TAHOE FOREST
HOSPITAL DISTRICT

2026-05-28 SPECIAL Meeting of the Board of Directors

(Agenda Revised 5/27/26 at 8:00 a.m.)

Thursday, May 28, 2026, at 2:30 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2026-05-28 SPECIAL Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST
HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

REVISED AGENDA

Thursday, May 28, 2026, at 2:30 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

If you would like to view the live meeting or speak on an agenda item, you can access the meeting remotely:
Please use this zoom link: https://tfhd.zoom.us/j/81070388983

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed:
(669) 900 6833 or (669) 444 9171
Meeting ID: 810 7038 8983

Public comment will also be accepted by email to sarah.jackson@tfhd.com or online at https://www.tfhd.com/board-of-directors/board-meetings/#comment. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the **three-minute** time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSON**
   - **5.1. Approval of Closed Session Minutes**◈
     - **5.1.1.** 04/23/2026 Regular Meeting
   - **5.2. TIMED ITEM – 2:35 p.m. Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: 1st Quarter CY 2026 Corporate Compliance Report
   - **5.3. TIMED ITEM – 2:55 p.m. Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: Liability Claim
     Number of items: David Goldman
   - **5.4. TIMED ITEM – 3:05 p.m. Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: Medical Staff Credentials

◈ Denotes Action Item

6. OPEN SESSION – CALL TO ORDER

7. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

8. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

9. INPUT AUDIENCE

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

10. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

10.1. Medical Executive Committee (MEC) Meeting Consent Agenda ..... ATTACHMENT

Privileges with Changes

- *Critical Care Privileges – Addition of Tele ICU*

New Policy

- *Respiratory Therapy Equipment Cleaning and Disinfection, DRT-100*

Policies with Minor Changes

- *ECC Policies*
- *DNS Policies*
- *Rehab Policies*

Policies with no Changes

- *Case Management Policies*

Medical Staff Bylaws – Review with no Changes

- *Medical Staff Bylaws*

11. CONSENT CALENDAR ◈

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

11.1. Approval of Minutes of Meetings

11.1.1. 04/23/2026 Regular Meeting ..... ATTACHMENT

11.2. Financial Reports ..... ATTACHMENT

11.2.1. Financial Report – April 2026 ..... ATTACHMENT

11.3. Affirm Board Committee Charters ..... ATTACHMENT

11.3.1. Board Finance Committee Charter ..... ATTACHMENT

11.3.2. Board Executive Compensation Committee Charter ..... ATTACHMENT

11.4. Approve Quarterly Compliance Report ..... ATTACHMENT

11.4.1. First Quarter CY 2026 Corporate Compliance Report ..... ATTACHMENT

12. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

13. CLOSED SESSON

13.1. Report Involving Trade Secrets (Health & Safety Code § 32106)

◈ Denotes Action Item

Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

14. OPEN SESSION – CALL TO ORDER

15. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

16. BOARD COMMITTEE REPORTS

17. BOARD MEMBERS' REPORTS/CLOSING REMARKS

18. CLOSED SESSION CONTINUED, IF NECESSARY

19. OPEN SESSION

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

21. ADJOURN

Tahoe Forest Hospital District has enabled live captioning and live Spanish translation in Zoom. To turn on live captions (subtitles) follow these steps:
1. In your Zoom meeting, look at the bottom toolbar.
You will see one of the following buttons:
- Captions
- Show Captions
- CC / Live Transcript

2. Click the button and select:
- Show Captions

3. To turn On Spanish Translation (live interpreted captions)
- Click the small arrow (^) next to the Captions button.
- Toggle the Translation button to the "on" position.
- Select: Caption Language
- Choose: Spanish

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is June 25, 2026 at Tahoe Forest Hospital – Eskridge Conference Room, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting. Materials related to an item on this Agenda submitted to the Board of Directors, or a majority of the Board, after distribution of the agenda are available for public inspection in the Administration Office, 10800 Donner Pass Rd, suite 200, Truckee, CA 96161, during normal business hours.

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

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic 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 or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Clerk of the Board at (530) 582-3583 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: May 28, 2026	**ITEM:** 10.0 Medical Executive Committee (MEC) Consent Agenda
DEPARTMENT: Medical Staff	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Johanna Koch, MD, Chief of Staff	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Policies**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Respective Departments have reviewed Department Policies and Privileges, recommended approval to MEC. The MEC and the Bylaws Committee have reviewed the Medical Staff Bylaws. During the May 21, 2026 Medical Executive Committee meeting, the MEC reviewed and made the following open session consent agenda item recommendations to the Board of Directors for the May 28, 2026 Special Meeting of the Board of Directors.

SUMMARY/OBJECTIVES:

Privileges with Changes
- Critical Care Privileges – Addition of Tele ICU

New Policy
- Respiratory Therapy Equipment Cleaning and Disinfection, DRT-100

Policies with Minor Changes
- ECC Policies
- DNS Policies
- Rehab Policies

Policies with no Changes
- Case Management Policies

Medical Staff Bylaws – Review with no Changes
- Medical Staff Bylaws

SUGGESTED DISCUSSION POINTS:
Medical Executive Committee has reviewed the Department recommendations on privileges, policies and Medical Staff Bylaws. The committee makes the following open session recommendation for consent agenda to the Board of Directors.

- §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1).
- Procedures shall be approved by the Administration and Medical Staff where such is appropriate.
- Medical Staff approval is required when direct patient care/clinical practice is addressed, including contract services for patients, prior to forwarding to the Medical Executive Committee and the Governing Board.

For complete policy refer to: Policy & Procedure Structure and Approval, AGOV-9

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the MEC consent agenda as presented.

Alternative: If a specific Policy, Procedure or Form is pulled from the MEC consent agenda, provide discussion under Item 16 on the Board Agenda. After discussion, request a motion to approve the pulled MEC item as presented.

LIST OF ATTACHMENTS:

SUMMARY/OBJECTIVES:

Privileges with Changes

- Critical Care Privileges – Addition of Tele ICU

New Policy

- Respiratory Therapy Equipment Cleaning and Disinfection, DRT-100

Policies with Minor Changes

- ECC Policies
- DNS Policies
- Rehab Policies

Policies with no Changes

- Case Management Policies

Medical Staff Bylaws – Review with no Changes

- Medical Staff Bylaws

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Specialty: Critical Care

Check one or more: □ **Tahoe Forest Hospital (TFH)**

Check one: □ **Initial** □ **Change in Privileges** □ **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Core Education:	MD or DO
Minimum Formal Training:	Successful completion of an ACGME- or AOA-accredited postgraduate training program in the relevant medical specialty and successful completion of an accredited fellowship in critical care medicine.
Board Certification:	Board qualification/certification required. Current subspecialty certification or active participation in the examination process (with achievement of certification within 5 years of completion of fellowship) leading to subspecialty certification in critical care medicine by the ABMS Board or the American Osteopathic Board. Maintenance of Board Certification required. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges (applies to all specialties).*
Required Previous Experience:	Required current experience: Inpatient care to at least 30 patients in the ICU, reflective of the scope of privileges requested, during the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character, and ability to work with others. Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring" section below for specific proctoring requirements. Where applicable, additional proctoring and evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in NV • Malpractice insurance in the amount of $1m/$3m • Use of Fluoroscopy Equipment: Current State of California Department of Health Services fluoroscopy certificate required. • Ability to participate in federally funded program (Medicare or Medicaid) • Current ACLS Required • Current ATLS, ENLS, OBLS Recommended

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED	GENERAL PRIVILEGES – CRITICAL CARE MEDICINE	Estimated # of patients or procedures performed in the past 24 months	Setting	Proctoring See below, plus additional cases at discretion of proctor.	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME.
□	□	Privileges include the ability to evaluate, diagnose, and provide management or consultative services for critically ill patients with life-threatening conditions, including: • Identification and management of critically ill patients requiring intensive care, including stabilization and triage for transfer when appropriate • Management of life-threatening conditions, including shock (cardiogenic, distributive, hypovolemic, and obstructive), respiratory failure, acute coronary syndromes, drug overdose, hemorrhage, and severe metabolic derangements • Management of respiratory failure, including initiation, adjustment, and weaning of mechanical ventilation and noninvasive respiratory support • Management of hemodynamic instability, including fluid resuscitation, vasopressors, and inotropes • Recognition and management of multiple organ dysfunction and failure • Identification and treatment of electrolyte and acid–base disturbances • Management of sepsis and severe infections, including care of the immunocompromised patient • Management of renal failure, including oliguria and acute kidney injury • Management of metabolic, nutritional, endocrine, hematologic, and coagulation disorders in critical illness	_____	TFH ONLY	Review of 10 representative cases.	Inpatient care to at least 30 patients in the ICU, reflective of the scope of privileges requested, during the past 12 months.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – CRITICAL CARE MEDICINE	Estimated # of patients or procedures performed in the past 24 months	Setting	Proctoring See below, plus additional cases at discretion of proctor.	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME.
		• Diagnosis and management of toxicologic and poisoning syndromes • Management of sedation, analgesia, and delirium in critically ill patients • Monitoring and assessment of metabolism and nutrition, including advanced nutritional support • Interpretation of physiologic and hemodynamic monitoring data • Interpretation of cardiac monitoring, electrocardiography, echocardiography reports, and intracranial pressure data • Interpretation of point-of-care ultrasound findings when images are available for review • Preliminary interpretation of imaging studies relevant to critical care • Implementation and monitoring of evidence-based ICU protocols (e.g., sepsis management, infection control, targeted temperature management, and ventilator liberation) • Prioritization and integration of complex clinical data to guide decision-making • Leadership and coordination of multidisciplinary ICU care, including communication with bedside clinicians to guide management and escalation of care • Participation in resuscitation and emergency response planning • Participation in brain death determination in accordance with institutional policy				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – CRITICAL CARE MEDICINE	Estimated # of patients or procedures performed in the past 24 months	Setting	Proctoring See below, plus additional cases at discretion of proctor.	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME.
☐	☐	***Telemedicine – Critical Care*** **Remote Critical Care Assessment:** Perform evaluation of ICU patients through review of clinical data, imaging, and physiologic monitoring; communicate recommendations to the bedside team. **Ventilator Management Support**: Assist bedside staff with ventilator management under established protocols. **Hemodynamic Management Support:** Recommend fluid management and titration of vasopressors and inotropes within established protocols. **Documentation and Orders:** Document remote assessments and recommendations; enter orders as permitted by institutional telemedicine policy. **Interdisciplinary Collaboration:** Coordinate care plans through remote collaboration with ICU physicians, nurses, respiratory therapists, and consulting specialists.				
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel, and equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

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

_____ _____

Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

_____ _____

Date Department Chair Signature

Modifications or Other Comments:

_____

_____

Medical Executive Committee:_____ (date of Committee review/recommendation)

□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

Board of Directors:_____(date of Board review/action)

□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

Modifications or Other Comments:

_____

_____

Department Review Dates: 2/1/23, 11/5/25
Medical Executive Committee: 2/16/23, 11/13/25
Board of Directors: 2/23/23, 11/20/25

Status **Active** PolicyStat ID **20047641**

Origination Date	03/2026	Department	Respiratory Therapy - DRT
Last Approved	03/2026	Applicabilities	Tahoe Forest Hospital
Last Revised	03/2026		
Next Review	03/2028		

Respiratory Therapy Equipment Cleaning and Disinfection DRT-100

RISK:

Failure to properly clean and disinfect reusable respiratory therapy equipment may result in cross-contamination, healthcare-associated infections (HAIs), regulatory non-compliance, compromised patient safety, and potential harm to patients, staff, and the organization.

POLICY:

A. All reusable respiratory therapy equipment, including but not limited to ventilator components, non-invasive ventilation interfaces, oxygen delivery devices, nebulizers, and bronchopulmonary hygiene equipment, will be cleaned and/or disinfected strictly in accordance with the manufacturer's instructions for use (IFU).

B. Cleaning and disinfection processes shall follow the specific method, agents, dilution ratios, contact times, and drying requirements outlined by the equipment manufacturer.

C. No deviations from manufacturer guidelines are permitted unless approved in writing by Infection Prevention and the Respiratory Therapy Department Manager.

Special Instructions / Definitions:

Respiratory Therapy staff are responsible for ensuring compliance with this policy. Oversight will be maintained by the Respiratory Therapy Department Manager in collaboration with Infection Prevention.

All Revision Dates

03/2026

Approval Signatures

Step Description	Approver	Date
	Jan Iida: CNO	03/2026
	Greg Tirdel: Physician	03/2026
	Jason Becker: Respiratory Care Manager	03/2026
	Jason Becker: Respiratory Care Manager	03/2026

Title	Department	Last Approved	Next Review	Summary of Changes
Care of the Dementia Resident, DECC-401	Extended Care Center - DECC	9/9/2025	9/3/2027	updated risk and date
ECC Abuse - Reporting of, DECC-002	Extended Care Center - DECC	9/9/2025	9/3/2027	updated risk and date
ECC Abuse; Prevention of, DECC-001	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Admission Criteria, DECC-004	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Admission of Resident, DECC-006	Extended Care Center - DECC	9/9/2025	9/30/2027	update risk and date. updated PT and OT eval. Removed "if applicable."
ECC Admission/Readmission, DECC-007	Extended Care Center - DECC	9/4/2025	9/4/2027	updated risk and date
ECC Bedhold, DECC-011	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date.
ECC Bowel Protocol, DECC-012	Extended Care Center - DECC	9/9/2025	9/3/2027	Added Miralax as day two intervention in addition to MOM , patient specific. updated risk and date
ECC Care of Residents CPAP or BiPAP, DECC-2302	Extended Care Center - DECC	11/3/2025	9/30/2027	updated risk and date
ECC Certified Nursing Assistant Charting, DECC-013	Extended Care Center - DECC	9/9/2025	9/3/2027	updated risk and date
ECC Change of Condition, DECC-016	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk, date and Code 250
ECC Clothing- Laundry and Linens DECC-017	Extended Care Center - DECC	11/3/2025	9/3/2027	updated risk and dates. Updated formatting and added hyperlink to related policy
ECC Computer Downtime, DECC-1219	Extended Care Center - DECC	9/9/2025	9/30/2027	Updated formatting, restarting approval process. updated risk and date
ECC Continuing Education, DECC-014	Extended Care Center - DECC	9/9/2025	9/4/2027	updated risk and date. updated risk statement and date
ECC Demand Billing, DECC-019	Extended Care Center - DECC	9/3/2025	9/3/2027	updated risk and date
ECC Diabetes Technology, DECC-2401	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk, date and that families will have to work with ins or private pay for CGM.
ECC Disaster Plan, DECC-022	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date

Title	Department	Last Approved	Next Review	Summary of Changes
ECC Disinfection of ARJO Bathing System, DECC-023	Extended Care Center - DECC	11/3/2025	9/30/2027	updated RISK and date
ECC Ear Care, DECC-024	Extended Care Center - DECC	9/9/2025	9/3/2027	Added space for RISK and restarted approval process. updated risks and date
ECC Elopement and Wandering, DECC-072	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Enhanced Barrier (Enhanced Standard) Precautions, DECC-1502	Extended Care Center - DECC	11/3/2025	9/30/2027	updated risk and date
ECC Equipment; Proper Use of, DECC-027	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Evacuation Guideline, DECC-028	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Fall Protocol, DECC-029	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk, date and CODE 250, post fall huddle and safety event.
ECC Financial Criteria for Admission, DECC-030	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Financial Responsibilities: Assisting Residents, DECC-031	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and dates
ECC Grievances, DECC-060	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk, date and letter of concern
ECC Incontinent Assessment/ Intervention, DECC-034	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC IV Policy, DECC-038	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Leave of Absence - Residents, DECC-039	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Medical Director Roles and Responsibilities, DECC-040	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Mental Status Assessment, DECC-042	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and dates
ECC Minimum Data Set (MDS) Admission Assessment/ Medicare Part A- Prospective Payment Model (PPS) Assessment(s), DECC-003	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date

Title	Department	Last Approved	Next Review	Summary of Changes
ECC Nursing Admit Assessment-Reassessment and Documentation, DECC-010	Extended Care Center - DECC	9/9/2025	9/3/2027	added space for RISK and restarted approval process. updated risk statement and date
ECC Orientation of CNA, DECC-70	Extended Care Center - DECC	9/9/2025	9/4/2027	updated risk and dates. restarted approval process
ECC Orientation of Licensed Staff, DECC-071	Extended Care Center - DECC	9/9/2025	9/4/2027	updated risk
ECC Oxygen Therapy, DECC-043	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Pain Assessment, DECC-044	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Parasite Infestation: Bed Bugs, Lice and Scabies DECC-2303	Extended Care Center - DECC	11/3/2025	9/30/2027	spelling and format. updated risk and date
ECC Permitting Residents to Return to Facility, DECC-2001	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Physician Services Title 22, Section 72303, DECC-046	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Physician Visits Delinquent Documentation and Medical Records, DECC-045	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Quality Improvement Program, DECC-048	Extended Care Center - DECC	9/3/2025	9/3/2027	updated risk and date
ECC Resident Care, DECC-051	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Resident Gait Belt Management, DECC-2501	Extended Care Center - DECC	11/3/2025	9/3/2027	updated risk and date. updated risk statement and date. Updated formatting and added hyperlinks to related policies
ECC Resident Sexual Rights and Behaviors, DECC-054	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Resident Transfer, Discharge, and Room Changes, DECC-055	Extended Care Center - DECC	9/4/2025	9/3/2027	updated risk and date
ECC Resident Tuberculosis (TB) Screening, DECC-2503	Extended Care Center - DECC	3/9/2026	3/9/2027	new policy for ECC for annual TB screening per regulations. added reference to Emp Health policy. Updated that LVNs CAN place the TSTs .

Title	Department	Last Approved	Next Review	Summary of Changes
ECC Residents Care- Restraints, DECC-057	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Respiratory Illness and Aerosol Transmissible Disease Plan, DECC-2201	Extended Care Center - DECC	11/3/2025	9/30/2027	annual approval. updated risk and date
ECC Restorative Care Program, DECC-050	Extended Care Center - DECC	9/3/2025	9/3/2027	updated risk and date
ECC Staff Development Program (The Certified Nurse Assistant Orientation and In-Service Program), DECC-059	Extended Care Center - DECC	1/29/2026	1/29/2027	updated risk. More details, updated with regulation references and details of the program. update approval. Updated owner to Sue McMullen, added hyperlinks to related policies, updated formatting.
ECC Staff meetings-DECC-2411	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Structures Standards, DECC-061	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Teaching: Residents/Family, DECC-062	Extended Care Center - DECC	9/9/2025	9/30/2027	update risk and date
ECC Theft and Loss Program, DECC-063	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Transfers and Discharges, DECC-073	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
ECC Trust Account Resident, DECC-064	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
ECC Unusual Occurrences, DECC-065	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk, date and changed CDPH office from Chico to Sacramento.
ECC Van, DECC-066	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and dates. updated policy from "Van" to "transportation". Updated policy to reflect that staff and volunteers may not take residents in personal cars.
ECC Weights, DECC-068	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
Influenza Outbreak Management Long Term Care/SNF-DECC 2303	Extended Care Center - DECC	11/3/2025	9/30/2027	updated risk and date

Title	Department	Last Approved	Next Review	Summary of Changes
Resident Council, DECC-403	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
Residents Rights, DECC-056	Extended Care Center - DECC	9/9/2025	9/30/2027	updated risk and date
Sanitizing Robotic Comfort Pets in the ECC, DECC-2301	Extended Care Center - DECC	11/3/2025	9/30/2027	updated risk and date
Skilled Nursing Facility: Rehabilitative Unit Services, DECC-2502	Extended Care Center - DECC	10/20/2025	10/20/2026	changed formatting and number
Survey Results	Extended Care Center - DECC	9/8/2025	9/3/2027	updated risk and date
Tahoe Forest DP SNF-Powered wheelchairs-DECC- 0723	Extended Care Center - DECC	9/8/2025	9/3/2027	update risk and date
Use of Psychotropic Drugs in the Elderly Demented Resident, DECC-402	Extended Care Center - DECC	9/3/2025	9/3/2027	updated risk

Title	Department	Last Approved	Next Review	Summary of Changes
Patient Diet Orders, DNS-107	Nutrition Services - DNS	4/9/2026	4/9/2027	Reviewed and updated language
Patient Menus, DNS-101	Nutrition Services - DNS	4/9/2026	4/9/2027	Updated to reflect the changes since the release of the new dietary guidelines. Clarified menu planning and diet pattern. Reviewed edits together. LOS added for RD assessment of micronutrients

Title	Department	Last Approved	Next Review	Summary of Changes
Activapatch, IntellaDose 2.5 - DRHB-1920	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	grammar, risk statement clean up, corrected formatting
Aquatic Therapist Competencies and Requirements, DRHB-21-01	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	formatting, grammar, risk statement updated
Assess and Reassess Outpatient Rehab, DRHB-1902	Rehabilitation PT/OT - DRHB	2/25/2026	2/25/2028	reviewed by Dr. Rezac and recommendations for changes completed. Would like approve now in order to add to ACHC binder
Bloodflow Restriction Therapy - DRHB-1907	Rehabilitation PT/OT - DRHB	3/23/2026	3/22/2028	updated recs and removal of point system
Clarification Orders-ECC, DRHB-00005	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk statement for compliance
Clarification Orders-Inpatient, DRHB-00006	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk updated and formatted
Clarification Orders-Outpatient, DRHB-0007	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk statement updated as well as formatting completed
Computer Downtime Procedure, DRHB-1919	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	formatting, removal of purpose, risk clarified.
CPM Set Up, DRHB-0011	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk clarification , purpose removed, formatting
Cryotherapy, DRHB-1904	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk statement and formatting
Daily Treatment Notes Outpatient OT/PT/ST, DRHB-1912	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	formatting, clarification of risk statement
Discharges of Patients From Outpatient PT/OT/ST, DRHB-1913	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	clarification of risk statement, removed purpose
ECC Referral & Documentation, DRHB-0015	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk updated
Emergency Management, DRHB-1905	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and removed purpose
Functional Documentation, DRHB-1908	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	formatting, renamed due to duplication of numbers
Hydrocollator Cleaning, DRHB-1910	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk statement
Inpatient Neurological Rehabiliation PT/OT/SLP - DRHB 2501	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	removed purpose, formatting
Inservice Education, DRHB- 1909	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk statement updated, punctuation

Title	Department	Last Approved	Next Review	Summary of Changes
Inversion Traction, DRHB-1911	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and removed purpose
Iontophoresis and Medicare, DRHB-1901	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk. not sure if required as rehab policy or is this covered in reg policy?
Iontophoresis, DRHP-1914	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk, policy language and hyperlinked to DHRB-1920
IP Care Plan, DRHB-00026	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and clarity of policy language
IP Multidisc Case Conf, DRHB-0027	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk statement
Iron Mountain, DRHB-1917	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk updated, removed purposes
Laser Therapy, DRHB-1903	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk statement clarified, applicability, online manual added as reference.
Massage Percussion, DRHB-0078	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	RISK UPDATED, added digital version of manual
MBS - Speech Therapy (SLP), DRHB-1614	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements, applicability to TFH
Medical Records Release, DRHB-0031	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated policy statement
Medication Use and Ordering, DRHB-0034	Rehabilitation PT/OT - DRHB	2/25/2026	2/25/2028	extensive changes - approved by Rezac.
Negative Pressure Wound Therapy Procedure, DRHB-0072	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	changed policy # to avoid duplication. Expanded Risk statement
Outpatient Therapy Services and Inclement Weather DRHB - 1930	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements. removed Saturday opening clearances with registration as we have regular Saturday coverage.
Outpatient Transfers, DRHB-00038	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements, formatted the procedure
Paraffin Cleaning Policy, DRHB-00070	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements
Paraffin, DRHB-00039	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements, reference to cleaning policy
Pelvic Floor Modalities, DRHB-2302	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	Updated formatting and policy number

Title	Department	Last Approved	Next Review	Summary of Changes
Phonophoresis, DRHB-0043	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	risk policy statement upgrades, formatting
Plan of Care Certification - DRHB - 2301	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and purpose statement. not sure if the 30 day requirement should be left in...
Pool & Water Safety, DRHB-1924	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements
Power Outage Safety, DRHB - 1926	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	hyperlinks, updated risk and policy statements
Preplacements, DRHB-00046	Rehabilitation PT/OT - DRHB	3/19/2026	3/18/2028	updated risk and policy statements - removed EMR storage information from policy as Occ health manages all data
Scope of Care, DRHB- 1915	Rehabilitation PT/OT - DRHB	3/18/2026	3/17/2028	Changes made from Dr. Rezac's review included.
Staffing Plan, DRHB-0059	Rehabilitation PT/OT - DRHB	3/11/2026	3/10/2028	modified and approved by Dr. Rezac

Title	Department	Last Approved	Next Review	Summary of Changes
Utilization Review Plan(UR), DCM-1701	Case Management - DCM	1/29/2026	1/29/2027	No changes

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

MEDICAL STAFF BYLAWS

2024

Approved by MEC 1/20/16, 7/21/16; 4/16/20 by BOD 1/28/16; 9/22/16; 06/22/2017; 10/25/18; 4/23/20; 08/27/20, 05/12/2023, 07/16/2024
5939478.1

Table of Contents

TAHOE FOREST HOSPITAL DISTRICT
MEDICAL STAFF BYLAWS

PREAMBLE

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE I

NAME

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

ARTICLE II

MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

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

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

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

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

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

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

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

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

5) Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

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

a. Document their current licensure as required by law.

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

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

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

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

2.2-2 PARTICULAR QUALIFICATIONS

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

b. Dentists, Oral Surgeons, and Podiatrists

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

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

2.2-3 PARTICULAR QUALIFICATIONS

A practitioner who does not meet the above basic qualifications is ineligible to apply for Medical Staff membership, and the application will not be accepted for review, except that members of the Honorary Status do not need to comply with the basic qualifications. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application will be discontinued.

An Applicant who does not meeting the basic qualifications is not entitled to the procedural rights set forth in Article Seven, but may submit comments and a request for reconsideration of the specific qualifications that adversely affect such practitioner. The comments and requests will be reviewed by the Medical Executive Committee and the Board of Directors, which will have the sole discretion whether to consider any changes in the basic qualifications.

2.3 EFFECT OF OTHER AFFILIATIONS

(a) No person shall be entitled to membership on the Medical Staff, assigned to a particular staff category, or granted or renewed particular clinical privileges merely because that person:

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

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

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or clinical privileges shall be determined on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

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

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

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

membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws.

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

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

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

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

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

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

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

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

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

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

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

(i) participate in continuing education programs;

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

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

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

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

(n) continuously meet the qualifications for membership as set forth in these Bylaws. (It is understood that a member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws and the Rules whenever the Medical Executive Committee has good cause to question whether the member continues to meet such requirement);

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

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

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

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

(2) an action by the medical staff executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

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

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

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

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

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

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

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

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

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

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

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

c. have offices or residences that, in the opinion of the Medical Executive Committee, are located close enough to the hospital to provide appropriate continuity of care;

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

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

3.2-2 PREROGATIVES

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

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

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

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

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

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

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

3.3 COURTESY STAFF

3.3-1 QUALIFICATIONS

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

The Courtesy Staff Shall Consist Of Members:

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

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

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

3.3-2 PREROGATIVES

Except as otherwise provided, the Courtesy Staff member:

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

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

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

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

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

3.3-3 TRANSFER TO ACTIVE STATUS:

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

3.4 HONORARY STAFF

3.4-1 QUALIFICATIONS

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

3.4-2 PREROGATIVES

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

3.5 LIMITATION OF PREROGATIVES

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

3.6 GENERAL EXCEPTIONS TO PREROGATIVES

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

3.7 MODIFICATION OF MEMBERSHIP

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

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

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

3.8 RESIDENT STAFF

3.8-1 QUALIFICATIONS

Resident staff membership shall be held by post-doctoral trainees (residents and fellows) in training programs of teaching institutions who are not eligible for another staff category and who

are either licensed or registered with the appropriate State of California and/or Nevada licensing board, if practicing medicine. All resident staff members must obtain a license to practice medicine within the State of California and/or Nevada, as appropriate.

3.8-2 APPOINTMENT

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

b. All medical care provided by resident staff is under the supervision of members of the Active or Courtesy Staff. Such care shall be in accordance with the provisions of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation. Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability, and experience

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

ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

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

4.2 QUALIFICATIONS FOR INITIAL APPOINTMENT

Threshold Eligibility Criteria for Initial Appointment:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) it would not be possible, with reasonable and good faith efforts, for him or her to become board certified, maintain board certification, or regain board certification, as applicable; and
(2) based on his or her qualifications, experience and demonstrated competence, he or she can be relied upon to provide care of the same quality and sophistication that is expected of those who have achieved initial board certified in the same specialty.

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

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

4.2 BURDEN OF PRODUCING INFORMATION

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

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

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

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

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

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

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

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

4.2-2 COMPLETE APPLICATION FOR NEW OR ADDITIONAL PRIVILEGES

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

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

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

4.2-3 INCOMPLETE APPLICATION

An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for credentialing recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given sixty (60) days to do so, the credentialing process will be terminated at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. An incomplete application will not be processed. Termination of the credentialing process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

4.2-4 APPLICANT RESPONSIBILITY FOR KEEPING APPLICATION CURRENT

Until notice is received from the Board of Directors regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any material change in the information provided or new information that might reasonably have an effect on the applicant's candidacy, including the filing of any malpractice claim against the applicant. Failure to meet this responsibility shall be grounds for denial of the application, nullification of any approval if granted, and/or termination of Medical Staff Membership.

4.2-5 COMPLETED APPLICATION TIME PERIOD

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

4.2-6 SIGNIFICANT MISREPRESENTATIONS OR OMISSIONS

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

4.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

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

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

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

4.5 BASIS FOR APPOINTMENT AND REAPPOINTMENT

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

4.5-1. APPLICATION FORM

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

a. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, Nevada pharmacy certificate and

fluoroscopy certificate as appropriate, professional affiliations, and continuing medical education information related to the privileges to be exercised by the applicant;

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

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

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

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

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

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

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

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

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

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

4.5-2 EFFECT OF APPLICATION

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

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

b. authorizes consultation with others who may have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and

performance, and authorizes those individuals and organizations to candidly provide that information;

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

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

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

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

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

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

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

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

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

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

4.5-3 APPLICATION FEE

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

4.5-4 VERIFICATION OF INFORMATION

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

4.6 ACTION ON THE APPLICATION

4.6-1 DEPARTMENT ACTION

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

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

4.6-2 MEDICAL EXECUTIVE COMMITTEE ACTION

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

4.6-3 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

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

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

4.6-4 BOARD OF DIRECTORS ACTION

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

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

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

d. **After Procedural Rights.** In the case of an adverse Medical Executive Committee recommendation pursuant to Section 4.6-3 (b) or an adverse Board decision pursuant to Sections 4.6-4 (a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights under the Bylaws. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final

determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Board of Directors shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Board shall make a final decision.

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

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

4.6-5 NOTICE OF FINAL DECISION

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

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

4.6-6 TIMELY PROCESSING OF APPLICATIONS

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

4.7 PROVISIONAL STATUS

4.7-1 OBSERVATION OF PROVISIONAL STAFF MEMBERS

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

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

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

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

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

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

4.7-2 DURATION OF PROVISIONAL STATUS

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

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

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

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

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

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

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

4.8 REAPPOINTMENT

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

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

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

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

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

4.8-2 EFFECT OF REAPPOINTMENT APPLICATION

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

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

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

4.8-3 FAILURE TO FILE REAPPOINTMENT APPLICATION

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

4.9 LEAVE OF ABSENCE

4.9-1 REQUEST FOR LEAVE STATUS

a. Routine Leave of Absence

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

using its sole discretion as to whether the requested leave of absence is in the best interests of the Hospital and the Medical Staff. Leave of absences must be requested if the Medical Staff member is going to be absent from practice for more than sixty (60) days. There shall be no right to a leave of absence; nor shall there be any procedural rights associated with failure to obtain approval for a requested leave. The member shall be notified in writing of the Medical Executive Committee decision and is only effective upon acceptance of the Medical Executive Committee.

b. Medical Leave of Absence

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

4.9.2 OBLIGATION UNDER LEAVE OF ABSENCE

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

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

4.9-3 EXTENSION OR TERMINATION OF LEAVE

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

4.9-4 FAILURE TO REQUEST REINSTATEMENT

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

4.9-5 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

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

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

4.10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

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

4.11 CONFIDENTIALITY, IMPARTIALITY

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

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

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

5.2 BASIS FOR PRIVILEGES DETERMINATION

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

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

5.3-1 ADMISSIONS

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

5.3-2 SURGERY

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

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

5.3-3 MEDICAL APPRAISAL

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

5.4 TEMPORARY CLINICAL PRIVILEGES

5.4-1 GENERAL

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

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

a. a written request for temporary privileges;

b. a completed application form;

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

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

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

f. fluoroscopy certificate if applicable

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

h. query for and receipt of criminal background check

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

j. other information as may be required per credentialing policy

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

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

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

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

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

5.4-2 CIRCUMSTANCES

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

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

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

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

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

5.4-3 CONDITIONS

There is no right to temporary privileges. Temporary privileges may be granted only when the practitioner has submitted a written application for appointment to the Medical Staff, or a written request for temporary privileges, and the information available reasonably supports a favorable determination regarding appointment or the practitioner's qualifications, respectively, and the applicant has satisfied the insurance requirements of these Bylaws or Rules. The Chair of the Department to which the practitioner is assigned, or to which the privileges correspond, shall be

responsible for determining the proctoring requirements or supervising the performance of any practitioner granted temporary privileges, or for designating a member of the Department to assume this responsibility. Special requirements of consultation and proctorship may be imposed by the Chair of that Department or the Medical Executive Committee. Temporary privileges will not be granted before the practitioner has acknowledged in writing that he/she has received, or has been given access to, the Medical Staff Bylaws and Rules and that he/she agrees to be bound by their terms in all matters relating to his/her Medical Staff status and the temporary privileges.

5.4-4 TERMINATION

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

5.4-5 RIGHTS OF THE PRACTITIONER

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

5.5 EMERGENCY PRIVILEGES

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

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

5.6 DISASTER PRIVILEGES

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

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

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

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

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

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

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

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

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

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

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

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

5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, or pursuant to a member's request, the Medical Executive Committee may recommend a change in the privileges or Department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in the Rules regarding proctoring.

5.8 LAPSE OF APPLICATION

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

5.9 CONFIDENTIALITY, IMPARTIALITY

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

5.10 ALLIED HEALTH PROFESSIONALS

5.10-1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

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

5.11 TELEMEDICINE PRIVILEGES

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

5.11-1 TELEMEDICINE CREDENTIALING

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

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

c. The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the Hospital and its Medical Staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the Medical Staff, as described in Section 2.6 of these Bylaws, modified only to take into account their distance from the Hospital.

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

5.11-2 RELIANCE ON DISTANT-SITE ENTITIES

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

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

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

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

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

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

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

5.11-3 RESPONSIBILITIES AND PREROGATIVES

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

ARTICLE VI

CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND CRITERIA FOR INITIATION OF AN INVESTIGATION

6.1-1 ROUTINE MONITORING AND PEER REVIEW

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

6.1-2 CRITERIA FOR INITIATION OF AN INVESTIGATION

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

6.2 INVESTIGATION

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

6.3 INITIATION

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

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

6.4 EXECUTIVE COMMITTEE ACTION

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

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

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

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

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

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

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

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

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

6.5 SUBSEQUENT ACTION

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

(a) If the Medical Executive Committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the Board of Directors may be advised of the action and

hearing request but shall take no action on the matter until the practitioner has either waived or exhausted his or her hearing rights.

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

6.6 INITIATION BY BOARD OF DIRECTORS

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

6.7 SUMMARY RESTRICTION OR SUSPENSION

6.7-1 CRITERIA FOR INITIATION

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

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

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

d. The summary restriction or suspension may be limited in duration and shall remain in effect for the period and/or subject to the terms stated, or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another member by the department chair or appropriate clinical service chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

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

6.7-2 WRITTEN NOTICE OF SUMMARY ACTION

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

6.7-3 MEDICAL EXECUTIVE COMMITTEE ACTION

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

6.7-4 PROCEDURAL RIGHTS

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

6.8 AUTOMATIC SUSPENSION OR LIMITATION

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

6.8-1 LICENSURE

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

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

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

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

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

6.8-2 CONTROLLED SUBSTANCES

Whenever a Member's DEA certificate:

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

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

6.8-3 MEDICAL RECORDS

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

6.8-4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments shall be grounds for automatic suspension of a Member's Clinical Privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the Member is given notice of delinquency and warned of the automatic suspension. If the Member still has not paid the required dues or assessments within six (6) months after such notice of delinquency, the Member's membership shall be automatically terminated.

6.8-5 PROFESSIONAL LIABILITY INSURANCE

If at any time a Member fails to maintain continuous professional liability insurance coverage (i.e., such coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, in whole or in part) for all of the Member's Clinical Privileges, the Member's affected Clinical Privileges shall be suspended automatically as of that date until the Chief of Staff determines there is acceptable documentation of adequate professional liability insurance coverage, which shall include, unless excused by the Medical Executive Committee for good cause, "prior acts" coverage for the period of time during which the Member had allowed his or her coverage to lapse or become noncompliant with Medical Staff requirements. If acceptable proof of

such coverage is not provided to the Chief of Staff within ninety (90) days of such lapse, then the Member's Clinical Privileges and membership shall automatically terminate.

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

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

a. Physical or mental examinations and reports;

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

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

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

6.8-9 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM

Whenever a practitioner is excluded from any Federal Health Care Program, the practitioner's Clinical Privileges shall be automatically suspended as of the effective date of such exclusion. Unless the Board of Directors determines, upon recommendation of the Medical Executive Committee, that the practitioner may still effectively practice at the hospital under such exclusion without creating unacceptable risk of penalty to the hospital or other Medical Staff members, unacceptable risk of disruption to hospital operations, or unacceptable publicity, the practitioner's Clinical Privileges and staff membership shall be terminated.

6.9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION FOLLOWING AUTOMATIC SUSPENSION OR LIMITATION

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

6.10 PRACTITIONER OBLIGATIONS

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

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

ARTICLE VII

HEARINGS AND APPEALS

7.1 GENERAL PROVISIONS

7.1-1 INTENT:

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

7.1-2 EXHAUSTION OF REMEDIES

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

7.1-3 INTRAORGANIZATIONAL REMEDIES

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

7.1-4 DEFINITIONS

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

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

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

c. "Day" means calendar day.

7.1-5 SUBSTANTIAL COMPLIANCE

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

7.1-6 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

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

7.2 GROUNDS FOR HEARING

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

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

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

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

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

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

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

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

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR RECOMMENDATION

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

a. A description of the action or recommendation;

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

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

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

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

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

7.3-2 REQUEST FOR HEARING

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

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

7.4 HEARING PROCEDURE

7.4-1 TIME AND PLACE FOR A HEARING

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

7.4-2 NOTICE OF REASONS OR CHARGES

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

7.4-3 HEARING COMMITTEE

a. When a hearing is requested the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders, or initial decision makers, and otherwise have not

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

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

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

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

7.4-4 THE HEARING OFFICER

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

7.4-5 EXAMINATION (VOIR DIRE)

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

7.4-6 REPRESENTATION

a. The parties may be represented by legal counsel. However, the body whose decision prompted the hearing shall not be represented by an attorney at law if the practitioner is

not so represented. The foregoing shall not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing, including the identification and resolution of pre-hearing procedural issues or disputes. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed in the State of California who is not also an attorney at law.

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

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

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

7.4-8 POSTPONEMENTS AND EXTENSIONS

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

7.5 DISCOVERY

7.5-1 RIGHTS OF INSPECTION AND COPYING

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

7.5-2 LIMITS ON DISCOVERY

The Hearing Officer shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied or safeguards may be imposed when justified to protect peer review or in the interest of fairness or equality. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the Practitioner under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

7.5-3 RULING ON DISCOVERY DISPUTES

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

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

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

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

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

7.5-4 PREHEARING DOCUMENT EXCHANGE

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

7.5-5 WITNESS LISTS

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

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

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

7.6 MISCELLANEOUS PROCEDURAL MATTERS

7.6-1 PROCEDURAL DISPUTES

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

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

7.6-2 RECORD OF HEARING

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

7.6-3 ATTENDANCE

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

7.6-4 RIGHTS OF THE PARTICIPANTS

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

7.6-5 RULES OF EVIDENCE

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

the content of any settlement discussions between the parties regarding the resolution of issues in the hearing shall not be admissible.

7.6-6 BURDENS OF PRESENTING EVIDENCE AND PROOF

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

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

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

7.6-7 ADJOURNMENT AND CONCLUSION

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

7.6-8 BASIS FOR DECISION

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

7.6-9 DECISION OF THE HEARING COMMITTEE

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

7.7 APPEAL

7.7-1 TIME FOR APPEAL

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

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

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

7.7-2 GROUNDS FOR APPEAL

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

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

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

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

7.7-3 TIME, PLACE AND NOTICE

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

(60) days from the date of notice. The time for appellate review may be extended by the appeal board for good cause.

7.7-4 APPEAL BOARD

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

7.7-5 APPEAL PROCEDURE

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

7.7-6 DECISION

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

7.8 RIGHT TO ONE HEARING

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

7.9 EXCEPTION TO HEARING RIGHTS

7.9-1 EXCLUSIVE CONTRACTS

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

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

No hearing provided for in this article shall be utilized to make determinations as to the merits or substantive validity of any Medical Staff bylaw, rule, regulation or policy. Where a Practitioner is

adversely affected by the application of a Medical Staff bylaw, rule, regulation or policy, the Practitioner's sole remedy is to seek review of such bylaw, rule, regulation or policy initially by the Medical Executive Committee. The Medical Executive Committee may in its discretion consider the request according to such procedures as it deems appropriate. If the Practitioner is dissatisfied with the action of the Medical Executive Committee, the Practitioner may request review by the Board of Directors, which shall have discretion whether to conduct a review according to such procedures as it deems appropriate. The Board of Directors shall consult with the Medical Executive Committee before taking such action regarding the bylaw, rule, regulation or policy involved. This procedure must be utilized prior to any legal action.

7.9-3 DEPARTMENT, SECTION OR SERVICE FORMATION OR ELIMINATION

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

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

ARTICLE VIII

OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

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

8.1-2 QUALIFICATIONS

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

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

8.1-3 NOMINATIONS

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

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

C. At least thirty (30) days prior to the deadline for voting as set forth in Section 8.1-4, below ("deadline for voting"), the Nominating Committee shall issue an announcement to the Medical Staff soliciting nominations for each office to be filled. Nominations may be submitted by any member of the Active Staff, and must be received by the Medical Staff Office at least fifteen (15) days prior to the deadline for voting.

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

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

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

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

8.1-4 ELECTIONS

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

8.1-5 TERM OF ELECTED OFFICE

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

An officer of the Medical Staff may be removed from office by a two-thirds vote of all Active Medical Staff members, for good cause, including but not limited to the following:
(a) neglect or misfeasance in office;
(b) serious acts of moral turpitude;
(c) failure to discharge satisfactorily the duties of office;
(d) failure of an officer to remain a member of the Active Medical Staff in good standing shall result in automatic removal from the medical staff office;
(e) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(f) conduct detrimental to the interests of the hospital and/or its Medical Staff;
(g) an infirmity that renders the individual incapable of fulfilling the duties of that office;
(h) or loss of confidence and support of the Medical Staff.

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

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

8.1-6 VACANCIES IN ELECTED OFFICE

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

8.2 ADMINISTRATIVE COVERAGE

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

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

8.2 DUTIES AND AUTHORITY OF OFFICERS

8.2-1 CHIEF OF STAFF

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff is the second officer of the Medical Staff. The Vice Chief of Staff shall serve for two years and assume all duties and authority of the Chief of Staff in the absence of the

Chief of Staff. The Vice Chief of Staff shall be a voting member of the Medical Executive Committee and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. The Vice Chief of Staff shall be a member of the Quality Assessment Committee. The Vice Chief of Staff will remain on the Medical Executive Committee and serve until the next Vice Chief of Staff has been elected.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Joint Conference Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by the Bylaws, or by the Medical Executive Committee. The Immediate Past Chief of Staff will remain on the Medical Executive Committee for at least three (3) months to assure a smooth transition with the change in leadership and longer as deemed necessary

8.2-4 SECRETARY-TREASURER

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

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

8.2-5 MEMBER-AT-LARGE

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

ARTICLE IX

CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

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

9.2 CURRENT DEPARTMENTS

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

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

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

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

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

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

9.3 ASSIGNMENT TO DEPARTMENTS

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

9.4 FUNCTIONS OF DEPARTMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

9.5 DEPARTMENT CHAIR AND VICE CHAIR

9.5-1 QUALIFICATIONS

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

9.5-2 SELECTION

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

9.5-3 TERMS OF OFFICE

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

9.5-4 REMOVAL

Department chairs and vice chairs may be removed from office for valid cause, including, but not limited to, to loss of confidence and support of the members of the Department, failure to cooperatively and effectively perform the responsibilities of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude. Removal of a department chair may be initiated by the Medical Executive Committee or by a petition which states the grounds for removal

and is signed by at least one-third of the members of the department eligible to vote. Removal shall be considered at a special meeting called for that purpose. The grounds for the proposed removal shall be presented to the chair or vice chair in writing at least seven (7) days prior to the special meeting, and the chair or vice chair shall be given the opportunity to address the stated grounds before the matter is put to a vote. Removal shall require a two-thirds vote of department members eligible to vote on Department matters, voting either in person at the special meeting or by mail ballot.

9.5-5 DUTIES OF DEPARTMENT CHAIR

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

a. act as presiding officer at departmental meetings;

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

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

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

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

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

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

h. endeavor to enforce the Medical Staff Bylaws, Rules, and policies within the Department;

i. communicate and implement within the Department actions taken by the Medical Executive Committee;

j. participate in every phase of administration of the Department, including making recommendations for space and other resources needed by the Department and cooperating with the nursing service and the Hospital Administration in matters such as personnel, supplies, special regulations, standing orders, and techniques;

k. assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department, as may be required by the Medical Executive Committee; and

l. perform such other duties commensurate with the office as may from time to time be requested by the Chief of Staff or the Medical Executive Committee.

9.5-6 DUTIES OF DEPARTMENT VICE CHAIR

The vice chair shall assume all duties and authority of the chair in the absence of the chair. The vice chair will be the Department representative to the Infection Control and Pharmacy and Therapeutics Committees. The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

ARTICLE X

COMMITTEES

10.1 DESIGNATION

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care services and perform other functions related to the needs of the Medical Staff, the hospital, or applicable standards and legal requirements. Any committee, whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc, including the Medical Staff meeting as a committee of the whole, that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

10.2 GENERAL PROVISIONS

10.2-1 APPOINTMENT OF MEMBERS

a. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee.

b. A Medical Staff committee shall be composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws or Rules, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members, allied health professionals, representatives from Hospital departments such as administration, nursing services, or health information services; representatives of the community, and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with vote unless the statement of committee composition designates the position as non-voting. Unless otherwise specified in these bylaws, all non-Medical Staff members appointed to committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure. The Chief of Staff shall be a nonvoting, ex-officio member on all committees to which he/she is not otherwise specifically assigned.

c. The committee chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

d. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his/her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

10.2-2 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, whichever is later, unless the member shall sooner resign or be removed from the committee.

10.2-3 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of privileges, or if any other good cause exists, that member may be removed by the Chief of Staff with the approval of the Medical Executive Committee.

10.2-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to that committee is made.

10.2-5 ACCOUNTABILITY

All committees shall be accountable to the Medical Executive Committee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

a. The officers of the Medical Staff;

b. The Department chairs;

c. The Chairman of Quality;

d. The Chairman of Ethics Committee;

e. The Incline Village Community Hospital Committee Chair;

f. The Chief Executive Officer, the Chief Operating Officer, the Chief Nursing Officer, the Director of Quality, the Chief Medical Officer, Diagnostic Imaging Representative, and a member of the IDPC representing Allied Health Professionals may attend on an ex-officio basis without a vote.

10.3-2 DELEGATION OF AUTHORITY

By adopting these Bylaws, the Medical Staff has delegated to the Medical Executive Committee the authority to perform on behalf of the Medical Staff the duties and functions described in these Bylaws, specifically including those described in this Section 10.3 and in Articles XIII and XIV. Such delegation can be limited or removed only by amendment of these Bylaws.

10.3-3 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

a. serving as the governing body of the Medical Staff, which shall include representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, committees, diagnostic imaging, and assigned activity groups;

d. recommending actions to the Board of Directors on matters of a medical-administrative nature;

e. recommending the organizational structure of the Medical Staff, the mechanism to review credentials, delineate individual clinical privileges, restrict or terminate privileges or membership and provide fair hearings, the organization of quality assessment activities and mechanisms of the Medical Staff, as well as other matters relevant to the operation of an organized Medical Staff;

f. evaluating the medical care rendered to patients in the Hospital as necessary to assure that all patients admitted or treated in any of the Hospital services receive a uniform standard of quality patient care, treatment, and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;

g. participating in the development and approval of all Medical Staff and Hospital policies, practice, and planning;

h. reviewing the qualifications, credentials, performance and professional competence and character of applicants for both clinical privileges and/or Medical Staff membership, obtaining and considering the recommendations of the concerned departments, and making recommendations to the Board of Directors regarding Medical Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

i. taking reasonable steps to promote ethical conduct and quality clinical performance on the part of all those requesting or holding clinical privileges and all members including requiring evaluation of performance whenever there is doubt about a practitioner's ability to perform requested privileges and/or the initiation of and participation in Medical Staff corrective or review measures when warranted;

j. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

k. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

l. reporting to the Medical Staff at each regular Medical Staff meeting;

m. assisting in the obtaining and maintenance of accreditation for the hospital and any related components;

n. developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

o. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

p. reviewing the quality and appropriateness of services provided by physicians and allied health professionals with executed agreements with the Hospital;

q. reviewing and approving the designation of the Hospital's Authorized Representative for National Practitioner Data Bank purposes; and

r. reviewing and approving the Utilization Review and Quality Assessment Plans; and

s. initiating, approving, and/or recommending to the Board of Directors, Medical Staff Bylaws, Rules and Regulations, and Policies, and amendments and technical corrections thereto, in accordance with Articles XIII and XIV of these Bylaws.

10.3-4 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least once a month and shall maintain a record of its proceedings and actions.

10.3-5 REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

Medical Staff Officers and Department Chairs shall be removed from the Medical Executive Committee following removal from their respective positions as provided for in the relevant provisions of these Bylaws.

All other members of the Committee may be removed for valid cause, including but not limited to substantial neglect or misfeasance or other failure to discharge satisfactorily the duties of a Medical Executive Committee member, according to the following procedures:

a. Proceedings to remove the member may be initiated by the Medical Executive Committee or by a petition signed by at least 25% of the Medical Staff members eligible to vote for Medical Staff officers.

b. Once initiated, removal shall be considered at a regular or special meeting of the Medical Staff.

c. The grounds for removal shall be presented in writing by the Chief of Staff to the member whose removal has been proposed, at least ten (10) days before the Medical Staff meeting at which the matter will be put to a vote.

d. The member shall be given an opportunity to make a statement at the meeting regarding the asserted grounds for removal, prior to the vote. The Chief of Staff has discretion to determine whether a representative of the Medical Executive Committee or other group of Medical Staff members who proposed removal also should be given an opportunity to speak prior to the vote. The Chief of Staff may establish a reasonable time limit for any such statements.

e. Voting shall be by secret ballot marked “for” or “against” removal. The member will be removed from the Medical Executive Committee if a majority of the eligible members who cast ballots at the meeting vote “for” removal.

10.4 JOINT CONFERENCE COMMITTEE

Except as otherwise provided in Section 13.11 of these Bylaws, with respect to any conflict between the Medical Staff and the Board of Directors, the Medical Staff and Board shall meet and confer in good faith to resolve the dispute. Unless otherwise agreed, the forum for this shall be a committee composed as specified below; however, the Medical Staff and Board can utilize additional or different forums or processes, such as mediation, so long as both the Medical Staff and Board mutually agree to the forum or process as well as any procedures that would govern the process.

10.4-1 COMPOSITION

The Joint Conference Committee shall consist of the Chief of Staff, the Vice-Chief of Staff, the immediate past Chief of Staff, the Chief Executive Officer, and two (2) members of the Board of Directors appointed by the President of the Board. The Chair shall alternate at the beginning of

the Medical Staff year between a Medical Staff JCC member selected by the Chief of Staff and a Board of Directors JCC member.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws or in the bylaws of the Hospital.

10.4-3 EXHAUSTION

Prior to seeking judicial relief over any dispute with the Hospital or Board of Directors, including any allegation that the Hospital or Board has engaged in, or is about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of the administrative remedies provided in these Bylaws.

10.4-4 MEETINGS

The Joint Conference Committee shall meet as often as necessary and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.

ARTICLE XI

MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETING

a. There shall be an Annual Meeting of the Medical Staff in November of each year. Notice of this meeting shall be given to the members at least thirty (30) days prior to the meeting.

b. The Chief of Staff, or such other officers, Department chairs, or committee chairs as designated, may present reports on actions taken during the preceding year and on other matters of interest and importance to the members.

c. Announcement of the results of the election of officers shall occur at this meeting.

11.1-2 REGULAR GENERAL MEDICAL STAFF MEETINGS

Regular meetings of the Medical Staff may be held each quarter, except that the Annual Meeting shall constitute the regular meeting during the quarter in which it occurs. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and adequate notice shall be given to the members.

11.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of not fewer than ten percent (10%) of the Active Medical Staff. The request for the special meeting shall state the purpose of the proposed meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10)

days prior to the meeting, notice shall be mailed or delivered to the members of the Medical Staff, which includes the stated purpose of the meeting.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the committees as a whole, the chairs of committees, and Departments as a whole may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the members are given adequate notice of meeting dates. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee or Department may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, or be called by written request of ten percent (10%) of the current members, eligible to vote, but no fewer than 2 members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of twenty-five (25%) percent of the total membership of the Active Medical Staff at any regular or special meeting in person or by proxy shall constitute a quorum.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of one-half of the voting members shall be required for Medical Executive Committee meetings. For other committees and for Departmental meetings, a quorum shall consist of not less than two voting members.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of the majority of the members present and voting at a meeting at which a quorum is present, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meetings, or such greater number as specifically required by these Bylaws. Committee or Department action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee or Department if it is acknowledged in writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be provided to the presiding officer of the meeting and forwarded to the Medical Executive Committee. The Medical Staff Office shall maintain those minutes.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Courtesy Staff shall be encouraged to attend the Annual Medical Staff meeting and required to attend at least fifty percent (50%) of all meetings of each Department (Active Staff) and committee of which he/she is a member. Active Staff members shall be required to attend at least 50% (two meetings per year) of regular General Medical Staff meetings each year.

Each member of the Courtesy Staff shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

Failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action, pursuant to these Bylaws.

11.6-2 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular Department, or committee meeting, the member may be requested to attend. The request shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the subject involved. Failure of a member to appear at any meeting, with respect to which he/she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for action pursuant to Section 6.4-3.

ARTICLE XII

CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Medical Staff membership or privileges within this Hospital, an applicant:

a. authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon the applicant's professional ability and qualifications;

b. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

c. agrees to be bound by the provisions of this Article and the Bylaws and to waive to the fullest extent permitted by law all legal claims against any representative of the Medical Staff or the Hospital or any third party who acts in accordance with the provisions of this Article and the Bylaws and Rules; and

d. acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership and privileges, the continuation of that membership, and to the exercise of privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

Minutes, files, records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff when meeting as a committee of the whole, meetings of

Departments, meetings of committees established under the Bylaws, and meetings of special or ad hoc committees created under the Bylaws, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential and protected by applicable state and/or federal peer review confidentiality laws, including but not limited to California Evidence Code Section 1157 and Nevada Rev. Stat. Sections 49.119-121 and 49.265. These records and information shall become a part of the Medical Staff committee files and shall not become part of any patient files, of general Hospital records, or of any member's personal or office files.

Access to such records for Medical Staff purposes shall be limited to duly appointed officers and committees of the Medical Staff as necessary to discharge medical staff responsibilities and subject to the requirements that confidentiality is maintained. By serving on a department, Medical Staff or Hospital committee, a Medical Staff member pledges that he or she will not waive the confidentiality respecting any committee on which he or she serves, except as expressly required by law.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment must be based on free and candid discussions, any breach of confidentiality of the discussion or deliberations of the Medical Staff Departments, or committees, except as authorized, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Staff or Hospital may undertake such corrective action as is deemed appropriate.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative, agent, member, and employee of the Medical Staff and Hospital shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief by reason of providing information concerning such person.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

a. application for appointment, reappointment, clinical privileges, or specified services;

b. periodic reappraisals for reappointment, clinical privileges, or specified services;

c. corrective action and peer review;

d. hearings and appellate reviews;

e. utilization review and quality assessment, including patient care audits and morbidity and mortality reviews;

f. other Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

g. the actions of peer review organizations, state medical boards, and other entities which engage in monitoring or evaluation of professional competence or conduct, including queries and reports to or from the National Practitioner Data Bank, Medical Board of California, Nevada State Board of Medical Examiners, specialty boards, peer review organizations and other professional or health care related entities.

12.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 CUMULATIVE EFFECT

Provisions in these Bylaws, in the Rules and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

12.7 ACCESS TO MEDICAL STAFF FILES BY PERSONS WITHIN THE HOSPITAL OR MEDICAL STAFF

12.7-1 MEANS OF ACCESS

Unless otherwise stated, a person permitted access under this section shall be given reasonable opportunity to inspect the records in question and to make notes regarding them, but not to remove them or to make copies of them. Removal or copying shall be only upon the express written permission of the Medical Executive Committee.

12.7-2 PERSONS GAINING ACCESS

a. **Chief Executive Officer or Designated Representative**. The Chief Executive Officer or his/her designated representative shall have access to all Medical Staff records.

b. **Medical Staff Department Members**. The Medical Staff Department chairs and other members of the Department to the extent that they are involved in a credentialing or peer review process conducted pursuant to the Medical Staff Bylaws shall have access to the files of the Department committee on which they serve and the credentials and peer review files of practitioners under evaluation.

c. **Officers of the Medical Staff**. Officers of the Medical Staff and others carrying out official Medical Staff duties and responsibilities as provided in these Bylaws (including members of ad hoc investigative committees) shall have access to credentials and peer review files as necessary to carry out their duties and responsibilities.

12.7-3 GENERAL ACCESS BY PRACTITIONERS TO MEDICAL STAFF RECORDS

a. **Credentials and Peer Review Files**. Upon request, a practitioner shall be afforded a copy of any document in the credentialing and any peer review file concerning him/her if the document was submitted by him/her (for example, an application for Medical Staff membership or correspondence) or if the document was addressed to him/her or if its author had provided a "cc" to him/her. At the discretion of the Chief of Staff, a summary of some or all other information in these files may be provided to the practitioner.

b. **Medical Staff Committee and Department Files**. A practitioner shall have access to Medical Staff committee and Department files regarding him/her only if, following a written request by the practitioner, the Medical Executive Committee grants permission upon a showing of good cause.

12.8 ACCESS BY PERSONS OR ORGANIZATIONS OUTSIDE OF THE HOSPITAL OR MEDICAL STAFF

12.8-1 CREDENTIALING OR PEER REVIEW AT OTHER HOSPITALS

Any request for credentialing or peer review information by another institution should be presented in writing. No information shall be released until a copy of an acceptable release signed by the subject practitioner has been received from the requesting institution.

12.8-2 OTHER REQUESTS

All other requests by persons or organizations outside of the Hospital for information contained in the Medical Staff records shall be forwarded to the Chief Executive Officer. Any such request shall be in writing and shall be accompanied by a release signed by the concerned practitioner. The release of any such information shall require the concurrence of the Chief of Staff and the Chief Executive Officer.

12.8-3 SUBPOENAS AND REQUESTS FROM GOVERNMENT AGENCIES

All subpoenas and requests from government agencies for Medical Staff records shall be referred to the Chief Executive Officer. The Medical Staff Office, the Risk Manager and the Chief of Staff shall be informed of the subpoena. No documents or records will be released without consultation with the Chief of Staff, or his/her designee

12.9 RESPONSIBILITIES OF MEMBERS OF THE MEDICAL STAFF

Recognizing the importance of preserving the confidentiality of information, all individuals covered by this policy agree to respect the confidentiality of all information obtained in connection with their responsibilities. This requirement of confidentiality extends not only to the information contained in the physical files of the Medical Staff, but to the discussions and deliberations of Medical Staff committees.

12.10. INSERTION, DELETION, AND/OR CHANGES TO MEDICAL STAFF MEMBERS' CREDENTIALS FILE

12.10-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

a. Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

b. When a request is made for insertion of adverse information into the Medical Staff member's credentials file, the respective Department chair and Chief of Staff shall review such a request.

c. After such a review, a decision will be made by the respective Department chair and Chief of Staff to:

i. not insert the information;
ii. notify the member of the adverse information by a written summary, and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

iii. notify the member of the adverse information, and insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation.

d. This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

12.10-2 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION, DELETION, OR ADDITIONS TO FILE

a. When a member has reviewed his/her file as provided in accordance with Medical Staff policy and these Rules, he/she may address to the Chief of Staff a written request for correction or deletion of information in his/her credentials file. Such a request shall include a statement of the basis for the action requested.

b. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

c. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

d. In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

ARTICLE XIII

GENERAL PROVISIONS

13.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES

Subject to approval by the Board of Directors, the Medical Executive Committee may supplement these Bylaws with Rules and Regulations or Policies that provide associated details, as it deems necessary to implement more specifically the general principles established in these Bylaws. Rules and Regulations and Policies shall become effective upon approval by the Board, which shall not be withheld unreasonably. Neither the Medical Staff nor the Board may unilaterally amend the Rules and Regulations or Policies.

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

The Medical Staff Bylaws, Rules and Regulations, and Policies shall not conflict with the Board Bylaws.

13.1-1 PROPOSALS BY THE MEDICAL EXECUTIVE COMMITTEE

a. The Medical Executive Committee shall initiate and adopt such general Rules and Regulations as it may deem necessary for the proper conduct of the Medical Staff's affairs and shall periodically review and revise the Rules and Regulations to comply with current Medical Staff practice. Additions or recommended changes to the general Medical Staff Rules and Regulations shall be generated by or submitted to the Medical Executive Committee for review and approval.

b. Any new or amended provisions for the Rules and Regulations proposed by the Medical Executive Committee shall be announced to the Medical Staff, which shall be afforded a period of at least thirty (30) days to submit written comments for consideration by the Medical Executive Committee before the provisions are submitted to the Board of Directors. Notice of the proposed provisions to the Medical Staff shall be in a reasonable manner, which may include posting in a newsletter or bulletin, distribution at a general Medical Staff meeting, or any other method regularly used by the Medical Staff Office to provide notices to members. The Medical Executive Committee may retain, modify or abandon the provisions, as it deems appropriate in light of the comments, if any. Notice of new or amended Policies adopted by the Medical Executive Committee shall be provided to the Medical Staff promptly upon approval by the Board of Directors.

13.1-2 PROPOSALS BY PETITION

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

a. A proposal bearing the signatures of 25% or more of the voting members of the Active Medical Staff (which will constitute notice of the proposal to the Medical Executive Committee) must identify two Active Medical Staff members who will serve as representatives and act on behalf of the proposal signers in the processes described below (including any conflict management processes):

b. If the Medical Executive Committee supports a proposed amendment of the Rules and Regulations as submitted, the proposal will be disseminated to the Medical Staff for comment as described in Section 13.1-1 above, before the Medical Executive Committee submits the proposal to the Board of Directors for approval. The Medical Executive Committee is not required to submit proposed Policies or proposed Policy amendments to the Medical Staff for comment.

c. If the Medical Executive Committee does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.

d. If the conflict is not resolved by withdrawal of the proposal, or by Medical Executive Committee support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified in the conflict management process, then as modified) to the Medical Staff for comment as described below before the proposal is submitted to the Board of Directors for approval.

e. With respect to any Rules and Regulations proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee has discretion to do any of the following:

- disseminate the proposal, as submitted, to the Medical Staff for comment;
- modify the proposal and disseminate it, as modified, to the Medical Staff for comment; or
- reject the proposal and not disseminate it to the Medical Staff for consideration.

f. With respect to any Policy proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee may accept, modify or reject the proposal without disseminating it to the Medical Staff for comment.

g. Except as otherwise provided in this Article, before the Medical Executive Committee submits any proposal for adoption or amendment of Rules and Regulations to the Board of Directors for approval, the Medical Executive Committee shall disseminate the proposal to the Medical Staff, as described in Section 13.1-1 above. Members of the Medical Staff shall be given an opportunity to submit written comments, through the Medical Staff Office, for a period of not less than thirty (30) days.

h. After considering any comments that have been received within the allotted period, the Medical Executive Committee may modify the proposal in light of the comments. The Medical Executive Committee will disseminate any such modified proposal to the Medical Staff, and may, in the Medical Executive Committee's discretion, solicit further comments in the manner described above.

i. If a proposal did not include the signatures of 25% or more of the voting members of the Active Medical Staff, but the Medical Executive Committee disseminated the proposal to the Medical Staff for comment, then after the comment period ends the Medical Executive Committee in its discretion may do either of the following:

- submit the proposal to the Board of Directors for approval, in its original form or as modified in light of the comments; or
- reject the proposal and not submit it to the Board of Directors.

13.1-3 DEPARTMENT RULES AND REGULATIONS AND POLICIES

Rules and Regulations and Policies for Medical Staff Departments may be established and amended by the same process as general Medical Staff Rules and Regulations and Policies, except that:

a. Department-initiated proposals for establishing or amending Department-specific Rules and Regulations or Policies shall be submitted to the Medical Executive Committee by the relevant Department Chair following adoption by a majority of the voting members of the Department.

b. Department-initiated proposals that are acceptable to the Medical Executive Committee as submitted may be adopted by the Medical Executive Committee and submitted to the Board of Directors for approval.

c. Each Medical Executive Committee-initiated proposal and Department-initiated proposal that the Medical Executive Committee proposes to modify or reject shall be disseminated for comment to the relevant Department, along with a statement of the Medical Executive Committee's reasons, before the Medical Executive Committee submits any

such proposal to the Board of Directors for approval. The Department will have 30 days to submit responsive comments to the Medical Executive Committee in writing, and any such Department comments will be submitted to the Board along with the Medical Executive Committee's proposal.

d. If the Medical Executive Committee has rejected a Department-initiated proposal, the Department Chair (or another Department representative chosen by the Department members, if the Chair does not support the proposal) may invoke the conflict management process set forth in Section 13.12 of these Bylaws within 30 days of receiving notice of the rejection. If the conflict management process is not invoked timely, it will be deemed waived. If the matter is not resolved in the conflict management process, the proposal will be submitted to the Board of Directors for approval along with the written comments of the Department and the Medical Executive Committee.

e. If the Board of Directors does not approve a Department-specific proposal, the Medical Executive Committee, Department Chair, and/or designated Department representative may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice of that the Board did not approve the proposal.

13.1-4 URGENT NEED

a. If the Medical Executive Committee receives documentation of an urgent need to amend the Medical Staff Rules and Regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit it to the Board of Directors for provisional approval, without prior notification of the Medical Staff. Immediately following the Medical Executive Committee's adoption of such an urgent provisional amendment to the Rules and Regulations, the Medical Executive Committee will notify the Medical Staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested Medical Staff member to submit written comments to the Medical Executive Committee within 30 days of the date of the notice. The amendment will become final at the end of the comment period if the comments indicate there is no substantial conflict regarding the provisional amendment. There is no substantial conflict unless at least 25% of voting Active Medical Staff members expresses opposition to the amendment in writing.

b. If the comments indicate a substantial conflict over the provisional amendment, then the Medical Executive Committee will implement the conflict management process set forth in Section 13.12 of these Bylaws, and may submit a revised amendment to the Board for approval if necessary.

13.1-5 ADOPTION BY THE BOARD

a. Following Medical Executive Committee approval of Medical Staff General Rules and Regulations, departmental Rules and Regulations, or Medical Staff policies as noted above, such Rules and Regulations or policies shall become effective following approval by the Board. Board approval shall not be withheld unreasonably. Upon approval by the Board, new Rules and Regulations, Policies, or amendments to existing Rules and Regulations or Policies, shall be announced promptly to the Medical Staff in a reasonable manner, as described in Section 13.1-1(b) above.

b. If a proposal is not approved by the Board, then the Medical Executive Committee (or the designated representatives of the group of Medical Staff members who submitted a non-Medical Executive Committee-supported proposal that went directly to the Board) may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice that the proposal was not approved by the Board.

c. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations and policies.

13.1-6 ADHERENCE TO MEDICAL STAFF RULES AND REGULATIONS, MEDICAL STAFF POLICIES, AND HOSPITAL ADMINISTRATIVE POLICIES

Applicants and Members of the Medical Staff and others holding Clinical Privileges or exercising Practice Prerogatives shall be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures which have been appropriately approved by the Medical Executive Committee and Board of Directors.

13.2 DUES OR ASSESSMENTS

The Medical Staff shall have the power to adopt the amount of annual dues or assessments, if any, for each category of Medical Staff membership and is solely responsible for the collection, use, and expenditure of Medical Staff funds. Provisional Medical Staff members shall not be required to pay dues until after serving one year on the medical staff.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. The words used in these Bylaws and the Rules shall be read to apply to both gender and to both the singular and the plural, as the context requires.

13.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first-class postage prepaid. The use of certified or registered mail is optional unless expressly required in these Bylaws. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained.

Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of Department, or committee (c/o Medical Staff Office, or Chief of Staff)
Tahoe Forest Hospital District
Post Office Box 759
Truckee, California 96160

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital, and, in the absence of proof of earlier receipt, shall be deemed received five days after mailing in accordance with this Section 13.4.

13.5 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

13.5-1 GENERAL

a. Medical Staff representatives, as designated by the Chief of Staff, shall participate in Hospital deliberations affecting the discharge of Medical Staff responsibilities.

b. The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

13.5-2 EXCLUSIVE CONTRACTING DECISIONS

The Medical Executive Committee shall review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee and individual members of Medical Staff shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

13.6 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance from a company authorized to sell insurance (in the State of California for California staff members and in the State of Nevada for Nevada staff members) or from an insurance trust incorporated under the laws of one of the United States of America in no less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Directors and the Medical Executive Committee.

13.7 BYLAWS NOT A CONTRACT

These Bylaws describe the intended relationship between the Medical Staff and its members, as well as between the Medical Staff (including its members) and the Hospital. It is intended that all affected parties and entities shall conduct themselves in good faith conformance with these Bylaws. However, these Bylaws are not intended to be a contract, and technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or for seeking remedies that are contractual in nature.

13.8 WAIVER OF BYLAWS/RULES PROVISIONS

Insofar as is consistent with applicable laws, the Medical Executive Committee, in consultation with the Board or its designated representative, or the Board, in consultation with the Medical Executive Committee, has the discretion to waive provisions of the Bylaws or Rules, if either determines that this waiver is necessary to serve the best interests of the patients and the Hospital. There is no right to have a request for a waiver considered and/or granted.

13.9 INTERPRETATION / RECONCILIATION OF PROVISIONS

In the event of any ambiguity or in the Medical Staff Bylaws, Rules and Regulations or Policies, or should there be any question of interpretation, the Medical Executive Committee shall have the authority to resolve such matters. In the event of an apparent conflict between the Bylaws and Medical Staff Rules and Regulations, the Bylaws shall prevail. If there is a conflict between Medical Staff Rules and Regulations and Medical Staff Policies and Procedures, the Rules and Regulations shall prevail.

13.10 MEDICAL STAFF LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel. The authority to engage legal counsel on behalf of the Medical Staff shall be the prerogative of the Medical Executive Committee; provided, however, that if the Medical Executive Committee declines to exercise this prerogative, a majority of the voting members of the Active Staff may elect to engage legal counsel on behalf of the Medical Staff.

13.11 DISPUTES WITH THE BOARD OF DIRECTORS

In the event of a dispute between the Medical Staff and the Board of Directors relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code section 2282.5, the following procedures shall apply:

13.11-1 INVOKING THE DISPUTE RESOLUTION PROCESS

a. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.

b. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.

13.11-2 DISPUTE RESOLUTION FORUM

a. Ordinarily, the initial forum for dispute resolution should be the Joint Conference Committee.

b. However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Board of Directors. A neutral mediator acceptable to both the Board of Directors and the Medical Executive Committee may be engaged to further assist the dispute resolution upon request of (a) at least a majority of the Medical Executive Committee plus two members of the Board of Directors; or (b) at least a majority of the Board of Directors plus two members of the Medical Executive Committee.

13.11-3 FINAL ACTION

If the parties are unable to resolve the dispute the Board of Directors shall make its final determination, giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Board of Directors' determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

13.12 DISPUTES INTERNAL TO THE MEDICAL STAFF

(a) Under the following circumstances, the Medical Executive Committee shall initiate a conflict management process to address a disagreement between members of the Medical Staff and the Medical Executive Committee about an issue relating to the Medical Staff's documents or functions, including but not limited to a proposal to adopt or amend the Medical Staff Bylaws, Rules and Regulations, or Policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws):

(1) upon written petition signed by either:
- at least 25% of the voting members of the Medical Staff, or
- at least 66% of the members of any Department of the Medical Staff; or

(2) upon the Medical Executive Committee's own initiative at any time; or

(3) as otherwise specified in these Bylaws.

(b) A request to invoke the conflict management process must be submitted within any deadline specified in these Bylaws.

(c) A petition to initiate the conflict management process shall designate two Active Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.

(d) With respect to each particular conflict, the Medical Executive Committee shall determine and specify a process that the Medical Executive Committee deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:

- provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;
- require good-faith participation by representatives of the parties; and
- provide for a written decision or recommendation by the Medical Executive Committee on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

(e) At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive Committee and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

(f) This conflict management process shall be a necessary prerequisite to any proposal to the Board of Directors by Medical Staff members for adoption or amendment of a Bylaw, Rules and Regulations provision, or Policy not supported by the Medical Executive Committee, including (but not limited to) a proposed Bylaws amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the Medical Staff.

(g) Nothing in this Section is intended to prevent Medical Staff members from communicating with the Board of Directors about Medical Staff Bylaws, Rules and Regulations, or Policies, according to such procedures as the Board may specify.

13.13 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by an appropriate practitioner, i.e., an MD or DO, DDS, DPM, Clinical Psychologist, oral maxillofacial surgeon, or other qualified licensed individual in accordance with California and/or Nevada law as applicable and the Medical Staff Rules and Regulations.

Whenever the medical history and physical examination have been completed before admission or registration (which may occur only as permitted in accordance with this Section and applicable law and accreditation requirements), an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by an appropriate practitioner, as defined above.

Additional requirements for completing the medical history and physical examination for each patient are set forth in the Medical Staff Rules and Regulations.

ARTICLE XIV

ADOPTION AND AMENDMENT OF BYLAWS

14.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Directors. Amendments to these Bylaws may be submitted for vote by the Medical Executive Committee or by petition signed by at least ten percent (10%) of the voting member of the Medical Staff.

14.2 METHODOLOGY

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

(a) The affirmative vote of two-thirds (2/3) of the Staff members voting on the matter by mailed or electronic ballot; provided at least 14 days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and,

(b) Amendments shall become effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Medical Staff bylaws or rules.

In recognition of the ultimate legal and fiduciary responsibility of the Board of Directors, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Board of Directors to such effect including a reasonable period of time for response, the Board of Directors may impose conditions on the Medical Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, Medical Staff recommendations and views shall be carefully considered by the Board of Directors in its actions.

The Medical Staff Bylaws, Rules and Regulations and policies will not conflict with the Governing Board Bylaws.

14.3 AMENDMENTS BY PETITION

Generally, proposals to adopt, amend or repeal Bylaws will emanate from or be endorsed by the Medical Executive Committee in accordance with its overall responsibility to represent and act on behalf of the Medical Staff and discharge its various functions as described in Section 10.3 of these Bylaws. However, in addition to the mechanisms set forth above by which the Medical Staff may adopt Medical Executive Committee-proposed amendments to these Bylaws, the Medical Staff may adopt and propose Bylaw amendments directly to the Board of Directors for its approval, but only in accordance with the following procedure:

(a) A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least 10% of Active Medical Staff members proposing a specific Bylaws amendment or amendments (which will constitute notice of the proposed Bylaws amendment(s) to the Medical Executive Committee). Any such petition must identify two Active Medical Staff members who will serve as representatives and act on behalf of the petition signers in the processes described below (including any conflict management processes).

(b) Upon submission of such a petition, the Medical Executive Committee will determine whether it supports the proposed Bylaws amendment(s), and if so, the Medical Staff Office will arrange for a vote on the proposed Bylaws amendment(s) by the voting members of the Active Medical Staff according to the process described above for voting on Medical Executive Committee-proposed Bylaws amendments.

- If the Medical Staff adopts the proposed Bylaws amendment(s) by a vote of the Medical Staff conducted according to the process described above, then the proposed Bylaws amendment(s) will be submitted to the Board of Directors for approval.

- If the Medical Staff does not adopt the proposed Bylaws amendment(s) by vote, then the proposed Bylaws amendment(s) will be deemed withdrawn.

(c) If the Medical Executive Committee does not support the proposed Bylaws amendment(s), the Medical Executive Committee will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed Bylaws amendment(s) will be deemed withdrawn.

(d) If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or by Medical Executive Committee support of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed Bylaws amendment(s) will be submitted (in original form or, if the original proposed Bylaws amendment(s) has/have been modified in the conflict management process, then as modified) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board of Directors if a majority of the Active Medical Staff members who are eligible to vote cast their ballots in favor of the proposed Bylaws amendment(s).

(e) A copy of the Medical Executive Committee's written statement of its decision and reasons issued at the conclusion of the conflict management process shall be provided to the Board of Directors along with any proposed Bylaws amendment(s) submitted to the Board after such process.

(f) Such proposed Bylaws amendment(s) will become effective immediately upon Board approval, which shall not be withheld unreasonably.

(g) If the Board of Directors does not approve the proposed Bylaws amendment(s), then the matter will be referred to the conflict management process set forth in Section 13.11 of these Bylaws.

14.4 EXCLUSIVITY

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and the Board of Directors.

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, April 23, 2026 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

Meeting was called to order at 4:00 p.m.

2. ROLL CALL

Board in Attendance: Dale Chamblin, Board Member; Alyce Wong, Secretary; Dr. Robert Darzynkiewicz, Vice Chair; Michael McGarry, Chair

Board Member Absent: Mary Brown, Treasurer (participated in discussion via zoom, non-voting);

Staff in attendance: Anna Roth, President & CEO; Crystal Felix, Chief Financial Officer, Kim McCarl, Chief Strategy Officer; Louis Ward, Chief Operating Officer; Matt Mushet, In-House Counsel; Brian Evans, CMO; Dylan Crosby, Chief of Clinical Operations; Forhad Islam, Director of Business Intelligence; Sarah Jackson, Clerk of the Board;

Other: David Ruderman, General Counsel; Tere LeBarron, Senior Director, Alvarez and Marsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

None

4. INPUT AUDIENCE

Open Session recessed at 4:03 p.m.

5. CLOSED SESSION

5.1. Report Involving Trade Secrets (Health & Safety Code § 32106)

Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

Discussion was held on a privileged item.

5.2. Report Involving Trade Secrets (Health & Safety Code § 32106)

Discussion will concern: Existing and potential new programs and service lines
Estimated date of disclosure: December 2026

Discussion was held on a privileged item.

5.3. Liability Claims (Gov. Code § 54956.95)◈

Claimant: Vaughn Brown

Claim Against: Tahoe Forest Hospital District

Discussion was held on a privileged item.

5.4. Approval of Closed Session Minutes◈

5.4.1. 03/26/2026 Regular Meeting

Discussion was held on a privileged item.

5.2. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)◈

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:05 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reported out from Closed Session. There were no reportable actions for items 5.1. or 5.2. Trade Secrets. Item 5.3 was a Liability Claim that was rejected with a 4-0 vote. Item 5.4. Closed Session Minutes of 03/26/2026 were approved on a 4-0 vote and Medical Staff Credentials, item 5.5 was approved with a vote of 4-0.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

None

10. INPUT – AUDIENCE

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

None.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

None.

12. PRESIDENT & CEO – MONTHLY HIGHLIGHTS

12.1. Monthly Highlights

President & CEO Anna M. Roth provided an update highlighting Health Within Reach, Peaks of Excellence, Transformation, key developments, initiatives, and recent activities impacting the District.

Discussion was held.

13. MEDICAL STAFF EXECUTIVE COMMITTEE

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda

MEC recommends the following for approval by the Board of Directors:

Privileges with Changes:

- Emergency Medicine

New Policies:

- DR2601 TFHS Standardized Procedure: Oxygen Administration & Pulse Oximetry Monitoring

Policies with Changes

- DED-1803 Standardized Procedure – Preparation of the Patient Presenting with Suspected Extremity Fracture or Dislocation
- Women and Family Center (DWFC) Policies

Policies with no Changes

- Dues and Fees – MSCP-6

Chief of Staff, Dr. Koch, provided an overview of the privileges and policies included within the Medical Executive Committee Consent Agenda.

Discussion was held.

ACTION: Motion made by Director Darzynkiewicz to approve the MEC Consent Agenda as presented, seconded by Director Wong.
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: Brown

14. CONSENT CALENDAR

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

14.1. Approval of Minutes of Meetings

14.1.1. 03/26/2026 Regular Meeting

14.2. Financial Reports

14.2.1. Financial Report – March 2026

14.3. Board Reports

14.3.1. Executive Board Report – April 2026

14.4. Approval of Revisions of Board and Governance Policies

14.4.1. ABD-09 Financial Assistance Program Full Charity Care and Discount Payment Policies

14.4.2. ABD-22 Trade Secrets

14.4.3. ABD-27 Ticket and Pass Distribution Policy

14.4.4. AGOV-19 Emergency Medical Services (EMS) of Patients on Hospital Property

14.5. TFHS Environment of Care Committee Report

Discussion was held.

ACTION: Motion made by Director Wong to approve the Consent Calendar as presented, seconded by Director Chamblin.
ROLL CALL VOTE:
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: Brown

15. ITEMS FOR BOARD DISCUSSION

15.1. Tahoe Forest Health System Foundation and Incline Village Community Hospital Foundation Update

The Board of Directors will receive an update on the TFHS Foundation and IVCH Foundation activities.

Karli Bunnell, Executive Director of Foundations, presented to the Board of Directors.

Discussion was held.

15.2. True North 5,000 Voices Campaign Update

The Board of Directors will receive a presentation on the True North community engagement efforts.

Kim McCarl, Chief Strategy Officer, presented to the Board of Directors.

Discussion was held.

Public Comment was received by: Barney Dewey.

16. TIMED ITEMS FOR BOARD ACTION ◈

16.1. CY 2025 Annual Infection Control Report ◈

The Board of Directors will review and consider approval of the CY 2025 Annual Infection Control Report.

Svetlana Schopp, Infection Control & Prevention Coordinator presented the Calendar Year 2025 Annual Infection Control Report.

Discussion was held.

ACTION: Motion made by Director Darzynkiewicz to approve the CY 2025 Annual Infection Control Report as presented, seconded by Director Wong.
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.

Abstention: None
NAYS: None
Absent: Brown

16.2. Placer County LAFCO Special District Representative Selection◈
The Board of Directors will review and consider selecting a nominated candidate for the Placer County Special District Representation on LAFCO.

Discussion was held.

ACTION: Motion made by Director Wong to vote for Incumbent Judy Friedman as the Placer County Special District LAFCO Representative, seconded by Director Chamblin.
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: Brown

16.3. Resolution 2026-03 Support of Tahoe Forest Level III Trauma Center◈
The Board of Directors will consider action on a resolution for continued support of the Tahoe Forest Hospital Level III Trauma Center program and designation.

Discussion was held.

ACTION: Motion made by Director Chamblin to approve Resolution 2026-03 Support Tahoe Forest Level III Trauma Center, seconded by Director Darzynkiewicz.
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: Brown

16.4. Resolution 2026-04 Consolidated Election Services◈
The Board of Directors will review and consider approval of a resolution determining to consolidate the Hospital District General Election with the Statewide General Election and Authorizing the Canvass of Returns by the respective Boards of Supervisors of Placer and Nevada Counties, California.

Discussion was held.

ACTION: Motion made by Director Darzynkiewicz to approve Resolution 2026-04 for Consolidated Election Services, seconded by Director Wong.
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: Brown

16.5. PUBLIC HEARING: AB 2561 – Status of Vacancies and Recruitment and Retention Efforts
The Board of Directors will conduct a public hearing regarding the job vacancy status and recruitment and retention efforts at Tahoe Forest Hospital District within the bargaining unit(s) in compliance with Assembly Bill ("AB") 2561.

District Staff presented to the Board of Directors. There was no Bargaining Unit presentation.

Discussion was held.

Chair McGarry opened the Public Hearing

There was no public comment.

Chair McGarry closed the Public Hearing.

No final comments made.

ACTION: Motion made by Director Darzynkiewicz to accept the report on Tahoe Forest Hospital District's workforce vacancies, recruitment and retention efforts, in compliance with Assembly Bill 2561, as presented, seconded by Director Wong.
AYES: Directors Chamblin, Darzynkiewicz, Wong, McGarry.
Abstention: None
NAYS: None
Absent: Brown

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY
None

18. BOARD COMMITTEE REPORTS
None

19. BOARD MEMBERS' REPORTS/CLOSING REMARKS
Chair McGarry noted that the May regular meeting will reconvene after the dinner break at 5:00 p.m. instead of 6 p.m.

Director Wong provided comments on the recent Tahoe Truckee Homeless Action Coalition Meeting.

20. CLOSED SESSION CONTINUED

21. OPEN SESSION

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

23. ADJOURN

Meeting Adjourned at: 8:22 p.m.

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: May 28, 2026 – Special Meeting of the Board of Directors	**ITEM:** 11.2 Financial Reports 11.2.1 Financial Report – April 2026
DEPARTMENT: Finance	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Crystal Felix, Chief Financial Officer	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Within the Bylaws of the Board of Directors of Tahoe Forest Hospital District, the Board has financial responsibilities outlined in Article II, Section 2, Item E. Item E.4 states, "Receives and reviews periodic financial reports. Considers comments and recommendations of its Finance Committee and management staff."

Consent Agenda Item 11.2.1 Financial Report – April 2026 is being provided to the Board of Directors to assist them in fulfilling their financial responsibilities.

SUMMARY/OBJECTIVES:
To provide the Board information about the District's monthly financial status in a meaningful format to assist them in fulfilling their financial responsibilities as Board members.

SUGGESTED DISCUSSION POINTS:
Opportunity to pull the Financial Report – April 2026 from Consent agenda to allow further discussion, clarification, or commentary under Board Agenda Item 12 Discussion of Consent Calendar Items Pulled, If Necessary.

SUGGESTED MOTION/ALTERNATIVES:
Motion to accept the Financial Report – April 2026 as part of the Consent agenda.

Alternative:
If pulled from Consent agenda, provide discussion under Item 12 on the Board agenda. After discussion, request a motion to approve the Financial Report – April 2026 as presented.

LIST OF ATTACHMENTS: Financial Report – April 2026

TAHOE FOREST HOSPITAL DISTRICT
APRIL 2026 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

APRIL 2026 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the ten months ended April 30, 2026.

Activity Statistics

- TFH acute patient days were 424 for the current month compared to budget of 379. This equates to an average daily census of 14.1 compared to budget of 12.6.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Home Health visits, Laboratory tests, Blood units, EKG, Medical Oncology procedures, Radiation Oncology procedures, MRI, Ultrasound, Briner Ultrasound, PET CT, Drugs Sold to Patients, Tahoe City Physical & Occupational Therapies, and Outpatient Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Hospice visits, Surgical cases, Diagnostic Imaging, Nuclear Medicine, Cat Scans, Oncology Drugs Sold to Patients, Respiratory Therapy, Gastroenterology cases, and Outpatient Physical Therapy, Physical Therapy Aquatic, and Speech Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 47.2% in the current month compared to budget of 45.8% and to last month's 43.1%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 46.1% compared to budget of 45.7% and prior year's 47.0%.
- EBIDA was $4,336,434 (6.6%) for the current month compared to budget of $2,611,476 (4.2%), or $1,724,958 (2.4%) above budget. Year-to-date EBIDA was $34,713,702 (5.3%) compared to budget of $25,673,204 (4.0%), or $9,040,498 (1.3%) above budget.
- Net Income/(Loss) was $3,937,404 for the current month compared to budget of $1,950,409 or $1,986,995 above budget. Year-to-date Net Income was $30,765,269 compared to budget of $19,837,237 or $10,928,033 above budget.
- Cash Collections for the current month were $28,795,846 which is 106% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $123,597,311 at the end of April compared to $124,733,707 at the end of March.

Balance Sheet

- Working Capital is at 38.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 214.90 days. Working Capital cash increased a net $5,541,000. Increase in Cash is related to: Accounts Payable increased $3,888,000, Accrued Payroll & Related Costs decreased $1,635,000, and Capital Project and Equipment expenditures totaled $4,606,000. Cash Collections were above target by 6%, and the District received $6,775,000 from the State for the CY24 QIP Program and the first half of CY24 District Hospital Directed Payment Program.
- Net Patient Accounts Receivable increased a net $1,303,000. Cash collections were 106% of target. EPIC Days in A/R were 57.2 compared to 56.7 at the close of March.
- Estimated Settlements, Medi-Cal & Medicare decreased a net $4,794,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal QIP programs and received $6,775,000 from the State for the CY24 QIP Program and the first half of the CY24 District Hospital Directed Payment Program.
- Unrealized Gain/(Loss) Cash Investment Fund increased $293,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of April.
- Investment in TSC, LLC increased $90,000 after recording the estimated loss for April and trueing up the losses for March.
- To comply with GASB No. 96, the District recorded Amortization Expense for April, decreasing its Right-To-Use Subscription asset $364,000.
- Accounts Payable increased $3,888,000 due to the timing of the final check run in April. The increase is primarily related to construction project invoices received towards the end of April with payments being made at the beginning of May.
- Accrued Payroll & Related Costs decreased a net $1,635,000 due to additional accrued payroll days in April and the District funded the Employers Portion of Deferred Compensation.
- To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for April, decreasing the liability by $348,000.

April 2026 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $65,698,928 compared to budget of $62,706,120 or $2,992,808 above budget.
- Current month's Gross Inpatient Revenue was $7,362,498 compared to budget of $7,817,577 or $455,079 below budget.
- Current month's Gross Outpatient Revenue was $58,336,430 compared to budget of $54,888,543 or $3,447,887 above budget.
- Current month's Gross Revenue Mix was 43.19% Medicare, 17.32% Medi-Cal, .94% Other, and 38.55% Commercial Insurance compared to budget of 38.87% Medicare, 16.64% Medi-Cal, 1.15% Other, and 43.34% Commercial Insurance. Last month's mix was 42.42% Medicare, 15.64% Medi-Cal, 1.37% Other, and 40.57% Commercial Insurance. Year-to-Date Gross Revenue Mix was 42.76% Medicare, 16.88% Medi-Cal, 1.27% Other, and 39.09% Commercial Insurance compared to budget of 39.08% Medicare, 16.57% Med-Cal, 1.19% Other, and 43.16% Commercial.
- Current month's Deductions from Revenue were $34,690,312 compared to budget of $34,001,707 or $688,605 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with 4.32% increase in Medicare, a .68% increase to Medi-Cal, a .21% increase in Other, and Commercial Insurance was below budget 4.79%, and 2) Revenues were above budget 4.8%.

DESCRIPTION	April 2026 Actual	April 2026 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	12,792,289	12,109,667	(682,622)	We saw negative variances in Technical, RN, Physicians, and PA/FNP salaries.
Employee Benefits	3,868,020	3,627,736	(240,284)	We saw increased use of Paid Leave in April, creating a negative variance in Employee Benefits.
Benefits – Workers Compensation	105,865	90,315	(15,550)	
Benefits – Medical Insurance	2,431,007	3,011,858	580,851	The District has a self-insured plan and expense is based on actual claims paid. The District also received a large pharmaceutical rebate, lending to the positive variance in Benefits – Medical Insurance.
Medical Professional Fees	690,866	636,227	(54,639)	Locums coverage for Urology and Pediatrics and Hospitalist and Emergency Department Physician fees were above budget, creating a negative variance in Medical Professional Fees.
Other Professional Fees	490,184	330,903	(159,281)	Human Resource Advisory consulting, work performed for a Physician Compensation Transformation model, and professional services provided by Mercy Health for EPIC module implementations created a negative variance in Other Professional Fees.
Supplies	4,652,549	5,020,042	367,493	Oncology Drugs Sold to Patients revenues were below budget 23.21%, creating a positive variance in Pharmacy Supplies.
Purchased Services	2,465,741	2,243,149	(222,592)	Outsourced billing and collection services for the Business Office, outsourced coding services for Medical Records, a termination invoice from the previous record retention company for Medical Records, Lab and Genetic testing, facility wide maintenance projects, and common area maintenance costs for The Center created a negative variance in Purchased Services.
Other Expenses	1,076,631	954,739	(121,892)	Dues and Subscriptions, recruitment expenses for key management positions, oxygen tank and surgical equipment rentals, and Marketing campaigns created a negative variance in Other Expenses.
Total Expenses	28,573,151	28,024,637	(548,514)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
APRIL 2026

	Apr-26	Mar-26	Apr-25	
ASSETS				
CURRENT ASSETS				
* CASH	$ 36,096,430	$ 30,555,493	$ 51,637,797	1
PATIENT ACCOUNTS RECEIVABLE - NET	57,908,135	56,605,625	52,582,444	2
OTHER RECEIVABLES	12,111,284	11,256,821	10,974,728	
GO BOND RECEIVABLES	1,409,693	941,168	1,386,740	
ASSETS LIMITED OR RESTRICTED	16,564,216	15,803,167	10,677,931	
INVENTORIES	7,284,569	7,287,043	5,551,123	
PREPAID EXPENSES & DEPOSITS	3,917,170	4,227,292	3,387,999	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	30,824,570	35,618,448	20,209,364	3
TOTAL CURRENT ASSETS	166,116,067	162,295,056	156,408,127	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	74,318,485	74,318,485	51,568,166	1
* CASH INVESTMENT FUND	93,923,781	94,050,366	96,656,913	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	9,287,343	8,994,230	6,081,649	4
MUNICIPAL LEASE 2025	3,418,185	3,418,185	4,593,879	
TOTAL BOND TRUSTEE 2017	23,853	23,793	22,980	
TOTAL BOND TRUSTEE 2015	897,750	922,515	1,145,649	
GO BOND TAX REVENUE FUND	3,111,952	3,111,952	2,966,850	
DIAGNOSTIC IMAGING FUND	3,700	3,700	3,700	
DONOR RESTRICTED FUND	1,202,655	1,202,654	1,202,647	
WORKERS COMPENSATION FUND	27,672	40,488	13,633	
TOTAL	186,215,375	186,086,367	164,256,065	
LESS CURRENT PORTION	(16,564,216)	(15,803,167)	(10,677,931)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	169,651,160	170,283,201	153,578,134	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(6,052,402)	(6,142,201)	(5,128,214)	5
PROPERTY HELD FOR FUTURE EXPANSION	1,716,972	1,716,972	1,716,972	
PROPERTY & EQUIPMENT NET	219,825,024	216,586,371	197,200,234	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,961,862	2,016,694	2,232,248	
TOTAL ASSETS	553,218,683	546,756,092	506,007,499	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	161,619	164,852	200,408	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	178,888	178,888	204,560	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	3,754,845	3,778,550	4,039,302	
GO BOND DEFERRED FINANCING COSTS	365,819	368,140	393,670	
DEFERRED FINANCING COSTS	89,464	90,504	101,947	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	13,447,186	13,642,356	10,346,942	
RIGHT-TO-USE SUBSCRIPTION ASSET NET OF ACCUM AMORTIZATION	21,772,907	22,136,859	23,930,062	6
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 39,770,728	$ 40,360,148	$ 39,216,890	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	17,714,648	13,826,212	$ 8,959,022	7
ACCRUED PAYROLL & RELATED COSTS	26,396,967	28,031,858	21,255,015	8
INTEREST PAYABLE	258,829	204,547	265,618	
INTEREST PAYABLE GO BOND	720,233	480,155	762,428	
SUBSCRIPTION LIABILITY	23,779,836	24,128,211	25,762,654	9
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,316,211	3,316,211	6,090,298	
HEALTH INSURANCE PLAN	5,128,800	5,128,800	3,219,201	
WORKERS COMPENSATION PLAN	2,315,069	2,315,069	2,297,841	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,876,447	2,876,447	2,771,063	
CURRENT MATURITIES OF GO BOND DEBT	2,730,000	2,730,000	2,440,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	4,606,719	4,606,719	4,371,046	
TOTAL CURRENT LIABILITIES	89,843,758	87,644,229	78,194,187	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	30,657,889	30,903,695	30,453,580	
GO BOND DEBT NET OF CURRENT MATURITIES	84,443,786	84,461,742	87,679,253	
DERIVATIVE INSTRUMENT LIABILITY	178,888	178,888	204,560	
TOTAL LIABILITIES	205,124,320	203,188,554	196,531,580	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	386,662,436	382,725,032	347,490,162	
RESTRICTED	1,202,655	1,202,654	1,202,647	
TOTAL NET POSITION	$ 387,865,090	$ 383,927,686	$ 348,692,809	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
APRIL 2026

1. Working Capital is at 38.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 214.9 days. Working Capital cash increased a net $5,541,000. Net increase in Cash is related to: Accounts Payable increased $3,888,000 (See Note 7), Accrued Payroll & Related Costs decreased $1,635,000 (See Note 8), and Capital Project and Equipment expenditures totaled $4,606,000. Cash Collections were above target by 6% (See Note 2), and the District received $6,775,000 from the State for the CY24 QIP Program and the first half of CY24 District Hospital Directed Payment Program (See Note 3).

2. Net Patient Accounts Receivable increased a net $1,303,000. Cash collections were 106% of target. EPIC Days in A/R were 57.2 compared to 56.7 at the close of March.

3. Estimated Settlements, Medi-Cal & Medicare decreased a net $4,794,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal QIP programs and received $6,775,000 from the State for the CY24 QIP Program and the first half of the CY24 District Hospital Directed Payment Program.

4. Unrealized Gain/(Loss) Cash Investment Fund increased $293,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of April.

5. Investment in TSC, LLC increased $90,000 after recording the estimated loss for April and trueing up the losses for March.

6. To comply with GASB No. 96, the District recorded Amortization Expense for April, decreasing its Right-To-Use Subscription asset $364,000.

7. Accounts Payable increased $3,888,000 due to the timing of the final check run in April. The increase is primarily related to construction project invoices received towards the end of April with payments being made at the beginning of May.

8. Accrued Payroll & Related Costs decreased a net $1,635,000. We had additional accrued payroll days in April and funded the Employers Portion of Deferred Compensation.

9. To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for April, decreasing the liability by $348,000.

Tahoe Forest Hospital District
Cash Investment
April 30, 2026

WORKING CAPITAL				
US Bank	$ 34,931,227	3.27%		
US Bank/Incline Village Thrift Store	19,140			
US Bank/Truckee Thrift Store	87,650			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,058,414	1.61%		
Total			$	36,096,430
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Cash Portfolio Fund	269	0.00%		
Chandler Investment Fund	93,923,512	VAR		
Total			$	93,923,781
Building Fund	$ -			
Cash Reserve Fund	74,318,485	3.81%		
Local Agency Investment Fund			$	74,318,485
Municipal Lease 2018			$	3,418,185
Bonds Cash 2017			$	23,853
Bonds Cash 2015			$	897,750
GO Bonds Cash 2008			$	3,111,952
DX Imaging Education	$ 3,700			
Workers Comp Fund - B of A	27,672			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	31,372
TOTAL FUNDS			$	211,821,808
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,390	0.09%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,166,955	3.81%		
TOTAL RESTRICTED FUNDS			$	1,202,655
TOTAL ALL FUNDS			$	213,024,463

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
APRIL 2026

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD APR 2025
				OPERATING REVENUE						
$ 65,698,928	$ 62,706,120	$ 2,992,808	4.8%	Total Gross Revenue	$ 655,230,188	$ 638,054,387	$ 17,175,801	2.7%	1	$ 606,905,703
				Gross Revenues - Inpatient						
$ 3,825,946	$ 3,560,583	$ 265,363	7.5%	Daily Hospital Service	$ 36,924,243	$ 35,048,497	$ 1,875,746	5.4%		$ 34,468,722
3,536,553	4,256,994	(720,441)	-16.9%	Ancillary Service - Inpatient	41,599,657	45,013,122	(3,413,465)	-7.6%		44,455,130
7,362,498	7,817,577	(455,079)	-5.8%	Total Gross Revenue - Inpatient	78,523,900	80,061,619	(1,537,719)	-1.9%	1	78,923,852
58,336,430	54,888,543	3,447,887	6.3%	Gross Revenue - Outpatient	576,706,288	557,992,768	18,713,520	3.4%		527,981,851
58,336,430	54,888,543	3,447,887	6.3%	Total Gross Revenue - Outpatient	576,706,288	557,992,768	18,713,520	3.4%	1	527,981,851
				Deductions from Revenue:						
33,228,884	31,787,017	(1,441,867)	-4.5%	Contractual Allowances	344,010,176	323,772,539	(20,237,637)	-6.3%	2	315,359,286
410,241	1,254,122	843,881	67.3%	Charity Care	3,200,533	12,761,088	9,560,555	74.9%	2	3,094,103
1,051,187	960,568	(90,619)	-9.4%	Bad Debt	6,459,653	9,780,565	3,320,912	34.0%	2	4,848,041
-	-	-	0.0%	Prior Period Settlements	(475,441)	-	475,441	0.0%	2	(1,489,889)
34,690,312	34,001,707	(688,605)	-2.0%	Total Deductions from Revenue	353,194,920	346,314,192	(6,880,728)	-2.0%		321,811,541
82,303	115,718	33,415	28.9%	Property Tax Revenue- Wellness Neighborhood	841,839	1,211,352	369,513	30.5%		1,020,393
1,818,665	1,815,981	2,684	0.1%	Other Operating Revenue	18,768,069	19,036,990	(268,921)	-1.4%	3	18,430,763
32,909,585	30,636,112	2,273,473	7.4%	TOTAL OPERATING REVENUE	321,645,175	311,988,537	9,656,639	3.1%		304,545,318
				OPERATING EXPENSES						
12,792,289	12,109,667	(682,622)	-5.6%	Salaries and Wages	124,531,082	121,614,069	(2,917,013)	-2.4%	4	111,807,934
3,868,020	3,627,736	(240,284)	-6.6%	Benefits	39,529,969	37,099,594	(2,430,375)	-6.6%	4	37,868,782
105,865	90,315	(15,550)	-17.2%	Benefits Workers Compensation	1,267,107	903,150	(363,957)	-40.3%	4	695,177
2,431,007	3,011,858	580,851	19.3%	Benefits Medical Insurance	28,009,912	30,118,580	2,108,668	7.0%	4	24,933,478
690,866	636,227	(54,639)	-8.6%	Medical Professional Fees	6,119,276	6,382,587	263,311	4.1%	5	5,260,585
490,184	330,903	(159,281)	-48.1%	Other Professional Fees	3,792,931	4,020,452	227,521	5.7%	5	3,588,759
4,652,549	5,020,042	367,493	7.3%	Supplies	49,665,500	52,183,322	2,517,822	4.8%	6	46,606,097
2,465,741	2,243,149	(222,592)	-9.9%	Purchased Services	22,683,002	22,683,940	938	0.0%	7	21,082,789
1,076,631	954,739	(121,892)	-12.8%	Other	11,332,694	11,309,640	(23,055)	-0.2%	8	10,333,771
28,573,151	28,024,637	(548,514)	-2.0%	TOTAL OPERATING EXPENSE	286,931,473	286,315,333	(616,140)	-0.2%		262,177,372
4,336,434	**2,611,476**	**1,724,958**	**66.1%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**34,713,702**	**25,673,204**	**9,040,498**	**35.2%**		**42,367,946**
				NON-OPERATING REVENUE/(EXPENSE)						
850,234	816,820	33,415	4.1%	District and County Taxes	8,582,745	8,114,028	468,717	5.8%	9	8,883,167
468,526	468,526	-	0.0%	District and County Taxes - GO Bond	4,685,255	4,685,255	-	0.0%		4,556,332
343,174	223,704	119,470	53.4%	Interest Income	3,885,418	3,167,549	717,869	22.7%	10	3,659,659
101,299	119,538	(18,239)	-15.3%	Donations	1,020,839	1,197,665	(176,826)	-14.8%	11	1,023,578
89,799	(151,882)	241,682	159.1%	Gain/(Loss) on Joint Investment	(642,087)	(1,518,823)	876,736	57.7%	12	(1,186,471)
188,799	300,000	(111,201)	-37.1%	Gain/(Loss) on Market Investments	2,824,376	3,000,000	(175,624)	-5.9%	13	5,493,292
-	-	-	0.0%	Gain/(Loss) on Disposal of Assets	(8,640)	-	(8,640)	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	-	-	-	0.0%	15	40,782
(1,982,795)	(1,995,743)	12,948	0.6%	Depreciation	(19,678,564)	(19,957,430)	278,866	1.4%	16	(17,915,759)
(209,919)	(193,881)	(16,038)	-8.3%	Interest Expense	(2,124,925)	(2,031,356)	(93,569)	-4.6%	17	(1,899,677)
(248,148)	(248,148)	0	0.0%	Interest Expense-GO Bond	(2,492,851)	(2,492,855)	4	0.0%		(2,613,462)
(399,030)	(661,067)	262,037	39.6%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,948,433)	(5,835,967)	1,887,534	32.3%		41,441
$ 3,937,404	**$ 1,950,409**	**$ 1,986,995**	**101.9%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 30,765,269**	**$ 19,837,237**	**$ 10,928,033**	**55.1%**		**$ 42,409,387**
				NET POSITION - BEGINNING OF YEAR	**357,099,821**					
				NET POSITION - AS OF APRIL 30, 2026	**$ 387,865,090**					
6.6%	**4.2%**	**2.4%**		**RETURN ON GROSS REVENUE EBIDA**	**5.3%**	**4.0%**	**1.3%**			**7.0%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
APRIL 2026

		Variance from Budget Fav / <Unfav>	
		APR 2026	YTD 2026
1) Gross Revenues			
Acute Patient Days were above budget 11.87% or 45 days. Swing Bed days were above budget 108.33% or 13 days.	Gross Revenue -- Inpatient	$ (455,079)	$ (1,537,719)
	Gross Revenue -- Outpatient	3,447,887	18,713,520
	Gross Revenue -- Total	$ 2,992,808	$ 17,175,801
Outpatient volumes were 5% or more above in the following departments: Home Health visits, Laboratory tests, Blood units, EKG, Medical Oncology Procedures, Radiation Oncology Procedures, MRI, Ultrasound, Briner Ultrasound, PET CT, Drugs Sold to Patients, Tahoe City Physical & Occupational Therapies, and Outpatient Occupational Therapy.			
Outpatient volumes were below budget 5% or more in the following departments: Emergency Departments visits, Hospice visits, Diagnostic Imaging, Nuclear Medicine Cat Scans, Oncology Drugs Sold to Patients, Respiratory Therapy, Gastroenterology cases, Outpatient Physical Therapy, Physical Therapy Aquatic, and Speech Therapy.			
2) Total Deductions from Revenue			
The payor mix for April shows a 4.32% increase to Medicare, a .68% increase to Medi-Cal, .21% decrease to Other, and a 4.80% decrease to Commercial when compared to budget. We saw a shift from Commercial into Medicare and Medi-Cal and revenues were above budget 4.80%.	Contractual Allowances	$ (1,441,867)	$ (20,237,637)
	Charity Care	843,881	9,560,555
	Bad Debt	(90,619)	3,320,912
	Prior Period Settlements	-	475,441
	Total	$ (688,605)	$ (6,880,728)
3) Other Operating Revenue	Community Pharmacy	$ 46,151	$ 478,064
Community Pharmacy revenues were above budget 5.69%.	Miscellaneous	(88,032)	(940,098)
	Oncology Drug Replacement	-	-
The revision to the FY26 HQAF and QIP budgeted receivables is creating a negative variance in Miscellaneous.	Hospice Thrift Stores	(741)	19,787
	Grants	0	82,082
	The Center (non-therapy)	7,262	68,876
IVCH ER Physician Guarantee is tied to collections, coming in above budget in April.	IVCH ER Physician Guarantee	56,748	213,186
	Children's Center	(18,703)	(190,819)
Child Care Days were below budget 12.76%.	Total	$ 2,684	$ (268,921)
4) Salaries and Wages	Total	$ (682,622)	$ (2,917,013)
We saw negative variances in Technical, RN, Physicians, and PA/FNP Salaries.			
Employee Benefits	PL/SL	$ (274,795)	$ (1,818,839)
We saw increased use of Paid Leave in April, creating a negative variance in PL/SL.	Other	24,571	(323,339)
	Pension/Deferred Comp	0	6
	Standby	12,149	(4,101)
	Nonproductive	(2,209)	(284,102)
	Total	$ (240,284)	$ (2,430,375)
Employee Benefits - Workers Compensation	Total	$ (15,550)	$ (363,957)
Employee Benefits - Medical Insurance	Total	$ 580,851	$ 2,108,668
The District has a self-insured plan and expense is based on actual claims paid. We also received a large pharmaceutical rebate, lending to the positive variance.			
5) Professional Fees	Multi-Specialty Clinics	$ (87,263)	$ (412,114)
Locums coverage in Urology and Pediatrics is creating a negative variance in Multi-Specialty Clinics.	TFH Locums	(77,932)	(337,963)
	Human Resources	(73,480)	(179,462)
	Multi-Specialty Clinics Administration	(55,366)	(174,730)
Hospitalist and Emergency Department Physician fees created a negative variance in TFH Locums.	Information Technology	(23,835)	(138,966)
	Financial Administration	10,670	(133,567)
	Oncology	(2,890)	(8,519)
Human Resources Advisory consulting work created a negative variance in this category.	Corporate Compliance	-	-
	Patient Accounting/Admitting	2,000	20,000
Consulting work for a Physician Compensation Transformation model created a negative variance in Multi-Specialty Clinics Administration.	Medical Staff Services	2,803	33,239
	Managed Care	4,839	39,403
	IVCH ER Physicians	11,207	41,522
Professional services provided by Mercy Health for implementation of new modules within EPIC were above budget, creating a negative variance in Information Technology.	Marketing	12,022	212,198
	Administration	(56,644)	404,693
	Miscellaneous	119,950	1,125,098
Graphic Design consulting services were below budget, creating a positive variance in Marketing.	Total	$ (213,920)	$ 490,832
Organizational Assessment and Strategic Planning consulting services created a negative variance in Administration.			
Anesthesia and Radiology Physician Fees were below budget, creating a positive variance in Miscellaneous.			
6) Supplies	Patient & Other Medical Supplies	$ (101,598)	$ (2,026,736)
Medical Supplies Sold to Patients revenues were above budget 17.51%, creating a negative variance in Patient & Other Medical Supplies.	Office Supplies	(701)	(13,166)
	Food	(12,403)	15,583
	Other Non-Medical Supplies	1,181	108,081
Oncology Drugs Sold to Patients revenues were below budget 23.21%, creating a positive variance in Pharmacy Supplies.	Minor Equipment	7,337	210,794
	Pharmacy Supplies	473,676	4,223,266
	Total	$ 367,493	$ 2,517,822

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
APRIL 2026

		Variance from Budget Fav / <Unfav> APR 2026	YTD 2026
7) Purchased Services	Patient Accounting	$ (280,272)	$ (928,566)
Outsourced billing and collection services for the Business Office created a negative variance in Patient Accounting.	Medical Records	(44,828)	(177,319)
	Laboratory	(16,175)	(116,729)
	Department Repairs	(69,898)	(113,293)
Outsourced coding services and a termination of services invoice from Iron Mountain Record Retention & Retrieval company created a negative variance in Medical Records.	Pharmacy IP	(7,328)	(92,869)
	The Center	(36,761)	(74,202)
	Home Health/Hospice	(6,585)	(28,264)
Outsourced Lab and Genetic testing created a negative variance in Laboratory.	Diagnostic Imaging Services - All	(11,331)	(11,978)
	Human Resources	24,625	(5,596)
Facility wide maintenance projects created a negative variance in Department Repairs.	Community Development	-	-
	Multi-Specialty Clinics	7,451	40,613
Common Area Maintenance pass through charges for FYTD26 created a negative variance in The Center.	Information Technology	38,972	132,334
	Miscellaneous	179,537	1,376,807
	Total	$ (222,592)	$ 938
Radiology Reads for MRI, Ultrasound, Briner Ultrasound, and PET CT created a negative variance in Diagnostic Imaging Services - All.			
Wellness Bank usage and Employee Health screenings were below budget, creating a positive variance in Human Resources.			
Network Maintenance services were below budget, creating a positive variance in Information Technology.			
Community Health Index support, Snow Removal services, Compliance Officer services and budgeted Workforce Management/AI services were below budget, creating a positive variance in Miscellaneous.			
8) Other Expenses	Dues and Subscriptions	$ (50,149)	$ (204,032)
We saw negative variances in Dues and Subscriptions across multiple departments in April, including the renewal of our participation in UC Davis Cancer Care Network.	Human Resources Recruitment	(54,139)	(190,359)
	Other Building Rent	(20,941)	(149,197)
	Equipment Rent	(61,140)	(132,425)
Recruitment for key management positions created a negative variance in Human Resources Recruitment.	Marketing	(52,298)	(54,311)
	Insurance	(7,499)	(41,900)
	Multi-Specialty Clinics Bldg. Rent	(4,775)	(40,669)
Rental rate increases for the District's employee housing units and common area maintenance services created a negative variance in Other Building Rent.	Multi-Specialty Clinics Equip Rent	170	(3,005)
	Physician Services	164	5,239
	Utilities	(16,419)	77,134
Oxygen tank rentals and specialized surgical equipment rentals created a negative variance in Equipment Rent.	Miscellaneous	123,914	228,619
	Outside Training & Travel	21,219	481,850
	Total	$ (121,892)	$ (23,055)
Marketing campaigns and Community Sponsorships created a negative variance in Marketing.			
Natural Gas/Propane, Electricity, Diesel, and Telephone costs were above budget, creating a negative variance in Utilities.			
Physician Recruitment expenses, JPA Housing expense reimbursements and District sponsorships were below budget, creating a positive variance in Miscellaneous.			
9) District and County Taxes	Total	$ 33,415	$ 468,717
10) Interest Income	Total	$ 119,470	$ 717,869
11) Donations	IVCH	$ (23,543)	$ (88,657)
	Operational	5,304	(88,169)
	Total	$ (18,239)	$ (176,826)
12) Gain/(Loss) on Joint Investment	Total	$ 241,682	$ 876,736
The District trued up its losses in TSC, LLC for March, creating a positive variance in Gain/(Loss) on Joint Investment.			
13) Gain/(Loss) on Market Investments	Total	$ (111,201)	$ (175,624)
Gain on Market Investments was below budget, creating a negative variance in Gain/(Loss) on Market Investments.			
14) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ -
15) Gain/(Loss) on Sale or Disposal of Equipment	Total	$ -	$ (8,640)
16) Depreciation Expense	Total	$ 12,948	$ 278,866
True-up of GASB 87 and GASB 96 schedules created a positive variance in Depreciation Expense.			
17) Interest Expense	Total	$ (16,038)	$ (93,569)
True-up of GASB 87 and GASB 96 schedules created a negative variance in Interest Expense.			

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
APRIL 2026

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD APR 2025
				OPERATING REVENUE						
$ 4,660,425	$ 3,812,678	$ 847,747	22.2%	Total Gross Revenue	$ 48,228,913	$ 45,241,884	$ 2,987,029	6.6%	1	$ 42,708,752
				Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%	Daily Hospital Service	$ -	$ -	$ -	0.0%		$ -
-	-	-	0.0%	Ancillary Service - Inpatient	-	-	-	0.0%		-
-	-	-	0.0%	Total Gross Revenue - Inpatient	-	-	-	0.0%	1	-
4,660,425	3,812,678	847,747	22.2%	Gross Revenue - Outpatient	48,228,913	45,241,884	2,987,029	6.6%		42,708,752
4,660,425	3,812,678	847,747	22.2%	Total Gross Revenue - Outpatient	48,228,913	45,241,884	2,987,029	6.6%	1	42,708,752
				Deductions from Revenue:						
2,045,967	1,844,166	(201,801)	-10.9%	Contractual Allowances	24,161,250	21,994,548	(2,166,702)	-9.9%	2	20,250,399
98,581	76,254	(22,327)	-29.3%	Charity Care	851,899	904,838	52,939	5.9%	2	546,180
174,429	57,190	(117,239)	-205.0%	Bad Debt	1,144,599	678,628	(465,971)	-68.7%	2	1,071,872
-	-	-	0.0%	Prior Period Settlements	(53,794)	-	53,794	0.0%	2	(749,343)
2,318,977	1,977,610	(341,367)	-17.3%	Total Deductions from Revenue	26,103,954	23,578,014	(2,525,940)	-10.7%	2	21,119,108
(2,292)	4,975	(7,267)	-146.1%	Other Operating Revenue	601,048	350,505	250,543	71.5%	3	587,455
2,339,156	1,840,043	499,113	27.1%	TOTAL OPERATING REVENUE	22,726,007	22,014,375	711,632	3.2%		22,177,099
				OPERATING EXPENSES						
834,523	731,802	(102,721)	-14.0%	Salaries and Wages	8,802,219	7,527,310	(1,274,909)	-16.9%	4	6,922,577
260,060	212,864	(47,196)	-22.2%	Benefits	2,346,134	2,144,375	(201,759)	-9.4%	4	2,200,545
4,119	1,957	(2,162)	-110.5%	Benefits Workers Compensation	71,849	19,570	(52,279)	-267.1%	4	14,394
144,440	178,944	34,504	19.3%	Benefits Medical Insurance	1,664,162	1,789,440	125,278	7.0%	4	1,556,468
167,339	178,640	11,301	6.3%	Medical Professional Fees	1,744,695	1,786,400	41,706	2.3%	5	1,756,273
5,341	6,140	799	13.0%	Other Professional Fees	53,853	61,400	7,548	12.3%	5	23,633
159,441	111,511	(47,930)	-43.0%	Supplies	1,557,801	1,373,703	(184,098)	-13.4%	6	1,168,975
45,386	111,035	65,649	59.1%	Purchased Services	994,784	1,073,806	79,022	7.4%	7	885,846
129,489	115,468	(14,021)	-12.1%	Other	1,173,332	1,135,802	(37,530)	-3.3%	8	1,009,681
1,750,138	1,648,361	(101,777)	-6.2%	TOTAL OPERATING EXPENSE	18,408,827	16,911,806	(1,497,021)	-8.9%		15,538,392
589,018	**191,682**	**397,336**	**207.3%**	**NET OPERATING REV(EXP) EBIDA**	**4,317,180**	**5,102,570**	**(785,389)**	**-15.4%**		**6,638,707**
				NON-OPERATING REVENUE/(EXPENSE)						
-	23,543	(23,543)	-100.0%	Donations-IVCH	149,055	237,712	(88,657)	-37.3%	9	88,252
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(206,191)	(207,021)	830	-0.4%	Depreciation	(2,061,916)	(2,070,215)	8,299	0.4%	11	(2,039,296)
(3,000)	(1,881)	(1,119)	59.5%	Interest Expense	(31,071)	(19,954)	(11,117)	55.7%	12	(14,480)
(209,191)	(185,360)	(23,832)	-12.9%	TOTAL NON-OPERATING REVENUE/(EXP)	(1,943,932)	(1,852,457)	(91,475)	-4.9%		(1,965,524)
$ 379,826	**$ 6,322**	**$ 373,504**	**5907.9%**	**EXCESS REVENUE(EXPENSE)**	**$ 2,373,248**	**$ 3,250,113**	**$ (876,864)**	**-27.0%**		**$ 4,673,183**
12.6%	**5.0%**	**7.6%**		**RETURN ON GROSS REVENUE EBIDA**	**9.0%**	**11.3%**	**-2.3%**			**15.5%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
APRIL 2026

		Variance from Budget Fav<Unfav>	
		APR 2026	**YTD 2026**
1) Gross Revenues			
Acute Patient Days were at budget at 0 days.	Gross Revenue -- Inpatient	$ -	$ -
	Gross Revenue -- Outpatient	847,747	2,987,029
Outpatient volumes were above budget in the following departments: Laboratory tests, Diagnostic Imaging, Mammography, Ultrasounds, Drugs Sold to Patients, Oncology Drugs Sold to Patients, and Physical Therapy.	Total	$ 847,747	$ 2,987,029
Outpatient volumes were below budget in the following departments: Emergency Department visits, Surgery cases, Lab Send Out Tests, EKGs, Cat Scans, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 5.82% increase in Medicare, a 1.33% decrease in Medicaid, a 4.55% decrease in Commercial insurance, and a .06% increase in Other. Revenues were above budget 22.2% and we saw a shift from Commercial and Medicaid to Medicare.	Contractual Allowances	$ (201,801)	$ (2,166,702)
	Charity Care	(22,327)	52,939
	Bad Debt	(117,239)	(465,971)
	Prior Period Settlement	-	53,794
	Total	$ (341,367)	$ (2,525,940)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, coming in above budget in April.	IVCH ER Physician Guarantee	$ 56,748	$ 213,186
	Miscellaneous	(64,015)	37,356
	Total	$ (7,267)	$ 250,543
A true-up was made to the first quarter FY26 Nevada Private Hospital Provider Tax fee, creating a negative variance in Miscellaneous.			
4) Salaries and Wages	Total	$ (102,721)	$ (1,274,909)
We saw increases in Technical, Physician and Management salaries, creating a negative variance in Salaries and Wages.			
Employee Benefits	PL/SL	$ (3,450)	$ (75,262)
Physician Productivity bonuses were above budget using the new model, creating a negative variance in Nonproductive.	Other	(8,211)	(79,988)
	Standby	670	(16,044)
	Pension/Deferred Comp	0	0
	Nonproductive	(36,205)	(30,466)
	Total	$ (47,196)	$ (201,759)
Employee Benefits - Workers Compensation	Total	$ (2,162)	$ (52,279)
Employee Benefits - Medical Insurance	Total	$ 34,504	$ 125,278
The District has a self-insured plan and expense is based on actual claims paid and a large pharmaceutical rebate was received in April, lending to the positive variance.			
5) Professional Fees	Administration	$ -	$ -
Extended patient care hours were below budget, creating a positive variance in IVCH ER Physicians.	Multi-Specialty Clinics	-	-
	Miscellaneous	94	188
	Foundation	798	7,543
	IVCH ER Physicians	11,207	41,522
	Total	$ 12,099	$ 49,253
6) Supplies	Pharmacy Supplies	$ (67,486)	$ (286,087)
Drugs Sold to Patients revenues were above budget 67.85%, creating a negative variance in Pharmacy Supplies.	Office Supplies	258	(1,074)
	Food	159	1,878
	Minor Equipment	1,322	7,758
Non Patient Chargeable supplies were below budget, creating a positive variance in Patient & Other Medical Supplies.	Non-Medical Supplies	(2,237)	29,266
	Patient & Other Medical Supplies	20,054	64,160
	Total	$ (47,930)	$ (184,098)

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
APRIL 2026

		Variance from Budget Fav<Unfav>	
		APR 2026	YTD 2026
7) Purchased Services	Department Repairs	$ 380	$ (9,944)
Lab Send Out Tests volumes were below budget, creating a positive variance in Laboratory.	Laboratory	2,215	(6,160)
	Pharmacy	(628)	(5,676)
	Multi-Specialty Clinics	35	(2,042)
Radiology reads for Diagnostic Imaging, Mammography, and Ultrasounds were above budget, creating a negative variance in Diagnostic Imaging Services - All.	EVS/Laundry	(254)	2,042
	Diagnostic Imaging Services - All	(2,501)	2,448
	Engineering/Plant/Communications	17,039	11,762
	Foundation	1,824	41,775
A reclassification of Snow Removal invoices created a positive variance in Engineering/Plant/Communications.	Miscellaneous	47,540	44,817
	Total	$ 65,649	$ 79,022
A true-up of Snow Removal invoice accruals and lack of snow in April created a positive variance in Miscellaneous.			
8) Other Expenses	Other Building Rent	$ (10,992)	$ (98,810)
Common Area Maintenance costs and a rental increase for an employee housing unit created a negative variance in Other Building Rent.	Miscellaneous	(1,420)	(37,906)
	Multi-Specialty Clinics Bldg. Rent	(1,087)	(11,136)
	Dues and Subscriptions	(2,243)	(5,490)
We saw increases in Dues and Subscriptions for Physicians and Administration, creating a negative variance in this category.	Equipment Rent	(808)	824
	Insurance	36	2,200
	Outside Training & Travel	(1,063)	25,467
Natural Gas/Propane and Electricity costs were below budget, creating a positive variance in Utilities.	Utilities	4,301	41,268
	Marketing	(746)	46,053
	Total	$ (14,021)	$ (37,530)
9) Donations	Total	$ (23,543)	$ (88,657)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ 830	$ 8,299
12) Interest Expense	Total	$ (1,119)	$ (11,117)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2025		**BUDGET** FYE 2026	PROJECTED FYE 2026	ACTUAL APR 2026	PROJECTED APR 2026	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	51,886,266		27,556,243	27,870,191	$ 4,336,434	$ 2,611,476	$ 1,724,958	$ 12,945,140	$ 9,028,708	$ 8,429,183	$ (2,532,840)
Interest Income	3,958,656		3,622,400	4,755,755	816,060	405,600	410,460	1,076,593	1,354,051	989,050	1,336,060
Property Tax Revenue	11,279,104		11,320,000	11,762,020	-	-	-	587,757	236,387	6,437,876	4,500,000
Donations	1,193,437		5,037,312	2,141,941	51,714	119,538	(67,824)	60,899	563,235	249,092	1,268,714
Debt Service Payments	(3,516,862)		(3,876,518)	(3,532,346)	(167,626)	(194,155)	26,529	(1,484,229)	(798,504)	(746,735)	(502,878)
Property Purchase Agreement	(811,927)		(473,624)	(541,285)	-	-	-	(202,982)	(202,982)	(135,321)	-
Municipal Lease 2025	(333,643)		(1,000,932)	(1,000,929)	(83,411)	(83,411)	0	(250,232)	(250,232)	(250,232)	(250,233)
Copier	-		-	-	-	-	-	-	-	-	-
2017 VR Demand Bond	(795,185)		(756,793)	(767,496)	-	-	-	(672,429)	(13,058)	(82,008)	-
2015 Revenue Bond	(1,576,107)		(1,645,169)	(1,222,636)	(84,215)	(110,744)	26,529	(358,585)	(332,232)	(279,174)	(252,645)
Physician Recruitment	(121,333)		(521,000)	(171,333)	-	(33,333)	33,333	(88,000)	(83,333)	-	-
Investment in Capital											
Equipment	(4,700,844)		(5,613,300)	(7,012,606)	(778,700)	(871,282)	92,582	(1,247,350)	(1,713,269)	(1,513,287)	(2,538,700)
Municipal Lease Reimbursement	1,340,632		4,780,000	2,371,777	-	-	-	-	-	1,175,694	1,196,083
IT/EMR/Business Systems	-		(5,027,825)	-	-	(451,469)	451,469	-	-	-	-
Building Projects/Properties	(12,436,705)		(55,592,169)	(46,825,788)	(3,827,755)	(8,085,520)	4,257,765	(5,592,451)	(12,181,170)	(9,024,413)	(20,027,755)
Change in Accounts Receivable	(8,996,668)	N1	(328,792)	5,026,456	(1,302,510)	(1,601,962)	299,452	6,006,700	1,943,603	(4,033,596)	1,109,749
Change in Settlement Accounts	(10,420,429)	N2	(5,011,279)	(7,052,471)	4,793,879	(1,822,699)	6,616,578	(5,260,008)	(11,199,598)	8,092,825	1,314,310
Change in Other Assets	(6,444,419)	N3	(2,248,346)	(7,244,035)	(451,018)	100,000	(551,018)	(3,518,928)	(1,052,013)	(1,967,254)	(705,840)
Change in Other Liabilities	6,736,574	N4	(7,815,000)	(1,842,363)	1,943,874	226,000	1,717,874	(664,024)	(8,365,438)	(3,773,498)	10,960,597
Change in Cash Balance	29,757,408		(33,718,273)	(19,752,804)	5,414,352	(9,597,806)	15,012,158	2,822,100	(22,267,341)	4,314,937	(4,622,501)
Beginning Unrestricted Cash	184,297,240		214,054,647	214,054,647	198,924,344	198,924,344	-	214,054,647	216,876,748	194,609,407	198,924,344
Ending Unrestricted Cash	214,054,647		180,336,374	194,301,843	204,338,696	189,326,538	15,012,158	216,876,748	194,609,407	198,924,344	194,301,843
Operating Cash	214,054,647		180,336,374	194,301,843	204,338,696	189,326,538	15,012,158	216,876,748	194,609,407	198,924,344	194,301,843
Expense Per Day	917,777		956,582	985,076	950,843	948,509	2,335	936,594	937,532	949,903	985,076
Days Cash On Hand	233		189	197	215	200	15	232	208	209	197

Footnotes:

Budget - Beginning Unrestricted Cash amount for Budget FYE 2026 has been restated to match the Ending Unrestricted Cash from Audited FYE 2025.

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

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: May 28, 2026	**ITEM:** Board Charters
DEPARTMENT: Board of Directors	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Clerk of the Board	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Committee Charters**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Each Board Committee will annually review and recommend for approval the Committee Charter with changes as needed.

SUMMARY/OBJECTIVES:
11.3.1. Board Finance Committee Charter
Committee reviewed the charter on April 29, 2026, Committee recommends changes to the Charter for 2026.

11.3.2. Board Executive Compensation Committee Charter
Committee reviewed the charter on May 06, 2026. Committee recommends changes to the Charter for 2026.

SUGGESTED DISCUSSION POINTS:

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the Board Finance Committee and Board Executive Compensation Committee Charters with changes.
(includes all consent items)

Alternate: Pull the either or both Charters from consent for further discussion.

LIST OF ATTACHMENTS:
Board Finance Committee Charter – redline & clean versions
Board Executive Compensation Committee Charter – redline & clean version

DRAFT Charter
Finance Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:
The purpose of this Charter is to delineate the Finance Committee's duties and responsibilities. The Committee assists the Board of Directors in fulfilling its fiduciary, ~~and~~ strategic and ~~oversight~~financial oversight responsibilities. The Committee provides oversight of the District's ~~by monitoring the~~ financial condition, financial planning, capital structure, and major financial strategies, and ensures ~~and performance of the District, ensuring~~ alignment between financial planning and strategic initiatives. The Committee ~~, and~~ recommend~~sing~~ actions to safeguard, preserve, and enhance the community's investment in the ~~hospital~~District.

RESPONSIBILITIES:
In carrying out its purpose, ~~T~~the Committee is responsible for assisting the Board in oversight of the District's financial and strategic affairs by:

- Monitoring the ~~organization's~~ District's overall financial and capital position, policies, and performance;
- Ensuring that long-range financial planning supports the District's strategic direction and operational priorities;
- Reviewing, advising, and making recommendations on strategic business initiatives, partnerships, and investments that have material financial implications; and
- Recommending actions to protect and enhance the District's fiscal sustainability, ~~, and~~ strategic competitiveness, and community benefit; and~~.~~
- Reviewing and evaluating the financial feasibility and impact of major capital expenditures, strategic initiatives, partnerships, affiliations, and investments prior to Board consideration.

DUTIES:
In addition to its existing duties, the Committee shall:

1. **Financial Oversight**
   - Review quarterly the District's operating, cash, and capital budgets, budget performance, and financial management, and make recommendations as appropriate.
   - Review financial statements quarterly and monitor key financial indicators relative to industry benchmarks, ~~and~~ peer organizations, and Board-approved targets.
   - Oversee the annual independent audit and supervision of any necessary corrective measures.
   - Review annually the investment of District funds.
   - Review and evaluate significant accounting policies and financial reporting practices.

2. **Strategic Alignment**

REVISED ~~10/21/2025~~04/29/2026 – Approved by the TFHD Board of Directors ~~11/20/2025~~
~~No Changes 2026 – Approved by the TFHD Board of Directors 03/26/2026~~

- Review and evaluate the District's strategic plan, ensuring financial feasibility, ~~and~~ sustainability, and alignment with the District's ~~of~~ strategic priorities, mission and community benefit goals.
- Assess the financial impact of strategic initiatives, partnerships, affiliations, joint ventures, acquisitions or service line expansions prior to Board consideration.
- Monitor progress toward achieving financial and strategic objectives, including return on strategic investments and alignment with mission and community benefit goals.
- Participate jointly with the Board and executive leadership in annual strategic and financial planning sessions to ensure cohesive integration of operational, financial, and strategic plans.
- Review key environmental, market, and regulatory trends that may impact the District's long-term financial or strategic position.
- Review and recommend to the Board on the acquisition, construction, utilization, financing, and disposition of major assets, including facilities and information technology.

3. Advisory Role

~~**3.**~~ **The Committee shall:**

- Provide guidance to the Board and management regarding strategic business opportunities, major capital investments, significant financial strategies, and resource allocation priorities.
- Recommend financial performance metrics, ~~and~~ dashboards and targets to ~~monitor progress toward strategic and financial goals.~~support Board oversight of strategic and financial goals.
- Coordinate, as appropriate, with other Board committees (such as the Board Quality and Community Engagement Committees) on matters where quality, cost, and financial risk intersect.

COMPOSITION:

The Committee is comprised of at least two (2) members. The Board Treasurer shall serve on the Committee, and the second Committee member shall be appointed by the Board Chair. Additional members with strategic planning or financial expertise may be appointed at the discretion of the Board Chair. Members should collectively possess expertise in financial management, budgeting, capital planning, healthcare finance, and strategic analysis.

MEETING FREQUENCY:

The Committee shall meet quarterly, or more frequently as necessary to review financial and strategic planning matters. A report will be made to the Board of Directors quarterly or otherwise as requested.

Charter
Finance Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:
The purpose of this Charter is to delineate the Finance Committee's duties and responsibilities. The Committee assists the Board of Directors in fulfilling its fiduciary, strategic and financial oversight responsibilities. The Committee provides oversight of the District's financial condition, financial planning, capital structure, and major financial strategies, and ensures alignment between financial planning and strategic initiatives. The Committee recommends actions to safeguard, preserve, and enhance the community's investment in the District.

RESPONSIBILITIES:
In carrying out its purpose, the Committee is responsible for assisting the Board in oversight of the District's financial and strategic affairs by:

- Monitoring the District's overall financial and capital position, policies, and performance;
- Ensuring that long-range financial planning supports the District's strategic direction and operational priorities;
- Reviewing, advising, and making recommendations on strategic business initiatives, partnerships, and investments that have material financial implications; and
- Recommending actions to protect and enhance the District's fiscal sustainability, strategic competitiveness, and community benefit; and
- Reviewing and evaluating the financial feasibility and impact of major capital expenditures, strategic initiatives, partnerships, affiliations, and investments prior to Board consideration.

DUTIES:
In addition to its existing duties, the Committee shall:

1. **Financial Oversight**
   - Review quarterly the District's operating, cash, and capital budgets, budget performance, and financial management, and make recommendations as appropriate.
   - Review financial statements quarterly and monitor key financial indicators relative to industry benchmarks, peer organizations, and Board-approved targets.
   - Oversee the annual independent audit and supervision of any necessary corrective measures.
   - Review annually the investment of District funds.
   - Review and evaluate significant accounting policies and financial reporting practices.

2. **Strategic Alignment**

- Review and evaluate the District's strategic plan, ensuring financial feasibility, sustainability, and alignment with the District's strategic priorities, mission and community benefit goals.
- Assess the financial impact of strategic initiatives, partnerships, affiliations, joint ventures, acquisitions or service line expansions prior to Board consideration.
- Monitor progress toward achieving financial and strategic objectives, including return on strategic investments and alignment with mission and community benefit goals.
- Participate jointly with the Board and executive leadership in annual strategic and financial planning sessions to ensure cohesive integration of operational, financial, and strategic plans.
- Review key environmental, market, and regulatory trends that may impact the District's long-term financial or strategic position.
- Review and recommend to the Board on the acquisition, construction, utilization, financing, and disposition of major assets, including facilities and information technology.

3. **Advisory Role**

The Committee shall:

- Provide guidance to the Board and management regarding strategic business opportunities, major capital investments, significant financial strategies, and resource allocation priorities.
- Recommend financial performance metrics, dashboards and targets to support Board oversight of strategic and financial goals.
- Coordinate, as appropriate, with other Board committees (such as the Board Quality and Community Engagement Committees) on matters where quality, cost, and financial risk intersect.

COMPOSITION:

The Committee is comprised of at least two (2) members. The Board Treasurer shall serve on the Committee, and the second Committee member shall be appointed by the Board Chair. Additional members with strategic planning or financial expertise may be appointed at the discretion of the Board Chair. Members should collectively possess expertise in financial management, budgeting, capital planning, healthcare finance, and strategic analysis.

MEETING FREQUENCY:

The Committee shall meet quarterly, or more frequently as necessary to review financial and strategic planning matters. A report will be made to the Board of Directors quarterly or otherwise as requested.

DRAFT Charter

Executive Compensation Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose of the charter is to delineate the responsibilities and duties of the Executive Compensation Committee of the District's Board of Directors. As needed, the Committee may engage an Executive Compensation Specialist recommended by management that; (i) assists in determining appropriate compensation plans, policies and programs for President & Chief Executive Officer (CEO) of the District; (ii) and reviews the benefits plan options for the CEO of the District; as well as (iii) verifies the CEO's compensation information is appropriately disclosed.

RESPONSIBILITIES:

The Executive Compensation Committee is responsible for assisting the Board in ensuring all CEO compensation decisions are competitive, fair, and equitable, as well as compliant with appropriate regulatory guidelines and representative of best market practices. The Committee is additionally responsible for the oversights of the CEO's comprehensive compensation package and Incentive Compensation criteria, and the CEO's performance objectives. ~~oversight of President & Chief Executive Officer (CEO) relations and the work done through the Winning Aspirations.~~

DUTIES:

1. ~~Oversee the identification and recruitment of the organization's CEO as directed by the Board of Directors.~~
2. ~~2.~~1. Ensure an annual CEO performance evaluation process is in place.
3. ~~3.~~2. In conjunction with the CEO, using a standardized evaluation tool, annually review and recommend modifications of the goals and objectives documents which will be used to evaluate the performance of the CEO.
4. ~~4.~~3. Review annually the CEO's comprehensive compensation ~~package, and~~package and make recommendations to the Board of Directors as necessary.
5. ~~5.~~4. Review metrics annually for the CEO's Incentive Compensation Criteria and make recommendations to the Board of Directors as necessary.
6. ~~Review annually the CEO's Employment Agreement, and make recommendations to the Board of Directors as necessary.~~
5. In conjunction with the CEO, review and evaluate annually the CEO position description to ensure its continued relevance. Recommend revisions to the Board of Directors as necessary.
6. As appropriate and upon the recommendation of management, engage independent, external advisors (e.g. compensation consultants, attorneys, etc) to provide objective and impartial compensation data and express an opinion on the equity and compliance of the total executive compensation.

7. Review and reassess this Charter annually and amend it as the Committee and Board deem appropriate.

COMPOSITION:

The Committee is comprised of at least two (2) board members appointed by the Board Chair.

MEETING FREQUENCY:

Per the "Brown Act" California Government Code Section § 54956 (b) discussion of salaries, salary schedules, or compensation in the form of fringe benefits to either the legislative body or for executives of the agency is prohibited except at a regularly scheduled meeting of the legislative body.

To comply with this code, the Executive Compensation Committee must limit discussion of salaries, salary schedules, and compensation in the form of fringe benefits to either the legislative body or for executives of the agency to regularly scheduled meetings with at least 72 hours' notice for agenda posting.

The Committee shall meet at least twice annually for a regular meeting on:

- The 1st Wednesday of May and the 1st Wednesday of October each year, and
- Additional meetings may be scheduled as needed.

~~The Committee shall meet at least once annually and then on an as needed basis.~~

DRAFT Charter

Executive Compensation Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose of the charter is to delineate the responsibilities and duties of the Executive Compensation Committee of the District's Board of Directors. As needed, the Committee may engage an Executive Compensation Specialist recommended by management that; (i) assists in determining appropriate compensation plans, policies and programs for President & Chief Executive Officer (CEO) of the District; (ii) and reviews the benefits plan options for the CEO of the District; as well as (iii) verifies the CEO's compensation information is appropriately disclosed.

RESPONSIBILITIES:

The Executive Compensation Committee is responsible for assisting the Board in ensuring all CEO compensation decisions are competitive, fair, and equitable, as well as compliant with appropriate regulatory guidelines and representative of best market practices. The Committee is additionally responsible for the oversights of the CEO's comprehensive compensation package and Incentive Compensation criteria, and the CEO's performance objectives.

DUTIES:

1. Ensure an annual CEO performance evaluation process is in place.
2. In conjunction with the CEO, using a standardized evaluation tool, annually review and recommend modifications of the goals and objectives documents which will be used to evaluate the performance of the CEO.
3. Review annually the CEO's comprehensive compensation package and make recommendations to the Board of Directors as necessary.
4. Review metrics annually for the CEO's Incentive Compensation Criteria and make recommendations to the Board of Directors as necessary.
5. In conjunction with the CEO, review and evaluate annually the CEO position description to ensure its continued relevance. Recommend revisions to the Board of Directors as necessary.
6. As appropriate and upon the recommendation of management, engage independent, external advisors (e.g. compensation consultants, attorneys, etc) to provide objective and impartial compensation data and express an opinion on the equity and compliance of the total executive compensation.
7. Review and reassess this Charter annually and amend it as the Committee and Board deem appropriate.

COMPOSITION:

The Committee is comprised of at least two (2) board members appointed by the Board Chair.

MEETING FREQUENCY:

Per the "Brown Act" California Government Code Section § 54956 (b) discussion of salaries, salary schedules, or compensation in the form of fringe benefits to either the legislative body or for executives of the agency is prohibited except at a regularly scheduled meeting of the legislative body.

To comply with this code, the Executive Compensation Committee must limit discussion of salaries, salary schedules, and compensation in the form of fringe benefits to either the legislative body or for executives of the agency to regularly scheduled meetings with at least 72 hours' notice for agenda posting.

The Committee shall meet at least twice annually for a regular meeting on:

- The 1st Wednesday of May and the 1st Wednesday of October each year, and
- Additional meetings may be scheduled as needed.

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: May 28, 2026	ITEM: 11.4. Corporate Compliance Report (Open Session)
DEPARTMENT: Compliance	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Scott G. Kraft and Sean Weiss, Compliance Officers, DoctorsManagement, LLC.	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Quarterly Compliance Report**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Quarterly Compliance Report detailing ongoing work, support, investigations, and review in progress and completed by the Compliance Committee.

SUMMARY/OBJECTIVES:
Objective: Review the current Quarterly Compliance Report.

SUGGESTED DISCUSSION POINTS:

Compliance Training, audit results, new vs. established patients, HCAI revisions

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the consent agenda as presented.
(includes all consent items)

Alternative: pull item from consent agenda for further discussion under Item 16 on the Board Agenda. After discussion, request a motion to approve the Second Quarter Corporate Compliance Plan as presented.

LIST OF ATTACHMENTS:
1st Quarter Corporate Compliance Report

TAHOE FOREST
HOSPITAL DISTRICT

Board Informational Report
Quarterly Compliance Officer's Report
By: Scott G. Kraft and Sean Weiss
Compliance Officers, DoctorsManagement, LLC

DATE: May 28, 2026

Dear Members of the Board,

As the appointed Compliance Officers for Tahoe Forest Hospital District (TFHD), we (Scott G. Kraft and Sean M. Weiss) are pleased to submit this compliance officer's open session report for 2026 Quarter 1.

Current Corporate Compliance Committee:
This is the composition of the Corporate Compliance Committee as of May 28, 2026:
Sean M Weiss, DoctorsManagement – Compliance Officer
Scott G. Kraft, DoctorsManagement – Compliance Officer
Anna Roth, President and Chief Executive Officer
Louis Ward, Chief Operating Officer
Jan Iida, RN, Chief Nursing Officer
Crystal Felix. Chief Financial Officer
Brian Evans, MD – Chief Medical Officer
Matt Mushet – In-house Legal Counsel
Gary Harper*, compliance analyst
Sarah Swezey, Privacy Officer
Jenny Parvin, Revenue Integrity Nurse
Janet Van Gelder, Director of Quality and Regulations

Condolence Cards and Other Communications:
We are finalizing a policy that provides clear guidance on how providers and other medical staff can send acknowledgment cards to patients and/or families based on life events. There is some debate on whether this constitutes a HIPAA violation but with a clear policy/procedure we believe this is addressed as a permitted business activity.

Charge Description Master/Fee Setting: Compliance was made aware of a situation where a supply was acquired by the district that comes in a box of five, with each unit being its own supply for use and billing. It appears that based on how the supply was loaded into the Charge Description Master, some patients were given one of these supply items as part of a procedure but were charged based on the box price. We are correcting that, but this has led to a request to perform a broader review of how supplies are priced based on Medicare policy and payer contracts and how they are loaded into the Charge Description Master. There are two preliminary goals here: Validate that charge setting and updating methodologies are compliant and ensure that supply descriptions are being entered in a way that enables clinicians and medical staff to promptly locate and use the correct supply.

Substance Use Disorder Treatment
We have finalized updated substance use disorder consent documentation that incorporates required privacy parameters for patients in SUD treatment programs to ensure compliance. We have also updated the Notice of Privacy Practices to incorporate these changes as well.

Annual Compliance Training
As part of our annual compliance work plan, we will look to schedule compliance training sessions in June and July for the Board of Directors, Medical Staff and Coding and Billing/Administrative staff. These will be separate sessions specific to these groups that can be recorded for others. One thing we will emphasize is responsibility for engaging Compliance and the Privacy Officer to mitigate the risk to the District.

Auditing & Monitoring
- **High Risk Services:** We continue to work with revenue cycle on monitoring these services as remote EPIC access process is finalized.
- **Botox Units:** We are reviewing how Botox is billed based on a concern that wastage units are not being billed correctly. There is not a revenue impact as the payer will pay for the entire single-use vial, but the reporting of Botox is supposed to be split among what is used for the patient and the remaining discarded drug in the vial.
- **Modifier 25:** This was recently targeted in the OIG Work Plan for Review and we will review high risk usage of this code (typically alongside in-office procedures)

Effective Lines of Compliance Reporting
A weekly compliance log is maintained for all calls to the Compliance Hotline and/or reports to the Compliance Department.

Compliance Reporting/Detected Offenses/Corrective Action Plans:
- We received a patient complaint that TFHD did not follow its own policies and procedures (and federal regulations) concerning a patient requesting a copy of their own medical records. We are investigating and, in conjunction with our compliance training, will reinforce this rule.

- We received a complaint involving ongoing potential HIPAA violations that we substantiated – we reported a recommendation to human resources and this was addressed via a written warning.

Ongoing Compliance Support
As Gary Harper has relocated to the area, we will begin additional outreach to introduce Gary to employees of Tahoe Forest and create a connection as the face of on-site compliance.

We are also available to answer queries from the Board of Directors.

Sincerely,
Sean M. Weiss
sweiss@drsmgmt.com

Scott G. Kraft
skraft@drsmgmt.com

Chief Compliance Officers
Tahoe Forest Health System