TAHOE FOREST HOSPITAL DISTRICT

2016-05-26 Regular Meeting of the Board of Directors

Thursday, May 26, 2016 at 4:00 p.m.

Tahoe Truckee Unified School District (TTUSD)

11603 Donner Pass Road, Truckee, CA 96161

Meeting Book - 2016-05-26 Regular Meeting of the Board of Directors

05/26/16 Regular Board Meeting - Agenda Packet Contents

REGULAR MEETING OF THE BOARD OF DIRECTORS

AGENDA

Thursday, May 26, 2016 at 4:00 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION:**
   - **5.1. Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Report of quality assurance/medical audit committee — 1st Quarter 2016 Corporate Compliance Program Report
   - **5.2. Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Report of quality assurance/medical audit committee — 1st Quarter Service Excellence Report
   - **5.3. Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Medical Staff Credentials
   - **5.4. Approval of Closed Session Minutes◈**
     04/28/2016

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

7. **OPEN SESSION – CALL TO ORDER**

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

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

10. **INPUT – AUDIENCE**
    This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take

◈ Denotes Action Item

action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

12. ACKNOWLEDGMENTS

12.1. Nurse of the Year
12.2. TFHD Volunteers
12.3. ACHD Presentation to TFHD at a future Board Meeting
12.4. June Board Meeting to be held in Tahoe City

13. MEDICAL STAFF REPORT◈

13.1. Medical Staff Report.....ATTACHMENT

14. ITEM FOR BOARD DISCUSSION AND/OR ACTION

14.1. Physician Contract Renewal Structure [15 minutes].....ATTACHMENT
The Board will receive a presentation on the Physician Contract Renewal Structure.

15. CONSENT CALENDAR◈

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

15.1. Approval of Minutes of Meetings◈
04/28/2016, 05/03/2016.....ATTACHMENT
15.2. Financial Report◈
Financial Report- April 2016.....ATTACHMENT
15.3. Contracts◈
15.3.1. Gerald Schaffer – Physician Professional Services Agreement Amendment..ATTACHMENT
15.3.2. Ellen Cooper – Physician Professional Services Agreement Amendment.....ATTACHMENT
15.3.3. Julie Conyers – Physician Professional Services Agreement Amendment.....ATTACHMENT
15.4. Board Policies◈
15.4.1. ABD-21 Physician and Professional Service Agreement.....ATTACHMENT
15.5. IVCH Foundation Memorandum of Understanding◈.....ATTACHMENT

16. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

16.1. IVCH Siding Bid Approval◈.....ATTACHMENT
The Board of Directors will authorize the award of a contract for siding replacement at Incline Village Community Hospital.
16.2. Sierra Nevada Oncology Physician Services Agreement◈.....ATTACHMENT
The Board of Directors will review and consider for approval the Physician Services Agreement for Sierra Nevada Oncology.
16.3. California End of Life Act◈.....ATTACHMENT
The Board of Directors will review upcoming legislation for the California End of Life Act.

16.4. Corporate Compliance Program Report..... ATTACHMENT
The Board will review the 1st Quarter 2016 Corporate Compliance Program Report.

16.5. LAFCO Ballot◈ ..... ATTACHMENT
The Board will consider a vote for the election of a Special District Representative to the Placer County Local Agency Formation Commission.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

18.1. Governance Committee Meeting – 05/18/2016.....ATTACHMENT
18.2. Finance Committee Meeting – 05/23/2016.....ATTACHMENT
18.3. Personnel-Retirement Subcommittee Meeting – 05/12/2016 .....ATTACHMENT
18.4. Quality Meeting – No meeting held in March.
18.5. Community Benefit Committee Meeting – No meeting held in March.

19. INFORMATIONAL REPORTS

These reports are provided for information only and not intended for discussion. Any Board Member may request discussion on an item, additional information from staff related to items included in a report, or request a topic be placed on a future agenda for further discussion.

19.1. CEO Strategic Updates.....ATTACHMENT
CEO will provide updates related to his key strategic initiatives.

19.2. Staff Report(s)

19.2.1. CNO/COO Board Report.....ATTACHMENT
19.2.2. CIO Board Report.....ATTACHMENT

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

21. ITEMS FOR NEXT MEETING

22. BOARD MEMBERS REPORTS/CLOSING REMARKS

23. CLOSED SESSION CONTINUED, IF NECESSARY

23.1. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Medical Staff Credentials

24. OPEN SESSION

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

26. MEETING EFFECTIVENESS ASSESSMENT.....ATTACHMENT
The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

◈ Denotes Action Item

27. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is June 23, 2016 and will be held at the Tahoe City Public Utility District, 221 Fairway Drive, Tahoe City, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

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

◈ Denotes Action Item

MEDICAL EXECUTIVE COMMITTEE
CONSENT AGENDA
RECOMMENDATIONS TO BOARD OF DIRECTORS
May 26, 2016

REFERRED BY:	AGENDA ITEMS:	RECOMMEND
1. Department of Medicine	The Department of Medicine recommended approval of the following: ➢ Community Family Physician privileges	Recommend approval
2. Department of OB/PEDS	The OB/PEDS Department recommended approval of the following: ➢ OB/GYN privileges revised ➢ Pediatric privileges revised	Recommend approval

PHYSICIAN COMPENSATION FY 17 OVERVIEW OF THE OPTIONS

Presented to Governance Committee

May 18, 2016

GOALS FOR PHYSICIAN COMPENSATION MODEL

- Meets compliance standards
  - Fair market value
  - Commercially reasonable
- Sufficient compensation and benefits to recruit and retain physicians
- Encourages and rewards both productivity and quality
  - Value becoming increasingly important to payers
- Internally equitable
- Clear and understandable to all parties

HOW DOES OUR CURRENT COMP MODEL STACK UP?

CRITERIA	COMMENTS
COMPLIANCE	• All contracts built on the current platform have been within FMV (so far)
RECRUITMENT / RETENTION	• Lack of benefits make it difficult to attract and retain physicians
GOAL ALIGNMENT	• Aligned with productivity goal, but lacks incentives to encourage and reward quality
INTERNAL EQUITY	• Basic platform (base plus bonus) has been applied to all physicians working more than half time • Most but not all physicians placed at a base compensation / production target level that enables them to bonus
CLARITY	• Benefit allowance not well understood • Not universally perceived as a production-based model

OPPORTUNITIES FOR IMPROVEMENT

- Better alignment of compensation metrics with those used by ECG for FMV
  - Reduce the risk of exceeding FMV
  - Move toward “omnibus” approval of the model
  - Obtain FMVs on an exception basis only
  - Specific changes:
    - Use of National rather than Western Region data
    - Use of published median ratio of compensation to WRVUs rather than median comp divided by median WRVUs
- Improve recruitment / retention with a fair market benefit allowance
- Incorporate incentives for patient satisfaction, quality and operational metrics

MANAGING THE TRANSITION TO A NEW MODEL

- Physician anxiety is already at a high level
  - High level of Board and public scrutiny of physician compensation arrangements
  - Past delays in contract approval
    - The FY 14 "holdover" during FMV completion
  - The formation of "NewCo" reflects yet more uncertainty and change
- Concern that an overhaul of the comp model would further increase the anxiety level
- The solution: Physicians offered a choice
  - Option A: New model with production-based comp, benefit allowance and incentives
  - Option B: Current platform with partial inflationary update
- Two year contract with model updated to most current MGMA 3-yr average at the one-year mark

OPTION A: THE BASICS

- $_____ per WRVU
- Customized benefit allowance
  - Represents a maximum reimbursement cap
  - Physician may allocate the allowance to malpractice, health insurance, payroll taxes normally paid by the employer (50% FICA, SUI/FUTA), retirement, CME, life/disability to best meet individual needs
  - Paid based on submission of documentation
- Incentive component
  - Earn up to $15K (prorated to FTE status) for performance on patient satisfaction, quality, compliance metrics
  - Continue Meaningful Use incentive at 20% of MU funds received
    - $862 for Medicare's final year (internists & specialists)
    - $1,700 for Medi-Cal (pediatricians)
- Hospitalist shifts paid at updated per shift rates

BENEFIT ALLOWANCE

	Medicine/Peds	Genl Surgery	GI
Fixed amount			
Malpractice allowance	$ 7,600	$ 28,100	$ 11,600
FICA-SS taxes (6.2% x $118,500)	$ 7,347	$ 7,347	$ 7,347
SUI/FUTA taxes (6.0% x $7,000)	$ 420	$ 420	$ 420
Health insurance	$ 12,489	$ 12,489	$ 12,489
CME	$ 4,200	$ 4,200	$ 4,200
Life/disability/other	$ 3,000	$ 3,000	$ 3,000
Total	$ 35,056	$ 55,556	$ 39,056
Variable amount (fixed based on prior year actual annzd, FTE adjusted)			
Retirement (on first $265K)	9.6%	9.6%	9.6%
FICA-Medicare taxes	1.45%	1.45%	1.45%
	11.05%	11.05%	11.05%

OPTION A: PURE PRODUCTIVITY PLUS BENEFITS PLUS INCENTIVE

FY 17 compensation model
Effective from 7/1/2016 - 6/30/2017
BlepharoNepharohospopathy
Tahoe Forest Multi-Specialty Clinics

OPTION A: PURE PRODUCTIVITY PLUS BONUS INCENTIVES PLUS BENEFITS		
MGMA National compensation per WRVU		
2013 book / 2012 data		$ 33.50
2014 book / 2013 data		$ 34.22
2015 book / 2014 data		$ 34.66
3- year average		$ 34.13
Inflation factor		3%
Inflated 3-year average	A	$ 35.15
Actual WRVUs (FY 16 Jul-Feb annzd)	B	4,268
Projected WRVU-based compensation	C=A*B	$ 150,020
Benefit allowance:		
Fixed Amount	D	$ 35,056
Variable Amount	E=(C*1.45%)+(Max(C,$265K)*9.6%)	$ 16,577
Total benefit allowance	F=D+E (rounded)	$ 51,600
Maximum incentive bonus payment	G	$ 15,000
Total compensation based on FY 16 annzd WRVU production		
Assume no incentive bonus	H=C+F	$ 201,620
Assume 50% incentive bonus	I=C+F+(G*50%)	$ 209,120
Assume 75% incentive bonus	J=C+F+(G*75%)	$ 212,870
Assume 100% incentive bonus	K=C+F+G	$ 216,620

MODEL B: THE BASICS

- Current model is updated halfway to what would have been adopted absent this change
- Same structure as current platform
  - Uses MGMA Western Region median (3 yr avg + 3%)
  - Base comp at x% of median
  - Production target at x-15% of median
  - Calculated rate per RVU for RVUs in excess of target
- Optional reduction to base comp to fund a Bonus Pool (up to $7,500) which is matched by the hospital
- Incentive Bonus pool administered in the same manner as under Model A

OPTION B: CURRENT MODEL WITH OPTIONAL INCENTIVE

FY 17 compensation model (Option B)
Effective from 7/1/2016 - 6/30/2017
BlepharoNepharohospopathy
Tahoe Forest Multi-Specialty Clinics

	Current Contract (FY 16)	Current Model Updated	(Midpoint) FY 17 Option B
MGMA Western Region median compensation			
2013 book / 2012 data		$ 146,000	
2014 book / 2013 data		$ 148,000	
2015 book / 2014 data		$ 150,000	
3-year average		$ 148,000	
Inflation factor		3%	
Base compensation	$ 148,000	$ 152,440	$ 150,220
MGMA Western Region median Work RVUs			
2013 book / 2012 data		4,500	
2014 book / 2013 data		4,200	
2015 book / 2014 data		4,400	
3-year average	4,300	4,367	4,333
Percentage of MGMA	85%	85%	85%
Contract target	3,655	3,712	3,683
Compensation per 2016 WRVU in excess of target*	$ 34.42	$ 34.91	$ 34.67
*100% MGMA comp target / 100% MGMA WRVU target			
FY 16 Jul-Feb annzd productivity (including credits)	4,268	4,268	4,268
Projected compensation based on FY 16 production	$ 169,099	$ 171,850	$ 170,502

OPTION B: CURRENT MODEL WITH OPTIONAL INCENTIVE (CONT'D.)

FY 17 compensation model
Effective from 7/1/2016 - 6/30/2017
BlepharoNepharohospopathy
Tahoe Forest Multi-Specialty Clinics

OPTION B: CURRENT MODEL ***(but with optional incentive bonus pool funding)***

		No pool	Partial pool	Max pool
FY 17 base compensation	L	$ 150,220	$ 150,220	$ 150,220
Voluntary reduction to fund bonus pool	M	$ -	$ (5,000)	$ (7,500)
FY 17 adjusted base compensation	N=L+M	$ 150,220	$ 145,220	$ 142,720
Actual WRVUs (FY 16 Jul-Feb annzd)	O	4,268	4,268	4,268
WRVU target	P	3,683	3,683	3,683
Production-based bonus:				
WRVUs subject to bonus	Q=O-P	585	585	585
Payment per RVU	R	$ 34.67	$ 34.67	$ 34.67
Production-based bonus amount	S=Q*R	$ 20,282	$ 20,282	$ 20,282
Other payments:				
Meaningful use (maximum)	T	$ 862	$ 862	$ 862
CME funding (maximum)	U	$ 4,200	$ 4,200	$ 4,200
Maximum incentive bonus payment	V=-M*200%	$ -	$ 10,000	$ 15,000
Total compensation based on FY 16 annzd WRVU production				
Assume no incentive bonus	W=N+S+T+U	$ 175,564	$ 170,564	$ 168,064
Assume 50% incentive bonus	X=N+S+T+U+(V*50%)	$ 175,564	$ 175,564	$ 175,564
Assume 75% incentive bonus	Y=N+S+T+U+(V*75%)	$ 175,564	$ 178,064	$ 179,314
Assume 100% incentive bonus	Z=N+S+T+U+V	$ 175,564	$ 180,564	$ 183,064

INCENTIVE BONUS: ALIGNING WITH THE VOLUME-TO-VALUE SHIFT

- $15K bonus potential for full-time physicians
- 4 key metrics
  - Meaningful use
  - Patient satisfaction
  - Timely chart completion
  - PQRS
- Measure what matters
- Keep it simple
- Use what we have now
- Provide choice on how to allocate $15K
  - Equal allocation
  - 40/40/20

ALIGNING WITH THE VOLUME-TO-VALUE SHIFT

METRIC	KEY MEASURE	COMMENT
Meaningful Use	As now-Pass/Fail	Need to maintain Hx of success
Patient Satisfaction	Meet or exceed national mean score of 93.1 ("top box")	•10 Qs from Press-Ganey •Tiered bonus •Majority of MSC MD/DOs currently would earn a bonus
Open Charts	Office visit charts 3+ days post encounter	Just physician portion of chart
PQRS	•PQRS measures per specialty •Meet or exceed national benchmarks	•TFHD will be fined if we do not pass •PQRS 16' to be folded into MACRA 17'

ALIGNING WITH THE VOLUME-TO-VALUE SHIFT: PATIENT SATISFACTION

Benchmark	Bonus Potential	Comment
<=93.0	0%	3 MDs below median
93.1-94.0	25%	2 physicians qualify
94.1-95.0	50%	2 physicians qualify
95.1-96.0	75%	None currently
96.1 +	100%	5 physicians qualify

ALIGNING WITH THE VOLUME-TO-VALUE SHIFT: OPEN CHARTS

Metric= percent of office visits open 3+days post visit	Bonus Potential	Comment
>6%	No bonus	4 MDs at this level *Group score is 6.9%*
5%-6%	25%	1 MD at this level
4%-5%	50%	None at this level
3.9% or less	100%	9 MDs at this level (4 were perfect!)

Applied to office encounters only - the key metric under physician control

ALIGNING WITH THE VOLUME-TO-VALUE SHIFT: PQRS

Number of measures=9	Bonus Potential	Comment
9/9	100%	•FP and IM have all 9 •TFHD must meet this or face a penalty
8/9	50%	
7/9	25%	Current state is 6/9

- Physicians in other specialties would be evaluated against only those criteria that are pertinent to their specialty
- Example: Pediatrics will only have four measures
  - Measured on medication review, BMI, tobacco use, flu shots
  - *Not* measured on osteoporosis, colorectal CA screening, antiplatelet therapy, breast CA screening & over 65 pneumovax

SUMMARY

- Goal is to reward progress, not perfection
- Changes to workflow will improve results
- Financial incentives will change behavior

REGULAR MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, April 28, 2016 at 4:00 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. CALL TO ORDER

Meeting was called to order at 4:01 p.m.

2. ROLL CALL

Board: Charles Zipkin, Board President; Gregory Jellinek, Vice President; Dale Chamblin, Treasurer; John Mohun, Secretary; Karen Sessler, Board Member

Staff: Harry Weis, CEO; Crystal Betts, CFO; Judy Newland, CNO; Jake Dorst, CIO; Martina Rochefort, Clerk of the Board

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

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

No changes were made to the agenda.

4. INPUT AUDIENCE:

No public comment was received.

Open Session recessed at 4:02 p.m.

5. CLOSED SESSION

Discussion was held on privileged matters.

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:01 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel advised there were no reportable actions taken on Items 5.1. and 5.2. The Board unanimously rejected the liability claim of Kim Boganes listed in Item 5.3. Items 5.4. and 5.5. were tabled for later this evening.

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

No changes were made.

10. INPUT – AUDIENCE

Public comment was received from Lynn Larson.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No comment received from the employee associations.

12. ACKNOWLEDGMENTS

12.1. National Nurses Week is May 6-12

12.2. National Hospital Week is May 8-14

13. MEDICAL STAFF REPORT

13.1. Medical Staff Report

ACTION: **Motion made by Director Sessler, seconded by Director Mohun, to accept the Medical Staff Report as presented.**
AYES: Directors Sessler, Mohun, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

14. CONSENT CALENDAR

Director Sessler pulled the minutes of 4/14/16 for discussion.

14.1. Approval of Minutes of Meetings
03/24/2016, 03/29/2016, 04/14/2016

14.2. Financial Report
Financial Report- March 2016

14.3. Contracts

14.3.1. Peter Bretan – Physician Service Agreement

14.3.2. John Hortareas – Hospitalist Services Agreement

14.3.3. Steve Segerstrom – Call Coverage Agreement

14.4. Board Retreat Follow-Up

14.4.1. Board Order and Decorum

ACTION: **Motion made by Director Zipkin, seconded by Director Jellinek, to accept the Consent Calendar as presented excluding the minutes of April 14, 2016.**
AYES: Directors Sessler, Mohun, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

15. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

15.1. Orthopedic Group Contracts

15.1.1. North Tahoe Orthopedic Professional Services Agreement

15.1.2. North Tahoe Orthopedic Employee Lease

15.1.3. TFHD-North Tahoe Orthopedic Asset Purchase Agreement

15.1.4. North Tahoe Orthopedic Services Agreement

Discussion was held.

Public comment was received from Dr. Shawni Coll, Dr. Julie Conyers and Gaylan Larson.

The Board of Directors directed staff to bring the contracts back at a later date in a Special Meeting.

15.2. Board Policy Discussion

Discussion was held on revisions to policy ABD-21 Physician and Professional Service Agreements.

Staff was directed to look at a possible change from "ratification" to "approval" on item 1.2.1.1.6.

15.3. BlueLife Presentation

CIO presented on the BlueLife program.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Item 14.1. Approval of Meeting Minutes of April 14, 2016 was discussed.

Staff was directed to remove "Sessler" from vote on item 5.1.2. and remove "via teleconference" from roll call when meeting reconvened at 6:00 p.m.

ACTION: **Motion made by Director Sessler, seconded by Director Zipkin, to approve the minutes of April 14, 2016 with changes noted above.**
AYES: Directors Sessler, Mohun, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

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

17.1. Governance Committee Meeting – 04/20/2016

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

17.2. Finance Committee Meeting – 04/25/2016

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

17.3. Quality Committee Meeting – 04/05/2016

Director Sessler provided an update from the recent Quality Committee meeting.

17.3.1. Daily Rounding Form Sample

Discussion was held.

17.4. Personnel-Retirement Subcommittee Meeting – No meeting held in March.

17.5. Community Benefit Committee Meeting – No meeting held in March.

18. INFORMATIONAL REPORTS

These reports are provided for information only and not intended for discussion. Any Board Member may request discussion on an item, additional information from staff related to items included in a report, or request a topic be placed on a future agenda for further discussion.

18.1. CEO Strategic Updates

CEO will provide updates related to his key strategic initiatives.

Discussion was held.

18.2. Staff Report(s)

18.2.1. CNO/COO Board Report

18.2.2. CIO Board Report

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

No discussion was held.

20. ITEMS FOR NEXT MEETING
Board would like to have a discussion on master planning in the next few months.

21. BOARD MEMBERS REPORTS/CLOSING REMARKS
No discussion was held.

Open Session recessed at 7:33 p.m.

22. CLOSED SESSION CONTINUED, IF NECESSARY
Closed Session continued on privileged items.

23. OPEN SESSION
Open Session reconvened at 8:31 p.m.

24. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
General Counsel reported that the Board approved the Closed Session minutes.

25. MEETING EFFECTIVENESS ASSESSMENT
No discussion was held.

26. ADJOURN
Meeting adjourned at 8:31 p.m.

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Tuesday, May 3, 2016 at 6:30 p.m.

Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

Meeting was called to order at 6:31 p.m.

2. ROLL CALL

Board: Charles Zipkin, Board President; Gregory Jellinek, Vice President; Dale Chamblin, Treasurer; John Mohun, Secretary; Karen Sessler, Board Member

Staff: Harry Weis, CEO; Crystal Betts, CFO; Judy Newland, CNO; Jake Dorst, CIO; Martina Rochefort, Clerk of the Board

Other: Michael Colantuono, General Counsel *(via teleconference)*; Jim Hook, The Fox Group *(via teleconference)*; Walter Kopp, Medical Management Services

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

No changes were made to the agenda.

4. INPUT – AUDIENCE

No public comment was received.

5. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

5.1. Orthopedic Group Contracts

Board ratified contracts related to the acquisition of an orthopedic group.

5.1.1. North Tahoe Orthopedic Professional Services Agreement
5.1.2. North Tahoe Orthopedic Employee Lease
5.1.3. TFHD-North Tahoe Orthopedic Asset Purchase Agreement
5.1.4. North Tahoe Orthopedic Services Agreement

Discussion was held.

Public comment was received from Dr. Johanna Koch (read by Dr. Shawni Coll).

Written public comment was received from Alicia Barr, Trinkie Watson, Sandy Evans Hall and Conrad Snover.

Discussion was held.

ACTION: Motion made by Director Mohun, seconded by Director Jellinek to approve the North Tahoe Orthopedic Employee Lease, TFHD-North Tahoe Orthopedic Asset Purchase Agreement and North Tahoe Orthopedic Services Agreement.

Public comment was received from Gaylan Larson.

Roll call vote taken.
Sessler – AYE
Mohun – AYE
Chamblin – AYE
Jellinek – AYE
Zipkin – AYE

Discussion was held.

ACTION: Motion made by Director Sessler, seconded by Director Zipkin, to approve the North Tahoe Orthopedic Professional Services Agreement.

Discussion was held.

Roll call vote taken.
Sessler – AYE
Mohun – NAY
Chamblin – AYE
Jellinek – Abstained
Zipkin – AYE

6. ITEMS FOR NEXT MEETING
No discussion was held.

7. BOARD MEMBERS REPORTS/CLOSING REMARKS
No discussion was held.

8. MEETING EFFECTIVENESS ASSESSMENT
No discussion was held.

9. ADJOURN
Meeting adjourned at 7:12 p.m.

TAHOE FOREST HOSPITAL DISTRICT
APRIL 2016 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

APRIL 2016 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the ten months ended April 30, 2016.

Activity Statistics

- TFH acute patient days were 291 for the current month compared to budget of 372. This equates to an average daily census of 9.70 compared to budget of 12.40.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Endoscopy procedures, Diagnostic Imaging, Oncology procedures, Nuclear Medicine exams, MRI exams, Cat Scans, PET CT, Pharmacy units, Oncology Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Surgery cases, Oncology Lab, and Respiratory Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 53.8% in the current month compared to budget of 53.2% and to last month's 59.4%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 57.9%, compared to budget of 53.3% and prior year's 55.8%.
- EBIDA was $(1,024,407) (-6.4%) for the current month compared to budget of $(344,231) (-2.2%), or $680,176 (4.2%) below budget. Year-to-date EBIDA was $14,307,875 (7.8%) compared to budget of $2,667,594 (1.5%) or $11,640,281 (6.3%) above budget.
- Cash Collections for the current month were $10,050,508 which is 81% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 55.0, compared to the prior month of 54.7. Gross Accounts Receivables are $30,385,708 compared to the prior month of $33,074,937. The percent of Gross Accounts Receivable over 120 days old is 21.1%, compared to the prior month of 18.0%.

Balance Sheet

- Working Capital Days Cash on Hand is 38.1 days. S&P Days Cash on Hand is 192.2. Working Capital cash increased $359,000. Cash collections fell short of target by 19%, the District received reimbursement of $640,206 for funds advanced on March Measure C projects, Accounts Payable decreased $322,000 and Accrued Payroll & Related Costs also decreased $437,000.
- Net Patients Accounts Receivable decreased approximately $3,314,000. Cash collections were at 81% of target and days in accounts receivable were 55.0 days, a .30 days increase. Cash collections on hospital accounts increased in April over March and revenues were substantially lower in April over March helping to decrease the District's net Accounts Receivable position.
- GO Bond Project Fund decreased $640,206 after reimbursing the District for funds advanced on the March Measure C Projects.
- Accounts Payable decreased $322,000 due to the timing of the final check run in April.
- Accrued Payroll & Related Costs decreased $437,000 as a result of fewer days being accrued in April.

April 2016 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $15,979,513, compared to budget of $15,870,524 or $108,989 above budget.
- Current month's Gross Inpatient Revenue was $4,646,800, compared to budget of $5,484,044 or $837,244 below budget.
- Current month's Gross Outpatient Revenue was $11,332,713 compared to budget of $10,386,480 or $946,233 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 31.4% Medicare, 20.8% Medi-Cal, .0% County, 2.1% Other, and 45.7% Insurance compared to budget of 36.7% Medicare, 18.8% Medi-Cal, .0% County, 3.6% Other, and 40.9% Insurance. Last month's mix was 32.3% Medicare, 16.5% Medi-Cal, .0% County, 3.7% Other, and 47.5% Insurance.
- Current month's Deductions from Revenue were $7,390,533 compared to budget of $7,423,703 or $33,170 under budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 5.25% decrease in Medicare, a 1.95% increase to Medi-Cal, a .02% decrease in County, a 1.45% decrease in Other, and Commercial was above budget 4.77%, and 2) Revenues exceeded budget by .7%.

Operating Expenses

DESCRIPTION	April 2016 Actual	April 2016 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,952,531	3,490,751	(461,779)	
Employee Benefits	1,028,544	1,142,741	114,196	
Benefits – Workers Compensation	53,972	60,541	6,568	
Benefits – Medical Insurance	1,007,638	750,099	(257,540)	
Professional Fees	1,485,907	1,336,528	(149,379)	Legal services, Physician Alignment services, contract oversight, FMV/Commercial Reasonableness analyses provided to Administration, accrual of physician RVU bonuses, an increase in OP and IP Therapy Services volumes, physician recruitment services, Financial and Strategic Planning services provided to Financial Administration, managed care contract consulting, and Locums coverage in the Emergency department created a negative variance in Professional Fees.
Supplies	1,429,352	1,203,861	(225,491)	Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues exceeded budget by 14.6% and small equipment needs to relocate the MSC Surgery and MSC Gastroenterology physicians created a negative variance in Supplies.
Purchased Services	797,507	829,968	32,461	Reduction in The Center management oversight, contracted services for personal training and fitness classes, and collection agency fees in Patient Financial Services came in below budget, creating a positive variance in Purchased Services.
Other Expenses	458,020	579,054	121,034	Positive variance in Other Expenses related to Board education and travel that did not transpire and expenses related to MSC Administration, Wellness Neighborhood, community Health, the GUGC event, and Quality fell short of budget estimations.
Total Expenses	10,213,471	9,393,543	(819,929)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
APRIL 2016

	Apr-16	Mar-16	Apr-15	
ASSETS				
CURRENT ASSETS				
* CASH	$ 12,562,588	$ 12,203,372	$ 10,064,155	1
PATIENT ACCOUNTS RECEIVABLE - NET	14,157,958	17,471,594	12,895,007	2
OTHER RECEIVABLES	5,250,138	4,811,471	4,581,942	
GO BOND RECEIVABLES	660,017	269,244	1,042,952	
ASSETS LIMITED OR RESTRICTED	4,993,755	4,984,503	5,725,402	
INVENTORIES	2,352,542	2,317,862	2,511,235	
PREPAID EXPENSES & DEPOSITS	1,436,949	1,325,918	1,504,357	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,475,167	3,398,822	4,257,788	
TOTAL CURRENT ASSETS	44,889,114	46,782,786	42,582,837	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	50,888,997	50,834,718	40,730,601	1
BANC OF AMERICA MUNICIPAL LEASE	979,155	979,155	2,295,723	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	970,790	893,144	3,186,866	
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	3,259,656	3,899,862	13,612,840	3
GO BOND TAX REVENUE FUND	1,361,348	1,361,348	549,282	
BOARD DESIGNATED FUND	-	-	2,297	
DIAGNOSTIC IMAGING FUND	2,979	2,976	2,969	
DONOR RESTRICTED FUND	1,139,848	1,271,595	1,093,240	
WORKERS COMPENSATION FUND	10,713	2,690	20,529	
TOTAL	58,613,488	59,245,489	61,494,349	
LESS CURRENT PORTION	(4,993,755)	(4,984,503)	(5,725,402)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	53,619,733	54,260,986	55,768,947	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	202,785	202,785	393,277	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	126,615,576	126,974,128	128,929,380	
GO BOND CIP, PROPERTY & EQUIPMENT NET	30,196,028	29,223,350	19,540,737	
TOTAL ASSETS	256,359,589	258,280,390	248,051,531	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	549,504	552,736	588,292	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	2,071,949	2,071,949	2,013,085	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	1,939,944	1,947,582	-	
GO BOND DEFERRED FINANCING COSTS	300,807	301,991	-	
DEFERRED FINANCING COSTS	214,297	215,337	-	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 5,076,502	$ 5,089,596	$ 2,601,377	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 5,271,995	$ 5,593,616	$ 5,458,608	4
ACCRUED PAYROLL & RELATED COSTS	7,288,468	7,725,702	7,286,135	5
INTEREST PAYABLE	391,158	290,600	516,530	
INTEREST PAYABLE GO BOND	1,070,911	709,886	1,169,293	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	300,682	300,682	512,695	
HEALTH INSURANCE PLAN	1,307,731	1,307,731	997,635	
WORKERS COMPENSATION PLAN	404,807	404,807	1,006,475	
COMPREHENSIVE LIABILITY INSURANCE PLAN	824,203	824,203	890,902	
CURRENT MATURITIES OF GO BOND DEBT	530,000	530,000	315,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,323,994	2,323,994	2,300,830	
TOTAL CURRENT LIABILITIES	19,713,947	20,011,221	20,454,103	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	29,804,919	29,908,944	33,282,248	
GO BOND DEBT NET OF CURRENT MATURITIES	100,001,378	100,005,320	98,130,000	
DERIVATIVE INSTRUMENT LIABILITY	2,071,949	2,071,949	2,013,085	
TOTAL LIABILITIES	151,592,193	151,997,434	153,879,436	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	108,704,050	110,100,956	95,680,232	
RESTRICTED	1,139,848	1,271,595	1,093,240	
TOTAL NET POSITION	$ 109,843,898	$ 111,372,552	$ 96,773,472	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
APRIL 2016

1. Working Capital is at 38.1 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 192.2 days. Working Capital cash increased $359,000. Cash collections fell short of target by 19%, the District received reimbursement of $640,206 for funds advanced on March Measure C projects (See Note 3), Accounts Payable decreased $322,000 (See Note 4), and Accrued Payroll & Related Costs decreased $437,000 (See Note 5).

2. Net Patient Accounts Receivable decreased approximately $3,314,000. Cash collections were 81% of target. Days in Accounts Receivable are at 55.0 days compared to prior months 54.7 days, a .30 days increase. Cash collections on hospital accounts were higher in April over March and revenues were substantially lower in April over the previous month which aided in the decrease of the District's net Patient Accounts Receivable.

3. GO Bond Project Fund decreased $640,206 after reimbursing the District for funds advanced on the March Measure C projects.

4. Accounts Payable decreased $322,000 due to the timing of the final check run in April.

5. Accrued Payroll & Related Costs decreased $437,000 as a result of fewer days being accrued at the close of April.

Tahoe Forest Hospital District
Cash Investment
April 2016

WORKING CAPITAL				
US Bank	$ 12,350,741			
US Bank/Kings Beach Thrift Store	59,088			
US Bank/Truckee Thrift Store	152,759			
Wells Fargo Bank				
Local Agency Investment Fund	-	0.53%		
Total			$	12,562,588
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	50,888,997	0.53%		
Local Agency Investment Fund			$	50,888,997
Banc of America Muni Lease			$	979,155
Bonds Cash 2002			$	2
Bonds Cash 2006			$	970,790
Bonds Cash 2008			$	4,621,003
DX Imaging Education	$ 2,979	0.53%		
Workers Comp Fund - B of A	10,713			
Insurance				
Health Insurance LAIF	-	0.53%		
Comprehensive Liability Insurance LAIF	-	0.53%		
Total			$	13,692
TOTAL FUNDS			$	70,036,228
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,368	0.03%		
Foundation Restricted Donations	$ 98,331			
Local Agency Investment Fund	1,033,149	0.53%		
TOTAL RESTRICTED FUNDS			$	1,139,848
TOTAL ALL FUNDS			$	71,176,076

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
APRIL 2016

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD APR 2015
					OPERATING REVENUE						
$ 15,979,513	$ 15,870,524	$ 108,989	0.7%		Total Gross Revenue	$ 183,630,994	$ 174,899,917	$ 8,731,077	5.0%	1	$ 171,023,849
					Gross Revenues - Inpatient						
$ 1,502,883	$ 1,776,776	$ (273,893)	-15.4%		Daily Hospital Service	$ 17,068,321	$ 18,076,360	$ (1,008,039)	-5.6%		$ 16,969,649
3,143,917	3,707,267	(563,350)	-15.2%		Ancillary Service - Inpatient	36,664,140	39,597,930	(2,933,790)	-7.4%		39,358,433
4,646,800	5,484,044	(837,244)	-15.3%		Total Gross Revenue - Inpatient	53,732,461	57,674,290	(3,941,829)	-6.8%	1	56,328,082
11,332,713	10,386,480	946,233	9.1%		Gross Revenue - Outpatient	129,898,533	117,225,627	12,672,906	10.8%		114,695,767
11,332,713	10,386,480	946,233	9.1%		Total Gross Revenue - Outpatient	129,898,533	117,225,627	12,672,906	10.8%	1	114,695,767
					Deductions from Revenue:						
6,386,539	6,527,514	140,976	2.2%		Contractual Allowances	72,992,470	71,767,508	(1,224,962)	-1.7%	2	67,070,048
496,358	518,187	21,829	4.2%		Charity Care	5,540,587	5,713,145	172,558	3.0%	2	5,243,315
20,299	-	(20,299)	0.0%		Charity Care - Catastrophic Events	580,655	-	(580,655)	0.0%	2	-
487,337	378,002	(109,335)	-28.9%		Bad Debt	(486,435)	4,202,699	4,689,135	111.6%	2	3,037,814
-	-	-	0.0%		Prior Period Settlements	(1,295,903)	-	1,295,903	0.0%	2	318,373
7,390,533	7,423,703	33,170	0.4%		Total Deductions from Revenue	77,331,373	81,683,352	4,351,979	5.3%		75,669,550
69,888	59,098	10,791	18.3%		Property Tax Revenue- Wellness Neighborhood	618,148	603,281	14,866	2.5%		660,773
530,196	543,393	(13,197)	-2.4%		Other Operating Revenue	6,911,366	5,544,019	1,367,347	24.7%	3	6,338,407
9,189,065	9,049,312	139,753	1.5%		TOTAL OPERATING REVENUE	113,829,135	99,363,865	14,465,269	14.6%		102,353,479
					OPERATING EXPENSES						
3,952,531	3,490,751	(461,779)	-13.2%		Salaries and Wages	36,063,632	36,268,838	205,207	0.6%	4	34,057,514
1,028,544	1,142,741	114,196	10.0%		Benefits	12,098,891	11,669,349	(429,542)	-3.7%	4	11,415,021
53,972	60,541	6,568	10.8%		Benefits Workers Compensation	523,931	605,409	81,478	13.5%	4	513,144
1,007,638	750,099	(257,540)	-34.3%		Benefits Medical Insurance	6,659,873	7,500,987	841,114	11.2%	4	7,146,586
1,485,907	1,336,528	(149,379)	-11.2%		Professional Fees	15,328,858	13,961,798	(1,367,060)	-9.8%	5	17,351,081
1,429,352	1,203,861	(225,491)	-18.7%		Supplies	15,031,235	12,846,376	(2,184,859)	-17.0%	6	13,779,380
797,507	829,968	32,461	3.9%		Purchased Services	8,850,544	8,727,191	(123,353)	-1.4%	7	8,967,354
458,020	579,054	121,034	20.9%		Other	4,964,296	5,116,323	152,027	3.0%	8	5,569,664
10,213,471	9,393,543	(819,929)	-8.7%		TOTAL OPERATING EXPENSE	99,521,260	96,696,271	(2,824,988)	-2.9%		98,799,744
(1,024,407)	**(344,231)**	**(680,176)**	**197.6%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**14,307,875**	**2,667,594**	**11,640,281**	**436.4%**		**3,553,735**
					NON-OPERATING REVENUE/(EXPENSE)						
382,319	393,109	(10,790)	-2.7%		District and County Taxes	3,931,272	3,918,785	12,487	0.3%	9	3,827,951
392,691	392,691	-	0.0%		District and County Taxes - GO Bond	3,929,305	3,926,913	2,392	0.1%		3,939,033
37,709	13,586	24,123	177.6%		Interest Income	298,251	185,980	112,271	60.4%	10	235,082
528	225	302	134.1%		Interest Income-GO Bond	17,127	12,091	5,036	41.6%		30,622
19,473	34,671	(15,198)	-43.8%		Donations	374,364	346,711	27,653	8.0%	11	408,097
-	-	-	0.0%		Gain/ (Loss) on Joint Investment	(121,610)	(112,500)	(9,110)	0.0%	12	(67,418)
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	7,500	-	7,500	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(856,217)	(855,178)	(1,039)	-0.1%		Depreciation	(8,530,778)	(8,551,781)	21,004	0.2%	15	(7,993,482)
(114,846)	(114,168)	(678)	-0.6%		Interest Expense	(1,187,742)	(1,152,692)	(35,050)	-3.0%	16	(1,399,686)
(365,904)	(362,660)	(3,244)	-0.9%		Interest Expense-GO Bond	(2,577,931)	(2,490,554)	(87,378)	-3.5%		(3,023,930)
(504,247)	(497,723)	(6,524)	-1.3%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,860,243)	(3,917,047)	56,804	1.5%		(4,043,731)
$ (1,528,654)	**$ (841,954)**	**$ (686,700)**	**-81.6%**		**INCREASE (DECREASE) IN NET POSITION**	**$ 10,447,633**	**$ (1,249,453)**	**$ 11,697,085**	**936.2%**		**$ (489,996)**
					NET POSITION - BEGINNING OF YEAR	**99,396,265**					
					NET POSITION - AS OF APRIL 30, 2016	**$ 109,843,898**					
-6.4%	**-2.2%**	**-4.2%**			**RETURN ON GROSS REVENUE EBIDA**	**7.8%**	**1.5%**	**6.3%**			**2.1%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
APRIL 2016

		Variance from Budget Fav / <Unfav>	
		APR 2016	YTD 2016
1) Gross Revenues			
Acute Patient Days were under budget 21.8% or 81 days. Swing Bed days were above budget 55.0% or 11 days. Ancillary revenues fell short of budget by 15.2% due to the decrease in patient days.	Gross Revenue -- Inpatient	$ (837,244)	$ (3,938,937)
	Gross Revenue -- Outpatient	946,233	12,670,014
	Gross Revenue -- Total	$ 108,989	$ 8,731,077
Outpatient volumes were above budget in the following departments: Emergency Department visits, Endoscopy procedures, Diagnostic Imaging, Oncology procedures, Nuclear Medicine, MRI exams, Ultrasound, Cat Scans, PET CT, Oncology Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for April shows a 5.25% decrease to Medicare, a 1.95% increase to Medi-Cal, 1.45% decrease to Other, a .02% decrease to County, and an 4.77% increase to Commercial when compared to budget. Contractual Allowances were under budget as a result of the payor mix shifting from Medicare to Commercial.	Contractual Allowances	$ 140,976	$ (1,224,962)
	Charity Care	21,829	172,558
	Charity Care - Catastrophic	(20,299)	(580,655)
	Bad Debt	(109,335)	4,689,135
	Prior Period Settlements	-	1,295,903
	Total	$ 33,170	$ 4,351,979
3) Other Operating Revenue	Retail Pharmacy	$ (15,406)	$ 112,037
IVCH ER Physician Guarantee is tied to collections which exceeded budget in April.	Hospice Thrift Stores	(13,442)	5,855
	The Center (non-therapy)	(3,488)	1,000
	IVCH ER Physician Guarantee	12,147	183,575
Children's Center revenue exceeded budget by 10.8%.	Children's Center	7,209	116,649
	Miscellaneous	1,034	913,180
	Oncology Drug Replacement	-	-
	Grants	(1,250)	35,050
	Total	$ (13,197)	$ 1,367,347
4) Salaries and Wages	Total	$ (461,779)	$ 205,207
Negative variance in Salaries and Wages related to Registry services provided to the Multi-Specialty Clinics and Radiation Oncology, leasing of North Tahoe Orthopedics employees, conversion of independent contractors to employees, and labor associated with the Laboratory software system conversion. This was offset, in part, by a positive pick up in PL/SL.			
Employee Benefits	PL/SL	$ 116,973	$ (26,627)
Positive variance in PL/SL was offset, in part, by negative variances in the Salaries and Wages category.	Nonproductive	(19,052)	(193,124)
	Pension/Deferred Comp	-	(7,114)
	Standby	(7,228)	(78,115)
	Other	23,504	(124,563)
	Total	$ 114,196	$ (429,542)
Employee Benefits - Workers Compensation	Total	$ 6,568	$ 81,478
Employee Benefits - Medical Insurance	Total	$ (257,540)	$ 841,114
5) Professional Fees	Administration	$ (167,264)	$ (506,312)
Legal services, Physician Alignment services, contract oversight, and FMV/Commercial Reasonableness analyses created a negative variance in Administration.	Multi-Specialty Clinics	(41,973)	(434,539)
	The Center (includes OP Therapy)	(27,704)	(314,239)
	TFH/IVCH Therapy Services	(23,875)	(278,041)
Negative variance in Multi-Specialty Clinics related to the booking of accrued physician RVU bonuses.	Miscellaneous	51,024	(219,843)
	Multi-Specialty Clinics Admin	(15,435)	(62,618)
	Financial Administration	(24,813)	(53,612)
Outpatient Therapy Services revenues exceeded budget by 26.0%, creating a negative variance in The Center (includes OP Therapy).	Managed Care	(7,105)	(36,244)
	Home Health/Hospice	(1,000)	(8,108)
	IVCH ER Physicians	(1,315)	(3,019)
TFH/IVCH Therapy Services revenues exceeded budget by 16.4%, creating a negative variance in this category.	Patient Accounting/Admitting	-	-
	Business Performance	-	-
	Respiratory Therapy	(25)	1,075
Physician recruitment services created a negative variance in Multi-Specialty Clinics Administration.	TFH Locums	(9,580)	5,229
	Sleep Clinic	1,284	19,034
	Marketing	2,375	23,750
Financial and Strategic Planning services provided to Financial Administration created a negative variance in this category.	Oncology	9,447	49,306
	Information Technology	39,343	50,653
	Medical Staff Services	21,533	78,816
Consulting services provided for our managed care contract negotiations created a negative variance in Managed Care.	Corporate Compliance	19,508	145,675
	Human Resources	26,196	175,977
	Total	$ (149,379)	$ (1,367,060)
Locum services provided to the Emergency Department created a negative variance in TFH Locums.			

6) Supplies Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues exceeded budget by 14.6%, creating a negative variance in Pharmacy Supplies. Purchases of copy paper, Patient Registration supplies, Town Hall supplies, and Wellness Neighborhood supplies created a negative variance in Office Supplies. Small equipment purchases needed to relocate MSC Surgery and MSC Gastroenterology to the Medical Office Building created a negative variance in Minor Equipment.	Pharmacy Supplies	$ (230,650)	$ (1,941,191)
	Food	(7,123)	(76,036)
	Office Supplies	(12,484)	(70,834)
	Patient & Other Medical Supplies	41,740	(70,607)
	Minor Equipment	(19,084)	(62,458)
	Imaging Film	66	(1,940)
	Other Non-Medical Supplies	2,044	38,207
	Total	$ (225,491)	$ (2,184,859)
7) Purchased Services Negative variance in Laboratory related to maintenance agreements on Lab equipment located at TFH. Positive variance in The Center related to a reduction in management oversight and contracted services for personal training and fitness classes. Pre-employment screenings, Employee Health, and pre-employment health screenings created a negative variance in Human Resources. Positive variance in Patient Accounting related to collection agency fees falling short of budget.	Miscellaneous	$ (1,734)	$ (297,944)
	Department Repairs	157	(65,922)
	Laboratory	(5,117)	(49,236)
	The Center	14,821	(43,654)
	Diagnostic Imaging Services - All	8,651	(33,956)
	Medical Records	(2,717)	(17,816)
	Pharmacy IP	(1,200)	(8,867)
	Human Resources	(6,441)	3,754
	Community Development	392	3,893
	Hospice	2,654	17,850
	Multi-Specialty Clinics	(979)	31,048
	Patient Accounting	13,134	134,572
	Information Technology	10,839	202,923
	Total	$ 32,461	$ (123,353)
8) Other Expenses Positive variance in Outside Training & Travel related to Board training that was set in the budget and did not take place this fiscal year. Recruitment agency fees for an Executive Director for Physician Services created a negative variance in Human Resources Recruitment. Purchased Services budgeted for MSC Administration, Wellness Neighborhood, Community Health, the GUGC event, and Quality fell short of budget, creating a positive variance in Miscellaneous. Negative variance in Marketing related to media branding, billboard snipes, and community sponsorships.	Equipment Rent	$ (1,158)	$ (58,355)
	Outside Training & Travel	32,654	(24,172)
	Dues and Subscriptions	(2,010)	(45,651)
	Human Resources Recruitment	(5,650)	(29,165)
	Multi-Specialty Clinics Bldg Rent	(332)	(13,888)
	Other Building Rent	(2,066)	(15,023)
	Multi-Specialty Clinics Equip Rent	(18)	(892)
	Innovation Fund	-	-
	Physician Services	189	1,350
	Miscellaneous	102,605	133,254
	Insurance	3,744	43,355
	Utilities	1,159	66,303
	Marketing	(8,083)	94,912
	Total	$ 121,034	$ 152,027
9) District and County Taxes	Total	$ (10,790)	$ 12,487
10) Interest Income	Total	$ 24,123	$ 112,271
11) Donations	IVCH	$ (4,333)	$ (7,677)
	Operational	(10,865)	35,330
	Capital Campaign	-	-
	Total	(15,198)	27,653
12) Gain/(Loss) on Joint Investment	Total	$ -	$ (9,110)
13) Gain/(Loss) on Sale	Total	$ -	$ 7,500
15) Depreciation Expense	Total	$ (1,039)	$ 21,004
16) Interest Expense	Total	$ (678)	$ (35,050)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
APRIL 2016

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD APR 2015
					OPERATING REVENUE						
$ 1,296,298	$ 1,073,398	$ 222,901	20.8%		Total Gross Revenue	$ 14,565,964	$ 12,674,720	$ 1,891,245	14.9%	1	$ 12,420,317
					Gross Revenues - Inpatient						
$ 11,649	$ 3,513	$ 8,136	231.6%		Daily Hospital Service	$ 34,247	$ 31,620	$ 2,627	8.3%		$ 33,538
10,493	4,743	5,750	121.2%		Ancillary Service - Inpatient	35,542	48,078	(12,536)	-26.1%		55,135
22,142	8,256	13,886	168.2%		Total Gross Revenue - Inpatient	69,789	79,698	(9,908)	-12.4%	1	88,673
1,274,156	1,065,142	209,015	19.6%		Gross Revenue - Outpatient	14,496,175	12,595,022	1,901,153	15.1%		12,331,644
1,274,156	1,065,142	209,015	19.6%		Total Gross Revenue - Outpatient	14,496,175	12,595,022	1,901,153	15.1%	1	12,331,644
					Deductions from Revenue:						
478,219	293,920	(184,299)	-62.7%		Contractual Allowances	4,692,536	3,475,275	(1,217,260)	-35.0%	2	3,526,270
42,819	37,280	(5,539)	-14.9%		Charity Care	485,476	440,826	(44,650)	-10.1%	2	402,565
20,299	-	(20,299)	0.0%		Charity Care - Catastrophic Events	62,781	-	(62,781)	0.0%	2	-
38,845	74,560	35,714	47.9%		Bad Debt	526,216	881,652	355,435	40.3%	2	995,908
-	-	-	0.0%		Prior Period Settlements	(150,715)	-	150,715	0.0%	2	5,409
580,183	405,760	(174,422)	-43.0%		Total Deductions from Revenue	5,616,293	4,797,753	(818,541)	-17.1%	2	4,930,152
75,406	62,985	12,421	19.7%		Other Operating Revenue	841,004	636,300	204,704	32.2%	3	735,040
791,522	730,622	60,900	8.3%		TOTAL OPERATING REVENUE	9,790,674	8,513,266	1,277,408	15.0%		8,225,205
					OPERATING EXPENSES						
256,618	231,890	(24,729)	-10.7%		Salaries and Wages	2,523,308	2,598,854	75,546	2.9%	4	2,434,831
75,713	80,383	4,670	5.8%		Benefits	762,472	813,011	50,539	6.2%	4	883,669
2,496	2,490	(6)	-0.2%		Benefits Workers Compensation	23,680	24,903	1,223	4.9%	4	30,946
64,383	47,919	(16,464)	-34.4%		Benefits Medical Insurance	427,795	479,189	51,394	10.7%	4	481,802
228,829	229,801	972	0.4%		Professional Fees	2,320,347	2,315,869	(4,478)	-0.2%	5	2,096,900
59,304	46,928	(12,375)	-26.4%		Supplies	743,140	521,701	(221,438)	-42.4%	6	516,501
45,531	42,495	(3,037)	-7.1%		Purchased Services	413,171	417,224	4,053	1.0%	7	399,166
47,446	52,940	5,494	10.4%		Other	579,948	520,256	(59,691)	-11.5%	8	497,742
780,320	734,846	(45,475)	-6.2%		TOTAL OPERATING EXPENSE	7,793,859	7,691,007	(102,852)	-1.3%		7,341,557
11,202	**(4,223)**	**15,425**	**-365.2%**		**NET OPERATING REV(EXP) EBIDA**	**1,996,815**	**822,259**	**1,174,556**	**142.8%**		**883,648**
					NON-OPERATING REVENUE/(EXPENSE)						
-	4,333	(4,333)	-100.0%		Donations-IVCH	35,656	43,333	(7,677)	-17.7%	9	22,091
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(58,359)	(58,359)	0	0.0%		Depreciation	(557,662)	(583,594)	25,932	-4.4%	11	(534,668)
(58,359)	(54,026)	(4,333)	-8.0%		TOTAL NON-OPERATING REVENUE/(EXP)	(522,006)	(540,261)	18,255	3.4%		(512,577)
$ (47,157)	**$ (58,249)**	**$ 11,092**	**-19.0%**		**EXCESS REVENUE(EXPENSE)**	**$ 1,474,809**	**$ 281,999**	**$ 1,192,810**	**423.0%**		**$ 371,071**
0.9%	**-0.4%**	**1.3%**			**RETURN ON GROSS REVENUE EBIDA**	**13.7%**	**6.5%**	**7.2%**			**7.1%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
APRIL 2016

		Variance from Budget Fav<Unfav> APR 2016	YTD 2016
1) Gross Revenues			
Acute Patient Days were above budget by 2 at 3 and Observation Days were at budget at 1.	Gross Revenue -- Inpatient	$ 13,886	$ (9,908)
	Gross Revenue -- Outpatient	209,015	1,901,153
		$ 222,901	$ 1,891,245
Outpatient volumes were above budget in Emergency Department visits, Surgical cases, Laboratory tests, Radiology exams, Cat Scans, and Pharmacy units.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with an .19% increase in Commercial Insurance, a 2.66% decrease in Medicare, a 6.08% increase in Medicaid, a 3.60% decrease in Other, and a .01% decrease in County. Negative variance in Contractual Allowances is a result of revenues exceeding budget by 20.8% and the shift in payor mix to Medicaid from Medicare and Commercial.	Contractual Allowances	$ (184,299)	$ (1,217,260)
	Charity Care	(5,539)	(44,650)
	Charity Care-Catastrophic Event	(20,299)	(62,781)
	Bad Debt	35,714	355,435
	Prior Period Settlement	-	150,715
	Total	$ (174,422)	$ (818,541)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which exceeded budget in April.	IVCH ER Physician Guarantee	$ 12,147	$ 183,575
	Miscellaneous	275	21,129
	Total	$ 12,421	$ 204,704
4) Salaries and Wages	Total	$ (24,729)	$ 75,546
Employee Benefits	PL/SL	$ 870	$ 55,578
	Standby	2,643	17,757
	Other	1,258	(15,490)
	Nonproductive	(100)	(9,711)
	Pension/Deferred Comp	(1)	2,405
	Total	$ 4,670	$ 50,539
Employee Benefits - Workers Compensation	Total	$ (6)	$ 1,223
Employee Benefits - Medical Insurance	Total	$ (16,464)	$ 51,394
5) Professional Fees	Therapy Services	$ 969	$ (18,620)
Services provided for project management oversight created a negative variance in Administration.	Administration	(2,809)	(13,324)
	Multi-Specialty Clinics	654	(10,417)
	IVCH ER Physicians	(1,315)	(3,019)
Foundation oversight was converted to an FTE, creating a positive variance in Foundation.	Miscellaneous	(1,110)	1,125
	Sleep Clinic	1,284	19,034
	Foundation	3,300	20,742
	Total	$ 972	$ (4,478)
6) Supplies	Patient & Other Medical Supplies	$ (7,458)	$ (99,424)
Surgery and Medical Supplies Sold to Patients revenues exceeded budget by 44.31%, creating a negative variance in Patient & Other Medical Supplies.	Pharmacy Supplies	(3,878)	(90,622)
	Minor Equipment	(155)	(17,379)
	Food	(1,292)	(11,036)
	Office Supplies	(156)	(2,082)
Drugs Sold to Patients revenue exceeded budget by 96.61%, creating a negative variance in Pharmacy Supplies.	Non-Medical Supplies	439	(858)
	Imaging Film	125	(37)
	Total	$ (12,375)	$ (221,438)

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
APRIL 2016

		Variance from Budget Fav<Unfav>	
		APR 2016	YTD 2016
7) Purchased Services	Laboratory	$ 268	$ (17,977)
Negative variance in Miscellaneous related to the management oversight of the Medically Managed Fitness program.	EVS/Laundry	(418)	(4,427)
	Department Repairs	(88)	(1,948)
	Pharmacy	(99)	(99)
Replacement of air filters throughout the hospital created a negative variance in Engineering/Plant/Communications.	Surgical Services	-	-
	Foundation	534	283
	Miscellaneous	(1,635)	2,522
	Multi-Specialty Clinics	204	4,402
	Diagnostic Imaging Services - All	313	7,153
	Engineering/Plant/Communications	(2,116)	14,143
	Total	$ (3,037)	$ 4,053
8) Other Expenses	Equipment Rent	$ 554	$ (78,163)
Electricity, Water, Sewer, and Natural Gas costs fell below budget, creating a positive variance in Utilities.	Dues and Subscriptions	(771)	(3,345)
	Outside Training & Travel	(16)	(107)
	Physician Services	-	-
Advertising for the Emergency Department and Sleep Center along with re-printing of the IVCH tri-fold brochures created a negative variance in Marketing.	Multi-Specialty Clinics Equip Rent	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Utilities	3,572	309
	Insurance	223	2,228
	Other Building Rent	871	2,612
	Marketing	(1,973)	8,234
	Miscellaneous	3,034	8,541
	Total	$ 5,494	$ (59,691)
9) Donations	Total	$ (4,333)	$ (7,677)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 25,932

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2015		BUDGET FYE 2016		PROJECTED FYE 2016		**ACTUAL APR 2016**	**PROJECTED APR 2016**	**DIFFERENCE**		ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 7,190,440		$ 2,054,135		$ 13,613,152		**$ (1,024,407)**	**$ (344,231)**	**$ (680,176)**		$ 4,890,732	$ 2,113,378	$ 8,328,650	$ (1,719,608)
Interest Income	97,528		107,488		129,230		**22,208**	**26,827**	**(4,619)**		29,198	33,631	44,193	22,208
Property Tax Revenue	5,352,075		5,420,000		5,420,119		**-**	**-**	**-**		309,907	78,742	3,316,470	1,715,000
Donations	757,929		923,000		541,427		**42,119**	**35,000**	**7,119**		76,191	164,788	188,329	112,119
Debt Service Payments	(3,505,561)		(3,565,581)		(3,441,270)		**(247,479)**	**(247,478)**	**(1)**		(1,069,568)	(742,436)	(886,831)	(742,435)
Bank of America - 2012 Muni Lease	(1,243,531)		(1,243,644)		(1,243,649)		**(103,637)**	**(103,637)**	**(0)**		(310,912)	(310,912)	(310,912)	(310,911)
Copier	(8,962)		(8,760)		(8,759)		**(730)**	**(730)**	**0**		(2,190)	(2,190)	(2,190)	(2,190)
2002 Revenue Bond	(660,296)		(668,008)		(483,555)		**-**	**-**	**-**		(327,132)	-	(156,423)	-
2006 Revenue Bond	(1,592,771)		-		-		**-**	**-**	**-**		-	-	-	-
2015 Revenue Bond	-		(1,645,169)		(1,705,308)		**(143,111)**	**(143,111)**	**(0)**		(429,334)	(429,334)	(417,306)	(429,333)
Physician Recruitment	(155,902)		(311,000)		(263,769)		**(41,100)**	**(42,000)**	**900**		(216,785)	(5,884)	-	(41,100)
Investment in Capital														
Equipment	(2,491,260)		(1,418,900)		(1,472,932)		**(261,869)**	**(140,655)**	**(121,214)**		(302,633)	(286,725)	(221,705)	(661,869)
Municipal Lease Reimbursement	-		2,295,723		1,319,139		**-**	**-**	**-**		1,319,139	-	-	-
GO Bond Project Personal Property	(186,062)		(500,180)		(500,180)		**(20,416)**	**-**	**(20,416)**		(8,587)	(8,029)	(14,334)	(469,230)
IT	(1,394,200)		(559,300)		(1,004,347)		**(58,155)**	**-**	**(58,155)**		(318,453)	(193,238)	(79,501)	(413,155)
Building Projects	(2,218,063)		(4,487,480)		(2,005,129)		**(86,117)**	**(300,000)**	**213,883**		(337,663)	(674,563)	(506,786)	(486,117)
Health Information/Business System	(230,852)		(500,000)		(341,014)		**(33,912)**	**-**	**(33,912)**		(1,623)	(18,375)	(37,104)	(283,912)
Capital Investments														
Properties	(600,000)		-		(150,000)		**-**	**-**	**-**		-	-	-	(150,000)
Measure C Scope Modifications	-		(749,287)		(749,287)		**(95,970)**	**(95,970)**	**(0)**		-	(232,174)	(229,205)	(287,908)
Change in Accounts Receivable	2,648,682		282,832	N1	687,316		**3,313,636**	**594,661**	**2,718,975**		522,392	(891,685)	(2,247,607)	3,304,216
Change in Settlement Accounts	(2,438,657)		500,000	N2	331,939		**-**	**-**	**-**		623,667	(1,173,529)	1,631,801	(750,000)
Change in Other Assets	(1,717,188)		(768,000)	N3	(2,504,059)		**(436,744)**	**(115,000)**	**(321,744)**		(1,531,558)	(1,330,040)	664,283	(306,744)
Change in Other Liabilities	(30,538)		(71,000)	N4	(582,895)		**(658,299)**	**(215,000)**	**(443,299)**		247,630	(648,182)	425,956	(608,299)
									-					
Change in Cash Balance	1,078,371		(1,347,550)		9,043,359		**413,495**	**(843,846)**	**1,257,340**		4,247,906	(3,814,322)	10,376,609	(1,766,834)
Beginning Unrestricted Cash	50,951,760		52,227,897		52,227,897		**63,038,090**	**63,038,090**	**-**		52,227,897	56,475,803	52,661,481	63,038,090
Ending Unrestricted Cash	52,227,897		50,880,347		61,271,256		**63,451,585**	**62,194,244**	**1,257,340**		56,475,803	52,661,481	63,038,090	61,271,256
Expense Per Day	333,932		321,141		330,856		**330,193**	**328,397**	**1,796**		317,753	322,438	328,657	330,856
Days Cash On Hand	156		158		185		**192**	**189**	**3**		178	163	192	185

Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections. For example, in July 2015 we are collecting June 2015.
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.

15.3. Contracts

Contracts redacted.

Available for public viewing via a Public Records request.

	TahoeForest Health System				
	Title: Physician and Professional Service Agreements			**Policy/Procedure #:** ABD-21	
	Responsible Department: Board of Directors				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Board	1/90	5/00; 01/12; 1/14	02/14; 07/15; 5/16	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒System ☐TahoeForestHospital ☐InclineVillageCommunityHospital					

PURPOSE:

This policy is intended to provide the District's Chief Executive Officer a general framework for professional services contracting and recognizes that flexibility may be required due to the broad scope of professional services that may be covered. Further, to insure that the professional service provider is meeting the needs of Tahoe Forest Hospital District and the community that it serves, as well as allowing the provider to update the actual services performed, a formal service review process will be utilized.

POLICY:

Written professional service agreements will be prepared for all physicians and health professionals who qualify as independent contractors and who provide diagnostic or therapeutic services to Tahoe Forest Hospital District's patients, or who provide certain medico-administrative duties within a hospital department or service.

The following list exemplifies physicians and health professionals who will be covered by this policy including but not limited to:

- Anesthesiologists
- Medical Directors of specific departments/services, and Medical Staff Officers
- Physicians providing services in the District's Medical Services Clinics and Cancer Center
- Physicians serving in medical-administrative roles or on hospital committees
- Nuclear Medicine Specialists
- Emergency Services physicians
- Occupational therapists
- Pathologists
- Physical therapists
- Radiologists
- Speech pathologists
- Emergency and urgent care providers
- Mid-level practitioners not employed by the District
- Hospitalists
- Other contracted physicians

Procedures

1.0 All professional service agreements will be developed between the District's Chief Executive Officer, or designee, and health professionals.

1.1 Health professionals are not permitted to provide professional services under any professional services agreement until the agreement has been fully signed and executed prior to the effective date by the parties. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amemded agreement.

1.2 New agreements shall utilize the model agreement for the type of service required from the contracting professional (See Exhibit A, attached, for a list of available model agreements); and

1.2.1 All new agreements shall be reviewed by the Compliance Department. New agreements not utilizing the model agreement for the type of service required shall be reviewed by ~~the Compliance Department and~~ legal counsel prior to submission to the District's Board of Directors.

1.2.2 Agreements committing $25,000.00 or more in any given twelve-month period:

1.2.2.1 Once agreement is reached between the District's Chief Executive Officer and health professional, CEO will present the Contract Routing Form (or equivalent data summary report) with the principal terms and conditions listed, to the Board of Directors for their consideration. Principal terms and conditions include, but are not limited to, purpose/need for the ~~of~~ agreement, agreement term, compensation, scope of duties, other similar agreements and differences with this agreement, total cost of contract, and other pertinent information, as applicable, in 6.2-6.4 below.

1.2.2.2 Upon their review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions, and revised terms and conditions be submitted to the Board at its next scheduled or special meeting.

1.2.2.3 After approval by the Board of Directors, the CEO will present the agreement to the health professional for review and signature, indicating his or her acceptance of the included terms

1.2.2.4 In the event the health professional requests changes in the principal terms and conditions of the agreement, the CEO will present a modified Contract Routing Form (or equivalent) to the Board of Directors

1.2.2.5 The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.

1.2.2.6 The professional service agreement will become effective following the Board of Directors' approval~~ratification~~, subject to the contract term identified in the agreement.

~~1.2.2.6~~1.2.2.7 The CEO will execute the agreement after approval by the Board of Directors.

1.2.3 New agreements committing less than $25,000 per twelve-month period can be authorized by the District's Chief Executive Officer without Board approval so long as funds have been authorized in the District's operating budget for that fiscal year.

1.3 Renewal agreements:

1.3.1 All renewing agreements shall utilize the model agreement for the type of service required from the contracting professional.

1.3.1.1 Agreements committing $25,000.00 or more in any given twelve-month period:

1.3.1.1.1 Once agreement is reached between the District's Chief Executive Officer and health professional, CEO will present the Contract Routing Form (or equivalent) with the principal terms and conditions listed, to the Board of Directors for their consideration. Principal terms and conditions include, but are not limited to, purpose/need for the ~~of~~ agreement, agreement term, compensation, scope of duties, other similar agreements and differences with this agreement, total cost of contract, and other pertinent information.

1.3.1.1.2 Upon their review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions, and revised terms and conditions be submitted to the Board at its next scheduled or special meeting.

1.3.1.1.3 After approval by the Board of Directors, the CEO will present the agreement to the contracting~~health~~ professional for review and signature, indicating his or her acceptance of the included terms

1.3.1.1.4 In the event the contracting~~health~~ professional requests changes in the principal terms and conditions of the agreement, the CEO will present a modified Contract Routing Form (or equivaent) to the Board of Directors

1.3.1.1.5 The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.

1.3.1.1.6 The professional service agreement will become effective following the Board of Directors' ratification, subject to the contract term identified in the agreement.

1.3.2 Renewal agreements committing less than $25,000 per twelve-month period can be authorized by the District's Chief Executive Officer without Board approval so long as funds have been authorized in the District's operating budget for that fiscal year.

1.4 Physician and other professional service agreements due for renewal may be held over for up to ~~six~~twelve months with no change in ~~compensation~~ terms at the discretion of the CEO, and in accordance with Stark Law and ~~OIG~~ regulations. Note: the Stark regulations currently permit unlimited holdover of physician professional service agreements.

1.5 Urgent Services:

1.5.1 At the discretion of the CEO, an agreement required for urgent services may be presented directly to the Board of Directors.

1.5.1.1 All terms and condition must be included at the time of presentation.

1.5.1.2 The signature of the health professional will be required on such agreements at the time of presentation to the Board.

1.6 All physician and professional service agreements will be processed by the Chief Executive Officer's administrative staff. The following guidelines will be utilized:

1.6.1 Material for agreements will be presented to the Chief Executive Officer's administrative staff in a timely manner to ensure that adequate time is available for preparation of the agreement within the required timeframes for timely execution and implementation.

1.6.2 Content and negotiations with health service professionals will remain the the responsibility of the Admin Council members.

2.0 Compensation under Professional Service Agreements With Physicians Only.

In all cases, agreement will specify the financial arrangements related to the provision of physician professional services. In no case shall compensation to physicians vary with the physician's referrals to TFHD. TFHD shall endevour to maintain a consistent approach with physicians within a specialty and among various specialties, irrespective of referrals to TFHD gererated, by an individual physician or the type of specialty. The following methodologies may be utilized:

2.1 Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, medical staff leadership positions, or committee attendance. Hourly rates or "per shift" rates with hours of coverage and response time specified are the preferred compensation method for on-call and hospitalist coverage.

2.1.1 Physicians shall be required to document the date, hours spent, and a description of work completed for all administrative duties.

2.1.2 On call calendars maintained by the medical staff office may be utilized as documentation for on-call and hospitalist agreements.

~~2.1.3 MSC physicians may receive RVU credit for administrative duties in lieu of cash compensation.~~

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2.2 Base compensation plus bonus. Payment of a fixed base compensation plus bonus is the preferred compensation method for multi-specialty clinic (MSC) physicians who are working more than half time. A consistent model for the compensation of MSC physicians shall be utilized, which may be subject to modification annually.

2.2.1 Management shall endeavor to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.

2.2.1.1 Pay within constraints of fair market value

2.2.1.2 Maintain internal equity within and between specialties

2.2.1.3 Provide sufficient compensation to recruit and retain physicians

2.2.1.4 Encourage quality and productivity

2.2.1.5 Be Clear and understandable to all parties

2.2.2 Base compensation shall be established based on an agreed upon percentage of the median compensation from one or more published compensation surveys, adjusted for the physician's FTE status.

2.2.2.1 FTE status shall be based on agreed number of days of work and/or hours of clinical availability, which may vary by specialty but which shall be consistent within each specialty.

2.2.2.2 The survey to be utilized shall be the annual MGMA Physician Compensation and Production Survey.

2.2.2.3 The Western Region median ~~shall~~may be utilized.

2.2.2.4 Data shall be smoothed by utilizing a 3-year average of the median from the three most recently published surveys.

2.2.2.5 In the event that, in management's professional opinion, the data from the MGMA survey in the Western Region is unreliable due to the low number of respondents or other factors, management may utilize the national median and/or data from other published surveys.

2.2.2.6 Survey data shall be adjusted for inflation that has occurred since the data was collected.

2.2.2.7 The percentage of median may be adjusted based on the physician's historic productivity, years of experience, special expertise, or the difficulty of recruiting a particular specialty to the area. However:

2.2.2.7.1 In no case shall the percentage of median compensation paid as base compensation (before FTE adjustment) ~~fall below 70% nor shall it~~ exceed 130% of the median.

~~2.2.2.7.2 In no case shall a physician's base compensation be decreased relative to the prior year unless either:~~Physician's base compensation may be adjusted once per year if:

~~2.2.2.7.3~~2.2.2.7.2 Physician's FTE status has changed.

~~2.2.2.7.4~~2.2.2.7.3 Physician's prior year productivity has fallen below 90% of the prior year's target, and physician

failed to reach this productivity level due to factors that are under the physician's control, such as leaving early or taking excessive time off. Determination of the reasons for any such failure shall be reviewed by a panel that includes the Executive Director (or designee), the Medical Director and at least one other physician.

2.2.3 The costs of malpractice insurance and benefits that are borne by the physicians shall be considered based on such reasonable methodology as may be developed by management, which may include but is not limited to:

2.2.3.1 Adding the estimated costs of malpractice insurance, health insurance, retirement benefits, employer-paid payroll taxes, and other benefits that are customarily paid by organizations with the ability to employ physicians.

2.2.3.2 Reducing the WRVU target by an amount that would enable physicians to earn all or a portion of those costs by reaching a production level that is commensurate with their compensation.

2.2.4 Physician contracts may include a production and/or quality incentive, to encourage physicians to work to their full capacity, provided:

2.2.4.1 Productivity is measured in Work Relative Value Units (WRVUs), unless physician works in a specialty for which WRVU benchmark data is either unavailable or insufficient, in which case an alternate measure such as visits may be utilized.

2.2.4.2 The production incentive is in no way tied to referrals or to use of Tahoe Forest Hospital facilities.

2.2.4.3 The production target is set based on the same survey benchmarks utilized for compensation, and is set at a level that is proportionate to base salary.

2.2.4.4 Quality incentives, if any, are measurable and linked to factors that are within the physician's control.

2.2.4.5 The total projected compensation, including incentives, does not exceed fair market value.

2.3 Rate per Work Relative Value Unit (WRVU). Payment at a set rate per Work Relative Value Unit (WRVU) is the preferred compensation method for multi-specialty clinic (MSC) physicians who are working less than half time, and may also be utilized for other physicians when mutually agreed upon by the parties.

2.3.1 The rate per RVU shall be based on the same compensation and production survey data that is utilized for physicians working half time or more, and may include an allowance for malpractice and benefits.

2.4 Percentage of professional fee collections. Payment based on a percentage of professional fees collected may be utilized for physicians who are not part of the MSC in those instances where the District accepts responsibility for billing and collecting from the patient or any third party payer for professional services and is able to separately bill for professional service fees.

2.4.1 Remuneration based upon a percentage of combined facility and professional gross charges or collections is prohibited.

2.4.2 The District will remit the amounts collected, depending upon the agreement, to the physician, deducting a percentage to account for the estimated expenses of the District's billing and collection services and other administrative and support services, if provided.

2.4.3 If the payment to the healthcare provider is based upon billings rather than collections, a further percentage will be deducted so to account for the estimated incidents of bad debts and contractual allowances. Furthermore, if the payment to the healthcare provider is based upon billings rather than collections, a revenue collection analysis will be performed at least annually to ensure compliance to the above compensation provision.

2.4.4 All professional fee schedules shall be made a part of the agreement and appropriately referenced. Professional fee schedules may be revised annually. Any changes to the professional fee schedule must be discussed between the District Chief Executive Officer and requesting physician prior to becoming effective. Requests shall conform to the following criteria:

2.4.4.1 Should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees;

2.4.4.2 All professional fees shall be reasonable and customary and comparable to professional fees charged by their peers within our region. The mechanism for determining compliance to this criteria will be determined on a case by case basis between the professional provider and District Chief Executive Officer.

2.4.4.3 Other relevant information should also be provided, e.g., changes required as a result of regulatory mandates; requests from individual physicians and Medical Staff; new service charges or extraordinary changes in provider costs not previously anticipated.

2.4.4.4 Written agreement reflecting mutual acceptance of the proposed revisions as meeting the above criteria shall be required prior to the changes becoming effective.

2.5 Payment per service.Payment at a specified rate per service is the preferred method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.

2.6 Specialty call activation fee.In specialties where a regular on-call panel is either infeasible due to the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.

2.7 Fair Market Value.In all cases, physician's compensation must be within fair market value and must be determined to be commercially reasonable.

2.7.1 Fair market value for any individual contract shall generally be defined as an amount equal to or less than the 75th percentile of fair market value compensation, considering the physician's FTE status and production levels.

2.7.2 However management shall endeavor to design a compensation model that maintains the average physician's compensation within +/- 10% of the median (or between the 40th and 60th percentiles~~?~~) based on the survey referenced in 2.2.2.2 above.

3.0 Multiple agreements

3.1 Nothing in this policy shall prohibit the hospital from entering into multiple agreements with physicians; provided however that the designated hours of service are clearly segregated.

3.1.1 Physicians whose MSC duties are typically during regular Monday through Friday daytime hours may be paid for on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.

3.1.2 MSC physicians who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.

3.1.3 The physician may perform administrative duties while on call, as long as clinical duties are not needed. If the physician is need for clinical duties, they m~~us~~ayt not bill administrative time when performing clinical duties.

3.1.4 Fair market valuations shall take into account the existence of multiple agreements with one contracting professional.

~~3.1.3~~3.1.5 The multiple agreements of a contracting professional shall be referenced in each of the agreements with that contracting professional.

4.0 Physician Qualifications:

4.1 Professional service agreements with physicians shall require:

4.1.1 A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board;

~~4.1.1~~4.1.2 The contracting professional is not suspended or excluded from participating in any federal health program;

~~4.1.2~~4.1.3 All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction;

~~4.1.3~~4.1.4 Prompt disclosure of the commencement or pendency of any action, proceeding, investigation or disciplinary proceeding against or involving Physician, including, without limitation, any medical staff investigation or disciplinary action;

~~4.1.4~~4.1.5 Prompt written notice of any threat, claim or legal proceeding against TFHD that Physician becomes aware of, and cooperate with TFHD in the defense of any such threat, claim or proceeding and enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies;

~~4.1.5~~4.1.6 No discrimination against a patient based on race, creed, national origin, gender, sexual orientation, disability (including, without limitation,

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the condition(s) for which the patient seeks professional services from Physician), ability to pay or payment source.

4.2 Physician Qualifications In Coordination With Medical Staff Bylaws:

4.2.1 Professional service agreements with physicians shall require their membership on the District's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

4.2.2 Termination of the agreement will cause the physician to lose the "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose his Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

4.3 Contract Termination Clause

4.3.1 :In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.

4.3.2 The following language will be utilized:

4.3.2.1 "For cause" termination of a physician contract at any time during the ~~during the first year of its~~ term;

~~4.3.2~~4.3.2.2 "No cause" termination ~~following~~during ~~the first year of its~~the initial or subsequent term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.

~~4.3.2.1~~4.3.2.3 The timeframe for prior written notice may range from 60-180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review pursuant to the Medical Staff By-Laws.

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5.0 Provisions For Health Professional Service Agreements

5.1 Compensation:

In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the District Chief Executive Officerand Board of Directors.

5.2 Compensation for health professional service agreements shall not exceed fair market value of the services.

~~5.2~~5.3 Professional Fee Schedule:

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~~5.2.1~~5.3.1 When reimbursement is based upon professional fee schedules, said fee schedule shall be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a timeframe that coincides with the District's operating budget.

~~5.2.1.1~~5.3.1.1 Requests for revisions must be submitted to the District Chief Executive Officer by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The District Chief Executive Officer will determine the acceptability of the proposed changes.

~~5.3~~5.4 Health Professional Qualifications in Coordination with Medical Staff By-Laws:

~~5.3.1~~5.4.1 Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

~~5.3.2~~5.4.2 Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose his allied health professional appointment or related privileges.

~~5.4~~5.5 Contract Termination Clause

~~5.4.1~~5.5.1 In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.

~~5.4.2~~5.5.2 The timeframe for prior written notice may range from 60-180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request the due process hearing described by the Medical Staff rules and regulations for allied health professionals.

6.0 Physician and Health Professional Service Agreement Contract and Service Review

6.1 Contract Review

6.1.1 Prior to the end of a contract period, the Chief Executive Officer, or designee, may choose to conduct a contract review or at any time during the contract period.

6.1.2 The Board of Directors can recommend that a contract review be done prior to most contract renewals but allows the CEO discretion to forego the review if the contract renewal is on an annual basis or if other factors indicate that the review is not necessary prior to that particular contract renewal.

At a minimum of every five years, the Chief Executive Officer will conduct a service review of the contract service provided by the physician, physician group and/or other professional service. The Chief Executive

Officer will undertake the service review and a report based upon this service review will be made to the Board of Directors.

6.2 Contract Review Elements

6.2.1 Analyze the continuing need for the services covered by the contract.
~~6.2.1~~6.2.2 Ensure that the terms of the contract are being met as outlined in the service agreement.
~~6.2.2~~6.2.3 Review the service as it related to consistency with the District's compliance program.
~~6.2.3~~6.2.4 Assessment of patient, physician and staff opinions/input/complaints.

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6.3 Service Review Elements

6.3.1 As part of the service review, the Chief Executive Officer will request feedback from the medical and clinical staff regarding the following:

6.3.1.1 Quality of care being provided based on the specialty's identified standards of care.
6.3.1.2 Availability and responsiveness.
6.3.1.3 Consistency with the District's compliance program.
6.3.1.4 Patient, physician and staff opinions/inputs/complaints

6.4 Other Review Elements: In addition the Chief Executive Officer will:

6.4.1 Ensure that the terms of the contract are being met as outlined in the service agreement.
6.4.2 Review market conditions with appropriate benchmarking and response to changes in the marketplace, and make recommendations as to the continuation of the current contract.
6.4.3 Seek a fair market valuation via written opinion of an experienced professional valuation expert, for any agreement, for the same specialty/scope of services, where the previous valuation was completed more than two years prior to the anticipated renewal date.
6.4.4 Document the community need for the physician or other healthcare professional services provided under the agreement.
6.4.5 Document how the agreement furthers specific strategic, business or operational goals of the District, increases integration of services, avoids costs/reduces expenses that would otherwise be incurred by the District, or furthers needed research and development within the District.
~~6.4.2~~6.4.6 Evaluate the use of less expensive alternatives.
~~6.4.3~~6.4.7 Ensure that the fee schedule is appropriate for current market conditions.
~~6.4.4~~6.4.8 Take in to consideration elements of the contractor's relationships with service providers, the District and the community.
~~6.4.5~~6.4.9 Review standards and best practice recommendations set by professional and specialty organizations with appropriate consideration of our community and Hospital District.

6.5 The Chief Executive Officer will compile a report based upon the service review and present it to the Board of Directors with recommendations related to continuation of the contract or consideration of a Request For Proposal (RPF) process.

Contract Inclusion terms:

7.0 General Provisions: Physician and Health Professional Service Agreements

7.1 Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:

7.1.1 Diagnostic and therapeutic services to be provided

7.1.2 Medico-administrative services to be provided

7.1.3 Coverage obligations to be assumed

7.1.4 The rights and obligations of the District and the health professional with regard to providing space, equipment, supplies, personnel and technicians.

7.2 Standards Of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws, Rules and Regulations, and standards established by the Executive Committee of the Medical Staff; with the ethical and professional standardsof the American Medical Association and the California and/or Nevada Medical Association; the standards of the Healthcare Facilities Accreditation Program (HFAP) and in any applicable specialty college or society or governmental regulation.

7.3 Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify TFHS in the event participation terminates.

7.4 Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System,Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for said service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health SystemQuality ImprovementProgram.

7.5 Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where

higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the Board of Directors be obtained.

7.6 Contract Term: Professional service agreements shall specify a specific term and termination date (i.e., not automatically renewable for successive years). In considering the term of the agreement, the termination date of related agreements should be considered by the District Chief Executive Officer so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.

7.7 Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of $l,000,000 per occurrence, $3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession. The agreement shall also specify that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of professional services provided at the District's Community Hospital in Incline Village, Nevada). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of said action.

7.8 Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to prevent the unauthorized use and disclosure of any and all Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.

7.9 Recitals: Exclusive professional service agreements should include a carefully developed description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.

7.10 Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.

7.11 Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.

7.12 Standard Contractual Language: The agreement should include certain standard provisions to theeffect that the provisions of the contract are severable and,

therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.

7.13 Managed Care:The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by District Administration and the Board of Directors.

Related Policies/Forms: Contracts Routing Form, Model Agreements
References:
Policy Owner: Clerk of the Board
Approved by: Chief Executive Officer

EXHIBIT A

No.	Contract Title	Last Date Modified
1	Call_Coverage_Agreement_Template_Individual_2015 **(version dated 8/11/14 does not have Master List provision)**	**3/30/2015**
2	Call_Coverage_Agreement_Template_Medical_Group_2015	4/16/2015
3	Confidentiality_Nondisclosure_Agreement_2015	3/25/2015
4	EKG_Letter_Agreement_Template_2014	10/29/2014
5	Non-Physician_Consultant_Agreement_Template_2014	9/25/2014
6	Hospitalist_Services_Agreement_Template_2014 **(Template has Master List provision Paragraph 2.4)**	**8/13/2014**
7	Interim_Physician_Designee_Contract_2014 **Version dated 02/23/2015 for Dr. Standteiner does not have Master List provision; add after 12. Governing Law)**	10/30/2014
8	Medical_Director_Agreement_Individual_2014 **(Dr. Tirdel's Med Dir of ICU & RT version on 2/23/15 has paragraph 11.3)**	**8/13/2014**
9	Medical_Director_Agreement_Medical_Group_2015	6/26/2015
10	MSC_PSA_Template_2014 **(Template has Master List provision Paragraph 2.5)**	8/13/2014
11	Retention_Agreement_Template_2015	4/23/2015
12	Recruitment_Agreement_Template_Co-obligors_2015 **(No Master List provision; add to VII Miscellaneous)**	**2/20/2015**
13	Recruitment_Agreement_Template_Physician-obligor_2015 **(No Master List provision; add to VII Miscellaneous)**	**2/20/2015**
14	Rural_Prime_Site_Preceptor_Template_2015	4/30/2015
15	TF2020_Agreement_for_Medical_Advisor_Services_2015	4/3/2015

This list was last updated on July 29, 2015. It should be noted that some of the templates listed above have been sourced from recent agreements which have been reviewed and approved by outside counsel. It should also be noted that the templates listed above may require further review by outside counsel prior to implementation by TFHD staff due to the individualized nature of each agreement, and to ensure that the provisions of each agreement have been updated to reflect recent changes in law.

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AGREEMENT BETWEEN
THE
TAHOE FOREST HOSPITAL DISTRICT
AND THE
INCLINE VILLAGE COMMUNITY HOSPITAL FOUNDATION
FOR
FUND RAISING AND SUPPORT ACTIVITIES

This Agreement is made and executed in Truckee, California this _____ day of _____, 2016, by and between Tahoe Forest Hospital District (TFHD), a Hospital District organized and existing under the California Local Health Care District Law, with a principal place of business at Truckee, California; and the Incline Village Community Hospital Foundation (Foundation), a hospital foundation organized and operating as a tax exempt 501(c)(3) corporation with its principal place of business at Incline Village, Nevada. TFHD and the Foundation may be referred to herein as "Party" or "Parties."

The Parties desire to enter into this Agreement in support of the Mission of the Foundation and TFHD as follows:

RECITALS

WHEREAS, TFHD owns and operates the Incline Village Community Hospital (IVCH), a licensed health care facility located in Incline Village, Nevada;

WHEREAS, the Foundation was formed in 2004 by TFHD with the Mission "to assist IVCH in delivering the best possible emergency and primary health care services by procuring financial resources, improving community awareness and involving community residents in developing a long term vision for health care on the north shore of Lake Tahoe";

WHEREAS, in support of this Mission, TFHD and the Foundation entered into an agreement (Memorandum of Understanding or MOU) executed February 27, 2006 providing for certain financial, administrative, and logistical support to the Foundation by TFHD; and

WHEREAS, the Parties have determined that this existing MOU is out of date and needs to be replaced by a new and updated Agreement.

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, and for other good and valuable consideration, it is agreed:

1. Responsibilities of the Foundation.

A. The Foundation will use its best efforts to carry out the Mission with which it is charged. To that end, the Foundation will develop annually a written Work Plan designed to address the three aspects of its Mission (fund raising, community awareness, and

community involvement) and outlines the programs and associated tasks with furthering its Mission. The Foundation shall annually submit the Work Plan to TFHD for consideration and approval by TFHD's Chief Executive Officer.

B. In support of the Work Plan, the Foundation shall submit to TFHD an operating plan and budget, in such detail as the Parties shall agree, that specifies the Financial, Administrative, Logistical and Operating Support the Foundation desires for the upcoming year. The Foundation may update the Work Plan and operation budget from time to time throughout each year.

C. The Foundation shall report to TFHD its performance against Work Plan periodically during the year, but no less than every six (6) months.

D. Each year, the Foundation will develop a one and three year fundraising plan and submit those plans to TFHD for consideration and approval by TFHD's Chief Executive Officer. The funds raised by the Foundation shall be used exclusively for the benefit of IVCH unless the donor(s) directs otherwise.

E. The Foundation shall submit to TFHD for consideration and approval from time to time any candidate for membership on the Board of the Foundation. The Board of TFHD must ratify any candidate for membership on the Board of the Foundation before that candidate may assume membership on the Foundation's Board.

F. The Foundation will ensure that the TFHD Chief Executive Officer will always be a voting member of the Foundation, and a member of its Executive Committee if there is one.

G. The Foundation shall maintain or cause to be maintained, to the extent required by law, books and records of its operations, and make those available to TFHD for review and inspection upon reasonable notice and at reasonable times.

2. Responsibilities of TFHD.

A. TFHD will provide such reasonable amount of Financial, Administrative, Logistical and Operating Support as it deems necessary to the Foundation in the discharge of the Foundation's annual Work Plan and fundraising plan. In determining such reasonable amount, TFHD will consider the Foundation's operating plan and budget, and any amendments thereto, as referenced in Section 1(B) above, the Foundation submits to TFHD.

B. TFHD will execute its responsibilities of review and approval as outlined above in a timely fashion.

C. TFHD will maintain with due care and confidentiality, to the extent requested by the Foundation and allowed by law, the books and records of the Foundation; shall provide on an agreed periodic basis the financial reports of the Foundation's performance

(including identified allocated service charges and expenditures made on the Foundation's behalf.)

D. TFHD will maintain principal contact with and responsibility for the independent outside auditors on behalf of the Foundation, and shall provide to the Foundation sufficient information about the financial performance to allow the Foundation and its officers to discharge the legal responsibility to sign off on the annual audit and the Federal tax return.

E. TFHD will provide any assistance reasonably requested and necessary to facilitate the management of donor relations by the Foundation.

F. TFHD agrees to honor donor wishes in the use of restricted funds raised by the Foundation. If donor wishes cannot be accommodated, the Foundation will negotiate a different use with the donor or return the donation.

G. TFHD will manage on behalf of the Foundation such bank accounts as may be agreed to from time to time, and provide the Foundation with timely bank statements and any necessary reconciliations.

3. Annual Review. To ensure that this Agreement reflects the current working relationship between the Parties, the Parties shall mutually review from time to time, but at least annually, the terms of the Agreement to determine whether they reflect the then current practices.

4. Definitions. The terms "Financial, Administrative, Logistical, and Operational Support" when used herein shall include, inter alia, operating funds, personnel support, insurance coverage, work space, equipment, and informational technology support including maintenance of a donor data base.

5. Term and Termination. The term of this Agreement shall be for five (5) years beginning on _____, 2016 and shall automatically renew midnight _____, 2021. This Agreement may be terminated by any Party, with or without cause, by giving sixty (60) days written notice as provided in Paragraph 12 of this Agreement.

6. Mediation and Arbitration Clause. In the event of disagreement or dispute between the Parties arising out of or connected with this Agreement which cannot be resolved by and between the Parties involved, the disputed matter shall be resolved as follows:

A. *Mediation*. The Parties agree to mediate any dispute or claim arising between them out of this Agreement or any resulting transaction before resorting to arbitration or court action. Mediation fees, if any, shall be divided equally among the Parties involved. If any Party commences an arbitration or court action based on a dispute or claim to which this paragraph applies without first attempting to resolve the matter through mediation, then that Party shall not be entitled to recover attorney's fees, even if they would otherwise be available to that Party in any such arbitration or court action.

B. *Arbitration*. The Parties agree that any dispute or claim in law or equity arising between them out of this Agreement or any resulting transaction, which is not settled through mediation, shall be decided by neutral, binding arbitration and not by court action. The arbitration shall be conducted by a retired judge or justice, unless the Parties mutually agree to a different arbitrator, who shall render an award in accordance with substantive California law. In all other respects, the arbitration shall be conducted in accordance with Part III, Title 9 of the California Code of Civil Procedure. Judgement upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The Parties shall have the right to discovery in accordance with Code of Civil Procedure § 1283.05.

7. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California.

8. Forum. Any mediation, arbitration or litigation to enforce or interpret the provisions of this Agreement or the Parties' rights and liabilities arising out of this Agreement or the performance hereunder shall be maintained only in the County of Nevada, California.

9. Severability. If any provision of the Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force and effect without being impaired or invalidated in any way.

10. Integration. This Agreement contains the entire agreement among the Parties and supersedes all prior and contemporaneous oral and written agreements, understandings, and representations among the Parties. No amendments to this Agreement shall be binding unless executed in writing by all of the Parties.

11. Waiver. No waiver of any of the provisions of this Agreement shall be deemed, or shall constitute a waiver of any other provision, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the Party making the waiver.

12. Notices. Any notice required by this Agreement shall be effective only if sent by certified or registered mail, postage prepaid, as follows:

If to District:

CEO/Administrator
Tahoe Forest Hospital District
P.O. Box 759
Truckee, CA 96160

If to Foundation:

President, Board of Trustees
Incline Village Community Hospital
Foundation
880 Alder Blvd
Incline Village, Nevada, 89451

For the purposes of determining compliance with any time limit in this Agreement, a notice shall be deemed to have been duly given on the second business day after mailing, if mailed to the Party to whom notice is to be given in the manner provided in this Section. Either Party may, at

any time, change its address designated above by giving to the other Party thirty (30) days' written notice of the new address to be used for the purposes of this Section.

13. Assignability. Neither this Agreement nor any duties or obligations hereunder shall be assignable by any Party hereto without the prior written consent of the other Parties.

14. Designees. The obligations assumed by any Party hereto may be performed by a suitably appointed and empowered designee of the Party, provided advance notice is given to and approved by the other Parties. However, subject to the provisions of Section 13, such designation shall not be interpreted to relieve the Party involved of responsibility for satisfactory performance.

15. Binding Effect. This Agreement is and shall be binding upon and inure to the benefit of the Parties and their respective heirs, affiliates, predecessors, successors and assigns. Each person executing this Agreement represents and warrants for the benefit of the Parties that he or she is actually authorized to enter into this Agreement.

Incline Village Community Hospital Foundation

Date: _____ By: _____
Warren Kocmond, President, Board of Trustees

Tahoe Forest Hospital District

Date: _____ By: _____
Harry Weis, Chief Executive Officer

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Rick McConn
Chief-Facilities Development

DATE: May 18, 2016

ISSUE:
Recommended Board Award of bids for the IVCH Siding Replacement Project

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BACKGROUND:

In August of 2014 the HFAP Survey cited IVCH with a deficiency for combustible material on the exterior of the IVCH. Pursuant to the POC the exterior siding is to be replaced with non-combustible material. The IVCH Siding Replacement Project will replace the existing combustible exterior siding with non-combustible material as required by the POC, as well as related roof repairs and replacement.

The Project would be funded from TFHD cash reserves.

ACTION REQUESTED:

1. **Award the bids outlined on page 2 of the Recommendation For Award.**
2. **Approve the Total Development Costs of $1,643,931.**

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Incline Village Community Hospital - Exterior Siding Replacement
Bids Received: **May 5, 2016**

May 26, 2016

RECOMMENDATION FOR AWARD

Incline Village Community Hospital - Exterior Siding Replacement

Construction		$	1,326,220
Soft Costs		$	224,876
Contingency/Escalation	7%	$	92,835
Total		***$***	***1,643,931***

TOTAL DEVELOPMENT COSTS	**$**	**1,643,931**

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Incline Village Community Hospital - Exterior Siding Replacement

Bids Received: **May 5, 2016**

COST SUMMARY BREAKDOWN

Element		Cost / SF		Total	Recommended Contractors
1	**General Requirements**		$	**263,455**	
2	**Sitework/Existing Conditions**		$	**172,550**	C&E Builders
3	**Concrete**		$	**-**	
4	**Masonry**		$	**20,262**	NorthEast Masonry
5	**Metals**		$	**5,775**	Precision Ladder Supply
6	**Wood & Plastics**		$	**541,100**	C&E Builders
7	**Thermal & Moisture**		$	**284,725**	Alpine Roofing
8	**Doors & Windows**		$	**1,450**	Brite Glass
9	**Finishes**		$	**7,468**	Jackson Quality Drywall
10	**Specialties**		$	**-**	
11	**Equipment**		$	**-**	
14	**Conveying Systems**		$	**-**	
21	**Fire Suppression**		$	**-**	
22	**Plumbing**		$	**25,595**	Intech Mechanical
23	**Mechanical**		$	**-**	Intech Mechanical
26	**Electrical**		$	**3,840**	Silver Knolls Electric Corp.
31	**Earthwork**		$	**-**	
32	**Exterior Improvements**		$	**-**	
	Subtotal Construction Hard Costs		$	**1,326,220**	
	Contingency/Escalation	7%	$	**92,835**	
	Equipment, Furniture, Signage		$	**-**	
	Professional Fees		$	**209,998**	
	Administrative Costs		$	**14,879**	
	Total Estimated Construction Cost		$	**1,643,931**	
	NON-MEASURE C EQUIPMENT		$	-	
	TOTAL DEVELOPMENT COST		$	**1,643,931**	

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

IVCH - Exterior Siding Replacement Estimate

Description	Quantity	UOM	Unit Cost	UOM	Total
CONSTRUCTION HARD COSTS					
01-01000 GENERAL REQUIREMENTS					
01-01300 Administration Requirements					
1301 Drawing and Reproduction	5	MO	125	MO	625
1302 Shipping/Postage	5	MO	50	MO	250
1310 Project Management- Principal (1/4 Time)	5	MO	4,300	MO	21,500
1311 Project Management (Third Time)	5	MO	4,300	MO	21,500
1311 Project Superintendency (Full Time)	6	MO	17,200	MO	103,200
1313 Project Engineer (Third Time)	5	MO	4,300	MO	21,500
1321 Photographic Documentation	1	LS	150	LS	150
1351 Safety/First/Aid/OSHA	1	LS	150	LS	150
Administration Requirements					**231,225**
01-01500 Temporary Facilities					
1522 Temp Toilets	5	MO	216	MO	1,080
1516 Cellular Charges	5	MO	300	MO	1,500
1523 Office Supplies/Equipment	5	MO	75	MO	375
1532 Miscellaneous Rental	5	LS	250	LS	1,250
1551 Vehicle Fuel/Maintenance	5	MO	500	MO	2,500
1561 Temp Fence - Staging Area	5	MO	400	MO	2,000
1561 Temp Storage -	5	MO	350	MO	1,750
1572 Weather Protection	5	MO	300	MO	1,500
Temporary Facilities					**11,955**
01-01700 Execution Requirements					
1741 Progress Cleaning	0	LS	2,500	LS	-
1743 Disposal/Off-Haul	0	MO	900	MO	-
1744 Final Cleaning	0	SF	1.00	SF	-
1745 Snow Removal	0	MO	1,000	MO	-
1745 SWWPP	0	MO	3,500	MO	-
1761 Protection of Finishes	5	MO	100	MO	500
1761 General Labor-Daily Cleaning (1/4 Time)	5	MO	3,655	MO	18,275
1761 Closeout Procedures	1	LS	1,500	LS	1,500
1742 Infection Control	0	LS	5,000	LS	-
Execution Requirements					**20,275**
GENERAL REQUIREMENTS					***263,455***

	Description	Quantity	UOM	Unit Cost	UOM	Total
	CONSTRUCTION HARD COSTS					
02-00000	***EXISTING CONDITIONS***					
02-40000	**Existing Conditions**					
	Exterior Siding Demolition	1	LS	172,550	LS	172,550
02-40000	**Existing Conditions**					**172,550**
	EXISTING CONDITIONS					***172,550***
04 00 00	***MASONRY***					
04 00 00	**Unit Masonry**					
04 43 13	New Stone Veneer	1	LS	20,262	LS	20,262
04 00 00	**Unit Masonry**					**20,262**
04 00 00	***MASONRY***					***20,262***
05-05000	***METALS***					
05 05 00	**Structural Steel Framing**					
05 12 23	Roof Ladder FOB/Precision Ladders	1	EA	5,095	EA	5,095
05 12 23	Remove & Relnstall Roof Ladder	4	HR	170	HR	680
05 05 00	**Structural Steel Framing**					***5,775***
	METALS					***5,775***
06 00 00	***WOODS AND PLASTICS***					
06 10 00	**Rough Carpentry**					
06 10 00	Siding Replacement/James Hardie/Parapet Wall Framing/Blocking/Window Install	1	LS	541,100.00	LS	541,100
06 10 00	**Rough Carpentry**					**541,100**
	WOODS AND PLASTICS					***541,100***
07 00 00	***THERMAL/ MOISTURE PROTECTION***					
07 54 19	**Roofing**					
07 54 19	Remove/Replace Existing Roof with new Single Ply TPO Roofing	1	LS	97,910	LS	97,910
07 60 00	Kynar Coping Cap; Edge Metal; Misc flashings and trim	1	LS	32,637	LS	32,637
07 54 19	**Roofing**					**130,547**
07 00 00	**Sheet Metal Flashing & Trim**					
07 42 13	Metal Soffit Panels/Fascia	1	LS	154,178	LS	154,178
07 00 00	**Sheet Metal Flashing & Trim**					**154,178**
07 92 00	**Joint Sealants**					
07 92 19	Caulking Allowance	0	LS	3,000.0	LS	-
07 92 19	**Joint Sealants**					**-**
07 00 00	***THERMAL/ MOISTURE PROTECTION***					***284,725***

	Description	Quantity	UOM	Unit Cost	UOM	Total
	CONSTRUCTION HARD COSTS					
08 00 00	***DOORS AND WINDOWS***					
08 50 00	**Metal Windows**					
08 51 23	Replace Exterior Aluminum Windows FOB	2	EA	325	EA	650
08 50 00	**Metal Windows**					**650**
08 90 00	**Louvers & Vents**					
08 91 19	Fixed Louvers - 15-0 x 4-8 (MK 300 thru 302)	1	EA	800	EA	800
08 90 00	**Louvers & Vents**					**800**
	DOORS AND WINDOWS					***1,450***
09-00000	**FINISHES**					
09 21 16	**Gypsum Board Assemblies**					
09 21 16	5/8" Type-X Gypsum Board - Windows/Ladder Patch	1	LS	1,000.00	LS	1,000
09 21 16	**Gypsum Board Assemblies**					**1,000**
09 90 00	**Painting & Coating**					
09 91 13	Exterior CMU	3696	SF	1.75	SF	6,468
09 90 00	**Painting & Coating**					**6,468**
09-00000	***FINISHES***					***7,468***
22-00000	***PLUMBING***					
22-00000	**Plumbing**					
22 00 00	New Roof Drains	1	LS	25,595	LS	25,595
22-00000	***Plumbing***					**25,595**
22-00000	***PLUMBING***					***25,595***
23-00000	***HEATING VENTILATING AND AIR CONDITIONING***					
23-00000	**Heating, Ventilating, and Air Conditioning**					
23 00 00	Remove/Reinstall Roof Top Equipment/Weather Hood	1	LS	0	LS	-
23 00 00	Weather Hood/EH30 Install	0	SF	0.00	SF	-
23-00000	**Heating, Ventilating, and Air Conditioning**					**-**
	HEATING VENTILATING AND AIR CONDITIONING					***-***
26-00000	***ELECTRICAL***					
	Remove/Reinstall Exterior Light Fixtures	1	LS	3,840.00	LS	3,840
26-00000	***Basic Electrical***					**3,840**
	ELECTRICAL					***3,840***
	SUBTOTAL CONSTRUCTION HARD COSTS					***1,326,220***

	Description	Quantity	UOM	Unit Cost	UOM	Total
	CONSTRUCTION HARD COSTS					
17-17000	***PROJECT CONTINGENCY***					
17-17000	**Project Contingency**					
1100	Construction Contingency/Escalation	7.00%	PC	Const Cost	PC	92,835
	Project Contingency					**92,835**
	PROJECT CONTINGENCY					***92,835***
	TOTAL CONSTRUCTION COSTS					***1,419,055***
	Total SF 14,768			***Total Construction Costs per SF***		***96.09***
	SOFT COSTS					
19-19000	***PROFESSIONAL FEES***					
019-0000	**Professional Fees**					
19000	Cost Estimating/Preconstruction Services	0.50	MOS	21,500.00	MOS	10,750
19000	Public Bid Process	1	LS	20,000.00	LS	20,000
19000	Construction Management	10%	PC	Const Cost/Const Con	PC	141,906
20103	Architectural Design	0	LS	0.00	LS	-
20103	Rubicon Group, Inc. - Architectural Design	1	LS	22,000.00	LS	22,000
20103	Rubicon Group, Inc. - Rendering	1	LS	1,000.00	LS	1,000
20103	Rubicon Group, Inc. - Roofing Changes	1	LS	4,500.00	LS	4,500
20103	Construction Administration	0	LS	20,760.00	LS	-
2500	Testing/Inspections	0.00%	PC	Const Cost/Const Con	PC	-
2500	I.O.R. Testing	0	LS	0.00	LS	-
	Builidng Permit- Washoe County	1	LS	9,842.00	LS	9,842
3400	Agency Fees	0	LS	35,000.00	LS	-
3400	10% Agency Fee Contingencies	10%	PC	0.00	PC	-
019-0000	**Professional Fees**					**209,998**
	PROFESSIONAL FEES					***209,998***
20-20000	***ADMINISTRATIVE COST***					
020-0000	**Administrative Cost**					
1300	State Review (OSHPD) - Fire & Life Safety	0.00%	PC	Const/Equip Cost	PC	-
1400	General Liability Insurance	0.70%	PC	Gen Req/CM	PC	2,838
1500	Performance/Payment Bonding	0.77%	PC	Const Cost/Cont/CM	PC	12,041
1600	Administrative Bond Contingency	0.00%	PC	Const Cost	PC	-
1700	Course of Construction Insurance	0.00%	PC	Const Cost	PC	-
020-0000	**Administrative Cost**					**14,879**
20-20000	***ADMINISTRATIVE COST***					***14,879***
	TOTAL SOFT COSTS					***224,876***
	TOTAL CONSTRUCTION COSTS					***1,419,055***
	TOTAL SOFT COSTS					***224,876***
	ESTIMATED TOTAL DEVELOPMENT COST					***1,643,931***

16.2. Sierra Nevada Oncology Physician Services Agreement

Contract redacted.

Available for public viewing via a Public Records request.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

California's End of Life Option Act

Talking Points

April 2016

California's End of Life Option Act, signed into law by Governor Jerry Brown in October 2015, will take effect on June 9, 2016. The Act allows an adult who has been diagnosed with a terminal illness and who has a life expectancy of no more than six months to request and be prescribed an aid-in-dying drug, if specified conditions are met. In order to qualify for the aid-in-dying medication, the patient must have the capacity to make medical decisions for him/herself, be a resident of California, make three voluntary requests (two oral and one written) and have the ability to self-administer the medication.

- California's hospitals are on the front lines of care, open 24 hours a day, seven days a week to anyone in need of care. Hospitals are where life's greatest joys and deepest sorrows play out every hour of every day.

- Providing comfort and support to patients and their families during the final phase of life is at the heart of what hospitals and their caregivers do every day.

- Hospitals encourage physicians, patients, families, loved ones, religious representatives and caregivers to have open conversations about medical care and end-of-life wishes. This includes completing an Advance Health Care Directive that explicitly states the patient's end-of-life preferences while the patient has the capacity to understand the consequences of their decisions.

- California's new End of Life Option Act is not intended to alter the mission or role of hospitals in caring for dying patients. Rather, it allows terminally ill patients who are able to make a conscious and voluntary choice about their final days to do so, and allows physicians, if they choose to do so, to assist these patients by providing them with information and a prescription for aid-in-dying medication.

- In most cases, the activities associated with the End of Life Option Act will not occur within a hospital; instead they are more likely to occur in doctors' offices and patients' homes. Hospitals, however, should be aware of this new law and develop appropriate policies to guide their staff and patients.

- Participation in activities authorized by the End of Life Option Act is completely voluntary. No person (including a physician), hospital, pharmacy or other entity that objects based on conscience, morality or ethics is required to provide any services in support of this new law.

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

- Additionally, hospitals and other health care providers may prohibit their employees, medical staff, independent contractors and others from engaging in any activities associated with the End of Life Option Act in two situations. These are:

  A) While those individuals are on premises owned or under the management or direct control of the provider (e.g. clinics, pharmacies, medical office buildings, etc.)

  or

  B) While those individuals are acting within the course and scope of any employment by or contract with the provider (e.g. home health and hospice workers, etc. who work away from the provider-owned or managed premises.)

- Hospitals, however, cannot prohibit their employees, medical staff, independent contractors or others from providing information about the End of Life Option Act to patients or others; nor can they prohibit them from referring a patient to another provider for the purposes of participating in activities authorized under the End of Life Option Act.

- A hospital that chooses to have a policy prohibiting participation in activities under the End of Life Option Act must provide written notice to those individuals and/or entities. The notice must be a separate statement specifying its policy on aid-in-dying assistance.

- California's End of Life Option Act establishes a very specific set of requirements for patients who wish to take advantage of this law:

  - The patient must be an adult (18 years of age or older) with a terminal disease (defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, result in death within six months").

  - The patient must be a resident of California and have the mental capacity to make this decision for him/herself.

  - The patient must make three separate requests for an aid-in-dying medication to his or her attending physician:

    - Two oral requests at least 15 days apart **and**

    - One written request on a form prescribed in the Act. This form must be signed and dated by the patient in the presence of two witnesses. There are limits on who may serve as a witness to the patient's written request:
      - Neither of the witnesses can be the patient's attending or consulting physician or mental health specialist.

      - Only one of the two witnesses may be related to the patient or entitled to a portion of the patient's estate upon death.

- Only one of the two witnesses may own, operate or be employed at a health facility where the patient is receiving medical treatment or resides.

- The request for aid-in-dying medication must be made solely and directly by the patient. The request cannot be made on behalf of the patient by anyone else, including the patient's legally recognized health care decision-maker.

- The patient must be making an informed decision with respect to the request, which means that the patient's attending physician must discuss with the patient all of the following things:

  - The patient's medical diagnosis and prognosis.
  - The potential risks associated with ingesting the requested aid-in-dying drug.
  - The probable result of ingesting the aid-in-dying drug.
  - The possibility that the patient may choose to obtain the aid-in-dying drug but not take it; and
  - The feasible alternatives or additional treatment options including but not limited to comfort care, hospice care, palliative care and pain control.

- The patient must have the physical and mental ability to self-administer the aid-in-dying medication.

- If the patient speaks a language other than English, the request for aid-in-dying medication must be made to the attending physician (orally and in writing) in the patient's primary language. However, the required written form ("Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner") may be prepared in English even when the oral conversations occur in a different language. The patient may utilize the assistance of an interpreter, as long as the interpreter is not related to the patient by blood, marriage, registered domestic partnership or adoption, or be entitled to a portion of the patient's estate upon death.

- CHA has developed a comprehensive set of guidelines to assist hospitals in the development of policies and procedures related to the End of Life Option Act. These guidelines can be found in Chapter 5 of CHA's 2016 Consent Manual.

- California's End of Life Option Act is a complex and controversial law that touches on important social, philosophical, ethical, moral and religious beliefs. Every hospital and health care provider must make their own decision as to whether they wish to assist terminally ill patients in choosing to end their life through aid-in-dying protocols.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: May 26, 2016

2016 Compliance Program 1st Quarter Update (Open Session)

The Compliance Committee is providing the Board of Directors(BOD) with a report of the 1st Quarter 2016 Compliance Program activities report (open session). This report assists the BOD to meet its obligations to be knowledgeable about the content and operation of the seven components of the Compliance Program.

2016 Corporate Compliance Program Annual Report

OPEN SESSION

Period Covered by Report: **January 1, 2016 – March 31, 2016**
Completed by: James Hook, Compliance Consultant, The Fox Group

1. Written Policies and Procedures

1.1. The District's Corporate Compliance Policies and Procedures are reviewed and updated as needed. The following policies were reviewed or revised by the Compliance Department with recommendations to the Board of Directors:

1.1.1. Physicians and Professional Services Policy/Procedure #ABD 21-Revised

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee Membership as of January 1, 2016:

2.1.1. The Fox Group – Compliance Consultants
2.1.2. Judy Newland, RN – Chief Operating Officer/Chief Nursing Officer
2.1.3. Harry Weis – Chief Executive Officer
2.1.4. Crystal Betts – Chief Financial Officer
2.1.5. Denise Hunt – Director of Health Information Management/ Privacy Officer
2.1.6. Jake Dorst – Chief Information and Innovation Officer
2.1.7. Jayne O'Flanagan – Chief Human Resources Officer
2.1.8. Stephanie Hanson, RN – Compliance Analyst
2.1.9. HLB-Legal Consul

3. Education & Training

3.1. All new employees are educated during orientation.

3.2. An education program on Compliance and the TFHD Compliance program was provided to the Managers and Directors of TFHD in February 2016.

3.3. "Compliance Corner" continues in the monthly employee newsletter providing on-going compliance education for staff.

3.4. The Compliance Department has completed one-on-one education with 8 new, supervisors, manager and directors.

3.5. The Board of Directors received a presentation on Compliance Program elements, risk areas for hospitals, and responsibilities of Board members for oversight and monitoring in February 2016,

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Department.

4.1.1. One call was received on the Hotline for the 1st quarter of 2016.
4.1.2. Eight-reports were made directly to the Compliance Department for the 1st quarter.

4.2. HIPAA violations are reported to the Privacy Officer. The Privacy Officer maintains a log of reported events.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. 99% of Health Stream corporate compliance modules were completed on time for eligible employees for the 1st quarter of 2016.

5.2. All new staff hires, and newly privileged physicians, receive criminal background checks and are checked against the OIG and GSA list of exclusions.

5.2.1. The Materials Management Department is evaluating its process for checking vendors and introducing new software that will perform the monitoring routinely.

6. Auditing &Monitoring

6.1. One audit was completed during the 1st quarter as part of the 2016 corporate compliance work plan.

6.1.1. Payments to Physicians for Medical Directors/Preceptors showed 2 of 56 invoices contained errors. These errors were corrected prior to being processed for payment. One error was related to a systemic problem, which was addressed with the submitter.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. Investigations of suspected and actual breach incidents were initiated. Several investigations revealed no violations. Remediation measures, including additional staff training and updated policies and procedures, were implemented to prevent further violations.

PLACER COUNTY
LOCAL AGENCY FORMATION COMMISSION

110 MAPLE STREET, AUBURN, CALIFORNIA 95603 - 530-889-4097
LAFCO@PLACER.CA.GOV

DATE: April 20, 2016

TO: Special District Board members

FROM: Linda Wilkie, Clerk to the Commission

RE: Election of Special District Representatives to the Local Agency Formation Commission (LAFCO)

Dear Special District Board Members:

The nomination period for Special District Representatives to the Local Agency Formation Commission (LAFCO) ended Friday, April 15, 2016. A total of four (4) nominations were received during the nomination period.

The attached ballot contains the names of all nominees. Each district shall receive one ballot and vote for two candidates. The candidate receiving the highest number of votes shall assume the regular special district seat for the term ending May 2020. The candidate receiving the second highest number of votes shall assume the alternate special district seat for the term ending in May 2020.

The enclosed ballot and certification sheet are to be completed by the district's independent special district selection committee member (the district's presiding officer) or the designated alternate selection committee member and returned to the LAFCO office by 4:30 PM Tuesday, May 31, 2016. Any ties will be broken by a coin toss at the June 8, 2016.

PLACER LAFCO

SPECIAL DISTRICT BALLOT

Please vote for 2

From District Name:_____

Signature:_____

Ballots due by May 30, 2016

Joshua Alpine, PCWA ____

Sue Daniels, No. Tahoe PUD ____

Mike Lynch, ARD ____

Chris Reams, Foresthill FPD ____

Joshua Alpine

Biography

Joshua Alpine is currently a member of the Placer County Water Agency Board of Directors. Elected in 2012, Mr. Alpine represents District 5 which extends eastward from Auburn to Lake Tahoe and the Nevada state line. He also serves on the Association of California Water Agencies Board of Directors representing region 3 which is comprised of 14 counties including the counties of Alpine, Amador, Calaveras, El Dorado, Inyo, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, Sierra and Tuolumne. He served on the Colfax City Council from 2003-2012, including two terms as Mayor. During that time he was very involved in waste water, regional water and land planning issues. He also served on Placer County LAFCO from 2011-2012.

Mr. Alpine works effectively with elected officials and agencies on the local, state and federal levels, including the Regional Water Quality Control Board and the State Water Resources Control Board, developing solutions to water and land use policies that affect our region. At the Federal level, he has worked with the EPA, U.S. Corps of Engineers, U.S. Department of Agriculture and U.S. Department of Housing & Urban Development. He has also served on the Placer County Economic Development Board.

Mr. Alpine has a B.S. in Information Systems Management and has held a California State Hydro Power System Operator certification since 2003. He worked as a Hydro System Operator from 2003 until 2009 for Pacific Gas & Electric (PG&E) on the Bear, South Yuba and the American Middle Fork river systems and currently is a Lead System Operator of PG&E's electric transmission system. He is a member of the Colfax Lions Club and lives in Colfax.

TAHOE FOREST HOSPITAL DISTRICT

GOVERNANCE COMMITTEE AGENDA

Wednesday, May 18, 2016 at 12:00 p.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
John Mohun, Chair; Greg Jellinek, M.D., Board Member

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

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

5. APPROVAL OF MINUTES OF: 04/20/2016

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Committee Education

6.1.1. Health and Safety Code § 31325(b)
General Counsel will provide Committee with education on the Health and Safety Code § 31325(b).

6.2. Contracts
New, amended, and auto renewed contracts are submitted to the Governance Committee for review and consideration for recommendation of approval by the Board of Directors.

6.2.1. Presentation on Upcoming Physician Contract Renewal Structure..... ATTACHMENT*
6.2.2. Gerald Schaffer – Professional Services Agreement Amendment..... ATTACHMENT
6.2.3. Ellen Cooper – Professional Services Agreement Amendment ..... ATTACHMENT
6.2.4. Julie Conyers – Professional Services Agreement Amendment..... ATTACHMENT

6.3. Policy Review
Governance Committee will review and discuss board policies.

6.3.1. ABD-21 Physician and Professional Service Agreements

6.4. Corporate Compliance Program

6.4.1. 1st Quarter 2016 Corporate Compliance Program Report
Governance Committee will review the 1st Quarter 2016 Corporate Compliance Program Report.

7. CLOSED SESSION

7.1. Approval of Closed Session Minutes: 04/20/2016

7.2. Hearing (Health & Safety Code § 32155)
Subject Matter: 1st Quarter 2016 Corporate Compliance Program Report – CLOSED SESSION
Number of items: One (1)

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE

The next Governance Committee meeting is scheduled for June 15, 2016 at 8:00 a.m.

10. ADJOURN

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

FINANCE COMMITTEE AGENDA

Monday, May 23, 2016 at 2:00 p.m.
Tahoe Conference Room, Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Dale Chamblin, Chair; John Mohun, Board Member

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

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 04/25/2016 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Financial Reports
- 6.1.1. Financial Report – April 2016 ..... ATTACHMENT
- 6.1.2. Quarterly Review of Multi-Specialty Clinics ..... ATTACHMENT
- 6.1.3. Quarterly Review of Truckee Surgery Center, LLC ..... ATTACHMENT
- 6.1.4. 2017 Budget Update

6.2. Board Education and Updates
- 6.2.1. Outmigration Strategy Update

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

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

9. NEXT MEETING DATE ..... ATTACHMENT

10. ADJOURN

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TAHOE FOREST HOSPITAL DISTRICT

PERSONNEL COMMITTEE-
RETIREMENT SUBCOMMITTEE
AGENDA

Thursday, May 12, 2016 at 10:00 a.m.
Tahoe Conference Room, Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Dale Chamblin, Board Member

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

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 2/11/2016..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Multnomah Group Retirement Plan Review

6.1.1. Investment and Investment Menu Review ..... ATTACHMENT
6.1.2. Plan Asset Review
6.1.3. Home Loan Discussion
6.1.4. In-Service Distributions

6.2. Fidelity Investments Annual Retirement Plan Review & Communication Plan..... ATTACHMENT
Fidelity Investments will provide the subcommittee with an update on 2015 insights and outcomes and the Annual Communication Plan.

7. CLOSED SESSION

7.1. Conference with Labor Negotiator (Gov. Code § 54957.6)
Agency Negotiator to Attend Closed Session: Jayne O'Flanagan
Employee Organization: Employee Association (Licensed) and Employee Association (Non-Licensed)

8. OPEN SESSION

9. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

10. NEXT MEETING DATE

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

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Personnel Committee will discuss its next meeting date.

11. ADJOURN

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TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 5/19/16

As a team we are very focused on the fundamentals of ever improving high quality, compassionate “sustainable” healthcare during the fastest change era in healthcare. We have tuned up our Mission, Vision and Values to be more teachable and to be more relevant to our team and to improve our focus and efficiency in all that we do as we serve our community. We have also been working on building solid foundations for service, sustainability and growth in our large OP Rehab program and in our very important Orthopedics program.

We also remain very focused on our 6 critical transformational strategies as well that I’ve shared in earlier CEO reports.

Our team is also working on a long list of business and physician contracts that need to be renewed.

We are actively engaged in our # 1 strategy which is a total makeover of physician services as no IP or OP hospital services would ever happen on an IP or OP basis without their first being a physician order for that care to be rendered. Here we are focused on moving in gradual thoughtful steps towards best practice, with a greater focus on production, quality, and upon increasing our focus on the value of the care we provide vs the volume of care provided with incentives to increase results in these areas.

As we increase the value of our physician service line, this means we are ever improving in our journey to proactive healthcare vs. the old model of reactive healthcare. This new proactive model of care seeks to keep residents in our district well or in ever improving health and to lower the frequency of ED visits or IP admits for medical issues. We as a system are committed to this journey even though the hospital portion of our system could see less ED visits or less IP admits from improvements in the value of care we provide outside of the hospital.

During this time of year we have been investing in very important team training and information sharing on our Mission, Vision, Values and our key Strategies to better serve our community and to be nimble for the rapid changes in healthcare which lie ahead. We have conducted 2 full days of training/strategy sharing and have another day of important training/strategy sharing coming up next month.

Important Update from Last Board Meeting:
We have completed additional independent confidential attorney client privileged research on our new important Orthopedics contract that was approved at our last BODs meeting and we

can say publicly that this “best practice” model contract in the healthcare industry does stay within the independently identified fair market range for orthopedics here within the District.

Core Principles I have followed since 1977:

My commitment has been from day one in my healthcare career has been and is to actively pursue all appropriate steps to deliver high quality, sustainable healthcare at the lowest possible cost for any community, region, state or group of states I have been responsible for in managing healthcare. As a team in many different locations we have been able to deliver on this core principle over and over in many locations of the US against great odds in many cases where we in fact made healthcare the least burdensome possible to all taxpayers and residents, performing well above what most observers ever thought possible.

Further when I share “healthcare change strategies” with any community over the past 39 years it is with a total unselfish intent that is focused solely on sustainable high quality healthcare for those communities even if that new strategy doesn’t preserve a job for me long term. What is most important in each community is sustainable healthcare and good access to quality healthcare. My hope is that all other individuals in our community can join me enthusiastically with this principle of unselfishness and love for our community and provide unselfish every growing community support to sustainable healthcare here in this district. The bottom line here is it’s not about me, it’s about how we can honor our residents with great sustainable care.

The challenges to sustainability will grow fiercely in the months and years ahead, so sustainability must never be taken for granted. If you research on Google, and type in 1/3rd of US hospitals will close by 2020, this should awaken every resident who desires sustainable healthcare. The goal of our team is to be among the strong and surviving healthcare systems not a part of the 33% who don’t. Other articles show that nearly 700 rural hospitals across America are at a high risk for closure.

It’s very easy to injure a healthcare system with incorrect decisions and exponentially expensive and time consuming to restore a healthcare system to health again. Some wrong decisions are fatal to healthcare systems. So we must do all in our power to avoid injury of a healthcare system.

We really value and appreciate our Private/Public Partnership with all residents as a District Hospital here in the Truckee/Tahoe region:

We really appreciate the strong community support over the approximate 65 years that Tahoe Forest has been in existence. We also remember the founding action by the Joseph family at the inception of hospital care here in the Truckee area after Mr. Joseph experienced a tragic loss in his family as they had to drive east for healthcare that wasn’t present in this community. This family and all other families who have donated land, made charitable donations, gave property taxes and who have supported Tahoe Forest as patients or in other ways, has really saved countless lives over these many years.

Today Tahoe Forest receives approximately $4.7 M in annual property taxes to cover our general obligation bonds which were approved by a super majority 72% vote of the district back in September of 2007. We also receive approximately $5.4 M in property taxes to support the general operations of TFHS for a grand total of approximately $10.1 M dollars.

This special Measure C ballot measure approved by approximately 72% of the voters of the district in September of 2007 says, ”To maintain[sustain, this word added by me] a full service hospital in our community; expand and enhance the Emergency Room to ensure access to lifesaving care; maintain critical medical services including pediatrics, maternity, long term care for seniors and cancer; and upgrade facilities that are outdated or do not meet state-mandated earthquake safety standards, shall Tahoe Forest Hospital District issue $98.5 million in bonds to improve healthcare facilities with an independent citizens’ oversight committee and all funds being spent on local projects.”

This official voice of the people with all due respect is binding on all team members at Tahoe Forest including all appointed and elected officials and upon all residents of the district until the year 2040 when the bonds are paid off, unless some person or persons step forward and pays them off earlier.

The sum of our Depreciation, Interest Expense, Principle payments on Debt and our Wellness Outreach programs total $18.5 M per year in relation to the just mentioned total of $10.1 M we receive from both categories of property taxes.

Stated another way, this very important and appreciated $10.1 M in property taxes equals 7.6% of our estimated annual expenses.

So approximately 92% of our expenses have to be covered by “other” traditional healthcare sources that all not for profit or for profit hospital participate in across CA and across the US. This is why we call it a private/public partnership for sustainable healthcare. Many districts operate almost entirely upon taxpayer sourced revenues. Also many districts in other industries do not provide a service regardless of the patient’s ability to pay.

I’ve had at least one resident say why can’t we have free healthcare, or discounted healthcare after all we believe we pay for at least all of the capital costs of healthcare here at this District hospital as taxpayers?

With all due respect, it’s true, we could opt out of Medicare, Medicaid and all commercial insurances and all of their accreditation and operating requirements and not bill any patients like a Shriner’s Hospital or St Jude’s Children’s Hospital but we would need to increase property taxes approximately 14 fold from present levels.

Today on a theoretical 600K assessed value home in our district, we receive approximately $78 dollars annually in property taxes based on County input for the general operations of the hospital. Separately we receive approximately $160 dollars on this same 600K assessed value home prior to our shared announcement last month of $15.8 M in property tax savings spread out over the next 24 years due to bond refinancing our team has initiated. So in total a 600K assessed home would generate approximately $238 dollars in total property taxes annually for this district hospital for which we are very appreciative on behalf of all residents who expect sustainable healthcare here in this region. Again this $238 dollar annual property tax amount on a 600K assessed value home will go down in future periods due to lower bond costs.

Community Education Section on How Does Healthcare Work, Why are Hospital Retail Prices so High -- Macro view – Next Month Micro view? See attachments!

This month I am providing an attachment which shows how goods or services typically purchased in other industries would have their pricing changed if all of sudden “hospital rules” were imposed on each of these industry segments and these industries had to bill retrospectively for all services, not knowing who would pay and who wouldn’t pay yet they must collect on average the current price listed. The footnotes are critical to read as well.

Next I have an attachment which shows the very large impact to high Retail Hospital Prices if we simply remove one dysfunctional element that all hospitals face across America except for Maryland, and that is the impact if we remove just the underinsured patient impact on hospital pricing. Maryland still has uninsured patients but no underinsured patients.

Next I show the “real value proposition” Tahoe Forest provides to all residents of the district from an aggregate or macro perspective vs. the CA Statewide average, the most important benchmark for any hospital in CA, in eyes of healthcare experts, and how does Tahoe Forest also compare to other local hospitals as well on a macro basis. This is irrefutable macro information that I examine on any hospital I manage from a sustainability perspective and I have had the privilege of managing more than 40 hospitals in CA and have studied the 360 or so hospitals that are available on OSHPD, a CA public data site over the years.

Next we take a look at the financial performance of County hospitals and then District hospitals in CA, both of which have elected Boards, in contrast to not for profit or for profit hospitals in the state who have skill set appointed boards. Clearly the governmental hospitals which include County and District hospitals, spoken of generically are at very high risk for non-sustainability and we want to be in the sustainability group!

Then we have slides which show the tremendous savings all inpatients and outpatients already experience at Tahoe Forest vs. all of CA and other hospital clusters in CA.

The last section is to share what is our experience on OP Medicare patients who are seen at Tahoe Forest and what percentage of these patients have any out of pocket costs and if they do, what are the stratified findings of any out of pocket costs.

Legislative Activities:

My team and I remain active monitoring all relevant state and federal legislation that could help or harm Tahoe Forest.

I would share as Tahoe Forest is licensed and accredited by the State of CA, and the federal government that all we do from a governance, management and clinical operations perspective is within the limitations of these state and federal accreditation and licensure requirements. So to really achieve healthcare reform our thoughtful efforts really need to be focused first at the state level, not at the local level and lastly at the federal level for true sustainable changes in healthcare.

Thank you.

What is the impact of "Hospital legal operating rules" being imposed on Other Industries?

Description	Estimated Private Sector Price	What would Price have to change to in CA if Hospital Rules are imposed? to collect the same monies on a weighted average basis?
Loaf of Bread in grocery store	3.00	12.00
Gallon of Milk in a grocery store	4.00	16.00
A new laptop computer	2,000.00	8,000.00
Local Attorney hourly rate	350.00	1,400.00
Paint and body shop repair on partially wrecked car	12,000.00	48,000.00
General Contractor asked to rebuild a burned down home	600,000.00	2,400,000.00

Note: Hospitals are the only private sector business in America who are required to provide a service regardless of the ability to pay! Only the State and Federal Court System and penal institutions have a similar duty! A hospital has to receive and treat all patients regardless of their ability to pay. It has to bill retrospectively for all services. If each of the above noted industries had to accept all customers and bill retrospectively, to have a math chance of collecting the average price they used to collect, their new retail pricing would have to as stated above based on the average CA hospital experience.

Are high hospital prices a root cause issue or a symptom of a very large problem in another area? Answer: They are a symptom of a very large problem elsewhere. So not solving the real root problem will never allow high retail prices for healthcare in CA and in all states except Maryland to go away. Free standing Lab, Imaging and Surgery Centers do not have to accept all customers as Hospitals do, nor are they open 24/7. These just mentioned business are highly inflationary to healthcare as supply and demand economic rules work in an opposite manner in healthcare vs any other industry due first to the obligation to provide a service regardless of the ability to pay and second due to excess capacity that existed within hospitals in the area for lab, xray and surgery services before these free-standing businesses existed.

In Maryland for over 40 years now they have had a "Federal and State Waiver" across all Payors What is the impact when Medicare, Medicaid and All insurances have to pay the same state prescribed rate unique to each hospital?

	California	Maryland
Estimated State wide IP Charges per Discharge	74,000.00	25,900.00
Estimated statewide collections per IP Discharge	18,500.00	22,792.00

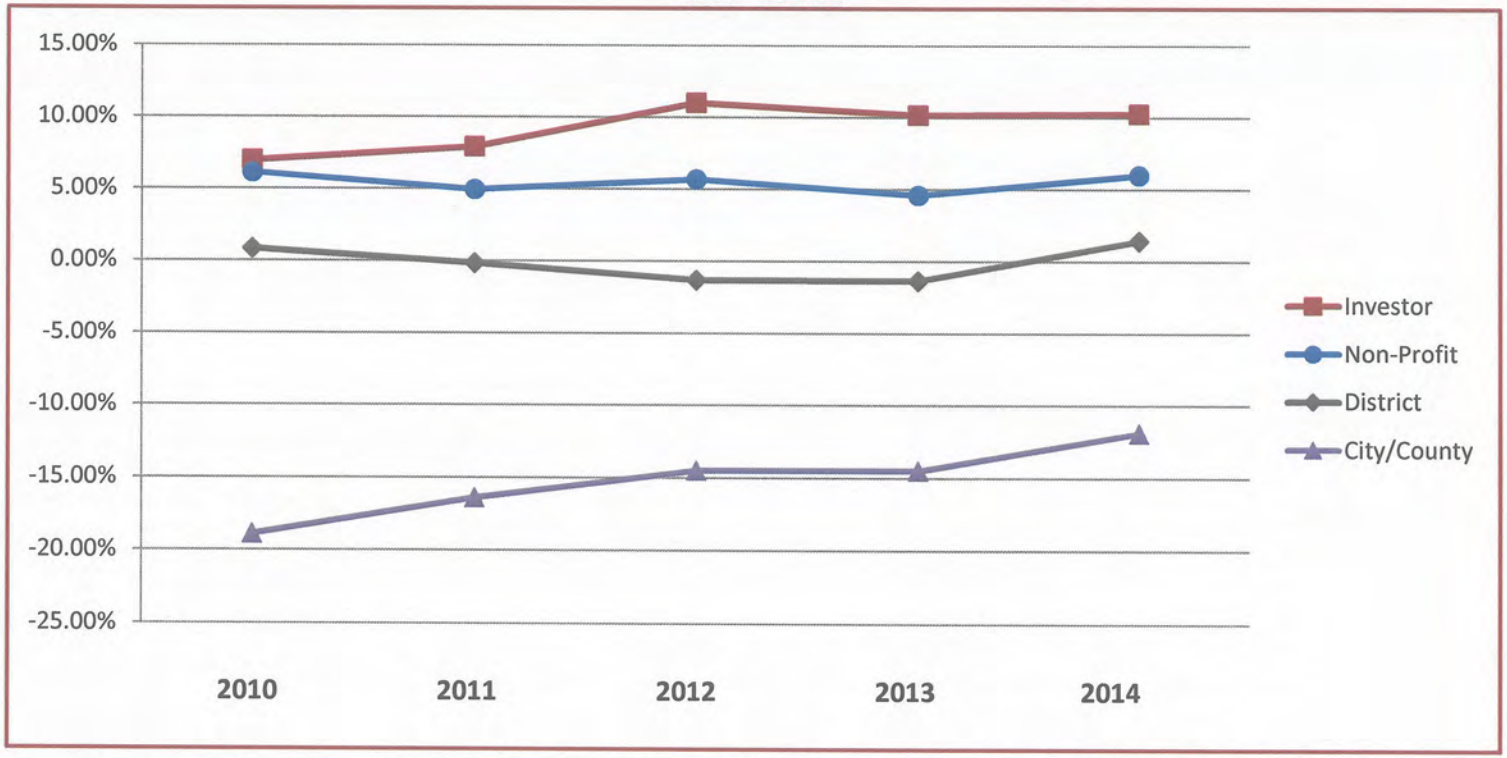
Note: Maryland has a policy for over 40 years now which states there shall not be any loss shifting on the losses of Medicare, Medicaid or any commercial insurance plan upon other commercially insured patients. So uniquely here Medicare, Medicaid and commercial insurances pay exactly the same custom built from the ground up reimbursement model for each of the 50 plus hospitals in the state. In all of the other 49 states over 80% of US hospitals lose money on Medicare and Medicaid patients plus incur the cost of care of the underinsured and from the uninsured. In Maryland there are no underinsured patients. There are uninsured but no underinsured patients. The above info is based on my actual experience working in Maryland several years ago and is intended to show how different policies can have very different results, so the amounts are for illustration purposes.

How Does Tahoe Forest Hospital Compare to Several Other Local Hospitals and the Statewide Average?

Description	CA Statewide Average	Tahoe Forest Hospital	Barton Memorial Hospital	Sierra Nevada Memorial Hospital	Sutter Auburn Faith Hospital	Marshall Medical Center	Sutter Roseville Medical Center	Southern Mono Healthcare	Renown Regional Medical Center	St. Mary's Regional Medical Center	Carson Tahoe Regional Med Ctr
Average IP Gross Revenue Per Discharge	73,875	37,668	61,204	61,011	47,944	97,581	63,275	53,331	54,672	47,541	44,977
Average OP Gross Revenue Per Visit	2,594	923	2,429	1,434	5,146	1,508	6,773	1,427	3,040	5,939	2,202
Average Gross Revenue Per ER Visit	n/a	3,780	6,852	5,236	5,117	9,121	5,982	3,082	7,502	2,872	3,436
Average Gross Revenue Per OP Surgery	n/a	6,833	9,131	10,801	12,434	7,793	11,404	15,433	20,371	23,373	10,642

Note: The CA Statewide average data comes from a 9/15/15 data extract from OSHPD Hospital Annual Disclosure Data Website: http://oshpd.ca.gov/HID/Hospital-Financial.asp#Profile. The Data for Tahoe Forest Hospital IP and OP Gross Revenue per Discharge or Per OP Visit comes from this just mentioned OSHPD source. Other CA or NV hospital data and other Tahoe Forest data comes from a data company in S. CA who can provide information if any person purchases work from their company. This source can be provided if a a person seeks to purchase their own independent research.

5B: Trends in California Hospital* Operating Margins by Type of Ownership 2010 -2014



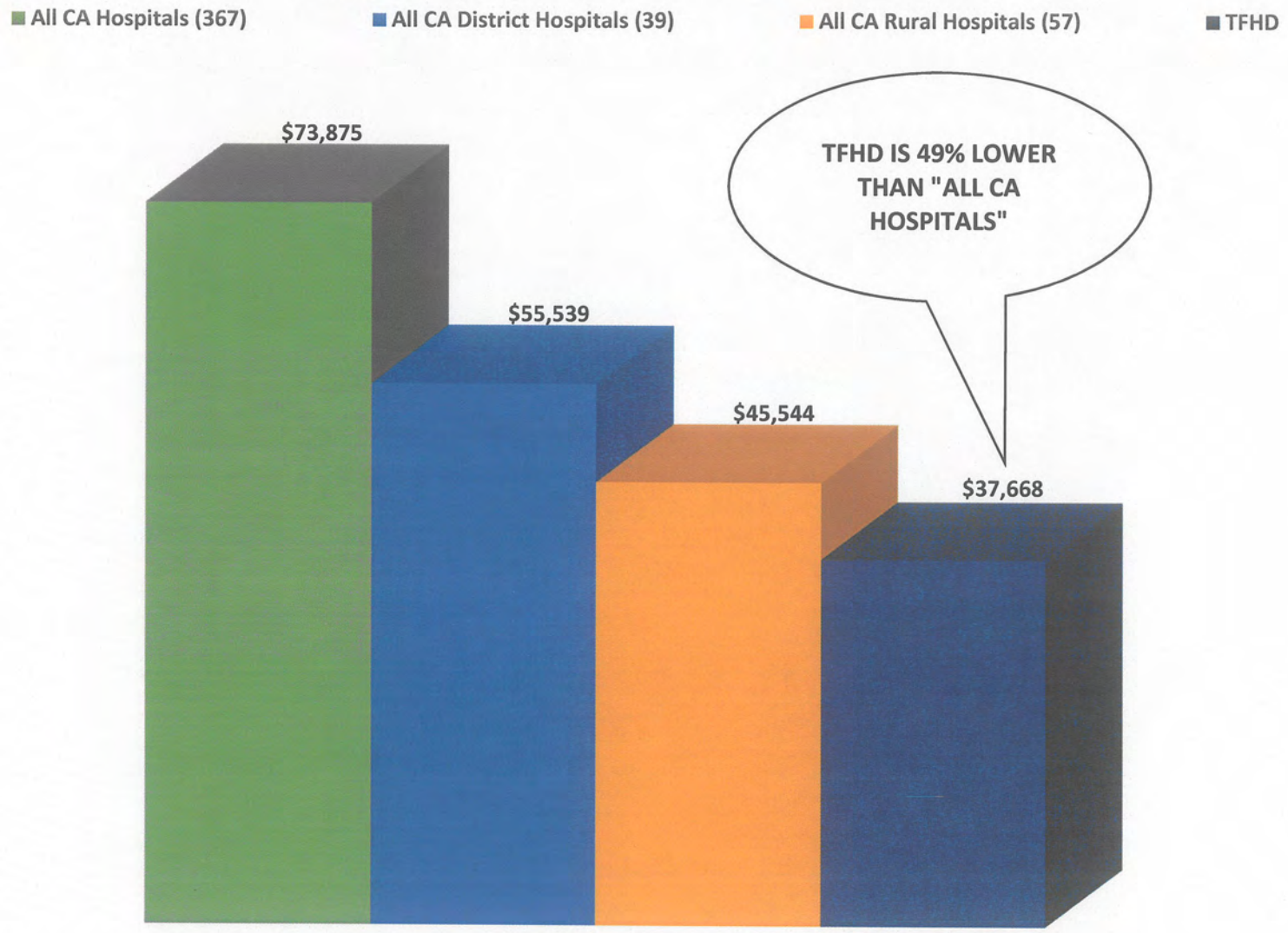
*Excludes Kaiser, Shriners, state hospitals, psychiatric health facilities, and hospitals with long-term care emphasis.

Type of Ownership	2010	2011	2012	2013	2014
Investor	6.95%	7.89%	10.99%	10.16%	10.25%
Non-Profit	6.12%	4.94%	5.67%	4.58%	5.98%
District	0.84%	-0.17%	-1.31%	-1.35%	1.42%
City/County	-18.92%	-16.41%	-14.53%	-14.52%	-11.93%

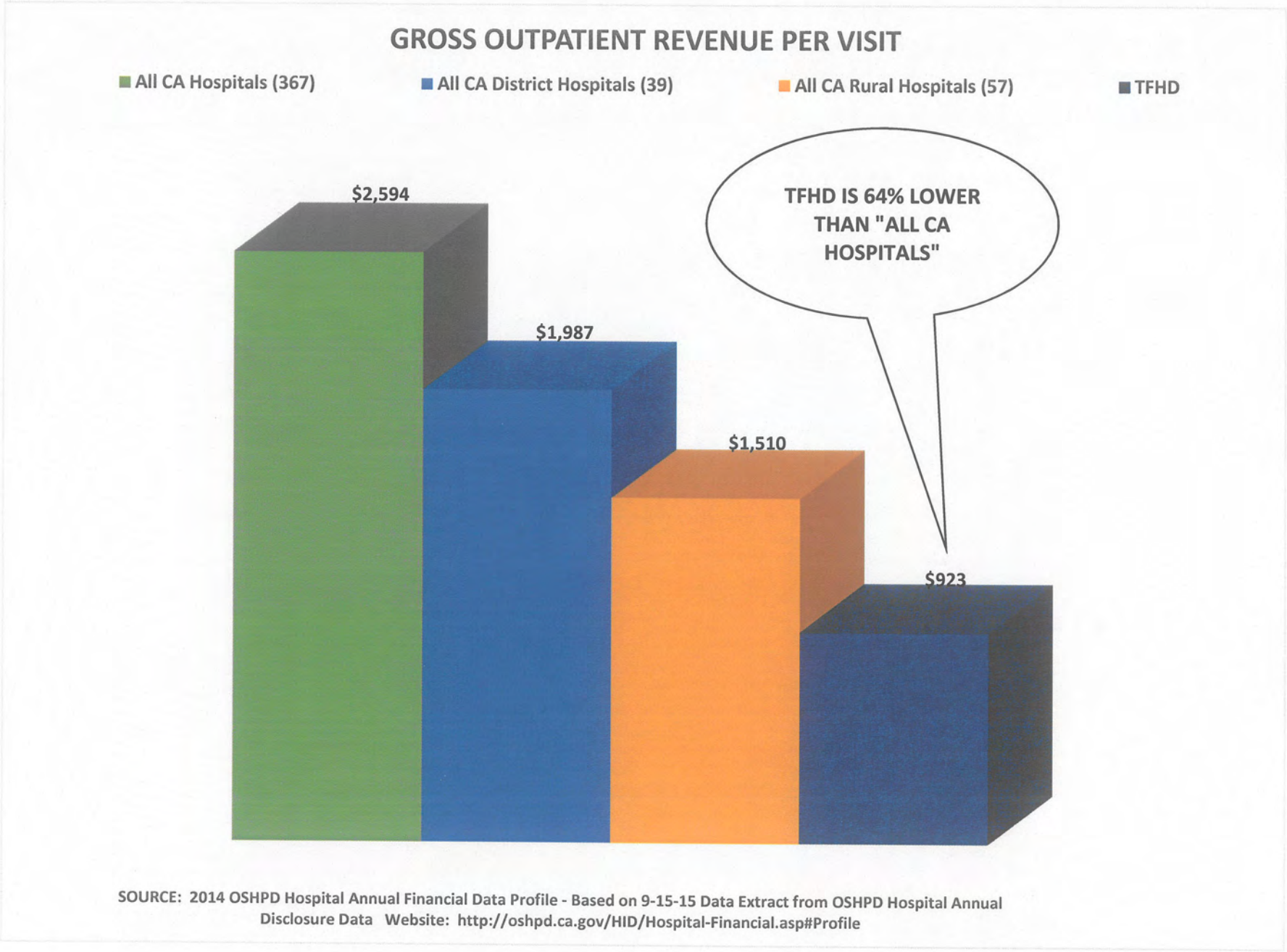
SOURCE: Office of Statewide Health Planning and Development, Hospital Quarterly Financial and Utilization Reports, 2010, 2011, 2012, 2013, and 2014 (April 24, 2015).

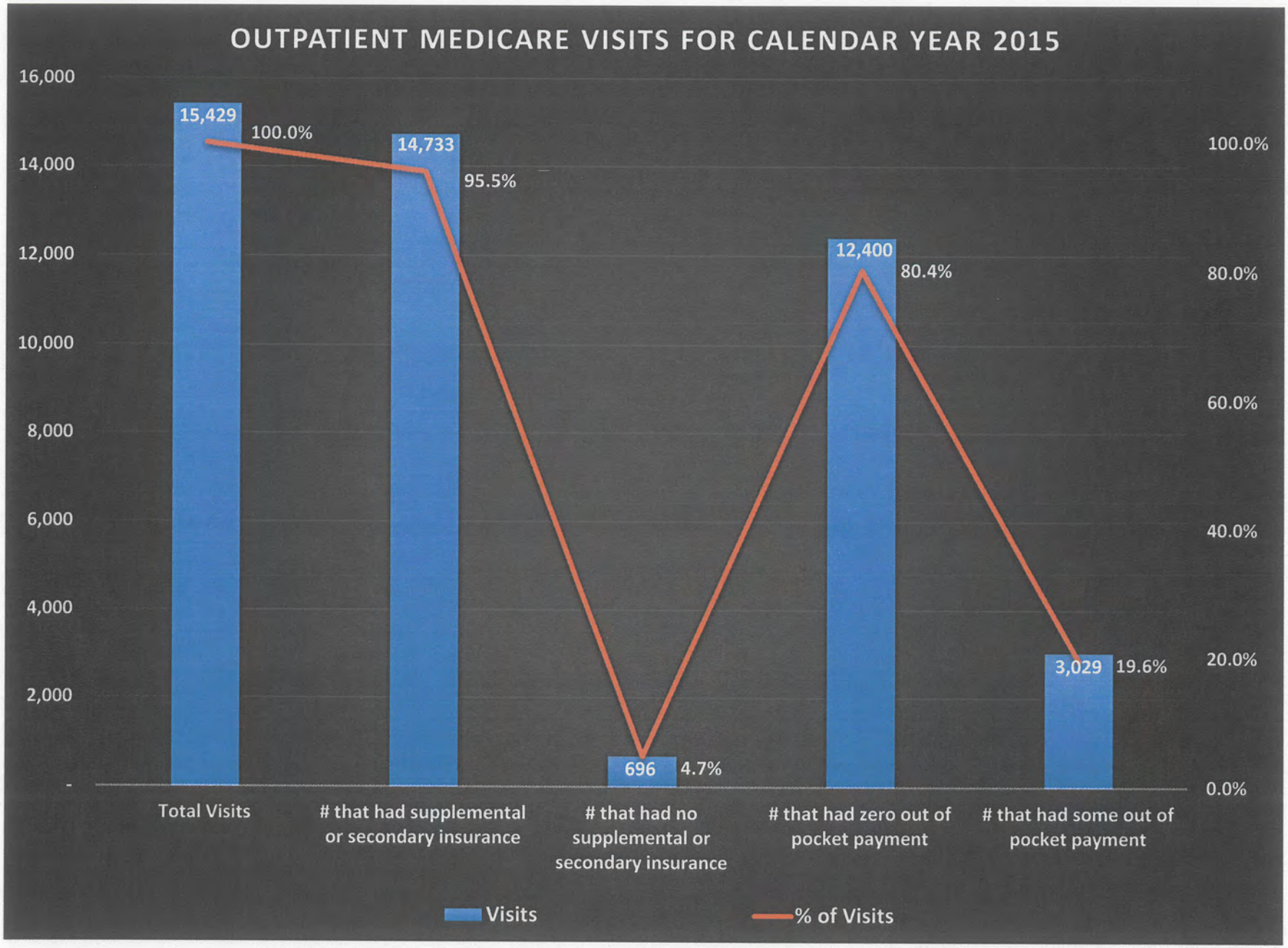
OSHPD
Office of Statewide Health Planning and Development

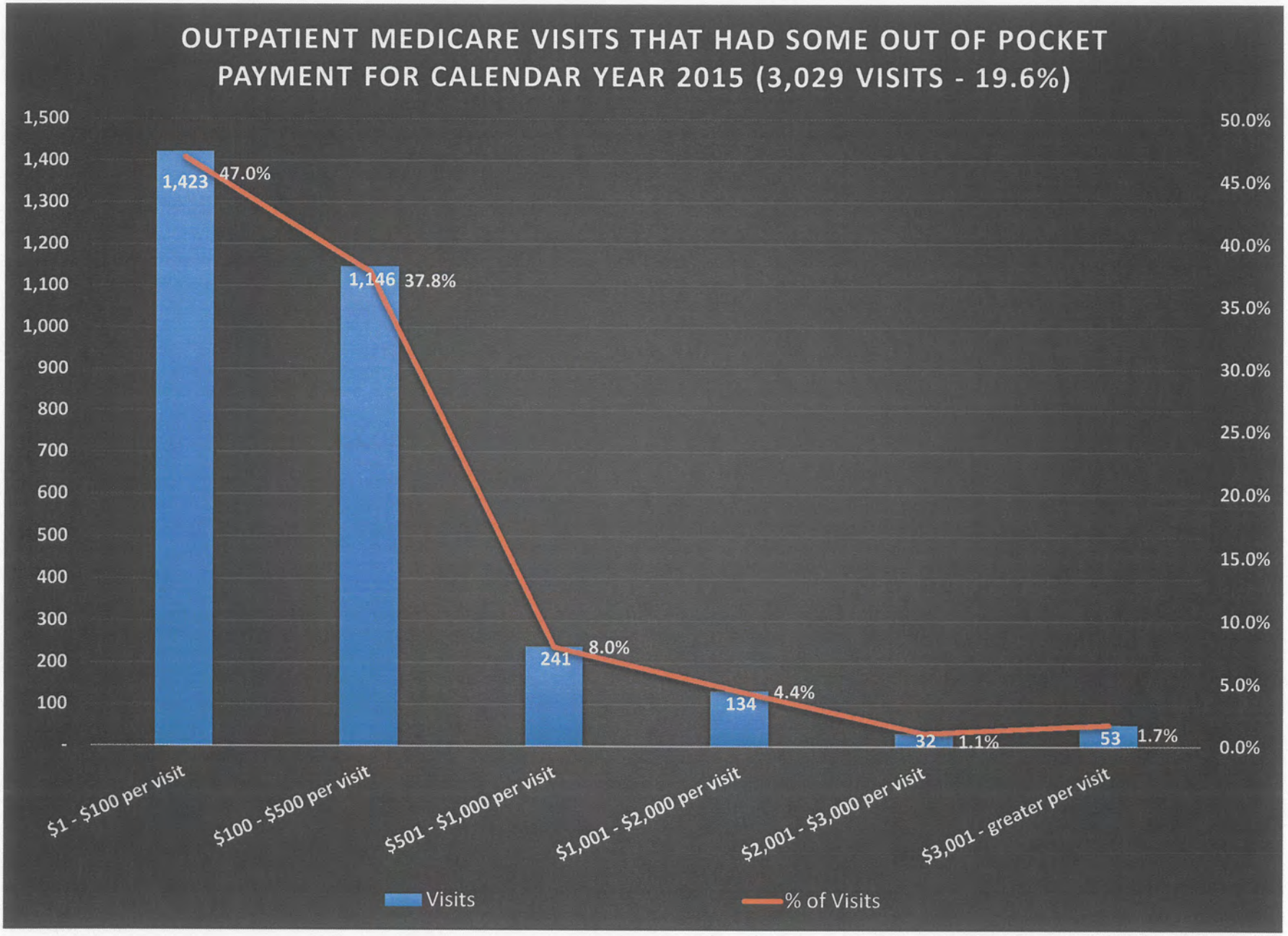
GROSS INPATIENT REVENUE PER DISCHARGE

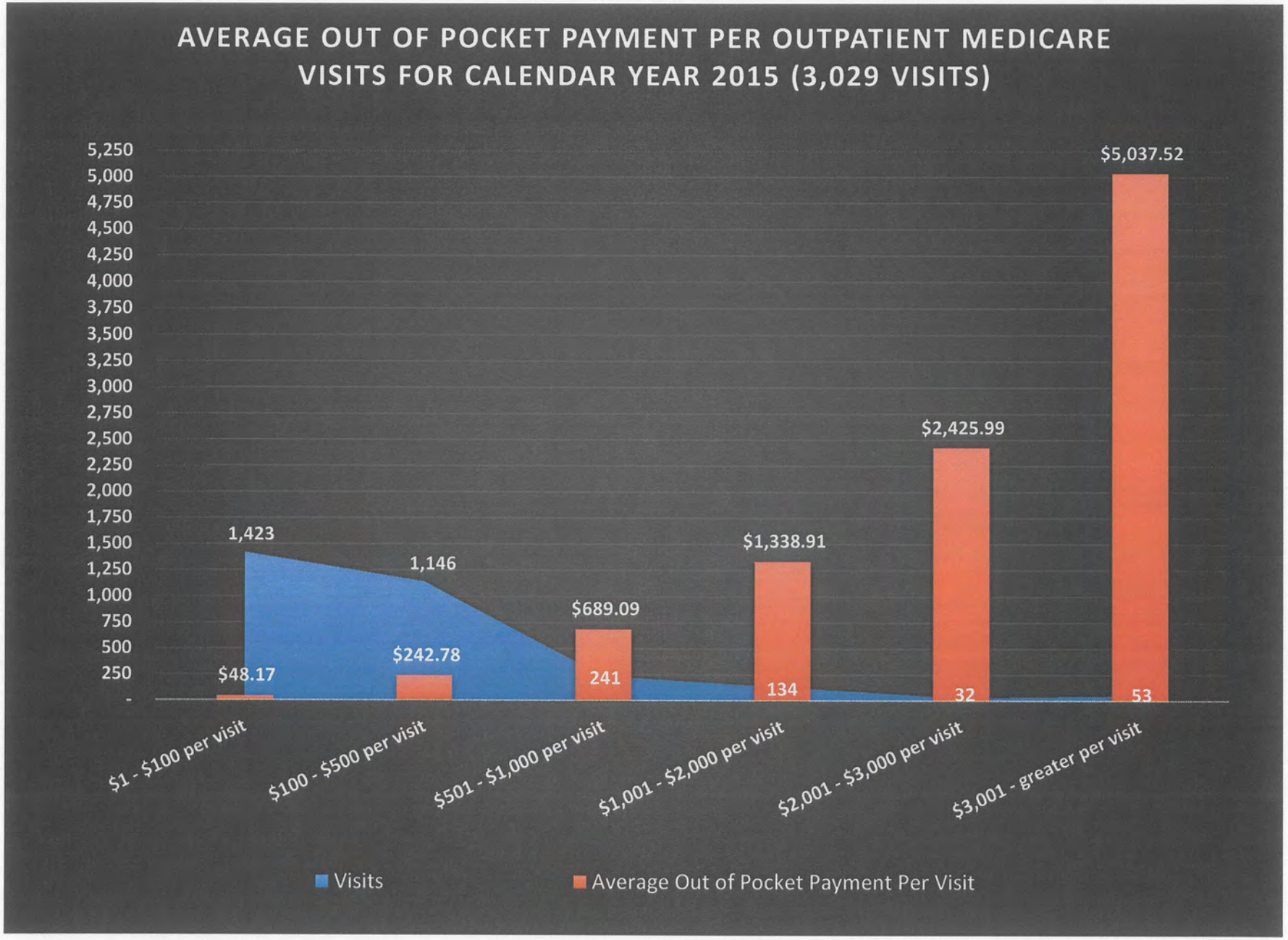


SOURCE: 2014 OSHPD Hospital Annual Financial Data Profile - Based on 9-15-15 Data Extract from OSHPD Hospital Annual Disclosure Data Website: http://oshpd.ca.gov/HID/Hospital-Financial.asp#Profile


GROSS OUTPATIENT REVENUE PER VISIT
All CA Hospitals (367)
All CA District Hospitals (39)
All CA Rural Hospitals (57)
TFHD
$2,594
$1,987
$1,510
$923
TFHD IS 64% LOWER THAN "ALL CA HOSPITALS"
SOURCE: 2014 OSHPD Hospital Annual Financial Data Profile - Based on 9-15-15 Data Extract from OSHPD Hospital Annual Disclosure Data Website: http://oshpd.ca.gov/HID/Hospital-Financial.asp#Profile


OUTPATIENT MEDICARE VISITS FOR CALENDAR YEAR 2015
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
-
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
15,429
100.0%
14,733
95.5%
696
4.7%
12,400
80.4%
3,029
19.6%
Total Visits
that had supplemental or secondary insurance
that had no supplemental or secondary insurance
that had zero out of pocket payment
that had some out of pocket payment
Visits
% of Visits


OUTPATIENT MEDICARE VISITS THAT HAD SOME OUT OF POCKET PAYMENT FOR CALENDAR YEAR 2015 (3,029 VISITS - 19.6%)
1,500
1,400
1,300
1,200
1,100
1,000
900
800
700
600
500
400
300
200
100
-
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
1,423
47.0%
1,146
37.8%
241
8.0%
134
4.4%
32
1.1%
53
1.7%
$1 - $100 per visit
$100 - $500 per visit
$501 - $1,000 per visit
$1,001 - $2,000 per visit
$2,001 - $3,000 per visit
$3,001 - greater per visit
Visits
% of Visits


AVERAGE OUT OF POCKET PAYMENT PER OUTPATIENT MEDICARE VISITS FOR CALENDAR YEAR 2015 (3,029 VISITS)
5,250
5,000
4,750
4,500
4,250
4,000
3,750
3,500
3,250
3,000
2,750
2,500
2,250
2,000
1,750
1,500
1,250
1,000
750
500
250
-
1,423
1,146
$48.17
$242.78
$689.09
241
$1,338.91
134
$2,425.99
32
$5,037.52
53
$1 - $100 per visit
$100 - $500 per visit
$501 - $1,000 per visit
$1,001 - $2,000 per visit
$2,001 - $3,000 per visit
$3,001 - greater per visit
Visits
Average Out of Pocket Payment Per Visit

TAHOE FOREST HOSPITAL DISTRICT

Board CNO/COO Report

By: Judith B. Newland **DATE: May, 2016**

Strategic Initiative 1. Patient Safety and Quality

The Incline Care Team, a new concept in consistent, quality family healthcare for the local Incline Village Community, was recently introduced. Led by Dr. Sutton-Pado, Family Medicine; Dr. Oleg Vayner, Pediatrician,; and Dr. Joshua Scholnick, Cardiologist and Internal Medicine, the Incline Care Team offers high quality, personalized medical for the individuals and their family. The Care Team is staffed by either a physician, a nurse practitioner or physician assistant. The new model improves access to local care, connecting and navigating patient of all ages.

The End of Life Option Act was signed into law in California and will take effect on June 9, 2016. The Act allows an adult who has been diagnosed with a terminal illness and who has a life expectancy of no more than six months to request and be prescribed an aid-in-dying drug, if specified conditions are met. In order to qualify for the aid-in-dying medication, the patient must have the capacity to make medical decisions for him/herself, be a resident of California, make three voluntary requests and have the ability to self-administer the medication. The Medical Staff Ethics Committee, comprised of medical staff, hospitals staff, community members and Board of Director are discussing the Act, benchmarking policies and procedures, and obtaining input from the medical staff community on this important Act.

The Clinical Leadership and Quality continue to monitor our HCAHPS scores with the expectation to return to a 5 star organization. Focused areas include: Quietness of Hospital Environment, Communication about Medication, Responsiveness of Hospital Staff, Cleanliness of Environment and Discharge Information Understanding. The inpatient units have improved their Quietness of Hospital Environment score, impressively ICU moved from a 25% Quietness of Hospital Environment satisfaction to a 89% Quietness of Hospital Environment. This improvement occurred through a process improvement initiative specific to Quietness of Hospital Environment. A performance improvement team continues to meet to work on all areas that need improvement.

A Late Charge Process Improvement Team has been implemented to decrease late charge entries in the revenue departments. We have begun by reviewing and understanding the processes for charges entry for charge entry for revenue departments. Improvement opportunities have been identified with the need to standardized process and work together to ensure late charge goals are met. It is the goal that no department has over 5% late charges.

Strategic Initiative 2.3 Conduct two-way communication with employees about health system goals, projects and priorities, conduct annual Town Hall Meetings.

Staff attended the Annual Employee Town Hall Meetings located at the Resort at Squaw Creek. These meetings included an education session on our Values, Senior Management presentations on Health System Strategic Initiatives and Goals and a question and answer session. Two sessions were made available for staff to attend with an additional session scheduled in June, each session being a full day.

Congratulations to Vanessa Childress, an RN for the Surgical Services Department, who received the honor of being the Nurse of the Year. This year nurses were also recognized for their commitment to the organization's values of QUEST. Those honored were Mike Davis, Surgical Services, for QUALITY; Bev Schnobrich, Case Management, for UNDERSTANDING; Vanessa Childress, Surgical Services, for EXCELLENCE; Mike Freed, IVCH for SERVICE; and Beth Pavone, Extended Care, for TEAMWORK. Nursing Management would like to extend a thank you to the Nurse Practice Council for organizing the annual event.

TAHOE FOREST HOSPITAL DISTRICT

CIO Board Informational Report

Jake Dorst
DATE: 5/17/2016

STRATEGIC INITIATIVE 4.0

Lab
- Scheduling site visit for Lab for June 9th week with possible new EHR vendor.
- Also a webex for Micro is being scheduled.

CPSI Evident Upgrade and Patches
- Copy of Production environment to Test underway in preparation for patch load.
- Once patches are loaded into the test system we will validate.

Agility Health
- Charge interface work has begun between the two EHR systems.

MD Staff Visit Importer
- All files have been sent.
- Validation to start next week.

M Modal Fluency for Transcription
- Interface testing with CPSI to start June 14. Resource obtained.
- Interface testing with Varian planned-initial call completed
- Go live date of Aug 1st.

AMION-Online Physician Scheduling and Secure Texting Software
- Project starting.

Press Ganey
- Working to automate this process to avoid future delays.

Storage
- Finalized a deal for new storage space from Cisco.

Security
- Currently interviewing 3 companies to perform this year's IT security Audit.
- Will engage with remote network and security monitoring added to our portfolio.

Tahoe Forest Hospital District

Board of Directors Meeting Evaluation Form

Date: _____

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

Please provide further feedback here: