TAHOE FOREST HOSPITAL DISTRICT

2017-03-23 Regular Meeting of the Board of Directors

Thursday, March 23, 2017 at 4:00 pm

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2017-03-23 Regular Meeting of the Board of Directors

3/23/17 Agenda Packet Contents

ITEMS 19 - 24: See Agenda

25. ADJOURN

REGULAR MEETING OF THE BOARD OF DIRECTORS

AGENDA

Thursday, March 23, 2017 at 4:00 p.m.

Please note location change:
Eskridge Conference Room - Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT AUDIENCE**
   This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Clerk of the Board 24 hours prior to the meeting to allow for distribution.

5. **CLOSED SESSION**
   - **5.1. Liability Claims (Gov. Code §54956.95)**
     Claimant: Kelly Campbell, BETA file No.: 16-000132
     Claim Against: Tahoe Forest Hospital District
   - **5.2. Liability Claims (Gov. Code §54956.95)**
     Claimant: Robert Schapper
     Claim Against: Tahoe Forest Hospital District
   - **5.3. Hearing (Health & Safety Code § 32155**)
     Subject Matter: Corporate Compliance Report – Closed Session
     Number of items: One (1)
   - **5.4. TIMED ITEM – 5:30PM – Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: Medical Staff Credentials
   - **5.5. Approval of Closed Session Minutes**◈
     2/23/2017

6. **DINNER BREAK**
   APPROXIMATELY 6:00 P.M.

7. **OPEN SESSION – CALL TO ORDER**

8. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**

◈ Denotes Action Item

9. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

10. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

This is an opportunity for members of the Employee Associations to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes.

12. ACKNOWLEDGMENTS

12.1. March 2017 Employee of the Month ..... ATTACHMENT

13. MEDICAL STAFF REPORT ◈

13.1. Medical Staff Report ..... ATTACHMENT

14. CONSENT CALENDAR ◈

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

14.1. Approval of Minutes of Meetings

2/23/2017 ..... ATTACHMENT

14.2. Financial Report

14.2.1. Financial Report- January 2017 ..... ATTACHMENT

14.2.2. Financial Report- February 2017 ..... ATTACHMENT

14.3. Policies

14.3.1. ABD-10 Emergency On Call ..... ATTACHMENT

14.4. Staff Reports (Information Only)

14.4.1. CEO Board Report ..... ATTACHMENT

14.4.2. COO Board Report ..... ATTACHMENT

14.4.3. CNO Board Report ..... ATTACHMENT

14.4.4. CIO Board Report ..... ATTACHMENT

14.4.5. CMO Board Report ..... ATTACHMENT

15. ITEMS FOR BOARD ACTION ◈

15.1. Incline Village Community Hospital HVAC Bid ..... ATTACHMENT

The Board of Directors will review and consider for approval a bid to replace the HVAC system at Incline Village Community Hospital.

15.2. CEO Incentive Compensation and Performance Review Criteria ..... ATTACHMENT

The Board of Directors will consider for approval an incentive compensation and performance review criteria for the Chief Executive Officer.

16. ITEMS FOR BOARD DISCUSSION

16.1. Quality Presentation on Infection Prevention and Control ..... ATTACHMENT
The Board of Directors will receive a presentation on Infection Control from Laurel Holmer, Infection Preventionist.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

18.1. Quality Committee Meeting – 03/14/2017 ..... ATTACHMENT
18.2. Personnel Committee Meeting – 03/21/2017 ..... ATTACHMENT
18.3. Finance Committee Meeting – 03/21/2017 ..... ATTACHMENT
18.4. Community Benefit Committee Meeting – Meeting will be held on 03/27/2017.
18.5. Governance Committee Meeting – No meeting held in March.

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

20. ITEMS FOR NEXT MEETING

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

22. CLOSED SESSION CONTINUED, IF NECESSARY

23. OPEN SESSION

24. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

25. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is April 27, 2017 at 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

◈ Denotes Action Item

Employee of the Month, March 2017

Luz Martinez, Receptionist Front Office- MSC Peds

We are honored to announce Luz Martinez, Receptionist Front Office, MSC Peds as our March Employee of the Month. Luz has been a staple of the Peds office for 25 years. Many people know her by "Mama Luz." Patients love and appreciate her kindness and the pride she takes in her work. Luz does everything with a smile. You can even hear her smile with happiness when she talks on the phone. Luz loves interacting with patients, she takes the time to get to know them and most of all, always remembers what their needs are.

Luz demonstrates quality in her ability to problem solve and provides help to patients, Peds staff, and physicians. She is kind and understanding of each patient and their needs. Patients feel very special when they walk into the office and Luz greets them by their first name. She portrays excellence in her follow through of any questions and/or concerns. Luz puts everyone else first and supports others in her office.

Luz meets and exceeds the definition of the TFHS mission and values but most of all has been an asset to our hospital with her excellent patient care.

MEDICAL EXECUTIVE COMMITTEE
CONSENT AGENDA
Thursday, March 16, 2017

REFERRED BY:	AGENDA ITEMS	OVERHEAD/ ATTACHMENT	RECOMMEND
MEDICAL STAFF	**A motion was made, seconded, and carried to recommend approval of the following to the Board of Directors:**		
1. Executive Committee	The Executive Committee recommends approval of the following policies and procedures: ➢ Allied Health Professional's Guidelines (revised) The Executive Committee recommends adding a new board certification "Pediatric Nursing Certification Board" (PNCB) as an additional credentialing certification option for nurse practitioners seeking to work in pediatrics at a TFHD facility.		Recommend approval

TAHOE FOREST HOSPITAL DISTRICT

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

~~2015~~2017~~6~~

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND

STANDARDIZED PROCEDURES

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GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

1. PROTOCOL FOR CONSIDERATION OF ALLIED HEALTH PROFESSIONAL CATEGORIES

1.1 Policy

It is the policy of Tahoe Forest Hospital District ("the Hospital") to give appropriate consideration to the question of whether a given category of Allied Health Professionals should be permitted to practice on its premises in Allied Health Professional status. The question will be addressed with respect to a particular category if the Hospital receives a serious expression of interest from the Hospital Administration, a member of the Board of Directors, or a committee or member of the Medical Staff.

The decision whether to accept or reject an Allied Health Professional category will rest with the Board of Directors ("the Board"). To assist the Board in making its decision, the Hospital adopts the procedures in these Guidelines, which are designed to provide the Board with complete information about the relevant issues and to afford all interested persons an opportunity to make their views known. The procedures described herein are intended to serve as guidelines, and may be varied for good cause in a particular case.

1.2 Procedure

A. The Board or the Administration will refer the matter to the appropriate Hospital body for review and recommendation. This may be, for example, the Administration itself, a standing or ad hoc Medical Staff or Department Committee, or a standing or ad hoc Hospital Committee. The Medical Executive Committee, on its own initiative, may also consider whether a particular category should be accepted, and make a recommendation accordingly to the Administration and the Board.

B. The body chosen will investigate the matter, including soliciting the views of those most directly involved and those able to assist it with its inquiry. This may include, for example, members of the Allied Health Professional category under consideration, any Medical Staff members who might provide supervision, practitioners from related areas, other Hospital or Medical Staff personnel, representatives from licensing or certification agencies, representatives from professional associations, insurers, or members of the interested public.

C. On the basis of its review, the body will make a recommendation to the Board or the Administration, as appropriate, to be accompanied by a report describing the underlying reasons for the recommendation. If the Administration initiated the review, it may present the matter to the Board with its own report and recommendations.

D. The Board will review the recommendation(s) and report(s) and will decide whether to hold an open forum before rendering a decision on behalf of the Hospital.

(1) Any open forum shall be designed to permit the Board to receive comments directly from interested persons inside and outside the Hospital. Comments shall be submitted in writing unless the Board decides to hold an oral proceeding.

(2) If the Board decides to hold an oral proceeding, it will conduct the proceeding as a meeting, at which interested persons are permitted to address comments to the Board according to guidelines established by the Board.

(3) Notice of any open forum, whether or not an oral proceeding is involved, shall be posted in appropriate locations in the Hospital and shall be sent, insofar as is practical, to all persons who have demonstrated an interest in the matter. The notice shall describe the action being considered, the recommendation received by the Board, and the process for participating in the open forum. It shall include a copy of the report(s) received by the Board or shall state where a copy may be obtained.

E. When the Board is satisfied that it has received sufficient information, it shall render its final decision on the matter in the form of a resolution. The Board of Directors shall issue a concise statement of the reasons for its decision, and shall indicate how various comments, arguments, and points of view were considered in arriving at its decision.

2. GENERAL STANDARDS FOR ALLIED HEALTH PROFESSIONALS

2.1 In General

A. Applicability

Generally, these ~~standards~~ Guidelines apply to non-employee practitioners who are accorded Allied Health Professional status at the Hospital and who are under the jurisdiction of the Medical Staff. These ~~standards~~ Guidelines do not apply to practitioners who are employed by the Hospital, or who, although in Allied Health Professional status, have been placed by the Hospital and Medical Staff under the jurisdiction of Hospital Administration, with the exception of~~.~~ Section 7, which describes the application of these Guidelines to Hospital-employed Allied Health Professionals. In addition, the ~~standards~~ Guidelines pertaining to credentialing and review in Sections 2.2~~2C 2A – 2.2J 2K and 2.2N 2M – 2.2P~~ and 2.4 apply to all Allied Health Professionals, regardless of their employment status.

Commented [KMD2]: Note: section 7.1, below states that only 2.2C-J and N-P apply to employed AHPs, but this states 2.2A-K and M-P. Alternatively, it may be simply to just refer to section 2.2 as a whole, since the sections you seek to exclude already are qualified by the phrase "if required." Let's discuss this.

B. Terminology

Under these Guidelines, non-employed Allied Health Professionals ~~under the jurisdiction of the Medical Staff undergo "appointment" and "reappointment" to "AHP status," whereas employed Allied Health Professionals~~ undergo ~~a~~ "credentialing" and "recredentialing" as an

Allied Health Professional at the Hospital. ~~process under the Medical Staff and also as part of the procedures of the Human Resources Department~~.

2.2 Standards

In order to qualify for initial and ongoing Allied Health Professional status at the Hospital, an Allied Health Professional shall:

A. Belong to an Allied Health Professional category that has been admitted to practice at the Hospital by the Board of Directors. The categories which have been so admitted are listed in Exhibit A;

B. Meet one of the following requirements:

(1) Belong to an Allied Health Professional category that is not subject to any exclusive contract or panel arrangement with the Hospital; or

(2) Be accepted by the Hospital as part of any exclusive contract or panel arrangement that applies to the Allied Health Professional's category;

C. Possess any license or certificate required under the laws of California and/or Nevada, as applicable, for his or her category;

D. Possess and document the background, training, experience, judgment, ability, and physical and mental health necessary to demonstrate with sufficient adequacy that he or she is able to provide professional services as requested and authorized in accordance with generally recognized professional standards of quality and efficiency;

E. Provide at least one recent professional reference from a previous hospital, chief, or department chair;

~~E.~~F. Adhere strictly to generally recognized standards of professional ethics;

~~F.~~G. Be capable of working cooperatively with others in furtherance of high quality patient care and efficient hospital operations;

~~G.~~H. Perform services for patients at the Hospital in conjunction with the Medical Staff member responsible for the patient's care;

~~H.~~I. Comply with all Hospital, Medical Staff and department bylaws, rules and regulations, and protocols, to the extent applicable to the Allied Health Professional;

~~I.~~J. Comply with the duties described in Section 11.2 of these Guidelines

~~J.~~K. Be willing to participate in the discharge of administrative responsibilities as reasonably determined by the Medical Staff and the Allied Health Professional's department;

Commented [KMD3]: If goal is to have same credentialing standards for all AHPs, regardless of employment status, does it still make sense to have different terminology for employed AHPs? Why not just call it "credentialed/recredentialed" for both types? AHPs are not "appointed" in the true sense.

Commented [KMD4]: This is required by HFAP standards 05.01.13, 05.01.16, and 05.03.01, which together require AHPs to be privileged through the same process as medical staff members, require at least one letter of reference, and have certain requirements for the letter of reference in the case of temporary privileges (these are included here so that privileging requirements are consistent for initial and temporary privileges).

~~K.~~L. Maintain professional liability insurance with a suitable insurer, with the minimum limits as determined by the Medical Executive Committee and the Board;

~~L.~~M. Pay a non-refundable application fee, if required;

~~M.~~N. Pay annual dues and assessments, if required;

~~N.~~O. Meet any specific requirements established by the applicable department, the Medical Executive Committee or the Board for his or her category of Allied Health Professional, including any specific requirements established for his or her category that is set forth in the attached Exhibits hereto;

~~O.~~P. Meet the conditions of any applicable contract with the Hospital; and

~~P.~~Q. Not be excluded from participation in any federally funded health care program, including Medicare or Medi-Cal.

2.3 Exception

From time to time, the Chief of the Medical Staff and the Hospital Administrator may jointly decide to approve clinical privilege(s) for specific individuals who do not meet one or more of the requirements described in Sections 2.2A and 2.2B above.

A. Any such privilege(s) shall be requested in writing by a member of the Medical Staff who will assume supervisory responsibility for the Allied Health Professional.

B. The writing requesting approval shall contain a statement of the facts and circumstances justifying each exception requested.

C. Except as otherwise expressly stated in the approval, all of the standards and requirements set forth in this Section 2 shall apply.

2.4 LEAVE OF ABSENCE

At the discretion of the medical executive committee, an allied health professional~~s~~ may request a leave of absence, for a period not to exceed a year, by submitting a written request to the ~~chairman of the~~ medical executive committee. Requests for leaves of absence that are made by allied health professionals shall be processed in the same manner as requests made by medical staff members, in accordance with the medical staff

bylaws. There shall be no right to a leave of absence; nor shall there be any procedural rights associated with failure to obtain approval for a requested leave.

Commented [KMD5]: These changes match the leave of absence provision in the medical staff bylaws.

3. PROTOCOL FOR NON-EMPLOYED ALLIED HEALTH PROFESSIONAL ~~APPOINTMENT~~ CREDENTIALING AND REVIEW

3.1 Terms of Allied Health Professional Status

A. All non-employed Allied Health Professionals shall receive annual skills/competence assessments and shall ~~have~~ be credentialed ~~two-year appointment~~ (pursuant to Section 3.2) and recredentialed~~reappointment~~ (pursuant to Section 3.3) terms.

3.2 ~~Appointment~~ Credentialing Procedures

A. Every Allied Health Professional seeking ~~appointment to~~credentialing as an Allied Health Professional ~~status~~ at the Hospital shall make an application on a prescribed form. Failure to complete the application shall preclude consideration of it. An applicant who fails to respond adequately to any request for further information during the review process will be deemed not to have completed the application.

B. The Hospital will request from the Medical Board of California or other appropriate board, if any, verification of current licensure status of the applicant. The National Practitioner Data Bank ("NPDB") shall be queried.

C. The application and all supporting materials shall be forwarded to the responsible department chair or designee. The department chair or designee shall review the application and all supporting material, may arrange for a personal interview of the applicant, and shall make a recommendation concerning Allied Health Professional status, "clinical privileges" (specified services that may be performed),and any special conditions to be attached.

D. The department chair or designee shall forward his or her recommendation to the ~~chairman of the~~ Interdisciplinary Practice Committee chair or designee, along with any supporting documentation. The ~~chairman of the~~ Interdisciplinary Practice Committee chair or designee shall review all pertinent information, may arrange for a personal interview of the applicant, and shall formulate ~~its~~ his or her recommendation on the application.

Commented [KMD6]: Change to match language relating to department "chair or designee."

E. The chairman of the Interdisciplinary Practice Committee shall forward ~~its~~ his or her recommendation to the Medical Executive Committee, along with any supporting documentation. The Medical Executive Committee shall review all pertinent information and shall formulate its recommendation to the Board of Directors.

F. If its recommendation is adverse to the Allied Health Professional, the Medical Executive Committee shall immediately inform the Allied Health Professional and shall hold the decision~~it~~ in abeyance until the Allied Health Professional has exercised or waived his or her right to review set forth in Section 4.2 below. If the Allied Health Professional exercises his or her right to review, the Hospital and the Allied Health Professional shall follow the prescribed procedure. If the Allied Health Professional waives his or her right to review, the Medical Executive Committee shall forward its recommendation to the Board of Directors for a final decision.

G. If its recommendation is favorable to the Allied Health Professional, the Medical Executive Committee shall forward it, together with any supporting documentation, to the Board for its ultimate decision. Provided, however, if the Board is disposed to deny the Allied Health Professional's application, it shall arrange, prior to rendering its final decision, for a review in which the Allied Health Professional participates, under procedures determined by it.

3.3 ~~Reappointment~~ Recredentialing Procedures

A. At least ninety (~~90~~120) days prior to the expiration of current Allied Health Professional status, the Allied Health Professional shall receive an application for ~~reappointment~~ recredentialing on a prescribed form. The Allied Health Professional shall complete the form, including a request for the renewal or modification of clinical privileges. Failure to complete and return the form in a timely manner may result in termination of Allied Health Professional status, including clinical privileges, as of the date of expiration.

B. The procedures for evaluation of an application for ~~reappointment~~ recredentialing ~~or re-credentialing~~ shall be identical to those set forth in Section 3.2 above for an application for initial credentialing ~~appointment~~. ~~or credentialing for employment~~.

~~. If the consideration of an application for reappointment that was submitted in a timely fashion has not been completed by the time that Allied Health Professional status expires, the Allied Health Professional may be reappointed with renewed clinical privileges on a short-term basis, for good cause, until a final decision has been made.~~

~~3.5~~3.4 Procedure for Requesting Additional Clinical Privileges

A. An Allied Health Professional may request additional clinical privilege(s) at any time by filing a written request, together with supporting documentation.

B. The procedures for evaluation of a request for additional clinical privilege(s) shall be identical to those set forth in Section 3.2above for

Commented [KMD7]: Change to match medical staff bylaws

Commented [KMD8]: Note medical staff bylaws state "4 months prior"; if goal is to match medical staff bylaws, may want to change this, as well.

~~appointment~~ credentialing as an~~to~~ Allied Health Professional ~~status~~at the Hospital.

~~3.6~~3.5 Temporary Clinical Privilege(s)

~~A.~~ A. The Hospital Administrator and the Chief of the Medical Staff, after consultation with the department chair and any supervising physician, may grant an Allied Health Professional temporary clinical privilege(s) if he or she meets the applicable requirements under ~~5.4-1 of the Medical Staff Bylaws~~ section 2.2 of these Guidelines~~presents satisfactory evidence of any required licensure or certification, malpractice insurance coverage, and sufficient additional information concerning the ability to exercise the clinical privilege(s) requested. The Hospital will query the NPDB before such privileges are granted.~~

~~B.~~A. Temporary clinical privilege(s) may be granted in any of the following circumstances following receipt of a complete application for Allied Health Professional status:

(1) ~~Temporary clinical privilege(s) may be granted upon preliminary review of a complete application for initial appointment to Allied Health Professional status,~~ During the pendency of review and consideration of a preliminary application for Allied Health Professional status, but only after completion of the processes set forth in Sections 3.2(A)-(D) of these Guidelines, to last for one or more specified periods or for as long as the application is pending, but not to exceed ~~90~~120 ~~days~~;

(2) ~~Temporary clinical privilege(s) may be granted, upon receipt and review of the form normally used for an application for Allied Health Professional status, for~~ For the care of patients as locum tenens ~~for a specified Allied Health Professional~~ at the Hospital, for a designated period that may not exceed ~~three (3) months~~ ~~90~~120 days ~~at any single time~~

(3) To assist with care of a specific patient for a designated period that may not exceed ~~90~~120 days.

(4) In times of emergency and/or disaster for a designated period that may not exceed ~~90~~120 days.

~~(2)~~

~~C.~~B. An Allied Health Professional who is granted temporary clinical privilege(s) shall be subject to observation under ~~procedures established by the appropriate department~~ Section 6. of these Guidelines.

~~D.~~C. The Hospital Administrator or the Chief of the Medical Staff may, at any time, suspend or terminate an Allied Health Professional's temporary clinical privilege(s).

Commented [KMD9]: This is required by HFAP standard 05.01.16

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~~E.~~D. An Allied Health Professional shall not be entitled to any of the review rights set forth in these Guidelines in the event that a request for temporary clinical privilege(s) is denied or in the event that temporary clinical privilege(s) are suspended or terminated, except as required by law.

4. CORRECTIVE ACTION AND HEARING RIGHTS

4.1 Corrective Action

A. A department chair, the ~~c~~Chair~~man~~ of the Interdisciplinary Practice Committee, the Chief of the Medical Staff, the Hospital Administrator, or the Board may make a request to the Medical Executive Committee for an investigation or corrective action whenever an Allied Health Professional engages in conduct that is perceived to be harmful to patient safety, detrimental to the delivery of quality patient care, in violation of applicable rules, policies, or these Guidelines, or disruptive of Hospital operations. The request shall be in writing and shall be supported by reference to the conduct or activities at issue.

B. The Medical Executive Committee may appoint an ad hoc committee to carry out an investigation. Any such ad hoc committee shall proceed in a prompt manner with the investigation, which may include an informal meeting with the Allied Health Professional. At the conclusion of its investigation, the ad hoc committee shall forward a report, together with any recommendation for corrective action, to the Medical Executive Committee.

C. The Medical Executive Committee shall consider the report and recommendation of any ad hoc committee and shall make its own recommendation concerning any corrective action.

D. In the event that the Medical Executive Committee recommends suspension or termination of Allied Health Professional status or reduction in clinical privilege(s), the Allied Health Professional shall be entitled to a review under Section 4.2. If the Allied Health Professional waives his or her right to a review, the matter shall be forwarded, together with the supporting materials, to the Board for a final decision.

E. In the event that immediate action is deemed necessary in the interests of patient care or hospital operations, any person or administrative body entitled to request an investigation or corrective action under Section 4.1~~.~~ ~~A~~above may restrict or suspend an Allied Health Professional's status or clinical privilege(s) immediately. The Allied Health Professional then shall have the right to meet informally as soon as practicable with the Medical Executive Committee, which shall have the authority to continue, modify, or terminate the restriction or suspension. In the event that the restriction or suspension is not lifted the Allied Health Professional shall

have the right to obtain review under Section 4.2below. The restriction or suspension shall remain in effect pending any such review.

F. The Allied Health Professional's status and clinical privileges shall be subject to automatic suspension, restriction, revocation, or other action as follows:

(1) If the Allied Health Professional's state license or other legal credential authorizing practice, certificate from the U.S. Drug Enforcement Agency ("DEA"), or provider status in a government-funded program is suspended, restricted, placed on probation, or revoked, his or her status and clinical privileges shall automatically be affected in the same manner.

(2) If an Allied Health Professional fails to comply with the Hospital's requirements for timely and adequate completion of medical records, his or her privileges may be automatically suspended pending resolution of the problem.

(3) If there is a lapse in the Allied Health Professional's maintenance of professional liability insurance as required by the Hospital, his or her privileges shall be automatically suspended until the requisite coverage is reinstated and documented.

(4) For Allied Health Professionals acting under the supervision of another practitioner, any lapse in the supervising practitioner's willingness or ability to provide such supervision shall result automatically in the suspension of the Allied Health Professional's privileges. This includes, without limitation, termination of the supervising practitioner's medical staff membership or suspension of the applicable privileges, whether such termination or suspension is voluntary or involuntary. Where the Allied Health Professional's privileges are automatically suspended for the reasons specified in this ~~§~~ Section 4.1.F(4), the Allied Health Professional may apply for reinstatement as soon as approved supervision is reinstated, which might necessitate the Allied Health Professional's procurement of another supervising practitioner in good standing who agrees to supervise the Allied Health Professional and receives the necessary privileges or approval to do so.

4.2 Review

A. An Allied Health Professional shall be given the opportunity to have any of the following actions or recommended actions reviewed, according to the procedures described below, before it becomes final and effective (except for a summary restriction which shall be effective immediately):

(1) Denial of an application for ~~appointment or reappointment~~credentialing or recredentialing as an ~~to~~ Allied Health Professional ~~status~~ for quality of care reasons;

(2) Denial of a request for initial or additional clinical privileges (except temporary clinical privileges) for quality of care reasons;

(3) Reduction or suspension for more than 30 days or termination of existing clinical privileges (except temporary clinical privilege(s) for quality of care reasons; or

(4) Suspension for more than 30 days or termination of Allied Health Professional status for quality of care reasons.

B. Notwithstanding Section 4.2.A above, an Allied Health Professional shall have no right to obtain review in any of the following instances:

(1) When an application is denied or not acted upon because it is incomplete;

(2) When an application is denied or not acted upon because the Allied Health Professional is not from a category that the Hospital has accepted for practice on its premises;

(3) When an application is denied or not acted upon, or Allied Health Professional status or clinical privilege(s) is revoked because of the existence of an employment, contractual, panel, or other relationship between the Hospital and one or more other Allied Health Professionals in the affected category which provides for exclusivity or limits the number of Allied Health Professionals in that category who may practice at the Hospital;

(4) When an application is denied or Allied Health Professional status or clinical privilege(s) is revoked because the physician who has agreed or is required by law or Medical Staff policy to act as the Allied Health Professional's supervising physician has given up or been deprived of that status or no longer holds the requisite Medical Staff membership or clinical privileges;

(5) When temporary clinical privileges are denied, suspended, restricted, or revoked under Section 3.5 above; or

(6) When clinical privileges are suspended, restricted, or revoked because of a lapse in licensure, a lapse in insurance, a lapse in DEA registration, a lapse of provider status in a government-funded health program, a lapse of supervision, medical record delinquencies, or other administrative reasons.

Where there is no right to review under the procedures described herein, the Allied Health Professional may be afforded an opportunity to address

the relevant factual issues informally before a final adverse decision is made.

C. The Allied Health Professional shall be notified of his or her right to obtain review as soon as practicable after the Medical Executive Committee has decided to make or recommend an adverse recommendation as described in Section 4.2.A. Notice shall be deemed given when deposited in the United States mail in a properly stamped envelope, certified or registered mail, return receipt requested, or when personally delivered to the Allied Health Professional.

D. To obtain review, the Allied Health Professional shall submit a written request to the Hospital Administrator. Such request must be received within fourteen (14) days of receipt of the notice to the Allied Health Professional. In the event that the Allied Health Professional does not request review in this manner, he or she shall be deemed to have waived any review rights. The matter then shall be forwarded to the Board for a final decision.

E. Review shall be in the form of a meeting with a panel, to be selected in accordance with Section F below. Within a reasonable time in advance of the meeting, the Hospital Administrator shall give the Allied Health Professional written notice of the time and date of the meeting and a written summary of the reasons for the recommendation or action. If appropriate, this summary shall include references to representative patient care situations or to relevant events.

F. The meeting shall be with an ad hoc panel consisting of at least three (3) persons appointed by the Medical Executive Committee. The Medical Executive Committee shall ensure that panel members have not participated earlier in the formal consideration of the case. The Medical Executive Committee shall designate one (1) member of the panel as its chairperson and may include an Allied Health Professional from the appropriate category as a panel member.

G. The panel shall set guidelines to assure that the meeting is held in an orderly manner and that the Allied Health Professional has a reasonable opportunity to challenge the recommendation or action and to respond to the reasons given for it. The guidelines shall allow for the following:

(1) A presentation by a representative of the Medical Executive Committee, in the presence of the Allied Health Professional, of the recommendation or action and the underlying reasons and supporting evidence, together with any additional information that the panel deems necessary.

(2) A presentation by the Allied Health Professional, which may include both an oral and a written statement, together with any other oral or documentary information pertaining to the issues.

(3) The presence of a practitioner who may accompany and represent the Allied Health Professional at the meeting. If possible, this practitioner shall be a member of the Medical Staff or in Allied Health Professional status at the Hospital. The panel in its discretion may permit the Allied Health Professional and the Medical Executive Committee to be accompanied or represented by legal counsel at the meeting. The panel itself may choose to be advised by legal counsel or attorney hearing officer without regard to whether the parties are represented by counsel. The panel shall arrange for any such counsel through the Hospital Administrator.

(4) A record of the meeting to be maintained by the panel in the form of minutes or a tape recording, or through use of a Certified Shorthand Reporter. If a record is maintained by means of a tape recording or a Certified Shorthand Reporter, any party requesting a transcript or copy thereof will bear the cost of its preparation.

H. The panel shall affirm the recommendation or action of the Medical Executive Committee, unless the Allied Health Professional demonstrates, by a preponderance of the evidence~~,~~ that it is arbitrary or unreasonable in light of the evidence presented at the meeting.

I. Following the meeting, the panel shall deliberate and shall issue a written decision and report. A copy of the decision and report shall be provided to the Allied Health Professional, the ~~President~~ Chief of the Medical Staff, and the Board of Directors.

J. The Board of Directors shall consider the decision and report of the panel. In its discretion, the Board of Directors may allow the Medical Executive Committee and the Allied Health Professional to submit written statements to it commenting on the decision and report. The Board of Directors then shall make the final decision on the matter, in accordance with its own procedures.

4.3 Exceptions for Licentiates as Defined by Section 805 of the California Business and Professions Code

If the Allied Health Professional is a "Licentiate" as defined by Section 805 of the California Business and Professions Code (including a clinical psychologist and a physician assistant), and the action or recommendation would be reportable to the state licensing authorities under that statute, the Allied Health Professional shall be afforded the procedural rights described in the Medical Staff Bylaws relating to Medical Staff members.

5. FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the medical executive committee, to pay dues or assessments shall be grounds for automatic suspension of an allied health professional's ~~member's~~ clinical privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the allied health professional ~~member~~ is

given notice of delinquency and warned of the automatic suspension. If the ~~member~~ allied health professional still has not paid the required dues or assessments within six (6) months after such notice of delinquency, the ~~member's membership~~allied health professional's status and clinical privileges shall be automatically terminated.

~~5.~~6.OBSERVATION

~~5.1~~6.1 An Allied Health Professional who is initially granted clinical privilege(s) shall automatically be subject to a period of observation, to extend for a minimum of six (6) months or twelve (12) cases, whichever is longer. The observation period shall last a maximum of eighteen (18) months or for such longer time as the department chair may specify, subject to Medical Executive Committee approval. The Allied Health Professional shall not be entitled to a review under Section 4.2of the decision to continue or extend observation. In the event that the department chair has not approved the full exercise of a particular clinical privilege within the established observation period, that clinical privilege shall cease, and the Allied Health Professional shall be entitled to review, upon request, pursuant to Section 4.2above. Provided, however, if the department chair has not given his or her approval due to the failure of the Allied Health Professional to perform a sufficient volume of work at the Hospital to facilitate an adequate evaluation within the time allotted, the Allied Health Professional will be deemed to have forfeited the clinical privilege in question, and shall have no right to review.

~~5.2~~6.2 The Medical Executive Committee, Chair ~~man~~ of the Interdisciplinary Practice Committee, appropriate department chair, Chief of the Medical Staff, or Board of Directors shall have authority at any time to require that an Allied Health Professional be subject to a period of observation to last as long as deemed appropriate, and shall have the authority to adopt any rules or procedures considered necessary to implement this requirement. Such observation requirement does not give rise to the review under Section 4.2, unless the rules or procedures adopted for the observation requirement have the effect of a suspension or reduction of privileges, as specified in Section 4.2A(3).

~~5.3~~6.3 Observation may consist of the methods customarily used at hospitals, including concurrent or retrospective chart review, proctoring, or the requirement of consultation. The observation methods shall be consistent with the Hospital's Ongoing Professional Performance Evaluations (OPPE) standards and Focused Professional Practice Evaluation (FPPE) standards, as adapted to the scope of practice and privileges of the Allied Health Professional.

~~5.4~~6.4 The observer shall be a practitioner on the Medical Staff or in Allied Health Professional status who exercises clinical privileges relevant to the activity being evaluated and who has previously satisfied their observation requirements. ~~Alternatively, the observer may be an outside practitioner with the necessary knowledge and experience.~~ Whenever possible, the observer should not be the sponsoring or supervising practitioner of the Allied Health Professional being observed.

~~6.~~7. ALLIED HEALTH PROFESSIONALS EMPLOYED BY THE HOSPITAL

As noted in Section 2.1A, these Guidelines apply to practitioners accorded Allied Health Professional status and who are under the jurisdiction of the Medical Staff. In addition, Hospital-employed Allied Health Professionals must be credentialed pursuant to certain procedures in these Guidelines. This Section 7 describes in full the application of these Guidelines to Hospital-employed Allied Health Professionals. Except as otherwise specified, the rights, responsibilities, and prerogatives of Hospital-employed Allied Health Professionals shall be governed by the policies and procedures of the Hospital's Human Resources Department, and not by these Guidelines.

~~6.1~~7.1 General Standards for Employed Allied Health Professionals

In addition to any standards required by the Human Resources Department, an Allied Health Professional applying for employment with the Hospital shall satisfy the standards described in Sections ~~2.2.2.2C2.2C - 2.2J2.2J and 2.2N 2.2N - 2.2P2.2P~~.

~~6.2~~7.2 Terms of Allied Health Professional Credentialing and Recredentialing

All Hospital-employed Allied Health Professionals shall receive annual skills/competence assessments and shall have two-year credentialing and recredentialing terms. This term shall not affect the evaluation or performance review cycle applicable to the employed Allied Health Professionals under Human Resources Department policies and procedures, which may be more frequent than every two (2) years.

~~6.3~~7.3 Credentialing Procedures

For every Allied Health Professional seeking employment with the Hospital, the procedures described in Sections 3.2A through ~~3.2D~~ 3.2E ~~3.2D~~ shall be followed for credentialing of the applicant.

~~Instead of Sections3.2E through 3.2G, the following procedure shall be followed after the Interdisciplinary Practice Committee formulates its recommendation on the application:~~

~~B. The Interdisciplinary Practice Committee shall forward its recommendation to the Medical Executive Committee, along with any supporting documentation.~~

~~C. The Medical Executive Committee shall review all pertinent information and shall formulate its recommendation to the Hospital's Human Resources Department.The recommendation must be presented to the Board of Directors with a written recommendation from the appropriate administrative representative for purposes of employment.~~

~~D.~~A. The applicant has no right of review under Sections 3.2F and 4.2. A right of review, if any, would be pursuant to the policies and procedures of the Hospital's Human Resources Department.

~~6.4~~7.4 Recredentialing Procedures

For recredentialing of the employed Allied Health Professional upon the expiration of the current credentialing term, the procedures described in Sections 3.3, as modified by Section 7.3, above,~~3.3A~~ **~~1.1A~~** shall be followed., ~~except as follows:~~

~~**With respect to Section 3.3A, the implications of the failure of an employed Allied Health Professionalto complete and return the form in a timely manner shall be determined in accordance with the policies and procedures of the Hospital's Human Resources Department.**~~

~~**With respect to Section 3.3B, the proceduresfor evaluating an application for recredentialing shall be identical to those described in Section 3.2, as modified by Section 6.3 above.**~~

~~6.7~~7.5 Procedure for Requesting Additional Clinical Privileges

An Allied Health Professional employed by the Hospital may request additional clinical privileges pursuant to Section 3.4, as modified by Section 7.3~~6.3~~ above.

Commented [KMD10]: This language seems like it should stay, since the employed AHP does not have the right to review—which is what 7.3 clarifies.

~~6.8~~7.6 Temporary Clinical Privilege(s)

Pursuant to Section 3.5, the Hospital Administrator and Chief of the Medical Staff may grant temporary clinical privilege(s) to an Allied Health Professional who has applied for employment at the Hospital and completed the application form and processes set forth in Sections 3.2(A)-(D) of these Guidelines.~~required by Section 3.2A~~.

~~6.9~~7.7 Disciplinary or Corrective Action

~~Whenever a practitioner is excluded from any federal health care program, the practitioner's clinical privileges shall be automatically suspended as of the effective date of such exclusion. Unless the board of directors determines, upon recommendation of the medical executive committee, that the practitioner may still effectively practice at the hospital under such exclusion without creating unacceptable risk of penalty to the hospital or other medical staff members, unacceptable risk of disruption to hospital operations, or unacceptable publicity, the practitioner's clinical privileges and staff membership shall be terminated.~~

Hospital-employed Allied Health Professionals are subject to disciplinary or corrective action pursuant to the policies and procedures of the Hospital's Human Resources Department, and not pursuant to Section 4 of these Guidelines, with the exception of "Licentiates," as defined by Section 805 of the California Business and Professions Code (including a clinical psychologist and a physician assistant), and as set forth in Section 4.3 and 7~~8~~.7 above.

However, if the Hospital-employed Allied Health Professional's state license or other legal credential authorizing practice, certificate from the U.S. Drug Enforcement Agency ("DEA"), or provider status in a government-funded program is suspended, restricted, placed on probation, or revoked, his or her status and clinical privileges shall automatically be affected in the same manner.

Commented [KMD11]: This matches language for non-employed AHPs in 4.1(F)(1), above.

~~6.10~~7.8Duties

In addition to any duties required by the Human Resources Department, Hospital-employed Allied Health Professionals shall be expected upon commencement of employment to satisfy the duties described in Section11.2.

7.9 Observation

For every Hospital-employed Allied Health Professional who is initially granted clinical privilege(s), the procedures described in Section 6, above, shall be followed for observation of the Allied Health Professional.

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Commented [KMD12]: HFAP standard 05.04.02 explanation requires observation and training when any AHP is initially affiliated with hospital.

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~~7.~~8. CONTRACT ALLIED HEALTH PROFESSIONALS

~~7.1~~8.1 The Board may determine that the interests of patient care or hospital operations are best served by entering into a contract with an entity which provides Allied Health Professionals to work within the Hospital. These Allied Health Professionals are neither employees nor independent contractors of the Hospital, nor are they independent professionals working in their own private practice. Rather, they are employees or independent contractors of an entity that has agreed to provide certain health services to the Hospital's patients. For purposes of these Guidelines, these persons shall be referred to as "Contract AHPs," and the entity employing or contracting with them shall be referred to as the "Contracting Entity."

~~7.2~~8.2 ~~Ordinarily, Contract AHPs must complete the full Allied Health Professionalcredentialing process described in Section 3prior to being permitted to render patient care within the Hospital. However, the Contracting Entity may be responsible for credentialing the Contract AHPs pursuant to the terms of the contract with the Hospital. In those cases, unless the AHPs involved are "Licensed Independent Practitioners" (defined as individuals permitted by law and the Hospital to provide care, treatment and services without direction or supervision), formal credentialing as described in these Guidelines will be waived for Contract AHPs whom the Contracting Entity warrants to be adequately qualified to perform the patient care activities described in the contract.~~ Contract AHPs, including Licensed Independent Practitioners (defined as individuals permitted by law and the Hospital to provide care, treatment and services without direction or supervision), must be credentialed individually as described in Section 3 of these Guidelines.

~~7.3 Whether the Contracting Entity is responsible for credentialing the ContractAHPs will be determined by the Administration and shall be made a part of the written contract between the Hospital and the Contracting Entity. If the Contracting Entity will credential Contract AHPs, the following shall apply:~~

~~. The Contracting Entity shall provide a written description of the activities to be performed by the Contract AHPs. This description may be contained~~

~~in the contract itself or in a separate job description subject to approval by the Administration.~~

~~. The Hospital Administrator may consult with the appropriate Medical Staff department and/or the Interdisciplinary Practice Committee regarding the job descriptions or contract provisions describing the activities of the Contract AHPs in order to determine completeness, accuracy, and appropriateness.~~

~~. The Contracting Entity shall evaluate each Allied Health Professional using standards comparable to those set forth in Section 2.2 at the time the Contract AHP is first associated with the Contracting Entity and then periodically (at least every two years) thereafter, based on actual performance. The Contracting Entity shall certify, in writing, that this condition is met for all of its Contract AHPs. Subject to this certification, Contract AHPs will not be required to submit applications for Allied Health Professional appointment or credentialing under Section 3.~~

~~7.7 Where the contract does not provide for delegated credentialing, eEach Contract AHP shall be subject to all of the credentialing procedures of these Guidelines.~~

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~~7.8~~8.3 Unless otherwise provided in the contract, the Administration may suspend or terminate an individual Contract AHP at any time for any lawful reason.

~~8.~~9. FORMAT FOR STANDARDIZED PROCEDURES

~~8.1~~9.1 Standardized procedures are appropriate for certain areas of registered nursing that overlap with areas traditionally reserved exclusively to physicians. With the assistance of nurses and physicians, the Interdisciplinary Practice Committee will identify particular medical functions, performed by nurses~~,~~ that are suitable for standardized procedures and will oversee the creation of individual standardized procedures for them.

~~8.2~~9.2 In order to be approved by the Interdisciplinary Practice Committee, a standardized procedure must be in writing and must contain the elements set forth below:

A. The standardized procedure must define the medical function, performed by nurses~~,~~ that it covers.

B. The standardized procedure must specify the functions that the registered nurses are authorized to perform and under what circumstances, including the following:

(1) Any specific requirements or steps for performing all or part of the functions covered by the standardized procedure;

(2) The setting or department in which the registered nurse may act;

(3) Any special record keeping requirements; and

(4) The nature and scope of supervision that the registered nurse must receive in performing the standardized procedure, (including any circumstances in which the registered nurse will be expected to communicate immediately with a physician).

C. The standardized procedure must include the following mechanisms for ensuring that only registered nurses with proper qualifications perform the function:

(1) A statement of the education, training, and experience that a registered nurse must have in order to perform the function;

(2) A system for evaluating, both initially and periodically afterwards, the competency of registered nurses to perform the function; and

(3) A mechanism for maintaining a list of the registered nurses at the Hospital who are authorized to perform the function.

D. The standardized procedure must contain the following information concerning its development and review:

(1) A schedule for periodic review and updating; and

(2) The date or dates on which the standardized procedure was approved, including approval by the Interdisciplinary Committee.

~~9.~~10. STANDARDS OF PRACTICE

Standards of practice for categories of Allied Health Professionals admitted by the Hospital to Allied Health Professional status are attached as Exhibits to these Guidelines.

~~10.~~11. MISCELLANEOUS

~~10.1~~11.1 Voting Privileges and Committee Meetings

Allied Health Professionals shall not be entitled to vote on Medical Staff matters, except as expressly provided in the Medical Staff Bylaws, Rules and Regulations, and only to the extent consistent with their license and expertise, as determined by the chair of the responsible Medical Staff committee. When authorized by the Medical Staff, they may be invited to attend and participate actively in the clinical meetings of their respective departments or services.

~~10.2~~11.2 Duties

All Allied Health Professionals shall satisfy all of the following duties, as applicable.

Upon ~~appointment~~credentialing, Allied Health Professionals shall be expected to:

A. Comply with these Guidelines, and with all other applicable rules of the Hospital and its Medical Staff, and with all applicable laws and standards.

B. Actively participate in the Hospital's and the Medical Staff's quality assessment program, peer review activities, and other quality evaluation and monitoring activities, as directed by appropriate representatives of the Hospital or the Medical Staff.

C. Promptly notify the Medical Staff Office and, if the Allied Health Professional is a Physician Assistant or Advanced Practice Registered Nurse employed by the Hospital, the Hospital's Human Resources Department, of an action by the Medical Executive Committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct.

D. Exercise independent judgment within their areas of competence, provided that a physician who is a member in good standing of the Medical Staff shall retain the ultimate responsibility for the patient's care.

E. Participate directly in the management of patients to the extent authorized by their license, certificate or other legal credentials.

F. Write and/or record such orders, reports and progress notes on patients' charts as are consistent with the rules and regulations of the Medical Staff.

G. Perform consultation on request as authorized by the Medical Staff.

~~10.3~~11.3 Billing

Allied Health Professionals shall bill independently only as permitted by applicable statutes or regulations.

~~10.4~~11.4 Confidential

Allied Health Professionals shall at all times respect the confidentiality of any and all information concerning patients treated at the Hospital and the confidentiality of all Medical Staff records and proceedings regarding peer review and credentialing activities.

~~10.5~~11.5 Informed Consent

In conjunction with the responsible physician, the Allied Health Professional may obtain the informed consent of the patient or the patient's representative for any care, treatment, or procedure to be performed by the Allied Health Professional. The discussion with the patient shall include explanation of the fact, if applicable, that the Allied Health Professional is not a Hospital employee, but rather practices independently under the supervision of the responsible physician. The responsible physician or Allied Health Professional shall ensure that there is written documentation that informed consent was obtained.

Date of Interdisciplinary Practice Committee Approval: 9/9/2015; 10/12/16

Date of Medical Executive Committee Approval: 10/21/2015; 02/16/2017

Date of Board of Directors Approval: 10/29/2015;

EXHIBIT A

ADMITTED CATEGORIES OF ALLIED HEALTH PROFESSIONALS

1. Clinical Psychologists
2. Advanced Nurse Practitioners
3. Physician Assistants
4. Dental Assistants
5. Audiologists
6. Acupuncturists

REGULAR MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, February 23, 2017 at 4:00 p.m.
Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 4:01 p.m.

2. ROLL CALL
Board: Charles Zipkin, M.D., Board President; Gregory Jellinek, M.D., Vice President; Dale Chamblin, Treasurer; Randy Hill, Secretary; Alyce Wong, R.N., Board Member

Staff: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Stephanie Hanson, Compliance Analyst; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel; Jim Hook, The Fox Group

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT AUDIENCE
No public comment was received.

5. CLOSED SESSION
Discussion was held on privileged items.

6. DINNER BREAK
APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:04 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel stated there was no reportable action on items 5.1.-5.5. and 5.7.
Items 5.6. and 5.8. were approved on a 5-0 vote.

9. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

10. INPUT – AUDIENCE
No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS
No public comment was received.

12. ACKNOWLEDGMENTS

12.1. January 2017 Employee of the Month was Payton Davis.
12.2. February 2017 Employee of the Month was Mona Fasesky.
12.3. Jake Dorst, TFHD Chief Information Officer, was named Becker's Top CIO's to Know.

13. MEDICAL STAFF REPORT

13.1. Medical Staff Report

As part of Item 13.1., sub item 1. Allied Health Professional Guidelines will be removed.

Discussion was held.
No public comment was received.

ACTION: **Motion made by Director Zipkin, seconded by Director Chamblin, to approve the Medical Staff Report excluding the Allied Health Professional Guidelines.**
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

14. CONSENT CALENDAR

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

14.1. Approval of Minutes of Meetings
1/26/2017
14.2. Financial Report
14.2.1. Financial Report- January 2017
14.3. Contracts
14.3.1. Jacob Blake, MD – Professional Services Agreement
14.3.2. UC Davis Health System Cancer Center Network Participation and License Agreement
14.4. Staff Reports (Information Only)
14.4.1. CEO Board Report
14.4.2. COO Board Report
14.4.3. CNO Board Report
14.4.4. CIO Board Report
14.4.5. CMO Board Report

Item 14.2.1. will be removed from the agenda entirely and presented at a later date.

Director Zipkin pulled item 14.3.2. for discussion.

ACTION: **Motion made by Director Jellinek, seconded by Director Chamblin, to accept the Consent Calendar as presented excluding Item 14.2.1. Financial Report – January 2017 and Item 14.3.2. UC Davis Health System Cancer Center Network Participation and License Agreement.**
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None

Abstention: None

15. ITEMS FOR BOARD ACTION

15.1. Corporate Compliance Program 2016 4th Quarter and Annual Report

Discussion was held.

15.2. 2017 Corporate Compliance Work Plan

Discussion was held.

ACTION: **Motion made by Director Zipkin, seconded by Director Jellinek, to approve the 2017 Corporate Compliance Work Plan as presented.**
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

15.3. CEO Incentive Compensation and Performance Review Criteria

Discussion was held.

ACTION: **Motion made by Director Jellinek, seconded by Director Zipkin, to create an Ad Hoc committee consisting of Directors Hill and Chamblin to consider CEO Incentive Compensation and Performance Review Criteria and return with a recommendation at the March Board Meeting.**
Discussion was held.
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

16. ITEMS FOR BOARD DISCUSSION

16.1. Risk Management Update

Discussion was held.

No public comment was received.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Discussion was held on item 14.3.2.

Public comment was received from Stephanie Hanson.

ACTION: **Motion made by Director Zipkin, seconded by Director Jellinek, to accept Item 14.3.2. from the Consent Calendar as presented.**
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

18. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

18.1. Governance Committee Meeting – 02/15/2017

Director Jellinek provided an update from the recent Governance Committee meeting.

18.2. Personnel Committee Meeting – 02/23/2017

Director Wong provided an update from the recent Personnel Committee meeting.

18.3. Finance Committee Meeting – 02/23/2017

Director Chamblin provided an update from the recent Finance Committee meeting.

18.4. Community Benefit Committee Meeting – No meeting held in February.

18.5. Quality Committee Meeting – No meeting held in February.

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

Board President suggested Governance Committee review ABD-21 at their next meeting.

20. ITEMS FOR NEXT MEETING

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

22. CLOSED SESSION CONTINUED, IF NECESSARY

None.

23. OPEN SESSION

24. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

None.

25. MEETING EFFECTIVENESS ASSESSMENT

No discussion was held.

26. ADJOURN

Meeting adjourned at 7:26 p.m.

TAHOE FORREST HOSPITAL DISTRICT
JANUARY 2017 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

JANUARY 2017 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2017.

Activity Statistics

- TFH acute patient days were 439 for the current month compared to budget of 390. This equates to an average daily census of 14.17 compared to budget of 12.58.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Surgical cases, Diagnostic Imaging, and Nuclear Medicine.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Home Health visits, Endoscopy procedures, Mammography, Oncology procedures, MRI exams, PET CT, Respiratory Therapy, Physical Therapy, and Speech Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 57.2% in the current month compared to budget of 54.2% and to last month's 59.8%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 54.5%, compared to budget of 54.1% and prior year's 58.4%.
- EBIDA was $1,106,443 (5.4%) for the current month compared to budget of $1,096,945 (5.2%), or $9,498 (.2%) above budget.
- Cash Collections for the current month were $9,970,122 which is 97% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 56.8, compared to the prior month of 54.9. Gross Accounts Receivables are $35,074,946 compared to the prior month of $33,331,180. The percent of Gross Accounts Receivable over 120 days old is 23.28%, compared to the prior month of 24.29%.

Balance Sheet

- Working Capital Days Cash on Hand is 27.5 days. S&P Days Cash on Hand is 185.3. Working Capital cash increased $4,635,000. Cash collections fell short of target by 3%, Accrued Payroll & Related Liabilities increased $497,000, the District received its first installment of property tax revenues in the amount of $3,378,000 and a tentative settlement of $172,000 on it FY16 Medicare Cost Report.
- Net Patients Accounts Receivable decreased approximately $334,000. Cash collections were at 97% of target and days in accounts receivable were 56.8 days, a 1.90 days increase.
- The District received its first installment of property tax revenues from Nevada and Placer counties in the amount of $3,378,000, decreasing Other Receivables.
- GO Bond Receivables decreased a net $2,208,000 after recording the January receipt of property tax revenues.
- Accrued Payroll & Related Liabilities increased $497,000 due to additional payroll days accrued at the close of January.
- The District remitted interest payments due on the G.O. Bond Series A, B, and C, decreasing Interest Payable GO Bond.

January 2017 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $20,666,813, compared to budget of $21,198,908 or $532,095 below budget.
- Current month's Gross Inpatient Revenue was $6,680,149, compared to budget of $6,365,249 or $314,900 above budget.
- Current month's Gross Outpatient Revenue was $13,986,664 compared to budget of $14,833,659 or $846,995 below budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 30.7% Medicare, 19.8% Medi-Cal, .0% County, 1.6% Other, and 47.9% Insurance compared to budget of 34.4% Medicare, 17.4% Medi-Cal, .0% County, 3.8% Other, and 44.4% Insurance. Last month's mix was 30.1% Medicare, 15.3% Medi-Cal, .0% County, 5.8% Other, and 48.8% Insurance.
- Current month's Deductions from Revenue were $8,850,709 compared to budget of $9,715,998 or $865,290 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 3.70% decrease in Medicare, a 2.49% increase to Medi-Cal, a .0% decrease in County, a 2.23% decrease in Other, and Commercial was over budget 3.45%, 2) Revenues fell short of budget by 2.50% and 2) AR Days over 90 and 120 decreased.

Operating Expenses

DESCRIPTION	January 2017 Actual	January 2017 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,824,671	3,992,417	167,746	
Employee Benefits	1,475,647	1,329,197	(146,450)	
Benefits – Workers Compensation	63,245	57,011	(6,233)	
Benefits – Medical Insurance	730,232	694,217	(36,015)	
Professional Fees	1,813,855	1,751,608	(62,247)	We saw negative variances in Emergency Department and Hospitalist coverage, Physical and Occupational Therapies fees, professional services provided to TIRHR and the Medi-Cal PRIME program, and consulting services and project management for Administration. These negative variances were offset, in part, by positive variances in Corporate Compliance legal fees, and Multi-Specialty Clinic Physician fees due to the Tahoe Forest Women's Center not joining the MSC structure as budgeted.
Supplies	1,526,320	1,726,312	199,992	Oncology Drugs Sold to Patients revenue fell short of budget by 7.72% creating a positive variance in Pharmacy Supplies.
Purchased Services	1,192,495	897,306	(295,189)	Snow removal and laundry & linen services, department repairs for Engineering, Mammography, Cat Scan, and surgery, and network SmartNet maintenance fees created a negative variance in Purchased Services..
Other Expenses	630,404	614,024	(16,381)	Travel costs related to onsite EPIC discovery meetings and Management leadership training courses created a negative variance in Other Expenses.
Total Expenses	11,256,868	11,062,091	(194,777)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2017

	Jan-17	Dec-16	Jan-16	
ASSETS				
CURRENT ASSETS				
* CASH	$ 9,773,963	$ 5,138,475	$ 8,589,595	1
PATIENT ACCOUNTS RECEIVABLE - NET	18,824,530	19,158,542	18,253,564	2
OTHER RECEIVABLES	3,970,555	6,899,637	3,860,562	3
GO BOND RECEIVABLES	(691,230)	1,516,503	(515,640)	4
ASSETS LIMITED OR RESTRICTED	5,918,679	7,306,256	4,942,148	
INVENTORIES	2,715,736	2,706,664	2,300,041	
PREPAID EXPENSES & DEPOSITS	2,007,760	1,903,775	1,630,575	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,715,425	3,855,247	6,222,208	
TOTAL CURRENT ASSETS	46,235,418	48,485,098	45,283,053	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	56,137,411	56,042,742	45,834,718	1
BANC OF AMERICA MUNICIPAL LEASE	981,619	981,619	979,155	
TOTAL BOND TRUSTEE 2002	3	3	2	
TOTAL BOND TRUSTEE 2015	1,029,359	893,627	606,921	
GO BOND PROJECT FUND	232,266	232,394	5,533,945	
GO BOND TAX REVENUE FUND	2,102,452	1,366,886	1,380,035	
DIAGNOSTIC IMAGING FUND	3,174	3,168	2,976	
DONOR RESTRICTED FUND	1,144,350	1,142,590	1,141,630	
WORKERS COMPENSATION FUND	51,573	17,575	4,090	
TOTAL	61,682,207	60,680,605	55,463,472	
LESS CURRENT PORTION	(5,918,679)	(7,306,256)	(4,942,148)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	55,763,528	53,374,349	50,521,324	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(53,723)	(53,723)	223,258	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	131,358,966	131,483,072	128,080,074	
GO BOND CIP, PROPERTY & EQUIPMENT NET	32,468,754	32,384,674	27,372,282	
TOTAL ASSETS	266,609,296	266,509,823	252,316,344	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	520,412	523,645	559,201	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,612,281	1,612,281	1,880,317	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	6,386,067	6,409,772	1,962,857	
GO BOND DEFERRED FINANCING COSTS	500,975	502,909	304,360	
DEFERRED FINANCING COSTS	204,935	205,975	217,418	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 9,224,670	$ 9,254,582	$ 4,924,153	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,364,268	$ 6,289,425	$ 4,645,468	
ACCRUED PAYROLL & RELATED COSTS	8,622,008	8,125,051	7,075,002	5
INTEREST PAYABLE	525,762	574,158	89,486	
INTEREST PAYABLE GO BOND	28,851	1,577,459	(12,163)	6
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	232,645	200,496	366,356	
HEALTH INSURANCE PLAN	1,307,731	1,307,731	1,307,731	
WORKERS COMPENSATION PLAN	1,120,980	1,120,980	404,807	
COMPREHENSIVE LIABILITY INSURANCE PLAN	751,298	751,298	824,203	
CURRENT MATURITIES OF GO BOND DEBT	1,260,000	1,260,000	530,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,953,186	1,953,186	2,323,994	
TOTAL CURRENT LIABILITIES	22,166,728	23,159,783	17,554,884	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	28,137,883	28,243,199	30,116,631	
GO BOND DEBT NET OF CURRENT MATURITIES	103,409,288	103,422,709	100,013,205	
DERIVATIVE INSTRUMENT LIABILITY	1,612,281	1,612,281	1,880,317	
TOTAL LIABILITIES	155,326,180	156,437,972	149,565,037	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	119,363,435	118,183,843	106,533,830	
RESTRICTED	1,144,350	1,142,590	1,141,630	
TOTAL NET POSITION	$ 120,507,785	$ 119,326,433	$ 107,675,460	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2017

1. Working Capital is at 27.5 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 185.3 days. Working Capital cash increased a net $4,635,000. Cash collections fell short of target by 3%, Accrued Payroll & Related Costs (See Note 5) increased $497,000, the District received its first installment of property tax revenues (See Note 3) in the amount of $3,378,000 and tentative settlement of $172,000 on its FY16 Medicare Cost Report.

2. Net Patient Accounts Receivable decreased approximately $334,000. Cash collections were 97% of target. Days in Accounts Receivable are at 56.8 days compared to prior months 54.9 days, a 1.90 days increase.

3. The District received $3,378,000 on its first installment of Property Tax Revenues, decreasing Other Receivables.

4. GO Bond Receivables decreased a net $2,208,000 after recording the January receipt of Property Tax Revenues.

5. Accrued Payroll & Related Liabilities increased $497,000 due to additional payroll days accrued at the close of January.

6. The District remitted interest payments due on the G.O. Bond Series A, B, and C, decreasing Interest Payable GO Bond.

Tahoe Forest Hospital District
Cash Investment
January 2017

WORKING CAPITAL				
US Bank	$ 9,472,358			
US Bank/Kings Beach Thrift Store	60,780			
US Bank/Truckee Thrift Store	177,617			
US Bank/Payroll Clearing	63,208			
Local Agency Investment Fund	-	0.75%		
Total			$	9,773,963
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	56,137,411	0.75%		
Local Agency Investment Fund			$	56,137,411
Banc of America Muni Lease			$	981,619
Bonds Cash 2002			$	3
Bonds Cash 2015			$	1,029,359
Bonds Cash 2008			$	2,334,718
DX Imaging Education	$ 3,174	0.75%		
Workers Comp Fund - B of A	51,573			
Insurance				
Health Insurance LAIF	-	0.75%		
Comprehensive Liability Insurance LAIF	-	0.75%		
Total			$	54,747
TOTAL FUNDS			$	70,311,820
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,363	0.03%		
Foundation Restricted Donations	$ 98,331			
Local Agency Investment Fund	1,037,656	0.75%		
TOTAL RESTRICTED FUNDS			$	1,144,350
TOTAL ALL FUNDS			$	71,456,170

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2017

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD JAN 2016
					OPERATING REVENUE						
$ 20,666,813	$ 21,198,908	$ (532,095)	-2.5%		Total Gross Revenue	$ 147,753,646	$ 140,066,651	$ 7,686,995	5.5%	1	$ 127,991,760
					Gross Revenues - Inpatient						
$ 2,055,848	$ 1,899,190	$ 156,658	8.2%		Daily Hospital Service	$ 14,091,411	$ 12,584,180	$ 1,507,231	12.0%		$ 11,828,746
4,624,301	4,466,058	158,243	3.5%		Ancillary Service - Inpatient	28,597,932	26,935,671	1,662,261	6.2%		25,255,620
6,680,149	6,365,249	314,900	4.9%		Total Gross Revenue - Inpatient	42,689,342	39,519,851	3,169,491	8.0%	1	37,084,366
13,986,664	14,833,659	(846,995)	-5.7%		Gross Revenue - Outpatient	105,064,304	100,546,800	4,517,504	4.5%		90,907,394
13,986,664	14,833,659	(846,995)	-5.7%		Total Gross Revenue - Outpatient	105,064,304	100,546,800	4,517,504	4.5%	1	90,907,394
					Deductions from Revenue:						
8,270,374	8,658,672	388,299	4.5%		Contractual Allowances	63,326,043	57,342,790	(5,983,254)	-10.4%	2	50,722,335
644,329	742,088	97,759	13.2%		Charity Care	4,393,521	4,905,544	512,024	10.4%	2	3,808,431
2,987	-	(2,987)	0.0%		Charity Care - Catastrophic Events	28,947	-	(28,947)	0.0%	2	394,072
(110,588)	315,237	425,825	135.1%		Bad Debt	(626,238)	2,100,629	2,726,867	129.8%	2	(577,708)
43,606	-	(43,606)	0.0%		Prior Period Settlements	179,377	-	(179,377)	0.0%	2	(1,133,224)
8,850,709	9,715,998	865,290	8.9%		Total Deductions from Revenue	67,301,651	64,348,963	(2,952,688)	-4.6%		53,213,906
35,147	56,103	(20,956)	-37.4%		Property Tax Revenue- Wellness Neighborhood	382,064	392,853	(10,789)	-2.7%		440,700
512,060	620,023	(107,963)	-17.4%		Other Operating Revenue	5,568,024	5,009,505	558,519	11.1%	3	4,874,027
12,363,311	12,159,036	204,276	1.7%		TOTAL OPERATING REVENUE	86,402,083	81,120,046	5,282,037	6.5%		80,092,581
					OPERATING EXPENSES						
3,824,671	3,992,417	167,746	4.2%		Salaries and Wages	26,889,392	27,019,837	130,444	0.5%	4	25,100,699
1,475,647	1,329,197	(146,450)	-11.0%		Benefits	9,113,330	8,534,815	(578,515)	-6.8%	4	8,813,191
63,245	57,011	(6,233)	-10.9%		Benefits Workers Compensation	386,848	399,078	12,231	3.1%	4	377,827
730,232	694,217	(36,015)	-5.2%		Benefits Medical Insurance	4,356,169	4,859,518	503,349	10.4%	4	4,286,768
1,813,855	1,751,608	(62,247)	-3.6%		Professional Fees	12,690,994	12,526,697	(164,297)	-1.3%	5	10,680,392
1,526,320	1,726,312	199,992	11.6%		Supplies	11,429,707	11,968,053	538,346	4.5%	6	10,273,900
1,192,495	897,306	(295,189)	-32.9%		Purchased Services	7,006,518	6,269,794	(736,724)	-11.8%	7	6,306,766
630,404	614,024	(16,381)	-2.7%		Other	3,892,437	4,095,498	203,060	5.0%	8	3,482,446
11,256,868	11,062,091	(194,777)	-1.8%		TOTAL OPERATING EXPENSE	75,765,395	75,673,291	(92,105)	-0.1%		69,321,989
1,106,443	**1,096,945**	**9,498**	**0.9%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**10,636,688**	**5,446,755**	**5,189,932**	**95.3%**		**10,770,592**
					NON-OPERATING REVENUE/(EXPENSE)						
499,722	450,397	49,325	11.0%		District and County Taxes	3,191,805	3,152,647	39,158	1.2%	9	2,752,098
391,933	391,933	-	0.0%		District and County Taxes - GO Bond	2,743,533	2,743,533	-	0.0%		2,751,231
52,088	38,503	13,585	35.3%		Interest Income	329,452	236,044	93,408	39.6%	10	194,046
2	-	2	0.0%		Interest Income-GO Bond	352	-	352	0.0%		15,723
60,822	38,917	21,906	56.3%		Donations	286,622	272,417	14,205	5.2%	11	232,013
-	-	-	0.0%		Gain/ (Loss) on Joint Investment	(97,095)	(62,500)	(34,595)	-55.4%	12	(101,137)
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(494,421)	(966,316)	471,895	48.8%		Depreciation	(6,298,559)	(6,764,213)	465,654	6.9%	15	(5,962,126)
(101,832)	(98,873)	(2,958)	-3.0%		Interest Expense	(712,017)	(696,334)	(15,683)	-2.3%	16	(843,796)
(327,710)	(315,492)	(12,219)	-3.9%		Interest Expense-GO Bond	(1,098,274)	(1,249,768)	151,494	12.1%		(1,529,450)
80,605	(460,931)	541,536	117.5%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(1,654,180)	(2,368,174)	713,994	30.1%		(2,491,398)
$ 1,187,047	**$ 636,013**	**$ 551,034**	**86.6%**		**INCREASE (DECREASE) IN NET POSITION**	**$ 8,982,507**	**$ 3,078,581**	**$ 5,903,926**	**191.8%**		**$ 8,279,194**
					NET POSITION - BEGINNING OF YEAR	**111,525,278**					
					NET POSITION - AS OF JANUARY 31, 2017	**$ 120,507,785**					
5.4%	**5.2%**	**0.2%**			**RETURN ON GROSS REVENUE EBIDA**	**7.2%**	**3.9%**	**3.3%**			**8.4%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2017

		Variance from Budget Fav / <Unfav> JAN 2017	Variance from Budget Fav / <Unfav> YTD 2017
1) Gross Revenues			
Acute Patient Days were above budget 12.56% or 49 days. Swing Bed days were below budget 73.91% or 17 days. Inpatient Ancillary revenues exceeded budget by 3.50% due to the increase in our acute patient days.	Gross Revenue – Inpatient	$ 314,900	$ 3,169,835
	Gross Revenue – Outpatient	(846,995)	4,517,160
	Gross Revenue – Total	$ (532,095)	$ 7,686,995
Outpatient volumes were below budget in the following departments: Emergency Department visits, Home Health visits, Endoscopy procedures, Mammography exams, Oncology procedures, MRI exams, PET CTs, Respiratory Therapy, Physical Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for January shows a 3.70% decrease to Medicare, a 2.49% increase to Medi-Cal, 2.23% decrease to Other, County at budget, and a 3.45% increase to Commercial when compared to budget. Contractual Allowances were under budget due to the shift in payor mix from Medicare and Self Pay to Commercial and Medi-Cal, a decrease to AR Days over 90 and 120 Days old, and Outpatient Revenues falling short of budget by 5.70%.	Contractual Allowances	$ 388,299	$ (5,983,254)
	Charity Care	97,759	512,024
	Charity Care - Catastrophic	(2,987)	(28,947)
	Bad Debt	425,825	2,726,867
	Prior Period Settlements	(43,606)	(179,377)
	Total	$ 865,290	$ (2,952,688)
3) Other Operating Revenue			
Retail Pharmacy revenues fell short of budget by 32.04%.	Retail Pharmacy	$ (83,113)	$ (33,454)
	Hospice Thrift Stores	(25,897)	(16,985)
	The Center (non-therapy)	(6,941)	11,255
Excessive snow fall during the month aided in a negative variance in the Hospice Thrift Stores revenues.	IVCH ER Physician Guarantee	1,543	54,942
	Children's Center	(3,043)	(5,425)
	Miscellaneous	9,488	548,186
	Oncology Drug Replacement	-	-
	Grants	-	-
	Total	$ (107,963)	$ 558,519
4) Salaries and Wages	Total	$ 167,746	$ 130,444
Employee Benefits			
Negative variance in PL/SL related to department closures due to heavy snow fall and planned vacations. This created a positive variance in Salaries and Wages.	PL/SL	$ (125,177)	$ (360,392)
	Nonproductive	(15,245)	(127,295)
	Pension/Deferred Comp	(2,258)	(3,289)
	Standby	5,316	114,458
	Other	(9,086)	(201,998)
	Total	$ (146,450)	$ (578,515)
Employee Benefits - Workers Compensation	Total	$ (6,233)	$ 12,231
Employee Benefits - Medical Insurance	Total	$ (36,015)	$ 503,349
5) Professional Fees			
Negative variance in TFH Locums related to Hospitalist and Emergency Department coverage.	TFH Locums	$ (63,677)	$ (298,370)
	The Center (includes OP Therapy)	(71,163)	(166,204)
	Information Technology	(14,721)	(149,527)
	Miscellaneous	(70,541)	(146,820)
Negative variance in The Center (includes OP Therapy) related to contract true-up of services provided in prior months for Physical and Occupational Therapies.	Administration	(26,145)	(77,731)
	Multi-Specialty Clinics Admin	427	(65,238)
	Oncology	(9,459)	(13,673)
Legal and Professional fees provided to TIRHR, consulting services for the Medi-Cal PRIME program, and IVCH Health Clinic physician fees created a negative variance in Miscellaneous.	IVCH ER Physicians	(1,249)	(7,876)
	Human Resources	(13,734)	(2,221)
	Respiratory Therapy	(0)	(1)
	Patient Accounting/Admitting	-	-
Consulting services provided for Ambulatory Surgery strategy, Executive Retreat preparation, project management, and contract oversight created a negative variance in Adminstration.	Business Performance	-	-
	Home Health/Hospice	50	471
	Medical Staff Services	4,913	5,381
	Managed Care	180	14,436
Pension and benefits consulting created a negative variance in Human Resources.	Marketing	2,375	16,625
	Sleep Clinic	2,278	18,635
Positive variance in Multi-Specialty Clinics related to Tahoe Forest Women's Center physician fees and a reduction in General Surgery physician fees.	Financial Administration	5,719	28,060
	TFH/IVCH Therapy Services	23,605	86,408
	Corporate Compliance	26,301	194,758
	Multi-Specialty Clinics	142,593	398,591
	Total	$ (62,247)	$ (164,297)
6) Supplies			
Surgery revenues exceeded budget by 4.39%, creating a negative variance in Patient & Other Medical Supplies.	Minor Equipment	$ 4,023	$ (48,218)
	Food	3,097	(15,769)
	Imaging Film	(438)	1,979
	Other Non-Medical Supplies	9,198	9,225
Oncology Drugs Sold to Patients revenue fell short of budget by 7.72%, creating a positive variance in Pharmacy Supplies.	Office Supplies	(777)	42,085
	Patient & Other Medical Supplies	(31,663)	176,511
	Pharmacy Supplies	216,551	372,533
	Total	$ 199,992	$ 538,346

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2017

		Variance from Budget Fav / <Unfav> JAN 2017	Variance from Budget Fav / <Unfav> YTD 2017
7) Purchased Services	Miscellaneous	$ (264,965)	$ (703,068)
Snow removal services exceeded budget by 439.38% as a result of the excessive snow and blizzard in January, creating a negative variance in Miscellaneous. We also saw over budget variances in Laundry & Linen services and purchased services provided to Engineering.	Hospice	1,890	(55,400)
	Department Repairs	(17,153)	(48,093)
	Laboratory	5,392	(20,933)
	Pharmacy IP	(1,461)	(11,846)
	Diagnostic Imaging Services - All	(871)	(11,045)
Negative variance in Department repairs related to Engineering, Mammography, CT Scan, and Surgery.	The Center	(2,214)	(6,293)
	Medical Records	7,642	3,986
	Community Development	2,700	6,369
Network SmartNet maintenance created a negative variance in Information Technology.	Multi-Specialty Clinics	230	8,678
	Information Technology	(40,385)	10,579
	Patient Accounting	5,722	35,353
	Human Resources	8,284	54,989
	Total	$ (295,189)	$ (736,724)
8) Other Expenses	Outside Training & Travel	$ (29,680)	$ (70,092)
Onsight discovery meetings for the EPIC conversion and Management leadership courses created a negative variance in Outside Training & Travel.	Equipment Rent	(9,365)	(25,165)
	Human Resources Recruitment	(2,517)	(14,847)
	Insurance	(1,378)	(12,062)
Negative variance in Equipment Rent related to special equipment needs for surgical procedures.	Utilities	(2,048)	(2,392)
	Innovation Fund	-	-
	Physician Services	9	65
Program production highlighting the Legacy of Gene Upshaw created a negative variance in Marketing.	Multi-Specialty Clinics Equip Rent	417	4,177
	Other Building Rent	(1,170)	6,438
	Multi-Specialty Clinics Bldg Rent	10,849	29,348
	Marketing	(14,127)	44,360
	Dues and Subscriptions	12,038	78,792
	Miscellaneous	20,592	164,439
	Total	$ (16,381)	$ 203,060
9) District and County Taxes	Total	$ 49,325	$ 39,158
10) Interest Income	Total	$ 13,585	$ 93,408
11) Donations	IVCH	$ -	$ 22,117
	Operational	21,906	(7,912)
	Capital Campaign	-	-
	Total	21,906	14,205
12) Gain/(Loss) on Joint Investment	Total	$ -	$ (34,595)
13) Gain/(Loss) on Sale	Total	$ -	$ -
15) Depreciation Expense	Total	$ 471,895	$ 465,654
Depreciation was trued up for the first six months of FY17, creating a positive variance in Depreciation Expense.			
16) Interest Expense	Total	$ (2,958)	$ (15,683)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2017

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD JAN 2016
					OPERATING REVENUE						
$ 1,684,703	$ 1,544,625	$ 140,078	9.1%		Total Gross Revenue	$ 11,442,892	$ 10,972,396	$ 470,496	4.3%	1	$ 10,291,982
					Gross Revenues - Inpatient						
$ -	$ 2,914	$ (2,914)	-100.0%		Daily Hospital Service	$ 29,332	$ 17,484	$ 11,848	67.8%		$ 19,427
-	3,695	(3,695)	-100.0%		Ancillary Service - Inpatient	42,710	23,973	18,737	78.2%		24,665
-	6,609	(6,609)	-100.0%		Total Gross Revenue - Inpatient	72,042	41,457	30,584	73.8%	1	44,092
1,684,703	1,538,016	146,687	9.5%		Gross Revenue - Outpatient	11,370,851	10,930,939	439,912	4.0%		10,247,890
1,684,703	1,538,016	146,687	9.5%		Total Gross Revenue - Outpatient	11,370,851	10,930,939	439,912	4.0%	1	10,247,890
					Deductions from Revenue:						
498,238	500,038	1,800	0.4%		Contractual Allowances	4,160,485	3,560,907	(599,578)	-16.8%	2	3,197,947
56,890	58,119	1,229	2.1%		Charity Care	392,048	413,064	21,017	5.1%	2	343,765
2,987	-	(2,987)	0.0%		Charity Care - Catastrophic Events	28,947	-	(28,947)	0.0%	2	-
127,531	55,801	(71,731)	-128.5%		Bad Debt	327,546	396,585	69,039	17.4%	2	409,291
-	-	-	0.0%		Prior Period Settlements	(22,833)	-	22,833	0.0%	2	(150,715)
685,647	613,958	(71,689)	-11.7%		Total Deductions from Revenue	4,886,194	4,370,557	(515,637)	-11.8%	2	3,800,288
73,229	73,280	(51)	-0.1%		Other Operating Revenue	571,687	516,708	54,979	10.6%	3	583,230
1,072,284	1,003,946	68,339	6.8%		TOTAL OPERATING REVENUE	7,128,386	7,118,547	9,839	0.1%		7,074,924
					OPERATING EXPENSES						
267,742	278,137	10,396	3.7%		Salaries and Wages	1,825,315	2,000,902	175,586	8.8%	4	1,772,900
100,113	99,158	(955)	-1.0%		Benefits	703,462	690,533	(12,930)	-1.9%	4	534,041
1,965	1,417	(548)	-38.7%		Benefits Workers Compensation	14,166	9,917	(4,249)	-42.8%	4	16,191
45,457	44,618	(839)	-1.9%		Benefits Medical Insurance	281,187	312,329	31,142	10.0%	4	276,165
243,003	232,357	(10,646)	-4.6%		Professional Fees	1,704,703	1,674,380	(30,323)	-1.8%	5	1,639,686
47,347	82,327	34,979	42.5%		Supplies	474,609	592,998	118,389	20.0%	6	506,509
57,140	44,399	(12,741)	-28.7%		Purchased Services	311,060	308,546	(2,514)	-0.8%	7	288,166
63,747	60,482	(3,265)	-5.4%		Other	381,806	380,545	(1,261)	-0.3%	8	402,212
826,513	842,895	16,382	1.9%		TOTAL OPERATING EXPENSE	5,696,308	5,970,149	273,841	4.6%		5,435,870
245,771	**161,051**	**84,720**	**52.6%**		**NET OPERATING REV(EXP) EBIDA**	**1,432,078**	**1,148,398**	**283,680**	**24.7%**		**1,639,054**
					NON-OPERATING REVENUE/(EXPENSE)						
-	-	-	0.0%		Donations-IVCH	22,117	-	22,117	0.0%	9	35,626
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(9,668)	(64,277)	54,609	-85.0%		Depreciation	(395,327)	(449,936)	54,609	-12.1%	11	(382,585)
(9,668)	(64,277)	54,609	85.0%		TOTAL NON-OPERATING REVENUE/(EXP)	(373,211)	(449,936)	76,725	17.1%		(346,959)
$ 236,103	**$ 96,775**	**$ 139,329**	**144.0%**		**EXCESS REVENUE(EXPENSE)**	**$ 1,058,867**	**$ 698,462**	**$ 360,405**	**51.6%**		**$ 1,292,095**
14.6%	**10.4%**	**4.2%**			**RETURN ON GROSS REVENUE EBIDA**	**12.5%**	**10.5%**	**2.0%**			**15.9%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2017

		Variance from Budget Fav<Unfav> JAN 2017	YTD 2017
1) Gross Revenues			
Acute Patient Days were above below by 1 at 0 and Observation Days were at budget at 1.	Gross Revenue -- Inpatient	$ (6,609)	$ 30,584
	Gross Revenue -- Outpatient	146,687	439,912
		$ 140,078	$ 470,496
Outpatient volumes exceeded budget in Emergency Department visits, Laboratory tests, Diagnostic Imaging, Cat Scans, Pharmacy units, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a .24% decrease in Commercial Insurance, a 3.32% increase in Medicare, a 1.50% decrease in Medicaid, a 1.57% decrease in Other, and County was at budget.	Contractual Allowances	$ 1,800	$ (599,578)
	Charity Care	1,229	21,017
	Charity Care-Catastrophic Event	(2,987)	(28,947)
	Bad Debt	(71,731)	69,039
	Prior Period Settlement		22,833
	Total	$ (71,689)	$ (515,637)
3) Other Operating Revenue			
	IVCH ER Physician Guarantee	$ 1,543	$ 54,942
	Miscellaneous	(1,594)	37
	Total	$ (51)	$ 54,979
4) Salaries and Wages	Total	$ 10,396	$ 175,586
Employee Benefits	PL/SL	$ 1,857	$ 7,680
	Standby	(3,525)	7,946
	Other	615	(4,967)
	Nonproductive	(100)	(26,065)
	Pension/Deferred Comp	198	2,476
	Total	$ (955)	$ (12,930)
Employee Benefits - Workers Compensation	Total	$ (548)	$ (4,249)
Employee Benefits - Medical Insurance	Total	$ (839)	$ 31,142
5) Professional Fees	Miscellaneous	$ (13,754)	$ (61,819)
IVCH Health Clinic professional fees exceeded budget, creating a negative variance in Miscellaneous.	Administration	80	(9,997)
	IVCH ER Physicians	(1,249)	(7,876)
	Foundation	(60)	(2,218)
	Multi-Specialty Clinics	933	1,813
	Sleep Clinic	2,278	18,635
	Therapy Services	1,125	31,141
	Total	$ (10,646)	$ (30,323)
6) Supplies	Food	$ (166)	$ (7,150)
Oncology Drugs Sold to Patients revenues were below budget by 100%, creating a positive variance in Pharmacy Supplies.	Office Supplies	(693)	(4,983)
	Imaging Film	216	786
	Non-Medical Supplies	(504)	2,256
	Minor Equipment	1,883	3,068
	Pharmacy Supplies	22,846	52,733
	Patient & Other Medical Supplies	11,397	71,679
	Total	$ 34,979	$ 118,389

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2017

		Variance from Budget Fav<Unfav>	
		JAN 2017	YTD 2017
7) Purchased Services	EVS/Laundry	$ (3,184)	$ (16,061)
Negative variance in Engineering/Plant/Communications related to snow removal.	Engineering/Plant/Communications	(13,969)	(11,007)
	Department Repairs	(4,510)	(5,658)
	Diagnostic Imaging Services - All	(1,324)	(2,019)
Maintenance agreements on surgical equipment created a negative variance in Department repairs.	Multi-Specialty Clinics	124	(388)
	Surgical Services	-	-
	Pharmacy	307	247
	Foundation	1,302	983
	Miscellaneous	2,083	10,808
	Laboratory	6,430	20,581
	Total	$ (12,741)	$ (2,514)
8) Other Expenses	Insurance	$ (1,872)	$ (13,127)
Memberships with Nevada Rural Hospital Association and dues paid to Healthie Nevada created a negative variance in Dues and Subscriptions.	Marketing	(1,596)	(8,809)
	Dues and Subscriptions	(3,370)	(7,694)
	Equipment Rent	20	(3,209)
	Physician Services	-	-
	Multi-Specialty Clinics Equip Rent	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Other Building Rent	-	-
	Outside Training & Travel	(15)	590
	Utilities	303	6,973
	Miscellaneous	3,265	24,016
	Total	$ (3,265)	$ (1,261)
9) Donations	Total	$ -	$ 22,117
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ 54,609	$ 54,609
Depreciation was trued up for the first six months of the fiscal year, creating a positive variance in Depreciation Expense.			

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2016		BUDGET FYE 2017		PROJECTED FYE 2017	ACTUAL JAN 2017	BUDGET JAN 2017	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 16,129,087		$ 8,354,249		$ 13,382,022	1,106,443	$ 1,096,945	9,498	$ 4,905,089	$ 4,482,756	$ 3,062,129	$ 932,048
Interest Income	163,091		249,285		323,104	96,447	60,097	36,350	70,617	85,905	96,447	70,136
Property Tax Revenue	6,120,208		5,682,000		6,091,781	3,378,468	3,020,000	358,468	345,312	94,001	3,378,468	2,274,000
Donations	668,318		1,023,000		1,152,870	129,160	125,000	4,160	211,916	53,794	409,160	478,000
Debt Service Payments	(3,441,272)		(3,568,341)		(3,527,864)	(380,686)	(405,698)	25,012	(1,217,943)	(720,763)	(864,075)	(725,083)
Bank of America - 2012 Muni Lease	(1,243,650)		(1,243,644)		(1,243,647)	(103,637)	(103,637)	(0)	(310,912)	(310,912)	(310,911)	(310,911)
Copier	(8,758)		(11,520)		(11,300)	(959)	(960)	1	(2,885)	(2,656)	(2,879)	(2,880)
2002 Revenue Bond	(483,555)		(668,008)		(637,310)	(140,358)	(164,004)	23,646	(496,951)	-	(140,358)	-
2015 Revenue Bond	(1,705,309)		(1,645,169)		(1,635,608)	(135,732)	(137,097)	1,366	(407,195)	(407,195)	(409,926)	(411,292)
Physician Recruitment	(263,769)		(120,000)		-	-	-	-	-	-	-	-
Investment in Capital											-	
Equipment	(1,495,214)		(1,262,750)		(1,262,750)	(75,752)	(319,660)	243,908	(452,617)	(419,544)	(390,589)	-
Municipal Lease Reimbursement	1,319,139		979,000		979,000	-	-	-	-	-	-	979,000
GO Bond Project Personal Property	(432,135)		(279,000)		(999,807)	(102,739)	-	(102,739)	(532,573)	(364,495)	(102,739)	-
IT	(888,802)		(297,578)		(297,578)	26,081	(159,019)	185,100	(90,239)	(48,320)	(159,019)	-
Building Projects	(2,095,500)		(4,315,500)		(4,315,500)	(268,457)	(436,333)	167,876	(1,630,513)	(678,916)	(1,309,000)	(697,071)
Health Information/Business System	(92,807)		(7,000,000)		(7,000,000)	-	(1,300,000)	1,300,000	-	(2,051,447)	(1,979,421)	(2,969,132)
Capital Investments												
Properties	-		(2,794,000)		(2,802,193)	-	-	-	(40,000)	(2,333,193)	-	(429,000)
Measure C Scope Modifications	-		(2,476,716)		(1,755,909)	(69,361)	(346,213)	276,851	(558,626)	(261,384)	(935,899)	-
Change in Accounts Receivable	(1,194,734)		(2,183,288)	N1	(535,906)	334,012	(1,151,617)	1,485,629	(2,178,112)	(931,014)	2,274,715	298,505
Change in Settlement Accounts	1,387,101		1,175,000	N2	2,908,851	171,971	1,565,000	(1,393,029)	1,126,982	(205,102)	1,736,971	250,000
Change in Other Assets	(3,180,399)		(890,622)	N3	(1,397,422)	(138,832)	259,718	(398,550)	(687,607)	(1,034,847)	78,168	246,864
Change in Other Liabilities	3,702,607		(320,000)	N4	(67,311)	523,404	(500,000)	1,023,404	(2,392,808)	2,093	1,723,404	600,000
Change in Cash Balance	16,404,918		(8,045,261)		875,388	4,730,157	1,508,320	3,221,837	(3,121,122)	(4,330,475)	7,018,718	1,308,267
Beginning Unrestricted Cash	52,227,897		68,632,815		68,632,815	61,181,217	61,181,217	-	68,632,815	65,511,692	61,181,218	68,199,935
Ending Unrestricted Cash	68,632,815		60,778,463		69,508,202	65,911,374	62,689,537	3,221,837	65,511,692	61,181,218	68,199,935	69,508,202
Expense Per Day	340,958		355,605		355,701	355,681	355,519	162	352,658	353,874	357,258	355,701
Days Cash On Hand	201		171		195	185	176	9	186	173	191	195

Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

TAHOE FOREST HOSPITAL DISTRICT
FEBRUARY 2017 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

FEBRUARY 2017 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the eight months ended February 28, 2017.

Activity Statistics

- TFH acute patient days were 335 for the current month compared to budget of 367. This equates to an average daily census of 11.96 compared to budget of 13.11.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Diagnostic Imaging, Ultrasounds, Respiratory Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Home Health Visits, Surgery cases, Oncology Lab, Medical and Radiation Oncology procedures, MRI exams, PET CT, and Speech Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 59.1% in the current month compared to budget of 54.2% and to last month's 57.2%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.0%, compared to budget of 54.1% and prior year's 58.1%.
- EBIDA was $1,558,706 (8.1%) for the current month compared to budget of $933,184 (4.7%), or $625,521 (3.4%) above budget. Year-to-date EBIDA was $12,195,393 (7.3%) compared to budget of $6,379,940 (4.0%), or $5,815,454 (3.3%) over budget.
- Cash Collections for the current month were $10,402,495 which is 78% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 54.6, compared to the prior month of 56.8. Gross Accounts Receivables are $34,039,907 compared to the prior month of $35,074,946. The percent of Gross Accounts Receivable over 120 days old is 19.64%, compared to the prior month of 23.28%.

Balance Sheet

- Working Capital Days Cash on Hand is 35.8 days. S&P Days Cash on Hand is 192.6. Working Capital cash increased $3,023,000. The District received its SB239 IGT funds in the amount of $3,637,000. Cash collections fell short of target by 22% and Accounts Payable decreased $1,135,000.
- Net Patients Accounts Receivable increased approximately $419,000. Cash collections were at 78% of target and days in accounts receivable were 54.6 days, a 2.20 days decrease.
- The District received $3,637,000 from the SB239 IGT program.
- Accounts Payable decreased $1,135,000 due to the timing of the final check run in February.

Operating Revenue

- Current month's Total Gross Revenue was $19,208,894, compared to budget of $19,665,043 or $456,149 below budget.
- Current month's Gross Inpatient Revenue was $5,447,123, compared to budget of $5,858,374 or $411,251 below budget.
- Current month's Gross Outpatient Revenue was $13,761,771 compared to budget of $13,806,669 or $44,898 below budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 28.5% Medicare, 16.5% Medi-Cal, .0% County, 4.1% Other, and 50.9% Insurance compared to budget of 34.4% Medicare, 17.2% Medi-Cal, .0% County, 3.9% Other, and 44.5% Insurance. Last month's mix was 30.7% Medicare, 19.8% Medi-Cal, .0% County, 1.6% Other, and 47.9% Insurance.
- Current month's Deductions from Revenue were $7,865,431 compared to budget of $9,014,513 or $1,149,082 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 5.99% decrease in Medicare, a .72% decrease to Medi-Cal, a .0% decrease in County, a .21% increase in Other, and Commercial was over budget 6.50%, 2) Revenues fell short of budget by 2.30% and 3) AR Days over 90 and 120 decreased.

Operating Expenses

DESCRIPTION	February 2017 Actual	February 2017 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,837,646	3,690,413	(147,232)	
Employee Benefits	1,106,427	1,139,213	32,786	
Benefits – Workers Compensation	54,656	57,011	2,355	
Benefits – Medical Insurance	753,582	694,217	(59,365)	
Professional Fees	1,574,181	1,722,480	148,299	We saw positive variances in Corporate Compliance legal fees and Multi-Specialty physician fees for MSC OB/GYN, General Surgery, ENT, and Orthopedics. These positive variances were offset, in part, by negative variances in TFH Locums and Hospitalist fees, project management consulting, and contract oversight.
Supplies	1,478,634	1,597,404	118,770	Drugs Sold to Patients revenue exceeded budget by 2.92%, however, lower cost pharmaceuticals were dispensed during the month creating a positive variance in Pharmacy Supplies.
Purchased Services	908,518	872,894	(35,624)	Snow removal and laundry & linen services, department repairs for Engineering, and outsourced laboratory testing services created a negative variance in Purchased Services.
Other Expenses	660,939	583,314	(77,626)	Travel costs related to onsite EPIC discovery meetings, Management leadership training courses, tuition reimbursement, and unbudgeted building rent created a negative variance in Other Expenses.
Total Expenses	10,374,582	10,356,946	(17,637)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
FEBRUARY 2017

	Feb-17	Jan-17	Feb-16	
ASSETS				
CURRENT ASSETS				
* CASH	$ 12,797,028	$ 9,773,963	$ 13,294,590	1
PATIENT ACCOUNTS RECEIVABLE - NET	19,243,926	18,824,530	17,341,902	2
OTHER RECEIVABLES	4,290,473	3,970,555	4,276,155	
GO BOND RECEIVABLES	(300,422)	(691,230)	(123,869)	
ASSETS LIMITED OR RESTRICTED	6,268,249	5,918,679	5,088,088	
INVENTORIES	2,714,077	2,715,736	2,332,842	
PREPAID EXPENSES & DEPOSITS	1,876,856	2,007,760	1,462,716	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	436,856	3,715,425	3,397,500	3
TOTAL CURRENT ASSETS	47,327,043	46,235,418	47,069,925	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	56,137,411	56,137,411	45,834,718	1
BANC OF AMERICA MUNICIPAL LEASE	981,619	981,619	979,155	
TOTAL BOND TRUSTEE 2002	3	3	2	
TOTAL BOND TRUSTEE 2015	1,165,091	1,029,359	750,032	
GO BOND PROJECT FUND	232,133	232,266	4,896,560	
GO BOND TAX REVENUE FUND	2,103,577	2,102,452	1,361,348	
DIAGNOSTIC IMAGING FUND	3,174	3,174	2,976	
DONOR RESTRICTED FUND	1,144,350	1,144,350	1,141,630	
WORKERS COMPENSATION FUND	16,235	51,573	5,870	
TOTAL	61,783,593	61,682,207	54,972,290	
LESS CURRENT PORTION	(6,268,249)	(5,918,679)	(5,088,088)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	55,515,344	55,763,528	49,884,202	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(53,723)	(53,723)	202,785	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	131,173,487	131,358,966	127,581,136	
GO BOND CIP, PROPERTY & EQUIPMENT NET	32,550,137	32,468,754	28,434,198	
TOTAL ASSETS	267,348,640	266,609,296	254,008,599	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	517,180	520,412	555,968	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,612,281	1,612,281	1,880,317	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	6,362,362	6,386,067	1,955,220	
GO BOND DEFERRED FINANCING COSTS	499,040	500,975	303,176	
DEFERRED FINANCING COSTS	203,894	204,935	216,378	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 9,194,758	$ 9,224,670	$ 4,911,058	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 5,229,240	$ 6,364,268	$ 5,091,997	4
ACCRUED PAYROLL & RELATED COSTS	8,832,776	8,622,008	7,434,064	
INTEREST PAYABLE	616,860	525,762	189,147	
INTEREST PAYABLE GO BOND	344,342	28,851	348,861	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	543,513	232,645	463,361	
HEALTH INSURANCE PLAN	1,307,731	1,307,731	1,307,731	
WORKERS COMPENSATION PLAN	1,120,980	1,120,980	404,807	
COMPREHENSIVE LIABILITY INSURANCE PLAN	751,298	751,298	824,203	
CURRENT MATURITIES OF GO BOND DEBT	1,260,000	1,260,000	530,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,953,186	1,953,186	2,323,994	
TOTAL CURRENT LIABILITIES	21,959,926	22,166,728	18,918,165	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	28,032,444	28,137,883	30,012,849	
GO BOND DEBT NET OF CURRENT MATURITIES	103,395,868	103,409,288	100,009,263	
DERIVATIVE INSTRUMENT LIABILITY	1,612,281	1,612,281	1,880,317	
TOTAL LIABILITIES	155,000,518	155,326,180	150,820,593	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	120,398,529	119,363,435	106,957,434	
RESTRICTED	1,144,350	1,144,350	1,141,630	
TOTAL NET POSITION	$ 121,542,880	$ 120,507,785	$ 108,099,064	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
FEBRUARY 2017

1. Working Capital is at 35.8 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 192.6 days. Working Capital cash increased a net $3,023,000. The District received its SB239 IGT remittance funds (See Note 3) in the amount of $3,637,000. Cash collections fell short of target by 22% and Accounts Payable decreased $1,135,000 (See Note 4).

2. Net Patient Accounts Receivable increased approximately $419,000. Cash collections were 78% of target. Days in Accounts Receivable are at 54.6 days compared to prior months 56.8 days, a 2.20 days decrease.

3. The District received $3,637,000 from the SB239 IGT program.

4. Accounts Payable decreased $1,135,000 due to the timing of the final check run in the month.

Tahoe Forest Hospital District
Cash Investment
February 2017

WORKING CAPITAL				
US Bank	$ 12,421,173			
US Bank/Kings Beach Thrift Store	76,684			
US Bank/Truckee Thrift Store	226,433			
US Bank/Payroll Clearing	72,738			
Local Agency Investment Fund	-	0.78%		
Total			$	12,797,028
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	56,137,411	0.78%		
Local Agency Investment Fund			$	56,137,411
Banc of America Muni Lease			$	981,619
Bonds Cash 2002			$	3
Bonds Cash 2015			$	1,165,091
Bonds Cash 2008			$	2,335,711
DX Imaging Education	$ 3,174	0.78%		
Workers Comp Fund - B of A	16,235			
Insurance				
Health Insurance LAIF	-	0.78%		
Comprehensive Liability Insurance LAIF	-	0.78%		
Total			$	19,409
TOTAL FUNDS			$	73,436,271
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,363	0.03%		
Foundation Restricted Donations	$ 98,331			
Local Agency Investment Fund	1,037,656	0.78%		
TOTAL RESTRICTED FUNDS			$	1,144,350
TOTAL ALL FUNDS			$	74,580,621

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2017

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD FEB 2016
					OPERATING REVENUE						
$ 19,208,894	$ 19,665,043	$ (456,149)	-2.3%		Total Gross Revenue	$ 166,962,540	$ 159,731,694	$ 7,230,846	4.5%	1	$ 146,536,567
					Gross Revenues - Inpatient						
$ 1,591,637	$ 1,783,758	$ (192,121)	-10.8%		Daily Hospital Service	$ 15,683,048	$ 14,367,938	$ 1,315,109	9.2%		$ 13,857,128
3,855,486	4,074,616	(219,130)	-5.4%		Ancillary Service - Inpatient	32,453,417	31,010,287	1,443,131	4.7%		29,094,628
5,447,123	5,858,374	(411,251)	-7.0%		Total Gross Revenue - Inpatient	48,136,465	45,378,225	2,758,240	6.1%	1	42,951,756
13,761,771	13,806,669	(44,898)	-0.3%		Gross Revenue - Outpatient	118,826,075	114,353,469	4,472,606	3.9%		103,584,811
13,761,771	13,806,669	(44,898)	-0.3%		Total Gross Revenue - Outpatient	118,826,075	114,353,469	4,472,606	3.9%	1	103,584,811
					Deductions from Revenue:						
7,375,517	8,032,931	657,415	8.2%		Contractual Allowances	70,701,560	65,375,721	(5,325,839)	-8.1%	2	58,296,264
598,425	688,482	90,057	13.1%		Charity Care	4,991,945	5,594,026	602,081	10.8%	2	4,365,256
-	-	-	0.0%		Charity Care - Catastrophic Events	28,947	-	(28,947)	0.0%	2	395,319
(108,511)	293,100	401,611	137.0%		Bad Debt	(734,748)	2,393,729	3,128,477	130.7%	2	(562,761)
-	-	-	0.0%		Prior Period Settlements	179,377	-	(179,377)	0.0%	2	(1,133,224)
7,865,431	9,014,513	1,149,082	12.7%		Total Deductions from Revenue	75,167,082	73,363,477	(1,803,605)	-2.5%		61,360,854
83,771	56,443	27,328	48.4%		Property Tax Revenue- Wellness Neighborhood	465,835	449,296	16,539	3.7%		491,631
506,054	583,157	(77,103)	-13.2%		Other Operating Revenue	6,074,078	5,592,662	481,416	8.6%	3	5,761,825
11,933,288	11,290,130	643,158	5.7%		TOTAL OPERATING REVENUE	98,335,371	92,410,176	5,925,195	6.4%		91,429,169
					OPERATING EXPENSES						
3,837,646	3,690,413	(147,232)	-4.0%		Salaries and Wages	30,727,038	30,710,250	(16,788)	-0.1%	4	28,639,807
1,106,427	1,139,213	32,786	2.9%		Benefits	10,219,757	9,674,028	(545,729)	-5.6%	4	9,967,913
54,656	57,011	2,355	4.1%		Benefits Workers Compensation	441,504	456,089	14,586	3.2%	4	420,163
753,582	694,217	(59,365)	-8.6%		Benefits Medical Insurance	5,109,751	5,553,735	443,984	8.0%	4	5,148,190
1,574,181	1,722,480	148,299	8.6%		Professional Fees	14,265,175	14,249,177	(15,998)	-0.1%	5	12,131,191
1,478,634	1,597,404	118,770	7.4%		Supplies	12,908,341	13,565,457	657,116	4.8%	6	12,182,969
908,518	872,894	(35,624)	-4.1%		Purchased Services	7,915,036	7,142,688	(772,348)	-10.8%	7	7,245,627
660,939	583,314	(77,626)	-13.3%		Other	4,553,377	4,678,812	125,435	2.7%	8	4,017,811
10,374,582	10,356,946	(17,637)	-0.2%		TOTAL OPERATING EXPENSE	86,139,978	86,030,236	(109,742)	-0.1%		79,753,671
1,558,706	**933,184**	**625,521**	**67.0%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**12,195,393**	**6,379,940**	**5,815,454**	**91.2%**		**11,675,498**
					NON-OPERATING REVENUE/(EXPENSE)						
422,729	450,057	(27,328)	-6.1%		District and County Taxes	3,614,534	3,602,704	11,830	0.3%	9	3,153,375
391,933	391,933	-	0.0%		District and County Taxes - GO Bond	3,135,467	3,135,467	-	0.0%		3,143,923
48,406	36,370	12,036	33.1%		Interest Income	377,858	272,413	105,444	38.7%	10	225,003
2	-	2	0.0%		Interest Income-GO Bond	354	-	354	0.0%		16,148
16,709	38,917	(22,208)	-57.1%		Donations	303,331	311,334	(8,003)	-2.6%	11	274,614
-	-	-	0.0%		Gain/ (Loss) on Joint Investment	(97,095)	(62,500)	(34,595)	-55.4%	12	(121,610)
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	7,500
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(967,356)	(966,316)	(1,040)	-0.1%		Depreciation	(7,265,915)	(7,730,529)	464,614	6.0%	15	(6,818,343)
(108,323)	(96,741)	(11,583)	-12.0%		Interest Expense	(820,340)	(793,075)	(27,266)	-3.4%	16	(957,956)
(327,710)	(315,492)	(12,219)	-3.9%		Interest Expense-GO Bond	(1,425,984)	(1,565,260)	139,276	8.9%		(1,895,354)
(523,611)	(461,272)	(62,340)	-13.5%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,177,792)	(2,829,446)	651,654	23.0%		(2,972,700)
$ 1,035,094	**$ 471,913**	**$ 563,182**	**119.3%**		**INCREASE (DECREASE) IN NET POSITION**	**$ 10,017,602**	**$ 3,550,494**	**$ 6,467,108**	**182.1%**		**$ 8,702,798**
					NET POSITION - BEGINNING OF YEAR	**111,525,278**					
					NET POSITION - AS OF FEBRUARY 28, 2017	**$ 121,542,880**					
8.1%	**4.7%**	**3.4%**			**RETURN ON GROSS REVENUE EBIDA**	**7.3%**	**4.0%**	**3.3%**			**8.0%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2017

		Variance from Budget Fav / <Unfav> FEB 2017	YTD 2017
1) Gross Revenues			
Acute Patient Days were below budget 8.72% or 32 days. Swing Bed days were above budget 23.08% or 6 days. Inpatient Ancillary revenues fell short of budget by 5.40% due to the decrease in our acute patient days.	Gross Revenue -- Inpatient	$ (411,251)	$ 2,758,584
	Gross Revenue -- Outpatient	(44,898)	4,472,262
	Gross Revenue -- Total	$ (456,149)	$ 7,230,846
Outpatient volumes were below budget in the following departments: Emergency Department visits, Home Health visits, Surgical cases, Endoscopy procedures, Mammography exams, Medical and Radiation Oncology procedures, MRI exams, PET CT, and Speech Therapy.			
2) Total Deductions from Revenue			
The payor mix for February shows a 5.99% decrease to Medicare, a .72% decrease to Medi-Cal, .21% increase to Other, County at budget, and a 6.50% increase to Commercial when compared to budget. Contractual Allowances were under budget due to the shift in payor mix from Medicare and Medi-Cal to Commercial, a decrease to AR Days over 90 and 120 Days old, and revenues falling short of budget by 2.30%.	Contractual Allowances	$ 657,415	$ (5,325,839)
	Charity Care	90,057	602,081
	Charity Care - Catastrophic	-	(28,947)
	Bad Debt	401,611	3,128,477
	Prior Period Settlements	-	(179,377)
	Total	$ 1,149,082	$ (1,803,605)
3) Other Operating Revenue			
Retail Pharmacy revenues fell short of budget by 24.31%.	Retail Pharmacy	$ (57,936)	$ (91,390)
	Hospice Thrift Stores	(20,263)	(37,248)
	The Center (non-therapy)	(6,185)	5,070
Continued snow fall during the month aided in a negative variance in the Hospice Thrift Stores revenues.	IVCH ER Physician Guarantee	3,450	58,392
	Children's Center	7,623	2,197
	Miscellaneous	(3,791)	544,395
	Oncology Drug Replacement	-	-
	Grants	-	-
	Total	$ (77,103)	$ 481,416
4) Salaries and Wages	Total	$ (147,232)	$ (16,788)
Employee Benefits	PL/SL	$ 3,552	$ (356,840)
	Nonproductive	(3,984)	(131,278)
	Pension/Deferred Comp	197	(3,092)
	Standby	22,293	136,751
	Other	10,728	(191,270)
	Total	$ 32,786	$ (545,729)
Employee Benefits - Workers Compensation	Total	$ 2,355	$ 14,586
Employee Benefits - Medical Insurance	Total	$ (59,365)	$ 443,984
5) Professional Fees	TFH Locums	$ (69,340)	$ (367,710)
Negative variance in TFH Locums related to Hospitalist and Emergency Department coverage.	The Center (includes OP Therapy)	5,080	(161,124)
	Information Technology	(10,912)	(160,439)
Project Management consulting fees created a negative variance in Information Technology.	Administration	(48,963)	(126,694)
	Miscellaneous	33,165	(113,655)
	Multi-Specialty Clinics Admin	2,550	(62,688)
	Oncology	(393)	(14,065)
Contract oversight and project management fees created a negative variance in Administration.	IVCH ER Physicians	(1,935)	(9,811)
	Human Resources	(513)	(2,735)
	Respiratory Therapy	(0)	(1)
Legal Fees budgeted for the Corporate Compliance department fell below budget, creating a positive variance in this category.	Patient Accounting/Admitting	-	-
	Business Performance	-	-
	Home Health/Hospice	-	471
Positive variance in Multi-Specialty Clinics related to Tahoe Forest Women's Center physician fees and a reduction in General Surgery, ENT, and Orthopedic physician fees.	Medical Staff Services	(3,780)	1,602
	Marketing	2,375	19,000
	Sleep Clinic	3,171	21,806
	Managed Care	9,000	23,436
	Financial Administration	(2,365)	25,695
	TFH/IVCH Therapy Services	3,843	90,251
	Corporate Compliance	36,150	230,908
	Multi-Specialty Clinics	191,166	589,757
	Total	$ 148,299	$ (15,998)
6) Supplies	Minor Equipment	$ (1,130)	$ (49,348)
Drugs Sold to Patients revenue exceeded budget by 2.92%, however, the mix of pharmaceuticals delivered to patients created a positive variance in Pharmacy Supplies.	Food	(2,212)	(17,981)
	Imaging Film	867	2,845
	Other Non-Medical Supplies	5,532	14,757
	Office Supplies	14,106	56,191
	Patient & Other Medical Supplies	19,332	195,843
	Pharmacy Supplies	82,275	454,808
	Total	$ 118,770	$ 657,116

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2017

		Variance from Budget Fav / <Unfav> FEB 2017	YTD 2017
7) Purchased Services	Miscellaneous	$ (48,614)	$ (751,682)
Services provided to Laundry & Linen and Engineering created a negative variance in Miscellaneous.	Hospice	(5,483)	(60,883)
	Department Repairs	(3,765)	(51,858)
	Laboratory	(12,308)	(33,240)
Outsourced lab testing created a negative variance in Laboratory.	Pharmacy IP	(3,202)	(15,048)
	Diagnostic Imaging Services - All	(1,042)	(12,087)
Positive variance in human resources related to Employee Health and Pre-Employment screenings.	The Center	5,416	(877)
	Information Technology	(4,605)	5,974
	Medical Records	3,484	7,470
	Community Development	2,700	9,069
	Multi-Specialty Clinics	2,064	10,742
	Patient Accounting	3,960	39,313
	Human Resources	25,772	80,760
	Total	$ (35,624)	$ (772,348)
8) Other Expenses	Outside Training & Travel	$ (60,614)	$ (130,706)
Onsight discovery meetings for the EPIC conversion, Management leadership courses, and tuition reimbursement created a negative variance in Outside Training and Travel.	Other Building Rent	(34,362)	(27,923)
	Equipment Rent	1,254	(23,911)
	Human Resources Recruitment	(7,172)	(22,020)
	Insurance	(1,378)	(13,441)
Unbudgeted rental expense on the Pioneer Commerce Center building created a negative variance in Other Building Rent.	Utilities	411	(1,981)
	Physician Services	9	74
	Multi-Specialty Clinics Equip Rent	877	5,053
Positive variance in Multi-Specialty Clinics Building Rent related to MSC OB/GYN and MSC Pediatrics.	Multi-Specialty Clinics Bldg Rent	11,528	40,876
	Marketing	3,445	47,805
	Dues and Subscriptions	5,681	84,473
	Miscellaneous	2,697	167,136
	Total	$ (77,626)	$ 125,435
9) District and County Taxes	Total	$ (27,328)	$ 11,830
10) Interest Income	Total	$ 12,036	$ 105,444
11) Donations	IVCH	$ -	$ 22,117
	Operational	(22,208)	(30,120)
	Capital Campaign	-	-
	Total	$ (22,208)	$ (8,003)
12) Gain/(Loss) on Joint Investment	Total	$ -	$ (34,595)
13) Gain/(Loss) on Sale	Total	$ -	$ -
15) Depreciation Expense	Total	$ (1,040)	$ 464,614
16) Interest Expense	Total	$ (11,583)	$ (27,266)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2017

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD FEB 2016
					OPERATING REVENUE						
$ 1,333,329	$ 1,461,919	$ (128,590)	-8.8%		Total Gross Revenue	$ 12,776,221	$ 12,434,315	$ 341,907	2.7%	1	$ 11,708,219
					Gross Revenues - Inpatient						
$ 2,996	$ 2,914	$ 82	2.8%		Daily Hospital Service	$ 32,328	$ 20,398	$ 11,930	58.5%		$ 19,427
7,655	3,184	4,471	140.4%		Ancillary Service - Inpatient	50,364	27,157	23,207	85.5%		24,665
10,651	6,098	4,553	74.7%		Total Gross Revenue - Inpatient	82,692	47,555	35,137	73.9%	1	44,092
1,322,679	1,455,821	(133,142)	-9.1%		Gross Revenue - Outpatient	12,693,529	12,386,760	306,770	2.5%		11,664,127
1,322,679	1,455,821	(133,142)	-9.1%		Total Gross Revenue - Outpatient	12,693,529	12,386,760	306,770	2.5%	1	11,664,127
					Deductions from Revenue:						
407,876	470,014	62,138	13.2%		Contractual Allowances	4,568,361	4,030,922	(537,440)	-13.3%	2	3,674,298
44,326	55,013	10,687	19.4%		Charity Care	436,374	468,078	31,704	6.8%	2	390,714
-	-	-	0.0%		Charity Care - Catastrophic Events	28,947	-	(28,947)	0.0%	2	8,541
89,034	52,819	(36,215)	-68.6%		Bad Debt	416,580	449,404	32,824	7.3%	2	533,152
-	-	-	0.0%		Prior Period Settlements	(22,833)	-	22,833	0.0%	2	(150,715)
541,236	577,846	36,610	6.3%		Total Deductions from Revenue	5,427,430	4,948,403	(479,026)	-9.7%	2	4,455,990
75,866	73,280	2,586	3.5%		Other Operating Revenue	647,553	589,987	57,566	9.8%	3	676,043
867,959	957,352	(89,393)	-9.3%		TOTAL OPERATING REVENUE	7,996,345	8,075,899	(79,554)	-1.0%		7,928,272
					OPERATING EXPENSES						
275,900	281,212	5,312	1.9%		Salaries and Wages	2,101,215	2,282,113	180,898	7.9%	4	2,019,803
84,439	87,326	2,887	3.3%		Benefits	787,901	777,859	(10,042)	-1.3%	4	611,234
1,965	1,417	(548)	-38.7%		Benefits Workers Compensation	16,131	11,334	(4,797)	-42.3%	4	18,687
49,358	44,618	(4,740)	-10.6%		Benefits Medical Insurance	330,545	356,947	26,402	7.4%	4	331,205
196,227	219,884	23,657	10.8%		Professional Fees	1,900,930	1,894,264	(6,665)	-0.4%	5	1,854,098
66,174	74,820	8,645	11.6%		Supplies	540,783	667,817	127,034	19.0%	6	587,300
46,533	44,683	(1,850)	-4.1%		Purchased Services	357,592	353,229	(4,364)	-1.2%	7	331,356
43,493	55,127	11,633	21.1%		Other	425,299	435,671	10,372	2.4%	8	477,897
764,088	809,086	44,998	5.6%		TOTAL OPERATING EXPENSE	6,460,396	6,779,235	318,839	4.7%		6,231,580
103,871	**148,266**	**(44,395)**	**-29.9%**		**NET OPERATING REV(EXP) EBIDA**	**1,535,949**	**1,296,664**	**239,285**	**18.5%**		**1,696,692**
					NON-OPERATING REVENUE/(EXPENSE)						
-	-	-	0.0%		Donations-IVCH	22,117	-	22,117	0.0%	9	35,656
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(64,277)	(64,277)	-	0.0%		Depreciation	(459,604)	(514,213)	54,609	-10.6%	11	(440,944)
(64,277)	(64,277)	-	0.0%		TOTAL NON-OPERATING REVENUE/(EXP)	(437,487)	(514,213)	76,725	14.9%		(405,288)
$ 39,594	**$ 83,989**	**$ (44,395)**	**-52.9%**		**EXCESS REVENUE(EXPENSE)**	**$ 1,098,461**	**$ 782,451**	**$ 316,010**	**40.4%**		**$ 1,291,404**
7.8%	**10.1%**	**-2.4%**			**RETURN ON GROSS REVENUE EBIDA**	**12.0%**	**10.4%**	**1.6%**			**14.5%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2017

		Variance from Budget Fav<Unfav> FEB 2017	YTD 2017
1) Gross Revenues			
Acute Patient Days were at budget at 1 and Observation Days were below budget by 3 at 0.	Gross Revenue -- Inpatient	$ 4,553	$ 35,137
	Gross Revenue -- Outpatient	(133,142)	306,770
		$ (128,590)	$ 341,907
Outpatient volumes fell short of budget in Emergency Department visits, Diagnostic Imaging, Pharmacy units, Surgical cases, and Physical Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 6.26% increase in Commercial Insurance, a 4.04% decrease in Medicare, a 1.36% decrease in Medicaid, a .87% decrease in Other, and County was at budget. The shift in payor mix from Medicare and Medicaid to Commercial and outpatient revenues falling short of budget by 9.1% created a positive variance in Contractual Allowances.	Contractual Allowances	$ 62,138	$ (537,440)
	Charity Care	10,687	31,704
	Charity Care-Catastrophic Event	-	(28,947)
	Bad Debt	(36,215)	32,824
	Prior Period Settlement		22,833
	Total	$ 36,610	$ (479,026)
3) Other Operating Revenue			
	IVCH ER Physician Guarantee	$ 3,450	$ 58,392
	Miscellaneous	(864)	(827)
	Total	$ 2,586	$ 57,566
4) Salaries and Wages	Total	$ 5,312	$ 180,898
Employee Benefits	PL/SL	$ 841	$ 8,521
	Standby	(341)	7,605
	Other	2,291	(2,675)
	Nonproductive	(100)	(26,165)
	Pension/Deferred Comp	196	2,672
	Total	$ 2,887	$ (10,042)
Employee Benefits - Workers Compensation	Total	$ (548)	$ (4,797)
Employee Benefits - Medical Insurance	Total	$ (4,740)	$ 26,402
5) Professional Fees	Miscellaneous	$ 21,499	$ (40,320)
IVCH Health Clinic professional fees came in below budget estimations creating a positive variance in Miscellaneous.	Administration	(130)	(10,127)
	IVCH ER Physicians	(1,935)	(9,811)
	Foundation	(1,077)	(3,295)
Positive variance in Sleep Clinic professional fees related to collections falling short of budget.	Multi-Specialty Clinics	2,005	3,818
	Sleep Clinic	3,171	21,806
	Therapy Services	124	31,265
	Total	$ 23,657	$ (6,665)
6) Supplies	Food	$ (1,688)	$ (8,838)
Small equipment purchases for IVCH MSC IM/Peds and Physical Therapy created a negative variance in Minor Equipment.	Office Supplies	104	(4,879)
	Minor Equipment	(3,487)	(419)
	Imaging Film	205	991
Drugs Sold to Patients revenues were below budget by 30.30%, creating a positive variance in Pharmacy Supplies.	Non-Medical Supplies	(958)	1,298
	Patient & Other Medical Supplies	(2,293)	69,386
	Pharmacy Supplies	16,761	69,494
	Total	$ 8,645	$ 127,034

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2017

		Variance from Budget Fav<Unfav>	
		FEB 2017	YTD 2017
7) Purchased Services	EVS/Laundry	$ (3,838)	$ (19,899)
Negative variance in Engineering/Plant/Communications related to snow removal.	Engineering/Plant/Communications	(2,245)	(13,253)
	Department Repairs	2,145	(3,513)
	Diagnostic Imaging Services - All	(371)	(2,390)
	Multi-Specialty Clinics	12	(376)
	Surgical Services	-	-
	Pharmacy	307	554
	Foundation	(122)	861
	Miscellaneous	2,601	13,410
	Laboratory	(339)	20,242
	Total	$ (1,850)	$ (4,364)
8) Other Expenses	Insurance	$ (1,872)	$ (14,999)
Memberships with Nevada Rural Hospital Association and American Hospital Association created a negative variance in Dues and Subscriptions.	Dues and Subscriptions	(1,447)	(9,141)
	Marketing	1,543	(7,265)
	Equipment Rent	(68)	(3,277)
	Physician Services	-	-
Natural Gas, Electricity, and Telephone costs came in below budget, creating a positive variance in Utilities.	Multi-Specialty Clinics Equip Rent	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Other Building Rent	311	311
	Outside Training & Travel	1,186	1,775
	Utilities	9,992	16,964
	Miscellaneous	1,989	26,005
	Total	$ 11,633	$ 10,372
9) Donations	Total	$ -	$ 22,117
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 54,609

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2016		BUDGET FYE 2017		PROJECTED FYE 2017	ACTUAL FEB 2017	BUDGET FEB 2017	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 16,129,087		$ 8,354,249		$ 14,003,953	1,558,706	$ 933,184	625,522	$ 4,905,089	$ 4,482,756	$ 3,684,060	$ 932,048
Interest Income	163,091		249,285		323,104	-	-	-	70,617	85,905	96,447	70,136
Property Tax Revenue	6,120,208		5,682,000		6,223,503	131,722	-	131,722	345,312	94,001	3,510,190	2,274,000
Donations	668,318		1,023,000		1,022,870	-	260,000	(260,000)	211,916	53,794	409,160	348,000
Debt Service Payments	(3,441,272)		(3,568,341)		(3,526,498)	(240,328)	(241,694)	1,366	(1,217,943)	(720,763)	(862,709)	(725,083)
Bank of America - 2012 Muni Lease	(1,243,650)		(1,243,644)		(1,243,648)	(103,637)	(103,637)	(0)	(310,912)	(310,912)	(310,912)	(310,911)
Copier	(8,758)		(11,520)		(11,299)	(959)	(960)	1	(2,885)	(2,656)	(2,878)	(2,880)
2002 Revenue Bond	(483,555)		(668,008)		(637,310)	-	-	-	(496,951)	-	(140,358)	-
2015 Revenue Bond	(1,705,309)		(1,645,169)		(1,634,242)	(135,732)	(137,097)	1,366	(407,195)	(407,195)	(408,560)	(411,292)
Physician Recruitment	(263,769)		(120,000)		-	-	-	-	-	-	-	-
Investment in Capital											-	
Equipment	(1,495,214)		(1,262,750)		(1,262,750)	(28,835)	(157,419)	128,584	(452,617)	(419,544)	(262,006)	(128,583)
Municipal Lease Reimbursement	1,319,139		979,000		979,000	-	-	-	-	-	-	979,000
GO Bond Project Personal Property	(432,135)		(279,000)		(1,066,513)	(66,706)	-	(66,706)	(532,573)	(364,495)	(169,445)	-
IT	(888,802)		(297,578)		(297,578)	(26,416)	(92,550)	66,134	(90,239)	(48,320)	(92,885)	(66,134)
Building Projects	(2,095,500)		(4,315,500)		(4,315,500)	(153,824)	(520,272)	366,448	(1,630,513)	(678,916)	(942,553)	(1,063,518)
Health Information/Business System	(92,807)		(7,000,000)		(5,143,929)	(523,046)	(989,711)	466,665	-	(2,051,447)	(1,165,405)	(1,927,077)
Capital Investments												
Properties	-		(2,794,000)		(2,802,193)	-	-	-	(40,000)	(2,333,193)	-	(429,000)
Measure C Scope Modifications	-		(2,476,716)		(1,689,203)	-	(433,269)	433,269	(558,626)	(261,384)	(469,277)	(399,916)
Change in Accounts Receivable	(1,194,734)		(2,183,288)	N1	(2,135,001)	(419,396)	1,179,699	(1,599,095)	(2,178,112)	(931,014)	675,620	298,505
Change in Settlement Accounts	1,387,101		1,175,000	N2	3,683,288	3,589,437	1,565,000	2,024,437	1,126,982	(205,102)	3,761,408	(1,000,000)
Change in Other Assets	(3,180,399)		(890,622)	N3	(1,522,509)	34,913	160,000	(125,087)	(687,607)	(1,034,847)	(46,919)	246,864
Change in Other Liabilities	3,702,607		(320,000)	N4	(1,000,473)	(833,162)	600,000	(1,433,162)	(2,392,808)	2,093	290,242	1,100,000
Change in Cash Balance	16,404,918		(8,045,261)		1,473,572	3,023,065	2,262,969	760,096	(3,121,122)	(4,330,475)	8,415,927	509,242
Beginning Unrestricted Cash	52,227,897		68,632,815		68,632,815	65,911,374	65,911,374	-	68,632,815	65,511,692	61,181,218	69,597,145
Ending Unrestricted Cash	68,632,815		60,778,463		70,106,386	68,934,438	68,174,342	760,096	65,511,692	61,181,218	69,597,145	70,106,386
Expense Per Day	340,958		355,605		355,782	357,861	357,596	265	352,658	353,874	357,366	355,782
Days Cash On Hand	201		171		197	193	191	2	186	173	195	197

Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: **Judy Newland, RN**
COO

DATE: March 20, 2017

ISSUE: Emergency On-Call Policy #ABD-10

In this policy, the Board of Directors adopts guidelines on services that will be supported through the use of specialty physicians who are on-call for consultations required for patients being treated in the Emergency Department. The policy has to be approved by the Board of Directors annually.

BACKGROUND:
This policy was originally adopted in 2001 to adopt guidelines for on-call specialty physician coverage the District would provide pursuant to its obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA does not provide definitive guidelines on medical specialties that must be supported with 24-hour on-call specialty physician coverage. Instead, it requires hospitals to maintain a list of specialists who are on call to support the stabilization or treatment of patients within the capabilities of the hospital.

The policy stipulated 24-hour on-call coverage should be provided for 9 specialties at Tahoe Forest Hospital:

1. Emergency Medicine
2. Ob/Gyn
3. General Medicine
4. Pediatrics
5. General Surgery
6. Orthopedics
7. Radiology
8. Anesthesia
9. Pathology

At Incline Village Community Hospital, the only specialties listed are Emergency Medicine and Medicine Services.

The policy also provided that coverage for other specialties would be provided within the capabilities of the specialty, which is permitted under EMTALA, and that the Board would review and approve the level of on-call services available at least annually.

There are two minor changes to the policy. The word “manual” has been added to “EMTALA-California Hospital Association” referenced on the last page. This would clarify that EMTALA is not a CHA policy or statute, but refers to that manual as an authoritative reference.
A hyperlink to AGOV-18, the actual policy and procedure on EMTALA compliance has been added.

ACTION REQUESTED:
Recommend annual approval of ABD-10 Emergency On-Call Policy.

ABD-10 Emergency On-Call Policy

PURPOSE:

Tahoe Forest Hospital District has an ethical, moral, social, and legal responsibility to provide screening examination and care to patients presenting to its facilities with emergency conditions. The Board understands the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "Act"), and federal and state regulations, require hospitals with a dedicated emergency department to maintain a list of physicians who are on call to come to the hospital and provide treatment as necessary to stabilize an individual with an emergency medical condition, within the capabilities of the District.

POLICY:

A. Patients who present to the Tahoe Forest Hospital District facilities requesting emergency care are entitled to a "Medical Screening Examination" as described in the Act, regardless of their ability to pay.
B. The District's Board of Directors, Administration and Medical Staff leadership will work collaboratively to determine the District's capabilities for providing 24-hour emergency health care.
C. Tahoe Forest Hospital District operates Tahoe Forest Hospital and Incline Village Community Hospital.
    1. Tahoe Forest Hospital (TFH), a Critical Access Hospital has been licensed by the State of California to provide Basic Emergency Services. TFH will provide on-call physician coverage in the Emergency Department for the basic services and supplemental services listed on the hospital license:
        a. Emergency Medicine
        b. General Medicine
        c. General Surgery
        d. Radiology
        e. Anesthesia
        f. Pathology
        g. OB/Gyn
        h. Pediatrics
        i. Orthopedics
    2. Incline Village Community Hospital, in Incline Village, Nevada will provide 24-hour physician coverage for Emergency and Medicine Services.
    3. TFH may provide specialty activation coverage for emergency consultations and services according to the capabilities of members of the medical staff who have privileges in that specialty.
D. The Chief Executive Officer will work with the Medical Staff to provide emergency consultative coverage that meets federal and state laws, licensing requirements and the needs of the community. To achieve these goals, the Chief Executive Officer may utilize, but not be limited to:
    1. Stipends for call coverage
    2. Contracts for professional services
    3. Locum tenens privileges
    4. Transfer agreements with other healthcare facilities
E. At least annually, Tahoe Forest Hospital District Board of Directors will review and approve the level of emergency on-call services available. We will utilize the hospital's quality assurance system to monitor emergency on-call practices.
F. In order to provide this coverage, every effort will be made to create a system that is voluntary, fair and equitable without imposing an undue burden on physicians or on the Tahoe Forest Hospital District. Collaboration with current members of the Tahoe Forest Hospital District's Medical Staff will be the preferred method for providing these services, with recruitment of new physicians as needed.

G. Physicians who seek charity care fund reimbursement at Medicare rates for emergency services provided in the hospital to indigent patients, should refer to *Financial Assistance Program Full Charity Care And Discount partial Charity Care (ABD-09)* for guidance and distribution criteria. Tahoe Forest Hospital District will keep abreast of other funds, state or otherwise, that might be available for the purpose of providing payment to physicians who treat the under/uninsured population.
H. A roster and procedure are in place to address the provision of specialty medical care when services are needed which are outside the capabilities of the Tahoe Forest Hospital District and its Medical Staff.

Related Policies/Forms: Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, AGOV-18

References: EMTALA-California Hospital Association manual

Policy Owner: Clerk of the Board

Approved by: Chief Executive Officer

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TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 3/15/17

As this has been my second winter here, it has been insightful to hear from many area residents who have lived here for more than 25 years as to just how unique our latest winter has been. One key question is are we on a trend of ever toughening winters for a few more years?

As a health system, we'll have some special work to do during the summer to better prepare for future outages, make general repairs and to also prepare for next winter.

We are very happy to share we have received the Temporary Occupancy Permit from the state for our Joseph Family Center for Women and Newborn Care. We still have to prepare for an additional inspection from the state before the new patient care site is fully approved. It has taken much longer than anticipated for all state approvals to date.

Our Administrative Council team met for 2 days last week to really examine and discuss all aspects of our operations, strategies, and external impact factors to clarify next steps and to improve team function and results going forward. Devoting time each year in the future for the team getting together in this manner will continue to be a high priority!

We are continuing to multi-task at a very high level across our organization with probably the largest number of important clinical and operational improvement projects underway versus anytime in our past. I want to thank our team for their willingness to work on this volume of improvements which will prove extremely helpful to our health system for many years to come.

We are continuing to change and strengthen our physician recruiting efforts as it is very clear that physician recruitment to Truckee and Incline Village is a significant challenge. We are engaging additional recruiting resources and new techniques to hopefully speed up successful recruiting. We are actively recruiting in Family Practice, Internal Medicine, GI, Neurology and General Surgery. National literature suggests there will be a physician shortage of up to 90,000 physicians in America by 2025. All physicians we visit with in recent months have multiple offers they are considering.

We continue to be in active discussions regarding possible win-win affiliations with two medical groups in our region as we focus on improving access to healthcare for all residents in our region and work on improving sustainability of physician and hospitals services for the long term.

It is very important to our entire team that all patients experience a "second to none positive experience" when visiting this health system. We know we have many opportunities to

improve. We really value all feedback both positive and negative as this patient input really helps us more rapidly improve in all we do. We continue to have opportunities for patients to volunteer in service with us in our Patient Family Advisory Council.

We are continuing to work on and develop more communication connections within our region, so please watch for more information on this important ongoing effort.

For all of our elective hip and knee surgery patients, the District now has a Patient Education Guide which assists in providing great information for before, during and after hip or knee surgery. Watch for more information as we are working to more proactively share and communicate key service lines of the health system.

It is important to share in our Orthopedic service line, based on the latest external information available we could obtain last year, Tahoe Forest Health System had 46% of its elective hip and knee surgeries “in-migrate” or come from zip codes outside of the District.

Further, looking at our Cancer service line, based on the latest external information we could obtain last year, Tahoe Forest Health System had 33% of its cancer patients “in-migrate” or come from zip codes outside the District.

We are humbled and honored that many patients who reside outside the District find value in coming to Tahoe Forest for healthcare services!

Individuals on my team and I are spending an increasing amount of time engaging at the state and federal level on the myriad of possible changes to healthcare the public is reading and seeing often in the media. Our goal is to talk honestly about what works and does not work in healthcare even if it steps on our toes a little and to share some real opportunities which do exist for improving quality and lowering the cost of care in the US. Again, as we are licensed by state and federal agencies, we need their support and approval for making state or federal productive healthcare improvements as we have to operate by their guidelines.

We look forward to the Board Retreat in April where we focus together on a list of important topics and strategies to keep our health system strong, relevant and sustainable for the future.

20 Health Conditions People Spent Most on in 2013 – and What the Bulk of Their Money Went Toward

By Molly Gamble

Of 155 medical conditions, people personally spent $1.2 trillion on the top 20 alone in 2013, according to a new analysis published in *JAMA*.

In their investigation "US Spending on Personal Health Care and Public Health 1996-2013," study authors collected and combined 183 sources of data to estimate spending for 155 conditions. They found the top 20 conditions accounted for an estimated 57.6 percent of personal healthcare spending in 2013.

Below is a ranking of the 20 top conditions, with spending amounts reflecting 2015 dollars. Each entry also contains where the majority of those dollars went — authors broke down the portion spent on ambulatory care, inpatient care, pharmaceuticals, emergency care or nursing facility care. Because cancer was disaggregated into 29 separate conditions, none were among the top 20 with the highest spending.

1. Diabetes — $101.4 billion; majority of spending on pharmaceuticals (57.6 percent)

2. Ischemic heart disease — $88.1 billion; majority of spending on inpatient care (56.5 percent)

3. Lower back and neck pain — $87.6 billion; majority of spending on ambulatory care (60.5 percent)

4. Hypertension treatment — $83.9 billion; majority of spending on ambulatory care (45.8 percent)

5. Falls — $76.3 billion; majority of spending on inpatient care (34.3 percent)

6. Depressive disorders — $71.1 billion; majority of spending on ambulatory care (53.1 percent)

7. Oral disorders (oral surgeries and procedures including crowns, extractions and dentures) — $66.4 billion (minor portion of spending goes to prescriptions or ambulatory, inpatient, emergency or nursing facility settings)

8. Sense organ diseases (cataracts, vision correction, adult hearing loss and macular degeneration) — $59 billion; majority of spending on ambulatory care (85.4 percent)

9. Skin and subcutaneous diseases (cellulitis, sebaceous cysts, acne and eczema) — $55.7 billion; majority of spending on ambulatory care (52 percent)

10. Pregnancy and postpartum care (normal pregnancy, including cesarean delivery) — $55.6 billion; majority of spending on inpatient care (50.5 percent)

11. Urinary diseases and male infertility (urinary tract infections and kidney cysts) — $54.9 billion; majority of spending on ambulatory care (37 percent)

12. Chronic obstructive pulmonary disease — $53.8 billion; majority of spending on inpatient care (34.8 percent)

13. Hyperlipidemia treatment — $51.8 billion; majority of spending on pharmaceuticals (78.5 percent)

14. Dental well care (general exams, cleanings, orthodontia and X-rays) — $48.7 billion; majority of spending N/A

15. Osteoarthritis — $47.9 billion; majority of spending on inpatient care (63.8 percent)

16. Other musculoskeletal disorders (joint, muscular and connective tissue disorders) — $44.9 billion; majority of spending on ambulatory care (49.4 percent)

17. Cerebrovascular disease — $43.8 billion; majority of spending on inpatient care (54 percent)

18. Other neurological disorders (pain syndromes and muscular dystrophy) — $43.7 billion; majority of spending on ambulatory care (50.9 percent)

19. Other digestive diseases (esophagus conditions and diverticulitis of the colon) — $38.8 billion; majority of spending on ambulatory care (39 percent)

20. Lower respiratory tract infections — $37.1 billion; majority of spending on inpatient care (48.6 percent) ■

UMass Memorial Points to Epic Implementation for Drop in Operating Income

By Ayla Ellison

Worchester, Mass.-based UMass Memorial Health Care saw revenue increase in fiscal year 2016, but the system said costs associated with implementing an Epic EHR system dragged down operating income.

UMass Memorial recorded revenue of $2.4 billion in FY 2016, up 5.8 percent from the year prior. The financial boost was largely attributable to a 6 percent year-over-year increase in patient service revenue, which grew to $2.3 billion in FY 2016, according to recently released bondholder documents.

The system ended the most recent fiscal year with operating income of $40.7 million, down from $72.2 million in FY 2015. The decline was largely attributable to $25 million in training and implementation costs associated with its new Epic EHR platform.

UMass Memorial officials announced plans to adopt Epic's EHR system in 2015. The project is expected to cost $700 million over a 10-year period.

UMass Memorial CFO Sergio Melgar told the *Boston Business Journal* the system expects Epic training costs to be about $50 million in FY 2017, but "most of the impact will be in fiscal 2018 in the beginning [of the year]." UMass Memorial plans to go live on the new system in October 2017, according to the report. ■

A State-by-State Breakdown of 80 Rural Hospital Closures

By Ayla Ellison

Of the 25 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program.

Thirteen hospitals in Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with eight hospitals closing since 2010. In third place is Georgia with six closures followed by Alabama and Mississippi, which have each seen five hospitals close over the past six years.

Listed below are the 80 rural hospitals that closed between January 2010 and November 2016, as tracked by the NCRHRP. For the purposes of its analysis, the NCRHRP defined a hospital closure as the cessation in the provision of inpatient services. As of November, all of the facilities listed below no longer provided inpatient care. However, many of them still offered other services, including outpatient care, imaging, emergency care, urgent care, primary care or skilled nursing and rehabilitation services.

Alabama
Chilton Medical Center (Clanton)
Elba General Hospital
Florala Memorial Hospital
Randolph Medical Center (Roanoke)
South West Alabama Medical Center (Thomasville)

Arizona
Cochise Regional Hospital (Douglas)
Florence Community Healthcare
Hualapai Mountain Medical Center (Kingman)

California
Colusa Regional Medical Center
Corcoran District Hospital
Kingsburg Medical Center

Georgia
Calhoun Memorial Hospital (Arlington)
Charlton Memorial Hospital (Folkston)
Hart County Hospital (Hartwell)
Lower Oconee Community Hospital (Glenwood)
North Georgia Medical Center (Ellijay)
Stewart-Webster Hospital (Richland)

Illinois
St. Mary's Hospital (Streator)

Kansas
Central Kansas Medical Center (Great Bend)
Mercy Hospital Independence

Kentucky
New Horizons Medical Center (Owenton)
Nicholas County Hospital (Carlisle)
Parkway Regional Hospital (Fulton)
Westlake Regional Hospital (Columbia)

Maine
Parkview Adventist Medical Center (Brunswick)
Southern Maine Health Care – Sanford Medical Center
St. Andrews Hospital (Boothbay Harbor)

Massachusetts
North Adams Regional Hospital

Michigan
Cheboygan Memorial Hospital

Minnesota
Albany Area Hospital
Lakeside Medical Center (Pine City)

Mississippi
Kilmichael Hospital
Merit Health Natchez – Community Campus
Patient's Choice Medical Center of Humphreys County (Belzoni)
Pioneer Community Hospital of Newton
Quitman County Hospital (Marks)

Missouri
Parkland Health Center – Weber Road (Farmington)
Sac-Osage Hospital (Osceola)
SoutheastHEALTH Center of Reynolds County (Ellington)

Nebraska
Tilden Community Hospital

Nevada
Nye Regional Medical Center (Tonopah)

North Carolina
Blowing Rock Hospital
Vidant Pungo Hospital (Belhaven)
Yadkin Valley Community Hospital (Yadkinville)

Ohio
Doctors Hospital of Nelsonville
Physicians Choice Hospital-Fremont

Oklahoma
Epic Medical Center (Eufaula)
Memorial Hospital & Physician Group (Frederick)
Muskogee Community Hospital
Sayre Memorial Hospital

Pennsylvania
Mid-Valley Hospital (Peckville)
Saint Catherine Medical Center Fountain Springs (Ashland)

South Carolina
Bamberg County Memorial Hospital
Marlboro Park Hospital (Bennettsville)
Southern Palmetto Hospital (Barnwell)
Williamsburg Regional Hospital (Kingstree)

South Dakota
Holy Infant Hospital (Hoven)

Tennessee
Gibson General Hospital (Trenton)
Haywood Park Community Hospital (Brownsville)
Humboldt General Hospital
McNairy Regional Hospital (Selmer)
Parkridge West Hospital (Jasper)
Pioneer Community Hospital of Scott (Oneida)
Starr Regional Medical Center-Etowah
United Regional Medical Center (Manchester)

Texas
Bowie Memorial
East Texas Medical Center-Clarksville
East Texas Medical Center-Gilmer
East Texas Medical Center-Mount Vernon
Good Shepherd Medical Center (Linden)
Gulf Coast Medical Center (Wharton)
Hunt Regional Hospital of Commerce
Lake Whitney Medical Center (Whitney)
Nix Community General Hospital (Dilley)
Renaissance Hospital Terrell
Shelby Regional Medical Center (Center)
Weimar Medical Center
Wise Regional Health System-Bridgeport

Virginia
Lee Regional Medical Center (Pennington Gap)

Wisconsin
Franciscan Skemp Medical Center (Arcadia) ■

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Judith B. Newland **DATE: March 2017**

"Just Do It" – Demonstrate measurable improvements annually in both Quality and Patient Satisfaction.

At Tahoe Forest Hospital, the Measure C project for South Building received approval for Temporary Certificate of Occupancy the new Joseph Family Women and Newborn Care Center. The California Department of Public Health has been notified and we are now awaiting a scheduled licensing survey from the Public Health Department. Once the state licenses the new unit we will be able to care for patients in the new area.

Tahoe Forest Health System is committed to providing the Perfect Care Experience for all individuals who receive services throughout organization. Every employee has an opportunity to be proactive and work together to improve our patient satisfaction scores. Our goal is to honor every person we encounter with a Perfect Care Experience. If we have a mindset of honoring every person that comes through the door with a smile and helpful attitude, that Perfect Care Experience can be achieved. There will be a monthly posting in the Pacesetter with regular tips that support that staff to improve patient satisfaction scores. For the month of March the service tip is simply to ask patients "Is there anything else I can do for you?" By asking individuals every day this question it will make a difference for that Perfect Care Experience.

The Respiratory Therapy Department began their new Pulmonary Function Testing (PFT) in March with volumes exceeding their expectation the first week. This testing measures how well your lungs work. Including how well you're able to breathe and how effective your lungs are able to bring oxygen to the rest of your body. Currently community members have to go outside our health system to obtain this testing.

The Incline Health Center construction improvements on the second floor at Incline Village Community Hospital is completed. The plan to improve access to the laboratory department is completed and in the review process. The Incline Village Community Hospital Foundation will be funding the laboratory improvements.

Creating and implementing a New Master Plan

The Master Plan development continues with focus on clinical space for physicians, hospital activities and critical parking needs. Key stakeholders have been engaged to gain knowledge of future needs in 3, 5 and 10 years. We continue to review and refine the master plan and are beginning the process of obtaining costs.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
CIIO

DATE: 3/13/2017

Mercy Epic

- Order Sets have all been sent to Mercy. They will match ours to their order sets for the best match and then we will revise as needed.
- Master Patient Index file completed from CPSI and OCHIN. Now going through Epic algorithms for duplicates.
- Began Meaningful Use meetings with Mercy.
- Team is scheduling vendor demos of smaller footprint Workstation on Wheels (WOWs) for the new WOWs needed in ED (TFH, IVCH), ASD/PACU (TFH, IVCH) and OP PT. Dates coming soon. Enovate Medical is committed, working on a second.
- Large volume of build work going on including all clinical areas and interfaces.
- MediWare for Blood Bank interfaced to Epic and will follow Mercy model: contract signed
- GE for Fetal Monitoring with interfaces/Epic integration: contract underway. Doctor demo was done with all OB docs attending and giving their approval.

Credentialed Trainers

- Clinical trainer list is finalized.
- Outside trainers needed for:
    - Lab (our staff will be testing and will train post go live)
    - Physicians (IP, Surgeons, Anesthesia. We will handle Ambulatory and ED)
    - DI (IN house staff will complete the training and do post go live training but DI director states they will not be able to handle the pre go live training)
    - Orders (this is Hospital Outpatient depts. and ancillaries

Aperek

- Materials management Item Master file created and sent to Mercy.

Upgrades

- Varian Upgrade was cancelled and will have to be completed post Epic go live. The timeline Varian could provide would not allow TFHD to complete interfaces and lab validation testing for results interface in time.
- CPSI patches were loaded into Test. We are testing now. Hopefully this is the last patch load we will have to do with CPSI.
- Pyxis server upgrade required to handle new interfaces to Epic. This should be an in-house upgrade.

CancerLinQ

- Go live went well. Issues now all fixed. Ending this project.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS **DATE: March 2017**
Chief Nursing Officer

Strategy Two: Choosing and implementing the correct new Electronic Health Record for our system that spans all physician, OP and IP services. Plus acquiring any other critical companion business operations software.

Clinical Operational Readiness (CORe) readiness kick off occurred on March 13, 2017. The purpose of the CORe is multi-faceted:

- Involves operational experts in the design and decision-making throughout the install
- Prepares organizational leadership to recognize and mitigate the risks brought about by system and operational changes
- Educates staff about the tools and reports they will use post-live to identify risks and improve performance and outcomes.

All groundwork for clinical implementation has been completed and we are on schedules to begin direction.

Strategy Four: Developing and implementing a comprehensive Care Coordination Plan coupled with Patient Navigation for all patients that touch our healthcare system.

Care Coordination and Navigation: Orthopedic Care Coordinator hired. Work between clinic operations and care coordination to optimize patient flow for joint replacements to be followed by all orthopedic clients by end of fiscal year.

Centralized scheduling discussions to collaborate with Navigation for the optimal experience accessing the system.

Next steps: Perinatal Care Coordination

Strategy Five: "Just Do It" Continue to show measureable annual improvements in Quality, and Patient Satisfaction.

- New OB and ED Directors have started. Kristy Blake is the new Women & Family Director and Joanna Young is the new ED director.

- Building the perfect patient experience:

    - Improved definition of all PI initiatives throughout the division
    - Improving definition of all areas of the patient experience (AIDET, patient satisfaction, CMS star rating, patient rounding, leader rounding)

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Shawni L. Coll D.O., FACOG
Chief Medical Officer

DATE: March 15, 2017

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1. **GOAL: A complete makeover of our Physician service line**
   Letter of Intent signed with Primary Care Physician and Orthopedic Surgeon, who both plan to start in August of 2017. The Primary Care Physician grew up in Truckee and is finishing residency in July while the Orthopedic Surgeon is finishing a sports medicine fellowship in August.

   Ongoing concentration on recruitment for Primary Care Providers to address known access issue. Overall goal is to recruit 1-2 providers each year for next 5 years.

   Continued physician recruitment, including interviewing multiple gastroenterologists, one of which we are waiting to hear if he is interested in joining our team. We are investigating a new Palliative Care Program to support the Cancer Center and our Primary Care Physicians. We are working to obtain accurate outmigration data to help guide physician recruitment.

2. **GOAL: Electronic Health Record**
   Continuing to keep the physicians informed of new developments with Epic. We will be informing the physicians soon of the Epic training schedule, which will be finalized next month. Continue to work on development of new policy regarding "Copy Forward" and "Make Me the Author" both of which are new functionality with Mercy Epic for our institution.

3. **GOAL: New Master Space Plan**
   We will continue to work collaboratively to make plans for the most efficient use of multipurpose space. The Master Plan was discussed and reviewed in depth at the AC retreat.

4. **GOAL: Care Coordination Plan**
   We are working with staff to add additional coordinators in select specialties to improve patient experience and decrease outmigration.

5. **GOAL: Just Do It**
   We are working with Quality Staff to develop a Care for the Caregiver Checklist. This will allow for consistent care after a difficult situation and provide all the resources available within this helpful tool.

   Chris Arth MD, as Chief of Staff, will be eliciting physician involvement on goals and feedback on the strategic direction of the Medical Staff.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Rick McConn
Chief-Facilities Development

DATE: March 16, 2017

ISSUE: Recommendation for award of bids for the Incline Village Community Hospital HVAC Upgrade Project.

BACKGROUND:

The IVCH HVAC Upgrade Project consists of replacing the existing 30+ year old M2 air handler that serves the isolation room and east side of the 2nd floor.

ACTION REQUESTED:

Award bids as outlined in the Recommendation.

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Incline Village Community Hospital
HVAC Upgrades

December 15, 2016

Bids Received:

RECOMMENDATION FOR AWARD

HVAC Upgrade

Construction		$	363,135
Soft Costs		$	198,943
Contingency/Escalation	8%	$	29,051
Total		***$***	***591,129***

TOTAL DEVELOPMENT COSTS	**$**	**591,129**

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Incline Village Community Hospital
HVAC Upgrades

Bids Received: **December 15, 2016**

COST SUMMARY BREAKDOWN

Element		Cost / SF		Total	Recommended Contractors
1	**General Requirements**		**$**	**128,818**	
2	**Sitework/Existing Conditions**		**$**	**71,110**	C& E Builders
5	**Metals**		**$**	**18,500**	Vertical Iron
6	**Wood & Plastics**		**$**	**-**	C& E Builders
7	**Thermal & Moisture**		**$**	**4,789**	GGI
9	**Finishes**		**$**	**250**	GGI
22	**Plumbing**		**$**	**-**	Intech Mechanical
23	**Mechanical**		**$**	**119,498**	Intech Mechanical
26	**Electrical**		**$**	**19,670**	Merit Electric
	Subtotal Construction Hard Costs		**$**	**363,135**	
	Contingency/Escalation	8%	**$**	**29,051**	
	Owner Furnished Equipment		**$**	**20,458**	
	Professional Fees		**$**	**171,647**	
	Administrative Costs		**$**	**6,839**	
	Total Estimated Construction Cost		**$**	**591,129**	
	TOTAL DEVELOPMENT COST		**$**	**591,129**	

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Incline Village Community Hospital
HVAC Upgrades
Recommendation for Award Estimate

	Description	Quantity	UOM	Unit Cost	UOM	Total	Notes
	CONSTRUCTION HARD COSTS						
01-01000	***GENERAL REQUIREMENTS***						
01-01300	**Administration Requirements**						
1301	Drawing and Reproduction	2.0	MO	650	MO	1,300	
1301	Advertisement	1	LS	1,000	LS	1,000	
1302	Shipping/Postage	2.0	MO	120	MO	240	
1310	Project Management- Principal (1/8 Time)	1.0	LS	2,600	LS	2,600	
1310	Project Management- Accounting	1.0	LS	7,000	LS	7,000	
1311	Project Management (HalfTime)	2.5	MO	10,750	MO	26,875	
1311	Project Superintendency (Full Time)	2.0	MO	21,500	MO	43,000	
1313	Project Engineer (Half Time)	2.5	MO	6,450	MO	16,125	
1313	Project Administrator (1/4 Time)	2.0	MO	2,795	MO	5,590	
1351	Safety/First/Aid/OSHA	1	LS	350	LS	350	
	Administration Requirements					**104,080**	
01-01500	**Temporary Facilities**						
1522	Temp Toilets	2.0	MO	308	MO	616	
1516	Cellular Charges	2.0	MO	350	MO	700	
1523	Office Supplies/Equipment	2.0	MO	115	MO	230	
1532	Miscellaneous Rental	1	LS	1,500	LS	1,500	
1551	Vehicle Fuel/Maintenance	2.0	MO	850	MO	1,700	
1572	Weather Protection	2.0	MO	300	MO	600	
	Temporary Facilities					**5,346**	
01-01700	**Execution Requirements**						
1741	Progress Cleaning	1	LS	2,500	LS	2,500	
1743	Disposal/Off-Haul	2.0	MO	900	MO	1,800	
1744	Final Cleaning	1782	SF	1.00	SF	1,782	
1745	Snow Removal	0.0	MO	500	MO	-	
1761	Protection of Finishes	1.0	LS	1,500	LS	1,500	
1761	General Labor-Daily Cleaning (1/4 Time)	2.0	MO	3,655	MO	7,310	
1761	Closeout Procedures	1	LS	2,000	LS	2,000	
1742	Infection Control	1	LS	2,500	LS	2,500	
	Execution Requirements					**19,392**	
	GENERAL REQUIREMENTS					***128,818***	

	Description	Quantity	UOM		Unit Cost	UOM	Total	Notes
02-00000	***EXISTING CONDITIONS***							
02-40000	**Existing Conditions**							
02 14 16.13	Tunel Siding/Lid Demolition A3.1.1	1	EA	$	71,110.00	EA	71,110	***C&E***
02 14 16.13	Remove Gypboard Ceiling	0	SF	$	8.00	LF	-	***C&E***
02 14 16.13	Remove 2 Hr Wall Assembly	0	SF	$	12.00	SF	-	***C&E***
02 14 16.13	Remove AC Tile Grid to remain	0	SF	$	3.00	EA	-	***C&E***
02 14 16.13	Light Fixtures to Remain in Place	0	EA	$	100.00	EA	-	***C&E***
02 14 16.13	Remove Weather Hood & Grill	0	EA	$	250.00	EA	-	***C&E***
	Existing Conditions						**71,110**	
	EXISTING CONDITIONS						***71,110***	
05-05000	***METALS***							
05 12 00	**Structural Steel Framing**							
05 12 23	TSS 3'x3"	1	EA		18,500	EA	18,500	***Vertical Iron***
05 12 23	HSS5x5x1/4" S0.3G	0	TNS		4,130	TNS	-	***Vertical Iron***
05 12 23	Unistrut Hanger System	0	LF		200	LF	-	***Vertical Iron***
05 12 00	**Structural Steel Framing**						**18,500**	
05 40 00	**Cold-Formed Metal Framing**							
05 41 00	Structural Metal Stud Framing							
	4" 16 GA Wall Framing	0	SF		30.00	SF	-	***C&E***
	6" GA Platform Framing	0	SF		35.00	SF	-	***C&E***
	6" 18 GA Ledger	0	LF		125.00	LF	-	***C&E***
	Framing @ Fire Damper	0	SF		250.00	SF	-	***C&E***
	Flat Strap Backing	0	LF		5.00	LF	-	***C&E***
	Fasteners	0	LS		2,703	LS	-	***C&E***
	Cold-Formed Metal Framing						**-**	
	METALS						***18,500***	
06 00 00	***WOODS AND PLASTICS***							
06 10 00	**Rough Carpentry**							
06 10 00	Plywood Platform 3/4" Fire Rated	0	SF		12	SF	-	***C&E***
06 10 00	Hardiboard Ceiling	0	SF		10	SF	-	***C&E***
06 10 00	Patch Hardi Cementious Siding	0	SF		12	SF	-	***C&E***
06 10 00	**Rough Carpentry**						**-**	
	WOODS AND PLASTICS						***-***	
07 00 00	***THERMAL/ MOISTURE PROTECTION***							
07 20 00	**Thermal Protection**							
07 21 16	R-11 Batts @ Patched Areas	50	SF		3	SF	150	***GGI***
07 20 00	**Thermal Protection**						**150**	
07 54 19	**Roofing**							
07 54 19	Cut/Patch Roof	1	EA		1,000	EA	1,000	***GGI***
07 54 19	**Roofing**						**1,000**	
07 62 00	**Sheet Metal Flashing & Trim**							
07 62 00	Prefinished Flashing	50	LF		25	LF	1,250	***GGI***
07 62 00	**Sheet Metal Flashing & Trim**						**1,250**	
07 81 16	**Cementitious Fireproofing**							
07 81 16	Cementitious Fireproofing; Beams, Columns, Braces, Canopy Deck	50	SF		26	SF	1,300	***GGI***
07 81 16	Patch & Repair Fireproofing	525	SF		1	SF	525	***GGI***
07 81 16	**Cementitious Fireproofing**						**1,825**	
07 84 00	**Firestopping**							
07 84 13	Penetration Firestopping	16	EA		24	EA	384	***GGI/Per Trade***
07 84 43	Fire Caulking	300	BSF		0.6	BSF	180	***GGI/Per Trade***
07 84 43	**Firestopping**						**564**	
07 00 00	***THERMAL/ MOISTURE PROTECTION***						***4,789***	

	Description	Quantity	UOM	Unit Cost	UOM	Total	Notes
09 00 00	***FINISHES***						
09 21 16	**Gypsum Board Assemblies**						
09 21 16	5/8" Type-X Gypsum Board - 2 Layers @ Corridor	0	SF	6.00	SF	-	***C&E***
09 21 18	Tape & Texture (Fire Tape)	0	SF	6.00	SF	-	***C&E***
09 21 20	Scaffolding & Equipment	0	LS	1,500.00	LS	-	***C&E***
09 50 00	**Ceilings**						
	Acoustical Panel Ceilings						
09 51 13	Rework & Re-use Existing Grid	0	RMS	200	RMS	-	***C&E***
09 51 13	2 x 4 Square Edge- Replace with New Tile	0	SF	15	SF	-	***C&E***
	Ceilings					-	
09 90 00	**Painting & Coating**						
09 91 13	Interior Walls	1	EA	250.00	EA	250	***GGI***
09 90 00	**Painting & Coating**					**250**	
09 00 00	***FINISHES***					***250***	
21-00000	***FIRE SUPPRESSION***						
	Fire Suppression						
	Fire Sprinklers (Adjust Existing Heads)	1	SF	500.00	SF	500	***GGI/TBD***
	Fire Suppression					**500**	
21-00000	***FIRE SUPPRESSION***					***500***	
22-00000	***PLUMBING***						
22-0000	**Plumbing**						
	Adjustments to HWQ & CHW Piping & Valves	0	Days	1,200	Days	-	***Intech***
	Piping Materials	0	LS	2,000	LS	-	***Intech***
22-00000	**Plumbing**					-	
22-00000	***PLUMBING***					***-***	
23-00000	***HEATING VENTILATING AND AIR CONDITIONING***						
23-00000	**Heating, Ventilating, and Air Conditioning**						
	Mechanical Demolition & Safe Off	1	LS	119,498	LS	119,498	***Intech***
	Air Handler Unit M-2/Blower Coil FC-206	0	LS	20,458	LS	-	***TFHD***
	New Humidifier	0	LS	50,000	LS	-	***Intech***
	Air Intake Louver/ F&I	0	EA	5,000	EA	-	***Intech***
	Fire Damper behind louver	0	LS	5,000	LS	-	***Intech***
	Duct - SQ/RECT-36"x36"	0	LF	325	LF	-	***Intech***
	Duct - SQ/RECT-14"x14"	0	LF	325	LF	-	***Intech***
	Duct - Round- 12"	0	LF	125	LF	-	***Intech***
	Duct - SQ/RECT- 36"x 20"	0	LF	300	LF	-	***Intech***
	S/A Registers	0	EA	500	EA	-	***Intech***
	Duct Hangers & Supports	0	LS	20,000	LS	-	***Intech***
	Seismic Bracing	0	LS	15,000	LS	-	***Intech***
	Wet Side						
	Condensate Drains & Humidifier Supply Piping	0	LF	25	LF	-	***Intech***
	Pipe Hangers & Supports	0	EA	250	EA	-	***Intech***
	Fire/Smoke Damper	0	EA	10,000.00	EA	-	***Intech***
	New Supply/Exhaust Grilles	0	EA	300.00	EA	-	***Intech***
	Test & Balance	0	SF	2.50	SF	-	***Intech***
	Heating, Ventilating, and Air Conditioning					**119,498**	
	HEATING VENTILATING AND AIR CONDITIONING					**119,498**	
26-00000	***ELECTRICAL***						
	Electrical (Re-Install Existing Fixtures)	1	EA	19,670.00	EA	19,670	***Merit***
	New Conduit	0	LF	75.00	LF	-	***Merit***
	New LED Wall Mount Fixture	0	EA	1,500.00	EA	-	***Merit***
	New J Boxes	0	EA	300.00	EA	-	***Merit***
	Electrical Panel Upgrades	0	LS	5,000.00	LS	-	***Merit***
	Fire Alarm Modifications	0	LS	2,000.00	LS	-	***Merit***
	Basic Electrical					**19,670**	
	ELECTRICAL					***19,670***	

	Description	Quantity	UOM	Unit Cost	UOM	Total	Notes
	SUBTOTAL CONSTRUCTION HARD COSTS					***363,135***	
17-17000	***PROJECT CONTINGENCY***						
17-17000	**Project Contingency**						
1100	Construction Contingency/Escalation	8.00%	PC	Const Cost	PC	29,051	
	Project Contingency					**29,051**	
	PROJECT CONTINGENCY					***29,051***	
	TOTAL CONSTRUCTION COSTS					***392,186***	
	Total SF 1782			***Total Construction Costs per SF***		***220.08***	
	SOFT COSTS						
18-18000	***OWNER FURNISHED EQUIPMENT (FFE)***						
018-0000	***Owner Furnished Equipment***						
1100	Air Handler Unit M-2/Blower Coil FC-206 (Trane)	1	LS	20,458	LS	20,458	***TFHD***
	Owner Furnished Equipment					***20,458***	
	OWNER FURNISHED EQUIPMENT (FFE)					***20,458***	
19-19000	***PROFESSIONAL FEES***						
019-0000	**Professional Fees**						
19000	Cost Estimating/Preconstruction Services	0.20	LS	21,500.00	LS	4,300	
19000	Public Bid Process	1	LS	40,000.00	LS	40,000	
19000	Construction Management	10%	PC	Const Cost/Const Con	PC	39,219	
20103	Architectural Design - KAP	1	LS	31,585.00	LS	31,585	
20103	KAP Design - Reimbursables	1	LS	4,666.00	LS	4,666	
20103	Structural Design/ A&D	1	LS	9,450.00	LS	9,450	
20103	Mechanical/Plumbing Design/ Bender	1	LS	16,740.00	LS	16,740	
20103	Electrical/ SA Eng.	1	LS	6,000.00	LS	6,000	
20103	Fire Alarm Design	1	LS	0.00	LS	-	
20103	Fire Sprinkler Design	1	LS	0.00	LS	-	
2500	Testing/Inspections	4.00%	LS	Const Cost/Const Con	LS	15,687	
2500	I.O.R. Testing/ NA	0	LS	0.00	LS	-	
	Building Permit	1	LS	4,000.00	LS	4,000	
3400	Agency Fees	1	LS	0.00	LS	-	
3400	10% Agency Fee Contingencies	10%	PC	0.00	PC	-	
019-0000	**Professional Fees**					**171,647**	
	PROFESSIONAL FEES					***171,647***	
20-20000	***ADMINISTRATIVE COST***						
020-0000	**Administrative Cost**						
1300	State Review (OSHPD) - NA	0.00%	PC	Const/Equip Cost	PC	-	
1400	General Liability Insurance	0.85%	PC	Gen Req/CM	PC	1,428	
1500	Performance/Payment Bonding	1.25%	PC	Const Cost/Cont/CM	PC	5,410	
1600	Administrative Bond Contingency	0.00%	PC	Const Cost	PC	-	
1700	Course of Construction Insurance	0.00%	PC	Const Cost	PC	-	
020-0000	**Administrative Cost**					**6,839**	
20-20000	***ADMINISTRATIVE COST***					***6,839***	
	TOTAL SOFT COSTS					***198,943***	
	TOTAL CONSTRUCTION COSTS					***392,186***	
	TOTAL SOFT COSTS					***198,943***	
	SUBTOTAL DEVELOPMENT COST					***591,129***	
	ESTIMATED TOTAL DEVELOPMENT COST					***591,129***	
	Total SF 1782				***Price per SF***	***331.72***	

CEO INCENTIVE COMPENSATION FY 2016/2017

AD HOC COMMITTEE (Directors Chamblin and Hill)

March 23, 2017

TAHOE FOREST HOSPITAL DISTRICT

At the February, 2017, board meeting several questions arose regarding the CEO's proposal for establishing incentive compensation for the fiscal year ending June 30, 2017. An ad hoc committee, consisting of directors Chamblin and Hill was authorized to review the issue and report back at the March, 2017, board meeting.

After numerous phone calls, emails and meetings, it is the recommendation of this ad hoc committee that we accept Harry Weis' incentive compensation proposal for the current 2016/2017 fiscal year. We also propose that for the fiscal year 2017/2018, and the years to follow, we consider significant modifications that will be highlighted in the presentation.

Setting the Stage

The establishment of comprehensive short and long term goals and objectives throughout the organization is critical to assuring that progress is reasonably and properly monitored on a regular and on-going basis.

This will help to assure that both challenges and opportunities are identified in a timely manner, thus affording the occasion to review options and consider course adjustments.

When crafting short and long term goals and objectives for the CEO (in concert with the CEO), a thoughtful array of objective and subjective elements should be considered for purposes of developing performance and performance measuring criteria.

Primary, over-arching goals should have specific, supporting programs, plans or objectives (dashboard-like) which offer a sense of progress, efforts expended, etc. The content within each goal serves as "legs of the stool" or waypoints on the road map to the goal or objective.

Those goals and objectives which are highly subjective require greater evidence of programs and efforts implemented to help achieve the objective.

Setting the Stage, continued

They should be structured in a manner that combines quantitative and qualitative criteria in the most clear and unambiguous terms. Thus, assuring specificity and more thoughtful, collective dialogue. They should also reflect and be linked, to the greatest extent possible, to the mission, values and beliefs of the organization.
Ideally, each goal and objective should be evaluated based on an identified, common scale. (e.g., 1 to 5 or minimum/meets/exceeds, etc.)

A tight but flexible set of criteria, with the ability to modify or adjust over time, will assure that the CEO, staff and next generation board members will be afforded stability and continuity.

Finding the proper balance between a limited or sparse set of criteria and overly comprehensive minutia should be the objective. It is important, however, to recognize that each paddle in the water has a purpose and impact on the pace and direction in which the vessel is moving.

CEO'S Incentive Compensation FY 2015/2016 (Abbreviated)

Financial/Quantitative — WEIGHTED: 50%

- EBIDA (Op Inc of $2,054,000 – 1%)
- Days cash on hand (158 days)
- AR (60 days)
- ROE (3.1%)

Qualitative/subjective — WEIGHTED: 10% each

- EMR
- Compliance
- Quality/Patient Satisfaction
- Physician Alignment
- Outmigration

TAHOE FOREST HOSPITAL DISTRICT

Process

The ad hoc committee met to discuss the board-directed mandate to evaluate and develop guidelines for the CEO's 2016/2017 performance goals and incentive program.

A series of related questions and discussion points were developed and documented by the ad hoc committee, and presented for review to the CEO. This was followed by a meeting between the ad hoc committee and the CEO for review, discussion and agreement in principle

It is important to note that several procedural, policy and contractual questions arose as part of this discussion which, by their nature, somewhat constrain options - at this time.

Recommendations

Net Income: $4,080,024 – FY ‘17 **WEIGHTED:60%**

Days cash on hand: 169 - 6/30/17 **WEIGHTED: 10%**

6 major goals (previously defined as strategies) **WEIGHTED: 30%**

Compliance *WEIGHTED: 10%*

The CEO will assure and demonstrate that a current and comprehensive compliance program is in place.

Patient Satisfaction/Quality *WEIGHTED: 10%*

Press Ganey (IP, OP, Ambulatory, TFH/IV ER, MSC) Use 6/30/16 as baseline target for the 2016/2017 year.

Physician service lines *WEIGHTED: 5%*

Complete makeover, Considering ECG work & task force work, Walter Kopp input

Information Technology *WEIGHTED: 2%*

Define with best terms the next EMR for TFHS and the related business software

Create a new Master Plan *WEIGHTED: 1%*

All physician services, clinical services, overhead services and parking

Community Relations *WEIGHTED: 2%*

TAHOE FOREST HOSPITAL DISTRICT

Ad Hoc Committee Recommendation

Deliberate, modify, agree and approve the CEO's 2016/2017 Incentive Compensation Program.

TAHOE FOREST HOSPITAL DISTRICT

Ad Hoc Committee Recommendations for Future Discussion

Issues arose during our discussions, which we believe warrant further board consideration and discussion at such time as they can be properly scheduled and noticed.

This is in keeping with the understanding that the mandate for the ad hoc committee was limited to the CEO's performance and incentive program for the 2016/2017 year consistent with the CEO's contract and all current, related policies.

Recommendations:

Revisit CEO's contract
Review all policies related to CEO's compensation, performance and incentive program.
Review evaluation process and methodology.
Review weighting criteria
Consider language giving the board discretion on incentive payout.
Consider both quantitative and high level qualitative efforts and programs be identified within the goals.
Consider more content/substance within objectives
    Programmatic efforts developed/implemented to support achievement of goals. ("Legs of the stool"/ Way Points)
Consider additional elements of import to the board
    Board relations (Communications/Education/Policies/SWOT/Road Rules)
    Employee Satisfaction (Climate, morale, labor relations, etc.)
    Physician relations
    Community relations (Development/involvement, etc.)
    Others TBD

Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Laurel Holmer,
Infection Preventionist

DATE: Mar. 13, 2017

INFECTION PREVENTION and CONTROL: Review of system-wide function

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ISSUE:

The Board of Directors (BOD) of Tahoe Forest Health System (TFHS) has the ultimate responsibility for the quality of care and services provided throughout the system. The BOD assures that a facility-wide systematic process is in place to identify, investigate, measure, analyze, report and improve quality and safety. The Infection Prevention and Control function performs essential activities that adhere to nationally recognized evidence-based practices and guidelines, and comply with applicable federal, state, and local agencies as well as accreditation requirements for critical assess hospitals.

Infection Prevention and Control is a foundational TFHS function driven by patient safety and harm reduction aimed to prevent healthcare-associated infections (HAI). To this aim, a discipline of knowledge, skills and practices are applied to achieve excellence in services provided, people and products delivering those services, and the environments where services occur. Design of reliable systems with the capacity for growth to sustain quality care in a fiscally responsible fashion is paramount.

BACKGROUND/SUMMARY:

An annual and as needed editing review of The Infection Control and Exposure Control Plans and pertinent policies and procedures occurs with subsequent approval from the required stakeholders. Ongoing education, adherence monitoring of evidence-based best practices, relevant and rigorous surveillance, data collection, analysis, and transparent reporting requires teamwork. Design of reliable systems to prevent and control infections and communicable diseases is done in a fiscally responsible fashion.

Training and education are essential to promote a culture of quality. Employees, contracted workers, volunteers and Medical Staff receive education about infection prevention and control at initial orientation; additional departmental orientation follows.

This presentation provides a brief overview of TFHS' Infection Prevention and Control function.

ACTION REQUESTED:

There is no action required. This is an educational presentation.

Infection Prevention & Control

Report to BOD
March 23, 2017

Presented by:
Laurel Holmer, Infection Preventionist
MEd, CLS(ASAP)SH

Janet VanGelder, Quality and Regulations Director
RN, DNP, CPHQ, NEA-BC

Infection Prevention & Control

- **Who:** all are called to be germ-busters
- **What**: measures taken system-wide to prevent, identify, control, investigate, and report transmission of disease-causing organisms; harm-reduction/safety initiative
- **Where**: TFH, IVCH, community outreach
- **When**: 24/7
- **Why**: prevent healthcare-associated infections (HAI)

Essential Components

- Customer-focused
- Evidence-based best practices
- Aligned with state/federal regulation mandates & public health policy
- Foundationally linked to Quality & Process Improvement
- Surveillance of process & outcome measures
- Risk assessment driven
- Survey ready

»HAI Prevention

- **Primary aim:** prevent healthcare-associated infections (HAI)
- Germ-busting processes require system-wide intentional coordinated efforts
- Involves all healthcare workers:
  - Employees, Medical Staff, Contracted, Volunteers
- Engages patients, families, visitors, community

HAI Prevention

- Infection Control Plan
- Exposure Control Plan
- Education: Initial, Annual & Ongoing
  - Hand hygiene & other standard precautions
  - Transmission-based precautions
  - Cleaning, disinfection, sterilization
  - Safe injection & device-insertion/removal practices
  - Checklists/Bundles
  - Adherence monitoring: practice matches P&P
- Antimicrobial Stewardship Program (ASP)

Communication & Accountability

Board of Directors

Medical Executive Committee

Quality Committee

Infection Control Committee

Quality Indicators: aligned with reporting mandates

- Surgical Site Infections (SSI)
- Device-related & other infections
    - Central line-associated bloodstream infections (CLABSI); insertion practices (CLIP)
    - Ventilator-associated events/pneumonias (VAE, VAP)
    - Catheter-associated urinary tract infections (CAUTI)
    - Lab ID events:
        - Clostridium difficile (c diff)
        - MRSA or VRE Bloodstream infections
- Hand Hygiene Compliance
- Employee Health's Occupational Exposure Tracking/Trending
- Healthcare Worker Influenza Vaccination Rates

Hip Prosthesis Surgical Site Infections (SSI)
CDPH Jan-Dec 2015 annual report

Hospital name	Procedure count	Infection count	Expected infection count	SIR	SIR 95% confidence interval	Com-parison
TFH	122	0	0.54	0	0.00 6.00	No diff.

Standardized Infection Ratio (SIR): Statistical metric to compare actual # of HAIs in a facility/state with a baseline U.S. experience; calculation similar to standardized mortality ration (SMR) used to analyze mortality data

- Adjusts for facility differences; types of patients can affect infection rates

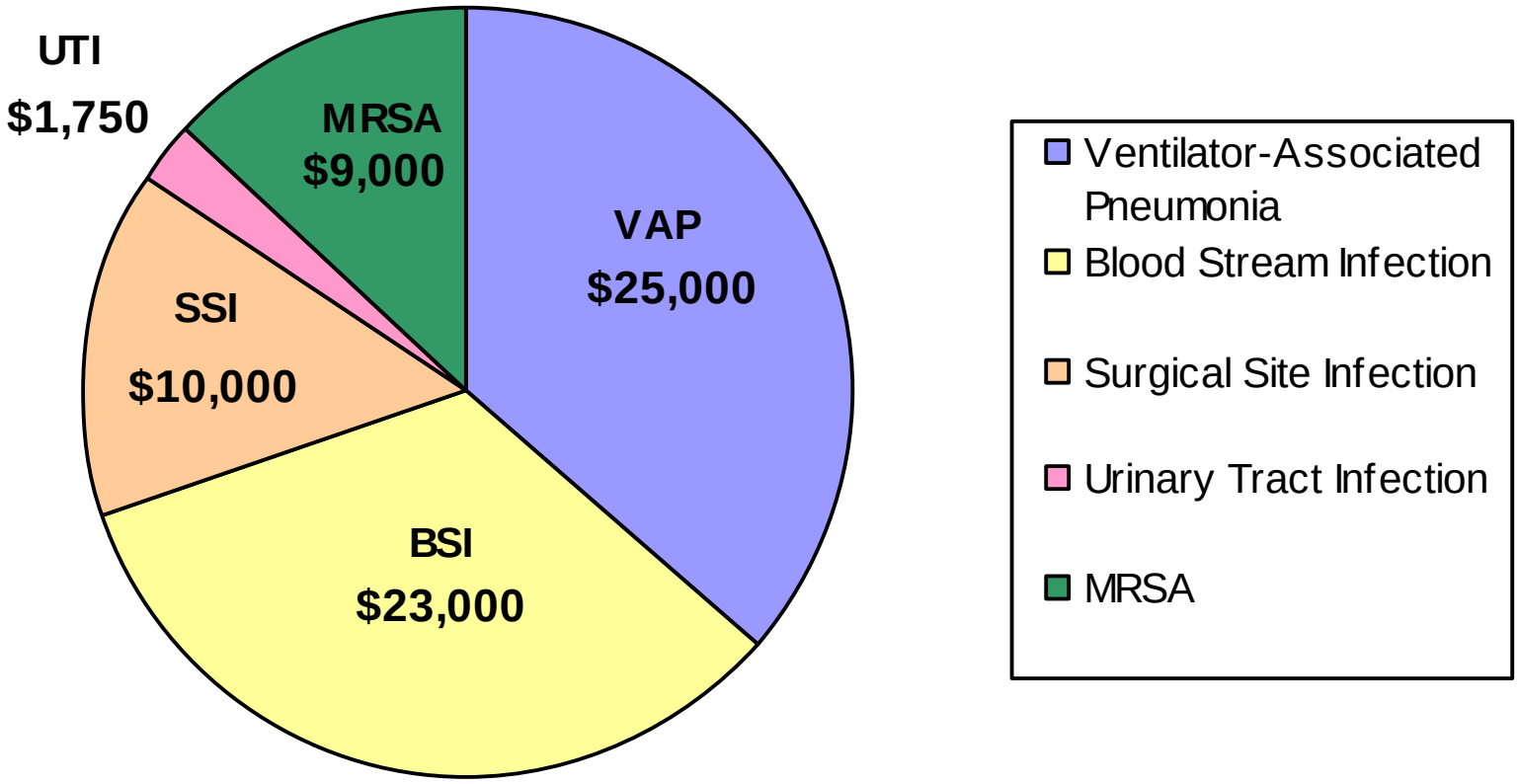
- SIR <1 is desirable; # of infections less than expected
- SIR = 0 means no difference between expected and observed # of infections
- SIR>1 means there were more infections than expected

- Annual statewide report done for 29 surgical procedure categories; TFHD does 20 of the 29 surgical procedures

HAI Prevention Saves Lives & $

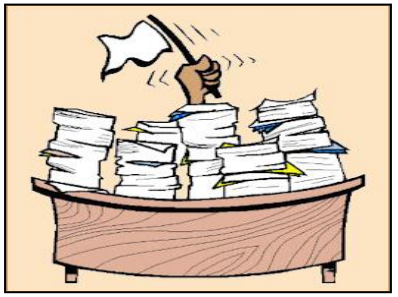
Treating *Clostridium difficile* adds about $7,285 in hospital costs per patient, not including readmissions.

Estimated Cost of Infections



* Values are based on 2007 Duke University Study

Challenges



- Apply EMR capabilities to IC processes
- Seek data mining solutions to replace manual paper methods to achieve real-time continuous surveillance & notification
- Combat acquisition and/or transmission of emerging multi-drug resistant organisms (MDROs)
- Assess effectiveness of IC measures
- Sustain system-wide IC prevention & control measures

Thank-you!
Questions & Comments

- lholmer@tfhd.com (530) 582-8231
- jvangelder@tfhd.com (530) 582-6629

TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE
AGENDA

Tuesday, March 14, 2017 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 1/23/2017 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter and 2017 Focus ..... ATTACHMENT
Review and approve the Quality Committee Charter and proposed 2017 goals.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Patient & Family Advisory Council Update
An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

6.2.2. TIMED ITEM – 12:15 PM - Patient Experience Presentation
Family member presentation about spouse's care at Gene Upshaw Memorial Cancer Center and Tahoe Forest Hospital.

6.3. Healthcare Facilities Accreditation Program (HFAP) Survey
Provide an update on preparation for the unannounced triennial HFAP accreditation survey in the spring of 2017.

6.4. Medical Staff Quality Committee (MSQAC)
Discuss the option of having two Board members attend the open session bimonthly MSQAC meeting instead of having a separate Board Quality Committee meeting.

6.5. Quadruple Aim

Discuss plan to obtain physician and staff engagement information with a goal to improve the experience of providing care.

6.6. Board Quality Education .....ATTACHMENT

Discuss the Governance Institute white paper on Maximizing the Effectiveness of the Board's Quality Committee: Leading Practices and Lessons Learned (Fall 2015). The Committee will review and discuss topics for future board quality education.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting, Tuesday, May 9, 2017, at 12:00 p.m. will be confirmed.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

PERSONNEL COMMITTEE
AGENDA

Tuesday, March 21, 2017 at 10:30 a.m.
Human Resources Conference Room, Tahoe Forest Hospital
10024 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong., Chair; Dale Chamblin, Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 02/23/2017..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Employee Retirement Plan Deferral
The Personnel Committee will discuss whether to move forward increasing automatic retirement plan deferrals and a communication plan for the increase.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
Personnel Committee will discuss its next meeting date.

9. ADJOURN

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TAHOE FOREST HEALTH SYSTEM

FINANCE COMMITTEE AGENDA

Tuesday, March 21, 2017 at 8:00 a.m.
Tahoe Conference Room, Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Dale Chamblin, Chair; Greg Jellinek, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 2/23/2017 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Financial Reports
- 6.1.1. Financial Report – January 2017 ..... ATTACHMENT
- 6.1.2. Financial Report – February 2017 ..... ATTACHMENT*

6.2. FY18 Budget Update ..... ATTACHMENT*
The Finance Committee will receive an update on the fiscal year 2018 budget.

6.3. ACA Repeal/Replacement ..... ATTACHMENT
The Finance Committee will receive information regarding the proposed Affordable Care Act partial repeal and replacement plan.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. AGENDA INPUT FOR NEXT FINANCE COMMITTEE MEETING ..... ATTACHMENT*

9. NEXT MEETING DATE ..... ATTACHMENT*

10. ADJOURN

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