTING.** All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is not only contrary to MCHS policy, but it may also be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.

H**. PROTECTION OF ASSETS.** MCHS will make available to employee's assets and equipment necessary to conduct MCHS business including such items as computer hardware and software, billing, and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of medical equipment. Employees should strive to use MCHS assets in a

prudent and effective manner. MCHS property should not be used for personal reasons or be removed from Medical Center Health System without approval from a departmental manager. An employee who believes that any medical equipment is not operating properly or has an inaccurate calibration should immediately report the problem to his or her supervisor.

I. **ANTI-COMPETITIVE CONDUCT.** Medical Center Health System will not engage in anti-competitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance. Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

J. **CREDIT BALANCES.** MCHS will comply with Federal and state laws and regulations governing credit balance reporting and refund all overpayments in a timely manner.

K. **FINANCIAL INDUCEMENTS.** No employee shall offer any financial inducement, gift, payoff, kickback, or bribe intended to induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transaction or any person in a position to benefit Medical Center Health System or the employee in any way. Employees are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Appropriate commissions, rebates, discounts, and allowances are customary and acceptable business inducements provided that they are approved by Administration and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to whom the original agreement or invoice was made or issued. Such payments should not be made to individual employees or agents of business entities.

L. **ADDITIONAL STANDARDS.** MCHS has adopted several other System-wide policies and procedures. Employees may obtain copies from the MCHS Intranet web page under MCHS policies. Additional standards and policies may be applicable only to particular departments and

copies may be obtained from supervisors or directors in those departments. It is particularly important that coding, billing, and submission of claims to Medicare, Medicaid and other third-party payors, be appropriate, accurate and in compliance with applicable laws and regulations. Standards relating to billing will be found in a later section of this document.

M.. **ADMINISTRATION AND APPLICATION OF MCHS COMPLIANCE STANDARDS**

MCHS Compliance Standards of Conduct apply to *all* MCHS employees, including supervisors, managers, directors, and the Executive team. They also apply to temporary and contract employees, as well as independent contractors doing business with Medical Center Health System, vendors, contractors, volunteers and to the physicians on the Medical Staff

MCHS Compliance Standards of Conduct are not intended to cover every situation which may be encountered, and employees should comply with all applicable laws and regulations whether or not specifically addressed in the Standards.

Questions about the existence, interpretation or application of any law, regulation, policy, or standard should be directed, without hesitation, to an employee's supervisor, manager/director or to the Chief Compliance & Privacy Officer. Because laws, regulations and policies are constantly evolving, this Compliance Program Manual will be revised and updated as needed. Revisions will be communicated timely to MCHS employees through administrative notification, as applicable, and changes will be posted to the Compliance Web page.

Failure to comply with MCHS Compliance Standards of Conduct or to conduct business in an honest, ethical, reliable manner can result in civil fines or criminal penalties against MCHS and its employees or disciplinary action by MCHS, including termination. Supervisors are responsible for ensuring that their new employees receive education on the MCHS Compliance Program and then participate in mandatory training related to the Program. Compliance with and promotion of MCHS Compliance Standards of Conduct will be a factor in evaluating the performance of MCHS employees.

XII.
BILLING AND AREAS OF CONCERN

A. **Prohibited Billing Practices.** Generally, federal laws and regulations provide civil and criminal penalties for individuals and hospitals that submit claims for services which were: (i) not provided; (ii) billed in a manner other than as actually provided; (iii) not medically necessary; or (iv) billed in a manner that did not comply with applicable government requirements. Examples of prohibited practices include:

1. Submitting a claim that represents that MCHS performed a service all or part of which was simply not performed;

2. Upcoding, that is, using a billing code that provides a higher payment rate than the billing code that actually reflects the services furnished to a patient;

3. DRG creep. Like upcoding, DRG creep is the practice of billing using a DRG code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient;

4. Duplicate billing, that is, submitting more than one claim for the same service or submitting a bill to more than one primary payor at the same time;

5. Misrepresenting the qualifications of the person rendering the service or representing that supervision requirements were met when they were not;

6. Billing separately for diagnostic services provided to a patient in the three calendar days preceding hospital admission rather than rolling such claims into the diagnosis related group;

7. Billing for discharge in lieu of transfer;

8. Billing for services which are not covered; and

9. Unbundling, that is, submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.

B. **Non-Covered Services.** Some services are not covered under Medicare. Examples include:

1. Services which are medically unnecessary. That is, items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or which are not medically necessary for the health of the patient;

2. Routine screening services;

3. Services considered by Medicare to be experimental in nature or not medically effective; and

4. Services that are considered not reasonable and appropriate or necessary for the diagnoses.

When a Medicare patient requests that a known non-covered service be performed and billed, an Advanced Beneficiary Notice should be obtained from the patient explaining that the service is non-covered and will be the patient's responsibility.

C. **Kickbacks.** Federal law prohibits the MCHS from paying a physician or anyone else for the referral of a patient for services which might be covered by Medicare or Medicaid. Illegal payments may be subtle. Examples include (i) payment to a heavy admitter for "Medical Director" fees in excess of the value of the work the physician actually performs as a medical director; (ii) providing reduced rate rent; (iii) paying excessive travel fees. All payments from MCHS to a physician and all leasing arrangements with physicians should be carefully examined to ensure that such payments or arrangements comply with applicable statutes and regulations and are not inducements to refer patients.

D. **Accurate Bills and Records.** Bills to Medicare and other federally funded health care programs, as well as to other payors, must be true, accurate and complete and for services believed to be medically necessary, and that were ordered by a physician or other appropriately licensed person. All physicians and other professional services should be documented timely, correctly, and properly. Patient records and other documentation which support the bills should also be true, accurate and complete in accordance with professional standards and available for audit and review. The diagnoses and procedures reported on the reimbursement claim must be based on the patient record and other relevant documentation.

E. **Training and Incentives.** Training, education, and documents necessary for accurate code assignment is and will continue to be made available to employees involved in coding. Billing department coders and billing consultants will not be provided with any financial incentive to improperly up-code claims or otherwise improperly increase MCHS revenue.

F. **Cost Reports.** The Chief Financial Officer shall prepare or cause to be prepared policies and

procedures ensuring against submission of false or inaccurate cost reports and ensuring that:

1. Costs are not claimed unless based on appropriate and accurate documentation;

2. Allocation of costs to various cost centers are accurately made and supportable by verifiable and auditable data;

3. Unallowable costs are not claimed for reimbursement;

4. Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;

5. Costs are properly classified;

6. Fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report;

7. All related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;

8. Requests for exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data;

9. MCHS's procedures for reporting of bad debts on the cost report are in accordance with federal statutes, regulations, guidelines and policies;

10. Procedures are in place and documented for notifying promptly the Medicare fiscal intermediary (or any other applicable payor, e.g. TRICARE and Medicaid) of errors discovered after the submission of the hospital's cost report.

G. **Bad Debts.** The Chief Financial Officer (CFO) shall develop or cause to be developed a mechanism to review, at least annually: (i) whether MCHS is properly reporting bad debts to Medicare and (ii) all Medicare bad debt expenses claimed, to ensure that MCHS's procedures are in accordance with applicable federal and state statutes, regulations, guidelines and policies. In addition, such a review should ensure that MCHS has appropriate and reasonable mechanisms in place regarding beneficiary deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived Medicare co-payments and deductibles, which waiver also constitutes a violation of the anti-kickback statute. The CFO or his or her designee may consult with the appropriate fiscal intermediary if there are questions relating to bad debt reporting requirements.

H. **Credit Balances.** The CFO shall develop or cause to be developed policies and procedures providing for the timely reporting of Medicare and other federal health care program credit balances.

The CFO shall designate appropriate employees to (i) review reports of credit balances and reimbursements or adjustments monthly and (ii) be responsible for tracking, recording, and reporting credit balances.

I. **Retention of Records.** The Chief Compliance and Privacy Officer shall prepare or cause to be prepared policies and procedures regarding the creation, distribution, retention, storage, retrieval, disclosure and destruction of records and documents. Such records and documents shall include: (i) all records for the local government that have retention schedules (ii) clinical and medical records and claims documentation required by federal or state law for participation in federal health care programs; and (iii) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of MCHS's auditing and monitoring efforts.

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
JANUARY 2026

	CURRENT MONTH					YEAR-TO-DATE				
		BUDGET		PRIOR YEAR			BUDGET		PRIOR YEAR	
	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%
Hospital InPatient Admissions										
Acute / Adult	1,226	1,219	0.6%	1,188	3.2%	4,755	4,552	4.5%	4,628	2.7%
Neonatal ICU (NICU)	29	23	26.1%	27	7.4%	114	85	34.1%	88	29.5%
Total Admissions	1,255	1,242	1.0%	1,215	3.3%	4,869	4,637	5.0%	4,716	3.2%
Patient Days										
Adult & Pediatric	5,050	4,619	9.3%	4,968	1.7%	19,221	17,249	11.4%	17,775	8.1%
ICU	485	471	3.0%	484	0.2%	1,871	1,758	6.4%	1,796	4.2%
CCU	503	470	7.0%	490	2.7%	1,828	1,754	4.2%	1,779	2.8%
NICU	374	417	-10.3%	357	4.8%	1,790	1,548	15.6%	1,708	4.8%
Total Patient Days	6,412	5,977	7.3%	6,299	1.8%	24,710	22,309	10.8%	23,058	7.2%
Observation (Obs) Days	798	804	-0.7%	829	-3.7%	3,132	3,002	4.3%	3,181	-1.5%
Nursery Days	306	296	3.4%	274	11.7%	1,202	1,106	8.7%	1,107	8.6%
Total Occupied Beds / Bassinets	7,516	7,077	6.2%	7,402	1.5%	29,044	26,417	9.9%	27,346	6.2%
Average Length of Stay (ALOS)										
Acute / Adult & Pediatric	4.92	4.56	8.0%	5.00	-1.5%	4.82	4.56	5.7%	4.61	4.5%
NICU	12.90	18.13	-28.9%	13.22	-2.5%	15.70	18.21	-13.8%	19.41	-19.1%
Total ALOS	5.11	4.81	6.2%	5.18	-1.5%	5.07	4.81	5.5%	4.89	3.8%
Acute / Adult & Pediatric w/o OB	5.76			5.83	-1.2%	5.73			5.53	3.7%
Average Daily Census	206.8	192.8	7.3%	203.2	1.8%	200.9	181.4	10.8%	187.5	7.2%
Hospital Case Mix Index (CMI)	1.7028	1.7598	-3.2%	1.7218	-1.1%	1.7228	1.7598	-2.1%	1.7769	-3.0%
CMI Adjusted LOS	3.00	2.73	9.7%	3.01	-0.4%	2.95	2.73	7.8%	2.75	7.1%
Medicare										
Admissions	489	487	0.4%	477	2.5%	1,890	1,818	4.0%	1,846	2.4%
Patient Days	2,792	2,713	2.9%	2,752	1.5%	10,818	10,119	6.9%	10,040	7.7%
Average Length of Stay	5.71	5.57	2.5%	5.77	-1.0%	5.72	5.57	2.8%	5.44	5.2%
Case Mix Index	1.8330	2.0302	-9.7%	1.8780	-2.4%	1.9020	2.0302	-6.3%	2.0011	-5.0%
Medicaid										
Admissions	106	125	-15.2%	118	-10.2%	487	466	4.5%	458	6.3%
Patient Days	682	506	34.8%	531	28.4%	2,989	1,887	58.4%	2,168	37.9%
Average Length of Stay	6.43	4.05	58.9%	4.50	43.0%	6.14	4.05	51.6%	4.73	29.7%
Case Mix Index	0.9817	1.2386	-20.7%	1.2545	-21.7%	1.1715	1.2386	-5.4%	1.2615	-7.1%
Commercial										
Admissions	409	402	1.7%	384	6.5%	1,637	1,500	9.1%	1,551	5.5%
Patient Days	2,022	1,709	18.3%	1,768	14.4%	7,671	6,374	20.3%	6,919	10.9%
Average Length of Stay	4.94	4.25	16.3%	4.60	7.4%	4.69	4.25	10.3%	4.46	5.0%
Case Mix Index	1.6705	1.6709	0.0%	1.6791	-0.5%	1.6705	1.6709	0.0%	1.6873	-1.0%
Self Pay										
Admissions	211	197	7.1%	202	4.5%	723	736	-1.8%	723	0.0%
Patient Days	725	859	-15.6%	1,040	-30.3%	2,529	3,209	-21.2%	3,175	-20.3%
Average Length of Stay	3.44	4.36	-21.2%	5.15	-33.3%	3.50	4.36	-19.8%	4.39	-20.3%
Case Mix Index	1.8560	1.7383	6.8%	1.6829	10.3%	1.7350	1.7383	-0.2%	1.7353	0.0%
All Other										
Admissions	40	31	29.0%	34	17.6%	132	117	12.8%	138	-4.3%
Patient Days	191	190	0.5%	208	-8.2%	703	720	-2.4%	756	-7.0%
Average Length of Stay	4.78	6.13	-22.1%	6.12	-21.9%	5.33	6.15	-13.5%	5.48	-2.8%
Case Mix Index	1.7774	2.0600	-13.7%	2.0550	-13.5%	2.0219	2.0600	-1.8%	2.0397	-0.9%
Radiology										
InPatient	5,273	4,895	7.7%	5,077	3.9%	19,953	18,269	9.2%	18,699	6.7%
OutPatient	8,086	9,171	-11.8%	8,192	-1.3%	33,582	34,249	-1.9%	34,411	-2.4%
Cath Lab										
InPatient	703	682	3.1%	903	-22.1%	2,480	2,548	-2.7%	2,620	-5.3%
OutPatient	315	396	-20.5%	420	-25.0%	1,351	1,480	-8.7%	1,551	-12.9%
Laboratory										
InPatient	92,812	85,815	8.2%	90,515	2.5%	352,544	320,301	10.1%	329,713	6.9%
OutPatient	71,262	77,830	-8.4%	79,052	-9.9%	279,960	290,674	-3.7%	294,009	-4.8%
Other										
Deliveries	195	194	0.5%	180	8.3%	769	723	6.4%	726	5.9%
Surgical Cases										
InPatient	223	251	-11.2%	240	-7.1%	941	939	0.2%	973	-3.3%
OutPatient	465	572	-18.7%	504	-7.7%	2,090	2,137	-2.2%	2,171	-3.7%
Total Surgical Cases	688	823	-16.4%	744	-7.5%	3,031	3,076	-1.5%	3,144	-3.6%
GI Procedures (Endo)										
InPatient	63	132	-52.3%	117	-46.2%	385	493	-21.9%	536	-28.2%
OutPatient	136	177	-23.2%	138	-1.4%	601	661	-9.1%	685	-12.3%
Total GI Procedures	199	309	-35.6%	255	-22.0%	986	1,154	-14.6%	1,221	-19.2%

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
JANUARY 2026

	CURRENT MONTH					YEAR-TO-DATE				
		BUDGET		PRIOR YEAR			BUDGET		PRIOR YEAR	
	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%
Emergency Room										
I/P Emergency Room Visits	550	769	-28.5%	930	-40.9%	2,992	2,872	4.2%	3,107	-3.7%
O/P Emergency Room Visits	4,244	4,719	-10.1%	5,472	-22.4%	17,078	17,625	-3.1%	18,898	-9.6%
Total Emergency Room Visits	4,794	5,488	-12.6%	6,402	-25.1%	20,070	20,497	-2.1%	22,005	-8.8%
Outpatient										
O/P Occasions of Service	20,664	21,222	-2.6%	21,150	-2.3%	81,330	79,257	2.6%	80,364	1.2%
Hospital Operations										
Manhours Paid	301,546	301,409	0.0%	302,195	-0.2%	1,201,947	1,154,880	4.1%	1,192,469	0.8%
FTE's	1,702.3	1,701.5	0.0%	1,705.9	-0.2%	1,710.1	1,643.1	4.1%	1,696.6	0.8%
Adjusted Patient Days	11,302	11,366	-0.6%	11,429	-1.1%	45,205	42,328	6.8%	43,813	3.2%
Hours / Adjusted Patient Day	26.68	26.52	0.6%	26.44	0.9%	26.59	27.28	-2.6%	27.22	-2.3%
Occupancy - Actual Beds	56.2%	55.2%	1.7%	55.2%	1.8%	54.6%	52.0%	5.0%	50.9%	7.2%
FTE's / Adjusted Occupied Bed	4.7	4.6	0.6%	4.6	0.9%	4.7	4.8	-2.6%	4.8	-2.3%
Family Health Clinic - Clements										
Total Medical Visits	656	658	-0.3%	626	4.8%	2,445	2,559	-4.5%	2,541	-3.8%
Manhours Paid	2,128	2,282	-6.8%	1,822	16.8%	8,293	9,005	-7.9%	7,188	15.4%
FTE's	12.0	12.9	-6.8%	10.3	16.8%	11.8	12.8	-7.9%	10.2	15.4%
Family Health Clinic - West University										
Total Medical Visits	667	1,112	-40.0%	737	-9.5%	2,926	4,158	-29.6%	2,958	-1.1%
Manhours Paid	1,570	2,305	-31.9%	1,861	-15.7%	6,850	8,528	-19.7%	6,440	6.4%
FTE's	8.9	13.0	-31.9%	10.5	-15.7%	9.7	12.1	-19.7%	9.2	6.4%
Family Health Clinic - JBS										
Total Medical Visits	852	1,083	-21.3%	1,051	-18.9%	3,838	4,192	-8.4%	4,070	-5.7%
Manhours Paid	1,768	2,211	-20.0%	1,195	48.0%	6,835	8,200	-16.6%	5,273	29.6%
FTE's	10.0	12.5	-20.0%	6.7	48.0%	9.7	11.7	-16.6%	7.5	29.6%
Family Health Clinic - Womens										
Total Medical Visits	1,270	1,930	-34.2%	1,694	-25.0%	5,578	7,206	-22.6%	6,436	-13.3%
Manhours Paid	3,311	4,504	-26.5%	3,596	-7.9%	12,855	16,865	-23.8%	13,854	-7.2%
FTE's	18.7	25.4	-26.5%	20.3	-7.9%	18.3	24.0	-23.8%	19.7	-7.2%
Total ECHD Operations										
Total Admissions	1,255	1,242	1.0%	1,215	3.3%	4,869	4,637	5.0%	4,716	3.2%
Total Patient Days	6,412	5,977	7.3%	6,299	1.8%	24,710	22,309	10.8%	23,058	7.2%
Total Patient and Obs Days	6,412	5,977	7.3%	6,299	1.8%	24,710	22,309	10.8%	23,058	7.2%
Total FTE's	1,751.8	1,765.3	-0.8%	1,753.8	-0.1%	1,759.6	1,703.7	3.3%	1,743.2	0.9%
FTE's / Adjusted Occupied Bed	4.8	4.8	-0.2%	4.8	1.0%	4.8	5.0	-3.3%	4.9	-2.2%
Total Adjusted Patient Days	11,302	11,366	-0.6%	11,429	-1.1%	45,205	42,328	6.8%	43,813	3.2%
Hours / Adjusted Patient Day	27.46	27.51	-0.2%	27.18	1.0%	27.36	28.29	-3.3%	27.96	-2.2%
Outpatient Factor	1.7627	1.9017	-7.3%	1.8144	-2.8%	1.8294	1.8973	-3.6%	1.9001	-3.7%
Blended O/P Factor	1.9302	2.1166	-8.8%	2.0191	-4.4%	2.0110	2.0998	-4.2%	2.0951	-4.0%
Total Adjusted Admissions	2,212	2,362	-6.3%	2,204	0.3%	8,908	8,798	1.2%	8,961	-0.6%
Hours / Adjusted Admisssion	140.28	132.40	6.0%	140.93	-0.5%	138.85	136.11	2.0%	136.73	1.5%
FTE's - Hospital Contract	42.9	39.1	9.7%	50.7	-15.4%	44.0	37.2	18.5%	46.3	-5.0%
FTE's - Mgmt Services	48.6	55.1	-11.8%	57.2	-15.0%	51.0	55.1	-7.5%	56.3	-9.5%
Total FTE's (including Contract)	1,843.3	1,859.5	-0.9%	1,861.7	-1.0%	1,854.7	1,796.0	3.3%	1,845.9	0.5%
Total FTE'S per Adjusted Occupied Bed (including Contract)	5.06	5.07	-0.3%	5.05	0.1%	5.05	5.22	-3.3%	5.18	-2.6%
ProCare FTEs	209.1	239.6	-12.7%	206.0	1.5%	213.0	240.6	-11.5%	206.3	3.2%
TraumaCare FTEs	8.4	8.2	1.7%	8.3	0.3%	8.4	8.3	0.5%	8.3	0.1%
Total System FTEs	2,060.7	2,107.3	-2.2%	2,076.1	-0.7%	2,076.0	2,045.0	1.5%	2,060.6	0.7%
Urgent Care Visits										
JBS Clinic	1,499	1,495	0.3%	1,697	-11.7%	5,632	5,582	0.9%	6,062	-7.1%
West University	916	966	-5.2%	1,263	-27.5%	3,314	3,607	-8.1%	4,159	-20.3%
Total Urgent Care Visits	2,415	2,461	-1.9%	2,960	-18.4%	8,946	9,189	-2.6%	10,221	-12.5%
Retail Clinic Visits										
Retail Clinic	192	295	-34.9%	295	-34.9%	756	631	19.8%	631	19.8%

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
JANUARY 2026

	CURRENT YEAR	PRIOR FISCAL YEAR END HOSPITAL UNAUDITED	PRO CARE UNAUDITED	TRAUMA CARE UNAUDITED	CURRENT YEAR CHANGE
ASSETS					
CURRENT ASSETS:					
Cash and Cash Equivalents	$ 22,555,360	$ 16,898,248	$ 4,700	$ -	$ 5,652,412
Investments	58,700,703	57,956,175	-	-	744,528
Patient Accounts Receivable - Gross	237,613,244	214,978,630	19,968,494	1,685,000	981,120
Less: 3rd Party Allowances	(153,154,306)	(139,548,613)	(11,202,864)	(1,298,612)	(1,104,218)
Bad Debt Allowance	(46,625,945)	(39,762,357)	(5,310,080)	(300,000)	(1,253,508)
Net Patient Accounts Receivable	37,832,993	35,667,660	3,455,550	86,388	(1,376,605)
Taxes Receivable	12,963,770	11,616,563	-	-	1,347,207
Accounts Receivable - Other	11,396,957	8,609,285	100,560	-	2,687,112
Inventories	10,530,857	10,073,960	496,748	-	(39,850)
Prepaid Expenses	8,266,498	5,545,302	128,278	18,231	2,574,686
Total Current Assets	162,247,139	146,367,192	4,185,837	104,619	11,589,490
CAPITAL ASSETS:					
Property and Equipment	541,638,970	535,446,720	403,173	-	5,789,077
Construction in Progress	34,458,275	20,318,667	-	-	14,139,608
	576,097,244	555,765,387	403,173	-	19,928,685
Less: Accumulated Depreciation and Amortization	(403,371,498)	(395,954,800)	(352,925)	-	(7,063,773)
Total Capital Assets	172,725,746	159,810,587	50,248	-	12,864,912
LEASE ASSETS					
Leased Assets	53,343	2,337,842	-	-	(2,284,500)
Less Accrumulated Amortization Lease Assets	(14,515)	(2,223,870)	-		2,209,355
Total Lease Assets	38,827	113,973	-	-	(75,145)
SUBSCRIPTION ASSETS					
Subscription Assets	13,277,230	15,473,212	-	-	(2,195,982)
Less Accrumulated Amortization Subscription Assets	(4,698,210)	(4,805,698)	-	-	107,488
Total Subscription Assets	8,579,020	10,667,514	-	-	(2,088,494)
LT Lease Recieivable	4,996,862	5,611,487	-	-	(614,624)
RESTRICTED ASSETS:					
Restricted Assets Held by Trustee	4,896	4,896	-	-	-
Restricted Assets Held in Endowment	6,587,957	6,527,822	-	-	60,136
Restricted TPC, LLC	1,826,505	1,826,505	-	-	-
Restricted ENFRA EasS and Hospital Projects	93,486,702	-	-	-	93,486,702
Investment in PBBHC	52,991,228	52,991,228	-	-	-
Restricted MCH West Texas Services	2,504,464	2,444,722	-	-	59,742
Pension, Deferred Outflows of Resources	10,254,779	10,254,779	-	-	-
Assets whose use is Limited	267,234	-	356,764	6,743	(96,273)
TOTAL ASSETS	$ 516,511,359	$ 396,620,704	$ 4,592,850	$ 111,362	$ 115,186,444
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES:					
Current Maturities of Long-Term Debt	$ 1,970,000	$ 1,970,000	$ -	$ -	$ -
Self-Insurance Liability - Current Portion	3,028,792	3,028,792	-	-	-
Current Portion of Lease Liabilities	3,863	278,336	-	-	(274,473)
Current Portion of Subscription Liabilities	2,321,691	2,608,445	-	-	(286,754)
Accounts Payable	23,342,811	27,085,249	(2,116,984)	(875,767)	(749,687)
A/R Credit Balances	2,842,182	2,429,902	-	-	412,281
Accrued Interest	683,313	251,049	-	-	432,263
Accrued Salaries and Wages	13,419,286	6,581,641	6,849,020	238,922	(250,297)
Accrued Compensated Absences	5,389,135	5,729,425	-	-	(340,290)
Due to Third Party Payors	5,618,765	7,251,974	-	-	(1,633,209)
Deferred Revenue	115,842,238	174,540	(106,356)	-	115,774,054
Total Current Liabilities	174,462,076	57,389,353	4,625,680	(636,845)	112,447,043
ACCRUED POST RETIREMENT BENEFITS	17,939,166	19,938,321	-	-	(1,999,156)
LESSOR DEFFERED INFLOWS OF RESOUCES	6,471,645	7,114,414			(642,769)
SELF-INSURANCE LIABILITIES - Less Current Portion	1,780,370	1,780,370	-	-	-
LEASE LIABILITIES	38,029	39,011			(982)
SUBSCRIPTION LIABILITIES	5,232,047	6,442,292			(1,210,245)
LONG-TERM DEBT - Less Current Maturities	25,641,529	25,818,179	-	-	(176,651)
					-
Total Liabilities	231,564,861	118,521,941	4,625,680	(636,845)	109,054,086
FUND BALANCE	284,946,497	278,098,763	(32,831)	748,207	284,979,328
TOTAL LIABILITIES AND FUND BALANCE	$ 516,511,359	$ 396,620,704	$ 4,592,850	$ 111,362	$ 115,186,444

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED OPERATIONS SUMMARY
JANUARY 2026

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Inpatient Routine Revenue	$ 63,740,936	$ 61,636,233	3.4%	$ 64,405,013	-1.0%	$ 248,007,402	$ 232,149,105	6.8%	$ 235,085,506	5.5%
Inpatient Ancillary Revenue	-	-		-		-	-		-	
Inpatient Revenue	$ 63,740,936	$ 61,636,233	3.4%	$ 64,405,013	-1.0%	$ 248,007,402	$ 232,149,105	6.8%	$ 235,085,506	5.5%
Outpatient Revenue	59,293,874	68,822,378	-13.8%	65,637,052	-9.7%	250,731,482	255,324,054	-1.8%	257,446,792	-2.6%
TOTAL PATIENT REVENUE	$ 123,034,810	$ 130,458,611	-5.7%	$ 130,042,066	-5.4%	$ 498,738,884	$ 487,473,159	2.3%	$ 492,532,298	1.3%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 76,791,785	$ 82,366,678	-6.8%	$ 84,315,703	-8.9%	$ 311,715,173	$ 308,045,494	1.2%	$ 317,152,651	-1.7%
Policy Adjustments	724,937	1,329,522	-45.5%	1,421,455	-49.0%	3,399,091	4,677,848	-27.3%	4,862,246	-30.1%
Uninsured Discount	11,671,728	9,860,637	18.4%	11,178,734	4.4%	35,161,205	36,983,752	-4.9%	38,688,663	-9.1%
Indigent	1,335,556	1,251,603	6.7%	1,079,215	23.8%	6,307,699	4,717,058	33.7%	5,298,375	19.0%
Provision for Bad Debts	7,644,020	6,898,508	10.8%	7,638,712	0.1%	33,943,264	25,629,494	32.4%	21,947,084	54.7%
TOTAL REVENUE DEDUCTIONS	$ 98,168,025	$ 101,706,948	-3.5%	$ 105,633,819	-7.1%	$ 390,526,432	$ 380,053,646	2.8%	$ 387,949,020	0.7%
	79.79%	77.96%		81.23%		78.30%	77.96%		78.77%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 1,729,610	$ 1,457,917	18.6%	$ 1,866,764	-7.3%	$ 6,721,653	$ 5,831,668	15.3%	$ 7,319,498	-8.2%
DSRIP/CHIRP	1,252,500	1,252,500	0.0%	370,362	238.2%	5,039,636	5,010,000	0.6%	(413,604)	-1318.5%
TOTAL OTHER PATIENT REVENUE	$ 2,982,110	$ 2,710,417	10.0%	$ 2,237,126	33.3%	$ 11,761,289	$ 10,841,668	8.5%	$ 6,905,894	70.3%
NET PATIENT REVENUE	$ 27,848,894	$ 31,462,080	-11.5%	$ 26,645,373	4.5%	$ 119,973,741	$ 118,261,181	1.4%	$ 111,489,171	7.6%
OTHER REVENUE										
Tax Revenue	$ 8,952,646	$ 7,308,592	22.5%	$ 7,529,886	18.9%	$ 31,667,532	$ 30,110,937	5.2%	$ 27,972,079	13.2%
Other Revenue	1,748,988	2,057,228	-15.0%	1,463,513	19.5%	7,325,840	7,879,949	-7.0%	6,099,275	20.1%
TOTAL OTHER REVENUE	$ 10,701,635	$ 9,365,820	14.3%	$ 8,993,399	19.0%	$ 38,993,372	$ 37,990,886	2.6%	$ 34,071,353	14.4%
NET OPERATING REVENUE	$ 38,550,529	$ 40,827,900	-5.6%	$ 35,638,772	8.2%	$ 158,967,114	$ 156,252,067	1.7%	$ 145,560,524	9.2%
OPERATING EXPENSES										
Salaries and Wages	$ 16,610,492	$ 16,955,794	-2.0%	$ 16,019,425	3.7%	$ 66,082,414	$ 65,774,657	0.5%	$ 63,859,700	3.5%
Benefits	1,825,148	2,515,245	-27.4%	2,505,702	-27.2%	8,911,940	9,597,608	-7.1%	9,592,647	-7.1%
Temporary Labor	1,490,245	1,305,287	14.2%	1,324,285	12.5%	5,616,713	5,094,986	10.2%	5,401,038	4.0%
Physician Fees	1,344,080	1,310,157	2.6%	1,280,717	4.9%	5,419,703	5,240,305	3.4%	5,165,143	4.9%
Texas Tech Support	1,042,301	1,042,618	0.0%	992,253	5.0%	4,163,081	4,170,472	-0.2%	4,004,746	4.0%
Purchased Services	5,163,198	5,217,593	-1.0%	5,199,483	-0.7%	21,471,867	20,404,462	5.2%	19,574,345	9.7%
Supplies	6,173,807	7,290,037	-15.3%	7,519,681	-17.9%	26,847,086	27,968,608	-4.0%	29,066,629	-7.6%
Utilities	388,100	380,555	2.0%	311,559	24.6%	1,389,464	1,304,874	6.5%	1,325,936	4.8%
Repairs and Maintenance	906,089	881,826	2.8%	930,344	-2.6%	3,707,562	3,596,928	3.1%	3,557,844	4.2%
Leases and Rent	173,647	203,735	-14.8%	151,047	15.0%	718,380	814,978	-11.9%	553,783	29.7%
Insurance	180,946	205,576	-12.0%	214,434	-15.6%	774,743	822,304	-5.8%	923,235	-16.1%
Interest Expense	82,878	79,147	4.7%	52,742	57.1%	334,728	317,113	5.6%	319,836	4.7%
ECHDA	108,997	113,629	-4.1%	(67,104)	-262.4%	472,393	454,516	3.9%	318,317	48.4%
Other Expense	64,729	236,867	-72.7%	197,734	-67.3%	711,575	929,424	-23.4%	800,419	-11.1%
TOTAL OPERATING EXPENSES	$ 35,554,658	$ 37,738,067	-5.8%	$ 36,632,302	-2.9%	$ 146,621,650	$ 146,491,235	0.1%	$ 144,463,616	1.5%
Depreciation/Amortization	$ 2,201,619	$ 2,177,540	1.1%	$ 1,921,433	14.6%	$ 8,809,487	$ 8,761,631	0.5%	$ 8,073,314	9.1%
(Gain) Loss on Sale of Assets	(3,048)	-	0.0%	-	0.0%	49,672	-	0.0%	(300)	-16657.3%
TOTAL OPERATING COSTS	$ 37,753,229	$ 39,915,607	-5.4%	$ 38,553,735	-2.1%	$ 155,480,809	$ 155,252,866	0.1%	$ 152,536,630	1.9%
NET GAIN (LOSS) FROM OPERATIONS	**$ 797,300**	**$ 912,293**	**12.6%**	**$ (2,914,963)**	**127.4%**	**$ 3,486,305**	**$ 999,201**	**248.9%**	**$ (6,976,105)**	**-150.0%**
Operating Margin	2.07%	2.23%	-7.4%	-8.18%	-125.3%	2.19%	0.64%	243.0%	-4.79%	-145.8%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 401,567	$ 485,615	-17.3%	$ 86,902	362.1%	$ 1,874,963	$ 1,643,344	14.1%	$ 539,179	247.7%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	
Opiod Abatement Fund	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	-	8,135	-100.0%	-	0.0%	-	32,540	-100.0%	64,243	-100.0%
COVID-19 Stimulus	-	-	0.0%	-	0.0%	-	-	0.0%	78,390	-100.0%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ 1,198,867	$ 1,406,043	14.7%	$ (2,828,061)	142.4%	$ 5,361,268	$ 2,675,085	-100.4%	$ (6,294,293)	185.2%
Unrealized Gain/(Loss) on Investments	$ 70,928	$ 100,093	0.0%	$ 110,194	-35.6%	$ 400,676	$ 400,372	0.0%	$ 365,295	9.7%
Investment in Subsidiaries	14,779	85,799	-82.8%	4,726	212.7%	370,413	343,196	7.9%	139,673	165.2%
CHANGE IN NET POSITION	**$ 1,284,574**	**$ 1,591,935**	**19.3%**	**$ (2,713,141)**	**147.3%**	**$ 6,132,358**	**$ 3,418,653**	**-79.4%**	**$ (5,789,325)**	**205.9%**
ADJUSTED OPERATING EBIDA	$ 2,399,505	$ 2,443,495	-1.8%	$ (1,423,887)	-268.5%	$ 9,818,186	$ 7,102,415	38.2%	$ (1,033,242)	-1050.2%

ECTOR COUNTY HOSPITAL DISTRICT
HOSPITAL OPERATIONS SUMMARY
JANUARY 2026

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Inpatient Revenue	$ 63,740,936	$ 61,636,233	3.4%	$ 64,405,013	-1.0%	$ 248,007,402	$ 232,149,105	6.8%	$ 235,085,506	5.5%
Outpatient Revenue	48,613,556	55,574,680	-12.5%	52,450,046	-7.3%	205,706,563	208,314,128	-1.3%	211,605,799	-2.8%
TOTAL PATIENT REVENUE	$ 112,354,492	$ 117,210,913	-4.1%	$ 116,855,059	-3.9%	$ 453,713,965	$ 440,463,233	3.0%	$ 446,691,305	1.6%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 71,182,406	$ 75,303,121	-5.5%	$ 76,921,304	-7.5%	$ 288,161,867	$ 283,257,854	1.7%	$ 293,282,273	-1.7%
Policy Adjustments	112,356	170,766	-34.2%	236,333	-52.5%	454,904	643,544	-29.3%	348,259	30.6%
Uninsured Discount	11,309,472	9,570,211	18.2%	10,879,693	4.0%	34,028,299	35,964,985	-5.4%	37,853,661	-10.1%
Indigent Care	1,325,575	1,240,616	6.8%	1,064,522	24.5%	6,240,522	4,678,021	33.4%	5,248,660	18.9%
Provision for Bad Debts	6,517,821	5,711,085	14.1%	6,338,621	2.8%	29,235,715	21,405,761	36.6%	17,642,081	65.7%
TOTAL REVENUE DEDUCTIONS	$ 90,447,630	$ 91,995,799	-1.7%	$ 95,440,473	-5.2%	$ 358,121,307	$ 345,950,165	3.5%	$ 354,374,933	1.1%
	80.50%	78.49%		81.67%		78.93%	78.54%		79.33%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 1,729,610	$ 1,457,917	18.6%	$ 1,866,764	-7.3%	$ 6,721,653	$ 5,831,668	15.3%	$ 7,319,498	-8.2%
DSRIP/CHIRP	1,252,500	1,252,500	0.0%	370,362	238.2%	5,039,636	5,010,000	0.6%	(413,604)	-1318.5%
TOTAL OTHER PATIENT REVENUE	$ 2,982,110	$ 2,710,417	10.0%	$ 2,237,126	33.3%	$ 11,761,289	$ 10,841,668	8.5%	$ 6,905,894	70.3%
NET PATIENT REVENUE	$ 24,888,972	$ 27,925,531	-10.9%	$ 23,651,712	5.2%	$ 107,353,948	$ 105,354,736	1.9%	$ 99,222,266	8.2%
OTHER REVENUE										
Tax Revenue	$ 8,952,646	$ 7,308,592	22.5%	$ 7,529,886	18.9%	$ 31,667,532	$ 30,110,937	5.2%	$ 27,972,079	13.2%
Other Revenue	1,458,577	1,784,625	-18.3%	1,209,545	20.6%	6,337,686	6,792,325	-6.7%	5,128,722	23.6%
TOTAL OTHER REVENUE	$ 10,411,223	$ 9,093,217	14.5%	$ 8,739,431	19.1%	$ 38,005,218	$ 36,903,262	3.0%	$ 33,100,800	14.8%
NET OPERATING REVENUE	$ 35,300,195	$ 37,018,748	-4.6%	$ 32,391,143	9.0%	$ 145,359,165	$ 142,257,998	2.2%	$ 132,323,066	9.9%
OPERATING EXPENSE										
Salaries and Wages	$ 11,894,002	$ 12,082,044	-1.6%	$ 11,406,865	4.3%	$ 47,280,623	$ 46,199,758	2.3%	$ 45,024,348	5.0%
Benefits	1,110,738	1,913,515	-42.0%	1,809,496	-38.6%	6,922,669	7,590,693	-8.8%	7,677,408	-9.8%
Temporary Labor	605,635	526,584	15.0%	727,161	-16.7%	2,518,185	1,988,174	26.7%	2,798,585	-10.0%
Physician Fees	1,417,305	1,357,136	4.4%	1,295,453	9.4%	5,667,450	5,428,221	4.4%	5,427,245	4.4%
Texas Tech Support	1,042,301	1,042,618	0.0%	992,253	5.0%	4,163,081	4,170,472	-0.2%	4,004,746	4.0%
Purchased Services	5,531,530	5,580,683	-0.9%	5,576,655	-0.8%	22,757,587	21,942,000	3.7%	20,767,114	9.6%
Supplies	6,115,808	7,213,458	-15.2%	7,448,993	-17.9%	26,600,787	27,671,215	-3.9%	28,792,506	-7.6%
Utilities	387,710	380,141	2.0%	310,559	24.8%	1,387,049	1,302,850	6.5%	1,322,213	4.9%
Repairs and Maintenance	900,730	881,350	2.2%	929,705	-3.1%	3,698,596	3,595,024	2.9%	3,557,204	4.0%
Leases and Rentals	10,829	41,354	-73.8%	3,334	224.8%	66,916	165,417	-59.5%	(35,050)	-290.9%
Insurance	118,912	136,272	-12.7%	151,581	-21.6%	514,286	545,088	-5.7%	659,666	-22.0%
Interest Expense	82,878	79,147	4.7%	52,742	57.1%	334,728	317,113	5.6%	319,836	4.7%
ECHDA	108,997	113,629	-4.1%	(67,104)	-262.4%	472,393	454,516	3.9%	318,317	48.4%
Other Expense	(11,805)	161,719	-107.3%	118,753	-109.9%	404,376	655,671	-38.3%	528,578	-23.5%
TOTAL OPERATING EXPENSES	$ 29,315,571	$ 31,509,651	-7.0%	$ 30,756,444	-4.7%	$ 122,788,725	$ 122,026,212	0.6%	$ 121,162,717	1.3%
Depreciation/Amortization	$ 2,190,159	$ 2,164,955	1.2%	$ 1,909,469	14.7%	$ 8,763,732	$ 8,711,291	0.6%	$ 8,025,525	9.2%
(Gain)/Loss on Disposal of Assets	(3,048)	-	0.0%	-	0.0%	49,672	-	0.0%	(300)	-16657.3%
TOTAL OPERATING COSTS	$ 31,502,682	$ 33,674,606	-6.4%	$ 32,665,913	-3.6%	$ 131,602,129	$ 130,737,503	0.7%	$ 129,187,943	1.9%
NET GAIN (LOSS) FROM OPERATIONS	**$ 3,797,513**	**$ 3,344,142**	**13.6%**	**$ (274,771)**	**1482.1%**	**$ 13,757,036**	**$ 11,520,495**	**19.4%**	**$ 3,135,123**	**-338.8%**
Operating Margin	10.76%	9.03%	19.1%	-0.85%	-1368.2%	9.46%	8.10%	16.9%	2.37%	299.5%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 401,567	$ 485,615	-17.3%	$ 86,902	362.1%	$ 1,874,963	$ 1,643,344	14.1%	$ 539,179	247.7%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	0.0%
Opiod Abatement Fund	-	-	0.0%	-	0.0%	-	-		-	0.0%
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	-	8,135	-100.0%	-	0.0%	-	32,540	-100.0%	64,243	-100.0%
COVID-19 Stimulus	-	-	0.0%	-	0.0%	-	-		78,390	-100.0%
CHANGE IN NET POSITION BEFORE CAPITAL CONTRIBUTION	$ 4,199,080	$ 3,837,893	9.4%	$ (187,869)	-2335.1%	$ 15,632,000	$ 13,196,379	18.5%	$ 3,816,936	309.5%
Procare Capital Contribution	(3,008,108)	(2,429,813)	23.8%	(2,644,335)	13.8%	(10,350,389)	(10,568,021)	-2.1%	(10,217,753)	1.3%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ 1,190,972	$ 1,408,080	15.4%	$ (2,832,203)	142.1%	$ 5,281,611	$ 2,628,358	-100.9%	$ (6,400,817)	182.5%
Unrealized Gain/(Loss) on Investments	$ 70,928	$ 100,093	-29.1%	$ 110,194	-35.6%	$ 400,676	$ 400,372	0.1%	$ 365,295	9.7%
Investment in Subsidiaries	14,779	85,799	-82.8%	4,726	212.7%	370,413	343,196	7.9%	139,673	165.2%
CHANGE IN NET POSITION	**$ 1,276,679**	**$ 1,593,972**	**19.9%**	**$ (2,717,283)**	**147.0%**	**$ 6,052,701**	**$ 3,371,926**	**-79.5%**	**$ (5,895,849)**	**202.7%**
ADJUSTED OPERATING EBIDA	$ 5,388,257	$ 4,862,759	10.8%	$ 1,204,341	347.4%	$ 20,043,163	$ 17,573,369	14.1%	$ 9,030,198	122.0%

ECTOR COUNTY HOSPITAL DISTRICT
PROCARE OPERATIONS SUMMARY
JANUARY 2026

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 10,475,481	$ 13,072,657	-19.9%	$ 12,926,820	-19.0%	$ 44,211,041	$ 46,284,905	-4.5%	$ 45,213,569	-2.2%
TOTAL PATIENT REVENUE	$ 10,475,481	$ 13,072,657	-19.9%	$ 12,926,820	-19.0%	$ 44,211,041	$ 46,284,905	-4.5%	$ 45,213,569	-2.2%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 5,499,653	$ 6,983,314	-21.2%	$ 7,261,236	-24.3%	$ 23,099,911	$ 24,455,272	-5.5%	$ 23,557,222	-1.9%
Policy Adjustments	581,620	1,127,131	-48.4%	1,145,459	-49.2%	2,829,319	3,903,315	-27.5%	4,431,987	-36.2%
Uninsured Discount	362,256	290,426	24.7%	299,042	21.1%	1,132,906	1,018,767	11.2%	835,003	35.7%
Indigent	9,980	10,987	-9.2%	14,692	-32.1%	67,177	39,037	72.1%	49,715	35.1%
Provision for Bad Debts	1,096,827	1,158,490	-5.3%	1,238,933	-11.5%	4,594,169	4,103,892	11.9%	4,203,426	9.3%
TOTAL REVENUE DEDUCTIONS	$ 7,550,337	$ 9,570,348	-21.1%	$ 9,959,362	-24.2%	$ 31,723,482	$ 33,520,283	-5.4%	$ 33,077,353	-4.1%
	72.08%	73.21%		77.04%		71.75%	72.42%		73.16%	
NET PATIENT REVENUE	$ 2,925,144	$ 3,502,309	-16.5%	$ 2,967,458	-1.4%	$ 12,487,559	$ 12,764,622	-2.2%	$ 12,136,216	2.9%
OTHER REVENUE										
Other Income	$ 289,774	$ 271,502	6.7%	$ 253,945	14.1%	$ 983,159	$ 1,083,220	-9.2%	$ 965,934	1.8%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 3,214,918	$ 3,773,811	-14.8%	$ 3,221,403	-0.2%	$ 13,470,717	$ 13,847,842	-2.7%	$ 13,102,150	2.8%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 4,465,806	$ 4,622,865	-3.4%	$ 4,369,091	2.2%	$ 17,807,308	$ 18,570,896	-4.1%	$ 17,872,267	-0.4%
Benefits	689,473	569,624	21.0%	670,179	2.9%	1,930,588	1,929,003	0.1%	1,863,696	3.6%
Temporary Labor	884,610	778,703	13.6%	597,124	48.1%	3,098,529	3,106,812	-0.3%	2,602,452	19.1%
Physician Fees	186,024	212,269	-12.4%	244,512	-23.9%	789,245	849,076	-7.0%	774,890	1.9%
Purchased Services	(370,218)	(365,580)	1.3%	(377,865)	-2.0%	(1,289,036)	(1,547,498)	-16.7%	(1,198,041)	7.6%
Supplies	57,998	76,250	-23.9%	70,530	-17.8%	245,622	296,036	-17.0%	272,570	-9.9%
Utilities	390	414	-5.8%	1,000	-61.0%	2,416	2,024	19.4%	3,722	-35.1%
Repairs and Maintenance	5,359	476	1025.9%	639.18	738.4%	8,966	1,904	370.9%	639	1302.8%
Leases and Rentals	162,164	161,579	0.4%	147,060	10.3%	648,849	646,353	0.4%	584,879	10.9%
Insurance	53,570	59,854	-10.5%	53,132	0.8%	226,601	239,416	-5.4%	224,683	0.9%
Other Expense	76,389	74,583	2.4%	78,371	-2.5%	306,263	271,493	12.8%	270,357	13.3%
TOTAL OPERATING EXPENSES	$ 6,211,566	$ 6,191,037	0.3%	$ 5,853,773	6.1%	$ 23,775,351	$ 24,365,515	-2.4%	$ 23,272,115	2.2%
Depreciation/Amortization	$ 11,460	$ 12,585	-8.9%	$ 11,964	-4.2%	$ 45,755	$ 50,340	-9.1%	$ 47,789	-4.3%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 6,223,026	$ 6,203,622	0.3%	$ 5,865,737	6.1%	$ 23,821,106	$ 24,415,855	-2.4%	$ 23,319,903	2.1%
NET GAIN (LOSS) FROM OPERATIONS	**$ (3,008,108)**	**$ (2,429,811)**	**23.8%**	**$ (2,644,335)**	**13.8%**	**$ (10,350,389)**	**$ (10,568,013)**	**-2.1%**	**$ (10,217,753)**	**1.3%**
Operating Margin	-93.57%	-64.39%	45.3%	-82.09%	14.0%	-76.84%	-76.32%	0.7%	-77.99%	-1.5%
COVID-19 Stimulus	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ 3,008,108	$ 2,429,811	23.8%	$ 2,644,335	13.8%	$ 10,350,389	$ 10,568,013	-2.1%	$ 10,217,753	1.3%
CAPITAL CONTRIBUTION	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**
ADJUSTED OPERATING EBIDA	$ (2,996,648)	$ (2,417,226)	-24.0%	$ (2,632,371)	-13.8%	$ (10,304,634)	$ (10,517,673)	2.0%	$ (10,169,964)	-1.3%

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Office Visits	7,704	8,170	-5.7%	8,506	-9.43%	30,605	29,363	4.2%	30,608	-0.01%
Total Hospital Visits	7,361	7,429	-0.9%	7,238	1.70%	27,926	27,404	1.9%	26,629	4.87%
Total Procedures	12,353	14,092	-12.3%	14,087	-12.31%	51,572	52,939	-2.6%	53,035	-2.76%
Total Surgeries	669	913	-26.7%	822	-18.61%	2,925	3,402	-14.0%	3,188	-8.25%
Total Provider FTE's	85.5	87.4	-2.2%	87.1	-1.83%	86.9	88.4	-1.7%	87.2	-0.30%
Total Staff FTE's	115.3	142.7	-19.2%	110.5	4.30%	117.8	142.7	-17.5%	110.9	6.21%
Total Administrative FTE's	8.3	9.5	-12.8%	8.4	-1.74%	8.2	9.5	-13.4%	8.2	-0.09%
Total FTE's	209.1	239.6	-12.7%	206.0	1.46%	213.0	240.6	-11.5%	206.3	3.21%

ECTOR COUNTY HOSPITAL DISTRICT
TRAUMACARE OPERATIONS SUMMARY
JANUARY 2026

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 204,837	$ 175,041	17.0%	$ 260,187	-21.3%	$ 813,878	$ 725,021	12.3%	$ 627,424	29.7%
TOTAL PATIENT REVENUE	$ 204,837	$ 175,041	17.0%	$ 260,187	-21.3%	$ 813,878	$ 725,021	12.3%	$ 627,424	29.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 109,726	$ 80,243	36.7%	$ 133,163	-17.6%	$ 453,395	$ 332,368	36.4%	$ 313,156	44.8%
Policy Adjustments	30,961	31,625	-2.1%	39,663	-21.9%	114,868	130,989	-12.3%	82,001	40.1%
Uninsured Discount	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Indigent	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Provision for Bad Debts	29,372	28,933	1.5%	61,158	-52.0%	113,380	119,841	-5.4%	101,577	11.6%
TOTAL REVENUE DEDUCTIONS	$ 170,059	$ 140,801	20.8%	$ 233,984	-27.3%	$ 681,643	$ 583,198	16.9%	$ 496,735	37.2%
	83.02%	80.44%		89.93%		83.75%	80.44%		79.17%	
NET PATIENT REVENUE	$ 34,778	$ 34,240	1.6%	$ 26,203	32.7%	$ 132,235	$ 141,823	-6.8%	$ 130,689	1.2%
						16.2%				
OTHER REVENUE										
Other Income	$ 638	$ 1,101	-42.1%	$ 23	2637.7%	$ 4,996	$ 4,404	13.4%	$ 4,618	8.2%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 35,416	$ 35,341	0.2%	$ 26,226	35.0%	$ 137,231	$ 146,227	-6.2%	$ 135,308	1.4%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 250,683	$ 250,885	-0.1%	$ 243,470	3.0%	$ 994,483	$ 1,004,003	-0.9%	$ 963,085	3.3%
Benefits	24,937	32,106	-22.3%	26,028	-4.2%	58,684	77,912	-24.7%	51,543	13.9%
Temporary Labor	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Physician Fees	(259,248)	(259,248)	0.0%	(259,248)	0.0%	(1,036,992)	(1,036,992)	0.0%	(1,036,992)	0.0%
Purchased Services	1,885	2,490	-24.3%	693	172.2%	3,316	9,960	-66.7%	5,271	-37.1%
Supplies	-	329	-100.0%	158	-100.0%	677	1,357	-50.1%	1,552	-56.4%
Utilities	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Repairs and Maintenance	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Leases and Rentals	653	802	-18.5%	653	0.0%	2,614	3,208	-18.5%	3,954	-33.9%
Insurance	8,464	9,450	-10.4%	9,722	-12.9%	33,856	37,800	-10.4%	38,886	-12.9%
Other Expense	146	565	-74.2%	609	-76.1%	936	2,260	-58.6%	1,484	-37.0%
TOTAL OPERATING EXPENSES	$ 27,521	$ 37,379	-26.4%	$ 22,084	24.6%	$ 57,573	$ 99,508	-42.1%	$ 28,784	100.0%
Depreciation/Amortization	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 27,521	$ 37,379	-26.4%	$ 22,084	24.6%	$ 57,573	$ 99,508	-42.1%	$ 28,784	100.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ 7,895**	**$ (2,038)**	**-487.4%**	**$ 4,142**	**90.6%**	**$ 79,657**	**$ 46,719**	**70.5%**	**$ 106,524**	**-25.2%**
Operating Margin	22.29%	-5.77%	-486.6%	15.79%	41.1%	58.05%	31.95%	81.7%	78.73%	-26.3%
COVID-19 Stimulus	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
CAPITAL CONTRIBUTION	**$ 7,895**	**$ (2,038)**	**-487.4%**	**$ 4,142**	**90.6%**	**$ 79,657**	**$ 46,719**	**70.5%**	**$ 106,524**	**-25.2%**
ADJUSTED OPERATING EBIDA	$ 7,895	$ (2,038)	-487.4%	$ 4,142	90.6%	$ 79,657	$ 46,719	70.5%	$ 106,524	-25.2%

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Procedures	632	500	26.40%	521	21.31%	2,644	2,071	27.67%	1,609	64.33%
Total Provider FTE's	7.3	7.3	0.00%	7.3	-0.25%	7.3	7.4	-0.69%	7.3	-0.34%
Total Staff FTE's	1.0	0.9	15.49%	1.0	4.29%	1.0	0.9	9.49%	1.0	3.12%
Total FTE's	8.4	8.2	1.70%	8.3	0.30%	8.4	8.3	0.46%	8.3	0.07%

ECTOR COUNTY HOSPITAL DISTRICT
JANUARY 2026

REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 43,209,460	38.5%	$ 45,100,633	38.6%	$ 173,037,447	38.1%	173,116,715	38.8%
Medicaid	11,186,218	10.0%	13,275,699	11.4%	44,471,073	9.8%	49,052,801	11.0%
Commercial	39,779,947	35.4%	40,925,182	35.0%	167,965,678	37.0%	163,599,115	36.6%
Self Pay	14,585,595	13.0%	14,958,121	12.8%	53,233,103	11.7%	46,453,163	10.4%
Other	3,593,272	3.2%	2,595,423	2.2%	15,006,665	3.3%	14,469,511	3.2%
TOTAL	**$ 112,354,492**	**100.0%**	**$ 116,855,059**	**100.0%**	**$ 453,713,965**	**100.0%**	**446,691,305**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 8,650,434	38.9%	$ 9,243,826	35.8%	$ 35,706,979	36.2%	36,671,614	38.2%
Medicaid	2,531,233	11.4%	3,253,047	12.6%	11,876,138	12.0%	9,367,706	9.8%
Commercial	8,804,507	39.6%	10,091,395	39.1%	42,160,809	42.7%	39,912,160	41.6%
Self Pay	1,466,291	6.6%	1,477,101	5.7%	5,072,141	5.1%	5,134,995	5.4%
Other	787,470	3.5%	1,752,507	6.8%	3,939,921	4.0%	4,842,732	5.1%
TOTAL	**$ 22,239,933**	**100.0%**	**$ 25,817,876**	**100.0%**	**$ 98,755,988**	**100.0%**	**95,929,207**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
STATEMENT OF CASH FLOW
JANUARY 2026

	Hospital	ProCare	TraumaCare	Blended
Cash Flows from Operating Activities and Nonoperating Revenue:				
Excess of Revenue over Expenses	$ 6,052,701	-	79,657	$ 6,132,358
Noncash Expenses:				
Depreciation and Amortization	4,744,707	2,223	-	4,746,930
Unrealized Gain/Loss on Investments	298,108	-	-	298,108
Accretion (Bonds) & COVID Funding	(176,651)	-	-	(176,651)
Changes in Assets and Liabilities				
Patient Receivables, Net	1,975,807	(592,648)	(6,553)	1,376,605
Taxes Receivable/Deferred Revenue	6,253,036	(9,770)	-	6,243,266
Inventories, Prepaids and Other	(4,440,203)	6,757	435	(4,433,010)
LT Lease Rec	614,624			614,624
Deferred Inflow of Resources	-			-
Accounts Payable	(584,185)	353,783	(107,004)	(337,406)
Accrued Expenses	(1,233,685)	239,655	33,465	(960,564)
Due to Third Party Payors	(1,633,209)	-	-	(1,633,209)
Deffered Inflows of Resources-GASB 87 Lessor	(642,769)			(642,769)
Accrued Post Retirement Benefit Costs	(1,999,156)	-	-	(1,999,156)
Net Cash Provided by Operating Activities	$ 9,229,127	0	-	$ 9,229,127
Cash Flows from Investing Activities:				
Investments	$ (1,145,205)	-	-	$ (1,145,205)
Acquisition of Property and Equipment	(562,779)	-	-	(562,779)
Net Cash used by Investing Activities	$ (1,707,983)	-	-	$ (1,707,983)
Cash Flows from Financing Activities:				
Current Portion Debt	$ 23,600	-	-	$ 23,600
Principal Paid on Subscription Liabitlities	(286,754)			(286,754)
Principal Paid on Lease Liabitlities	(274,473)			(274,473)
LT Liab Subscriptions	(1,210,245)			(1,210,245)
LT Liab Leases	(982)			(982)
Net Repayment of Long-term Debt/Bond Issuance	-	-	-	-
Net Cash used by Financing Activities	(1,748,855)	-	-	(1,748,855)
Net Increase (Decrease) in Cash	5,772,289	0	-	5,772,289
Beginning Cash & Cash Equivalents @ 9/30/2025	27,702,192	4,700	-	27,706,892
Ending Cash & Cash Equivalents @ 1/31/2026	$ 33,474,482	$ 4,700	$ -	$ 33,479,182

Financial Presentation

For the Month Ended

January 31, 2026

Results From Operations
January 31, 2026

	Actual	Budget	Variance	
Inpatient Revenue	$63,740,936	$61,636,233	$2,104,703	3.4%
Outpatient Revenue	59,293,874	68,822,378	(9,528,504)	-13.8%
Total Patient Revenue	123,034,810	130,458,611	(7,423,801)	-5.7%
Less: Deductions	98,168,025	101,706,948	(3,538,923)	-3.5%
Net Patient Revenue	24,866,785	28,751,663	(3,884,878)	-13.5%
Supplemental Funding	2,982,110	2,710,417	271,693	10.0%
Tax Revenue	8,952,646	7,308,592	1,644,054	22.5%
Other Revenue	1,748,988	2,057,228	(308,240)	-15.0%
Total Operating Revenue	38,550,529	40,827,900	(2,277,371)	-5.6%
Salaries, Benefits & Contract Labor	19,925,885	20,776,326	(850,441)	-4.1%
Physician Fees incl TTU	2,386,381	2,352,775	33,606	1.4%
Purchased Services	5,163,198	5,217,593	(54,395)	-1.0%
Supplies	6,173,807	7,290,037	(1,116,230)	-15.3%
Repairs and Maintenance	906,089	881,826	24,263	2.8%
Other Expense	807,422	1,026,733	(219,311)	-21.4%
ECHD Assistance	108,997	113,629	(4,632)	-4.1%
Interest Expense	82,878	79,147	3,731	4.7%
Depreciation	2,198,571	2,177,540	21,031	1.0%
Total Operating Expenses	37,753,228	39,915,606	(2,162,378)	-5.4%
Gain (Loss) from Operations	797,300	912,294	(114,994)	-12.6%
Non-operating Income	487,274	679,642	(192,368)	-28.3%
Excess Income over Expenses	$1,284,574	$1,591,936	($307,362)	-19.3%

Results From Operations - YTD January 31, 2026

	YTD Actual	YTD Budget	Variance	
Inpatient Revenue	$248,007,402	$232,149,105	$15,858,297	6.8%
Outpatient Revenue	250,731,482	255,324,054	(4,592,572)	-1.8%
Total Patient Revenue	498,738,884	487,473,159	11,265,725	2.3%
Less: Deductions	390,526,432	380,053,646	10,472,786	2.8%
Net Patient Revenue	108,212,452	107,419,513	792,939	0.7%
Supplemental Funding	11,761,289	10,841,668	919,621	8.5%
Tax Revenue	31,667,532	30,110,937	1,556,595	5.2%
Other Revenue	7,325,840	7,879,949	(554,109)	-7.0%
Total Operating Revenue	158,967,113	156,252,067	2,715,046	1.7%
Salaries, Benefits & Contract Labor	80,611,067	80,467,251	143,816	0.2%
Physician Fees incl TTU	9,582,784	9,410,777	172,007	1.8%
Purchased Services	21,471,867	20,404,462	1,067,405	5.2%
Supplies	26,847,086	27,968,608	(1,121,522)	-4.0%
Repairs and Maintenance	3,707,562	3,596,928	110,634	3.1%
Other Expense	3,594,162	3,871,580	(277,418)	-7.2%
ECHD Assistance	472,393	454,516	17,877	3.9%
Interest Expense	334,728	317,113	17,615	5.6%
Depreciation	8,859,159	8,761,631	97,528	1.1%
Total Operating Expenses	155,480,808	155,252,866	227,942	0.1%
Gain from Operations	3,486,305	999,201	2,487,104	248.9%
Non-operating Income	2,646,052	2,419,452	226,600	9.4%
Excess Income over Expenses	$6,132,357	$3,418,653	$2,713,704	79.4%

Results From Operations January 31, 2026

Gain From Operations	Actual	Budget	Variance
Current Month	**$797,300**	**$912,294**	**($114,994)**
Year-To-Date	**$3,486,305**	**$999,201**	**$2,487,104**

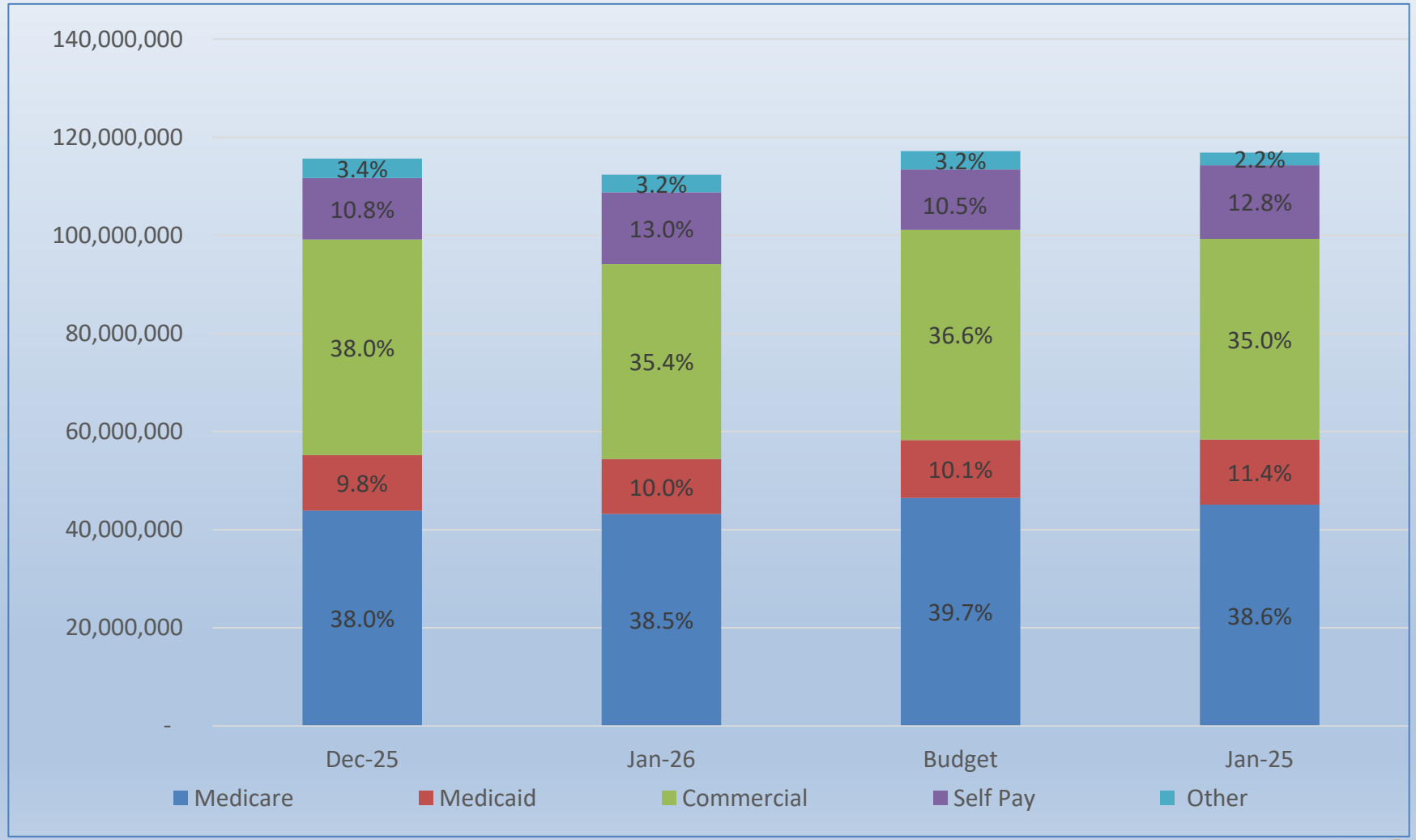
Major Variances

- Net revenue is $3.9M unfavorable due to primarily to decreased volume ($1.2M) , increased aging ($886k), and unfavorable payor mix ($629K).
- Tax revenue is favorable $1.6M due to increased sales tax collections in December.
- Supplemental Funding was over due to an ATLIS program credit from FY25.
- Salaries are favorable ($160k) due to decreased patient volume and Benefits are favorable ($690k) with lower insurance claims and pharmacy cost.
- Supplies were favorable $1.1M due to decreased outpatient volumes in the Cath Lab, Surgery, and Lab. Retail Pharmacy revenue and expense were under due to volumes.
- Other Expense were under $219K primarily due to tax exemption of several properties.
- Non-operating income was under budget due to mark-to-market investments and timing of subsidiary income recognition.

Key Statistics
January 31, 2026

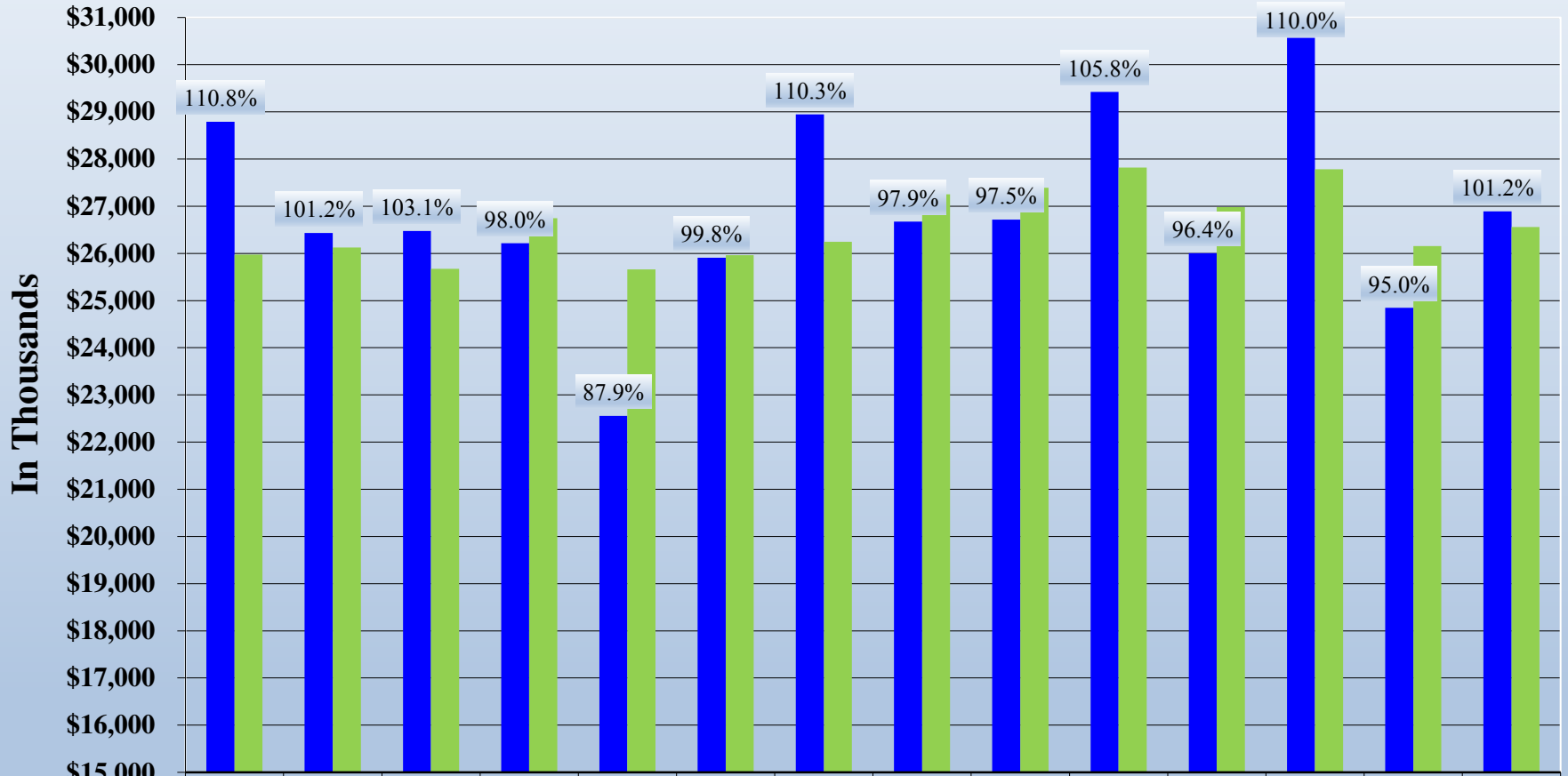
	CURRENT MONTH				YEAR-TO-DATE			
	Actual	Budget	Variance	Var %	Actual	Budget	Variance	Var %
Inpatient Days	6,412	5,977	435	7.3%	24,710	22,309	2,401	10.8%
Length of Stay	5.11	4.81	0.30	6.2%	5.07	4.81	0.26	5.5%
GMLOS	5.11	3.88	1.23	31.7%	5.07	3.90	1.17	30.0%
Surgeries	688	823	(135)	-16.4%	3,031	3,076	(45)	-1.5%
Emergency Visits	4,794	5,488	(694)	-12.6%	20,070	20,497	(427)	-2.1%
Urgent Care Visits	2,415	2,461	(46)	-1.9%	8,946	9,189	(243)	-2.6%
FHC Visits	3,445	4,783	(1,338)	-28.0%	14,787	18,115	(3,328)	-18.4%
Primary & Specialty Clinic	7,704	8,170	-466	-5.7%	30,605	29,363	1,242	4.2%

Hospital Payor Mix



Total AR Cash Receipts

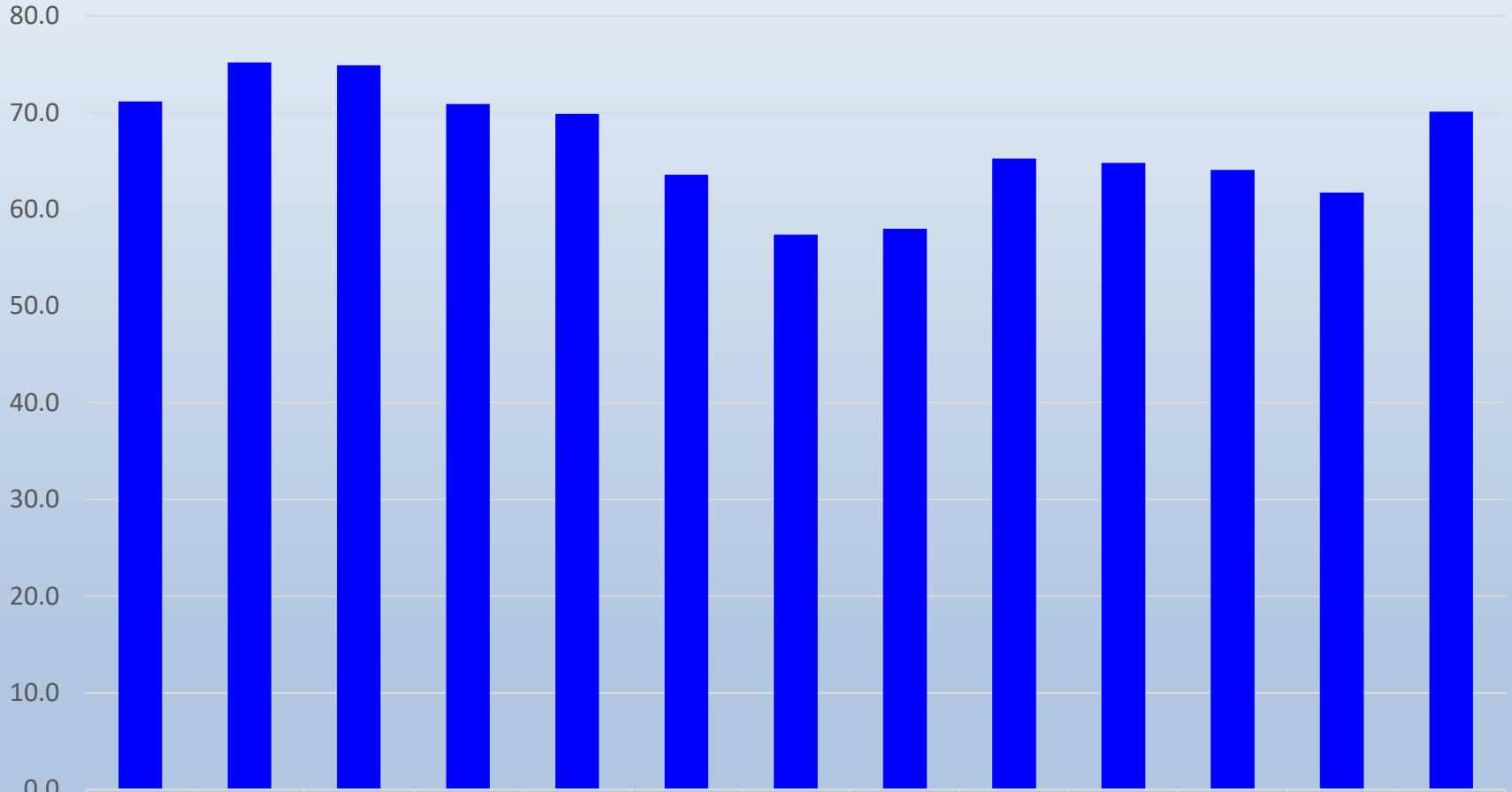
13 Month Trending



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	13 Mos AVG
Collections	28,790	26,434	26,473	26,216	22,554	25,909	28,946	26,672	26,718	29,423	26,006	30,569	24,844	26,889
Avg Net Rev	25,976	26,124	25,673	26,743	25,662	25,962	26,244	27,251	27,390	27,819	26,978	27,782	26,154	26,561

Days Cash on Hand

Thirteen Month Trending



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Days	71.2	75.2	74.9	70.9	69.9	63.6	57.4	58.0	65.2	64.8	64.1	61.7	70.1

Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: ECHD Board of Directors

FROM: Linda Carpenter, Chief Information Officer

SUBJECT: Oracle Remote Hosting Scope-of-Use True-Up

DATE: March 1, 2026

Cost:

Remote Hosting Scope-of-Use True-Up	$480,000.00

Budget Reference:

Operational Budget	$480,000.00

Objective:

Approval is requested to execute the Oracle Remote Hosting (RHO) scope-of-use true-up to align contracted concurrent user counts with sustained actual usage, as permitted under the existing master ITWorks / Cerner agreement and related amendments.

Actual system utilization has consistently exceeded the current contracted threshold. The agreement allows for scope-of-use adjustments and execution of an ordering document reflecting additional usage at established contractual rates. Oracle has not invoiced for prior periods of over-utilization.

The true-up reflects 300 additional concurrent users at the contractual rate of $50 per user per month, resulting in an incremental cost of $15,000 per month for the remaining contract term (January 2026 through August 2028), with a total remaining term commitment of $480,000. Oracle has not invoiced for prior periods of over-utilization.

Approval of this item maintains compliance with existing contractual obligations and aligns system utilization with agreed-upon terms.

Mission:
Medical Center Health System is a community-based teaching organization dedicated to providing high-quality and affordable healthcare to improve the health and wellness of all residents of the Permian Basin.
Vision:
MCHS will be the premier source for health and wellness.
ICARE Values:
Integrity | Customer Centered | Accountability | Respect | Excellence

Executive Policy Committee

Team Leader:	Crystal Sanchez	Date:	02/26/2026	Start Time:	1200
Location:	Admin Conference Room A			End Time:	1300

Agenda Item (Topic)	Time Allotted	Presenter	Notes
Meeting Called to Order			**1204** **By Russell Tippin**
Review of meeting minutes from previous meeting	1 min	All	• ***Motion to approve as is by Russell Tippin, seconded by Sylvia Rodriguez-Sanchez*** • ***All members in favor***
Old Business			
– N/A			
New Business			
– New Policy: ○ Blood Product Utilization Parameters	10 min	Crystal Sanchez	• ***Policy to provide guidance for acceptable parameters when ordering blood products*** ○ ***Motion to approve as is by Kathy Rhodes, seconded by Russell Tippin*** ○ ***All members in favor***
– Revised Policy (Trauma): ○ TR-08 Transferring and Referring Patients who require services not provided by Medical Center Hospital or Per the Patient/Physician Request • Hyperlink to be added- Guidelines for Burn Patient Referral ○ TR-27 Major Neurological/Spinal Trauma	10 min	Crystal Sanchez	• ***TR-08: Verbiage added to align with Pediatric Readiness*** ○ ***Motion to approve as is by Kathy Rhodes, seconded by Russell Tippin*** ○ ***All members in favor*** • ***TR-27:*** ○ ***Motion to approve as is by Kathy Rhodes, seconded by Kathy Rhodes*** ○ ***All members in favor***

– Revised Policy (Patient Safety): ○ MCH-2004 Disclosure and Consent for Medical and Surgical Procedures, and Radiation Therapy ○ Surgical Consent Form	15 min	Mary Gallgos	• ***Policy edits to align with CMS required changes to the consent*** ○ ***Motion to approve as is by Kathy Rhodes, seconded by Russell Tippin*** ○ ***All members in favor*** • ***Changes made to the consent to align with current CMS requirements*** ○ ***Committee requested an edit to the title at the top of page 3 to read "Teaching, Training, and Education" and remove the word "Research"*** ○ ***Motion to approve with requested changes by Gingie Sredanovich, seconded by Sylvia Rodriguez-Sanchez*** ○ ***All members in favor***
– Policies to be retired: ○ NICU 6550-020 Cesarean Section, NICU Nurse's Role in ○ NICU 6550-016 Catheterization: Straight Cath & Indwelling ○ N5W-6080-002 Intravenous (IV) Therapy & Maintenance	10 min	Crystal Sanchez	****Retired policies will come to the committee for a vote and approval moving forward*** • ***These polices are no longer needed per the Director, approval to retire by CNO and ACNO of CWI*** • ***Motion to approve by Russell Tippin, seconded by Sylvia Rodriguez-Sanchez*** • ***All members in favor***
– Policy review compliance rate to be reported up to QMS: ○ Crystal will report compliance to QMS beginning March 2026 ○ Goal set at 95% ○ Action plans for non-compliance will be decided on by the Policy & Forms Committee as a whole	10 min	Crystal Sanchez	• ***Compliance report presented to the committee in a graph*** • ***Committee discussed actions to be taken moving forward*** • ***Crystal Sanchez to email Russell Tippin a list of overdue reviews weekly***
Open Forum	5 min		
Meeting Adjourned			**1235** **By Russell Tippin**

Audit Presentation

Ector County Hospital District
d/b/a Medical Center Health System
September 30, 2025

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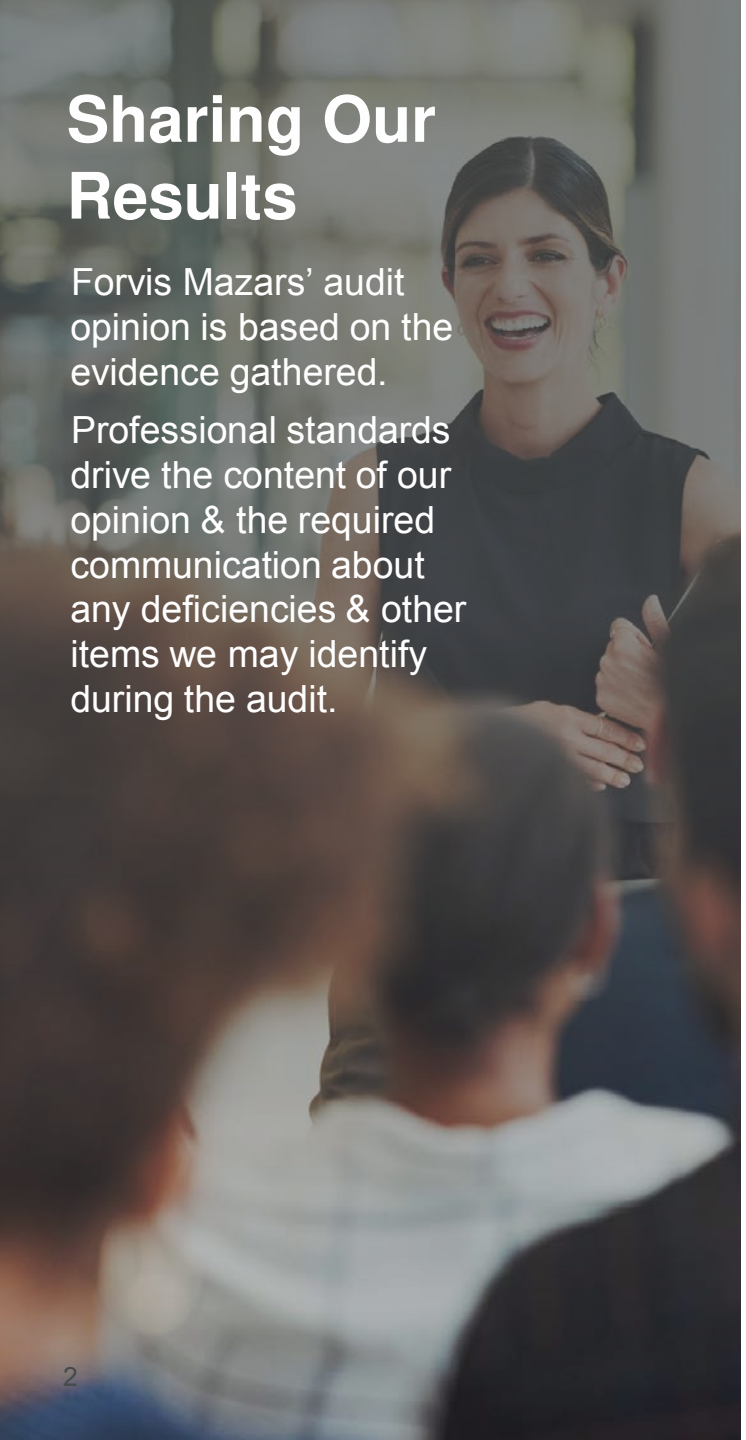

Sharing Our Results

Forvis Mazars' audit opinion is based on the evidence gathered.

Professional standards drive the content of our opinion & the required communication about any deficiencies & other items we may identify during the audit.

Forvis Mazars Responsibility & Opinion

UNMATCHED CLIENT EXPERIENCE

- **Auditor's Responsibility**
  - Draft report is presented for board consideration
  - We are prepared to issue an unmodified, or clean opinion
  - We did not identify any material weaknesses or significant deficiencies in internal control

- **Qualitative Components of the Audit**
  - Significant accounting policies were reviewed and compared to industry practice
  - Accounting treatments were reviewed for variations from GAAP
  - Financial statement disclosures were reviewed for completeness and accuracy
  - Methodologies for developing accounting estimates were challenged and recorded estimates were reviewed for reasonableness and evidence of management bias

- **There were no**
  - Difficulties encountered by our team when conducting the audit
  - Disagreements with management
  - Contentious accounting issues
  - Consultations with other accountants

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Audit Risk Areas & Key Disclosures

UNMATCHED CLIENT EXPERIENCE

Significant Judgments & Accounting Estimates

- Allowances for contractual adjustments and uncollectible accounts
- Estimates for third party payor settlements
- Supplemental Medicaid funding revenue and related settlements
- Defined benefit pension plan assumptions

Financial Disclosures

- Patient service revenue
- Medicaid supplemental funding programs
- Defined benefit pension plan
- Other postemployment benefit plan (OPEB)
- Subsequent event (Energy Contract)

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Financial Statement Adjustments

UNMATCHED CLIENT EXPERIENCE

- ## Proposed Adjustments Unrecorded
  - ✓ District proposed entry relating to recording of revenue earned in fiscal year 2025 under Alternative Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) for $2.91 million
  - ✓ Reduction of cost report receivable to reduce revenue in fiscal year 2025 for $1.36 million
- ## Proposed Adjustments Recorded
  - ✓ Summarized on next slide

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Financial Statement Adjustments

Increase in net position, per start of audit	$ 10,306,850
Audit Entries with Net Position Impact	
PBBHC equity method investment	8,235,035
Impact of audit entries	8,235,035
Client provided entries ("PBC")	
True up to actuary report - OPEB	(785,781)
True up to actuary report - WC/GL/PL	(68,142)
GASB 96 Adjustment	(112,560)
Impact of PBC entries	(966,483)
Impact of adjustments recorded during the audit	7,268,552
Increase in net position, per audit report	$ 17,575,402

Industry Comparison (000's)

	Total Assets	Total Debt	NPSR + Supplemental	Tax Revenue
Ector County	**$407,000**	**$27,788**	**$356,000**	**$83,000**
Parkland (Dallas)	$4,298,000	$526,000	$2,357,000	$863,000
Harris Health (Houston)	$4,025,000	$1,111,000	$1,476,000	$874,000
JPS (Tarrant)	$3,190,000	$447,000	$1,139,000	$509,000
UHS – San Antonio	$5,326,000	$1,361,000	$1,817,000	$678,000
UMC - Lubbock	$1,285,000	$0	$917,000	$36,000
El Paso County	$1,072,000	$626,000	$1,139,000	$154,000
Midland County	$642,000	$223,000	$423,000	$81,000

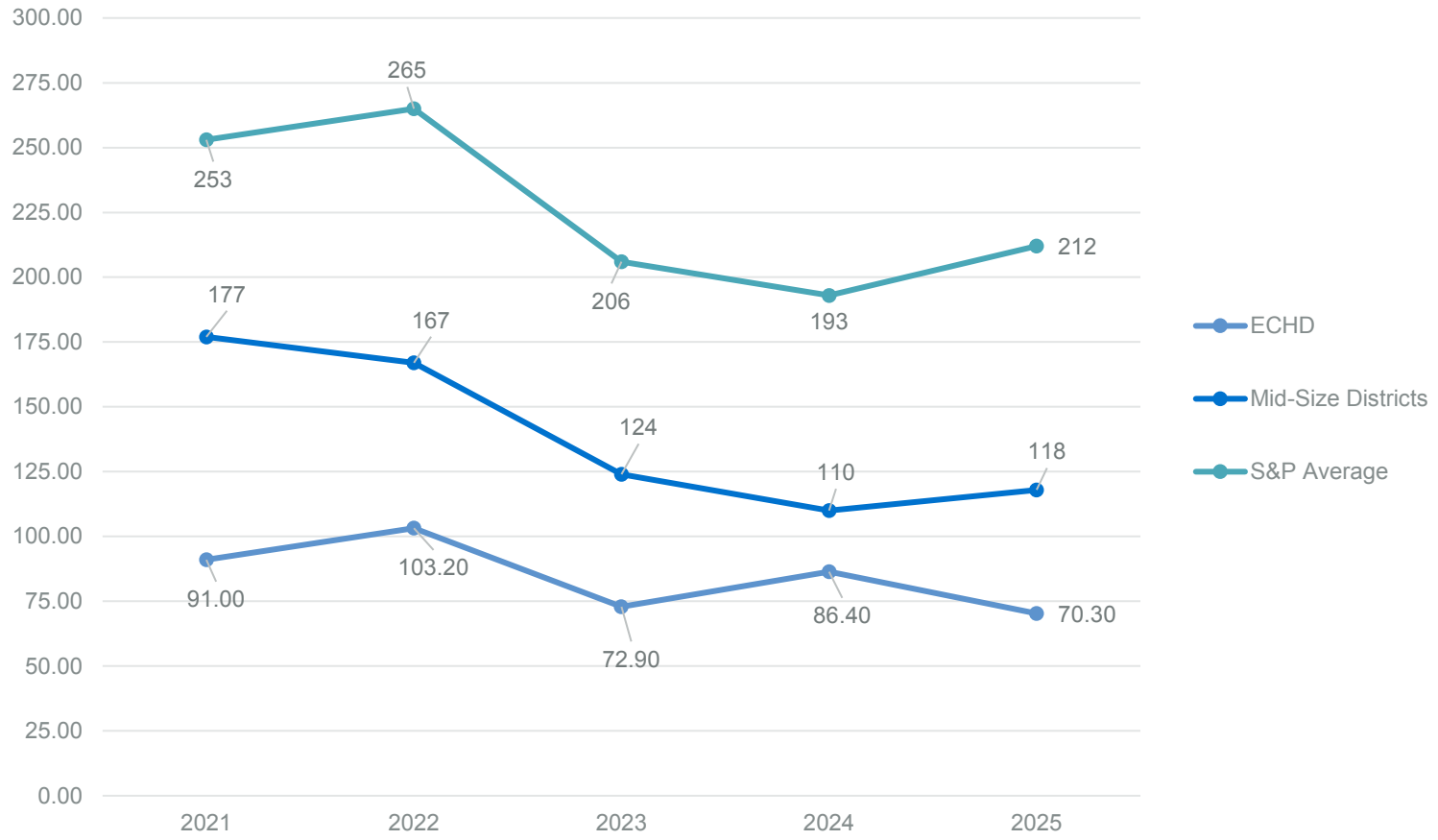
Balance Sheets Assets and Deferred Outflows of Resources (In Thousands)

	2021	2022	2023	2024	2025
Current Assets					
Cash and cash equivalents	$ 51,191	$ 32,038	$ 16,572	$ 39,085	$ 16,902
Patient accounts receivable, net	35,747	29,613	37,854	43,395	39,523
Taxes receivable	8,122	11,105	13,086	11,081	11,616
Other current assets	26,406	20,398	24,466	23,088	29,627
Total current assets	121,466	93,154	91,978	116,649	97,668
Noncurrent Cash and Investments	70,105	74,084	62,493	57,935	64,325
Capital Assets, Net	170,330	162,434	157,769	162,088	159,861
Lease Assets, Net	-	2,188	690	560	114
Subscriptions Assets, Net	-	3,319	5,678	5,661	10,667
Net Pension Asset	-	29,997	-	-	-
Other Assets	5,140	4,955	43,422	56,300	63,698
Deferred Outflows of Resources	29,138	19,348	19,214	10,796	10,255
Total assets and deferred outflows of resources	$396,179	$389,479	$381,244	$409,989	$ 406,588

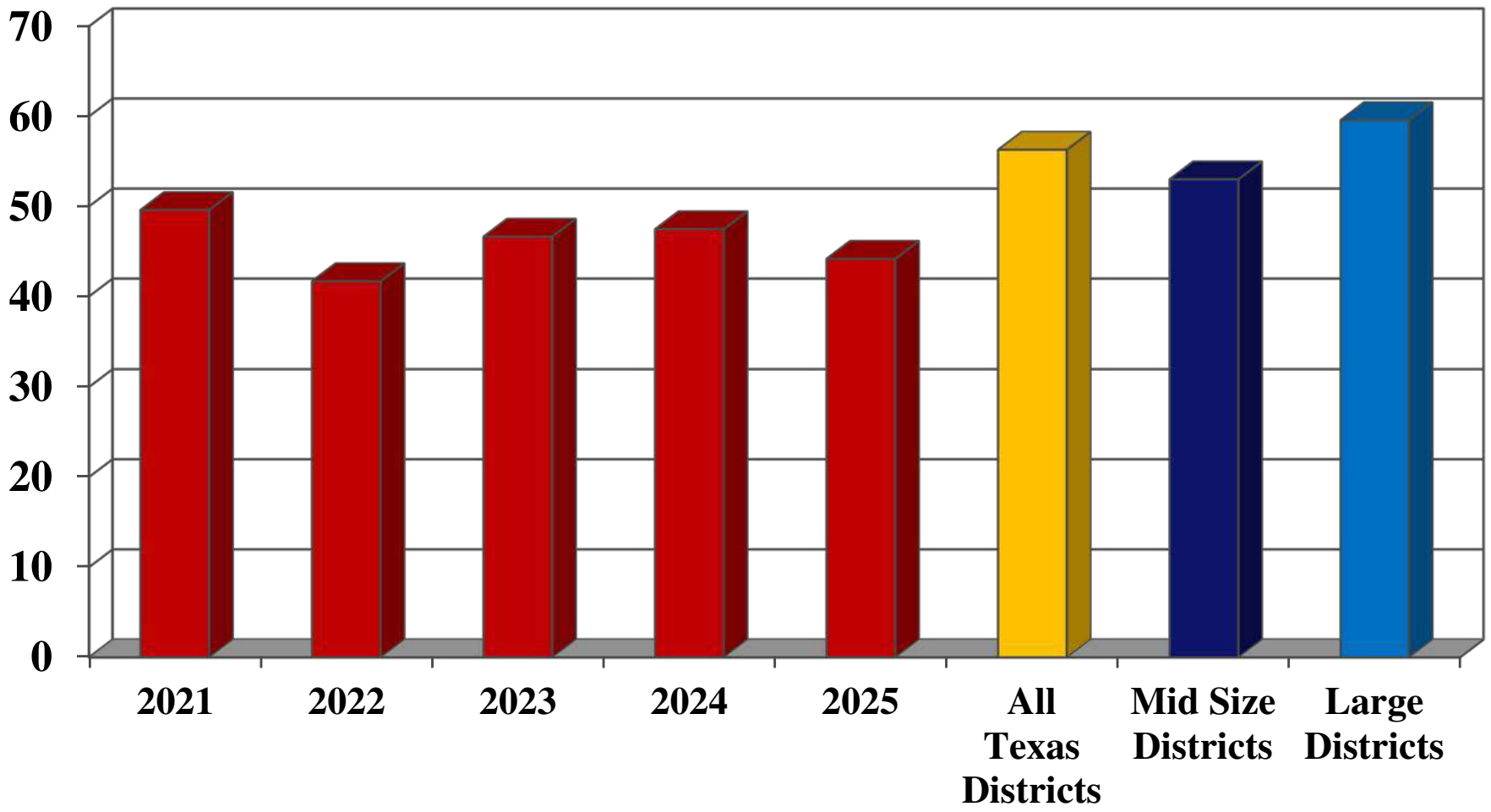
Balance Sheets Liabilities, Deferred Inflows of Resources and Net Position (In Thousands)

	2021	2022	2023	2024	2025
Liabilities					
Medicare advance payments	$ 31,541	$ 16,200	$ -	$ -	$ -
Other current liabililities	36,214	54,211	54,290	64,678	54,480
Long-term debt	39,915	34,999	32,643	36,355	37,155
Net pension liability	44,515	-	44,111	22,207	4,145
OPEB liability	20,950	12,633	9,916	9,381	9,047
Other liabilities	1,793	6,415	7,065	8,772	9,016
	174,928	124,458	148,025	141,393	113,843
Deferred Inflows of Resources	19,386	71,694	7,619	7,209	13,782
Net Position	201,865	193,327	225,600	261,387	278,963
Total liabilities and deferred inflows of resources	$ 396,179	$ 389,479	$ 381,244	$ 409,989	$ 406,588

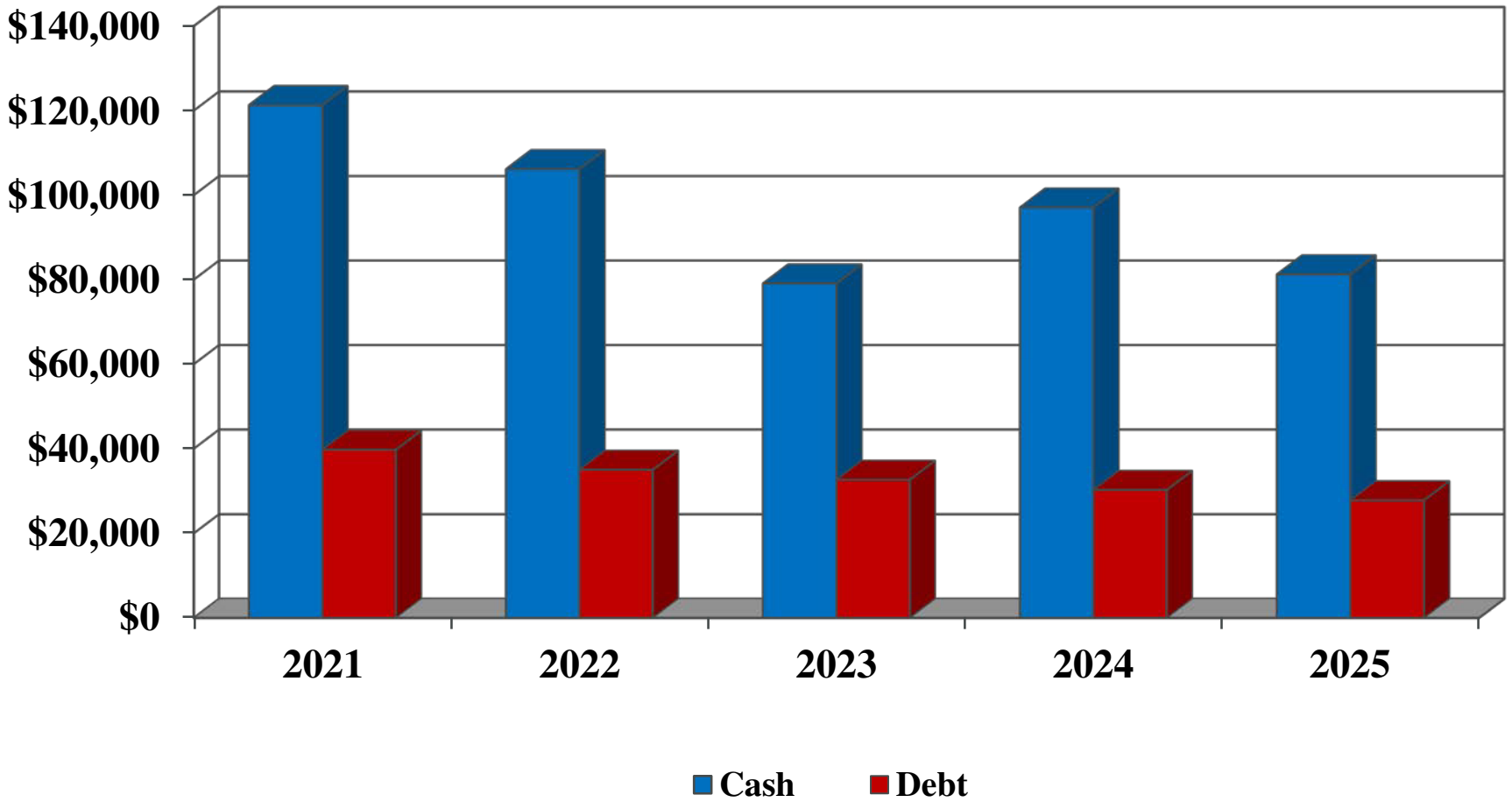
Days Cash on Hand



Days in Accounts Receivable



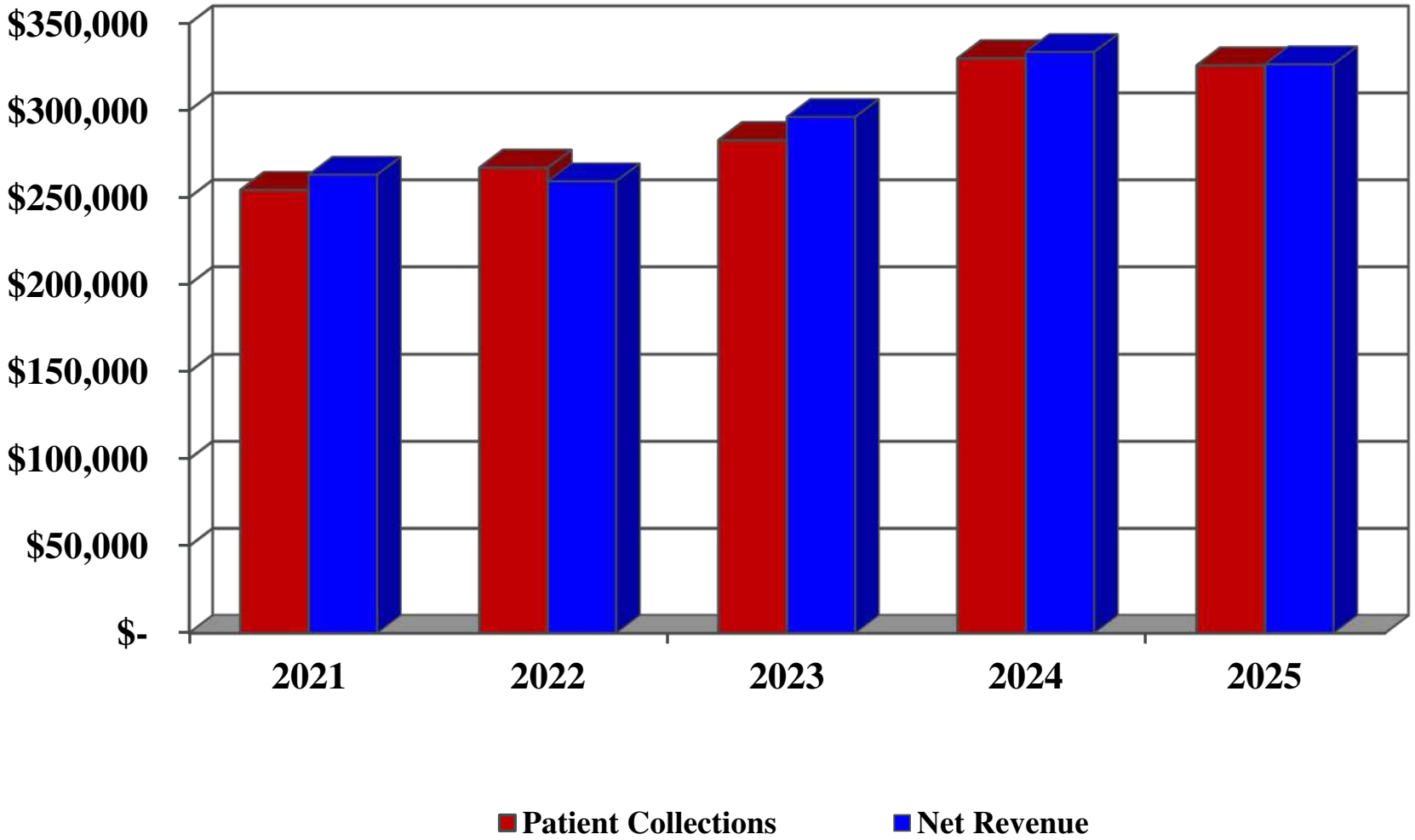
Cash to Long-Term Debt



Statement of Revenues, Expenses and Changes in Net Position (In Thousands)

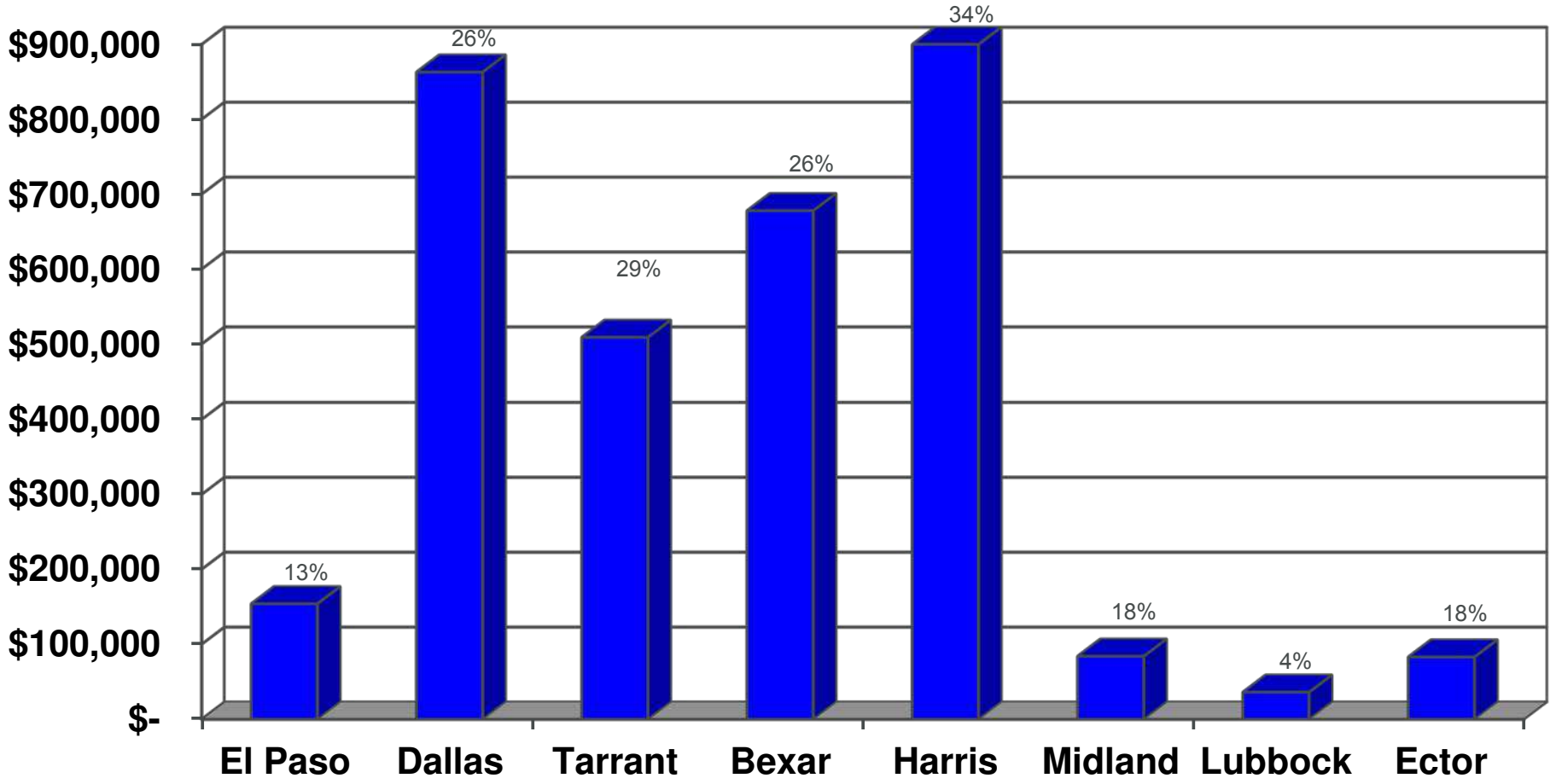
	2021	2022	2023	2024	2025
Net Patient Service Revenue	$ 263,116	$ 259,341	$ 296,335	$ 333,716	$ 326,631
Supplemental Medicaid Funding	42,318	36,496	26,998	24,825	29,427
Other Revenue	11,045	11,966	11,977	12,265	13,419
	316,479	307,803	335,310	370,806	369,477
Expenses					
Salaries and employee benefits	187,358	173,536	209,378	203,727	214,029
Purchased services and pro fees	90,029	115,631	96,680	105,137	104,400
Supplies/other	79,847	85,769	87,166	98,554	103,264
Depreciation and amortization	19,309	19,967	23,749	24,014	25,732
	376,543	394,903	416,973	431,432	447,425
Operating Loss	(60,064)	(87,100)	(87,100)	(60,626)	(77,948)
Tax revenues, net	64,420	77,829	78,171	77,344	83,050
CARES Act/PRF Revenue	23,708	3,114	-	-	-
Other Revenue (Expense)	2,701	(2,389)	35,764	19,070	12,473
Increase (Decrease) in Net Position	$ 30,765	$ (8,546)	$ 26,835	$ 35,788	$ 17,575

Patient Collections VS. Net Revenue

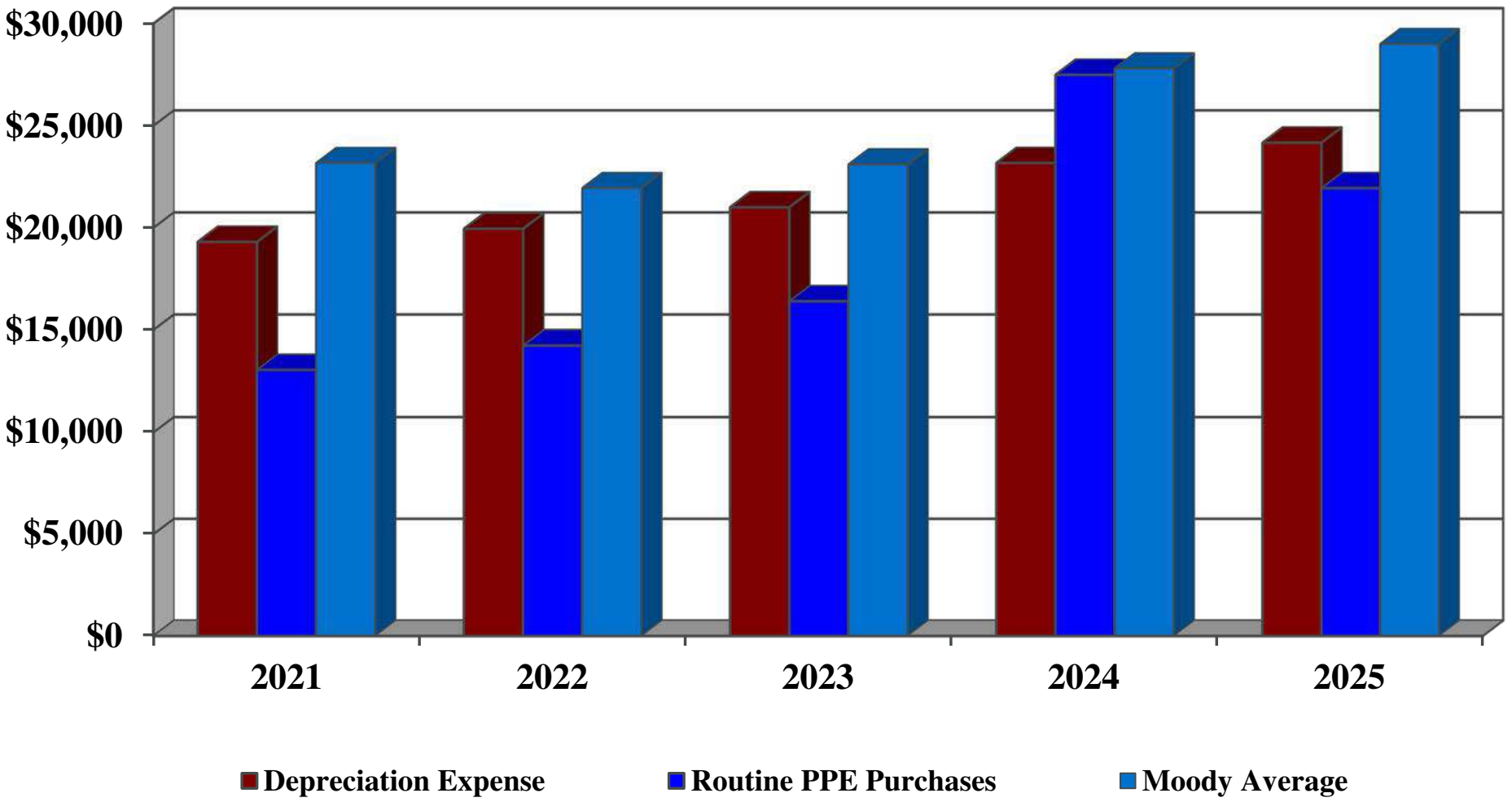


Property Tax Revenue

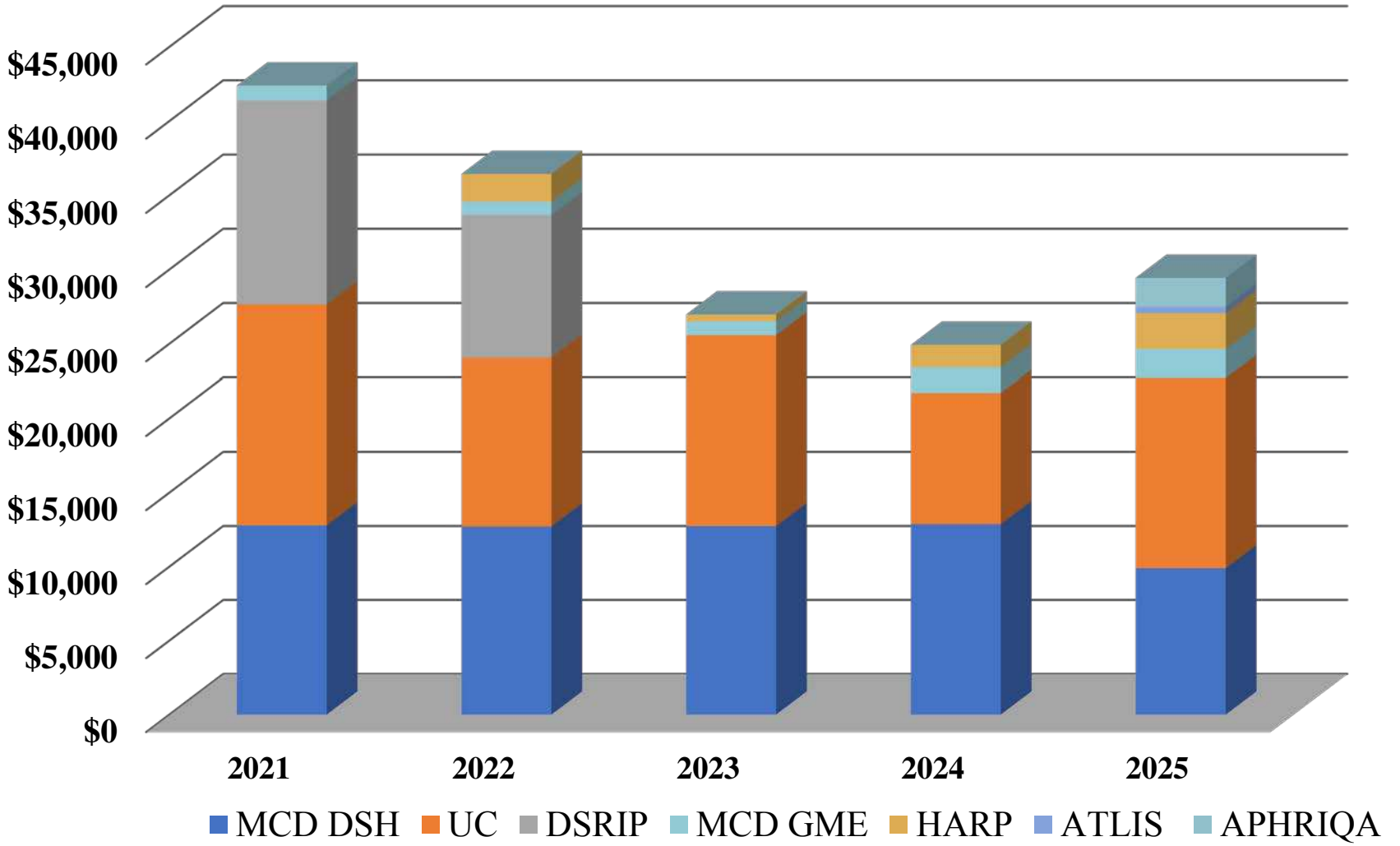
Total Collections and % of Total Revenue



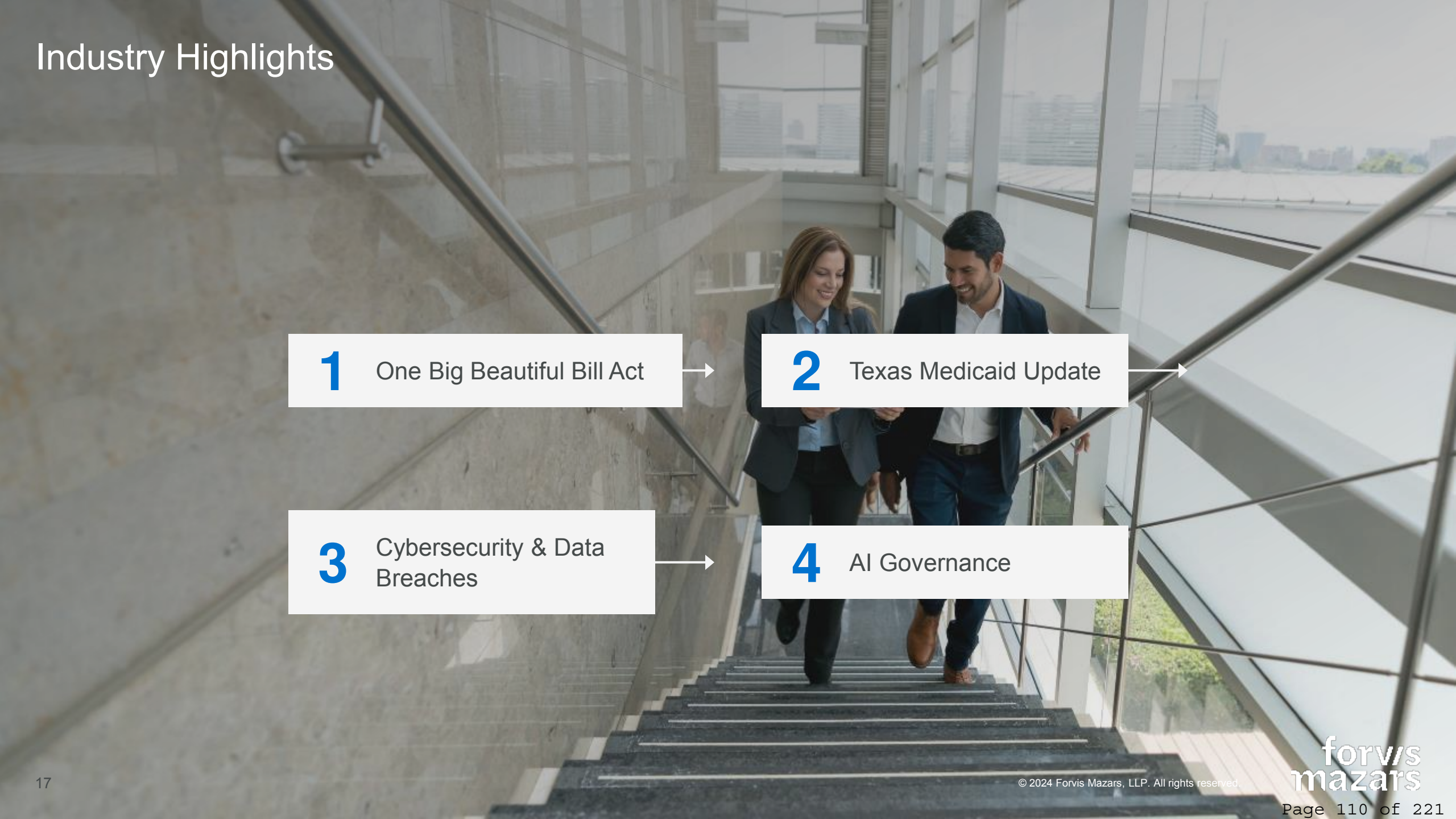
Capital Asset Purchases vs. Depreciation Expense



1115 Waiver Support



Industry Highlights



1 One Big Beautiful Bill Act

2 Texas Medicaid Update

3 Cybersecurity & Data Breaches

4 AI Governance

Upcoming Accounting Standards

Focuses on improving the financial reporting model governmental entities. Its primary objective is to enhance the usefulness, clarity, and consistency of governmental financial statements, making them more effective for decision-making and accountability purposes.

Reported **retroactively** to all periods presented

Effective for the year ending **September 30, 2026**

Questions?

Contact

Forvis Mazars

Thank you!

Danielle Zimmerman, Partner
Danielle.Zimmerman@us.forvismazars.com
972.361.3740

David Harwood, Partner
David.Harwood@us.forvismazars.com
972.898.8878

Representation of:
Ector County Hospital District d/b/a Medical Center Health System
500 W. 4th St.
Odessa, TX 79761-5001

Provided to:
Forvis Mazars, LLP
Certified Public Accountants
14221 North Dallas Parkway, Suite 400
Dallas, TX 75254

The undersigned ("We") are providing this letter in connection with Forvis Mazars' audit of our financial statements as of and for the years ended September 30, 2025 and 2024.

Our representations are current and effective as of the date of Forvis Mazars' report: February 25, 2026.

Our engagement with Forvis Mazars is based on our contract for services dated: May 29, 2025.

Our Responsibility & Consideration of Material Matters

We confirm that we are responsible for the fair presentation of the financial statements subject to Forvis Mazars' report in conformity with accounting principles generally accepted in the United States of America.

We are also responsible for adopting sound accounting policies; establishing and maintaining effective internal control over financial reporting, operations, and compliance; and preventing and detecting fraud.

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement. An omission or misstatement that is monetarily small in amount could be considered material as a result of qualitative factors.

Confirmation of Matters Specific to the Subject Matter of Forvis Mazars' Report

We confirm, to the best of our knowledge and belief, the following:

Broad Matters

1. We have fulfilled our responsibilities, as set out in the terms of our contract, for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America.

2. We acknowledge our responsibility for the design, implementation, and maintenance of:

    a. Internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

    b. Internal control to prevent and detect fraud.

3. We have provided you with:

    a. Access to all information of which we are aware that is relevant to the preparation and fair presentation of the financial statements, such as financial records and related data, documentation, and other matters.

    b. Additional information that you have requested from us for the purpose of the audit.

    c. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

d. All minutes of directors' and committee of directors meetings, held through the date of this letter or summaries of actions of recent meetings for which minutes have not yet been prepared. All unsigned copies of minutes provided to you are copies of our original minutes approved by the board, if applicable, and maintained as part of our records.

e. All significant contracts and grants.

4. We have responded fully and truthfully to all your inquiries.

Misappropriation, Misstatements, & Fraud

5. We have informed you of all current risks of a material amount that are not adequately prevented or detected by our procedures with respect to:

   a. Misappropriation of assets.

   b. Misrepresented or misstated assets, deferred outflows of resources, liabilities, deferred inflows of resources, or net position.

6. We have no knowledge of fraud or suspected fraud affecting the entity involving:

   a. Management or employees who have significant roles in internal control over financial reporting, or

   b. Others when the fraud could have a material effect on the financial statements.

7. We understand that the term “fraud” includes misstatements arising from fraudulent financial reporting and misstatements arising from misappropriation of assets. Misstatements arising from fraudulent financial reporting are intentional misstatements, or omissions of amounts or disclosures in financial statements to deceive financial statement users. Misstatements arising from misappropriation of assets involve the theft of an entity’s assets where the effect of the theft causes the financial statements not to be presented in conformity with accounting principles generally accepted in the United States of America.

8. We have no knowledge of any allegations of fraud or suspected fraud affecting the entity received in communications from employees, former employees, customers, analysts, SEC or other regulators, citizens, suppliers, or others.

9. We have assessed the risk that the financial statements may be materially misstated as a result of fraud and disclosed to you any such risk identified.

Related Parties

10. We have disclosed to you the identity of all of the entity’s related parties and all the related-party relationships of which we are aware.

    In addition, we have disclosed to you all related-party transactions and amounts receivable from or payable to related parties of which we are aware, including any modifications during the year that were made to related-party transaction agreements that existed prior to the beginning of the year under audit, as well as new related-party transaction agreements that were executed during the year under audit.

    Related-party relationships and transactions have been appropriately accounted for and disclosed in accordance with accounting principles generally accepted in the United States of America.

11. We understand that the term <u>related party</u> refers to:

    - Affiliates
    - Entities for which investments are accounted for by the equity method

- Trusts for the benefits of employees, such as pension and profit-sharing trusts that are managed by or under the trusteeship of management
- Principal owners and members of their immediate families
- Management and members of their immediate families
- Any other party with which the entity may deal if one party can significantly influence the management or operating policies of the other to an extent that one of the transacting parties might be prevented from fully pursuing its own separate interests.

Another party is also a related party if it can significantly influence the management or operating policies of the transacting parties or if it has an ownership interest in one of the transacting parties and can significantly influence the other to an extent that one or more of the transacting parties might be prevented from fully pursuing its own separate interests.

The term affiliate refers to a party that directly or indirectly controls, or is controlled by, or is under common control with, the entity.

Litigation, Laws, Rulings, & Regulations

12. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with accounting principles generally accepted in the United States of America.

13. We have no knowledge of communications, other than those specifically disclosed, from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations, deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

14. We have disclosed to you all known instances of violations or noncompliance or possible violations or suspected noncompliance with laws and regulations whose effects should be considered when preparing financial statements or as a basis for recording a loss contingency.

15. We have no reason to believe the entity owes any penalties or payments under the Employer Shared Responsibility Provisions of the *Patient Protection and Affordable Care Act*, nor have we received any correspondence from the IRS or other agencies indicating such payments may be due.

16. We have not been designated as a potentially responsible party (PRP or equivalent status) by the Environmental Protection Agency (EPA) or other cognizant regulatory agency with authority to enforce environmental laws and regulations.

Nonattest Services

17. You have provided nonattest services, including the following, during the period of this engagement:

    - Preparing a draft of the financial statements and related notes and supplementary information
    - Preparation of the Medicare/Medicaid cost reports
    - Assistance with the completion of the Leasecrunch tool

18. With respect to these services:

    a. We have designated a qualified management-level individual to be responsible and accountable for overseeing the nonattest services.

    b. We have established and monitored the performance of the nonattest services to ensure they meet our objectives.

    c. We have made any and all decisions involving management functions with respect to the nonattest services and accept full responsibility for such decisions.

    d. We have evaluated the adequacy of the services performed and any findings that resulted.

    e. We have established and maintained internal controls, including monitoring ongoing activities.

    f. When we receive final deliverables from you, we will store those deliverables in information systems controlled by us. We have taken responsibility for maintaining internal control over these deliverables.

Financial Statements & Reports

19. We have reviewed and approved a draft of the financial statements and related notes referred to above, which you prepared in connection with your audit of our financial statements. We acknowledge that we are responsible for the fair presentation of the financial statements and related notes.

20. The entity has revised the 2025 financial statements to conform with accounting principles generally accepted in the United States of America. Management has provided you with all relevant information regarding the revision. We are not aware of any other known matters that required correction in the financial statements.

21. We acknowledge our responsibility for presenting the supplementary information in accordance with accounting principles generally accepted in the United States of America, and we believe the supplementary information, including its form and content, is fairly presented in accordance with accounting principles generally accepted in the United States of America.

22. We do not issue an annual report, nor do we have plans to issue an annual report at this time.

Transactions, Records, & Adjustments

23. All transactions have been recorded in the accounting records and are reflected in the financial statements.

24. The entity has appropriately reconciled its general ledger accounts to their related supporting information. All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the financial statements. All intracompany (and intercompany) accounts have been eliminated or appropriately measured and considered for disclosure in the financial statements.

25. We have everything we need to keep our books and records.

26. We have disclosed any significant unusual transactions the entity has entered into during the period, including the nature, terms, and business purpose of those transactions.

27. We are in agreement with the adjusting journal entries you have proposed, and they have been posted to the entity's accounts.

28. We believe the effects of the uncorrected financial statement misstatement(s) and omitted disclosures summarized in the attached schedule and aggregated by you during the current engagement are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Healthcare Matters

29. We have provided you with all peer review organizations, administrative contractor, and third-party payer reports and information.

30. We have informed you of all pending or completed investigations by regulatory authorities of which we are aware. There are no known circumstances that could jeopardize the entity's participation in the Medicare or other governmental healthcare programs.

31. Adequate provisions and allowances have been accrued for any material losses from Medicare/Medicaid and other third-party payer contractual, audit, or other adjustments.

32. With respect to the entity's possible exposure to past or future medical malpractice assertions:

    a. We have disclosed to you all incidents known to us that could possibly give rise to an assertion of malpractice.

    b. All known incidents have been reported to our actuarial consultants and are appropriately considered in our malpractice liability accrual. Any claims that should be reported to our excess liability carrier have been reported.

    c. There is no known lapse in coverage, including any lapse subsequent to the fiscal year-end, that would result in any known incidents being uninsured above our customary self-insured retention amounts.

    d. Management does not expect any claims to exceed any applicable excess policy malpractice insurance limits.

    e. We believe our accruals for uninsured malpractice claims are sufficient for all known and any probable potential claims.

    f. We have reviewed the assumptions used by our actuarial consultant to estimate our self-insured accrual and believe those assumptions are appropriate.

33. Billings to third-party payers comply in all material respects with applicable coding guidelines, laws, and regulations. Billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies, if required; and properly rendered.

34. With regard to cost reports filed with Medicare, Medicaid, or other third parties:

    a. All required reports have been properly filed.

    b. Management is responsible for the accuracy and propriety of those reports.

    c. All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payers.

    d. The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

    e. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the cost report.

    f. Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based upon historical experience or new or ambiguous regulations that may be subject to differing interpretations. While

management believes the entity is entitled to all the amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate.

35. With respect to the entity's possible exposure to past or future workers' compensation assertions:

    a. We have disclosed to you all incidents known to us that could possibly give rise to workers' compensation assertion.

    b. All known incidents have been reported to the appropriate workers' compensation insurer.

    c. Management does not expect any claims to exceed workers' compensation insurance limits.

36. There are no instances of noncompliance with laws or regulations with respect to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects we believe should be considered for disclosure in the financial statements or as a basis for recording a loss contingency, other than those disclosed or accrued in the financial statements. This is including, but not limited to, the Anti-Kickback Statute of the *Medicare and Medicaid Patient and Program Protection Act of 1987*, limitations on certain physician referrals (the Stark law), and the *False Claims Act*.

Governmental Accounting & Disclosure Matters

37. With regard to deposit and investment activities:

    a. All deposit, repurchase and reverse repurchase agreements, and investment transactions have been made in accordance with legal and contractual requirements.

    b. Investments, derivative instrument transactions, and land and other real estate held by endowments are properly valued.

    c. Disclosures of deposit and investment balances and risks in the financial statements are consistent with our understanding of the applicable laws regarding enforceability of any pledges of collateral.

    d. We understand that your audit does not represent an opinion regarding the enforceability of any collateral pledges.

    e. Risk disclosures associated with deposit and investment securities transactions are presented in accordance with Governmental Accounting Standards Board (GASB) requirements.

38. The financial statements include all component units, appropriately present majority equity interests in legally separate organizations and joint ventures with an equity interest, and properly disclose all other joint ventures and other related organizations.

39. We have identified and evaluated all potential fiduciary activities. The financial statements include all fiduciary activities required by GASB Statement No. 84, *Fiduciary Activities*, as amended.

40. Components of net position (net investment in capital assets, restricted, and unrestricted) and classifications of fund balance (nonspendable, restricted, committed, assigned, and unassigned) are properly classified and, if applicable, approved.

41. Capital assets, including infrastructure and intangible assets, are properly capitalized, reported, and, if applicable, depreciated or amortized.

42. Leases have been properly identified, recorded, and disclosed in accordance with GASB Statement No. 87, *Leases*.

43. Public-private and public-public partnerships (PPP) and availability payment arrangements (APAs) have been properly identified, recorded, and disclosed in accordance with GASB Statement No. 94, *Public-Private and Public-Public Partnerships and Availability Payment Arrangements*.

44. Subscription-based information technology arrangements (SBITA) have been properly identified, recorded, and disclosed in accordance with GASB Statement No. 96, *Subscription-Based Information Technology Arrangements*.

45. The government has properly measured, recorded, and disclosed compensated absences and other salary-related payments in accordance with GASB Statement No. 101, *Compensated Absences*.

46. We have identified and evaluated all potential tax abatements, and we believe there are no material tax abatements.

47. The supplementary information required by GASB, consisting of management's discussion and analysis and pension information, has been prepared and is measured and presented in conformity with the applicable GASB pronouncements, and we acknowledge our responsibility for the information. The information contained therein is based on all facts, decisions, and conditions currently known to us and is measured using the same methods and assumptions as were used in the preparation of the financial statements. We believe the significant assumptions underlying the measurement and/or presentation of the information are reasonable and appropriate. There has been no change from the preceding period in the methods of measurement and presentation.

48. With regard to pension and other postemployment benefits (OPEB):

    a. We believe the actuarial assumptions and methods used to measure pension and OPEB liabilities and costs for financial accounting purposes are appropriate in the circumstances.

    b. We have provided you with the entity’s most current pension and OPEB plan instrument for the audit period, including all plan amendments.

    c. The participant data provided to you related to pension and OPEB plans are true copies of the data submitted or electronically transmitted to the plan’s actuary.

    d. The participant data that we provided the plan’s actuary for the purposes of determining the actuarial present value of accumulated plan benefits and other actuarially determined amounts in the financial statements were complete.

Nonprofit Accounting & Disclosure Matters

49. We are an entity exempt from income tax under Section 501(c) of the Internal Revenue Code and a similar provision of state law and, except as disclosed in the financial statements, there are no activities that would jeopardize our tax-exempt status or subject us to income tax on unrelated business income or excise tax on prohibited transactions and events.

Accounting & Disclosure

50. All transactions entered into by the entity are final. We are not aware of any unrecorded transactions, side agreements or other arrangements (either written or oral) that are in place.

51. Except as reflected in the financial statements, there are no:

    a. Plans or intentions that may materially affect carrying values or classifications of assets, deferred outflows of resources, liabilities, deferred inflows of resources, or net position.

    b. Material transactions omitted or improperly recorded in the financial records.

    c. Material unasserted claims or assessments that are probable of assertion or other gain/loss contingencies requiring accrual or disclosure, including those arising from environmental remediation obligations.

    d. Events occurring subsequent to the balance sheet date through the date of this letter, which is the date the financial statements were available to be issued, requiring adjustment or disclosure in the financial statements.

    e. Agreements to purchase assets previously sold.

    f. Arrangements with financial institutions involving compensating balances or other arrangements involving restrictions on cash balances, lines of credit, or similar arrangements.

    g. Guarantees, whether written or oral, under which the entity is contingently liable.

    h. Known or anticipated asset retirement obligations.

52. Except as disclosed in the financial statements, the entity has:

    a. Satisfactory title to all recorded assets, and those assets are not subject to any liens, pledges, or other encumbrances.

    b. Complied with all aspects of contractual agreements for which noncompliance would materially affect the financial statements.

53. We agree with the findings of specialists in evaluating the certain accruals and have adequately considered the qualification of the specialists in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had impact on the independence or objectivity of the specialists.

Revenue, Accounts Receivable, & Inventory

54. Adequate provisions, allowances, or other adjustments in basis have been recorded for any material losses from uncollectible receivables.

Estimates

55. We have identified all accounting estimates that could be material to the financial statements and we confirm the appropriateness of the methods and the consistency in their application, the accuracy and completeness of data, and the reasonableness of significant assumptions used by us in making the accounting estimates, including those measured at fair value reported in the financial statements.

56. Significant estimates that may be subject to a material change in the near term have been properly disclosed in the financial statements. We understand that “near term” means the period within one year of the date of the financial statements. In addition, we have no knowledge of concentrations, which refer to a lack of diversity related to employers, industries, inflows of resources, workforce covered by collective bargaining agreements, providers of financial resources, or suppliers of material, labor or services revenues, available sources of supply, investments, or constraints, which refer to a limitation imposed by an external party or by formal

action of a government's highest level of decision-making authority related to limitations on raising revenue, limitations on spending, limitations on the incurrence of debt, or mandated spending, existing at the date of the financial statements that would make the entity vulnerable to the risk of severe impact in the near term that have not been properly disclosed in the financial statements.

Fair Value

57. With respect to the fair value measurements of financial and nonfinancial assets and liabilities, if any, recognized in the financial statements or disclosed in the notes thereto:

    a. The underlying assumptions are reasonable and they appropriately reflect management's intent and ability to carry out its stated course of action.

    b. The measurement methods and significant assumptions used in determining fair value are appropriate in the circumstances for financial statement measurement and disclosure purposes and have been consistently applied.

    c. The significant assumptions appropriately reflect market participant assumptions.

    d. The disclosures related to fair values are complete, adequate, and in conformity with accounting principles generally accepted in the United States of America.

    e. There are no subsequent events that require adjustments to the fair value measurements and disclosures included in the financial statements.

Tax-Exempt Bonds

58. Tax-exempt bonds issued have retained their tax-exempt status.

59. We have notified you of any instances of noncompliance with applicable disclosure requirements of the SEC Rule 15c2-12 and applicable state laws.

GASB Statement 101, Compensated Absences

60. In connection with the adoption of GASB Statement No. 101, *Compensated Absences*, we represent that we have evaluated all paid time off programs for consideration and do not believe the adoption of GASB 101 to be material.

Other Matters

61. We acknowledge all federal and state awards expended during the year did not meet the threshold to require a single audit.

_____
Russell Tippin, Chief Executive Officer
rtippin@echd.org

_____
Sharon Clark, Chief Financial Officer
sclark@echd.org

Ector County Hospital District

Period Ending: September 30, 2025

ATTACHMENT

This analysis and the attached "Schedule of Uncorrected Misstatements (Adjustments Passed)" reflect the effects on the financial statements if the uncorrected misstatements identified were corrected.

QUANTITATIVE ANALYSIS

	Before Misstatements	Misstatements	Subsequent to Misstatements	% Change
Current Assets	97,668,660	1,551,672	99,220,332	1.59%
Non-Current Assets & Deferred Outflows	298,665,037		298,665,037	
Current Liabilities	(66,571,326)		(66,571,326)	
Non-Current Liabilities & Deferred Inflows	(50,799,560)		(50,799,560)	
Current Ratio	1.467		1.490	1.57%
Total Assets & Deferred Outflows	396,333,697	1,551,672	397,885,369	0.39%
Total Liabilities & Deferred Inflows	(117,370,886)		(117,370,886)	
Total Net Position	(278,962,811)	(1,551,672)	(280,514,483)	0.56%
Operating Revenues	(369,476,597)	(1,551,672)	(371,028,269)	0.42%
Operating Expenses	447,424,989		447,424,989	
Nonoperating (Revenues) Exp	(95,523,794)		(95,523,794)	
Change in Net Position	(17,575,402)	(1,551,672)	(19,127,074)	8.83%

Client: Ector County Hospital District
Period Ending: September 30, 2025

Major Enterprise Fund

SCHEDULE OF UNCORRECTED MISSTATEMENTS (ADJUSTMENTS PASSED)

Description	Financial Statement Line Item	Factual (F), Judgmental (J) or Projected (P)	Assets & Deferred Outflows		Liabilities & Deferred Inflows		Operating Revenues	Operating Expenses	Nonoperating (Revenues) Exp	Net Position	Net Effect on Following Year	
			Current	*Noncurrent*	*Current*	*Noncurrent*					*Change in Net Position*	*Net Position*
			DR (CR)	DR (CR)	DR (CR)	DR (CR)	DR (CR)	DR (CR)	DR (CR)	DR (CR)	DR (CR)	DR (CR)
Client proposed APHRIQA revenue received subsequent to year end		F	2,910,696	0	0	0	(2,910,696)	0	0	0	2,910,696	(2,910,696)
	Estimated amounts due from third-party payors		2,910,696									
	Supplemental Medicaid funding revenue						(2,910,696)				2,910,696	(2,910,696)
To reduce cost report receivable		F	(1,359,024)	0		0	1,359,024		0	0		
	Estimated amounts due from third-party payors		(1,359,024)									
	Net patient service revenue						1,359,024				(1,359,024)	1,359,024
Total passed adjustments			1,551,672	0	0	0	(1,551,672)	0	0	0	1,551,672	(1,551,672)

Impact on Change in Net Position	**(1,551,672)**
Impact on Net Position	**(1,551,672)**

Medical Center Health System
Emergency Management Plan 2026 Annual Evaluation

Purpose

The purpose of this document is to evaluate the scope, objectives and effectiveness of the above-referenced plan.

Scope

This is a Medical Center Health System plan that incorporates all services and sites of care provided by the organization and includes Continued Care Hospital located at Medical Center Hospital. This plan applies to staff, licensed independent practitioners, contract workers, and others as appropriate and indicated throughout this document. MCHS uses the calendar year for full-scale exercises.

Objectives

The specific objectives of the Emergency Management Plan are determined by Medical Center Health System. Objectives are specific targets identified by the organization to reduce the risks associated with large and small disaster events. Current objectives are:

- Employ an all-hazards risk-based approach to mitigate, prepare, respond, and recover, from emergencies that overwhelm normal operations of the Health System.
- Support Health System understanding and utilization of the Incident Command System/National Incident Management.
- Continually develop and enhance disaster capabilities through preparing, training, and exercising.
- Address and plan for continuity of operations and sustainability in all practices.
- Work with regional planning partners to ensure seamless operations during any catastrophic event.
- Establish redundant communications within the hospital as well as throughout the community.
- Establish memorandums of understanding with vendors in all areas of the hospital to ensure the best possible care during a catastrophic event.

Evaluation of Plan

Annual evaluation objectives are developed through interactions with the EOC Committee and Hospital administration. Objectives will be developed based on review of data and performance indicators. Any changes in objectives will be addressed during the Annual evaluation and

incorporated into the updated plan. These objectives will address the primary operational initiatives for maximizing safety and minimizing risk at MCHS.

Performance Indicators

Goals for 2025

2025 Goals	Evaluation
QAPI: Increase the awareness and preparedness for an I.T. utility failure throughout the health system by Education, training, and a full-scale exercise with the entire system, documentation will be presented to the QAPI committee quarterly	This goal was not met and it was recommended by the QAPI team to find a different goal
• Creating the Multi-year drill planning document by meeting with departments that need specific elements in drills (i.e. trauma) and plan with outside agencies to continue the relationship • Design training and education specific to each department in the house and deploy the creation by meeting with department directors on the needs of each department and ensuring the training and elements coincide with the year's drill scenario	This goal was met with strategic planning for future drills and needed education related to changes in the HVA.

Evaluation of Effectiveness

Based on the performance indicators noted above, the Safety Management Plan is effective in meeting its stated goals.

Performance Indicators

Goals for 2026

2026 Goals	Action Plan

For community involvement drills, get the participation of 2 or more new community partners to participate.	Engage with the Odessa Fire and Rescue for other companies in Ector County that are required to put on disaster drills for TCEQ and other organizations, to broaden our relationships and awareness of the possible hazards in our community.

Medical Center Health System
Hazardous Materials (HAZMAT) Management Plan
2025 Annual Evaluation

Purpose

The purpose of this document is to evaluate the scope, objectives and effectiveness of the above referenced plan.

Scope

The Hazardous Materials and Waste Management Plan describes the risks and daily management activities put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and visitors, coming to the organization. The Hazardous and Waste Management Program is based on applicable laws, regulations, and accreditation standards and designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services.

This plan covers activities performed in the various locations of the organization, including the hospital and hospital-based clinic operations of Medical Center Health System.

Objectives

The objectives of the Hazardous Materials and Waste Management Plan include:

- Comply with standards and regulation pertaining to hazardous materials and waste
- Develop and enforce current hazardous materials and waste practices for patients, staff, students and visitors
- Provide hazardous materials and waste education and training as appropriate
- Identify and implement opportunities to improve hazardous materials and waste management

Evaluation of Plan

Annual evaluation objectives are developed through interactions with the EOC Committee and Hospital administration. Objectives will be developed based on a review of data and performance indicators. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan. These objectives will address the primary operational initiatives for minimizing the risk associated with the use of hazardous materials.

Performance Indicators

Goals for 2025

2025 Goal	Evaluation
QAPI: increasing hand sanitizer compliance from 94% to 96% but physically auditing hand sanitizer so product is always available	**This goal was met and completed.**
• Enhance SDS data program in the hospital by Determine if a software upgrade is necessary and a clean-up of the software • Continue gas cylinder revamping program by Reducing the amount of gas cylinders in the organization, removing bottles that are not in use, ensuring all signage is up to date and present, and weekly rounding	Software upgrade was completed and user friendly education is being prepared for the staff members on the use of the SDS software and location. Changes have been made in the world of gas cylinders including reducing PAR level throughout the house to decrease the opportunity for the tank to be placed incorrectly. Signage has been replaced and updated as well.

Evaluation of Effectiveness

Based on the performance indicators noted above, the Hazardous Material Management Plan is effective in meeting its stated goals.

Performance Indicators

Goals for 2026

2026 Goal	Action Plan
Monitor and improve the cleanliness of the back dock area, increasing compliance to >90% by 12/31/2026	Developing a weekly check sheet, monthly powerwashing, and continuing to work with the City of Odessa on the types of dumpsters that are available and the periodicity of the pick up.

Medical Center Health System
Life Safety Management Plan 2025 Annual Evaluation

Purpose

The purpose of this document is to evaluate the scope, objectives and effectiveness of the above referenced plan.

Scope

Objectives

The objectives of the Life Safety Management Plan include:

- Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.
- Conduct required fire drills in all buildings of Medical Center Health System housing patient care services.
- Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
- Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2000 edition of the *Life Safety Code.*
- Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

Evaluation of Plan

Annual evaluation objectives are developed through interactions with the EOC Committee and Hospital administration. Objectives will be developed based on review of data and performance indicators. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan. These objectives will address the primary operational initiatives for minimizing the risk associated with life and fire safety.

Performance Indicators

2025 Goal Performance	Evaluation
• Conduct quarterly mock surveys to identify gaps in compliance by performing Mock surveys with engineering department to ensure that all of the life safety documentation is appropriately gathered and available	• Mock surveys were completed twice in the 2024-2025 fiscal year. Several findings were noted and corrected as well as documentation and management plans were thoroughly assessed and strengthened

Evaluation of Effectiveness

Based on the performance indicators noted above, the Life Safety Management Plan is effective in meeting its stated goals.

Performance Indicators

2026 Goal	Action Plan
• Create one event/game per quarter to engage the employees in fire safety and increase awareness and acknowledgement of surroundings in MCH and the fire suppression system components.	• Work through the department director's meetings to push out the education to all staff members on the awareness of their departments. Utilizing games like scavenger hunts, crossword puzzles and other engaging fun items.

Medical Center Health System
Safety Management Plan 2025 Annual Evaluation

Purpose

The purpose of this document is to evaluate the scope, objectives and effectiveness of the above referenced plan.

Scope

The Safety Management Plan at Medical Center Health System applies to all facilities and to all safety processes, activities, departments, structures and grounds as well as patients, staff, students, and visitors. The Safety Management Plan addresses all elements required to provide a safe and healthy environment free of hazards and to collaborate with department management to provide staff training and monitoring in order to minimize the risk of injuries.

Objectives

The objectives of the Safety Management Plan include:

- Comply with all relevant safety standards and regulations.
- Enforce current safety practices for patients, staff, students, and visitors.
- Provide regular safety education to all staff.
- Monitor the effectiveness of the safety program.
- Identify opportunities and to improve safety performance and develop and implement improvements.

Evaluation of Plan

Annual evaluation objectives are developed through interactions with the EOC Committee and Hospital administration. Objectives will be developed based on review of data and performance indicators. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan. These objectives will address the primary operational initiatives for maximizing safety and minimizing risk at MCHS.

Performance Indicators

Goals for 2025

2025 Goal	Evaluation
Elevate our air pressure relations program to include all rooms that require negative or positive pressure to regulations and requirements by Adding monitoring devices to assist clinical staff to make better judgements on patient safety in rooms and Rounding for audits on the monitoring systems and staff behaviors related to these specials rooms	• this goal was met after we added all of the needed equipment to the rooms that were lacking monitoring as well as educating the nursing staff on the perimeters of the isolation room (red and green lights on monitors) to determine if the room is safe for a infectious patients

Evaluation of Effectiveness

Based on the performance indicators noted above, the Safety Management Plan is effective in meeting its stated goals.

Performance Indicators

Goals for 2026

2026 Goal	Action Plan
Conduct rounds weekly, evaluating at least 2-3 departments per week to achieve > 90% compliance for all physical environment standards.	Utilizing the Sentact system to provide real-time data for findings and look closures.

Medical Center Health System
Utility Management Plan 2025 Annual Evaluation

Purpose

The purpose of this document is to evaluate the scope, objectives and effectiveness of the above referenced plan.

Scope

The Utility Systems Management Plan and programs apply to all facilities, Main Hospital Campus, FHC, Urgent Care Sites and to all processes, activities and departments, as well as to patients, staff, and visitors at Medical Center Health System.

All critical elements of the utility systems used for life support, infection control, environmental support, equipment support, and communications will be included in the program. The Utility Systems Management Plan addresses the safe operation, maintenance, and emergency response procedures for these critical operating systems. Utilities include systems for electrical distribution, emergency power, heating, ventilating, and air conditioning, plumbing, boiler and steam, medical gas, medical/surgical vacuum, and communication systems.

Objectives

The objectives of the Utility Systems Management Plan include:

- Comply with all relevant safety standards and regulations.
- Provide a safe, controlled, and comfortable environment for patients, staff, and visitors.
- Ensure the operational reliability of the utility systems:
    - Direct Life Support systems
    - Infection Control systems
    - Non-Life Support utility support systems
- Reduce the potential for hospital-acquired illness.
- Assess special risks of the utility systems.
- Provide a plan for response to utility systems failures.

- Effect essential coordination for scheduled utility systems interruptions.
- Establish and maintain a program of policies and procedures consistent with the organization's mission, vision, and values.
- Enhance of maintenance of the utility systems to reduce and minimize system failures and/or interruptions.

Evaluation of Plan

Annual evaluation objectives are developed through interactions with the EOC Committee and Hospital administration. Objectives will be developed based on review of data and performance indicators. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan. These objectives will address the primary operational initiatives for minimizing the risk associated with utility safety.

Performance Indicators

Goals for 2025

Goal 2025	Evaluation
QAPI: Increase the compliance of pressure relations rooms from current to 95% compliance by Utilizing weekly team rounding, improving the documentation and tracking, installing more continuous monitoring equipment, and having third party vendors onsite	**This goal was completed and will continue to be monitored through leadership and the infection prevention committee.**
Develop and implement a program designed to monitor all major utilities up time and costs related to maintenance and upkeep by creating a list of all major utilizes, creating a graph to display uptime versus downtime, and align costs with equipment to monitor all dollars spent on each piece of equipment	This goal was not met and will continue into 2026 through the partnership with ENFRA.

Evaluation of Effectiveness

Based on the performance indicators noted above, the Utility Management Plan is effective in meeting its stated goals.

Performance Indicators

Goals for 2026

Goal 2026	Action Plan
Develop and implement a program designed to monitor all major utilities up time and costs related to maintenance and upkeep by creating a list of all major utilizes, creating a graph to display uptime versus downtime, and align costs with equipment to monitor all dollars spent on each piece of equipment	Through the partnership with ENFRA, we are hoping to complete this goal in 2026.

Medical Center Health System
Facility Management Plan 2025 Annual Evaluation

Review and Update in Accordance with Latest DNV Standards

Purpose of the Annual Evaluation

The purpose of this annual evaluation is to systematically review the Facility Management Plan for Medical Center Hospital (MCH), ensuring that all elements of the plan are effective in maintaining a safe, well-functioning physical environment for patient care. This evaluation is designed to measure performance, identify areas for improvement, and confirm adherence to newly released DNV standards and other regulatory requirements.

Scope

This evaluation applies to all facilities covered by the Facility Management Plan, including the Main Hospital Campus, Family Health Center (FHC), and Urgent Care Sites. The assessment encompasses all aspects of design, maintenance, testing, and inspection of infrastructure and equipment within these sites.

Objectives Identified

- Maintain safe and adequate facilities for the delivery of patient care services.
- Adopt and adhere to the Life Safety Code (NFPA 101 and applicable amendments).
- Develop and implement effective policies and procedures that support a safe environment.
- Sustain an organization-wide process for evaluating and responding to unfavorable events related to the physical environment.

Evaluation of the Plan

The Facility Management Plan has been thoroughly reviewed and updated in accordance with the latest DNV standards, ensuring alignment with current best practices and regulatory expectations. Construction criteria, maintenance schedules, testing protocols, and inspection procedures were examined for completeness and efficacy. Policies and procedures were cross-referenced with DNV requirements to verify compliance and operational integrity. The plan's organizational oversight mechanisms were assessed for capacity to monitor, report, and respond to risks or adverse outcomes.

Performance Indicators

The following performance indicators were tracked during the evaluation period:

- Completion rate of scheduled maintenance and inspections
- Number of reportable adverse events or safety incidents related to the physical environment
- Timeliness of corrective actions following unfavorable events
- Compliance with Life Safety Code (NFPA 101) and DNV standards
- Staff training and competency assessments regarding facility policies and procedures

Evaluation of Effectiveness

Based on the analysis of performance indicators and organizational outcomes, the Facility Management Plan has demonstrated substantial effectiveness in achieving its stated objectives. Facilities were maintained at safe and adequate standards, and instances of adverse patient outcomes related to environmental factors have been minimized or swiftly addressed. The organization's process for monitoring and evaluating unfavorable events was found to be robust and responsive. Improvements were made where gaps were identified, and the incorporation of updated DNV standards has further strengthened the plan's regulatory compliance and operational excellence.

Conclusion:

This annual evaluation confirms that the Facility Management Plan is a living document supporting continuous improvement, safety, and regulatory alignment. The recent review and updates ensure that MCH remains proactive in managing the risks associated with its physical environment and delivering high-quality patient care. Future evaluations will continue to build on these foundations, adapting to emerging standards and organizational needs.

- **Goals 2025**

2025 Goal	Evaluation
QAPI: Increase compliance with the safety and storage of compressed gas cylinders from 83% to 98% by Weekly rounding of two different teams, meeting with material management on PAR levels, and reviewing the contract with third party vendor	**This goal was not met, major changes have been made in the new DNV/Calendar year showing improvements but not to 98%. This will continue to be followed and monitored in the EOC meetings.**
• Promote Environmental Sustainability and Incorporate more data-driven decision making by Reduce energy and resource consumption while managing costs effectively, Implement sustainable waste disposal and recycling practices, and Use performance metrics and KPIs to guide facility management strategies	**GOAL MET:** Partnered with an external vendor to perform light checks and have the lights changed over to LED, saving time, energy, and dollars for the hospital.

- **Goals 2026**

2026 Goal	Action Plan
Create 2 SOPs or policies along with competencies related to facilities maintenance and operation of the overall hospital processes per quarter.	**Utilize templates and guides to create Medical Center standards of procedure while meeting with Engineering department director and assistant director and other team leads.**
Focus on Fire doors and decreasing the number of doors out of compliance and on the ALSM by 15% before 12/31/2026.	Working and consistent attention to the companies that are building the doors and ensuring thorough assessments and follow through with the replacement and correction with all fire door issue.

Medical Center Health System Emergency Management Plan

Purpose

The purpose of the Emergency Management Plan is to establish a basic emergency program to provide timely, integrated, and coordinated response to the wide range of natural and manmade events that may disrupt normal operations and require pre-planned response to internal and external incidents. Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to shelter in place. The six (6) critical areas of consideration are Communications, Resources and assets, Safety and security, Staffing, Utilities, and Clinical Activities.

Scope

This is a Medical Center Health System plan that incorporates all services and sites of care provided by the organization and includes Continued Care Hospital located at Medical Center Hospital. This plan applies to staff, licensed independent practitioners, contract workers, and others as appropriate and indicated throughout this document. MCHS uses the calendar year for the purposes of full-scale exercises.

Principles

The fundamental principles of emergency management are based on four phases, mitigation, preparedness, response, and recovery.

Mitigation is the most cost-efficient method for reducing the impact of hazards. A precursor activity to mitigation is the identification of risks. Physical risk assessment refers to the process of identifying and evaluating hazards. The higher the risk, the more urgent the need is to target hazard-specific vulnerabilities through mitigation efforts. One example of mitigation at University Hospital is the 96-Hour Business Continuity Plan, which includes mitigation strategies and plans that have been developed to ensure continuity of operations in areas such as utilities, communications, food, water, medication, staffing, and medical supplies when the community is unable to support the hospital due to an external disaster scenario.

Preparedness is a continuous cycle of planning, organizing, training, equipping, exercising, evaluation, and improvement activities that allows Upstate Medical University and Hospital to ensure effective coordination and the enhancement of capabilities to prevent, protect against, respond to, recover from, and mitigate against disaster events that have been identified within the Hazard Vulnerability Analysis (HVA).

In the preparedness phase, the Emergency Management Department develops plans of action to manage and counter risks and acts to build the necessary capabilities needed to implement such plans.

The Response phase includes the mobilization of the identified emergency staff, including first responders, to an internal or external event that could have an impact on patient care operations or the campus. Response procedures are pre-determined by the university and hospital and are detailed in disaster plans during the Preparedness phase. Response to an internal or external incident on campus or in the hospital is directed through the Incident Command System (ICS). Response plans remain flexible in nature due to the varying members of staff available at any given time.

Response procedures and plans are constantly evaluated and changed based on improvements identified during After Action Review (AARs) meetings and documentation, which are held after training exercises and disaster responses. Response actions are also evaluated regularly by the campus and hospital through drills, exercises, tracers, and live events.

The aim of the Recovery phase is to restore the affected area to its previous state. It differs from the Response phase in its focus: recovery efforts are concerned with issues and decisions that must be made after immediate needs are addressed. Recovery efforts are primarily concerned with actions that involve rebuilding destroyed property, re-employment, the repair of other essential infrastructure, as well as the re-opening of essential services in the hospital.

Recovery operations are an extremely important phase in the Emergency Management continuum and yet one that is often overlooked. The Incident Command System team is responsible for the implementation of the Recovery phase.

Objectives

The specific objectives of the Emergency Management Plan are determined by Medical Center Health System. Objectives are specific targets identified by the organization to reduce the risks associated with large and small disaster events. Current objectives are:

- Employ an all-hazards risk-based approach to mitigate, prepare, respond, and recover, from emergencies that overwhelm normal operations of the Health System.
- Support Health System understanding and utilization of the Incident Command System/National Incident Management.
- Continually develop and enhance disaster capabilities through preparing, training, and exercising.
- Address and plan for continuity of operations and sustainability in all practices.
- Work with regional planning partners to ensure seamless operations during any catastrophic event.
- Establish redundant communications within the hospital as well as throughout the community.

- Establish memorandums of understanding with vendors in all areas of the hospital to ensure the best possible care during a catastrophic event.

Program Management Structure

The governing body authorizes the establishment of this plan. The President/CEO has delegated the oversight of this plan to the Emergency Management Director. The senior leadership of the Medical Center Health System – including those of the medical staff – is responsible for actively participating in emergency management planning.

Specialized Department Directors are responsible for ensuring the development and implementation of department specific procedures in coordination with this plan, for ensuring training of staff on their individual roles and responsibilities consistent with the plan and ensuring active participation of their department in the implementation of the plan. Staff is responsible for assuring that their behaviors, work practices and operations are safe, responsible, and in alignment with organizational and departmental procedures, applicable training, and the provisions of this plan.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE6 SR1	**The organization shall develop and maintain an emergency preparedness plan that shall be reviewed and updated at least annually. The plan shall do all of the following:** Note: MCHS actively participates and collaborates in local and regional planning meetings. Additionally, the organization engages in disaster drills on a biannual basis to ensure preparedness and effective response during emergencies.	• HPP meeting minutes • drill planning meeting minutes • Participating in the community and regional HVA conversations
PE6 SR1a	**Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.** Note:	• Hazardous Vulnerability Analysis

	MCHS bases all disaster preparedness activities and drills on the results of the Hazardous Vulnerability Analysis (HVA) conducted within our healthcare system. Additionally, we incorporate findings from community and regional assessments, ensuring an all-hazards approach to preparedness.	
PE6 SR1b	**Include strategies for addressing emergency events identified by the risk assessment.** Note: MCHS has meticulously planned for each of the top 5-10 hazards identified in the Hazardous Vulnerability Analysis. For each of these potential incidents, an Incident Response Guide has been developed to ensure a swift and effective response should any of these events occur.	• Incident Response Guides
PE6 SR1c	**Address patient population, including, but not limited to, persons at-risk (including populations at risk); the type of services the organization has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** Note: MCHS addresses vulnerable populations during disasters by incorporating specific provisions into Incident Response Guides and the Emergency Operations Plan. In 2025, special efforts are being made through the Pediatric Readiness Movement to develop tailored plans for the pediatric population, focusing on pediatric supplies, education, and family reunification.	• Emergency Operations Plan • Incident Response Guides
PE6 SR1d	**Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.** Note: MCHS has an integral relationship with local, regional, state, and federal officials due to our hospital being the only Level Two Trauma Center between Ft. Worth and El Paso. This relationship is strengthened by years of collaboration with community partners, regional	• HICS258-Hospital Resource Directory

	advisory councils, and active participation in state-level committees and the Governor's EMS and Trauma Advisory Council.	
PE6 SR2	**The organization shall develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in PE.6 (SR.1), risk assessment at PE.6 (SR.1a), and the communication plan at PE.6 (SR.3). The policies and procedures shall be reviewed and updated at least annually. At a minimum, the policies and procedures shall address the following:** Note: MCHS reviews its Incident Response Guides and other disaster preparedness documents annually. This ensures that all materials are up-to-date and ready for immediate implementation in the event of a disaster.	• Incident Response Guides • Hazardous Vulnerability Analysis • Communications Plan
PE6 SR2a	**The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to:** Note: MCHS has developed an extensive 96-hour plan that includes multiple mutual aid agreements to ensure a coordinated response during disasters. Our newest addition is the Texas Purchasing Coalition's 'disaster drop ship list,' which has been compiled with input from various hospital departments to identify essential supplies needed immediately in the event of a disaster. We are currently working on finalizing the timeframe from when we declare a disaster on campus to when this shipment will arrive at our door.	• 96-Hour Plan • Mutual Aid Agreements
PE6 SR2(1)	**Food, water, medical, and pharmaceutical supplies;** Note:	• 96-Hour Plan • Mutual Aid Agreements
PE6 SR2(2)	**Alternate sources of energy to maintain the following:** Note:	• 96-Hour Plan • Mutual Aid Agreements
PE6 SR2a(2)(i)	**Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;**	• Extreme Heat Incident Response Guide

	Note:	
PE6 SR2a(2)(ii)	**Emergency lighting;** Note:	• Utility Failure plan: Electricity with an incident response guide included
PE6 SR2a(2)(iii)	**Fire detection, extinguishing, and alarm systems;** Note:	• MCH – 4050 Fire Response Policy
PE6 SR2a(2)(iv)	**Sewage and waste disposal.** Note:	• Utility Failure Plan : Water with an incident response guide included
PE6 SR2b	**A system to track the location of on-duty staff and sheltered patients in the organization's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the organization shall document the specific name and location of the receiving facility or other location.** Note: MCHS has several methods to track staff and patients during a disaster. Through our payroll system and CCure badging security system, we can immediately pull reports to determine who is on campus. Additionally, we utilize the hospital's EMR system to track and identify all patients present at any given time.	• Emergency Operations Plan • CCure Security Badge system • Paycom – Payroll HR system
PE6 SR2c	**Safe evacuation from the organization, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.** Note:	• Evacuation Plan with Incident Response Guide
PE6 SR2d	**A means to shelter in place for patients, staff, and volunteers who remain in the organization.** Note:	• Evacuation Plan with Incident Response Guide

PE6 SR2e	**A system of medical documentation that preserves patient information, protects the confidentiality of patient information, and secures and maintains the availability of records.** Note: MCHS utilizes an advanced electronic medical record (EMR) system with both on-site and off-site redundancy to ensure continuous availability. In collaboration with our Cyber Security Committee, we have implemented numerous fail-safes and firewalls to protect our patients' information from any potential threats.	• Cyber Security Documents have proprietary information and are not published to the system
PE6 SR2f	**The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.** Note: MCHS partners with our Regional Advisory Council through mutual aid agreements for staffing and shared identification and credentialing policies. Additionally, we maintain relationships with state organizations like the Texas S.T.E.A.R. programs to ensure all volunteers are effectively coordinated during a disaster.	• Emergency Operations Plan
PE6 SR2g	**The development of arrangements with other organizations and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to organization patients.** Note: MCHS has established relationships and mutual aid agreements through Regional Advisory Councils and state committees. These partnerships ensure that our community patients continue to receive necessary care, including surgical procedures, even if we are unable to perform such activities ourselves.	• Regional Advisory Council Mutual Aid Agreement
PE6 SR2h	**The role of the organization under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.**	• Policy MCH-4054 Use of 1135 Waiver

	Note: MCHS is committed to upholding all CMS and other healthcare governing bodies' guidelines and requirements to the fullest extent possible. Only after thorough strategizing and obtaining Executive and Board approval will MCHS implement any modifications to daily operations in accordance with the approved Secretary's waivers.	
PE6 SR3	**The organization shall develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and shall be reviewed and updated at least annually. The communication plan shall include all of the following:** Note:	• Communication Plan
PE6 SR3a	**Names and contact information for the following:** Note:	
PE6 SR3a(1)	**Staff.** Note:	• Communication plan • Payroll System with Human Resources
PE6 SR3a(2)	**Entities providing services under arrangement.** Note:	• Communication plan • Symplr system with Material Management • Engineering Vendor List
PE6 SR3a(3)	**Patients' physicians.** Note:	• Communication plan • Med Staff System for credentialing and provider list
PE6 SR3a(4)	**Other hospitals and CAHs.** Note:	• Communication Plan • HICS258-Hospital Resource Directory
PE6 SR3a(5)	**Volunteers.** Note:	• Communication Plan • Volunteer Services Department • Texas S.T.E.A.R.
PE6 SR3b	**Contact information for the following:** Note:	

PE6 SR3b(1)	**Federal, State, tribal, regional, and local emergency preparedness staff.** Note: MCHS actively participates with the Regional Emergency Preparedness Committee through the State Hospital Preparedness Program. In the event of a disaster, a representative from this organization assists in making connections with federal, state, regional, and local preparedness staff. This collaboration allows MCHS employees to focus on managing the immediate disaster while other organizations coordinate relief and support efforts.	• Communication plan
PE6 SR3b(2)	**Other sources of assistance.** Note:	• Communication plan
PE6 SR3c	**Primary and alternate means for communicating with the following:** Note:	• Communication plan
PE6 SR3c(1)	**Organization's staff.** Note:	• Communication Plan
PE6 SR3c(2)	**Federal, State, tribal, regional, and local emergency management agencies.** Note:	• Communication plan
PE6 SR3d	**A method for sharing information and medical documentation for patients under the organization's care, as necessary, with other health care providers to maintain the continuity of care.** Note: MCHS ensures that pertinent medical record information accompanies the patient during transport. Additional information will be provided to the receiving facility as soon as possible. Whenever feasible, a portal into MCHS's EMR system will be established to facilitate access to the transported patients' records.	• Emergency Operations Plan

PE6 SR3e	**A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).** Note: MCHS follows the protocol outlined in 45 CFR 164.510(b)(1)(ii) to share pertinent information with other entities involved in the care of the patient, as well as with known family members and the public. Consistent verbiage has been created to ensure that we provide the same message to all parties on a need-to-know basis only.	• Communication Plan
PE6 SR3f	**A means of providing information about the general condition and location of patients under the organization's care as permitted under 45 CFR 164.510(b)(4).** Note:	• Emergency Operations Plan •Communication Plan • MCH 1098 – Media Policy
PE6 SR3g	**A means of providing information about the organization's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.** Note: MCHS actively participates with the Regional Emergency Preparedness Committee through the State Hospital Preparedness Program. In the event of a disaster, a representative from this organization assists in making connections with federal, state, regional, and local preparedness staff. This collaboration allows MCHS employees to focus on managing the immediate disaster while other organizations coordinate relief and support efforts.	
PE6 SR4	**The organization shall develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in PE.6 (SR.1), risk assessment at PE.6 (SR.1a), policies and procedures at PE.6 (SR.2), and the communication plan at PE.6 (SR.3). The training and testing program shall be reviewed and updated at least annually.** Note: MCHS utilizes an educational platform in collaboration with the Human Resources Department to distribute disaster preparedness education and training on an annual	• Symplyr Learning Modules

	basis. This ensures that all staff members are well-informed and equipped to handle emergencies effectively.	
PE6 SR4a	**The organization shall do all of the following:** Note:	
PE6 SR4a(1)	**Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.** Note:	• New Employee Orientation • Symplyr Learning Modules • National Incident Management System Learning Modules
PE6 SR4a(2)	**Provide emergency preparedness training at least annually.** Note:	• Symplyr Learning Modules
PE6 SR4a(3)	**Maintain documentation of the training.** Note:	• Symplyr Learning Modules
PE6 SR4a(4)	**Demonstrate staff knowledge of emergency procedures.** Note: MCHS demonstrates staff knowledge of roles and responsibilities during a disaster through various types of drills conducted throughout the year. Some of these drills are small in scale and focus on ensuring the comprehension of specific staff members, while others are more generic and provide a high-level understanding of disaster preparedness components.	• Missing Infant Drills • Full Scale Community Drills • Participation in Regional Drills • Department-specific education and training
PE6 SR4a(5)	**If the emergency preparedness policies and procedures are significantly updated, the organization shall conduct training on the updated policies and procedures.** Note: MCHS meticulously reviews all after-action reports from drills and notes from hot wash meetings to determine if changes in plans or policies are required. If deemed appropriate, the changes will be made and go through all necessary approval channels.	• Different platforms will be utilized and will be determined by the sensitivity of the education

	Once approvals are granted, education and training will be disseminated through the most suitable platform, ranging from system-wide emails and additions to learning modules to specific department in-person training.	
PE6 SR4b	**The organization shall conduct exercises to test the emergency plan at least twice per year. The organization shall do all of the following:** Note:	• Disaster Drills
PE6 SR4b(1)	**Participate in an annual full-scale exercise that is community-based; or** Note:	• Disaster Drills with community involvement
PE6 SR4b(1)(i)	**When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or** Note:	• Annual Disaster Drills
PE6 SR4b(1)(ii)	**If the organization experiences an actual natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the emergency event.** Note: In the event of an actual disaster, MCHS will diligently gather documentation on the incident, including records of any hot washes or debriefs conducted. This documentation will be instrumental in identifying our strengths and areas for improvement.	
PE6 SR4b(2)	**Conduct an annual additional exercise that may include, but is not limited to the following:** Note:	
PE6 SR4b(2)(i)	**A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or** Note:	• Disaster Drill

PE6 SR4b(2)(ii)	**A mock disaster drill; or** Note:	• Disaster Drill
PE6 SR4b(2)(iii)	**A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.** Note:	• Disaster Drill
PE6 SR4c	**Analyze the organization's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the organization's emergency plan, as needed.** Note:	• After Action Documentation
PE6 SR5	**The organization shall implement emergency and standby power systems based on the emergency plan set forth in PE.6 (SR.1) and in the policies and procedures set forth in PE.6 (SR.2a(1)) and PE.6 (SR.2a(2)).** Note: MCHS integrates utility failures into disaster drills to ensure comprehensive preparedness. In addition to documenting actual utility failures and disruptions, these simulated scenarios help identify vulnerabilities and enhance response strategies. This proactive approach ensures that we are well-equipped to handle real-life utility disruptions effectively.	
PE6 SR5a	**The generator shall be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.** Note:	

<table>
<tr><td></td><td>The locations of all MCHS' generators are meticulously documented in the utility failure plan for electricity. This ensures that in the event of a power outage, the necessary information is readily available to facilitate a swift and efficient response.</td><td></td></tr>
<tr><td>PE6 SR5b</td><td>The organization shall implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

Note:</td><td>• Testing Schedule
• HEMS Work order system</td></tr>
<tr><td>PE6 SR5c</td><td>Organizations that maintain an onsite fuel source to power emergency generators shall have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

Note:
Each of MCHS' generators is equipped with a large fuel capacity, and approximate calculations have been made to determine the duration each generator can operate at full load. Additionally, we have a Memorandum of Understanding (MOU) with a local fuel supplier to ensure timely refueling if needed.
<table>
<tr><th>Generator</th><th>Location</th><th>Services</th><th>Fuel Capacity</th><th>Hours at 50%</th></tr>
<tr><td>#1 Cat</td><td></td><td>W & C Tower</td><td>10,000 gals</td><td>116</td></tr>
<tr><td>#2 Cummins</td><td></td><td>CWI</td><td>6,000 gals</td><td>74</td></tr>
<tr><td>#3 ONAN</td><td></td><td>Pro Building</td><td></td><td></td></tr>
<tr><td>#4 Olympian</td><td></td><td>Annex</td><td>500 gals</td><td>50</td></tr>
<tr><td>#4A Cummins</td><td></td><td>Annex</td><td>350 gals</td><td>25</td></tr>
<tr><td>#5 Cummins</td><td></td><td>West Tower</td><td>6,000 gals</td><td>206</td></tr>
<tr><td>#6 Cat</td><td></td><td>WSMP</td><td>2,400 gals</td><td>56</td></tr>
<tr><td>#7 Cat</td><td></td><td>CHW</td><td>350 gals</td><td>87</td></tr>
</table></td><td>• MOU</td></tr>
<tr><td>PE6 SR6</td><td>Integrated healthcare systems. If an organization is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and</td><td>• Not applicable</td></tr>
</table>

	integrated emergency preparedness program, the organization may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program shall: Note:	
PE6 SR6a	**Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.** Note: MCHS includes all offsite locations under our license in our Hazardous Vulnerability Analysis. This comprehensive approach ensures that we plan for hazards affecting the entire organization, not just the main campus.	• Hazardous Vulnerability Analysis
PE6 SR6b	**Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.** Note: The administration for each MCHS location has a direct line of communication with the hospital. In addition to being included in the Hazardous Vulnerability Analysis (HVA), each location will participate in a risk assessment for current and potential events.	
PE6 SR6c	**Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.** Note: Each of our offsite locations is seamlessly integrated into the MCHS emergency preparedness program through the use of mass communication software, planning meetings, drills, education/training, and small-scale drills based on risk assessments. This comprehensive approach ensures that all locations are well-prepared and coordinated in the event of an emergency.	
PE6 SR6d	**Include a unified and integrated emergency plan that meets the requirements of PE.6 (SR.1b), PE,6 (SR.1c), and PE.6 (SR.1d). The unified and integrated emergency plan shall also be based on and include the following:**	

	Note:	
PE6 SR6d(1)	**A documented community-based risk assessment, utilizing an all-hazards approach.** Note:	• Hazardous Vulnerability Assessment
PE6 SRd(2)	**A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.** Note:	• Hazardous Vulnerability Assessment
PE6 SR6e	**Include integrated policies and procedures that meet the requirements set forth in PE.6 (SR.2), a coordinated communication plan and training and testing programs that meet the requirements of PE.6 (SR.3) and PE.6 (SR.4), respectively.** Note:	• Communication Plans
PE6 SR7	**If an organization has one or more transplant programs (as defined in 482.70):** Note:	• Not Applicable
PE6 SR7a	**A representative from each transplant program shall be included in the development and maintenance of the organization's emergency preparedness program; and** Note:	• Not Applicable
PE6 SR7b	**The organization shall develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the organization, each transplant program, and the OPO for the DSA where the organization is situated, unless the hospital has been granted a waiver to work with an OPO, during an emergency.** Note:	• Not Applicable
PE6 SR8	**NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009, is incorporated for reference in this chapter in addition to the references incorporated by reference in PE.1.** Note:	• Utility Failure: Electricity Plan

Evaluation of Plan

An annual evaluation of the emergency operations plan is completed by the emergency management coordinator and brings any changes to the emergency management committee. With every event, more information is added to the plan to show progression in the ability to plan and prepare for disaster.

Performance Indicators

- **2025 Goals**

2025 Goals	Evaluation
QAPI: Increase the awareness and preparedness for an I.T. utility failure throughout the health system by Education, training, and a full-scale exercise with the entire system, documentation will be presented to the QAPI committee quarterly	This goal was not met and it was recommended by the QAPI team to find a different goal
• Creating the Multi-year drill planning document by meeting with departments that need specific elements in drills (i.e. trauma) and plan with outside agencies to continue the relationship • Design training and education specific to each department in the house and deploy the creation by meeting with department directors on the needs of each department and ensuring the training and elements coincide with the year's drill scenario	This goal was met with strategic planning for future drills and needed education related to changes in the HVA.

- **2026 Goals**

2026 Goals	Action Plan
For community involvement drills, get the participation of 2 or more new community partners to participate.	Engage with the Odessa Fire and Rescue for other companies in Ector County that are required to put on disaster drills for TCEQ

	and other organizations, to broaden our relationships and awareness of the possible hazards in our community.

Medical Center Health System
Facility Management Plan

Purpose

The physical environment and the range of patient care services provided to the patients served by Medical Center Hospital (MCH) present a wide range of applications and risks. The Facility Management Plan is designed to provide organizational oversight for the design and maintenance of the physical environment infrastructure and equipment. The plan was developed using various construction criteria, maintenance, testing, and inspection procedures to eliminate or reduce the probability of adverse patient outcomes. The plan also seeks to maintain appropriate policies and procedures to manage safe activities within the organization, as well as monitor the performance of the environment.

Scope

The program is applied to the Main Hospital Campus, FHC, and Urgent Care Sites.

Objectives

A) Maintain safe and adequate facilities for our services.
B) Adopt and adhere to the Life Safety Code (NFPA 101 and applicable amendments).
C) Develop and implement policies and procedures that maintain a safe environment.
D) Maintain an organizational-wide process for evaluating unfavorable events related to the physical environment
E) Monitor events, occurrences, and impairments to continually improve performance
F) Disseminate appropriate data to the Quality Management Committee

Program Management Structure

A. The Director of Facilities assures that an appropriate Facilities Maintenance program is implemented. The Director of Facilities also collaborates with the Safety Officer to develop reports of program performance for presentation to the Environment of Care Committee. The reports summarize organizational experience, performance management and improvement activities, and other physical environment issues.

B. The MCH Senior Leadership Team receives regular reports of the activities of the program through the Quality Management Committee. The Chief Operating Officer collaborates with the Director of Facilities, Safety Officer, and other appropriate staff to address system issues and concerns as well as capital infrastructure planning. The Chief Operating Officer also collaborates with the Director of Facilities, and Chief Financial Officer to develop a budget and operational objective for the program.

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE1 SR1	**The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients, visitors, and staff are assured.** Note:	• HEMS work order system • Life Safety Rounds • EOC Rounds
PE1 SR2	**The organization shall maintain safe and adequate facilities for its services.** Note: MCH follows numerous standards of safety requirements to ensure our facility and equipment are properly operating to fulfill the necessities of preserving human life.	• DNV Certification • TDH Requirements • NFPA
PE1 SR. 5i	**Diagnostic and therapeutic facilities shall be located for the safety of patients.** Note:	

PE1 SR5j	**Facilities, supplies, and equipment shall be maintained to ensure an acceptable level of safety and quality.** Note:	• DNV requirements • Biomed Rounds • Management Plans • HEMS work order system • MCHS Policy 4020
PE1 SR5k	**The extent and complexity of facilities shall be determined by the services offered.** Note:	• Critical equipment maintenance • HEMS work order procedures 540, 566, 578
PE1 SR3	**Except as otherwise provided in this section, the organization shall meet the applicable provisions and shall proceed in accordance with the 2012 Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6), and Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), when a new structure is built or when an existing structure or building is renovated.** Note: MCH follows healthcare guidelines for new constructions and renovations for all buildings in the system.	• MCHS follows Healthcare Facilities Occupancy Rules, Type II (222), TDH, DNV
PE1 SR3a	**Chapters 7, 8, and 12 of the adopted Health Care Facilities Code do not apply to a hospital.** Note:	N/A
PE1 SR3b	**If application of the Health Care Facilities Code as required in PE.1, SR.3 would result in unreasonable hardship for the organization, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.** Note: The waiver allowance afforded by PE.1 (SR.3b) is not applicable to Chapter 13 of the adopted Health Care Facilities Code (HCFC). Compliance with Chapter 13 of the HCFC is a DNV specific requirement. Note:	N/A

	MCH is currently not following any waivers and chose to continue with recommended maintenance requirements through the COVID pandemic.	
PE1 SR4	**The organization shall have policies, procedures and processes, and management plans, in place to manage staff activities, as required and/or recommended by local, State, and national authorities or related professional organizations, to maintain a safe environment for the organization's patients, staff, and others.** Note: MCH has the 4000 policy guides to assist employees with safety of the environment and continued education.	• See MCHS Policies 4000's • Continuing Education
PE1 SR5	**The organization shall have a documented processes, management plans, policies and procedures to define how unfavorable occurrences, incidents, or impairments in the facility's infrastructure, Life Safety, Safety, Security, Hazardous Material/Waste, Emergency, Medical Equipment, and Utilities Management Systems are prevented, controlled investigated, and reported throughout the organization.** Note: After action reports, patient safety event program, rounds, EOC committee	• EOC Committee, Patient Safety Event Program • Rounding
PE1 SR6	**The organization shall evaluate the effectiveness of the facility's physical environment management systems at least annually. This evaluation shall be forwarded to QMS oversight.** Note:	• Life Safety Rounds, Building & Ground Rounds scheduled PM's through HEMS system
PE1 SR7	**Occurrences, incidents, or impairments shall be measured and analyzed to identify any patterns or trends and used to evaluate the effectiveness of the organization's physical environmental management system.** Note: Utility disruptions and failures are documented and trended for repeated failures and areas for improvement	
PE1 SR8	**The organization, through its senior leadership shall ensure that the physical environment and associated management systems adequately address issues identified throughout the organization and there are prevention, correction, improvement and training programs to address these issues.**	• EOC meeting minutes • QAPI meeting minutes

	Note:	• E-Team meeting minutes
PE1 SR9	**Significant physical environment data/information shall be disseminated regularly to Quality Management Oversight.** Note:	• QAPI Goals • EOC reports to QMS on a quarterly basis
PE1 SR10	**Construction, Repair, and Improvement operations shall involve the following activities:** Note:	
PE1 SR10a	**During construction, repairs, or improvement operations, or activities otherwise affecting the space, the current edition of the Guidelines for Design and Construction of Hospitals or the Guidelines for Design and Construction of Outpatient Facilities (FGI), as appropriate, shall be consulted for design Purposes.** **Note:** MCHS Hospital collaborates closely with an external architecture firm to ensure that all design and construction projects comply with the necessary guidelines. This partnership is crucial for maintaining high standards during all our hospital's remodels and upgrades.	
PE1 SR10b	**The organization shall assess, document, and minimize the impact of construction, repairs, or improvement operations upon occupied area(s). The assessment shall include, but not be limited to, provisions for infection control, utility requirements, noise, vibration, and alternative life safety measures (ALSM).** **Notes:** MCHS Hospital has an extensive interim life safety and infection prevention program that addresses utility disruptions, noise, and vibrations. The program also places significant attention on any changes in paths of egress or fire exit strategies to ensure the safety and well-being of all patients and staff during remodels and upgrades.	• MCH -4045
PE1 SR10c	**In occupied areas where construction, repairs, or improvement operations occur, all required means of egress and required fire protection features shall be in place and continuously**	• MCH-4045

	maintained or where alternative life safety measures acceptable to the authority having local jurisdiction are in place. NFPA 241- 2009, Standard for Safeguarding Construction, Alteration, and Demolition Operations, shall be referenced in identifying and implementing alternative life safety measures. **Notes:** MCHS is deeply committed to upholding the highest standards throughout all construction and improvement projects, rigorously ensuring that safety protocols and alternative life safety measures are executed with unwavering precision. Every action undertaken reflects our dedication to protecting patients, staff, and visitors, demonstrating not only compliance, but an enthusiastic pursuit of excellence in every aspect of our operations.	
PE1 SR10d	**All construction, repairs, or improvement operations shall be in accordance with applicable 2012 National Fire Protection Association (NFPA) 101- Life Safety Code (LSC), the 2012 edition of the NFPA 99-Health Care Facilities Code (HCFC) and State and local building and fire codes. Should standards and codes conflict, the most stringent standard or code shall prevail.** **Notes:** MCHS is unwavering in its commitment to adhere to all local and state regulations governing life safety codes, consistently upholding the highest standards across every project and operational process. We maintain a close and collaborative relationship with our local Authority Having Jurisdiction, ensuring that every action and protocol not only meets but exceeds regulatory requirements, fostering a culture of safety and trust throughout our organization.	• MCH 4052
PE1 SR11	**The organization, through its senior leadership shall ensure that a tobacco-free policy be developed and enforced campus-wide. Substantial progress toward complete conformity shall be demonstrated over time. DNV Healthcare will permit temporary tobacco use in the areas of the hospital where patient visits may be abbreviated, in behavioral health units and other areas near the main campus that are not under hospital control. In order for this to be permissible the hospital shall obtain from the local and/or state fire prevention agencies (Authority Having Jurisdiction or AHJ) written documentation stating that these areas which are to be located outdoors, can be used for smoking while the hospital continues to demonstrate progression toward a tobacco free campus over time. (See the PE.1 Interpretive Guidelines for specific direction on this procedure)**	• MCH 1033 Tobacco-free campus • MCHS Policy 1033

	Notes: MCH utilizes programs such as incentives through health insurance and other opportunities to promote a smoke-free campus as well as posted signs that have been placed throughout the campus.	
Ligature Assessment	The organization's department(s) that is responsible for the hospital's buildings and equipment (both facility equipment and patient care equipment) shall be evaluated for maintaining the appropriate work environment and related infrastructure to be safe for all staff, patients and visitors. **Notes:** Medical Center Health System utilizes a dedicated sitter program for all behavioral health patients at risk of self-harm or aggression. This approach, chosen after careful risk analysis, aligns with CMS and DNV standards and provides continuous, one-to-one supervision. While making every patient area ligature-free can be costly and may not prevent all incidents, sitters offer immediate intervention and ongoing support, which is recognized as a best practice by regulatory agencies. Continuous observation not only meets compliance requirements but also improves patient safety and outcomes in behavioral health settings. The program is regularly evaluated to ensure adherence to the highest safety standards.	• Ligature Assessment • NADM-0015 Augmented Care/Sitter at Bedside
Tobacco Free Campus		• MCH – 1033 Tobacco Free Campus

Evaluation of Plan

On an annual basis, the Engineering Director will evaluate the objectives, scope, effectiveness, and performance of the Facility Management Plan. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Engineering Director collaborates with the EOC Committee and other appropriate associates to convey and address facility issues and/or concerns.

The Annual evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary initiatives for minimizing the risk associated with the operations of a healthcare facility.

Performance Indicators

- **Goals 2025**

2025 Goal	Evaluation
QAPI: Increase compliance with the safety and storage of compressed gas cylinders from 83% to 98% by Weekly rounding of two different teams, meeting with material management on PAR levels, and reviewing the contract with third party vendor	**This goal was not met, major changes have been made in the new DNV/Calendar year showing improvements but not to 98%. This will continue to be followed and monitored in the EOC meetings.**
• Promote Environmental Sustainability and Incorporate more data-driven decision making by Reduce energy and resource consumption while managing costs effectively, Implement sustainable waste disposal and recycling practices, and Use performance metrics and KPIs to guide facility management strategies	**GOAL MET:** Partnered with an external vendor to perform light checks and have the lights changed over to LED, saving time, energy, and dollars for the hospital.

- **Goals 2026**

2026 Goal	Action Plan
Create 2 SOPs or policies along with competencies related to facilities maintenance and operation of the overall hospital processes per quarter.	**Utilize templates and guides to create Medical Center standards of procedure while meeting with Engineering department director and assistant director and other team leads.**

Focus on Fire doors and decreasing the number of doors out of compliance and on the ALSM by 15% before 12/31/2026.	Working and consistent attention to the companies that are building the doors and ensuring thorough assessments and follow through with the replacement and correction with all fire door issue.

Medical Center Health System
Hazardous Material (HAZMAT) Management Plan

Purpose

The Environment of Care (EC) poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Hazardous Materials and Wastes (HMW) Program is designed to identify and manage the risks related to the presence of hazardous materials and wastes present in the buildings and portions of buildings operated and owned by Medical Center Health System. The specific risks of each environment are identified by applying appropriate criteria to materials and wastes to determine which have hazards.

Scope

The Hazardous Materials and Waste Management Plan describes the risks and daily management activities put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and visitors, coming to the organization. The Hazardous and Waste Management Program is based on applicable laws, regulations, and accreditation standards and designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services.

This plan covers activities performed in the various locations of the organization, including the hospital and hospital-based clinic operations of Medical Center Health System.

Principles

- The activities of the hazardous materials and waste management program are designed based on applicable national, state, and local codes and regulations and the inventory of materials in use and wastes generated at each location housing healthcare services.
- The specific activities, environments, protective equipment, and engineering controls required to the risk of adverse human or environmental impact related to the handling, use, storage, or disposal of materials and wastes are determined from Safety Data Sheets (SDS), which replaces the Material Safety Data Sheet (MSDS) or other documents provided by suppliers and manufacturers.
- The four basic management requirements for assuring the minimum potential of adverse human or environmental impact of HMW

include:

- Appropriate design of space, including installation and maintenance of engineering control systems and other equipment to manage the hazards of the types of materials or wastes to be stored in the area
- Regular inspection and maintenance of the spaces where HMW is stored, handled, held for disposal, etc. to assure that all engineering controls are working properly, that proper procedures and controls for the separation, storing, and handling of HMW are being implemented, and that other equipment is used effectively.
- Education and training of staff responsible for handling and using any HMW that addresses the specific hazards of each type of HMW and the procedures and controls required to manage those hazards.
- Development and testing of emergency response procedures designed to minimize the human and environmental impact of any exposure to, release of, or spill of HMW.

Objectives

The objectives of the Hazardous Materials and Waste Management Plan include:

- Comply with standards and regulation pertaining to hazardous materials and waste
- Develop and enforce current hazardous materials and waste practices for patients, staff, students and visitors
- Provide hazardous materials and waste education and training as appropriate
- Identify and implement opportunities to improve hazardous materials and waste management

Program Management Structure

- The Environmental Services Director conducts a risk assessment of hazardous materials and wastes throughout the organization. The results of the risk assessment are used to develop appropriate procedures and controls as the foundation of an appropriate HMW management program is implemented. The HMW Manager also collaborates with the Safety Officer to develop reports of HMW performance for presentation to the EC Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other HMW issues.

- The Administrative Leadership Team receives regular reports of the activities of the HMW program from the EC Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of the HMW and appropriate clinical staff. The Administrative Leadership Team collaborates with senior managers to assure budget and staffing resources are available to support the HMW program.

- Leadership receives regular reports of the activities of the HMW program. Leadership collaborates with the HMW Manager and other appropriate staff to address HMW issues and concerns. Leadership also assists in the development of a budget and operational objectives for the HMW program.

- Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE5 SR1	**The organization shall provide a Hazardous Material (HAZMAT) Management System to manage hazardous materials and waste.** Note: The management plan describes the procedures and controls in place to minimize the risks of exposure to hazardous material and waste to patients, staff, and other people coming to the facilities.	
PE5 SR2	**The HAZMAT Management System shall provide processes to manage the environment, selection, handling, storing, transporting, using, and disposing of hazardous materials and waste.** Note:	• MCH-4021 • NUCMED-0027 • NUCMED-0025
PE5 SR3	**The HAZMAT Management System shall provide processes to manage reporting and investigation of all spills, exposures, and other incidents.** Note: MCH utilizes the Patient Safety Event Reporting System to document all spills, exposures, and other incidents. The Patient Safety Events are completed by the staff member or	• MCH 4012 -

	members involved in the event and forwarded to the Risk Manager and those department directors related to the event. They will also be forwarded to the appropriate Executive member.	
PE5 SR4	**The organization monitors staff exposure levels in hazardous environments and report the results of the monitoring to the QMS.** Note: Radiation Safety Committee reports exposure levels and trends to the Quality Committee quarterly,	• RS-0042
PE5 SR5	**All compressed gas cylinders in service and in storage shall be individually secured and located to prevent abnormal mechanical shock or other damage to the cylinder valve or safety device.** Note: All gas cylinders are stored in rack barricades to monitor amount depending on the area and room size as well as the protection of the cylinder themselves against damage to the valve or safety device.	• MCH-2013
PE5 SR6	**In anesthetizing locations, which use alcohol-based skin preparations, the organization shall implement effective fire risk reductions measures in accordance with NFPA 99, 15.13.3 which will include, but is not limited to:** Note: Before every surgery a fire risk evaluation is performed, a checklist that includes draping procedures were performed correctly, no pooling or spilled antiseptic solutions, and appropriate protocol for the use of electrosurgery/electrocautery or laser equipment.	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR6a	**The use of unit dose skin prep solutions;** Note:	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR6b	**Application of skin prep follows manufacture/supplier instructions and warnings;** Note:	• Annual OR Assessment tool • SSMOR-6620-028

	All manufacturer's guidelines are followed for the use of all skin prep solutions including dry times, appropriate locations, as well as appropriate procedures for pooling and removal of solution-soaked materials.	
PE5 SR6c	**Sterile towels are used to absorb drips and runs during the application and then removed from the anesthetizing location prior to draping; and,** Note: Any pooling of antiseptic solution must be avoided. Should pooling occur, this must be blotted out using proper aseptic technique	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR6d	**Verifying that all of the above has occurred prior to initiating the surgical procedure.** Note: Before every surgery a fire risk evaluation is performed, a checklist that includes draping procedures were performed correctly, no pooling or spilled antiseptic solutions, and appropriate protocol for the use of electrosurgery/electrocautery or laser equipment.	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR7	**An organization may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access and in accordance with NFPA 101, Life Safety Code, 2012 edition.** Note: All dispensers will be locked and EVS staff will be responsible for replacement of the alcohol-based hand rub. There will be 5 replacement containers of the hand rub in each of the supply rooms in patient care areas with one key. These replacements will be used if the dispenser runs out before the staff is able to replace the used containers.	• Alcohol based sanitizer program

Evaluation of Plan

On an annual basis, the safety and hazardous materials teams will evaluate the objectives, scope, effectiveness, and performance of the Hazardous Materials Management Plan. Any changes in objectives will be addressed during the Annual Assessment and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Safety Department collaborates with the EOC Committee and other appropriate associates to convey and address hazardous material issues and/or concerns.

The Annual Assessment objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with the use of hazardous materials.

Performance Indicators

- Goals 2025

2025 Goal	Evaluation
QAPI: increasing hand sanitizer compliance from 94% to 96% but physically auditing hand sanitizer so product is always available	**This goal was met and completed.**
• Enhance SDS data program in the hospital by Determine if a software upgrade is necessary and a clean-up of the software • Continue gas cylinder revamping program by Reducing the amount of gas cylinders in the organization, remove bottles that are not in use, ensure all signage is up to date and present, and weekly rounding	Software upgrade was completed and user friendly education is being prepared for the staff members on the use of the SDS software and location. Changes have been made in the world of gas cylinders including reducing PAR level throughout the house to decrease the opportunity for tank to be placed incorrectly. Signage has been replaced and updated as well.

- Goals 2026

2026 Goal	Action Plan
Monitor and improve the cleanliness of the back dock area, increasing compliance to >90% by 12/31/2026	Developing a weekly check sheet, monthly powerwashing, and continuing to work with the City of Odessa on the types of dumpsters that are available and the periodicity of the pick up.

EVENT	RISK
Terrorism, Cyber-Attack	83%
Earthquake	78%
Information Systems Failure	72%
Wild Fire	67%
HVAC Failure	67%
Electrical Failure	61%
Communications Failure	61%
Mass Casualty Incident (medical/infectious)	61%
Chemical Exposure, External	61%
Mass Casualty Incident (trauma)	56%
Temperature Extremes (including drought, hail, ice, snow storms)	56%
Epidemic / Pandemic	56%
Severe Thunderstorm	56%
Mass Casualty Hazmat Incident (>= 5 victims)	56%
Bomb Threat	56%
Tornado	52%
Flood, External	48%
Structural Damage	48%
Radiologic Exposure, External	48%
Winds, Extreme (including straight line winds and Haboobs)	44%
E-Power / Generator Failure	44%
Fire, Internal	44%
Hazmat Exposure, Internal	44%
Hostage Situation	44%
Human Trafficking	37%
Small Casualty Hazmat Incident (with < 5 victims)	37%
Water Failure	37%
Transportation Failure	33%
Sewer Failure	30%
Infant/Pediatric Abduction	30%
Terrorism, Biological	28%
Civil Disturbance	26%
VIP Situation	26%
Small-Medium Sized Internal Spill	26%
Supply Shortage	24%
Terrorism, Chemical	22%
Radiologic Exposure, Internal	22%
Terrorism, Radiologic	22%
Flood, Internal	20%
Medical Vacuum Failure	20%
Medical Gas Failure	19%
Natural Gas Failure	19%
Large Internal Spill	19%
Fuel Shortage	19%
Fire Alarm Failure	15%

Natural
Human
HazMat
Tech

Medical Center Health System
Life Safety Management Plan

Purpose

Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The fire safety management program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System. The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Medical Center Health System.

The Management Plan for Fire Safety describes the risk and daily management activities that Medical Center Health System has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the fire safety management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to the Medical Center Hospital and the hospital-based clinic operations of Medical Center Health System.

Scope

Principles

- All buildings of Medical Center Health System housing patient care services must be designed, operated, and maintained to comply with the 2012 edition of the *Life Safety Code*.
- All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
- All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimizing the potential of loss of life or property in the event of a fire.

- Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

Objectives

- Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.
- Conduct required fire drills in all buildings of Medical Center Health System housing patient care services.
- Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
- Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2000 edition of the *Life Safety Code.*
- Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

Program Management Structure

- The Manager of the FSM program assures that an appropriate maintenance program is implemented. The manager of the FSM program also collaborates with the Safety Officer to develop reports of FSM performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
- The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
- Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

- The Administrative Leadership Team (ALT) receives regular reports of the activities of the FSM program from the Safety Committee. The Administrative Leadership Team reviews the reports and, as appropriate, communicates concerns about identified issues back to the manager of the FSM and appropriate clinical staff. The ALT collaborates with the CEO and other senior managers to assure budget and staffing resources are available to support the FSM program.

- The CEO of Medical Center Health System receives regular reports of the activities of the FSM program. The CEO collaborates with the FSM program manager and other appropriate staff to address fire safety issues and concerns. The CEO also collaborates with the FSM program manager to develop a budget and operational objective for the FSM program.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE2 SR1	**Except as otherwise provided in NIAHO® Accreditation Requirements:**	
PE2 SR1a	**The organization shall meet the applicable provisions and shall proceed in accordance with the 2012 Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). Outpatient surgical departments shall meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.** Note: Medical Center Health System (MCHS) strictly adheres to the 2012 Life Safety Code (NFPA 101) and all relevant Tentative Interim Amendments to ensure the safety of patients, staff, and visitors across our healthcare facilities.	
PE2 SR1b	**Corridor doors and doors to rooms containing flammable or combustible materials shall be provided with positive latching hardware. Roller latches are prohibited on such doors.** Note:	• FIRE DOOR Program SOP in draft form

PE2 SR1c	**In consideration of a recommendation by the state survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients.** Note: All waivers are carefully considered by the EOC committee and MCH administration. If the waiver allows the staff and facility to better serve our patients in times of disaster or need without having adverse effects on the health or safety of our patients, MCHS will prepare the appropriate documentation, and approved waivers will be held in the Safety Office.	
PE2 SR1d	**The provisions of the Life Safety Code do not apply in a state where CMS finds that a fire and safety code imposed by state law adequately protects patients in hospitals.** Note:	
PE2 SR2	**The organization shall maintain drawings depicting the current configuration of life safety features, including, but not necessarily limited to fire and smoke barriers, suite boundaries and smoke compartments**. Note: Life safety drawings are maintained continuously after any renovations or construction projects. Copies are held in the engineering office and with the architect	• Held in engineering office and with the architect
PE2 SR3	**The organization shall maintain written evidence of regular inspection and approval by State or local fire control agencies.** Note: The city of Odessa Fire Marshall's office has an annual assessment. These documents are kept in the Engineering offices.	• Fire Marshall inspection notebook, held in the engineering office.

PE2 SR4	**The organization shall have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel, and guests; evacuation; and cooperation with firefighting authorities. The fire control plan shall provide for training of staff in the following areas (NFPA 101-2012, 18.7.2.2 & 19.7.2.2)** Note: Please see Document	• Fire Response Plan MCH- 4050
PE2 SR4a	**Use of alarms;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4b	**Transmission of alarm to fire department;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4c	**Emergency phone call to fire department;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4d	**Response to alarms;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4e	**Isolation of fire;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4f	**Evacuation of immediate area;** Note: Please See Document	• Fire Response Plan MCH- 4050 • Evacuation Plan
PE2 SR4g	**Evacuation of smoke compartment;** Note: Please See Document	• Fire Response Plan MCH- 4050 • Evacuation Plan

PE2 SR4h	**Preparation of floors and building for evacuation; and** Note: Please See Document	• Fire Response Plan MCH- 4050 • Evacuation Plan
PE2 SR4i	**Extinguishment of fire** Note: Please See Document	• Fire Response Plan MCH- 4050
PE 2 SR5	**The Life Safety Management System shall include in the elements of SR.4 e a written barrier protection plan for the preservation of the integrity of hospital smoke and fire barriers. The plan shall include:** Note: Please See Document	• SOP Fire Barrier Management
PE2 SR5a	**Name(s) of responsible hospital staff for barrier protection program;** Note: Please See Document	• SOP Fire Barrier Management
PE2 SR5b	**Requirement for written permission for anyone (including all hospital staff, contractors and vendors) to penetrate a smoke or fire barrier wall, ceiling or floor;** Note: MCHS has an Above Ceiling program, where any individuals that will be performing any type of work above the ceiling will be required to obtain a permit for such work. Upon the completion of the work, an engineering department employee will verify the area for no penetrations or complications with the fire suppression system.	• SOW Above Ceiling Permit
PE2 SR5c	**Input from Infection Control and Prevention Practitioner on critical clinical areas prior to issuance of written permit for performing work on barriers; and** Note:	• ALSM and ICRA assessment
PE2 SR5d	**Establishment of monitoring process to ensure all work is completed correctly.** Note:	• SOW Above Ceiling Permit

	After the above ceiling work is completed at Medical Center, it will be inspected by MCH Engineering Staff. After the inspection is complete the work order will be closed.	
PE2 SR6	**Health care occupancies shall conduct unannounced fire drills, but not less than one (1) drill per shift per calendar quarter that transmits a fire alarm signal (i.e. audible alarm) and simulates an emergency fire condition. When fire drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. (NFPA 101-2012, 18.7.1.7. & 19.7.1.7).** Note: The safety department conducts quarterly unannounced fire drills on all three shifts. All documentation of the drills and staff evaluations are aggregated and reported to the Quality Committee.	• Drill Evaluations are kept in the Safety Department • MCH-3003 shifts • Fire Drill Matrix • Aggregated fire drill evaluations
PE2 SR6a	**Business occupancies shall conduct at least one unannounced fire drill annually per shift.** Note: Safety Department conducts annual fire unannounced fire drills for business occupancies. All documentation of the drills and staff evaluations are held in the Safety department.	• Fire Drill Matrix • Fire Drill evaluations
PE2 SR6b	**Fire drills shall be thoroughly documented and evaluate the organization's knowledge of the items listed in PE.2, SR.4.** Note: All items are listed on the drill evaluation forms and reports of	• Fire Drill evaluations • Aggregated data to Quality Committee
PE2 SR6c	**At least annually, the organization shall evaluate the effectiveness of the fire drills. The report of effectiveness shall be forwarded to Quality Management Oversight.** Note:	• Aggregated data to Quality Committee through consent agenda

PE2 SR6d	**Operating room fire exit drills and operating room fire safety training shall be conducted in accordance with the requirements of NFPA 99-2012.** Note: Physicians are included in the education and drill for fire exit.	• Fire exit drills are completed annually and kept in the OR admin office.
PE2 SR7	**The Life Safety Management System shall address applicable Alterative Life Safety Measures (ALSM) that shall be implemented whenever life safety features, systems, or processes are impaired, or deficiencies are created or occur. Thorough documentation is required.** Note: During every type of construction or remodel, an ALSM and ICRA assessments are performed. The results will determine the actions needed for the project.	• ALSM and ICRA assessments • Pre-construction book
PE2 SR7a	**All alternative life safe measures shall be approved by the authority having local jurisdiction. Life safety measures for redundant and/or common minor renovations/repairs/testing may be preapproved for the specific task by the AHJ.** Note: Our ALSM and ICRA assessments categorize our projects and determine the level of jurisdiction that must provide approvals. All projects in need of a permit will go through the City of Odessa and the Fire Marshall's Division.	• ALSM and ICRA assessments • Pre-Construction book
PE2 SR8	**When a sprinkler system is shut down for more than 10 hours, the hospital shall:** Note: MCH will perform an assessment of the area and consult with the Fire Marshall to determine if evacuation or fire watch is necessary.	• ALSM and ICRA assessments • Pre-Construction book
PE2 SR8a	**Evacuate the building or portion of the building affected by the system outage until the system is back in service, or** Note: MCH Safety Officer, Engineering Director, and Chief Operating Officer will determine if the occupants of the affected area will need to be relocated or if a Fire Watch should be initiated	• ALSM and ICRA assessment • Pre-Construction book

PE2 SR8b	**Establish a fire watch until the system is back in service.** Note:	• MCH 4047 – Fire Watch
PE2 SR9	**Buildings shall have an outside window or outside door in every patient sleeping room, and for any building constructed after July 5, 2016, the sill height shall not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.** Note: With any new construction, all building codes will be followed. All construction before the above-mentioned date will be grandfathered in.	
PE2 SR9a	**The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.** Note: The Center for Women and Infants was constructed following the appropriate building code with required sill heights.	
PE2 SR9b	**The sill height in special nursing care areas of new occupancies shall not exceed 60 inches.** Note: Center for Women and Infants was constructed following the appropriate building code with required sill heights.	
PE2 SR10	**The Life Safety Management System shall require that Life Safety systems (e.g., fire suppression, notification, and detection equipment) shall be tested and inspected, and maintained (including portable systems) in accordance with applicable requirements.** Note: All testing and inspections are per manufacturing specifications and guidance from OSHA and NFPA.	• EOC Committee Testing Schedule
PE2 SR10a	**Portable fire extinguishers shall be inspected at least once per calendar month with no more than 31 days between inspections at intervals not exceeding 31 days.**	• Fire extinguisher inspection

	Note: Fire extinguishers inspections are handled in house monthly and a vendor performs the annual.	information is held in the safety office
PE2 SR11	**The Life Safety Management System shall require a process for reviewing the acquisition of bedding, draperies, furnishings, and decorations for fire safety.** Note: The material safety review team reviews all bedding, draperies, and furnishings prior to purchase. The team rounds and reviews all holiday decorations as well as special approved events or program décor.	• Material Safety Review Team
PE2 SR12	**All non-patient sleeping rooms shall be equipped with an approved, single-station smoke alarm.** **Note: NFPA 101, 2012 9.6.2.10.1.4: System smoke detectors in accordance with NFPA 72, National Fire Alarm and Signaling Code, and arranged to function in the same manner as single-station or multiple-station smoke alarms shall be permitted in lieu of smoke alarms.** Note: Every sleep room in Medical Center is equipped with a smoke detector and a visual alert.	
PE2 SR13	**Construction, Repair, and Improvement operations shall involve the following activities:** Note:	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR13a	**During construction, repairs, or improvement operations, or activities otherwise affecting the space, the current edition of the Guidelines for Design and Construction of Hospitals or the Guidelines for Design and Construction of Outpatient Facilities (FGI), as appropriate shall be consulted for designing purposes.** Note: All construction projects are subject to a pre-construction assessment which will determine the safety requirements that will be needed for each project. If the pre-construction	• ALSM and ICRA assessment • Pre-Construction book

	assessment deems necessary, a full ALSM will be complete and appropriate pre-designed processes will be followed.	
PE2 SR13b	**The organization shall assess, document, and minimize the impact of construction, repairs, or improvement operations upon occupied area(s). The assessment shall include, but not be limited to, provisions for infection control, utility requirements, noise, vibration, and alternative life safety measures (ALSM).** Note: Every project includes a pre-construction assessment is performed. Infection prevention, Safety, and engineering are all responsible to complete the pre-construction assessment.	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR13c	**In occupied areas where construction, repairs, or improvement operations occur, all required means of egress and required fire protection features shall be in place and continuously maintained or where alternative life safety measures acceptable to the authority having local jurisdiction are in place. NFPA 241-2009, Standard for Safeguarding Construction, Alteration, and Demolition Operations, shall be referenced in identifying and implementing alternative life safety measures.** Note: Egress and fire suppression systems are assessed for the level of involvement in the construction project. If the pre-construction and ALSM assessment deem appropriate other procedures are followed i.e. fire watch and other types of education.	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR13d	**All construction, repairs, or improvement operations, shall be in accordance with applicable NFPA 101-2012 standards, and State and local building and fire codes. Should standards and codes conflict, the most stringent standard or code shall prevail.** Note: All construction projects utilize architects' groups that ensure the highest level of healthcare safety is used. All safety drawings are kept in the engineering department.	• Life Safety Drawings are held in the Engineering Department

Evaluation of Plan

On an annual basis, the Safety Department will evaluate the objectives, scope, effectiveness, and performance of the Life Safety Management Plan. Any changes in objectives will be addressed during the Annual Evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Safety Department collaborates with the EOC Committee and other appropriate associates to convey and address any life safety issues and/or concerns.

The Annual Evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with life and fire safety.

Performance Indicators

- **Goals 2024**

2025 Goal	Evaluation
• Conduct quarterly mock surveys to identify gaps in compliance by performing Mock surveys with engineering department to ensure that all of the life safety documentation is appropriately gathered and available	• Mock surveys were completed twice in the 2024-2025 fiscal year. Several findings were noted and corrected as well as documentation and management plans were thoroughly assessed and strengthened

- **Goals 2026**

2026 Goal	Action Plan
• Create one event/game per quarter to engage the employees in fire safety and increase awareness and acknowledgement of surroundings in MCH and the fire suppression system components.	• Work through the department director's meetings to push out the education to all staff members on the awareness of their departments. Utilizing games like scavenger hunts, crossword puzzles and other engaging fun items.

Medical Center Health System
Safety Management Plan

Purpose

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The environmental safety program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Medical Center Health System.

The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Medical Center Health System has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and all others that visit the organization's facilities. Safety management plan ensures compliance and continued maintenance held to OSHA, CMS, DNV, NFPA, and ASHE guidelines and standards.

Scope

The Safety Management Plan at Medical Center Health System applies to all facilities and to all safety processes, activities, departments, structures and grounds as well as patients, staff, students, and visitors. The Safety Management Plan addresses all elements required to provide a safe and healthy environment free of hazards and to collaborate with department management to provide staff training and monitoring in order to minimize the risk of injuries.

Principles

- The identification of specific risks faced by patients and employees, and others is essential for designing safe work areas and work practices.

- The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work

environments and safe work practices to minimize the potential for adverse impact on them, patients, and all others that are in the environment.

- Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and staff knowledge.

Objectives

The objectives of the Safety Management Plan include:

- Comply with all relevant safety standards and regulations.
- Enforce current safety practices for patients, staff, students, and visitors.
- Provide regular safety education to all staff.
- Monitor the effectiveness of the safety program.
- Identify opportunities and to improve safety performance and develop and implement improvements.

Program Management Structure

- The Chief Operating Officer, Safety Officer, Engineering Director, Risk Manager, and Infection Control Officer work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education, training materials, and manage day-to-day activities of the environmental safety program.

- The Environmental Safety Leadership team coordinates the development of reports to the Environment of Care Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.

- The Environment of Care Committee monitors and evaluates the processes used to manage the environment of care. Members of the committee are by appointed by the Chairman (the Safety Officer). The Environment of Care Committee meets a minimum once per month. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes, and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

- The Human Resources Staff Development Coordinator and other leadership staff are responsible the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and to job and task specific safety and infection control procedures. The orientation and ongoing education and training emphasis environmental safety.

- Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.

- Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, job-related procedures, and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE3 SR1	**The organization shall provide a Safety Management System that shall maintain safe and adequate facilities for its services. Diagnostic and therapeutic facilities shall be located for the safety of patients.** Note: Facilities are designed and maintained per applicable building codes and design requirements.	• EOC rounds and assessments • City of Odessa Fire Marshall Inspections • Insurance Risk Assessments
PE3 SR2	**The Safety Management System shall require that facilities, supplies and equipment be maintained and ensure an acceptable level of safety and quality. The extent and complexity of facilities shall be determined by the services offered.** Note:	• EOC Testing Schedule • Clinical Engineering performance reports • EOC safety performance improvement activities (QAPI)
PE3 SR3	**The Safety Management System shall require proper ventilation, light and temperature controls in pharmaceutical, food preparation, and other appropriate areas including where equipment is in use (e.g., computers, sterilizing equipment, refrigerators).** Note: Monitoring, testing, and maintenance of all temperature, humidity, and air balancing is kept in the engineering department.	• Siemens • Versa Trak • ND White testing
PE3 SR4	**The Safety Management System shall require that the organization maintain an environment free of hazards and manages staff activities to reduce the risk of occupational-related illnesses or injuries.** Note:	• ALSM/ICRA assessments prior to and during construction, renovation, and maintenance

		• Minimal lift education and program MCH-4034 • Patient safety event reporting MCH- 4012 • Health and Wellness employee accident and education program
PE3 SR5	**The Safety Management System shall require periodic surveillance of the hospital facilities and grounds to observe and correct safety issues that may be identified.** Note: Environmental safety rounds are performed on a weekly basis. Teams members from Environmental Services, Infection Prevention, Quality, Engineering, and Safety perform rounds weekly for observation and identification of improvement areas within the hospital and clinical areas. The findings are recorded and shared with the department directors and engineering department for correction and education.	• MCH Environmental surveillance procedure • Monthly Grounds inspection report
PE3 SR6	**The Safety Management System shall address safety recalls and alerts.** Note: Safety recalls and alerts are tracked and disseminated by our Device Tracker Coordinator in the Material Management Department. The department directors that have said devices in their departments will receive notification of the recall and/or alert along with the options for corrective actions recommended by the manufacturer or the FDA, and templates for documentation for such efforts via the recall tracking system in a timely manner. A list of the recall/alerts and their progress of completion is presented to the Environment of Care Committee every two weeks.	• MCH-4041 Product recall Procedure
PE3 SR7	**All eyewashes and emergency drench showers shall be tested and maintained according to the current ANSI Z358.1 Standard.** Note:	• Eyewash and Emergency drench shower SOP • HEMS work order

	Eyewashes and Emergency drench showers operations are tested on a weekly basis as well as a full inspection annually. Documentation is archived in the Safety Department.	
PE3 SR8	**The organization shall have procedures for the proper routine storage and prompt disposal of trash.** Note:	• MCH 4021 • IC 1042
PE3 SR9	**An organization utilizing respirators for protection of staff shall have a documented Respiratory Protection Program (RPP).** Note: The respiratory protect program has been a collaboration between MCH Employee Health Department and the Safety Department. A draft has been completed incorporating all of the regulations for the programs as well as all the new guidelines that have been suggested. The draft policy was approved in the November 2025 board meeting.	• HW - 0031
PE3 SR9a	**The RPP shall meet the requirements of OSHA 1910.134.** Note: Our respiratory protection program adheres to all the requirements outlined in OSHA 1910.134, ensuring comprehensive safety measures are in place. This program is the result of a collaborative effort among several MCH departments, aimed at achieving the highest level of safety and quality for our team members.	•
PE3 SR9b	**If an organization is not subject to OSHA compliance, the organization shall establish and implement a written respiratory protection program at least as stringent as the OSHA requirements for respiratory protection.** Notes:	• HW-0031
PE3 SR9c	**For non-employed and contract staff and providers, an organization may accept evidence of proper fit-testing from the non-employed and contract staff and providers to satisfy the requirements of PE.3 (SR.9).**	• HW-0031

	Notes: Collaboration with our higher Education facilities on guidelines for students and residents that are gaining clinical experience in our facility. This collaboration has been documented in the draft respiratory protection program policy draft.	

Evaluation of Plan

On an annual basis, the Safety Department will evaluate the objectives, scope, effectiveness, and performance of the Safety Management Plan. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The safety department collaborates with the EOC Committee and other appropriate associates to convey and address safety issues and/or concerns.

The Annual evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for maximizing safety and minimizing risk at MCHS.

Performance Indicators

- Goals 2025

2025 Goal	**Evaluation**
Elevate our air pressure relations program to include all rooms that require negative or positive pressure to regulations and requirements by adding monitoring devices to assist clinical staff to make better judgments on patient safety in rooms and rounding for audits on the monitoring systems and staff behaviors related to these special rooms	• This goal was met after we added all of the needed equipment to the rooms that were lacking monitoring as well as educating the nursing staff on the perimeters of the isolation room (red and green lights on monitors) to determine if the room is safe for infectious patients

- Goals 2026

2026 Goal	**Action Plan**

Conduct rounds weekly, evaluating at least 2-3 departments per week to achieve > 90% compliance for all physical environment standards.	Utilizing the Sentact system to provide real-time data for findings and look closures.

Medical Center Health System
Utility Management Plan

Purpose

The environment of care and the range of patient care services provided to the patients served by Medical Center Hospital (MCH) present unique challenges. A utility management plan (UMP) is in place and is developed using various risk criteria to establish selection, maintenance, testing, and inspection procedures to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the management activities that MCH has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The management plan and its utility systems management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

Scope

The Utility Systems Management Plan and programs apply to all facilities, Main Hospital Campus, FHC, Urgent Care Sites and to all processes, activities and departments, as well as to patients, staff, and visitors at Medical Center Health System.

All critical elements of the utility systems used for life support, infection control, environmental support, equipment support, and communications will be included in the program. The Utility Systems Management Plan addresses the safe operation, maintenance, and emergency response procedures for these critical operating systems. Utilities include systems for electrical distribution, emergency power, heating, ventilating, and air conditioning, plumbing, boiler and steam, medical gas, medical/surgical vacuum, and communication systems.

Principles

- Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.

- Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe effective

care and treatments are rendered to persons receiving services.

- Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

Objectives

The objectives of the Utility Systems Management Plan include:

- Comply with all relevant safety standards and regulations.
- Provide a safe, controlled, and comfortable environment for patients, staff, and visitors.
- Ensure the operational reliability of the utility systems:
  - Direct Life Support systems
  - Infection Control systems
  - Non-Life Support utility support systems
- Reduce the potential for hospital-acquired illness.
- Assess special risks of the utility systems.
- Provide a plan for response to utility systems failures.
- Effect essential coordination for scheduled utility systems interruptions.
- Establish and maintain a program of policies and procedures consistent with the organization's mission, vision, and values.
- Enhance of maintenance of the utility systems to reduce and minimize system failures and/or interruptions.

Program Management Structure

- The Director of Facilities assures that an appropriate utility system maintenance program is implemented. The Director of Facilities also collaborates with the Safety Officer to develop reports of UMP performance for presentation to the Environment of Care Committee on a quarterly basis. The reports summarize organizational experience, performance management, improvement activities, and other utility systems issues.

- The MCH Senior Leadership Team receives regular reports of the activities of the USM program through the Quality Council. The Chief Operating Officer collaborates with the Director of Facilities and other appropriate staff to address utility system issues and concerns. The Chief Operating Officer also collaborates with the Director of Facilities to develop a budget and operational objective for the program.

- The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

- Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE8 SR1	**The organization shall require a Utility Management System that provides for a safe and efficient facility that reduces the opportunity for organization-acquired illnesses.** Note:	HEMS work order: Procedures 528, 540, 545, 546, 559, 584
PE8 SR1a	**The Utility Management System shall have a water management program to reduce the risk of growth and spread of legionella and other opportunistic pathogens in building water systems.**	MCH-1204
PE8 SR2	**The Utility Management System shall provide for a process to evaluate critical operating components, to include, but not limited to cybersecurity issues.** Note:	All critical operating components are inventoried & scheduled PM's are in HEMS System
PE8 SR3	**The Utility Management System shall develop maintenance, testing, and inspection processes for critical utilities.** Note:	All critical utilities are inventoried & scheduled PM's are in HEMS System
PE8 SR4	**The Utility Management System shall contain a process to address medical gas systems and HVAC systems (e.g., includes areas for negative pressure).**	HEMS work order: Procedure 545

	Note:	
PE8 SR5	**The Utility Management System shall provide for emergency processes for utility system failures or disruptions.** Note:	HEMS work order: Procedure 543
PE8 SR6	**The Utility Management System shall provide for reliable emergency power sources with appropriate maintenance as required. The organization shall implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.** Note:	HEMS work order: Procedure 51, 542, 543
PE8 SR7	**The Utility Management System shall require proper ventilation, light and temperature controls in patient care areas, operating rooms, sterile supply rooms, special procedures, isolation and protective isolation rooms, pharmaceutical, food preparation, and other appropriate areas.** Note:	HEMS work order: Procedures 523, 533, 545, 575
PE8 SR8	**There shall be emergency power and lighting in at least the operating, recovery, intensive care, emergency rooms, and in other areas where invasive procedures are conducted, stairwells, and other areas identified by the organization (e.g., blood bank refrigerator, etc.). In all other areas not serviced by the emergency supply source, battery lamps and flashlights shall be available.** Note:	HEMS work order: Procedures 523, 533
PE8 SR8a	**Emergency lighting standards shall comply with Section 7.9 of the Life Safety Code, 101-2012, and applicable references, such as, NFPA-99, 2012: Health Care Facilities, for emergency lighting and emergency power.** Note:	HEMS work order: Procedures 86, 523, 533, 541, 542, 543
PE8 SR8b	**NFPA 99, 2012 6.3.2.2.11 Battery-Powered Lighting Units, shall apply to new and existing healthcare facilities and shall be installed in accordance with NFPA 70, National Electric Code, 2011 edition.**	Installation is in accordance with IBC NFPA occupancy Type

	Note:	Group 1. Construction Type 1B Sprinkled
PE8 SR9	**There shall be facilities for emergency gas and water supply.** Note:	Emergency water supply is under an MOU with Culligan
PE8 SR10	**All relevant utility systems shall be maintained inspected, and, tested.** Note: Please refer to documents	Please refer to HEMS System & testing schedule

Evaluation of Plan

On an annual basis, the Engineering Director will evaluate the objectives, scope, effectiveness, and performance of the utility Management Plan. Any changes in objectives will be addressed during the Annual Evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The engineering director collaborates with the EOC Committee and other appropriate associates to convey and address any utility issues and/or concerns.

The Annual Evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with utility safety.

Performance Indicators

- Goals 2025

Goal 2025	**Evaluation**
QAPI: Increase the compliance of pressure relations rooms from current to 95% compliance by Utilizing weekly team rounding, improving the documentation and tracking, installing more continuous monitoring equipment, and having third party vendors onsite	**This goal was completed and will continue to be monitored through leadership and the infection prevention committee.**
Develop and implement a program designed to monitor all major utilities up time and costs related to maintenance and upkeep by creating a list of all major utilizes, creating a graph to display	This goal was not met and will continue into 2026 through the partnership with ENFRA.

uptime versus downtime, and align costs with equipment to monitor all dollars spent on each piece of equipment	

- Goal 2026

Goal 2026	**Action Plan**
Develop and implement a program designed to monitor all major utilities up time and costs related to maintenance and upkeep by creating a list of all major utilizes, creating a graph to display uptime versus downtime, and align costs with equipment to monitor all dollars spent on each piece of equipment	Through the partnership with ENFRA, we are hoping to complete this goal in 2026.

Medical Center Health System
Security Management Plan 2025 Annual Evaluation

Purpose

The purpose of this document is to evaluate the scope, objectives and effectiveness of the above referenced plan.

Scope

The program is applied to the Main Hospital Campus, FHC, Urgent Care Sites, and any property owned by the Ector County Hospital District.

Objectives

The objectives of the Security Management Plan include:

- Patrol the hospital buildings and property on a consistent basis, to identify and document potential or actual problems.
- Take appropriate and timely action to prevent crime, injury, or property loss.
- Establish and maintain security/police policies and procedures to direct staff performance when responding to security incidents. Security policies are reviewed annually.
- Provide timely response to emergencies and requests for assistance. Report any fire, injury, or other incidents. Communicate externally with local, state, or federal law enforcement and other civil authorities. Provide internal communications, as needed.
- Control vehicle movement on system grounds, including control of parking and access to the Emergency Department.
- Provide timely response to reports of violent activity or requests for assistance in restraining violent or aggressive patients, visitors, and/or staff.
- Limit access to the grounds, building, and sensitive areas by enforcement of staff identification policies and by assisting in the removal of persons from unauthorized areas.
- Provide timely response to requests for escort, keys and door openings, or other routine requests for assistance.
- Provide Security Management Training of all new employees including what types of incidents Police or Security Department staff can respond to, how to report incidents and obtain assistance in an emergency and training for staff in designated sensitive areas.
- Manage a documentation system for security incidents.

- Document police department activity; including investigations, routine patrol activity, special and routine requests for assistance, and other activities.
- Identify problems, failures, and user errors that require attention and action. These are reported to the Environment of Care Committee monthly.
- Identify performance improvement opportunities.
- Conduct an annual evaluation of the scope, objectives, performance, and effectiveness of the program.
- Evaluate the potential for workplace violence and develop an appropriate program to deal with it.

Evaluation of Plan

Annual evaluation objectives are developed through interactions with the EOC Committee and Hospital administration. Objectives will be developed based on review of data and performance indicators. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan. These objectives will address the primary operational initiatives for minimizing the risk associated with security of the facility.

Performance Indicators

Goals for 2025

Performance Objective	Performance Assessment
Police/Security rounding, at a minimum, once an hour through the emergency department following a specific guard tour to provide a visible presence and reduce the risk of workplace violence from occurring.	• CCure guard tour was established. • Monthly reported generated and placed in spreadsheet for compliance of a minimum of 95%. • Results were reviewed and provided to staff during department meetings.
Ensure proper functioning of all panic alarms in an effort to reduce workplace violence occurrences and injuries.	• Quarterly inspections and testing of all panic alarms across the campus were completed. • Any malfunctioning panic alarms were corrected and made operable by the vendor.

Evaluation of Effectiveness

Based on the performance indicators noted above, the Security Management Plan is effective in meeting its stated goals.

Performance Indicators

Goals for 2026

Performance Objective	How performance will be assessed
Ensure exterior light checks are completed monthly at all district owned locations, including all stairwells in parking garages, to enhance the safety and security in and around the buildings and parking structures.	• Officers/Guards Daily Logs • RMS security checks • Monthly reports submitted to Chief and Director of Engineering for repairs. • Review light report in the EOC Committee.
Improve the perception of safety and security among patients, visitors, and staff through service-focused initiatives.	• Implement “Security Rounds with Purpose”, where officers engage with patients and staff while conduction rounds. • Train and/or retrain staff on AIDET. • Ensure security visibility in high traffic public areas during peak hours. • Documentation of “Security Rounds with Purpose” on daily logs.

** Medical Center Health System**

(DNV Version)

2026 Medical Equipment Management Plan

_____ _____

Facility Representative **TRIMEDX Site Manager**

(Signature Approval or EOC Minutes Approval Required)

APPROVAL DATE: _____

A. PURPOSE

The purpose of the **Medical Equipment Management Plan (MEMP)** is to support a safe patient care and treatment environment by managing risks associated with the use of medical equipment. The specific medical equipment risks of the environment are identified by conducting and maintaining a proactive risk assessment plan based on various risk criteria, including risks identified by outside sources such as Det Norske Veritasor other accreditation agencies.

B. SCOPE

The MEMP describes the risk and routine management and identifies the policies and procedures implemented to mitigate the potential for adverse impact on the safety and health of patients, associates, and other people, entering the organization's facilities, and to assure compliance with applicable standards and regulations.

The program is applied to the hospitals, clinics and operations of Medical Center Hospital, in accordance with the TRIMEDX contract for Medical Equipment Management for the organization.

C. PRINCIPLES

- Selection of appropriate equipment is an essential part of providing safe, effective care and treatment.
- Orientation, education, and training of operators of medical equipment are essential parts of the program.
- Assessment of needs for continuing technical support of medical equipment and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that medical equipment is safe and reliable.

D. OBJECTIVES

- Use established criteria and relevant historical information to identify potential equipment risks. Identified risks are mitigated through development of appropriate processes for equipment management to ensure that equipment is appropriate for intended use and that associates are properly trained. It also ensures that equipment is maintained appropriately by qualified individuals.
- Identify and respond appropriately to equipment hazard and recall notices in a timely manner.
- Record, report, and analyze medical equipment problems, failures, and use errors, and implement processes designed to further reduce the risks associated with medical equipment throughout the facility, to improve the overall Environment of Care.

E. PROGRAM MANAGEMENT STRUCTURE

- The authority over the plan and responsibility for the plan development, performance measures, appropriate regulatory compliance, and achievement of the goals has been delegated to the EOC Committee in collaboration with the Safety Officer and Clinical Engineering staff. The Management Plan is approved by the Environment of Care Committee.
- The manager of the medical equipment management program administers the plan through the services of the Clinical Engineering department, in conjunction with the applicable clinical care areas.
- The Clinical Engineering associates manage the timely completion of scheduled maintenance activities required for safe, reliable performance of medical equipment. In addition, technicians facilitate necessary repairs, hazard alerts/recalls, and other unscheduled service activities as requested.

F. DEFINITIONS

High-Risk Equipment (Life Support & Critical Equipment) – Equipment that is critical to patient health and safety. At a minimum such critical equipment includes, but is not limited to, life-support devices, key resuscitation devices, critical monitoring devices, and other devices whose failure may result in serious injury to or death of patients or associates.

Medical Equipment – Fixed and portable equipment used for the diagnosis, treatment, monitoring, and direct care of individuals.

Temporary Equipment – Equipment brought into the facility and intended for short-term use. Typically, the length of time the equipment resides in the facility is not to exceed the duration of one Default PM cycle or one year. Temporary equipment can be classified as loaner, rental, trial, patient-owned, or physician-owned.

Computerized Maintenance Management System (CMMS) – TRIMEDX proprietary system for maintaining medical equipment inventory and service records.

G. ELEMENTS OF THE PROGRAM

Physical Environment (PE): PE.7 Medical Equipment Management System

STANDARD	STANDARD REQUIREMENT	EVIDENCE OF COMPLIANCE
PE.7	**Medical Equipment shall be maintained to ensure an acceptable level of safety and quality. This shall include provisions for cybersecurity of medical equipment.**	Hospital Policy and Procedure - MCH Cybersecurity Incident Response Plan
PE.7 SR.1	**The organization shall establish a Medical Equipment Management System that provides processes for the acquisition, safe use, and the appropriate selection of equipment.**	TRIMEDX Policy and Procedure - Electrical Safety Testing - Performance Verification - Preventive Maintenance (PM) - Temporary Equipment

PE.7 SR.2	**The Medical Equipment Management System shall address issues related to the organization's initial service inspection, the orientation, and the demonstration of use for rental or physician owned equipment.**	TRIMEDX Policy and Procedure - Electrical Safety Testing - Performance Verification - Preventive Maintenance (PM) - Temporary Equipment

PE.7 SR.3	**The Medical Equipment Management System shall address criteria for the selection of equipment.**	TRIMEDX Policy and Procedure - Preventive Maintenance (PM) Performance Verification - Alternative Equipment Management (AEM) and Default Maintenance - Program Assignment
PE.7 SR.4	**The Medical Equipment Management System shall address incidents related to serious injury or illness or death (See SMDA 1990).**	Hospital Policy and Procedure - MCH 4025 – Safe Medical Device
PE.7 SR.5	**The Medical Equipment Management System shall have a process for reporting and investigating equipment management problems, failures, and user errors.**	TRIMEDX Policy and Procedure - Equipment Repairs Hospital Policy and Procedure - MCH 4025 – Safe Medical Device
PE.7 SR.6	**The Medical Equipment Management System shall address a process for determining timing and complexity of medical equipment maintenance.**	TRIMEDX Policy and Procedure - Preventive Maintenance (PM) - Alternative Equipment Management (AEM) - PM Schedule Assignment

PE.7 SR.7	**The Medical Equipment Management System shall address the process of receiving and responding to recalls and alerts.**	TRIMEDX Policy and Procedure - Alerts and Recalls Management Hospital Policy and Procedure - MCH 4041

MI.2 SR.2	**Medical Imaging** **Staff who work in radiation areas shall be monitored continually for the amount of radiation** **exposure by the use of exposure meters or badge dosimeters.**	TRIMEDX Policy and Procedure - Radiation Exposure Monitoring for TRIMEDX Imaging Associates *(employed by TRIMEDX)* Hospital Policy and Procedure - RAD – 0170 – Preventive Maintenance Program
MI.3 SR.1	**Medical Imaging** **Periodic inspection of equipment shall be performed, at least minimally according to manufacturer's recommendations (see PE.7). Hazards shall be identified and promptly corrected (See PE.1).**	TRIMEDX Policy and Procedure - Preventive Maintenance (PM) - Equipment Repairs Hospital Policy and Procedure - RAD – 0170 – Preventive Maintenance Program
MI.3 SR.2	**Medical Imaging**	TRIMEDX Policy and Procedure

	Documentation of preventive maintenance and repairs of radiology equipment shall be maintained (See PE.7).	- Preventive Maintenance (PM) - Equipment Repairs <u>Hospital Policy and Procedure</u> - RAD – 0170 – Preventive Maintenance Program
NM.3 SR.2	**<u>Nuclear Medicine</u>** **The equipment shall be maintained in safe operating condition and inspected, tested, and calibrated at least annually by qualified personnel (See PE.7).**	<u>TRIMEDX Policy and Procedure</u> - Preventive Maintenance (PM) - PM Schedule Assignment <u>Hospital Policy and Procedure</u> - RAD – 0170 – Preventive Maintenance Program

NM.3 SR.3	**Nuclear Medicine** **Documentation of equipment testing, and preventive maintenance shall be maintained (See PE.7).**	TRIMEDX Policy and Procedure - Preventive Maintenance (PM) - Equipment Repairs Hospital Policy and Procedure - RAD – 0170 – Preventive Maintenance Program
SS.10 SR.5	**The organization shall have a process in place for all surgical instruments, implants, medical equipment, and devices not solely owned by the organization, including:** **SR.5a Acceptance of items;** **SR.5b Inventory of items;**	TRIMEDX Policy and Procedure - Performance Verification - Temporary Equipment

H. EVALUATION OF PLAN

On an annual basis, the Clinical Engineering Manager will evaluate the objectives, scope, effectiveness, and performance of the Medical Equipment Management Plan. Any changes in objectives will be addressed during the Annual Assessment and incorporated into the updated MEMP plan.

The EC Committee receives regular reports of the program activities monthly. The program manager collaborates with the EC Committee and other appropriate associates to convey and address medical equipment issues and concerns.

The Annual Assessment objectives are developed through interactions with the EC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with the use of medical equipment.

The Annual Assessment is a 12 Month summary that is compiled by the Clinical Engineering Manager and presented to the EC Committee and Safety Officer annually for approval.

PERFORMANCE INDICATORS

I. Goals for 2025 are to continue Mandatory Daily Rounding and use clear labels to protect the PM sticker

II. Goals for 2026 are to continue Mandatory Daily Rounding and the use of clear labels to protect the PM sticker and clean the old sticker residue

Hospital EOC Committee

Medical Center Health System
Security Management Plan

Purpose

Each environment of care poses unique risks to the patients served, the employees and medical staff who manage it, and to others who enter the environment. The security program is designated to identify and manage the risks of the environment of care operated and owned by Medical Center Health System. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental security program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or potions of buildings housing healthcare services, parking lots and parking structures operated by Medical Center Health System.

The Management Plan for Environmental Security describes the risks, safety, security and daily management activities that Medical Center Health System has put into place to achieve the lowest potential for adverse impact on the security and health of patients, staff and other people, coming to the organization's facilities. The management plan and security program is evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The Security Management Program is designed to manage the security risks the environment of MCHS presents to patients, staff, and visitors. The program is designed to assure identification of general and high security risks and to develop effective responses.

Scope

The program is applied to the Main Hospital Campus, FHC, Urgent Care Sites, and any property owned by the Ector County Hospital District.

Principles

- A visible security/police presence in the hospital helps reduce crime and increase feelings of security by patients, visitors, and staff.
- Assessment of risks to identify potential problems is key to reducing crime, injury, and other incidents.
- Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.
- Training hospital staff is critical to their performance. Staff members are trained to recognize and report either potential or actual incidents to ensure a timely response. Staff members in sensitive areas are trained about the protective measures designed for those areas and their responsibilities to assist in protection of patients, visitors, staff and property.
- Violence in the workplace is a growing problem in healthcare. It is necessary to develop a program to address workplace violence.

Objectives

- Patrol the hospital buildings and property on a consistent basis, to identify and document potential or actual problems.
- Take appropriate and timely action to prevent crime, injury, or property loss.
- Establish and maintain security/police policies and procedures to direct staff performance when responding to security incidents. Security policies are reviewed annually.
- Provide timely response to emergencies and requests for assistance. Report any fire, injury, or other incidents. Communicate externally with local, state, or federal law enforcement and other civil authorities. Provide internal communications, as needed.
- Control vehicle movement on system grounds, including control of parking and access to the Emergency Department.
- Provide timely response to reports of violent activity or requests for assistance in restraining violent or aggressive patients, visitors, and/or staff.

- Limit access to the grounds, building, and sensitive areas by enforcement of staff identification policies and by assisting in the removal of persons from unauthorized areas.
- Provide timely response to requests for escort, keys and door openings, or other routine requests for assistance.
- Provide Security Management Training of all new employees including what types of incidents Police or Security Department staff can respond to, how to report incidents and obtain assistance in an emergency and training for staff in designated sensitive areas.
- Manage a documentation system for security incidents.
- Document police department activity; including investigations, routine patrol activity, special and routine requests for assistance, and other activities.
- Identify problems, failures, and user errors that require attention and action. These are reported to the Safety Committee monthly.
- Identify performance improvement opportunities.
- Conduct an annual evaluation of the scope, objectives, performance, and effectiveness of the program.
- Evaluate the potential for workplace violence and develop an appropriate program to deal with it.

Program Management Structure

- The ECHD Board of Directors receives regular reports on the activities of the Security Program from the Safety Committee and Patient Safety and Quality Council. The Board of Directors reviews, reports and, as appropriate, communicates concerns about identified issues and regulatory compliance. The Board of Directors provides support to facilitate the ongoing activities of the Security Program.
- The CEO receives regular reports on the activities of the Security Program. The CEO reviews reports and, as appropriate, communicates concerns about key issues and regulatory compliance to the Chairman of the Safety Committee or other appropriate personnel. The Chief Operating Officer collaborates with the Chief of Police to establish operating and capital budgets of the Security Program.

- The Chief of Police works under the general direction of the Chief Operating Officer. The Chief of Police in collaboration with other department heads, and the Safety Committee, manages all aspects of the Security Program. The Chief of Police advises the Safety Committee regarding security issues which may necessitate changes to policies, orientation or education, or purchase of equipment.

- Department heads will assure orientation of all new personnel to the department and, as appropriate, to job and task specific security procedures. Department heads with security sensitive areas are responsible for training their personnel in any special security procedures or precautions. Where necessary, the Chief of Police assists department heads in developing department security programs or policies.

- Individual personnel are responsible for learning and following hospital and departmental procedures for security.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE4 SR 1	**The organization shall develop a Security Management System that provides for a secure environment.** Note:	• Annual review of crime statistics submitted to the Board • Annual report submitted to the EOC Committee • MCH-4010
PE4 SR 2	**The organization shall meet the requirements set forth in NFPA 99, 2012 Chapter 13, Security Management**. Note:	• Each element is identified in the Annual Security Vulnerability Assessment
PE4 SR 3	**The Security Management System shall require that the organization conduct a security vulnerability assessment (SVA) and shall implement procedures and controls in accordance with the risks identified by the SVA.** Note:	• Security Vulnerability Assessment

PE4 SR 4	**The Security Management System shall at a minimum:** Note:	
PE4 SR 4a	**Provide for identification of patients, employees and others.** Note:	• MCH-4037 • MCH-3000
PE4 SR 4b	**Address issues related to abduction, elopement, visitors, workplace violence, and investigation of property losses.** Note:	• MCH-4013 • NADM-0009 • MCH-4015 • MCH-4031 • HPD-1022 • HPD-1003 • HPD-1011
PE4 SR 4c	**Develop a written, comprehensive workplace violence control and prevention program based on guidelines from national authorities such as the OSHA Publication 3148-04R 2015 Guidelines for Preventing Workplace Violence for Healthcare and Social Workers.** Note:	• MCH-4015
PE4 SR 4d	**Establish emergency security procedures to include all hazard events identified in the SVA.** Note:	
PE4 SR 4e	**Require vehicular access to emergency service areas.** Note:	• HPD-1010 • HPD-1061
PE$ SR 4f	**Require a process for reporting and investigating security related issues.** Note:	• MCH-4001

Evaluation of Plan

On an annual basis, the Security Department will evaluate the objectives, scope, effectiveness, and performance of the Security Management Plan. Any changes in objectives will be addressed during the Annual Evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Security Department collaborates with the EOC Committee and other appropriate associates to convey and address any security issues and/or concerns.

The Annual Evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with security of the facility.

Performance Indicators

- Goal 2025

2025 Goal	**Evaluation**
Police/Security rounding, at a minimum, once an hour through the emergency department following a specific guard tour to provide a visible presence and reduce the risk of workplace violence from occurring.	• CCure guard tour was established. • Monthly reported generated and placed in spreadsheet for compliance of a minimum of 95%. • Results were reviewed and provided to staff during department meetings.
Ensure proper functioning of all panic alarms in an effort to reduce workplace violence occurrences and injuries.	• Quarterly inspections and testing of all panic alarms across the campus were completed. • Any malfunctioning panic alarms were corrected and made operable by the vendor.

- Goals 2026

2026 Goal	**How to……**
• Ensure exterior light checks are completed monthly at all district owned locations, including all stairwells in parking garages, to	• Officers/Guards Daily Logs • RMS security checks

enhance the safety and security in and around the buildings and parking structures.	• Monthly reports submitted to Chief and Director of Engineering for repairs. • Review light report in the EOC Committee.Review performance with all staff during department meetings.
• Improve the perception of safety and security among patients, visitors, and staff through service-focused initiatives.	• Implement “Security Rounds with Purpose”, where officers engage with patients and staff while conduction rounds. • Train and/or retrain staff on AIDET. • Ensure security visibility in high traffic public areas during peak hours. • Documentation of “Security Rounds with Purpose” on daily logs.

ENVIRONMENT OF CARE RISK ASSESSMENT

SECURITY MANAGEMENT 2025-2026

Category NFPA 99 13.3.2	Description	Location	Responsible Party	Last Reviewed Date	Revised Yes/No/NA	Changes Implemented?
1	ID of patient, staff, & other people	MCH-3000 MCH-4037	Safety Officer CNO	8/2025 11/2022	yes & yes	
2	Access control in sensitive areas	HPD-1053	Chief of Police	06/2023	No	
3.a	Security incident	MCH-4001	Safety Officer / Chief of Police	07/2023	yes	
3.b	Hostage situation	HPD-1021	Chief of Police	5/2023	yes	
3.c	Bomb threat	MCH-4004 HPD-1057	Safety Officer / Chief of Police	07/2025 05/2023	Yes & No	
3.d	Criminal threat	SOP - 105	Chief of Police	09/2025	No	
3.e	Labor action	NA	NA	NA	NA	NA
3.f	Disorderly conduct	MCH-4001 MCH-4015 HPD-1019	Safety Officer / Chief of Police	07/2023 12/2024 05/2023	Yes, Yes, & Yes	
3.g	Workplace violence	MCH-4015	Safety Officer / Chief of Police	12/2024	Yes	
3.h	Restraining order	HPD-1039	Chief of Police	06/2023	No	
3.i	Infant/pediatric abduction	MCH-4013 HPD-1025	Director L&D/Post Chief of Police	8/2022 9/2022	Yes & No	
3.j	Situations involving VIPs or media	EOP	Safety Officer			
3.k	Maintenance of access to emergency area	HPD-1038	Chief of Police	09/2022	No	
3.l	Civil disturbance	SOP - 106	Chief of Police	09/2025	No	
3.m	Forensic patients	HPD-1029 MCH-2010	Chief of Police Safety Officer	12/2024 9/2022	Yes & No	
3.n	Patient elopement	HPD-1022	Chief of Police	05/2023	Yes	
3.o	Homeland security advisory system	EOP	Safety Officer			
3.p	Suspicious powder or substance	MCH-4004 HPD-1057	Safety Officer Chief of Police	07/2025 05/2023	Yes & No	
3.q	Use of force	HPD-1035	Chief of Police	10/2024	Yes	
3.r	Security Staff augmentation	Verbal Agreement	Chief of Police Safety Officer		N/A	

4	Security at alternate care sites or vacated facilities	SOP - 102	Chief of Police	09-2025	No	
5	Control traffic on facility Property	SOP - 103	Chief of Police	09/2025	No	
6	Protect facility assets	SOP - 104	Chief of Police	09/2025	No	
7	interaction with law enforcement agencies	Job Description / HPD-1029	Chief of Police	12/02/2024	Yes	
8	Comply with applicable laws, regulations, and standards regarding security management operations	SOP - 107	Chief of Polcie	09/2025	No	
	Education and Training					
9a	Customer Service	AIDET	Chief of Police		N/A	
9b	Use of Physical Restraints	HPD-1035	Chief of Police	10/2024	Yes	
9c	Use of force	HPD-1035	Chief of Police	10/2024	Yes	
9d	Response Criteria	SOP - 103	Chief of Police	09/2025	No	
9e	Fire watch procedures	MCH-4047	Chief of Police Safety Officer	06/2022	Yes	
9f	Lockdown procedures	EOP	Chief of Police Safety Officer		N/A	
9g	Emergency notification procedures	Everbridge	Safety Officer		N/A	
9h	Emergency Communication procedures	Everbridge	Safety Officer		N/A	