TAHOE FOREST HOSPITAL DISTRICT

2018-10-25 Regular Meeting of the Board of Directors

Thursday, October 25, 2018 at 4:00 p.m.

Tahoe Truckee Unified School District

11603 Donner Pass Road, Truckee, CA 96161

Meeting Book - 2018-10-25 Regular Meeting of the Board of Directors

10/25/18 Agenda Packet Contents

later time.

18. ITEMS FOR BOARD DISCUSSION

19. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

ITEMS 21 - 26: See Agenda

27. ADJOURN

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, October 25, 2018 at 4:00 p.m.

Tahoe Truckee Unified School District
11603 Donner Pass Road, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **DELETIONS/CORRECTIONS TO 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. **ITEMS FOR BOARD ACTION**◈
   5.1. Fiscal Year 2018 Audited Financial Statements Report◈ .....ATTACHMENT
   The Board of Directors will consider acceptance of the audited financial statements presented by Moss Adams.

6. **CLOSED SESSION**
   6.1. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: Third Quarter 2018 Corporate Compliance Report
   Number of items: One (1)
   6.2. Report Involving Trade Secrets (Health & Safety Code § 32106)
   Discussion will concern: Proposed new programs and facilities
   Estimated date of disclosure: October 2018
   6.3. Approval of Closed Session Minutes◈
   09/27/2018
   6.4. TIMED ITEM – 5:30PM – Hearing (Health & Safety Code § 32155)◈
   Subject Matter: Medical Staff Credentials

7. **DINNER BREAK**

   APPROXIMATELY 6:00 P.M.

8. **OPEN SESSION – CALL TO ORDER**

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

10. **DELETIONS/CORRECTIONS TO THE POSTED AGENDA**

11. **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

◈ Denotes Action Item

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 President 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.

12. 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.

13. SAFETY FIRST

13.1. October Safety First Topic

14. ACKNOWLEDGMENTS

14.1. October 2018 Employee of the Month.....ATTACHMENT
14.2. October is Breast Health Awareness Month .....ATTACHMENT
14.3. BETA Quest for Zero Recognition.....ATTACHMENT
14.4. Harry Weis Named in Becker's Hospital Review's List of "71 Critical Access Hospital CEOs to Know" .....ATTACHMENT
14.5. Healthcare Quality Week – October 21-27, 2018.....ATTACHMENT

15. MEDICAL STAFF EXECUTIVE COMMITTEE◈

15.1. Medical Executive Committee (MEC) Meeting Consent Agenda .....ATTACHMENT
MEC recommends the following for approval by the Board of Directors: *PA/NP Privilege Form, Pediatric Early Warning Score (PEWS) and Algorithm, Medical Staff Bylaws amendments, and Medical Staff Rules and Regulations amendments.*

16. 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.

16.1. Approval of Minutes of Meetings

16.1.1. 09/27/2018 .....ATTACHMENT
16.1.2. 10/08/2018 .....ATTACHMENT

16.2. Financial Reports

16.2.1. Financial Report – September 2018 .....ATTACHMENT

16.3. Staff Reports

16.3.1. CEO Board Report .....ATTACHMENT
16.3.2. COO Board Report.....ATTACHMENT
16.3.3. CNO Board Report.....ATTACHMENT
16.3.4. CIIO Board Report .....ATTACHMENT
16.3.5. CMO Board Report.....ATTACHMENT
16.3.6. CHRO Board Report .....ATTACHMENT

16.4. Policy Review

16.4.1. ABD-07 Conflict of Interest Policy.....ATTACHMENT

17. ITEMS FOR BOARD ACTION◈

17.1. First Reading of Proposed Revisions to TFHD Board of Directors Bylaws.....ATTACHMENT
The Board of Directors will review proposed revisions to the TFHD Board of Directors Bylaws.

◈ Denotes Action Item

17.2. Minority Shares Purchase in an Outpatient Medical Facility .....ATTACHMENT*
The Board of Directors will discuss and consider for approval the purchase of the minority shares in an outpatient medical facility.

18. ITEMS FOR BOARD DISCUSSION

18.1. Corporate Compliance Report ..... ATTACHMENT
The Board of Directors will receive a third quarter corporate compliance report.

18.2. Board Education

18.2.1. High Reliability Organization .....ATTACHMENT
The Board of Directors will receive education on High Reliability Organization.

19. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

20.1. Governance Committee Meeting – 09/28/2018 ..... ATTACHMENT
20.2. Finance Committee Meeting – No meeting held in October.
20.3. Executive Compensation Committee Meeting – No meeting held in October.
20.4. Quality Committee Meeting – No meeting held in October.

21. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

22. ITEMS FOR NEXT MEETING

23. BOARD MEMBERS REPORTS/CLOSING REMARKS

24. CLOSED SESSION CONTINUED, IF NECESSARY

25. OPEN SESSION

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

27. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is November 29, 2018 at Tahoe Truckee Unified School District, 11603 Donner Pass Road, 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.

Report of Independent Auditors and Financial Statements

Tahoe Forest Hospital District

June 30, 2018 and 2017

Table of Contents

Management's Discussion and Analysis

Tahoe Forest Hospital District (the "District") is a public entity organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The District includes the following component units which are included as blended component units of the District's combined financial statements: Tahoe Forest Health System Foundation ("TFHSF"), Incline Village Community Hospital Foundation ("IVCHF"), TIRHR, LLC ("TIRHR"), and the Tahoe Institute for Rural Health Research (the "Institute").

Our discussion and analysis of the District financial performance provides an overview of the District's financial activities for the years ended June 30, 2018, 2017, and 2016. Please read this in conjunction with the District's combined financial statements and accompanying notes, which begin on page 11. Our discussion and analysis of the District does not include Truckee Surgery Center, LLC, which is a discretely presented component unit.

Financial Highlights for Fiscal Year 2018

- The District's increase in net position was $5.4 million for 2018 as compared to $18.5 million for 2017.
- The District's income from operations for fiscal year 2018 was ($3.9) million as compared to $7.3 million for 2017.
- Nonoperating revenues were $8.9 million in fiscal year 2018 as compared to $10.9 million for 2017.

The District's combined financial statements consist of the following: combined statements of net position; combined statements of revenues, expenses, and changes in net position; and combined statements of cash flows. These combined financial statements and accompanying notes provide information about the operations of the District as of and for the fiscal years ended June 30, 2018, and 2017.

The Statement of Net Position and Statement of Revenues, Expenses, and Changes in Net Position

One of the most important questions asked about the District's finances is, "Is the District, as a whole, better off or worse off as a result of the year's activities?" The statement of net position and the statement of revenues, expenses, and changes in net position report information about the District's resources and its operations in a way that helps answer this question. These two statements include all assets and liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account, regardless of when cash is received or paid.

These two statements report the District's net position and changes in them. You can think of the District's net position (the difference between assets and liabilities) as one way to measure the District's financial health or financial position. Over time, increases or decreases in the District's net position are one indicator of whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the District's patient base, and measures of quality of service it provides to the community, as well as local economic factors, in order to assess the overall financial health of the District.

The Statement of Cash Flows

The final required financial statement is the statement of cash flows. This statement reports cash receipts, cash payments, and net changes in cash resulting from operating, noncapital financing, capital and related financing, and investing activities. It provides answers to questions such as "where did the cash come from," "what was cash used for," or "what was the change in cash balance during the reporting period?"

The District's Net Position

The District's net position is the difference between its assets and liabilities reported in the combined statement of net position found on page 11. The District's net position changed by $5.4 million for 2018 as compared to $18.5 million for 2017, as presented in the following table (amounts are in thousands):

	As of June 30,		
	2018	**2017**	**2016**
Current assets	$ 61,802	$ 52,817	$ 40,358
Capital assets	167,112	165,456	158,613
Restricted and other assets	55,959	63,890	64,122
Total assets	284,873	282,163	263,093
Deferred outflows of resources	7,394	8,194	9,243
Current liabilities	27,739	28,224	25,650
Long-term liabilities	129,579	132,614	135,631
Total liabilities	157,318	160,838	161,281
Net investment in capital assets	43,982	40,931	32,287
Restricted - expendable	3,655	3,121	2,907
Restricted - nonexpendable	32	29	-
Unrestricted	87,280	85,438	75,861
Total net position	$ 134,949	$ 129,519	$ 111,055

Operating Results and Changes in the District's Net Position

During 2018, the District's net position increased by $5.4 million as compared to $18.5 million in 2017, as presented in the following table. These increases are comprised of operating and nonoperating components and represent the total change in net position of the District. Three areas of expenses created significant differences between 2018 and 2017: salaries, wages, and benefits $5.5 million, professional fees $2.0 million, and supplies $2.1 million. The increase in salaries, wages, and benefits is due to increased staffing, merit increases, management incentive compensation bonuses, and the employee gain-sharing bonus program (new starting in 2017). The increase in professional fees is due to the addition of several new physician providers. The increase in supplies is due to the cost of pharmaceuticals primarily related to our cancer program.

	Fiscal years ended June 30,		
Operating revenues (thousands)	2018	2017	2016
Net patient service revenues	$ 148,737	$ 148,296	$ 130,395
Other operating revenues	9,962	8,965	8,025
Total operating revenues	158,700	157,262	138,421
Operating expenses (thousands)			
Salaries and wages	53,747	51,111	44,146
Employee benefits	27,763	24,925	24,633
Professional fees	24,857	22,864	19,690
Supplies	21,490	19,430	17,854
Purchased services	13,870	13,085	11,066
Depreciation and amortization	11,296	10,747	10,280
Other operating expenses	9,534	7,845	7,635
Total operating expenses	162,557	150,007	135,304
Total operating (loss) income	(3,857)	7,255	3,117
Nonoperating revenue (expenses) (thousands)			
Property tax revenue	7,037	7,315	5,462
Property tax revenue - general obligation bonds	3,869	5,561	4,715
Interest expense	(5,020)	(3,980)	(4,061)
Other nonoperating items	2,995	1,952	1,930
Total nonoperating revenues	8,880	10,848	8,045
Income before other revenue, expenses, gains and losses	5,023	18,103	11,162
Capital contributions	407	361	551
Increase in net position	$ 5,430	$ 18,464	$ 11,713

Operating Gains

The primary component of the overall change in the District's net position is its total income from operations, generally the difference between net patient service revenues and the expenses incurred to perform those services. Total income from operations in 2018 was ($3.9) million as compared to $7.3 million in 2017.

These changes in the District's operations are attributable to:

- Net patient service revenues increased in 2018 by $0.4 million (.3%) due to a combination of changes in volumes, changes in payor mix, a charge increase, and additional reimbursements related to prior periods. Inpatient census days decreased in 2018 to 4,356 from 4,829 in 2017. Adjusted patient days were up 16.3% in 2018 as compared to 2017. Inpatient charges increased by $1.3 million to $73.0 million in 2018 from $71.7 million in 2017. Outpatient charges increased by $14.9 million to $195.7 million in 2018 from $180.8 million in 2017, and as a percentage of total charges, outpatient charges increased to 72.8% of the total in 2018 from 71.6% in 2017. In addition, contractual allowances, charity care, and bad debt increased $16.9 million to $125.9 million in 2018 from $109.0 million in 2017. Prior period settlements increased $1.2 million to $6.0 million in 2018 from $4.8 million in 2017.

- An increase in other operating revenues of $1.0 million (11.1%) in 2018.

- Operating expenses increase of $12.5 million (8.4%) in 2018 due to added services, higher outpatient volumes, employee gain sharing program, and preparation for and post go-live recovery from a system conversion in 2018.

Employee salaries, wages, and benefits were $81.5 million in 2018 and $76.0 million in 2017. The components of these costs are as follows:

- Salaries and wages, totaled $53.7 million in 2018 and $51.1 million in 2017. Staffing, as measured by paid full-time equivalents ("FTEs"), was 683 in 2018 and 664 in 2017. The employee gain-sharing program and management incentive compensation bonuses totaled $1.7 million in 2018 and $4.2 million in 2017.

- Benefits totaled $27.8 million in 2018 and $24.9 million in 2017. The benefits associated with the employee gain-sharing program and management incentive compensation bonuses totaled $0.2 million in 2018 and $0.5 million in 2017.

- Salaries and wages per paid FTE were $119,340 in 2018 and $118,068 in 2017. If we were to remove the 2018 and 2017 gain-sharing program and management incentive compensation bonuses from the salaries, wages and benefits, then the amount per paid FTE was $116,604 in 2018 and $110,810 in 2017.

- Other changes were as follows:

    - There was an increase of $2.0 million (8.7%) in professional fees. This was primarily due to an increase in providers contracted under professional services agreements to provide care in our multi-specialty clinics.

    - There was a $2.1 million (10.6%) increase in supplies primarily due to an increase in pharmaceutical costs.

    - There was a $0.8 million (6.0%) increase in purchased services primarily due to our annual fee related to our new electronic medical record, repairs and maintenance to the hospital campuses and outlying buildings, contracting out our self-pay collections to a third party, and adding additional billing and follow-up resources.

- There was an increase of $0.5 million (5.1%) in depreciation expense due mainly to projects coming on line out of construction in progress offset by capital assets reaching the end of their estimated useful lives.

- Other expense category changes (utilities, building and equipment rent, insurance, dues and subscriptions, travel and education, and other) increased $1.7 million (21.5%) primarily due to an increase in insurance costs, building rents, and utility costs.

Nonoperating Revenues and Expenses

Nonoperating revenues consist of property taxes paid to the District, investment income, contributions, unrealized gains and losses, interest expense, and other various types of items not specifically related to the operations of patient care.

The District's Cash Flows

Changes in the District's cash flows are consistent with the operating income and nonoperating revenues and expenses discussed earlier.

Capital Assets

At the end of 2017, the District had $165.5 million in capital assets, net of depreciation, as detailed in the footnotes to the financial statements. At the end of 2018, the District had $167.1 million invested in capital assets, net of depreciation. In 2018, the District improved facilities and acquired new equipment for a total net investment of $1.6 million, net of disposals, as compared to $6.8 million in 2017.

Debt Borrowings

At the end of 2018, the District has $131.1 million in long-term debt borrowings outstanding including current maturities. At the end of 2017, the District had $133.2 million in long-term debt borrowings outstanding including current maturities. In March 2017, the District advance refunded the Series 2002 variable rate demand revenue bonds totaling $8,890,000 with the Series 2017 variable rate demand revenue bonds totaling $9,060,000.

Other Economic Factors

The District is located in Truckee, California, and Incline Village, Nevada.

The State of California continues to experience fiscal difficulties. As a result, the District will continue to see pressure placed on its Medi-Cal reimbursement for the foreseeable future.

The District's Board of Directors approved the fiscal year 2019 budget at its August 2018 meeting. For fiscal year 2019, the District is budgeted to increase its net position by $5.1 million. The increase is due to the following assumptions:

- Inpatient volumes are budgeted to be approximately 5% higher than 2018 volumes.

- Outpatient volumes, primarily in the multi-specialty clinics, are projected to increase 37%. This is due to the addition of several new providers in the areas of family practice, urology, gastroenterology, orthopedics, and neurology.

- Loss from operations of $4.0 million.

- The District will increase charges by 5%. As a result, the percentages of contractual allowance are budgeted to increase with an approximate 2.4% increase in net patient service revenue percentage.

- Overall operating costs will increase 7.8% due to an increase in FTE's, professional fees related to providers contracted under professional services agreements to provide care in our multi-specialty clinics, and purchased services related to dual maintenance from our EMR/EHR/business systems as we continue to transition to our new systems.

Payments from Federal and State Health Care Programs

Entities doing business with governmental payors, including Medicare and Medicaid (Medi-Cal in California), are subject to risks unique to the government-contracting environment that are difficult to anticipate and quantify. Revenues are subject to adjustment as a result of examination by government agencies as well as auditors, contractors, and intermediaries retained by federal, state, or local governments (collectively "Government Agents"). Resolution of such audits or reviews often extends (and in some cases does not even commence until) several years beyond the year in which services were rendered and/or fees received.

Moreover, different Government Agents frequently interpret government regulations and other requirements differently. For example, Government Agents might disagree on a patient's principal medical diagnosis, the appropriate code for a clinical procedure, or many other matters. Such disagreements might have a significant effect on the ultimate payout due from the government to fully recoup sums already paid. Governmental agencies may make changes in program interpretations, requirements, or "conditions of participation," some of which may have implications for amounts previously estimated. In addition to varying interpretation and evolving codification of the regulations, standards of supporting documentation and required data are subject to wide variation.

In accordance with generally accepted accounting principles, to account for the uncertainty around Medicare and Medi-Cal revenues, the District estimates the amount of revenue that will ultimately be received under the Medicare and Medi-Cal programs. Amounts ultimately received or paid may vary significantly from these estimates.

Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME)

The Public Hospital Redesign and Incentives in Medi-Cal Program ("PRIME") was created to build upon the foundational delivery system transformation work, expansion of coverage, and increased access to coordinated primary care achieved through the prior California Section 1115 Bridge to Reform demonstration. Activities supported by the PRIME program are designed to accelerate efforts by participating PRIME entities to change care delivery to maximize health care value and strengthen their ability to successfully perform under risk-based alternative payment models ("APMs") in the long term, consistent with Centers for Medicare and Medicaid Services ("CMS") and Medi-Cal 2020 goals. The PRIME program is intentionally designed to be ambitious in scope and time-limited. Using evidence-based, quality improvement methods, the initial work required the establishment of performance baselines followed by target setting and the implementation and ongoing evaluation of quality improvement interventions. Participating PRIME entities consist of two types of entities: Designated Public Hospital ("DPH") systems and the District/Municipal Public Hospitals ("DMPH"). The District if focused on two projects: Million Hearts Initiative and Chronic Non-malignant Pain Management. The District is eligible to receive $7.9 million in total funding over a five-year period, from 2016 through 2021, and must meet infrastructure building metrics, pay-for-reporting project metrics, and pay-for-performance project metrics for each of the two projects. In 2018, the District received $0.75 million in PRIME funds related to demonstration year (DY) 12, $1.5 million related to DY 11, and is expected to receive an additional $0.95 million related to DY 12 in 2019. In 2017, the District received $0.20 million related to DY 12, and $1.7 million related to DY 11.

Cautionary Note Regarding Forward-Looking Statements

Certain information provided by the District, including written as outlined above or oral statements made by its representatives, may contain forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. All statements, other than statements of historical facts, which address activities, events, or developments that the District expects or anticipates will or may occur in the future, contain forward-looking information.

Statistical Analysis

	2018	2017	2016
Acute			
Admissions	1,839	1,802	1,575
Length of stay	2.37	2.68	2.73
Average daily census	11.93	13.23	11.80
Occupancy percentage	41.15%	45.62%	40.60%
Patient days	4,356	4,829	4,295
Total ICU days	689	662	608
Total medical/surgical days	2,756	3,202	2,849
Total obstetrics days	911	965	838
Total swing days	389	390	437
Nursery days	763	933	768
Deliveries	305	398	336
Skilled nursing units			
Patient days	11,890	11,508	11,650
Average daily census	32.58	31.53	32.01
Occupancy percentage	88.04%	85.21%	86.30%

Report of Independent Auditors

To the Board of Directors
Tahoe Forest Hospital District

Report on Combined Financial Statements

We have audited the accompanying combined financial statements of Tahoe Forest Hospital District (the "District"), and its discretely presented component unit, Truckee Surgery Center, LLC (the "TSC"), which comprise the combined statements of net position as of June 30, 2018 and 2017, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Purpose Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the net position of the District and its discretely presented component unit, the TSC, as of June 30, 2018 and 2017, and the changes in its net position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

The Management's Discussion and Analysis on pages 1 through 7, are not a required part of the basic financial statements but are supplementary information required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational economic, or historical context. This supplementary information is the responsibility of the District's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements and other knowledge we obtained during our audits of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Rancho Cordova, California
_____, 2018

Combined Financial Statements
As of and for the Years Ended June 30, 2018 and 2017

Tahoe Forest Hospital District
Combined Statements of Net Position
June 30, 2018 and 2017

	2018		2017	
	Tahoe Forest Hospital District	Truckee Surgery Center, LLC	Tahoe Forest Hospital District	Truckee Surgery Center, LLC
ASSETS				
Current assets				
Cash and cash equivalents	$ 18,757,750	$ 35,935	$ 13,056,466	$ 175,342
Patient accounts receivable, net of allowances for doubtful accounts of $4,369,686 and $97,251 in 2018 and $2,983,311 and $121,254 in 2017	24,724,297	216,187	18,563,694	162,200
Other receivables	6,819,895	-	9,713,327	-
Assets limited as to use - required for current liabilities	6,360,727	-	5,837,348	-
Inventories	3,125,793	-	2,999,560	-
Prepaid expenses and deposits	1,738,575	16,406	1,459,014	31,417
Estimated third-party payor settlements	275,458	-	1,187,549	-
Total current assets	61,802,495	268,528	52,816,958	368,959
Assets limited as to use, net of current	53,696,191	-	62,066,412	-
Capital assets				
Nondepreciable	9,213,704	-	45,318,918	-
Depreciable, net of accumulated depreciation	157,898,599	725,710	120,137,011	776,798
	167,112,303	725,710	165,455,929	776,798
Other assets				
Beneficial interest in trusts	1,628,771	-	1,560,206	-
Other receivables	633,743	20,656	263,743	20,256
Total assets	284,873,503	1,014,894	282,163,248	1,166,013
DEFERRED OUTFLOWS OF RESOURCES				
Deferred loss on defeasance, net	6,330,799	-	6,646,194	-
Accumulated decrease in fair value of hedging derivative	1,063,457	-	1,548,299	-
Total deferred outflows of resources	7,394,256	-	8,194,493	-
LIABILITIES				
Current liabilities				
Current maturities of long-term debt and capital lease	2,554,645	-	2,094,306	-
Accounts payable and accrued expenses	6,433,823	150,596	6,358,728	32,680
Patient balances payable	-	-	379,986	-
Accrued payroll and related expense	11,552,844	26,737	13,028,753	39,185
Estimated claims incurred but not reported	4,383,018	-	3,773,266	-
Other accrued expenses	779,208	26,159	620,645	14,166
Accrued interest	2,035,633	-	1,968,750	-
Total current liabilities	27,739,171	203,492	28,224,434	86,031
Long-term debt and capital lease obligations, net of current portion	128,515,422	-	131,065,286	-
Derivative instrument liability	1,063,457	-	1,548,299	-
Total liabilities	157,318,050	203,492	160,838,019	86,031
NET POSITION				
Net investment in capital assets	43,983,410	-	40,931,927	-
Restricted - expendable	3,654,574	-	3,120,791	-
Restricted - nonexpendable	32,209	-	29,209	-
Unrestricted	87,279,516	811,402	85,437,795	1,079,982
Total net position	$ 134,949,709	$ 811,402	$ 129,519,722	$ 1,079,982

See accompanying notes.

Tahoe Forest Hospital District
Combined Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended June 30, 2018 and 2017

	2018		2017	
	Tahoe Forest Hospital District	Truckee Surgery Center, LLC	Tahoe Forest Hospital District	Truckee Surgery Center, LLC
Operating revenues				
Net patient service revenue (net of provision for bad debts of $10,405,185 and $23,861 in 2018 and $6,358,566 and $3,893 in 2017)	$ 148,736,770	$ 1,445,458	$ 148,296,052	$ 1,467,440
Other operating revenue	9,963,176	-	8,965,930	-
Total operating revenues	158,699,946	1,445,458	157,261,982	1,467,440
Operating expenses				
Salaries and wages	53,746,958	533,773	51,110,972	528,459
Employee benefits	27,762,618	118,479	24,925,127	137,515
Professional fees	24,856,521	17,327	22,864,336	23,397
Supplies	21,489,722	616,185	19,430,044	465,988
Purchased services	13,870,463	-	13,084,603	-
Depreciation and amortization	11,296,223	51,088	10,746,536	69,520
Insurance	1,130,450	18,204	794,689	15,972
Other	8,404,033	358,982	7,050,220	416,213
Total operating expenses	162,556,988	1,714,038	150,006,527	1,657,064
(Loss) income from operations	(3,857,042)	(268,580)	7,255,455	(189,624)
Nonoperating revenues (expenses)				
Property tax revenue	7,037,222	-	7,315,131	-
Property tax revenue - general obligation bonds	3,869,465	-	5,561,486	-
Contributions, net	794,425	-	299,349	-
Special event revenue	732,741	-	503,334	-
Interest income	982,274	-	621,235	-
Rental income	416,171	-	361,021	-
Interest expense	(5,020,361)	-	(3,979,875)	-
Other	67,938	-	166,102	261
Total nonoperating revenues	8,879,875	-	10,847,783	261
Income (loss) before other revenue, expenses, gains and losses	5,022,833	(268,580)	18,103,238	(189,363)
Capital contributions	407,154	-	361,256	-
Increase (decrease) in net position	5,429,987	(268,580)	18,464,494	(189,363)
Net position, beginning of year	129,519,722	1,079,982	111,055,228	1,269,345
Net position, end of year	$ 134,949,709	$ 811,402	$ 129,519,722	$ 1,079,982

See accompanying notes.

Tahoe Forest Hospital District
Combined Statements of Cash Flows
For the Years Ended June 30, 2018 and 2017

	2018		2018	
	Tahoe Forest Hospital District	Truckee Surgery Center, LLC	Tahoe Forest Hospital District	Truckee Surgery Center, LLC
Cash flows from operating activities				
Cash received from patients and third-party payors	$ 143,108,272	$ 1,391,471	$ 146,187,839	$ 1,478,493
Cash received from other sources	13,226,103	-	217,658	261
Cash paid to suppliers for goods and services	(69,923,325)	(865,778)	(63,823,700)	(917,405)
Cash paid to employees for services	(82,745,733)	(665,100)	(72,478,568)	(657,970)
Net cash provided by (used in) operating activities	3,665,317	(139,407)	10,103,229	(96,621)
Cash flows from noncapital financing activities				
Property tax revenues	7,087,664	-	8,091,003	-
Noncapital grants and contributions, net of other expenses	1,527,166	-	802,683	-
Net cash provided by noncapital financing activities	8,614,830	-	8,893,686	-
Cash flows from capital and related financing activities				
Purchase of capital assets	(12,952,597)	-	(17,589,924)	(3,563)
Payments on general obligation bonds	(1,660,176)	-	(952,834)	-
Interest payments on general obligation bonds	(4,485,584)	-	(2,653,075)	-
Payment of debt issuance cost	-	-	(140,000)	-
Advanced refunding of long-term debt	-	-	(8,890,000)	-
Proceeds from issuance of long-term debt	-	-	9,060,000	-
Payments on long-term debt and capital leases	(113,954)	-	(2,248,407)	-
Interest payments on long-term debt and capital leases	(467,894)	-	(1,103,649)	-
Capital contributions	407,154	-	361,256	-
Property tax revenue received for general obligation bonds	3,460,115	-	6,406,462	-
Net cash used in capital and related financing activities	(15,812,936)	-	(17,750,171)	(3,563)
Cash flows from investing activities				
Purchases of investments related to assets limited as to use	(11,931,647)	-	(7,520,881)	-
Sales of investments related to assets limited as to use	19,778,489	-	3,778,182	-
Interest received	982,274	-	621,235	-
Net cash received for rental activities	416,171	-	361,021	-
Purchases of investments in beneficial interest in trusts	(11,214)	-	(38,055)	-
Net cash provided by (used in) investing activities	9,234,073	-	(2,798,498)	-
Net change in cash and cash equivalents	5,701,284	(139,407)	(1,551,754)	(100,184)
Cash and equivalents, beginning of year	13,056,466	175,342	14,608,220	275,526
Cash and equivalents, end of year	$ 18,757,750	$ 35,935	$ 13,056,466	$ 175,342

See accompanying notes.

Tahoe Forest Hospital District
Combined Statements of Cash Flows (Continued)
For the Years Ended June 30, 2018 and 2017

	2018		2017	
	Tahoe Forest Hospital District	Truckee Surgery Center, LLC	Tahoe Forest Hospital District	Truckee Surgery Center, LLC
Reconciliation of income from operations to net cash from operating activities				
Income from operations	$ (3,857,042)	$ (268,580)	$ 7,255,455	$ (189,624)
Adjustments to reconcile operating income to net cash from operating activities				
Depreciation and amortization	11,296,223	51,088	10,746,536	69,520
Provision for doubtful accounts	10,404,881	23,861	6,357,628	3,893
Change in assets and liabilities:				
Patient receivables	(16,565,788)	(77,848)	(8,623,553)	7,160
Other receivables	3,246,586	-	(8,756,709)	-
Inventories	(126,233)	-	(327,950)	-
Unconditional promises to give, net	6,058	-	9,375	-
Beneficial interest in trusts	(257)	-	-	-
Prepaid expenses and deposits	(279,561)	15,011	(124,320)	499
Other assets	(370,000)	(400)	(13,255)	-
Accounts payable and accrued expenses	75,095	117,916	(309,613)	4,025
Accrued payroll and related expense	(1,475,909)	(12,448)	2,977,529	8,004
Estimated third-party payor settlements	912,091	-	26,070	-
Patient balances payable	(379,986)	-	130,704	-
Estimated claims incurred but not reported	609,752	-	593,257	-
Other	169,407	11,993	162,075	(98)
Total adjustments	7,522,359	129,173	2,847,774	93,003
Net cash provided by (used in) operating activities	$ 3,665,317	$ (139,407)	$ 10,103,229	$ (96,621)

See accompanying notes.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Reporting entity – Tahoe Forest Hospital District (the "District") is a political subdivision of the State of California. The District was established in 1949 under the provisions of Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The District operates Tahoe Forest Hospital in Truckee, California, and Incline Village Community Hospital in Incline Village, Nevada, which provide health care services to residents of the surrounding communities and visitors to the area. The District derives a significant portion of revenue from third-party payors, including Medicare, Medi-Cal, and commercial insurance organizations.

The District includes the following component units, which are included as blended component units of the District's combined financial statements: Tahoe Forest Health System Foundation (the "TFHSF"), Incline Village Community Hospital Foundation (the "IVCHF"), collectively (the "Foundations"), Tahoe Institute for Rural Health Research (the "Institute"), and TIRHR, LLC ("TIRHR"). The Institute is a nonprofit public benefit corporation and is not organized for the private gain of any person. The purposes for which the Institute is formed are for scientific research. The Institute, as a tax-exempt, nonprofit public corporation, was ill-suited to pursue proposals for support that hinged on participation by private person in future profit. Therefore, TIRHR, a for-profit, was formed in order that research programs that the Institute was pursuing and that were identified as potentially suitable for private investment could be transferred. The Truckee Surgery Center, LLC (the "TSC"), is organized and operated for the purpose of owning and lawfully operating the facility as a Medicare certified ambulatory surgery center that principally performs musculoskeletal surgery and related anesthesia services, all consistent with the purposes of the District of furthering the health care services of the surrounding communities and visitors to the area. TSC is included in the District's combined financial statements as a discretely presented component unit and is discussed further in Note 2.

The District maintains its financial records in conformity with guidelines set forth by Local Health Care District Law and the Office of Statewide Health Planning and Development of the State of California.

Basis of preparation – The combined financial statements of the District have been prepared in accordance with accounting principles generally accepted in the United States of America, including all applicable statements of the Governmental Accounting Standards Board ("GASB"). The proprietary fund method of accounting is followed and uses the economic resources measurement focus and the accrual basis of accounting. In addition, these statements follow generally accepted accounting principles applicable to the health care industry, which are included in the American Institute of Certified Public Accountants' Audit and Accounting Guide, *Health Care Entities,* to the extent that these principles do not contradict GASB standards.

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

Use of estimates – The preparation of combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amount of revenues and expenses during the reporting period. Major items requiring estimates and assumptions include net patient service revenue, allowance for contractual and doubtful accounts receivables, third-party payor settlements, uninsured losses for medical malpractice liabilities, liabilities for worker's compensation claims, useful lives of capital assets, and valuation of financial instruments. Actual results could differ from those estimates.

Cash and cash equivalents – The District considers cash and cash equivalents to include cash on deposit and investments in highly liquid debt instruments with an initial maturity of three months or less, excluding amounts whose use is limited by board designation or other arrangements. Cash and cash equivalents also include investments in the Local Agency Investment Fund ("LAIF"), the State Treasurer's pooled investment program and values participants' shares on an amortized cost basis.

Assets limited as to use – Assets limited as to use include amounts designated by the Board of Directors for replacement or purchases of capital assets, and other specific purposes, and amounts held by trustees under specified agreements. Amounts required to meet current liabilities of the District are included in current assets. Assets limited as to use also include investments in the LAIF.

Patient accounts receivable – Patient accounts receivable consist of amounts owed by various governmental agencies, insurance companies, and private patients. The District manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability, and providing for allowances in its accounting records for estimated contractual adjustments and doubtful accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Inventories – Inventories are stated at the lower of cost or market. Cost is determined by the weighted-average, first-in, first-out method.

Beneficial interest in trusts – The TFHSF has been named a beneficiary under the terms of the Community for Cancer Care Endowment (the "Fund") administered by the Tahoe Truckee Community Foundation ("TTCF"). Under the terms of the agreement, distributions from the Fund shall be in accordance with the spending policy established by the Board of Directors of TTCF. Distributions shall be made annually or, as the parties may, from time to time, agree. Distributions in excess of TTCF's spending policy may be made to the Foundation in any year as determined by the Board of Directors of TTCF. The TFHSF may request, at any time, that TTCF disburse up to 100% of the Fund to the TFHSF. Such a request, however, is not binding on TTCF and may be accepted or rejected, in whole or in part, by TTCF at its sole and absolute discretion. At the establishment of the Fund, the TFHSF granted variance power to TTCF. That power gives TTCF the right to distribute the income and principal of the Fund to another not-for-profit organization of its choice if the TFHSF ceases to exist or if that governing board of TTCF votes that support of the Foundation is no longer necessary or inconsistent with the needs of TTCF. The Fund had a value of $1,587,161 and $1,528,044 as of June 30, 2018 and 2017, respectively, and is reported in the combined financial statements as beneficial interest in trusts.

The IVCHF entered into agreements with The Parasol Tahoe Community Foundation ("Parasol") to establish endowment and improvement funds with Parasol. The purpose of the endowment and improvement funds is to provide support to or for the benefit of the IVCHF and its activities in pursuit of its mission to deliver optimal health care services in the communities served by Incline Village Community Hospital. The IVCHF Endowment Fund (the "Endowment") is protected from obsolescence in accordance with the provisions specified in the Articles of Incorporation and Bylaws creating Parasol. Should the purposes for which the Endowment was created become obsolete or incapable of fulfillment, it is Parasol's Board of Director's responsibility, after contacting and being advised by the IVCHF, to revise the charitable intent of remaining funds to use for a purpose as similar to those set forth in the agreement. The Endowment had a value of $41,610 and $32,162 as of June 30, 2018 and 2017, respectively, and is reported in the combined financial statements as beneficial interest in trusts.

The change in fair value attributable to the interests of the Foundations are recorded in other nonoperating revenues in the accompanying statements of revenues, expenses, and changes in net position.

Capital assets – Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. All purchased capital assets are valued at cost when historical records are available and at an estimated historical cost when no historical records exist. Donated capital assets are valued at their estimated fair market value on the date received. Construction-in-progress includes capitalized interest costs of related borrowings, net of interest earned on unspent proceeds of the related borrowings. It is the policy of the District to capitalize equipment costing more than $1,500. Costs of assets sold or retired are removed from the accounts in the year of sale or retirement, with any gain or loss included in the operating statements.

The District periodically evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset. There were no impairment losses in 2018 and 2017, respectively.

Depreciation of capital assets and amortization of capital assets under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 2 to 40 years for land improvements, 5 to 40 years for buildings and improvements, and 3 to 20 years for equipment and software.

Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities, or extend useful lives are capitalized.

Capitalized interest – Interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The District's interest cost capitalized was approximately $0 and $1,150,792 for the years ended June 30, 2018 and 2017, respectively.

Deferred loss on defeasance – The deferred loss on defeasance of the 1999 Series B Bonds is amortized using the straight-line method over the life of the bonds. The original amount of deferred loss on defeasance is $769,305. Accumulated amortization as of June 30, 2018 and 2017, was $303,843 and $265,055, respectively. Amortization expense for each of the years ended June 30, 2018 and 2017, was $38,788, and is estimated to be $38,788 for each of the next five years.

The deferred gain on defeasance of the Series 2006 Revenue bonds is amortized using the straight-line method over the life of the bonds. The original amount of deferred gain on defeasance is $141,300. Accumulated amortization as of June 30, 2018 and 2017, was $23,550 and $15,700, respectively. Amortization income for each of the years ended June 30, 2018 and 2017, was $7,850; and is estimated to be $7,850 for each of the next five years.

The deferred loss on defeasance of the Series A (2008) General Obligation Bonds is amortized using the effective-interest method over the life of the bonds. The original amount of deferred loss on defeasance is $2,016,320. Accumulated amortization as of June 30, 2018 and 2017, was $274,953 and $183,302, respectively. Amortization expense for each of the years ended June 30, 2018 and 2017, was $91,651; and is estimated to be approximately $92,000 for each of the next five years.

The deferred loss on defeasance of the Series B (2010) General Obligation Bonds is amortized using the effective-interest method over the life of the bonds. The original amount of deferred loss on defeasance is $4,627,331. Accumulated amortization as of June 30, 2018 and 2017, was $385,610 and $192,805, respectively. Amortization expense for each of the years ended June 30, 2018 and 2017, was $192,805; and is estimated to be approximately $193,000 for each of the next five years.

There was no significant gain or loss on defeasance of the Series 2002 Revenue Bonds with the Series 2017 Revenue Bonds.

Deferred outflows of resources – In addition to assets, the combined statements of net position include a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net position that applies to future periods and, as such, will not be recognized as an outflow of resources (expense/expenditures) until that time. The District has two items that qualify for reporting in this category, which are the net deferred loss on defeasance and accumulated decrease in fair value of hedging derivatives reported in the combined statement of net position. A deferred loss on refunding results from the difference in the carrying value of the refunded debt and its reacquisition price. This amount is deferred and amortized over the shorter life of the refunded or refunding debt.

Net position – The net position of the District is comprised of net investment in capital assets, restricted - expendable, restricted - nonexpendable, and unrestricted net positions.

Net investment in capital assets – Net investment in capital assets represents investments in all capital assets (land, construction in progress, land improvements, building and building improvements, and equipment), net of depreciation/amortization, less any debt issued to finance those capital assets.

Restricted - expendable – The restricted expendable net position is restricted through external constraints imposed by creditors, grantors, contributors, laws or regulations of other governments, or constraints imposed by law through constitutional provisions or enabling legislation and includes assets in self-insurance trust funds, revenue bond reserve fund assets, and net position restricted to use by donors.

Restricted - nonexpendable – The restricted nonexpendable net position is equal to the principal portion of permanent endowments. The endowments remain intact, with unrestricted earnings on such funds available for use as expendable assets.

Unrestricted – Unrestricted net position consists of net position that does not meet the definition of net investment in capital assets, restricted expendable, or restricted nonexpendable.

Statements of revenues, expenses, and changes in net position – All revenues and expenses directly related to the delivery of health care services are included in operating revenues and operating expenses in the combined statement of revenues, expenses, and changes in net position. Nonoperating revenues and expenses consist nonexchange revenues, including property tax revenues, gifts, bequests, and contributions received for purposes other than capital asset acquisition.

Net patient service revenues – Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Delinquent patient accounts are recorded as bad debts and transferred for collection. Recoveries are recorded, net of recovery costs estimated, as an increase to net patient service revenue**.**

Charity care – The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District accepts all patients regardless of their ability to pay. Partial payments to which the District is entitled from public assistance programs on behalf of patients that meet the District's charity care criteria are reported as patient service revenue. Charity care, which is excluded from recognition as receivables or revenue in the combined financial statements, is measured on the basis of uncompensated cost. The gross charges excluded from net patient service revenue under the District's charity care policy were, $8,810,418 and $7,903,223 for the years ended June 30, 2018 and 2017, respectively. Using the District's Medicare Cost to Charge Ratio, the estimated cost of these charges was $4,449,931 and $3,991,728 for the years ended June 30, 2018 and 2017, respectively.

Property tax revenues – Property taxes are levied by Nevada and Placer Counties on the District's behalf during the year, and are intended to help finance the District's activities during the same year. The amount of property tax received is dependent upon the assessed real property valuation, as determined by Nevada and Placer Counties Assessors. Nevada and Placer Counties have established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Property taxes are considered delinquent on the day following each payment due date. These funds are used to support the general maintenance and operation of the District, including charity care and uncompensated care programs, and to service the debt on the general obligation bonds. The District received approximately 7% and 8% of its financial support from property taxes for the years ended June 30, 2018 and 2017, respectively, exclusive of property taxes received to pay principal and interest payments of the general obligation bonds.

Risk management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

The District participates in a risk management authority for comprehensive liability self-insurance. The District is also partially self-insured for employee health insurance and workers' compensation insurance, up to certain stop-loss limits. The District estimates liabilities for claims incurred but not reported based on historical claims' activity. Paid claims, estimated losses, and changes in reserves are expensed in the current period. These self-insurance programs are more fully described in Note 9.

Income taxes – The District operates under the purview of the Internal Revenue Code ("IRC"), Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income.

The Foundations are exempt from federal income tax under Section 501(c)(3) of the IRC. TFHSF is also exempt under Section 23701d of the California Franchise Tax Board except to the extent of unrelated business taxable income as defined under IRC Sections 511 through 515. The Foundations have not entered into any activities that would jeopardize its tax-exempt status. Therefore, no provision for income taxes is required.

New accounting pronouncements – In March 2017, the GASB issued GASB Statement No. 85, *Omnibus 2017* ("GASB 85"). GASB 85 addresses practice issues that have been identified during implementation and application of certain GASB Statements, including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits (pensions and other postemployment benefits). The district adopted GASB 85 in the current fiscal year. The adoption did not have a material impact on the District's combined financial statements.

In May 2017, the GASB issued GASB Statement No. 86, *Certain Debt Extinguishment Issues* ("GASB 86"), which provides guidance for transactions in which cash and other monetary assets acquired with only existing resources, that is, resources other than the proceeds of refunding debt, are placed in an irrevocable trust for the sole purpose of extinguishing debt. Under this statement, in financial statements using the economic resources measurement focus, governments should recognize any difference between the reacquisition price (the amount required to be placed in the trust) and the net carrying amount of the debt defeased in substance using only existing resources as a separately identified gain or loss in the period of the defeasance. The adoption of GASB 86 is effective for the District beginning July 1, 2018. The District is currently assessing the impact of this standard on the District's combined financial statements.

In June 2017, the GASB issued GASB Statement No. 87, *Leases* ("GASB 87"). GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. The adoption of GASB 87 is effective for the District beginning July 1, 2020. The District is currently assessing the impact of this standard on the District's combined financial statements.

In April 2018, the GASB issued GASB Statement No. 88, *Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements* ("GASB 88"). Among other things, GASB 88 clarifies which liabilities governments should include in their note disclosures related to debt. GASB 88 requires that all debt disclosures present direct borrowings and direct placements of debt separately from other types of debt. GASB 88 further defines debt for purposes of disclosure in notes to financial statements as a liability that arises from a contractual obligation to pay cash (or other assets that may be used in lieu of cash) in one or more payments to settle an amount that is fixed at the date the contractual obligation is established. This statement further requires that additional essential information related to debt be disclosed in notes to financial statements, including unused lines of credit; assets pledged as collateral for the debt; and terms specified in debt agreements related to significant events of default with finance-related consequences, significant termination events with finance-related consequences, and significant subjective acceleration clauses. The adoption of GASB 88 is effective for the District beginning July 1, 2019. The District is currently assessing the impact of this standard on the District's combined financial statements.

In June 2018, the GASB issued GASB Statement No. 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period* ("GASB 89"). GASB 89 establishes accounting requirements for interest cost incurred before the end of a construction period. This statement requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost is incurred for financial statements prepared using the economic resources measurement focus. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of a capital asset reported in a business-type activity or enterprise fund. The adoption of GASB 89 is effective for the District beginning July 1, 2020. The District is currently assessing the impact of this standard on the District's combined financial statements.

Reclassifications – Certain reclassifications have been made to the 2017 combined financial statements to conform to the 2018 combined financial statement presentation. These reclassifications had no effect on the changes in net position.

NOTE 2 – NET PATIENT SERVICE REVENUE

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare: Payments for inpatient acute care services rendered to Medicare program beneficiaries are based on prospectively determined rates, which vary according to the patient diagnostic classification system. Outpatient services are generally paid under an outpatient classification system subject to certain limitations. Certain reimbursement areas are still subject to final settlement that are determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. At June 30, 2018, Tahoe Forest Hospital and Incline Village Community Hospital cost reports through June 30, 2016, have been audited or otherwise final settled.

Medi-Cal: Prior to July 1, 2013, inpatient acute care services rendered to Medi-Cal program beneficiaries were reimbursed under a cost reimbursement methodology; however, the District is also subject to per discharge limits. The District was paid for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. Per discharge limits for the District have been determined by Medi-Cal through June 30, 2011. Beginning on July 1, 2013, inpatient acute care services were rendered to Medi-Cal program beneficiaries under a diagnostic related group ("DRG") methodology. Under this methodology, similar to Medicare, services are paid at prospectively determined rates per discharge according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient skilled nursing care services rendered to Medi-Cal program beneficiaries are reimbursed at prospectively determined per diem rates. Outpatient services rendered to Medi-Cal program beneficiaries are reimbursed based on prospectively determined fee schedules. At June 30, 2018, cost reports through June 30, 2016, have been audited or otherwise final settled. Medi-Cal I-IMO services are paid on a pre-determined rate and are not subject to cost reimbursement.

Other: Payments for services rendered to other than Medicare and Medi-Cal program beneficiaries are based on established rates or on agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations that provide for various discounts from established rates.

Net patient service revenue is comprised of the following for the years ended June 30, 2018 and 2017:

	2018	2017
Daily hospital service	$ 27,486,491	$ 23,458,129
Inpatient ancillary services	47,073,026	49,962,845
Outpatient services	199,927,791	183,843,575
Gross patient service revenues	274,487,308	257,264,549
Less contractual allowances and provision for doubtful accounts	(125,750,538)	(108,968,497)
Net patient service revenue at Tahoe Forest Hospital District	148,736,770	148,296,052
Net patient service revenue at Truckee Surgery Center, LLC	1,445,458	1,467,440
Total net patient service revenue	$ 150,182,228	$ 149,763,492

Gross patient service revenue, before any provision for bad debts, summarized by payor is as follows, for the years ended June 30:

	2018	2017
Medicare	36%	34%
Medi-Cal	18%	18%
Commercial	42%	44%
Others	4%	4%
Total	100%	100%

Medicare and Medi-Cal revenue accounts for a large percentage of the District's gross patient revenues for each year. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Over five years, up to $7.5 billion in combined federal and state funds will be available to participating entities from the Public Hospital Redesign and Incentives in Medi-Cal Program ("PRIME"), which is a successor program within the Medi-Cal waiver. As a result of participating in PRIME, the District recorded a receivable of $472,222 and $690,625 at June 30, 2018 and 2017, respectively. This program requires a qualitative assessment of certain metrics and is subject to future audits by CMS.

The District receives funds through the AB 915 legislation through an intergovernmental transfer ("IGT"), where funds are put up by the District to be matched by the federal government. As a result of two of these IGT programs, the District recorded a receivable of $6,634,867 at June 30, 2018, for funds related to fiscal years 2018 and 2017, and a receivable of $7,126,521 at June 30, 2017, for funds related to fiscal years 2017 and 2016.

NOTE 3 – CASH AND CASH EQUIVALENTS AND ASSETS LIMITED AS TO USE

The District has deposits invested in various financial institutions in the form of operating cash and cash equivalents. All of these funds are held in deposits, which are collateralized in accordance with the California Government Code ("CGC"), except for $250,000 per account that is federally insured.

The District is generally authorized, under state statue and local resolutions, to invest in demand deposits with financial institutions, savings accounts, certificates of deposit, U.S. Treasury securities, federal agency securities, State of California notes or bonds, notes or bonds of agencies within the State of California, obligations guaranteed by the Small Business Administration, bankers' acceptances, commercial paper, and the LAIF.

As of June 30, 2018 and 2017, cash and cash equivalents and assets limited as to use, at carrying value, consisted of the following:

	2018	2017
Cash and cash equivalents	$ 18,757,750	$ 13,056,466
Assets limited as to use - to meet current liabilities	6,360,727	5,837,348
Assets limited as to use, net of current	53,696,191	62,066,412
Total at Tahoe Forest Hospital District	78,814,668	80,960,226
Total Truckee Surgery Center, LLC	35,935	175,342
Total	$ 78,850,603	$ 81,135,568

As of June 30, 2018 and 2017, assets limited as to use, at carrying value, have been set aside as follows:

	2018	2017
Board designated assets	$ 55,048,794	$ 62,339,053
Assets held by trustees	5,008,124	5,564,707
Total	$ 60,056,918	$ 67,903,760

A summary of scheduled maturities by investment type at June 30, 2018 and 2017, were as follows:

	2018			
		Investment Maturities (in years)		
	Carrying Value	Less than 1	1 to 5	6 to 10+
Investment type				
Cash and cash equivalents	$ 24,356,014	$ 24,356,014	$ -	$ -
Local agency investment fund	54,494,589	54,494,589	-	-
Total	$ 78,850,603	$ 78,850,603	$ -	$ -

	2017			
		Investment Maturities (in years)		
	Carrying Value	Less than 1	1 to 5	6 to 10+
Investment type				
Cash and cash equivalents	$ 19,059,322	$ 19,059,322	$ -	$ -
Local agency investment fund	62,076,246	62,076,246	-	-
Total	$ 81,135,568	$ 81,135,568	$ -	$ -

Interest rate risk – Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Investments held for longer periods are subject to increased risk of adverse interest rate changes.

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

CGC, Section 53635, places the following concentration limits on LAIF, which is unrated:

> No more than 40% may be invested in eligible commercial paper; no more than 10% may be invested in the outstanding commercial paper of any single issuer; and no more than 10% of the outstanding commercial paper of any single issuer may be purchased.

CGC, Section 53601, places the following concentration limits on the District's investments:

> No more than 5% may be invested in the securities of any one issuer, except the obligations of the U.S. government, U.S. government agencies, and U.S. government-sponsored enterprises; no more than 10% may be invested in any one mutual fund; no more than 25% may be invested in commercial paper; no more than 10% of the outstanding commercial paper of any single issuer may be purchased; no more than 30% may be invested in bankers' acceptances of any one commercial bank; no more than 30% may be invested in negotiable certificates of deposit; no more than 20% of the value of the portfolio may be invested in reverse repurchase agreements; and no more than 30% may be invested in medium-term notes.

The District's policy maximizes the return on invested cash while minimizing risk of capital loss. The District's policy limits investments to one and one half years, unless otherwise approved by the Board of Directors. This District was in compliance with their investment policies as of June 30, 2018.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event or failure of the counter party (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investments or collateral securities that are in the possession of another party.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the District's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the District's deposits. California law also allows financial institutions to secure the District's deposits by pledging first trust deed mortgage notes having a value of 150% of the District's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the District.

NOTE 4 – FAIR VALUE MEASUREMENT OF FINANCIAL INSTRUMENTS

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There is a hierarchy of three levels of inputs that may be used to measure fair value:

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

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

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

Following is a description of the valuation methodologies and inputs used for instruments measured at fair value on a recurring basis and recognized in the accompanying combined statements of net position or for which the fair value is disclosed in the notes to the combined financial statements, as well as the general classification of such instruments pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the years ended June 30, 2018 and 2017.

Beneficial interest in trusts – As described in Note 1, the Foundations are the beneficiary of funds held at TTCF and Parasol. The fair value of the beneficial interest is estimated using the fair value of the assets held in trust reported by the trustees as of June 30, 2018 and 2017.

The following tables present the fair value measurements of instruments recognized in the accompanying combined statements of net position measured on a recurring basis and the level within the GASB 72 fair value hierarchy in which the fair value measurements fall at June 30:

	2018			
Description	**Level 1**	**Level 2**	**Level 3**	**Total**
Hedging derivative	$ -	$ (1,063,457)	$ -	$ (1,063,457)
Beneficial interest in trusts	-	-	1,628,771	1,628,771
Total by fair value level	$ -	$ (1,063,457)	$ 1,628,771	565,314
Cash and cash equivalents				24,356,014
Total				$ 24,921,328

	2017			
Description	**Level 1**	**Level 2**	**Level 3**	**Total**
Hedging derivative	$ -	$ (1,548,299)	$ -	$ (1,548,299)
Beneficial interest in trusts	-	-	1,560,206	1,560,206
Total by fair value level	$ -	$ (1,548,299)	$ 1,560,206	11,907
Cash and cash equivalents				19,059,322
Total				$ 19,071,229

The following table summarizes the changes in the District's Level 3 financial instruments for the years ended June 30, 2018 and 2017:

	2018	**2017**
Beginning balance	$ 1,560,206	$ 1,356,049
Purchases	11,214	38,055
Change in value of beneficial interest in trusts	57,351	166,102
Ending balance	$ 1,628,771	$ 1,560,206

The table below presents information about significant unobservable inputs related to material categories of Level 3 financial instruments as of June 30, 2018:

Description	**Fair Value as of June 30, 2018**	**Valuation Technique**	**Unobservable Input**	**Range**
Beneficial interest in trusts	$ 1,628,771	Asset fair value from Trustee	Asset fair value from Trustee	Varies

NOTE 5 – PATIENT ACCOUNTS RECEIVABLE

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe that there are any credit risks associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities subject to differing economic conditions, and do not represent any concentrated credit risks to the District.

Patient accounts receivable is comprised of the following as of June 30, 2018 and 2017:

	2018	2017
Medicare and Medicare managed care	$ 17,060,156	$ 11,506,089
Medi-Cal and Medi-Cal managed care	15,576,761	8,981,243
Other payors	25,313,858	15,577,893
Self-pay	6,166,886	5,432,845
Gross patient accounts receivable	64,117,661	41,498,070
Less allowances for contractual adjustments and bad debts	(39,393,364)	(22,934,376)
Net patient accounts receivable at Tahoe Forest Hospital District	24,724,297	18,563,694
Net patient accounts receivable at Truckee Surgery Center, LLC	216,187	162,200
Total net patient accounts receivable	$ 24,940,484	$ 18,725,894

Concentration of net patient accounts receivable as of June 30, 2018 and 2017, were as follows:

	2018	2017
Medicare	27%	18%
Medi-Cal	17%	19%
Commercial and other payors	53%	55%
Self-pay	3%	8%
Total	100%	100%

NOTE 6 – CAPITAL ASSETS

The capital asset activity of the District for the years ended June 30, 2018 and 2017, were as follows:

	2018				
	Balance June 30, 2017	Increases	Decreases	Transfers	Balance June 30, 2018
Capital assets - nondepreciable					
Land	$ 2,829,147	$ -	$ -	$ -	$ 2,829,147
Construction in progress, net	41,653,418	8,933,576	-	(45,043,458)	5,543,536
Property held for future expansion	836,353	4,668	-	-	841,021
	45,318,918	8,938,244	-	(45,043,458)	9,213,704
Capital assets - depreciable					
Land improvements	3,867,334	46,670	-	-	3,914,004
Building and improvements	162,251,200	926,553	-	35,045,400	198,223,153
Equipment and software	75,768,073	3,041,129	-	9,998,058	88,807,260
Capital assets at Truckee Surgery Center, LLC	1,197,538	-	-	-	1,197,538
	243,084,145	4,014,352	-	45,043,458	292,141,955
Less accumulated depreciation for					
Land improvements	2,825,528	156,420	-	-	2,981,948
Building and improvements	54,459,700	6,009,221	-	-	60,468,921
Equipment and software	64,464,368	5,130,581	-	-	69,594,949
Capital assets at Truckee Surgery Center, LLC	420,740	51,088	-	-	471,828
	122,170,336	11,347,310	-	-	133,517,646
Total capital assets - depreciable, net	120,913,809	(7,332,958)	-	45,043,458	158,624,309
Total capital assets, net	$ 166,232,727	$ 1,605,286	$ -	$ -	$ 167,838,013

	2017				
	Balance June 30, 2016	Increases	Decreases	Transfers	Balance June 30, 2017
Capital assets - nondepreciable					
Land	$ 2,829,147	$ -	$ -	$ -	$ 2,829,147
Construction in progress, net	32,809,859	13,233,739	-	(4,390,180)	41,653,418
Property held for future expansion	836,353	-	-	-	836,353
	36,475,359	13,233,739	-	(4,390,180)	45,318,918
Capital assets - depreciable					
Land improvements	3,789,772	77,562	-	-	3,867,334
Building and improvements	155,244,482	2,624,767	(4,500)	4,386,451	162,251,200
Equipment and software	74,711,640	1,658,353	(605,649)	3,729	75,768,073
Capital assets at Truckee Surgery Center, LLC	1,193,975	3,563	-	-	1,197,538
	234,939,869	4,364,245	(610,149)	4,390,180	243,084,145
Less accumulated depreciation for					
Land improvements	2,653,671	171,857	-	-	2,825,528
Building and improvements	48,759,131	5,700,569	-	-	54,459,700
Equipment and software	60,195,910	4,874,107	(605,649)	-	64,464,368
Capital assets at Truckee Surgery Center, LLC	351,220	69,520	-	-	420,740
	111,959,932	10,816,053	(605,649)	-	122,170,336
Total capital assets - depreciable, net	122,979,937	(6,451,808)	(4,500)	4,390,180	120,913,809
Total capital assets, net	$ 159,455,296	$ 6,781,931	$ (4,500)	$ -	$ 166,232,727

NOTE 7 – LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS

A summary of long-term debt and capital lease obligations as of June 30, 2018 and 2017, were as follows:

	2018					
	Date of Issue	Date of Maturity	Interest Rates	Annual Principal Installments	Original Issue Amount	Outstanding at June 30, 2018
General obligation bonds						
2016 GOB	March 2016	August 2040	2.00% - 5.00%	$530,000 - $3,625,000	$ 45,110,000	$ 44,015,000
2015 GOB	February 2015	August 2038	2.00% - 5.00%	$310,000 - $2,895,000	30,810,000	30,085,000
Series C (2012) GOB	July 2012	August 2042	3.00% - 5.50%	$135,000 - $2,440,000	26,100,000	25,965,000
Revenue bonds						
Series 2017	March 2017	July 2032	1.49%	$360,000 - $663,805	9,060,000	8,700,000
Series 2015	March 2015	July 2033	3.87%	$896,124 - $1,583,873	20,979,000	19,355,149
Capital lease obligations						
Bank of America Public Capital	July 2012	July 2017	1.41%	$103,515 monthly	6,000,000	-
US Bank Equipment Financing	June 2016	July 2021	5.28%	$228 monthly	12,069	7,619
US Bank Equipment Financing	June 2014	July 2019	4.40%	$727 monthly	39,240	9,249
					$ 138,110,309	$ 128,137,017

	2017					
	Date of Issue	Date of Maturity	Interest Rates	Annual Principal Installments	Original Issue Amount	Outstanding at June 30, 2017
General obligation bonds						
2016 GOB	March 2016	August 2040	2.00% - 5.00%	$530,000 - $3,625,000	$ 45,110,000	$ 44,545,000
2015 GOB	February 2015	August 2038	2.00% - 5.00%	$165,000 - $2,895,000	30,810,000	30,395,000
Series C (2012) GOB	July 2012	August 2042	3.00% - 5.50%	$135,000 - $2,440,000	26,100,000	26,100,000
Revenue bonds						
Series 2017	March 2017	July 2032	1.49%	$360,000 - $663,805	9,060,000	8,700,000
Series 2015	March 2015	July 2033	3.87%	$761,114 - $1,583,873	20,979,000	20,217,886
Capital lease obligations						
Bank of America Public Capital	July 2012	July 2017	2.21%	$103,515 monthly	6,000,000	103,516
US Bank Equipment Financing	June 2016	July 2021	5.28%	$228 monthly	12,069	9,903
US Bank Equipment Financing	June 2014	July 2019	4.40%	$727 monthly	39,240	17,404
					$ 138,110,309	$ 130,088,709

The following tables summarize the District's long-term debt and capital lease transactions for the years ended June 30, 2018 and 2017:

	2018				
	Balance June 30, 2017	Net Borrowings	Payments During Year	Balance June 30, 2018	Current Portion
2016 General obligation bond	$ 44,545,000	$ -	$ (530,000)	$ 44,015,000	$ 600,000
2015 General obligation bond	30,395,000	-	(310,000)	30,085,000	370,000
Series C (2012) General obligation bond	26,100,000	-	(135,000)	25,965,000	175,000
General obligation bond premium/discount	3,070,883	-	(137,833)	2,933,050	-
Series 2017 Revenue bonds	8,700,000	-	-	8,700,000	503,082
Series 2015 Revenue bonds	20,217,886	-	(862,737)	19,355,149	896,124
Bank of America public capital	103,516	-	(103,516)	-	-
US Bank equipment financing	9,903	-	(2,284)	7,619	2,284
US Bank equipment financing	17,404	-	(8,155)	9,249	8,155
	$ 133,159,592	$ -	$ (2,089,525)	$ 131,070,067	$ 2,554,645

	2017				
	Balance June 30, 2016	Net Borrowings	Payments During Year	Balance June 30, 2017	Current Portion
2016 General obligation bond	$ 45,110,000	$ -	$ (565,000)	$ 44,545,000	$ 530,000
2015 General obligation bond	30,645,000	-	(250,000)	30,395,000	310,000
Series C (2012) General obligation bond	26,100,000	-	-	26,100,000	135,000
General obligation bond premium/discount	3,208,716	-	(137,833)	3,070,883	-
Series 2017 Revenue bonds	-	9,060,000	(360,000)	8,700,000	143,082
Series 2015 Revenue bonds	20,979,000	-	(761,114)	20,217,886	862,737
Series 2002 Revenue bonds	9,230,000	-	(9,230,000)	-	-
Bank of America public capital	1,336,234	-	(1,232,718)	103,516	103,516
US Bank equipment financing	12,069	-	(2,166)	9,903	2,166
US Bank equipment financing	25,209	-	(7,805)	17,404	7,805
	$ 136,646,228	$ 9,060,000	$ (12,546,636)	$ 133,159,592	$ 2,094,306

As of June 30, 2018, the District's long-term debt and capital lease obligation requirements to maturity are as follows:

	Long-Term Debt			Capital Lease Obligations		
Years Ending June 30,	Principal	Interest	Total	Principal	Interest	Total
2019	$ 2,544,206	$ 4,416,530	$ 6,960,736	$ 10,439	$ 581	$ 11,020
2020	2,773,947	4,339,398	7,113,345	3,265	217	3,482
2021	3,020,233	4,246,969	7,267,202	3,164	77	3,241
2022	3,273,117	4,139,209	7,412,326	-	-	-
2023	3,552,659	4,011,245	7,563,904	-	-	-
2024 - 2028	22,618,771	17,650,483	40,269,254	-	-	-
2029 - 2033	32,598,343	12,583,821	45,182,164	-	-	-
2034 - Thereafter	57,738,873	8,024,016	65,762,889	-	-	-
	$ 128,120,149	$ 59,411,671	$ 187,531,820	$ 16,868	$ 875	$ 17,743

Advanced refunding – On April 13, 2006, the District advance refunded the 1999 Series A Bonds totaling $11,790,000 with Series 2006 Revenue Bonds totaling $24,347,998. The 1999 Series A Bonds were redeemed on July 1, 2009, in accordance with the escrow agreement.

On March 10, 2015, the District advance refunded the Series A (2008) General Obligation Bonds totaling $29,345,000 with the 2015 General Obligation Bonds totaling $30,810,000 at a premium of $1,040,802. Resources totaling $31,361,320 were placed in an escrow account for the purpose of generating resources for all future debt service payments.

This advance refunding was undertaken to obtain an economic gain (difference between the present value of the debt service payments of the refunded and refunding general obligation bonds) of $3,631,371. As a result of the refunding, total debt service payments over the next 24 years will decrease by $5,184,014.

On May 29, 2015, the District advance refunded the Series 2006 Revenue Bonds totaling $23,240,000 with the Series 2015 Revenue Bonds totaling $20,979,000. Resources totaling $24,036,325 were placed in an escrow account for the purpose of generating resources for all future debt service payments.

This advance refunding was undertaken to obtain an economic gain (difference between the present value of the debt service payments of the refunded and refunding revenue bonds) of $2,331,620. As a result of the refunding, total debt service payments over the next 22 years will decrease by $2,570,928.

On April 7, 2016, the District advance refunded the Series B (2010) General Obligation Bonds totaling $42,785,000 with the 2016 General Obligation Bonds totaling $45,110,000. Resources totaling $47,412,331 were placed in an escrow account for the purpose of generating resources for all future debt service payments.

This advance refunding was undertaken to obtain an economic gain (difference between the present value of the debt service payments of the refunded and refunding general obligation bonds) of $7,718,216. As a result of the refunding, total debt service payments over the next 22 years will decrease by $10,617,709.

On March 27, 2017, the District advance refunded the Series 2002 Variable Rate Demand Revenue Bonds totaling $8,890,000 with the Series 2017 Variable Rate Demand Revenue Bonds totaling $9,060,000.

This advance refunding was undertaken to obtain an economic gain by eliminating the required line of credit associated with the Series 2002 Bonds, therefore saving approximately $100,000 annually for the District. The Series 2017 Bonds were issued on a parity as to payment and security with the District's Series 2015 Bonds.

NOTE 8 – INTEREST RATE SWAP AGREEMENT

In May 2005, as a means to lower its borrowing costs when compared against fixed rate bonds, the District entered into an interest rate swap in connection with its Series 2002 Variable Rate Revenue Bonds. The intention of the swap was to effectively change the District's variable interest rate on the Bonds to a synthetic fixed rate of 3.54%.

The Series 2002 Bonds, and the related swap agreement, mature on July 1, 2033. The swap's original notional amount of $11,800,000 matched the variable-rate bonds at the agreement date. The swap commenced three years after the Bonds were issued (July 2002). Starting in fiscal year 2005, the notional value of the swap, and the principal amount of the associated debt, will decline each principal payment made by the District. Under the swap, the District pays the counterparty a fixed payment of 3.54% and receives a variable payment computed as 70% of the London Interbank Offered Rate (LIBOR) one-month rate.

During 2017, the 2002 bonds were defeased and the funds were used to issue the Series 2017 Revenue Bonds. The Series 2017 Revenue bonds are for a marginally larger notional amount, with the same end date, the same interest rate based on the same driver. The swap was then found to be still effective with the new Series 2017 Revenue Bonds, and hedge accounting for the swap continued forward. At the date of defeasance, the value of the swap was approximately $1,400,000.

As interest rates have declined since execution of the swap, the swap had negative fair values of $1,063,457 and $1,548,299 as of June 30, 2018 and 2017, respectively. The swap's negative fair value may be countered by a reduction in total interest payments required under the variable-rate bonds, creating a lower synthetic interest rate. Because the coupons on the District's variable-rate bonds adjust to changing interest rates, the bonds do not have a corresponding fair value increase. The fair value was estimated using mathematical approximations of market values derived from proprietary models. The valuations are calculated on a mid-market basis and do not include bid/offer spread that would be reflected in an actual price quotation. It should be assumed that the actual price quotations for unwinding the transactions would be different. In connection with the fair value determination of the interest rate swap, the District has recorded a derivative instrument liability in the amount of $1,063,457 and $1,548,299 at June 30, 2018 and 2017, respectively, and a corresponding accumulated decrease in fair value of hedging derivative (deferred outflow of resources). Fair values are based on a market to market report which is considered a Level 2 fair value input.

Credit risk – As of June 30, 2018, the District was not exposed to credit risk because the swap had a negative fair value. However, should interest rates change and the fair value of the swap become positive, the District would be exposed to credit risk in the amount of the derivative's fair value. The swap counterparty was rated AA-/Aa3 as of June 30, 2018. To mitigate the potential for credit risk, if the counterparty's credit quality falls below AA/Aa, the fair value of the swap will be fully collateralized by the counterparty with U.S. government securities. Collateral would be posted with a third-party custodian.

Termination risk – The District, or the counterparty, may terminate the swap if the other party fails to perform under the terms of the contract. The swap may be terminated by the District if the counterparty's credit rating falls below A3/A-/A-. If the swap is terminated, the variable-rate bond would no longer carry a synthetic interest rate. If at the time of termination, the swap has a negative fair value, the District would also be liable to the counterparty for a payment equal to the swap's fair value.

NOTE 9 – INSURANCE PLANS

The District is exposed to various risks of loss related to torts, theft of, damage to, and destruction of assets, errors, and omissions, injuries to employees, and natural disasters. The District carries insurance for medical malpractice and general comprehensive liability, and workers' compensation claims.

Workers' compensation insurance – The District is self-insured for workers' compensation claims. A stop-loss insurance contract executed with an insurance carrier covers individual claims in excess of $500,000 per plan year with an aggregate limit of $1,000,000. There were no significant changes in insurance coverage from the prior year.

Workers' compensation benefits costs from reported and unreported claims were accrued based on estimates that incorporate the District's past experience, as well as other considerations, including the nature of each claim or incident and other relevant trend factors. While the ultimate amount of workers' compensation liability is dependent on future developments, management is of the opinion that the associated liabilities for claims pending and incurred but no reported recognized in the accompanying combined financial statements is adequate to cover such claims. The liability has not been discounted. Management is aware of no potential workers' compensation liability the settlement of which, if any, would have a material adverse effect on the District's net position for the years ended June 30, 2018 and 2017.

Employee health insurance – The District is self-insured to provide group medical, dental, and vision coverage. The District funds its liability based on actual claims. A stop-loss insurance contract executed with an insurance carrier provides a specific stop-loss deductible per claim of $225,000 with an aggregate specific annual deductible of $100,000. There were no significant changes in insurance coverage from the prior year.

The liability for unpaid claims is estimated using an industry average that is based on actual claims paid. The estimated liability for claims pending and incurred but not reported at June 30, 2018 and 2017, has been included in the accompanying combined statements of net position under estimated claims incurred but not reported.

The following is a summary of the changes in the workers' compensation and employee health insurance liabilities for the years ended June 30, 2018 and 2017:

	2018			
	Balance June 30, 2017	Increases	Decreases	Balance June 30, 2018
Workers' compensation	$ 1,703,225	$ 182,938	$ -	$ 1,886,163
Employee health	1,211,751	100,685	-	1,312,436
	$ 2,914,976	$ 283,623	$ -	$ 3,198,599

	2017			
	Balance June 30, 2016	Increases	Decreases	Balance June 30, 2017
Workers' compensation	$ 1,120,980	$ 582,245	$ -	$ 1,703,225
Employee health	1,307,731	-	(95,980)	1,211,751
	$ 2,428,711	$ 582,245	$ (95,980)	$ 2,914,976

Medical malpractice insurance – The District participates in a joint powers agreement ("JPA") with the Program BETA Risk Management Authority (the "Program").

The Program was formed for the purpose of operating a comprehensive liability self-insurance program for certain hospital districts of the Association of California Healthcare Districts, Inc. ("ACHD"). The Program operates as a separate JPA established as a public agency separate and distinct from ACHD. Each member hospital pays a premium commensurate with the level of coverage requested and shares surpluses and deficits proportionate to its participation in the Program. The District maintains coverage on a claims-made basis.

Coverage under a claims-made policy could expose the District to a gap in coverage if the District were to terminate coverage with the Program. In order to mitigate this potential gap in coverage, the District has accrued and estimated premium to purchase an unlimited extended reporting amendment (tail coverage) in the amount of $1,184,419 and $858,290 for the years ended June 30, 2018 and 2017, respectively.

NOTE 10 – RESTRICTED NET ASSETS

Net assets are maintained for the following programs and services at June 30:

	2018	2017
Restricted - expendable net assets		
Cancer prevention	$ 823,471	$ 442,919
Cancer care	1,591,155	1,536,329
Hospice and other	1,239,948	1,141,543
	$ 3,654,574	$ 3,120,791
Restricted - nonexpendable net assets		
Investments in perpetuity, the income from which is expendable to support;		
Parasol endowment	$ 32,209	$ 29,209
	$ 32,209	$ 29,209

NOTE 11 – EMPLOYEES' RETIREMENT PLANS

The District contributes to the Tahoe Forest Hospital District Employee Money Purchase Pension Plan (the "MPP Plan"), a defined contribution pension plan administered by the District. The MPP Plan covers employees who complete 1,000 hours of service in a calendar year. The District is required to make annual contributions to the MPP Plan equal to 3% of each eligible employee's annual compensation, plus 3% of an eligible employee's annual compensation in excess of the Social Security tax wage base. Employee contributions are voluntary and are limited to 10% of an employee's annual compensation.

The District also offers its employees a deferred compensation plan (the "457 Plan") created in accordance with Internal Revenue Code Section 457(b). The 457 Plan allows employees to defer a portion of their current compensation until future years. The District matches participant's deferrals from 3% to 7% of compensation. Employee contributions are limited to 100% of total employee compensation or the maximum amount allowable by law. The employer matching contributions under the 457 Plan are deposited into employee accounts in the MPP Plan.

Total employer contributions under the above retirement plans were $3,900,305 and $3,809,287 for the years ended June 30, 2018 and 2017, respectively.

NOTE 12 – COMMITMENTS AND CONTINGENCIES

Construction in progress – As of June 30, 2018 and 2017, the District had recorded $5,543,536 and $41,653,418, respectively, as construction-in-progress representing cost capitalized for various remodeling, major repair, and expansion projects on the District's premises. Estimated cost to complete all projects as of June 30, 2018, is approximately $2,192,768.

Litigation – The District is a defendant in various legal proceedings arising out of the normal conduct of its business. In the opinion of management and its legal representatives, the District has valid and substantial defenses, and settlements or awards arising from legal proceedings, if any, will not exceed existing insurance coverage, nor will they have a material adverse effect on the net position, results of operations, or liquidity of the District.

Regulatory environment – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. The District is subject to routine surveys and reviews by federal, state, and local regulatory authorities. The District has also received inquiries from health care regulatory authorities regarding its compliance with laws and regulations. Although the District management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and ongoing surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and noncompliance with survey corrective action requests could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Hospital Seismic Safety Act – The California Hospital Facilities Seismic Safety Act ("SB 1953") specifies certain requirements that must be met at various dates in order to increase the probability that a California hospital can maintain uninterrupted operations following a major earthquake. Management believes that the Hospital is currently substantially in compliance with these requirements.

Arbitrage – The Tax Reform Act of 1986 instituted certain arbitrage restrictions with respect to the issuance of tax-exempt bonds after August 31, 1986. Arbitrage regulations deal with the investment of all tax-exempt bond proceeds at an interest yield greater than the interest yield paid to bondholders. Generally, all interest paid to bondholders can be retroactively rendered taxable if applicable rebates are not reported and paid to the Internal Revenue Service at least every five years. During the current year, the District performed calculations of excess investment earnings on various bonds and financings and, at June 30, 2018, does not expect to incur a significant liability.

Operating leases – The District leases various equipment and facilities under operating leases expiring at various dates. Total building and equipment rent expense for the years ended June 30, 2018 and 2017 were $2,614,423 and $2,298,832, respectively. Future minimum lease payments, by year and in the aggregate, for all operating leases consist of the following:

Years ending June 30,	
2019	$ 1,790,461
2020	1,234,582
2021	1,068,456
2022	493,852
2023	169,058
Thereafter	562,792
	$ 5,319,201

NOTE 13 – SUBSEQUENT EVENTS

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

Employee of the Month, October 2018
Katrina Nunez, Medical Assistant/Surgery Scheduler
MSC, Urology Department

We are honored to announce Katrina Nunez, Medical Assistant/Surgery Scheduler of the MSC Urology Department as our October 2018 Employee of the Month!

Katrina has been a part of Tahoe Forest Health System for over 4 years.

Katrina has worked hard and shown excellent teamwork as the Urology office has been temporarily placed in Dr. Tirdel's office. Katrina works hard for each patient and provides the best customer service. She has ridden the ups and downs of not only having to learn preferences of a new provider but she has handled the limited space and other resources with grace, and she is understanding of new processes.

Katrina has always gone the extra mile for the patients, providers and co-workers. Katrina is the first to offer help. It's been an honor getting to know Katrina.

Please join us in congratulating all of our Terrific Nominees!

Amelia Espinoza
Andrea Garcia
Bety Nevarez
Brenda Medina
Chelsea Cochrane
Gillian Collom
Janet Brooks
Nicole Klein
Wilber Hernandez

FOR IMMEDIATE RELEASE
September 24, 2018

Contact: Paige Thomason
Director of Marketing & Communications, TFHS
pthomason@tfhd.com
(530) 582-6290

OCTOBER IS BREAST HEALTH AWARENESS MONTH

www.tfhd.com

(Tahoe/Truckee. Calif.) – October is National Breast Health Awareness Month, an initiative created to increase awareness of early detection and prevention of breast cancer. If you've never had a mammogram, call Tahoe Forest Health System during October for an appointment. Women scheduling mammograms during the month of October will receive a free gift.

Mammograms and monthly self-checks are the most effective methods for detecting breast cancer early. The earlier breast cancer is found, the better the chances treatment will work. A mammogram is a quick and easy procedure performed by a certified mammography technologist and interpreted by a board-certified radiologist. A doctor's order is not required for a screening mammogram, and follow-up care is available through local physicians.

The Briner Imaging Center at Tahoe Forest Hospital offers 3D Mammography™, the most accurate mammogram available. The new exam technology improves cancer detection in all breast types.

Physician referrals are not necessary to schedule a mammogram, and most insurance plans are accepted. To schedule, please call Briner Imaging Center at (530) 582-6510.

Free or reduced cost screenings may be available to those who qualify. For eligibility details, please call (530) 582-3277.

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About Tahoe Forest Health System

Tahoe Forest Health System, which includes Tahoe Forest Hospital in Truckee, CA, and Incline Village Community Hospital in Incline Village, NV, offers 24-hour emergency care, a total joint orthopedic program including direct anterior hip replacement surgery, physician multi-specialty clinics, OB department, and CoC-accredited cancer center. With a strong focus on high quality patient care, community collaboration, clinical excellence and innovation, Tahoe Forest Health System is a UC Davis Rural Center of Excellence. For a complete list of physician specialties and services, visit www.tfhd.com.

BETA HEALTHCARE GROUP | OB INITIATIVE

QUEST FOR ZERO: Excellence in OB

It is an honor and a privilege to congratulate

Tahoe Forest Hospital

for your commitment to deliver optimal perinatal care in our joint effort to reach zero preventable harm.

I would like to recognize your perinatal team's outstanding achievement for having met Tier 1 and Tier 2 requirements of

BETA Healthcare Group's Quest for Zero: OB initiative in 2018.

In your seventh year of participation, we know you are making an impact in the lives of moms and babies by implementing strategies focused strategies focused on Interdisciplinary Strip Review and 2nd Stage of Labor Management.

Congratulations for making a difference in the lives of families!

TOM WANDER
CHIEF EXECUTIVE OFFICER
BETA HEALTHCARE GROUP

BETA*rm OB
SAFETY & CARE — UNITED

BETA HEALTHCARE GROUP | ED INITIATIVE

QUEST FOR ZERO: Excellence in ED

It is my distinct privilege to congratulate

Tahoe Forest Hospital

for your commitment to constant improvement as, together,
we strive to eliminate preventable harm to those in need of emergent care.

I would like to recognize your team's commendable achievement
for having met Tier 1 requirements of

BETA Healthcare Group's Quest for Zero: ED initiative in 2018.

In your seventh year of participation, a significant impact
is being made to the lives of those entrusted to your care.

Congratulations for making quality of care a priority!

TOM WANDER
CHIEF EXECUTIVE OFFICER
BETA HEALTHCARE GROUP

BETA*rm ED
SAFETY & CARE—UNITED

BETA HEALTHCARE GROUP | ED INITIATIVE

QUEST FOR ZERO: Excellence in ED

It is my distinct privilege to congratulate

Tahoe Forest Hospital- Incline Village

for your commitment to constant improvement as, together,
we strive to eliminate preventable harm to those in need of emergent care.

I would like to recognize your team's commendable achievement
for having met Tier 1 requirements of

BETA Healthcare Group's Quest for Zero: ED initiative in 2018.

In your fifth year of participation, a significant impact
is being made to the lives of those entrusted to your care.

Congratulations for making quality of care a priority!

TOM WANDER
CHIEF EXECUTIVE OFFICER
BETA HEALTHCARE GROUP

BETA*rm ED
SAFETY & CARE—UNITED

BECKER'S
Hospital Review

71 critical access hospital CEOs to know | 2018

Becker's Healthcare is pleased to recognize the following 71 CEOs, presidents and administrators of critical access hospitals.

The men and women included on this list lead organizations regularly recognized for patient safety and quality. Several have overseen hospital expansions, mergers and EHR implementations as well as the construction of satellite clinics and strategic partnerships with local healthcare organizations. These individuals hold an important role within their community, serving on corporate boards and state-level initiatives to improve access to care.

Becker's Healthcare compiled this list through nominations and editorial research. The leaders presented are in alphabetical order, and individuals do not pay and cannot pay for inclusion on this list.

Harry Weis. CEO of Tahoe Forest Hospital (Truckee, Calif.). After serving as Salinas, Calif.-based Natividad Medical Center's CEO for eight years, Mr. Weis took the helm at Tahoe Forest Health System in December 2015. He leads the system with about four decades of clinical and financial experience, as well as healthcare strategy and acquisition expertise. In January 2018, Mr. Weis was one of two individuals the American Hospital Association appointed to represent six western states on the Council of the AHA Section for Small or Rural Hospitals.

October 21–27, 2018

Healthcare Quality Week (HQW), brought to you by National Association of Hospital Quality, is the week dedicated to celebrating the contributions professionals have made to improve healthcare quality. It also gives us an opportunity to bring greater awareness to the profession of healthcare quality.

HEALTHCARE QUALITY | week

Brought to you by the National Association for Healthcare Quality

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE BOARD OF DIRECTORS
Thursday, October 25, 2018

REFERRED BY:	AGENDA ITEMS	RECOMMEND
MEDICAL STAFF	**A motion was made, seconded, and carried to recommend approval of the following to the Board of Directors:**	
	The Executive Committee recommends approval of the following:	Recommend approval
Interdisciplinary Practice Committee	PA/NP Privilege Form: Include American Nurses Credentialing Center (ANCC) as an eligibility option of board certification for pediatric nurse practitioners applying to work in pediatrics at any TFHD facility. [Revised]	
OB/Pediatrics Department	Pediatric Early Warning Score (PEWS) and Algorithm New Policy and Procedure	

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE BOARD OF DIRECTORS
Thursday, October 25, 2018

REFERRED BY:	AGENDA ITEMS	RECOMMEND
	The Executive Committee recommends approval of the following: On May 23, 2018, the Bylaws Committee met and conducted its annual review of the Medical Staff Bylaws, Rules and Regulations. Legal counsel reviewed and approved the proposed amendments and on August 16, 2018 the Medical Executive Committee recommended amendments to the voting members of the Active Medical Staff. As per Article 14.2 of the Medical Staff Bylaws, an affirmative vote was received by two thirds (2/3) of the staff members voting on the proposed amendments. The amendments are now provided to the Board of Directors for their consideration and approval. Please see the attached red-lined versions of the Bylaws, and Rules and Regulations. Changes may be found under the following referenced articles in the Bylaws and Rules and Regulations: **BYLAWS**: ARTICLE 3.4-2 HONORARY STAFF: PREROGATIVES ARTICLE 3.8 / 3.8-1 RESIDENT STAFF - QUALIFICATIONS ARTICLE 3.8-2 RESIDENT STAFF – APPOINTMENT (A,B,C) ARTICLE 4.2 QUALIFICATIONS ARTICLE 4.5-5 HEALTH INFORMATION ARTICLE 4.8-2(D) EFFECT OF REAPPOINTMENT APPLICATION ARTICLE 5.4-1(C) (E) TEMPORARY PRIVILEGES ARTICLE 5.11-1(A) TELEMEDICINE PRIVILEGES ARTICLE 5.11-3 TELEMEDICINE PRIVILEGES: NO DUES ARTICLE 13.6 PROFESSIONAL LIABILITIY INS ARTICLE 14.2(A) ADOPTION & AMENDMENT OF BYLAWS	

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE BOARD OF DIRECTORS
Thursday, October 25, 2018

REFERRED BY:	AGENDA ITEMS	RECOMMEND
	RULES AND REGULATIONS: ARTICLE 2.4-1 IDPC COMPOSITION ARTICLE 2.5-2(E) (H) WBC - DUTIES ARTICLE 4.1-1 ADMISSION & DISCHARGE OF PATIENTS ARTICLE 4.1-6 (REPLACE “CHART” WITH “MEDICAL RECORD”) ARTICLE 4.1-7 (DELETE) ARTICLE 4.1-8 (REPLACE “CHART” WITH “MEDICAL RECORD”) ARTICLE 4.1-15(A) (DELETE “WRITTEN” RECORD) ARTICLE 4.1-18 CLINICAL RESUME ARTICLE 4.3-3 /4.3-4 MEDICAL RECORDS: AUTHENTICATION ARTICLE 4.4-1 HISTORY AND PHYSICAL ARTICLE 4.4-3 OBSERVATION ARTICLE 4.4-4 DELETE ARTICLE 4.5-1 PROGRESS NOTES: ADD ARTICLE 4.6 OPERATIVE NOTE ARTICLE 4.7 CONSULTATIONS ARTICLE 4.8 ABBREVIATIONS ARTICLE 4.11 ORDERS ARTICLE 4.12 MEDICAL RECORD DELINQUENCY ARTICLE 4.13 LONG TERM CARE ARTICLE 4.14-3 SURGERY ORDERS: ADD ARTICLE 4.15-13 INVASIVE PROCEDURES ARTICLE 4.18-4 EMERGENCY CARE: REVISED ARTICLE 4.18-9 EMERGENCY CARE: ADD ARTICLE 4.20 CRITICAL/INTENSIVE CARE UNIT: ADD ARTICLE 5.1 DISASTER PLANNING: ADD ARTICLE 6.1 NEW PHYSICIAN ORIENTATION: ADD	

TAHOE FOREST HEALTH SYSTEM

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

NAME: _____

Check which applies:
□ Tahoe Forest Hospital (TFH), Inpatient, Oncology, ECC, Outpatient, Emergency, TFH Clinics
□ Incline Village Community Hospital (IVCH), Inpatient, Outpatient, Emergency, Health Clinic

Check which applies: □ Nurse Practitioner □ Physician Assistant
Check one: □ Initial □ Change in Privileges □ Renewal of Privileges
To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education, Training, Licensure, and Experience	Nurse Practitioner: • Certification from an accredited school for nurse practitioner training • Current advance practice RN licensure to practice in California, and/or • Current advance practice RN licensure to practice in Nevada, as appropriate. • Provide evidence of Collaborative Service Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable.
	Physician Assistant (PA): • Completion of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant. • Current California and/or Nevada license in good standing, as applicable. • Provide evidence of Delegation of Service Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable.
Certification:	**Nurse Practitioner (NP):** Current ANCC (American Nurses Credentialing Center) or AANP (American Academy of Nurse Practitioners) certification required. Current PNCB (Pediatric Nursing Certification Board) or current ANCC is required if requesting to work in pediatrics. **Physician Assistant:** Current NCCPA (National Commission on Certification of Physician Assistants) certified. **NP and PA:** Current BLS (Basic Life Support) certified (must submit copy & maintain current certification.)
Clinical Competency References: 3	***Initial and Reappointment*:** At least one peer reference should have the same licensure as the applicant; e.g., nurse practitioner or physician assistant. Other references should include physicians with whom the applicant has worked and/or been employed. ***Reappointment*:** At least one reference from a supervising physician, if applicable.
Proctoring/Evaluation:	See "Proctoring New Applicant" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring/evaluation may be required if minimum number of cases cannot be documented.
Other:	• Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA and/or NV, as applicable (Schedules II-V). Nevada Pharmacy Board Certificate, if applicable • Ability to participate in federally funded program (Medicare or Medicaid) • PAs must have an identified Physician Supervisor who is a member of the Hospital's medical staff. • PAs must complete an educational course in controlled substances that meets the standards of practice by TFHD and State of California witihin six (6) months of being granted privileges and AHP membership. • NPs must have a Collaborative Agreement with a designated *supervising physician member of the Hospital's medical staff. • Must function under defined standardized procedures or protocols.

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.
***Per the CA Physician Assistant Practice Act [Section 3516] No physician and surgeon shall supervise more than four physician assistants at any one time.**

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
□	□	**OUTPATIENT** (Tahoe Forest/Incline Village Hospital) This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges: • History documentation and physical examinations. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays and other diagnostic studies following approved protocols. • Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. • Medication management, including controlled substances, with physician consultation following approved protocols. • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. • Specialty consultation with physician when level of competence or comfort exceeded per approved protocols. **<u>Procedures and minor surgery including</u>**: • Splinting & Casting, simple • Incision and drainage of non-facial abscess less than 5 cm in size • Suture non-facial laceration less than 5 cm in size • Wart removal with cryotherapy • Toenail removal • Excision and Biopsy • Joint Injections	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Actively seeing patients in occ health/health clinic setting (minimum of 100 in two years) On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist

□	□	**INPATIENT or OUTPATIENT HOSPITAL SETTING** **Core privileges for the inpatient or outpatient hospital setting include the following: [NOTE: Any patient requiring ICU or step-down ICU status will be transferred to the on-call physician.]** • History documentation and Physical examinations, • Preop/Preadmission • Dictation of admission H&P and initiation of admitting orders. • Obtain informed consent • POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. • Patient visits and recording progress notes. • Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. • Assess medical risks and appropriately prevent and treat risks (e.g., VTE). • Ordering of diagnostic lab, wound cultures, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. • Consultation with care coordinators, nursing staff, or clinical educators. • Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. • Specialty consultation with physician when level of competence exceeded per approved protocols. • Provision of patient education and make appropriate referrals	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Minimum of 5 patients managed in inpatient setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years) On going bi-monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist
□	□	**<u>Procedures and minor surgery including</u>:** • Apply and remove wound vacs • Arthrocentesis for joint & bursa aspirations to rule out infections • Casting, simple • Closed reductions of dislocations • Reductions of extremity fractures • Hardware removal requiring only local anesthesia • Incision and drainage of non-facial abscess less than 5 cm in size • Suture non-facial laceration less than 5 cm in size • Excision and Biopsy • Joint injections • Injections of hematoma blocks for reductions • Injections IM, IV, Intra articular, SQ and Tendon Sheaths • Traction and Insertion of Steinman Pins for Skeletal Traction • Wound care, assessment & dressing changes • Pronounce a patient death.			
□	□				

		PA SURGICAL FIRST ASSIST – OPERATING ROOM **Core privileges include:** The supervising physician may delegate to a PA only those tasks and procedures consistent with the supervising physician's specialty. The PA may assist with any procedure/surgery approved by the Department of Surgery for the supervising physician/surgeon: • Positioning, prepping and draping the patient • Manipulation tissue/bone • Providing retraction • Drilling, reaming, nail/plate and screw placement • Intraoperative fracture reductions • Providing hemostasis • Performing suturing and knot tying • *Providing closure of tissue layers with suture, staples, or steristrips • *Affixing and stabilize drains • Reduction of fractures/dislocations • Removal of external fixaters • Joint/tissue injections • Applying dressings and splints or casts **NOTE**: *The PA may surgically close all layers, affix and stabilize drains deemed appropriate by the supervising physician. The supervising physician is responsible for all aspects of the invasive/surgical procedure including wound closure and must be **immediately available (need not be present in the room) when the PA closes the wound. [***Immediately available* is defined as "able to return to the patient without delay, upon the request of the PA or to address any situation requiring the supervising physician's services".]	_____	Ten cases reviewed at random (list of patients are provided by practitioner if needed) Review and evaluation of care by surgeons and surgical supervisor	Actively assisting surgeons (minimum of 5 in two years) with annual review and favorable competency evaluations On going monthly chart review(5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
SKILLED NURSING FACILITY (SNF)					
□	□	Core privileges for the skilled nursing facility are limited to performing alternating federally mandated physician visits, at the option of the physician, after initial visit by the physician in the SNF and medically necessary visits for the diagnosis or treatment of an illness or injury as needed. • History documentation and Physical examinations. • Patient visits and recording progress notes. • Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. • Assess medical risks and appropriately prevent and treat risks (e.g., VTE). • Ordering of diagnostic lab, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. • Consultation with care coordinators, nursing staff, or clinical educators. • Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. • Provision of patient education and make appropriate referrals. • POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. • Pronounce a patient death. Specialty consultation with physician when level of competence exceeded per approved protocols.	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Minimum of 5 patients managed in Skilled Nursing setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years) On going bi-monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
INPATIENT / OUTPATIENT CHEMOTHERAPY					
□	□	• Order adjustment per protocol. Specialty consultation with physician when level of competence exceeded per approved protocols.	_____	Ten cases proctored at random (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Actively seeing patients in cancer center setting/inpatient (minimum of 100 in two years, including 5 inpatient cases) On going bi-monthly chart review(5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
EMERGENCY DEPARTMENT (TFH or IVCH)					
□	□	Core privileges for physician assistants and nurse practitioners in emergency medicine include the care for patients of all ages to correct or treat various conditions, illnesses, or injuries including the provision of consultation on behalf of their supervising physician. Core privileges also include assisting the supervising physician with diagnosis and management in the following areas: • History documentation and physical examinations. • Perform a Medical Screening Examination. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays, ECGs, and other diagnostic studies following approved protocols. • Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. • Medication management, including controlled substances, with physician consultation following approved protocols. • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. **Procedures:** Procedures within scope of practice may be performed with consultation when appropriate. These may include but are not limited to: • Splinting & casting • Local anesthesia • Incision and drainage • Wound management and closure • Nail removal • Joint, bursa, and trigger point injection • Foreign body removal • Urinary bladder catheterization		3 and 6 month reviews through random chart review and physician feedback Ten cases proctored (list of patients seen are provided by practitioner)	Actively seeing patients in ER setting (minimum of 100 in two years, may include outpatient or ortho) On going bi-monthly chart review(5% of charts) by Medical Director or Supervising Physician); special review as needed

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Services Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria,. Please include with your request your case logs for the privileges you are requesting. These case logs should be from the facility(s) where the advanced practice privileges were performed in the past two (2) years..			
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.			

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____ _____

Date Applicant's Signature

Department Review Dates: previously approved as separate privilege forms
IDPC Review Dates 10/14/08; 3/12; 4/13/16; 11/11/16; 2/6/17
Medicine/Emerg Department: 5/5/16; 11/14/16
Surgery Department: 6/1/16
Medical Executive Committee: 10/15/08; 3/12; 6/15/16; 11/16/16; 3/16/17
Board of Directors: 10/28/08; 3/12; 6/23/16; 11/17/16; 3/23/17

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Nursing Services - ANS*
Applies To:	

Pediatric Early Warning Score (PEWS) and Algorithm, ANS-1804

PURPOSE:

Infants and children admitted to hospital require regular clinical observations in order to ensure the early detection of deterioration. The Pediatric Early Warning Score (PEWS) is a specialized tool that measures the infant/child's clinical status and recommends an appropriate response. This procedure is to be adhered to for all infants and children, from 30 days old up to 18 years old, admitted to the Emergency Departments or inpatient units of Tahoe Forest Hospital District (TFHD). This policy will describe the PEWS tool and provide an algorithm to guide the interdisciplinary team's plan of care for the deteriorating pediatric patient.

The purpose of this policy is to provide a consistent, evidence based standard of care which ensures that all sick infants and children are assessed and a PEWS obtained. It directs nursing and medical staff to provide safe, timely, and effective management of care in response to a patient's deteriorating condition. The PEWS algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers.

SCOPE:

The policy applies to all infants and children, 30 days old up to 18 years of age, who require acute medical assessment in any clinical areas within TFHD. It is the responsibility of every registered nurse to ensure this PEWS policy is adhered to when assessing infants and children.

POLICY:

The PEWS tool assists with the recognition and appropriate management of clinically deteriorating patients and the patient at risk of clinical deterioration and is complimentary to skilled clinical assessment and decision making.

In the Emergency Department, the PEWS tool will help decision-making for admitting vs. transferring a patient, deciding level of care, and to assess patient stability during transport.

PROCEDURE:

A. For a pediatric patient, the following assessments/symptoms must be completed on admission to obtain accurate PEWS. Subsequent assessment requirements are determined by the PEWS algorithm and/or the medical team.
   1. Respiratory rate calculated over one minute
   2. Respiratory effort
   3. Pulse oximetry and oxygen requirements
   4. Heart rate for at least 30 seconds
   5. Skin color
   6. Capillary refill time
   7. Behavior
   8. Note, while temperature and blood pressure are not included in the PEWS, a baseline temperature and blood pressure recording are taken on admission and q4hours thereafter for an inpatient.

B. At minimum, a full PEWS score must be calculated on admission, when the patient deteriorates, and on transfer between clinical areas.

C. Some children will transgress the PEWS criteria in their normal state due to chronic illness. The medical and nursing staff must jointly agree and set alternative parameters so that they can be alerted of potential deterioration.

D. This tool does not replace clinical judgment. If a child is deteriorating acutely or is peri-arrest, call a Rapid Response or Code White as indicated.

Protocol Management and Documentation

A. Nursing staff must calculate the PEWS from the assessment and symptoms and document the score in the electronic medical record (EMR).

B. All clinical staff must follow the appropriate PEWS management protocol according to the PEWS algorithm.

C. All clinical staff will document any variances from the PEWS in the EMR.

Communication/Handover Requirements

A. Upon transfer between clinical units, report must be provided in SBAR format stating:
   1. Patient's condition/diagnosis
   2. Patient's PEWS score
   3. The components of the observations that drove the score
   4. What actions have already been taken
   5. Clarification of actions to take following the transfer (i.e. repeat PEWS score timeframe)

B. Communication with physicians must be communicated in SBAR and CUS format (see policy: Hand-Off Communications SBAR and C-U-S Reports, AGOV-1504).
   1. If escalation is warranted, utilize the chain of command (see policy: Chain of Command for Medical Plan of Care, ANS-1404).

Special Instructions / Definitions:

The PEWS tool generates a numerical score in relation to assessed neurological, cardiovascular and respiratory status.

Pediatric Early Warning Score (PEWS)	**Score[1]**			
	0	1	2	3
Behavior	• Playing • Appropriate	• Irritable, but consolable	• Irritated, but not consolable	• Lethargic • Confused • Reduced response to pain
Cardiovascular System				
Rate	• Within normal parameters for age	• Tachycardia less than 20 above normal for age	• Tachycardia 20-29 above normal for age	• Tachycardia at least 30 above **or** bradycardia at least 10 below for normal age
Color	• Pink	• Pale **or** dusky	• Mottled	• Gray
Perfusion	• Capillary refill 1-2 seconds	• Capillary refill 3 seconds	• Capillary refill 4 seconds	• Capillary refill at least 5 seconds
Respiratory System				
Rate	• Within normal parameters for age	• Tachypnea 10-19 above normal parameters for age	• Tachypnea at least 20 above normal parameters for age with retractions	•Bradypnea at least 5 below normal parameters for age with retractions •Tachypnea at least 30 above normal parameters with retractions
Effort	• No retractions	• Mild retractions/accessory muscle use	• Moderate retractions/ accessory muscle use (including tracheal tugging)	• Severe retractions/accessory muscle use (including tracheal tugging) **and** grunting
Oxygen	N/A	• Oxygen required to maintain normal[2] SpO? • 2L/min O? • Any assisted ventilation[3] or initiation of O?	• Oxygen required to maintain normal[2] SpO? • At least 3L/min O?	• Oxygen required to maintain normal[2] SpO? • At least 4L/min O?

[1]Add 2 extra points if patient requires frequent interventions (i.e. suctioning, positioning, change in O? needs, multiple IV attempts required, or q15min or continuous nebulized treatments) or has persistent post-op vomiting

[2]As defined in patient's orders

[3]Includes home BiPAP/CPAP or home ventilator at baseline settings

MedSurg PEWS Algorithm (a Rapid Response or Code White may be called at any time):

PEWS Total Score 0-2	Continue routine assessment by RN/RT • Reassess and rescore q4h with vital signs
PEWS Total Score 3	Notify charge nurse. Agree on reassessment plan. • Recommend reassess and rescore q2h • Consider placing IV if no current IV access
PEWS Total Score 4	Notify charge nurse, confirm score, and notify physician • Recommend reassess and rescore q1h • Perform interventions as ordered • No improvement in 1 hour, request evaluation at bedside • Consider placing IV if no current IV access
PEWS Total Score ≥5 ***or 3 in any one category***	Immediate consult with charge nurse. Request evaluation at bedside by physician. • Perform interventions as ordered • Establish IV access • Recommend reassess and rescore q30min • No improvement in 1 hour, call Rapid Response • Consider transfer to higher level of care

Emergency Department PEWS Algorithm:

PEWS Total Score 0-2	Reassess PEWS score with the decision to admit patient.
PEWS Total Score 3	Reassess PEWS score q1h • If score is stable, continue reassessing q1h until transfer to floor • If score is increasing, RN consults with physician prior to transfer to floor to determine next steps including appropriate admission/ transfer • Consider IV access for scores 3-4 prior to transfer to floor
PEWS Total Score 4	
PEWS	RN has conversation with physician regarding next steps including appropriate bed placement (admit vs. transfer out, critical care vs.

Total Score ≥5 ***or 3 in any one category***	non-critical care bed). • Reassess PEWS score q30min until transfer • Perform interventions as ordered

Normal Pediatric Vital Signs:

Age	Heart Rate	Respiratory Rate	Average Optimal Blood Pressure
Infant (1-12 months)	120-160	30-53	85/54
Toddler (1-2 years)	90-140	22-37	95/65
Preschooler (3-5 years)	80-110	20-28	95/65
School-Age Child (6-9 years)	75-100	18-25	105/65
Adolescent (10-15 years)	60-90	12-20	110/65 – 119/75

Related Policies/Forms:

Code Blue Code White, ANS-21; Rapid Response Team, ANS-99; Nursing Management of Pediatric Patient, ANS-298; Pediatric Vital Signs, ANS-304; Pediatric Structure Standards, ANS-85; Intraosseous Device (IO), ANS-1401; Chain of Command for Medical Plan of Care, ANS-1404; Hand-Off Communications SBAR and C-U-S Reports, AGOV-1504

References:

Children's of Minnesota *Pediatric Early Warning Score (PEWS) Algorithm*, 2012; Canterbury DHB *Early Warning Score (EWS) Management Protocol*, 2014; MD Anderson Cancer Center *Detecting Pediatric Patient Deterioration using PEWS*, 2017; CHOC *Children's Pediatric Early Warning System (PEWS)*, 2017; Potter and Perry, *Fundamentals of Nursing 9th Ed*, 2017

All revision dates:

Attachments:

PEWS Algorithms and Scoring DRAFT 03 18.pptx

Applicability

Tahoe Forest Hospital District

JUNE 27, 2018
TFHD MEDICAL STAFF BYLAWS COMMITTEE
ANNUAL REVIEW

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TAHOE FOREST HOSPITAL
(CAH)
INCLINE VILLAGE COMMUNITY HOSPITAL (CAH)

MEDICAL STAFF BYLAWS

2017

1197911.2 Approved by MEC 1/20/16, 7/21/16; by BOD 1/28/16; 9/22/16; 06/22/2017; _____

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TAHOE FOREST HOSPITAL DISTRICT
MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted In recognition of the mutual accountability, interdependence, and responsibility of the Medical Staff and the Board of Directors of Tahoe Forest Hospital District which include Tahoe Forest Hospital and Incline Village Community Hospital; both are Critical Access Hospitals in protecting the quality of medical care provided in the Hospital and assuring the competency of the Hospital's Medical Staff. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, including but not limited to structuring itself to provide a uniform standard of quality patient care, treatment and services; to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes; and to account to the Board of Directors for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities, including but not limited to, periodic meetings of the Medical Staff, its committees, and departments and review and analysis of patient medical records; they describe the standards and procedures for selecting and revoking Medical Staff officers; and address the respective rights and responsibilities of the Medical Staff and the Board of Directors.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Board of Directors must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Board of Directors commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Board of Directors will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Each member of the Medical Staff shall abide by the Medical Staff Bylaws and Rules and lawful standards and policies of the Medical Staff and the Hospital, including, but not limited to, any applicable Medical Staff and/or Hospital policies respecting unlawful harassment and Practitioner conduct.

DEFINITIONS

1. HOSPITAL means Tahoe Forest Hospital and Incline Village Community Hospital.

2. BOARD OF DIRECTORS means the Board of Directors of the Hospital, and may include a committee or individual authorized by the Board of Directors to act on its behalf.

3. CHIEF EXECUTIVE OFFICER means that individual appointed as Chief Executive Officer of the Hospital by the Board of Directors to act on its behalf in the overall management of the Hospital.

4. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), dentists, and podiatrists who have been appointed to the Medical Staff pursuant to the terms of these Bylaws.

5. MEDICAL EXECUTIVE COMMITTEE means the Medical Executive Committee of the Medical Staff.

6. PHYSICIAN means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

7. DENTIST means an individual with a D.D.S. or D.M.D. degree who is currently licensed to practice dentistry. It shall include oral surgeons.

8. PODIATRIST means an individual with a D.P.M. degree who is currently licensed to practice podiatric medicine.

9. PRACTITIONER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, or Allied Health Professional holding a current license to practice who may or may not be a member of the Medical Staff.

10. MEMBER means a practitioner who is a member of the Medical Staff.

11. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to Medical Staff members to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

12. MEDICAL STAFF YEAR means the period from January 1 through December 31.

13. CHIEF OF STAFF means the chief officer of the Medical Staff selected pursuant to these Bylaws.

14. AUTHORIZED REPRESENTATIVE or Hospital's Authorized Representative means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

15. EMERGENCIES are defined as "an acute life threatening situation or acute sensory or limb threatening situation".

16. URGENT CASES are defined as "sub-acute situations where undue delay will produce Irreversible damage".

17. TELEMEDICINE is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

18. INELIGIBLE PERSON means any person who is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or has been convicted of a criminal offense related to the

provision of health care items or services and has not been reinstated in a federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

ARTICLE I

NAME

The name of this organization is the Medical Staff of Tahoe Forest Hospital District.

ARTICLE II

MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical-administrative position by virtue of an agreement with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he/she is a member of the Medical Staff enjoying corresponding privileges or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws and the Rules. Appointment to the Medical Staff shall confer only those privileges and prerogatives, which have been granted in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

A practitioner must demonstrate compliance with all the basic standards set forth in this section in order to qualify for Medical Staff membership. To meet the basic qualifications for membership, all applicants must:

a. Demonstrate and maintain their experience, ability (including mental and physical fitness, with or without reasonable accommodations, to perform the functions associated with requested privileges), and current competence to exercise the privileges they wish to hold. These general standards shall require proficiency in all of the following areas:

1) Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and/or injury, and care at the end of life, as applicable to their specialties.

2) Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

3) Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.

4) Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.

5) Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and

sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

6) Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

a. Document their current licensure as required by law.

b. Demonstrate that they are willing to participate in and properly discharge those responsibilities determined according to these Bylaws;

c. Not be ineligible to participate in federally-funded health care programs, and not become ineligible during any term of membership;

d. Provide ongoing verification of medical malpractice insurance coverage meeting the requirements of these Bylaws in the amount of $1,000,000 and $3,000,000; and

e. If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

2.2-2 PARTICULAR QUALIFICATIONS

a. Physicians: An applicant for physician membership in the Medical Staff must hold a current valid license to practice medicine issued by the Medical Board or Board of Osteopathic Examiners in (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

b. Dentists, Oral Surgeons, and Podiatrists

(1) Dentists and Oral Surgeons: An applicant for dental membership in the Medical Staff must hold a valid license to practice dentistry issued by the Board of Dental Examiners (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

(2) Podiatrists: An applicant for podiatric membership on the Medical Staff must hold a valid license to practice podiatry issued by the appropriate licensing board (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

2.3 EFFECT OF OTHER AFFILIATIONS

(a) No person shall be entitled to membership in the Medical Staff, assignment to a particular staff category, or the granting or renewal of particular clinical privileges merely because that person:

(1) holds a certain degree;
(2) is licensed to practice in California, Nevada, or any other state;
(3) is a member of any particular professional organization;

(4) is certified by any particular specialty board;
(5) had, or presently has, membership or privileges at this or any other health care facility; or
(6) requires a hospital affiliation in order to participate on health plan provider panels, to obtain or maintain malpractice insurance coverage, or to pursue other personal or professional business interests unrelated to the treatment of patients at this facility and the furtherance of this facility's programs and services.

(b) A revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board or health care facility regarding a practitioner's license, certificate, membership or clinical privileges, whether contested or voluntarily accepted, shall constitute grounds for an unfavorable credentialing or peer review action by this Medical Staff. The Medical Staff shall consider the nature and gravity of the charges or allegations and the resulting disciplinary or corrective action, but shall not be obligated to conduct evidentiary proceedings regarding events that occurred elsewhere.

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or clinical privileges shall be determined on the basis of color, national origin, gender, religion or creed, marital status, age, sexual preference, or disability including AIDS and related conditions.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

(a) A practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff.

(b) A practitioner contracting with the Hospital in an administrative capacity with clinical duties or privileges must be a member of the Medical Staff, achieving his/her status by the normal application and appointment procedures described in these Bylaws.

(c) Unless a contract or agreement executed after the adoption of this provision provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the fair hearing procedures of Article VII of these Bylaws, upon termination or expiration of such practitioner's contract or agreement with the Hospital. Furthermore, if the practitioner's privileges are limited to those subject to the exclusive or semi-exclusive arrangement, Medical Staff membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws.

(d) Contracts between practitioners and the Hospital shall prevail over these Bylaws; except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the National Practitioner Data Bank.

(e) Practitioners who subcontract with practitioners who contract with the Hospital will automatically forfeit (without the right of access to the fair hearing procedures of Article VII of these Bylaws) any privileges that are subject to an exclusive or semi-exclusive arrangement if their relationship with the contracting practitioner is terminated. Furthermore, if the practitioner's privileges are limited to those subject to the exclusive or semi-exclusive arrangement, Medical Staff membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws. The Hospital may enforce such automatic termination even if the subcontractor's agreement fails to specifically recognize this right.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The responsibilities of each member of the Medical Staff and of any practitioner holding temporary clinical privileges are to:

(a) provide patients with the high quality of care, which meets the professional standards of the Medical Staff and the Hospital;

(b) abide by the Medical Staff Bylaws, Medical Staff Rules, Medical Staff and Departmental policies, and Hospital policies that relate to patient care and safety;

(c) discharge in a responsible and cooperative manner, those responsibilities which are assigned by virtue of Medical Staff membership, category, assignment, election, or otherwise, including committee assignments and other credentialing, peer review, and quality assessment and performance improvement duties;

(d) prepare and complete in timely fashion medical and other required records for all the patients to whom the member provides care in the Hospital;

(e) abide by the ethical principles of the appropriate state medical or other professional association(s), and, as applicable, the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Osteopathic Association, and the Code of Ethics of the American Podiatry Association;

(f) work with and relate to other staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner so as to create and maintain a working environment conducive to quality and efficient patient care;

(g) make appropriate arrangements for coverage for his/her patients as determined by the Medical Staff, refrain from delegating the responsibility for diagnosis or care of hospitalized patients to any practitioner who lacks the qualifications or privileges to undertake this responsibility, and seek appropriate consultations when indicated;

(h) refuse to engage in division of fees, under any guise whatsoever, or any other improper inducements for patient referral;

(i) participate in continuing education programs;

(j) upon request, provide information from his/her office records as necessary to facilitate the care of or review of the care of specific patients;

(k) participate in such emergency service coverage or consultant panels as may be established by appropriate committees and officials of the Medical Staff;

(l) discharge such other obligations as may be lawfully established from time to time;

(m) notify the Department chairperson or the Chief of Staff in the event the member or practitioner develops a physical, mental, or emotional disability that would significantly interfere with his/her medical practice;

(n) continuously meet the qualifications for membership as set forth in these Bylaws. (It is understood that a member may be required to demonstrate continuing satisfaction of any of the requirements

of these Bylaws and the Rules whenever the Medical Executive Committee has good cause to question whether the member continues to meet such requirement);

(o) protect and preserve the confidentiality of patient health or payment information, including compliance with applicable confidentiality laws and with the confidentiality policies and rules of the Hospital and Medical Staff concerning the use and disclosure of patient health information and records;

(p) provide the Medical Staff Office with a complete and current mailing address and accept Certified or Registered Mail from the Medical Staff;

(q) promptly notify the Medical Staff Office in writing of:

(1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;

(2) an action by the medical staff 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;

(3) the member's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;

(4) any formal allegations of fraud or abuse or illegal activity relating to a member's professional practice or conduct made by any State or Federal government agency;

(5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,

(6) the filing of any malpractice claim or action in which the Practitioner is a named defendant; or

(7) any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Hospital.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy and Honorary. At each time of reappointment, the member's Medical Staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 2.2 of the Bylaws;

b. have satisfactorily completed the provisional requirements for new staff as described in Section 4.7;

(1) Until completion of such requirements, they shall be referred to as Provisional Active. References in these bylaws to "Active Staff" shall not be deemed to include members of the Provisional Active Staff unless the intent to include Provisional members is clear.

c. have primary offices and residences in the Truckee/Incline Village area which are located closely enough to the hospital to allow for appropriate continuity of care;

d. regularly admit and care for inpatients and outpatients in the Hospital and are regularly involved in Medical Staff activities, including attendance at Department meetings; and

e. provide specialty call back-up and consultation as may be required by the Rules and Regulations.

3.2-2 PREROGATIVES

Except as otherwise provided the prerogatives of an Active Staff member shall be to:

a. admit patients and exercise such privileges as are granted pursuant to the Bylaws and the Rules and Regulations;

b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member;

c. hold Medical Staff and Department office and serve as chairman and/or a voting member of committees to which he/she is duly appointed or elected by the Medical Staff or duly authorized representative thereof;

d. be assigned to an appropriate Medical Staff department based upon clinical practice;

e. elect not to be included on the call schedule if they have been an Active Member for the past fifteen (15) years and who are aged 55 or more.

Provisional Active members may not vote or hold office or chairmanship until they have completed their provisional requirements as described in Section 4.7.

3.3 COURTESY STAFF

3.3-1 QUALIFICATIONS

A physician or dentist may be eligible for Courtesy Staff membership if he/she is an active staff member at his/her primary hospital, and if he/she plans to make significant use of Tahoe Forest Hospital and/or Incline Village Community Hospital's hospital services. When loss of membership at his/her primary hospital occurs, the practitioner shall automatically lose his membership and privileges at Tahoe Forest Hospital and/or Incline Village Community Hospital.

The Courtesy Staff Shall Consist Of Members:

a. who can demonstrate current competence and the maintenance of their knowledge and skills by documenting that they have routinely practiced in this or another acute care hospital, or another setting similarly calling for the exercise of their professional knowledge and skills, over the last twenty-four (24) months.

b. who meet the general qualifications set forth in Section 2.2 of the Bylaws; and,

c. Specific clinical privileges shall be applied for and restricted in the same manner as privileges of Active Staff members. At the time of appointment and every two years at the time of reappointment, a practitioner shall provide documentation from his/her primary hospital. In the case of inpatients, the Courtesy Staff member shall find an appropriate active staff member who agrees to attend patients in case of an emergency where distance makes it impossible for the Courtesy Staff member to be at the patient's bedside in a reasonable time.

3.3-2 PREROGATIVES

Except as otherwise provided, the Courtesy Staff member:

a. shall be entitled to admit patients and exercise such privileges as are granted pursuant to these Bylaws and the rules and regulations;

b. shall provide for continuous care of his/her patients;

c. shall be entitled to attend in a non-voting capacity meetings of the Medical Staff and the department and committees of which he/she is a member, but shall not have the right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

d. shall be assigned to an appropriate medical staff department based on clinical practice, but shall be ineligible to hold medical staff office; and,

e. must pay application fees, dues and assessments to the medical staff.

3.3-3 TRANSFER TO ACTIVE STATUS:

Involvement in the care of greater than fifty (50) patients in a two (2) year period shall result in a transfer of the physician to the Active Staff. The applicant may petition the MEC for an exception. Consideration for exceptions may be given by the MEC on a case-by-case basis. Examples for consideration of an exception may include physician's working as hospitalists, emergency medicine, radiology, or pathology.

3.4 HONORARY STAFF

3.4-1 QUALIFICATIONS

The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not practice at the Hospital, and who might not reside in the community, but are deemed deserving of membership by virtue of their outstanding reputation, and/or their previous service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct. Such individuals must be nominated by the Medical Executive Committee and/or clinical department and approved by the Board.

3.4-2 PREROGATIVES

Honorary Staff members are not eligible to admit or care for patients in the Hospital or to exercise privileges in the Hospital, or to vote or hold office in the Medical Staff. They may serve on Medical Staff committees, with or without vote, only at the discretion of the Medical Executive Committee. They may attend Medical Staff and Department meetings. Members of the Honorary Staff are not required to pay medical staff dues.

3.5 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership by other sections of the Bylaws and these Rules.

3.6 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, eligible podiatrists and dentists shall exercise admitting and clinical privileges only within the scope of their licensure and as set forth in Article V of these Bylaws.

3.7 MODIFICATION OF MEMBERSHIP

(a) On its own initiation or pursuant to a request by a member, the Medical Executive Committee may recommend a change in the Medical Staff status of a member consistent with the provisions of the Bylaws. Unless the change has been requested by the practitioner, the Medical Executive Committee shall afford the practitioner an opportunity to comment either in writing or in person before its recommendation is finalized and forwarded to the Board of Directors. There shall be no right to a Hearing under Article VII except as expressly provided therein or required by law.

(b) After two consecutive years in which a member of the Active Staff fails to regularly care for patients in the Hospital as required by that staff category, that member may be automatically transferred by the Medical Executive Committee to the appropriate Medical Staff category, if any, for which the member is qualified.

(c) Action may be initiated to evaluate and possibly terminate the privileges and membership of any staff member (except Honorary) who has failed to have any activity within the Hospital during the previous two years.

3.8 RESIDENT ~~MEDICAL~~ STAFF

3.8-1 QUALIFICATIONS

Resident ~~medical~~ staff membership shall be held by post-doctoral trainees (residents and fellows) in training programs of teaching institutions who are not eligible for another staff category and who are either licensed or registered with the appropriate State of California and/or~~/~~Nevada licensing board. All resident ~~medical~~ staff members must obtain a license to practice medicine within the State of California and/or~~/~~Nevada~~, when eligible~~, as appropriate.

3.8-2 APPOINTMENT

a. Post-doctoral trainees who are enrolled in accredited residency training programs, with whom TFHD has a Memorandum of Understanding (MOU), and who meet the above qualifications shall be appointed to the resident ~~medica~~l staff. Members of the resident staff are not members of the TFHD Medical Staff, they are not eligible to hold office within the medical staff but may participate in the activities of the medical staff through membership on medical staff committees, with the right to vote within committees if specified at the time of appointment, and non-voting attendance at medical staff meetings. Resident staff members are not required to pay dues or assessments.

b. All medical care provided by resident ~~medical~~ staff is under the supervision of members of the Active or Courtesy Staff. Such care shall be in accordance with the provisions of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation.

Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability, and experience

c. Appointment to the resident ~~medical~~ staff shall be for no more than one year and may be renewed annually. Resident ~~medical~~ staff membership may not be considered as the observational period required to be completed by provisional staff. Resident ~~medical~~ staff membership terminates with termination from the training program.

~~c.~~

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ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person, including those in a medical-administrative position by virtue of a contract with the Hospital, shall exercise privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that during the credentialing process and throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the member only such privileges as have been granted in accordance with these Bylaws.

4.2 QUALIFICATIONS FOR INITIAL APPOINTMENT

Threshold Eligibility Criteria for Initial Appointment:

To be eligible to apply for initial appointment to the Medical Staff, physicians, dentists, and oral surgeons must meet all of the following:

(a) have a current, license to practice medicine in California and/or Nevada, as appropriate;

~~(a)~~(b) where applicable to their practice, have a current, unrestricted DEA registration;

~~(b)~~(c) be located close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital, including the Emergency Department, if applicable;

~~(c)~~(d) have current, valid professional liability insurance coverage in amounts of $1 million/$3 million, or such other amount established by Board policy.

~~(d)~~(e) are not currently excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

~~(e)~~(f) agree to fulfill all responsibilities regarding emergency call established by the medical staff;

~~(f)~~(g) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;

~~(g)~~(h) have successfully completed a residency training program and be certified or eligible by an American Board of Medical Specialties (ABMS) member board in the specialty in which the applicant seeks clinical privileges; or by the American Osteopathic Association (AOA) in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

~~(h)~~(i) be board certified or qualified to sit for the boards in their primary area of practice at the Hospital subject to the recertification provision, below. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training are required to become board certified within five (5) years of residency or fellowship training[1];

[1] The provision requiring board certification shall only apply to those physicians who were granted hospital privileges on or after September 22, 2016, the date of adoption by the Board of Directors.

~~(i)~~(j) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements.[2] If a physician has not met the recertification requirements of his/her board for his primary specialty by the time the reappointment is required, the physician will have up to two (2) years from the date of his/her board's expiration to attain such recertification. If a physician does not meet the recertification requirements of his/her board by the end of this time, the physician shall not be eligible for reappointment;

An individual who does not meet the Medical Staff's board certification requirements may request a waiver. The individual requesting the waiver bears the burden of showing that:

(1) it would not be possible, with reasonable and good faith efforts, for him or her to become board certified, maintain board certification, or regain board certification, as applicable; and

(2) based on his or her qualifications, experience and demonstrated competence, he or she can be relied upon to provide care of the same quality and sophistication that is expected of those who have achieved initial board certified in the same specialty.

A request for a waiver must be submitted in writing to the Medical Executive Committee, and be accompanied by a written statement and relevant documentation in support of it. The MEC shall consider the request and make a recommendation to the Board. The MEC may give the practitioner an opportunity to make an oral presentation and respond to questions before formulating its recommendation. The denial of a waiver shall not entitle the practitioner to a hearing under Article VII of these Bylaws.

~~(j)~~(k) demonstrate recent clinical activity in their primary area of practice by submitting a case list from the last two years.

[2] This provision shall only apply to physicians who were granted staff privileges on or after September 22, 2016, the date of initial adoption by the Board of Directors.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information necessary for a proper evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to complete his/her application will be grounds for a refusal to take action on that application, which shall not be subject to appeal or review under Article VII of these Bylaws.

In order for the Medical Executive Committee to make a recommendation to the Board of Directors concerning an applicant for appointment or reappointment to the Medical Staff or additional clinical privileges, the Medical Staff must have in its possession adequate information for a conscientious evaluation of the applicant's training, experience and background as measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application that is not "complete."

4.2-1. COMPLETE APPLICATION FOR APPOINTMENT, REAPPOINTMENT, OR NEW PRIVILEGES

An application for appointment, reappointment or new clinical privileges shall not be deemed "complete," for purposes of subparagraph 4.2-3 below, until:

a. The applicant submits a written application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable and substantively responsive on every point of inquiry.

b. The applicant responds to all further requests from the Medical Staff, through its authorized representative, for clarifying information or the submission of supplementary materials. This may include, but not necessarily be limited to, submission to a medical or psychiatric evaluation, at the applicant's expense, if deemed appropriate by the Medical Executive Committee to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges. If the requested items of information or materials, such as reports or memoranda, are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source.

c. The applicant has assisted as necessary in the solicitation of written evaluations from those listed by the applicant as references and from other potential sources of relevant information. Such assistance may include the signing of a special release or similar document, as requested.

4.2-2 COMPLETE APPLICATION FOR NEW OR ADDITIONAL PRIVILEGES

An application for new or additional privileges by a member of the Medical Staff in good standing, for which there might or might not be a prescribed form, shall not be complete unless and until:

a. The applicant submits a written request for privileges, supported by a complete description of the applicant's training, experience and other qualifications for the requested privileges, with documentation as appropriate.

b. The applicant responds to requests for information and materials as described above.

4.2-3 INCOMPLETE APPLICATION

An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for credentialing recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given a reasonable opportunity to do so, the credentialing process will be terminated, at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. An incomplete application will not be processed. Termination of the credentialing process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

4.2-4 APPLICANT RESPONSIBILITY FOR KEEPING APPLICATION CURRENT

Until notice is received from the Board of Directors regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any material change in the information provided or new information that might reasonably have an

effect on the applicant's candidacy, including the filing of any malpractice claim against the applicant. Failure to meet this responsibility shall be grounds for denial of the application, nullification of any approval if granted, and/or termination of Medical Staff Membership.

4.2-5 COMPLETED APPLICATION TIME PERIOD

A complete application shall be acted upon within a reasonable time period not to exceed 60 days except that action by the Board of Directors may be delayed for a good cause.

4.2-6 **SIGNIFICANT MISREPRESENTATIONS OR OMISSIONS**

An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant's absolute responsibility to review the application carefully and verify that the information provided in it, or as part of it, is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in, or omission from, an application shall, in itself alone, constitute cause for denial of the application. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is discovered after the application has been approved; it shall constitute cause for summary suspension and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the Medical Executive Committee, at is discretion, after giving the applicant an opportunity to address the issues in writing or at a meeting.

4.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, appointments to the Medical Staff shall be for a period of two years. Reappointments shall be for a period of up to two years.

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

An applicant for appointment and reappointment shall complete written application forms that request information regarding the applicant and document the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and Rules. Following its investigation, the Medical Executive Committee shall recommend to the Board of Directors whether to appoint, reappoint, and/or grant specific privileges.

4.5 BASIS FOR APPOINTMENT AND REAPPOINTMENT

Recommendations for appointment to the Medical Staff and for granting of privileges shall be based upon the applicant's training, experience and professional performance at this Hospital and in other settings, whether the applicant meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner. Evidence of the applicant's identity, character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current chiefs or chairmen at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

4.5-1. APPLICATION FORM

An application form shall be developed by the Hospital and the Medical Staff. The form shall require detailed information which shall include but not be limited to, information concerning:

a. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, Nevada pharmacy certificate and fluoroscopy certificate as appropriate, professional affiliations, and continuing medical education information related to the privileges to be exercised by the applicant;

b. peer references (at least three), some of whom are in the same specialty, who have had extensive experience in practicing with, or otherwise observing, the applicant and who are therefore familiar with the applicant's current professional competence and ethical character; no more than one reference may be from a practitioner with whom the applicant is currently in practice or would be in practice upon obtaining membership;

c. requests for Medical Staff status, Department affiliation, and privileges;

d. any past or pending, voluntary or involuntary, professional disciplinary actions, licensure, DEA Permit, or Nevada certificate limitation; federal or state investigations, or related matters;

e. physical and mental status relative to the clinical privileges requested;

f. professional liability insurance coverage which shall be maintained in effect in limits set in accordance with these Bylaws;

g. a detailed description of any proposed or implemented restrictions or denial of licensure or governmental certification or registration;

h. a description of any suspension or termination of specialty board certification or eligibility;

i. a detailed description of any professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition against the applicant; any additional information concerning such proceedings or actions as the Medical Executive Committee, or the Board of Directors may request; and

j. A current valid state or federal agency photo identification card (passport or driver's license) or, at the discretion of the Medical Staff, a current valid Hospital picture ID card, in order to verify that the applicant is the same practitioner identified in the credentialing documents.

Each application for initial appointment to the Medical Staff shall be in writing, or electronically submitted on the prescribed form with all provisions completed, and signed by the applicant.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1 of the Bylaws, by applying for appointment to the Medical Staff each applicant:

a. signifies his/her willingness to appear for interviews in regard to the application;

b. authorizes consultation with others who may have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes those individuals and organizations to candidly provide that information;

c. consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out the privileges and status requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

d. releases from any liability, to the fullest extent permitted by the law, all persons for their acts performed in connection with investigating and evaluating the applicant, all individuals and organizations who provide information regarding the applicant, including information otherwise deemed confidential;

e. consents to the disclosure, upon appropriate request, to other hospitals, medical associations, licensing boards, and to any other relevant organization, of any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for doing so to the fullest extent permitted by law;

f. acknowledges responsibility for timely payment of Medical Staff dues as specified by the Medical Staff in accordance with the Bylaws and these Rules;

g. pledges to provide for continuous quality care for patients;

h. pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals, providing continuous care of his/her patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

i. pledges to be bound by the Medical Staff Bylaws, Rules, and policies;

j. acknowledges that any omission or falsification of information may result in denial of an application;

k. consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee; and

l. signifies his/her willingness to abide by all the conditions of membership, as stated on the application form, the reapplication form, and in these Rules.

4.5-3 APPLICATION FEE

The applicant shall deliver a completed application to the Chief of Staff or his/her designee, a non-refundable application fee, and any dues per Medical Staff Policy.

4.5-4 VERIFICATION OF INFORMATION

The Chief of Staff and the Chief Executive Officer shall be notified of the application. The Medical Staff office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Hospital's Authorized Representative shall query the National Practitioner Data Bank, the appropriate state medical board(s), and other relevant sources, such as but not limited to the Federation of State of Medical Boards Physician Disciplinary Data Bank, regarding the applicant and include any resulting information in the applicant's credentials file. The Medical Staff Office shall also obtain such additional information or documentation as necessary to confirm that the individual requesting membership and privileges is the same individual identified in the credentialing documents. After the application is completed, the application and incidental credentialing materials shall be transmitted to the chair of each Department in which the applicant seeks privileges. The applicant shall be notified of any difficulties encountered in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.

~~4.5-5 HEALTH INFORMATION~~

~~Information regarding the applicant's health status shall be immediately transferred to the custody of the Well-Being Committee, and shall not be considered by the Medical Executive Committee until after the applicant has otherwise been determined to qualify for membership.~~

4.6 ACTION ON THE APPLICATION

4.6-1 DEPARTMENT ACTION

After receipt of the application, the Department to which the application has been submitted shall review the application and the incidental credentialing materials. This review shall be conducted by the chairperson of the Department with the optional assistance of an ad hoc committee of members of the Department. That ad hoc committee is to be selected by the chairperson and membership shall be open to all members of the Department who are interested in contributing to the credentialing process. As part of this process, the applicant may be required to attend a personal interview with a representative of the Department. The chairperson of the Department shall then transmit to the Medical Executive Committee a written report and recommendation of the Department as to appointment and, if appointment is recommended, concerning the applicant's qualifications for the request for clinical privileges, applicant's character, professional competency, prior behavior and ethical standing and whether the applicant has established and satisfied all of the necessary qualifications for appointment. Included in the report shall be recommendation as to membership category, Department affiliation, privileges to be granted and any special conditions to be attached.

If the chairperson of the Department is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise considered incomplete under Section 4.2, the chairperson may delay further processing of the application, or may begin processing the application based only on the available information with an indication that further information may be considered upon receipt (this latter section referring only to particular clinical privileges requested that cannot be acted upon until requested documentation or other information is received). If the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the application shall be considered incomplete under Section 4.2 and the affected practitioner shall be so informed. Such an applicant's application may, thereafter, be

reconsidered only if all requested information is submitted, and all other information has been updated.

4.6-2 MEDICAL EXECUTIVE COMMITTEE ACTION

After receipt of the Departmental report and recommendation, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Department for further review, and/or elect to interview the applicant. As part of making its recommendation, in the manner and to the extent permitted by law, the Medical Executive Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Medical Executive Committee**.** The Medical Executive Committee shall then formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status, including any reports of the Well-Being Committee, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff. The Medical Executive Committee shall then finalize a recommendation regarding the application**.** The Medical Executive Committee may also defer action on the application but not indefinitely and shall be addressed at the next regularly scheduled meeting. The reasons for each recommendation should be stated.

4.6-3 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. **Favorable Recommendation.** Favorable recommendations shall be promptly forwarded to the Board of Directors together with the supporting documentation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

b. **Adverse Recommendation.** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the applicant, and he/she shall be entitled to the procedural rights as provided in Article VII of the Bylaws. The Board of Directors shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

4.6-4 BOARD OF DIRECTORS ACTION

a. **On Favorable Medical Executive Committee Recommendation.** The Board of Directors shall adopt, reject, or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond.

b. If the board is inclined to reject or modify a favorable recommendation, the Board shall refer the matter back to the Medical Executive Committee for further review and comments, which may include a second recommendation**.** The Executive Committee's response shall be considered by the Board before adopting a resolution.

c. If the Board's resolution constitutes grounds for a hearing under Article VII of the Bylaws, the Chief Executive Officer shall promptly inform the applicant, and he/she shall be entitled to the procedural rights as provided in that Article.

d. **After Procedural Rights.** In the case of an adverse Medical Executive Committee recommendation pursuant to Section 4.6-3 (b) or an adverse Board decision pursuant to

Sections 4.6-4 (a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights under the Bylaws. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Board of Directors shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Board shall make a final decision.

e. **Conflict Resolution.** The Board of Directors shall give great weight to the actions and recommendations of the Medical Executive Committee and in no event shall act in an arbitrary and capricious manner.

f. The Governing Body may delegate decision-making authority to a committee of the Governing Body; however, any final decision of the Governing Body committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting.

4.6-5 NOTICE OF FINAL DECISION

a. Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the applicant, and the Chief Executive Officer.

b. A notice of decision to appoint or reappoint shall include, if applicable: (1) the Medical Staff category to which the applicant is appointed; (2) the Department to which that person is assigned; (3) the privileges granted; and (4) any special conditions attached.

4.6-6 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

4.7 PROVISIONAL STATUS

4.7-1 OBSERVATION OF PROVISIONAL STAFF MEMBERS

a. Each new member of the Medical Staff shall be observed, or proctored, by one or more appropriate member(s) of the Active or Courtesy Staff per Medical Staff Policy. The proctor shall monitor the practitioner's performance and evaluate the member's (1) proficiency in the exercise of privileges initially granted and (2) overall eligibility for continued Medical Staff membership and clinical privileges and advancement within Medical Staff Categories.

b. Proctoring will be reported on forms setting forth criteria to be used by proctors in evaluating performance. Included in the criteria to be evaluated shall be professional skill and judgment, cooperation with other professionals and Hospital staff, timely and thorough completion of medical records, and ethical conduct. Observation shall include those mechanisms customarily used to evaluate a practitioner's initial performance including, but not necessarily limited to, concurrent chart review, retrospective chart review, discussion, and proctoring by direct visual observation. The respective obligations of the observer and the practitioner being observed may be established in more detail through department clinical privileges criteria description, department rules, and/or medical staff policies. Although flexibility in the

proctoring process is to be stressed, policy guidelines should require the timely completion of written evaluation forms.

c. A proctor may intervene in the care of a patient only if he or she believes that an error is being made that either may be life-threatening or that may result in permanent harm. In such circumstances, the proctored physician must step aside and/or follow the proctor's orders.

d. Proctoring may be concurrent or retrospective depending upon the nature of the privileges requested. A department may utilize an external proctor who is not a member of the Medical Staff if it is necessary to monitor a physician in a procedure not currently being done by other physicians on the staff. Medical Staff policies will define the process for proctoring by a practitioner not on the Medical Staff.

e. In the event of an unsatisfactory proctoring report, the practitioner being proctored shall be notified and shall be afforded an opportunity to have an informal conference with his/her Department chair concerning such report, provided, however, such opportunity shall not include access by the practitioner being proctored to written proctoring reports which shall be maintained as part of the peer review activities of the Medical Staff and shall be kept in strictest confidence unless or until such reports are used to deny or restrict privileges; then they shall be made available to the proctored physician.

f. Proctoring of practitioners with temporary privileges shall be performed pursuant to Section 5.4-3.

4.7-2 DURATION OF PROVISIONAL STATUS

a. All initial appointments to the Medical Staff shall be provisional for a period of no less than six (6) months and no more than twenty-four (24) months as provided for in these bylaws, and new appointments and/or practitioners granted new privileges shall be subject to proctoring in accordance with standards and procedures set forth in these bylaws. If, at the end of twenty-four (24) months, the practitioner has not satisfied the requirements for advancement to full Active or Courtesy Staff for unsupervised privileges, the Medical Executive Committee may recommend to the Board of Directors that membership and privileges not be extended beyond the expiration of the current term of appointment. However, if during this provisional period, a staff member has met the ethical requirements for continued membership and has otherwise discharged all assigned obligations, but, for reasons beyond his control (e.g., practice seldom requires a hospital utilization), he has not been proctored or observed sufficiently to accommodate an evaluation of current competence for all of the requested clinical privileges, he may be granted a six (6) month extension of the provisional membership.

b. Advancement to the full Courtesy or Active Staff may be granted with some privileges remaining under proctorship as recommended by the Medical Executive Committee should the provisional privileges not be utilized.

c. A lapse of membership or clinical privileges by reason of the expiration of the maximum term of this provisional period shall not give rise to formal hearing rights, unless it is under circumstances which require a report to the Medical Boards of California or Nevada, Osteopathic Medical Boards of California or Nevada or the National Practitioner Data Bank, or the dental or podiatric boards of either California or Nevada.

d. Members of the provisional staff are required to fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities.

e. In addition, members may be required to be proctored as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competence in that area).

Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information-gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in Article VII of these Bylaws unless the proctoring has the effect of restricting a practitioner's privileges because the proctoring is imposed for reasons other than assessment of new or infrequently performed privileges and carries the condition that procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

f. The practitioner shall remain subject to such proctoring until the Medical Executive Committee has been furnished with a report signed by the chair of the Department to which the member is assigned describing: (i) that competencies are met and no further proctoring is necessary; (ii) the types and numbers of cases observed and the evaluation of the applicant's performance; (iii) a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, with any exceptions noted, has discharged all of the responsibilities of membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made, and (iv) any adverse information or recommendation based on review of the proctoring reports with follow up as described in 4.7-2**.** In all cases, the Medical Executive Committee shall make its recommendation to the Board of Directors regarding approval**,** modification or termination of privileges and Medical Staff membership.

4.8 REAPPOINTMENT

Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's performance at this Hospital and in other settings. The reappraisal is to include confirmation of adherences to the Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules, the Medical Staff and Hospital policies, and the applicable department rules. Such reappraisal should also include relevant practitioner-specific information from performance improvement activities and where appropriate comparisons to aggregate information about performance, judgment and clinical technical skills. Where applicable, the results of specific peer review activities shall also be considered.

Reappointments are granted for a period not to exceed two years and may be granted for less than two years as recommended by the Medical Executive Committee.

4.8-1 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

a. At least four (4) months prior to the expiration date of the current Medical Staff appointment, a reapplication form developed by the Hospital and Medical Staff shall be mailed or delivered to the member. The completed reappointment application must be returned to the Medical Staff Office within 30 days of receipt. Upon receipt of the application, it shall be processed in the manner described in Section 4.5-4 through 4.5-10 of these Bylaws.

b. A Medical Staff member who seeks a change in Medical Staff status, category or modification of privileges by submitting a written request through Medical Staff Services may submit such a request at any time except that such application may not be filed within two (2) years of the time a similar request has been denied. Such application shall be processed in substantially the same manner as provided in these Bylaws regarding initial applications for Appointment. The exercise of new privileges by medical staff members shall be subject to observation in accordance with procedures adopted by the Medical Staff.

4.8-2 EFFECT OF REAPPOINTMENT APPLICATION

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such member's:

a. Relevant practitioner specific information from organization performance improvement activities, including morbidity and mortality data, is considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance;

b. Results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty;
c. Any focused professional practice evaluations;
d. Verified complaints received through documentation from patients, family, and/or staff;
e. Compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and Hospital;
f. Participation in Medical Staff duties, including committee assignments and emergency call;
g. Demonstrated ethical behavior and clinical competence, current licensure, National Practitioner Data Bank query and receipt of response, and clinical judgment including professional and technical skills, in the treatment of patients.
h. Other reasonable indicators of continuing qualifications.

4.8-3 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a complete application for reappointment (i.e., failure to return the application within the time required by Section 4.8-1 and to make the application complete within sufficient time for it to be processed) shall result in the automatic expiration of the practitioner's Medical Staff membership and clinical privileges at the end of the current Medical Staff appointment. In the event membership terminates for the reasons set forth herein, the member shall not be entitled to any hearing or review as set forth in Article VII of the Bylaws.

4.9 LEAVE OF ABSENCE

4.9-1 REQUEST FOR LEAVE STATUS

a. Routine Leave of Absence

At the discretion of the Medical Executive Committee, a Medical Staff member may request a voluntary leave of absence from the Medical Staff upon submitting a written request to the Medical Executive Committee no less than thirty (30) days prior to the requested effective date of the leave of absence, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic relinquishment of medical staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the end of the leave and granted by the Medical Executive Committee with TFHD Board of Directors approval. The Medical Executive Committee shall act on such requests,

using its sole discretion as to whether the requested leave of absence is in the best interests of the Hospital and the Medical Staff. Leave of absences must be requested if the Medical Staff member is going to be absent from practice for more than sixty (60) days. 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. The member shall be notified in writing of the Medical Executive Committee decision and is only effective upon acceptance of the Medical Executive Committee.

b. Medical Leave of Absence

The Chief of Staff, in consultation with the appropriate department chair, may approve a medical leave of absence of any duration to accommodate a member's treatment for, or recovery from, a mental or physical condition affecting his or her fitness to practice safely. The member shall be notified in writing by the Chief of Staff granting the leave. The member may be required to submit a letter of release from the treating physician as a condition of return from such leave of absence and prior to exercising any patient care.

4.9.2 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the member shall not exercise privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless excused by the Medical Executive Committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current unless excused by the Medical Executive Committee. Meeting attendance requirements will be waived during period of leave.

4.9-3 EXTENSION OR TERMINATION OF LEAVE

At least thirty (30) days prior to the proposed termination of the leave of absence, or at any earlier time, the Medical Staff member may request extension of the leave or reinstatement of privileges by submitting a written request to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the extension of the leave or reinstatement of the member's privileges and prerogatives, and the procedures provided in Section 4.5 and 4.7 of these Bylaws shall be followed, including processing as a full reappointment under Section 4.8 if the time period since the member's appointment or last reappointment is eighteen (18) months or greater or if the member's appointment or last reappointment is expired.

4.9-4 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall result in automatic expiration of membership and clinical privileges. A member whose membership automatically expires under this provision may contest this action to the Medical Executive Committee by submitting a written statement or request a meeting before the committee. The Medical Executive Committee's decision shall be final. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

4.9-5 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a member's term of appointment is scheduled to expire during the period for which a leave is requested, the member may: (i) seek and obtain reappointment prior to going on leave and before the expiration of the member's current term, which would result in an adjustment of the member's subsequent term of appointment to reflect the new date of reappointment; (ii) apply for

reappointment at the scheduled time while on leave, subject to the Medical Staff's prerogative that supplemental information be produced to confirm current competence upon reinstatement; (iii) or permit the current term of appointment to expire and reapply for membership and privileges as a new candidate upon termination of the leave of absence.

4.10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment or reappointment to the Medical Staff shall not be eligible to apply again to the Medical Staff for a period of two years. Any such application shall be processed as an initial application, and the applicant shall submit any additional information that may be required to demonstrate that the basis for the earlier adverse action no longer exists along with any other information needed to demonstrate his/her qualifications.

4.11 CONFIDENTIALITY, IMPARTIALITY

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to committee meetings and the formal processes provided in these Bylaws for processing applications for appointment and reappointment.

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a practitioner providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Those privileges and services shall be specifically delineated for each facility operated by the Hospital, and must be within the scope of any license, certificate, or other legal credential authorizing practice and consistent with any restrictions thereon. Privileges may be granted, continued, modified, or terminated by the Board of Directors only in accordance with the provisions of the Medical Staff Bylaws.

5.2 BASIS FOR PRIVILEGES DETERMINATION

Requests for privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated professional competence and clinical performance, and the other factors specified in these Bylaws regarding qualifications for membership and privileges.

5.3 ADDITIONAL CONDITIONS FOR PRIVILEGES OF Dentists, ORAL SURGEONS, AND PODIATRISTS

5.3-1 ADMISSIONS

Dentists, oral surgeons and podiatrists who are members of the Medical Staff may only admit patients if an Active or Courtesy physician member of the Medical Staff performs the admitting history and physical examination, except the portion directly related to dentistry or podiatry, and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

5.3-2 SURGERY

a. Surgical procedures performed by dentists, oral surgeons, and podiatrists shall be under the overall supervision of the Chair of the Department of Surgery or the Chair's designee.

b. (b) Additionally, the finding, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

5.3-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist, oral surgeon, or a podiatrist shall receive the same basic medical appraisal as patients admitted for other care, and a physician member of the Medical Staff shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s). This action affords no right to appeal or review under Article VII of these Bylaws.

5.4 TEMPORARY CLINICAL PRIVILEGES

5.4-1 GENERAL

Temporary privileges may be granted by the Chief Executive Officer of the Hospital or his designee on the recommendation of the department chairman and the Chief of Staff under certain circumstances to practitioners who are not members of the Medical Staff under the terms and conditions described in 5.4-2 and 5.4-3 below. Temporary privileges may be granted here for a specific period not to exceed one hundred and twenty (120) consecutive days. Approval should be sought sufficiently in advance of the anticipated exercise of privileges to allow for collection and evaluation of such information in the normal course of Hospital business.

In all instances, prior to the granting of temporary privileges, there shall be:

a. a written request for temporary privileges;

b. a completed application form;

c. verification of current, unrestricted state medical, dental, or podiatric license from the State of California and/or State of Nevada, as applicable;

~~c.~~d. queries to and results from the National Practitioner Data Bank; Medical Board of California, Osteopathic Medical Board of California and/or State of Nevada, Board of Dental Examiners for California and/or Nevada, or appropriate licensing Boards for Podiatry in California and/or Nevada;

~~d.~~e. verification of current DEA for California and/or Nevada and/or Nevada State Pharmacy registration depending upon practice location;

~~e.~~f. fluoroscopy certificate if applicable

~~f.~~g. verification of professional liability insurance meeting Medical Staff and Board of Directors specifications

~~g.~~h. query for and receipt of criminal background check

~~h.~~i. professional references for competency from previous hospital affiliation, chief or department chair familiar with the applicant's background and practice relevant to the requested temporary privileges per credentialing policy

~~i.~~j. other information as may be required per credentialing policy

~~j.~~k. evidence of no current or previously successful challenge to licensure or registration

~~k.~~l. evidence of no subjection to involuntary termination of medical staff membership at another organization

~~l.~~m. no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

~~m.~~n. A current valid state or federal agency picture ID card (passport or driver's license) or, at the discretion of the Medical Staff, a current valid Hospital picture ID card, in order to verify that the applicant is the same practitioner identified in the credentialing documents.

For new applicants for Medical Staff Membership and Clinical Privileges, a completed application is required which includes the above information as well as references below in 5.4-2 (a).

5.4-2 CIRCUMSTANCES

a. Pendency of Application – Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee and Governing Board provided the application meets the criteria listed in the description above, Sections 4.2-1 and 4.5-1of these Bylaws.

b. Care of Specific Patient - A practitioner with specialized skills and experience not otherwise available on the Medical Staff or a practitioner not on the medical staff who is requested to assist with patient care by a member of the Medical Staff may be granted temporary privileges to care for a specific patient. Should the time period exceed one hundred and twenty (120) days, a time limited extension of temporary privileges may be granted based on documented special circumstances, These practitioners shall have no admitting or attending physician responsibilities.

c. Locum Tenens – A practitioner who is requested by a medical staff member to cover an expected absence may be granted temporary privileges per 5.4-2 (a) above.

d. Temporary adjuncts (proctoring physician and/or visiting professor) may be granted temporary privileges for the introduction of new procedures; all outside proctors must acquire temporary privileges.

e. Other circumstances that are necessary to fulfill an important patient care need that mandates an immediate authorization to practice shall be considered for temporary privileges.

5.4-3 CONDITIONS

There is no right to temporary privileges. Temporary privileges may be granted only when the practitioner has submitted a written application for appointment to the Medical Staff, or a written request for temporary privileges, and the information available reasonably supports a favorable determination regarding appointment or the practitioner's qualifications, respectively, and the applicant has satisfied the insurance requirements of these Bylaws or Rules. The Chair of the Department to which the practitioner is assigned, or to which the privileges correspond, shall be responsible for determining the proctoring requirements or supervising the performance of any practitioner granted temporary privileges, or for designating a member of the Department to assume this responsibility. Special requirements of consultation and proctorship may be imposed by the Chair of that Department or the Medical Executive Committee. Temporary privileges will not

be granted before the practitioner has acknowledged in writing that he/she has received, or has been given access to, the Medical Staff Bylaws and Rules and that he/she agrees to be bound by their terms in all matters relating to his/her Medical Staff status and the temporary privileges.

5.4-4 TERMINATION

Temporary privileges may be terminated without cause at any time by the Chief of Staff, the responsible Department Chair, or the Chief Executive Officer with the concurrence of the Chief of Staff or the responsible Department Chair. In addition, where the life or wellbeing of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Section 6.3. In the event of any such termination or restriction, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Chair of the concerned Department. The wishes of the patient will be considered, where feasible, in choosing an alternative practitioner.

5.4-5 RIGHTS OF THE PRACTITIONER

Except in cases where denial, termination, or suspension of temporary privileges must be reported to the National Practitioner Data Bank or the Medical Board of California, a practitioner or allied health professional shall not be entitled to the procedural rights afforded by Article VII because of his/her inability to obtain temporary privileges or because of any termination, suspension, or non-renewal of temporary privileges.

5.5 EMERGENCY PRIVILEGES

(a) In the case of an emergency, any member, to the degree permitted by his/her license and regardless of Departmental assignment, Medical Staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chair with respect to further care of the patient at the Hospital.

(b) In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when one becomes available.

5.6 DISASTER PRIVILEGES

(a) Disaster privileges may be granted to a non-Medical Staff member when the organization has activated its Emergency Management Plan and has determined that there are important and immediate patient care needs the Hospital is unable to meet without the assistance of practitioners in addition to those currently holding Medical Staff membership and/or clinical privileges. The Hospital Chief Executive Officer or designee, upon recommendation of the Chief of Staff or designee, may grant disaster privileges should the need arise.

(b) Privileges shall be considered on a case-by-case basis upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

1. A current picture hospital ID badge (card) from a hospital where the practitioner holds clinical privileges that clearly identifies professional designation;

2. A current license to practice, or primary source verification of such license;

3. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;

5. Identification by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

(c) Written notification/signed approval evidencing the granting of privileges shall be directed to Medical Staff Services to initiate verification. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. (Note: In the extraordinary circumstance that primary source verification cannot be completed within 72 hours, it must be done as soon as possible with documentation as to (i) why it could not be performed within the required time frame, (ii) evidence of demonstrated ability to continue to provide adequate care, treatment, and services and (iii) an attempt to rectify the situation as soon as possible).

(d) The practitioner who has been granted disaster privileges will be provided an identification badge or other designated means of identification, to be worn during the emergency. Specific means of organization-wide communication as designated by the incident commander (Hospital Chief Executive Officer or designee) will be utilized to disseminate basic information about non-Medical Staff member volunteer practitioners.

(e) The volunteer practitioner shall be assigned to a department of the Medical Staff under the supervision of the department chair or designee. The frequency and intensity of data collection and analysis shall be accelerated as appropriate to the emergency situation to evaluate clinical competence.

(f) The following information must be obtained, verified as soon as possible, and retained as a permanent record by Medical Staff Services:

1. Current professional license to practice including sanctions, if any
2. Photo identification, as specified above in (b)
3. Certificate of professional liability coverage
4. Current hospital affiliations
5. NPDB query (includes OIG, state sanction info, board certification, DEA information)
6. Relevant training/experience
7. Criminal background check

5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, or pursuant to a member's request, the Medical Executive Committee may recommend a change in the privileges or Department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made

subject to monitoring in accordance with procedures similar to those outlined in the Rules regarding proctoring.

5.8 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignment fails to furnish, in a timely manner, the information necessary to evaluate the request, the application shall be regarded as incomplete under Section 4.2 and shall not qualify for a credentialing recommendation. The applicant shall not be entitled to a hearing under Article VII.

5.9 CONFIDENTIALITY, IMPARTIALITY

To maintain confidentiality, and to assure the unbiased performance of privilege review functions, Medical Staff members participating in the credentialing process shall limit their discussion of the matters involved to committee meetings and the formal processes provided in these Bylaws for processing applications for clinical privileges.

5.10 ALLIED HEALTH PROFESSIONALS

5.10-1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Allied health professionals (AHPs) are not eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of AHPs that the Board of Directors (after securing Medical Executive Committee recommendations) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Allied Health Professional Manual. The Allied Health Professional Manual is incorporated herein by reference, as part of the Medical Staff Bylaws.

5.11 TELEMEDICINE PRIVILEGES

After consulting with the Medical Executive Committee, the Board of Directors may approve specific types of telemedicine services to be utilized at the Hospital. Such services may be provided pursuant to a contract. Practitioners who wish to provide permitted types of telemedicine services will be credentialed in accordance with this Section, but, unless they separately qualify, apply and are approved for membership in a staff category described in Article III of these Bylaws, will not be appointed to the Medical Staff in any membership category.

5.11-1 TELEMEDICINE CREDENTIALING

a. In processing a request for telemedicine privileges, the Medical Staff and Hospital may follow the normal credentialing process described in Article IV of these Bylaws, including but not limited to the collection of information from primary sources. Alternatively, the Medical Staff may elect to rely upon the information provided ~~credentialing and privileging decisions made~~ by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in this Section 5.11.

b. Telemedicine privileges shall be for a period not to exceed two years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these Bylaws for the renewal of clinical privileges held by Medical Staff members.

c. The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the Hospital and its Medical Staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic

responsibilities that must be met by members of the Medical Staff, as described in Section 2.6 of these Bylaws, modified only to take into account their distance from the Hospital.

d. Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the Medical Executive Committee or the Chief of Staff acting on its behalf, without hearing rights as described in Article VII of these Bylaws, except as required by law.

5.11-2 RELIANCE ON DISTANT-SITE ENTITIES

The Medical Staff may rely upon the ~~credentialing and privileging decisions made~~ information provided by a distant-site hospital or distant-site telemedicine entity if the Hospital's Board of Directors ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

a. The distant-site entity acknowledges that it is a contractor of services to this Hospital and, in accordance with 42 CFR §485.635(c) (4) (ii), furnishes services in a manner that permits this Hospital to be in compliance with the Medicare Conditions of Participation.

b. The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation at 42 CFR §485.616(c).

c. The distant-site entity acknowledges, or the Hospital confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the Healthcare Facilities Accreditation Program standards for critical access hospitals (currently 05.00.14 and 05.00.15).

d. The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the Hospital with a current list of the distant-site practitioner's privileges at the distant-site entity.

e. The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to Medical Staff members at this Hospital.

f. The Medical Staff of this Hospital performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to Hospital patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this Hospital will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this Hospital's patients, and all complaints this Hospital has received about the distant-site practitioners.

5.11-3 RESPONSIBILITIES AND PREROGATIVES

a. Distant-site practitioners holding telemedicine privileges at TFHD are not required to pay medical staff dues.

ARTICLE VI

CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND CRITERIA FOR INITIATION OF AN INVESTIGATION

6.1-1 ROUTINE MONITORING AND PEER REVIEW

Medical Staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) in the course of carrying out those delegated peer review functions without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in Medical Staff minutes or Medical Staff reports. Medical Executive Committee approval is not required for such actions. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights as described in Article VII of these Bylaws.

6.1-2 CRITERIA FOR INITIATION OF AN INVESTIGATION

Any person may provide information to the Medical Staff about the conduct, performance or competence of a Medical Staff Member. The Chief of Staff, a department chair, or the Chief Executive Officer may request, or the Medical Executive Committee may undertake on its own initiative, an investigation of a Member under this Article whenever reliable information indicates the Member may have exhibited acts, demeanor, or conduct reasonably likely to be 1) detrimental to patient safety or to the delivery of quality patient care within the hospital; 2) unethical, unprofessional or illegal; 3) contrary to the Medical Staff Bylaws, Rules and Regulations, or Medical Staff and Hospital administrative policy; 4) below applicable professional standards or the standards of the Medical Staff; or 5) disruptive of Medical Staff or hospital operations and the delivery of patient care.

6.2 INVESTIGATION

An investigation under these Bylaws ("Investigation") means a process specifically initiated by the Medical Executive Committee, or by the Chief of Staff on its behalf, based upon information indicating that a Member has exhibited acts, demeanor or conduct as described above in Section 6.1-2. An Investigation does not include the usual activities of departments or other committees of the Medical Staff, including the usual peer review, quality assessment and improvement activities undertaken by the Medical Staff in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, the activities of the Medical Staff Aid Committee, or preliminary deliberations or inquiries of the Medical Executive Committee or its representatives to determine whether to order an Investigation.

6.3 INITIATION

A request for action or for an Investigation under the auspices of the Medical Executive Committee must be supported by reference to specific activities or conduct alleged. The Medical Executive Committee shall determine how to proceed. The Chief of Staff may act on behalf of the Medical Executive Committee to initiate an Investigation, subject to subsequent review and approval by that Committee. In addition, the Chief of Staff or any other Medical Staff official may, instead of initiating an Investigation, initiate or conduct such reviews as may be appropriate to his or her responsibilities under the Medical Staff's Bylaws, Rules and Regulations, or Policies.

If the Medical Executive Committee concludes an Investigation is warranted, it may conduct the investigation itself, or may assign the task to an appropriate Medical Staff official, Medical Staff

department, or standing or Ad Hoc Committee of the Medical Staff. The Medical Executive Committee may in its discretion appoint members of Administration and practitioners who are not members of the Medical Staff for the purpose of assisting a standing or Ad Hoc Committee conducting an Investigation. The Member shall, at an appropriate time, be notified that an Investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigator or investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such Investigation shall not constitute a "hearing," nor shall the procedural rules with respect to hearings or appeals apply. At the conclusion of the Investigation a written summary of the findings and recommendation(s) shall be forwarded to the Medical Executive Committee. Despite the status of any Investigation, at all times the Medical Executive Committee shall have the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the Investigative process, or other action.

6.4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the Investigation, the Medical Executive Committee shall make a decision which may include but is not limited to:

(a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's credentials file;

(b) Deferring action for a reasonable time where circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand, or warning ("Letter of Reprimand"). In the event a Letter of Reprimand is issued, the affected Member may make a written response which shall be placed in the Member's file. Nothing herein shall be deemed to preclude a department or section chair, committee chair, or the Medical Executive Committee from issuing informal written or oral warnings outside of the mechanism for issuance of a Letter of Reprimand as described in these Bylaws;

(d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation or monitoring;

(e) Recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) Imposing a suspension or restriction of Clinical Privileges and/or Medical Staff membership for a duration of fourteen (14) days or less, after giving the Member written notice of the issues and an opportunity to be heard by the Medical Executive Committee;

(g) Summarily suspending or restricting Medical Staff membership and/or Clinical Privileges; and

(h) Taking other actions deemed appropriate under the circumstances, including such other actions as may be provided for in these Bylaws.

6.5 SUBSEQUENT ACTION

The Medical Executive Committee's action or recommendation following an Investigation as described herein shall be presented to the Board of Directors at its next regularly scheduled meeting.

(a) If the Medical Executive Committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the Board of Directors may be advised of the action and hearing request but shall take no action on the matter until the practitioner has either waived or exhausted his or her hearing rights.

(b) If the Medical Executive Committee decides not to take or recommend corrective action, or to take or recommended corrective action as to which the practitioner either has no rights of hearing or appeal or has waived such rights, and the Board of Directors questions or disagrees with the action of the Medical Executive Committee, the matter may be remanded back to the Medical Executive Committee for further consideration. If the decision of the Board of Directors is to take corrective action more severe than the action of the Medical Executive Committee, and a hearing is required pursuant to Article VII, the procedure shall be as described in that Article for hearings that are prompted by action of the Board of Directors. The decision following the hearing shall be the final decision of the Hospital.

6.6 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee decides not to conduct an Investigation or otherwise initiate corrective action proceedings as set forth above, the Board of Directors may concur in the Medical Executive Committee's decision, or, if the Board of Directors reasonably determines the Medical Executive Committee's decision to be contrary to the weight of the evidence presented, the Board of Directors may consult with the Chief of Staff and thereafter direct the Medical Executive Committee to conduct an investigation or otherwise initiate corrective action proceedings. In the event the Medical Executive Committee fails to take action in response to a directive from the Board of Directors, the Board of Directors may, after written notification to the Medical Executive Committee, conduct an investigation or otherwise initiate corrective action proceedings on its own initiative. Any such proceedings shall afford the Member the rights to which he or she is entitled under California law. If a hearing is required pursuant to Article VII, the procedure shall be as described in that Article for hearings that are prompted by action of the Board of Directors. The decision following such proceedings shall be the final decision of the Hospital.

6.7 SUMMARY RESTRICTION OR SUSPENSION

6.7-1 CRITERIA FOR INITIATION

a. A Member's Clinical Privileges may be summarily suspended or restricted where it is believed that the failure to take such action may result in an imminent danger to the health or safety of any individual, including current or future hospital patients. Such suspensions may be imposed as an interim or precautionary measure for the protection of patients and in the absence of complete information so long as prompt steps are taken to gather information and to determine whether the suspension should be continued or discontinued, or if other less restrictive action is appropriate.

b. The following persons are authorized to impose a summary suspension or restriction: The Chief of Staff; the Medical Executive Committee, or the Chair of the Department(s) in which the Member holds Privileges. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon notice to the Member, or sooner if necessary.

c. When none of the persons listed above is available to impose a summary suspension or restriction, the Board of Directors or its designee may take such action if the Board or its designee believes that a failure to do so would be likely to result in an imminent danger to the health or safety of any individual, including current or future hospital patients. Prior to exercising this authority, the Board of Directors must make a reasonable attempt to contact the Chief of Staff. Summary action by the Board of Directors which has not been ratified by the Chief of Staff within two (2) working days after the suspension, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

d. The summary restriction or suspension may be limited in duration and shall remain in effect for the period and/or subject to the terms stated, or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another member by the

department chair or appropriate clinical service chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

e. Unless an Investigation of the suspended practitioner is already underway at the time the summary suspension or restriction is imposed, that action shall automatically constitute a request for Investigation or action pursuant to this Article. If the Medical Executive Committee imposed the summary suspension or restriction on its own initiative, it shall determine what, if any, Investigation and further actions are warranted.

6.7-2 WRITTEN NOTICE OF SUMMARY ACTION

As soon as possible after imposition of a summary suspension or restriction, the affected Medical Staff Member shall be provided with written notice of such action. This initial written notice shall include a statement of the reasons why summary action was deemed necessary. Notice of the suspension shall also be given to the Board of Directors and, as needed, the Medical Executive Committee and the Chief Executive Officer.

6.7-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The Member shall attend and make a statement concerning the issues, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee shall determine whether the summary restriction or suspension should be continued and may modify, continue or terminate the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision within two working days of the meeting.

6.7-4 PROCEDURAL RIGHTS

If the summary restriction or suspension is not lifted, the Member shall be entitled to hearing rights to the extent provided under Article VII.

6.8 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's Privileges or membership may be suspended or limited as described below. A practitioner whose membership and/or Privileges have been suspended or limited pursuant to the provisions of this Section shall not be entitled to procedural rights afforded under Article VII. However, the Member shall be given an opportunity to be heard by the Medical Executive Committee related solely to the question whether grounds exist for the special action as described above; the Medical Executive Committee shall reverse any action that was based on a material mistake of fact as to the existence of the grounds for such special action. Additional actions taken by the Medical Executive Committee on a discretionary basis shall be subject to hearing rights to the extent provided by Article VII.

6.8-1 LICENSURE

Whenever a Member's license or other legal credential authorizing practice in this state:

a. is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked or suspended, as applicable, as of the date such action becomes effective and throughout its term.

b. is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. is placed on probation or made subject to restrictions by the applicable licensing or certifying authority, his or her membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation or restrictions as of the date such action becomes effective and throughout its term.

d. lapses, expires or is not renewed by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the hospital shall be automatically suspended as of the date such expiration of licensure becomes effective. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of Medical Staff membership and Clinical Privileges.

6.8-2 CONTROLLED SUBSTANCES

Whenever a Member's DEA certificate:

a. expires, is revoked, limited, or suspended, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. is subject to probation or conditions, the Member's right to prescribe such medications shall automatically become subject to the same terms of probation or conditions, as of the date such action becomes effective and throughout its term.

6.8-3 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Hospital and the Medical Staff. A limited suspension in the form of withdrawal of admitting and clinical privileges until medical records are completed shall be automatically imposed after notice of delinquency for failure to complete medical records within that period. The suspension shall continue until those medical records have been completed.

6.8-4 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 a Member's Clinical Privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the Member is given notice of delinquency and warned of the automatic suspension. If the Member still has not paid the required dues or assessments within six (6) months after such notice of delinquency, the Member's membership shall be automatically terminated.

6.8-5 PROFESSIONAL LIABILITY INSURANCE

If at any time a Member fails to maintain continuous professional liability insurance coverage (i.e., such coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, in whole or in part) for all of the Member's Clinical Privileges, the Member's affected Clinical Privileges shall be suspended automatically as of that date until the Chief of Staff determines there is acceptable documentation of adequate professional liability insurance coverage, which shall include, unless excused by the Medical Executive Committee for good cause, "prior acts" coverage for the period of time during which the Member had allowed his or her coverage to lapse or become noncompliant with Medical Staff requirements. If acceptable proof of such coverage is not provided to the Chief of Staff within ninety (90) days of such lapse, then the Member's Clinical Privileges and membership shall automatically terminate.

6.8-6 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENTS

Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. It also includes submitting to mental or physician examinations, as requested by the Chief of Staff or the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's Privileges or related issues of reasonable accommodation. Failure to comply shall constitute grounds for Chief of Staff or a Department Chair to suspend the Member's Clinical Privileges or to take other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action shall remain in effect until the Member is expressly notified that it is rescinded. For purposes of this Section, the information a Member can be expected to provide includes but is not limited to the following:

a. Physical or mental examinations and reports;

b. Information related to an investigation or other peer review action by another entity, including information concerning action taken by licensing or accreditation bodies and other healthcare entities;

c. Information from a Member's private office that is necessary to resolve questions that could have a bearing on the quality of care provided to patients in the Hospital; and

d. Information related to professional liability coverage and/or actions.

6.8-9 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM

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.

6.9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION FOLLOWING AUTOMATIC SUSPENSION OR LIMITATION

As soon as practicable after action is taken or warranted as described in Section 6.8, above, with the exception of routine suspensions for failure to complete medical records, the Medical Executive Committee shall review and consider the facts related to the automatic suspension and may recommend further corrective action as it may deem appropriate.

6.10 PRACTITIONER OBLIGATIONS

Practitioners are responsible for complying with the limitations imposed by the provisions of Section 6.8 and shall immediately provide written notice to the Medical Staff office of any of the actions or events described therein; i.e. action taken by a state licensing agency, failure to maintain adequate insurance, action by the DEA, or action by a government funded health program. Whenever this occurs, the practitioner shall also promptly provide the Medical Staff Office with a written explanation of the basis for such actions, including copies of relevant documents. The limitations described above shall take effect automatically as of the date of the underlying action or event, regardless of whether the practitioner

provides notice thereof to the Medical Staff Office. The Medical Executive Committee may request the practitioner to provide additional information concerning the above described actions or events, and a failure of the practitioner to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed. A practitioner's failure to observe the limitations of Section 6.8 shall be grounds for corrective action.

ARTICLE VII

HEARINGS AND APPEALS

7.1 GENERAL PROVISIONS

7.1-1 INTENT:

The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as described below) and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Board of Directors from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board of Directors to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, Board of Directors, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

7.1-2 EXHAUSTION OF REMEDIES

If adverse action as described in these provisions is taken or recommended, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.1-3 INTRAORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The Hearing Committees have no authority to adopt new rules and standards, to modify existing rules and standards, or to resolve questions regarding the merits or substantive validity of Bylaws, Rules, Regulations or policies. Challenges to the substantive validity of any Bylaw, Rule, Regulation or policy shall be handled according to Section 7.9-2 below.

7.1-4 DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

a. "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Board of Directors in all cases where the Board of Directors or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. "Practitioner" as used in this Article refers to the practitioner who may request or has requested a hearing pursuant to this Article.

c. "Day" means calendar day.

7.1-5 SUBSTANTIAL COMPLIANCE

Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or recommended by the bodies whose decisions prompted the hearing.

7.1-6 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse action by the Board of Directors, the Chair of the Board of Directors shall fulfill the functions assigned in this Article to the Chief of Staff, and the Board of Directors shall fulfill the functions assigned in this Article to the Medical Executive Committee. The procedure may be modified as warranted under the circumstances, but the practitioner shall have all of the same rights to a fair hearing.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in applicable Bylaws, Rules, Regulations or policies, any one of the following adverse actions or recommended actions shall be deemed grounds for a hearing:

(a) Denial of Medical Staff membership, reappointment and/or Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(b) Revocation of Medical Staff membership, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(c) Revocation or reduction of Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(d) Significant restriction of Clinical Privileges (except for proctoring incidental to Provisional status, new privileges, insufficient activity, or return from leave of absence) for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(e) Suspension of Medical Staff membership and/or Clinical Privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients; and,

(f) Any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

No actions or recommendations except those described above shall entitle the practitioner to request a hearing as described in this Article.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR RECOMMENDATION

In all cases in which action has been taken or recommended as set forth in Section 7.2, the practitioner shall be given prompt written notice of the action or recommendation including the following information:

a. A description of the action or recommendation;

b. A concise statement of the reasons for the action or recommendation;

c. A statement that the practitioner may request a hearing;

d. A statement of the time limit within which a hearing may be requested;

e. A summary of the practitioner's rights at a hearing; and

f. A statement as to whether the action or recommendation must be reported to California licensing authorities and/or the National Practitioner Data Bank.

7.3-2 REQUEST FOR HEARING

a. The practitioner shall have thirty (30) days following receipt of the notice of the action or recommendation within which to request a hearing. The request shall be in writing addressed to the Chief of Staff, and received by the Medical Staff Office within the deadline. A copy shall also be sent to the Chief Executive Officer. Executive Officer.

b. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the Board of Directors, which shall not be bound by it. If the Board of Directors ratifies the action or recommendation, it shall thereupon become the final action of the hospital. However, if the Board of Directors, after consulting with the Medical Executive Committee, is inclined to take action against the practitioner that is more adverse than the action recommended by the Medical Staff, the practitioner shall be so notified and given an opportunity for a hearing based on "an adverse action by the Board of Directors" as provided herein.

7.4 HEARING PROCEDURE

7.4-1 TIME AND PLACE FOR A HEARING

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date he or she received the request for a hearing, give written notice to the practitioner of the time, place and date of the hearing. The date of commencement of the hearing shall be not less than thirty (30) days or more than sixty (60) days from the date the Chief of Staff received the request for hearing.

7.4-2 NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse action taken or recommended (if not already provided), including a description of the acts or omissions with which the practitioner is charged and a list of the charts or cases in question, where applicable. The Notice of Reasons or Charges may be supplemented or amended at any time prior to the issuance of the Hearing Committee's decision, provided the practitioner is afforded a fair and reasonable opportunity to respond.

7.4-3 HEARING COMMITTEE

a. When a hearing is requested the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders, or initial decision makers, and otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical

Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories. Such appointment shall include, where feasible, at least one member who has the same healing arts licensure and practices in the same specialty as the Practitioner involved.

b. Alternatively, the Chief of Staff shall have the discretion to enter into an agreement with the practitioner involved to hold the hearing before a mutually acceptable arbitrator or arbitrators. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff's responsibility to provide a fair hearing.

c. A majority of the Hearing Committee must be present throughout the hearing. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

d. The Hearing Committee or the arbitrator (if one is used) shall have such powers as are necessary to discharge its or his or her responsibilities.

7.4-4 THE HEARING OFFICER

The Chief Executive Officer shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law who is qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence that are raised prior to, during, or after the hearing. If the Hearing Officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such action as he or she deems warranted by the circumstances. The Hearing Officer should participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

7.4-5 EXAMINATION (VOIR DIRE)

The practitioner shall have the right to a reasonable opportunity to examine (voir dire) the Hearing Committee members and the Hearing Officer, and the right to challenge the appointment of any member or the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and Hearing Officers in proceedings of this type.

7.4-6 REPRESENTATION

a. The parties may be represented by legal counsel. However, the body whose decision prompted the hearing shall not be represented by an attorney at law if the practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing, including

the identification and resolution of pre-hearing procedural issues or disputes. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed in the State of California who is not also an attorney at law.

b. In all instances, whether or not attorneys are allowed to represent the parties during the hearing, the Medical Executive Committee shall be represented by a Member of the Medical Staff who shall be responsible for representing the Medical Executive Committee's interests in connection with the peer review matter and proceeding. This responsibility shall include the authority to make decisions regarding the detailed contents of the Notice of Reasons or Charges; to make decisions regarding the presentation of testimony and exhibits; to direct the activities of the Medical Executive Committee's attorney, if any; to consult with specialists; and to amend the Notice of Reasons or Charges as he or she deems warranted during the course of the proceedings, subject to the practitioner's procedural rights. However, the Medical Executive Committee's representative shall not have the authority to modify the nature of the Medical Executive Committee's action or recommendation without the Medical Executive Committee's approval.

7.4-7 FAILURE TO APPEAR OR PROCEED; NON-COOPERATION OR DISRUPTION

Failure without good cause of the practitioner to personally attend and proceed at a hearing in an efficient and orderly manner, or serious or persistent misconduct or failure to cooperate in the hearing process by either party, shall be grounds for termination of the hearing as determined by the Hearing Committee in consultation with the Hearing Officer. Such conduct by the Practitioner shall be deemed to constitute a waiver of any hearing rights and voluntary acceptance of the recommendation(s) or action(s) involved. Such conduct by the Medical Executive Committee shall be deemed a failure to show that its action(s) or recommendation(s) are reasonable and warranted or, in the case of an initial application, a failure to present evidence in opposition to the application. The Hearing Committee's determination pursuant to this provision shall be presented for consideration by the Board of Directors, which shall exercise its independent judgment as to the appropriateness of the Hearing Committee's action in terminating the hearing.

7.4-8 POSTPONEMENTS AND EXTENSIONS

Once a timely request for a hearing has been made, postponements and extensions of the time beyond those referenced in this Article may be permitted by the Hearing Officer within his or her discretion.

7.5 DISCOVERY

7.5-1 RIGHTS OF INSPECTION AND COPYING

The Practitioner may inspect and copy, at his or her expense, any documentary information relevant to the charges that the Medical Executive Committee has in its possession or under its control. The Medical Executive Committee may inspect and copy, at its expense, any documentary information relevant to the charges that the Practitioner has in his or her possession or under his or her control. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

7.5-2 LIMITS ON DISCOVERY

The Hearing Officer shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied or safeguards may be imposed when justified to protect peer review or in the interest of fairness or equality. Further, the right to inspect and copy by either party does not

extend to confidential information referring to individually identifiable practitioners other than the Practitioner under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

7.5-3 RULING ON DISCOVERY DISPUTES

In ruling on discovery disputes, the factors that may be considered include:

a. whether the information sought may be introduced to support or to defend against the charges;

b. whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation;

c. the burden imposed on the party in possession of the information sought, if access is granted, and

d. any previous requests for access to information submitted or resisted by the parties to the same proceeding.

7.5-4 PREHEARING DOCUMENT EXCHANGE

The parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. Failure to comply with this rule is a good cause for the Hearing Officer to grant a continuance, or to limit the introduction of any documents not provided to the other party in a timely manner.

7.5-5 WITNESS LISTS

Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.5-6 OBJECTIONS TO INTRODUCTION OF EVIDENCE PREVIOUSLY NOT PRODUCED FOR THE MEDICAL STAFF

The Medical Executive Committee may object to the introduction of evidence that was not provided during an appointment, reappointment or privilege application review, or during a corrective action investigation or process despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the Practitioner can prove he or she previously acted diligently and could not have submitted the information prior to the hearing.

7.6 MISCELLANEOUS PROCEDURAL MATTERS

7.6-1 PROCEDURAL DISPUTES

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as soon as possible in advance of the scheduled hearing, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

b. The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the Hearing Officer.

7.6-2 RECORD OF HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the prehearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of preparing a transcript, if any, or a copy of a transcript that has already been prepared, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only under oath administered by a person lawfully authorized to administer such oath.

7.6-3 ATTENDANCE

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the Hearing Officer, the court reporter, and the parties (with attorneys, if allowed): The Medical Staff Manager or Coordinator, one or more key consultants for each party, one or more key witnesses for each party, and the Chief Executive Officer or designee. An individual shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.

7.6-4 RIGHTS OF THE PARTICIPANTS

Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available by the other party to the Hearing Committee; and submit a written statement, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may question witnesses or call additional witnesses if it deems such action appropriate. The Hearing Officer shall also have the discretion to ask questions of witnesses if he or she deems it appropriate for purposes of clarification or efficiency.

7.6-5 RULES OF EVIDENCE

Judicial rules of evidence and procedure relating to the conduct of a trial regarding the examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these provisions. Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Notwithstanding the foregoing, the content of any settlement discussions between the parties regarding the resolution of issues in the hearing shall not be admissible.

7.6-6 BURDENS OF PRESENTING EVIDENCE AND PROOF

a. The body whose decision prompted the hearing shall have the initial duty to present evidence which supports the recommendation or action. The Practitioner shall be obligated to present evidence in response.

b. An applicant for Membership and/or Privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is sufficiently

qualified to be awarded such Membership and/or Privileges at this hospital. This burden requires the production of information which allows for adequate evaluation and resolution of reasonable doubts concerning the Practitioner's current qualifications. The applicant shall not be permitted to introduce information that was not produced upon the request of any committee or person on behalf of the Medical Staff during the application process, unless the Member establishes that the information could not have been produced in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford a Practitioner a hearing regarding, an incomplete application.

c. Except as provided above, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Hearing Committee. If the Hearing Committee finds, based on the evidence presented at the hearing, that the action being challenged is not within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, the Hearing Committee may recommend a different result, which may be either more adverse or less adverse to the Practitioner than the action that prompted the hearing.

7.6-7 ADJOURNMENT AND CONCLUSION

The Hearing Officer may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due regard for the objective of reaching an expeditious conclusion to the hearing.

7.6-8 BASIS FOR DECISION

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence.

7.6-9 DECISION OF THE HEARING COMMITTEE

Within thirty (30) days after the final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief of Staff, the Practitioner involved, and the Chief Executive Officer. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision shall include or be accompanied by a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or review as are described in these Bylaws.

7.7 APPEAL

7.7-1 TIME FOR APPEAL

a. Within ten (10) days after receipt of the decision of the Hearing Committee, either the Practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief Executive Officer and the other party in the hearing. If a request for appellate review is not received by the Chief Executive Officer within such period, the decision of the Hearing Committee shall thereupon become final, except if modified or reversed by the Board of Directors.

b. It shall be the obligation of the party requesting appellate review to produce the record of the Hearing Committee's proceedings. If the record is not produced within a reasonable period, as determined by the Board of Directors or its authorized representative, appellate rights shall be deemed waived.

c. In the event of a waiver of appellate rights by a Practitioner, if the Board of Directors is inclined to take action which is more adverse than that taken or recommended by the Medical Executive Committee, the Board of Directors must consult with the Medical Executive Committee before taking such action. If after such consultation the Board of Directors is still inclined to take such action, then the Practitioner shall be so notified. The notice shall include a brief summary of the reasons for the Board's contemplated action, including a reference to any factual findings in the Hearing Committee's Decision that support the action. The Practitioner shall be given ten (10) days from receipt of that notice within which to request appellate review, notwithstanding his or her earlier waiver of appellate rights. The grounds for appeal and the appellate procedure shall be as described below. However, even If the Practitioner declines to appeal any of the Hearing Committee's factual findings, he or she shall still be given an opportunity to argue, in person and in writing, that the contemplated action which is more adverse than that taken or recommended by the Medical Executive Committee is not reasonable and warranted. The action taken by the Board of Directors after following this procedure shall be the final action of the Hospital.

7.7-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal. The recognized grounds for appeal from a Hearing Committee decision are:

a. substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice; or

b. the factual findings of the Hearing Committee are not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to this section; or

c. the Hearing Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the Hearing Committee's factual findings, was reasonable and warranted.

7.7-3 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of a request for appellate review, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The appellate review shall not commence less than thirty (30) or more than sixty (60) days from the date of notice. The time for appellate review may be extended by the appeal board for good cause.

7.7-4 APPEAL BOARD

The Board of Directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board so long as that person did not take part in a prior hearing on the action or recommendation being challenged. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

7.7-5 APPEAL PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the proceedings before the Hearing Committee. However, the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The appeal board shall also have the discretion to remand the matter to the Hearing Committee for the taking of further evidence or for clarification or reconsideration of the Hearing Committee's decision. In such instances, the Hearing Committee shall report back to the appeal board, within such reasonable time limits as the appeal board imposes. Each party shall have the right to be represented by legal counsel before the appeal board, to present a written argument to the appeal board, to personally appear and make oral argument and respond to questions in accordance with the procedure established by the appeal board. After the arguments have been submitted, the appeal board shall conduct its deliberations outside the presence of the parties and their representatives.

7.7-6 DECISION

Within thirty (30) days after the submission of arguments as provided above, the appeal board shall send a written recommendation to the Board of Directors. The appeal board may recommend, and the Board of Directors may decide, to affirm, reverse or modify the decision of the Hearing Committee. The decision of the Board shall constitute the final decision of the Hospital and shall become effective immediately upon notice to the parties. The parties shall be provided a copy of the appeal board's recommendation along with a copy of the Board of Director's final decision.

7.8 RIGHT TO ONE HEARING

No practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any adverse action or recommendation.

7.9 EXCEPTION TO HEARING RIGHTS

7.9-1 EXCLUSIVE CONTRACTS

The hearing rights described in this Article shall not apply as a result of a decision to close or continue closure of a department or service pursuant to an exclusive contract or to transfer an exclusive contract, or as a result of action by the holder of such an exclusive contract.

7.9-2 VALIDITY OF BYLAW, RULE, REGULATION OR POLICY

No hearing provided for in this article shall be utilized to make determinations as to the merits or substantive validity of any Medical Staff bylaw, rule, regulation or policy. Where a Practitioner is adversely affected by the application of a Medical Staff bylaw, rule, regulation or policy, the Practitioner's sole remedy is to seek review of such bylaw, rule, regulation or policy initially by the Medical Executive Committee. The Medical Executive Committee may in its discretion consider the request according to such procedures as it deems appropriate. If the Practitioner is dissatisfied with the action of the Medical Executive Committee, the Practitioner may request review by the Board of Directors, which shall have discretion whether to conduct a review according to such procedures as it deems appropriate. The Board of Directors shall consult with the Medical Executive Committee before taking such action regarding the bylaw, rule, regulation or policy involved. This procedure must be utilized prior to any legal action.

7.9-3 DEPARTMENT, SECTION OR SERVICE FORMATION OR ELIMINATION

A Medical Staff department, section, or service can be formed or eliminated only following a review and recommendation by the Medical Executive Committee regarding the appropriateness of the department, section, or service elimination or formation. The Board of Directors shall consider the recommendations of the Medical Executive Committee prior to making a final determination regarding the formation or elimination.

The Medical Staff Member(s) who's Privileges may be adversely affected by department, section, or service formation or elimination are not afforded hearing rights pursuant to Article VII.

ARTICLE VIII

OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer and Member-At -Large.

8.1-2 QUALIFICATIONS

Officers must be members of the Active Staff at the time of nomination and election, and must remain members in good standing during their terms of office. Failure to maintain that status shall immediately create a vacancy in the office involved. Only those members who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) be members in good standing of the non-provisional Active Staff, and must remain members in good standing during their term of office. A "member in good standing" means the physician is not the subject of an adverse recommendation, as noted below:
(2) Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
(3) Not presently be serving as Medical Staff officers, Board members or chiefs at any other hospital and shall not so serve during their terms of office;
(4) Be willing to faithfully discharge the duties and responsibilities of the position;
(5) Have experience in a leadership position, or other involvement in performance improvement activities;
(6) Attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;
(7) Have demonstrated an ability to work well with others.

8.1-3 NOMINATIONS

A. The Medical Staff shall provide for the election of the four (4) officers identified in Section 8.1-1, above, every two (2) years.

B. A Nominating Committee shall be convened, comprised of the Chief of Staff and two (2) other Active Staff members appointed by the Medical Executive Committee.

C. At least thirty (30) days prior to the deadline for voting as set forth in Section 8.1-4, below ("deadline for voting"), the Nominating Committee shall issue an announcement to the Medical Staff soliciting nominations for each office to be filled. Nominations may be submitted by any

member of the Active Staff, and must be received by the Medical Staff Office at least fifteen (15) days prior to the deadline for voting.

D. After the close of nominations as provided above, the Nominating Committee will screen the nominees to confirm that they meet the qualifications for office in Article 8.1-2. Each nominee will also be contacted to confirm his or her willingness to serve if elected. The Nominating Committee will then apply the following criteria to determine, in its discretion, which nominees will appear on the ballot and for which offices:

(i) Balance of representation among specialties on the Medical Staff;
(ii) Avoidance of having more than three (3) candidates run for a given office;
(iii) Avoidance of having a single candidate run for more than one office;
(iv) The preference of the nominee regarding the office for which he or she will run, if nominated for more than one office; and
(v) Conflicting demands on the nominee if he or she is serving or has been elected to serve as Department Chair or Vice Chair.

E. In the event that the above process does not yield any qualified and willing candidates for a given office, or the Nominating Committee determines, in its discretion, that there should be one or more additional candidates for a given office, the Nominating Committee may nominate candidates on its own initiative and include them on the ballot.

F. Ballots will be issued at least five (5) days prior to the deadline for voting.

8.1-4 ELECTIONS

The election shall be by written or electronic ballot, and the outcome shall be determined by a majority of signed votes cast. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. Only members of the non-provisional Active Staff are eligible to vote in the election.

8.1-5 TERM OF ELECTED OFFICE

All officers shall serve a two (2) year term and shall take office on the first day of the Medical Staff year. At the end of that officer's term, the Chief of Staff shall automatically assume the office of the immediate Past Chief of Staff

An officer of the Medical Staff may be removed from office by a two-thirds vote of all Active Medical Staff members, for good cause, including but not limited to the following:
(a) neglect or misfeasance in office;
(b) serious acts of moral turpitude;
(c) failure to discharge satisfactorily the duties of office;
(d) failure of an officer to remain a member of the Active Medical Staff in good standing shall result in automatic removal from the medical staff office;
(e) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
(f) conduct detrimental to the interests of the hospital and/or its Medical Staff;
(g) an infirmity that renders the individual incapable of fulfilling the duties of that office;
(h) or loss of confidence and support of the Medical Staff.

To bring the matter to a vote, a motion must be made and seconded at a regular or special Medical Staff meeting or by a letter to the Medical Executive Committee requesting the removal of an officer. The letter must be signed by a minimum of three (3) members of the Active Medical Staff. If a vote affirming the removal of an officer is obtained, the officer will immediately relinquish his/her position.

At least ten days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee prior to a vote on removal.

8.1-6 VACANCIES IN ELECTED OFFICE

Vacancies of the Secretary/Treasurer during the Medical Staff year shall be filled by the Medical Executive Committee. If there is a vacancy in the Office of the Chief of Staff, the Vice Chief of Staff shall serve for the remainder of his/her term. Should the Vice Chief of Staff be elevated to fill the Chief of Staff position, a special election shall be held to fill the Vice Chief of Staff position. In the event there is a vacancy in the Office of the Vice Chief of Staff, the Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the Executive Committee.

8.2 ADMINISTRATIVE COVERAGE

When a Medical Staff, quality, or peer review issue or event needs immediate attention, in the absence of the Chief of Staff, the following representatives, in the order of succession, shall have all the powers of and be subject to all the restrictions upon the Chief of Staff, as defined in these Bylaws:

(1) Vice Chief of Staff, or
(2) Immediate Past Chief of Staff;
(3) Secretary/Treasurer;
(4) Member-At-Large;
(5) Appropriate Chief of Service or Chairman;
(6) Hospital CEO

8.2 DUTIES AND AUTHORITY OF OFFICERS

8.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief executive officer of the Medical Staff. The duties and authority of the Chief of Staff shall include, but not be limited to:

a. enforcing the Medical Staff Bylaws and Rules, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

b. exercising such authority as he/she deems necessary so that at all times patient welfare takes precedence over all other concerns;

c. in the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his/her opinion, must be accomplished prior to the next regular or special meeting of the Committee;

d. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

e. serving with a vote as Chair of the Medical Executive Committee;

f. serving as an ex officio member of all other Medical Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws, in which case voting rights shall apply unless otherwise specified;

g. interacting with the Chief Executive Officer and the Board of Directors in all matters of mutual concern within the Hospital;

h. appointing, with the agreement of the Medical Executive Committee, committee members and chair persons for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairperson of these committees with the approval of the Medical Executive Committee;

i. representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

j. being a spokesman for the Medical Staff in external professional and public relations;

k. performing such other functions as may be assigned to the Chief of Staff by these Bylaws or the Rules, or by the Medical Executive Committee;

l. serving on liaison committees with the Board of Directors and Hospital Administration, as well as outside licensing or accreditation agencies; and,

m. being the designated person who receives reports or concerns on physician impairment.

n. continue to serve on the Medical Executive Committee, as the Past Chief of Staff, immediately following the election term for as much time as needed to assure continuity in the transition with the change in leadership.

8.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff is the second officer of the Medical Staff. The Vice Chief of Staff shall serve for two years and assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a voting member of the Medical Executive Committee and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. The Vice Chief of Staff shall be a member of the Quality Assessment Committee. The Vice Chief of Staff will remain on the Medical Executive Committee and serve until the next Vice Chief of Staff has been elected.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Joint Conference Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by the Bylaws, or by the Medical Executive Committee.

The Immediate Past Chief of Staff will remain on the Medical Executive Committee for at least three (3) months to assure a smooth transition with the change in leadership and longer as deemed necessary

8.2-4 SECRETARY-TREASURER

The Secretary-Treasurer is the third officer of the Medical Staff. The Secretary-Treasurer shall be a voting member of the Medical Executive Committee. His/her duties shall include, but not be limited to:

a. maintaining a roster of Medical Staff members;
b. keeping accurate and complete minutes of all Medical Executive Committee and general and special Medical Staff meetings;
c. calling meetings on the order of the Chief of Staff or Medical Executive Committee;
d. attending to all appropriate correspondence and notices on behalf of the Medical Staff;
e. receiving and safeguarding all funds of the Medical Staff including operational and scholarship funds and presenting financial reports to the Medical Executive Committee;
f. serving on any committee as assigned; and,
g. performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.2-5 MEMBER-AT-LARGE

a. Serves as chairman of the Ethics Committee.
b. Perform such other functions as may be assigned by the Chief of Staff or Medical Executive Committee.

ARTICLE IX

CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.5 of these Bylaws. A department may be further divided, as appropriate, into different clinical services. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments. Three or more physicians on the Active Staff are required to organize a separate department.

9.2 CURRENT DEPARTMENTS

The current departments are: Anesthesia, Medicine, Surgery, Obstetrics-Pediatrics, and Emergency Medical Care.

(a) The Department of Medicine shall include the clinical services of internal medicine, mental health, family practice, diagnostic imaging, gastroenterology, and medical subspecialties.

(b) The Department of Surgery shall include the clinical services of general surgery, orthopedics, gynecology, otolaryngology, ophthalmology, urology, vascular surgery, general dentistry, pathology, plastic and reconstructive surgery, and podiatry.

(c) The Department of Obstetrics and Pediatrics shall include the clinical services of obstetrics and pediatrics.

(d) The Department of Emergency Medical Care shall include the clinical service of emergency medicine.

(e) The Department of Anesthesia shall include the clinical service of anesthesia.

9.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one department.

9.4 FUNCTIONS OF DEPARTMENTS

Each department, functioning as a committee of the whole, is responsible for the quality of care within the Department, and for the effective performance of the following:

(a) conducting patient care reviews and utilization review through analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department with the purpose of improving care. The manner of patient care review will be outlined in the Quality Assessment Plan, and shall be approved by the Medical Staff;

(b) recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department;

(c) conducting, participating, and making recommendations regarding educational programs pertinent to Departmental clinical practice;

(d) reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

(e) coordinating patient care provided by the Department's members with nursing and ancillary patient care services;

(f) submitting written reports to the Medical Executive Committee concerning: (1) the Department's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital; and (3) how quality and utilization review functions will be addressed;

(g) meeting regularly for the purpose of considering patient care review findings and the result of the Department's other review and evaluation activities, as well as reports on other Department and Medical Staff functions;

(h) establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

(i) taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

(j) accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Department;

(k) formulating recommendations for Departmental Rules reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff; and

(l) Recommending space and other resources needed by the Department; and assessing and recommending off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Department.

9.5 DEPARTMENT CHAIR AND VICE CHAIR

9.5-1 QUALIFICATIONS

Each department shall have a chair and vice chair who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department. Demonstrated ability may be shown through certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process. Attendance at relevant educational conferences, previous service as a Department Chief, or other prior active participation in Department and Medical Staff affairs are also relevant factors.

9.5-2 SELECTION

The chair and vice chair shall be elected by those members of the Department who are eligible to vote for general officers of the Medical Staff. In the fall of every other year but no later than the end of November, each Department shall select its chief. If the Department fails to do so, the Chief of Staff shall appoint the Department chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

9.5-3 TERMS OF OFFICE

Each department chair and vice chair shall serve a two (2) year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or privileges in that department. Department chairs shall be eligible, without further vote, to succeed themselves. The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

9.5-4 REMOVAL

Department chairs and vice chairs may be removed from office for valid cause, including, but not limited to, to loss of confidence and support of the members of the Department, failure to cooperatively and effectively perform the responsibilities of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude. Removal of a department chair may be initiated by the Medical Executive Committee or by a petition which states the grounds for removal and is signed by at least one-third of the members of the department eligible to vote. Removal shall be considered at a special meeting called for that purpose. The grounds for the proposed removal shall be presented to the chair or vice chair in writing at least seven (7) days prior to the special meeting, and the chair or vice chair shall be given the opportunity to address the stated grounds before the matter is put to a vote. Removal shall require a two-thirds vote of department members eligible to vote on Department matters, voting either in person at the special meeting or by mail ballot.

9.5-5 DUTIES OF DEPARTMENT CHAIR

Each Department chair shall have the following authority, duties and responsibilities:

a. act as presiding officer at departmental meetings;

b. report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Department;

c. evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that Department;

d. generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the Department through a planned and systematic process; and oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Medical Executive Committee. At the discretion of the chair, this function may be delegated to the vice chair;

e. develop and implement Departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment;

f. be a voting member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department;

g. transmit to the Medical Executive Committee the Department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the Department;

h. endeavor to enforce the Medical Staff Bylaws, Rules, and policies within the Department;

i. communicate and implement within the Department actions taken by the Medical Executive Committee;

j. participate in every phase of administration of the Department, including making recommendations for space and other resources needed by the Department and cooperating with the nursing service and the Hospital Administration in matters such as personnel, supplies, special regulations, standing orders, and techniques;

k. assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department, as may be required by the Medical Executive Committee; and

l. perform such other duties commensurate with the office as may from time to time be requested by the Chief of Staff or the Medical Executive Committee.

9.5-6 DUTIES OF DEPARTMENT VICE CHAIR

The vice chair shall assume all duties and authority of the chair in the absence of the chair. The vice chair will be the Department representative to the Infection Control and Pharmacy and Therapeutics Committees. . The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

ARTICLE X

COMMITTEES

10.1 DESIGNATION

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care services and perform other functions related to the needs of the Medical Staff, the hospital, or applicable standards and legal requirements. Any committee, whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc, including the Medical Staff meeting as a committee of the whole, that is carrying out all or any portion of a

function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

10.2 GENERAL PROVISIONS

10.2-1 APPOINTMENT OF MEMBERS

a. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee.

b. A Medical Staff committee shall be composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws or Rules, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members, allied health professionals, representatives from Hospital departments such as administration, nursing services, or health information services; representatives of the community, and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with vote unless the statement of committee composition designates the position as non-voting. Unless otherwise specified in these bylaws, all non-Medical Staff members appointed to committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure. The Chief of Staff shall be a nonvoting, ex-officio member on all committees to which he/she is not otherwise specifically assigned.

c. The committee chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

d. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his/her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

10.2-2 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, whichever is later, unless the member shall sooner resign or be removed from the committee.

10.2-3 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of privileges, or if any other good cause exists, that member may be removed by the Chief of Staff with the approval of the Medical Executive Committee.

10.2-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to that committee is made.

10.2-5 ACCOUNTABILITY

All committees shall be accountable to the Medical Executive Committee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

a. The officers of the Medical Staff;

b. The Department chairs;

c. The Chairman of Quality;

d. The Chairman of Ethics Committee;

e. The Incline Village Community Hospital Committee Chair; and,

f. The Chief Executive Officer, the Chief Operating Officer, the Chief Nursing Officer, the Director of Quality, the Chief Medical Officer, and a member of the IDPC representing Allied Health Professionals may attend on an ex-officio basis without a vote.

10.3-2 DELEGATION OF AUTHORITY

By adopting these Bylaws, the Medical Staff has delegated to the Medical Executive Committee the authority to perform on behalf of the Medical Staff the duties and functions described in these Bylaws, specifically including those described in this Section 10.3 and in Articles XIII and XIV. Such delegation can be limited or removed only by amendment of these Bylaws.

10.3-3 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

a. serving as the governing body of the Medical Staff, which shall include representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups;

d. recommending actions to the Board of Directors on matters of a medical-administrative nature;

e. recommending the organizational structure of the Medical Staff, the mechanism to review credentials, delineate individual clinical privileges, restrict or terminate privileges or membership and provide fair hearings, the organization of quality assessment activities and mechanisms of the Medical Staff, as well as other matters relevant to the operation of an organized Medical Staff;

f. evaluating the medical care rendered to patients in the Hospital as necessary to assure that all patients admitted or treated in any of the Hospital services receive a uniform standard of quality patient care, treatment, and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;

g. participating in the development and approval of all Medical Staff and Hospital policies, practice, and planning;

h. reviewing the qualifications, credentials, performance and professional competence and character of applicants for both clinical privileges and/or Medical Staff membership,

obtaining and considering the recommendations of the concerned departments, and making recommendations to the Board of Directors regarding Medical Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

i. taking reasonable steps to promote ethical conduct and quality clinical performance on the part of all those requesting or holding clinical privileges and all members including requiring evaluation of performance whenever there is doubt about a practitioner's ability to perform requested privileges and/or the initiation of and participation in Medical Staff corrective or review measures when warranted;

j. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

k. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

l. reporting to the Medical Staff at each regular Medical Staff meeting;

m. assisting in the obtaining and maintenance of accreditation for the hospital and any related components;

n. developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

o. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

p. reviewing the quality and appropriateness of services provided by physicians and allied health professionals enjoying agreements with the Hospital;

q. reviewing and approving the designation of the Hospital's Authorized Representative for National Practitioner Data Bank purposes; and

r. reviewing and approving the Utilization Review and Quality Assessment Plans; and

s. initiating, approving, and/or recommending to the Board of Directors, Medical Staff Bylaws, Rules and Regulations, and Policies, and amendments and technical corrections thereto, in accordance with Articles XIII and XIV of these Bylaws.

10.3-4 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least once a month and shall maintain a record of its proceedings and actions.

10.3-5 REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

Medical Staff Officers and Department Chairs shall be removed from the Medical Executive Committee following removal from their respective positions as provided for in the relevant provisions of these Bylaws.

All other members of the Committee may be removed for valid cause, including but not limited to substantial neglect or misfeasance or other failure to discharge satisfactorily the duties of a Medical Executive Committee member, according to the following procedures:

a. Proceedings to remove the member may be initiated by the Medical Executive Committee or by a petition signed by at least 25% of the Medical Staff members eligible to vote for Medical Staff officers.

b. Once initiated, removal shall be considered at a regular or special meeting of the Medical Staff.

c. The grounds for removal shall be presented in writing by the Chief of Staff to the member whose removal has been proposed, at least ten (10) days before the Medical Staff meeting at which the matter will be put to a vote.

d. The member shall be given an opportunity to make a statement at the meeting regarding the asserted grounds for removal, prior to the vote. The Chief of Staff has discretion to determine whether a representative of the Medical Executive Committee or other group of Medical Staff members who proposed removal also should be given an opportunity to speak prior to the vote. The Chief of Staff may establish a reasonable time limit for any such statements.

e. Voting shall be by secret ballot marked "for" or "against" removal. The member will be removed from the Medical Executive Committee if a majority of the eligible members who cast ballots at the meeting vote "for" removal.

10.4 JOINT CONFERENCE COMMITTEE

Except as otherwise provided in Section 13.11 of these Bylaws, with respect to any conflict between the Medical Staff and the Board of Directors, the Medical Staff and Board shall meet and confer in good faith to resolve the dispute. Unless otherwise agreed, the forum for this shall be a committee composed as specified below; however, the Medical Staff and Board can utilize additional or different forums or processes, such as mediation, so long as both the Medical Staff and Board mutually agree to the forum or process as well as any procedures that would govern the process.

10.4-1 COMPOSITION

The Joint Conference Committee shall consist of the Chief of Staff, the Vice-Chief of Staff, the immediate past Chief of Staff, the Chief Executive Officer, and two (2) members of the Board of Directors appointed by the President of the Board. The Chair shall alternate at the beginning of the Medical Staff year between a Medical Staff JCC member selected by the Chief of Staff and a Board of Directors JCC member.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws or in the bylaws of the Hospital.

10.4-3 EXHAUSTION

Prior to seeking judicial relief over any dispute with the Hospital or Board of Directors, including any allegation that the Hospital or Board has engaged in, or is about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of the administrative remedies provided in these Bylaws.

10.4-4 MEETINGS

The Joint Conference Committee shall meet as often as necessary and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.

ARTICLE XI

MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETING

a. There shall be an Annual Meeting of the Medical Staff in November of each year. Notice of this meeting shall be given to the members at least thirty (30) days prior to the meeting.

b. The Chief of Staff, or such other officers, Department chairs, or committee chairs as designated, may present reports on actions taken during the preceding year and on other matters of interest and importance to the members.

c. Announcement of the results of the election of officers shall occur at this meeting.

11.1-2 REGULAR GENERAL MEDICAL STAFF MEETINGS

Regular meetings of the Medical Staff may be held each quarter, except that the Annual Meeting shall constitute the regular meeting during the quarter in which it occurs. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and adequate notice shall be given to the members.

11.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of not fewer than ten percent (10%) of the Active Medical Staff. The request for the special meeting shall state the purpose of the proposed meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the Medical Staff, which includes the stated purpose of the meeting.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the committees as a whole, the chairs of committees, and Departments as a whole may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the members are given adequate notice of meeting dates. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee or Department may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, or be called by written request of ten percent (10%) of the current members, eligible to vote, but no fewer than 2 members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of twenty-five (25%) percent of the total membership of the Active Medical Staff at any regular or special meeting in person or by proxy shall constitute a quorum.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of one-half of the voting members shall be required for Medical Executive Committee meetings. For other committees and for Departmental meetings, a quorum shall consist of not less than two voting members.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of the majority of the members present and voting at a meeting at which a quorum is present, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meetings, or such greater number as specifically required by these Bylaws. Committee or Department action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee or Department if it is acknowledged in writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be provided tow the presiding officer of the meeting and forwarded to the Medical Executive Committee. The Medical Staff Office shall maintain those minutes.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Courtesy Staff shall be encouraged to attend the Annual Medical Staff meeting and required to attend at least fifty percent (50%) of all meetings of each Department (Active Staff) and committee of which he/she is a member. Active Staff members shall be required to attend at least 50% (two meetings per year) of regular General Medical Staff meetings each year.

Each member of the Courtesy Staff shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

Failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action, pursuant to these Bylaws,

11.6-2 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular Department, or committee meeting, the member may be requested to attend. The request shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the subject involved. Failure of a member to appear at any meeting, with respect to which he/she was given such

notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for action pursuant to Section 6.4-3.

ARTICLE XII

CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Medical Staff membership or privileges within this Hospital, an applicant:

a. authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon the applicant's professional ability and qualifications;

b. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

c. agrees to be bound by the provisions of this Article and the Bylaws and to waive to the fullest extent permitted by law all legal claims against any representative of the Medical Staff or the Hospital or any third party who acts in accordance with the provisions of this Article and the Bylaws and Rules; and

d. acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership and privileges, the continuation of that membership, and to the exercise of privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

Minutes, files, records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff when meeting as a committee of the whole, meetings of Departments, meetings of committees established under the Bylaws, and meetings of special or ad hoc committees created under the Bylaws, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential and protected by applicable state and/or federal peer review confidentiality laws, including but not limited to California Evidence Code Section 1157 and Nevada Rev. Stat. Sections 49.119-121 and 49.265. These records and information shall become a part of the Medical Staff committee files and shall not become part of any patient files, of general Hospital records, or of any member's personal or office files.

Access to such records for Medical Staff purposes shall be limited to duly appointed officers and committees of the Medical Staff as necessary to discharge medical staff responsibilities and subject to the requirements that confidentiality is maintained. By serving on a department, Medical Staff or Hospital committee, a Medical Staff member pledges that he or she will not waive the confidentiality respecting any committee on which he or she serves, except as expressly required by law.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment must be based on free and candid discussions, any breach of confidentiality of the discussion or deliberations of the Medical Staff Departments, or committees, except as authorized, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Staff or Hospital may undertake such corrective action as is deemed appropriate.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative, agent, member, and employee of the Medical Staff and Hospital shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief by reason of providing information concerning such person.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

a. application for appointment, reappointment, clinical privileges, or specified services;

b. periodic reappraisals for reappointment, clinical privileges, or specified services;

c. corrective action and peer review;

d. hearings and appellate reviews;

e. utilization review and quality assessment, including patient care audits and morbidity and mortality reviews;

f. other Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

g. the actions of peer review organizations, state medical boards, and other entities which engage in monitoring or evaluation of professional competence or conduct, including queries and reports to or from the National Practitioner Data Bank, Medical Board of California, Nevada State Board of Medical Examiners, specialty boards, peer review organizations and other professional or health care related entities.

12.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 CUMULATIVE EFFECT

Provisions in these Bylaws, in the Rules and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

12.7 ACCESS TO MEDICAL STAFF FILES BY PERSONS WITHIN THE HOSPITAL OR MEDICAL STAFF

12.7-1 MEANS OF ACCESS

Unless otherwise stated, a person permitted access under this section shall be given reasonable opportunity to inspect the records in question and to make notes regarding them, but not to remove them or to make copies of them. Removal or copying shall be only upon the express written permission of the Medical Executive Committee.

12.7-2 PERSONS GAINING ACCESS

a. **Chief Executive Officer or Designated Representative**. The Chief Executive Officer or his/her designated representative shall have access to all Medical Staff records.

b. **Medical Staff Department Members**. The Medical Staff Department chairs and other members of the Department to the extent that they are involved in a credentialing or peer review process conducted pursuant to the Medical Staff Bylaws shall have access to the files of the Department committee on which they serve and the credentials and peer review files of practitioners under evaluation.

c. **Officers of the Medical Staff**. Officers of the Medical Staff and others carrying out official Medical Staff duties and responsibilities as provided in these Bylaws (including members of ad hoc investigative committees) shall have access to credentials and peer review files as necessary to carry out their duties and responsibilities.

12.7-3 GENERAL ACCESS BY PRACTITIONERS TO MEDICAL STAFF RECORDS

a. **Credentials and Peer Review Files**. Upon request, a practitioner shall be afforded a copy of any document in the credentialing and any peer review file concerning him/her if the document was submitted by him/her (for example, an application for Medical Staff membership or correspondence) or if the document was addressed to him/her or if its author had provided a "cc" to him/her. At the discretion of the Chief of Staff, a summary of some or all other information in these files may be provided to the practitioner.

b. **Medical Staff Committee and Department Files**. A practitioner shall have access to Medical Staff committee and Department files regarding him/her only if, following a written request by the practitioner, the Medical Executive Committee grants permission upon a showing of good cause.

12.8 ACCESS BY PERSONS OR ORGANIZATIONS OUTSIDE OF THE HOSPITAL OR MEDICAL STAFF

12.8-1 CREDENTIALING OR PEER REVIEW AT OTHER HOSPITALS

Any request for credentialing or peer review information by another institution should be presented in writing. No information shall be released until a copy of an acceptable release signed by the subject practitioner has been received from the requesting institution.

12.8-2 OTHER REQUESTS

All other requests by persons or organizations outside of the Hospital for information contained in the Medical Staff records shall be forwarded to the Chief Executive Officer. Any such request shall be in writing and shall be accompanied by a release signed by the concerned practitioner. The release of any such information shall require the concurrence of the Chief of Staff and the Chief Executive Officer.

12.8-3 SUBPOENAS AND REQUESTS FROM GOVERNMENT AGENCIES

All subpoenas and requests from government agencies for Medical Staff records shall be referred to the Chief Executive Officer. The Medical Staff Office, the Risk Manager and the Chief of Staff shall be informed of the subpoena. No documents or records will be released without consultation with the Chief of Staff, or his/her designee

12.9 RESPONSIBILITIES OF MEMBERS OF THE MEDICAL STAFF

Recognizing the importance of preserving the confidentiality of information, all individuals covered by this policy agree to respect the confidentiality of all information obtained in connection with their responsibilities. This requirement of confidentiality extends not only to the information contained in the physical files of the Medical Staff, but to the discussions and deliberations of Medical Staff committees.

12.10. INSERTION, DELETION, AND/OR CHANGES TO MEDICAL STAFF MEMBERS' CREDENTIALS FILE

12.10-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

a. Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

b. When a request is made for insertion of adverse information into the Medical Staff member's credentials file, the respective Department chair and Chief of Staff shall review such a request.

c. After such a review, a decision will be made by the respective Department chair and Chief of Staff to:

   i. not insert the information;
   ii. notify the member of the adverse information by a written summary, and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

   iii. notify the member of the adverse information, and insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation.

d. This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

12.10-2 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION, DELETION, OR ADDITIONS TO FILE

a. When a member has reviewed his/her file as provided in accordance with Medical Staff policy and these Rules, he/she may address to the Chief of Staff a written request for correction or deletion of information in his/her credentials file. Such a request shall include a statement of the basis for the action requested.

b. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

c. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

d. In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

ARTICLE XIII

GENERAL PROVISIONS

13.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES

Subject to approval by the Board of Directors, the Medical Executive Committee may supplement these Bylaws with Rules and Regulations or Policies that provide associated details, as it deems necessary to implement more specifically the general principles established in these Bylaws. Rules and Regulations and Policies shall become effective upon approval by the Board, which shall not be withheld unreasonably. Neither the Medical Staff nor the Board may unilaterally amend the Rules and Regulations or Policies.

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

The Medical Staff Bylaws, Rules and Regulations, and Policies shall not conflict with the Board Bylaws.

13.1-1 PROPOSALS BY THE MEDICAL EXECUTIVE COMMITTEE

a. The Medical Executive Committee shall initiate and adopt such general Rules and Regulations as it may deem necessary for the proper conduct of the Medical Staff's affairs and shall periodically review and revise the Rules and Regulations to comply with current Medical Staff practice. Additions or recommended changes to the general Medical Staff Rules and Regulations shall be generated by or submitted to the Medical Executive Committee for review and approval.

b. Any new or amended provisions for the Rules and Regulations proposed by the Medical Executive Committee shall be announced to the Medical Staff, which shall be afforded a period of at least thirty (30) days to submit written comments for consideration by the Medical Executive Committee before the provisions are submitted to the Board of Directors. Notice of the proposed provisions to the Medical Staff shall be in a reasonable manner, which may include posting in a newsletter or bulletin, distribution at a general Medical Staff meeting, or any other method regularly used by the Medical Staff Office to provide notices to members. The Medical Executive Committee may retain, modify or abandon the provisions, as it deems appropriate in light of the comments, if any. Notice of new or amended Policies adopted by the Medical Executive Committee shall be provided to the Medical Staff promptly upon approval by the Board of Directors.

13.1-2 PROPOSALS BY PETITION

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

a. A proposal bearing the signatures of 25% or more of the voting members of the Active Medical Staff (which will constitute notice of the proposal to the Medical Executive Committee) must identify two Active Medical Staff members who will serve as representatives and act on behalf of the proposal signers in the processes described below (including any conflict management processes):

b. If the Medical Executive Committee supports a proposed amendment of the Rules and Regulations as submitted, the proposal will be disseminated to the Medical Staff for comment as described in Section 13.1-1 above, before the Medical Executive Committee submits the proposal to the Board of Directors for approval. The Medical Executive Committee is not required to submit proposed Policies or proposed Policy amendments to the Medical Staff for comment.

c. If the Medical Executive Committee does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.

d. If the conflict is not resolved by withdrawal of the proposal, or by Medical Executive Committee support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified in the conflict management process, then as modified) to the Medical Staff for comment as described below before the proposal is submitted to the Board of Directors for approval.

e. With respect to any Rules and Regulations proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee has discretion to do any of the following:

- disseminate the proposal, as submitted, to the Medical Staff for comment;
- modify the proposal and disseminate it, as modified, to the Medical Staff for comment; or
- reject the proposal and not disseminate it to the Medical Staff for consideration.

f. With respect to any Policy proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee may accept, modify or reject the proposal without disseminating it to the Medical Staff for comment.

g. Except as otherwise provided in this Article, before the Medical Executive Committee submits any proposal for adoption or amendment of Rules and Regulations to the Board of Directors for approval, the Medical Executive Committee shall disseminate the proposal to the Medical Staff, as described in Section 13.1-1 above. Members of the Medical Staff shall be given an opportunity to submit written comments, through the Medical Staff Office, for a period of not less than thirty (30) days.

h. After considering any comments that have been received within the allotted period, the Medical Executive Committee may modify the proposal in light of the comments. The Medical Executive Committee will disseminate any such modified proposal to the Medical Staff, and may, in the Medical Executive Committee's discretion, solicit further comments in the manner described above.

i. If a proposal did not include the signatures of 25% or more of the voting members of the Active Medical Staff, but the Medical Executive Committee disseminated the proposal to the Medical Staff for comment, then after the comment period ends the Medical Executive Committee in its discretion may do either of the following:

- submit the proposal to the Board of Directors for approval, in its original form or as modified in light of the comments; or
- reject the proposal and not submit it to the Board of Directors.

13.1-3 DEPARTMENT RULES AND REGULATIONS AND POLICIES

Rules and Regulations and Policies for Medical Staff Departments may be established and amended by the same process as general Medical Staff Rules and Regulations and Policies, except that:

a. Department-initiated proposals for establishing or amending Department-specific Rules and Regulations or Policies shall be submitted to the Medical Executive Committee by the relevant Department Chair following adoption by a majority of the voting members of the Department.

b. Department-initiated proposals that are acceptable to the Medical Executive Committee as submitted may be adopted by the Medical Executive Committee and submitted to the Board of Directors for approval.

c. Each Medical Executive Committee-initiated proposal and Department-initiated proposal that the Medical Executive Committee proposes to modify or reject shall be disseminated for comment to the relevant Department, along with a statement of the Medical Executive Committee's reasons, before the Medical Executive Committee submits any such proposal to the Board of Directors for approval. The Department will have 30 days to submit responsive comments to the Medical Executive Committee in writing, and any such Department comments will be submitted to the Board along with the Medical Executive Committee's proposal.

d. If the Medical Executive Committee has rejected a Department-initiated proposal, the Department Chair (or another Department representative chosen by the Department members, if the Chair does not support the proposal) may invoke the conflict management process set forth in Section 13, 12 of these Bylaws within 30 days of receiving notice of the rejection. If the conflict management process is not invoked timely, it will be deemed waived. If the matter is not resolved in the conflict management process, the proposal will be submitted to the Board of Directors for approval along with the written comments of the Department and the Medical Executive Committee.

e. If the Board of Directors does not approve a Department-specific proposal, the Medical Executive Committee, Department Chair, and/or designated Department representative may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice of that the Board did not approve the proposal.

13.1-4 URGENT NEED

a. If the Medical Executive Committee receives documentation of an urgent need to amend the Medical Staff Rules and Regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit it to the Board of Directors for provisional approval, without prior notification of the Medical Staff. Immediately following the Medical Executive Committee's adoption of such an urgent provisional amendment to the Rules and Regulations, the Medical Executive Committee will notify the Medical Staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested Medical Staff member to submit written comments to the Medical Executive Committee within 30 days of the date of the notice. The amendment will become final at the end of the comment period if the comments indicate there is no substantial conflict regarding the provisional

amendment. There is no substantial conflict unless at least 25% of voting Active Medical Staff members expresses opposition to the amendment in writing.

b. If the comments indicate a substantial conflict over the provisional amendment, then the Medical Executive Committee will implement the conflict management process set forth in Section 13.12 of these Bylaws, and may submit a revised amendment to the Board for approval if necessary.

13.1-5 ADOPTION BY THE BOARD

a. Following Medical Executive Committee approval of Medical Staff General Rules and Regulations, departmental Rules and Regulations, or Medical Staff policies as noted above, such Rules and Regulations or policies shall become effective following approval by the Board. Board approval shall not be withheld unreasonably. Upon approval by the Board, new Rules and Regulations, Policies, or amendments to existing Rules and Regulations or Policies, shall be announced promptly to the Medical Staff in a reasonable manner, as described in Section 13.1-1(b) above.

b. If a proposal is not approved by the Board, then the Medical Executive Committee (or the designated representatives of the group of Medical Staff members who submitted a non-Medical Executive Committee-supported proposal that went directly to the Board) may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice that the proposal was not approved by the Board.

c. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations and policies.

13.1-6 ADHERENCE TO MEDICAL STAFF RULES AND REGULATIONS, MEDICAL STAFF POLICIES, AND HOSPITAL ADMINISTRATIVE POLICIES

Applicants and Members of the Medical Staff and others holding Clinical Privileges or exercising Practice Prerogatives shall be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures which have been appropriately approved by the Medical Executive Committee and Board of Directors.

13.2 DUES OR ASSESSMENTS

The Medical Staff shall have the power to adopt the amount of annual dues or assessments, if any, for each category of Medical Staff membership and is solely responsible for the collection, use, and expenditure of Medical Staff funds. Provisional Medical Staff members shall not be required to pay dues until after serving one year on the medical staff.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. The words used in these Bylaws and the Rules shall be read to apply to both gender and to both the singular and the plural, as the context requires.

13.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first-class postage prepaid. The use of certified or registered mail is optional unless expressly required in these Bylaws. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained.

Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of Department, or committee (c/o Medical Staff Office, or Chief of Staff)
Tahoe Forest Hospital District
Post Office Box 759
Truckee, California 96160

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital, and, in the absence of proof of earlier receipt, shall be deemed received five days after mailing in accordance with this Section 13.4.

13.5 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

13.5-1 GENERAL

a. Medical Staff representatives, as designated by the Chief of Staff, shall participate in Hospital deliberations affecting the discharge of Medical Staff responsibilities.

b. The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

13.5-2 EXCLUSIVE CONTRACTING DECISIONS

The Medical Executive Committee shall review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee and individual members of Medical Staff shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

13.6 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance from a company authorized to sell insurance (in the State of California for California staff members and in the State of Nevada for ~~Incline Village~~Nevada s~~S~~taff members) or from an insurance trust incorporated under the laws of one of the United States of America in no less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Directors and the Medical Executive Committee.

13.7 BYLAWS NOT A CONTRACT

These Bylaws describe the intended relationship between the Medical Staff and its members, as well as between the Medical Staff (including its members) and the Hospital. It is intended that all affected parties and entities shall conduct themselves in good faith conformance with these Bylaws. However, these Bylaws are not intended to be a contract, and technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or for seeking remedies that are contractual in nature.

13.8 WAIVER OF BYLAWS/RULES PROVISIONS

Insofar as is consistent with applicable laws, the Medical Executive Committee, in consultation with the Board or its designated representative, or the Board, in consultation with the Medical Executive Committee, has the discretion to waive provisions of the Bylaws or Rules, if either determines that this

waiver is necessary to serve the best interests of the patients and the Hospital. There is no right to have a request for a waiver considered and/or granted.

13.9 INTERPRETATION / RECONCILIATION OF PROVISIONS

In the event of any ambiguity or in the Medical Staff Bylaws, Rules and Regulations or Policies, or should there be any question of interpretation, the Medical Executive Committee shall have the authority to resolve such matters. In the event of an apparent conflict between the Bylaws and Medical Staff Rules and Regulations, the Bylaws shall prevail. If there is a conflict between Medical Staff Rules and Regulations and Medical Staff Policies and Procedures, the Rules and Regulations shall prevail.

13.10 MEDICAL STAFF LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel. The authority to engage legal counsel on behalf of the Medical Staff shall be the prerogative of the Medical Executive Committee; provided, however, that if the Medical Executive Committee declines to exercise this prerogative, a majority of the voting members of the Active Staff may elect to engage legal counsel on behalf of the Medical Staff.

13.11 DISPUTES WITH THE BOARD OF DIRECTORS

In the event of a dispute between the Medical Staff and the Board of Directors relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code section 2282.5, the following procedures shall apply:

13.11-1 INVOKING THE DISPUTE RESOLUTION PROCESS

a. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.

b. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.

13.11-2 DISPUTE RESOLUTION FORUM

a. Ordinarily, the initial forum for dispute resolution should be the Joint Conference Committee.

b. However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Board of Directors. A neutral mediator acceptable to both the Board of Directors and the Medical Executive Committee may be engaged to further assist the dispute resolution upon request of (a) at least a majority of the Medical Executive Committee plus two members of the Board of Directors; or (b) at least a majority of the Board of Directors plus two members of the Medical Executive Committee.

13.11-3 FINAL ACTION

If the parties are unable to resolve the dispute the Board of Directors shall make its final determination, giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Board of Directors' determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

13.12 DISPUTES INTERNAL TO THE MEDICAL STAFF

(a) Under the following circumstances, the Medical Executive Committee shall initiate a conflict management process to address a disagreement between members of the Medical Staff and the Medical Executive Committee about an issue relating to the Medical Staff's documents or functions, including but not limited to a proposal to adopt or amend the Medical Staff Bylaws, Rules and Regulations, or Policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws):

(1) upon written petition signed by either:
- at least 25% of the voting members of the Medical Staff, or
- at least 66% of the members of any Department of the Medical Staff; or

(2) upon the Medical Executive Committee's own initiative at any time; or

(3) as otherwise specified in these Bylaws.

(b) A request to invoke the conflict management process must be submitted within any deadline specified in these Bylaws.

(c) A petition to initiate the conflict management process shall designate two Active Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.

(d) With respect to each particular conflict, the Medical Executive Committee shall determine and specify a process that the Medical Executive Committee deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:

- provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;
- require good-faith participation by representatives of the parties; and
- provide for a written decision or recommendation by the Medical Executive Committee on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

(e) At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive Committee and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

(f) This conflict management process shall be a necessary prerequisite to any proposal to the Board of Directors by Medical Staff members for adoption or amendment of a Bylaw, Rules and Regulations provision, or Policy not supported by the Medical Executive Committee, including (but not limited to) a proposed Bylaws amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the Medical Staff.

(g) Nothing in this Section is intended to prevent Medical Staff members from communicating with the Board of Directors about Medical Staff Bylaws, Rules and Regulations, or Policies, according to such procedures as the Board may specify.

13.13 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by an appropriate practitioner, i.e., an MD or DO, DDS, DPM, Clinical Psychologist, oral maxillofacial surgeon, or other qualified licensed individual in accordance with California and/or Nevada law as applicable and the Medical Staff Rules and Regulations.

Whenever the medical history and physical examination have been completed before admission or registration (which may occur only as permitted in accordance with this Section and applicable law and accreditation requirements), an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by an appropriate practitioner, as defined above.

Additional requirements for completing the medical history and physical examination for each patient are set forth in the Medical Staff Rules and Regulations.

ARTICLE XIV

ADOPTION AND AMENDMENT OF BYLAWS

14.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Directors. Amendments to these Bylaws may be submitted for vote by the Medical Executive Committee or by petition signed by at least ten percent (10%) of the voting member of the Medical Staff.

14.2 METHODOLOGY

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

(a) The affirmative vote of two-thirds (2/3) of the Staff members voting on the matter by mailed or electronic ballot; provided at least 14 days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and.

(b) Amendments shall become effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Medical Staff bylaws or rules.

In recognition of the ultimate legal and fiduciary responsibility of the Board of Directors, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Board of Directors to such effect including a reasonable period of time for response, the Board of Directors may impose conditions on the Medical Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, Medical Staff recommendations and views shall be carefully considered by the Board of Directors in its actions.

The Medical Staff Bylaws, Rules and Regulations and policies will not conflict with the Governing Board Bylaws.

14.3 AMENDMENTS BY PETITION

Generally, proposals to adopt, amend or repeal Bylaws will emanate from or be endorsed by the Medical Executive Committee in accordance with its overall responsibility to represent and act on behalf of the Medical Staff and discharge its various functions as described in Section 10.3 of these Bylaws. However, in addition to the mechanisms set forth above by which the Medical Staff may adopt Medical Executive Committee-proposed amendments to these Bylaws, the Medical Staff may adopt and propose Bylaw amendments directly to the Board of Directors for its approval, but only in accordance with the following procedure:

(a) A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least 10% of Active Medical Staff members proposing a specific Bylaws amendment or amendments (which will constitute notice of the proposed Bylaws amendment(s) to the Medical Executive Committee). Any such petition must identify two Active Medical Staff members who will serve as representatives and act on behalf of the petition signers in the processes described below (including any conflict management processes).

(b) Upon submission of such a petition, the Medical Executive Committee will determine whether it supports the proposed Bylaws amendment(s), and if so, the Medical Staff Office will arrange for a vote on the proposed Bylaws amendment(s) by the voting members of the Active Medical Staff according to the process described above for voting on Medical Executive Committee-proposed Bylaws amendments.

- If the Medical Staff adopts the proposed Bylaws amendment(s) by a vote of the Medical Staff conducted according to the process described above, then the proposed Bylaws amendment(s) will be submitted to the Board of Directors for approval.
- If the Medical Staff does not adopt the proposed Bylaws amendment(s) by vote, then the proposed Bylaws amendment(s) will be deemed withdrawn.

(c) If the Medical Executive Committee does not support the proposed Bylaws amendment(s), the Medical Executive Committee will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed Bylaws amendment(s) will be deemed withdrawn.

(d) If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or by Medical Executive Committee support of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed Bylaws amendment(s) will be submitted (in original form or, if the original proposed Bylaws amendment(s) has/have been modified in the conflict management process, then as modified) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board of Directors if a majority of the Active Medical Staff members who are eligible to vote cast their ballots in favor of the proposed Bylaws amendment(s).

(e) A copy of the Medical Executive Committee's written statement of its decision and reasons issued at the conclusion of the conflict management process shall be provided to the Board of Directors along with any proposed Bylaws amendment(s) submitted to the Board after such process.

(f) Such proposed Bylaws amendment(s) will become effective immediately upon Board approval, which shall not be withheld unreasonably.

(g) If the Board of Directors does not approve the proposed Bylaws amendment(s), then the matter will be referred to the conflict management process set forth in Section 13.11 of these Bylaws.

14.4 EXCLUSIVITY

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and the Board of Directors.

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June 27, 2018
Updated August 2, 2018
TFHD MEDICAL STAFF BYLAWS COMMITTEE ANNUAL REVIEW

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TAHOE FOREST HOSPITAL DISTRICT

MEDICAL STAFF
RULES AND REGULATIONS

~~2017~~2018

MEDICAL STAFF RULES AND REGULATIONS

Field Code Changed

MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I

PREAMBLE

1.1 These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws ("Bylaws"). In the event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

1.2 All Rules contained herein have been recommended by the Medical Executive Committee of the Tahoe Forest Hospital District Medical Staff and approved by the Board of Trustees in accordance with Section 13.1 of the Medical Staff Bylaws. These Rules are binding on all Members of the Medical Staff and holders of clinical privileges, to the extent consistent with the Bylaws.

1.3 All definitions contained in the Bylaws are incorporated in these Rules.

ARTICLE II
COMMITTEES

2.1 ETHICS COMMITTEE

2.1-1 COMPOSITION

The Ethics Committee shall be composed of at least the following members: One physician, one registered nurse, one clergy, one medical social worker (or comparable), one member of Hospital administration, and one non-Hospital local community member at large. Additional members may be appointed by the Chief of Staff. The chairperson shall be the Member-at-Large, and the vice-chairperson shall be a member selected by the Ethics Committee. The chairman of the Ethics Committee shall serve as a voting member of the Medical Executive Committee.

2.1-2 PURPOSE

The purpose of the Ethics Committee is to impact positively upon the quality of health care provided by the Hospital by:

(a) Providing assistance and resources in decision-making processes that have bioethical implications. The Ethics Committee shall not, however, be a decision maker in any such processes.

(b) Educating members within the Hospital community of bioethical issues and dilemmas.

(c) Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

(d) Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and educative guidance relating to such matters.

2.1-3 MEETINGS

The Ethics Committee shall meet as often as necessary to accomplish its purpose and shall maintain a limited record of its proceedings and report its activities to the Medical Executive Committee.

2.2 BYLAWS COMMITTEE

2.2-1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including at least the Vice Chief of Staff and a past Chief of Staff appointed by the Chief of Staff.

2.2-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a periodic review of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its Departments;

(b) submitting recommendations to the Medical Executive Committee for changes in these documents as necessary and desirable; and

(c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of those items.

2.2-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

2.3 QUALITY ASSESSMENT COMMITTEE

2.3-1 COMPOSITION

The Quality Assessment Committee shall consist of a chair of the Committee appointed by the Chief of Staff in consultation with Administration, interested physicians from each clinical Department, and such members as may be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, including representatives from the Quality Department, Nursing Services, and from Hospital Administration.

2.3-2 DUTIES

The Quality Assessment Committee shall perform the following duties:

(a) Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These may include mechanisms to:

(1) establish systems to identify potential problems in patient care;
(2) set priorities for action on problem correction;
(3) refer priority problems for assessment and corrective action to appropriate Department or committees;
(4) monitor the results of quality assessment activities throughout the Hospital; and
(5) coordinate quality assessment activities.

(b) Submit regular reports to the Medical Executive Committee and Board of Directors on the quality of medical care provided, quality review activities conducted, and Professional Review Committee (PRC) and Professional Performance Evaluation Committee (PPEC) functions:
(1) Periodic review of Peer Review Policy
(2) Review of individual cases as requested by department Chairs.

(c) Risk management practices as they relate to aspects of patient care and safety within the Hospital, and ensure that the Medical Staff actively participates, as appropriate, in the following risk management activities related to the clinical aspects of patient care and safety:

(1) The identification of general areas of potential risk in the clinical aspects of patient care.

(2) The development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety and evaluation of these cases.

(3) The correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

(4) The design of programs to reduce risk in the clinical aspects of patient care and safety.

(d) Medical Records: Review and evaluate health information management including paper and electronic health records for compliance with Hospital needs and regulatory requirements. Additional medical record functions include:

(1) ensuring that medical records are maintained at an acceptable standard of completeness
(2) submitting written reports to the Medical Executive Committee and providing recommendations to the Medical Executive Committee regarding corrective action recommendations pertaining to compliance with medical records policies;
(3) recommending new use or changes in the format of medical records;
(4) recommending policies for medical record maintenance including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement; and policies related to privileged communication and release of information;

(e) Blood Usage: The Quality Assessment Committee shall receive quarterly reports to evaluate blood and blood product transfusion appropriateness and usage.

(f) Drug Usage: The Quality Assessment Committee shall be responsible for the oversight of the Pharmacy and Therapeutics Committee and an annual review of the Medication Error Reporting Policy (MERP)

(g) Infection Control: The Quality Assessment Committee shall be responsible for the oversight of the Infection Control Committee.

(h) Tissue Review: The Quality Assessment Committee shall also be responsible for receiving quarterly reports from a pathologist, who is a member of the Medical Staff with privileges in pathology concerning (I) pre-operative, post-operative, and

pathological diagnoses for surgical cases in which no specimen is removed; (II) all transfusions of whole blood and blood derivatives;(III) all removed tissue where the tissue is found to be normal or not consistent with clinical diagnosis. Any cases not meeting criteria established by policy shall be referred to the appropriate Medical Staff Committee or Department for discussion.

(i) The Quality Assessment Committee shall review all deaths and all removed tissue where the tissue is found to be normal or not consistent with the clinical diagnosis, and shall develop and implement measures to correct any problems discovered. It shall develop rules governing which cases must be reviewed, and outlining any exceptions to this general rule. Such rules shall be subject to Medical Executive Committee and Board of Directors approval. The Quality Assessment Committee shall also develop and implement measures to promote autopsies in all cases of unusual death or deaths of medico-legal or educational interest.

(j) The Quality Assessment Committee shall review utilization of resources as they relate to aspects of patient care within Hospital-provided services as outlined in the Utilization Review Plan.

(k) Surgical and other invasive procedures, including: selecting appropriate procedures; preparing the patient for the procedure; equipment availability; safety of the environment; performing the procedure and monitoring the patient; and providing post-procedure care.

(l) Radiation Safety: Report from Radiation Safety Officer regarding research, diagnostic, and therapeutic uses of radioactive materials

(i) Reduction of both personnel and patient exposure to the minimum while pursuing the medical objective.
(ii) All applications for uses or authorizations for uses of radiation will be reviewed by the Radiation Safety Officer to assure that “as low as reasonably achievable” (ALARA) exposures will be maintained.
(iii) When reviewing new uses of radiation, details of efforts of applicants to maintain exposures ALARA must be included.

(m) Imaging Services: The Quality Assessment Committee shall be responsible for establishing, approving and enforcing policies relating to administration of imaging services through the hospital; and

(i) Conducting, approving and interpreting a quality assessment review for radiology services

(n) The Quality Assessment Committee shall be responsible for annual review of the

following:

(i) All clinical/critical pathways.
(ii) Quality Assessment Plan.
(iii) The Utilization Review and Discharge Plan.
(iv) The Risk Management Plan
(iv) The Patient Safety Plan.
(v) The Social Service Plan.

2.3-3 MEETINGS

The Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

2.4 INTERDISCIPLINARY PRACTICE COMMITTEE

2.4-1 COMPOSITION

The Interdisciplinary Practice Committee ("IDPC") shall be appointed by the Medical Executive Committee of the Medical Staff and shall include at least five (5) representatives of the various allied health professionals and two (2) physicians, ~~, at a minimum, the Chief Nursing Officer, the Chief Executive Officer or designee, and an equal number of physicians appointed by the Medical Executive Committee of the medical staff.~~ as voting members of the committee. The Chief Nursing Officer and the Chief Executive Officer or designee may also attend meetings of the IDPC on an ex-officio basis without a vote. ~~In addition, representatives of the various allied health professions shall serve as voting members of the IDPC.~~

The chair of the Committee, who shall be a nurse practitioner or physician assistant, shall be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, and may attend meetings of the Medical Executive Committee on an ex-officio basis without a vote.

~~A member of the IDPC may attend meetings of the Medical Executive Committee on an ex-officio basis without a vote.~~

2.4-2 DUTIES

The Interdisciplinary Practice Committee shall establish written policies and procedure for the conduct of its business including serving as consultants regarding expanded role privileges to advanced practice nurses, whether or not employed by the facility and other allied health professionals. These policies and procedures will be administered by the Committee. The Committee shall be responsible for the formulation and adoption of standardized procedures and for initiating the preparation of such standardized procedure in accordance with Title 22.

2.4-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

2.5 WELL-BEING COMMITTEE

2.5-1 COMPOSITION

(a) In order to improve the quality of care and promote the competence of the Medical Staff, the Chief of Staff, with the approval of the Medical Executive Committee, shall appoint the Well-Being Committee composed of at least two (2) active members of the Medical Staff. The majority of the committee, including the chair, shall be physicians.

(b) Individuals who are not members of the Medical Staff (including non-physician(s)) may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

(c) The members shall be appointed as appropriate to achieve continuity.

(d) Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

2.5-2 DUTIES

(a) The Well-Being Committee shall serve as an identified resource to take note of and evaluate issues related to health, well-being, or impairment of Medical Staff members and shall provide assistance to Department Chairs and Medical Staff officers when information and/or concerns are brought forth regarding a Practitioner's health or behavior related to physical, emotional, or drug dependency related conditions.

(b) The committee shall provide advice, recommendations and assistance to any practitioner who is referred and to the referring source, but shall act only in an advisory capacity and not as a substitute for a personal physician.

(c) The Well-Being Committee will receive reports, information and concerns related to the health, well-being, or impairment of Medical Staff members, whether from third parties, upon request of a Medical Staff or department committee or office or upon self-referrals from the practitioners themselves and, as it deems appropriate, may investigate such reports.

(d) With respect to matters involving individual Medical Staff members, the committee may offer advice, counseling, or referrals as may seem appropriate.

(e) Activities shall be confidential; however, if unreasonable risk of harm to patients is perceived, that information must be referred to appropriate officials of the Medical Staff for action as necessary to protect patients and/or for corrective action. This shall include instances in which a practitioner fails to complete a required rehabilitation program.

(f) The committee shall assess and determine appropriate outside assistance resources and programs for practitioners also consider general matters related to the health and well being of the Medic al Staff and, with the approval of the Medical Executive Committee, shall develop educational programs or related activities.

(g) The Committee will make a response to the referral source of any written letter of concern regarding well-being but shall not compromise the confidentiality of its

activities or the privacy of the individuals concerned.

(h) The Well-Being Committee may be asked to review responses from applicants concerning physical or mental disabilities, and recommend what, If any, reasonable accommodations may be indicated to assure that the practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. ~~The timing of these assessments shall be closely coordinated so that the Medical Executive Committee does not consider the issue of physical or mental disabilities until after an applicant has been otherwise determined to be qualified for Medical Staff membership.~~ The Committee shall also perform this function during a Staff membership. The Committee shall also perform this function during member's term, upon request from the Medical Executive Committee.

2.5-3 MEETINGS

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee. Any records regarding individual practitioners shall be kept strictly confidential and maintained separate from credentials files and other Medical Staff records.

2.6 CANCER COMMITTEE

2.6-1 COMPOSITION

The Cancer Committee is a standing committee of the Medical Staff. It is multidisciplinary and provides leadership to the Cancer Program. The Cancer Committee and Cancer Conference are also known as the Tahoe Forest Hospital's Tumor Board.

The Cancer Committee shall be a multidisciplinary committee composed of physician

representatives who care for cancer patients including, but it is not limited to the following:
a. Cancer Committee Chair
b. Cancer Liaison physician
c. Diagnostic Radiologist
d. Medical Oncologist
e. Radiation Oncologist
f. Pathologist
g. Surgeon
h. Gynecologist

Non-physician members must include, but are not necessarily limited to, the following:
a. Cancer program Administrator
b. Oncology nurse
c. Social Workers and/or Case Manager
d. Certified Tumor Registrar
e. Performance Improvement or quality management representative
f. Hospice manager
g. Palliative Care Nurse Specialist
h. Clinical Research Coordinator
i. CoC Appointed Coordinators
j. American Cancer Society Representative
k. Nurse Navigator

The Cancer Committee chair is elected by the physician committee membership for a 2 year term and may also fulfill the role of one of the required physician specialties. Individual members of the Committee are appointed to coordinate important aspects of the Cancer Program. An individual cannot fulfill more than 1 coordinator role (for the CoC appointed coordinator positions). Each person coordinates one of each of the following four major areas of program activity:
a. Cancer Conference
b. Quality Control of Cancer Registry Data
c. Quality Improvement
d. Community Outreach
e. Clinical Research
f. Psychosocial Services

2.6.2 DUTIES

a. The Cancer Committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care;
b. The Cancer Committee establishes the frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis;
c. The Cancer Committee ensures that the required number of cases are discussed at the Cancer Conference on an annual basis and that a minimum of 75% of the cases discussed are presented prospectively;
The Cancer Committee monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective cases presentation annually. Each year, the Cancer Committee participates in the CoC CP3R National Data Outcomes measures. Committee annually reviews outcomes, develops outcomes as indicated and follows the measures through to Quality Improvements projects.
Each year, the Cancer Committee analyses patient outcomes and disseminates the results of the analysis. This will be accomplished by publishing an Annual Report that includes a cancer site analysis with survival analysis and comparison of our data to NCDB

data.

2.6.3 MEETINGS

The Committee shall meet at least quarterly, for a minimum of 4 times each year or as often as necessary at the call of its Chair (currently meets every other month for a total of six meetings per year)). It shall maintain a record of its proceedings and report its activities to the Medical Staff Quality Assessment Committee. Each member is required to attend at least 75% of the Cancer Committee meeting held annually. Participation may include through teleconference. The Cancer Committee needs to monitor the individual attendance of all members and address attendance that does not fulfill the needs of the program or falls below the requirements set forth.

2.7 CANCER CONFERENCE

2.7-1 COMPOSITION:

The Cancer Conference reports to the Cancer Committee. The Cancer Conference shall consist of a multidisciplinary group of physicians including the major disciplines involved in the management of cancer; surgery, medical oncology, radiation oncology, diagnostic imaging and pathology and other specialties as needed. The Chair will be elected by the Cancer Committee**.**

2.7-2 DUTIES

(a) Utilize the clinical case presentation format to educate the staff in oncology and oncologic practice;
(b) Promote an active interchange of ideas for case management, assuring that patients with malignancies will benefit from the combined thinking of the staff;
(c) Ensure that a broad base of oncology knowledge is available, either from within the Cancer Conference, or from guest participants;
(d) Accept and consider any responsible and practical method established by a hospital to evaluate cases of malignancy. Whether done by a representative cross section of the staff or specified departments, evaluations shall reflect a broad base of knowledge of oncology, assuring that all patients with malignancies will benefit from the combined thinking of the staff in case management.
(e) Report on new trends in the diagnosis and therapy of malignancy;
(f) Encourage presentations to the Cancer Conference early in the patient's management;
(g) Recommend the most appropriate diagnostic and therapeutic approaches for the patients presented and their malignancies;
(h) Cases presented, at a minimum, include 15% of the annual analytic case load) and the prospective presentation rate (a minimum of 80% or a maximum of 450 of the annual analytic case presentations). Prospective cases include, but are not limited to, the following:
(i) 1. Newly diagnosed and treatment not yet initiated;
(j) 2. Newly diagnosed and treatment initiated, but discussion of additional treatment is needed;
(k) 3. Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed;
(l) 4. Previously diagnosed, and discussion of supportive or palliative care is needed;
(m) 5. Note that cases may be discussed more than once and counted each time as a prospective presentation if management issues are discussed.

Cancer Conference activities are reported to the Cancer Care Committee at least quarterly.

2.7.3 MEETINGS

The Cancer Conference is held monthly or as often as necessary at the call of its chair. Each member is required to attend at least 50% of the Cancer Conferences. The Cancer Committee reviews the annual Cancer Conference attendance rate to ensure compliance with

the CoC standard.

2.8 INCLINE VILLAGE COMMITTEE

2.8-1 COMPOSITION

(a) The Incline Village Committee shall consist of all physicians who are on the Medical Staff and exercising clinical privileges at Incline Village Community Hospital.

(b) The Chairperson shall be elected on a bi-annual basis by majority vote of physicians on the committee. The Chairperson shall serve for a three (3)-year term with election held 3 months prior to the last meeting of the calendar year. In addition to the physicians, there will be representation by nursing and Hospital administration.

(c) All medical and hospital staff may attend the Open Session of this meeting, however, agenda Items must be cleared In advance with the Chairperson.

(d) The Chairperson will serve as liaison between the Administration and the physicians practicing at Incline Village Community Hospital. The Chairperson will report directly to the Medical Executive Committee and attend Medical Executive Committee as a voting member.

2.8-2 DUTIES

a) Review policies and procedures relating to nursing and ancillary services throughout the Incline Village Community Hospital.

b) Conduct all quality review of care at Incline Village Community Hospital with further review or optional alternative review by appropriate Tahoe Forest Hospital District Medical Staff departments if requested. Those specialties that only have one physician representing the specialty will have cases reviewed by the appropriate department of the Tahoe Forest Hospital District Medical Staff . (Department of Surgery will review surgical cases, etc.)

c) Conduct, participate, and make recommendations regarding educational programs pertinent to clinical practice;

d) Reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

e) Coordinate patient care provided at Incline Village Community Hospital by the Medical Staff with nursing and ancillary patient care services;

f) Submit written reports to the Medical Executive Committee concerning: (1) the Committee's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided at Incline Village Community Hospital and the Hospital; and (3) how quality and utilization review functions will be addressed;

g) Meet regularly for the purpose of considering patient care review findings and the result of the Committee's other review and evaluation activities, as well as reports on

other Committee and Medical Staff functions;

h) Take appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

i) Account to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Committee; and

j) Recommend space and other resources needed by the Committee; and assess and recommend off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Committee.

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2.8-3 MEETINGS

The Incline Village Committee shall meet on a quarterly basis. Additional meetings or cancellations may be determined by the Chairperson. A Committee report will be submitted to the Medical Executive Committee for review. Each member of the Active Staff whose primary practice is at Incline Village Community Hospital shall be encouraged to attend the Annual Medical Staff meeting; and required to attend at least fifty percent (50%) of all meetings of the Incline Village Committee or the appropriate Tahoe Forest Hospital Department meetings. There will be no exceptions from the meeting attendance requirements.

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2.9 MEDICAL EDUCATION COMMITTEE

2.9-1 COMPOSITION

The Medical Education Committee will consist of, at a minimum, the Medical Director of Medical Education who will also act as the chair. The committee will include designated Clerkship Directors and any other participating preceptors. The committee members will be appointed by the Medical Executive Committee. In addition, representatives of the various nursing and allied health professions will participate on an as-needed basis. The Medical Education Committee is accountable to the Medical Executive Committee.

2.9-2 DUTIES

The Medical Education Committee shall establish written policies and procedures for the conduct of its business, including oversight of the medical students, interns, and residents in coordination with the University, College, or School of Medicine. The committee will ensure that the program operates in a structured manner according to the teaching policies of the affiliated University, College or School of Medicine. They will also provide oversight of the medical students, interns, and residents activities and progress in collaboration with the Instructors of Record. The Committee will also provide oversight of telemedicine conferencing, continuing medical education for the Medical Staff, and other programs as assigned. The Committee recommends the acquisition, purchase, or disposal of educational materials and assists in establishing rules and regulations for use of the medical library services by the members of the Medical Staff.

2.9-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair. Meetings may be held in person or via electronic or e-mail communication. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive

Committee.

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ARTICLE III

MEETINGS

3.1 AGENDA FOR GENERAL MEDICAL STAFF MEETINGS

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda may include the following:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) verbal or written administrative reports from the Chief of Staff, Departments, and committees, and the Chief Executive Officer;

(c) verbal or written reports by responsible officers, committees, and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;

(d) old business; and

(e) new business.

ARTICLE IV

PATIENT CARE

4.1 ADMISSION AND DISCHARGE OF PATIENTS

4.1-1 The Hospital will accept all patients for care and treatment to the extent it has appropriate facilities and qualified personnel available to provide necessary services or care. ~~Accordingly, the Hospital will not accept patients for care and treatment with severe neurological trauma, severe and extensive third degree burns, and psychiatric patients with suicidal predilection.~~ All physicians shall be governed by the official admitting policy of the Hospital. A patient can be admitted to the Hospital only by practitioners with admitting privileges who holds appropriate licensure and clinical privileges.

4.1-2 A member of the Medical Staff with clinical privileges appropriate to the patient's needs shall be responsible for the medical care and treatment for each patient in the Hospital, for the prompt completion and accuracy of the medical record, for the necessary special instructions, and for transmitting reports of the condition of the patient to other members of the health care team and to relatives of the patient, subject to legal and privacy limitations. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record stating the date and time of such transfer.

4.1-3 A Conditions of Admission Form signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Medical Staff member whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the member's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, specific consent that informs the patient of the nature of, and

risks inherent in, any special treatment or surgical procedure shall be obtained.

4.1-4 Current medications being used by patients at the time of admission may be used on a continuing basis following admission providing that all such drugs be identified by the Hospital pharmacist and be in authorized identifiable pharmacy containers with appropriate labeling.

4.1-5 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. The admitting practitioner is responsible for informing Hospital administration and the nursing staff at the time of admission if the practitioner suspects the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending physician shall initiate any appropriate restrictions with respect to where in the Hospital the patient will be placed (i.e. isolated area for contagious disease) and shall recommend appropriate precautionary measures to protect the patient and others. In the event the patient or others cannot be appropriately protected, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

4.1-6 Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded ~~on~~ in the patient's ~~chart~~ medical record as soon as possible after admission.

~~**4.1-7** A patient admitted on an emergency basis who does not have a private physician may select any physician on the applicable service to attend to him. Where no such selection is made, the member of the Active, Courtesy, or Provisional Staff serving on-call for the appropriate service will be assigned to the patient and contacted by the emergency physician. The chiefs of each service shall provide a schedule for such assignments~~

4.1-8 Each member of the Medical Staff must assure continuing timely, adequate, professional care for patients under his/her care in the Hospital. Failure of an attending physician to meet these requirements may be a ground for corrective action under the Medical Staff Bylaws. A member of the Medical Staff who will be unavailable must, ~~on~~ in the ~~order sheet of~~ medical record ~~the chart~~ of each patient, indicate ~~in writing,~~ the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. It is the responsibility of the attending practitioner to make prior arrangements ~~with the indicated practitioner, who must have privileges~~ to provide appropriate continuing care.

4.1-9 In the event of a need to categorize admitting priorities in an emergency situation, the Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical Department and approved by the Medical Executive Committee.

4.1-10 As a routine basis for admitting, the admitting policies of the Hospital will be based on the following order of priorities:

(a) Emergency admissions

(b) Urgent admissions

(c) Pre-operative admissions

(d) Routine admissions

4.1-11 Patient transfer priorities shall be as follows:

(a) Emergency Department to appropriate bed.

(b) From obstetrical patient care area to general care area, when medically indicated.

(c) From Intensive Care Unit to general care area. No patient will be transferred from the ICU without such transfer being approved by the responsible physician.

4.1-12 For the protection of patients, the medical and nursing staffs and the Hospital, due to the lack of adequate facilities and personnel for the treatment of patients with serious mental illness and patients who may be dangerous to themselves and/or others, such patients shall be transferred to an appropriate facility when medically stable. When the transfer of such patients is not possible, the patient may be temporarily admitted to the general area of the Hospital with appropriate nursing and security supervision to allow for crisis intervention as available through community and Medical Staff clinical psychological/psychiatric services.

4.1-13 Any patient known or suspected to be suicidal or otherwise a danger to self, who is treated as a Hospital inpatient or through the Emergency Department should be offered a psychological or psychiatric consultation through available community and Medical Staff resources.

4.1-14 If any question as to the necessity of admission to, or discharge from the Intensive Care Unit should arise, appropriate review of the decision is to be made by the Medical Director of the Intensive Care Unit in consultation with the attending physician.

4.1-15 The attending physician is required to document the need for continued hospitalization after specific periods of stay per disease categories as defined by the Medical Staff. This medical record documentation must contain:

(a) An adequate ~~written~~ record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not considered sufficient.

(b) The estimated period of time the patient will need to remain in the Hospital.

(c) Plans for post-Hospital care.

4.1-16 The patient shall be discharged from the Hospital only on a written order of the attending Medical Staff member. If the patient indicates an intent to leave the hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner to arrange for the patient to discuss his or her plan with the attending practitioner before the patient leaves. The attending practitioner shall advise the patient of the implications of leaving the hospital against medical advice, including the risks involved and the benefits of remaining for treatment, and shall

document this in the medical record. Should a patient insist upon leaving, the Hospital against the advice of the attending Medical Staff member or without proper discharge, a notation of the incident shall be made on the patient's medical record, and the patient shall be asked to sign the appropriate "Leaving Hospital Against Medical Advice" form acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the hospital. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

4.1-17 In the event of a hospital death, the deceased patient shall be pronounced dead by the attending physician or his/her designated covering physician within a reasonable period of time, or by a registered nurse who has been certified to pronounce a patient's death pursuant to the nursing standardized procedure. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of deceased patients shall conform to local law.

The patient's attending physician is responsible for notifying the next of kin in all cases of patient death and shall facilitate the reporting of patient deaths to the coroner or to other agencies as required by laws.

(a) If the basis for pronouncement of death is "brain death" (i.e. the total and irreversible cessation of all functions of the entire brain, including the brain stem), death must be pronounced by a physician, and a second, independent physician must confirm the determination of brain death. Both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, hospital administration shall be advised and consulted before medical interventions (e.g. respiratory) are discontinued.

(b) If the patient or the patient's family indicates that the patient has or will contribute anatomical gifts, the hospital protocol for identifying potential organ and tissue donors shall be followed.

4.1-18 Except in the case of patients hospitalized less than 48 hours and in cases of normal obstetrical deliveries and normal newborn infants, in which case a final progress note may be substituted, a clinical resume discharge summary shall be written or dictated on all medical records of hospitalized patients. In the event a patient expires within 48 hours following admission, a clinical discharge summary will be required.

4.2 AUTOPSIES

4.2-1 It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever appropriate, as described below, and consistent with applicable law. An autopsy may be performed only with a written authorization signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded ~~on~~ in the medical record within 72 hours and the complete autopsy protocol should be made a part of the deceased's medical record within 60 days. Autopsies are felt to be of particular value in the following circumstances and the Medical Staff is encouraged to actively seek family permission for autopsy for all in-patient

deaths meeting these criteria:

(a) Deaths where there are significant questions related to the effectiveness of therapy.

(b) Deaths where there are significant questions relating to the extent of disease.

(c) Deaths where ante mortem diagnostic procedures have resulted in unusual or unexplained findings.

(d) Deaths where genetic diseases are suspected but not confirmed prior to death. An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy costs.

An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy rates.

4.3 MEDICAL RECORDS

4.3-1 The attending Medical Staff member shall be responsible for the complete and legible medical record for each patient. ~~Its contents shall be pertinent and current.~~ The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Its contents shall be pertinent and current. The inpatient record shall have appropriate identification data; including, but not limited to:

(a) Chief complaint resulting in admission

(b) History of present illness

(c) Personal and family history

(d) Applicable systems review

(e) Physical examination

(f) Special reports such as consultation, clinical laboratory and radiology services

(g) Provisional diagnosis

(h) Medical or surgical treatment

(i) Operative reports, when appropriate

(j) Pathological finding, when appropriate

(k) Progress notes

(l) Final diagnosis

(m) Condition on discharge

(n) Summarizing clinical resume

(o) Autopsy report when performed

(p) Procedural, therapeutic, and operative consents when appropriate

(q) Post-discharge follow-up plans and medications

4.3-2 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by signature. Clinical entries may be counter signed by physicians caring for the same patient.

4.3-3 **Authentication shall be** by legible written signature, computer-generated or electronic signature, or unique physician ID number and shall be completed only by the individual responsible for the entry.

~~4.3-2~~**4.3-4** **Systems of authentication** of dictated, computer, or electronically generated documents must ensure that the author of the entry has verified the accuracy of the document

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4.3-35 The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval admission note must be written at the time of admission that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.4 HISTORY AND PHYSICAL

4.4.1 A complete admission history and physical examination shall be signed and completed no more than 30 days before or 24 hours after the inpatient admission, and it must be recorded in the patient's medical record within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history and physical examination has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports the report may be used in lieu of the admission history and report of the physical examination report, provided that an appropriate assessment is performed, including a physical examination within the previous 24 hours to update any components of the patient's medical status that may have changed since the earlier history and physical or to address any areas where more current data is needed. In such instances, a physician or other practitioner qualified to perform the history and physical writes an interval admission note addressing the patient's current status and/or any changes to such status, which includes all additions to the history and any subsequent changes in the physical findings. This update examination must be completed, signed, and documented in the patient's medical record by an appropriately qualified and privileged member of the Medical Staff within 24 hours after admission. If the history and physical that was performed prior to the patient's admission is determined to be incomplete, inaccurate or otherwise unacceptable, the physician responsible for the update examination may disregard the existing history and physical, and perform a new history and physical. Any such history and physical must be completed, signed and documented in a timely manner, as described in these Rules ~~these reports were recorded by a member of the Medical Staff~~. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded at the time of admission. All such outside records of histories and physicals shall be on a form approved by the Hospital and compatible with the current medical record system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the Hospital's medical record.

4.4-2 When a patient is readmitted to the Hospital within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available in a unit record.

4.4-3 When a patient is admitted for observation or outpatient~~a~~ hospitalization under 48 hours, a Short Stay History and Physical ~~form~~ may be ~~used~~ performed in lieu of a regular history and physical ~~format~~. On patients admitted from the emergency room for a short stay, the emergency room record will be deemed sufficient, provided that it is complete and contains at least the same information as indicated necessary ~~on the~~for a Short Stay History and Physical ~~form~~.

~~**4.4-4** The medical record system utilized by the Hospital shall be a unit record system.~~

4.4-5 When a history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the

attending physician states in writing that such delay would be detrimental to the patient. However, this requirement shall not preclude rendering emergency medical or surgical care to a patient in dire circumstances, as documented by the attending physician.

4.4-6 The attending physician shall authenticate by countersignature the history, physical examination and preoperative note when they have been recorded by an authorized allied health professional, a medical student, or resident staff physician from an outside educational institution performing preceptorship at the Hospital.

4.4-7 The history and physical examination may be performed and documented by any physician permitted by law as long as a physician who is currently a member of the Medical Staff, with privileges to perform a history and physical examination, updates the history and physical examination consistent with these Rules and Regulations. This shall include at least the following:

a. Review of the history and physical examination document;
b. Determination that the information is compliant with the hospital's defined content requirements for history and physical examinations;
c. Obtaining missing information through further assessment as needed;
d. Update information and findings as necessary:
    1. Inclusion of absent or incomplete required information;
    2. A description of the patient's condition and course of care since the history and physical examination was performed;
    3. A signature, date and time on any document with updated or revised information as an attestation that it is current.

The history and physical examination must have been performed within thirty days prior to the patient's admission to the hospital and the update must be completed and documented in the patient's medical record within 24 hours of admission and on the day of any outpatient surgical procedure.

4.5 PROGRESS NOTES

4.5-1 Attending physician of record, or the covering physician, or the appropriate practitioner shall be required to make daily rounds on their inpatients followed by the timely documentation of a progress note. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written daily on all acute care patients. In addition, appropriate progress notes shall be written at least every week on swing bed patients.

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4.6 OPERATIVE NOTE

4.6-1 Complete operative reports shall be dictated or written immediately after surgery, specifying the name of surgeon, procedure, diagnosis, anesthesia, and pertinent findings. The complete operative report shall include, but not be limited to:

(a) ~~(a)~~ Name of s~~S~~urgeons, assistant surgeons, and anesthesiologist
(b) Pre-operative and post-operative diagnosis
(c) Name of specific surgical procedure performed

(b) Type of anesthesia

(c) Detailed procedural account with description of techniques

(d) Any remarkable or unusual findings

(e) Complications

(f) Tissue removal and disposition

(g) Drains, appliances, or prostheses used

(h) Post-op condition

(i) Disposition from the operating room

4.7 CONSULTATIONS

4.7-1 Consultation reports shall show evidence of a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to the operation. Consultations must be signed by the consultant.

4.7-2 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

4.7-3 The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rest with the practitioner responsible for the care of the patient. Except in cases of emergency, when time does not permit, consultation should be obtained in the following situations:

(a) when the patient is not a good risk for operation or treatment;

(b) when the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) where there is doubt as to the choice of therapeutic measures to be utilized;

(d) in unusually complicated situations where specific skills of other practitioners may be

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needed;

(e) in instances in which the patient exhibits severe psychiatric symptoms; and

(f) when requested by the patient or his/her family.

4.7-4 Appropriate pediatric consultation in the wards should be considered for sick children under the following circumstances:

(a) A prolonged hospitalization if a child is involved with potential medical pediatric problems (e.g., multiple trauma, septic orthopedic problems, acute burns).

(b) Infectious problems of a life threatening nature (e.g., epiglotitis, meningitis).

(c) Other problems involving intensive care hospitalization (e.g., diabetes, ketoacidosis, and status asthmaticus).

(d) All patients admitted for surgical procedures less than two years of age.

4.7-5 The attending Medical Staff member should request consultations when the patient would seemingly benefit by the additional skills or abilities of other practitioners. The attending Medical Staff member is responsible for directly requesting the consultant to assist and he/she shall provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. The attending physician shall document the order for the consultant in the Physician Orders section and also indicate of the reason for the consultation on the Physician Orders section or Progress Notes in the patient's medical record. A consultation has not been fully requested or authorized unless the attending Medical Staff member has personally contacted the consultant or the consultant's office and the attending member has written a note in the chart. No practitioner is obligated to accept any request for consultation.

4.7-6 If a nurse or licensed registered pharmacist has any reason to doubt or question the care provided to any patient or believes appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nursing supervisor who in turn may refer the matter to the Nursing Executive. The Nursing Executive may bring the matter to the attention of the chief of the Department where the practitioner has privileges. Where circumstances are such to justify such action, the chief of the Department may himself/herself request the consultation.

4.8 ABBREVIATIONS

4.8-1 Symbols and abbreviations may be used ~~only when they have been approved~~ except when prohibited by the Medical Staff, hospital policy, bylaw, statute, or regulation. ~~An~~ TFHD will maintain an official record of ~~un~~approved abbreviations and they shall be kept on file in the Medical Record Department and made available through the TFHD Intranet.

4.8-2 Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and timed, dated and signed by the responsible Medical Staff member at the time of discharge of all patients.

4.9 CONSENTS

4.9-1 Unless otherwise authorized by law, written authorization of the patient, guardian or other legally authorized individual is required for release of medical information to persons not otherwise authorized to receive this information.

4.10 REMOVAL AND ACCESS OF MEDICAL RECORDS: CONFIDENTIALITY

4.10-1 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without the written approval of the Chief Executive Officer. Unauthorized removal of charts from the Hospital is grounds for corrective action, to be determined by the Medical Executive Committee of the Medical Staff.

4.10-2 In case of re-admission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

4.10-3 Access to medical records may be afforded to members of the Medical Staff for a bona fide study and research consistent with preserving the confidentiality of professional individually-identifiable information concerning the individual patients. All such projects and access shall be approved by a duly constituted Institutional Review Committee in accordance with applicable state and federal law, including the HIPAA Privacy Regulations. Approval must also be obtained from the Medical Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, and in accordance with applicable laws, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering the periods during which they attended such patients in the Hospital.

4.10-4 A medical record shall not be permanently filed until it is completed by the responsible Medical Staff member or is ordered filed by the Medical Executive Committee in the event that the Medical Staff member is permanently unable to sign.

4.11 ORDERS

4.11-1 A Medical Staff member's routine orders, when applicable to a given patient, shall be reproduced in detail ~~on the order sheet of~~ in the patient's record, dated, timed, and signed by the Medical Staff member. ~~All pre-printed orders shall be reviewed annually by the Medical Executive Committee for appropriateness~~.

4.12 MEDICAL RECORD DELINQUENCY

4.12-1 The patient's medical records shall be completed and signed at the time of discharge, or in no event later than 14 days following discharge. This will include progress notes, final diagnosis, and a dictated clinical resume. If the record still remains incomplete 15 days after discharge, the Medical Records Manager shall notify the Medical Staff member by certified, receipted mail that his/her privileges to admit or attend patients shall be suspended 7 days from the date of notice, and such Medical Staff members shall remain suspended until the records have been completed. The admitting office shall be notified of this action. Ongoing care of patients already in the Hospital may be continued. The suspended member shall not care for any patients other than those currently admitted under his/her own name and may not provide consults on Hospital or emergency room patients. If the suspended member is on call, he/she is responsible for finding another physician to see any patients requiring care while he/she is

on call. Suspension of admitting privileges does not affect the Medical Staff member's privilege to provide patient care in emergency circumstances when the suspended member is the only provider available to provide that necessary care. Any member whose privileges have been suspended for failure to complete medical records in a timely fashion for a total of thirty (30) days or longer in a twelve (12) month period may be reported to the Medical Board of California by the Chief Executive Officer, pursuant to California Business and Professions Code section 805 and the National Practitioner Data Bank.

4.13 LONG TERM CARE

4.13-1 Physicians must visit their Long Term Care residents in the Extended Care Center (ECC) as needed and at least every 30 days unless there is an alternate schedule. Any change of condition must be documented in the progress notes. Progress notes and orders must be signed and dated at the time of the visit. Histories and physicals must be updated yearly. Histories and Physicals for residents, and updated Histories and Physicals for residents returning to ECC from Acute must be completed within 48 hours of admission to ECC. Failure to comply with the above constitutes a deficiency. Physicians will be notified by the Extended Care Center Director of Nursing, in writing, of any Extended Care Center record deficiencies. address the matter as warranted. A suspension may be imposed pending correction of the deficiency.

4.14 VERBAL AND WRITTEN ORDERS

4.14-1 All orders for treatment shall be in writing. Verbal orders are to be used infrequently. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom the orders were dictated, with the name of the ordering practitioner per his/her own name noted. The date and time the orders were received shall also be noted. The responsible prescriber or another practitioner who is responsible for the care of the patient and is authorized to write orders shall authenticate such orders by signature, date and time, within 48 hours. Duly authorized persons who may receive verbal orders or telephone orders for orders within their scope of practice are licensed registered nurses, licensed vocational nurses, occupational therapists, speech therapists, pharmacists, laboratory technologists, respiratory therapists, physical therapists, and medical nutritional therapists.

4.14-2 A practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4.14-3 Surgery Orders: All previous orders are cancelled when patients are transferred to surgery.

4.14-3.1. Inpatient Surgical Orders.

A) Specific pre-operative orders are required for all patients going to surgery.

B) All prior inpatient orders cease when patient is taken to surgery.

C) All intraoperative orders must be authenticated at the end of surgery.

4.14-3.2. Outpatient Surgical Orders.

A) All outpatients must have pre-operative orders prior to the patient's arrival.

B) All intraoperative orders must be authenticated at the end of surgery.

C) Post-operatively, all orders must be completed.

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4.14-4 A qualified full-time, part time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist or other practitioner who performs radiology services including nuclear medicine must sign reports of his or her own interpretations.

4.14-5 Radiology Services must be provided only on the order of practitioners with clinical privileges or, consistent with State Law, other practitioners authorized by the medical staff and the governing body to order the services.

4.15 GENERAL RULES REGARDING SURGICAL CARE

4.15-1 All surgical patients must receive a pre-operative study so that an accurate diagnostic impression as well as an estimated operative risk to the patient can be clearly established prior to proceeding with the surgical treatment.

4.15-2 Surgeons must be in the operating room and ready to commence operations at the time scheduled. As the anesthesiologist will not administer anesthesia until the surgeon is present or is in the immediate area, the surgeon should arrive at least 10 minutes before the scheduled surgery. Repeated tardiness problems shall be handled by the Chair of Surgery and/or the OR supervisor and may result in the temporary restriction of scheduling privileges.

4.15-3 Surgery scheduling:

(a) Surgery shall be scheduled on the following priority situations:

(1) Emergency:

(a) Acute life threatening situation.

(b) Acute sensory or limb threatening situation - surgery must begin with all deliberate speed.

(2) Urgency: Sub acute situation where undue delay will produce irreversible damage. Surgery will begin at the earliest available time appropriate for the degree of urgency.

(3) Elective: Chronic, relapsing, or volitional situations where postponement would create no undue risk or hardship. Surgery is scheduled at a time mutually convenient for the patient, surgeon, and Hospital.

(b) Priority scheduling should appropriately reflect the patient's situation and not reflect the surgeon's situation. Abuse of priority scheduling may result in restriction or suspension of OR privileges.

4.15-4 The medical record must document a thorough physical examination prior to the performance of surgery. When the history and physical examination is not recorded prior to the time stated for the operation, the patient will not be taken into the surgical suite.

4.15-5 Except in severe emergencies, the pre-operative diagnosis and laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, there must be adequate documentation. In any emergency, the physician shall make at least a

comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

4.15-6 All anatomical parts, foreign objects and tissues removed at the operation shall be sent to the Hospital pathologist for examination excluding teeth. The pathologist's authenticated report shall be made a part of the patient's medical record.

4.15-7 All tissues of potential diagnostic value removed in the Emergency Department shall be sent to the Hospital pathologist for examination. Other tissues, such as fragments from debridement of wounds, foreign bodies, etc., removed in the Emergency Department shall be submitted to the Hospital pathologist at the discretion of the physician performing the removal excluding teeth.

4.15-8 Written and signed surgical consents shall be obtained prior to the operative procedure except in situations wherein the patient's life is in jeopardy, when suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a temporarily or permanently incompetent adult or minor for whom consent for surgery cannot be immediately obtained, the circumstances should be fully explained in the patient's medical record.

4.15-9 The surgeon should exercise professional judgment in selecting an assistant who is capable of safely concluding the procedure if necessary.

4.15-10 Oral and maxillofacial surgeons may admit and perform history and physical examinations without supervision as long as they provide documentation of training and experience and are granted the clinical privilege to do so. Otherwise, a patient admitted for dental or podiatric care is a dual responsibility involving the dentist and/or podiatrist and a physician member of the Medical Staff.

(a) Dentist and podiatrist responsibilities:

(1) A detailed dental and/or podiatric history justifying the Hospital admission.

(2) A detailed description of the examination of the oral cavity/lower extremity and a pre-operative diagnosis.

(3) A complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues with the exception of teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes pertinent to the oral/podiatric condition.

(5) Clinical resume statement at the time of discharge.

(b) Physician's responsibilities:

(1) A medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general medical status while hospitalized.

(c) The discharge of patients shall be on written order of the dentist and/or podiatrist

member of the Medical Staff with the written concurrence of the attending physician involved.

4.15-11 Operations shall be scheduled through the surgical services office, or with the appropriate nursing shift supervisor. A surgical log shall be maintained for the scheduling of all surgeries. The surgical assistant, if required, shall be stated at the time surgery is scheduled.

4.15-12 For all outpatient surgical cases, local post-operative coverage will be provided by the attending Medical Staff member or by an alternate Medical Staff member by pre-arrangement.

4.15-13 A complete admission history and physician examination shall be recorded within 24-hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports may be used In lieu of the admission history and report of the physician examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours prior to commencing ~~the surgery~~ any invasive procedure, or a procedure requiring anesthesia services. All such outside records shall be on a form approved by the Hospital and compatible with the current medical records system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the hospital's medical records.

4.16 GENERAL RULES REGARDING ANESTHESIA CARE

4.16-1 A pre anesthesia evaluation (is documented) by an individual qualified to administer anesthesia performed within 48 hours prior to surgery. Anesthesia is defined as general, regional, or MAC. The pre anesthesia evaluation documentation must include the following:

- 4.16-1.1 A patient interview to assess medical history, anesthetic history and medication history, and allergy history, including anesthesia risk.
- 4.16-1.2 An appropriate physician exam that includes, at a minimum airway assessment, a pulmonary exam to include auscultation of the lungs, and a cardiovascular exam.
- 4.16-1.3 Review of objective diagnostic data.
- 4.16.1-4 Assignment of ASA physical status.
- 4.16.1-5 The anesthesia plan and discussion of risks and benefits of the plan with the patient or the patient’s legal representative.
- 4.16.1-6 Assessment of pain management using visual scale of zero to ten or the “FACES” tool for children.

4.16-2 There is an intra-operative Anesthesia Record. This record accurately reflects critical techniques, management, and patient responses including condition at the end of the anesthetic. The intra operative anesthesia record must include the following time-based record of events.

- 4.16-2.1 Immediate review prior to initiation of anesthetic procedures including patient re-evaluation and a check of equipment, drugs and gas supply.
- 4.16-2.2 Monitoring of the patient.
- 4.16-2.3 Amounts of drugs and agents used, and times of administration.
- 4.16-2.4 The types and amounts of intravenous fluids used, including blood and

blood products, and times of administration.
4.16-2.5 The techniques used.
4.16-2.6 Unusual events during the administration of anesthesia.
4.16-2.7 The status of the patient at the conclusion of anesthesia.

4.**16-3** With respect to inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. For the outpatient surgical patient, this post anesthesia assessment must be done prior to discharge from the facility. At a minimum, the post anesthesia assessment follow up report documents the following:
4.16-3.1 Cardiopulmonary status.
4.16-3.2 Level of consciousness.
4.16-3.3 Any follow up care and/or observations, and patient instructions.
4.16-3-4 Any complications occurring during post-anesthesia recovery.

4.17 GENERAL RULES REGARDING HOME CARE

4.17-1 Patients requiring home care services shall have a written order from the attending physician. Such orders shall be reviewed at least every sixty (60) days.

4.17-2 Treatment plans shall be signed by the physician no later than thirty (30) days after initiation of service.

4.18 GENERAL RULES REGARDING EMERGENCY CARE

4.18-1 All patients who present to the Emergency Department of either Tahoe Forest Hospital or IVCH shall be given a medical screening examination by an Emergency Department physician. Patients determined to have an emergency medical condition shall be given such stabilizing treatment as necessary within the capabilities of the facility, including consultation and treatment by specialty physicians if applicable. Any discharge or transfer of emergency patients shall be done in accordance with the Hospital's policy regarding the treatment and transfer of emergency patients. Such policy shall be in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Classifications of staff who may conduct medical screening examinations in accordance with EMTALA shall include: (a) in the Emergency Department, licensed physicians in accordance with their privileges; and (b) in the Women and Family Center, licensed physicians in accordance with their privileges and registered nurses who have been approved to perform such examinations based on demonstrated competence and action pursuant to approved standardized procedures.

4.18-2 Medical Staff members shall provide call coverage according to schedules drawn up by the Chiefs of the Anesthesia, Medicine, Ob/Pediatrics and Surgical Departments for Tahoe Forest Hospital, and by the IVCH Committee's Chair or designee.

4.18-3 A physician on call, upon being called for an acute emergency patient, must respond within 30 minutes.

4.18-4 **~~Should a difference of opinion exist between the referring emergency physician and the on-call doctor as to patient management and disposition, the emergency physician, being physically present and responsible for the patient's care, shall direct the immediate patient management. Decisions shall primarily reflect what is best for the patient. When resolutions of the differing opinions are not immediately achieved and the on-call specialist continues to disagree on the need for his/her treatment, the~~**

~~**emergency doctor may:**~~

~~(a) Contact the relevant Department chairperson for assistance in resolving the matter or,~~

~~(b) Call another appropriate physician from the on-call roster.~~

~~Issues raised by the conflicting opinions shall be discussed at the next Departmental meeting with additional referral to the Medical Executive Committee as needed.~~

Should a difference of opinion exist between the referring emergency physician and the on-call physician as to the need for the latter to come in and personally evaluate the patient, the emergency physician, being physically present and responsible for the patient's care, shall decide that issue.

If the on-call physician comes in and personally evaluates the patient, and there is a difference of clinical opinion with the emergency physician with respect to stabilization, treatment, and/or transfer (including discharge) that the on-call physician and emergency physician are unable to resolve, either of them may contact the on-call physician's Department chairperson for assistance in resolving the matter. This may include having the on-call physician assume the responsibility for the patient, arranging for another appropriate physician who may be available to evaluate the patient, or other means of resolving the difference of opinion.

All decisions shall be based on a good-faith determination of what is best for the patient, taking into account the nature and seriousness of the patient's condition(s), the capabilities of the hospital, the on-call physician's scope of clinical privileges, emergency department policies and EMTALA obligations, and any other relevant clinical factors. Pending the resolution of the dispute, the emergency physician, in consultation with the on-call physician, shall be responsible for further evaluation, monitoring and treatment for the patient.

If these options are not pursued or do not result in a resolution that meets the immediate needs of the patient involved, the emergency physician and the on-call physician shall be obligated to meet their respective responsibilities as described above. Residual issues or disputes shall be reported to the appropriate Department chairperson(s) and/or the Chief of Staff for resolution through the Medical Staff's peer review process

4.18-5 Any on-call Medical Staff member who fails to respond in a timely manner or who refuses to consult on and attend an emergency patient at the request of the Emergency Department physician shall be subject to corrective action by the Medical Executive Committee, in accordance with the Medical Staff Bylaws.

4.18-6 Out of town practitioners who are not members of the Medical Staff shall not use the Emergency Department to care for any patients, friends or relatives. All practitioners wishing to utilize the Emergency Department must submit applications and satisfy all other requirements for staff privileges as stated in the Medical Staff Bylaws and these Rules.

4.18-7 An appropriate medical record shall be kept for every patient receiving emergency service and this record shall be incorporated into the patient's records, if such exists. The records shall include:

(a) Adequate patient information.

(b) Information concerning the time of the patient's arrival.

(c) Pertinent history of the injury or illness including details relative to first aid or

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emergency care given to the patient prior to his arrival at the Hospital.

(d) Description of significant clinical, laboratory, and radiographic findings.

(e) Diagnosis.

(f) Treatment given.

(g) Condition of the patient on discharge or transfer.

(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

(I) Method of arrival.

4.18-8 Each patient's medical record shall be signed by the physician in attendance who is responsible for its clinical accuracy.

4.18-9 The above provisions are to be read in conjunction with applicable Hospital Policies relating to the provision of emergency care, including but not necessarily limited to those entitled "Notification of On-Call Physicians, DED-20," and "Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, AGOV-18."

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4.19 **Rehabilitative Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology)**

4.19-1 Rehabilitative Services must be provided by individuals who are licensed as specified in the California Business & Professions Code for the functions to be performed. A licensed physical therapist, occupational therapist or speech therapist may be authorized by the Medical Staff, through the process described in the Allied Health Professional Manual, to hold and exercise such privileges as are consistent with the scope of his or her license and the hospital licensing laws. These privileges shall include, but not necessarily be limited to, the authority to receive and implement orders as described below.

4.19-2 Rehabilitative Services must be furnished in accordance with a written plan of treatment, and in accordance with the orders of duly authorized practitioners. The orders must be incorporated in the patient's medical record.

4.19-3 The initial order for Rehabilitative Services must be issued in writing by a physician, who shall retain overall responsibility for the patient's care. The order should state the reasons for the referral, and may specify: "Evaluate patient, develop a plan of care, and implement plan." It may also be more limited in scope or more detailed, at the discretion of the physician. It may not state, simply: "Evaluate and treat." Pre-printed orders may be approved by the Medical Executive Committee to enhance the efficiency of the ordering process.

4.19-4 If the physician's order provides for the therapist to develop and implement a plan of care, the therapist shall document the plan in the medical record, and shall collaborate with the physician before the plan is implemented or modified. The documented plan shall include the type, amount, frequency and duration of the service to be provided, and indicate the diagnosis and anticipated goals. The physician's approval of the plan or modification, which may be conveyed orally while collaborating with the therapist, shall be documented by the therapist in the medical record.

4.20 CRITICAL/INTENSIVE CARE UNIT:

4.20-1. The intensive care unit (ICU) has been established to provide a facility for the intensive care of the critically ill patient; to improve the actual nursing care by concentrating personnel specifically qualified for this type of service and by making available in one place all commonly used emergency drugs, instruments, and supplies necessary for the proper care of critically ill patients; to serve as a recovery room for postoperative patients at times when the recovery room is closed; and to provide assurance for the physicians that their patients will be receiving the best continuous care available within the most economical means of the patient and the hospital.

4.20-2 The admitting physician will consult appropriate specialist(s). Proper critical care requires coverage for each case by appropriate medical and surgical specialties.

ARTICLE V

DISASTER PLANNING

5.1 DISASTER PLANNING (Detailed information about the TFHD emergency preparedness procedure is referenced in hospital policy.)

5.1-1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency programs in the community. It shall be developed by a disaster planning committee. Membership shall include a member of the medical staff, the nurse executive, or designee, and a representative from hospital administration. The disaster plan shall be approved by the Executive Committee and the governing board.

5.1-2 The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing and other hospital personnel. Actual evacuation of patients during drills is optional. There should be a written report and evaluation of all drills.

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ARTICLE VI

NEW PHYSICIAN ORIENTATION

6.1 NEW PHYSICIAN ORIENTATION

6.1-1 Orientation is mandatory for all new members to the medical staff, except for those appointed to the Honorary Staff.

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

Thursday, September 27, 2018 at 4:00 p.m.

Eskridge Conference Room - Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

Meeting was called to order at 4:00 p.m.

2. ROLL CALL

Board: Dale Chamblin, Board President; Randy Hill, Vice President; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Crystal Betts, Chief Financial Officer; Judy Newland, Chief Operating Officer; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel,

Charles Zipkin, M.D., Treasurer, and Jake Dorst, Chief Information and Innovation Officer participated via phone.

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

Item 15.3.3. will be pulled from the consent calendar and discussed under item 18.

4. INPUT AUDIENCE

No public comment was received.

5. CLOSED SESSION

Closed Session convened at 4:04 p.m.

5.1. Report Involving Trade Secrets (Health & Safety Code § 32106)

Discussion will concern: Proposed new programs and facilities
Estimated date of disclosure: September 2019

Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)◈

Subject Matter: Second Quarter 2018 Quality Report
Number of items: One (1)

Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)

Subject Matter: Quality Assurance Reports
Number of items: Two (2)

Discussion was held on a privileged item.

5.4. Approval of Closed Session Minutes◈
08/23/2018
Discussion was held on a privileged item.

5.5. TIMED ITEM – 5:30PM – Hearing (Health & Safety Code § 32155)◈
Subject Matter: Medical Staff Credentials
Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER
Meeting reconvened at 6:17 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported the Board considered five items in closed session. There was no reportable action taken on items 5.1 through 5.3. Items 5.4 and 5.5 were both approved on 4-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Board President noted item 15.3.3. no longer needed to be pulled.

10. INPUT – AUDIENCE
No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS
Public comment was received from Juan Abarca-Sanchez.

12. SAFETY FIRST
12.1. Chief Operating Officer Judy Newland presented the September Safety First Topic on the District's recent active shooter drill.

13. ACKNOWLEDGMENTS
13.1. Thank you to Wellness Neighborhood for Truckee Thursdays Baby Station.
13.2. Stephen Hicks was named September 2018 Employee of the Month.
13.3. Jake Dorst named on Becker's Community Hospital CIOs to Know 2018 list.
13.4. Tahoe Forest Hospital named in Becker's Hospital Review's 2018 List of "Critical Access Hospitals to Know".
13.5. National Customer Service Week is October 1-5, 2018.

14. MEDICAL STAFF EXECUTIVE COMMITTEE◈
14.1. Medical Executive Committee (MEC) Meeting Consent Agenda
MEC recommends the following for approval by the Board of Directors: *Policies and Procedures: Immunizations/Vaccinations for Medical Staff and Allied Health Professional Staff, MSGEN-1603 [Revised]*
Discussion was held.

ACTION: **Motion made by Director Brown, seconded by Director Wong, to approve the Policies and Procedures: Immunizations/Vaccinations for Medical Staff and Allied Health Professional Staff, MSGEN-1603 [Revised] as presented.**
No public comment was received.
AYES: Directors Brown, Wong, Hill and Chamblin
Abstention: None
NAYS: None
Absent: Zipkin

15. 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.

15.1. Approval of Minutes of Meetings
- **15.1.1.** 08/23/2018
- **15.1.2.** 09/12/2018

15.2. Financial Reports
- **15.2.1.** Financial Report – August 2018

15.3. Staff Reports
- **15.3.1.** CEO Board Report
- **15.3.2.** COO Board Report
- **15.3.3.** CNO Board Report
- **15.3.4.** CIIO Board Report
- **15.3.5.** CMO Board Report

15.4. Policy Review
- **15.4.1.** ABD-11 Fiscal Policy
- **15.4.2.** ABD-23 Post-Issuance Compliance Procedure for Outstanding Tax-Exempt Bonds

ACTION: **Motion made by Director Wong, seconded by Director Hill, to approve the Consent Calendar as presented.**
AYES: Directors Brown, Wong, Hill and Chamblin
Abstention: None
NAYS: None
Absent: Zipkin

16. ITEMS FOR BOARD ACTION◈

16.1. Resolution 2018-08◈

Crystal Betts, Chief Financial Officer, and Gary Hicks, TFHD's Financial Advisor, presented a resolution for proposed equipment financing.

ACTION: **Motion made by Director Brown, seconded by Director Hill, to approve Resolution 2018-08 as presented.**
Public comment was received from Juan Abarca-Sanchez.
Roll call vote taken.
Brown – AYE
Wong – AYE
Hill – AYE

Chamblin – AYE
Zipkin - Absent

16.2. Community Health Improvement Plan (CHIP)◈

Karen Baffone, Chief Nursing Officer, presented the 2018 Community Health Improvement Plan. Discussion was held.

ACTION: **Motion made by Director Hill, seconded by Director Brown, to accept the Community Health Improvement Plan as presented.**
AYES: Directors Brown, Wong, Hill and Chamblin
Abstention: None
NAYS: None
Absent: Zipkin

16.3. Award of Construction Bid◈

Dylan Crosby, Manager of Construction and Facilities, and Jason Shakespeare, Project manager with Geney Gassiot, presented construction bids for the demolition and paving of 10054 Pine Avenue. Discussion was held.

ACTION: **Motion made by Director Brown, seconded by Director Wong, to award the construction bid as presented.**
Counsel noted for the record that Director Zipkin is participating by phone but cannot vote.
AYES: Directors Brown, Wong, Hill and Chamblin
Abstention: None
NAYS: None
Absent: Zipkin

16.4. 2019-2021 Strategic Plan Approval◈

COO and Karma Bass of VIA Healthcare Consulting presented the draft 2019-2021 Strategic Plan. Discussion was held.

ACTION: **Motion made by Director Wong, seconded by Director Hill, to approve the Strategic Plan Framework as presented.**
No public comment was received.
AYES: Directors Brown, Wong, Hill and Chamblin
Abstention: None
NAYS: None
Absent: Zipkin

17. ITEMS FOR BOARD DISCUSSION

17.1. Recap of Governance Institute Leadership Conference

Discussion was held on the board's attendance at a recent Governance Institute Leadership Conference.

Director Chamblin and Director Wong will send their top 5 conference takeaways to Clerk of the Board for distribution at Governance Committee.

Discussion was held.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY
None.

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

19.1. Finance Committee Meeting – 09/21/2018
Director Brown noted the topic of the last Finance Committee was already addressed in item 16.1.

19.2. Governance Committee Meeting – Meeting scheduled for September 28, 2018.
Update will take place at October board meeting.

19.3. Executive Compensation Committee Meeting – No meeting held in September.

19.4. Quality Committee Meeting – No meeting held in September.

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS
None.

21. ITEMS FOR NEXT MEETING
-Juan Abarca-Sanchez asked the Board to consider bringing its board meetings back to hospital.

22. BOARD MEMBERS REPORTS/CLOSING REMARKS
None.

23. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

24. OPEN SESSION

25. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
Not applicable.

26. ADJOURN
Meeting adjourned at 7:29 p.m.

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Monday, October 8, 2018 at 9:00 a.m.
Tahoe Conference Room – Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 9:00 a.m.

2. ROLL CALL
Board: Dale Chamblin, Board President; Randy Hill, Vice President; Chuck Zipkin, Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Ted Owen, Executive Director of Governance and Business Development; Martina Rochefort, Clerk of the Board

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. ITEMS FOR BOARD DISCUSSION
5.1. Recap of Governance Institute Leadership Conference
The Board of Directors discussed their takeaways from a recent Governance Institute Leadership Conference.

Discussion was held.

Dr. Shawni Coll, Chief Medical Officer, joined the meeting at 9:35 a.m.

The board felt important topics to focus on were:
- Loyalty building
- Technology
- Consumerism
- Service
- Millennials

CMO departed and continued to participate via phone at 10:00 a.m.

The board would like to have a more thorough report from the Wellness Neighborhood.

6. ADJOURN
Meeting adjourned at 10:50 a.m.

TAHOE FOREST HOSPITAL DISTRICT
SEPTEMBER 2018 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

SEPTEMBER 2018 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the three months ended September 30, 2018.

Activity Statistics

- TFH acute patient days were 561 for the current month compared to budget of 483. This equates to an average daily census of 18.70 compared to budget of 16.10.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Surgical cases, Laboratory tests, Diagnostic Imaging, Mammography, Nuclear Medicine, MRI, Cat Scan, Pharmacy units, Respiratory Therapy, Endoscopy procedures, Physical Therapy, and Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 47.0% in the current month compared to budget of 53.9% and to last month's 51.3%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 49.8%, compared to budget of 53.6% and prior year's 54.4%.

- EBIDA was $1,963,786 (6.6%) for the current month compared to budget of $966,241 (3.9%), or $997,545 (2.7%) above budget. Year-to-date EBIDA was $7,158,158 (8.1%) compared to budget of $3,845,953 (4.9%), or $3,312,205 (3.4%) above budget.

- Cash Collections for the current month were $11,013,331 which is 78% of targeted Net Patient Revenue. We have resolved the issue with the post office returning mail to our payors since mid-August and started to receive the reissued payments the first two weeks of October.

- EPIC Gross Accounts Receivables were $77,835,025 at the end of September compared to $68,240,466 at the end of August. Legacy Gross Accounts Receivable was $2,150,546 at the end of September compared to $2,342,027 at the end of August, a reduction of $191,481.

Balance Sheet

- Working Capital Days Cash on Hand is 8.4 days. S&P Days Cash on Hand is 152.0. Working Capital cash increased $958,000. Accounts Payable increased $848,000, Accrued Payroll & Related Costs increased $295,000, and cash collections fell short of target by 22%.

- Net Patients Accounts Receivable increased approximately $4,042,000 and Cash collections were at 78% of target. EPIC Days in A/R at the close of September were 82.0.

- Estimated Settlements, Medi-Cal and Medicare decreased $2,861,000 after booking an amount received from the State for the SFY2016-2017 Outpatient Supplemental Reimbursement receivable booked at the close of FY19.

- The District booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of September.

- Accounts Payable increased $848,000 due to the timing of the final check run in September.

- Accrued Payroll & Related Costs increased a net $295,000.

- Estimated Settlements, Medi-Cal and Medicare increased $160,000 after booking an amount due to the Medicare program for overpayment on Part A (Inpatient) claims

Operating Revenue

- Current month's Total Gross Revenue was $29,659,761, compared to budget of $24,645,823 or $5,013,938 above budget.
- Current month's Gross Inpatient Revenue was $8,842,224, compared to budget of $6,271,945 or $2,570,280 above budget.
- Current month's Gross Outpatient Revenue was $20,817,536 compared to budget of $18,373,878 or $2,443,658 above budget.
- Current month's Gross Revenue Mix was 42.6% Medicare, 13.5% Medi-Cal, .0% County, 4.8% Other, and 39.1% Insurance compared to budget of 36.3% Medicare, 17.4% Medi-Cal, .0% County, 3.8% Other, and 42.5% Insurance. Last month's mix was 41.0% Medicare, 14.6% Medi-Cal, .0% County, 3.5% Other, and 40.9% Insurance. Year-to-date Gross Revenue Mix was 41.1% Medicare, 15.2% Medi-Cal, .0% County, 3.6% Other, and 40.1% Insurance.
- Current month's Deductions from Revenue were $15,718,973 compared to budget of $11,371,044 or $4,347,928 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 6.29% increase in Medicare, a 3.96% decrease to Medi-Cal, County at budget, a 1.07% increase in Other, and Commercial was below budget 3.41%, 2) Revenues exceeded budget by 20.3%, and 3) a large number of outsourced Self-pay accounts were returned to the District in a status of Bad Debt.

DESCRIPTION	September 2018 Actual	September 2018 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	4,622,630	4,963,697	341,068	Positive variance in Salaries and Wages, offset in part, by an increased usage of Paid Leave and Long-term Sick. We are also seeing a positive variance in wages against budget estimates.
Employee Benefits	1,496,961	1,429,026	(67,936)	
Benefits – Workers Compensation	62,141	55,820	(6,320)	
Benefits – Medical Insurance	647,765	598,402	(49,364)	We saw greater usage of our self-insured health insurance in September, causing a negative variance in Benefits-Medical Insurance.
Professional Fees	2,090,093	2,193,657	103,564	We saw positive variances in Physician RVU bonuses and the timing of new physicians onboarding, Managed Care, Human Resources, and Financial Administration professional fees.
Supplies	2,169,184	1,870,002	(299,183)	Negative variance in Supplies related to Medical Supplies Sold to Patients. Revenues exceeded budget by 54.49%.
Purchased Services	1,199,277	1,309,845	110,569	Positive variance in Purchased Services related to decrease usage of classes at the Center, Wellness Bank dollars, and Collection Agency fees.
Other Expenses	718,321	744,817	26,496	Controllable costs continue to be monitored closely by Senior Leadership, aiding in a positive variance in Other Expenses.
Total Expenses	13,006,372	13,165,265	158,894	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
SEPTEMBER 2018

	Sep-18	Aug-18	Sep-17	
ASSETS				
CURRENT ASSETS				
* CASH	$ 3,632,905	$ 2,675,287	$ 7,250,660	1
PATIENT ACCOUNTS RECEIVABLE - NET	32,737,636	28,695,735	18,200,267	2
OTHER RECEIVABLES	7,192,415	6,398,068	5,732,844	
GO BOND RECEIVABLES	749,772	374,886	1,211,282	
ASSETS LIMITED OR RESTRICTED	7,043,218	6,853,249	6,301,401	
INVENTORIES	3,127,024	3,123,845	3,034,352	
PREPAID EXPENSES & DEPOSITS	1,922,423	2,830,612	1,957,090	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	5,766,412	8,627,067	13,855,314	3
TOTAL CURRENT ASSETS	62,171,803	59,578,748	57,543,211	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	62,129,099	62,129,099	61,374,995	1
BANC OF AMERICA MUNICIPAL LEASE	-	-	32,222	
TOTAL BOND TRUSTEE 2017	19,973	19,973	19,779	
TOTAL BOND TRUSTEE 2015	552,027	414,930	546,496	
GO BOND PROJECT FUND	-	-	1	
GO BOND TAX REVENUE FUND	799,532	799,532	1,390,830	
DIAGNOSTIC IMAGING FUND	3,229	3,229	3,186	
DONOR RESTRICTED FUND	1,124,440	1,127,440	1,113,547	
WORKERS COMPENSATION FUND	12,765	11,137	23,146	
TOTAL	64,641,065	64,505,339	64,504,202	
LESS CURRENT PORTION	(7,043,218)	(6,853,249)	(6,301,401)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	57,597,847	57,652,091	58,202,801	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	-	-	(301,864)	
PROPERTY HELD FOR FUTURE EXPANSION	873,491	873,491	836,353	
PROPERTY & EQUIPMENT NET	166,308,420	165,548,680	130,619,249	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,822,165	1,822,165	33,816,451	
TOTAL ASSETS	288,773,726	285,475,175	280,716,202	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	455,765	458,997	494,553	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	899,886	1,063,457	1,446,560	4
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,911,973	5,935,678	6,196,430	
GO BOND DEFERRED FINANCING COSTS	462,284	464,218	485,498	
DEFERRED FINANCING COSTS	184,129	185,169	196,612	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 7,914,037	$ 8,107,519	$ 8,819,654	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,007,675	$ 5,159,382	$ 4,171,592	5
ACCRUED PAYROLL & RELATED COSTS	13,276,391	12,981,459	14,574,436	6
INTEREST PAYABLE	307,510	224,240	264,323	
INTEREST PAYABLE GO BOND	635,685	317,842	617,192	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	422,412	262,512	47,577	7
HEALTH INSURANCE PLAN	1,312,436	1,312,436	1,211,751	
WORKERS COMPENSATION PLAN	1,886,757	1,886,559	1,703,225	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,184,419	1,184,419	858,290	
CURRENT MATURITIES OF GO BOND DEBT	1,330,000	1,330,000	860,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,454,876	1,454,876	1,049,645	
TOTAL CURRENT LIABILITIES	27,818,161	26,113,725	25,358,031	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	25,515,259	25,517,831	27,350,537	
GO BOND DEBT NET OF CURRENT MATURITIES	100,950,875	100,964,295	102,726,923	
DERIVATIVE INSTRUMENT LIABILITY	899,886	1,063,457	1,446,560	4
TOTAL LIABILITIES	155,184,180	153,659,308	156,882,050	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	140,379,143	138,795,947	131,540,258	
RESTRICTED	1,124,440	1,127,440	1,113,547	
TOTAL NET POSITION	$ 141,503,583	$ 139,923,387	$ 132,653,805	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
SEPTEMBER 2018

1. Working Capital is at 8.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 152.0 days. Working Capital cash increased a net $958,000. Accounts Payable increased $848,000 (See Note 5), Accrued Payroll & Related Costs increased $295,000 (See Note 6), and Cash Collections fell short of target by 22%.

2. Net Patient Accounts Receivable increased approximately $4,042,000 and Cash collections were 78% of target. EPIC Days in A/R were 82.00 compared to 79.00 at the close of August, a 3.00 days increase. We have worked through our issue with the post office that was causing return mail to our payors since mid-August. Payors reissued payments which we started to receive the first weeks of October. We are also seeing an increase to Net Patient A/R as a result of working through claim corrections.

3. Estimated Settlements, Medi-Cal and Medicare decreased a net $2,861,000 after receiving payment on the SFY2016-2017 Medi-Cal Outpatient Supplemental Reimbursement program which was booked as a receivable at the close of FY18.

4. To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of September.

5. Accounts Payable increased $848,000 due to the timing of the final check run in the month.

6. Accrued Payroll & Related Costs increased a net $295,000.

7. Estimated Settlements, Medi-Cal and Medicare increased $160,000 after booking an amount due to the Medicare program for overpayment of Part A claims for the first quarter of FY19.

Tahoe Forest Hospital District
Cash Investment
September 2018

WORKING CAPITAL				
US Bank	$ 2,516,774			
US Bank/Kings Beach Thrift Store	20,974			
US Bank/Truckee Thrift Store	82,666			
US Bank/Payroll Clearing	6,374			
Umpqua Bank	1,006,116	0.40%		
Total			$	3,632,905
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	62,129,099	2.06%		
Local Agency Investment Fund			$	62,129,099
Banc of America Muni Lease			$	-
Bonds Cash 2017			$	19,973
Bonds Cash 2015			$	552,027
GO Bonds Cash 2008			$	799,532
DX Imaging Education	$ 3,229			
Workers Comp Fund - B of A	12,765			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	15,994
TOTAL FUNDS			$	67,149,530
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,365	0.03%		
Foundation Restricted Donations	34,641			
Local Agency Investment Fund	1,081,434	2.06%		
TOTAL RESTRICTED FUNDS			$	1,124,440
TOTAL ALL FUNDS			$	68,273,970

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
SEPTEMBER 2018

	Current Status	Desired Position	Target	Bond Covenants	FY 2019 Jul 18 to Sept 2018	FY 2018 Jul 17 to June 2018	FY 2017 Jul 16 to June 2017	FY 2016 Jul 15 to June 16	FY 2015 Jul 14 to June 15	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13
Return On Equity: Increase (Decrease) in Net Position / Net Position		⇧	3.7%		4.2%	5.1%	14.4%	10.9%	2.19%	.001%	-4.0%
EPIC Days in Accounts Receivable (excludes SNF, Home Health & Hospice) Gross Accounts Receivable / 90 Days		⇩	FYE 63 Days		81	68	55	57	60	75	97
Gross Accounts Receivable / 365 Days					82	73	55	55	62	75	93
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments / (Total Expenses - Depreciation Expense)/ by 365	 	⇧	Budget FYE 146 Days Budget 1st Qtr 160 Days Actual 1st Qtr 152 Days	60 Days A- 203 Days BBB- 142 Days	152	176	191	201	156	164	148
EPIC Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)		⇩	13%		29%	22%	17%	19%	18%	22%	29%
EPIC Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)		⇩	18%		33%	25%	18%	24%	23%	25%	34%
Cash Receipts Per Day (based on 60 day lag on Patient Net Revenue) excludes managed care reserve	 	⇧	FYE Budget $431,753 End 1st Qtr Budget $407,798 End 1st Qtr Actual $414,041		$383,346	$333,963	$348,962	$313,153	$290,776	$286,394	$255,901
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation / Debt Principal Payments + Interest Expense		⇧	Without GO Bond 7.42 With GO Bond 1.65	1.95	13.02 2.75	9.27 2.07	6.64 3.54	6.19 2.77	3.28 1.59	2.18 1.29	.66 .89

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
SEPTEMBER 2018

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD SEPT 2017
				OPERATING REVENUE						
$ 29,659,761	$ 24,645,823	$ 5,013,938	20.3%	Total Gross Revenue	$ 88,028,670	$ 78,893,283	$ 9,135,387	11.6%	1	$ 67,872,351
				Gross Revenues - Inpatient						
$ 3,160,292	$ 2,448,079	$ 712,213	29.1%	Daily Hospital Service	$ 8,967,426	$ 7,694,616	$ 1,272,809	16.5%		$ 6,142,138
5,681,932	3,823,866	1,858,067	48.6%	Ancillary Service - Inpatient	14,912,771	12,524,737	2,388,034	19.1%		11,016,976
8,842,224	6,271,945	2,570,280	41.0%	Total Gross Revenue - Inpatient	23,880,197	20,219,353	3,660,843	18.1%	1	17,159,114
20,817,536	18,373,878	2,443,658	13.3%	Gross Revenue - Outpatient	64,148,473	58,673,930	5,474,543	9.3%		50,713,237
20,817,536	18,373,878	2,443,658	13.3%	Total Gross Revenue - Outpatient	64,148,473	58,673,930	5,474,543	9.3%	1	50,713,237
				Deductions from Revenue:						
13,796,365	10,314,786	(3,481,579)	-33.8%	Contractual Allowances	40,675,860	33,131,719	(7,544,142)	-22.8%	2	28,649,404
933,485	768,795	(164,690)	-21.4%	Charity Care	2,861,100	2,496,501	(364,599)	-14.6%	2	2,152,050
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	63,941
989,123	287,463	(701,660)	-244.1%	Bad Debt	740,931	958,321	217,390	22.7%	2	89,154
-	-	-	0.0%	Prior Period Settlements	(95,577)	-	95,577	0.0%	2	(14,430)
15,718,973	11,371,044	(4,347,928)	-38.2%	Total Deductions from Revenue	44,182,314	36,586,541	(7,595,773)	-20.8%		30,940,118
85,651	86,780	1,129	1.3%	Property Tax Revenue- Wellness Neighborhood	225,984	263,163	(37,179)	-14.1%		203,279
943,719	769,948	173,771	22.6%	Other Operating Revenue	2,593,477	2,309,143	284,334	12.3%	3	1,865,627
14,970,158	14,131,507	838,651	5.9%	TOTAL OPERATING REVENUE	46,665,817	44,879,048	1,786,768	4.0%		39,001,139
				OPERATING EXPENSES						
4,622,630	4,963,697	341,068	6.9%	Salaries and Wages	14,247,914	15,646,841	1,398,927	8.9%	4	12,954,794
1,496,961	1,429,026	(67,936)	-4.8%	Benefits	4,652,972	4,451,478	(201,494)	-4.5%	4	4,191,491
62,141	55,820	(6,320)	-11.3%	Benefits Workers Compensation	169,421	167,461	(1,959)	-1.2%	4	160,141
647,765	598,402	(49,364)	-8.2%	Benefits Medical Insurance	2,248,776	1,795,205	(453,572)	-25.3%	4	2,316,910
2,090,093	2,193,657	103,564	4.7%	Professional Fees	6,363,485	6,479,157	115,672	1.8%	5	5,269,363
2,169,184	1,870,002	(299,183)	-16.0%	Supplies	6,300,556	6,318,365	17,810	0.3%	6	4,994,617
1,199,277	1,309,845	110,569	8.4%	Purchased Services	3,526,637	4,100,401	573,764	14.0%	7	3,250,741
718,321	744,817	26,496	3.6%	Other	1,997,899	2,074,186	76,287	3.7%	8	1,760,500
13,006,372	13,165,265	158,894	1.2%	TOTAL OPERATING EXPENSE	39,507,659	41,033,096	1,525,437	3.7%		34,898,558
1,963,786	**966,241**	**997,545**	**103.2%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**7,158,158**	**3,845,953**	**3,312,205**	**86.1%**		**4,102,581**
				NON-OPERATING REVENUE/(EXPENSE)						
557,307	556,178	1,129	0.2%	District and County Taxes	1,702,890	1,665,712	37,179	2.2%	9	1,316,221
374,886	374,886	0	0.0%	District and County Taxes - GO Bond	1,124,657	1,124,657	0	0.0%		1,212,038
122,994	126,491	(3,497)	-2.8%	Interest Income	365,542	386,059	(20,516)	-5.3%	10	214,479
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
36,846	93,711	(56,865)	-60.7%	Donations	36,846	267,633	(230,787)	-86.2%	11	-
-	-	-	0.0%	Gain/ (Loss) on Joint Investment	-	-	-	0.0%	12	-
-	-	-	0.0%	Loss on Impairment of Asset	-	-	-	0.0%	12	-
1,000	-	1,000	0.0%	Gain/ (Loss) on Sale of Equipment	1,000	-	1,000	0.0%	13	-
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(1,059,977)	(1,059,977)	(0)	0.0%	Depreciation	(3,179,931)	(3,179,931)	(0)	0.0%	15	(2,902,069)
(86,584)	(87,091)	507	0.6%	Interest Expense	(293,375)	(261,273)	(32,102)	-12.3%	16	(246,681)
(330,061)	(312,044)	(18,017)	-5.8%	Interest Expense-GO Bond	(980,747)	(938,161)	(42,586)	-4.5%		(964,531)
(383,590)	(307,846)	(75,744)	-24.6%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(1,223,117)	(935,304)	(287,813)	-30.8%		(1,370,544)
$ 1,580,196	**$ 658,395**	**$ 921,801**	**140.0%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 5,935,041**	**$ 2,910,649**	**$ 3,024,392**	**103.9%**		**$ 2,732,037**
				NET POSITION - BEGINNING OF YEAR	**135,568,542**					
				NET POSITION - AS OF SEPTEMBER 30, 2018	**$ 141,503,583**					
6.6%	**3.9%**	**2.7%**		**RETURN ON GROSS REVENUE EBIDA**	**8.1%**	**4.9%**	**3.4%**			**6.0%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
SEPTEMBER 2018

		Variance from Budget Fav / <Unfav> SEPT 2018	YTD 2019
1) Gross Revenues			
Acute Patient Days were above budget 16.35% or 79 days. Swing Bed days were over budget 94.73% or 18 days. Inpatient Ancillary revenues exceeded budget by 48.60% due to the increase in Acute and Swing Bed patient days.	Gross Revenue -- Inpatient	$ 2,570,280	$ 3,660,843
	Gross Revenue -- Outpatient	2,443,658	5,474,543
	Gross Revenue -- Total	$ 5,013,938	$ 9,135,387
Outpatient volumes were above budget in the following departments: Emergency Department visits, Surgical cases, Medical Supplies Sold to Patients, Laboratory tests, Diagnostic Imaging, Nuclear Medicine, MRI, Cat Scan, Mammography, Pharmacy units, Respiratory Therapy, Endoscopy procedures, Physical Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for September shows a 6.29% increase to Medicare, a 3.96% decrease to Medi-Cal, 1.07% increase to Other, County at budget, and a 3.41% decrease to Commercial when compared to budget. Contractual Allowances were over budget due to revenues exceeding budget by 20.3% coupled with a shift in Payor Mix from Commercial to Medicare.	Contractual Allowances	$ (3,481,579)	$ (7,544,142)
	Charity Care	(164,690)	(364,599)
	Charity Care - Catastrophic	-	-
	Bad Debt	(701,660)	217,390
	Prior Period Settlements	-	95,577
	Total	$ (4,347,928)	$ (7,595,773)
Outsourced Self-pay accounts were returned to the District in Bad Debt status in September. This has created a negative variance in Bad Debt. We continue to work with Patients and our outsourced vendor to collect on these accounts.			
3) Other Operating Revenue	Retail Pharmacy	$ 36,349	$ 93,076
Retail Pharmacy revenues exceeded budget by 17.36%.	Hospice Thrift Stores	38,297	102,349
	The Center (non-therapy)	(5,571)	(33,431)
Hospice Thrift Store revenues exceeded budget by 52.68% in September.	IVCH ER Physician Guarantee	(2,674)	52,873
	Children's Center	6,266	13,969
Rebates & Refunds and the quarterly Quality Assurance Fee received from the State exceeded budget, creating a positive variance in Miscellaneous.	Miscellaneous	101,104	55,497
	Oncology Drug Replacement	-	-
	Grants	-	-
	Total	$ 173,771	$ 284,334
4) Salaries and Wages	Total	$ 341,068	$ 1,398,927
Positive variance in Salaries and Wages partially offset by a negative variance in PL/SL. We are also seeing this area of expense coming in below budget estimations for the first quarter of FY19.			
Employee Benefits	PL/SL	$ (88,843)	$ (192,391)
Employee vacation requests for the month of September and usage of Long-term Sick created a negative variance in PL/SL.	Nonproductive	(23,781)	(148,334)
	Pension/Deferred Comp	48,836	87,009
	Standby	(10,442)	(14,385)
	Other	6,294	66,607
	Total	$ (67,936)	$ (201,494)
Employee Benefits - Workers Compensation	Total	$ (6,320)	$ (1,959)
Employee Benefits - Medical Insurance	Total	$ (49,364)	$ (453,572)
The District's health insurance plan is self-funded. We are witnessing an increased amount of employee claims being paid by our Third Party Administrator.			
5) Professional Fees	Miscellaneous	$ 1,231	$ (66,789)
Consulting work being performed for the Beacon conversion in EPIC and preparation of the Professional Billing implementation in EPIC is creating a negative variance in Information Technology.	The Center (includes OP Therapy)	1,419	(55,656)
	TFH Locums	(2,134)	(42,257)
	Information Technology	(13,302)	(20,911)
	Home Health/Hospice	(16,885)	(11,424)
Negative variance in Home Health/Hospice related to outsourced Therapist fees.	Administration	(5,577)	(7,169)
	TFH/IVCH Therapy Services	956	(4,785)
Physician RVU bonuses and timing of new physicians onboarding are falling short of budget estimations, creating a positive variance in Multi-Specialty Clinics.	IVCH ER Physicians	1,773	(1,929)
	Patient Accounting/Admitting	-	-
	Respiratory Therapy	-	-
	Medical Staff Services	(228)	845
	Marketing	(1,742)	3,008
	Multi-Specialty Clinics Administratio	738	6,295
	Corporate Compliance	2,000	7,305
	Managed Care	6,000	13,943
	Financial Administration	7,125	16,250
	Human Resources	6,702	18,302
	Oncology	2,877	20,014
	Sleep Clinic	27	30,547
	Multi-Specialty Clinics	112,584	210,083
	Total	$ 103,564	$ 115,672

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
SEPTEMBER 2018

		Variance from Budget Fav / <Unfav>	
		SEPT 2018	YTD 2019
6) Supplies	Patient & Other Medical Supplies	$ (310,396)	$ (213,240)
Medical Supplies Sold to Patients revenues exceeded budget by 54.49%, creating a negative variance in Patient & Other Medical Supplies.	Minor Equipment	1,129	(41,948)
	Food	8,699	(5,787)
	Imaging Film	42	155
	Other Non-Medical Supplies	(7,384)	20,215
	Office Supplies	3,511	28,389
	Pharmacy Supplies	5,216	230,026
	Total	$ (299,183)	$ 17,810
7) Purchased Services	Laboratory	$ (27,686)	$ (32,953)
Negative variance in Laboratory related to outsourced lab testing.	Information Technology	(11,146)	(29,019)
	Diagnostic Imaging Services - All	1,195	(22,781)
Software and Network maintenance created a negative variance in Information Technology.	Pharmacy IP	(6,929)	(2,101)
	Community Development	180	180
	Home Health/Hospice	1,000	895
Positive variance in The Center due to Sports Performance and Fitness Center classes performed by contractors coming in below budget.	Medical Records	1,553	14,803
	The Center	13,664	24,207
	Human Resources	15,058	52,383
Usage of Employee Wellness Bank dollars fell short of budget, creating a positive variance in Human Resources.	Multi-Specialty Clinics	11,046	69,688
	Patient Accounting	27,443	120,229
	Department Repairs	18,640	134,192
Collection Agency fees came in below budget estimations, creating a positive variance in Patient Accounting.	Miscellaneous	66,551	244,042
	Total	$ 110,569	$ 573,764
Purchased Services for the Emergency Department, Quality, Central Scheduling, the Wellness Neighborhood, Accounting, Laundry & Linen, Communications, and Cardiac Rehab fell short of budget, creating a positive variance in Miscellaneous.			
8) Other Expenses	Miscellaneous	$ (7,053)	$ (43,182)
On site go-live training for the Home Health/Hospice conversion to EPIC created a negative variance in Outside Training & Travel.	Outside Training & Travel	(16,996)	(36,738)
	Equipment Rent	(6,206)	(12,383)
	Other Building Rent	(3,171)	(12,060)
Negative variance in Equipment Rent related to oxygen tank rentals.	Multi-Specialty Clinics Equip Rent	36	11
	Dues and Subscriptions	1,268	574
Additional rental space for Employee Housing and the Foundation were secured after the FY19 budget was created. This is causing a negative variance in Other Building Rent.	Insurance	570	2,021
	Physician Services	628	2,082
	Multi-Specialty Clinics Bldg Rent	823	8,061
	Utilities	989	29,541
Controllable costs continue to be monitored by Senior Leadership, creating a positive variance in the remainder of the Other Expense categories.	Human Resources Recruitment	18,750	37,126
	Marketing	36,856	101,234
	Total	$ 26,496	$ 76,287
9) District and County Taxes	Total	$ 1,129	$ 37,179
10) Interest Income	Total	$ (3,497)	$ (20,516)
11) Donations	IVCH	$ (36,679)	$ (110,601)
	Operational	(20,186)	(120,186)
	Capital Campaign		
	Total	$ (56,865)	$ (230,787)
12) Gain/(Loss) on Joint Investment	Total	$ -	$ -
13) Gain/(Loss) on Sale	Total	$ 1,000	$ 1,000
15) Depreciation Expense	Total	$ -	$ -
16) Interest Expense	Total	$ 507	$ (32,102)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
SEPTEMBER 2018

	Current Status	Desired Position	Target	FY 2019 Jul 18 to Sept 18	FY 2018 Jul 17 to June 18	FY 2017 Jul 16 to June 17	FY 2016 Jul 15 to June 16	FY 2015 Jul 14 to June 15	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13
Total Margin: Increase (Decrease) In Net Position / Total Gross Revenue			FYE 1.8% 1st Qtr 3.7%	6.7%	2.6%	7.4%	5.5%	1.0%	.01%	-2.2%
Charity Care: Charity Care Expense / Gross Patient Revenue			FYE 3.1% 1st Qtr 3.2%	3.3%	3.3%	3.1%	3.4%	3.1%	3.2%	3.2%
Bad Debt Expense: Bad Debt Expense / Gross Patient Revenue			FYE .1% 1st Qtr .1%	.0%	.1%	-.0%	-.2%	1.6%	1.6%	4.6%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue			FYE 8.3% 1st Qtr 10.8%	23.3%	4.8%	7.9%	11.3%	9.1%	4.9%	11.5%
Operating Expense Variance to Budget (Under<Over>)			-0-	$1,525,437	$1,061,378	$(9,700,270)	$(7,548,217)	$(6,371,653)	$2,129,279	$(1,498,683)
EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue			FYE 2.7% 1st Qtr 4.5%	8.1%	4.5%	7.9%	7.3%	3.5%	2.0%	.9%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JUNE 2018 - PRELMINARY

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JUNE 2017
				OPERATING REVENUE						
$ 1,534,866	$ 1,586,057	$ (51,191)	-3.2%	Total Gross Revenue	$ 18,324,368	$ 19,469,494	$ (1,145,126)	-5.9%	1	$ 18,325,851
				Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%	Daily Hospital Service	$ 101,764	$ 56,574	$ 45,190	79.9%		$ 32,328
-	2,503	(2,503)	-100.0%	Ancillary Service - Inpatient	99,003	35,903	63,100	175.8%		44,416
-	2,503	(2,503)	-100.0%	Total Gross Revenue - Inpatient	200,767	92,477	108,290	117.1%	1	76,744
1,534,866	1,583,555	(48,689)	-3.1%	Gross Revenue - Outpatient	18,123,601	19,377,017	(1,253,416)	-6.5%		18,249,107
1,534,866	1,583,555	(48,689)	-3.1%	Total Gross Revenue - Outpatient	18,123,601	19,377,017	(1,253,416)	-6.5%	1	18,249,107
				Deductions from Revenue:						
341,209	579,261	238,052	41.1%	Contractual Allowances	7,347,788	7,086,133	(261,655)	-3.7%	2	6,338,572
56,023	53,756	(2,267)	-4.2%	Charity Care	647,239	719,287	72,048	10.0%	2	618,066
2,612	-	(2,612)	0.0%	Charity Care - Catastrophic Events	52,631	-	(52,631)	0.0%	2	49,786
61,320	48,951	(12,369)	-25.3%	Bad Debt	660,985	660,523	(462)	-0.1%	2	720,886
(162,285)	-	162,285	0.0%	Prior Period Settlements	(268,723)	-	268,723	0.0%	2	39,034
298,879	681,968	383,088	56.2%	Total Deductions from Revenue	8,439,920	8,465,943	26,024	0.3%	2	7,766,343
152,096	76,214	75,882	99.6%	Other Operating Revenue	998,565	986,568	11,997	1.2%	3	936,841
1,388,082	980,303	407,779	41.6%	TOTAL OPERATING REVENUE	10,883,013	11,990,119	(1,107,106)	-9.2%		11,496,349
				OPERATING EXPENSES						
288,473	285,021	(3,452)	-1.2%	Salaries and Wages	3,457,986	3,638,316	180,330	5.0%	4	3,479,913
115,264	103,882	(11,382)	-11.0%	Benefits	1,159,468	1,167,552	8,084	0.7%	4	1,248,977
15,052	2,357	(12,696)	-538.7%	Benefits Workers Compensation	41,812	28,278	(13,534)	-47.9%	4	23,991
39,478	39,151	(327)	-0.8%	Benefits Medical Insurance	423,875	469,816	45,941	9.8%	4	448,503
368,403	274,566	(93,837)	-34.2%	Professional Fees	2,939,704	3,149,744	210,040	6.7%	5	2,844,083
42,890	74,652	31,762	42.5%	Supplies	522,548	844,388	321,840	38.1%	6	754,001
50,705	46,833	(3,872)	-8.3%	Purchased Services	502,075	619,841	117,766	19.0%	7	594,519
148,693	60,317	(88,376)	-146.5%	Other	784,607	701,828	(82,779)	-11.8%	8	661,169
1,068,958	886,778	(182,179)	-20.5%	TOTAL OPERATING EXPENSE	9,832,074	10,619,762	787,688	7.4%		10,055,157
319,124	**93,525**	**225,600**	**241.2%**	**NET OPERATING REV(EXP) EBIDA**	**1,050,939**	**1,370,356**	**(319,418)**	**-23.3%**		**1,441,192**
				NON-OPERATING REVENUE/(EXPENSE)						
18,284	-	18,284	0.0%	Donations-IVCH	447,800	-	447,800	0.0%	9	396,399
-	-	-	0.0%	Gain/ (Loss) on Sale		-	-	0.0%	10	
(40,461)	(56,857)	16,396	-28.8%	Depreciation	(688,144)	(682,282)	(5,863)	-0.9%	11	(685,353)
(22,177)	(56,857)	34,680	61.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(240,345)	(682,282)	441,937	64.8%		(288,954)
$ 296,948	**$ 36,668**	**$ 260,280**	**709.8%**	**EXCESS REVENUE(EXPENSE)**	**$ 810,594**	**$ 688,075**	**$ 122,519**	**17.8%**		**$ 1,152,238**
20.8%	**5.9%**	**14.9%**		**RETURN ON GROSS REVENUE EBIDA**	**5.7%**	**7.0%**	**-1.3%**			**7.9%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
SEPTEMBER 2018

		Variance from Budget Fav<Unfav> SEPT 2018	YTD 2019
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were 1 day below budget at 0 days.	Gross Revenue -- Inpatient	$ (5,989)	$ (23,771)
	Gross Revenue -- Outpatient	69,728	184,300
		$ 63,739	$ 160,530
Outpatient volumes exceeded budget in Emergency Department visits, Laboratory tests, Pharmacy units, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a .59% decrease in Commercial Insurance, a 1.21% increase in Medicare, a 3.60% decrease in Medicaid, a 2.98% increase in Other, and County was at budget. We saw a positive variance in Contractual Allowances as a result of a shift from Commercial and Medicaid Deductions from Revenue to Bad Debt.	Contractual Allowances	$ 117,207	$ 327,381
	Charity Care	(11,233)	216
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(87,207)	90,106
	Prior Period Settlement	-	-
	Total	$ 18,767	$ 417,702
3) Other Operating Revenue			
	IVCH ER Physician Guarantee	$ (2,674)	$ 52,873
	Miscellaneous	912	951
	Total	$ (1,762)	$ 53,824
4) Salaries and Wages	Total	$ 9,282	$ 116,464
Employee Benefits	PL/SL	$ (1,853)	$ (18,895)
	Standby	349	4,023
	Other	(875)	3,789
	Nonproductive	(133)	(857)
	Pension/Deferred Comp	-	-
	Total	$ (2,511)	$ (11,940)
Employee Benefits - Workers Compensation	Total	$ 1,860	$ 4,905
Employee Benefits - Medical Insurance	Total	$ (1,870)	$ (26,716)
5) Professional Fees	IVCH ER Physicians	$ 1,773	$ (1,929)
Physician Fees in MSC Primary Care and MSC Orthopedic Surgery fell short of budget, creating a positive variance in Multi-Specialty Clinics.	Administration	-	-
	Foundation	-	1
	Miscellaneous	830	2,330
	Multi-Specialty Clinics	6,848	17,424
	Therapy Services	(463)	18,224
	Sleep Clinic	27	30,547
	Total	$ 9,014	$ 66,597
6) Supplies	Non-Medical Supplies	$ (12,744)	$ (9,991)
Negative variance in Non-Medical Supplies due to the purchase of bulk units of battery replacements for the Cat Scan machine.	Minor Equipment	(1,028)	(3,053)
	Imaging Film	-	-
	Food	1,515	1,514
Positive variance in Patient & Other Medical Supplies related to Laboratory and Implant supply costs falling short of budget estimations.	Office Supplies	288	1,935
	Patient & Other Medical Supplies	19,352	31,267
	Pharmacy Supplies	(36,084)	33,116
After working with our primary pharmacy vendor to identify missing invoices over the past several months the issue was rectified and invoices received and paid during the month of September. This created a negative variance in Pharmacy Supplies, however, year-to-date purchases show a positive variance over budget projections.	Total	$ (28,701)	$ 54,788

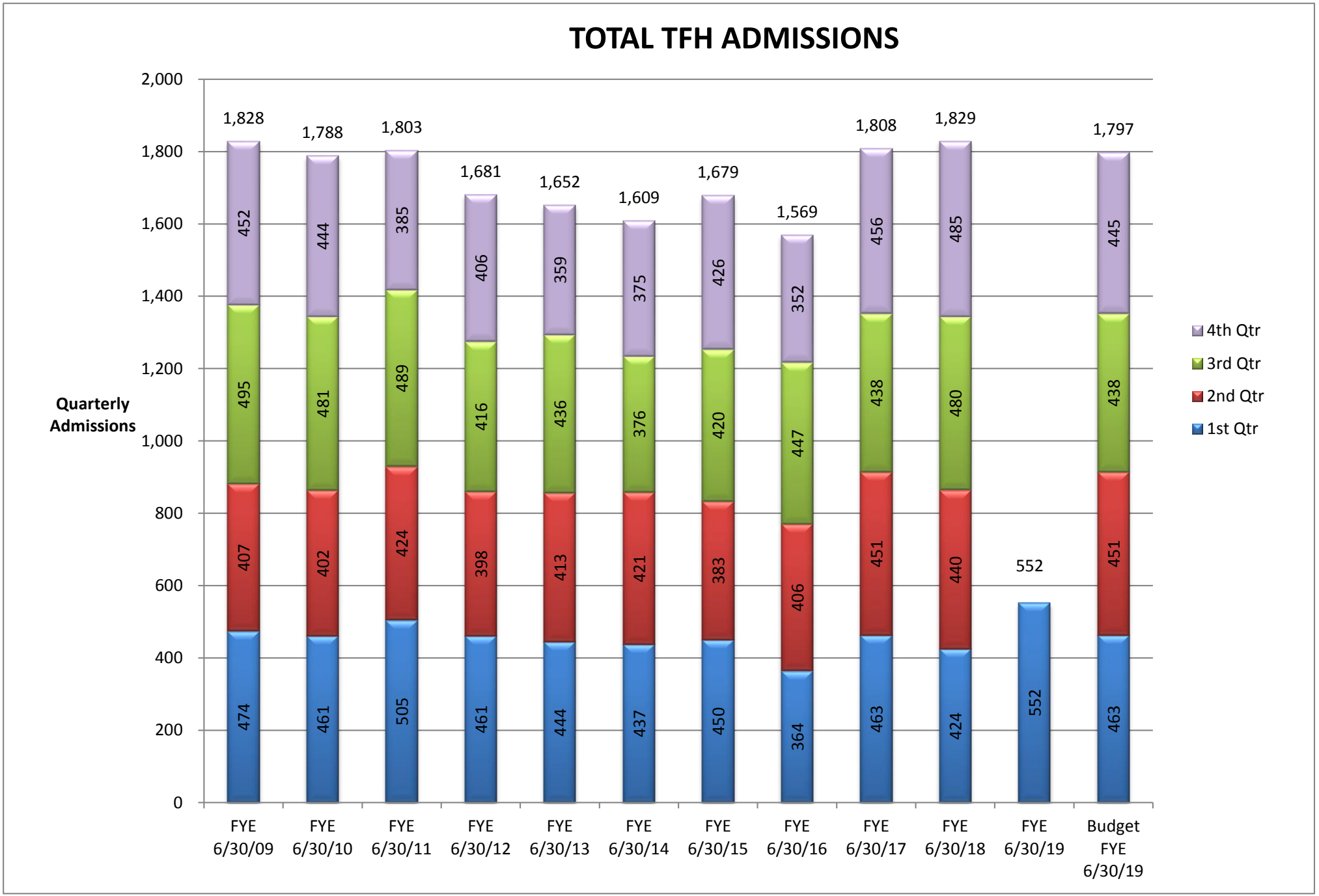
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
SEPTEMBER 2018

		Variance from Budget Fav<Unfav>	
		SEPT 2018	**YTD 2019**
7) Purchased Services	Engineering/Plant/Communications	$ (6,187)	$ (5,089)
Annual fire alarm and elevator inspections, Nurse Call maintenance work, and winterization of the campus caused a negative variance in Engineering/ Plant/Communications.	Multi-Specialty Clinics	(1,961)	(3,609)
	EVS/Laundry	1,833	(460)
	Foundation	(175)	(188)
	Surgical Services	-	-
Negative variance in Multi-Specialty Clinics related to a deep and clinical clean performed at MSC Primary Care.	Pharmacy	-	-
	Department Repairs	(522)	227
	Diagnostic Imaging Services - All	782	2,121
	Laboratory	2,193	5,121
	Miscellaneous	519	5,944
	Total	$ (3,518)	$ 4,068
8) Other Expenses	Miscellaneous	$ (9,719)	$ (25,345)
Negative variance in Miscellaneous associated with Laboratory transfer of labor costs from TFH to IVCH. Tests performed at TFH for IVCH exceeded budget during the month of September.	Outside Training & Travel	816	(6,902)
	Insurance	(155)	(155)
	Other Building Rent	-	1
	Physician Services	-	-
Oxygen tank rentals created a negative variance in Equipment Rent.	Marketing	2,356	2,791
	Dues and Subscriptions	(476)	2,125
	Multi-Specialty Clinics Bldg Rent	-	3,776
	Utilities	1,940	6,028
	Equipment Rent	(3,648)	1,552
	Total	$ (8,885)	$ (16,128)
9) Donations	Total	$ (36,679)	$ (110,601)
Capital Campaign donations fell short of budget estimations, creating a negative variance in Donations.			
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2018		BUDGET FYE 2019	PROJECTED FYE 2019	ACTUAL SEPT 2018	BUDGET SEPT 2018	DIFFERENCE	ACTUAL 1ST QTR	PROJECTED 2ND QTR	BUDGET 3RD QTR	BUDGET 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 9,897,289		$ 8,876,838	$ 12,273,640	$ 1,963,786	$ 966,241	$ 997,545	$ 7,158,158	$ 1,058,382	$ 1,911,636	$ 2,145,464
Interest Income	667,478		1,232,724	1,219,283	-	-	-	231,207	331,763	331,763	324,550
Property Tax Revenue	6,938,847		6,965,000	6,992,497	-	-	-	442,497	90,000	3,660,000	2,800,000
Donations	1,449,325		800,000	780,000	-	10,000	(10,000)	-	105,000	250,000	425,000
Debt Service Payments	(2,078,463)		(3,058,371)	(3,058,206)	(137,975)	(138,057)	82	(1,012,051)	(560,614)	(414,171)	(1,071,370)
Bank of America - 2012 Muni Lease	(103,515)		-	-	-	-	-	-	-	-	-
Copier	(11,482)		(11,520)	(11,354)	(878)	(960)	82	(2,714)	(2,880)	(2,880)	(2,880)
2017 VR Demand Bond	(319,664)		(1,401,687)	(1,401,687)	-	-	-	(598,045)	(146,443)	-	(657,199)
2015 Revenue Bond	(1,643,802)		(1,645,164)	(1,645,165)	(137,097)	(137,097)	(0)	(411,292)	(411,291)	(411,291)	(411,291)
Physician Recruitment	(160,536)		(187,500)	(185,863)	(110,863)	(112,500)	1,637	(145,863)	-	(20,000)	(20,000)
Investment in Capital											
Equipment	(2,766,680)		(2,911,369)	(2,911,369)	(259,134)	(159,779)	(99,355)	(936,378)	(561,525)	(1,200,000)	(213,466)
Municipal Lease Reimbursement	219,363		-	-	-	-	-	-	-	-	-
IT/EMR/Business Systems	(4,182,129)		(3,986,507)	(3,986,507)	595,530	(421,504)	1,017,034	(844,873)	(1,606,634)	(1,025,000)	(510,000)
Building Projects/Properties	(4,415,940)		(15,438,772)	(15,438,772)	(719,988)	(1,314,957)	594,969	(1,819,774)	(8,040,942)	(4,295,774)	(1,282,282)
Capital Investments	(475,000)		(452,000)	(452,000)	-	(452,000)	452,000	-	(452,000)	-	-
Change in Accounts Receivable	(6,540,593)	N1	3,103,131	2,870,556	(4,041,900)	2,443,755	(6,485,655)	(8,013,339)	9,465,104	1,172,497	246,294
Change in Settlement Accounts	6,898,578	N2	1,609,698	1,453,458	2,860,655	2,041,667	818,988	853,760	(2,339,510)	2,911,430	27,778
Change in Other Assets	(6,700,275)	N3	(2,812,500)	(3,861,139)	(418,987)	(137,500)	(281,487)	(1,651,139)	(750,000)	(730,000)	(730,000)
Change in Other Liabilities	(857,461)	N4	375,000	519,254	1,226,495	750,000	476,495	694,254	(1,800,000)	1,525,000	100,000
Change in Cash Balance	(2,106,197)		(5,884,628)	(3,785,169)	957,619	3,475,366	(2,517,747)	(5,043,542)	(5,060,976)	4,077,381	2,241,968
Beginning Unrestricted Cash	72,911,743		70,805,546	70,805,546	64,804,386	64,804,386	-	70,805,546	65,762,004	60,701,028	64,778,409
Ending Unrestricted Cash	70,805,546		64,920,918	67,020,377	65,762,004	68,279,751	(2,517,747)	65,762,004	60,701,028	64,778,409	67,020,377
Expense Per Day	414,300		448,115	444,024	432,620	448,850	(16,230)	432,620	440,451	441,656	444,024
Days Cash On Hand	171		145	151	152	152	(0)	152	138	147	151

Footnotes:
N1 - Change in Accounts Receivable reflects the 60 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.


TOTAL TFH ADMISSIONS
Quarterly Admissions
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,828
1,788
1,803
1,681
1,652
1,609
1,679
1,569
1,808
1,829
1,797
452
444
385
406
359
375
426
352
456
485
445
495
481
489
416
436
376
420
447
438
480
438
407
402
424
398
413
421
383
406
451
440
451
552
474
461
505
461
444
437
450
364
463
424
552
463
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
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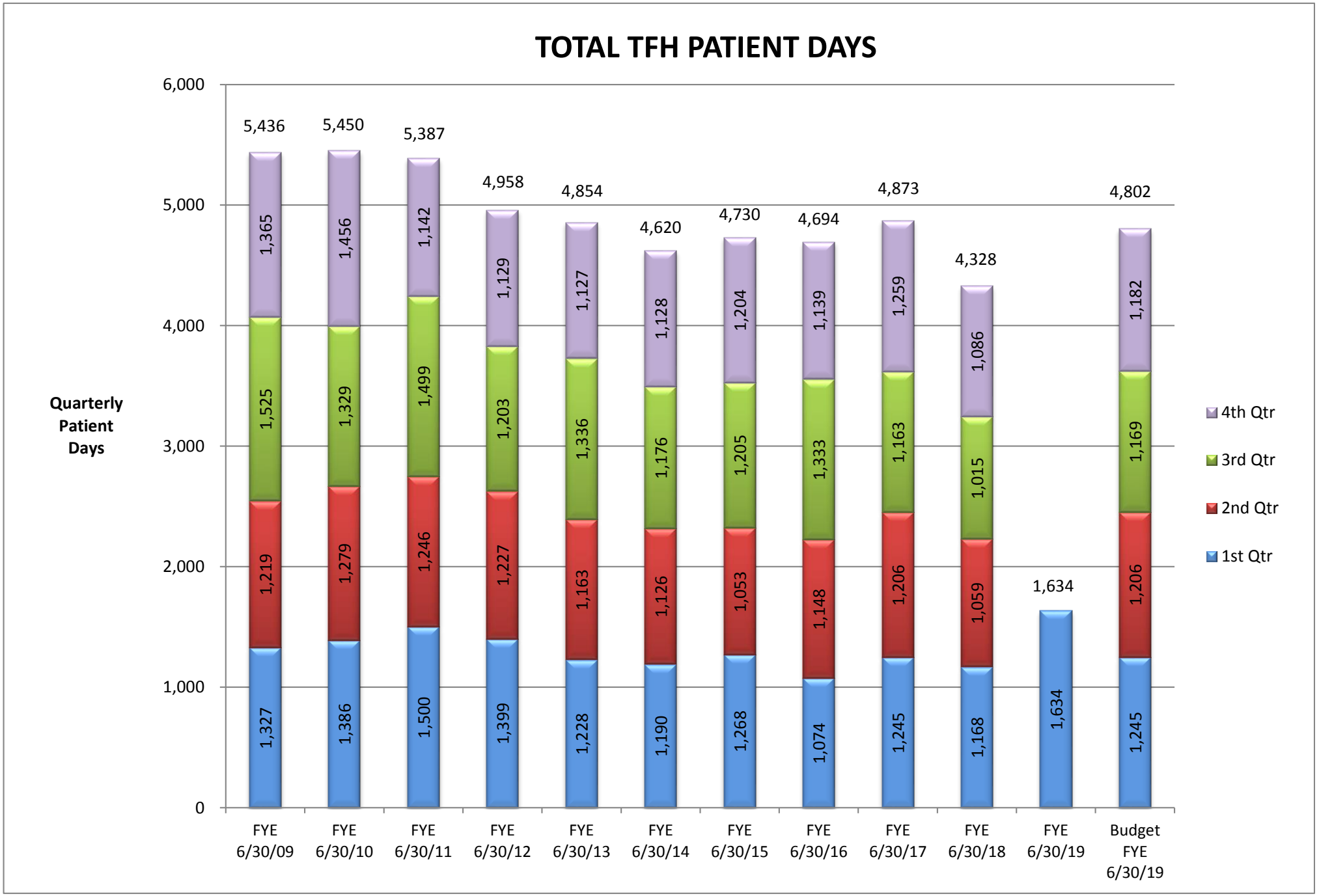
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH PATIENT DAYS
Quarterly Patient Days
6,000
5,000
4,000
3,000
2,000
1,000
0
5,436
5,450
5,387
4,958
4,854
4,620
4,730
4,694
4,873
4,328
1,634
4,802
1,365
1,456
1,142
1,129
1,127
1,128
1,204
1,139
1,259
1,086
1,182
1,525
1,329
1,499
1,203
1,336
1,176
1,205
1,333
1,163
1,015
1,169
1,219
1,279
1,246
1,227
1,163
1,126
1,053
1,148
1,206
1,059
1,206
1,327
1,386
1,500
1,399
1,228
1,190
1,268
1,074
1,245
1,168
1,634
1,245
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
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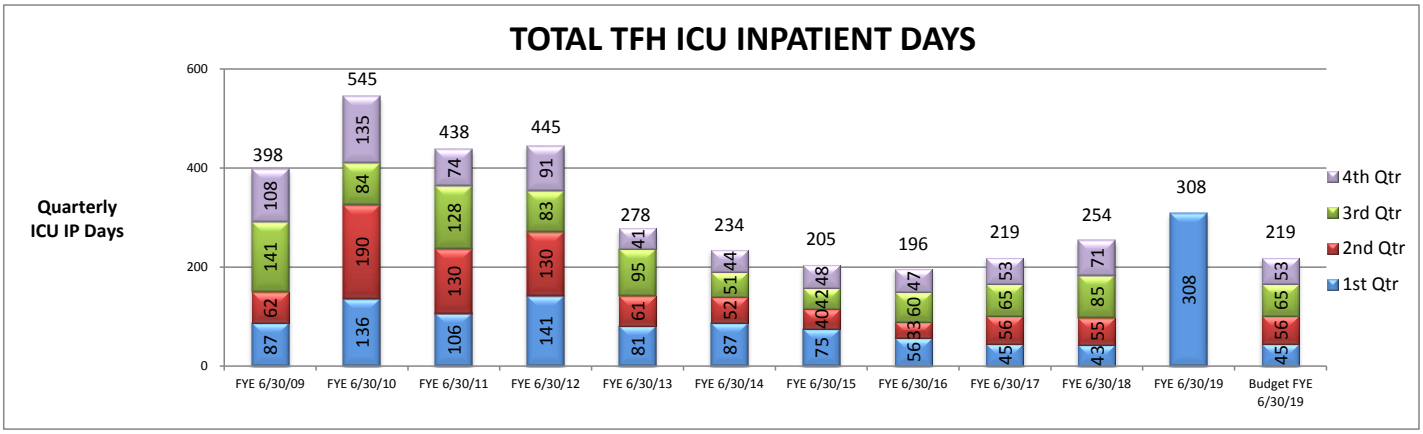
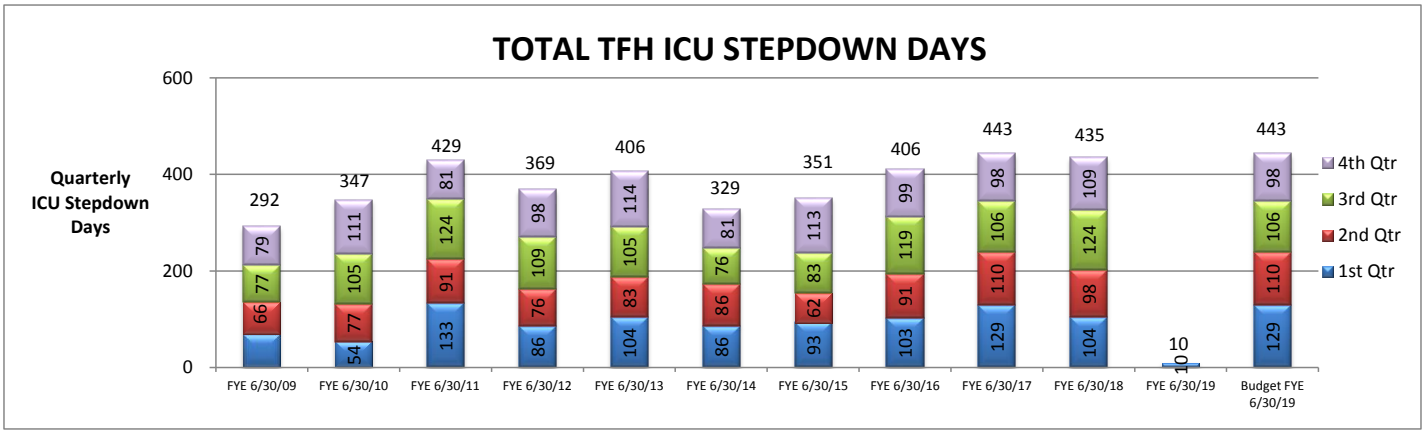
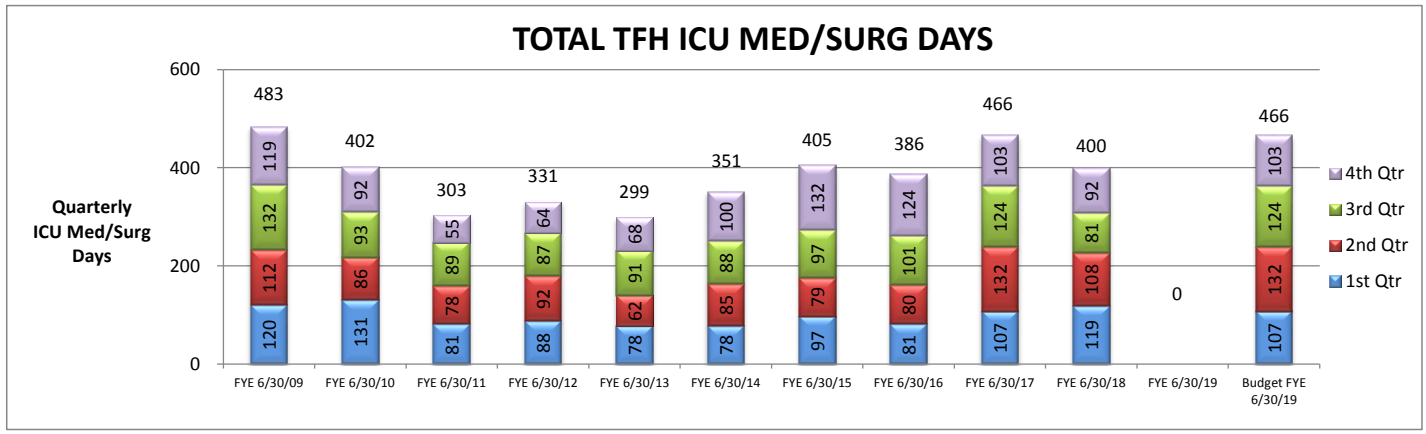
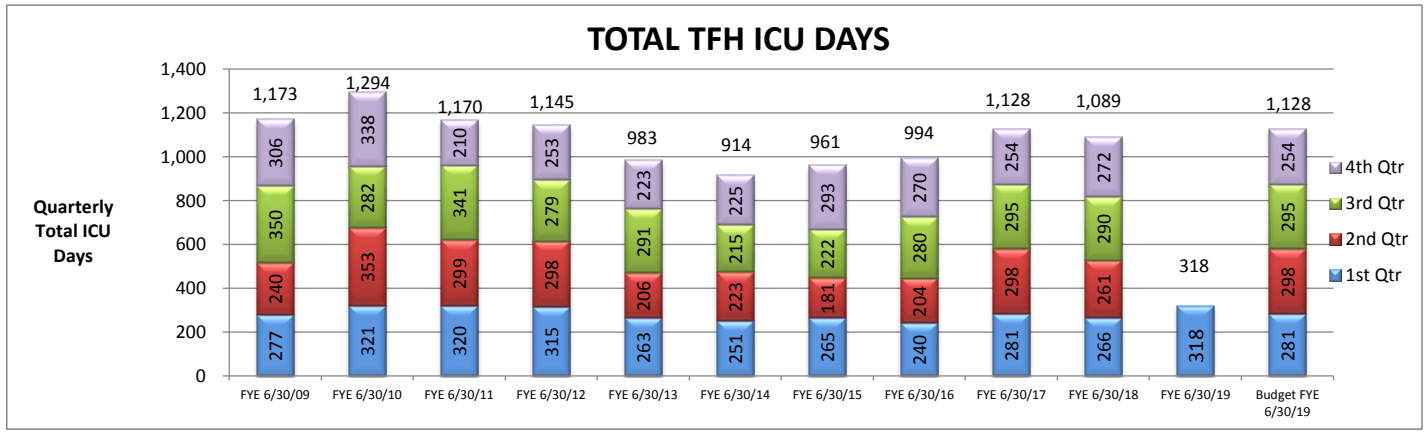
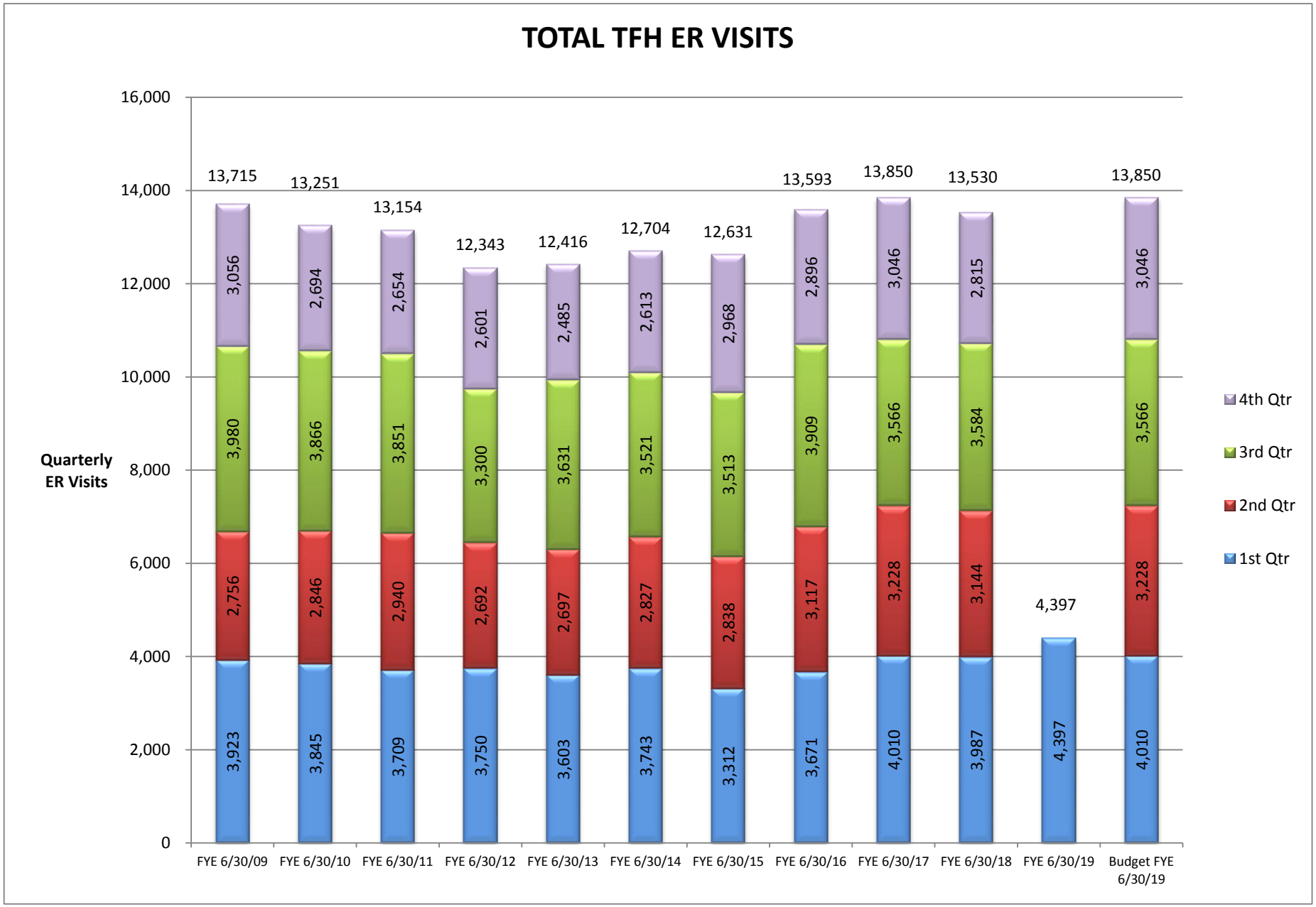
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ICU INPATIENT DAYS
Quarterly ICU IP Days
600
400
200
0
FYE 6/30/09: 398 (87, 62, 141, 108)
FYE 6/30/10: 545 (136, 190, 84, 135)
FYE 6/30/11: 438 (106, 130, 128, 74)
FYE 6/30/12: 445 (141, 130, 83, 91)
FYE 6/30/13: 278 (81, 61, 95, 41)
FYE 6/30/14: 234 (87, 52, 51, 44)
FYE 6/30/15: 205 (75, 40, 42, 48)
FYE 6/30/16: 196 (56, 33, 60, 47)
FYE 6/30/17: 219 (45, 56, 65, 53)
FYE 6/30/18: 254 (43, 55, 85, 71)
FYE 6/30/19: 308 (308)
Budget FYE 6/30/19: 219 (45, 56, 65, 53)
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

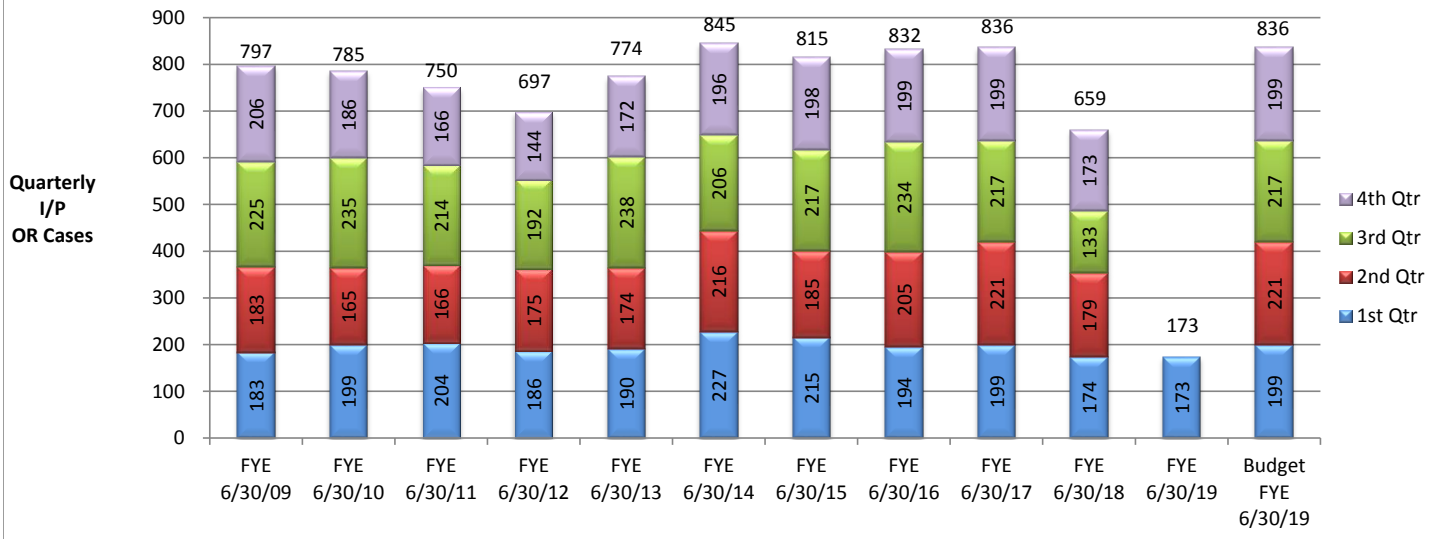

TOTAL TFH ICU STEPDOWN DAYS
Quarterly ICU Stepdown Days
600
400
200
0
FYE 6/30/09: 292 (66, 77, 79)
FYE 6/30/10: 347 (54, 77, 105, 111)
FYE 6/30/11: 429 (133, 91, 124, 81)
FYE 6/30/12: 369 (86, 76, 109, 98)
FYE 6/30/13: 406 (104, 83, 105, 114)
FYE 6/30/14: 329 (86, 86, 76, 81)
FYE 6/30/15: 351 (93, 62, 83, 113)
FYE 6/30/16: 406 (103, 91, 119, 99)
FYE 6/30/17: 443 (129, 110, 106, 98)
FYE 6/30/18: 435 (104, 98, 124, 109)
FYE 6/30/19: 10 (10)
Budget FYE 6/30/19: 443 (129, 110, 106, 98)
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ICU MED/SURG DAYS
Quarterly ICU Med/Surg Days
600
400
200
0
FYE 6/30/09: 483 (120, 112, 132, 119)
FYE 6/30/10: 402 (131, 86, 93, 92)
FYE 6/30/11: 303 (81, 78, 89, 55)
FYE 6/30/12: 331 (88, 92, 87, 64)
FYE 6/30/13: 299 (78, 62, 91, 68)
FYE 6/30/14: 351 (78, 85, 88, 100)
FYE 6/30/15: 405 (97, 79, 97, 132)
FYE 6/30/16: 386 (81, 80, 101, 124)
FYE 6/30/17: 466 (107, 132, 124, 103)
FYE 6/30/18: 400 (119, 108, 81, 92)
FYE 6/30/19: 0
Budget FYE 6/30/19: 466 (107, 132, 124, 103)
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

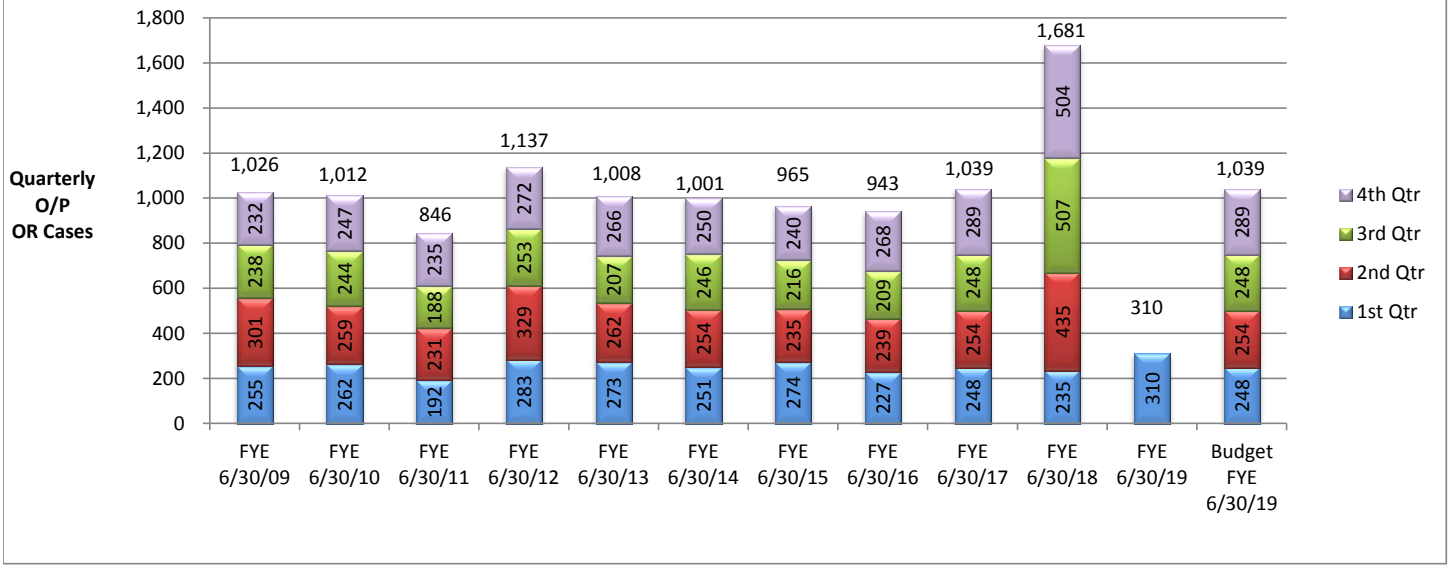

TOTAL TFH ICU DAYS
Quarterly Total ICU Days
1,400
1,200
1,000
800
600
400
200
0
FYE 6/30/09: 1,173 (277, 240, 350, 306)
FYE 6/30/10: 1,294 (321, 353, 282, 338)
FYE 6/30/11: 1,170 (320, 299, 341, 210)
FYE 6/30/12: 1,145 (315, 298, 279, 253)
FYE 6/30/13: 983 (263, 206, 291, 223)
FYE 6/30/14: 914 (251, 223, 215, 225)
FYE 6/30/15: 961 (265, 181, 222, 293)
FYE 6/30/16: 994 (240, 204, 280, 270)
FYE 6/30/17: 1,128 (281, 298, 295, 254)
FYE 6/30/18: 1,089 (266, 261, 290, 272)
FYE 6/30/19: 318 (318)
Budget FYE 6/30/19: 1,128 (281, 298, 295, 254)
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ER VISITS
Quarterly ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
13,715
13,251
13,154
12,343
12,416
12,704
12,631
13,593
13,850
13,530
4,397
13,850
3,056
2,694
2,654
2,601
2,485
2,613
2,968
2,896
3,046
2,815
3,046
3,980
3,866
3,851
3,300
3,631
3,521
3,513
3,909
3,566
3,584
3,566
2,756
2,846
2,940
2,692
2,697
2,827
2,838
3,117
3,228
3,144
3,228
3,923
3,845
3,709
3,750
3,603
3,743
3,312
3,671
4,010
3,987
4,397
4,010
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

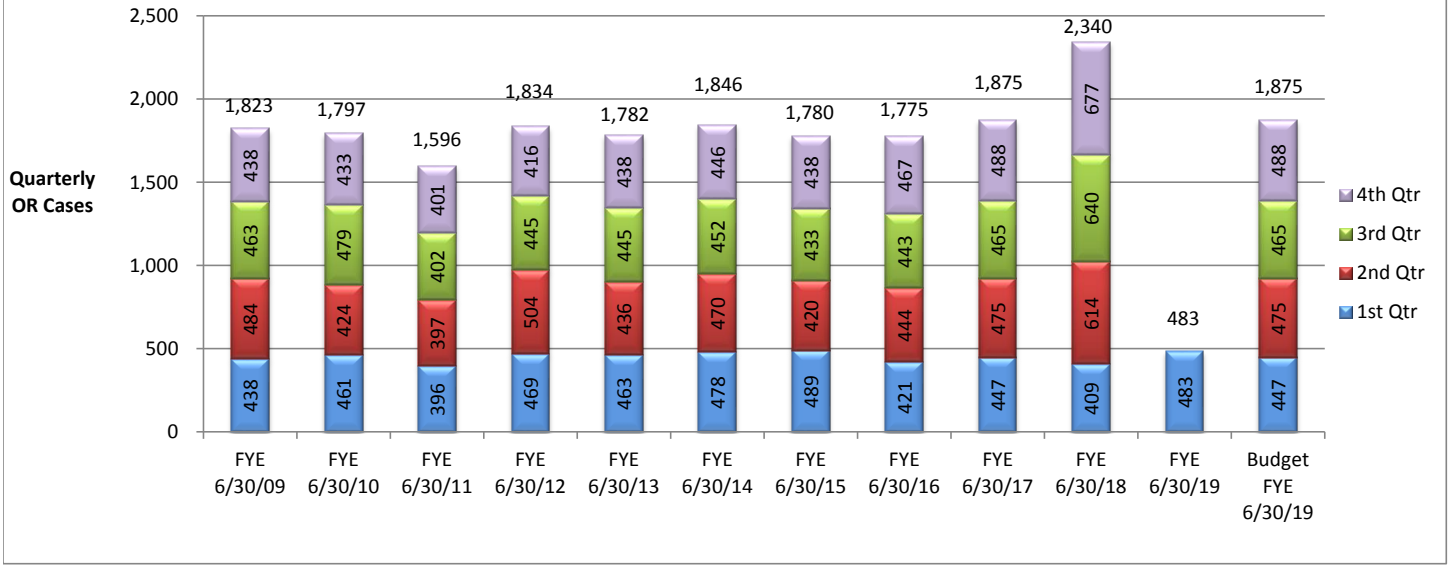
TOTAL TFH INPATIENT OR CASES

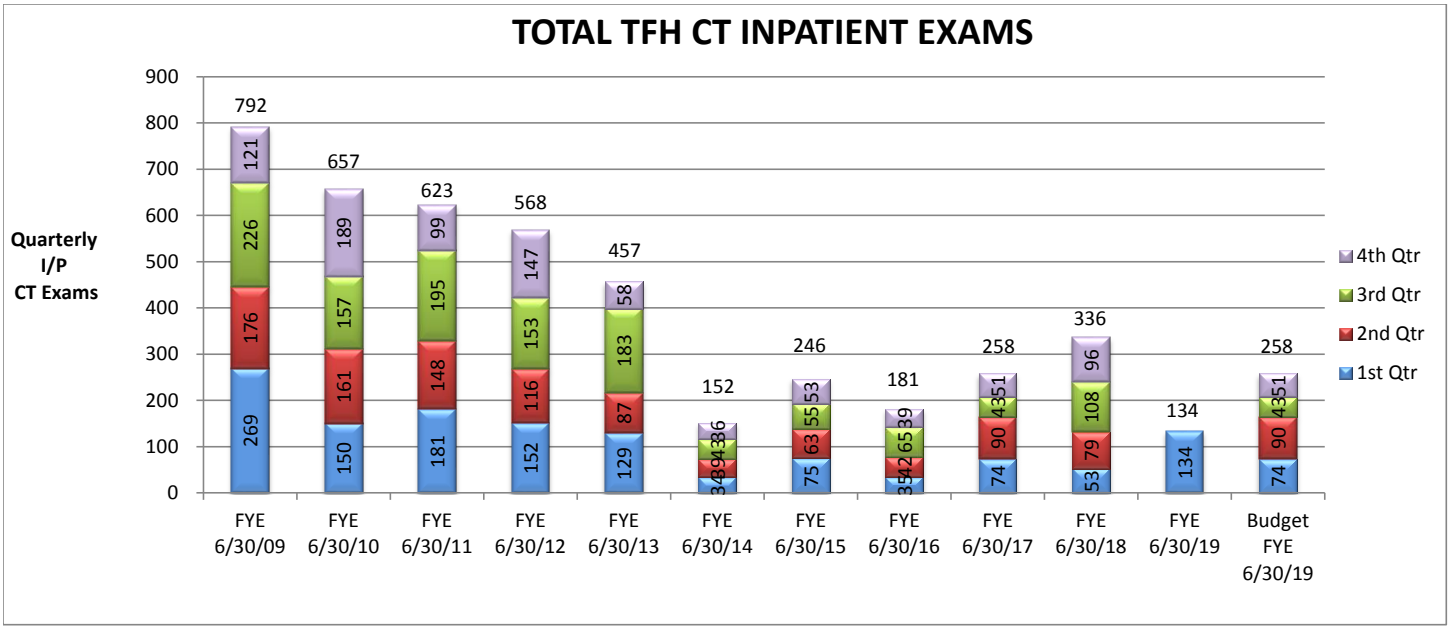


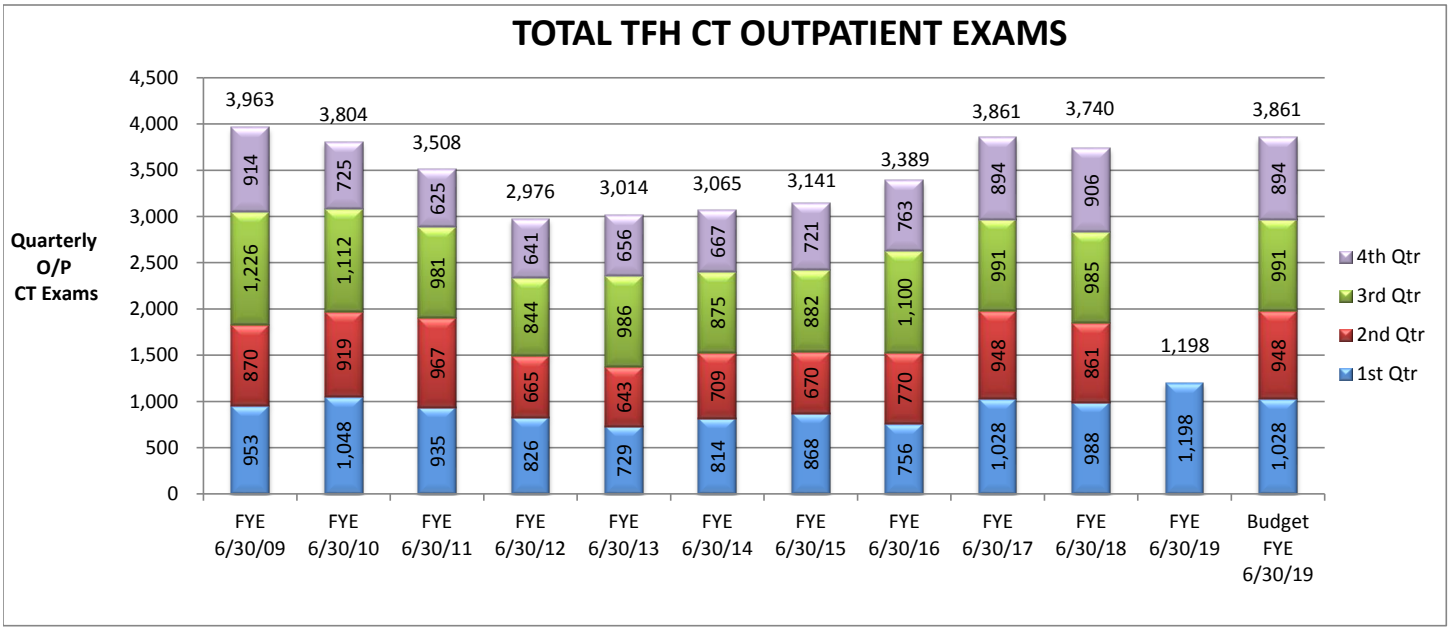
TOTAL TFH OUTPATIENT OR CASES

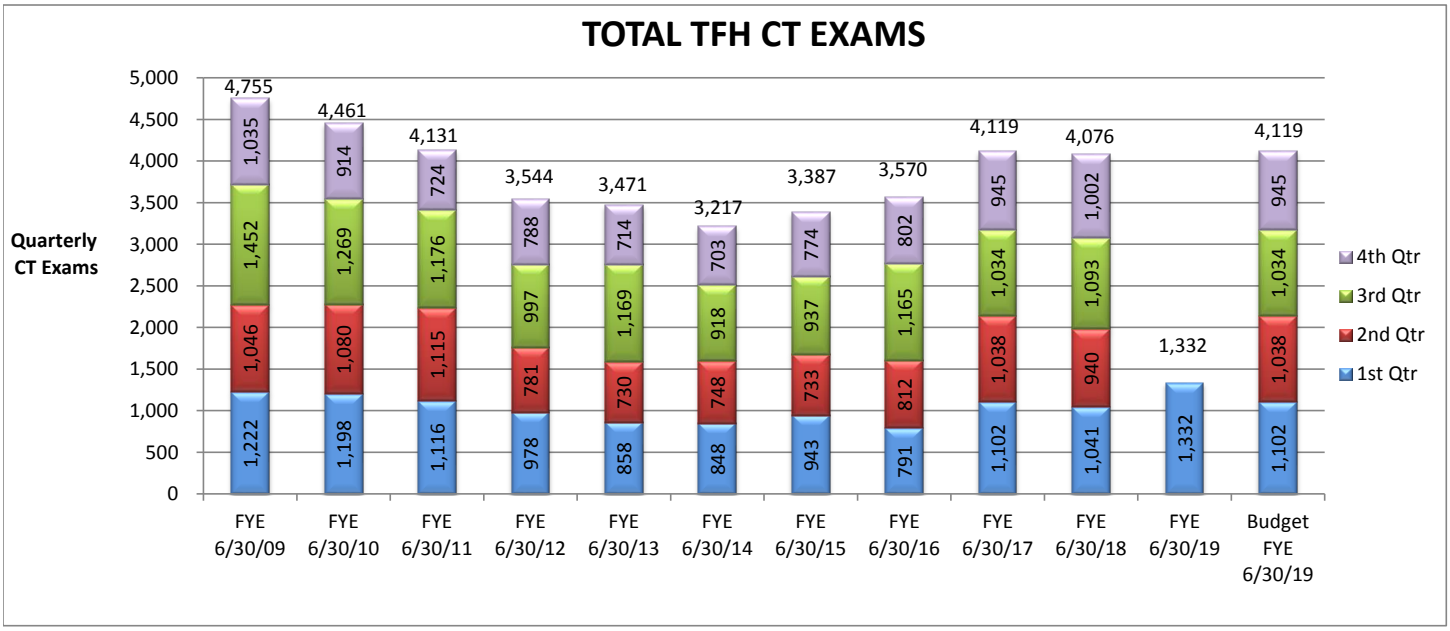


TOTAL TFH OR CASES

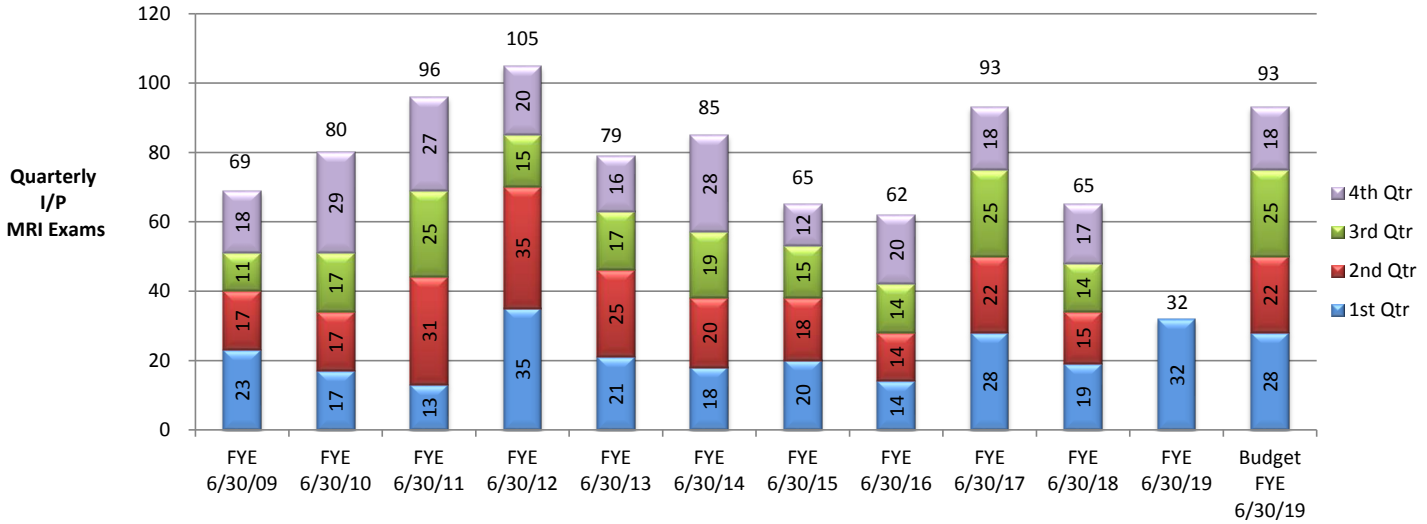



TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
900
800
700
600
500
400
300
200
100
0
792
657
623
568
457
152
246
181
258
336
134
258
269 176 226 121
150 161 157 189
181 148 195 99
152 116 153 147
129 87 183 58
34 9 43 36
75 63 55 53
35 12 65 39
74 90 43 51
53 79 108 96
134
74 90 43 51
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

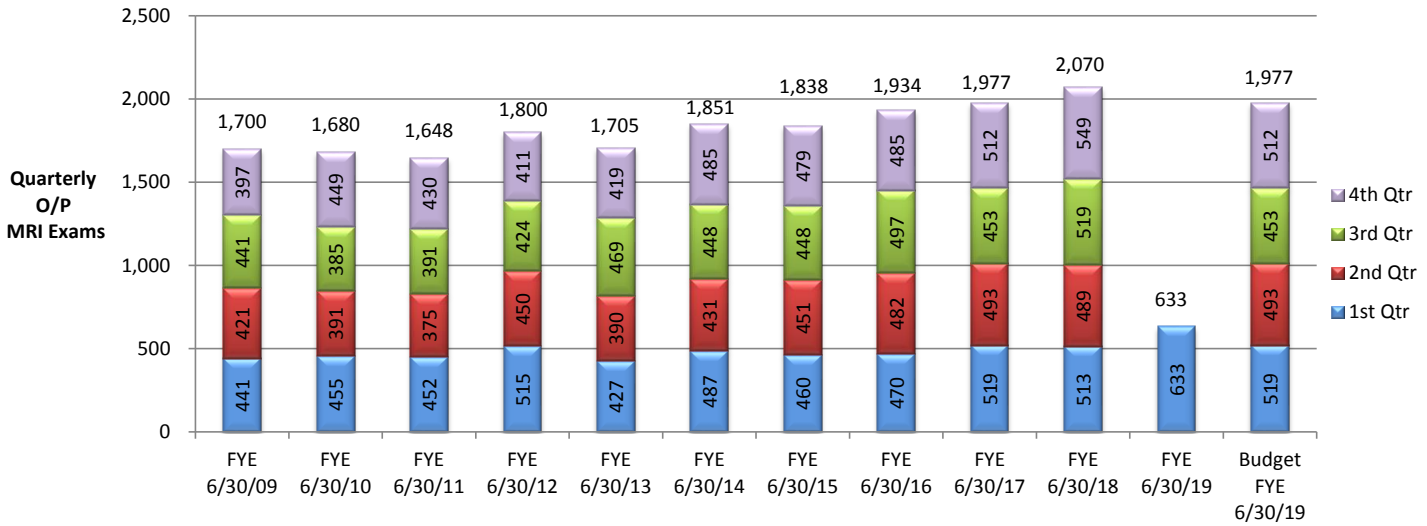

TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,963
3,804
3,508
2,976
3,014
3,065
3,141
3,389
3,861
3,740
1,198
3,861
953 870 1,226 914
1,048 919 1,112 725
935 967 981 625
826 665 844 641
729 643 986 656
814 709 875 667
868 670 882 721
756 770 1,100 763
1,028 948 991 894
988 861 985 906
1,198
1,028 948 991 894
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT EXAMS
Quarterly CT Exams
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
4,755
4,461
4,131
3,544
3,471
3,217
3,387
3,570
4,119
4,076
1,332
4,119
1,222 1,046 1,452 1,035
1,198 1,080 1,269 914
1,116 1,115 1,176 724
978 781 997 788
858 730 1,169 714
848 748 918 703
943 733 937 774
791 812 1,165 802
1,102 1,038 1,034 945
1,041 940 1,093 1,002
1,332
1,102 1,038 1,034 945
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

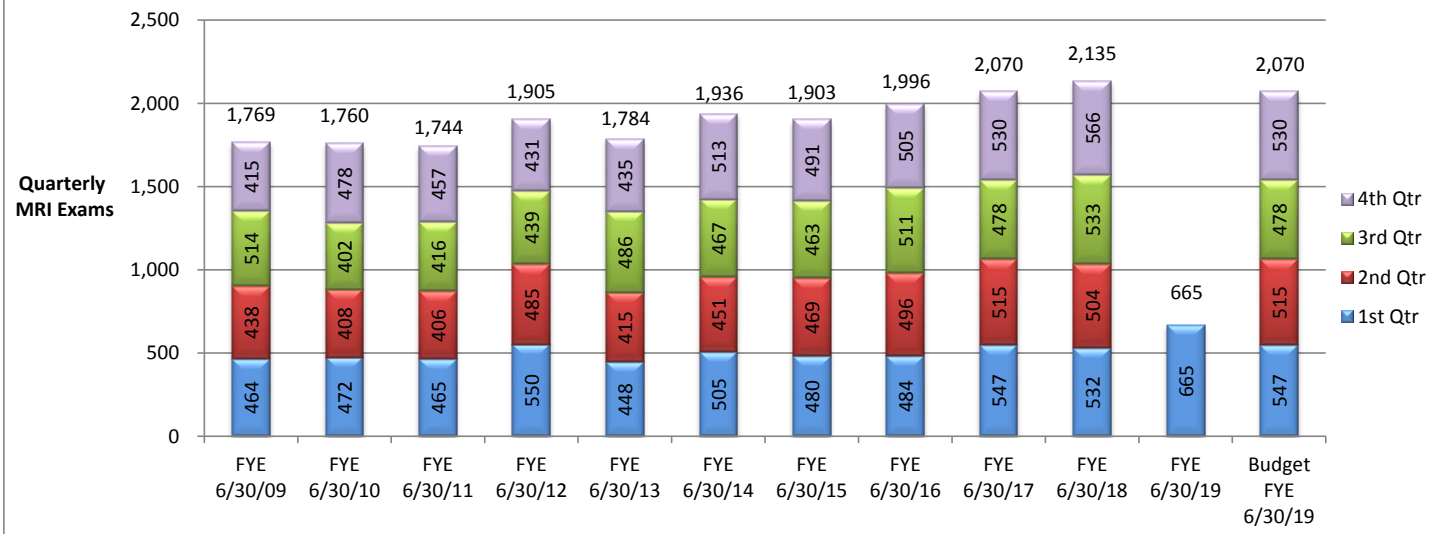
TOTAL TFH MRI INPATIENT EXAMS



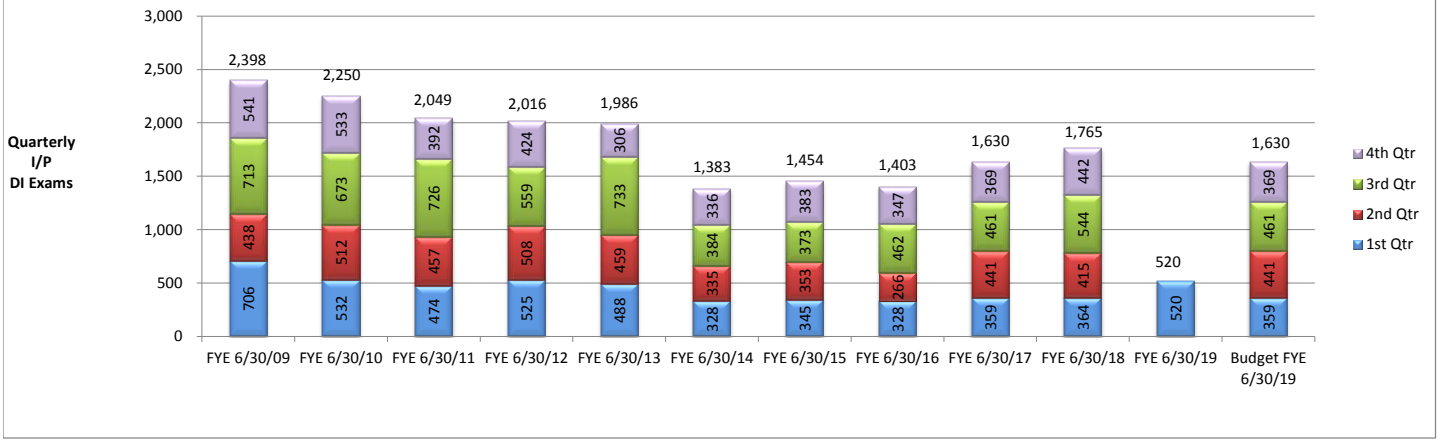
TOTAL TFH MRI OUTPATIENT EXAMS



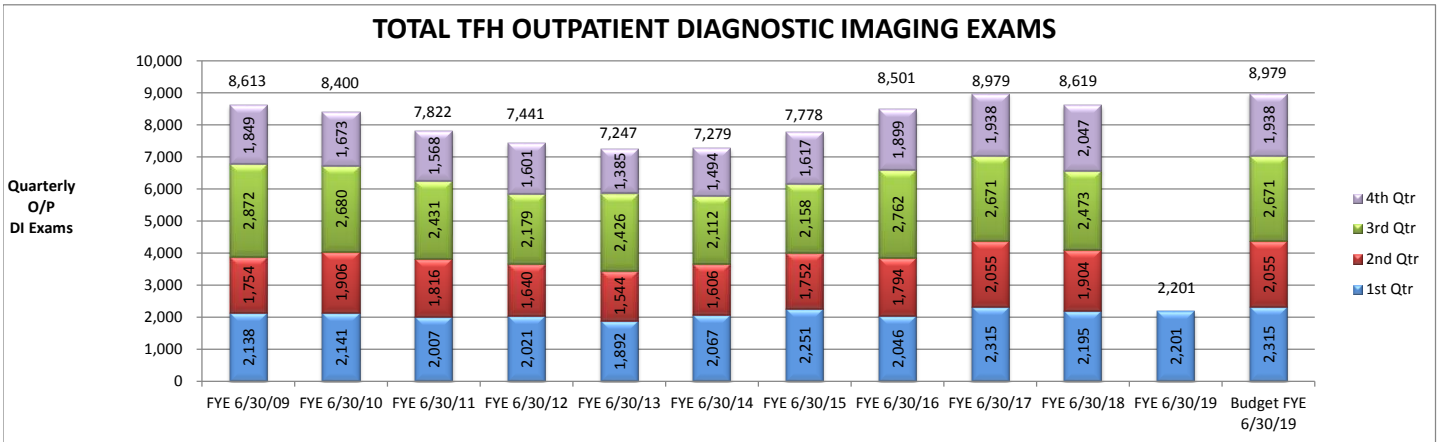
TOTAL TFH MRI EXAMS



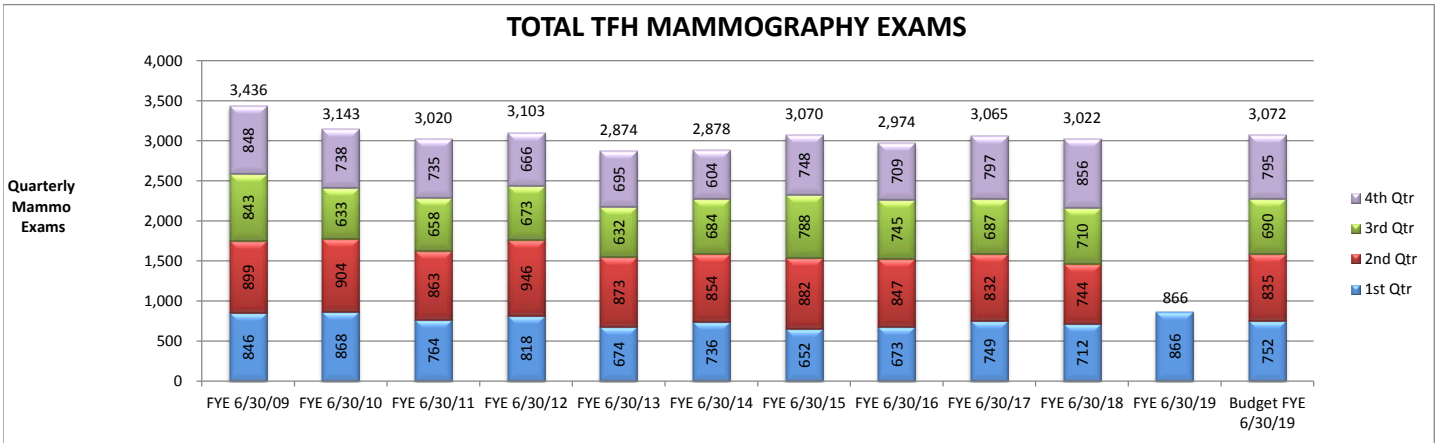
TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS



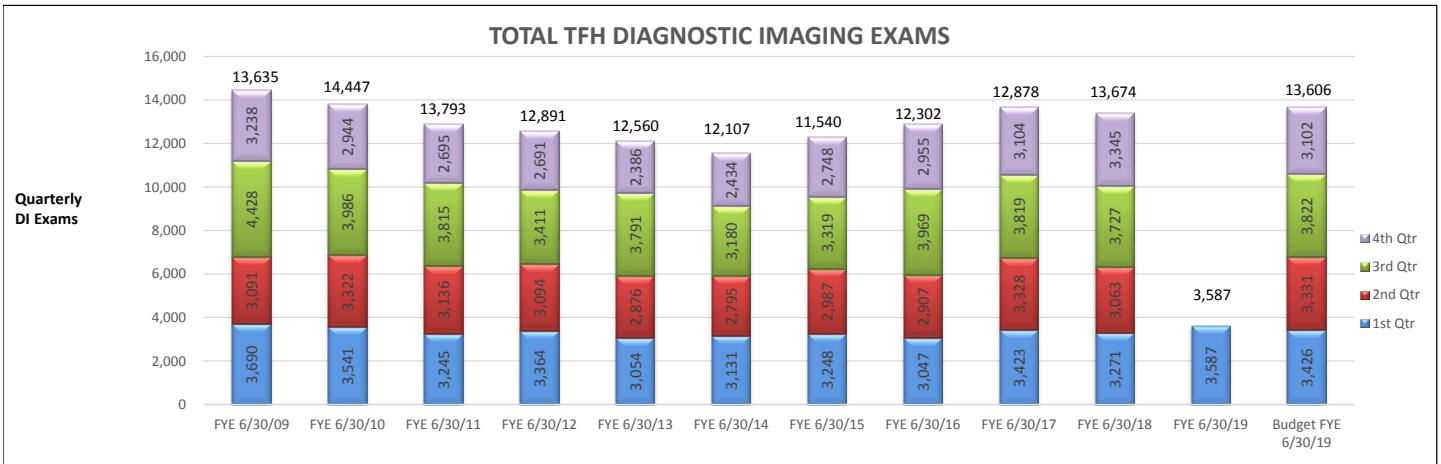
TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS



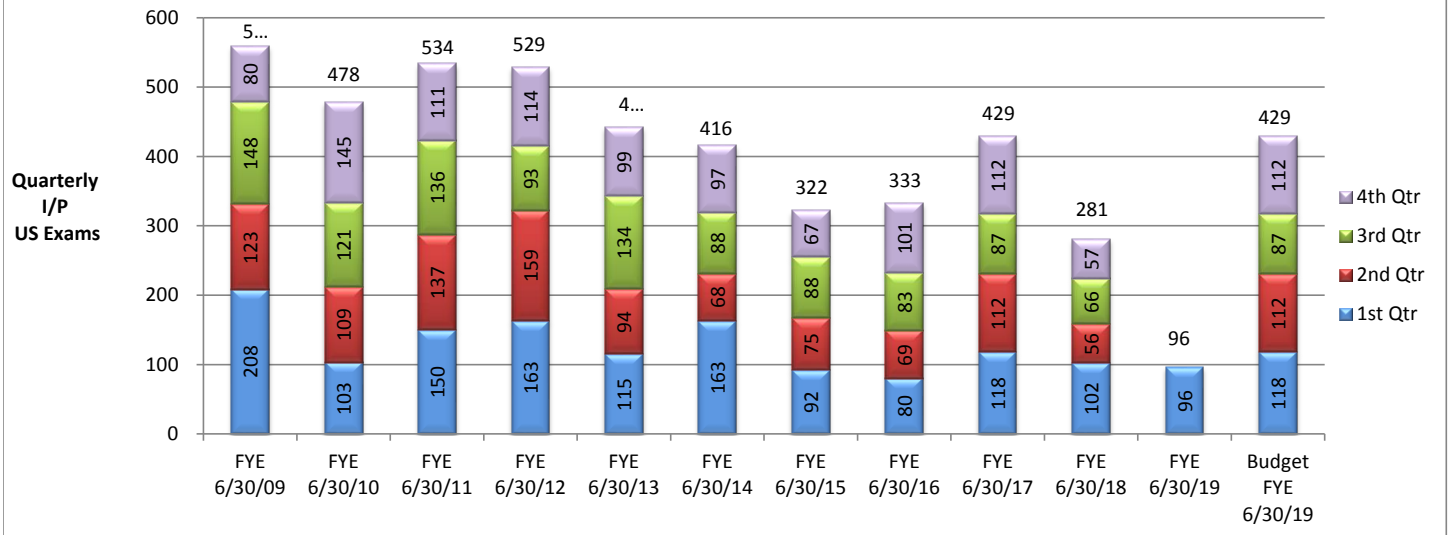
TOTAL TFH MAMMOGRAPHY EXAMS



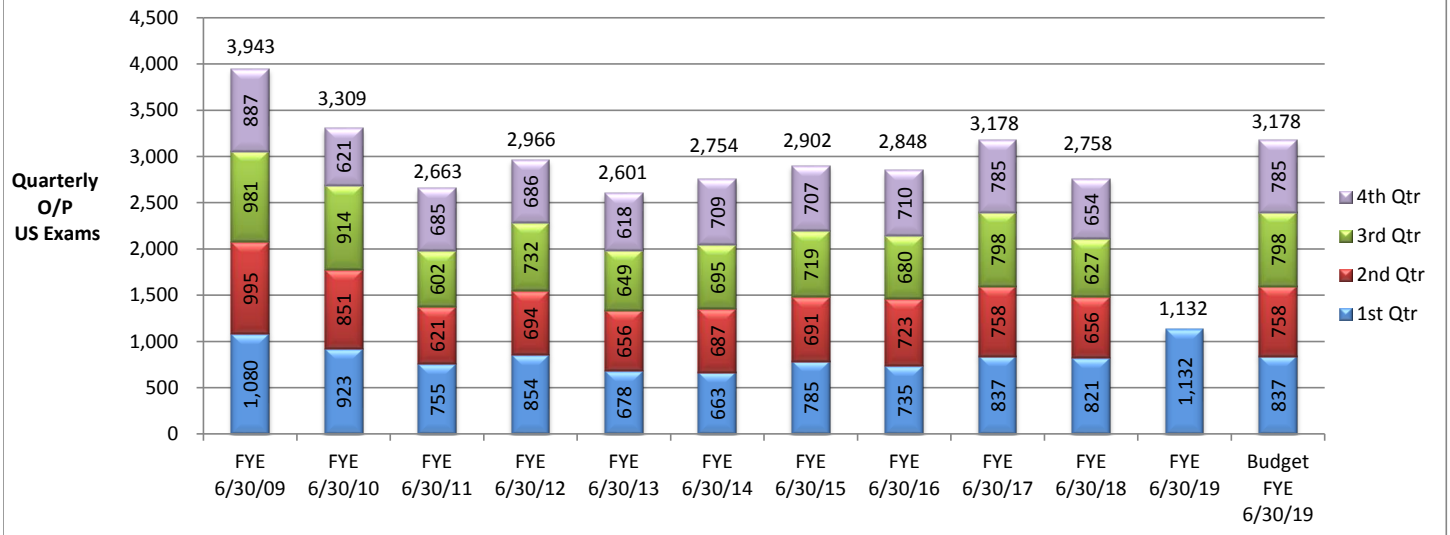
TOTAL TFH DIAGNOSTIC IMAGING EXAMS



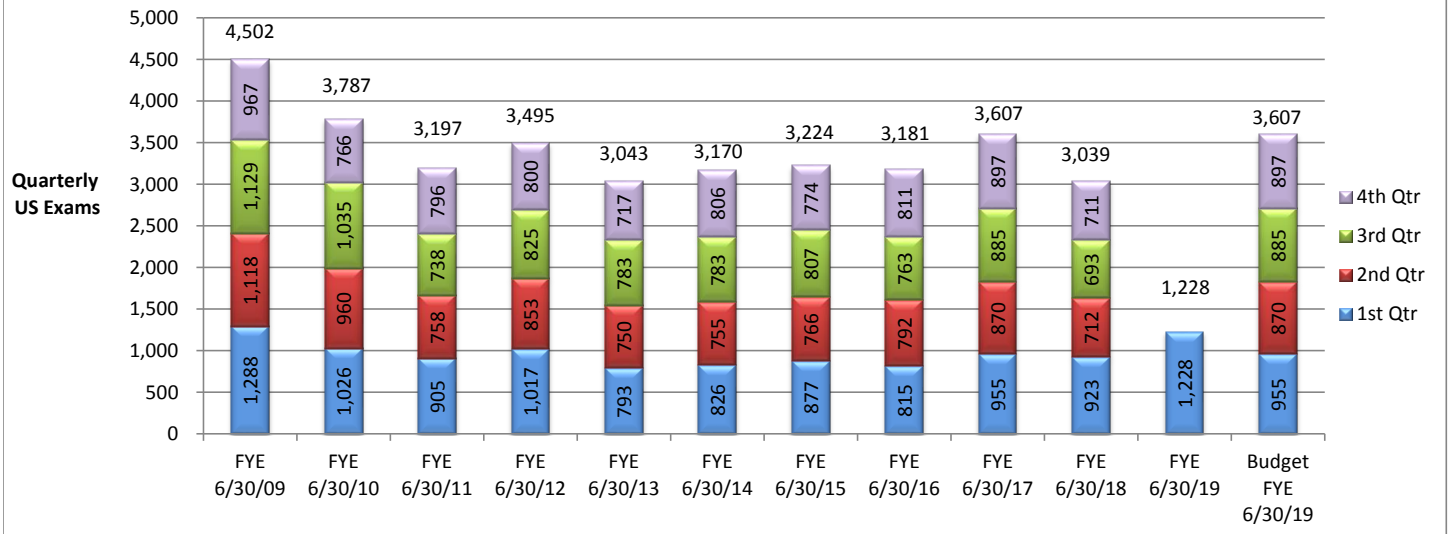
TOTAL TFH ULTRASOUND INPATIENT EXAMS



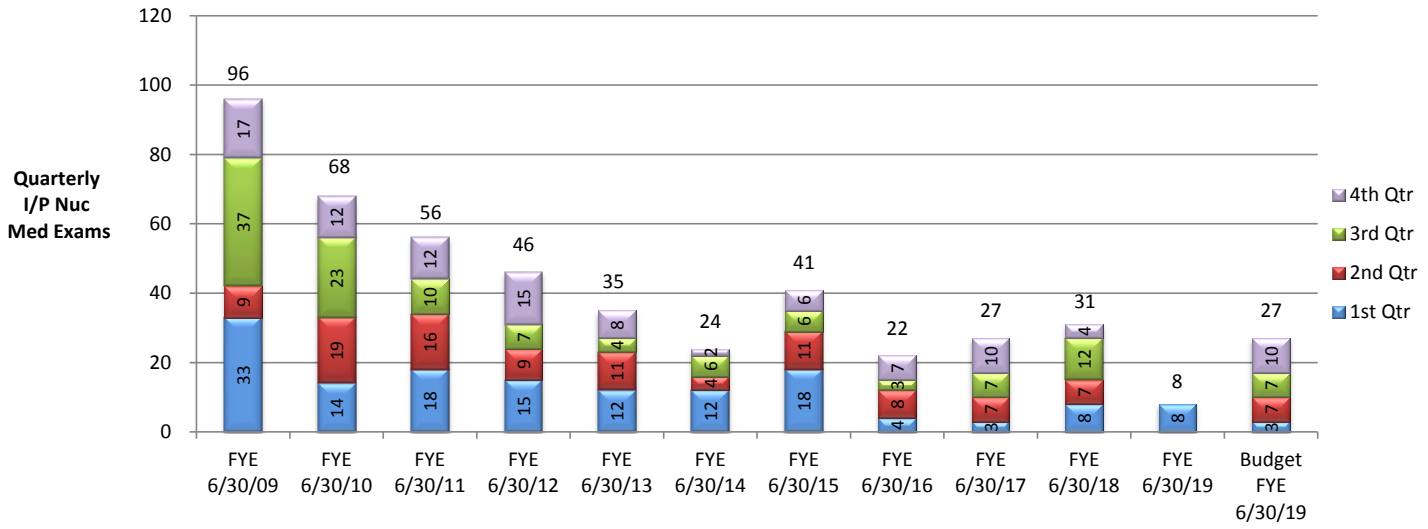
TOTAL TFH ULTRASOUND OUTPATIENT EXAMS



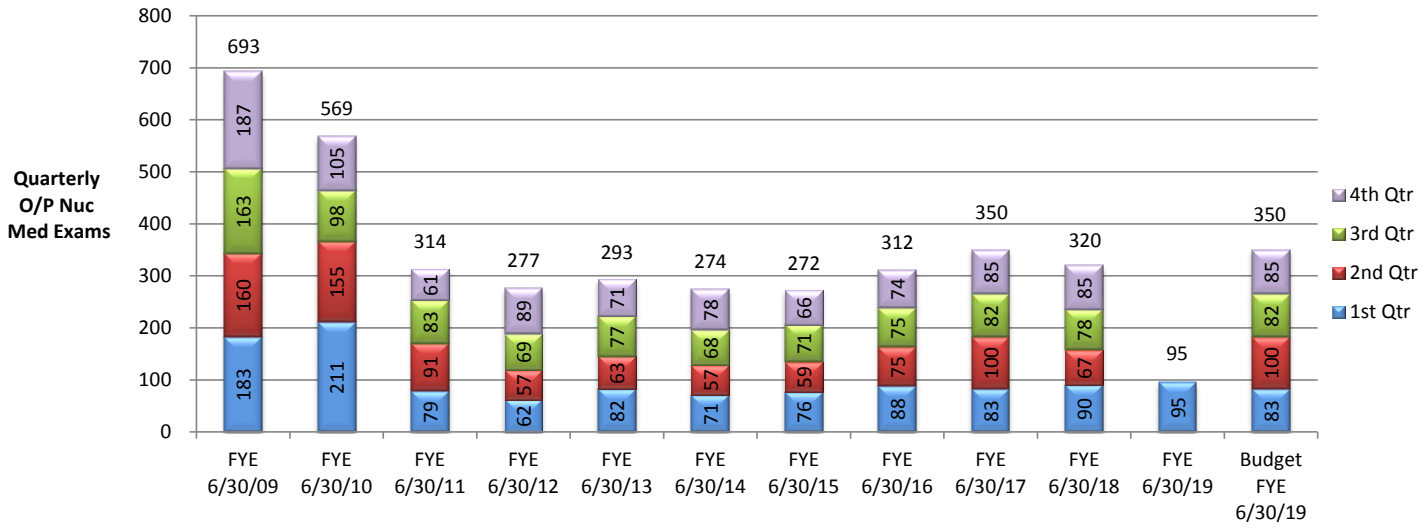
TOTAL TFH ULTRASOUND EXAMS



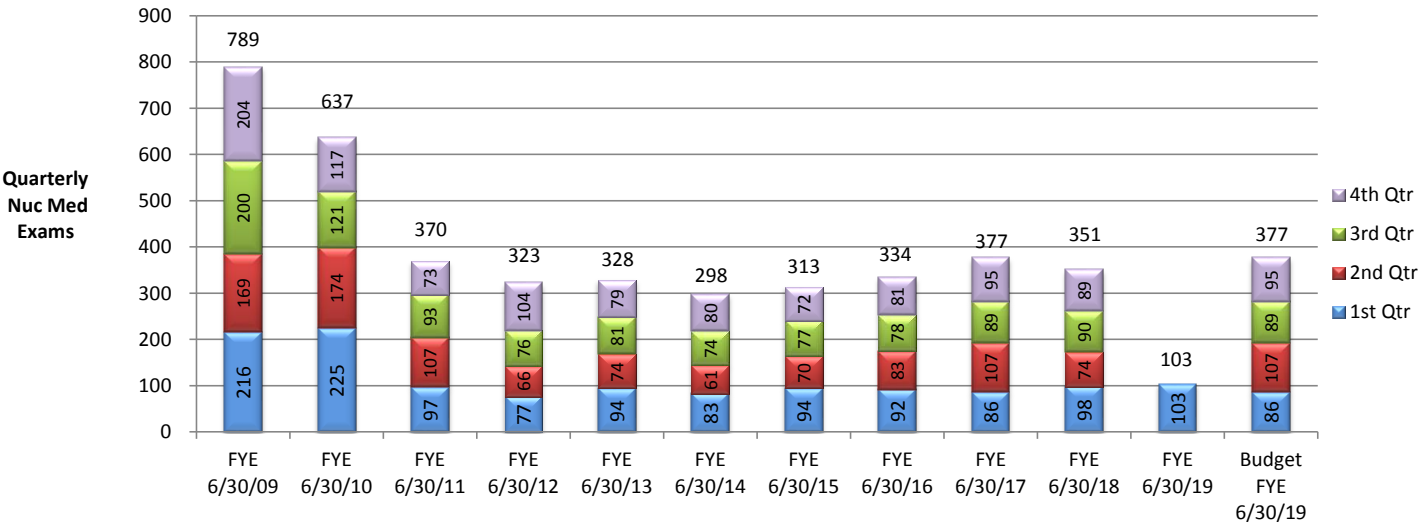
TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS

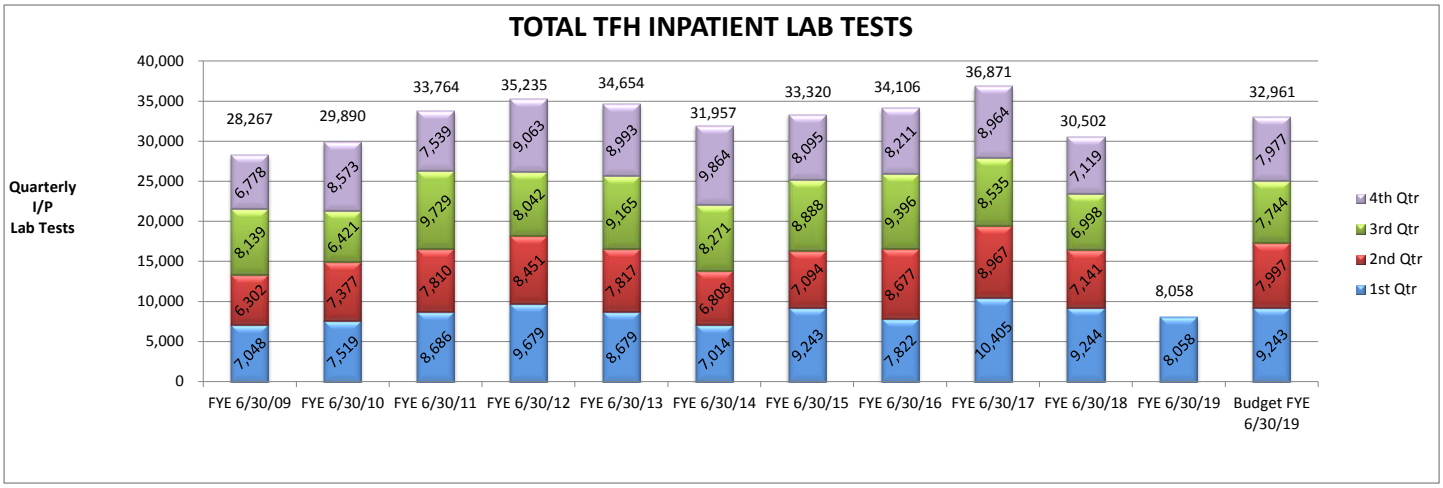


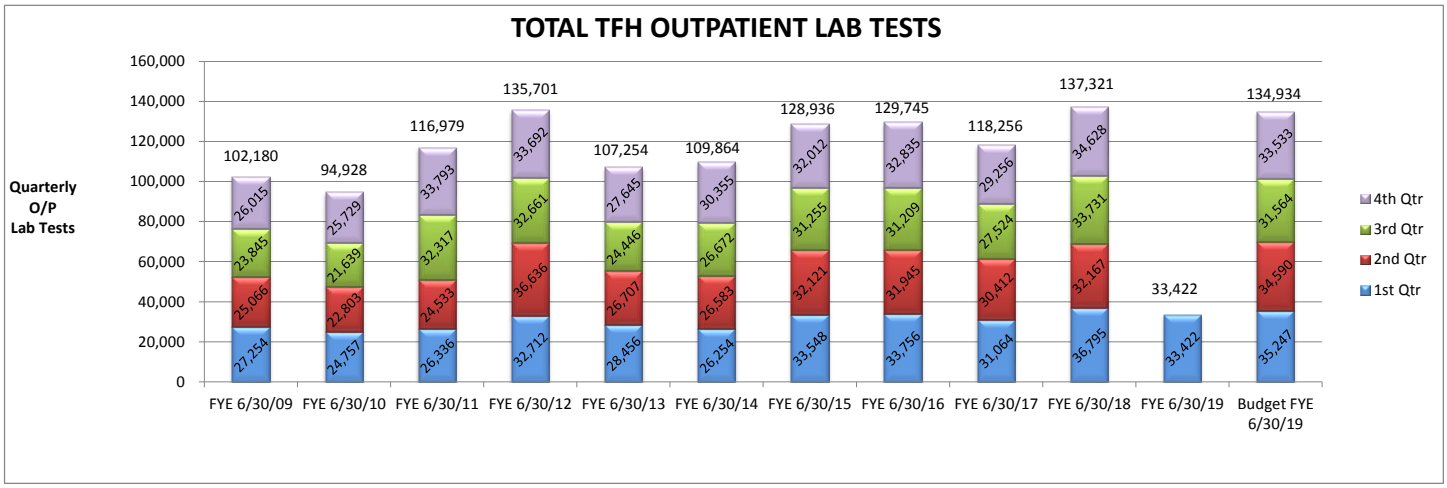
TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS

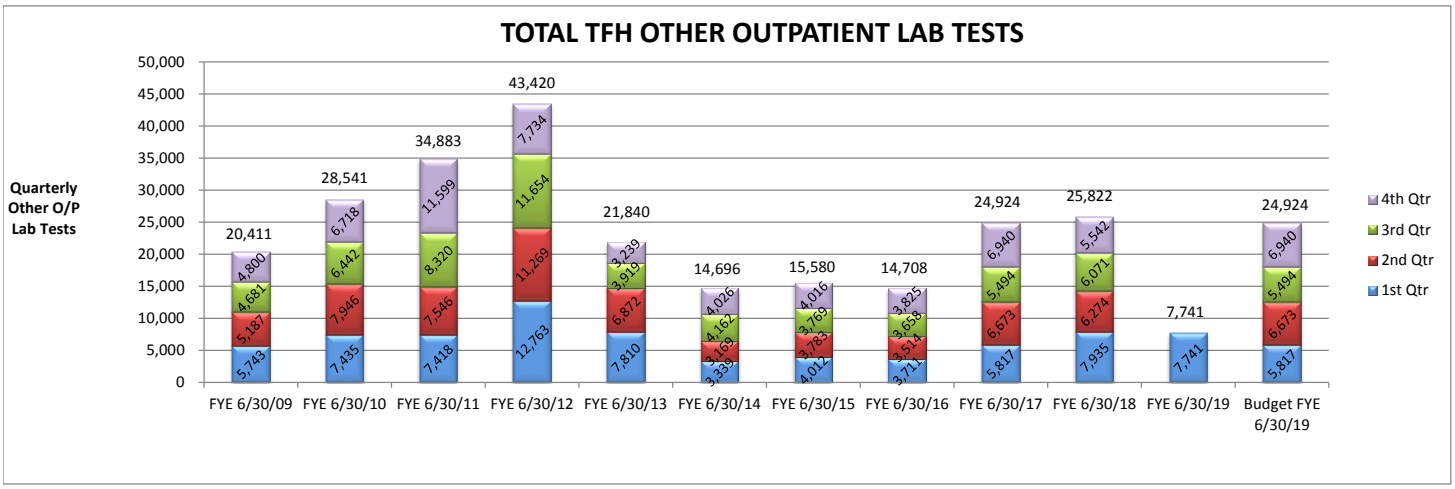


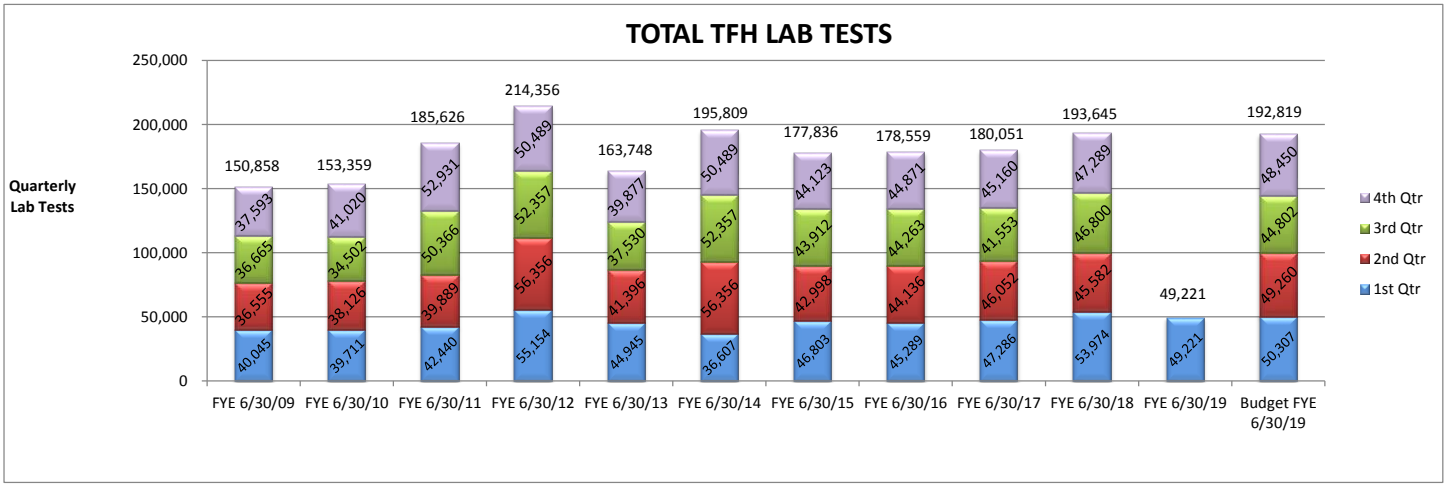
TOTAL TFH NUCLEAR MEDICINE EXAMS

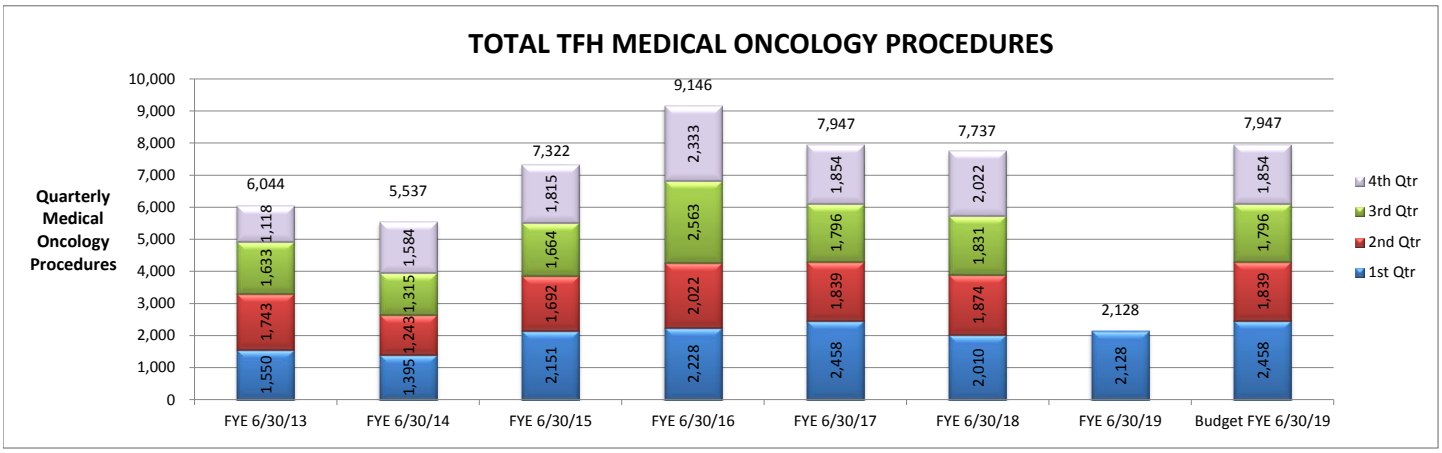


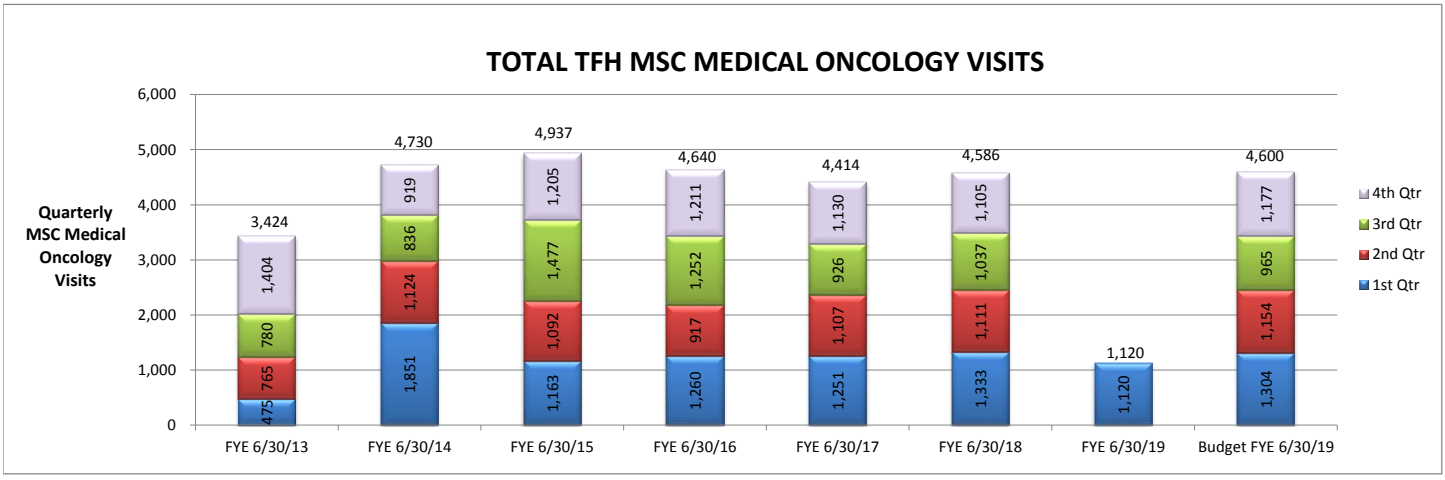

TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
28,267
29,890
33,764
35,235
34,654
31,957
33,320
34,106
36,871
30,502
8,058
32,961
6,778
8,139
6,302
7,048
8,573
6,421
7,377
7,519
7,539
9,729
7,810
8,686
9,063
8,042
8,451
9,679
8,993
9,165
7,817
8,679
9,864
8,271
6,808
7,014
8,095
8,888
7,094
9,243
8,211
9,396
8,677
7,822
8,964
8,535
8,967
10,405
7,119
6,998
7,141
9,244
8,058
7,977
7,744
7,997
9,243
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

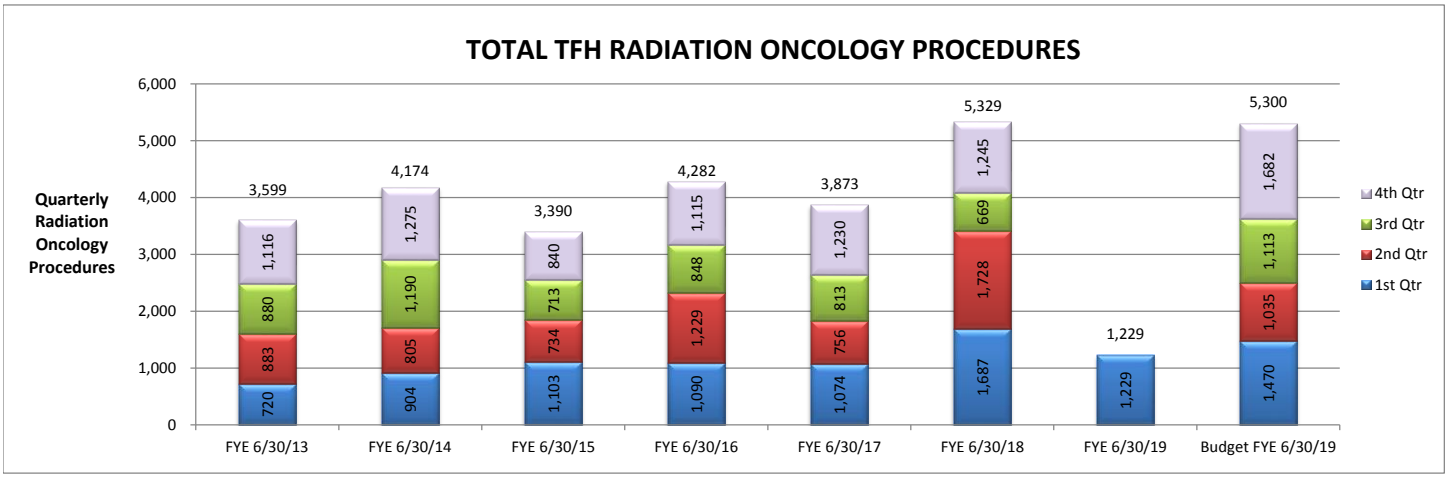

TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
102,180
94,928
116,979
135,701
107,254
109,864
128,936
129,745
118,256
137,321
33,422
134,934
26,015
23,845
25,066
27,254
25,729
21,639
22,803
24,757
33,793
32,317
24,533
26,336
33,692
32,661
36,636
32,712
27,645
24,446
26,707
28,456
30,355
26,672
26,583
26,254
32,012
31,255
32,121
33,548
32,835
31,209
31,945
33,756
29,256
27,524
30,412
31,064
34,628
33,731
32,167
36,795
33,422
33,533
31,564
34,590
35,247
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

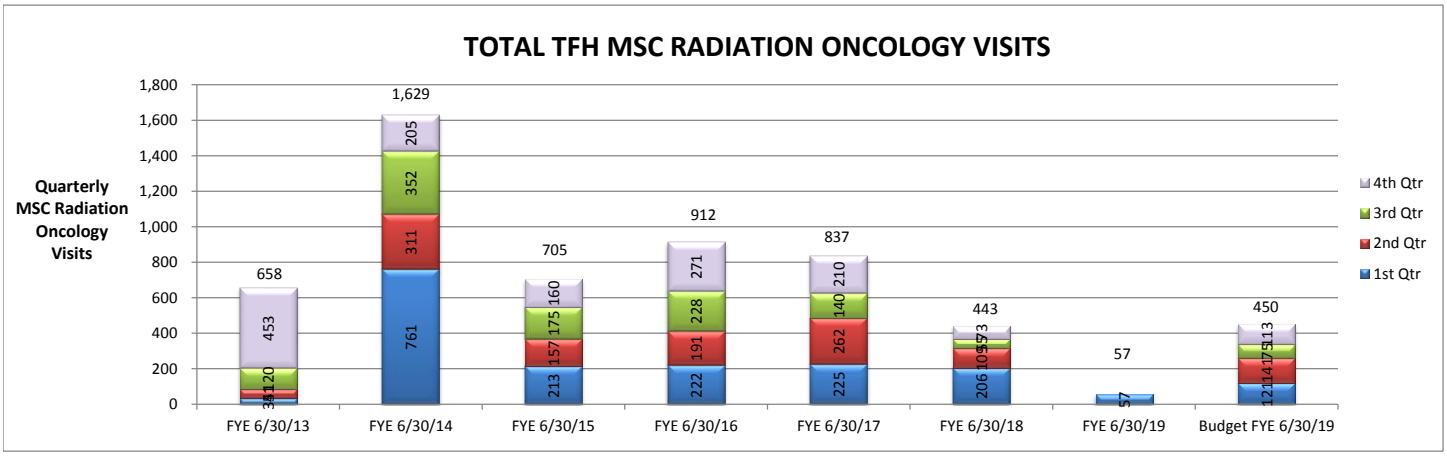

TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
20,411
28,541
34,883
43,420
21,840
14,696
15,580
14,708
24,924
25,822
7,741
24,924
4,800
4,681
5,187
5,743
6,718
6,442
7,946
7,435
11,599
8,320
7,546
7,418
7,734
11,654
11,269
12,763
3,239
3,915
6,872
7,810
4,026
4,162
3,153
3,338
4,016
3,769
3,783
4,012
3,825
3,658
3,514
3,711
6,940
5,494
6,673
5,817
5,542
6,071
6,274
7,935
7,741
6,940
5,494
6,673
5,817
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

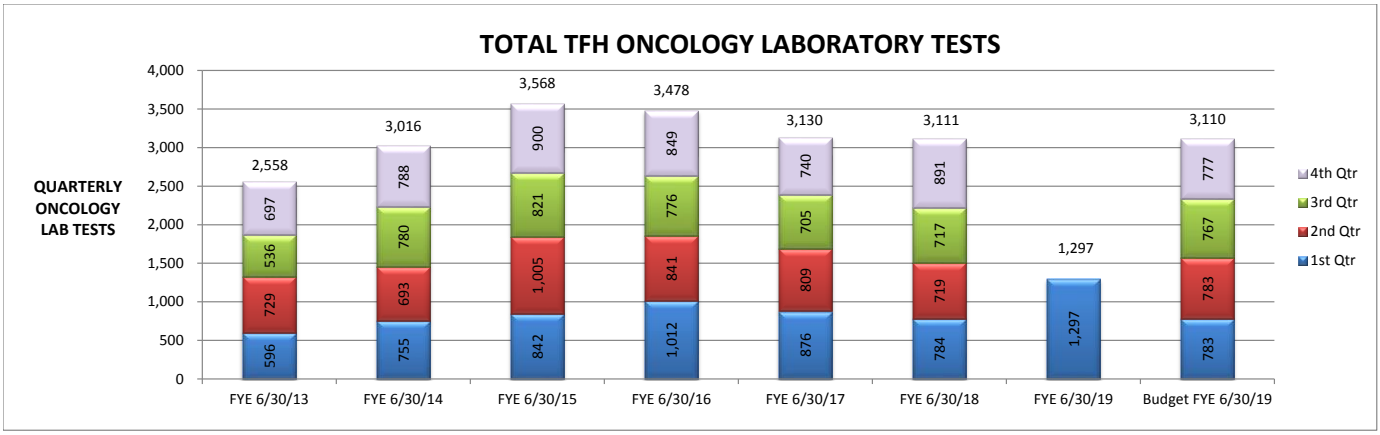

TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
150,858
153,359
185,626
214,356
163,748
195,809
177,836
178,559
180,051
193,645
49,221
192,819
37,593
36,665
36,555
40,045
41,020
34,502
38,126
39,711
52,931
50,366
39,889
42,440
50,489
52,357
56,356
55,154
39,877
37,530
41,396
44,945
50,489
52,357
56,356
36,607
44,123
43,912
42,998
46,803
44,871
44,263
44,136
45,289
45,160
41,553
46,052
47,286
47,289
46,800
45,582
53,974
49,221
48,450
44,802
49,260
50,307
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

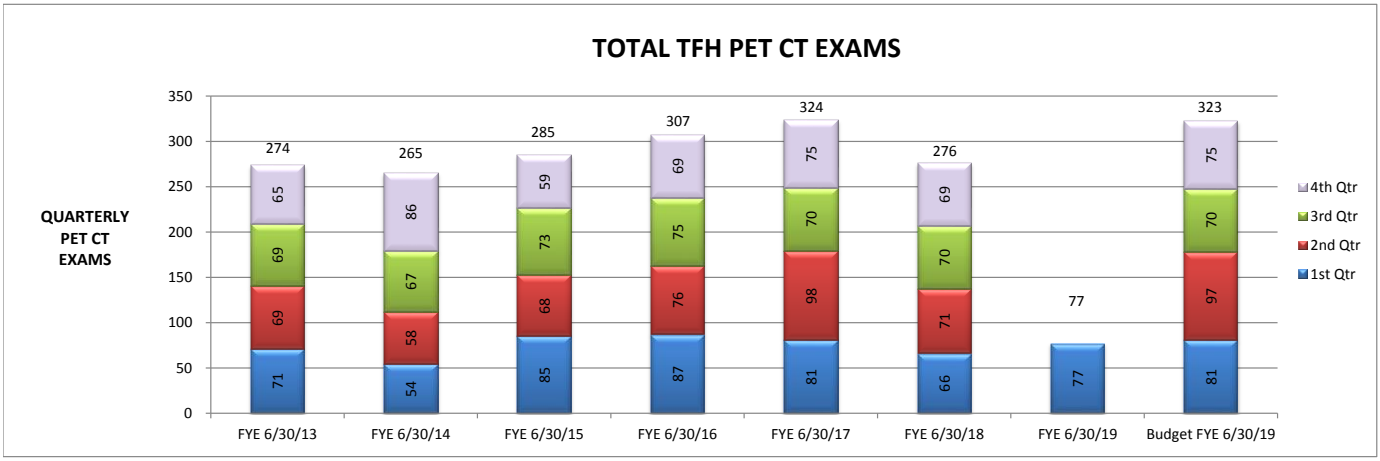

TOTAL TFH MEDICAL ONCOLOGY PROCEDURES
Quarterly Medical Oncology Procedures
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
6,044
1,550
1,743
1,633
1,118
5,537
1,395
1,243
1,315
1,584
7,322
2,151
1,692
1,664
1,815
9,146
2,228
2,022
2,563
2,333
7,947
2,458
1,839
1,796
1,854
7,737
2,010
1,874
1,831
2,022
2,128
2,128
7,947
2,458
1,839
1,796
1,854
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH MSC MEDICAL ONCOLOGY VISITS
Quarterly MSC Medical Oncology Visits
6,000
5,000
4,000
3,000
2,000
1,000
0
3,424
475
765
780
1,404
4,730
1,851
1,124
836
919
4,937
1,163
1,092
1,477
1,205
4,640
1,260
917
1,252
1,211
4,414
1,251
1,107
926
1,130
4,586
1,333
1,111
1,037
1,105
1,120
1,120
4,600
1,304
1,154
965
1,177
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

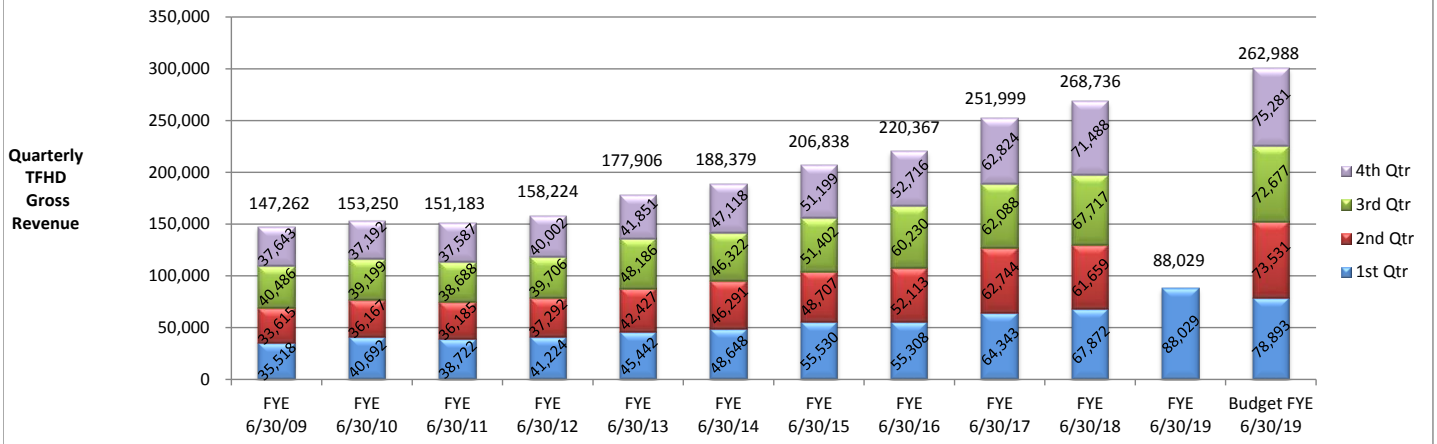

TOTAL TFH RADIATION ONCOLOGY PROCEDURES
Quarterly Radiation Oncology Procedures
6,000
5,000
4,000
3,000
2,000
1,000
0
3,599
720
883
880
1,116
4,174
904
805
1,190
1,275
3,390
1,103
734
713
840
4,282
1,090
1,229
848
1,115
3,873
1,074
756
813
1,230
5,329
1,687
1,728
669
1,245
1,229
1,229
5,300
1,470
1,035
1,113
1,682
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH MSC RADIATION ONCOLOGY VISITS
Quarterly MSC Radiation Oncology Visits
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
658
453
120
1,629
761
311
352
205
705
213
157
175
160
912
222
191
228
271
837
225
262
140
210
443
206
105
73
57
57
57
450
121
41
75
113
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

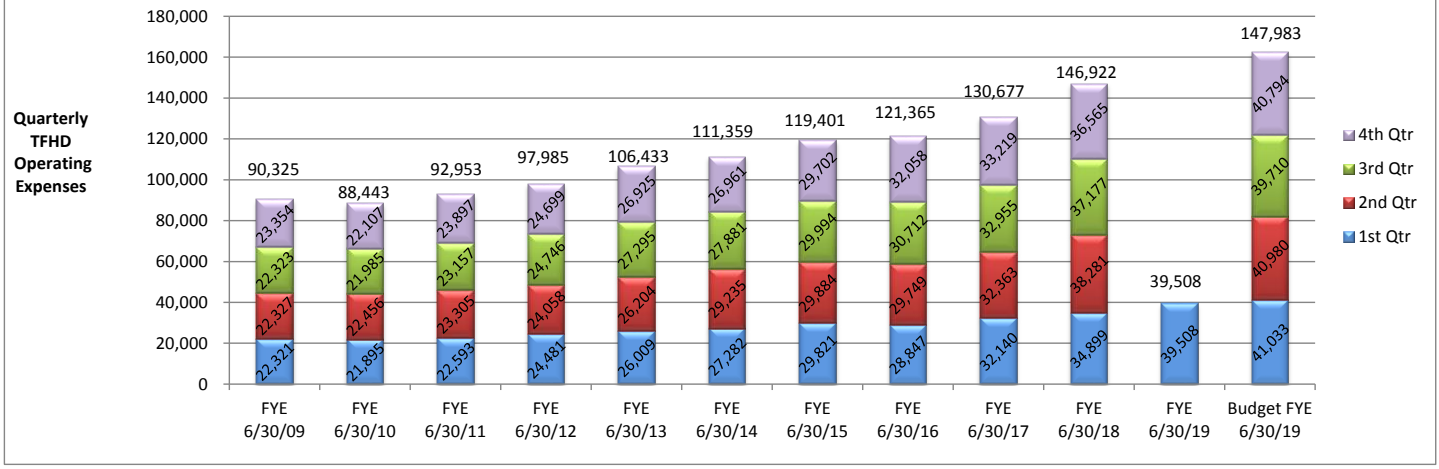

TOTAL TFH ONCOLOGY LABORATORY TESTS
QUARTERLY ONCOLOGY LAB TESTS
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2,558
596
729
536
697
3,016
755
693
780
788
3,568
842
1,005
821
900
3,478
1,012
841
776
849
3,130
876
809
705
740
3,111
784
719
717
891
1,297
1,297
3,110
783
783
767
777
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH PET CT EXAMS
QUARTERLY PET CT EXAMS
350
300
250
200
150
100
50
0
274
71
69
69
65
265
54
58
67
86
285
85
68
73
59
307
87
76
75
69
324
81
98
70
75
276
66
71
70
69
77
77
323
81
97
70
75
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
Budget FYE 6/30/19
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

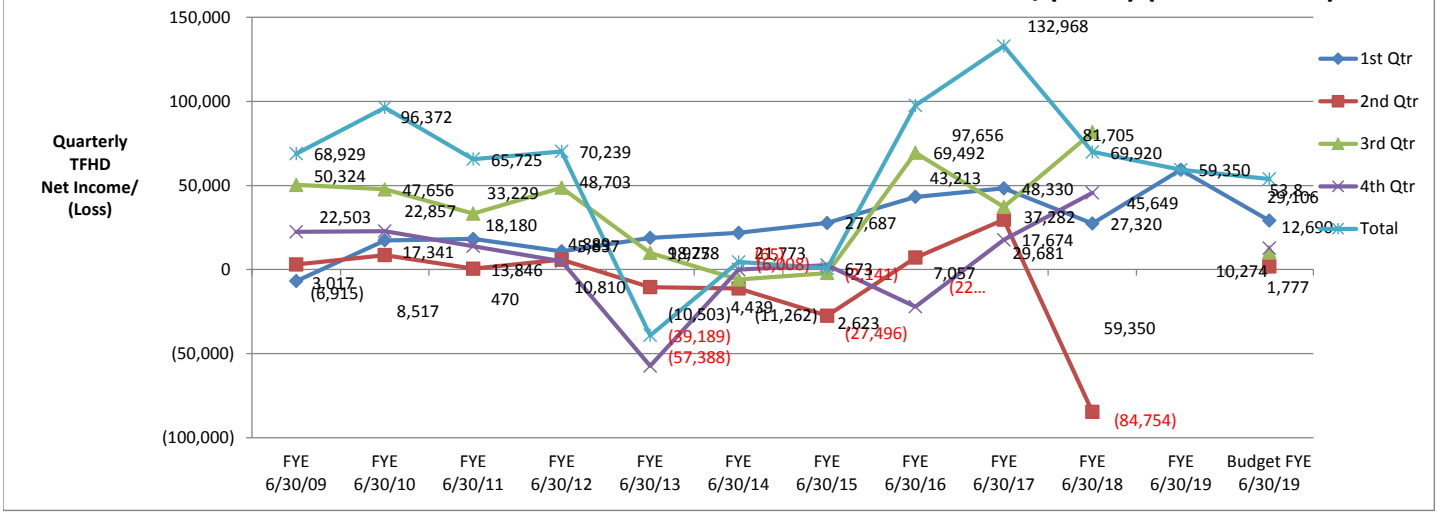
TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL NET INCOME/(LOSS) (In Hundreds)



TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 10/17/18

Our first quarter volumes have been really strong overall with life-time record breaking volumes in some areas. In the month of September, I estimate our overall volumes are 20% higher than budget. Also, year to date after the first quarter, I estimate our volumes are more than 10% higher than budget year to date.

We are grateful for the privilege of serving an ever growing number of patients in this region each year. Our patients come first and are the focus of everyone on our team!

Our financial performance continues to be strong and well above budget for the first three months of this fiscal year. Please see the financial report included in the board packet for additional details.

Our external auditors will present the audited financial report for the Health System this month for your review and approval. The last 3 fiscal years represent an amazing team effort providing very strong growth in both total assets and in the growth of the net worth or equity of this 69-year-old health system. These team results have and will allow us to make critical investments to more completely fulfill the Mission of this Health System than was thought possible in many earlier decades.

We will be working with the Board of Directors for a possible board retreat early next calendar year to discuss a variety of important matters including possible revisions to the View of 2021 Statement in our new Strategic Plan, new ways to engage more efficiently with consumers of healthcare and other possible positive changes in our healthcare system to be able to retain and recruit talent across the team!

Our team continues to focus on improving all aspects of our revenue cycle along with a very strong focus on reducing the growth in our Accounts Receivable since our go live on EPIC. Additionally, we are working on a rapid go live of a customer service team to help all patients navigate our health system and to have their questions answered regarding any financial “out of pocket” costs.

The overall competitiveness of our pricing continues to improve over two years ago. Now on an inpatient basis, our average inpatient total charges per discharge are 52% below the California statewide average, where two years ago they were 49% below the CA statewide average. Further our outpatient average total charges per outpatient visit were 62% below the statewide average two years ago and now they are 65% below the statewide average. This is the lowest total charge pricing structure I have seen in California versus the statewide average for a profitable health system since I arrived in California in 1980.

We share this information to honor all residents and guests of our region. We recognize healthcare in America is not inexpensive. As we have shared in past CEO and other reports, our goal is to keep our residents and guests healthy and out of our inpatient nursing units and out of our Emergency Department to the maximum degree possible for illness challenges. This focus provides material additional savings for all residents and guests in our region.

Our provider office visits continue to grow strongly on annualized basis in fiscal year 2019 against fiscal year 2018.

In the last two weeks, for the first time in the health system's history, we began to directly provide primary care physicians who serve our community 7 days a week. These services are located in our Internal Medicine/Cardiology offices in the Gateway Center at 10978 Donner Pass Road.

Our previous Administration building on Pine Avenue has been totally demolished and was used by local fire agencies for special practice drills. This will enable a larger footprint for critical parking which will be a growing challenge for several years into the future.

We are also about to commence the construction work on the second floor of the Cancer Center and on the third floor of the medical office building.

We are also actively working on the go live of several rural health clinics in our health system.

Our team is focused on the Strategic Plan that was recently approved by the Board.

We have been and remain very active on critical state level legislation with many team successes in our industry to protect and improve healthcare in our region.

Keeping you informed.

Harry

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Judith B. Newland DATE: October 2018

Strategic Plan Update

The Strategic Plan Framework was approved at the September 27th Board of Directors meeting. This past month education to hospital and medical staff has begun. Directors/Managers have begun, or will be educating their staff to the Health System Strategic Plan with a completion date of December 1, 2018. Each Director/Manager has been given talking points to assure all important information is shared with staff. Administrative Council members are participating in the Lunch and Learns that have been set up at Tahoe Forest Hospital, Incline Village Community Hospital, and Pioneer Center to educate staff. Education on the Strategic Plan to the Medical Executive Committee and Quarterly Medical Staff meeting has been placed on their agendas. The high-level strategic plan overview pamphlet is still in draft format.

Pursue Excellence in Quality, Safety and Patient Experience

Focus on our culture of safety

As part of the Health System's commitment to safety and being a high reliability organization, we have begun training for a high reliability team. Training begins with review of 47 modules covering principles of reliability and 24 modules designed to walk individuals through using the systems and behaviors response guide. A two-day training is also scheduled in December.

Tahoe Forest Hospital District participated in a Hazardous Material drill in conjunction with Nevada County and the Truckee Fire HazMat Team. The Incident Command System was implemented with pre-assigned participant positions. Each position was filled by a mentor and a trainee. It was a very successful drill.

A multidisciplinary team of quality, nursing and medical staff attended a two-day training as part of our participation in the BETA HEART program. The program focused on transforming employee and patient safety.

Prioritize the patient and family perspective

Development of a two hour patient and family experience training program has begun. The purpose of the training program is to align all staff in our approach to patients, visitors, and each other. Training will begin in 2019.

Foster and Grow Community and Regional Relationships

Enhance and promote our value to the community

The Incline Village Community Hospital Foundation (IVCHF) had a successful Donor Appreciation Luncheon in October. The luncheon was held at IVCH with excellent catering by TFHS dietary services. Dr. Koch and Dr. Kim, both Family Practice physicians in Incline Village gave a talk on flu immunizations. Flu shots were made available to those attending.

Optimize Deliver Model to Achieve Operational and Clinical Efficiency

Implement a focused master plan

Report provided by Dylan Crosby, Manger Facilities and Construction Management

Moves:

- The TFHS Foundation moved to a new location at 11075 Donner Pass Road.
- The Physician Services leadership has moved to the old TFHS Foundation location at 10976 Donner Pass Road.
- The offices for Medical Staff, Chief Medical Officer, Marketing, Governance and Compliance have moved to 10985 Spring Lane.

Projects in Progress:

Project: TFH Fire Alarm Replacement Project
Start of Construction: 3/12/2018
Estimated Completion: 7/12/2019
Summary of Work: Remove and replace existing Fire Alarm System.
Update Summary: Loop transition is 99% complete, Chime and Strobe replacement is 99% complete. The last phase of the project, the replacement of fire smoke damper maintenance switches, was started early October and is estimated to complete in 75 days.

Project: TFHD Pharmacy Clean Room, OSHPD S170926-29-00
Estimated Start of Construction: 4/30/2018
Estimated Completion: Spring 2019
Summary of Work: To meet new federal USP 800 regulations the surgical special procedures room will be reconstructed to house pharmacy compounding during construction, Phase 1. Phase 2 will be to reconstruct the Pharmacy to meet USP 800 requirements.
Update Summary: Certification of the temporary room is in progress.

Project: IM Cardiology Expansion
Estimated Start of Construction: 6/11/2018
Estimated Completion: 10/1/2018
Summary of Work: Construct 3 new exam rooms and a MD/MA office in the west end of IM Cardiology to increase access for care.
Update Summary: Project has been given occupancy and providers are working in the area. There is one punch list item remaining which is in progress.

Project: 3rd Floor MOB Phase 1
Estimated Start of Construction: 11/19/2018
Estimated Completion: Fall 2019
Summary of Work: Phase 1 reconstruct the 3rd Floor MOB 2 western suites for increased flexibility and additional exam rooms.
Update Summary: Board approved. Project is scheduled to start in November.

Project: Cancer Center 2nd Floor
Estimated Start of Construction: 10/18/2018
Estimated Completion: Fall 2019
Summary of Work: Construct the 2nd floor of the Cancer Center for expansion of Rural Health Clinic Services.
Update Summary: Board approved. Project is starting 10/18/2018

Project: Administration House Renovation
Estimated Start of Construction: 9/3/2018
Estimated Completion: 10/5/2018
Summary of Work: Renovate the new Administration Services house, old home health house, in preparation for the site improvement project.
Update Summary: Project is Completed.

Project: Tahoe Forest Hospital Site Improvements Phase 1
Estimated Start of Construction: 10/15/2018

Estimated Completion: 12/7/2018
Summary of Work: Demolish the existing administrative building to increase patient parking.
Update Summary: Project is underway. We were very pleased to allow the Truckee Fire Department to train in the vacated space prior to demolition.

Project: Campus Water Improvements
Estimated Start of Construction: June 2019
Estimated Completion: August 2019
Summary of Work: Move the PRV station to Donner Pass Rd allowing the Hospital campus to tie into the high pressure water line in Donner Pass Rd. This will allow for a higher average of water pressure throughout the campus.
Update Summary: Project is out to bid.

Projects in Permitting:

Project: Tahoe City Physical Therapy Expansion
Estimated Start of Construction: February 2019
Estimated Completion: May 2019
Summary of Work: Lease and renovate the remainder of the second floor of existing building.
Update Summary: Permit has been approved. The project will be sent to bid early November.

Project: Center for Health and Sports Performance Renovation
Estimated Start of Construction: February 2019
Estimated Completion: May 2019
Summary of Work: Transform existing center into open floor concept and provide additional treatment tables.
Update Summary: Permit has been approved. The project will be sent to bid early November.

Projects in Design:

Project: Day tank and Underground Storage tank replacement.
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remove and replace the 30-year-old underground storage tank and existing day tank.
Update Summary: Project is in the process of being designed.

Project: 2nd Floor MOB
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel 3 suites of the 2nd floor of the MOB.
Update Summary: Project is in the process of being designed.

Project: ECC Interior Upgrades
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel all patient rooms and dining area of the 1985 building of the ECC
Update Summary: Project is in the process of being designed.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS
Chief Nursing Officer

DATE: October 2018

Strategic Goal: Use technology to improve efficiencies

- Home Health and Hospice EPIC implementation continues to move forward with focus on billing and collections through our third party biller
- Care Coordination will be making a trip to Mercy Epic to continue work on the Population Health and retail components of services that we offer at TFHD. This will also include work on our growing behavioral health services that are now being offered through the District.

Strategic Goal: Prioritize the patient and family perspective

- Karyn Grow, our Administrative Director of Case Management and Care Coordination will be receiving the District award from CALNOC and has been asked to speak at the Annual Conference regarding our readmission efforts through the Care Coordination efforts that has lowered our readmission rate at TFHD.
- Our volumes continue to rise and as a result we have elected to move forward with increasing our case management department to seven days a week. This change will occur after the first of the year.

Strategic Goal: Focus on our culture of safety

- This month we completed our HAZMAT drill with the supporting efforts of the Truckee Fire department, the Emergency Department, the Truckee Police and county representatives. We had great participation by all departments within the facility and are really showing effort at improving emergency response to situations that could occur in our community.
- The PRIME program submitted their report to the State and we were able to meet all of our initiatives. TFHD PRIME was chosen as one of the outstanding programs and was asked to submit additional information regarding specific cases. If chosen as the leader, additional funding may become available to the District.
- Score survey reviews with staff have been completed and final action items are being addressed within the individual departments.
- The Emergency Department is moving forward with the Level III trauma and are in the process of hiring a trauma coordinator and medical director for the program. The second group of nurses has completed their trauma certification.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst **DATE:** 10/12/2018

CIIO

- Network/Infrastructure Refresh project continues October 22/23 for Corporate Firewalls.
- Xcelera-Cardiology software for Echocardiograms large upgrade in progress.
- Imprivata-Single sign on/tap card/rapid access to Epic project beginning.
- Varian Oncology Server Virtualization Project started.
- Dietary Software project underway. Interfacing to Epic ADT and Orders.
- Mediware Blood Bank large upgrade to begin in December 2018.
- Epic Cancer Center/Beacon project will kick off the week of November 12 with Mercy onsite.
- M Modal Voice Recognition integration with Epic to allow auto sign on to M Modal for providers using Epic password. Go live next week.
- CA and NV Prescription Drug Monitoring sites added to TFH Intranet and all provider dashboards in Epic.
- HIPAA Meaningful Use Security Audit vendor selected and kick off call completed. Data gathering is underway.

TAHOE FOREST HEALTH SYSTEM

Board Informational Report

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

DATE: September 13, 2018

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1. **PEOPLE: Strengthen a highly-engaged culture that inspires teamwork**
   We enjoyed a very successful social event welcoming the new physicians at my house with about 85-90 physicians, their partners and children. This was very well received and brought the team together enjoying each other outside of work. We welcome Dr. Katy Schousen and Dr. Josh Pfent, new Family Practice physicians, this month.

2. **SERVICE: Optimize delivery model to achieve operational and clinical efficiency**
   Our IT team is planning to hire a physician IT advocate for Inpatient Epic support to continue individualizing our Epic build to maximize our efficiency and operability.

3. **QUALITY: Pursue excellence in quality, safety, and patient experience**
   Dr. Josh Pfent has successful started our first weekend clinic! We are happy to now have 7 days a week access with same day appointment availability. This has been very wells received.

4. **FINANCE: Ensure a highly sustainable financial future**
   We continue to optimize our charging with providers and will soon have feedback to providers from our recent M-Modal Audit of provider charges.

5. **GROWTH: Foster and grow community and regional relationships**
   A small leadership team will be going to Renown's first annual "Transfer Center Symposium" in hopes of further solidifying our transfer arrangement with Renown and learn how they can help keep our patients within our hospital and community when appropriate.

TAHOE FOREST HOSPITAL DISTRICT

Board CHRO Report

By: Alex MacLennan, PHR **DATE: October 2018**
Chief Human Resources Officer

Priority One: Strengthen a highly-engaged culture that inspires teamwork

- Goal – Build Trust
  - We have been working hard to improve communication.
  - We have implemented a weekly Bulletin while also have been improving the communications on the internal current intranet site. Many employees have expressed has been a positive change.
  - The adoption of a new intranet site will be launched soon.
  - An employee engagement survey is scheduled to be rolled out in November and we are working on the employee mapping of this project now.
  - We continue to hold employee focus groups with HR and the CEO. These have proven to be a very valuable way for information gathering. Our next session is scheduled in November.
  - We have started a Values Advocacy committee. This group of 21 employees will help us communicate, help us understand the employee perspective, and help narrow the trust gap.
  - We have started negotiations with both the Employees Association (EA) and Employees Association of Professionals (EAP) under their new affiliation with AFSCME Council 57. We have been working collaboratively to simplify language and clean up many of the provisions of both MOU's. I appreciate the efforts of all parties on the negotiation teams.
- Goal – Build a culture based on the foundation of our Values
  - We continue to hold our Values based training monthly where new employee attend a full day to understand our unique TFHS culture.
  - We have been developing an orientation for Managers, Supervisors and Directors to help guide them with many of the Human Resources policies and practices as well as important laws and regulations that are unique to us.
- Goal – Attract, develop and retain strong talent and promote great careers
  - We have modified how we use Nurse Unit Based Educators to allow them more focused time to assist in departmental education.
  - We are in the process of hiring a Non-Clinical Educator to assist us in developing organizational wide development opportunities. This position will also be responsible for non-clinical education throughout the district.

Stats:

19	New Employees
1	Ended Employment
29	New Leave of Absence (LOA)
82	Total LOA (18 Intermittent)

ABD-07 Conflict of Interest

PURPOSE:

A. To protect the interests of Tahoe Forest Hospital District (TFHD) when it is contemplating entering into a transaction or arrangement that has the potential for benefiting the private interests of a member of the Board of Directors ("Director"), committee member or other "Interested Person," as defined below.
B. To educate and guide Directors and staff on the statutory Conflict of Interest policy which requires that public officials, whether elected or appointed, should perform their duties in an impartial manner, free from bias caused by their own financial interests or the financial interests of persons who have supported them, (Political Reform Act Cal. Gov. Code §§ 81000-81016 and Cal. Gov. Code §§1090-1098), and to supplement the multiple laws that govern conflicts of interest for public officials.
C. To guide, assist and protect TFHD in determining whether a conflict exists under these laws and what required steps, if any, must be taken.
D. To ensure that all individuals who, due to their position, can influence decisions affecting the business, operations, ethical, and/or competitive position of TFHD, perform their duties in an impartial manner free from any bias created by personal interests of any kind.
E. To clarify the duties and obligations of public officials, in the context of potential conflicts of interest and to provide them with a method for disclosing and resolving potential conflicts of interest.
F. To establish general principles for the management of conflicts of interest in order to protect against situations that could prevent a public official from acting in the best interest of the organization.

DEFINITIONS:

A. **Conflict of Interest**: An Interested Person has a Conflict of Interest with respect to a governmental decision, contract, transaction, or arrangement in which the District is (or would be, if approved) a party if the person has, directly or indirectly, through a business, investment, family, or other relationship:
    1. an ownership or investment interest in any entity involved in such contract, transaction, or arrangement.
    2. a compensation arrangement with an individual or entity involved in such contract, transaction, or arrangement.
    3. a potential ownership or investment interest in, or compensation arrangement with, an individual or entity with which the District is negotiating such contract, transaction, or arrangement.
    4. a fiduciary position (e.g., member, officer, Director, committee member) with respect to an entity involved in such contract, transaction, or arrangement.
    5. a non-economic affiliation or relationship, directly (or indirectly, through a third party) with an individual or entity with which the District is negotiating or maintains a contract, transaction, or arrangement such that the affiliation or relationship could render the ~~Director~~ Interested Person incapable of making a decision with only the best interests of the District in mind.

    A conflict of interest may exist when an obligation or situation resulting from an individual's personal activities or financial interest may adversely influence, or reasonably be perceived as influencing, the individual's judgment in the performance of duties to the District. For purposes of this policy, personal activities or financial interests include, but are not limited to, a business, commercial or financial interest, either of the Director or staff deriving from family or marital relationships, from friends, or from former, existing or prospective business associations.
B. **Interested Persons**: For purposes of applying this Policy to any contract, transaction, or arrangement involving TFHD, "Interested Person" shall mean any person in a position to exercise substantial influence over the District in the twelve month period ending on the date the proposed contract, transaction or arrangement is formally presented to the Board for approval. Interested Person includes, but is not limited to, Directors, any executive leader or manager, or members of a committee with board-delegated powers. The Board may also determine, based upon all the facts

and circumstances (with the advice of legal counsel, if necessary) that a person other than an Interested Person shall be treated as an Interested Person with respect to a particular contract, transaction or arrangement.

POLICY:

A. It is the policy of TFHD to comply with all laws, including all conflict of interest rules and regulations.

B. Each person who is a Board Director, or all employees of TFHD shall exercise good faith and best efforts in the performance of his or her duties to TFHD and all entities affiliated with TFHD. In all dealings with and on behalf of TFHD or any affiliated entity, each such person shall be held to a strict rule of honest and fair dealing with TFHD and its affiliated entities, and no such person shall use his or her position, or knowledge gained thereby, in such a manner as to create a conflict, or the appearance of a conflict, between the interest of TFHD or any affiliated entity and the interest of such person. The appearance of a conflict of interest is present if a reasonable person would conclude there is a potential for the personal interests of an individual to clash with his/her fiduciary duties. It is the policy of TFHD to require that any individual subject to this Policy promptly and fully disclose a written description of the material facts of the actual, apparent, or potential Conflict of Interest to the Board of Directors. The disclosure requirement is an ongoing responsibility as conditions change. An oral statement reflected in the minutes of a meeting constitutes a written disclosure under this policy.

C. TFHD will not make a governmental decision or engage in any contract, transaction, or arrangement involving a Conflict of Interest unless the disinterested members of the Board of Directors (acting at a duly constituted meeting thereof) (with the advice of legal counsel, if necessary) determine that appropriate safeguards to protect TFHD have been implemented, and, if allowed by law, the disinterested members approve the governmental decision, contract, transaction, or arrangement by a majority vote of a quorum of the Board or consistently with a rule of necessity provided under the Political Reform Act or applicable law.

D. No person who is a Director, Chief, or employee of TFHD shall accept any (material) compensation, gift, or other favor which could influence or appear to a reasonable person to influence such person's actions affecting TFHD or any affiliated entity.

E. In compliance with the law, all Interested Persons and individuals occupying designated positions on TFHD's Conflict of Interest Code shall complete and file Statements of Economic Interest (Form 700) annually with TFHD. Disclosure is required as determined by the individual's Disclosure Category, which is listed in the Conflict of Interest Code.

PROCEDURE:

A. **Duty to Disclose.**

1. An Interested Person has a continuing obligation to disclose (in the manner provided in this Policy) the existence and nature of any actual, apparent or potential conflict of interest he/she may have.
2. Whenever an Interested Person has a financial or personal interest, whether or not said matter is an actual, apparent or potential conflict of interest, in any matter coming before the Board of Directors, the affected person shall fully disclose the nature of the interest to the Board of Directors, and such disclosure shall be recorded in the minutes of the meeting, including enough of the material facts to adequately reflect the nature of the actual, apparent, or potential conflict of interest. The Statement of Disclosure may be oral or written.
    a. **TFHD Board of Director as an Interested Person.** If the Interested Person is a member of the TFHD Board of Directors, the Director:
        i. Must publicly announce at a duly scheduled TFHD public meeting the specific financial interest that is the source of the disqualification, and
        ii. After announcing the financial interest, must leave the room during any discussion or deliberations on the matter in question, and may not participate in the decision or be counted for purposes of a quorum; as consent calendar items are not the subject of discussion or deliberation, a

Director need not leave the room as to such items unless they are pulled from the consent calendar for discussion;

iii. In the case of a closed session, the Director still must publicly declare his or her conflict in general terms but may do so in a way that does not disclose closed session information;

iv. A disqualified Director may not attend a closed session or obtain any confidential information from the closed session.

All of these restrictions are separate and apart from the Director's right to appear in the same manner as any other member of the general public before an agency in the course of its prescribed governmental function solely to represent himself or herself on a matter which is related to his or her personal interests provided that such participation is permitted under applicable rules of the Fair Political Practices Commission.

b. **All Other Interested Persons.** All other Interested Persons, at the discretion of the Board of Directors, may be required to leave either the room or refrain from discussion during any discussion or deliberations on the matter in question or while the proposed governmental decision, contract, transaction or arrangement is discussed, and may not attend a closed session or obtain any confidential information from the closed session. The Interested Person shall leave the room while the matter is voted on and only disinterested Directors may vote to determine whether to approve the transaction or arrangement. No duty to leave the room shall apply to matters on the consent calendar which are not pulled from that calendar for discussion.

3. In determining whether and when to require an Interested Person to leave the room during discussion of the proposed governmental decision, contract, transaction or arrangement, the disinterested Directors shall balance the need to facilitate the discussion by having such person on hand to provide additional information with the need to preserve the independence of the Board's decision.

B. **Determining Whether a Conflict Exists.**

1. Generally, it is the legal responsibility of the Interest Person to comply with conflict of interest laws. However, when it has information that an Interest Person has an actual or potential conflict of interest with respect to one of its decisions and have not voluntarily abstained, the Board shall examine each transaction under its consideration in light of the relevant laws mandating impartiality and freedom from bias, and conduct an analysis of all the facts to determine if a conflict of interest exists which triggers a disqualification requirement.
2. At any time that an actual, apparent, or a potential Conflict of Interest is identified to the Board of Directors, whether through the voluntary submission of a Disclosure Statement, or by a disclosure by a person other than the subject Interested Person, the disinterested Board members shall review the matter and determine by majority vote whether a Conflict of Interest exists. While the Board may not have the power to bar an interested Board member from participating in a discussion due to its conclusion he or she has a disqualifying conflict of interest, it can instruct its Clerk not to record the vote of a Director the Board determines on the advice of legal counsel to be disqualified from voting on a matter.
3. The Board shall evaluate whether a conflict of interest exists under the multiple laws governing conflicts by first applying the four-step analysis promulgated by the Fair Political Practices Commission.

STEP 1: Is it reasonably foreseeable that the decision with have an effect on a financial interest of a public official?

STEP 2: If yes, is that effect material?

~~**STEP 3**: Will the official make, participate in making, or use his or her official position to attempt to influence the decision?~~

STEP 43: If the answers to steps 1 and 2 are both yes, is the effect on the public official's material financial interest the same as its effect on the interests of the public generally?

~~3.~~ **STEP 4**: If the effects are not the same on the public generally, will the public

official be making, participating in the making of, or using their position to influence the making of the governmental decision that will cause those effects?

If the answer to the first ~~three~~ two of these questions is "yes," ~~,~~ the answer to the third question is "no," and ~~unless~~ the answer to the fourth question is also "yes," then the official may have a conflict of interest and be required to disqualify him/herself from all participation in that decision.

4. If disqualification of the Interested Individual is not required as a result of this analysis, the Board shall further evaluate whether a conflict exists or has arisen out of matters other than a financial interest, e.g., friendship, blood relationship, or general sympathy for a particular viewpoint. The potential for a conflict arises when a Board Member (or committee member) has, directly or through a family member, a material personal interest in a proposed contract, transaction, arrangement, or affiliation to which TFHD may be a party.
5. To the extent that other Federal or State laws may impose more restrictive conflict-of-interest standards (including more extensive disclosures of actual or potential conflicts of interest), the Board of Directors, the District and any Interested ~~person~~ Person shall also comply with such additional standards.
6. The following is a non-exclusive list of the ***types of questions*** the Board may use as part of its efforts to determine whether an Interested Person's interest constitutes a conflict of interest:
    a. With respect to an **ownership or investment interest**:
        i. The dollar value of the interest;
        ii. The dollar value of the interest as a percentage of ownership interest in the entity;
        iii. The perceived importance of the transaction or arrangement to TFHD and to the entity, respectively;
        iv. Whether the transaction or arrangement can reasonably be expected to have a materially favorable impact on the value of the ownership or investment interest;
        v. The extent to which the ownership or investment interest might reasonably be expected to influence the entity in connection with its performance under the transaction or arrangement; and
        vi. Other similar factors.
    b. With respect to a **compensation arrangement**:
        i. The dollar value of the arrangement;
        ii. The nature of the underlying compensation arrangement.
    c. With respect to **public office and campaign contributions**:
        i. Whether a single official holds two public offices simultaneously;
        ii. Whether jurisdiction overlaps;
        iii. Whether there is a pending issuance of a license, permit or entitlement;
        iv. Whether there is a receipt of contributions of more than $250 from any affected person in the twelve months before the decision;
        v. There is a receipt of gift(s);
        vi. The date of contribution(s).
    d. For **Vendors**:
        i. The dollar value of the services;
        ii. The dollar value of the goods or services relative to the overall volume of goods or services: (i) purchased by TFHD in general; (ii) purchased by TFHD for this particular good or service, i.e., legal services, etc.; or (iii) provided by the Interested Person or Interested Person's affiliated entity in general;
        iii. The Interested Person's position within the vendor entity, i.e., owner, partner, or employee;
        iv. The impact the business relationship with TFHD has on the Interested Person's compensation from or career advancement within this entity;
        v. Whether the Interested Person provides the services directly, supervises the delivery of services, or has no connection to the delivery of services; and

vi. Where in the TFHD organizational hierarchy lays the decision to authorize the goods or services to be purchased from the Interested Person/vendor directly or indirectly.

e. With respect to **non-financial interests**:
   i. The materiality of the interest;
   ii. The nature of the interest;
   iii. The presence of specific factors that may prevent the Interested Person from acting in the best interests of TFHD in connection with the transaction or arrangement;
   iv. With respect to multiple board memberships, the presence of specific factors indicating a potential whereby the Interested Person may subordinate his/her duty to TFHD to his/her duty to the other entity for which he serves as a board member; and
   v. Other similar factors.

7. Common ***examples of financial interests*** which could potentially create a conflict of interest, include, but are not limited to the following:
   a. An ownership or investment interest in a business involved in a contract, transaction or arrangement with TFHD;
   b. A compensation arrangement with an individual or entity involved in a contract, transaction or arrangement with TFHD;
   c. A potential ownership or investment in, or compensation arrangement with, an individual or entity with which the non-profit organization is negotiating a contract, transaction, or arrangement for services
8. Some ***examples of non-financial interests*** which could potentially create a conflict of interest, include, but are not limited to the following:
   a. Director A serves on the board of a hospital, which is considering an expansion of its community ambulatory surgery centers, while simultaneously serving on the board of a local community college, which plans on establishing medical clinics to serve the needs of students, faculty, employees and those living in the area;
   b. Foundation Director B simultaneously serves on the board of a Museum, both of which are considering the commencement of a capital campaign that will target the same community of potential donors;
   c. The brother of Hospital Director A serves as the uncompensated chairman of the board of physician group, which is considering an affiliation with the hospital.

   A finding of conflict of interest is not contingent on willful wrongdoing, or upon whether an individual's judgment has actually been affected. A conflict of interest may exist regardless of whether a monetary advantage has been or may have been given to an individual.
9. The Board may request additional information from all reasonable sources and may involve General Counsel in its deliberations.
10. Once all necessary information has been obtained, the Board shall make a finding by majority vote as to whether a conflict of interest indeed exists.

C. **Addressing the Conflict of Interest.**

1. Once the disinterested members of the Board of Directors have determined that an actual conflict of interest exists with respect to a particular transaction or arrangement:
   a. The disinterested members of the Board of Directors shall exercise due diligence to determine whether TFHD could obtain a more advantageous contract, transaction or arrangement with reasonable efforts under the circumstances and, if appropriate, shall appoint a non-Interested Person or committee to investigate lawful alternatives to the proposed contract, transaction or arrangement.
   b. In considering whether to enter into the proposed contract, transaction or arrangement, the Board of Directors may approve such a contract, transaction or arrangement by a majority vote only if the disinterested Directors determine that:
      i. The proposed contract, transaction or arrangement is in TFHD's best interests and for TFHD's own benefit; and
      ii. The proposed transaction is fair and reasonable to TFHD, taking into

account, among other relevant factors, whether TFHD could obtain a more advantageous contract, transaction or arrangement with reasonable efforts under the circumstances.

D. **Violations of the Conflicts of Interest Policy.**

1. If the Board of Directors or committee has reason to believe that an Interested Person has failed to comply with the disclosure obligations of this Policy, the Board of Directors shall inform that person of the basis for its belief and provide that person an opportunity to address the alleged failure to disclose.
2. After hearing the response of such person and conducting such further investigation as may be warranted under the circumstances, the Board of Directors shall determine whether such person has, in fact, violated the disclosure requirements of this conflicts of interest policy.
3. If the Board determines that there has been a violation of the conflict of interest policy, the Board shall take appropriate disciplinary and corrective action, which may include removal from a Committee, if the Interested Person is a Board or committee member, or disciplinary action up to and including termination, if the Interested Person is an employee.
4. Board of Director violations of the conflict of interest policy may result in various consequences, such as citizen recall or criminal or civil sanctions or penalties imposed by the Fair Political Practices Commission (FPPC) for violations of the Political Reform Act.

E. **Records of Proceedings.**

The minutes of meetings of the Board of Directors and any committee with board delegated powers shall include:

1. the names of persons who disclosed or were otherwise found to have actual, apparent, or potential interests relevant to any matter under discussion at the meeting, a general statement as to the nature of such interest (e.g., employment arrangement, equity interest or board membership or officer position in another corporation), any action taken to determine whether a conflict of interest existed, and the board or committee's conclusion as to whether a conflict exists; and
2. the names of the persons (other than members of the general public) present for the discussions and votes relating to the transaction, or arrangement, a summary of the content of these discussions that contains the type of information regularly reported in board or committee minutes and identifies whether any alternatives were considered, and a record of any vote taken in connection therewith.

F. Annual Statements

1. Statement of Economic Interests (Form 700):
    a. The ~~Human Resources Department~~ Clerk of the Board or his/her designee shall notify all designated positions of the requirements for completion of the Statement of Economic Interests. For more information, access the form and user instructions at fppc.ca.gov. ~~http://fppc.ca.gov/index.php?id=755~~
    b. Each individual will complete the form as required and return to ~~Administration or the Human Resources Department~~ the Clerk of the Board as requested;
    c. All forms are maintained by Administration ~~and/or the Human Resource Department~~ as required by regulation.
2. Form 700 Filing Deadlines
    a. Individuals required to complete and file Statements of Economic Interest (Form 700) must do so:
        i. Within thirty (30) days after the effective date of the adoption of the Conflict of Interest Code;
        ii. Within thirty (30) days after assuming a position requiring filing such Statement;
        iii. Within thirty (30) days after leaving a position requiring filing of such Statement; and,
        iv. Annually, no later than April 1st, each year in which the individual occupies a position requiring filing of such Statement.
    b. In the event the Statement of Economic Interest is not filed when due, the FPPC may impose fines or other civil and criminal sanctions for non-compliance~~.~~.
3. Conflict-of-Interest Policy Acknowledgement:

Each person who is a required to fill out a Form 700 shall review this Conflict of Interest Policy. Each of those individuals shall annually acknowledge that he/she:

a. has received a copy of this Policy;
b. has read and understands the Policy;
c. agrees to comply with the Policy;
d. understands that the Policy applies to members of committees and subcommittees;
e. agrees to report to the Board any change to matters disclosed on the Form 700. The Conflict-of-Interest Disclosure Questionnaire is an available resource.

4. Monitoring and Auditing
The Corporate Compliance Officer shall conduct or oversee periodic auditing and monitoring of:
   a. Timely filing of Form 700s and Conflict-of-Interest Policy Acknowledgement; and
   b. Submitted Statements of Economic Interests to determine if disclosures of actual, potential, or perceived conflicts of interest have been brought to the attention of the Board of Directors, and have been addressed, resolved, or removed.

Related Policies/Forms: ~~Conflict of Interest Code; Statement of Economic Interests (Form 700); Conflict-of-Interest Disclosure Questionnaire~~

References: Political Reform Act (Cal Gov. Code, §§ 87100 et seq.)
The Brown Act (Cal Gov. Code, §§ 54950 et seq.)
~~The Bagley Keene Open Meeting Act (Cal Gov. Code §§ 11120 et seq.)~~
Public Reporting of Financial Interests Political Reform Act (Cal Gov. Code, §§ 87200-87313)
Financial Interests in Contracts (Cal Gov. Code, §§ 1090 et seq.)
Conflict of Interest Resulting from Campaign Contributions (Cal Gov. Code, § 84308)
Prohibitions Applicable to Specified Officers (Cal Gov. Code §§ 1090-1099)
Local Health Care District Law Conflict of Interest Provisions (Health & Saf. Code, §§ 32110–32111)
Receipt of Direct Monetary Gain or Loss (Cal Gov. Code, § 8920)
Transportation, Gifts or Discounts Cal. Const., art. XII, § 7
Incompatible Activities (Cal Gov. Code, §§ 1125 et seq.) (local officials); (Cal Gov. Code, § 19990) (state officials)
Former State Officials and Their Former Agencies Political Reform Act (Cal Gov. Code, §§ 87400-87405)
The Governance Institute

Policy Owner: Corporate Compliance Officer

Approved by: Chief Executive Officer

BYLAWS OF THE BOARD OF DIRECTORS

TAHOE FOREST HOSPITAL DISTRICT

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BYLAWS OF THE BOARD OF DIRECTORS
OF
TAHOE FOREST HOSPITAL DISTRICT

Pursuant to the provisions of Sections 32104, 32125, 32128, and 32150 of the Health and Safety Code of the State of California, the Board of Directors of TAHOE FOREST HOSPITAL DISTRICT adopts these Bylaws for the government of TAHOE FOREST HOSPITAL DISTRICT.

ARTICLE I. NAME, AUTHORITY AND PURPOSE

Section 1. Name.

The name of this District shall be "TAHOE FOREST HOSPITAL DISTRICT".

Section 2. Authority.

A. This District, having been established May 2, 1949, by vote of the residents of said District under the provisions of Division 23 of the Health and Safety Code of the State of California, otherwise known and referred to herein as "The Local Health Care District Law", and ever since that time having been operated there under, these Bylaws are adopted in conformance therewith, and subject to the provisions thereof.

B. In the event of any conflict between these Bylaws and "The Local Health Care District Law", the latter shall prevail.

C. These Bylaws shall be known as the "District Bylaws".

D. Non-Discrimination: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of service, hiring, training and employment practices on the basis of age; race; color; creed; ethnicity; religion; national origin; marital status; sex; sexual orientation; gender identity or expression; disability; association; veteran or military status; or any other basis prohibited by federal, state, or local law.

Section 3. Purpose and Operating Policies.

A. Purpose.

Tahoe Forest Hospital District will strive to be the best mountain health system in the nation. We exist to make a difference in the health of our communities through excellence and compassion in all we do.

B. Operating Policies.

In order to accomplish the Mission of the District, the Board of Directors establishes the following Operating Policies:

1. Through planned development and responsible management, the assets of the District will be used to meet the service needs of the area in an efficient and cost effective manner, after evaluation of available alternatives and other resources available to the District. This may include the development and operation of programs, services and facilities at any location within or without the District for the benefit of the people served by the District.

2. The District shall dedicate itself to the maximum level of quality consistent with sound fiscal management, and community based needs.

3. Improvement of the health status of the area will be the primary emphasis of services offered by the District. In addition, the District may elect to provide other programs of human service outside of the traditional realm of health care, where unmet human service needs have been identified through the planning process.

ARTICLE II. BOARD OF DIRECTORS

The Board of Directors:

Section 1. Election.

There shall be five members of the Board of Directors who shall be elected for four year terms as provided in "The Local Health Care District Law".

Section 2. Responsibilities.

Provides oversight for planning, operation, and evaluation of all District programs, services and related activities consistent with the District Bylaws.

A. Philosophy and Objectives.

Considers the health requirements of the region and the responsibilities that the District should assume in helping to meet them.

B. Programs and Services.

1. Takes action on recommendations of the Chief Executive Officer or designee with regard to long and short range plans for the development of programs and services.

2. Provides oversight to the Chief Executive Officer in the implementation of programs and service plans.

3. Takes action on board policies and other policies brought forth by the Chief Executive Officer or designee.

4. Evaluates the results of programs and services on the basis of previously

established objectives and requirements. Receives reports from the Chief Executive Officer or designees and directs the Chief Executive Officer to plan and take appropriate actions, where warranted.

C. Organization and Staffing.

1. Selects and appoints the Chief Executive Officer.

2. Evaluates the continuing effectiveness of the organization.

D. Medical Staff.

1. Appoints all Medical Staff members.

2. Ensures that the District Medical Staff is organized to support the objectives of the District.

3. Reviews and takes final action on appeals involving Medical Staff disciplinary action.

4. Approves Medical Staff Bylaws and proposed revisions.

E. Finance.

1. Assumes responsibility for the financial soundness and success of the District and its wholly owned subsidiaries.

2. Assumes responsibility for the appropriate use of endowment funds and of other gifts to the District. Exercises trusteeship responsibility to see that funds are used for intended purposes.

3. Adopts annual budgets of the District, including both operating and capital expenditure budgets.

4. Receives and reviews periodic financial reports. Considers comments and recommendations of its Finance Committee or management staff.

5. Receives and reviews reports of the District's auditors.

6. Approves policies which govern the financial affairs of the District.

7. Authorizes officers of the District to act for the District in the execution of financial transactions.

F. Grounds, Facilities and Equipment.

1. Approves plans for development, expansion, modernization and replacement of the District's grounds, facilities, major equipment and other tangible assets.

2. Approves the acquisition, sale and lease of real property.

G. External Relations.

Assumes ultimate responsibility for representing the communities served by the District and representing the District to the communities served.

H. Assessment And Continuous Improvement Of Quality Of Care

Ensures that the proper organizational environment and systems exist to continuously improve the quality of care provided. Responsible for a system wide quality assessment and performance improvement program that reflects all departments and services. Reviews Quality Assessment Reports focused on indicators related to improving health outcomes and the prevention and reduction of medical errors. Provides oversight to and annually approves the written Quality Assurance / Process Improvement plan.

I. Strategic Planning.

1. Oversees the strategic planning process.

2. Establishes long range goals and objectives for the District's programs and facilities.

Section 3. Powers.

A. Overall Operations.

The Board of Directors shall determine policies and shall have control of, and be responsible for, the overall operations and affairs of this District and its facilities.

B. Medical Staff.

The Board of Directors shall authorize the formation of a Medical Staff to be known as "The Medical Staff of Tahoe Forest Hospital District". The Board of Directors shall determine membership on the Medical Staff, as well as the Bylaws for the governance of said Medical Staff, as provided in ARTICLE VIII of these Bylaws.

C. Auxiliary.

The Board of Directors may authorize the formation of service organizations from time to time as needed ("Auxiliary"), the Bylaws of which shall be approved by the Board of Directors.

D. Other Affiliated or Subordinate Organizations.

The Board of Directors may authorize the formation of other affiliated or subordinate organizations which it may deem necessary to carry out the purposes of the District; the Bylaws of such organizations shall be approved by the Board of Directors.

E. Delegation of Powers.

The Medical Staff, Auxiliary, and any other affiliated or subordinate organizations shall have those powers set forth in their respective Bylaws. All powers and functions not set forth in their respective Bylaws are to be considered residual powers still vested in the Board of Directors.

F. Provisions to Prevail.

These District Bylaws shall override any provisions to the contrary in the Bylaws, or Rules and Regulations of the Medical Staff, Auxiliary or any affiliated or subordinate organizations. In case of conflict, the provisions of these District Bylaws shall prevail.

G. Resolutions and Ordinances.

From time to time, the Board of Directors may pass resolutions regarding specific policy issues, which resolutions may establish policy for the operations of this District.

H. Residual Powers.

The Board of Directors shall have all of the other powers given to it by "The Local Health Care District Law" and other applicable provisions of law.

I. Grievance Process

The Board of Directors may delegate the responsibility to review and resolve grievances.

Section 4. Vacancies.

Any vacancy upon the Board of Directors shall be filled by appointment by the remaining members of the Board of Directors within sixty (60) days of the vacancy. Notice of the vacancy shall be posted in at least three (3) places within the District at least fifteen (l5) days before the appointment is made. The District shall notify the elections officials for Nevada and Placer Counties of the vacancy no later than fifteen (15) days following either the date on which the District Board is notified of the vacancy or the effective date of the vacancy, whichever is later, and of the appointment no later than fifteen (15) days after the appointment. In lieu of making an appointment, the remaining members of the Board of Directors may within sixty (60) days of the vacancy call an election to fill the vacancy. If the vacancy is not filled by the Board of Directors or an election called within sixty (60) days, the Board of Supervisors of the County representing the larger portion of the Hospital District area in which an election to fill the vacancy would be held may fill the vacancy, within ninety (90) days of the vacancy, or may order the District to call an election. If the vacancy is not filled or an election called for within ninety (90) days of the vacancy, the District shall call an election to be held on the next available election date. Persons appointed to fill a vacancy shall hold office until the next District general election that is scheduled 130 or more days after the date the District and the elections officials for Nevada and Placer Counties were notified of

the vacancy and thereafter until the person elected at such election to fill the vacancy has been qualified, but persons elected to fill a vacancy shall hold office for the unexpired balance of the term of office.

Section 5. Meetings.

A. Regular Meetings.

Unless otherwise specified at the preceding regular or adjourned regular meeting, regular meetings of the Board of Directors shall be held on the fourth Thursday of each month at 4:00 PM at a location within the Tahoe Forest Hospital District Boundaries. The Board shall take or arrange for the taking of minutes at each regular meeting.

B. Special Meetings.

Special meetings of the Board of Directors may be held at any time and at a place designated in the notice and located within the District, except as provided in the Brown Act, upon the call of the ~~President~~Chair, or by not fewer than three (3) members of the Board of Directors, and upon written notice to each Director specifying the business to be transacted, which notice shall be delivered personally or by mail and shall be received at least twenty-four (24) hours before the time of such meeting, provided that such notice may be waived by written waiver executed by each member of the Board of Directors. Notice shall also be provided within such time period to local newspapers and radio stations which have requested notice of meetings. Such notice must also be posted twenty-four (24) hours before the meeting in a location which is freely accessible to the public. In the event of an emergency situation involving matters upon which prompt action is necessary due to disruption or threatened disruption of District services (including work stoppage, crippling disaster or other activity which severely impairs public health, safety or both), the Board may hold a special meeting without complying with the foregoing notice requirements, provided at least one (l) hour prior telephone notice shall be given to local newspapers and radio stations which have requested notice of meetings, and such meetings shall otherwise be in compliance with the provisions of Government Code Section 54956.5. The Board shall take or arrange for the taking of minutes at each special meeting.

C. Policies and Procedures.

The Board may from time to time adopt policies and procedures governing the conduct of Board meetings and District business. All sessions of the Board of Directors, whether regular or special, shall be open to the public in accordance with the Brown Act (commencing with Government Code Section 54950), unless a closed session is permitted under the Brown Act or Health and Safety Code Sections 32106 and 32155 or other applicable law.

Section 6. Quorum.

The presence of a majority of the Board of Directors shall be necessary to

constitute a quorum to transact any business at any regular or special meeting, except to adjourn the meeting to a future date.

Section 7. Medical Staff Representation.

The Chief of the Medical Staff shall be appointed as a special representative to the Board of Directors without voting power and shall attend the meetings of the Board of Directors. In the event the Chief of Staff cannot attend a meeting, the Vice-Chief of the Medical Staff or designee shall attend in the Chief of Staff's absence.

Section 8. Director Compensation and Reimbursement Of Expenses.

The Board of Directors shall be compensated in accordance with ABD-03 Board Compensation and Reimbursement policy.

Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of the District as approved by the Board or Chief Executive Officer, per Board policy.

Section 9. Board Self-Evaluation.

The Board of Directors will monitor and discuss its process and performance at least annually. The self-evaluation process will include comparison of Board activity to its manner of governance policies.

ARTICLE III. OFFICERS

Section 1. Officers.

The officers of the Board of Directors shall be ~~President~~Chair, Vice-~~President~~Chair, Secretary and Treasurer who shall be members of the Board.

Section 2. Election of Officers.

The officers of the Board of Directors shall be chosen every year by the Board of Directors in December of the preceding calendar year and shall serve at the pleasure of the Board. The person holding the office of ~~President~~Chair of the Board of Directors shall not serve successive terms, unless by unanimous vote of the Board of Directors taken at a regularly scheduled meeting. In the event of a vacancy in any office, an election shall be held at the next regular meeting following the effective date of the vacancy to elect the officer to fill such office.

Section 3. Duties of Officers.

A. ~~President~~Chair. Shall preside over all meetings of the Board of Directors.

Shall sign as ~~President~~Chair, on behalf of the District, all instruments in writing which he/she has been authorized and obliged by the Board to sign and such other duties as set forth in these Bylaws as well as those duties charged to the president under the Local Health Care District Law.

B. Vice-~~President~~Chair. The Vice-~~President~~Chair shall perform the functions of the ~~President~~Chair in case of the ~~President~~Chair's absence or inability to act.

C. Secretary. The Secretary shall ensure minutes of all meetings of the Board of Directors are recorded and shall see that all records of the District are kept and preserved.

D. Treasurer. The Treasurer will serve as the chairperson of the Board Finance Committee and shall ensure the Board's attention to financial integrity of the District.

ARTICLE IV. COMMITTEES

No Committee shall have the power to bind the District, unless the Board provides otherwise in writing.

Section 1. Ad Hoc Committees.

Ad Hoc Committees may be appointed by the ~~President~~Chair of the Board of Directors from time to time as he/she deems necessary or expedient. No Committee shall have the power to bind the District, unless the Board provides otherwise in writing, but shall perform such functions as shall be assigned to them by the ~~President~~Chair, and shall function for the period of time specified by the ~~President~~Chair at the time of appointment or until determined to be no longer necessary and disbanded by the ~~President~~Chair of the Board of Directors. The ~~President~~Chair shall appoint each Committee chair.

Section 2. Standing Committees.

Standing Committees and their respective charters will be affirmed annually by resolution, duly adopted by the Board of Directors.

The ~~President~~Chair shall recommend appointment of the members of these committees and the Chair thereof, subject to the approval of the Board by majority of Directors present. Committee appointments shall be for a period of one (1) year and will be made annually at the December Board meeting, following the election of Board Officers.

ARTICLE V. MANAGEMENT

Section 1. Chief Executive Officer.

The Board of Directors shall select and employ a Chief Executive Officer who shall act as its executive officer in the management of the District. The Chief Executive Officer shall be given the necessary authority to be held responsible for the administration of the District in all its activities and entities, subject only to the policies as may be adopted from time to time, and orders as may be issued by the Board of Directors or any of its committees to which it has delegated power for such action by a writing. The Chief Executive Officer shall act as the duly authorized representative of the Board of Directors.

Section 2. Authority and Responsibility.

The duties and responsibilities of the Chief Executive Officer shall be outlined in the Employment Agreement and job description. Other duties may be assigned by the Board. Chief Executive Officer, personally or through delegation, hires, assigns responsibility, counsel, evaluates and (as required) terminates all District employees.

ARTICLE VI. TAHOE FOREST HOSPITAL

Section 1. Establishment

The District owns and operates Tahoe Forest Hospital (TFH), which shall be primarily engaged in providing, including but not limited to, Emergency Services, Inpatient/Observation Care, Critical Care, Diagnostic Imaging Services, Laboratory Services, Surgical Services, Obstetrical Services and Long Term Care Services.

ARTICLE VII. INCLINE VILLAGE COMMUNITY HOSPITAL

Section 1. Establishment

The District owns and operates Incline Village Community Hospital (IVCH), which shall be primarily engaged in providing, including but not limited to, Emergency Services, Inpatient/Observation Care, Diagnostic Imaging Services, Laboratory Services, and Surgical Services to patients.

ARTICLE VIII. MEDICAL STAFF

Section 1. Nature of Medical Staff Membership.

Membership on the Medical Staff of Tahoe Forest Hospital District is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth herein and in the Bylaws of the Medical Staff.

Section 2. Qualifications for Membership.

A. Only physicians, dentists or podiatrists who:

1. Demonstrate and document their licensure, experience, education, training, current professional competence, good judgment, ethics, reputation and physical and mental health status so as to establish to the satisfaction of the Medical Staff and the Board of Directors that they are professionally qualified and that patients treated by them can reasonably expect to receive high quality medical care;

2. Demonstrate that they adhere to the ethics of their respective professions and that they are able to work cooperatively with others so as not to adversely affect patient care or District operations;

3. Provide verification of medical malpractice insurance coverage;

4. Establish that they are willing to participate in and properly discharge those responsibilities determined according to the Medical Staff Bylaws and shall be deemed to possess basic qualifications for membership on the Medical Staff. No practitioner shall be entitled to membership on the Medical Staff, assignment to a particular staff category, or be able to exercise particular clinical privileges solely by virtue of the fact that he/she is duly licensed to practice in California, Nevada, or any other state, or that he/she is a member of any particular professional organization, or is certified by any particular specialty board, or that he/she had or presently has, membership or privileges at this or another health care facility, or requires a hospital affiliation in order to participate on health plan provider panels, to obtain or maintain malpractice insurance coverage, or to pursue other personal or professional business interests unrelated to the treatment of patients at this facility and the furtherance of this facility's programs and services.

Section 3. Organization and Bylaws.

The Bylaws, Rules and Regulations, and policies of the Medical Staff shall be subject to approval of the Board of Directors of the District, and amendments thereto shall be effective only upon approval of such amendments by the Board of Directors, which shall not be withheld unreasonably. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. The Bylaws of the Medical Staff shall set forth the procedure by which eligibility for Medical Staff membership and establishment of clinical privileges shall be determined, including standards for qualification. Such Bylaws shall provide that the Medical Staff, or a committee or committees thereof, shall study the qualifications of all applicants and shall establish and delineate clinical privileges and shall submit to the Board of Directors recommendations thereon and shall provide for reappointment no less frequently than biennially. The Medical Staff shall also adopt Rules and Regulations or policies that provide associated details consistent with its Bylaws, as it deems necessary to implement more specifically the general principles established in the Bylaws.

Section 4. Appointment to Medical Staff

All appointments and reappointments to the Medical Staff shall be made by the Board of Directors as provided by the standards of the Healthcare Facility Accreditation Program. Final responsibility for appointment, reappointment, new clinical privileges, rejection or modification of any recommendation of the Medical Staff shall rest with the Board of Directors.

All applications for appointment and reappointment to the Medical Staff shall be processed by the Medical Staff in such manner as shall be provided by the Bylaws of the Medical Staff and, upon completion of processing by the Medical Staff, the Medical Staff shall make a report and recommendation regarding such application to the Board of Directors. This recommendation will also include the request by the practitioner for clinical privileges, and the Medical Staff's recommendation concerning these privileges.

Upon receipt of the report and recommendation of the Medical Staff, the Board of Directors adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond.

If the Board of Directors is inclined to reject or modify a favorable recommendation, the Board shall refer the matter back to the Medical Executive Committee for further review and comments, which may include a second recommendation**.** The Executive Committee's response shall be considered by the Board before adopting a resolution.

If the Board's resolution constitutes grounds for a hearing under Article VII of the Medical Staff Bylaws, the Chief Executive Officer shall promptly inform the applicant, and he/she shall be entitled to the procedural rights as provided in that Article.

In the case of an adverse Medical Executive Committee recommendation or an adverse Board decision, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights under the Medical Staff Bylaws. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which a reply to the Board of Directors shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Board shall make a final decision.

Conflict Resolution. The Board of Directors shall give great weight to the actions and recommendations of the Medical Executive Committee and in no event shall act in an arbitrary and capricious manner.

The Governing Body may delegate decision-making authority to a committee of the Governing Body; however, any final decision of the Governing Body committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting.

Section 5. Staff Meetings: Medical Records

The Medical Staff shall be self-governing with respect to the professional work performed in the Hospital. The Medical Staff shall meet in accordance with the minimum requirements of the Healthcare Facility Accreditation Program. Accurate, legible and complete medical records shall be prepared and maintained for all patients and shall be the basis for review and analysis.

For purposes of this section, medical records include, but are not limited to, identification data, personal and family history, history of present illness, review of systems, physical examination, special examinations, professional or working diagnosis, treatment, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge and other matters as the Medical Staff shall determine.

Section 6. Medical Quality Assurance

The Medical Staff shall, in cooperation with the administration of the District, establish a comprehensive and integrated quality assurance and risk control program for the District which shall assure identification of problems, assessment and prioritization of such problems, implementation of remedial actions and decisions with regard to such problems, monitoring of activities to assure desired results, and documentation of the undertaken activities. The Board of Directors shall require, on a quarterly basis, reports of the Medical Staff's and District's quality assurance activities.

Section 7. Hearings and Appeals

Appellate review of any action, decision or recommendation of the Medical Staff affecting the professional privileges of any member of, or applicant for membership on, the Medical Staff is available before the Board of Directors. This appellate review shall be conducted consistent with the requirements of Business and Professions Code Section 809.4 and in accordance with the procedures set forth in the Medical Staff Bylaws. Nothing in these Bylaws shall abrogate the obligation of the District and the Medical Staff to comply with the requirements of Business and Professions Code Sections 809 through 809.9, inclusive. Accordingly, discretion is granted to the Medical Staff and Board of Directors to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret the Medical Staff Bylaws in that light. The Medical Staff, Board of Directors, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

If adverse action as described in these provisions is taken or recommended, the practitioner must exhaust the remedies afforded by the Medical Staff Bylaws before resorting to legal action.

The rules relating to appeals to the Board of Directors as set forth in the Medical Staff Bylaws are as follows; capitalized terms have the meaning defined by the Medical Staff Bylaws:

A. Time For Appeal

Within ten (10) days after receipt of the decision of the Hearing Committee, either the Practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief Executive Officer and the other party in the hearing. If a request for appellate review is not received by the Chief Executive Officer within such period, the decision of the Hearing Committee shall thereupon become final, except if modified or reversed by the Board of Directors.

It shall be the obligation of the party requesting appellate review to produce the record of the Hearing Committee's proceedings. If the record is not produced within a reasonable period, as determined by the Board of Directors or its authorized representative, appellate rights shall be deemed waived

In the event of a waiver of appellate rights by a Practitioner, if the Board of Directors is inclined to take action which is more adverse than that taken or recommended by the Medical Executive Committee, the Board of Directors must consult with the Medical Executive Committee before taking such action. If after such consultation the Board of Directors is still inclined to take such action, then the Practitioner shall be so notified. The notice shall include a brief summary of the reasons for the Board's contemplated action, including a reference to any factual findings in the Hearing Committee's Decision that support the action. The Practitioner shall be given ten (10) days from receipt of that notice within which to request appellate review, notwithstanding his or her earlier waiver of appellate rights. The grounds for appeal and the appellate procedure shall be as described below. However, even If the Practitioner declines to appeal any of the Hearing Committee's factual findings, he or she shall still be given an opportunity to argue, in person and in writing, that the contemplated action which is more adverse than that taken or recommended by the Medical Executive Committee is not reasonable and warranted. The action taken by the Board of Directors after following this procedure shall be the final action of the Hospital.

B. Grounds For Appeal

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal. The recognized grounds for appeal from a Hearing Committee decision are:

1. substantial noncompliance with the standards or procedures required by the Bylaws, or applicable law, which has created demonstrable prejudice; or

2. the factual findings of the Hearing Committee are not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to this section; or

3. The Hearing Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the Hearing Committee's factual findings, was reasonable and warranted.

C. Time, Place and Notice

The appeal board shall, within thirty (30) days after receipt of a request for appellate review, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The appellate review shall not commence less than thirty (30) or more than sixty (60) days from the date of notice. The time for appellate review may be extended by the appeal board for good cause.

D. Appeal Board

The Board of Directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board so long as that person did not take part in a prior hearing on the action or recommendation being challenged. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

E. Appeal Procedure

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the proceedings before the Hearing Committee. However, the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The appeal board shall also have the discretion to remand the matter to the Hearing Committee for the taking of further evidence or for clarification or reconsideration of the Hearing Committee's decision. In such instances, the Hearing Committee shall report back to the appeal board, within such reasonable time limits as the appeal board imposes. Each party shall have the right to be represented by legal counsel before the appeal board, to present a written argument to the appeal board, to personally appear and make oral argument and respond to questions in accordance with the procedure established by the appeal board. After the arguments have been submitted, the appeal board shall conduct its deliberations outside the presence of the parties and their representatives.

F. Decision

Within thirty (30) days after the submission of arguments as provided above, the appeal board shall send a written recommendation to the Board of Directors. The appeal board may recommend, and the Board of Directors may decide, to affirm, reverse or modify the decision of the Hearing Committee. The decision of the Board shall constitute the final decision of the Hospital and shall become effective immediately upon notice to the parties. The parties shall be provided a copy of the appeal board's recommendation along with a copy of the Board of Director's final decision.

G. Right To One Hearing

No practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any adverse action or recommendation.

H. Exception to Hearing Rights

1. Exclusive Contracts

The hearing rights described in this Article shall not apply as a result of a decision to close or continue closure of a department or service pursuant to an exclusive contract or to transfer an exclusive contract, or as a result of action by the holder of such an exclusive contract.

2. Validity of Bylaw, Rule, Regulation or Policy

No hearing provided for in this article shall be utilized to make determinations as to the merits or substantive validity of any Medical Staff bylaw, rule, regulation or policy. Where a Practitioner is adversely affected by the application of a Medical Staff bylaw, rule, regulation or policy, the Practitioner's sole remedy is to seek review of such bylaw, rule, regulation or policy initially by the Medical Executive Committee. The Medical Executive Committee may in its discretion consider the request according to such procedures as it deems appropriate. If the Practitioner is dissatisfied with the action of the Medical Executive Committee, the Practitioner may request review by the Board of Directors, which shall have discretion whether to conduct a review according to such procedures as it deems appropriate. The Board of Directors shall consult with the Medical Executive Committee before taking such action regarding the bylaw, rule, regulation or policy involved. This procedure must be utilized prior to any legal action.

3. Department, Section or Service Formation or Elimination

A Medical Staff department, section, or service can be formed or eliminated only following a review and recommendation by the Medical Executive Committee regarding the appropriateness of the department, section, or service elimination or formation. The Board of Directors shall consider the recommendations of the Medical Executive Committee prior to making a final determination regarding the formation or elimination.

The Medical Staff Member(s) who's Privileges may be adversely affected by department, section, or service formation or elimination are not afforded hearing rights pursuant to Article VII.

ARTICLE IX. AUXILIARY

The formation of Auxiliary organizations Bylaws shall be approved by the Board of Directors.

ARTICLE X. REVIEW AND AMENDMENT OF BYLAWS

Section 1. At intervals of no more than two (2) years, the Board of Directors shall review these Bylaws in their entirety to ensure that they comply with all provisions of the Local Health Care District Law, that they continue to meet the needs of District Administration and Medical Staff, and that they serve to facilitate the efficient administration of the District.

These Bylaws may from time to time be amended by action of the Board of Directors. Amendments may be proposed at any Regular meeting of the Board of Directors by any member of the Board. Action on proposed amendments shall be taken at the next Regular meeting of the Board of Directors following the meeting at which such amendments are proposed.

ADOPTION OF BYLAWS

Originally passed and adopted at a meeting of the Board of Directors of the TAHOE FOREST HOSPITAL DISTRICT, duly held on the 9th day of January, 1953 and most recently revised on the ~~30~~29th day of November 201~~7~~8.

REVISION HISTORY

1975
Revised – March, 1977
Revised – October, 1978
Revised – April, 1979
Revised – March, 1982
Revised – May, 1983
Revised – February, 1985
Revised – July, 1988
Revised – March, 1990
Revised – November, 1992
Revised – February, 1993
Revised – May, 1994
Revised – April, 1996
Revised – September, 1996
Revised – April, 1998
Revised – September, 1998
Revised – March, 1999

Revised – July, 2000
Revised – January, 2001
Revised – November, 2002
Revised – May, 2003
Revised – July, 2003
Revised – September, 2004
Revised – March, 2005
Revised – December, 2005
Revised – October, 2006
Revised – March, 2007
Revised – April, 2008
Revised – January, 2009
Revised – September, 2010
Revised – September, 2012
Revised – November, 2014
Revised – December, 2015
Revised – November, 2017
Revised – November, 2018

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: **October** 25, 2018

2018 Compliance Program 3rd Quarter Report (Open Session)

The Compliance Committee is providing the Board of Directors (BOD) with a report of the 3rd Quarter 2018 Compliance Program activities (Open Session). This report assists the BOD to meet its obligations to be knowledgeable about the content and operation of the seven components of the Compliance Program.

2018 Corporate Compliance Program 3rd Quarter Report

OPEN SESSION

Period Covered by Report: **July 1, 2018- September 30, 2018**
Completed by: James Hook, Compliance Consultant, The Fox Group

1. Written Policies and Procedures

1.1. The Tahoe Forest Hospital District's (TFHD) Corporate Compliance Policies and Procedures are reviewed and updated as needed. The following policies were reviewed or revised by the Compliance Department with recommendations to the Board of Directors:

1.1.1. AGOV-1705 Code of Conduct

1.1.2. AGOV-13 Corporate Compliance Violations Suspected

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee Membership as of September 30, 2018:

2.1.1. Jim Hook, The Fox Group – Compliance Consultants
2.1.2. Judy Newland, RN – Chief Operating Officer
2.1.3. Karen Baffone RN- Chief Nursing Officer
2.1.4. Harry Weis – Chief Executive Officer
2.1.5. Crystal Betts – Chief Financial Officer
2.1.6. Jake Dorst – Chief Information and Innovation Officer
2.1.7. Alex MacLennan – Chief Human Resources Officer
2.1.8. Matt Mushet – In-house Legal Counsel
2.1.9. Stephanie Hanson, RN – Compliance Analyst/Interim Privacy Officer
2.1.10. Shelley Thewlis, Interim HIM Director
2.1.11. Scott Baker, Executive Director of Physician Services

3. Education & Training

3.1. The Compliance Department furnishes Compliance Program training to new directors, managers and supervisors every quarter.

3.2. All new employees now receive the Tahoe Forest Health System Code of Conduct during preplacement. Annual re-attestation will be assigned as part of the annual evaluation process in the 4th quarter of 2018.

3.3. All employees were assigned new HIPAA and Compliance Program training via HealthStream in the 3rd quarter of 2018.

3.4. Representatives for Noridian, the Medicare Administrative Contractor for northern California, visited TFHD on September 18, and provided information on several billing issues raised by staff members.

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Department. Four reports were made during the 3rd quarter either directly to the Compliance Department or through the hot line.

4.2. HIPAA violations are reported to the Privacy Officer. The Privacy Officer maintains a log of reported events and investigations. Fourteen reports were made to the Privacy Officer in the 3rd Quarter of 2018.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. 95% of the employees' of TFHD completed their corporate compliance modules for the 3rd Quarter of 2018.

5.2. Attestation statements completed for Code of Conduct training reached 100% by the end of the 3rd quarter for all new employees, employees and contracted employees.

5.3. All new staff hires, and newly privileged physicians, receive criminal background checks and are checked against the Office of Inspector General (OIG) and General Services Administration (GSA) list of exclusions prior to hiring/appointment. Members of the Medical Staff are checked against the OIG/GSA exclusion lists each month. All employees are screened against the OIG/GSA exclusion list every quarter. All vendors are checked continuously using the vendor credentialing program.

6. Auditing &Monitoring

6.1. Seven audits were completed during the 3rd Quarter of 2018 as part of the 2018 corporate compliance work plan.

6.1.1. Physician payment audit (MSC Physicians): An audit of payments to MSC physicians providing services in the 2nd calendar quarter was completed. One discrepancy was found and corrected in a subsequent physician payment.

6.1.2. All four leases with physicians were reviewed for current fair market value and conformance with the terms of the lease; no discrepancies found.

6.1.3. An audit of employee access to own electronic medical records in 2018 year to date was completed; findings from the sample were that only one staff member accessed her own medical record in the EHR system, instead of through the Portal.

6.1.4. An audit of all physician contracts completed in the 1st calendar quarter of 2018 was completed; findings were that 100% of contracts effective in the 1st calendar quarter were signed timely, e.g., prior to the effective date.

6.1.5. An audit of entry of resuscitation charges for newborns was completed; no erroneous charges were entered.

6.1.6. Physician payment audit (ED on-call physicians): an audit of payments to physicians providing ED on-call coverage in June-August 2018 was completed. Three discrepancies were resolved after further investigation.

6.1.7. An audit of Cardiac Rehab program was completed on patient charts in the 2nd calendar quarter of 2018; findings were that 100% of required medical record documentation was completed.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. Investigations of suspected and actual compliance issues incidents were initiated. Some investigations revealed no violations. Remediation measures included: refunds of overpayments, additional staff training, new leases, and updated policies and procedures implemented to prevent further violations.

AGENDA ITEM COVER SHEET

ITEM	High Reliability Organization (HRO) Presentation
RESPONSIBLE PARTY	Alex MacLennan, CHRO
ACTION REQUESTED?	For Information Only

BACKGROUND:

The Board had previously asked for education explaining what a High Reliability Organization (HRO) is.

The Health System is moving to adopt the principles so that we can become more reliable.

SUMMARY/OBJECTIVES:

To educate on the HRO concept.

SUGGESTED DISCUSSION POINTS:

The board should recognize the efforts that the organization is making to constantly strive for better patient safety, as well as fail accountability systems.

SUGGESTED MOTION/ALTERNATIVES:

Not applicable.

LIST OF ATTACHMENTS:

- HRO PowerPoint Presentation

Becoming a High Reliability Organization

Hilary Ward, PharmD, BCOP

re·li·a·ble
rəˈlīəb(ə)l/

adjective

1. consistently good in quality or performance; able to be trusted.

"a reliable source of information“

Synonyms: dependable, good, well founded, authentic, valid, genuine, sound, true

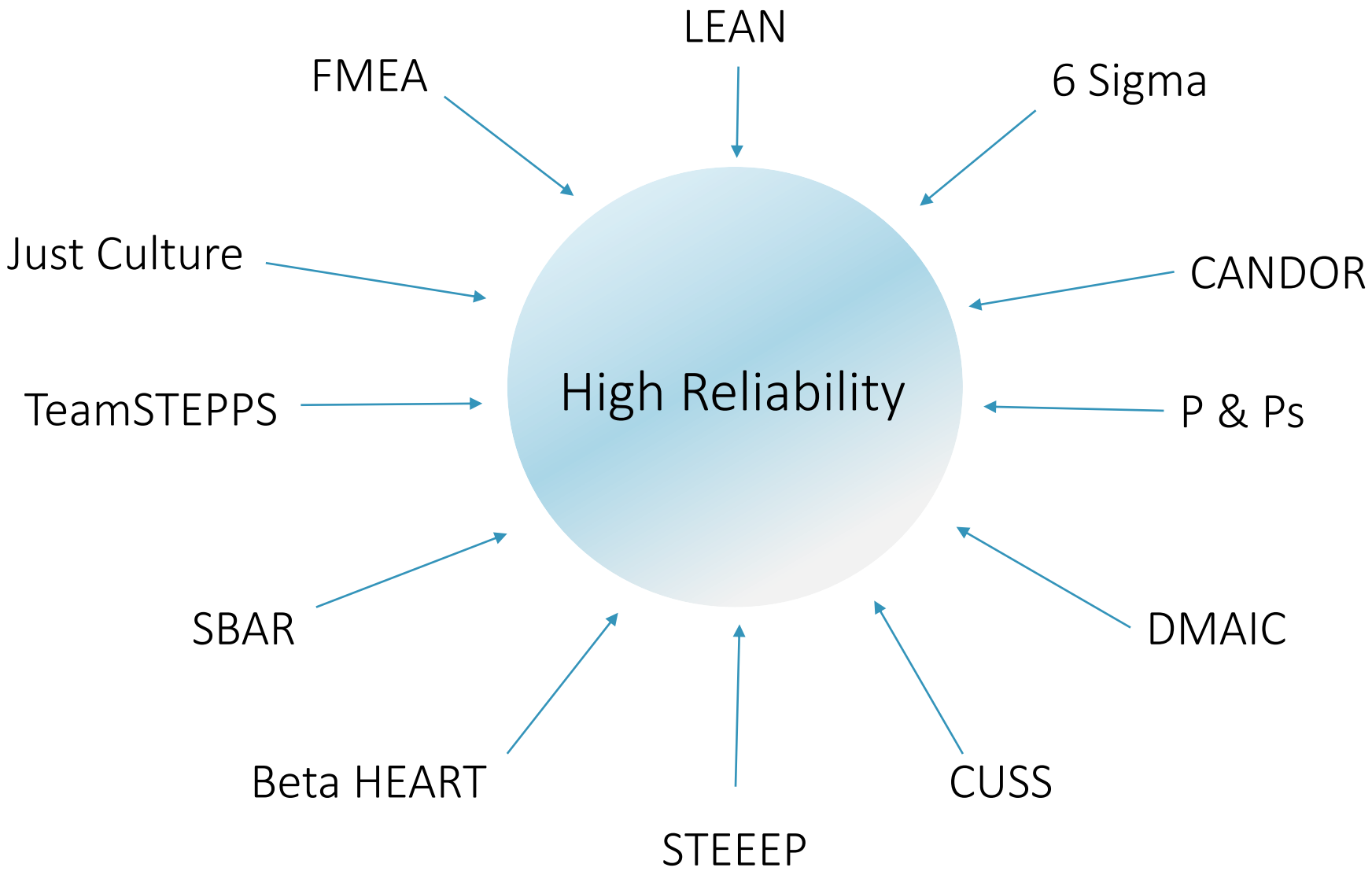
noun

1. a person or thing with trustworthy qualities

What does being “HIGHLY” reliable mean?

Training has occurred on multiple concepts

- Increase reliability in systems
  - LEAN, 6 Sigma, RCA or Event Analysis, DMAIC, FMEA, Risk Register, Event Investigation, “Just Culture”
- Increase reliability in communication
  - Huddles, SBAR, CUSS, Critical conversations, Conflict management, CANDOR, TeamSTEPPS, Beta HEART
- Increase reliability in human behavior
  - “Just Culture,” Policies & Procedures, Beta HEART
- Increase reliability in strategy
  - STEEEP

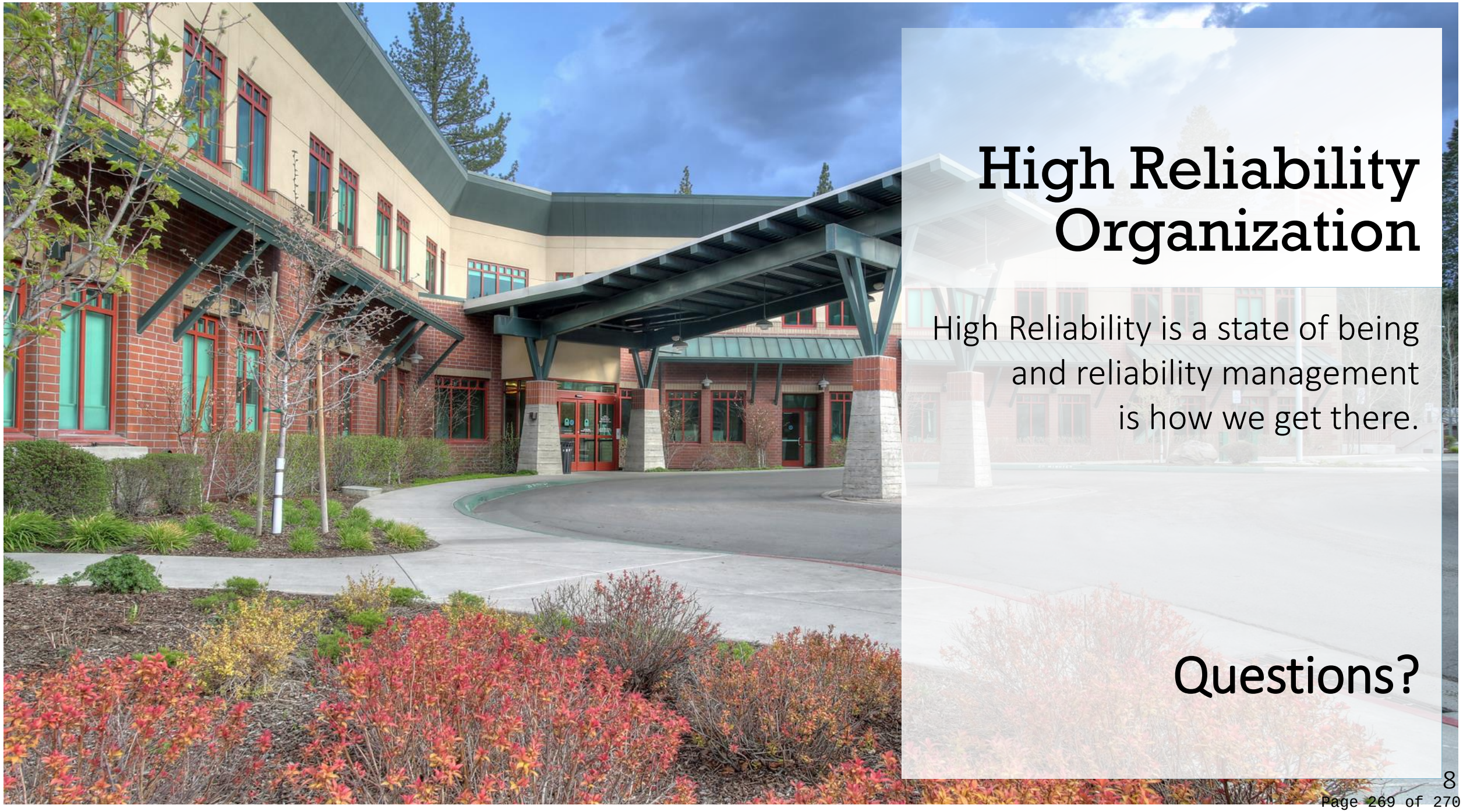

LEAN
FMEA
6 Sigma
Just Culture
CANDOR
High Reliability
TeamSTEPPS
P & Ps
SBAR
DMAIC
Beta HEART
CUSS
STEEEP

Highly Reliable Organization

- High Reliability occurs when these skills are combined to proactively identify vulnerability and risk in the organization
- Who manages/coordinates the effort?
  - Reliability Management Team (RMT)

“Signs and Symptoms” of High Reliability

- Proactive, not reactive
- Focus on building a strong system—one that makes human behavior inconsequential
- Understand vulnerabilities
- Recognize bias
- Efficient resource management
- Less rule-based, more risk-based



High Reliability Organization

High Reliability is a state of being and reliability management is how we get there.

Questions?

TAHOE FOREST HOSPITAL DISTRICT

GOVERNANCE COMMITTEE AGENDA

Friday, September 28, 2018 at 10:00 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Mary Brown, Chair; Randy Hill, 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: 06/11/2018

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Policy Review
Governance Committee will review and discuss the following policies:

6.1.1. TFHD Board of Directors Bylaws ..... ATTACHMENT
6.1.2. ABD-07 Conflict of Interest Code ..... ATTACHMENT
6.1.3. ABD-17 Manner of Governance for the TFHD Board of Directors ..... ATTACHMENT

6.2. Board Governance

6.2.1. Overall Meeting Effectiveness
Governance Committee will discuss overall meeting effectiveness, including the schedule of board presentations, review the agenda item cover sheet and review potential presentation templates.

6.2.1.1. Second Quarter 2018 Meeting Evaluations ..... ATTACHMENT
6.2.1.2. Agenda Matrix ..... ATTACHMENT
6.2.1.3. Agenda Item Cover Sheet ..... ATTACHMENT
6.2.1.4. Presentation Templates ..... ATTACHMENT

6.2.2. Board Education Plan
Governance Committee will develop a Board Education Plan for next quarter.

6.2.3. Governance Institute Leadership Conference Follow-Up
Governance Committee will follow up on the board's discussion of the Governance Institute Leadership Conference.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

9. ADJOURN

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.