APPROVED BY THE SNCHC GOVERNING BOARD
JANUARY 20, 2026

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD MEETING
December 9, 2025 – 2:30 p.m.
Meeting was conducted via Microsoft Teams

MEMBERS PRESENT:	Donna Feliz-Barrows, Chair Jasmine Coca, First Vice Chair Sara Hunt, Second Vice Chair Rebeca Aceves Ashley Brown Marie Dukes Blanca Macias-Villa Jose L. Melendrez David Neldberg
ABSENT:	Erin Breen
ALSO PRESENT	Josh Findlay, Director and Audit Engagement Executive, Forvis Mazars LLC
LEGAL COUNSEL:	Edward Wynder, Associate General Counsel
CHIEF EXECUTIVE OFFICER:	Randy Smith
STAFF:	Emily Anelli, Andria Cordovez Mulet, David Kahananui, Justin Tully, Felicia Sgovio, Cassius Lockett, Todd Bleak, Yin Jie Qin, Robin Carter, Luann Province, Chelle Alfaro, Emma Rodriguez

I. CALL TO ORDER and ROLL CALL

The Southern Nevada Community Health Center (SNCHC) Governing Board Meeting was called to order at 2:30 p.m. A quorum was not established.

II. PLEDGE OF ALLEGIANCE

Member Melendrez joined the meeting at 2:31 p.m.

Ms. Cordovez Mulet, Executive Assistant, administered the roll call and confirmed a quorum. Ms. Cordovez Mulet provided clear and complete instructions for members of the general public to call in to the meeting to provide public comment, including a telephone number and access code.

III. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. Please clearly state your name and address and spell your last name for the record. If any member of the Board

wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the Chair closed the First Public Comment period.

IV. ADOPTION OF THE DECEMBER 9, 2025 MEETING AGENDA *(for possible action)*

The Chair called for questions or comments on the agenda. There were none.

A motion was made by Member Melendrez, seconded by Member Dukes, and carried unanimously to approve the December 9, 2025 meeting agenda, as presented.

V. CONSENT AGENDA: Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: November 18, 2025 *(for possible action)*

2. **Approve Updates to the CHCA-021 Responding to Medical Emergencies Policy;** *direct staff accordingly or take other action as deemed necessary (for possible action)*

   The Chair inquired if there were any items on the Consent Agenda that board members wanted to remove for further discussion. There were no requests.

   A motion was made by Member Melendrez, seconded by Member Dukes, and carried unanimously to approve the Consent Agenda, as presented.

Member Aceves joined the meeting at 2:33 p.m.

VI. REPORT / DISCUSSION / ACTION

1. **Review, Discuss, and Accept the Financial Statement Report, as of June 30, 2025, from FORVIS MAZARS LLP;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Josh Findlay, Director and Audit Engagement Executive, Forvis Mazars LLC, provided a high-level overview of the financial statement audit results for the Southern Nevada Health District's FY2025 financial audit.

   - Audit Scope and Results - three separate opinions were issued:
     - Financial Statement Opinion: Unmodified (clean) opinion issued in late November.
     - Single Audit Opinions: Required due to federal expenditure exceeding $750,000.
       - Internal control over financial reporting: No reportable findings.
       - Compliance with federal grant requirements: No reportable findings.
     - The compliance supplement from the Office of Management and Budget was delayed due to a government shutdown, which postponed issuance of the third opinion. The supplement was received last week, and the final opinion will be issued within the next few days.

- Programs Audited Under Single Audit
  - Four major federal programs were reviewed for compliance.
  - All programs received unmodified opinions with no reportable findings.
- Required Auditor Communications
  - Significant accounting policies are documented in Note 1 of the financial statements and comply with GASB standards.
  - Adoption of GASB Statement 101 (Compensated Absences) was completed smoothly with no material impact.
  - No alternative accounting treatments or disagreements with management were noted.
- Future Accounting Pronouncements
  - GASB 103 – Financial Reporting Mode Improvements: Improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a governmental entity's accountability. Effective next fiscal year: no material impact expected on the financials.
  - GASB 104 – Disclosure of Certain Capital Assets: Requires capital assets held for sale, intangible assets, lease assets, and subscription assets to be broken out separately in note disclosure; no impact on the financials.

Mr. Findlay confirmed that the audit process was completed smoothly and commended the District's finance team for their cooperation.

The Chair called for questions and there were none.

A motion was made by Member Melendrez, seconded by Member Hunt, and carried unanimously to accept the Financial Statement Report, as of June 30, 2025, from FORVIS MAZARS LLP, as presented.

Member Coca joined the meeting at 2:41 p.m.

2. **Receive, Discuss and Approve Updates to the Southern Nevada Community Health Center Governing Board Bylaws;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Randy Smith, Chief Executive Officer, FQHC, provided an overview of recent updates to the Health Center bylaws, prompted by revisions to the HRSA Compliance Manual for Federally Qualified Health Centers (FQHCs). Mr. Smith shared the following changes:

- Mission Statement: Updated language to reflect current organizational mission.
- Service References: Removed outdated references to dental services.
- Non-Discrimination Language: Revised language regarding race, creed, and nationality to align with HRSA guidance and laws protecting free speech.
- Patient Board Member Requirements: Previous requirements focused on demographic representation (race, ethnicity, gender) of patients served.
  - Updated requirement broadens representation to reflect individuals served by the Health Center without limiting specific demographic indicators.
  - The Health District will continue to ensure compliance with HRSA standards while maintaining practical approaches to board composition.

Mr. Smith advised these changes align the health center's bylaws with current HRSA compliance standards.

A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to approve Updates to the Southern Nevada Community Health Center Governing Board Bylaws, as presented.

3. **Receive, Discuss and Approve New Board Member;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Smith presented the candidacy of Father Rafael for appointment as a community board member. Father Rafael previously served on the Board and brings extensive experience in ministry and financial oversight as a CPA. Mr. Smith further shared that Father Rafael's return would provide valuable expertise, particularly considering the upcoming departure of Member Dukes in January 2026.

   Mr. Smith advised the board that Father Rafael is a strong advocate for Behavioral Health Services and has supported program development at the Health Center. The previous conflict of interest has been resolved, and he is no longer affiliated with the business where services were provided. Mr. Smith stated that Father Rafael's application has been received, his orientation has been completed, and he has confirmed his availability to attend meetings.

   The Chair called for questions and there were none.

   A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to approve New Board Member, Father Rafael Pereira, as presented.

   Member Melendrez inquired about appointing Father Rafael to the Finance Committee. Mr. Smith confirmed that upon Father Rafael's official onboarding in January, he will be assigned to a committee, and he has expressed interest in serving on the Finance Committee.

   Mr. Smith also extended appreciation to Member Dukes for her service on the Board, noting her significant contributions to the Health Center's financial oversight and governance. Member Dukes expressed gratitude for the opportunity to serve and commended the leadership team and fellow board members.

   The Chair echoed thanks on behalf of the Board, acknowledging Member Dukes dedication and impact.

4. **Receive, Discuss and Approve Changes to the Southern Nevada Community Health Center's Vision Statement;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Smith presented a proposed revision to the Southern Nevada Community Health Center's Vision statement. The change involves replacing the word "equitable" with "fair" to ensure compliance with recent federal executive orders.

Mr. Smith stated that replacing "equitable" with "fair" preserves the vision statement's intent to provide access to care by reducing healthcare disparities in our community and doing so in a comprehensive and fair way.

The Chair called for questions and there were none.

A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to approve Changes to the Southern Nevada Community Health Center's Vision Statement, as presented.

5. **Receive, Discuss and Accept the Third Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

David Kahananui, FQHC Administrative Manager/Risk Manager, presented the Third Quarter Risk Management Report as required by FTCA. Key highlights included:

- Quarterly Risk Assessment:
  - Behavioral Health risk assessment completed in collaboration with the Medical Director and Behavioral Health Manager.
  - 67 criteria reviewed with 61 found in compliance.
- Incident Reporting & Peer Review:
  - 25 incidents reported in Q3 (70 YTD); three (3) required root cause analysis and were promptly addressed.
  - Provider peer review audits averaged 94% compliance.
- FTCA Training Compliance:
  - Five (5) annual FTCA-required trainings for clinical staff achieved 99.76% completion by Q3; now at 100%.
  - Risk Manager completed two (2) required FTCA risk-related training courses in May 2025.
- Performance Metrics:
  - Patient satisfaction averaged 98.3% for Q3; 98.1% YTD.
  - No grievances filed; no pharmacy labeling errors; one (1) HIPAA breach occurred but was contained and corrected.
  - Credentialing for all licensed practitioners remains at 100%.
  - No FTCA claims filed during Q3.
- Data Accuracy & UDS Reporting:
  - Manual data tracking implemented due to EMR mapping issues to ensure accurate UDS reporting.
  - Monthly data review meetings ongoing; improvements noted.
  - Plans underway to create a new position to support EMR optimization, onboarding, and reporting accuracy.

Mr. Smith emphasized the importance of accurate data for HRSA quality awards and Medicaid managed care partnerships, noting that manual processes and additional staffing will strengthen compliance and reporting.

The Chair called for questions and there were none.

Member Macias-Villa joined the meeting at 2:58 p.m.

A motion was made by Member Melendrez, seconded by Member Hunt, and carried unanimously to accept the Third Quarter Risk Management Report, as presented.

6. **Receive, Discuss and Accept the Third Quarter Risk Management Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Robin Carter, Medical Director, presented the Behavioral Health Risk Assessment results, noting overall score was 61 of 67 criteria compliant or 91%. Dr. Carter identified five (5) areas requiring corrective action.

   The following action items were outlined:
   - Policies & Procedures:
     - Develop and implement a policy for conducting debriefings and safety huddles to support safe and effective behavioral health services.
   - Patient-Centered Care:
     - Recruit or designate a patient navigator specifically for behavioral health services.
     - Explore internal reassignment of existing health navigators to fulfill this role.
   - Staffing and Workforce Development:
     - Establish a formal plan to address behavioral health workforce shortages and burnout.
     - Current informal practices, such as self-care discussions during staff meetings, activities will be formalized into policy.
   - Safe Environment & Infrastructure:
     - Enhance behavioral health waiting area with toys and comfortable furniture; explore options for soothing music.
     - Collaboration with facilities team underway.
   - Firearm Safety Counseling:
     - Develop a standardized process for counseling patients and families on firearm safety.
     - Options include educational materials (posters, pamphlets) and integration into counseling sessions.

   Dr. Carter noted that action items are in progress, with completion targeted by summer 2026.

   Member Hunt inquired whether policies would be HRSA-based or evidence-based. Dr. Carter advised it is a combination of things. Dr. Carter will look at risk management, best practices from other health centers and policies that have been developed.

   The Chair called for further questions and there were none.

   A motion was made by Member Hunt, seconded by Member Melendrez, and carried unanimously to accept the Third Quarter Risk Management Assessment, as presented.

VII. **BOARD REPORTS:** The Southern Nevada District Board of Health members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada District Board of Health unless that subject is on the agenda and scheduled for action. *(Information Only)*

There were no reports from board members.

VIII. CEO & STAFF REPORTS *(Information Only)*

- CEO Comments

  Mr. Smith provided updates on key operational and strategic items:

  - HRSA Funding Update:
    - HRSA intends to provide six months of funding for Health Centers with project start dates of January 1st, February 1st, or March 1st to mitigate risks from potential government shutdowns.
    - SNCHC's new grant period begins February 1st; a Notice of Award for six months of funding is expected before January 30th.
  - 340B Rebate Pilot:
    - Effective January 1st, a rebate model will apply to 10 medications previously purchased at 340B pricing.
    - Medications will now be purchased at wholesale cost, with rebates submitted to recover the difference.
    - Initial impact is limited due to low volume of affected drugs, but future expansion could create significant cash flow challenges.
    - Litigation is underway nationally; SNCHC is monitoring developments and implementing mitigation strategies.
    - The addition of Clinical Pharmacist Dr. Peña will allow Dr. Bleak to focus on pharmacy program administration, critical for managing increased complexity under the rebate model.
  - Medicaid Shadow Billing Transition:
    - Nevada Health Authority and MCOs are transitioning to a shadow billing model, where MCOs will pay the full PPS rate directly, eliminating the need for separate PPS Wrap payments from the State.
    - While beneficial long-term, concerns exist due to lack of testing and readiness, creating potential cash flow risks.
    - SNHD's Revenue Cycle Manager is coordinating with MCOs, other Health Centers, and the Nevada Primary Care Association to ensure smooth implementation and has established manual processes for claim verification during transition.
  - Patient-Centered Medical Home (PCMH) Accreditation:
    - Notice of Intent filed with HRSA to pursue NCQA PCMH accreditation.
    - Goals: First NCQA check-in by June 30, 2026; full accreditation by December 31, 2026.
    - Accreditation will enhance care quality and strengthen competitive grant applications.
    - Consultant engagement underway; board education session planned for January.
  - Holiday Celebration:
    - Health Center holiday party scheduled for December 16th at the Decatur location, Red Rock Conference Room, 1:00–5:00 PM. Board members invited to attend.

  Mr. Smith expressed his gratitude to the Board for their continued support and guidance throughout a challenging year. Mr. Smith noted that the progress made in serving clients and improving operations will be evident in January's review. Mr. Smith extended holiday greetings and wished all members a successful and productive new year.

IX. INFORMATIONAL ITEMS

There were no informational items.

X. **SECOND PUBLIC COMMENT: A** period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the Chair closed the Second Public Comment period.

XI. ADJOURNMENT

The meeting was adjourned at 3:27 p.m.

Randy Smith
Chief Executive Officer - FQHC

/tab

AGENDA

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
GOVERNING BOARD MEETING
December 9, 2025 – 2:30 p.m.
Meeting will be conducted via Microsoft Teams

NOTICE

Microsoft Teams:
https://events.teams.microsoft.com/event/168df812-2e20-4589-a429-da494dca3d4a@1f318e99-9fb1-41b3-8c10-d0cab0e9f859

To call into the meeting, dial (702) 907-7151 and enter Phone Conference ID: 454 825 392#

NOTE:
- Agenda items may be taken out of order at the discretion of the Chair.
- The Board may combine two or more agenda items for consideration.
- The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.

I. CALL TO ORDER & ROLL CALL

II. PLEDGE OF ALLEGIANCE

III. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. Please clearly state and spell your name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote. **There will be two public comment periods. To submit public comment on either public comment period on individual agenda items or for general public comments:**

- **By Teams:** Use the meeting controls at the top of the screen and select the Raise Hand icon. When called upon, select the Microphone icon to unmute yourself.
- **By telephone:** Call 702-907-7151 and when prompted to provide the Meeting ID, enter 454 825 392#. Press *5 to raise your hand. When called upon, press *6 on your phone keypad to unmute yourself.
- **By email:** public-comment@snhd.org. For comments submitted prior to and during the live meeting, include your name, zip code, the agenda item number on which you are commenting, and your comment. Please indicate whether you wish your email comment to be read into the record during the meeting or added to the backup materials for the record. If not specified, comments will be added to the backup materials.

IV. ADOPTION OF DECEMBER 9, 2025 AGENDA *(for possible action)*

V. CONSENT AGENDA: Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: November 18, 2025 *(for possible action)*

2. **Approve Updates to the CHCA-021 Responding to Medical Emergencies Policy;** *direct staff accordingly or take other action as deemed necessary (for possible action)*

VI. REPORT / DISCUSSION / ACTION

1. **Review, Discuss, and Accept the Financial Statement Report, as of June 30, 2025, from FORVIS MAZARS LLP;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

2. **Receive, Discuss and Approve Updates to the Southern Nevada Community Health Center Governing Board Bylaws;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Receive, Discuss and Approve New Board Member;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

4. **Receive, Discuss and Approve Changes to the Southern Nevada Community Health Center's Vision Statement;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

5. **Receive, Discuss and Accept the Third Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

6. **Receive, Discuss and Accept the Third Quarter Risk Management Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

VII. BOARD REPORTS: The Southern Nevada Community Health Center Governing Board members may identify and comment on Health Center related issues or ask a question for clarification. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada Community Health Center Governing Board unless that subject is on the agenda and scheduled for action. ***(Information Only)***

VIII. CEO & STAFF REPORTS *(Information Only)*

- CEO Comments

IX. INFORMATIONAL ITEMS

X. SECOND PUBLIC COMMENT: A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote. **See above for instructions for submitting public comment.**

XI. ADJOURNMENT

NOTE: Disabled members of the public who require special accommodations or assistance at the meeting are requested to notify the Administration Office at the Southern Nevada Health District by calling (702) 759-1201.

THIS AGENDA HAS BEEN PUBLICLY NOTICED on the Southern Nevada Health District's Website at https://snhd.info/meetings, the Nevada Public Notice website at https://notice.nv.gov, and a copy will be provided to any person who has requested one via U.S mail or electronic mail. All meeting notices include the time of the meeting, access instructions, and the meeting agenda. For copies of agenda backup material, please contact the Administration Office at 280 S. Decatur Blvd, Las Vegas, NV, 89107 or (702) 759-1201.

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD MEETING
November 18, 2025 – 2:30 p.m.
Meeting was conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Rooms A and B

MEMBERS PRESENT:	Jasmine Coca, First Vice Chair Sara Hunt, Second Vice Chair Rebeca Aceves Erin Breen Ashley Brown Blanca Macias-Villa Jose L. Melendrez David Neldberg
ABSENT:	Donna Feliz-Barrows, Chair Marie Dukes
ALSO PRESENT	
LEGAL COUNSEL:	Edward Wynder, Associate General Counsel
CHIEF EXECUTIVE OFFICER:	Randy Smith
STAFF:	Emily Anelli, Tawana Bellamy, Donna Buss, Robin Carter, Andria Cordovez Mulet, Jason Frame, David Kahananui, Ryan Kelsch, Cassius Lockett, Cassondra Major, Bernie Meily, Kyle Parkson, Luann Province, Yin Jie Qin, Emma Rodriguez, Felicia Sgovio, Greg Tordjman, Justin Tully, Donnie (DJ) Whitaker, Merylyn Yegon

I. CALL TO ORDER and ROLL CALL

The Southern Nevada Community Health Center (SNCHC) Governing Board Meeting was called to order at 2:33 p.m. Tawana Bellamy, Senior Administrative Specialist, administered the roll call and confirmed a quorum.

II. PLEDGE OF ALLEGIANCE

III. OATH OF OFFICE

Ms. Bellamy administered the Members' Oath of Office to Member Breen.

IV. RECOGNITION

1. **Southern Nevada Health District – Manager & Supervisor of the Quarter (Q3 and Q4)**
   - Bernie Meily
   - Merylyn Yegon

The Governing Board recognized Bernie Meily, Community Health Nurse Manager and Merylyn Yegon, Community Health Nurse Manager as Southern Nevada Health District's Manager & Supervisor of the Quarter (Q3 and Q4). Ms. Bellamy read an excerpt of their nominations into the record. On behalf of the SNCHC Governing Board, the board congratulated Ms. Meily and Ms. Yegon.

Member Coca and Member Aceves congratulated Ms. Meily and Ms. Yegon.

Mr. Smith expressed appreciation for their leadership and noted that nominations originated from their employees.

2. **Outgoing Board Member**
   - Luz Castro

Mr. Smith acknowledged the recent departure of Ms. Luz Castro from the Board. Mr. Smith noted that November was Ms. Castro's final month of service and expressed appreciation for her contributions. Ms. Castro joined the Board in November 2022 and played an instrumental role in supporting the health center's growth following its first operational site visit. Mr. Smith conveyed his gratitude for her dedication and leadership over the past three years and shared that he had personally reached out to Ms. Castro to thank her for her service.

V. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. Please clearly state your name and address and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the First Public Comment period was closed.

VI. ADOPTION OF THE NOVEMBER 18, 2025 MEETING AGENDA *(for possible action)*

There were no questions or changes to the agenda.

A motion was made by Member Coca, seconded by Member Breen, and carried unanimously to approve the changes to the November 18, 2025 meeting agenda, as presented.

VII. CONSENT AGENDA: Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: October 21, 2025 *(for possible action)*

2. **Approve Updates to CHCA-005 Behavioral Health Crisis Event and Security Communication Policy;** *direct staff accordingly or take other action as deemed necessary (for possible action)*

3. **Approve Re-Credentialing and Renewal of Privileges for Providers;** *direct staff accordingly or take other action as deemed necessary (for possible action)*
   - Victoria Allen, APRN I
   - Alireza Farabi, MD
   - Jerry Cade, MD

There were no changes or questions to the Consent Agenda.

A motion was made by Member Coca, seconded by Member Breen, and carried unanimously to approve the Consent Agenda, as presented.

VIII. REPORT / DISCUSSION / ACTION

1. **Receive, Discuss and Accept the September 2025 Year to Date Financial Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Revenue
- General Fund revenue (Charges for Services & Other) is $10.59M compared to a budget of $9.76M, a favorable variance of $823K.
- Special Revenue Funds (Grants) is $1.12M compared to a budget of $1.91M, an unfavorable variance of $791K.
- Total Revenue is $11.71M compared to a budget of $11.67M, a favorable variance of $32K.

Expenses
- Salary, Tax, and Benefits is $3.61M compared to a budget of $4.15M, a favorable variance of $541K.
- Other Operating Expense is $7.87M compared to a budget of $7.77M, an unfavorable variance of $105K.
- Indirect Cost/Cost Allocation is $2.71M compared to a budget of $3.22M, a favorable variance of $510K.
- Total Expense is $14.19M compared to a budget of $15.13M, a favorable variance of $946K.

Net Position: is ($2.48M) compared to a budget of ($3.46M), a favorable variance of $978K.

Member Hunt joined the meeting at 2:50 p.m.

Ms. Whitaker further advised of the following:
- Percentage of Revenues and Expenses - by Department
- Revenues by Department - Budget to Actuals
- Expenses by Department - Budget to Actuals
- Patient Encounters - By Department
  - FY2025 – 9,219
  - FY2026 – 10,901
  - 18% year-over-year growth
- Month-to-Month Comparisons - Year-to-Date revenues and expenses by department and by type.

Member Coca commented that Ms. Whitaker did a good job. Member Coca inquired about the clients attending the Health Center's second location, expressing concern regarding refugees who may be unable to seek services due to suspended Medicaid coverage.

Mr. Smith responded that both the Fremont and Decatur health centers are designed to provide the same core set of services, with minor variations. One such variation is that the Refugee Health Services Program is exclusively offered at Fremont. Clients at Fremont are similar to those at Decatur, primarily seeking primary care services, while also accessing programs such as family planning, sexual health, Ryan White services, and behavioral health. Mr. Smith noted that the behavioral health team has grown significantly, and the behavioral health provider at Fremont has been instrumental in supporting integrated care at that site.

There were no further questions.

A motion was made by Member Coca, seconded by Member Macias-Villa, and carried unanimously to Accept the September 2025 Year to Date Financial Report, as presented.

2. **Receive, Discuss and Approve the Southern Nevada Community Health Center Governing Board Committee Memberships;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Mr. Randy Smith presented the proposed committee memberships for calendar year 2026. Mr. Smith provided a brief review of the descriptions of the existing standing committees noting that each board member must serve on at least one committee and committee membership is capped at three members. Ms. Bellamy contacted board members to gauge interest in participation on the committees.

The board reviewed and discussed the committee membership for calendar year 2026. The Chair also expressed her willingness to serve on additional committees to ensure full participation.

Member Coca reminded board members that, aside from the Finance Committee, which meets monthly, other committees meet less frequently, alleviating concerns about time commitments. Mr. Smith confirmed that committee charters were reviewed and meeting frequency were reduced where possible.

Ms. Bellamy advised of the proposed committee assignments as follows:

CY26 GOVERNING BOARD COMMITTEE					
Executive Committee	**Chief Executive Officer Annual Review Committee**	**Finance and Audit Committee**	**Quality, Credentialing & Risk Management Committee**	**Nominations Committee**	**Strategic Planning Committee**
Donna Feliz-Barrows	Dave Neldberg	Marie Dukes	Sara Hunt	Dave Neldberg	Rebeca Aceves
Jasmine Coca	Jose Melendrez	Jasmine Coca	Rebeca Aceves	Jose Melendrez	Jasmine Coca
Sara Hunt	Jasmine Coca	Ashley Brown	Erin Breen	Erin Breen	Erin Breen
		Blanca Macias-Villa			

There were no further questions.

A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to approve the Southern Nevada Community Health Center Governing Board Committee Memberships, as presented.

3. **Receive, Discuss and Approve the 2026 Governing Board Meeting Schedule**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Randy Smith presented the results of the meeting schedule survey conducted by Ms. Bellamy. The survey gathered board members' preferences for meeting days and times. An analysis of responses indicated the existing meeting time works best for most of the board members, which is the third Tuesday of each month from 2:30 p.m. to 4:00 p.m.

   Mr. Smith reviewed the proposed meeting schedule for 2026, noting that the December meeting will be held earlier and occur on the second Tuesday, December 8, 2026.

   Mr. Smith reminded the board that the next board meeting will be held on December 9, 2025.

   Mr. Smith expressed his sincere appreciation to all board members for their commitment and willingness to serve, acknowledging the time and effort each member dedicates despite busy schedules. He reaffirmed his commitment to working collaboratively to ensure the board experience is meaningful and productive, while creating opportunities for in-person engagement when appropriate.

   Mr. Smith shared that preliminary discussions have taken place with his team regarding leveraging National Health Center Week in August as a potential occasion for an in-person gathering. This event could also serve as an opportunity to conduct the Chief Executive Officer's annual evaluation earlier in the year. Mr. Smith noted that further dialogue will occur as plans develop.

   There were no further questions or concerns from the board.

   A motion was made by Member Aceves, seconded by Member Breen, and carried unanimously to approve the 2026 Governing Board Meeting Schedule, as presented.

4. **Receive, Discuss and Approve Updates to CHCA-002 Sliding Fee Policy**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   David Kahananui, FQHC Administrative Manager, provided an overview of proposed updates to the CHCA-002 Sliding Fee Policy. Mr. Kahananui noted that the revisions were made to ensure compliance with Title X program requirements and to reinforce the health center's commitment to providing services regardless of a patient's ability to pay.

   Key Policy updates include:

   - Compliance with Title X Requirements: Added language addressing emancipated and unemancipated minors, specifying that their eligibility for sliding fee discounts will be based on their own resources.

- Definition of Low-Income Individuals: Introduced a new section under procedures to clearly define low-income status.
- Income Verification Process: Incorporated the use of a Certificate of Income to verify income in a manner that avoids creating barriers to care.
- Income Thresholds: Updated thresholds to reflect program-specific requirements:
    - Family Planning Program: 250% of Federal Poverty Level (FPL)
    - Ryan White Program: 400% of FPL
    - Health Center Program Fee: 200% of FPL

Mr. Kahananui emphasized that sliding fee discounts apply uniformly to all patients, regardless of insurance status, and cover all services within the HRSA-approved scope of project.

There were no further questions.

A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to approve Updates to CHCA-002 Sliding Fee Policy, as presented.

5. **Receive, Discuss and Approve Updates to CHCA-010 Informational and Educational Materials Review and Approval Process**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Mr. Dave Kahananui, FQHC Administrative Manager, presented proposed updates to the Informational and Educational Materials Review and Approval Process Policy (CHCA 010). Mr. Kahananui noted that approval of this policy will resolve the final Title X program finding from the recent compliance review. Mr. Kahananui advised of the purpose and scope of the policy.

Key policy updates include:

- Policy Title Revision: Updated name to "Informational and Educational Materials Review and Approval Process" for consistency with related policies and procedures.
- Evidence-Based Criteria: Added language requiring materials to be assessed against evidence-based standards.
- Intellectual Property and Grant Acknowledgment: Introduced a review step to ensure materials include proper acknowledgment of intellectual property, data rights, and federal grant support.
- Disclaimer Requirement: Incorporated Title X requirement for disclaimers on all materials and websites funded by Title X, including brochures, flyers, and digital content.
- Advisory Board Representation: Updated language to allow patient representatives to serve as population proxies when the Advisory Board does not meet composition requirements.

Mr. Kahananui emphasized that these updates will enable the health center to begin reviewing all materials for compliance and apply disclaimers where required.

There were no further questions.

A motion was made by Member Melendrez, seconded by Member Neldberg, and carried unanimously to approve Updates to CHCA-010 Informational and Educational Materials Review and Approval Process, as presented.

6. **Receive and Discuss the Third Quarter Clinical Performance Measures**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Felicia Sgovio, Quality Management Coordinator, presented the third-quarter FQHC clinical performance measures. Ms. Sgovio advised that one of the organization's strategic goals for the year is to pursue accreditation as a Patient-Centered Medical Home (PCMH). As part of this process, performance reporting is required at either the clinician or practice level. Based on current progress, the decision was made to share reports at the practice or site-specific level, which will be reflected in the data presented.

Key updates:

- Childhood Immunization Status: Historically, no data was reported for this measure. A new tracker has been implemented to monitor patients who fall within this category.
- Early Entry into Prenatal Care and Birth Weight: These UDS-required measures are being standardized through workflow improvements to capture trimester entry and birth weight data. Manual tracking continues as part of this effort.
- Breast Cancer Screening: Following HRSA reviewer feedback, reporting requirements were clarified, and missed data points are now being captured.
- Tobacco Use Screening and Cessation: Mapping issues previously led to underreporting. After corrections, performance improved significantly.

Ms. Sgovio advised the year-over-year comparisons showed improvement across most measures. From Q2 to Q3, notable increases include:

- Depression Screening and Follow-Up Plan: +5.8%
- Weight Assessment and Counseling for Children/Adolescents: +3.6%
- Controlling High Blood Pressure: +2.3%
- Breast Cancer Screening: +2%
- Tobacco Use Screening and Cessation improved from 50.2% to 70%, surpassing the target of 64%.

Ms. Sgovio provided an overview of the following:

- Site comparison data
- 2025 Quality Focus Measures
- Patient Satisfaction Survey results

Ms. Sgovio advised of the Net Promoter Score (NPS), which measures patient satisfaction by asking, "How would you rate the overall care you received from your provider?" on a scale from 0 (worst) to 10 (best). The organization achieved an NPS of 89, reflecting a strong level of patient satisfaction. Additionally, this quarter included the first review of site-specific NPS data, providing valuable insight into performance across locations.

Ms. Sgovio also shared patient comments, noting that feedback continues to be overwhelmingly positive.

Member Coca commented that Ms. Sgovio did a good job and that we like to see good comments from our patients. Member Breen agreed with Member Coca.

No action required.

IX. **<u>BOARD REPORTS</u>:** The Southern Nevada District Board of Health members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada District Board of Health unless that subject is on the agenda and scheduled for action. *(Information Only)*

Member Breen shared details about an upcoming community event, "Save Santa," scheduled for Saturday, December 6, from 11:00 a.m. to 2:00 p.m. at the Boulevard Mall's main court. The event is family-friendly and includes numerous raffles, with prizes such as bicycles and scooters awarded approximately every 15 minutes. Children are encouraged to visit various tables, and organizations are invited to host a table at no cost.

Member Breen further shared that the event also features Santa Claus and a bilingual elf to ensure Spanish-speaking families are accommodated. Parents are welcome to take their own photos with Santa, providing an affordable alternative to traditional holiday photo sessions. Member Breen noted that flyers are available in both English and Spanish and will be shared with board members. She encouraged anyone interested in displaying the flyer or hosting a table to contact her.

Member Breen also provided an update on the "Safe and Warm" initiative, noting that efforts to secure jackets for distribution will intensify in the coming weeks. She will coordinate with Mr. Smith regarding potential press coverage, particularly if commitments are received from local businesses to provide funding. Member Breen expressed interest in hosting a press conference at the Fremont location, as she believes it would be an ideal venue for the jacket distribution event. Additionally, Member Coca may assist with distributing jackets as part of this effort.

X. **CEO & STAFF REPORTS** *(Information Only)*

- CEO Comments

  Mr. Smith shared the following organizational achievements and updates:
  - As of October 31, the Health Center has served 11,922 unique patients, surpassing last calendar year's total of 11,501, which was previously a record. This milestone reflects exceptional growth despite a challenging year. With two months remaining, projections indicate the organization may reach 13,000 patients by year-end. For context, in 2022—the CEO's first year—the total number of unduplicated patients served was 7,050, underscoring significant progress in a short period.
  - Federal funding for FQHCs, including the National Health Service Corps loan repayment program, has been extended at current levels through January 30, 2026.
  - HRSA 340B Program Changes - HRSA will pilot a new rebate-based model for 10 medications in 2026, requiring health centers to pay full cost upfront and seek reimbursement later. This change may create cash flow challenges. Dr. Bleak and the finance team are analyzing potential financial impacts.
  - The Title X project officer has returned following the federal furlough and confirmed receipt of the corrective action plan. Approval of two policies earlier in the meeting addresses audit findings, and remaining steps will be completed promptly.
  - A new clinical pharmacist has been hired for the Decatur location, starting December 8th. This addition will strengthen pharmacy operations, support medical teams (including PrEP services), and allow Dr. Bleak to focus on administrative and strategic initiatives.
  - Recruitment continues for a staff physician at the Fremont site. Efforts include a national search through an employment agency and internal outreach. The goal is to enhance

access to care and provide clinical leadership for mid-level providers, supporting initiatives led by Dr. Carter.

Mr. Smith highlighted that last year marked a significant improvement in employee engagement within the health center, largely due to targeted actions implemented by the management team. Mr. Smith then outlined plans for 2025, which include two short-term goals and one long-term goal:

- Short-Term Goals:
    1. Maintain Employee Recognition Program: Each division receives allocated funds to recognize staff through on-the-spot awards and exemplary service awards. The health center uses these funds during monthly all-staff meetings to celebrate achievements. The current year's budget for recognition is approximately $2,500.
    2. Employee Engagement Meetings: Previously, new hires met individually with the CEO to review the FQHC mission and strategic plan. Due to the hiring freeze, this goal has been modified. In 2025, the CEO will meet with employees in small groups to reorient them to the mission, discuss strategic priorities, and gather feedback on successes and areas for improvement.
- Long-Term Goal:
  Continue advancing initiatives originally developed during the OVS process to strengthen organizational culture and engagement.

Mr. Smith emphasized that these efforts aim to foster a positive work environment, enhance communication, and ensure employees feel valued and connected to the Health Center's mission.

Mr. Smith shared that the Employee Engagement Committee organizes activities throughout the year, including holiday celebrations, and has successfully raised funds to support these initiatives. Management continues to learn from and support the committee, with plans to refine engagement strategies in the coming year.

Mr. Smith also announced details for the Year-End Holiday Party, hosted by the Employee Engagement Committee on Tuesday, December 16, from 1:00 PM to 5:00 PM in the Red Rock conference room. The event will feature a taco bar, Filipino cuisine, games, and activities, providing an opportunity for staff from both sites to gather. Board members are invited to attend, and Ms. Bellamy will follow up to confirm availability. Contributions are welcome but not required as the focus is on celebrating together as a team.

Mr. Smith advised of the following upcoming board activities:

- Marie Dukes will resign in January 2026 due to changes in her availability.
- Former member Father Rafael, also a CPA, is interested in returning. The previous conflict of interest has been resolved. Board members unanimously supported moving his candidacy forward for a vote at the December 9th meeting, following an orientation and application update.
- The next board meeting is on December 9, 2025 and will be virtual.

XI. INFORMATIONAL ITEMS

- Community Health Center (FQHC) October 2025 Monthly Report

XII. **SECOND PUBLIC COMMENT: A** period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the Second Public Comment period was closed.

XIII. **ADJOURNMENT**

The meeting was adjourned at 3:53 p.m.

Randy Smith
Chief Executive Officer - FQHC

/tab

SOUTHERN NEVADA HEALTH DISTRICT
DIVISIONAL POLICY AND PROCEDURE

DIVISION:	Primary and Preventive Care/FQHC	**NUMBER(s):**	PPC-ADM-001-C / CHCA-021
PROGRAM:	Division Wide	**VERSION:**	1.03
TITLE:	Responding to Medical Emergencies	**PAGE:**	1 of 6
		EFFECTIVE DATE: Click or tap here to enter text.	
DESCRIPTION: To provide guidance for responding to a medical emergency		**ORIGINATION DATE:** June 18, 2008	
APPROVED BY: **CHIEF MEDICAL OFFICER:**		**REPLACES:** CS-ADM-001-C, version dated 4/24/2024	
Robin Carter, D.O.	Date		
FQHC - CHIEF EXECUTIVE OFFICER:			
Randy Smith, MPA	Date		
CHIEF ADMINISTRATIVE NURSE & DIRECTOR OF PUBLIC HEALTH AND PREVENTIVE CARE:			
Lourdes C. Yapjoco, MSN, RN, CCM	Date		
DISTRICT HEALTH OFFICER:			
Cassius Lockett, PhD	Date		

I. PURPOSE

To provide a timely and appropriate response to a medical emergency affecting a patient, client, employee, volunteer, student, vendor, contractor, or other person that occurs on or adjacent to a Health District location.

II. SCOPE

Applies to all Workforce members while responding to a medical emergency or while engaged in other activities required to support this response (e.g., training or quality improvement activities). This policy only applies to locations where there are Workforce members trained and equipped to respond. A list of such locations is attached.

III. POLICY

It is the policy of the Health District to train and provide the necessary resources to Workforce members so that they can provide a timely and appropriate response to a medical emergency. Only those Workforce members who are properly licensed and/or trained are authorized to respond.

IV. PROCEDURE

Medical Emergency Response (MER)

Definition: A coordinated response to a medical emergency occurring in a common area, a programmatic or administrative area, any area immediately outside of but adjacent to the premises of a Health District location. Does not include clinical areas.

A. Assignment of Roles

1) Nurses from the Division of Public Health and Preventive Care (PPC) and the Southern Nevada Community Health Center (SNCHC) will be pre-identified to participate. The PPC Division Director and the FQHC Chief Executive Officer (CEO), or their designees, will be responsible for identifying such nurses.

2) Medical Emergency Response Teams (MERT) will be assigned on rotation in locations where there are nurses from both PPC and SNCHC (e.g., 280 s. Decatur). Rotation schedule will be set by PPC Division Director and the FQHC Chief Executive Officer (CEO) and submitted to the Chief Administrative Nurse by December prior to the next calendar year.
3) Nurses pre-identified to respond will be provided with the appropriate training.
4) Security personnel will provide assistance.

B. Activation and Response

1) The Medical Emergency Response Team (MERT) is activated by dialing ‘28’ and announcing the incident using plain language communication to reduce confusion and effectively communicate emergency situations.

Medical Team → [Location]

e.g. *"Medical Team → Front of pharmacy"*

a. This announcement should be made a minimum of three (3) consecutive times.

b. This activation can be done by any Workforce member, who may also call 911 if appropriate.

2) The MERT will respond immediately to the specific location, with at least one nurse bringing an emergency cart and oxygen tank. Security will also respond.

3) Upon arrival, the assembled team will:

a. Designate someone as the lead who in addition to assisting the other team member(s), will oversee the response and ensure other team member(s) are wearing the appropriate personal protective equipment (PPE).

b. Assess the person to determine the nature, extent, and severity of the medical emergency.

c. Administer the appropriate response using protocols such as those referenced in this policy.

d. Request the assistance of a physician or other provider, additional nursing staff, or administrative staff, if needed, and alert them.

e. Request EMS, if needed, and upon their arrival, inform them of the response.

f. Secure the area, ensuring safety of the response team and privacy for the person experiencing the medical emergency.

g. Inform the person as well as anyone accompanying them (provided the appropriate consents are obtained) of the response, answer any questions and provide appropriate instructions and education.

h. Document the response on the Medical Event Form.

C. Follow-up

A. A member of the response team will contact the person who experienced the medical emergency within one to two (1-2) business days to inquire about their current health status. This information will be documented on the Medical Event Form.

a. No follow-up contact is needed for non-patients/non-clients (e.g., visitors to the building only).

B. Once completed, email the form to medeventreview@snhd.org which is distributed to the District Health Officer, Chief Medical Officer, Chief Administrative Nurse/PPC Division Director, FQHC CEO, FQHC Administrative Manager, the General Counsel or their designee, and Nurse Managers.

Medical Event Response within a Clinical Area

Definition: A coordinated response to a medical emergency occurring within a clinical area.

A. Assignment of Roles

1) Clinic staff will respond to **their own patients or clients within the clinic** as part of a Medical Event Response. Designated Medical Event Response Teams will not be pre-identified or scheduled.
2) Clinical staff will be provided with the appropriate training.
3) Security personnel will assist.

B. Activation and Response

1) An in-clinic response is activated by dialing '28' and announcing **"Medical Team"** followed by the **location** of the person experiencing the medical emergency. This ensures security is notified of any medical event.
    a. This announcement should be made a minimum of three (3) consecutive times.
    b. This activation can be done by any clinical staff member, who may also call 911 if appropriate.
    c. Alternatively, a staff member, upon recognizing that a patient or client is experiencing a medical emergency, may just call out to other staff in the vicinity, alerting them to the situation, requesting their assistance, and informing them of the location.
2) Clinic staff in the area will respond immediately to the specific location, with at least one staff bringing along the emergency cart and oxygen tank. Security will also respond.

C. Follow-up

1) A member of the response team will contact the person who experienced the medical emergency within one to two (1-2) business days to inquire about their current health status. This information will be documented on the Medical Event Form.
    a. No follow-up contact is needed for non-patients/non-clients (e.g., visitors to the building only).
2) Once completed, a designated Workforce member will black out personal identifiers of the person who experienced the medical emergency prior to emailing the form to medeventreview@snhd.org which is distributed to the District Health Officer, Chief Medical Officer, Chief Administrative Nurse/PPC Division Director, FQHC CEO, FQHC Administrative Manager, the General Counsel or their designee.

Additional Sections

A. Emergency Carts and AEDs

1) Emergency carts are pre-positioned at pre-determined PPC and SNCHC locations.

2) The type of equipment and supplies needed to stock the carts will be reviewed periodically for appropriateness to a medical event response. An oxygen tank will be placed next to each cart and will be included in its inventory. A checklist will be used to aid in maintaining the inventory, and expiration dates will accompany each of these items to aid in their rotation.

3) Staff designated by the PPC and SNCHC location's CHN Manager will be responsible for maintaining the inventory and rotating-out expired items, to be checked on monthly schedule and following every response. Staff will then document their effort by affixing their initials and the date on the checklist. A copy of the checklist will be submitted to the Chief Administrative Nurse or designee every 6 months, on January and July of each year.

4) Automated External Defibrillators (AEDs) are pre-positioned throughout SNHD and SNCHC locations.

B. Required Training

1) Excluding security personnel, all Workforce members pre-identified to respond to medical events and all providers that may be called-in to assist in such a response will be required to complete the following:

a. Basic Life Support (BLS), a training offered by SNHD staff or an outside entity which includes administering CPR and using an AED - every two (2) years.

b. Lifesaver Skills Course, a training developed and offered by SNHD staff which includes administering basic first aid - annually.

c. Overdose Response with Naloxone Training, a training developed and offered by SNHD staff which includes administering Naloxone (Narcan) to those suspected of overdosing on Opioids - one time.

d. Medical Emergency Response, a training which includes reviewing and acknowledging this policy and participating in a mock exercise - annually.

C. Quality Improvement

1) Key stakeholders, including the District Health Officer, Chief Medical Officer, Chief Administrative Nurse/PPC Division Director, FQHC CEO, Clinical Staff Physicians, Nursing Managers and Supervisors, the Quality Management Coordinator, and representatives from Security and Legal will meet quarterly to:

a. Review events and responses that occurred in the previous quarters, using the completed Medical Event Forms as well as input from the respondents to inform the discussion.
b. Identify areas in need of improvement.
c. Recommend changes.
d. Develop a plan to inform staff of any changes and/or provide additional training.
e. In addition to discussing and recommending changes based on the review of past responses, identify and discuss new or emerging recommendations or guidelines that may be relevant and make recommendations for changes, as appropriate.

Acronyms/Definitions

None

V. REFERENCES

- Administering Epinephrine or Benadryl
- Responding to a syncopal or pre-syncopal episode
- Responding to an opioid overdose
- Managing an adverse reaction to a medication or vaccine

VI. DIRECT RELATED INQUIRIES TO

Chief Administrative Nurse

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 3		Changed verbiage of Dr. Bluebird to Medical Emergency Response (MER)
Version 2	04/24/2024	Changed to a Division Wide policy, changed policy numbering for PPC, same policy used by PPC (PPC-ADM-001-C) and FQHC (CHCA-021); updated content
Version 1	09-18-2017	Updated policy, renumbered to CS-ADM-001-C
Version 0	06-10-2008	First issuance

VII. ATTACHMENTS

Attachment No. PPC-ADM-001-C ATT-1, Emergency Cart and AED Locations

Attachment No. PPC-ADM-001-C ATT-2, SNHD Clinical Services Medical Event Form

Attachment No. PPC-ADM-001-C ATT-3, Outreach Emergency Kit Checklist

SOUTHERN NEVADA
Community
HEALTH CENTER

Southern Nevada Community Health Center Governing Board Meeting

December 9, 2025

V. CONSENT AGENDA

Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: November 18, 2025 *(for possible action)*

2. **Approve Updates to the CHCA-021 Responding to Medical Emergencies Policy;** *direct staff accordingly or take other action as deemed necessary (for possible action)*

Motion to Approve the Consent Agenda, as presented.

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

VI. REPORT / DISCUSSION / ACTION

VI. REPORT / DISCUSSION / ACTION

1. **Review, Discuss, and Accept the Financial Statement Report, as of June 30, 2025, from FORVIS MAZARS LLP;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Southern Nevada Health District

FY2025 Audit Presentation

forvis mazars

Introductions

Josh Findlay, CPA

Director

Audit Engagement Executive

Josh.Findlay@us.forvismazars.com

Global Presence

Leading
Global Network*

$5bn
Combined Revenue (2023)

100+
Combined Countries & Territories

400+
Combined Offices & Locations

1,800+
Combined Partners

40,000+
Combined Employees

As of June 1, 2024

- Forvis Mazars
- Correspondents of Forvis Mazars Group

- Afghanistan
- Albania
- Algeria
- Angola
- Argentina
- Australia
- Austria
- Bahrain
- Belgium
- Benin
- Bermuda
- Bosnia and Herzegovina
- Botswana
- Brazil
- Bulgaria
- Burkina Faso
- Cameroon
- Canada
- Cayman Islands
- Chile
- China
- Colombia
- Congo
- Côte d'Ivoire
- Croatia
- Cyprus
- Czech Republic
- Democratic Republic of the Congo (DRC)
- Denmark
- Egypt
- Finland
- France
- Gabon
- Germany
- Ghana
- Greece
- Hong Kong
- Hungary
- India
- Indonesia
- Ireland
- Israel
- Italy
- Japan
- Jordan
- Kazakhstan
- Kenya
- Korea
- Kosovo
- Kuwait
- Kyrgyzstan
- Latvia
- Lebanon
- Libya
- Lithuania
- Luxembourg
- Madagascar
- Malawi
- Malaysia
- Malta
- Mauritius
- Mexico
- Moldova
- Morocco
- Mozambique
- Netherlands
- New Caledonia
- Niger
- Nigeria
- North Macedonia
- Norway
- Oman
- Pakistan
- Palestine
- Panama
- Peru
- Philippines
- Poland
- Portugal
- Qatar
- Romania
- Rwanda
- Saudi Arabia
- Senegal
- Serbia
- Singapore
- Slovakia
- Slovenia
- South Africa
- Spain
- Sweden
- Switzerland
- Taiwan
- Tanzania
- Thailand
- Togo
- Tunisia
- Turkey
- Uganda
- Ukraine
- United Arab Emirates
- United Kingdom
- United States
- Uruguay
- Uzbekistan
- Venezuela
- Vietnam
- Zimbabwe

* Source: IAB World Network rankings, based on most recent rankings

2023 revenues: FORVIS $1.7bn (€1.6bn), Mazars (estimated) $3bn (€2.8bn)

Forvis Mazars is the brand name for the Forvis Mazars Global network (Forvis Mazars Global Limited) and its two independent members: Forvis Mazars, LLP in the United States and Forvis Mazars Group SC, an internationally integrated partnership operating in over 100 countries and territories.

forvis mazars

U.S. Presence

Leading U.S. Firm

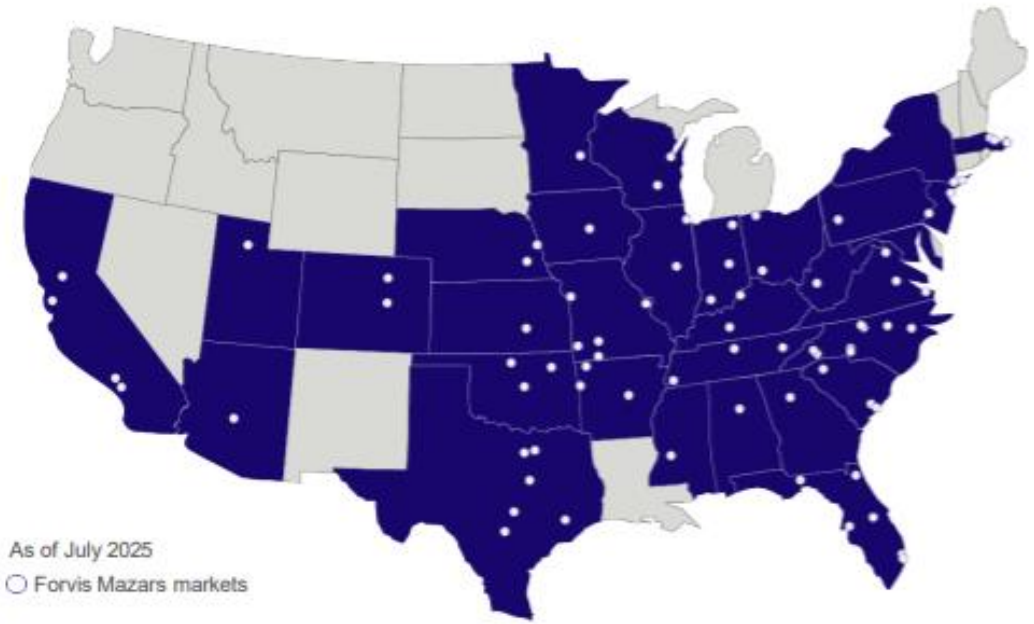
$2.24B
Revenue (FY 2025)*

76
Markets

30
States

600+
Partners & Principals

7,000+
Employees



As of July 2025
○ Forvis Mazars markets

Alabama
Birmingham

Arizona
Phoenix

Arkansas
Fort Smith
Little Rock
Rogers

California
Irvine
Los Angeles
Sacramento
San Jose

Colorado
Colorado Springs
Denver

Florida
Boca Raton
Fort Lauderdale
Jacksonville
Orlando
Tallahassee
Tampa Bay

Georgia
Atlanta

Illinois
Chicago
Decatur

Indiana
Evansville
Fort Wayne
Indianapolis

Iowa
Des Moines

Kansas
Wichita

Kentucky
Bowling Green
Louisville

Massachusetts
Boston
Brewster
Chestnut Hill

Minnesota
Minneapolis

Mississippi
Jackson

Missouri
Branson
Joplin
Kansas City
Springfield
St. Louis

Nebraska
Lincoln
Omaha

New Jersey
Iselin

New York
Long Island
New York City

North Carolina
Asheville
Charlotte SouthPark
Charlotte Uptown
Greensboro
Greenville
Hendersonville
Raleigh
Winston-Salem

Ohio
Cincinnati
Toledo

Oklahoma
Enid
Oklahoma City
Tulsa

Pennsylvania
Fort Washington
Pittsburgh

South Carolina
Charleston
Greenville
Summerville

Tennessee
Knoxville
Memphis
Nashville

Texas
Austin
Dallas
Fort Worth
Houston
San Antonio
Waco

Utah
Salt Lake City

Virginia
Norfolk
Richmond
Tysons

West Virginia
Charleston

Wisconsin
Appleton
Madison

*FY 2025 revenue: period ending 5/31/25.

Updated 8/22/2025

forvis mazars

Agenda

- Audit Scope and Results
- Future Pronouncements
- Questions

Audit Scope and Results

Audit Scope and Results

1 Financial Statement Opinions

- Unmodified “Clean” Opinions

2 Report on Internal Control Over Financial Reporting and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards* – Independent Auditor’s Report

- No reportable findings

3 Report on Compliance for Each Major Federal Program; Report on Internal Control over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by Uniform Guidance

- No reportable findings

Audit Scope and Results (Continued)
Single Audit

Major Federal Programs for FY2025

Major Program	Federal Assistance Listing Number	Expenditures
Opioid STR	93.788	$2,488,200
National Bioterrorism Hospital Preparedness Program	93.889	$1,420,070
HIV Prevention Activities Health Department Based	93.940	$102,134
Centers for Disease Control and Prevention Collaboration with Academia to Strengthen Public Health	93.967	$6,818,216

Audit Scope and Results (Continued)

Qualitative Aspects of Significant Accounting Policies and Practices

- Significant Accounting Policies
  - The Health District's significant accounting policies are described in *Note 1* of the audited financial statements.
  - With respect to new accounting standards adopted during the year, we call to your attention the following topics detailed in the following pages:
    - Note 1 - Governmental Accounting Standards Board (GASB) Statement No. 101, *Compensated Absences*
- Alternative Accounting Treatments
  - No matters are reportable.

Audit Scope and Results (Continued)

Qualitative Aspects of Significant Accounting Policies and Practices

- Management Judgments and Accounting Estimates
  - Accounts receivable and related allowance for uncollectible amounts
  - Total other postemployment benefits (OPEB) liability and related deferred inflows and outflows of resources
  - Net pension liability and related deferred inflows and outflows of resources
  - Key estimates related to leases and SBITAs – discount rate, term, and payments
- Financial Statement Disclosures
  - Net pension liability
  - Total OPEB liability
  - Leases & SBITAs

Audit Scope and Results (Continued)

Auditor's Judgments About the Quality of the District's Accounting Principles

- No matters are reportable.

Significant Issues Discussed with Management During the Audit Process

- No matters are reportable.

Disagreements with Management

- No matters are reportable.

Future Pronouncements and Other Matters

Accounting Updates - GASB Statement No. 103, *Financial Reporting Model Improvements*

Summary

- Improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a governmental entity's accountability.
- Updates impact Management's Discussion and Analysis, Unusual or Infrequent Items, Presentation of the Proprietary Fund Statement of Revenues, Expenses, and Changes in Fund Net Position, Major Component Unit Information, and Budgetary Comparison Information.
- GASB 103 is effective for the District's 2026 fiscal year. Earlier application is encouraged.

Potential Impact

- Statement requires that the information presented in MD&A be limited to the related topics discussed in five sections: (1) Overview of the Financial Statements, (2) Financial Summary, (3) Detailed Analyses, (4) Significant Capital Asset and Long-Term Financing Activity, and (5) Currently Known Facts, Decisions, or Conditions.
- Display the inflows and outflows related to unusual or infrequent items separately.
- Requires governments to present budgetary comparison information using a single method of communication—RSI and present (1) variances between original and final budget amounts and (2) variances between final budget and actual amounts. An explanation of significant variances is required to be presented in notes to RSI.

Accounting Updates - GASB Statement No. 104, *Disclosure of Certain Capital Assets*

Summary

- Requires capital assets held for sale, intangible assets, lease assets, and subscription assets to be broken out separately in note disclosure.
- GASB 104 is effective for the District's 2026 fiscal year. Earlier application is encouraged.

Potential Impact

- For the capital assets notes disclosure required by Statement 34, the following items should be broken out separately:
  - Lease assets (*Statement 87*) by major class of underlying assets
  - Intangible RTU recognized by an operator (*Statement 94*) by major class of underlying public-private and public-public partnership asset
  - Subscription assets (*Statement 96*)
  - Other intangible assets by major class of asset
- Intangible assets that represent the right to use intangible underlying assets are not required to be disclosed separately but should not be reported with owned intangible assets.

Questions?

The information set forth in this presentation contains the analysis and conclusions of the author(s) based upon his/her/their research and analysis of industry information and legal authorities. Such analysis and conclusions should not be deemed opinions or conclusions by Forvis Mazars or the author(s) as to any individual situation as situations are fact-specific. The reader should perform their own analysis and form their own conclusions regarding any specific situation. Further, the author(s)' conclusions may be revised without notice with or without changes in industry information and legal authorities.

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Southern Nevada Health District

Independent Auditor's Report, Financial Statements, and Supplementary Information

June 30, 2025

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Financial Section

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Independent Auditor's Report

Board of Health and District Health Officer
Southern Nevada Health District
Las Vegas, Nevada

Report on the Audit of the Financial Statements

Opinions

We have audited the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of the Southern Nevada Health District (Health District), as of and for the year ended June 30, 2025, and the related notes to financial statements, which collectively comprise the Health District's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, each major fund, and the aggregate remaining fund information of the Health District, as of June 30, 2025, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (*Government Auditing Standards*). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Health District, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health District's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, budgetary comparison, and pension and other postemployment benefit information as listed in the table of contents be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the Health District's basic financial statements. The supplementary information including the budget to actual comparisons and the schedule of expenditures of federal awards required by Title 2 *U.S. Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements Federal Awards*, as listed in the table of contents, are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the budget to actual comparisons and the schedule of expenditures of federal awards are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November __, 2025 on our consideration of the Health District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Health District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health District's internal control over financial reporting and compliance.

Dallas, Texas
November __, 2025

As members of the Southern Nevada Health District's management, we offer the readers of the financial statements of Southern Nevada Health District (Health District) this narrative overview and analysis of the financial activities of the Health District for the fiscal year ended June 30, 2025. This narrative is designed to:

- Provide an overview of the Health District's financial condition and results of operations
- Assist readers in identifying significant financial activities and trends
- Explain significant changes from the prior fiscal year and ability to address future priorities

Financial Highlights

The Health District's liabilities and deferred inflows of resources exceeded its assets and deferred outflows of resources at the close of the most recent fiscal year by $35,249,505. Unrestricted net position could be used to meet the government's ongoing obligations to citizens and creditors, if it were a positive number.

The Health District's total net position (deficit) improved by $1,507,485 primarily due to an increase in property tax revenue and increases in charges for services offset with an increase in related expenditures as well as a decrease in pandemic-related operating grants and related expenditures.

The Health District's total revenue increased by $9,634,646. This was primarily driven by increases in charges for services, regulatory fees, and property tax revenues offset with a decrease in pandemic-related grants. Expenses increased by $2,004,746 primarily due to increase in personnel costs including both salaries and benefits.

Overview of the Financial Statements

The discussion and analysis provided herein is intended to serve as an introduction to the Health District's basic financial statements. The Health District's basic financial statements consist of three components:

- Government-wide financial statements
- Fund financial statements
- Notes to financial statements

This report also includes both required supplementary information and supplementary information intended to furnish additional detail to support the basic financial statements themselves.

Government-Wide Financial Statements

The *government-wide financial statements* are designed to provide readers with a broad overview of the Health District's finances, in a manner similar to a private-sector business.

The *statement of net position* presents financial information on all of the Health District's assets, deferred outflows, liabilities and deferred inflows. The difference between these elements is reported as net position. Over time, increases or decreases in net position may serve as a useful indicator of whether the financial position of the Health District is improving or deteriorating.

The *statement of activities* presents information showing how the Health District's net position changed during the most recent fiscal year. All changes in net position are reported as soon as the underlying event giving rise to the change occurs, regardless of the timing of related cash flows. Thus, revenues and expenses are reported for some items that will only result in cash flows in future fiscal periods (*e.g.*, earned but unused vacation leave).

Both of the government-wide financial statements distinguish functions of the Health District that are principally supported by taxes and intergovernmental revenues (*governmental activities*) from other functions that are intended to recover all or a significant portion of their costs through user fees and charges (*business-type activities*). There were no business-type activities in 2025. The governmental activities of the Health District are comprised of the following functions:

Clinical Services. Includes programs for primary care, communicable diseases, clinical services administration, immunizations, women's health, children's health, refugee health, sexual health program, behavioral health, and other clinical programs.

Environmental Health. Includes programs for environmental health and sanitation, waste management, and other environmental health programs.

Community Health. Includes programs for community health administration, chronic disease prevention and health promotion, epidemiology, food handler education, laboratory services, public health preparedness, emergency medical/trauma services, disease surveillance, vital statistics, and informatics.

Administration. Includes programs for general administration, financial services, legal services, public information, facilities maintenance, information technology, human resources, and business group.

The government-wide financial statements can be found beginning on page 15 of this report.

Fund Financial Statements

A *fund* is a grouping of related accounts that is used to maintain control over resources that have been segregated for specific activities or objectives. The Health District, like other state and local governments, uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements. All of the funds of the Health District can be divided into three categories:

- Governmental funds
- Proprietary funds
- Fiduciary funds

Governmental funds are used to account for essentially the same functions reported as governmental activities in the government-wide financial statements. However, unlike the government-wide financial statements, governmental fund financial statements focus on *near-term inflows and outflows of spendable resources, as well as on balances of spendable resources* available at the end of the fiscal year. Such information may be useful in assessing the Health District's near-term financing requirements.

Governmental Funds

Because the focus of governmental funds is narrower than that of the government-wide financial statements, it is useful to compare the information presented for *governmental funds* with similar information presented for governmental activities in the government-wide financial statements. By doing so, readers may better understand the long-term impact of the Health District's near-term financing decisions. Both the governmental fund balance sheet and the governmental fund statement of revenues, expenditures, and changes in fund balances provide a reconciliation to facilitate this comparison between *governmental funds* and *governmental activities*.

The Health District maintains four individual governmental funds. Information is presented separately in the governmental fund balance sheet and in the governmental fund statement of revenues, expenditures, and changes in fund balances for the general fund and special revenue fund, both of which are considered to be major funds.

The Health District adopts an annual appropriated budget for its governmental funds. A budgetary comparison statement has been provided for all funds to demonstrate compliance with each budget in either required supplementary information or supplementary information.

The basic governmental fund financial statements can be found beginning on page 18 of this report.

Proprietary Fund

As of June 30, 2025, the Health District only maintains an internal service fund:

An *internal service fund* is used to accumulate and allocate costs internally among various functions. The Health District uses an internal service fund to account for the management of its self-insured workers compensation claims and payment for current non-self-insured workers compensation premiums. The Health District's self-insured workers compensation program became effective on July 1, 2005 after it was approved by the Division of Insurance of the State of Nevada on May 12, 2005 and the Southern Nevada District Board of Health on May 26, 2005. The Health District made the decision in August 2015 to move to a fully funded plan to manage the workers compensation claims. The internal service fund must remain open for future claims from injuries between 2005 and 2015. The internal service fund has been included within the governmental activities in the government-wide financial statements.

Proprietary funds provide the same type of information as the government-wide financial statements, only in more detail. The internal service fund is a single, aggregated presentation in the proprietary fund financial statements. The basic proprietary fund financial statements can be found beginning on page 22 of this report.

Fiduciary Funds

Fiduciary funds are used to account for resources held for the benefit of parties outside of the government. Fiduciary funds are not reported in the government-wide financial statements because the resources of those funds are not available to support the Health District's own programs. The Health District created an Employee Events Fund in July 2015 to manage funds collected by employees to be managed and used by and for employees.

Notes to Financial Statements

The notes provide additional information that is necessary to acquire a full understanding of the data provided in the government-wide and fund financial statements.

The notes to financial statements can be found beginning on page 27 of this report.

Other Information

In addition to the basic financial statements and accompanying notes, this report also presents required supplementary information concerning the Health District's progress in funding its obligation to provide pension and other postemployment benefits (OPEB) to its employees.

Required supplementary information can be found beginning on page 50 of this report.

Government-Wide Overall Financial Analysis

Summary Statement of Net Position

	Governmental Activities	
	2025	**2024**
Assets		
Current and other assets	$ 92,522,446	$ 72,414,910
Net capital, lease, and subscription assets	37,326,755	38,141,386
Total Assets	129,849,201	110,556,296
Deferred Outflows of Resources	82,179,853	73,071,605
Liabilities		
Short-term liabilities	21,201,902	12,555,402
Long-term liabilities	183,979,113	186,744,388
Total Liabilities	205,181,015	199,299,790
Deferred Inflows of Resources	42,097,544	21,085,101
Net Position (Deficit)		
Net investment in capital assets	29,325,955	29,751,622
Restricted	119,425	80,053
Unrestricted (deficit)	(64,694,885)	(66,588,665)
Total Net Position (Deficit)	$ (35,249,505)	$ (36,756,990)

Total unrestricted net position represents negative 187% of total net position of Governmental Activities and is not available to meet the Health District's ongoing obligations to citizens and creditors. The remainder of the Health District's net position reflects its investment in capital, lease, and subscription assets (*e.g.*, land, buildings, equipment, vehicles, infrastructure) and funds restricted for grants and insurance liability reserve. The Health District uses these capital assets to provide a variety of services to citizens. Accordingly, these assets are not available for future spending.

The Health District's total net position (deficit) improved by $1,507,485 primarily due to increased fees for services, increased regulatory revenue, and increased property tax revenues, offset by a decrease in federal grants revenue and an increase in clinical services and environmental health-related expenditures.

The increase for charges for services was due to an overall increase in immunizations and other medical services. The increase in regulatory services was primarily due to increased fees during fiscal year 2025.

The property tax increase was due to a growing local economy and increases in property values.

The decrease in operating grants was mainly due to the termination of pandemic-related grants during fiscal year 2025.

Summary Statement of Changes in Net Position

	Governmental Activities	
	2025	**2024**
Revenues		
Program revenues		
Charges for services	$ 78,438,113	$ 67,347,827
Operating grants and contributions	49,014,470	57,783,029
General revenues		
Property tax allocation	37,651,176	34,088,562
Other income	4,936,348	2,575,284
Unrestricted investment income	3,532,996	2,143,755
Total Revenues	173,573,103	163,938,457
Expenses		
Public health		
Clinical services	72,910,245	61,460,781
Environmental health	33,489,858	31,127,930
Community health	55,376,183	61,936,949
Administration	9,914,726	15,218,402
Interest	374,606	316,810
Total Expenses	172,065,618	170,060,872
Change in Net Position	1,507,485	(6,122,415)
Net Position, Beginning	(36,756,990)	(30,634,575)
Net Position, Ending	$ (35,249,505)	$ (36,756,990)

Governmental Activities

During the current fiscal year, net position for governmental activities improved $1,507,485 from the 2024 fiscal year to an ending balance of negative $35,249,505.

Financial Analysis of Governmental Funds

As noted earlier, the Health District uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements.

The focus of the Health District's governmental funds is to provide information on near-term inflows, outflows, and balances of spendable resources. Such information is useful in assessing the Health District's financing requirements. In particular, unassigned fund balance may serve as a useful measure of a government's net resources available for discretionary use as they represent the portion of fund balance which has not yet been limited to use for a particular purpose by either an external party, the Health District itself, or a group or individual that has been delegated authority to assign resources for use for particular purposes by the Health District's Board of Health.

At June 30, 2025, the Health District's governmental funds reported combined fund balances of $72,036,301, an increase of $11,308,409 in comparison with the prior year. Approximately 75%, or $54,049,140, of this amount constitutes unassigned fund balance, which is available for spending at the Health District's discretion.

The remainder of governmental fund balance is classified as follows: $4,597,441 is nonspendable; restricted funds of $119,425 is grant-related; $1,000,000 is committed for emergency reserve; $6,786,283 is assigned to capital project improvements; $3,000,000 is assigned for contingency; $2,379,682 is assigned to administrative projects; and $104,330 is assigned to pharmacy projects. The General Fund is the chief operating fund of the Health District. At the end of the current fiscal year, unassigned fund balance of the General Fund was $54,049,140, while the total fund balance is $65,128,565. As a measure of operating liquidity, it may be useful to compare both unassigned fund balance and total fund balance to total combined general fund and special revenue fund expenditures.

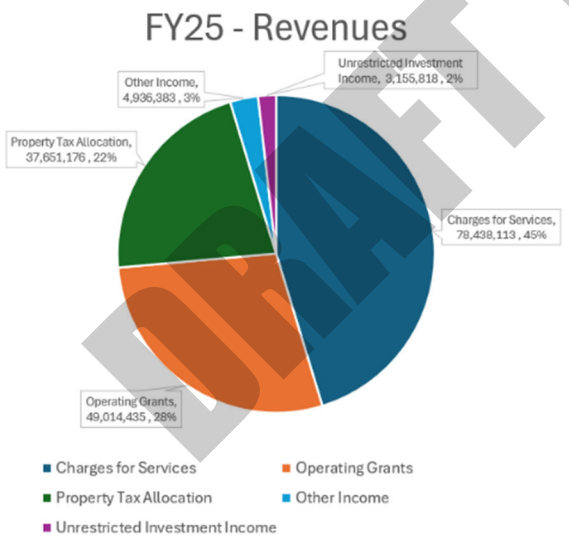
Unassigned fund balance represents approximately 33.8% of total combined general fund and special revenue fund expenditures and transfers, while total governmental fund balance represents approximately 46.0% of the total governmental expenditures and transfers. The Health District's general fund balance increased by $10,255,737 during the current fiscal year, attributable to increased fees for services, increased regulatory revenue, and increased property tax allocation, offsetting with reductions in community health-related expenditures and net administration costs and a reduction in transfers to other funds.

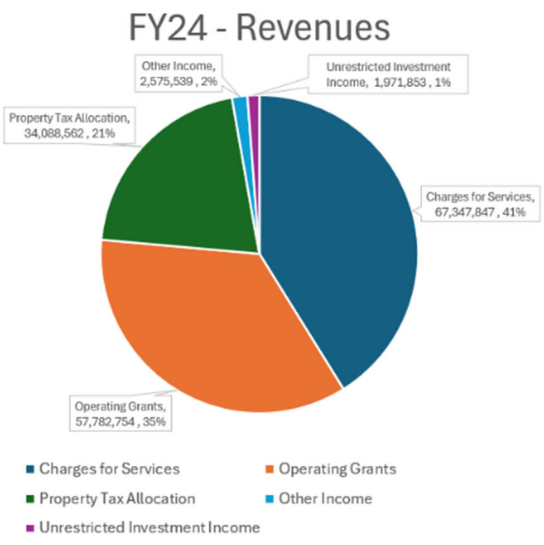
Other governmental funds consist of the Special Revenue Fund, the Bond Reserve Fund (also known as Building Fund), and the Capital Projects Fund. The Special Revenue Fund was created in fiscal year 2016 to account for the grant funds the Health District receives and has a nonspendable fund balance of $2,028 and restricted fund balance of $119,425. The Bond Reserve Fund was approved by the Board of Health on March 27, 2008, so that the Health District will be able to pay bonded debt in the event that Clark County issues bonds on behalf of the Health District in order to fund a new facility replacement for the main campus. On December 16, 2010, the Southern Nevada District Board of Health amended the original purpose of the Bond Reserve Fund to allow the Board of Health to utilize the resources of the debt service fund for any identifiable projects at the discretion of the Board that benefit the public health of Clark County.

The Bond Reserve and Capital Funds have an assigned fund balance of $6,786,283 at the end of the current fiscal year, which increased by $1,013,300 as compared to the prior fiscal year, primarily attributable to a budgeted transfer of $2,000,000 from the General Fund.

Fund Revenues by Source

	2025		2024		Increase (Decrease)	
	Amount	Percent	Amount	Percent	Amount	Percent
General Fund Revenues						
Charges for services						
Fees for service	$ 46,360,664	37.74%	$ 35,119,778	33.61%	$ 11,240,886	32.01%
Regulatory revenue	28,482,125	23.19%	27,422,167	26.24%	1,059,958	3.87%
Title XIX and other	3,595,324	2.93%	4,805,902	4.60%	(1,210,578)	-25.19%
Total charges for services	78,438,113	63.85%	67,347,847	64.45%	11,090,266	16.47%
Intergovernmental revenues						
Property tax	37,651,176	30.65%	34,088,562	32.62%	3,562,614	10.45%
General receipts						
Contributions and donations	35	0.00%	255	0.00%	(220)	-86.27%
Interest income	3,155,818	2.57%	1,971,853	1.89%	1,183,965	60.04%
Other	3,592,739	2.92%	1,094,229	1.05%	2,498,510	228.34%
Total General Fund Revenues	$122,837,881	100.00%	$104,502,746	100.00%	$ 18,335,135	17.55%
Special Revenue Fund Revenues						
Intergovernmental revenues						
Direct federal grants	$ 18,175,097	36.09%	$ 21,913,784	36.98%	$ (3,738,687)	-17.06%
Indirect federal grants	27,305,731	54.22%	34,797,567	58.72%	(7,491,836)	-21.53%
State funding	3,533,607	7.02%	1,071,403	1.81%	2,462,204	229.81%
Total intergovernmental revenues	49,014,435	97.33%	57,782,754	97.50%	(8,768,319)	-15.17%
Program Contract Services	1,343,609	2.67%	1,481,055	2.50%	(137,446)	-9.28%
Total Special Fund Revenues	$ 50,358,044	100.00%	$ 59,263,809	100.00%	$ (8,905,765)	-15.03%
Combined Special Revenue and General Funds	$173,195,925		$163,766,555		$ 9,429,370	5.76%





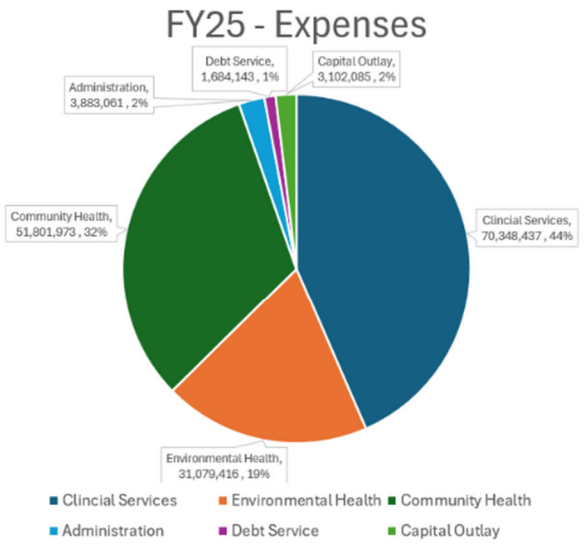
The increase in fees for service, including immunizations and other medical services and regulatory services, is due to increased fees, number of patients, permits, and inspections.

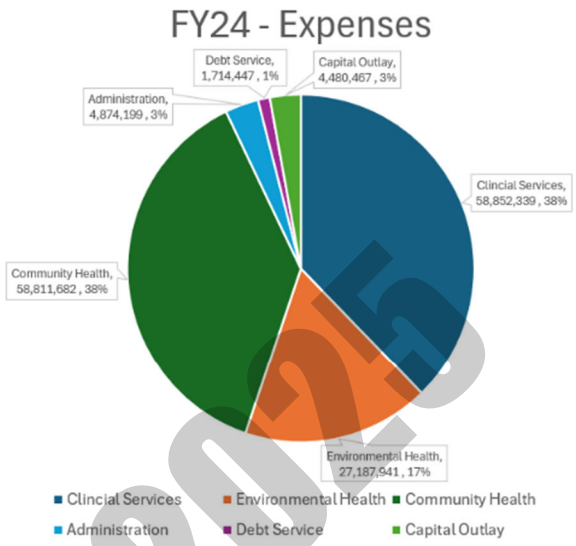
The increase in the property tax allocation of $3,562,614 is due to a growing local economy, increases in property values, and subsequent increased property taxes. There is a 3% property tax cap on increases for primary residence property in the State of Nevada.

The increase in interest income was due to increased fair market value compared to book value and improved earnings rate based on increased balances at year-end from investments.

The decrease in intergovernmental grant revenues was primarily due to a decrease in grants received and related eligible expenditures in clinical services and community health services areas. These grants were primarily COVID-19-related.

	2025		2024		Increase (Decrease)	
	Amount	Percent	Amount	Percent	Amount	Percent
General Fund Expenditures						
Current						
Public health						
Clinical services	$ 56,454,440	52.85%	$ 43,768,571	47.77%	$ 12,685,869	28.98%
Environmental health	29,376,372	27.50%	24,218,749	26.43%	5,157,623	21.30%
Community health services	16,903,125	15.82%	16,430,847	17.93%	472,278	2.87%
Administration	851,186	0.80%	3,016,484	3.29%	(2,165,298)	-71.78%
Debt service						
Principal	1,309,537	1.23%	1,397,637	1.53%	(88,100)	-6.30%
Interest	374,606	0.35%	316,810	0.35%	57,796	18.24%
Capital outlay						
Public health	1,543,923	1.45%	2,470,015	2.70%	(926,092)	-37.49%
Total General Fund Expenditures	$106,813,189	100.00%	$ 91,619,113	100.00%	$ 15,194,076	16.58%
Special Revenue Fund Expenditures						
Current						
Public health						
Clinical services	$ 13,893,997	25.22%	$ 15,083,768	23.46%	$ (1,189,771)	-7.89%
Environmental health	1,703,044	3.10%	2,969,192	4.61%	(1,266,148)	-42.64%
Community health services	34,898,848	63.35%	42,380,835	65.91%	(7,481,987)	-17.65%
Administration	3,031,875	5.50%	1,857,715	2.89%	1,174,160	63.20%
Capital outlay						
Public health	1,558,162	2.83%	2,010,452	3.13%	(452,290)	-22.50%
Total Special Revenue Fund Expenditures	$ 55,085,926	100.00%	64,301,962	100.00%	$ (9,216,036)	-14.33%
Combined Special Revenue and General Funds	$161,899,115		$155,921,075		$ 5,978,040	3.83%





The increase in general fund expenditures was primarily due to an increase in personnel expenses for services provided and operating costs for supplies in relation to the increase in fees for service and an increase in personnel expenses related to inspections and permit issuance in relation to the increase in regulatory services.

The decrease in special revenue fund expenditures was primarily due to a decrease in grants received and expended in clinical services, environmental health, and community health services areas.

General Fund Budget Highlights

Final Budget Compared to Actual Results

Current budget procedure allows funds to be moved within programs and departments. Revenues are underbudgeted amounts by $4,881,731. This is attributable to higher than expected medical and immunization fee activity and investment earnings. Expenditures fell short of budgeted amounts by $5,059,481 primarily due to lower than expected services and supplies expense for standard operations.

Detailed information of budgeted revenue and expenditures and actual revenue and expenditures is included in the Supplementary Information on page 50 of the Financial Report.

Capital, Lease, and Subscription Assets

As of June 30, 2025, the Health District's net investment in capital, lease, and subscription assets for its governmental activities was $37,326,755. This investment in capital assets includes land, buildings and improvements, and vehicles and equipment. The net decrease in capital assets for the current fiscal year was approximately $814,631, or 2%, primarily due to an increase in construction in progress, right-to-use leased building, subscription IT assets, and furniture, offset by retirement and depreciation and amortization on existing assets.

	Balance June 30, 2024	Increases	Decreases	Transfers	Balance June 30, 2025
Governmental activities	$ 38,141,386	$ 4,117,157	$ (4,931,788)	$ -	$ 37,326,755

The Health District disposed capital assets by $397,383. This was primarily due to obsolete furniture, fixtures, and equipment.

Additional detailed information on the Health District's capital assets can be found in Note 4 of this report.

Long-Term Debt

At the end of the current fiscal year, the Health District has no outstanding debt other than lease liabilities and subscription liabilities.

Economic Factors and Next Year's Budgets and Rates

The Health District's financial position improved during fiscal year 2024-2025. The national public health emergency put in place at the start of the pandemic expired on May 11, 2023. Grant revenue provided for the pandemic response has begun to expire and is expected to continue to be reduced as remaining projects and deliverables for the existing grants are completed.

Although created as an independent governmental entity pursuant to Nevada Revised Statute (NRS) 439.361, the Health District has no taxing authority and relies on revenue from fees and other governmental sources in order to operate. Funding for all capital improvements must be derived from operating revenue unless capital grant funds or other allocated funding is awarded.

Currently, the Health District is faced with the need to maintain a reserve to respond effectively to public health emergencies. The Board of Health continued its previous approval of $1,000,000 of fund balance to be used if needed for that purpose. The amount is included as committed fund balance in the financial statements.

The Health District is confronted with inflationary factors affecting the cost of equipment; clinical, laboratory, and pharmaceutical supplies; and other services. As of June 30, 2025, the Consumer Price Index has increased 2.7% over the past 12 months as an average annual percentage indicating these costs may continue to grow in the immediate future. Bargaining unit negotiation increases scheduled for budget year 2025-2026 will result in significant increased labor costs going forward. In addition, benefit costs will be higher due to increased retirement contributions on increased salaries and increased group insurance costs in budget year 2025-2026.

The Health District will continue to pursue not only proportional allocation of federal pass-through dollars through the State but also direct funding from the federal government. Clark County has 70% of Nevada's population and is 4.7 times the population of Washoe County in Northern Nevada. The additional federal support will enable the Health District to better address the needs of residents requiring services. Senate Bill 118 was approved during the State of Nevada 2023 Legislative Session. Section 9.2 of the bill made an appropriation to the Division of Public and Behavioral Health of the Department of Health and Human Services for allocation to specified entities for the improvement of public health. The Health District received an allocation of $10,950,000 to be utilized over fiscal year 2024-2025 and fiscal year 2025-2026. During fiscal year 2025, $1.9 million of the $10.95 million was expended with the remainder to be expended in fiscal year 2026 on projects to support identified public health priorities. In August 2025, the Health District also received an allocation of $10,786,480 to be utilized over the fiscal year 2025-2026 and fiscal year 2026-2027 in installments of $5,393,240, respectively.

Property tax revenue is anticipated to increase by approximately 10% for the 2025-2026 budget year. Fees for services for clinical services continue to grow as services expand. Regulatory revenue, environmental health licenses, and permit revenues are anticipated to increase as fees are adjusted and regulated activities with national and international venues occur in the community. The increase for the 2025-2026 budget year is anticipated to be approximately 1% for charges for services, licenses, and permits.

At present, the Health District has the financial resources and capacity to maintain current service levels. As pandemic relief funding expires or terminates, the Health District will need to ensure operational viability by closely monitoring revenues and expenditures in addition to making operational adjustments and pursuing additional funding sources.

Request for Information

These financial statements are designed to provide a general overview to all parties who are interested in the Southern Nevada Health District's finances. Questions concerning any of the information provided in this report or requests for additional financial information should be addressed to:

Southern Nevada Health District
Attention: Chief Financial Officer
280 S. Decatur Blvd.
P.O. Box 3902
Las Vegas, NV 89127

This entire report is available online at: http://www.southernnevadahealthdistrict.org.

Basic Financial Statements

Southern Nevada Health District
Statement of Net Position
June 30, 2025

	Primary Government
	Governmental Activities
ASSETS	
Cash, cash equivalents, and investments	$ 72,798,826
Grants receivable	8,873,290
Accounts receivable, net	6,236,667
Interest receivable	374,112
Other receivables	451,242
Prepaid items	1,203,132
Inventories	2,585,177
Capital assets, not depreciated	
Land	3,447,236
Construction in progress	3,061,594
Capital, lease, and subscription assets, net of accumulated depreciation and amortization	
Buildings	15,179,196
Improvements other than buildings	2,076,471
Furniture, fixtures, and equipment	5,094,867
Lease assets	6,589,301
Subscription assets	1,504,871
Vehicles	373,219
Total Assets	129,849,201
DEFERRED OUTFLOWS OF RESOURCES	
Deferred amounts related to pensions	59,549,437
Deferred amounts related to OPEB	22,630,416
Total Deferred Outflows of Resources	82,179,853

	Primary Government
	Governmental Activities
LIABILITIES	
Accounts payable	$ 3,898,278
Accrued expenses	2,432,660
Workers compensation self-insurance claims	43,586
Unearned revenue	14,827,377
Long-term liabilities, due within one year	
Compensated absences	5,827,425
Lease liabilities	1,042,365
Subscription liabilities	251,416
Long-term liabilities, due in more than one year	
Compensated absences	7,592,924
Lease liabilities	6,159,579
Subscription liabilities	237,650
Net pension liability	127,620,524
Total OPEB liability	35,247,231
Total Liabilities	205,181,015
DEFERRED INFLOWS OF RESOURCES	
Deferred amounts related to pensions	18,818,672
Deferred amounts related to OPEB	23,278,872
Total Deferred Inflows of Resources	42,097,544
NET POSITION (DEFICIT)	
Net investment in capital assets	29,325,954
Restricted	119,425
Unrestricted (deficit)	(64,694,884)
Total Net Position (Deficit)	$ (35,249,505)

Southern Nevada Health District
Statement of Activities
For the Fiscal Year Ended June 30, 2025

Functions/Programs	Expenses	Program Revenues: Charges for Services	Program Revenues: Operating Grants and Contributions	Net (Expenses) Revenues and Changes in Net Position Primary Government: Governmental Activities
Primary Government				
Governmental activities				
Public health				
Clinical services	$ 72,910,245	$ 41,698,049	$ 12,479,441	$ (18,732,755)
Environmental health	33,489,858	28,093,516	1,558,720	(3,837,622)
Community health	55,376,183	5,799,366	31,758,403	(17,818,414)
Administration	9,914,726	2,847,182	3,217,906	(3,849,638)
Interest	374,606	-	-	(374,606)
Total governmental activities	172,065,618	78,438,113	49,014,470	(44,613,035)
Total Function/Program	$ 172,065,618	$ 78,438,113	$ 49,014,470	$ (44,613,035)
General Revenues				
Property tax allocation				$ 37,651,176
Other income				4,936,348
Unrestricted investment income				3,532,996
Total General Revenues and Transfers				46,120,520
Change in Net Position (Deficit)				1,507,485
Net Position (Deficit), Beginning of Year				(36,756,990)
Net Position (Deficit), End of Year				$ (35,249,505)

Southern Nevada Health District
Governmental Funds – Balance Sheet
June 30, 2025

	General Fund	Special Revenue Fund	Other Governmental Funds	Total Governmental Funds
ASSETS				
Cash, cash equivalents, and investments	$ 64,801,125	$ -	$ 7,885,466	$ 72,686,591
Grants receivable	-	8,873,290	-	8,873,290
Accounts receivable, net	6,236,667	-	-	6,236,667
Other receivables	450,972	270	-	451,242
Interest receivables	333,279	-	40,770	374,049
Due from other funds	8,738,622	9,395,920	-	18,134,542
Inventories	2,585,177	-	-	2,585,177
Prepaid items	2,010,236	2,028	-	2,012,264
Total Assets	$ 85,156,078	$ 18,271,508	$ 7,926,236	$ 111,353,822
LIABILITIES				
Accounts payable	$ 2,994,800	$ 593,688	$ 309,791	$ 3,898,279
Accrued expenses	2,432,659	-	-	2,432,659
Workers compensation self-insurance claims	23,586	-	-	23,586
Unearned revenue	5,534,065	9,293,312	-	14,827,377
Due to other funds	9,042,403	8,263,055	830,162	18,135,620
Total Liabilities	20,027,513	18,150,055	1,139,953	39,317,521
FUND BALANCES				
Nonspendable				
Inventories	2,585,177	-	-	2,585,177
Prepaid items	2,010,236	2,028	-	2,012,264
Restricted for				
Grants	-	119,425	-	119,425
Committed for				
Emergency reserve	1,000,000	-	-	1,000,000
Assigned for				
Capital improvements	-	-	6,786,283	6,786,283
Contingency	3,000,000	-	-	3,000,000
Administration	2,379,682	-	-	2,379,682
Pharmacy	104,330	-	-	104,330
Unassigned	54,049,140	-	-	54,049,140
Total Fund Balances	65,128,565	121,453	6,786,283	72,036,301
Total Liabilities and Fund Balances	$ 85,156,078	$ 18,271,508	$ 7,926,236	$ 111,353,822

Southern Nevada Health District
Reconciliation of the Balance Sheet – Governmental Funds to the Statement of Net Position – Governmental Activities
June 30, 2025

Total Fund Balance – Governmental Funds	$	72,036,301
Amounts reported for governmental activities in the statement of net position are different because:		
Capital, lease, and subscription assets used in governmental activities are not current financial resources and, therefore, are not reported in governmental funds. Capital, lease, and subscription asset balance presented below is net of $809,132 of prepaid subscription assets already reported in the governmental funds.		
Capital, lease, and subscription assets, net of accumulated depreciation and amortization		36,517,623
Long-term liabilities and related deferred inflows and outflows of resources are not due in payable in the current period or are not current financial resources and, therefore, are not reported in the funds. A summary of these items is as follows:		
Postemployment benefits other than pensions		(35,247,231)
Deferred outflows related to postemployment benefits other than pensions		22,630,416
Deferred inflows related to postemployment benefits other than pensions		(23,278,872)
Compensated absences		(13,420,349)
Lease liability		(7,201,944)
Subscription liability		(489,066)
Net pension liability		(127,620,524)
Deferred outflows related to pensions		59,549,437
Deferred inflows related to pensions		(18,818,672)
Internal service funds are used by management to charge the costs of certain activities to individual funds:		
Internal service fund assets and liabilities included in governmental activities in the statement of net position		93,376
Net Position of Governmental Activities	$	(35,249,505)

Southern Nevada Health District
Governmental Funds Statement of Revenues, Expenditures, and Changes in Fund Balances
For the Fiscal Year Ended June 30, 2025

	General Fund	Special Revenue Fund	Other Governmental Funds	Total Governmental Funds
Revenues				
Charges for services				
Fees for service	$ 46,360,664	$ -	$ -	$ 46,360,664
Regulatory revenue	28,482,125	-	-	28,482,125
Title XIX and other	3,595,324	-	-	3,595,324
Intergovernmental revenues				
Property tax	37,651,176	-	-	37,651,176
Direct federal grants	-	18,175,097	-	18,175,097
Indirect federal grants	-	27,305,731	-	27,305,731
State grant funds	-	3,533,607	-	3,533,607
General receipts				
Contributions and donations	35	-	-	35
Interest income	3,155,818	-	375,097	3,530,915
Other	3,592,739	1,343,609	-	4,936,348
Total Revenues	122,837,881	50,358,044	375,097	173,571,022
Expenditures				
Current				
Public health				
Clinical and nursing services	56,454,440	13,893,997	-	70,348,437
Environmental health	29,376,372	1,703,044	-	31,079,416
Community health	16,903,125	34,898,848	-	51,801,973
Administration	851,186	3,031,875	489,261	4,372,322
Total current	103,585,123	53,527,764	489,261	157,602,148
Debt service				
Principal	1,309,537	-	-	1,309,537
Interest	374,606	-	-	374,606
Capital outlay	1,543,923	1,558,162	872,536	3,974,621
Total debt service	3,228,066	1,558,162	872,536	5,658,764
Total Expenditures	106,813,189	55,085,926	1,361,797	163,260,912
Excess (Deficiency) of Revenues Over Expenditures	16,024,692	(4,727,882)	(986,700)	10,310,110
Other Financing Sources (Uses)				
Transfers in	-	4,767,254	2,000,000	6,767,254
Transfers out	(6,767,254)	-	-	(6,767,254)
Leases issued	422,069	-	-	422,069
Subscriptions	576,230	-	-	576,230
Total Other Financing Sources (Uses)	(5,768,955)	4,767,254	2,000,000	998,299
Net Change in Fund Balances	10,255,737	39,372	1,013,300	11,308,409
Fund Balances, Beginning of Year	54,872,828	82,081	5,772,983	60,727,892
Fund Balances, End of Year	$ 65,128,565	$ 121,453	$ 6,786,283	$ 72,036,301

See Notes to Financial Statements

Southern Nevada Health District
Reconciliation of the Statement of Revenues, Expenditures, and Changes in Fund Balances – Governmental Funds to the Statement of Activities – Governmental Activities
For the Fiscal Year Ended June 30, 2025

Net change in fund balances – total governmental funds	$	11,308,409
Amounts reported for governmental activities in the statement of activities are different because:		
Governmental funds report capital outlays as expenditures. However, in the Statement of Activities the cost of those assets is allocated over their estimated useful lives and reported as depreciation or amortization. This is the amount of capital outlay recorded in the current period.		
Expenditures for capital assets, excludes amounts in prepaid assets of $142,536		3,974,621
Less current year depreciation and amortization		(4,534,405)
Disposal of capital assets		(397,383)
The issuance of long-term debt (*e.g.* , lease and subscription liabilities) provides current financial resources to governmental funds, while the repayment of the principal of long-term debt consumes the current financial resources of governmental funds.		
Principal payments on lease and subscription liabilities		1,309,537
Leases issued		(422,069)
Subscriptions		(576,230)
Some expenses reported in the statement of activities (do)/do not require the use of current financial resources and, therefore, (are)/are not reported as expenditures in governmental funds:		
Change in postemployment benefits other than pensions		(6,492,501)
Change in deferred outflows related to postemployment benefits other than pensions		9,425,113
Change in deferred inflows related to postemployment benefits other than pensions		(3,491,032)
Change in compensated absences		(2,028,783)
Change in prepaid subscription assets		293,083
Change in deferred outflows related to pensions		(316,865)
Change in deferred inflows related to pensions		(17,521,411)
Change in net pension liability		10,975,320
Internal service funds are used by management to charge the costs of certain activities to individual funds:		
Internal service fund change in net position included in governmental activities in the statement of activities		2,081
Change in net position of governmental activities	$	1,507,485

Southern Nevada Health District
Statement of Net Position – Proprietary Funds
June 30, 2025

	Governmental Activities
	Insurance Liability Reserve
ASSETS	
Current Assets	
Cash and cash equivalents	$ 12,235
Restricted cash	100,000
Interest receivable	63
Due from other funds	1,078
Total Current Assets	113,376
LIABILITIES	
Current Liabilities	
Workers compensation self-insurance claims	20,000
Total Current Liabilities	20,000
NET POSITION	
Restricted	93,376
Total Net Position	$ 93,376

Southern Nevada Health District
Statement of Revenues, Expenses, and Changes in Net Position – Proprietary Funds
For the Fiscal Year Ended June 30, 2025

	Governmental Activities
	Insurance Liability Reserve
Nonoperating Revenues	
Investment income	$ 2,081
Change in Net Position	2,081
Net Position, Beginning of Year	91,295
Net Position, End of Year	$ 93,376

Southern Nevada Health District
Statement of Cash Flows – Proprietary Funds
For the Fiscal Year Ended June 30, 2025

	Governmental Activities
	Insurance Liability Reserve
Cash Flows From Noncapital and Related Financing Activities	
Repayment of advances received from other funds	$ (989)
Net Cash Used in Noncapital Financing Activities	(989)
Cash Flows From Investing Activities	
Investment income	2,141
Net Cash Provided by Investing Activities	2,141
Change in Cash, Restricted Cash, and Cash Equivalents	1,152
Cash, Restricted Cash, and Cash Equivalents, Beginning of Year	111,083
Cash, Restricted Cash, and Cash Equivalents, End of Year	$ 112,235
Reconciliation of Cash Balances at End of Year	
Unrestricted	$ 12,235
Restricted	100,000
	$ 112,235

Southern Nevada Health District
Statement of Fiduciary Net Position
June 30, 2025

	Custodial Fund
ASSETS	
Cash and cash equivalents	$ 10,673
Total Assets	10,673
LIABILITIES	
Payable to primary government	1,421
Total Liabilities	1,421
NET POSITION	
Restricted for individuals and organizations	9,252
Total Net Position	$ 9,252

Southern Nevada Health District
Statement of Changes in Fiduciary Net Position
June 30, 2025

	Custodial Fund
Additions	
Contributions	$ 8,332
Total Additions	8,332
Deductions	
Services and supplies	7,681
Total Deductions	7,681
Net Increase in Fiduciary Net Position	651
Fiducuary Net Position, Beginning of Year	8,601
Fiduciary Net Position, End of Year	$ 9,252

Note 1. Summary of Significant Accounting Policies

The Reporting Entity

The accompanying financial statements include all of the activities that comprise the financial reporting entity of the Southern Nevada Health District (Health District). The Health District is governed by an 11-member policymaking board (Board of Health) comprised of two representatives each from the Board of County Commissioners and the largest city in Clark County, one elected representative from each of the four remaining jurisdictions in the county, a physician member at-large, one representative of a nongaming business, and one representative of the Association of Gaming Establishments. The Health District represents a unique consolidation of the public health needs of the cities of Boulder City, Las Vegas, North Las Vegas, Henderson, Mesquite, and others within Clark County.

The accounting policies of the Health District conform to generally accepted accounting principles as applicable to governmental entities. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles.

Basic Financial Statements

The Health District's basic financial statements consist of government-wide financial statements, fund financial statements, and related notes. The government-wide financial statements include a statement of net position and a statement of activities, and the fund financial statements include financial information for the governmental, proprietary, and fiduciary funds. Reconciliations between the governmental funds and the governmental activities are also included.

Government-Wide Financial Statements

The government-wide financial statements are made up of the statement of net position and the statement of activities. These statements include the aggregated financial information of the Health District as a whole, except for fiduciary activity. The effect of interfund activity has been removed from these statements.

The statement of activities demonstrates the degree to which the direct expenses of a given function or program are offset by program revenues. Direct expenses are those that are clearly identifiable with a specific function. Program revenues include: 1) charges to customers or applicants who purchase, use, or directly benefit from goods, services, or privileges provided by a given function, and 2) grants and contributions that are restricted to meeting the operational or capital requirements of a particular function. Other sources of revenue not properly included among program revenues are reported instead as general revenues. This statement provides a net cost or net revenue of specific functions within the Health District. Those functions with a net cost are consequently dependent on general-purpose revenues, such as the property tax allocation from Clark County collected from various jurisdictions, to remain operational.

Fund Financial Statements

The financial accounts of the Health District are organized on a basis of funds, each of which is considered a separate accounting entity. The operations of each fund are accounted for using a separate set of self-balancing accounts comprised of assets, liabilities, fund balance, revenues, and expenditures/expenses. Separate financial statements are provided for governmental funds, proprietary funds, and fiduciary funds, even though the latter are excluded from the government-wide financial statements.

The presentation emphasis in the fund financial statements is on major funds. All governmental funds considered major funds are reported as separate columns in the fund financial statements. All remaining governmental funds are aggregated and reported as other governmental funds in a separate column.

The Health District reports the following major governmental funds:

General Fund. Accounts for all financial resources which are not accounted for in another fund and is the general operating fund of the Health District.

Special Revenue Fund. Accounts for all grant resources that have been restricted for specific programs.

The proprietary fund distinguishes operating revenues and expenses from nonoperating items. Operating revenues and expenses generally result from providing services in connection with the proprietary fund's principal ongoing operations. Operating expenses of the internal service fund include claims and administrative expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

The Health District reports the following internal service fund:

Insurance Liability Reserve Fund. Accounts for the costs associated with the self-funded workers compensation insurance.

Measurement Focus, Basis of Accounting, and Financial Statement Presentation

The government-wide, proprietary, and fiduciary fund financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows. Grants, contributions, and similar items are recognized as revenue as soon as all eligibility requirements imposed by the provider have been met.

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized as soon as they are both measurable and available. Revenues are considered "measurable" when in the hands of the intermediary collecting governments and are considered to be available when they are collectible within the current period or soon enough thereafter (within 60 days) to pay liabilities of the current period. For this purpose, the Health District considers property tax revenues to be available if they are collected within 60 days of the current fiscal year-end. The major revenue sources of the Health District include the property tax allocation from Clark County collected from various jurisdictions, regulatory revenue, fees for service, and other intergovernmental revenues from state and federal sources, which have been treated as susceptible to accrual as well as other revenue sources. In general, expenditures are recorded when liabilities are incurred, as under accrual accounting. The exception to this rule is that principal and interest on debt service, as well as liabilities related to compensated absences, postemployment benefits, and claims and judgments, are recorded when payment is due.

Cash and Cash Equivalents

The Health District considers short-term, highly liquid investments that are both readily convertible to cash and have original maturity dates of three months or less to be cash equivalents. This includes all of the Health District's cash and cash equivalents held by the Clark County Treasurer, which are combined with other Clark County funds in a general investment pool. As the Health District maintains the right to complete access to its funds held in the investment pool, these invested funds are presented as cash equivalents in the accompanying basic financial statements.

Accounts Receivable

Accounts receivable from patients for services rendered are reduced by the amount of such billings deemed by management to be ultimately uncollectible. The Health District utilizes historical experience for determining the estimated allowance for uncollectible accounts. Under this methodology, historical data is utilized to determine the historical bad debt percentages and applied prospectively to new billings.

Interfund Receivables and Payables

During the course of operations, numerous transactions occur between individual funds for goods provided or services rendered. The resulting payables and receivables outstanding at year-end, if any, are referred to as due to or due from other funds. Transactions that constitute reimbursements to a fund for expenditures or expenses initially made from it that are properly applicable to another fund are recorded as expenditures or expenses in the reimbursing fund and as reductions of expenditures or expenses in the fund that is reimbursed.

Inventories

Inventories are stated at the lower of cost or market. Cost is determined on an average cost basis. Governmental fund inventories are accounted for under the consumption method where the costs are recorded as expenditures when the inventory item is used rather than when purchased.

Additionally, the Health District receives medical vaccines from the State of Nevada (State) for use in the Health District's clinics, which are not included in the Health District's inventory since these vaccines remain the property of the State until they are administered. At June 30, 2025, the estimated value of such vaccines in the Health District's possession was $1,334,478.

Prepaid Items

Certain payments to vendors reflect costs applicable to future periods and are recorded as prepaid items in both the government-wide and fund financial statements. In the fund financial statements, prepaid items are recorded as expenditures when consumed rather than when purchased.

Capital, Lease, and Subscription Assets

Capital, lease, and subscription assets, which include property, plant, and equipment, are reported in the government-wide financial statements. The Health District considers assets with an initial individual cost of more than $5,000 and an estimated useful life in excess of one year to be capital assets. Purchased or constructed capital assets are recorded at historical cost or estimated historical cost and updated for additions and retirements during the year. Donated capital assets, if any, are valued at their acquisition value as of the date of donation.

The cost of normal maintenance and repairs that do not significantly increase the functionality of the assets or materially extend the assets' lives is not capitalized. Major outlays for capital assets and improvements are capitalized as the projects are constructed.

Right-to-use leased assets are recognized at the lease commencement date and represent the Health District's right to use an underlying asset for the lease term. Right-to-use leased assets are measured at the initial value of the lease liability plus any payments made to the lessor before commencement of the lease term, less any lease incentives received from the lessor at or before the commencement of the lease term, plus any initial direct costs necessary to place the lease asset into service. Right-to-use leased assets are amortized over the shorter of the lease term or useful lives of the underlying asset using the straight-line method.

Subscription assets are initially recorded at the initial measurement of the subscription liability, plus subscription payments made at or before the commencement of the subscription-based information technology arrangement (SBITA) term, less any SBITA vendor incentives received from the SBITA vendor at or before the commencement of the SBITA term, plus capitalizable initial implementation costs. Subscription assets are amortized on a straight-line basis over the shorter of the SBITA term or the useful life of the underlying IT asset.

Depreciation and amortization are computed using the straight-line method over the following estimated useful lives:

Buildings	30 to 50 years
Improvements other than buildings	5 to 25 years
Furniture, fixtures, and equipment	3 to 20 years
Vehicles	6 years

Compensated Absences

It is the Health District's policy to permit employees to accumulate earned but unused vacation and sick pay benefits, which are collectively referred to as compensated absences. The Health District's policy is that leave earned in the prior period is used before leave earned in current periods.

Vacation benefits earned by employees are calculated based on years of full-time service as follows:

Years of Service	Vacation Benefits
Less than 1	10
1 to 8	15
8 to 13	18
More than 13	20

The vacation pay benefits for any employee not used during the calendar year may be carried over to the next calendar year but are not permitted to exceed twice the vacation pay benefits the employee earned per year. The employee forfeits any excess leave.

An employee is entitled to sick pay benefits accrued at one day for each month of full-time service. After 120 months of full-time service, an employee is entitled to 1.25 days of sick pay benefits for each month of full-time service. There is no limit on the amount of sick pay benefits that can be accumulated.

Upon termination:

- A bargaining employee hired before July 1, 2014 with at least three years of service will receive 100% of the sick pay benefits accrual for the first 800 hours, 50% of the accrued hours between 801 hours through 1,600 hours, and 25% of the accrued hours greater than 1,600.
- A bargaining employee hired after June 30, 2014 with four years of service will receive 100% of the sick pay benefits accrual for up to 800 hours.
- A non-bargaining employee hired prior to June 30, 2014 will receive 100% of sick leave benefits accrual for the first 800 hours, 50% of the accrued hours between 801 hours through 1,600 hours, and 25% of the accrued hours greater than 1,600.
- A non-bargaining employee hired after June 30, 2014 with a minimum of one year of service will receive 100% of the sick pay benefits accrual for up to 800 hours.

Upon death of an employee, the estate will receive a lump sum payment for all sick pay benefits accrued.

Vacation and sick pay benefits are accrued when incurred in the government-wide financial statements. A liability for these amounts is reported in governmental funds only if the liability is due and payable, for example, as a result of employee resignations, terminations, and retirements. The liability for compensated absences is funded from currently budgeted payroll accounts from the general fund.

Lease Liabilities

The Health District is a lessee for noncancellable leases for office, clinical, and warehouse space. The Health District recognizes a lease liability and an intangible right-to-use lease asset (lease asset) in the government-wide financial statements. The Health District recognizes lease liabilities with an initial, individual value of $5,000 or more.

At the commencement of a lease, the Health District initially measures the lease liability at the present value of payments expected to be made during the lease term. Subsequently, the lease liability is reduced by the principal portion of lease payments made.

The lease asset is initially measured as the initial amount of the lease liability, adjusted for lease payments made at or before the lease commencement date, plus certain initial direct costs. Subsequently, the lease asset is amortized on a straight-line basis over its useful life or term of lease, whichever is shorter.

Key estimates and judgments related to leases include how the Health District determines (1) the discount rate it uses to discount the expected lease payments to present value, (2) lease term, and (3) lease payments.

- The Health District uses the interest rate charged by the lessor as the discount rate. When the interest rate charged by the lessor is not provided, the Health District generally uses its estimated incremental borrowing rate as the discount rate for leases.
- The lease term includes the noncancellable period of the lease. Lease payments included in the measurement of the lease liability are composed of fixed payments and purchase option price that the Health District is reasonably certain to exercise.

The Health District monitors changes in circumstances that would require a remeasurement of its lease and will remeasure the lease asset and liability if certain changes occur that are expected to significantly affect the amount of the lease liability.

Lease assets are reported with other capital assets and lease liabilities are reported with long-term liabilities on the statement of net position.

Postemployment Benefits Other Than Pensions (OPEB)

The Health District recognizes OPEB amounts for all benefits provided through the plans which include the total OPEB liability, deferred outflows of resources, deferred inflows of resources, and OPEB expense.

The Health District uses the same basis used by Public Employees' Benefits Plan (PEBP) and Retiree Health Program Plan (RHPP) for reporting the total OPEB liability, OPEB-related deferred outflows and inflows of resources, and OPEB expense. For this purpose, benefit payments are recognized by the Health District when due and payable in accordance with the benefit terms.

Multiple-Employer Cost-Sharing Defined Benefit Pension Plan

The Health District uses the same basis used in the Public Employees' Retirement System of Nevada's (PERS) ACFR for reporting its proportionate share of the PERS collective net pension liability, deferred outflows and inflows of resources related to pensions, and pension expense, including information regarding PERS fiduciary net position and related additions to/deductions from. Benefit payments (including refunds of employee contributions) are recognized by PERS when due and payable in accordance with the benefit terms. PERS investments are reported at fair value.

Deferred Inflows and Outflows of Resources

Deferred outflows of resources represent a consumption of net assets that applies to a future period(s) and so will not be recognized as an outflow of resources (expense/expenditure) until then. Deferred outflows for the changes in assumptions and differences between expected and actual experience and actual pension contributions and the Health District's proportionate share of pension contributions are deferred and amortized over the average expected remaining service life of all employees that are provided with pension benefits. Deferred outflows for pension contributions made by the Health District subsequent to the pension plan's actuarial measurement date are deferred for one year. Deferred outflows for the difference between actual and expected experience and changes in assumptions in the net pension liability and total OPEB liability are deferred and amortized over the average expected remaining service life of all employees that are provided with health benefits. Deferred outflows for OPEB contributions made by the Health District subsequent to the OPEB plan's actuarial measurement date are deferred for one year.

Deferred inflows of resources represent an acquisition of net assets that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. The government-wide statement of net position also reports: 1) the net difference between projected and actual earnings on pension plan investments are deferred and amortized over five years, and 2) difference between actual and expected experience and changes in assumptions to the total OPEB liability which are deferred and amortized over the average expected remaining service life of all employees that are provided with health benefits.

Fund Balance and Net Position Classifications

In the government-wide statements, equity is classified as net position and displayed in three components:

Net Investment in Capital Assets. This is the component of net position that represents capital assets net of accumulated depreciation and amortization and reduced by outstanding balances of long-term debt (lease liabilities and subscription liabilities) that are attributable to the acquisition, construction, or improvement of those assets.

Restricted. This component of net position reports the constraints placed on the use of assets by either external parties and/or enabling legislation.

Unrestricted. All other net position that does not meet the definition of net investment in capital assets and restricted net position.

In the fund financial statements, proprietary fund equity is classified the same as in the government-wide statements. Governmental fund balances are classified as follows:

Nonspendable. Includes amounts that cannot be spent because they are either (a) not in spendable form or (b) legally or contractually required to be maintained intact. This classification includes inventories and prepaid items.

Restricted. Similar to restricted net position discussed above, includes constraints placed on the use of resources that are either externally imposed by grantors, contributors, or other governments or are imposed by law (through constitutional provisions or enabling legislation).

Committed. Includes amounts that can only be used for a specific purpose due to a formal resolution approved by the Board of Health, which is the Health District's highest level of decision-making authority. Those constraints remain binding unless removed or changed in the same manner employed to previously commit those resources.

Assigned. Includes amounts that are constrained by the Health District's intent to be used for specific purposes but do not meet the criteria to be classified as restricted or committed. The Board of Health has set forth by resolution authority to assign fund balance amounts to the District Health Officer. Constraints imposed on the use of assigned amounts can be removed without formal resolution by the Board of Health.

Unassigned. This is the residual classification of fund balance in the general fund, which has not been reported in any other classification. The general fund is the only fund that can report a positive unassigned fund balance. Other governmental funds might report a negative unassigned fund balance as a result of overspending an amount which has been restricted, committed, or assigned for specific purposes.

The Health District considers restricted amounts to have been spent when expenditures are incurred for purposes for which both restricted and unrestricted fund balance is available. Committed amounts are considered to have been spent when expenditures are incurred for purposes for which amounts in any of the unrestricted fund balance classifications could be used.

It is the Health District's policy to expend restricted resources first and use unrestricted resources when the restricted resources have been depleted. It is also the Health District's policy to maintain a minimum unassigned fund balance in the general fund of 16.6% of general fund expenditures (the general fund reserve).

The general fund reserve will be maintained to provide the Health District with sufficient working capital and a comfortable margin of safety to support one-time costs in the event of either a natural disaster or any other unforeseen emergency (as declared by the Board of Health), unforeseen declines in revenue, and/or large, unexpected expenditures/expenses. These circumstances are not expected to occur routinely, and the general fund reserve is not to be used to support recurring operating expenditures/expenses.

Use of Estimates

The preparation of these financial statements includes estimates and assumptions made by management that affect the reported amounts. Actual results could differ from those estimates.

Accounting Pronouncements Adopted in Fiscal Year 2025

The Health District adopted GASB Statement No. 101, *Compensated Absences*, for the year ended June 30, 2025. The new accounting guidance updates the recognition and measurement guidance for compensated absences under a unified model. Specifically, the new standard clarifies that a liability should be recorded for compensated absences that are more likely than not to be paid or otherwise settled. Additionally, it amends certain existing disclosure requirements. The adoption of GASB 101 had no impact on the Health District's beginning of year net position.

The Health District adopted GASB Statement No. 102, *Certain Risk Disclosures,* for the year ended June 30, 2025. The new accounting guidance requires governments to disclose information about certain concentrations or constraints that could affect services provided or the ability to meet obligations as they come due. The adoption of GASB 102 had no impact on the Health District's beginning of year net position.

Future Financial Reporting Requirements

GASB has issued the following potentially significant statements which the Health District has not yet adopted and which require adoption subsequent to June 30, 2025. The Health District will evaluate the potential impact on the Health District's net position.

Statement No.	Title	Adoption Required
103	*Financial Reporting Model Improvements*	June 30, 2026
104	*Disclosure of Certain Capital Assets*	June 30, 2026

Note 2. Stewardship and Accountability

Budgets and Budgetary Accounting

Nevada Revised Statutes (NRS) require that local governments legally adopt budgets for all funds except fiduciary funds. The annual budgets for all funds are adopted on a basis consistent with accounting principles generally accepted in the United States. Budget augmentations made during the year ended June 30, 2025 were as prescribed by law.

The budget approval process is summarized as follows:

At the March Board of Health meeting, management of the Health District submits a final budget for the fiscal year commencing the following July. The operating budget includes proposed expenditures/expenses and the means of financing them.

Upon approval by the Board of Health, the final budget is submitted to Clark County where it is included in Clark County's public hearing held in May.

The Health District's budget is then filed with the State of Nevada, Department of Taxation by Clark County.

NRS allows appropriations to be transferred within or among any functions or programs within a fund without an increase in total appropriations. If it becomes necessary during the course of the year to change any of the departmental budgets, transfers are initiated by department heads and approved by the appropriate administrator. Transfers within program or function classifications can be made with appropriate administrator approval. The Board of Health is advised of transfers between funds, and function classifications and the transfers are recorded in the official Board of Health minutes.

At June 30, 2025, indirect cost amounts between the clinical and nursing services, environmental health, and community health programs and the administration program in the general fund have been eliminated in accordance with accounting principles generally accepted in the United States.

Encumbrance accounting, under which purchase orders, contracts, and other commitments for the expenditure of resources are recorded to reserve that portion of the applicable appropriation, is utilized in the governmental funds.

Per NRS 354.626, actual expenditures may not exceed budgetary appropriations of the public health function of the general fund, or total appropriations of the internal service fund, special revenue fund or the individual capital projects funds. The sum of operating and nonoperating expenses in the internal service fund may not exceed total appropriations.

Note 3. Cash and Cash Equivalents

Deposits

The Health District's deposit policies are governed by the NRS. Deposits are carried at cost, which approximates market value. and are maintained with insured banks in Nevada. At June 30, 2025, the carrying amount of the Health District's deposits was $0 as all amounts were swept into the Clark County Investment Pool at the end of the day.

Clark County Investment Pool

The Health District participates in Clark County's investment pool. At June 30, 2025, all rated investments in the Clark County investment pool were in compliance with the rating criteria listed below. Pooled funds are invested according to the NRS which are limited to the following (the Health District has no investment policy that would further limit Clark County's investment choices):

- Obligations of the U.S. Treasury and U.S. agencies in which the maturity dates do not extend more than 10 years from the date of purchase.
- Negotiable and non-negotiable certificates of deposit issued by commercial banks or insured savings and loan associations, except certificates that are not within limits of insurance provided by the Federal Deposit Insurance Corporation (FDIC), unless those certificates are collateralized as is required for uninsured deposits, not to exceed 5-year maturity from date of purchase with rating service of "A-1" by Standard & Poor's, "P-1" by Moody's, or "F-1" by Fitch equivalent or better. If negotiable certificate of deposit is issued for longer than one year, issuing entity shall have a long-term rating of "A" category or equivalent or better.
- Negotiable notes or short-term negotiable bonds issued by other local governments of the State of Nevada.
- Notes, bonds, and other unconditional obligations issued by corporations organized and operating in the United States. The obligations must be purchased from a registered broker/dealer. At the time of purchase, the obligations must have a remaining term to maturity of no more than five years, be rated by a nationally recognized rating service as "A" or its equivalent or better, and cannot exceed 25% of the investment portfolio.
- Commercial paper issued by a corporation organized and operating in the United States or by a depository institution licensed by the United States or any state and operating in the United States, having a "P-1" rating or equivalent, not to exceed 270 days' maturity and 20% of the total investments.
- Obligations of state and local governments if the interest on the obligation is tax exempt and the obligation is rated "A" or equivalent or better.
- Forward delivery agreements executed with a bank or financial institution rated "A" or equivalent.
- Supranational obligations of the International Bank for Reconstruction and Development, the International Finance Corporation, or the Inter-American Development Bank that are rated "Aa" or equivalent or better, not to exceed five years maturity or 15% of the total investment.
- Bankers' acceptances eligible for rediscount with Federal Reserve Banks, not to exceed 180 days' maturity and does not exceed 20% of the portfolio.
- Collateralized mortgage obligations that are rated "AAA" or its equivalent not to exceed 20% of the portfolio.
- Repurchase agreements that are collateralized at 102% of the repurchase price and do not exceed 90 days' maturity. Securities used for collateral must meet the criteria listed above.
- Money market mutual funds which are rated "AAA" or its equivalent and invest only in securities issued by the federal government, U.S. agencies, or repurchase agreements fully collateralized by such securities not to exceed five years' maturity and does not exceed 20% of the portfolio.
- Asset-backed securities that are rated AAA or its equivalent, not to exceed 20% of the portfolio.
- Investment contracts for bond proceeds only, issuance for $10,000,000 or more, and collateralized at a market value of at least 102% by obligations of the U.S. Treasury or agencies of the federal government.
- The State of Nevada's Local Government Investment Pool.

Custodial credit risk is the risk that in the event a financial institution or counterparty fails, the Health District would not be able to recover the value of its deposits and investments. The Clark County Investment Policy states that securities purchased by Clark County shall be delivered against payment (delivery vs. payment) and held in a custodial safekeeping account with the trust department of a third-party bank insured by the FDIC and designated by the Clark County Treasurer for this purpose in accordance with NRS 355.172. A custody agreement between the bank and Clark County is required before execution of any transactions; Clark County's public deposits are in participating depositories of the Nevada Collateral Pool (Pool).

The Pool, which is administered by the State of Nevada, Office of the State Treasurer, is set up as a single financial institution collateral pool that requires each participating depository to collateralize with eligible collateral those ledger deposits not within the limits of insurance provided by an instrumentality of the United States through NRS 356.133 (*i.e.*, in excess of the FDIC levels). The collateral is pledged in the name of the Pool, and the market value of the collateral must be at least 102% of the uninsured ledger balances of the public money held by the depository in accordance with NRS 356.360.

Interest rate risk is defined as the risk that changes in interest rates will adversely affect the fair value of an investment. Through its investment policy, Clark County (as the external investment pool operator) manages interest rate risk by limiting the average weighted duration of the investment pool portfolio to less than 2.5 years. Duration is a measure of the present value of a fixed income's cash flows and is used to estimate the sensitivity of a security's price to interest rate changes.

Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. At June 30, 2025, all of the Health District's investments held by the Clark County Treasurer are invested in authorized investments in accordance with NRS 350.659, 355.165, 355.171, and 356.120. The limitations on amounts invested are covered on the aforementioned type of security.

As of June 30, 2025, the carrying amount and market value of the Health District's investments in the Clark County Investment Pool was $72,702,633.

Combined Cash and Cash Equivalents

The Health District's cash and cash equivalents were as follows at June 30, 2025:

Cash on hand	$ 6,866
Restricted cash	100,000
Clark County Investment Pool	72,702,633
Total cash and cash equivalents	$ 72,809,499

The Health District's cash and cash equivalents were presented in the District's financial statements as follows at June 30, 2025:

Governmental funds	$ 72,686,591
Proprietary fund	112,235
Custodial funds	10,673
Total cash and cash equivalents	$ 72,809,499

Note 4. Capital, Lease, and Subscription Assets

Changes in capital, lease, and subscription assets were as follows for the year ended June 30, 2025:

	Balance June 30, 2024	Additions	Retirements	Transfers	Balance June 30, 2025
Governmental Activities					
Capital assets not being depreciated/amortized					
Construction in progress	$ 2,781,056	$ 709,457	$ -	$ (428,919)	$ 3,061,594
Land	3,447,236	-	-	-	3,447,236
Total capital assets not being depreciated	6,228,292	709,457	-	(428,919)	6,508,830
Capital, leased, and subscription assets being depreciated/amortized					
Buildings	21,050,944	866,613	-	17,320	21,934,877
Improvements other than buildings	6,293,486	124,549	(29,577)	-	6,388,458
Furniture, fixtures, and equipment	18,437,555	1,259,714	(1,482,465)	411,599	18,626,403
Right-to-use leased building	8,710,946	282,787	(94,083)	-	8,899,650
Right-to-use leased equipment	715,346	139,282	-	-	854,628
Subscription IT asset	2,502,309	706,835	(207,582)	-	3,001,562
Vehicles	1,686,103	27,920	(299,843)	-	1,414,180
Totals capital, lease, and subscription assets being depreciated/amortized	59,396,689	3,407,700	(2,113,550)	428,919	61,119,758
Accumulated depreciation/amortization					
Buildings	(6,030,711)	(724,970)	-	-	(6,755,681)
Improvements other than buildings	(3,975,589)	(365,975)	29,577	-	(4,311,987)
Furniture, fixtures, and equipment	(13,094,838)	(1,527,915)	1,091,217	-	(13,531,536)
Right-to-use leased building	(1,650,121)	(929,602)	3,871	-	(2,575,852)
Right-to-use leased equipment	(477,368)	(193,853)	82,096	-	(589,125)
Subscription IT asset	(1,074,870)	(629,403)	207,582	-	(1,496,691)
Vehicles	(1,180,098)	(162,687)	301,824	-	(1,040,961)
Total accumulated depreciation/amortization	(27,483,595)	(4,534,405)	1,716,167	-	(30,301,833)
Total capital, leased, and subscription assets being depreciated/amortized, net	31,913,094	(1,126,705)	(397,383)	428,919	30,817,925
Total Governmental Activities	$ 38,141,386	$ (417,248)	$ (397,383)	$ -	$ 37,326,755

Depreciation and amortization expense was charged to the following functions and programs for the year ended June 30, 2025:

Governmental activities	
Clinical services	$ 111,425
Environmental health	73,606
Community health	997,520
Administration	3,351,854
Total depreciation and amortization expense – governmental activities	$ 4,534,405

Note 5. Interfund Balances and Transfers

Interfund balances are as follows at June 30, 2025:

Receivable Fund	Payable Fund	Amount
General Fund	Special Revenue Fund	$ 8,263,055
General Fund	Other governmental funds	475,567
Special Revenue Fund	General Fund	9,042,403
Special Revenue Fund	Other governmental funds	353,517
Insurance Reserve	Other governmental funds	1,078
		$ 18,135,620

These balances result from the time lag between the dates that: (1) interfund goods and services are provided or reimbursable expenditures occur, (2) transactions are recorded in the accounting system, and (3) payments between funds are made.

Interfund transfers consisted of the following for the year ended June 30, 2025:

Transfers Out of Fund	Transfers In to Fund	Amount
General Fund	Special Revenue Fund	$ 4,767,254
General Fund	Other governmental funds	2,000,000
		$ 6,767,254

Transfers were used to: (1) move revenues from the fund that statute or budget requires to collect them to the fund that statute or budget requires to expend them, and (2) use unrestricted revenues collected in the general fund to finance various programs accounted for in special revenue fund and finance the administrative cost allocation to special revenue fund, in accordance with budgetary authorization.

Note 6. Changes in Long-Term Liabilities

Long-term liabilities activity was as follows for the year ended June 30, 2025:

	Balance June 30, 2024	Increases	Decreases	Balance June 30, 2025	Due Within One Year
Governmental Activities					
Compensated absences	$ 11,391,566	$ 2,028,783	$ -	$ 13,420,349	$ 5,827,425
Lease liability	7,700,584	422,069	(920,709)	7,201,944	1,042,365
Subscription liability	301,664	576,230	(388,828)	489,066	251,416
Total Long-Term Liabilities	$ 19,393,814	$ 3,027,082	$ (1,309,537)	$ 21,111,359	$ 7,121,206

Changes in compensated absences balances are reflected net. Lease and subscription liabilities typically have been liquidated by the fund where employees earned and accrued the amounts.

Lessee Activities

The Health District has entered into multiple leases for office, clinical, warehouse space, and medical and office equipment. The Health District is required to make principal and interest payments on these spaces. These lease agreements have terms expiring through March 2037. The lease liability was valued using discount rates between 3.25% and 8.50%. This rate was determined using the U.S. Prime Rates applicable for each lease based on the lease period and date of initiation.

Remaining principal and interest payments on leases are as follows:

For the Year Ending June 30,	Principal	Interest
2026	$ 1,042,365	$ 288,326
2027	917,692	238,304
2028	740,741	193,597
2029	685,253	152,369
2030	444,667	125,741
2031–2035	2,360,158	391,682
2036–2037	1,011,068	33,255
	$ 7,201,944	$ 1,423,274

Subscription Liabilities

The Health District has various SBITAs, the terms of which expire in various years through 2028. The subscription liability was valued using discount rates between 3.25% and 8.50%. This rate was determined using the U.S. Prime Rates applicable for each subscription agreement based on the subscription period and date of initiation.

Remaining principal and interest payments on subscription liabilities are as follows:

For the Year Ending June 30,	Principal	Interest
2026	$ 251,416	$ 28,722
2027	217,748	11,582
2028	19,902	780
	$ 489,066	$ 41,084

Note 7. Risk Management

The Health District, like any governmental entity, is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; and natural disasters.

Effective July 1, 2024, the Health District is no longer with Nevada Public Agency Insurance Pool (POOL) & Public Agency Compensation Trust (PACT) and obtained coverage via the commercial insurance private market.

The Health District obtained private insurance coverage via an insurance broker and maintains multiple policies. The types of coverage, carriers, corresponding deductibles, and aggregates are as follows:

Coverage Type	Carrier	Deductible	Aggregate
Cyber	Corvus	$ 25,000	$ 2 million
EPLI	Markel	$ 50,000	$ 1 million
General liability	Vantage	$ 25,000	$ 3 million
Professional liability	Vantage	$ 25,000	$ 3 million
Auto	Chubb	$ 3,000	$ 1 million
Commercial property	Chubb	$ 25,000	$ 73,477,044: equivalent to total property values
Workers Compensation	RAS	$ –	None
FQHC	HRSA	$ –	None

The Health District pays premiums based on payroll costs to Risk Administrative Services, Inc. (RAS) for its workers compensation insurance coverage.

The Health District's Community Health Center is Federal Torts Claims Act (FTCA) "deemed" as a federal contractor wherein the federal government represents us in medical malpractice cases. The Health District also carries supplemental medical professional liability coverage, covering the Public Health and Preventive Care (P&PC) division and any malpractice matters not covered by Health Resources and Services Administration. There were no claims for medical malpractice in the past three fiscal years.

Litigation

Various legal claims have arisen against the Health District during the normal course of operations. According to the Health District's legal counsel, there were no outstanding matters at this time with a material impact and, therefore, no provision for loss has been made in the financial statements in connection therewith.

The Health District does not accrue for estimated future legal and defense costs, if any, to be incurred in connection with outstanding or threatened litigation and other disputed matters but rather records such as period costs when the services are rendered.

Note 8. Contingencies

Government Grants

Support funded by grants is recognized as the Health District meets the conditions prescribed by the grant agreement, performs the contracted services, or incurs outlays eligible for reimbursement under the grant agreements. Grant activities and outlays are subject to audit and acceptance by the granting agency and, as a result of such audit, adjustments could be required.

Note 9. Multiple-Employer Cost-Sharing Defined Benefit Pension Plan

The Health District's employees are covered by the Public Employees' Retirement System of Nevada, which was established by the Nevada Legislature in 1947, effective July 1, 1948, and is governed by the Public Employees Retirement Board (PERS Board) whose seven members are appointed by the governor. The Health District does not exercise any control over PERS.

PERS is a cost-sharing, multiple-employer, defined benefit public employees' retirement system which includes both regular and police/fire members. PERS is administered to provide a reasonable base income to qualified employees who have been employed by a public employer and whose earnings capacities have been removed or substantially impaired by age or disability.

Benefits, as required by NRS, are determined by the number of years of accredited service at time of retirement and the member's highest average compensation in any 36 consecutive months with special provisions for members entering the system on or after January 1, 2010 and July 1, 2015. Benefit payments to which participants or their beneficiaries may be entitled under the plan include pension benefits, disability benefits, and survivor benefits.

Monthly benefit allowances for members are computed as 2.5% of average compensation for each accredited year of service prior to July 1, 2001. For service earned on or after July 1, 2001, this multiplier is 2.67% of average compensation. For members entering PERS on or after January 1, 2010, there is a 2.5% service time factor and for regular members entering PERS on or after July 1, 2015, there is a 2.25% factor. PERS offers several alternatives to the unmodified service retirement allowance which, in general, allow the retired employee to accept a reduced service retirement allowance payable monthly during their lifetime and various optional monthly payments to a named beneficiary after their death.

Post-retirement increases are provided by authority of NRS 286.571 - .579, which for members entering the system before January 1, 2010, is equal to the lesser of:

1. 2% per year following the third anniversary of the commencement of benefits, 3% per year following the sixth anniversary, 3.5% per year following the ninth anniversary, 4% per year following the twelfth anniversary, and 5% per year following the fourteenth anniversary, or

2. The average percentage increase in the Consumer Price Index (or other PERS Board-approved index) for the three preceding years.

In any event, a member's benefit must be increased by the percentages in paragraph 1, above, if the benefit of a member has not been increased at a rate greater than or equal to the average of the Consumer Price Index (All Items) (or other PERS Board-approved index) for the period between retirement and the date of increase.

For members entering PERS with an effective date of membership on or after January 1, 2010 and before July 1, 2015, the post-retirement increases are the same as above, except that the increases do not exceed 4% per year.

For members entering PERS after July 1, 2015, the post-retirement increases are 2% per year following the third anniversary of the commencement of benefits, 2.5% per year following the sixth anniversary, the lesser of 3% or the CPI for the preceding calendar year following the ninth anniversary.

Regular members entering PERS prior to January 1, 2010 are eligible for retirement at age 65 with five years of service, age 60 with 10 years of service, or any age with 30 years of service. Regular members entering PERS on or after January 1, 2010 are eligible for retirement at age 65 with five years of service, age 62 with 10 years of service, or any age with 30 years of service. Regular members entering PERS on or after July 1, 2015 are eligible for retirement at age 65 with five years of service, age 62 with 10 years of service, age 55 with 30 years of service, or any age with 33 1/3 years of service.

The normal ceiling limitation on the monthly benefit allowances is 75% of average compensation. However, a member who has an effective date of membership before July 1, 1985 is entitled to a benefit of up to 90% of average compensation. Both regular and police/fire members become fully vested as to benefits upon completion of five years of service.

The authority for establishing and amending the obligation to make contributions and member contribution rates rests with NRS. New hires in agencies which did not elect the employer-pay contribution (EPC) plan prior to July 1, 1983 have the option of selecting one of two alternative contribution plans. Contributions are shared equally by employer and employee in which employees can take a reduced salary and have contributions made by the employer or can make contributions by a payroll deduction matched by the employer.

The PERS basic funding policy provides for periodic contributions at a level pattern of cost as a percentage of salary throughout an employee's working lifetime in order to accumulate sufficient assets to pay benefits when due.

PERS receives an actuarial valuation on an annual basis for determining the prospective funding contribution rates required to fund the system on an actuarial reserve basis. Contributions actually made are in accordance with the required rates established by NRS. These statutory rates are periodically updated pursuant to NRS 286.421 and 286.450. The actuarial funding method used is the entry age normal cost method. It is intended to meet the funding objective and result in a relatively level long-term contributions requirement as a percentage of salary.

For the measurement year ended June 30, 2024, the Health District's required contribution rates for regular members was 33.50% EPC. The Health District's portion of contributions was $11,221,725 for the fiscal year ended June 30, 2025.

PERS collective net pension liability was measured as of June 30, 2024, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. For this purpose, certain actuarial valuation assumptions are stipulated by the GASB and may vary from those used to determine the prospective funding contribution rates.

The total PERS pension liability was determined using the following economic actuarial assumptions (based on the results of an Experience Study dated September 10, 2021, applied to all periods included in the measurement).

Inflation	2.50%
Productivity pay increase	0.50%
Investment rate of return	7.25%, net of pension plan investment expense, including inflation
Actuarial cost method	Entry age normal and level percentage of payroll
Projected salary increases	Regular: 4.20% to 9.10%, depending on service Police/Fire: 4.60% to 14.50%, depending on service Rates include inflation and productivity increases
Other assumptions	Same as those used in the June 30, 2024 funding actuarial valuation
Rationale for assumptions	The information and analysis used in selecting each assumption that has a significant effect on this actuarial valuation is shown in the Actuarial Experience Study dated September 10, 2021.

PERS' policies which determine the investment portfolio target asset allocation are established by the PERS Board. The asset allocation is reviewed annually and is designed to meet the future risk and return needs of PERS. The following was the PERS Board-adopted policy target asset allocation as of June 30, 2024:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return (Arithmetic)
Large cap U.S. equity	42%	6.65%
Developed international equity	18%	7.18%
U.S. fixed income	28%	0.91%
Real estate	6%	5.25%
Private equity	6%	12.40%
Total	100%	

The discount rate used to measure the total pension liability was 7.25% as of June 30, 2024. The projection of cash flows used to determine the discount rate assumed that employee and employer contributions will be made at the rate specified by NRS. Based on that assumption, PERS' fiduciary net position at June 30, 2024 was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments (7.25%) was applied to all periods of projected benefit payments to determine the total pension liability as of June 30, 2024.

The Health District's proportionate share of the net pension liability is calculated using a discount rate of 7.25%. The following shows the sensitivity of the valuation of the Health District's proportionate share of the net pension liability assuming the discount rate was either 1% lower or 1% higher at June 30, 2025:

	1% Decrease (6.25%)	Current Discount Rate (7.25%)	1% Increase (8.25%)
Net pension liability	$ 205,229,551	$ 127,620,524	$ 63,592,570

Detailed information about PERS' fiduciary net position is available in the PERS ACFR, which is available on the PERS website, www.nvpers.org under publications.

The Health District's proportionate share of the collective net pension liability was $127,620,524, which represents 0.70634% of the collective net pension liability, which is a decrease from the previous year's proportionate share of 0.75931%. Contributions for employer pay dates within the fiscal year ending June 30, 2024 were used as the basis for determining each employer's proportionate share.

For the period ended June 30, 2025, the Health District's pension expense was $18,057,232 and its reported deferred outflows and inflows of resources related to pensions were as follows as of June 30, 2025:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 27,074,239	$ -
Net difference between projected and actual earnings on investments	-	12,572,266
Changes in proportion and differences between actual contributions and proportionate share of contributions	13,018,596	6,246,406
Change in assumptions	8,234,877	-
Contributions subsequent to the measurement date	11,221,725	-
Total	$ 59,549,437	$ 18,818,672

Deferred outflows of resources related to pensions resulting from contributions subsequent to the measurement date totaling $11,221,725 will be recognized as a reduction of the net pension liability for the year ending June 30, 2026. Other amounts reported as deferred outflows and inflows of resources related to pensions will be recognized in pension expense as follows:

For the Year Ending June 30,	
2026	$ 3,333,455
2027	16,148,088
2028	1,206,949
2029	(17,883)
2030	2,066,274
Thereafter	6,772,157
Total	$ 29,509,040

Note 10. Postemployment Benefits Other Than Pensions

General Information About the Other Postemployment Benefit Plans

Plan Description: The Health District subsidizes eligible retirees' contributions to the Public Employees' Benefits Plan (PEBP), a non-trust, agent multiple-employer defined benefit postemployment healthcare plan administered by the State of Nevada. NRS 287.041 assigns the authority to establish and amend benefit provisions to the PEBP nine-member board of trustees. The plan is now closed to future retirees; however, district employees who previously met the eligibility requirement for retirement within the Nevada Public Employee Retirement System had the option upon retirement to enroll in coverage under the PEBP with a subsidy provided by the Health District as determined by their number of years of service. The PEBP issues a publicly available financial report that includes financial statements and required supplementary information.

That report may be obtained by writing to Public Employee's Benefits Program, 901 S. Stewart Street, Suite 1001, Carson City, NV, 89701, by calling (775) 684-7000, or by accessing the website at www.pebp.state.nv.us/informed/financial.htm.

Plan Description: The Retiree Health Program Plan (RHPP) is a non-trust, single-employer defined benefit postemployment healthcare plan administered by Clark County, Nevada. Retirees may choose between Clark County Self-Funded Group Medical and Dental Benefits Plan (Self-Funded Plan) and an Exclusive Provider Organization (EPO) plan.

Benefits Provided

PEBP provides medical, dental, prescription drug, Medicare Part B, and life insurance coverage to eligible retirees and their spouses. Benefits are provided through a third-party insurer.

As of November 1, 2008, PEBP was closed to any new participants.

RHPP provides medical, dental, prescription drug, and life insurance coverage to eligible active and retired employees and beneficiaries. Benefit provisions are established and amended through negotiations between the respective unions and the Health District.

Employees Covered by Benefit Terms

The following employees were covered by the benefit terms at June 30, 2024:

	PEBP	RHPP	Total All Plans
Inactive employees or beneficiaries currently receiving benefits	63	69	132
Active members	-	789	789
Total	63	858	921

Total OPEB Liability

The Health District's total OPEB liability of $35,247,231 was measured as of June 30, 2024 and was determined by an actuarial valuation as of that date.

Actuarial assumptions and other inputs: The total OPEB liability for all plans as of June 30, 2025 was determined using the following actuarial assumptions and other inputs, applied to all periods included in the measurement, unless otherwise specified:

Discount Rate	3.93%
Pre-Medicare Trend Rate	Select: 7.75%, Ultimate 4.0%
Post-Medicare Trend Rate	Select: 6.75%, Ultimate 4.0%
Mortality	Pub-2010 headcount weighted mortality table, projected generationally using scale MP-2021, applied on a gender-specific and job class basis (teacher, safety, or general, as applicable)
Termination Tables	2023 NPERS Actuarial Valuation
Healthcare cost trend rates	The healthcare cost trend assumptions are used to project the cost of healthcare in future years. The following annual trends are applied on a select and ultimate basis. Select trends are reduced 0.30% each year for nine years, and 0.10% thereafter until reaching the ultimate trend rate.

Expense Type	Select	Ultimate
Pre-Medicare Medical and Rx Benefits	7.75%	4.00%
Medical Benefits	6.75%	4.00%
Dental	4.00%	4.00%
Stop Loss Fees	7.75%	4.00%
Administrative Fees	4.00%	4.00%

Changes in the Total OPEB Liability

	PEBP	RHPP	Total OPEB Liability
Balance at June 30, 2024	$ 3,278,995	$ 25,475,735	$ 28,754,730
Changes for the year			
Service cost	-	1,683,367	1,683,367
Interest	116,670	987,832	1,104,502
Differences between expected and actual experience	(1,118,180)	11,183,547	10,065,367
Changes of assumptions	114,060	(6,119,288)	(6,005,228)
Benefit payments	(165,108)	(190,399)	(355,507)
Net changes	(1,052,558)	7,545,059	6,492,501
Balance at June 30, 2025	$ 2,226,437	$ 33,020,794	$ 35,247,231

Changes in Assumptions and Experience

Certain key assumptions were changed as part of the actuary's updated study. Those changes are summarized below:

- The discount rate was updated from 3.65% as of June 30, 2023 to 3.93% as of June 30, 2024 (the actuarial measurement date).
- The trend rates were updated to an initial rate of 7.75% (6.75% for Post-65) grading down to an ultimate rate of 4.00%. The Select trend rates are updated to reflect the higher than anticipated rising healthcare costs environment.
- The termination and retirement rates were updated to the rates from the Nevada PERS Actuarial Valuation report as of June 30, 2023.
- The salary scale was updated from 3.0% to 3.5% based on the wage growth assumption from the 2023 NVPERS.

Sensitivity of the total OPEB liability to changes in the discount rate. The following presents the total OPEB liability of the Health District, as well as what the Health District's total OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.93%) or 1-percentage point higher (4.93%) than the current discount rate:

	1% Decrease Rate (2.93%)	Discount Rate (3.93%)	1% Increase Rate (4.93%)
PEBP	$ 2,471,000	$ 2,226,437	$ 2,019,000
RHPP	39,770,000	33,020,794	27,737,000
Total OPEB liability	$ 42,241,000	$ 35,247,231	$ 29,756,000

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rates. The following presents the total OPEB liability of the Health District, as well as what the Health District's total OPEB liability would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower (or 1-percentage-point higher the current healthcare cost trend rates:

	1% Decrease	Trend Rates	1% Increase
PEBP	$ 2,029,000	$ 2,226,437	$ 2,454,000
RHPP	27,274,000	33,020,794	40,561,000
Total OPEB liability	$ 29,303,000	$ 35,247,231	$ 43,015,000

OPEB Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

For the year ended June 30, 2025, the Health District recognized OPEB expense of $992,926. The breakdown by plan is as follows:

	PEBP	RHPP	Total All Plans
OPEB Expense (Income)	$ (887,450)	$ 1,880,376	$ 992,926

The Health District reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources at June 30, 2025:

	Deferred Outflows of Resources	Deferred Inflows of Resources
PEBP		
Contributions made in fiscal year ending 2025 after July 1, 2024, measurement date	$ 160,000	$ -
Total PEBP	160,000	-
RHPP		
Differences between expected and actual experience	20,769,733	4,010,196
Changes of assumptions or other inputs	1,208,683	19,268,676
Contributions made in fiscal year ending 2025 after July 1, 2024, measurement date	492,000	-
Total RHPP	22,470,416	23,278,872
All plans		
Differences between expected and actual economic experience	20,769,733	4,010,196
Changes in actuarial assumptions	1,208,683	19,268,676
Contributions made in fiscal year ending 2025 after July 1, 2024, measurement date	652,000	-
Total all plans	$ 22,630,416	$ 23,278,872

The amount of $652,000 reported as deferred outflows of resources related to OPEB from Health District contributions subsequent to the measurement date will be recognized as a reduction of the OPEB liability in the year ended June 30, 2026. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

For the Year Ending June 30,	RHPP
2026	$ (515,786)
2027	(433,124)
2028	(418,181)
2029	(418,181)
2030	(418,181)
Thereafter	902,997
Total	$ (1,300,456)

Note 11. 457(b) and 401(a) Retirement Plans

The Health District offers all employees an opportunity to participate in two deferred compensation plans that have been established in accordance with Internal Revenue Code Section 457 and 401. These plans are 457(b) or 401(a) plans, and both are administered by Empower Retirement, LLC. The plans' provisions and contribution requirements are established and may be amended by the plan administrator. Empower Trust Company, LLC is the trustee of the Empower Retirement, LLC plans. Employees may enroll in the 457(b) plan and/or change their contribution amounts at any time. The 401(a) plan enrollment is limited to Executives that have elected to participate in the 401(a) plan. The Health District does not contribute to the 457(b) plan and provides discretionary contributions to the 401(a) plan.

Note 12. Encumbrances

The Health District utilizes encumbrance accounting in its governmental funds. Encumbrances are recognized as a valid and proper charge against a budget appropriation in the year in which a purchase order, contract, or other commitment is issued. In general, unencumbered appropriations lapse at year-end. Open encumbrances at fiscal year-end are included in restricted, committed, or assigned fund balance, as appropriate. Significant encumbrances included in governmental fund balances are as follows:

	Assigned Fund Balance
General Fund	$ 2,484,012

General Fund

$1,565,757 of the total encumbrance balance was assigned to purchase clinical health services. $206,239 of the total encumbrance balance was assigned to purchase community health services. $4,625 of the total encumbrance balance was assigned to purchase environmental health services. $603,061 of the total encumbrance balance was assigned to purchase administrative services. $104,330 of the total encumbrance balance was assigned to purchase pharmacy services.

Required Supplementary Information

Southern Nevada Health District
Statement of Revenues, Expenditures, and Changes in Fund Balance
Budget to Actual – General Fund
For the Fiscal Year Ended June 30, 2025

	Budgeted Amounts			Variance With Final Budget – Increase (Decrease)
	Original	Final	Actual	
Revenues				
Fees for service	$ 36,215,729	$ 42,365,912	$ 46,360,664	$ 3,994,752
Other	1,899,388	2,782,373	3,592,774	810,401
Property tax	37,651,176	37,651,176	37,651,176	-
Regulatory revenue	27,881,249	29,623,788	28,482,125	(1,141,663)
Title XIX and other	3,638,963	3,560,001	3,595,324	35,323
Investment earnings	669,772	1,972,900	3,155,818	1,182,918
Total Revenues	107,956,277	117,956,150	122,837,881	4,881,731
Expenditures				
Public health				
Clinical and nursing services				
Salaries and wages	11,052,142	11,459,832	11,462,609	(2,777)
Employee benefits	5,056,511	5,119,842	5,035,366	84,476
Services and supplies	37,568,826	43,912,423	39,965,633	3,946,790
Capital outlay	63,000	16,000	16,000	-
Total clinical and nursing services	53,740,479	60,508,097	56,479,608	4,028,489
Environmental health				
Salaries and wages	14,995,597	16,695,381	16,329,690	365,691
Employee benefits	6,801,895	7,379,622	7,246,047	133,575
Services and supplies	6,282,928	6,511,191	5,800,623	710,568
Capital outlay	2,000	2,000	-	2,000
Total environmental health	28,082,420	30,588,194	29,376,360	1,211,834
Community health				
Salaries and wages	8,855,927	7,934,884	7,861,936	72,948
Employee benefits	4,059,651	3,607,017	3,519,733	87,284
Services and supplies	7,597,417	6,789,347	5,704,429	1,084,918
Capital outlay	410,800	435,000	362,176	72,824
Total community health	20,923,795	18,766,248	17,448,274	1,317,974
Administration				
Salaries and wages	12,275,808	13,855,522	13,926,820	(71,298)
Employee benefits	5,827,830	6,561,853	6,896,250	(334,397)
Services and supplies	(19,277,382)	(18,702,989)	(18,479,870)	(223,119)
Capital outlay	213,000	295,745	1,165,747	(870,002)
Total administration	(960,744)	2,010,131	3,508,947	(1,498,816)
Total Expenditures	101,785,950	111,872,670	106,813,189	5,059,481
Excess of Revenues Over Expenditures	6,170,327	6,083,480	16,024,692	9,941,212
Other Financing Sources (Uses)				
Transfers out	(10,530,735)	(9,125,913)	(6,767,254)	2,358,659
Leases issued	-	-	422,069	422,069
Subscriptions	-	-	576,230	576,230
Total Other Financing Sources (Uses)	(10,530,735)	(9,125,913)	(5,768,955)	3,356,958
Net Change in Fund Balance	(4,360,408)	(3,042,433)	10,255,737	13,298,170
Fund Balance, Beginning of Year	54,872,828	54,872,828	54,872,828	-
Fund Balance, End of Year	$ 50,512,420	$ 51,830,395	$ 65,128,565	$ 13,298,170

Southern Nevada Health District
Statement of Revenues, Expenditures, and Changes in Fund Balance
Budget to Actual – Special Revenue Fund
For the Fiscal Year Ended June 30, 2025

	Budgeted Amounts			Variance With Final Budget – Increase (Decrease)
	Original	Final	Actual	
Revenues				
Direct federal grants	$ 14,359,394	$ 20,303,558	$ 18,175,097	$ (2,128,461)
Indirect federal grants	31,949,804	29,604,235	27,305,731	(2,298,504)
State grant funds	6,954,077	4,051,551	3,533,607	(517,944)
Other	10,887,091	1,415,546	1,343,609	(71,937)
Total Revenues	64,150,366	55,374,890	50,358,044	(5,016,846)
Expenditures				
Public health				
Clinical and nursing services				
Salaries and wages	7,106,200	6,776,094	6,516,398	259,696
Employee benefits	3,273,981	3,069,422	2,961,580	107,842
Services and supplies	5,188,099	5,680,923	4,416,019	1,264,904
Capital outlay	935,607	967,989	599,833	368,156
Total clinical and nursing services	16,503,887	16,494,428	14,493,830	2,000,598
Environmental health				
Salaries and wages	1,169,929	897,768	871,782	25,986
Employee benefits	540,509	409,733	398,354	11,379
Services and supplies	495,826	521,160	432,908	88,252
Capital outlay	-	-	-	-
Total environmental health	2,206,264	1,828,661	1,703,044	125,617
Community health				
Salaries and wages	10,909,617	11,006,467	10,923,453	83,014
Employee benefits	5,018,113	4,972,112	4,928,872	43,240
Services and supplies	19,875,922	23,120,841	19,046,523	4,074,318
Capital outlay	1,191,996	454,748	434,421	20,327
Total community health	36,995,648	39,554,168	35,333,269	4,220,899
Administration				
Salaries and wages	1,364,500	1,283,224	1,316,230	(33,006)
Employee benefits	629,808	557,460	553,359	4,101
Services and supplies	3,229,189	1,447,861	1,162,286	285,575
Capital outlay	8,751,805	1,335,000	523,908	811,092
Total administration	13,975,302	4,623,545	3,555,783	1,067,762
Total Expenditures	69,681,101	62,500,802	55,085,926	7,414,876
Deficiency of Revenues Over Expenditures	(5,530,735)	(7,125,912)	(4,727,882)	2,398,030
Other Financing Sources				
Transfers in	5,530,735	7,125,913	4,767,254	(2,358,659)
Total Other Financing Sources	5,530,735	7,125,913	4,767,254	(2,358,659)
Net Change in Fund Balance	-	1	39,372	39,371
Fund Balance, Beginning of Year	82,081	82,081	82,081	-
Fund Balance, End of Year	$ 82,081	$ 82,082	$ 121,453	$ 39,371

Southern Nevada Health District
Schedules of Changes in the Total OPEB Liability and Related Ratios[1]
For the Fiscal Year Ended June 30, 2025

PEBP	2018	2019	2020	2021	2022	2023	2024	2025
A. Total OPEB Liability								
Interest (on the total OPEB liability)	$ 136,641	$ 158,929	$ 142,210	$ 132,809	$ 104,479	$ 101,093	$ 115,735	$ 116,670
Difference between expected and actual experience	(2,407)	(935)	-	240,495	-	(719,219)	-	(1,118,180)
Changes of assumptions	(408,034)	(582,796)	196,172	770,760	51,775	(575,624)	6,884	114,060
Benefit payments	(201,454)	(210,183)	(213,733)	(223,274)	(198,836)	(208,349)	(225,925)	(165,108)
Net Change in Total OPEB Liability	(475,254)	(634,985)	124,649	920,790	(42,582)	(1,402,099)	(103,306)	(1,052,558)
Total OPEB Liability – Beginning	4,891,782	4,416,528	3,781,543	3,906,192	4,826,982	4,784,400	3,382,301	3,278,995
Total OPEB Liability – Ending	$ 4,416,528	$ 3,781,543	$ 3,906,192	$ 4,826,982	$ 4,784,400	$ 3,382,301	$ 3,278,995	$ 2,226,437
Covered Payroll	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total OPEB Liability as a Percentage of Covered Payroll	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1] Fiscal year 2018 is the first year of implementation; therefore, only eight years are shown. As it becomes available this schedule will ultimately present information for the 10 most recent fiscal years.

Southern Nevada Health District
Schedules of Changes in the Total OPEB Liability and Related Ratios[2]
For the Fiscal Year Ended June 30, 2025

RHPP	2018	2019	2020	2021	2022	2023	2024	2025
A. Total OPEB liability								
Service cost	$ 2,037,506	$ 1,984,184	$ 865,693	$ 1,035,479	$ 1,570,297	$ 2,053,521	$ 1,772,849	$ 1,683,367
Interest (on the total OPEB liability)	753,304	922,521	675,421	696,006	546,330	590,543	894,861	987,832
Difference between expected and actual experience	26,065	(8,138,337)	-	2,485,316	-	11,098,817	-	11,183,547
Changes of assumptions	(3,119,749)	(1,686,349)	1,204,893	577,780	221,432	(15,399,138)	(602,456)	(6,119,288)
Benefit payments	(339,476)	(236,966)	(322,093)	(643,182)	(345,742)	(58,543)	(190,437)	(190,399)
Net Change in Total OPEB Liability	(642,350)	(7,154,947)	2,423,914	4,151,399	1,992,317	(1,714,800)	1,874,817	7,545,059
Total OPEB Liability – Beginning	24,545,385	23,903,035	16,748,088	19,172,002	23,323,401	25,315,718	23,600,918	25,475,735
Total OPEB Liability – Ending	$ 23,903,035	$ 16,748,088	$ 19,172,002	$ 23,323,401	$ 25,315,718	$ 23,600,918	$ 25,475,735	$ 33,020,794
Covered Payroll	$ 34,126,701	$ 34,918,861	$ 34,918,861	$ 40,103,356	$ 49,853,806	$ 47,400,387	$ 57,146,546	$ 61,304,122
Total OPEB Liability as a Percentage of Covered Payroll	70.04%	47.96%	54.90%	58.16%	50.78%	49.79%	44.58%	53.86%

[2] Fiscal year 2018 is the first year of implementation; therefore, only eight years are shown. As it becomes available this schedule will ultimately present information for the 10 most recent fiscal years.

Southern Nevada Health District
Multiple-Employer Cost-Sharing Defined Benefit Pension Plan
Proportionate Share of the Collective Net Pension Liability Information
For the Fiscal Year Ended June 30, 2025

For the Year Ended June 30	Proportion of the Collective Net Pension Liability	Proportion of the Collective Net Pension Liability	Covered Payroll	Proportion of the Collective Pension Liability as a Percentage of Covered Payroll	PERS Fiduciary Net Position as a Percentage of Total Pension Liability
2015	0.54090%	$ 61,984,011	$ 32,508,190	190.67198%	75.13000%
2016	0.52151%	$ 70,180,332	$ 32,917,342	213.20170%	72.20000%
2017	0.50906%	$ 67,704,469	$ 33,079,430	204.67242%	74.40000%
2018	0.50995%	$ 69,546,020	$ 33,744,349	206.09679%	75.20000%
2019	0.54171%	$ 73,866,832	$ 37,250,362	198.29829%	76.50000%
2020	0.56339%	$ 78,470,784	$ 38,532,689	203.64731%	77.04000%
2021	0.64435%	$ 58,760,106	$ 44,284,315	132.68830%	86.51000%
2022	0.69636%	$ 125,727,302	$ 49,627,892	253.34000%	75.12000%
2023	0.75931%	$ 138,595,844	$ 58,077,925	238.63773%	76.16000%
2024	0.70634%	$ 127,620,524	$ 61,032,305	209.10323%	78.11000%

Southern Nevada Health District
Multiple-Employer Cost-Sharing Defined Benefit Pension Plan
Proportionate Share of Statutorily Required Contribution Information
For the Fiscal Year Ended June 30, 2025

For the Year Ended June 30	Actuarially Determined Contributions	Contributions in Relation to the Actuarially Determined Contributions	Contribution Deficiency (Excess)	Covered Payroll	Contributions as a Percentage of Covered Payroll
2016	$ 4,565,587	$ 4,565,587	$ -	$ 33,079,430	13.80%
2017	$ 4,724,209	$ 4,724,209	$ -	$ 33,744,349	14.00%
2018	$ 5,215,051	$ 5,215,051	$ -	$ 37,250,362	14.00%
2019	$ 5,876,235	$ 5,876,235	$ -	$ 38,532,689	15.25%
2020	$ 6,753,358	$ 6,753,358	$ -	$ 44,284,315	15.25%
2021	$ 6,744,173	$ 6,744,173	$ -	$ 44,224,085	15.25%
2022	$ 7,659,900	$ 7,659,900	$ -	$ 50,228,852	15.25%
2023	$ 8,259,408	$ 8,259,408	$ -	$ 55,028,438	15.01%
2024	$ 10,184,839	$ 10,184,839	$ -	$ 54,115,741	18.82%
2025	$ 11,221,725	$ 11,221,725	$ -	$ 54,026,368	20.77%

Note 1. Postemployment Benefits Other Than Pensions

There are no assets accumulated in a trust to pay related benefits.

Changes of Assumptions and Experience

Certain key assumptions were changed as part of the actuary's updated study. Those changes are summarized below:

- The discount rate was updated from 3.65% as of June 30, 2023 to 3.93% as of June 30, 2024.
- The Pre-Medicare Select Trend Rate was decreased from 6.50% to 7.75% in 2024
- The Post-Medicare Select Trend Rate was increased from 5.50% to 6.75% in 2024.

Note 2. Multiple-Employer Cost-Sharing Defined Benefit Pension Plan

For the year ended June 30, 2025, there were no changes in the pension benefit plan terms to the actuarial methods and assumptions used in the actuarial valuation report dated June 30, 2024.

Additional pension plan information can be found at Note 9 to the basic financial statements.

Note 3. Budget Information

The accompanying required supplementary schedules of revenues, expenditures, and changes in fund balance for the general and major special revenue funds present the original adopted budget, the final amended budget, and actual data. The original budget was adopted on a basis consistent with financial accounting policies and with accounting principles generally accepted in the United States.

Additional budgetary information can be found in Note 2 to the basic financial statements.

Other Supplementary Information

Nonmajor Governmental Funds

Southern Nevada Health District
Nonmajor Capital Projects Funds
For the Fiscal Year Ended June 30, 2025

Capital project funds are used to account for financial resources that are restricted, committed, or assigned to the improvement, acquisition, or construction of capital assets.

Bond Reserve

Accounts for resources that have been committed or assigned to the future acquisition of a new administration building.

Capital Projects

Accounts for resources committed or assigned to the acquisition or construction of capital assets other than a new administration building.

Southern Nevada Health District
Statement of Revenues, Expenditures, and Changes in Fund Balance – Budget to Actual – Bond Reserve Fund
For the Fiscal Year Ended June 30, 2025

	Original	Final	Actual	Variance With Final Budget – Increase (Decrease)
Revenues				
Interest income	$ 30,000	$ 30,000	$ 172,993	$ 142,993
Total Revenues	30,000	30,000	172,993	142,993
Change in Fund Balance	30,000	30,000	172,993	142,993
Fund Balance, Beginning of Year	3,042,808	3,042,808	3,042,808	-
Fund Balance, End of Year	$ 3,072,808	$ 3,072,808	$ 3,215,801	$ 142,993

Southern Nevada Health District
Statement of Revenues, Expenditures, and Changes in Fund Balance – Budget to Actual – Capital Projects Fund
For the Fiscal Year Ended June 30, 2025

	Original	Final	Actual	Variance With Final Budget – Increase (Decrease)
Revenues				
Interest income	$ 70,000	$ 70,000	$ 202,104	$ 132,104
Total Revenues	70,000	70,000	202,104	132,104
Expenditures				
Public health				
Administration	-	-	489,261	(489,261)
Capital outlay	1,800,575	1,800,575	872,536	928,039
Total Expenditures	1,800,575	1,800,575	1,361,797	438,778
Deficiency of Revenues Over Expenditures	(1,730,575)	(1,730,575)	(1,159,693)	570,882
Other Financing Sources				
Transfers in	2,000,000	2,000,000	2,000,000	-
Change in Fund Balance	269,425	269,425	840,307	570,882
Fund Balance, Beginning of Year	2,730,175	2,730,175	2,730,175	-
Fund Balance, End of Year	$ 2,999,600	$ 2,999,600	$ 3,570,482	$ 570,882

Internal Service Funds

Southern Nevada Health District
Statement of Revenues, Expenditures, and Changes in Net Position – Budget to Actual –
Insurance Liability Reserve Fund
For the Fiscal Year Ended June 30, 2025

	Original	Final	Actual	Variance With Final Budget – Increase (Decrease)
Revenues				
Other operating income	$ 1,000	$ 1,000	$ -	$ (1,000)
Total Revenues	1,000	1,000	-	(1,000)
Nonoperating Revenues				
Interest income	5,000	5,000	2,081	(2,919)
Change in Net Position	$ 6,000	$ 6,000	2,081	$ (3,919)
Net Position, Beginning of Year			91,295	
Net Position, End of Year			$ 93,376	

INFORMATIONAL ONLY

NO ACTION

Southern Nevada Health District

Single Audit Reports

June 30, 2025

Southern Nevada Health District
Contents
June 30, 2025

Southern Nevada Health District
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2025

Federal Grantor/Pass-Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Provided to Subrecipients	Total Federal Expenditures
Department of Justice				
Direct Program				
Comprehensive Opioid, Stimulant, and other Substances Use Program	16.838		$ 136,880	$ 382,948
Total Department of Justice			**136,880**	**382,948**
Department of Treasury				
Passed through from				
City of Las Vegas, Nevada				
COVID-19 — Coronavirus State and Local Fiscal Recovery Funds	21.027	C2300074	-	497,577
City of Boulder City, Nevada				
COVID-19 — Coronavirus State and Local Fiscal Recovery Funds	21.027	30240806	-	462
Board of Regents, NSHE, obo University of Nevada, Las Vegas				
COVID-19 — Coronavirus State and Local Fiscal Recovery Funds	21.027	GR17278	-	48,650
Nevada Department of Health and Human Services				
COVID-19 — Coronavirus State and Local Fiscal Recovery Funds	21.027	SG26289-1	-	65,152
Total Department of Treasury			**-**	**611,841**
Environmental Protection Agency				
Passed through from				
Nevada Department of Conservation & Natural Resources				
State Public Water System Supervision	66.432	DEP 24-001	-	149,203
Total Environmental Protection Agency			**-**	**149,203**
Department of Health and Human Services				
Passed through from				
Nevada Department of Health and Human Services				
Public Health Emergency Preparedness	93.069	SG-2025-00378, SG-2025-00379, SG-2025-00454, SG-2025-00455, SG26317	-	2,764,228
Direct Programs				
Environmental Public Health and Emergency Response	93.070		31,185	304,646
Birth Defects and Developmental Disabilities – Prevention and Surveillance	93.073		-	388,145
Passed through from				
National Environmental Health Association				
Food and Drug Administration Research	93.103	2109-00984, 2309-04499, 2310-04968, 2410-06216	-	46,820
Passed through from				
Comagine Health				
Maternal and Child Health Federal Consolidated Programs	93.110	4100.CE0.19.SNHD	-	149,491
Passed through from				
Nevada Department of Health and Human Services				
Project Grants and Cooperative Agreements for Tuberculosis Control Programs	93.116	SG-2025-00791, SG26901	-	356,522
Direct Program				
Injury Prevention and Control Research and State and Community Based Programs	93.136		1,251,408	2,604,711
Passed through from				
Nevada Department of Health and Human Services				
Injury Prevention and Control Research and State and Community Based Programs	93.136	DO 1416, DO 1517, SG-2025-00543, SG26449	120,750	412,687
Total Injury Prevention and Control Research and State and Community Based Programs			*1,372,158*	*3,017,398*

Southern Nevada Health District
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2025 (Continued)

Federal Grantor/Pass-Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Provided to Subrecipients	Total Federal Expenditures
Passed through from				
University of Nevada, Las Vegas				
Childhood Lead Poisoning Prevention Projects, State and Local Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children	93.197	GR14034	-	56,148
Direct Programs				
Family Planning Services	93.217		-	1,163,574
Health Center Program Cluster				
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		-	1,247,611
Grants for New and Expanded Services Under the Health Center Program	93.527		-	53,098
Total Health Center Program Cluster			-	*1,300,709*
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243		-	545,042
Passed through from				
Nevada Department of Health and Human Services				
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	SP084007	-	8,364
Total Substance Abuse and Mental Health Services Projects of Regional and National Significance			-	*553,406*
Immunization Cooperative Agreements	93.268	SG-2024-00291, SG-2025-00535, SG-2025-00548, SG-2025-00713	-	1,988,616
COVID-19 — Immunization Cooperative Agreements	93.268	SG25388	-	1,143,351
Total Immunization Cooperative Agreements			-	*3,131,967*
Viral Hepatitis Prevention and Control	93.270	SG-2024-00551, SG-2025-00963	-	26,385
Direct Program				
Racial and Ethnic Approaches to Community Health	93.304		199,274	626,262
Passed through from				
National Association of County Health Officials				
Protecting and Improving Health Globally: Building and Strengthening Public Health Impact, Systems, Capacity ,and Security	93.318	2024-031902	-	7,746
Passed through from				
Nevada Department of Health and Human Services				
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)	93.323	SG-2024-00036, SG-2024-00056, SG-2024-00067, SG-2024-00095, SG-2025-00553, SG-2025-00660, SG-2025-00742, SG25489, SG26045, SG26215, SG26388, SG26896, SG-2025-00463	82,828	6,950,848
COVID-19 — Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)	93.323	SG26045	19,926	216,884
Total Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)			*102,754*	*7,167,732*
National and State Tobacco Control Program	93.387	SG-2024-00369-02	-	489,263

Southern Nevada Health District
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2025 (Continued)

Federal Grantor/Pass-Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Provided to Subrecipients	Total Federal Expenditures
Direct Program				
COVID-19 – Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises	93.391		1,105,951	1,907,146
Passed through from				
Nevada Department of Health and Human Services				
The National Cardiovascular Health Program	93.426	SG-2025-00580	-	93,662
Direct Programs				
Grants for Capital Development in Health Centers	93.526		-	591,502
Passed through from				
Catholic Charities Homeless Shelter Las Vegas				
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	F2410002	-	122,020
Passed through from				
Nevada Department of Health and Human Services				
CCDF Cluster				
Child Care And Development Block Grant	93.575	SG-2025-00602	-	684,386
Total CCDF Cluster			-	*684,386*
Passed through from				
Nevada Department of Health and Human Services				
Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A and B	93.686	4800012270-028, 4800013704-028	-	260,189
Passed through from				
University of Nevada, Reno				
Opioid STR	93.788	UNR-24-126	-	1,300,000
Passed through from				
Nevada Department of Health and Human Services				
Opioid STR	93.788	SG-2025-00828, SG-2025-00871	42,739	1,188,200
Total Opioid STR			*42,739*	*2,488,200*
Passed through from				
Nevada Department of Health and Human Services				
Maternal, Infant, and Early Childhood Home Visiting Grant	93.870	SG-2025-00765, SG26395	-	446,095
Passed through from				
Nevada Department of Health and Human Services				
National Bioterrorism Hospital Preparedness Program	93.889	SG-2025-00483, SG-2025-00384, SG-2025-00615	95,928	1,420,070
Passed through from				
Clark County				
Minority HIV/AIDS Fund (MHAF)	93.899	4800012229-028, 4800012677-028	-	262,759
HIV Emergency Relief Project Grants	93.914	4500404004-028, 4800011669-028, 4800012245-028, PO4800012245-028	-	1,159,507
Passed through from				
Nevada Department of Health and Human Services				
HIV Care Formula Grants	93.917	SG-2024-00297, SG-2024-00298, SG-2025-00927, SG-2025-00926	-	369,170
Direct Program				
Healthy Start Initiative	93.926		-	1,147,279
Direct Program				
HIV Prevention Activities Health Department Based	93.940		65,978	102,134

Southern Nevada Health District
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2025 (Continued)

Federal Grantor/Pass-Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Provided to Subrecipients	Total Federal Expenditures
Passed through from				
Nevada Department of Health and Human Services				
HIV Prevention Activities Health Department Based	93.940	SG-2025-00586, SG-2025-00611, SG-2025-00659, SG26073-2, SG26077-1, SG-2025-00975, SG-2025-00976, SG-2025-00977	515,778	3,729,110
Total HIV Prevention Activities Health Department Based			*581,756*	*3,831,244*
Direct Program				
Cooperative Agreements to Support State-Based Safe Motherhood and Infant Health Initiative Programs	93.946		49,569	291,702
Passed through from				
Nevada Department of Health and Human Services				
Block Grants for Prevention and Treatment of Substance Abuse	93.959	SG-2025-00590, SG26478	-	37,919
Direct Program				
Centers for Disease Control and Prevention Collaboration with Academia to Strengthen Public Health	93.967		176,070	6,818,216
Passed through from				
Nevada Department of Health and Human Services				
Sexually Transmitted Diseases (STD) Prevention and Control Grants	93.977	SG-2024-00059, SG-2025-00863	-	562,753
Passed through from				
Comagine Health				
Cooperative Agreements for Diabetes Control Programs	93.988	4100.CEO.17.SNHD	-	49,587
Passed through from				
Nevada Department of Health and Human Services				
Preventive Health and Health Services Block Grant	93.991	SG-2025-00689, SG26460	-	58,408
Total Department of Health and Human Services			**3,757,384**	**44,152,256**
Department of Homeland Security				
Passed through from				
Nevada Division of Emergency Management, Homeland Security				
Homeland Security Grant Program	97.067	AppID401421, AppID435471	-	109,462
Passed through from				
University of Nevada, Las Vegas				
Homeland Security Biowatch Program	97.091	GR20493	-	17,790
Total Department of Homeland Security			**-**	**127,252**
Total Federal Awards Expended			**$ 3,894,264**	**$ 45,423,500**

Note 1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (Schedule) includes the federal award activity of the Southern Nevada Health District (Health District) under programs of the federal government for the year ended June 30, 2025. The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of the Health District, it is not intended to and does not present the financial position, changes in net position/fund balance, or cash flows of the Health District.

Note 2. Summary of Significant Accounting Policies

The Health District's summary of significant accounting policies is presented in Note 1 to the Health District's basic financial statements for the year ended June 30, 2025.

Expenditures reported on the Schedule are reported on the modified accrual basis when they become a demand on current available federal resources and eligibility requirements are met, except for subrecipient expenditures, which are recorded on the cash basis.

Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Negative amounts, if any, shown on the Schedule represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years.

Note 3. Indirect Cost Rate

The Health District has not elected to use the 10% de minimis indirect cost rate allowed under the Uniform Guidance prior to October 1, 2024 nor elected to use the 15% de minimis indirect cost rate allowed under the Uniform Guidance effective October 1, 2024.

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Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Independent Auditor's Report

Board of Health and District Health Officer
Southern Nevada Health District
Las Vegas, Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of Southern Nevada Health District (Health District), as of and for the year ended June 30, 2025, and the related notes to the financial statements, which collectively comprise the Health District's basic financial statements, and have issued our report thereon dated November __, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Health District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health District's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material

effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dallas, Texas
November __, 2025

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Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance

Independent Auditor's Report

Board of Health and District Health Officer
Southern Nevada Health District
Las Vegas, Nevada

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited Southern Nevada Health District's (Health District) compliance with the types of compliance requirements identified as subject to audit in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Health District's major federal programs for the year ended June 30, 2025. The Health District's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, the Health District complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2025.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the Health District and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major federal program. Our audit does not provide a legal determination of the Health District's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to the Health District's federal programs.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the Health District's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the Health District's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the Health District's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of the Health District's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of the Health District's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Dallas, Texas
November __, 2025

Southern Nevada Health District
Schedule of Findings and Questioned Costs
Year Ended June 30, 2025

Section I – Summary of Auditor's Results

Financial Statements

1. Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:

   ☒ Unmodified ☐ Qualified ☐ Adverse ☐ Disclaimer

2. Internal control over financial reporting:

   Significant deficiency(ies) identified? ☐ Yes ☒ None reported

   Material weakness(es) identified? ☐ Yes ☒ No

3. Noncompliance material to the financial statements noted? ☐ Yes ☒ No

Federal Awards

4. Internal control over compliance for major federal programs:

   Significant deficiency(ies) identified? ☐ Yes ☒ None reported

   Material weakness(es) identified? ☐ Yes ☒ No

5. Type of auditor's report issued on compliance for major federal programs:

   ☒ Unmodified ☐ Qualified ☐ Adverse ☐ Disclaimer

6. Any audit findings disclosed that are required to be reported by 2 CFR 200.516(a)?

   ☐ Yes ☒ No

7. Identification of major federal programs:

Assistance Listing Number(s)	Name of Federal Program or Cluster
93.788	Opioid STR
93.889	National Bioterrorism Hospital Preparedness Program
93.940	HIV Prevention Activities Health Department Based
93.967	Centers for Disease Control and Prevention Collaboration with Academia to Strengthen Public Health

8. Dollar threshold used to distinguish between Type A and Type B programs: $1,362,705.

9. Auditee qualified as a low-risk auditee? ☒ Yes ☐ No

Section II – Financial Statement Findings

Reference Number	Finding
	No matters are reportable.

Section III – Federal Award Findings and Questioned Costs

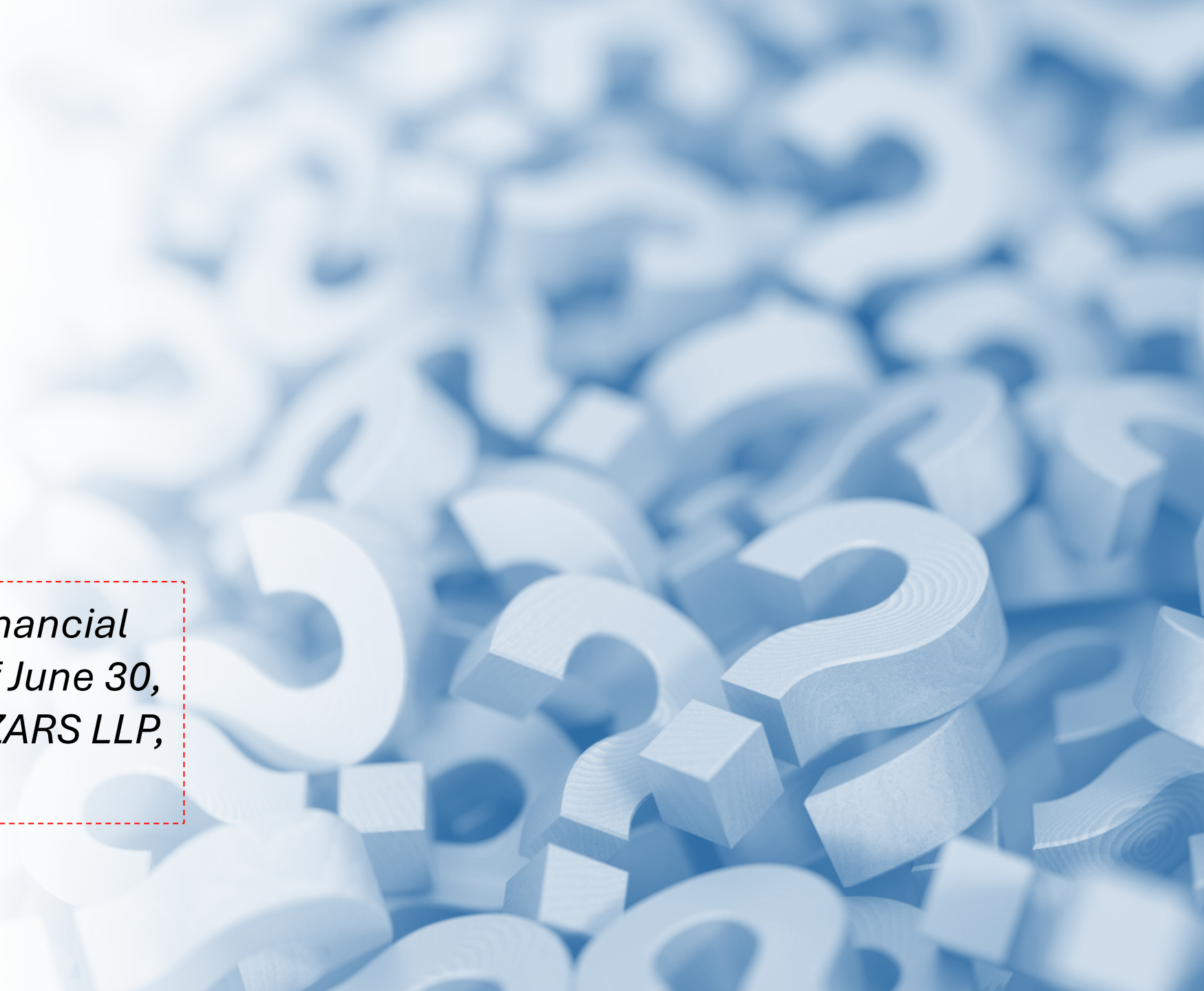
Reference Number	Finding
	No matters are reportable.

Southern Nevada Health District
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2025

Reference Number	Summary of Finding	Status
	No matters are reportable.	

Questions?

Motion to Accept the Financial Statement Report, as of June 30, 2025, from FORVIS MAZARS LLP, as presented.



VI. REPORT / DISCUSSION / ACTION

2. **Receive, Discuss and Approve Updates to the Southern Nevada Community Health Center Governing Board Bylaws;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Governing Board Bylaws - Proposed Changes

- Updated the mission to the health center's current board approved mission statement.
- Remove references to dental services.
- Removed reference to age, race, creed, national origin, sexual orientation or identity, military status, sex, disability, genetics or marital status.
- Added HRSA language regarding laws protecting free speech, religious liberty, public welfare, the environment, and prohibiting discrimination.
- Updated the board's demographics as it relates to its representation of the individuals who are served by the health center oppose to individuals being served.

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

BYLAWS OF THE SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD (COAPPLICANT BOARD)

SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD
280 S. Decatur Blvd, Las Vegas, NV 89107

Contents

Adopted: October 30, 2019
Amended: January 23, 2020
Amended: June 24, 2021
Amended: October 27, 2022
Amended: December 19, 2023
Amended: August 19, 2025
Amended: December 9, 2025

Bylaws of the Southern Nevada Community Health Center Governing Board

ARTICLE I: NAME

This body shall be known as the Southern Nevada Health Community Center Governing Board (CHC Board or Board). The Board shall serve as the independent local co-applicant governing board pursuant to the Public Health Services Act and its implementing regulations. The Board is organized as designated by the Health Resources and Services Administration's (HRSA) Federally Qualified Health Center (FQHC) guidelines. The Southern Nevada District Board of Health (District Board) a public entity and political subdivision of the State of Nevada, is the Southern Nevada Health District's (Health District) governing board and shall act as co-applicant with the Board.

ARTICLE II: MISSION

The Board's mission is to serve Clark County residents ~~in underserved areas with appropriate and comprehensive outpatient health and wellness, emphasizing prevention and education in a culturally respectful environment~~by providing patient-centered primary health care services to the underserved community with an emphasis on integrated, high-quality, and affordable care in a culturally respectful environment.

ARTICLE III: PURPOSE

The Board is a patient/community-based governing board mandated by HRSA to set health center policy and provide oversight of the FQHC Southern Nevada Community Health Center (CHC). The CHC designated sites will:

a) Provide outpatient primary care~~,~~ and behavioral health~~, and dental~~ services in underserved areas for medically underserved populations.
b) Deliver high quality primary care~~,~~ and behavioral health~~, and dental~~ services under conditions meeting the proper standards for the delivery of such care, rendered by competent, credentialed professionals subject to established quality controls.
c) Provide health care and related services and operate its facilities in compliance with applicable Federal, State, and local laws and regulations including provisions protecting free speech, religious liberty, public welfare, the environment, and prohibiting discrimination~~without regard to age, race, creed, color, national origin, sexual orientation or identity, military status, sex, disability, genetics, or marital status~~.
d) Educate the public in the principles of health prevention and promote other projects in the interest of the public's health.
e) Cooperate with other organizations or governmental agencies engaged in similar or like activities provided that such collaboration neither restricts nor infringes upon the Board's authority or function.
f) Engage in such other activities as directed by the Board.

ARTICLE IV: BOARD COMPOSITION AND TERMS

Section 1: Composition

The Board shall be comprised of not less than nine (9) and not more than twenty-five (25) voting members who shall stand for regular elections (Members). The Chief Executive Officer shall be an ex-officio non-voting member. The Members shall serve staggered terms.

Section 2: Member Categories

a) Consumer Members: Consumer members are Members who, as a group, represent the individuals who are served by the health center~~as a group, represent the individuals being served in terms of demographic factors, such as race, ethnic background, and sex~~. A majority of the Board (at least 51%) shall be Consumer Members.

b) Community Members: Community Members are representatives of the community ~~-~~served by the health center or the health center's service area and shall be selected for their expertise in relevant subject areas, such as community affairs, local government, legal affairs, trade unions, finance and banking, and other commercial and industrial concerns or social services within the community. No more than one-half of the Community Members may derive more than 10% of their income from the healthcare industry.

Section 3: Member Qualifications

All Board members shall meet the following additional minimal qualifications:

a) Members shall be residents of Clark County, Nevada and at least eighteen (18) years old.

b) Members shall participate in appropriate training and educational programs necessary to properly fulfill their responsibilities as Board Members.

c) Consumer Members must be a current registered CHC patient and must have accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generate a health center visit.

A legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant consumer may also be considered a patient for purposes of Board representation.

Section 4: Prohibited Board Members

No Member shall be a CHC or Heath District employee, or an immediate family member (i.e., spouse, child, parent, brother, or sister by blood, adoption, or marriage) of such employee.

Section 5: Term of Office

The Governing Board Members will be elected to terms as follows:

a) Members shall each serve three (3) year terms;

b) Unless otherwise provided in these Bylaws, a Member shall be limited to three (3) consecutive terms of membership.

Section 6: Term Extensions

A current or former Member may serve additional terms if the Board determines after careful deliberation and as reflected in the minutes, it is in the best interest of the organization and in furtherance of best practices.

Section 7: Selection

New Board members shall be elected by the full CHC Board during the annual meeting or as needed to fill Board vacancies.

ARTICLE V: REMOVAL OF MEMBERS

Section 1: Removal

Any Member may be removed whenever it's in the best interests of the CHC or the Board. The Member whose removal is placed in issue shall be given prior notice of his/her proposed removal. At any meeting where a vote is to be taken to remove a Member, the Member in question may attend and shall be given a reasonable opportunity to be heard. A Member may be removed by a vote of two-thirds (2/3) of the Board at any official meeting provided there is a quorum for the meeting at which the action is taken.

Section 2: Attendance Requirements

A Member who has been absent from three (3) consecutive meetings or more than fifty percent (50%) of regularly scheduled meetings in a twelve (12) month rolling period, without reasonable excuse, duly noted in the minutes of the meeting, shall be subject to removal from the Board.

Section 3: Resignations

Any Member may resign at any time by giving written notice to the Chair or Board. Such resignation shall take effect at the time specified therein, and if no time is specified in the written resignation, it shall take effect upon receipt by the Chair. Acceptance is not a prerequisite to the effectiveness of any resignation and such resignation shall be irrevocable upon delivery of such notice.

ARTICLE VI: BOARD AUTHORITY AND RESPONSIBILITIES

The CHC Board's responsibilities include providing advice, leadership, and guidance in support of the CHC's mission. No individual Board Member or group of Members has the authority to bind the Board or speak on its behalf without express authorization from it setting forth the limited purpose and duration.

Section 1: Responsibilities

The Board shall be responsible for:

a) Attend monthly meetings.
b) Evaluate, at least annually, the CHC's achievements, the performance of its CEO, and its compliance with FQHC requirements.
c) Identify and ensure that it meets its educational and training needs including orientation and training new Board members.
d) Approve the annual CHC budget, quality of care protocols, and audits.
e) Adopt, and as needed amend, Bylaws.
f) Provide financial oversight requiring control of major resource decisions and monitoring financial viability.
g) Review and accept the annual financial audit report.
h) Prohibit conflict of interest or appearance of the same by Members, employees, consultants, and those who provide services or goods to the CHC.
i) Ensure the CHC is operated in compliance with applicable Federal, State, and local laws and regulations; and
j) Adopt and approve policies necessary for the efficient and effective operation of the CHC, including but not limited to, scope and availability of services, location and hours of services, and quality-of-care audit procedures.
k) Approve the selection and dismissal of the Chief Executive Officer of the CHC who has direct administrative and operational responsibility for the CHC designated sites.

l) Approve CHC budget for designated site operations. Such approval shall be completed no later than the June Board meeting. The budget shall be within appropriations available for such purposes and shall be initially prepared by the person or persons having direct administrative responsibility for the operation of the CHC designated sites or their delegates.
m) Develop CHC designated site's financial priorities and strategies for major resource utilization.
n) Conduct an annual evaluation of the effectiveness of CHC designated sites. Such evaluation shall include but not be limited to utilization patterns, provider resources, productivity, patient satisfaction, and achievement of program objectives including performance to budget.
o) Approve and implement a procedure for hearing and resolving patient grievances consistent with applicable federal, state, and local laws and regulations.
p) Approve CHC designated site quality of care assessment procedures and metrics.
q) Ensure CHC designated site is in compliance with federal, state and local laws and regulations.
r) Approve such other policies as are necessary for the efficient and effective operation of CHC designated sites.
s) Provide, at least bi-annually, an informational report to the District Board regarding the CHC designated site utilization, productivity, patient satisfaction, achievement of project objectives and financial performance.
t) Renew and approve the CHC renewal of designation application.

Section 2: Limitations of Authority

The District Board shall maintain the authority to set general policy of fiscal and personnel matters pertaining to the CHC, including financial management practices, charges and rate setting, and labor relations and conditions of employment. The CHC Board may not adopt any policy or practice or take any action which is inconsistent with these Bylaws or Co-Applicant Agreement, or which alters the scope of any Health District policy regarding fiscal or personnel issues.

ARTICLE VII: MEMBER RESPONSIBILITIES

All Members must:

a) Attend monthly Board meetings.
b) Sit on a minimum of one Committee.
c) Attend committee meetings.
d) Serve without compensation. However, travel and mileage expenses shall be allowable in accordance with any CHC approved reimbursement policies.
e) Be subject to applicable state and federal Conflict of Interest laws and CHC policies.

ARTICLE VIII: VACANCIES

Member vacancies on the Board or any Committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of the original appointment.

ARTICLE IX: MEETINGS

Section 1: Location
Meetings of the Members may be held at the main office of the CHC or at such other place as may be designated for that purpose in the notice of the meeting.

Section 2: Open and Public
All meetings will be conducted consistent with Nevada's Open Meeting Law and generally follow Parliamentary Procedures for the timely and orderly progression of the meeting. A closed session may be placed on an agenda, when applicable.

Section 3: Regular and Annual Meetings
Regular meetings shall take place monthly and may occur more frequently. The first meeting of the new year shall constitute the Annual Meeting at which time elections shall be held for Officers and Directors.

Section 4: Special Meetings
Special meetings may be held whenever called by the Chair, or any four (4) Members. Notice of the meeting shall state the date, time, place, and purpose of the meeting.

Section 5: Quorum
Unless otherwise required by law or these Bylaws, a quorum is necessary to conduct business and make recommendations. A quorum constitutes a majority of Board Members. Each Member shall be entitled to one (1) vote. Voting must be in person, via videoconference, or telephonically; no proxy votes will be accepted.

Section 6: Meetings by Telephone or Teleconference
Members may participate in a meeting by electronic and teleconference means so long as all persons participating in the meeting can hear each other at the same time and have an opportunity speak. Such participation shall constitute presence in person at the meeting.

ARTICLE X: OFFICERS, DUTIES, ELECTION, AND TERM OF OFFICE

Section 1: Officers
A Chair, a First Vice Chair, and Second Vice Chair and such other officers the Board deems necessary shall be chosen from among the Board membership.

Section 2: Chair
The Chair shall preside over, plan, and carry out the agenda for each Board meeting, and:

a) May delegate a reasonable portion of his/her duties to the First Vice Chair, in the event of the Chair's absence, resignation, or inability to perform.
b) Shall appoint, with the approval of the Board, all standing and special committees of the Board, serve as an ex-officio member of all standing committees, and report annually to the Board on the current state of the CHC and plans for the future.
c) Shall discharge all other duties as may be required by these Bylaws and from time to time may be assigned by the Board.

Section 3: Vice-Chairs

a) First Vice Chair:
   1) Shall assist the Chair in his or her duties as needed.
   2) Shall perform the duties of Chair in the latter's absence and shall discharge additional duties that may from time to time be prescribed by the Chair or the Board.

b) Second Vice-Chair
   1) Shall assist the Chair and the First Vice Chair in their respective duties as needed.
   2) Shall perform the duties of the Chair in the absence of the Chair and First Vice Chair and shall discharge additional duties that may from time to time be prescribed by the Chair, the First Vice Chair, or the Board.

Section 4: Nomination, Election, and Term of Office.

Officers shall be elected annually by the Board.

a) At each Annual Meeting, and at other times when vacancies occur, the Nominations Committee shall present nominations for the offices of Chair, First Vice Chair, and Second Vice Chair. Additional nominations may be made from the floor. The term of each office shall be two (2) year, or any portion of an unexpired term thereof. Members may serve in any officer role for a maximum of 4 (four) consecutive terms. Vacancies may be filled, or new offices created and filled, at any Board meeting. A term of office for an officer shall start October 1, and shall terminate September 30, or until a successor is elected.

Section 5: Board Member Elections

a) The Nominations Committee shall determine the number of vacancies for the following year, review all nominations received, and nominate the number of nominees equal to the number of vacancies. In so doing, the Nominations Committee shall take into account the requirements concerning the composition of the Board as set forth in Article IV herein.
b) At the Annual Meeting, each vacancy shall be filled by majority vote of the directors voting, except that no nominee may be elected if the effect of such election would be to cause the composition of the Board to be in violation of the requirements contained in Article IV.

ARTICLE XI: COMMITTEES

Section 1: Committees Generally

Board Committees shall provide assistance and advice to the Board and may exercise such power and carry out such functions as are designated by these Bylaws or as delegated by the Board. All committees shall be advisory only and subject to the control of the Board. The Board may appoint committees as circumstances warrant as provided herein. There shall be no limitation on the length of time individuals may serve as members of a committee. All actions taken by any committee shall be reported at the next meeting of the Board and shall be binding only when approved by formal Board vote. Delegation of authority to a committee shall not operate to relieve the Board or any individual Member of any responsibility imposed on it or him/her by law, by the CHC, or these Bylaws.

Section 2: Standing Committees

Standing committees shall consist of the Executive Committee, Finance and Audit Committee, Quality, Credentialing & Risk Management Committee, Nominations Committee, Strategic Planning Committee, and Chief Executive Officer Annual Review Committee. The Board may create additional standing committees and dissolve such additional committees.

Section 3: Special Committees
Special committees may be appointed by the Chair with the approval of the Board for such special tasks as circumstances warrant. A special committee shall limit its activities to the accomplishment of the task for which it is appointed and shall have no power to act except such as is specifically conferred by action of the Board Members. Upon completion of the task for which appointed, such special committee shall stand dissolved.

ARTICLE XII: INDEMNIFICATION

a) The CHC, to the extent legally permissible, indemnify each person who may serve or who has served as a CHC Chief Executive Officer against all costs and expenses reasonably incurred by or imposed upon him or her in connection with or resulting from any action, suit, or proceeding to which he or she may be a party by reason of his or her being or having been a Chief Executive Officer, except:1) in connection with an action, suit or proceeding by or in the right of the CHC in which the Chief Executive Officer was adjudged liable to the CHC, 2) in any action, suit or proceeding charging improper personal benefit to the Chief Executive Officer, whether or not involving an action in his or her official capacity, in which the Chief Executive Officer was adjudged liable on the basis that personal benefit was improperly received, or 3) in relation to any other such matters as to which he or she shall finally be adjudicated in such action, suit, or proceeding to have acted in bad faith and to have been liable by reason of willful misconduct in the performance of his or her duty as Chief Executive Officer.

b) Costs and expenses of actions for which this Article provides indemnification shall include, among other things, attorney's fees, damages, and reasonable amounts paid in settlement. The duty to indemnify is conditioned upon full cooperation by the Chief Executive Officer in the defense of the action and any action against the CHC based upon the same act or omission and in the prosecution of any appeal.

ARTICLE XIII: CONFLICT OF INTEREST AND ETHICS

Section 1: Determination of Conflict of Interest

A conflict of interest is a transaction with the CHC in which a Member has a direct or indirect economic or financial interest. Conflict of interest or the appearance of conflict of interest by Members, employees, consultants, agents, and those who furnish goods or series to the CHC must be declared. Members, including all Committee Members, shall:

a) Declare any potential conflicts of interest by completing a conflict of interest declaration form (see Appendix "A").
b) Comply with all federal and state conflict of interest laws.
c) Decline to participate in a discussion of or vote on a matter where a conflict of interest exists for that Member.
d) In addition to the requirements imposed by these Bylaws, be subject to all applicable state and federal conflict of interest laws and the rule and reporting requirements.

Section 2: Gifts & Inducements
Members shall not offer, solicit, pay, or accept anything of value in exchange for healthcare referrals or for actions that may be perceived as creating an advantage for the individual or entity that conducts business with the CHC. This applies to offering or receiving money, gifts, free or discounted items or services, meals, professional courtesies, or other arrangements with the intent to induct referrals or

preferential treatment in their capacity as CHC Board Members.

a) Accepting, offering, or paying anything of value in return for recommending products or services (including referrals) in violation of the Anti-Kickback Statute is a conflict of interest.

ARTICLE XIV: GENERAL PROVISIONS

Section 1: Patient Rights
The Board shall respect patient confidentiality, patient rights, and will comply with CHC policies.

Section 2: Fiscal Year
The fiscal year of this CHC shall end on June 30 of each year.

Section 3: Medical Care and Its Evaluation
The Board, in conjunction with the CHC's Chief Executive Officer, shall provide for a continuing review and appraisal of the quality of professional care rendered in the CHC whether by contracting for evaluation or otherwise.

Section 4: Adoption and Amendments
These Bylaws may be amended by a majority vote of a quorum of the Board at any regular or special meeting; provided that, in the case of any amendment, written notice of the amendment shall have been submitted to each Member at least seven (7) days prior to the meeting.

Section 5: Preservation of Confidential Information.
The Board has adopted policies and will comply with all federal and state laws and regulations regarding the protection of confidential, privileged or proprietary information and all such provisions shall apply to all Members both during committee service and thereafter.

ARTICLE XV: WINDING UP AND DISSOLUTION

These Bylaws are conditional upon the granting of the application for classification of this CHC as a Federal Qualified Health Center and the maintenance of such classification. In the event such classification does not occur within a reasonable time or is revoked, these Bylaws shall become ineffective and the CHC shall wind up and dissolve.

~~August 19,~~December 9, 2025

Donna Feliz-Barrows, Chair
Southern Nevada Health Community Health Center
Governing Board

Date

APPENDIX "A" CONFLICT OF INTEREST

Conflict of Interest. Defined as an actual or perceived interest by the Southern Nevada Community Health Center Member which results or has the appearance of resulting in person, organizational, or professional gain.

Duty of Loyalty. The Southern Nevada Community Health Center Board Members must be faithful to the organization and can never use information obtained in his/her position as a Board Member for personal gain.

Responsibility of Board Members:

1. A Board member must declare and explain any potential conflicts of interest related to:
    a. Using his/her Board appointment in any way to obtain financial gain for the Member's household or family; or, for any business with which either the Member or the Member's household or family is associated; and
    b. Taking any action on behalf of the Board, the effect of which would be to the Member's household or family's private financial gain or loss.
2. No Member shall vote in a situation where a personal conflict of interest exists for that Member.
3. No Member shall be a CHC or Heath District employee, or an immediate family member (i.e., spouse, child, parent, brother, or sister by blood, adoption, or marriage) of such employee.
4. Any Member may challenge any other Member(s) as having a conflict of interest by the procedures outlined in the Board's Bylaws, Article XIII, Conflict of Interest.

As a Member of the Southern Nevada Community Health Center's Governing Board, my signature below acknowledges that I have received, read, and had an opportunity to ask clarifying questions regarding these conflict of interest requirements. I understand that any violation of these requirements may be grounds for my removal from the Board. I further understand that I may be subject to all other applicable state and federal conflict of interest requirements in addition to the provisions set forth in these Bylaws.

Should my circumstances change, I will provide an updated disclosure to the Chief Executive Officer.

_____
Print Name

_____ _____
Board Member's Signature Date

Questions?

Motion to Approve Updates to the Southern Nevada Community Health Center Governing Board Bylaws, as presented.

VI. REPORT / DISCUSSION / ACTION

3. **Receive, Discuss and Approve New Board Member;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Board Member Candidate

Name: Father Rafael Pereira

Profession: On call chaplain at the Sunrise hospital, marriage counselor, priest, CPA, consultant for non-profits, tax advisor and planner.

Education: CPA, Master in Finance Management, Priesthood thru the Episcopal Church, chaplaincy, parenting facilitator, marriage and family counselor.

Why are you interested in becoming a member of the Southern Nevada Community Health Center's Governing Board?

- I remain committed to supporting the mission of expanding access to quality healthcare for the most vulnerable in our community.

What do you believe are the unmet health needs of our community?

- Access and to quality healthcare and uninsured.

Candidate meets HRSA requirements.

Motion to Approve New Board Member, as presented.

VI. REPORT / DISCUSSION / ACTION

4. **Receive, Discuss and Approve Changes to the Southern Nevada Community Health Center's Vision Statement;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SNCHC Vision Statement

Current Vision Statement:

- It is the vision of the Southern Nevada Community Health Center to reduce health disparities in the community by empowering patients to achieve their best possible health through equitable access to comprehensive care.

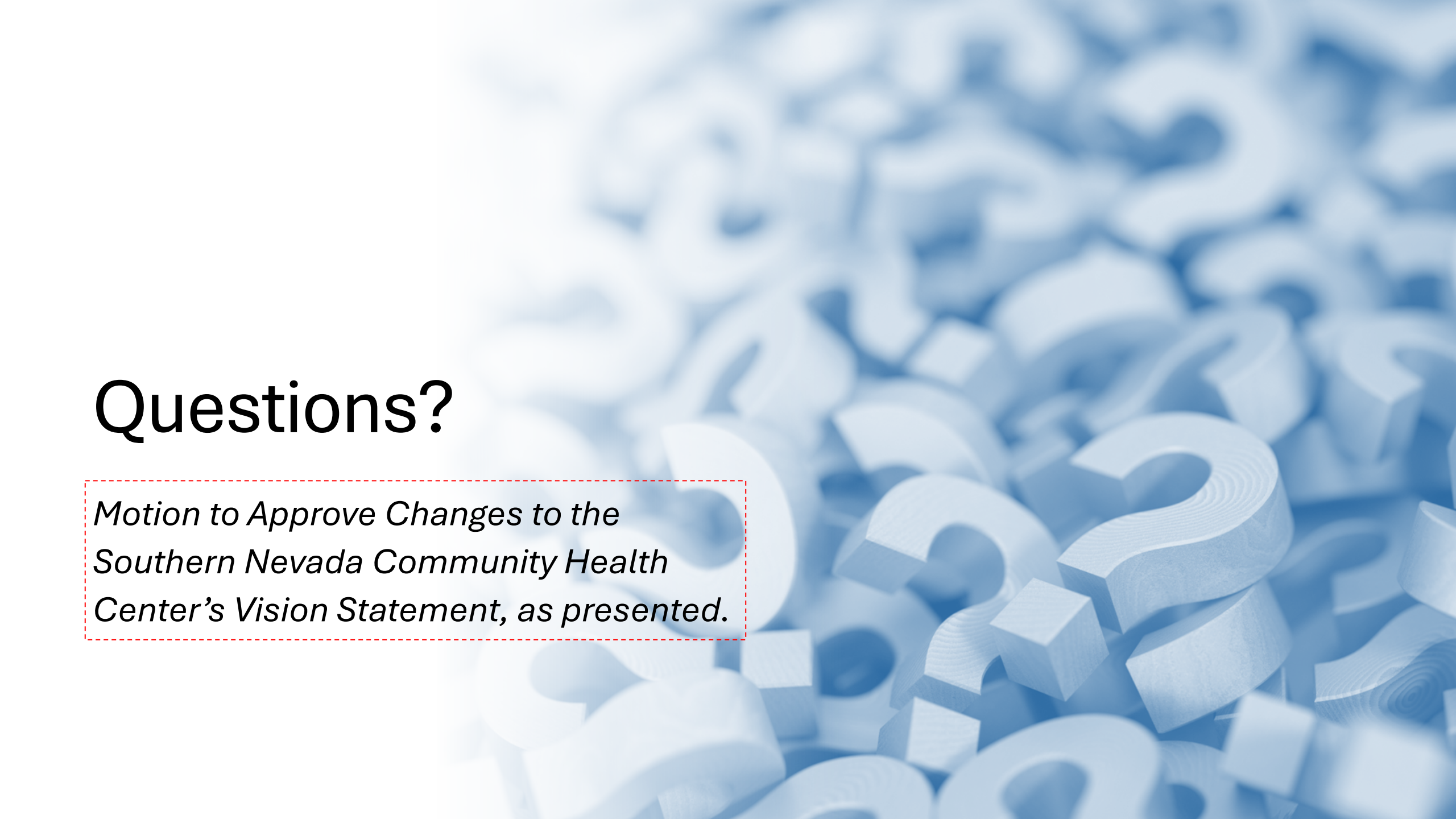
Proposed Change:

- Replace equitable with “fair”

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Questions?

Motion to Approve Changes to the Southern Nevada Community Health Center's Vision Statement, as presented.



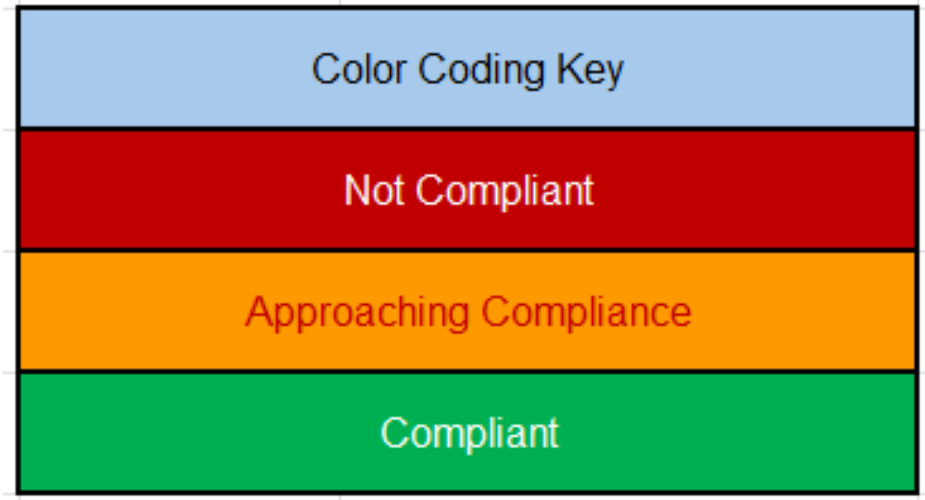
VI. REPORT / DISCUSSION / ACTION

5. **Receive, Discuss and Accept the Third Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

2025 Q3 Quarterly Risk Management Report

2025 Q2 Quarterly Risk Assessment

- Grading Scale



2025 Q2 Quarterly Risk Assessment

- FTCA requires one risk assessment to be completed each quarter. 2 of the 4 risk assessments must cover a high-risk area.
- The one required risk assessment for Q2 is complete, making the requirement at 100% compliance through Q2.
- The tool used for the Q2 Risk Assessment is called the SNHD Annual HIPAA Risk Assessment
  - 45 Criteria Audited
  - 40/45 compliant (88.9%)
  - Action Plan to correct other 5 criteria done and under way.
- Open Action plan goal = 75% or less

HRSA Health Resources & Services Administration ECRI

Risk Assessment and Mitigation Tool: Safeguards for Behavioral Health Services

Risk Assessments					
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3
RM	# Completed annual high-risk assessments	≥ 2/yr	1	-	-
RM	# Completed quarterly assessments	Min 1/qtr	1	1	1
RM	% Open action plans	≤75%	100%	75%	75%

Q3 2025 Incident Reporting and Peer Reviews

- FTCA requires SNCHC to track the quantity and level of severity of all incidents.
- Last year 70 incidents were reported
- Q3 of 2025 there were 25 incidents reported, 0 of which were sentinel events, and 2 of which were high risk.
- 3/25 incidents required root cause analysis and follow up.
- The average score for Provider Peer Reviews in Q3 was 94%.

Adverse Events/ Incident Reports					
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0
Center staff	# High Risk Incidents	Total /qtr.	1	5	2
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0
Quarterly Incident Totals		Prior Year - 70	18	25	25
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8
Medical Director	# Peer review audits completed (5/provider/qtr)	80%	95%	95%	94%

Q3 2025 FTCA Required Annual Training Compliance

- There are five FTCA required trainings that all clinical staff MUST participate in each year.
- By the end of Q3, 99.76% of SNCHC's clinical staff had completed 2025's annual required trainings for FTCA.
- FTCA requires that the Risk Manager take two FTCA risk related trainings each year.
- The Risk Manager, Dave Kahananui, has already completed his two annual trainings in May of 2025.

Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3
FQHC Leadership	Planning , review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%
FQHC Leadership	Planning , review and completion of annual High Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%
FQHC Leadership	Planning , review and completion of annual High Risk Area (Hand Hygiene) training.	≥90% by year-end	84.26%	99.07%	99.02%
FQHC Leadership	Planning , review and completion of annual HIPAA training.	≥90% by year-end	81.51%	99.13%	100.00%
FQHC Leadership	Planning , review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	86.90%	100.00%	100.00%
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%

Q3 2025 Risk and Patient Safety Activities

- Patient satisfaction score averaged 98.3% for Q3 and 98.1% for the year.
- 0 grievances filed in Q3.
- No pharmacy packaging and labeling errors.
- 1 HIPAA breach that was contained internally and corrected.
- All referrals ordered were processed and sent.
- 46.55% of Pts eligible for Pregnancy Intention Screening were screened.
- No pregnant patients have documentation of which trimester they were in when first seen.
- 1 patient who had a baby this year has birthweight/race data documented for their newborn.
- 100% of LIP/OLCPs had current credentialing at the end of Q3.

Risk and Patient Safety Activities					
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%
Compliance/RM	HIPAA breaches	Total # of breaches	0	0	1
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	100%	100%	100%
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total #	1766	1902	1914
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total #	913	909	891
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	51.70%	47.79%	46.55%
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	22	25	19
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	18	25	19
QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	0	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	0%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1
RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%

Q3 2025 Claims Management

- No claims were reported or filed in Q3.

Claims Management					
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3
CM	# Claims submitted to HHS	NA	0	0	0
CM	# Claims settled or closed	NA	0	0	0
CM	# Claims open	NA	0	0	0
CM	# Lawsuits filed	NA	0	0	0
CM	# Lawsuits settled	NA	0	0	0
CM	# Lawsuits litigated	NA	0	0	0


Questions?

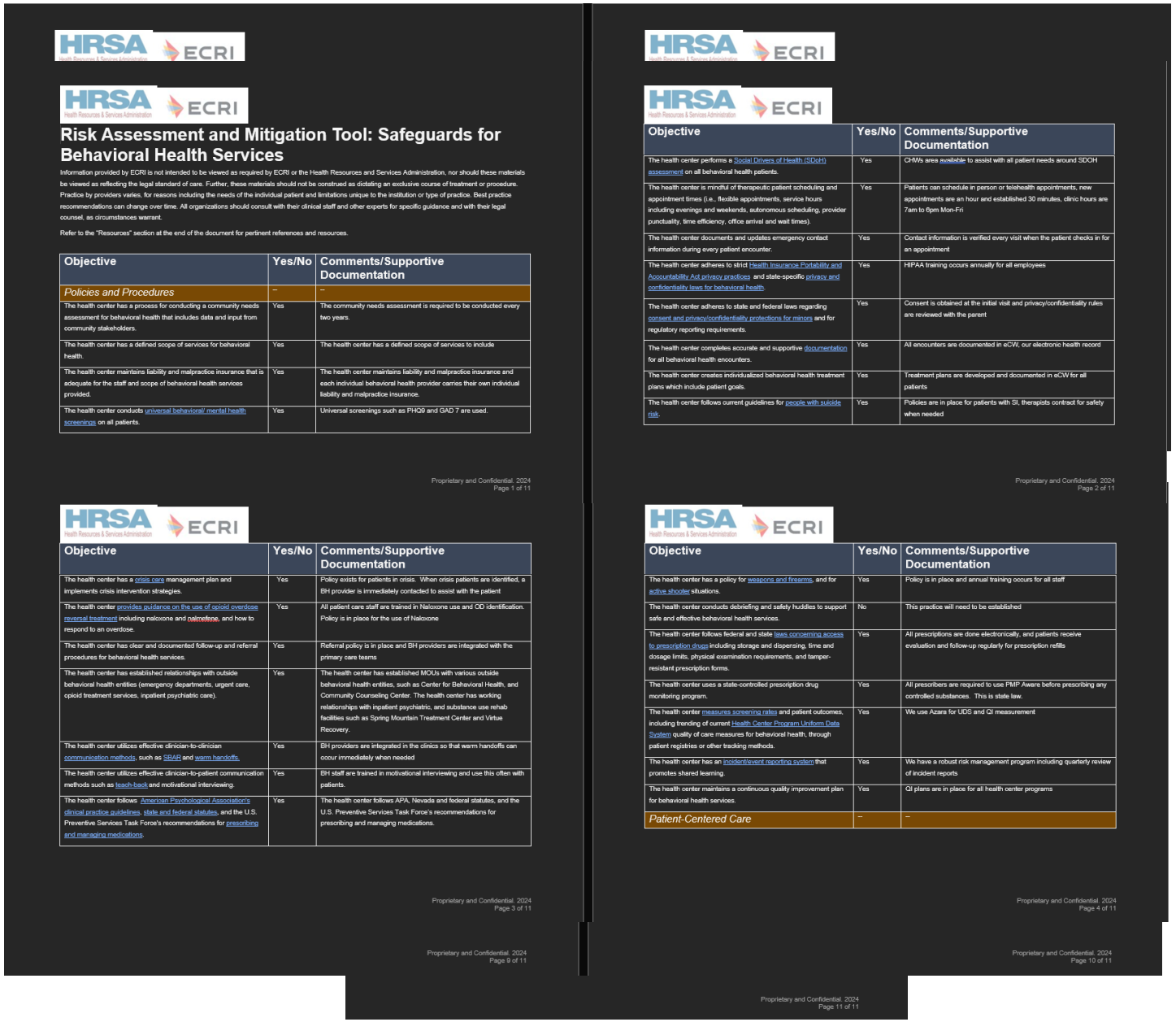
VI. REPORT / DISCUSSION / ACTION

6. **Receive, Discuss and Accept the Third Quarter Risk Management Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

2025 Q3 Quarterly Risk Management Assessment

2025 Q3 Quarterly Risk Assessment

- FTCA requires one risk assessment to be completed each quarter. 2 of the 4 risk assessments must cover a high-risk area.
- The one required risk assessment for Q3 is complete, making the requirement at 100% compliance through Q3.
- The tool used for the Q3 Risk Assessment is called the Risk Assessment and Mitigation Tool – Safeguards for Behavioral Health Services
  - 67 Criteria Audited
  - 61/67 compliant (91%)
  - Action Plan to correct other 5 criteria done and under way.
- Open Action plan goal = 75% or less



HRSA ECRI

HRSA ECRI

Risk Assessment and Mitigation Tool: Safeguards for Behavioral Health Services

Information provided by ECRI is not intended to be viewed as required by ECRI or the Health Resources and Services Administration, nor should these materials be viewed as reflecting the legal standard of care. Further, these materials should not be construed as dictating an exclusive course of treatment or procedure. Practice by providers varies, for reasons including the needs of the individual patient and limitations unique to the institution or type of practice. Best practice recommendations can change over time. All organizations should consult with their clinical staff and other experts for specific guidance and with their legal counsel, as circumstances warrant.

Refer to the "Resources" section at the end of the document for pertinent references and resources.

Objective	Yes/No	Comments/Supportive Documentation
Policies and Procedures	–	–
The health center has a process for conducting a community needs assessment for behavioral health that includes data and input from community stakeholders.	Yes	The community needs assessment is required to be conducted every two years.
The health center has a defined scope of services for behavioral health.	Yes	The health center has a defined scope of services to include
The health center maintains liability and malpractice insurance that is adequate for the staff and scope of behavioral health services provided.	Yes	The health center maintains liability and malpractice insurance and each individual behavioral health provider carries their own individual liability and malpractice insurance.
The health center conducts universal behavioral/ mental health screenings on all patients.	Yes	Universal screenings such as PHQ9 and GAD 7 are used.

Proprietary and Confidential. 2024
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Objective	Yes/No	Comments/Supportive Documentation
The health center has a crisis care management plan and implements crisis intervention strategies.	Yes	Policy exists for patients in crisis. When crisis patients are identified, a BH provider is immediately contacted to assist with the patient
The health center provides guidance on the use of opioid overdose reversal treatment including naloxone and nalmefene, and how to respond to an overdose.	Yes	All patient care staff are trained in Naloxone use and OD identification. Policy is in place for the use of Naloxone
The health center has clear and documented follow-up and referral procedures for behavioral health services.	Yes	Referral policy is in place and BH providers are integrated with the primary care teams
The health center has established relationships with outside behavioral health entities (emergency departments, urgent care, opioid treatment services, inpatient psychiatric care).	Yes	The health center has established MOUs with various outside behavioral health entities, such as Center for Behavioral Health, and Community Counseling Center. The health center has working relationships with inpatient psychiatric, and substance use rehab facilities such as Spring Mountain Treatment Center and Virtue Recovery.
The health center utilizes effective clinician-to-clinician communication methods, such as SBAR and warm handoffs.	Yes	BH providers are integrated in the clinics so that warm handoffs can occur immediately when needed
The health center utilizes effective clinician-to-patient communication methods such as teach-back and motivational interviewing.	Yes	BH staff are trained in motivational interviewing and use this often with patients.
The health center follows American Psychological Association's clinical practice guidelines, state and federal statutes, and the U.S. Preventive Services Task Force's recommendations for prescribing and managing medications.	Yes	The health center follows APA, Nevada and federal statutes, and the U.S. Preventive Services Task Force's recommendations for prescribing and managing medications.

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HRSA ECRI

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Objective	Yes/No	Comments/Supportive Documentation
The health center has a policy for weapons and firearms, and for active shooter situations.	Yes	Policy is in place and annual training occurs for all staff
The health center conducts debriefing and safety huddles to support safe and effective behavioral health services.	No	This practice will need to be established
The health center follows federal and state laws concerning access to prescription drugs including storage and dispensing, time and dosage limits, physical examination requirements, and tamper-resistant prescription forms.	Yes	All prescriptions are done electronically, and patients receive evaluation and follow-up regularly for prescription refills
The health center uses a state-controlled prescription drug monitoring program.	Yes	All prescribers are required to use PMP Aware before prescribing any controlled substances. This is state law.
The health center measures screening rates and patient outcomes, including trending of current Health Center Program Uniform Data System quality of care measures for behavioral health, through patient registries or other tracking methods.	Yes	We use Azara for UDS and QI measurement
The health center has an incident/event reporting system that promotes shared learning.	Yes	We have a robust risk management program including quarterly review of incident reports
The health center maintains a continuous quality improvement plan for behavioral health services.	Yes	QI plans are in place for all health center programs
Patient-Centered Care	–	–

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2025 Q3 Quarterly Risk Assessment Findings

5 Findings

CY25 Safeguards for BH Services - Findings and Action Plan

Assessment conducted by: Tabitha Johnson, LMFT, LCADC, Behavioral Health Manager and Dr. Robin Carter, DO, Medical Director

Q3 Assessment Completed on: 9/15/2025

Overall Score: 61/67 or 91%

Findings/areas of highest risk identified:

1. **Policies and Procedures –**
    a. The health center conducts debriefing and safety huddles to support safe and effective behavioral health services.
        i. Assessment Notes
            1. This practice will need to be established.
2. Patient Centered Care
    a. The health center utilizes patient navigators specific to behavioral health services.
        i. Assessment Notes
            1. At this time, this position is not filled.
3. **Staffing and Workforce Development**
    a. The health center has a plan to identify and address behavioral health workforce shortages and burnout.
        i. Assessment Notes
            1. This will need to be formally established. However, the behavioral health manager connects often with behavioral health staff to ensure that adequate self-care is being used to prevent burnout.
4. **Safe Environment and Infrastructure**
    a. The health center provides soothing music, toys, and comfortable furniture.
        i. Assessment Notes
            1. There is no music, or toys in the BH area, but comfortable seating is available.
    b. The health center counsels patients and their families about firearms and gun safety.
        i. Assessment Notes
            1. Policy needs to be established and posted in BH Center.

2025 Q3 Quarterly Risk Assessment Action Plan

5 Activities will correct and prevent 5 findings by March of 2026.

CY25 Safeguards for BH Services - Findings and Action Plan

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up
Correct Criterion #1a – The health center conducts debriefing and safety huddles to support safe and effective behavioral health services.	• BH Manager & Medical Director consult on policy verbiage and workflow for huddles by January 2026. • Identify what constitutes a safety issue (consult with safety officer and security as needed) and what needs to be communicated to mitigate and prevent future safety incidents by January 2026. • Define workflow and procedure for huddles with ops teams and BH team. • Create a procedure in the proper SNHD/SNCHC format and have CEO review by January 2026. • Implement new debriefing and safety huddles process for all BH and Clinic operations teams by April 2026.	January 2026 – April 2026 – July 2026 –
		3 & 6 Month Follow Up
Correct Criterion #2a – The health center utilizes patient navigators specific to behavioral health services.	• CEO, BH Manager, & Medical Director must decide what this role entails and if another FTE is required, or if these responsibilities can be shouldered by existing staff. Job descriptions need to be updated as determined by April 2026. • Once duties have been defined, and whether a new or existing FTE will assume those duties, a process must be developed for tracking the activities of this team member for reporting, transparency, and quality improvement by July of 2026.	January 2026 – April 2026 – July 2026 –
		3 & 6 Month Follow Up
Correct Criterion #3a – The health center has a plan to identify and address behavioral health workforce shortages and burnout.	• BH Manager & Medical Director will define what burnout is and identify mitigation and planning tactics to minimize burnout. Cadence of review and first meeting will occur by July 2026. • BH Manager & Medical Director will regularly review staffing levels and patient demands and proactively plan access and service provision growth through new providers and operational efficiencies where, when, and how it is logistically possible.	January 2026 – April 2026 – July 2026 –
		3 & 6 Month Follow Up
Correct Criterion #4a – The health center provides soothing music, toys, and comfortable furniture.	• BH Manager & Medical Director will work with Business Office on budget needs for ambiance in patient areas, which items to purchase. • BH Manager will work with AA to place a purchase order and get materials in and activate or place all new supplies appropriately for the BH Center by April 2026.	January 2026 – April 2026 – July 2026 –
		3 & 6 Month Follow Up
Correct Criterion #4b – The health center counsels patients and their families about firearms and gun safety.	• BH Manager and Medical Director will work with the Safety Officer to post current SNHD policy compliant firearm and gun safety disclaimers in the BH waiting area by January 2026.	January 2026 – April 2026 – July 2026 –


Questions?

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AT THE SOUTHERN NEVADA HEALTH DISTRICT

VIII. CHIEF EXECUTIVE OFFICER & STAFF REPORTS

Randy Smith, MPA, Chief Executive Officer - FQHC

Administrative Updates

- HRSA Health Center Program funding update
- HRSA 340b Rebate Pilot Update
- NVHA/MCO Shadow Billing Update
- Patient Centered Medical Home (PCMH) Update

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AT THE SOUTHERN NEVADA HEALTH DISTRICT

Upcoming Board Activities

End of the Year Party

- **Date/Time**: December 16, 1-5 p.m.
- **Location**: Decatur in Red Rock Conf Room
- **Theme:** FQHC Winter Wonderland Party

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AT THE SOUTHERN NEVADA HEALTH DISTRICT