TAHOE FOREST HOSPITAL DISTRICT

2023-10-26 Regular Meeting of the Board of Directors

Thursday, October 26, 2023 at 4:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2023-10-26 Regular Meeting of the Board of Directors

Agenda Packet Contents

Achievements
No related materials.

15. ITEMS FOR BOARD ACTION

15.1. 2023_TFHS_FoundationsofExcellence_Graphic_Draft4.pdf 116

ITEMS 16 - 21: See Agenda

22. ADJOURN

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, October 26, 2023 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
   - **5.1. Liability Claim (Gov. Code § 54956.95)**◈
     Claimant: Elisa Chapman
     Claim Against: Tahoe Forest Hospital District
   - **5.2. Hearing (Health & Safety Code § 32155)**
     Subject Matter: BETA SCOR Survey Action Plan Update
     Number of items: One (1)
   - **5.3. Hearing (Health & Safety Code § 32155)**
     Subject Matter: BETA HEART Validation Survey Action Plan
     Number of items: One (1)
   - **5.4. Conference with Real Property Negotiator (Gov. Code § 54956.8)**
     Property Parcel Numbers: 018-570-063 & 018-570-060
     Agency Negotiator: Louis Ward
     Negotiating Party: Gateway Village Truckee, LLC
     Under Negotiation: Price & Terms of Payment
   - **5.5. Approval of Closed Session Minutes**◈
     5.5.1. 09/20/2023 Special Meeting
     5.5.2. 09/28/2023 Regular Meeting
   - **5.6. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: Medical Staff Credentials

APPROXIMATELY 6:00 P.M.

6. **DINNER BREAK**

7. **OPEN SESSION – CALL TO ORDER**

◈ Denotes Action Item

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

10. INPUT – AUDIENCE

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

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. MEDICAL STAFF EXECUTIVE COMMITTEE◈

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

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

Revised Privilege Form:

- *General Surgery Privilege Form*

Revised Policies:

- *Immunizations Vaccinations for Medical Staff and Allied Health Professional Staff, MSGEN-1603*
- *Neonate – Patient Admission Care and Discharge of, DWFC-1449*
- *Neonate – Late Preterm Newborn, DWFC-1486*

13. 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.

13.1. Approval of Minutes of Meetings

13.1.1. 09/20/2023 Special Meeting ..... ATTACHMENT
13.1.2. 09/28/2023 Regular Meeting ..... ATTACHMENT

13.2. Financial Reports

13.2.1. Financial Report – September 2023 ..... ATTACHMENT

13.3. Board Reports

13.3.1. President & CEO Board Report ..... ATTACHMENT
13.3.2. COO Board Report ..... ATTACHMENT
13.3.3. CNO Board Report ..... ATTACHMENT
13.3.4. CMO Board Report ..... ATTACHMENT
13.3.5. CIIO Board Report ..... ATTACHMENT
13.3.6. CHRO Board Report ..... ATTACHMENT

13.4. Approve Board Policy

13.4.1. Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policy, ABD-09 ..... ATTACHMENT

◈ Denotes Action Item

14. ITEMS FOR BOARD DISCUSSION

14.1. Surgical Services & Optum Report ..... ATTACHMENT
The Board of Directors will receive a report on Surgical Services and work performed by Optum.

14.2. Public Notices for Seismic Compliance Plan & Structural Performance Category Ratings ..... ATTACHMENT
The Board of Directors will receive public notice of the District's Seismic Compliance Plan and Structural Performance Category Ratings.

14.3. Celebrating Excellence: A Year of Outstanding Achievements
The Board of Directors will receive a presentation on Fiscal Year 2023 Accomplishments.

15. ITEMS FOR BOARD ACTION

15.1. Updated Foundations of Excellence..... ATTACHMENT
The Board of Directors will review and approve the District's Foundation of Excellence.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17. BOARD COMMITTEE REPORTS

18. BOARD MEMBERS REPORTS/CLOSING REMARKS

19. CLOSED SESSION CONTINUED

19.1. Public Employee Performance Evaluation (Government Code § 54957)
Title: President & Chief Executive Officer

20. OPEN SESSION

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

22. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is November 16, 2023 at Tahoe Forest Hospital – Eskridge Conference Room, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting. Materials related to an item on this Agenda submitted to the Board of Directors, or a majority of the Board, after distribution of the agenda are available for public inspection in the Administration Office, 10977 Spring Lane, Truckee, CA 96161, during normal business hours.

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

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Clerk of the Board at 582-3481 at least 24 hours in advance of the meeting.

◈ Denotes Action Item

AGENDA ITEM COVER SHEET

ITEM	Medical Executive Committee (MEC) Consent Agenda
RESPONSIBLE PARTY	Johanna Koch, MD Chief of Staff
ACTION REQUESTED	For Board Action

BACKGROUND:
During the October 19, 2023 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the October 26, 2023 meeting.

Revised Policy

- General Surgery Privilege Form

Revised Policies

- Immunizations Vaccinations for Medical Staff and Allied Health Professional Staff, MSGEN-1603
- Neonate – Patient Admission Care and Discharge of, DWFC-1449
- Neonate – Late Preterm Newborn, DWFC-1486

SUGGESTED DISCUSSION POINTS:
None.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the Medical Executive Committee Consent Agenda as presented.

TAHOE FOREST HOSPITAL DISTRICT
Department of Surgery
Delineated Privilege Request

SPECIALTY: GENERAL SURGERY **NAME:** _____
(Please print)

- ☐ **Tahoe Forest Hospital (TFH)**
- ☐ **Multi-Specialty Clinic (MSC)**

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

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

Basic Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in General Surgery.
Board Certification:	Board certified or board eligible by the American Board of General Surgery required (or AOA equivalent Board); or attain Board Certification within five years of completion of residency or fellowship training program.
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has performed 100 procedures as primary surgeon in the past 12 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. At least one peer reference must be a general surgeon.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA. • Malpractice insurance in the amount of $1m/$3m. • Current, unrestricted DEA certificate in CA (approved for all drug schedules). • Current State of California Department of Health Services fluoroscopy certificate required for selected (*) procedures • Ability to participate in federally funded program (Medicare or Medicaid). • Current verification as an ATLS (Advanced Trauma Life Support) provider

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

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery Name: _____

APPLICANT: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **At this time, privileges are available only at Tahoe Forest Hospital and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

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

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL SURGERY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria Based on Current demonstrated competence and provision of care. Insufficient activity may require proctoring and/or additional CME
☐	☐	**Core privileges in General Surgery**: Admit (including swing admissions, ECC, and critical care unit per rules and regulations,), perform history and physical, consultations, work up, and provide pre-operative, operative and post-operative care to patients of all ages to correct or treat various conditions, illnesses, injuries, and disorders in areas of primary surgical responsibility. Core privileges also include the following; Anorectal procedures: Hemorrhoidectomy Sphincterotomy/sphincteroplasty Drainage procedure for anorectal abscess Fistula repair Occult Blood Testing Repair of rectal prolapse Pilonidal cystectomy Sinus treatment - Transanal removal of rectal tumors/polyps Breast procedures: Biopsies Mastectomy, segmental Axillary dissection Esophagus procedures: Anti-reflux procedure (lap or open) Esophageal diverticulectomy Repair of perforation Esophagectomy Esophagogastrectomy Esophageal bypass Operation for esophageal stenosis General abdomen procedures: Paracentesis Exploratory laparotomy Drainage of intra-abdominal abscess Retroperitoneal lymphadenectomy Adrenalectomy General vascular procedures: Amputations- upper and lower extremity Central venous access catheters * Portacaths using fluoroscopy* Portacaths using flat plate imaging Genitourinary/OB-GYN procedures: Hydrocelectomy Nephrectomy Ureteral surgery Cystostomy Cystectomy Hysterectomy	_____	**TFH**	1ST case proctored and 4 add'l representative cases proctored	100 cases/2 years Related CME

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name: _____**

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL SURGERY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria Based on Current demonstrated competence and provision of care. Insufficient activity may require proctoring and/or additional CME
		Salpingo-oophorectomy **Core (continued):** Head and neck procedures: Lip and tongue surgery Temporal artery biopsy Thyroglossal ducts Tracheostomy Gland surgery – submandibular and parotid Brachial cleft surgery Thyroidectomy (partial or total) Parathyroidectomy Hernia procedures: Inguinofemoral, umbilical Ventral Incisional Intestinal procedures: Enterectomy Repair of perforation Ileostomy Pyloroplasty Appendectomy Colectomy (partial or total) Colectomy with ileoanal pull-through Colostomy closure Abdominoperineal resection Repair of perforation Operative choledochoscopy Liver/Biliary Tract procedures: biopsy Hepatic resections * Cholecystectomy (with or without cholangiograms) with fluoroscopy* Cholecystectomy (with or without cholangiograms) with flat plate imaging Common bile duct exploration Choledochoenteric anastomosis Choledochoscopy Pancreas/Spleen Drainage of pancreatic abscess Pancreatic resection Drainage of pancreatic pseudocyst Pancreaticojejunostomy Splenectomy Pediatric procedures General surgical procedures including appendectomy, hernia, and GI procedures Stomach (no obesity surgery - see separate section for lap banding): Gastrostomy (open) Gastric resection Repair of perforation				

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name:** _____

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL SURGERY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria Based on Current demonstrated competence and provision of care. Insufficient activity may require proctoring and/or additional CME
		Vagotomy (truncal or selective with drainage procedure) Pyloromyotomy Miscellaneous procedures: Arterial Lines Biopsies CVP lines Cystorrhaphy Excision/repair/graft for skin/soft tissue tumors Miscellaneous procedures (continued): Incision and drainage of abscess Major lymphadenectomies Management of trauma (e.g., chest, abdomen, extremity, head and neck) Peritoneal dialysis Simple and complex suture repair and excision of benign skin lesions Skin lacerations/split thickness skin grafts Swan ganz catheter insertion * Temporary transvenous pacemaker insertion with fluoroscopy* Temporary transvenous pacemaker insertion with flat plate imaging Thoracic procedures for trauma/ hemostasis Ventilatory management *** Denotes procedures above that require a fluoroscopy permit**				
☐	☐	**Core privileges in General Surgery (OUTPATIENT)**: Evaluate, diagnose and treat surgical patients including consultations, work up, and provide pre-operative, care to patients of all ages to correct or treat various conditions, illnesses, injuries, and disorders in areas of primary surgical responsibility. Core privileges also include the following; • Lipoma removal • Skin lesion removal • Punch biopsies • I&D of wounds • Packing of wounds • Wound Vac care • G-tube change and removal • Minor debridement • Hemorrhoids		Outpt Clinic		
☐	☐	REMOVAL FROM CORE PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of Core privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. **If extensive list of exclusions, initial and cross out above.** _____ _____				
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.** **In those areas with multiple procedures, initial and cross out those you are NOT requesting**	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria Based on Current demonstrated competence and provision of care . Insufficient activity may require proctoring and/or

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name: _____**

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL SURGERY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria Based on Current demonstrated competence and provision of care. Insufficient activity may require proctoring and/or additional CME required CME
☐	☐	**Endoscopy/Gastroenterology:** Bronchoscopy Capsule endoscopy Colonoscopy with/without biopsy EGD – with biopsy, hemorrhage control, * ERCP – with sphincterotomy, stent placement, nasobiliary drain placement, stone extraction, lithotripsy, or biopsy * Esophageal stent placement Flexible sigmoidoscopy (with/without biopsy)/rigid sigmoidoscopy/anoscopy Foreign body removal, sclerotherapy and banding of upper GI varices Laryngoscopy Percutaneous endoscopic gastrostomy Percutaneous Liver biopsy Peritoneoscopy for diagnosis and treatment Colonpolypectomy Proctosigmoidoscopy General surgery training/certification and documentation of experience and training supporting the privileges requested *** Denotes procedures that require a fluoroscopy permit**	_____	TFH	1st case proctored and 4 add'l cases representative cases proctored	30 cases/2 years
☐	☐	**Dilation with bogie** Documentation of experience/training including 10 supervised dilations	_____	TFH	1 case proctored	2 cases/2 yeas
☐	☐	**Thoracic procedures for:** Drainage of empyema Pulmonary resection Thoracic aorta Thoracic esophagus Thoracoscopy/Thoracotomy Plication of pulmonary blebs Decortication Completion of ACGME/AOA accredited training program in general surgery, AND Completion of approved fellowship—training program in general thoracic surgery, OR Documentation of training and experience for consideration (Medical Staff Office will obtain)	_____	TFH	1st case proctored	20 cases/2 years
☐	☐	**Fluoroscopy:** Current State of California Department of Health Services fluoroscopy certificate is required for endoscopic and vascular privileges. [Must provide copy]	_____	TFH	None	Maintenance of current fluoro certificate and utilization of privileges requiring fluoro
☐	☐	**Intravenous Procedural Sedation** (see attached credentialing criteria)	N/A	TFH	Successful completion of competency test (initial appointment)	Maintain privileges requiring this procedure
☐	☐	**Lap Banding** _____ Included in residency/fellowship program (must be confirmed), OR,	_____	TFH	2 cases proctored	30 cases/2 years

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name: _____**

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL SURGERY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria Based on Current demonstrated competence and provision of care. Insufficient activity may require proctoring and/or additional CME
		_____ Documentation of approved course including didactic and hands on surgery and evaluation of procedures performed (including laparoscopic experience) And documentation of 15 procedures performed in past 12 months				

☐	☐	**Vascular Surgery: (initial and cross out those that you are not requesting)** Aneurysm repair – abdominal aorta, and peripheral vessels (emergent and elective) Cervical, thoracic, or lumbar sympathectomy Diagnostic biopsy or other diagnostic procedures on blood Vessels Embolectomy or thrombectomy for all vessels excluding coronary and intracranial vessels Endarterectomy for all vessels excluding coronary and intracranial vessels Extracranial carotid and vertebral artery surgery Hemodialysis access procedures Intraoperative angiography Intraoperative angioplasty, balloon dilatation (peripheral only) Other major open peripheral vascular arterial and venous reconstructions Reconstruction, resection, repair of major vessels with anastomosis or replacement (excluding cardiopulmonary, intracranial) Sclerotherapy Thoracic outlet decompression procedures, including rib Resection Vein ligation and stripping Venous reconstruction Venous RF Ablation, stripping, phlebectomy Completion of an ACGME/AOA accredited five year residency training program in General Surgery plus one year of dedicated vascular surgery training/fellowship**;** OR, Completion of an ACGME accredited program in vascular surgery and is ABMS board qualified or certified in vascular surgery; AND, Provision of letters from the Chief of Vascular Surgery and/or Chief of Surgery at the applicant's current hospital attesting to current competence in vascular surgery (Medical Staff Office will request the letters). May be requested to submit a representative sample of discharge summaries and/or operative notes for major vascular surgery reconstructions or management of vascular surgery problems over last two years	_____	TFH	1st case proctored plus 4 add'l representative cases proctored	20 cases/2 years Vascular CME

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name: _____**

		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

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

_____ _____

Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

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

□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

_____ _____

Date Department Chair Signature

Modifications or Other Comments:

_____

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

□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

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

□ privileges as requested □ with modifications (see attached description of modifications) □ not approved (explain)

PURPOSE:

The purpose of this policy is to protect the health and safety of employees, patients, family members, and the community as a whole by ensuring that current Medical Staff and Allied Health Staff (*Health Care Professionals) are immune to vaccine preventable diseases.

POLICY:

A. The Federal Advisory Committee on Immunization Practices (ACIP), the Centers for Disease Control (CDC) and the California Department of Public Health (CDPH) make recommendations for vaccine administration to healthcare personnel. There are no federal or state laws that require healthcare personnel to accept any vaccination. However, those who choose not to be vaccinated must sign a *declination form for the particular vaccine and follow the procedure below (See "Procedure"). The following vaccines are required per Aerosol Transmissible Disease (ATD) and Blood Borne Pathogen (BBP) standards:

1. **Hepatitis B**
    a. Proof of 3 vaccines
    b. OR proof of immunity (do not draw titer unless it is 1-2 months following the 3rd vaccine).
    c. Physician may *decline this vaccine, but it is being offered free of charge for those who are at risk of coming in contact with blood and other potentially infectious body fluids.
2. **Measles, Mumps, and Rubella (MMR)**
    a. Proof of 2 vaccines
    b. OR laboratory evidence of immunity (Titers)
3. **Varicella (Chicken Pox)**
    a. Proof of 2 vaccines
    b. OR history of Varicella from a physician
    c. OR laboratory evidence of immunity (Titers)
4. **Influenza**
    a. Proof of current year's vaccination.
    b. Education on annual influenza is provided at the time of new physician orientation.
    c. *Declination of annual influenza requires that a surgical mask be worn while working throughout the flu season as defined by the County Health Officer.
5. **Tdap**
    a. Proof of one time vaccination booster.
6. **TB Screening**
    a. No previous history of a positive screening
        i. TB Risk Assessment Form annually, and
        ~~a.~~ii. QuantiFERON Blood Test every 3 years
        ~~i. Two step TB skin test~~
        ~~ii. OR Quantiferon blood test result~~
    b. History of positive TB screening in past:
        i. Show proof of chest x-ray (one view is acceptable) and provide history of review of symptoms related to TB.
        ii. Must complete the TB Symptom Review Form annually as the TB screening
7. **Effective February 2022, proof of full COVID-19 Vaccine.**

B. Tahoe Forest Hospital District ("TFHD"), through Occupational Health Services, will ensure that all healthcare personnel are offered immunizations/vaccines based on the recommendations and guidelines from ACIP, CDC, and CDPH.

C. Health Care Professionals ("HCPs") not employed by TFHD may be eligible for MMR, Varicella, Hepatitis B and Tdap vaccines at low or no cost, in accordance with the TFHD policy on

Professional Courtesy Discounts for Health Care Professionals.

PROCEDURE:

The prevention and control of infections is a shared responsibility among all clinical and non-clinical people in the hospital.

A. Medical Staff Services will maintain the record of immunity status for all HCPs not employed by TFHD. Occupational Health will maintain the record of immunity status for all HCPs employed by TFHD.
B. All HCPs will receive a flu/influenza vaccination annually per Tahoe Forest Hospital District policy.
C. Upon initial credentialing application, applicants are required to provide proof of immunity and TB screening.
D. All HCPs are required to have an annual TB screening per TFHD.
E. The District will provide other immunizations on a case by case basis following exposure/events.
F. *If declination of vaccines is requested for religious or other reasons, the request must be in writing and provided to the Medical Staff Services office who will provide it to the Occupational Health nurse to make a determination whether the request is acceptable and will notify the Medical Staff Services office of the medical exception. Medical Staff Services will maintain a record of any approved medical exceptions for all HCPs not employed by TFHD. If a declination is accepted, the Medical Staff Services office will notify the HCP and the HCP's appropriate department manager who will monitor the unvaccinated HCP to ensure the HCP is wearing a mask (for flu) to protect patients. Restrictions on presence in the facility may be placed on the HCP at any time based upon current exposures.
G. The privileges of those HCPs who do not begin the vaccination schedule or receive a medical exception will lapse until they meet this requirement.
H. All current HCPs will follow the procedures listed above for continuation of privileges.

Special Instructions / Definitions:

Health Care Professional ("HCPs) means members of the Tahoe Forest Hospital or Incline Village Community Hospital Medical or Allied Health Professional Staff or Residents, or medical students; or, applicants requesting Medical or Allied Health Professional Staff membership and privileges, or Residents who request clinical privileges.

References:

Immunization and Immunity Testing Recommendations, California Department of Public Health; AICP guidelines for "Evidence of Immunity", www.cdc.gov/vaccines/hcp/acip-recs/index.html, www.immunize.org/acip, Title 8 Section 5199

Status **Draft** PolicyStat ID **13728651**

Origination Date	N/A	Department	Women and Family Center - DWFC
Last Approved	N/A	Applicabilities	Tahoe Forest Hospital
Last Revised	N/A		
Next Review	N/A		

Neonate - Patient Admission Care and Discharge of, DWFC-1449

RISK:

A thorough assessment should be performed within 24 hours of birth to identify any abnormality that would alter the newborn course or identify a medical condition that should be addressed during the first days of after birth. The assessment includes a review of the maternal, family, and prenatal history and a complete physical examination.The optimal length of hospital stay (LOHS) varies for each mother-infant pair and should be long enough to permit detection of early neonatal problems and to ensure that the family is able and prepared to care for the infant at home. Factors involved in this decision include the health of the mother, the health and stability of the infant, the ability and confidence of the mother to care for the infant, the adequacy of support systems at home, and access to appropriate follow-up care.

POLICY:

A. All observations, care and necessary treatments of the Newborn as well as all Parent/Guardian education will be completed and documented during the hospitalization of the newborn.

B. Verification of the completion of all necessary treatments/procedures and parent education will be confirmed prior to the Newborn being discharged from the hospital.

PROCEDURE:

A. **Care at Birth**

1. At every delivery there will be at least one member of the healthcare team whose primary responsibility is the newborn and who is capable of initiating resuscitation per the Neonatal Resuscitation Program (NRP) guidelines.
    a. Assemble and check newborn resuscitation supplies and equipment in

anticipation of the birth.

b. Before delivery, review the mother's admission history and assessment record and labor course for any risk factors such as prematurity, known fetal anomalies, maternal substance use, abnormal fetal heart rate patterns, and presence of meconium. Collection of any unreported data or prenatal labs should be completed.

c. Follow the American Academy of Pediatrics Neonatal Resuscitation Guidelines (NRP) for stabilization of newborn.

d. Dry and stimulate the newborn immediately after birth on the mother's chest or under the radiant warmer as indicated.

e. Promote newborn thermoregulation with skin-to-skin contact. If the newborn is placed under the warmer for 15 minutes or longer, place a covered temperature probe on the abdomen or chest soft tissue, and set the warmer to 36.5°C on servo skin mode. If the temperature of the newborn is falling, increase the servo set point to 37°C until the temperature rises.

f. Document the servo set point with each temperature assessment.

g. Determine the infant's Apgar score at 1 and 5 minutes of age. Continue to assign Apgar scores every 5 minutes, up to 20 minutes of age, until a score of 7 or higher is obtained.

h. Obtain a rectal temperature, apical heart rate, and respiratory rate. Apply newborn identification bands and security device before the mother and infant are separated.

i. Allow the newborn to remain with the mother continuously, unless the infant's clinical condition requires transfer to Level I nursery.

j. Admit newborn in Electronic Medical Record (EMR).

2. The transfer of a neonate born in an outside facility to TFHD requires a physician to physician hand-off report to determine appropriateness of admission and provide acceptance of admission. Following physician to physician communication, the House Supervisor shall be notified of the incoming admission to assess and coordinate bed availability and assignment.

3. For the admission of an outborn neonate (those born at home or in a vehicle prior to arrival to Hospital), Follow Standardized Procedure: Healthy Newborn Admission, DWFC-1803 with notification of pediatrician during rounds unless otherwise indicated by standardized procedure.

B. **Transition**

1. The transition period begins after immediate stabilization, and lasts until the newborn is stable for at least 2 hours. Assessments of the infant may take place in the mother's arms.

2. Every 30 minutes, assess:

a. Temperature (rectal preferred)

b. Apical heart rate
c. Respiratory rate
d. Type of respiration
e. Skin color
f. Adequacy of peripheral circulation
g. Activity level
h. Level of consciousness
i. Tone

3. Educate all parents on the benefits of breastfeeding.
4. Help the mother to breastfeed without time limits.
5. Assist with positioning, latch and comfort.
6. Assess infant suck, swallow, and breathe synchrony.
7. If the mother chooses to bottle-feed the infant, limit the first intake to 5–15 ml.
8. Administer eye prophylaxis and Vitamin K as ordered within 2 hours of age.
9. Obtain birth measurements including weight, length, and head circumference.
10. Obtain a blood glucose level if indicated, per Tahoe Forest Hospital District Newborn Blood Glucose Monitoring/Screening Algorithm.
11. Per physician orders, collect and hold cord blood on all babies for one week. Send for type and Rh if mother is O or Rh negative with direct Coombs if indicated.
12. Per physician orders, obtain H&H between 4-6 hours of newborn age for all newborns born to a mother symptomatic of polycythemia or with history of placental abruption or previa.
13. Complete a full assessment, including cardiovascular, respiratory, HEENT, neurological, genitourinary, gastrointestinal, musculoskeletal, and integumentary systems.
14. Follow Standardized Procedure: Healthy Newborn Admission, DWFC-1803.

C. **Ongoing Care**

1. Newborn should remain with the mother unless clinical condition warrants transfer to a higher level of care (Level I nursery or tertiary care center).
2. Assess temperature, pulse, respirations, and pain (using NIPS) at least every 6 hours and within 4 hours of discharge. A rectal temperature needs to be demonstrated to parents including education on normal parameters.
3. Assess color, respiratory effort, cardiac, nutritional intake, urinary and bowel elimination, and neuromuscular status at least every 6 hours.
    a. Any newborn with a persistent respiratory rate greater than 60 or signs of labored breathing/respiratory distress (grunting, flaring, or retracting) and/or with questionable color may be further assessed with periodic oximetry.

b. Hold oral feeding for newborns with a respiratory rate greater than 60 breaths per minute, while intervening to correct the tachypnea.

4. Complete a full system assessment (including cardiac, respiratory, musculoskeletal, HEENT, integumentary, genitourinary, gastrointestinal, and genitalia) once per 12–hour shift.
5. Weigh daily. Notify physician during rounding, if >3% weight loss from previous weight or ≥ 7% total weight loss since birth.
6. Administer hepatitis vaccine and HBIG (when indicated) per physician orders, and with parental consent.
7. Encourage and assist mothers to breastfeed on demand (at least 8-12 feedings/day), with no more than 4-5 hours between feedings.
8. Formula-fed newborns should feed on demand (at least 8-12 feedings/day), gradually increasing formula volume as indicated by newborn hunger and satiation cues.
9. Keep umbilical cord stump clean and dry. Fold down the top of the diaper as needed to avoid irritation. Do not use alcohol on the cord.
10. Collect urine and meconium for neonatal drug screen per policy: WFC – Testing for Suspected Substance Abuse- Mother, DWFC-1497
11. Circumcision care with each diaper change (when indicated).
12. Bathing should be delayed until 6-24 hours post birth, once temperature has stabilized, and as needed during hospital stay.
13. All Infants will be screened for elevated bilirubin levels per physician orders, with appearance of jaundice prior to 24 hours of age, as needed per nurse discretion, and pre-discharge, following policy Neonate Transcutaneous Bili Monitoring, DWFC-1460.

D. **Deviation from Normal Assessment Parameters**

1. Any deviation of temperature, pulse, and/or respirations from normal limits should warrant reassessment within 30–60 minutes including a rectal temperature, initiating further assessment with pulse oximetry when indicated. Notify the physician if the reassessment remains outside normal limits or sooner if indicated.
2. Normal values and assessment data include:
    a. Respiratory rate of 30 to 60 breaths per minute
    b. Heart rate of 100 to 160 beats per minute
    c. Regular cardiac rhythm
    d. Axillary temperature between 97.6° F and 99.0° F
    e. Pulse oximetry between 90% or greater (after the first 10 minutes of life)
    f. Absence of jitteriness, lethargy, or excessive sleeping
    g. Bowel sounds without distention or bilious vomiting
    h. Meconium stool within 48 hours after birth

i. Voiding within 24 hours after birth

E. **Discharge Criteria**

1. Discharge of the term newborn will not be considered prior to 24 hours of age. The infant will be ready for discharge if meeting the following requirements:
    a. Vital signs are within normal ranges and are stable for at least 12 hours before discharge.
    b. The infant has urinated and passed at least one stool spontaneously.
    c. Well established feeding plan.
    d. Newborn hearing screening has been completed, unless other arrangements for follow-up have been made.
    e. All infants will be screened for critical congenital heart defects before discharge. If the pulse oximetry screening is positive, a complete clinical evaluation by a licensed independent practitioner is necessary and requires transfer to a tertiary care facility.
    f. If the infant was circumcised, there is no evidence of excessive bleeding at the circumcision site for at least two hours.
    g. Confirmation that an appropriate car seat has been obtained and the parents have demonstrated to hospital personnel the ability to place the infant in the proper position.
        i. Car seat testing completed, when directed by the physician.
    h. The care giver has received education and demonstrated competency in the care of the infant.
    i. Medical follow-up appointment scheduled for 1-4 days after discharge to recheck weight, feeding adequacy, and assess for jaundice.
        i. If the infant is discharged before 48 hours after delivery, a follow-up appointment should occur within 48 hours. If an appropriately timed follow-up appointment cannot be ensured then discharge should be deferred until an appointment can be made.
        ii. Instruct parents on appointment scheduling procedures and expected time-frame for follow-up should discharge occur during off-hours or follow-up is to be completed with an outside facility.
    j. Confirmation that family members or other support persons, including health care professionals, are available to the mother and her infant after discharge.
    k. Family, environmental, and social risk factors have been assessed and addressed (eg, substance abuse, child abuse or neglect, domestic violence, mental illness, lack of social support, lack of reliable income). Barriers to follow-up care are assessed and addressed (eg, transportation, access to telephone communication).

2. Once all above mentioned discharge criteria have been met, removal of the infant security device and identification bands may take place per policy guidelines, Postpartum - Patient Care and Discharge of, DWFC-1466

Documentation:

All documentation to be completed in the electronic medical record (EMR)

RESPONSIBILITY:

It is the responsibility fo the Pediatrician to perform a thorough evaluation within 24 hours of birth to identify any abnormality that would alter the newborn course or identify a medical condition that should be addressed during the first days of life. The assessment includes a review of the maternal, family, and prenatal history and a complete physical examination.

It is the responsibility fo the nursing staff caring for the newborn to provide optimal routine care, which begins in the delivery room, includes promoting early bonding with skin-to-skin contact and early initiation of breastfeeding, and monitoring the clinical status to determine whether further intervention is required, reporting any abnormal findings to the pediatrician as necessary.

It is the responsibility of the nursing staff caring for the newborn to complete all routine care task including prophylactic administration of vitamin K1, erythromycin ointment, hepatitis B vaccination (HBV), universal newborn screening for hearing loss and disorders that are threatening to life or long-term health (PKU and CCHD), assessing newborns for hyperbilirubinemia and hypoglycemia, and provide feeding assistance.

Related Policies/Forms:

Neonate - California Department of Public Health Screening, DWFC-1435, Child Safety Seats, ANS-20, Standardized Procedure - Healthy Newborn Admission, DWFC-1803, Neonate - Hearing Screen, DWFC-1442, Neonate - Circumcision Procedure, Postpartum - Breastfeeding Support, DWFS-1462, Neonate - Critical Congenital Heart Defect Screening, DWFC-1439, Neonate – Transcutaneous Bili Monitoring, DWFC-1460, WFC – Testing for Suspected Substance Abuse- Mother, DWFC-1497, Newborn Blood Glucose Monitoring/Screening Algorithm. Postpartum - Patient Care and Discharge of, DWFC-1466

References:

American Academy of Pediatrics, & American College of Obstetricians and Gynecologists. (2007). *Guidelines for perinatal care* (6th ed.). Washington, D.C.: Authors.

AWHONN Templates for Protocols and Procedures for Maternity Services 2013

UpToDate: Overview of the routine management of the healthy newborn infant

Attachments

Glucose Management of the Newborn.docx

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **13728634**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A
Department	Women and Family Center - DWFC
Applicabilities	Tahoe Forest Hospital

Neonate - Late Preterm Newborn, DWFC-1486

RISK:

Late preterm infants born at a gestational age (GA) between 34 weeks and 0 days, and 36 weeks and 6 days and have an increased risk of temperature instability, respiratory distress, hypoglycemia, hyperbilirubinemia, low APGAR scores, sepsis, feeding difficulties, and increased length of stay. To add, feeding on demand, without interventions, can be associated with progressively poor feeding and a greater than 10 percent weight loss within the first few days, warranting vigilant assessment and care.

POLICY:

A. All observations, care and necessary treatments of the Late Preterm (LPT) Newborn as well as all Parent/Guardian education will be completed during the hospitalization with verification of completion prior to discharge.

PROCEDURE:

A. Prior to Delivery
    1. Review maternal admission history and physical assessment and labor course for any additional risk factors such as maternal diabetes (all types), known fetal anomalies, maternal substance use, abnormal fetal heart rate patterns, prolonged rupture of membranes (greater than 18 hours), intrapartum fever, positive or unknown GBS status, gestational Hypertension, anemia etc.
    2. Notify all necessary delivery personnel.
        a. An NRP Certified RN and/or Respiratory Therapist (RT) shall be at the bedside at time of delivery.
        b. When possible, an additional RN will be present at delivery for newborn care.

c. The pediatrician shall be alerted to all anticipated high risk deliveries with attendance requested at delivery, when appropriate.

3. All equipment for support and resuscitation of the infant should be prepared and checked prior to delivery, ensuring that appropriately-sized newborn resuscitation supplies are available and functioning, including an oxygen blender and pulse oximeter.
4. Preheat the radiant warmer, blankets, and towels.
5. Increase the room temperature to 79–81 degrees F (26–27 degrees C).

B. At the Time of Delivery:

1. Initiate stabilization and immediate care of the newborn, assisting Pediatrician/RT as needed.
2. This may be completed on the mother's chest, unless resuscitative efforts are necessary, in which case neonatal resuscitation and assessment will be done on radiant warmer prior to placing infant skin to skin with mother. Basic NRP and STABLE guidelines are to be followed.
    a. If a radiant warmer is needed to assess and stabilize the late preterm infant, place a covered temperature probe on the abdomen or chest soft tissue and set the warmer to 36.5°C on Servo/Skin mode.
    b. Assess for signs of respiratory distress (retractions, cyanosis, nasal flaring, or grunting). The respiratory rate of the late preterm infant may be irregular and/or rapid (60-80 breaths per minute, or up to 100 for a limited time) during the first 15 minutes of life.
    c. Notify Pediatrician (if not in attendance) of any signs of respiratory distress.
    d. Administer supplemental oxygen as needed based on the late preterm infant's pre-ductal SpO2 values compared to the targeted values during the first 10 minute of life.

C. Transitional Care, 0-2 hours of life:

1. Monitor respiratory rate and type, tone, heart rate, temperature (rectal), and activity every 30 minutes until stable for a minimum of 2 hours.
2. Promote newborn/maternal/family bonding, early and frequent breastfeeding.
    a. Begin breastfeeding as soon as possible when medically stable within the first hour of life without time limits.
    b. If baby does not feed well in first two hours, teach and assist mother in hand expression and collect in cup, spoon or syringe. Give to newborn.
    c. If baby is unstable and separated from mother: teach hand expression. Begin pumping or hand expression within 6 hours after birth to establish mother’s milk supply.
    d. If the mother chooses to bottle feed, provide education on formula feeding, limiting the first intake to 2-10 ml.

3. Administer eye prophylaxis and Vitamin K per Physician orders.
4. Initiate Blood Glucose Management on all preterm neonates (less than 37 weeks) and Early Term infants if indicated. Monitor the infant closely for signs of hypoglycemia.
    a. Follow the TFH Hypoglycemia Algorithm.
    b. Feeding should be initiated within 1 hour of age with initial POC glucose completed 30 minutes after initiation of feeding, (preferably within the first hour and no longer than 2 hours after birth).
5. Complete a full system assessment including: cardiovascular; respiratory; HEENT; neurological; genitourinary; gastrointestinal musculoskeletal; and integumentary systems within the first two hours. Document gestational age, weight, length, and head circumference.
6. Complete a gestational age assessment using the Ballard Score Form within 12 hours of birth or sooner (if late or no prenatal care).
7. Notify Pediatrician of birth, assessment, gestational age, presence of risk factors, and current condition (if not previously in attendance).
8. Delay the first bath until temperature, heart rate, and respiration have stabilized at least 6 to 24 hours of birth. Bathing at 24 hours after birth is recommended by the World Health organization (WHO) and AWHONN.
    a. Minimize heat loss during bath by bathing under the radiant warmer using warm towels and water warmed to 100-104 degrees F (38-40 degrees C).
    b. Place infant skin-to-skin with mother after bath to maintain warmth. Apply hat after bathing.

D. Initial 2-24 Hours:

1. Newborn should remain with the mother unless clinical condition warrants transfer to Level I nursery, higher level of care, or mother otherwise indicates.
2. Assess temperature (rectal), oxygen saturation, heart and respiratory rates every 4 hours.
3. Assess color, respiratory effort, cardiac, nutritional intake, urinary and bowel elimination, and neuromuscular status at least every 6 hours.
    a. Notify the Pediatrician of any signs of respiratory distress, persistent respiratory rate greater than 60, grunting, retracting, pallor, or oxygen saturation <90% sustained for >60seconds.
    b. Hold oral feeding for newborns with a respiratory rate greater than 60 breaths per minute while intervening to correct the tachypnea.
    c. Continue to follow the THF Hypoglycemia Algorithm for the first 24 hours
        i. Obtain a POC Glucose every 2-3 hours (preferably before feeding)
        ii. Routine screening may be discontinued following 3 consecutive values within normal limits with the exception of infants that are

Late Preterm (LPT), Small for Gestational Age (SGA) or of Low Birth Weight <2500gm (LBW).

a. LPT, SGA, and LBW infants require an additional POC Glucose 6-8 hours following the third normal value (prior to feeding) and again at 24 hours of age (with the newborn screen).

d. Weigh daily. Reweigh and notify physician if weight is >3% ± previous weight or ≥ 7% total weight form birth.

e. Encourage breastfeeding on demand. Do not allow late preterm and early term infants to go any longer than 3 hours between feeds.

i. Sometimes it may be necessary to wake the baby if he or she does not indicate hunger cues, which is not unusual in the late preterm infant and some early term infants. Teach parents early feeding cues. Teach mother and recommend hand expression and feeding colostrum after each feed.

ii. Encourage and teach mom to hand express and/or use breast pump within 6 hours of birth and continue at least 4 times/day.

iii. Show the mother techniques to facilitate effective latch with careful attention to adequate support of the jaw and head. Educate the mother about breastfeeding her late preterm infant (e.g., position, latch, duration, early feeding cues, breast compressions, etc.)

iv. If formula fed, feed on demand or at least every 3 hours gradually increasing amounts as indicated by newborn hunger and satiation cues.

f. Daily Transcutaneous Bili: use Bili tool for risk assessment. If the Bili Tool algorithm indicates the newborn is in the high Intermediate risk zone, obtain a Total Serum Bili and notify Pediatrician.

E. Feeding Plan:

1. The infant should be breastfed (or breastmilk fed) 8 to 12 times per 24-hour period. The mother will need to hand express her milk and give it to the baby using alternative feeding methods if the baby is not able to effectively breastfeed. Do not allow late preterm and early term infants to go any longer than 3 hours between feeds.
2. Supplementation (ideally with colostrum) is to be routinely implemented in the following scenarios:
    a. Poor reserve evidenced by temperature instability or hypoglycemia
    b. Poor feeding as evidenced by LATCH score of less than 7 or less than 10 minutes actively feeding at the breast, not resolved by 12 hours of age.
    c. Weight loss more than 3% per day, or more than 7% total (to be assessed by physician and lactation consultant on a case by case basis).

3. If supplementing, the mother should pump and/or hand express milk after breastfeeding, up to six to eight times per 24 hours, until the baby is breastfeeding well to establish and maintain her milk supply.
    a. Frequency of pumping to be evaluated on a case by case basis related to milk supply.
    b. Use of a hospital-grade electric pump is recommended. Milk production may be increased by hand massage and compression of the breasts while pumping.
    c. Provide mother with the anticipatory guidance that pumping should continue until the infant is at least 38 weeks gestation and gaining weight without supplementation.
4. Feeding plan should be written in detail in the medical record with a copy provided to the family.
5. To avoid conflicting advice to mother and family about the feeding plan, a multidisciplinary approach between the patient, physicians, nursing staff and lactation consultant should be accomplished.
6. At 24 - 48 hours of age, re-evaluate need to add formula depending on criteria above: 24 hour weight loss and volume of expressed breastmilk available. Total supplemental volumes per age should fall in the below ranges:
   Time Intake (mL/feed)
   1st 24 hours 5–10
   24–48 hours 10-15
   48-96 hours 15-30
   72-96 hours 30-60
7. Re-evaluate feeding plan daily while infant is hospitalized.
8. If ineffective latch/milk transfers, after 24 hours consider the use of an ultrathin silicone nipple shield to aid the baby in attaining effective latch. If a nipple shield is used, the mother and baby should be followed closely (inpatient and outpatient) by a trained lactation consultant.

F. Normal Assessment Parameters:
    1. Normal assessment parameters include:
        a. Respiratory rate of 30 to 60 breaths per minute
        b. Heart rate of 100 to 160 beats per minute
        c. Axillary temperature between 36.5 C (97.7 F) and 37.4 C (99.3 F)
        d. Pulse oximetry between 90% and 95% (after the first 10 minutes of life)
        e. Regular cardiac rhythm
        f. Absence of jitteriness, lethargy, or excessive sleeping
        g. Bowel sounds without abdominal distention or bilious vomiting
        h. Meconium stool within 48 hours after birth
        i. Voiding within 12 hours after birth

j. Coordination of sucking, swallowing, and breathing during feeding.

2. Notify the physician if the assessment is outside of normal limits.
3. All POC Glucose readings < 35 mg/dl require lab confirmation
    a. Follow THF Hypoglycemia Algorithm
    b. Place an order for a STAT Glucose and notify lab at ext. 3401
    c. Notify Pediatrician.
    d. Do not delay treatment while awaiting confirmation result.
    e. Administer Dextrose Gel per Dosage chart
    f. Feed infant (if appropriate)
    g. Recheck POC Glucose 1 hour after Gel administration

G. Discharge Criteria:

1. Discharge of the Late Preterm Infant will not be considered prior to 48 hours of age. The LPT infant will be ready for discharge if meeting the following requirements:
    a. Thermal stability for more than 24 hours.
    b. Well established feeding plan.
    c. Confirmation that an appropriate car seat has been obtained and the parents have demonstrated to hospital personnel the ability to place the infant in the proper position.
        i. Car seat testing completed, when ordered by the physician. see policy entitled: Neonate - Car Seat Challenge Test
    d. If the infant was circumcised, there is no evidence of excessive bleeding at the circumcision site for at least two hours.
    e. The care giver has received education and demonstrated competency in the care of her infant.
    f. Follow up scheduled for the day after discharge with either the Breastfeeding Support Group or Lactation consultant when possible.
    g. Make an appointment for medical follow-up 1-2 days after discharge to recheck weight, feeding adequacy, and assess for jaundice.
    h. Confirmation that family members or other support persons, including health care professionals, are available to the mother and her infant after discharge.
    i. Family, environmental, and social risk factors have been assessed and addressed (eg, substance abuse, child abuse or neglect, domestic violence, mental illness, lack of social support, lack of reliable income). Barriers to follow-up care are assessed and addressed (eg, transportation, access to telephone communication).
    j. Recommended primary care follow-up weekly until corrected gestational age of 40 weeks

Documentation:

All documentation to be completed in the Electronic Medical Record (EMR), with the exception of the Ballard Score Form (this will be scanned into the EMR at a later date).

RESPONSIBILITY:

It is the responsibility of the Obstetrician to avoid induced vaginal or planned cesarean delivery prior to 39 weeks gestation unless medically indicated.

It is the responsibility of all clinicians who care for late preterm infants need to be aware that these infants are at increased risk for neonatal morbidity and mortality. They need to be familiar with the associated complications of late preterm birth and provide appropriate intervention.

It is the responsibility of the Pediatrician to determine the accurate gestational age, and ensure that there are no abnormalities or medical conditions (ie, poor feeding and/or hyperbilirubinemia) that require further hospitalization prior to discharge.

It is the responsibility of the W&F nursing staff to educated parents that their infant is at increased risk for hyperbilirubinemia, feeding difficulties, and dehydration. Teaching should focus on developing the parents' ability to recognize these conditions and seek appropriate care after hospital discharge.

Completion of other routine newborn care is the responsibility of the nursing staff providing care for the late preterm newborn. This includes screening tests (ie, hearing, critical congenital heart disease, and other disorders that are threatening to life or long-term health), vaccinations (ie, hepatitis B vaccine), and prophylactic treatment (ie, vitamin K prophylaxis).

Related Policies/Forms:

Neonate - Car Seat Challenge Test, DWFC-1436

Neonate - Neonatal Hypoglycemia Management Guideline, DWFC-1506

Labor - Delivery Nurse's Roles and Responsibilities, DWFC-1411

References:

UpToDate: Late preterm infants,

Boyle, E. M., Johnson, S., Manktelow, B., Seaton, S.E., Draper, E.S., Smith, L.K., Dorling, J., Marlow, N., Petrou, S. and Field, D.J. (2015). Neonatal outcomes and delivery of care for infants born late preterm or moderately preterm: A prospective population-based study. Arch Dis Child Fetal Neonatal Ed, 100 (6), F479-F485.

Boies, E.G., Vaucher,Y.E & Academy of Breastfeeding Medicine (2016). ABM Clinical Protocol #10: Breastfeeding the Late Preterm (34–36 6/7 Weeks of Gestation) and Early Term Infants (37–38 6/7 Weeks of Gestation), Second Revision 2016. Breastfeeding Medicine (11) 10. DOI: 10.1089/bfm.2016.29031.egb

Wight, N. & Marinelli, K.A. (2014). ABM Clinical Protocol# 1: guidelines for blood glucose monitoring and treatment of hypoglycemia in term and late-preterm neonates, revised 2014. Breastfeeding Medicine 9(4), 173-179.

Kugelman, A., Amir, A.A. (2012). Late preterm infants: Near term But still in a critical developmental time period. Pediatrics, 132(4), 741-751.

Briere, C.-E., Lucas, R., McGrath, J. M., Lussier, M. and Brownell, E. (2015), Establishing Breastfeeding with the Late Preterm Infant in the NICU. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 44(1)102–113. doi: 10.1111/1552-6909.12536

American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2007). *Guidelines for perinatal care* (6th ed.). Washington, D.C.: Author.
Association of Women's Health, Obstetric and Neonatal Nurses. (2010). *Assessment and care of the late preterm infant* (Evidence-Based Clinical Practice Guideline). Washington, D. C.: Author.

Attachments

BallardScore_scoresheet.pdf

Approval Signatures

Step Description	Approver	Date

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT RETREAT MINUTES

Wednesday, September 20, 2023 at 9:00 a.m.
Springhill Suites by Marriott Truckee – Conference Room
10640 E. Jibboom Street, Truckee, CA 96161

Alternate teleconference location available at:
1334 San Vicente Boulevard, Santa Monica, CA 90402
(ADA access available via 14th Street)

1. CALL TO ORDER

Meeting was called to order at 9:07 a.m.

2. ROLL CALL

Board: Alyce Wong, Board Chair; Michael McGarry, Vice Chair (attendance via teleconference); Robert (Bob) Barnett, Secretary; Dale Chamblin, Treasurer; Mary Brown, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Dr. Brian Evans, Chief Medical Officer; Matt Mushet, In-House Counsel; Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: David Ruderman, General Counsel; Pam Knecht of ACCORD Limited

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

No changes were made to the agenda.

4. ITEMS FOR BOARD DISCUSSION

4.1. Welcome, Opening Comments and Retreat Objectives

Director Wong welcomed everyone to the meeting. Pam Knecht, Retreat Facilitator, reviewed the retreat objectives.

4.2. Communication Protocols

Ms. Knecht reviewed interview themes from Administration and the Board of Directors.

The Board of Directors discussed best practices in board and staff communication protocols. Discussion was held.

Open Session recessed at 11:01 a.m.
Open Session reconvened at 11:11 a.m.

4.3. Hospital-Physician Alignment Best Practices and Discussion

Dr. Brian Evans, Chief Medical Officer, presented best practices in hospital-physician alignment. Discussion was held.

In-House Counsel departed the meeting at 11:59 a.m.
Open Session recessed at 11:59 a.m.
Open Session reconvened at 12:01 p.m.

Discussion on physician alignment continued.

CMO reviewed activities to assist with improvement of culture such as rounding, journal clubs, engagement bonus, medical director meetings, financial transparency and management systems.

CMO provided an update on management systems and access to care project.

Open Session recessed at 2:10 p.m.
CMO, Executive Director of Governance and Clerk of the Board departed the meeting at 2:10 p.m.

5. CLOSED SESSION

5.1. Public Employee Performance Evaluation (Government Code § 54957)

Title: President & Chief Executive Officer

Discussion was held on a privileged item.

Director Brown departed at 4:10 p.m.

6. OPEN SESSION
Open Session reconvened at 4:12 p.m.

7. ITEMS FOR DISCUSSION

7.1. Next Steps and Wrap up

The Board of Directors discussed proposed changes to Order & Decorum.

Order & Decorum was reviewed.

Executive Director of Governance will meet with Director Barnett on proposed changes ahead of the Board Governance Committee meeting to review the policy and follow up.

8. ADJOURN
Meeting adjourned at 4:33 p.m.

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, September 28, 2023 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 4:02 p.m.

2. ROLL CALL
Board: Alyce Wong, Board Chair; Michael McGarry, Vice Chair; Robert (Bob) Barnett, Secretary; Dale Chamblin, Treasurer; Mary Brown, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Louis Ward, Chief Operating Officer; Dr. Brian Evans, Chief Medical Officer; Matt Mushet, In-House Counsel; Martina Rochefort, Clerk of the Board

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:03 p.m.

5. CLOSED SESSION
David Ruderman, General Counsel, joined the meeting during Closed Session.

5.1. Conference with Real Property Negotiator (Gov. Code § 54956.8)
Property Parcel Numbers: 093-203-010-000
Agency Negotiator: Louis Ward
Negotiating Party: Joseph F. Lombard and J. Timothy Lombard, Trustee of J. Timothy Lombard Trust of 2007
Under Negotiation: Price & Terms of Payment
Discussion was held on a privileged item.

5.2. Conference with Legal Counsel; Existing Litigation (Gov. Code § 54956.9(d)(1))
The Board finds, based on advice from legal counsel, that discussion in open session will prejudice the position of the local agency in the litigation.
Name of Case: Ellen Wrynn v. Tahoe Forest Hospital and Tahoe Forest Health System
Name of Parties: Ellen Wrynn
Nevada County Superior Court Case No. CU21-084365
Discussion was held on a privileged item.

5.3. Approval of Closed Session Minutes

5.3.1. 08/24/2023 Regular Meeting

Discussion was held on a privileged item.

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

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reported the Board considered four items in Closed Session. There was no reportable action on items 5.1. and 5.2. Items 5.3. and 5.4. were both approved on a 5-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

10. INPUT – AUDIENCE

Public comment was received from Deidre Henderson.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. MEDICAL STAFF EXECUTIVE COMMITTEE

12.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Revised Privilege Form:

- *NP-PA Urgent Care Privileges*

New Standardized:

- *Standardized Procedure - Stroke Alert, ANS-2201*

ACTION: **Motion made by Director Brown to approve the Medical Executive Committee Meeting Consent Agenda as presented, seconded by Director Barnett.**
AYES: Directors Brown, Chamblin, Barnett, McGarry and Wong
Abstention: None
NAYS: None
Absent: None

13. CONSENT CALENDAR

13.1. Approval of Minutes of Meetings

13.1.1. 08/24/2023 Regular Meeting

13.1.2. 08/29/2023 Special Meeting

13.2. Financial Reports
13.2.1. Financial Report – August 2023
13.3. Board Reports
13.3.1. President & CEO Board Report
13.3.2. COO Board Report
13.3.3. CNO Board Report
13.3.4. CMO Board Report
13.4. Ratify Tahoe Forest Health System Foundation Board Member
13.4.1. Scott Wessel

ACTION: **Motion made by Director McGarry to approve the Consent Calendar as presented, seconded by Director Chamblin.**
AYES: Directors Brown, Chamblin, Barnett, McGarry and Wong
Abstention: None
NAYS: None
Absent: None

14. ITEMS FOR BOARD DISCUSSION

14.1. Kidzone Museum

Carol Meagher, Executive Director of Kidzone Museum, provided an update on future Kidzone Museum operations and programming to the Board of Directors. Discussion was held.

14.2. Seismic Compliance Update

Louis Ward, Chief Operating Officer, provided an update to the Board of Directors on seismic compliance. Discussion was held.

14.3. Senate Bill 525 Update

Louis Ward, Chief Operating Officer, provided an update to the Board of Directors on Senate Bill 525 legislation. Discussion was held.

15. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Not applicable.

16. BOARD COMMITTEE REPORTS

Director McGarry provided an update from the September 25, 2023 Board Community Engagement Committee meeting and Tahoe Forest Health System Foundation meeting.

Director Chamblin shared an update from the September 11, 2023 Incline Village Community Hospital Foundation board meeting.

17. BOARD MEMBERS REPORTS/CLOSING REMARKS

No discussion was held.

18. CLOSED SESSION CONTINUED

Not applicable.

19. OPEN SESSION
Not applicable.

20. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
Not applicable.

21. ADJOURN
Meeting adjourned at 7:53 p.m.

TAHOE FOREST HOSPITAL DISTRICT
SEPTEMBER 2023 FINANCIAL REPORT - PRE-AUDIT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

SEPTEMBER 2023 FINANCIAL NARRATIVE – PRE-AUDIT

The following is the financial narrative analyzing financial and statistical trends for the three months ended September 30, 2023.

Activity Statistics

- TFH acute patient days were 355 for the current month compared to budget of 369. This equates to an average daily census of 11.8 compared to budget of 12.3.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Home Health visits, Lab Send Out tests, Blood units, Diagnostic Imaging, Medical Oncology procedures, Nuclear Medicine, MRI, CT Scans, Drugs Sold to Patients, Gastroenterology cases, Tahoe City Physical Therapy, and Outpatient Speech Therapy.

- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Hospice visits, Surgery cases, Oncology Lab, Radiation Oncology procedures, Briner Ultrasound, PET CT, Respiratory Therapy, Tahoe City Occupational Therapy, and Outpatient Physical Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 40.05% in the current month compared to budget of 48.00% and to last month's 48.51%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 45.35% compared to budget of 47.90% and prior year's 47.86%.

- EBIDA was $569 (0.0%) for the current month compared to budget of $1,265,264 (2.6%), or $(1,264,695) (-2.6%) below budget. Year-to-date EBIDA was $6,814,876 (4.4%) compared to budget of $3,678,661 (2.5%), or $3,136,215 (1.9%) above budget.

- Net Income was $(338,208) for the current month compared to budget of $1,010,717 or $1,348,925 below budget. Year-to-date Net Income was $6,336,121 compared to budget of $2,911,491 or $3,424,630 above budget.

- Cash Collections for the current month were $22,767,921, which is 98% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $103,449,623 at the end of September compared to $104,515,071 at the end of August.

Balance Sheet

- Working Capital is at 34.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 188.3 days. Working Capital cash decreased a net $3,687,000. Accounts Payable increased $1,174,000 and Accrued Payroll & Related Costs decreased $4,882,000. Cash Collections were 2% below target.

- Net Patient Accounts Receivable decreased $3,064,000 and cash collections were 98% of target. EPIC Days in A/R were 60.4 compared to 60.1 at the close of August, a .30 day increase.

- Estimated Settlements, Medi-Cal & Medicare increased a net $969,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs.

- Unrealized Gain/(Loss) Cash Investment Fund increased $141,000 after recording the unrealized losses in its funds held with Chandler Investments in September.

- GO Bond Tax Revenue Fund increased $1,800 after recording the final FY23 property tax revenues received from Placer County.

- Investment in TSC, LLC decreased $20,000 after recording the estimated loss for September and truing up the losses for July and August.

- To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of September.

- Accounts Payable increased $1,174,000 due to the timing of the final check run in September.

- Accrued Payroll & Related Costs decreased a net $4,882,000 due to fewer accrued payroll days in September.

Operating Revenue

- Current month's Total Gross Revenue was $50,776,503 compared to budget of $48,982,687 or $1,793,816 above budget.
- Current month's Gross Inpatient Revenue was $6,525,604, compared to budget of $6,710,355 or $184,751 below budget.
- Current month's Gross Outpatient Revenue was $44,250,899 compared to budget of $42,272,332 or $1,978,567 above budget.
- Current month's Gross Revenue Mix was 42.69% Medicare, 17.08% Medi-Cal, .0% County, 1.37% Other, and 38.86% Commercial Insurance compared to budget of 38.01% Medicare, 14.72% Medi-Cal, .0% County, 1.93% Other, and 45.34% Commercial Insurance. Last month's mix was 42.11% Medicare, 14.25% Medi-Cal, .0% County, 1.41% Other, and 42.23% Commercial Insurance. Year-to-date Gross Revenue Mix was 41.64% Medicare, 15.21% Medi-Cal, .0% County, 1.29% Other, and 41.86% Commercial compared to budget of 38.05% Medicare, 14.90% Medi-Cal, .0% County, 1.97% Other, and 45.09% Commercial.
- Current month's Deductions from Revenue were $30,442,720 compared to budget of $25,471,943 or $4,970,777 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 4.68% increase in Medicare, a 2.36% increase to Medi-Cal, County at budget, a .56% decrease in Other, and Commercial Insurance was below budget 6.48%, 2) Revenues were above budget by 3.7%, and 3) A/R Days over 120 and 180 increased 2.0%.

DESCRIPTION	September 2023 Actual	September 2023 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	9,835,481	10,047,611	212,130	
Employee Benefits	3,277,335	3,476,497	199,162	Paid Leave and Sick Leave came in below budget, creating a positive variance in Employee Benefits.
Benefits – Workers Compensation	54,256	108,106	53,850	
Benefits – Medical Insurance	1,801,238	1,953,389	152,151	
Medical Professional Fees	481,355	557,135	75,780	Occupational Health Medical Director fees and Emergency Department & Hospitalist Physician Fees were below budget, creating a positive variance in Medical Professional Fees.
Other Professional Fees	192,464	281,619	89,155	Decreased use of outsourced legal fees in Medical Staff Services, Consulting services and Legal fees for Administration, and consulting services for Financial Administration were below budget, creating a positive variance in Other Professional Fees.
Supplies	3,641,674	3,986,679	345,005	Oncology Drugs Sold to Patients revenues were below budget 10.85% and Non-Patient Chargeable Supplies were below budget, creating a positive variance in Supplies.
Purchased Services	1,901,322	2,212,107	310,785	We saw positive variances in Purchased Services in record retention and outsourced coding for Medical Records, Employee Health screenings, Facility maintenance projects and I/T Network Maintenance costs, Scribe services and Help4Access expenses for Multi-Specialty Clinics, and outsourced billing and collections services for Patient Accounting.
Other Expenses	897,381	1,073,470	176,089	Physician recruitment expenses, Dues & Subscriptions, and Utilities were below budget, creating a positive variance in Other Expenses.
Total Expenses	22,082,506	23,696,613	1,614,107	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
SEPTEMBER 2023 - PRE-AUDIT

	Sep-23	Aug-23	Sep-22	
ASSETS				
CURRENT ASSETS				
* CASH	$ 25,925,348	$ 29,612,783	$ 18,630,153	1
PATIENT ACCOUNTS RECEIVABLE - NET	46,644,699	49,708,380	39,996,490	2
OTHER RECEIVABLES	14,234,893	13,041,129	10,928,246	
GO BOND RECEIVABLES	1,333,569	890,271	1,293,043	
ASSETS LIMITED OR RESTRICTED	11,054,725	11,371,849	11,545,574	
INVENTORIES	5,268,064	5,260,265	4,456,441	
PREPAID EXPENSES & DEPOSITS	4,734,714	4,778,077	3,179,947	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	21,957,381	20,988,223	20,680,521	3
TOTAL CURRENT ASSETS	131,153,392	135,650,977	110,710,414	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	10,245,543	10,245,543	44,608,697	1
* CASH INVESTMENT FUND	105,720,455	105,829,959	80,260,540	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	(3,066,187)	(2,925,255)	(5,034,153)	4
MUNICIPAL LEASE 2018	-	-	726,242	
TOTAL BOND TRUSTEE 2017	21,325	21,325	20,568	
TOTAL BOND TRUSTEE 2015	446,213	309,116	416,654	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	1,300,198	1,298,360	1,014,136	5
DIAGNOSTIC IMAGING FUND	3,431	3,431	3,352	
DONOR RESTRICTED FUND	1,153,848	1,153,847	1,139,564	
WORKERS COMPENSATION FUND	36,963	19,138	(8,520)	
TOTAL	115,867,554	115,961,228	123,152,844	
LESS CURRENT PORTION	(11,054,725)	(11,371,849)	(11,545,574)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	104,812,829	104,589,380	111,607,270	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(3,565,311)	(3,544,847)	(2,320,282)	6
PROPERTY HELD FOR FUTURE EXPANSION	1,696,042	1,696,042	1,694,072	
PROPERTY & EQUIPMENT NET	195,169,976	194,786,598	188,855,489	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,791,406	1,791,406	1,821,450	
TOTAL ASSETS	431,058,335	434,969,555	412,368,412	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	261,823	265,055	300,611	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	124,578	262,970	343,424	7
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,489,691	4,513,396	4,774,148	
GO BOND DEFERRED FINANCING COSTS	437,766	440,087	465,616	
DEFERRED FINANCING COSTS	121,712	122,753	134,196	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	7,771,798	7,913,201	8,762,819	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 13,207,368	$ 13,517,462	$ 14,780,814	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 8,509,927	$ 7,335,951	$ 11,611,635	8
ACCRUED PAYROLL & RELATED COSTS	19,157,812	24,039,647	25,780,139	9
INTEREST PAYABLE	353,323	286,386	251,159	
INTEREST PAYABLE GO BOND	523,238	261,619	537,630	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	290,618	290,618	2,621,304	
HEALTH INSURANCE PLAN	2,722,950	2,722,950	2,224,062	
WORKERS COMPENSATION PLAN	3,287,371	3,287,371	2,947,527	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,586,926	2,586,926	2,082,114	
CURRENT MATURITIES OF GO BOND DEBT	2,195,000	2,195,000	1,945,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	4,268,310	4,552,127	5,594,718	
TOTAL CURRENT LIABILITIES	43,895,475	47,558,595	55,595,288	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	25,809,822	25,873,460	28,918,597	
GO BOND DEBT NET OF CURRENT MATURITIES	90,705,410	90,723,365	93,365,877	
DERIVATIVE INSTRUMENT LIABILITY	124,578	262,970	343,424	7
TOTAL LIABILITIES	160,535,285	164,418,391	178,223,187	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	282,576,570	282,914,778	247,786,475	
RESTRICTED	1,153,848	1,153,847	1,139,564	
TOTAL NET POSITION	$ 283,730,418	$ 284,068,625	$ 248,926,039	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
SEPTEMBER 2023 – PRE-AUDIT

1. Working Capital is at 34.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 188.3 days. Working Capital cash decreased a net $3,687,000. Accounts Payable increased $1,174,000 (See Note 8) and Accrued Payroll & Related Costs decreased $4,882,000 (See Note 9). Cash Collections were below target by 2% (See Note 2).

2. Net Patient Accounts Receivable decreased a net $3,064,000. Cash collections were 98% of target. EPIC Days in A/R were 60.4 compared to 60.1 at the close of August, a .30 day increase.

3. Estimated Settlements, Medi-Cal & Medicare increased $969,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs.

4. Unrealized Gain/(Loss) Cash Investment Fund increased $141,000 after recording the unrealized losses in its funds held with Chandler Investments for the month of September.

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7. To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of September.

8. Accounts Payable increased $1,174,000 due to the timing of the final check run in September.

9. Accrued Payroll & Related Costs decreased a net $4,882,000 due to fewer accrued payroll days in September.

Tahoe Forest Hospital District
Cash Investment
September 30, 2023 Pre-Audit

WORKING CAPITAL				
US Bank	$ 24,843,835	4.94%		
US Bank/Kings Beach Thrift Store	11,307			
US Bank/Truckee Thrift Store	54,467			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,015,739	0.01%		
Total			$	25,925,348
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Investment Fund	105,720,455	4.94%		
Total			$	105,720,455
Building Fund	$ -			
Cash Reserve Fund	10,245,543	3.50%		
Local Agency Investment Fund			$	10,245,543
Municipal Lease 2018			$	-
Bonds Cash 2017			$	21,325
Bonds Cash 2015			$	446,213
GO Bonds Cash 2008			$	1,305,962
DX Imaging Education	$ 3,431			
Workers Comp Fund - B of A	36,963			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	40,394
TOTAL FUNDS			$	143,705,241
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,370	0.10%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,118,169	3.50%		
TOTAL RESTRICTED FUNDS			$	1,153,848
TOTAL ALL FUNDS			$	144,859,089

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
SEPTEMBER 2023 – PRE-AUDIT

	Current Status	Desired Position	Target	Bond Covenants	FY 2024 Jul 23 to Sept 23	FY 2023 Jul 22 to June 23	FY 2022 Jul 21 to June 22	FY 2021 Jul 20 to June 21	FY 2020 Jul 19 to June 20	FY 2019 Jul 18 to June 19	FY 2018 Jul 17 to June 18
Return On Equity: Increase (Decrease) in Net Position Net Position		⇧	FYE 6.0% Budget 1st Qtr 1.0%		2.24%	11.2%	13.0%	12.3%	17.1%	13.1%	5.1%
EPIC Days in Accounts Receivable (excludes SNF) Gross Accounts Receivable 90 Days Gross Accounts Receivable 365 Days		⇩	FYE 60 Days		60 66	59 62	63 67	65 67	89 73	69 71	68 73
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments (Total Expenses - Depreciation Expense)/ by 365		⇧	Budget FYE 160 Days Budget 1st Qtr 157 Projected 1st Qtr 176 Days	Bond Covenant 60 Days A- 301 Days BBB- 160 Days	188	197	234	272	246	179	176
EPIC Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)		⇩	22%		35%	24%	27%	26%	31%	35%	22%
EPIC Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)		⇩	27%		43%	33%	36%	32%	40%	42%	25%
Cash Receipts Per Day (based on 60 day lag on Patient Net Revenue)		⇧	FYE Budget $774,295 End 1st Qtr Based on Budgeted Net Revenue $742,690 End 1st Qtr Based on Actual Net Revenue $775,414		$761,486	$713,016	$634,266	$603,184	$523,994	$473,890	$333,963
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation Debt Principal Payments + Interest Expense		⇧	Without GO Bond 6.47 With GO Bond 3.64	1.95	7.20 3.99	9.74 5.25	9.72 5.22	8.33 4.49	9.50 5.06	20.45 4.12	9.27 2.07

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
SEPTEMBER 2023 - PRE-AUDIT

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD SEPT 2022
				OPERATING REVENUE						
$ 50,776,503	$ 48,982,687	$ 1,793,816	3.7%	Total Gross Revenue	$ 156,625,048	$ 149,366,660	$ 7,258,388	4.9%	1	$ 135,575,024
				Gross Revenues - Inpatient						
$ 3,174,348	$ 3,204,202	$ (29,854)	-0.9%	Daily Hospital Service	$ 9,812,144	$ 10,481,590	$ (669,446)	-6.4%		$ 9,621,120
3,351,256	3,506,153	(154,897)	-4.4%	Ancillary Service - Inpatient	11,628,668	11,409,606	219,062	1.9%		11,459,465
6,525,604	6,710,355	(184,751)	-2.8%	Total Gross Revenue - Inpatient	21,440,812	21,891,196	(450,384)	-2.1%	1	21,080,585
44,250,899	42,272,332	1,978,567	4.7%	Gross Revenue - Outpatient	135,184,236	127,475,464	7,708,772	6.0%		114,494,439
44,250,899	42,272,332	1,978,567	4.7%	Total Gross Revenue - Outpatient	135,184,236	127,475,464	7,708,772	6.0%	1	114,494,439
				Deductions from Revenue:						
29,751,776	23,746,981	(6,004,795)	-25.3%	Contractual Allowances	83,549,913	72,568,637	(10,981,276)	-15.1%	2	67,616,713
138,914	979,654	840,740	85.8%	Charity Care	471,860	2,987,333	2,515,473	84.2%	2	1,792,025
552,029	745,308	193,279	25.9%	Bad Debt	1,583,892	2,275,499	691,607	30.4%	2	1,367,241
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	(75,440)
30,442,720	25,471,943	(4,970,777)	-19.5%	Total Deductions from Revenue	85,605,664	77,831,469	(7,774,195)	-10.0%		70,700,539
91,592	102,355	10,763	10.5%	Property Tax Revenue- Wellness Neighborhood	342,082	304,904	(37,178)	-12.2%		295,876
1,657,700	1,348,778	308,922	22.9%	Other Operating Revenue	4,503,337	4,204,752	298,585	7.1%	3	3,866,444
22,083,075	24,961,877	(2,878,802)	-11.5%	TOTAL OPERATING REVENUE	75,864,802	76,044,847	(180,045)	-0.2%		69,036,805
				OPERATING EXPENSES						
9,835,481	10,047,611	212,130	2.1%	Salaries and Wages	30,031,703	31,350,887	1,319,184	4.2%	4	27,792,247
3,277,335	3,476,497	199,162	5.7%	Benefits	10,096,042	10,036,554	(59,488)	-0.6%	4	9,881,475
54,256	108,106	53,850	49.8%	Benefits Workers Compensation	251,323	324,317	72,994	22.5%	4	396,086
1,801,238	1,953,389	152,151	7.8%	Benefits Medical Insurance	5,745,453	5,860,167	114,714	2.0%	4	4,420,091
481,355	557,135	75,780	13.6%	Medical Professional Fees	1,663,253	1,691,667	28,414	1.7%	5	1,529,078
192,464	281,619	89,155	31.7%	Other Professional Fees	590,570	845,625	255,055	30.2%	5	623,895
3,641,674	3,986,679	345,005	8.7%	Supplies	11,807,023	12,342,575	535,552	4.3%	6	9,983,475
1,901,322	2,212,107	310,785	14.0%	Purchased Services	6,165,917	6,920,063	754,146	10.9%	7	5,715,711
897,381	1,073,470	176,089	16.4%	Other	2,698,642	2,994,331	295,689	9.9%	8	2,922,156
22,082,506	23,696,613	1,614,107	6.8%	TOTAL OPERATING EXPENSE	69,049,926	72,366,186	3,316,260	4.6%		63,264,214
569	**1,265,264**	**(1,264,695)**	**-100.0%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**6,814,876**	**3,678,661**	**3,136,215**	**85.3%**		**5,772,591**
				NON-OPERATING REVENUE/(EXPENSE)						
770,908	760,145	10,763	1.4%	District and County Taxes	2,245,418	2,282,596	(37,178)	-1.6%	9	2,087,893
445,136	445,136	(0)	0.0%	District and County Taxes - GO Bond	1,335,407	1,335,407	(0)	0.0%		1,294,527
74,135	171,898	(97,763)	-56.9%	Interest Income	677,438	522,463	154,975	29.7%	10	245,050
255,049	61,115	193,934	317.3%	Donations	320,839	183,344	137,495	75.0%	11	147,030
(20,464)	(67,000)	46,536	69.5%	Gain/(Loss) on Joint Investment	(154,464)	(201,000)	46,536	23.2%	12	(244,411)
(127,885)	100,000	(227,885)	227.9%	Gain/(Loss) on Market Investments	313,817	300,000	13,817	-4.6%	13	(1,442,674)
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	-	-	-	0.0%	14	-
(1,373,992)	(1,364,492)	(9,500)	-0.7%	Depreciation	(4,117,670)	(4,094,902)	(22,768)	-0.6%	15	(3,992,659)
(91,974)	(91,660)	(314)	-0.3%	Interest Expense	(283,276)	(278,814)	(4,462)	-1.6%	16	(329,821)
(269,689)	(269,689)	(0)	0.0%	Interest Expense-GO Bond	(816,264)	(816,264)	1	0.0%		(837,980)
(338,777)	(254,547)	(84,230)	-33.1%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(478,756)	(767,170)	288,414	37.6%		(3,073,045)
$ (338,208)	**$ 1,010,717**	**$ (1,348,925)**	**-133.5%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 6,336,121**	**$ 2,911,491**	**$ 3,424,630**	**117.6%**		**$ 2,699,546**
				NET POSITION - BEGINNING OF YEAR	**277,394,297**					
				NET POSITION - AS OF SEPTEMBER 30, 2023	**$ 283,730,418**					
0.0%	**2.6%**	**-2.6%**		**RETURN ON GROSS REVENUE EBIDA**	**4.4%**	**2.5%**	**1.9%**			**4.3%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
SEPTEMBER 2023 - PRE-AUDIT

		Variance from Budget Fav / <Unfav>	
		SEPT 2023	YTD 2023
1) Gross Revenues			
Acute Patient Days were below budget 3.79% or 14 days. Swing Bed days were below budget 13.33% or 4 days. Inpatient Ancillary Revenues were below budget 4.41% due to the decrease in Patient Days.	Gross Revenue -- Inpatient	$ (184,751)	$ (450,384)
	Gross Revenue -- Outpatient	1,978,567	7,708,772
	Gross Revenue -- Total	$ 1,793,816	$ 7,258,388
Outpatient volumes were above budget in the following departments: Home Health visits, Laboratory tests, Lab Send Out tests, Blood units, Diagnostic Imaging, Medical Oncology procedures, Nuclear Medicine, MRI, Ultrasounds, CT Scans, Drugs Sold to Patients, Gastroenterology cases, Tahoe City Physical Therapy, and Outpatient Physical Therapy Aquatic, Speech Therapy, and Occupational Therapy.			
Outpatient volumes were below budget in the following departments: Emergency Department visits, Hospice visits, Surgery cases, Oncology Lab, Mammography, Radiation Oncology procedures, Briner Ultrasound, PET CT, Respiratory Therapy, and Tahoe City Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for September shows a 4.68% increase to Medicare, a 2.36% increase to Medi-Cal, .56% decrease to Other, County at budget, and a 6.48% decrease to Commercial when compared to budget. Revenues were above budget 3.70%, we saw a shift in Payor Mix from Commercial to Medicare and Medi-Cal, and A/R Days over 120 and 180 increased 2.0%, creating a negative variance in Contractual Allowances.	Contractual Allowances	$ (6,004,796)	$ (10,981,275)
	Charity Care	840,739	2,515,474
	Bad Debt	193,279	691,606
	Prior Period Settlements	-	
	Total	$ (4,970,777)	$ (7,774,195)
3) Other Operating Revenue	Retail Pharmacy	110,014	169,200
Retail Pharmacy revenues were above budget 25.18%.	Hospice Thrift Stores	1,755	19,984
	The Center (non-therapy)	(2,042)	(5,637)
Hospice Thrift Store revenues were above budget 1.91%.	IVCH ER Physician Guarantee	35,233	26,437
	Children's Center	42,094	63,933
Children's Center revenues were above budget 25.62%.	Miscellaneous	137,200	70,668
	Oncology Drug Replacement	-	-
Rebates & Refunds were above budget, creating a positive variance in Miscellaneous.	Grants	(15,333)	(46,000)
	Total	$ 308,922	$ 298,585
4) Salaries and Wages	Total	$ 212,130	$ 1,319,184
Employee Benefits	PL/SL	$ 291,277	$ (50,818)
Paid Leave & Sick Leave were below budget, creating a positive variance in PL/SL.	Nonproductive	(72,550)	54,533
	Pension/Deferred Comp	-	7,020
	Standby	(21,641)	(42,887)
	Other	2,076	(27,335)
	Total	$ 199,162	$ (59,488)
Employee Benefits - Workers Compensation	Total	$ 53,850	$ 72,994
Employee Benefits - Medical Insurance	Total	$ 152,151	$ 114,714
5) Professional Fees	Multi-Specialty Clinics	$ (3,959)	$ (60,825)
Occupational Health Medical Director fees were below budget, creating a positive variance in Miscellaneous.	Oncology	(2,694)	(15,802)
	IVCH ER Physicians	(4,932)	(5,715)
	Marketing	378	(2,408)
Outsourced legal services were below budget, creating a positive variance in Medical Staff Services.	Home Health/Hospice	-	-
	Patient Accounting/Admitting	-	-
	Respiratory Therapy	-	-
We saw decreased use of Legal fees and Consulting fees in Administration, creating a positive variance in this category.	The Center	-	-
	TFH/IVCH Therapy Services	-	-
	Multi-Specialty Clinics Administration	2,148	2,943
Emergency Department and Hospitalist Physician fees were below budget, creating a positive variance in TFH Locums.	Corporate Compliance	2,000	6,000
	Miscellaneous	13,206	6,265
	Managed Care	2,667	12,906
Consulting services for the Access to Care project came in below budget estimations, creating a positive variance in Financial Administration.	Information Technology	584	20,560
	Human Resources	3,231	27,728
	Medical Staff Services	12,600	38,250
	Administration	45,544	71,091
	TFH Locums	66,662	77,869
	Financial Administration	27,500	104,606
	Total	$ 164,935	$ 283,469

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
SEPTEMBER 2023 - PRE-AUDIT

		Variance from Budget Fav / <Unfav>	
		SEPT 2023	YTD 2023
6) Supplies	Food	$ (5,380)	$ (17,098)
Non-Patient Chargeable Supplies were below budget 31.46%, creating a positive variance in Patient & Other Medical Supplies.	Other Non-Medical Supplies	14,633	(5,652)
	Office Supplies	5,142	11,264
	Minor Equipment	6,641	27,430
Oncology Drugs Sold to Patients revenues were below budget 10.85%, creating a positive variance in Pharmacy Supplies.	Patient & Other Medical Supplies	162,762	239,141
	Pharmacy Supplies	161,206	280,467
	Total	$ 345,005	$ 535,552
7) Purchased Services	Information Technology	$ (3,642)	$ (21,626)
Record retention and outsourced coding services were below budget, creating a positive variance in Medical Records.	Laboratory	3,014	(13,452)
	Pharmacy IP	124	(530)
	Home Health/Hospice	1,918	788
Employee Health screenings were below budget, creating a positive variance in Human Resources.	Community Development	3,333	9,500
	The Center	3,597	12,074
	Medical Records	13,257	16,615
Facility maintenance projects and Information Technology Network Maintenance costs were below budget, creating a positive variance in Department Repairs.	Diagnostic Imaging Services - All	6,530	24,737
	Human Resources	17,462	78,894
	Department Repairs	69,059	106,053
Scribe services and Help4Access expenses were below budget, creating a positive variance in Multi-Specialty Clinics.	Multi-Specialty Clinics	43,628	117,735
	Patient Accounting	136,156	189,651
	Miscellaneous	16,349	233,706
Outsourced billing and collections services came in below budget, creating a positive variance in Patient Accounting.	Total	$ 310,785	$ 754,146
8) Other Expenses	Miscellaneous	$ 85,737	$ (63,134)
Physician Recruitment expenses, Dietary department transfers, and Construction Labor Transfers to building projects were below budget, creating a positive variance in Miscellaneous.	Other Building Rent	(11,232)	(27,659)
	Multi-Specialty Clinics Bldg. Rent	(206)	(3,676)
	Equipment Rent	(6,735)	(582)
	Multi-Specialty Clinics Equip Rent	1,252	(580)
Job postings on various recruitment websites were above budget, creating a negative variance in Human Resources Recruitment.	Physician Services	-	139
	Human Resources Recruitment	(14,714)	5,278
	Insurance	7,911	5,681
Dues and Subscription expenses were below budget in Laboratory, Medical Oncology, and Administration.	Dues and Subscriptions	15,606	37,427
	Marketing	10,937	47,515
	Outside Training & Travel	41,123	140,011
Natural Gas/Propane, Telephone, and Electricity costs were below budget, creating a positive variance in Utilities.	Utilities	46,410	155,270
	Total	$ 176,089	$ 295,689
9) District and County Taxes	Total	$ 10,763	$ (37,178)
10) Interest Income	Total	$ (97,763)	$ 154,975
Accrued Interest on our holdings with Chandler Investments decreased in September, creating a negative variance in Interest Income.			
11) Donations	IVCH	$ 156,902	$ 123,569
The IVCH Foundation transferred funds to the District in support of Oral Health Improvement, Behavioral Health, and Emergency Services, creating a positive variance in IVCH Donations.	Operational	37,032	13,926
	Total	$ 193,934	$ 137,495
The TFH Foundation transferred funds to the District in support of Behavioral Health, creating a positive variance in Operational Donations.			
12) Gain/(Loss) on Joint Investment	Total	$ 46,536	$ 46,536
13) Gain/(Loss) on Market Investments	Total	$ (227,885)	$ 13,817
The District booked the value of unrealized losses in its holdings with Chandler Investments.			
14) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ -
15) Depreciation Expense	Total	$ (9,500)	$ (22,768)
16) Interest Expense	Total	$ (314)	$ (4,462)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
SEPTEMBER 2023 – PRE-AUDIT

	Current Status	Desired Position	Target	FY 2024 Jul 23 to Sept 23	FY 2023 Jul 22 to June 23	FY 2022 Jul 21 to June 22	FY 2021 Jul 20 to June 21	FY 2020 Jul 19 to June 20	FY 2019 Jul 18 to June 19	FY 2018 Jul 17 to June 18
Total Margin: Increase (Decrease) In Net Position / Total Gross Revenue			FYE 2.6% 1st Qtr 2.0%	4.1%	5.5%	6.2%	5.8%	8.5%	5.7%	2.6%
Charity Care: Charity Care Expense / Gross Patient Revenue			FYE 2.0% 1st Qtr 2.0%	.01%	.01%	2.6%	3.4%	4.0%	3.8%	3.3%
Bad Debt Expense: Bad Debt Expense / Gross Patient Revenue			FYE 1.5% 1st Qtr 1.5%	1.0%	1.2%	-.01%	1.2%	1.4%	.1%	.1%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue			FYE 12.0% 1st Qtr 13.9%	17.3%	12.2%	12.2%	13.7%	.1%	11.5%	4.8%
Operating Expense Variance to Budget (Under<Over>)			-0-	$3,316,260	$(1,499,954)	$(10,431,192)	$(8,685,969)	$(9,484,742)	$(13,825,198)	$1,061,378
EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue			FYE 2.1% 1st Qtr 2.5%	4.4%	6.3%	7.9%	7.8%	6.2%	7.1%	4.5%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
SEPTEMBER 2023 - PRE-AUDIT

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD SEPT 2022
				OPERATING REVENUE						
$ 3,666,030	$ 3,406,713	$ 259,317	7.6%	Total Gross Revenue	$ 12,179,797	$ 10,694,915	$ 1,484,882	13.9%	1	$ 9,832,458
				Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%	Daily Hospital Service	$ -	$ 5,627	$ (5,627)	-100.0%		$ 10,719
-	1,022	(1,022)	-100.0%	Ancillary Service - Inpatient	-	6,325	(6,325)	-100.0%		6,785
-	1,022	(1,022)	-100.0%	Total Gross Revenue - Inpatient	-	11,952	(11,952)	-100.0%	1	17,504
3,666,030	3,405,691	260,339	7.6%	Gross Revenue - Outpatient	12,179,797	10,682,963	1,496,834	14.0%		9,814,954
3,666,030	3,405,691	260,339	7.6%	Total Gross Revenue - Outpatient	12,179,797	10,682,963	1,496,834	14.0%	1	9,814,954
				Deductions from Revenue:						
1,935,706	1,553,600	(382,106)	-24.6%	Contractual Allowances	5,636,600	4,840,853	(795,747)	-16.4%	2	4,368,601
13,804	68,134	54,330	79.7%	Charity Care	58,623	213,898	155,275	72.6%	2	222,648
119,596	51,101	(68,495)	-134.0%	Bad Debt	345,137	160,424	(184,713)	-115.1%	2	226,629
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	-
2,069,106	1,672,835	(396,271)	-23.7%	Total Deductions from Revenue	6,040,360	5,215,175	(825,185)	-15.8%	2	4,817,878
98,717	50,254	48,463	96.4%	Other Operating Revenue	243,706	204,125	39,581	19.4%	3	196,431
1,695,641	1,784,132	(88,491)	-5.0%	TOTAL OPERATING REVENUE	6,383,143	5,683,865	699,278	12.3%		5,211,011
				OPERATING EXPENSES						
629,559	584,998	(44,561)	-7.6%	Salaries and Wages	1,991,539	1,951,823	(39,716)	-2.0%	4	1,789,374
186,307	210,368	24,061	11.4%	Benefits	591,139	626,493	35,354	5.6%	4	643,469
6,916	3,157	(3,759)	-119.1%	Benefits Workers Compensation	7,980	9,471	1,491	15.7%	4	6,396
110,417	119,744	9,327	7.8%	Benefits Medical Insurance	351,928	359,232	7,304	2.0%	4	280,307
151,832	147,567	(4,265)	-2.9%	Medical Professional Fees	455,775	452,061	(3,714)	-0.8%	5	446,236
1,706	2,306	600	26.0%	Other Professional Fees	5,631	6,919	1,288	18.6%	5	6,413
105,919	69,862	(36,057)	-51.6%	Supplies	342,620	202,988	(139,632)	-68.8%	6	188,147
53,710	48,945	(4,765)	-9.7%	Purchased Services	156,778	347,718	190,940	54.9%	7	184,144
216,228	125,525	(90,703)	-72.3%	Other	373,555	242,785	(130,770)	-53.9%	8	292,025
1,462,593	1,312,472	(150,121)	-11.4%	TOTAL OPERATING EXPENSE	4,276,945	4,199,490	(77,455)	-1.8%		3,836,511
233,048	**471,660**	**(238,612)**	**-50.6%**	**NET OPERATING REV(EXP) EBIDA**	**2,106,198**	**1,484,375**	**621,823**	**41.9%**		**1,374,500**
				NON-OPERATING REVENUE/(EXPENSE)						
173,569	16,667	156,902	941.4%	Donations-IVCH	173,569	50,000	123,569	247.1%	9	3,568
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(122,785)	(121,288)	(1,497)	1.2%	Depreciation	(369,918)	(366,240)	(3,678)	-1.0%	11	(276,751)
(1,454)	(1,403)	(51)	3.6%	Interest Expense	(4,392)	(4,286)	(106)	2.5%	12	(9,909)
49,330	(106,024)	155,354	146.5%	TOTAL NON-OPERATING REVENUE/(EXP)	(200,741)	(320,526)	119,785	37.4%		(283,092)
$ 282,379	**$ 365,636**	**$ (83,257)**	**-22.8%**	**EXCESS REVENUE(EXPENSE)**	**$ 1,905,457**	**$ 1,163,849**	**$ 741,608**	**63.7%**		**$ 1,091,408**
6.4%	**13.8%**	**-7.5%**		**RETURN ON GROSS REVENUE EBIDA**	**17.3%**	**13.9%**	**3.4%**			**14.0%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
SEPTEMBER 2023 - PRE-AUDIT

		Variance from Budget Fav<Unfav> SEPT 2023	YTD 2023
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were at budget at 1.	Gross Revenue -- Inpatient	$ (1,022)	$ (11,952)
	Gross Revenue -- Outpatient	260,339	1,496,834
	Total	$ 259,317	$ 1,484,882
Outpatient volumes were above budget in Surgery cases, Laboratory tests, Lab Send Out tests, Ultrasounds, Physical Therapy, and Occupational Therapy.			
Outpatient volumes were below budget in Diagnostic Imaging, CT Scans, Drugs Sold to Patients, Respiratory Therapy, Gastroenterology cases, and Speech Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 5.17% increase in Medicare, a .81% increase in Medicaid, a 5.30% decrease in Commercial insurance, a .68% decrease in Other, and County was at budget. Outpatient Revenues were above budget 7.6%, we saw shift in Payor Mix from Commercial to Medicare and Medicaid, and A/R Days over 120 and 180 increased 3.8%, creating the negative variance in Contractual Allowances.	Contractual Allowances	$ (382,106)	$ (795,747)
	Charity Care	54,330	155,275
	Bad Debt	(68,495)	(184,713)
	Prior Period Settlement	-	-
	Total	$ (396,271)	$ (825,185)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, coming in over budget in September.	IVCH ER Physician Guarantee	$ 35,233	$ 26,437
	Miscellaneous	13,230	13,144
	Total	$ 48,463	$ 39,581
4) Salaries and Wages	Total	$ (44,561)	$ (39,716)
Employee Benefits	PL/SL	$ 23,624	$ 31,418
Sick Leave came in below budget, creating a positive variance in PL/SL.	Pension/Deferred Comp	-	-
	Standby	(2,200)	(8,816)
	Other	(2,741)	(9,338)
	Nonproductive	5,378	22,091
	Total	$ 24,061	$ 35,354
Employee Benefits - Workers Compensation	Total	$ (3,759)	$ 1,491
Employee Benefits - Medical Insurance	Total	$ 9,327	$ 7,304
5) Professional Fees	IVCH ER Physicians	$ (4,932)	$ (5,713)
Telehealth visits were above budget, creating a negative variance in IVCH ER Physicians.	Administration	-	-
	Miscellaneous	-	-
	Foundation	600	1,288
	Multi-Specialty Clinics	667	2,000
	Total	$ (3,665)	$ (2,426)
6) Supplies	Pharmacy Supplies	$ (52,857)	$ (131,008)
Oncology Drugs Sold to Patients revenues exceeded budget by 195.6%, creating a negative variance in Pharmacy Supplies.	Patient & Other Medical Supplies	13,059	(9,026)
	Non-Medical Supplies	2,309	(1,229)
	Office Supplies	(10)	99
Non-Patient Chargeable supplies were below budget, creating a positive variance in Patient & Other Medical Supplies.	Food	94	361
	Minor Equipment	1,349	1,171
	Total	$ (36,057)	$ (139,632)

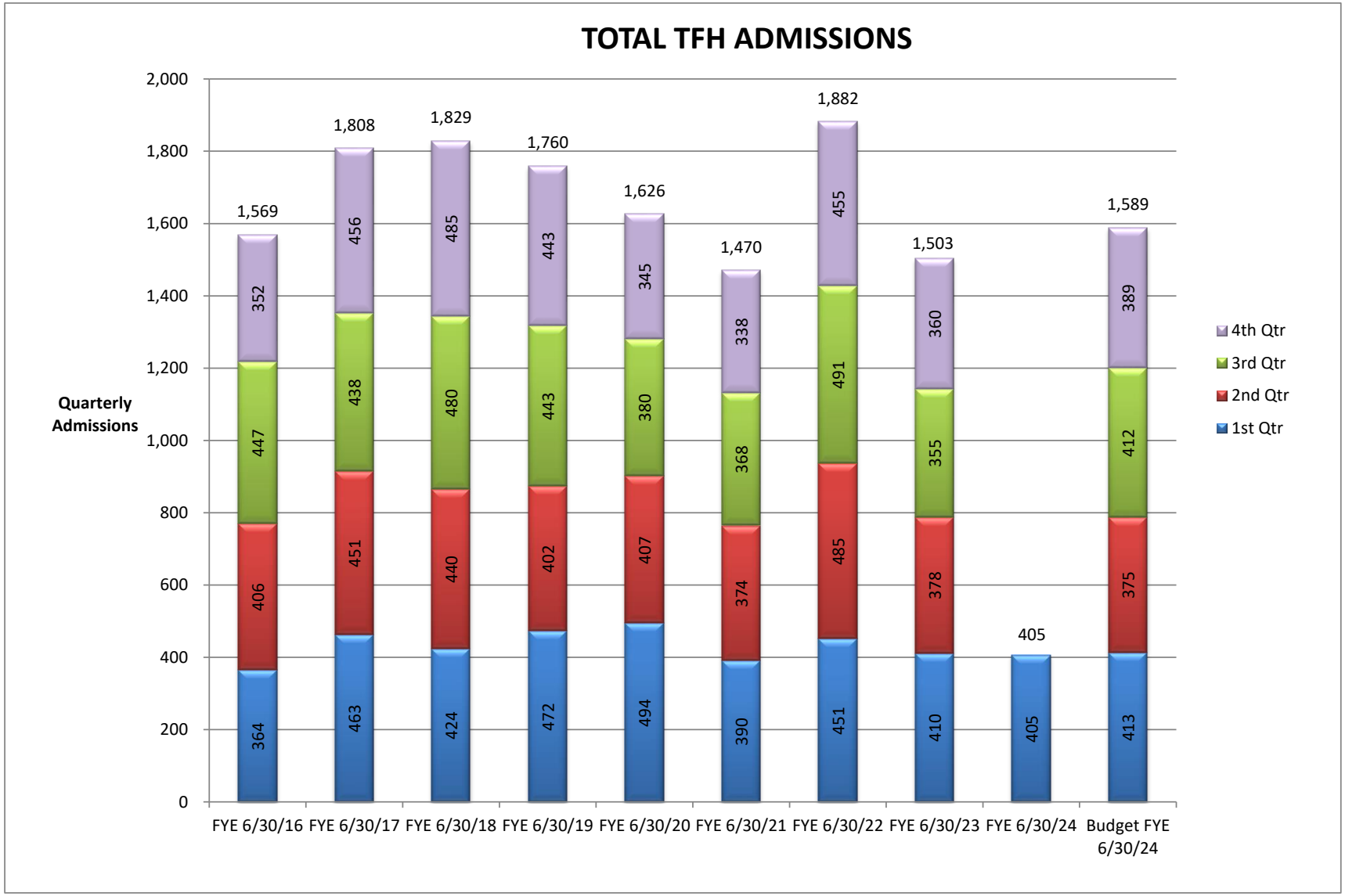
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
SEPTEMBER 2023 - PRE-AUDIT

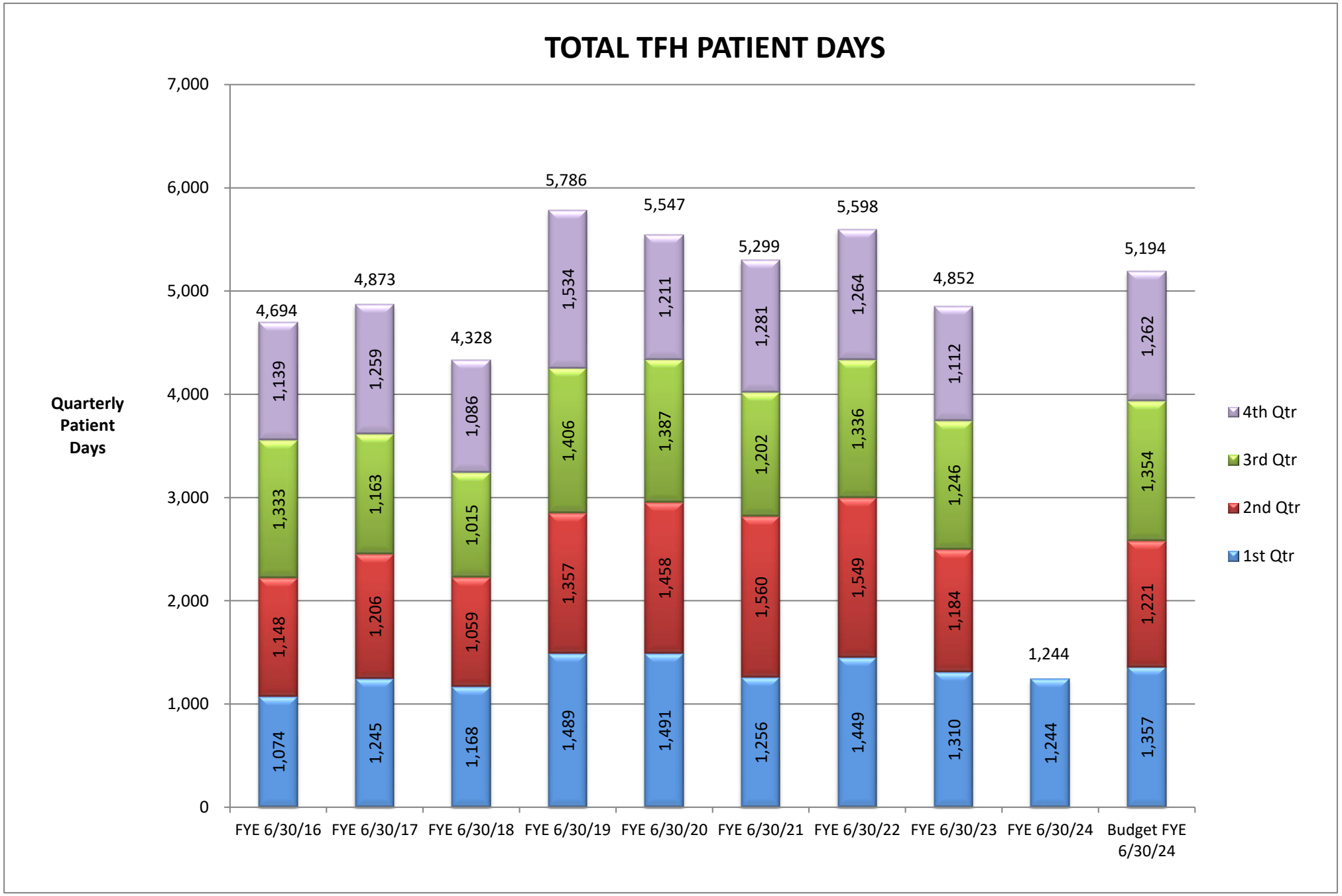
		Variance from Budget Fav<Unfav>	
		SEPT 2023	YTD 2023
7) Purchased Services	Laboratory	$ (4,137)	$ (6,565)
Lab Send Out Tests were above budget 6.54%, creating a negative variance in Laboratory.	EVS/Laundry	(4,364)	(4,827)
	Engineering/Plant/Communications	2	(2,972)
	Diagnostic Imaging Services - All	(41)	(2,783)
Laundry & Linen costs per week increased due to volume increases, creating a negative variance in EVS/Laundry.	Pharmacy	133	60
	Multi-Specialty Clinics	592	971
	Department Repairs	119	1,214
	Miscellaneous	1,596	1,842
	Foundation	1,333	204,000
	Total	$ (4,765)	$ 190,940
8) Other Expenses	Miscellaneous	$ (82,356)	$ (141,486)
Final expenses associated with the Beach Boys Concert created a negative in Miscellaneous.	Other Building Rent	(3,920)	(11,861)
	Dues and Subscriptions	(6,372)	(10,635)
	Equipment Rent	(3,137)	(6,264)
Dues & Subscriptions were above budget in Pharmacy Overhead, Administration, MSC Ophthalmology & Behavioral Health.	Multi-Specialty Clinics Bldg. Rent	(315)	(1,192)
	Physician Services	-	-
	Insurance	716	2,148
Oxygen tank rentals created a negative variance in Equipment Rent.	Marketing	(404)	4,581
	Outside Training & Travel	1,414	10,538
Telephone expenses were below budget, creating a positive variance in Utilities.	Utilities	3,672	23,401
	Total	$ (90,703)	$ (130,770)
9) Donations	Total	$ 156,902	$ 123,569
The IVCH Foundation transferred funds to the District in support of Oral Health Improvement, Behavioral Health, and Emergency Services, creating a positive variance in Donations.			
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ (1,497)	$ (3,678)
12) Interest Expense	Total	$ (51)	$ (106)

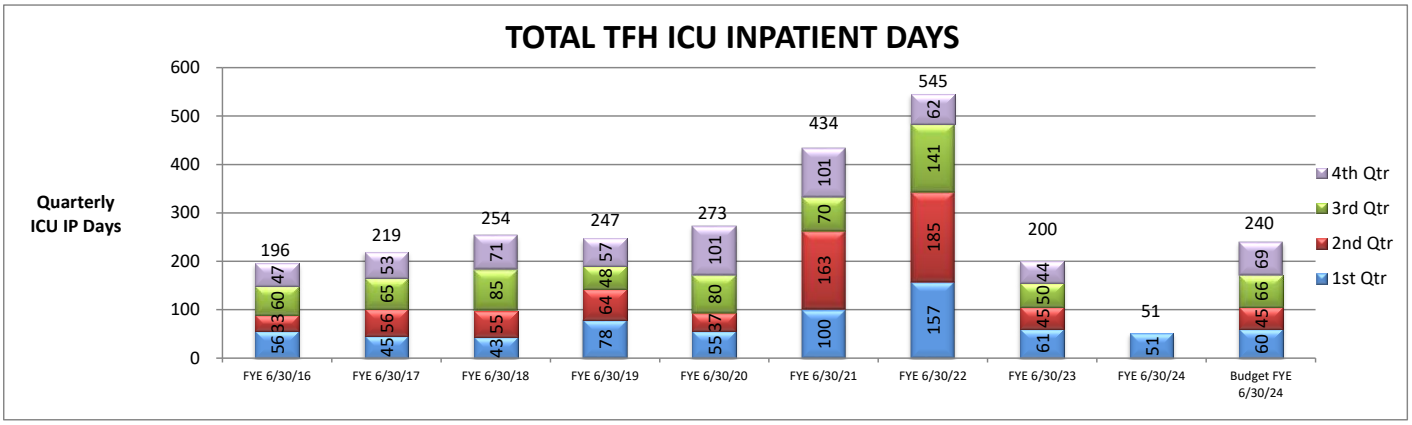
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

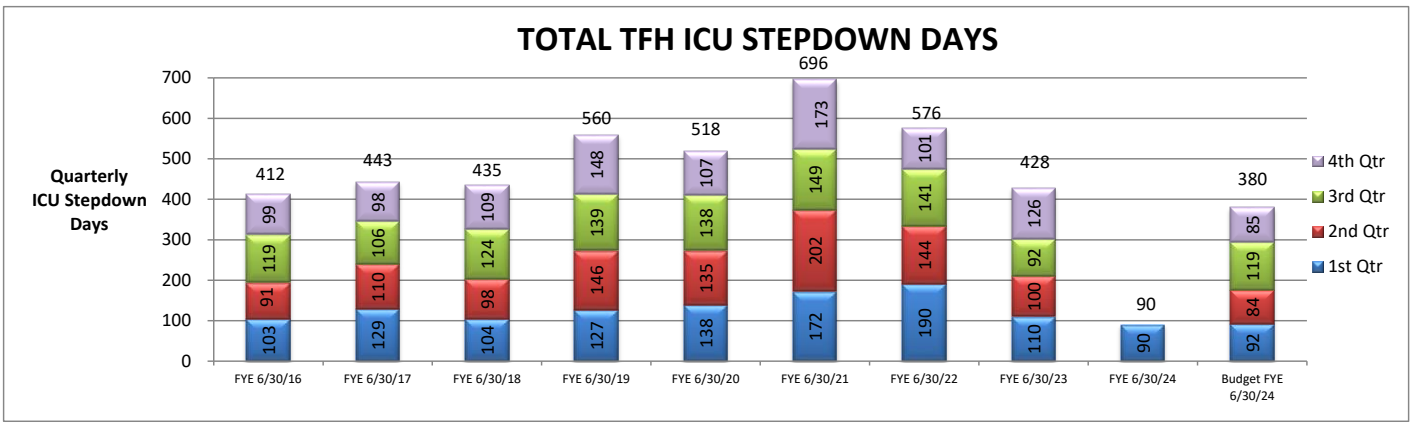
	PRE-AUDIT FYE 2023		BUDGET FYE 2024	PROJECTED FYE 2024	**ACTUAL SEPT 2023**	**PROJECTED SEPT 2023**	**DIFFERENCE**	PROJECTED 1ST QTR	PROJECTED 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	35,246,181		12,535,783	15,671,998	$ 569	$ 1,265,265	$ (1,264,696)	6,814,877	3,793,952	2,815,796	2,247,373
Interest Income	1,348,932		2,000,000	2,082,090	16,195	75,000	(58,805)	582,090	500,000	500,000	500,000
Property Tax Revenue	10,063,960		10,190,000	10,136,999	4,417	-	4,417	596,999	-	5,400,000	4,140,000
Donations	1,574,358		6,733,375	6,699,203	15,881	61,115	(45,234)	149,171	183,344	183,344	6,183,344
Debt Service Payments	(5,216,044)		(3,981,665)	(3,977,187)	(353,350)	(352,963)	(388)	(1,054,410)	(915,777)	(727,486)	(1,279,514)
Property Purchase Agreement	(811,927)		(811,927)	(811,928)	(67,661)	(67,661)	-	(202,983)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,717,326)		(715,553)	(715,553)	(143,111)	(143,111)	-	(429,332)	(286,221)	-	-
Copier	(63,919)		(47,871)	(43,392)	(5,482)	(5,094)	(388)	(10,803)	(15,282)	(15,282)	(2,025)
2017 VR Demand Bond	(840,606)		(761,145)	(761,145)	-	-	-	-	-	(97,930)	(663,215)
2015 Revenue Bond	(1,782,266)		(1,645,169)	(1,645,169)	(137,097)	(137,097)	0	(411,292)	(411,292)	(411,292)	(411,292)
Physician Recruitment	(476,666)		(1,146,666)	(1,013,332)	(33,333)	(133,333)	100,000	(83,333)	(316,666)	(280,000)	(333,333)
Investment in Capital											
Equipment	(2,315,113)		(4,545,602)	(4,545,602)	(525,919)	(1,325,967)	800,048	(682,703)	(1,483,125)	(1,209,137)	(1,170,637)
IT/EMR/Business Systems	(710,081)		(2,818,739)	(2,818,739)	-	(339,575)	339,575	-	(1,224,994)	(922,920)	(670,825)
Building Projects/Properties	(21,471,856)		(21,287,010)	(21,287,010)	(1,089,008)	(1,912,936)	823,928	(2,714,000)	(5,087,072)	(7,327,260)	(6,158,678)
Change in Accounts Receivable	(6,688,560)	N1	(2,859,354)	(2,737,098)	3,063,680	(214,799)	3,278,479	1,910,240	(3,708,739)	(625,643)	(312,955)
Change in Settlement Accounts	(8,255,522)	N2	4,265,118	3,063,693	(969,158)	(758,333)	(210,825)	(2,878,378)	(896,806)	(4,874,080)	11,712,957
Change in Other Assets	(4,867,539)	N3	(3,500,000)	(4,777,128)	(285,990)	(500,000)	214,010	(2,377,128)	(1,050,000)	(100,000)	(1,250,000)
Change in Other Liabilities	(7,640,029)	N4	(4,400,000)	(4,116,855)	(3,640,922)	(2,500,000)	(1,140,922)	(3,216,855)	(3,000,000)	(2,900,000)	5,000,000
Change in Cash Balance	(9,407,979)		(8,814,760)	(7,618,968)	(3,796,939)	(6,636,526)	2,839,587	(2,953,429)	(13,205,883)	(10,067,387)	18,607,731
Beginning Unrestricted Cash	154,252,753		144,844,775	144,844,775	145,688,285	145,688,285	-	144,844,775	141,891,346	128,685,462	118,618,076
Ending Unrestricted Cash	144,844,775		136,030,015	137,225,807	141,891,346	139,051,759	2,839,587	141,891,346	128,685,462	118,618,076	137,225,807
Operating Cash	144,844,775		136,030,015	137,225,807	141,891,346	139,051,759	2,839,587	141,891,346	128,685,462	118,618,076	137,225,807
Expense Per Day	736,531		803,035	793,961	753,622	789,620	(35,998)	753,622	770,584	788,502	793,961
Days Cash On Hand	197		169	173	188	176	12	188	167	150	173

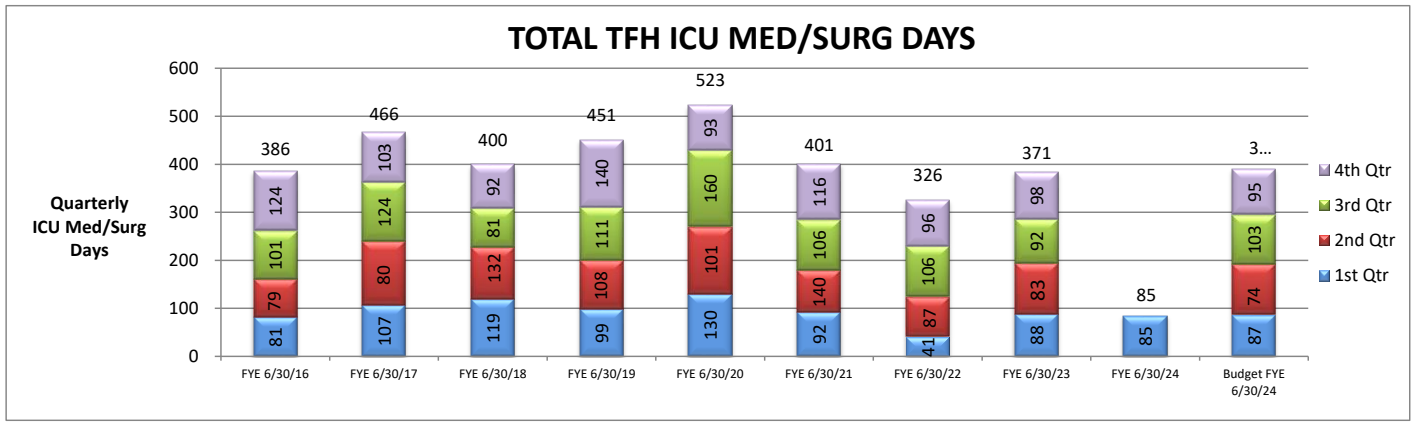
Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts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

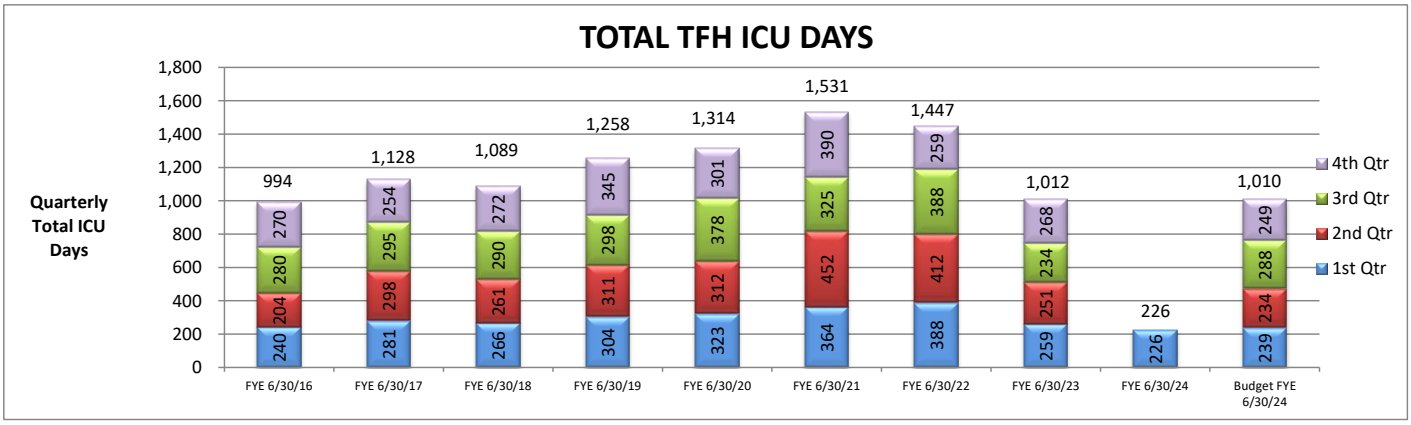

TOTAL TFH ADMISSIONS
Quarterly Admissions
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,569
1,808
1,829
1,760
1,626
1,470
1,882
1,503
405
1,589
352
456
485
443
345
338
455
360
389
447
438
480
443
380
368
491
355
412
406
451
440
402
407
374
485
378
375
364
463
424
472
494
390
451
410
405
413
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24

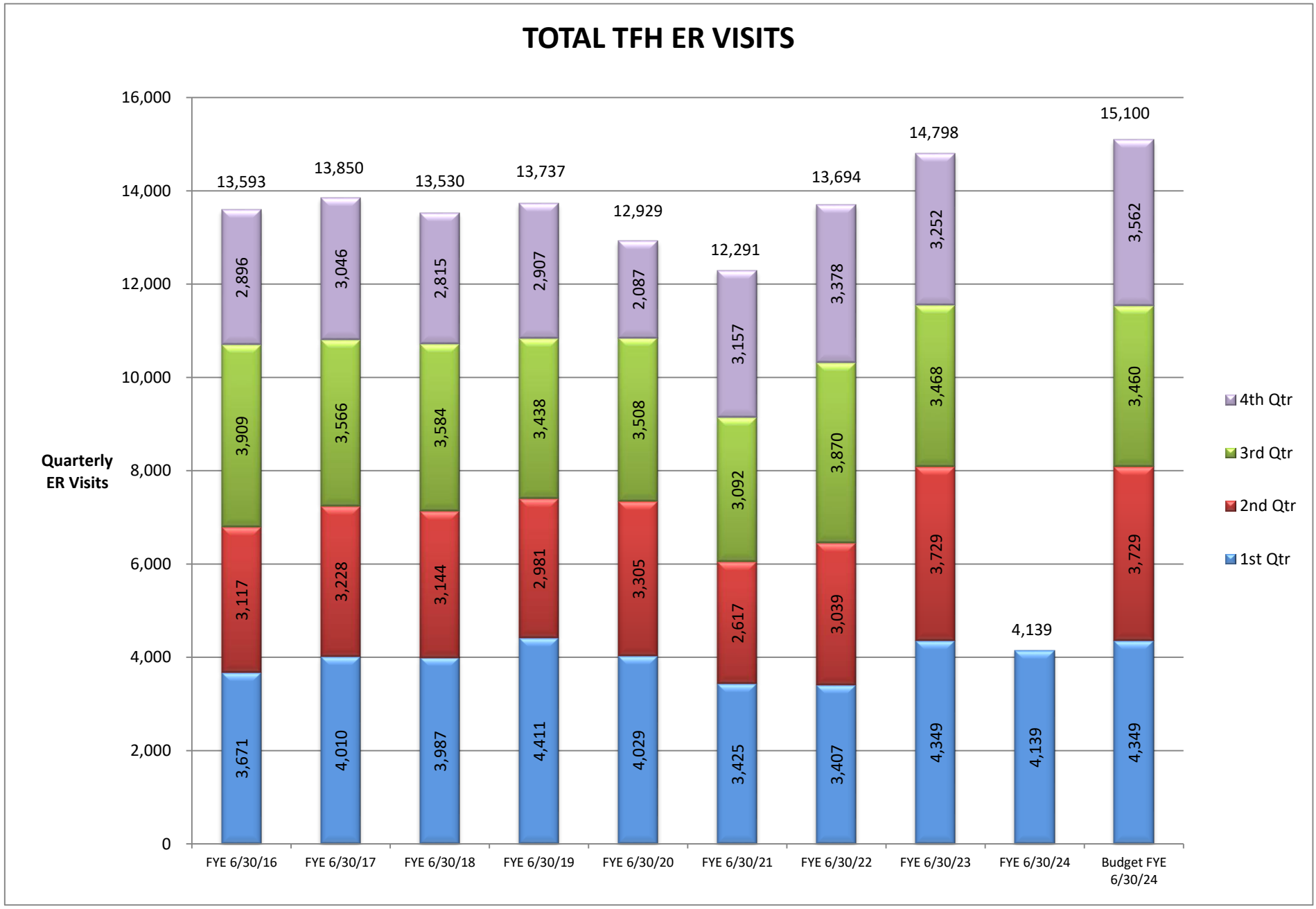

TOTAL TFH PATIENT DAYS
Quarterly Patient Days
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,694
4,873
4,328
5,786
5,547
5,299
5,598
4,852
1,244
5,194
1,139
1,259
1,086
1,534
1,211
1,281
1,264
1,112
1,262
1,333
1,163
1,015
1,406
1,387
1,202
1,336
1,246
1,354
1,148
1,206
1,059
1,357
1,458
1,560
1,549
1,184
1,221
1,074
1,245
1,168
1,489
1,491
1,256
1,449
1,310
1,244
1,357
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ICU INPATIENT DAYS
Quarterly ICU IP Days
600
500
400
300
200
100
0
196
219
254
247
273
434
545
200
51
240
56 33 60 47
45 56 65 53
43 55 85 71
78 64 48 57
55 37 80 101
100 163 70 101
157 185 141 62
61 45 50 44
51
60 45 66 69
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

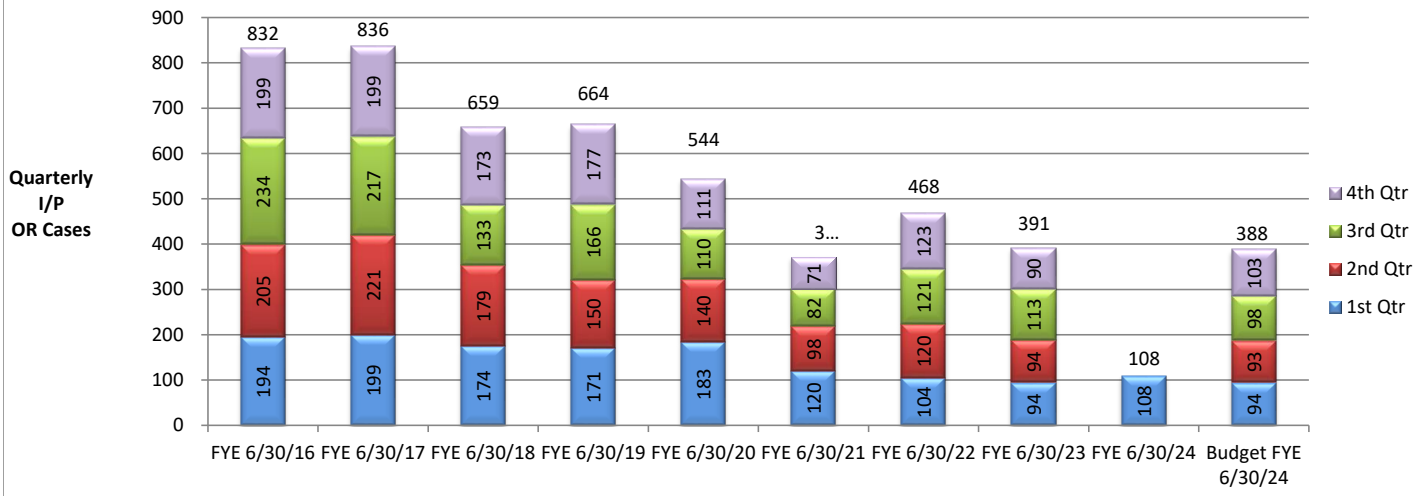

TOTAL TFH ICU STEPDOWN DAYS
Quarterly ICU Stepdown Days
700
600
500
400
300
200
100
0
412
443
435
560
518
696
576
428
90
380
103 91 119 99
129 110 106 98
104 98 124 109
127 146 139 148
138 135 138 107
172 202 149 173
190 144 141 101
110 100 92 126
90
92 84 119 85
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ICU MED/SURG DAYS
Quarterly ICU Med/Surg Days
600
500
400
300
200
100
0
386
466
400
451
523
401
326
371
85
3...
81 79 101 124
107 80 124 103
119 132 81 92
99 108 111 140
130 101 160 93
92 140 106 116
41 87 106 96
88 83 92 98
85
87 74 103 95
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

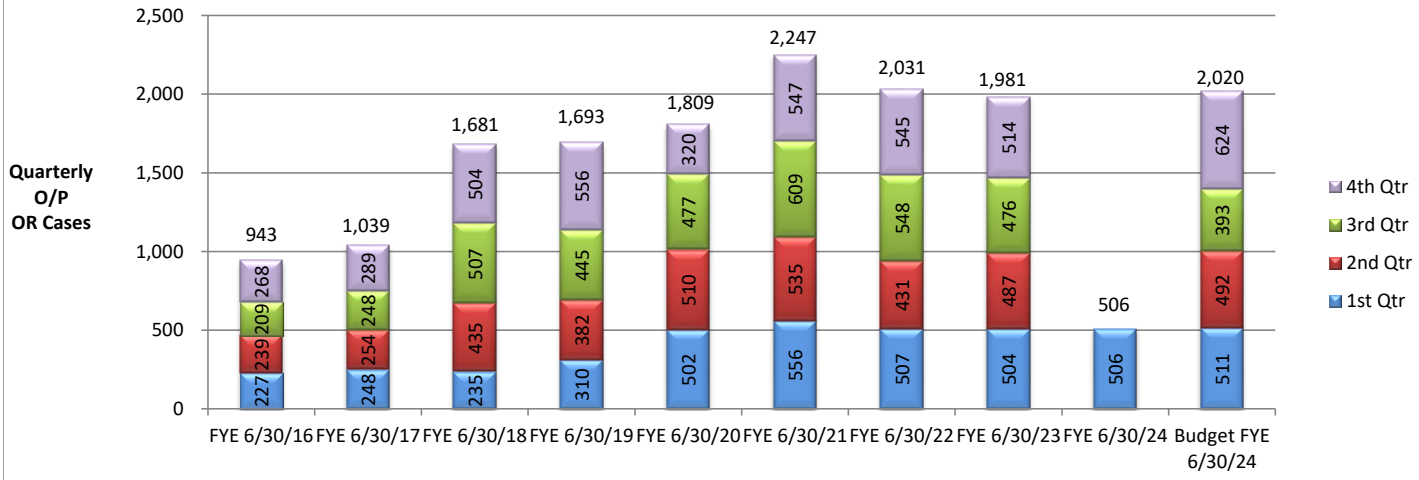

TOTAL TFH ICU DAYS
Quarterly Total ICU Days
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
994
1,128
1,089
1,258
1,314
1,531
1,447
1,012
226
1,010
240 204 280 270
281 298 295 254
266 261 290 272
304 311 298 345
323 312 378 301
364 452 325 390
388 412 388 259
259 251 234 268
226
239 234 288 249
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ER VISITS
Quarterly ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
13,593
13,850
13,530
13,737
12,929
12,291
13,694
14,798
4,139
15,100
2,896
3,046
2,815
2,907
2,087
3,157
3,378
3,252
3,562
3,909
3,566
3,584
3,438
3,508
3,092
3,870
3,468
3,460
3,117
3,228
3,144
2,981
3,305
2,617
3,039
3,729
3,729
3,671
4,010
3,987
4,411
4,029
3,425
3,407
4,349
4,139
4,349
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

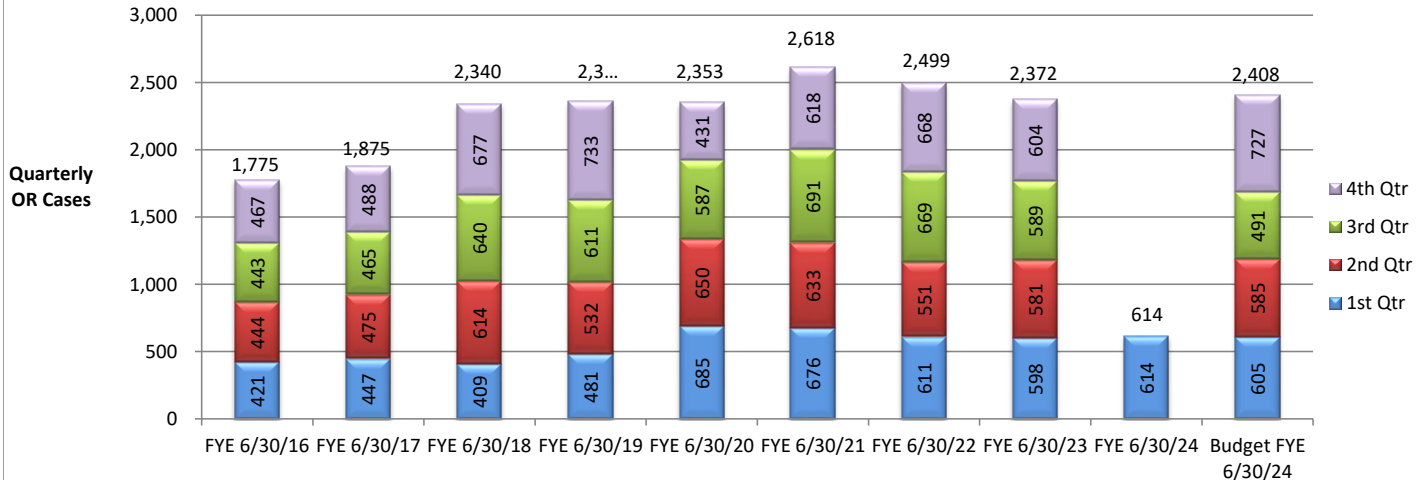
TOTAL TFH INPATIENT OR CASES

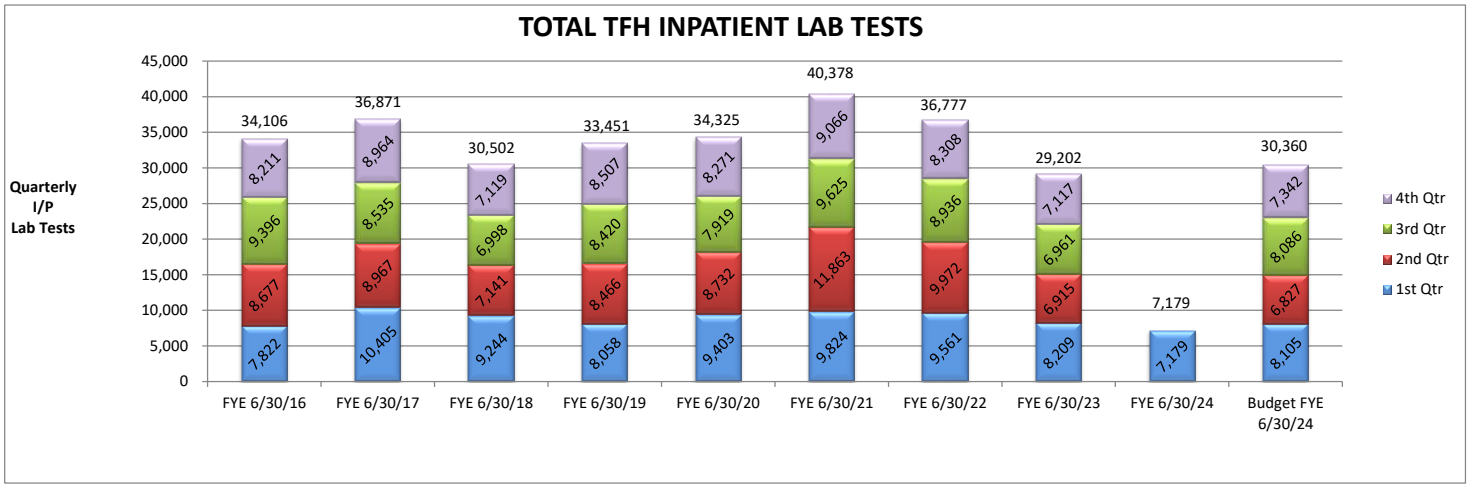


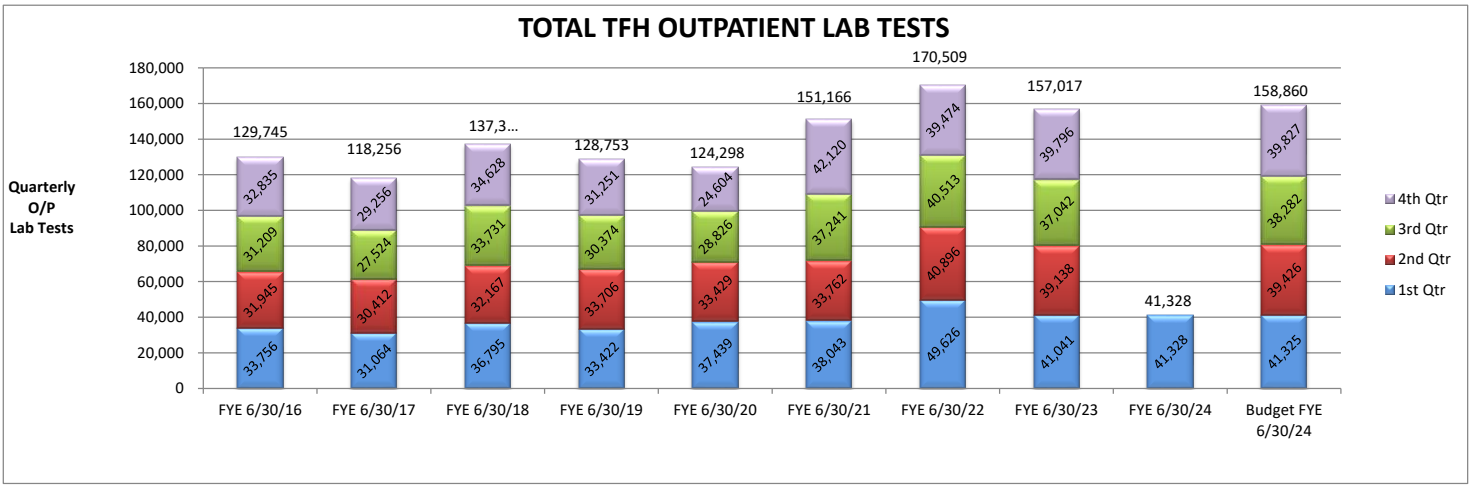
TOTAL TFH OUTPATIENT OR CASES

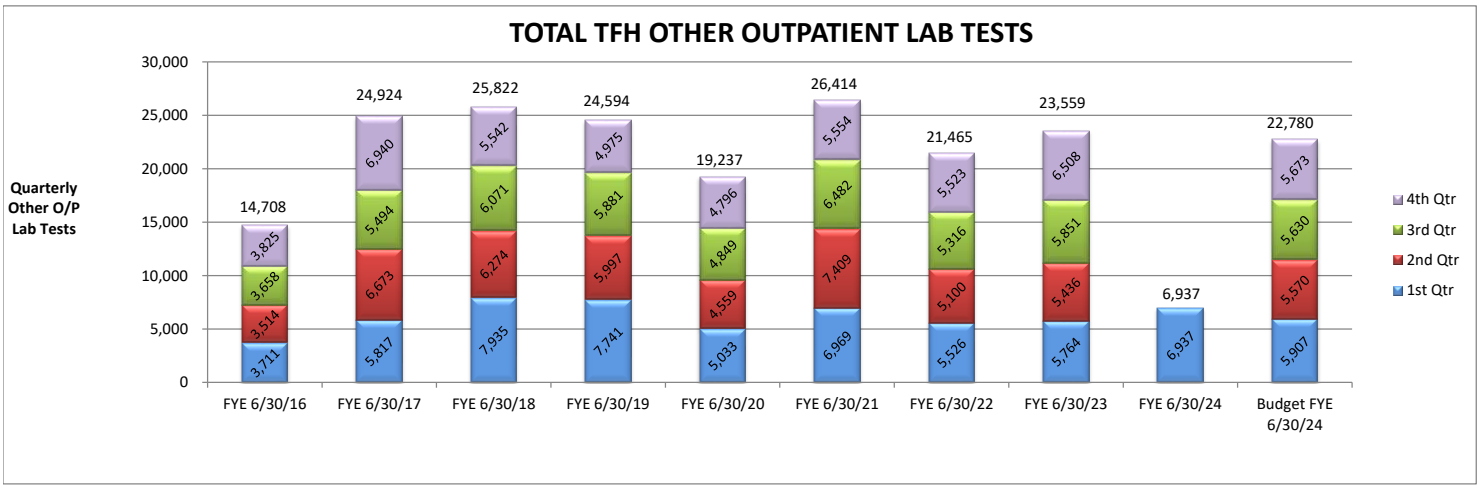


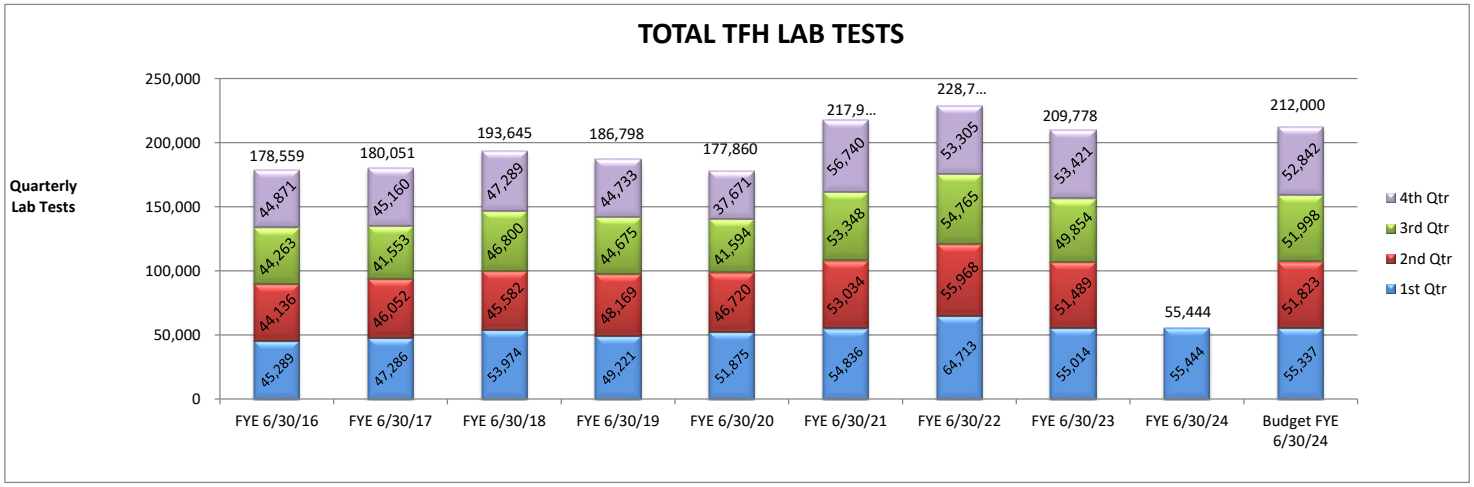
TOTAL TFH OR CASES



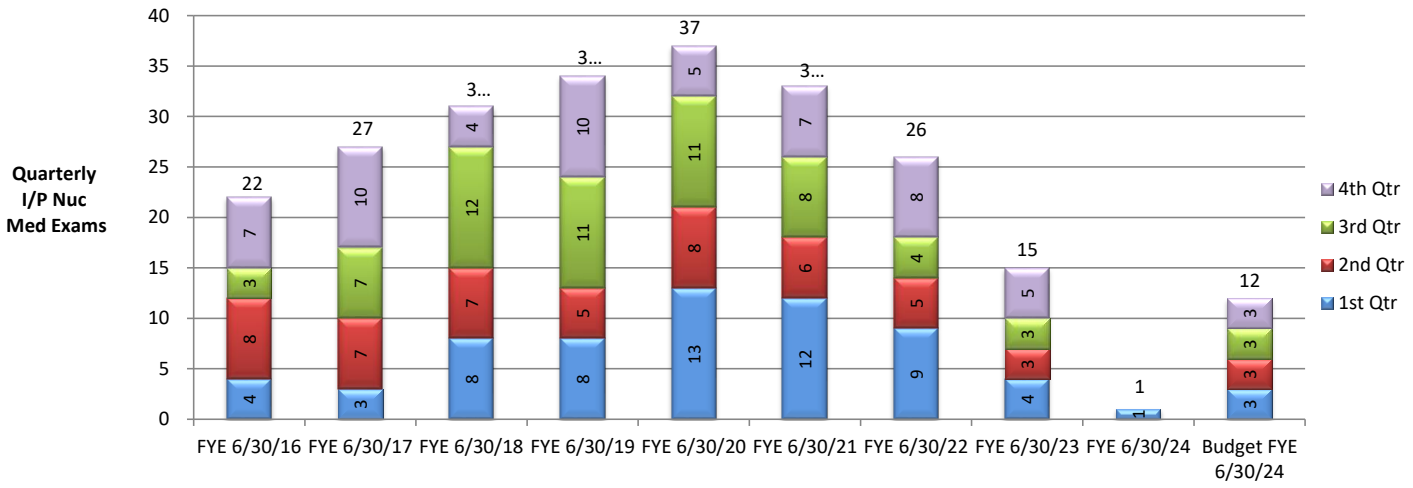

TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
34,106
36,871
30,502
33,451
34,325
40,378
36,777
29,202
7,179
30,360
8,211
9,396
8,677
7,822
8,964
8,535
8,967
10,405
7,119
6,998
7,141
9,244
8,507
8,420
8,466
8,058
8,271
7,919
8,732
9,403
9,066
9,625
11,863
9,824
8,308
8,936
9,972
9,561
7,117
6,961
6,915
8,209
7,179
7,342
8,086
6,827
8,105
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
129,745
118,256
137,3...
128,753
124,298
151,166
170,509
157,017
41,328
158,860
32,835
31,209
31,945
33,756
29,256
27,524
30,412
31,064
34,628
33,731
32,167
36,795
31,251
30,374
33,706
33,422
24,604
28,826
33,429
37,439
42,120
37,241
33,762
38,043
39,474
40,513
40,896
49,626
39,796
37,042
39,138
41,041
41,328
39,827
38,282
39,426
41,325
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

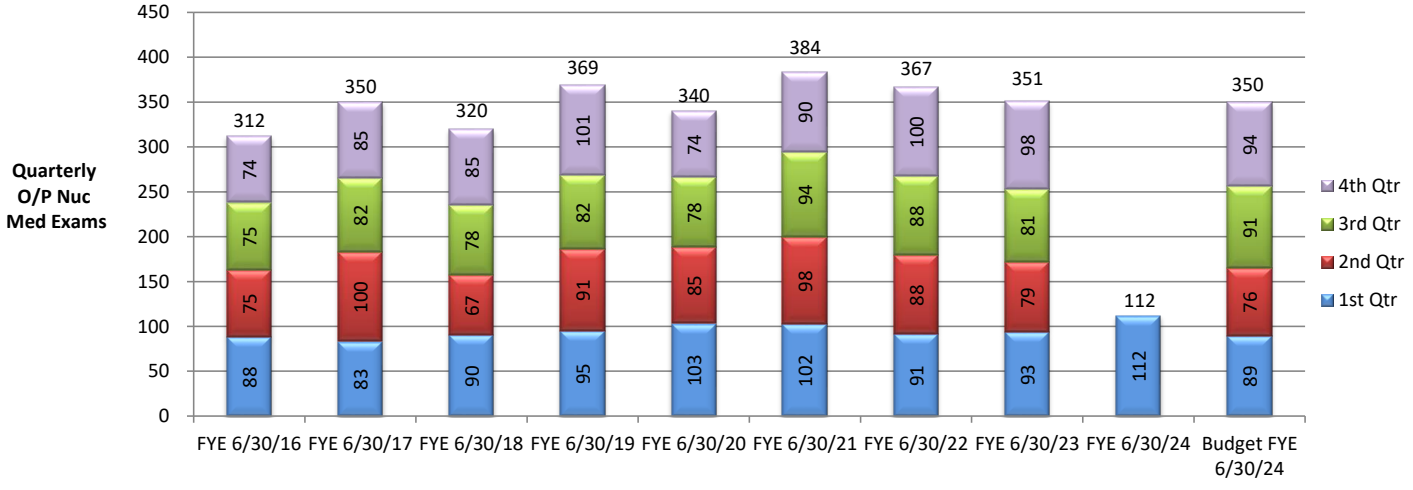

TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
30,000
25,000
20,000
15,000
10,000
5,000
0
14,708
24,924
25,822
24,594
19,237
26,414
21,465
23,559
6,937
22,780
3,825
3,658
3,514
3,711
6,940
5,494
6,673
5,817
5,542
6,071
6,274
7,935
4,975
5,881
5,997
7,741
4,796
4,849
4,559
5,033
5,554
6,482
7,409
6,969
5,523
5,316
5,100
5,526
6,508
5,851
5,436
5,764
6,937
5,673
5,630
5,570
5,907
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
178,559
180,051
193,645
186,798
177,860
217,9...
228,7...
209,778
55,444
212,000
44,871
44,253
44,136
45,289
45,160
41,553
46,052
47,286
47,289
46,800
45,582
53,974
44,733
44,675
48,169
49,221
37,671
41,594
46,720
51,875
56,740
53,348
53,034
54,836
53,305
54,765
55,968
64,713
53,421
49,854
51,489
55,014
55,444
52,842
51,998
51,823
55,337
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

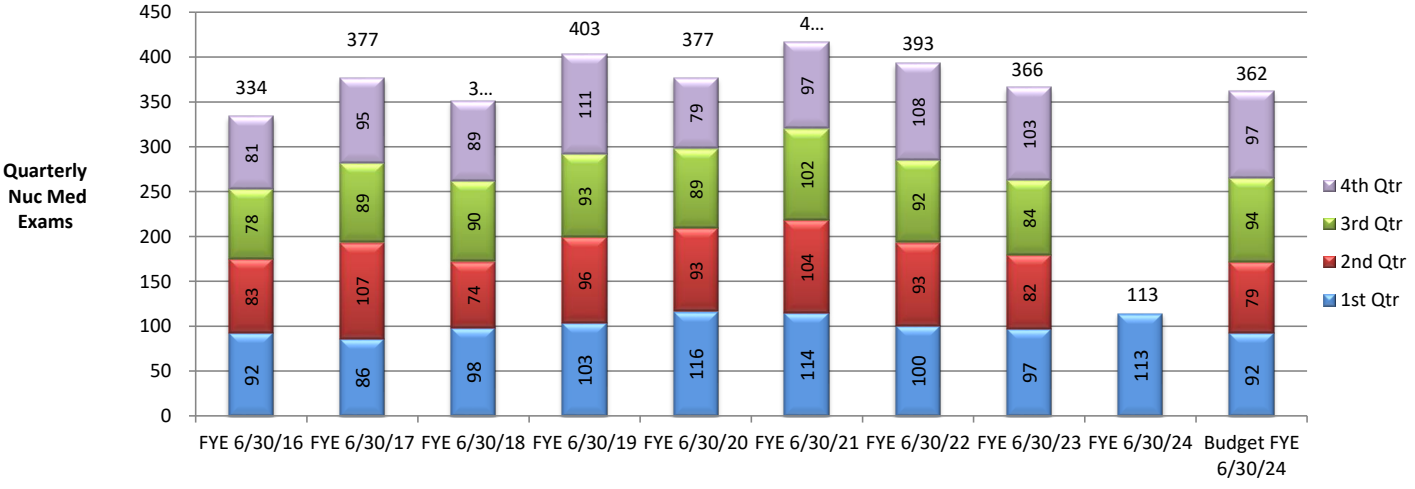
TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS

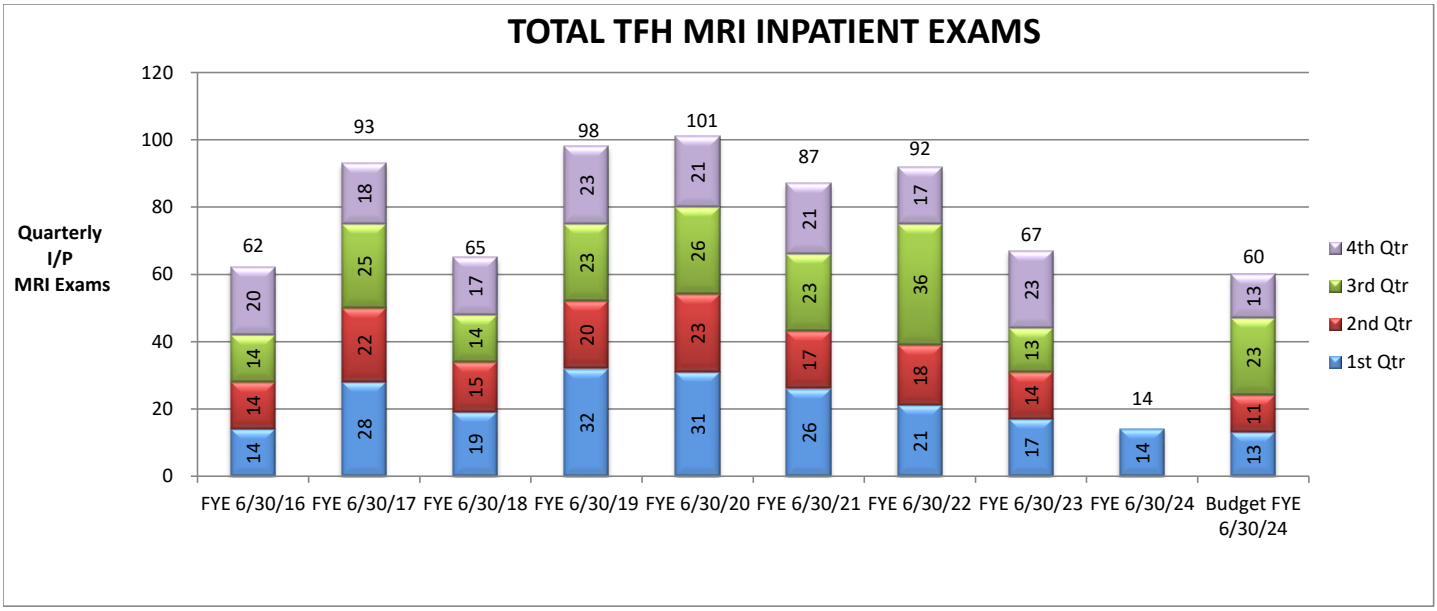


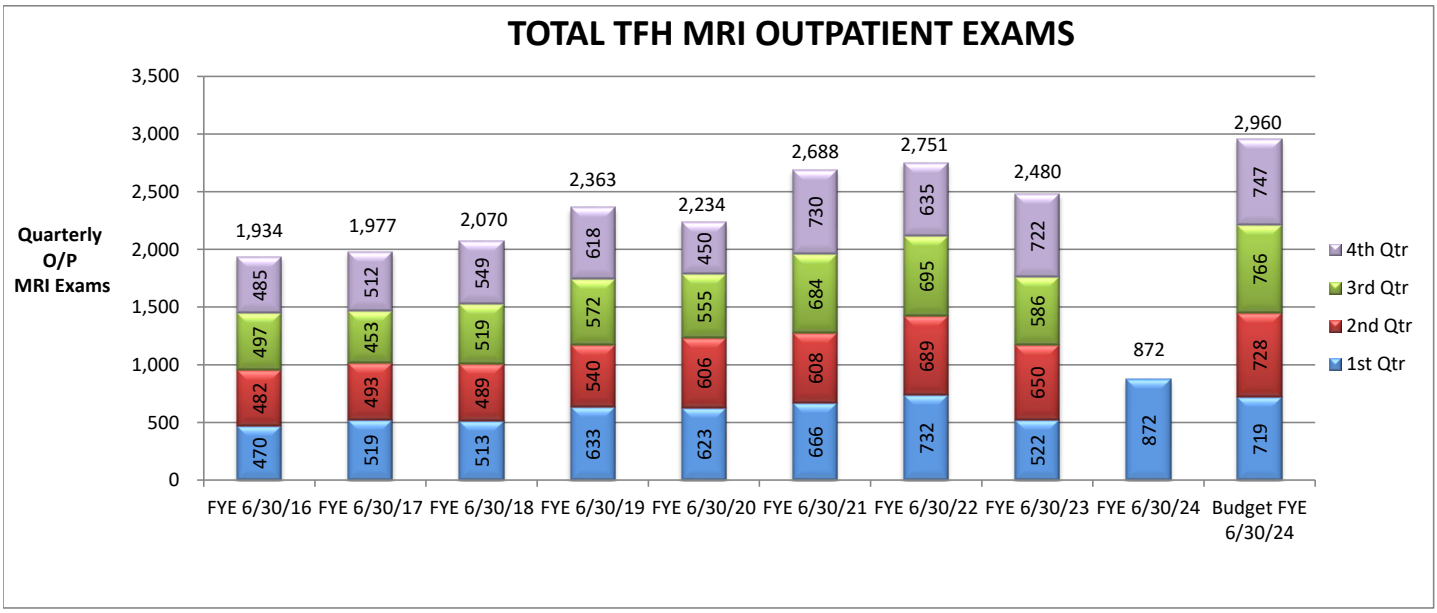
TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS

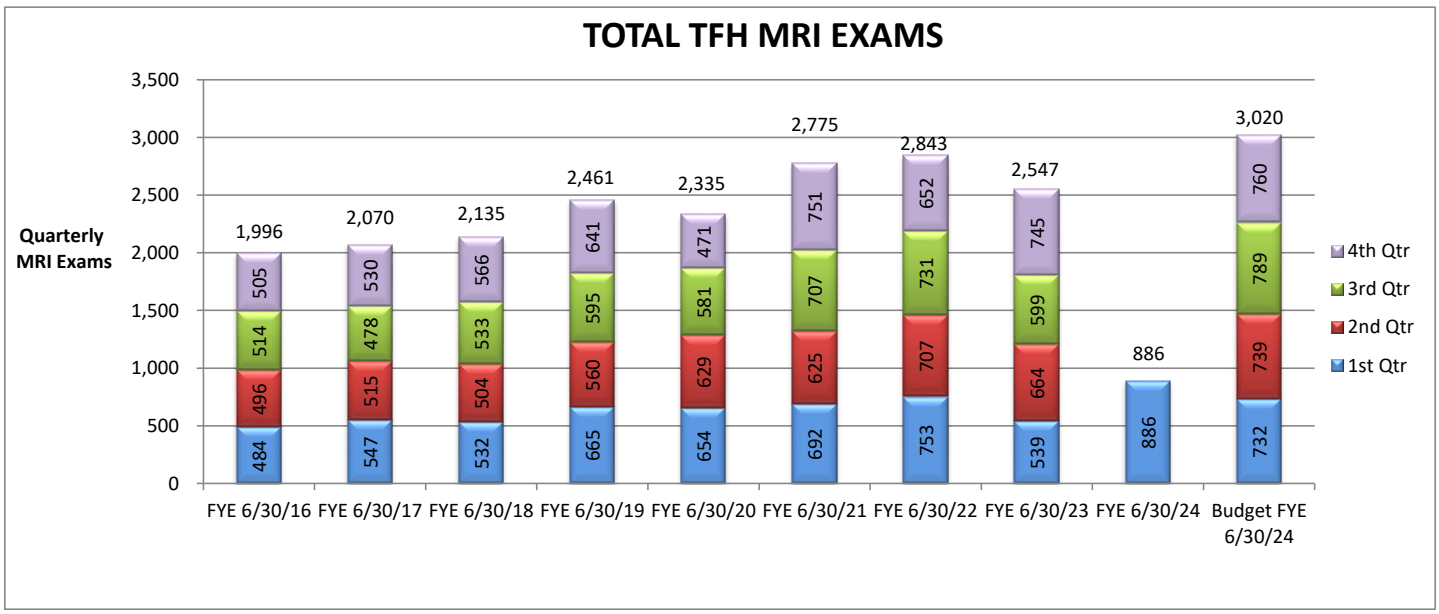


TOTAL TFH NUCLEAR MEDICINE EXAMS

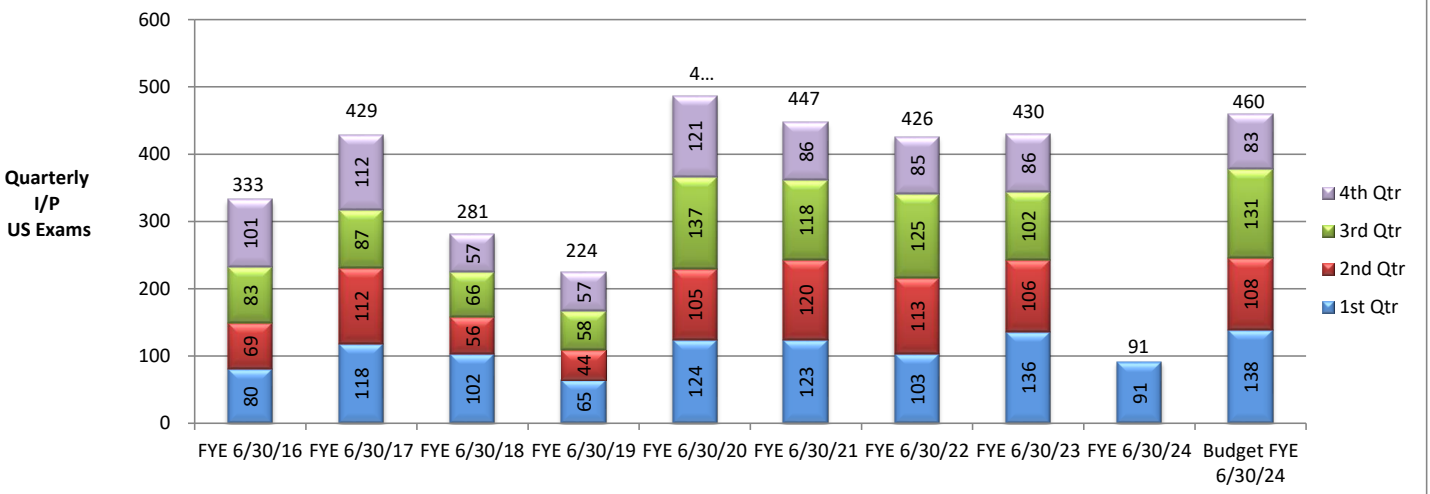



TOTAL TFH MRI INPATIENT EXAMS
Quarterly I/P MRI Exams
120
100
80
60
40
20
0
62
93
65
98
101
87
92
67
14
60
14 14 14 20
28 22 25 18
19 15 14 17
32 20 23 23
31 23 26 21
26 17 23 21
21 18 36 17
17 14 13 23
14
13 11 23 13
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

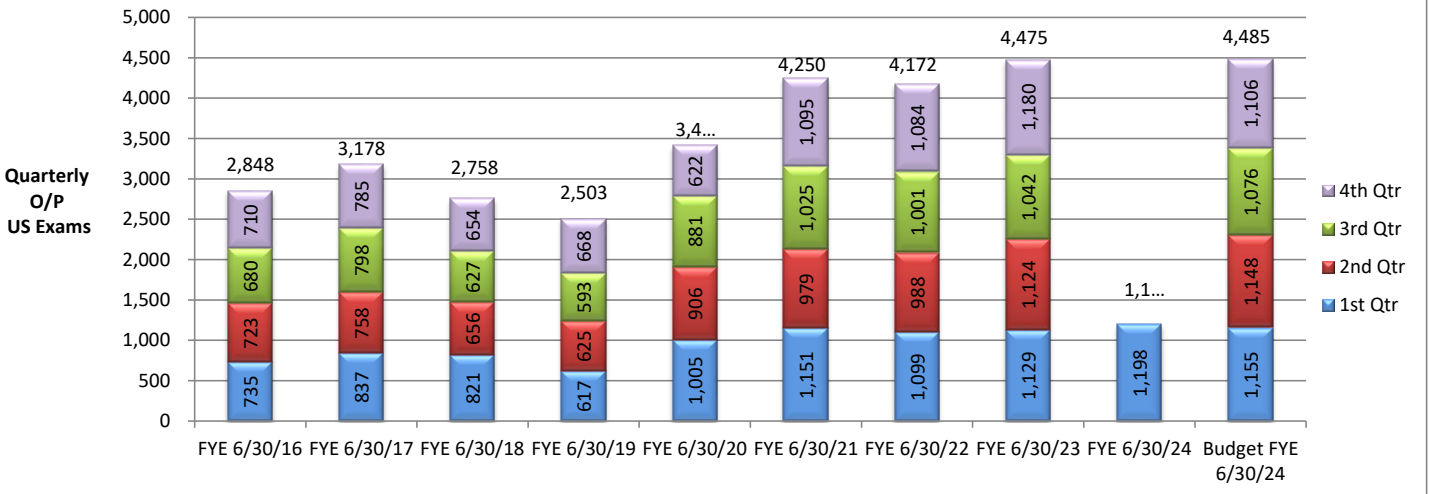

TOTAL TFH MRI OUTPATIENT EXAMS
Quarterly O/P MRI Exams
3,500
3,000
2,500
2,000
1,500
1,000
500
0
1,934
1,977
2,070
2,363
2,234
2,688
2,751
2,480
872
2,960
470 482 497 485
519 493 453 512
513 489 519 549
633 540 572 618
623 606 555 450
666 608 684 730
732 689 695 635
522 650 586 722
872
719 728 766 747
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH MRI EXAMS
Quarterly MRI Exams
3,500
3,000
2,500
2,000
1,500
1,000
500
0
1,996
2,070
2,135
2,461
2,335
2,775
2,843
2,547
886
3,020
484 496 514 505
547 515 478 530
532 504 533 566
665 560 595 641
654 629 581 471
692 625 707 751
753 707 731 652
539 664 599 745
886
732 739 789 760
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

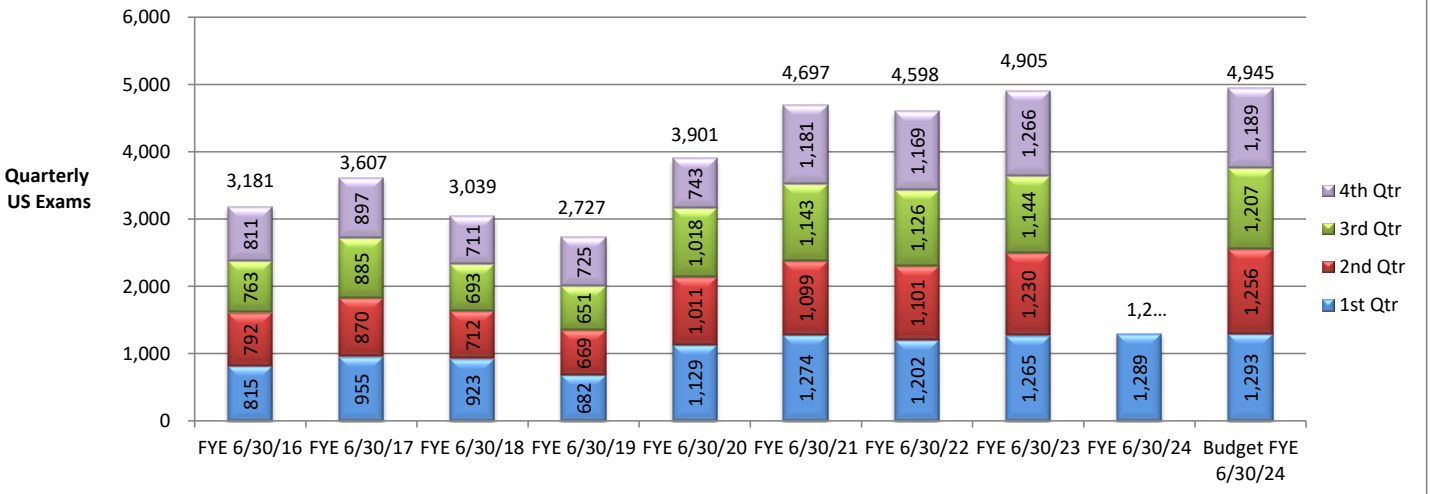
TOTAL TFH ULTRASOUND INPATIENT EXAMS

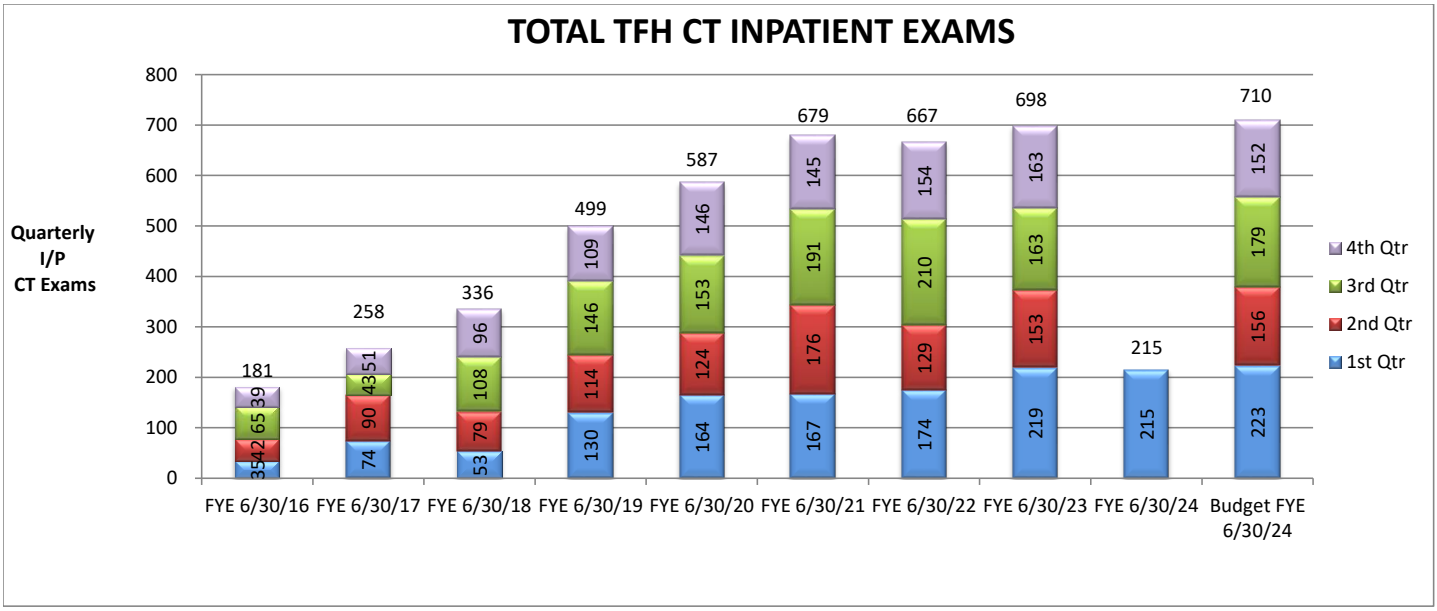


TOTAL TFH ULTRASOUND OUTPATIENT EXAMS



TOTAL TFH ULTRASOUND EXAMS




TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
800
700
600
500
400
300
200
100
0
181
258
336
499
587
679
667
698
710
215
39
65
35
42
51
43
90
74
96
108
79
53
109
146
114
130
146
153
124
164
145
191
176
167
154
210
129
174
163
163
153
219
152
179
156
223
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
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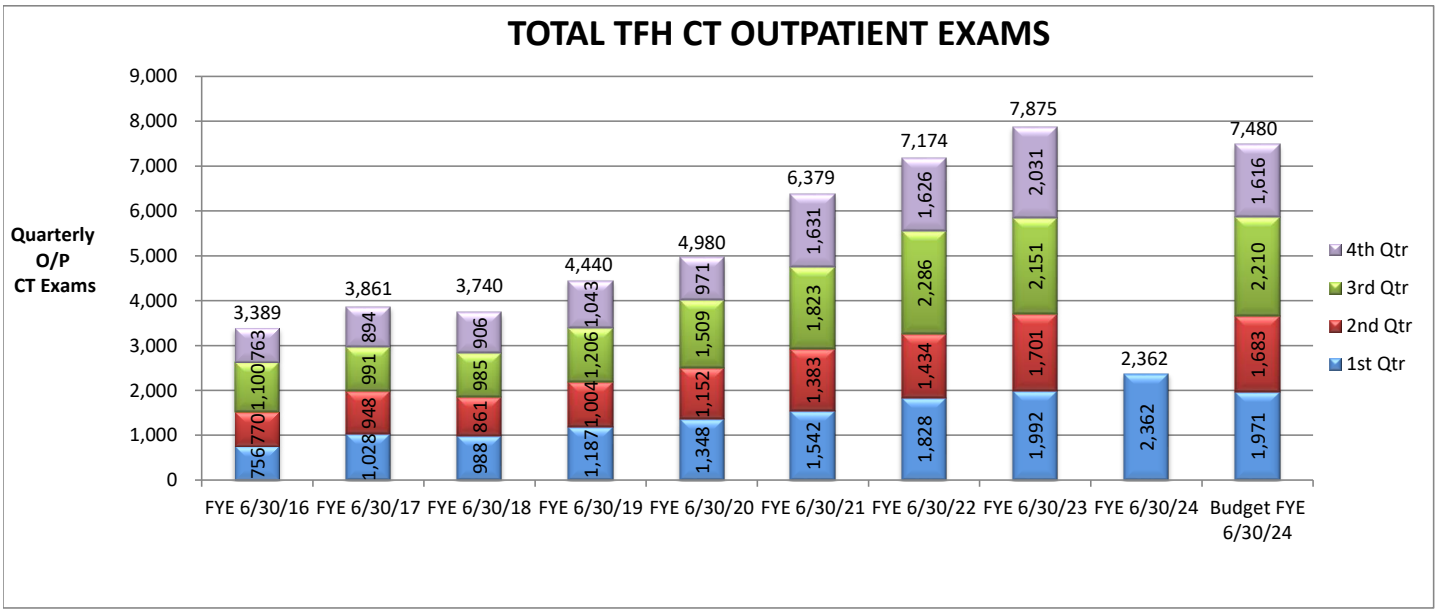
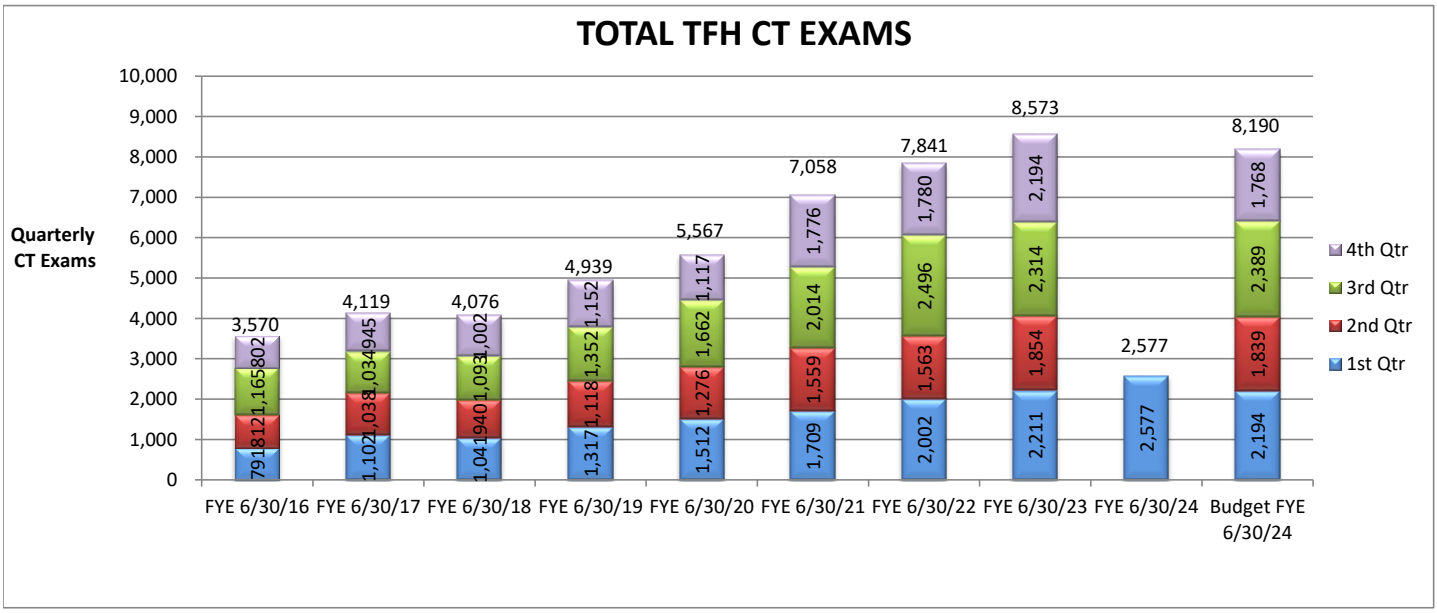
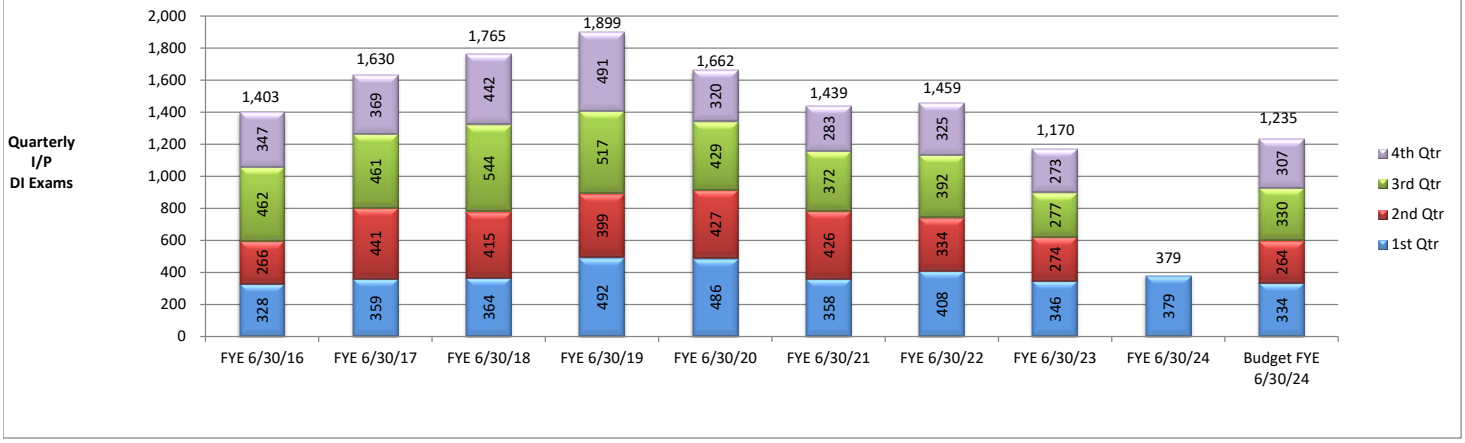
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24

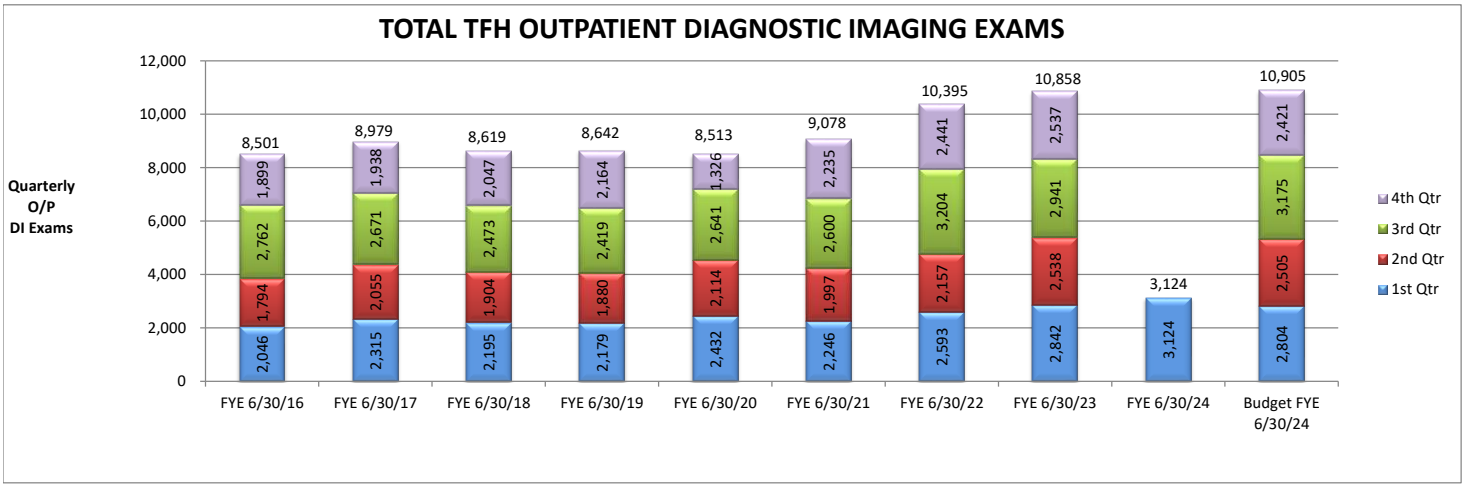

TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,389
3,861
3,740
4,440
4,980
6,379
7,174
7,875
2,362
7,480
763
1,100
770
756
894
991
948
1,028
906
985
861
988
1,043
1,206
1,004
1,187
971
1,509
1,152
1,348
1,631
1,823
1,383
1,542
1,626
2,286
1,434
1,828
2,031
2,151
1,701
1,992
2,362
1,616
2,210
1,683
1,971
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24


TOTAL TFH CT EXAMS
Quarterly CT Exams
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,570
4,119
4,076
4,939
5,567
7,058
7,841
8,573
2,577
8,190
802
1,165
812
791
945
1,034
1,038
1,102
1,002
1,093
1,040
1,041
1,152
1,352
1,118
1,317
1,117
1,662
1,276
1,512
1,776
2,014
1,559
1,709
1,780
2,496
1,563
2,002
2,194
2,314
1,854
2,211
2,577
1,768
2,389
1,839
2,194
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24

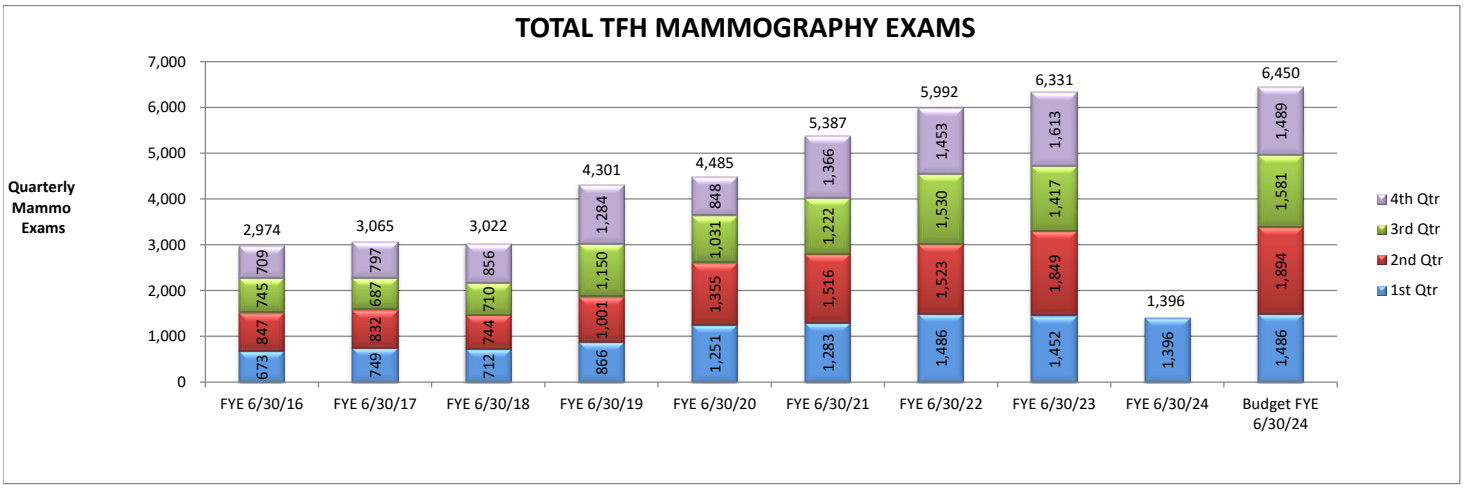
TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS



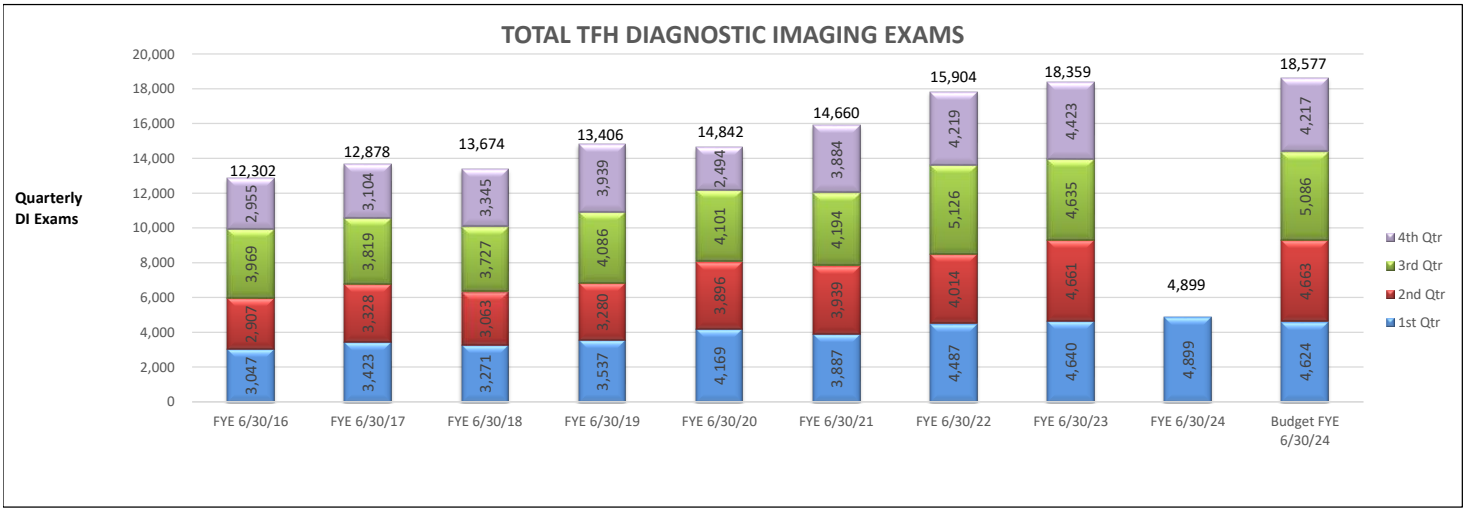
TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS

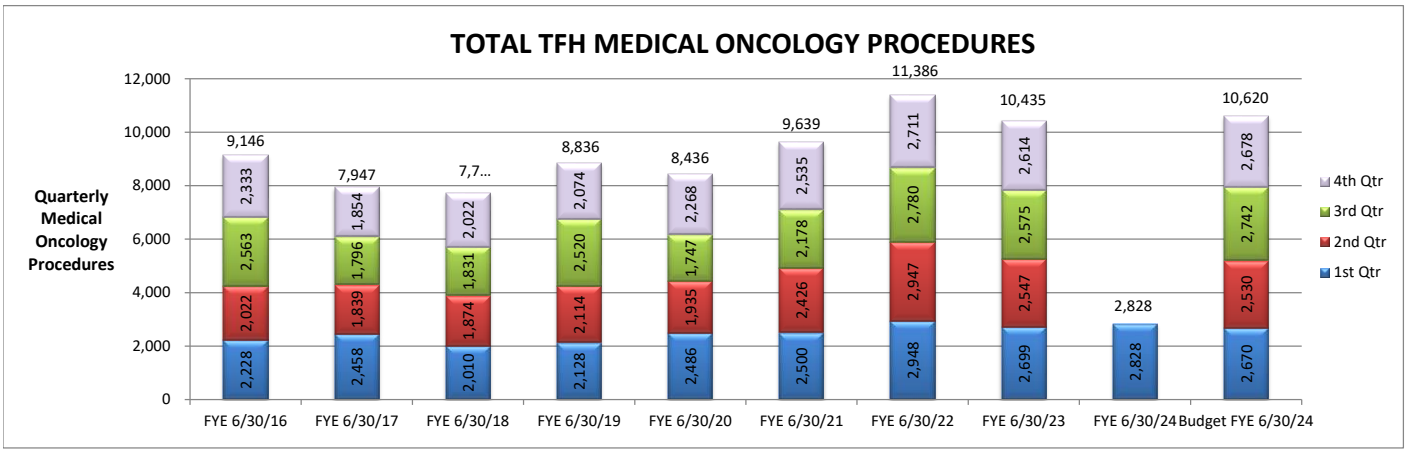


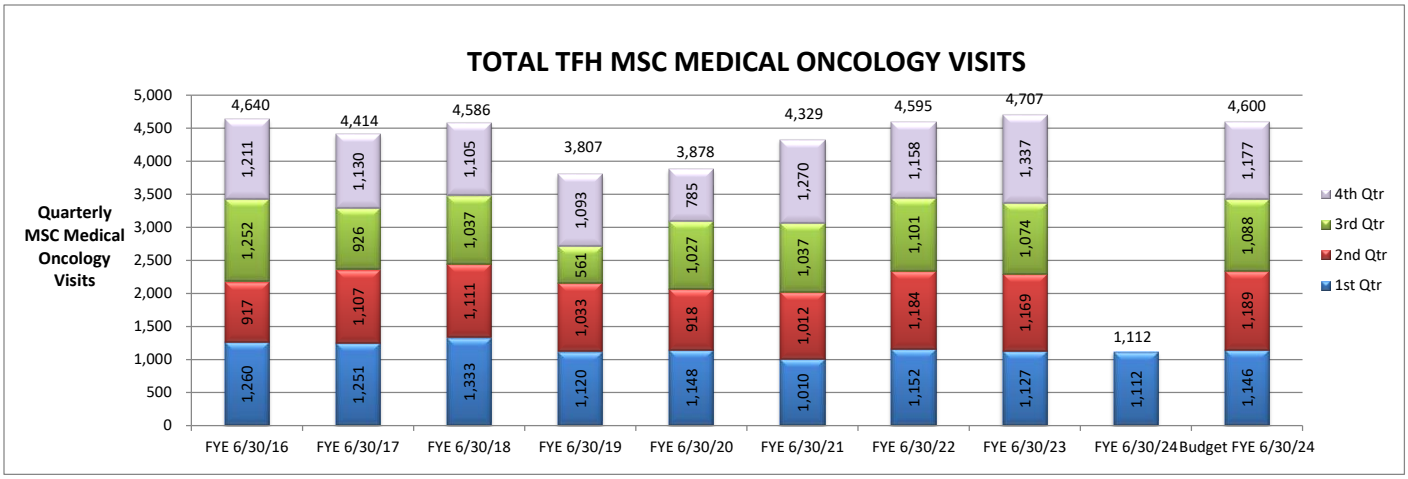
TOTAL TFH MAMMOGRAPHY EXAMS



TOTAL TFH DIAGNOSTIC IMAGING EXAMS




TOTAL TFH MEDICAL ONCOLOGY PROCEDURES
Quarterly Medical Oncology Procedures
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
9,146
7,947
7,7...
8,836
8,436
9,639
11,386
10,435
2,828
10,620


TOTAL TFH MSC MEDICAL ONCOLOGY VISITS
Quarterly MSC Medical Oncology Visits
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
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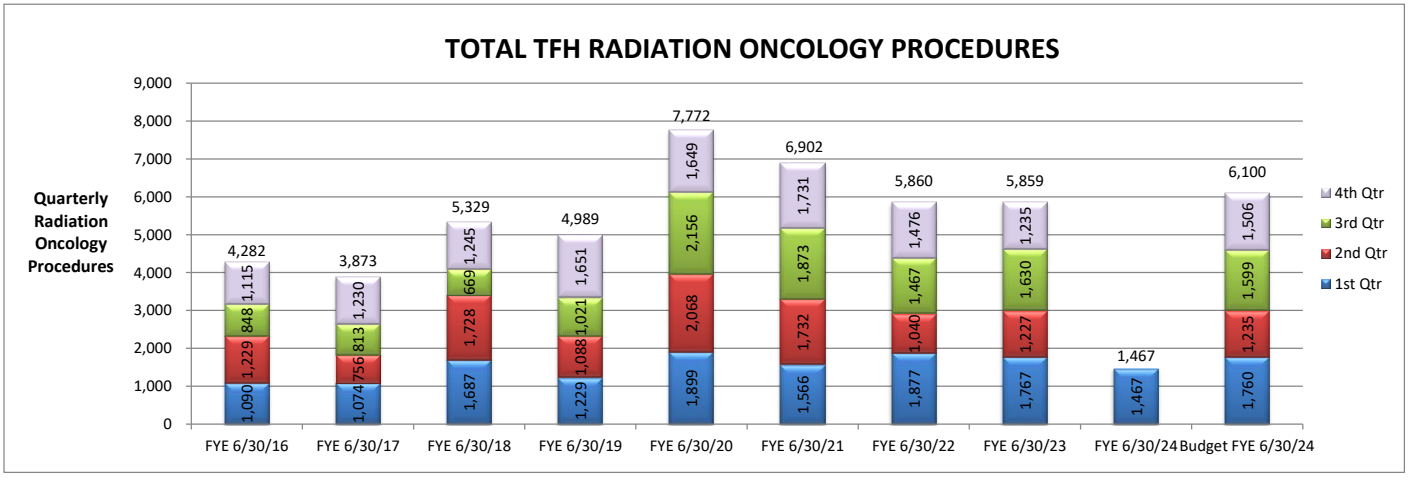
4,414
4,586
3,807
3,878
4,329
4,595
4,707
1,112
4,600


TOTAL TFH RADIATION ONCOLOGY PROCEDURES
Quarterly Radiation Oncology Procedures
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
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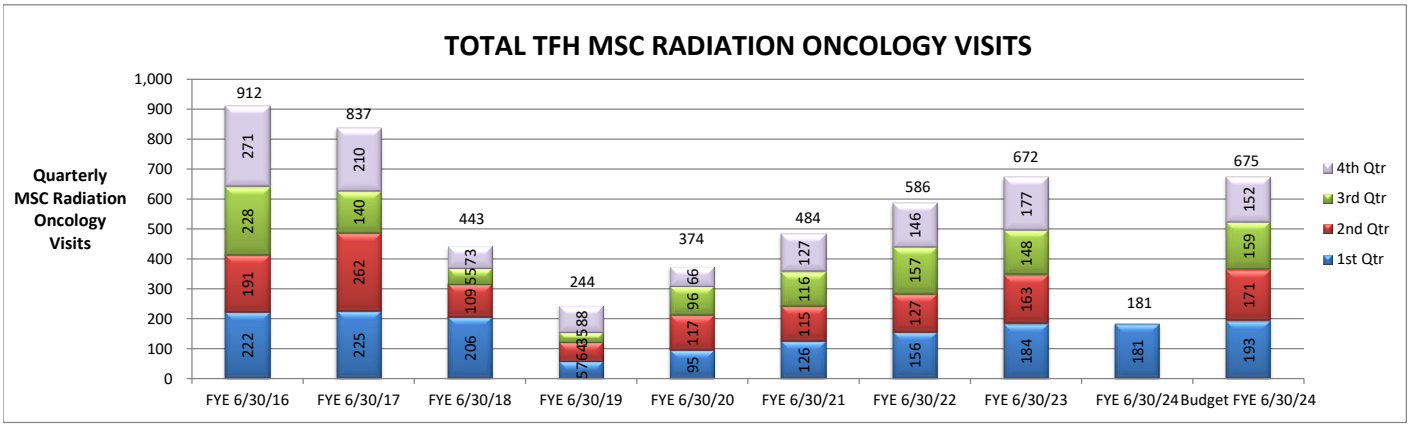
7,772
6,902
5,860
5,859
1,467
6,100


TOTAL TFH MSC RADIATION ONCOLOGY VISITS
Quarterly MSC Radiation Oncology Visits
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
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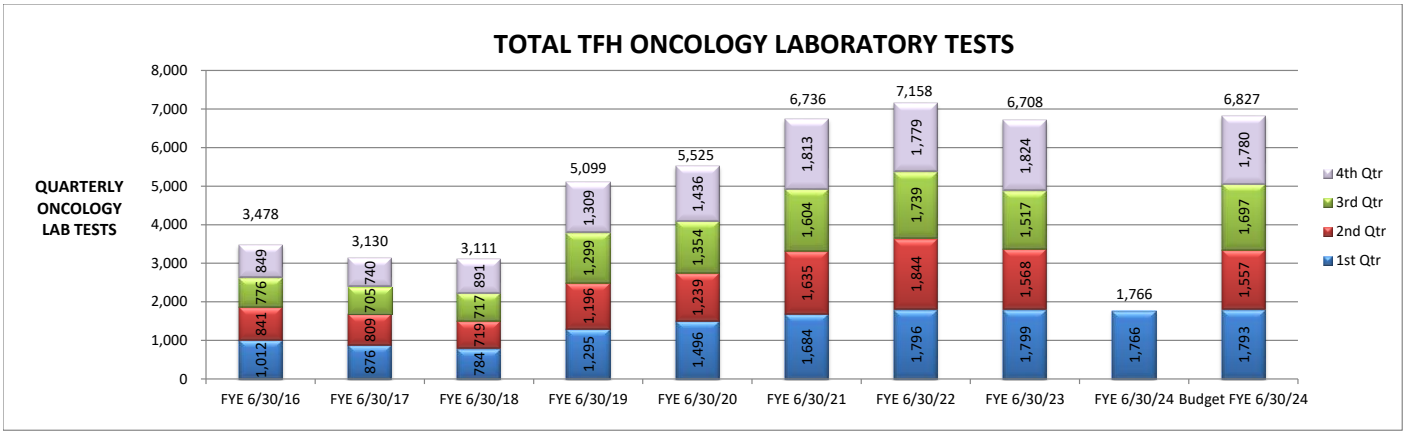
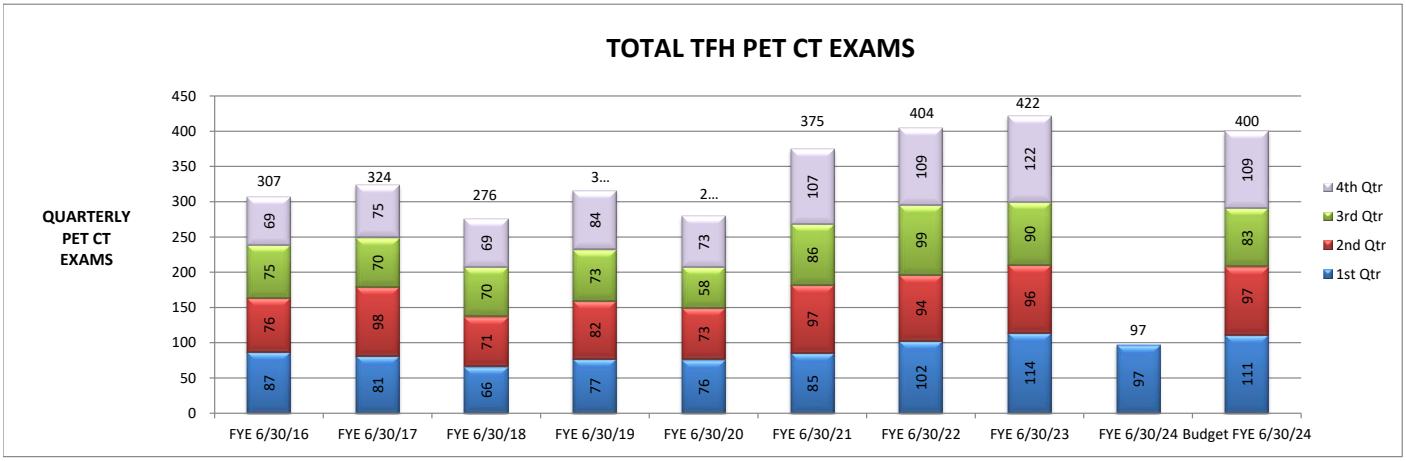
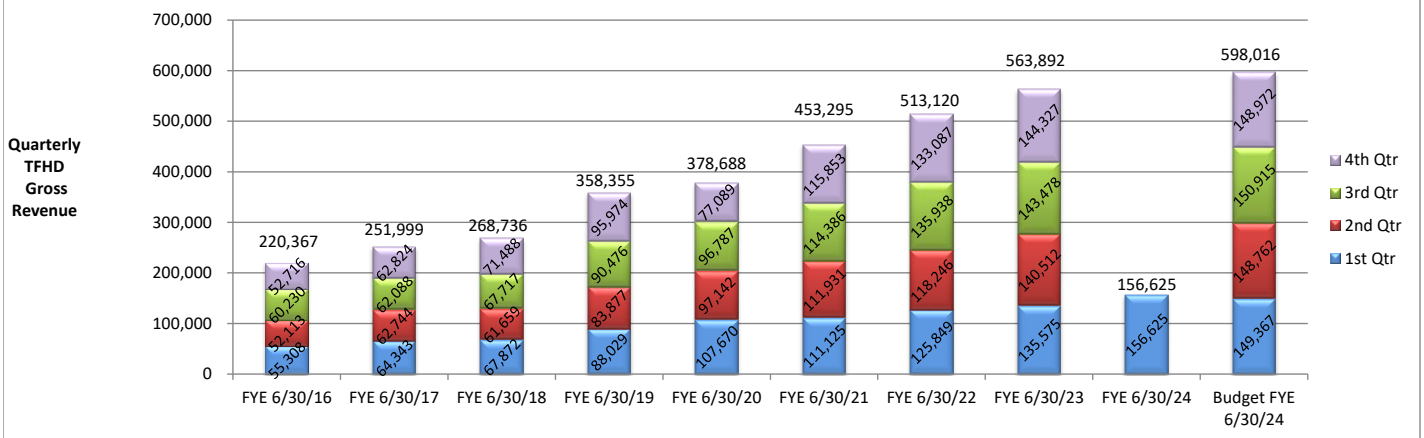
837
443
244
374
484
586
672
181
675

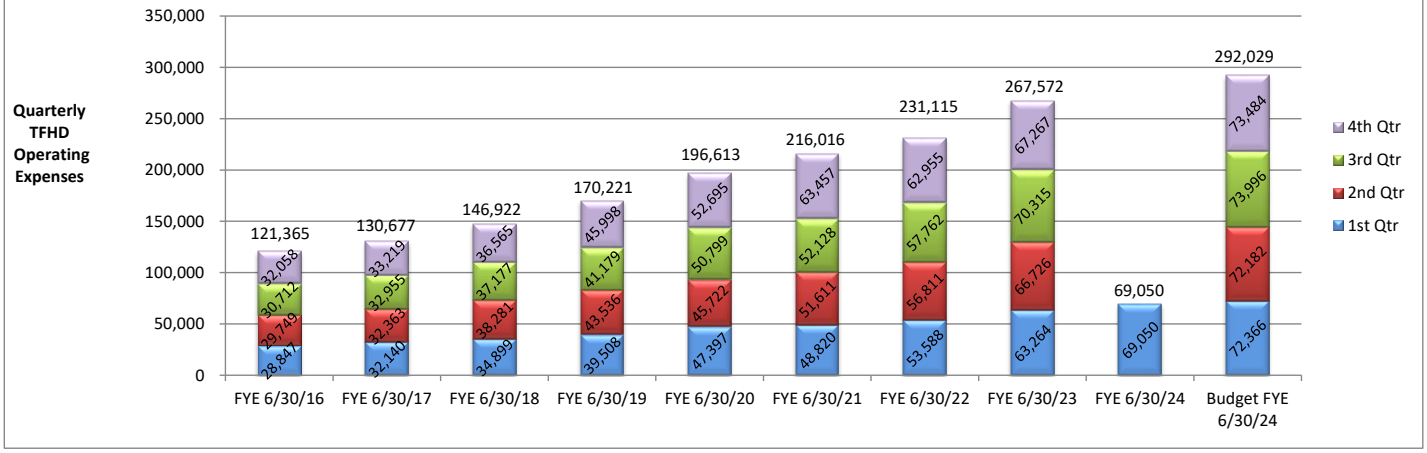

TOTAL TFH ONCOLOGY LABORATORY TESTS
QUARTERLY ONCOLOGY LAB TESTS
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,478
3,130
3,111
5,099
5,525
6,736
7,158
6,708
1,766
6,827
1,012 841 776 849
876 809 705 740
784 719 717 891
1,295 1,196 1,299 1,309
1,496 1,239 1,354 1,436
1,684 1,635 1,604 1,813
1,796 1,844 1,739 1,779
1,799 1,568 1,517 1,824
1,766
1,793 1,557 1,697 1,780
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH PET CT EXAMS
QUARTERLY PET CT EXAMS
450
400
350
300
250
200
150
100
50
0
307
324
276
3...
2...
375
404
422
97
400
87 76 75 69
81 98 70 75
66 71 70 69
77 82 73 84
76 73 58 73
85 97 86 107
102 94 99 109
114 96 90 122
97
111 97 83 109
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
Budget FYE 6/30/24
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

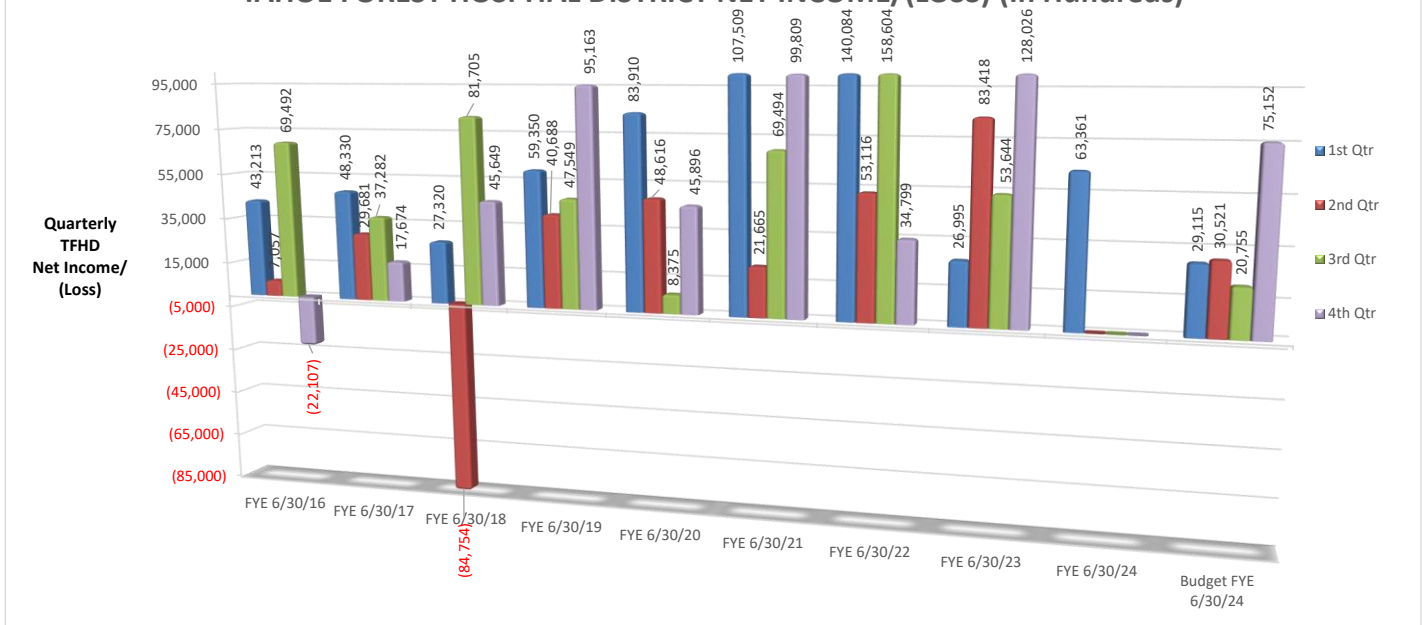
TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT NET INCOME/(LOSS) (In Hundreds)



TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
President and CEO

DATE: October 20, 2023

Now after our first three months of the new fiscal year, we are illustrating approximately 10% overall growth in the Health System vs the same three months last year. Last month, I had reported our growth estimate was 13% year over year, so with the inclusion of a weaker September, it reduced our year over year growth.

Our provider clinic visits weakened in September causing our annualized clinic visit total for Fiscal Year 2024 to drop from an estimate of 139,000 to 137,000 now based on three months of actual performance. As a point of context in Fiscal Year 2023, we achieved approximately 129,000 provider clinic visits.

As we focus on our Strategic Plan, we are bringing forward a new updated sheet to be framed around the Health System that illustrates our Mission, Vision, Values and our 5-Year Aspirational Goals for Board consideration and approval at our October board meeting.

We are also thrilled to share at the October board meeting a partial list of the many team accomplishments over the past fiscal year that are all focused on our patients. We are proud of our team!

We were thrilled to hold four Town Hall meetings in early October to reach “in person” as many team members as possible. We were able to talk about the large external factors that are impacting the present and future of rural and urban healthcare across America, share the very serious challenges we face in our 10-year Financial Forecast, provide an update on our Master Plan and share our Management Systems investment processes and strategies to engage our front line staff on vital changes which are necessary to be sustainable for the longer term.

Choosing to keep the status quo for any health system is in nearly all cases a dangerous unsustainable strategy.

The State of California requires that we notify many key stakeholders on where we are as to being fully complete on the 2030 CA Seismic laws, which covers more than just seismic structural improvements. So our team will share with the Board in October and with other stakeholders where we presently are in this very difficult and costly journey. This seismic law is one of many examples of a very large unfunded mandate by the state.

Again, California requires, that hospitals have certain levels of structural and nonstructural strength levels or building code levels of performance and the State also requires that each licensed hospital operate as an “independent city” should electrical, natural gas, water and

sewage services be disrupted. So we are required to use very specific “highly reliable” sources in each of these domains.

Parking continues to be a big challenge for our patients and even obtaining remodel permits for the Old Gateway Center on Donner Pass Road are proving to be a real challenge as we are being requested to lower the number of parking spots we have used for decades that serve our patients at the Old Gateway Center.

California did pass a new minimum wage law for healthcare in urban, rural, large and small health systems across State that begins to go into effect next year. This new law is a large unfunded mandate by the State, which will drive up the annual increases in the cost of healthcare for the future.

We are grateful to be operating in the “black” when many communities such as Reno, Carson City, Bishop, Ridgecrest, South Lake Tahoe, Hollister, Watsonville, Madera, Montebello, Visalia, and many more communities in Nevada and California are really struggling or have closed their healthcare facilities.

We just hosted a meeting of several hospitals in Northern CA with their CEOs to learn of the successes and challenges our neighboring hospitals are facing.

After listening to many other Northern CA healthcare CEOs, it does appear that we have been able to recruit and retain, key medical staff and other healthcare staff with much greater success than we heard on October 17th from many of our area CEOs.

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Louis Ward
Chief Operating Officer

DATE: October 2023

Service: Deliver Outstanding Patient & Family Experience

Continuously improve access to care

- Ski agreements

2023-2024 ski season agreements have been sent to ski resort leadership. All executed agreements are due back to Tahoe Forest Administration in late October to allow for counter signature and staffing preparation.

People: Strengthen a highly-engaged culture that inspires teamwork & joy

Nuture mutual trust

- Celebrating Tahoe Forest Retail Pharmacy

This month the administrative council celebrated with the TFHS retail pharmacy staff. The pharmacy was named the best pharmacy by residents in the North Lake Tahoe region. The staff of the pharmacy truly do a wonderful job!

Growth: Expand and foster community and regional relationships

Explore and engage beneficial collaborations and partnerships

- Hospital Council Visit

This month Tahoe Forest Administration hosted the Northern Section Hospital Council Meeting. In attendance at the meeting was the President of the California Hospital Association, President of the Hospital Council, and over 20 Hospital CEOs representing small, medium, and large hospitals and health systems from all around Northern California. Various topics were discussed at the meeting including SB525 (minimum wage bill), seismic readiness, workforce shortage, housing, telehealth reimbursement, and future legislation strategies. It was a great to see many familiar faces and share Tahoe Forest Health Systems successes and opportunities with other healthcare leaders.

Quality: Provide excellent patient focused quality care

Identify and promote best practice and evidence-based medicine

- Hospital Quality Institute Annual Conference

The Hospital Quality Institute (HQI) conference was held at Everline Resort this month. Administration joined a number of Tahoe Forest Health Systems Quality Professionals at the content filled conference. I had the pleasure of opening the conference by welcoming the over 600 healthcare leaders attending the conference to the Truckee/Tahoe Community. The conference hosted great speakers who shared valuable content related to healthcare quality, employee resilience, patient safety, and just culture.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency

Implement a focused master plan

- Report provided by Dylan Crosby, Director Facilities and Construction Management

Planned Moves:
Care Coordination - October 23, 2023

Active Projects:

Project: Martis Outlook Plastics
Background: Staff have focused on providing health care services in the Eastern portion of Truckee. Property was acquired in 2021 at the Martis Outlook Building to realize this goal.
Summary of Work: Demo interiors of existing suite to build out new clinic space.
Update Summary: Drywall is half complete. Project is paused waiting on new lighting design installation.
Start of Construction: Spring 2023
Estimated Completion: Spring 2024

Project: Martis Outlook Primary Care
Background: Staff have focused on providing health care services in the Eastern portion of Truckee. Property was acquired in 2021 at the Martis Outlook Building to realize this goal.
Summary of Work: Demo interiors of existing suite to build out new clinic space.
Update Summary: Drywall and Painting have been completed.
Start of Construction: Spring 2023
Estimated Completion: Winter 2023

Project: Incline Village Community Hospital X-Ray and CT Replacement
Background: Incline Village Community Hospital has been provided a grant opportunity to support the replacement of the X-Ray and CT at the Hospital. Various components of the X-Ray are end of service and end of support. The CT is approaching end of service. The new CT will be replaced with a new 128 slice machine, existing 16 slices. Install new Mammography Machine.
Summary of Work: Provide temporary accommodations to ensure hospital can provide X-Ray and CT services during the project. Replace X-Ray and CT equipment and modify space for code compliance and improved staff and patient workflow.
Update Summary: New X-Ray and CT are being delivered 10/23-24/23 and install to commence. Mammography has been submitted to the Authority Having Jurisdiction and is under review.
Start of Construction: Spring 2023
Estimated Completion: Spring 2024

Projects in Planning:

Project: Tahoe Forest Hospital Seismic Improvement
Background: In 2012, Tahoe Forest Hospital completed an expansive seismic improvement job to extend the allowance of acute care service in many of the Hospital buildings up to and beyond the 2030 deadline determined by Senate Bill 1953. This project is Phase one of three in a compliance plan to meet the full 2030 deadline.
Summary of Work: Upgrade four buildings (the 1978, 1990, 1993 and Med Gas) to Non-Structural Performance Category “NPC” 4 status. Renovate the Diagnostic Imaging reception, waiting room and X-Ray to increase capacity and receive new equipment. Renovate Emergency Department beds 8-15 to provide addition patient privacy. Renovate Emergency Department beds 4-7 to private rooms. Aesthetic upgrades of the 1978 and 1990 buildings including but not limited to flooring, ceilings, signage and painting.
1978 Building – Diagnostic Imaging, portions of Emergency Department
1990 Building – Portions of the Surgical Department
1993 Building – Portions of the Dietary Department
Med Gas Building – Primary Med Gas distribution building.
Update Summary Project has been put on hold.

Start of Construction: Summer 2024
Estimated Completion: Winter 2026

Project: Levon Parking Structure
Background: Demand for parking Tahoe Forest Hospital has far exceeded its capacity. This project is to create a staff parking structure to meet the current and future needs of staff and importantly provide accessible parking for our patients.
Summary of Work: Project intent is to concurrently work on this project thru the entitlements effort on the Tahoe Forest Master Plan effort. This project being dependent on the Master Plan approval. This project will provide upwards of 225 parking stalls and various biking parking opportunities to support the parking need of the Tahoe Forest campus. The use intent is for this structure to service staff being located off Levon Ave, the Hospital service corridor.
Update Summary: Project is in programming. Site survey has been completed and site design has commenced.
Start of Construction: TBD
Estimated Completion: TBD

Project: Gateway RHC Expansion
Background: With the longevity of the existing Gateway Building in the Master Plan staff are looking to maximize the utilization. Staff will be working to expand the current RHC to provide Dental, Opto, Behavioral Health and Out Patient Lab Services.
Summary of Work: Remodel 8 suites within the Building.
Update Summary Tenant Improvement is an approved program. Site design and demolition plan have commenced.
Start of Construction: Spring 2024
Estimated Completion: Fall 2026

Chief Nursing Officer Board Report

October 2023
Eskridge Conference Room
10121 Pine Ave, Truckee, CA 96161

By: Jan Iida, RN, MSN, CEN, CENP
Chief Nursing Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

- A project to implement E-Consents for hospital procedures is currently in development. This project involves Nursing, Quality, Physicians, and Clinics. This was a HFAP/ACHC-identified deficiency. This project will be live by end of year.
- Integration of the IV pump is progressing with the nursing departments in ED, ICU, Med-Surg and Cancer Center. Workflows and testing have begun. We are making progress towards a timely go-live.

Quality: Provide clinical excellence in clinical outcomes

- Svieta Schopp will train the staff nurses of the inpatient nursing section so they understand how Svieta reacts to patients who present an infection. They will have the knowledge to discuss our infection rates. She will be attending staff meetings at the inpatient units.

Growth: Meeting the needs of the community

- TelStroke Program started August 22nd with the first phase of Stroke Alerts. We have received 24 stroke alerts to date. TFH had 24 stroke alerts and IVCH 4, The second phase will begin in December and include non-urgent neruo consultations as well as EEG services.

TAHOE FOREST HOSPITAL DISTRICT

Board CMO Report

By: Brian Evans, MD, MBA
Chief Medical Officer

DATE: October 17, 2023

People: Strengthen a highly-engaged culture that inspires teamwork & joy

- Physician engagement bonus was restructured to better meet the needs of eligible providers. This process was undertaken using a "ground up" approach where input from affected physicians was solicited and used to create a better policy.
- "Tahoe Forest Jeopardy" was conducted at the four town halls as an educational vehicle designed to create a cohesive and energized team.
- Rounding continues throughout the system.

Service: Deliver Outstanding Patient & Family Experience

- Communication about Management Systems and the Access to Care project was conducted in multiple venues, meetings, rounding, and town halls.

Quality: Provide excellent patient focused quality care

- Access to Care project continued into the implementation phase with operational improvements designed to create a more efficient patient journey in pediatrics, OB/GYN, primary care and diagnostic imaging. Best practices from these tests of change will be spread throughout the system.

Finance: Ensure strong operational & financial performance for long term sustainability

- Analysis of clinical options in the Gateway center has begun, looking at community need, financial sustainability and operational priorities.

Growth: Expand and foster community and regional relationships

- Current state partnerships between six local area ski resorts and the health district were assessed and a report presented to the administrative council. Next steps will include strategic analysis of potential changes to benefit patients in our community.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst **DATE: October 2023**
Chief Information and Innovation Officer

Service: Optimize delivery model to achieve operational and clinical efficiency:

General IT

- Maintenance and repair of Primary Rate Interface (PRI) lines at IVCH.
    - Preventive maintenance is necessary to minimize disruption to voice, data, and video communication needs.
- Updated security system for the double doors at the Extended Care Center (ECC).
    - Upgrade includes enhanced video monitoring capabilities and door security system. Enhancements will increase our ability to monitor and control access to our ECC more efficiently.
- Suite 110 Patch Panel Relocation and Enhancement.
    - In support of continuous efforts to increase capabilities in our existing clinical and office space, primary junction and patch panels are being relocated and upgraded to better support greater capabilities in the same square footage.
- Verification testing for Office 365 Intune capabilities.
    - Intune will significantly enhance our mobile device management capabilities, allowing us to effectively manage and secure TFHD owned and personal devices that are used to access company data. This includes threat protection.
- Evaluating replacement vendor for next steps of Office 365 rollout.
    - After careful consideration and in the best interest of TFHS we will be replacing the existing vendor for our implementation. This is due to set milestones not being met.
    - Note that TFHD has not incurred any financial obligation related to the architectural rollout portion of this project. Investment at this point only applies to licensing.
- Moss Adams Audit Update.
    - TFHS has submitted all necessary documentation for analysis by the auditor. Mercy is working to finalize documentation required from their operational processes.
- Team conducted thorough review of existing Multi Factor Authentication (MFA)/access licenses (DUO/Imprivata).
    - Results provide us with a fair recoupment of available licensing.
    - This ongoing efficiency improvement will enable our IT department to avoid unnecessary additional purchases.
- A previously identified security issue associated with the use of Office 13 within our district has been successfully mitigated.
    - We have implemented upgrades and comprehensive measures to negate the security vulnerability and can confirm that the issue is complete resolved.
- Upgraded foundational printer solution to be compatible with latest Microsoft server version.

    - This upgrade reduces the time to install new printers and allows the team access to advanced troubleshooting tools. Expectations are the team will be able to enhance staff productivity and reduce downtime related to printer issues.
- Martis Networking: Designed and prepared to implement comprehensive IP (Network) addressing schema for the upcoming Martis Camp site.
    - By performing this exercise early, the team will be ready to implement rapidly once hardware is delivered and installed.
    - Networking circuit has already been ordered.
- Parlance 2019 Upgrade:
    - SIP trunks, essential for establishing voice and video communications, have been provisioned.
        - Infrastructure is now staged and prepared for vendor upgrade of critical system: (Parlance is used by our Access Center as a solution that offloads calls from a switchboard approach and increase self-service when possible.)
- Workstation On Wheeles (WoW) Cart updates:
    - We have successfully achieved a 20% completion milestone in our ongoing project to enhance our Workstation on Wheels (W0Ws).
    - The upgrade involves integration of an advanced battery system that extends battery life and allows for on demand charging.
- Neuro Teledoc accounts have been successfully created and provisioned in support of our newly implemented Tele-Stroke Cart solution.
- 654 I.T. support tickets closed.

Clinical Informatics

Ambulatory:

- In-person provider and support staff review
- Plastics department discovery
- Provider and support staff training

Lab:

- Wellsky Blood Bank System Upgrade. 9 https://wellsky.com/blood-bank-software/)
    - We are doing round-trip testing now between Wellsky and Epic. Mercy is still working on the access for Korchek to have access for third-party validation of the application.
- Kick-off call for Aura/ Natera interface was held today. Mercy is putting together the SOW with a proposed kick-off in November.

Surgery:

- E-consent for surgical procedures,
- PreOp Clinic development and workflow
- Provider post-op workflow r/t coding and billing issues (analyzing where the problem is coming from and what to do to fix it),
- Trained 2 float nurses.

ED:

- Completed build for new NORTHSTAR clinic department build.
- Completed build for POC US EFAST exam -in testing phase and should go to PRD on OCT 25
- Met with Dr. Gladman to do much-needed updates to build of quicklist, trackboard views and tip sheets for the ED.

- Created an SBAR for Trent to present to Legal regarding language for MIT form for both IVCH and TFH
    - Tested build in the test environment- This is to be compliant with billing companies for transfers from our facility -so they can bill appropriately.

Inpatient:

- ECC projects, including E-prescribe.
- coordinated fixes for TFH Up to Date link & GE fetal monitoring Restore function.
- Order set update to GEN: acute alcohol withdrawal TFH & coordinating new referral for SUN service line.

SmartPumps:

- Pyxis fixes/workflows. Track and trend.

Global:

- Standardizing the Communications within Epic-functionality. Policy and process
- Onboarding new hire-Jenna Raber for AMB position
- Break/fix and ticketing
- SlicerDicer rollout
    - Epic's SlicerDicer data exploration, analytics and reporting tool simplifies access to clinical data pertaining to highly definable populations. SlicerDicer allows clinicians, managers, and researchers to answer questions about health risks, diagnoses, interventions, outcomes, costs, etc.
- New MarketWare software for Provider Onboarding process
- Mercy collab:
    - Project ANEW
    - Community Connect Forum
    - Micro365 testing
    - Transitioning to Teams vs Zoom
    - Starting to gather next year's scheduled downtimes/Upgrades. Prepping.

Project Management Office

Proposed Projects:

- SAMACARE for Oncology Services

Initiating:

- Affiliate Builders for Mercy Epic Hospital Billing & Practice Billing

Axiom Sandbox:

- Axiom Comparative Analysis
- Bright Futures
- Epiphany
    - Simplify cardiopulmonary data management with Cardio Server Cloud. Reduce server requirements, storage, and IT costs. Save your hospital time and resources to focus on delivering the best patient care while we focus on the rest.
- Provation
    - https://www.provationmedical.com/provation-md/

- EPIC Aura as a step towards Invitae & Natera
- Behavioral Health Service line analysis

AB133: (AB133 establishes a mandate for data sharing for most health care providers beginning in January 2024, with the requirement to sign the finalized data sharing agreement by January 2023).

- Had an introductory call to get the specification on the data transfer the state is requesting.
- Will begin building the data feed for eventual connection to the states chosen Health Information Exchange (HIE).

Retail Pharmacy IVR:

- Check writing replacement.

Executing:

- Mercy Contract Renewal
- A2C & Management Systems with Vizient
- Martis Outlook ENT/AUD/Plastics
- Tahoe City Urgent Care/Primary Care
- Olympic Valley Urgent Care
- PEDS – Direct Scheduling and online forms
- AXIOM cost accounting upgrade
- Volpara
- CashArc
- EEG Service line
- eConsent
- eFAST for in ED
- Infusion Pump Integration
- IVMC Neurology
- UKG Dimensions
- TFMC Northstar Urgent Care
- SAN workflow
- POC ultrasound imaging in Truckee Ortho

Cyber Data:

Top 10 Attackers by Source Country:

Panorama : 2023/09/01 - 2023/09/30

Source Country
United States
Netherlands
Canada
Isle Of Man
Japan
Singapore
Mexico
Spain
France
Germany

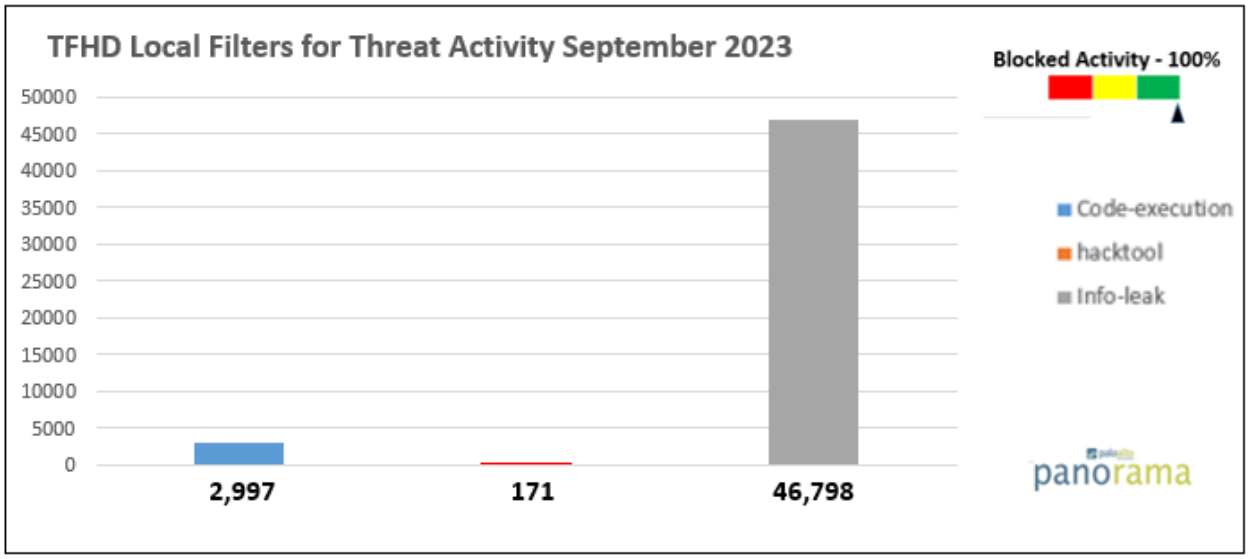
Top 10 Threats:

Panorama : 2023/09/01 - 2023/09/30

Threat ID/Name	ID	Threat Category	Threat Type
Microsoft Windows RPC Encrypted Data Detected	33836	code-execution	vulnerability
Microsoft Windows NTLMSSP Detection	92322	info-leak	vulnerability
Non-RFC Compliant DNS Traffic on Port 53/5353	56499	protocol-anomaly	vulnerability
Suspicious TLS Evasion Found	14978	spyware	spyware
Suspicious HTTP Evasion Found	14984	spyware	spyware
Windows Local Security Architect Isardelete access	30857	info-leak	vulnerability
Microsoft Windows Registry Read Attempt	34940	info-leak	vulnerability
Microsoft Windows Registry Write Attempt	34941	code-execution	vulnerability
Compromised username and/or password from previous data breach in inbound FTP login	58317	insecure-credentials	vulnerability
Microsoft Windows Registry Enumeration	30840	info-leak	vulnerability

Threat Blocking:

Successful Threat Execution Block



Code Execution: Attempts to identify execution vulnerabilities that can be run by a privileged user

hacktool: riskware that is intended to provide access to computers and networks

Info-leak: Attempt to detect software vulnerabilities and craft request exploits for unprotected data

TAHOE FOREST HOSPITAL DISTRICT

Board CHRO Report

By: Alex MacLennan
Chief Human Resources Officer

DATE: October 2023

People: Strengthen a highly-engaged culture that inspires teamwork & joy

Nurture mutual trust

- Our High-Reliability team has scheduled training for individuals to solidify their roles on the team. This is getting us one step closer to becoming certified as a High Reliability Organization.
- Administration meets quarterly with Union leadership to maintain an open and transparent line of communication. The Union introduced us virtually to Tina Acree the Business Agent for ASCME Council 57.

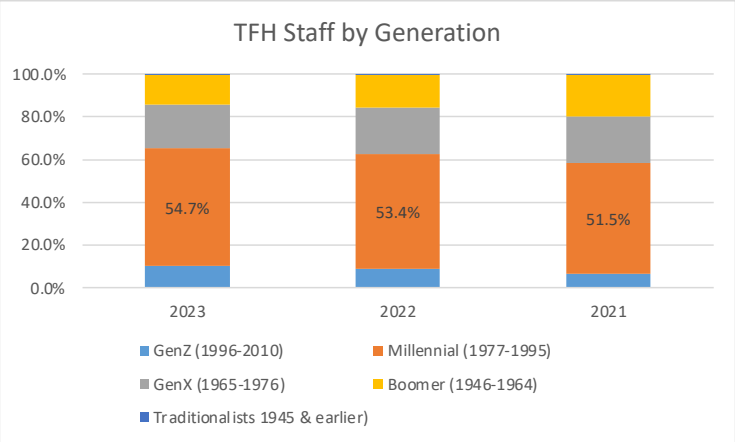
Exemplify a culture based on the foundation of our values

- We held our annual Service Awards in September. Over 100 attendees enjoyed Dinner while we celebrated them and their many years of service to Tahoe Forest.
- Our Volunteers provided 920 hours to date in the fiscal year.

Attract, develop, and retain strong talent and promote great careers

- Sepsis September Awareness Month recognized with a Lunch and Learn, case review CE evening event, and 4 Sepsis Education stations where staff participated in different activities (sepsis quiz, Faces of Sepsis case review, education cards)
- Over 20 simulation events (mock codes) were conducted to maintain staff skills and competencies in the Emergency Department, Women and Family, Primary Care, MSC-Pediatrics, Cardiac Rehab, Med-Surg, ICU, ECC, IM Cardiology, and all 3 Urgent Care clinics.
- Provided the Vituity ED physicians with a Workplace Violence Prevention training customized to their education/training needs.
- Monthly Lunch and Learns continue with growing participation in person as well as over Zoom.
- Upgraded to CINAHL Ultimate to provide TFHS staff with a robust search engine for evidence-based practice and access to over 900 medical/nursing journals.
- We are gearing up for Open Enrolment and our annual Benefits Fair.
- We are doing a Dependent audit this year to ensure only those that are eligible hold our health insurance.

Stats for 2Q23	
74	New Employees
60	Terminations
1307	Headcount as of 6/30/2023
11.58	Average Span of Control
6.61	Average Seniority Years
15	Temporary Staff
24	Status change
42	Transfer

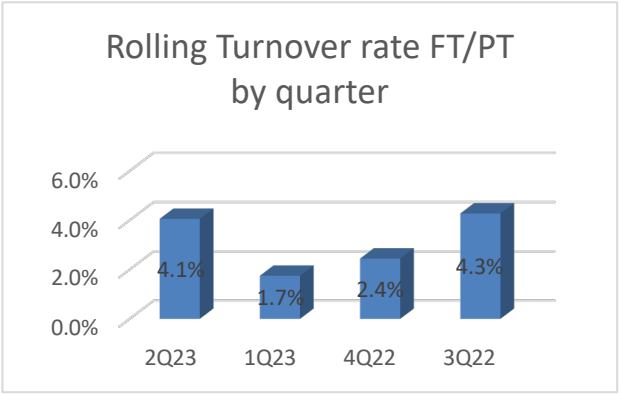


FY23 - current	
124	Fiscal year to date LOA's
136	Active LOA's
7	Work Comp LOA's
78	Modified (includes intermittent) Work Schedules
7	Modified Duty (excluding modified work schedule)

Turnover:

#	Term Types 2Q23	Percentage
8	Involuntary	12.31%
57	Voluntary	87.69%
65		100.00%

#	Voluntary Term Reasons 2Q23	Percentage
18	Other	31.58%
12	Other job	21.05%
10	Moving	17.54%
4	Retirement/Early Retire	7.02%
4	Education	7.02%
4	Mutual Agreement	7.02%
3	Temporary job ended	5.26%
2	Dissatsified w/job	3.51%
0	Job Abandonment	0.00%
0	Commute	0.00%
57		100.00%



AGENDA ITEM COVER SHEET

ITEM	Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09
RESPONSIBLE PARTY	Kat Sigafoose, Director of Patient Access
ACTION REQUESTED?	For Board Action

BACKGROUND:

In an effort to clarify the family size in the policy, CFO and Director of Patient Access agreed to expand the definition.

SUMMARY/OBJECTIVES:

The policy was updated to reflect the change in family size definition. CFO did not have any additional edits.

SUGGESTED DISCUSSION POINTS:
None.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve via consent calendar.

LIST OF ATTACHMENTS:

- Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09

PURPOSE:

A. Tahoe Forest Hospital District (hereinafter referred to as "TFHD") provides hospital and related medical services to residents and visitors within district boundaries and the surrounding region. As a regional healthcare provider, TFHD is dedicated to providing high quality, customer oriented and financially strong healthcare services that meet the needs of its patients. Providing patients with opportunities for financial assistance coverage for healthcare services is also an essential element of fulfilling the TFHD mission. This policy defines the TFHD Financial Assistance Program; its criteria, systems, and methods.

B. California acute care hospitals must comply with the "Hospital Fair Pricing Policies" law at Health & Safety Code Section 127400 et seq. (the "Fair Pricing Law"), including requirements for written policies providing discounts and charity care to financially qualified patients. Under the Fair Pricing Law and California Assembly Bill 1020, uninsured patients or patients with high medical costs who are at or below 400 percent (400%) of the federal poverty level shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. This policy is intended to fully comply with all such legal obligations by providing for both charity care and discounts to patients who qualify under the terms and conditions of the TFHD Financial Assistance Program. Additionally, although the Fair Pricing Law requires hospitals to provide financial assistance to certain qualifying patients for services they have received, it does not require hospitals to provide future services. Nevertheless, TFHD has allowed individuals to apply for financial assistance for future services under this policy. However, any individuals who qualify for such assistance will still be subject to admission and other criteria for receiving services and becoming patients, and will have to demonstrate their ability to meet any applicable financial obligation which is not covered by any discount or other financial assistance granted.

C. The finance department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TFHD. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of TFHD.

D. Patients are hereby notified that a physician employed or contracted to provide services in the emergency department of TFHD's hospital in Truckee, California is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent (400%) of the federal poverty level.

DEFINITIONS:

A. "Discount Partial Charity Care" means an amount charged for services to a patient who qualifies for financial assistance under the TFHD Financial Assistance Program which is discounted to the amount Medicare would pay for the same services or less. Discount Partial Charity Care, when granted to a patient, will in no case excuse a third party, or the patient, from their respective obligations to pay for services provided to such patient.

B. "Elective Services" means any services which are not medically necessary services.

C. "Emergency Services" means services required to stabilize a patient's medical condition initially provided in the TFHD emergency department or otherwise classified as "emergency services" under the federal EMTALA Law or Section 1317.1 et.seq. of the California Health & Safety Code, and continuing until the patient is medically stable and discharged, transferred, or otherwise released from treatment.

D. "Federal Poverty Level" or "FPL" means the current poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

E. "Financial Assistance Program" means the TFHD Financial Assistance Program established by this policy for providing Full Charity Care or Discount Partial Charity Care (each, as defined below) to qualified patients.

F. "Full Charity Care" means medically necessary services provided by TFHD to a patient who qualifies under the TFHD Financial Assistance Program which are not covered by a third party, and for which the patient is otherwise responsible for paying, for which the patient will not be billed. Full Charity Care, when granted to a patient, in no case will excuse a third party from its obligation to pay for services provided to such patient.

G. "Medically Necessary Services" means hospital-based medical services determined, based upon a medical evaluation, to be necessary to preserve a patient's life or health.
H. "Monetary Assets" means all monetary assets of the patient's family excluding retirement or deferred compensation plans (both qualified and non-qualified under the Internal Revenue Code), not counting the first $10,000 of such assets, nor fifty percent (50%) of the amount of such assets over the first $10,000.
I. "Non-Emergency Services" means medically necessary services that are not Emergency Services.
J. "Patient" means an individual who has received Emergency Services or Non-Emergency Services at a facility operated by TFHD who is requesting financial assistance with respect to such services.
K. "The amount Medicare would have paid" means the amount Medicare would pay for the services provided, or, in the event there is no specific amount that can be determined that Medicare would pay for such services, the highest amount payable for such services by any other state-funded program designed to provide health coverage.
L. "Third Party Insurance" means health benefits coverage by a public or private program, insurer, health plan, employer, multiple employer trust, or any other third party obligated to provide health benefits coverage to a patient.

SCOPE:

A. This policy applies to all TFHD patients. This policy does not require TFHD to accept as a patient and provide services to any person who does not qualify for treatment or admission under any of TFHD's applicable policies, practices, and procedures, and does not prohibit TFHD from discharging, or otherwise limiting the scope of services provided to, any person in accordance with its normal policies, practices and procedures. This policy does not require TFHD to provide patients with any services that are not medically necessary or to provide access to non-emergency services or to elective services.
B. The acute care hospital operated by TFHD provides many specialized inpatient and outpatient services. In addition to services provided at the main hospital location, Tahoe Forest Hospital operates primary care and multi-specialty clinics, home health, hospice and therapy service programs at sites in the same community but not located on the main hospital campus. Tahoe Forest Hospital also operates a distinct part skilled nursing facility. Only medically necessary services provided at facilities listed on the Tahoe Forest Hospital acute care license are included within the scope of this Financial Assistance Policy. TFHD has extended this policy to services proved at the Incline Village Community Hospital location, and clinics and therapy service programs.
C. This policy pertains to financial assistance provided by TFHD. All requests for financial assistance from patients shall be addressed in accordance with this policy.
D. During an Access to Healthcare Crisis, TFHD may “flex” its patient financial assistance policy to meet the needs of the community in crisis. It must be proclaimed by hospital leadership and attached to this patient financial assistance document as an addendum. An Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of the hospital’s community during the Access to Healthcare Crisis. These changes will be included in the patient financial assistance policy as included as an addendum. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis).

Hospital Inpatient, Outpatient and Emergency Service Programs:

A. Introduction:
    1. This policy sets forth a program to assist patients who are uninsured or underinsured in obtaining financial assistance in paying their hospital bill. Such financial assistance may include government sponsored coverage programs, Full Charity Care, and Discount Partial Charity Care.
B. Full Charity Care and Discount Partial Charity Care Reporting
    1. TFHD will report actual Charity Care (including both Full Charity Care and Discount

Partial Charity Care) provided in accordance with regulatory requirements of the California Department of Health Care Access and Information (HCAI) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. The hospital will maintain written documentation regarding its Charity Care criteria and, for individual patients, written documentation regarding all Charity Care determinations. As required by HCAI, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

2. TFHD will provide HCAI with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Partial Charity Care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount partial charity care; and 3) the review process for both full charity care and discount partial charity care. Forms of these documents shall be supplied to HCAI every two years or whenever a substantial change is made.

C. Full and Discount Charity Care Eligibility: General Process and Responsibilities:

1. Any patient whose family income is less than 400% of the FPL, is not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account, is eligible to apply for financial assistance under the TFHD Financial Assistance Program.
2. The TFHD Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to apply for the maximum financial assistance benefit for which he or she may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to determine the maximum coverage under the TFHD Financial Assistance Program for which the patient or patient's family may qualify.
3. Eligible patients may apply for financial assistance under the TFHD Financial Assistance Program by completing an application consistent with application instructions, together with documentation and health benefits coverage information sufficient to determine the patient's eligibility for coverage under the program. Eligibility alone is not an entitlement to financial assistance under the TFHD Financial Assistance Program. TFHD must complete a process of applicant evaluation and determine, in accordance with this policy, whether financial assistance will be granted.
4. The TFHD Financial Assistance Program relies upon the cooperation of individual patients to determine who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, TFHD will use a financial assistance application. All patients without adequate financial coverage by Third Party Insurance will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs may also be eligible for financial assistance. Any patient who would like to ~~recieve~~receive financial assistance will be asked to complete a financial assistance application.
5. The financial assistance application is provided to all patients with billing statements. It is also available upon patient request. The application form may be completed at any time prior to or within one year after discharge, or within one year after the patient became eligible, whichever comes first.
6. To the extent it deems necessary, in its sole and reasonable discretion, TFHD may require an applicant for financial assistance to provide supplemental information in addition to a complete financial assistance application to provide:
    a. Confirmation of the patient's income and health benefits coverage;
    b. Complete documentation of the patient's monetary assets;
    c. Other documentation as needed to confirm the applicant's qualification for financial assistance; and
    d. Documentation confirming the hospital's decision to provide financial assistance, if

financial assistance is provided.

7. However, a completed financial assistance application may not be required if TFHD determines, in its sole discretion, that it has sufficient patient information from which to make a financial assistance qualification decision.

PROCEDURES:

A. **Qualification: Full Charity Care and Discount Partial Charity Care**

1. Eligibility for financial assistance shall be determined based on the patient's and/or patient's family's ability to pay and on the other factors set forth in this policy. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
2. The patient and/or the patient's family representative who requests assistance in meeting their financial obligation to TFHD shall make every reasonable effort to provide information necessary for TFHD to make a financial assistance qualification determination. TFHD will provide guidance and assistance to patients or their family representative as reasonably needed to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Whether financial assistance will be granted is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy, as it may be amended from time to time. While financial assistance shall not be provided on a discriminatory or arbitrary basis, TFHD retains full discretion, consistent with this policy, laws and regulations, to determine when a patient has provided sufficient evidence to establish eligibility for financial assistance, and what level of financial assistance an eligible patient is will receive.
4. Except as otherwise approved by TFHD, patients or their family representative must complete an application for the Financial Assistance Program in order to qualify for eligibility. The application and required supplemental documents are submitted to Financial Counseling at TFHD. This office shall be clearly identified on the application instructions. Patients have thirty (30) days to complete the application along with supporting materials or to request an extension.
5. TFHD will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.
6. Approval of an application for financial assistance to eligible patients will be made only by approved TFHD personnel according to the following levels of authority:
    a. Financial Counselor: Accounts less than $2,500
    b. Director of Patient Access: Accounts less than $10,000
    c. Chief Financial Officer: Accounts less than $50,000
    d. Chief Executive Officer: Accounts greater than $50,000
7. Factors considered when determining whether to grant an individual financial assistance pursuant to this policy may include (but are not limited to):
    a. Extent of Third Party Insurance;
    b. Family income based upon tax returns or recent pay stubs;
    c. Monetary assets, if the patient requests any level of financial assistance greater than the Basic Discount (as defined below);
    d. The nature and scope of services for which the patient seeks financial assistance;
    e. ~~Family size and circumstances;~~ For patients 18 years or older, family includes the patient’s spouse, registered domestic partner, and dependent children under 21 whether living at home or not. For patients under 18 years of age, family includes patient’s parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker. If a patient claims a dependent on their income tax return, according to the Internal Revenue Service rules, that individual may be considered a dependent for the purposes of determining financial assistance eligibility.
    f. Hospital budget for financial assistance;

g. Other criteria set forth in this policy.

8. Financial assistance will be granted based upon consideration of each individual application for financial assistance in accordance with the Financial Assistance Program set forth in this policy.
9. Financial assistance may be granted for Full Charity Care or Discount Partial Charity Care, based upon this Financial Assistance Program policy.
10. Once granted, financial assistance will apply only to the specific services and service dates for which the application has been approved by TFHD. In cases of care relating to a patient diagnosis which requires continuous, on-going related services, the hospital, at its sole discretion, may treat such continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital will not be included unless applied for and approved by TFHD pursuant to this policy.
11. Patient obligations for Medi-Cal/Medicaid Share of Cost payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/ patient (such as a provided service where coverage is denied) may be considered for financial assistance.

B. **Full and Discount Partial Charity Care Qualification Criteria**

1. Cap On Patient Liability For Services Rendered to Patients Eligible for Financial Assistance:
   Following completion of the application process for financial assistance, if it is established that the patient's family income is at or below 400% of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the entire patient liability portion of the bill for services rendered will be no greater than the amount Medicare would have paid for the services, net of any Third Party Insurance ("the Basic Discount"). This shall apply to all medically necessary hospital inpatient, outpatient and emergency services provided by TFHD.
2. Financial Assistance For Emergency Services
   If an individual receives Emergency Services and applies for financial assistance under the Financial Assistance Program, the following will apply:
   a. If the patient's family income is at or below 200% or less of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Full Charity Care for Emergency Services provided.
   b. If the patient's family income is between 201% and 400% of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Partial Discount Charity Care for Emergency Services provided in accordance with the following:
      i. Patient's care is not covered by Third Party Insurance. If the services are not covered by Third Party Insurance, the patient's payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1
Sliding Scale Payment Schedule

Family Percentage of FPL	**Percentage of Medicare Amount Payable** (subject to an additional discount if TFHD determines, in its sole

discretion, that unusual circumstances warrant an additional discount).

201 – 215% 10%

216 – 230% 20%

231 – 245% 30%

246 – 260% 40%

261 – 275% 50%

276 – 290% 60%

291 - 305% 70%

306 - 320% 80%

321 – 335% 90%

336 – 400% 100%

ii. Patient's care is covered by Third Party Insurance. If the services are covered by Third Party Insurance, but such coverage or liability is insufficient to pay TFHD's billed charges, leaving the patient responsible for a portion of the billed charges (including, without limitation, any applicable deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between the gross amount paid by Third Party Insurance and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by Third Party Insurance exceeds what Medicare would have paid, the patient will have no further payment obligation. In no event shall the patient's obligation to pay a percentage of the unpaid amount be greater than the percentages of the amounts Medicare would pay for the same services set forth in Table 1, above.

c. If a patient who meets all other Financial Assistance Program requirements whose family income is either greater than 400% the current FPL, or has family income of less than 400% of the FPL and the seeks a discount for emergency services greater than the discount set forth above, then TFHD may decide, in its sole discretion, whether to provide such financial assistance, and the extent to which it will be provided, if at all. In making its decision, TFHD may consider the following factors, without limitation:
    i. The patient's need for financial assistance.
    ii. The extent of TFHD's limited charitable resources, and whether they are best spent providing these services at an additional discount or whether there are other patients with greater immediate need for TFHD's charitable assistance.
    iii. Any other facts (such as the patient's monetary assets) that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's

request for charity care.

3. **Financial Assistance For Non-Emergency Services:**
   If a patient requests financial assistance for Non-emergency Services (with the exception of primary care clinic, multispecialty care clinic, home health, hospice or skilled nursing services, which are covered as described below), the following will apply:
   If the patient's family income is 400% or less of FPL and meets all other Financial Assistance Program qualification requirements, the patient will be granted the Basic Discount. TFHD may decide, in its sole discretion, whether and to what extent additional financial assistance will be provided, such as whether to provide the level of assistance the patient would receive if he/she had received Emergency Services.
   a. In addition to the information required by the financial assistance application, TFHD may require the individual to provide additional information regarding the individual's family monetary assets, as it deems appropriate in its sole discretion.
   b. TFHD will decide, in its sole discretion, whether and to what extent to grant financial assistance in addition to the Basic Discount. Only medically necessary services will be considered. In making its determination, TFHD may, in addition to any other criteria set forth in this policy and without limitation, consider the following factors:
      i. The degree of urgency that the services be performed promptly.
      ii. Whether the services must be performed at TFHD, or whether there are other providers in the patient's geographic area that could provide the services in question.
      iii. Whether the services can most efficiently be performed at TFHD, or whether there are other providers that could perform the services more efficiently.
      iv. The extent, if any, that TFHD's limited charitable resources are best spent providing the requested service and whether there are others with greater immediate need for TFHD's charitable assistance.
      v. The patient's need for financial assistance.
      vi. Any other facts that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for financial assistance.

C. **Refunds**
In the event that a patient is determined to be eligible for financial assistance for services for which he/she or his/her guarantor has made a deposit or partial payment, and it is determined that the patient is due a refund because the payments already made exceed the patient's liability under this policy, any refund due shall be processed under TFHD's Credit and Collection Policy, which provides, in pertinent part, as follows:
" In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services and subsequently is determined to qualify for full Financial Assistance or discount partial Financial Assistance, all amounts paid which exceed the payment obligation, if any, as determined through the Financial Assistance Program process, shall be refunded to the patient. Any overpayment due to the patient under this obligation may not be applied to other open balance accounts or debt owed to TFHD by the patient or family representative. Any or all amounts owed shall be reimbursed to the patient or family representative within a reasonable time period."

D. **Primary Care and Multi-Specialty Clinics**
TFHD operates certain outpatient clinics which can be located apart from the main campus of the hospital. Because of the lower cost of these services performed on an outpatient basis, the following shall apply to office visit services and professional fees rendered in these outpatient clinics:
1. Clinic patients are patients of the hospital, and will complete the same basic financial assistance application form
2. The patient's family income will primarily be determined using pay stubs
3. Tax returns will not be required as proof of income unless Financial Counseling determines it is reasonable and necessary due to unusual circumstances

4. A patient attestation letter may be used on a limited basis when appropriate to an individual patient's circumstance
5. Subject to consideration of the factors set forth in paragraph 3 above for non-emergency services, to be determined by TFHD in its sole discretion, patients will pay a reduced fee based on the sliding scale below. If the Patient is covered by a third party obligation, the Patient's obligation will be to pay the difference between the amount paid by the third party and the amounts of the sliding scale, if any.

Clinic Sliding Scale

Patient/Family FPL Qualification	***Amount of Payment Due for Clinic Visit***
Incomes less than or equal to 200%	$25 flat fee per visit
Incomes between 201% and 400%	Actual Medicare Fee Schedule

E. **Home Health and Hospice Services**

TFHD operates both Home Health and Hospice Services that are located apart from the hospital campus and provide care and services in patient homes per Medicare and Medi-Cal/Medicaid guidelines. Due to the lower cost related to providing care in the home for patients who are homebound verses the related additional cost of transportation and follow up in outpatient clinic or the hospital, the following shall apply to services rendered in the home setting:

1. Home Health and Hospice patients are patients of TFHD, and will complete the same basic financial assistance application form.
2. The patient's family income will primarily be determined using pay stubs.
3. Tax returns will not be required as proof of income unless Financial Counseling or Home Health and Hospice personnel determine it is reasonable and necessary due to unusual circumstances.
4. A patient attestation letter may be used on a limited basis when appropriate to an individual patient's circumstance.
5. Subject to consideration of the factors set forth above for non-emergency services, to be determined by TFHD in its sole discretion, patients will pay a reduced fee based on the sliding scale below. If the patient is covered by a third party obligation, the patient's obligation will be to pay the difference between the amount paid by the third party and the amounts of the sliding scale, if any.

Home Health and Hospice Sliding Scale

Patient/Family FPL Qualification	***Amount of Payment Due for Home Visit***
Incomes less than or equal to 200%	50% of the Medicare Payment Rate
Incomes between 201% and 400%	Actual Medicare Fee Schedule

F. **Distinct Part Skilled Nursing Services**

1. Skilled nursing services are also quite different in nature than acute care inpatient, outpatient and emergency services. Patients at the distinct part skilled nursing facility are often residents at the hospital and require special programs designed to meet their long-term care needs.

2. Given the unique nature of providing care to skilled nursing facility patients, the following financial assistance requirements shall apply:
    a. All skilled nursing patients and/or their family representatives shall complete the TFHD financial assistance application and provide supporting documents as required by the standard application
    b. Patients will pay a reduced fee based on the following sliding scale

Distinct Part Skilled Nursing Sliding Scale

Patient/Family FPL Qualification	***Amount of Payment Due for Distinct Part Skilled Nursing Facility Services***
Incomes less than or equal to 200%	50% of the Medi-Cal Payment Rate
Incomes between 201% and 400%	100% of the Medi-Cal Payment Rate

G. **Payment Plans**

1. When a determination to grant Discount Partial Charity Care has been made by TFHD, the patient may be given the option to pay any or all outstanding amount due through a scheduled term payment plan, as an alternative to a single lump sum payment.
2. TFHD will discuss payment plan options with each patient that requests to make arrangements for long-term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than three (3) months. In addition, TFHD works with an outside vendor if patients need payment plan terms that exceed three (3) months. Payment plan terms are subject to vendor requirements. TFHD shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

H. **Special Circumstances**

1. Any application for financial assistance by or on behalf of patients covered by the Medicare Program must be made prior to service completion by TFHD.
2. If a patient is determined to be homeless he/she may be deemed eligible for charity care, in the sole discretion of TFHD.
3. Deceased patients who do not have any third party coverage, an identifiable estate, or for whom no probate hearing is to occur, may be deemed eligible for charity care, in the sole discretion of TFHD.
4. Charges for patients who receive Emergency Services for whom TFHD is unable to issue a billing statement may be written off as Full Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

I. **Other Eligible Circumstances**

1. TFHD deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid and any other applicable state or local low-income program) to be eligible under the Financial Assistance Policy when services are provided which are not covered by the governmental program. For example, services to patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients which the government program does not cover, are eligible for Financial Assistance Program coverage. Under TFHD's Financial Assistance Policy, these resulting non-reimbursed patient account balances are eligible for full write-off as Full Charity Care. Specifically included as Charity Care are charges related to denied stays,

denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care if, at the time that the services were provided TFHD believed that the services rendered were medically necessary.

2. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payor including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:
    a. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or
    b. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

J. **Catastrophic Care Consideration**

1. Patients who do not qualify for charity care or discount partial charity care may nevertheless be eligible for financial assistance in the event of an illness or condition qualifying as a catastrophic event. Determination of a catastrophic event shall be made on a case-by-case basis. The determination of a catastrophic event shall be based upon the amount of the patient's liability at billed charges, and consideration of the individual's family income and assets as reported at the time of occurrence. Management may use its reasonable discretion on a case-by-case basis to determine whether and to what extent an individual or family is eligible for financial assistance based upon a catastrophic event. Financial assistance will be in the form of a percentage discount of some or all of the applicable monthly charges. The Catastrophic Event Eligibility Table will be used as a guideline by management to determine eligibility and the level of any financial assistance. The Catastrophic Event Eligibility Table does not guarantee that any individual will receive financial assistance, or the level of any assistance given.

K. **Criteria for Re-Assignment from Bad Debt to Charity Care**

1. TFHD will make all attempts to deem patients are ineligible for financial assistance prior to sending accounts to collections. Patient accounts will only be assigned to collections when they are severely past due and patients have a). been determined to be ineligible for financial assistance b). have not responded to attempts to bill or offer financial assistance for 180 days.
2. Any account returned to TFHD from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation. An application may also be requested.

L. **Determination**

1. Once a determination of eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:
    a. Approval: The letter will indicate that financial assistance has been approved, the level of assistance, and any outstanding or prospective liability by the patient.
    b. Denial: If the patient is not eligible for financial assistance due to his/her income, and/or monetary assets, or type of service, the reasons for denial of eligibility will be explained to the patient. Any outstanding amount owed by the patient will also be identified.
    c. Incomplete: The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and requested to be supplied to TFHD by the patient or family representative within a specified timeframe. In general, patients will have thirty (30) days from receipt of the application to return the completed application and applicable supporting documents

M. **Reconsideration of Eligibility Denial**

1. In the event that a patient disputes TFHD's determination of eligibility, the patient may file a written request for reconsideration with TFHD within 60 days of receiving notification of eligibility. The written request should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any additional relevant documentation to support the patient's claim should be attached to the written appeal.
2. Any or all appeals will be reviewed by TFHD's Chief Financial Officer. The Chief Financial Officer or his/her designee shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Chief Financial Officer shall provide the patient with a written explanation of the results of the reconsideration of the patient's eligibility. All determinations by the Chief Financial Officer shall be final. There are no further appeals.
3. All discretionary decisions by TFHD shall not be subject to further review or reconsideration.

N. **Public Notice**

1. TFHD shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay his/her bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. Notices will also include information about obtaining applications for potential coverage through Covered California and Medi-Cal as well as contact information for Health Consumer Alliance.
2. These notices shall be posted in English and Spanish and any other languages that are representative of the primary language of 5% or greater of residents in the hospital's service area.
3. Patients are notified at the time of service that Charity Care or Financial Assistance may be available within the Guide to Billing and Financial Assistance
4. Patients will receive an application as part of the billing statement cycle. Additional documentation and patient information may be requested following the initial application.
5. TFHD displays a summary of its financial assistance program on its website.
    a. A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.

O. **Confidentiality**

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

P. **Good Faith Requirements**

1. TFHD makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all Full Charity Care or Partial Discount Charity Care services when information has been intentionally withheld or inaccurate information has been intentionally provided by the patient or family representative to the extent such inaccurate or withheld information affects the eligibility of the patient for financial assistance, or any financial assistance provided at TFHD's discretion. In addition, TFHD reserves the right to seek all remedies, including but not limited to civil and criminal remedies from those patients or family representatives who have intentionally withheld or provided inaccurate information in order qualify for the TFHD Financial Assistance Program.

References:

See TFHD BOD Meeting Minutes of January 26, 2015 and May 24, 2011;

The Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119)

(2010) Section 9007; Health and Safety Code Sections 127360-127360; Health and Safety Code Sections 127400-127440

~~1 A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.~~

Board Presentation

By Trent Foust & Jan Iida

October 26, 2023

Surgical Services & Optum Report

Optum Report

- Optum is a consultant company that performed a 9 month evaluation of Tahoe Forest Hospital Surgical Services for efficiencies & opportunities for growth.
- Optum took an in depth look at current practices & provided recommendations for improvements

Changes Made from Optum Report

- Perioperative Governance Committee established
- Pre-Operative Clinic established
- On Time Case Start
- Scorecards
- Resource Management
- Accountability

Perioperative Governance Committee

Meeting Schedule, Renewal, & Duration

- Monthly Meetings
- Evergreen (Ongoing)
- Duration: 1 hour

Scope & Responsibilities

- The Perioperative Governance Committee serves as the responsible body for addressing surgical efficiency, utilization, and access.

Perioperative Governance Committee

Participation Expectations

- Members are expected to attend at least 75% of meetings
- Member replacement may be initiated following three consecutive absences or missing more than 25% of meetings

Permanent Seats

- Chief Medical Officer (CMO)
- Chief Operating Officer (COO)
- Chief Nursing Officer (CNO)
- Chief of Surgery
- Medical Director of Anesthesiology
- Medical Director of OB/GYN
- Medical Director of Trauma Surgery
- Director of Surgical Services
- Manager of Ambulatory Surgery
- Manager of Operating Room (OR)

Perioperative Governance Committee

What PGC has been working on:

- Updating Policies
  - to match industry standards & best practice
- E-Consents
  - Having all consent forms provided electronically
    - General Consent
    - Anesthesia consent
- Block Utilization
  - Physician Scorecards
  - Block Requests, Warnings, & Revisions
- Case Minimum at IVCH
  - 3 Case Minimum to ensure appropriate use of resources (i.e. Anesthesia & OR staffing)
- Surgeon & Anesthesia Involvement & Participation

Pre-Operative Clinic

Pre-Admit Nurses (PAN)

- Performs the initial screening of a patient
- Uses a standard questionnaire to determine if the patient needs further follow up at the Pre-Operative Clinic
- Goal is to optimize patients for success postoperatively
- Working towards system wide initiative for all surgical cases
- Reducing patient contact for repetitive reasons

Pre-Operative Clinic

Pre-Operative Clinic with Dr. Nicole Jernick

- Working towards maximizing appointments with patients that require a more in depth optimization
- Patients need to be referred by the surgeon, anesthesiologist, or fail the standard questionnaire given by the PAN
- RN assisting at clinic during working phase

On Time Case Start

Optum Focus

- First case on time start
  - Downstream effects
  - Have cases in the OR at 0730

TFH Focus

- Identifying what the delays are between ASD, OR, SPD, & Anesthesia
- Looking at all cases for delays & opportunities to become more efficient
  - Pre-op process
  - Anesthesia blocks

Physician Scorecards

Optum Suggestions

- Data review

TFH Implementation

- Tracking data monthly
- Reporting to physicians quarterly
- Procedure volume
- Block utilization
- Delays

Physician Scorecards

Block Time:	1,3,5 Wednesday ,Flip Day 0730-1700 / 2, 4 Wednesday single room 0730-1700											
Month	**Apr-23**		**Month**	**May-23**		**Month**	**Jun-23**		**Quarter**	**Q2 23**		
# of cases	19		# of cases	26		# of cases	23		# of cases	68		
In block	16		In block	24		In block	20		In block	60		
out of block	3		out of block	2		out of block	3		out of block	8		
SD Cancel	0		SD Cancel	0		SD Cancel	1		SD Cancel	1		
Block minutes	2280		Block minutes	4560		Block minutes	2850		Block minutes	9690		
Minutes used	1832		Minutes used	3134		Minutes used	2377		Minutes used	7343		
Block Utilization	80%		Block Utilization	69%		Block Utilization	83%		Block Utilization	76%		
Delays	0		Delays	4		Delays	2		Delays	6		
			↳ 3 Anesthesia			↳ 1 Anesthesia			↳ 4 Anesthesia			
			↳ 1 Patient			↳ 1 Surgeon			↳ 1 Surgeon			
									↳ 1 Patient			
Released 4/5 date			early out and late start			Released 6/28						
flip day release												

Resource Management

- Reducing supply waste
- Maximizing charge capture accuracy
- Staffing management to daily cases

Accountability

- Staff, surgeon, & anesthesia accountability
- Growth accountability
  - Cardiac service line
  - Endo at IVCH
  - Increasing urology
- Goals of TFH to have OR constantly running during business hours

Questions

TAHOE FOREST HOSPITAL DISTRICT

Tahoe Forest Hospital District Board of Directors
10121 Pine Ave
Truckee, CA 96161

Tahoe Forest Hospital District Seismic Compliance Plan

Tahoe Forest Hospital District ("TFHD") is not currently compliant with the Seismic Safety Building Standards of Senate Bill 1953 "SB 1953". SB 1953 requires full compliance by January 1, 2030 and notifications to the public and staff from present until full compliance is met. There exists three types of deficiencies, in which TFHD intends to phase in compliance; these include: upgrading four buildings "interior" nonstructural performance, "NPC", to NPC 4, upgrading the site to NPC 5 (onsite storage of essential systems for 72 hours of sustainability) and lastly the demolition and replacement of HCAI building 01676.

The compliance plan mandated by the state includes key milestones to ensure facilities can meet the compliance deadline. These forward-looking milestones are:

- January 1, 2024 complete nonstructural evaluation for each building.
- January 1, 2026 construction documents submitted to HCAI(California Department of Health Care Access and Information) for full compliance with SB 1953
- January 1, 2028 building permits to begin construction obtained by HCAI.
- January 1, 2030 full compliance met and accepted.

TFHD has completed a complete nonstructural evaluation for each building and is poised to submit the report to HCAI prior to the end of the calendar year. The remaining compliance is intended to be completed in the following Phases:

Phase 1: Scope: Upgrade four NPC 2 buildings to NPC 4. Cost: $5,500,000.00. Update: Project has been designed and accepted by HCAI, building permits are ready to be obtained. Construction work is scheduled to commence Fall of 2024 and be completed Fall of 2026.

Phase 2a: Scope: NPC 5 upgrades which consist of water and liquid waste infrastructure capable of sustaining critical acute care services for 72 hours post a major seismic event. Cost: $20,000,000.00. Update: Project programming is underway with the intention to bid the project in Fall of 2024.

Phase 2b: Scope: Replacement of building 01676 as well as moving the environmental service and central supply departments within a compliant structure: Costs $52,500,000. Update: Project programming is underway with the intention to bid the demo portion of the project in Fall of 2024.

Total cost of compliance is anticipated at a present value cost of $78,000,000.00.

Sincerely,

Harry Weis
President & CEO
Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT

October 16, 2023

Board of Directors
Tahoe Forest Hospital District
10121 Pine Ave
Truckee, CA 96161

Tahoe Forest Hospital District Structural Performance Category Ratings

Assembly Bill (AB) 1882 (chapter 584, Statutes of 2022) seeks to raise the awareness of a general acute care hospital's compliance with the seismic safety regulations or standards outlined in the Alfred E Alquist Hospital Facilities Seismic Safety Act of 1983 though public notices, hospital campus postings, Department of Health Care Access and Information (HCAI) website, and annual status updates until compliance is achieved. AB 1882 amended Health and Safety Code Section (HSC) 130055, and added Sections 130002, 130006, and 130066.5.

HSC 130066.5 requires an acute care inpatient hospital that includes a building that does not substantially comply with the seismic safety regulations or standards described in HSC 130065 to provide and annual status update on the Structural Performance Category ratings of the buildings and the services provided in each building until compliance is met. Tahoe Forest Hospital District is not in full compliance of HSC 130065. The following attachments provide the current condition and services provided in each building of Tahoe Forest Hospital District.

Attachment A: Tahoe Forest Hospital Site Plan Site plan and building location, note BLD-05480 and BLD-03236 are not required to meet HSC 130065.

Attachment B: Tahoe Forest Hospital Building Table Current building information and services.

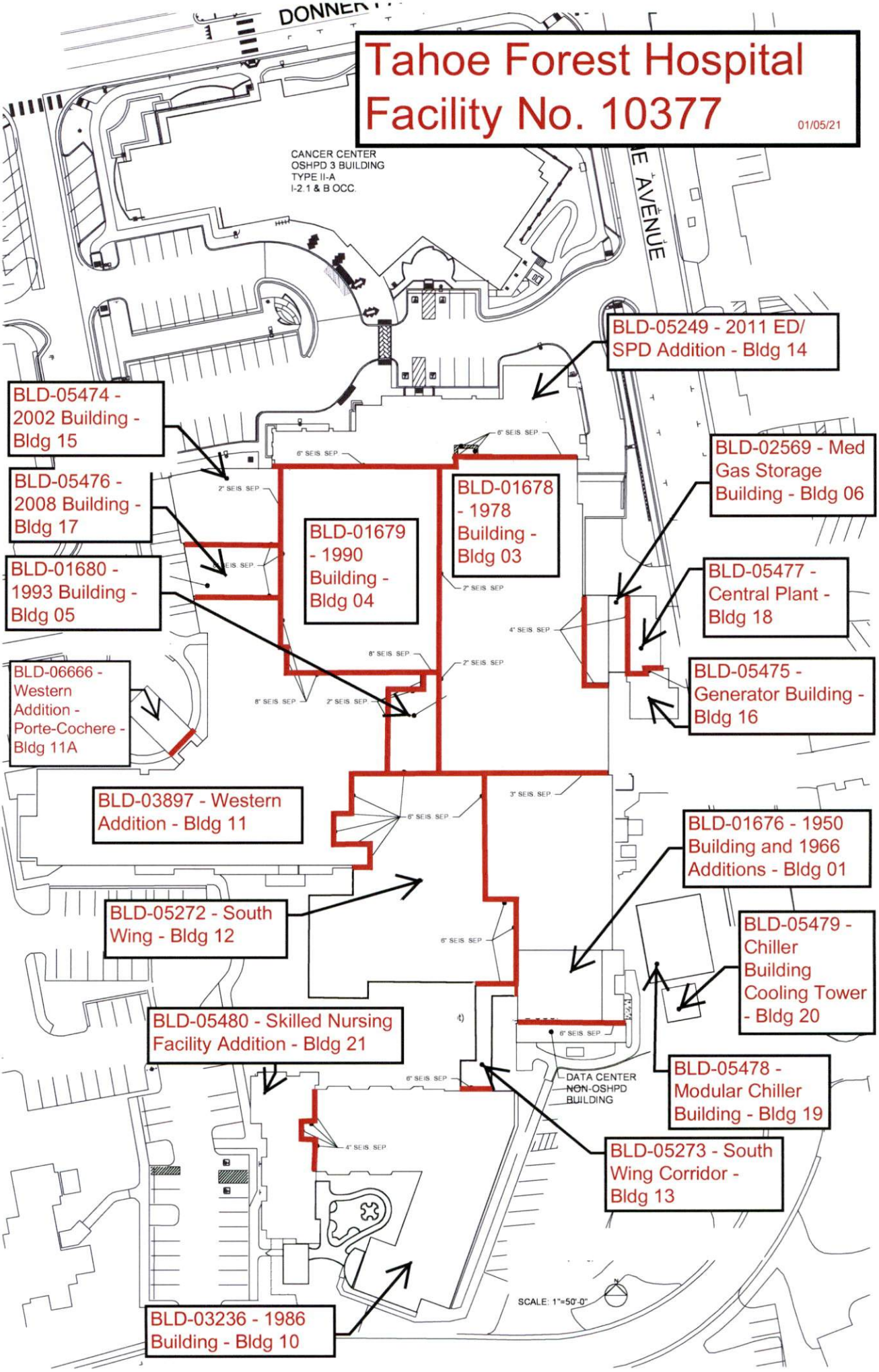
Resources:
HCAI Seismic Compliance and Safety: https://hcai.ca.gov/construction-finance/seismic-compliance-and-safety/
HCAI Facility Detail: https://hcai.ca.gov/construction-finance/facility-detail/

For more information, please reach out to Dylan Crosby, Director of Facilities and Construction Management, Safety Officer DCrosby@tfhd.com

Sincerely,

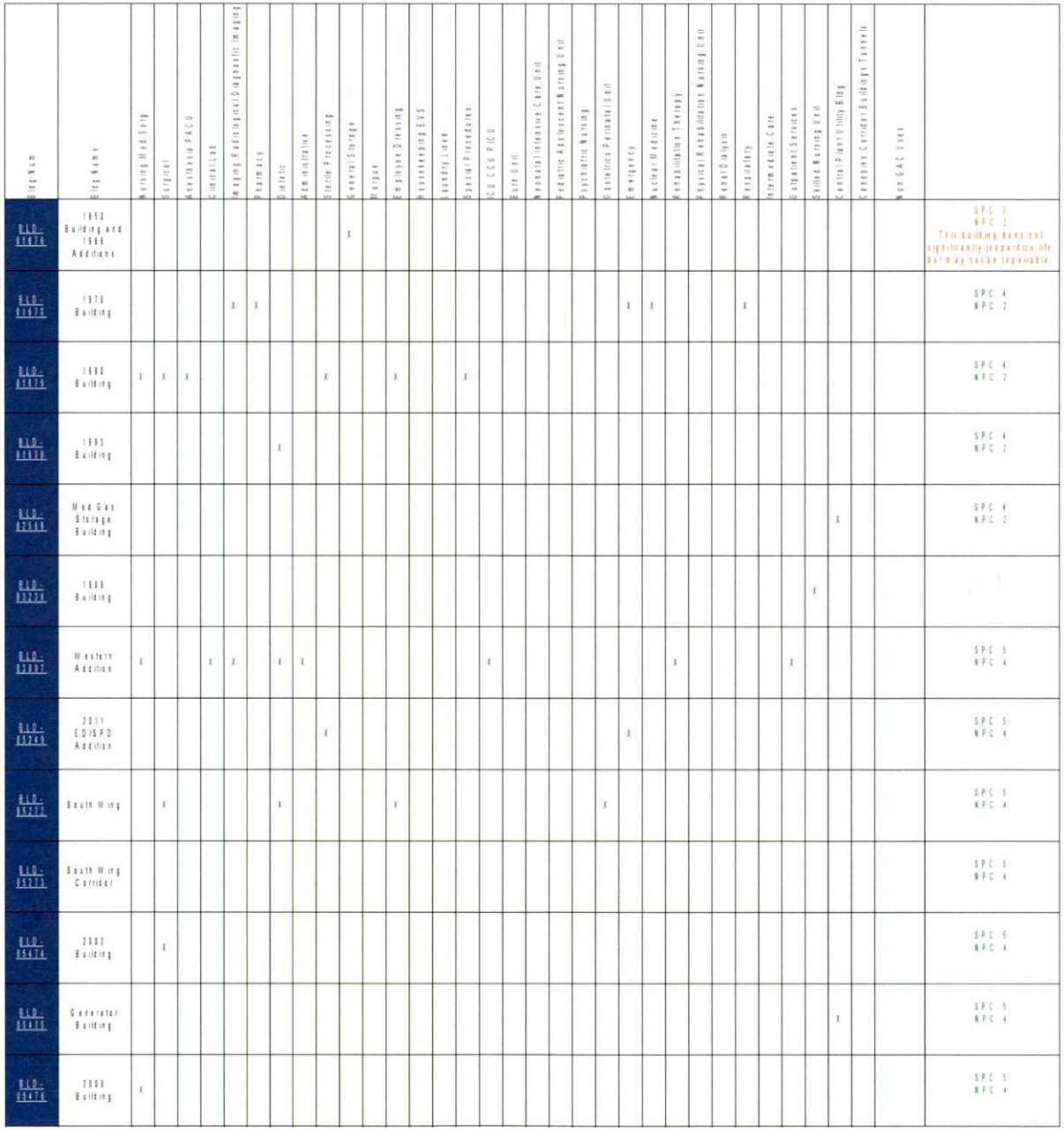
Harry Weis
President & CEO
Tahoe Forest Hospital District

Attachment A: Tahoe Forest Hospital Site Plan


Tahoe Forest Hospital
Facility No. 10377
01/05/21
CANCER CENTER
OSHPD 3 BUILDING
TYPE II-A
I-2.1 & B OCC.
BLD-05249 - 2011 ED/ SPD Addition - Bldg 14
BLD-05474 - 2002 Building - Bldg 15
BLD-05476 - 2008 Building - Bldg 17
BLD-01680 - 1993 Building - Bldg 05
BLD-06666 - Western Addition - Porte-Cochere - Bldg 11A
BLD-01679 - 1990 Building - Bldg 04
BLD-01678 - 1978 Building - Bldg 03
BLD-02569 - Med Gas Storage Building - Bldg 06
BLD-05477 - Central Plant - Bldg 18
BLD-05475 - Generator Building - Bldg 16
BLD-03897 - Western Addition - Bldg 11
BLD-01676 - 1950 Building and 1966 Additions - Bldg 01
BLD-05272 - South Wing - Bldg 12
BLD-05479 - Chiller Building Cooling Tower - Bldg 20
BLD-05480 - Skilled Nursing Facility Addition - Bldg 21
BLD-05478 - Modular Chiller Building - Bldg 19
DATA CENTER
NON-OSHPD
BUILDING
BLD-05273 - South Wing Corridor - Bldg 13
BLD-03236 - 1986 Building - Bldg 10
SCALE: 1"=50'-0"

Attachment B: Tahoe Forest Hospital Building Table

10377 Tahoe Forest Hospital - Reported Services in 2023



SPC, Measure Names
2, No Measure Value
4, No Measure Value
5, No Measure Value
N/A, No Measure Value

10377 Tahoe Forest Hospital - Reported Services in 2023

Bldg Num	Bldg Name	Nursing Med Surg	Surgical	Anesthesia PACU	Clinical Lab	Imaging Radiological Diagnostic Imaging	Pharmacy	Dietetic	Administrative	Sterile Processing	General Storage	Morgue	Employee Dressing	Housekeeping EVS	Laundry Linen	Special Procedures	ICU CCU PICU	Burn Unit	Neonatal Intensive Care Unit	Pediatric Adolescent Nursing Unit	Psychiatric Nursing	Obstetrics Perinatal Unit	Emergency	Nuclear Medicine	Rehabilitation Therapy	Physical Rehabilitation Nursing Unit	Renal Dialysis	Respiratory	Intermediate Care	Outpatient Services	Skilled Nursing Unit	Central Plant Utility Bldg	Canopies Corridor Buildings Tunnels	Non GAC Uses	
BLD-05477	Central Plant																															X			SPC 5 NPC 4
BLD-05473	Modular Chiller Building																															X			SPC 5 NPC 4
BLD-05479	Chiller Building Cooling Tower																															X			[illegible]
BLD-05450	Skilled Nursing Facility Addition																														X				[illegible]
BLD-06666	Western Addition - Porte-Cochere																																		SPC 5 NPC 4

SPC, Measure Names
- 2. No Measure Value
- 4. No Measure Value
- 5. No Measure Value
- N/A. No Measure Value

OUR **VISION**

To serve our region by striving to be the best mountain health system in the nation

OUR **MISSION**

We exist to make a difference in the health of our communities through excellence and compassion in all we do

OUR **VALUES**

Quality | Holding ourselves to the highest standards and having personal integrity in all we do

Understanding | Being aware of the concerns of others, caring for and respecting each other as we interact

Excellence | Doing things right the first time, every time, and being accountable and responsible

Stewardship | Being a community steward in the care, handling, and responsible management of resources while providing quality healthcare

Teamwork | Looking out for those we work with, finding ways to support each other in the jobs we do

WINNING ASPIRATIONS

FINANCE
Aspire for long-term financial strength

SERVICE
Aspire to deliver a timely, outstanding patient and family experience

QUALITY
Aspire to deliver the best possible outcomes for our patients

PEOPLE
Aspire for a highly engaged culture that inspires teamwork and joy

COMMUNITY
Aspire to be an integrated partner in an exceptionally healthy and thriving community

TAHOE FOREST HEALTH SYSTEM