

the purpose of performing such EMS Medical Director Duties. Nothing contained in this Agreement shall be construed by the parties to constitute a lease of any such premises to Physician, and no part of said premises shall be used at any time by Physician hereunder as an office for the general or private practice of medicine or for any other private business concern.

**4.2 In-Service and Supplies.** Hospital shall furnish such ordinary janitor, photocopying, telecommunication, computer system, internet access, secretarial, and administrative support, electricity for light and power, and other in-services and supplies, all as reasonably required for Physician to carry out his Director Duties hereunder.

## **ARTICLE V TERM AND TERMINATION**

**5.1 Term.** The term of this Agreement shall commence on the Effective Date set forth herein above and continue for a period of one (1) year thereafter, unless terminated earlier pursuant to the terms of this Agreement. The parties may renew this Agreement upon written terms and conditions mutually approved by the parties; provided, however, that neither party is obligated hereunder to renew this Agreement.

**5.2 Termination Without Cause.** Hospital and Physician shall each have the right to terminate this Agreement, without cause, upon giving not less than thirty (30) days' prior written notice to the other party.

**5.3 Termination with Cause.** Hospital shall have the right to terminate this Agreement upon failure of Physician to cure a breach of any term hereof which Hospital, at its sole discretion, has given Physician an opportunity to cure, within thirty (30) calendar days after written notice of said breach and opportunity to cure.

**5.4 Immediate Termination by Hospital.** Notwithstanding Sections 5.2 and 5.3, Hospital shall have the right, but not the obligation, to terminate this Agreement immediately upon notice to Physician in the event of the occurrence of any of the following events:

(a) Physician is excluded, suspended, terminated or otherwise determined to be ineligible from participation in any state or federally funded healthcare program (each, a "**Government Program Exclusion**");

(b) Any restriction, suspension or revocation of Physician's license to practice medicine in any state, without regard to whether such adverse action has been fully adjudicated;

(c) Any restriction, suspension or revocation of Physician's medical staff privileges at any health care facility, without regard to whether such adverse action had been fully adjudicated;

(d) Any restriction, suspension or revocation of Physician's federal DEA number, without regard to whether such adverse action had been fully adjudicated;

(e) Physician engages in conduct which is reasonably determined by the Hospital to be contrary to the Hospital's or Facility's bylaws, rules, regulations, code of conduct

or policies or procedures, all as may be amended from time-to-time by Hospital (collectively, “Rules”);

(f) Physician engages in conduct which is reasonably determined by Hospital to be prejudicial or adverse to the best interest, reputation or welfare of Hospital or its patients;

(g) Physician is investigated or convicted of a criminal offense relating to health care, or is investigated or convicted of any felony or any other crime involving moral turpitude or immoral conduct;

(h) The death of Physician or the inability of Physician to attend to the Director Duties for a period in excess of thirty (30) days, whether consecutive or not, during the term hereof, for any reason other than absence approved by Hospital in advance;

(i) Hospital enters into an agreement for the sale, assignment, lease or other transfer of the Hospital or all or substantially all of Hospital’s assets to another person or entity;

(j) Hospital suffers an appointment of a receiver, custodian, examiner or a trustee for any of its property or assets;

(k) Failure of Physician to comply with the insurance requirements of Section 6.1 of this Agreement.

**5.5 Legal Requirements.** If either party’s legal counsel advises such party that this Agreement, or any practices which could be, or are, employed by either party in exercising rights or discharging obligations under this Agreement, pose a material risk of violating any of the legal requirements imposed on or otherwise governing the performance of this Agreement, including without limitation any federal or state anti-kickback or physician self-referral laws, regulations, or guidelines, such party shall promptly notify the other party of such advice. The parties in good faith shall undertake to revise this Agreement to comply with such legal requirements. In the event that the parties are unable to agree upon the revised terms within thirty (30) days after such notice of advice is received by the other party, then either party may terminate this Agreement immediately upon giving written notice to the other party.

**5.6 Effect of Termination.**

(a) Upon the expiration or termination of this Agreement, neither party shall have any further obligation hereunder except for: (i) obligations due and owing which arose prior to the date of expiration or termination; and (ii) obligations, promises or covenants contained in this Agreement which expressly extend beyond the term hereof.

(b) Upon the expiration or termination of this Agreement, Physician shall promptly deliver and return to Hospital all of Hospital’s property, including without limitation all of Hospital’s supplies, patient records, and all materials, records and writings of any type (including all copies thereof) in his possession that constitute confidential, proprietary or trade secret information and/or property owned by Hospital.

(c) Notwithstanding anything in this Agreement to the contrary, in the event of any termination of this Agreement effective during the initial twelve (12) months of its term, the parties shall not enter into the same or substantially the same arrangement during such initial twelve (12) month period; provided, however, the parties shall not be prohibited from renegotiating this Agreement if, with the advice of legal counsel, the parties mutually agree that such renegotiation is not prohibited by applicable federal or state statutes and regulations, including without limitation the federal anti-kickback statute set forth at 42 U.S.C. Section 1320a-7b, the federal physician self-referral prohibition set forth at 42 U.S.C. Section 1395nn, or similar state laws.

## **ARTICLE VI INSURANCE AND INDEMNIFICATION**

**6.1 Insurance - General Liability.** During the term of this Agreement, Hospital agrees that it shall maintain, at Hospital's sole expense, general insurance in the minimum amounts of One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) annual aggregate from a reputable insurance company. Hospital agrees to provide proof of such coverage upon the reasonable request of Physician. Hospital shall notify Physician at least thirty (30) days prior to any change to or cancellation of such insurance coverage.

**6.2 Insurance – Professional Liability.** During the term of this Agreement, Physician agrees that he shall maintain, at Physician's sole expense, professional liability insurance in the minimum amounts of One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) annual aggregate from a reputable insurance company. Physician agrees to provide proof of such coverage upon the reasonable request of Hospital. Physician shall notify Hospital at least thirty (30) days prior to any change to or cancellation of such insurance coverage. For insurance on a claims-made basis, Physician agrees that not less than thirty (30) days prior to the effective date of termination by Physician of said insurance that Physician shall: (1) purchase tail or retroactive coverage in the above-stated amounts for all claims arising out of incidents occurring prior to termination of coverage; and (2) provide Hospital with a certificate of such coverage.

### **6.3 Indemnification.**

(a) Except as otherwise provided in this Agreement, Physician shall defend, indemnify, and hold harmless Hospital, its officers, employees, agents and affiliated entities from and against all losses, expenses, including attorneys' fees, damages, and liabilities of any kind incurred by Hospital (collectively, the "**Claims**") resulting from or arising out of Physician's performance hereunder, which are caused or claimed to be caused by the negligent or willful acts or omissions of Physician, its officers, employees, agents, subcontractors, or anyone directly or indirectly employed by them, or any other person or persons under Physician's direction and control; provided however, that Physician shall not have responsibility to indemnify, protect and hold Hospital harmless from and against any Claim occurring through the negligence of Hospital or any of Hospital's employees or agents.

(b) Except as otherwise provided in this Agreement, Hospital shall defend, indemnify and hold harmless Physician, his officers, employees, agents and affiliated entities

from and against all Claims resulting from or arising out of Hospital's performance hereunder, which are caused or claimed to be caused by the negligent or willful acts or omissions of Hospital, its officers, employees, agents, subcontractors, or anyone directly or indirectly employed by them, or any other person or persons under Hospital's direction and control; provided however, that Hospital shall have no responsibility to indemnify, protect and hold Physician harmless from and against any Claim occurring through the negligence of Physician or any of Physician's employees or agents.

## **ARTICLE VII HOSPITAL AND FACILITY NAMES AND MARKS**

Physician shall not use the name, logos, symbols, service marks or trademarks of Hospital and/or any facility owned Hospital (collectively, the "**Names and Marks**") without the prior written consent of Hospital. In this regard, the parties mutually acknowledge and agree that all right, title and interest in and to any such Names and Marks shall be the exclusive property of Hospital. Notwithstanding anything in this Agreement to the contrary, Physician shall have no claim whatsoever regarding the use or ownership of any such Names and Marks.

## **ARTICLE VIII EXCLUSIVITY; RESTRICTIONS**

**8.1 Intent.** The parties acknowledge and agree that, in furtherance of Hospital's principal business goals and initiatives, Hospital must assure appropriate and continuous medical administrative leadership in Facility with regard to the development and operation of the Facility; and, in so doing, Hospital must be assured that Physician will maintain an active commitment to achieving Hospital's business goals in the performance of this Agreement. Therefore, during the term of this Agreement, Physician shall be bound by and shall fully comply with the following restrictions as set forth in Section 8.2 below.

### **8.2 Restrictions.**

(a) Except as otherwise provided herein, during the term of this Agreement, Physician shall not, without the prior written consent of Hospital, provide similar medical administrative or consulting services for or on behalf of any hospital which is or will be in competition with Hospital. Each party specifically acknowledges and agrees that the foregoing restrictions are a condition precedent to Hospital's entering into this Agreement, that such restrictions are reasonable and necessary to protect the legitimate business interests of Hospital, and that such parties would not have entered into this Agreement in the absence of such restrictions. The parties further acknowledge that any violation of this Section 8.2 would result in irreparable injury to Hospital and that the remedy at law for monetary compensation resulting from any breach of this Section 8.2 would be inadequate. Accordingly, in the event of any such breach by Physician, and in addition to any other relief available to it, Hospital shall be entitled to temporary injunctive relief against Physician, as applicable, before arbitration or trial from any court of competent jurisdiction as a matter of course, upon the posting of not more than a nominal bond, and to permanent injunctive relief without the necessity of proving actual damages. In the event that the provisions contained in this Section 8.2 shall ever be deemed to

exceed the time or geographic limits or any other limitation permitted by applicable law, then such provisions shall be deemed reformed to the maximum extent permitted by applicable law.

(b) Nothing contained in the foregoing provisions of this Section 8.2 shall be construed to control, prohibit or restrict the methods by which Physician shall perform Director Duties in accordance with or otherwise contemplated under this Agreement.

(c) Nothing contained in the foregoing provisions of this Section 8.2 shall be construed to prohibit or otherwise restrict Physician from referring, admitting or treating patients to or at any hospital inpatient or outpatient facility, or otherwise engaging in the private practice of medicine.

## **ARTICLE IX CONFIDENTIALITY**

**9.1 Proprietary Information.** The parties recognize that, due to the nature of this Agreement, Physician will have access to and knowledge of information of a confidential and proprietary nature owned by Hospital, including without limitation any and all form documents, any and all information relating to payor contracts and accounts, billing practices and procedures, any and all computer programs devised by or licensed to Hospital, any and all copyrights, inventions and other intellectual property, any and all operating manuals, any and all clinical studies and other research, customer and patient lists, and other materials or records that constitute or describe the systems, policies and procedures, methods of doing business, administrative, advertising or marketing techniques or work product, financial affairs and other similar information or property utilized in connection with the operation of Hospital's business (collectively, "**Proprietary Information**"). Consequently, Physician acknowledges and agrees that Hospital has a proprietary interest in all such Proprietary Information and that all such Proprietary Information constitutes confidential and proprietary information and the trade secret property of Hospital. Physician hereby expressly and knowingly waives any and all right, title and interest in and to such trade secrets and proprietary and confidential information included in Hospital's Proprietary Information.

**9.2 Nondisclosure.** During the term of this Agreement, Physician shall not use or otherwise disclose to anyone, other than authorized persons or entities engaged or employed by Hospital with an appropriate need to know, any Proprietary Information obtained from or otherwise owned by Hospital, without Hospital's prior written consent, except as otherwise required by law. After the expiration or other termination of this Agreement, Physician shall not use or otherwise disclose to anyone any Proprietary Information obtained from or otherwise owned by Hospital, without Hospital's prior written consent, except as otherwise required by law. The parties acknowledge and agree that the foregoing covenant is perpetual and shall survive the expiration or other termination of this Agreement. For purposes of this Article IX, Proprietary Information shall not include information which is now, or becomes, generally available to the public other than by any disclosure made in violation of this Article IX.

**9.3 Confidentiality of Agreement.** The terms of this Agreement are confidential and shall not be disclosed, except as necessary to the performance of this Agreement or as required by law. Notwithstanding the foregoing, a party may disclose this Agreement to its lawyers,

accountants and other professional advisors. The foregoing obligations and requirements concerning confidentiality of this Agreement shall survive the expiration or other termination of this Agreement.

**9.4 Patient Records.** Notwithstanding and in addition to the requirements set forth in Article IX above, Physician shall maintain and safeguard the confidentiality of all patient records, charts and other related patient information, generated in connection with the operation of the Hospital or ICU, in accordance with all applicable federal and state statutes and related governmental regulations and with all other legal or contractual requirements imposed on Hospital or Facility, or Physician in connection therewith. In this regard, without limiting the generality or scope of the foregoing, Physician shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (“HITECH Act”), and regulations promulgated there under by the U.S. Department of Health and Human Services (“HIPAA Regulations”), the California Confidentiality of Medical Information Act, and other applicable laws, including without limitation state patient privacy laws, as such laws may be amended from time to time. Physician covenants that Physician will not copy any portion of these records manually, electronically or otherwise, except in the case of medical necessity, or with Hospital’s prior written approval. The foregoing obligations and requirements concerning patient confidentiality shall survive the expiration or other termination of this Agreement.

**9.5 Injunctive Relief.** Physician specifically acknowledges and agrees that the restrictions set forth in this Article IX are reasonable and necessary to protect Hospital’s legitimate business interests. The parties acknowledge that any violation of this Article IX would result in irreparable injury to Hospital, and that the remedy at law for monetary compensation resulting from any breach of this Article IX would be inadequate. Accordingly, in the event of any such breach by Physician, and in addition to any other relief available to it, Hospital shall be entitled to temporary injunctive relief before arbitration or trial from any court of competent jurisdiction as a matter of course, upon the posting of not more than a nominal bond, and to permanent injunctive relief without the necessity of proving actual damages. Physician also acknowledges and agrees that Hospital shall be entitled to an equitable accounting of all earnings, profits and other benefits arising from such breach and further agrees to pay the reasonable fees and expenses, including without limitation attorneys’ fees incurred by Hospital in enforcing the restrictions contained in this Article IX. In the event that the provisions contained in this Article IX shall ever be deemed to exceed any limitation permitted by applicable law, then such provisions shall be deemed reformed to the maximum extent permitted by applicable law.

## ARTICLE X ACCESS TO BOOKS AND RECORDS

**10.1 Cooperation.** Physician shall, in connection with the subject matter of this Agreement, cooperate fully with Hospital, by maintaining and making available all necessary books, documents and records, in order to assure that Hospital will be able to meet all requirements for participation in and payment associated with public or private third-party payment programs (e.g., the Medicare Program), including without limitation matters covered by Section 1861(v) (1) (I) of the Social Security Act, as amended.

**10.2 Compliance.** For the purpose of implementing Section 1861(v) (1) (I) of the Social Security Act, and any written regulations promulgated there under, Physician shall comply with the following statutory requirements governing the maintenance of documentation to verify the cost of services rendered under this Agreement:

(a) Until the expiration of ten (10) years after the furnishing of services pursuant to this Agreement, Physician shall make available to the Secretary of Health and Human Services or the Comptroller General of the United States, or their duly authorized representatives, upon written request of any of them, this Agreement, and all books, documents and records that are necessary to certify the nature and extent of the cost of such services, and

(b) If Physician carries out any of the duties of this Agreement through a subcontract with a value or cost of Ten Thousand Dollars (\$10,000) or more over a twelve (12) month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of ten (10) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request, to the Secretary or the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

**10.3 Notification.** If Physician is requested to disclose books, documents or records pursuant to this Article X, Physician shall, unless otherwise constrained by law or applicable regulation of any governmental authority, notify Hospital of the nature and scope of such request and shall make available, upon the written request of Hospital, all such books, documents or records during the regular business hours of Physician.

## **ARTICLE XI ANTI-REFERRAL LAWS**

**11.1 No Consideration for Referrals.** Hospital and Physician hereby acknowledge and agree that: (a) nothing in this Agreement or in any other written or oral agreement between Hospital and Physician, nor any consideration offered or paid in connection with such agreements, contemplates or requires the admission or referral of any patient to the Hospital; (b) any such agreements are not intended to influence Physician's judgment in choosing the medical facility appropriate for the proper care and treatment of Physician's patients; and (c) the overall value of the services and other consideration exchanged by and between Hospital and Physician pursuant to this Agreement are substantially equivalent.

**11.2 Specific Laws.** Each party acknowledges, and is hereby bound by, the obligation of such party to comply with applicable federal and state laws governing referral of patients, as may be in effect or amended from time-to-time, including without limitation:

(a) Payments for referral or to induce the referral of patients (California Business and Professions Code Section 650; California Labor Code Section 3215; and the Medicare/Medicaid Fraud and Abuse Law, Section 1128B of the Social Security Act and the regulations promulgated there under); and

(b) The referral of patients by a physician for certain designated health services to any entity with which the physician (or his/her immediate family) has a financial relationship (California Labor Code Sections 139.3 and 139.31, applicable to referrals for workers' compensation services; California Business and Professions Code Sections 650.01 and 650.02, applicable to all other patient referrals within the State of California; and Section 1877 of the Social Security Act, applicable to referrals of Medicare patients, and the regulations promulgated there under).

## **ARTICLE XII ADDITIONAL REPRESENTATIONS**

**12.1 Representations and Obligations of Physician.** Physician represents, warrants, and covenants to Hospital that upon execution and throughout the term of this Agreement:

(a) Physician shall comply with all applicable federal, state and local laws, related governmental regulations and accrediting standards governing or otherwise concerning any and all of Physician's business operations as well as the business operations of Hospital, including without limitation all licensure, reimbursement, anti-kickback and self-referral statutes, regulations and standards.

(b) Physician has not been excluded from any federal and/or state health care payment program by action of the Office of Inspector General of the Department of Health and Human Services or by any equivalent or coordinating federal or state governmental agencies.

(c) Physician shall fully comply with all applicable Rules and otherwise fully cooperate with Hospital in the performance of this Agreement during the term hereof, including without limitation preparing and executing all documents and attending all meetings, as may be reasonably requested by Hospital or otherwise required by applicable law, in connection with the provision of medical administrative Director Duties or for the conduct of the operations of Hospital.

(d) Physician is currently, and for the duration of the term hereof shall remain at all times, duly licensed and/or authorized to practice medicine in the State of California, duly qualified to render specialized professional medical services in the specialty of emergency medicine and in good standing with the Medical Board of California.

(e) Physician is currently a member in good standing with Facility's medical staff.

(f) Physician has a Federal DEA license without restriction.

(g) Physician's license to practice medicine in the State of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action or restricted in any way.

(h) Physician's medical staff privileges at any health care facility have never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction.



(i) Physician is not the subject of an investigatory, disciplinary or other proceeding or action before any governmental, professional, medical staff or peer review body.

(j) Physician is board certified in the specialty of emergency medicine.

(k) Physician is not in any manner whatsoever breaching any other agreement, covenant or obligation, or otherwise violating any statute, regulation or ordinance, by entering into this Agreement or otherwise acting as a party or performing hereunder, and that the consent of any third party is not required in any manner whatsoever for Physician to enter into this Agreement and/or act as a party or perform hereunder.

**12.2 Notification to Hospital or Facility.** Upon the occurrence of any event which causes any of the above representations set forth in this Article XII to no longer be true, Physician shall provide written notification to Hospital or Facility within forty-eight (48) hours of such event.

### **ARTICLE XIII MISCELLANEOUS**

**13.1 Assignment and Delegation.** Neither this Agreement nor any right or duty hereunder may be assigned or delegated by Physician without the prior written consent of Hospital in its sole discretion. Any attempted or purported assignment by Physician in violation of this provision shall be void and without force or effect. Hospital, in the exercise of its sole and absolute discretion, shall have the right at any time, without the consent of Physician, to assign, delegate or in any manner transfer all or any portion of its interests, obligations or duties under this Agreement to any person, group or entity affiliated with Hospital or to any successor-in-interest which acquires the Hospital or which acquires substantially all of Hospital's assets.

**13.2 Binding on Successor-in-Interest.** The provisions of this Agreement and the obligations and interests arising hereunder shall extend to and be binding upon and inure to the benefit of the lawful assigns and successors of the respective parties.

**13.3 Third Party Beneficiary.** None of the provisions contained in this Agreement is intended by the parties, nor shall any be deemed, to confer any benefit on any person or entity not a party.

**13.4 Notices.** Written notice required under this Agreement shall be given personally or sent by United States certified mail, return receipt requested, or by private overnight mail service, postage prepaid, and addressed to the parties at addresses shown below (or such other address as may hereafter be designated by a party by written notice thereof to the other party). Such notice shall be effective upon delivery, if given personally, or if mailed as provided for above such notice shall be effective upon the date shown on the delivery receipt.

HOSPITAL:	Tahoe Forest Hospital 10121 Pine Avenue P.O. Box 759 Truckee, CA 96160 Attention: Chief Executive Officer
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PHYSICIAN: Casey Jowers, M.D.

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Either party may change its address indicated above by notifying all other parties in writing of such change of address in the manner specified in this Section 13.4.

**13.5 Gender and Pronouns.** Whenever appropriate from the context of this Agreement, the use of any gender shall include any and all other genders, and the single number shall include the plural, and the plural number shall include the singular.

**13.6 Severability.** If any term or provision of this Agreement is held to be invalid, void or illegal by a court of competent jurisdiction, the validity and enforceability of the remaining terms and provisions of this Agreement shall not be affected thereby, and such remaining terms and provisions shall continue to be in full force and effect.

**13.7 Governing Law.** The existence, validity, interpretation and performance of this Agreement shall be governed by and construed in accordance with the laws of the State of California, without reference to its principles of conflict of laws.

**13.8 Entire Agreement; Amendment.** The making, execution and delivery of this Agreement by the parties have not been induced by any representations, statements, warranties or agreements other than those expressed in this Agreement. This Agreement, together with any attachments or exhibits, embodies the entire understanding of the parties regarding the subject matter of this Agreement, and there are no further or other agreements or understandings, written or oral, in effect between the parties relating to such subject matter. This Agreement shall supersede and terminate any previous oral or written agreements between the parties with respect to the subject matter hereof, and any such prior agreements are null and void. This Agreement may be amended or modified only by an instrument in writing signed by all of the parties.

**13.9 Waiver of Provisions.** The failure of a party to insist upon strict adherence to or performance of any provision of this Agreement on any occasion shall not be considered a waiver nor shall it deprive that party of the right thereafter to enforce performance of or adherence to that provision or any other provision of this Agreement. Any waiver of any terms and conditions hereof must be in writing, and signed by the parties.

**13.10 Captions and Headings.** Any captions to or headings of the articles, sections, subsections, paragraphs or subparagraphs of this Agreement are solely for the convenience of the parties, are not a part of this Agreement, and shall not be used for the interpretation or determination of validity of this Agreement or any provision hereof.

**13.11 Dispute Resolution.**

(a) Informal Resolution Processes. Any questions or disagreements arising under this Agreement regarding the quality of care provided to Hospital patients shall be

submitted to the Medical Executive Committee. Any other questions or disagreements (other than those regarding quality of care) arising under this Agreement, including any questions concerning the interpretation of this Agreement, shall be submitted to Hospital's Chief Executive Officer. If the dispute cannot be resolved by the Chief Executive Officer within ninety (90) days of submission, either party may submit the resolution to arbitration pursuant to Section 6.5(b).

(b) Arbitration. With the exception of disputes regarding the quality of care, which shall be resolved according to the provisions of Section 6.5(a), all disputes relating to, arising out of or in connection with the validity, interpretation or performance of this Agreement, including tort claims, shall be resolved by arbitration. The arbitration will proceed in accordance with the commercial rules of arbitration of the American Arbitration Association, as supplemented or modified by this Agreement. Written notice of a claim and demand for arbitration must be given to the other party (the "Respondent") not more than one hundred and twenty (120) days after the date of (i) the events giving rise to the claim occur or (ii) the date the claim is discovered. Response to the demand for arbitration shall be due not later than twenty (20) days after receipt of notice. The claim will be deemed denied if Respondent does not answer the demand within that time period. Not more than twenty (20) days after Respondent answers the demand (or if there is no answer, after the time for answer has elapsed) (the "Answer Date"), the parties shall select a single neutral arbitrator. If the parties cannot agree upon such arbitrator within twenty (20) days of the Answer Date, then each party shall choose an arbitrator and the two arbitrators together shall select a third arbitrator (the "Arbitrators") and the matter shall be arbitrated by the panel of three Arbitrators. If the two Arbitrators are unable to agree upon a third Arbitrator prior to the thirtieth (30th) day after the Answer Date, then either party may request the American Arbitration Association to select the third Arbitrator. Any Arbitrator selected under this Section shall be a person with business, financial or legal experience in the health care industry of at least five (5) years, who is generally familiar with the issues in dispute. The arbitration shall take place in Truckee, California, or another location mutually agreed upon by the parties. The Arbitrator(s) may construe or interpret but shall not ignore the terms of this Agreement and shall be bound by California substantive law. The arbitration decision shall include written findings of fact and conclusions of law. The arbitration decision may include equitable relief, but may not include punitive or exemplary damages. The Arbitrator(s) shall not have the power to commit errors of law or legal reasoning and the Arbitrator's(s') decision may be vacated or corrected pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for any such error. The prevailing party, as determined by the Arbitrator(s), shall be entitled to reasonable attorneys' fees and costs. In cases submitted to arbitration, the parties agree to share equally in the administrative fee, if any, unless otherwise assessed against the non-prevailing party by the Arbitrator(s). The parties agree that the decision of the Arbitrator(s) shall be final and binding as to each of them, and that the arbitration award may be enforced in any court having jurisdiction thereof, by the filing of a petition to enforce said award.

(c) **Equitable Relief.** The foregoing provisions of this Article XXIII shall not be interpreted in any manner whatsoever to restrict the right of either party to this Agreement to pursue equitable relief from a court of competent jurisdiction at any time or to terminate this Agreement in accordance with the terms hereof. In the event that either party wishes to obtain injunctive relief or a temporary restraining order from a court of competent jurisdiction, the decision of such court with respect to the requested injunctive relief or temporary restraining order shall be subject to appeal only as allowed under California law. Such court shall not, however, have the authority to review or grant any request or demand for damages.

**13.12 Venue.** The parties agree that Nevada County, California shall be the only proper venue for disputes related to this Agreement.

**13.13 Attorneys' Fees.** Notwithstanding and in addition to the provisions in Article XXIII above, if legal action is required by either party to enforce the terms of this Agreement, the prevailing party in such action shall be entitled to reimbursement for reasonable costs and attorneys' fees incurred in connection therewith.

**13.14 Survival of Provisions.** The provisions of sections 3.5; 6.1; 6.2; 9.1; 9.2; 9.3; 9.4; 9.5; 10.1; 10.2; 10.3; 12.1; 13.7, 13.11, 13.12, 13.14, and Article VII hereof shall survive any expiration or termination of this Agreement.

**13.15 Force Majeure.** Neither party shall be liable nor deemed to be in default for any delay, interruption or failure in performance under this Agreement that results, directly or indirectly, from Acts of God, acts of civil or military authority, war, terrorism, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, riots, civil disturbances, strike or other work interruptions by such party's employees or any similar or dissimilar cause beyond the reasonable control of such party. However, the parties shall make good faith efforts to perform under this Agreement in the event of any such circumstances.

**13.16 Disclosure of Conflicts of Interest.** Physician agrees to adhere to Hospital's conflicts of interest policy, as from time to time in effect, and to disclose to Hospital any matter or transaction in which Physician is involved that conflicts with the interest of Hospital in Physician's satisfactory performance of Specialty services under this Agreement.

**13.17 Tax-Exempt Financing.** In the event Hospital intends to seek tax-exempt financing, Hospital and Physician shall negotiate in good faith to amend this Agreement to the extent deemed necessary by bond counsel involved in that financing. If Hospital and Physician do not agree to the terms of such an amendment, Hospital may terminate this Agreement pursuant to Section 5.2.

**13.18 Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute but one and the same instrument.

**IN WITNESS WHEREOF**, the parties, for themselves or by their authorized officers, as applicable, have caused this Agreement to be executed effective as of the Effective Date set forth hereinabove.

**“Hospital”**  
**Tahoe Forest Hospital District,**  
**a California Hospital District**

**By:** \_\_\_\_\_  
**Robert A. Schapper, CEO**

**“Physician”**  
**Casey Jowers, M.D., an individual**

**By:** \_\_\_\_\_  
**Casey Jowers, M.D.**

**EXHIBIT A**  
**TAHOE FOREST HOSPITAL DISTRICT**  
**EMS MEDICAL DIRECTOR – SCOPE OF RESPONSIBILITIES**

PHYSICIAN serves as Modified Base Hospital EMS Medical Director with responsibilities that shall include the following and other responsibilities that may from time to time be deemed necessary and mutually agreed upon.

The Modified Base Hospital EMS Medical Director shall be responsible for providing medical direction and supervision for pre-hospital care.

**ESSENTIAL FUNCTIONS:**

1. **Program Oversight:** Provide medical direction for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfers, while in the emergency department of a general acute care hospital, until care responsibility is assumed by regular staff of that hospital.
2. **Program Integration:** Work closely with the Sierra Sacramento Valley Emergency Medical Services Agency in accordance with the Modified Base Hospital Agreement. **(EXHIBIT B)**
3. **Medical Administration:** Provide medical control and to assure medical accountability throughout the planning, implementation, and evaluation of the local EMS system including pre-hospital policies, procedures and protocols. Assure that Hospital has transfer agreements establishing medically appropriate referral patterns for specialty care that is not provided at Hospital.
4. **Education Oversight:** Oversight responsibility of formal education programs (including lectures/seminars, tape critiques, and supervised clinical experience) for pre-hospital personnel including EMT-1's, EMT-Paramedics, pursuant to policies established by SSV EMS Agency. In addition, provide oversight for supervised clinical experience for pre-hospital care trainees.
5. **Compliance:** Assure compliance with the Sierra-Sacramento Valley Emergency Medical Services Agency, Modified Base Hospital Agreement.
6. **Program Development:** Participation at Pre-hospital Services Committee meetings and other appropriate committee meetings.
7. **Public Relations:** Participate in regional disaster drills as requested.
8. **Quality Improvement:** EMS Medical Director shall oversee in all elements of SSV EMS regional CQI process
  - a. EMS Medical Director shall have direct oversight of the Modified Base Hospital CQI Committee that reviews the appropriateness and adequacy of patient care rendered by pre-hospital care personnel

- b. EMS Medical Director shall ensure the Modified Base Hospitals CQI medical staff committee:
  - i. Meets regularly
  - ii. Coordinates an orientation program for new hospital staff. This includes training in local EMS agency policies, procedures, and radio communication techniques to personnel who provide medical direction to pre-hospital professionals
  - iii. Ensure the quality of continuing education
  - iv. Audit the quality of pre-hospital care provided by physicians, and pre-hospital personnel through review of tape recordings of calls, logs, EMS reports, and Modified Base Hospital patient treatment forms.
  - v. Investigates and forwards appropriately to the service provider and SSV EMS Agency problems not resolved during regular Modified Base Hospitals meetings.
  - vi. Offers opinions and comments regarding the need for follow-up care, or other services that may be necessary to improve the level and quality of pre-hospital care delivered to patients.

**EXHIBIT B**  
**SIERRA-SACRAMENTO VALLEY EMERGENCY**  
**MEDICAL SERVICES AGENCY**  
**MODIFIED BASE HOSPITAL AGREEMENT**

Due to the size of the Agenda Packet, the full version of the contract referenced as Exhibit B has been extracted.

A copy is available upon request.



**EXHIBIT C - EMS MEDICAL DIRECTOR – OCCUPATIONAL HEALTH CLINIC**



**SERVICE TIME LOG -**

**Name:** \_Casey Jowers, MD

**Physician:** Each month please complete & submit this log for services you rendered. Please add more pages to this log if needed to ensure all dates, times, services are listed. If you use a computer/phone application, please attach and sign this log to the documentation generated by the program. Thank you.

<b>Date of Service</b>	<b>Description of Services as specified by the contract</b>	<b>Hours</b>

Total time: \_\_\_\_\_ hours @ \$125.00/hour not to exceed \_\_\_\_ ( ) hours per month = Total balance due \$ \_\_\_\_\_

I hereby attest that I personally performed all of the services listed for the time periods indicated and that there has been no duplication of hours or services. I declare that the above statement is true and accurate to the best of my knowledge. Physician's Signature: \_\_\_\_\_  
Date \_\_\_\_\_

**CONTRACT ROUTING FORM**

Email Completed Form to Executive Assistant ([pbarrett@tfhd.com](mailto:pbarrett@tfhd.com)) for Processing and Compliance Review

<b>NEW CONTRACT</b> <input checked="" type="checkbox"/> <b>AMENDMENT</b> <input type="checkbox"/> <b>RENEWAL</b> <input type="checkbox"/> <b>EXTENSION</b> <input type="checkbox"/> <b>BAA</b> <input type="checkbox"/>		
<b>ORIGINATING DEPARTMENT:</b> Medical Staff Services	<b>CONTACT PERSON:</b> Terri Schnieder <b>PHONE:</b> 582-6640	
<b>RESPONSIBLE ADMINISTRATIVE COUNCIL (AC):</b> CEO <input type="checkbox"/> CFO <input type="checkbox"/> COO <input checked="" type="checkbox"/> CNO <input type="checkbox"/> CIO <input type="checkbox"/> IVCH <input type="checkbox"/>	<b>REQUIRES BOARD GOVERNANCE COMMITTEE REVIEW?</b> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> <b>MEETING DATE:</b> 10/16/14 <b>COMMITTEE RECOMMENDS:</b> Approval	
<b>TYPE OF CONTRACT:</b>		
Physician Professional Service Agreement (P-PSA) <input checked="" type="checkbox"/> Physician Medical Director Agreement (MDA) <input type="checkbox"/> Vendor Professional Service Agreement (V-PSA) <input type="checkbox"/> Other <input type="checkbox"/>	Type: Educational Agreement Type: _____ Type: _____ Type: _____	
❖ <b>Business Associated Agreement Required?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>CONTRACTOR/VENDOR DETAILS:</b> <i>If needed, additional instructions and information may be provided on Page 2</i>		
<b>LEGAL NAME OF CONTRACTOR/ VENDOR:</b> North Tahoe Radiology Group		
<b>Purpose of the Contract/Alternatives:</b> North Tahoe Radiology Group attends an annual conference as a member of the medical staff of TFHS be able to evaluate new modalities of imaging studies.		
<b>Scope of the Contract:</b> District agrees to pay for reasonable out of pocket expenses incurred as a result of approved training and education.		
<b>DATES OF CONTRACT:</b>	<b>EFFECTIVE DATE:</b> 11/1/14	<b>END DATE:</b> 10-31-15
<b>Version History:</b>	Original Effective date: Renewal Dates: n/a Amendment Dates:	
<b>PHYSICIAN CONTRACTS: FOR STARK LAW COMPLIANCE, THE TERMS OF THIS CONTRACT CANNOT CHANGE FOR 1 YEAR</b>		
<b>Compensation Structure:</b> <i>Include "other comp" (i.e. education, phone stipend, etc.)</i> Reasonable out of pocket expenses incurred as a result of approved training and education.		
<b>Contract Term:</b> <i>(anything other than Net 30 requires AC approval)</i> Net 30		
<b>Total Cost of Contract:</b>	Travel (airline \$580 to Chicago), room & meals (no cost for seminar)	
<b>Compensation Audit Process:</b>	See Policies AGOV-10 and ABD-21	
<b>Is Cost of Contract Budgeted?</b>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>If NOT budgeted or exceeds budgeted amount, identify the offset:</b>		
<b>TFHS Primary Responsible Party:</b>	Terri Schnieder, Director of Medical Staff Services	
<b>TFHS Secondary Responsible Party:</b>	Virginia Razo, Chief Operating Officer	

<b>ORIGINATING DEPARTMENT:</b> Medical Staff Services	<b>CONTACT PERSON:</b> Terri Schnieder Phone: 582-6640
--	---

<b>LEGAL NAME OF CONTRACTOR/ VENDOR:</b> North Tahoe Radiology Group
--

REQUIRED COMPLIANCE INFORMATION	
<b>Commercially Reasonable Verified</b> Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/> <b>Fair Market Value Verified</b> Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>	<b>Compliance Officer Signature:</b> 

CONTRACTOR INFORMATION	
<b>Contractor Representative Name:</b>	North Tahoe Radiology Group
<b>Mailing Address:</b>	10121 Pine Avenue
<b>Telephone and Fax Number:</b>	<b>Phone:</b> 582-3420 <b>Fax:</b> 582-3425
<b>Email Address of Contact:</b>	gmohr@tfhd.com; tlaire@tfhd.com; mkamenetsky@tfhd.com
<b>Accounts Receivable Representative:</b>	

REQUIRED FINANCIAL INFORMATION
<b>W-9 and Certificates of Insurance Must Be Submitted with any Contract</b>

ADDITIONAL INFORMATION
------------------------

I have recommended that this provision be added to their NTRG PSA in the future amendments.

Fair Market Value (FMV) & Commercial Reasonableness (CR): There is no FMV range for attending an educational conference - the market value is the cost of attending the program. CR is satisfied because providing this education to the radiologist will improve the District's ability to provide quality of patient care services.

**Reference:**  
 Policy ABD – 21 Physician and Professional Service Agreements  
 Policy AGOV – 10 Contract Review Policy  
 Policy AFIN – 03 Accounts Payable Policy

*W-9s are required for any contract on which we are making payments.  
 Certificates of Insurance are required for any contract in which any service is being provided.*

THIS SECTION FOR CONTRACTS COORDINATOR USE ONLY:			
<b>W-9 Received?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	<b>Certificate of Insurance Received?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
<b>New Vendor information Sent to Accounts Payable?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	<i>Email a copy of Section D (page 2) of the completed Routing Form to A/P. This is required for A/P to process their payments.</i>	

<b>Contracts Review:</b>	_____	_____
Date	Initials	
<b>CFO Review:</b>	_____	_____
Date	Initials	

<b>BOARD ACTION:</b>	_____	<b>MEETING DATE:</b>	_____
Out for TFHD Signature:	Date: _____	Receive Date:	_____
Out for Vendor Signature:	Date: _____	Receive Date:	_____
Uploaded to Contracts System:	Date: _____	Trigger dates set:	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>CONTRACT #:</b>	_____	<b>Document Reference:</b>	_____
(i.e. 10001)		(i.e. #####.C)	

TAHOE FOREST HOSPITAL DISTRICT  
PROFESSIONAL SERVICES AGREEMENT FOR EDUCATION

This Agreement is made and entered into effective on November 1, 2014 (“Effective Date”) by and between North Tahoe Radiology Group (hereinafter referred to as “NTRG”) and Tahoe Forest Hospital District (hereinafter referred to as “DISTRICT”).

DISTRICT currently operates two state licensed, Medicare certified, critical access hospitals (the “FACILITIES”) and has an exclusive contract with the NTRG, which is a medical group of physicians who are current members of the Medical Staff of the FACILITIES, to provide radiology and diagnostic imaging services for patient’s at the FACILITIES. DISTRICT desires NTRG to designate a NTRG physician to attend the annual RSNA radiology conference in November 2014 in Chicago, Illinois as further described in the attached EXHIBIT A (“PROGRAM”) so that NTRG may develop skills to identify, manage, and implement best practices relating to a range of issues relevant to the provision of radiology and diagnostic imaging services at FACILITIES, which skills the DISTRICT has determined will enhance the quality and effectiveness of medical services at the FACILITIES. The parties are entering into this agreement (“AGREEMENT”) to enable DISTRICT to pay for NTRG to designate a physician to attend the PROGRAM as approved by the Hospital’s Chief Executive Officer or designee. The parties hereby incorporate the above recitals into the terms of this document and mutually agree as follows:

1. Expenses: DISTRICT agrees to reimburse NTRG for reasonable out-of-pocket travel, room and board expenses at rates, not to exceed the threshold set by the DISTRICT’s administration, that are incurred as a result of attending this approved PROGRAM. The costs and expenses to be reimbursed by DISTRICT to NTRG are set forth in the attached EXHIBIT B. All such expenses must be approved by DISTRICT prior to reimbursement.
2. Value to the DISTRICT: The DISTRICT has determined that the value to the DISTRICT of NTRG’s physician representative attendance at the PROGRAM is equal to or greater than the PROGRAM costs to be incurred by the DISTRICT.
3. Term: This AGREEMENT shall commence as of the first date written above and shall conclude upon completion of the PROGRAM.
4. Termination: This AGREEMENT may be terminated with or without cause by either party upon provision of ten (10) days written notice to the other party addressed to the other party as follows:

DISTRICT  
Chief Executive Officer  
Tahoe Forest Hospital District  
P.O. Box 759  
Truckee, CA 96160

North Tahoe Radiology Group  
10121 Pine Avenue  
P. O. Box 759  
Truckee, CA 96160

Any notice required or permitted hereunder shall be in writing and shall be deemed given as of the date deposited in the United States mail, postage prepaid.

5. Independent Contractor: NTRG and its member physicians are independent contractors in relation to DISTRICT and are not an employee, agent or partner of, or joint venture with DISTRICT.
6. Compliance with Laws and Regulations: NTRG and its member physicians are licensed to practice medicine in the State of California and/or the State of Nevada and shall maintain Medical Staff privileges in good standing on the DISTRICT's Medical Staff. NTRG and its member physicians shall comply with the laws of the State of California, (and if providing services at DISTRICT's FACILITIES in Nevada will comply with the laws of the State of Nevada), the standards of the Health Care Facilities Accreditation Program (HFAP), and the Ethics of the American Medical Association and the American Osteopathic Association.
7. Entire Agreement. This AGREEMENT contains the entire agreement of the parties hereto and supersedes all prior agreements, representations and understandings between the parties relating to the subject matter thereof.
8. Governing Law. This AGREEMENT shall be governed by, construed and enforced under the laws of the state of California.

IN WITNESS WHEREOF, the parties have caused the agreement to be executed and delivered as of the date first above written.

**DISTRICT:**

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
Robert A. Schapper,  
Chief Executive Officer

**NTRG:**

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
Thaddeus Laird, M.D.

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
Myron Kamenetsky, M.D.

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
Greg Mohr, M.D.

ATTACHED: Exhibit A – Radiology Conference Brochure

EXHIBIT A  
100<sup>th</sup> SCIENTIFIC ASSEMBLY AND ANNUAL MEETING



# Registration and Housing

*A Century  
of Transforming Medicine*  
**100<sup>th</sup> RSNA<sup>®</sup> 2014**

MCCORMICK PLACE, CHICAGO

NOV  
30  
*thru*  
DEC  
05

Register & book your hotel room: [RSNA.org/Register](http://RSNA.org/Register)

205 of 366

SAVE UP TO \$560  
ON REGISTRATION  
WHEN YOU BECOME  
A MEMBER

# OUR 100<sup>th</sup> ANNUAL MEETING WILL BE OUR MOST CAPTIVATING EVENT YET



### Discover the finest in science and education

See the latest discoveries and techniques by investigators and educators from all over the world while earning CME. We've selected hundreds of courses and thousands of scientific presentations and education exhibits for you.



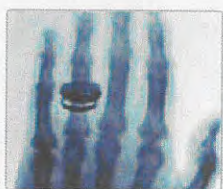
### Put your hands on the latest in technology

Nearly 700 companies from across the globe show you products, services, equipment and software to streamline your practice or institution. See and touch them on the exhibit floor.



### Enhance your experience with the Virtual Meeting

Add the Virtual Meeting during your registration to access select courses, presentations and Cases of the Day on your own time, from any internet connection.



### Experience the Centennial Showcase

Explore an interactive showcase that lets you see, hear and touch the advancements that shaped radiology. View a historical timeline, hear a special welcome from a virtual Wilhelm Roentgen and explore the Centennial Gallery featuring stories behind RSNA.



### Celebrate with the Sip & Savor Social

Celebrate our 100th annual meeting with the RSNA community. Enjoy drinks, entertainment, and tastings by some of Chicago's top restaurants. Reserve your ticket(s) during the registration process!



### Take advantage of exclusive hotel rates

We've secured 84 downtown hotels to offer you a wide range of options, new flexible terms and the lowest rates in Chicago. Register NOW, hotel rooms fill up fast!

## IMPORTANT DATES

<b>MAY 1</b> Member registration and housing opens 10:30 AM CT	<b>JUNE 4</b> Non-member registration and housing opens 10:30 AM CT	<b>JULY 9</b> Course enrollment opens 10:30 AM CT	<b>OCT. 24</b> Deadline for International badge mailing	<b>NOV. 7</b> Final housing and discounted registration deadline 5 PM CT	<b>NOV. 26</b> Deadline to guarantee a seat for all ticketed courses	<b>NOV. 30 - DEC. 5</b> 100th Scientific Assembly and Annual Meeting
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This live activity has been approved for *AMA PRA Category 1 Credit*™.

The Commission on Accreditation of Medical Physics Education Programs (CAMPEP) has approved the direct transfer of *AMA PRA Category 1 Credit*™ to Medical Physics Continuing Education Credit (MPCEC) on a credit-for-credit basis for medical physicists.

RSNA is an ARRT®-approved Recognized Continuing Education Evaluation Mechanism Plus (RCEEM+) and will provide Category A/A+ continuing education credits for radiologic technologists and radiologist assistants.





## Bistro RSNA

Sunday, November 30 – Wednesday, December 3, 2014

11:00 a.m. – 2:30 p.m.

Technical Exhibit Hall A & Hall B

With an extensive gourmet menu and ample seating, Bistro RSNA is an excellent option to sit down to a comfortable lunch and network with colleagues. Purchase your ticket now for only \$20 per day.

Visit [www.BistroRSNA.com/attendee.php](http://www.BistroRSNA.com/attendee.php) for more information.



## JOIN THE 5k Fun Run TO FUEL CRITICAL RESEARCH

Tuesday, December 2, 2014, 6:30 a.m.

Arvey Field, South Grant Park, Chicago

Join us for the RSNA 2014 5k Fun Run and help the RSNA R&E Foundation keep our specialty at the forefront of healthcare. Whether you run, walk or wheel, enjoy an outing for a good cause with your colleagues along Chicago's beautiful Lake Michigan shore.



Your fully tax-deductible donation will benefit the RSNA R&E Foundation. Participants will receive commemorative T-shirt, while supplies last.

*Please note, in case of inclement weather, the Fun Run may be cancelled. All Fun Run fees are non-refundable and non-transferable.*



## EXPERIENCE RSNA 2014 HIGHLIGHTS ON YOUR OWN TIME

With the vast offerings RSNA 2014 provides, it's impossible to see it all at McCormick Place. Add the Virtual Meeting to your registration package to access selected live-streamed and on-demand sessions, scientific presentations and education exhibits, Cases of the Day, and virtual technical exhibits. The Virtual Meeting is available on-demand until December 19 at 4 p.m. CST. Earn CME for select live sessions only.



## Sip & Savor Social

Wednesday, December 3, 2014, 5:00 p.m. – 7:00 p.m.

Skyline Ballroom, 3rd Floor

McCormick Place, West Building

You're invited to celebrate RSNA's 100th annual meeting in the Skyline Ballroom.

Enjoy drinks, entertainment, and tastings by some of Chicago's top restaurants. Don't miss the celebration of a century. Tickets are available for \$40 (Children under the age of 16 will not be admitted to this event).

S O C I A L

# Hotel Reservations

▶ HOUSING DEADLINE: NOVEMBER 7

Hotel rooms are available only to registered individuals. For RSNA 2014 we've secured 84 downtown hotels offering the lowest rates in the city.

## Top reasons why you should reserve your hotel rooms via the RSNA housing system:

- ▶ **Lowest rates.** We've secured 84 hotels in the heart of the city offering a wide range of options, price points and the lowest rates possible.
- ▶ **New! Flexible terms.** Book today, and have the flexibility to change or cancel your reservation without charge up to 72 hours prior to arrival.
- ▶ **Easy booking.** Attendees have the ease of booking a hotel while registering.
- ▶ **Customer service.** RSNA is your advocate if a dispute or problem arises and is also available to assist with housing questions or concerns.
- ▶ **Supporting the association.** When you book through our system, you are supporting RSNA. The society is able to negotiate the best deals on room rates.
- ▶ **Free transportation.** Free shuttle bus and Metra train service is available between all 84 hotels and McCormick Place.



REGISTER AND  
RESERVE YOUR HOTEL  
TODAY. POPULAR  
HOTELS FILL UP  
QUICKLY!

### Hotel Deposit and Cancellation Policy

A deposit equal to one night stay including tax is required to confirm your hotel reservation. The credit card must be valid through December 2014 and will be charged by the hotel approximately two weeks before the annual meeting. If the credit card is declined, the reservation may be canceled by the Hotel. Reservations may be canceled without charge up to 72 hours prior to guest's scheduled arrival date. Failure to comply will result in forfeiture of the deposit equal to one night's room and tax. Early departures will result in the loss of one night's room and tax. Registrants can also send a check, money order or wire transfer (payable to RSNA) for the hotel deposit. (Attendees are responsible for all wire transfer fees.)

### Reservation Changes

#### Prior to November 7

Make changes online at [RSNA.org/Register](http://RSNA.org/Register) or contact [RSNA@Experient-inc.com](mailto:RSNA@Experient-inc.com) for hotel changes. Name changes and/or swapping of room reservations is not allowed.

#### November 10-18

Reservations and deposits will be transferred from Experient to the hotels and therefore cannot be altered during this period.

### Cancellations and Early Departures

Written requests for room cancellations must reach [RSNA@Experient-inc.com](mailto:RSNA@Experient-inc.com) by November 7.

#### After November 18

Contact the hotel directly for date changes and room cancellations. Room availability and rates are at the hotel's discretion.

Reservations may be canceled without charge up to 72 hours prior to guest's scheduled arrival date. Failure to comply will result in forfeiture of the deposit equal to one night's room and tax.

Early departures will result in the loss of one night's room and tax.

Failure to check in at the hotel on your scheduled arrival day will result in forfeiture of your reservation and hotel deposit. The hotel will accommodate you on a space-available basis.

When canceling your room reservation directly with the hotel document the date and time of your call, name of the person with whom you spoke, and obtain a cancellation number.

### Special Notes

The hotel information provided on the following page is based on single occupancy. Type of bed (single, double, twin) may be requested but cannot be confirmed until check-in. Suites are available upon request. Contact Experient at 1-800-650-7018 or 1-847-996-5862 for triple and quad rate information. If you plan to arrive after 6:00 PM, contact the hotel for a late check-in.

- Attendees may not request housing through technical exhibitors.
- Rates do not include a 16.4% Chicago hotel tax (subject to change). A service fee has been included in your room rate to defray the cost of registration and to provide complimentary shuttle service to and from McCormick Place.

### Hostelling International – Chicago

The Chicago hostel offers lodging in dormitory-style rooms with separate accommodations for men and women.

Rooms range in size from 6–12 beds. Bathrooms and shower facilities are plentiful, with many available in the dorm rooms as well as down the hall. Individual lockers are provided in each room, and luggage storage is also available. Please bring your own lock for the lockers or purchase a lock at the front desk.

### Private Bedroom

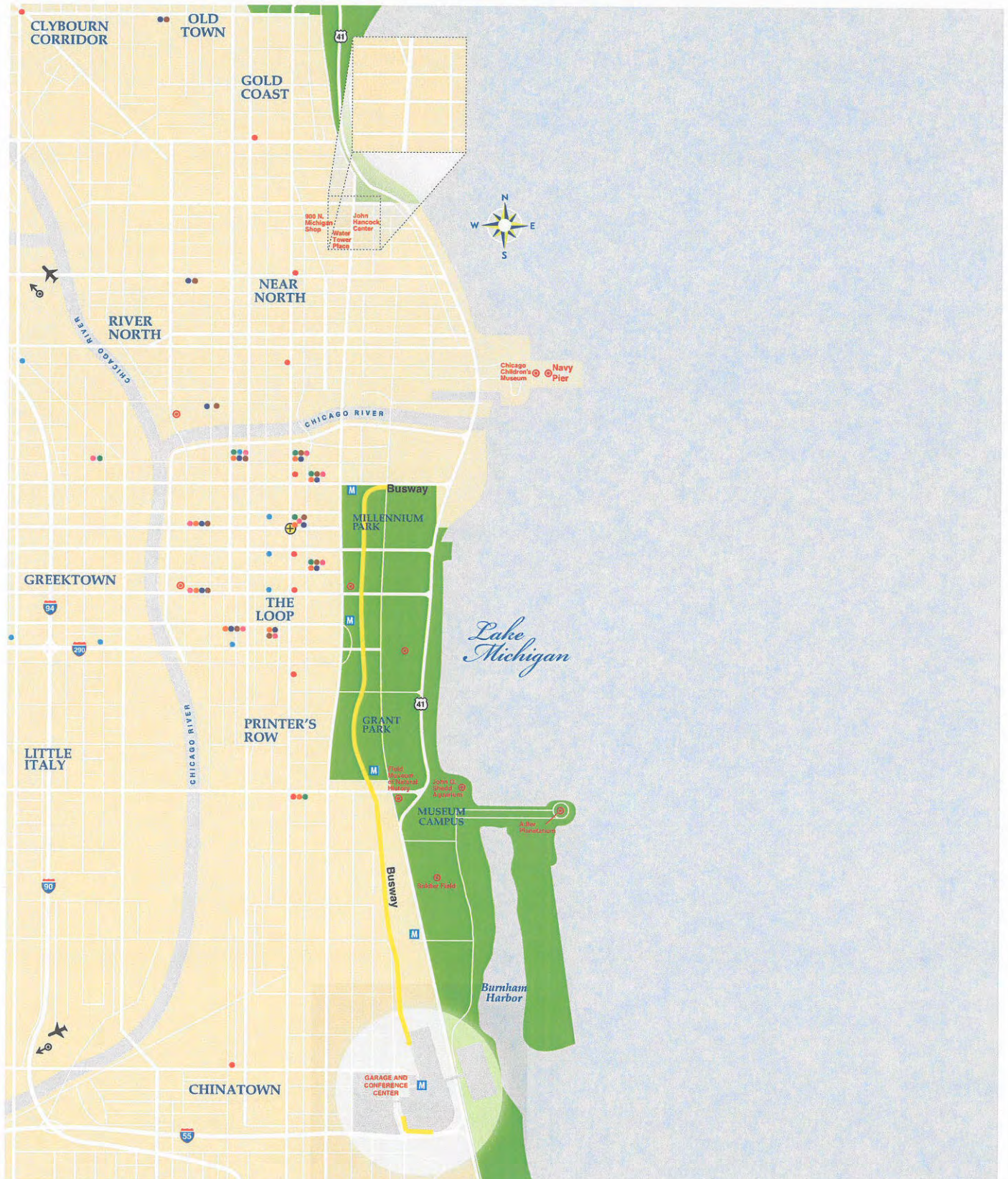
Private bedrooms have a single bed lofted over a full bed, shared suite bathroom, lounge and kitchenette area (maximum 2 people per bedroom), sheets and towels included.

# Hotel Rates

HOTEL NAME	SINGLE	DOUBLE
1 Acme Hotel Company	\$238	\$258
2 Allegro Chicago, A Kimpton Hotel	\$215	\$215
3 Allerton Warwick	\$217	\$217
4 ALOFT Chicago City Center	\$240	\$240
5 Best Western Grant Park Hotel	\$167	\$167
6 Best Western River North Hotel	\$158	\$158
7 The Blackstone, A Renaissance Hotel	\$265	\$265
8 Burnham Chicago, A Kimpton Hotel	\$246	\$246
9 Congress Plaza Hotel	\$173	\$173
10 Conrad Chicago Hotel	\$300	\$300
11 Courtyard Chicago Downtown Magnificent Mile	\$213	\$213
12 Courtyard Chicago Downtown River North	\$216	\$216
13 Crown Plaza Chicago Metro	\$194	\$194
14 Dana Hotel	\$239	\$239
15 Doubletree Hotel Chicago Magnificent Mile	\$230	\$250
16 Drake Hotel	\$277	\$297
Deluxe	\$307	\$327
17 Embassy Suites Hotel	\$272	\$312
18 Embassy Suites Lakefront	\$268	\$288
19 Essex Inn	\$164	\$174
20 Fairfield Inn & Suites Chicago Downtown/ Magnificent Mile	\$199	\$199
21 Fairfield Inn & Suites River North	\$211	\$211
22 Fairmont Hotel Chicago	\$281	\$281
Gold	\$356	\$356
23 Four Points Hotel by Sheraton	\$214	\$214
24 Four Seasons Hotel	\$399	\$399
Executive	\$480	\$480
25 Hampton Inn & Suites (formerly Avenue Crowne Plaza)	\$235	\$235
26 Hampton Inn and Suites Chicago Magnificent Mile	\$214	\$224
27 Hampton Majestic	\$228	\$228
28 Hard Rock Hotel Chicago	\$249	\$249
29 Hilton Chicago	\$233	\$253
Executive	\$284	\$304
30 Hilton Garden Inn	\$211	\$211
31 Hilton Suites	\$276	\$276
32 Holiday Inn & Suites	\$167	\$167
33 Holiday Inn Mart Plaza	\$196	\$221
34 Homewood Suites By Hilton	\$234	\$234
35 Homewood Suites Chicago Magnificent Mile (formerly Avenue Crowne Plaza)	\$244	\$244
36 Hostelling International - Chicago	\$41	
Semi-Private	\$96	\$96
37 Hotel Cass - A Holiday Inn Express	\$199	\$199
38 Hotel Chicago Downtown (formerly Hotel Sax)	\$239	\$239
39 Hotel Felix	\$212	\$212
40 Hotel Indigo	\$165	\$185
41 Hyatt Chicago - Magnificent Mile	\$266	\$286
42 Hyatt Place Chicago River North	\$240	\$240
43 Hyatt Regency Chicago Hotel	\$227	\$227
Regency Club	\$277	\$277

HOTEL NAME	SINGLE	DOUBLE
44 Hyatt Regency McCormick Place Hotel	\$256	\$266
45 Inn of Chicago	\$174	\$174
46 InterContinental Hotel Chicago Towers	\$239 \$279	\$259 \$299
47 James Hotel	\$267	\$267
48 JW Marriott	\$276	\$276
49 Kinzie Hotel Chicago (formerly Amalfi Hotel Chicago)	\$267	\$307
50 The Langham, Chicago	\$375	\$375
51 Marriott Downtown Magnificent Mile Club	\$227 \$294	\$227 \$294
52 MileNorth, A Chicago Hotel	\$212	\$212
53 Millennium Knickerbocker Hotel	\$221	\$221
54 Monaco Chicago, A Kimpton Hotel	\$245	\$245
55 Omni Chicago Hotel	\$282	\$301
56 Palmer House Hilton Hotel Executive	\$227 \$266	\$247 \$286
57 Palomar Chicago, A Kimpton Hotel	\$255	\$255
58 Park Hyatt Hotel	\$389	\$429
59 Peninsula Hotel	\$399	\$421
60 Public Chicago	\$195	\$195
61 Radisson Blue Aqua Hotel Chicago	\$267	\$267
62 Raffaello Hotel	\$219	\$219
63 Renaissance Chicago Hotel Club	\$268 \$353	\$268 \$353
64 Residence Inn By Marriott Magnificent Mile	\$224	\$224
65 Residence Inn Chicago Downtown River North	\$241	\$241
66 Ritz-Carlton Chicago Hotel Executive	\$399 \$480	\$399 \$480
67 Sheraton Chicago Hotel & Towers Towers	\$232 \$295	\$232 \$295
68 Silversmith Hotel Premium	\$216 \$259	\$216 \$259
69 Sofitel Chicago Water Tower Hotel	\$292	\$292
70 Springhill Suites Chicago Downtown River North	\$231	\$231
71 Swissotel Chicago	\$248	\$248
72 Talbott Hotel	\$249	\$249
73 Thompson Chicago	\$226	\$226
74 Tremont Hotel	\$179	\$179
75 Trump International Hotel and Tower	\$405	\$405
76 Union League Club (20% non-member surcharge in lieu of the 16.4% city tax)	\$185	\$185
77 W Chicago City Center Hotel	\$247	\$247
78 W Lake Shore Drive Hotel	\$247	\$247
79 Waldorf Astoria Chicago	\$399	\$429
80 Westin Michigan Avenue Hotel	\$263	\$283
81 Westin River North Chicago Hotel	\$269	\$269
82 Whitehall Hotel	\$214	\$214
83 theWit Chicago, A Doubletree by Hilton Hotel	\$280	\$300
84 Wyndham Grand Chicago Riverfront	\$220	\$240

# Hotel Locations



# Registration Information

## ► REGISTER ONLINE AT [RSNA.ORG/REGISTER](http://RSNA.ORG/REGISTER)

### Telephone

(Mon – Fri, 8:00 AM – 5:00 PM CT)  
1-800-650-7018  
1-847-996-5862

### Fax

(Available 24 hours)  
1-888-772-1888  
1-301-694-5124

### Mail

Experient/RSNA 2014  
5202 Presidents Court, Suite 310  
Frederick, MD 21703 USA

### Questions?

[RSNA@experient-inc.com](mailto:RSNA@experient-inc.com)



If you need aid or services at RSNA 2014 as identified under the Americans with Disabilities Act, call RSNA at 1-630-571-7862 by October 24.

### Badges and Tickets

Badges and course tickets will be mailed starting in late October/early November to all full conference international registrants enrolled by October 24 and domestic full conference registrants enrolled by November 7. After these dates, badges must be printed at the McCormick Place Convention Center.

### Spouse/Family Member Badge

Full conference professional registrants are entitled to one complimentary spouse/family member badge; each additional badge is \$50. This badge is intended for use by a spouse or family member (16 and over) accompanying a full conference professional registrant to the meeting. It allows access to technical exhibit halls, Lakeside Learning Center, and classrooms, space permitting, after all professional registrants have been seated. CME credit is not tracked or awarded. A co-worker or industry associate is not eligible for this badge and must register as a professional and pay the applicable registration fee.

To uphold the professional and educational standards of the RSNA annual meeting, children under 16 years of age are not permitted in the exhibit halls or sessions or issued a badge.

### Registration Changes and Cancellations

- Name changes are not allowed—new registration and payment is required.
- All registration cancellations must be made in writing to [rsna@experient-inc.com](mailto:rsna@experient-inc.com) by Nov. 7.
- A \$50 administrative charge applies per canceled registration.
- Refund requests received after November 7 will not be accepted.
- A new e-mail confirmation is sent each time a change is made to your registration and housing record. Please check your “spam” or detained email folder.
- No refunds will be issued for Virtual Meeting registration purchased but not used.

### Technical Exhibits Only

- A technical exhibits only badge is available for 1 or 2 day(s) admission to the technical exhibit halls. Admission to sessions and/or CME credit is not offered for this category.
- Attendance for more than 2 days requires a full conference registration. See page 8 for categories and rates.
- A name badge will not be mailed in advance and requires pick-up on the day of exhibit attendance at the McCormick Place Convention Center.
- A complimentary spouse/family badge is not available with this registration category.

### Photography and Video Recording

Photography and video recording will be used throughout McCormick Place. By registering, you acknowledge the possibility of being photographed or filmed and give RSNA® consent to use your image which may be used for marketing or promotional purposes.

### Course Enrollment Brochure

The course enrollment brochure will mail in early July and will be available online beginning July 9.

### Onsite Registration

Registrations processed after November 7 will reflect a \$100 increase over advance registration rates for most categories.

### Bistro RSNA

With an extensive menu and ample seating, Bistro RSNA is an excellent option to sit down to a comfortable lunch and network with colleagues. Find Bistro RSNA in Technical Exhibit Halls A and B.

### RSNA Welcomes International Attendees

International services and special signage featuring images will be placed in key areas at McCormick Place to assist you onsite. Although the annual meeting is officially in English, RSNA offers translation services in Chinese, Dutch, French, German, Italian, Japanese and Spanish.

### International Invitation Letter

RSNA offers an official letter of invitation for RSNA 2014 attendees. The letter of invitation, though not required for the visa application, can assist as a supporting document. Present this letter of invitation from RSNA to the Consular Officer during the visa interview.

Request a customized letter during online registration by visiting [RSNA.org/Visas](http://RSNA.org/Visas).

All visa applicants are advised to apply for their visas as soon as travel to the United States is contemplated, and not later than 3-4 months in advance. **Apply early!**

### Visa Waiver Program

The Visa Waiver Program (VWP) enables nationals of certain countries to travel to the United States for tourism or business for stays of 90 days or less without obtaining a visa. For more information go to [travel.state.gov/content/visas/english/visit/visa-waiver-program.html](http://travel.state.gov/content/visas/english/visit/visa-waiver-program.html).

# Registration Categories and Rates

Conference Rate	Exhibits Only Daily Rate	Registration Categories and Codes	
<i>Includes admission to RSNA educational sessions and exhibit halls for the duration of the meeting. +Virtual includes Virtual program live and on-demand.</i>	<i>Includes admission only to the exhibit halls</i>	<input type="checkbox"/> Eligible for advance member registration starting May 8 <i>(All other categories may register starting June 4)</i>	
<b>RSNA MEMBERS</b>			
<b>BY 11/7</b>	<b>+VIRTUAL</b>		
\$0	\$100	*	<b>11</b> RSNA Active Member
\$0		*	RSNA Active Member Presenter A. radiologist C. radiation oncologist B. radiologic physicist/scientist D. nuclear medicine physician
\$0	\$100	*	<b>10</b> RSNA Associate Member
\$0		*	RSNA Associate Member Presenter A. administrator/business mgr F. medical dosimetrist K. radiologic physicist/scientist B. architect G. non-radiologist physician L. radiologist (board eligible) C. assistant (physician/radiologist) H. nurse practitioner M. registered nurse D. dentist I. radiation therapist N. sonographer E. educator J. radiographer O. technologist
\$0	\$0	*	<b>12</b> RSNA Member-in-Training
\$0	\$0	*	<b>17</b> RSNA Medical Student Member <sup>†</sup>
<b>NON-MEMBERS</b>			
\$825	\$1,125	\$325	<b>14</b> Non-Member Physician A. radiologist B. radiologic scientist C. non-radiologist physician
\$180	\$480	*	<b>15</b> Non-Member Resident/Trainee — <i>verification required</i>
\$0	\$300	*	<b>18</b> Non-Member Student <sup>†</sup> — <i>verification required</i>
<b>MEDICAL PHYSICISTS</b>			
\$0	\$100	*	<b>21</b> AAPM Member
\$825	\$1,125	\$325	<b>22</b> Non-Member Physicist
<b>HEALTHCARE PROFESSIONALS</b>			
			<i>Individuals directly employed by: a hospital, healthcare network, university, or a hospital's free-standing facility administering to patients.</i>
\$180	\$480	*	<b>23</b> Radiology Support Personnel — <i>verification required</i> A. technologist E. nurse/nurse practitioner I. information technology/system support B. engineer F. educator J. telemedicine/communications specialist C. radiology business manager G. architect K. facility manager D. radiology administrator H. govt. employee (non-physician) L. assistant (physician/radiologist)
\$825	\$1,125	\$325	<b>24</b> Hospital or Facility Executive A. hospital or facility administrator C. officer (CEO, CFO, CIO, COO) E. other senior-level personnel B. legal (in-house counsel) D. purchasing
<b>INDUSTRY PERSONNEL</b>			
\$825	\$1,125	\$325	<b>25</b> Commercial Research and Development Personnel
\$825	\$1,125	\$325	<b>27</b> Industry Personnel A. distributor B. manufacturer C. prospective exhibitor D. other
\$825	\$1,125	\$325	<b>31</b> Healthcare Consultant A. attorney C. financial analyst E. staffing/recruitment B. computer analyst D. purchasing F. other

## To Complete Your Registration

Go to [RSNA.org/Register](http://RSNA.org/Register) or:

- 1) Select a registration category, code and rate from this page.
- 2) Select housing on page 4.
- 3) Complete the registration form on page 9.

## Verification Required

Registration categories **15**, **18** and **23** require proper verification in order to be processed. These categories require a business card, a letter from hospital administration stating your role in radiology, a valid RT license or student ID copy.

Email [RSNAverify@experient-inc.com](mailto:RSNAverify@experient-inc.com), fax or mail verification with your registration form or upon completion of online registration.

Registrations without proper verification documentation will be charged the non-member full conference registration rate.

Badge classification is subject to RSNA approval and code/rate change.

**Note:** Registrations processed after November 7 will reflect a \$100 increase over advance registration rates.

\* Exhibits Only registration is not applicable for this registration category — full conference registration is required (includes access to Technical Exhibits). See corresponding Full Conference Rate column.

† CME/CE credit is not tracked or awarded.

# Registration and Housing Form

## STEP 2: REGISTRATION CATEGORY

Registration Category/Code \_\_\_\_\_ (ie, 23A).

Refer to page 8

Are you a presenter?

Registration Categories 15, 18, and 23 must submit verification in order to be processed.

Add Virtual Meeting

Practice setting:

Academic  Private  Other

## STEP 3: PRIMARY SPECIALTY

Check only one subspecialty code from the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Breast/Mammography   | <input type="checkbox"/> Head & Neck              |
| <input type="checkbox"/> Cardiac Radiology    | <input type="checkbox"/> Health Policy & Practice |
| <input type="checkbox"/> Chest                | <input type="checkbox"/> Informatics              |
| <input type="checkbox"/> Computed Tomography  | <input type="checkbox"/> Interventional           |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/>                          |
| <input type="checkbox"/> Emergency Radiology  |   |
| <input type="checkbox"/> Gastrointestinal     |   |
| <input type="checkbox"/> Genitourinary        |   |

## STEP 5: HOTEL RESERVATION

Arrival Day / Date \_\_\_\_\_

Departure Day / Date \_\_\_\_\_

1st Choice: Hotel Number & Name \_\_\_\_\_

2nd Choice: Hotel Number & Name \_\_\_\_\_

3rd Choice: Hotel Number & Name \_\_\_\_\_

Single (1 bed)  Double (2 persons / 1 bed)  Twin (2 persons / 2 beds)  Suite  Smoking  Non-smoking

Person(s) sharing my room (Other than Spouse / Family Member listed in Step 1 above) \_\_\_\_\_

If my choices are unavailable, please book a room based on:  Rate \$ \_\_\_\_\_  Location \_\_\_\_\_  Other: \_\_\_\_\_  
Room Rate Desired

I do not require a hotel reservation because:  I will reserve a room later.  I am staying at a local residence.

I have reservations at (hotel): \_\_\_\_\_  I am sharing a room reserved by: \_\_\_\_\_

## STEP 6: PAYMENT INFORMATION

Registration rate (Refer to page 8) \$ \_\_\_\_\_

Spouse/family member badge fees (Refer to page 7) \$ \_\_\_\_\_

Bistro RSNA tickets (Refer to page 2) \$ \_\_\_\_\_

5k Fun Run tickets (Refer to page 2) \$ \_\_\_\_\_

Sip & Savor tickets (Refer to page 2) \$ \_\_\_\_\_

A deposit equal to one night stay, including 16.4% hotel tax, will be charged to your credit card by the hotel approximately 2 weeks before the meeting. Credit card must be valid through December 2014.

Total payment enclosed \$ \_\_\_\_\_

Check # \_\_\_\_\_  American Express  Discover  MasterCard  Visa  
(payable to RSNA 2014 in U.S. funds, drawn on a U.S. bank)

Card number \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

Expires Month / Year \_\_\_\_\_

Cardholder signature required

I authorize my credit card to be charged the total amount listed. If my fees are totaled incorrectly, RSNA will make the necessary adjustments and charge my credit card accordingly.

Online  
RSNA.org/Register

Fax  
1-888-772-1888  
1-301-694-5124  
(Outside U.S. & Canada)

Telephone  
1-800-650-7018  
1-847-996-5862  
(Outside U.S. & Canada)

Mail  
Experient/RSNA 2014  
5202 Presidents Court, Suite 310  
Frederick, MD 21703 USA

Email questions to:  
rsna@experient-inc.com

ATTACHED: Exhibit B – Costs and Expenses

Program Registration: for the radiology conference in Chicago from Nov 30 – Dec 5, 2014 (per Dr. Mohr who will be attending for NTRG there is no charge for him to attend)

Hotel Accommodations: Rate for room plus taxes (as evidenced by receipts submitted to DISTRICT for the total number of overnight stays relating to RSNA Chicago conference attendance.)

Transportation: airfare (estimated at \$580 based on documentation from Dr. Mohr) plus transportation, mileage, parking and tolls related to travel to attend RSNA radiology conference. Receipts to be submitted with mileage to be reimbursed at IRS rate of \$.56 cents per mile.)

Meal Allowance: In accordance with the DISTRICT'S policies.





**Policy:**

The presence of children in the workplace with the employee parent during the employee's workday is inappropriate and is to be avoided. This policy is established to avoid disruptions in job duties of the employee and co-workers, reduce property liability, and help maintain a professional work environment.

**Purpose:**

This policy is established to avoid disruptions in job duties of the employee and co-workers, reduce property liability, and help maintain a professional work environment.

**Definitions:**

**Parent:** Any staff, student, or visitor who has responsibility for a child while in the workplace, regardless of relationship.

**Workplace:** A TFHS-maintained room, office, waiting areas (solarium, family waiting rooms), shop, laboratory, vehicle, or any other campus area where people are conducting work on behalf of TFHS or patient family members may be present.

**High Risk Area:** Patient care areas, utility plants, mechanical rooms, shops, food prep areas, vehicles or motorized equipment, rooftops, construction zones, and/or laboratories or work areas that contain chemicals.

**Procedure:**

TFHS does not permit the presence of children in the workplace on a regular or sporadic basis.

In the rare instance when there are no other alternatives, and a staff member must bring a child to the workplace, advance approval should be obtained from the supervisor and the duration of the child's visit to the workplace should be kept to a minimum of no more than 30 minutes. Examples of a rare instance:

- Parent has forgotten an item and needs to come to work to pick it up.
- Parent needs to take care of an essential task of short (15-30min) duration and the child cannot be left at home.
- Co-workers would like to meet child. If this takes place it should be for a brief visit and should occur in a public space (lobby or solarium) to minimize work disruptions.
- An emergency has occurred and a supervisor has asked the parent to come assist.

In the unavoidable circumstance when a child must be in the workplace, under no circumstances may the child:

- Have access to any confidential information, including but not limited to patient information or proprietary information.
- Enter a High Risk Area.



Effective Date:	Date Revised:
Approval:	Date Reviewed:



These prohibitions cannot be waived by the department manager or supervisor.

Any staff member that brings his/her child into the workplace without approval of his/her supervisor will be requested to leave which will be considered an unplanned absence which will be assessed through Just Culture principles and managed accordingly.

Effective Date:	Date Revised:
Approval:	Date Reviewed:

		<b>Tahoe Forest Health System</b>			
		<b>Title: Professional Expectations Policy</b>		<b>Policy/Procedure #: AGOV-</b>	
		<b>Responsible Department: ADMINISTRATIVE</b>			
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
<input checked="" type="checkbox"/>	Administrative	12/23/07	1/10; 1/11; 1/12	1/09, 7/14	
<input type="checkbox"/>	Medical Staff				
<input type="checkbox"/>	Departmental				
Applies to: <input checked="" type="checkbox"/> System <input type="checkbox"/> Tahoe Forest Hospital <input type="checkbox"/> Incline Village Community Hospital					

**PURPOSE:**

Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care along with efficient and orderly operations. Personal responsibility for individual behaviors is expected. This outlines the expectations of professional behavior as a framework for addressing specific conduct issues.

**DUTIES:**

The policy on Professional Expectations is a Duty to Produce an Outcome. When there is a Duty to Produce an Outcome, the organization sets an expectation and the individual has the responsibility to develop a system for compliance. These are policies in which the organization states an objective, outcome, or expectation but does not provide a detailed procedure on how to accomplish the outcome. Individuals are left to create series of tasks, a system if you will, that will best achieve the outcome and that still supports the organization’s values.

Some of the expectations listed below also fall under The Duty to Avoid Unjustifiable Risk and Harm. The Duty to Avoid Unjustifiable Risk and Harm is the duty that we all owe each other. It is the highest duty. This is the duty we will all be judged by when we engage in behaviors that make it appear we breached this duty in the performance of our daily work. For example, engaging in threatening behavior is not only a breach of the Duty to Produce an Outcome (the organizational breach); it is also a breach of the Duty to Avoid Causing Unjustifiable Risk and Harm (the duty owed to the individual being threatened).

**RISK of NON-COMPLIANCE:**

The risks of an individual who chooses to not follow the professional expectations include compromising patient safety, emotional distress, poor work environment, staff safety, work place errors (including but not limited to medical errors that could lead to adverse outcomes), and financial loss or poor reputation to the organization.

## **POLICY:**

This Policy outlines collegial and educational efforts that can be used by medical staff leaders or Human Resources to address behavior that does not meet professional standards. The organization upholds professionalism in a manner that is reasonable and fair to all people involved and any reported incidents will be looked through Just Culture process with collaboration from appropriate leadership within Medical Staff and Health System Management.

### **1.0 Expectations:**

This policy does not describe all expectations, situations, and/or potential problems. This is general information to be used in conjunction with other specific practices, operating unit and department policies. In the event issues arise that are not covered in this policy, managers, medical staff leadership, and the Human Resources Director have the absolute discretion to determine appropriate actions or solutions.

Tahoe Forest Hospital District is committed to providing efficient, personalized, evidence-based quality healthcare while treating patients with compassion, confidence and respect to surpass expectations and ensure the best healthcare experience. The District is also committed to ensuring a safe and professional work environment for all employees and medical staff whereby our core values are upheld. We believe in and uphold the principles of a fair and just culture and communicate these beliefs and values throughout the institution. This policy applies in all situations in a work related context, such as hospital premises, office or jobsite, business travel situations or educational seminars, TFHD sponsored events or any TFHD related venue.

We expect our employees, medical staff members and contractors to:

- 1.1 Adhere to all applicable laws, regulations, along with organizational policies and procedures
- 1.2 Act honestly and ethically
  - 1.2.1 Listen and respond to patients, patients' families, and community members while respecting diversity.
  - 1.2.2 Maintain the highest ethical standards and address conflicts of interest honestly and directly.
  - 1.2.3 Be honest and forthright in representing information and ensure accurate attribution for all work.
  - 1.2.4 Make wise use of the hospital's human, financial, and environmental resources.
  - 1.2.5 Follow established attendance practices applicable by position.
  - 1.2.6 Never falsify records, documents, or any other act of dishonesty.
  - 1.2.7 Not engage in theft, misuse or unauthorized use and/or removal of funds, property, or other assets.
  - 1.2.8 Decline gifts from patients, vendors, or others unless such gifts are of nominal value and not in the form of cash and never solicits gifts or cash.
- 1.3 Maintain a professional demeanor:
  - 1.3.1 Treat each person with courtesy, decency, and respect.
  - 1.3.2 Use words and actions that are thoughtful, constructive, tolerate, and compassionate.
  - 1.3.3 Be collegial team members and recognize and support each member's value in our interactions with them
  - 1.3.4 Be accountable for our behavior and avoid retaliation against those who report concerns

- 1.3.5 Never engage in or tolerate inappropriate, disruptive, or abusive behavior.
  - 1.4 Never engage in and report Harassment or abusive treatment of others, sexual misconduct, or use of abusive, profane, or threatening language or gestures.
  - 1.5 Never work while impaired by any substance or condition that compromises ability to function safely and competently.
  - 1.6 Respect our patients' confidentiality and privacy along with employee information, financial or other proprietary information for TFHD. Report near misses and errors and disclose and apologize to patients in order to improve patient care.
  - 1.7 Support quality, safety and efficiency initiatives in order to enhance patient care.
  - 1.8 Attempt to resolve differences in a spirit of cooperation and to create solutions that benefit all parties. Cooperate with investigations and/or searches when required.
  - 1.9 Not engaging in any criminal activity on premises or off premises, or otherwise potentially jeopardizes the health and safety of patients or other employees.
  - 1.10 Keep current all licenses and certifications required for his/her job, such as professional licenses, CPR and/or Driver's License (if applicable).
- 2.0 If you have a question or concern regarding lack of professional behavior, you are encouraged to discuss this with the appropriate person below:
- 2.1 Medical Staff concerns: Please contact the Point of Contact on their cell phone or via x3269.
  - 2.2 Employees are encouraged to discuss concerns with the director of their department or with one of the following resources:
    - 2.2.1 Human Resources Department: 530 582-3592
    - 2.2.2 Human Resources Director: 530 582-6590
    - 2.2.3 The Confidential Message Line (530) 582-3269 or Ext. 3269.
    - 2.2.4 Corporate Compliance Officer: 530 582-6637

Related Policies/Forms:
References:
Policy Owner:
Approved by:

**TAHOE FOREST  
HOSPITAL DISTRICT**

**Truckee, California**

**FINANCIAL STATEMENTS WITH  
INDEPENDENT AUDITORS' REPORT**

**June 30, 2014 and 2013**

**DRAFT**

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June 30, 2014 and 2013

*Tahoe Forest Hospital District*

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**DRAFT**

## INDEPENDENT AUDITORS' REPORT

To the Board of Directors  
Tahoe Forest Hospital District  
Truckee, California

We have audited the accompanying financial statements of Tahoe Forest Hospital District, a California political subdivision (the District), which comprise the statements of net position as of June 30, 2014 and 2013; the related statements of revenues, expenses, and changes in net position; and cash flows for the years then ended; and the related notes to the financial statements.

### *Management's Responsibility for the Financial Statements*

Management is responsible for the preparation and fair presentation of these 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 financial statements that are free from material misstatement, whether due to fraud or error.

### *Auditors' Responsibility*

Our responsibility is to express an opinion on these 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 State Controller's *Minimum Audit Requirements for California Special Districts*. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the District's preparation and fair presentation of the 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 District'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 financial statements.

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

### *Basis for Qualified Opinion*

The financial statements do not include financial data for the District's legally separate component units, which should have been presented as discretely presented component units. Accounting principles generally accepted in the United States of America require the financial data for those component units to be reported with the financial data of the primary government unless the District also issues financial statements for the financial reporting entity that includes the financial data for its component units. The District has not issued such reporting entity financial statements. Financial information for the component units is disclosed in note 13 to the financial statements.



**INDEPENDENT AUDITORS' REPORT**

Continued

***Qualified Opinion***

In our opinion, except for the effects of not discretely presenting component units as described in the Basis for Qualified Opinion paragraph, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2014 and 2013, and the results of its operations, changes in net position, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

***Other Matters - Required Supplementary Information***

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 4 through 14 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

DATE  
Chico, California

OVERVIEW OF THE FINANCIAL STATEMENTS

The financial statements of the Company are prepared in accordance with the International Financial Reporting Standards (IFRS) as issued by the International Accounting Standards Board (IASB). The financial statements are prepared on a going concern basis. The Company's financial statements are audited by the independent auditors.

The financial statements are prepared on a going concern basis. The Company's financial statements are audited by the independent auditors. The financial statements are prepared in accordance with the International Financial Reporting Standards (IFRS) as issued by the International Accounting Standards Board (IASB). The financial statements are prepared on a going concern basis. The Company's financial statements are audited by the independent auditors.

**MANAGEMENT'S DISCUSSION AND ANALYSIS  
(Required Supplementary Information)**

**DRAFT**

**OVERVIEW OF THE FINANCIAL STATEMENTS**

This annual report consists of Management's Discussion and Analysis, financial statements, and notes to those statements. These statements are organized to present the Tahoe Forest Hospital District (the District) as a financial whole, an entire operating entity. The statements then proceed to provide an increasingly detailed look at specific financial activities. Readers should also review the accompanying notes to the financial statements to enhance their understanding of the District's financial performance.

The Statements of Net Position, the Statements of Revenues, Expenses, and Changes in Net Position and Statements of Cash Flows provide an indication of the District's financial health. The Statements of Net Position include all of the District's assets, deferred outflows of resources, and liabilities, using the accrual basis of accounting, as well as an indication about which assets can be utilized for general purposes and which are restricted as a result of bond covenants, donor restrictions, or other purposes. The Statements of Revenues, Expenses, and Changes in Net Position report all of the revenues, expenses, increases and decreases in net position during the time period indicated that resulted from the District's operating and non-operating transactions and capital contributions during the year. The Statements of Cash Flows report the cash provided and used by operating activities, as well as other cash sources such as investment income, repayment of bonds, and capital additions and improvements.

**FINANCIAL HIGHLIGHTS**

- Total assets decreased \$1.1 million in 2014. Total cash and cash equivalents decreased \$0.3 million in 2014. Net patient accounts receivable decreased \$1.7 million. Days net patient service revenue in net patient accounts receivable decreased to 70 days at June 30, 2014. Capital assets increased \$6.8 million. Assets Limited as to Use – Net decreased by \$5.0 million.
- Total liabilities decreased \$1.2 million, current liabilities increased \$1.1 million, and noncurrent liabilities decreased \$2.3 million.
- The increase in net position for 2014 was \$.02 million.

**FINANCIAL ANALYSIS OF THE DISTRICT**

The District's net position increased \$.02 million from a year ago to \$97.3 million. Table 1 provides a summary of the District's net position for 2014 and 2013.

**Table 1**  
**SUMMARY OF ASSETS, LIABILITIES, AND NET POSITION**  
**(In thousands)**  
**AS OF JUNE 30**

	<b>2014</b>	<b>2013</b>
<b>Assets:</b>		
Current assets	\$41,102	\$43,766
Board-designated and restricted funds	67,471	72,446
Net capital assets	144,885	138,067
Other assets	1,166	1,437
<b>Total Assets</b>	<b>254,624</b>	<b>255,716</b>
<b>Total Deferred Outflow of Resources:</b>	<b>2,331</b>	<b>2,370</b>
<b>Liabilities:</b>		
Current liabilities	24,190	23,045
Noncurrent liabilities	135,501	137,797
<b>Total Liabilities</b>	<b>159,691</b>	<b>160,842</b>
<b>Net Position:</b>		
Unrestricted	59,776	57,162
Net investment in capital assets	36,733	39,440
Restricted by donor for specific uses	754	642
<b>Total Net Position</b>	<b>\$97,263</b>	<b>\$97,244</b>

In 2014, the District's cash and investments position decreased \$.03 million.

**Table 2**  
**SUMMARY OF CASH AND INVESTMENTS**  
**(In thousands)**

<b>Account:</b>	<b>2014</b>	<b>2013</b>
Cash and cash equivalents and short-term investments	\$10,316	\$10,345
Board designated fund	40,636	33,552
Specific purpose fund	3,049	3,680
Workers' compensation fund	19	1
Unexpended capital bond fund	25,644	37,120
<b>Total Available Cash and Investments</b>	<b>\$79,664</b>	<b>\$84,698</b>

The District maintains sufficient cash balances to cover all short-term liabilities. All excess cash is transferred to the Board designated funds for future needs. Cash and cash equivalents and short-term investments combined with Board designated funds increased by a total of \$7.1 million. An increase in our cash position was anticipated as we recovered from the system conversion done in 2013. The lag time in billing and collections has been reduced and collections have greatly improved. The Unexpended Capital Bond Fund shows a decrease of \$11.5 million over the prior year due to the expenditure of project funds directly related to capital asset projects approved as part of the general obligation bonds (Measure C).

**CAPITAL ASSETS - NET**

Net capital assets increased \$6.8 million to \$144.9 million at June 30, 2014. This increase resulted from \$17.4 million in capital additions offset by \$8.7 million in depreciation, and \$1.9 million of asset transfers from construction in progress. The capital additions include \$4.3 million in equipment, building and land improvements (of which \$1.9 million were transfers from construction in progress), and \$13.1 million in construction in progress. Major capital additions during the year included investment in surgical, imaging and lab equipment, continued investment in our computer information systems, and construction for projects related to Measure C on the Tahoe Forest Hospital campus.

**DEBT ADMINISTRATION**

The District has debt obligations as follows:

	2014	2013
General Obligation Bonds Series 2007	\$98,495,000	\$98,500,000
Revenue Bonds Series 2006	23,975,000	24,675,000
Variable Rate Demand Revenue Bonds Series 2002	9,865,000	10,155,000
Bank equipment leases	1,846	516,138
Municipal Lease	3,749,992	4,931,515
<b>Total</b>	<b>\$136,086,838</b>	<b>\$138,777,653</b>

The District saw a decrease in its debt obligations by \$2.7 million due to principal payments on the 2006 and 2002 Revenue Bonds, equipment leases, and the Municipal Lease.

**REVENUES, EXPENSES, AND NET POSITION**

Table 3 shows the revenues, expenses, and net position for 2014 and 2013.

**Table 3**  
**SUMMARY OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION**  
**(In thousands)**  
**YEAR ENDED**

	2014	2013
<b>Operating Revenues:</b>		
Net patient service revenue	\$107,664	\$101,567
Other	6,711	6,142
<b>Total Operating Revenues</b>	<b>114,375</b>	<b>107,709</b>
<b>Operating Expenses:</b>		
Salaries and wages	40,493	38,779
Employee benefits	20,765	19,944
Professional fees	18,674	17,850
Supplies	14,940	15,207
Purchased services	10,104	7,681
Depreciation	8,642	7,239
Insurance	711	636
Other operating expenses	5,938	6,134
<b>Total Operating Expenses</b>	<b>\$120,267</b>	<b>\$113,470</b>

**MANAGEMENT'S DISCUSSION AND ANALYSIS**

June 30, 2014 and 2013

*Tahoe Forest Hospital District*

<b>OPERATING LOSS</b>	<b><u>\$(5,892)</u></b>	<b><u>\$(5,761)</u></b>
<b>Nonoperating Revenues (Expenses)</b>		
District tax revenue	9,647	10,704
Loss recognized on joint venture	(192)	(31)
Interest income	280	330
Rental income-net	238	242
Donations	659	550
Gain (Loss) on sale of assets	1	(12)
Interest expense	(5,390)	(4,448)
<b>Total Nonoperating Revenues (Expenses)</b>	<b><u>5,243</u></b>	<b><u>7,335</u></b>
<b>Income (Loss) Before Other Revenue, Expenses, Gains and Losses</b>	<b>(649)</b>	<b>1,574</b>
Capital contributions	668	396
Impairment losses	-	(5,679)
<b>Increase (Decrease) in Net Position</b>	<b>19</b>	<b>(3,709)</b>
<b>Net Position - Beginning of Year</b>	<b>97,244</b>	<b>100,953</b>
<b>Net Position - End of Year</b>	<b><u>\$97,263</u></b>	<b><u>\$97,244</u></b>

## **NET PATIENT SERVICE REVENUES**

For the year ended June 30, 2014, net patient service revenues increased by \$6.1 million or 6%. This was primarily driven by outpatient revenue and revenue derived from the cancer program. Net patient service revenue is composed of gross patient service revenue, less contractual allowances, charity care, provision for bad debts, and prior period settlements.

Gross patient service revenues increased by \$10.5 million or 5.9% due to increases in volumes in a few of our outpatient areas when compared to our previous year. Significant volume percentage increases were as follows: radiation oncology procedures 15.9%, PET/CT exams 1.6%, ultrasound exams 5.2%, MRI exams 8.6%, endoscopy procedures 26.8%, and physical therapy procedures 17.7%.

Contractual allowances as a percent of gross patient service revenues increased from prior year by 3.4%. This increase primarily comes from shifting in the gross revenue payor mix. A small amount of the increase is for additional reserves due to the lag time in billing and collections related to our information technology system conversions. (See DEDUCTIONS FROM REVENUE below).

Charity care remained the same when compared to prior year. Fiscal year 2014 was approximately 3.2% of gross patient service revenues, and fiscal year 2013 was approximately 3.2%. (See CHARITY CARE AND COMMUNITY BENEFIT below). In addition, provision for bad debts as a percent of gross patient service revenues showed a 2.9% decrease compared to previous year.



**INPATIENT BUSINESS ACTIVITY**

Total admissions decreased by 44 and total patient days decreased by 228 reflecting a decrease in our average length of stay of .06 days. TFH became a critical access hospital effective July 1, 2007, reducing its acute care beds to 25, down from 35. Table 4 presents a summary of inpatient business activity.

**Table 4**  
**INPATIENT BUSINESS ACTIVITY**

	<b>Acute</b>	<b>2014</b>	<b>2013</b>
Admissions		1,617	1,661
Length of stay		2.89	2.95
Average daily census		12.8	13.4
Occupancy percentage		44.2%	46.4%
Patient days		4,679	4,907
Total ICU days		914	983
Total medical/surgical days		2,845	3,040
Total obstetrics days		920	872
Total M/S swing days		283	252
Nursery days		877	797
Deliveries		366	365
<b>Skilled Nursing Unit</b>			
Patient days		12,133	11,723
Average daily census		33	32
Occupancy percentage		89.8%	86.8%

### OUTPATIENT BUSINESS ACTIVITY

The District's outpatient revenue was 9.3% higher than the prior year. The increase is attributable to an increase in volumes related to radiation procedures, CT and MRI exams, endoscopy procedures, the Hospitalists program, and physical therapy procedures.

**Table 5**  
**OUTPATIENT BUSINESS ACTIVITY**

	2014	2013
Emergency department visits	16,264	16,324
Laboratory tests	143,751	146,388
Home health visits	3,778	3,980
Radiology exams	10,600	10,542
Ultrasound exams	3,848	3,658
Cat scan exams (including PET CT)	3,951	3,889
MRI scan exams	1,851	1,705
Radiation oncology procedures	4,174	3,599
Surgery cases	1,093	1,132
Surgery minutes	99,961	86,167

### DEDUCTIONS FROM REVENUE

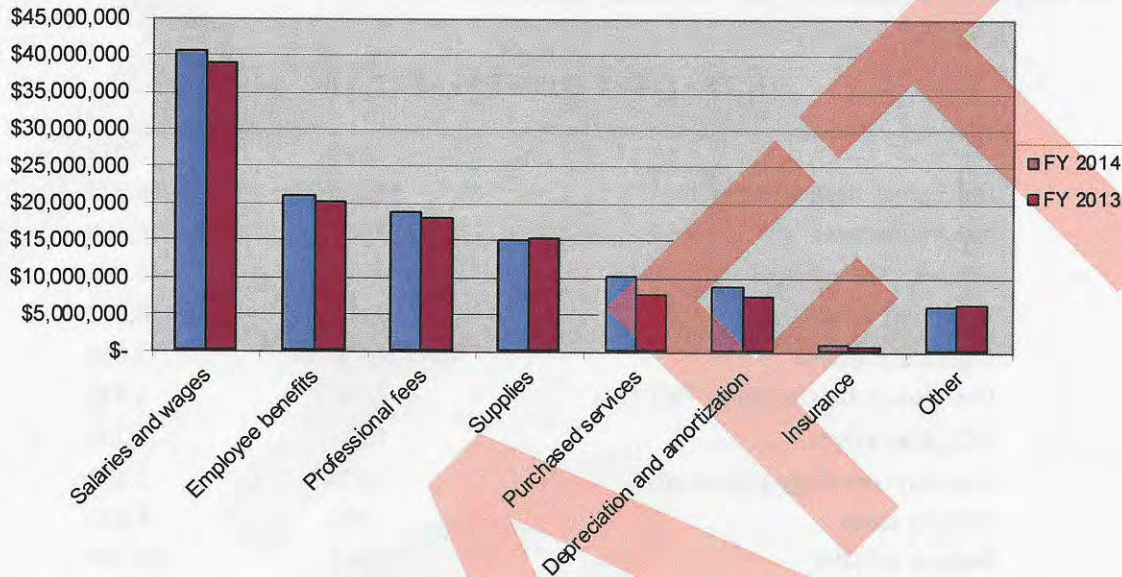
Contractual allowance adjustments (expressed as a percentage of gross revenues) were 38.6% for fiscal year 2014 and 35.2% for fiscal year 2013. The District's payor mix for fiscal year 2014 was 34.3% Medicare, 13.1% Medi-Cal, 1.3% County, 6.4% other, and 44.9% insurance compared to fiscal year 2013 mix of 33.0% Medicare, 12.1% Medi-Cal, 2.7% County, 7.4% other, and 44.8% insurance. The State programs, as well as some federal programs, continue to hold reimbursements to the District below actual increases (inflation) in costs. TFH became a critical access hospital effective July 1, 2007, which changed its Medicare reimbursement methodology to cost-based reimbursement.

### CHARITY CARE AND COMMUNITY BENEFIT

The District provides care without charge or at amounts less than established rates to patients who meet certain criteria under its charity care policy. Charity allowances are based upon the customary charges for the services provided under this program. The District recorded \$6.1 million in charity care for patient services during fiscal year 2014 and \$5.6 million for fiscal year 2013.

**OPERATING EXPENSES**

Total operating expenses were \$120.3 million for the year ended June 30, 2014, and \$113.5 million for the year ended June 30, 2013, as summarized in the graph.



Total operating expenses increased \$6.8 million, or 6% from the prior year.

The District experienced an increase in the area of salaries, wages and employee benefits, for a combined increase of \$2.5 million, due to the result of wage increases as outlined in the employee bargaining unit agreements which took effect July 1, 2013. These agreements have a three-year term. In addition, we experienced an increase in our health insurance costs. Both of these increases were offset by a reduction in our workers' compensation costs and our retirement plan costs. Professional fees increased \$0.8 million due to our contract with an anesthesiology group to provide exclusive anesthesia services, development of the Hospitalists program, and the addition of a general surgeon to the multi-specialty clinics. Purchased services increased \$2.4 million due to the maintenance agreements for the linear accelerator, PET/CT scanner, the CT scanner at Incline Village, plant repair and maintenance, process improvement work related to the District's revenue cycle, services provided as part of the new wellness program, and for a survey readiness assessment. Depreciation and amortization increased \$1.4 million due to a full year of depreciation on the general obligation bond (Measure C) capital projects such as the cancer center and skilled nursing facility. In addition, several buildings were renovated in preparation of moving staff to interim locations during the next phases of construction related to Measure C. We also had depreciation associated with the continued investment in our information technology systems, and other large capital purchases in surgery, lab and imaging.

## **ECONOMIC FACTORS AFFECTING NEXT YEAR**

Fiscal year 2013-14 was another challenging year for the health system. Much of the fiscal year, the health system managed to effectively control operating expenses and nimbly navigated through a terrible winter season to balance what could be characterized as one of the most challenging financial years in recent memory. The year was plagued by multiple challenges in market conditions. Notwithstanding the dismal winter season, our market began to realize the impact of first-year implementation of the Affordable Care Act with the start-up of both the California and Nevada Insurance Exchanges. This past year saw significant changes in the financing model for the California Medi-Cal program by assigning all Medi-Cal eligible patients into managed care plans. Statewide, Tahoe Forest and similar hospitals with Distinct Part Skilled Nursing Facilities (DP/NF) were challenged by the threat of retroactive reimbursement reductions and continue to be challenged in fiscal year 2014-15.

Operationally challenged by EMR issues, management was able to identify and deploy third-party resources that effectively managed the transition of the Version 19 EMR installation while also concurrently deploying additional targeted resources to stabilize health system revenue cycle processes. Information systems optimization will continue over the next two years as the health system evolves its strategy to shift away from a "best of breed" applications strategy to a more integrated enterprise IS architecture.

The Tahoe Forest Hospital Facilities Development Plan continues to be executed within the general board approved budgets for each project. In 2014-15, management is looking forward to occupying the emergency department and sterile processing expansions, the interim birthing area in the western addition, and initiating the final phase of the Measure C projects with the scheduled demolition of the 1952 building and beginning construction of the Women and Family Center.

The 2014-15 fiscal year is an aggressive year. Although management is projecting earnings from operations (EBIDA) of only around \$2 million and a drop in days' cash on hand, management is projecting favorable cash flow from operations, philanthropic activities and property tax to exceed \$8 million. The largest impact on cash is the exceptional number of capital projects that are scheduled to be staged during the fiscal year. The scope of projects includes the continuation of information system transitions, completion of the ICU remodel, installation of the replacement CT scanner and surgical lights and booms, and the funding of personal property for Measure C project occupancies. These projects alone exceed over \$4.6 million in capital investment.

Combined with the phase-in of the second year of the Affordable Care Act and the predictable pressure on shifting payor reimbursements associated with the new large deductible commercial products, management will continue its efforts to reduce overall operating expense to maintain level operating margins.

Our assumptions for fiscal year 2014-15 have been carefully constructed to balance key investments with a conservative approach to the maintenance of our strong capital structure. To complement this approach, management will continue to take an aggressive and proactive position on managing controllable expenses in fiscal year 2014-15 to assure that we are able to balance our budget in this dynamic era of health reform. Balance sheet management and organization redesign will continue to be dominant themes as we lead our health system through these challenging times.

ECONOMIC FACTORS AFFECTING NEXT YEAR

From 2011-14 and as the challenges of the next year, the District will be faced with a number of economic factors that will affect its ability to meet its obligations. The most significant of these factors are the impact of the federal government's fiscal policies, the impact of the state government's fiscal policies, and the impact of the local government's fiscal policies. The federal government's fiscal policies are expected to have a significant impact on the District's economy. The state government's fiscal policies are expected to have a significant impact on the District's economy. The local government's fiscal policies are expected to have a significant impact on the District's economy.

The District's economic outlook for next year is uncertain. The District's economy is expected to be affected by a number of factors, including the impact of the federal government's fiscal policies, the impact of the state government's fiscal policies, and the impact of the local government's fiscal policies. The District's economy is expected to be affected by a number of factors, including the impact of the federal government's fiscal policies, the impact of the state government's fiscal policies, and the impact of the local government's fiscal policies.

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**FINANCIAL SECTION**

The District's financial outlook for next year is uncertain. The District's financial position is expected to be affected by a number of factors, including the impact of the federal government's fiscal policies, the impact of the state government's fiscal policies, and the impact of the local government's fiscal policies. The District's financial position is expected to be affected by a number of factors, including the impact of the federal government's fiscal policies, the impact of the state government's fiscal policies, and the impact of the local government's fiscal policies.

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**STATEMENTS OF NET POSITION**

*Tahoe Forest Hospital District*  
Page 1 of 2

June 30	2014	2013
<b>ASSETS</b>		
<b>CURRENT ASSETS</b>		
Cash and cash equivalents	\$ 10,315,543	\$ 10,344,645
Patient accounts receivable - net of allowance for uncollectible accounts of \$19,740,807 in 2014 and \$24,859,330 in 2013	21,124,945	22,807,619
Advances to related party	1,709,926	981,983
Other receivables	1,193,192	1,648,605
Assets limited as to use	1,878,250	1,907,125
Inventories	2,506,410	2,267,147
Prepaid expenses and deposits	1,568,323	1,066,115
Estimated third-party payor settlements	805,104	2,742,612
<b>Total Current Assets</b>	<b>41,101,693</b>	<b>43,765,851</b>
<b>ASSETS LIMITED AS TO USE</b>		
Assets limited as to use	69,348,918	74,353,498
Less: Amount required to meet current obligations	(1,878,250)	(1,907,125)
<b>Assets Limited as to Use - Net</b>	<b>67,470,668</b>	<b>72,446,373</b>
<b>NONCURRENT ASSETS AND INVESTMENTS</b>		
Investment in joint venture	496,395	728,349
Physician notes receivable	586,511	608,224
Other noncurrent assets	83,333	100,000
Capital assets - net	144,885,483	138,067,395
<b>Total Assets</b>	<b>254,624,083</b>	<b>255,716,192</b>
<b>DEFERRED OUTFLOW OF RESOURCES</b>		
Deferred loss on defeasance	620,616	659,404
Accumulated decrease in fair value of hedging derivative	1,710,011	1,710,354
<b>Total Deferred Outflow of Resources</b>	<b>\$ 2,330,627</b>	<b>\$ 2,369,758</b>

*The accompanying notes are an integral part of these financial statements.*

**STATEMENTS OF NET POSITION**

*Tahoe Forest Hospital District*

Page 2 of 2

June 30	2014	2013
<b>LIABILITIES</b>		
<b>CURRENT LIABILITIES</b>		
Current maturities of long-term debt and capital lease obligations	\$ 2,295,193	\$ 2,690,814
Accounts payable	5,754,727	6,037,480
Patient balances payable	1,282,330	930,945
Accrued payroll and related expenses	8,302,901	7,668,236
Estimated claims incurred but not reported	2,895,012	3,139,995
Estimated third-party payor settlements	1,097,690	-
Accrued interest	2,561,726	2,577,226
<b>Total Current Liabilities</b>	<b>24,189,579</b>	<b>23,044,696</b>
<b>NONCURRENT LIABILITIES</b>		
Long-term debt and capital lease obligations - net of current maturities	133,791,645	136,086,839
Derivative instrument liability	1,710,011	1,710,354
<b>Total Liabilities</b>	<b>159,691,235</b>	<b>160,841,889</b>
<b>NET POSITION</b>		
Net investment in capital assets	36,733,130	39,440,311
Restricted	753,931	641,469
Unrestricted	59,776,414	57,162,281
<b>Total Net Position</b>	<b>\$ 97,263,475</b>	<b>\$ 97,244,061</b>

*The accompanying notes are an integral part of these financial statements.*

**STATEMENTS OF REVENUES, EXPENSES,  
AND CHANGES IN NET POSITION**

*Tahoe Forest Hospital District*

Years Ended June 30	<b>2014</b>	<b>2013</b>
<b>OPERATING REVENUES</b>		
Net patient service revenue - net of contractual allowances and provision for bad debts of \$80,714,236 in 2014 and \$76,338,828 in 2013	\$ 107,664,272	\$ 101,566,879
Other revenue	6,710,952	6,142,592
<b>Total Operating Revenues</b>	<b>114,375,224</b>	<b>107,709,471</b>
<b>OPERATING EXPENSES</b>		
Salaries and wages	40,492,967	38,778,617
Employee benefits	20,764,643	19,943,943
Professional fees	18,673,595	17,850,419
Supplies	14,939,799	15,206,878
Purchased services	10,104,398	7,680,764
Depreciation and amortization	8,642,417	7,239,280
Insurance	711,516	636,454
Other	5,938,373	6,133,885
<b>Total Operating Expenses</b>	<b>120,267,708</b>	<b>113,470,240</b>
<b>Operating Loss</b>	<b>(5,892,484)</b>	<b>(5,760,769)</b>
<b>NONOPERATING REVENUES (EXPENSES)</b>		
Property tax revenue	4,902,246	5,716,834
Property tax revenue - general obligation bonds	4,744,356	4,986,760
Loss recognized on joint venture	(191,666)	(30,517)
Interest income	280,574	330,077
Rental income - net	237,992	242,348
Donations	659,104	549,507
Gain (Loss) on disposal of assets	1,000	(11,867)
Interest expense	(5,390,206)	(4,448,220)
<b>Total Nonoperating Revenues (Expenses)</b>	<b>5,243,400</b>	<b>7,334,922</b>
<b>Income Before Other Revenues, Expenses, Gains and Losses</b>	<b>(649,084)</b>	<b>1,574,153</b>
Capital contributions	668,498	395,838
Impairment losses	-	(5,679,078)
<b>Increase (Decrease) in Net Position</b>	<b>19,414</b>	<b>(3,709,087)</b>
<b>Net Position - Beginning of Year</b>	<b>97,244,061</b>	<b>100,953,148</b>
<b>Net Position - End of Year</b>	<b>\$ 97,263,475</b>	<b>\$ 97,244,061</b>

*The accompanying notes are an integral part of these financial statements.*



**STATEMENTS OF CASH FLOWS**

*Tahoe Forest Hospital District*

Page 1 of 2

Years Ended June 30	2014	2013
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Receipts from and on behalf of patients	\$ 112,733,529	\$ 95,765,008
Payments to suppliers and contractors	(51,375,238)	(49,307,260)
Payments to and on behalf of employees	(60,867,928)	(59,038,656)
Other receipts and payments - net	6,603,799	5,613,627
<b>Net Cash Provided (Used) by Operating Activities</b>	<b>7,094,162</b>	<b>(6,967,281)</b>
<b>CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES</b>		
Property tax revenue received for operations	5,290,791	5,337,349
Donations	659,104	549,507
<b>Net Cash Provided by Noncapital Financing Activities</b>	<b>5,949,895</b>	<b>5,886,856</b>
<b>CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES</b>		
Capital contributions	668,498	395,838
Acquisition of property and equipment	(14,497,404)	(18,378,834)
Transfers (to) from board-designated assets	(7,211,504)	6,205,487
Proceeds from municipal lease	-	6,000,000
Proceeds from issuance of bonds	-	25,960,704
Change in assets held by trustee	12,216,084	(21,997,098)
Property tax revenue received for general obligation bonds	4,944,094	4,684,579
Principal paid on general obligation bonds	(5,000)	-
Interest payments on general obligation bonds	(4,678,774)	(4,153,059)
Principal paid on long-term debt and capital leases	(2,685,815)	(2,553,954)
Interest paid on long-term debt and capital leases	(1,727,737)	(1,806,031)
<b>Net Cash Used by Capital and Related Financing Activities</b>	<b>(12,977,558)</b>	<b>(5,642,368)</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Interest received	281,790	364,714
Net cash received for rental activities	310,264	316,693
Advances to related party	(727,943)	(550,812)
Cash received from joint venture	40,288	97,390
<b>Net Cash Provided (Used) by Investing Activities</b>	<b>(95,601)</b>	<b>227,985</b>
<b>Net Decrease in Cash and Cash Equivalents</b>	<b>(29,102)</b>	<b>(6,494,808)</b>
<b>Cash and Cash Equivalents - Beginning of Year</b>	<b>10,344,645</b>	<b>16,839,453</b>
<b>Cash and Cash Equivalents - End of Year</b>	<b>\$ 10,315,543</b>	<b>\$ 10,344,645</b>

*The accompanying notes are an integral part of these financial statements.*

**STATEMENTS OF CASH FLOWS**

Years Ended June 30	<u>2014</u>	<u>2013</u>
<b>RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES</b>		
Operating loss	\$ (5,892,484)	\$ (5,760,769)
Adjustments to reconcile operating loss to net cash provided (used) by operating activities:		
Depreciation and amortization	8,642,417	7,239,280
Provision for bad debts	3,062,443	8,277,732
Changes in:		
Patient accounts receivable	(1,379,769)	(14,833,606)
Inventories	(239,263)	(1,511)
Prepaid expenses	(502,208)	(200,980)
Estimated third-party payor settlements	3,035,198	119,557
Accounts payable and accrued expenses	106,929	(2,130,111)
Patient balances payable	351,385	634,446
Other	(90,486)	(311,319)
<b>Net Cash Provided (Used) by Operating Activities</b>	<u>\$ 7,094,162</u>	<u>\$ (6,967,281)</u>
<b>NONCASH INVESTING AND FINANCING ACTIVITIES</b>		
<b>ISSUANCE OF GENERAL OBLIGATION BONDS 2008, SERIES C</b>		
Par amount of 2008, Series C bonds	\$ -	\$ 26,100,000
Payments for bond issuance costs	-	(139,296)
<b>Net Proceeds</b>	<u>\$ -</u>	<u>\$ 25,960,704</u>
<b>CAPITALIZED INTEREST</b>		
Interest payments on general obligation bonds	\$ 4,678,774	\$ 4,153,059
Interest capitalized	(1,039,593)	(1,970,278)
<b>Net Interest Expense on General Obligation Bonds</b>	<u>\$ 3,639,181</u>	<u>\$ 2,182,781</u>

*The accompanying notes are an integral part of these financial statements.*

**1. DESCRIPTION OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**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 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 Presentation** The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus in accordance with Governmental Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989, FASB and AICPA Pronouncements*. The statement incorporates into the GASB's authoritative literature certain accounting and financial reporting guidance that is included in the following pronouncements issued on or before November 30, 1989, which does not conflict with GASB pronouncements: 1) Financial Accounting Standards Board (FASB) Statements and Interpretations; 2) Accounting Principles Board (APB) Opinions; and 3) Accounting Research Bulletins (ARB) of the American Institute of Certified Public Accountants' (AICPA) Committee on Accounting Procedure.

The District also applies GASB Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*, and GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*. These statements establish standards for reporting deferred outflows of resources, deferred inflows of resources, and net position for all state and local governments.

GASB Statement No. 39, *Determining Whether Certain Organizations are Component Units*, requires organizations that are "closely related to, or financially integrated with, the primary government" be reported as component units by the primary government. Tahoe Forest Health System Foundation and Incline Village Community Hospital Foundation (the Foundations) are component units of the District. The Foundations issue separate audited financial statements for their fiscal year ends. Accounting principles generally accepted in the United States of America require the financial data for the component units to be reported with the financial data of the District unless the District also issues financial statements for the financial reporting entity that includes the financial data of its component units. The District has not issued such reporting entity financial statements. Financial information for the Foundations is disclosed in note 13.

**Use of Estimates** The preparation of financial statements in conformity with generally accepted accounting principles 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 financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

**Cash and Cash Equivalents** The District considers cash on deposit and highly liquid investments, such as pooled investment funds, as “cash equivalents.”

In accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*, highly liquid market investments with maturities of one year or less at time of purchase are stated at amortized cost. All other investments are stated at fair value. Market value is used as fair value for those securities for which market quotations are readily available.

The District participates in an investment pool managed by the State of California titled Local Agency Investment Fund (LAIF). As of June 30, 2014, the LAIF pool includes structured notes and asset-backed securities which total 1.86% of the total portfolio. These structured notes and asset-backed securities are subject to market risk as to change in interest rates. As of June 30, 2014, the fair value of LAIF was 100.03% of the carrying value and is deemed to not represent a material difference. There are no LAIF funds invested in derivatives as of June 30, 2014. LAIF has oversight by the Local Investment Advisory Board (LIAB), which consists of five members as designated by statute. The chairperson of the LIAB is the State Treasurer or a designated representative. The District is considered to be a voluntary participant in the LAIF investment pool.

**Patient Accounts Receivable** The District reports patient accounts receivable for services rendered at net realizable amounts from third-party payors, patients, and others. The District provides an allowance for doubtful accounts based upon a review of outstanding receivables, historical collection information, and existing economic conditions. The District bills third-party payors directly and bills the patient when the patient’s liability is determined. Patient accounts receivable are due in full when billed. Accounts are considered delinquent and subsequently written-off as bad debts based on individual credit evaluation and specific circumstances of the account.

**Advances to Related Party** The District has agreed to make advances to the Tahoe Institute of Rural Health Research (the Institute), a nonprofit research organization, of up to \$2,000,000 on an as-needed basis. Outstanding advances accrue interest at a rate of 5.00%. Interest income of \$61,147 and \$32,059 was recorded by the District for the years ended June 30, 2014 and 2013, respectively.

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

**Assets Limited as to Use** Assets limited as to use consist of assets held by trustees under indenture agreements and Board designated assets. Assets held by the trustees under indenture agreements are used by the trustees to make principal, interest, and insurance payments related to bonds; to maintain reserve funds as required by bond agreements; and to fund future approved capital acquisitions. Board designated assets have been set aside by the District's Board of Directors for property and equipment replacement and to satisfy future liabilities. The Board retains control over Board designated assets and may at its discretion subsequently use them for other purposes. Purchases and sales of underlying investments are reported net in the statements of cash flows.

**Investment in Joint Venture** In December 2010, the District purchased a 51% equity interest in the Truckee Surgery Center, LLC (the Center), an ambulatory surgery center. However, under the terms of the Center's operating agreement, the District is unable to unilaterally impose its will on the Center. Accordingly, the District accounts for its investment in the Center under the equity method. The District shares in the operating results of the Center and reports its share of the operating results in nonoperating income. The Center has not issued audited financial statements. Summarized financial information for the Center is disclosed in note 14.

**Capital Assets** Capital assets are recorded at cost or, in the case of donated items, at fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. The District's capitalization policy states that all items with a unit cost of \$1,500 or more, and an estimated useful life of greater than two years, will be capitalized at the time of purchase. Expenditures which increase values, change capacities, or extend useful lives are also capitalized. Depreciation is computed using the straight-line method over the estimated useful lives of the assets. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation expense in the financial statements. Useful lives are 2 to 40 years for land improvements, 5 to 40 years for buildings and improvements, and 5 to 20 years for equipment.

**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 \$1,040,000 and \$1,970,000 for the years ended June 30, 2014 and 2013, 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 the deferred loss on defeasance is \$769,305. Accumulated amortization as of June 30, 2014 and 2013, was \$148,689 and \$109,901, respectively. Amortization expense for each of the years ended June 30, 2014 and 2013, amounted to \$38,788, and is estimated to be \$38,788 for each of the next five years.

**Net Position** The District's net position is classified into three components, as follows:

**Net Investment in Capital Assets:** Consists of capital assets, net of accumulated depreciation, reduced by the outstanding balances of any outstanding bonds, leases, notes or other borrowings that are attributable to the acquisition, construction, or improvement of those assets, plus assets held by the bond trustee for debt service payments and capital asset acquisitions.

**Restricted Net Position:** Consists of equity where constraints are placed on the use either by external groups such as creditors, grantors, contributors, laws or regulations of other governments, or laws through constitutional provisions or enabling legislation.

**Unrestricted Net Position:** Consists of the remaining equity that does not meet the definition of "restricted" or "net investment in capital assets."

**Operating Revenues and Expenses** The statements of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenue and expenses. Operating revenues result from exchange transactions associated with providing health care services. Nonexchange revenues, including property tax revenues, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating income. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

**Net Patient Service Revenue** 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 and net of charity care. 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.

**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. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charges excluded from revenue under the District's charity care policy were \$6,074,298 and \$5,545,287 for 2014 and 2013, respectively.

**Contributions** Contributions received may be designated by the donor for restricted purposes or may be without restriction as to their use. Contributions restricted by donors as to use or time period are recorded as restricted net position until used in the manner designated or upon expiration of the time period. When there are no legally imposed restrictions on contributions or on income earned from restricted contributions, they are recorded as nonoperating revenues.

**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; medical malpractice; natural disasters; and employee health, dental, and accident benefits. 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 11.

**Property Tax Revenues** Secured property taxes attach as an enforceable lien on property as of January 1. Taxes are payable in two installments on November 1 and February 1 and become delinquent if paid after December 10 and April 10. Property taxes are levied by Nevada and Placer County Assessors on the District's behalf. They are intended to support general maintenance and operations of the District, including charity care and uncompensated care programs, and to service the debt on the 2008 Series A, Series B, and Series C general obligation bonds. The amount of property tax received is dependent upon the assessed real property valuation, as determined by Nevada and Placer County Assessors. The District received approximately 8% and 9% of its financial support from property taxes in 2014 and 2013, respectively.

**Reclassifications** Various reclassifications have been made to the 2013 financial statements in order to reflect the presentation adopted with the 2014 financial statements.

#### **Impact of Recently Issued Accounting Standards**

In January 2013, GASB issued Statement No. 69, *Government Combinations and Disposals of Government Operations*, with required implementation for the District during the 2014-15 fiscal year. The statement is intended to improve accounting and financial reporting for U.S. state and local government combinations and disposals of government operations. Management does not expect the implementation of this statement to have a material effect on the financial statements.

## 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** Tahoe Forest Hospital and Incline Village Community Hospital are each designated as a “critical access hospital” under the Medicare program. Accordingly, inpatient acute and outpatient services rendered to Medicare program beneficiaries are reimbursed under a cost reimbursement methodology pursuant to the facilities’ designation as “critical access hospitals.” Costs incurred are reimbursed at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. The District’s classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the District. Incline Village Community Hospital Medicare cost reports have been audited by the Medicare fiscal intermediary through June 30, 2012, and final settlements have been received through that date. Tahoe Forest Hospital Medicare cost reports have been audited by the Medicare fiscal intermediary through June 30, 2012, and final settlements have been received through that date.

**Medi-Cal** Inpatient services rendered to Medi-Cal program beneficiaries were reimbursed under a cost reimbursement methodology through December 31, 2013. Beginning January 1, 2014, Medi-Cal began reimbursing based on diagnostic related groups. Reimbursement is at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medi-Cal fiscal intermediary. Medi-Cal cost reports have been audited by the Medi-Cal fiscal intermediary through June 30, 2012, and final settlements have been paid through that date. Outpatient services related to Medi-Cal beneficiaries are paid at prospectively determined rates per procedure.

Revenue from the Medicare and Medi-Cal programs accounted for approximately 34% and 14% of gross patient service revenue in 2014 and approximately 33% and 15% of gross patient revenue in 2013, respectively. Net patient service revenue is reported at estimated realizable amounts, 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. 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. Net patient service revenue increased by approximately \$1,060,000 in 2014 and decreased by approximately \$27,000 in 2013 due to changes in prior-year retroactive adjustments compared with amounts previously estimated. The District believes it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory actions.

**Other Arrangements** The District has entered into payment agreements with certain commercial insurance carriers and preferred provider organizations. The payments to the District under these agreements may be based on discounts from established charges.



**3. CASH, DEPOSITS, AND INVESTMENTS**

The District is generally authorized, under state statute 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.

Deposits and investments at carrying value consisted of the following:

June 30	Maturities	2014	Fair Value at 2013
<b>CASH AND CASH EQUIVALENTS</b>			
Deposits (1)		\$ 10,522,702	\$ 10,424,372
LAIF (2)	7.6 months average	41,207,274	34,123,202
<b>Subtotal</b>		<b>51,729,976</b>	<b>44,547,574</b>
<b>ASSETS HELD BY TRUSTEES</b>			
Cash		6,181,419	5,761,408
Money market funds		2,564,125	2,497,851
LAIF (2)	7.6 months average	18,288,562	30,990,931
Government bonds	22 years	900,379	900,379
<b>Total Assets Held by Trustees</b>		<b>27,934,485</b>	<b>40,150,569</b>
<b>Total Cash, Deposits, and Investments</b>		<b>\$ 79,664,461</b>	<b>\$ 84,698,143</b>

- (1) **Deposits** The carrying amount of deposits includes checking accounts, savings accounts, and nonnegotiable certificates of deposit at financial institutions, if any.
- (2) **Investments That are Not Securities** A "security" is a transferable financial instrument that evidences ownership or creditorship, whether in physical or book-entry form. Investments that are not securities do not have custodial credit risk because they do not involve a transferable financial instrument. The deposits in LAIF are pooled investment funds, which are not evidenced by securities. Thus, the District's LAIF investment is not categorized into custodial credit risk categories.

Deposits and investments are reflected on the accompanying statements of net position under the following captions:

June 30	2014	2013
Cash and cash equivalents	\$ 10,315,543	\$ 10,344,645
Assets limited as to use	69,348,918	74,353,498
<b>Total Cash, Deposits, and Investments</b>	<b>\$ 79,664,461</b>	<b>\$ 84,698,143</b>

### **Custodial Credit Risk – Deposits and Investments**

Custodial credit risk is the risk that, in the event of a financial institution failure, the District's deposits might not be recovered. The District has collateralization agreements with the financial institutions, which mitigate custodial credit risk. Uninsured deposits collateralized with financial institutions amounted to \$13,417,330 and \$11,124,342 at June 30, 2014 and 2013, respectively. Deposits amounting to \$250,000 in each qualifying financial institution are covered by federal depository insurance, and the remaining balances are subject to collateralization agreements.

### **Concentration of Credit Risk – Investments**

*California Government Code*, 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.

*California Government Code*, 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 has a formal investment policy in place to maximize the return on invested cash while minimizing risk of capital loss. District policy limits investments to one and one half years, unless otherwise approved by the Board of Directors. The District was in compliance with their investment policies as of June 30, 2014.

**4. ASSETS LIMITED AS TO USE**

The composition of assets limited as to use is set forth in the following table:

June 30	2014	2013
<b>BOARD DESIGNATED ASSETS</b>		
Cash	\$ 152,659	\$ 235,378
LAIF	41,261,774	33,967,551
<b>Subtotal</b>	<b>41,414,433</b>	<b>34,202,929</b>
<b>ASSETS HELD BY TRUSTEES</b>		
Cash	6,181,419	5,761,408
Money market funds	2,564,125	2,497,851
LAIF	18,288,562	30,990,931
Government bonds	900,379	900,379
<b>Subtotal</b>	<b>27,934,485</b>	<b>40,150,569</b>
<b>Total Assets Limited as to Use</b>	<b>\$ 69,348,918</b>	<b>\$ 74,353,498</b>

**5. PATIENT ACCOUNTS RECEIVABLE**

The District grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2014 and 2013, was as follows:

	2014	2013
Medicare	28%	24%
Medi-Cal	16%	16%
Patients	17%	29%
Commercial insurance and others	39%	31%
<b>Total</b>	<b>100%</b>	<b>100%</b>

6. CAPITAL ASSETS

A summary of changes in capital assets is as follows:

June 30, 2014	Beginning Balance	Additions	Retirements/ Transfers	Ending Balance
Land and improvements	\$ 6,318,481	\$ 52,016	\$ -	\$ 6,370,497
Buildings and improvements	130,865,525	955,867	-	131,821,392
Equipment	63,994,537	3,298,159	-	67,292,696
<b>Subtotal</b>	201,178,543	4,306,042	-	205,484,585
Less: Accumulated depreciation	(82,811,747)	(8,719,909)	-	(91,531,656)
Property held for future expansion	836,353	-	-	836,353
Construction in progress	18,864,246	13,124,629	1,892,674	30,096,201
<b>Capital Assets - Net</b>	<b>\$138,067,395</b>	<b>\$ 8,710,762</b>	<b>\$ 1,892,674</b>	<b>\$144,885,483</b>

June 30, 2013	Beginning Balance	Additions	Retirements/ Transfers	Ending Balance
Land and improvements	\$ 6,313,855	\$ 4,626	\$ -	\$ 6,318,481
Buildings and improvements	79,515,830	51,349,695	-	130,865,525
Equipment	51,624,745	12,410,076	40,284	63,994,537
<b>Subtotal</b>	137,454,430	63,764,397	40,284	201,178,543
Less: Accumulated depreciation	(75,662,839)	(7,123,491)	25,417	(82,811,747)
Property held for future expansion	836,353	-	-	836,353
Construction in progress	63,254,575	16,680,096	61,070,425	18,864,246
<b>Capital Assets - Net</b>	<b>\$125,882,519</b>	<b>\$ 73,321,002</b>	<b>\$ 61,136,126</b>	<b>\$138,067,395</b>

**7. PROCEEDS AND EXPENDITURES OF THE 2007 GENERAL OBLIGATION BOND**

In September 2007, the voters of the District authorized the issuance of general obligation bonds in an aggregate amount not to exceed \$98,500,000 to fund the construction and equipping of additions and improvements to the District's healthcare facilities and to refinance up to \$3,500,000 of existing debt. In August 2008, the District issued \$29,400,000 in bonds (Series A); in August 2010, the District issued another \$43,000,000 in bonds (Series B); and in July 2012, the District issued the remaining \$26,100,000 in bonds (Series C) totaling \$98,500,000.

The District has utilized the bond funds for a variety of projects. A summary of these projects and the expenditures incurred are as follows:

Construction Project	Expenditures			Total	Status
	Prior	2013	2014		
Dietary #1	\$ 240,579	\$ 2,956,579	\$ 1,285,917	\$ 4,483,075	In Progress
Emergency Dept/Sterile Processing	2,201,852	4,067,447	5,563,534	11,832,833	In Progress
Infill/Medical Records	1,885,291	97,734	37,951	2,020,976	In Progress
S. Building/Interim	2,406,179	282,723	3,196,114	5,885,016	In Progress
TFH Master Plan	1,169,473	189,812	41,041	1,400,326	In Progress
Cancer Center Building	25,704,450	1,266,713	139,250	27,110,413	Completed
Cancer Center Equipment	2,250,552	50,543	-	2,301,095	Completed
Central Plant Upgrades	14,587,694	807,366	-	15,395,060	Completed
Fiber West Installation	950	-	-	950	Completed
IT Data Center Building	1,306,111	-	-	1,306,111	Completed
IT Data Center Equipment	9,109	-	-	9,109	Completed
IT/Administration Relocation	401,124	-	-	401,124	Completed
MPOE Fiber Installation	183,577	-	-	183,577	Completed
Nuclear Medicine Camera/Flourosocopy	2,242,176	-	-	2,242,176	Completed
Skilled Nursing Facility	4,571,851	696,432	-	5,268,283	Completed
Skilled Nursing Facility Flooring	199,774	-	-	199,774	Completed
<b>Total</b>	<b>\$ 59,360,742</b>	<b>\$ 10,415,349</b>	<b>\$ 10,263,807</b>	<b>\$ 80,039,898</b>	

**NOTES TO THE FINANCIAL STATEMENTS**  
June 30, 2014 and 2013

**8. LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS**

Long-term debt and capital lease obligations consisted of the following:

	June 30, 2014	Beginning Balance	Additions	Reductions	Ending Balance	Amounts Due Within One Year
Series 2006 Revenue Bonds	\$ 24,675,000	\$ -	\$ -	\$ 700,000	\$ 23,975,000	\$ 735,000
Series 2002 Variable Rate Demand Revenue Bonds	10,155,000	-	-	290,000	9,865,000	310,000
Series A (2008) General Obligation Bonds	29,400,000	-	-	5,000	29,395,000	50,000
Series B (2010) General Obligation Bonds	43,000,000	-	-	-	43,000,000	-
Series C (2012) General Obligation Bonds	26,100,000	-	-	-	26,100,000	-
Lease agreement with Bank of America Public Capital payable in monthly installments of \$103,637, including interest at 1.42% through July 2017. The lease is collateralized by equipment and any unspent lease proceeds.	4,931,515	-	-	1,181,523	3,749,992	1,198,347
Lease agreement with US Bank payable in monthly installments of \$4,809, including interest at 4.62% through July 2014. The lease is collateralized by equipment.	56,291	-	-	56,291	-	-
Lease agreement with Bank of America payable in monthly installments of \$38,350, including interest at 4.06% through May 2014. The lease is collateralized by equipment.	413,411	-	-	413,411	-	-
Lease agreement with US Bank payable in monthly installments of \$773, including interest at 6.71% through June 2014. The lease is collateralized by equipment.	8,948	-	-	8,948	-	-
Lease agreement with Great America Leasing payable in monthly installments of \$473, including interest at 2.60% through June 2014. The lease is collateralized by equipment.	5,581	-	-	5,581	-	-
Lease agreement with Graphic Savings Group payable in monthly installments of \$1,631, including interest at 0.04% through June 2014. The lease is collateralized by equipment.	19,569	-	-	19,569	-	-
Lease agreement with Great America Leasing payable in monthly installments of \$934, including interest at 0.01% through August 2014. The lease is collateralized by equipment.	12,338	-	-	10,492	1,846	1,846
<b>Total Long-Term Debt and Capital Lease Obligations</b>	<b>\$ 138,777,653</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 2,690,815</b>	<b>\$ 136,086,838</b>	<b>\$ 2,295,193</b>

**NOTES TO THE FINANCIAL STATEMENTS**

June 30, 2014 and 2013

**Tahoe Forest Hospital District**

	Beginning Balance	Additions	Reductions	Ending Balance	Amounts Due Within One Year
June 30, 2013	\$ 25,355,000	\$ -	\$ 680,000	\$ 24,675,000	\$ 700,000
Series 2006 Revenue Bonds	10,430,000	-	275,000	10,155,000	290,000
Series 2002 Variable Rate Demand Revenue Bonds	29,400,000	-	-	29,400,000	5,000
Series A (2008) General Obligation Bonds	43,000,000	-	-	43,000,000	-
Series B (2010) General Obligation Bonds	-	26,100,000	-	26,100,000	-
Series C (2012) General Obligation Bonds	-	-	-	-	-
Lease agreement with Bank of America Public Capital payable in monthly installments of \$103,637, including interest at 1.42% through July 2017. The lease is collateralized by equipment and any unspent lease proceeds.	-	6,000,000	1,068,485	4,931,515	1,181,523
Lease agreement with US Bank payable in monthly installments of \$4,809, including interest at 4.62% through July 2014. The lease is collateralized by equipment.	110,047	-	53,756	56,291	56,291
Lease agreement with Bank of America payable in monthly installments of \$38,350, including interest at 4.06% through May 2014. The lease is collateralized by equipment.	847,228	-	433,817	413,411	413,411
Lease agreement with US Bank payable in monthly installments of \$773, including interest at 6.71% through June 2014. The lease is collateralized by equipment.	17,316	-	8,368	8,948	8,948
Lease agreement with Great America Leasing payable in monthly installments of \$473, including interest at 2.60% through June 2014. The lease is collateralized by equipment.	10,991	-	5,410	5,581	5,581
Lease agreement with Graphic Savings Group payable in monthly installments of \$1,631, including interest at 0.04% through June 2014. The lease is collateralized by equipment.	39,130	-	19,561	19,569	19,569
Lease agreement with Great America Leasing payable in monthly installments of \$934, including interest at 0.01% through August 2014. The lease is collateralized by equipment.	21,895	-	9,557	12,338	10,491
<b>Total Long-Term Debt and Capital Lease Obligations</b>	<b>\$ 109,231,607</b>	<b>\$ 32,100,000</b>	<b>\$ 2,553,954</b>	<b>\$ 138,777,653</b>	<b>\$ 2,690,814</b>

**NOTES TO THE FINANCIAL STATEMENTS**  
June 30, 2014 and 2013

*Tahoe Forest Hospital District*

Scheduled principal and interest repayments on long-term debt and payments on capital lease obligations are as follows:

	<b>Long-Term Debt</b>		<b>Capital Lease Obligations</b>	
	<b>Principal Amount</b>	<b>Interest Amount</b>	<b>Principal Amount</b>	<b>Interest Amount</b>
2015	\$ 1,095,000	\$ 6,187,683	\$ 1,200,193	\$ 45,324
2016	1,410,000	6,140,461	1,215,411	29,238
2017	1,575,000	6,080,046	1,232,718	10,932
2018	1,895,000	6,012,270	103,516	122
2019	2,130,000	5,929,281	-	-
2020-2024	14,740,000	27,956,435	-	-
2025-2029	23,300,000	23,684,310	-	-
2030-2034	31,695,000	17,413,599	-	-
2035-2039	38,100,000	9,268,375	-	-
2040-2043	16,395,000	1,488,550	-	-
<b>Total</b>	<b>\$ 132,335,000</b>	<b>\$ 110,161,010</b>	<b>\$ 3,751,838</b>	<b>\$ 85,616</b>

Following is a summary of equipment under capital leases:

<b>June 30</b>	<b>2014</b>	<b>2013</b>
Cost of equipment	\$ 3,709,721	\$ 10,469,247
Less: Accumulated depreciation	974,183	7,616,761
<b>Capital Lease Equipment - Net</b>	<b>\$ 2,735,538</b>	<b>\$ 2,852,486</b>



Following is a summary of bonded debt:

	<u>Maturity</u>	<u>Annual Interest Rate</u>	<u>Amount Issued</u>
<b>REVENUE BONDS</b>			
Series 2002 Variable Rate Demand Revenue Bonds	July 2033	3.54%	\$ 12,000,000
Series 2006 Revenue Bonds - Serial Bonds	July 2007 to 2021	3.70% to 4.75%	10,335,000
Series 2006 Revenue Bonds - Term Bonds	July 2026 to 2036	5.00%	<u>17,050,000</u>
<b>Total Revenue Bonds</b>			<u>39,385,000</u>
<b>GENERAL OBLIGATION BONDS</b>			
Series A (2008) General Obligation Bonds - Serial Bonds	August 2013 to 2038	4.00% to 5.50%	27,140,000
Series A (2008) General Obligation Bonds - Term Bonds	August 2025	5.125%	2,260,000
Series B (2010) General Obligation Bonds - Serial Bonds	August 2015 to 2027	4.00% to 5.50%	9,290,000
Series B (2010) General Obligation Bonds - Term Bonds	August 2030 to 2040	4.75% to 5.50%	33,710,000
Series C (2012) General Obligation Bonds - Serial Bonds	August 2017 to 2035	3.00% to 5.50%	9,925,000
Series C (2012) General Obligation Bonds - Term Bonds	August 2034 to 2042	4.00%	<u>16,175,000</u>
<b>Total General Obligation Bonds</b>			<u>98,500,000</u>
<b>Total</b>			<u>\$ 137,885,000</u>

Accrued interest is paid on January 1 and July 1 each year for the 2002 Variable Rate Demand Revenue Bonds (the Series 2002 Bonds) and the 2006 Revenue Bonds (the Series 2006 Bonds), and on February 1 and August 1 for the General Obligation Bonds (the G.O. Bonds).

Principal payments on the bonds are as follows:

	<u>Annual Installments</u>
<b>REVENUE BONDS</b>	
Series 2002 Variable Rate Demand Revenue Bonds	July 1 ranging from \$200,000 to \$805,000
Series 2006 Revenue Bonds	July 1 ranging from \$135,000 to \$2,780,000
<b>GENERAL OBLIGATION BONDS</b>	
Series A (2008) General Obligation Bonds	August 1 ranging from \$5,000 to \$3,060,000
Series B (2010) General Obligation Bonds	August 1 ranging from \$215,000 to \$3,965,000
Series C (2012) General Obligation Bonds	August 1 ranging from \$135,000 to \$2,440,000

Mandatory sinking fund deposits for each of the bonds are as follows:

	<u>Required Deposits</u>	<u>Commencing</u>	<u>Due Annually Ending</u>
2002 Variable Rate			
Demand Revenue Bonds	\$275,000 to \$805,000	July 2006	July 2033
2006 Revenue			
Bonds - Term Bonds	\$690,000 to \$2,780,000	July 2022	July 2035
Series A (2008) General			
Obligation Bonds -			
Term Bonds	\$655,000 to \$750,000	August 2023	August 2024
Series B (2010) General			
Obligation Bonds -			
Term Bonds	\$1,485,000 to \$3,685,000	August 2028	August 2039
Series C (2012) General			
Obligation Bonds -			
Term Bonds	\$1,175,000 to \$2,265,000	August 2033	August 2041

The District issued the Series 2002 Bonds to finance the costs of constructing and equipping new health care facilities and remodeling certain existing facilities. The Series 2002 Bonds are secured by a pledge of gross revenues and by a direct-pay letter of credit issued by U.S. Bank National Association.

The District issued the Series 2006 Bonds to construct and equip the western addition expansion project, to renovate and equip portions of the existing facility, and to advance refund \$11,790,000 of 1999 Series A Bonds outstanding. The Series 2006 Bonds are secured by a pledge of gross revenues.

In connection with the Series 2006 bond agreement, the District is required to make monthly deposits to the trustee for the term bond sinking fund payments, serial bond principal payments, insurance premiums becoming due and payable within the next 12 months, and for interest payments becoming due and payable within the next six months. The aggregate future monthly deposit required is \$156,521 at June 30, 2014.

The G.O. Bonds were issued for the purpose of financing the expansion, improvement, acquisition, construction, equipping and renovation of health facilities of the District, refinancing \$3,500,000 in outstanding debt, and to pay costs incident thereto.

All of the G.O. Bonds represent the general obligations of the District. The District has the power and is obligated to cause to be levied and collected by both Nevada and Placer Counties annual ad valorem taxes on all property within the District's boundaries subject to taxation by the District for payment when due of the principal and interest on the bonds. However, the District is legally required to repay the G.O. Bonds if ad valorem taxes are insufficient.

The District is required to maintain a debt service coverage ratio of at least 1.75 to 1.00 and at least 60 days' cash on hand. The District is also limited in the incurrence of future indebtedness and encumbrances.

## 9. INTEREST RATE SWAP AGREEMENT

**Objective of the Interest Rate Swap** 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%.

**Terms** The Series 2002 Bonds and the related swap agreement mature on July 1, 2033, and the swap's original notional amount of \$11,800,000 matched the variable-rate bonds at the agreement date. The swap was entered into 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 with 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.

**Fair Value** Because interest rates have declined since execution of the swap, the swap had negative fair values of \$1,710,011 and \$1,710,354 as of June 30, 2014 and 2013, 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. These 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 \$1,710,011 and \$1,710,354 at June 30, 2014 and 2013, respectively, and a corresponding accumulated decrease in fair value of hedging derivative (deferred outflow of resources).

**Credit Risk** As of June 30, 2014, 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 A2/A/A as of June 30, 2014. 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 quality 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.

**10. BENEFIT PROGRAMS**

The District contributes to the Tahoe Forest Hospital District Employee Money Purchase Pension Plan, a defined contribution pension plan administered by the District. The money purchase pension plan covers employees who complete 1,000 hours of service in a calendar year. The District is required to make annual contributions to the money purchase pension 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 provides a deferred compensation plan created in accordance with the Internal Revenue Code, Section 457. The deferred compensation plan allows employees to defer a portion of their current compensation until future years. The District matches participant 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 this deferred compensation plan are deposited into employee accounts in the money purchase pension plan.

Total employer contributions under the above benefit programs were \$2,175,058 and \$2,723,868 in 2014 and 2013, respectively.

**11. RISK MANAGEMENT**

**Joint Powers Agreement**

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 an estimated premium to purchase an unlimited extended reporting amendment (tail coverage) in the amount of \$890,902 and \$887,362 at June 30, 2014 and 2013, respectively.

**Employee Health Insurance**

The District is self-insured to provide group medical, dental, and vision coverage. A third party administers these coverages for the District. The District funds its losses based on actual claims. A stop-loss insurance contract executed with an insurance carrier provides a specific stop-loss deductible per claim of \$175,000 with an aggregate specific annual deductible of \$100,000. There were no significant changes in insurance coverage from the prior year.

**NOTES TO THE FINANCIAL STATEMENTS**

June 30, 2014 and 2013

*Tahoe Forest Hospital District*

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, 2014 and 2013, has been included in the accompanying balance sheets under estimated claims incurred but not reported. Changes in the claims liability are as follows:

	<b>2014</b>	<b>2013</b>
Estimated claims incurred but not reported - beginning of year	\$ 860,027	\$ 1,030,171
Incurred claims and claims adjustment expense	7,611,788	6,225,754
Claim payments	<u>(7,474,180)</u>	<u>(6,395,898)</u>
<b>Estimated Claims Incurred But Not Reported - End of Year</b>	<u>\$ 997,635</u>	<u>\$ 860,027</u>

**Workers' Compensation Insurance**

The District is self-insured for workers' compensation losses. A third party administers this coverage for the District. The District funds its losses based on future claims projections developed by the third-party administrator. 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.

The liability for unpaid claims is estimated using development factors, including actual claims paid industry standards and actuarial factors. The estimated liability for claims pending and incurred but not reported at June 30, 2014 and 2013, has been included in the accompanying balance sheets under estimated claims incurred but not reported. Changes in the claims liability are as follows:

	<b>2014</b>	<b>2013</b>
Estimated claims incurred but not reported - beginning of year	\$ 1,392,606	\$ 1,438,552
Incurred claims and claims adjustment expense	237,675	561,814
Claim payments	<u>(623,806)</u>	<u>(607,760)</u>
<b>Estimated Claims Incurred But Not Reported - End of Year</b>	<u>\$ 1,006,475</u>	<u>\$ 1,392,606</u>

## 12. COMMITMENTS AND CONTINGENCIES

### Construction Project Commitments

Construction project commitments as of June 30, 2014, were as follows:

<b>Construction Project</b>	<b>Remaining Construction Commitments</b>
Emergency Department/Sterile Processing Department	\$ 20,443
Interim Birthing at WA	89,042
<b>Total</b>	<b>\$ 109,485</b>

### Operating Leases

The District leases certain facilities and equipment under non-cancelable operating leases. Total lease expense was \$1,994,493 and \$2,180,897 for 2014 and 2013, respectively. Future minimum payments under these non-cancelable operating lease agreements at June 30, 2014, are as follows:

<b>Years Ending June 30</b>	
2015	\$ 477,445
2016	131,429
2017	63,529
2018	16,077
2019	16,399
2020-2021	18,135
<b>Total Minimum Payments</b>	<b>\$ 723,014</b>

The District entered into a cancelable sublease agreement to sublease a specific facility during 2014. Under the terms of the agreement, the subtenant shall pay the District fixed monthly rent in the amount of \$2,917 for the duration of the agreement. Sublease revenue realized by the District during 2014 was approximately \$7,500 and was included in net rental income on the statement of revenues, expenses, and changes in net position.

### Litigation

The District is involved in claims and other litigation arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the District's future financial position or results from operations.

**Seismic Compliance**

California Senate Bill 1953 (SB 1953) required hospital acute care buildings to meet more stringent seismic guidelines by 2008. In fiscal 2013, the District received approval of a time extension from the Office of Statewide Health Planning and Development for compliance with SB 1953 until January 1, 2015. The Board of Directors has approved a \$98.5 million expansion plan, which includes expanding and enhancing the emergency room to ensure access to lifesaving care; maintaining critical medical services including pediatrics, maternity, long-term care for seniors and cancer care; and upgrading facilities that are outdated or do not meet state-mandated earthquake safety standards. This plan will enable the District to comply with SB 1953 seismic guidelines. The financing for this expansion plan has multiple parts, including \$98.5 million of general obligation bonds to be repaid through ad valorem property taxes of the residents of the District (see note 8).

**13. FOUNDATIONS**

**Tahoe Forest Health System Foundation**

The Tahoe Forest Health System Foundation (TFHSF) is a legally separate nonprofit organization, exempt from federal tax, formed to assist in developing and increasing the facilities of the District. TFHSF’s activities are governed by a separate board of directors. TFHSF’s financial activity is not included in the District’s financial statements, but is a component unit of the District. During the years ended June 30, 2014 and 2013, TFHSF distributed approximately \$618,000 and \$517,000, respectively, to the District. TFHSF has issued separate financial statements for the year ended June 30, 2014. A copy of TFHSF’s financial statements can be obtained through the District.

A summary of TFHSF’s financial information is as follows:

	<u>2014</u>	<u>2013</u>
Total assets	\$ 1,934,025	\$ 1,707,755
Total liabilities	241,192	135,584
<b>Net Assets</b>	<u>\$ 1,692,833</u>	<u>\$ 1,572,171</u>
<b>Total Revenue</b>	<u>\$ 1,648,746</u>	<u>\$ 1,561,077</u>
<b>Total Expenses</b>	<u>\$ 1,528,085</u>	<u>\$ 1,188,646</u>

**Incline Village Community Hospital Foundation**

The Incline Village Community Hospital Foundation (IVCHF) is a legally separate nonprofit organization, exempt from federal tax, formed to assist in developing and increasing the facilities of the District. IVCHF’s activities are governed by a separate board of directors. IVCHF’s financial activity is not included in the District’s financial statements, but is a component unit of the District. During the years ended June 30, 2014 and 2013, IVCHF distributed approximately \$691,000 and \$428,000, respectively, to the District. IVCHF has issued separate financial statements for the year ended June 30, 2014. A copy of IVCHF’s financial statements can be obtained through the District.

A summary of IVCHF's financial information is as follows:

	<b>2014</b>	<b>2013</b>
Total assets	\$ 478,633	\$ 709,201
Total liabilities	301,055	-
<b>Net Assets</b>	<b>\$ 177,578</b>	<b>\$ 709,201</b>
<b>Total Revenue</b>	<b>\$ 270,227</b>	<b>\$ 486,322</b>
<b>Total Expenses</b>	<b>\$ 801,850</b>	<b>\$ 613,498</b>

**14. INVESTMENT IN JOINT VENTURE**

The District owns 51% of Truckee Surgery Center, LLC (the Center). Summarized financial information for the Center as of June 30 was as follows:

	<b>2014</b>	<b>2013</b>
Total assets	\$ 4,674,238	\$ 4,818,428
Total liabilities	102,143	128,348
<b>Total Equity</b>	<b>\$ 4,572,095</b>	<b>\$ 4,690,080</b>
<b>EQUITY POSITIONS</b>		
Tahoe Forest Hospital District	\$ 4,092,095	\$ 4,324,049
Truckee Surgery Center, Inc.	480,000	366,031
<b>Total</b>	<b>\$ 4,572,095</b>	<b>\$ 4,690,080</b>
<b>Net Loss</b>	<b>\$ (126,605)</b>	<b>\$ (59,837)</b>

Reconciliation of the District's equity position according to the Center's records of the District's investment in joint venture as of June 30 was as follows:

	<b>2014</b>	<b>2013</b>
Tahoe Forest Hospital District equity position	\$ 4,092,095	\$ 4,324,049
Impairment reserve (see note 15)	(3,595,700)	(3,595,700)
<b>Investment in Joint Venture</b>	<b>\$ 496,395</b>	<b>\$ 728,349</b>



**15. IMPAIRMENT LOSSES**

During 2013, the District determined that assets with a carrying value of \$6,617,336 were either partially or fully impaired; and, accordingly, an impairment loss was recognized. Impairment losses as of June 30, 2013, were comprised of the following:

<b>Description</b>	<b>Carrying Value Prior to Write Off</b>	<b>Carrying Value June 30, 2013</b>	<b>Impairment Loss</b>
Investment in gastroenterology practice	\$ 970,380	\$ -	\$ 970,380
Investment in Truckee Surgery Center, LLC	4,324,049	728,349	3,595,700
Investment in orthopedic practice	134,958	-	134,958
Capitalized software and hardware	1,187,949	209,909	978,040
<b>Total Impairment Losses</b>	<b>\$ 6,617,336</b>	<b>\$ 938,258</b>	<b>\$ 5,679,078</b>

The District had investments in gastroenterology and orthopedic practices. Operations of both practices were integrated into the Hospital, and no separate investment value remained. Therefore, an impairment loss for the full amount of the investment has been recognized.

The District has an investment in Truckee Surgery Center, LLC (see note 14). Due to current and projected income from operations, the District determined that the goodwill recognized on the purchase of the Center should be written off, and only the District's portion of the basis in the underlying assets of the investment should remain.

The District made investments in software and related hardware in prior years and determined in the current year that the software would not be used and should be written off. Hardware previously purchased that could be used was transferred out of construction in progress and placed into service.

The District recognized no impairment losses during the year ended June 30, 2014.

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](#) and [32128](#) 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".

Section 3. Purpose and Operating Policies.

A. Purpose.

Tahoe Forest Hospital District is committed to be the best mountain community health care system in our nation. All members of our team, working together, will ensure that the services we provide are satisfying, effective, efficient and of the highest quality, with access for all. We will strive each day to exceed patient, community, physician and employee expectations.

B. Operating Policies.

In order to accomplish the Mission of the District, the Board of Directors establishes the following Operating Policies:

1. 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; ancestry; color; disability; gender, gender identity, or gender expression; marital status; medical condition; national origin; political affiliation; race; religion; sexual orientation; veteran status/military service; genetic](#)

**Comment [A1]:** I believe the most applicable reference is to section 32125. However, it would also be appropriate to reference to H&S Sections 32104 and 32128.

**32104.** The board of directors shall provide for the time and place of holding its regular meetings and the manner of calling the same, and shall establish rules for its proceedings and may adopt such rules and regulations not inconsistent with law as may be necessary for the exercise of the powers conferred and the performance of the duties imposed upon the board.

**32125.** (a) The board of directors shall be responsible for the operation of all health care facilities owned or leased by the district, according to the best interests of the public health and shall make and enforce all rules, regulations and bylaws necessary for the administration, government, protection and maintenance of health care facilities under their management and all property belonging thereto and may prescribe the terms upon which patients may be admitted thereto. Minimum standards of operation as prescribed in this article shall be established and enforced by the board of directors.

**32128.** (a) The rules of the hospital, established by the board of directors pursuant to this article, shall include all of the following:

(Subsection a discusses medical staff and medical records)

~~information, color, national origin, gender, religion or creed, marital status, age, sexual preference or disability including AIDS and related conditions.~~

2. 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.

3. The District shall dedicate itself to the maximum level of quality consistent with sound fiscal management, and community based needs.

4. The Board shall provide a means for effective consumer participation and involvement in planning the future course of the District. Planning shall be accomplished in conjunction with other community resources, and will be coordinated with other service providers, when appropriate.

5. Improvement of the health status of the area will be the primary emphasis of services offered by the District. This will be accomplished through programs of inpatient and outpatient care, as well as outreach services in the areas of health education and prevention.

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 continuing direction 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 District and the responsibilities that the District should assume in helping to meet them.

#### B. Programs and Services.

**Comment [A2]:** We may want to compare this statement with the District's Personnel Policies for consistency. The list may be longer and more comprehensive in the Personnel Policies.

1. Approves long and short range plans for the development of programs and services to be provided by the District. Takes action on recommendations of the Planning Committee and Chief Executive Officer.

2. Provides general direction to the Chief Executive Officer in the implementation of programs and service plans.

3. Approves policies which govern programs and services.

4. Evaluates the results of programs and services on the basis of previously established objectives and requirements. Receives reports from the Chief Executive Officer and directs the Chief Executive Officer to plan and take appropriate actions, where warranted.

C. Organization and Staffing.

1. Adopts the plan of organization of the District, including plans of organization of the Board of Directors, Administration and Medical Staff.

2. Elects officers of the District in accordance with provisions of the Bylaws.

3. Confirms the appointment of both Directors and others to committees of the Board.

4. Selects and appoints the Chief Executive Officer.

5. 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 ultimate responsibility for the financial soundness and success of the ~~Hospital~~ District.

2. Assumes ultimate 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.

**Comment [A3]:** I deleted this for consistency. In most other places the reference is to the "District"



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 government of said Medical Staff, as provided in ARTICLE IX of these Bylaws.

C. Auxiliary.

The Board of Directors may authorize the formation of service organizations to be known as "The Tahoe Forest Hospital Auxiliary" and "The North Lake Tahoe Community Health Care Auxiliary", the Bylaws of which shall be approved by the Board of Directors.

D. Other Adjuncts.

The Board of Directors may authorize the formation of other adjunct organizations which ~~they~~ 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 adjunct 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 of the adjunct 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 ~~and ordinances~~ regarding specific policy issues, which resolutions ~~and ordinances~~ may establish policy for the operations of this District.

**Comment [A4]:** The District really isn't empowered to adopt ordinances.

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 delegates the responsibility to review and resolve grievances to the Grievance Committee.

#### 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 (15) 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-last~~ Tuesday of each month at 6:00 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 lying within the District, except as provided in the Brown Act, upon the call of the President, 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 (1) 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.

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 thereof to the Board of Directors without voting power, however, 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 shall attend during the absence of the Chief of Staff.

Section 8. Director Compensation and Reimbursement Of Expenses.

The Board of Directors shall serve without compensation, except that the Board of Directors, by a resolution adopted by a majority vote of the members of the Board, may authorize the payment of not to exceed one hundred dollars (\$100.00) per meeting, not to exceed five (5) meetings a month, as compensation to each member of the Board of Directors.

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.

**Comment [A5]:** H&S Code section 32103. 32103. The board of directors shall serve without compensation except that the board of directors, by a resolution adopted by a majority vote of the members of the board, may authorize the payment of not to exceed one hundred dollars (\$100) per meeting not to exceed five meetings a month as compensation to each member of the board of directors.

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. For purposes of this section, the determination of whether a director's activities on any specific day are compensable shall be made pursuant to Article 2.3 (commencing with Section 53232) of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code. Reimbursement for these expenses is subject to Sections 53232.2 and 53232.3 of the Government Code.

/ /

Section 9. Board Self-Evaluation.

The Board of Directors will monitor and discuss ~~their-its~~ process and performance at least annually. The self-evaluation process will include comparison of Board activity to ~~their-its~~ manner of governance policies.

**ARTICLE III. OFFICERS**

Section 1. Officers.

The officers of the Board of Directors shall be President, Vice-President, Secretary and Treasurer who shall be members of the Board, and a Clerk.

Section 2. Election of Officers.

The officers of the Board of Directors shall be chosen every year by the Board of Directors at the first meeting of such calendar year and each officer shall hold office for a one (1) year term or until such officer's successor shall be elected and qualified or until such officer is otherwise disqualified to serve. The person holding the office of President of the Board of Directors shall not serve two successive terms. 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. Shall preside over all meetings of the Board of Directors. Shall sign as President, 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. ~~Shall have, subject to the advice and control of the Board of Directors, general responsibility for the affairs of the District during his term of office.~~

**Comment [A6]:** See Article IV, Section 1 for one such additional duty re appointment of committees and chairs.

B. Vice-President. The Vice-President shall perform the functions of the President in case of the President's absence or inability to act.

**Comment [A7]:** This authority may encroach upon the delegation of authority to the CEO to be in charge of the day-to-day operations of the District. It is not clear where the line is between "affairs" and "operations."

C. Secretary. The Secretary shall be responsible to record minutes of all meetings of the Board of Directors and shall see that all records of the District are kept and preserved.

D. Treasurer. The Controller may be appointed by the Treasurer, and shall be charged with the safekeeping and disbursement of the funds in the treasury of the District, subject to the policies established by the Board of Directors.

Will serve as the chairperson of the Board Finance Committee.

E. Clerk. The Chief Executive Officer or his designee shall be appointed the Clerk of the Board of Directors, and shall perform the functions of the Secretary in case of the Secretary's absence or inability to act.

## **ARTICLE IV. COMMITTEES**

### **Section 1. Special Committees.**

Special Committees may be appointed by the President of the Board of Directors from time to time as he/she deems necessary or expedient. Such Committees shall have no power to commit the Board of Directors or the District in any manner, but shall perform such functions as shall be assigned to them by the President, and shall function for the period of time specified by the President at the time of appointment or until determined to be no longer necessary and disbanded by the President of the Board of Directors. The President shall appoint each Committee chair.

### **Section 2. Standing Committees.**

Standing Committees may from time to time be created by resolution duly adopted by the Board of Directors. The President shall appoint the members of these committees and the Chair thereof. Committee appointments shall be for a period of one (1) year and will be made annually at the January Board meeting, following the election of Board Officers. The initial Standing Committees will consist of the following:

#### **A. Joint Conference Committee.**

1. The Joint Conference Committee (JCC) shall consist of the Chief of Staff, the Vice Chief of Staff, the Chief Executive Officer, and the President of the Board of Directors and one other member of the Board appointed by the President. 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 selected by the President of the Board of Directors.

2. The Committee shall meet as needed.

3. The ~~Joint Conference Committee~~ JCC shall review policy relating to the performance of the Medical Staff and shall serve as a forum for discussion of mutual concerns of the Board of Directors, the Chief Executive Officer and his/her management staff, and the Medical Staff.

4. The ~~Joint Conference Committee~~ JCC shall constitute a forum for the discussion of matters of District 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 Executive Committee or the Board of Directors. The ~~Joint Conference Committee~~ JCC shall exercise other responsibilities set forth in these Bylaws.

#### **B. Finance Committee.**

1. The Committee shall comprise two (2) Board Members. The Board Treasurer shall serve as Chairperson of the ~~e~~Committee, and the second ~~e~~Committee member shall be appointed by the Board President.

2. The Committee shall meet as needed. A report will be made to the Board of Directors quarterly, or otherwise as requested.

3. The Committee shall have the following responsibilities pursuant to the policies of the Board of Directors:

- a. Development of District operating, cash and capital budgets for approval by the Board of Directors.
- b. Monitoring of District budget performance and financial management.
- c. Review of capital purchase recommendations before presentation to the Board of Directors.
- d. Review and comment on monthly financial statements and expenditure reports.
- e. Oversight of annual independent audit and supervision of any necessary corrective measures.
- f. Supervision of the investment of District funds.
- g. Special projects, as required in the area of financial management, or as directed by the Board of Directors.
- h. Oversight of budget and expenditures for facility projects.

**Comment [A8]:** I believe this is correct and I am suggesting this change to make it clear that the Committee doesn't have the authority to develop and adopt budgets that would bind the Board.

C. Governance Committee

1. The Committee shall comprise two (2) Board Members appointed by the Board President.

2. The Committee shall meet as needed.

3. The Committee shall be advisory in nature with the following responsibilities pursuant to the policies of the Board of Directors:

- a. Provide oversight of the Compliance program efforts to achieve regulatory compliance by reviewing its activities, quality and effectiveness, and to monitor that management appropriately addresses compliance recommendations;
- b. Conduct periodic review of ~~the Tahoe Forest Hospital District these~~ Bylaws and Board policies.
- c. Submit recommendations to the ~~Hospital~~ Board of Directors for changes in these documents as necessary and desirable.
- d. Draft new Board policies and procedures as necessary or as directed by the Board of Directors for recommendation to the Board.

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e. Advance best practices in board governance.

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f. Conduct the annual board self-assessment and board goal setting process.

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D. Personnel Committee

1. The Committee shall comprise two (2) Board Members appointed by the Board President.

2. The Committee shall meet as needed.

3. The Committee shall be advisory in nature with the following responsibilities pursuant to the policies of the Board of Directors:

a. Chief Executive Officer Relations

1. Employment Agreement

2. Performance Evaluation

3. Incentive Compensation Program

b. Chief Executive Officer/Board of Directors Liaison

4. Memorandum of Understanding with ~~Tahoe Forest Hospital~~-District bargaining units

E. Retirement Plan Committee

1. The ~~Retirement Plan~~-Committee is a sub-committee of the Personnel Committee.

2. The ~~Retirement Plan~~-Committee shall comprise the two (2) Board Members of the Personnel Committee appointed by the Board President, Chief Executive Officer, CFO, and Human Resources Director.

3. The Committee shall meet as needed.

4. The Committee shall have the following responsibilities:

a. Establish and administer the ~~Tahoe Forest Hospital~~-District's Investment Policy Statement.

b. Provide administrative oversight for the Tahoe Forest Hospital District Money Purchase Pension Plan and the Tahoe Forest Hospital District Deferred Compensation Plan.

G. Quality Committee

1. The Committee membership shall be comprised of a minimum of two members of the Board of Directors as appointed by the Board President and two (2) members of the Tahoe Forest Hospital Medical Staff as appointed by the Medical

Executive Committee. {Recommend Chief of Staff or designee and Chairperson of the Quality Assessment and Improvement Committee}

2. The Committee shall meet a minimum of four (4) times per calendar year.
3. The Committee is accountable to the Board of Directors for the following:
  - a. Provide oversight for the organization-wide Quality Assessment and Performance Improvement Plan;
  - b. Set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization;
  - c. Ensure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization;
  - d. Monitor the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable;
  - e. Oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities;
  - f. Assure the development and implementation of ongoing education focusing on service excellence, performance improvement, risk-reduction/safety enhancement, and healthcare outcomes.

#### H. Community Benefit Committee

1. The Committee shall comprise two (2) Board Members.
2. The Committee shall meet at least 4 times a year and additionally as needed.
3. The Committee shall be advisory in nature with the following responsibilities pursuant to the policies of the Board of Directors:
  - a. Ensure Health System strategic planning and stated goals include community and population health initiatives to improve health, decrease costs, and improve the patient experience.
  - b. Provide advice and input in the deployment of the tri-annual Community Health Needs Assessment (CHNA).
  - c. Review resulting data from CHNA, provide input into the Community Health Improvement Plan (CHIP), and assist in development of long term strategies,

- aligned with Health System goals, to address key health issues.
- d. Monitor the planning, development, implementation and results of major programs aimed at improving the health of ~~eu~~the community.
  - e. With collaborative partners, make recommendations for program continuation or termination based on progress toward identified measurable objectives, available resources, level of community ownership, and alignment with criteria for priorities.
  - f. Review and provide input on proposed public communications about the organization's community benefit activities.
  - g. Engage the community to achieve community health improvement goals through partnerships.
  - h. Review the mission of the health system and if necessary make recommendation for changes to the board.

## **ARTICLE V. MANAGEMENT**

### Section 1. Chief Executive Officer.

The Board of Directors shall select and employ a~~n~~ 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. The Chief Executive Officer shall act as the duly authorized representative of the Board of Directors.

### Section 2. Authority and Responsibility.

The Chief Executive Officer shall have the following duties and responsibilities as follows. Other duties may be assigned.

- A. Assists, counsels, and advises the Board of Directors on the establishment of ~~h~~Hospital policies; acts as agent of the Board in carrying out such policies.
- B. Recommends District policy positions regarding legislation, government, administrative operation and other matters of public policy as required.
- C. Assists the Board of Directors in effectively fulfilling ~~their its~~ responsibilities by keeping the Board informed, on a monthly basis, of the operating results of the District; compares monthly operations to Board approved plans and budgets explaining variances that may arise.
- D. Assists and advises the Board with respect to ~~the District's authority under the law public District authority~~ and changes in state statutory guidelines and requirements.
- E. Develops and implements appropriate strategic and annual operating plans that document the long and short-term goals and objectives of the District.
- F. Actively pursues and supports the appraisals and development of new programs which could benefit the long-range success and survival of the District.
- G. Establishes concise reporting relationships for all positions and departments in the ~~hospital~~District. Establishes methods which will foster the achievement of District goals and objectives and support the efficiency and effectiveness of all operations through proper communication and coordination.
- H. Coordinates all operations with the ~~m~~Medical ~~s~~Staff, its committee structure and its leadership; demonstrates a proactive and positive relationship with the ~~m~~Medical ~~s~~Staff.
- I. Ensures a consistency of purpose and mutuality of interest between the operations and bylaws of the ~~m~~Medical ~~s~~Staff and the policies and bylaws of the District.
- J. Develops and maintains ~~Q~~quality ~~i~~improvement ~~P~~programs designed to enhance quality and customer satisfaction.
- K. Establishes operating policies and procedures for all departments, delegating specific responsibility for documentation, monitoring, compliance, and reporting or results to subordinates, as required.
- L. Establishes, implements and maintains a comprehensive budgeting program for the District. This program includes an appropriate consideration of operational, financial and statistical information needed to efficiently and effectively control all District operations.
- M. Consistently generates sufficient net income to meet established financial

goals.

- N. Develops strong marketing and public relations programs.
- O. Ensures the competitive viability and continuance of the District.
- P. Through various techniques, encourages the development of services which promote District growth and expanded potential constituencies.
- Q. Ensures the coordination of Auxiliary and Foundation ~~b~~Bylaws and operations with the ~~b~~Bylaws and operations of the District.
- R. Establishes a proper, consistent image of the District and its operations.
- S. Personally represents the District to a variety of individuals, community groups, and health industry organizations.
- T. Maintains active professional contacts through local, state and national associations in order to effectively network, as required.
- U. Demonstrates the ability to effectively represent the District at national, state and local meetings, conferences and conventions, as required.
- V. Remains current with national and local issues affecting District administration and their potential impact on the District; serves as a well-informed advisor to the Board of Directors.
- W. Personally or through delegation, hires, assigns responsibility, counsel, evaluates and (as required) terminates all District employees.
- X. Personally or through delegation sServes as Clerk of the Board of Directors.
- Y. Actively participates in outside programs and community affairs in order to represent the District as appropriate.
- Z. Assists, counsels, and advises the Board of Directors on the establishment of personnel policies; acts as agent of the Board in carrying out such policies.

## **ARTICLE VI: HOME HEALTH CARE SERVICE**

### **Section 1. Establishment**

There is hereby established, as a subdivision of this ~~Hospital~~ District, Tahoe Forest Home Health Service (TFHHS), which shall be primarily engaged in providing skilled nursing services and other therapeutic services such as physical, speech, occupational, medical social, medical nutritional therapy and home health aide services and infusion therapy to patients in their homes.

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; ancestry; color; disability; gender, gender identity, or gender expression; marital status; medical condition; national origin; political affiliation; race; religion; sexual orientation;; veteran status/military service; or genetic information.](#) ~~color, national origin, gender, religion or creed, marital status, age, sexual preference or disability including AIDS and related conditions.~~

## Section 2. Governing Body/Professional Advisory Committee

The governing body of TFHHS shall be the Board of Directors of Tahoe Forest Hospital District (Governing Body). To assist the Governing Body, the Director of TFHHS may appoint a Professional Advisory Committee. The Professional Advisory Committee of TFHHS shall consist of at least the Director of TFHHS, the Medical Director of TFHHS, the Chief Executive Officer, the Director of Quality Management, the Director of Inpatient Services, a registered nurse, appropriate representation from three (3) other professional disciplines, and at least (1) one member of the community at large. The Professional Advisory Committee shall be subject to the control and direction of the Governing Body. Appointments must be made every 2 (two) years.

## Section 3. Policies, Rules and Regulations

Policies, rules and regulations for the [Agency-TFHHS](#) may be adopted from time to time by the Governing Body, after recommendation of such policies, rules and regulations by the Professional Advisory Committee.

# **ARTICLE VII. HOSPICE**

## Section 1. Establishment

There is hereby established, as a subdivision of this [Hospital-District](#), Tahoe Forest Hospice which shall be engaged primarily in providing interdisciplinary health care that is designed to provide palliative care and alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease. Tahoe Forest Hospice provides services directly or through arrangements with other qualified providers. Core services include the following: skilled nursing services, social services/counseling, medical direction, bereavement services, volunteer services, inpatient care arrangements, and home health aide/homemaker services. Other therapeutic services such as physical, speech, occupational, nutritional therapy, respite care and infusion care will also be provided.

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; ancestry; color; disability; gender, gender identity, or gender expression; marital status; medical condition; national origin; political affiliation; race; religion; sexual orientation;; veteran status/military service; or genetic information.](#) ~~color, national origin, gender, religion or creed, marital status, age, sexual preference or disability including AIDS and related conditions.~~

Section 2. Governing Body/Appointment Of Qualified Administrator

The governing body of Tahoe Forest Hospice shall be the Board of Directors of Tahoe Forest Hospital District (Governing Body). The Governing Body assumes full legal authority and responsibility for the operation of the hospice. The Governing Body oversees the management and fiscal affairs of the hospice. To assist the Governing Body, the Board appoints a qualified administrator. The qualified administrator is responsible for organizing and directing hospice functions and maintaining liaison with the Governing Body and the interdisciplinary team. Under the direction of the Governing Body, the qualified administrator arranges for professional services and designates in writing all services provided by the hospice.

Section 3. Policies, Rules and Regulations

Policies, rules and regulations for Tahoe Forest Hospice may be adopted from time to time by the Governing Body, after recommendation of such policies, rules and regulations by the Chief Executive Officer, the qualified administrator, and the Interdisciplinary Hospice Team.

**ARTICLE VIII. TAHOE FOREST HOSPITAL**

Section 1. Establishment

There is hereby established as a subdivision of this ~~Hospital~~-District, Tahoe Forest Hospital (TFH), which shall be primarily engaged in providing Emergency Services, Inpatient/Observation Care, Critical Care, Diagnostic Imaging Services, Laboratory Services, Surgical Services, Obstetrical Services and Long Term Care Services.

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; ancestry; color; disability; gender, gender identity, or gender expression; marital status; medical condition; national origin; political affiliation; race; religion; sexual orientation; veteran status/military service; or genetic information.](#) ~~color, national origin, gender, religion or creed, marital status, age, sexual preference or disability including AIDS and related conditions.~~

Section 2. Governing Body

The governing body of TFH shall be the Board of Directors of Tahoe Forest Hospital District (Governing Body).

Section 3. Policies, Rules and Regulations

Policies, rules and regulations for TFH must be approved by the Governing Body after recommendation of such policies, rules and regulations by the Chief Executive Officer. TFH shall operate under the California Department of Health Services.



**ARTICLE IX. INCLINE VILLAGE COMMUNITY HOSPITAL**

**Section 1. Establishment**

There is hereby established, as a subdivision of this ~~Hospital~~ District, Incline Village Community Hospital (IVCH), which shall be primarily engaged in providing Emergency Services, Inpatient/Observation Care, Radiological Services including Mammography and Ultrasound, Laboratory Services, Outpatient Surgery and Sleep Disorder Services to patients.

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; ancestry; color; disability; gender, gender identity, or gender expression; marital status; medical condition; national origin; political affiliation; race; religion; sexual orientation; veteran status/military service; or genetic information. ~~color, national origin, gender, religion or creed, marital status, age, sexual preference or disability including AIDS and related conditions.~~

**Section 2. Governing Body**

The governing body of IVCH shall be the Board of Directors of Tahoe Forest Hospital District (Governing Body).

**Section 3. Policies, Rules and Regulations**

Policies, rules and regulations for IVCH must be approved by the Governing Body, after recommendation of such policies, rules and regulations by the Chief Executive Officer. IVCH shall operate under the Nevada State Bureau of Licensing.

**ARTICLE X. 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 at the hospital 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 shall be deemed to possess basic qualifications for membership on the Medical Staff. No practitioner shall be entitled to membership on the Medical Staff or be able to exercise particular clinical privileges in the Hospital solely by virtue of the fact that he/she is duly licensed to practice in this or any other state, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at [Tahoe Forest Hospital](#) or another hospital.

### Section 3. Organization and Bylaws.

The Medical Staff shall have the authority to organize itself and to adopt Bylaws not inconsistent with these Bylaws for the government of the Medical Staff.

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 consistent with its Bylaws for the conduct of the Medical Staff in its practice in the Hospital.

The Bylaws and Rules and Regulations 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. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

### 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, rejection or cancellation of any appointment shall rest with the Board of Directors.

Non-Discrimination: It is the policy of ~~the Tahoe Forest Hospital~~ District to not discriminate in admissions, provisions of service, hiring, training and employment practices on the basis of [age; ancestry; color; disability; gender, gender identity, or gender expression; marital status; medical condition; national origin; political affiliation; race; religion; sexual orientation; veteran status/military service; or genetic](#)

~~information, color, national origin, gender, religion or creed, marital status, age, sexual preference or disability including AIDS and related conditions.~~

All applications for appointment 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 specific clinical privileges requested by the practitioner, and the Medical Staff's recommendation concerning these privileges. No duly licensed physician or surgeon shall be excluded from Medical eStaff membership solely because he or she is licensed by the Osteopathic Medical Boards of California and Nevada.

Upon receipt of the report and recommendation of the Medical Staff, the Board of Directors shall take action upon the application by granting or rejecting the same and shall cause notice of its actions to be given to the applicant and to the Medical Staff. Whenever the Board of Directors does not concur in a Medical Staff recommendation relative to clinical privileges, the matter will be referred to the Joint Conference Committee for review before final action is taken by the Board of Directors.

#### 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 ~~and~~ through ~~809-8809.9~~, inclusive. The rules relating to appeals to the Board of Directors as set forth in the Medical Staff Bylaws are as follows:

A. Time For Appeal Within fifteen (15) days after receipt of the decision of the Judicial Review Committee, either the practitioner or the Executive Committee may request an appellate review. A written request for that review shall be delivered to the Chief of Staff, the Chief Executive Officer and the other party in the hearing. If a request for appellate review is not presented within that period, both parties shall be deemed to have waived their rights to appeal. Thereafter, the Board of Directors shall consider whether to accept the Judicial Review Committee decision as the final decision of the District or to initiate an appellate review by its own action. If the Board of Directors votes to initiate an appellate review, the Board of Directors shall consider the matter as an appeal in accordance with this Article. Its decision following that appeal shall constitute the final action of the District.

B. Grounds For Appeal A written request for an appeal shall include a specification of the grounds for appeal and a concise statement of the arguments in support of the appeal. The grounds for appeal from the hearing shall be: (1) substantial and material failure to comply with the procedures required by these Bylaws or applicable law for the conduct of a hearing; (2) the decision was not supported by substantial evidence in the hearing record.

C. Time, Place and Notice If an appellate review is to be conducted, the appeal board shall, within thirty (30) days after receipt of notice of appeal, decide upon the specific procedures to be followed and endeavor to advise each party. The date for completion of the appellate review shall not be fewer than thirty (30) days nor more than sixty (60) days from the date of such receipt of that notice, provided, however, that when a request for appellate review concerns a member who is under suspension or restriction which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the Board of Directors or its Chair for good cause.

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

E. Appeal Procedure The proceeding by the appeal board shall be in the nature of an appellate review based upon the record of the hearing before the Judicial Review

Committee, provided that 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 Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing; or the appeal board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his/her position on appeal. During the appeal, each party or representative shall have the right to appeal-appear personally before the Board of Directors or the appeal board, for the purpose of presenting oral argument and responding to questions in accordance with procedures to be established by the Board of Directors or appeal board. Each party shall have the right to be represented by an attorney or by any other designated representative during that appearance. The Board of Directors or the appeal board shall determine the procedures to be observed during that meeting and shall determine the role of legal counsel. The appeal board may then conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

F. Decision

1. Except as otherwise provided herein, within thirty (30) days after the conclusion of any appellate meeting, the Board of Directors shall render a decision in writing and shall transmit copies thereof to each side involved in the appeal. The Board's decision shall be final.

2. The Board of Directors may affirm, modify, or reverse the decision of the Judicial Review Committee or remand the matter to the Judicial Review Committee for reconsideration. If the matter is remanded to the Judicial Review Committee for further review and recommendation, that Committee shall promptly conduct its review and issue any appropriate decision and report.

G. Right To One Hearing No member or applicant shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

H. Review Initiated By Board of Directors

1. Notice of Action In the event neither the person who requested the hearing before the Medical Staff Judicial Review Committee nor the body whose decision prompted the hearing requests an appeal according to this Article, the decision of the Judicial Review Committee shall be delivered to the Chief Executive Officer for transmittal to the Board of Directors.

2. Board of Directors Review The Board of Directors may, at any time within

fifteen (15) days of such delivery, initiate appellate review. The procedures for such review shall be as set forth in Subsections A through G above, substituting the date of action by the Board of Directors initiating appellate review for the date of Notice of Appeal.

#### **ARTICLE XI. AUXILIARY**

The Auxiliary organizations shall be known as the "Tahoe Forest Hospital Auxiliary" and the "North Lake Tahoe Community Health Care Auxiliary." The Bylaws of the Auxiliaries shall be approved by the Board of Directors.

#### **ARTICLE XII. REVIEW AND AMENDMENT OF BYLAWS**

Section I 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 28<sup>th</sup> 25<sup>th</sup> day of September 2010 November 2014.

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#### **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





**September 16, 2014**

**TO:** TFHD Board of Directors

**FROM:** Laurence J Heifetz, MD

**SUBJECT:** Cancer Program Update

**SUMMARY:**

The Tahoe Forest Cancer Program has been a remarkably successful endeavor since being started in 2006.

**ACTION REQUESTED**

- Policy review and approval

**DISCUSSION**

This presentation will address:

- Timeline of key events since start of program in 2006
- Number of patients seen since 2006
- Systems addressing fears amplified in rural setting
- Psychosocial services review
- UC Davis relationship
- Virtual Tumor Board program
- Clinical trials program
- Radiation therapy program
- Sierra Crest Initiative
- Peer reviewed journal publications
- Future plans



Gene Upshaw Memorial  
Tahoe Forest Cancer Center

# Cancer Program Timeline

- 2006
  - First patient seen (shared space)
- 2008
  - Opened 4-chair cancer center in MOB
  - Joined UC Davis Cancer Care Network
- 2010
  - Dr. Ahrin Koppel, Hematology & Med Oncology
- 2012
  - Dr. Daphne Palmer, Radiation Oncology
  - Opened Gene Upshaw Memorial Tahoe Forest Cancer Center
- 2013
  - Dr. Melissa Kaime, Hematology & Med Oncology
  - Sierra Crest telemedicine clinics
  - ACOS accreditation with commendation
- 2014
  - Radiation oncology residency program (UC Davis)

# We see everyone

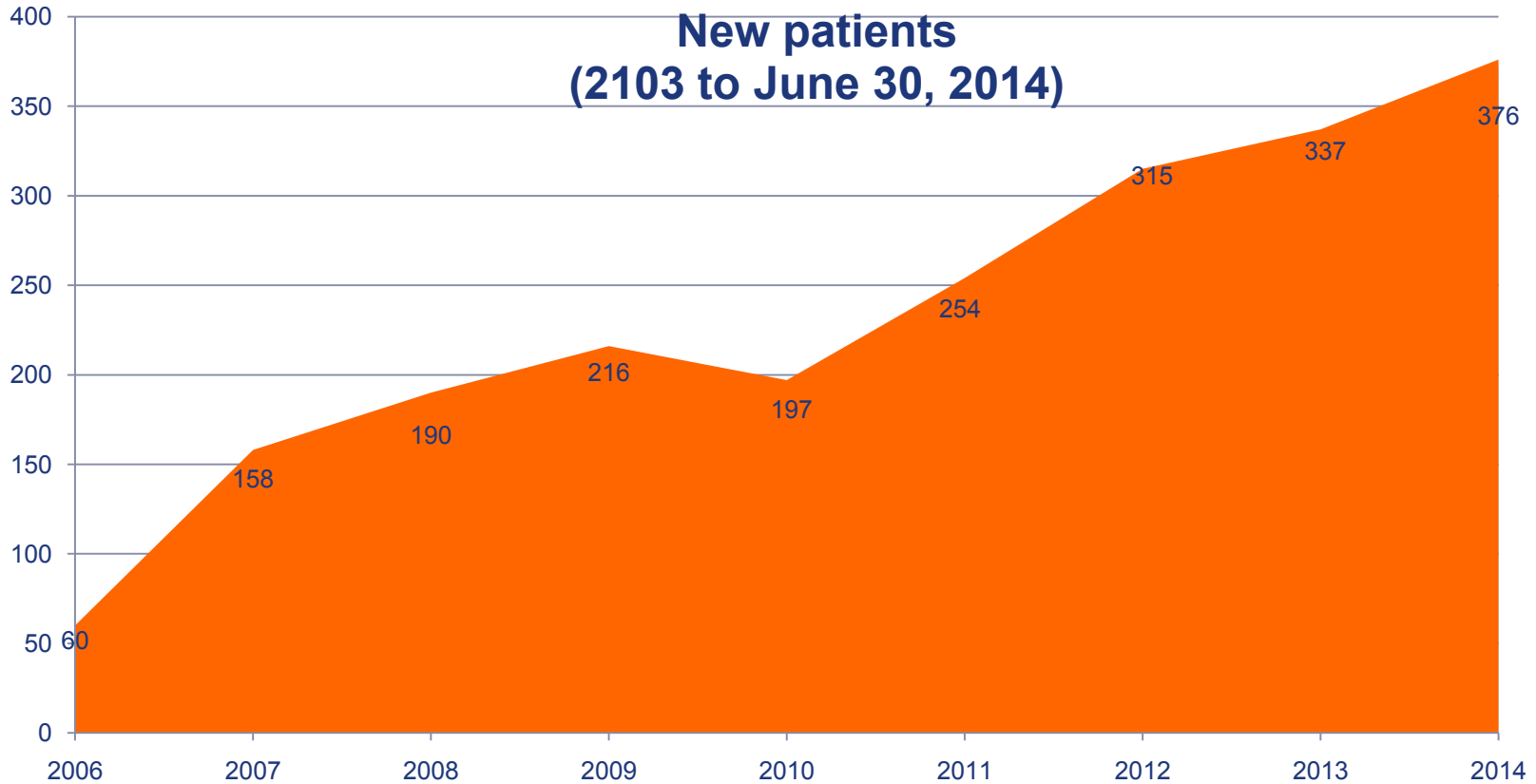
- All insurance plans accepted by the Tahoe Forest Multispecialty Clinics
- Medicare
- Medi-Cal
- Covered California
- No-Cal

# Nobody can afford to get cancer!

- Two systems for cancer patients and doctors in USA
  - Free standing (private practice) - controlled access
  - Hospital based (salaried, MSC, foundation) - open access
- Chemotherapy charges
  - Free standing 2-3 x cost of drugs
  - Hospital based 4-5 x cost of drugs
- True cost differential to the patient – zero!
  - Free standing – patient reaches annual maximum by Feb 1
  - Hospital based – patient reaches annual maximum by Jan 21
- Earnings to oncologists
  - Hospital based MD's earn 40% less than private practice MD's
  - “900 independent oncology practices in the USA have closed, been acquired by a hospital or merged with another entity in the past 7 years”

HemOnc Today 10/10/14, v15, n19

# Increasing area under the curve



# An increasing Medicare population

60% of patients > 65 years old

## **Bracing for the Silver Tsunami**

Is Tahoe/Truckee Prepared for An Aging Population?

- Melissa Siig, Moonshine Ink
- August 8, 2014

# Universal fears from a cancer diagnosis

- Death
- Pain
- Disability



# Fears amplified in rural setting

- Disorganized care
- Unreasonable burden on family & caregivers
- Getting yesterday's therapy

# Disorganized Care

- Falling through the cracks
- “My docs don’t all know what’s happening to me”
- Navigating the labyrinths of:
  - Staging
  - Therapy
  - Survivorship

# Omnipresent & Human Technology

- Electronic Medical Record
  - Automatic Flow Sheets
  - Demonstrate ease of auto faxing to all docs
- Online access to PACS system
  - Explaining diagnostic imaging to patients
  - Comparing DI images from multiple sources
- Nurse navigator

# Burdens on Family & Caregivers

- Integrated Patient and Family Services Program
- PhD Psychologist led team
- From Cancer to Health Program (C2H)
- Exercise for Energy
- Group & Individual Therapy
- Art Therapy, Music therapy
- Massage, Acupuncture, Biofeedback
- “Road to Recovery”, “Look Good...Feel Better”
- “We Care” – peer navigators (patients & caregivers)

# New cancer treatment patients seen by a clinical psychologist

- National average
  - 15%
- Tahoe Forest
  - 97%

# Getting Yesterday's Therapy

- Academic affiliation
  - UC Davis Comprehensive Cancer Center
- Clinical Trials
  - SWOG, ECOG, NRG, ALCMI, Ohio State
  - UC Davis IRB
- Tumor Boards
  - Virtual Tumor Boards
  - Monthly Cancer Conference

# NCI Designated Cancer Centers (9)

So. California	No. California	Nevada
UCLA	UC Davis	
USC	UCSF	
City of Hope	Stanford	
UC Irvine		
UC San Diego		
Salk Institute		

# NCI Designated Comprehensive Cancer Centers (7)

So. California	No. California	Nevada
UCLA	UC Davis	
USC	UCSF	
City of Hope		
UC Irvine		
UC San Diego		



# UC DAVIS Cancer Care Network



**UC DAVIS**  
COMPREHENSIVE  
CANCER CENTER



Rideout  
Cancer Center



Mercy  
Cancer Center



Gene Upshaw Memorial  
Tahoe Forest  
Cancer Center



AIS Cancer Center at San  
Joaquin Community Hospital

# The 80/20 Rule of Life

- 20 major cancer sites
- 4 (20%) of them comprise 80% of the patients
  - Colorectal
  - Prostate
  - Lung
  - Breast
- First manage these properly
- Remaining cancers will automatically be served

# The 80/20 Rule of Life

- 20 major cancer sites
- 4 (20%) of them comprise 80% of the patients
  - **Colorectal - Monday**
  - Prostate
  - Lung
  - Breast
- First manage these properly
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# The 80/20 Rule of Life

- 20 major cancer sites
- 4 (20%) of them comprise 80% of the patients
  - **Colorectal – Monday**
  - **Prostate - Tuesday**
  - Lung
  - Breast
- First manage these properly
- Remaining cancers will automatically be served

# The 80/20 Rule of Life

- 20 major cancer sites
- 4 (20%) of them comprise 80% of the patients
  - **Colorectal – Monday**
  - **Prostate - Tuesday**
  - **Lung - Wednesday**
  - Breast
- First manage these properly
- Remaining cancers will automatically be served

# The 80/20 Rule of Life

- 20 major cancer sites
- 4 (20%) of them comprise 80% of the patients
  - **Colorectal – Monday**
  - **Prostate - Tuesday**
  - **Lung - Wednesday**
  - **Breast - Thursday**
- First manage these properly
- Remaining cancers will automatically be served

# Virtual tumor boards: community–university collaboration to improve quality of care

Richard J. Bold, MD,<sup>1</sup> Marlene M. von Friederichs-Fitzwater, PhD, MPH,<sup>2</sup>  
Joel Kugelmass, BA,<sup>4</sup> Laurence J. Heifetz, MD,<sup>5</sup> Scott Christensen, MD,<sup>2</sup>  
Ralph deVere White, MD,<sup>3</sup> and Frederick J. Meyers, MD<sup>2</sup>

Departments of <sup>1</sup>Surgery, <sup>2</sup>Internal Medicine, <sup>3</sup>Urology, UC Davis Medical Center, <sup>4</sup>Administrative Support Unit, UC Davis Cancer Center, Sacramento, California; <sup>5</sup>Department of Medical Oncology, Tahoe Forest Health System, Truckee, California

**Objective** To develop and implement virtual interactive multidisciplinary cancer tumor boards (VTBs), created through telemedicine links between the University of California, Davis Cancer Center and community-based cancer care providers. The goal of this project was to facilitate communication among community and academic cancer specialists.

**Materials and methods** Four geographically remote sites were selected to participate with established disease-specific tumor boards of the UC Davis Cancer Center. Telemedicine links were created using dedicated T1 lines, and PolyCom HDX 9000 was used by the center for teleconference hosting. Participants were then surveyed on their perception of the benefit of VTBs.

**Results** The results across disease-specific virtual tumor boards show that most of the participants reported that the right amount of clinical information on the cases was presented and that new information was discussed that helped providers manage the care of the patients.

**Conclusions** Teleconferencing of disease-specific tumor boards allowed providers in a geographically remote group of providers to make prospective, case-based treatment decisions that increased their knowledge of treatment options and facilitated their decision making. This transfer of knowledge and experience speeds up the dissemination of rapidly evolving cancer care, which could lead to higher quality patient outcomes.

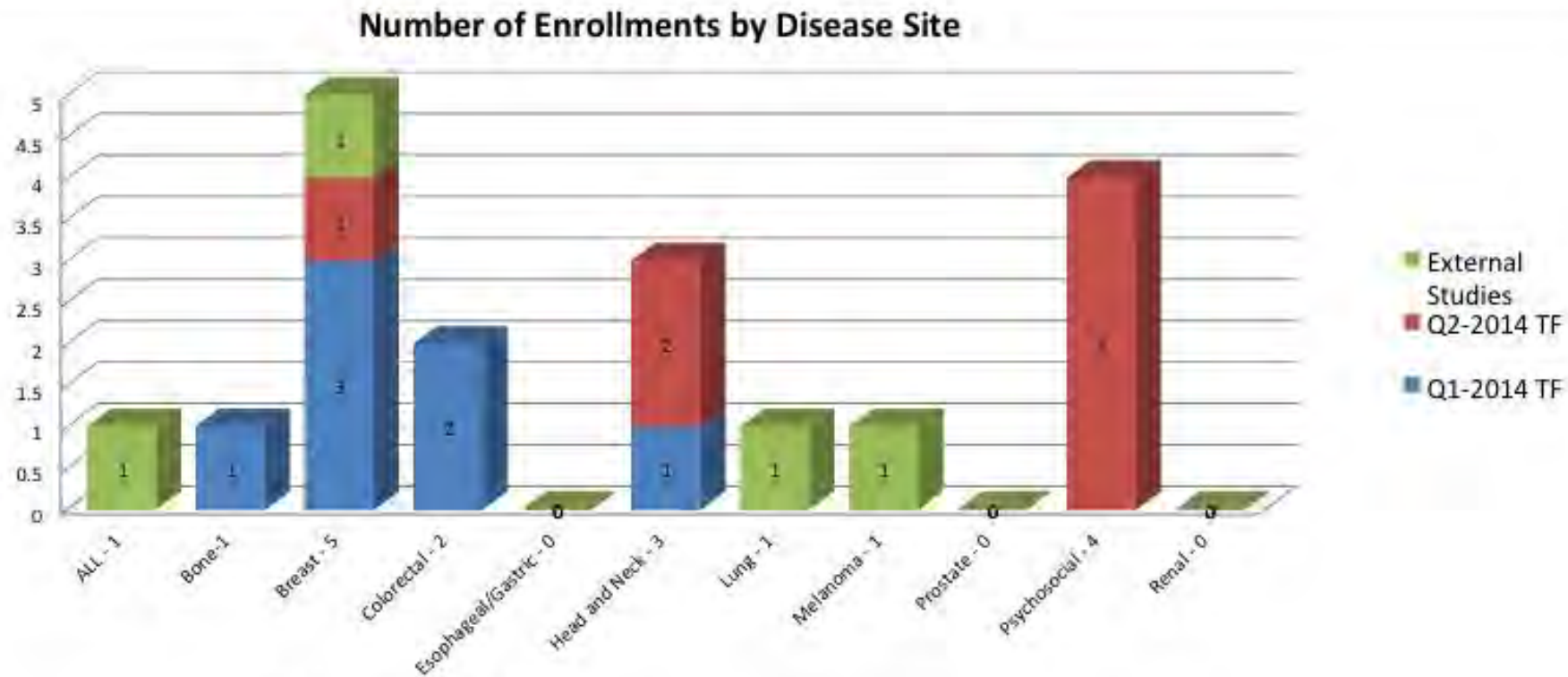




# Clinical Trials

- Essential element of a quality program
- Average accrual rate for community oncology programs
  - 3.5%

# Clinical trial accrual (10.5%)



Total New Enrollment: 18

% of Analytic Patients Accrued to Clinical Trials: 10.5%, 18 of 171 patients

COC Minimum Required Percentage Accrual to Clinical Trials: 2%

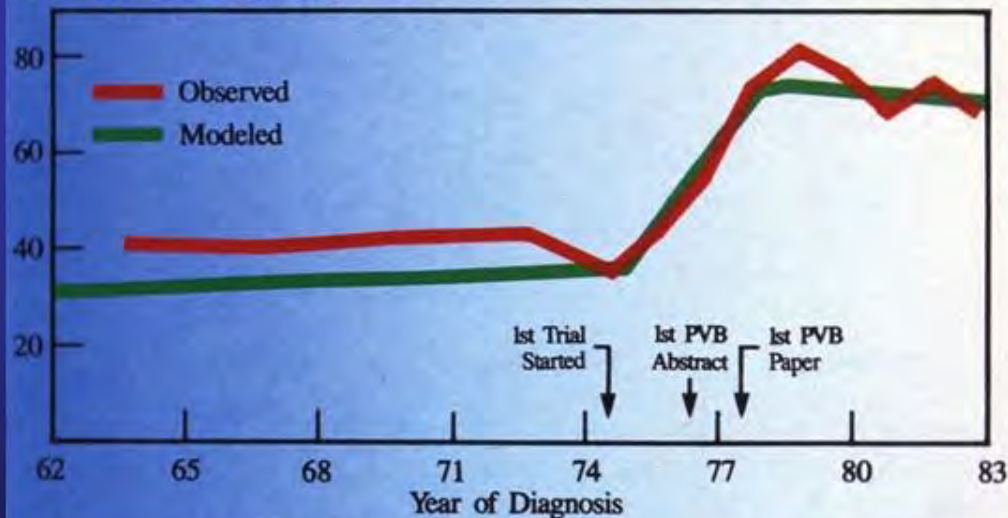
Commendation Percentage Accrual to Clinical Trials: 4%

## Stat Bite

# Impact of Combination Chemotherapy for Advanced Testicular Cancer

In advanced testicular cancer, 18-month survival is an early indicator of effective treatment. In the mid-1970s, a new combination chemotherapy regimen (PVB) showed excellent results against this cancer in clinical trials. During this period, 18-month cause-specific population survival increased dramatically and then leveled off. Statistical modeling shows the impact of improved treatments took 3 years. Survival started to increase even before publication of the PVB trial's results, and may be associated with moderately successful "precursor" trials.

Percent Survival (18-month)



Source: Connecticut Tumor Registry and SEER  
Citation: *J. Clin. Epidemiol.*, 1991; 44: 141

— By Eric J. Feuer, Ph.D.

# Active Clinical Trials (UC Davis)

- Colorectal (2)
- Esophageal (1)
- Prostate (3)
- Kidney (1)
- Lung (3)
- Breast cancer (3)
- Head & Neck (1)

# From Cancer to Health (C2H Trial)

- Ohio State University (Lead site)
- Indiana University
- Baylor University
- University of Texas Southwestern
- East Alabama Medical Center
- Tahoe Forest Cancer Center

# Addario Lung Cancer Medical Institute (ALCMI)

- Scientific Review Board
  - UC Davis, Ohio State, Yale, U Torino
- Participants
  - Beth Israel, Boston
  - Catalan Institute, Barcelona
  - Dana-Farber, Boston
  - USC
  - U Colorado
  - UCSF
  - UCLA
  - U Michigan
  - U Kentucky
  - U Pittsburgh
  - Tahoe Forest

# Radiation as primary therapy

- Rectal (combined modality pre-op)
  - Possible conversion to sphincter saving procedure
- Lung (combined modality)
  - Improves surgical cure rate (Stage II – IIIA)
- Prostate
  - Alternative to radical prostatectomy
  - Lower impotence and incontinence rates
- Breast
  - Alternative to mastectomy
  - Breast conservation

# Modified radical mastectomy



Breast

Pectoralis minor

Axillary sentinel  
node biopsy



# Breast conservation



Radiation therapy details:

- 15 minutes/day
- 5 days/week
- 7 weeks

Closest unit – Reno

- 1.5 - 2.5 hours RT
- 30 minute treatment delays
- 2 - 3 hours/day

**Unnecessary burden for  
working women**

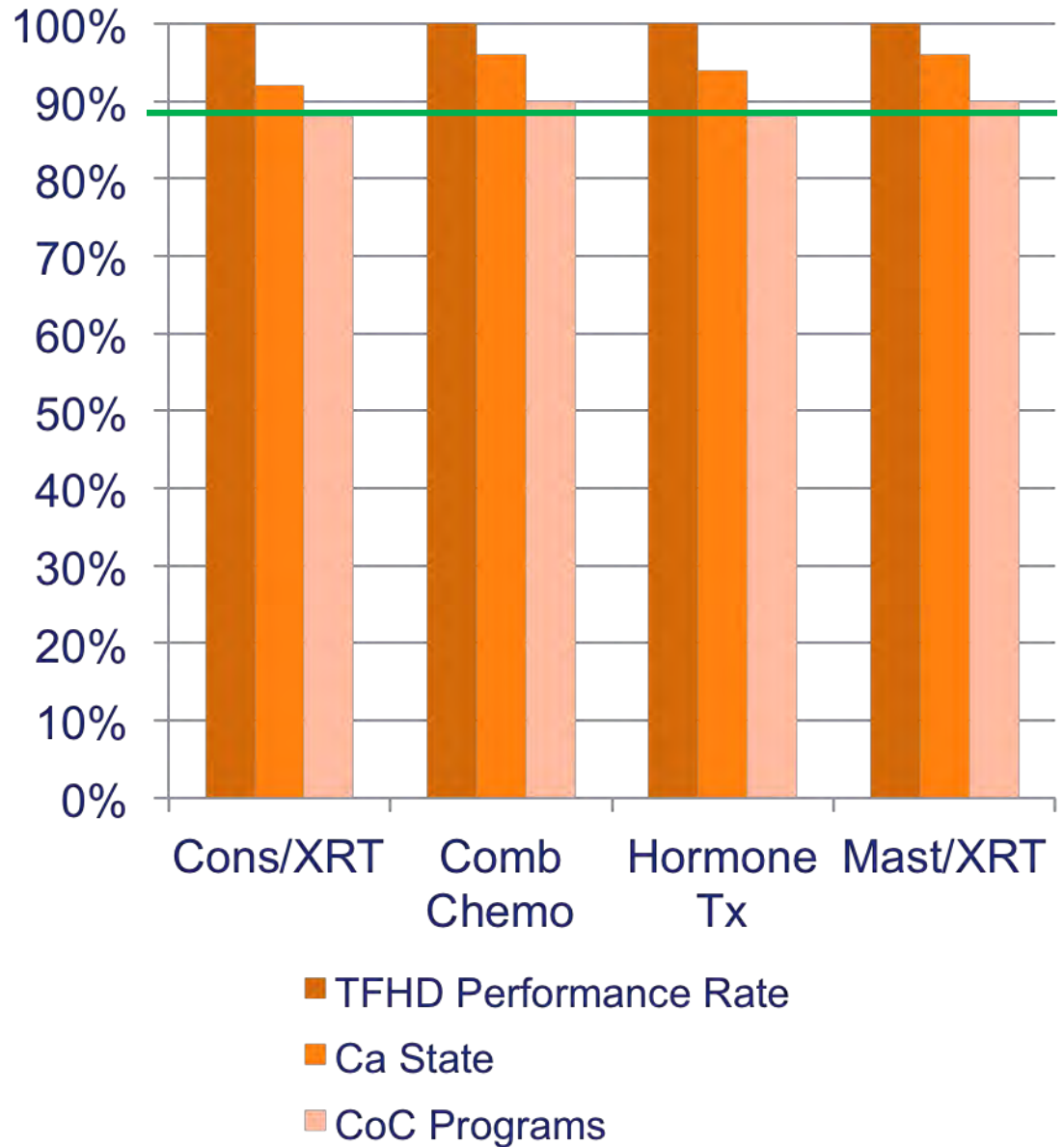
# Tahoe Forest Cancer Program

## Breast Cancer Management

**2011-2013 Quality Outcome Measures utilized for Best Practice and Reimbursement by the following monitoring agencies:**

- CoC – Commission on Cancer
- NQF – National Quality Forum
- CMS – Centers for Medicare & Medicaid Services

Best Practice: Outcome must be maintained at least 90%.



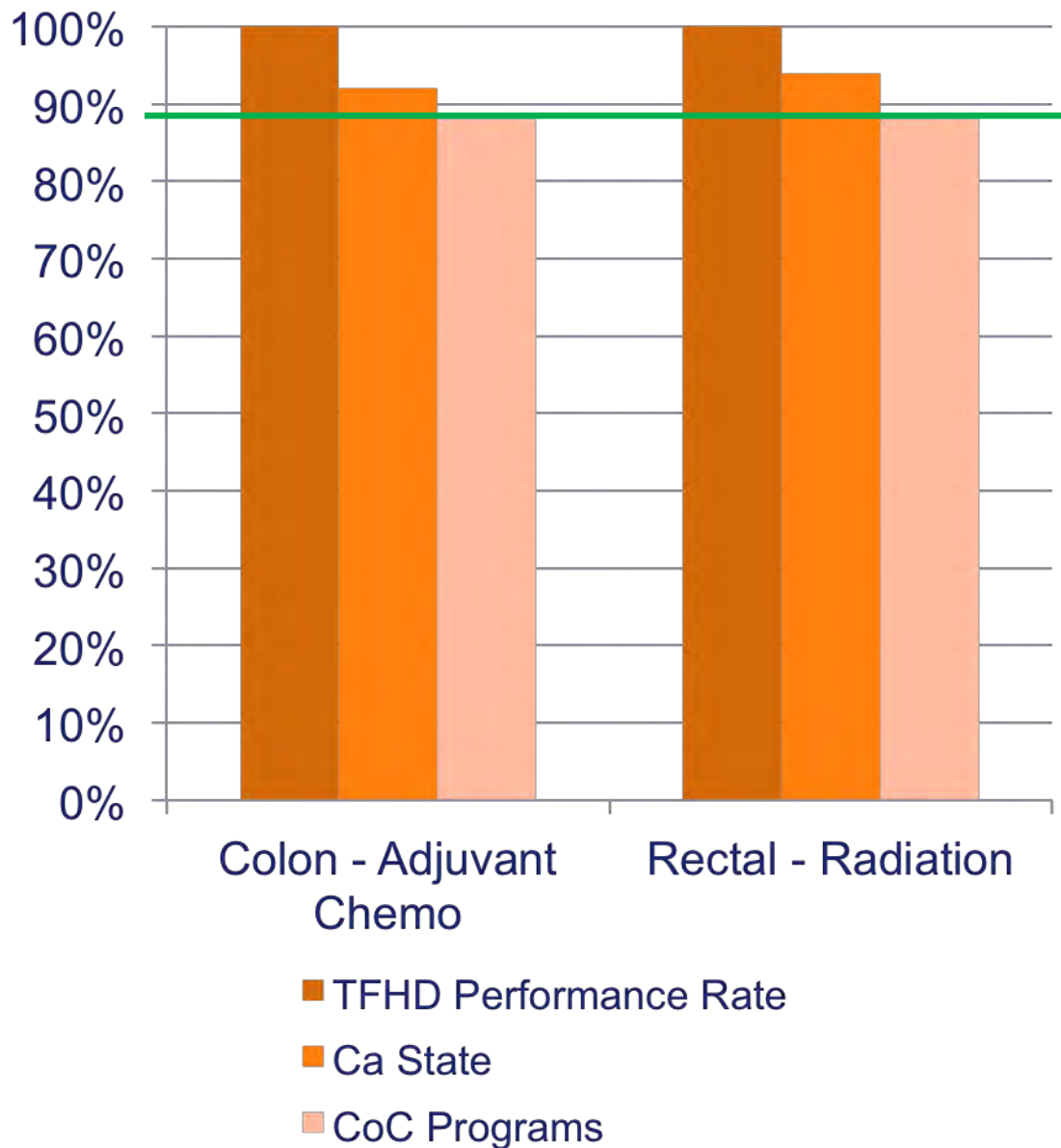
## Tahoe Forest Cancer Program

### Colon & Rectal Cancer Management

**2011-2013 Quality Outcome Measures utilized for Best Practice and Reimbursement by the following monitoring agencies:**

- CoC – Commission on Cancer
- NQF – National Quality Forum
- CMS – Centers for Medicare and Medicaid Services.

Best Practice: Outcome must be maintained at least 90%.



July 2014

# ASCO<sup>®</sup> connection

The official member magazine of the American Society of Clinical Oncology • [ASCOconnection.org](http://ASCOconnection.org)



The Society's  
Mission to  
**Reduce  
Cancer Health  
Disparities**

10



2012

St. Mary's (2)

Renown (3)

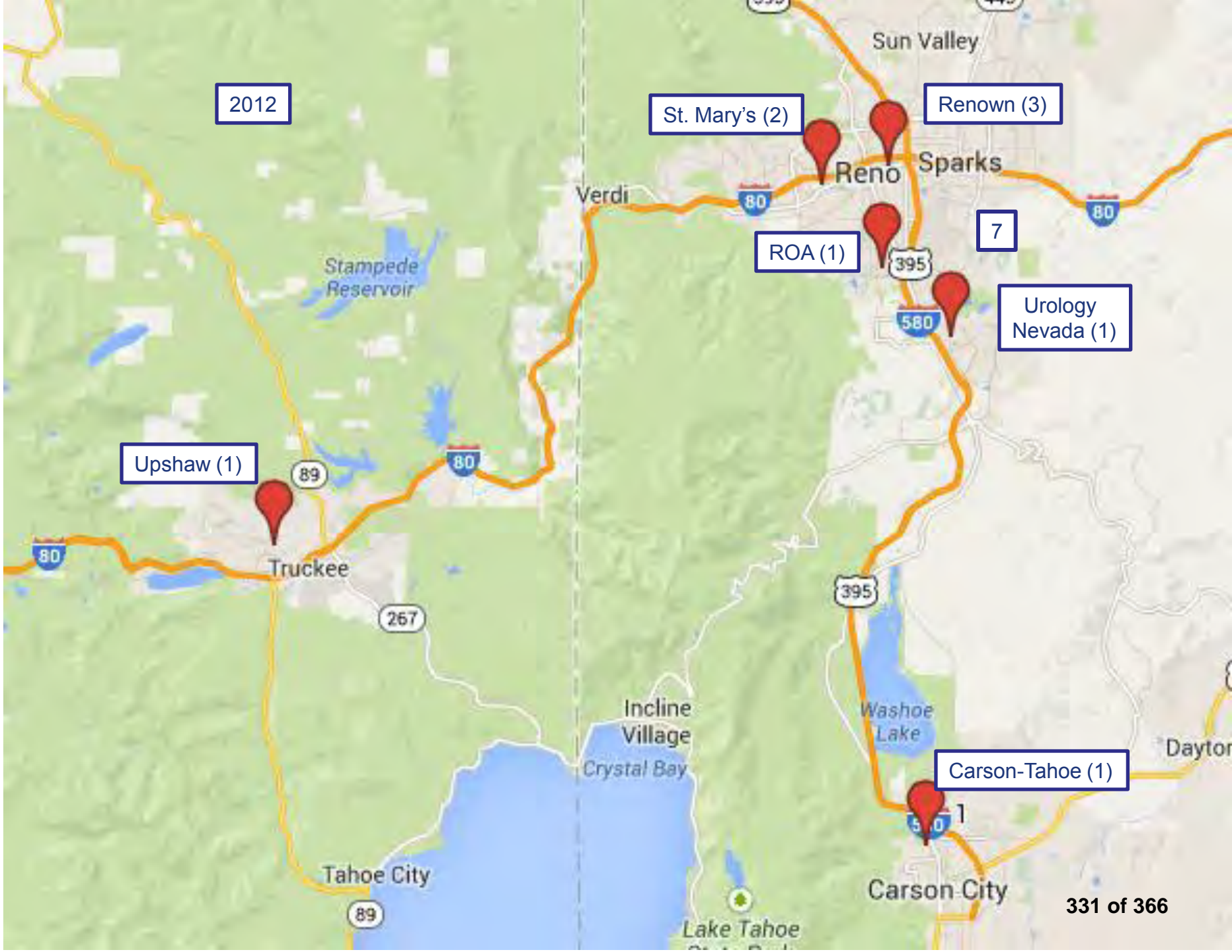
ROA (1)

7

Urology Nevada (1)

Upshaw (1)

Carson-Tahoe (1)



2013

Upshaw (1)

St. Mary's (2)

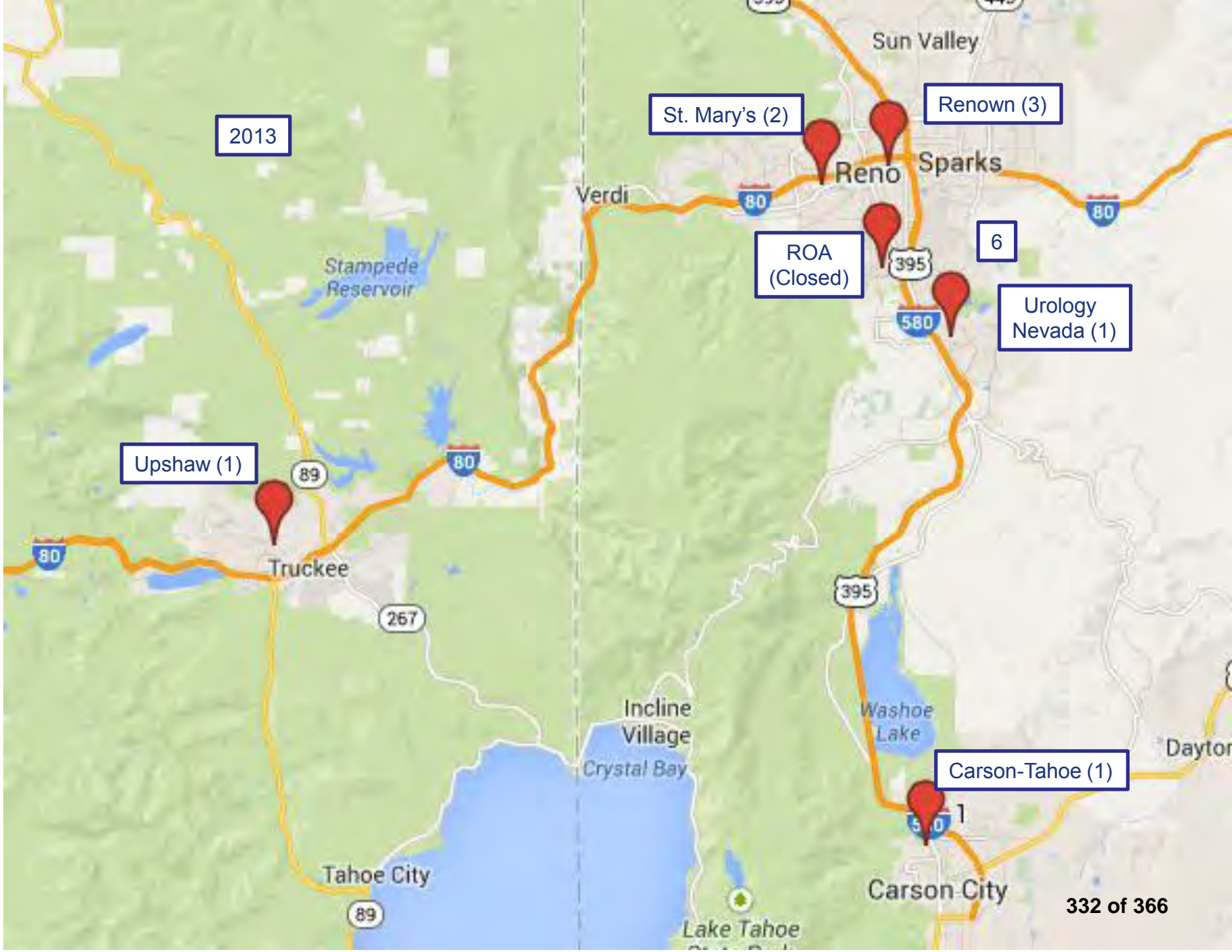
Renown (3)

ROA  
(Closed)

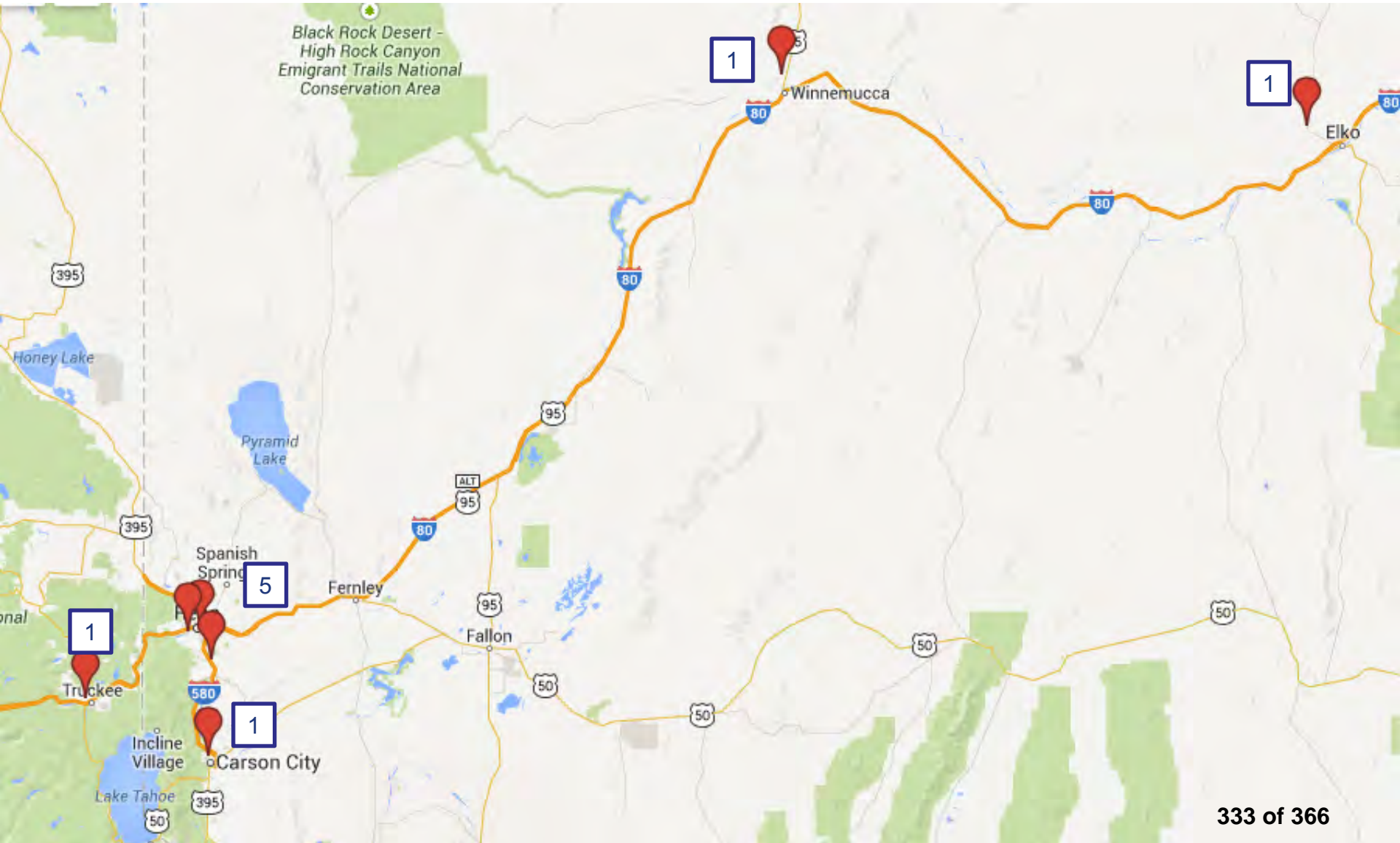
6

Urology  
Nevada (1)

Carson-Tahoe (1)



# Proper action to address disparities

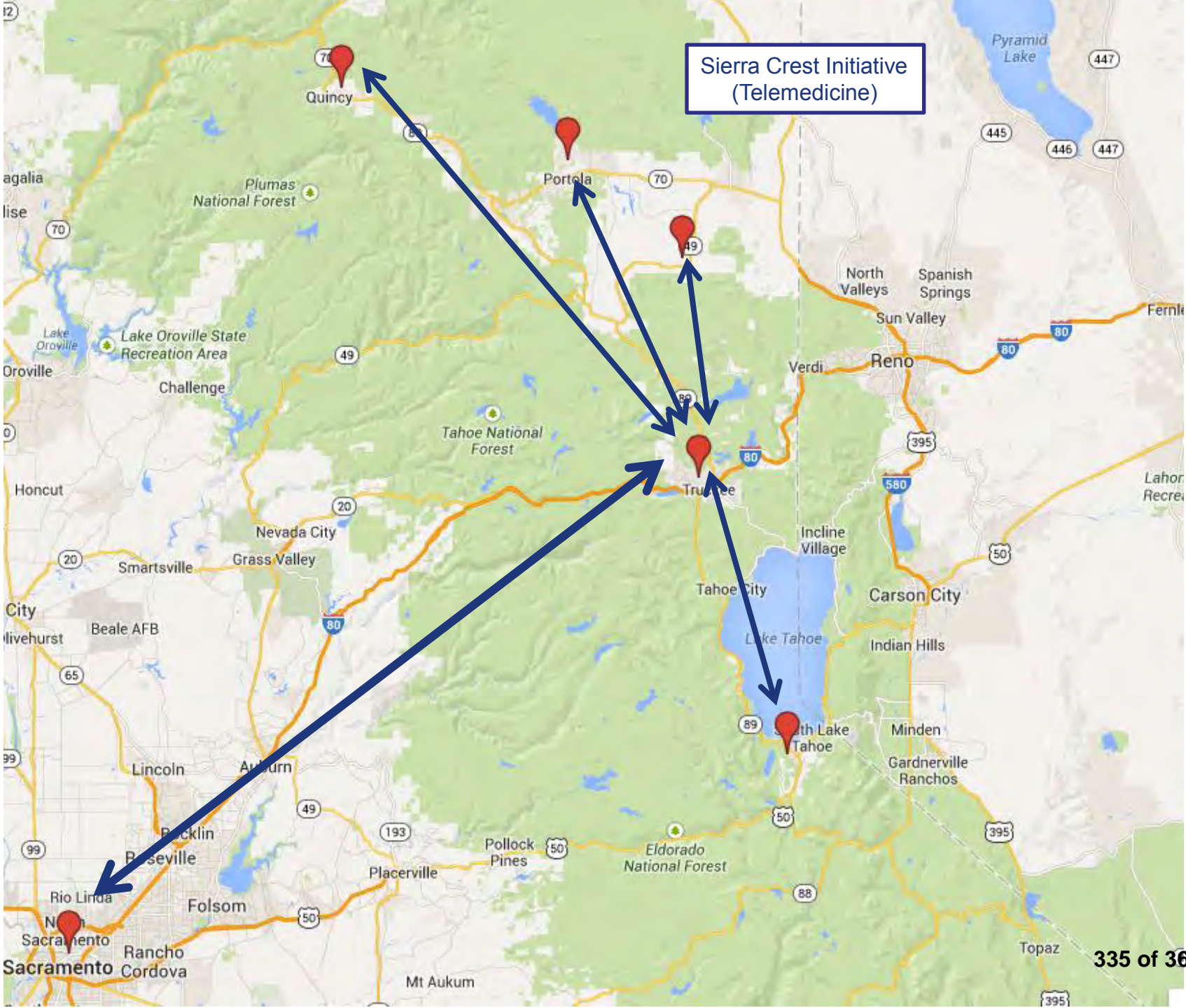


# Helping our Rural Neighbors (Sierra Crest Initiative)

- Enhance local functionality
- Maintain financial viability
- Improved use of mid-level providers
  - NP's, PA's
- Telemedicine & Technology
  - Remote office visits
  - Integration of diagnostic imaging
  - Integration of laboratory studies



Sierra Crest Initiative  
(Telemedicine)



## A Model for Rural Oncology

*By Laurence J. Heifetz, MD, FACP, Scott D. Christensen, MD, Ralph W. deVere-White, MD, and Fredrick J. Meyers, MD, MACP*

Tahoe Forest Cancer Center, Truckee; University of California, Davis Cancer Center, Sacramento, CA

### Abstract

Small rural hospitals in the United States have had challenging issues developing sustainable oncology programs. This is a report on the development of a successful rural oncology program. In 2006, the Tahoe Forest Health System in Truckee, CA, a remote mountain resort town, started a cancer program that was focused on addressing patient and family fears that are common

to all cancer patients but more frightening in the rural setting. Four years later, it is a thriving program with significant community support, a creative academic affiliation, and a central focus of the future of the hospital. The Tahoe Forest Cancer Center developed a sustainable model for high quality cancer care that overcomes geographic, cultural and financial barriers. This structure may serve as a model for national rural health care.

# *15<sup>th</sup> Annual* **Advances in Oncology 2014**

**October 10-11, 2014**  
**Hyatt Regency | Sacramento, CA**

(The October 10th conference is held at the Cancer Center Auditorium  
UC Davis Comprehensive Cancer Center)

## CONFERENCE DIRECTORS

*Helen K. Chew, M.D.*

Professor of Medicine  
Division of Hematology and Oncology  
Department of Internal Medicine  
UC Davis School of Medicine

*Primo Lara, Jr., M.D.*

Professor of Medicine  
Division of Hematology and Oncology  
Department of Internal Medicine  
UC Davis School of Medicine

## PRESENTED BY

**UC DAVIS**  
**COMPREHENSIVE**  
**CANCER CENTER**

## SPONSORED BY:

**THE MEDICAL EDUCATOR**  
**CONSORTIUM**

# Active program development

- Urology program (Prostate CA – 20%)
- Develop an appropriate portion of 2<sup>nd</sup> floor
  - General surgery
  - ENT
  - GI
  - Urology
- Explore potential expansion to Barton

# “Teamwork makes the dream work”

- Tahoe Forest Medical Staff
- Tahoe Forest Board & Administration
- Cancer Advisory Council
- Interdepartmental relationships at TFH
- UC Davis leadership and medical staff
- UC Davis Cancer Care Network
- Barton Memorial, Plumas District,  
Eastern Plumas District
- Cancer Center Staff

# Believe in your future, ...not your past

- Rural community with basic medical services
- One hour to the nearest mid-sized city with excellent medical care
- Two hours to the state capitol with a state university medical school
- Absolute commitment to quality
- Ability to rapidly adapt to change
  
- **The Mayo Clinic**

# Believe in your future, ...not your past

- Rural community with basic medical services
- One hour to the nearest mid-sized city with excellent medical care
- Two hours to the state capitol with a state university medical school
- Absolute commitment to quality
- Ability to rapidly adapt to change
  
- **Model for Rural Oncology**

## MEMORANDUM

**TO:** Board of Directors

**FROM:** Bob Schapper, Chief Executive Officer

**SUBJECT:** Chief Executive Officer Report – September

**DATE:** October 21, 2014

### Overview

Financial performance for the month of September was below plan. Income from operations (EBIDA) was (\$392,311) for the month compared to a budget of (\$224,429). However, first quarter earnings from operations (EBIDA) were favorable, \$3,469,187, compared to a budget of \$600,526, or \$2,868,661 ahead of plan. Net income for the first quarter was \$2,768,663 compared to the budget of \$547,595, or \$2,221,068 ahead of plan.

For the first quarter of the fiscal year the health system out performed budget by over 400%, and by nearly 43% over the same period last year. This performance is noteworthy given that the second quarter is typically a slow period for the health system.

Notwithstanding the strong first quarter performance, payer mix continues to change. Volumes for the most recent quarter have experienced the largest growth in Medicare as a percent of business in our recent history. Both Medicare and MediCal volumes are growing while the health system is experiencing a decrease in commercial volumes. This trend will require continued vigilance in expense management and will force new levels of delivery redesign, as these factors will have a very detrimental impact on future earnings.

### TFH Facility Development Plan

The final phase of the Measure C projects began the first week of October with the demolition of the original 1952 building.

### TF 2020 - EMR Project

The CPSI Point of Care phase implementation began in September. The process of transitioning to the Point of Care EMR applications has gone very well. The physician component of the installation begins on a phased plan by specialty in November.

CPSI has shared with management that the Tahoe Forest Hospital/IVCH Point of Care install has been the best CPSI install in the company. This is highly complementary to our staff and the pre-installation preparation teams. Barb Thomas, Clinical Program Administrator, has been asked to present at a future CPSI conference on this topic. This is a great honor and recognition for Ms. Thomas, her leadership on this project, and the work of all of our team members.



Mr. Jake Dorst, our new Chief Information Officer, will be providing a brief update to the board on our progress with CPSI at the October board meeting.

#### Wellness Neighborhood

The Community Needs Assessment is in final form. The results of the assessment will be shared in a formal presentation to the board of directors. This special board meeting is tentatively scheduled for the second week in December.

#### Operational Improvement Plan

The Revenue Cycle Performance Improvement Project continues to produce excellent results. Days in Accounts Receivable are down to 63.1 at the end of September. Days Cash On Hand has grown to 162 days at month end.

Jacobus is scheduled to provide its quarterly update to the finance committee at its October meeting. As noted in previously presentations by Jacobus, the Tahoe Forest Health System conversion is going very well. The revenue cycle process improvement component of this project, which is a typical initiative associated with all hospital EMR system transitions, is proceeding ahead of what would be considered normal for complex system transitions of this nature.

#### Orthopedic Advisory Council (OAC)

The business subcommittee continues to meet to assess potential business models and evaluate the possibility of developing a consolidated facility for orthopedics, sports medicine, rehabilitation services and other adjunct human performance programming.

Management is working closely with the North Tahoe Orthopedic Group physicians to study the potential of developing a co-management model for orthopedics and sports medicine. This model will facilitate closer collaboration with the orthopedic and sports medicine providers and enable more aggressive options to manage cost and bundle pricing for total joint procedures.

Dan Coll has been appointed the director for the orthopedic and sports medicine service line. Management has also engaged the services Mr. John Hawkins the former orthopedic service line director at Eisenhower and Renown Medical Centers to assist our process with this assessment.

These projects are all progressive initiatives evolving out of the work of the many community leaders and providers participating in the Orthopedic Advisory Council (OAC). The goal of this committee is to identify options to advance orthopedic, sports medicine, and human performance programming in a manner that enhances current service levels and differentiates our health system and partners as a national leader in this area of programming.

October 2014

**Chief Operating Officer**

**Virginia Razo, Pharm D, DSc**

Radiology and Technology Evaluation

Tomosynthesis:

Mr. Stokich, Director of Diagnostic Imaging and Patient Registration, and Dr. Mohr, MD. will be attending the Radiological Society of North America (RSNA) conference in November to assess emerging technology for Diagnostic Imaging and specifically Tomosynthesis, a recent advancement in mammography services that will likely become standard of care. If Dr. Mohr and his colleagues believe this advanced technology will become standard in the industry and will benefit the community for mammography services in the future, education will be provided to the medical staff and a business plan will be completed and submitted to the Board of Directors for consideration for next fiscal year (FY).

Dietary Services

Recruitment for Director of Dietary Services:

Since the departure of Neal Nadeau in September 2014, Margaret Holmes, previous Director of Dietary Services for the past 38 years, has graciously stepped back into the role of Interim Director of Dietary Services. Human Resources and I have worked with the managers and staff in the department to define specific skill sets and key attributes we seek as we recruit a full time Director for the department. We will be engaging the management team and staff in the interview process and are hoping to select a candidate in the coming months.

Quality

Health System Quality Metrics:

Tahoe Forest Health System recognizes the need to benchmark itself against external entities to differentiate itself in the market place and meet the expectations of patients and payers regarding the quality of care it provides. To that end, the quality department has been working to define new quality metrics for the Hospitalist program, Orthopedics and Sports Medicine and Multi-specialty Clinics. These metrics will be incorporated into the overall Health System's quality program and reported to the Med Staff Quality Committee on a quarterly basis and incorporated into the overall Health System reporting structure.

Cost Reduction Strategies

1-800-WeAnswer

Mr. Stokich, Director of Diagnostic Imaging and Patient Registration, has been working to improve phone services with a Private Exchange Branch Operator (PBX- Operator) and reduce the cost of these services to the District. TFHD entered into an Agreement with 1-800-WeAnswer to answer phone calls on behalf of TFH and IVCH. While we believe we will reduce annual operating expenses by approximately \$48,000, as a result of taking advantage of natural attrition in the Registration department, no positions will be eliminated. This service will also ensure that non-English speaking individuals will be able to speak with the language of their choice, a situation that was not easily accomplished with the main hospital lines being answered by registration staff that is not all multi-lingual.

Language Line:

Tahoe Forest Health System (TFHS) is required to provide translation services to patients in their native language. For many years, TFHS contracted with a local provider to provide these services on site; however, with the resources available we were unable to meet the

requirements of the Centers for Medicare and Medicaid Services (CMS) in that we did not have immediate access to all languages. In early 2014, Mr. Stokich received notice from the local provider that they would no longer be able to provide services to the Health System. Mr. Stokich worked to leverage technology to improve access to translation services at a fraction of the cost. To date, the Health System has realized an annualized total savings of \$67,000 by increasing utilization of interpretive services with Language Line. Now, staff and physicians can access translation in more than 200 languages via video, phone and in-person services.

#### Just Culture Sustainability

##### Training Program Development:

Over the past two years, employees, medical staff leaders, management and Board members have received training in the tenants of the Just Culture. Alex MacLennan, Education Coordinator, created a training plan to will ensure the tenants of the Just Culture continues to be the organization's model and ensure we are continuously committed to being a learning organization.

#### Employee Relations

##### Employee Engagement Survey:

In our quest to be "The best place to work and practice", Tahoe Forest Health System has engaged Press Ganey, the national leader in employee engagement surveys, to collect actionable information that will drive improvements in the work place that our employees feel are valuable. The survey has been widely distributed electronically, and employees in Human Resources have been rounding in departments to encourage participation. Once the results are compiled, the information will be shared with the staff, management team, medical staff and Board of Directors. The organization will prioritize key initiatives and put action plans in place to improve overall employee engagement.

Board of Directors -Chief Nursing Officer Report  
Judy Newland, RN, CNO  
October, 2014

Electronic Medical Record – CPSI

1. Point of Care (POC)
  - a. The nursing and ancillary inpatient electronic medical record documentation project, Point of Care, was implemented on Monday, October 13<sup>th</sup> successfully. Preparation for go live was extensive with training of Superusers occurring September 30-October 2 and all ancillary and nursing staff training for the POC took place the week of October 6-10. Each training began with a welcome and outline of go live resource support and communication by members of the Nurse Executive Council.
  - b. The resource support system for CPSI POC implementation has been extensive. CPSI staff has been on site 24/7 at TFH and IVCH to assist staff in the transition from paper to electronic medical record. Daily communication and bulletins have been effective in listening to staff recommendations for process changes and answering questions. An IT help line is in place 24/7 to assist in immediate computer access needs. A detailed workflow binder was developed to help staff in learning new electronic workflows. The resource support system put into place, especially the workflow binders, has impressed CPSI and they have invited Barb Thomas, Nursing Informatics Manager, to speak at their national conference regarding our successful implementation process.
  - c. The POC program has been a positive change to medication safety and patient safety. Key improvements include access to patient information, Bar Code Scanning for medication safety, and medication reconciliation/allergy identification beginning at patient point of entry in ambulatory surgery and emergency department to bedside patient care and then to discharge.
  - d. It has been a privilege to work with such dedicated hospital staff on this project. Their commitment in supporting this transition has been extraordinary. The POC Coordinating Team has been devoted to ensure a successful implementation and have been available long hours to assist where needed.
2. Physician Applications

The Physician Applications Project is moving forward to Go-Live in November. The team has completed the initial Physician Documentation electronic templates. The physician training schedule has been released through Medical Staff Services. Tena Mather and Jennifer Ingalls continue to work with physicians to support their familiarization with ChartLink. The Physician Advisory Team of Dr. Thompson, Dr. Standteiner, Dr. Scholnick, and Dan Coll PA-C have continue to meet every other week and have been active in the decision making process for implementation of the physician applications.

Construction

Demolition of the 1952 building is in process. Execution of the plan to service the residents of ECC now that it is disconnected from the hospital has been successful. Access into the hospital is from one of three entrances, ASD Entrance, Main Entrance, and Solarium/Big Rock Entrance. A big thank you and recognition of Dietary, EVS, and Central Supply staff for making the construction transitions smooth for patients, visitors, and staff.

### Volunteers

The annual Hospice and Thrift Store Volunteer Appreciation Luncheon was held on September 23, 2014 at Sunnyside. The Thrift Store staff and volunteers were recognized for their financial achievements resulting from outstanding sales at the stores, and the support this provides to sustaining the Hospice Program. Thank you to the volunteers for all you do.

Board of Directors –Incline Village Community Hospital  
Judy Newland, IVCH Chief Administrative Officer  
October, 2014

Outreach

- IVCH, in partnership with North Lake Tahoe Fire Protection District, Incline Village Park & Recreation, Sierra Nevada College, Incline Village & Crystal Bay Veterans Club and the North Lake Tahoe Bonanza, offered several flu shot clinics in October. The clinics were on October 3rd at a Bonanza Meeting, October 11<sup>th</sup> at the annual Oktoberfest in Incline Village, and October 15th at Sierra Nevada College for students and faculty.
- On Saturday, September 27, 2014, National Rx Drug Roundup day, Incline Village Community Hospital (IVCH) and Washoe County Sheriffs Office (WCSO) partnered to provide a local Rx Drug Roundup collection site in the Community Room of the Incline Village Community Hospital. WCSO Deputies, Carlos Bonilla and David Astles, IVCH Hospital Administrator, Judy Newland and IVCH Community Outreach Coordinator, Shelia Leijon collected over 73 pounds of prescription and over the counter drugs! Thanks to the residents of Incline Village/Crystal Bay, these drugs are off our streets.
- A brief presentation on Incline Village Community Hospital services was given to the Philanthropic Education Organization by Ms. Newland in Incline Village. Following the presentation, multiple questions were asked by the audience.

Foundation

- IVCH Foundation hosted a donor luncheon on October 9th and a presentation on the OCHIN EPIC Portal was provided by Jen Tirdel, MSC Informatics Manager. Donors learned how to get into their portal and staff was available to assist individuals as needed. The audience was appreciative of the information provided on the portal. Flu shots were made available to donors at the luncheon. Lunch was provided by our Dietary Department.



**October 21, 2014**

**TO:** TFHD Board of Directors  
**FROM:** Jake Dorst, Chief information Officer  
**SUBJECT:** CIO Update

**SUMMARY:** Updates for the following areas provided:

- Point of Care Go-Live
- Forthcoming Changes
- Future plans

## **DISCUSSION**

### Point of Care:

In order to fulfill the Tahoe Forest Health System (TFHS) strategic goal of developing and deploying the IT Electronic Medical Record (EMR) plan to optimize use of the current CPSI software to meet meaningful use stage one and ICD-10, I am pleased to announce that TFHS has "gone live" with Point Of Care services in both hospitals.

Utilizing new workstations on wheels (WoW's) and new barcode recognition technology, TFHS has been able to move from an all paper hand written system that manually charted patient information to an all-electronic system. This new system aids in getting pertinent patient information to the care giver in real time to aid in the clinical decision making processes. The new system will also automatically check to make sure each patient is getting the correct drug, the right dosage, at the right time. The software also checks for adverse combinations of drugs, allergy and food interactions.

Speech Therapy, Nutrition, Respiratory Therapy, Physical Therapy, Occupational Therapy, and Care Management departments are also charting electronically. All of this information is available immediately for the entire care team to view and digest, and aid in making more timely and informed care delivery decisions. This has been a successful step in preparing TFHS for the second stage of the project plan which will be implementation of Computerized Provider Order Entry (CPOE). CPOE will also help TFHS prepare to meet current meaningful use measures and prepare TFHS for meeting future benchmarks.

Forthcoming changes:

In the next three weeks from this writing, TFHS will start using CPOE for physician order entries. This will be a phased approach and will have all the physician specialties using the system by the spring of 2015. This is the next step in moving to an electronic order entry system and having a complete electronic health record.

Future Plans:

As we move into this new world of electronic record keeping and information exchange, TFHS should be cognizant of the goal of unifying this data. TFHS is working towards implementing a patient portal which will allow TFHS to be considered compliant as meaningful users; the goal is to enhance the patient experience and increase the level of care provided to our community.





**MEMORANDUM**

DATE: October 6, 2014  
 TO: Personnel / Retirement Committee Members – See Distribution List Below  
 FROM: Robert A. Schapper, CEO  
 SUBJECT: Personnel / Retirement Committee Meeting

The next meeting of the **Personnel / Retirement Committee** will be held on **Wednesday, October 8, 2014 at 1:00 p.m.**, in the Human Resources Conference Room, Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA 96161

**AGENDA**

1. Call to Order
2. Roll Call
3. Clear The Agenda/Items Not On The Posted Agenda
4. Input – Audience  
Employee Associations
5. Approval of minutes of 09/17/14..... ATTACHMENT
6. Closed Session
  - A. Government Code Section 54957: CEO Annual Performance Evaluation.... \* ATTACHMENT
7. Open Session
8. Report of Actions Taken in Closed Session
9. Review Follow Up Items / Board Meeting Recommendations
10. Next Meeting Date
11. Adjourn

RAS:pab

Distribution List:	Larry Long, Chair	Roger Kahn
	Jayne O'Flanagan, Director HR	Ginny Razo, PharmD, COO
	Ann Mazzini	DeeDee Holmes
	Barbara Wong (EA)	Stacey Tedsen (EAP)
	Judy Newland, RN, CNO	Alex MacLennan
	Crystal Betts, CFO	

\*Denotes material (or a portion thereof) may be distributed at a later date

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.



## MEMORANDUM

DATE: October 15, 2014  
TO: Governance Committee Members – See Distribution List Below  
FROM: Bob Schapper, Chief Executive Officer  
SUBJECT: Special Governance Committee Meeting

The next meeting of the Governance Committee will be held on Thursday, October 16, 2014 at 11 a.m. at the Foundation Conference Room, Tahoe Forest Health System Foundation, 10976 Donner Pass Rd, Truckee, CA.

## AGENDA

1. Call To Order
2. Roll Call
3. Clear The Agenda/Items Not On The Posted Agenda
4. Input – Audience
5. Approval of minutes of: 08/22/2014 ATTACHMENT
6. Items for Committee Discussion and/or Recommendation
  - A. Contracts:
    - i. Auto Renew Review:
      - a. Surgery Coverage Agreement – Crystine M. Lee, M.D. ATTACHMENT
      - b. On Call Coverage of Specialty Services to the Emergency Department – James Kelly, M.D. ATTACHMENT
      - c. Medical Director Agreement for Tahoe Center for Health and Sports Performance – Nina Winans, M.D. ATTACHMENT
      - d. Medical Director Agreement for Occupational Health – Edward Heneveld, M.D. ATTACHMENT
      - e. Medical Director Agreement for Infection Control – Timothy Lombard, M.D. ATTACHMENT
    - ii. New Contracts for Review:
      - f. Rural PRIME Site Preceptor Clerkship Director – Oleg Vayner, M.D. ATTACHMENT
      - g. EMS Medical Director Agreement – Casey Jowers, M.D. ATTACHMENT
      - h. Agreement-Education Contract – North Tahoe Radiology Group ATTACHMENT
  - B. Biennial Bylaws Review ATTACHMENT
  - C. Board Policy Review Update
    - i. Review of Policies Pending Approval ATTACHMENT
    - ii. Recommended Policy Additions/Updates
      - a. ABD-19: Orientation and Continuing Education Policy ATTACHMENT
  - D. Board Self-assessment Process Update
  - E. Report out/Next steps from Karma Bass Governance Workshop ATTACHMENT

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## Agenda Continued

7. Closed Session
8. Open Session
9. Report of Actions Taken in Closed Session
10. Review Follow Up Items / Board Meeting Recommendations
11. Next Meeting Date
12. Meeting Effectiveness Assessment
13. Adjourn

RAS:pab

Distribution List:            Karen Sessler, Chair            John Mohun  
   Judy Newland            Crystal Betts            Ginny Razo  
   Jayne O'Flanagan            Janet Van Gelder            Ted Owens

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

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Tahoe Forest Hospital District  
Board Governance Educational Workshop  
Summary Report  
September 18, 2014

## **Background and Overview**

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The board of Tahoe Forest Hospital District (TFHD) met for a half-day Board Governance Educational Workshop on September 18, 2014. The meeting was duly noticed and members of the public were in attendance. Additionally, candidates for the TFHD Board who attended were invited to participate. The objectives of this session were:

1. Hear the Current Industry Challenges Facing California Healthcare District Boards
2. Work on Developing a Strong and Healthy Board Culture
3. Reach Agreement on Governance Standards and Board Roles
4. Discuss Meeting Effectiveness & Identify Opportunities for Improvement

The session was presented and discussions were facilitated by Karma Bass, Principal, Via Healthcare Consulting. To prepare for the retreat, Board members participated in structured individual telephone interviews in advance that sought their input on desired educational topics and key issues facing the TFHD Board.

## **Discussion Summary**

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The Board and invited participants discussed an array of topics related to the workshop's objectives. There was also consideration of the best way to manage the transition and orientation for any incoming Board members who may be elected this fall. Ms. Bass presented information on healthcare trends and governance best practices. She also provided examples of governance effectiveness from other California Hospital Districts with whom she has worked.

The Board and invited participants generally agreed that meeting effectiveness would be enhanced with the implementation of certain key practices. In particular, consideration was given to a potential 'code of conduct' that might be adopted. Attached to this report is a draft TFHD Board Code of Conduct for consideration and potential adoption at a future meeting. Additionally the Board requested follow up information on the following:

- TFHD's policy on attendance (to be included in upcoming Board meeting materials)
- A draft meeting evaluation form that could be used at the end of each Board meeting to identify areas for improvement (attached)
- A process for summarizing follow-up items and agreed-upon timelines at end of each Board meeting
- Timeframes for each agenda item that could be added to Board meeting agendas
- Elimination of the verbal reporting of any information that had been included in the packet distributed in advance
- Board meeting packets made available to the public in advance of meetings

At the conclusion of the session, all those present were thanked for their participation and the workshop was adjourned.

## Tahoe Forest Hospital District Board

### Proposed Code of Conduct

- “Lower the water line” (discuss how group dynamics are impacting the discussion at hand)
- Be honest and kind
- Encourage and respect all opinions
- Declare if you are playing ‘devil’s advocate’ (taking a position for argument’s sake, one that you may not believe)
- Avoid side conversations
- Be fully engaged (phones on mute or put away)
- Use modified consensus-decision making
- Ensure all actions are assigned
- Utilize a parking lot to keep discussion focused and moving forward
- Separate the person from the position
- Embrace truthfulness and honesty in all discussions

**Tahoe Forest Hospital District  
 Board of Directors Meeting  
 Evaluation Form**

	<b>Exceed Expectations</b>		<b>Meets Expectations</b>		<b>Below Expectations</b>
1) Overall, the meeting agenda is clear and includes appropriate topics for Board consideration	5	4	3	2	1
2) The <b>consent</b> agenda includes appropriate topics and worked well	5	4	3	2	1
3) The Board packet & handout materials were sufficiently clear and at a 'governance level'	5	4	3	2	1
4) Discussions were on target	5	4	3	2	1
5) Board members were prepared and involved	5	4	3	2	1
6) The education was relevant and helpful	5	4	3	2	1
7) Board focused on issues of strategy and policy	5	4	3	2	1
8) Objectives for meeting were accomplished	5	4	3	2	1
9) Meeting ran on time	5	4	3	2	1

**Please provide further feedback here:**



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		<b>Tahoe Forest Health System</b>			
		<b>Title:</b> Orientation And Continuing Education		<b>Policy/Procedure #:</b> ABD-19	
		<b>Responsible Department:</b> Administration			
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
<input checked="" type="checkbox"/>	Board	8/90	3/08; 01/12; 1/14	1/10; <u>10/14</u>	
<input type="checkbox"/>	Medical Staff				
<input type="checkbox"/>	Departmental				
Applies to: <input checked="" type="checkbox"/> System <input type="checkbox"/> Tahoe Forest Hospital <input type="checkbox"/> Incline Village Community Hospital					

**POLICY:**

It is the policy of the Board of Directors of Tahoe Forest Hospital District to provide for the continuing education of all Board Members. It is also the policy to ensure that all new Board Members are appropriately oriented concerning the hospital's mission, organization, scope of services, long range plans, legal responsibilities, quality assurance program and the governing board and medical staff bylaws of the hospital.

**PROCEDURE:**

- 1.0 In carrying out the above policy concerning orientation of new Board Members, the following materials and information will be provided by the Chief Executive Officer or designees:
  - ~~4.1 — An orientation to the physical plant of Districts' facilities. This will be conducted by the Chief Executive Officer or designees.~~
    - ~~Orientation materials will include Organizational Chart, Business Goals and Objectives/Strategic Plan, QA Plan, Guidelines for the Conduct of Business Policy, and other information pertinent to the role and responsibilities of the new Board Member. An overview of these documents discussing their importance, legal implications and relevance will be provided as well by the Chief Executive Officer. An additional manual will be made which will contain the Tahoe Forest Hospital District, Medical Staff and Auxiliary Bylaws, and the policies of the Board of Directors.~~
  - ~~4.2 — A copy of the District's operating and capital expenditure plan for the current fiscal year for review with the Chief Executive Officer.~~
  - 1.1 Scheduling for attendance at the next convenient Governance educational event. Review of the Board Quick Reference Guide which includes:
    - 1.1.1 Organizational Excellence Model
      - 1.1.1.1 Mission
      - 1.1.1.2 Vision

- 1.1.1.3 Values
  - 1.1.1.4 Foundation of Excellence
  - 1.1.2 Guidelines for the Conduct of Business and related Policies
  - 1.1.3 The District's Conflict Of Interest Code and Statement Of Economic Interest.
  - 1.1.4 Tahoe Forest Hospital District Bylaws
  - 1.1.5 District Roster of Board of Directors / Board Officers & Committees
  - 1.1.6 Board Committee Summary
    - 1.1.6.1 Charters
    - 1.1.6.2 Goals
  - 1.1.7 Organizational Chart
  - 1.1.8 Strategic Plan
    - 1.1.8.1 Tahoe Forest Health System
    - 1.1.8.2 Medical Staff
  - 1.1.9 District History / Fact Sheet
    - 1.1.9.1 Service Area Statistics
    - 1.1.9.2 District Service Map
  - 1.1.10 Brown Act
  - 1.1.11 Health Care District Law for the State of California
- 
- 1.2 A copy of the District's operating and capital expenditure plan for the current fiscal year.
  - 1.3 The District's most recently completed financial audit, as well as the current financial report on District's operations.
  - 1.4 An orientation to the physical plant of Districts' facilities. This will be conducted by the Chief Executive Officer or designees.
  - 1.5 The system facility master plan.
  - 1.6 The District's Foundations' Mission Statements.
  - 1.7 The standard agenda format for governing board meetings.
  - 1.8 A meeting with the District's legal counsel. The purpose of this meeting will be to review in greater detail various aspects of hospital law that impact upon governing board members, including The Brown Act.
  - 4.3 A copy of the current Quality Improvement Program of the District.

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4.4.1.9 The District has implemented a [Board Portal](#) to help board members organize and streamline the governance process, and to support best practices. The Portal contains:

~~1.4.11.9.1~~ ~~Board Meeting Books and the~~ Board [Resource Manual](#) will provide additional information pertinent to the role and responsibilities of the Board Member.

**1.9.2** Committee Workrooms

[1.9.2.1 Board Meeting Books](#)

[1.9.2.2 Meeting Calendar](#)

~~1.4.21.9.2.3~~ [Committee Working Documents](#)

~~1.4.31.9.3~~ [Master Calendar](#)

~~1.4.41.9.4~~ [Board and Staff Directory](#); and

~~1.4.51.9.5~~ A Resource Library (including, but not limited to, relevant journals, texts and conference materials).

Access to the Portal is maintained by the ~~Executive Assistant~~[Clerk of the Board](#) who assigns access permissions and will provide portal training and support.

~~1.5 The District's Conflict Of Interest Code and Statement Of Economic Interest.~~

~~1.6 A meeting with the District's legal counsel. The purpose of this meeting will be to review in greater detail various aspects of hospital law that impact upon governing board members, including The Brown Act.~~

~~1.7 The standard agenda format for governing board meetings.~~

~~1.8 The District's most recently completed financial audit, as well as the current financial report on District's operations.~~

~~1.9 The system facility master plan.~~

~~1.10 The District's Foundations' Mission Statements.~~

**2.0 Documentation Updates**

2.1 ~~Orientation~~[The Board Quick Reference Guide and online Portal Board Reference Resource Manual](#) binders will be periodically updated and maintained.

**3.0 Procedure For Providing Continuing Education**

3.1 In carrying out the Board of Director's policy concerning continuing education, the following procedures will be offered:

~~3-23.1.1~~ Board Members are expected to expand their knowledge of District governance and key healthcare issues. Attendance at a relevant program at least annually will be encouraged. To ensure financial resources are spent in alignment with the Mission, Vision and Strategic Plan of the District, the Chief Executive Officer will apprise Board Members of educational opportunities as they arise.

~~3-33.1.2~~ As necessary, relevant in-service educational programs will be conducted in conjunction with the Board meeting scheduled for that

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month. The subjects that will be covered during this in-service will relate to various medico-administrative issues, new technology, quality assurance, Board Member responsibilities, etc.



~~3.43.1.3~~ All reasonable expenses arising out of the continuing education and orientation activities required by this policy will be reimbursed using the procedures as outlined in the Board of Directors policy entitled [Board of Directors Compensation and Reimbursement](#) ABD-3.

Field Code Changed

**4.0 Documentation Procedure**

- 4.1 In carrying out the governing board's policy concerning orientation and continuing education, the following documents will be maintained:
  - 4.1.1 A checklist documenting adherence to the governing board's policy on orientation will be maintained for each Board Member.
  - 4.1.2 A file documenting formal continuing education attendance at the governing board level will also be maintained.
  - 4.1.3 Upon completion of a Board Member's attendance at a seminar/course/workshop, the Board Member shall deliver an oral or written report to the Board as a whole so as to allow others to gain from the attendee's experience.

Related Policies/Forms: <del>ABD-03 Board of Director Compensation and Reimbursement</del>
References:
Policy Owner: <del>Michelle Cook</del> , Clerk of the Board
Approved by: <del>Robert Schapper</del> , Chief Executive Officer

	<b>Tahoe Forest Health System</b>				
	<b>Title:</b> Orientation And Continuing Education		<b>Policy/Procedure #:</b> ABD-19		
	<b>Responsible Department:</b> Administration				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
<input checked="" type="checkbox"/>	Board	8/90	3/08; 01/12; 1/14	1/10; 10/14	
<input type="checkbox"/>	Medical Staff				
<input type="checkbox"/>	Departmental				
Applies to: <input checked="" type="checkbox"/> System <input type="checkbox"/> Tahoe Forest Hospital <input type="checkbox"/> Incline Village Community Hospital					

**POLICY:**

It is the policy of the Board of Directors of Tahoe Forest Hospital District to provide for the continuing education of all Board Members. It is also the policy to ensure that all new Board Members are appropriately oriented concerning the hospital's mission, organization, scope of services, long range plans, legal responsibilities, quality assurance program and the governing board and medical staff bylaws of the hospital.

**PROCEDURE:**

- 1.0 In carrying out the above policy concerning orientation of new Board Members, the following materials and information will be provided by the Chief Executive Officer or designees:
  - 1.1 Review of the Board Quick Reference Guide which includes:
    - 1.1.1 Organizational Excellence Model
      - 1.1.1.1 Mission
      - 1.1.1.2 Vision
      - 1.1.1.3 Values
      - 1.1.1.4 Foundation of Excellence
    - 1.1.2 Guidelines for the Conduct of Business and related Policies
    - 1.1.3 The District's Conflict Of Interest Code and Statement Of Economic Interest.
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  - 1.1.9.2 District Service Map
- 1.1.10 Brown Act
- 1.1.11 Health Care District Law for the State of California
- 1.2 A copy of the District's operating and capital expenditure plan for the current fiscal year.
- 1.3 The District's most recently completed financial audit, as well as the current financial report on District's operations.
- 1.4 An orientation to the physical plant of Districts' facilities. This will be conducted by the Chief Executive Officer or designees.
- 1.5 The system facility master plan.
- 1.6 The District's Foundations' Mission Statements.
- 1.7 The standard agenda format for governing board meetings.
- 1.8 A meeting with the District's legal counsel. The purpose of this meeting will be to review in greater detail various aspects of hospital law that impact upon governing board members, including The Brown Act.
- 1.9 The District has implemented a [Board Portal](#) to help board members organize and streamline the governance process, and to support best practices. The Portal contains:
  - 1.9.1 Board Resource Manual will provide additional information pertinent to the role and responsibilities of the Board Member.
  - 1.9.2 Committee Workrooms
    - 1.9.2.1 Board Meeting Books
    - 1.9.2.2 Meeting Calendar
    - 1.9.2.3 Committee Working Documents
  - 1.9.3 Master Calendar
  - 1.9.4 Board and Staff Directory
  - 1.9.5 A Resource Library (including, but not limited to, relevant journals, texts and conference materials).

Access to the Portal is maintained by the Clerk of the Board who assigns access permissions and will provide portal training and support.

2.0 **Documentation Updates**

2.1 The Board Quick Reference Guide and online Portal Board Resource Manual will be periodically updated and maintained.

3.0 **Procedure For Providing Continuing Education**

3.1 In carrying out the Board of Director’s policy concerning continuing education, the following procedures will be offered:

3.1.1 Board Members are expected to expand their knowledge of District governance and key healthcare issues. Attendance at a relevant program at least annually will be encouraged. To ensure financial resources are spent in alignment with the Mission, Vision and Strategic Plan of the District, the Chief Executive Officer will apprise Board Members of educational opportunities as they arise.

3.1.2 As necessary, relevant in-service educational programs will be conducted in conjunction with the Board meeting scheduled for that month. The subjects that will be covered during this in-service will relate to various medico-administrative issues, new technology, quality assurance, Board Member responsibilities, etc.

3.1.3 All reasonable expenses arising out of the continuing education and orientation activities required by this policy will be reimbursed using the procedures as outlined in the Board of Directors policy entitled [Board of Directors Compensation and Reimbursement](#) ABD-3.

4.0 **Documentation Procedure**

4.1 In carrying out the governing board’s policy concerning orientation and continuing education, the following documents will be maintained:

4.1.1 A checklist documenting adherence to the governing board’s policy on orientation will be maintained for each Board Member.

4.1.2 A file documenting formal continuing education attendance at the governing board level will also be maintained.

4.1.3 Upon completion of a Board Member’s attendance at a seminar/course/workshop, the Board Member shall deliver an oral or written report to the Board as a whole so as to allow others to gain from the attendee’s experience.

Related Policies/Forms: ABD-03 Board of Director Compensation and Reimbursement
References:
Policy Owner: Clerk of the Board
Approved by: Chief Executive Officer



## MEMORANDUM

DATE: October 21, 2014  
TO: Quality Committee Members – See Distribution List Below  
FROM: Bob Schapper, Chief Executive Officer  
SUBJECT: Quality Committee Meeting

The next meeting of the Quality Committee will be held on Wednesday, October 22, 2014 at 12:00 p.m. in the Eskridge Conference Room, 10121 Pine Avenue, Tahoe Forest Hospital, Truckee, CA

### AGENDA

1. Call To Order
2. Roll Call
3. Clear The Agenda/Items Not On The Posted Agenda
4. Input – Audience
- Approval of Minutes of Meeting of 7/17/14 ..... ATTACHMENT
5. Items for Committee Review and/or Recommendation for Approval
  - A Committee Charter & 2014 Goals..... ATTACHMENT
  - B Patient & Family Centered Care ..... ATTACHMENT
    - Patient Advisory Council Update
    - Patient Experience Sharing: Benchmark & Recommendation
  - C Meaningful Use Quality Indicators ..... ATTACHMENT
  - D TFHS Quality Reporting Matrix..... ATTACHMENT
  - E Ebola Viral Disease Preparedness ..... ATTACHMENT
  - F Board Quality Education
    - Regulatory agency education (CDPH, NV HCQC, HFAP, CMS)
    - Strategic Quality Oversight by the BOD..... ATTACHMENT
    - Hospital Quality Institute: Quality Work Guide ..... ATTACHMENT
    - Baldrige Performance Excellence Education
    - STEEEP Academy Leadership: Board Governance in Quality & Patient Safety
    - IHI: The Role of the Board in Quality & Safety
  - G. Next Quarterly Quality Committee Meeting
  - H. Adjourn

RAS: pab

Distribution List:

John Mohun

Karen Sessler, M.D.

Peter Taylor, M.D.

Jeff Dodd, M.D.

Crystal Betts

Judy Newland

Ginny Razo

Janet Van Gelder, RN

Paige Thomason

Terri Schnieder

Shawni Coll, D.O.

Trish Foley

Linda Harman

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\*Denotes material (or a portion thereof) may be distributed at a later date

\*\*The entire manual/document is available for review via the Chief Executive Officer's Office.

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. Tahoe Forest Hospital District is an 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.