TAHOE FOREST HOSPITAL DISTRICT

Regular Meeting of the Board of Directors

Mar 31, 2015 at 04:00 PM - 10:00 PM

TTUSD Board Room

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Meeting Book - 2015 Mar 31 Regular Meeting of the Board of Directors

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TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT

AGENDA

Tuesday, March 31, 2015 at 4 p.m.

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

4. **INPUT AUDIENCE:**
   This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda.

5. **CLOSED SESSION:**
   5.1. Approval of closed session minutes of: 1/27/15 and 2/24/15
   5.2. Health & Safety Code Section 32155: Quality Report (2 items)
   5.3. Government Code Section 54956.9(d)(2): Exposure to Litigation (3 matters)
   5.4. Government Code Section 54957: Interim CEO Performance Review
   5.5. Health & Safety Code Section 32155: Medical Staff Credentials

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

7. **OPEN SESSION – CALL TO ORDER**

8. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA◈**

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

10. **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.

11. **MEDICAL STAFF REPORT**
    11.1. Medical Staff Report ..... ATTACHMENT

◈ Denotes Action Item

12. CONSENT CALENDAR ◈

These items are expected to be routine and non-controversial. They will be acted upon by the Board at one time 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.

12.1. Approval of Minutes of Meetings:
2/24/15 ..... ATTACHMENT

12.2. Financial Report: February 2015 Financials ..... ATTACHMENT

12.3. Policies:
12.3.1. Conflict of Interest Code (ABD-06) ..... ATTACHMENT
12.3.2. Physician Non-Monetary Compensation Policy..... ATTACHMENT

12.4. Small Rural Hospital Improvement Program (SHIP) Grant Authorization to Bind ..... ATTACHMENT

13. ITEMS FOR BOARD DISCUSSION AND ACTION

13.1. Medical Staff Succession Planning ◈ *[15 minutes]* ..... ATTACHMENT
Staff is seeking board approval to engage a consultant to educate the TFHD Board of Directors, Administration, and the Medical Staff as to the impetus for change due to changing healthcare industry along with educating to various integration and alignment options being implemented across the country.

14. PRESENTATIONS

14.1. Facilities Development Plan Quarterly Update *[5 minutes plus Q&A]* ..... ATTACHMENT
The Chief Facilities Development Officer will present a quarterly update of the Facilities Development Plan to include status of current capital projects.

14.2. Truckee Donner Recreation and Parks District Aquatic Center *[5 minutes plus Q&A]* .... ATTACHMENT
The Truckee Donner Recreation & Park District will make a presentation to the Tahoe Forest Hospital Board of Directors to request the Board consider funding for the overall project or dedicating funds to the warm water components of the aquatic center that would be used for therapy.

15. INFORMATIONAL REPORTS

15.1. Strategic Initiatives Update ..... ATTACHMENT
Staff reports will provide updates related to key strategic initiatives.

15.2. Disaster Recovery of Data and Electronic Communication Systems ..... ATTACHMENT
Staff report provides a synopsis of the disaster recovery process that would be deployed at Tahoe Forest Hospital District (TFHD) in the event that we lost our data storage servers.

15.3. CPSI Computerized Provider Order Entry (CPOE) ..... ATTACHMENT
Staff report provides an update related to key strategic initiatives.

15.4. IT Electronic Medical Records Plan..... ATTACHMENT
Staff report provides an update related to the RFI process to better understand the future state of EMR.

15.5. HCAHPS Survey Tool Review..... ATTACHMENT
Staff report provides an overview of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

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

16.1. Retirement Plan, Subcommittee of Personnel Committee Meeting – 03/09/15 ..... ATTACHMENT
16.2. Governance Committee Meeting – 03/12/15 ..... ATTACHMENT
The Fox Group will present reports provided to Governance Committee related to their compliance consulting work for Tahoe Forest Hospital District.
16.2.1. *2014 Compliance Report [15 minutes]* ◈
16.2.2. *2015 TFHD Compliance Work Plan [20 minutes]* ◈
16.2.3. *Analysis of 2013 Quality Matters Report [30 minutes]*
16.3. Board Retreat – 03/17/15 and 03/18/15 ..... ATTACHMENT
16.3.1. Discussion and Potential Approval of Board Goals [15 minutes] ◈
The Board identified eight goals for focus by the Board over the next 12 months.
16.4. Finance Committee Meeting – 03/24/15 *[15 minutes]* ..... ATTACHMENT
16.4.1. Resolution Authorizing The Issuance And Sale Of The District's 2015 Revenue Refunding Bonds ◈
The District intends to issue refunding revenue bonds (2015 bonds) pursuant to proposed Resolution to provide for the redemption of all outstanding 2006 revenue bonds.
16.5. Community Benefit Committee – 03/27/15 ..... ATTACHMENT
16.6. Quality Committee – No Meeting

17. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS
18. ITEMS FOR NEXT MEETING
19. BOARD MEMBERS REPORTS/CLOSING REMARKS
20. CLOSED SESSION CONTINUED, IF NECESSARY
21. OPEN SESSION
22. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

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

24. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is February 24, 2015, 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

◈ Denotes Action Item

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

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

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

MEDICAL EXECUTIVE COMMITTEE'S
REPORT TO THE BOARD OF DIRECTORS - OPEN MEETING
MARCH 31, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION

Discussion Items	Medical Executive Committee	
1. Presentation	Alex MacClennan, HR Manager, provided a Just Culture update and shared the new Collaborative Culture of Safety Systems and Behaviors Response Guide.	Information
2. Chief of Staff	Dr. Dodd reported that the next Quarterly General Staff meeting is scheduled for 5/14/2015 at 5:30 pm at The Lodge.	Information
3. Strategic Planning – Medical Staff Tactics	Dr. Coll reported on the following: • Communication Education Update was provided. Planning for education is underway with Beta. • The revised Medical Staff Strategic Plan with the completed projects was reviewed.	Information
4. Administrative Report	Ms. Razo reported on the following: • Meeting was held with UC Davis CEO and Dr. Nesbitt on various joint strategic initiatives including patient referrals.. • Further CEO Reports will be provided at the Quarterly Medical Staff meetings.	Information
5. Chief Nursing Officer Report	Ms. Newland reported on the following: • Management is preparing for FY 16 and need capital equipment needs for anything over $500. Jake Dorst, Chief Information Officer was in attendance and thanked the doctors who have participated on the CPSI Physician Advisory team and the various specialty workflow meetings. At this time, TFHS will meet MU 1 with CPSI without CPOE. Further efforts will be focused on fine tuning the Point of Care already in place. An implementation date for CPOE will be determined when it is ready and fully tested.	Information

MEDICAL EXECUTIVE COMMITTEE'S
REPORT TO THE BOARD OF DIRECTORS - OPEN MEETING
MARCH 31, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
6. Board Report	Dr. Sessler reported on the following: • Last month the Board participated in a Retreat. • Education was provided on Co Management agreements. • An update on the Patient and Family Centered Care initiative was provided. • One of the Measure C GO Bonds was refinanced. • The Personnel Committee will begin to look at the process for the CEO search which will include identifying the qualities wanted in a CEO. Input from employees, physicians and the community will be sought. • Update on Just Culture was provided.	Information
7. Medical Staff Financial Update	Dr. Arth provided an update on the Medical Staff Financial Account. Current monies are used to provide Employee and Nurse of the Year gifts, Educational Assistance for employees and the various social medicals staff events. The medical staff will discuss other possible community needs projects to support.	Information
Consent Approval Items	None	

REGULAR MEETING OF THEBOARD OF DIRECTORS

DRAFT MINUTES

Tuesday, February 24, 2015 at 4 p.m.

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

1. **CALL TO ORDER**
   Meeting called to order at 4:00 p.m.

2. **ROLL CALL**
   Board: Karen Sessler, President; Chuck Zipkin, Vice President; Greg Jellinek, Secretary; Dale Chamblin, Treasurer; John Mohun, Director

   Staff: Virginia Razo, *Interim* Chief Executive Officer; Crystal Betts, Chief Financial Officer; Jayne O'Flanagan, Director Human Resources; Patricia Barrett, Clerk of the Board

   Other: Steve Gross, General Counsel; John Hawkins

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**
   No Changes to items 1 – 7.

4. **INPUT AUDIENCE:**
   None.

5. **DESIGNATE MEDICAL OFFICE BUILDING SUITE 210 REAL PROPERTY NEGOTIATOR(S)**
   Chief Facilities Development Officer, Rick McConn, shared with the Board that Dr. Kitts has indicated an interest in selling his Medical Office Building suite #210. Mr. McConn requested that he be designated as real property negotiator.

   General Counsel provided background related to the purpose of appointing a negotiation, noting that the Board is not committing to anything by doing so.

   ACTION: Motion made by Director Zipkin, seconded by Director Jellinek, to designate Rick McConn as Medical Office Building Suite 210 Real Property Negotiator. Roll call vote taken. Approved unanimously.

   Meeting adjourned at 4:05 p.m.

6. **CLOSED SESSION:**
   Discussion held on privileged matters.

7. **DINNER BREAK**

   APPROXIMATELY 6:00 P.M.

8. **OPEN SESSION – CALL TO ORDER**

Meeting reconvened at 6:03 p.m.

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

ACTION: Motion made by Director Zipkin, seconded by Director Jellinek, to approve the agenda as posted. Roll call vote taken. Approved unanimously.

10. INPUT – AUDIENCE

Community member addressed the Board related to a survey she received dated February 12 and signed by Mr. Schapper. Concern was expressed regarding the content of the questions and that Mr. Schapper's signature was used after his date of departure. A copy of the written statement will be provided to the Clerk of the Board.

Dennis Chez, addressed the Board related to the issues presented at the last board meeting. Dr. Chez shared that at 3pm [the date of this board meeting] that he received a hand delivered letter from the interim CEO related to a new policy pertaining to freedom of choice by patients. Dr. Chez expressed that a change in CEO was all it took to have the issue addressed and thanked the Board.

Pete Rivera addressed the Board related to agendas. Mr. Rivera stated that the praise of the former CEO should have been stopped at the last meeting as it was not included on the agenda; adding that if the Board cannot run the meeting the way it should be run, the issue should be addressed.

Director Sessler shared that the Board conducts a board self assessment at the end each meeting. One of the goals of the Board is to improve community involvement. One of the places that much of the work gets done is in board committee. No action is taken at the committee level, but recommendations are made to the Board. The committee schedule and agendas will be posted on the TFHD.com website. The Board invites and welcomes the community to attend the committee meetings.

A summary of agenda topics for this evening's Board meeting was provided by Director Sessler.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

None.

12. MEDICAL STAFF REPORT

12.1. Approval of the Medical Staff Consent Agenda

Dr. Dodd provided a summary of the February MEC meeting. Consent items included policy and procedure items presented for approval.

At the request of Director Mohun, Dr. Dodd provided some background related to the Orthopedic Advisory Committee.

ACTION: Motion made by Director Zipkin, seconded by Director Mohun, to approve Medical Staff Consent items as presented. Roll call vote taken. Approved unanimously.

13. CONSENT CALENDAR:

These items were routine and non-controversial.

13.1. Approval of Minutes of Meetings:

01/08/2015, 01/13/2015, 01/26/2015, and 1/27/2015

ACTION: Motion made by Director Jellinek, seconded by Director Mohun, to approve consent item 13.1. Roll call vote taken. Approved unanimously.

13.2. Financial Report: January 2015 Financials

At the request of Director Chamblin the Financial Report was pulled from the Consent Agenda for discussion. Director Chamblin stated that despite the weak winter season, the District has a positive financial report. Director Mohun asked for clarification related to the professional fee amounts. The CFO provided clarification and reviewed steps being taken to curtail this area.

Community member, Gaylan Larson, addressed the Board. Mr. Larson attended the February Board Finance Committee meeting and commented on his observations related to Multi-specialty Clinics (MSC). Mr. Larson provided a summary of what he understands triggered the development of the MSC formula and his conclusion that the hospital probably incurred losses as a result of the MSC but increased business. Mr. Larson believes the practice is a serious problem and needs to be corrected.

Community member, Jack Cashton, asked that clarifications be sought related to the whether under the district law, the contracts that provide incentive used to recruit and retain physicians have a 3 year maximum term.

ACTION: Motion made by Director Chamblin, seconded by Director Mohun, to approve consent items 13.2. Roll call vote taken. Approved unanimously.

13.3. Contracts:

At the request of Director Mohun all contracts were pulled from the Consent agenda for discussion.

Director Sessler indicated she would recuse herself from the discussion related to Dr. Barta's contract due to the potential of a perceived conflict.

13.3.1. **New**

a. Krause _Rural PRIME Site Clerkship Director
b. Krause_Rural PRIME Site Medical Director
c. Samelson_PSA Medical Director Medical Education Committee

13.3.2. **Auto Renew**

a. Brown_Medical Director Pediatric Health Clinic

13.3.3. **Amendment**

a. Barta_ Tahoe Center for Health and Sports Performance
Diabetes Medical Director

Director Mohun applauded Management for development of the contract routing form. A review of the routing from was provided by Director Mohun. Calling attention to policy ABD-21 referenced on the contract routing form, Director Mohun indicated that all professional services agreements (PSA) will be developed between the District CEO and the health professional, and the health professional will sign the contracts prior to presenting for approval to the Board.

Director Sessler provided background as discussed in the Governance Committee. The interim CEO indicated the District is in the process of complying with the policy as stated.

Director Mohun expressed concerns related to the sign off of FMV and Commercial Reasonableness as he did not recognize the initials of the signer and requested to be provided the supporting documentation confirming the contracts are within FMV and commercially reasonable.

Discussion took place regarding contracts that go into effect prior to the next board meeting. It was agreed that if a special meeting is required to revisit the contracts presented for approval, the Board would be in favor of a special meeting.

Director Zipkin indicated he has issues with the language of certain contracts. Specifically, the contract language related to unrestricted privileges. The Interim CEO provided background related to the Krause contract, indicating that Dr. Krause declined to continue certain privileges but retains other privileges related to his contract. Director Zipkin noted that language in Dr. Samelson's contract pertaining to quality review as a purpose of a medical education director needs to be removed.

A question was presented related to Dr. Brown's contract signature date reflected in the contract provided for review. Clarification was provided regarding how auto renew contracts are processed.

Discussion took place related to the insurance provision in contracts. The Interim CEO indicated that the verbiage would have been provided by an attorney. Staff will review language to ensure accuracy and consistency.

ACTION: Motion made by Director Jellinek, seconded by Director Mohun, to have contracts made fully compliant with policy ABD-21 and resubmitted to the Board for approval. Roll call vote taken. Approved unanimously.

14. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

14.1. Patient and Family Center Care

Dr. Standteiner introduced the Patient and Family Center Care (PFCC) team including, Tammy Melrose, Eileen Knudsen and Trish Foley. Dr. Standteiner provided an overview of the PFCC model. Tammy Melrose reviewed the patient and family centered principles.

Trish Foley provided background related to the Patient and Family Advisory Council representing a collective voice of patients, patient families, staff and administrative representative.

The PFCC team would like approval of the PFAC charter. If approved, the PFCC team will work with management to develop a budget for consideration into the next fiscal year. Budget considerations may consist of: additional staff hours, funds to support PFAC meetings, and annual PFCC conference attendance/reimbursement.

Discussion took place related to the presence of this process or councils thorough the industry. It was shared that this international program has been progressing over the last ten years, but has become more prominent over the last couple of years.

Director Zipkin asked for clarification related to ensuring HIPAA compliance with the participants. The team was recognized for their efforts.

ACTION: Motion made by Director Mohun, seconded by Director Zipkin, to approve the PFAC charter as presented. Roll call vote taken. Approved unanimously.

14.2. Wellness Neighborhood

Caroline Ford addressed the Board regarding requested approval of proposed Community Health Priority Issues and Community Health Improvement planning work by the Wellness Neighborhood and Community Health Programs.

Major findings necessitating either corrective action or attention included:

- High rates of alcohol consumption
- Prescription drug misuse
- Access to and availability of mental health services
- Health care costs and affordability
- Oral health care access barriers
- Vaccination rates among adults and children
- Access to care ethnic disparities
- Transportation to services

Ms. Ford reviewed some disturbing trends related to youth and substance use gathered during the survey.

Assessment findings and clarifications leading to board recommendation of 2015 priority health issues include:

- Optimizing Community Health
- Substance Use and Abuse
- Mental/Behavioral Health
- Access to Care and Preventive/Primary Health Services

Director Sessler asked Ms. Ford to expand on the concept of collective impact.

Five major pieces of the collective impact approach that resonate with the work of the wellness neighborhood were reviewed.

Director Sessler summarized the requested approval item presented to the Board and confirmed that the intent is to have TFHD identified as a backbone organization.

Director Zipkin recognized Ms. Ford and her team for their efforts. Director Mohun inquired about the buy-in by the medical community. Dissemination of the information is complex and will require more one on one communication. Members of medical staff are very supportive and have started some related initiatives on their own.

Director Chamblin inquired about strategies adopted by other community to address these issues. Ms. Ford and Ms. Knudsen are reviewing this area and will be attending a quality conference to engage with others working on similar initiatives.

Director Jellinek requested feedback related to whether there is a recognizable correlation between the substance use and mental health issues identified. Feedback was provided related to self injury paired up with alcohol or drug use; the Board was referred to the mental health report included as part of the needs assessment for additional data.

Director Sessler acknowledged the work done by Ms. Ford and her team in identifying the four key priorities.

ACTION: **Motion made by Director Mohun, seconded by Director Zipkin, to approve the priority health issue umbrellas of: Optimizing Community Health, Substance Use and Abuse, Mental/Behavioral Health, and Access to Care and Preventive/Primary Health Services as the focus of the 2015 Community Health Improvement Plan. Roll call vote taken. Approved unanimously.**

Discussion took place regarding next Wellness Neighborhood presentation.

14.3. Board Education

14.3.1. **Co-Management Agreements**

John Hawkins introduced himself to the Board and provided background related to his knowledge of the area and TFHD.

TFHD's management team continues to explore contractual arrangements with physicians to achieve the Institute for Healthcare Improvement's Triple Aim for the health care industry; improved quality and patient satisfaction, improved access and reduced costs. While most states allow for direct hospital employment of physicians, California does not.

Mr. Hawkins provided an overview of what Co-Management Agreements are, and how hospitals have used them to align hospital and physicians around common goals.

Director Mohun departed the meeting at 8:10 p.m.

Director Mohun rejoined the meeting at 8:13 p.m.

The idea of Alignment refers to the ability of Hospitals and Physicians to pursue common goals while limiting conflicts of interest, lack of trust or other impediments to success.

For Physicians, participation as co-managers provide them a means to supplement declining reimbursement and to have a greater voice in the operation of Orthopedic Service Line related to their particular field of expertise.

For Hospitals, they gain from this expertise as well by granting the physicians greater responsibility for the oversight of work done at the hospital resulting in motivating staff and implementing new procedures for insuring efficient, high quality of care.

Discussion took place regarding co-management agreements and incorporated physician incentives. Dr. Dodd addressed the quality metrics included in the agreement.

Discussion took place related to the management component of the agreement. Physicians are the leaders, but are not managers in this arrangement. HCAHPS are part of the pay for performance. An example of physician payment of incentive compensation under a co-management agreement was reviewed. Data mining would be the responsibility of the hospital. A review of the payment criteria was provided.

A summary of how an orthopedic co-management agreement may work was provided.

- Co-management is designed to manage and improve quality and efficiency in the Orthopedic Service Line.
- The agreement provides for a base payment consistent with Fair Market Value "FMV" on the time the orthopedist dedicates to service line management, development, implementation and oversight.
- The agreement also provides bonus payments of pre determined amounts for meeting specific and measurable quality improvement and efficiency goals. These goals are called "Performance Measurements."
- Base payments are generally paid monthly whereas the incentive payment is paid 90 days after the Term of the agreement ends. Usually, term is for 12 months.

Director Sessler inquired about Mr. Hawkins' experience in response to physicians who are not participating in co-management agreements. Mr. Hawkins indicated that specialties are easy to do, but Primary Care is all over the board which makes it challenging.

Discussion took place related to whether there are conflicts with co-management agreements.

Discussion took place related to the contractual arrangement and whether payor agreements will need to be renegotiated.

Director Zipkin departed the meeting at 8:41 p.m.
Director Zipkin rejoined the meeting at 8:43 p.m.

TFHD service line administrator is well placed with both clinical and administrative background.

It was noted that the key is to craft an agreement that is clear to all parties related to metrics. The agreement delineates the benefits from the costs; there are opportunities for hard and soft revenue.

15. PRESENTATIONS/STAFF REPORTS *[potential action items]*

15.1. Citizen's Oversight Committee Annual Report and Amended Bylaws

Gerald Herrick, Chair of the Citizen's Oversight Committee, presented the Citizens Oversight Committee (COC), annual report of its activities during the year. This annual reporting is required per the COC Bylaws established by the Tahoe Forest Hospital District Board of Directors.

Included in the report are:

- A statement indicating whether the District is in compliance with the letter and intent of Measure C
- A summary of the Committee's proceedings and activities for the preceding year

The COC believes that the District is in compliance with the letter and intent of Measure C based on the detailed oversight exerted during the past year.

A request to approved amendment to the COC Bylaws was presented. The Committee is required to remain as a committee until all dollars are spent. The committee has asked the Board to amend the COC Bylaws so that the current Chair and Vice Chair can remain in their offices until the project is wrapped up.

ACTION: Motion made by Director Mohun, seconded by Director Sessler, to modify the bylaws to extend the term limitation to three terms instead of two. Roll call vote taken. Approved unanimously.

Mr. Herrick recognized staff for helping the project to be successful; specifically, Ted Owens, Crystal Betts, Carey Hood and Bob Schapper.

15.2. Facilities Development Plan Quarterly Update

The Chief Facilities Development Officer and Mike Genet, Construction Manager, presented a quarterly update of the Facilities Development Plan including the status of current capital projects.

The quarterly update prepared on September 30, 2014 was scheduled to be presented to the Board at the December 2014 meeting and was deferred to February 2015 meeting.

The quarterly update of the Facilities Development Plan (FDP) includes updates pertaining to the Measure C Projects and related Owner and Regulatory Scope Modifications.

No construction disputes are pending.

Clarification was provided related to scope modification.

The next update will be provided at the March 31, 2015 meeting of the Board of Directors.

16. STRATEGIC INITIATIVE UPDATE

Director Sessler shared that this part of the meeting had previously been listed as the various Chiefs' reports and has been re-crafted to have the data more closely tie to the strategic initiatives of the District.

A review of the strategic plan to identify key priorities for the interim CEO will take place at the board retreat. A more robust review would be best delayed until the long-term CEO is identified and would include engagement of medical staff related to future services that will benefit the community.

The interim CEO is working with the Director of Marketing to update the current strategic plan to identify the status of each goal to date.

17. BOARD COMMITTEE REPORTS/RECOMMENDATIONS[potential action items]

17.1. Community Benefit Committee – No Meeting

17.2. Finance Committee Meeting – 02/23/15

The CFO provided an update related to the GO bond sale. The bond will be fully closed on March 9th and the CFO will work with Marketing to craft communication for the community.

17.3. Governance Committee Meeting – 02/13/15

Director Sessler provided an update from the Governance Committee.

17.3.1. **Board Draft Goals**

An updated draft grid reflecting board goals was provided to the Board for reference. Goals will be discussed in detail at the board retreat.

17.3.2. **Board Retreat Planning**

Tentative dates for the retreat are March 16 – 17, 2015; no over-night planned.
The retreat will be at a different location within the District and held as an open public meeting. The retreat is a workshop for the Board and public can attend to observe but are not intended to be participants. Director of Community Development shared that the notification of the board retreat would be handled though the usual meeting posting process.

Request made by Director Mohun to consider changing the dates to March 17 -18, 2015 as he has a conflict on the 16th.

Draft retreat priorities were reviewed by Director Sessler.

17.4. Personnel/Retirement Committee Meeting – No meeting

17.5. Quality Committee – 02/10/15

Director Jellinek provided an update from the Quality Committee meeting. Director Jellinek shared with the Board that a link to a video related to the PFCC will be provided to the board for viewing.

18. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

Director Mohun shared that he has been appointed to the Orthopedic Advisory Council (OAC) and there is benefit to consider having two board members assigned to this committee. Director Mohun would further recommend a report out to the Board on a set schedule. Director Mohun thanked Dr. Dodd and the OAC for the work done by the group.

Discussion took place related to having the other non-board committees on which there are board representatives present to the Board on the activities of their committees.

19. ITEMS FOR NEXT MEETING

a) **Radiology Contract**

The interim CEO provided an update related to the work being done to prepare for presentation to the Board noting that she is not confident that the work will be done in time for the March meeting.

Consideration will be given to including contract review as part of the retreat agenda as this would preclude the Board from having to call a special meeting prior to the retreat.

It was restated that the results of the employee survey will go first to the Personnel Committee prior to rolling up to the Board.

20. BOARD MEMBERS REPORTS/CLOSING REMARKS

ACHD legislative day is April 13 -14. Board members interested in attending are directed to coordinate with Director of Community Development.

Meeting recessed at 9:34 p.m.

21. CLOSED SESSION CONTINUED, IF NECESSARY

22. OPEN SESSION

Open session reconvened at 10:47 p.m.

23. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

The Board authorized the law firm of Porter Simon to engage an outside investigator to investigate a complaint.

24. MEETING EFFECTIVENESS ASSESSMENT

The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

25. ADJOURN

Meeting adjourned at 10:47 p.m.

TAHOE FOREST HOSPITAL DISTRICT
FEBRUARY 2015 FINANCIAL REPORT
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Board of Directors
Of Tahoe Forest Hospital District

FEBRUARY 2015 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the eight months ended February 28, 2015.

Activity Statistics

- TFH acute patient days were 336 for the current month compared to budget of 415. This equates to an average daily census of 12.0 compared to budget of 14.8.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Endoscopy procedures, Laboratory tests, Oncology Laboratory, Mammography, Oncology procedures, Ultrasounds, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Diagnostic Imaging, MRI exams, Cat Scans, Pet CT, Oncology Pharmacy units, and Respiratory Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 55.8% in the current month compared to budget of 55.2% and to last month's 56.6%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.4%, compared to budget of 55.0% and prior year's 58.3%.
- EBIDA was $45,853 (.3%) for the current month compared to budget of $573,279 (3.5%), or $(527,426) (-3.2%) under budget. Year-to-date EBIDA was $2,802,833 (2.0%) compared to budget of $1,976,414 (1.5%) or $826,419 (.6%) over budget.
- Cash Collections for the current month were $7,634,704 which is 71% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 65.9, compared to the prior month of 70.0. Gross Accounts Receivables are $33,516,821 compared to the prior month of $34,647,671. The percent of Gross Accounts Receivable over 120 days old is 26.9%, compared to the prior month of 27.8%.

Balance Sheet

- Working Capital Days Cash on Hand is 22.4 days. S&P Days Cash on Hand is 145.5. Working Capital cash decreased $1,749,000. Cash collections fell short of target by 29% and Accounts Payable decreased $1,832,000.
- Net Patients Accounts Receivable decreased approximately $54,000. Cash collections were at 71% of target and days in accounts receivable were 65.9 days, a 4.1 days decrease.
- GO Bond Project Fund decreased $990,972 after remitting payment to the District for funds advanced on the January Measure C projects.
- Accounts Payable decreased $1,832,000 due to the timing of the final check run in February.

February 2015 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $15,245,843, compared to budget of $16,323,678 or $1,077,835 under budget.
- Current month's Gross Inpatient Revenue was $4,600,495, compared to budget of $5,724,522 or $1,124,026 below budget.
- Current month's Gross Outpatient Revenue was $10,645,348, compared to budget of $10,599,156 or $46,192 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 30.8% Medicare, 19.3% Medi-Cal, .0% County, 3.6% Other, and 46.3% Insurance compared to budget of 34.4% Medicare, 12.8% Medi-Cal, 1.7% County, 7.1% Other, and 44.0% Insurance. Last month's mix was 34.1% Medicare, 17.7% Medi-Cal, .0% County, 4.6% Other, and 43.6% Insurance.
- Current month's Deductions from Revenue were $6,745,480 compared to budget of $7,314,844 or $569,364 under budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 3.60% decrease in Medicare, a 6.42% increase to Medi-Cal, a 1.73% decrease in County, a 3.42% decrease in Other, and Commercial was over budget 2.33%, 2) revenues fell short of budget by 6.6%, and 3) we are seeing increased activity on the collection of outsourced, older patient accounts creating a positive variance in Bad Debt.

Operating Expenses

DESCRIPTION	February 2015 Actual	February 2015 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,171,918	3,213,990	42,072	
Employee Benefits	1,010,183	1,063,598	53,416	
Benefits – Workers Compensation	71,539	51,566	(19,973)	
Benefits – Medical Insurance	1,052,848	717,510	(335,339)	
Professional Fees	1,465,265	1,406,952	(58,314)	Legal services provided to the Corporate Compliance department, services provided to Patient Accounting/Admitting and Revenue Cycle by Jacobus Consulting, an increase in Inpatient and Outpatient Therapy revenues, FY15 Physician RVU Bonuses paid, and pension plan consulting for Human Resources created a negative variance in Professional Fees.
Supplies	960,727	1,135,062	174,336	Medical Supplies Sold to Patients and Surgery revenues were under budget by 10.64% and Drugs Sold to Patients Revenue also came in below budget by 30.45% creating a positive variance in the Supplies category.
Purchased Services	759,466	830,731	71,265	Negative variances in Locum coverage for IP Pharmacy and MSC Ochin calendar year visit buy-ups were offset by positive variances in most of the other Purchased Services categories.
Other Expenses	526,432	574,684	48,252	Negative variance in Outside Training & Travel for Jacobus consultants and Other Building rents were offset by positive variances in the remainder of the Other Expenses categories.
Total Expenses	9,018,378	8,994,094	(24,284)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
FEBRUARY 2015

	Feb-15	Jan-15	Feb-14	
ASSETS				
CURRENT ASSETS				
* CASH	$ 7,417,436	$ 9,166,070	$ 11,386,585	1
PATIENT ACCOUNTS RECEIVABLE - NET	16,046,120	16,100,428	20,522,911	2
OTHER RECEIVABLES	3,776,795	3,248,230	3,296,087	
GO BOND RECEIVABLES	257,264	(138,146)	605,964	
ASSETS LIMITED OR RESTRICTED	5,719,035	5,629,382	5,960,217	
INVENTORIES	2,470,281	2,477,144	2,287,780	
PREPAID EXPENSES & DEPOSITS	1,463,629	1,505,074	1,588,675	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,313,502	3,277,186	2,775,552	
OTHER CURRENT ASSETS	-	-	-	
TOTAL CURRENT ASSETS	40,464,063	41,265,368	48,423,772	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	40,705,163	40,705,163	33,614,370	1
BANC OF AMERICA MUNICIPAL LEASE	2,294,253	2,294,253	2,288,616	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	2,868,311	2,709,034	2,802,876	
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	14,921,275	15,912,247	21,932,188	3
GO BOND TAX REVENUE FUND	556,531	555,788	395,117	
BOARD DESIGNATED FUND	2,297	2,297	2,297	
DIAGNOSTIC IMAGING FUND	2,967	2,967	3,140	
DONOR RESTRICTED FUND	1,115,568	1,130,562	722,722	
WORKERS COMPENSATION FUND	14,245	1,903	16,833	
TOTAL	62,480,612	63,314,215	61,778,159	
LESS CURRENT PORTION	(5,719,035)	(5,629,382)	(5,960,217)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	56,761,576	57,684,833	55,817,942	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	393,277	393,277	592,497	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	129,996,949	130,533,916	118,181,985	
GO BOND CIP, PROPERTY & EQUIPMENT NET	18,008,052	17,472,778	25,910,028	
TOTAL ASSETS	246,460,269	248,186,525	249,762,576	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	594,757	597,989	633,545	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,936,176	1,936,176	1,389,291	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,530,933	$ 2,534,165	$ 2,022,836	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 3,818,482	$ 5,650,712	$ 4,666,008	4
ACCRUED PAYROLL & RELATED COSTS	7,195,309	7,094,678	7,005,234	
INTEREST PAYABLE	269,396	148,148	276,684	
INTEREST PAYABLE GO BOND	389,820	83	389,889	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	1,285,397	1,245,100	450,006	
HEALTH INSURANCE PLAN	997,635	997,635	860,027	
WORKERS COMPENSATION PLAN	1,006,475	1,006,475	1,392,606	
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	890,902	887,362	
CURRENT MATURITIES OF GO BOND DEBT	315,000	315,000	50,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,300,830	2,300,830	2,392,710	
TOTAL CURRENT LIABILITIES	18,469,246	19,649,563	18,370,527	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,483,513	33,584,150	35,742,576	
GO BOND DEBT NET OF CURRENT MATURITIES	98,130,000	98,130,000	98,450,220	
DERIVATIVE INSTRUMENT LIABILITY	1,936,176	1,936,176	1,389,291	
TOTAL LIABILITIES	152,018,935	153,299,889	153,952,613	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	95,856,699	96,290,239	97,110,077	
RESTRICTED	1,115,568	1,130,562	722,722	
TOTAL NET POSITION	$ 96,972,267	$ 97,420,801	$ 97,832,799	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
FEBRUARY 2015

1. Working Capital is at 22.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 145.5 days. Working Capital cash decreased $1,749,000. Cash collections fell short of target by 29% and Accounts Payable (See Note 4) decreased $1,832,000.

2. Net Patient Accounts Receivable decreased approximately $54,000. Cash collections were 71% of target. Days in Accounts Receivable are at 65.9 days compared to prior months 70.0 days, a 4.10 day decrease.

3. G.O. Bond Project Fund decreased $990,972 after reimbursing the District for funds advanced on Measure C projects.

4. Accounts Payable decreased $1,832,000 due to the timing of the final check run in the month.

Tahoe Forest Hospital District
Cash Investment
February 2015

WORKING CAPITAL				
US Bank	$ 6,994,414			
US Bank/Kings Beach Thrift Store	129,780			
US Bank/Truckee Thrift Store	308,171			
Wells Fargo Bank				
Local Agency Investment Fund	-	0.266%		
Total			$	7,432,365
BOARD DESIGNATED FUNDS				
US Bank Savings	$ 2,297	0.03%		
Capital Equipment Fund	-			
Total			$	2,297
Building Fund	$ -			
Cash Reserve Fund	40,705,163	0.266%		
Local Agency Investment Fund			$	40,705,163
Banc of America Muni Lease			$	2,294,253
Bonds Cash 1999			$	2
Bonds Cash 2002			$	-
Bonds Cash 2006			$	2,868,311
Bonds Cash 2008			$	15,477,806
DX Imaging Education	$ 2,967	0.266%		
Workers Comp Fund - B of A	14,245			
Insurance				
Health Insurance LAIF	-	0.266%		
Comprehensive Liability Insurance LAIF	-	0.266%		
Total			$	17,212
TOTAL FUNDS			$	68,797,409
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,367	0.03%		
Foundation Restricted Donations	$ 302,342			
Local Agency Investment Fund	804,858	0.266%		
TOTAL RESTRICTED FUNDS			$	1,115,568
TOTAL ALL FUNDS			$	69,912,977

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2015

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD FEB 2014
					OPERATING REVENUE						
$ 15,245,843	$ 16,323,678	$ (1,077,835)	-6.6%		Total Gross Revenue	$ 137,794,999	$ 133,584,885	$ 4,210,114	3.2%	1	$ 125,308,141
					Gross Revenues - Inpatient						
$ 1,529,420	$ 1,630,389	$ (100,969)	-6.2%		Daily Hospital Service	$ 13,609,071	$ 12,809,948	$ 799,123	6.2%		$ 12,485,462
3,071,075	4,094,133	(1,023,058)	-25.0%		Ancillary Service - Inpatient	32,122,494	31,432,341	690,153	2.2%		29,238,726
4,600,495	5,724,522	(1,124,026)	-19.6%		Total Gross Revenue - Inpatient	45,731,564	44,242,289	1,489,276	3.4%	1	41,724,188
10,645,348	10,599,156	46,192	0.4%		Gross Revenue - Outpatient	92,063,434	89,342,596	2,720,838	3.0%		83,583,953
10,645,348	10,599,156	46,192	0.4%		Total Gross Revenue - Outpatient	92,063,434	89,342,596	2,720,838	3.0%	1	83,583,953
					Deductions from Revenue:						
5,972,690	6,106,892	134,202	2.2%		Contractual Allowances	54,421,230	50,247,156	(4,174,074)	-8.3%	2	47,161,605
454,287	555,005	100,718	18.1%		Charity Care	4,269,459	4,541,886	272,427	6.0%	2	3,965,323
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
318,504	652,947	334,443	51.2%		Bad Debt	2,491,667	5,343,397	2,851,730	53.4%	2	2,001,821
-	-	-	0.0%		Prior Period Settlements	270,924	-	(270,924)	0.0%	2	(829,615)
6,745,480	7,314,844	569,364	7.8%		Total Deductions from Revenue	61,453,280	60,132,439	(1,320,841)	-2.2%		52,299,134
49,183	95,371	(46,188)	-48.4%		Property Tax Revenue- Wellness Neighborhood	560,967	696,284	(135,318)	-19.4%		343,736
514,684	463,168	51,517	11.1%		Other Operating Revenue	5,143,338	4,455,865	687,473	15.4%	3	4,819,294
9,064,231	9,567,372	(503,142)	-5.3%		TOTAL OPERATING REVENUE	82,046,023	78,604,595	3,441,428	4.4%		78,172,037
					OPERATING EXPENSES						
3,171,918	3,213,990	42,072	1.3%		Salaries and Wages	27,046,703	27,444,002	397,299	1.4%	4	26,656,282
1,010,183	1,063,598	53,416	5.0%		Benefits	9,277,799	9,061,094	(216,705)	-2.4%	4	9,122,831
71,539	51,566	(19,973)	-38.7%		Benefits Workers Compensation	410,883	412,531	1,649	0.4%	4	692,014
1,052,848	717,510	(335,339)	-46.7%		Benefits Medical Insurance	5,744,753	5,740,077	(4,676)	-0.1%	4	5,485,980
1,465,265	1,406,952	(58,314)	-4.1%		Professional Fees	14,211,388	13,037,867	(1,173,521)	-9.0%	5	12,538,408
960,727	1,135,062	174,336	15.4%		Supplies	10,841,172	9,590,289	(1,250,883)	-13.0%	6	10,572,085
759,466	830,731	71,265	8.6%		Purchased Services	7,250,403	6,713,071	(537,332)	-8.0%	7	6,344,245
526,432	574,684	48,252	8.4%		Other	4,460,090	4,629,252	169,162	3.7%	8	3,916,899
9,018,378	8,994,094	(24,284)	-0.3%		TOTAL OPERATING EXPENSE	79,243,190	76,628,181	(2,615,008)	-3.4%		75,328,744
45,853	**573,279**	**(527,426)**	**-92.0%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**2,802,833**	**1,976,414**	**826,419**	**41.8%**		**2,843,293**
					NON-OPERATING REVENUE/(EXPENSE)						
398,825	352,637	46,188	13.1%		District and County Taxes	3,031,741	2,887,780	143,962	5.0%	9	3,366,602
393,903	393,903	-	0.0%		District and County Taxes - GO Bond	3,151,227	3,151,227	-	0.0%		3,168,212
23,097	21,142	1,956	9.3%		Interest Income	185,001	175,186	9,815	5.6%	10	151,971
2,287	1,306	981	75.2%		Interest Income-GO Bond	24,900	17,254	7,646	44.3%		40,723
23,206	60,951	(37,745)	-61.9%		Donations	296,617	487,607	(190,990)	-39.2%	11	365,501
-	-	-	0.0%		Gain/ (Loss) on Joint Investment	(67,418)	(112,500)	45,082	0.0%	12	(95,564)
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(809,066)	(809,066)	0	0.0%		Depreciation	(6,308,288)	(6,472,532)	164,243	2.5%	15	(5,949,713)
(137,393)	(137,111)	(282)	-0.2%		Interest Expense	(1,119,893)	(1,118,853)	(1,040)	-0.1%	16	(1,173,806)
(389,737)	(389,723)	(14)	0.0%		Interest Expense-GO Bond	(2,287,921)	(1,526,690)	(761,232)	-49.9%		(2,116,415)
(494,877)	(505,962)	11,084	2.2%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,094,035)	(2,511,521)	(582,514)	-23.2%		(2,242,489)
$ (449,025)	**$ 67,317**	**$ (516,342)**	**767.0%**		**INCREASE (DECREASE) IN NET POSITION**	**$ (291,201)**	**$ (535,107)**	**$ 243,905**	**45.6%**		**$ 600,804**
					NET POSITION - BEGINNING OF YEAR	**97,263,468**					
					NET POSITION - AS OF FEBRUARY 28, 2015	**$ 96,972,267**					
0.3%	**3.5%**	**-3.2%**			**RETURN ON GROSS REVENUE EBIDA**	**2.0%**	**1.5%**	**0.6%**			**2.3%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2015

		Variance from Budget Fav / <Unfav> FEB 2015	YTD 2015
1) Gross Revenues			
Acute Patient Days were under budget 19.04% or 79 days. Swing bed days were above budget 4.17% or 1 day. Ancillary Service revenues fell short of budget by 25.00% due to the decrease in patient days and lower acuity levels in our patient population.	Gross Revenue -- Inpatient	$ (1,124,026)	$ 1,489,276
	Gross Revenue -- Outpatient	46,192	2,720,838
	Gross Revenue -- Total	$ (1,077,835)	$ 4,210,114
Outpatient volumes were over budget in the following departments: Home Health visits, Endoscopy procedures, Laboratory tests, Mammography, Oncology procedures, Ultrasounds, Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for February shows a 3.60% decrease to Medicare, a 6.42% increase to Medi-Cal, 3.42% decrease to Other, a 1.73% decrease to County, and a 2.33% increase to Commercial when compared to budget. Contractual Allowances were under budget due to revenues falling short of target by 6.6%.	Contractual Allowances	$ 134,202	$ (4,174,074)
	Managed Care Reserve	-	-
	Charity Care	100,718	272,427
	Charity Care - Catastrophic	-	-
	Bad Debt	334,443	2,851,730
We saw a large pick up in Bad Debt write-off as an increasing patient population retrocatively qualifies and becomes insured through the Medi-Cal program as well as increased collection activity on older AR accounts.	Prior Period Settlement	-	(270,924)
	Total	$ 569,364	$ (1,320,841)
3) Other Operating Revenue			
Retail Pharmacy revenues were below budget 9.71%.	Retail Pharmacy	$ (18,128)	$ 158,233
	Hospice Thrift Stores	3,935	(6,875)
	The Center (non-therapy)	(4,907)	12,208
IVCH ER Physician Guarantee is tied to collections, which exceeded budget in February.	IVCH ER Physician Guarantee	50,486	136,776
	Children's Center	6,509	5,489
	Miscellaneous	11,444	144,183
Positive variance in Miscellaneous related to AT&T Rural Health credits for the 2013 year.	Oncology Drug Replacement	-	-
	Grants	2,177	237,458
	Total	$ 51,517	$ 687,473
4) Salaries and Wages	Total	$ 42,072	$ 397,299
Employee Benefits	PL/SL	$ 46,583	$ 101,199
	Nonproductive	(12,115)	(127,029)
	Pension/Deferred Comp	316	1,494
	Standby	(525)	(56,087)
	Other	19,157	(136,282)
	Total	$ 53,416	$ (216,705)
Employee Benefits - Workers Compensation	Total	$ (19,973)	$ 1,649
Employee Benefits - Medical Insurance	Total	$ (335,339)	$ (4,676)
5) Professional Fees			
Negative variance in Corporate Compliance attributed to legal services provided to the department.	Corporate Compliance	$ (7,724)	$ (622,495)
	Patient Accounting/Admitting	(88,053)	(483,865)
	Miscellaneous	(24,697)	(264,314)
	The Center (includes OP Therapy)	(33,309)	(148,986)
	Financial Administration	(4,083)	(106,467)
Patient Accounting/Admitting exceeded budget due to services provided by Jacobus Consulting.	TFH/IVCH Therapy Services	(13,122)	(93,534)
	Oncology	7,831	(25,160)
	Business Performance	-	-
Negative variance in Miscellaneous related to services provided by Jacobus Consulting in the Revenue Cycle department.	Marketing	1,000	7,875
	Home Health/Hospice	1,000	8,400
	Multi-Specialty Clinics Admin	119	12,229
Outpatient Therapy revenues exceeded budget by 42.72%, creating a negative variance in The Center (includes OP Therapy).	Information Technology	6,518	16,274
	Multi-Specialty Clinics	(7,707)	16,445
TFH/IVCH Therapy Services revenue exceeded budget by 15.35%, creating a negative variance in this category.	Human Resources	(6,117)	23,436
	Sleep Clinic	7,051	34,302
	Managed Care	1,513	34,892
Negative variance in Multi-Specialty Clinics related to RVU Bonuses paid.	Medical Staff Services	4,639	35,819
	Administration	58,645	68,850
Pension Plan consulting created a negative variance in Human Resources.	IVCH ER Physicians	18,947	71,817
	TFH Locums	2,356	117,038
Positive variance in Administration related to lessened use of Legal Counsel as well as refunds received on legal bills paid out in prior months.	Respiratory Therapy	16,879	123,923
	Total	$ (58,314)	$ (1,173,521)

6) Supplies

Medical Supplies Sold to Patients and Surgery revenues came in below budget by 10.64% creating a positive variance in Patient & Other Medical Supplies.

Drugs Sold to Patients revenues fell short of budget by 30.45%, creating a positive variance in Pharmacy Supplies.

Certain controllable supply costs are being monitored creating a positive variance in the remainder of the supply categories.

Patient & Other Medical Supplies	$ 56,557	$ (838,905)
Pharmacy Supplies	93,103	(463,765)
Minor Equipment	5,497	(25,918)
Other Non-Medical Supplies	7,804	(5,479)
Imaging Film	587	6,629
Food	49	37,043
Office Supplies	10,739	39,511
Total	$ 174,336	$ (1,250,883)

7) Purchased Services

Locums coverage created a negative variance in Pharmacy IP.

Negative variance in Multi-Specialty clinics attributed to calendar year 2014 Ochin visit buy-ups.

Positive variance in Department Repairs primarily related to Information Systems repairs coming in below budget estimations.

Miscellaneous	$ 48,359	$ (422,258)
Pharmacy IP	(15,600)	(184,218)
Patient Accounting	7,510	(82,161)
Laboratory	7,228	(58,849)
Multi-Specialty Clinics	(6,851)	(12,649)
Human Resources	(2,110)	(8,854)
Community Development	184	(2,542)
The Center	(1,078)	(156)
Medical Records	(552)	3,412
Hospice	3,699	7,040
Department Repairs	17,938	37,716
Information Technology	7,243	72,165
Diagnostic Imaging Services - All	5,294	114,022
Total	$ 71,265	$ (537,332)

8) Other Expenses

Negative variance in Outside Training & Travel associated with Jacobus Consultants lodging and travel.

Other Building Rent exceeded budget due to increased need for off site storage and Employee/Locums housing rentals.

Electricity, Diesel, and Natural Gas came in below budget due to the mild winter we continue to experience.

Controllable expenses continue to be monitored, creating positive variances in the remainder of the Other Expenses categories.

Outside Training & Travel	$ (59,142)	$ (233,955)
Physician Services	(2)	(94)
Innovation Fund	-	-
Multi-Specialty Clinics Equip Rent	(63)	332
Human Resources Recruitment	3,542	2,131
Other Building Rent	(3,680)	10,640
Multi-Specialty Clinics Bldg Rent	1,535	19,233
Miscellaneous	28,084	30,260
Equipment Rent	3,230	34,892
Insurance	5,824	41,375
Dues and Subscriptions	11,478	45,408
Utilities	40,387	79,187
Marketing	17,059	139,752
Total	$ 48,252	$ 169,162

9) District and County Taxes

Total	$ 46,188	$ 143,962

10) Interest Income

Total	$ 1,956	$ 9,815

11) Donations

IVCH	$ (4,200)	$ (11,509)
Operational	(33,545)	(179,481)
Capital Campaign	-	-
Total	(37,745)	(190,990)

12) Gain/(Loss) on Joint Investment

Total	$ -	$ -

12) Gain/(Loss) on Impairment of Asset

Total	$ -	$ -

13) Gain/(Loss) on Sale

Total	$ -	$ -

14) Impairment Loss

Total	$ -	$ -

15) Depreciation Expense

Total	$ -	$ 164,243

16) Interest Expense

Total	$ (282)	$ (1,040)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2015

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD FEB 2014
					OPERATING REVENUE						
$ 1,153,293	$ 1,197,711	$ (44,418)	-3.7%		Total Gross Revenue	$ 9,970,312	$ 9,644,525	$ 325,787	3.4%	1	$ 9,340,786
					Gross Revenues - Inpatient						
$ -	$ 6,988	$ (6,988)	-100.0%		Daily Hospital Service	$ 23,422	$ 27,952	$ (4,530)	-16.2%		$ 39,932
-	6,822	(6,822)	-100.0%		Ancillary Service - Inpatient	26,199	48,603	(22,404)	-46.1%		54,319
-	13,810	(13,810)	-100.0%		Total Gross Revenue - Inpatient	49,621	76,555	(26,934)	-35.2%	1	94,251
1,153,293	1,183,902	(30,609)	-2.6%		Gross Revenue - Outpatient	9,920,690	9,567,969	352,721	3.7%		9,246,535
1,153,293	1,183,902	(30,609)	-2.6%		Total Gross Revenue - Outpatient	9,920,690	9,567,969	352,721	3.7%	1	9,246,535
					Deductions from Revenue:						
326,577	355,970	29,393	8.3%		Contractual Allowances	2,773,190	2,900,419	127,229	4.4%	2	2,872,703
37,539	40,722	3,183	7.8%		Charity Care	322,145	327,914	5,769	1.8%	2	345,420
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
123,483	47,908	(75,575)	-157.8%		Bad Debt	831,007	385,782	(445,225)	-115.4%	2	554,971
-	-	-	0.0%		Prior Period Settlements	15,278	-	(15,278)	0.0%	2	18,147
487,599	444,600	(42,999)	-9.7%		Total Deductions from Revenue	3,941,620	3,614,115	(327,505)	-9.1%	2	3,791,241
80,841	28,919	51,922	179.5%		Other Operating Revenue	580,895	441,065	139,831	31.7%	3	466,213
746,535	782,030	(35,495)	-4.5%		TOTAL OPERATING REVENUE	6,609,587	6,471,474	138,113	2.1%		6,015,758
					OPERATING EXPENSES						
221,965	239,622	17,657	7.4%		Salaries and Wages	1,968,731	2,031,201	62,470	3.1%	4	1,980,228
77,925	83,537	5,612	6.7%		Benefits	718,861	720,427	1,565	0.2%	4	721,717
3,075	2,717	(359)	-13.2%		Benefits Workers Compensation	24,765	21,732	(3,033)	-14.0%	4	14,459
70,803	48,049	(22,753)	-47.4%		Benefits Medical Insurance	387,371	384,395	(2,977)	-0.8%	4	334,290
181,818	217,084	35,266	16.2%		Professional Fees	1,671,895	1,786,972	115,077	6.4%	5	1,681,505
45,548	52,249	6,702	12.8%		Supplies	408,212	385,512	(22,700)	-5.9%	6	386,067
44,288	41,345	(2,942)	-7.1%		Purchased Services	329,312	306,225	(23,087)	-7.5%	7	291,855
52,537	50,057	(2,479)	-5.0%		Other	397,321	409,132	11,811	2.9%	8	378,969
697,958	734,660	36,702	5.0%		TOTAL OPERATING EXPENSE	5,906,469	6,045,596	139,127	2.3%		5,789,090
48,577	**47,370**	**1,207**	**2.5%**		**NET OPERATING REV(EXP) EBIDA**	**703,119**	**425,878**	**277,240**	**65.1%**		**226,668**
					NON-OPERATING REVENUE/(EXPENSE)						
-	4,200	(4,200)	-100.0%		Donations-IVCH	22,091	33,600	(11,509)	-34.3%	9	77,510
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(53,601)	(53,601)	0	0.0%		Depreciation	(427,124)	(428,811)	1,687	-0.4%	11	(415,267)
(53,601)	(49,401)	(4,200)	-8.5%		TOTAL NON-OPERATING REVENUE/(EXP)	(405,033)	(395,211)	(9,822)	-2.5%		(337,757)
$ (5,024)	**$ (2,031)**	**$ (2,992)**	**147.3%**		**EXCESS REVENUE(EXPENSE)**	**$ 298,085**	**$ 30,667**	**$ 267,418**	**872.0%**		**$ (111,089)**
4.2%	**4.0%**	**0.3%**			**RETURN ON GROSS REVENUE EBIDA**	**7.1%**	**4.4%**	**2.6%**			**2.4%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2015

		Variance from Budget Fav<Unfav> FEB 2015	YTD 2015
1) Gross Revenues			
Acute Patient Days were below budget by 2 at 0 and Observation Days were under budget by 3 at 0.	Gross Revenue -- Inpatient	$ (13,810)	$ (26,934)
	Gross Revenue -- Outpatient	(30,609)	352,721
		$ (44,418)	$ 325,787
Outpatient volumes were below budget in Emergency Department visits, Radiology Exams, Sleep Clinic visits, and Physical Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 3.37% increase in Commercial, Insurance, a 5.79% decrease in Medicare, a 7.55% increase in Medicaid, a 4.74% decrease in Other, and a .38% decrease in County. We continue to see an increase in Bad Debt as Aged A/R accounts are worked.	Contractual Allowances	$ 29,393	$ 127,229
	Charity Care	3,183	5,769
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(75,575)	(445,225)
	Prior Period Settlement	-	(15,278)
	Total	$ (42,999)	$ (327,505)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which exceeded budget in February.	IVCH ER Physician Guarantee	$ 50,486	$ 136,776
	Miscellaneous	1,436	3,055
	Total	$ 51,922	$ 139,831
4) Salaries and Wages	Total	$ 17,657	$ 62,470
Employee Benefits	PL/SL	$ 1,841	$ 15,901
	Standby	1,901	(706)
	Other	1,520	(15,391)
	Nonproductive	34	(1,081)
	Pension/Deferred Comp	316	2,843
	Total	$ 5,612	$ 1,565
Employee Benefits - Workers Compensation	Total	$ (359)	$ (3,033)
Employee Benefits - Medical Insurance	Total	$ (22,753)	$ (2,977)
5) Professional Fees	Multi-Specialty Clinics	$ 9,913	$ (11,073)
Dr. Osgood left the MSC Orthopedic structure, creating a positive variance in Multi-Specialty clinics.	Foundation	1,905	(9,238)
	Administration	150	1,200
	Miscellaneous	547	2,270
IVCH OP Occupational Therapy revenues exceeded budget by 59.60%, creating a negative variance in Therapy Services Pro Fees.	Therapy Services	(3,248)	25,800
	Sleep Clinic	7,051	34,302
	IVCH ER Physicians	18,947	71,817
	Total	$ 35,266	$ 115,077
6) Supplies	Patient & Other Medical Supplies	$ 476	$ (27,287)
Drugs Sold to Patients revenue fell short of budget by 22.46%, creating a positive variance in Pharmacy Supplies.	Pharmacy Supplies	8,616	(3,061)
	Food	302	690
	Non-Medical Supplies	(312)	749
Small equipment purchases for the Sterile Processing Department created a negative variance in Minor Equipment.	Imaging Film	(322)	1,451
	Office Supplies	396	2,002
	Minor Equipment	(2,455)	2,755
	Total	$ 6,702	$ (22,700)

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2015

7) Purchased Services

Negative variance in Miscellanous primarily related to Purchased Services paid for outside management of the Medically Managed Fitness program.

Laboratory revenues exceeded budget by 8.03%, creating a negative variance in this category.

Cat Scan revenues also exceeded budget by 8.04%, creating a negative variance in Diagnostic Imaging - All.

8) Other Expenses

Negative variance in Equipment Rent related to oxygen tank rentals.

9) Donations

10) Gain/(Loss) on Sale

11) Depreciation Expense

	Variance from Budget Fav<Unfav>	
	FEB 2015	YTD 2015
Miscellaneous	$ (3,719)	$ (26,152)
Engineering/Plant/Communications	7,080	(6,501)
EVS/Laundry	439	(6,367)
Pharmacy	(207)	(2,799)
Surgical Services	-	-
Laboratory	(3,996)	190
Multi-Specialty Clinics	61	574
Department Repairs	(87)	3,644
Foundation	333	3,813
Diagnostic Imaging Services - All	(2,846)	10,511
Total	$ (2,942)	$ (23,087)
Outside Training & Travel	$ (916)	$ (13,717)
Equipment Rent	(3,552)	(987)
Other Building Rent	(582)	(582)
Multi-Specialty Clinics Equip Rent	-	-
Physician Services	-	-
Multi-Specialty Clinics Bldg Rent	-	-
Miscellaneous	387	788
Insurance	213	1,707
Dues and Subscriptions	(35)	2,384
Utilities	(217)	9,735
Marketing	2,222	12,483
Total	$ (2,479)	$ 11,811
Total	$ (4,200)	$ (11,509)
Total	$ -	$ -
Total	$ -	$ 1,687

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2014	BUDGET FYE 2015		PROJECTED FYE 2015	ACTUAL FEB 2015	BUDGET FEB 2015	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 3,742,843	$ 2,008,740		$ 2,809,724	**$ 45,853**	**$ 573,279**	**$ (527,426)**	$ 3,469,494	$ (1,330,346)	$ 1,128,125	$ (457,549)
Interest Income	90,129	96,542		96,335	-	-	-	19,503	25,120	26,432	25,279
Property Tax Revenue	5,285,587	5,376,000		5,337,891	-	-	-	237,157	73,132	2,877,602	2,150,000
Donations	1,132,315	600,300		595,107	**23,492**	**58,000**	**(34,508)**	221,165	146,247	150,695	77,000
Debt Service Payments	(4,308,075)	(3,926,699)		(3,693,414)	**(263,644)**	**(271,825)**	**8,180**	(1,123,831)	(790,940)	(963,170)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)	(1,243,644)		(1,243,530)	**(103,637)**	**(103,637)**	**(0)**	(310,795)	(310,912)	(310,912)	(310,911)
Bank of America - 2007 Muni Lease	(421,721)	-		-		-	-	-	-	-	-
Copier	(100,214)	(105,000)		(41,043)	**(730)**	**(8,750)**	**8,020**	(2,393)	(2,197)	(10,202)	(26,250)
2002 Revenue Bond	(633,393)	(664,805)		(496,875)	-	-	-	(332,811)	-	(164,064)	-
2006 Revenue Bond	(1,909,100)	(1,913,250)		(1,911,966)	**(159,277)**	**(159,438)**	**160**	(477,831)	(477,831)	(477,992)	(478,313)
Physician Recruitment	(129,886)	(150,000)		(104,185)	**(5,411)**	**(12,500)**	**7,089**	(27,246)	(16,112)	(23,327)	(37,500)
Investment in Capital				-						-	
Equipment	(2,157,004)	(1,748,150)		(1,748,150)	**(77,645)**	**(85,000)**	**7,355**	(270,964)	(334,607)	(1,001,207)	(141,372)
Municipal Lease Reimbursement	748,489	1,250,000		1,250,000	-	-	-	-	-	-	1,250,000
GO Bond Project Personal Property	(703,327)	(747,761)		(747,761)	**(70,835)**	-	**(70,835)**	(24,369)	(38,923)	(70,835)	(613,634)
IT	(339,004)	(2,804,763)		(2,804,763)	**(5,161)**	**(100,000)**	**94,839**	(113,054)	(1,092,933)	(278,907)	(1,319,869)
Building Projects	(1,339,652)	(3,557,916)		(3,557,916)	**(117,222)**	**(476,076)**	**358,854**	(617,090)	(596,944)	(781,013)	(1,562,870)
Health Information/Business System	(349,125)	(1,105,000)		(1,105,000)	-	**(134,148)**	**134,148**	(30,303)	(200,549)	(200,000)	(674,148)
Capital Investments											
MOB Suite Acquistion-Unbudgeted	-	-		(600,000)	-	-	-	-	-	-	(600,000)
Change in Accounts Receivable	3,825,683	1,989,042	N1	2,043,383	**54,308**	**(308,424)**	**362,732**	1,214,891	874,623	(505,322)	459,191
Change in Settlement Accounts	1,070,839	(900,000)	N2	(1,001,621)	-	-	-	(310,047)	(368,631)	(322,943)	-
Change in Other Assets	527,205	(548,326)	N3	(311,820)	**516,126**	**(281,518)**	**797,644**	(997,401)	(1,846,663)	2,460,459	71,785
Change in Other Liabilities	(40,000)	805,000	N4	715,084	**(1,610,351)**	**315,000**	**(1,925,351)**	547,692	(1,069,219)	(903,389)	2,140,000
Change in Cash Balance	7,057,017	(3,362,991)		(2,227,107)	**(1,510,491)**	**(723,212)**	**(787,279)**	2,195,597	(6,566,746)	1,593,201	550,840
Beginning Unrestricted Cash	43,894,743	50,951,760	N5	50,951,760	**49,871,922**	**49,871,922**	-	50,951,760	53,147,357	46,580,611	48,173,812
Ending Unrestricted Cash	50,951,760	47,588,769		48,724,653	**48,361,431**	**49,148,710**	**(787,279)**	53,147,357	46,580,611	48,173,812	48,724,652
Expense Per Day	311,010	316,480		323,680	**330,771**	**319,957**	**10,814**	328,735	329,124	328,314	323,680
Days Cash On Hand	164	150		151	**146**	**154**	**(7)**	162	142	147	151

Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.
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.
N5 - Change in Beginning Unrestricted Cash is different than as presented in budget package due to final adjustments for fiscal year end 2014.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: **Patricia Barrett**
Clerk of the Board

DATE: March 24, 2015

ISSUE:

As part of a required biennial review of the TFHD Conflict of Interest Code, an amendment is required to revise the designated positions included as part of the Code.

BACKGROUND:

The law requires that multi-county agencies have a Conflict of Interest Code which identifies all agency officials and employees who make governmental decisions. To ensure each Conflict of Interest Code remains current and accurate, each multi-county agency is required to review its Conflict of Interest Code biennially.

ACTION REQUESTED:

TFHD is seeking board approval of the amended conflict of interest code reflecting additions, deletions and title changes to the designated positions.

Alternatives: *None. Required by law to be submitted to the FPPC.*

	Tahoe Forest Health System				
	Title: Conflict of Interest Code			**Policy/Procedure #:** ABD-06	
	Responsible Department: Board of Directors				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Board	5/2/78	1/12; 1/14	6/91; 4/10; 3/14; 3/15	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE:

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation (2 California Code of Regulations Section 18730) that contains the terms of a standard conflict-of-interest code, which can be incorporated by reference in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices, designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Tahoe Forest Hospital District [District]**.

Individuals holding designated positions shall file their statements of economic interests with the **District**, which will make the statements available for public inspection and reproduction. (Gov. Code Sec. 81008.) All statements will be retained by the **District**.

Appendix A
Designated Positions

Designated Positions		Category
1.	**Members of the Board of Directors**	1
2.	Chief Executive Officer	1
3.	Chief Operating Officer	1
4.	Chief Nursing Officer	1
5.	Chief Human Resources Officer	1
6.	Chief Information and Innovation Officer – Title Change	
7.	*Chief Development Officer - REMOVED*	1
8.	Administrator, Incline Village Community Hospital (IVCH) – Title Change	1
9.	Director, Facilities Management	1
10.	Chief Facilities Development Officer	2, 3
11.	Director, Materials Management	3
12.	Buyer	3
13.	Director, Surgical Services	4
14.	Director, Post Acute Services – Title Change	4
15.	*REMOVED [position combined w/#13 above]*	
16.	Director, Diagnostic Imaging/Patient Registration Services	4
17.	Director, Patient Financial Services	4
18.	Director, Information Technology	4
19.	Coordinator, OR Materials	4
20.	Director, Pharmacy	4
21.	Director, Community Health Services - *REMOVED*	4
22.	Director, Tahoe Center For Health & Sports Performance Operations - *REMOVED*	4
23.	Director, Laboratory Services	4
24.	Director, Nutrition & Environmental Services, TFH & IVCH	4
25.	Director, Marketing & Communications	4
26.	Director, Rehabilitation Services	4
27.	Director, MultiSpecialty Clinics – Title Change	4
28.	Number not previously used	
29.	*REMOVED [position combined w/#27 above]*	4
30.	Director, Emergency Services	4
31.	Director, Quality & Regulations	4
32.	Director, Cancer Center	4
33.	Director, Respiratory Therapy	4
34.	Director, Tahoe Forest Foundation	4
35.	Director, IVCH Foundation Development	4
36.	Director, Community Development – Title Change	4
37.	Director, IVCH Patient Care Services	4
38.	Controller	4
39.	Director, Medical Staff Services	4
40.	Director, Infection Control	4
41.	Director, Education	4

42.	Director, Children's Center	4
43.	Director, Volunteer Services	4
44.	Director, Health Information Management	4
45.	Manager, Revenue Cycle/Case Management	4
46.	Purchasing Assistant	4
47.	Manager, Network Infrastructure	4
48.	Manager, Systems Administration - *REMOVED*	4
49.	Manager, Nursing Informatics – Title Change	4
50.	Senior Infrastructure Architect - *REMOVED*	4
51.	Compliance Officer	4
52.	General Counsel	1
53.	Consultants	*
54.	ADD: Business Manager, ECC	4
55.	ADD: Director, Orthopedics & Sports Medicine	4

*Consultants are included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code, subject to the following limitation:

The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

Note: The positions of General Counsel, Director, Rehabilitation Services and Director, Respiratory Therapy, Director, Tahoe Center For Health & Sports Performance Operations are filled by outside consultants, but act in a staff capacity.

Officials Who Manage Public Investments

It has been determined that the positions listed below manage public investments and will file a statement of economic interests pursuant to Government Code Section 87200. These positions are listed for informational purposes only:

- Chief Financial Officer

An individual holding one of the above-listed positions may contact the Fair Political Practices Commission for assistance or written advice regarding their filing obligations if they believe their position has been categorized incorrectly. The Fair Political Practices Commission makes the final determination whether a position is covered by Government Code Section 87200.

Appendix B
Disclosure Categories

1. All investments, business positions, and sources of income, including loans, gifts, and travel payments.

   All interests in real property, located in whole or in part within the boundaries of the District or within two miles of the District.

2. All interests in real property, located in whole or in part within the boundaries of the District or within two miles of the District.

3. All investments, business positions, and sources of income, including loans, gifts, and travel payments, from sources that provide, or have provided, in the last two years, services, supplies, materials, machinery, or equipment of the type utilized by the District. Services include the full range of medical products, services and supplies including but not limited to pharmaceutical products, medical equipment, and medical consultants used by any patient.

4. All investments, business positions, and sources of income, including loans, gifts, and travel payments, from sources that provide, or have provided, in the last two years, services, supplies, materials, machinery, or equipment of the type utilized by designated employee's department or division.

Related Policies/Forms: Conflict of Interest Policy ABD-07
References: Government Code Section 81000, et seq
Policy Owner: Patricia Barrett, Clerk of the Board – New individual referenced
Approved by: Virginia Razo, Chief Executive Officer – New individual referenced

	Tahoe Forest Health System				
	Title: Conflict of Interest Code			**Policy/Procedure #:** ABD-06	
	Responsible Department: Board of Directors				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Board	5/2/78	1/12; 1/14	6/91; 4/10; 3/14; 3/15	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE:

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation (2 California Code of Regulations Section 18730) that contains the terms of a standard conflict-of-interest code, which can be incorporated by reference in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices, designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Tahoe Forest Hospital District [District]**.

Individuals holding designated positions shall file their statements of economic interests with the **District**, which will make the statements available for public inspection and reproduction. (Gov. Code Sec. 81008.) All statements will be retained by the **District**.

Appendix A
Designated Positions

Designated Positions		Category
1.	**Members of the Board of Directors**	1
2.	Chief Executive Officer	1
3.	Chief Operating Officer	1
4.	Chief Nursing Officer	1
5.	Chief Human Resources Officer	1
6.	Chief Information and Innovation Officer	1
7.	Administrator, Incline Village Community Hospital (IVCH)	1
8.	Chief Facilities Development Officer	2,3
9.	General Counsel	1
10.	Consultants	*
11.	Business Manager, ECC	4
12.	Buyer	3
13.	Compliance Officer	4
14.	Controller	4
15.	Coordinator, OR Materials Coordinator	4
16.	Director, Cancer Center	4
17.	Director, Children's Center	4
18.	Director, Community Development	4
19.	Director, Diagnostic Imaging/Patient Registration Services	4
20.	Director, Education	4
21.	Director, Emergency Services	4
22.	Director, Facilities Management	4
23.	Director, Health Information Management	4
24.	Director, Infection Control	4
25.	Director, Information Technology	4
26.	Director, IVCH Foundation Development	4
27.	Director, IVCH Patient Care Services	4
28.	Director, Laboratory Services	4
29.	Director, Marketing & Communications	4
30.	Director, Materials Management	3
31.	Director, Medical Staff Services	4
32.	Director, MultiSpecialty Clinics	4
33.	Director, Nutrition & Environmental Services, TFH & IVCH	4
34.	Director, Orthopedics & Sports Medicine	4
35.	Director, Patient Financial Services	4
36.	Director, Pharmacy	4
37.	Director, Post Acute Services	4
38.	Director, Quality & Regulations	4

39.	Director, Rehabilitation Services	4
40.	Director, Respiratory Therapy	4
41.	Director, Surgical Services	4
42.	Director, Tahoe Forest Foundation	4
43.	Director, Volunteer Services	4
44.	Manager, Network Infrastructure	4
45.	Manager, Nursing Informatics	4
46.	Manager, Revenue Cycle/Case Management	4
47.	Purchasing Assistant	4

*Consultants are included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code, subject to the following limitation:

The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

Note: The positions of General Counsel, Director, Rehabilitation Services and Director, Respiratory Therapy, Director, Tahoe Center For Health & Sports Performance Operations are filled by outside consultants, but act in a staff capacity.

Officials Who Manage Public Investments

It has been determined that the positions listed below manage public investments and will file a statement of economic interests pursuant to Government Code Section 87200. These positions are listed for informational purposes only:

- Chief Financial Officer

An individual holding one of the above-listed positions may contact the Fair Political Practices Commission for assistance or written advice regarding their filing obligations if they believe their position has been categorized incorrectly. The Fair Political Practices Commission makes the final determination whether a position is covered by Government Code Section 87200.

Appendix B
Disclosure Categories

1. All investments, business positions, and sources of income, including loans, gifts, and travel payments.

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3. All investments, business positions, and sources of income, including loans, gifts, and travel payments, from sources that provide, or have provided, in the last two years, services, supplies, materials, machinery, or equipment of the type utilized by the District. Services include the full range of medical products, services and supplies including but not limited to pharmaceutical products, medical equipment, and medical consultants used by any patient.

4. All investments, business positions, and sources of income, including loans, gifts, and travel payments, from sources that provide, or have provided, in the last two years, services, supplies, materials, machinery, or equipment of the type utilized by designated employee's department or division.

Related Policies/Forms: Conflict of Interest Policy ABD-07
References: Government Code Section 81000, et seq
Policy Owner: Patricia Barrett, Clerk of the Board
Approved by: Virginia Razo, Chief Executive Officer

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: **Virginia A. Razo**
Chief Executive Officer

DATE: March 24, 2015

ISSUE:

A new policy has been created to provide guidelines to the officers, administrators and other employees of Tahoe Forest Hospital District ("TFHD") regarding the following:

A. How compensation in the form of certain items and services is treated under the non-monetary compensation exception to the Federal "Stark" law;
B. How compensation in the form of certain items and services is treated under the medical staff incidental benefits exception to the Federal "Stark" law; and,
C. The procedures for recording and tracking non-monetary compensation and medical staff incidental benefits.

BACKGROUND:

Under the federal Stark law, if a hospital has a financial relationship with a physician, or an immediate family member of a physician, the physician may not refer Medicare patients to the hospital for the provision of "designated health services" which include all inpatient and outpatient hospital services, and the hospital may not bill for such services, unless an exception under the Stark law is met. A "financial relationship" under Stark is very broad, and includes any remuneration from a hospital to a physician, including in-kind compensation. "Immediate family member" is defined to include husband or wife; natural, or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

There are two separate exceptions to the Stark law that permit limited compensation and benefits to be provided to physicians and their immediate family members.

The Non-Monetary Compensation exception protects certain items or services, up to a limited value, that are provided to a physician, such as entertainment, meals, and other non-cash equivalent benefits.

The Medical Staff Incidental Benefits exception applies to non-cash items and services that are of a low value and are provided while the physician is on campus.

ACTION REQUESTED:

TFHD is seeking board approval of the Policy for Non-Monetary Compensation for Physicians and Medical Staff Incidental Benefits.

Alternatives: Not have a policy to provide guidelines related to Non-Monetary Compensation for Physicians and Medical Staff Incidental Benefits.

		Tahoe Forest Health System			
		Title: Policy for Non-Monetary Compensation for Physicians and Medical Staff Incidental Benefits		**Policy/Procedure #: AGOV- XX**	
		Responsible Department: Administration			
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative				
☒	Medical Staff				
☐	Departmental				
Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE:

The purpose of this policy is to provide guidelines to the officers, administrators and other employees of Tahoe Forest Hospital District ("TFHD") regarding the following:

A. How compensation in the form of certain items and services is treated under the non-monetary compensation exception to the Federal "Stark" law;

B. How compensation in the form of certain items and services is treated under the medical staff incidental benefits exception to the Federal "Stark" law; and,

C. The procedures for recording and tracking non-monetary compensation and medical staff incidental benefits.

OVERVIEW:

Under the federal Stark law, if a hospital has a financial relationship with a physician, or an immediate family member of a physician, the physician may not refer Medicare patients to the hospital for the provision of "designated health services" which include all inpatient and outpatient hospital services, and the hospital may not bill for such services, unless an exception under the Stark law is met. A "financial relationship" under Stark is very broad, and includes any remuneration from a hospital to a physician, including in-kind compensation. "Immediate family member" is defined to include husband or wife; natural, or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

There are two separate exceptions to the Stark law that permit limited compensation and benefits to be provided to physicians and their immediate family members.

The Non-Monetary Compensation exception protects certain items or services, up to a limited value, that are provided to a physician, such as entertainment, meals, and other non-cash equivalent benefits.

The Medical Staff Incidental Benefits exception applies to non-cash items and services that are of a low value and are provided while the physician is on campus.

STATEMENT OF POLICY*:*

TFHD may provide non-monetary compensation and incidental medical staff benefits to physician or his or her immediate family members in accordance with the requirements set forth below.

All non-monetary compensation or incidental benefits offered to physicians and/or their immediate family members must meet the guidelines stated in this policy and must be properly documented. Nothing in this policy permits the provision of a non-monetary compensation or incidental benefits that are intended to induce or reward the referrals of patients or that is intended to induce or reward the purchasing, leasing, ordering, or arranging for any good, facility, service, or item, nor may a non-monetary compensation or incidental benefit be extended to a potential referral source who solicits it.

The federally calculated compensation limits for non-monetary compensation and incidental benefits are adjusted each calendar year to the nearest whole dollar as designated by the increase in the Consumer Price Index-Urban All Item (CPI-U) for the 12-month period ending the preceding September 30, in accordance with federal regulations. For the calendar year beginning January 1, 2014 (CY2014), the non-monetary compensation limit is an annual aggregate amount of $385 per year per physician (the "**Annual Limit**") and the value of any Medical Staff incidental benefits to be furnished must be less than $32 per occurrence of the benefit (the "**Cap**"). This policy shall incorporate and apply annual threshold changes, and all other regulatory amendments, as applicable.

Annual Limit and the Cap are updated each year on September 30th and available on the CMS website at: *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates.html*.

For purposes of external review and TFHD's internal accounting, TFHD will keep a log of Non-Monetary Compensation which TFHD provides to referring physicians.

1.0 DESCRIPTION OF NON-MONETARY COMPENSATION EXCEPTION

1.1. Compensation to a physician or a physician's immediate family member from TFHD in the form of items or services (not including cash or cash equivalents) that does not exceed the Annual Limit in any calendar year is permitted if all of the following conditions are satisfied:

1.1.1 The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated by the physician.

1.1.2 The compensation is not solicited by the physician or the physician's practice (including employees and staff members).

1.1.3 The compensation arrangement does not violate the Anti-Kickback Statute or any Federal or State law or regulation governing billing or claims submission.

1.2. In addition to non-monetary compensation up to the Annual Limit, TFHD may provide one local Medical Staff appreciation event per year for the entire Medical Staff. However, any gifts or gratuities provided in connection with the Medical Staff appreciation event are subject to the Annual Limit.

1.3. EXAMPLES of non-monetary compensation include, but are not limited to:

1.3.1 Non-working meals, events such as picnics and golf tournaments;, gift baskets, or any type of gift or giveaway; flowers or donations made upon

death of a family member of friend of a physician; physician appreciation events or items (such as car wash, movie tickets, holiday food items; holiday parties; tickets to concerts or cultural or sporting events;, coffee certificates, service awards, and thank you gifts.

1.3.2 CME seminars solely for the benefit of the physician held off-campus, and such CME seminars held on-campus if the value of the on-campus CME seminar is greater than the Cap per invited physician per occurrence.

1.3.3 Non-monetary compensation given by TFHD's Foundation or Auxiliary.

1.3.4 An item provided to a group of physicians may not be allocated among the individual physicians in the group. For example, a gift valued at $300 given to a three-person group practice may not be valued at $100 per physician, but must be valued at $300 for each physician member of the group.

1.3.5 Neither cash nor cash equivalents (such as gift cards) qualify under this exception and may not be provided pursuant to this policy.

2.0 DESCRIPTION OF MEDICAL STAFF INCIDENTAL BENEFITS EXCEPTION

2.1. Compensation in the form of items or services (not including cash or cash equivalents) from TFHD to a member of the Medical Staff are permitted when the item or service is used on the campus of a TFHD hospital facility, if *all* of the following conditions are satisfied:

2.1.1. The compensation is offered to all members of the Medical Staff or all members practicing in the same specialty (but not necessarily accepted by every member to whom it is offered) without regard to the volume or value of referrals or other business generated between the parties.

2.1.2. Except with respect to identification of Medical Staff members on TFHD's website or in its advertising, the compensation is provided only during periods when the Medical Staff members are making rounds or are engaged in other services or activities that benefit TFHD or its patients.

2.1.3. The compensation is provided by TFHD and used by the Medical Staff members only on the TFHD campus. Compensation, including, but not limited to, internet access, pagers, or two-way radios, used away from the campus only to access hospital medical records or information or to access patients or personnel who are on the hospital campus, as well as the identification of the Medical Staff on a hospital web site or in hospital advertising, meets this "on campus" requirement.

2.1.4. The compensation is reasonably related to the provision of, or designed to facilitate directly or indirectly the delivery of, medical services at the TFHD's facilities.

2.1.5. Each benefit has a value of less than the Cap (for example, each meal given to a physician while he or she is serving patients who are hospitalized must be less than the Cap).

2.1.6. The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.

2.1.7. The compensation arrangement does not violate the Anti-Kickback Statute or any Federal or State law or regulation governing billing or claims submission.

2.2. Examples of Medical Staff Incidental Benefits exceptions include, but are not limited to:

2.2.1. Free or discounted meals (such as meals served in the physician's lounge), free parking during the time when the physician is providing services at TFHD, lab coats and scrubs.

2.2.2. Identification on TFHD's website or in TFHD's advertising. Note: Advertising or promoting a physician's private practice on TFHD's website or in its advertising is not protected by the Medical Staff Incidental Benefits Exception, and must be reported as non-monetary compensation subject to the Annual Limit, or must comply with another Stark law exception. If TFHD does not charge the physician for such advertising, then the fair market value of the advertising must be allocated to the physician.

2.2.3. Computer/internet access provided in TFHD's hospital facilities.

2.2.4. CME seminars held on campus, provided the value of the CME seminar is less than the Cap per invited physician per occurrence.

2.2.5. Meals served at governing board meetings or committee meetings.

2.2.6. Neither cash nor cash equivalents (such as gift cards) qualify under this exception and may not be provided pursuant to this policy.

PROCEDURE:

1.0 Non-monetary Compensation

1.1 All non-monetary compensation must be tracked on an annual basis for each physician.

1.2 All non-monetary compensation to physicians must be recorded in a physician non-monetary compensation documentation log ("Physician Compensation Log") and must be maintained by the Medical Staff Office.

1.3 Prior to providing the items or services, the individual or Department seeking to provide such items or service must complete the Physician Non-Monetary Compensation form attached as Annex A (the "Form") and submit the Form to the Medical Staff Office to be included in the Physician compensation Log, along with copies of receipts or other supporting documentation of the costs and expenses.

1.4 The Physician Compensation Log must include the name of the physician receiving the compensation, the nature of the compensation, and the value of the compensation.

1.5 The Medical Staff Office will enter the information from the form into a tracking data base and the Physician Compensation Log, and will determine if the amount of the compensation will cause the physician to exceed the Annual Limit. If the Annual Limit will be exceeded as a result of the compensation, the Medical Staff Office will notify the individual or Department, and the compensation may not be given or provided.

1.6 If the individual or Department seeking to provide the non-monetary compensation is unclear if such compensation meets the criteria for the exception, such individual or Department should promptly contact the Medical Staff Office prior to providing such compensation or benefit.

1.7 Under no circumstances may TFHD staff give the compensation to a physician for the sole purpose of ensuring that the physician receives the entire Annual Limit.

1.8 The Medical Staff Office or designee will periodically audit expenditures for appropriateness, to assure that the Annual Limit is not exceeded, and to meet any reporting obligations.

2.0 Medical Staff Incidental Benefits

2.1 Medical staff incidental benefits less than the Cap do not need to be tracked (there is no aggregate limit so long as each occurrence is below the Cap).

2.2 Medical staff incidental benefits with a value exceeding the Cap must be reported as non-monetary compensation and recorded pursuant to the procedure described above.

2.3 If the individual or Department providing the incidental benefit is unclear if such benefit meets the criteria for the exception, such individual or Department should promptly contact the Medical Staff Office prior to providing such compensation or benefit.

3.0 Access to Physician Compensation Log

3.1 Access to the Physician Compensation Log shall be limited to the Medical Staff Director or designee, the TFHD CEO, CFO, general counsel and COO, the Education Department Clinical Instructor, and the Compliance Officer.

4.0 Fair Market Value

4.1 The fair market value of items or services provided to physicians pursuant to this policy shall be the full market value of the item or service, not the cost of providing such item or service. For example, if the Hospital purchased tickets to a charity golf event at a cost of $25 each, the actual value of the ticket if the physician purchased it him/herself would have been $75, the amount of non-monetary compensation for such Physician will be $75.

Related Policies/Forms:
References: Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn); 42 U.S.C. § 1320a-7b(b); 42 C.F.R. § 411.357; Cal Business & Professions Code §§650-650.1; Annual Indexed Limits for Non-Monetary Compensation and Incidental Benefits: http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates.html Physician Self Referral: http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html?redirect=PhysicianSelfReferral/10_CPI-U-Updates.asp#TopofPage
Policy Owner: Compliance Officer
Approved by:

ANNEX A

Tahoe Forest Hospital District
Non-Monetary Compensation Form

PHYSICIAN NON-MONETARY COMPENSATION REPORTING FORM

Date provided:

Description of Item/Service:

Value of Item/Service:

Describe how the value was determined:

Recipient:
Physician's Name: _____

Requested By:	
Date Requested:	
Approved By:	
Date Approved:	

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Janet Van Gelder, RN, DNP
Director of Quality & Regulations

DATE: March 11, 2015

ISSUE:
As an applicant of a 1 year SHIP grant (Small Rural Hospital Improvement Program) from the Department of Health Care Services, Tahoe Forest Hospital must submit a signed Authorization to Bind, ensuring the individual requesting payment is authorized to do so by the Board of Directors. With the change in CEO, an updated authorization must be submitted.

BACKGROUND: The purpose of the funding is to assist small rural hospitals implement requirements of the Patient Protection & Affordable Care Act. Funding is made available from HRSA Office of Health Policy. The program is administered through the Department of Health Care Services California State Office of Rural Health.

The anticipated grant funding amount is $9,000 for the grant term beginning September 1, 2015 through May 31, 2016. The Hospital is prepared to submit the grant application. The grant funding will support Management training of Lean principles for process improvement.

ACTION REQUESTED:
Approval and signing of Authorization to Bind from Karen Sessler, Board Chair, and Virginia Razo, interim CEO.

Alternatives: Do not apply for this grant funding and pay for the training out of operational funds.

AUTHORIZATION TO BIND CORPORATION

THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT, IN A DULY EXECUTED MEETING HELD ON MARCH 31, 2015 (DATE) AND WHERE A QUORUM WAS PRESENT, RESOLVED TO AUTHORIZE:

Virginia A. Razo	AND/OR DESIGNEE	
(TYPED NAME)		(TYPED NAME)
CHIEF EXECUTIVE OFFICER		
(TITLE)		(TITLE)
(SIGNATURE)		(SIGNATURE)

TO NEGOTIATE AND SIGN THE SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM APPLICATION AND/OR GRANT AGREEMENT FOR ANY PAYMENT REQUESTS THAT MAY RESULT.

THE UNDERSIGNED HEREBY AFFIRMS HE/SHE IS A DULY AUTHORIZED OFFICER OF THE CORPORATION AND STATEMENTS CONTAINED IN THIS APPLICATION PACKAGE ARE TRUE AND COMPLETE TO THE BEST OF THE HIS/HER KNOWLEDGE, AND ACCEPTS AS A CONDITION OF A GRANT AWARD THE OBLIGATION TO COMPLY WITH THE APPLICABLE STATE AND FEDERAL REQUIREMENTS, POLICIES, STANDARDS, AND REGULATIONS. THE UNDERSIGNED RECOGNIZES THIS IS A PUBLIC DOCUMENT AND OPEN FOR PUBLIC INSPECTION.

AUTHORITY TO CONTRACT:

IF SOMEONE OTHER THAN THE CORPORATE BOARD OF DIRECTOR'S CHAIRPERSON IS TO NEGOTIATE AND SIGN ANY RESULTANT GRANT OF THIS APPLICATION, A LETTER OF AGREEMENT AND AUTHORIZATION MUST BE SIGNED AND DATED BY THE BOARD OF DIRECTOR'S CHAIRPERSON, INDICATING THE NAME OF SUCH PERSON AND STATING THAT PERSON'S AREA OF RESPONSIBILITY IN THIS MATTER.

BOARD CHAIRPERSON: Karen Sessler, M.D.
(TYPED NAME)

(CHAIRPERSON'S SIGNATURE)

(DATE)

SMALL RURAL HOSPITAL IMPROVEMENT GRANT PROGRAM (SHIP)
Hospital Grant Application for Fiscal Year 2015 (FY15)
September 1, 2015 – May 31, 2016

Due back to State Office of Rural Health (SORH) by: **February 26 2015**
Please email form to **SHIP@dhcs.ca.gov**

To help facilitate the awards process, the SORH will submit one SHIP application on behalf of all eligible hospital applicants to the Health Resources and Services Administration, Federal Office of Rural Health Policy. This form must be completed and returned to the SORH for inclusion in the FY15 SHIP application.

A. Hospital Information:

Hospital Name: Tahoe Forest Hospital District

Address: 10121 Pine Avenue, PO Box 759

City: Truckee **State:** CA **Zip:** 96160 **County:** Nevada

Phone: (530) 582-6011 **Fax:** 582-3567

Administrator/CEO Name: Virginia Razo **E-Mail:** vrazo@tfhd.com

SHIP Project Director Name: Janet Van Gelder **E-Mail:** jvangelder@tfhd.com
(Individual responsible for managing SHIP-funded project for the hospital)

Quality Improvement Staff Name: Stephanie Hanson **E-Mail:** shanson@tfhd.com
(Individual responsible for data collection and reporting Hospital Compare Measures for the hospital)

CAH status: Yes ☒ No ☐

(Check one) Returning SHIP hospital (funded in FY14) ☒ **Or** New SHIP hospital (not funded in FY14) ☐

If returning hospital, please answer the following questions:

Is there a change in hospital name since FY14 SHIP application? Yes ☐ No ☒

Is there a change in hospital address since FY14 SHIP application? Yes ☐ No ☒

Is there a change in Administrator/CEO information since FY14 SHIP application? Yes ☒ No ☐

Number of beds per Line 14 of the most recently filed Medicare Cost Report*: 25

Cost Reporting Period of most recently filed Medicare Cost Report: 7/1/13 - 6/30/14
Attach part I of Worksheet S-3 from most recently filed Medicare Cost Report (PPS Hospitals only).

***Note:** If hospital reports a licensed bed count greater than 49 on Line 14 but staffs 49 beds or fewer, you may certify eligibility by submitting a written statement to the SORH that includes: 1) the number of staffed beds at the time of the most recent cost report submission, 2) the cost reporting period of the most recently filed cost report, and 3) the signature of the certifying official.*

B. Planned FY15 (September 1, 2015 – May 31, 2016) Expenditures:

Indicate the percent and dollar amount that will be used to support activities listed on the SHIP Purchasing Menu (page 3). **Total Requested Budget estimate = $9,000 per hospital.**

Please follow these instructions/priorities:

a. Hospitals may select more than 1 category to participate if priorities are followed and available funds exist.
b. Please check applicable investments and measures on the SHIP Purchasing Menu.
c. SHIP funded purchases are prioritized as follow :
    1. 1st Priority– Activities relating to **MBQIP** implementation and reporting (if that hospital has yet to register and transmit MBQIP data). Non-CAHs are exempt from this provision;
    2. 2nd Priority – **HCAHPS and/or ICD-10** activities if that hospital is not in the process of implementing both systems. In no particular order, hospitals may select one or both; and
    3. 3rd Priority – If a hospital is already participating in all three of these activities, **MBQIP, HCAHPS, and ICD-10,** then that hospital may select a different activity listed on the SHIP Purchasing Menu.
    4. If a hospital has already completed **ALL** pre-selected investments (equipment and/or services) listed on the SHIP Purchasing Menu, that hospital may identify an alternative piece of equipment and/or service PROVIDED: a) this purchase will optimally affect a hospital's transformation into an accountable care organization, increase value based purchasing objectives, and/or aid in the adoption of ICD-10; and b) that hospital receives pre-approval from both their state SHIP director and the appropriate Federal Office of Rural Health Policy project officer.

Please answer the following investment questions:

Questions for CAHs only:

My hospital has signed-up for MBQIP	Yes ☒	No ☐

Questions for all hospitals:

My hospital has begun to implement or has implemented HCAHPS:	Yes ☒	No ☐
My hospital has begun to implement or has implemented ICD-10:	Yes ☒	No ☐

SHIP Purchasing Menu: Planned FY15 (September 1, 2015 – May 31, 2016) Expenditures

Select (check) applicable investments and indicate the dollar ($) amount and percent (%) of FY15 requested budget that will be used to support the selected investments up to $9000.

Category	Value-Based Purchasing (VBP)	Accountable Care Organizations or Shared Savings (ACOs)	Payment Bundling/PPS (PB/PPS)	Care Transitions
Description	Activities that support improved data collection to facilitate quality reporting.	Activities that support the development of ACOs.	Activities that improve the revenue cycle process.	Activities that reduce hospital readmissions.
Investments	☐ A. Training specific to coordinating the collection of **MBQIP** measure(s') data and/or software that would enable the collection of data ☐ B. **HCAHPS** Software or Hardware ☐ C. Training Specific to **HCAHPS** implementation or further application ☒ D. Efficiency Training (Six Sigma or Lean) in 1 of the following areas: patient satisfaction, improving ER efficiency (ies), or efficiencies to clinical care delivery areas	☐ A. Computerized Provider Entry ☐ B. Pharmacy Services ☐ C. Hardware/Software Related to Purchase of Disease Registry ☐ D. Efficiency Training (Six Sigma or Lean) in 1 of the following areas: non-clinical operations, board organization/operation, or multi-hospital/network projects ☐ E. Baldrige or systems performance training ☒ F. Quality Health Indicator (QHi) or other quality improvement training	☐ A. **ICD-10** Software ☐ B. **ICD-10** Training ☐ C. QI or Efficiency Training (Six Sigma or Lean) in 1 of the following areas: financial improvement, operational multi-hospital/network projects ☐ D. Purchase of Six Sigma and/or Lean software ☐ E. Revenue Cycle Management ☐ F. S-10 Cost Reporting	☐ A. Emergency Department transfer communication improvement ☐ B. Training to reduce readmissions and/or infections ☐ C. Medical provider quality improvements ☐ D. Telemedicine or mobile health equipment ☐ E. Community Paramedicine equipment and/or training ☐ F. HIE subscription within state or region or adding direct address
Budget	100 % 9000 $	% $	% $	% $

Measures: By selecting an investment above you are agreeing to report on the measure corresponding to the investments.

Corresponding Measures	☐ A. Training completed related to MBQIP data collection ☐ B. Installation of HCAHPS software or hardware ☐ C. Implementation and completion of HCAHPS training ☒ D. Completion of Efficiency training and project implementation with identification of a specific measure selection and target	☐ A. Implementation and/or training completed regarding use of a computerized provider entry system ☐ B. Implementation of a pharmacy service with selection of a process measure to improve upon ☐ C. Implementation and/or training completed regarding use of a disease registry ☐ D. Completion of efficiency training, with identification of a specific measure selection and target ☐ E. Completion of Baldrige or systems performance training ☐ F. Implementation and use of QHi or quality improvement training	☐ A. Installation and use of ICD-10 software ☐ B. Implementation of ICD-10 training ☐ C. Implementation of an efficiency project , with identification of a specific measure selection and target ☐ D. Installation of Six Sigma or lean software ☐ E. Completion of Revenue Cycle Management training or equipment purchase ☐ F. S-10 Cost Reporting improvement	☐ A. Implementation and/or training regarding ED transfer communications ☐ B. Complete training for reducing readmissions and/or infections ☐ C. Implementation and/or training of a medical provider quality improvement project ☐ D. Installation/use of telemedicine or mobile health equipment ☐ E. Installation/use of community Paramedicine equipment and/or completion of training ☐ F. Installation/use of state or region HIE or direct address **Overall Outcome Measure**: Decrease in hospital readmission rate over last year

C. Reporting on most recently completed funding cycle FY13 (September 1, 2013 – August 31, 2014)

If you received SHIP funds in FY13, did you expend over 90% of funds? Yes ☒ No ☐

If not, please explain:

D. Indicate if your hospital is participating in the following CMS programs:

a. Medicare Shared Savings Program Yes ☐ No ☒

b. Pioneer Accountable Care Organization Model Yes ☐ No ☒

c. Hospital Inpatient Quality Reporting Program Yes ☒ No ☐

d. Hospital Compare Yes ☒ No ☐

e. Hospital Value-Based Purchasing Program Yes ☐ No ☒

E. Network Participation

Is your hospital affiliated with a rural health network? Yes ☒ No ☐

If yes, network name: UC Davis

F. Recommendations

Please list any recommendations you may have to improve the Small Hospital Improvement Program. (Due to space limitations, you may submit additional recommendations on a separate page and subit with SHIP application)

Meaningful use stage 2 for small rural hospitals

G. Signatures

By signing this document, you are affirming:

a. That your hospital has selected menu investment(s) based upon the specific selection priorities listed on page 2. Hospitals that do not follow purchase priorities, and/or purchase equipment/services that are not listed on the SHIP Purchasing Menu, will be subject to penalties including suspension from the next year's Small Hospital Improvement Program.

b. That you are not only selecting an investment, but also a measure that correlates to your purchase. Your hospital will be expected to report to your State Office of Rural Health regarding progress at the end of the year.

Note: Prior approval from your state SHIP Coordinator/SORH is required before changing investments; no changes can be made after the mid-year point.

CEO Signature: **Date:**

SHIP Project Director Signature: **Date:**

(Individual responsible for managing SHIP-funded project for the hospital)

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: **Virginia A. Razo**
Chief Executive Officer

Shawni L. Coll D.O.
Medical Director of Strategic Planning and Innovation

DATE: March 10, 2015

ISSUE:

Consultant needed for education on different practice management models and physician alignment options

Tied to Strategic Plan:
Strategic Initiative 5. Partner with regional and local medical providers
Measurable Goal 3.Explore potential opportunities to collaborate with local medical providers to improve health delivery.

BACKGROUND:

Although many physicians are contractually aligned with the hospital through 1206(d) model clinics (MSC Clinics), TFHD continues to experience financial and operational inefficiencies in the delivery of ambulatory services. We are looking to find a consultant that can educate the TFHD BOD, Administration and the Medical Staff as to the impetus for change due to changing healthcare industry along with educating to various integration and alignment options being implemented across the country. We would like assistance to evaluate alignment structures that would fit the TFHD goals and resources while being nimble enough for succession/recruitment planning purposes. This consultant would also help to determine a preferred physician alignment strategy and help to gain consensus among the community physicians on this new structure. Due to current space restrictions and OSHPD requirements,, we have physicians that are not able to work to their full potential and a different practice model may help to alleviate the space constraints thereby improving productivity, physician morale, and financial performance of the outpatient clinics.

ACTION REQUESTED:

- Approve budget variance of up to $100,000 for consulting fees

Alternatives:
Using our own manpower to investigate alternative practice and alignment options. This would take manpower away from other needed tasks along with having the potential to not be as informed and efficient, since we do not have a subject matter expert in this area. Knowing all the options, in order to be the most informed, prior to making any changes is of the upmost importance. This may not be possible without a subject matter expert. Additionally, administration and the physician community feel an independent third party would present an unbiased recommendation for future hospital and physician alignment strategies.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Virginia A. Razo
Chief Executive Officer

Shawni L. Coll D.O.
Medical Director of Strategic Planning and Innovation

DATE: March 9, 2015

Monthly Medical Director of Strategic Planning & Innovation Report

Tied to Strategic Plan:

Strategic Initiative 5. Partner with regional and local medical providers
Measurable Goal 4. Develop and deploy a succession-planning model for all specialties of the medical staff

Succession Planning for General Surgery

Currently, THFD has three general surgeons (two within the MSC structure and one in private practice). It has come to our attention that the private practice physician no longer wants to have an elective practice and wants to close his office. He has also decreased availability for call in the coming months. In order to continue to provide ED On Call for General Surgery Service 24/7 and due to the high volumes of cases/calls when on call for the ED, at least one more general surgeon is needed. We are currently collecting data to evaluate whether it is best to higher a third general surgeon verses using locums coverage physicians. We plan to evaluate what cases are leaving the area, what attributes we would want/need in a new surgeon, and which model would best serve our community.

Succession Planning for Obstetrics and Gynecology

For the past ten years, we have had 4 Ob/Gyns in the community (with one only practicing gynecology for the last few years). The physician who was only practicing gynecology has recently retired his practice and is in the process of selling his office space. Two of the three current Ob/Gyn are of the age that they could opt out of call, if they desire. Both of these physicians have expressed that they would like to retire in the next 5+ years and one would like to consider going down to less than full-time work. We believe it is time to bring in another Ob/Gyn, either part or full time, to transition this service line. Concern from the physicians is that they are still in a private practice setting and would like to explore other models to help support this transition. Since OB is a key driver to where families choose to get their future care and the reason the land was donated to open this hospital, it is an important to continue this service line.

Succession Planning for Gastroenterology

Community data shows that about 50% of colonoscopies are leaving the area. This is a profitable service line, which utilizes our OR readily and provides a much-needed service to our community. Currently, we have three physicians that are doing colonoscopies, 2gastroenterologists (GI) and 1

general surgeon. One of the GI physicians is only here 3 days per month (performing ~175 colonoscopies/year) and the other is here full time (performing ~420 colonoscopies/year). However, the full time GI physician is planning to go part-time in the summer of 2016 in preparation for retirement. Our general surgeon is doing about ~120 colonoscopies per year. Since we have found it difficult to recruit a GI specialist in the past, we are anticipating the succession planning needs for this service line and are looking into a possible full time or part time GI specialist to come in and make this transition. We've been approached by a GI physician who is interested in part-time work with the possibility of increasing to full time in the future. We will be exploring this option along with looking further, if needed.

Tied to Strategic Plan:

Strategic Initiative 5. Partner with regional and local medical providers
Measurable Goal 3. Explore potential opportunities to collaborate with local medical providers to improve health delivery.

Expanding services to have Infectious Disease (ID) Specialty Services at TFHD:

California is the first and remains the only state to enact antimicrobial stewardship legislation. Since 2008 California law required that general acute care hospitals develop a process for monitoring the judicious use of antibiotics and that the results are monitored by quality improvement committee(s). In September 2014, California Senate Bill 1311 was signed into law, further requiring hospitals to adopt and implement an antimicrobial stewardship policy in accordance with guidelines established by federal government and professional organizations, and to establish a physician-supervised multidisciplinary antimicrobial stewardship committee with at least one physician or pharmacist who has undergone specific training related to stewardship. Bringing in an expert in ID from the Reno market to participatein the Pharmacy and Therapeutics Committee, which has been designated to oversee our Antimicrobial Stewardship Program,would fulfill the new California requirement. They would also provideconsultative support to community patients and educate TFHD physicians on specific infectious disease related topics, which increases our qualitycare while reducing excess antibiotic use and drug resistance. Wound care experts are important due to rapidly change products with advancing care and technology. We have an excellent wound care clinic however we have been looking for a physician champion in this area to keep up on the best treatment options. The ID specialists are also wound care experts therefore they would also be able to fill the role for us under their Medical Directorship.

Expanding services to have Urologic Services at TFHD:

Our community previously had urologic services and has been at a disadvantage since urology left the area. We are continuing to recruit for a Urologist, as approved by TFHD BOD in Fall 2013. Having a urologist will bring in revenue from urologic outpatient and inpatient services including procedures, supporting our urologic cancer patients with a local physician thereby keeping the radiation oncology local, along with possible partnerships with Barton Memorial Hospital and use of their De Vinci robotic technology.

Facilities Development Plan

Tahoe Forest Hospital District

December 31, 2014

TFHD FDP STATUS SUMMARY

Measure C Projects	$	96,183,430
Owner Scope Modifications	$	4,871,919
Regulatory Scope Modifications	$	1,963,725
FDP with Scope Modifications / Total Projects Cost	$	103,019,074
Development Completed / Paid to Date (82%)	$	(84,678,979)
Balance to Complete	$	18,340,095
Project Fund Balance	$	(17,335,843)
Projected Interest Earned		TBD
Balance - TFHD Capital Budget	$	1,004,252

- 13 of 15 Measure C Projects complete.
  - o ED/SPD complete April 2015
  - o South Building complete Summer 2016
  - o Remaining Projects within budget
- Campus-wide seismic compliance as of August 26, 2014.
- 233 prime contracts for construction issued to date and at present we are working with zero contractors regarding change order requests that are in dispute.
- Permitting

  (11) OSHPD permits issued to date

  (5) Town of Truckee permits issued to date

  No further permitting is required

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

December 31, 2014

CURRENT PROJECTS - NON QUALIFIED EXPENDITURES COST SUMMARY

PROJECTS (*)	Current Project Estimate	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q4 2014)	Current Projects with Scope Modifications	Status/Notes
Current Projects - Non Qualified Expenditures											
ICU Renovations											
HARD COSTS: Construction Costs	$ 629,394		$ 629,394	$ -		$ 556,087	$ 73,307	88%	$ 69,700	$ 629,394	
SOFT COSTS	$ 315,407		$ 315,407	$ -		$ 278,051	$ 37,356	88%	$ 56,465	$ 315,407	
CONTINGENCY	$ 89,374		$ 89,374	$ -		$ 51,481	$ 37,893	58%	$ 31,293	$ 89,374	
SUBTOTAL PROJECT COSTS	**$ 1,034,175**	**$ -**	**$ 1,034,175**	**$ -**		**$ 885,619**	**$ 148,556**	**86%**	**$ 157,458**	**$ 1,034,175**	**Construction in Progress**
CT Scanner Replacement											
HARD COSTS: Construction Costs	$ 620,711		$ 620,711	$ -		$ 338,730	$ 281,981	55%	$ 248,268	$ 620,711	
SOFT COSTS	$ 1,542,926		$ 1,542,926	$ -		$ 408,075	$ 1,134,851	26%	$ (8,112)	$ 1,542,926	
CONTINGENCY	$ 124,142		$ 124,142	$ -		$ 6,738	$ 117,404	5%	$ 6,738	$ 124,142	
SUBTOTAL PROJECT COSTS	**$ 2,287,779**	**$ -**	**$ 2,287,779**	**$ -**		**$ 753,543**	**$ 1,534,236**	**33%**	**$ 246,894**	**$ 2,287,779**	**Construction in Progress**
OR Exam Lights Replacement											
HARD COSTS: Construction Costs	$ 356,066		$ -	$ -			$ 356,066	0%	$ -	$ 356,066	
SOFT COSTS	$ 839,851		$ -	$ -		$ 360,029	$ 479,822	43%	$ 65,674	$ 839,851	
CONTINGENCY COSTS	$ 71,213		$ -	$ -			$ 71,213	0%	$ -	$ 71,213	
SUBTOTAL PROJECT COSTS	**$ 1,267,130**	**$ -**	**$ -**	**$ -**		**$ 360,029**	**$ 907,101**	**28%**	**$ 65,674**	**$ 1,267,130**	**Conceptual Design in Progress**
NPC-2 Filings											
HARD COSTS: Construction Costs	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ 100,000		$ -	$ -		$ -	$ 100,000	0%	$ -	$ 100,000	
CONTINGENCY COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ 100,000**	**$ -**	**$ -**	**$ -**		**$ -**	**$ 100,000**	**0%**	**$ -**	**$ 100,000**	
PROJECT SUMMARY COSTS (Hard Costs + Soft Costs + Contingency) ****	**$ 4,689,084**	**$ -**	**$ 3,321,954**	**$ -**		**$ 1,999,191**	**$ 2,589,893**	**60%**	**$ 470,026**	**$ 4,589,084**	

Definitions:

Hard Costs = Administrative Requirements, Temporary Facilities, Execution Requirements, Site Construction, Concrete Construction, Masonry, Metals, Woods & Plastics, Thermal/Moisture Protection, Doors, Windows, Glazing, Finishes, Specialties, Equipment, Furnishings, Special Construction, Conveying Systems, Plumbing/Mechanical, Electrical.
Soft Costs = Equipment, Furniture, Signage, Preconstruction Services, Construction Scheduling, Architectural, Engineering, Testing & Inspections, IOR Testing, Agency Fees, State Review Fees (OSHPD), CM Fee, Insurance, Performance/Payment Bonding, Administrative Bond Contingency
Contingency Costs = Inflation, Unforeseen Conditions & Events

Footnotes:

(2) Overage includes additional equipment costs, related OSHPD Fees and other fee reallocations.

* Project Descriptions located within applicable project section.
** FDP Report dated 12/31/2014
*** Reconciled with TFHD General Ledger dated December 31, 2014. Reference Application for Payment SOV located within applicable project section.

On or under budget
1-5% over budget
6% or beyond over budget

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

December 31, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q4 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
Cancer Center; Building + LINAC											
HARD COSTS: Construction Costs	$ 10,257,781	$ 151,973	$ 10,369,754	$ (40,000)		$ 10,369,754	$ 40,000	100%	$ -	$ 10,409,754	
SOFT COSTS	$ 6,124,371		$ 6,449,302	$ 324,931		$ 6,124,371	$ -	100%	$ -	$ 6,124,371	
CONTINGENCY	$ 1,017,160		$ 1,036,975	$ -		$ 1,017,160	$ -	100%	$ -	$ 1,017,160	
SUBTOTAL PROJECT COSTS	**$ 17,399,312**	**$ 151,973**	**$ 17,856,031**	**$ 284,931**		**$ 17,511,285**	**$ 40,000**	**100%**	**$ -**	**$ 17,551,285**	**Construction Complete**
Cancer Center; Sitework, Concrete Construction, Structural Steel											
HARD COSTS: Construction Costs	$ 5,154,785		$ 5,154,785	$ -		$ 5,139,922	$ 14,863	100%	$ -	$ 5,154,785	
SOFT COSTS	$ 4,421,594		$ 5,018,684	$ 597,090		$ 4,440,146	$ (18,552)	100%	$ -	$ 4,421,594	
CONTINGENCY	$ 515,479		$ 515,479	$ -		$ 511,790	$ 3,689	99%	$ -	$ 515,479	
SUBTOTAL PROJECT COSTS	**$ 10,091,858**	**$ -**	**$ 10,688,948**	**$ 597,090**		**$ 10,091,858**	**$ -**	**100%**	**$ -**	**$ 10,091,858**	**Construction Complete**
Utility Bypass, Phase I											
HARD COSTS: Construction Costs	$ 522,092		$ 522,092	$ -		$ 522,092	$ -	100%	$ -	$ 522,092	
SOFT COSTS	$ 99,565		$ 130,145	$ 30,580		$ 99,565	$ -	100%	$ -	$ 99,565	
CONTINGENCY COSTS	$ 78,314		$ 78,314	$ -		$ 78,314	$ -	100%	$ -	$ 78,314	
SUBTOTAL PROJECT COSTS	**$ 699,971**	**$ -**	**$ 730,551**	**$ 30,580**		**$ 699,971**	**$ -**	**100%**	**$ -**	**$ 699,971**	**Construction Complete**
Cancer Center; Utility Bypass, Phase II (Undergrounding)											
HARD COSTS: Construction Costs	$ -	$ 525,199	$ 544,877	$ (19,678)		$ 520,660	$ 4,539	99%	$ -	$ 525,199	
SOFT COSTS	$ -	$ 349,974	$ 349,974	$ -		$ 354,513	$ (4,539)	101%	$ -	$ 349,974	
CONTINGENCY COSTS	$ -	$ 31,437	$ 31,437	$ -		$ 31,437	$ -	100%	$ -	$ 31,437	
SUBTOTAL PROJECT COSTS (Hard Costs+Soft Costs+Contingency Costs)	**$ -**	**$ 906,610**	**$ 926,288**	**$ 19,678**		**$ 906,610**	**$ -**	**100%**	**$ -**	**$ 906,610**	**Construction Complete**
Cancer Center; Equipment Upgrades											
LINEAR ACCELERATOR EQUIPMENT		$ 860,000	$ 860,000	$ -		$ 860,000	$ -	100%	$ -	$ 860,000	
CT SIMULATOR (Pet CT)		$ -	$ 82,528	$ 82,528		$ -	$ -	0%	$ -	$ -	
CHILLER EQUIPMENT		$ 111,536	$ 143,679	$ 32,143		$ 111,536	$ -	100%	$ -	$ 111,536	
IT EQUIPMENT		$ 58,211	$ 133,250	$ 75,039		$ 58,211	$ -	100%	$ -	$ 58,211	
ADDITIONAL EQUIPMENT		$ -	$ 69,633	$ 69,633		$ -	$ -	0%	$ -	$ -	
SNOW MELT SYSTEM		$ 81,523	$ 71,904	$ (9,619)		$ 81,523	$ -	100%	$ -	$ 81,523	
SECURITY ACCESS SYSTEM		$ 99,257	$ 99,257	$ -		$ 99,257	$ -	100%	$ -	$ 99,257	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 1,210,527**	**$ 1,460,251**	**$ 249,724**		**$ 1,210,527**	**$ -**	**100%**	**$ -**	**$ 1,210,527**	**Construction Complete**
Cancer Center; CAC Recommended Upgrades											
HARD COSTS: Construction Costs	$ -	$ 838,256	$ 847,281	$ 9,025		$ 838,256	$ -	100%	$ -	$ 838,256	
SOFT COSTS	$ -	$ 54,568	$ 59,864	$ 5,296		$ 51,626	$ 2,942	95%	$ -	$ 54,568	
CONTINGENCY COSTS	$ -	$ 84,728	$ 84,728	$ -		$ 87,670	$ (2,942)	103%	$ -	$ 84,728	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 977,552**	**$ 991,873**	**$ 14,321**		**$ 977,552**	**$ -**	**100%**	**$ -**	**$ 977,552**	**Construction Complete**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 28,191,141**	**$ 3,246,662**	**$ 32,653,942**	**$ 1,196,324**		**$ 31,397,803**	**$ 40,000**	**100%**	**$ -**	**$ 31,437,803**	
Office Relocations											
HARD COSTS: Construction Costs	$ 109,691	$ -	$ 111,305	$ 1,614		$ 109,691	$ -	100%	$ -	$ 109,691	
SOFT COSTS	$ 281,988	$ -	$ 281,995	$ 7		$ 281,988	$ -	100%	$ -	$ 281,988	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 391,680**	**$ -**	**$ 393,300**	**$ 1,621**		**$ 391,680**	**$ -**	**100%**	**$ -**	**$ 391,680**	**Construction Complete**

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q4 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
IT Data Center											
HARD COSTS: Construction Costs	$ 899,833		$ 903,465	$ 3,632		$ 899,833	$ -	100%	$ -	$ 899,833	
SOFT COSTS	$ 299,483		$ 301,122	$ 1,639		$ 299,483	$ -	100%	$ -	$ 299,483	
CONTINGENCY COSTS	$ 116,754		$ 121,740	$ 4,986		$ 116,754	$ -	100%	$ -	$ 116,754	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 1,316,070**	**$ -**	**$ 1,326,327**	**$ 10,257**		**$ 1,316,070**	**$ -**	**100%**	**$ -**	**$ 1,316,070**	**Construction Complete**
Central Plant Upgrades & Relocations; Utility Spine											
HARD COSTS: Construction Costs	$ 2,640,481		$ 2,642,537	$ 2,056		$ 2,640,481	$ -	100%	$ -	$ 2,640,481	
SOFT COSTS	$ 694,681		$ 824,282	$ 129,601		$ 694,681	$ -	100%	$ -	$ 694,681	
CONTINGENCY COSTS	$ 657,714		$ 658,011	$ 297		$ 657,714	$ -	100%	$ -	$ 657,714	
SUBTOTAL PROJECT COSTS	**$ 3,992,876**	**$ -**	**$ 4,124,830**	**$ 131,954**		**$ 3,992,876**	**$ -**	**100%**	**$ -**	**$ 3,992,876**	**Construction Complete**
Central Plant Upgrades & Relocations; Generator Building											
HARD COSTS: Construction Costs	$ 2,150,583	$ 20,772	$ 2,174,334	$ 2,979		$ 2,171,355	$ -	101%	$ -	$ 2,171,355	
SOFT COSTS	$ 1,612,171		$ 1,655,159	$ 42,988		$ 1,612,171	$ -	100%	$ -	$ 1,612,171	
CONTINGENCY COSTS	$ 315,278		$ 315,278	$ -		$ 315,278	$ -	100%	$ -	$ 315,278	
SUBTOTAL PROJECT COSTS	**$ 4,078,032**	**$ 20,772**	**$ 4,144,771**	**$ 45,967**		**$ 4,098,804**	**$ -**	**100%**	**$ -**	**$ 4,098,804**	**Construction Complete**
Central Plant Upgrades & Relocations; Modular Units, Phase I											
HARD COSTS: Construction Costs	$ 418,497		$ 422,030	$ -		$ 418,497	$ -	100%	$ -	$ 418,497	
SOFT COSTS	$ 574,317		$ 598,765	$ 24,448		$ 574,317	$ -	100%	$ -	$ 574,317	
CONTINGENCY COSTS	$ 245,335		$ 245,887	$ 552		$ 245,335	$ -	100%	$ -	$ 245,335	
SUBTOTAL PROJECT COSTS	**$ 1,238,149**	**$ -**	**$ 1,266,682**	**$ 25,000**		**$ 1,238,149**	**$ -**	**100%**	**$ -**	**$ 1,238,149**	**Construction Complete**
Central Plant Upgrades & Relocations; Modular Units, Phase II											
HARD COSTS: Construction Costs	$ 4,800,719		$ 4,800,719	$ -		$ 4,800,719	$ -	100%	$ -	$ 4,800,719	
SOFT COSTS	$ 1,083,872		$ 1,189,314	$ 105,442		$ 1,083,872	$ -	100%	$ -	$ 1,083,872	
CONTINGENCY COSTS	$ 180,640		$ 185,000	$ 4,360		$ 180,640	$ -	100%	$ -	$ 180,640	
SUBTOTAL PROJECT COSTS	**$ 6,065,231**	**$ -**	**$ 6,175,033**	**$ 109,802**		**$ 6,065,231**	**$ -**	**100%**	**$ -**	**$ 6,065,231**	**Construction Complete**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 15,374,288**	**$ 20,772**	**$ 15,711,316**	**$ 312,723**		**$ 15,395,060**	**$ -**	**100%**	**$ -**	**$ 15,395,060**	
Skilled Nursing Facility											
HARD COSTS: Construction Costs	$ 3,372,928	$ 8,466	$ 3,422,324	$ 40,930		$ 3,381,394	$ -	100%	$ -	$ 3,381,394	
SOFT COSTS	$ 1,505,346		$ 1,496,355	$ -		$ 1,505,346	$ -	100%	$ -	$ 1,505,346	
CONTINGENCY COSTS	$ 342,232		$ 342,232	$ -		$ 342,232	$ -	100%	$ -	$ 342,232	
SUBTOTAL PROJECT COSTS	**$ 5,220,506**	**$ 8,466**	**$ 5,260,911**	**$ 40,930**		**$ 5,228,972**	**$ -**	**100%**	**$ -**	**$ 5,228,972**	**Construction Complete**
Skilled Nursing; Storage TI at '66 Bldg											
HARD COSTS: Construction Costs	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	**Conceptual Design in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 5,220,506**	**$ 8,466**	**$ 5,260,911**	**$ 40,930**		**$ 5,228,972**	**$ -**	**100%**	**$ -**	**$ 5,228,972**	

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

December 31, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q4 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
ECC Flooring / Nurses Station											
HARD COSTS: Construction Costs	$ -	$ 199,774	$ 217,550	$ 17,776		$ 199,774	$ -	92%	$ -	$ 199,774	
SOFT COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ -**	**$ 199,774**	**$ 217,550**	**$ 17,776**		**$ 199,774**	**$ -**	**92%**	**$ -**	**$ 199,774**	**Completed**
Infill Projects; Phase I Dietary / RT / MR / Dietary Office / Staff Lockers											
HARD COSTS: Construction Costs	$ 2,722,504		$ 2,722,504	$ -		$ 2,658,221	$ 64,283	98%	$ 1,696	$ 2,722,504	
SOFT COSTS	$ 1,699,858	$ 13,970	$ 1,713,828	$ -		$ 1,713,828	$ -	100%	$ -	$ 1,713,828	
CONTINGENCY COSTS	$ 898,541	$ 29,052	$ 272,250	$ (655,343)		$ 536,889	$ 390,704	58%	$ -	$ 927,593	
SUBTOTAL PROJECT COSTS	**$ 5,320,903**	**$ 43,022**	**$ 4,708,582**	**$ (655,343)**		**$ 4,908,938**	**$ 454,987**	**92%**	**$ 1,696**	**$ 5,363,925**	**Construction Complete**
Infill Projects; Interim Birthing at Western Addition											
HARD COSTS: Construction Costs	$ 1,309,206		$ 1,309,206	$ -		$ 1,299,543	$ 9,663	99%	$ 4,207	$ 1,309,206	
SOFT COSTS	$ 688,893		$ 688,893	$ -		$ 660,737	$ 28,156	96%	$ -	$ 688,893	
CONTINGENCY COSTS	$ 130,921		$ 130,921	$ -		$ 129,953	$ 968	99%	$ -	$ 130,921	
SUBTOTAL PROJECT COSTS	**$ 2,129,020**	**$ -**	**$ 2,129,020**	**$ -**		**$ 2,090,233**	**$ 38,787**	**98%**	**$ 4,207**	**$ 2,129,020**	**Construction Complete**
Infill Projects; Pharmacy Relocation											
HARD COSTS: Construction Costs	$ 652,777		$ 652,777	$ -		$ 652,777	$ -	100%	$ -	$ 652,777	
SOFT COSTS	$ 588,803		$ 631,283	$ 42,480		$ 588,803	$ -	93%	$ -	$ 588,803	
CONTINGENCY COSTS	$ 95,724		$ 127,292	$ 31,568		$ 95,724	$ -	75%	$ -	$ 95,724	
SUBTOTAL PROJECT COSTS	**$ 1,337,304**	**$ -**	**$ 1,411,353**	**$ 74,048**		**$ 1,337,304**	**$ -**	**95%**	**$ -**	**$ 1,337,304**	**Construction Complete**
Infill Projects; Medical Records at '66 Building											
HARD COSTS: Construction Costs	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	**Conceptual Design in Progress**
Infill Projects; Final Personnel Move TI Office Space											
HARD COSTS: Construction Costs	$ -	$ 250,000	$ 250,000	$ -		$ 238,327	$ 11,673	95%	$ -	$ 250,000	
SOFT COSTS	$ -	$ 125,000	$ 125,000	$ -		$ 139,099	$ (14,099)	111%	$ -	$ 125,000	
CONTINGENCY COSTS	$ -	$ 30,000	$ 30,000	$ -		$ 24,718	$ 5,282	82%	$ -	$ 30,000	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 405,000**	**$ 405,000**	**$ -**		**$ 402,144**	**$ 2,856**	**0%**	**$ -**	**$ 405,000**	**Conceptual Design in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 8,787,227**	**$ 448,022**	**$ 8,653,955**	**$ (581,295)**		**$ 8,738,619**	**$ 496,630**	**101%**	**$ 5,903**	**$ 9,235,249**	
Emergency Department & Sterile Processing Department; Increment I											
HARD COSTS: Construction Costs	$ 2,593,743		$ 2,593,743	$ -		$ 2,593,743	$ -	100%	$ -	$ 2,593,743	
SOFT COSTS	$ 2,898,599		$ 2,907,826	$ -		$ 2,898,599	$ -	100%	$ -	$ 2,898,599	
CONTINGENCY COSTS	$ 236,999		$ 236,999	$ -		$ 236,999	$ -	100%	$ -	$ 236,999	
EQUIPMENT UPGRADES - ATS Upgrades		$ 27,824	$ 27,824	$ -		$ 27,824	$ -	100%	$ -	$ 27,824	
SUBTOTAL PROJECT COSTS	**$ 5,729,341**	**$ 27,824**	**$ 5,766,392**	**$ -**		**$ 5,757,165**	**$ -**	**100%**	**$ -**	**$ 5,757,165**	**Construction Complete**

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

December 31, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q4 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
Emergency Department & Sterile Processing Department; Increment II											
HARD COSTS: Construction Costs	$ 4,534,232		$ 4,534,232	$ -		$ 4,318,596	$ 215,636	95%	$ 45,395	$ 4,534,232	
SOFT COSTS	$ 2,135,294		$ 2,135,294	$ -		$ 1,827,060	$ 308,234	86%	$ 55,523	$ 2,135,294	
CONTINGENCY COSTS	$ 1,725,651		$ 453,423	$ (1,272,228)		$ 1,034,849	$ 690,802	228%	$ 441,658	$ 1,725,651	
EQUIPMENT UPGRADES - Trump Exam Lights	$ -	$ 68,362	$ 68,362	$ -		$ 68,362	$ -	100%	$ 68,362	$ 68,362	
SUBTOTAL PROJECT COSTS	**$ 8,395,177**	**$ 68,362**	**$ 7,191,311**	**$ (1,272,228)**		**$ 7,248,867**	**$ 1,214,672**	**101%**	**$ 610,938**	**$ 8,463,539**	**Construction in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 14,124,518**	**$ 96,186**	**$ 12,957,703**	**$ (1,272,228)**		**$ 13,006,032**	**$ 1,214,672**	**100%**	**$ 610,938**	**$ 14,220,704**	
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement											
HARD COSTS: Construction Costs	$ 533,565		$ 619,422	$ 85,857		$ 533,565	$ -	100%	$ -	$ 533,565	
SOFT COSTS	$ 1,616,669		$ 1,575,493	$ (41,176)		$ 1,616,669	$ -	100%	$ -	$ 1,616,669	
CONTINGENCY COSTS	$ 92,913		$ 92,913	$ -		$ 92,913	$ -	100%	$ -	$ 92,913	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 2,243,147**	**$ -**	**$ 2,287,828**	**$ 44,681**	**(2)**	**$ 2,243,147**	**$ -**	**100%**	**$ -**	**$ 2,243,147**	**Construction Complete**
South Building; Birthing / Dietary Phase II											
HARD COSTS: Construction Costs	$ 13,033,262		$ 13,033,262	$ -		$ 1,246,057	$ 11,787,205	10%	$ 1,145,528	$ 13,033,262	
SOFT COSTS	$ 5,355,106		$ 5,355,106	$ -		$ 3,604,011	$ 1,751,095	67%	$ 231,678	$ 5,355,106	
CONTINGENCY COSTS	$ 1,262,026		$ 1,262,026	$ -		$ 26,037	$ 1,235,989	2%	$ 26,037	$ 1,262,026	
EQUIPMENT UPGRADES - Headwalls, Exam Lights, IT Equipment	$ -	$ 185,160	$ 185,160	$ -		$ -	$ 185,160	0%	$ -	$ 185,160	
SUBTOTAL PROJECT COSTS	**$ 19,650,394**	**$ 185,160**	**$ 19,835,554**	**$ -**		**$ 4,876,105**	**$ 14,959,449**	**25%**	**$ 1,403,243**	**$ 19,835,554**	**OSHPD Permitting in Progress**
South Building; Birthing Fourth LDR											
HARD COSTS: Construction Costs	$ -	$ 286,428	$ 286,428	$ -		$ -	$ 286,428	0%	$ -	$ 286,428	
SOFT COSTS	$ -	$ 187,720	$ 187,720	$ -		$ -	$ 187,720	0%	$ -	$ 187,720	
CONTINGENCY COSTS	$ -	$ 42,964	$ 42,964	$ -		$ -	$ 42,964	0%	$ -	$ 42,964	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 517,112**	**$ 517,112**	**$ -**		**$ -**	**$ 517,112**	**0%**	**$ -**	**$ 517,112**	**OSHPD Permitting in Progress**
South Building; Phase 5 Interim Birthing											
HARD COSTS: Construction Costs	$ -	$ 746,422	$ 746,422	$ -		$ -	$ 746,422	0%	$ -	$ 746,422	
SOFT COSTS	$ -	$ 172,765	$ 172,765	$ -		$ -	$ 172,765	0%	$ -	$ 172,765	
CONTINGENCY COSTS		$ 37,321	$ 37,321	$ -		$ -	$ 37,321	0%	$ -	$ 37,321	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 956,508**	**$ 956,508**	**$ -**		**$ -**	**$ 956,508**	**0%**	**$ -**	**$ 956,508**	**OSHPD Permitting in Progress**
South Building; Continuity Phase											
HARD COSTS: Construction Costs		$ 996,982	$ 996,982	$ -		$ 899,203	$ 97,779	90%	$ 107,806	$ 996,982	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 996,982**	**$ 996,982**	**$ -**		**$ 899,203**	**$ 97,779**	**90%**	**$ 107,806**	**$ 996,982**	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 19,650,394**	**$ 2,655,762**	**$ 22,306,156**	**$ -**		**$ 5,775,308**	**$ 16,530,848**	**26%**	**$ 1,511,049**	**$ 22,306,156**	
Master Planning											
SOFT COSTS	$ 802,508		$ 802,508	$ -		$ 802,508	$ -	100%	$ -	$ 802,508	
CONTINGENCY COSTS	$ 81,951		$ 81,951	$ -		$ 77,193	$ 4,758	94%	$ 121	$ 81,951	
CAMPUS SIGNAGE PLAN		$ 85,000	$ 85,000	$ -		$ 78,075	$ 6,925	92%	$ -	$ 85,000	
SECURITY UPGRADES		$ 75,000	$ 75,000	$ -		$ 28,738	$ 46,262	38%	$ -	$ 75,000	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 884,459**	**$ 160,000**	**$ 1,044,459**	**$ -**		**$ 986,514**	**$ 57,945**	**94%**	**$ 121**	**$ 1,044,459**	**Ongoing**
PROJECT SUMMARY COSTS (Hard Costs + Soft Costs + Contingency) ****	**$ 96,183,430**	**$ 6,835,644**	**$ 102,813,447**	**$ (229,211)**		**$ 84,678,979**	**$ 18,340,095**	**82%**	**$ 2,128,011**	**$ 103,019,074**	

Tahoe Forest Hospital District
Facilities Development Plan

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MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q4 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											

Definitions:

Hard Costs = Administrative Requirements, Temporary Facilities, Execution Requirements, Site Construction, Concrete Construction, Masonry, Metals, Woods & Plastics, Thermal/Moisture Protection, Doors, Windows, Glazing, Finishes, Specialties, Equipment, Furnishings, Special Construction, Conveying Systems, Plumbing/Mechanical, Electrical.
Soft Costs = Equipment, Furniture, Signage, Preconstruction Services, Construction Scheduling, Architectural, Engineering, Testing & Inspections, IOR Testing, Agency Fees, State Review Fees (OSHPD), CM Fee, Insurance, Performance/Payment Bonding, Administrative Bond Contingency
Contingency Costs = Inflation, Unforeseen Conditions & Events

Footnotes:
(2) Overage includes additional equipment costs, related OSHPD Fees and other fee reallocations.

* Project Descriptions located within applicable project section.
** FDP Report dated 12/31/2014
*** Reconciled with TFHD General Ledger dated December 31, 2014. Reference Application for Payment SOV located within applicable project section.
**** Total Owner Scope Modifications $6,835,644 Regulatory Scope Modification $1,963,721
*****Balance to Finish is calculated from FDP with Scope Modifications less Total Amount PTD

On or under budget
1-5% over budget
6% or beyond over budget

GENEY/GASSIOT, INC
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

December 31, 2014

MEASURE C PROJECTS - NON QUALIFIED EXPENDITURE COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q4 2014)	FDP with Scope Modifications	Status/Notes
Measure C Projects - Non Qualified Expenditures											
Cancer Center; Building + LINAC											
PERSONAL PROPERTY		$ 1,281,523	$ 1,246,012	$ (35,511)		$ 1,281,523	$ -	100%	$ -	$ 1,281,523	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 1,281,523**	**$ 1,246,012**	**$ (35,511)**		**$ 1,281,523**	**$ (35,511)**	**100%**	**$ -**	**$ 1,281,523**	**Complete**
Skilled Nursing Facility											
PERSONAL PROPERTY	$ -	$ 56,582	$ 391,614	$ 335,032		$ 56,582	$ -	100%	$ -	$ 56,582	
TOTAL PROJECT COSTS	**$ -**	**$ 56,582**	**$ 391,614**	**$ 335,032**		**$ 56,582**	**$ -**	**100%**	**$ -**	**$ 56,582**	**Complete**
Infill Projects; Phase I Dietary / RT / MR / Dietary Office / Staff Lockers											
PERSONAL PROPERTY	$ -	$ 116,280	$ 116,280	$ -		$ 89,155	$ 27,125	77%	$ -	$ 116,280	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 116,280**	**$ 116,280**	**$ -**		**$ 89,155**	**$ 27,125**	**77%**	**$ -**	**$ 116,280**	
Infill Projects; Interim Birthing at Western Addition											
PERSONAL PROPERTY	$ -	$ 23,074	$ 15,396	$ -		$ 30,437	$ (15,041)	198%	$ -	$ 23,074	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 23,074**	**$ 15,396**	**$ -**		**$ 30,437**	**$ (15,041)**	**198%**	**$ -**	**$ 23,074**	
Infill Projects; Pharmacy Relocation											
PERSONAL PROPERTY	$ -	$ 5,477	$ 2,372	$ (3,105)		$ 5,477	$ (3,105)	100%	$ -	$ 5,477	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 5,477**	**$ 2,372**	**$ (3,105)**		**$ 5,477**	**$ (3,105)**	**100%**	**$ -**	**$ 5,477**	
TOTAL PROJECT COSTS	**$ -**	**$ 144,831**	**$ 134,048**	**$ (3,105)**		**$ 125,069**	**$ 8,979**	**86%**	**$ -**	**$ 144,831**	**Complete**
Emergency Department & Sterile Processing Department; Increment 1											
PERSONAL PROPERTY	$ -	$ -		$ -			$ -	0%		$ -	
TOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	
Emergency Department & Sterile Processing Department; Increment 2											
PERSONAL PROPERTY	$ -	$ 708,123	$ 708,123	$ -		$ 753,881	$ (45,758)	106%	$ 158,579	$ 708,123	
TOTAL PROJECT COSTS	**$ -**	**$ 708,123**	**$ 708,123**	**$ -**		**$ 753,881**	**$ (45,758)**	**106%**	**$ 158,579**	**$ 708,123**	
TOTAL PROJECT COSTS	**$ -**	**$ 708,123**	**$ 708,123**	**$ -**	**$ -**	**$ 753,881**	**$ (45,758)**	**106%**	**$ 158,579**	**$ 708,123**	
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement											
PERSONAL PROPERTY	$ -	$ 5,500	$ 5,500	$ -		$ 5,500	$ -	100%	$ -	$ 5,500	
TOTAL PROJECT COSTS	**$ -**	**$ 5,500**	**$ 5,500**			**$ 5,500**	**$ -**	**100%**	**$ -**	**$ 5,500**	**Complete**
South Building / Birthing / Dietary Phase II											
PERSONAL PROPERTY	$ -	$ 750,272	$ 973,312	$ 973,312		$ -	$ 973,312	0%	$ -	$ 750,272	
TOTAL PROJECT COSTS	**$ -**	**$ 750,272**	**$ 973,312**	**$ 973,312**		**$ -**	**$ -**	**0%**	**$ -**	**$ 750,272**	
Non-Measure C Design Contingency											
PERSONAL PROPERTY	$ -	$ 150,000	$ -	$ -		$ -	$ -	0%	$ -	$ 150,000	
TOTAL PROJECT COSTS	**$ -**	**$ 150,000**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ 150,000**	
PROJECT SUMMARY COSTS	**$ -**	**$ 3,096,831**	**$ 3,458,609**	**$ 1,269,728**	**$ -**	**$ 2,222,555**	**$ (72,290)**	**64%**	**$ 158,579**	**$ 3,096,831**	

* Project Descriptions located within applicable project section.
** FDP Report dated 12/31/2014
*** Reconciled with TFHD General Ledger dated December 31, 2014. Reference Application for Payment SOV located within applicable project section.

On or under budget
1-5% over budget
6% or beyond over budget

Truckee Donner
Recreation and Park District

8924 Donner Pass Road, Truckee, California 96161
PHONE: (530) 582-7720 • FAX (530) 582-7724

General Manager
Steve Randall

March 10, 2015

Karen Sessler
Board Chair
Tahoe Forest Hospital

Re: Request from Truckee Donner Recreation & Park District Aquatic Center

Dear Karen,

The Truckee Donner Recreation & Park District requests to make a presentation to the Tahoe Forest Hospital board of Directors at their March 31st regular board meeting. We would need about 10-15 minutes to make our presentation about potential funding for the Truckee Aquatic Center. Steve Randall, General manger of the District and Kevin Murphy, board member will be making the presentation. We request the board consider funding for the overall project or dedicating funds to the warm water components of the aquatic center that would be used for therapy. These facilities include the two warm water lap lanes and a current channel The warm water lap lanes are budgeted at $338,758 and the current channel is budgeted at $216,428.

The Truckee Donner Recreation & Park District has been working on building a new aquatic center for the Truckee community since 2006. Our first phase to build the Community Recreation Center was completed in December 2009, and since that time we've prioritized both Arts and Aquatics as our future efforts. In 2012, the District allocated funds to art programs completed the renovation of the old recreation center for performing arts. We then moved aggressively to initiate the aquatics project.

The current pool is 43 years old and does not provide warm water components for children and seniors, therapy for those needing aquatic healing, enough lanes for competitions, or does it have an efficient mechanical system. Typical life span of a pool is 40 years old. The current facility has now out lived its usefulness and is increasingly becoming a drag on financial operations and a burden to use by the community.

Current plan for the aquatic center is to have two bodies of water comprised of:

1. 10 lane competition/lap pool

2. Second warm body of water used for recreation, competition, teaching and therapy

The final District aquatic designs were completed in late 2012 and were submitted for a bid open in January 2013. The bid results exceeded the amount of District funds reserved for the project. The District value engineered and redesigned the aquatic center and rebid the project in December,

2014. The District again opened the re-bid in January 2015, but again the bids were far in excess of District capital by approximately $1,000,000 just for the 10 lane lap pool.

During the month of February, 2015 the District worked with the Town of Truckee, the Truckee Tahoe Airport District, a private fund, and an internal District team to access additional funds and to drawdown reserves to come up with the shortfall to guarantee the construction of just the building and 10 lane completion/lap pool. The District left the warm water element and a pool community room for a future phase; estimated to be 5 years hence. The contract was awarded to the low bidder and the project will begin in April, 2015.

The District has now immediately begun working on the $1,000,000 fund raising mechanism to capitalize the final phase of construction specifically for the warm water component. The Truckee Tahoe Airport District amazingly committed $525,000 in available matching funds to jump start the Aquatics campaign. The private fund committed to matching dollar for dollar any funds the District can raise to accelerate the fund raising and to bring the project to fruition while the contractor is on-site building this year. Every dollar that the District can raise will be a 3 to 1 match. For example, $1 donated will be matched by the private fund $1, and then those $2 will be matched by the Airport District $2, thus generating a substantial fund raising acceleration. The District has now aggressively started a capital campaign to raise funds from any and all sources. The goal is for the District to raise approximately $262,500. If we can hit this figure, the District will realize its vision of an aquatic center for Truckee and that center will create tremendous community purpose while enhancing the lives of each and every citizen and visitor to our area. More amazing will be a real chance to have a therapeutic facility to help those in need of aquatic therapy and to have a public facility that will be a boon to our youth.

This project has been a true collaboration of public and private working together to get a much needed facility in Truckee. Any help you can provide in this effort will be thoroughly recognized, and will be greatly appreciated.

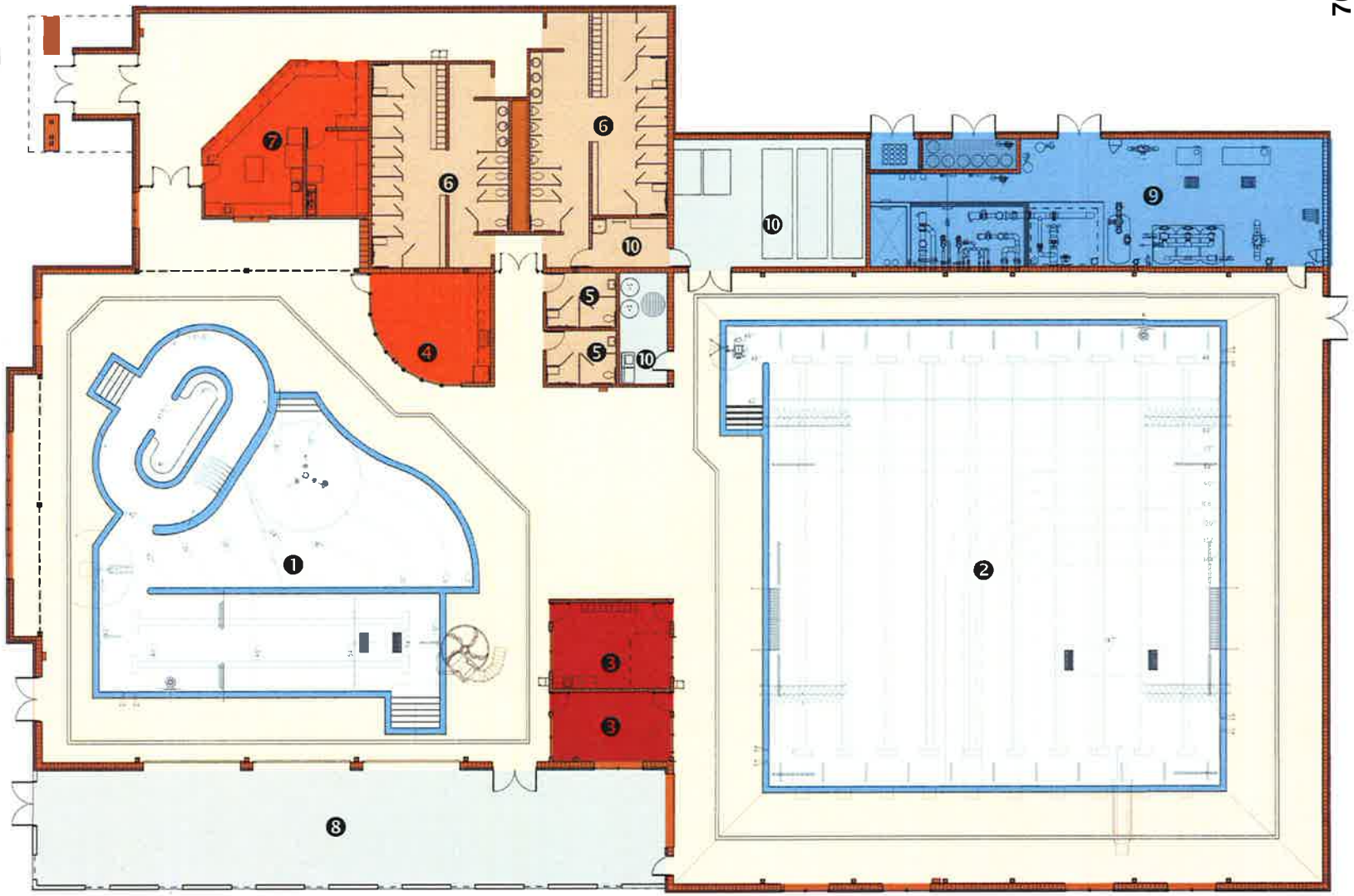
Attached for your information are renderings which include the 3-D drawing of the building, the floor plan and the leisure warm water pool.

Steve Randall
General Manager

Kevin Murphy
TDRPD Board Member

L DECK

1. Leisure Pool – 2,500 s.f. total
   70 foot Current Channel
   20 yard warm water Lap Lanes
2. 25 yard x 10 Lane Competition Pool
3. Office / Guard / First Aid
4. Party Room -19'x18' –19 persons
5. Family Change Rooms
6. Locker Rooms
7. Lobby / Front Desk / Concessions
8. Outdoor Pool Deck
9. Chemicals / Equipment
10. Storage / Janitor



FLOOR PLAN

INNOVATE
46 WEST MAIN LEHI UTAH 84043 T 801-768-2620 F 801-768-2624
WWW.INNOVATEARCH.COM

LEISURE POOL

TRUCKEE-DONNER
RECREATION & PARK DISTRICT

INNOVATE
ARCHITECTURE
46 WEST MAIN, LEHI, UTAH 84043 T 801-768-2620 F 801-768-2624
WWW.INNOVATEARCH.COM

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Virginia A. Razo
Chief Executive Officer

DATE: March 19, 2015

Strategic Initiative 2.3
Conduct two-way communication with employees about health system goals, projects and priorities

Tahoe Forest Hospital District's Senior Leadership team has been actively engaging with employees by rounding in departments, attending staff meetings, conducting monthly Management Team meetings, and by being available in the café' during posted hours to encourage open communication. In addition, articles will continue to be published in the Health System's Pace Setter to help keep employees informed of important issues. Lastly, an email was sent to all employees and medical staff informing them of the Health System's compliance program, demonstrating a commitment to Compliance from Senior Leadership.

Strategic Initiative 5.1
Collaboration with UC Davis

Collaboration continues to be a priority for TFHD and UC Davis. This was confirmed by two meetings between UC Davis CEO, Anne Rice and TFHD CEO, Virginia Razo. A concern expressed by TFHD's Medical Staff about the difficulties referring local patients into UC Davis was one of many topics discussed. A tele-video conference is scheduled for members of UC Davis Medical Staff and TFHD Medical Staff to work on solutions. Other topics included the Rural Prime Education Program and its success to date, the Cancer Care Network and the benefits both organizations gain by TFHD's participation in the Network. Lastly, new concepts and ideas were shared enthusiastically by both parties.

Strategic Initiative 5.2 & 5.3
Explore partnership opportunities with regional and local health system/ Collaborate with local medical providers to improve health delivery

In addition to meeting with UC Davis, TFHD's CEO and CNO met with three senior leaders of Renown to discuss future collaborative projects that could benefit both communities. This meeting resulted in both organizations having a desire to meet quarterly to explore future opportunities.

Efforts are underway to strengthen the District's relationship with the Tahoe Truckee Medical Group. TFHD has assisted TTMG to reduce expenses to the group by receiving a more competitive mal-practice rate through the District's insurer, Beta. Also, the District is working with legal council to enter into a "physician retention" Agreement with Dr. Samelson. This type of agreement will ensure Dr. Samuelson can remain working in the community by eliminating his education loan payments in exchange for a commitment to remain in the community to provide medical services.

Significant local provider collaboration under way is the recruitment of an Orthopedic Surgeon to North Tahoe Orthopedics (NTO). In November 2014, one of the orthopedic surgeons of NTO indicated that he would be leaving the group; however, it remains unclear if this surgeon will continue to provide ED On-call services. In preparation of this transition, the remaining partners of NTO have been actively recruiting a replacement physician. TFHD has engaged ECG Management Consultants to evaluate FMV for an income guarantee and Education Loan Forgiveness Agreement which will be necessary to recruit and retain a new physician.

Strategic Initiative 5.6
Optimize performance of the Truckee Surgery Center (TSC)

The Truckee Surgery Center Board of Directors met in January to discuss potential opportunities to improve the financial performance and operations of the TSC. TFHD is actively evaluating strategies related to contracts and supply costs that may improve the operating income of TSC. Additionally, as TFHD begins a capital upgrade in its operating rooms, the Board agreed that the Operating Agreement between TFHD and TSC may need to be modified to allow additional surgical procedures be performed there.

Strategic Initiative 6.1
Market study and potential service line investments

TFHD engaged Kaufman Hall, a consulting firm that offers management consulting services for capital planning, budgeting, and debt transactions, to complete a market analysis which will inform TFHDs strategic planning and financial planning and budgeting for FY2016. A special Board meeting will be convened to review the information and incorporate goals into its strategic plan.

Strategic Initiative 6.4
Facilities Development Plan

TFHD has been gathering data and meeting with Medical Staff members and management to inform its preliminary space planning for the future. Through this process TFHD will develop a plan, based on industry standards to meet the current and future needs of the community for health care services.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
Chief Information Officer

DATE: March 16, 2015

Disaster Recovery of Data and Electronic Communication Systems

This is informational report is intended to give a brief synopsis on the disaster recovery process that would be deployed at Tahoe Forest Health District (TFHD) in the event that we lost our data storage servers.

Virtualized Computing Environment

TFHD works in a virtualized computing environment. In a virtual server environment one physical server hosts multiple virtual servers, each isolated from the others. This is accomplished with software, called a hypervisor that segments the physical server and keeps each segment separate from the rest. Each virtual server is capable of running its own operating system and/or Personal Computer desktop independent of the others running on the same virtual server platform. TFHD runs a large majority of its desktops and servers virtually, that is, all of the data is housed in one location instead of spread out among the 100's of desktops and individual servers. This allows us to increase our server and desktop capacity without expensive upgrades and new hardware. It is also easier to manage this type of environment since all of the data is housed in one place and all of the desktops are controlled in a single location.

Requests for Data and or Hardware Containing Data

In the event that TFHD was legally compelled to relinquish out physical data storage hardware, TF. TFHD would offer to relinquish its back up data storage device where we currently copy the district's data. This would be an exact match to our current production data. If this was an acceptable method for the requestor we would experience no downtime. IF the requestor simply arrive and removed all hardware we would have to begin working from our Disaster Recovery (DR) plan in effect working from a catastrophic level of destruction. In this event that we lost our production data and the hardware that runs the environment, we would be buying and configuring new virtual servers and restoring our data from the various backup types that we perform both to tape, locally and in the cloud. Listed below are our excepted response times for individual systems after we have received new hardware. New hardware delivery and setup is expected to take two weeks in an emergent situation. Listed after the criticality level definitions below, is the inventory of our systems and their respective response levels.

Virtualized environment recovery

Mission Critical Level	Risk	Disaster Level	Response level
1 return to operation less than **6 hours**	**Complete loss of Data Center due to physical, electrical, or equipment failure forcing failover to DR site or loss of both due to Tahoe Hospital Disaster Currently Loss of Data Center or SAN would force this response**	**Disaster Response Level 1**	**Invoke AIT -165 Disaster Recover Plan**
2 return to operation less than **12 hours**.	**Loss of Sever (Virtual or Standing) due to Hardware/ Software failure example loss of all VMware Servers due to software failure or loss of SAN due to hardware or software failure.**	**Disaster Response Level 2**	**Invoke AIT -162 Disaster Recovery and Contingency Operation Contingency Policy**
3 return to operation less than **24 hours**.	**Loss of Access due to loss of Network Infrastructure for entire hospital and clinics example Nexus failure**	**Disaster Response Level 3**	**Invoke AIT -162 Disaster Recovery and Contingency Operation Contingency Policy**
4 return to operation less than **48 hours**.	**Loss of Access due to Software failure for individual application example Internet Explorer failure**	**Disaster Response Level 4**	**Invoke AIT -162 Disaster Recovery and Contingency Operation Contingency Policy**
5 return to operation less than **72 hours**.	**Loss of Access due to physical work area loss of access example Loss of Voice Dictation due to office electrical problem.**	**Disaster Response Level 5**	**ITIL Service Provider Response**
6 return to operation**more** than**72 hours**.	**Loss of Access due to local software failure example due to loss of local workstation where users can move to different machine to get work done.**	**Disaster Response Level 6**	**ITIL Service Provider Response**

Operational Criticality Level & Area of Operation Clinical , Financial, Operations	*Vendor*	*Application Name*
1 Operational	Cisco ASA/Putty/WireShark/ACS/	
2 Clinical & Financial &Operations when used by EMRs, Clinical Software or Financial Software.	MicroSoft	Office Suite
2 Clinical & Financial& Operational	CPSI	CPSI EMR
2 Clinical & Financial& Operational	Epic	Epic Ambulatory
2 Clinical & Financial& Operational	SCC Soft Laboratory System	
2 Clinical & Financial& Operational	T-System	T-System EVA
2 Operational	Cisco Call manager/IPCelerate/Unity connection	
2 Operational	VM Ware/V Kernal/VM Tools/	
2 Operational	What's Up Gold(Network)/Arcscan(SANS)/RTO(application)	
3 Clinical	Adobe PDF used in EMR, Financial, Clinical Software	
3 Clinical	First Data Bank	Drug to Drug checking software
3 Clinical	Fukuda Monitoring System	ICU, Med Srug Telemetry
3 Clinical	Interfaces to Bio Med	Needed for EMR's
3 Clinical	Medi-Dose	
3 Clinical	Micromedex Care Notes and Health Series	
3 Clinical	Varian	ARIA EMR
3 Clinical	Phillips	iSight
3 Clinical & Financial	MIRTH	

Operational Criticality Level & Area of Operation Clinical , Financial, Operations	*Vendor*	*Application Name*
3 Clinical & Financial	RVI Document Imaging	
3 Clinical & Financial	Thin Print	
3 Financial	3 M	Medical Coder
3 Financial	Emdeon	EDI, Eligibility, Accut Post
3 Operations	Spice Works Help Desk	
4 Clinical	OBIX	OBIX
4 Clinical	AG Mednet	Oncology
4 Clinical	AG Mednet	
4 Clinical	ESHA	ESHA Nutrition
4 Clinical	PICIS	PICIS OR Manager
4 Clinical	Up- To-Date	
4 Clinical & Financial	FutureNet Transcription	HIM
4 Clinical & Financial	NTT	Net Solutions
4 Clinical & Financial	QS1	
4 Financial	MBA and Wattland Physician Billing	
4 Financial	MedAmerica	Interface
4 Financial	NBF and CBSJ Bad DeBarb Thomas Programs	
4 Financial	Par-Ex Interfaces	
4 Financial	Par-EX Materials system	
4 Financial	Passport	
4 Financial	Pay Nav- Third Eligibility software	
4 Financial	Statements/ Patient	
5 Clinical	BioEx Systems	Exercise Pro
5 Clinical	Birth Cert	Birth Certification
5 Clinical	Cardinal	RXeView

Operational Criticality Level & Area of Operation Clinical , Financial, Operations	Vendor	Application Name
5 Clinical	Cardio Stream	Cardiostream
5 Clinical	Codeonics	CD writer
5 Clinical	Collector Trauma Registry	
5 Clinical	compwatch	CompWatch
5 Clinical	EP Evaluator	
5 Clinical	M.D. Staff	Physician Credentialing
5 Clinical	Our 365	
5 Clinical	Pandora /DEA	
5 Clinical	PenRad (MammoBase)	
5 Clinical	Pharmacia Drug Module	
5 Clinical	Phillips	Xcellera
5 Clinical	Radiance RT	
5 Clinical	Radware Dictation (Nuance)	
5 Clinical	RXE View	
5 Clinical	Talyst Auto Split	
5 Clinical	Visual Staff Scheduler	
5 Financial	ADP	E-Time
5 Financial	ADP	HR
5 Financial	ADP	Payroll
5 Financial	Appeals Writer	Appeal letter formatter
5 Financial	CareVoyant	CareVoyan Billing
5 Financial	Vision Share- Access DDE CMS	
5 if just software 4 if actual cabinets on floor	Pyxis	MS4000
5 Operations	Adobe 7 & 8	
5 Operations	BIZ Card Reader	

Operational Criticality Level & Area of Operation Clinical , Financial, Operations	Vendor	Application Name
5 Operations	Quantros	
5 Operations	Welch Allyn Holter System (Ritchie, Lombard, Rau, & Tirdel)	
5 Operations	ZIX	Zix E-mail Encryption
6 Clinical	NextGen archived	NextGen EMR
6 Financial	Sage FAST Fixed Assets Program	
6 Operations	Air Magnet/Air Defense	
6 Operations	Aloha	Cash Register
6 Operations	ATT&T Dialer	CMS reporting of Oasis data
6 Operations	Barracuda/ Symantec/Sophos	
6 Operations	Book Smart	
6 Operations	Citrix/Google Chrome/*About 10 small apps to support Citrix/ Sentillion SSO	
6 Operations	Symphonix	
6 Operations	Departmental Quality Worksheets	
6 Operations	E-Copy	
6 Operations	Facilities Work request system	
6 Operations	Filezilla/Microsoft Kristina Martins Licensing/Java versioning/Active X/Symantic imaging software/	
6 Operations	Halogen	Evaluation software
6 Operations	Health Source for community health programs	
6 Operations	healthstream	On line training
6 Operations	Illustrator	
6 Operations	Intellimed	Market Share
6 Operations	Kaufman Hall	Budget Advisor
6 Operations	Keane Archived data	5
6 Operations	Lectora	
6 Operations	Map Point &Queark	

Operational Criticality Level & Area of Operation Clinical , Financial, Operations	*Vendor*	*Application Name*
6 Operations	Med Trak System for OCC Health	
6 Operations	MicroSoft	Exchange
6 Operations	MicroSoft	Office Suite
6 Operations	Mind Body	
6 Operations	Nuance	Power Scribe
6 Operations	Nuance	Dragon Speak dictation
6 Operations	Org Plus	
6 Operations	PC&PS 2008	
6 Operations	Photoshop	
6 Operations	Picassa	
6 Operations	Press Ganey customer satisfaction	
6 Operations	Print ID for Badges	
6 Operations	Procare	Child Care software
6 Operations	R Admin/VNC/Go-to-Assist	
6 Operations	Raisers Edge	
6 Operations	Roxio	
6 Operations	Sigma Master Drug Library	
6 Operations	Smart Draw	
6 Operations	Spool Explorer	
6 Operations	Suite of Microsoft Office Products	
6 Operations	Synthes (SIMS)	
6 Operations	Ultimate- Old work request system	
6 Operations	Veritas	
6 Operations	YAMAS	

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
Chief Information Officer

DATE: March 24,2015

CPSI Computerized Provider Order Entry (CPOE)

Based on strategic initiative 4.1 and 4.2 TFHD is working to prepare for the coming changes in moving from the **International Classification of Diseases** (ICD) version 9, to version 10. The new classification system allows more than 155,000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17,000 codes available in ICD-9. We are also on track to meet the Federal Meaningful Use stage 1 requirements for this fiscal year.

With the confidence that we will be able to complete these initiatives in our current state of software implementation with CPSI's Electronic Medical Records software (EMR) without having to implement the CPSI CPOE module, we have a consensus among the staff and physicians that we will not move forward with the scheduled implementation of the CPOE module.

TFHD has been working on the premise that with our software vendor, our highly skilled internal team of clinical informaticists and information technology professionals, we would be able to correct any known issues before the pre-determined go-live date for CPOE implementation. We have worked diligently with all of our physician specialties to perform detailed process mappings of their routines and have labored to create a system with templates and order sets that would work within those parameters. However, there have been nagging issues we have not been able to correct while waiting on software patches from our vendor and we are now experiencing time constraints in doing so. We will change the paradigm from setting a date and working to fix the issues before we go-live; to working towards completely preparing the system for implementation first and only then setting the go-live date.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
Chief Information Officer

DATE: March 24, 2015

Strategic Initiative 4.3

Develop a long-range IT EMR Plan (3-10 years) to optimize potential strategic technology investments and execute after approval from the Board of Directors.

TFHD is moving forward with a request for information (RFI) process to better understand our EMR opportunities as they exist in the market place and with our current vendors, as prescribed in strategic initiative 4.3.

With the realization that TFHD will confidently meet the requirements for strategic goals 4.1 and 4.2:

1. Goal: Develop and deploy short-term IT EMR Plan to optimize use of current CPSI software to meet Meaningful Use stage one and ICD-10. (FY 2015-2017

- ✓ *FY15 program plan has been developed and budgeted to achieve CMS Meaningful Use during TFHD FY15*
- ✓ *FY15 program plan to meet ICD10 requirements by October 1, 2015, including the use of CPSI application software, has been developed and is being implemented.*

"2. Goal: Develop and approve Meaningful Use stage one attestation plan"

- ✓ *A FY15 program plan has been developed and budgeted to achieve CMS Meaningful User during TFHD FY15.*

TFHD will meet these goals with the current state of implementation of its EMR supplied by CPSI. TFHD is now looking to better understand the future state of its EMR as dictated in the aforementioned strategic initiative 4.3.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Janet Van Gelder, RN, DNP
Director of Quality & Regulations

DATE: March 5, 2015

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey

The HCAHPS Survey, also known as the CAHPS® Hospital Survey, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice. The HCAHPS sampling protocol is designed to capture uniform information on hospital care from the patient's perspective. Three broad goals shape the HCAHPS Survey:

1. The survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers.
2. Public reporting of the survey results is designed to create incentives for hospitals to improve quality of care.
3. Public reporting serves to enhance public accountability in health care by increasing transparency. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are available to the public.

TFHS utilizes the CAHPS survey process for inpatients, Home Health, and Hospice patients.

What items are on the HCAHPS survey?

The HCAHPS Survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness of the hospital environment, quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and recommendation of hospital); four items to skip patients to appropriate questions; three items to adjust for the mix of patients across hospitals; and two items to support congressionally-mandated reports. The core set of HCAHPS questions can be combined with customized, hospital-specific items to complement the data hospitals collect to support internal customer service and quality-related activities.

Which results are publically reported?

Hospital-level HCAHPS results are publicly reported on the Hospital Compare website at http://www.hospitalcompare.hhs.gov. Results are reported for four quarters on a rolling basis Ten HCAHPS measures are publicly reported on Hospital Compare:

- Nurse Communication (Question 1, Q2, Q3)
- Doctor Communication (Q5, Q6, Q7)

- Responsiveness of Hospital Staff (Q4, Q11)
- Pain Management (Q13, Q14)
- Communication About Medicines (Q16, Q17)
- Discharge Information (Q19, Q20)
- Cleanliness of Hospital Environment (Q8)
- Quietness of Hospital Environment (Q9)
- Overall Rating of Hospital (Q21)
- Willingness to Recommend Hospital (Q22)

Do we survey other areas of the Health System?

In addition to the HCAPHS survey, we also survey patients that are treated in the TFH & IVCH Emergency Department, Ambulatory Surgery Department, Multispecialty Clinics, and Outpatient Departments. We utilize the standardized Press Ganey satisfaction survey. The Cancer Center utilizes Sullivan Luallin for their patient satisfaction survey. Home Health and Hospice utilize Strategic Healthcare Programs for their CAHPS survey.

Cover Letter to our Patients

The current cover letters are Press Ganey templates. Cover letters are able to be customized; however, the cover letter for the HCAHPS survey can only be slightly modified based on CMS requirements. The letters are addressed to the patient and signed by our interim CEO. The interim CEO signature was updated on February 9, 2015, however, and uploaded to the Press Ganey system on March 3, 2015 due to vendor error.

TAHOE FOREST HEALTH SYSTEM

RETIREMENT PLAN COMMITTEE
A Subcommittee of the Board Personnel Committee
AGENDA

Monday, March 9, 2015 at 12:00 p.m.
Tahoe Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

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

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

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

5. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

5.1. **Fiduciary Education and Plan Review**
Tahoe Forest Hospital District's investment advisor will provide retirement plan education and plan reviews for the committee.

- 5.1.1. **Fiduciary Responsibility & Education** ..... ATTACHMENT
- 5.1.2. **Plan Governance Review** ..... ATTACHMENT
- 5.1.3. **Plan Document and Administrative Compliance Review** ..... ATTACHMENT
- 5.1.4. **Plan Fee Benchmarking** ..... ATTACHMENT
- 5.1.5. **Investment Menu & Investment Quality Review** ..... ATTACHMENT

6. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

7. NEXT MEETING DATE
The next scheduled meeting of the Board Personnel Committee is scheduled to take place Thursday, April 9, 2015.

8. ADJOURN

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

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

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

TAHOE FOREST HEALTH SYSTEM

GOVERNANCE COMMITTEE
AGENDA

Thursday, March 12, 2015 at 11 a.m.
Foundation Conference Room - Tahoe Forest Health System Foundation
10976 Donner Pass Rd, Truckee, CA.

1. CALL TO ORDER

2. ROLL CALL
Karen Sessler, M.D., Chair; Greg Jellinek, M.D., Board Member

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

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

5. APPROVAL OF MINUTES OF: 02/13/2015 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Contracts** *[10 minutes]*
New, amended, and auto renewed contracts are submitted to the Governance Committee for review and consideration for recommendation of approval by the Board of Directors.

6.1.1. **New**

6.1.1.1. Thompson_PSA_Training_and_Education_2015 ..... ATTACHMENT
6.1.1.2. Taylor_PSA_Training_and_Education_2015 ..... ATTACHMENT
6.1.1.3. Coll_PSA_Training_and_Education_2015 ..... ATTACHMENT

Staff Recommendation: Committee recommendation to full board for approval of contracts as submitted.

6.2. **Policies** *[5 minutes]*

6.2.1. **Physician Non-Monetary Compensation (New)** ..... ATTACHMENT
New policy presented for review related to how compensation in the form of certain items and services is treated under the non-monetary compensation exception and the medical staff incidental benefits exception of the Federal "Stark" law.

6.2.2. **Payment of Professional Service Agreements (New)** ..... ATTACHMENT
New policy presented for review related to implementation of a method to ensure proper review of PSA's and invoices for payment.

6.2.3. **Conflict of Interest Code (ABD-06)** ..... ATTACHMENT
A review of the policy and referenced designated positions included in the Conflict of Interest Code policy is required every two years. The policy is being updated to reflect changes to titles for certain designated positions.

Staff Recommendation: Committee recommendation to full board for approval of updated Conflict of Interest Code Policy.

6.3. **Compliance**
The Fox Group will present reports on the following items as part of their compliance consulting work for Tahoe Forest Hospital District.

6.3.1. **2014 Compliance Report** *[15 minutes]* ..... ATTACHMENT
6.3.2. **OIG Work Plan** *[15 minutes]* ..... ATTACHMENT
6.3.3. **2015 TFHD Compliance Work Plan** *[20 minutes]* ..... ATTACHMENT
6.3.4. **Analysis of 2013 Quality Matters Report** *[30 minutes]* ..... ATTACHMENT

6.4. **Board Retreat Planning** *[15 minutes]* ..... ATTACHMENT
Committee will discuss details related to planning of the annual board retreat.

7. CLOSED SESSION

7.1. **Health & Safety Code Section 32155: Quality Report** (2 items)
7.2. **Government Code Section 54956.9(d)(2): Exposure to** Litigation (3 matters)

8. OPEN SESSION

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE
The next regularly scheduled meeting of the Board Governance Committee will take place on Wednesday, April 8, 2015.

10. ADJOURN

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

March 6, 2015

TO: TFHD Governance Committee

FROM: James Hook, Corporate Compliance Consultant, The Fox Group, LLC

SUBJECT: 2015 Compliance Program Annual Report

Documents: 2014 Compliance Report (Open Session)

SUMMARY: Providing the BOD with a summary of 2014 Corporate Compliance Program Annual Report of compliance activities to meet its obligations to be knowledgeable about the content and operation of the Compliance Program.

1. Policies and Procedures to prevent and detect violations of law
2. Compliance Oversight
3. Education and Training
4. Effective Lines of Communication and Reporting
5. Auditing and Monitoring
6. Enforcing Standards and Promoting Guidelines for Ethical Conduct
7. Responding to Detected Offenses and Corrective Action Initiatives

ACTION REQUESTED

- Review and approval

DISCUSSION

OPEN SESSION

Period Covered by Report: **January 1, 2014 – December 31, 2014**
Completed by: James Hook, Compliance Consultant, The Fox Group

1. Written Policies and Procedures

1.1 The District's Corporate Compliance Policies and Procedures have been reviewed and updated as needed. Policies have been adopted, revised, or are in development to meet regulatory changes or in response to compliance activities.

2. Compliance Oversight / Designation of Compliance Individuals

2.1 Corporate Compliance Committee:

Gail Betz – Compliance Officer

Ginny Razo – Chief Operating Officer

Crystal Betts – Chief Financial Officer

Denise Hunt – Director of Health Information Management/ Privacy Officer

John Hummel – Director, IT/Information Security Officer

2.2 A Corporate Compliance sub-committee consisting of Privacy Officer (Denise Hunt), Information Security Officer (John Hummel), Compliance Officer (Gail Betz), focuses on HIPAA Privacy and Security compliance measures.

3. Education & Training

3.1 All new employees are educated during orientation. Ninety-nine percent (99%) of Health System staff participated in mandatory annual education.

3.2 2014 Accreditation Fair complemented annual Compliance Training

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

3.4 Gail Betz attended the March 2014 California Hospital Association (CHA) Compliance Seminar and the Health Care Compliance Association (HCCA) annual HCCA Institute.

4. Effective Lines of Communication/Reporting

4.1 A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Officer. The log was not maintained properly for the last nine months of the year.

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

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1 Orientation and Health Stream annual training

5.2 All new staff hires, newly privileged physicians, and vendors registered with vendor credentialing program screened by checking against the OIG and GSA exclusion lists and receive criminal background checks. Annually, ongoing monitoring continues at various intervals.

5.3 The employee newsletter provides educational scenarios in which violations occurred.

6. Auditing & Monitoring

6.1 The annual external financial audit report was presented.

6.2 An audit of the credentialing process of the Medical Staff was conducted and showed no deficiencies in the process based on review of a sample of physician credential files.

6.3 Two-Midnight Rule: The Center for Medicare and Medicaid Services (CMS) has established a two-midnight benchmark for physicians to note in determining patient status for inpatient or outpatient care. CMS Specifies that when the physician expects the patient to require care that crosses two midnights and orders admission based upon that expectation, inpatient status is generally appropriate. This Two-Midnight Rule went into effect on October 1, 2013.

The data below shows a reduction from 2013 to 2014 in observation admissions and observation patient stays of 2 days or greater. The difference of 241 observation admissions from 2013 to 2014 indicates physicians are admitting patients to inpatient status as defined in the Two-Midnight Rule. Monitoring will continue in 2015 with quarterly reporting to Medical Staff.

CY Year	Total Observation Admissions	Percent of Observation Patients 1 Day Stay	Percent of Observation Patients 2 Day Stay	Percent of Observation Patients >2 Days Stay
2013	457	86.98%	13%	0.024%
2014	216	89.35%	10.65%	**0.004%**

6.4 2014 HIPAA Data Risk Assessment

6.4.1 A Data Security Risk Assessment was undertaken as required for attestation of Meaningful Use of Certified EHR Technology.

6.4.2 The risk assessment determined that TFHS had 8 areas of High or Medium Risk that need mitigation.

6.4.3 The risks and threats are related to possible unauthorized access to ePHI, loss of data, loss of availability and data breach.

6.4.4 All risks and threats are addressed as part of the 2014 Data Risk Assessment Mitigation Plan through Disaster Recovery Plan, Business Continuity Plan, Contingencies Plan and Physical Data Security Plan.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1 Investigations of suspected and actual breach incidents were conducted. Remediation measures were implemented to prevent further violations. Corrective action included updated policies and procedures and additional staff training.

TAHOE FOREST HOSPITAL DISTRICT

March 6, 2015

TO: TFHD Governance Committee

FROM: James Hook, Corporate Compliance Consultant, The Fox Group, LLC

SUBJECT: 2015 Corporate Compliance Program Annual Work Plan

Document: 2015 Corporate Compliance Program Annual Work Plan

SUMMARY: Providing the Board of Directors with a draft copy of the 2015 Corporate Compliance Program Annual Work Plan, outlining the objectives identified for focus in 2015 related to the elements of an effective compliance program using items identified in the 2015 OIG Work Plan and risk areas identified by Tahoe Forest Health System.

1. Policies and Procedures to prevent and detect violations of law
2. Compliance Oversight
3. Education and Training
4. Effective Lines of Communication and Reporting
5. Auditing and Monitoring
6. Enforcing Standards and Promoting Guidelines for Ethical Conduct
7. Responding to Detected Offenses and Corrective Action Initiatives

ACTION REQUESTED

- Review and approval

DISCUSSION

TAHOE FOREST HOSPITAL SYSTEM
CORPORATE COMPLIANCE PROGRAM
2015 TFHS WORK PLAN

Tahoe Forest Hospital System is committed to full compliance with all applicable laws, rules and regulations, and to conduct itself with the highest level of business and community ethics and standards.
Objectives identified for focus in the current year relate to the elements of an effective compliance program as defined in the Federal Sentencing Guidelines, items identified in the OIG's 2015 Work Plan, and risk areas identified by the Tahoe Forest Health System.

			ACTION COMPLETION TARGET				STATUS
OBJECTIVE / ACTION	**Assigned To**	**GOAL**	**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
1. Policies & Procedures							
A. Identify, review and revise P&Ps related to Compliance	CCO	Policy approval		**X**			
2. High Level Oversight							
A. Corporate Compliance Officer provides annual compliance reports to the Governance Committee of the Board of Directors. Report forwarded to the Board.	CCO	Annual report to Board		**X**			
B. Conduct evaluation of Compliance Committee responsibilities and functions	CCO	Revise Committee functions and statutory committee membership; revise Compliance Program Policy.	**X**				
C. Review FMV calculations with ECG to ensure multiple arrangements with individual physicians are considered when establishing FMV.	CCO CEO	Determine revised FMVs, if any; recommend changes to agreements if necessary		**X**			
3. Education, Training, & Communication							
A. Annual Compliance Health Stream training (100% staff complete annual system-wide compliance training in Health Stream)	HR Director Non-Clinical Coordinator	100%					Ongoing
B. Review and revise Health Stream training content related to compliance and HIPAA	CCO HR Director Non-Clinical Coordinator						Ongoing
C. BOD compliance training	CCO	Annual training at Board of Directors	**X**				Completed

TAHOE FOREST HOSPITAL SYSTEM
CORPORATE COMPLIANCE PROGRAM
2015 TFHS WORK PLAN

			ACTION COMPLETION TARGET				STATUS
OBJECTIVE / ACTION	**Assigned To**	**GOAL**	**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
4. Monitor and Audit							
A. Review sample of invoices from ED On-call physicians and Medical Directors to monitor data submitted and compliance with reporting requirements	CCO Med Staff Svcs Dir			**X**			
B. Hospital: Patient admission Criteria (2 midnight rule) (OIG WP)	CNO Dir, HH and Hospice				**X**		
C. Hospital: Patient admission Criteria (96 hour rule) (CAHS Guidance from CMS)	CNO Dir, HH and Hospice					**X**	
D. Hospital: Physician credentialing (OIG WP)	Med Staff Svcs Dir					**X**	
E. Nursing Home: Acute care hospitalizations of nursing home residents for manageable and preventable conditions (OIG WP)	CNO Dir, HH and Hospice					**X**	
F. Home Health Services: Employment of individuals with criminal convictions	HR Director					**X**	
G. Public Health: Contingency Plan for EHR (OIG WP)	Hummel				**X**		
H. Screen all new hires / medical staff / vendors by checking against the OIG and GSA exclusion lists and receive criminal background checks.	HR Director Med Staff Svcs Dir Materials Mgr						Ongoing
5. Response, Investigation, Corrective Action, Reporting							
A. Respond, investigate, and follow up all Hotline calls / complaints within 30 days.	CCO	100% within 30 days					Ongoing
B. HIPAA 2014 annual report of unauthorized disclosures to HHS	HIM Director	Timely Submission	**X**				Completed

TAHOE FOREST HOSPITAL SYSTEM
CORPORATE COMPLIANCE PROGRAM
2015 TFHS WORK PLAN

			ACTION COMPLETION TARGET				STATUS
OBJECTIVE / ACTION	**Assigned To**	**GOAL**	**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
6. Enforcement and Discipline							
A. Enforce Exclusion policy for employees, medical staff and vendors	HR/Med Staff/ Purchasing CCO						Ongoing
7. Responding Promptly to Detected Offenses and Undertaking Corrective Action							
A. Respond, investigate, and report to State and Federal authorities for HIPAA and other Compliance issues	CCO HIM Director	100% timely completion					Ongoing

TAHOE FOREST HOSPITAL DISTRICT

Board Governance Committee
Informational Report

By: Virginia A. Razo
Interim CEO

DATE: 3/5/2015

Quality Matters Consulting Report and Summary document

In April 2012, Tahoe Forest Hospital District entered into an Agreement with Quality Matters Consulting (QMC) to provide education to TFHD's Medical Staff about regulations surrounding Physician Emergency Department (ED) On-call services. At this time, some physicians on the Medical Staff did not feel they were being compensated fairly and requested Administration to evaluate if compensation changes were warranted. QMC provided education to a Medical Staff ED On-call task force about regulations and recommendations published by the Office of Inspector General about Physician ED On-call agreements. The laws, regulations and OIG opinions surrounding Physicians ED On-call Agreements are complex. This summary is not intended to provide a comprehensive review of regulations and recommendation; rather, it is intended to summarize the findings identified in the QMC report, prepared for a Board Governance Committee in April 2013, and how TFHD's current practices are related to the recommendations made by QMC.

Included in your packet is the original report provided by Quality Matters Consulting and a summary document with actions taken by TFHD since this report was generated.

Report to

Tahoe Forest Hospital District's

Board of Directors
Governance Committee

March 12, 2015

Prepared by Virginia Razo, Interim CEO

Issue Identified in Report	Current State of TFHD / Statement
1. QMC report of FMV Assessment	Quality Matters Consulting (QMC) was initially contracted to assess the ED On-call model for providing Physician ED On-call coverage and compensating physicians for on-call services. The work was intended to educate and inform the Medical Staff and TFHD's Senior Leadership about 1. Providing fair, objective methods to compensate physicians for services; 2. Limit the risk of Stark "anti-kickback claims; 3. Assess the on-call needs in quantitative terms; and 4. Determine if the current ED On-call model is consistent with TFHD's mission, vision and values. In the course of conducting its work, QMC compared contracts for Physician ED On-call Agreements against six national physician compensation surveys. However; it did not use a recognized, systematic, proven approach to draw conclusions that TFHD may be compensating above FMV for Physician ED On-Call serves for Anesthesia, Family Practice, General Surgery, Hospitalist, and Ophthalmology, as stated in the April 2013 QMC report. Because QMC raised this issue, TFHD engaged compliance legal counsel who contracted with an industry leader, ECG Management Consultants, to perform a comprehensive FMV analysis for all Physician ED On-call Agreements. The results of their findings did not find any of the Physician ED On-call Agreements to be paid above FMV.

Issue Identified in Report	Current State of TFHD / Statement
2. When developing anPhysician ED On-call program there are a number of items (listed on page 3 & 4 of report) that require quantification and documentation AS RECOMMENDED by CMS and the OIG.	The Department of Health and Human Services has promulgated safe harbor regulations that define practices that are not subject to the anti-kickback statute because such practices would be unlikely to result in fraud or abuse. See 42 C.F.R. § 1001.952. The safe harbors set forth specific conditions that, if met, assure entities involved of not being prosecuted or sanctioned for the arrangement qualifying for the safe harbor. However, safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the safe harbor. The safe harbor for personal services and management contracts, 42 C.F.R. § 1001.952(d), potentially applies to this Arrangement. This safe harbor provides protection for personal services contracts if all of the following seven standards are met: (i) the agreement is set out in writing and signed by the parties; (ii) the agreement covers and specifies all of the services to be provided; (iii) if the services are to be performed on a periodic, sporadic, or part-time basis, the agreement exactly specifies the schedule, length, and charge for the performance intervals; (iv) the agreement is for at least one year; (v) the aggregate amount of compensation is set in advance, is consistent with fair market value in arm's-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made by Medicare, Medicaid, or other Federal health care programs; (vi) the services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law; and (vii) the aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services. (Excerpt from OIG Advisory Opinion No. 12-15 of October 30, 2012) TFHD continues to review contracts for compliance.
3. Commercial Reasonableness	According to Hooper, Lundy & Bookman, TFHD's legal counsel for compliance related matters, all ED On-call Agreements in effect in 2013 and now are within FMV and commercially reasonable.

<table>
<tr><th>Issue Identified in Report</th><th>Current State of TFHD / Statement</th></tr>
<tr><td>4. Current State:
More hospitals are requiring physicians to document the number of phone calls, the number of ED patients they care for while on call and number of surgeries / procedures while on call</td><td>Since this report TFHD has taken the following steps to capture ED On-call consultations:
TFHD invested in electronic medical record technology (T-System) and this allows data capture forPhysician ED On-call consultations.
Staff and Medical staff were educated to the data capture fields required to capture data regarding ED On-call services and are utilizing the T-System.

During the last quarter of 2014 on-call physicians were consulted by the ED as follows:

<table><tr><th>Month</th><th>Consults</th><th>Admissions</th></tr><tr><td>Oct</td><td>154</td><td>57</td></tr><tr><td>Nov</td><td>148</td><td>63</td></tr><tr><td>Dec</td><td>225</td><td>107</td></tr></table></td></tr>
<tr><td>5. No call schedule is provided although call pay is provided to Ophthalmology, Plastic Surgery and Dental</td><td>Since this report TFHD changed its practice to require a call schedule be generated and posted in the ED for all Physician ED On-call services where TFHD pays for professional services.</td></tr>
<tr><td>6. Policy ABD-10 does not state who maintains the call schedules or how the organization responds when there isn’t a specialty available.</td><td>Although policy ABD-10 does not include this language, policy DED-20; Notification of On-Call Physicians, section 1.0 does state that TFH will maintain a list of physicians who are on-call for admissions. It also describes how the schedule is generated and maintained. Lastly, it also states what is to occur if a specialist is unavailable to cover an ED On-call shift.</td></tr>
</table>

Issue Identified in Report	Current State of TFHD / Statement
7. Stated in report: medical staff office retrieves call schedule and develops invoices for each physician according to call schedule	Invoices for ED On-call services are generated by the Medical Staff office, from the ED On-call schedule. Invoices are presented to provider and provider then reviews and signs the invoice or sends an electronic signature via email with an attestation that he/she provided the services listed on the invoice. Payments are not made until such documentation is obtained by providers.
8. Tracking methodology for On-call limited	The ED electronic record, T-System, captures consultations requested by the ED medical staff of On-Call physicians. Data is currently collected and will be incorporated into an annual report to the Board of Directors during the 4th quarter, FY 2015.
9. Data Elements for FMV	TFHD has been working with legal counsel who engaged ECG Management Consulting to conduct a comprehensive FMV assessment of all Physician ED On-call Agreements. ECG uses a standardized method to determine if an Agreement is being paid with FMV. Using this method, all Physician ED On-call agreements were found to be within FMV.
10. Unmet need	TFHD does capture ED payer mix data. Total charity care provided by the District is captured and reported to the BOD regularly through finance reports. In addition, TFHD is located in a federally recognized healthcare professional shortage area. Payer mix for TFH ED: FY 2013 Medicare 18.60% Medi-Cal 9.30% County 2.10% Other 17.40% Commercial 52.70% FY 2014 Medicare 19.10% Medi-Cal 12.60% County 1.40% Other 15.40% Commercial 51.50%

Issue Identified in Report	Current State of TFHD / Statement
11. Although QMC documents unmet need, historical precedence and call burden, none of this information is considered in the compensation analysis. QMC concluded that some specialties were paid above the median of 5 or 6 surveys, but did not have a method to weigh the other factors	FMV analysis has been completed by a qualified organization (ECG) for all Physician ED On-Call Agreements. All Physician ED Call Agreements were found to be within FMV per ECG. ECG used a standardized method to determine if Agreements met FMV.
12. When only looking at compensation surveys, TFHD was found to compensate physicians above the median for Anesthesia, Family Practice- Medicine, Internal Medicine-Medicine, General Surgery, Hospitalist,	TFHD no longer has Physician ED call agreements with Anesthesia, Family Practice or Internal Medicine. The Hospitalist Agreement with a Hospitalist Company was terminated shortly after this report. Contrary to the QMC report, ECG found Physician ED On-call Agreements for General Surgery, Ophthalmology and Hospitalist Agreements all to be within FMV.

Issue Identified in Report	Current State of TFHD / Statement
and Ophthalmology	
13. Paying above market Value	ECG has confirmed that all Physician ED On-call Agreements are within FMV.
14. Paying for call without a defined call schedule	TFHD only pays for Physician ED On-call services if the physician is on a call schedule posted in the ED and the physician attests to having provided the services for which payment is sought.
15. Concurrent Stipends for Med Director and ED Call	TFHD has included the auditing of concurrent stipends in its 2015 Compliance work plan to determine if this practice is actually occurring. This work will be completed before the end of June, 2015 and reported to TFHDs Compliance Committee and Board of Directors.
16. Double payment for Employed physicians	TFHD does not employ physicians. MSC Internal Medicine and Cardiology are part of hospitalist agreement and are not paid for both services during a 24 hour period. RVUs for work performed by MSC physicians as hospitalists is credited to MD productivity, while non-MSC physicians bill and collect independently for professional fees for ED On Call services.
17. Preferential Treatment	The RVUs credited to MSC physicians performing duties as hospitalists or for ED on-call services are Work RVUs, which reflect only the physician effort, and do not account for practice overhead expenses. Therefore, the incorporation of WRVUs for hospitalists or other MSC physicians providing ED on-call services is an appropriate method for compensating these physicians.
18. Documentation process included in contract development	TFHD contract development is described in policy ABD-21, Physician and Professional Service Agreements. TFHD has included auditing for compliance with its policy in its 2015 Compliance work plan.
19. Legal counsel does not review contracts each year	Since this report, all Physician ED On-call Agreements were reviewed by legal counsel to ensure Agreements are within FMV, commercially reasonable and compliant with regulations.
20. Contracts auto renew	TFHD Board Governance Committee reviews all auto-renew contracts annually. Since working with legal counsel, and when appropriate, TFHD is moving away from physician contracts that auto-renew and is looking to place an appropriate term, not to exceed 3 years into new Agreements.
21. On-call Responsibilities	Physician ED On-call responsibilities are defined in the Medical Staff Bylaws and are described in all professional service contracts.
22. Charity Care Policy	Process for physicians to receive payment for uninsured patients requires the hospital verify patient does not qualify for any 3rd party payment. If qualified, TFHD assists patients in the enrollment period. TFHD

Issue Identified in Report	Current State of TFHD / Statement
	only pays MDs for those patients who do not qualify for any third party payment, Medicare, Medicaid or commercial plan.

Tahoe Forest Hospital District

ED On-Call System
Fair Market Value Assessment

QualityMatters
Emergency Medicine Consulting

3267 East 3300 South #122
Salt Lake City, UT 84109
(888) 916-6226

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Executive Summary

Tahoe Forest Hospital District (TFHD) leadership contracted with *Quality Matters Consulting* to perform a Fair Market Value (FMV) assessment of physician on-call reimbursements in April 2012. This was part of a larger project involving an assessment of the current on-call system at TFHD. This report will assist the executive and medical leaders in designing a transparent and equitable program that meets the needs of the community and the medical staff. It will also ensure that the new on-call coverage system is compliant with OIG standards and other regulations.

Reimbursed ED on-call coverage is a new phenomenon in healthcare: Historically physicians provided call coverage to hospital emergency departments (EDs) on an uncompensated basis.[1] Medical staff bylaws and specific departmental rules and regulations frequently required physicians to take ED call as a condition of 1) membership on the medical staff, and/or 2) the granting and renewal of clinical privileges. Junior physicians joining the medical staff of a hospital often would be obligated to provide the majority of a hospital's on-call coverage, but often found this would allow them to build their practices. More than half of emergency departments were reporting a crisis in ED call coverage by 2007, however, and were paying stipends to at least one specialty.[2] A study from Yale University revealed that three-fourths of EDs were experiencing problems maintaining ED on-call panels by 2010, and many had lost coverage for certain specialties requiring the transfer of patients to receive appropriate care.[3] Nearly two-thirds of healthcare organizations provide call pay to at least some physicians.[4] California has been particularly hard hit by this problem. The state is in a deep recession, and unemployment has topped 12%, leading to growing ranks of uninsured who delay seeking urgent care, and this hurts hospital's bottom line.[5] Eighty percent of emergency physicians in California reported that the reluctance of specialists to respond to call doubled between 2000 and 2006.[6]

A confluence of factors has reduced the willingness of physicians to serve on ED call panels without some form of payment. These include:

- Increasing numbers of uninsured patients who receive their only healthcare in the ED.
- The aging of active-staff physicians (who often opt out of on-call coverage past a certain age as mandated by hospital bylaws).
- Rising malpractice premiums.
- Falling reimbursement for physician services.
- A perceived risk of lawsuits, particularly with respect to uninsured or under-insured patients who present to the ED.

Against this backdrop, hospitals have struggled to ensure adequate physician call coverage in accordance with the requirements of EMTALA (the federal Emergency Medical Treatment and Labor Act) and state licensing requirements. ED on-call violations are now the number one violation that initiates an inspection by the federal government under EMTALA. A potential or actual violation can be very costly to the hospital and physician as they march through an investigation. The associated penalties if a violation is substantiated can be severe. As a result, there has been a marked increase in the willingness of hospitals to pay physicians to provide call coverage for emergency patients.

Prior to developing an on-call program or initiating a contract with a provider, there are a number of items that require quantification and documentation as recommended by the Center for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG)[7]:

1. There must be an unmet need for on-call coverage and indigent care services.
2. The likelihood that the on-call physician will have to provide care to an uninsured ED patient is documented.
3. The severity of illness the physician in that specialty typically treats when on-call for the ED is quantified.
4. The physician time associated with that specialty is documented.
5. The burden of call for each service is documented.
6. The willingness of physicians to take call is noted.
7. The ED payer mix by specialty is documented.

8. The ED call volume by specialty is quantified.
9. The Agreement terms are determined.
10. The reason for on-call pay is documented.
11. The actual services provided are documented.

Commercial Reasonableness must be established by the hospital as a legitimate business need prior to the implementation of any on-call reimbursement arrangement.[8] Commercial reasonableness depends upon whether the purchased services have intrinsic commercial value to the purchaser, are reasonably calculated to further the business of the purchaser, and are services the purchaser needs.[9] Documentation should be developed that not only includes the need for commercial reasonableness, but also instances when a service is not considered by the hospital to be required and therefore not reimbursed. Commercial reasonableness could include difficulty in maintaining on-call panels because of:

- High numbers of Medicare/Medicaid patients.
- High numbers of uninsured patients.
- High frequency of ED on-call events.
- Limited numbers of physicians in a specialty available to take call.

Regulatory requirements must be met when developing and deciding which specialty a hospital should reimburse for ED call coverage. The most important requirement is that the hospital does not give the appearance of using the call stipend to entice a physician or group to bring business to the hospital. This philosophy also applies to the physician or group: The physicians cannot demand call compensation under threat (expressed or implied) of taking patients to another facility. The on-call process should clearly document the need for each compensation agreement. Contracts should clearly document what the call compensation covers.

Regulatory Considerations

Consider these regulations when developing an on-call program:

- EMTALA
- Stark Law
- Anti-Kickback Statute
- Federal tax code and State tax code
- Office of the Inspector General (OIG) Advisory Opinions

EMTALA

EMTALA requires that any patient presenting to a dedicated emergency department receive a medical screening exam to determine whether an Emergency Medical Condition (EMC) exists. EMC is defined by the statute and not by the general clinical definition. The federal government defines EMC as a condition with acute symptoms (includes severe pain) that without treatment could result in:

- Serious jeopardy to health of the individual or unborn child.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

An EMC must be provided for within the capabilities of the dedicated ED without taking into consideration the patient's ability to pay for such services. EMTALA is the regulation most tied to the need for an on-call system. EMTALA (42 USC 1395dd) requires the hospital to stabilize and provide medical screening within the capability of the ED and to have a list of on-call physicians. The EMTALA definition of "stabilized" is also very specific: "To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described (above)."[10] Under EMTALA, physicians are allowed to schedule surgery and have simultaneous on-call duties while participating in hospital on-call programs.

Failure to respond or failure to respond in a timely manner, however, puts the hospital *and* the physician at risk for EMTALA violations. Violations of EMTALA can result in:

- Loss of Medicare provider agreement.
- Hospital fine $25,000 (fewer than 100 beds) per violation.
- Physician fine $50,000 per violation.
- Civil monetary penalties for hospital, physician, and nurses.
- Personal injury lawsuit.
- Lawsuit from receiving hospital against sending hospital.
- Costs related to the OIG investigation.

The EMTALA Interpretive Guidelines in State Operations Manual, Appendix V, clarifies that the hospital must maintain a list of on-call physicians to provide stabilizing treatment and that physician's names must be identified (not a group practice) on the on-call list. EMTALA also requires that the hospital inform patients of their rights to a medical screening exam, keep a central log indicating all patients treated and their disposition, enforce an EMTALA compliance policy, and maintain records of patients transferred for five years.[11]

The Stark Law

The Stark Law is, in a nutshell, a prohibition of Physician "Self-Referrals." It prohibits a physician from referring Medicare patients for furnishing certain types of healthcare services called designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship. The physician is also prohibited from filing a Medicare claim for services arising from a prohibited self-referral. It also articulates the manner in which physicians will be reimbursed for services.

The Stark Law definition of Fair Market Value: *"The Stark law generally requires remuneration to be set at fair market value and not determined in a way that takes into account the volume or value of referrals to the entity. The Stark statute defines "fair market value" as the value in arms-length transactions, consistent with the general market value."*[12] General market value is the price an asset or service would bring during negotiating between well-informed buyers and sellers. In layman's terms, an "arms-length transaction" is one between a buyer and seller where both are acting in their own best interests to get the best price. Presumably, the seller wants the highest price possible, and the buyer wants to pay the least possible. This ends up determining the fair market value of the transaction. The majority of private-party real estate transactions proceed in this way. An example of a deal that is *not* an arms-length transaction would be a father selling his home to his son. In that case, the father would likely give the son a large discount, and the home would sell far below market value.

Because on-call programs do not fall into the typical hospital employment models, it can be difficult to conduct an exact fair market value analysis. Stark does, however, give some guidelines for what to consider for an ED on-call program. First, determine what is actually required of an on-call physician including whether the physician is required be on-site at the hospital. Second, base a physician's on-call pay on that of other physicians of the same specialty in the geographic market or develop a payment based on specialty physician salaries. Third, incorporate past experience with on-call requirements for a particular specialty. Finally, make the on-call physician hourly payment comparable with an employed physician's hourly rate.

The Stark Law restricts a designated health service (DHS) and a referring physician from having a financial relationship unless it meets an exception. Call coverage agreements can be deemed a financial relationship between the hospital and physician. Statutory and regulatory exceptions that may protect on-call arrangements are:

- Direct compensation personal services.
- Bona fide employment relationships.
- Fair Market Value.
- Indirect compensation arrangements.

Within the framework of these exceptions, the following conditions must be met:

- There must be a signed agreement with a one year contract term.
- It must be commercially reasonable.
- The compensation must be set in advance and consistent with FMV, and it cannot take into account volume or value of referral.
-

Further understanding of Fair Market Value can be gleaned from three OIG Opinions which are mentioned later. Civil penalties can be incurred when violations of the Stark Law are found including denial of payment, refunds of amounts collected in violation of the law, up to $15,000 in civil monetary penalties per violation, up to $100,000 in penalties for each arrangement "scheme" that violates the law, a civil monetary penalty of up to three times the amount claimed, or exclusion from participation in Medicare or other government health programs.

The Federal Anti-Kickback Stature (AKS)

The federal Anti-Kickback Statute (AKS) for healthcare is a broad criminal statute that prohibits providers from knowingly and willfully receiving or providing reimbursement in exchange for referrals or items of value. Providers are defined as hospitals and physicians. Hospitals cannot entice physicians by paying a stipend to increase referrals, nor can physicians demand the hospital pay a stipend to them to keep cases/business at that hospital.

Physicians contracting to provide on-call services and coverage for hospitals may order items and services paid for by governmental healthcare programs, which in turn may implicate federal and state AKS statutes.[12,13] Akin to the exceptions in the Stark Law itself, the AKS provides safe harbors that provide a way to compensate physicians for on-call services. Although on-call and coverage payments to physicians constitute remuneration, federal statutory and regulatory safe harbors limit the statute's reach by permitting certain non-abusive arrangements. AKS safe harbors include employment and personal services and management contracts. On-call arrangements that potentially fail the personal service and management contracts safe harbor elements include part-time arrangements. Additionally, safe harbor requires that services be predictable and prescheduled and state at the outset the total amount of compensation to be paid as a liquidated sum.

State and Federal Tax Code

Federally, tax-exempt entities contracting with physicians for on-call and coverage services must ensure that those arrangements do not result in private inurement or convey "more than an insubstantial private benefit" to avoid jeopardizing the entity's tax exempt status.[14,15] Payment of taxes, loss of associated tax-exempt bonds, and intermediate sanctions could be incurred. The entity can also risk an excise tax because of an excess benefit transaction. Another potential issue that requires clarification from the IRS is the employment status of the physician providing ED on-call. Two private ruling letters from the IRS address this employee versus independent contractor status (PLR 9335055 & PLR9410041), and this affects on-call arrangements.

Office of the Inspector General (OIG) Advisory Opinions

An advisory opinion is an opinion by the government about whether a physician referral arrangement is prohibited by the Stark Law. Such opinions are very fact specific and are binding only on the Secretary of DHHS and the requesting party. Still, they provide guidance when trying to develop reimbursement models for on-call services that are Stark-compliant. Fair Market Value remains an area of vulnerability for hospitals and other health care organizations, partly because it is so complex. The OIG's definition of fair market value has two critical stipulations. The FMV should involve actual and necessary items furnished or services provided based upon an arm's-length transaction and should not take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties.

The OIG cautions hospitals to consider the following to avoid potential risk of fraud and abuse:

- FMV is developed in an arm's-length transaction.

- A more conducive arrangement is not available.
- Cannot take into account the value or volume of any past or future referrals.
- Compensation methodology is used, applied, and documented.
- Compensation matches the skill level and experience required for services provided.

Three OIG Advisory Opinions have been rendered in recent years that affect on-call compensation arrangements:

OIG Advisory Opinion 07-10 (Sept. 20, 2007)[16]: Compensating physicians on a per diem basis is the most common system for reimbursing for on-call services. This advisory discusses physicians receiving a per diem daily rate to be on call for the ED. Issues with this type of compensation that may put the hospital at risk include:

- "Lost opportunity" payments that do not reflect bona fide lost income.
- Payment structures that compensate physicians when no identifiable services were provided.
- Disproportionately high on-call payments, unrelated to the physicians regular practice income.
- The on-call physician receives compensation from the hospital and then receives separate reimbursement from the insurer or patient, resulting in the physician being paid twice.
- Agreements that fail to include on-call obligations and timely response definitions.
- Physicians within the specialty having unequal opportunity for on-call coverage and compensation.
- Call coverage that is not administered uniformly.
- Physicians suggesting that unless they receive compensation they will not do business with the hospital.
- The hospital offers on-call to entice physicians to bring patients to them.

In this same advisory, the OIG considered the following factors to place the parties at *low risk* if considered during the FMV:

- An independent review for FMV is conducted.
- The per diem rate is designed to compensate each physician based on the burden of being on call.
- The likelihood that the physician would be required to provide inpatient care is considered in the FMV determination.
- Physicians in each specialty receive the same per diem rate without regard to referral patterns or business generated from that physician.
- On-call physicians are "obligated" to provide follow-up care to the ED patient no matter the patient's ability to pay.
- There must be an unmet need for the on-call coverage and indigent care services. This can be determined by the need to transfer patients to another facility.
- Eighteen days or more of uncompensated call per year was provided by the subject physicians.
- The likelihood that the on-call physician will have to provide care to an uninsured ED patient is incorporated into the payment process.
- The severity of illness the physician in that specialty typically treats when on-call for the ED is factored into the system.
- Physician time associated with specialty is considered in FMV determinations.

The second advisory provided more guidance for hospitals and physicians regarding on-call arrangements.

OIG Advisory Opinion 09-05 (May 14, 2009)[17]: This advisory is a favorable review of payment arrangements that require the physician to waive rights to bill for the services rendered. This opinion involved very low reimbursement: $100 ED consultant, $300 ED admission, $350 ED surgical procedure.

OIG Advisory Opinion 12-15 (Oct. 30, 2012)[18]: This opinion approved an arrangement that provided per diem payments to physicians for providing on-call coverage. The advisory addresses an existing arrangement under which a hospital pays a per diem fee to physicians for providing on-call coverage for the hospital's emergency department.

The OIG found that the arrangement described in the advisory would not constitute grounds for imposing sanctions under a variety of federal laws, including the Federal Anti-Kickback Statute. Under the arrangement described in the advisory, a hospital pays a per diem fee to specialist physicians to provide unrestricted call coverage for the emergency department. All specialists on the hospital's medical staff are offered the opportunity to participate in the call arrangement. Physicians who elect to participate in the program enter into one-year written agreements containing automatic renewal provisions, under which they agree to serve on the call coverage panel. The arrangement is limited to specialists who are only required to provide "unrestricted call" that does not require physical presence at the hospital during the call time but requires availability within 30 minutes. Physicians who participate must agree to provide the inpatient care required by any patient admitted by the physician. The participating physician is also required to provide certain follow-up care in his office following discharge of the patient. A uniform methodology is used by the hospital to allocate call coverage equitably among participants within each specialty. Physicians are monitored for compliance with the program requirements.

The hospital compensates physicians who agree to participate in the program on a per diem fee. A fixed amount is allocated to the call program, and is divided by 365 to determine the daily fee. Physician participants in the call program are paid the per diem fee regardless of whether they are actually called or consulted during the day that they are on call. The hospital also hired an independent consultant to evaluate the per diem rates and certified that the per diem rates paid under the arrangement are commercially reasonable and fair market value for the services provided. The hospital certified that the program was created because of a shortage of experience in Neurosurgery and Neurology and because many members of its medical staff no longer wished to take call for a variety of reasons. Although the advisory is only binding to the requesting party, it does provide some insight into the factors that the OIG considers when examining the structure of "call pay" arrangements.

The Tuomey and Bradford Cases

Two other recent court cases involving fair market value and Stark allegations are worthy of quick review as they affect physician compensation agreements.

Tuomey Hospital in Sumter, S.C., paid $49.4 million for violating the Stark Act. In April, a federal jury ruled that Tuomey Hospital violated the Stark Act because of employment contracts it held with physicians at its Outpatient Surgery Center. Tuomey employed surgeons part-time through a new wholly-owned LLC to provide surgery at Tuomey's new outpatient surgery center. Agreements were 10 years long, and required the employed surgeons to exclusively perform outpatient surgery at the Tuomey outpatient surgery center; Surgeons were paid in excess of 100% of collections. The health system has since appealed the ruling that awarded the government $49.4 million, arguing its actions were consistent with guidance by CMS for complying with the Stark Law. The American Hospital Association has joined in Tuomey's cause by filing an amicus brief in support of the health system. The takeaway points:

1. If a proposed arrangement appears to have been developed in response to the fear of losing a referral stream, the government may look closely at issues of commercial reasonableness.
2. Long-term arrangements should be reviewed periodically for compliance.
3. Providers cannot blindly follow a fair market value or commercial reasonableness determination.

Bradford (Penn.) Regional Medical Center under fire for allegedly violating the anti-kickback statute. In November, a federal judge found BRMC guilty of violating the federal Stark Act by entering into an illegal financial relationship with two physicians and their medical practice and for submitting claims to Medicare based upon referrals from them. V&S Medical Associates was a physician group and a significant source of referrals for Bradford, including referrals for nuclear testing. In 2001, V&S leased a nuclear camera from GE, which was maintained at V&S' offices. Bradford threatened the physicians with the loss of staff privileges, arguing that the lease violated a hospital policy on physicians having competing financial interests. To resolve the dispute, V&S and Bradford entered into a sublease agreement (with a noncompete provision) in October 2003. According to the prosecution, a lease agreement between the hospital and the two physicians was not a bona fide sublease of equipment needed by the hospital, which already had its own nuclear camera, but was instead a disguised attempt to pay the physicians for patient

referrals. A jury must decide whether the defendants possessed the necessary intent to be liable under the anti-kickback statute. While no decision has been made about whether BRMC indeed violated the anti-kickback statute, the presiding judge in the Stark Act case stated the hospital will find it difficult to prove they did not possess intent. The takeaway points:

1. A hospital may not be able to allocate payment to noncompetes and other intangible assets when entering into financial arrangements with physicians.
2. Fair Market Value should be based on Stark law definitions.
3. Valuations that consider anticipated referrals may be subject to challenge.

All of these recent decisions have relevance to systems for on-call payment, and will come up in this analysis.

Current State

Methods of Compensation

Overview: Hospitals utilize a number of different methods to pay physicians to take emergency department call.[19] The "per diem" method, however, remains the most common. In addition to a "per diem" payment by the hospital for emergency department on-call pay, most non-employed physicians are retaining the professional fees generated while on-call. Furthermore, some clients choose to put a portion of the "per diem" at risk to ensure certain quality metrics are achieved.

Given that most organization's medical staff bylaws require physicians to take emergency department call, call is generally more frequent than one in four nights before any call pay is considered. In addition to considering national benchmark call pay survey data, a number of factors can affect on-call rates, including but not limited to local market rates, frequency of call, severity of illness encountered while treating patients, likelihood of having to respond when on-call, degree of inpatient care required, payer mix, and malpractice risk.

Given recent advisory opinions on-call pay practices, more hospitals are now requiring physicians to document the number of phone calls received while on call, the number of visits they receive while on call, and the number of surgeries they perform. The time incurred for each of these activities is often included as well. Hospitals have various options for structuring on-call compensation arrangements and the structure of a particular compensation arrangement.

Common Structures: The most common structures for on-call compensation arrangements are set forth in the following section:

1. *Per Diem/Shift Compensation:* This is considered to be the most common structure for compensated on-call arrangements. Typically compensation covers a 24-hour period but may cover 12- or 24hour shifts. In some cases, differentials are made for weekends or holidays, and this is thought to be in keeping with OIG Advisory Opinions. In high-volume specialties, some arrangements provide an on-call stipend for telephone triage.
2. *Fee-for-Service Payments for Care to Unfunded Patients:* Hospitals may pay for services provided to unfunded ED patients using a percentage of the Medicare allowable rate (adjusted for the hospital's region) or an hourly rate based on the time spent delivering services (although this is uncommon because it is difficult to determine). In some cases, a pool of funds is created and divided into quarterly payments based on the amount of unfunded care provided.
3. *Per Diem/Shift Plus Fee-for-Service Payments for Care to Unfunded Patients:* In this hybrid model, the Per Diem rate is lower because it is combined with fee-for-service for actual care delivered, generally calculated as a percentage of the Medicare allowable reimbursement for that particular care.
4. *Activation Fees:* Hospitals may elect to compensate physicians only for those on-call days when the physician is actually required to present at the hospital to respond to an on-call event. If the physician is on call but is not required to be present at the hospital, the physician receives no compensation for the on-call

day. An activation fee is payable only once per day. This is a good model for specialties with a low incidence of on-call hospital presence, but it does not acknowledge the "weight" of carrying the beeper, that is, the physician must remain within 30 minutes of the hospital, must consume no alcohol, cannot engage in certain social activities, etc.

5. *Per Diem Plus Activation Fee:* Some hospitals use this hybrid model. The per diem is generally set lower than a straight per diem model, and the activation fee is also lower than a straight activation fee model. This is generally more acceptable to physicians because they are compensated for beeper burden.
6. *Hospitalist Programs to Reduce Coverage Needs:* Hospitals may use a combination of employed physicians and independent contractor hospitalists to assist in meeting on-call coverage needs. In most cases, hospitalists provide call for appropriate specialties when other physicians are unavailable without compensation.
7. *Paying for Concurrent Coverage at Multiple Facilities:* Hospitals that have multiple campuses in close proximity may pay for a single specialist to cover multiple sites. This model has the advantage of requiring a smaller pool of physicians and less call for physicians, but the days on call will be more clinically intense for the provider and therefore command a higher per diem while still costing the hospital system less to maintain.
8. *In Kind Compensation:* Some hospitals are covering malpractice insurance or professional fees as part of a reimbursement strategy for on-call services. Some are setting up deferred taxations retirement instruments to compensate physicians.

Trends

Of the six surveys we employed for comparative analysis, only the SullivanCotter Survey polled its participants on related reimbursement issues.[20] Participants reported:

- 63% have experienced difficulty finding physicians to provide on-call services.
- 7% have had to shut down one or more services because of the lack of physicians available for on-call coverage.
- 86% employ physicians to provide on-call coverage.
- 23% use locum tenens to provide on-call coverage.
- 72% of non-employed physician always retain the professional fee.
- 88% of survey participants indicate that on-call pay is fully funded by hospital.
- Physician extenders are employed by 68% of the survey participants, of which 38% of the physician extenders provide on-call coverage.

According to SullivanCotter, the top five reasons survey respondents are exempted from on-call duties are:

- Age (71%).
- Courtesy/consulting privileges only (61%).
- Length of service (39%).
- Administrative responsibilities (25%).
- Individual basis (7%).

Table 1 indicates the different practices used in compensating non-employed physicians for being on call. The use of a formal process to develop an on-call system is used by 55% of the survey participants, but only 10% of the survey respondents use a FMV to determine the compensation. Table 2 indicates the variables used by the survey respondents when determining compensation for on-call coverage.

Table 1. Methods for Compensating Physicians for On Call

Practices Used to Compensate Non-Employed Physicians for Providing Care When Called In	Percent[a]
No compensation	56%
Subsidy for unassigned/uninsured patients	25%
Hourly rate	16%
Response rate/activation fee/fee-for-service payment	10%
Payment based on RVUs	10%
Subsidy for malpractice insurance	5%
Other	3%
[a]Totals more than 100% because of overlapping practices.	

Table 2. Variables Affecting On-Call Rates

Variables Impacting On-Call Rates	Percent[a]
Local market rates	79%
National market rates	75%
Frequency of call	61%
Likelihood of being called in when on call	51%
Acuity and intensity of care provided when on call	46%
Payer mix	33%
Amount of inpatient follow-up required	19%
Malpractice risk	15%
Other	3%
[a]Totals more than 100% because of multiple response categories.	

Common Compliance Issues

Below are key compliance issues for ED on-call coverage:

- Compensating targeted specialties vs. all specialty compensation.
- Documentation supporting ED on-call services: Call schedule and physician certification of call services provided.
- Paying for call without a defined call schedule.
- Paying for "backup" call when the call frequency does not support it.
- Paying for call when service is considered a normally compensated service (i.e., EKG interpretations).
- Double payment: Most providers keep the payer's reimbursement, but this has the potential to be considered a double payment.
- Medical directorship: Paying for on-call services when the physician is already collecting a medical director stipend is considered a risky arrangement.

Employed physicians can mean additional compliance issues in an on-call system:

- Call pay cannot be concurrent with other services such as clinical or medical director services.
- Most call requirements for employed physicians are for weekend and night coverage only.
- Paying for call coverage through physician contracts and paying again with stipends.

- Consideration should be given to the differences in overhead requirements from an employed to an independent physician. (If call pay is the same for employed physicians and independent contractors, then the employed physician is receiving a higher FMV.)

Current Process at TFHD

TFHD does not have a centralized call sheet; instead each specialty has its own monthly calendar. The monthly call schedule development varies from service line to service line. The department chair, however, is ultimately responsible for the call schedule. The ED maintains the call schedule once it has been posted. A physician is assigned to take call from the ED for each of these services: Medicine, OB/Gyn, Pediatrics, Orthopedics, Surgery, Anesthesia, and Radiology.

No call schedule is provided for the following specialties, even though call pay is provided: Ophthalmology, Plastic Surgery, and Dental. These specialties do not receive an on-call stipend even though uncompensated call is often provided for unassigned patients on emergency and semi-urgent bases: Pulmonology, Cardiology, and Critical Care Medicine.

Hospital Policy

The Emergency On-Call Policy (#ABD-10) was originally drafted and approved by the Board in 2001, and applies to the TFHD system at large. It is a fluid and regularly updated policy, responding to the changing needs of the community. It was revised in March 2008, February 2010, and January 2012. Section 4 gives the CEO a number of options for trying to maintain the on-call coverage for which the hospital has committed in the policy. The policy has been excerpted below:

Purpose: Tahoe Forest Hospital Districts has an ethical, moral, social, and legal responsibility to serve emergency patients. The Board understands, based on EMTALA and CMS regulations, that federal law requires hospitals to provide on-call physicians in appropriate specialties.

Policy:

1.0 Patients who present to the Tahoe Forest Hospital District facilities are entitled to timely, quality emergency consultative services regardless of their ability to pay.

2.0 The District's Board of Directors, Administration and Medical Staff leadership will work collaboratively to determine the District's capabilities for providing 24-hour emergency health care.

3.0 Tahoe Forest Hospital District operates Tahoe Forest Hospital and Incline Village Community Hospital.

3.1 Tahoe Forest Hospital, a Critical Access Hospital that has been designated by the State of California as providing "basic" emergency services, will provide 24-hour physician coverage for emergency consultation and services for these specialties to the best of our capabilities:

- 3.1.1 Emergency Medicine
- 3.1.2 General Medicine
- 3.1.3. General Surgery
- 3.1.4. Radiology
- 3.1.5. Anesthesia
- 3.1.6. Pathology
- 3.1.7. OB/Gyn
- 3.1.8. Pediatrics
- 3.1.9. Orthopedics

3.2 Incline Village Community Hospital, Incline Village, Nevada, will provide 24-hour physician coverage for Emergency Medicine Services.

3.3 Other specialties will provide on-call coverage for emergency consultations and services according to the capabilities of that specialty.

4.0 The Chief Executive Officer will work with the Medical Staff to provide emergency consultative coverage that meets federal and state laws, our licensing requirements and the needs of our community. To achieve these goals, the Chief Executive Officer may utilize, but not be limited to:
- 4.1 Stipends for call coverage.
- 4.2 Contracts for professional services.
- 4.3 Locum tenens privileges.

5.0 Transfer agreements with other healthcare facilities.

6.0 At least annually, Tahoe Forest Hospital District Board of Directors will review and approve the level of on-call services available.

7.0 To provide this coverage, every effort will be made to create a system that is voluntary, fair, and equitable without imposing an undue burden on physicians or on the Tahoe Forest Hospital District. Collaboration with current members of the Tahoe Forest Hospital District's Medical Staff will be the preferred method for providing these services, with recruitment of new physicians as needed.

8.0 Physicians who seek charity care fund reimbursement at Medicare rates for emergency services provided in the hospital to indigent patients should refer to *Financial Assistance Program Full Charity Care and Discount Partial Charity Care (ABD-09)* for guidance and distribution criteria. Tahoe Forest Hospital District will keep abreast of other funds, state or otherwise, that might be available for the purpose of providing payment to physicians who treat the under-insured population.

9.0 We will utilize the hospital's quality assurance system to monitor emergency on-call practices with annual reports to the Board of Directors on the actual call coverage, effectiveness of these practices, as well as physician, patient and employee satisfaction.

10.0 A roster and procedure are in place to address the provision of specialty medical care when services are needed that are outside the capabilities of the Tahoe Forest Hospital District and its Medical Staff.

The written process does not address who maintains the call schedules once drafted or how the organization responds when there is not a specialty available. The medical staff office retrieves the on-call schedules from the ED for the previous month. Invoices are developed for each physician for the number of times they were called from the schedules and submitted for monthly payment by the medical staff office.

Medical Staff Rules & Regulations

The Medical Staff Rules and Regulations that involve ED on-call coverage are included in the following excerpts below. Section 4.18-4 indicates that difficulties and conflicts over providing on call to unassigned patients have occurred and rules were drafted for the real time management of these problems:

4.18-2 Medical Staff members shall provide call coverage according to schedules drawn up by the IVCH Medical Director for IVCH and by the Chiefs of the Anesthesia, Medicine, OB/Pediatrics and Surgical Departments for Tahoe Forest Hospital District.

4.18-3 A physician on call, upon being called for an acute emergency patient, must respond and be present in the Hospital within 60 minutes. Those physicians who do not respond appropriately may be removed from the call schedule by their Department.

4.18-4 Should a difference of opinion exist between the referring emergency physician and the on-call doctor as to patient management and disposition, the emergency physician, being physically present and responsible for the patient's care, shall direct the immediate patient management. Decisions shall primarily reflect what is best for the patient. When resolutions of the differing opinions are not immediately achieved and the on-call specialist continues to disagree on the need for his/her treatment, the emergency doctor may: (a) Contact the relevant Department chairperson for assistance in resolving the matter or (b) Call another appropriate physician from the on-call roster. Issues raised by the conflicting opinions shall be discussed at the next Departmental meeting with additional referral to the Medical Executive Committee as needed.

4.18-5 Any on-call Medical Staff member who fails to respond or who refuses to consult on and attend an emergency patient at the request of the Emergency Department physician shall be subject to corrective action by the Medical Executive Committee.

The rules and regulations provide a method for adjudicating disputes in the ED in real time and at a later time. These sections are evidence to support the difficulty faced by emergency department providers in obtaining coverage for ED patients.

Current Compensation

This table represents unrestricted call; no service is required to provide restricted in-house coverage at TFHD. Total annual cost (when hospitalist coverage is included) is $1,844,362 to TFHD. According to other surveys, the average annual cost of on-call compensation for a hospital of this size without trauma center designation is $1.5 million/year.

Table 3. Current Compensation for ED Call by Specialty

Specialty	Compensation	Number of Doctors Taking Call/Comment	Professional Fees	Annual Cost: Fiscal Year 2011
Medicine	$750/day	10 (11 with Locum Tenens hospitalist) Hospitalist does one of every four weeks. Two medical groups: TTMG & MSC.	Hospital keeps MSC's pro fees. TTMG & hospitalist keep pro fees.	$262,550 ($128,154 for hospitalist)
General Surgery	Full-time: $1,000/day	2 full-time (1 private practice, 1 MSC)	MSC – Hospital keeps pro fees Private practice – MD & Locums keep pro fees	$461,200
	Locums: $1700/day pro fees kept by hospital	2 part-time call only		
Pediatrics	$200/day	4 Part of MSC	TFHD keeps pro fees	$74,000
OB/Gyn	$350/day	3	MDs keep pro fees	$129,325
Orthopedic Surgery	$750/day	3 full-time 2 part-time call only	MDs keep pro fees	$313,400
Cardiology	$0	1 – Part of medicine call. If not on medicine call, does not receive stipend when called. Rarely bills.	MDs keep pro fees	
Pulmonology	$0	1 – Part of medicine call. If not on medicine call, does not receive stipend when called. Rarely bills.	MDs keep pro fees	
Plastic Surgery	$500/day	1 -- Rarely bills - Monthly sends list of patients to Med Staff office, which is verified.	MD keeps pro fees	
Radiology	0 (only coverage and compensation for x-ray after hours)	3 – Is on a monthly call schedule. Rarely called, only if x-ray is done or there is a need for a radiologist.	MD keeps pro fees	$61,496
Ophthalmology	$750/day. Is paid if he is called and is available; no more than 1 stipend/day	1 -- No call schedule provided. Monthly sends list of patients to Med Staff office, which is verified.	MD keeps pro fees	$65,250

Specialty	Compensation	Number of Physicians Taking Call/Comments	Pro Fees	Annual Cost
Anesthesia	$1500 1st call; $750 2nd call. $500/24 hours when called and not on schedule. $500 IVCH if no patients	4 full-time 7 part-time call only	MD keeps pro fees	$321,791
Psychiatry	$0	No coverage		$5,250
Gastroenterology	$0	3 part-time -- 1 under contract negotiations/hosp either for own group or to join MSC	MD keeps pro fees	
Pathology	$0	Contracted with Western Pathology		
Dentistry	$0	2 No coverage		$600
IVCH – Medicine	$250	3		
Urology	$750 per day, if called and available; paid no more than 1 stipend/day	1	MD keeps pro fees	0

FMV Methodology

Quality Matters Consulting conducted the FMV through data review, research, surveys, and interviews with medical staff members and hospital leadership. Comparative studies included in this report are six well known compensation studies: the Sullivan-Cotter 2011 Survey, the MGMA 2012 Survey, the Camden Group 2011 California Survey, the AGMA survey, the HealthCare Appraisers report, and the HHCS Compensation Survey. The first four resources record on-call compensation as per diem payments. The latter two studies provide salary data that can be converted to on-call pay. Caution should be used when comparing TFHD with any survey because limited data are available for Critical Access Hospitals (CAHs) regarding ED on call compensation. These studies are nationally recognized, however, and are recommended and accepted by regulatory bodies as a basis for a FMV assessment. In addition, while all of these studies' compensation rates are based on a 24-hour day, many specialties at TFHD employ different scheduling models for on-call (many of the physicians do not provide coverage to the ED from 6 pm to 6 am). In this regard, the TFHD's rates for those specialties may be inflated in an equal comparison.

Challenges in performing a FMV for TFHD include the lack of data regarding the actual need for different on-call services by TFHD. Tracking actual services provided by the on-call provider is also lacking in 2012. At the start of this project, it became apparent that a tracking methodology for on-call is extremely limited at TFHD, and this became one of the project goals and deliverables.

Developing an On-Call Process

Regulatory bodies recommend that the following items be addressed when developing an on-call process:

1. Unmet Need: There must be a documented unmet need for the on-call coverage and indigent care services.
2. Historical Precedence: Past history of on-call requirements and arrangements are taken into consideration.
3. Call Burden: The organization must determine what is actually required of an on-call physician:

- Likelihood that the on-call physician will have to provide care to an uninsured ED patient is documented.
- Severity of illness the physician in that specialty typically treats in the ED is documented.
- Physician time associated with specialty is noted.
- Data elements A-G in Table 1 help quantify the burden of call.

4. Comparative Analysis:
    - A physician's on-call pay should be correlated with that of other physicians of the same specialty in the geographic market.
    - A ratio of the on-call physician hourly payment to an employed physician's hourly rate is determined.
    - The hospital can develop its own payment based in part on specialty physician salary.
    - Data elements H-M in Table 1 help inform the comparative analysis.

Relevant Data

Performing a FMV for ED on-call has regulatory requirements that should be considered. The Office of Inspector General for Health and Human Resources recommend the following data elements be gathered and assessed. To provide an accurate and comprehensive assessment, *QM* requested 24 months of data to complete the analysis and report. Table 4 represents the data elements requested for the FMV assessment. Yellow indicates the data elements that were unavailable.

Table 4. Data Elements for FMV

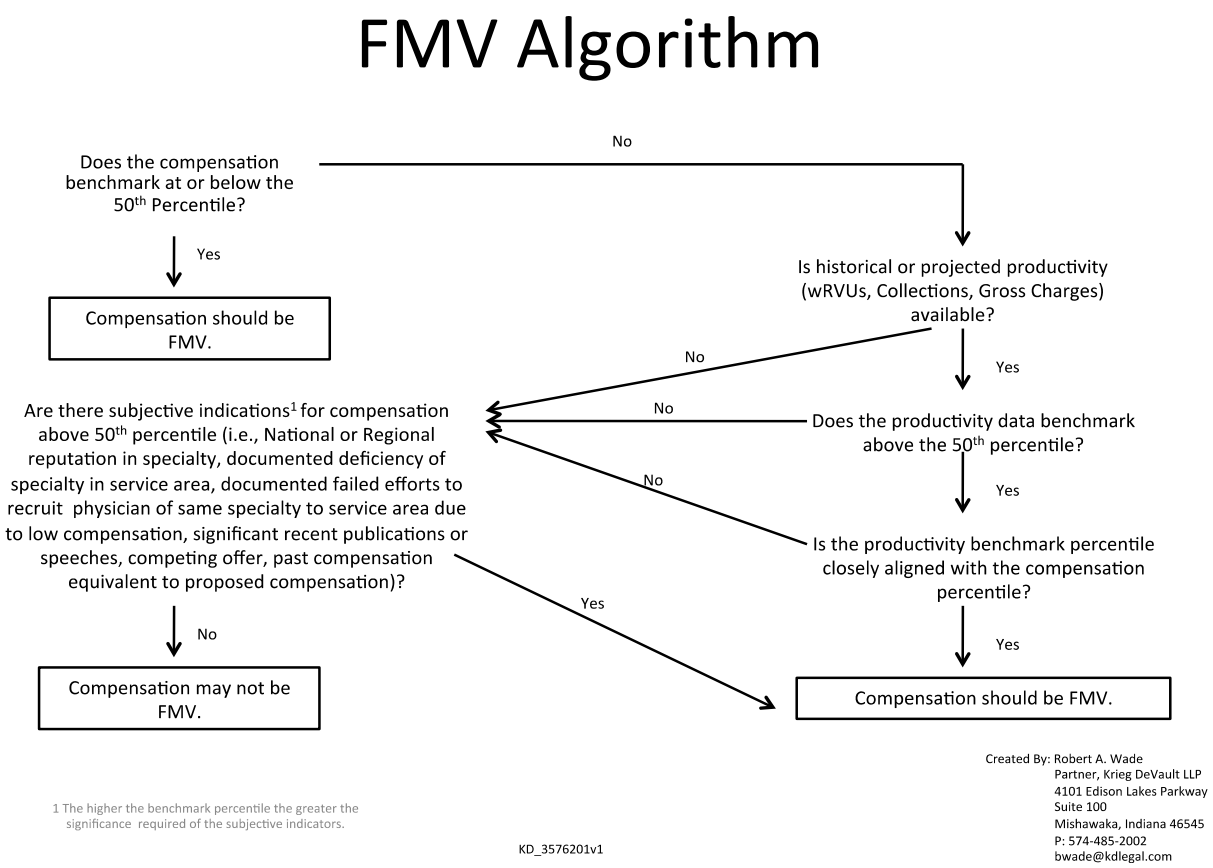
Data Element	Actual Data
A. Unassigned patient volume by specialty	Unassigned patients/specialty/month
B. Number of physicians taking call by specialty	Physicians/specialty/year
C. Number of patients seen by on-call by specialty	Unassigned patients/specialty/month
D. Number of patients seen by day by specialty	Unassigned patients/on-call day
E. Payer Mix	Percentages unfunded, underfunded, charity care
F. Average number of RVUs generated on-call by specialty	RVUs/on-call day
G. Average number of RVUs/patient by specialty	RVUs/ unassigned patient
H. Average RVUs delivered by payer – not applicable	RVUs paid by payer
I. Average number dollars per RVU delivered by payer	Dollars/RVU paid
J. Percent collection rate from payer	Percent
K. Number of dollars spent per service for on-call annually	Dollars/Service/Year
L. Number of dollars spent for hospital on-call annually	Dollars/Hospital/Year
M. Average Hourly Rate for Emergency Physician	Dollars/Hour

Highlighted areas indicate data that are currently unavailable.

In September as part of an ED Admissions Improvement Project a small sample audit of ED calls was performed. Over a 19 day period, 73 calls were made to on-call physicians and by tracking in real time (by hand) the following statistics were noted:

- The ED made approximately 3.9 calls to on-call physicians of all specialties (this is a low season month)
- Medicine received the highest number of calls, followed by surgery and orthopedics
- 93% of on-call physicians answered on the first call, all within 2 calls
- 84% of the patients tracked had involving these calls had insurance
- 65% of the time the on-call physician needed to come to the hospital
- 46% of the time the call resulted in a hospital admission

Figure 1.



FMV Algorithm

There are three major approaches to determining Fair Market Value in this setting: The Survey Model (Market Based Research), the Productivity Model, and the Tiered Approach. Attorney Bob Wade of Krieg Devalt developed a decision matrix[i] that assists hospitals and physicians with determining compensation rates.[21] Each of the items above (in Table 4.) should be considered and documentation should indicate justification when determining FMV for compensation. The algorithm in Figure 1 can be used to help determine appropriate compensation for ED call. The left pathway in the diagram shows The Market Based approach. The right side of the diagram shows the Productivity Model. As can be readily noted, the lack of available data on RVUs, collections, and gross charges precludes the use of the productivity arm for determining FMV at TFHD.

The third methodology currently in use, though less widely than the two schemes already described is the Tiered Approach. Score each of the following: Call per month, the likelihood of being called in, the median market rate per specialty and then use modifiers such as trauma center designation or multiple facilities covered. Each element gives a score and the score converts to a tier (1-4). Each tier has pay range: For example, Tier 1 $45-55/hour, Tier 2 $35-44/hr, Tier 3 $25-34/hr,Tier 4 $15-24/hr. This translates into $360-$1320/day for being on call. This methodology might be an option in future determinations of on call reimbursement at TFHD as it requires less data collection than the Productivity model.

TFHD is currently obligated to determine FMV solely through unmet need and comparative analyses using survey comparisons. Though most appraisers recommend using four nationally recognized surveys for comparison, *Quality Matters* has brought in six surveys for comparative analysis.

The Analysis

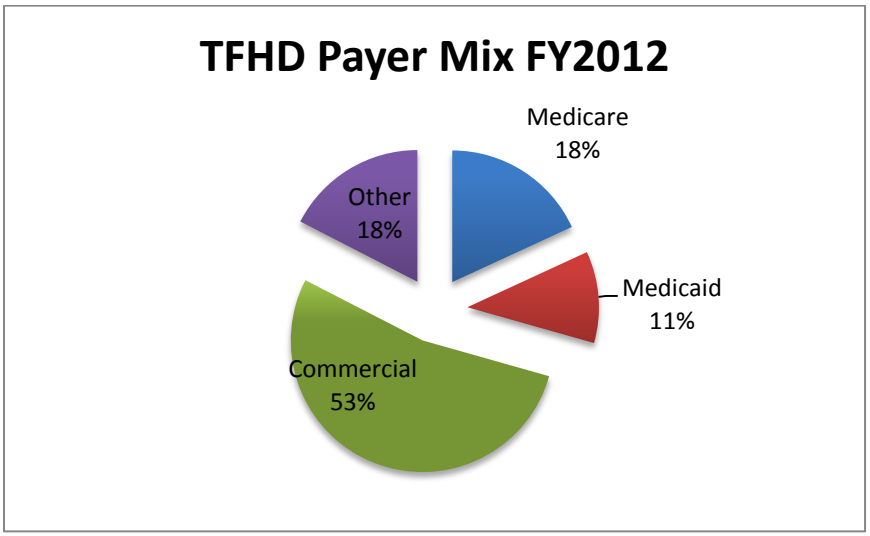
Unmet Need: Unmet need can be quantified in many ways including charity care, the ED on-call coverage schedule, and documentation of transfers because of lack of coverage. We have used the first two measures.

Charity Care and Payer Mix: Indigent care was the driving force behind the development of ED on-call stipends. The organization and providers should monitor the number of patients who receive services under the on-call program. This will protect the provider as well as the organization. Charity Care for 2011 and 2012 can be seen in Table 5. The medical staff reportedly underutilizes this program because it is cumbersome and often takes several months for reimbursement. As can be seen, charity care is on the rise. The breakdown of Payer Mix in 2012 can be seen in Figure 2.

Table 5. TFHD Charity Care 2011,2012

	FY 2012	FY 2011
July	4,977.46	5,330.18
August	-	-
September	4,246.63	10,707.23
October	17,909.58	-
November	20,330.31	-
December	(199.25)	9,230.05
January	8,973.21	-
February	8,987.96	9,552.00
March	(96.17)	-
April	-	-
May	13,857.13	9,913.62
June	-	-
Total	**$51,853.19**	**$ 28,695.67**

Figure 2.



Sullivan-Cotter reported a payer mix for non-trauma organizations for the uninsured or Medicaid patients:

- 37% had 0-15% uninsured/Medicaid rate.
- 51% had 16-30% uninsured/Medicaid rate.
- 10% had 31-45% uninsured/Medicaid rate.
- 2% had >45% uninsured/Medicaid rate.

All of this would suggest a favorable payer mix, but without data on billing and collections, this is still effectively guesswork. Currently there is no tracking at TFHD for the amount of indigent care provided by on-call physicians. However a brief survey of on-call data retrieved from the new ED tracking system suggested that 84% of patients seen by on-call physicians had insurance. Physicians do have the option to apply for charity care for these patients, but it was reported that very few do apply because of the cumbersome process.

On-Call Schedules: To further articulate the unmet need, *QM* reviewed six months of 2012 on-call schedules. The majority of the physicians in the on-call rotation take call at least nine times in a six month cycle, or 18 days a year. Because the medical staff at TFHD is small, the call burden for unassigned patients presenting to the ED is particularly heavy in terms of the number of days on-call, demonstrating need. Of the 37 physicians in the call schedule for this 6 month period, nine were locum tenens physicians, also demonstrating need.

A survey monkey conducted by *Quality Matters* in October 2012 sheds further light on the issue of unmet need. Of the survey responses:

- 50% of the physicians taking call are on call 8 to 10 times a month (Ortho, Surgery, OB/Gyn)
- 37% percent of respondents indicated a desire to be taken out of the call rotation
- Most physicians reported being unable to go to dinner or a movie while on-call
- By almost 2 to 1 physicians surveyed were interested in a model involving MLPs or hospitalists to assist with the night call burden.
- One half of those surveyed interested in deferred compensation models.

Historical Precedence

The TFHD began paying for on-call services as early as 2001. It has a unique set of circumstances that led to on-call compensation for many of its services ahead of other parts of the country. It is located in a resort community, and the

population varies almost fivefold between the low and the high seasons. Year-round resident population of Lake Tahoe and Truckee is given as between 55,000 and 66,000. During peak tourism, the population can swell to 200,000. This means in the two low seasons (fall and spring), the community can only support a finite number of physicians. As a result, the call burden is heavier on most physicians than in nearby communities. In addition, as a critical access hospital, TFHD leadership has felt a commitment to providing certain medical services to the community. Finally, in the high seasons (winter and summer) the level of urgent medical need presenting to the emergency department rises proportionately, overwhelming the providers.

Quantifying the Call Burden

The next step that may be used to determine the need for an ED call stipend is the number of days a physician would have to provide uncompensated care to ED patients. To determine the number of days each provider provides call annually the six-month call schedules provided to QM was doubled. The next table indicates the projected call for 12 months. It should be noted that this projection would not include any changes in the call schedule that have occurred since August 2012. A number of physicians do not meet the 18 calls per year requirement and these are highlighted in yellow.

Table 7. Annual On-Call Burden

Orthopedics		Pediatrics		General Medicine		Surgery		Anesthesia		Obstetrics	
Osgood	119	Brown	126	Scholnik	36	Kitts	164	Saaramets	88	Coll	120
Foley	106	Arth	122	Krause	26	Cooper	112	Thomas	86	Thompson	124
Dodd	102	Uglum	116	Neer,Sheiko	60	Reynolds	22	Silver	32	Taylor	120
Kelly	9			Tirdel	46	Delgado	32	Specht	60		
Hart	10			Winter	16	Sweeney	34	Alpert	84		
Scheffel	18			Barta	36			Woods	6		
				Jensen	18			Fisher	6		
				Lombard	40			Durbin	2		
				Plumb	14						
				Ganong	44						
				Sheiko	28						
				Burkholder	28						

Missing Elements: In part because of the absence of a comprehensive system wide electronic health record and in part because of a lack of processes for tracking relevant data, there are many relevant data (shown in table 4) missing from this part of the analysis. Though new tracking measures are being implemented in the ED and in the medical staff office, to date there is no information to quantify the likelihood of a physician in a particular specialty being called to the hospital. There are also no data about how much time will be spent and how much uncompensated care will be delivered.

Comparative Analysis

To determine compensated care, *QM* used five national surveys and one state survey against which to benchmark TFHD. The next section is a brief overview of each of these surveys. The five national surveys are the SullivanCotter ED On-Call Survey, the Medical Group Management Association (MGMA) Medical Directorship and On-Call Compensation Survey, the American Medical Group Association (AMGA), the HealthCare Appraisers Survey, and

the HHCS Compensation Survey and their respondents are compared in table 8. The California survey comes from the Camden Group. Some surveys report their actual per diem fees, which is useful because 75% of hospitals use this reimbursement method. Other surveys report only salary data, and the on-call per diem must be calculated using a formula. This will be described below.

The SullivanCotter survey is one of the oldest of its kind and has a solid reputation. This FMV assessment used the Sullivan-Cotter's seventh annual study released in 2011; 189 organizations from across the United States participated in the study. Of the respondents, 34% were in the western region and 11 respondents were from California. The study does not include any regional cross-sectional data. Unfortunately, SullivanCotter has data for Family Medicine but not for Internal Medicine, which has particular relevance for TFHD. Sullivan-Cotter survey respondents were located in rural settings (25%), suburban settings (34%) and urban settings (41%). The study does not include any regional cross-sectional data. The SullivanCotter data set offers insight about how facilities are determining call (see section on Current State). It also includes some data on market rates for Critical Access Hospitals though only 3% of respondents were CAHs.

The MGMA survey is the most robust data set, and we can analyze the data many ways because it has been broken down along a number of parameters. For instance, they have some breakdown of metropolitan versus non-metropolitan areas. The trend appears to be slightly lower reimbursement for non-metropolitan areas. MGMA presents its data as percentiles including the median, 25th, 75th, and 90th. As a blink response, the MGMA survey is at the higher end of reimbursements relative to the other surveys.

The third national survey to provide per diem data for analysis is the HealthCare Appraisers 2011 Report (based on 2010 data). Unfortunately, there is no breakdown by region, hospital size, or metropolitan area. It does, however, provide another data set for our comparative analysis. HealthCare Appraisers also collects data on the size of on-call panels and how often the physicians on-call are required to be present in the ED. These data may be useful in the future as TFHD implements its process for collecting these types of data.

The Camden Survey is much smaller, but offers the advantage of being a survey exclusively of California hospitals with a small number of low-volume and rural hospitals. It also provides per diem data. The Camden Survey has at most 11 respondents to its survey, and only three hospitals with fewer than 150 beds provided data. Still it is the most comparable data set available.

Table 8. Respondents for the Four Surveys Reporting Per Diem Data

SullivanCotter	N	MGMA	N	Camden	N	Health Appraisers*	N
TOTAL Respondents	189	TOTAL Respondents	308	TOTAL Respondents	11	TOTAL Respondents	NA
Anesthesiology	14	Anesthesiology	35	Anesthesiology	8		
Family Practice/Medicine	5	Cardiology	15	Cardiology	6		
General Surgery	64	Family Practice/Medicine	38	Family Practice/Medicine	2		
Hospitalist	8	Gastroenterology	21	Gastroenterology	4		
OB/Gyn 1st Call	47	General Surgery	64	General Surgery	9		
Ophthalmology	21	Hospitalist	8	Internal Medicine	5		
Orthopedic Surgery	94	Internal Medicine	31	OB/Gyn	9		
Pediatrics	12	OB/Gyn	62	Ophthalmology	5		
Plastic Surgery	32	Ophthalmology	16	Orthopedic Surgery	11		

Psychiatry	22	Orthopedic Surgery	235	Pediatrics	6		
Pulmonology	13	Pediatrics	15	Plastic Surgery			
Urology	43	Psychiatry	24	Psychiatry	5		
Cardiology	33	Pulmonology	19	Pulmonology	2		
Gastroenterology	24	Radiology	120	Urology	9		
		Urology	33	Vascular Surgery			

***Though HealthCare Appraisers publishes its annual compensation data and it is widely referenced by other valuation companies and Health Lawyers Groups, they are very proprietary about the details of this survey. In personal communication with company representatives they refer to "thousands of clients," but would divulge no more details.**

The AMGA 2011 Survey (based on 2010 data) conducted by McGladrey includes submission by 239 medical groups and 51,700 physicians. The HHSC Survey and the AMGA report provide their data in terms of physician compensation and AMGA also has RVU data, but this is not useful to TFHD to determine FMV for on-call because there is no historical or projected RVU data for on-call services. HealthCare Appraisers suggest that the hourly payment for a physician working in practice is not equivalent to an hour on call because no actual work may be performed. They argue the need to convert "work time" to "on-call time."[9]

HealthCare Appraisers, Inc., recommends the following conversion from salary to on-call pay:

$$\frac{\text{Annual salary for specific specialty/region/year}}{\text{2000 work hours/year}} \times \text{value factor (0.05-0.2)} \times 24 \text{ hours}$$

The 0.05 to 0.2 "on-call factor" converts an hourly work rate to an hourly on-call rate that is then multiplied by 24 hours. For perspective, nurses on call are typically reimbursed at 5% their work rate. *Quality Matters* argues that in the absence of productivity data and given the small size of the medical staff and the heavy call requirements that exist in the somewhat unique environment at TFHD, that the highest conversion factor (0.2 or 20%) be used.

Table 9. Respondents for the Two Surveys Reporting Salary Data

HHCS	N	AGMA	N
TOTAL Respondents	303	TOTAL Respondents	239
Anesthesiology	21	Anesthesiology	
Internal Medicine	66	Cardiology	
General Surgery	37	Family Practice/Medicine	
Hospitalist	27	Gastroenterology	
OB/Gyn	18	General Surgery	
Ophthalmology	13	Hospitalist	
Orthopedic Surgery	22	Internal Medicine	
Pediatrics	12	OB/Gyn	
Plastic Surgery	8	Ophthalmology	
Psychiatry	54	Orthopedic Surgery	

Pulmonology	23	Pediatrics	
Urology	24	Psychiatry	
Cardiology	32	Pulmonology	
Gastroenterology	35		

SullivanCotter

SullivanCotter is one of the most respected surveys with 189 organizations reporting. While there is good representation among western states and California, only 3% of S-C respondents (5 hospitals) were CAH and another four hospitals were identified as "remote care" facilities. Below are the hourly on-call rates for these nine hospitals for unrestricted call for combined primary care specialties. The sample is so small and the exact categorization of on-call services so vague that we are unclear how to apply these rates.

Table 10. SullivanCotter Primary Care Remote/Critical Access

Primary Care - Remote/Critical Access		
Market Statistic	Non-Trauma Center Hourly Rate	Converted to Daily Rate (24 hr)
25th Percentile	30.62	734.88
Median	60	1440
75th Percentile	72	1728
90th Percentile	isd	
isd = insuffient data		

SullivanCotter and Associates' 2011 Physician Compensation and Productivity Survey gathered data from more than 60,000 physicians, residents, midlevel providers, and medical group executives, and revealed a number of market trends. Below is a summary of some of the overall trends in physician compensation:

- **Economics don't support significant increases in physician salary.** According to SullivanCotter's survey, 62 percent of physician employers planned to provide salary increases to at least some of their physicians in 2011, and 16 percent planned to decrease certain physician salaries in 2011. However, physicians who received an increase should not have expected it to be significant. A competitive labor market coupled with declining reimbursements is causing healthcare organizations to save costs wherever they can. Some salary increases appear to be in the pipeline, but they might not be on par with physician expectations.
- **On-call pay is rising.** Last year, 54 percent of organizations said they provided on-call pay to at least some physicians, and this year that figure grew to 64 percent. All types of physician specialties are seeing an increase in on-call pay, not just surgical specialties. In particular, there is a high demand for stroke neurologists, who can provide a significant amount of on-call coverage. There are several factors that go into the amount of on-call pay. The "on-call burden," or the likelihood of being called in, is a major factor. The amount of on-call pay should relate back to that." Other determinants include payer mix, hospital location and percentage of uncompensated care.

- **Different pay models are emerging.** More healthcare systems are forming medical groups to help improve their coordination of care, they are trying to find efficient and common themes in compensation models for their physicians. The three most preeminent models are for primary care physicians, hospital-based shift work physicians (such as emergency physicians and hospitalists), and specialists. According to SullivanCotter's survey, the average mix for physician compensation is 81 percent salary and 19 percent incentives, but those incentives vary. Primary care physicians and specialists are still mostly being paid with a base salary plus a productivity component, with specialists having a lot of pay tied to productivity. Physicians who do shift-based work are being paid for their shift hours of work or salary plus quality incentives. Quality incentives, rather than productivity incentives, are the growing trend for those types of physicians.
- **Telephonic Consultations are becoming increasingly prevalent** and models for reimbursement (typically a fraction of the on-site fee) are developing**.**
- **On-call pay is funded solely by the hospital in 88% of cases**. In a few percent of cases, the medical group contributes.

Table 11. Comparing TFHD On-Call Per Diem Rates with Sullivan-Cotter Percentiles

Respondents	N	25th	Median	75th	90th	TFHD
Anesthesiology	14	750	1100	1843	2200	1500
Family Practice /Medicine	5	300	500	750	isd	750
General Surgery	64	500	800	1025	1400	1000
Hospitalist	8	509	1000	1200	isd	1400
OB/Gyn 1st Call	47	300	500	772	1250	350
Ophthalmology	21	250	400	548	1000	750
Orthopedic Surgery	94	750	1000	1500	2000	750
Pediatrics	12	150	275	308	360	200
Plastic Surgery	32	350	500	1000	1400	500
Psychiatry	22	250	413	500	1000	0
Pulmonology	13	275	685	1000	1100	0
Urology	43	300	480	700	1000	0
Cardiology	33	400	600	1000	1250	0
Gastroenterology	24	350	520	761	1200	0

Specialties in red are below the median. isd signifies insufficient data.

QM used unrestricted call data, and this collection of tables indicate TFHD percentile comparisons with S-C. Table 12 indicates where TFHD falls within each of the percentiles. When using compensation surveys to determine FMV, the OIG recommends that reimbursement come in at the median or below. TFHD pays at or below the median for four specialties and above the median for five specialties, according to the Sullivan-Cotter survey. Orthopedics and OB/Gyn appear to be relatively undervalued compared with the Sullivan-Cotter data set.

Table 12. Comparing TFHD On-Call Rates with S-C Survey Percentiles

TFHD Current Pay by Specialty Within Percentile Ranges				
At/Below 25th	At/Below Median	At/Below 75th	At/Below 90th	Over 90th

Orthopedic		Anesthesiology	Ophthalmology	
	OB/Gyn	Medicine	Hospitalist	
	Pediatrics	General Surgery		
	Plastic Surgery			

Specialties in red are above median.

MGMA Medical Directorship & On-Call Compensation Survey

The Medical Group Management Association's (MGMA) 2012 Medical Directorship and On-Call Compensation Survey[ii] was released in 2012 and is based on 2011 data.[22] MGMA has been reporting compensation survey results for more than 20 years. MGMA received 308 responses for the on-call portion of the survey. All surveys were conducted via the web. To review the comprehensive data from MGMA in this study, we recommend that TFHD order the report from www.mgma.com. The majority of the results in this section, unless otherwise noted, will be general responses because the majority of specialties had insufficient data by specialty for unrestricted on-call reimbursements.

The MGMA survey includes many breakouts of the data and many ways to compare the data. Breakouts by region were available, but state data were not. Not all specialties had enough data to be included in the regional data. Table 13 is a summary of some specialty data from the Western Region. **No trends** could be recognized in the western states. Some specialties reported higher per diems in the western region relative to the overall survey (Surgery, OB/Gyn) while some reported lower (Gastroenterology, Pulmonology).

Table 13. Comparing TFHD with MGMA Western Region Comparisons

Western Region	N	Median	TFHD
Gastroenterology	10	480	0
General Surgery	15	1000	1000
OB/Gyn	30	1500	350
Orthopedic Surgery	67	800	750
Pulmonology	12	200	0
Urology	10	798	0

Table 14 indicates the compensation rate for non-metropolitan areas (<250,000 population). The MGMA survey does not have any particular data reported for CAHs. However, we can find comparisons with non-metropolitan hospitals and with hospitals with one or fewer other hospitals in the area in the MGMA data set. Of the eight TFHD specialties that can be compared with the nonmetropolitan data, four have higher rates, three have lower rates, and one is the same as the median rate. Thus, 50% of these specialties meet FMV.

Table 14. Comparing TFHD with MGMA Non-Metropolitan Area Hospitals

Nonmetropolitan (<250,000)	N	Median	TFHD
Anesthesiology	24	1890	1500
Cardiology	8	642	0
Family Practice/Medicine	38	100	750
General Surgery	42	854	1000
Hospitalist	8	234	1400

Internal Medicine	11	150	750
OB/Gyn	29	500	350
Orthopedic Surgery	125	1000	750
Pediatrics	14	200	200

Specialties in red are above median.

The MGMA survey did break down hospitals by the number of beds (<99, 100-199, & >200 beds), and only one specialty was receiving on-call pay in the <99-bed range. This specialty was Gastroenterology, which had 13 respondents with a median rate of $100. This was not particularly helpful to the FMV Analysis at TFHD.

Table 15 shows the comparison of the on-call pay for TFHD with the primary locations of the respondents that have one or fewer hospitals in the area. Of the five TFHD specialties, two compensate higher, two lower, and one at the median rate, putting three of the five at the FMV rate.

Table 15. One or No Hospitals in Primary Location Comparisons

One or No Hospitals in Primary Location	N	Median	TFHD
Cardiology	7	633	0
Family Practice/Medicine	27	100	750
General Surgery	19	854	1000
OB/Gyn	25	500	350
Orthopedic Surgery	50	1000	750
Pediatrics	14	200	200
Urology	7	250	0

Specialties in red are above the median.

Of the 29 specialties in the MGMA survey, only four specialties reported that the medical group was responsible for funding the on-call pay (OB/Gyn, Orthopedics, Radiology, and General Surgery). Medical groups paid a higher rate than the hospital funded compensation. This tendency for medical specialty groups to pay higher than hospitals for on-call compensation is seen in a number of surveys, but is still an uncommon arrangement.

Professional fees are retained by all specialties in the MGMA report with the exception of "All Other Surgeries" specialty. Only two specialties reported receiving subsidies for uninsured/unassigned patients: Interventional Cardiology and Orthopedics. There was no payer mix data provided within the MGMA report. TFHD comparisons with the overall MGMA data set are shown in Table 16. Though Family Practice, General Medicine, and Internal Medicine are broken out in the MGMA data, TFHD covers them with one coverage system.

Table 16. Comparing TFHD On-Call Per Diems with MGMA Survey Percentiles

Respondents	N	25th	Median	75th	90th	TFHD
Anesthesiology	35	1100	1500	2850	4557	1500
Family Practice/Medicine	38	100	100	125	234	750
General Surgery	64	500	920	1100	1530	1000
Hospitalist	8	234	234	1235	-	1400

Internal Medicine	31	234	1000	1000	1000	750
OB/Gyn	62	300	500	975	1500	350
Ophthalmology	16	325	400	400	955	750
Orthopedic Surgery	235	500	854	1100	1814	750
Pediatrics	15	200	200	234	240	200
Psychiatry	24	500	1438	2000	3000	0
Pulmonology	19	200	200	1000	1500	0
Urology	33	300	798	1225	1219	0
Cardiology	15	300	650	1000	1620	0
Gastroenterology	21	480	800	900	2700	0
Radiology	120	234	1000	2000	2000	na

Specialties in red are above the median.

When comparing specialties by percentile using the MGMA data, TFHD pays at or below market value for three specialties and above market value (defined as above the median) for four specialties. These comparisons include restricted and unrestricted call rates together.

Table 17. Comparing TFHD Current On-Call Rates with MGMA Percentiles

TFHD Current Pay by Specialty Within Percentile Ranges				
At/Below 25th	At/Below Median	At/Below 75th	At/Below 90th	Over 90th
Pediatric	Anesthesiology	General Surgery	Ophthalmologist	Family Practice
	Internal Medicine		Hospitalist	
	OB/Gyn			
	Orthopedic			

Specialties in red are above the median.

Once again, as in the Sullivan-Cotter survey, TFHD is reimbursing at or below the median for some specialties and above for others. As with the S-C survey Pediatrics, OB/Gyn and Orthopedics come in under the median. Anesthesia falls in at the 50th percentile on the MGMA survey but not the S-C survey. Family Practice, Hospitalist and General Surgery are high.

The Camden Group

The Camden Group performed an ED On-Call Survey in California from March through September 2011.[23] Eleven hospitals participated in the survey with eight in Southern California and three in Northern California. All three in Northern California are smaller hospitals with fewer than 150 beds. Table 18 shows the Camden Survey Respondents and the pay ranges given as the median, low, and high payments.

The Camden Study is based on hospital responses as opposed to the above two studies which were based on physician responses. In addition, all of the participants reported paying a flat 24-hour per diem rate. The top five specialties the respondents pay for ED on-call in this survey:

- Orthopedic Surgery
- General Surgery
- OB/Gyn

- Urology
- Neurosurgery

The Camden Group breaks General Medicine into Internal Medicine and Family Practice/medicine but does not capture data for hospitalists.

Table 18. Camden Survey Respondents and Compensation Ranges

Respondents	N	Median	Low	High	TFHD
Anesthesiology	8	1352	650	*	1500
Cardiology	6	425	350	500	
Family Practice/Medicine	2	500	250	750	750
Gastroenterology	4	497	290	600	
General Surgery	9	600	200	1526	1000
Internal Medicine	5	600	100	750	750
OB/Gyn	9	400	150	1250	350
Ophthalmology	5	400	143	750	750
Orthopedic Surgery	11	800	400	1400	750
Pediatrics	6	300	100	450	200
Plastic Surgery					
Psychiatry	5	200	131	750	
Pulmonology	2	550	350	750	
Urology	9	400	200	800	
Vascular Surgery					

Specialties in red are above the median.

Table 19 shows the median rates for the three respondents with fewer than 150 beds in Northern California. The TFHD rates are the current rates paid for on-call. Hospitals were blinded in the study that was shared with all study participants. Note that TFHD payment for OB/Gyn and Pediatrics are the lowest, Orthopedics is on the low side, and Medicine is high. The range for General Surgery is very wide, and TFHD falls in the middle.

Table 19. TFHD Against Two Northern California Hospital Comparisons < 150 Beds

Paid Stipends <150 beds, Northern California Hospital	D	G	TFHD
Anesthesiology			1500
Cardiology	500	500	0
Family Practice/Medicine			750
Gastroenterology		600	0
General Surgery	1526	500	1000
Internal Medicine	600		750

OB/Gyn	656	500	350
Ophthalmology			750
Orthopedic Surgery	1270	750	750
Pediatrics	450	250	200
Plastic Surgery			500
Psychiatry			0
Pulmonology		350	0
Urology	500	200	0

Table 20 shows the ED on-call compensation from the California participants, and is broken out into high, median, and low compensation as opposed to percentiles. The data are broken out for each specialty above or below median ranges. When compared with the Camden Group Data, TFHD pays no specialists at the low rate, three at the median rate, and five at the high rate. Unfortunately, there are no hospitalist data.

Table 20. Comparing TFHD Current On-Call Rates with Camden Group Compensation Rates

TFHD Current Pay by Specialty At or Below Median in the Camden Group Study		
At or Below Low	At or Below Median	At or Above Median
	OB/Gyn	Anesthesiology
	Orthopedics	Family Practice
	Pediatrics	General Surgery
		Internal Medicine
		Ophthalmology

HealthCare Appraisers

Table 21 shows HealthCare Appraisers' per diem rates reported as high and low.[24] Because HealthCare Appraisers would not share the details of their sample size, it was impossible to calculate an average or determine a median for the sample. Still it is apparent that TFHD reimburses to the low end of the range for Pediatrics, OB/Gyn, and orthopedics. There are no comparison data for hospitalists or anesthesiologists, and all per diem values are within range.

Table 21. Comparison TFHD Per Diems with HealthCare Appraisers

Specialty	Low	High	TFHD
Anesthesia	NA	NA	1500
Family Practice			750
General Surgery	340	2210	1000
Hospitalist			1400

Internal Med	250	1170	750
OB/Gyn	170	1250	350
Ophthalmology	190	1420	750
Orthopedics	340	2250	750
Pediatrics	170	1070	200
Plastic Surgery	290	1320	
Psychiatry	160	790	
Pulmonology	280	510	
Urology	280	1280	
Cardiology	350	2060	
Gastroenterology	280	1750	

AGMA

The American Group Medical Association physician compensation survey is performed by McGaladrey Consultants, and is a robust data set utilizing input from 239 medical groups and nearly 52,000 physicians.[25] The data are reported as median salary data, and the conversion to on-call stipends was performed using the formula described above.

Table 22. Comparison TFHD with AGMA Calculated On-Call Pay

Respondents	AGMA	TFHD
Anesthesiology	895	1500
Family Practice/Medicine	501	750
General Surgery	882	1000
Hospitalist	550	1400
Internal Medicine	527	750
OB/Gyn 1st Call	726	350
Ophthalmology	855	750
Orthopedic Surgery	1204	750
Pediatrics	512	200
Psychiatry	521	
Pulmonology	728	
Urology	993	
Cardiology	1015	
Gastroenterology	998	
Radiology	1181	

Specialties in red are above average calculated stipends for this survey.

HHCS

HHCS survey is compiled nationally and by region with more than 303 organizations and 27,000 physicians reporting their compensation data.[26] It is also reported by hospital size. Using the conversion methodology previously described, the HHCS salary data is converted and broken into percentiles (25th, average, 75th and 90th) and compared to TFHD data. Note HHCS used averages instead of medians.

Table 23. Comparison TFHD On-Call Pay with HHCS Percentiles

Respondent	25th	Average	75th	90th	TFHD
Anesthesia	628	690	707	780	1500
Family Practice	395	448	492	543	750
General Surgery	601	850	847	1365	1000
Hospitalist	425	469	504	526	1400
Internal Medicine	401	468	507	634	750
OB/Gyn	537	669	636	1013	350
Ophthalmology	511	561	636	660	750
Orthopedics	748	1054	1313	1551	750
Pediatrics	448	506	553	603	200
Plastic Surgery	627	799	709	933	500
Psychiatry	432	460	464	506	
Pulmonology	505	569	620	747	
Urology	605	809	826	1336	
Cardiology	704	1064	1145	1712	
Gastroenterology	547	667	710	917	
	636	670	697	726	

Specialties in red are above median calculated on-call stipends.

Table 24. Comparison TFHD On-Call Pay with HHCS Percentile Ranges

TFHD Current Pay by Specialty Within Percentile Ranges				
At/Below 25th	At/Below Median	At/Below 75th	At/Below 90th	Over 90th
Pediatrics				Anesthesia
OB/Gyn			General Surgery	Family Practice
	Orthopedics			Hospitalist
				Internal Medicine

Specialties in red above median calculated rates.

Summary of Comparisons

A basic consideration in determining FMV rate is *does the compensation fall at or below the median in comparison with market surveys?* TFHD compensates the majority of the specialties they pay for ED on-call services at over the median rate, highlighted in red (Table 25). Only four of the specialties are at the median.

Table 25. Trends Across the Six Surveys

	Sullivan-Cotter	MGMA	Camden	HealthCare Appraisers	AGMA	HHCS	Trends	TFHD
Anesthesiology	1100	1500	1352	NA	895	690	4/5	1500
Family Practice	500	100	500	NA	501	448	5/5	750
Internal Medicine	NA	1000	600	250-1170	527	468	4/6	750
General Surgery	800	650	600	340-2210	850	882	5/6	1000
Hospitalist	1000	234	NA	NA	550	469	3/4	1400
OB/Gyn 1st Call	500	500	400	170-1250	726	669	5/6	350
Ophthalmology	400	400	400	190-1420	855	561	4/6	750
Orthopedic Surgery	1000	854	800	290-1320	1204	1054	5/6	750
Pediatrics	275	200	300	170-1030	512	506	4/6	200
Plastic Surgery	500							500
Psychiatry	413	1438	200					0
Pulmonology	685	200	550					0
Radiology		1000						0
Urology	480	798	400					0
Cardiology	600	650	425					0

Specialties in red are above the median for more than half of surveys summarized in this report. Specialties in green are below median for more than half of surveys summarized.

Findings and Recommendations

- **Paying Above Market Value.** TFHD is paying above market value for five specialties. It may be paying well below market value for at least one, possibly three specialties. The process is vulnerable from a regulatory standpoint is vulnerable in this and other areas.
- **Paying for call without a defined call schedule**. Specialties that receive on-call compensation are required to submit a call schedule for tracking purposes and to meet the requirement of having a prearranged agreement. Because limited numbers of physicians are available, the Ophthalmology, Plastic Surgery, and Dental specialties do not provide a monthly call schedule.
- **Capturing data relative to services provided**. TFHD has not been capturing data sets relative to productivity as measured by RVUs, collections, and gross revenue. This prohibits FMV determination using the alternative methodology. Further, this creates a significant compliance risk around failure to provide adequate documentation of services provided.
- **Second call payment without data to justify such a model.** For at least one service (Anesthesia), TFHD is considering the implementation of a second call system. The need for this does not appear to have enough adequate documentation, and this is an area often investigated by the OIG.

- **Call pay cannot be paid concurrent with stipends for medical director services.** Some experts have suggested that the safest way around this is to eliminate per diem payments for medical directors.
- **Double payment for employed physicians.** For the MSC physicians being paid through contracts and then being paid again through per diem stipends, there can be a compliance issue.
- **The appearance of preferential treatment for certain physicians**. In addition, paying MSC physicians the same as independent contractors, without accommodation for the overhead of an independent contractor's practice, is considered a common compliance issue.
- **Payment for on-call when a baseline level of service has not been met.** The OIG has somewhat arbitrarily set 18 on-call days per year as the level at which reimbursement for on-call services should begin. A number of physicians do not meet that baseline level.

Data Collection
Additional documentation should be developed to monitor actual services provided. An effort should be made to track the data elements outlined in Table 4. This will allow both parties (the hospital and the physicians) to challenge or request mitigation of FMV determinations based on productivity data and a data-driven characterization of the burden of call. Further, the hard wiring of data capture for these elements will support the hospital's ability to declare on-call pay as an operating expense, and this will be a great help to the bottom line.

Contracts
Contracts should provide documentation of the reason for on-call compensation. Currently, TFHD does not have a documentation process included in the contract development. It was also reported that legal counsel does not review contracts. *QM* recommends that a template on-call contract be developed to ensure regulatory requirements are met and that legal counsel for both the hospital and providers review all contracts. Contracts moving forward will be standardized and include articulation of the elements identified below.

Clear Articulation of On-Call Responsibilities
These newly articulated responsibilities should require physician sign-off yearly and include:

1. Time response requirements.
2. Telephonic response.
3. Standardized reimbursement strategies.
4. Documentation requirements.
5. Quality metrics.

Streamlined Charity Care
Recent trends suggest that charity care is on the rise at TFHD and the process for physicians to document the care they provided and to collect for services provided to unfunded patients should be simple and intuitive. The hospital should provide payment for these services in a timely fashion. This may help provide incentive to physicians providing unfunded care.

On-Call Solutions
With *Quality Matters* acting as facilitator, the Medical Staff task force has been identified to move forward on finding solutions to the on-call crisis at TFHD. The following work has been laid out:

- The task force will review the results of this FMV report.
- The task force will respond to aberrations in the current reimbursement system and develop a way to compensate physicians more fairly for work done.
- The task force will review the efficacy of the existing on-call system and establish goals to improve it.
- The task force will review other models for managing the on-call burden.
- The task force will focus on strategies to improve the working conditions for physicians taking call.
- The task force will make recommendations to the Medical Executive Committee.

Oversight

This FMV assessment indicates that TFHD could be at risk if ever audited for the existing on-call compensation model. There has been increased scrutiny under EMTALA, the Stark law, and Anti-Kickback statues as ED on-call stipends are becoming common and financially unsustainable for most organizations. Developing a new compensation model that better meets regulatory requirements is recommended. The task force should consider the following as they move forward:

1. Commercial Reasonableness
    - Must be a legitimate business purpose for the parties.
    - Must have documented unmet need.
2. Fair Market Value
    - Comparison of market compensation by surveys.
    - Rates of pay that exceed industry norms should be avoided unless there are documented exceptions by service lines, such as limited physicians to provide that service.
    - Gathering more productivity data to characterize the workload of the on-call commitment will help physicians feel that their particular contribution to the on-call needs is recognized and compensated.
3. Documentation (recommend development of a database)
    - Substantiate services provided.
    - Supports regulatory requirements & compliance.
        - ✓ Copy of the arrangement (or its term, effective date, expiration date and automatic renewal provisions).
        - ✓ Description of the methodology used for the determination of fair market value of the compensation.
        - ✓ Amount of compensation, the method of payment, and whether the amount is based on the value or volume of referrals.
        - ✓ Whether the arrangement satisfies the requirements of an Anti-Kickback and/or Stark exception.
4. Monitoring
    - Services performed for payment.
    - Documentation must be accurate, complete, and timely.
    - Investigation of unusual patterns of reporting or suspicious issues.
    - Development of oversight procedures.
    - Training.
        - ✓ Anti-Kickback and Stark training to medical staff and hospital leaders should be provided.
        - ✓ Training should occur within thirty (30) days of hire or the effective date of the arrangement with the physician.
        - ✓ Training requirements for physicians should be articulated.

Conclusion

TFHD is commended on taking steps to meet the community's needs and working with the medical staff in creating a fair compensation model for providing on-call compensation. They are currently paying above market value for a number of specialties based on comparative analysis. There is not enough data to use other methodologies and TFHD needs to ramp up its collection methodology to support its on-call reimbursements. Physicians should be motivated to help in this process to support and maintain on-call reimbursements. The task force addressing on call issues can determine the equity of the existing reimbursements.

References

1. Ferrari AM, et al. On-Call Arrangements—Selection of the Appropriate Structure in light of OIG Advisory Opinion 07-10. Hospitals & Health Systems Rx. 2008;10(2):1.
2. McConnell KJ, et al. The on-call crisis: a statewide assessment of the costs of providing on-call specialist coverage. Ann Emerg Med. 2007;49(6):727.
3. Rao MB, Lerro C, Gross CP. The shortage of on-call surgical specialist coverage: a national survey of emergency department directors. Acad Emerg Med. 2010;17(12):1374.
4. Mobley KA, Wade RA. Physicians On-Call Pay: Market Trends, Fair Market Value and Oversight. American Health Lawyers Association presentation, Feb. 9, 2012; http://www.healthlawyers.org/Events/Programs/Materials/Documents/HHS12/papers/D_mobley_wade_slides.pdf.
5. Maiuro LS, et al. *California Hospital Facts and Figures*, California Healthcare Foundation, April 2010; http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniaHospitalFactsFigures2010.pdf.
6. Green L, et al. *Physicians On Call: California's Patchwork Approach to Emergency Department Coverage*, California Healthcare Foundation, February 2011; http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysiciansOnCallCAPatchwork.pdf.
7. Johnson J, Pinna J. Structure and Valuation of Quality Management and Call Coverage Arrangements. American Bar Association's Health Law Section and ABA Center for Continuing Legal Education. Teleconference Presentation. April 29, 2010; http://www.vmghealth.com/wp-content/themes/verycreative/pdf/VMG_ABA_CallCoMgmt042910.pdf.
8. Safrient S. Approaches to Ensuring ED Call Coverage – What is Working, What's Not, and What's on the Horizon, AHLS Teleconference. March 27, 2007.
9. Johnson DP, Lehman J. The Fair Market Value of Physician On-Call Compensation. HealthCare Appraisers. The RAP Sheet. 2006;9(3); 1http://www.healthcareappraisers.com/data/arts-files/The%20Fair%20Market%20Value%20of%20Physician%20On-Call%20Compensation.pdf.
10. Examination and treatment for emergency medical conditions and women in labor. 42 USC 1395dd (1986).
11. EMTALA Interpretive Guidelines in State Operations Manual, Appendix V.
12. Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule, 64 Fed. Reg. 63518, 63525 (No. 19, 1999).
13. Medicare and Medicaid Patients and Program Protection Act of 1987 (Federal Anti-Kickback Statute). Pub. L, No. 100-93 (July 30, 1987).
14. Burroughs JH, Buser MB, et al, Emergency Department On-Call Strategies: Solutions for Physician-Hospital Alignment, Danvers, MD: HCPro. 2009, Chapter 2, 2nd Edition.
15. Newman DM, Anderson GD. On-Call Coverage Arrangements: A Formula for Hospital-Physician Tension. Medical Staff News. American Health Lawyers Association. 8(1) April 2009; http://publish.healthlawyers.org/Events/Programs/Materials/Documents/AM09/hofstra_newman.pdf.
16. OIG Advisory Opinion No. 07-10; https://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-10A.pdf.
17. OIG Advisory Opinion No. 09-05; https://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf.
18. OIG Advisory Opinion No. 12-15; https://oig.hhs.gov/fraud/docs/advisoryopinions/2012/AdvOpn12-15.pdf.
19. Lefko L. Fair Market Value in Health Care Transactions. July 20, 2007; http://www.worldservicesgroup.com/publications.asp?action=article&artid=2086
20. SullivanCotter and Associates. Physician On-Call Pay Survey. January 2012; http://www.sullivancotter.com/physician-call-pay-survey.
21. Hospitals Navigate Fair-Market Value Under Stark as Feds Scrutinize Arrangements, *Report on Medicare Compliance,* 2012;201(29):1; http://www.healthcareappraisers.com/Publicationpdf/Rpt_Medicare_Compliance-FMVStark_FL_0811.pdf.
22. MGMA Medical Directorship and On-Call Compensation Survey-2012 Report Based on 2011 Data. Glacier Publishing Services, Inc. 2012 MGMA-ACMPE.
23. The Camden Group. Internal Document to TFHD, Nov. 8, 2011.
24. FMVantage Point: A Review of 2010 Trends and Transactions. HealthCare Appraisers, Inc.; http://www.healthcareappraisers.com/HTYIR_2011.pdf

25. AGMA Medical Group Association 2011 Compensation and Financial Survey;
http://www.amga.org/Research/2011ExecSummary.pdf
26. HHCS 2012 Physician Salary and Benefits Report, Published by HHCS, Oakland, NJ, April 2012.

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT

RETREAT AGENDA
(Day 1 of 2)

Tuesday, March 17, 2015 at 8:00 a.m.

Big Pine Room, Granlibakken Conference Center & Lodge
725 Granlibakken Road Tahoe City, CA 96145

1. CALL TO ORDER

2. ROLL CALL

3. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Board on items which are, or are not, on the agenda. 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 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.

4. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

4.1. **Contracts** [*8:00 – 8:15 a.m.]*

4.1.1. **New**

a. Krause _Rural PRIME Site Clerkship Director ..... ATTACHMENT
b. Krause_Rural PRIME Site Medical Director ..... ATTACHMENT
c. Samelson_PSA Medical Director Medical Education Committee ..... ATTACHMENT
d. Thompson_PSA_Training_and_Education_2015 ..... ATTACHMENT
e. Taylor_PSA_Training_and_Education_2015 ..... ATTACHMENT
f. Coll_PSA_Training_and_Education_2015 ..... ATTACHMENT

5. RETREAT ITEMS FOR BOARD DISCUSSION

No formal action will be taken by the Board of Directors; only direction to staff. Any action items will be agendized for a regular meeting of the Board of Directors.

5.1. **CEO Search Process** *[8:15 – 9:15 a.m.]* ..... ATTACHMENT
The Board will be provided background related to the process of selection for an executive search firm and recruitment of a Chief Executive Officer.

BREAK

5.2. **Board Order & Decorum** *[9:30 a.m. – 12:00 p.m.]* ..... *ATTACHMENT
The Board will be provided education and training related to board order and decorum best practices, review of the Brown Act and ethics laws.

LUNCH

5.3. **Board Order & Decorum – continued** *[1:00 p.m. – 2:30 p.m.] ..... *ATTACHMENT
The Board will be provided education and training related to board order and decorum best practices, review of the Brown Act and ethics laws.

BREAK

5.4. **Strategic Plan Review and Chief Executive Officer Goals** *[2:45 p.m. – 3:45 p.m.] .....* ATTACHMENT
The current strategic plan will be reviewed and the Board will identify priority initiatives on which the Interim Chief Executive Officer should focus.

6. PUBLIC COMMENT *[3:45 p.m. – 4:00 p.m.]*

7. ADJOURNMENT
Adjourn meeting to Wednesday, March 18, 2015 at 8:00 a.m. at the Big Pine Room, Granlibakken Conference Center & Lodge, 725 Granlibakken Road Tahoe City, CA 96145

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RETREAT AGENDA
(Day 2 of 2)

Wednesday, March 18, 2015 at 8:00 a.m.
Big Pine Room, Granlibakken Conference Center & Lodge
725 Granlibakken Road Tahoe City, CA 96145

8. CALL TO ORDER

9. ROLL CALL

10. RETREAT ITEMS FOR BOARD DISCUSSION
No formal action will be taken by the Board of Directors; only direction to staff. Any action items will be agendized for a regular meeting of the Board of Directors.

10.1. **Introduction and Ground Rules** [*8:00 – 8:45 a.m.]..... *ATTACHMENT
The Board will discuss and agree to ground rules for the conduct of the day's retreat activities.

BREAK

10.2. **Board SWOT Analysis** *[9:00 – 11:00 a.m.] ..... *ATTACHMENT
The Board will participate in a Strengths, Weaknesses, Opportunities and Threats (SWOT) exercise.

LUNCH

10.3. **Board Priorities and Goals** *[11:30 a.m. – 2:00 p.m.]* ..... ATTACHMENT
The Board will discuss 2015 board priorities and goals.

BREAK

11. SUMMARY and NEXT STEPS *[2:15 – 3:15 p.m.]*

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

13. PUBLIC COMMENT *[3:15 – 3:30 p.m.]*

14. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 31, 2015, 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

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

Tahoe Forest Hospital

Board of Directors Retreat – Meeting Notes

March 18, 2015

TAHOE FOREST HOSPITAL DISTRICT

Agenda

On March 18, 2015, the Tahoe Forest Board of Directors met to focus on strategic direction of the Board and the Hospital.

Agenda	
Introduction & Ground Rules	**8:00 – 8:45 AM**
Break	
SWOT Analysis	**9:00 – 11:00 AM**
Lunch	
Board Goals – 2015	**11:30 – 2:00 PM**
Break	
Summary & Next Steps	**2:15 – 3:15 PM**

TAHOE FOREST HOSPITAL DISTRICT

Established Ground Rules

Meeting ground rules were established to ensure meeting success and a general sense of accomplishment.

- Use a “time-out” motion to refocus the group
- Put an idea on trial, not a person
- Use your inside voice
- Do not interrupt
- Stay on point
- Use reflective listening – repeat to understand
- Participate
- Maintain a written record

Pre-Workshop Observations

Prior to the Board Retreat, ELTE spoke with each Board Member and the key Administrators at the Hospital. Here are the themes from those discussions:

What does this mean?

Pre-Workshop Observations and Key Themes

The previously displayed infographic utilizes word emphasis to provide a visual of common topics and themes. The information is shared below in a more traditional format.

Financial Stability	Compliance	Community
• CEO Search • Board Focus (micromanagement) • Strategic Goals • Board Governance • Public Image/ Transparency • Respect	• Brown Act • Community Needs • Affordable Care Act • Board Goals • Staff • Competitive Assessment	

Board is Unanimously Focused on the Success of the Hospital

Tahoe Forest Hospital District

SWOT Analysis

The Board of Directors took time to complete a SWOT analysis that focused on Tahoe Forest Hospital. After exhaustively completing the SWOT, each Director used stars to denote key items of greater importance. The results will be leveraged for future planning.

Strengths	Weaknesses	Opportunities	Threats
Characteristics of the business that give it an advantage over the others	Characteristics that place the business at a disadvantage over others	External elements the business could exploit to its advantage	External elements that could cause trouble for the business
Internal		*External*	

Create a baseline understanding of today's reality.
The output allows for future planning/goal setting.

Note: The following four slides contain the SWOT information. Items in bold received between 1 & 4 stars of importance. Items in bold and larger font received 5 stars or greater.

TAHOE FOREST HOSPITAL DISTRICT

Strengths

- Highly skilled employees
- **Competent & dedicated staff**
- Longevity of employees
- **Patient experience**
- **Quality initiatives/results**
- **MD participation**
- Admin/Staff relationship
- **Commitment to community wellness**
- Best HR department
- **High care/satisfaction ratings**
- **New facilities/equipment**
- "State of the Art" cancer center
- Intelligent & capable retired community
- Bond ratings
- **Relative current financial position**
- **Strong reputation in community**
- Facilities seismically updated
- **UC Davis**
- Physician leadership
- **New leadership**
- Economic driver of community
- **21st Century healthcare**
- Modern technology
- **Nursing staff**
- Availability of consultants
- **Good emergency room**
- Robust tourism
- **Quality of care**
- **Innovation**
- **Nimble/agile**
- **Critical access**
- Public supported
- Support between medical staff & administration
- **Community support**
- Integral part of the community
- Continuum of care

TAHOE FOREST HOSPITAL DISTRICT

Weaknesses

- **Data analytics**
- Public elected board
- Brown act
- **Price competition with other institutions (Reno Diagnostic)**
- Small population
- **Increasing MediCal**
- **Difficulty communicating value to community**
- Poor payer mix
- Difficulty in developing economies of scale
- **Difficulty attracting/retaining key highly skilled "single" job positions**
- Baggage from previous CEO's legal issues
- **MD recruitment/retention**
- **Board dysfunction undermines public perception of TFHD**
- **MSC conflict**
- **EMR/IT**
- **Compliance**
- Education + current practices
- **Physician referrals**
- **Consumer referrals**
- Physician/patient demand (low)
- **Better communicate with the public – transparent, educate**
- Legal team
- **Mission/vision statements**
- **Cultural differences in community**
- **Communication in community (bi-lingual)**

Opportunities

- Board/C-suite relations
- **New relations with MDs**
- Capture market share of possible out migration
- Multiple community organization/partners
- **Keep patients from going off the hill**
- **Partnerships with others in our community/outside community**
- **Innovation with regards to IT, HER, HIS, etc.**
- **Chronic disease management = better health = better ACA**
- Overcome bad press from 2014
- **Use focus on TFHD to engage and involve community with our initiatives**
- **Build cancer and orthopedic volumes**
- **Enormous intellectual capital in community**
- **Community focus on substance abuse/ mental health issues**
- **Include Hispanic population**
- **Affordable Care Act**
- **Increase revenue from non-traditional sources**
- **Community health needs**
- **Better financial consulting for patients**
- **MD education of economics of reimbursement**
- Strategic planning
- CEO search
- Board governance
- **Product line vs. community needs – educate the public**

Tahoe Forest Hospital District

Threats

- Investigative reporting
- **Declining insurance reimbursement**
- **Payer type/mix**
- **Public opinion perception**
- **Aging MDs**
- **Regulatory agencies, compliance (National)**
- **Governmental regulatory uncertainties**
- **Expense of compliance/legal impairs ability to provide healthcare**
- Ongoing distraction from 1090 investigation
- **Misinformation**
- Global warming
- Vocal anti-tax group in community
- Natural disasters
- Medicaid expansion program
- Economic trends
- Disease
- **Competitive threats**
- Poor snow conditions
- Covered California

TAHOE FOREST HOSPITAL DISTRICT

Board Goals/Priorities

After completing the SWOT analysis, the Board directed their attention to identifying goals for themselves to achieve in the next 12 months. They worked to create realistic, strategic goals that were SMART (specific, measurable, attainable, realistic and timely). Eight areas of focus were identified.

- CEO search
- Board/Administration relationship
- District sustainability
- Board/Community relationship
- Mission/Vision update
- Compliance
- Ethics
- Meeting strategy – decrease meeting time

Board Goals/Priorities – CEO Search

Stated Goal: Confirm a CEO within 12 months

Tactics

1. The personnel committee will create a CEO search process plan
   - Commence on April 9
   - Communicate the plan/process
2. Personnel staff to establish CEO criteria with input from medical staff, employees, the community and Board (all stakeholder groups)
3. Vet a search firm/negotiate contract

Board Goals/Priorities – Board/Administration Relationship

Stated Goal: Develop a Strong Partnership between the Board & CEO

Tactics

1. Establish a formalized/systematic CEO review process
   - Driven by the Personnel Committee
   - Commence on April 9
2. Friday Update provided to the Board by the CEO
3. No surprises – both directions

Tahoe Forest Hospital District

Board Goals/Priorities – District Sustainability

Stated Goal: Ensure the Long-term Viability of the Hospital District

Tactics

1. Board to be educated and understand the necessary business models for the future
   - CEO to provide education materials on a consistent basis

Board Goals/Priorities – Board/Community Relationship

Stated Goal: Improve the Relationship between the Board, Hospital and the Community

Tactics

1. Develop a plan with the small vocal community group
   - Rotating Board Director and CEO to provide a feedback/communication loop
   - Breakfast meeting approximately every six weeks
   - Establish an "ears open, mouth closed" approach
2. Monthly Board Director/CEO rounding for staff
3. Board Directors to continue to engage in the community
   - Coordination with Ted and Paige

Tahoe Forest Hospital District

Board Goals/Priorities – Mission/Vision Update

Stated Goal: Update the Mission and Vision Statements

Tactics

1. CEO will determine best practices and make a recommendation to the Board
2. Process will be completed prior to hiring a new CEO
3. Process will be collaborative with all stakeholders

Tahoe Forest Hospital District

Board Goals/Priorities – Compliance

Stated Goal: Ensure Effective Compliance Program is a Priority of the Board

Tactics

1. Work closely with Administration
2. Quarterly update report to the Board from the CEO
3. Review the consultant reports/recommendations

Board Goals/Priorities – Ethics

Stated Goal: It is a Priority of the Board that TFHD Functions to the Highest Ethical Standards

Tactics

1. Review current ethics policies
2. Adopt the JUST Culture
3. Lead by example at the Board level
4. Ongoing education

Board Goals/Priorities – Meeting Strategy

Stated Goal: Limit regular, open-session, Board meetings to 3-4 hours, once a month

Tactics

1. Limit presenters to 5 minutes
2. Develop a hard stop time limit (10:00 PM)
3. Move consent to the end of the agenda
4. No surprises

Summary/Next Steps

Over the course of the day, the Board successfully identified goals for the next 12 months. And, through a SWOT analysis, provided information to Administration regarding priorities for the Hospital.

- Next Steps
  - Review & adopt goals at March Board Meeting
  - Communicate goals and intent to stakeholders
  - Follow-up on goals in six months in a retreat style meeting

TAHOE FOREST HEALTH SYSTEM

FINANCE COMMITTEE AGENDA

Tuesday, March 24, 2015 at 9:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Dale Chamblin, Chair; Greg Jellinek, M.D., Board Member

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

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

5. APPROVAL OF MINUTES OF: 02/23/2015 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Financial Reports:
- 6.1.1. Financial Report – February 2015 ..... ATTACHMENT
- 6.1.2. Tahoe Forest Health System Foundation Financial Report – Six Months Ending December 31, 2014 ..... ATTACHMENT
- 6.1.3. 2016 Budget Update – Volumes and Gross Revenues ..... ATTACHMENT

6.2. Refinancing of Bonds – Revenue Bonds, Series 2006 ..... ATTACHMENT

6.3. Board Education
- 6.3.1. 96 Hour Physician Certification Rule – Potential financial impact ..... ATTACHMENT
- 6.3.2. Delivery System Reform Incentive Program (DSRIP) ..... ATTACHMENT

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

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

9. NEXT MEETING DATE ..... ATTACHMENT

10. ADJOURN

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

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TAHOE FOREST HOSPITAL DISTRICT (the "District")
FINANCE DIVISION MEMORANDUM

TO: Finance Committee and Board of Directors

FROM: Crystal Betts, Chief Financial Officer

DATE: March 24, 2015

SUBJECT: 2015 Refunding Revenue Bonds Financing Summary

On March 31, 2015, the District's Board of Directors (the "Board") will be asked to approve Resolution No. 2015-02 that authorizes the sale and issuance of Hospital Refunding Revenue Bonds (the "2015 Refunding Bonds") in an amount not exceeding the amount necessary to defease and redeem the District's outstanding 2006 Hospital Revenue Bonds (the "Bonds to be Refunded") and authorizing certain "Designated Officers" of the District to execute documents and take action necessary for the sale and issuance of the 2015 Refunding Bonds. Adoption of this resolution gives management the authority to negotiate and approve final terms and conditions with the underwriters and/or placement agent (the "Initial Purchasers") of the 2015 Refunding Bonds and to issue the 2015 Refunding Bonds, contingent upon the ability to provide a minimum net present value savings as a percentage of the par amount of the outstanding Bonds to be Refunded (net of costs of issuance) of at least 5%. Current estimated net present value savings is approximately $2,324,000 or 10.0%.

Management believes that tax-exempt interest rates currently available offer the District an opportunity to generate adequate debt service savings relative to the Bonds to be Refunded without extending the final maturity of said bonds. In fact, the final maturity of the 2015 Refunding Bonds may be shorter than the final maturity of the Bonds to be Refunded. While interest rates for underwritten bonds are not determined until the bonds are sold, the current interest rate environment suggests a likely all-in true interest cost (TIC) of approximately 3.67% based upon discussions with our underwriting syndicate. Given current market conditions, we estimate that total debt service savings over the life of the Bonds to be Refunded to be approximately $2,565,000. Final savings may be greater or less than indicated above depending on the final structure of the 2015 Refunding Bonds.

The following summarizes the purpose of the final bond resolution to be reviewed by the Board on March 31, 2015.

Resolution No. 2015-02. The final bond resolution describes the uses of proceeds of the 2015 Refunding Bonds, establishes a limit as to the principal amount of bonds authorized to be issued and establishes a minimum net present value debt service savings to be achieved with the refunding. This final bond resolution states that debt service payments due for the 2015 Refunding Bonds will be repaid from revenues of the District just as the Bonds to be Refunded have been repaid since their issuance in 2006. This resolution authorizes the sale and issuance of the 2015 Refunding Bonds and authorizes the President, Vice President, Secretary and Assistant Secretary of the Board, the District's Chief Executive Officer and/or its Chief Financial Officer to take any and all necessary action needed to carry out the resolution's intended purposes, including the negotiation of final terms and conditions with the Initial Purchasers of the 2015 Refunding Bonds.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Crystal Betts
Chief Financial Officer

DATE: March 19, 2015

ISSUE:

The District intends to issue refunding revenue bonds (2015 bonds) pursuant to this Resolution to provide for the redemption of all outstanding 2006 revenue bonds.

BACKGROUND:

February 1, 2006, the District issued its Tahoe Forest Hospital District Revenue Bonds, Series 2006, in the original principal amount of $27,385,000, of which $23,240,000 principal amount remains outstanding. These bonds were issued for the purpose of (a) refunding a portion of the 1999A Revenue Bonds, and (b) financing the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District (known primarily as the Western Addition).

Per this Resolution, these 2015 bonds may be issued only if the present value savings to be realized by the District with respect to the 2006 Bonds is not less than 5% of the outstanding principal balance of the 2006 Bonds and the maturity date of the 2015 Bonds shall not be any later than the maturity date of the 2006 Bonds.

ACTION REQUESTED:

Approval of Resolution 2015-02 Authorizing the Issuance and Sale of the District's 2015 Refunding Revenue Bonds

Alternatives:

Not issuing the refunding revenue bonds and foregoing the resulting savings to the District.

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2015-02

RESOLUTION APPROVING THE FORM AND AUTHORIZING THE EXECUTION AND DELIVERY OF A FOURTH SUPPLEMENTAL INDENTURE OF TRUST, AN ESCROW AGREEMENT, A PRELIMINARY OFFICIAL STATEMENT AND BOND PURCHASE AGREEMENTS IN CONNECTION WITH THE ISSUANCE, SALE AND DELIVERY OF THE TAHOE FOREST HOSPITAL DISTRICT HOSPITAL REFUNDING REVENUE BONDS, SERIES 2015, AND APPROVING CERTAIN OTHER ACTIONS

WHEREAS, TAHOE FOREST HOSPITAL DISTRICT ("District") is a hospital district duly organized and existing under the Local Health Care District Law of the State of California;

WHEREAS, the District has heretofore issued its $14,830,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Revenue Bonds, Series 1999A (the "1999A Bonds"), and its $5,125,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Revenue Bonds, Series 1999B (the "1999B Bonds, and, with the 1999A Bonds, the "1999 Bonds"), for the purpose of financing and refinancing the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District;

WHEREAS, the 1999 Bonds were issued pursuant to that certain Indenture of Trust, dated as of July 1, 1999 (the "Original Indenture"), by and between the District and BNY Western Trust Company (now known as The Bank of New York Mellon Trust Company, N.A.), as trustee (the "Trustee");

WHEREAS, the District has also heretofore issued its $12,000,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Variable Rate Demand Revenue Bonds, Series 2002, currently outstanding in the principal amount of $9,555,000 (the "2002 Bonds"), for the purpose of financing the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District;

WHEREAS, the 2002 Bonds were issued pursuant to the Original Indenture, as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Trustee;

WHEREAS, the District has also heretofore issued its $27,385,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, currently outstanding in the principal amount of $23,240,000 (the "2006 Bonds"), for the purpose of (a) refunding a portion of the 1999A Bonds and (b) financing

the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District;

WHEREAS, the 2006 Bonds were issued pursuant to the Original Indenture, as amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee;

WHEREAS, none of the 1999 Bonds is currently outstanding;

WHEREAS, the District desires to refund all outstanding 2006 Bonds;

WHEREAS, to refund the 2006 Bonds, the District has determined to issue its Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015 (the "2015 Bonds"), on a parity as to payment and security with the 2002 Bonds; and

WHEREAS, the District has determined to authorize the officers of the District to take all necessary action to accomplish the issuance, sale and delivery of the 2015 Bonds;

NOW, THEREFORE, it is hereby ORDERED and DETERMINED, as follows:

Section 1. The issuance of the 2015 Bonds is hereby authorized and approved. The President of the Board of Directors (the "Board") of the District, the Vice President of the Board, the Secretary of the Board, the Assistant Secretary of the Board, the Chief Executive Officer of the District, the Chief Financial Officer of the District, or any other person authorized by this Resolution or other resolution of the Board to act on behalf of the District with respect to this the 2015 Bonds (the "Designated Officers") shall determine, on behalf of the District, whether the 2006 Bonds shall be refunded; *provided, however*, that, in any case, the 2015 Bonds may be issued only if the net present value savings to be realized by the District with respect to the 2006 Bonds as a result of the issuance of the 2015 Bonds is not less than 5% of the outstanding principal balance of the 2006 Bonds. The maturity date of the 2015 Bonds shall not be any later than the maturity date of the 2006 Bonds.

Section 2. The form of the fourth supplemental indenture of trust, by and between the District and U.S. Bank National Association, as successor to Trustee (the "Successor Trustee"), amending and supplementing the Original Indenture, as amended, as presented to this meeting, is hereby approved. Any Designated Officer, acting alone, is hereby authorized and directed, for and in the name of the District, to execute and deliver a fourth supplemental indenture of trust in substantially the form presented to this meeting, with such changes therein as the officer executing the same may approve, including but not limited to revisions that may be necessary or appropriate to provide for a private placement of the 2015 Bonds, as described below, such approval to be conclusively evidenced by the execution and delivery of such fourth supplemental indenture of trust. The date, maturity dates, interest rates, interest payment dates, denominations, forms, registration privileges, place or places of payment, terms of redemption and other terms

of the 2015 Bonds shall be as provided in said fourth supplemental indenture of trust, as finally executed.

Section 3. The form of escrow deposit and trust agreement, by and between the District and The Bank of New York Mellon Trust Company, N.A., as escrow bank, relating to the refunding of the 2006 Bonds, as presented to this meeting, is hereby approved. Any Designated Officer, acting alone, is hereby authorized and directed, for and in the name of the District, to execute and deliver an escrow deposit and trust agreement in substantially the form presented to this meeting, with such changes therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of such escrow deposit and trust agreement.

Section 4. The form of official statement relating to the 2015 Bonds if sold pursuant to a public offering, as presented to this meeting, is hereby approved. Any Designated Officer, acting alone, is hereby authorized and directed, for and in the name of the District, to execute and deliver an official statement in substantially the form presented to this meeting, with such changes therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of such official statement and to certify or represent that prior to purchase, offer or sale of the 2015 Bonds, the official statement is deemed final by the District for purposes of Rule 15(c)2-12 of the Securities and Exchange Commission. Distribution of the final official statement to the purchasers of the 2015 Bonds is hereby authorized and distribution of the official statement in preliminary form to persons interested in the purchase of the 2015 Bonds is hereby approved.

Section 5. The form of bond purchase agreement by and between the District and Southwest Securities, Inc., Piper Jaffray & Co. and Raymond James & Associates, Inc. (the "Underwriters"), as presented to this meeting, is hereby approved. Any Designated Officer, acting alone, is hereby authorized and directed for and in the name of the District, to execute and deliver a bond purchase agreement, in substantially the form presented to this meeting, with such changes therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of such bond purchase agreement, so long as the Underwriters' discount for purchase of the 2015 Bonds does not exceed 1.00% (not including any original issue discount which does not constitute compensation to the Underwriter). If a Designated Officer determines to sell a portion of the Bonds on a private placement basis, the Bond Purchase Agreement approved by this paragraph shall relate only to the portion of the Bonds sold pursuant to a public offering.

If a Designated Officer shall determine, in consultation with the District's financial advisor and Underwriters, that a private placement of all or a portion of the Bonds, will produce greater present value savings of the 2015 Bonds, the Board hereby authorizes the private placement of all or a portion of the Bonds to the institutional purchaser or purchasers identified by the District's financial advisor and Underwriters. The form of private placement bond purchase agreement by and between the District and such institutional purchaser or purchasers, as presented to this meeting, is hereby

approved. Any Designated Officer, acting alone, is hereby authorized and directed for and in the name of the District, to execute and deliver a private placement bond purchase agreement, in substantially the form presented to this meeting, with such changes therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of such bond purchase agreement. If a Designated Officer determines to sell a portion of the Bonds on a public offering basis, the Bond Purchase Agreement approved by this paragraph shall relate only to the portion of the Bonds sold pursuant to a private placement.

Section 6. Each Designated Officer is hereby authorized and directed, for and in the name of the District, to execute and deliver any other documents as may be deemed necessary or appropriate to implement the refunding of the 2006 Bonds or to issue the 2015 Bonds, such approval to be conclusively evidenced by the execution and delivery of such documents.

Section 7. The 2015 Bonds shall be executed by the manual or facsimile signature of the President, the Vice President, the Chief Executive Officer or the Chief Financial Officer, or the designee thereof, and attested by the manual or facsimile signature of the Secretary or Assistant Secretary of the Board, in the form set forth in and otherwise in accordance with said fourth supplemental indenture of trust.

Section 8. The 2015 Bonds, when so executed, shall be delivered to the Successor Trustee for authentication by the Successor Trustee. The Successor Trustee is hereby requested and directed to authenticate the 2015 Bonds by executing the Trustee's Certificate of Authentication appearing thereon, and to deliver the 2015 Bonds, when duly executed and authenticated, to the order of the Underwriter in accordance with written instructions of the District. Said instructions shall provide for the delivery of the 2015 Bonds to the order of the Underwriters upon payment of the purchase price thereof.

Section 9. The Secretary or the Assistant Secretary of the Board is hereby authorized and directed to attest the signature of the President, the Vice President, the Chief Executive Officer, the Chief Financial Officer, or the designee thereof, as may be required in connection with the execution and delivery of the fourth supplemental indenture, the bond purchase contract, the official statement and the 2015 Bonds in accordance with this Resolution.

Section 10. The President, the Vice President, the Chief Executive Officer, the Chief Financial Officer, or the designee thereof, are each hereby authorized and directed to do the following with respect to the issuance of the 2015 Bonds:

(a) take any and all actions and execute, acknowledge, deliver and file any and all agreements, instruments or other documents of any kind required of the District; and

(b) act as an agent to the District for the purposes of issuing the 2015 Bonds and any additional negotiations, authorizations, approval, executions, consents, notices, deliveries or other acts required to issue such 2015 Bonds.

Section 11. All actions taken by the President, the Vice President, the Chief Executive Officer, the Chief Financial Officer, or the designee thereof, and other officers or directors of the District which have been undertaken to date or which will be undertaken with respect to the planning, negotiation, authorization, approvals and implementation of the financing plan are hereby ratified, confirmed and approved in all respects.

Section 12. This resolution shall take effect immediately upon its passage.

* * * * * * *

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 31st day of March, 2015 by the following vote:

AYES: _____, _____, _____,

_____, _____

NOES: _____, _____

ABSENT: _____, _____

ABSTAIN: _____, _____

_____
Karen Sessler, M.D.
President, Board of Directors
Tahoe Forest Hospital District

ATTEST:

_____
Greg Jellinek, M.D.
Secretary, Board of Directors
Tahoe Forest Hospital District

FOURTH SUPPLEMENTAL INDENTURE OF TRUST

by and between the

TAHOE FOREST HOSPITAL DISTRICT

and

U.S. BANK NATIONAL ASSOCIATION, as Trustee

Dated as of April 1, 2015

Relating to
$_____
Tahoe Forest Hospital District
(Placer and Nevada Counties, California)
Hospital Refunding Revenue Bonds, Series 2015

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EXHIBIT A - FORM OF 2015 BOND

FOURTH SUPPLEMENTAL INDENTURE OF TRUST

THIS FOURTH SUPPLEMENTAL INDENTURE OF TRUST, is dated as of April 1, 2015 (the "Fourth Supplemental Indenture"), by and between the TAHOE FOREST HOSPITAL DISTRICT, a local health care district organized and existing under the constitution and laws of the State of California (the "District"), and U.S. BANK NATIONAL ASSOCIATION, a national banking association organized and existing under the laws of the United States of America, with a corporate trust office in San Francisco, California, and being qualified to accept and administer the trusts hereby created, as trustee (the "Trustee"), amending and supplementing that certain Indenture of Trust, dated as of July 1, 1999, by and between the District and the Trustee (the "Original Indenture"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Trustee (the "First Supplemental Indenture"), as amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Trustee (the "Second Supplemental Indenture"), and as amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee (the "Third Supplemental Indenture" and, with the First Supplemental Indenture and the Second Supplemental Indenture, the "Indenture");

W I T N E S S E T H :

WHEREAS, the District has heretofore issued its $14,830,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Revenue Bonds, Series 1999A (the "1999A Bonds"), and its $5,125,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Revenue Bonds, Series 1999B (the "1999B Bonds, and, with the 1999A Bonds, the "1999 Bonds"), for the purpose of financing and refinancing the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District;

WHEREAS, the 1999 Bonds were issued pursuant to that certain Indenture of Trust, dated as of July 1, 1999 (the "Original Indenture"), by and between the District and BNY Western Trust Company (now known as The Bank of New York Mellon Trust Company, N.A.), as trustee (the "Trustee");

WHEREAS, the District has also heretofore issued its $12,000,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Variable Rate Demand Revenue Bonds, Series 2002, currently outstanding in the principal amount of $9,555,000 (the "2002 Bonds"), for the purpose of financing the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District;

WHEREAS, the 2002 Bonds were issued pursuant to the Original Indenture, as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Trustee;

WHEREAS, the District has also heretofore issued its $27,385,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, currently outstanding in the principal amount of $23,240,000 (the "2006 Bonds"), for the purpose of (a) refunding a portion of the 1999A Bonds and (b) financing the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District;

WHEREAS, the 2006 Bonds were issued pursuant to the Original Indenture, as amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee;

WHEREAS, none of the 1999 Bonds is currently outstanding;

WHEREAS, the District desires to refund all outstanding 2006 Bonds;

WHEREAS, to refund the 2006 Bonds, the District has determined to issue its Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015 (the "2015 Bonds"), on a parity as to payment and security with the 2002 Bonds;

WHEREAS, it is also appropriate to amend certain provisions of the Indenture to correct certain ambiguous and inconsistent provisions therein;

WHEREAS, in order to provide for the authentication and delivery of the 2015 Bonds, to establish and declare the terms and conditions upon which the 2015 Bonds are to be issued and secured and to secure the payment of the principal thereof and of the interest and premium, if any, thereon, the Board of Directors of the District has authorized the execution and delivery of this Fourth Supplemental Indenture; and

WHEREAS, the District has determined that all acts and proceedings required by law necessary to make the 2015 Bonds, when executed by the District, authenticated and delivered by the Trustee and duly issued, the valid, binding and legal special obligations of the District, and to constitute the Fourth Supplemental Indenture a valid and binding agreement for the uses and purposes herein set forth, in accordance with its terms, have been done and taken; and the execution and delivery of the Fourth Supplemental Indenture have been in all respects duly authorized;

NOW, THEREFORE, THE FOURTH SUPPLEMENTAL INDENTURE WITNESSETH, that in order to secure the payment of the principal of and the interest and premium (if any) on all 2015 Bonds at any time issued and Outstanding under the Indenture, according to their tenor, and to secure the performance and observance of all the covenants and conditions therein and herein set forth, and to declare the terms and conditions upon and subject to which the 2015 Bonds are to be issued and received, and in consideration of the premises and of the mutual covenants herein contained and of the purchase and acceptance of the 2015 Bonds by the Bondowners thereof, and for other valuable consideration, the receipt whereof is hereby acknowledged, the District does hereby covenant and agree with the Trustee, for the benefit of the respective Bondowners from time to time of the 2015 Bonds, as follows:

ARTICLE I

DEFINITIONS; AUTHORIZATION AND PURPOSE OF BONDS;
EQUAL SECURITY

Section 1.01. Definitions. All terms which are defined in Section 1.01 of the Indenture shall have the same meanings in this Fourth Supplemental Indenture as such terms are given in said Section 1.01. Unless the context otherwise requires, the additional terms defined in this Section 1.01 or in the preambles hereof shall for all purposes of this Fourth Supplemental Indenture and of the 2015 Bonds and of any certificate, opinion, request or other documents herein mentioned have the meanings specified in the recitals and in this Section 1.01.

"*Authorized Denomination*" means $5,000 or any integral multiple thereof.

"*Business Day*" means (a) any day that is not a Saturday, Sunday or legal holiday on which banking institutions in the State or in any state in which the city in which the principal corporate trust office of the Trustee is located, or (b) a day on which the New York Stock Exchange is closed.

"*Closing Date*" means the date upon which there is a physical delivery of the 2015 Bonds in exchange for the amount representing the purchase price of the 2015 Bonds by the Original Purchaser.

"*Code*" means the Internal Revenue Code of 1986 as in effect on the Closing Date or (except as otherwise referenced in the Indenture or this Fourth Supplemental Indenture) as it may be amended to apply to obligations issued on the Closing Date, together with applicable temporary and final regulations promulgated under the Code.

"*Escrow Agreement*" means that certain Escrow Deposit and Trust Agreement, dated the Closing Date, by and between the District and the Escrow Bank, relating to the refunding of the 2006 Bonds.

"*Escrow Bank*" means The Bank of New York Mellon Trust Company, N.A.

"*Escrow Fund*" means the fund by that name established and held by the Escrow bank under the Escrow Agreement.

"*Fair Market Value*" means the price at which a willing buyer would purchase the investment from a willing seller in a bona fide, arm's length transaction (determined as of the date the contract to purchase or sell the investment becomes binding) if the investment is traded on an established securities market (within the meaning of section 1273 of the Code) and, otherwise, the term "Fair Market Value" means the acquisition price in a bona fide arm's length transaction (as referenced above) if (i) the investment is a certificate of deposit that is acquired in accordance with applicable regulations under the Code, (ii) the investment is an agreement with specifically negotiated withdrawal or reinvestment provisions and a specifically negotiated interest rate (for example, a guaranteed investment contract, a forward supply contract or other investment agreement) that is acquired in accordance with applicable regulations under the Code, (iii) the investment is a United States Treasury Security--State and Local Government Series that is acquired in accordance with applicable regulations of the United States Bureau of Public Debt, or (iv) the investment is the Local Agency Investment Fund of the State.

"*Interest Payment Date*" means, with respect to the 2015 Bonds, January 1 and July 1 in each year, beginning July 1, 2015, and continuing so long as any 2015 Bonds remain Outstanding.

"*Original Purchaser*" means the first purchaser of the 2015 Bonds upon their authentication and delivery by the Trustee on the Closing Date.

"Refunding Bond Law" means the provisions of section 53570 *et seq.* of the California Government Code.

"*Trustee*" means U.S. Bank National Association or another trustee, which must be a banking association, banking corporation or trust company acting in the capacity of trustee under this Fourth Supplemental Indenture.

"*2015 Bonds*" means the Bonds authorized by Article II hereof.

"*2015 Costs of Issuance Account*" means the account by that name established and held by the Trustee pursuant to Section 3.02.

"*2015 Reserve Account*" means the account by that name established and held by the Trustee pursuant to Section 3.03.

"*2015 Reserve Requirement*" means, as of any calculation date, an amount, calculated by or on behalf of the District and certified to the Trustee in writing, equal to the least of (a) maximum annual debt service on the 2015 Bonds, (b) 125% of average annual debt service on the 2015 Bonds, (c) 10% of the then outstanding principal amount of the 2015 Bonds, and (d) $\$\_\_\_\_\_$.

Section 1.02. Rules of Construction. All references in this Fourth Supplemental Indenture to "Articles," "Sections," and other subdivisions are to the corresponding Articles, Sections or subdivisions of this Fourth Supplemental Indenture; and the words "herein," "hereof," "hereunder," and other words of similar import refer to this Fourth Supplemental Indenture as a whole and not to any particular Article, Section or subdivision hereof.

Words of the masculine gender shall be deemed and construed to include correlative words of the feminine and neuter genders. Unless the context shall otherwise indicate, words importing the singular number shall include the plural number and vice versa, and words importing persons shall include corporations and associations, including public bodies, as well as natural persons.

Section 1.03. Authorization and Purpose of 2015 Bonds. The District has reviewed all proceedings heretofore taken relative to the authorization of the 2015 Bonds and has found, as a result of such review, and hereby finds and determines that all things, conditions, and acts required by law to exist, happen and/or be performed precedent to and in the issuance of the 2015 Bonds do exist, have happened and have been performed in due time, form and manner as required by law, and the District is now authorized, as an exercise of the municipal affairs power of the District under the constitution and laws of the State and pursuant to the Local Health Care District Law and each and every requirement of law, to issue the 2015 Bonds in the manner and form provided in this Fourth Supplemental Indenture. Accordingly, the District hereby authorizes the issuance of the 2015 Bonds pursuant to the Refunding Bond Law, the Indenture and this Fourth Supplemental Indenture.

ARTICLE II

ISSUANCE OF 2015 BONDS

Section 2.01. Issuance of the Bonds; Terms of the 2015 Bonds.

(a) *Issuance of the 2015 Bonds*. The 2015 Bonds authorized to be issued by the District under and subject to the Refunding Bond Law, the Indenture and this Fourth Supplemental Indenture shall be designated the "Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015" and shall be issued in the original aggregate principal amount of _____ dollars ($_____).

(b) *Terms of the Bonds*. The 2015 Bonds shall be registered initially in the name of "Cede & Co.," as nominee of The Depository Trust Company as the initial Securities Depository, and shall be evidenced by one Bond for each maturity of the 2015 Bonds in the principal amount of the respective maturities of the 2015 Bonds. Registered ownership of the 2015 Bonds, or any portion thereof, may not thereafter be transferred except as set forth herein.

The 2015 Bonds shall be issued as fully registered Bonds in denominations of $5,000 or any integral multiple thereof. The 2015 Bonds shall be dated as of the Closing Date and interest thereon shall be payable semiannually on January 1 and July 1 of each year, commencing on July 1, 2015. The 2015 Bonds shall mature on the following dates in the following amounts and shall bear interest at the following rates per annum:

Maturity Date (July 1)	Principal Amount	Interest Rate	Maturity Date (July 1)	Principal Amount	Interest Rate

The principal or sinking fund installments of, and redemption premium, if any, of the Bonds shall be payable in lawful money of the United States of America at the Principal Corporate Trust Office. Payment of the interest on any Bond shall be made to the person whose name appears on the bond registration books of the Trustee as the Owner thereof as of the Record Date for each Interest Payment Date, such interest to be paid by check or draft mailed on each Interest Payment Date to the Owner at his or her address as it appears on such registration books; provided that such interest shall be paid by wire transfer to any Owner of at least $1,000,000 in aggregate principal amount of Bonds if the Owner makes a written request of the Trustee prior to the Record Date for an Interest Payment Date specifying the account address in the United States.

The 2015 Bonds shall be numbered consecutively, beginning with number R-1, and shall bear interest from the Closing Date. Interest shall be calculated on the basis of a three hundred sixty (360) day year of twelve thirty (30) day months.

Any such interest not so punctually paid or duly provided for shall forthwith cease to be payable to the Owners on such Record Date and shall be paid to the person in whose name the 2015 Bond is registered at the close of business on a Special Record Date for the payment of

such defaulted interest to be fixed by the Trustee, notice of which shall be given to the Owners by first class mail not less than ten (10) days prior to such Special Record Date.

Section 2.02. Redemption of the 2015 Bonds.

(a) *Optional Redemption of 2015 Bonds*. The 2015 Bonds maturing on or before July 1, ____, are not subject to redemption prior to their respective stated maturities. The 2015 Bonds maturing on or after July 1, ____, are subject to redemption prior to their respective stated maturities, at the option of the District, in whole or in part on any date by such maturities as are selected by the District (or if the District fails to designate such maturities, in inverse order of maturity) and by lot within a maturity, on or after July 1, ____, at a redemption price equal to the principal amount of 2015 Bonds called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium.

(b) *Mandatory Sinking Fund Redemption of 2015 Bonds*.

(i) The 2015 Bonds maturing on July 1, ____ (the "____ Term Bonds"), are subject to mandatory redemption on July 1 in each year on and after July 1, ___, to and including July 1, ____, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount

†Maturity

In the event that the Trustee shall redeem ____ Term Bonds in part but not in whole pursuant to subsection (a) of this Section 2.02, the amount of the ____ Term Bonds to be redeemed in each subsequent year pursuant to this subsection (b)(i) shall be reduced *pro rata*.

(ii) The 2015 Bonds maturing on July 1, ____ (the "____ Term Bonds"), are subject to mandatory redemption on July 1 in each year on and after July 1, ___, to and including July 1, ____, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount

†Maturity

In the event that the Trustee shall redeem ____ Term Bonds in part but not in whole pursuant to subsection (a) of this Section 2.02, the amount of the ____ Term Bonds to be redeemed in each subsequent year pursuant to this subsection (b)(ii) shall be reduced *pro rata*.

(c) *Partial Redemption; Selection*. All or a portion of any 2015 Bond may be redeemed, by lot but only in a principal amount equal to an Authorized Denomination. In the event that less than all of the 2015 Bonds outstanding are to be redeemed, the Trustee shall select the 2015 Bonds to be redeemed in such order of redemption as shall be selected by the District. Upon surrender of any 2015 Bond for redemption in part, the Trustee shall authenticate and deliver to the Owner thereof, at the expense of the District, a new 2015 Bond or 2015 Bonds of Authorized Denominations of the same type and maturity and in an aggregate principal amount equal to the unredeemed portion of the 2015 Bond so surrendered.

(d) *Notice of Redemption*. Notice of any such redemption shall be given by the Trustee on behalf and at the expense of the District by mailing a copy of a redemption notice by first class mail at least thirty (30) days and not more than sixty (60) days prior to the date fixed for redemption to each Owner of the 2015 Bond or 2015 Bonds to be redeemed at the address shown on the Registration Books; *provided, however*, that neither the failure to receive such notice nor any defect in any notice shall affect the sufficiency of the proceedings for the redemption of the 2015 Bonds.

All notices of redemption shall be dated and shall state: (i) the redemption date, (ii) the redemption price, (iii) if less than all Outstanding 2015 Bonds are to be redeemed, the identification (and, in the case of partial redemption, the respective principal amounts) of the 2015 Bonds to be redeemed, (iv) that on the redemption date the redemption price will become due and payable with respect to each such 2015 Bond or portion thereof called for redemption, and that interest with respect thereto shall cease to accrue from and after said date, (v) the place where such 2015 Bonds are to be surrendered for payment of the redemption price, and (vi) in the case of a redemption pursuant to Section 2.02(a), that such notice of redemption is revocable, no later than five days prior to the date set for redemption, notification of such revocation to be provided in the same manner as notice of redemption had been provided.

Notice of redemption having been given as aforesaid, the 2015 Bonds or portions of 2015 Bonds so to be redeemed shall, on the redemption date, become due and payable at the redemption price therein specified, and from and after such date (unless the District shall default in the payment of the redemption price) interest with respect to such 2015 Bonds or portions of 2015 Bonds shall cease to accrue and be payable. Upon surrender of such 2015 Bonds for redemption in accordance with said notice, such 2015 Bonds shall be paid by the Trustee at the redemption price. Installments of interest due on or prior to the redemption date shall be payable as herein provided for payment of interest. Upon surrender for any partial redemption of any 2015 Bond, there shall be prepared for the Owner a new 2015 Bond or 2015 Bonds of the same maturity in the amount of the unpaid principal. All 2015 Bonds which have been

redeemed shall be canceled by the Trustee, shall not be reissued and shall be destroyed pursuant to Section 12.04 of the Indenture.

In addition to the foregoing notice to the Owners, notice shall also be given by the Trustee at least thirty (30) days before the redemption date, by telecopy, registered, certified or overnight mail or by such other acceptable means, to all Securities Depositories and to an Information Service which shall state the information set forth above, but no defect in said notice nor any failure to give all or any portion of such further notice shall in any manner defeat the effectiveness of a call for redemption if notice thereof is given the Owners as described above.

The Trustee shall have no responsibility for a defect in the CUSIP number that appears on any 2015 Bond or in the redemption notice. The redemption notice may provide that the CUSIP numbers have been assigned by an independent service and are included in the notice solely for the convenience of 2015 Bondowners and that the Trustee and the District shall not be liable in any way for inaccuracies in said numbers.

Section 2.03. Book-Entry System. Notwithstanding any provision of this Fourth Supplemental Indenture to the contrary:

(a) The 2015 Bonds shall be initially issued registered in the name of "Cede & Co.," as nominee of The Depository Trust Company, the depository designated by the Original Purchaser, and shall be evidenced by one certificate in a denomination corresponding to the total principal of the 2015 Bonds. Registered ownership of such 2015 Bonds, or any portions thereof, may not thereafter be transferred except:

(i) to any successor of The Depository Trust Company or its nominee, or of any substitute depository designated pursuant to paragraph (ii) of this subsection (a) ("substitute depository"); provided that any successor of The Depository Trust Company or substitute depository shall be qualified under any applicable laws to provide the service proposed to be provided by it;

(ii) to any substitute depository designated in a written request of the District, upon (i) the resignation of The Depository Trust Company or its successor (or any substitute depository or its successor) from its functions as depository or (ii) a determination by the District that The Depository Trust Company or its successor is no longer able to carry out its functions as depository; provided that any such substitute depository shall be qualified under any applicable laws to provide the services proposed to be provided by it; or

(iii) to any person as provided below, upon (A) the resignation of The Depository Trust Company or its successor (or any substitute depository or its successor) from its functions as depository or (B) a determination by the District that The Depository Trust Company or its successor is no longer able to carry out its functions as depository; provided that no substitute depository which is not objected to by the District and the Trustee can be obtained.

(b) In the case of any transfer pursuant to paragraph (i) or paragraph (ii) of subsection (a) of this Section 2.03, upon receipt of all Outstanding 2015 Bonds by the Trustee, together with a written request of an Authorized Representative of the District to the Trustee, a single new 2015 Bond shall be issued, authenticated and delivered for each maturity of such 2015 Bond then outstanding, registered in the name of such successor or such substitute depository or their nominees, as the case may be, all as specified in such written request of an Authorized Representative of the District. In the case of any transfer pursuant to paragraph (iii) of

subsection (a) of this Section 2.03, upon receipt of all Outstanding 2015 Bonds by the Trustee together with a written request of an Authorized Representative of the District, new 2015 Bonds shall be issued, authenticated and delivered in such denominations and registered in the names of such persons as are requested in a written request of the District provided the Trustee shall not be required to deliver such new 2015 Bonds within a period less than sixty (60) days from the date of receipt of such a written request of an Authorized Representative of the District.

(c) In the case of partial redemption or an advance refunding of any 2015 Bonds evidencing all of the principal maturing in a particular year, The Depository Trust Company shall, at the District's expense, deliver the 2015 Bonds to the Trustee for cancellation and re-registration to reflect the amounts of such reduction in principal.

(d) The District and the Trustee shall be entitled to treat the person in whose name any 2015 Bond is registered as the absolute Owner thereof for all purposes of this Indenture and any applicable laws, notwithstanding any notice to the contrary received by the Trustee or the District; and the District and the Trustee shall have no responsibility for transmitting payments to, communication with, notifying or otherwise dealing with any beneficial owners of the 2015 Bonds. Neither the District nor the Trustee will have any responsibility or obligations, legal or otherwise, to the beneficial owners or to any other party including The Depository Trust Company or its successor (or substitute depository or its successor), except for the registered owner of any 2015 Bond.

(e) So long as all outstanding 2015 Bonds are registered in the name of Cede & Co. or its registered assign, the District and the Trustee shall reasonably cooperate with Cede & Co., as sole registered Owner, or its registered assign in effecting payment of the principal and redemption premium, if any, and interest due with respect to the 2015 Bonds by arranging for payment in such manner that funds for such payments are properly identified and are made immediately available on the date they are due.

(f) So long as all Outstanding 2015 Bonds are registered in the name of Cede & Co. or its registered assigns (hereinafter, for purposes of this paragraph (f), the "Owner"):

(i) All notices and payments addressed to the Owners shall contain the 2015 Bonds' CUSIP number.

(ii) Notices to the Owner shall be forwarded in the manner set forth in the form of blanket issuer letter of representations (prepared by The Depository Trust Company) executed by the District and received and accepted by The Depository Trust Company.

ARTICLE III

APPLICATION OF PROCEEDS

Section 3.01. Application of Proceeds of Sale of 2015 Bonds. Upon the receipt of payment for the 2015 Bonds on the Closing Date, the Trustee shall apply the proceeds of sale thereof (being $_____) as follows:

(a) The Trustee shall transfer to the Escrow Bank the amount of $_____, to be applied in accordance with the terms of the Escrow Agreement for the refunding of the 2006 Bonds;

(b) The Trustee shall deposit in the 2015 Costs of Issuance Account the amount of $_____, which represents the amount necessary for the payment of the Costs of Issuance of the 2015 Bonds; and

(c) The Trustee shall deposit in the 2015 Reserve Account the amount of $_____, which represents the 2015 Reserve Account Requirement.

The Trustee may, in its discretion, establish a temporary fund or account to facilitate the foregoing transfers.

Section 3.02. 2015 Costs of Issuance Account. There is hereby created a separate account within the Costs of Issuance Fund to be known as the "2015 Costs of Issuance Account," to be held in trust by the Trustee. The Trustee shall disburse moneys in the 2015 Costs of Issuance Account for the purpose of paying or reimbursing the payment of the Costs of Issuance of the 2015 Bonds, in accordance with the provisions of the Indenture. The moneys in the 2015 Costs of Issuance Account shall be used and withdrawn by the Trustee to pay the Costs of Issuance of the 2015 Bonds, first from amounts deposited therein derived from the District's contribution and second from 2015 Bond proceeds.

Any amounts remaining in the 2015 Costs of Issuance Account after July 28, 2015, shall be applied to the payment of debt service on the 2015 Bonds.

Section 3.03. 2015 Reserve Account. There is hereby created a separate account within the Bond Reserve Fund to be known as the "2015 Reserve Account," to be held in trust by the Trustee. All amounts in the 2015 Reserve Account shall be used and withdrawn by the Trustee solely for the purpose of (a) paying interest on or principal of the 2015 Bonds when due and payable to the extent that moneys deposited in the Interest Account or Principal Account, respectively, for the payment of the 2015 Bonds are not sufficient for such purpose, and (b) making the final payments of principal of and interest on the 2015 Bonds. On the date on which all 2015 Bonds shall be retired hereunder or provision made therefor, all moneys then on deposit in the 2015 Reserve Account shall be withdrawn by the Trustee and paid to the District.

Amounts in the 2015 Reserve Account shall be valued by the Trustee not less often than semi-annually. If, on any date of computation, moneys and securities on deposit in the 2015 Reserve Account are less than the 2015 Reserve Account Requirement (unless such deficiency is a result of a transfer therefrom), the District covenants and agrees that it will, within twelve months thereof, increase the amount therein to the 2015 Reserve Account Requirement. If such deficiency is a result of a transfer therefrom, the District covenants and agrees that it will, within twenty-four months thereof, increase the amount therein to the 2015 Reserve Account Requirement. If, on any date of computation, moneys and securities on deposit in the 2015 Reserve Account are in excess of the 2015 Reserve Account Requirement, the Trustee shall withdraw such excess amount and transfer such amount to the Interest Account.

The 2015 Reserve Account is established solely for the benefit of the 2015 Bonds and may not be used to pay debt service on the 2002 Bonds or any other bonds issued or to be issued by the District.

Section 3.04. Satisfaction of Requirements of Additional Bonds. The District hereby certifies that all provisions of Sections 3.05 and 3.06 of the Indenture relating to the issuance of Additional Bonds have been satisfied such that the 2015 Bonds are payable from Revenues and secured by the pledge made under the Indenture equally and ratably with the 2002 Bonds and such Additional Bonds as the District may hereafter issue.

Section 3.05. Validity of Bonds. The validity of the authorization and issuance of the 2015 Bonds shall not be affected in any way by any proceedings taken by the District and the recital contained in the 2015 Bonds that the same are issued pursuant to the Refunding Bond Law shall be conclusive evidence of their validity of their issuance.

ARTICLE IV

REVENUES; FUNDS AND ACCOUNTS

Section 4.01. Pledge of Revenues, Revenue Fund. The District has heretofore transferred, placed a charge upon, assigned and set over to the Trustee, for the benefit of the Bondowners, that portion of the Revenues which is necessary to pay the principal or Redemption Price of and interest on the Bonds (including the 2015 Bonds) in any year, together with all moneys on deposit in the Revenue Fund, to the punctual payment of the principal or Redemption Price of and interest on the Bonds (including the 2015 Bonds).

Section 4.02. Administration of Funds and Accounts. All funds and accounts created pursuant to the Indenture shall continue to be administered by the Trustee in the manner provided by the Indenture and this Fourth Supplemental Indenture as if there were a single issue of Bonds concurrently sold and delivered.

Section 4.03. Application of Sinking Fund Account.

(a) The Trustee shall establish and maintain a separate account within the Principal Account, such account to be designated "Series 2015 Sinking Fund Account."

(b) All amounts in the Series 2015 Sinking Fund Account shall be used and withdrawn by the Trustee solely to purchase or redeem or pay at maturity the Series 2015 Term Bonds as provided herein and in the Indenture.

(c) Subject to the terms and conditions set forth in the Indenture and in this Section 4.03, the 2015 Bonds shall be redeemed (or paid at maturity, as the case may be) by application of sinking fund installments in the amounts and upon the dates set forth in Section 2.02(b) hereof.

Section 4.04. Fees, Charges and Expenses of Trustee. Notwithstanding the provisions of Sections 8.04 and 9.06 of the Indenture, the Trustee shall be entitled to payment and reimbursement for reasonable fees for its services rendered hereunder and all advances, if any, including interest on all such advances at its prime rate then in effect, external counsel fees (including expenses), the allocated cost of internal legal services (to the extent such services are not redundant of services performed by external counsel) and all disbursements of internal counsel, and other expenses reasonably and necessarily made or incurred by the Trustee in connection with such services and, in the Event of Default, the Trustee shall have a first and prior lien on the funds held hereunder to secure the same; *provided, however*, that in no event shall the Trustee have a lien on premiums paid in connection with an optional redemption of 2015 Bonds or of any moneys held for the benefit of 2015 Bondowners. The Trustee's compensation shall not be limited by any provision of law in regard to the compensation of a trustee of an express trust. The Trustee's rights hereunder shall survive its resignation or removal and final payment of the 2015 Bonds.

Section 4.05. Investments.

(a) All moneys in any of the funds or accounts established with the Trustee pursuant to this Fourth Supplemental Indenture shall be invested by the Trustee solely in Investment Securities, as directed pursuant to the Request of the District filed with the Trustee at least two (2) Business Days in advance of the making of such investments. In the absence of any such directions from the District, the Trustee shall invest any such moneys in Investment Securities described in clause (5) of the definition thereof. Obligations purchased as an investment of moneys in any fund shall be deemed to be part of such fund or account. All interest or gain

derived from the investment of amounts in any of the funds or accounts established hereunder shall be deposited in the fund or account from which such investment was made. The Trustee may act as principal or agent in the acquisition of any investment. The Trustee shall incur no liability for losses arising from any investments made pursuant to this Section 4.08. The District acknowledges that to the extent regulations of the Comptroller of the Currency or other applicable regulatory entity grant the District the right to receive brokerage confirmations of security transactions as they occur, the District specifically waives receipt of such confirmations to the extent permitted by law. The Trustee will furnish the District with monthly account statements as provided herein which include detail for all investment transactions made by the Trustee hereunder.

(b) For investment purposes, the Trustee may commingle the funds and accounts established hereunder, but shall account for each separately.

Section 4.06. Acquisition; Valuation and Disposition of Investments. Except as otherwise provided in the next sentence, all investments of amounts deposited in any fund or account created by or pursuant to this Indenture, or otherwise containing gross proceeds of the 2015 Bonds (within the meaning of section 148 of the Code) shall be acquired, disposed of, and valued (as of the date that valuation is required by this Indenture of the Code) by the District at Fair Market Value. Investments in funds or accounts (or portions thereof) that are subject to a yield restriction under applicable provisions of the Code shall be valued at their present value (within the meaning of section 148 of the Code).

ARTICLE V

COVENANTS

Section 5.01. Tax Covenants.

(a) *Federal Guarantee Prohibition*. The District shall not take any action or permit or suffer any action to be taken if the result of the same would be to cause any of the 2015 Bonds to be "federally guaranteed" within the meaning of section 149(b) of the Code.

(b) *Rebate Requirement*. The District shall take any and all actions necessary to assure compliance with section 148(f) of the Code, relating to the rebate of excess investment earnings, if any, to the federal government, to the extent that such section is applicable to the 2015 Bonds.

(c) *No Arbitrage*. The District shall not take, or permit or suffer to be taken by the Trustee or otherwise, any action with respect to the proceeds of the 2015 Bonds which, if such action had been reasonably expected to have been taken, or had been deliberately and intentionally taken, on the date of issuance of the 2015 Bonds would have caused the 2015 Bonds to be "arbitrage bonds" within the meaning of section 148 of the Code.

(d) *Prohibited Facilities*. No portion of the proceeds of the 2015 Bonds shall be used to provide any airplane, skybox or other private luxury box, health club facility, facility primarily used for gambling, or store the principal business of which is the sale of alcoholic beverages for consumption off premises. No portion of the proceeds of the 2015 Bonds shall be used for an office unless the office is located on the premises of the facilities constituting the Project and unless not more than a *de minimis* amount of the functions to be performed at such office is not related to the day-to-day operations of the Project.

(e) *Use Covenant*. The District shall not use or knowingly permit the use of any proceeds of 2015 Bonds or any other funds of the District, directly or indirectly, in any manner, and shall not take or permit to be taken any other action or actions, which would result in any of the 2015 Bonds being treated as an obligation not described in section 145 of the Code by reason of such 2015 Bond not meeting the requirements of section 145 of the Code.

(f) *Maintenance of Tax-Exemption*. The District shall take all actions necessary to assure the exclusion of interest on the 2015 Bonds from the gross income of the Owners of the 2015 Bonds to the same extent as such interest is permitted to be excluded from gross income under the Code as in effect on the date of issuance of the 2015 Bonds.

(g) *Rebate of Excess Investment Earnings to United States*. The District hereby covenants to calculate or cause to be calculated excess investment earnings to the extent required by section 148(f) of the Code and shall cause payment of an amount equal to excess investment earnings to the United States in accordance with the Regulations, in each case at the sole expense of the District.

In order to provide for the administration of this Section 5.01(g), the District may provide for the employment of independent attorneys (including Bond Counsel), accountants and consultants compensated on such reasonable basis as the District or the Trustee may deem appropriate, and in addition to and without limitation of the provisions hereof, the Trustee may rely conclusively upon and shall be fully protected from all liability in relying upon the opinions, calculations, determinations, directions and advice of such attorneys, accountants and consultants employed by the District or the Trustee hereunder. The Trustee may rely conclusively upon the District's determinations, calculations and certifications required by this

Section 5.01. The Trustee shall have no responsibility to independently make any calculation or determination or to review the District's calculations hereunder.

Section 5.02. Confirmation of Indenture. Except as otherwise provided herein, all covenants made in Article VII of the Indenture are hereby confirmed as applicable to the 2015 Bonds under this Fourth Supplemental Indenture.

Section 5.03. Continuing Disclosure. The District shall undertake the continuing disclosure requirements promulgated under S.E.C. Rule 15c2-12, as it may from time to time hereafter be amended or supplemented. Notwithstanding any other provision of this Fourth Supplemental Indenture, failure of the District to comply with the requirements of S.E.C. Rule 15c2-12, as it may from time to time hereafter be amended or supplemented, shall not be considered an Event of Default hereunder.

ARTICLE VI

MISCELLANEOUS

Section 6.01. Amendments to the Indenture.

(a) The definition of "Bond Reserve Account Requirement" set forth in Section 1.01 of the Indenture is hereby amended in full as follows:

> "Bond Reserve Account Requirement" means, as of any date of calculation by the District for any Series of Bonds, the amount, if any, set as the Bond Reserve Account Requirement for that Series of Bonds which may be in any amount, subject to the applicable provisions of the Code for the funding of reserve funds.

(b) The definition of "Income Available for Debt Service" set forth in Section 1.01 of the Indenture is hereby amended in full as follows:

> "Income Available for Debt Service" means, as to any period of time, the excess of revenues over expenses of the District for such period, to which shall be added depreciation, amortization and interest, all as determined in accordance with generally accepted accounting principles, provided that no such determination shall include (1) any gain or loss resulting from (a) the extinguishment of Indebtedness, (b) any disposition of Property not made in the ordinary course of business or (c) adjustments to the value of assets or liabilities resulting from changes in generally accepted accounting principles or (2) any nonrecurring items of an extraordinary nature which do not involve the receipt, expenditure or transfer of assets. For the purposes of this definition, "revenues" do not include ad valorem property taxes levied to pay voter approved general obligation bonds.

(c) The definition of "Revenues" set forth in Section 1.01 of the Indenture is hereby amended in full as follows:

> "Revenues" means all revenues, income, receipts, moneys and present and future accounts and general intangibles received in any period by the District (other than donor-restricted gifts, grants, bequests, donations and contributions), including, but without limiting the generality of the foregoing: (a) gross revenues derived from its operation and possession of and pertaining to its properties, (b) each of the following and proceeds with respect to, arising from, or relating to its properties and derived from: (i) insurance (including business interruption insurance) or condemnation proceeds, (ii) accounts, including but not limited to, accounts receivable, (iii) securities and other investments, (iv) inventory and intangible property, or (v) payment/reimbursement programs and agreements, and contract rights, accounts, instruments, claims for the payment of moneys and other rights and assets now or hereafter owned, held or possessed by or on behalf of the District, and (c) rental received from the lease of the District's properties or space in its facilities. Revenues do not include ad valorem property taxes levied to pay voter approved general obligation bonds.

(d) Section 3.05 of the Indenture is hereby amended by adding a new subsection (f) as follows:

> (f) The District may but shall not be required to fund a Bond Reserve Account with respect to an additional Series of Bonds. If a Bond Reserve Account is funded for an additional Series of Bonds, such Bond Reserve Account shall secure only such additional Series of Bonds and shall not support any other Series of Bonds.

(e) Paragraph "Third" Section 5.02 of the Indenture is hereby amended in full as follows:

Third: to the Bond Reserve Account, if such account has been created for a Series of Bonds, at least one-twelfth of the aggregate amount of each prior withdrawal from such Bond Reserve Account for the purpose of making up a deficiency in the Interest Account or Principal Account; provided that no deposit need be made into a Bond Reserve Account so long as the balance in said account shall be at least equal to the Bond Reserve Account Requirement for such Bond Reserve Account.

(f) Section 5.05 of the Indenture is hereby amended in full as follows:

SECTION 5.05. Application of Bond Reserve Account.

(a) All amounts in the Bond Reserve Account, if created for a Series of Bonds, shall be used and withdrawn by the Trustee solely for the purpose of making up any deficiency in the Interest Account or the Principal Account with respect to such Series, or (together with any other moneys available therefor) for the payment or redemption of all Bonds of that Series then Outstanding or as provided below.

(b) All Permitted Investments in a Bond Reserve Account shall be valued semiannually by the Trustee on or about June 30 and December 31 of each year (and monthly beginning on the last Business Day of the month following any withdrawal therefrom or deficiency referred to in clause (ii) below until the amount therein again equals the Bond Reserve Account Requirement for such Bond Reserve Account) at market value, and in making any valuations the Trustee may utilize and rely upon such pricing services as may be available to it, including those within its accounting system. Any amount in such Bond Reserve Account in excess of the Bond Reserve Account Requirement for such Bond Reserve Account shall be transferred to the Revenue Fund and credited to the debt service due for the Series of Bonds applicable to such Bond Reserve Account. To the extent that amounts in a Bond Reserve Account are less than the Bond Reserve Account Requirement for such Bond Reserve Account, (i) as a result of the reduction in fair market value of the investments in such Bond Reserve Account valued semiannually as described above to a value that is less than 95% of the Bond Reserve Account Requirement for such Bond Reserve Account, the District shall replenish such Bond Reserve Account within 120 days of such valuation to an amount equal to the Bond Reserve Account Requirement or (ii) as a result of a withdrawal from such Bond Reserve Account for the purpose of making up a deficiency in the Interest Account or Principal Account with respect to the applicable Series of Bonds, the District shall restore such Bond Reserve Account to the Bond Reserve Account Requirement for such Bond Reserve Account in equal monthly installments within one year after such withdrawal as provided in clause "Third" of Section 5.02. The Trustee shall incur no liability for any sales of investments, or the consequences thereof, caused by a valuation made pursuant to this Section 5.05(b).

Section 6.02. Notices. All written notices to be given under this Fourth Supplemental Indenture shall be given by mail or personal delivery to the party entitled thereto at its address set forth below, or at such address as the party may provide to the other party in writing from time to time. All notices, certificates or other communications hereunder shall be sufficiently given and shall be deemed to have been received upon actual receipt.

If to the District:	Tahoe Forest Hospital District 10121 Pine Avenue Truckee, CA 96160 Attention: Chief Financial Officer Phone: (530) 582-3489 Telecopy: (530) 587-2532
If to the Trustee	U.S. Bank National Association One California Street, Suite 1000 San Francisco, CA 94111 Attention: Global Corporate Trust Services Phone: (415) 677-3593 Fax: (415) 677-3769

Section 6.03. Special Notices. The Trustee shall give written notice to Moody's, if Moody's shall have rated the 2015 Bonds, and S&P, if S&P shall have rated the 2015 Bonds, of any of the following, but only if the Trustee has actual knowledge thereof:

(a) Any amendment shall be made to the Indenture;

(b) Any resignation or removal of the Trustee;

(c) Any redemption (other than Mandatory Sinking Fund Redemption); and

(d) Any defeasance.

Section 6.04. Execution in Several Counterparts. This Fourth Supplemental Indenture may be executed in any number of counterparts and each of such counterparts shall for all purposes be deemed to be an original; and all such counterparts, or as many of them as the District and the Trustee shall preserve undestroyed, shall together constitute but one and the same instrument.

Section 6.05. Force Majeure. From the effective date of this Fourth Supplemental Indenture, the Trustee, or any successor in interest, shall not be considered in breach of or in default in its obligations with respect to any obligations created hereunder or progress in respect thereto, in the event of enforced delay "unavoidable delay") in the performance of such obligations due to unforeseeable causes beyond its control and without its fault or negligence, including, but not limited to, acts of God, or of the public enemy, acts of a government, acts of the other party, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, earthquakes, explosion, mob violence, riot, inability to procure or general sabotage or rationing of labor, equipment, facilities, sources of energy, material or supplies in the open market, litigation or arbitration involving a party or others relating to zoning or other governmental action or inaction pertaining to the project, malicious mischief, condemnation, and unusually severe weather or delays of suppliers or subcontractors due to such causes or any similar event and/or occurrences beyond the control of the Trustee.

Section 6.06. Instructions Via Facsimile. The Trustee agrees to accept and act upon facsimile transmission of written instructions and/or directions pursuant to this Fourth Supplemental Indenture provided, however that: (a) the District, subsequent to such facsimile

transmission of written instructions, shall provide the originally executed instructions and/or directions to the Trustee in a timely manner, (b) such originally executed instructions and/or directions shall be signed by a person as may be designated and authorized to sign for the District by an Authorized Officer of the District and, (c) the District shall provide to the Trustee an incumbency certificate listing such designated persons which such incumbency certificate shall be amended whenever a person is to be added or deleted from the listing.

IN WITNESS WHEREOF, the TAHOE FOREST HOSPITAL DISTRICT has caused this Fourth Supplemental Indenture to be signed in its name by its Chief Financial Officer, and U.S. BANK NATIONAL ASSOCIATION, as Trustee, in token of its acceptance of the trusts created hereunder, has caused this Indenture to be signed in its corporate name by its authorized officers, all as of the day and year first above written.

TAHOE FOREST HOSPITAL DISTRICT

By _____
Crystal Betts
Chief Financial Officer

U.S. BANK NATIONAL ASSOCIATION, as Trustee

By _____
Andrew Fung
Vice President

EXHIBIT A

FORM OF 2015 BOND

STATE OF CALIFORNIA
PLACER AND NEVADA COUNTIES

TAHOE FOREST HOSPITAL DISTRICT
Hospital Refunding Revenue Bond, Series 2015

INTEREST RATE	MATURITY DATE	DATED DATE	CUSIP
_____	July 1, ____	April __, 2015	_____

REGISTERED OWNER: CEDE& CO.

PRINCIPAL AMOUNT: _____ DOLLARS

The TAHOE FOREST HOSPITAL DISTRICT, a local health care district, duly organized and existing under the laws of the State of California (herein called the "District"), for value received, hereby promises to pay (but only out of the Revenues and other moneys and securities hereinafter referred to) to the Registered Owner identified above or registered assigns (the "Registered Owner"), on the Maturity Date stated above (subject to any right of prior redemption hereinafter mentioned), the Principal Amount stated above, in lawful money of the United States of America; and to pay interest thereon in like lawful money from the Interest Payment Date (as herein defined) next preceding the date of authentication of this Bond (unless this Bond is authenticated on or before June 15, 2015, in which event it shall bear interest from the Dated Date stated above) until payment of such principal sum shall be discharged as provided in the Indenture hereinafter mentioned, at the Interest Rate per annum stated above, payable semiannually on each January 1 and July 1, commencing July 1, 2015 (each, an "Interest Payment Date"). The principal (or redemption price) hereof is payable at the Principal Corporate Trust Office (as such term is defined in the hereinafter defined Indenture) of U.S. Bank National Association (together with any successor trustee under the indenture, the "Trustee"). Interest hereon is payable by check of the Trustee mailed by first class mail on each Interest Payment Date to the Registered Owner as of the fifteenth (15th) day of the month preceding each Interest Payment Date (except as otherwise provided in the Indenture with respect to defaulted interest) at the address shown on the registration books maintained by the Trustee; *provided however*, that payment of interest will be made by wire transfer in immediately available funds to an account in the United States of America to any Registered Owner of Bonds (hereinafter defined) in the aggregate principal amount of $1,000,000 or more who shall furnish written wire instructions to the Trustee before the fifteenth day of the month preceding the applicable Interest Payment Date. Interest on the Bonds shall be calculated on the basis of a 360-day year comprised of twelve 30-day months.

This Bond is one of a duly authorized issue of bonds of the District designated as Tahoe Forest Hospital District (Placer and Nevada Counties, California) Health Facility Revenue Bonds" (herein called the "Bonds"), unlimited in aggregate principal amount, except as otherwise provided in the Indenture hereinafter mentioned, which issue consists or may consist of one or more series of varying dates, maturities, interest rates, redemption and other provisions, all issued pursuant to the provisions of the section 53570 *et seq.* of the California Government Code (herein called the "Law"), and pursuant to an Indenture of Trust, dated as of

July 1, 1999, by and between the District and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Trustee"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Trustee, as further amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Trustee, as further amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee, and as further amended and supplemented by that certain Fourth Supplemental Indenture, dated as of April 1, 2015, by and between the District and U.S. Bank National Association, as successor trustee (collectively, the "Indenture").

This Bond is also one of a duly authorized series of Bonds designated "Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bond, Series 2015 (herein called the "2015 Bonds"), in the aggregate principal amount of _____ dollars ($_____), issued to refund the District's outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006.

Reference is hereby made to the Indenture (a copy of which is on file at the Principal Corporate Trust Office of the Trustee) and all indentures supplemental thereto and to the Law for a description of the rights thereunder of the registered owners of the Bonds, of the nature and extent of the security, of the rights, duties and immunities of the Trustee and of the rights and obligations of the District thereunder, to all the provisions of which Indenture the registered owner of this Bond, by acceptance hereof, assents and agrees.

The 2015 Bonds are subject to redemption prior to their respective stated maturities at the option of the District as a whole on any date, or in part by such maturities as are selected by the District (or if the District fails to designate such maturities, in inverse order of maturity and by lot within a maturity) on any Interest Payment Date, from moneys deposited in the Special Redemption Account derived from the proceeds of insurance or condemnation awards with respect to the Facilities, at the principal amount thereof and interest accrued thereon to the date fixed for redemption, without premium.

The 2015 Bonds maturing on and after July 1, ____, are subject to redemption prior to their respective stated maturity date, at the option of the District, in whole or in part on any date, on and after July 1, ____, at a redemption price equal to the principal amount of 2015 Bonds called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium.

The 2015 Bonds maturing on and after July 1, ____ (the ____ Term Bonds"), are subject to mandatory redemption on July 1 in each year on and after July 1, ____, to and including July 1, ____, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed	Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed

†Maturity

In the event that the Trustee shall optionally redeem ____ Term Bonds in part but not in whole, the amount of ____ Term Bonds to be redeemed from mandatory sinking fund installments in each subsequent year shall be reduced *pro rata*.

The 2015 Bonds maturing on and after July 1, ____ (the ____ Term Bonds"), are subject to mandatory redemption on July 1 in each year on and after July 1, ____, to and including July 1, ____, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed	Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed

†Maturity

In the event that the Trustee shall optionally redeem ____ Term Bonds in part but not in whole, the amount of ____ Term Bonds to be redeemed from mandatory sinking fund installments in each subsequent year shall be reduced *pro rata*.

If an Event of Default (as that term is defined in the Indenture) shall occur, the principal of all Bonds may be declared due and payable upon the conditions, in the manner and with the effect provided in the Indenture. The Indenture provides that in certain events such declaration and its consequences may be rescinded by the registered owners of not less than a majority in aggregate principal amount of the Bonds then outstanding, or by the Trustee.

The Bond is transferable by the registered owner hereof, in person or by his attorney duly authorized in writing, at the office of the Trustee but only in the manner, subject to the limitations and upon payment of the charges, if any, provided in the Indenture, and upon surrender and cancellation of this Bond. Upon such transfer a new Bond or Bonds, of

authorized denomination or denominations, of the same series and maturity for the same aggregate principal amount, will be issued to the transferee in exchange herefor.

The District and the Trustee may treat the registered owner hereof as the absolute owner hereof for all purposes, and the District and the Trustee shall not be affected by any notice to the contrary.

The Bonds are issuable as fully registered Bonds in "Authorized Denominations." The term Authorized Denominations means $5,000 or any integral multiple thereof. Subject to the limitations provided in the Indenture, Bonds may be exchanged, at said corporate trust office of the Trustee, for a like aggregate principal amount of Bonds of other authorized denominations of the same maturity.

The Indenture and the rights and obligations of the District and of the registered owners of the Bonds and of the Trustee may be modified or amended from time to time and at any time in the manner, to the extent, and upon the terms provided in the Indenture; provided that no such modification or amendment shall (i) extend the fixed maturity of this Bond, or reduce the amount of principal hereof, or extend the time of payment or reduce the amount of any Mandatory Sinking Account Payment provided for in the Indenture for the payment of this maturity of Bonds, or reduce the rate of interest thereon, or extend the time of payment of interest hereon, or reduce any premium payable upon the redemption hereof, without the consent of the registered owner hereof, or (ii) reduce the percentage of Bonds the consent of the registered owners of which is required to effect any such modification or amendment, or permit the creation of any lien on the Revenues and other assets pledged as security for the Bonds prior to or on a parity with the lien created by the Indenture, or deprive the registered owners of the Bonds of the lien created by the Indenture on such Revenues and other assets (except as expressly provided in the Indenture), without the consent of the registered owners of all Bonds then outstanding, all as more fully set forth in the Indenture.

The Bonds and the interest thereon are payable from Revenues (as that term is defined in the Indenture) and are secured by a pledge and assignment of said Revenues and of amounts held in the funds and accounts established pursuant to the Indenture (except any amounts held in the Rebate Fund, as such term is defined in the Indenture), subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth in the Indenture.

The Bonds are limited obligations of the District and are not a lien or charge upon the funds or property of the District, except to the extent of the aforementioned pledge and assignment. NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE DISTRICT IS PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE BONDS.

It is hereby certified and recited that any and all conditions, things and acts required to exist, to have happened and to have been performed precedent to and in the issuance of this Bond do exist, have happened and have been performed in due time, form and manner as required by the Law and by the Constitution and laws of the State of California, and that the amount of this Bond, together with all other indebtedness of the District, does not exceed any limit prescribed by the Law, or by the Constitution and laws of the State of California, and is not in excess of the amount of Bonds permitted to be issued under the Indenture.

Unless this certificate is presented by an authorized representative of The Depository Trust Company; a New York corporation ("DTC"), to the District or the Trustee for registration of transfer, exchange, or payment, and any certificate issued is registered in the name of Cede & Co. or in such other name as is requested by an authorized representative of DTC (and any

payment is made to Cede & Co. or to such other entity as is requested by an authorized representative of DTC), ANY TRANSFER, PLEDGE, OR OTHER USE HEREOF FOR VALUE OR OTHERWISE BY OR TO ANY PERSON IS WRONGFUL inasmuch as the registered owner hereof, Cede & Co., has an interest herein.

This Bond shall not be entitled to any benefit under the Indenture, or become valid or obligatory for any purpose, until the certificate of authentication and registration hereon endorsed shall have been signed by the Trustee.

IN WITNESS HEREOF, the Tahoe Forest Hospital District has caused this Bond to be executed in its name and on its behalf by the facsimile signature of its President and attested by the facsimile signature of its Secretary, all as of the dated date identified above.

TAHOE FOREST HOSPITAL DISTRICT

By _____
President

Attest:

_____
Secretary

FORM OF TRUSTEE'S CERTIFICATE OF AUTHENTICATION

This is one of the 2015 Bonds described in the within-mentioned Indenture and registered on the registration books of the Trustee.

Dated:

U.S. BANK NATIONAL ASSOCIATION, as Trustee

By _____
Authorized Signatory

FORM OF ASSIGNMENT

For value received the undersigned hereby sells, assigns and transfers unto

_____

_____

_____

(Name, Address and Tax Identification or Social Security Number of Assignee)

the within-registered Bond and hereby irrevocably constitute(s) and appoints(s)

_____

attorney, to transfer the same on the Bond register of the Trustee with full power of substitution in the premises.

Dated: _____

Signature:

_____

Note: The signature(s) on this Assignment must correspond with the name(s) as written on the face of the within Bond in every particular without alteration or enlargement or any change whatsoever.

Signature Guaranteed:

_____

Note: Signature(s) must be guaranteed by a financial institution that is a member of the Securities Transfer Agents Medallion Program ("STAMP"), the Stock Exchanges Medallion Program ("SEMP") or the New York Stock Exchange, Inc. Medallions Securities Program ("MSP") or an "eligible guarantor."

ESCROW DEPOSIT AND TRUST AGREEMENT

by and between the

TAHOE FOREST HOSPITAL DISTRICT

and

THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A., as Escrow Bank

Dated April 28, 2015

Refunding of the outstanding
Tahoe Forest Hospital District
(Placer and Nevada Counties, California)
Hospital Revenue Bonds, Series 2006

ESCROW DEPOSIT AND TRUST AGREEMENT

This Escrow Deposit and Trust Agreement (this "Escrow Deposit and Trust Agreement"), dated April 28, 2015, is by and between the TAHOE FOREST HOSPITAL DISTRICT, a health care district duly created and existing pursuant to the laws of the State of California (the "District"), and THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A., a national banking association organized and existing under the laws of the United States of America, as escrow bank (the "Escrow Bank").

W I T N E S S E T H:

WHEREAS, the Board of Directors (the "Board") of the District has heretofore issued the District's Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006 (the "2006 Bonds"), in the original principal amount of $27,385,000, issued for authorized hospital purposes, of which $23,240,000 principal amount remains outstanding;

WHEREAS, the 2006 Bonds were issued under and pursuant to an Indenture of Trust, dated as of July 1, 1999, by and between the District and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Trustee"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Trustee, as further amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Trustee, as further amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee (the "Indenture");

WHEREAS, pursuant to section 53570 *et seq.* of the California Government Code, the District is empowered to issue refunding revenue bonds;

WHEREAS, the District has determined that it is in the best interests of the District to provide for the redemption, on July 1, 2015, all 2006 Bonds then outstanding, and it is desirable to enter into this Escrow Deposit and Trust Agreement to do so;

WHEREAS, the Board, by resolution adopted on March 31, 2015, and a Fourth Supplemental Indenture, dated as of April 1, 2015 (with the Indenture, the "Supplemented Indenture"), has authorized the issuance and sale of the District's Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015 (the "2015 Refunding Bonds"), and has determined to use a portion of the proceeds of the 2015 Refunding Bonds to provide for the redemption of the outstanding 2006 Bonds in full on July 1, 2015 (the "Redemption Date"), at a redemption price equal to 101% of the principal amount thereof, together with accrued interest to such date (the "Redemption Price");

WHEREAS, the District, in the Supplemented Indenture, has directed that a portion of the proceeds of the sale of the 2015 Refunding Bonds be deposited hereunder, and that such amount will be in an amount sufficient to provide for the redemption of the 2006 Bonds on the Redemption Date at the Redemption Price;

WHEREAS, the Escrow Bank has full powers to perform the duties and obligations to be undertaken by it pursuant to this Escrow Deposit and Trust Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants herein set forth, the parties hereto do hereby agree as follows:

Section 1. Discharge of 2006 Bonds. The District hereby irrevocably elects to pay and discharge all indebtedness payable by the District under the Indenture with respect to the 2006 Bonds, and to terminate all obligations of the District thereunder with respect thereto.

Section 2. Escrow Fund.

(a) There is hereby established a special fund, to be held in trust by the Escrow Bank for the benefit of the owners of the 2006 Bonds, to be known as the "Escrow Fund." Upon the issuance of the 2015 Refunding Bonds, there shall be deposited into the Escrow Fund an amount equal to $_____, derived as follows:

(i) $_____ from the proceeds of the 2015 Refunding Bonds;

(ii) $_____ from the reserve fund held under the Indenture for the 2006 Bonds (the "2006 Reserve Fund"); and

(iii) $_____from the project fund held under the Indenture for the 2006 Bonds (the "2006 Project Fund").

(b) The Escrow Bank shall invest $_____ of the moneys deposited into the Escrow Fund pursuant to the preceding paragraph in the securities set forth in Exhibit A attached hereto and by this reference incorporated herein (the "Escrowed Federal Securities") and shall hold the remaining $_____ in cash, uninvested. The Escrowed Federal Securities shall be deposited with and held by the Escrow Bank in the Escrow Fund solely for the uses and purposes set forth herein.

(c) The Escrow Bank may rely upon the conclusion of Grant Thornton LLP, as contained in its opinion and accompanying schedules (the "Report") dated April 28, 2015, that the Escrowed Federal Securities mature and bear interest payable in such amounts and at such times as, together with cash on deposit in the Escrow Fund, will be sufficient to redeem the outstanding 2006 Bonds in full on the Redemption Date at the Redemption Price.

(d) The Escrow Bank shall not be liable or responsible for any loss resulting from its full compliance with the provisions of this Escrow Deposit and Trust Agreement.

(e) Any money left on deposit in the Escrow Fund after payment in full of the 2006 Bonds, and the payment of all amounts due to the Escrow Bank hereunder, shall be transferred to U.S. Bank National Association, the trustee for the 2015 Refunding Bonds, to be applied to the payment of debt service on the 2015 Refunding Bonds.

(f) If the Escrow Bank learns that the Department of the Treasury or the Bureau of Public Debt will not, for any reason, accept a subscription of state and local government series securities ("SLGS") that is to be submitted pursuant to this Escrow Deposit and Trust Agreement, the Escrow Bank shall promptly request alternative written investment instructions from the District with respect to funds which were to be invested in SLGS. The Escrow Bank shall follow such instructions and, upon the maturity of any such alternative investment, the Escrow Bank shall hold such funds uninvested and without liability for interest until receipt of further written instructions from the District. In the absence of investment instructions from the District, the Escrow Bank shall not be responsible for the investment of such funds or interest thereon. The Escrow Bank may conclusively rely upon the District's selection of an alternative investment as a determination of the alternative investment's legality and suitability and shall

not be liable for any losses related to the alternative investments or for compliance with any yield restriction applicable thereto.

Section 3. Instructions as to Application of Deposit; Defeasance Notice; Redemption Notice.

(a) The moneys deposited in the Escrow Fund pursuant to Section 2 shall be applied by the Escrow Bank for the sole purpose of redeeming the outstanding 2006 Bonds in full on the Redemption Date at the Redemption Price, all as set forth in Exhibit B attached hereto and by this reference incorporated herein.

(b) The Escrow Bank, in its capacity as Trustee for the 2006 Bonds, is hereby requested, and the Escrow Bank, in its capacity as Trustee for the 2006 Bonds, hereby agrees to give notice of the defeasance of the 2006 Bonds in the form of defeasance notice attached hereto as Exhibit C.

(c) The Escrow Bank, in its capacity as Trustee for the 2006 Bonds is hereby requested, and the Escrow Bank, as Trustee for the 2006 Bonds, hereby agrees to give notice, as soon as practicable, of the redemption of the 2006 Bonds on the Redemption Date in accordance with the applicable provisions of the Indenture and the form of redemption notice attached hereto as Exhibit D.

Section 4. Application of 2006 Funds. The Escrow Bank, as Trustee for the 2006 Bonds, is hereby directed to transfer to the Escrow Bank for deposit in the Escrow Fund, from the 2006 Reserve Fund, the sum of $_____ and from the 2006 Project Fund, the sum of $_____.

Section 5. Investment of Any Remaining Moneys. The Escrow Bank shall invest and reinvest the proceeds received from any of the Escrowed Federal Securities, and the cash originally deposited into the Escrow Fund, for a period ending not later than the next succeeding interest payment date relating to the 2006 Bonds, in Federal Securities pursuant to written directions of the District; *provided, however*, that (a) such written directions of the District shall be accompanied by (i) a certification of an independent certified public accountant or firm of certified public accountants of favorable national reputation experienced in the refunding of obligations of political subdivisions that the Federal Securities then to be so deposited in the Escrow Fund, together with the cash then on deposit in the Escrow Fund, together with the interest to be derived therefrom, shall be in an amount at all times at least sufficient to make the payments specified in Section 3 hereof, and (ii) an opinion of nationally recognized bond counsel ("Bond Counsel") that investment in accordance with such directions will not affect, for Federal income tax purposes, the exclusion from gross income of interest due with respect to the 2006 Bonds, and (b) if the District directs such investment or reinvestment to be made in United States Treasury Securities-State and Local Government Series, the District shall, at its cost, cause to be prepared all necessary subscription forms therefor in sufficient time to enable the Escrow Bank to acquire such securities. In the event that the District shall fail to file any such written directions with the Escrow Bank concerning the reinvestment of any such proceeds, such proceeds shall be held uninvested by the Escrow Bank. Any interest income resulting from investment or reinvestment of moneys pursuant to this Section 4 and not required for the purposes set forth in Section 2, as indicated by such verification, shall, promptly upon the receipt of such interest income by the Escrow Bank, be paid to the District.

Section 6. Substitution or Withdrawal of Federal Securities. The District may, at any time, direct the Escrow Bank in writing to substitute Federal Securities for any or all of the Escrowed Federal Securities then deposited in the Escrow Fund, or to withdraw and transfer to the District any portion of the Federal Securities then deposited in the Escrow Fund, provided that any such direction and substitution or withdrawal shall be simultaneous and shall be

accompanied by (a) a certification of an independent certified public accountant or firm of certified public accountants of favorable national reputation experienced in the refunding of obligations of political subdivisions that the Federal Securities then to be so deposited in the Escrow Fund together with interest to be derived therefrom, or in the case of withdrawal, the Federal Securities to be remaining in the Escrow Fund following such withdrawal together with the interest to be derived therefrom, together with the cash then on deposit in the Escrow Fund, shall be in an amount at all times at least sufficient to make the payments specified in Section 3 hereof; and (b) an opinion of Bond Counsel that the substitution or withdrawal will not affect, for Federal income tax purposes, the exclusion from gross income of interest on the 2006 Bonds. In the event that, following any such substitution of Federal Securities pursuant to this Section 5, there is an amount of moneys or Federal Securities in excess of an amount sufficient to make the payments required by Section 2 hereof, as indicated by such verification, such excess shall be paid to the District.

Section 7. Compensation to Escrow Bank. The District shall pay the Escrow Bank full compensation for its duties under this Escrow Deposit and Trust Agreement, including out-of-pocket costs such as publication costs, prepayment or redemption expenses, legal fees and other costs and expenses relating hereto. Under no circumstances shall amounts deposited in the Escrow Fund be deemed to be available for said purposes.

Section 8. Liabilities and Obligations of Escrow Bank. The Escrow Bank shall have no obligation to make any payment or disbursement of any type or incur any financial liability in the performance of its duties under this Escrow Deposit and Trust Agreement unless the District shall have deposited sufficient funds with the Escrow Bank. The Escrow Bank may rely and shall be protected in acting upon the written instructions of the District or its agents relating to any matter or action as Escrow Bank under this Escrow Deposit and Trust Agreement.

The Escrow Bank and its respective successors, assigns, agents and servants shall not be held to any personal liability whatsoever, in tort, contract, or otherwise, in connection with the execution and delivery of this Escrow Deposit and Trust Agreement, the establishment of the Escrow Fund, the acceptance of the moneys deposited therein, the sufficiency of the uninvested moneys held hereunder to accomplish the purposes set forth herein, or any payment, transfer or other application of moneys by the Escrow Bank in accordance with the provisions of this Escrow Deposit and Trust Agreement or by reason of any non-negligent act, non-negligent omission or non-negligent error of the Escrow Bank made in good faith in the conduct of its duties. The recitals of fact contained in the "whereas" clauses herein shall be taken as the statement of the District, and the Escrow Bank assumes no responsibility for the correctness thereof. The Escrow Bank makes no representations as to the sufficiency of the uninvested moneys to accomplish the purposes set forth herein or to the validity of this Escrow Deposit and Trust Agreement as to the District and, except as otherwise provided herein, the Escrow Bank shall incur no liability in respect thereof. The Escrow Bank shall not be liable in connection with the performance of its duties under this Escrow Deposit and Trust Agreement except for its own negligence, willful misconduct or default, and the duties and obligations of the Escrow Bank shall be determined by the express provisions of this Escrow Deposit and Trust Agreement. The Escrow Bank may consult with counsel, who may or may not be counsel to the District, and in reliance upon the written opinion of such counsel shall have full and complete authorization and protection in respect of any action taken, suffered or omitted by it in good faith in accordance therewith. Whenever the Escrow Bank shall deem it necessary or desirable that a matter be proved or established prior to taking, suffering, or omitting any action under this Escrow Deposit and Trust Agreement, such matter (except the matters set forth herein as specifically requiring a certificate of a nationally recognized firm of independent certified public accountants or an opinion of counsel) may be deemed to be conclusively established by a written certification of the District.

Anything in this Escrow Deposit and Trust Agreement to the contrary notwithstanding, in no event shall the Escrow Bank be liable for special, indirect, punitive or consequential loss or damage of any kind whatsoever (including but not limited to lost profits), even if the Escrow Bank has been advised of the likelihood of such loss or damage and regardless of the form of action.

The Escrow Bank agrees to accept and act upon instructions or directions pursuant to this Escrow Deposit and Trust Agreement sent by unsecured e-mail, facsimile transmission or other similar unsecured electronic methods, provided, however, that, the Escrow Bank shall have received an incumbency certificate listing persons designated to give such instructions or directions and containing specimen signatures of such designated persons, which such incumbency certificate shall be amended and replaced whenever a person is to be added or deleted from the listing. If the District elects to give the Escrow Bank e-mail or facsimile instructions (or instructions by a similar electronic method) and the Escrow Bank in its discretion elects to act upon such instructions, the Escrow Bank's understanding of such instructions shall be deemed controlling. The Escrow Bank shall not be liable for any losses, costs or expenses arising directly or indirectly from the Escrow Bank's reliance upon and compliance with such instructions notwithstanding such instructions conflict or are inconsistent with a subsequent written instruction. The District agrees to assume all risks arising out of the use of such electronic methods to submit instructions and directions to the Escrow Bank, including without limitation the risk of the Escrow Bank acting on unauthorized instructions, and the risk of interception and misuse by third parties.

The District hereby assumes liability for, and hereby agrees (whether or not any of the transactions contemplated hereby are consummated), to the extent permitted by law, to indemnify, protect, save and hold harmless the Escrow Bank and its respective successors, assigns, agents, officers, directors, employees and servants from and against any and all liabilities, obligations, losses, damages, penalties, claims, actions, suits, costs, expenses and disbursements (including legal fees and disbursements) of whatsoever kind and nature which may be imposed on, incurred by, or asserted against, at any time, the Escrow Bank (whether or not also indemnified against by any other person under any other agreement or instrument) and in any way relating to or arising out of the execution and delivery of this Escrow Deposit and Trust Agreement, the establishment of the Escrow Fund, the retention of the moneys therein and any payment, transfer or other application of moneys by the Escrow Bank in accordance with the provisions of this Escrow Deposit and Trust Agreement, or as may arise by reason of any act, omission or error of the Escrow Bank made in good faith in the conduct of its duties; provided, however, that the District shall not be required to indemnify the Escrow Bank against its own negligence or misconduct. The indemnities contained in this Section 7 shall survive the termination of this Escrow Deposit and Trust Agreement or the resignation or removal of the Escrow Bank.

The District acknowledges that to the extent regulations of the Comptroller of the Currency or other applicable regulatory entity grant the District the right to receive brokerage confirmations of security transactions as they occur, the District specifically waives receipt of such confirmations to the extent permitted by law. The Escrow Bank will furnish the District monthly cash transaction statements which include detail for all investment transactions made by the Escrow Bank hereunder.

No provision of this Escrow Deposit and Trust Agreement shall require the Escrow Bank to expend or risk its own funds or otherwise incur any financial liability in the performance or exercise of any of its duties hereunder, or in the exercise of its rights or powers.

The Escrow Bank may execute any of the trusts or powers hereunder or perform any duties hereunder either directly or by or through agents, attorneys, custodians or nominees appointed with due care and shall not be responsible for any willful misconduct or negligence on the part of any agent, attorney, custodian or nominee so appointed.

The Escrow Bank may conclusively rely and shall be fully protected in acting or refraining from acting upon any resolution, certificate, statement, instrument, opinion, report, notice, request, consent, order, approval or other paper or document believed by it to be genuine and to have been signed or presented by the proper party or parties.

The Escrow Bank may at any time resign by giving 30 days written notice of resignation to the District. Upon receiving such notice of resignation, either District shall promptly appoint a successor and, upon the acceptance by the successor of such appointment, release the resigning Escrow Bank from its obligations hereunder by written instrument, a copy of which instrument shall be delivered to each of the District, the resigning Escrow Bank and the successor. If no successor shall have been so appointed and have accepted appointment within 30 days after the giving of such notice of resignation, the resigning Escrow Bank may petition any court of competent jurisdiction for the appointment of a successor.

Section 9. Amendment. This Escrow Deposit and Trust Agreement may be modified or amended at any time by a supplemental agreement which shall become effective when the written consents of the owners of one hundred percent (100%) in aggregate principal amount of the 2006 Bonds shall have been filed with the Escrow Bank. This Escrow Deposit and Trust Agreement may be modified or amended at any time by a supplemental agreement, without the consent of any such owners, but only (1) to add to the covenants and agreements of any party, other covenants to be observed, or to surrender any right or power herein or therein reserved to the District, (2) to cure, correct or supplement any ambiguous or defective provision contained herein, (3) in regard to questions arising hereunder or thereunder, as the parties hereto or thereto may deem necessary or desirable and which, in the opinion of counsel, shall not materially adversely affect the interests of the owners of the 2006 Bonds or the 2015 Refunding Bonds, and that such amendment will not cause interest on the 2006 Bonds or the 2015 Refunding Bonds to become subject to federal income taxation. In connection with any contemplated amendment or revocation of this Escrow Deposit and Trust Agreement, prior written notice thereof and draft copies of the applicable legal documents shall be provided by the District to each rating agency then rating the 2006 Bonds.

Section 10. Notice of Escrow Bank and District. Any notice to or demand upon the Escrow Bank may be served and presented, and such demand may be made, at the corporate trust office of the Escrow Bank as specified by the Escrow Bank as Trustee for the 2006 Bonds in accordance with the provisions of the Indenture. Any notice to or demand upon the District shall be deemed to have been sufficiently given or served for all purposes by being mailed by first class mail, and deposited, postage prepaid, in a post office letter box, addressed to such party as provided in the Indenture (or such other address as may have been filed in writing by the District with the Escrow Bank).

Section 11. Merger or Consolidation of Escrow Bank. Any company into which the Escrow Bank may be merged or converted or with which it may be consolidated or any company resulting from any merger, conversion or consolidation to which it shall be a party or any company to which the Escrow Bank may sell or transfer all or substantially all of its corporate trust business, provided such company shall be eligible to act as trustee under the Indenture, shall be the successor hereunder to the Escrow Bank without the execution or filing of any paper or any further act.

Section 12. Governing Law. This Escrow Deposit and Trust Agreement shall be construed and governed in accordance with the laws of the State of California.

Section 13. Severability. In case any one or more of the provisions contained in this Escrow Deposit and Trust Agreement shall for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Escrow Deposit and Trust Agreement, but this Escrow Deposit and Trust Agreement shall be construed as if such invalid or illegal or unenforceable provisions had never been contained herein.

Section 14. Counterparts. This Escrow Deposit and Trust Agreement may be executed in any number of counterparts and each of such counterparts shall for all purposes be deemed to be an original; and such counterparts, or as many of them as the District and the Escrow Bank shall preserve undestroyed, shall together constitute but one and the same instrument.

Section 15. Business Days. Whenever any act is required by this Escrow Deposit and Trust Agreement to be done on a specified day or date, and such day or date shall be a day other than a business day for the Escrow Bank, then such act may be done on the next succeeding business day.

IN WITNESS WHEREOF the parties hereto have caused this Escrow Deposit and Trust Agreement to be executed in their respective names by their respective duly authorized officers, all as of the day and year first above written.

TAHOE FOREST HOSPITAL DISTRICT

By _____
Crystal Betts
Chief Financial Officer

THE BANK OF NEW YORK MELLON
TRUST COMPANY, N.A., as Escrow Bank

By _____
Deborah D. Young, CCTS
Vice President

EXHIBIT A

SCHEDULE OF ESCROW SECURITIES

Type	Maturity	Coupon	Par	Price	Cost	Accrued	Total

EXHIBIT B

PAYMENT AND REDEMPTION SCHEDULE

Date	Maturing Principal	Called Principal	Interest	Redemption Premium	Total Payment
7/1/15	$770,000	$22,470,000	$571,625.00	$224,700.00	$24,036,325.00

EXHIBIT C

NOTICE OF DEFEASANCE

Tahoe Forest Hospital District
(Placer and Nevada Counties, California)
Hospital Revenue Bonds, Series 2006

Maturity Date	Amount Defeased	Interest Rate	CUSIP No.
7/1/2015	$ 770,000	4.600%	873825 CY7
7/1/2016	800,000	4.650	873825 CZ4
7/1/2017	840,000	4.700	873825 DA8
7/1/2018	880,000	4.700	873825 DB6
7/1/2019	920,000	4.700	873825 DC4
7/1/2020	970,000	4.750	873825 DD2
7/1/2021	1,010,000	4.750	873825 DE0
7/1/2026	5,855,000	5.000	873825 DJ9
7/1/2036	11,195,000	5.000	873825 DL4

NOTICE IS HEREBY GIVEN, on behalf of the Tahoe Forest Hospital District (the "District") to the owners of the outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, described above (the "Bonds"), that pursuant to the indenture authorizing the issuance of the Bonds (the "Indenture"), the lien of the Indenture with respect to the Bonds has been discharged through the irrevocable deposit of cash and U.S. Treasury securities in an escrow fund (the "Escrow Fund"). The Escrow Fund has been established and is being maintained pursuant to that certain Escrow Deposit and Trust Agreement, dated April 28, 2015, by and between the District and The Bank of New York Mellon Trust Company, N.A., as escrow bank. As a result of such deposit, the Bonds are deemed to have been paid and defeased in accordance with the Indenture. The pledge of the funds provided for under the Indenture and all other obligations of the District to the owners of the defeased Bonds shall hereafter be limited to the application of moneys in the Escrow Fund for the payment of the principal and interest with respect to the Bonds as the same become due and payable as described below.

As evidenced by the verification report delivered to the Escrow Bank, amounts deposited in the Escrow Fund are calculated to provide sufficient moneys to redeem the outstanding Bonds in full on July 1, 2015 (the "Redemption Date"), at a redemption price equal to 101% of the principal amount thereof, together with accrued interest to such date. From and after the Redemption Date, interest with respect to the Bonds shall cease to accrue and be payable.

Dated: _____, 2015

THE BANK OF NEW YORK
MELLON TRUST COMPANY,
N.A., as Escrow Bank

EXHIBIT D

NOTICE OF FULL AND FINAL REDEMPTION

Tahoe Forest Hospital District
(Placer and Nevada Counties, California)
Hospital Revenue Bonds, Series 2006

Dated Date	Maturity Date	Amount Redeemed	Redemption Premium	Redemption Price (1)	Interest Rate	CUSIP No.
5/2/2006	8/1/2016	$ 800,000	$ 8,000	$ 808,000	4.650%	873825 CZ4
5/2/2006	8/1/2017	840,000	8,400	848,400	4.700	873825 DA8
5/2/2006	8/1/2018	880,000	8,800	888,800	4.700	873825 DB6
5/2/2006	8/1/2019	920,000	9,200	929,200	4.700	873825 DC4
5/2/2006	8/1/2020	970,000	9,700	979,700	4.750	873825 DD2
5/2/2006	8/1/2021	1,010,000	10,100	1,020,100	4.750	873825 DE0
5/2/2006	8/1/2026	5,855,000	58,550	5,913,550	5.000	873825 DJ9
5/2/2006	8/1/2036	11,195,000	111,950	11,306,950	5.000	873825 DL4

(1) Plus accrued interest.

NOTICE is hereby given that the Tahoe Forest Hospital District (the "District") has called for redemption on July 1, 2015 (the "Redemption Date"), the outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, described above (the "Bonds"), in the aggregate principal amount of $22,470,000 at a price equal to 101% of the principal amount thereof, plus accrued interest to the date fixed for redemption (the "Redemption Price").

Payment of principal will be made upon presentation on and after July 1, 2015, at the following addresses:

First Class/Registered/Certified
The Bank of New York Mellon
Global Corporate Trust
P.O. Box 396
East Syracuse, NY 13057

Express Delivery Only
The Bank of New York Mellon
Global Corporate Trust
111 Sanders Creek Parkway
East Syracuse, NY 13057

By Hand Only
The Bank of New York Mellon
Global Corporate Trust
Corporate Trust Window
101 Barclay Street 1st Floor East
New York, NY 10286

Owners of Bonds presenting their Bonds in person for the same day payment must surrender their Bonds by 1:00 p.m. on the Redemption Date and a check will be available for pickup after 2:00 p.m. Checks not picked up by 4:30 p.m. will be mailed to the owner by first class mail.

Interest with respect to the principal amount designated to be redeemed shall cease to accrue on and after the Redemption Date.

If payment of the Redemption Price is to be made to the owner of the Bonds, such owner is not required to endorse the Bond to collect the Redemption Price.

Under the Economic Growth and Tax Relief Reconciliation Act of 2001 (the "Act") 28% of the Redemption Price will be withheld if a tax identification number is not properly certified. The Form W-9 may be obtained from the Internal Revenue Service.

Neither the District nor The Bank of New York Mellon Trust Company, N.A., the Trustee, shall be held responsible for the selection or use of the CUSIP number, nor is any representation made as to its correctness as shown in this Redemption Notice. It is included solely for convenience of the Owners.

Dated: _____, 2015

THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A., as Trustee

$_____
TAHOE FOREST HOSPITAL DISTRICT
(Placer and Nevada Counties, California)
Hospital Refunding Revenue Bonds, Series 2015

BOND PURCHASE AGREEMENT

April 9, 2015

Tahoe Forest Hospital District
10121 Pine Avenue
Truckee, California 96160

Ladies and Gentlemen:

The undersigned, Southwest Securities, Inc. (the "Representative") on behalf of itself and Piper Jaffray & Co. and Raymond James & Associates, Inc., as underwriters (collectively, the "Underwriters"), offers to enter into this Bond Purchase Agreement (the "Bond Purchase Agreement") with the Tahoe Forest Hospital District (the "District"), which, upon acceptance, will be binding upon the District and the Underwriters. This offer is made subject to the District's acceptance on or before 11:59 P.M., California time, on the date hereof, and, if not so accepted, will be subject to withdrawal by the Underwriters upon written notice delivered by the Underwriters to the District at any time prior to acceptance. The undersigned Representative has been duly authorized to execute this Bond Purchase Agreement on behalf of the Underwriters and to act hereunder.

The District hereby acknowledges and agrees that (a) the purchase and sale of the Bonds (as defined herein) pursuant to this Bond Purchase Agreement is an arm's-length commercial transaction between the District and the Underwriters, (b) in connection therewith and with the discussions, undertakings and procedures leading up to the consummation of such transaction, the Underwriters are and have been acting solely as principals and are not acting as the agent or fiduciary of the District, (c) the Underwriters have not assumed an advisory or fiduciary responsibility in favor of the District with respect to the offering and sale of the Bonds contemplated hereby or the discussions, undertakings and procedures leading thereto (irrespective of whether the Underwriters have provided other services or are currently providing other services to the District on other matters) and the Underwriters have no obligation to the District with respect to the offering and sale of the Bonds contemplated hereby except the obligations expressly set forth in this Bond Purchase Agreement, and (d) the District has consulted its own legal, financial and other advisors to the extent it has deemed appropriate, in connection with the issuance of the Bonds and the other matters contemplated by this Bond Purchase Agreement.

1. Purchase, Sale and Delivery of the Bonds.

(a) Subject to the terms and conditions and in reliance upon the representations, warranties and agreements set forth herein, the Underwriters hereby agree to purchase from the District, and the District hereby agrees to sell to the Underwriters, all (but not less than all) of $_____ aggregate principal amount of Tahoe Forest Hospital District (Placer and Nevada

Counties, California) Hospital Refunding Revenue Bonds, Series 2015 (the "Bonds"), dated as of the date of their delivery, bearing interest and maturing on the dates and in the amounts set forth on Exhibit A attached hereto. The purchase price for the Bonds shall be $_____ (which consists of the principal amount of the Bonds of $_____, less an Underwriters' discount of $_____, plus an original issue premium of $_____).

(b) The Bonds shall be substantially in the form described in, shall be issued and secured under the provisions of, and shall be payable as provided in that certain Indenture of Trust, dated as of July 1, 1999, by and between the District and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Prior Trustee"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Prior Trustee, as further amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Prior Trustee, as further amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Prior Trustee, and as further amended and supplemented by that certain Fourth Supplemental Indenture, dated as of April 1, 2015, by and between the District and U.S. Bank National Association, as successor trustee (the "Trustee") (collectively, the "Indenture").

(c) The proceeds from the sale of the Bonds will be used, together with certain other moneys, to (i) refund the District's outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, currently outstanding in the principal amount of $23,240,000 (the "2006 Bonds"), issued to finance the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District, (ii) fund a reserve fund for the Bonds, and (iii) pay certain costs and expenses related to the issuance and sale of the Bonds.

(d) The Bonds will be limited obligations of the District payable solely from Revenues and secured by a pledge of the District's Gross Revenues and of amounts held in certain funds and accounts established pursuant to the Indenture, subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth in the Indenture. The 2015 Bonds will be on a parity as to payment and security with the District's Tahoe Forest Hospital District (Placer and Nevada Counties, California) Variable Rate Demand Revenue Bonds, Series 2002, currently outstanding in the principal amount of $9,555,000 (the "2002 Bonds");

(e) At 10:00 A.M., California time, on April 28, 2015, or at such earlier or later time or date as shall be agreed by the District and the Representative (such time and date being herein referred to as the "Closing Date"), the District will direct the Trustee to deliver the Bonds to The Depository Trust Company ("DTC") in New York, New York (or to the Trustee in the event of a Fast Automated Securities Transaction ("F.A.S.T.")), for the account of the Underwriters (or at such other location as may be designated by the Representative), the Bonds in the form of a separate single fully-registered Bond for each of the Bond maturities (all Bonds being typewritten and bearing CUSIP numbers), duly executed by the District and authenticated by the Trustee, and in San Francisco, California, and the other documents herein mentioned; and the Underwriters will accept such delivery and pay the purchase price of the Bonds as set forth in paragraph (a) of this Section by wire transfer, payable in immediately available funds (such delivery and payment being herein referred to at the "Closing"). The Bonds shall be registered in the name of Cede & Co., as nominee for DTC. Notwithstanding the foregoing, neither the failure to place CUSIP numbers on any Bond nor any error with respect thereto shall constitute cause for a failure or refusal by the Underwriters to accept delivery of and pay for the Bonds on the Closing Date in accordance with the terms of this Bond Purchase Agreement.

(e) Concurrently with its acceptance hereof, or as soon as practicable but within the time period specified below, the District will deliver to the Underwriters the Official Statement with respect to the Bonds, dated the date hereof, in substantially the same form as the Preliminary Official Statement referred to below, with only such changes therein as shall be mutually agreed upon, signed on behalf of the District (such Official Statement, together with all appendices thereto and any amendments or supplements thereto, is hereinafter referred to as the "Official Statement"). The District hereby authorizes the use by the Underwriters of the Indenture, the that certain Escrow Deposit and Trust Agreement relating to the refunding of the 2006 Bonds, to be dated the date of the Closing (the "Escrow Agreement"), by and between the District and The Bank of New York Mellon Trust Company, N.A., as escrow bank (the "Escrow Bank"), and the Official Statement and the information contained therein in connection with the offering and sale of the Bonds, and consents to and ratifies the use by the Underwriters prior to the date hereof of the Preliminary Official Statement, dated April 1, 2015 (such Preliminary Official Statement, together with all appendices thereto, is herein referred to as the "Preliminary Official Statement"). The District has heretofore "deemed final" certain respective portions of the Preliminary Official Statement so as to enable the Underwriters to comply with the provisions of paragraph (b)(1) of Rule 15c2-12 of the Securities and Exchange Commission under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). The District hereby confirms that the information in the Official Statement is "deemed final" pursuant to said Rule. The District hereby agrees to provide to the Underwriters within seven business days of the date hereof sufficient copies of the Official Statement to enable the Underwriters to comply with the requirements of paragraph (b)(4) of Rule 15c2-12 of the Securities and Exchange Commission and with the requirements of Rule G-32 and Rule G-36 of the Municipal Securities Rulemaking Board.

2. Representations, Warranties and Agreements of the District. The District represents and warrants to, and agrees with, the Underwriters that:

(a) The District is and will be at the Closing Date duly organized and existing under the Constitution and laws of the State of California as a local health care district with the full power and authority to issue the Bonds, and to carry out and consummate the transactions contemplated by this Bond Purchase Agreement, the Indenture, the Official Statement, the Continuing Disclosure Certificate of the District, dated the Closing Date (the "Disclosure Certificate") and the Escrow Agreement;

(b) When delivered to and paid for by the Underwriters at the Closing in accordance with the provisions of this Bond Purchase Agreement, the Bonds will have been duly authorized, executed, issued and delivered and will constitute valid and binding limited obligations of the District in conformity with, and entitled to the benefit and security of, the Indenture, and will be the subject of insurance under the California Health Facility Construction Loan Insurance Program;

(c) By official action of the District prior to or concurrently with the acceptance hereof, the District has ratified or authorized the distribution of the Preliminary Official Statement, approved and authorized the distribution of the Official Statement, authorized and approved the execution and delivery of, and the performance by the District of the obligations on its part contained in, the Bonds, the Indenture, this Bond Purchase Agreement, the Disclosure Certificate, the Environmental Indemnity and the Escrow Agreement;

(d) There is no action, suit, proceeding, inquiry or investigation, at law or in equity, before or by any court, governmental agency, public board or body, pending or, to the knowledge of the District, threatened against the District or its properties or operations (i) seeking to restrain or enjoin the issuance, sale, execution or delivery of the Bonds, (ii) in any way contesting or affecting the validity of the Bonds, any proceedings of the District taken

concerning the issuance or sale thereof, the pledge or application of any moneys or security provided for the payment of the Bonds, the completeness or accuracy of the Preliminary Official Statement or the Official Statement, or the existence or powers of the District relating to the issuance of the Bonds, or (iii) which, if determined adversely to the interests of the District or its interests, would have a material and adverse effect on the consummation of the transactions contemplated by or the validity of the Indenture, the Disclosure Certificate, the Official Statement, the Escrow Agreement or this Bond Purchase Agreement or on the financial condition, properties or operations of the District;

(e) The execution and delivery of the Bonds, the Indenture, the Disclosure Certificate, the Escrow Agreement and this Bond Purchase Agreement, and the consummation of the transactions therein and herein contemplated, and the fulfillment of or compliance with the terms and conditions thereof and hereof will not conflict with or constitute a violation or breach of or default (with due notice or the passage of time or both) under any applicable law or administrative rule or regulation, or any applicable court or administrative decree or order, or any indenture, mortgage, deed of trust, loan agreement, lease, contract or other agreement or instrument to which the District is a party or by which it or its properties are otherwise subject or bound, or result in the creation or imposition of any prohibited lien, charge or encumbrance of any nature whatsoever upon any of the property or assets of the District, which conflict, violation, breach, default, lien, charge or encumbrance might have consequences that would materially and adversely affect the consummation of the transactions contemplated by this Bond Purchase Agreement or the financial condition, properties or operations of the District or its properties.

(f) The District is not in breach or default under any applicable law or administrative regulation of the State of California or the United States or any applicable judgment or decree or any loan agreement, indenture, bond, note, resolution, agreement or other instrument to which the District is a party or is otherwise subject, which breach or default may have consequences that would materially and adversely affect the consummation of the transactions described in the Indenture, the Disclosure Certificate, this Bond Purchase Agreement, the Escrow Agreement or the Official Statement, and no event has occurred and is continuing which, with the passage of time or the giving of notice, or both, would constitute such a default or an event of default under any such instrument;

(g) Both at the time of acceptance hereof by the District, and at the Closing Date, neither the Preliminary Official Statement nor the Official Statement does or will not contain any untrue statement of a material fact or omit any statement or information concerning the District which is necessary to make such statements and information therein, in the light of the circumstances under which they were made, not misleading in any material respect;

(h) If between the date of this Bond Purchase Agreement and 90 days following the Closing Date any event shall occur which might or would cause the Official Statement to contain any untrue statement of a material fact or to omit to state any material fact necessary to make the statements therein, in the light of the circumstances under which they were made, not misleading, the District shall notify the Underwriters and if, in the opinion of the Representative, such event requires the preparation and publication of a supplement or amendment to the Official Statement, the District will supplement or amend the Official Statement in a form and in a manner approved by the Representative, provided all expenses thereby incurred will be paid by the District. If the Official Statement is so supplemented or amended prior to the Closing, such approval by the Representative of a supplement or amendment to the Official Statement shall not preclude the Underwriters from thereafter terminating this Bond Purchase Agreement, and if the Official Statement is so amended or supplemented subsequent to the date hereof and prior to the Closing, the Underwriters may terminate this Bond Purchase Agreement by notification to the District at any time prior to the

Closing if, in the reasonable judgment of the Underwriters, such amendment or supplement has or will have a material adverse effect on the marketability of the Bonds.

(i) The District has not incurred any material liabilities, direct or contingent, nor has there been any material adverse change in the financial position, results of operation or condition, financial or otherwise, of the District since June 30, 2012, which is not described in the Preliminary Official Statement or the Official Statement, whether or not arising from transactions in the ordinary course of business;

(j) Between the date hereof and the date of the Closing, the District will not, without the prior written consent of the Representative, except as described in or contemplated by the Official Statement, incur any material liabilities, direct or contingent, other than in the ordinary course of business;

(k) All approvals, consents, authorizations, certifications and other orders of any governmental authority, board, agency or commission having jurisdiction, and all filings with any such entities, which would constitute conditions precedent to or the failure to obtain which would materially adversely affect the performance by the District of its obligations hereunder or under the Indenture, the Disclosure Certificate or the Escrow Agreement or the consummation of the transactions described in the Official Statement have been or will be duly obtained and no further consent, approval, authorization or other action by any governmental or regulatory authority having jurisdiction over the District is or will be required for the issue and sale of the Bonds or the consummation by the District of the other transactions described in this Bond Purchase Agreement and the Official Statement, except as such may be required under the state securities or Blue Sky laws in connection with the distribution of the Bonds by the Underwriters (as to which no representation or warranty is given by the District);

(l) After the Closing, the District will (a) not participate in the issuance of any amendment of or supplement to the Official Statement to which, after being furnished with a copy, the Underwriters shall reasonably object in writing or which shall be disapproved by its counsel and (b) for so long as the Underwriters are obligated by Rule 15c2-12 to deliver Official Statements to prospective purchasers, if any event relating to or affecting the District or its present or proposed facilities shall occur as a result of which it is necessary, in the opinion of counsel for the Underwriters, to amend or supplement the Official Statement in order to make the Official Statement not misleading in the light of the circumstances existing at the time it is delivered to a purchaser, forthwith prepare and furnish to the Underwriters (at the expense of the District for 25 days from the date of Closing, and thereafter at the expense of the Underwriters) a reasonable number of copies of an amendment of or supplement to the Official Statement (in form and substance satisfactory to counsel for the Underwriters) which will amend or supplement the Official Statement so that it will not contain an untrue statement of a material fact or omit to state a material fact necessary in order to make the statements therein, in the light of the circumstances existing at the time the Official Statement is delivered to a purchaser, not misleading. For the purposes of this subsection, the District will furnish such information with respect to itself and its present and proposed facilities as the Underwriters may from time to time reasonably request. Unless otherwise notified by the Underwriters, the District can assume that the underwriting period (as defined in Rule 15c2-12) ends on the Closing Date; and

(m) The District will furnish such information, execute such instruments and take such other action in cooperation with the Underwriters as the Underwriters may reasonably request in order for the Underwriters (i) to qualify the Bonds for offer and sale under the Blue Sky or other securities laws and regulations of such states and other jurisdictions of the United States as the Underwriters may designate and (ii) to determine the eligibility of the Bonds for investment under the laws of such state and other jurisdictions, and will use its best efforts to

continue such qualification in effect so long as required for distribution of the Bonds; provided, however, that in no event shall the District be required to take any action which would subject it to general or unlimited service of process in any jurisdiction in which it is not now so subject; and

(n) The audited financial statements of the District for the fiscal year ended June 30, 2012 which are referred to in the Preliminary Official Statement and the Official Statement (and summarized in Appendix A thereto), present fairly and accurately the financial condition and operations of the District for that period in accordance with generally accepted accounting principles and on a basis consistent with past accounting practices reflected in the prior fiscal year's audited financial statements.

(o) The District has complied, in all material respect, with all continuing disclosure obligations it has undertaken and which have been in effect for the past five years.

The execution and delivery of this Bond Purchase Agreement by the District shall constitute a representation by the District to the Underwriters that the representations, warranties and agreements contained in this Section 2 are true as of the date hereof; provided that as to all matters of law the District is relying on the advice of counsel to the District; and provided further that no member of the governing body of the District shall be individually liable for the breach of any representation, warranty or agreement contained herein.

3. Conditions to the Obligations of the Underwriters. The obligation of the Underwriters to accept delivery of and pay for the Bonds on the Closing Date shall be subject, at the option of the Underwriters, to the accuracy in all material respects of the representations, warranties and agreements on the part of the District contained herein as of the date hereof and as of the Closing Date, to the accuracy in all material respects of the statements of the officers and other officials of the District made in any certificates or other documents furnished pursuant to the provisions hereof, and to the performance by the District of its obligations to be performed hereunder at or prior to the Closing Date and to the following additional conditions:

(a) At the Closing Date, the Official Statement, the Indenture, this Bond Purchase Agreement, the Disclosure Certificate and the Escrow Agreement shall be in full force and effect in the form heretofore submitted to the Underwriters, with only such changes as shall be agreed to in writing by the Underwriters, and there shall have been taken in connection with the issuance of the Bonds and with the transactions contemplated thereby and by this Bond Purchase Agreement, all such actions as, in the opinion of Quint & Thimmig LLP, Bond Counsel, shall be necessary and appropriate;

(b) At the Closing Date, the Official Statement, the Indenture, this Bond Purchase Agreement, the Disclosure Certificate and the Escrow Agreement shall not have been amended, modified or supplemented, except as may have been agreed to in writing by the Representative;

(c) Between the date hereof and the Closing Date, the market price or marketability, at the initial offering prices set forth in the Official Statement, of the Bonds shall not have been materially adversely affected, in the judgment of the Representative, by reason of any of the following:

(1) legislation shall have been enacted by the Congress of the United States or the Legislature of the State of California or favorably reported thereto for passage by any Committee to which such legislation has been referred for consideration or be pending before any such Committee or shall have been recommended to the Congress of the United States for passage by the President of the United States or recommended to the Legislature of the State of California for passage by the Governor of the State of

California, or a decision shall have been rendered by a court of the United States, including the Tax Court of the United States, or of the State of California, or a ruling or an official release shall have been made or a regulation shall have been proposed or made by the Treasury Department of the United States or the Internal Revenue Service or other federal or State of California authority having jurisdiction over tax matters, with respect to federal or State of California taxation upon revenues or other income of the District or upon interest on obligations of the general character of the Bonds, or other actions or events shall have transpired that would, in the reasonable judgment of the Underwriters, have the purpose or effect, directly or indirectly, of changing the federal or State of California tax consequences of any of the transactions contemplated in connection herewith and that in the reasonable judgment of the Representative, affects materially and adversely (i) the market price or marketability of the Bonds or (ii) the ability of the Underwriters to enforce contracts for the sale of the Bonds;

(2) legislation shall have been enacted or introduced in the Congress or recommended for passage by the President of the United States, or a decision rendered by a court of competent jurisdiction or by the Tax Court of the United States, or an order, ruling, regulation (final, temporary or proposed) or official statement issued or made by or on behalf of the Securities and Exchange Commission, or any other governmental agency having jurisdiction of the subject matter, to the effect that obligations of the general character of the Bonds, or the Bonds, including any or all underlying obligations, are not exempt from registration under the Securities Act of 1933, as amended (the "Securities Act"), that the Indenture is not exempt from qualification under the Trust Indenture Act of 1939, as amended (the "Trust Indenture Act"), or that the issuance, offering or sale of the Bonds, including any or all underlying obligations, is or would be in violation of the federal securities laws as amended and then in effect or that suspends the use of the Official Statement or any supplement thereto or any proceeding for such purpose shall have been initiated or threatened in any such court or by any such authority;

(3) the outbreak or escalation of hostilities involving the United States or the declaration by the United States of a national emergency or war or the engagement in major hostilities by the United States or the occurrence of any other national emergency or calamity relating to the effective operation of the government of or the financial community in the United States;

(4) the declaration of a general banking moratorium by federal, New York or California authorities, or the general suspension of trading on any national securities exchange;

(5) the imposition by the New York Stock Exchange or other national securities exchange, or any governmental authority, of any material restrictions not now in force with respect to the Bonds or obligations of the general character of the Bonds or securities generally, or the material increase of any such restrictions now in force, including those relating to the extension of credit by, or the charge to the net capital requirements of, underwriters;

(6) the withdrawal or downgrading of any rating of the Bonds by a national rating agency or notice having been given by a national rating agency of any intended or potential downgrading or other review or possible change in such rating that does not indicate the direction of such possible change; or

(7) any event occurring, or information becoming known which, in the reasonable judgment of the Underwriters, makes untrue in any material respect any

statement or information contained in the Official Statement, or has the effect that the Official Statement contains any untrue statement of material fact or omits to state a material fact required to be stated therein or necessary to make the statements therein, in the light of the circumstances under which they were made, not misleading.

(8) an order, ruling, regulation (final, temporary or proposed), press release, statement or other form of notice by or on behalf of the Treasury Department of the United States, the Internal Revenue Service or other governmental agency relating to Circular 230 (31 C.F.R. part 10) is issued, made or proposed, that, in the judgment of the Underwriters, affects materially and adversely the market for the Bonds or the market price generally of obligations of the general character of the Bonds.

(d) At or prior to the Closing Date, the Underwriters shall have received the following documents, in each case satisfactory in form and substance to the Representative:

(1) Copies of the Indenture, the Disclosure Certificate and EscrowAgreement, duly executed and delivered by the respective parties thereto, with such amendments, modifications or supplements as may have been agreed to in writing by the Representative;

(2) An unqualified approving opinion, dated the Closing Date and addressed to the District, of Quint & Thimmig LLP, Bond Counsel, in substantially the form attached as Appendix D to the Official Statement, together with a letter from said Bond Counsel authorizing the Underwriters to rely on said opinion, and a supplemental opinion in form acceptable to the Representative and the District, dated the Closing Date and addressed to the Underwriters and the District, to the effect that:

(i) the Bond Purchase Agreement has been duly executed and delivered by the District and, assuming due authorization, execution and delivery by the Underwriters, is a valid and binding obligation of the District, subject to laws relating to bankruptcy, insolvency, reorganization arrangement, fraudulent conveyance, moratorium or other laws affecting creditors' rights generally, to the application of equitable principles, to the exercise of judicial discretion in appropriate cases and to the limitations on legal remedies against a local health care district in the State of California;

(ii) the statements contained in the Official Statement in the sections thereof entitled: "THE BONDS," "SECURITY FOR THE BONDS," "TAX MATTERS," "EXHIBIT C—SUMMARY OF PRINCIPAL LEGAL DOCUMENTS," and "EXHIBIT D—FORM OF FINAL OPINION OF BOND COUNSEL; insofar as such statements expressly summarize certain provisions of the Bonds, the Indenture, the Disclosure Certificate and Bond Counsel's opinion concerning certain federal tax matters are accurate in all material respects; and

(iii) the Bonds are not subject to the registration requirements of the Securities Act of 1933, as amended, and the Indenture is exempt from qualification as an indenture pursuant to the Trust Indenture Act of 1939, as amended.

(3) An opinion dated the Closing Date and addressed to the District and the Underwriters, of Porter Simon, counsel to the District, in substantially the form attached hereto as Exhibit B.

(4) A certificate of the President of the Board of Directors of the District, or such other officer as is acceptable to the Representative, dated the Closing Date, to the effect that the representations and agreements of the District contained herein are true and correct in all material respects as of the Closing Date, and:

(i) no litigation is pending or, to the knowledge of such officer, threatened (a) to restrain or enjoin the issuance or delivery of any of the Bonds or the collection of Revenues pledged under the Indenture, (b) in any way contesting or affecting the authority for the issuance of the Bonds or the validity of the Bonds, the Indenture, the Disclosure Certificate, the Escrow Agreement or this Bond Purchase Agreement, or (c) in any way contesting the existence or powers of the District;

(ii) no event affecting the District has occurred since the date of the Official Statement which would cause as of the Closing Date any statement or information contained in the Official Statement to contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements and information therein, in light of the circumstances under which they were made, not misleading;

(iii) since June 30, 2012, no material and adverse change has occurred in the financial position or results of operations of the District other than as is set forth in the Official Statement;

(iv) the District has not, since June 30, 2012, incurred any material liabilities other than in the ordinary course of business or as set forth in or contemplated by the Official Statement; and

(v) no proceedings are pending or threatened (1) in any way contesting or affecting the District's status as a local health care district or (2) to subject any income of the District to federal income taxation;

(5) An arbitrage/tax certificate in form satisfactory to Bond Counsel;

(6) A copy of the completed Form 8038-G of the Internal Revenue Service, executed by the District;

(7) Satisfactory evidence that the Bonds have been rated "A-" or better by Standard & Poor's Ratings Services;

(8) An opinion of Jennings, Strouss & Salmon, P.L.C., as Disclosure Counsel for the District, addressed to the Underwriters, to the effect that, based upon its participation in the preparation of the Official Statement as disclosure counsel and without having undertaken to determine independently the fairness, accuracy or completeness of the statements contained in the Official Statement, such counsel has no reason to believe that, as of the date of the Closing, the Official Statement (excluding therefrom the reports, financial and statistical data and forecasts therein, the information with respect to DTC and the book-entry system, the information included in Appendices thereto, as to which no opinion need be expressed) contains any untrue statement of a material fact or omits to state a material fact required to be stated therein or necessary to make the statements therein, in the light of the circumstances under which they were made, not misleading;

(9) A certified copy of the resolution of the District authorizing the execution and delivery of the Bonds, the Indenture, the Disclosure Certificate, the Bond Purchase Agreement, the Escrow Agreement and the Official Statement and ratifying the distribution of the Preliminary Official Statement and authorizing distribution of the Official Statement;

(10) A policy of title insurance in form and substance reasonably acceptable to Bond Counsel;

(11) An opinion of counsel to the Trustee in form and substance satisfactory to the Representative and Bond Counsel;

(12) A certificate of the Trustee, dated the Closing Date and signed by an authorized representative of the Trustee, to the effect that:

(i) The Trustee is a duly organized and existing national banking association in good standing under the laws of the United States of America and has all necessary power and authority to enter into and perform its duties under the Indenture;

(ii) The Trustee is duly authorized to enter into the Indenture and has duly executed and delivered the Indenture;

(iii) The Bonds have been duly authenticated and delivered by the Trustee;

(iv) The execution and delivery of the Indenture and the authentication and delivery of the Bonds and compliance with the provisions thereof, will not conflict with, or constitute a breach of or default under, the Trustee's duties under any law, administrative regulation, court decree, resolution, articles of association, bylaws or other agreement to which the Trustee is subject or by which it is or may be bound; provided, however, the Trustee need not make any representations and warranties with respect to compliance with any federal and state securities laws; and

(v) There is no action, suit, proceeding, inquiry or investigation, at law or in equity, before or by any court, governmental agency, public board or body, served upon or, to the best of the Trustee's knowledge, threatened against the Trustee, affecting the existence of the Trustee, or the entitlement of its officers to their respective offices or seeking to prohibit, restrain or enjoin the execution and delivery of the Bonds or the collection of revenues pledged or to be pledged to pay the principal, redemption premium, if any, and interest represented by the Bonds, or the pledge thereof, or in anyway contesting or affecting the validity or enforceability of the Indenture, or the Bonds; or contesting the power or authority of the Trustee to enter into, adopt or perform its obligations under any of the foregoing, wherein an unfavorable decision, ruling or finding would materially adversely affect the validly or enforceability of the Indenture or the Bonds;

(13) An opinion of counsel to the Escrow Bank in form and substance satisfactory to the Representative and Bond Counsel;

(14) A certificate of the Escrow Bank , dated the Closing Date and signed by an authorized representative of the Escrow Bank , to the effect that:

(i) The Escrow Bank is a duly organized and existing national banking association in good standing under the laws of the United States of America and has all necessary power and authority to enter into and perform its duties under the Escrow Agreement;

(ii) The Escrow Bank is duly authorized to enter into the 1998 Escrow Agreement and the Escrow Agreement and has duly executed and delivered the Escrow Agreement;

(iii) The execution and delivery of the Escrow Agreement and compliance with the provisions thereof, will not conflict with, or constitute a breach of or default under, the Escrow Bank's duties under any law, administrative regulation, court decree, resolution, articles of association, bylaws or other agreement to which the Escrow Bank is subject or by which it is or may be bound; provided, however, the Escrow Bank need not make any representations and warranties with respect to compliance with any federal and state securities laws; and

(iv) There is no action, suit, proceeding, inquiry or investigation, at law or in equity, before or by any court, governmental agency, public board or body, served upon or, to the best of the Escrow Bank's knowledge, threatened against the Escrow Bank, affecting the existence of the Escrow Bank, or the entitlement of its officers to their respective offices or in anyway contesting or affecting the validity or enforceability of the Escrow Agreement; or contesting the power or authority of the Escrow Bank to enter into, adopt or perform its obligations under any of the foregoing, wherein an unfavorable decision, ruling or finding would materially adversely affect the validly or enforceability of the Escrow Agreement;

(15) A defeasance opinion of Bond Counsel, relating to the 2006 Bonds; and

(16) Such additional legal opinions, certificates, proceedings, instruments and other documents as the Representative, Bond Counsel or counsel to the Underwriters may reasonably request to evidence compliance by the District with legal requirements, the truth and accuracy, as of the Closing Date, of the representations of the District contained herein, and the due performance or satisfaction by the District at or prior to such time of all agreements then to be performed and all conditions then to be satisfied by the District.

If the District shall be unable to satisfy the conditions to the Underwriters' obligations contained in this Bond Purchase Agreement or if the Underwriters' obligations shall be terminated for any reason permitted herein, this Bond Purchase Agreement shall terminate and neither the Underwriters nor the District shall have any further obligation hereunder.

4. Indemnification. To the extent permitted by law, the District agrees to indemnify and hold harmless the Underwriters and each person, if any, who controls (as such term is defined in Section 15 of the Securities Act) the Underwriters against any and all losses, claims, damages, liabilities and expenses (i) arising out of any statement or information in the Preliminary Official Statement or in the Official Statement that is or is alleged to be untrue or incorrect in any material respect or the omission or alleged omission therefrom of any statement or information that should be stated therein or that is necessary to make the statements therein not misleading in any material respect, and (ii) to the extent of the aggregate amount paid in settlement of any litigation commenced or threatened arising from a claim based upon any such untrue statement

or omission if such settlement is effected with the written consent of the District; provided, however, that in no event shall this indemnification agreement inure to the benefit of the Underwriters (or any person controlling the Underwriters) on account of any losses, claims, damages, liabilities or actions founded on any untrue statement or omission contained in the Preliminary Official Statement or Official Statement arising from the sale of the Bonds upon the public offering to any person by the Underwriters if such losses, claims, damages, liabilities or actions arise out of, or are based upon, an untrue statement or omission or alleged untrue statement or omission which is the basis of the loss, claim, damage, liability or action for which indemnification is sought and a copy of the Official Statement had not been sent or given to such person at or prior to confirmation of such sale to him or her, unless such failure to deliver the Official Statement was a result of noncompliance by the District with Section 1(g), Section 2(h) or Section 2(l) hereof. In case any claim shall be made or action brought against the Underwriters or any controlling person based upon the Official Statement for which indemnity may be sought against the District, as provided above, the Underwriters shall promptly notify the District in writing setting forth the particulars of such claim or action and the District shall assume the defense thereof, including the retaining of counsel acceptable to the District and the payment of all expenses. The Underwriters or any such controlling person shall have the right to retain separate counsel in any such action but shall bear the fees and expenses of such counsel unless (i) the District shall have specifically authorized the retaining of such counsel or (ii) the parties to such suit include the Underwriters or any controlling person or persons, and the District and the Underwriters or controlling person or persons have been advised by such counsel that one or more legal defenses may be available to it or them which may not be available to the District, in which case the District shall not be entitled to assume the defense of such suit notwithstanding its obligation to bear the fees and expenses of such counsel.

5. Contribution. In order to provide for just and equitable contribution in circumstances in which the indemnification provided for in Paragraph 4 hereof is applicable but for any reason is held to be unavailable from the District, to the extent permitted by law, the District and the Underwriters shall contribute to the aggregate losses, claims, damages and liabilities (including any investigation, legal and other expenses incurred in connection with, and any amount paid in settlement of, any action, suit or proceeding or any claims asserted, but after deducting any contribution received by the District from persons who control the District within the meaning of the federal securities acts, officers of the District who signed the Official Statement, who may also be liable for contribution) to which the District and the Underwriters may be subject in such proportions that the Underwriters is responsible for that portion represented by the percentage that the underwriting discount set forth in the Official Statement bears to the offering price appearing thereon and the District is responsible for the balance; provided, however, that (i) in no case shall the Underwriters be responsible for any amount in excess of the underwriting discount applicable to the Bonds purchased by the Underwriters pursuant to the Bond Purchase Agreement and (ii) no person guilty of fraudulent misrepresentation (within the meaning of Section 11(f) of the Securities Act)) shall be entitled to contribution from any person who was not guilty of such fraudulent misrepresentation. For purposes of this Paragraph 5, each person, if any, who controls the Underwriters within the meaning of the federal securities acts, shall have the same rights to contribution as the Underwriters, each person, if any, who controls the District within the meaning of the federal securities acts and each officer of the District who shall have signed the Official Statement shall have the same rights to contribution as the District, subject in each case to clauses (i) and (ii) of this Paragraph 5. Any party entitled to contribution will, promptly after receipt of notice of commencement of any action, suit or proceeding against such party in respect of which a claim for contribution may be made against another party or parties under this Paragraph 5, notify such party or parties from whom contribution may be sought, but the omission to so notify such party from whom contribution may be sought shall not relieve the party or parties from whom contribution may be sought from any other obligation or they may have hereunder or otherwise

than under this Paragraph 5. No party shall be liable for contribution with respect to any action or claim settled without its consent.

6. Expenses. All reasonable expenses and costs of the District incident to the performance of its obligations in connection with the authorization, issuance and sale of the Bonds to the Underwriters, including printing costs, fees and expenses of the Trustee, fees and expenses of consultants and reasonable fees and expenses of Bond Counsel, counsel to the District and Disclosure Counsel, shall be paid by the District. All fees and expenses to be paid by the District pursuant to this Bond Purchase Agreement may be paid from Bond proceeds to the extent permitted by the Indenture. All out-of-pocket expenses of the Underwriters, including travel and other expenses, CUSIP Service Bureau charges and California Debt Advisory Commission fees, shall be paid by the Underwriters.

7. Notices. Any notice or other communication to be given to the District under this Bond Purchase Agreement may be given by delivering the same in writing at the District's address set forth above; any notice or other communication to be given to the Underwriters under this Bond Purchase Agreement may be given by delivering the same in writing to Southwest Securities, Inc., 2533 South Coast Highway 101, Suite 250, Cardiff, CA 92007,Attention: Mr. Michael Cavanaugh, Senior Vice President. The approval of the Underwriters when required hereunder or the determination of its satisfaction as to any document referred to herein shall be in writing signed by the Representative and delivered to the District.

8. Parties in Interest; Survival of Representations and Warranties. This Bond Purchase Agreement is made solely for the benefit of the District and the Underwriters (including the successors or assigns of the Underwriters), and no other person shall acquire or have any right hereunder or by virtue hereof. All the representations, warranties and agreements made by the District in this Bond Purchase Agreement shall remain operative and in full force and effect, regardless of (i) any investigations made by or on behalf of the Underwriters, (ii) delivery of and payment for the Bonds hereunder, and (iii) any termination of this Bond Purchase Agreement.

9. Governing Law. This Bond Purchase Agreement shall be governed by the laws of the State of California.

10. Miscellaneous. The headings of the sections of this Bond Purchase Agreement are inserted for convenience only and shall not be deemed to be part hereof.

11. Counterparts. This Bond Purchase Agreement may be signed in two or more counterparts (including counterparts represented by facsimile copies and/or containing facsimile signatures); all such counterparts, when signed by all parties, shall constitute but one single agreement.

Very truly yours,

SOUTHWEST SECURITIES, INC.,
PIPER JAFFRAY & CO. and
RAYMOND JAMES & ASSOCIATES, INC.,
as Underwriters

By SOUTHWEST SECURITIES, INC., as Representative

By _____
Name _____
Title _____

Accepted and Agreed to:

TAHOE FOREST HOSPITAL DISTRICT

By _____
Crystal Betts
Chief Financial Officer

EXHIBIT A

MATURITY SCHEDULE

Maturity (July 1)	Principal Amount	Interest Rate	Price	Yield

REDEMPTION PROVISIONS

Optional Redemption. The Bonds maturing on or before July 1, ____, are not subject to optional redemption prior to maturity. The Bonds maturing on or after July 1, ____, are subject to redemption prior to their respective maturity dates, at the option of the District, as a whole or in part, in such order of maturity as shall be selected by the District (or in inverse order of maturity if the District shall fail to select a particular order) and by lot within a maturity, on any date on or after July 1, ____, from any source of available funds, at a redemption price equal to the principal amount of the Bonds to be redeemed, plus accrued interest thereon to the date of redemption, without premium.

Mandatory Sinking Fund Redemption. The Bonds maturing on and after July 1, ____ (the ____ Term Bonds"), are subject to mandatory redemption on July 1 in each year on and after July 1, ____, to and including July 1, ____, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed	Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed

†Maturity

The Bonds maturing on and after July 1, ____ (the ____ Term Bonds"), are subject to mandatory redemption on July 1 in each year on and after July 1, ____, to and including July 1, ____, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed	Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed

†Maturity

EXHIBIT B

FORM OF OPINION OF COUNSEL TO THE DISTRICT

[Closing Date]

Piper Jaffray & Co.
8235 Forsyth Boulevard, Suite 600
St. Louis, MO 63105

Raymond James & Associates, Inc.
One Embarcadero Center, Suite 650
San Francisco, CA 94111

Southwest Securities, Inc
2533 South Coast Highway 101, Suite 210
Cardiff, CA 92007

Re: Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds Series 2015

Ladies and Gentlemen:

We have served as special District Counsel for Tahoe Forest Hospital District (the "District") in connection with the issuance of Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015 (the "Bonds"), by the District in the aggregate principal amount of $_____. The Bonds are issued pursuant to the provisions of section 53570 *et seq.* of the California Government Code and are issued under and secured by an Indenture of Trust, dated as of July 1, 1999, by and between the District and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Prior Trustee"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Prior Trustee, as further amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Prior Trustee, as further amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee, and as further amended and supplemented by that certain Fourth Supplemental Indenture, dated as of April 1, 2015, by and between the District and U.S. Bank National Association, as successor trustee (the "Trustee") (collectively, the "Indenture"). The Bonds are being sold pursuant to a Bond Purchase Agreement, dated April 9, 2015 (the "Bond Purchase Agreement"), between the District and Southwest Securities Inc., Piper Jaffray & Co. and Raymond James & Associates, Inc., as underwriters.

The proceeds from the sale of the Bonds will be used to (i) refund the District's outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, currently outstanding in the principal amount of $23,240,000 (the "2006 Bonds"), issued to finance the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District, and (iii) pay certain costs and expenses related to the issuance and sale of the Bonds, on a parity as to payment and security with the District's Tahoe Forest Hospital District (Placer and Nevada Counties, California) Variable Rate Demand Revenue Bonds, Series 2002.

In connection with this opinion, we have assumed the authenticity of all records, documents, and instruments submitted to us as originals, the genuineness of all signatures, the legal capacity of natural persons and the conformity to the originals of all records, documents, and instruments submitted to us as copies. We also have assumed that there are no facts or circumstances relating to you that might prevent you from enforcing any of the rights to which our opinion relates. We have based our opinion upon our review of the following records, documents and instruments:

(a) A copy of the Indenture.

(b) A copy of the Bond Purchase Agreement.

(e) A copy of the Disclosure Certificate (hereinafter defined).

(f) A copy of that certain Escrow Deposit and Trust Agreement relating to the refunding of the 2006 Bonds, to be dated the date hereof (the "Escrow Agreement"), by and between the District and The Bank of New York Mellon Trust Company, N.A., as escrow bank (the "Escrow Bank").

(h) A copy of the Preliminary Official Statement, dated April 1, 2015 (the "Preliminary Official Statement") and the Official Statement, dated April 9, 2015 (the "Official Statement") relating to the Bonds.

(j) Resolution No. ____ adopted by the District authorizing the execution and delivery of the Bonds and the Transaction Documents (hereinafter defined).

The documents and instruments listed in items (a) through (g) above are collectively referred to herein as the "Transaction Documents."

Where our opinion relates to our "knowledge", such knowledge is based upon our examination of the records, documents, instruments, and certificates enumerated or described above and the actual knowledge of attorneys in this firm who are currently involved in substantive legal representation of the District. With your consent, we have not examined any records of any court, administrative tribunal or other similar entity in connection with our opinion. Except as described herein, we have undertaken no investigation or verification of such matters.

Based upon the foregoing and our examination of such questions of law as we have deemed necessary or appropriate for the purpose of this opinion, and subject to the limitations and qualifications expressed below, it is our opinion that:

(1) The District is a local health care district duly existing under the laws of the State of California, has full legal right, power and authority to enter into the Indenture, the Bond Purchase Agreement, the Continuing Disclosure Certificate, dated April 28, 2015 (the "Disclosure Certificate"), the Official Statement and the Escrow Agreement and to carry out and consummate all transactions contemplated by the Indenture, the Bond Purchase Agreement, the Disclosure Certificate, the Official Statement and the Escrow Agreement .

(2) The Official Statement has been duly authorized, executed and delivered by the District.

(3) Resolution No. ____ of the District approving and authorizing the execution of the Indenture, the Bond Purchase Agreement, the Bonds, the Disclosure Certificate, the Official Statement and the Escrow Agreement was duly adopted at a meeting of the governing body of the District which was called and held pursuant to law and with all public notice required by law and at which a quorum was present and voted.

(4) To our knowledge, except for litigation disclosed in the Official Statement, there is no action, suit, proceeding or investigation at law or in equity before or by any court, public board or body pending or threatened against the District to restrain or enjoin the issuance or delivery of the Bonds or the collection of revenues pledged under the Indenture, contesting any authority for the issuance of the Bonds or the validity of the Bonds, the Indenture, the Disclosure Certificate, the Escrow Agreement or the Bond Purchase Agreement, contesting the existence or powers of the District with respect to the issuance of the Bonds or the security therefor wherein an unfavorable decision, ruling or finding would adversely affect the transactions contemplated by the Official Statement, the Indenture, the Disclosure Certificate, the Bond Purchase Agreement or the Escrow Agreement or the validity of the Bonds.

(5) The Bonds, the Indenture, the Official Statement, the Disclosure Certificate, the Bond Purchase Agreement and the Escrow Agreement have been duly authorized, executed and delivered by the District and, assuming due authorization, execution and delivery by the other parties thereto where applicable, are valid and binding limited obligations of the District enforceable in accordance with their terms.

(6) Based upon the information made available to us in the course of our participation in the preparation of the Official Statement as special counsel for the District, and without having undertaken to determine independently or assuming any responsibility for the accuracy, completeness or fairness of the statements contained in the Official Statement, to our knowledge the Official Statement (excluding therefrom the financial, statistical and economic data or determinations or forecasts, numbers, charts, tables, graphs, estimates, projections, assumptions and expressions of opinion, and the information about DTC and the book-entry system included in the Official Statement, as to which we express no opinion) contains any untrue statement of a material fact or omits to state a material fact necessary in order to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

This opinion is limited to the federal laws of the United States of America and the laws of the State of California. We disclaim any opinion as to the laws of any other jurisdiction and we further disclaim any opinion as to any statute, rule, regulation, ordinance, order or other promulgation of any regional or local governmental body. This opinion is based upon the law in effect on the date hereof, and we assume no obligations to revise or supplement this opinion should such law be changed by legislative action, judicial decision, or otherwise. In connection with this opinion letter, we also have assumed the following: (a) consideration has been duly given under the Transaction Documents; (b) the District is the legal, beneficial and record owner of the collateral described in any Transaction Documents and the descriptions of collateral in the Transaction Documents sufficiently describe the collateral intended to be covered by such documents; (c) any lien documents are in suitable form, notarized if required, and duly filed or recorded with the appropriate government offices; (d) the Transaction Documents accurately describe the mutual understanding of the parties thereto, and that there are no oral or written statements that modify, amend, or vary, or purport to modify, amend, or vary, any of the terms of the Transaction Documents; (e) the information, factual matters, representations and warranties contained in the Transaction Documents, records, certificates and other documents we have reviewed are true, correct and complete; and (f) the other parties to Transaction Documents have the proper authority to engage in the transactions contemplated thereunder and at all times have complied and will comply with the Transaction Documents and related

documents and with all applicable requirements governing their actions and will act in a commercially reasonable manner.

In connection with this opinion, we advise you that:

A. Enforceability is subject (i) to bankruptcy, insolvency, reorganization, arrangement, moratorium, and other laws of general applicability relating to or affecting creditors' rights, (ii) to general principles of equity, whether such enforcement is considered in a proceeding in equity or at law, (iii) to limitations imposed by applicable law or public policy on the enforceability of the indemnification provisions, and (iv) to the qualification that certain waivers, procedures, remedies, and other provisions of the Transaction Documents may be unenforceable under or limited by applicable law.

B. The enforceability of the Transaction Documents is further subject to the effect of general principles of equity. These principles include, without limitation, concepts of commercial reasonableness, materiality and good faith and fair dealing. These principles require the parties to act reasonably, in good faith and in a manner that is not arbitrary or capricious in the administration and enforcement of the Transaction Documents and will preclude them from invoking penalties for defaults that bear no reasonable relation to the damage suffered or that would otherwise work a forfeiture.

C. The effectiveness of indemnities, rights of contribution, exculpatory provisions and waivers of the benefits of statutory provisions may be limited on public policy grounds.

D. Section 1717 of the California Civil Code provides that, in any action on a contract where the contract specifically provides that attorneys' fees and costs incurred to enforce that contract shall be awarded either to one of the parties or to the prevailing party, then the party who is determined to be the party prevailing in the action, whether that party is the party specified in the contract or not, shall be entitled to reasonable attorneys' fees in addition to other costs.

E. Any provisions of the Transaction Documents requiring that waivers must be in writing may not be binding or enforceable if a non-executory oral agreement has been created modifying any such provision or an implied agreement by trade practice or course of conduct has given rise to a waiver.

F. Section 9109(d)17 of the California Uniform Commercial Code (the "Code") provides that the secured transactions provisions of the Code do not apply to transfers by a government or governmental unit, and, therefore, the rights and remedies of the Trustee under the Transaction Documents which purport to incorporate rights and remedies under the Code may not be enforceable and as such, we express no opinion on such matters.

G. Any provisions of the Transaction Documents regarding another party's right to apply proceeds of fire or other casualty insurance policies or awards of damages in condemnation proceedings against the District's secured obligations will not be enforceable unless application of such proceeds or damages is reasonably necessary to protect such security interests.

H. We assume that in the enforcement of any lien documents, all parties will act in accordance with applicable statutory and other legal requirements, including applicable case law and that enforcement of rights or remedies thereunder may be limited when imposing fees and charges in the event of default, upon acceleration of the District's obligations for transfers of interests, leases, or grants of junior encumbrances, attempting to secure a deficiency claim before exhausting the secured property or other remedies, among other things.

I. We have further relied on certain representations, warranties and covenants of the District in the Transaction Documents. Any variations may affect the opinions we are giving.

J. In connection with our opinion, we have not reviewed and express no opinion on (i) financial statements or covenants, financial or audit reports or the consents related thereto or similar provisions requiring financial calculations or determinations, (ii) provisions relating to the occurrence of a "material adverse effect" or similar words, or (iii) parol evidence bearing on interpretation or construction.

We express no opinion as to: (a) the priority of any lien or security interest created, or purported to be created, by any of the Transaction Documents or the enforceability of any lien in the real property of the District; (b) any securities, tax, anti-trust, land use, export, safety, environmental, hazardous materials, choice of law, insurance company or banking laws, rules or regulations; (c) applicable interest rate limitations of California law for loans or forbearances; or (d) the effect on the District's obligations, and any other party's rights, under the Transaction Documents of laws relating to fraudulent transfers and fraudulent obligations set forth in Sections 544 and 548 of the federal Bankruptcy Code and Sections 3439 et seq. of the California Civil Code.

In rendering our opinion, we are expressing no opinion on the validity of the Bonds.

We furnish this opinion as special counsel to the District and only the addressee and Quint & Thimmig LLP may rely upon it. This letter shall not be used, quoted, distributed, circulated or relied upon by any other person or entity for any purpose, without our prior written consent.

Respectfully submitted,

$_____
TAHOE FOREST HOSPITAL DISTRICT
(Placer and Nevada Counties, California)
Hospital Refunding Revenue Bonds, Series 2015

BOND PURCHASE AGREEMENT

April 9, 2015

Tahoe Forest Hospital District
10121 Pine Avenue
Truckee, California 96160

Ladies and Gentlemen:

_____ (the "Purchaser"), offers to enter into this Bond Purchase Agreement (the "Bond Purchase Agreement") with Tahoe Forest Hospital District (the "District"), which, upon acceptance of this offer, will be binding upon the District and the Purchaser.

This offer is made subject to acceptance by the District at or before 11:59 p.m., California time, on the date hereof, and, if not so accepted, will be subject to withdrawal by the Purchaser upon written notice delivered to the District at any time prior to such acceptance. The Purchaser is not acting as a fiduciary of the District or the Corporation, but rather is acting solely in its capacity as Purchaser for its own account.

Capitalized terms used but not otherwise defined herein shall have the meanings assigned to them in the Indenture of Trust, dated as of July 1, 1999, by and between the District and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Prior Trustee"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Prior Trustee, as further amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Prior Trustee, as further amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee, and as further amended and supplemented by that certain Fourth Supplemental Indenture, dated as of April 1, 2015, by and between the District and U.S. Bank National Association, as successor trustee (the "Trustee") (collectively, the "Indenture").

The District hereby acknowledges and agrees that (a) the purchase and sale of the Bonds pursuant to this Bond Purchase Agreement is an arm's-length commercial transaction between the District and the Purchaser, (b) in connection therewith and with the discussions, undertakings and procedures leading up to the consummation of such transaction, the Purchaser is and has been acting solely as a principal and are not acting as the agent or fiduciary of the District, (c) the Purchaser has not assumed an advisory or fiduciary responsibility in favor of the District with respect to the offering and sale of the Bonds contemplated hereby or the discussions, undertakings and procedures leading thereto (irrespective of whether the Purchaser has provided other services or is currently providing other services to the District on other matters) and the Purchaser has no obligation to the

District with respect to the offering and sale of the Bonds contemplated hereby except the obligations expressly set forth in this Bond Purchase Agreement, and (d) the District has consulted its own legal, financial and other advisors to the extent it has deemed appropriate in connection with the issuance of the Bonds and the other matters contemplated by this Bond Purchase Agreement.

Section 1. **Purchase, Sale, Offering and Delivery of Bonds**.

(a) Upon the terms and conditions and upon the basis of the representations, warranties and agreements set forth herein, the Purchaser hereby agree to purchase from the District, and the District hereby agrees to sell to the Purchaser, all (but not less than all) of the District's $_____ aggregate principal amount of Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015 (the "2015 Bonds"), at a purchase price of $_____ (representing the aggregate principal amount of the 2015 Bonds. The 2015 Bonds will be dated as of the Closing Date and interest thereon will be payable semiannually on January 1 and July 1 of each year, commencing on July 1, 2015. The 2015 Bonds will mature on July 1, 2036, and will bear interest at the rate of ____% per annum. The 2015 will be subject to optional and sinking fund redemption as set forth in Schedule A attached hereto.

(b) The Bonds will be as described in and will be issued pursuant to the Indenture, substantially in the form previously submitted to the Purchaser, with only such changes therein as shall be mutually agreed upon. The proceeds from the sale of the Bonds will be used to (i) refund the District's outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006, currently outstanding in the principal amount of $23,240,000 (the "2006 Bonds"), issued to finance the remodeling, expansion, improvement and equipping of the health facilities owned and operated by the District, and (iii) pay certain costs and expenses related to the issuance and sale of the Bonds.

(c) The Bonds will be limited obligations of the District payable solely from Revenues and secured by a pledge of the District's Gross Revenues and of amounts held in certain funds and accounts established pursuant to the Indenture, subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth in the Indenture. The 2015 Bonds will be on a parity as to payment and security with the District's Tahoe Forest Hospital District (Placer and Nevada Counties, California) Variable Rate Demand Revenue Bonds, Series 2002;

Section 2. **Private Placement; 2015 Bonds Constitute a Loan by Purchaser**.

(a) The Purchaser has sufficient knowledge and experience in financial and business matters, including purchase and ownership of municipal and other obligations of a nature similar to the 2015 Bonds to be able to evaluate the risks and merits of the investment represented by the purchase of the 2015 Bonds.

(b) The Purchaser is acquiring the 2015 Bonds for its own account and not with a view to, or for sale in connection with, any distribution of the 2015 Bonds or any part thereof. The Purchaser has not offered to sell, solicited offers to buy, or agreed to sell the 2015 Bonds or any part thereof, and the Purchaser has no current intention of reselling or otherwise disposing of the 2015 Bonds *provided, however*, such representation shall not preclude the Purchaser from transferring or selling of the 2015 Bonds in accordance with the Indenture. The Purchaser is not acting in a broker-dealer capacity in connection with its purchase of the 2015 Bonds. The Purchaser intends to book and hold the 2015 Bonds as a loan in its loan portfolio.

(c) As a sophisticated investor, the Purchaser has made its own credit inquiry and analysis with respect to the District and the 2015 Bonds and has made an independent credit

decision based upon such inquiry and analysis and in reliance on the truth, accuracy, and completeness of the representations and warranties of the District set forth in the Lease Agreement, the Indenture and this Bond Purchase Agreement and in the information set forth in any materials submitted to the Purchaser by the District. The Purchaser acknowledges that it has reviewed information, including financial statements and other financial information regarding the District, and the Purchaser has had the opportunity to ask questions of and receive answers from knowledgeable individuals concerning the District and the 2015 Bonds.

(d) The Purchaser understands that the 2015 Bonds have not been registered under the United States Securities Act of 1933 or under any state securities laws. The Purchaser agrees that it will comply with any applicable state and federal securities laws then in effect with respect to any disposition of the 2015 Bonds by it, and further acknowledges that any current exemption from registration of the 2015 Bonds does not affect or diminish such requirements.

(e) The Purchaser has authority to purchase the 2015 Bonds and to execute this Bond Purchase Agreement and any other instruments and documents required to be executed by the Purchaser in connection with the purchase of the 2015 Bonds. The undersigned is a duly appointed, qualified, and acting officer of the Purchaser and is authorized to cause the Purchaser to make the representations and warranties contained herein by execution of this Bond Purchase Agreement on behalf of the Purchaser.

(f) The Purchaser has been informed that the 2015 Bonds (i) have not been and will not be registered or otherwise qualified for sale under the "Blue Sky" laws and regulations of any jurisdiction, and (ii) will not be listed on any stock or other securities exchange.

(g) The Purchaser acknowledges that the 2015 Bonds are transferable with certain requirements, as described in the Indenture.

(h) The Purchaser has been informed that the 2015 Bonds are exempt from the requirements of Rule 15c2-12 of the Securities and Exchange Commission and that the District has not undertaken to provide any continuing disclosure with respect to the 2015 Bonds.

(i) The Purchaser intends to treat the acquisition of the 2015 Bonds as a loan and to hold the loan in its loan portfolio.

Section 3. **Closing**.

(a) At 8:00 a.m., Pacific Daylight time, on April 28, 2015, or on such earlier or later date and time as shall be agreed upon in writing by the District and the Purchaser (the "Closing Date"), the District shall direct the Trustee to deliver the Bonds (which may be typewritten) to the Purchaser, in definitive form, duly executed and authenticated, at the offices of Quint & Thimmig LLP, Larkspur, California ("Bond Counsel"), or at such other location as may be designated by the Purchaser and approved by the District, and shall deliver to the Purchaser the other documents herein mentioned at the offices of Bond Counsel, or such other location as may be mutually agreed upon by the District and the Purchaser. The Purchaser will accept such delivery and pay the purchase price of the Bonds as set forth in Section 1(a) hereof in immediately available funds by federal funds or wire transfer to the order of the Trustee. The Bonds shall be issued in the form of one fully registered Bond registered in the name of the Purchaser.

(b) It shall be a condition to the obligation of the Purchaser to purchase and accept delivery of the Bonds that all Bonds be sold and delivered by the District to the Purchaser at the Closing and that all obligations of the parties to this Bond Purchase Agreement shall have been satisfied or waived in writing prior to the Closing.

Section 2. **Representations, Warranties and Agreements of the District**. The District represents and warrants to and agrees with the Purchaser that:

(a) The District is and will be at the Closing Date a political subdivision of the State of California and a local health care district duly organized and existing under The Local Health Care District Law, constituting Division 23 of the California Health and Safety Code, with the full power and authority to issue the Bonds and to execute this Bond Purchase Agreement, the Indenture and the Escrow Agreement, dated the Closing Date, by and between the District and The Bank of New York Mellon Trust Company, N.A., as escrow bank (the "Escrow Bank"), relating to the defeasance and redemption of the 2006 Bonds (the "Escrow Agreement"), and to carry out and consummate all transactions on its part contemplated by this Bond Purchase Agreement, the Indenture and the Escrow Agreement;

(b) When delivered to and paid for by the Purchaser at the Closing in accordance with the provisions of this Bond Purchase Agreement, the Bonds will have been duly authorized, executed, issued and delivered and will constitute valid and binding limited obligations of the District in conformity with, and entitled to the benefit and security of, the Indenture;

(c) The issuance of the Bonds and the execution and delivery of the Indenture, the Escrow Agreement and this Bond Purchase Agreement, and compliance with the provisions on the District's part contained therein or herein, will not conflict with or constitute a breach of or default under any law, administrative regulation, judgment, decree, loan agreement, indenture, bond, note, resolution, agreement or other instrument to which the District is a party or is otherwise subject, nor will any such issuance, execution, delivery, adoption or compliance result in the creation or imposition of any lien, charge or other security interest or encumbrance of any nature whatsoever upon any of the properties or assets of the District under the terms of any such law, administrative regulation, judgment, decree, loan agreement, indenture, bond, note, resolution, agreement or other instrument, except as provided by the Indenture;

(d) To the best of its knowledge, the District is not in breach of or in default under any existing law or administrative regulation of the State of California or the United States or any applicable judgment or decree or any loan agreement, indenture, bond, note, mortgage, resolution, agreement or other instrument to which the District is a party or is otherwise subject, and no event has occurred and is continuing which, with the passage of time or the giving of notice, or both, would constitute a default or an event of default thereunder, in either case in any manner or to any extent which could have a material adverse effect on the financial condition of the District, the operation by the District of the Health Facilities or the transactions contemplated by this Bond Purchase Agreement, or have an adverse effect on the validity or enforceability in accordance with their respective terms of the Bonds, the Escrow Agreement, the Indenture or the Second Supplement, or in any way adversely affect the existence or powers of the District or in any way materially adversely affect the excludability from gross income for federal income tax purposes of interest on the Bonds;

(e) The District is not, nor has it been at any time subsequent to June 30, 2014, in default in the payment of principal of or interest on any obligation issued or guaranteed by the District;

(f) No consent or approval of any trustee or holder of any indebtedness of the District, and no consent, permission, authorization, order or license of, or filing or registration with, any governmental authority (except in connection with Blue Sky proceedings, as to which no representation is being made) is necessary in connection with the execution and delivery of this Bond Purchase Agreement, the Indenture or the Escrow Agreement or the consummation of any transaction therein or herein contemplated, except as have been obtained or made and are

in full force and effect. The District makes no representation as to any approvals or actions as may be required under any state or federal blue sky or securities laws;

(g) The District has received and there remain currently in full force and effect, or will receive prior to the delivery of the Bonds, all governmental consents and approvals (i) that would constitute a condition precedent to the performance by the District of its obligations hereunder, the Escrow Agreement or under the Indenture or the consummation of the transactions contemplated by this Bond Purchase Agreement, and (ii) to qualify the District for reimbursement for its costs and expenses under all third party payor programs accounting for a significant portion of the District's gross revenues, including without limitation, Medicare and Medi-Cal;

(h) The District has met, and as of the Closing will have met, all of its continuing disclosure obligations with respect to the 2006 Bonds, the 2010 Bonds and with respect to any other obligations subject to similar continuing disclosure undertakings;

(i) Between the date hereof and the Closing Date, the District will not, without the prior written consent of the Purchaser, incur any material liabilities, direct or contingent, other than in the ordinary course of business;

(j) The Health Facilities are owned or leased and operated by the District. The District has all necessary leases, licenses, permits, accreditations and certifications required to carry on and operate the Health Facilities. The District has all power and authority to consummate the transactions contemplated by this Bond Purchase Agreement, including the execution, delivery and/or approval of all documents and agreements referred to herein. The District has not received notice of an alleged violation and, to the best of its knowledge, the District is not in violation of any zoning, land use, environmental or other similar law or regulation applicable to any of the District's property or the Health Facilities that could adversely affect the District's operations or financial condition;

(k) The District duly authorized all necessary action to be taken by it for: (i) the issuance and sale of the Bonds by the District upon the terms and conditions set forth herein and in the Indenture and the approval of the Bonds; and (ii) the execution, delivery and receipt of this Bond Purchase Agreement, the Indenture and the Escrow Agreement, and any and all such agreements, certificates and documents as may be required to be executed, delivered and received by the District to carry out, effect and consummate the transactions contemplated hereby, including but not limited to such certifications as may be necessary to establish and preserve excludability from gross income for federal income tax purposes of interest on the Bonds;

(l) The District's audited financial statements as of June 30, 2014, and for the fiscal year then ended, are a fair presentation of the financial position of the District as of the dates indicated and the results of its operations and changes in its net assets for the periods specified. Since June 30, 2014, there has been no material adverse change in the condition, financial or otherwise, of the District from that set forth in the audited financial statements as of and for the period ended that date; and the District has not, since June 30, 2014, incurred any material liabilities, directly or indirectly, except in the ordinary course of its operations;

(m) The District will not take or omit to take any action that will in any way cause the proceeds from the sale of the Bonds to be applied or result in such proceeds being applied in a manner other than as provided in the Indenture; and

(n) Each representation, warranty or agreement stated in any certificate signed by any official of the District and delivered to the Purchaser on or before the Closing Date shall

constitute a representation, warranty or agreement by the District upon which the Purchaser shall be entitled to rely.

Section 3. **Conditions to the Obligations of the Purchaser**. The obligation of the Purchaser to purchase, accept delivery of, and pay for the Bonds on the Closing Date shall be subject to the performance prior to or concurrently with the Closing Date by the District of its obligations to be performed under this Bond Purchase Agreement and the accuracy of the representations and warranties of the District contained herein as of the date hereof and as of the Closing Date, and shall also be subject to the following additional conditions:

(a) At the time of Closing, (i) each of the Indenture, the Escrow Agreement and the Bonds shall have been duly authorized, executed and delivered, and each of the foregoing shall be in full force and effect in the form heretofore submitted to the Purchaser and shall not have been amended, modified or supplemented except as may have been agreed to by the Purchaser, (ii) the proceeds of sale of the Bonds shall be paid to the Trustee for deposit or use as described in the Indenture and (iii) there shall have been taken in connection with the issuance of the Bonds and with the transactions contemplated thereby and by this Bond Purchase Agreement all such actions as, in the opinion of Bond Counsel, shall be necessary and appropriate.

(b) Between the date hereof and the Closing Date, the market price of the 2015 Bonds shall not have been materially adversely affected, in the reasonable judgment of the Purchaser, by reason of any of the following:

(i) legislation enacted (or resolution passed) by or introduced or pending legislation amended in the Congress or recommended for passage by the President of the United States, the Secretary of the Treasury or any member of Congress, or a decision rendered by a court established under Article III of the Constitution of the United States or by the Tax Court of the United States, or an order, ruling, regulation (final, temporary or proposed), official statement, press release or other form of notice or communication issued or made by or on behalf of the Treasury Department or the Internal Revenue Service of the United States, by the President or other agency of the federal government or members of Congress with the purpose or effect, directly or indirectly, of imposing federal income taxation upon interest as would be received by the owners of the 2015 Bonds;

(ii) the United States shall have become engaged in hostilities which have resulted in a declaration of war or a national emergency, or there shall have occurred any other outbreak or escalation of hostilities, or a local, national or international calamity or crisis, financial or otherwise, the effect of such outbreak or escalation, calamity or crisis being such as, in the reasonable opinion of the Purchaser, would affect materially and adversely the ability of the Purchaser to market 2015 Bonds;

(iii) the declaration of a general banking moratorium by federal, New York or California authorities, or the general suspension of trading on any national securities exchange;

(iv) the imposition by the New York Stock Exchange or other national securities exchange, or any governmental authority, of any material restrictions not now in force with respect to the 2015 Bonds or obligations of the general character of the 2015 Bonds or securities generally, or the material increase of any such restrictions now in force, including those relating to the extension of credit by, or the charge to the net capital requirements of, underwriters;

(v) an order, decree or injunction issued by any court of competent jurisdiction, or order, ruling, regulation (final, temporary or proposed), official statement or other form of notice or communication issued or made by or on behalf of the Securities and Exchange Commission, or any other governmental agency having jurisdiction of the subject matter, to the effect that (A) obligations of the general character of the 2015 Bonds, or the 2015 Bonds, including any or all underlying arrangements, are not exempt from registration under the Securities Act of 1933, as amended, or that the Indenture is not exempt from qualification under the Trust Indenture Act of 1939, as amended, or (B) the execution and delivery, offering or sale of obligations of the general character of the 2015 Bonds, or the execution and delivery, offering or sale of the 2015 Bonds, including any or all underlying obligations, as contemplated hereby, is or would be in violation of the federal securities laws as amended and then in effect; or

(vi) there shall have occurred any materially adverse change in the affairs or financial condition of the District.

(c) At or prior to the Closing, the Purchaser shall have received the following, in each case satisfactory in form and substance to the Purchaser:

(i) A certificate, dated the Closing Date, signed by an authorized officer of the District to the effect that (A) since June 30, 2014, the District has not incurred any material liabilities, direct or contingent, nor has there been any material adverse change in the financial position, results of operation or condition of the District, unless arising from transactions in the ordinary course of business; (B) no litigation is pending or, to such officer's best knowledge, threatened (i) to restrain or enjoin the collection of Gross Revenues pledged or to be pledged under the Indenture, (ii) in any way contesting or affecting any authority for the issuance of the Bonds, the validity of the Bonds, the Indenture, the Second Supplement, the Escrow Agreement or this Bond Purchase Agreement or the exemption from federal income taxation of interest on the 2015 Bonds or (iii) in any way contesting the powers or operations of the District; (C) there has been no change or threatened change in the governmental status of the District; (D) at the time of Closing, no default or event of default has occurred and is continuing, and no event has occurred and is continuing which with the lapse of time or the giving of notice, or both, would constitute a default or an event of default under the Indenture, this Bond Purchase Agreement, the Escrow Agreement, or any other material agreement or material instrument to which the District is a party or by which it is or may be bound or to which any of the District's property or other assets is or may be subject; (E) the resolution of the Board of Directors of the District authorizing and approving the execution and delivery of the Indenture, the Second Supplement, this Bond Purchase Agreement and the Escrow Agreement and the form of the Bonds have been duly adopted by such Board of Directors and have not been modified, amended or repealed; and (F) the representations of the District herein and in the Indenture are true and correct in all material respects as of the date of Closing.

(ii) A certificate, satisfactory in form and substance to the Purchaser, of one or more duly authorized officers of the Trustee, dated the Closing Date, as to the due acceptance, execution and delivery of the Indenture by the Trustee and the due authentication and delivery of the Bonds by the Trustee thereunder.

(iii) The approving opinion, dated the Closing Date, of Bond Counsel, together with a reliance letter addressed to the Purchaser.

(iv) An opinion, dated the Closing Date, addressed to the District and the Purchaser, of Porter Simon, counsel to the District, in substantially the form attached hereto as Exhibit A.

(v) A supplemental opinion of Bond Counsel, dated the Closing Date, addressed to the District and the Purchaser to the effect that: (A) this Bond Purchase Agreement has been duly authorized, executed and delivered by the District and, assuming due authorization, execution and delivery by and validity against the Purchaser, is a valid and binding agreement of the District, subject to bankruptcy, insolvency, reorganization, arrangement, moratorium, fraudulent conveyance and other laws relating to or affecting creditors' rights, to the application of equitable principles and to the exercise of judicial discretion in appropriate cases in the State of California; and (B) the Bonds are not subject to the registration requirements of the Securities Act and the Indenture is exempt from qualification under the Trust Indenture Act.

(vi) A certificate of the Trustee dated the Closing Date, signed by a duly authorized officer of the Trustee, and in form and substance satisfactory to the Purchaser, to the effect that:

(A) the Trustee is a national banking association duly organized and existing under and by virtue of the laws of the United States of America authorized to carry out corporate trust powers and has all necessary power and authority to enter into and perform its duties under the Indenture and to authenticate the Certificates;

(B) the representations of the Trustee in the Indenture are true and correct in all material respects as of the Closing Date;

(C) to the best of its knowledge, no litigation is pending or threatened (either in state or federal courts) (1) to restrain or enjoin the authentication or delivery of any of the Certificates or the collection of revenues pledged under the Indenture, or (2) in any way contesting or affecting any authority for the authentication or delivery of the Certificates or the validity or enforceability of the Indenture;

(D) the Trustee is duly authorized to authentication and deliver the Certificates to the Purchaser upon instruction by the District pursuant to the terms of the Indenture, and the Indenture constitutes the legal, valid and binding obligations of the Trustee enforceable in accordance with its terms;

(E) to the best of its knowledge, the execution and delivery of the Indenture and compliance with the provisions thereof, will not conflict with, or constitute a breach of or default, of the Trustee's duties under said documents or any law, administrative regulation, court decree, resolution, charter, bylaws or other agreement to which the Trustee is subject or by which it is bound; and

(F) the Certificates have been validly authenticated and delivered by the Trustee;

(vii) The opinion of counsel to the Trustee, addressed to the Purchaser and the District, dated the Closing Date, to the effect that:

(A) the Trustee has been duly organized and is validly existing in good standing as a national banking association under the laws of the United States of

America, with full corporate power to enter into the Indenture and to accept the trust as provided therein, and to perform its obligations under the Indenture;

(B) the Trustee has duly authorized, executed and delivered the Indenture and by all proper corporate action has authorized the acceptance of the trust of the Indenture;

(C) assuming the due authorization, execution and delivery by the other parties to the Indenture, the Indenture constitutes the legally valid and binding agreement of the Trustee, enforceable against the Trustee in accordance with their respective terms, except as enforcement may be limited by bankruptcy, insolvency, moratorium or other similar laws or equitable principles relating to or limiting creditors' rights generally;

(D) the Certificates have been validly authenticated by the Trustee; and

(E) to the best of such counsel's knowledge, no authorization, approval, consent or order of any governmental agency or any other person or corporation is required for the valid authorization, execution and delivery of the Indenture by the Trustee or the authentication by the Trustee of the Certificates;

(viii) A certificate of the Escrow Bank dated the Closing Date, signed by a duly authorized officer of the Escrow Bank, and in form and substance satisfactory to the Purchaser, to the effect that:

(A) the Escrow Bank is a national banking association duly organized and existing under and by virtue of the laws of the United States of America authorized to carry out corporate trust powers and has all necessary power and authority to enter into and perform its duties under the Escrow Agreement;

(B) the representations of the Escrow Bank in the Escrow Agreement are true and correct in all material respects as of the Closing Date;

(C) to the best of its knowledge, no litigation is pending or threatened (either in state or federal courts) (1) to restrain or enjoin the collection of revenues pledged under the Indenture, or (2) in any way contesting or affecting the validity or enforceability of the Escrow Agreement;

(D) the Escrow Agreement constitutes the legal, valid and binding obligations of the Escrow Bank enforceable in accordance with its terms; and

(E) to the best of its knowledge, the execution and delivery of the Escrow Agreement and compliance with the provisions thereof, will not conflict with, or constitute a breach of or default, of the Escrow Bank's duties under said documents or any law, administrative regulation, court decree, resolution, charter, bylaws or other agreement to which the Escrow Bank is subject or by which it is bound;

(ix) The opinion of counsel to the Escrow Bank, addressed to the Purchaser and the District, dated the Closing Date, to the effect that:

(A) the Escrow Bank has been duly organized and is validly existing in good standing as a national banking association under the laws of the United States of America, with full corporate power to enter into the Escrow Agreement

and to accept the trust as provided therein, and to perform its obligations under the Escrow Agreement;

(B) the Escrow Bank has duly authorized, executed and delivered the Escrow Agreement and by all proper corporate action has authorized the acceptance of the trust of the Escrow Agreement;

(C) assuming the due authorization, execution and delivery by the other parties to the Escrow Agreement, the Escrow Agreement constitutes the legally valid and binding agreement of the Escrow Bank, enforceable against the Escrow Bank in accordance with their respective terms, except as enforcement may be limited by bankruptcy, insolvency, moratorium or other similar laws or equitable principles relating to or limiting creditors' rights generally; and

(D) to the best of such counsel's knowledge, no authorization, approval, consent or order of any governmental agency or any other person or corporation is required for the valid authorization, execution and delivery of the Escrow Agreement by the Escrow Bank or the authentication by the Escrow Bank of the Certificates;

(x) A copy of the general resolution of the Trustee authorizing the execution and delivery of the Indenture;

(xi) A tax certificate and agreement by the District in form and substance satisfactory to Bond Counsel;

(xii) A copy of the executed Information Returns for Tax-Exempt Governmental Bond Issues, Form 8038-G (current revision), and evidence of the filing thereof with the Internal Revenue Service regarding the Bonds;

(xiii) A certified copy of the resolution of the Board of Directors of the District approving and authorizing the execution and delivery of the Indenture, the Second Supplement, the Escrow Agreement and this Bond Purchase Agreement;

(xiv) The Certificate of the District required by Section 3.06(b) of the Indenture;

(xv) Original or certified copies of the documents required pursuant to Section 3.06(c) of the Indenture;

(xvi) The opinion of Bond Counsel required by Section 3.06(d) of the Indenture;

(xviii) The opinion of Bond Counsel as to the defeasance of the 2006 Bonds; and

(xviii) Such additional certificates, proceedings, opinions, instruments and other documents as the Purchaser may reasonably request in connection with the transactions contemplated by this Bond Purchase Agreement, including, but not limited to, such additional certificates, proceedings, instruments and opinions as the Purchaser may reasonably request to evidence the consummation of the transactions contemplated by this Bond Purchase Agreement and all matters relating to this Bond Purchase Agreement, the Bonds and the sale thereof, and the Indenture.

If the District shall be unable to satisfy the conditions to the obligation of the Purchaser contained in this Bond Purchase Agreement, or if the obligation of the Purchaser shall be terminated for any reason permitted by this Bond Purchase Agreement, this Bond Purchase

Agreement may be canceled by the Purchaser, and, upon such cancellation, neither the Purchaser nor the District shall be under any further obligation hereunder except as provided in Section 5 hereof.

Section 4. **Expenses**. All reasonable expenses and costs of the District incident to the performance of its obligations in connection with the authorization, issuance and sale of the Bonds to the Purchaser, including printing costs, fees and expenses of the Trustee, fees and expenses of consultants and reasonable fees and expenses of Bond Counsel and counsel to the District, shall be paid by the District. All fees and expenses to be paid by the District pursuant to this Bond Purchase Agreement may be paid from Bond proceeds to the extent permitted by the Indenture. All out-of-pocket expenses of the Purchaser, including travel and other expenses, CUSIP Service Bureau charges and California Debt Advisory Commission fees, shall be paid by the Purchaser.

Section 5. **Notices**. Any notice or other communication to be given to the District under this Bond Purchase Agreement may be given by delivering the same in writing at the District's address set forth above; any notice or other communication to be given to the Purchaser under this Bond Purchase Agreement may be given by delivering the same in writing to _____. The approval of the Purchaser when required hereunder or the determination of its satisfaction as to any document referred to herein shall be in writing signed by the Purchaser and delivered to the District.

Section 6. **Parties in Interest; Survival of Representations and Warranties**. This Bond Purchase Agreement is made solely for the benefit of the District and the Purchaser (including the successors or assigns of the Purchaser), and no other person shall acquire or have any right hereunder or by virtue hereof. All the representations, warranties and agreements made by the District in this Bond Purchase Agreement shall remain operative and in full force and effect, regardless of (i) any investigations made by or on behalf of the Purchaser, (ii) delivery of and payment for the Bonds hereunder and (iii) any termination of this Bond Purchase Agreement.

Section 7. **Governing Law**. This Bond Purchase Agreement shall be governed by the laws of the State of California.

Section 8. **Miscellaneous**. The headings of the sections of this Bond Purchase Agreement are inserted for convenience only and shall not be deemed to be part hereof.

Section 9. **Counterparts**. This Bond Purchase Agreement may be signed in two or more counterparts (including counterparts represented by facsimile copies and/or containing facsimile signatures); all of such counterparts, when signed by the parties, shall constitute but one single agreement.

Very truly yours,

_____, as Purchaser

By _____
By _____
By _____

The foregoing is hereby accepted as of the date first written above.

TAHOE HOSPITAL DISTRICT

By _____
Crystal Betts
Chief Financial Officer

SCHEDULE A

REDEMPTION PROVISIONS

Optional Redemption. The 2015 Bonds are subject to redemption prior to their maturity date, at the option of the District, in whole or in part on any date, on or after July 1, ____, at a redemption price equal to the principal amount of 2015 Bonds called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium.

(c) *Mandatory Sinking Fund Redemption*. The 2015 Bonds are subject to mandatory redemption on July 1 in each year on and after July 1, 2015, to and including July 1, 2034, from mandatory sinking fund installments to be paid by the District with respect to each such redemption date, at a redemption price equal to the principal amount thereof to be redeemed, together with accrued interest thereon to the date fixed for redemption, without premium, as follows:

Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed	Mandatory Redemption Date (July 1)	Principal Amount to be Redeemed
2015		2025	
2016		2026	
2017		2027	
2018		2028	
2019		2029	
2020		2030	
2021		2031	
2022		2032	
2023		2033	
2024		2034†	

†Maturity

EXHIBIT A

OPINION OF DISTRICT COUNSEL

[Closing Date]

[PURCHASER]

Re: $_____ Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015

Ladies and Gentlemen:

We have served as special District Counsel for Tahoe Forest Hospital District (the "District") in connection with the issuance by the District of its Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015, in the aggregate principal amount of $_____ (the "2015 Bonds").

The Bonds are issued pursuant to the provisions of section 53570 *et seq.* of the California Government Code and are issued under and secured by an Indenture of Trust, dated as of July 1, 1999, by and between the District and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Trustee"), as amended and supplemented by that certain First Supplemental Indenture, dated as of October 1, 2002, by and between the District and the Trustee, as further amended and supplemented by that certain Second Supplemental Indenture, dated as of February 1, 2006, by and between the District and the Trustee, as further amended and supplemented by that certain Third Supplemental Indenture, dated as of May 1, 2006, by and between the District and the Trustee, and as further amended and supplemented by that certain Fourth Supplemental Indenture, dated as of April 1, 2015, by and between the District and U.S. Bank National Association, as successor trustee (collectively, the "Indenture"). The Bonds are being sold pursuant to a Bond Purchase Agreement, dated April 9, 2015 (the "Bond Purchase Agreement"), by and between the District and _____. Capitalized terms used herein, unless otherwise defined, shall have the meanings set forth in the Bond Purchase Agreement.

In connection with this opinion, we have assumed the authenticity of all records, documents, and instruments submitted to us as originals, the genuineness of all signatures, the legal capacity of natural persons and the conformity to the originals of all records, documents, and instruments submitted to us as copies. We also have assumed that there are no facts or circumstances relating to you that might prevent you from enforcing any of the rights to which our opinion relates. We have based our opinion upon our review of the following records, documents and instruments:

(a) A copy of the Indenture.

(b) A copy of the Bond Purchase Agreement.

(c) A copy of the Escrow Agreement (hereinafter defined).

(d) Resolution No. _____ (the "Resolution"), adopted by the District authorizing the execution and delivery of the Bonds and the Transaction Documents (hereinafter defined).

The documents and instruments listed in items (a) through (d) above are collectively referred to herein as the "Transaction Documents."

Where our opinion relates to our "knowledge", such knowledge is based upon our examination of the records, documents, instruments, and certificates enumerated or described above and the actual knowledge of attorneys in this firm who are currently involved in substantive legal representation of the District. With your consent, we have not examined any records of any court, administrative tribunal or other similar entity in connection with our opinion. Except as described herein, we have undertaken no investigation or verification of such matters.

Based upon the foregoing and our examination of such questions of law as we have deemed necessary or appropriate for the purpose of this opinion, and subject to the limitations and qualifications expressed below, it is our opinion that:

(1) The District is a local health care district duly existing under the laws of the State of California, has full legal right, power and authority to enter into the Indenture, the Bond Purchase Agreement and Escrow Agreement, dated April 28, 2015 (the "Escrow Agreement"), by and between the District and The Bank of New York Mellon Trust Company, N.A., as escrow bank (collectively, the "Transaction Documents"), and to carry out and consummate all transactions contemplated by the Indenture, the Bond Purchase Agreement and the Escrow Agreement.

(2) The Resolution was duly adopted at a meeting of the governing body of the District which was called and held pursuant to law and with all public notice required by law and at which a quorum was present and voted.

(3) To our knowledge, there is no action, suit, proceeding or investigation at law or in equity before or by any court, public board or body pending or threatened against the District to restrain or enjoin the issuance or delivery of the Bonds or the collection of revenues pledged under the Indenture, contesting any authority for the issuance of the Bonds or the validity of the Bonds, the Indenture, the Escrow Agreement or the Bond Purchase Agreement, contesting the existence or powers of the District with respect to the issuance of the Bonds or the security therefor wherein an unfavorable decision, ruling or finding would adversely affect the transactions contemplated by the Indenture, the Escrow Agreement or the Bond Purchase Agreement or the validity of the Bonds.

(4) The Bonds, the Indenture, the Escrow Agreement and the Bond Purchase Agreement have been duly authorized, executed and delivered by the District and, assuming due authorization, execution and delivery by the other parties thereto where applicable, are valid and binding limited obligations of the District enforceable in accordance with their terms.

This opinion is limited to the federal laws of the United States of America and the laws of the State of California. We disclaim any opinion as to the laws of any other jurisdiction and we further disclaim any opinion as to any statute, rule, regulation, ordinance, order or other promulgation of any regional or local governmental body. This opinion is based upon the law in effect on the date hereof, and we assume no obligations to revise or supplement this opinion should such law be changed by legislative action, judicial decision, or otherwise. In connection with this opinion letter, we also have assumed the following: (a) consideration has been duly given under the Transaction Documents; (b) the District is the legal, beneficial and record owner of the collateral described in any Transaction Documents and the descriptions of collateral in the Transaction Documents sufficiently describe the collateral intended to be covered by such documents; (c) any lien documents are in suitable form, notarized if required, and duly filed or

recorded with the appropriate government offices; (d) the Transaction Documents accurately describe the mutual understanding of the parties thereto, and that there are no oral or written statements that modify, amend, or vary, or purport to modify, amend, or vary, any of the terms of the Transaction Documents; (e) the information, factual matters, representations and warranties contained in the Transaction Documents, records, certificates and other documents we have reviewed are true, correct and complete; and (f) the other parties to Transaction Documents have the proper authority to engage in the transactions contemplated thereunder and at all times have complied and will comply with the Transaction Documents and related documents and with all applicable requirements governing their actions and will act in a commercially reasonable manner.

In connection with this opinion, we advise you that:

A. Enforceability is subject (i) to bankruptcy, insolvency, reorganization, arrangement, moratorium, and other laws of general applicability relating to or affecting creditors' rights, (ii) to general principles of equity, whether such enforcement is considered in a proceeding in equity or at law, (iii) to limitations imposed by applicable law or public policy on the enforceability of the indemnification provisions, and (iv) to the qualification that certain waivers, procedures, remedies, and other provisions of the Transaction Documents may be unenforceable under or limited by applicable law.

B. The enforceability of the Transaction Documents is further subject to the effect of general principles of equity. These principles include, without limitation, concepts of commercial reasonableness, materiality and good faith and fair dealing. These principles require the parties to act reasonably, in good faith and in a manner that is not arbitrary or capricious in the administration and enforcement of the Transaction Documents and will preclude them from invoking penalties for defaults that bear no reasonable relation to the damage suffered or that would otherwise work a forfeiture.

C. The effectiveness of indemnities, rights of contribution, exculpatory provisions and waivers of the benefits of statutory provisions may be limited on public policy grounds.

D. Section 1717 of the California Civil Code provides that, in any action on a contract where the contract specifically provides that attorneys' fees and costs incurred to enforce that contract shall be awarded either to one of the parties or to the prevailing party, then the party who is determined to be the party prevailing in the action, whether that party is the party specified in the contract or not, shall be entitled to reasonable attorneys' fees in addition to other costs.

E. Any provisions of the Transaction Documents requiring that waivers must be in writing may not be binding or enforceable if a non-executory oral agreement has been created modifying any such provision or an implied agreement by trade practice or course of conduct has given rise to a waiver.

F. Section 9109(d)17 of the California Uniform Commercial Code (the "Code") provides that the secured transactions provisions of the Code do not apply to transfers by a government or governmental unit, and, therefore, the rights and remedies of the Trustee under the Transaction Documents which purport to incorporate rights and remedies under the Code may not be enforceable and as such, we express no opinion on such matters.

G. Any provisions of the Transaction Documents regarding another party's right to apply proceeds of fire or other casualty insurance policies or awards of damages in condemnation proceedings against the District's secured obligations will not be enforceable

unless application of such proceeds or damages is reasonably necessary to protect such security interests.

H. We assume that in the enforcement of any lien documents, all parties will act in accordance with applicable statutory and other legal requirements, including applicable case law and that enforcement of rights or remedies thereunder may be limited when imposing fees and charges in the event of default, upon acceleration of the District's obligations for transfers of interests, leases, or grants of junior encumbrances, attempting to secure a deficiency claim before exhausting the secured property or other remedies, among other things.

I. We have further relied on certain representations, warranties and covenants of the District in the Transaction Documents. Any variations may affect the opinions we are giving.

J. In connection with our opinion, we have not reviewed and express no opinion on (i) financial statements or covenants, financial or audit reports or the consents related thereto or similar provisions requiring financial calculations or determinations, (ii) provisions relating to the occurrence of a "material adverse effect" or similar words, or (iii) parol evidence bearing on interpretation or construction.

We express no opinion as to: (a) the priority of any lien or security interest created, or purported to be created, by any of the Transaction Documents or the enforceability of any lien in the real property of the District; (b) any securities, tax, anti-trust, land use, export, safety, environmental, hazardous materials, choice of law, insurance company or banking laws, rules or regulations; (c) applicable interest rate limitations of California law for loans or forbearances; or (d) the effect on the District's obligations, and any other party's rights, under the Transaction Documents of laws relating to fraudulent transfers and fraudulent obligations set forth in Sections 544 and 548 of the federal Bankruptcy Code and Sections 3439 et seq. of the California Civil Code.

In rendering our opinion, we are expressing no opinion on the validity of the Bonds.

We furnish this opinion as special counsel to the District and only the addressee and Quint & Thimmig LLP may rely upon it. This letter shall not be used, quoted, distributed, circulated or relied upon by any other person or entity for any purpose, without our prior written consent.

Respectfully submitted,

PRELIMINARY OFFICIAL STATEMENT DATED APRIL __, 2015

NEW ISSUE - BOOK ENTRY ONLY **RATING: ___**
(See "RATING" herein)

In the opinion of Quint & Thimmig LLP, Larkspur, California, Bond Counsel, subject to compliance by the District with certain covenants, interest on the 2015 Bonds is excludable from gross income of the owners thereof for federal income tax purposes and is not included as an item of tax preference in computing the federal alternative minimum tax for individuals and corporations, but such interest is taken into account in computing an adjustment used in determining the federal alternative minimum tax for certain corporations. In addition, in the opinion of Bond Counsel, interest on the 2015 Bonds is exempt from personal income taxation imposed by the State of California. See "TAX MATTERS" herein

**$_____*
TAHOE FOREST HOSPITAL DISTRICT
(PLACER AND NEVADA COUNTIES, CALIFORNIA)
HOSPITAL REFUNDING REVENUE BONDS, SERIES 2015**

Dated: Date of delivery Due: July 1, as shown below

The Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Refunding Revenue Bonds, Series 2015, described herein (the "2015 Bonds"), will be issued in the form of fully registered bonds, without coupons, in the name of Cede & Co., as nominee of The Depository Trust Company ("DTC"), New York, New York. DTC will act as securities depository for the 2015 Bonds. Purchases will be made in book-entry form through DTC participants only in the principal amount of $5,000 or any integral multiple thereof. Except as described herein, purchasers will not receive physical certificates representing the 2015 Bonds purchased but will receive a credit balance on the books of the nominees of such beneficial owners. As long as DTC or its nominee is the registered owner of the 2015 Bonds, payment of principal of, premium (if any) and interest on the 2015 Bonds will be made directly by U.S. Bank National Association, San Francisco, California, as successor trustee (the "Trustee"), to DTC or its nominee. Disbursement of such payments to DTC participants is the responsibility of DTC, and disbursement of such payments to beneficial owners is the responsibility of the DTC participants. See "THE BONDS - Book-Entry System" herein. Interest on the 2015 Bonds is payable on each January 1 and July 1, commencing July 1, 2015.

The 2015 Bonds will be subject to redemption as described under "THE 2015 BONDS - Redemption" herein.

The 2015 Bonds will constitute limited obligations of Tahoe Forest Hospital District (the "District"), will be secured under the provisions of the Indenture, dated as of July 1, 1999, as supplemented by the First Supplemental Indenture, dated as of October 1, 2002, by the Second Supplemental Indenture, dated as of February 1, 2006, and by the Third Supplemental Indenture, dated as of May 1, 2006, and by the Fourth Supplemental Indenture, dated as of April 1, 2015, between the District and the Trustee (collectively, the "Indenture"), and will be equally and ratably payable from Revenues (as that term is defined in the Indenture) and certain funds held under the Indenture. The 2015 Bonds will be on a parity as to payment and security with $12,000,000 Tahoe Forest Hospital District (Placer and Nevada Counties, California) Variable Rate Demand Revenue Bonds, Series 2002 (the "2002 Bonds"), currently outstanding in the principal amount of $9,555,000, issued under the Indenture and on a parity as to security with any other District Parity Debt (as defined herein) issued in the future.

The 2015 Bonds are being issued by the District to refund all outstanding Tahoe Forest Hospital District (Placer and Nevada Counties, California) Hospital Revenue Bonds, Series 2006 (the "2006 Bonds") issued in the original principal amount of $27,385,000 and currently outstanding in the amount of $23,240,000. See "PLAN OF REFINANCING" herein.

* Preliminary, subject to change.

THE 2015 BONDS ARE THE LIMITED OBLIGATIONS OF THE DISTRICT PAYABLE SOLELY FROM REVENUES IN ACCORDANCE WITH THE INDENTURE. THE TAX REVENUES OF THE DISTRICT ARE NOT PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE 2015 BONDS. THE 2015 BONDS ARE NOT A DEBT OF THE STATE OF CALIFORNIA, AND SAID STATE IS NOT LIABLE FOR THE PAYMENT THEREOF.

The purchase of the 2015 Bonds involves various investment risks described throughout this Official Statement, including those described under "BONDHOLDERS' RISKS" herein.

The following firm served as financial advisor to the District on this financing:

G.L. Hicks Financial, LLC

**MATURITY SCHEDULE*
$_____ Serial Bonds**

Maturity (July 1)	Principal Amount	Interest Rate	Price or Yield	Maturity (July 1)	Principal Amount	Interest Rate	Price or Yield
2016				2024			
2017				2025			
2018				2026			
2019				2027			
2020				2028			
2021				2029			
2022				2030			
2023				2031			

$_____ ___% Term Bonds due July 1, 20__, Price ___%
$_____ ___% Term Bonds due July 1, 20__, Price ___%

The 2015 Bonds are offered when, as and if issued by the District and received by the Underwriters, subject to prior sale and to the approval of validity by Quint & Thimmig LLP, Larkspur, California, Bond Counsel, and the approval of certain matters for the District by its counsel, Porter Simon, Truckee, California, and by Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, as Disclosure Counsel to the District, and for the Underwriters by their counsel Fulbright & Jaworski LLP, Los Angeles, California, a member of Norton Rose Fulbright. It is expected that the 2015 Bonds in definitive form will be available for delivery through the facilities of DTC on or about April 28, 2015.

This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information essential to the making of an informed investment decision.

SOUTHWEST SECURITIES PIPER JAFFRAY RAYMOND JAMES

The date of this Official Statement is April ___ 2015, and information contained herein speaks only as of that date.

* Preliminary, subject to change.

GENERAL INFORMATION ABOUT THIS OFFICIAL STATEMENT

Use of Official Statement. This Official Statement is submitted in connection with the offering and sale of the 2015 Bonds referred to herein and may not be reproduced or used, in whole or in part, for any other purpose. This Official Statement is not to be construed as a contract with the purchasers of the 2015 Bonds.

The Preliminary Official Statement has been "deemed final" as of its date by the District pursuant to Rule 15c2-12 of the Securities Exchange Commission. The District has undertaken to provide continuing disclosure on certain matters, including annual financial information and specific enumerated events, as more fully described hereunder under "CONTINUING DISCLOSURE."

Estimates and Forecasts. When used in this Official Statement and in any continuing disclosure by the District, in any press release and in any oral statement made with the approval of an authorized officer of the District, the words or phrases "will likely result," "are expected to", "will continue", "is anticipated", "estimate", "project," "forecast", "expect", "intend" and similar expressions identify "forward looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Such statements are subject to risks and uncertainties that could cause actual results to differ materially from those contemplated in such forward-looking statements. Any forecast is subject to such uncertainties. Inevitably, some assumptions used to develop the forecasts will not be realized and unanticipated events and circumstances may occur. Therefore, there are likely to be differences between forecasts and actual results, and those differences may be material. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, give rise to any implication that there has been no change in the affairs of the District since the date hereof.

Limit of Offering. No dealer, broker, salesperson or other person has been authorized by the District to give any information or to make any representations in connection with the offering or sale of the 2015 Bonds other than those contained herein and if given or made, such other information or representation must not be relied upon as having been authorized by the District or the Underwriters. This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy nor shall there be any sale of the 2015 Bonds by a person in any jurisdiction in which it is unlawful for such person to make such an offer, solicitation or sale.

Involvement of Underwriters; Summary Information. The Underwriters have reviewed the information in this Official Statement in accordance with, and as a part of, their responsibilities to investors under federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriters do not guarantee the accuracy or completeness of such information. All summaries of the documents referred to in this Official Statement, are made subject to the provisions of such documents, respectively, and do not purport to be complete statements of any such document.

Offer and Sale of 2015 Bonds. The Underwriters may offer and sell the 2015 Bonds to certain dealers and others at prices lower than the public offering prices set forth on the cover page hereof and said public offering prices may be changed from time to time by the Underwriters.

Website. The District maintains a website. However, the information presented on the website is not a part of this Official Statement and should not be relied upon in making an investment decision with respect to the 2015 Bonds. None of the information on the District's website is incorporated in this Official Statement by reference or otherwise.

THE 2015 BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, IN RELIANCE UPON AN EXCEPTION FROM THE REGISTRATION REQUIREMENTS CONTAINED IN SUCH ACT. THE 2015 BONDS HAVE NOT BEEN REGISTERED OR QUALIFIED UNDER THE SECURITIES LAWS OF ANY STATE. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY A FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS DOCUMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

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Appendix A - Information Concerning Tahoe Forest Hospital District
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Appendix C - Summary of the Indenture
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OFFICIAL STATEMENT

**$_____*
TAHOE FOREST HOSPITAL DISTRICT
(PLACER AND NEVADA COUNTIES, CALIFORNIA)
HOSPITAL REFUNDING REVENUE BONDS, SERIES 2015**

INTRODUCTORY STATEMENT

This Official Statement is furnished in connection with the offering of $_____* aggregate principal amount of Hospital Refunding Revenue Bonds, Series 2015 (the "2015 Bonds") of Tahoe Forest Hospital District (the "District"). All capitalized terms used in this Official Statement and not otherwise defined herein have the same meanings as in that certain Indenture, dated as of July 1, 1999, as supplemented by the First Supplemental Indenture, dated as of October 1, 2002, by the Second Supplemental Indenture, dated as of February 1, 2006, by the Third Supplemental Indenture, dated as of May 1, 2006, and by the Fourth Supplemental Indenture, dated as of April 1, 2015 (the "Fourth Supplemental Indenture" and collectively with the Indenture as previously supplemented, the "Indenture"), by and between the District and U.S. Bank National Association, as successor trustee (the "Trustee"). The Fourth Supplemental Indenture will expressly provide for the issuance and the terms of the 2015 Bonds as well as amend certain provisions in the existing Indenture, including provisions related to any Bond Reserve Account securing a series of Bonds pursuant to the Indenture. See Appendix C - "Summary of the Indenture – Original Indenture - Definitions of Certain Terms" and Appendix C – "Summary of Indenture - "Fourth Supplemental Indenture."

The 2015 Bonds; Security for the 2015 Bonds. The 2015 Bonds will be issued pursuant to and secured by the Indenture. The principal of the 2015 Bonds, the interest and premium, if any, thereon will be payable solely from and secured by a pledge of Revenues of the District and by amounts held in the funds and accounts established pursuant to the Indenture. Under the Indenture, the District is required to deposit all of the Revenues into the District Gross Revenue Fund established under the Indenture as soon as practicable upon receipt; and transfer to the Trustee monthly an amount sufficient to pay the principal of, and interest and premium (if any) on, the 2015 Bonds when due (which includes the 2015 Bonds, the 2002 Bonds and any Additional Bonds hereafter issued pursuant to the Indenture as described herein) as the same become due and payable.

The 2015 Bonds will be on a parity with the 2002 Bonds and District Parity Debt with respect to the District's pledge of Revenues. However, the Bond Reserve Account established to secure the 2015 Bonds will not secure the 2002 Bonds or any Additional Bonds or other District Parity Debt hereafter issued. See "SECURITY FOR THE 2015 BONDS - Pledge Under the Indenture; Revenues of the District; Gross Revenue Fund," and "Additional Bonds; District Parity Debt, Senior Security Interest."

The District covenants and agrees in the Indenture to fix, charge and collect, or cause to be fixed, charged and collected, such rates, fees and charges for the use of and for the services furnished or to be furnished by the District which, together with all other receipts and revenues of the District and any other funds available therefor, are reasonably projected in each Fiscal Year to produce a Long-Term Debt Service Coverage Ratio at the end of each such Fiscal Year of not less than 1.75:1.00. The District also covenants to maintain an actual Long-Term Debt Service Coverage Ratio of not less than 1.25 to 1.0 (1.10:1.0 as long as the District has 75 or more Days Cash on Hand) for each Fiscal Year. For a discussion of action, if any, required of the District should the actual Long-Term Debt Service Coverage Ratio fall below the required level, see "SECURITY FOR THE 2015 BONDS –Debt Service Coverage" and Appendix C - "Summary of the Indenture – Original Indenture – Rates and Charges; Debt Coverage."

THE 2015 BONDS ARE LIMITED OBLIGATIONS OF THE DISTRICT AND ARE NOT A LIEN OR CHARGE UPON THE FUNDS OR PROPERTY OF THE DISTRICT, EXCEPT TO THE EXTENT OF THE PLEDGE AND ASSIGNMENT OF THE REVENUES AND OF AMOUNTS HELD IN THE FUNDS AND ACCOUNTS ESTABLISHED PURSUANT TO THE INDENTURE. THE TAX REVENUES OF THE DISTRICT ARE NOT PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF OR INTEREST ON THE

* Preliminary, subject to change.

2015 BONDS. THE 2015 BONDS ARE NOT A DEBT OF THE STATE OF CALIFORNIA OR ANY COUNTY OR ANY OTHER POLITICAL SUBDIVISION THEREOF, AND NEITHER THE STATE OF CALIFORNIA NOR ANY POLITICAL SUBDIVISION THEREOF (OTHER THAN THE DISTRICT TO THE EXTENT PROVIDED IN THE INDENTURE) IS LIABLE FOR THE PAYMENT THEREOF.

Use of 2015 Bond Proceeds. Proceeds from the sale of the 2015 Bonds will be used by the District to refund the 2006 Bonds (described below), to fund the Bond Reserve Account securing only the 2015 Bonds and to pay certain costs of issuance related to the 2015 Bonds. See –PLAN OF REFINANCING" and –ESTIMATED SOURCES AND USES OF FUNDS" herein.

Additional Indebtedness; Senior Security Interest. The 2015 Bonds will be issued in compliance with the limitation on Indebtedness provisions contained in the Indenture requiring that Maximum Annual Debt Service on the 2015 Bonds not exceed by more than 10% the Maximum Annual Debt Service on the 2006 Bonds. The District may also incur Indebtedness other than the 2015 Bonds and the 2002 Bonds that may be secured on a parity with the District's obligations under the Indenture, including Additional Bonds issued under the Indenture, as long as such other Indebtedness is incurred for the purposes authorized by and subject to the conditions provided in the Indenture including limitations on Indebtedness therein. The parity obligations the District has incurred and that it may hereafter incur are herein referred to as –District Parity Debt." The 2015 Bonds, the 2002 Bonds and any Additional Bonds hereafter issued pursuant to the Indenture are herein referred to collectively as the –Bonds." Subject to certain limitations, the District is permitted to incur Short-Term Indebtedness secured by the District's accounts receivable. Such a security interest would have priority as to that collateral over the District's pledge of Revenues to secure payment of the Bonds and other District Parity Debt. See –SECURITY FOR THE SERIES 2015 BONDS—Additional Bonds; District Parity Debt; Senior Security Interest" and Appendix C – –Summary of Indenture – Original Indenture - Limitation on Indebtedness" herein.

Bondholders' Risks. There are risks associated with the purchase of the 2015 Bonds discussed throughout this Official Statement, including the discussion in –BONDHOLDERS' RISKS" herein.

Professionals Involved in the Offering. Quint & Thimmig LLP, Larkspur, California, serves as Bond Counsel to the District. G.L. Hicks Financial, LLC, Provo, Utah, has advised the District on financial matters in connection with the 2015 Bonds. Porter Simon, Truckee, California, has acted as legal counsel to the District in connection with the 2015 Bonds. Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, has acted as Disclosure Counsel for the District. Fulbright & Jaworski LLP, Los Angeles, California, a member of Norton Rose Fulbright, has acted as counsel for the Underwrwiters. v Both Quint & Thimmig LLP and Jennings, Strouss & Salmon, PLC have acted as counsel to one or more of the Underwriters in the past and may do so in the future.

Continuing Disclosure. The District will undertake, pursuant to the Indenture and a Continuing Disclosure Certificate, to provide certain annual and quarterly financial information and notices of the occurrence of certain events. See —CONTINUING DISCLOSURE" herein.

General. The descriptions and summaries of various documents herein set forth do not purport to be comprehensive or definitive, and reference is made to each document for the complete details of its terms and conditions. All statements herein are qualified in their entirety by reference to such documents. See –Summary of the Indenture — Original Indenture - Definitions" in Appendix C hereto for definitions of certain words and terms used but not otherwise defined herein

THE 2015 BONDS

General

The 2015 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York (–DTC"). DTC will act as securities depository of the 2015 Bonds, and all payments due with respect to the 2015 Bonds will be made to DTC or its nominee. Individual purchases will be made only in book-entry form. See –THE 2015 BONDS –Book-Entry System," herein. The 2015 Bonds will be dated the date that they are delivered and bear interest (computed on the basis of a 360-day year of twelve 30-day months) from that date, payable on January l and July 1 of each year, commencing July 1, 2015 (each an –Interest Payment Date"). The 2015 Bonds will mature, subject to the redemption provisions described herein, in

the amounts and on the dates and will bear interest at the rates per annum set forth on the cover page of this Official Statement. The 2015 Bonds will be issued only as fully registered bonds without coupons, initially in book-entry form, and ownership interests in the 2015 Bonds will be in denominations of $5,000 or any integral multiple thereof.

The principal or redemption price of the 2015 Bonds is payable upon presentation and surrender thereof at the principal corporate trust office of the Trustee in San Francisco, California. Interest on the 2015 Bonds is payable by check or draft mailed on each Interest Payment Date to the person whose name appears in the registration books maintained by the Trustee as the registered holder thereof at the close of business on the fifteenth day of the month next preceding each Interest Payment Date (the "Record Date"), except as provided in the Indenture with respect to defaulted interest. Interest on the 2015 Bonds will be paid by wire transfer of immediately available funds to any registered holder of at least $1,000,000 in aggregate principal amount of 2015 Bonds, at its option, according to a request received by the Trustee for such purpose on or before the close of business on the respective Record Date.

Redemption

Optional Redemption. The 2015 Bonds maturing on or after July 1, 20__, are subject to redemption prior to their respective stated maturities, at the option of the District, in whole or in part on any date by such maturities as are selected by the District (or if the District fails to designate such maturities, in inverse order of maturity) and by lot within a maturity, on or after July 1, 20__ at the following redemption prices (expressed as a percentage of the principal amount of 2015 Bonds called for redemption), together with interest accrued thereon to the date fixed for redemption (all in the manner provided in the Indenture):

Redemption Period (Both Dates Inclusive)	Redemption Price (%)
July 1, 20__ through June 30, 20__	
July 1, 20__ and thereafter	

Mandatory Sinking Account Redemption. The 2015 Bonds maturing on July 1, 20__ and July 1, 20__ (the "Term Bonds") are subject to mandatory redemption by operation of Mandatory Sinking Account Payments prior to their stated maturities in part by lot on July 1 as shown in the table under "ANNUAL DEBT SERVICE REQUIREMENTS" herein. Each such redemption of the Term Bonds will be made at a Redemption Price equal to 100% of the principal amount thereof together with interest accrued thereon to the date fixed for redemption, without premium. The Indenture requires funds to be provided sufficient to redeem (after credit as provided in the Indenture for Term Bonds previously purchased or redeemed and not credited to the Mandatory Sinking Account Payments) and pay the amounts of Term Bonds as indicated under the "Principal Maturities" column under the caption "ANNUAL DEBT SERVICE REQUIREMENTS" herein.

Extraordinary Redemption. The 2015 Bonds are subject to redemption prior to their respective stated maturities at the option of the District as a whole on any date or in part by such maturities as are selected by the District (or if the District fails to designate such maturities, in inverse order of maturity) and by lot within a maturity on any Interest Payment Date, from hazard insurance or condemnation proceeds received with respect to the District's facilities, in each case under the circumstances described and as provided in the Indenture, at a Redemption Price equal to 100% of the principal amount thereof together with interest accrued thereon to the date fixed for redemption, without premium.

Selection of 2015 Bonds for Redemption. If less than all the 2015 Bonds shall be redeemed, the particular 2015 Bonds to be redeemed shall be selected from all 2015 Bonds subject to redemption or such given part thereof not previously called for redemption in any manner which the Trustee in its sole discretion deems appropriate; provided, however, that in such instances as provided in the Indenture where the District is to specify the amount or maturities of 2015 Bonds to be redeemed, the Trustee shall redeem 2015 Bonds in accordance with any such specification. The portion of any 2015 Bond to be redeemed and the portion of any 2015 Bond not to be redeemed shall be in authorized denominations. A new 2015 Bond representing the unredeemed balance of the principal amount of such 2015 Bond shall be issued to the registered Holder thereof without charge therefor.

Notice of Redemption; Effect of Redemption. Prior to the discontinuance of the book-entry system, notice of any redemption shall be given by the Trustee to DTC for the benefit of the Beneficial Owners (as described in

APPENDIX F -"Book-Entry System" herein). After the discontinuance of the book-entry system, the Trustee is required to mail notice of redemption, not less than 30 days nor more than 60 days prior to the redemption date, to the respective registered Holders of 2015 Bonds designated for redemption at their addresses shown on the date of such mailing on the registration books maintained by the Trustee; provided that failure to receive such notice will not affect the sufficiency of the proceedings for the redemption of any of the 2015 Bonds. As provided in the Indenture, the Trustee is required to give further notice of redemption to certain registered national securities depositories and national information services, provided, however, that no defect in such further notice or failure to give all or any portion of such further notice shall in any manner affect the sufficiency of the proceedings for redemption.

Interest on all 2015 Bonds for which notice of redemption has been given pursuant to the Indenture and for which moneys for the payment of the redemption price of such 2015 Bonds are held by the Trustee shall cease to accrue on the date fixed for redemption, such 2015 Bonds (or portions thereof) shall cease to be entitled to any benefit or security under the Indenture and the registered Holders of such 2015 Bonds shall have no rights in respect thereof except to receive payment of such redemption price plus accrued interest to the date fixed for redemption.

Registration, Transfer and Exchange

The Trustee will keep or cause to be kept sufficient books for the registration and transfer of the 2015 Bonds, which will at all times be open to inspection by the District. In the event that the book-entry system is discontinued, any 2015 Bond may, in accordance with its terms, be transferred upon the registration books by the person in whose name it is registered, in person or by such person's duly authorized attorney, upon surrender of such Bond for cancellation, accompanied by delivery of a written instrument of transfer, duly executed in a form approved by the Trustee. Whenever any 2015 Bonds are surrendered for transfer, the District is required to execute and the Trustee to authenticate and deliver new 2015 Bonds of the same maturity and interest rate for a like aggregate principal amount. In the event that the book-entry system is discontinued, 2015 Bonds may be exchanged at the principal corporate trust office of the Trustee in San Francisco, California, for a like aggregate principal amount of 2015 Bonds of other authorized denominations of the same maturity and interest rate. The Trustee will require the Bondholder requesting such transfer or exchange to pay any tax or other governmental charge required to be paid with respect to such transfer or exchange.

No transfer or exchange of 2015 Bonds will be required to be made (a) after such Bonds have been selected for redemption as provided in the Indenture and (b) between any Record Date and the next succeeding Interest Payment Date.

Book-Entry System

The Depository Trust Company ("DTC"), New York, NY, will act as securities depository for the 2015 Bonds. The 2015 Bonds will be issued as fully-registered 2015 Bonds registered in the names of Cede & Co. (DTC's nominee, or such other name as may be requested by an authorized representative of DTC. The ownership of one fully-registered 2015 Bond for each maturity, each in the aggregate principal amount of such maturity, will be registered in the name of Cede & Co. See Appendix F – "Book-Entry System."

ANNUAL DEBT SERVICE REQUIREMENTS

The following table sets forth for the 2015 Bonds the amounts required to be set aside each year ended July 1 for the payment of principal due on the 2015 Bonds, for the payment of interest on the 2015 Bonds (interest payable semi-annually on January 1 and July 1 of each year commencing July 1, 2015 and for total debt service on the 2015 Bonds. The table also shows the annual debt service on all other Outstanding Long-Term Indebtedness of the District (exclusive of general obligation bonds) and the total of all such Long-Term Indebtedness (exclusive of general obligation bonds), plus the 2015 Bonds.

Year Ending July 1,	2015 Bonds Principal Maturities	Interest	Total Debt Service	Debt Service on All Other Long-Term Indebtedness[1]	Aggregate Debt Service on the 2015 Bonds and All Other Long-Term Indebtedness[1]
2016	$	$	$	$1,904,246.10	
2017				1,908,228.70	
2018				1,911,678.20	
2019				1,919,594.60	
2020				$683,156.20	
2021				$689,651.00	
2022				$700,435.00	
2023				$705,330.50	
2024				$714,515.20	
2025				$727,811.40	
2026				$735,041.40	
2027				$746,382.90	
2028				$756,658.20	
2029				$765,867.30	
2030				$779,010.20	
2031				$105,909.20	
2032				$790,909.20	
2033				$806,564.30	
2034				$820,797.80	
2035				$833,609.70	
2036				1,904,246.10	

[*] Mandatory Sinking Account Payments on the Term Bonds.

[1] Assumes a rate of 3.544% for the District's variable rate 2002 Bonds which have been swapped to a fixed rate. Includes a municipal lease obligation at an interest rate of 1.42% maturing July 1, 2017. Excludes the general obligation bonds repaid from special *ad valorem* taxes.

ESTIMATED SOURCES AND USES OF FUNDS

Proceeds to be received from the sale of the 2015 Bonds will be applied as estimated in the following table:

Sources of Funds:	
Par Amount of 2015 Bonds	$_____
Net Original Issue Premium	
Transfer from 2006 Bonds[1]	_____
Total Sources	$_____
Uses of Funds:	
Refunding of 2006 Bonds[2]	
Deposit to 2015 Bond Reserve Account	
Costs of Issuance[3]	_____
Total Uses	$_____

[1] This amount consists of certain funds held under the Indenture relating to the 2006 Bonds.

[2] See "PLAN OF REFINANCING" herein.

[3] Includes Underwriters' discount and legal, financial advisory, printing, rating agency, Trustee and other miscellaneous fees and costs associated with issuance of the 2015 Bonds.

PLAN OF REFINANCING

A portion of the 2015 Bonds will be used to refund all outstanding 2006 Bonds on July 1, 2015. Accordingly, the District will enter into an Escrow Agreement, dated as of the date of delivery of the 2015 Bonds, with Bank of New York Mellon, as Escrow Bank. On the date of delivery of the 2015 Bonds there will be deposited with the Escrow Bank (i) a portion of the proceeds of the 2015 Bonds and (ii) certain moneys released from the Indenture securing the 2006 Bonds, which will be used on such date to purchase open market United States Treasury Securities ("Federal Securities") with the balance to be held by the Escrow Bank in cash. The uninvested moneys deposited with the Escrow Bank and the principal amount of Federal Securities, together with investment income to be earned thereon, will be sufficient to pay the principal and interest on the 2006 Bonds to their redemption date on July 1, 2015, and to pay a redemption premium equal to 1% of the principal amount of 2006 Bonds redeemed.

Sufficiency of the maturing principal of the Federal Securities, the investment earnings on such Federal Securities and the uninvested cash will be verified by Grant Thornton LLP (the "Verification Agent"). See "VERIFICATION OF MATHEMATICAL ACCURACY." Assuming the accuracy of the Verification Agent's computations, the District's obligations with respect to the 2006 Bonds will be discharged.

The moneys and Federal Securities held and invested by the Escrow Bank in the escrow fund are pledged solely to the payment of amounts due and payable with respect to the 2006 Bonds. The funds deposited in the escrow fund will not be available for the payment of debt service on the 2015 Bonds.

Other Uses

Proceeds of the 2015 Bonds will also be used to fund the Bond Reserve Account for the 2015 Bonds and to pay certain costs incidental to issuance of the 2015 Bonds.

SECURITY FOR THE 2015 BONDS

General

The 2015 Bonds will be special limited obligations of the District, issued pursuant to the Indenture, and, as described below, will be payable solely from the funds held under the Indenture, until expended in accordance with the Indenture, and from payments made by the District pursuant to the Indenture. The obligation of the District to pay debt service on the 2015 Bonds will be secured by a security interest in the Revenues of the District subject to its right to grant superior, parity or subordinate security interests and other Permitted Encumbrances. See "Pledge Under the Indenture; Revenues; Gross Revenue Fund" below. In particular, the District may grant a prior security interest in its accounts receivable to provide short-term borrowing.

Pledge Under the Indenture; Revenues; Gross Revenue Fund

Subject to and for the purposes and on the terms and conditions set forth in the Indenture, there are pledged to secure the payment of the principal of, and interest on, the 2015 Bonds, all of the Revenues and any other amounts (including proceeds of the sale of the Bonds other than proceeds placed in escrow to refund the 2006 Bonds) held in any fund or account established pursuant to the Indenture (except the Rebate Fund). Subject to the terms of the Indenture, the Revenues of the District are pledged to the payment of the principal of, and interest on the 2015 Bonds and other District Parity Debt. "Revenues" means, in general, all revenues, income, receipts and money received in any period by or on behalf of the District related to its properties and operations (other than donor-restricted gifts, grants, bequests, donations and contributions). *Ad valorem* taxes collected by Placer County and Nevada County in California to pay the District's general obligation bonds are not considered "Revenues" or deposited in the District Gross Revenue Fund. However, pursuant to Section 32127 of the California Health and Safety Code, the District is required to use moneys in its maintenance and operation fund whenever *ad valorem* taxes are insufficient to pay principal of and interest on its general obligations bonds. While theoretically this obligation may create competition for the Revenues, the District has never experienced such an insufficiency in any manner materially affecting its operations.

The District agrees that, so long as any 2015 Bonds remain outstanding under the Indenture, all of the Revenues shall be deposited as soon as practicable upon receipt in a fund designated as the "District Gross Revenue Fund" which the District shall establish and maintain at such banking or financial institution or institutions as the District shall designate for such purpose (the "Depository Bank(s)"). Currently, the District Gross Revenue Fund is held by U.S. Bank National Association. Subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth therein, the District pledges and, to the extent permitted by law, grants a security interest to the Trustee in the District Gross Revenue Fund to secure the payment of the principal of and interest on the 2015 Bonds and other District Parity Debt.

See "BONDHOLDERS' RISKS – General Risks – Security Interest Limitations" for a discussion of certain limitations that any pledge or security interest in the Revenues might incur in collateralizing repayment of the 2015 Bonds.

Debt Service Coverage

The District covenants and agrees in the Indenture to fix, charge and collect, or cause to be fixed, charged and collected, such rates, fees and charges for the use of and for the services furnished or to be furnished by the District which, together with all other receipts and revenues of the District and any other funds available therefor, are reasonably projected in each Fiscal Year to produce a Long-Term Debt Service Coverage Ratio at the end of each such Fiscal Year of not less than 1.75 to 1.00. The District also covenants to maintain an actual Long-Term Debt Service Coverage Ratio of not less than 1.25 to 1.00 (1.10 to 1.00 as long as the District has 75 or more Days Cash on Hand) for each Fiscal Year. Should the Long-Term Debt Service Coverage Ratio fall below the required level for any Fiscal Year, the District must employ an Independent Consultant to make recommendations to change District operations to produce the required ratio in the current Fiscal Year. If the District complies in all material respects with such recommendations (other than those recommendations determined in good faith by the District's Board of Directors not to be in the best interests of the District), the District shall be deemed to have complied with the Long-Term Debt Service Coverage Ratio for each Fiscal Year it maintains at least a 1.00 to 1.00 ratio.

In particular, see the following definitions in Appendix C – "Summary of Indenture – Original Indenture": "Long-Term Debt Service Coverage Ratio," "Long-Term Indebtedness, "Indebtedness," "Net Income Available for Debt Service" and "Maximum Annual Debt Service." See also Appendix C – Summary of Indenture – Original Indenture – Rates and Charges; Debt Coverage."

Bond Reserve Account

A Bond Reserve Account has been established pursuant to the Fourth Supplemental Indenture to secure the 2015 Bonds. The amount to be maintained in the Bond Reserve Account is the Bond Reserve Account Requirement, initially $_____. This amount may reduce over time as long as the amount in the Bond Reserve Account equals the least of (a) Maximum Annual Debt Service on the 2015 Bonds, (b) 10% of the then outstanding principal amount of the 2015 Bonds, (c) 125% of average annual debt service on the 2015 Bonds and $_____.

All amounts in the Bond Reserve Account are required to be used and withdrawn by the Trustee solely for the purpose of making up any deficiency in the Interest Account or Principal Account or (together with any other moneys available therefor) for the payment or redemption of the 2015 Bonds. Any amount in the Bond Reserve Account in excess of the Bond Reserve Account Requirement is required to be transferred to the Interest Account or Principal Account for payment of the 2015 Bonds. Investments held in the Bond Reserve Account are to be valued by the Trustee at least annually on the basis of their fair market value as provided in the Indenture. To the extent that amounts in the Bond Reserve Account are less than the Bond Reserve Account Requirement (a) as a result of the reduction in fair market value of the investments in the Bond Reserve Account valued annually as described above to a value that is less than 90% of the Bond Reserve Account Requirement, the District is required to replenish the Bond Reserve Account within 120 days of such valuation to an amount equal to the Bond Reserve Account Requirement or (b) as a result of a withdrawal from the Bond Reserve Account for the purpose of making up a deficiency in the Interest Account or Principal Account for the 2015 Bonds, the District is required to restore the Bond Reserve Account to the Bond Reserve Account Requirement in equal monthly installments within one year after such withdrawal. The Bond Reserve Account for the 2015 Bonds does not secure the payment of any other Bonds or District Parity Debt.

Days Cash on Hand

The District covenants to maintain at least 60 days' Cash on Hand measured at the six-month and year-end dates in each Fiscal Year of the District. The District's obligation to maintain 60 Days Cash on Hand went into effect in 1999 with the District's execution of the original Indenture. The District has never failed to comply with this requirement.

Limited Obligations

THE 2015 BONDS ARE LIMITED OBLIGATIONS OF THE DISTRICT AND ARE NOT A LIEN OR CHARGE UPON THE FUNDS OR PROPERTY OF THE DISTRICT, EXCEPT TO THE EXTENT OF THE PLEDGE AND ASSIGNMENT OF THE REVENUES AND OF AMOUNTS HELD IN THE FUNDS

AND ACCOUNTS ESTABLISHED PURSUANT TO THE INDENTURE. THE TAX REVENUES OF THE DISTRICT ARE NOT PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF OR INTEREST ON THE 2015 BONDS. THE 2015 BONDS ARE NOT A DEBT OF THE STATE OF CALIFORNIA OR ANY OTHER POLITICAL SUBDIVISION THEREOF, AND NEITHER THE STATE OF CALIFORNIA NOR ANY POLITICAL SUBDIVISION THEREOF (OTHER THAN THE DISTRICT TO THE EXTENT PROVIDED IN THE INDENTURE) IS LIABLE FOR THE PAYMENT THEREOF.

Additional Bonds; District Parity Debt; Senior Security Interest

The District may authorize the issuance of one or more additional series of Bonds upon the terms and conditions provided in the Indenture (—Additional Bonds"). The District may also incur other District Parity Debt, subject to the provisions of the Indenture, which will be secured on a parity with the 2002 Bonds and the 2015 Bonds by the Revenues of the District. The District is also permitted, subject to certain restrictions, to incur other forms of Indebtedness. See Appendix C - —Summary of the Indenture – Original Indenture – Limitation on Indebtedness."

Under certain limitations set out in the Indenture, the District may incur Short-Term Indebtedness up to 20% of the value of the District's accounts receivable and secured by those accounts receivable. Such a security interest would have priority as to that collateral over the pledge of Revenues which secures District Parity Debt. See Appendix C – —Summary of the Indenture – Original Indenture – Limitation on Indebtedness" and the definition of —Permitted Encumbrances" in Appendix C.

No Real Property Security

The District's Health Facilities are not made subject to any lien, mortgage or deed of trust interest to secure repayment of the 2015 Bonds or any other Parity Debt now outstanding.

Amendment of Indenture Without Bondholder Consent; Deletion of Financial Covenants

The Indenture provides that the Indenture and the rights and obligations of the District and the Holders of the Bonds may be amended or modified by one or more supplemental indentures, for the purpose of deleting the District's financial covenants, including the rate covenant and limitation on indebtedness covenant, without obtaining the consent of Holders of the Bonds. Before the District is permitted to enter into such a supplemental indenture, the following must be received by the Trustee:

(1) a written request of the District requesting such amendment and stating that the District has become a member of an obligated group under a master indenture (the —Master Indenture") and that an obligation is being issued to the Trustee under the Master Indenture;

(2) a properly executed obligation (the —Obligation") issued under the Master Indenture and registered in the name of the Trustee, duly authenticated by the master trustee under the Master Indenture;

(3) an Opinion of Counsel to the effect that the Obligation has been validly issued under the Master Indenture and constitutes a valid and binding obligation of each member of the obligated group under the Master Indenture;

(4) a copy of the Master Indenture, certified as a true and accurate copy of the master trustee under the Master Indenture; and

(5) written evidence that the Bonds will be rated at least —A" by Moody's or —A by S & P following amendment of the Indenture upon delivery of the Obligation.

The District has no present intention to enter into any such master indenture arrangement. However, the District has preserved the ability to do so as described above, subject to compliance with the requirements and limitations of the Indenture, to position itself to respond to the future marketplace for health care providers such as the District.

THE DISTRICT

The District is a political subdivision of the State of California that is organized and operates under the provisions of the Law. The District was organized in 1949 by a vote of the residents of the District. See Appendix A hereto for additional general information about the District.

THE HEALTH FACILITIES

The Health Facilities are owned and operated by the District and located in the Town of Truckee, California, and Incline Village, Nevada. Appendix A hereto contains information regarding the history, operations and financial performance of the Health Facilities.

BONDHOLDERS' RISKS

The purchase of the 2015 Bonds involves certain investment risks that are discussed throughout this Official Statement. Accordingly, each prospective purchaser of the 2015 Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. Certain of these risks are described herein.

This discussion of risk factors below is not, and is not intended to be, exhaustive or an attempt to prioritize such risks.

General Risks

Introduction

As described under "SECURITY FOR THE 2015 BONDS—Pledge Under the Indenture; Revenues of the District," the principal of, and premium, if any, and interest on, the 2015 Bonds will be payable from amounts to be paid by the District pursuant to the Indenture. If the District fails to make its payments under the Indenture and other amounts are not then available under the Indenture, no assurance or any representation is given or can be made that, if the Trustee is required to pursue its remedies under the Indenture, revenues will be produced in amounts sufficient to pay principal of and interest on the 2015 Bonds when due. The ability of the District to produce revenues in amounts sufficient to pay principal of and interest on the 2015 Bonds when due is affected by and subject to conditions that may change in the future to an extent and with effects that cannot be determined at this time. The risk factors discussed herein should be considered in evaluating the District's ability to make payments under the Indenture, in amounts sufficient to provide for payment of the principal of, and premium, if any, and interest on, the 2015 Bonds.

The District derives a significant portion of its revenues from Medicare, Medicaid (referred to as "Medi-Cal" in California) and other third party payor programs. See "Healthcare Operations Risks" below and Appendix A -- "Information Concerning Tahoe Forest Hospital District – Health Facilities – Third-Party Payments."

With respect to the financial condition of the District, see the audited financial statements of the District attached hereto as Appendix B and Appendix A – "Information Concerning Tahoe Forest Hospital District -- Financial Information."

Security Interest Limitations

The Revenues of the District have been pledged to repayment of the 2015 Bonds and other District Parity Debt, including the 2002 Bonds. California Government Code Sections 5450 and 5451 make any such pledge immediately effective and enforceable against the District and creditors of the District without physical delivery of the collateral by the District or filings or recordings.

While the foregoing is strong statutory protection, in general, pledges and security interests may, in certain instances, be subordinated to the interest and claims of others. Some examples are (i) statutory lien claims, (ii) rights arising in favor of the United States of America or any agency thereof, (iii) present or future prohibitions against assignment in any federal statutes or regulations, (iv) constructive trusts, equitable liens or other rights

impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction, (v) federal or State bankruptcy laws that may affect enforceability, (vi) rights of third parties in cash not in the possession of the Trustee or the Depository Bank(s), (vii) provisions prohibiting the direct payment of amounts due to healthcare providers from Medicare and Medi-Cal programs to persons other than such providers, (viii) certain judicial decisions that cast doubt upon the right of the Trustee, in the event of the bankruptcy, to collect and retain accounts receivable from Medicare and Medi-Cal and other governmental programs, (ix) commingling of proceeds of the Revenues of the District with other moneys of the District not subject to the security interest in the Revenues of the District, (x) claims that might arise if appropriate financing or continuation statements are not filed in accordance with the California Uniform Commercial Code, as from time to time in effect, and (xi) claims that might arise if a control agreement is not in effect as to the bank deposits holding Revenues of the District. In addition, it may not be possible to perfect a security interest in any manner whatsoever in certain types of Revenues of the District (e.g., gifts, donations, certain insurance proceeds, Medicare and Medi-Cal payments, tax revenues) prior to actual receipt by the District and deposit in the District Gross Revenue Fund. While healthcare providers are currently prohibited from assigning such receivables, it is not clear whether this prohibition will be interpreted so as to preclude the granting of security interests in such receivables. Further, because the District is a governmental entity, it is not certain how or if the California Uniform Commercial Code and its principles would be applied to the security interest granted by the District in the Revenues or to the conflicting claims of others.

There is no mortgage or deed of trust recorded against the District's Health Facilities to secure repayment of the 2015 Bonds. The pledge of Revenues is the only collateral for such repayment.

No Assurance of Secondary Market for the 2015 Bonds

It is the present practice of each Underwriter to make a secondary market in the bond issues that it underwrites. Occasionally, because of general market conditions or because of adverse history or economic prospects connected with a particular bond issue, secondary marketing practices in connection with a particular issue are suspended or terminated. Additionally, prices of issues for which a market is being made will depend upon their prevailing circumstances. Such prices could be substantially lower than the original purchase price. There can be no guarantee that there will be a secondary market for the 2015 Bonds or, if a secondary market exists, that the 2015 Bonds can be sold for any particular price. Accordingly, purchasers of the 2015 Bonds should be prepared to have their funds committed until the 2015 Bonds mature.

Tax Revenues

The District currently expects revenues derived from operation of the Health Facilities to be sufficient to fully pay the costs of operating and maintaining the Health Facilities and payment of debt service on the 2002 Bonds, and the 2015 Bonds and any other District Parity Debt; however, the District may use operating tax revenues assessed and collected by either Placer County or Nevada County and turned over to the District to partially pay such costs. See Appendix B – "Audited Financial Statements of the District for the years Ended June 30, 2014 and 2013 – Statements of Cash Flows."

The authority of the District to continue to receive such operating tax revenues may be limited or restricted by the adoption of voter initiatives or similar actions. While the District does not currently know of any such initiatives or actions, there can be no assurance that such initiatives or actions will not be adopted and that operating tax revenues currently available to the District will continue to be available, if needed, to maintain the Health Facilities and to pay debt service on the 2015 Bonds.

The District may use any legally available funds to pay debt service on the 2015 Bonds and other District Parity Debt. Operating tax revenues are not pledged under the Indenture to the payment of the 2015 Bonds, but upon deposit of such tax receipts into the District's general bank account, they become part of the pledge of the District Gross Revenue Fund to secure the 2015 Bonds.

Payment of the 2015 Bonds in no manner is secured by real property or *ad valorem* taxes collected by either Placer County or Nevada County. Such *ad valorem* taxes are applied solely to repayment of voter approved general obligation bonds of the District. *Ad valorem* tax revenues are distinct from operating tax revenues discussed above.

Tax Exempt Status of Interest on the 2015 Bonds

The Internal Revenue Code of 1986, as amended (the "Code") imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the 2015 Bonds, to be excludable from gross income for federal income tax purposes. These requirements include, among others, limitations on the use of bond proceeds, limitations on the investment earnings of bond proceeds prior to expenditure, a requirement that certain investment earnings on bond proceeds be paid periodically to the United States, and a requirement that the issuers file an information report with the Internal Revenue Service. The District has covenanted in certain of the documents referred to herein that it will comply with such requirements. Failure by the District to comply with the requirements stated in the Code and related regulations, rulings and policies may subject interest on the 2015 Bonds to federal income taxation, retroactive to the date of issuance.

Current and future legislative proposals, if enacted into law, clarification of the Code or court decisions may cause interest on the 2015 Bonds to be subject, directly or indirectly, to federal income taxation or to be subject to or exempted from State income taxation, or otherwise prevent beneficial owners from realizing the full current benefit of the tax status of such interest. As one example, the Obama Administration announced in 2012 a legislative proposal which, for tax years beginning on or after January 1, 2013, generally would limit the exclusion from gross income of interest on obligations like the 2015 Bonds to some extent for taxpayers who are individuals and whose income is subject to higher marginal income tax rates. While that proposal was not enacted, it or similar proposals may be discussed in connection with attempts by the Congress and the President to increase revenues for the federal government. Other proposals have been made that could significantly reduce the benefit of, or otherwise affect, the exclusion from gross income of interest on obligations like the 2015 Bonds. The introduction or enactment of any such legislative proposals, clarification of the Code or court decisions may also affect, perhaps significantly, the market price for, or marketability of the 2015 Bonds. Prospective purchasers of the 2015 Bonds should consult their own tax advisors regarding any pending or proposed federal or State tax legislation, regulations or litigation, and regarding the impact of future legislation, regulations or litigation, as to which Bond Counsel expresses no opinion.

Factors That Could Affect the Enforceability of the Indenture

The legal right and practical ability of the Trustee to enforce its rights and remedies against the District under the Indenture and related documents may be limited by laws relating to bankruptcy, insolvency, reorganization, fraudulent conveyance or moratorium and by other similar laws affecting creditors' rights. In addition, the Trustee's ability to enforce such terms will depend upon the exercise of various remedies specified by such documents which may in many instances require judicial actions that are often subject to discretion and delay or that otherwise may not be readily available or may be limited.

Bankruptcy. As discussed immediately below, the Trustee's enforcement of its rights, including security interests and other liens, in the Revenues could be delayed, altered, or otherwise modified during the pendency of a bankruptcy proceeding.

In the event that the District filed a bankruptcy petition under the United States Code (the "Bankruptcy Code"), the rights and remedies of the owners of the 2015 Bonds could be impacted by various provisions of the Bankruptcy Code. Given the legal characteristics of the District, such a petition would be eligible to be filed only under chapter 9 of the Bankruptcy Code (the chapter intended for use by governmental bodies defined in the Bankruptcy Code as "municipalities").

The filing of a chapter 9 petition by the District would automatically operate as an injunction against, among other things: (i) the commencement or continuation of any judicial or other proceedings against the District and its property, (ii) acts to recover on preexisting claims against the District, (iii) acts to enforce a lien or otherwise obtain possession of, or exercise control over, property of the District, or (iv) setoff of any obligations against preexisting claims held by the District.

In connection with a chapter 9 bankruptcy case, the District could propose and confirm a plan for the adjustment of debts and thereby modify or alter the rights of creditors generally, or of any class of creditors, secured or unsecured. To confirm a chapter 9 plan of reorganization of the District, the bankruptcy court must determine that the plan, among other requirements, has been accepted by all classes of creditors, or as to any non-accepting class is "fair and equitable," and (i) has received any necessary regulatory or electoral approvals and (ii) is feasible

for performance by the District. The bankruptcy court must also determine that the District is not prohibited by law from taking the steps called for by the plan for the adjustment of debts.

Judicial decisions under chapter 9 are limited, and the treatment of governmental bodies under chapter 9 is subject to broad judicial discretion. Accordingly, the effect of a chapter 9 filing on repayment of the 2015 Bonds cannot be determined in advance with any certainty.

Parity and Short-Term Debt

As described in "SECURITY FOR THE BONDS – Additional Bonds; Parity Debt; Senior Security Interest" above, the Indenture permits the District to issue or incur District Parity Debt which is secured on a parity with the 2015 Bonds and the 2002 Bonds by a security interest in or lien on the District's Revenues. Additionally, subject to certain limitations, including Indebtedness not exceeding 20% of the value of the District's accounts receivable, the District may incur Short-Term Indebtedness which may be secured by the District's accounts receivable on a senior basis. In the event of the District's inability to make debt payments on its obligations, the existence of Parity Debt and Short-Term Indebtedness secured by accounts receivable of the District would dilute the Bondholders' claim on the security for payment of the 2015 Bonds.

General Litigation and Insurance

Litigation. As with most hospitals, there are, at any point in time, a number of medical malpractice actions filed or pending. Generally, these will be paid or settled from insurance and/or self-insurance coverage, and some will not be pursued by plaintiffs. Litigation may also arise from the corporate and business activities of the District, from their status as major employers, and as a result of medical staff peer review or the denial of medical staff privileges. A U.S. Supreme Court decision now allows physicians who are subject to adverse peer review proceedings to file federal antitrust actions against hospitals and seek treble damages. As with medical malpractice, many of these risks are covered by insurance or self-insurance, but some are not. In the event that a substantial number of uncovered claims were to be determined adversely to the District as defendant in such claims, and substantial monetary damages were to be awarded in each, there could be a material negative effect on the District's financial condition. See "LITIGATION" herein.

Insurance. The District currently carries no earthquake insurance for the Health Facilities. See "Healthcare Operations Risks – Other Risks" in this BONDHOLDERS' RISKS section.

Healthcare Operations Risks

General

The District is subject to a wide variety of federal and state regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare, Medicaid and other payors and is subject to actions by, among others, the National Labor Relations Board, the Centers for Medicare and Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS"), State of California (the "State") Attorney General, and other federal, State and local government agencies. The future financial condition of the District could be adversely affected by, among other things, changes in the method, timing and amount of payments to the District by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other healthcare entities, the costs associated with responding to governmental audits, inquiries and investigations, demand for healthcare, other forms of care or treatment, changes in the methods by which employers purchase healthcare for employees, capability of management, changes in the structure of how healthcare is delivered and paid for (e.g., accountable care organizations and other health reform payment mechanisms), future changes in the economy, demographic changes, availability of physicians, nurses and other healthcare professionals, malpractice claims and other litigation. These factors and others may adversely affect the District's revenues.

In addition, future economic and other conditions, including inflation, demand for hospital services, the ability of the District to provide the services required or requested by patients, physicians' confidence in the Health Facilities and management, economic developments in the service area served by the Health Facilities, employee relations and unionization, competition, rates, increased costs, availability of professional liability insurance, hazard losses, third party reimbursement and changes in governmental regulations may adversely affect revenues. There

can be no assurance given that revenues realized by the District, or utilization of the Health Facilities will not decrease.

With respect to the financial condition of the District, see the audited financial statements of the District attached to the Official Statement as APPENDIX B.

Significant Risk Areas Summarized

Certain of the primary risks associated with the operations of the District as a hospital and healthcare provider are briefly summarized in general terms below, and are explained in greater detail in subsequent sections. The occurrence of one or more of these risks could have a material adverse effect on the financial condition and results of operations of the District.

Federal Healthcare Reform and Deficit Reduction. The federal healthcare reform legislation has changed and will change how healthcare services are covered, delivered and reimbursed. These changes will result in lower hospital reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for healthcare providers to assess, and potentially alter, their business strategy and practices, among other consequences. While most providers will receive reduced payments for care, millions of previously uninsured Americans will have coverage. Efforts to reduce the federal deficit and balance the State budget will likely curb Medicare and Medi-Cal spending further to the detriment of providers.

General Economic Conditions; Bad Debt, Indigent Care and Investment Performance. Healthcare providers are economically influenced by the environment in which they operate. To the extent that (1) unemployment rates are high, (2) employers reduce their budgets for employee healthcare coverage or (3) private and public insurers seek to reduce payments to healthcare providers or curb utilization of healthcare services, healthcare providers may experience decreases in insured patient volume and reductions in payments for services. In addition, to the extent that State, county or city governments are unable to provide a safety net of medical services, pressure is applied to local healthcare providers to increase free care. Furthermore, economic downturns and lower funding of federal Medicare and Medi-Cal programs may increase the number of patients who are unable to pay for their medical and healthcare services. These conditions may give rise to increases in healthcare providers' uncollectible accounts, or "bad debt," and, consequently, to reductions in operating income. Declines in investment portfolio values may reduce or eliminate non-operating revenues. Investment losses (even if unrealized) may trigger debt covenants to be violated and may jeopardize healthcare providers' economic security. Losses in pension and benefit funds may result in increased funding requirements. Potential failure of lenders, insurers or vendors may negatively impact the results of operations and the overall financial condition of healthcare providers. Philanthropic support may also decrease or be delayed.

Capital Needs vs. Capital Capacity. Hospital and other healthcare operations are capital intensive. Regulation, technology and physician/patient expectations require constant and often significant capital investment. In California, seismic requirements mandated by the State may require that many hospital facilities be substantially modified, replaced or closed. Estimated construction costs generally are substantial and actual costs of compliance may exceed estimates. Total capital needs may exceed capital capacity. Furthermore, capital capacity of hospitals and health systems may be reduced as a result of recent credit market dislocations, and it is uncertain how long those conditions may persist.

Technical and Clinical Developments. New clinical techniques and technology, as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in ways that are currently unanticipated, and that may dramatically change medical and hospital care. These could result in higher hospital costs, reductions in patient populations and/or new sources of competition for hospitals.

Proliferation of Competition and Increasing Consumer Choice. Hospitals increasingly face competition from specialty providers of care and ambulatory care facilities. This may cause hospitals to lose essential inpatient or outpatient market share. Competition may be focused on services or payor classifications for which hospitals realize their highest margins, thus negatively affecting programs that are economically important to hospitals.

Hospitals and other healthcare providers face increased pressure to operate transparently and make available information about cost and quality of services. Consumers and payors accessing cost and quality

information accumulated on various data-bases may shift business among providers or make different healthcare choices based on such information.

Rate Pressure from Insurers and Major Purchasers. Certain healthcare markets, including many communities in California, are strongly impacted by large health insurers and, in some cases, by major purchasers of health services. In those areas, health insurers may have significant influence over the rates, utilization and competition of hospitals and other healthcare providers. Rate pressure imposed by health insurers or other major purchasers, including managed care payors, may have a material adverse impact on hospitals and other healthcare providers, particularly if major purchasers put increasing pressure on payors to restrain rate increases. Business failures by health insurers also could have a material adverse impact on contracted hospitals and other healthcare providers in the form of payment shortfalls or delays, and/or continuing obligations to care for managed care patients without receiving payment. In addition, disputes with non-contracted payors may result in an inability to collect billed charges from these payors.

Reliance on Medicare. Inpatient hospitals rely to a high degree on payment from the federal Medicare program. Recent changes in the underlying laws and regulations, as well as in payment policy and timing, create uncertainty and could have a material adverse impact on hospitals' payment streams from Medicare. With healthcare and hospital spending reported to be increasing faster than the rate of general inflation, Congress and CMS are expected to take action in the future to decrease or restrain Medicare outlays for hospitals.

Costs and Restrictions from Governmental Regulation. Nearly every aspect of healthcare operations is regulated, in some cases by multiple agencies of government. The level and complexity of regulation and compliance audits appear to be increasing, imposing greater operational limitations, enforcement and liability risks, and significant and sometimes unanticipated costs.

Government "Fraud" Enforcement. "Fraud" in government funded healthcare programs is a significant concern of federal and state regulatory agencies overseeing healthcare programs, and is one of the federal government's prime law enforcement priorities. The federal government and, to a lesser degree, state governments impose a wide variety of extraordinarily complex and technical requirements intended to prevent over-utilization based on economic inducements, misallocation of expenses, overcharging and other forms of "fraud" in the Medicare and Medicaid programs, as well as other state and federally-funded healthcare programs. This body of regulation impacts a broad spectrum of hospital and other healthcare provider commercial activity, including billing, accounting, recordkeeping, medical staff oversight, physician contracting and recruiting, cost allocation, clinical trials, discounts and other functions and transactions.

Violations and alleged violations may be deliberate, but also frequently occur in circumstances where management is unaware of the conduct in question, as a result of mistake, or where the individual participants do not know that their conduct is in violation of law. Violations may occur and be prosecuted in circumstances that do not have the traditional elements of fraud, and enforcement actions may extend to conduct that occurred in the past. Violations carry significant sanctions. The government periodically conducts widespread investigations covering categories of services, or certain accounting or billing practices.

Violations and Sanctions. The government and/or private "whistleblowers" often pursue aggressive investigative and enforcement actions. The government has a wide array of civil, criminal, monetary and other penalties, including suspending essential hospital and other healthcare provider payments from the Medicare or Medicaid programs, or exclusion from those programs. Aggressive investigation tactics, negative publicity and threatened penalties can be, and often are, used to force healthcare providers to enter into monetary settlements in exchange for releases of liability for past conduct, as well as agreements imposing prospective restrictions and/or mandated compliance requirements on healthcare providers. Such negotiated settlement terms may have a materially adverse impact on hospital and other healthcare provider operations, financial condition, results of operations and reputation. Multi-million dollar fines and settlements for alleged intentional misconduct, fraud or false claims are not uncommon in the healthcare industry. These risks are generally uninsured. Government enforcement and private whistleblower suits may increase in the hospital and healthcare sector. Many hospital and other healthcare provider systems have been and are liable to be adversely impacted.

State Medicaid Programs. The California Medicaid program, known as Medi-Cal is an important payor source to many hospitals and may become a proportionately larger source of revenue as federal healthcare reform is

implemented, expanding Medicaid coverage to significant numbers of uninsured Americans. This program often pays hospitals and physicians at levels that may be below the actual cost of the care provided. As Medi-Cal is partially funded by the State, the financial condition of the State may result in lower funding levels and/or payment delays. These could have a material adverse impact on California hospitals.

Professional Staffing. From time to time, a shortage of certain physician specialties, nurses and medical technicians exists which may have an impact on hospitals. The shortages are particularly acute in the fields of primary care and certain medical and surgical specialties. Such shortages may adversely affect hospitals, which rely on skilled healthcare practitioners to deliver care. Hospital operations, patient and physician satisfaction, financial condition, results of operations and future growth could be negatively affected by these shortages, resulting in a material adverse impact to hospitals.

Labor Costs and Disruption. The delivery of healthcare services is labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant impact on hospital and healthcare provider operations and financial condition. Hospital and healthcare employees are increasingly organized in collective bargaining units, and may be involved in work actions of various kinds, including work stoppages and strikes. Overall costs of the hospital workforce are high, and turnover is high. Pressure to recruit, train and retain qualified employees is expected to accelerate. These factors may materially increase costs of operation. Workforce disruption may negatively impact revenues, expenses and employment recruitment efforts.

Pension and Benefit Funds. As large employers, hospitals may incur significant expenses to fund pension and benefit plans for employees and former employees, and to fund required workers' compensation benefits. Plans are often underfunded or may become underfunded and funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed for other purposes.

Medical Liability Litigation and Insurance. Medical liability litigation is subject to public policy determinations and legal and procedural rules that may be altered from time to time, with the result that the frequency and cost of such litigation, and resultant liabilities, may increase in the future. Healthcare providers may be affected by negative financial and liability impacts on physicians. Costs of insurance, including self-insurance, may increase dramatically.

Other Class Actions. Hospitals and health systems have long been subject to a wide variety of litigation risks, including liability for care outcomes, employer liability, property and premises liability, and peer review litigation with physicians, among others. In recent years, consumer class action litigation has emerged as a potentially significant source of litigation liability for hospitals and health systems. Many of these class action suits focused on hospital billing and collection practices, and they may be used for a variety of currently unanticipated causes of action. Since the subject matter of class action suits may involve uninsured risks, and since such actions often involve alleged large classes of plaintiffs, they may have material adverse consequences to hospitals and health systems in the future.

Facility Damage. Hospitals and healthcare providers are highly dependent on the condition and functionality of their physical facilities. Damage from earthquake, floods, fire, other natural causes, deliberate acts of destruction, or various facilities system failures may have a material adverse impact on operations, financial conditions and results of operations.

Federal Budget Cuts

On August 2, 2011, Congress enacted the Budget Control Act of 2011 (the "BCA"), which mandated significant reductions and spending caps on the federal budget for fiscal years 2012-2021. The BCA also created a Joint Select Committee on Deficit Reduction (the "Super Committee") to develop a plan to further reduce the federal deficit by $1.5 trillion on or before November 23, 2011. Because the Super Committee was unable to reach agreement on a plan, the BCA mandated that a 2% reduction in Medicare spending, among other reductions, was scheduled to take effect on January 2, 2013.

The American Taxpayer Relief Act of 2012 ("ATRA") postponed this scheduled reduction (commonly referred to as "sequestration") until March 1, 2013, when the automatic spending cuts were triggered. A wide range of spending is exempted from sequestration, including Social Security, Medicaid, Veteran's Benefits and pensions,

federal retirement funds, civil and military pay, child nutrition and other programs. However, Medicare is not exempted from sequestration. Medicare payments are reduced in part as a result of these across the board spending reductions, limited to 2% of total program costs. In December of 2013, Congress partially replaced the mandatory budget cuts for two years. While that legislation lifted certain sequestration cuts for defense and non-defense spending for fiscal years 2014 and 2015, it did not reduce the sequestration reductions impacting mandatory programs including Medicare.

Because Congress may make changes to the budget in the future, it is impossible to predict the impact any spending cuts that are approved may have upon the District. Similarly, it is impossible to predict whether any automatic reductions to Medicare may be triggered in lieu of other spending cuts that may be proposed by Congress. If Medicare spending continues to be reduced, it may have a material adverse effect upon the financial condition of the District.

Taxpayer Relief Act of 2012

The ATRA also extended the number of supplemental Medicare payments, including supplemental payments for some low-volume hospitals, ambulance charges and physical therapy costs. The $30 billion cost of these provisions is expected to be partially offset by a reduction in payments to hospitals over the 10-year period following the passage of ATRA, including an estimated $10.5 billion reduction in projected Medicare hospital payments for inpatient and overnight care and a reduction in the Medicare disproportionate share payments to hospitals by an additional $4.2 billion during that period. These cuts are in addition to those made to Medicare hospital payments as part of the Patient Protection and Affordable Care Act (the "ACA").

Job Creation Act

The Middle Class Tax Relief Act and Job Creation Act of 2012 (the "Job Creation Act"), as amended by the Taxpayer Relief Act, delayed through the end of 2013 the implementation of certain scheduled cuts to physicians payments mandated by the sustainable grown rate ("SGR") formula that ties physician reimbursement under Medicare to the gross domestic product. The Bipartisan Budget Act of 2013 extended the delay through March 31, 2014, and increased Medicare payments to physicians during the same period. The Job Creation Act provides that the cost of delaying scheduled cuts to physician payments be achieved by providing for cuts in other areas of health care, including reductions in Medicaid payments to hospitals with a disproportionate share of uninsured patients through 2023, as well as reductions in Medicare reimbursement to providers for beneficiaries' unpaid coinsurance and deductible amount after reasonable collection efforts. Prior to the enactment of the Job Creation Act, Medicare reimbursed hospital providers 70% of beneficiary bad debt; the Job Creation Act reduces that reimbursement to 65%. In March 2014 Congress acted to temporarily delay the cuts to physician reimbursement for another year. That delay expires April 1, 2015, unless Congress again extends the delay of the reduction. Some efforts are currently being made by Congressional leaders to extend the delay in such cuts or, possibly, to eliminate some or all of such cuts.

California State Budget

California has faced in the past severe financial challenges, including erosion of general fund tax revenues, falling real estate values, slow economic growth and high unemployment. Shortfalls between revenues and spending have in the past and may in the future result in cutbacks to State and local government healthcare programs. Failure by the California legislature to approve budgets prior to the start of a new fiscal year can also result in a temporary hold on or delay of Medi-Cal reimbursement. However, the addition of legislative incentives to pass the State budget on time makes this less likely than in the past.

The financial challenges which California and the Medi-Cal program have faced in the past have negatively affected healthcare organizations in a number of ways. Despite better current budget predictions, these past challenges still affect providers and may worsen in the future. California may enact legislation to reduce Medi-Cal payments, attempt to impose copayments on Medi-Cal recipients which could result in a reduction in provider reimbursement, or reduce covered benefits or restrict eligibility. The ACA allows for significant expansions to the Medicaid program and additional federal funding. Such funding is conditioned, however, on the State's maintaining specified beneficiary eligibility criteria, which may require additional State funding or prompt the State to reduce

provider reimbursement. The BCA may also shift further funding responsibility from the federal government to state governments, creating new financial challenges.

Local Ballot Measures

California local governments and districts face severe financial challenges that are expected to continue or worsen over the coming years. Shortfalls between revenues and spending have in the past and may in the future result in cutbacks in payments and reimbursements to local healthcare facilities. Healthcare districts are subject to ballot initiatives passed by voters living in the district. In response to perceived excesses in executive compensation, pension, and other benefits paid to district executives and service providers, taxpayers in certain healthcare districts in the State placed certain healthcare district initiatives on the ballot. These ballot measures, if passed, would severely restrict the amount of compensation payable to district executives and healthcare providers. It is impossible to predict what actions may be taken in future years by voters in the District to address budgetary shortfalls, increased tax burdens, and perceived compensation excesses. Any restriction on the District's ability to offer competitive compensation and other perquisites to attract and retain management and providers may have a material adverse impact on the operations and financial results of the District.

Healthcare Regulation and Reform Generally

The healthcare industry in general is subject to regulation by a number of governmental and private agencies, including those which administer the Medicare and Medicaid programs discussed under the headings "Patient Service Revenues—Medicare" and "—Medicaid" herein. The healthcare industry is also affected by federal, state and local policies developed to regulate the manner in which healthcare is provided, administered and paid for nationally and locally. As a result, the healthcare industry is sensitive to frequent and substantial legislative and regulatory changes. Congress and the states have consistently attempted to curb the growth of spending on healthcare programs. In addition, Congress and other governmental agencies have focused on the provision of care to indigent and uninsured patients, prevention of "dumping" such patients on public hospitals in order to avoid the provision of non-reimbursed care, the unlawful payment of remuneration in exchange for referral of patients, the unauthorized use or disclosure of patients' protected health information, billing for services not in accordance with governmental requirements and other issues. It is unlikely that the District could attract sufficient numbers of private pay patients to become self-sufficient without reimbursement from governmental programs. Cost shifting to private sources of payment is not an option to offset declining federal and State reimbursement because private insurance companies have adopted cost containment measures similar to those used by government agencies. These cost containment mechanisms include "managed care" and capitated payment.

Despite these efforts, due to, among other things, the growing percentage of older persons in the population, improved technology and administrative costs in a highly regulated industry, health care expenditures as a percentage of the gross national product continue to rise. Consequently, it can be expected that aggressive cost containment measures and anti-fraud and abuse investigation and enforcement could have a material adverse effect on the District. Continued efforts in the form of statutory and regulatory activity to reduce the rate of increase in reimbursement for health care costs, particularly costs paid under the Medicare and Medicaid programs, can be expected.

The Medicare and Medicaid programs have been and continue to be affected by numerous legislative initiatives. In general, the purpose of much of the statutory and regulatory activity has been to reduce the rate of increase in healthcare costs, particularly costs paid under the Medicare and Medicaid programs. Diverse and complex mechanisms to limit the amount of money paid to healthcare providers under both the Medicare and Medicaid programs have been enacted, and have caused reductions in reimbursement.

Numerous other proposals have been advanced by various parties to require or promote alternate methods of healthcare delivery, to establish healthcare cost containment measures, to provide alternatives for payment of healthcare costs under Medicare, Medicaid and private reimbursement programs, and to institute other changes in healthcare payment and reimbursement.

The District is subject to governmental regulation under the federal Medicare program and the joint federal and State Medi-Cal program. Healthcare providers, including the District, have been and will continue to be affected

by changes that have occurred during the last several years in the administration of the Medicare and Medi-Cal programs.

Federal Health Care Reform and Other Governmental Initiatives

In March, 2010, the Patient Protection and Affordable Care Act was enacted and approved by the President.

Some of the provisions of the ACA took effect immediately, while others will take effect or will be phased in over time, ranging from a few months following approval to ten years. Because of the complexity of the ACA generally, additional legislation is likely to be considered and enacted over time. The ACA also requires the promulgation of substantial regulations with significant effects on the healthcare industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to healthcare providers are expected to impose new and additional contractual terms and conditions. Thus, the healthcare industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions and, consequently to structural and operational changes and challenges, for a substantial period of time.

Management of the District are analyzing the ACA and will continue to do so in order to assess the effects of the legislation and evolving regulations on current and projected operations, financial performance and financial condition. However, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

A significant component of the ACA is reformation of the sources and methods by which consumers will pay for healthcare for themselves and their families and by which employers will procure health insurance for their employees and dependents and, as a consequence, expansion of the base of consumers of healthcare services. One of the primary purposes of the ACA is to provide or make available, or subsidize the premium costs of, healthcare insurance for some of the millions of uninsured (or underinsured) consumers who fall below certain income levels. The ACA proposes to accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase healthcare insurance for themselves and their families or their employees and dependents, (ii) providing subsidies for insurance premium costs to individuals and families based upon their income relative to federal poverty levels, (iii) mandating that individual consumers obtain and certain employers provide a minimum level of healthcare insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates, (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, and (v) expansion of existing public programs, including Medicaid, for individuals and families. The Congressional Budget Office ("CBO") estimated that in federal fiscal year 2015, 19 million consumers who have not been insured will become insured, followed by an additional 6 million consumers in federal fiscal year 2016. To the extent all or any of those provisions produce the expected result, an increase in utilization of healthcare services by those who are currently avoiding or rationing their healthcare can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues.

Some of the specific provisions of the ACA that may affect hospital operations, financial performance or financial conditions of the District, are described below. This listing is not, is not intended to be, nor should be considered by the reader as, exhaustive. The ACA is complex and comprehensive, and includes many new programs and initiatives and changes to existing programs, policies, practices and laws. At this time, management of the District cannot predict the aggregate effect of the ACA upon the District over time.

- Commencing upon enactment and through September 30, 2019, the annual Medicare market basket updates for hospitals will be reduced. Beginning October 1, 2011, the market basket updates became subject to productivity adjustments. The reductions in market based updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates have been effective prior to the periods during which insurance coverage and the insured consumer base will expand. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in Medicare payment per discharge on a year-to-year basis.

- Commencing October 1, 2010 and continuing through September 30, 2019, payments under the "Medicare Advantage" programs (Medicare managed care) will be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program, The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues.

- Commencing October 1, 2012, a value-based purchasing program was established under the Medicare program designed to provide incentive payments to hospitals based on performance on quality and efficiency measures. These incentive payments are funded through a pool of money collected and withheld from all hospital providers; funds are restored to hospitals according to how they performed on specified quality measures.

- Commencing October 1, 2013, Medicare disproportionate share hospital ("DSH") payments were reduced initially by 75%. DSH payments will be increased thereafter to account for the national rate of consumers who do not have healthcare insurance and are provided uncompensated care. Commencing October 1, 2013, a state's Medicaid DSH allotment from federal funds was reduced.

- Expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels. In 2010, CMS had estimated that 18 million consumers, who had been uninsured prior to the ACA, would become newly eligible for Medicaid through 2019 as a result of this expansion. However, the U.S. Supreme Court decision in 2011 resulted in many states choosing not to participate in the Medicaid expansion, which reduced the anticipated number of new enrollees. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. At the same time, the increase in utilization can also be expected to increase the costs of providing that care, which may or may not be balanced by increased revenues. California opted for Medicaid expansion.

- Commencing October 1, 2012, Medicare payments that would otherwise be made to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions have been reduced by specified percentages to account for those excess and "preventable" hospital readmissions.

- Commencing October 1, 2014, Medicare payments to certain hospitals for hospital-acquired conditions have been reduced by 1%. Effective July 1, 2011, federal payments to states for Medicaid services related to healthcare-acquired conditions are prohibited.

- Effective October 1, 2011, healthcare insurers are required to include quality improvement covenants in their contracts with hospital providers, and are required to report their progress on such actions to the Secretary of HHS.

- Commencing January 1, 2015, healthcare insurers participating in the health insurance exchanges have been allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

- With varying effective dates, the ACA enhances the ability to detect and reduce waste, fraud, and abuse in public programs through provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The ACA requires the development of a database to capture and share healthcare provider data across federal healthcare programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.

- Effective for tax years commencing immediately after enactment, additional requirements for tax-exemption have been imposed upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the lowest amount charged to

insured patients; and control the billing and collection processes. Additionally, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

- The ACA calls for an Independent Payment Advisory Board (the "Board") to be established to develop proposals to improve the quality of care and limitations on cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the prescribed target, the Board is required to develop proposals to reduce the growth rate and require HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The ACA included the Community Living Assistance Services and Supports (CLASS) Act to create a national, voluntary, long-term care insurance program to supplement Medicaid and private long-term care insurance; however, the CLASS Act was repealed in the January 2013 budget deal. In its place, Congress created a new national commission to develop a plan for better financing and delivery of long-term care services.

The ACA provisions relating to skilled nursing facilities (—SNFs) include requirements that facilities (i) make certain disclosures regarding ownership; (ii) implement compliance and ethics programs; and (iii) make certain disclosures regarding expenditures for wages and benefits for direct care staff.

The ACA creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce healthcare expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new healthcare delivery models, such as accountable care organizations or combinations of provider organizations, that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

The ACA establishes a Medicare Shared Savings Program that seeks to promote accountability and coordination of care through the creation of Accountable Care Organizations ("ACOs"). The program allows hospitals, physicians and others to form ACOs and work together to invest in infrastructure and redesign integrated delivery processes to achieve high quality and efficient delivery of services. ACOs that achieve quality performance standards will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. While a significant number of ACO's have been formed, it remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by shared savings achieved through efficiencies in care delivery. Nevertheless, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change. The potential impacts of these initiatives are unknown, but introduce greater risk and complexity to healthcare finance and operations.

The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

On June 28, 2012, the United States Supreme Court upheld the constitutionality of the ACA generally, but struck down certain provisions which would have permitted federal Medicaid funding to be entirely eliminated for states that do not comply with the expanded Medicaid coverage required under the ACA. Since the Supreme Court's decision was handed down, certain Congressional leaders have announced their intention to proceed with legislation to repeal or substantially amend provisions of the ACA. That position has been reinforced by Republicans who now control both houses of Congress. The President has vowed to veto any such legislation. In addition, the Supreme Court has heard, but not yet decided, a challenge to the subsidies provided under the ACA in states that do not run their own insurance exchanges. The ultimate outcomes of legislative attempts or judicial considerations to repeal or amend portions of the ACA are unknown at this time.

California Healthcare Reform.

The State has passed several laws to implement the ACA. The State has established a state health insurance exchange, initially called the "California Health Benefit Exchange" now named "Covered California," as required by the ACA. Enrollment under Covered California began October 1, 2013, with coverage effective January 1, 2014. Effective January 1, 2014, Medi-Cal coverage was expanded to include adults (under 65, who are not pregnant or otherwise eligible for Medi-Cal) with incomes up to 138% of the federal poverty level. In addition, the majority of California counties participated in the "Bridge to Reform" program, which implemented the ACA's Medicaid expansion ahead of schedule. Legislation also passed prohibiting insurers from denying health coverage to individuals of any age with pre-existing conditions.

Patient Service Revenues

A substantial portion of the net patient service revenues of the District is derived from third-party payors which pay for the services provided to patients covered by third parties for services. These third-party payors include the federal Medicare program, state Medicaid programs and private health plans and insurers, including health maintenance organizations and preferred provider organizations. Many of those programs make payments to the District in amounts that may not reflect the direct and indirect costs of the District providing services to patients.

The financial performance of the District has been and could be in the future adversely affected by the financial position or the insolvency or bankruptcy of or other delay in receipt of payments from third-party payors that provide coverage for services to District patients.

Healthcare providers have been and continue to be affected significantly by changes made in the last several years in federal and state health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of this statutory and regulatory activity has been to reduce the rate of increase in healthcare costs, particularly costs paid under the Medicare and Medicaid programs.

Medicare and Medicaid Programs

Approximately 37% and 18% of the net patient service revenue of the District for the its year ended June 30, 2014, were derived from the Medicare program and Medi-Cal program, respectively. Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program, and Medicaid, called Medi-Cal in California, is a combined federal and State program.

Medicare. Medicare is a federal governmental health insurance system pursuant to the Social Security Act under which physicians, hospitals and other healthcare providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons. Medicare provides certain healthcare benefits to beneficiaries who are 65 years of age or older, blind, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient hospital services, skilled nursing care and some home health care, and Medicare Part B covers physician services and some supplies. Medicare is administered by CMS. In order to achieve and maintain Medicare certification, a healthcare provider must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located and/or an acceptable accreditation organization.

The ACA has made several changes to the Medicare program, ranging from changes to amounts payable to providers through imposition, directly or indirectly, of quality assurance measures. Certain of those changes, such as market basket reductions, market productivity adjustments, hospital acquired conditions penalties, readmission rate penalties and reduced DSH payments, are summarized above under the caption "Federal Health Care Reform and Other Governmental Initiatives."

Because Tahoe Forest Hospital is designated as a "Critical Access Hospital," it receives more favorable reimbursement under Medicare than hospitals not so designated. Inpatient and outpatient services are reimbursed to the District pursuant to a cost reimbursement methodology.

The ACA amended certain provisions of the federal False Claims Act and added provisions respecting the timing of the obligation to reimburse overpayments. The effect of these changes on existing programs and systems of the District cannot be predicted.

Effective October 1, 2013, CMS adopted a policy known as the Inpatient Hospital Prepayment Review —Probe & Educate" review process or the –Two-Midnight" rule. The –Two-Midnight" policy specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be –reasonable and necessary" for purposes of inpatient reimbursement. CMS adopted the policy due to growing concern with the overuse of the –observation" status at hospitals. On March 31, 2014, Congress delayed the implementation of the Two-Midnight rule until March 31, 2015. There remains ambiguity about the implementation of the rule and the impact on the District is yet unknown, although Medicare auditors can be expected to select this concern for review and the District's finances could be adversely affected if claims are not reimbursed as a result.

The Medicare program provides coverage for skilled nursing care (1) up to 100 days per year, (2) immediately following at least three days of hospitalization and (3) for care related to the condition treated by the prior hospitalization. The Balanced Budget Act of 1997 implemented a Prospective Payment System ("PPS") for all skilled nursing facilities with annual cost reporting periods beginning on or after July 1, 1998. The PPS pays an all-inclusive per diem rate for routine, ancillary and capital costs, and is adjusted geographically for wages and case mix index to reflect a patient's resource requirements. Higher acuity patients receive more reimbursement under the payment formula. The per diem prospective payment amount covers all Medicare Part A skilled nursing services and any items in therapy services furnished during the patient's Medicare covered stay (with a few minor exceptions). "Ancillary" services furnished to skilled nursing residents are also covered under Medicare Part B and may be reimbursed after Medicare Part A coverage is exhausted. The Balanced Budget Act of 1997 also provided for the implementation of consolidated billing for skilled nursing facilities, whereby skilled nursing facilities are required to bill the Medicare program for virtually all Medicare services and supplies provided to Medicare residents.

In federal Fiscal Year 2014 skilled nursing facility prospective payment rates reflected a 2.3% increase based on market basket index, reduced by a 0.5% multi-factor productivity adjustment. As a result, skilled nursing facility prospective payment rates increased by 1.8% in federal Fiscal Year 2014.

For federal Fiscal Year 2015, CMS has increased rates by 2.0% attributable to a 2.5% market basket update less a 0.5% adjustment imposed by the ACA.

Medicaid. Medicaid is a health insurance program for certain low-income and needy individuals that is jointly funded by the federal government and the states. Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid. Medicaid is funded by federal and state appropriations and administered by the various states. Pursuant to broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the payment rates for services; and administers its own programs.

Under the Medicaid program, the federal government supplements funds provided by the various states for medical assistance to the medically indigent. Payment for medical and health services is made to providers in amounts determined in accordance with procedures and standards established by state law under federal guidelines. Fiscal considerations of both federal and state governments in establishing their budgets will directly affect the funds available to the providers for payment of services rendered to Medicaid beneficiaries.

Payment for Medicaid patients is subject to appropriation by the respective state legislatures of sufficient funds to pay the incurred patient obligations. Delays in appropriations and state budget deficits which may occur from time to time create a risk that payment for services to Medicaid patients will be withheld or delayed.

The federal and state governments of many states have considered, and are continuing to consider, changes to Medicaid funding, particularly in light of the budget crises facing many such states. The United States Congress approved an increase in Medicaid funding to states in 2009; however, the enhanced funding expired June 30, 2011. The federal government continues to explore options for a long-term solution to the funding difficulties with Medicaid and certain additional proposals being examined may ultimately result in reduced federal Medicaid funding to the states. This could adversely impact the amount of revenue received by the District.

Certain states have created programs that impose a fee or assessment on healthcare providers, the proceeds of which are intended to qualify for federal matching funds for such state's Medicaid program and are to be used to provide additional reimbursement from the federal government for Medicaid inpatient and outpatient services. California has enacted such a program.

The ACA makes changes to Medicaid funding and substantially increases the potential number of Medicaid beneficiaries, as well as federal financial support for that increased enrollment, and expanded the recovery audit contractor ("RAC') Medicare program to include Medicaid, using state-based RAC contracts.

California Medi-Cal. Medi-Cal is the Medicaid program in California. The State selectively contracts with general acute care hospitals to provide impatient services to Medi-Cal patients. The State is obligated to make contractual payments only to the extent the legislature appropriates adequate funding. Except in areas of the State that have been excluded from contracting, a general acute care hospital generally will not qualify for payment for non-emergency acute inpatient services rendered to a Medi-Cal beneficiary unless it is a contracting hospital. Typically, either party may terminate such contract on 120 days' notice and the State may terminate without notice under certain circumstances. The District currently participates in the Medi-Cal program. Inpatient services to Medi-Cal beneficiaries are reimbursed to the District under a cost reimbursement methodology. Outpatient services are paid at prospectively determined rates. No assurances can be made that the District's reimbursement under the Medi-Cal program for services will reimburse the District for the cost of delivering those services. In addition, as Medi-Cal is partially funded by the State, any deterioration in the financial condition of the State could result in lower funding levels and/or payment delays.

The District's skilled nursing facility is considered a "distinct part" skilled nursing facility and, consequently, is reimbursed more favorably than free-standing skilled nursing facilities. However, the District continues to face a claw back of 10% of its skilled nursing facility charges for the two-year period beginning in approximately June 2011 under an initiative instituted by the Medi-Cal program.

Many states, including California, have faced severe financial challenges, including erosion of general fund tax revenues, falling real estate values, slower economic growth and higher unemployment, which may continue or worsen over the coming years. Shortfalls between State revenues and spending demands, along with balanced budget requirements, have in the past and may in the future result in cutbacks to government healthcare programs. Failure by the California legislature to approve budgets prior to the beginning of a new fiscal year can also result in a temporary hold on or delay of Medi-Cal reimbursement.

California enacted a Fiscal Year 2014-15 State budget which took effect July 1, 2014, and resulted in a significant allocation to the State's Rainy Day Fund. The fiscal outlook for California is improving, with California's unemployment rate dropping in recent quarters, corporate profits trending favorably, housing prices increasing and the percentage of foreclosures dropping. One reason for California's improved fiscal outlook is the result of temporary tax revenues generated by Proposition 30, passed by California voters in November 2012. Proposition 30 provides new State General Fund revenue by increasing personal income taxes and State sales tax. These taxes are temporary and are considered to be a "bridge" in helping the State maintain a balanced budget while the economy recovers. The Governor's proposed Fiscal Year 2015-16 State budget remains guardedly optimistic for the State.

It is impossible to predict the impact of future financial challenges to the California economy, including threat of future recessions, changes in federal spending policy and other events that could result in budget deficits. It is also impossible to predict what the State's budget will be in future years or the actions of the Governor, the Legislature or voters (via ballot initiative) will take in the future. It is reasonable to expect, however, that the Governor and the Legislature will continue to pursue cost containment measures to keep the State's budget in balance, in part by aggressively managing the State's healthcare spending, which may have an adverse effect on the financial condition of the District. Past actions such as those described below may be indicative:

- Aggressive healthcare cost-containment efforts by the Governor and the Legislature to help eliminate prior years' budget deficits, including the State's substantial cuts to healthcare provider reimbursement, including Medi-Cal payments to hospitals. For example, California enacted legislation to reduce its Medicaid expenditures through eligibility restrictions, (causing a greater number of indigent, uninsured or underinsured patients) and reductions in Medicaid payment rates. In October 2011, CMS approved the State's request for 10% reductions in Medi-Cal payments for certain outpatient services and for long-term care. A Ninth Circuit Court of

Appeals panel in December 2012, and later the full court in May 2013, upheld the reductions. In January 2014, the Supreme Court declined to review.

- The significant expansions to Medicaid programs (Medi-Cal in California) under the ACA. This expansion will require additional program funding. Federal funding is available for some of this expansion, but it is conditioned on states maintaining specified beneficiary eligibility criteria and California has sought to limit program eligibility in recent years to reduce program costs.

- While federal funding is available to facilitate Medicaid program expansion, this funding is expected to be temporary. The Medicaid program expansion and the expected longer-term loss of federal financial support to offset longer-term expansion-related costs may require the State to reduce provider reimbursement rates further.

The District cannot predict what actions will be taken in the current and future years by the California State Legislature and the Governor to address California's financial problems. Such actions will likely depend on national and California economic conditions and other factors that are uncertain at this time.

Children's Health Insurance Program

The Children's Health Insurance Program ("CHIP") is a federally funded insurance program for families which are financially ineligible for Medicaid, but cannot afford commercial health insurance. The CMS administers CHIP, but each state creates its own program based upon minimum federal guidelines. CHIP insurance is provided through private health plans contracting with the state.

Each state must periodically submit its CHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for the program.

Private Health Plans and Managed Care

Managed care plans generally use discounts and other economic incentives to reduce or limit the cost and utilization of healthcare services. Payments to the District from managed care plans typically are lower than those received from traditional indemnity/commercial insurers. Defined broadly, for the fiscal year ended June 30, 2014, managed care payments constituted approximately 45% of the net patient service revenues of the District. There is no assurance that the District will maintain managed care contracts or obtain other similar contracts in the future. Failure to maintain contracts could have the effect of reducing the market share of the District and the District’s net patient service revenues. Conversely, participation may maintain or increase the patient base but could result in lower net income or operating losses to the District if it is unable to adequately contain its costs.

Management of the District anticipate that the ACA will substantially alter the commercial healthcare insurance industry. The ACA imposes, over time, increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the ACA imposes many new obligations on states related to healthcare insurance. It is unclear how the increased federal oversight of State healthcare may affect future State oversight or affect the District. The effects of these changes upon the financial condition of any third-party payor that offer healthcare insurance, rates paid by third-party payors to providers and thus the revenues of the District, and upon the operations, results of operations and financial condition of the District cannot be predicted.

Many preferred provider organizations, or PPOs, and health maintenance organizations, or HMOs, currently pay providers on a negotiated fee-for-service basis or on a fixed rate per day of care, which, in each case, usually is discounted from the typical charges for the care provided. The discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and/or changes in the utilization of certain services offered by the provider may be dramatic and unexpected, thus further jeopardizing the provider's ability to contain costs.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. In a capitation payment system, the hospital assumes a financial risk for the cost and scope of care given to the HMO's enrollees. In some cases, the capitated payment covers total hospital patient care provided. However, if payment under an HMO or PPO contract is insufficient to meet the hospital's costs of care or if utilization by enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly.

As a consequence of the above factors, the effect of managed care on the District's financial condition is difficult to predict and may be different in the future than the financial statements for the current periods reflect.

Physician Contracting and Relations

The District may wish to contract with physician organizations ("POs") (e.g., independent physician practices or associations, physician-hospital organizations, etc.) to arrange for the provision of physician and ancillary services. Because POs are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the POs.

The success of the District will be partially dependent upon its ability to contract with POs, and upon the abilities of the POs, including their employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that the District will be able to contract with and retain the requisite number of POs, or that such POs will deliver high quality healthcare services. Without contracting with a sufficient number and type of POs, the District could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until it has arranged for physician services necessary to provide adequate access for patients. Such occurrences could have a material adverse affect on the business or operations of the District.

Regulatory Environment

Licensing, Surveys, Investigations and Audits. Healthcare facilities, including those of the District, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare Conditions of Participation, requirements for participation in Medicaid/Medi-Cal, state licensing agencies, private payors and the accreditation standards. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require affirmative actions by the District.

Hospitals that participate in the Medicare and Medicaid programs are subject from time to time to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments with respect to reimbursements claimed under those programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments under certain circumstances. New billing rules and reporting requirements for which there is not clear guidance from CMS or the State could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medi-Cal program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal healthcare programs.

The Medicare Integrity Program ("MIP") was established, as authorized by HIPAA (defined below), to deter fraud and abuse in the Medicare program. MIP allows CMS to enter into contracts with outside entities and insure the "integrity" of the Medicare program. Such entities, Medicare zone program integrity contractors ("ZPICs"), formerly known as program safeguard contractors, are contracted by CMS to review claims and medical charts, both on a prepayment and post-payment basis, conduct cost report audits and identify cases of suspected fraud. ZPICs have the authority to deny and recover payments as well as to refer cases to the Office of Inspector General.

Medicare audits may result in reduced reimbursement or in repayment obligations related to past alleged overpayments and may also delay Medicare payments to providers pending resolution of the appeals process. The ACA explicitly gives the Secretary of HHS the authority to suspend Medicare and Medicaid payments to a provider or supplier during a pending investigation of fraud. The ACA also amended certain provisions of the FCA (defined

below) to include retention of overpayments as a violation. It also added provisions relating to the timing of the obligations to identify, report and reimburse overpayments. The effect of these changes on existing programs and systems of the District cannot be predicted.

Management of the District currently anticipate no difficulty renewing or continuing currently held licenses, certifications or accreditations, nor does such management anticipate a reduction in third-party payments from events that would materially adversely affect the operations or financial condition of the District. Nevertheless, actions in any of these areas could result in the loss of utilization or revenues, or the ability of the District to operate all or a portion of its Health Facilities, and consequently, could have a material and adverse effect on the District.

Negative Ranking Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures. Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of healthcare services provided by hospitals and physicians. Published rankings, such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and members of their medical staffs and to influence the behavior of consumers and providers such as the District. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a healthcare provider negatively may adversely affect its reputation and financial condition.

Civil and Criminal Fraud and Abuse Laws and Enforcement. Federal and state healthcare fraud and abuse laws regulate both the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to beneficiaries. Under these laws, individuals and organizations can be penalized for submitting claims for services that are not provided, billed in a manner other than as actually provided, not medically necessary, provided by an improper person, accompanied by an illegal inducement to utilize or refrain from utilizing a service or product, or billed in a manner that does not otherwise comply with applicable government requirements.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud and abuse, including exclusion of the provider from participation in the Medicare/Medicaid/Medi-Cal programs, fines, civil monetary penalties, and suspension of payments and, in the case of individuals, imprisonment. Fraud and abuse may be prosecuted by one or more government entities and/or private individuals, and more than one of the available penalties may be imposed for each violation.

Laws governing fraud and abuse apply to all individuals and healthcare enterprises with which a hospital does business, including other hospitals, home health agencies, long-term care entities, infusion providers, pharmaceutical providers, insurers, health maintenance organizations, preferred provider organizations, third-party administrators, physicians, physician groups, and physician practice management companies. Fraud and abuse prosecutions can have a catastrophic effect on a provider.

Based upon the prohibited activity in which the provider has engaged, governmental agencies and officials may bring actions against providers under civil or criminal False Claims Acts, statutes prohibiting referrals for compensation (including the federal "Anti-Kickback Law") or fee-splitting, or the "Stark law," which prohibits certain referrals by a physician to certain organizations in which the physician has a financial relationship, unless an exception applies. Many states also have self-referral prohibitions. The civil and criminal monetary assessments and penalties arising out of such investigations and prosecutions may be substantial. Additionally, the provider may be denied participation in the Medicare and/or Medicaid/Medi-Cal programs. If and to the extent the District engaged in a prohibited activity and judicial or administrative proceedings concluded adversely to the District, the outcome could materially affect the District.

The District has internal policies and procedures and has developed and implemented a compliance program that management of the District believe will effectively reduce exposure for violations of these laws. However, because the government's enforcement efforts presently are widespread within the industry and may vary from region to region, there can be no assurance that the compliance program will significantly reduce or eliminate the exposure of the District to civil or criminal sanctions or adverse administrative determinations.

False Claims Act. The False Claims Act ("FCA") makes it illegal to submit or present a false, fictitious or fraudulent claim to the federal government and may include claims that are simply erroneous. FCA investigations and cases have become common in the healthcare field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and compliance agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," share in the damages recovered by the government or recovered independently if the government does not participate. The FCA has become one of the government's primary weapons against healthcare fraud. FCA violations or alleged violations could lead to settlements, fines, exclusions or reputation damage that could have a material adverse impact on a healthcare provider. The ACA amended certain provisions of the FCA and added provisions respecting the timing of the obligation to reimburse overpayments.

Review of Outlier Payments. CMS is reviewing healthcare providers that are receiving large proportions of their Medicare revenues from outlier payments. Healthcare providers found to have obtained inappropriately high outlier payments will be subject to further investigation by the CMS Program Integrity Unit and potentially the Office of Inspector General.

Patient Records and Patient Confidentiality. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") addresses the confidentiality of individuals' health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These add costs and create potentially unanticipated sources of legal liability. HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. The criminal penalties range from $50,000 to $250,000 and/or imprisonment if the information was obtained or used with the intent to sell, transfer or use the information for commercial advantage, personal gain or malicious harm.

The American Recovery and Reimbursement Act of 2009 includes broad, sweeping changes to the HIPAA provisions regarding confidentiality of patient medical records. In general, that Act increases the enforcement of violations of patient medical record confidentiality.

The HITECH Act. Provisions in the 2008 Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the economic stimulus legislation, increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA-covered entities, (iii) limits certain uses and disclosures of individually identifiable health information and (iv) restricts covered entities' marketing communications.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health record ("EHR") technology. The Medicare and Medicaid EHR incentive programs provide incentive payments to eligible professionals and eligible hospitals for demonstrating meaningful use of certified EHR technology. Healthcare providers demonstrate their meaningful use of EHR technology by meeting objectives specified by CMS for using health information technology and by reporting on specified clinical quality measures. Beginning in 2015, hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced.

Security Breaches and Unauthorized Releases of Personal Information. Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on

patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a healthcare provider's reputation and materially adversely affect business operations.

Patient Transfers. A federal "anti-dumping" statute imposes certain requirements that must be met before transferring a patient to another facility. Failure to comply with the law can result in exclusion from the Medicare and/or Medicaid programs as well as civil and criminal penalties. Failure of the District to meet its responsibilities under the law could adversely affect the financial condition of the District.

California Nursing Legislation. California law requires the California Department of Health Services to adopt regulations specifying nurse-to-patient ratios for general acute care hospitals. These regulations, which became effective on January 1, 2004, require hospitals to comply with specified nurse-to-patient ratios at all times. They range from one nurse per patient in trauma units to one nurse to 6 patients in a medical/surgery unit. The required staffing, in aggregate, is more costly than prior staffing patterns.

Environmental Laws and Regulations. The District's healthcare operations generate medical waste that must be disposed of in compliance with federal, State and local environmental laws, rules and regulations. The District's operations, as well as the District's purchases and sales of real property, also are subject to compliance with various other environmental laws, rules and regulations.

Certain Business Transactions

Physician Relations. The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges, or who have membership or privileges curtailed, denied or revoked, often file legal actions against hospitals. Such action may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of the medical staff may result in hospital liability to third parties. The District is subject to such risk.

*Physician Contractin*g. The District may contract with POs to arrange for the provision of physician and ancillary services. Because POs are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the POs.

The success of the District will be partially dependent upon its ability to attract physicians to join the POs at facilities operated by the District and to participate in their networks, and upon the ability of the physicians to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that the District will be able to attract and retain the requisite number of physicians, or that physicians will deliver high quality healthcare services. Without paneling a sufficient number and type of providers, the District could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until its panel provided adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of the District.

Physician Recruitment. HHS and the Internal Revenue Service have issued various pronouncements that could limit physician recruiting and retention arrangements. Management of the District believe that the District is in material compliance with the legal standards applicable to recruitment and retention arrangements and does not anticipate any adverse impact on the ability of the District to recruit and retain physicians.

Affiliations, Mergers, Acquisitions and Divestitures. The District evaluates and pursues potential acquisition, merger and affiliation candidates as part of the overall strategic planning and development process. As part of its ongoing planning and property management functions, the District reviews the use, compatibility and business viability of many of its operations. Discussions with respect to affiliation, merger, acquisition, disposition or change of use of facilities are held from time to time with other parties. As a result, it is possible that the current organization and assets of the District may change from time to time.

Because of the integration occurring throughout the healthcare field, management of the District will consider affiliation and other arrangements if there is a perceived strategic or operational benefit for the District. Any such initiative may involve significant capital commitments and/or capital or operating risk (including, potentially, insurance risk) in a business in which the District may have less expertise than in hospital and skilled nursing operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences to the District.

Antitrust. Enforcement of antitrust laws against healthcare providers is becoming more common, and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third party contracting, physician relations, and joint venture, merger, affiliation and acquisition activities. While the application of federal and state antitrust laws to healthcare is still evolving, enforcement activities by federal and state agencies appear to be increasing. Violators of antitrust laws could be subject to criminal and civil liability by both federal and state agencies, as well as by private litigants.

Other Risks

Indigent Care. Tax-exempt hospitals often treat large numbers of "indigent" patients who, for various reasons, are unable to pay for their medical care. These hospitals may be susceptible to economic and political changes which could increase the number of indigent persons or the responsibility for caring for this population. General economic conditions which affect the number of employed individuals who have health insurance coverage will similarly affect the ability of patients to pay for their care. The ACA imposes requirements on tax-exempt hospitals to develop, implement and monitor charity care policies and procedures. In addition, as described above, one of the objectives of the ACA has been to extend the availability and affordability of healthcare insurance to those segments of the population who have not been able to afford healthcare insurances or who have not had access to healthcare services. As a consequence, a reduction in the volume of patients who have historically been afforded care under indigent care programs is probable.

Staffing Shortages. In recent years, the healthcare industry has suffered from a scarcity of nursing and other qualified health care technicians and personnel. This scarcity may intensify if utilization of healthcare services increases as a consequence of the expansion of the number of insured consumers occurs as anticipated as a result of the ACA. This trend could force the District to pay higher salaries to nursing and other qualified healthcare technicians and personnel as competition for such employees intensifies and, in an extreme situation, could lead to difficulty in keeping the facilities licensed to provide nursing care and thus eligible for reimbursement under Medicare and Medi-Cal.

Earthquakes. Earthquakes affecting California hospitals have prompted the State to put into place hospital seismic safety standards. Such standards require, generally by 2030, at the latest, that California hospitals meet stringent seismic safety criteria which may necessitate major renovation in certain facilities or even their replacement. The facilities of the District are presently in compliance with such seismic safety standards.

Drought. California has been suffering through an extended and nearly unprecedented drought, which among other concerns, has affected snowfall at the ski resorts within the District. As a consequence, fewer ski and snowboard accident patients present at the Health Facilities for care. This has adversely affected District patient revenues. Moreover, continued worsening of the drought could put some of the ski resorts out of business thereby diminishing this potential source of revenue to the District.

Professional Liability Claims and Liability Insurance. In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased nationwide, resulting in substantial increases in malpractice insurance premiums. Professional liability and other actions alleging wrongful conduct and seeking punitive damages often are filed against healthcare providers. Litigation may also arise from the corporate and business activities of the District, employee-related matters, medical staff and provider network matters and denials of medical staff and provider network membership and privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims, business disputes and workers' compensation claims are not covered by insurance or other sources and, in whole or in part, may be a liability of the District if determined or settled adversely. Claims for punitive damages may not be covered by insurance under certain State laws; however, district hospitals in California are exempted from punitive damages. Although the District currently maintains actuarially determined self-insurance reserves and carries excess

malpractice and general liability insurance which management of the District consider adequate, the District is unable to predict the availability, cost or adequacy of such insurance in the future.

Other Risk Factors Generally Affecting Healthcare Facilities. In the future, the following factors, among others, may adversely affect the operations of healthcare providers, in general and the District in particular, to an extent that cannot be determined at this time:

1. A portion of the revenues of the District is derived from investments in securities. Any significant disruption of the securities markets or weakness in the investment climate may potentially materially adversely affect the District's revenues.

2. Hospitals are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single operation. As with all large employers, the District bears a wide variety of risks in connection with its employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance. The District is subject to all of the risks listed above, and such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the District.

3. Competition from other hospitals and other competitive facilities now or hereafter located in the service area of the Health Facilities of the District may adversely affect revenues of the District. Development of health maintenance and other alternative health delivery programs could result in decreased usage of the District's Health Facilities.

4. Cost and availability of any insurance, including self-insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other healthcare facilities of similar size and type as those operated by the District generally carry may adversely affect revenues. The costs of such insurance have increased significantly in the past few years, and such increases are likely to continue in the near future,

5. The occurrences of natural disasters, in addition to earthquakes, may damage some or all of the District's Health Facilities, interrupt utility service to some or all of such facilities or otherwise impair the operation of some or all of such facilities.

6. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient healthcare delivery may reduce utilization and revenues of the District, Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the District to offer the equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance these acquisitions or operations.

7. Reduced demand for the services of the District that might result from decreases in population in its service areas could materially and adversely affect the District.

8. Increased unemployment or other adverse economic conditions in the service areas of the District which would increase the proportion of patients who are unable to pay fully for the cost of their care, could materially and adversely affect the District.

9. Any increase in the quantity of indigent care provided which is mandated by law or required due to increased needs of the community in order to maintain the charitable status of the District could materially and adversely affect the District.

10. Regulatory actions which might limit the ability of the District to undertake capital improvements at its facilities or to develop new institutional health services could materially and adversely affect the District.

11. The occurrence of a large scale terrorist attack that increases the proportion of patients who are unable to pay fully for the cost of their care and that disrupts the operation of certain healthcare facilities by resulting in an abnormally high demand for healthcare services could materially and adversely affect the District.

TAX MATTERS

In the opinion of Quint & Thimmig LLP, Larkspur, California, Bond Counsel, subject, however to the qualifications set forth below, under existing law, interest on the 2015 Bonds is excluded from gross income for federal income tax purposes, such interest is not an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations, provided, however, that, for the purpose of computing the alternative minimum tax imposed on corporations (as defined for federal income tax purposes), such interest is taken into account in determining certain income and earnings.

The opinions set forth in the preceding paragraph are subject to the condition that the District comply with all requirements of the Code that must be satisfied subsequent to the issuance of the 2015 Bonds in order that such interest be, or continue to be, excluded from gross income for federal income tax purposes. The District has covenanted to comply with each such requirement. Failure to comply with certain of such requirements may cause the inclusion of such interest in gross income for federal income tax purposes to be retroactive to the date of issuance of the 2015 Bonds.

In the further opinion of Bond Counsel, interest on the 2015 Bonds is exempt from California personal income taxes.

Owners of the 2015 Bonds should also be aware that the ownership or disposition of, or the accrual or receipt of interest on, the 2015 Bonds may have federal or state tax consequences other than as described above. Bond Counsel expresses no opinion regarding any federal or state tax consequences arising with respect to the 2015 Bonds other than as expressly described above.

LITIGATION

There is no material litigation pending against the District and, to the knowledge of its officers, there is no controversy or litigation threatened that in any way questions or affects the validity of the 2015 Bonds or any proceedings or transactions relating to their issuance, sale and delivery or the pledge or application of any moneys or security provided for the payment of the 2015 Bonds.

APPROVAL OF LEGALITY

The validity of the 2015 Bonds and certain legal matters is subject to the approving opinion of Quint & Thimmig LLP, Larkspur, California, Bond Counsel. A complete copy of the proposed form of Bond Counsel opinion is contained in Appendix D hereto.

Other legal matters will be passed upon for the District by Porter Simon, Truckee, California, and by Jennings, Strouss & Salmon, PLC, Phoenix, Arizona, as the District's Disclosure Counsel.

Legal matters will be passed upon for the Underwriters by Fulbright & Jaworski LLP, Los Angeles, California, a member of Norton Rose Fulbright.

RATING

Standard & Poor's Rating Services (~~S~~S&P"), has assigned the rating of "___" to the 2015 Bonds. Such rating reflects only the views of S&P and any explanation of the significance of such rating may only be obtained from S&P. There is no assurance that such rating will continue for any given period of time or that it will not be revised downward or withdrawn entirely by S&P, if in the judgment of S&P circumstances so warrant. Except pursuant to the Continuing Disclosure Certificate, the District and the Underwriters have not undertaken any responsibility either to bring to the attention of the registered holders or beneficial owners of the 2015 Bonds any proposed change in or withdrawal of such rating or to oppose any such proposed revision or withdrawal. Any downward revision or withdrawal of such rating may have an adverse effect on the market price or marketability of the 2015 Bonds.

FINANCIAL STATEMENTS

The audited financial statements of the District for the fiscal years ended June 30, 2013 and 2014, are included in Appendix B to this Official Statement.

UNDERWRITING

The 2015 Bonds are being purchased by the underwriters listed on the cover of this Official Statement (the "Underwriters") at a purchase price of $_____ (being equal to the aggregate principal amount of the 2015 Bonds ($_____), less/plus a net original issue discount/premium of $_____, and less $_____ retained by the Underwriters to pay the Underwriters' discount).

The bond purchase contract for the Bonds provides that the Underwriters will purchase all of the 2015 Bonds, if any are purchased, and contain the agreement of the District to indemnify the Underwriters against certain liabilities to the extent permitted by law. The obligation of the Underwriters to make such purchase is subject to certain terms and conditions set forth in the bond purchase contract.

The Underwriters may offer and sell the 2015 Bonds to certain dealers and others at prices or yields different from the prices or yields stated on the cover to this Official Statement. The offering prices or yields may be changed from time to time without notice by the Underwriters.

Piper Jaffray & Co. ("Piper") and Pershing LLC, a subsidiary of The Bank of New York Mellon Corporation entered into an agreement (the "Agreement") which enables Pershing LLC to distribute certain new issue municipal securities underwritten by or allocated to Piper, including the 2015 Bonds. Under the Agreement, Piper will share with Pershing LLC a portion of the fee or commission paid to Piper.

Piper has entered into a distribution agreement (the "CS&Co Distribution Agreement") with Charles Schwab & Co., Inc. ("CS&Co") for the retail distribution of certain securities offerings at the original issue prices. Pursuant to the CS&Co Distribution Agreement, CS&Co will purchase 2015 Bonds from Piper at the original issue price less a negotiated portion of the selling concession applicable to any 2015 Bonds that CS&Co sells.

Piper has also entered into a distribution agreement (the "UnionBank Distribution Agreement") with UnionBank Investment Securities LLC ("UnionBank") for the retail distribution of certain securities offerings at the original issue prices. Pursuant to the UnionBank Distribution Agreement, UnionBank will purchase 2015 Bonds from Piper at the original issue price less a negotiated portion of the selling concession applicable to any 2015 Bonds that UnionBank sells.

CONTINUING DISCLOSURE

The District has covenanted for the benefit of bondholders and Beneficial Owners of the 2015 Bonds to disseminate certain financial information and operating data relating to the District, and to provide notices of the occurrence of certain enumerated events. See Appendix E – "Form of Continuing Disclosure Certificate." These covenants have been made in order to assist the Underwriters in complying with Rule 15c2-12 promulgated by the Securities and Exchange Commission. The District has had continuing disclosure obligations with respect to its 1999 Bonds and its 2006 Bonds and with respect to the District's 2008 General Obligation Bonds, 2010 General Obligation Bonds, 2012 General Obligation Bonds and 2015 General Obligation Refunding Bonds. The 1999 Bonds were no longer outstanding after September 10, 2010.

The District has determined that its continuing disclosure submissions since 2010 with respect to the 2006 Bonds, the District's 2008 General Obligation Bonds, 2010 General Obligation Bonds and 2012 General Obligation Bonds pertaining to annual and quarterly (as applicable) disclosure of financial information and operating data have not fully complied with its continuing disclosure obligations. While continuing disclosure is required with respect to the District's recently issued 2015 General Obligation Bonds, no postings with EMMA (defined below) have yet been required of this bond issue.

Moreover, rating changes affecting the 2008 General Obligation Bonds during the last five years were posted late or not made. For example, the rating on most maturities of the 2008 General Obligation Bonds began as

a Moody's rating of Aaa based on the bond insurance on such maturities of the 2008 General Obligation Bonds provided by Assured Guaranty Corp. The rating on such insured maturities changed each time Moody's rating of Assured Guaranty Corp. changed. Assured Guaranty Corp.'s rating fell from the Aaa rating at the time the 2008 General Obligation Bonds were issued to Aa2 in November 2008, to Aa3 in November 2009 to A3 in January 2013. The underlying Moody's rating of A2 on the 2008 General Obligation Bonds not insured by Assured Guaranty Corp. was upgraded to Aa3 in June 2010.

The District has in the past and more recently supplemented its disclosure submissions with respect to those bonds still outstanding at the time by posting additional information with Electronic Municipal Market Access ("EMMA"). Additionally, the District has adopted a policy appointing its Chief Financial Officer to have the principal responsibility for all continuing disclosure for the District's bond issues. The District and the dissemination agent, D.K. Goulding Financial Services, LLC, have agreed to have earlier contact with one another in the continuing disclosure process to ensure proper information exchange between the District and the dissemination agent and, therefore, to help produce timely and complete continuing disclosure in the future.

Set forth below in table form is information outlining separately the required Annual Report (audited financials), quarterly financial information (as applicable) and operating data disclosures pertaining to the 2006 Bonds, the 2008 General Obligation Bonds, the 2010 General Obligation Bonds and the 2012 General Obligation Bonds (for example, the annual audit, tax information and other operating data as required by the applicable official statement). The table shows the date each filing was required and the actual date of posting on EMMA. In no case involving a late filing was a notice of failure to timely file the required continuing disclosure posted to EMMA by the dissemination agent or the District.

2006 Bonds	**Due Date**	**Date Posted**
2009 Annual Report	12/31/09	11/05/09
2009 Operating Data [(1)]	12/31/09	11/05/09
2010 Annual Report	12/31/10	12/28/10
2010 Operating Data [(1)]	12/31/10	11/08/11
2011 Annual Report	12/31/11	11/08/11
2011 Operating Data [(1)]	12/31/11	11/08/11
2012 Annual Report	12/31/12	11/15/12
2012 Operating Data [(1)]	12/31/12	11/15/12
2013 Annual Report	12/31/13	02/20/14
2013 Operating Data [(1)]	12/31/13	01/27/15
2014 Annual Report	12/31/14	12/29/14
2014 Operating Data [(1)]	12/31/14	12/29/14
Quarterly Financials (12/31/09)	01/31/10	12/18/10[*]
Quarterly Financials (03/31/10)	04/30/10	11/25/13
Quarterly Financials (06/30/10)	07/31/10	01/27/15
Quarterly Financials (09/30/10)	10/31/10	04/26/11
Quarterly Financials (12/31/10)	01/31/11	04/26/11
Quarterly Financials (03/31/11)	04/30/11	05/18/11
Quarterly Financials (06/30/11)	07/31/11	08/02/11
Quarterly Financials (09/30/11)	10/31/11	11/04/11
Quarterly Financials (12/31/11)	01/31/12	08/28/13
Quarterly Financials (03/31/12)	04/30/12	04/30/12
Quarterly Financials (06/30/12)	07/31/12	08/17/12
Quarterly Financials (09/30/12)	10/31/12	08/28/13
Quarterly Financials (12/31/12)	01/31/13	08/28/13
Quarterly Financials (03/31/13)	04/30/13	06/24/13
Quarterly Financials (06/30/13)	07/31/13	08/28/13
Quarterly Financials (09/30/13)	10/31/13	11/25/13
Quarterly Financials (12/31/13)	01/31/14	02/20/14
Quarterly Financials (03/31/14)	04/30/14	01/27/15
Quarterly Financials (06/30/14)	07/31/14	07/29/14
Quarterly Financials (09/30/14)	10/31/14	10/24/14
Quarterly Financials (12/31/14)	01/31/15	01/22/15

2008 General Obligation Bonds	Due Date	Date Posted
2009 Annual Report	03/31/10	11/05/09
2009 Operating Data [2]	03/31/10	05/23/12
2010 Annual Report	03/31/11	12/28/10
2010 Operating Data [2]	03/31/11	05/23/12
2011 Annual Report	03/31/12	11/08/11
2011 Operating Data [2]	03/31/12	05/23/12
2012 Annual Report	03/31/13	11/15/12
2012 Operating Data [2]	03/31/13	04/01/14
2013 Annual Report	03/31/14	04/01/14
2013 Operating Data [2]	03/31/14	04/01/14
2014 Annual Report	03/31/15	12/09/14
2014 Operating Data [2]	03/31/15	02/03/15

2010 General Obligation Bonds [4]	Due Date	Date Posted
2010 Annual Report	04/01/11	12/28/10
2010 Operating Data [2]	04/01/11	05/23/12
2011 Annual Report	04/01/12	11/08/11
2011 Operating Data [2]	04/01/12	05/23/12
2012 Annual Report	04/01/13	11/15/12
2012 Operating Data [2]	04/01/13	04/03/14
2013 Annual Report	04/01/14	02/20/14
2013 Operating Data [2]	04/01/14	04/03/14
2014 Annual Report	04/01/15	02/03/15
2014 Operating Data [2]	04/01/15	02/03/15

2012 General Obligation Bonds	Due Date	Date Posted
2012 Annual Report	04/01/13	03/29/13
2012 Operating Data [2]	04/01/13	04/03/14
2013 Annual Report	04/01/14	04/01/14
2013 Operating Data [2]	04/01/14	04/03/14
2014 Annual Report	04/01/15	02/03/15
2014 Operating Data [2]	04/01/15	02/03/15

[1] Consists of utilization data, medical staff data, payor mix, debt service coverage ratio and days cash on hand.
[2] Consists of assessed values in the District, property tax levies, collections and delinquencies.
* This posting can be found under "Other Financial/Operating Data" rather than "Quarterly/Monthly Financial Information."

On February 6, 2015, a notice filing was posted on EMMA with respect to each outstanding bond issue containing substantially the same information as set out on the above table, as well as information about rating changes.

VERIFICATION OF MATHEMATICAL COMPUTATIONS

The Verification Agent will examine the arithmetical accuracy of certain computations included in the schedules relating to the refunding of the 2006 Bonds. See "REFINANCING PLAN." The Verification Agent has restricted its procedures to examining the arithmetical accuracy of certain computations and has not made any study or evaluation of the assumptions and information upon which the computations are based and, accordingly, has not expressed an opinion on the data used, the reasonableness of the assumptions, or the achievability of the forecasted outcome.

FINANCIAL ADVISOR

G.L. Hicks Financial, LLC has served as financial advisor to the District for purposes of assisting with the development and implementation of a bond structure in connection with the 2015 Bonds. G.L. Hicks Financial, LLC is an independent advisory firm and is not engaged in the business of underwriting or distributing municipal securities or other public securities. G.L. Hicks Financial, LLC is a registered municipal advisor with the Municipal Securities Rulemaking Board and the Securities and Exchange Commission.

MISCELLANEOUS

The foregoing and subsequent summaries or descriptions of the 2015 Bonds and the Indenture, and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof, and reference is made to said documents for full and complete statements of their provisions. Copies in reasonable quantity of the Indenture may be obtained during the offering period upon request directed to the Underwriters and thereafter upon request directed to the principal corporate trust office of the Trustee.

This Official Statement has been issued by the District. This Official Statement is not to be construed as a contract or agreement between the District and the purchasers or owners of any of the 2015 Bonds.

TAHOE FOREST HOSPITAL DISTRICT

By: _____

Title: Chief Financial Officer

APPENDIX A

Information Concerning Tahoe Forest Hospital District

APPENDIX B

Audited Financial Statements of the District for the Fiscal Years Ended June 30, 2014 and 2013

APPENDIX C

Summary of the Indenture

APPENDIX D

Form of Final Opinion of Bond Counsel

APPENDIX E

Form of Continuing Disclosure Certificate

APPENDIX F

Book-Entry System

APPENDIX A

INFORMATION CONCERNING THE TAHOE FOREST HOSPITAL DISTRICT

The information contained in this Appendix A has been obtained from Tahoe Forest Hospital District.

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TAHOE FOREST HOSPITAL DISTRICT

THE DISTRICT

The District was created in 1949 as a political subdivision of the State of California. The District is organized and operates under The Local Health Care District Law of the State of California, constituting Division 23 of the California Health and Safety Code (the "District Law"). The District is located in portions of Placer and Nevada Counties and covers an area of approximately 500 square miles. The permanent resident population of the District is approximately 40,000 persons with an estimated two-thirds of the year-round residents under the age of 45. Seasonal influxes increase the resident population to over 70,000 persons, due to recreational and other attractions. Under District Law the District may own and operate health care facilities. The District currently owns and operates Tahoe Forest Hospital and Incline Village Community Hospital under the provisions of District Law.

Cities and communities located within the District's boundaries include, in addition to the Town of Truckee, to the west, Norden, Soda Springs and Emigrant Gap and to the southeast along the Lake Tahoe shoreline, Crystal Bay, Kings Beach, Tahoe Vista, Carnelian Bay, Tahoe City, Tahoe Pines, Homewood and Tahoma. The District is a political agency and receives operating tax revenues from the Counties annually based upon the assessed value of taxable property located within its boundaries. The District is able to use its operating tax revenues for general operating purposes. These operating tax revenues are not pledged to the repayment of the 2015 Bonds. Additionally, *ad valorem* taxes are collected by the Counties and distributed to the District to pay the District's general obligation bonds. The *ad valorem* taxes are pledged only to the repayment of such general obligation bonds.

The District incorporates an area of mountainous terrain having an elevation ranging between 5,800 and 9,600 feet above sea level. Within the District's boundaries are well established summer and winter resort areas which include the northwest quadrant of Lake Tahoe and several winter ski resorts. Summer recreation areas around Lake Tahoe include the shoreline communities of Tahoe City, Kings Beach, Tahoe Vista, Crystal Bay, Tahoe Pines, Carnelian Bay, Incline Village and Homewood. Other summer recreation areas are located at and around Donner Lake, Prosser Reservoir, Donner Summit and Boca Reservoir near the Town of Truckee. Winter ski areas include Squaw Valley, Alpine Meadows, Tahoe Donner, Northstar at Tahoe, Boreal Ridge, Soda Springs, Sugar Bowl, Homewood Mountain Resort and Mount Rose, among others.

The District is governed by a Board of Directors (the "Board"), which consists of five members, each elected at large to four-year terms. The Board has ultimate responsibility for quality patient care, District policies, strategic planning, as well as fiduciary responsibility for protecting and enhancing the District's assets. The Board hires a Chief Executive Officer to manage the District's operations and appoints physicians to an organized medical staff. Regular Board meetings are held monthly and are open to the public. The current members of the Board, including their titles, occupations, dates on which their current terms expire and total years as Board members, are set forth in the following table:

Name and Title	Occupation	Term in Office Expires	Years as a Board Member
Karen Sessler, M.D. President	Physician/Business Owner	12/2016	14
Charles Zipkin, M.D. Vice President	Physician	12/2018	0
Greg Jellinek, M.D. Secretary	Physician	12/2018	0
Dale Chamblin Treasurer	Retired Chief Financial Officer	12/2018	2
John Mohun, Esq. Member	Attorney at Law	12/2016	4

THE HEALTH FACILITIES

General Background

The District operates Tahoe Forest Hospital in Truckee, California, and Incline Village Community Hospital in Incline Village, Nevada (the "Health Facilities"), representing an aggregate of 76 beds (39 acute and 37 skilled nursing beds, of which 10 acute and 2 skilled nursing beds are in suspense) licensed by the State of California Department of Health Services and the State of Nevada, Department of Human Resources, Division of Health, Bureau of Licensure and Certification. Incline Village Community Hospital is located outside the District's boundaries and was acquired by the District in 1996. The District also operates outpatient facilities located in Tahoe City and Truckee, California. These outpatient facilities provide laboratory and physical therapy services, among other services.

Tahoe Forest Hospital is located in the southeastern quadrant of Nevada County off Interstate 80 in the Town of Truckee, California, approximately 15 miles northwest of Lake Tahoe and approximately 35 miles southwest of Reno, Nevada. Tahoe Forest Hospital opened in 1952 as a 12-bed acute care hospital. The first expansion of Tahoe Forest Hospital occurred in 1966 when it expanded to a total of 42 beds. In 1986, services were expanded in the areas of emergency care and ancillary services and its intensive care unit was expanded to 6 beds and a skilled nursing unit was added. Also in 1986, the District initiated a development program to modernize and expand its services to meet the projected needs of its service area residents. This development included the expansion and renovation of surgery suites, laboratory and admissions, the remodeling of general hospital areas, a renovation and expansion of the obstetrics department as well as the replacement of radiology equipment. It also included an upgrade of the intensive care unit, a remodeling of the emergency room and an expansion of the cafeteria and dining facilities. In 1995, the District completed the construction of a three-story medical office complex adjacent to Tahoe Forest Hospital comprising approximately 30,000 square feet of new space. Some of this building has been sold to physicians on a condominium basis with the remaining footage housing the District's retail pharmacy and other related hospital services. In 2005, the District developed a new Center for Health and Sports Performance. In 2006, the District opened its 40,000 square foot Western Addition including medical, surgical and intensive care beds, clinical laboratory, women's imaging, magnetic resonance imaging, cardiac rehabilitation, outpatient surgery and expanded space for dietary, ancillary and admission services. In 2006, Tahoe Forest Hospital started an oncology program with a newly recruited medical oncologist. Over its first two years of operation the Tahoe Forest Cancer Center expanded its scope of services to include chemotherapy and in early 2008 it became part of the University of California at Davis Cancer Care Network. The Tahoe Forest Cancer Center affiliation with the University of California at Davis Cancer Center provided access to clinical trials offerings for the Truckee – Tahoe region beginning in 2008. In 2007, the District also developed a hospital based multi-specialty clinic providing expanded hospital based clinics for ENT, pulmonary medicine, cardiology, gastroenterology, and internal medicine services. In 2008, oncology, urology and orthopedics were added as new service lines. In 2009 and early 2010, the District added sports medicine and audiology services. In 2011 and 2012, the District added pediatrics, general surgery and radiation oncology services.

Tahoe Forest Hospital has a heliport on its site which allows helicopter ambulances to bring emergency patients to and from Tahoe Forest Hospital. Helicopter ambulances are often used because of the mountainous terrain in the District's service area. Tahoe Forest Hospital also operates a Women's and Family Center which provides a combination of clinical and educational services. Obstetrical services provided include labor, delivery, recovery and postpartum units. Home health services offered by Tahoe Forest Hospital include skilled nursing assessment and monitoring, infusion services, post surgical care, wound care, ostomy care, medical social services, nutrition counseling, and occupational, speech and physical therapies. The District also operates a retail pharmacy, a medical radiation and oncology program and a children's care center, all located adjacent to Tahoe Forest Hospital.

Incline Village Community Hospital is located in Incline Village, Nevada, approximately 18 miles east of Tahoe Forest Hospital near the northeast shore of Lake Tahoe. It is located outside of the District's boundaries but within the District's service area. Incline Village Community Hospital is operated primarily as an outpatient medical center with only occasional inpatient admissions. It provides a fully equipped and staffed 24-hour emergency room and an active surgicenter as well as radiology, laboratory, pharmacy, physical therapy and a sleep disorder clinic.

Approximately 78% of the Health Facilities' admissions originate from District residents. A majority of the remaining admissions originate from visitors to Lake Tahoe area ski resorts or from auto accidents along the Interstate 80 corridor between Auburn, California, and Reno, Nevada. Both Tahoe Forest Hospital and Incline Village Community Hospital are designated as Critical Access Hospitals for Medicare reimbursement purposes.

Bed Complement

The Health Facilities have a licensed capacity of 76 beds (39 acute and 37 skilled nursing), with 12 of those beds currently in suspense. The current bed count classified by service type is as follows:

Service	Tahoe Forest	Incline Village	Total
Medical/Surgical [(1)]	25	4	29
Intensive Care	6	--	6
Prenatal/Obstetrics	4	--	4
Skilled Nursing [(1)]	37	--	37
Total	72	4	76

Source: State of California, Department of Public Health License and State of Nevada, Department of Health and Human Services.

[(1)] Ten medical/surgical beds at Tahoe Forest Hospital were placed in suspense on July 1, 2007, for use as patient observation extended recovery beds. Ten medical/surgical beds were also designated as swing beds, as of the same date. Designated swing beds can be used for the treatment of medical/surgical patients or skilled nursing patients, as needed. Two skilled nursing beds were placed in suspense on April 18, 2011.

Services Provided

The District presently offers a range of inpatient and outpatient services at the Health Facilities, including basic medical, surgical and obstetrical services, in addition to its general and administrative services. Medical and surgical services currently provided at the Health Facilities include the following:

Medical Services		
Alternate Birthing Center	Hospice Care	Oncology (Radiation and Medical)
Audiology	Intensive Care	Pain Center
Cardiac Rehabilitation	Internal Medicine	Pharmacy
Cardiopulmonary Therapy	Laboratory, Clinical	Physical Therapy
Clinic	Laboratory, Pathology	Pulmonary Testing
CT Scanning (including PET CT)	LDRP Maternity	Radiology
Diagnostic	Mammography	Respiratory Therapy
EKG, EEG and Endoscopy	MRI Scanning	Sleep Center
General (FP/GP)	Newborn Nursery	Speech Therapy
Gynecology	Nuclear Medicine	Sports Medicine Services
Hematology	Occupational Health	Telemetry
Home Health	Occupational Therapy	Ultrasound

Surgical Services		
Ambulatory	General	Outpatient
Anesthesiology	Gynecology	Urology
Dental	Ophthalmology	Vascular
Cosmetic	Orthopedics	
Gastroenterology	Otolaryngology	

Tahoe Forest Hospital provides 24-hour emergency medical service and trauma care with a licensed physician on duty at all times. The District also provides skilled nursing services at Tahoe Forest Hospital. Home health services offered include skilled nursing assessment and monitoring, infusion services, post surgical care, wound care, ostomy care, nutritional support, medical social services and occupation, speech and physical therapies.

Senior Management

After discussing for several months the possibility of Robert Schapper continuing his employment as Chief Executive Officer of the District beyond his contracted term of June 30, 2015, the Board and Mr. Schapper determined in mid-January 2015 that there would be no extension of his employment contract. By the end of January 2015, however, Mr. Schapper was relieved of all of his duties as Chief Executive Officer by the Board, although his compensation will continue through June 30, 2015.

Beginning in May 2014 the Board ordered an investigation into whether certain actions taken by Mr. Schapper in his position as Chief Executive Officer involved a conflict of interest in violation of California law. Specifically, as has been reported extensively by local print and on-line news sources, Mr. Schapper's hiring of a company owned by his spouse as an independent contractor to perform services on behalf of the District in negotiating with health insurance carriers and her subsequent personal employment by the District was questioned. This concern was investigated by an independent law firm. This investigation was concluded in September 2014, and the independent law firm reported its findings to the Board. Based on that report and other expert input to the Board, the Board determined there was insufficient evidence to conclude that Mr. Schapper had violated California law.

The local Nevada County District Attorney's Office may have opened its own investigation of Mr. Schapper, but whether that has occurred or the status of any such investigation is not known by the District.

The Board will undertake a search for someone to fill the Chief Executive Officer position, but, in the meantime, the Board has selected Virginia Razo, the current Chief Operating Officer of the District, who has a three-year employment agreement for that position, to serve as Interim Chief Executive Officer. Ms. Razo has agreed to serve as Interim Chief Executive Officer for as long as 18 months or until a permanent Chief Executive Officer is hired by the District, if that occurs before the 18 month period has expired. As frequently occurs when a long-serving Chief Executive Officer is terminated or resigns employment, the senior management personnel who have worked with that person may look for other employment opportunities. There can be no assurance, therefore, that those now serving in senior management positions at the District will remain in their positions for any extended period of time or that if any should leave, the District will not incur difficulty in finding a replacement.

The current principal members of the administrative staff responsible for the daily operations of the Health Facilities are profiled below:

Virginia Razo, Pharm D, DSc, Chief Operating Officer and Interim Chief Executive Officer. Ms. Razo has held various positions with increasing responsibilities at the District since 1996, including Director of Pharmacy Services, Chief of Ancillary Services, Chief Operating Officer and now Interim Chief Executive Officer. She now directs all functions of the Health Facilities and other District activities in accordance with the policies established by the Board. She completed undergraduate work (pre-pharmacy) at Marietta College, Marietta, Ohio, received a Doctor of Pharmacy Degree from the University of the Pacific, Stockton, California and received a DSc in Healthcare Administration from the University of Alabama at Birmingham. Ms. Razo has participated in various professional and civic organizations and currently is affiliated with the American College of Healthcare Executives.

Crystal Betts, CPA (inactive), Chief Financial Officer. Ms. Betts has been with the District since 2004, initially as its Controller and since 2007, as its Chief Financial Officer. She is responsible for all aspects of the financial operations of the District's activities. From 2000 to 2004, Ms. Betts was with Trinity Hospital, a 65-bed acute care facility located in Weaverville, California, as the Controller and then as the Chief Financial Officer. From 1996 to 2000, she was the Audit Senior/Accountant at Matson and Isom Accountancy Corporation located in Chico, California, where she was responsible for conducting audits for governmental, not-for-profit and for-profit entities including eleven healthcare entities. Ms. Betts received a Bachelor of Science degree in Accounting and Management Information Systems from California State University at Chico in Chico, California, and is a Certified Public Account, licensed in the State of California.

Judith Newland, Chief Nursing Officer. Ms. Newland was appointed to serve as Chief Nursing Officer in April 2012. She has spent most of her career with the District, first serving as a staff nurse in the Medical/Surgical Unit and then in the Emergency Department from 1980 to 1985; from 1985 to 2001 she was the Director of Emergency Services; from 2001 to 2011 she was the Director of Quality and Regulations; and just prior to her present position she was the Director of Operations/Chief Nursing Officer. Ms. Newland earned her Bachelor of Science degree in Nursing from California State University, Fresno, in 1979. Ms. Newland has continued her education by completing Executive MBA courses in Health Administration in 2012 through the University of Colorado, Denver.

Accreditations, Designations, Memberships and Affiliations

Tahoe Forest Hospital has been fully accredited since it was opened in 1952. Tahoe Forest Hospital's most recent three-year accreditation from the American Osteopathic Association's Bureau of Healthcare Facilities Accreditation expires on or about July 2, 2017. Incline Village Community Hospital's and associated multispecialty clinic's most recent three-year accreditation from the American Osteopathic Association's Bureau of Healthcare Facilities Accreditation expires on or about September 8, 2017. Laboratory services at Tahoe Forest Hospital and satellite operations located in Tahoe City, California, and Incline Village, Nevada, are accredited by the College of American Pathologists. Incline Village Community Hospital received Critical Access Hospital designation in 2000 and Tahoe Forest Hospital received its Critical Access Hospital designation in 2007. Critical Access Hospitals are also certified by the Department of Health and Human Services and are eligible for more favorable cost-based reimbursement from Medicare for Medicare program beneficiaries treated at these hospitals.

The Health Facilities are eligible providers under Medicare, Medi-Cal, Blue Cross and other commercial insurance programs and the District holds memberships in the California Hospital Association, the Association of California Healthcare Districts, the District Hospital Leadership Forum and other professional health care organizations.

The District plans for and evaluates potential affiliations as part of its overall strategic planning. The District has an affiliation with Premier to provide group purchasing services and educational opportunities and with UC Davis Health System to provide services related to cancer care, cancer research and rural health care.

Historical Utilization

The table below provides selected statistical indicators of inpatient and outpatient activity for the Health Facilities during the past five fiscal years ended June 30, 2014, and for the six-month period ended December 31, 2013 and 2014:

	Fiscal Year Ended June 30					Six Months Ended Dec. 31	
	2010	2011	2012	2013	2014	2013	2014
Acute Care:							
Licensed Beds [(1)]	29	29	29	29	29	29	29
Patient Days	5,496	5,449	5,004	4,905	5,118	2,519	2,332
Admissions	1,794	1,811	1,716	1,705	1,658	878	852
Occupancy	52%	51%	47%	46%	48%	47%	44%
Acute Length of Stay (Days)	2.9	3.0	3.0	3.0	3.1	2.7	2.7
Emergency Room Visits	17,372	17,348	16,235	16,324	16,264	8,167	8,134
Total Surgery Cases	1,916	1,751	1,947	1,906	1,938	995	955
Skilled Nursing:							
Licensed Beds [(1)]	37	37	35	35	35	35	35
Patient Days	12,366	11,446	11,828	11,723	12,133	6,203	6,365
Occupancy	92%	85%	93%	92%	95%	96%	99%
Combined:							
Licensed Beds[(1)]	66	66	64	64	64	64	64
Patient Days	17,862	16,895	16,832	16,628	17,251	8,722	8,697
Occupancy	74%	70%	72%	71%	74%	74%	74%

Source: District records.

[(1)] Ten medical/surgical beds at Tahoe Forest Hospital were placed in suspense on July 1, 2007. Two skilled nursing beds at Tahoe Forest Hospital were placed in suspense on April 18, 2011.

Medical Staff

As of December 31, 2014, the medical staff at the Health Facilities consisted of 105 physicians, 64 of whom were active or provisional active medical staff members. Approximately 98% of the active medical staff members are board certified. The current medical staff includes approximately 41 physicians who are courtesy staff or consulting staff members. Active medical staff members are the primary admitters to the Health Facilities. The Health Facilities' active medical staff has an average age of approximately 53 years.

The top ten admitting physicians of the District, based upon gross inpatient revenues for the fiscal year ended June 30, 2014, represented approximately 59% of total inpatient revenues of the District for the same period. The District is recruiting a new urologist for addition to the medical staff of the Hospital.

Employees

As of December 31, 2014, the District employed approximately 554 full-time equivalent employees. Included in this group are registered nurses, licensed vocational nurses, technicians, specialists, environment and food service personnel, and various management, supervisory and clerical personnel.

Most of the District's employees are covered by collective bargaining agreements. The District has two employee non-unionized bargaining groups covering licensed and non-licensed employees. These bargaining groups provide representation and advocacy for District employees, particularly in the area of compensation. The informal bargaining relationship has been in existence for many years. The District believes that its employee relations are good.

Service Area and Competition

The service area for the Health Facilities extends beyond the District's boundaries to include Sierra and Plumas Counties to the north and west, Incline Village in Washoe County, Nevada to the east, and Nevada and Placer Counties to the east and south. Tahoe Forest Hospital is the only acute care hospital within the District's boundaries, its primary service area. There are no other acute care hospitals, urgent care centers or skilled nursing facilities located within the District. In 2003, a free standing ambulatory surgery center owned and operated by physicians practicing at the Health Facilities began operating in the Town of Truckee. In 2010, the District became a 51% partner in this ambulatory surgery center.

The closest acute care hospitals are located approximately 35 miles northeast of Tahoe Forest Hospital in the city of Reno, Nevada. The next closest acute care hospitals located within the state of California are Sutter Auburn Faith Hospital (65 miles southwest), a 105-bed acute care hospital, located in the City of Auburn, Sierra Nevada Memorial Hospital (50 miles southwest), a 107-bed acute care hospital, located in Nevada City, California, and Eastern Plumas Hospital (50 miles northwest), a 24-bed (9 acute care and 27 long-term care) rural hospital, located in Portola, California.

Located within the Health Facilities' service area, for which the Health Facilities are the nearest acute care hospitals, are fifteen winter ski resorts, including Squaw Valley, Sugar Bowl, Soda Springs, Northstar at Tahoe and Alpine Meadows, among others. For services not provided at the Health Facilities, patients are usually referred to Prime Healthcare Services - Reno or Renown Medical Center, both located in Reno, Nevada or to UC Davis Medical Center located in Sacramento, California. Services not currently provided at the Health Facilities include neonatal ICU and cardiology surgery, among others.

Third-Party Payments

The District participates in the Medicare and Medi-Cal/Medicaid programs. The percentage of gross patient revenues derived from Medicare, Medi-Cal/Medicaid, managed care contracts and commercial insurance for each of the past five fiscal years ended June 30, 2014, and for the six-month period ended December 31, 2013 and 2014, is set forth below.

	Percent of Gross Patient Service Revenue Fiscal Year Ended June 30					Six Months Ended Dec. 31	
	2010	2011	2012	2013	2014	2013	2014
Medicare	30%	32%	34%	33%	34%	34%	37%
Medi-Cal/Medicaid[(1)]	9	10	11	15	14	12	18
Commercial, HMO, PPO & Private	61	58	55	52	52	54	45
Total	100%	100%	100%	100%	100%	100%	100%

Source: District records.
(1) Less than 1% of the District's revenues are derived from the Nevada Medicaid program.

Medicare is a federal program, administered by the Centers for Medicare and Medicaid Services available to individuals age 65 or over and certain disabled persons. Medicaid is a federal and state program, known as Medi-Cal in California, under which the Health Facilities furnish services to program eligible persons.

The Health Facilities' inpatient acute and outpatient services rendered to Medicare program beneficiaries are reimbursed under a cost reimbursement methodology pursuant to their designation as a "Critical Access Hospital." Effective July 1, 2007, Tahoe Forest Hospital received Critical Access Hospital Designation. Costs incurred are reimbursed at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. The District's Medicare cost reports have been audited by the Medicare fiscal intermediary through June 30, 2012, and final settlements have been received through that date.

Inpatient services rendered to Medi-Cal program beneficiaries are reimbursed based upon a rate per day. Outpatient services rendered are paid at prospectively determined rates per procedure. Medi-Cal cost reports have been audited by the Medi-Cal fiscal intermediary through June 30, 2012, and final settlements have been received through that date.

Adults who do not meet Medi-Cal eligibility criteria but who are medically indigent, as defined by California law, are eligible for medical services under the state-funded "MIA" program. Placer County administers the MIA program by contracting with providers on a per diem basis for patients requiring inpatient services. Nevada County contracts with the State of California to administer its MIA program, with the District receiving reimbursement on a cost-based methodology for patients treated at the Health Facilities. The MIA contract accounts for less than 1% of gross patient revenues of the District.

The District has contracts with approximately 42 prepaid plans and preferred provider discount contractors which comprise approximately 45% of its revenues for the fiscal year ended June 30, 2014. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established rates and prospectively determined daily rates.

Inpatient services rendered to Medi-Cal program beneficiaries are reimbursed based upon a cost reimbursement methodology. Reimbursement is at tentative rates with final settlement determined after submission of annual cost reports by the District and audits by the Medi-Cal fiscal intermediary. Medi-Cal cost reports have been audited by the Medi-Cal fiscal intermediary through June 30, 2013, and final settlements have been received through that date. Outpatient services rendered are paid at prospectively determined rates per procedure.

Adults who do not meet Medi-Cal eligibility criteria but who are medically indigent, as defined by California law, are eligible for medical services under the state-funded "MIA" program. The County of Placer administers the MIA program by contracting with providers on a per diem basis for patients requiring inpatient services. Nevada County contracts with the State of California to administer its MIA program, with the District receiving reimbursement on a cost-based methodology for patients treated at its facilities. The MIA contract accounts for approximately 1% of gross patient revenues of the District.

Public and Professional Liability Insurance Considerations

The District currently carries comprehensive liability insurance through a pooled self-insurance program insuring the Health Facilities and all District employees, while acting within the scope of their duties, against malpractice liability with limits of $10,000,000 per claim and $20,000,000 annual aggregate. The District's current comprehensive liability insurance contract is in continuous effect until June 30, 2015. The District contracts such insurance through a joint powers authority ("BETA Healthcare Group") under California law authorizing governmental agencies, such as local health care districts, to join together for insurance purposes. Currently, 102 participants representing health care districts, nonprofit healthcare providers, city and county hospitals participate in BETA Healthcare Group. Coverage is on a claims-made basis.

BETA Healthcare Group is funded by monthly contributions paid by the health care providers participating in BETA Healthcare Group. The contributions are used to fund a reserve for expected losses to be paid by BETA Healthcare Group on a pooled, self-insured basis. The amount of the monthly contribution to be paid by a participant is based on independent actuarial computations taking into account factors such as, among others, total number of beds, outpatient and inpatient visits, surgeries, deductible and loss experience of the participant. The reserve for claims and

claims expenses has been determined using the developed loss and loss expense method. For the fiscal year ended June 30, 2014, the District paid $468,896 in net contributions to BETA Healthcare Group.

At June 30, 2014, BETA Healthcare Group had a reserve for claims and claims expenses relating to the District of $46,628. For the fiscal year ended June 30, 2014, BETA Healthcare Group paid claims and claims expenses on behalf of the District totaling $71,847.

The District is unaware of any claim paid on its behalf which was not covered by insurance. There are no material malpractice or professional liability claims or lawsuits now pending against the District which exceed insurance coverage. The District does not currently have any pending malpractice or professional liability claims or lawsuits for compensatory damages not covered by insurance. In California, district health facilities like the Health Facilities are not subject to punitive damage awards. Property damage is covered by Driver Alliant Insurance Services.

The District does not maintain separate flood insurance coverage or earthquake insurance covering its Health Facilities against damages caused by flooding or seismic activity. The District is self-insured for employee medical, dental and vision insurance and for workers' compensation losses.

Employee Retirement Plans

The District does not participate in the California Public Employees' Retirement System (CalPERS) or any other defined benefit plan.

The District has a defined contribution pension plan covering any employee who completes 1,000 hours of service in a calendar year. The District is required to make annual contributions equal to 3% of each employee's annual compensation plus 3% of each employee's annual compensation in excess of the social security tax wage base. Employee contributions are voluntary and limited to 10% of an employee's annual compensation.

The District also offers its employees a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The plan, available to all employees, permits them to defer a portion of their current salary until future years. The District matches participation deferrals up to 3% to 7% of earnings for full-time and regular part-time participants. Employee contributions are limited to 100% of total employee compensation or $17,500, whichever is less. Since January 1, 2006, the employer matching contributions under this deferred compensation plan are deposited into employee accounts in the money purchase pension plan.

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

Largest Employers

The Town of Truckee and the Counties enjoy a diverse labor pool as a result of their role as a destination for recreation, regional manufacturing, service and retail center. Nevada County's recreation dominated employment distribution affects the Town of Truckee's job market and unemployment rates. Placer County is a growing regional manufacturing center that provides ample land zoned for industrial use that is governed by an industrial development policy that promotes growth in industrial expansion and employment opportunities and is one of the fastest growing business communities in California at this time. The following table summarizes the ten largest private and public employers located in or around the District.

Largest Employers

Company	Product/Service	Employees*
Squaw Valley & Alpine Resort	Ski Resort	2,369
Tahoe Forest Hospital	Health Care	554
Tahoe Truckee Unified School District	School District	520
Boreal Mountain Resort	Ski Resort	475
Tahoe Donner	Ski Resort	400
Resort at Squaw Creek	Resort Hotel	330
Ritz-Carlton, Lake Tahoe	Resort Hotel	260
Northstar California	Ski Resort	250
Sugar Bowl Resort	Ski Resort	250
Clear Capital	Real Estate Appraiser	237

Source: Placer County Economic Development, California Employment Development Department and the District.
* During peak season.

Service Area Economy

During the past twenty-four years the populations of Nevada County and Placer County have increased 24% and 112%, respectively, while the population of the State of California has increased 29% over the same period. Population figures as reported for the 1990, 2000 and 2010 census reports and estimated for 2014 for Nevada County, Placer County and the State of California (the Town of Truckee does not have population data for 1990 due to it being unincorporated at that time), are as follows:

	1990	2000	2010	2014	1990-2014 % Change
Town of Truckee	N/A	13,864	16,180	15,981	N/A
Nevada County	78,510	92,033	98,764	97,225	24%
Placer County	172,796	248,399	348,432	366,115	112%
California	29,760,021	33,871,648	37,253,956	38,340,074	29%

Source: California State Department of Finance. The 1990, 2000 and 2010 are census figures reported as of April 1 in each of those years and 2010 figures are estimates by the Department of Finance reported as of January 1, 2014.
N/A: Not available

The District's boundaries and the Tahoe Forest Hospital service area, which extends beyond the District's boundaries, incorporate a good portion of both Nevada and Placer Counties. Although the seasonality of many of the major employers in this area contributes to the area's unemployment data, the Town of Truckee, Placer County and Nevada County unemployment percentages are below the State of California's average. This is in large part attributed to the diversity of employment in these areas. The December 2014 labor market can be divided into the following sectors:

	Town of Truckee	Nevada County	Placer County	State of California
Civilian Labor Force	9,490	49,070	178,700	18,726,400
Employed	9.050	46,360	169,300	17,474,600
Unemployed	440	2,710	9,400	1,251,800
Percentage Unemployment	4.6%	5.5%	5.2%	6.7%

Source: State Employment Development Department, December 2014.

Affiliations

Tahoe Forest Health System Foundation. The Tahoe Forest Health System Foundation (the "Foundation") was organized in 1987 and is a California nonprofit 501(c)(3) public benefit corporation organized for the purpose of soliciting and distributing contributions and property to facilitate the building of a healthier community and the ongoing enhancement of the District's health care system. The Foundation contributed a total of approximately $6 million in community wide contributions towards the construction and equipping of the Western Addition. Donations to the Foundation are passed directly to the District, either to restricted purchases or programs per the donor's directions or retained in the Foundation's general funds. Of those funds, 15% are withheld each year and will be distributed to the District in amounts and in periods determined by the Foundation's board of trustees, who may also restrict the use of the general funds for plant replacement or expansion or other specific purposes. The Foundation has a membership of over 5,000 donors and a governing board of five trustees. The Foundation has raised just over $11.3 million for Tahoe Forest Hospital since 2000 and distributed approximately $1,135,000 to the District over the past two fiscal years. The Foundation is not liable for repayment of the Bonds.

Incline Village Community Hospital Foundation. The Incline Village Community Hospital Foundation (the "Incline Village Foundation") was organized in 2004 and is an independent Nevada nonprofit 501(c)(3) corporation organized for the purpose of soliciting and distributing contributions and property for the benefit of the Incline Village Community Hospital. The Incline Village Foundation concluded a capital campaign that contributed a total of approximately $1.5 million in community wide contributions towards the construction and equipping of the emergency room expansion and remodel of Incline Village Community Hospital. A second capital campaign generated approximately $500,000 in contributions to renovate and equip Incline Village Community Hospital's imaging department. The Incline Village Foundation's general funds, which represent its unrestricted resources, will be distributed to the District in amounts and in periods determined by the Incline Village Foundation's board of trustees, who may also restrict the use of the general funds for plant replacement or expansion or other specific purposes. The Incline Village Foundation has a membership of over 1,500 donors and a governing board of approximately thirteen trustees. The Incline Village Foundation has raised just over $3.6 million for Incline Village Community Hospital improvements since 2004 and distributed approximately $1,120,000 to the District over the past two fiscal years. The Incline Village Foundation is not liable for repayment of the Bonds.

Tahoe Forest Hospital Auxiliary. The Tahoe Forest Hospital Auxiliary (the "Auxiliary") was formed in 1978 and has been an active participant in the delivery of healthcare services at Tahoe Forest Hospital since that time. The Auxiliary provides volunteer support to the Health Facilities in several areas, including fundraising, office staff assistance, operating of the gift shop, the thrift shop, staffing of health fairs, the Health Facilities' lobby, assisting patients, among other services. Auxiliary volunteers provide in excess of 10,000 hours annually in support of the Health Facilities and their patients. The Auxiliary is not liable for repayment of the Bonds.

Tahoe Institute for Rural Health Research. The Tahoe Institute for Rural Health Research (the "Research Institute") was formed in 2009 by the District as a California nonprofit public benefit corporation and has applied to the Internal Revenue Service for a determination of charitable, exempt status under Sections 501(a) and 501(c)(3) of the Code. The District is the sole member of the Research Institute. It is anticipated that the Research Institute will be a vehicle through which scientific research and collaboration with medical practitioners will produce innovative solutions for rural health care issues. The Research Institute is not liable for repayment of the Bonds.

UC Davis Health System. The District has entered into a participation and license agreement with the UC Davis Health System pursuant to its UC Davis Cancer Care Network to provide cancer care expertise and support to the District and to patients treated at the District's cancer center facilities. Advanced cancer therapies and clinical trial opportunities are made available to oncology patients treated at the Cancer Center. The affiliated status affords the District expertise, technology and training opportunities not otherwise available to its oncology programs. The District is also a site for the UC Davis Rural Prime Program that, among other benefits, provides access to ongoing training and support for over twenty of the District's medical staff members who serve on the volunteer medical staff of UC Davis Medical Center located in Sacramento, California. The Tahoe Institute for Rural Health Network has also entered into a separate affiliation agreement with UC Davis Health System for the sharing of resources relating to research opportunities. The UC Davis Health System is not liable for payment of the Bonds.

Other Affiliations. The District contracts with various other medical providers to provide clinical and professional services in the areas of radiology, pathology, anesthesia, emergency medicine, and mobile lithotripsy.

The District plans for and evaluates potential affiliations as part of its overall strategic planning. Tahoe Forest Hospital has a number of training affiliations with various colleges and educational institutions to advance its employees' training in medicine, nursing and other ancillary medical professional fields. Some of these affiliations include: University of Nevada, Reno, Stanford, California State University at Chico, Feather River College, Sierra College, Northern California Training Institute, University of Vermont, Touro University, Midwestern University, University of Nevada at Las Vegas, and University of St. Francis. No other affiliation agreements are in place and no serious discussions are occurring with other potential affiliation partners.

CERTAIN FINANCIAL INFORMATION

Financial Statements

The following summary of statements of revenues, expenses and excess of revenues over expenses of the District for each of the five fiscal years ended June 30, 2014, were prepared from audited financial statements of the District, of which the 2013 and 2014 fiscal years appear in Appendix B to this Official Statement. These summaries should be read in conjunction with the financial statements and notes thereto (which are an integral part of the financial statements) included in Appendix B to this Official Statement.

The summaries of statements of revenues, expenses and excess of revenues over expenses for the six-month periods ended December 31, 2013 and 2014, are unaudited and have been obtained from unaudited financial statements of the District. These financial statements have been prepared in accordance with generally accepted accounting principles on a basis consistent with the accounting policies reflected in the audited financial statements of the District presented below. They do not, however, include all of the information and footnotes required by generally accepted accounting principles for complete financial statements. In the opinion of management, the unaudited financial statements reflect all significant adjustments (which are of a normal, recurring nature) necessary for a fair presentation of the results for the interim periods presented. Operating results for the interim periods presented are not necessarily indicative of the results that may be expected for any other interim period or for the year as a whole.

	Fiscal Year Ended June 30					Six Months Ended Dec. 31	
(000's Omitted)	2010 (Audited)	2011 (Audited)	2012 (Audited)	2013 (Audited)	2014 (Audited)	2013 (Unaudited)	2014 (Unaudited)
Net Patient Revenue	$ 92,422	$ 94,324	$ 99,795	$101,567	$107,664	$55,290	$57,467
Other Revenue	6,335	6,596	6,711	6,142	6,711	8,722	8,965
Total Operating Revenues	98,757	100,920	106,506	107,709	114,375	64,012	66,432
Salaries, Benefits & Professional Fees	63,097	65,941	71,572	76,573	79,931	31,337	31,344
Depreciation & Amortization	5,303	5,372	4,966	7,239	8,642	4,462	4,690
Other Operating Expenses	25,278	26,894	26,614	29,658	31,694	27,403	30,709
Total Operating Expenses	93,678	98,207	103,152	113,470	120,267	63,202	66,743
Operating Income (Loss)	5,079	2,713	3,354	(5,761)	(5,892)	810	(311)
Net Nonoperating Revenues	4,427	3,695	4,642	7,335	5,243	186	330
Excess of Revenues Over Expenses [(1)]	$ 9,506	$ 6,408	$ 7,996	$ 1,574	$ (649)	$ 996	$ 19
Capital Contributions	131	159	145	395	668	55	0
Impairment Losses	0	0	0	(5,679)	0	0	0
Increase (Decrease) in Net Position	$ 9,637	$ 6,567	$ 8,141	$ (3,709)	$ 19	$ 1,051	$ 19

Sources: Audited and unaudited financial statements of the District, as indicated above.
(1) Represented in the audited financials as Income Before Other Revenues, Expenses, Gains and Losses.

Management's Analysis of Financial Performance

The District's audited excess of revenues over expenses for the fiscal year ended June 30, 2014, was $(649,000), which is approximately $2,223,000 below results for the fiscal year ended June 30, 2013. Over the past five years, the District's excess of revenues over expenses has averaged approximately $4,967,000, per annum. The District's fiscal year 2015 operating plan and budget provides for a minus 2.7% return on equity and a 1.0% return on gross revenue. However, projected fiscal year 2015 return on equity is targeting 0.0% and return on gross revenue is targeting 2.1%. The District Board approved the reduced return on equity based on the additional depreciation costs anticipated with the completion of the Western Addition to Tahoe Forest Hospital and several general obligation bond (Measure C) projects.

Over the past several years, the District has consistently maintained a market share of approximately 70% for its service area. This strong market dominance along with a combined Medicare/Medicaid payor mix of 48% as of the fiscal year ended June 30, 2014, have provided positive margins for the District over those years. The District's service area has enjoyed a growth rate of more than twice that of the state of California over the past twenty-five years and has generally experienced lower unemployment rates than the state of California as a whole. The economic base of the District's service area continues to remain strong, with available jobs growing in market segments other than simply the recreation and resort industries.

The District maintains a liquidity position with its day's cash on hand of 142 days as of December 31, 2014, and a good leverage position as indicated by its present debt to capital ratio of 27% for revenue based debt.

Over the past ten years, the District has made substantial investments in its Health Facilities through the construction of a $5,700,000 medical office complex adjacent to Tahoe Forest Hospital and the purchase of an acute care health facility located in nearby Incline Village, Nevada, for $3,500,000. Additionally, through the issuance of voter approved general obligation bonds payable from *ad valorem* taxes, the District has financed and refinanced significant improvements to its campus and the Health Facilities. The District has issued three series of such general obligation bonds that, in the aggregate, total $98,500,000. The first authorized issuance was in August of 2008 in the principal amount of $29,400,000. The purpose of these general obligation bonds was to fund portions of the master planning, design and/or construction and equipping of five project components. Proceeds from these general obligation bonds were used to fund the master planning costs associated with these projects, architectural and engineering costs associated with most of these projects and construction costs relating to two of these projects. The second issuance in August 2010, in the amount of $43,000,000 was used to fund approximately $39,300,000 in costs associated with preconstruction, soft costs and construction costs relating to several projects including: radiology upgrades, a portion of the new cancer center facility, skilled nursing facility improvements, central plant upgrades, south building improvements, birthing center improvements, dietary relocation, medical records, respiratory therapy, emergency room and sterile processing improvements. Project-related expenditures funded or to be funded with proceeds of the 2010 general obligation bonds are projected to be incurred through December 2015. The third issuance, in the amount of $26,100,000 was used to fund approximately $25,950,000 in costs to complete campus-wide master planning, additional upgrades to radiology services, completion of a new cancer center, and other campus infill projects, upgrades and relocations.

Both Tahoe Forest Hospital and Incline Village Community Hospital are designated as Critical Access Hospitals, and they are the only acute care hospitals located within the District's primary service area. The District operates the closest hospitals to twelve of the most active winter ski resorts in California.

The District desires to remain an independently governed community health services provider that delivers highly competent and personalized emergency, primary, and prevention services with a focus on operational excellence and innovation. The District's Mission is to be "The Best Mountain Community Health System in the Nation."

See also "Management's Discussion and Analysis" in the financial statements for the District set forth in Appendix B hereto.

Capitalization

Capitalization of the District as of June 30, 2014 and pro-forma capitalization as of June 30, 2014, as adjusted to reflect issuance of the 2015 Bonds and the redemption of the 2006 Bonds as if such issuance and redemption had occurred on June 30, 2014, are set forth in the following table:

	As of June 30, 2014	
(000's omitted)	**Actual**	**Proforma** *
Long-term Debt:		
2015 Bonds	0	$
2006 Bonds	$ 23,975	0
2002 Bonds	9,865	9,865
Other Long-term Debt	3,752	3,752
Total Long-term Debt	37,592	(____)
Less Current Maturities	(2,245)	
Net Long-term Debt	35,347	
Fund Balances (unrestricted)	96,510	96,510
Total Capitalization	$131,857	_____
Net Long-term Debt as a Percentage of Total Capitalization	27%	__%

Source: Audited financial statements of the District. The above-listed debt excludes the District's general obligation bonds as this debt is not secured by revenues and is repaid from special *ad valorem* property taxes.

* Preliminary, subject to change

Debt Service Coverage Ratio

The following table provides the actual and proforma debt service coverage ratio for all Long-Term Indebtedness of the District for the five-year period ended June 30, 2014. The Proforma debt service coverage ratio is calculated as if the 2015 Bonds were outstanding and the 2006 Bonds were not outstanding at the beginning of each of those years, based on the ratio of Income Available for Debt Service to Maximum Annual Debt Service on the proposed 2015 Bonds and other revenue based Long-Term Indebtedness of the District (excepting the 2006 Bonds). Also excluded from the table are *ad valorem* taxes received by the District for repayment of voter-approved general obligation bonds and the debt service related to such general obligation bonds.

(000's omitted)	Fiscal Year Ended June 30 2010	2011	2012	2013	2014
Excess of Revenues Over Expenses[1]	$ 9,506	$ 6,408	$ 7,996	$ 1,574	$ (649)
Add: Depreciation and Amortization	5,304	5,372	4,966	7,239	8,642
Interest Expense	3,357	4,867	4,484	4,448	5,390
Less: General Obligation Bond Tax Revenues	(1,590)	(2,918)	(3,223)	(4,987)	(4,744)
Income Available to Meet Debt Service	$16,577	$13,729	$14,223	$ 8,274	$8,639
Actual Debt Service	$ 4,559	$ 3,723	$ 3,095	$ 4,241	$4,305
Actual Debt Service Coverage Ratio	3.64x	3.69x	4.60x	1.95x	2.01x
Proforma Maximum Annual Debt Service[2] *					
Proforma Debt Service Coverage Ratio *					

Source: Audited financial statements of the District.
(1) Based on the District's fiscal year. Represented in the audited financial statements as Income Before Other Revenues, Expenses, Gains and Losses.
(2) Assumes that interest accrues at 3.544% per annum on the variable rate 2002 Bonds, the swap rate applicable to the 2002 Bonds.
* Preliminary, subject to change.

The District's Maximum Annual Debt Service, estimated to be approximately $_____, occurs in the District's fiscal year ending June 30, 20__. After that fiscal year, the District's Maximum Annual Debt Service is reduced to approximately $_____.

Total Unrestricted Funds and Days Cash on Hand

The following table provides total unrestricted funds and day's cash on hand for the District as of June 30, 2010 through June 30, 2014, and as of December 31, 2014. Marketable securities are carried at market.

(000's omitted)	As of June 30 2010 (Audited)	2011 (Audited)	2012 (Audited)	2013 (Audited)	2014 (Audited)	As of Dec. 31 2014 (Unaudited)
Cash and Cash Equivalents	$16,324	$16,019	$16,839	$10,345	$10,316	$ 5,901
Board Designated Funds	39,024	38,919	40,408	34,203	41,414	40,680
Total Unrestricted Funds	$55,348	$54,938	$57,247	$44,548	$51,730	$46,581
Daily Expenses	$ 242	$ 254	$ 281	$ 303	$ 321	329
Days Cash on Hand[1]	229	216	204	147	161	142

Source: Audited and unaudited financial statements of the District, as indicated above.
(1) Determined by adding cash and cash equivalents plus board designated funds for capital replacement; and dividing that sum by total operating expenses minus depreciation and amortization expenses plus interest expense divided by 365 or 184 for the interim period as of December 31, 2014 (daily expenses).

Capital Expenditures

Aside from construction and equipping costs related to the Project to be funded from the general obligation bonds, total capital expenditures of approximately $17,606,000 are expected to occur over the next three years beginning in the fiscal year ended June 30, 2015. As for the other planned capital expenditures over the next three years, they represent regular annual expenditures made in connection with the normal routine maintenance and equipment replacement for the District's Health Facilities, information technology expenditures and equipment related to the Project that cannot be funded with general obligation bond proceeds. These capital expenditures are planned to be funded from capital lease obligations, cash reserves and community based contributions. The District does not contemplate the issuance of additional revenue bonds or general obligation bonds to fund new money projects over the next three years.

TAHOE FOREST HEALTH SYSTEM

COMMUNITY BENEFIT COMMITTEE
AGENDA

Friday, March 27, 2015 at 1:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Karen Sessler, M.D., Board Member

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

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

5. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

5.1. **Committee Charter and Goals**..... ATTACHMENT
The Committee's charter and board approved goals identified through the community needs assessment will be reviewed and discussed.

5.2. **Committee Membership**
Discussion will take place regarding composition of this new board committee.

5.3. **Board Reviewed Priorities and Community Health Improvement Methods**..... ATTACHMENT
2015 TFHD Board-endorsed Community Improvement Issue Priorities will be discussed.

- 5.3.1. Optimizing Community Health
- 5.3.2. Substance Use and Abuse
- 5.3.3. Mental/Behavioral Health
- 5.3.4. Access to Care and Preventive/Primary Health Services

6. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

7. AGENDA INPUT FOR NEXT COMMITTEE MEETING

8. NEXT MEETING DATE

9. ADJOURN

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

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

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

Tahoe Forest Hospital District

Board of Directors Meeting Evaluation Form

Date: _____

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

Please provide further feedback here: