RESPONSE #1

TO QUESTIONS

SUBMITTED DECEMBER 22, 2016

BY

VIRGINIA DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1

and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance

Wellmont Health System

Date: December 30, 2016

V. Additional Information

In addition to the information requested above in accordance with Virginia's Rules and Regulations Governing Cooperative Agreements, the Commissioner requests the information as set forth below and deems such information necessary to her assessment of whether to approve the proposed cooperative agreement.

A. Financial (in detail for each facility)

1. Please describe how any bond covenants presently encumber any Virginia facility.MSHA

RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit A-1A MSHA Summary of Bond Covenants for Virginia Facilities

WHS RESPONSE: The only WHS properties included in the Deed of Trust for the bonds are Holston Valley Medical Center in Kingsport, TN and Bristol Regional Medical Center in Bristol, TN. The revenues of all operations of the WHS Obligated Group are pledged as general collateral.

2. Please describe discussions (e.g., meetings, conversations) the applicants have had with any and each bond rating agency or rating official concerning this merger or Application.

MSHA RESPONSE: MSHA conducted its annual meetings with the rating agencies (Moody's, Standard and Poor's, and Fitch Ratings) on December 3 and 4, 2015. The information contained in **Exhibit A-2A** was provided by MSHA to the rating agencies at that time as an update and overview of the proposed merger.

MSHA believes that **Exhibit A-2A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit A-2A MSHA Information Provided to Rating Agencies – **PROPRIETARY**

WHS RESPONSE: WHS conducted its annual meetings with the rating agencies (Standard and Poor's and Fitch Ratings) on January 16, 2015, March 23, 2015, and February 3, 2016. The information contained in **Exhibit A-2B** was provided by WHS to the rating agencies at that time as an update and overview of the proposed merger.

WHS believes that the documents contained in **Exhibit A-2B** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the

Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit A-2B WHS Information Provided to Rating Agencies – **PROPRIETARY**

3. Please provide the names, positions and contact information of any bond rating agency or rating official that has been communicated with concerning this merger or Application.

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit A-3A Mountain States Rating Agency Contact Information

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit A-3B WHS Contact Information for Bond Agency or Rating Officials

4. Provide audited versions of all schedules presented in the audited financial statements at MSHA and WHS for the year end June 30, 2016.

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit A-4A MSHA FY16 Audited Financial Statements

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit A-4B WHS FY16 Audited Financial Statements

B. Graduate Medical Education

Please provide all reports issued by the Accreditation Council for Graduate Medical Education (ACGME) or individual residency review committees for each residency and fellowship program at any NHS facility in the past seven (7) years.

MSHA RESPONSE: Graduate Medical Education (GME) at MSHA collaborates with three (3) different institutions – East Tennessee State University (Johnson City Medical Center and Franklin Woods Community Hospital), Lincoln Memorial University (Norton Community Hospital and Indian Path Medical Center), and Virginia College of Osteopathic Medicine (Johnston Memorial Hospital).

Residents from Johnson City Medical Center may rotate to Franklin Woods Community Hospital, but because Franklin Woods does not have a residency program or program cap, these rotations are not separately tracked and are non-allowable for reimbursement by Medicare/Medicaid on cost reports. The requested information is provided in the Exhibits listed below.

MSHA believes that **Exhibits B-1A through B-1J** are proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

Johnson City Medical Center and Franklin Woods Community Hospital

- Exhibit B-1A MSHA ACGME Reports JCMC & FWCH, ETSU **PROPRIETARY**

Norton Community Hospital and Indian Path Medical Center

- Exhibit B-1B MSHA ACGME Reports_NCH & IPMC Corrective Action Plan 2009 **PROPRIETARY**
- Exhibit B-1C MSHA ACGME Reports_NCH & IPMC Norton IM Cont Appr 2009 AOA **PROPRIETARY**
- Exhibit B-1D MSHA ACGME Reports_NCH & IPMC 2011 AOA – Approval for Additional FTE Slots **PROPRIETARY**
- Exhibit B-1E MSHA ACGME Reports_NCH & IPMC Residency Slot Award Notification of Additional DGME **PROPRIETARY**
- Exhibit B-1F MSHA ACGME Reports_NCH & IPMC Program 138301 Norton Community Hospital Crosswalk Final **PROPRIETARY**
- Exhibit B-1G MSHA ACGME Reports_NCH & IPMC Institutional Inspection Cont Approval 136843 **PROPRIETARY**
- Exhibit B-1H MSHA ACGME Reports_NCH & IPMC NCH SI ACGME Notification Letter **PROPRIETARY**

Johnston Memorial Hospital

- Exhibit B-1I MSHA AOA PRTC_JMH_Family Medicine **PROPRIETARY**
- Exhibit B-1J MSHA AOA PRTC_JMH_Internal Medicine **PROPRIETARY**

WHS RESPONSE: WHS maintains academic graduate medical education affiliations for its residency programs with two universities. Lincoln Memorial University's DeBusk College of Osteopathic Medicine is the academic partner for both the Wellmont Holston Valley Medical Center Orthopedic Surgery Residency Program in Kingsport, Tennessee and the Wellmont Health System Lonesome Pine Hospital Family Medicine Residency Program in Big Stone Gap, Virginia. WHS also works with East Tennessee State University to operate family medicine and internal medicine residency programs at Bristol Regional Medical Center in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee. The referenced residency programs represent a combined total of 96.22, with caps of 34.8 at Bristol Regional Medical Center, 41.14 at Holston Valley Medical Center and

20.28 at Lonesome Pine Hospital. WHS also maintains a number of agreements with institutions of higher learning and facilitates clinical learning experiences for various training programs for various health professions, as well as medical student rotations. In particular, Wellmont's hospitals serve as a core training site for 3rd and 4th year medical students from Lincoln Memorial University's DeBusk College of Medicine to complete their training.

WHS believes that **Exhibits B-1K through B-1R** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

WHS ACGME Reports

- EXHIBIT B-1K — ACGME Institution Accreditation Letter for Holston Valley Medical Center – **PROPRIETARY**
- EXHIBIT B-1L — ACGME Program Accreditation Site Visit Notification Letter for Orthopaedic Surgery Program at Holston Valley Medical Center – **PROPRIETARY**
- EXHIBIT B-1M — ACGME - Program Pre-Accreditation Status for Orthopaedic Surgery Program at Holston Valley Medical Center – **PROPRIETARY**
- EXHIBIT B-1N — AOA Program Director Approval for Orthopaedic Surgery Residency Program at Holston Valley Medical Center – **PROPRIETARY**
- EXHIBIT B-1O — AOA Family Practice Training Program Approval at Lonesome Pine – **PROPRIETARY**
- EXHIBIT B-1P — AOA Continued Approval for Family Practice Program at Lonesome Pine – **PROPRIETARY**
- EXHIBIT B-1Q — ACGME Continued Accreditation Reports – **PROPRIETARY**
- EXHIBIT B-1R — AOA New Program Approval for Orthopedic Surgery Program at Holston Valley Medical Center – **PROPRIETARY**

Please provide all schedules from the Medicare Cost Reports for the two (2) year historical baseline period detailing graduate medical education activity at any facility that will be part of the NHS. Transcribe these schedules into an Excel file.

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit B-2A — MSHA Medicare Cost Report Schedules

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit B-2B WHS Medicare Cost Report Schedules

Please list all residency and fellowship programs, identifying the sponsoring institutions and individuals responsible for each residency and fellowship program. Provide contact information for all responsible individuals.

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit B-3A MSHA Residency and Fellowship Programs and Contact Info: ETSU, JMH and NCH

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit B-3B WHS Residency and Fellowship Programs
- Exhibit B-3C WHS Contact Information for Responsible Individuals

Please provide an organization chart for the graduate medical education (GME) programs currently in place. List the individuals, with their titles responsible for each residency and fellowship program displayed on the organization chart. Provide the contact information for these individuals.

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit B-4A MSHA GME Organizational Chart for ETSU Programs
- Exhibit B-4B MSHA GME Organizational Chart for JMH
- Exhibit B-4C MSHA GME Organizational Chart for NCH

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit B-4D WHS - Lonesome Pine GME Organizational Chart
- Exhibit B-4E WHS - Holston Valley GME Organizational Chart
- Exhibit B-4F WHS ETSU Organizational Chart
- Exhibit B-4G WHS ACGME Membership List
- Exhibit B-4H WHS ETSU Program Contact Information

Please provide copies of affiliation agreements that exist related to the graduate medical education programs (residency and fellowship).

MSHA RESPONSE: The requested information is provided separately by MSHA.

MSHA believes that **Exhibit B-5A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit B-5A MSHA GME Affiliation Agreements – **PROPRIETARY**

WHS RESPONSE: The requested information is provided separately by WHS.

WHS believes that **Exhibit B-5B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit B-5B WHS GME Affiliation Agreements – **PROPRIETARY**
  - Bristol Regional Medical Center Affiliation Agreement
  - Holston Valley Medical Center Affiliation Agreement
  - Lincoln Memorial University - DeBusk College of Osteopathic Medicine Clinical Affiliation Agreement
  - Cincinnati Children's Hospital Medical Center Clinical Affiliation Agreement
  - Agreement with Holston Valley Surgery Center, LLC for Training of Orthopedic Surgery Residents
  - Agreement with Indian Path Medical Center for Training of Orthopedic Surgery Residents
  - Agreement with Johnson City Medical Center for Training of Orthopedic Surgery Residents
  - Agreement with Kingsport Day Surgery Center for Training of Orthopedic Surgery Residents
  - Sponsorship Agreement with Lincoln Memorial University - DeBusk College of Osteopathic Medicine
  - Agreement with Mountain Empire Surgery Center for Training of Orthopedic Surgery Residents

Provide a chart for all facilities showing the resident and fellow FTE positions by program and by location for the two (2) year historical baseline period and the YTD. Provide a five (5) year forecast of FTEs by program and by location. The historical numbers should tie to the Medicare Cost Report data requested above.

MSHA RESPONSE: The requested information is provided. MSHA does not have a five (5) year forecast of FTE's by program and by location.

INDEX OF DOCUMENTS:

- Exhibit B-6A MSHA Resident and Fellow FTEs 2014 to 2016

WHS RESPONSE: The requested information is provided. WHS does not have a five (5) year forecast of FTE's by program and by location.

INDEX OF DOCUMENTS:

- Exhibit B-6B WHS Residency and Fellowship Programs

Please provide two (2) year historical baseline period, YTD and a five (5) year financial forecast period investments by any facility that will be part of the NHS in graduate medical education programs by program and facility. Clearly demonstrate whether the investments proposed are incremental.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please provide detail of all present and planned relationships and affiliations of the NHS GME programs with Virginia institutions of higher education. Please provide the names, positions and contact information for the Virginia institutions concerning NHS GME programs.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Edward Via College of Osteopathic Medicine is located at Virginia Tech. Although this college is located outside the intended service area, are there any plans to develop academic or research programs at this or any Virginia institution of higher learning?

[The Parties are compiling the information requested and will provide it as soon as possible.]

C. Research

Provide the resumes of the individuals responsible for research at MSHA and WHS. Provide the organizational charts of each existing research program. Indicate in detail how the research programs will be consolidated without having harmful effects on their stated purposes.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Provide the revenues and expenses for the two (2) year historical baseline period, YTD, and the five (5) year forecast period for the core research budget. Detail how the core research budget will be financed. Clearly demonstrate whether the investments proposed are incremental or lump sum.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Describe by facility any charitable endowment available for medical research. List the amount of the endowment, the type of medical research supported, the year the endowment was received, its duration and when it is expected to culminate in findings.

MSHA RESPONSE: MSHA does not have any charitable endowments available for medical research.

WHS RESPONSE: WHS does not have any charitable endowments available for medical research.

Please provide a listing by facility of any research protocol presently in force at any NHS facility. List the principal investigator of the protocol (and provide contact information). List the NHS investigator (and provide contact information). List the research sponsor (and provide contact information). List the amount of financing from the sponsor and the duration of the research.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit C-4A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit C-4A MSHA Research Protocols – **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibits C-4B and 4C** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit C-4B WHS Research Protocol – **PROPRIETARY**
- Exhibit C-4C WHS Cardiovascular Associates Research Information – **PROPRIETARY**

Please provide all minutes of all committees which have evaluated informed consent and patient participation and protection for the two (2) year historical baseline period and YTD. Please describe in detail all collaborative effort in research with institutions located in Virginia.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please describe the future of the research program at each Virginia facility in the NHS.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Describe the strategy by which the NHS will offer research benefits to Virginia residents greater than already offered at other Virginia academic medical centers?

[The Parties are compiling the information requested and will provide it as soon as possible.]

For each research protocol list the number of patients and number of Virginia patients for the two (2) year historical baseline period.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Provide specific dollar amounts expected to be provided to research programs. Specify dollar amount, research program, issues studied and the expected outcome measures?

[The Parties are compiling the information requested and will provide it as soon as possible.]

D. Tertiary Programs

Please detail the utilization by DRG (using VHI and an equivalent Tennessee patient level data base) of Virginia patients from the Virginia geographic service area at each of the three (3) NHS tertiary hospitals in Tennessee and at other Virginia tertiary competitors including Carilion Clinic, Inova, UVA Health System, VCU Medical Center and Sentara Healthcare over the two (2) year historical baseline period.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please provide a DRG based definition of the tertiary services that each Applicant facility provides. This definition should be based on an assessment of DRGs that are uniquely or predominantly provided at an applicant's academic medical center and other Virginia academic medical centers.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please calculate the market share of tertiary service in the Virginia geographic market defined in the Application that is held by each NHS tertiary provider and each Virginia competitor.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Assess the strengths and weaknesses in the NHS tertiary program compared to Carilion Clinic, Inova, UVA Health System, VCU Health, and Sentara Healthcare. Be specific for each specialty and sub-specialty program. Describe the strategy by which the NHS will offer benefits to Virginia residents greater than already offered at other Virginia academic medical centers. Justify that investment in the Applicants' academic medical centers is more effective than investment in Virginia competitors.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Provide a detailed description of how NHS tertiary programs will be consolidated and improved. Provide a two (2) year historical baseline information for current state, YTD changes and the expected condition for the end of the five (5) year forecast period. Be specific.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Why are there no plans for locating tertiary care services in a Virginia hospital or other facility within the merged system?

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please provide a listing by diagnostic related grouping (DRG) of the number of Virginia Medicaid patients admitted to each of the three tertiary hospitals for the two (2) year historical baseline period and YTD.

JOINT RESPONSE: The requested information is provided. Note that Virginia providers are highlighted in yellow in the MSHA data.

INDEX OF DOCUMENTS:

- Exhibit D-7A MSHA DRGs of VA Medicaid Patients Admitted to Johnson City Medical Center
- Exhibit D-7B WHS DRGs of VA Medicaid Patients Admitted to Holston Valley Hospital and Medical Center and Bristol Regional Medical Center

Please provide a listing of all physicians and physician groups that provide tertiary specialty services at the three tertiary hospitals. Please provide contact information for each practice. For each practice, list all physicians by specialty and sub-specialty, practice and indicate which have accepted Virginia Medicaid patients during the two (2) year historical baseline period and for YTD, and provide patient volumes by physician.

[The Parties are compiling the information requested and will provide it as soon as possible.]

E. Medical Staff

Please provide copies of the existing medical staff by-laws for each Virginia facility of the NHS.

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit E-1A MSHA Medical Staff Bylaws of Dickenson Community Hospital and Norton Community Hospital
- Exhibit E-1B MSHA Medical Staff Bylaws of Johnston Memorial Hospital
- Exhibit E-1C MSHA Medical Staff Bylaws Russell County Medical Center
- Exhibit E-1D MSHA Medical Staff Bylaws of Smyth County Community Hospital

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

WHS Medical Staff Bylaws and Credentialing Policies

- Exhibit E-1E Lonesome Pine Credentialing Policies
- Exhibit E-1F Lonesome Pine Medical Staff Bylaws
- Exhibit E-1G Lonesome Pine Medical Staff Rules & Regulations

For the Virginia facilities, please provide a listing of medical staff members (name, credentials, age, unique physician identification number (UPIN), date of first appointment and specialty or board certifications held).

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please provide any report, memorandum or analysis of medical staff shortages developed in the five (5) year historical baseline period by WHS and by MSHA.

MSHA RESPONSE: The requested information is provided separately by MSHA. The reports include community needs assessment (internal and external), hospital physician alignment committee (HPAC) analysis, and strategic plans.

MSHA believes that **Exhibit E-3A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit E-3A MSHA Medical Staff Shortage Information – **PROPRIETARY**

WHS RESPONSE: The requested information is provided separately by WHS.

WHS believes that **Exhibit E-3B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit E-3B WHS Medical Staff Shortage Information – **PROPRIETARY**

Please provide a listing of employed medical staff full time equivalents (FTE's) for each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period.

MSHA RESPONSE: The requested information is provided separately by MSHA; however, MSHA does not forecast employed medical staff FTE's, so it is unable to provide five-year forecast data.

MSHA believes that **Exhibit E-4A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit E-4A MSHA Employed Medical Staff VA FTEs – **PROPRIETARY**

WHS RESPONSE: The requested information is provided separately by WHS; however, WHS does not forecast employed medical staff FTE's so it is unable to provide five-year forecast data.

WHS believes that **Exhibit E-4B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this proprietary, competitively sensitive Exhibit to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit E-4B List of WHS Employed Medical Staff at Virginia Facilities – **PROPRIETARY**

Provide documents relating to how past physician acquisitions and physician contractual agreements or affiliations have contributed to the NHS's ability to enter into risk based and/or value based contracts.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Consulting firms can typically conduct a physician needs assessment in 90 days. Please explain why this cannot be completed for Virginia facilities within 180 days post-merger?

[The Parties are compiling the information requested and will provide it as soon as possible.]

F. Exclusive Contracts and Other Contracts

Please provide a listing of any officer, board member, advisory board member, employee, and their immediate family members that are a party directly or through stock ownership to a contract with either Applicant or their subsidiaries. Please provide financial disclosure statements of these individuals filed during the five (5) year historical baseline period.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please provide a list of any exclusive contracts, by facility, for the provision of medical or healthcare services at each Virginia facility.

MSHA RESPONSE: The requested information is provided separately by MSHA.

MSHA believes that **Exhibit F-2A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit F-2A MSHA List of Exclusive Contracts – **PROPRIETARY**

WHS RESPONSE: The requested information is provided separately by WHS.

WHS believes that **Exhibit F-2B** is a proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit F-2B WHS List of Exclusive Contracts at Virginia Facilities – **PROPRIETARY**

Please provide a copy of all such exclusive contracts.

MSHA RESPONSE: The requested information is provided separately by MSHA.

MSHA believes that **Exhibit F-3A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

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- Exhibit F-3A MSHA Copies of Exclusive Contracts – **PROPRIETARY**

WHS RESPONSE: The requested information is provided separately by WHS.

WHS believes that **Exhibit F-3B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit F-3B WHS Copies of Exclusive Contracts – **PROPRIETARY**

Provide a list of all Virginia physicians with UPIN and contact information who operate under each exclusive contract. List the Virginia facilities where the physicians practice.

MSHA RESPONSE: The requested information is provided separately by MSHA.

MSHA believes that **Exhibit F-4A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit F-4A MSHA Virginia Physicians with Exclusive Contracts – **PROPRIETARY**

WHS RESPONSE: The requested information is provided separately by WHS.

WHS believes that **Exhibit F-4B** contains confidential information. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit F-4B Information for WHS's Virginia Physicians – **PROPRIETARY**

What existing groups, organizations, or associations will NHS work with or finance toward achieving the stated goals and commitments?

[The Parties are compiling the information requested and will provide it as soon as possible.]

G. Governance

The applicants state that the proposed system will be "locally governed." What is meant by "local"? How will it be ensured that the health concerns of local communities expressed demographically or by the communication of local leaders continue to be addressed after the merger and that local governance is maintained?

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please list all current board members of MSHA, WHS and NHS and board or advisory board members for each individual facility in Virginia. For each member listed provide the address of residence, phone number, email address, business position and address and business phone number. Provide their date of actual appointment to the board. Show committee service with date of committee service.

[The Parties are compiling the information requested and will provide it as soon as possible.]

What is the total number of MSHA board members? How many reside in Tennessee, in Virginia, or elsewhere?

MSHA RESPONSE: The MSHA Board of Directors is currently comprised of twelve (12) members. Eleven (11) members reside in Tennessee and one (1) member resides in Virginia. However, it should be noted that a thirteenth member of the MSHA Board resigned on August 5, 2015 due to new teaching commitments at Emory & Henry College. The MSHA Board elected not to replace the individual in anticipation of the proposed merger.

What is the total number of WHS board members? How many reside in Tennessee, in Virginia, or elsewhere?

WHS RESPONSE: The WHS Board of Directors is currently comprised of nineteen (19) members. Fourteen (14) members reside in Tennessee and five (5) members reside in Virginia.

Please provide all disclosure of conflict of interest statements that have been filed in the three (3) most recent years by any board member, executive officer or physician that operates under an exclusive contract with any health care facility.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Please provide detail and documents on the current and proposed legal corporate organizational structure of each Virginia facility.

[The Parties are compiling the information requested and will provide it as soon as possible.]

The mix of the board of directors and of senior management for the new system appears to parcel out duties equally between Mountain States Health Alliance and Wellmont Health System. How will the mix of the board of directors and senior management at NHS provide for a greater representation of Virginia facilities? Provide specific details..

[The Parties are compiling the information requested and will provide it as soon as possible.]

Will NHS Executive compensation be linked to performance metrics designed to ensure that the NHS addresses the unique healthcare challenges that exist in the Southwest Virginia community? If so, please describe the components of the executive compensation system that will be utilized. If not, please explain why.

[The Parties are compiling the information requested and will provide it as soon as possible.]

Provide a detailed plan, including an organization chart, for the streamlined management structure at the parent corporation and individual facility level.

[The Parties are compiling the information requested and will provide it as soon as possible.]

EXHIBIT LIST

Exhibit Number	Description
A-1A	MSHA Summary of Bond Covenants for Virginia Facilities
A-2A	MSHA Information Provided to Rating Agencies ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
A-2B	WHS Information Provided to Rating Agencies ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
A-3A	Mountain States Rating Agency Contact Information
A-3B	WHS Contact Information for Bond Agency or Rating Officials
A-4A	MSHA FY16 Audited Financial Statements
A-4B	WHS FY16 Audited Financial Statements
B-1A	MSHA ACGME Reports JCMC & FWCH, ETSU ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1B	MSHA ACGME Reports_NCH & IPMC Corrective Action Plan 2009 ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1C	MSHA ACGME Reports_NCH & IPMC Norton IM Cont Appr 2009 AOA ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1D	MSHA ACGME Reports_NCH & IPMC 2011 AOA – Approval for Additional FTE Slots ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

B-1E	MSHA ACGME Reports_NCH & IPMC Residency Slot Award Notification of Additional DGME ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1F	MSHA ACGME Reports_NCH & IPMC Program 138301 Norton Community Hospital Crosswalk Final ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1G	MSHA ACGME Reports_NCH & IPMC Institutional Inspection Cont Approval 136843 ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1H	MSHA ACGME Reports_NCH & IPMC NCH SI ACGME Notification Letter ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1I	MSHA AOA PRTC_JMH_Family Medicine ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1J	MSHA AOA PRTC_JMH_Internal Medicine ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1K	ACGME Institution Accreditation Letter for Holston Valley Medical Center ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1L	ACGME Program Accreditation Site Visit Notification Letter for Orthopaedic Surgery Program at Holston Valley Medical Center ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

B-1M	ACGME - Program Pre-Accreditation Status for Orthopaedic Surgery Program at Holston Valley Medical Center ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1N	AOA Program Director Approval for Orthopaedic Surgery Residency Program at Holston Valley Medical Center ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1O	AOA Family Practice Training Program Approval at Lonesome Pine ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1P	AOA Continued Approval for Family Practice Program at Lonesome Pine ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D)**
B-1Q	ACGME Continued Accreditation Reports ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-1R	AOA New Program Approval for Orthopedic Surgery Program at Holston Valley Medical Center ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-2A	MSHA Medicare Cost Report Schedules
B-2B	WHS Medicare Cost Report Schedules
B-3A	MSHA Residency and Fellowship Programs and Contact Info: ETSU, JMH and NCH
B-3B	WHS Residency and Fellowship Programs
B-3C	WHS Contact Information for Responsible Individuals
B-4A	MSHA GME Organizational Chart for ETSU Programs

B-4B	MSHA GME Organizational Chart for JMH
B-4C	MSHA GME Organizational Chart for NCH
B-4D	WHS Lonesome Pine GME Organizational Chart
B-4E	WHS Holston Valley GME Organizational Chart
B-4F	WHS ETSU Organizational Chart
B-4G	WHS ACGME Membership List
B-4H	WHS ETSU Program Contact Information
B-5A	MSHA GME Affiliation Agreements ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-5B	WHS GME Affiliation Agreements ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
B-6A	MSHA Resident and Fellow FTEs 2014 to 2016
B-6B	WHS Residency and Fellowship Programs
C-4A	MSHA Research Protocols ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
C-4B	WHS Research Protocol ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
C-4C	WHS Cardiovascular Associates Research Information ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
D-7A	MSHA DRGs of VA Medicaid Patients Admitted to Johnson City Medical Center
D-7B	WHS DRGs of VA Medicaid Patients Admitted to Holston Valley Hospital and Medical Center and Bristol Regional Medical Center

E-1A	MSHA Medical Staff Bylaws of Dickenson Community Hospital and Norton Community Hospital
E-1B	MSHA Medical Staff Bylaws of Johnston Memorial Hospital
E-1C	MSHA Medical Staff Bylaws Russell County Medical Center
E-1D	MSHA Medical Staff Bylaws of Smyth County Community Hospital
E-1E	Lonesome Pine Credentialing Policies
E-1F	Lonesome Pine Medical Staff Bylaws
E-1G	Lonesome Pine Medical Staff Rules & Regulations
E-3A	MSHA Medical Staff Shortage Information ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
E-3B	WHS Medical Staff Shortage Information ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
E-4A	MSHA Employed Medical Staff VA FTEs ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
E-4B	List of WHS Employed Medical Staff at Virginia Facilities ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
F-2A	MSHA List of Exclusive Contracts ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
F-2B	WHS List of Exclusive Contracts at Virginia Facilities ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

F-3A	MSHA Copies of Exclusive Contracts ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
F-3B	WHS Copies of Exclusive Contracts ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
F-4A	MSHA Virginia Physicians with Exclusive Contracts ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
F-4B	Information for WHS's Virginia Physicians ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

Summary of Financial Covenants

MTI and Bank Documents as of September 2016

MSHA currently has the following covenants in place in the MTI and bank documents

Master Trust Indenture

Subject Matter	Current Covenant
Historical and Maximum Annual Debt Service Coverage Test	1.30x historical and MADS measured annually based upon audited financial statements; Consultant call-in below 1.30x and event of default below 1.0x
Liquidity Test (1)	Minimum days cash on hand of 75 measured annually at end of fiscal year
Debt to Capitalization	None
Other Covenants	MTI also includes provisions that govern additional debt, addition and withdrawl of members of the Obligated Group, permitted encumbrances, asset dispositions, mergers, hedge agreements and other items

Bank Documents – all letter of credit and direct purchase documents contain the same covenants

Subject Matter	Current Covenant
Maximum Annual Debt Service Coverage Test	1.30x measured quarterly based upon rolling 4 quarters; Event of default below 1.30x
Liquidity Test	Minimum days cash on hand of 100 measured semi-annually at December 31/June 30 of each fiscal year
Debt to Capitalization (2)	None
Favored Nations	All bank documents contain a provision that extends all "new" covenants to existing creditors
Other Covenants	Bank documents contain additional covenants that principally mirror the MTI

(1) As long as there are MBIA insured bonds outstanding, there is a liquidity covenant, solely for the benefit of MBIA, of 110 days cash on hand. That covenant is included in a Supplemental Master Trust Indenture.

(2) There are no covenants with the exception of Johnston Memorial Hospital. JMH has a covenant of a Debt to Capital Ratio of not less than 65% in the credit agreement with SunTrust Bank dated November 1, 2011.

Mountain States Health Alliance

Commentary

- Mountain States Health Alliance has granted a deed of trust on Johnson City Medical Center and Sycamore Shoals Hospital to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The members pledged pursuant to the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Mellon Trust Company, NA as Master Trustee include Johnson City Medical Center Hospital, Indian Path Medical Center, Franklin Woods Community Hospital, Sycamore Shoals Hospital, Johnson County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Norton Community Hospital (hospital only), Smyth County Community Hospital (hospital only) and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group.

- With the exception of Johnston Memorial Hospital (as they are not a member of the Obligated Group) all outstanding bonds are issued under Mountain States Health Alliance. The debt related to bonds issued under Mountain States Health alliance for the benefit of Norton Community Hospital and Smyth County Community Hospital is reflected on the Balance Sheet of those facilities.

Rating Agency Contacts

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MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)

Years Ended June 30, 2016 and 2015

PYA
Certified Public Accountants

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)
(Dollars in Thousands)

Years Ended June 30, 2016 and 2015

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mountain States Health Alliance and its subsidiaries (the Alliance), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatements, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Alliance's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mountain States Health Alliance and its subsidiaries as of June 30, 2016 and 2015, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental consolidated and consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Pursley Godfrey & Associates, P.C.

Knoxville, Tennessee
October 24, 2016

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2016	June 30, 2015
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	**$ 89,751**	$ 79,714
Current portion of investments	**25,772**	19,598
Patient accounts receivable, less estimated allowances for uncollectible accounts of $72,531 in 2016 and $73,805 in 2015	**155,002**	162,256
Other receivables, net	**35,062**	33,286
Inventories and prepaid expenses	**34,898**	33,969
TOTAL CURRENT ASSETS	**340,485**	328,823
INVESTMENTS, less amounts required to meet current obligations	**625,823**	694,542
PROPERTY, PLANT AND EQUIPMENT, net	**830,853**	847,089
OTHER ASSETS		
Goodwill	**156,565**	156,596
Net deferred financing, acquisition costs and other charges	**22,024**	24,755
Other assets	**55,397**	53,040
TOTAL OTHER ASSETS	**233,986**	234,391
	$ 2,031,147	$ 2,104,845

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Dollars in Thousands)

	June 30, 2016	June 30, 2015
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	**$ 13,586**	$ 18,159
Current portion of long-term debt and capital lease obligations	**23,391**	40,286
Accounts payable and accrued expenses	**95,200**	100,301
Accrued salaries, compensated absences and amounts withheld	**68,722**	72,066
Estimated amounts due to third-party payers, net	**9,150**	4,781
TOTAL CURRENT LIABILITIES	**210,049**	235,593
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	**963,879**	1,031,661
Estimated fair value of derivatives	**4,483**	2,541
Estimated professional liability self-insurance	**7,394**	8,461
Other long-term liabilities	**36,980**	38,683
TOTAL LIABILITIES	**1,222,785**	1,316,939
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and M		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	**594,303**	583,287
Noncontrolling interests in subsidiaries	**199,842**	191,118
TOTAL UNRESTRICTED NET ASSETS	**794,145**	774,405
Temporarily restricted net assets		
Mountain States Health Alliance	**14,091**	13,303
Noncontrolling interests in subsidiaries	**99**	71
TOTAL TEMPORARILY RESTRICTED NET ASSETS	**14,190**	13,374
Permanently restricted net assets		
Mountain States Health Alliance	**27**	127
TOTAL NET ASSETS	**808,362**	787,906
	$ 2,031,147	$ 2,104,845

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	Year Ended June 30, 2016	2015
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	**$ 1,159,436**	$ 1,130,495
Provision for bad debts	**(137,706)**	(127,519)
Net patient service revenue	**1,021,730**	1,002,976
Other operating revenue	**51,041**	41,162
TOTAL REVENUE, GAINS AND SUPPORT	**1,072,771**	1,044,138
Expenses:		
Salaries and wages	**351,967**	344,137
Physician salaries and wages	**84,043**	80,279
Contract labor	**21,311**	5,341
Employee benefits	**78,810**	77,051
Fees	**112,738**	115,581
Supplies	**179,142**	175,925
Utilities	**16,180**	16,770
Medical costs	**(762)**	(541)
Other	**85,049**	80,028
Depreciation	**66,418**	67,210
Amortization	**1,517**	1,557
Interest and taxes	**42,678**	43,697
TOTAL EXPENSES	**1,039,091**	1,007,035
OPERATING INCOME	**33,680**	37,103
Nonoperating gains (losses):		
Interest and dividend income	**15,034**	13,872
Net realized gains on the sale of securities	**6,514**	9,260
Change in net unrealized gains on securities	**(17,511)**	(6,138)
Derivative related income	**5,605**	6,204
Loss on early extinguishment of debt - Note F	**(2,827)**	-
Change in estimated fair value of derivatives	**(2,287)**	7,718
Other nonoperating losses	**(9,728)**	(4,591)
NET NONOPERATING GAIN (LOSS)	**(5,200)**	26,325
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES FROM CONTINUING OPERATIONS	**28,480**	63,428
LOSS FROM DISCONTINUED OPERATIONS	**(6,492)**	(8,328)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	**$ 21,988**	$ 55,100

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets
(Dollars in Thousands)

Year Ended June 30, 2016

	Mountain States Health Alliance	*Noncontrolling Interests*	*Total*
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	$ 11,473	$ 10,515	$ 21,988
Pension and other defined benefit plan adjustments	(1,443)	(1,436)	(2,879)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,987	-	1,987
Repurchases of noncontrolling interests, net	(1,001)	-	(1,001)
Distributions to noncontrolling interests	-	(355)	(355)
INCREASE IN UNRESTRICTED NET ASSETS	11,016	8,724	19,740
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	5,840	104	5,944
Net assets released from restrictions	(5,052)	(76)	(5,128)
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	788	28	816
PERMANENTLY RESTRICTED NET ASSETS:			
Net assets released from restrictions by donor	(100)	-	(100)
DECREASE IN PERMANENTLY RESTRICTED NET ASSETS	(100)	-	(100)
INCREASE IN TOTAL NET ASSETS	11,704	8,752	20,456
NET ASSETS, BEGINNING OF YEAR	596,717	191,189	787,906
NET ASSETS, END OF YEAR	$ 608,421	$ 199,941	$ 808,362

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2015

	Mountain States Health Alliance	*Noncontrolling Interests*	*Total*
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	$ 41,008	$ 14,092	$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478
Noncontrolling interest in acquired subsidiary	-	(1,014)	(1,014)
Distributions to noncontrolling interests	-	(355)	(355)
INCREASE IN UNRESTRICTED NET ASSETS	41,308	12,571	53,879
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,663	69	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	12,558	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	178,631	732,941
NET ASSETS, END OF YEAR	$ 596,717	$ 191,189	$ 787,906

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30,	
	2016	*2015*
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	**$ 20,456**	$ 54,965
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	**68,295**	69,242
Provision for bad debts	**137,706**	127,519
Loss on early extinguishment of debt	**2,827**	-
Change in estimated fair value of derivatives	**2,287**	(7,718)
Equity in net income of joint ventures, net	**(1,382)**	(79)
Loss (gain) on disposal of assets	**(221)**	(2,192)
Amounts received on interest rate swap settlements	**(5,605)**	(6,172)
Capital Appreciation Bond accretion and other	**2,799**	2,780
Restricted contributions	**(5,944)**	(3,732)
Pension and other defined benefit plan adjustments	**2,879**	330
Increase (decrease) in cash due to change in:		
Patient accounts receivable	**(130,452)**	(128,457)
Other receivables, net	**(1,694)**	12,303
Inventories and prepaid expenses	**(929)**	(3,131)
Trading securities	**59,553**	(39,873)
Other assets	**(5,760)**	(3,128)
Accrued interest payable	**(4,573)**	(489)
Accounts payable and accrued expenses	**(1,213)**	16,745
Accrued salaries, compensated absences and amounts withheld	**(3,344)**	(115)
Estimated amounts due to third-party payers, net	**4,369**	(5,682)
Estimated professional liability self-insurance	**(1,067)**	(496)
Other long-term liabilities	**(4,582)**	2,379
Total adjustments	**113,949**	30,034
NET CASH PROVIDED BY OPERATING ACTIVITIES	**134,405**	84,999
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment and property held for expansion	**(57,586)**	(44,569)
Purchases of held-to-maturity securities	**2,461**	(1,417)
Net distribution from joint ventures and unconsolidated affiliates	**2,442**	4,859
Proceeds from sale of property, plant and equipment and property held for resale	**3,836**	2,654
NET CASH USED IN INVESTING ACTIVITIES	**(48,847)**	(38,473)

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows - Continued
(Dollars in Thousands)

	Year Ended June 30,	
	2016	*2015*
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	**(71,864)**	(36,210)
Refinanced debt obligations	**(134,367)**	-
Proceeds from issuance of long-term debt and other financing arrangements	**118,941**	-
Net amounts received on interest rate swap settlements	**5,605**	6,172
Restricted contributions received	**6,164**	4,041
NET CASH USED IN FINANCING ACTIVITIES	**(75,521)**	(25,997)
NET INCREASE IN CASH AND CASH EQUIVALENTS	**10,037**	20,529
CASH AND CASH EQUIVALENTS, beginning of year	**79,714**	59,185
CASH AND CASH EQUIVALENTS, end of year	**$ 89,751**	$ 79,714
SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:		
Cash paid for interest	**$ 41,934**	$ 38,982
Cash paid for federal and state income taxes	**$ 777**	$ 917
Construction related payables in accounts payable and accrued expenses	**$ 3,405**	$ 7,293
Assets contributed into joint venture	**$ -**	$ 8,668

The Consolidated Statements of Cash Flows were prepared by treating all items as if they were from Continuing Operations.

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, Unicoi, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The primary operations of the Alliance consist of eleven acute and specialty care hospitals.

The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets attributable to the noncontrolling interests in the following subsidiaries:

- Smyth County Community Hospital and Subsidiary - the Alliance holds an 80% interest
- Norton Community Hospital and Subsidiaries - the Alliance holds a 50.1% interest
- Johnston Memorial Hospital, Inc. and Subsidiaries - the Alliance holds a 50.1% interest

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices, real estate and ambulatory surgery centers and provides other healthcare services to individuals in Tennessee and Virginia.

The Alliance is a 99.9% shareholder of Integrated Solutions Health Network, LLC (ISHN). During the current year, CrestPoint Health Insurance Company (CHIC), a component unit of ISHN, ceased operations. See Note P for additional information.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc., a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance.

In April, 2015, the Alliance and Wellmont Health System (Wellmont) agreed to exclusively explore the creation of a new, integrated and locally governed health system. Wellmont operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia.

In February, 2016, the Alliance and Wellmont executed a definitive agreement outlining how the two health systems would unite their operations upon approval of a Certificate of Public Advantage (COPA) in Tennessee and a cooperative agreement in Virginia. The systems have filed applications for a COPA in Tennessee and a cooperative agreement in Virginia and the applications have been deemed complete. The applications are now under formal review by the Tennessee Department of Health and the Southwest Virginia Health Authority. If state officials grant permission to move forward, the Alliance and Wellmont will become Ballad Health in the Spring of 2017.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its consolidated subsidiaries after elimination of all significant intercompany accounts and transactions.

Use of Estimates: The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

Cash and Cash Equivalents: Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents.

Investments: Investments include trading securities and held-to-maturity securities. Within the trading securities portfolio, all debt securities, and marketable equity securities with readily determinable fair values, are reported at either the net asset value per share as a practical expedient or fair value based on quoted market prices. Investments without readily determinable fair values are reported at estimated fair market value utilizing observable and unobservable inputs. Investments which the Alliance has the positive intent and ability to hold to maturity are classified as held-to-maturity and are stated at amortized cost. Realized gains and losses are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Management evaluates whether unrealized losses on held-to-maturity investments indicate other-than-temporary impairment. Such evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2016.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value. Other assets include investments in joint ventures of $7,250 and $5,180 at June 30, 2016 and 2015, respectively. During 2015, the Alliance contributed assets into a joint venture which owns and operates a rehabilitation hospital.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market with cost determined by first-in, first-out method.

Property, Plant and Equipment: Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is amortized under the straight-line method over the shorter of the lease term or estimated useful life. Amortization of buildings and equipment held under capital leases is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from restricted for capital assets. The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2016 and 2015.

Other assets include property held for resale and expansion of $18,857 and $19,316, respectively, at June 30, 2016 and 2015. Property held for resale and expansion primarily represents land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2016 and 2015.

Goodwill: Goodwill is evaluated for impairment at least annually. The Alliance comprises a single reporting unit for evaluation of goodwill. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe the goodwill to be impaired as of June 30, 2016 and 2015. Management's estimates utilized in the evaluation contain significant estimates and it is reasonably possible that such estimates could change in the near term.

Deferred Financing, Acquisition Costs and Other Charges: Other assets include deferred financing, acquisition costs and other charges of $22,024 and $24,755 at June 30, 2016 and 2015, respectively. Deferred financing costs are amortized over the life of the respective bond issue using the average bonds outstanding method.

Derivative Financial Instruments: The Alliance is a party to various interest rate swaps. These financial instruments are not designated as hedges and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets as either current or long-term liabilities, based upon the remaining term of the instrument.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payers emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations estimated based upon the age of the patient accounts receivable, historical writeoffs and recoveries and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Additions to the allowance for uncollectible accounts result from the provision for bad debts. Patient accounts written off as uncollectible are deducted from the allowance for uncollectible accounts.

For uninsured patients that do not qualify for charity care, the Alliance recognizes revenue on the basis of discounted rates under the Alliance's self-pay patient policy. Under the policy, a patient who has no insurance and is ineligible for any government assistance program has their bill reduced to the amount which generally would be billed to a commercially insured patient. The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Charity Care: The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue. Charges forgone, based on established rates, totaled $78,306 and $85,988 during 2016 and 2015, respectively. The estimated direct and indirect cost of providing these services totaled $14,872 and $17,953 in 2016 and 2015, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated.

In addition to the charity care services, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, Medicaid, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

Excess of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and the Consolidated Statements of Changes in Net Assets includes the caption Excess of Revenue, Gains and Support Over Expenses and Losses (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, certain pension and related adjustments, and transactions with noncontrolling interests.

Income Taxes: The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. The Alliance's taxable subsidiaries are discussed in Note L. The Alliance has no significant uncertain tax positions at June 30, 2016 and 2015. At June 30, 2016, tax returns for 2013 through 2015 are subject to examination by the Internal Revenue Service.

Temporarily and Permanently Restricted Net Assets: Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the Consolidated Statements of Operations and Changes in Net Assets as net assets released from restrictions. The Alliance's policy is to net contribution and grant revenues against related expenses and present such amounts as a part of nonoperating gains (losses) in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Premium Revenue: Premium revenue includes premiums from individuals and the Centers for Medicare & Medicaid Services (CMS). CMS premium revenue is based on predetermined prepaid rates under Medicare risk contracts. Premiums are recognized in the month in which the members are entitled to health care services. Premiums collected in advance are deferred and recorded as unearned premium revenue. Premium deficiency losses are recognized when it is probable that expected future claim expenses will exceed future premiums on existing contracts.

Management evaluated the need for a premium deficiency reserve and recorded an estimated reserve of $2,000 at June 30, 2015. No premium deficiency reserve was required at June 30, 2016 due to the discontinuation of the Medicare Advantage plan. Premium revenue for both 2016 and 2015 has been reclassified to discontinued operations.

Medicare Shared Savings Program (MSSP): The Alliance participates in CMS' Medicare Shared Savings Program which is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Accountable care organizations participating in the program are assigned beneficiaries by CMS and are entitled to share in the savings if they are able to lower growth in Medicare Parts A and B fee-for-service costs while meeting performance standards on quality of care. Management recognized $5,600 and $2,857 of shared savings in other revenue, gains and support in 2016 and 2015, respectively.

Electronic Health Record (EHR) Incentives: The American Recovery and Reinvestment Act of 2009 (ARRA) provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified EHR technology. The incentive payments are calculated based upon estimated discharges, charity care and other input data and are recorded upon the Alliance's attainment of program and attestation criteria. The incentive payments are subject to regulatory audit. During the years ending June 30, 2016 and 2015, the Alliance recognized EHR incentive revenues of $6,552 and $1,883, respectively. EHR incentive revenues are included in other operating revenue in the accompanying Consolidated Statements of Operations. The Alliance incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Alliance's receipt or recognition of the EHR incentive payments.

Medical Costs: The cost of health care services is recognized in the period in which services are provided. Medical costs include an estimate of the cost of services provided to members by third-party providers, which have been incurred but not reported. Medical costs associated with the Medicare Advantage plan for 2016 and 2015 have been reclassified to discontinued operations.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2016, through October 24, 2016, the date the consolidated financial statements were available to be

issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2016 consolidated financial statements.

Reclassifications: Certain 2015 amounts have been reclassified to conform with the 2016 presentation in the accompanying consolidated financial statements.

New Accounting Pronouncements: In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*. Under ASU 2014-09, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the accounting standard requires disclosure of the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The standard is effective for fiscal years beginning after December 15, 2017. Management is currently evaluating the impact of adopting the accounting standard.

In July 2015, the FASB issued ASU No. 2015-11, *Inventory (Topic 330) - Simplifying the Measurement of Inventory, (ASU-2015-11)*. ASU 2015-11 was issued as part of FASB's Simplification Initiative, the objective of which is to identify, evaluate and improve areas of GAAP for which cost and complexity can be reduced while maintaining or improving the usefulness of the information provided to users of financial statements. ASU 2015-11 will require inventory within its scope to be measured at the lower of cost and net realizable value. Net realizable value is defined as the estimated selling prices in the ordinary course of business, less reasonably predictable costs of completion, disposal and transportation. The guidance within this ASU will be effective for fiscal years beginning after December 15, 2016. The Alliance does not anticipate the adoption of ASU 2015-11 to have a significant impact on the consolidated financial statements.

In April 2015, the FASB issued ASU No. 2015-03, *Interest-Imputation of interest (Topic 835-30) - Simplifying the Presentation of Debt Issuance Costs, (ASU-2015-03)*. ASU 2015-03 was issued as part of FASB's Simplification Initiative, the objective of which is to identify, evaluate and improve areas of GAAP for which cost and complexity can be reduced while maintaining or improving the usefulness of the information provided to users of financial statements. ASU 2015-03 will require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. The guidance within this ASU will be effective for fiscal years beginning after December 15, 2015. The Alliance does not anticipate the adoption of ASU 2015-03 to have a significant impact on the consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases*, which requires balance sheet recognition of a liability and right-to-use asset for substantially all leases. ASU 2016-02 is effective

for fiscal years beginning after December 15, 2018 and requires a modified retrospective transition approach for leases existing at the date of adoption. Management is currently evaluating the impact of the adoption of this standard on the consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities: Presentation of Financial Statements of Not-for-Profit Entities*, which requires not-for profit entities to present two classes of net assets in the financial statements, rather than the three classes required by current standards. The two classes of net assets under the ASU are "net assets with donor restrictions" and "net assets without donor restrictions." ASU 2016-14 is effective for fiscal years beginning after December 15, 2017, and early adoption is permitted. Management is currently evaluating the impact of the adoption of this standard on the consolidated financial statements.

NOTE C--INVESTMENTS

Assets limited as to use are summarized by designation or restriction as follows at June 30:

	2016	*2015*
Designated or restricted:		
Under safekeeping agreements	$ 8,115	$ 8,221
By Board to satisfy regulatory requirements	1,550	1,529
Under bond indenture agreements:		
For debt service and interest payments	33,045	53,812
For capital acquisitions	-	8,507
	42,710	72,069
Less: amount required to meet current obligations	(25,772)	(19,598)
	$ 16,938	$ 52,471

Assets limited as to use consist of the following at June 30:

	2016	*2015*
Cash and cash equivalents	$ 33,008	$ 49,665
U.S. Government and agency securities	7,943	19,757
Corporate and foreign bonds	-	860
Municipal obligations	1,759	1,787
	$ 42,710	$ 72,069

Held-to-maturity securities (other than assets limited as to use) are carried at amortized cost and consist of the following at June 30:

	2016	*2015*
Cash and cash equivalents	$ 3,600	$ 2,781
Corporate and foreign bonds	27,194	30,967
Municipal obligations	5,706	5,765
	$ 36,500	$ 39,513

Held-to-maturity securities had gross unrealized gains and losses of $736 and $48, respectively, at June 30, 2016 and $98 and $425, respectively, at June 30, 2015. At June 30, 2016, the Alliance held securities within the held-to-maturity portfolio with a fair value and gross unrealized loss of $3,770 and $41, respectively, which had been at an unrealized loss position for over one year. At June 30, 2015, the Alliance held securities within the held-to-maturity portfolio with a fair value and gross unrealized loss of $12,710 and $359, respectively, which had been at an unrealized loss position for over one year. At June 30, 2016, the contractual maturities of held-to-maturity securities were $12,665 due in one year or less, $12,075 due from one to five years and $11,760 due after five years.

Trading securities consist of the following at June 30:

	2016	*2015*
Cash and cash equivalents	$ 14,376	$ 20,789
U.S. Government and agency securities	61,100	76,167
Corporate and foreign bonds	71,915	95,726
Municipal obligations	11,517	23,330
U.S. equity securities	11,618	5,419
Mutual funds	307,007	293,983
Alternative investments	94,852	87,144
	$ 572,385	$ 602,558

The Alliance is a member of Premier Inc.'s (Premier) group purchasing organization and holds Class B Units which are convertible into cash or Class A common stock over a seven year vesting period. The Alliance records an investment relative to the estimated fair value of its Class B units, $10,298 and $14,724 at June 30, 2016 and 2015, respectively. In addition, as the vesting period is tangential to the Alliance's continued participation in the group purchasing contract, the Alliance recorded a liability equivalent to the estimated fair value of the Class B units, which is included within other long-term liabilities in the Consolidated Balance Sheets. The liability is being amortized as a vendor incentive over the vesting period. During 2016 and 2015, the Alliance recognized $3,377 and

$4,045, respectively, related to the vendor incentive which is included within other revenue, gains and support in the Consolidated Statements of Operations.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is subject to an enforceable master netting arrangement in the form of an ISDA agreement with Bank of America, Merrill Lynch (BofAML). The ISDA agreement requires that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2016 and 2015, the Alliance was not required to post additional collateral. Under the terms of this agreement, offsetting of derivative contracts is permitted in the event of default of either party to the agreement.

The following is a summary of the interest rate swap agreements at June 30, 2016 and 2015:

Notional Amount	*Termination*	*Counterparty*	*Current Payments: Receive*	*Pay*	*Estimated Fair Value 2016*	*2015*
$170,000	4/2026	BofAML	71.10% 5 year USD-LIBOR	USD-SIFMA	$ 2,698	$ 5,205
$95,000	4/2026	BofAML	71.18% 5 year USD-LIBOR	USD-SIFMA	1,519	2,929
$173,030	4/2034	BofAML	72.35% 5 year USD-LIBOR	USD-SIFMA	232	884
$82,055	7/2033	BofAML	67% USD-LIBOR-BBA	0.312% + USD-SIFMA	(7,106)	(8,253)
$50,000	7/2038	BofAML	67% (USD-LIBOR-BBA + 0.15%)	USD-SIFMA	(2,130)	(3,351)
$18,300	7/2018	BofAML	4.50%	0.75% + USD-SIFMA	27	48
$118,870	6/2019	BofAML	3.80%	70% USD-LIBOR-BBA + 0.70%	277	-
$0	7/2015	First Tennessee Bank	0.00%	USD-LIBOR-BBA	-	(3)
					$ (4,483)	$ (2,541)

The Alliance recognized net settlement income on the interest rate swap agreements of $5,605 and $6,204 in June 30, 2016 and 2015, respectively.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of the following at June 30:

	2016	2015
Land	$ 61,043	$ 60,337
Buildings and leasehold improvements	790,178	766,089
Property and improvements held for leasing	84,252	83,582
Equipment and information technology infrastructure	757,216	733,315
Buildings and equipment held under capital lease	249	249
	1,692,938	1,643,572
Less: Allowances for depreciation and amortization	(880,657)	(815,105)
	812,281	828,467
Construction in progress	18,572	18,622
	$ 830,853	$ 847,089

Accumulated depreciation and amortization on property and improvements held for leasing purposes is $31,871 and $29,520 at June 30, 2016 and 2015, respectively. Net interest capitalized was $330 and $925 for the years ended June 30, 2016 and 2015, respectively.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

Description	Rate as of June 30, 2016	Outstanding Balance 2016	Outstanding Balance 2015
2016 Hospital Refunding Revenue Bond			
$118,870 fixed rate tax exempt term bond, due July 2036	3.80%	$ 118,870	$ -
2013 Hospital Revenue and Refunding Revenue Bonds:			
$61,180 variable rate tax-exempt term bond, due August 2031	1.34%	$ 327,065	$ 327,785
$47,500 variable rate tax-exempt term bond, due August 2032	1.10%		
$13,350 variable rate tax-exempt term bond, due August 2038	1.34%		
$89,120 variable rate tax-exempt term bonds, due August 2042	1.30% - 1.41%		
$16,235 variable rate tax-exempt term bond, due August 2043	0.41%		
$99,680 variable rate taxable term bond due August 2043	0.45%		
2012 Hospital Revenue Bonds: (net of unamortized premium of $1,635 and $1,696 at June 30, 2016 and 2015, respectively)			
$55,000 fixed rate tax-exempt term bond, due August 2042	5.00%	56,635	56,696
2011 Hospital Revenue and Refunding and Improvement Bonds:			
$72,285 variable rate tax-exempt term bonds, due July 2033	0.42%	90,690	94,320
$18,405 variable rate tax-exempt term bond, due July 2033	1.34%		

Description	*Rate as of June 30, 2016*	*Outstanding Balance 2016*	*2015*
2010 Hospital Revenue Refunding Bonds:			
(net of unamortized premium of $1,359 and $1,441 at June 30, 2016 and 2015, respectively)			
$26,045 fixed rate tax-exempt serial bonds, through 2020	4.00% to 5.00%	165,274	173,271
$4,355 fixed rate tax-exempt term bond, due July 2023	5.00%		
$14,985 fixed rate tax-exempt term bond, due July 2025	5.38%		
$4,250 fixed rate tax-exempt term bond, due July 2028	5.50%		
$19,230 fixed rate tax-exempt term bond, due July 2030	5.63%		
$95,050 fixed rate tax-exempt term bonds, due July 2038	6.00% - 6.50%		
2009 Hospital Revenue Bonds:			
(net of unamortized discount of $2,084 and $2,176 at June 30, 2016 and 2015, respectively)			
$10,665 fixed rate tax-exempt term bonds, due July 2019	7.25%	114,616	117,264
$22,830 fixed rate tax-exempt term bonds, due July 2029	7.50%		
$83,205 fixed rate tax-exempt term bonds, due July 2038	7.75% - 8.00%		
2007B Taxable Hospital Revenue Bonds:			
$12,140 variable rate taxable term bond due July 2019	0.43%	12,140	15,920
2006 Hospital First Mortgage Revenue Bonds:			
(net of unamortized premium $128,761 at June 30, 2015)			
Defeased with the issuance of the 2016 Hospital Revenue Refunding Bond	N/A	-	167,143
2001 Hospital First Mortgage Revenue Bond:			
$18,300 fixed rate tax-exempt term bond, due July 2026	4.50%	18,300	19,400
2000 Hospital First Mortgage Revenue and Refunding Bonds:			
$39,835 fixed rate tax-exempt term bond, due July 2026	8.50%	82,073	81,538
$42,238 fixed rate tax-exempt Capital Appreciation Bond, interest and principal due July 2026 through 2030	6.63%		
Capitalized lease obligations secured by equipment			
Various monthly principal and interest payments through December 2022	Various	167	350
Promissory notes secured by assets of certain subsidiaries			
Various monthly principal and interest payments through 2019	Various	1,440	1,705
Term note			
Note repaid during 2016	N/A	-	16,160
Notes payable secured by equipment			
Note repaid during 2016	N/A	-	395
		987,270	1,071,947
Less current portion		(23,391)	(40,286)
		$ 963,879	$ 1,031,661

Series 2016 Bonds: In June 2016, the Alliance issued $118,870 (Series 2016A) Hospital Revenue Refunding Bonds through the Health and Educational Facilities Board of the City of Johnson City, Tennessee. The proceeds from the 2016A Bonds were used to pay issuance costs and refinance outstanding indebtedness, specifically related to the series 2006A Bonds.

Capital Appreciation Bonds: The Series 2000 Bonds include $14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The

Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is $93,675.

Other: Outstanding tax-exempt bond obligations that were insured under municipal bond insurance policies were $82,073 and $81,538 at June 30, 2016 and 2015, respectively. Under terms of these policies, the insurer guarantees the Alliance's payment of principal and interest. At June 30, 2016 and 2015, the Alliance held $200,340 and $206,630, respectively, in variable rate demand bonds with letter of credit support and $229,555 and $231,395, respectively, in variable rate bonds held under direct purchase agreements.

Early Redemption: Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

Derecognized Bonds: In previous years, the Alliance advance refunded debt by placing required funds in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments of the outstanding debt. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2016 due to previous advance refundings totaled $308,540.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the original amount of $54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

Financing Arrangements: The Alliance granted a deed of trust on Johnson City Medical Center and Sycamore Shoals Hospital to secure the payment of the outstanding bond indebtedness. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The Johnston Memorial Hospital, Inc. and Subsidiaries (JMH) Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

Certain members of the Alliance and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated

Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property. These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance and JMH are in compliance with all such covenants at June 30, 2016.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2016 are as follows:

Year Ending June 30,		
2017	$	23,391
2018		24,638
2019		26,356
2020		26,810
2021		28,069
Thereafter		857,096
		986,360
Net premium		910
	$	987,270

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is substantially self-insured for professional and general liability claims and related expenses. The Alliance maintains a $25,000 umbrella liability policy that attaches over the self-insurance limits of $10,000 per claim and a $15,000 annual aggregate retention. The Alliance's insurance program also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is also substantially self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of $1,000 per occurrence. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2016, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2016 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Management has

estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2016 and 2015 was $10,987 and $12,616, respectively. The discount rate utilized was 5% at June 30, 2016 and 2015.

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid. Such amount is included in accounts payable and accrued expenses in the Consolidated Balance Sheets.

NOTE H--NET PATIENT SERVICE REVENUE

Patient service revenue, net of contractual allowances and discounts, is composed of the following for the years ended June 30:

	2016	*2015*
Third-party payers	$ 988,192	$ 979,406
Patients	171,244	151,089
Patient service revenue	$ 1,159,436	$ 1,130,495

Patient deductibles and copayments under third-party payment programs are included within the patients' amount above.

The Alliance also provides services to uninsured and underinsured patients that do not qualify for financial assistance. Based on historical experience, a significant portion of uninsured and underinsured patients are unable or unwilling to pay the portion of their bill for which they are financially responsible, and a significant provision for bad debts is recorded in the period the services are provided.

The Alliance's allowance for doubtful accounts totaled $72,531 and $73,805 at June 30, 2016 and 2015, respectively. The allowance for doubtful accounts increased from 31% of patient accounts receivable, net of contractual allowances in 2015 to 32% of patient accounts receivable, net of contractual allowances in 2016. Management's estimate of the allowance for doubtful accounts is an estimate subject to change in the near term. The provision for bad debts associated with the Alliance's ancillary service lines are not significant.

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare and various other commercial payers. The Medicare program pays for inpatient services

on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance also receives additional supplemental payments from the State of Tennessee and Medicaid. These payments recognized totaled $9,282 and $10,386 for the years ended June 30, 2016 and 2015, respectively.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are also based on a prospective payment system, using the Enhanced Ambulatory Patient Group (EAPG) methodology.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The impact of final settlements of cost reports or changes in estimates increased net patient service revenue by $2,292 and $3,076 in 2016 and 2015, respectively.

Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts, if any. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements.

However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2017, although the amount of any change cannot be estimated.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may

result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2016.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

NOTE J--EMPLOYEE BENEFIT PLANS

The Alliance sponsors a defined contribution retirement plan (the Plan) which covers substantially all employees. The Alliance makes contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2016 and 2015 was $15,915 and $15,601, respectively.

NCH maintains a frozen defined benefit pension plan and a frozen post-retirement employee benefit plan. The accrued unfunded pension liability was $3,835 and $1,806, and the accrued unfunded post-retirement liability was $7,451 and $6,307 at June 30, 2016 and 2015, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement dates, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed $508 and $1,727 to the plan during 2016 and 2015, respectively. Other assets at June 30, 2016 and 2015 include $13,567 and $13,030, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. Contributions to the Section 457(f) plan during 2016 and 2015 were not significant.

NOTE K--CONCENTRATION OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia, a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee acute-care operations was approximately 51% and 52% of total net patient service revenue in 2016 and 2015, respectively.

The mix of receivables from patients and third-party payers based on charges at established rates is as follows as of June 30. The patient responsibility related to charges for which the third-party has not yet paid is included within the third-party payer categories.

	2016	*2015*
Medicare	42%	41%
Tenncare/Medicaid	15%	15%
Commercial	24%	26%
Other third-party payers	10%	8%
Patients	9%	10%
	100%	100%

Approximately 95% and 94% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2016 and 2015, respectively. Admitting physicians are primarily practitioners in the regional area.

The Hospital maintains bank accounts at various financial institutions covered by the Federal Deposit Insurance Corporation (FDIC). At times throughout the year, the Alliance may maintain bank account balances in excess of the FDIC insured limit. Management believes the credit risk associated with these deposits is not significant.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2016 and 2015, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of $31,890 and $30,700, respectively, related to operating loss carryforwards, which expire through 2034. At June 30, 2016 and 2015, BRMM had state net operating loss carryforwards of $70,852 and $75,619, respectively, which expire through 2030. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

NOTE M--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2016 represents costs incurred related to various hospital and medical office building facility renovations and additions and information technology infrastructure. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be $9,705 at June 30, 2016. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Employee Scholarships: In previous years, the Alliance offered scholarships to certain individuals which required that the recipients return to the Alliance to work for a specified period of time after they completed their degree. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately, and interest is charged until the funds are repaid. Other receivables at June 30, 2016 and 2015 include $5,088 and $7,095, respectively, related to students in school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program, net of an estimated allowance.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2016 and 2015 was $6,983 and $7,414, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

Year Ending June 30,		
2017	$	7,067
2018		5,423
2019		4,624
2020		3,681
2021		3,124
Thereafter		11,124
	$	35,043

NOTE N--FAIR VALUE MEASUREMENT

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2016 and 2015, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.

Held-to-Maturity Securities: The estimated fair value of the Alliance's held-to-maturity securities at June 30, 2016 and 2015, is $37,188 and $39,186, respectively, and would be classified in Level 2 of the fair value hierarchy (described below). The fair value is based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations.

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities.

Long-Term Debt: The estimated fair value of the Alliance's long-term debt at June 30, 2016 and 2015, is $1,062,091 and $1,130,580, respectively, and would be classified in Level 2 in the fair value hierarchy. The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

FASB Accounting Standards Codification 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- *Level 1:* Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.

- *Level 2:* Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.

- *Level 3:* Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Alliance's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial instruments measured at fair value as of June 30, 2016 and 2015:

	Total	*Level 1*	*Level 2*	*Level 3*
June 30, 2016				
Cash and cash equivalents	$ 47,317	$ 47,317	$ -	$ -
U.S. Government and agency securities	61,202	61,202	-	-
Corporate and foreign bonds	71,915	-	71,915	-
Municipal obligations	11,503	-	11,503	-
U.S. equity securities	11,618	11,618	-	-
Mutual funds	307,007	179,045	127,962	-
Alternative investments	94,852	-	84,554	10,298
Total assets	$ 605,414	$ 299,182	$ 295,934	$ 10,298
Derivative agreements	$ (4,483)	$ -	$ -	$ (4,483)
June 30, 2015				
Cash and cash equivalents	$ 70,439	$ 70,439	$ -	$ -
U.S. Government and agency securities	88,083	88,083	-	-
Corporate and foreign bonds	96,586	-	96,586	-
Municipal obligations	23,329	-	23,329	-
U.S. equity securities	5,419	5,419	-	-
Mutual funds	293,983	212,323	81,660	-
Alternative investments	87,144	-	72,420	14,724
Total assets	$ 664,983	$ 376,264	$ 273,995	$ 14,724
Derivative agreements	$ (2,541)	$ -	$ -	$ (2,541)

Fair values for the Alliance's fixed maturity securities are based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations. Fair values of equity securities have been determined by the Alliance from market quotations.

Alternative Investments: The Alliance generally uses net asset value per unit as provided by external investment managers without further adjustment as the practical expedient estimate of the fair value of its alternative investment in a real estate fund. Accordingly, such values may differ from values

that would have been used had an active market for the investments existed. The real estate fund invests primarily in U.S. commercial real estate. The Alliance may request redemption of all or a portion of its interests as of the end of a calendar quarter by delivering written notice to the fund managers at least 60 days prior to the end of the quarter. Such redemptions are subject to the capital requirements of the fund manager.

The Alliance's investment in Premier Class B units does not have a readily determinable fair value and has been reported at estimated fair market value. The significant unobservable inputs primarily relate to management's estimate of the discount for lack of marketability of 12%. Accordingly, such value may differ from values that would have been used had an active market for the investment existed and as such it has been classified in Level 3 of the fair value hierarchy.

Derivative Agreements: The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses certain observable market-based inputs. The fair values of interest rate agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates and the underlying notional amount. The Alliance also incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2016 and 2015 resulted in a decrease in the fair value of the related liability of $231 and $713, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2016 and 2015:

	Alternative Investment	*Derivatives, Net*
July 1, 2014	$ 14,713	$ (10,603)
Total unrealized/realized gains	6,978	7,718
Net investment income	-	344
Settlements	(6,967)	-
June 30, 2015	14,724	(2,541)
Total unrealized/realized losses	(1,049)	(2,287)
Net investment income	-	345
Settlements	(3,377)	-
June 30, 2016	$ 10,298	$ (4,483)

NOTE O--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

The Alliance does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the Alliance receives substantially all of its resources from providing healthcare services in a manner similar to business enterprises, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

NOTE P--DISCONTINUED OPERATIONS

Effective June 1, 2016, CHIC mutually terminated its Medicare Advantage contract with the U.S. Centers for Medicare and Medicaid Services. CHIC, a for-profit entity subsidiary of ISHN, offered 4-star rated Medicare Advantage coverage to the Medicare eligible population in an eight county region of Northeast Tennessee served by the Alliance. CHIC also discontinued acting as the third-party health insurance administrator for Mountain States employees effective June 30, 2016. Employees of the Alliance transitioned to an outside third-party administrator effective July 1, 2016. The Alliance made the decision to cease CHIC operations in order to refocus on achieving the Alliance's core mission of delivering high value patient care at a lower cost including focusing on measurable quality, outstanding patient experience, and excellent outcomes for patients. Other ISHN functions, including the Anewcare ACO, remain operational. The ceased operations of CHIC represented a disposal of a component entity. As such, the operating results of CHIC have been reported as discontinued operations in the Consolidated Statements of Operations for the periods presented. All assets and liabilities associated with CHIC have been retained by the Alliance, thus classification as discontinued operations on the Consolidated Balance Sheets is not considered necessary.

The loss from discontinued operations is comprised of the following for the years ending June 30:

	2016	*2015*
Net revenue	$ 44,027	$ 32,184
Expenses	(50,519)	(40,512)
Loss from discontinued operations	$ (6,492)	$ (8,328)

All cash activities prior to discontinuing operations were for operating activities in 2016 and 2015. Medical claims will continue to be paid for the discontinued Medicare Advantage plan in 2017. Significant cash outflows after 2017 are not anticipated. While these paid claims will impact cash, the claims have been reserved and are not expected to have a material impact to the Consolidated Statement of Operations in 2017.

Supplemental Information

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Smyth County Community Hospital and Subsidiary, Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2016

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 3,103	$ 8,478
Patient accounts receivable, less estimated allowances for uncollectible accounts	6,561	10,691
Other receivables, net	321	1,282
Inventories and prepaid expenses	1,081	1,917
Receivables from affiliates, net	198	-
Estimated amounts due from third-party payers, net	13	-
TOTAL CURRENT ASSETS	11,277	22,368
INVESTMENTS, less amounts required to meet current obligations	25,043	26,108
PROPERTY, PLANT AND EQUIPMENT, net	64,033	51,792
OTHER ASSETS		
Net deferred financing, acquisition costs and other charges	127	202
Other assets	729	-
TOTAL OTHER ASSETS	856	202
	$ 101,209	$ 100,470

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Smyth County Community Hospital and Subsidiary, Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2016

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	$ 13	$ 16
Current portion of long-term debt and capital lease obligations	154	126
Accounts payable and accrued expenses	2,400	3,999
Accrued salaries, compensated absences and amounts withheld	1,851	4,382
Payables to affiliates, net	-	80
Estimated amounts due to third-party payers, net	-	322
TOTAL CURRENT LIABILITIES	4,418	8,925
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	15,679	20,859
Estimated professional liability self-insurance	380	550
Other long-term liabilities	818	11,377
TOTAL LIABILITIES	21,295	41,711
NET ASSETS		
Unrestricted net assets	79,905	58,619
Temporarily restricted net assets	9	140
TOTAL NET ASSETS	79,914	58,759
	$ 101,209	$ 100,470

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations and Changes in Net Assets
(Smyth County Community Hospital and Subsidiary, Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

Year Ended June 30, 2016

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	$ 49,796	$ 81,121
Provision for bad debts	(5,294)	(11,069)
Net patient service revenue	44,502	70,052
Other operating revenue	1,921	2,960
TOTAL REVENUE, GAINS AND SUPPORT	46,423	73,012
Expenses		
Salaries and wages	17,609	24,954
Physician salaries and wages	269	7,415
Contract labor	228	1,620
Employee benefits	4,475	8,693
Fees	9,466	8,742
Supplies	5,555	6,891
Utilities	971	1,235
Other	5,768	7,910
Depreciation	4,344	4,656
Amortization	13	8
Interest and taxes	180	266
TOTAL EXPENSES AND LOSSES	48,878	72,390
OPERATING INCOME (LOSS)	(2,455)	622
Nonoperating gains (losses):		
Interest and dividend income	487	548
Net realized gains on the sale of securities	328	239
Change in net unrealized gains on securities	(882)	(725)
Other nonoperating gains	423	80
NONOPERATING GAINS	356	142
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(2,099)	764

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations and Changes in Net Assets - Continued
(Smyth County Community Hospital and Subsidiary, Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

Year Ended June 30, 2016

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
Pension and postretirement liability adjustments	-	(2,879)
Net Asset Transfer	(110)	-
DECREASE IN UNRESTRICTED NET ASSETS	(2,209)	(2,115)
TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	8	153
Net assets released from restrictions	(8)	(149)
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	4
DECREASE IN TOTAL NET ASSETS	(2,209)	(2,111)
NET ASSETS, BEGINNING OF YEAR	82,123	60,870
NET ASSETS, END OF YEAR	$ 79,914	$ 58,759

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2016

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 57,455	$ 32,296	$ -	$ 89,751
Current portion of investments	25,772	-	-	25,772
Patient accounts receivable, less estimated allowance for uncollectible accounts	128,525	26,477	-	155,002
Other receivables, net	21,300	20,195	(6,433)	35,062
Inventories and prepaid expenses	26,597	8,301	-	34,898
TOTAL CURRENT ASSETS	259,649	87,269	(6,433)	340,485
INVESTMENTS, less amounts required to meet current obligations	387,199	238,624	-	625,823
EQUITY IN AFFILIATES	353,116	-	(353,116)	-
PROPERTY, PLANT AND EQUIPMENT, net	602,235	228,618	-	830,853
OTHER ASSETS				
Goodwill	152,600	3,965	-	156,565
Net deferred financing, acquisition costs and other charges	20,584	1,440	-	22,024
Other assets	47,413	7,984	-	55,397
TOTAL OTHER ASSETS	220,597	13,389	-	233,986
	$ 1,822,796	$ 567,900	$ (359,549)	$ 2,031,147

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet – Continued
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2016

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accrued interest payable	$ 13,566	$ 20	$ -	$ 13,586
Current portion of long-term debt and capital lease obligations	22,005	7,819	(6,433)	23,391
Accounts payable and accrued expenses	76,193	19,007	-	95,200
Accrued salaries, compensated absences and amounts withheld	50,996	17,726	-	68,722
Payables to (receivables from) affiliates, net	11,586	(11,586)	-	-
Estimated amounts due to third-party payers, net	8,459	691	-	9,150
TOTAL CURRENT LIABILITIES	182,805	33,677	(6,433)	210,049
OTHER LIABILITIES				
Long-term debt and capital lease obligations, less current portion	945,253	18,626	-	963,879
Estimated fair value of derivatives, net	4,483	-	-	4,483
Estimated professional liability self-insurance	6,368	1,026	-	7,394
Other long-term liabilities	34,709	2,271	-	36,980
TOTAL LIABILITIES	1,173,618	55,600	(6,433)	1,222,785
NET ASSETS				
Unrestricted net assets				
Mountain States Health Alliance	594,303	344,914	(344,914)	594,303
Noncontrolling interests in subsidiaries	40,684	153,779	5,379	199,842
TOTAL UNRESTRICTED NET ASSETS	634,987	498,693	(339,535)	794,145
Temporarily restricted net assets				
Mountain States Health Alliance	14,091	13,547	(13,547)	14,091
Noncontrolling interests in subsidiaries	73	33	(7)	99
TOTAL TEMPORARILY RESTRICTED NET ASSETS	14,164	13,580	(13,554)	14,190
Permanently restricted net assets	27	27	(27)	27
TOTAL NET ASSETS	649,178	512,300	(353,116)	808,362
	$ 1,822,796	$ 567,900	$ (359,549)	$ 2,031,147

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations
(Obligated Group and Other Entities)
(Dollars in Thousands)

Year Ended June 30, 2016

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
Revenue, gains and support:				
Patient service revenue, net of contractual allowances and discounts	$ 948,183	$ 211,441	$ (188)	$ 1,159,436
Provision for bad debts	(113,468)	(24,238)	-	(137,706)
Net patient service revenue	834,715	187,203	(188)	1,021,730
Other operating revenue	33,381	112,252	(94,592)	51,041
Equity in net gain of affiliates	(5,963)	1,161	4,802	-
TOTAL REVENUE, GAINS AND SUPPORT	862,133	300,616	(89,978)	1,072,771
Expenses:				
Salaries and wages	289,478	68,658	(6,169)	351,967
Physician salaries and wages	67,676	78,056	(61,689)	84,043
Contract labor	18,029	3,685	(403)	21,311
Employee benefits	64,768	20,037	(5,995)	78,810
Fees	93,339	32,998	(13,599)	112,738
Supplies	149,615	29,630	(103)	179,142
Utilities	12,515	3,669	(4)	16,180
Medical Costs	-	(762)	-	(762)
Other	63,549	28,291	(6,791)	85,049
Depreciation	50,015	16,403	-	66,418
Amortization	1,457	60	-	1,517
Interest and taxes	40,139	2,539	-	42,678
TOTAL EXPENSES	850,580	283,264	(94,753)	1,039,091
OPERATING INCOME	11,553	17,352	4,775	33,680
Nonoperating gains (losses):				
Interest and dividend income	9,893	5,141	-	15,034
Net realized gains on the sale of securities	4,763	1,751	-	6,514
Change in net unrealized gains on securities	(11,946)	(5,565)	-	(17,511)
Derivative related income	5,605	-	-	5,605
Loss on early extinguishment of debt	(2,827)	-	-	(2,827)
Change in estimated fair value of derivatives	(2,287)	-	-	(2,287)
Other nonoperating losses	(3,563)	(5,733)	(432)	(9,728)
NET NONOPERATING LOSS	(362)	(4,406)	(432)	(5,200)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES FROM CONTINUING OPERATIONS	11,191	12,946	4,343	28,480
LOSS FROM DISCONTINUED OPERATIONS	-	(6,492)	-	(6,492)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	$ 11,191	$ 6,454	$ 4,343	$ 21,988

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets (Obligated Group and Other Entities) (Dollars in Thousands)

Year Ended June 30, 2016

	Obligated Group		*Total*	*Other Entities*		*Total*		
	Mountain States Health Alliance	*Noncontrolling Interests*	*Obligated Group*	*Mountain States Health Alliance*	*Noncontrolling Interests*	*Other Entities*	*Eliminations*	*Total*
UNRESTRICTED NET ASSETS:								
Excess of Revenue, Gains and Support over Expenses and Losses	$ 11,230	$ (39)	$ 11,191	$ (394)	$ 6,848	$ 6,454	$ 4,343	$ 21,988
Pension and other defined benefit plan adjustments	(1,443)	(1,436)	(2,879)	236	236	472	(472)	(2,879)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,987	-	1,987	1,987	-	1,987	(1,987)	1,987
Repurchases of noncontrolling interests, net	(1,100)	-	(1,100)	-	-	-	99	(1,001)
Distributions to noncontrolling interests	-	-	-	(4,762)	(355)	(5,117)	4,762	(355)
Net asset transfers	-	-	-	3,409	3,828	7,237	(7,237)	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	10,674	(1,475)	9,199	476	10,557	11,033	(492)	19,740
TEMPORARILY RESTRICTED NET ASSETS:								
Restricted grants and contributions	5,840	77	5,917	4,947	34	4,981	(4,954)	5,944
Net assets released from restrictions	(5,052)	(76)	(5,128)	(4,288)	(9)	(4,297)	4,297	(5,128)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	788	1	789	659	25	684	(657)	816
PERMANENTLY RESTRICTED NET ASSETS:								
Net assets released from restrictions	-	-	-	(100)	-	(100)	-	(100)
DECREASE IN PERMANENTLY RESTRICTED NET ASSETS	-	-	-	(100)	-	(100)	-	(100)
INCREASE (DECREASE) IN TOTAL NET ASSETS	11,462	(1,474)	9,988	1,035	10,582	11,617	(1,149)	20,456
NET ASSETS, BEGINNING OF YEAR	596,959	42,231	639,190	357,453	143,230	500,683	(351,967)	787,906
NET ASSETS, END OF YEAR	$ 608,421	$ 40,757	$ 649,178	$ 358,488	$ 153,812	$ 512,300	$ (353,116)	$ 808,362

See Note to Supplemental Information.

NOTE A--OBLIGATED GROUP MEMBERS

As described in Note F to the consolidated financial statements, the Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The members pledged pursuant to the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Mellon Trust Company, NA as Master Trustee include Johnson City Medical Center Hospital, Indian Path Medical Center, Franklin Woods Community Hospital, Sycamore Shoals Hospital, Johnson County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Norton Community Hospital (hospital only), Smyth County Community Hospital (hospital only) and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating information includes the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance are not pledged to secure the payment of the outstanding bonds as they are not part of the Obligated Group. These affiliates have been accounted for within the Obligated Group based upon the Alliance's original and subsequent investments, as adjusted for the Alliance's pro rata share of income or losses and any distributions, and are included as a part of equity in affiliates in the supplemental consolidating balance sheet.

Indian Path Medical Center
Provider No. 44-0176
Period: July 1, 2013 through June 30, 2014
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine			0.0000
1400	Internal Medicine	0.0000	1.2742	1.2742
2000	Pediatrics			0.0000
	Total	0.0000	1.2742	1.2742

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology			0.0000
1407	Gastroenterology			0.0000
1410	Infectious Disease			0.0000
1419	Hematology	0.0000	0.6490	0.6490
1420	Pulmonary - Critical Care			0.0000
1550	Internal Medicine & Pyschiatry			0.0000
1750	OB/GYN	0.0000	1.0970	1.0970
1950	Pathology			0.0000
2200	Psychiatry			0.0000
2450	Surgery			0.0000
	Total	0.0000	1.7460	1.7460
	Grand Total	0.00	3.02	3.02

IPMC
Provider No: 44-0176
FYE: June 30, 2015
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1400	Internal Medicine	0.0000	1.6012	1.6012
	Total	0.0000	1.6012	1.6012

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1750	OB/GYN	0.0000	0.0186	0.0186
	Total	0.0000	0.0186	0.0186
	Grand Total	0.00	1.62	1.62

IPMC
Provider No: 44-0176
FYE: June 30, 2016
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1400	Internal Medicine	0.0000	1.8129	1.8129
	Total	0.0000	1.8129	1.8129

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
		0.0000	0.0000	0.0000
	Total	0.0000	0.0000	0.0000
	Grand Total	0.00	1.81	1.81

Johnson City Medical Center
Provider No. 440063
Period: July 1, 2013 through June 30, 2014
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	10.2009	7.4423	17.6432
1400	Internal Medicine	0.0000	8.0843	8.0843
2000	Pediatrics	0.0000	16.6077	16.6077
	Total	10.2009	32.1343	42.3352

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology	0.0000	5.8001	5.8001
1407	Gastroenterology	0.0000	4.2745	4.2745
1410	Infectious Disease	0.0000	3.2235	3.2235
1419	Hematology	0.0000	6.2873	6.2873
1420	Pulmonary - Critical Care	0.0000	2.0081	2.0081
1550	Internal Medicine & Pyschiatry	0.0000	0.5603	0.5603
1750	OB/GYN	0.0000	9.4249	9.4249
1950	Pathology	0.0000	3.9667	3.9667
2200	Psychiatry	0.6248	7.4282	8.0530
2450	Surgery	0.0674	12.3898	12.4571
	Total	0.6922	55.3634	56.0555
	Grand Total	10.89	87.50	98.3907

Johnson City Medical Center
Provider No. 44-0063
Period: July 1, 2014 through June 30, 2015
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	3.7303	13.7377	17.4680
1400	Internal Medicine	0.0000	13.9680	13.9680
2000	Pediatrics	0.0849	17.2205	17.3054
	Total	3.8152	44.9262	48.7414

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology	0.0000	3.9519	3.9519
1407	Gastroenterology	0.0000	2.6156	2.6156
1410	Infectious Disease	0.0000	1.9777	1.9777
1419	Hematology	0.0000	3.2637	3.2637
1420	Pulmonary - Critical Care	0.0000	1.0525	1.0525
1550	Internal Medicine & Pyschiatry	0.0000	0.0000	0.0000
1750	OB/GYN	0.0000	8.8878	8.8878
1950	Pathology	0.0000	3.9608	3.9608
2200	Psychiatry	2.1900	2.0045	4.1946
2450	Surgery	0.0539	10.6382	10.6921
	Total	2.2440	38.3527	40.5967
	Grand Total	6.06	83.28	89.34

Johnson City Medical Center
Provider No. 44-0063
Period: July 1, 2015 through June 30, 2016
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	0.0000	16.7813	16.7813
1400	Internal Medicine	0.0000	11.7081	11.7081
2000	Pediatrics	0.0000	18.5893	18.5893
	Total	0.0000	47.0787	47.0787

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology	0.0000	3.9579	3.9579
1407	Gastroenterology	0.0000	2.5724	2.5724
1410	Infectious Disease	0.0000	2.0002	2.0002
1419	Hematology	0.0000	4.0878	4.0878
1420	Pulmonary - Critical Care	0.0000	1.9104	1.9104
1550	Internal Medicine & Pyschiatry	0.0000	0.0000	0.0000
1750	OB/GYN	0.0000	8.4808	8.4808
1950	Pathology	0.0000	3.8712	3.8712
2200	Psychiatry	1.7248	2.6696	4.3944
2450	Surgery	0.0729	11.5275	11.6003
	Total	1.7977	41.0778	42.8755
	Grand Total	1.80	88.16	89.95

Johnston Memorial Hospital
Provider No: 490053
Period: July 1, 2015 through June 30, 2016
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	0.0000	4.9560	4.9560
1400	Internal Medicine	0.0000	0.4109	0.4109
	Total	0.0000	5.3669	5.3669

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
	Total	0.0000	0.0000	0.0000
	Grand Total	0.00	5.37	5.37

Norton Community Hospital
Provider No: 490001
INTERNAL MEDICINE
FYE: September 30, 2014

Program Name	Internal Medicine	
Program Code	1400	
Unweighted primary care FTE residents with rotations at non-provider settings	5.13	S-2, Pt I, Ln 67, Col 3
Unweighted primary care FTE residents trained at hospital	13.83	S-2, Pt I, Ln 67, Col 4

Norton Community Hospital
Provider No: 490001
INTERNAL MEDICINE
FYE: September 30, 2015

Program Name	Internal Medicine	
Program Code	1400	
Unweighted primary care FTE residents with rotations at non-provider settings	4.67	S-2, Pt I, Ln 67, Col 3
Unweighted primary care FTE residents trained at hospital	15.93	S-2, Pt I, Ln 67, Col 4

Norton Community Hospital
Provider No: 490001
INTERNAL MEDICINE
FYE: June 30, 2016

Program Name	Internal Medicine	
Program Code	1400	
Unweighted primary care FTE residents with rotations at non-provider settings	2.88	S-2, Pt I, Ln 67, Col 3
Unweighted primary care FTE residents trained at hospital	11.46	S-2, Pt I, Ln 67, Col 4

DIRECT GRADUATE MEDICAL EDUCATION (GME)& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 440012 Period: From 7/1/2013 To 6/30/2014 Date/Time Prepared: 11/17/2014 5:01:00 PM

		Title XVIII	Hospital	PPS	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT			1.00	
1	unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			30.00	1
2	unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			-	2
3	Amount of reduction to Direct GME cap under section 422 of MMA			-	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b)and § 413.79 (f))			-	4
4.01	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			-	4.01
4.02	ACA section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			-	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus 1i nes 4.01 and 4.02 plus applicable subscripts			30.00	5
6	unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			37.69	6
7	Enter the lesser of line 5 or line 6			30.00	7
		Primary Care 1.00	Other 2.00	Total 3.00	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	32.61	5.07	37.68	8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	25.96	4.04	30.00	9
10	Weighted dental and podiatric resident FTE count for the current year			-	10
11	Total weighted FTE count	25.96	4.04		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	25.86	4.14		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	25.98	4.02		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	25.93	4.07		14
15	Adjustment for residents in initial years of new programs	0	0		15
16	Adjustment for residents displaced by program or hospital closure	0	0		16
17	Adjusted rolling average FTE count	25.93	4.07		17
18	Per resident amount	80031.89	80031.89		18
19	Approved amount for resident costs	2075227	325730	2,400,957.00	19
				1.00	
20	Additiona1 unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413.79(c)(4)			4.80	20
21	Direct GME FTE unweighted resident count over cap (see instructions)			7.69	21
22	Allowable additional direct GME FTE Resident count (see instructions)			4.80	22
23	Enter the locally adjustment national average per resident amount (see instructions)			94,155.16	23
24	Multiply line 22 time line 23			451,945.00	24
25	Total direct GME amount (sum of lines 19 and 24)			2,852,902.00	25
		Inpatient Part A 1.00	Managed care 2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient Days (see instructions)	25053	13794		26
27	Total Inpatient Days (see instructions)	64210	64210		27
28	Ratio of inpatient days to total inpatient days	0.390173	0.214826		28
29	Program direct GME amount	1113125	612878		29
30	Reduction for direct GME payments for Medicare Advantage		86600		30
31	Net Program direct GME amount			1,639,403.00	31

	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING S0100L AND PARAMEDICAL EDUCATION COSTS)		
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	-	32
33	Renal dialysis and home dialysis total charges (Wkst. c, Pt. I, col. 8, sum of lines 74 and 94)	1,095,960.00	33
34	Ratio of direct medical education costs to total charges (line 32 / line 33)	0.0000000	34
35	Medicare outpatient ESRD charges (see instructions)	-	35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	-	36
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable cost		
37	Reasonable cost (see instructions)	37,595,165.00	37
38	Organ acquistion costs (Wkst. D-4, Pt. III, col. 1, line 69)	-	38
39	Cost of physicians' services in a teaching hospital (see instructions)	-	39
40	Ptimary payer payments (see	77,961.00	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	37,517,204.00	41
	Part B Reasonable cost		
`	Reasonable cost (see instructions)	19,386,611.00	42
43	Primary payer payments (see instructions)	25,726.00	43
44	Total Part B reasonable cost (line 42 minus line 43)	19,360,885.00	44
45	Total reasonable cost (sum of lines 41 and 44)	56,878,089.00	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41/ line 45)	0.66	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44/ line 45)	0.34	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	Total program GME payment (line 31)	1,639,403.00	48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instractions)	1,081,362.00	49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instractions)	558,041.00	50

DIRECT GRADUATE MEDICAL EDUCATION (GME)& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 440012 Period: From 7/1/2014 To 6/30/2015 Date/Time Prepared: 11/13/2015 6:22:00 PM

		Title XVIII	Hospital	PPS	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1	unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			30	1
2	unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			-	2
3	Amount of reduction to Direct GME cap under section 422 of MMA			-	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b)and § 413.79 (f))			-	4
4.01	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			-	4.01
4.02	ACA section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			-	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus 1i nes 4.01 and 4.02 plus applicable subscripts			30	5
6	unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			35	6
7	Enter the lesser of line 5 or line 6			30	7
		Primary Care 1.00	Other 2.00	Total 3.00	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	29.09	4.66	34	8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	25.24	4.04	29	9
10	Weighted dental and podiatric resident FTE count for the current year		0	-	10
11	Total weighted FTE count	25.24	4.04		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	25.96	4.04		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	25.86	4.14		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	25.69	4.07		14
15	Adjustment for residents in initial years of new programs	0	0		15
16	Adjustment for residents displaced by program or hospital closure	0	0		16
17	Adjusted rolling average FTE count	25.69	4.07		17
18	Per resident amount	80031.89	80031.89		18
19	Approved amount for resident costs	2056019	325730	2,381,749	19
				1.00	
20	Additiona1 unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413.79(c)(4)			5	20
21	Direct GME FTE unweighted resident count over cap (see instructions)			5	21
22	Allowable additional direct GME FTE Resident count (see instructions)			4	22
23	Enter the locally adjustment national average per resident amount (see instructions)			94,155	23
24	Multiply line 22 time line 23			419,932	24
25	Total direct GME amount (sum of lines 19 and 24)			2,801,681	25

		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient Days (see instructions)	24178	15022		26
27	Total Inpatient Days (see instructions)	65003	65003		27
28	Ratio of inpatient days to total inpatient days	0.371952	0.231097		28
29	Program direct GME amount	1042091	647460		29
30	Reduction for direct GME payments for Medicare Advantage		91486		30
31	Net Program direct GME amount			1,598,065	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING S0100L AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			-	32
33	Renal dialysis and home dialysis total charges (Wkst. c, Pt. I, col. 8, sum of lines 74 and 94)			1,024,227	33
34	Ratio of direct medical education costs to total charges (line 32 / line 33)			-	34
35	Medicare outpatient ESRD charges (see instructions)			-	35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			-	36
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
	Part A Reasonable cost				
37	Reasonable cost (see instructions)			38,645,382	37
38	Organ acquistion costs (Wkst. D-4, Pt. III, col. 1, line 69)			-	38
39	Cost of physicians' services in a teaching hospital (see instructions)			-	39
40	Ptimary payer payments (see			69,189	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			28,576,193	41
	Part B Reasonable cost				
42	Reasonable cost (see instructions)			18,769,445	42
43	Primary payer payments (see instructions)			26,835	43
44	Total Part B reasonable cost (line 42 minus line 43)			18,742,610	44
45	Total reasonable cost (sum of lines 41 and 44)			57,318,803	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41/ line 45)			0.673011	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44/ line 45)			0.326989	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			1,598,065	48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instractions)			1,075,515	49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instractions)			522,550	50

DIRECT GRADUATE MEDICAL EDUCATION (GME)& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 440017 Period: From 7/1/2013 To 6/30/2014 Date/Time Prepared: 11/17/2014 7:13:00 PM

		Title XVIII	Hospital	PPS	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1	unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			34.91	1
2	unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			-	2
3	Amount of reduction to Direct GME cap under section 422 of MMA			-	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b)and § 413.79 (f))			-	4
4.01	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			-	4.01
4.02	ACA section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			-	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus 1i nes 4.01 and 4.02 plus applicable subscripts			34.91	5
6	unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			46.04	6
7	Enter the lesser of line 5 or line 6			34.91	7
		Primary Care 1.00	Other 2.00	Total 3.00	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	28.68	17.36	46.04	8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	21.75	13.16	34.91	9
10	Weighted dental and podiatric resident FTE count for the current year		0	-	10
11	Total weighted FTE count	21.75	13.16		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	23.24	11.67		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	25.05	9.86		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	23.35	11.56		14
15	Adjustment for residents in initial years of new programs	0	0		15
16	Adjustment for residents displaced by program or hospital closure	0	0		16
17	Adjusted rolling average FTE count	23.35	11.56		17
18	Per resident amount	80024.2	80024.2		18
19	Approved amount for resident costs	1868565	925080	2,793,645.00	19
				1.00	
20	Additiona1 unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413.79(c)(4)			6.23	20
21	Direct GME FTE unweighted resident count over cap (see instructions)			11.13	21
22	Allowable additional direct GME FTE Resident count (see instructions)			6.23	22
23	Enter the locally adjustment national average per resident amount (see instructions)			94,146.12	23
24	Multiply line 22 time line 23			586,530.00	24
25	Total direct GME amount (sum of lines 19 and 24)			3,380,175.00	25
		Inpatient Part A 1.00	Managed care 2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient Days (see instructions)	23347	22057		26
27	Total Inpatient Days (see instructions)	78097	78097		27
28	Ratio of inpatient days to total inpatient days	0.298949	0.282431		28
29	Program direct GME amount	1010500	954666		29
30	Reduction for direct GME payments for Medicare Advantage		134894		30
31	Net Program direct GME amount			1,830,272.00	31

	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING S0100L AND PARAMEDICAL EDUCATION COSTS)		
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	-	32
33	Renal dialysis and home dialysis total charges (Wkst. c, Pt. I, col. 8, sum of lines 74 and 94)	1,258,178.00	33
34	Ratio of direct medical education costs to total charges (line 32 / line 33)	0.0000000	34
35	Medicare outpatient ESRD charges (see instructions)	-	35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	-	36
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable cost		
37	Reasonable cost (see instructions)	45,942,628	37
38	Organ acquistion costs (Wkst. D-4, Pt. III, col. 1, line 69)	-	38
39	Cost of physicians' services in a teaching hospital (see instructions)	-	39
40	Ptimary payer payments (see	175,622	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	45,767,006	41
	Part B Reasonable cost		
42	Reasonable cost (see instructions)	18,535,175	42
43	Primary payer payments (see instructions)	19,283	43
44	Total Part B reasonable cost (line 42 minus line 43)	18,515,892	44
45	Total reasonable cost (sum of lines 41 and 44)	64,282,898	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41/ line 45)	0.711962	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44/ line 45)	0.288038	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	Total program GME payment (line 31)	1,830,272	48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instractions)	1,303,084	49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instractions)	527,188	50

DIRECT GRADUATE MEDICAL EDUCATION (GME)& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 440017 Period: From 7/1/2014 To 6/30/2015 Date/Time Prepared: 11/13/2015 7:36:00 PM

		Title XVIII	Hospital	PPS
	COMPUTATION OF TOTAL DIRECT GME AMOUNT			**1.00**
`	unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			34.91
2	unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			-
3	Amount of reduction to Direct GME cap under section 422 of MMA			-
3	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b)and § 413.79 (f))			-
4	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			-
4	ACA section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			-
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus 1i nes 4.01 and 4.02 plus applicable subscripts			34.91
6	unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			48.71
7	Enter the lesser of line 5 or line 6			34.91
		Primary Care 1.00	Other 2.00	Total 3.00
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	30.21	17.88	48.09
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	21.2	12.55	33.75
10	Weighted dental and podiatric resident FTE count for the current year		0	-
11	Total weighted FTE count	21.2	12.55	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	21.75	13.16	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	23.24	11.67	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	22.06	12.46	
15	Adjustment for residents in initial years of new programs	0	0	
16	Adjustment for residents displaced by program or hospital closure	0	0	
17	Adjusted rolling average FTE count	22.06	12.46	
18	Per resident amount	80024.2	80024.2	
19	Approved amount for resident costs	1765334	997102	2,762,436.00
				1.00
20	Additiona1 unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413.79(c)(4)			6.23
21	Direct GME FTE unweighted resident count over cap (see instructions)			14.52
22	Allowable additional direct GME FTE Resident count (see instructions)			6.15
23	Enter the locally adjustment national average per resident amount (see instructions)			94,146.12
24	Multiply line 22 time line 23			578,999.00
25	Total direct GME amount (sum of lines 19 and 24)			3,341,435.00
		Inpatient Part A 1.00	Managed care 2.00	3.00
	COMPUTATION OF PROGRAM PATIENT LOAD			
26	Inpatient Days (see instructions)	23410	23244	
27	Total Inpatient Days (see instructions)	77163	77163	
28	Ratio of inpatient days to total inpatient days	0.303384	0.301232	
29	Program direct GME amount	1013738	1006547	
30	Reduction for direct GME payments for Medicare Advantage		142225	
31	Net Program direct GME amount			1,878,060.00

	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING S0100L AND PARAMEDICAL EDUCATION COSTS)	
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	-
33	Renal dialysis and home dialysis total charges (Wkst. c, Pt. I, col. 8, sum of lines 74 and 94)	1,076,038.00
34	Ratio of direct medical education costs to total charges (line 32 / line 33)	0.0000000
35	Medicare outpatient ESRD charges (see instructions)	-
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	-
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY	
	Part A Reasonable cost	
37	Reasonable cost (see instructions)	47,029,697
38	Organ acquistion costs (Wkst. D-4, Pt. III, col. 1, line 69)	-
39	Cost of physicians' services in a teaching hospital (see instructions)	-
40	Ptimary payer payments (see	10,902
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	47,018,795
	Part B Reasonable cost	
42	Reasonable cost (see instructions)	19,786,602
43	Primary payer payments (see instructions)	34,309
44	Total Part B reasonable cost (line 42 minus line 43)	19,752,293
45	Total reasonable cost (sum of lines 41 and 44)	66,771,088
46	Ratio of Part A reasonable cost to total reasonable cost (line 41/ line 45)	0.704179
47	Ratio of Part B reasonable cost to total reasonable cost (line 44/ line 45)	0.295821
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B	
48	Total program GME payment (line 31)	1,878,060
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instractions)	1,322,490
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instractions)	555,570

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DIRECT GRADUATE MEDICAL EDUCATION (GME)& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 490114 Period: From 7/1/2013 To 6/30/2014 Date/Time Prepared: 7/25/2016 4:14:00 PM

		Title XVIII	Hospital	PPS	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1	unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			-	1
2	unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			20	2
3	Amount of reduction to Direct GME cap under section 422 of MMA			-	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b)and § 413.79 (f))			-	4
4.01	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			-	4.01
4.02	ACA section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			-	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus 1i nes 4.01 and 4.02 plus applicable subscripts			20	5
6	unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			17	6
7	Enter the lesser of line 5 or line 6			17	7
		Primary Care 1.00	Other 2.00	Total 3.00	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	16.97	0	17	8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	16.97	0	17	9
10	Weighted dental and podiatric resident FTE count for the current year		0	-	10
11	Total weighted FTE count	16.97	0		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	16.32	0		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	9.78	0		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	14.36	0		14
15	Adjustment for residents in initial years of new programs	0	0		15
16	Adjustment for residents displaced by program or hospital closure	0	0		16
17	Adjusted rolling average FTE count	14.36	0		17
18	Per resident amount	89128.5	0		18
19	Approved amount for resident costs	1279885	0	1,279,885	19
				1.00	
20	Additiona1 unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413.79(c)(4)			-	20
21	Direct GME FTE unweighted resident count over cap (see instructions)			-	21
22	Allowable additional direct GME FTE Resident count (see instructions)			-	22
23	Enter the locally adjustment national average per resident amount (see instructions)			-	23
24	Multiply line 22 time line 23			-	24
25	Total direct GME amount (sum of lines 19 and 24)			1,279,885	25

		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient Days (see instructions)	3592	843		26
27	Total Inpatient Days (see instructions)	7647	7647		27
28	Ratio of inpatient days to total inpatient days	0.469727	0.110239		28
29	Program direct GME amount	601197	141093		29
30	Reduction for direct GME payments for Medicare Advantage		19936		30
31	Net Program direct GME amount			722,354	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING S0100L AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			-	32
33	Renal dialysis and home dialysis total charges (Wkst. c, Pt. I, col. 8, sum of lines 74 and 94)			-	33
34	Ratio of direct medical education costs to total charges (line 32 / line 33)			-	34
35	Medicare outpatient ESRD charges (see instructions)			-	35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			-	36
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
	Part A Reasonable cost				
37	Reasonable cost (see instructions)			7,068,983	37
38	Organ acquistion costs (Wkst. D-4, Pt. III, col. 1, line 69)			-	38
39	Cost of physicians' services in a teaching hospital (see instructions)			-	39
40	Ptimary payer payments (see			38,043	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			7,030,940	41
	Part B Reasonable cost				
42	Reasonable cost (see instructions)			8,664,797	42
43	Primary payer payments (see instructions)			3,368	43
44	Total Part B reasonable cost (line 42 minus line 43)			8,661,429	44
45	Total reasonable cost (sum of lines 41 and 44)			15,692,369	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41/ line 45)			0.448048	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44/ line 45)			0.551952	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			722,354	48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instractions)			323,649	49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instractions)			398,705	50

DIRECT GRADUATE MEDICAL EDUCATION (GME)& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 490114 Period: From 7/1/2014 To 6/30/2015 Date/Time Prepared: 11/17/2015 4:06:00 PM

		Title XVIII	Hospital	PPS	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1	unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			-	1
2	unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			-	2
3	Amount of reduction to Direct GME cap under section 422 of MMA			-	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b)and § 413.79 (f))			-	4
4.01	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			-	4.01
4.02	ACA section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			-	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus 1i nes 4.01 and 4.02 plus applicable subscripts			-	5
6	unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			14.68	6
7	Enter the lesser of line 5 or line 6			-	7
		Primary Care 1.00	Other 2.00	Total 3.00	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	14.62	-	14.62	8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	-	-	-	9
10	Weighted dental and podiatric resident FTE count for the current year		-	-	10
11	Total weighted FTE count	-	-		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	16.97	-		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	16.63	-		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	11.20	-		14
15	Adjustment for residents in initial years of new programs	-	-		15
16	Adjustment for residents displaced by program or hospital closure	-	-		16
17	Adjusted rolling average FTE count	11.20	-		17
18	Per resident amount	90,652.27	90,652.27		18
19	Approved amount for resident costs	1,015,305.00	-	1,015,305.00	19
				1.00	
20	Additiona1 unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413.79(c)(4)			-	20
21	Direct GME FTE unweighted resident count over cap (see instructions)			14.68	21
22	Allowable additional direct GME FTE Resident count (see instructions)			-	22
23	Enter the locally adjustment national average per resident amount (see instructions)			-	23
24	Multiply line 22 time line 23			-	24
25	Total direct GME amount (sum of lines 19 and 24)			1,015,305	25
		Inpatient Part A 1.00	Managed care 2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient Days (see instructions)	3,045	967		26
27	Total Inpatient Days (see instructions)	6,414	6,414		27
28	Ratio of inpatient days to total inpatient days	0.474743	0.150764		28
29	Program direct GME amount	482,009	153,071		29
30	Reduction for direct GME payments for Medicare Advantage		21,629		30
31	Net Program direct GME amount			613,451	31

	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING S0100L AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32
33	Renal dialysis and home dialysis total charges (Wkst. c, Pt. I, col. 8, sum of lines 74 and 94)			0	33
34	Ratio of direct medical education costs to total charges (line 32 / line 33)			0	34
35	Medicare outpatient ESRD charges (see instructions)			0	35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
	Part A Reasonable cost				
37	Reasonable cost (see instructions)			747131	37
38	Organ acquistion costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38
39	Cost of physicians' services in a teaching hospital (see instructions)			0	39
40	Primary payer payments (see			1099	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			7470214	41
	Part B Reasonable cost				
42	Reasonable cost (see instructions)			9814915	42
43	Primary payer payments (see instructions)			2583	43
44	Total Part B reasonable cost (line 42 minus line 43)			9812332	44
45	Total reasonable cost (sum of lines 41 and 44)			17282546	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41/ line 45)			0	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44/ line 45)			0.56776	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			613451	48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instractions)			265158	49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instractions)			348293	50

GME Programs 2016-17
Sponsoring Instituion - East Tennessee State University

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Kingsport Family Medicine	Mark Brummel, DO	brummel@etsu.edu	Amy E Murphy	murphya@etsu.edu	(423) 245-9626
Internal Medicine	Jonathan P Moorman MD, PhD	moorman@etsu.edu	Heather M Grove	groveh@etsu.edu	(423) 439-6389
Infectious Disease	James W Myers, MD	myersj@etsu.edu	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Cardiovascular Disease	Vijay K Ramu, MD	ramuv@etsu.edu	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Oncology	Devapiran Jaishankar, MD	jaishank@etsu.edu	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Pulmonary Disease and Critical Care	Girendra Hoskere, MD	hoskereg@etsu.edu	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Gastroenterology	Mark F Young, MD	mfyoung2004@yahoo.com	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Obstetrics and Gynecology	T Watson Jernigan, MD, MA	jernigan@etsu.edu	Patti D Davison	davisonp@etsu.edu	(423) 439-6262
Pathology - Anatomic & Clincial	Salah Shurbaji, MD	shurbaji@etsu.edu	Terri L McFeature	mcfeatur@etsu.edu	(423) 439-6790
Pediatrics	Dawn S Tuell, MD	tuell@etsu.edu	Laura B Smith	smithcb2@etsu.edu	(423) 439-6763
Psychiatry	Shambhavi Chandraiah, MD	chandraiah@etsu.edu	Dakotah L Williams	williamsdl1@etsu.edu	(423) 439-2225
Surgery	Joseph R Lee, MD	leejr1@etsu.edu	Julie B Simerly	simerlyjb@etsu.edu	(423) 439-6267

Sponsoring Institution	ACGME Designated Institutional Official (DIO)		Institutional Coordinator		
East Tennessee State University	David Linville, MD, EdD	linville@etsu.edu	Renee McNeely	mcneely@etsu.edu	423-439-8023

IV. Academic and Research Opportunities
A. Graduate Medical Education

3. **Please list all residency and fellowship programs, identifying the sponsoring institutions and individuals responsible for each residency and fellowship program. Provide contact information for all responsible individuals.**

August 22, 2016

Residency Programs
Family Medicine
Ronna D. New, DO, Director
newrd@msha.com
Brooke Davis, MBA, Interim Manager
davisbe@msha.com

Internal Medicine
Camelia Chirculescu, MD, Director
chirculescuc@msha.com
Brooke Davis, MBA, Manager
davisbe@msha.com

Administrative Director of Graduate Medical Education
Lynn Elliott, MDiv
elliottl@msha.com

Brian E. Condit MD. MSHA, FAAPMR
Vice President/Chief Medical Officer/
Designated Institutional Officer GME
Northeast Market
Mountain States Health Alliance
ConditBE@msha.com
Office: (276) 258-2820
Cell: (276) 623-7288

Johnston Memorial Hospital has a relationship with the Edward Via College of Osteopathic Medicine in Blacksburg, Virginia, to provide clinical rotations for third and fourth-year medical students.

IV. Academic and Research Opportunities

A. Graduate Medical Education

3. **Please list all residency and fellowship programs, identifying the sponsoring institutions and individuals responsible for each residency and fellowship program. Provide contact information for all responsible individuals.**

Residency Program: Internal Medicine

Sponsoring Institution: Norton Community Hospital

Program Director: Jody Bentley, DO, FACOI
Internal Medicine Residency Program
Norton Community Hospital, GME office
NW Market Mountain States Health Alliance
96 15th St NW Suite 106
Norton, VA 24273
BentleyJB@msha.com

Graduate Medical Education Due Diligence
Question 3 & 6

Bristol Regional Medical Center											
		2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Cap	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**Affiliation**	**Contact**
Family Medicine		23.24	23.73	NA	NA	NA	NA	NA	NA	ETSU	
Internal Medicine										ETSU	
- Residents		8.17	5.19	NA	NA	NA	NA	NA	NA		
- Fellows		1.20	0.99	NA	NA	NA	NA	NA	NA		
Surgery		5.07	4.66	NA	NA	NA	NA	NA	NA	ETSU	
Total	34.80	37.68	34.57								

Holston Valley Medical Center											
		2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Cap	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**Affiliation**	**Contact**
Family Medicine		17.26	17.82	NA	NA	NA	NA	NA	NA	ETSU	
Internal Medicine										ETSU	
- Residents		11.38	12.22	NA	NA	NA	NA	NA	NA		
- Fellows		0.04	0.17	NA	NA	NA	NA	NA	NA		
Surgery		7.99	7.31	NA	NA	NA	NA	NA	NA	ETSU	
Orthopedic Surgery		9.37	10.57	NA	NA	NA	NA	NA	NA	LMU	
Total	41.14	46.04	48.09								

Lonesome Pine Hospital											
		2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Cap	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**Affiliation**	**Contact**
Family Medicine		16.97	14.62	NA	NA	NA	NA	NA	NA	LMU	
Total	20.28	16.97	14.62								

GME Programs 2016-17
Sponsoring Instituion - East Tennessee State University

Program	Program Director	Email	Program Coordinator	Email	Phone
Bristol Family Medicine	Gregory E Clarity, MD	clarity@etsu.edu	Julie Robinette	robinett@etsu.edu	(423) 990-3014
Johnson City Family Medicine	Diana L Heiman, MD	heiman@etsu.edu	Terry Xixis	xixise@etsu.edu	(423) 439-6464
Kingsport Family Medicine	Mark Brummel, DO	brummel@etsu.edu	Amy E Murphy	murphya@etsu.edu	(423) 245-9626
Internal Medicine	Jonathan P Moorman MD, PhD	moorman@etsu.edu	Heather M Grove	groveh@etsu.edu	(423) 439-6389
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Pulmonary Disease and Critical Care	Girendra Hoskere, MD	hoskereg@etsu.edu	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Gastroenterology	Mark F Young, MD	mfyoung2004@yahoo.com	Carla M Hill	hillc@etsu.edu	(423) 439-8048
Obstetrics and Gynecology	T Watson Jernigan, MD, MA	jernigan@etsu.edu	Patti D Davison	davisonp@etsu.edu	(423) 439-6262
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Psychiatry	Shambhavi Chandraiah, MD	chandraiah@etsu.edu	Dakotah L Williams	williamsdl1@etsu.edu	(423) 439-2225
Surgery	Joseph R Lee, MD	leejr1@etsu.edu	Julie B Simerly	simerlyjb@etsu.edu	(423) 439-6267

Sponsoring Institution	ACGME Designated Institutional Official (DIO)		Institutional Coordinator		
East Tennessee State University	David Linville, MD, EdD	linville@etsu.edu	Renee McNeely	mcneely@etsu.edu	423-439-8023

East Tennessee State University
ACGME Sponsoring Institution 8004700524

Dean of Medicine
Robert T Means, Jr., MD
meansr@etsu.edu

Graduate Medical Education Committee (GMEC)
Chair:
David Linville, MD, EdD
linville@etsu.edu

ACGME Designated Institutional Official (DIO)
Assoc. Dean for GME
David Linville, MD, EdD
linville@etsu.edu

Health System Leadership primary contacts for DIO

Mountain States Health Alliance
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EVP & Chief Medical Officer
seligmanmh@msha.com

Wellmont Bristol Regional Medical Center
Chad Couch, MD
Chief Medical Officer
chad.couch@wellmont.org

Wellmont Holston Valley Medical Center
Herbert D Ladley, MD
Chief Medical Officer
HLadley@mycva.com

Veterans Affairs Quillen Medical Center
Martin P Eason, MD, JD
Assoc Chief of Staff - Education
martin.eason@va.gov

Kingsport Family Medicine
Mark Brummel, DO
brummel@etsu.edu

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Gregory E Clarity, MD
clarity@etsu.edu

Johnson City Family Medicine
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heiman@etsu.edu

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Internal Medicine
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Obstetrics and Gynecology
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jernigan@etsu.edu

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Pathology - Anatomic & Clinical
Salah Shurbaji, MD
shurbaji@etsu.edu

Psychiatry
Shambhavi Chandraiah, MD
chandraiah@etsu.edu

- GME Leadership, *DIO*
- Residency, *Program Director*
- Fellowship, *Program Director*
- Health System Leadership

Gastroenterology
Mark F Young, MD
mfyoung2004@yahoo.com

Cardiovascular Disease
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ramuv@etsu.edu

Pulmonary Disease and Critical Care
Girendra Hoskere, MD
hoskereg@etsu.edu

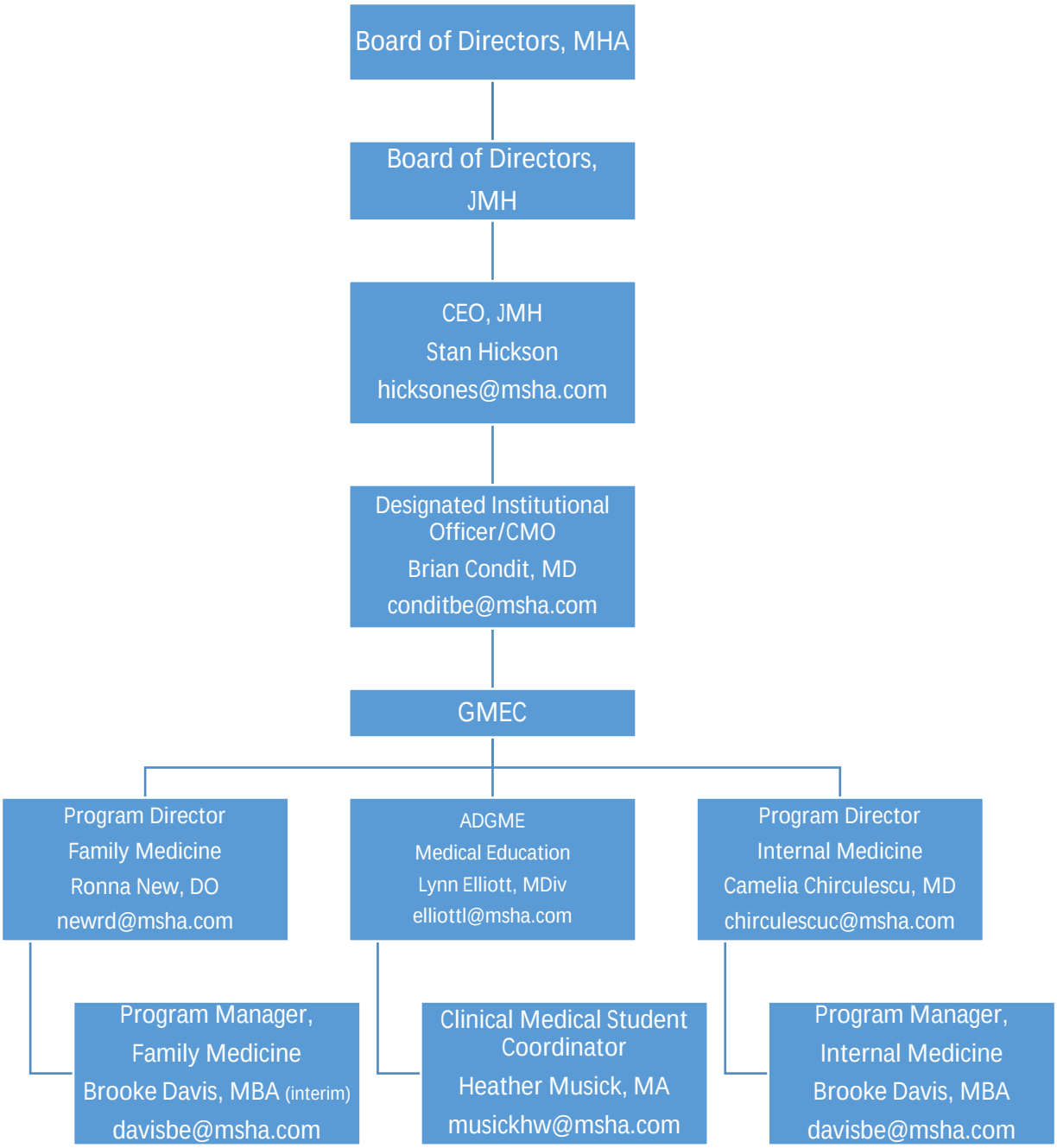
Infectious Disease
James W Myers, MD
myersj@etsu.edu

Oncology
Devapiran Jaishankar, MD
jaishank@etsu.edu

IV. Academic and Research Opportunities

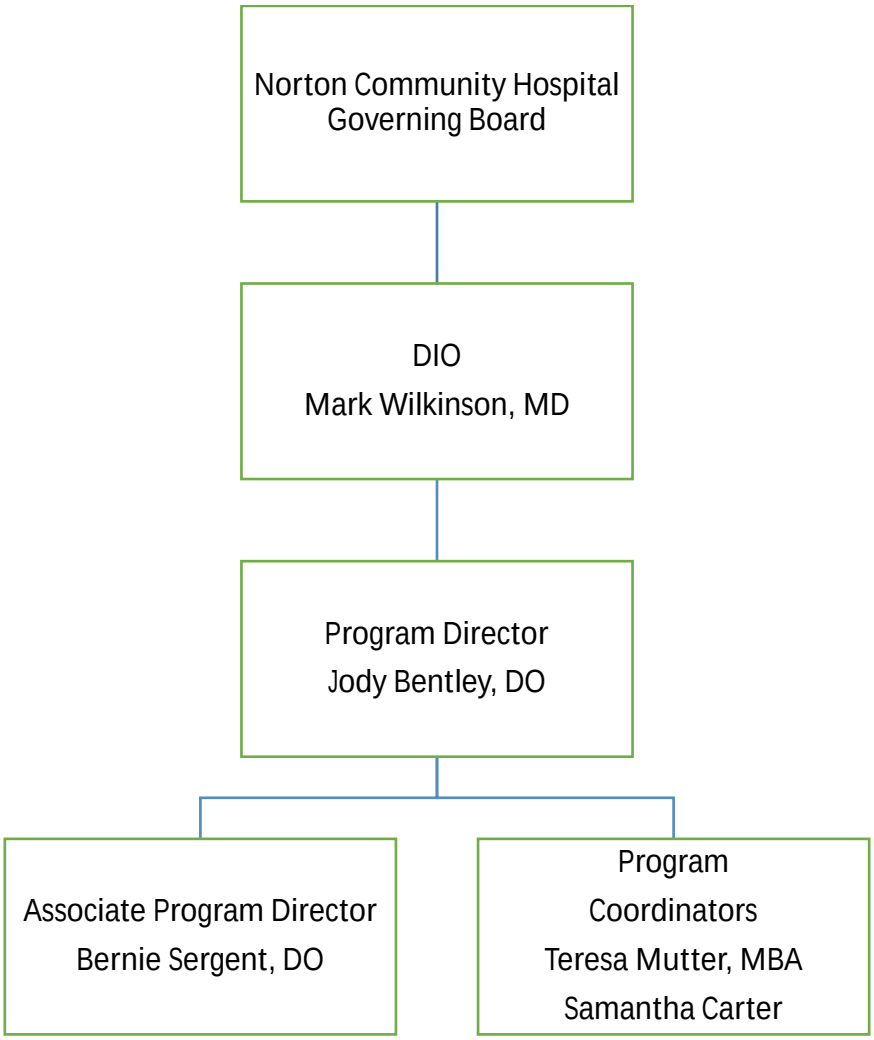
A. Graduate Medical Education

4. **Please provide an organization chart for the GME programs currently in place. List the individuals, with their titles responsible for each component displayed on the organization chart. Provide the contact information for these individuals.**



IV. Academic and Research Opportunities
A. Graduate Medical Education

4. **Please provide an organization chart for the GME programs currently in place. List the individuals, with their titles responsible for each component displayed on the organization chart. Provide the contact information for these individuals.**



Contact Information:

Norton Community Hospital Board of Directors,
Norton Community Hospital,
100 15th St NW, Norton, VA 24273
Contact: 276-439-1015

Mark Wilkinson, MD, Designated Instructional Officer/Chief Medical Office
Norton Community Hospital
NW Market Mountain States Health Alliance
100 15th St NW
Norton, VA 24273
Contact: 276-439-1015
WilkinsonMJ@msha.com

Jody Bentley, DO, Program Director and Director of Medical Education
Internal Medicine Residency Program
Norton Community Hospital, GME office
NW Market Mountain States Health Alliance
96 15th St NW Suite 106
Norton, VA 24273
BentleyJB@msha.com

Bernie Sergent, DO, Associate Program Director
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Norton, VA 24273
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Teresa Mutter, MBA, Program Coordinator
Internal Medicine Residency Program
Norton Community Hospital, GME office
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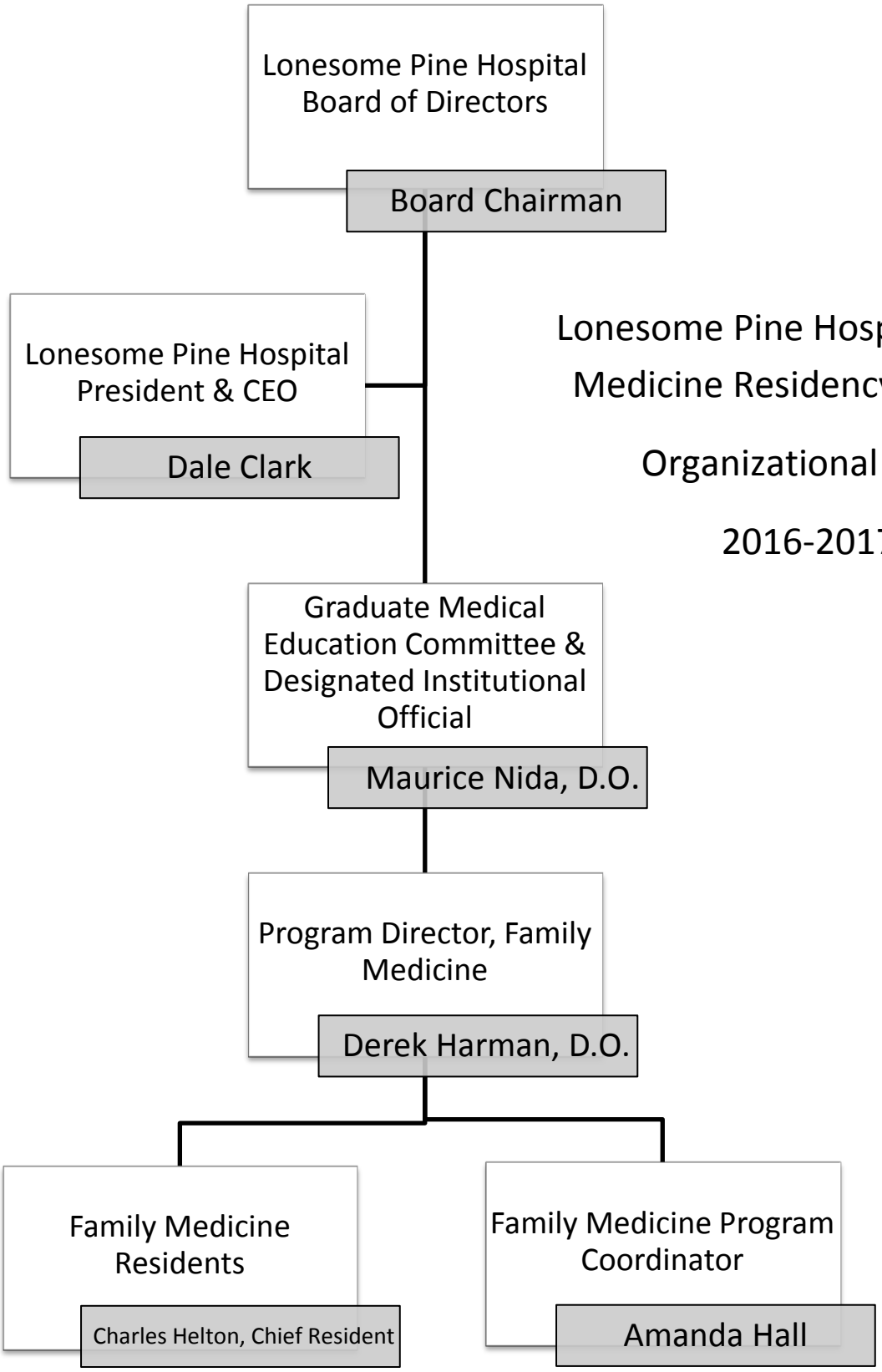
Norton, VA 24273
MutterTR3@msha.com

Samantha Carter, Assistant Program Coordinator
Internal Medicine Residency Program
Norton Community Hospital, GME office
NW Market Mountain States Health Alliance
96 15th St NW Suite 106
Norton, VA 24273
Coordinator office: 276-679-3488
CarterSP@msha.com

Lonesome Pine Hospital Family Medicine Residency Program

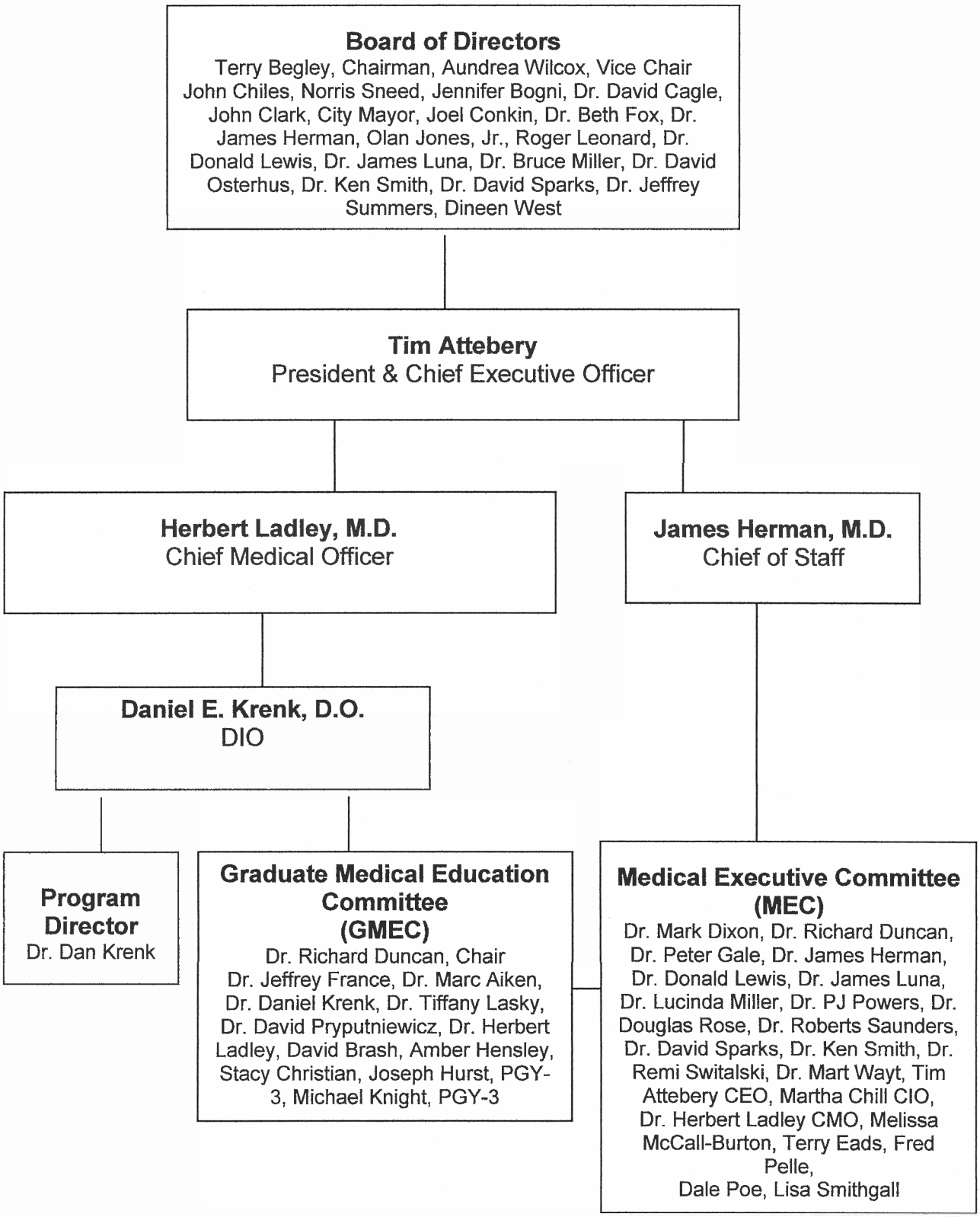
Organizational Chart

2016-2017



HOLSTON VALLEY MEDICAL CENTER
Institution Number 470379

Organizational Chart



East Tennessee State University
ACGME Sponsoring Institution 8004700524

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meansr@etsu.edu

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linville@etsu.edu

ACGME Designated Institutional Official (DIO)
Assoc. Dean for GME
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linville@etsu.edu

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EVP & Chief Medical Officer
seligmanmh@msha.com

Wellmont Bristol Regional Medical Center
Chad Couch, MD
Chief Medical Officer
chad.couch@wellmont.org

Wellmont Holston Valley Medical Center
Herbert D Ladley, MD
Chief Medical Officer
HLadley@mycva.com

Veterans Affairs Quillen Medical Center
Martin P Eason, MD, JD
Assoc Chief of Staff - Education
martin.eason@va.gov

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Mark Brummel, DO
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Pathology - Anatomic & Clinical
Salah Shurbaji, MD
shurbaji@etsu.edu

Psychiatry
Shambhavi Chandraiah, MD
chandraiah@etsu.edu

- GME Leadership, *DIO*
- Residency, *Program Director*
- Fellowship, *Program Director*
- Health System Leadership

Gastroenterology
Mark F Young, MD
mfyoung2004@yahoo.com

Cardiovascular Disease
Vijay K Ramu, MD
ramuv@etsu.edu

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Infectious Disease
James W Myers, MD
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Oncology
Devapiran Jaishankar, MD
jaishank@etsu.edu

HOLSTON VALLEY MEDICAL CENTER
ORTHOPEDIC RESIDENCY PROGRAM
Graduate Medical Education Committee
"GMEC" Membership

Non-Resident Members

Name	Title	Program (if applicable)
Richard Duncan, MD	Chairman, GMEC	Orthopedics
Jeffery France, MD	Faculty	Orthopedics
Marc Aiken, MD	Faculty	Orthopedics
Daniel Krenk, DO	DIO, PD of Orthopedic Program	Orthopedics
David Pryputniewicz, MD	Chairman, HVMC Surgery Department	Surgery
Herbert Ladley, MD	HVMC Chief Medical Officer	
Tiffany Lasky, DO	Medical Director, Acute Care Surgery/Trauma	Trauma Surgery
David Brash	President & CEO, Wellmont Medical Associates	WMA
Amber Hensley	HVMC Director of Quality, Safety and Accreditation	
Stacy Christian	Orthopedic Residency Program Coordinator	Orthopedics

Resident Members

Name (if available)	Program	Post-Graduate Year
Joseph Hurst, DO	HVMC Orthopedic Surgery Residency	PGY-3
Michael Knight, DO	HVMC Orthopedic Surgery Residency	PGY-3

Approved by:
Reviewed/Approved GMEC [7/26/2016]

GME Programs 2016-17
Sponsoring Instituion - East Tennessee State University

Program	Program Director	Email	Program Coordinator	Email	Phone
Bristol Family Medicine	Gregory E Clarity, MD	clarity@etsu.edu	Julie Robinette	robinett@etsu.edu	(423) 990-3014
Johnson City Family Medicine	Diana L Heiman, MD	heiman@etsu.edu	Terry Xixis	xixise@etsu.edu	(423) 439-6464
Kingsport Family Medicine	Mark Brummel, DO	brummel@etsu.edu	Amy E Murphy	murphya@etsu.edu	(423) 245-9626
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Pulmonary Disease and Critical Care	Girendra Hoskere, MD	hoskereg@etsu.edu	Carla M Hill	hillc@etsu.edu	(423) 439-8048
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Obstetrics and Gynecology	T Watson Jernigan, MD, MA	jernigan@etsu.edu	Patti D Davison	davisonp@etsu.edu	(423) 439-6262
Pathology - Anatomic & Clincial	Salah Shurbaji, MD	shurbaji@etsu.edu	Terri L McFeature	mcfeatur@etsu.edu	(423) 439-6790
Pediatrics	Dawn S Tuell, MD	tuell@etsu.edu	Laura B Smith	smithcb2@etsu.edu	(423) 439-6763
Psychiatry	Shambhavi Chandraiah, MD	chandraiah@etsu.edu	Dakotah L Williams	williamsdl1@etsu.edu	(423) 439-2225
Surgery	Joseph R Lee, MD	leejr1@etsu.edu	Julie B Simerly	simerlyjb@etsu.edu	(423) 439-6267

Sponsoring Institution	ACGME Designated Institutional Official (DIO)		Institutional Coordinator		
East Tennessee State University	David Linville, MD, EdD	linville@etsu.edu	Renee McNeely	mcneely@etsu.edu	423-439-8023

Indian Path Medical Center
Provider No. 44-0176
Period: July 1, 2013 through June 30, 2014
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine			0.0000
1400	Internal Medicine	0.0000	1.2742	1.2742
2000	Pediatrics			0.0000
	Total	0.0000	1.2742	1.2742

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology			0.0000
1407	Gastroenterology			0.0000
1410	Infectious Disease			0.0000
1419	Hematology	0.0000	0.6490	0.6490
1420	Pulmonary - Critical Care			0.0000
1550	Internal Medicine & Pyschiatry			0.0000
1750	OB/GYN	0.0000	1.0970	1.0970
1950	Pathology			0.0000
2200	Psychiatry			0.0000
2450	Surgery			0.0000
	Total	0.0000	1.7460	1.7460
	Grand Total	0.00	3.02	3.02

IPMC
Provider No: 44-0176
FYE: June 30, 2015
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1400	Internal Medicine	0.0000	1.6012	1.6012
	Total	0.0000	1.6012	1.6012

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1750	OB/GYN	0.0000	0.0186	0.0186
	Total	0.0000	0.0186	0.0186
	Grand Total	0.00	1.62	1.62

IPMC
Provider No: 44-0176
FYE: June 30, 2016
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1400	Internal Medicine	0.0000	1.8129	1.8129
	Total	0.0000	1.8129	1.8129

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
		0.0000	0.0000	0.0000
	Total	0.0000	0.0000	0.0000
	Grand Total	0.00	1.81	1.81

Johnson City Medical Center
Provider No. 440063
Period: July 1, 2013 through June 30, 2014
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	10.2009	7.4423	17.6432
1400	Internal Medicine	0.0000	8.0843	8.0843
2000	Pediatrics	0.0000	16.6077	16.6077
	Total	10.2009	32.1343	42.3352

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology	0.0000	5.8001	5.8001
1407	Gastroenterology	0.0000	4.2745	4.2745
1410	Infectious Disease	0.0000	3.2235	3.2235
1419	Hematology	0.0000	6.2873	6.2873
1420	Pulmonary - Critical Care	0.0000	2.0081	2.0081
1550	Internal Medicine & Pyschiatry	0.0000	0.5603	0.5603
1750	OB/GYN	0.0000	9.4249	9.4249
1950	Pathology	0.0000	3.9667	3.9667
2200	Psychiatry	0.6248	7.4282	8.0530
2450	Surgery	0.0674	12.3898	12.4571
	Total	0.6922	55.3634	56.0555
	Grand Total	10.89	87.50	98.3907

Johnson City Medical Center
Provider No. 44-0063
Period: July 1, 2014 through June 30, 2015
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	3.7303	13.7377	17.4680
1400	Internal Medicine	0.0000	13.9680	13.9680
2000	Pediatrics	0.0849	17.2205	17.3054
	Total	3.8152	44.9262	48.7414

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology	0.0000	3.9519	3.9519
1407	Gastroenterology	0.0000	2.6156	2.6156
1410	Infectious Disease	0.0000	1.9777	1.9777
1419	Hematology	0.0000	3.2637	3.2637
1420	Pulmonary - Critical Care	0.0000	1.0525	1.0525
1550	Internal Medicine & Pyschiatry	0.0000	0.0000	0.0000
1750	OB/GYN	0.0000	8.8878	8.8878
1950	Pathology	0.0000	3.9608	3.9608
2200	Psychiatry	2.1900	2.0045	4.1946
2450	Surgery	0.0539	10.6382	10.6921
	Total	2.2440	38.3527	40.5967
	Grand Total	6.06	83.28	89.34

Johnson City Medical Center
Provider No. 44-0063
Period: July 1, 2015 through June 30, 2016
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	0.0000	16.7813	16.7813
1400	Internal Medicine	0.0000	11.7081	11.7081
2000	Pediatrics	0.0000	18.5893	18.5893
	Total	0.0000	47.0787	47.0787

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1402	Cardiology	0.0000	3.9579	3.9579
1407	Gastroenterology	0.0000	2.5724	2.5724
1410	Infectious Disease	0.0000	2.0002	2.0002
1419	Hematology	0.0000	4.0878	4.0878
1420	Pulmonary - Critical Care	0.0000	1.9104	1.9104
1550	Internal Medicine & Pyschiatry	0.0000	0.0000	0.0000
1750	OB/GYN	0.0000	8.4808	8.4808
1950	Pathology	0.0000	3.8712	3.8712
2200	Psychiatry	1.7248	2.6696	4.3944
2450	Surgery	0.0729	11.5275	11.6003
	Total	1.7977	41.0778	42.8755
	Grand Total	1.80	88.16	89.95

Johnston Memorial Hospital
Provider No: 490053
Period: July 1, 2015 through June 30, 2016
Total Provider/Non-Provider FTEs for Cost Report (Unweighted)

PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
1350	Family Medicine	0.0000	4.9560	4.9560
1400	Internal Medicine	0.0000	0.4109	0.4109
	Total	0.0000	5.3669	5.3669

NON-PRIMARY CARE

Residency	Description	Non-provider FTEs	Provider FTEs	Total
	Total	0.0000	0.0000	0.0000
	Grand Total	0.00	5.37	5.37

Norton Community Hospital
Provider No: 490001
INTERNAL MEDICINE
FYE: September 30, 2014

Program Name	Internal Medicine	
Program Code	1400	
Unweighted primary care FTE residents with rotations at non-provider settings	5.13	S-2, Pt I, Ln 67, Col 3
Unweighted primary care FTE residents trained at hospital	13.83	S-2, Pt I, Ln 67, Col 4

Norton Community Hospital
Provider No: 490001
INTERNAL MEDICINE
FYE: September 30, 2015

Program Name	Internal Medicine	
Program Code	1400	
Unweighted primary care FTE residents with rotations at non-provider settings	4.67	S-2, Pt I, Ln 67, Col 3
Unweighted primary care FTE residents trained at hospital	15.93	S-2, Pt I, Ln 67, Col 4

Norton Community Hospital
Provider No: 490001
INTERNAL MEDICINE
FYE: June 30, 2016

Program Name	Internal Medicine	
Program Code	1400	
Unweighted primary care FTE residents with rotations at non-provider settings	2.88	S-2, Pt I, Ln 67, Col 3
Unweighted primary care FTE residents trained at hospital	11.46	S-2, Pt I, Ln 67, Col 4

Graduate Medical Education Due Diligence
Question 3 & 6

Bristol Regional Medical Center											
		2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Cap	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**Affiliation**	**Contact**
Family Medicine		23.24	23.73	NA	NA	NA	NA	NA	NA	ETSU	
Internal Medicine										ETSU	
- Residents		8.17	5.19	NA	NA	NA	NA	NA	NA		
- Fellows		1.20	0.99	NA	NA	NA	NA	NA	NA		
Surgery		5.07	4.66	NA	NA	NA	NA	NA	NA	ETSU	
Total	34.80	37.68	34.57								

Holston Valley Medical Center											
		2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Cap	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**Affiliation**	**Contact**
Family Medicine		17.26	17.82	NA	NA	NA	NA	NA	NA	ETSU	
Internal Medicine										ETSU	
- Residents		11.38	12.22	NA	NA	NA	NA	NA	NA		
- Fellows		0.04	0.17	NA	NA	NA	NA	NA	NA		
Surgery		7.99	7.31	NA	NA	NA	NA	NA	NA	ETSU	
Orthopedic Surgery		9.37	10.57	NA	NA	NA	NA	NA	NA	LMU	
Total	41.14	46.04	48.09								

Lonesome Pine Hospital											
		2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Cap	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**GME FTE**	**Affiliation**	**Contact**
Family Medicine		16.97	14.62	NA	NA	NA	NA	NA	NA	LMU	
Total	20.28	16.97	14.62								

ALL DISCHARGES

JCMC MEDICAID PATIENTS by DRG

FACILITY	DRG	DRG DESCRIPTION	FY14	FY15	FY16***
Johnson City Medical Center	793	FULL TERM NEONATE W MAJOR PROBLEMS	23	30	44
	765	CESAREAN SECTION W CC/MCC	10	13	23
	603	CELLULITIS W/O MCC	12	24	16
	790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	21	22	16
	847	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	6	1	15
	791	PREMATURITY W MAJOR PROBLEMS	7	13	14
	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	13	15	13
	792	PREMATURITY W/O MAJOR PROBLEMS	4	6	11
	203	BRONCHITIS & ASTHMA W/O CC/MCC	18	17	11
	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	16	28	11
	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	6	15	10
	866	VIRAL ILLNESS W/O MCC	2	10	10
	682	RENAL FAILURE W MCC	4		9
	778	THREATENED ABORTION	8	10	9
	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	3	4	8
	101	SEIZURES W/O MCC	2	8	8
	774	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	7	3	8
	202	BRONCHITIS & ASTHMA W CC/MCC	9	16	8
	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	12	13	8
	872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	3	5	8
	639	DIABETES W/O CC/MCC		13	7
	864	FEVER	4	7	7
	781	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	6	9	7
	328	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	3	4	6
	153	OTITIS MEDIA & URI W/O MCC	6	4	6
	789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	5	4	6
	194	SIMPLE PNEUMONIA & PLEURISY W CC	3	10	5
	918	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	9	7	5
	766	CESAREAN SECTION W/O CC/MCC	1	6	5
	65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	2		4
	917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	2	4	4
	812	RED BLOOD CELL DISORDERS W/O MCC	3	2	4
	199	PNEUMOTHORAX W MCC	1		4
	460	SPINAL FUSION EXCEPT CERVICAL W/O MCC		2	4
	100	SEIZURES W MCC	4	2	4
	440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	2	5	4
	690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	7	6	3
	638	DIABETES W CC	4	3	3
	470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC			3
	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2	3	3
	641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	9	10	3
	189	PULMONARY EDEMA & RESPIRATORY FAILURE	4	9	3
	982	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC			3
	195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	2	4	3
	472	CERVICAL SPINAL FUSION W CC			3
	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	3	4	3
	640	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	3	3	3
	303	ATHEROSCLEROSIS W/O MCC		2	3
	683	RENAL FAILURE W CC	2	9	3

***** NOTE: FY16 REPRESENTS 2 QTRS. OF 2015 and 1 QTR OF 2016 DATA.**

Includes:

Medicaid
Medicaid (Not Tenncare)
Medicaid Managed Care (Undesignated) VA Payer Code A
Virginia Medicaid

314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	4	6	3
87	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	1	1	3
326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	1		3
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4		3
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC			2
782	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	1		2
742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC			2
390	G.I. OBSTRUCTION W/O CC/MCC	1		2
816	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	3	1	2
395	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	1	2	2
204	RESPIRATORY SIGNS & SYMPTOMS	4	1	2
418	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	2		2
767	VAGINAL DELIVERY W STERILIZATION &/OR D&C	1		2
439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC		2	2
809	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	3		2
207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS	3	6	2
846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC			2
39	EXTRACRANIAL PROCEDURES W/O CC/MCC			2
923	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC			2
178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1	1	2
315	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC		2	2
951	OTHER FACTORS INFLUENCING HEALTH STATUS	2	4	2
4	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	3	2	2
987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC			2
776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE		2	2
534	FRACTURES OF FEMUR W/O MCC	1	1	2
206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC			2
540	OSTEOMYELITIS W CC		1	2
811	RED BLOOD CELL DISORDERS W MCC			2
552	MEDICAL BACK PROBLEMS W/O MCC	1	6	2
841	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1		2
281	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1	5	2
103	HEADACHES W/O MCC	1		2
180	RESPIRATORY NEOPLASMS W MCC	1	1	2
920	COMPLICATIONS OF TREATMENT W CC	1		2
306	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC		1	2
342	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC		1	2
64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC		1	2
473	CERVICAL SPINAL FUSION W/O CC/MCC			2
983	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC			2
96	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC			1
291	HEART FAILURE & SHOCK W MCC		1	1
914	TRAUMATIC INJURY W/O MCC	2		1
343	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	2	2	1
70	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	2		1
345	MINOR SMALL & LARGE BOWEL PROCEDURES W CC			1
844	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC			1
347	ANAL & STOMAL PROCEDURES W MCC		1	1
334	RECTAL RESECTION W/O CC/MCC			1
351	INGUINAL & FEMORAL HERNIA PROCEDURES W CC			1
299	PERIPHERAL VASCULAR DISORDERS W MCC		1	1
353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	1		1
86	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	2	1	1
374	DIGESTIVE MALIGNANCY W MCC			1
309	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC		2	1
164	MAJOR CHEST PROCEDURES W CC			1
865	VIRAL ILLNESS W MCC	1		1
391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1	5	1

948	SIGNS & SYMPTOMS W/O MCC	2	2	1
176	PULMONARY EMBOLISM W/O MCC		1	1
282	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC			1
410	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC			1
750	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC			1
152	OTITIS MEDIA & URI W MCC	1	1	1
301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC			1
419	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	3	3	1
302	ATHEROSCLEROSIS W MCC	1	1	1
432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC			1
92	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1	1	1
25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC			1
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1	3	1
3	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	5	1	1
838	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT			1
441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC		2	1
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	1		1
219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	1	1	1
903	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC			1
236	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	2	2	1
40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC			1
471	CERVICAL SPINAL FUSION W MCC			1
333	RECTAL RESECTION W CC			1
238	MAJOR CARDIOVASC PROCEDURES W/O MCC	1		1
184	MAJOR CHEST TRAUMA W CC			1
240	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC		1	1
287	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	2	6	1
478	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC		1	1
743	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1	2	1
480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC			1
759	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC			1
481	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC			1
69	TRANSIENT ISCHEMIA	2	1	1
493	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC			1
769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE			1
494	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1	1	1
74	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC		2	1
242	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC			1
157	DENTAL & ORAL DISEASES W MCC			1
134	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1		1
304	HYPERTENSION W MCC			1
517	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC			1
94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC		2	1
243	PERMANENT CARDIAC PACEMAKER IMPLANT W CC			1
808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	1		1
246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	1	2	1
307	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	1		1
544	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC			1
824	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC			1
545	CONNECTIVE TISSUE DISORDERS W MCC			1
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC		1	1
547	CONNECTIVE TISSUE DISORDERS W/O CC/MCC		1	1
159	DENTAL & ORAL DISEASES W/O CC/MCC		1	1
251	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC		1	1
862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1	1	1
581	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC			1
198	INTERSTITIAL LUNG DISEASE W/O CC/MCC			1
596	MAJOR SKIN DISORDERS W/O MCC			1

327	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2	1	1
600	NON-MALIGNANT BREAST DISORDERS W CC/MCC			1
131	CRANIAL/FACIAL PROCEDURES W CC/MCC			1
253	OTHER VASCULAR PROCEDURES W CC		2	1
330	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC			1
272	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC			1
950	AFTERCARE W/O CC/MCC			1
156	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC		1	1
964	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC		1	1
645	ENDOCRINE DISORDERS W/O CC/MCC	1		1
31	VENTRICULAR SHUNT PROCEDURES W MCC	1	1	1
674	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	1		1
464	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC			1
988	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1		1
442	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1		
870	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS	1	1	
840	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC		1	
556	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC		1	
543	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1	2	
557	TENDONITIS, MYOSITIS & BURSITIS W MCC		1	
55	NERVOUS SYSTEM NEOPLASMS W/O MCC	1		
558	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	1	1	
857	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC		1	
562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC		1	
346	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1		
563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	2		
312	SYNCOPE & COLLAPSE	1	2	
564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC		1	
804	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1	2	
565	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	1	1	
815	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC		1	
580	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1	1	
234	CORONARY BYPASS W CARDIAC CATH W/O MCC	1		
372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC		1	
340	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	2		
585	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1		
300	PERIPHERAL VASCULAR DISORDERS W CC	1		
595	MAJOR SKIN DISORDERS W MCC		1	
934	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ		1	
373	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	1		
546	CONNECTIVE TISSUE DISORDERS W CC	1		
598	MALIGNANT BREAST DISORDERS W CC	1		
193	SIMPLE PNEUMONIA & PLEURISY W MCC	3	1	
205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC		1	
799	SPLENECTOMY W MCC		1	
601	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	1	1	
445	DISORDERS OF THE BILIARY TRACT W CC	1	2	
602	CELLULITIS W MCC	1		
813	COAGULATION DISORDERS	10	6	
56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC		2	
26	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC		1	
605	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC		3	
842	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC		1	
607	MINOR SKIN DISORDERS W/O MCC		2	
286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	1		
637	DIABETES W MCC	1	2	
863	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	1		
377	G.I. HEMORRHAGE W MCC		3	

868	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1	
59	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC		1
115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT		1
378	G.I. HEMORRHAGE W CC	2	3
916	ALLERGIC REACTIONS W/O MCC	1	1
379	G.I. HEMORRHAGE W/O CC/MCC		1
921	COMPLICATIONS OF TREATMENT W/O CC/MCC		2
643	ENDOCRINE DISORDERS W MCC	1	
940	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC		1
381	COMPLICATED PEPTIC ULCER W CC	1	
963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC		1
669	TRANSURETHRAL PROCEDURES W CC	1	
548	SEPTIC ARTHRITIS W MCC		1
673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC		2
313	CHEST PAIN	4	2
389	G.I. OBSTRUCTION W CC		3
93	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC		1
305	HYPERTENSION W/O MCC	2	2
443	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	1	1
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2	2
801	SPLENECTOMY W/O CC/MCC	2	
684	RENAL FAILURE W/O CC/MCC		2
444	DISORDERS OF THE BILIARY TRACT W MCC		1
689	KIDNEY & URINARY TRACT INFECTIONS W MCC		1
810	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	1	3
53	SPINAL DISORDERS & INJURIES W/O CC/MCC	1	
97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC		1
694	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	1	1
814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC		1
696	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC		1
254	OTHER VASCULAR PROCEDURES W/O CC/MCC		1
698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	2	
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	2	
700	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC		1
225	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC		1
737	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	1	
329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC		1
393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC		1
20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	1	
394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	1	2
855	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC		1
746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	2	
235	CORONARY BYPASS W/O CARDIAC CATH W MCC	1	1
747	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	1	
24	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC		1
250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	1	1
187	PLEURAL EFFUSION W CC	1	
758	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1	
869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC		1
405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	2	1
114	ORBITAL PROCEDURES W/O CC/MCC	1	
406	PANCREAS, LIVER & SHUNT PROCEDURES W CC	1	
27	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	1	
407	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1	
515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC		1
308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC		1
121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1	
182	RESPIRATORY NEOPLASMS W/O CC/MCC	1	

168	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1		
770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY		1	
350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC		1	
310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC		1	
935	NON-EXTENSIVE BURNS	1		
311	ANGINA PECTORIS		2	
541	OSTEOMYELITIS W/O CC/MCC	1		
433	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1		
32	VENTRICULAR SHUNT PROCEDURES W CC	1		
83	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1		
352	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1		
779	ABORTION W/O D&C	1	1	
165	MAJOR CHEST PROCEDURES W/O CC/MCC		3	
85	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	1	2	
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC		1	
438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1		
502	SOFT TISSUE PROCEDURES W/O CC/MCC	1		
512	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	2		
Grand Total		**457**	**601**	**555**

VA Medicaid
Inpatient Count by Fiscal Year, Facility, DRG

Fiscal Year	Facility	MS-DRG	Count
FY 2014	Bristol Regional Medical Center (Parent Location)	3	5
FY 2014	Bristol Regional Medical Center (Parent Location)	4	6
FY 2014	Bristol Regional Medical Center (Parent Location)	23	1
FY 2014	Bristol Regional Medical Center (Parent Location)	25	2
FY 2014	Bristol Regional Medical Center (Parent Location)	27	1
FY 2014	Bristol Regional Medical Center (Parent Location)	54	3
FY 2014	Bristol Regional Medical Center (Parent Location)	55	1
FY 2014	Bristol Regional Medical Center (Parent Location)	60	1
FY 2014	Bristol Regional Medical Center (Parent Location)	65	7
FY 2014	Bristol Regional Medical Center (Parent Location)	68	1
FY 2014	Bristol Regional Medical Center (Parent Location)	69	1
FY 2014	Bristol Regional Medical Center (Parent Location)	71	1
FY 2014	Bristol Regional Medical Center (Parent Location)	72	1
FY 2014	Bristol Regional Medical Center (Parent Location)	74	1
FY 2014	Bristol Regional Medical Center (Parent Location)	85	1
FY 2014	Bristol Regional Medical Center (Parent Location)	88	1
FY 2014	Bristol Regional Medical Center (Parent Location)	90	1
FY 2014	Bristol Regional Medical Center (Parent Location)	91	1
FY 2014	Bristol Regional Medical Center (Parent Location)	100	1
FY 2014	Bristol Regional Medical Center (Parent Location)	101	5
FY 2014	Bristol Regional Medical Center (Parent Location)	103	1
FY 2014	Bristol Regional Medical Center (Parent Location)	125	1
FY 2014	Bristol Regional Medical Center (Parent Location)	133	1
FY 2014	Bristol Regional Medical Center (Parent Location)	153	1
FY 2014	Bristol Regional Medical Center (Parent Location)	155	1
FY 2014	Bristol Regional Medical Center (Parent Location)	163	2
FY 2014	Bristol Regional Medical Center (Parent Location)	164	4
FY 2014	Bristol Regional Medical Center (Parent Location)	166	1
FY 2014	Bristol Regional Medical Center (Parent Location)	167	1
FY 2014	Bristol Regional Medical Center (Parent Location)	176	2
FY 2014	Bristol Regional Medical Center (Parent Location)	177	6
FY 2014	Bristol Regional Medical Center (Parent Location)	178	3
FY 2014	Bristol Regional Medical Center (Parent Location)	179	1
FY 2014	Bristol Regional Medical Center (Parent Location)	180	3
FY 2014	Bristol Regional Medical Center (Parent Location)	186	4
FY 2014	Bristol Regional Medical Center (Parent Location)	189	13
FY 2014	Bristol Regional Medical Center (Parent Location)	190	7
FY 2014	Bristol Regional Medical Center (Parent Location)	191	2
FY 2014	Bristol Regional Medical Center (Parent Location)	192	3
FY 2014	Bristol Regional Medical Center (Parent Location)	193	9
FY 2014	Bristol Regional Medical Center (Parent Location)	194	12
FY 2014	Bristol Regional Medical Center (Parent Location)	195	5
FY 2014	Bristol Regional Medical Center (Parent Location)	197	1
FY 2014	Bristol Regional Medical Center (Parent Location)	199	1
FY 2014	Bristol Regional Medical Center (Parent Location)	200	3
FY 2014	Bristol Regional Medical Center (Parent Location)	202	2
FY 2014	Bristol Regional Medical Center (Parent Location)	203	4
FY 2014	Bristol Regional Medical Center (Parent Location)	204	1
FY 2014	Bristol Regional Medical Center (Parent Location)	205	1
FY 2014	Bristol Regional Medical Center (Parent Location)	206	1

FY 2014	Bristol Regional Medical Center (Parent Location)	207	8
FY 2014	Bristol Regional Medical Center (Parent Location)	208	12
FY 2014	Bristol Regional Medical Center (Parent Location)	216	1
FY 2014	Bristol Regional Medical Center (Parent Location)	229	2
FY 2014	Bristol Regional Medical Center (Parent Location)	236	4
FY 2014	Bristol Regional Medical Center (Parent Location)	237	1
FY 2014	Bristol Regional Medical Center (Parent Location)	239	1
FY 2014	Bristol Regional Medical Center (Parent Location)	243	1
FY 2014	Bristol Regional Medical Center (Parent Location)	247	4
FY 2014	Bristol Regional Medical Center (Parent Location)	249	1
FY 2014	Bristol Regional Medical Center (Parent Location)	251	1
FY 2014	Bristol Regional Medical Center (Parent Location)	280	2
FY 2014	Bristol Regional Medical Center (Parent Location)	281	2
FY 2014	Bristol Regional Medical Center (Parent Location)	282	1
FY 2014	Bristol Regional Medical Center (Parent Location)	283	2
FY 2014	Bristol Regional Medical Center (Parent Location)	291	3
FY 2014	Bristol Regional Medical Center (Parent Location)	292	3
FY 2014	Bristol Regional Medical Center (Parent Location)	293	1
FY 2014	Bristol Regional Medical Center (Parent Location)	296	1
FY 2014	Bristol Regional Medical Center (Parent Location)	299	1
FY 2014	Bristol Regional Medical Center (Parent Location)	300	2
FY 2014	Bristol Regional Medical Center (Parent Location)	303	1
FY 2014	Bristol Regional Medical Center (Parent Location)	305	1
FY 2014	Bristol Regional Medical Center (Parent Location)	308	1
FY 2014	Bristol Regional Medical Center (Parent Location)	309	1
FY 2014	Bristol Regional Medical Center (Parent Location)	311	2
FY 2014	Bristol Regional Medical Center (Parent Location)	312	1
FY 2014	Bristol Regional Medical Center (Parent Location)	313	2
FY 2014	Bristol Regional Medical Center (Parent Location)	314	4
FY 2014	Bristol Regional Medical Center (Parent Location)	315	1
FY 2014	Bristol Regional Medical Center (Parent Location)	316	1
FY 2014	Bristol Regional Medical Center (Parent Location)	326	1
FY 2014	Bristol Regional Medical Center (Parent Location)	329	5
FY 2014	Bristol Regional Medical Center (Parent Location)	330	3
FY 2014	Bristol Regional Medical Center (Parent Location)	331	4
FY 2014	Bristol Regional Medical Center (Parent Location)	334	1
FY 2014	Bristol Regional Medical Center (Parent Location)	336	3
FY 2014	Bristol Regional Medical Center (Parent Location)	337	2
FY 2014	Bristol Regional Medical Center (Parent Location)	340	1
FY 2014	Bristol Regional Medical Center (Parent Location)	341	1
FY 2014	Bristol Regional Medical Center (Parent Location)	343	1
FY 2014	Bristol Regional Medical Center (Parent Location)	352	1
FY 2014	Bristol Regional Medical Center (Parent Location)	354	1
FY 2014	Bristol Regional Medical Center (Parent Location)	355	2
FY 2014	Bristol Regional Medical Center (Parent Location)	368	2
FY 2014	Bristol Regional Medical Center (Parent Location)	371	1
FY 2014	Bristol Regional Medical Center (Parent Location)	373	1
FY 2014	Bristol Regional Medical Center (Parent Location)	374	1
FY 2014	Bristol Regional Medical Center (Parent Location)	377	2
FY 2014	Bristol Regional Medical Center (Parent Location)	378	3
FY 2014	Bristol Regional Medical Center (Parent Location)	379	1
FY 2014	Bristol Regional Medical Center (Parent Location)	384	1
FY 2014	Bristol Regional Medical Center (Parent Location)	385	2
FY 2014	Bristol Regional Medical Center (Parent Location)	386	1
FY 2014	Bristol Regional Medical Center (Parent Location)	389	2

FY 2014	Bristol Regional Medical Center (Parent Location)	390	3
FY 2014	Bristol Regional Medical Center (Parent Location)	392	13
FY 2014	Bristol Regional Medical Center (Parent Location)	393	3
FY 2014	Bristol Regional Medical Center (Parent Location)	394	1
FY 2014	Bristol Regional Medical Center (Parent Location)	415	1
FY 2014	Bristol Regional Medical Center (Parent Location)	416	1
FY 2014	Bristol Regional Medical Center (Parent Location)	417	2
FY 2014	Bristol Regional Medical Center (Parent Location)	418	3
FY 2014	Bristol Regional Medical Center (Parent Location)	419	2
FY 2014	Bristol Regional Medical Center (Parent Location)	423	1
FY 2014	Bristol Regional Medical Center (Parent Location)	432	4
FY 2014	Bristol Regional Medical Center (Parent Location)	433	2
FY 2014	Bristol Regional Medical Center (Parent Location)	435	1
FY 2014	Bristol Regional Medical Center (Parent Location)	438	3
FY 2014	Bristol Regional Medical Center (Parent Location)	439	3
FY 2014	Bristol Regional Medical Center (Parent Location)	440	7
FY 2014	Bristol Regional Medical Center (Parent Location)	441	5
FY 2014	Bristol Regional Medical Center (Parent Location)	442	7
FY 2014	Bristol Regional Medical Center (Parent Location)	443	2
FY 2014	Bristol Regional Medical Center (Parent Location)	445	2
FY 2014	Bristol Regional Medical Center (Parent Location)	457	2
FY 2014	Bristol Regional Medical Center (Parent Location)	459	1
FY 2014	Bristol Regional Medical Center (Parent Location)	460	7
FY 2014	Bristol Regional Medical Center (Parent Location)	470	12
FY 2014	Bristol Regional Medical Center (Parent Location)	473	1
FY 2014	Bristol Regional Medical Center (Parent Location)	477	1
FY 2014	Bristol Regional Medical Center (Parent Location)	478	2
FY 2014	Bristol Regional Medical Center (Parent Location)	481	1
FY 2014	Bristol Regional Medical Center (Parent Location)	482	1
FY 2014	Bristol Regional Medical Center (Parent Location)	485	1
FY 2014	Bristol Regional Medical Center (Parent Location)	490	1
FY 2014	Bristol Regional Medical Center (Parent Location)	491	2
FY 2014	Bristol Regional Medical Center (Parent Location)	493	5
FY 2014	Bristol Regional Medical Center (Parent Location)	494	4
FY 2014	Bristol Regional Medical Center (Parent Location)	495	1
FY 2014	Bristol Regional Medical Center (Parent Location)	501	1
FY 2014	Bristol Regional Medical Center (Parent Location)	536	1
FY 2014	Bristol Regional Medical Center (Parent Location)	538	1
FY 2014	Bristol Regional Medical Center (Parent Location)	539	1
FY 2014	Bristol Regional Medical Center (Parent Location)	540	1
FY 2014	Bristol Regional Medical Center (Parent Location)	551	1
FY 2014	Bristol Regional Medical Center (Parent Location)	552	2
FY 2014	Bristol Regional Medical Center (Parent Location)	553	1
FY 2014	Bristol Regional Medical Center (Parent Location)	556	1
FY 2014	Bristol Regional Medical Center (Parent Location)	581	1
FY 2014	Bristol Regional Medical Center (Parent Location)	592	1
FY 2014	Bristol Regional Medical Center (Parent Location)	602	1
FY 2014	Bristol Regional Medical Center (Parent Location)	603	16
FY 2014	Bristol Regional Medical Center (Parent Location)	617	1
FY 2014	Bristol Regional Medical Center (Parent Location)	629	1
FY 2014	Bristol Regional Medical Center (Parent Location)	637	2
FY 2014	Bristol Regional Medical Center (Parent Location)	638	7
FY 2014	Bristol Regional Medical Center (Parent Location)	639	1
FY 2014	Bristol Regional Medical Center (Parent Location)	641	7
FY 2014	Bristol Regional Medical Center (Parent Location)	645	1

FY 2014	Bristol Regional Medical Center (Parent Location)	656	1
FY 2014	Bristol Regional Medical Center (Parent Location)	657	1
FY 2014	Bristol Regional Medical Center (Parent Location)	661	1
FY 2014	Bristol Regional Medical Center (Parent Location)	682	12
FY 2014	Bristol Regional Medical Center (Parent Location)	683	4
FY 2014	Bristol Regional Medical Center (Parent Location)	687	1
FY 2014	Bristol Regional Medical Center (Parent Location)	690	4
FY 2014	Bristol Regional Medical Center (Parent Location)	691	1
FY 2014	Bristol Regional Medical Center (Parent Location)	693	1
FY 2014	Bristol Regional Medical Center (Parent Location)	694	2
FY 2014	Bristol Regional Medical Center (Parent Location)	700	1
FY 2014	Bristol Regional Medical Center (Parent Location)	743	10
FY 2014	Bristol Regional Medical Center (Parent Location)	744	1
FY 2014	Bristol Regional Medical Center (Parent Location)	748	1
FY 2014	Bristol Regional Medical Center (Parent Location)	749	1
FY 2014	Bristol Regional Medical Center (Parent Location)	754	1
FY 2014	Bristol Regional Medical Center (Parent Location)	760	1
FY 2014	Bristol Regional Medical Center (Parent Location)	765	17
FY 2014	Bristol Regional Medical Center (Parent Location)	766	37
FY 2014	Bristol Regional Medical Center (Parent Location)	767	4
FY 2014	Bristol Regional Medical Center (Parent Location)	774	9
FY 2014	Bristol Regional Medical Center (Parent Location)	775	98
FY 2014	Bristol Regional Medical Center (Parent Location)	776	2
FY 2014	Bristol Regional Medical Center (Parent Location)	777	1
FY 2014	Bristol Regional Medical Center (Parent Location)	778	1
FY 2014	Bristol Regional Medical Center (Parent Location)	779	2
FY 2014	Bristol Regional Medical Center (Parent Location)	781	6
FY 2014	Bristol Regional Medical Center (Parent Location)	789	4
FY 2014	Bristol Regional Medical Center (Parent Location)	791	2
FY 2014	Bristol Regional Medical Center (Parent Location)	792	8
FY 2014	Bristol Regional Medical Center (Parent Location)	793	14
FY 2014	Bristol Regional Medical Center (Parent Location)	794	47
FY 2014	Bristol Regional Medical Center (Parent Location)	795	91
FY 2014	Bristol Regional Medical Center (Parent Location)	811	1
FY 2014	Bristol Regional Medical Center (Parent Location)	813	2
FY 2014	Bristol Regional Medical Center (Parent Location)	835	1
FY 2014	Bristol Regional Medical Center (Parent Location)	836	2
FY 2014	Bristol Regional Medical Center (Parent Location)	847	1
FY 2014	Bristol Regional Medical Center (Parent Location)	853	4
FY 2014	Bristol Regional Medical Center (Parent Location)	854	1
FY 2014	Bristol Regional Medical Center (Parent Location)	856	1
FY 2014	Bristol Regional Medical Center (Parent Location)	857	2
FY 2014	Bristol Regional Medical Center (Parent Location)	862	1
FY 2014	Bristol Regional Medical Center (Parent Location)	863	5
FY 2014	Bristol Regional Medical Center (Parent Location)	864	4
FY 2014	Bristol Regional Medical Center (Parent Location)	870	5
FY 2014	Bristol Regional Medical Center (Parent Location)	871	16
FY 2014	Bristol Regional Medical Center (Parent Location)	872	3
FY 2014	Bristol Regional Medical Center (Parent Location)	880	5
FY 2014	Bristol Regional Medical Center (Parent Location)	881	40
FY 2014	Bristol Regional Medical Center (Parent Location)	882	2
FY 2014	Bristol Regional Medical Center (Parent Location)	883	3
FY 2014	Bristol Regional Medical Center (Parent Location)	884	2
FY 2014	Bristol Regional Medical Center (Parent Location)	885	235
FY 2014	Bristol Regional Medical Center (Parent Location)	886	1

FY 2014	Bristol Regional Medical Center (Parent Location)	894	2
FY 2014	Bristol Regional Medical Center (Parent Location)	895	1
FY 2014	Bristol Regional Medical Center (Parent Location)	897	11
FY 2014	Bristol Regional Medical Center (Parent Location)	908	1
FY 2014	Bristol Regional Medical Center (Parent Location)	917	4
FY 2014	Bristol Regional Medical Center (Parent Location)	918	7
FY 2014	Bristol Regional Medical Center (Parent Location)	919	1
FY 2014	Bristol Regional Medical Center (Parent Location)	920	3
FY 2014	Bristol Regional Medical Center (Parent Location)	922	1
FY 2014	Bristol Regional Medical Center (Parent Location)	933	1
FY 2014	Bristol Regional Medical Center (Parent Location)	947	1
FY 2014	Bristol Regional Medical Center (Parent Location)	948	1
FY 2014	Bristol Regional Medical Center (Parent Location)	951	10
FY 2014	Bristol Regional Medical Center (Parent Location)	956	2
FY 2014	Bristol Regional Medical Center (Parent Location)	964	1
FY 2014	Bristol Regional Medical Center (Parent Location)	977	1
FY 2014	Bristol Regional Medical Center (Parent Location)	981	3
FY 2014	Bristol Regional Medical Center (Parent Location)	999	6
FY 2014	Holston Valley Medical Center (Parent Location)	3	2
FY 2014	Holston Valley Medical Center (Parent Location)	4	5
FY 2014	Holston Valley Medical Center (Parent Location)	26	1
FY 2014	Holston Valley Medical Center (Parent Location)	28	1
FY 2014	Holston Valley Medical Center (Parent Location)	36	2
FY 2014	Holston Valley Medical Center (Parent Location)	38	1
FY 2014	Holston Valley Medical Center (Parent Location)	54	1
FY 2014	Holston Valley Medical Center (Parent Location)	61	1
FY 2014	Holston Valley Medical Center (Parent Location)	64	1
FY 2014	Holston Valley Medical Center (Parent Location)	65	2
FY 2014	Holston Valley Medical Center (Parent Location)	66	3
FY 2014	Holston Valley Medical Center (Parent Location)	68	1
FY 2014	Holston Valley Medical Center (Parent Location)	69	1
FY 2014	Holston Valley Medical Center (Parent Location)	70	1
FY 2014	Holston Valley Medical Center (Parent Location)	71	1
FY 2014	Holston Valley Medical Center (Parent Location)	73	1
FY 2014	Holston Valley Medical Center (Parent Location)	85	1
FY 2014	Holston Valley Medical Center (Parent Location)	87	2
FY 2014	Holston Valley Medical Center (Parent Location)	100	3
FY 2014	Holston Valley Medical Center (Parent Location)	101	8
FY 2014	Holston Valley Medical Center (Parent Location)	103	1
FY 2014	Holston Valley Medical Center (Parent Location)	132	1
FY 2014	Holston Valley Medical Center (Parent Location)	151	1
FY 2014	Holston Valley Medical Center (Parent Location)	153	2
FY 2014	Holston Valley Medical Center (Parent Location)	158	1
FY 2014	Holston Valley Medical Center (Parent Location)	159	1
FY 2014	Holston Valley Medical Center (Parent Location)	164	1
FY 2014	Holston Valley Medical Center (Parent Location)	166	4
FY 2014	Holston Valley Medical Center (Parent Location)	167	1
FY 2014	Holston Valley Medical Center (Parent Location)	176	1
FY 2014	Holston Valley Medical Center (Parent Location)	177	1
FY 2014	Holston Valley Medical Center (Parent Location)	178	4
FY 2014	Holston Valley Medical Center (Parent Location)	179	1
FY 2014	Holston Valley Medical Center (Parent Location)	180	1
FY 2014	Holston Valley Medical Center (Parent Location)	184	1
FY 2014	Holston Valley Medical Center (Parent Location)	185	2
FY 2014	Holston Valley Medical Center (Parent Location)	188	1

FY 2014	Holston Valley Medical Center (Parent Location)	189	10
FY 2014	Holston Valley Medical Center (Parent Location)	190	4
FY 2014	Holston Valley Medical Center (Parent Location)	191	5
FY 2014	Holston Valley Medical Center (Parent Location)	192	6
FY 2014	Holston Valley Medical Center (Parent Location)	193	5
FY 2014	Holston Valley Medical Center (Parent Location)	194	12
FY 2014	Holston Valley Medical Center (Parent Location)	195	2
FY 2014	Holston Valley Medical Center (Parent Location)	199	1
FY 2014	Holston Valley Medical Center (Parent Location)	200	1
FY 2014	Holston Valley Medical Center (Parent Location)	202	5
FY 2014	Holston Valley Medical Center (Parent Location)	203	9
FY 2014	Holston Valley Medical Center (Parent Location)	204	2
FY 2014	Holston Valley Medical Center (Parent Location)	206	2
FY 2014	Holston Valley Medical Center (Parent Location)	207	5
FY 2014	Holston Valley Medical Center (Parent Location)	208	6
FY 2014	Holston Valley Medical Center (Parent Location)	216	1
FY 2014	Holston Valley Medical Center (Parent Location)	220	1
FY 2014	Holston Valley Medical Center (Parent Location)	226	1
FY 2014	Holston Valley Medical Center (Parent Location)	233	1
FY 2014	Holston Valley Medical Center (Parent Location)	234	2
FY 2014	Holston Valley Medical Center (Parent Location)	236	4
FY 2014	Holston Valley Medical Center (Parent Location)	237	1
FY 2014	Holston Valley Medical Center (Parent Location)	238	3
FY 2014	Holston Valley Medical Center (Parent Location)	239	1
FY 2014	Holston Valley Medical Center (Parent Location)	246	3
FY 2014	Holston Valley Medical Center (Parent Location)	247	10
FY 2014	Holston Valley Medical Center (Parent Location)	251	1
FY 2014	Holston Valley Medical Center (Parent Location)	252	2
FY 2014	Holston Valley Medical Center (Parent Location)	254	1
FY 2014	Holston Valley Medical Center (Parent Location)	264	1
FY 2014	Holston Valley Medical Center (Parent Location)	281	7
FY 2014	Holston Valley Medical Center (Parent Location)	282	1
FY 2014	Holston Valley Medical Center (Parent Location)	286	1
FY 2014	Holston Valley Medical Center (Parent Location)	287	3
FY 2014	Holston Valley Medical Center (Parent Location)	291	2
FY 2014	Holston Valley Medical Center (Parent Location)	292	2
FY 2014	Holston Valley Medical Center (Parent Location)	293	1
FY 2014	Holston Valley Medical Center (Parent Location)	300	2
FY 2014	Holston Valley Medical Center (Parent Location)	301	1
FY 2014	Holston Valley Medical Center (Parent Location)	302	1
FY 2014	Holston Valley Medical Center (Parent Location)	308	2
FY 2014	Holston Valley Medical Center (Parent Location)	309	4
FY 2014	Holston Valley Medical Center (Parent Location)	310	4
FY 2014	Holston Valley Medical Center (Parent Location)	312	2
FY 2014	Holston Valley Medical Center (Parent Location)	313	5
FY 2014	Holston Valley Medical Center (Parent Location)	314	3
FY 2014	Holston Valley Medical Center (Parent Location)	315	1
FY 2014	Holston Valley Medical Center (Parent Location)	326	2
FY 2014	Holston Valley Medical Center (Parent Location)	327	2
FY 2014	Holston Valley Medical Center (Parent Location)	329	3
FY 2014	Holston Valley Medical Center (Parent Location)	331	3
FY 2014	Holston Valley Medical Center (Parent Location)	354	2
FY 2014	Holston Valley Medical Center (Parent Location)	375	1
FY 2014	Holston Valley Medical Center (Parent Location)	377	3
FY 2014	Holston Valley Medical Center (Parent Location)	378	2

FY 2014	Holston Valley Medical Center (Parent Location)	379	2
FY 2014	Holston Valley Medical Center (Parent Location)	384	1
FY 2014	Holston Valley Medical Center (Parent Location)	385	1
FY 2014	Holston Valley Medical Center (Parent Location)	388	1
FY 2014	Holston Valley Medical Center (Parent Location)	389	2
FY 2014	Holston Valley Medical Center (Parent Location)	390	1
FY 2014	Holston Valley Medical Center (Parent Location)	391	1
FY 2014	Holston Valley Medical Center (Parent Location)	392	4
FY 2014	Holston Valley Medical Center (Parent Location)	393	1
FY 2014	Holston Valley Medical Center (Parent Location)	394	3
FY 2014	Holston Valley Medical Center (Parent Location)	417	1
FY 2014	Holston Valley Medical Center (Parent Location)	418	2
FY 2014	Holston Valley Medical Center (Parent Location)	432	1
FY 2014	Holston Valley Medical Center (Parent Location)	438	2
FY 2014	Holston Valley Medical Center (Parent Location)	439	6
FY 2014	Holston Valley Medical Center (Parent Location)	441	3
FY 2014	Holston Valley Medical Center (Parent Location)	442	6
FY 2014	Holston Valley Medical Center (Parent Location)	445	1
FY 2014	Holston Valley Medical Center (Parent Location)	446	1
FY 2014	Holston Valley Medical Center (Parent Location)	464	2
FY 2014	Holston Valley Medical Center (Parent Location)	466	1
FY 2014	Holston Valley Medical Center (Parent Location)	468	1
FY 2014	Holston Valley Medical Center (Parent Location)	470	7
FY 2014	Holston Valley Medical Center (Parent Location)	480	1
FY 2014	Holston Valley Medical Center (Parent Location)	481	1
FY 2014	Holston Valley Medical Center (Parent Location)	488	1
FY 2014	Holston Valley Medical Center (Parent Location)	489	1
FY 2014	Holston Valley Medical Center (Parent Location)	490	1
FY 2014	Holston Valley Medical Center (Parent Location)	493	6
FY 2014	Holston Valley Medical Center (Parent Location)	494	3
FY 2014	Holston Valley Medical Center (Parent Location)	497	1
FY 2014	Holston Valley Medical Center (Parent Location)	506	1
FY 2014	Holston Valley Medical Center (Parent Location)	510	1
FY 2014	Holston Valley Medical Center (Parent Location)	516	2
FY 2014	Holston Valley Medical Center (Parent Location)	536	1
FY 2014	Holston Valley Medical Center (Parent Location)	543	2
FY 2014	Holston Valley Medical Center (Parent Location)	552	4
FY 2014	Holston Valley Medical Center (Parent Location)	558	1
FY 2014	Holston Valley Medical Center (Parent Location)	563	3
FY 2014	Holston Valley Medical Center (Parent Location)	571	1
FY 2014	Holston Valley Medical Center (Parent Location)	573	1
FY 2014	Holston Valley Medical Center (Parent Location)	575	1
FY 2014	Holston Valley Medical Center (Parent Location)	592	1
FY 2014	Holston Valley Medical Center (Parent Location)	603	5
FY 2014	Holston Valley Medical Center (Parent Location)	605	1
FY 2014	Holston Valley Medical Center (Parent Location)	607	1
FY 2014	Holston Valley Medical Center (Parent Location)	637	2
FY 2014	Holston Valley Medical Center (Parent Location)	638	5
FY 2014	Holston Valley Medical Center (Parent Location)	639	4
FY 2014	Holston Valley Medical Center (Parent Location)	640	5
FY 2014	Holston Valley Medical Center (Parent Location)	641	7
FY 2014	Holston Valley Medical Center (Parent Location)	644	1
FY 2014	Holston Valley Medical Center (Parent Location)	669	1
FY 2014	Holston Valley Medical Center (Parent Location)	674	1
FY 2014	Holston Valley Medical Center (Parent Location)	682	4

FY 2014	Holston Valley Medical Center (Parent Location)	683	5
FY 2014	Holston Valley Medical Center (Parent Location)	684	1
FY 2014	Holston Valley Medical Center (Parent Location)	689	1
FY 2014	Holston Valley Medical Center (Parent Location)	690	7
FY 2014	Holston Valley Medical Center (Parent Location)	699	1
FY 2014	Holston Valley Medical Center (Parent Location)	734	1
FY 2014	Holston Valley Medical Center (Parent Location)	740	1
FY 2014	Holston Valley Medical Center (Parent Location)	741	1
FY 2014	Holston Valley Medical Center (Parent Location)	743	3
FY 2014	Holston Valley Medical Center (Parent Location)	758	1
FY 2014	Holston Valley Medical Center (Parent Location)	765	14
FY 2014	Holston Valley Medical Center (Parent Location)	766	19
FY 2014	Holston Valley Medical Center (Parent Location)	767	1
FY 2014	Holston Valley Medical Center (Parent Location)	769	1
FY 2014	Holston Valley Medical Center (Parent Location)	774	6
FY 2014	Holston Valley Medical Center (Parent Location)	775	40
FY 2014	Holston Valley Medical Center (Parent Location)	776	3
FY 2014	Holston Valley Medical Center (Parent Location)	778	1
FY 2014	Holston Valley Medical Center (Parent Location)	781	1
FY 2014	Holston Valley Medical Center (Parent Location)	782	2
FY 2014	Holston Valley Medical Center (Parent Location)	789	1
FY 2014	Holston Valley Medical Center (Parent Location)	790	12
FY 2014	Holston Valley Medical Center (Parent Location)	791	10
FY 2014	Holston Valley Medical Center (Parent Location)	792	6
FY 2014	Holston Valley Medical Center (Parent Location)	793	13
FY 2014	Holston Valley Medical Center (Parent Location)	794	14
FY 2014	Holston Valley Medical Center (Parent Location)	795	60
FY 2014	Holston Valley Medical Center (Parent Location)	809	1
FY 2014	Holston Valley Medical Center (Parent Location)	811	1
FY 2014	Holston Valley Medical Center (Parent Location)	816	2
FY 2014	Holston Valley Medical Center (Parent Location)	824	1
FY 2014	Holston Valley Medical Center (Parent Location)	844	1
FY 2014	Holston Valley Medical Center (Parent Location)	847	6
FY 2014	Holston Valley Medical Center (Parent Location)	853	10
FY 2014	Holston Valley Medical Center (Parent Location)	854	1
FY 2014	Holston Valley Medical Center (Parent Location)	862	1
FY 2014	Holston Valley Medical Center (Parent Location)	863	3
FY 2014	Holston Valley Medical Center (Parent Location)	866	1
FY 2014	Holston Valley Medical Center (Parent Location)	870	5
FY 2014	Holston Valley Medical Center (Parent Location)	871	18
FY 2014	Holston Valley Medical Center (Parent Location)	872	3
FY 2014	Holston Valley Medical Center (Parent Location)	880	1
FY 2014	Holston Valley Medical Center (Parent Location)	896	1
FY 2014	Holston Valley Medical Center (Parent Location)	903	1
FY 2014	Holston Valley Medical Center (Parent Location)	907	1
FY 2014	Holston Valley Medical Center (Parent Location)	908	1
FY 2014	Holston Valley Medical Center (Parent Location)	917	9
FY 2014	Holston Valley Medical Center (Parent Location)	918	2
FY 2014	Holston Valley Medical Center (Parent Location)	923	1
FY 2014	Holston Valley Medical Center (Parent Location)	947	4
FY 2014	Holston Valley Medical Center (Parent Location)	948	3
FY 2014	Holston Valley Medical Center (Parent Location)	951	1
FY 2014	Holston Valley Medical Center (Parent Location)	957	1
FY 2014	Holston Valley Medical Center (Parent Location)	963	1
FY 2015	Bristol Regional Medical Center (Parent Location)	3	5

FY 2015	Bristol Regional Medical Center (Parent Location)	4	5
FY 2015	Bristol Regional Medical Center (Parent Location)	12	1
FY 2015	Bristol Regional Medical Center (Parent Location)	23	1
FY 2015	Bristol Regional Medical Center (Parent Location)	25	2
FY 2015	Bristol Regional Medical Center (Parent Location)	28	1
FY 2015	Bristol Regional Medical Center (Parent Location)	30	1
FY 2015	Bristol Regional Medical Center (Parent Location)	38	1
FY 2015	Bristol Regional Medical Center (Parent Location)	54	1
FY 2015	Bristol Regional Medical Center (Parent Location)	55	2
FY 2015	Bristol Regional Medical Center (Parent Location)	56	1
FY 2015	Bristol Regional Medical Center (Parent Location)	57	4
FY 2015	Bristol Regional Medical Center (Parent Location)	62	1
FY 2015	Bristol Regional Medical Center (Parent Location)	64	1
FY 2015	Bristol Regional Medical Center (Parent Location)	65	3
FY 2015	Bristol Regional Medical Center (Parent Location)	70	1
FY 2015	Bristol Regional Medical Center (Parent Location)	71	2
FY 2015	Bristol Regional Medical Center (Parent Location)	73	1
FY 2015	Bristol Regional Medical Center (Parent Location)	76	1
FY 2015	Bristol Regional Medical Center (Parent Location)	82	1
FY 2015	Bristol Regional Medical Center (Parent Location)	86	3
FY 2015	Bristol Regional Medical Center (Parent Location)	87	1
FY 2015	Bristol Regional Medical Center (Parent Location)	91	1
FY 2015	Bristol Regional Medical Center (Parent Location)	92	1
FY 2015	Bristol Regional Medical Center (Parent Location)	100	11
FY 2015	Bristol Regional Medical Center (Parent Location)	101	3
FY 2015	Bristol Regional Medical Center (Parent Location)	153	2
FY 2015	Bristol Regional Medical Center (Parent Location)	165	2
FY 2015	Bristol Regional Medical Center (Parent Location)	166	1
FY 2015	Bristol Regional Medical Center (Parent Location)	167	1
FY 2015	Bristol Regional Medical Center (Parent Location)	176	1
FY 2015	Bristol Regional Medical Center (Parent Location)	177	5
FY 2015	Bristol Regional Medical Center (Parent Location)	178	1
FY 2015	Bristol Regional Medical Center (Parent Location)	181	1
FY 2015	Bristol Regional Medical Center (Parent Location)	189	5
FY 2015	Bristol Regional Medical Center (Parent Location)	190	8
FY 2015	Bristol Regional Medical Center (Parent Location)	191	11
FY 2015	Bristol Regional Medical Center (Parent Location)	192	6
FY 2015	Bristol Regional Medical Center (Parent Location)	193	6
FY 2015	Bristol Regional Medical Center (Parent Location)	194	13
FY 2015	Bristol Regional Medical Center (Parent Location)	195	8
FY 2015	Bristol Regional Medical Center (Parent Location)	200	1
FY 2015	Bristol Regional Medical Center (Parent Location)	202	1
FY 2015	Bristol Regional Medical Center (Parent Location)	203	5
FY 2015	Bristol Regional Medical Center (Parent Location)	204	2
FY 2015	Bristol Regional Medical Center (Parent Location)	205	1
FY 2015	Bristol Regional Medical Center (Parent Location)	207	3
FY 2015	Bristol Regional Medical Center (Parent Location)	208	7
FY 2015	Bristol Regional Medical Center (Parent Location)	220	1
FY 2015	Bristol Regional Medical Center (Parent Location)	229	1
FY 2015	Bristol Regional Medical Center (Parent Location)	234	1
FY 2015	Bristol Regional Medical Center (Parent Location)	235	1
FY 2015	Bristol Regional Medical Center (Parent Location)	246	1
FY 2015	Bristol Regional Medical Center (Parent Location)	247	5
FY 2015	Bristol Regional Medical Center (Parent Location)	249	1
FY 2015	Bristol Regional Medical Center (Parent Location)	253	1

FY 2015	Bristol Regional Medical Center (Parent Location)	254	1
FY 2015	Bristol Regional Medical Center (Parent Location)	280	3
FY 2015	Bristol Regional Medical Center (Parent Location)	281	4
FY 2015	Bristol Regional Medical Center (Parent Location)	282	1
FY 2015	Bristol Regional Medical Center (Parent Location)	286	2
FY 2015	Bristol Regional Medical Center (Parent Location)	287	2
FY 2015	Bristol Regional Medical Center (Parent Location)	291	5
FY 2015	Bristol Regional Medical Center (Parent Location)	292	5
FY 2015	Bristol Regional Medical Center (Parent Location)	293	1
FY 2015	Bristol Regional Medical Center (Parent Location)	299	2
FY 2015	Bristol Regional Medical Center (Parent Location)	300	4
FY 2015	Bristol Regional Medical Center (Parent Location)	309	1
FY 2015	Bristol Regional Medical Center (Parent Location)	312	2
FY 2015	Bristol Regional Medical Center (Parent Location)	313	2
FY 2015	Bristol Regional Medical Center (Parent Location)	314	3
FY 2015	Bristol Regional Medical Center (Parent Location)	328	1
FY 2015	Bristol Regional Medical Center (Parent Location)	329	1
FY 2015	Bristol Regional Medical Center (Parent Location)	330	3
FY 2015	Bristol Regional Medical Center (Parent Location)	331	1
FY 2015	Bristol Regional Medical Center (Parent Location)	333	1
FY 2015	Bristol Regional Medical Center (Parent Location)	335	1
FY 2015	Bristol Regional Medical Center (Parent Location)	337	3
FY 2015	Bristol Regional Medical Center (Parent Location)	340	3
FY 2015	Bristol Regional Medical Center (Parent Location)	342	1
FY 2015	Bristol Regional Medical Center (Parent Location)	343	1
FY 2015	Bristol Regional Medical Center (Parent Location)	348	1
FY 2015	Bristol Regional Medical Center (Parent Location)	351	1
FY 2015	Bristol Regional Medical Center (Parent Location)	356	1
FY 2015	Bristol Regional Medical Center (Parent Location)	368	1
FY 2015	Bristol Regional Medical Center (Parent Location)	371	1
FY 2015	Bristol Regional Medical Center (Parent Location)	372	3
FY 2015	Bristol Regional Medical Center (Parent Location)	377	4
FY 2015	Bristol Regional Medical Center (Parent Location)	378	3
FY 2015	Bristol Regional Medical Center (Parent Location)	379	1
FY 2015	Bristol Regional Medical Center (Parent Location)	381	1
FY 2015	Bristol Regional Medical Center (Parent Location)	385	1
FY 2015	Bristol Regional Medical Center (Parent Location)	386	3
FY 2015	Bristol Regional Medical Center (Parent Location)	389	5
FY 2015	Bristol Regional Medical Center (Parent Location)	390	2
FY 2015	Bristol Regional Medical Center (Parent Location)	392	15
FY 2015	Bristol Regional Medical Center (Parent Location)	394	4
FY 2015	Bristol Regional Medical Center (Parent Location)	405	1
FY 2015	Bristol Regional Medical Center (Parent Location)	407	1
FY 2015	Bristol Regional Medical Center (Parent Location)	416	1
FY 2015	Bristol Regional Medical Center (Parent Location)	418	4
FY 2015	Bristol Regional Medical Center (Parent Location)	419	2
FY 2015	Bristol Regional Medical Center (Parent Location)	423	1
FY 2015	Bristol Regional Medical Center (Parent Location)	432	8
FY 2015	Bristol Regional Medical Center (Parent Location)	433	3
FY 2015	Bristol Regional Medical Center (Parent Location)	438	4
FY 2015	Bristol Regional Medical Center (Parent Location)	439	17
FY 2015	Bristol Regional Medical Center (Parent Location)	440	4
FY 2015	Bristol Regional Medical Center (Parent Location)	441	2
FY 2015	Bristol Regional Medical Center (Parent Location)	442	2
FY 2015	Bristol Regional Medical Center (Parent Location)	446	2

FY 2015	Bristol Regional Medical Center (Parent Location)	460	8
FY 2015	Bristol Regional Medical Center (Parent Location)	464	1
FY 2015	Bristol Regional Medical Center (Parent Location)	469	1
FY 2015	Bristol Regional Medical Center (Parent Location)	470	3
FY 2015	Bristol Regional Medical Center (Parent Location)	472	1
FY 2015	Bristol Regional Medical Center (Parent Location)	473	2
FY 2015	Bristol Regional Medical Center (Parent Location)	474	2
FY 2015	Bristol Regional Medical Center (Parent Location)	475	1
FY 2015	Bristol Regional Medical Center (Parent Location)	477	1
FY 2015	Bristol Regional Medical Center (Parent Location)	478	1
FY 2015	Bristol Regional Medical Center (Parent Location)	481	4
FY 2015	Bristol Regional Medical Center (Parent Location)	482	1
FY 2015	Bristol Regional Medical Center (Parent Location)	484	1
FY 2015	Bristol Regional Medical Center (Parent Location)	485	1
FY 2015	Bristol Regional Medical Center (Parent Location)	490	1
FY 2015	Bristol Regional Medical Center (Parent Location)	493	4
FY 2015	Bristol Regional Medical Center (Parent Location)	494	1
FY 2015	Bristol Regional Medical Center (Parent Location)	501	1
FY 2015	Bristol Regional Medical Center (Parent Location)	503	1
FY 2015	Bristol Regional Medical Center (Parent Location)	513	1
FY 2015	Bristol Regional Medical Center (Parent Location)	515	1
FY 2015	Bristol Regional Medical Center (Parent Location)	519	2
FY 2015	Bristol Regional Medical Center (Parent Location)	520	1
FY 2015	Bristol Regional Medical Center (Parent Location)	535	1
FY 2015	Bristol Regional Medical Center (Parent Location)	536	1
FY 2015	Bristol Regional Medical Center (Parent Location)	537	1
FY 2015	Bristol Regional Medical Center (Parent Location)	539	2
FY 2015	Bristol Regional Medical Center (Parent Location)	540	4
FY 2015	Bristol Regional Medical Center (Parent Location)	541	1
FY 2015	Bristol Regional Medical Center (Parent Location)	552	6
FY 2015	Bristol Regional Medical Center (Parent Location)	553	1
FY 2015	Bristol Regional Medical Center (Parent Location)	556	1
FY 2015	Bristol Regional Medical Center (Parent Location)	558	3
FY 2015	Bristol Regional Medical Center (Parent Location)	563	1
FY 2015	Bristol Regional Medical Center (Parent Location)	579	1
FY 2015	Bristol Regional Medical Center (Parent Location)	584	1
FY 2015	Bristol Regional Medical Center (Parent Location)	593	1
FY 2015	Bristol Regional Medical Center (Parent Location)	596	1
FY 2015	Bristol Regional Medical Center (Parent Location)	602	1
FY 2015	Bristol Regional Medical Center (Parent Location)	603	15
FY 2015	Bristol Regional Medical Center (Parent Location)	604	2
FY 2015	Bristol Regional Medical Center (Parent Location)	605	1
FY 2015	Bristol Regional Medical Center (Parent Location)	616	1
FY 2015	Bristol Regional Medical Center (Parent Location)	624	1
FY 2015	Bristol Regional Medical Center (Parent Location)	629	1
FY 2015	Bristol Regional Medical Center (Parent Location)	637	3
FY 2015	Bristol Regional Medical Center (Parent Location)	638	7
FY 2015	Bristol Regional Medical Center (Parent Location)	639	2
FY 2015	Bristol Regional Medical Center (Parent Location)	640	1
FY 2015	Bristol Regional Medical Center (Parent Location)	641	11
FY 2015	Bristol Regional Medical Center (Parent Location)	643	1
FY 2015	Bristol Regional Medical Center (Parent Location)	657	1
FY 2015	Bristol Regional Medical Center (Parent Location)	660	1
FY 2015	Bristol Regional Medical Center (Parent Location)	669	2
FY 2015	Bristol Regional Medical Center (Parent Location)	682	8

FY 2015	Bristol Regional Medical Center (Parent Location)	683	6
FY 2015	Bristol Regional Medical Center (Parent Location)	689	3
FY 2015	Bristol Regional Medical Center (Parent Location)	690	8
FY 2015	Bristol Regional Medical Center (Parent Location)	694	4
FY 2015	Bristol Regional Medical Center (Parent Location)	698	1
FY 2015	Bristol Regional Medical Center (Parent Location)	699	1
FY 2015	Bristol Regional Medical Center (Parent Location)	724	1
FY 2015	Bristol Regional Medical Center (Parent Location)	728	1
FY 2015	Bristol Regional Medical Center (Parent Location)	742	1
FY 2015	Bristol Regional Medical Center (Parent Location)	743	1
FY 2015	Bristol Regional Medical Center (Parent Location)	765	20
FY 2015	Bristol Regional Medical Center (Parent Location)	766	37
FY 2015	Bristol Regional Medical Center (Parent Location)	767	5
FY 2015	Bristol Regional Medical Center (Parent Location)	770	1
FY 2015	Bristol Regional Medical Center (Parent Location)	774	10
FY 2015	Bristol Regional Medical Center (Parent Location)	775	94
FY 2015	Bristol Regional Medical Center (Parent Location)	776	4
FY 2015	Bristol Regional Medical Center (Parent Location)	777	1
FY 2015	Bristol Regional Medical Center (Parent Location)	778	2
FY 2015	Bristol Regional Medical Center (Parent Location)	781	10
FY 2015	Bristol Regional Medical Center (Parent Location)	789	10
FY 2015	Bristol Regional Medical Center (Parent Location)	790	1
FY 2015	Bristol Regional Medical Center (Parent Location)	791	1
FY 2015	Bristol Regional Medical Center (Parent Location)	792	7
FY 2015	Bristol Regional Medical Center (Parent Location)	793	14
FY 2015	Bristol Regional Medical Center (Parent Location)	794	51
FY 2015	Bristol Regional Medical Center (Parent Location)	795	93
FY 2015	Bristol Regional Medical Center (Parent Location)	808	2
FY 2015	Bristol Regional Medical Center (Parent Location)	812	2
FY 2015	Bristol Regional Medical Center (Parent Location)	834	1
FY 2015	Bristol Regional Medical Center (Parent Location)	841	1
FY 2015	Bristol Regional Medical Center (Parent Location)	846	2
FY 2015	Bristol Regional Medical Center (Parent Location)	847	3
FY 2015	Bristol Regional Medical Center (Parent Location)	848	1
FY 2015	Bristol Regional Medical Center (Parent Location)	853	1
FY 2015	Bristol Regional Medical Center (Parent Location)	857	1
FY 2015	Bristol Regional Medical Center (Parent Location)	862	2
FY 2015	Bristol Regional Medical Center (Parent Location)	864	1
FY 2015	Bristol Regional Medical Center (Parent Location)	870	2
FY 2015	Bristol Regional Medical Center (Parent Location)	871	14
FY 2015	Bristol Regional Medical Center (Parent Location)	872	4
FY 2015	Bristol Regional Medical Center (Parent Location)	880	5
FY 2015	Bristol Regional Medical Center (Parent Location)	881	89
FY 2015	Bristol Regional Medical Center (Parent Location)	882	4
FY 2015	Bristol Regional Medical Center (Parent Location)	883	1
FY 2015	Bristol Regional Medical Center (Parent Location)	884	1
FY 2015	Bristol Regional Medical Center (Parent Location)	885	272
FY 2015	Bristol Regional Medical Center (Parent Location)	897	4
FY 2015	Bristol Regional Medical Center (Parent Location)	906	1
FY 2015	Bristol Regional Medical Center (Parent Location)	917	3
FY 2015	Bristol Regional Medical Center (Parent Location)	918	7
FY 2015	Bristol Regional Medical Center (Parent Location)	920	1
FY 2015	Bristol Regional Medical Center (Parent Location)	923	1
FY 2015	Bristol Regional Medical Center (Parent Location)	935	1
FY 2015	Bristol Regional Medical Center (Parent Location)	947	1

FY 2015	Bristol Regional Medical Center (Parent Location)	948	5
FY 2015	Bristol Regional Medical Center (Parent Location)	956	1
FY 2015	Bristol Regional Medical Center (Parent Location)	975	1
FY 2015	Bristol Regional Medical Center (Parent Location)	981	2
FY 2015	Bristol Regional Medical Center (Parent Location)	987	1
FY 2015	Bristol Regional Medical Center (Parent Location)	989	1
FY 2015	Holston Valley Medical Center (Parent Location)	3	7
FY 2015	Holston Valley Medical Center (Parent Location)	4	4
FY 2015	Holston Valley Medical Center (Parent Location)	12	1
FY 2015	Holston Valley Medical Center (Parent Location)	20	1
FY 2015	Holston Valley Medical Center (Parent Location)	23	1
FY 2015	Holston Valley Medical Center (Parent Location)	36	1
FY 2015	Holston Valley Medical Center (Parent Location)	54	1
FY 2015	Holston Valley Medical Center (Parent Location)	55	1
FY 2015	Holston Valley Medical Center (Parent Location)	64	3
FY 2015	Holston Valley Medical Center (Parent Location)	65	2
FY 2015	Holston Valley Medical Center (Parent Location)	66	2
FY 2015	Holston Valley Medical Center (Parent Location)	70	4
FY 2015	Holston Valley Medical Center (Parent Location)	72	1
FY 2015	Holston Valley Medical Center (Parent Location)	74	2
FY 2015	Holston Valley Medical Center (Parent Location)	77	1
FY 2015	Holston Valley Medical Center (Parent Location)	81	1
FY 2015	Holston Valley Medical Center (Parent Location)	84	1
FY 2015	Holston Valley Medical Center (Parent Location)	87	1
FY 2015	Holston Valley Medical Center (Parent Location)	101	4
FY 2015	Holston Valley Medical Center (Parent Location)	151	1
FY 2015	Holston Valley Medical Center (Parent Location)	153	1
FY 2015	Holston Valley Medical Center (Parent Location)	163	1
FY 2015	Holston Valley Medical Center (Parent Location)	164	2
FY 2015	Holston Valley Medical Center (Parent Location)	165	2
FY 2015	Holston Valley Medical Center (Parent Location)	166	1
FY 2015	Holston Valley Medical Center (Parent Location)	175	1
FY 2015	Holston Valley Medical Center (Parent Location)	176	1
FY 2015	Holston Valley Medical Center (Parent Location)	177	2
FY 2015	Holston Valley Medical Center (Parent Location)	178	2
FY 2015	Holston Valley Medical Center (Parent Location)	179	1
FY 2015	Holston Valley Medical Center (Parent Location)	186	1
FY 2015	Holston Valley Medical Center (Parent Location)	187	2
FY 2015	Holston Valley Medical Center (Parent Location)	189	11
FY 2015	Holston Valley Medical Center (Parent Location)	190	5
FY 2015	Holston Valley Medical Center (Parent Location)	191	1
FY 2015	Holston Valley Medical Center (Parent Location)	192	2
FY 2015	Holston Valley Medical Center (Parent Location)	193	5
FY 2015	Holston Valley Medical Center (Parent Location)	194	12
FY 2015	Holston Valley Medical Center (Parent Location)	199	1
FY 2015	Holston Valley Medical Center (Parent Location)	202	2
FY 2015	Holston Valley Medical Center (Parent Location)	203	4
FY 2015	Holston Valley Medical Center (Parent Location)	204	2
FY 2015	Holston Valley Medical Center (Parent Location)	207	7
FY 2015	Holston Valley Medical Center (Parent Location)	208	16
FY 2015	Holston Valley Medical Center (Parent Location)	219	1
FY 2015	Holston Valley Medical Center (Parent Location)	234	3
FY 2015	Holston Valley Medical Center (Parent Location)	235	1
FY 2015	Holston Valley Medical Center (Parent Location)	236	1
FY 2015	Holston Valley Medical Center (Parent Location)	237	1

FY 2015	Holston Valley Medical Center (Parent Location)	238	1
FY 2015	Holston Valley Medical Center (Parent Location)	240	1
FY 2015	Holston Valley Medical Center (Parent Location)	247	6
FY 2015	Holston Valley Medical Center (Parent Location)	251	3
FY 2015	Holston Valley Medical Center (Parent Location)	252	2
FY 2015	Holston Valley Medical Center (Parent Location)	254	2
FY 2015	Holston Valley Medical Center (Parent Location)	264	2
FY 2015	Holston Valley Medical Center (Parent Location)	267	1
FY 2015	Holston Valley Medical Center (Parent Location)	280	4
FY 2015	Holston Valley Medical Center (Parent Location)	281	1
FY 2015	Holston Valley Medical Center (Parent Location)	282	1
FY 2015	Holston Valley Medical Center (Parent Location)	287	3
FY 2015	Holston Valley Medical Center (Parent Location)	288	1
FY 2015	Holston Valley Medical Center (Parent Location)	291	4
FY 2015	Holston Valley Medical Center (Parent Location)	292	2
FY 2015	Holston Valley Medical Center (Parent Location)	293	2
FY 2015	Holston Valley Medical Center (Parent Location)	298	1
FY 2015	Holston Valley Medical Center (Parent Location)	299	1
FY 2015	Holston Valley Medical Center (Parent Location)	303	1
FY 2015	Holston Valley Medical Center (Parent Location)	304	1
FY 2015	Holston Valley Medical Center (Parent Location)	309	4
FY 2015	Holston Valley Medical Center (Parent Location)	310	1
FY 2015	Holston Valley Medical Center (Parent Location)	312	2
FY 2015	Holston Valley Medical Center (Parent Location)	313	7
FY 2015	Holston Valley Medical Center (Parent Location)	314	4
FY 2015	Holston Valley Medical Center (Parent Location)	315	2
FY 2015	Holston Valley Medical Center (Parent Location)	327	1
FY 2015	Holston Valley Medical Center (Parent Location)	329	2
FY 2015	Holston Valley Medical Center (Parent Location)	330	1
FY 2015	Holston Valley Medical Center (Parent Location)	331	1
FY 2015	Holston Valley Medical Center (Parent Location)	372	1
FY 2015	Holston Valley Medical Center (Parent Location)	374	1
FY 2015	Holston Valley Medical Center (Parent Location)	377	2
FY 2015	Holston Valley Medical Center (Parent Location)	378	3
FY 2015	Holston Valley Medical Center (Parent Location)	379	2
FY 2015	Holston Valley Medical Center (Parent Location)	382	1
FY 2015	Holston Valley Medical Center (Parent Location)	384	1
FY 2015	Holston Valley Medical Center (Parent Location)	386	4
FY 2015	Holston Valley Medical Center (Parent Location)	389	3
FY 2015	Holston Valley Medical Center (Parent Location)	390	2
FY 2015	Holston Valley Medical Center (Parent Location)	391	3
FY 2015	Holston Valley Medical Center (Parent Location)	392	8
FY 2015	Holston Valley Medical Center (Parent Location)	393	3
FY 2015	Holston Valley Medical Center (Parent Location)	395	1
FY 2015	Holston Valley Medical Center (Parent Location)	412	1
FY 2015	Holston Valley Medical Center (Parent Location)	415	1
FY 2015	Holston Valley Medical Center (Parent Location)	418	2
FY 2015	Holston Valley Medical Center (Parent Location)	432	1
FY 2015	Holston Valley Medical Center (Parent Location)	435	1
FY 2015	Holston Valley Medical Center (Parent Location)	436	1
FY 2015	Holston Valley Medical Center (Parent Location)	438	1
FY 2015	Holston Valley Medical Center (Parent Location)	439	1
FY 2015	Holston Valley Medical Center (Parent Location)	440	1
FY 2015	Holston Valley Medical Center (Parent Location)	441	2
FY 2015	Holston Valley Medical Center (Parent Location)	442	3

FY 2015	Holston Valley Medical Center (Parent Location)	443	1
FY 2015	Holston Valley Medical Center (Parent Location)	445	1
FY 2015	Holston Valley Medical Center (Parent Location)	460	2
FY 2015	Holston Valley Medical Center (Parent Location)	464	1
FY 2015	Holston Valley Medical Center (Parent Location)	470	10
FY 2015	Holston Valley Medical Center (Parent Location)	473	2
FY 2015	Holston Valley Medical Center (Parent Location)	475	1
FY 2015	Holston Valley Medical Center (Parent Location)	481	1
FY 2015	Holston Valley Medical Center (Parent Location)	482	2
FY 2015	Holston Valley Medical Center (Parent Location)	492	1
FY 2015	Holston Valley Medical Center (Parent Location)	493	4
FY 2015	Holston Valley Medical Center (Parent Location)	496	1
FY 2015	Holston Valley Medical Center (Parent Location)	501	2
FY 2015	Holston Valley Medical Center (Parent Location)	505	1
FY 2015	Holston Valley Medical Center (Parent Location)	516	2
FY 2015	Holston Valley Medical Center (Parent Location)	520	1
FY 2015	Holston Valley Medical Center (Parent Location)	536	2
FY 2015	Holston Valley Medical Center (Parent Location)	540	1
FY 2015	Holston Valley Medical Center (Parent Location)	546	1
FY 2015	Holston Valley Medical Center (Parent Location)	552	1
FY 2015	Holston Valley Medical Center (Parent Location)	554	1
FY 2015	Holston Valley Medical Center (Parent Location)	556	1
FY 2015	Holston Valley Medical Center (Parent Location)	557	1
FY 2015	Holston Valley Medical Center (Parent Location)	559	1
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FY 2015	Holston Valley Medical Center (Parent Location)	596	1
FY 2015	Holston Valley Medical Center (Parent Location)	602	3
FY 2015	Holston Valley Medical Center (Parent Location)	603	5
FY 2015	Holston Valley Medical Center (Parent Location)	607	1
FY 2015	Holston Valley Medical Center (Parent Location)	626	1
FY 2015	Holston Valley Medical Center (Parent Location)	627	1
FY 2015	Holston Valley Medical Center (Parent Location)	629	1
FY 2015	Holston Valley Medical Center (Parent Location)	638	2
FY 2015	Holston Valley Medical Center (Parent Location)	639	4
FY 2015	Holston Valley Medical Center (Parent Location)	640	2
FY 2015	Holston Valley Medical Center (Parent Location)	641	5
FY 2015	Holston Valley Medical Center (Parent Location)	660	2
FY 2015	Holston Valley Medical Center (Parent Location)	661	1
FY 2015	Holston Valley Medical Center (Parent Location)	674	1
FY 2015	Holston Valley Medical Center (Parent Location)	682	6
FY 2015	Holston Valley Medical Center (Parent Location)	683	12
FY 2015	Holston Valley Medical Center (Parent Location)	684	2
FY 2015	Holston Valley Medical Center (Parent Location)	687	1
FY 2015	Holston Valley Medical Center (Parent Location)	689	5
FY 2015	Holston Valley Medical Center (Parent Location)	690	9
FY 2015	Holston Valley Medical Center (Parent Location)	698	2
FY 2015	Holston Valley Medical Center (Parent Location)	699	2
FY 2015	Holston Valley Medical Center (Parent Location)	729	1
FY 2015	Holston Valley Medical Center (Parent Location)	742	2
FY 2015	Holston Valley Medical Center (Parent Location)	743	2
FY 2015	Holston Valley Medical Center (Parent Location)	765	18
FY 2015	Holston Valley Medical Center (Parent Location)	766	10
FY 2015	Holston Valley Medical Center (Parent Location)	767	2
FY 2015	Holston Valley Medical Center (Parent Location)	774	4
FY 2015	Holston Valley Medical Center (Parent Location)	775	43

FY 2015	Holston Valley Medical Center (Parent Location)	776	3
FY 2015	Holston Valley Medical Center (Parent Location)	778	3
FY 2015	Holston Valley Medical Center (Parent Location)	781	1
FY 2015	Holston Valley Medical Center (Parent Location)	782	2
FY 2015	Holston Valley Medical Center (Parent Location)	789	4
FY 2015	Holston Valley Medical Center (Parent Location)	790	19
FY 2015	Holston Valley Medical Center (Parent Location)	791	13
FY 2015	Holston Valley Medical Center (Parent Location)	792	5
FY 2015	Holston Valley Medical Center (Parent Location)	793	24
FY 2015	Holston Valley Medical Center (Parent Location)	794	9
FY 2015	Holston Valley Medical Center (Parent Location)	795	43
FY 2015	Holston Valley Medical Center (Parent Location)	808	1
FY 2015	Holston Valley Medical Center (Parent Location)	809	2
FY 2015	Holston Valley Medical Center (Parent Location)	811	2
FY 2015	Holston Valley Medical Center (Parent Location)	812	2
FY 2015	Holston Valley Medical Center (Parent Location)	813	3
FY 2015	Holston Valley Medical Center (Parent Location)	815	2
FY 2015	Holston Valley Medical Center (Parent Location)	853	1
FY 2015	Holston Valley Medical Center (Parent Location)	856	2
FY 2015	Holston Valley Medical Center (Parent Location)	857	1
FY 2015	Holston Valley Medical Center (Parent Location)	862	1
FY 2015	Holston Valley Medical Center (Parent Location)	863	1
FY 2015	Holston Valley Medical Center (Parent Location)	870	10
FY 2015	Holston Valley Medical Center (Parent Location)	871	19
FY 2015	Holston Valley Medical Center (Parent Location)	872	4
FY 2015	Holston Valley Medical Center (Parent Location)	901	1
FY 2015	Holston Valley Medical Center (Parent Location)	907	2
FY 2015	Holston Valley Medical Center (Parent Location)	917	2
FY 2015	Holston Valley Medical Center (Parent Location)	918	1
FY 2015	Holston Valley Medical Center (Parent Location)	920	1
FY 2015	Holston Valley Medical Center (Parent Location)	947	3
FY 2015	Holston Valley Medical Center (Parent Location)	948	4
FY 2015	Holston Valley Medical Center (Parent Location)	951	2
FY 2015	Holston Valley Medical Center (Parent Location)	957	2
FY 2015	Holston Valley Medical Center (Parent Location)	963	1
FY 2015	Holston Valley Medical Center (Parent Location)	964	2
FY 2015	Holston Valley Medical Center (Parent Location)	975	2
FY 2015	Holston Valley Medical Center (Parent Location)	983	1
FY 2015	Holston Valley Medical Center (Parent Location)	987	1
FY 2016	Bristol Regional Medical Center (Parent Location)	3	2
FY 2016	Bristol Regional Medical Center (Parent Location)	4	1
FY 2016	Bristol Regional Medical Center (Parent Location)	23	1
FY 2016	Bristol Regional Medical Center (Parent Location)	25	2
FY 2016	Bristol Regional Medical Center (Parent Location)	26	2
FY 2016	Bristol Regional Medical Center (Parent Location)	28	1
FY 2016	Bristol Regional Medical Center (Parent Location)	33	1
FY 2016	Bristol Regional Medical Center (Parent Location)	38	1
FY 2016	Bristol Regional Medical Center (Parent Location)	52	1
FY 2016	Bristol Regional Medical Center (Parent Location)	54	1
FY 2016	Bristol Regional Medical Center (Parent Location)	57	1
FY 2016	Bristol Regional Medical Center (Parent Location)	60	1
FY 2016	Bristol Regional Medical Center (Parent Location)	64	6
FY 2016	Bristol Regional Medical Center (Parent Location)	65	5
FY 2016	Bristol Regional Medical Center (Parent Location)	66	3
FY 2016	Bristol Regional Medical Center (Parent Location)	69	1

FY 2016	Bristol Regional Medical Center (Parent Location)	70	1
FY 2016	Bristol Regional Medical Center (Parent Location)	71	1
FY 2016	Bristol Regional Medical Center (Parent Location)	74	1
FY 2016	Bristol Regional Medical Center (Parent Location)	84	1
FY 2016	Bristol Regional Medical Center (Parent Location)	85	1
FY 2016	Bristol Regional Medical Center (Parent Location)	86	1
FY 2016	Bristol Regional Medical Center (Parent Location)	88	1
FY 2016	Bristol Regional Medical Center (Parent Location)	91	2
FY 2016	Bristol Regional Medical Center (Parent Location)	97	1
FY 2016	Bristol Regional Medical Center (Parent Location)	98	1
FY 2016	Bristol Regional Medical Center (Parent Location)	100	2
FY 2016	Bristol Regional Medical Center (Parent Location)	101	2
FY 2016	Bristol Regional Medical Center (Parent Location)	103	3
FY 2016	Bristol Regional Medical Center (Parent Location)	165	1
FY 2016	Bristol Regional Medical Center (Parent Location)	166	4
FY 2016	Bristol Regional Medical Center (Parent Location)	176	1
FY 2016	Bristol Regional Medical Center (Parent Location)	177	5
FY 2016	Bristol Regional Medical Center (Parent Location)	178	1
FY 2016	Bristol Regional Medical Center (Parent Location)	180	2
FY 2016	Bristol Regional Medical Center (Parent Location)	184	1
FY 2016	Bristol Regional Medical Center (Parent Location)	187	2
FY 2016	Bristol Regional Medical Center (Parent Location)	189	4
FY 2016	Bristol Regional Medical Center (Parent Location)	190	8
FY 2016	Bristol Regional Medical Center (Parent Location)	191	5
FY 2016	Bristol Regional Medical Center (Parent Location)	192	1
FY 2016	Bristol Regional Medical Center (Parent Location)	193	8
FY 2016	Bristol Regional Medical Center (Parent Location)	194	9
FY 2016	Bristol Regional Medical Center (Parent Location)	195	5
FY 2016	Bristol Regional Medical Center (Parent Location)	196	1
FY 2016	Bristol Regional Medical Center (Parent Location)	200	1
FY 2016	Bristol Regional Medical Center (Parent Location)	201	1
FY 2016	Bristol Regional Medical Center (Parent Location)	202	2
FY 2016	Bristol Regional Medical Center (Parent Location)	203	4
FY 2016	Bristol Regional Medical Center (Parent Location)	204	1
FY 2016	Bristol Regional Medical Center (Parent Location)	207	2
FY 2016	Bristol Regional Medical Center (Parent Location)	208	7
FY 2016	Bristol Regional Medical Center (Parent Location)	219	1
FY 2016	Bristol Regional Medical Center (Parent Location)	229	2
FY 2016	Bristol Regional Medical Center (Parent Location)	236	2
FY 2016	Bristol Regional Medical Center (Parent Location)	246	1
FY 2016	Bristol Regional Medical Center (Parent Location)	247	5
FY 2016	Bristol Regional Medical Center (Parent Location)	249	1
FY 2016	Bristol Regional Medical Center (Parent Location)	253	2
FY 2016	Bristol Regional Medical Center (Parent Location)	264	1
FY 2016	Bristol Regional Medical Center (Parent Location)	270	1
FY 2016	Bristol Regional Medical Center (Parent Location)	280	10
FY 2016	Bristol Regional Medical Center (Parent Location)	281	1
FY 2016	Bristol Regional Medical Center (Parent Location)	283	1
FY 2016	Bristol Regional Medical Center (Parent Location)	286	2
FY 2016	Bristol Regional Medical Center (Parent Location)	287	1
FY 2016	Bristol Regional Medical Center (Parent Location)	291	8
FY 2016	Bristol Regional Medical Center (Parent Location)	292	1
FY 2016	Bristol Regional Medical Center (Parent Location)	296	1
FY 2016	Bristol Regional Medical Center (Parent Location)	300	3
FY 2016	Bristol Regional Medical Center (Parent Location)	302	1

FY 2016	Bristol Regional Medical Center (Parent Location)	303	2
FY 2016	Bristol Regional Medical Center (Parent Location)	308	3
FY 2016	Bristol Regional Medical Center (Parent Location)	311	2
FY 2016	Bristol Regional Medical Center (Parent Location)	312	1
FY 2016	Bristol Regional Medical Center (Parent Location)	313	1
FY 2016	Bristol Regional Medical Center (Parent Location)	314	4
FY 2016	Bristol Regional Medical Center (Parent Location)	315	2
FY 2016	Bristol Regional Medical Center (Parent Location)	326	1
FY 2016	Bristol Regional Medical Center (Parent Location)	327	3
FY 2016	Bristol Regional Medical Center (Parent Location)	328	2
FY 2016	Bristol Regional Medical Center (Parent Location)	329	3
FY 2016	Bristol Regional Medical Center (Parent Location)	330	2
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FY 2016	Bristol Regional Medical Center (Parent Location)	348	1
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FY 2016	Bristol Regional Medical Center (Parent Location)	355	1
FY 2016	Bristol Regional Medical Center (Parent Location)	357	1
FY 2016	Bristol Regional Medical Center (Parent Location)	371	1
FY 2016	Bristol Regional Medical Center (Parent Location)	372	2
FY 2016	Bristol Regional Medical Center (Parent Location)	375	1
FY 2016	Bristol Regional Medical Center (Parent Location)	377	4
FY 2016	Bristol Regional Medical Center (Parent Location)	378	2
FY 2016	Bristol Regional Medical Center (Parent Location)	379	2
FY 2016	Bristol Regional Medical Center (Parent Location)	380	1
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FY 2016	Bristol Regional Medical Center (Parent Location)	384	1
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FY 2016	Bristol Regional Medical Center (Parent Location)	388	1
FY 2016	Bristol Regional Medical Center (Parent Location)	389	5
FY 2016	Bristol Regional Medical Center (Parent Location)	391	1
FY 2016	Bristol Regional Medical Center (Parent Location)	392	9
FY 2016	Bristol Regional Medical Center (Parent Location)	394	1
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FY 2016	Bristol Regional Medical Center (Parent Location)	417	3
FY 2016	Bristol Regional Medical Center (Parent Location)	418	2
FY 2016	Bristol Regional Medical Center (Parent Location)	419	1
FY 2016	Bristol Regional Medical Center (Parent Location)	420	1
FY 2016	Bristol Regional Medical Center (Parent Location)	432	7
FY 2016	Bristol Regional Medical Center (Parent Location)	433	5
FY 2016	Bristol Regional Medical Center (Parent Location)	435	1
FY 2016	Bristol Regional Medical Center (Parent Location)	438	2
FY 2016	Bristol Regional Medical Center (Parent Location)	439	2
FY 2016	Bristol Regional Medical Center (Parent Location)	440	3
FY 2016	Bristol Regional Medical Center (Parent Location)	441	3
FY 2016	Bristol Regional Medical Center (Parent Location)	442	8
FY 2016	Bristol Regional Medical Center (Parent Location)	444	2
FY 2016	Bristol Regional Medical Center (Parent Location)	460	3
FY 2016	Bristol Regional Medical Center (Parent Location)	464	2
FY 2016	Bristol Regional Medical Center (Parent Location)	465	1
FY 2016	Bristol Regional Medical Center (Parent Location)	469	1
FY 2016	Bristol Regional Medical Center (Parent Location)	470	2
FY 2016	Bristol Regional Medical Center (Parent Location)	473	1
FY 2016	Bristol Regional Medical Center (Parent Location)	478	2

FY 2016	Bristol Regional Medical Center (Parent Location)	480	2
FY 2016	Bristol Regional Medical Center (Parent Location)	481	2
FY 2016	Bristol Regional Medical Center (Parent Location)	482	5
FY 2016	Bristol Regional Medical Center (Parent Location)	483	2
FY 2016	Bristol Regional Medical Center (Parent Location)	488	2
FY 2016	Bristol Regional Medical Center (Parent Location)	493	2
FY 2016	Bristol Regional Medical Center (Parent Location)	501	1
FY 2016	Bristol Regional Medical Center (Parent Location)	512	1
FY 2016	Bristol Regional Medical Center (Parent Location)	515	1
FY 2016	Bristol Regional Medical Center (Parent Location)	519	3
FY 2016	Bristol Regional Medical Center (Parent Location)	520	1
FY 2016	Bristol Regional Medical Center (Parent Location)	536	1
FY 2016	Bristol Regional Medical Center (Parent Location)	540	1
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FY 2016	Bristol Regional Medical Center (Parent Location)	552	3
FY 2016	Bristol Regional Medical Center (Parent Location)	555	2
FY 2016	Bristol Regional Medical Center (Parent Location)	556	2
FY 2016	Bristol Regional Medical Center (Parent Location)	563	1
FY 2016	Bristol Regional Medical Center (Parent Location)	564	1
FY 2016	Bristol Regional Medical Center (Parent Location)	572	1
FY 2016	Bristol Regional Medical Center (Parent Location)	579	1
FY 2016	Bristol Regional Medical Center (Parent Location)	580	2
FY 2016	Bristol Regional Medical Center (Parent Location)	581	1
FY 2016	Bristol Regional Medical Center (Parent Location)	601	1
FY 2016	Bristol Regional Medical Center (Parent Location)	602	2
FY 2016	Bristol Regional Medical Center (Parent Location)	603	12
FY 2016	Bristol Regional Medical Center (Parent Location)	605	1
FY 2016	Bristol Regional Medical Center (Parent Location)	617	1
FY 2016	Bristol Regional Medical Center (Parent Location)	621	1
FY 2016	Bristol Regional Medical Center (Parent Location)	623	1
FY 2016	Bristol Regional Medical Center (Parent Location)	626	1
FY 2016	Bristol Regional Medical Center (Parent Location)	637	1
FY 2016	Bristol Regional Medical Center (Parent Location)	638	6
FY 2016	Bristol Regional Medical Center (Parent Location)	639	1
FY 2016	Bristol Regional Medical Center (Parent Location)	640	4
FY 2016	Bristol Regional Medical Center (Parent Location)	641	5
FY 2016	Bristol Regional Medical Center (Parent Location)	682	7
FY 2016	Bristol Regional Medical Center (Parent Location)	683	12
FY 2016	Bristol Regional Medical Center (Parent Location)	684	1
FY 2016	Bristol Regional Medical Center (Parent Location)	689	3
FY 2016	Bristol Regional Medical Center (Parent Location)	690	6
FY 2016	Bristol Regional Medical Center (Parent Location)	694	6
FY 2016	Bristol Regional Medical Center (Parent Location)	698	2
FY 2016	Bristol Regional Medical Center (Parent Location)	741	1
FY 2016	Bristol Regional Medical Center (Parent Location)	742	1
FY 2016	Bristol Regional Medical Center (Parent Location)	743	2
FY 2016	Bristol Regional Medical Center (Parent Location)	758	1
FY 2016	Bristol Regional Medical Center (Parent Location)	765	20
FY 2016	Bristol Regional Medical Center (Parent Location)	766	38
FY 2016	Bristol Regional Medical Center (Parent Location)	767	3
FY 2016	Bristol Regional Medical Center (Parent Location)	770	1

FY 2016	Bristol Regional Medical Center (Parent Location)	774	14
FY 2016	Bristol Regional Medical Center (Parent Location)	775	93
FY 2016	Bristol Regional Medical Center (Parent Location)	777	1
FY 2016	Bristol Regional Medical Center (Parent Location)	781	5
FY 2016	Bristol Regional Medical Center (Parent Location)	789	4
FY 2016	Bristol Regional Medical Center (Parent Location)	791	1
FY 2016	Bristol Regional Medical Center (Parent Location)	792	3
FY 2016	Bristol Regional Medical Center (Parent Location)	793	15
FY 2016	Bristol Regional Medical Center (Parent Location)	794	30
FY 2016	Bristol Regional Medical Center (Parent Location)	795	127
FY 2016	Bristol Regional Medical Center (Parent Location)	809	1
FY 2016	Bristol Regional Medical Center (Parent Location)	811	1
FY 2016	Bristol Regional Medical Center (Parent Location)	812	1
FY 2016	Bristol Regional Medical Center (Parent Location)	815	1
FY 2016	Bristol Regional Medical Center (Parent Location)	847	3
FY 2016	Bristol Regional Medical Center (Parent Location)	853	4
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FY 2016	Bristol Regional Medical Center (Parent Location)	871	17
FY 2016	Bristol Regional Medical Center (Parent Location)	872	7
FY 2016	Bristol Regional Medical Center (Parent Location)	880	8
FY 2016	Bristol Regional Medical Center (Parent Location)	881	41
FY 2016	Bristol Regional Medical Center (Parent Location)	882	2
FY 2016	Bristol Regional Medical Center (Parent Location)	884	2
FY 2016	Bristol Regional Medical Center (Parent Location)	885	269
FY 2016	Bristol Regional Medical Center (Parent Location)	886	1
FY 2016	Bristol Regional Medical Center (Parent Location)	894	1
FY 2016	Bristol Regional Medical Center (Parent Location)	896	2
FY 2016	Bristol Regional Medical Center (Parent Location)	897	11
FY 2016	Bristol Regional Medical Center (Parent Location)	902	1
FY 2016	Bristol Regional Medical Center (Parent Location)	917	7
FY 2016	Bristol Regional Medical Center (Parent Location)	918	5
FY 2016	Bristol Regional Medical Center (Parent Location)	920	2
FY 2016	Bristol Regional Medical Center (Parent Location)	941	1
FY 2016	Bristol Regional Medical Center (Parent Location)	949	1
FY 2016	Bristol Regional Medical Center (Parent Location)	963	3
FY 2016	Bristol Regional Medical Center (Parent Location)	975	1
FY 2016	Bristol Regional Medical Center (Parent Location)	981	3
FY 2016	Bristol Regional Medical Center (Parent Location)	982	2
FY 2016	Bristol Regional Medical Center (Parent Location)	987	1
FY 2016	Bristol Regional Medical Center (Parent Location)	988	4
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FY 2016	Holston Valley Medical Center (Parent Location)	4	5
FY 2016	Holston Valley Medical Center (Parent Location)	27	1
FY 2016	Holston Valley Medical Center (Parent Location)	30	1
FY 2016	Holston Valley Medical Center (Parent Location)	32	1
FY 2016	Holston Valley Medical Center (Parent Location)	35	1
FY 2016	Holston Valley Medical Center (Parent Location)	36	1
FY 2016	Holston Valley Medical Center (Parent Location)	38	1
FY 2016	Holston Valley Medical Center (Parent Location)	39	3
FY 2016	Holston Valley Medical Center (Parent Location)	40	1
FY 2016	Holston Valley Medical Center (Parent Location)	57	1
FY 2016	Holston Valley Medical Center (Parent Location)	60	1
FY 2016	Holston Valley Medical Center (Parent Location)	64	4
FY 2016	Holston Valley Medical Center (Parent Location)	65	2

FY 2016	Holston Valley Medical Center (Parent Location)	66	2
FY 2016	Holston Valley Medical Center (Parent Location)	67	1
FY 2016	Holston Valley Medical Center (Parent Location)	69	1
FY 2016	Holston Valley Medical Center (Parent Location)	84	1
FY 2016	Holston Valley Medical Center (Parent Location)	86	1
FY 2016	Holston Valley Medical Center (Parent Location)	87	2
FY 2016	Holston Valley Medical Center (Parent Location)	93	1
FY 2016	Holston Valley Medical Center (Parent Location)	100	1
FY 2016	Holston Valley Medical Center (Parent Location)	101	3
FY 2016	Holston Valley Medical Center (Parent Location)	103	1
FY 2016	Holston Valley Medical Center (Parent Location)	125	1
FY 2016	Holston Valley Medical Center (Parent Location)	131	1
FY 2016	Holston Valley Medical Center (Parent Location)	133	1
FY 2016	Holston Valley Medical Center (Parent Location)	158	1
FY 2016	Holston Valley Medical Center (Parent Location)	163	1
FY 2016	Holston Valley Medical Center (Parent Location)	166	1
FY 2016	Holston Valley Medical Center (Parent Location)	176	2
FY 2016	Holston Valley Medical Center (Parent Location)	177	4
FY 2016	Holston Valley Medical Center (Parent Location)	178	1
FY 2016	Holston Valley Medical Center (Parent Location)	180	1
FY 2016	Holston Valley Medical Center (Parent Location)	183	1
FY 2016	Holston Valley Medical Center (Parent Location)	184	1
FY 2016	Holston Valley Medical Center (Parent Location)	187	2
FY 2016	Holston Valley Medical Center (Parent Location)	189	10
FY 2016	Holston Valley Medical Center (Parent Location)	190	9
FY 2016	Holston Valley Medical Center (Parent Location)	191	2
FY 2016	Holston Valley Medical Center (Parent Location)	192	2
FY 2016	Holston Valley Medical Center (Parent Location)	193	6
FY 2016	Holston Valley Medical Center (Parent Location)	194	10
FY 2016	Holston Valley Medical Center (Parent Location)	195	6
FY 2016	Holston Valley Medical Center (Parent Location)	202	4
FY 2016	Holston Valley Medical Center (Parent Location)	203	4
FY 2016	Holston Valley Medical Center (Parent Location)	204	2
FY 2016	Holston Valley Medical Center (Parent Location)	206	1
FY 2016	Holston Valley Medical Center (Parent Location)	207	6
FY 2016	Holston Valley Medical Center (Parent Location)	208	10
FY 2016	Holston Valley Medical Center (Parent Location)	216	1
FY 2016	Holston Valley Medical Center (Parent Location)	220	1
FY 2016	Holston Valley Medical Center (Parent Location)	221	1
FY 2016	Holston Valley Medical Center (Parent Location)	225	1
FY 2016	Holston Valley Medical Center (Parent Location)	227	1
FY 2016	Holston Valley Medical Center (Parent Location)	234	3
FY 2016	Holston Valley Medical Center (Parent Location)	235	1
FY 2016	Holston Valley Medical Center (Parent Location)	236	2
FY 2016	Holston Valley Medical Center (Parent Location)	242	1
FY 2016	Holston Valley Medical Center (Parent Location)	243	1
FY 2016	Holston Valley Medical Center (Parent Location)	246	1
FY 2016	Holston Valley Medical Center (Parent Location)	247	6
FY 2016	Holston Valley Medical Center (Parent Location)	252	2
FY 2016	Holston Valley Medical Center (Parent Location)	253	2
FY 2016	Holston Valley Medical Center (Parent Location)	254	1
FY 2016	Holston Valley Medical Center (Parent Location)	269	2
FY 2016	Holston Valley Medical Center (Parent Location)	272	1
FY 2016	Holston Valley Medical Center (Parent Location)	280	3
FY 2016	Holston Valley Medical Center (Parent Location)	281	1

FY 2016	Holston Valley Medical Center (Parent Location)	282	2
FY 2016	Holston Valley Medical Center (Parent Location)	287	1
FY 2016	Holston Valley Medical Center (Parent Location)	289	1
FY 2016	Holston Valley Medical Center (Parent Location)	291	3
FY 2016	Holston Valley Medical Center (Parent Location)	292	3
FY 2016	Holston Valley Medical Center (Parent Location)	299	2
FY 2016	Holston Valley Medical Center (Parent Location)	300	1
FY 2016	Holston Valley Medical Center (Parent Location)	308	2
FY 2016	Holston Valley Medical Center (Parent Location)	309	1
FY 2016	Holston Valley Medical Center (Parent Location)	310	3
FY 2016	Holston Valley Medical Center (Parent Location)	311	1
FY 2016	Holston Valley Medical Center (Parent Location)	312	2
FY 2016	Holston Valley Medical Center (Parent Location)	313	2
FY 2016	Holston Valley Medical Center (Parent Location)	314	4
FY 2016	Holston Valley Medical Center (Parent Location)	315	1
FY 2016	Holston Valley Medical Center (Parent Location)	327	1
FY 2016	Holston Valley Medical Center (Parent Location)	329	2
FY 2016	Holston Valley Medical Center (Parent Location)	330	1
FY 2016	Holston Valley Medical Center (Parent Location)	337	1
FY 2016	Holston Valley Medical Center (Parent Location)	342	1
FY 2016	Holston Valley Medical Center (Parent Location)	353	1
FY 2016	Holston Valley Medical Center (Parent Location)	355	1
FY 2016	Holston Valley Medical Center (Parent Location)	356	1
FY 2016	Holston Valley Medical Center (Parent Location)	371	3
FY 2016	Holston Valley Medical Center (Parent Location)	372	1
FY 2016	Holston Valley Medical Center (Parent Location)	374	1
FY 2016	Holston Valley Medical Center (Parent Location)	377	3
FY 2016	Holston Valley Medical Center (Parent Location)	378	1
FY 2016	Holston Valley Medical Center (Parent Location)	385	1
FY 2016	Holston Valley Medical Center (Parent Location)	387	1
FY 2016	Holston Valley Medical Center (Parent Location)	388	1
FY 2016	Holston Valley Medical Center (Parent Location)	389	3
FY 2016	Holston Valley Medical Center (Parent Location)	390	1
FY 2016	Holston Valley Medical Center (Parent Location)	392	4
FY 2016	Holston Valley Medical Center (Parent Location)	394	1
FY 2016	Holston Valley Medical Center (Parent Location)	395	1
FY 2016	Holston Valley Medical Center (Parent Location)	406	1
FY 2016	Holston Valley Medical Center (Parent Location)	418	1
FY 2016	Holston Valley Medical Center (Parent Location)	419	2
FY 2016	Holston Valley Medical Center (Parent Location)	432	2
FY 2016	Holston Valley Medical Center (Parent Location)	433	1
FY 2016	Holston Valley Medical Center (Parent Location)	438	2
FY 2016	Holston Valley Medical Center (Parent Location)	439	5
FY 2016	Holston Valley Medical Center (Parent Location)	440	2
FY 2016	Holston Valley Medical Center (Parent Location)	441	2
FY 2016	Holston Valley Medical Center (Parent Location)	442	5
FY 2016	Holston Valley Medical Center (Parent Location)	443	2
FY 2016	Holston Valley Medical Center (Parent Location)	459	1
FY 2016	Holston Valley Medical Center (Parent Location)	460	5
FY 2016	Holston Valley Medical Center (Parent Location)	464	2
FY 2016	Holston Valley Medical Center (Parent Location)	466	1
FY 2016	Holston Valley Medical Center (Parent Location)	469	1
FY 2016	Holston Valley Medical Center (Parent Location)	470	12
FY 2016	Holston Valley Medical Center (Parent Location)	472	1
FY 2016	Holston Valley Medical Center (Parent Location)	475	1

FY 2016	Holston Valley Medical Center (Parent Location)	478	1
FY 2016	Holston Valley Medical Center (Parent Location)	480	2
FY 2016	Holston Valley Medical Center (Parent Location)	481	2
FY 2016	Holston Valley Medical Center (Parent Location)	482	2
FY 2016	Holston Valley Medical Center (Parent Location)	485	2
FY 2016	Holston Valley Medical Center (Parent Location)	494	1
FY 2016	Holston Valley Medical Center (Parent Location)	513	1
FY 2016	Holston Valley Medical Center (Parent Location)	519	1
FY 2016	Holston Valley Medical Center (Parent Location)	535	1
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FY 2016	Holston Valley Medical Center (Parent Location)	555	1
FY 2016	Holston Valley Medical Center (Parent Location)	558	1
FY 2016	Holston Valley Medical Center (Parent Location)	560	2
FY 2016	Holston Valley Medical Center (Parent Location)	571	1
FY 2016	Holston Valley Medical Center (Parent Location)	572	1
FY 2016	Holston Valley Medical Center (Parent Location)	579	1
FY 2016	Holston Valley Medical Center (Parent Location)	580	1
FY 2016	Holston Valley Medical Center (Parent Location)	592	1
FY 2016	Holston Valley Medical Center (Parent Location)	593	1
FY 2016	Holston Valley Medical Center (Parent Location)	598	1
FY 2016	Holston Valley Medical Center (Parent Location)	602	2
FY 2016	Holston Valley Medical Center (Parent Location)	603	7
FY 2016	Holston Valley Medical Center (Parent Location)	606	1
FY 2016	Holston Valley Medical Center (Parent Location)	617	2
FY 2016	Holston Valley Medical Center (Parent Location)	638	6
FY 2016	Holston Valley Medical Center (Parent Location)	639	5
FY 2016	Holston Valley Medical Center (Parent Location)	640	1
FY 2016	Holston Valley Medical Center (Parent Location)	641	7
FY 2016	Holston Valley Medical Center (Parent Location)	669	1
FY 2016	Holston Valley Medical Center (Parent Location)	674	1
FY 2016	Holston Valley Medical Center (Parent Location)	682	12
FY 2016	Holston Valley Medical Center (Parent Location)	683	7
FY 2016	Holston Valley Medical Center (Parent Location)	690	5
FY 2016	Holston Valley Medical Center (Parent Location)	734	1
FY 2016	Holston Valley Medical Center (Parent Location)	737	2
FY 2016	Holston Valley Medical Center (Parent Location)	740	1
FY 2016	Holston Valley Medical Center (Parent Location)	742	1
FY 2016	Holston Valley Medical Center (Parent Location)	743	1
FY 2016	Holston Valley Medical Center (Parent Location)	748	1
FY 2016	Holston Valley Medical Center (Parent Location)	765	10
FY 2016	Holston Valley Medical Center (Parent Location)	766	12
FY 2016	Holston Valley Medical Center (Parent Location)	767	1
FY 2016	Holston Valley Medical Center (Parent Location)	774	8
FY 2016	Holston Valley Medical Center (Parent Location)	775	34
FY 2016	Holston Valley Medical Center (Parent Location)	776	3
FY 2016	Holston Valley Medical Center (Parent Location)	778	3
FY 2016	Holston Valley Medical Center (Parent Location)	780	2
FY 2016	Holston Valley Medical Center (Parent Location)	781	1
FY 2016	Holston Valley Medical Center (Parent Location)	790	13
FY 2016	Holston Valley Medical Center (Parent Location)	791	4
FY 2016	Holston Valley Medical Center (Parent Location)	792	4
FY 2016	Holston Valley Medical Center (Parent Location)	793	36

FY 2016	Holston Valley Medical Center (Parent Location)	794	24
FY 2016	Holston Valley Medical Center (Parent Location)	795	40
FY 2016	Holston Valley Medical Center (Parent Location)	801	1
FY 2016	Holston Valley Medical Center (Parent Location)	808	2
FY 2016	Holston Valley Medical Center (Parent Location)	809	1
FY 2016	Holston Valley Medical Center (Parent Location)	811	1
FY 2016	Holston Valley Medical Center (Parent Location)	812	3
FY 2016	Holston Valley Medical Center (Parent Location)	813	1
FY 2016	Holston Valley Medical Center (Parent Location)	815	1
FY 2016	Holston Valley Medical Center (Parent Location)	847	2
FY 2016	Holston Valley Medical Center (Parent Location)	848	1
FY 2016	Holston Valley Medical Center (Parent Location)	853	4
FY 2016	Holston Valley Medical Center (Parent Location)	856	1
FY 2016	Holston Valley Medical Center (Parent Location)	857	1
FY 2016	Holston Valley Medical Center (Parent Location)	862	1
FY 2016	Holston Valley Medical Center (Parent Location)	863	1
FY 2016	Holston Valley Medical Center (Parent Location)	864	1
FY 2016	Holston Valley Medical Center (Parent Location)	867	2
FY 2016	Holston Valley Medical Center (Parent Location)	870	1
FY 2016	Holston Valley Medical Center (Parent Location)	871	23
FY 2016	Holston Valley Medical Center (Parent Location)	872	4
FY 2016	Holston Valley Medical Center (Parent Location)	882	1
FY 2016	Holston Valley Medical Center (Parent Location)	901	1
FY 2016	Holston Valley Medical Center (Parent Location)	902	2
FY 2016	Holston Valley Medical Center (Parent Location)	904	1
FY 2016	Holston Valley Medical Center (Parent Location)	908	1
FY 2016	Holston Valley Medical Center (Parent Location)	909	1
FY 2016	Holston Valley Medical Center (Parent Location)	917	7
FY 2016	Holston Valley Medical Center (Parent Location)	918	8
FY 2016	Holston Valley Medical Center (Parent Location)	919	1
FY 2016	Holston Valley Medical Center (Parent Location)	920	1
FY 2016	Holston Valley Medical Center (Parent Location)	940	1
FY 2016	Holston Valley Medical Center (Parent Location)	947	1
FY 2016	Holston Valley Medical Center (Parent Location)	948	1
FY 2016	Holston Valley Medical Center (Parent Location)	959	1
FY 2016	Holston Valley Medical Center (Parent Location)	963	2
FY 2016	Holston Valley Medical Center (Parent Location)	965	1
FY 2016	Holston Valley Medical Center (Parent Location)	981	2
FY 2016	Holston Valley Medical Center (Parent Location)	987	2

MOUNTAIN STATES HEALTH ALLIANCE

MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

MEDICAL STAFF BYLAWS

FOR

NORTON COMMUNITY HOSPITAL

DICKENSON COMMUNITY HOSPITAL

Horty, Springer & Mattern, P.C.

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APPENDIX A

APPENDIX B

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix B to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least 24 patient contacts per two-year appointment term; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Ambulatory Care, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Governing Body;

(b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;

(c) hold office, serve as department chairs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such clinical privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) accepting inpatient consultations, when requested;

(g) paying application fees, dues, and assessments; and

(h) performing assigned duties.

Members of the Active Staff who have served on the Medical Staff for at least 15 years and who are at least 60 years of age may be relieved of on-call duties when adequate call coverage exists for the specialty area in which the physician practices, in the discretion of the MEC and the Governing Body. The individual must make a formal request to the MEC with the MEC's assessment based on need and the effect on others who serve on the call roster for that specialty. The MEC will then make a recommendation to the Governing Body for a final decision. Any request that is granted is subject to change by the Governing Body upon its determination that call coverage in the member's specialty area is not adequate.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in more than six, but fewer than 24, patient contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than six patient contacts during his/her two-year appointment term must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting or Ambulatory Care).

** Any member who has more than 24 patient contacts during his/her two-year appointment term must request Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff and department meetings (without vote);

(b) may not hold office or serve as department chairs or committee chairs, unless waived by the Governing Body;

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician, and

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes;

(f) shall exercise such clinical privileges as are granted to them; and

(g) shall pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments);

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff (any Consulting Staff member who has more than 24 patient contacts during his/her two-year appointment term must request Active Staff status);

(b) may not hold office or serve as department chairs or committee chairs, unless waived by the MEC and the Governing Body;

(c) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);

(d) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients, unless the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes; and

(f) shall pay application fees, dues, and assessments.

2.D. AMBULATORY CARE STAFF

2.D.1. Qualifications:

The Ambulatory Care Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital. Except as noted in (b), it is a membership-only category, with no clinical privileges being granted. The primary purpose of the Ambulatory Care Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care;

(b) may wish to request only limited outpatient-related therapies for the care and treatment of their patients at the Hospital; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

(a) may attend meetings of the Medical Staff and applicable departments (without vote);

(b) may not hold office or serve as department chairs or committee chairs;

(c) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients, and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may also be granted limited privileges to order certain outpatient therapies (e.g., infusion therapy injections), but should these privileges be requested, (i) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies in the discretion of the MEC, and (ii) they must also establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients, should that be necessary;

(k) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(l) may actively participate in the professional practice evaluation and performance improvement processes;

(m) may refer patients to the Hospital's diagnostic facilities and order such tests;

(n) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(o) must pay application fees, dues, and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy the response time requirements set forth in Section 2.A.1(d) of the Credentials Policy, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as department chairs or committee chairs;

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote); and

(f) shall pay applicable fees, dues, and assessments.

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, and the Immediate Past President.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the Governing Body. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years at any MSHA Hospital;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, board members, or department chairs at any other non-MSHA hospital and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CMO and the CEO in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the CEO and the Governing Body;

(c) be accountable to the Governing Body and the CEO, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) appoint all committee chairs and committee members;

(f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio,* without vote;

(g) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(h) recommend Medical Staff representatives to Hospital committees after presentation to the MEC for discussion;

(i) be the spokesperson for the Medical Staff in its external professional and public relations; and

(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice-President:

The Vice-President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the MEC; and

(c) assume all such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the MEC;

(b) cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;

(c) call Medical Staff meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the office of Secretary-Treasurer;

(d) be responsible for the collection of, accounting for, and disbursements of, any funds collected, donated, or otherwise assessed and present in the Medical Staff account and report to the Medical Staff; and

(e) perform such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.4. Immediate Past President:

The Immediate Past President shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.D. NOMINATIONS

(1) The Nominating Committee for all general and special elections shall consist of the President of the Medical Staff and the two most recent Past Presidents, when available and willing to serve.

(2) The Nominating Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve.

(4) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Candidates receiving a majority of the written votes cast at the meeting shall be elected, subject to Governing Body confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, at the discretion of the MEC, the election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Governing Body confirmation.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected. Officers may be reelected for one additional term.

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice-President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff shall be organized into departments as listed in the Medical Staff Organization Manual. Subject to the approval of the Governing Body, the MEC may create new departments, eliminate departments, create divisions within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges or a scope of practice in a given department, and (iii) to provide appropriate specialty

coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND VICE CHAIRS

Each department chair and vice chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Governing Body after considering the recommendation of the MEC.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Except as otherwise provided by contract, department chairs and vice chairs shall be elected by the voting members of the department, subject to approval by the MEC and the Governing Body.

(2) Department chairs and vice chairs shall serve a term of two years. They may be reelected for one additional term.

(3) Any department chair or vice chair may be removed by a two-thirds vote of the Active Staff members of the department, subject to Governing Body confirmation; or by a two-thirds vote of the MEC, subject to Governing Body confirmation; or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(4) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be considered. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

4.F. DUTIES OF DEPARTMENT CHAIRS AND VICE CHAIRS

Department chairs and vice chairs are responsible for the following, either individually or in collaboration with Hospital personnel:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(7) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating interdepartmental and intradepartmental services;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the department;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the department;

(15) making recommendations for space and other resources needed by the department; and

(16) performing all functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Governing Body.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairs and members shall be appointed for a term of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO. All such representatives shall serve on the committees, without vote.

(4) The President of the Medical Staff, the CMO, and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, the Immediate Past President, and the department chairs.

(b) The President of the Medical Staff shall chair the MEC.

(c) The CEO, the CMO, and the Director of Medical Education shall be *ex officio* members of the MEC, without vote.

(d) Other individuals may be invited to MEC meetings (without vote).

5.D.2. Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to the Governing Body on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(h) providing and promoting effective liaison among the Medical Staff, Administration, and the Governing Body; and

(i) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet at least monthly and shall maintain a permanent record of its proceedings and actions. Meetings of the MEC shall be considered closed meetings and members of the Medical Staff may only attend if requested.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance;

(t) review and update of the disaster plan and overall disaster preparedness; and

(u) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Governing Body.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may, by resolution and upon approval of the Governing Body and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least annually, at which meeting the officers are elected.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the CEO, the Governing Body, or by a petition signed by not less than one-fourth of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, each department and committee shall meet as necessary to accomplish their functions, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the MEC, the CEO, or by a petition signed by not less than one-fourth of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC and the Professional Practice Evaluation Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for any amendments to these Medical Staff Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals that are presented to the voting members of the Medical Staff, at least 10% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals and actions by the MEC and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the Presiding Officer for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC, the CEO, and the Governing Body.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by

the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC and the Professional Practice Evaluation Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in Medical Staff meetings and applicable department and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Governing Body shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 10% of the voting members of the Medical Staff.

(3) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present proposed amendments to the Active Staff by written ballot or e-mail, to be returned to the Medical Staff Services Department by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Governing Body.

(7) If the Governing Body has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Governing Body and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Governing Body's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These documents include, but are not limited to, the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) All proposed amendments to the Medical Staff Credentials Policy or the Policy on Allied Health Professionals must be reviewed in advance by the four MSHA Virginia MECs prior to a vote on the amendment(s) by the MEC. If any MSHA MEC has an objection to such an amendment, it shall be shared with each of the four MECs for discussion. Any disputes over any proposed amendments to this Policy shall be discussed and resolved during a joint meeting of the four MSHA MECs. Following review by the four MSHA Virginia MECs, notice of all proposed amendments shall then be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting where the amendment will be considered for adoption. Any voting member of the Medical Staff may submit written comments to the MEC. The Medical Staff Credentials Policy and the Policy on Allied Health Professionals may then be amended by a majority vote of the members of the MEC. Amendments shall be effective only after approval by the Governing Body, which approval shall not be unreasonably withheld.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(4) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(5) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Governing Body for its final action.

(6) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Governing Body. Approval may not be unreasonably withheld by any of these groups. Any disputes over any proposed amendments shall be discussed and resolved during a joint meeting of the four MSHA MECs and the Governing Body.

(7) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the MEC; or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 10% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Governing Body for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Governing Body. Communication from Medical Staff members to the Governing Body will be directed through the CEO, who will forward the request for communication to the Chair of the Governing Body. The CEO will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Governing Body will determine the manner and method of the Governing Body's response to the Medical Staff member(s).

ARTICLE 9

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Governing Body, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

July 2, 2013 _____ Lance Dozier, M. D. _____
(Date) President of the Medical Staff

Approved by the Governing Body of Norton Community Hospital:

July 25, 2013 _____ Mrs. Ann Fleming _____
(Date) Chair - Governing Body

Approved by the Governing Body of Dickenson Community Hospital:

March 28, 2014 _____ Mr. Donald Baker _____
(Date) Chair - Governing Body

APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS AND DISCHARGE SUMMARIES

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;

- social history, including any abuse or neglect;

- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

- data reviewed;

- assessments, including problem list;

- plan of treatment; and

- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) <u>H&Ps Performed Prior to Admission</u>

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these

circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(d) Short Stay Documentation Requirements

A Short Stay History and Physical Form, approved by the MEC, may be utilized for (i) ambulatory or same day procedures, or (ii) short stay observations which do not meet inpatient criteria. These forms shall document the chief complaint or reason for

the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

(e) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

(f) Discharge Summaries

All discharge summaries shall be completed within seven days of patient discharge. [NOTE: While this is the only element of discharge summaries required to be "in the bylaws," for continuity purposes, the Medical Staff Leadership may want to move any and all provisions in the Rules and Regulations pertaining to discharge summaries (i.e., content and who can complete them) into this same section.]

APPENDIX B

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Consulting	Ambulatory Care	Coverage	Honorary
Basic Requirements						
Number of hospital contacts/2-year	≥ 24	> 6 & < 24	NA	N	NA	N
Rights						
Admit	Y	> 6 & < 24	N	N	P	N
Exercise clinical privileges	Y	Y	Y	N	P	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N	N	N
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Emergency call coverage	Y	FUC	N	FUC	P	N

Meeting requirements	Y	N	N	N	N	N
Comply w/ guidelines	Y	Y	Y	Y	Y	N

Y = Yes

N = No

P = Partial (with respect to voting, only when appointed to a committee)

FUC = Follow-up care

MOUNTAIN STATES HEALTH ALLIANCE MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

JOHNSTON MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

June 11, 2014
Horty, Springer & Mattern, P.C.

206183.5

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APPENDIX A

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.

(2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff and the Secretary-Treasurer.

(4) The dues collected shall be used for Medical Staff education and leadership responsibilities.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentials Policy are eligible to apply for appointment to one of the categories listed below.

2.A. ACTIVE MEDICAL STAFF

There shall be two classifications of the Active Medical Staff: the Active Hospital Admitting Staff and the Active Hospital Non-Admitting Staff, each of which shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(1) are involved in a practice that involves some activity such as patient care, test interpretation, surgery, or other procedures in the hospital environment; and

(2) have expressed a willingness to contribute to medical staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital and Medical Staff committees and /or active participation in performance improvement or professional practice evaluation functions.

2.A.1. ACTIVE HOSPITAL ADMITTING STAFF

The Active Hospital Admitting Staff shall consist of those physicians, dentists, oral surgeons, and podiatrists with an active hospital-based practice that often includes patients being admitted to the hospital environment. Active Hospital Admitting Staff members are the attending physician of the patient in their care. Representative practitioners in this category would include Hospitalists, Internists and Family Medicine providers who manage in-hospital patient care, Pediatricians, Obstetrical and Gynecological surgeons, general surgeons, orthopedic surgeons, and other surgeons granted block space in the operating suites.

2.A.1.a. Active Hospital Admitting Staff Prerogatives:

Members of the Active Hospital Admitting Staff may:

(1) treat patients without limitations in accordance with the granted delineation of privileges, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the MSHA Board;

(2) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;

(3) hold office, serve as department chairs, serve on Medical Staff committees, and serve as chairs of committees;

(4) exercise such clinical privileges as are granted to them;

(5) attend meetings of the MEC (without vote) so long as notice is given to the President of the Medical Staff. Attendance and participation at such meetings shall be at the discretion of the President of the Medical Staff. The Hospital Admitting Staff members shall leave for any discussion of confidential peer review issues; and

(6) be excused from all dues, fees, and assessments by virtue of performing full active admitting services for patients and the Hospital.

2.A.1.b. Active Hospital Admitting Staff Responsibilities:

Members of the Active Hospital Admitting Staff must assume all the responsibilities of membership on the Active Staff, including:

(1) serving on committees as requested;

(2) providing specialty coverage for the Emergency Department and in disaster situations;

(3) providing care for unassigned patients;

(4) accepting inpatient consultations when requested;

(5) participation in performance improvement or professional practice evaluation functions;

(6) participation in development of clinical practice protocols and guidelines pertinent to their medical specialty; and

(7) abiding by the bylaws, rules, and regulations of the Medical Staff.

2.A.2. ACTIVE HOSPITAL NON-ADMITTING STAFF

The Active Hospital Non-Admitting Staff shall consist of those physicians, dentists, oral surgeons, and podiatrists with an active hospital-based practice that provides services, test interpretations, procedures, treatments, and consultations in the hospital environment. Members of the Active Hospital Non-Admitting Staff often provide essential patient care in some aspect of the hospital environment and are responsible for their scope of practice. They often provide patient services on request from other members of the Medical Staff. Representative practitioners in this category would include Anesthesiologists, Emergency Medicine doctors, Pathologists, and Radiologists. The Active Hospital Non-Admitting

Staff also includes those specialists and subspecialists who provide primarily consultative services and do not admit their own patients.

2.A.2.a. Active Hospital Non-Admitting Staff Prerogatives:

Members of the Active Hospital Non-Admitting Staff may:

(1) exercise such clinical privileges as are granted to them;

(2) evaluate and treat (but not admit) patients in conjunction with other members of the Active Hospital Admitting Staff;

(3) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;

(4) hold office, serve as department chairs, serve on Medical Staff committees, and serve as chairs of committees; and

(5) attend meetings of the MEC (without vote) so long as notice is given to the President of the Medical Staff. Attendance and participation at such meetings shall be at the discretion of the President of the Medical Staff. The Active Hospital Non-Admitting Staff members shall leave for any discussion of confidential peer review issues.

2.A.2.b. Active Hospital Non-Admitting Staff Responsibilities:

Members of the Active Hospital Non-Admitting Staff must assume all the responsibilities of membership on the Active Staff, including:

(1) serving on committees as requested;

(2) providing specialty coverage for the Emergency Department on an as needed basis determined by the MEC:

(a) 24 hours a day/seven days a week or as provided by the Hospital for mission critical services (e.g., emergency department, radiology, and anesthesiology services); or

(b) as reasonable for a solo specialist or subspecialist which, in the discretion of the MEC, means that the individual maintains coverage for his/her own patients (either personally or through his/her coverage arrangement) and that the individual is available to the emergency department on a frequency that will not be greater than one out of four days;

(3) responding in the event of a disaster situation;

(4) providing care for unassigned patients;

(5) accepting inpatient consultations when requested;

(6) participation in performance improvement or professional practice evaluation functions;

(7) participation in development of clinical practice protocols and guidelines pertinent to their medical specialty; and

(8) abiding by the bylaws, rules, and regulations of the Medical Staff.

2.B. COMMUNITY AFFILIATE STAFF

2.B.1. Qualifications:

The Community Affiliate Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital. Except as noted in (b), it is a membership-only category, with no clinical privileges being granted. The primary purpose of the Community Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care;

(b) may wish to request only limited outpatient-related therapies for the care and treatment of their patients at the Hospital; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Affiliate Staff as outlined in Section 2.B.2.

2.B.2. Prerogatives and Responsibilities:

Community Affiliate Staff members:

(a) may attend meetings of the Medical Staff and applicable departments but cannot vote at these meetings unless the individual was previously a member of the Active Staff for a period of at least four years and transitioned to the Community Affiliate Staff in response to changes in the individual's clinical practice patterns (in order to maintain voting rights, such individuals must attend at least 50% of applicable Medical Staff, department and committee meetings each year);

(b) may not hold office or serve as department chairs or committee chairs unless waived by the MEC and Governing Body (the MEC may only consider waivers of

this provision for members of the Community Affiliate Staff who had previously been appointed to the Active Staff for a period of at least four years and who only transitioned to the Community Affiliate Staff in response to changes in that individual's clinical practice patterns);

(c) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients, and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may also be granted limited privileges to order certain outpatient therapies (e.g., infusion therapy injections), but should these privileges be requested, (i) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies in the discretion of the Credentials Committee, and (ii) they must also establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients, should that be necessary;

(k) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(l) may actively participate in the professional practice evaluation and performance improvement processes;

(m) may refer patients to the Hospital's diagnostic facilities and order such tests;

(n) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(o) must pay application fees, dues, and assessments.

2.C. COVERAGE STAFF

2.C.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy the response time requirements set forth in Section 2.A.1(d) of the Credentials Policy, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.C.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as department chairs or committee chairs; and

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote).

2.D. HONORARY STAFF

2.D.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.D.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, and the Immediate Past President.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the Governing Body. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years at any MSHA Hospital;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, Governing Body members, or department chairs at any other non-MSHA hospital and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CMO and the CEO in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the CEO and the Governing Body;

(c) be accountable to the Governing Body and the CEO, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) appoint all committee chairs and committee members;

(f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio,* without vote;

(g) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(h) recommend Medical Staff representatives to Hospital committees after presentation to the MEC for discussion;

(i) be the spokesperson for the Medical Staff in its external professional and public relations; and

(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice-President:

The Vice-President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the MEC and the Credentials Committee; and

(c) assume all such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the MEC;

(b) cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;

(c) call Medical Staff meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the office of Secretary-Treasurer;

(d) be responsible for the collection of, accounting for, and disbursements of, any funds collected, donated, or otherwise assessed and present in the Medical Staff account and report to the Medical Staff; and

(e) perform such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.4. Immediate Past President:

The Immediate Past President shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.D. NOMINATIONS

(1) The Nominating Committee for all general and special elections shall consist of the President of the Medical Staff and the two most recent Past Presidents, when available and willing to serve.

(2) The Nominating Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve.

(4) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Candidates receiving a majority of the written votes cast at the meeting shall be elected, subject to Governing Body confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, at the discretion of the MEC, the election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Governing Body confirmation.

3.F. TERM OF OFFICE

Officers shall serve for a term of one year or until a successor is elected. Officers may be reelected for one additional term.

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice-President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff shall be organized into departments as listed in the Medical Staff Organization Manual. Subject to the approval of the Governing Body, the MEC may create new departments, eliminate departments, create divisions within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges or a scope of practice in a given department, and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND VICE CHAIRS

Each department chair and vice chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Governing Body after considering the recommendation of the MEC.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Except as otherwise provided by contract, department chairs and vice chairs may be appointed by the Chief of Staff or elected by the voting members of the department, subject to approval by the MEC and the Governing Body.

(2) Department chairs and vice chairs shall serve a term of one year. They may be reelected for one additional term.

(3) Any department chair or vice chair may be removed by a two-thirds vote of the Active Staff members of the department, subject to Governing Body confirmation; or by a two-thirds vote of the MEC, subject to Governing Body confirmation; or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(4) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be considered. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

4.F. DUTIES OF DEPARTMENT CHAIRS AND VICE CHAIRS

Department chairs and vice chairs are responsible for the following, either individually or in collaboration with Hospital personnel:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(7) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating interdepartmental and intradepartmental services;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the department;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the department;

(15) making recommendations for space and other resources needed by the department; and

(16) performing all functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Governing Body.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairs and members shall be appointed for a term of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO. All such representatives shall serve on the committees, without vote.

(4) The President of the Medical Staff, the CMO, and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, the Immediate Past President, and the department chairs.

(b) The President of the Medical Staff shall chair the MEC.

(c) The Chair of the Credentials Committee shall be an *ex officio* member of the MEC, with vote.

(d) The CEO and the CMO shall be *ex officio* members of the MEC, without vote.

(e) Other individuals may be invited to MEC meetings (without vote).

5.D.2. Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to the Governing Body on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(h) providing and promoting effective liaison among the Medical Staff, Administration, and the Governing Body; and

(i) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Governing Body.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may, by resolution and upon approval of the Governing Body and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function

required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least annually, at which meeting the officers are elected.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the CEO, the Governing Body, or by a petition signed by not less than one-fourth of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, each department and committee shall meet as necessary to accomplish their functions, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the MEC, the CEO, or by a petition signed by not less than one-fourth of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC, the Credentials Committee, and the Professional Practice Evaluation Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for any amendments to these Medical Staff Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals that are presented to the voting members of the Medical Staff, at least 10% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals and actions by the MEC, the Credentials Committee, and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the Presiding Officer for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC, the CEO, and the Governing Body.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, the Credentials Committee, and the Professional Practice Evaluation Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in Medical Staff meetings and applicable department and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials and Allied Health Professionals Policies.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Governing Body for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Governing Body for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with educational or training requirements; or

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the CEO and CMO.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, or the chair of a clinical department, in conjunction with either the CMO or the CEO, or the MEC is authorized to suspend or restrict all or any portion of an individual's clinical privileges, as a precaution, pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO and the CMO or the MEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

8.F. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

8.G. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Governing Body.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Governing Body shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 10% of the voting members of the Medical Staff.

(3) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present proposed amendments to the Medical Staff by written ballot or e-mail, to be returned to the Medical Staff Services Department by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Governing Body.

(7) If the Governing Body has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Governing Body and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Governing Body's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These documents include, but are not limited to, the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Medical Staff Credentials Policy or the Policy on Allied Health Professionals may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Proposed amendments to these policies shall be reviewed in advance by the four MSHA Virginia MECs prior to a vote on the amendment(s) by the MEC. If any MSHA Virginia MEC has an objection to such an amendment, it shall be shared with each of the four MECs for discussion. Any disputes over any proposed amendments to these Policies shall be discussed and resolved during a joint meeting of the four MSHA Virginia MECs. Following review by the four MSHA Virginia MECs, notice of all proposed amendments shall then be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting where the amendment will be considered for adoption. Any voting member of the Medical Staff may submit written comments to the MEC prior to the vote.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(4) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(5) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Governing Body for its final action.

(6) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when

approved by the Governing Body. Approval may not be unreasonably withheld by any of these groups. Any disputes over any proposed amendments shall be discussed and resolved during a joint meeting of the four MSHA MECs and the Governing Body.

(7) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the MEC; or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 10% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Governing Body for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Governing Body. Communication from Medical Staff members to the Governing Body will be directed through the CEO, who will forward the request for communication to the Chair of the Governing Body. The CEO will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Governing Body will determine the manner and method of the Governing Body's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Governing Body, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

8/6/14
(Date)

President of the Medical Staff
Johnston Memorial Hospital

Approved by the Governing Body:

July 23 2014
(Date)

Chair
Governing Body

APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record a complete history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

(d) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

(e) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

MOUNTAIN STATES HEALTH ALLIANCE MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

RUSSELL COUNTY MEDICAL CENTER

MEDICAL STAFF BYLAWS

Adopted by the Medical Staff: March 21, 2013

Approved by the Board: May 20, 2013

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APPENDIX A

APPENDIX B

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.

(2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff and the Secretary-Treasurer.

(4) The dues collected shall be used for Medical Staff education and leadership responsibilities.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix B to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least 24 patient contacts per two-year appointment term; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Community Affiliate, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Governing Body;

(b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;

(c) hold office, serve as department chairs, serve on Medical Staff committees, and serve as chairs of committees;

(d) exercise such clinical privileges as are granted to them; and

(e) attend meetings of the MEC (without vote) so long as notice is given to the President of the Medical Staff. Attendance and participation at such meetings shall be at the discretion of the President of the Medical Staff. The Active Staff members shall leave for any discussion of confidential peer review issues.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) accepting inpatient consultations, when requested;

(g) paying application fees, dues, and assessments; and

(h) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in more than six, but fewer than 24, patient contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than six patient contacts during his/her two-year appointment term must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting or Community Affiliate).

** Any member who has more than 24 patient contacts during his/her two-year appointment term must request Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff and department meetings (without vote);

(b) may not hold office or serve as department chairs or committee chairs, unless waived by the Governing Body;

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician, and

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes;

(f) shall exercise such clinical privileges as are granted to them; and

(g) shall pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments);

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as department chairs or committee chairs, unless waived by the MEC and the Governing Body;

(c) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);

(d) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients, unless the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes; and

(f) shall pay application fees, dues, and assessments.

2.D. COMMUNITY AFFILIATE STAFF

2.D.1. Qualifications:

The Community Affiliate Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital. Except as noted in (b), it is a membership-only category, with no clinical privileges being granted. The primary purpose of the Community Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care;

(b) may wish to request only limited outpatient-related therapies for the care and treatment of their patients at the Hospital; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Affiliate Staff as outlined in Section 2.D.2.

2.D.2. Prerogatives and Responsibilities:

Community Affiliate Staff members:

(a) may attend meetings of the Medical Staff and applicable departments but cannot vote at these meetings unless the individual was previously a member of the Active Staff for a period of at least four years and transitioned to the Community Affiliate Staff in response to changes in the individual's clinical practice patterns (in order to maintain voting rights, such individuals must attend at least 50% of applicable Medical Staff, department and committee meetings each year);

(b) may not hold office or serve as department chairs or committee chairs unless waived by the MEC and Governing Body (the MEC may only consider waivers of this provision for members of the Community Affiliate Staff who had previously been appointed to the Active Staff for a period of at least four years, and who only transitioned to the Community Affiliate Staff in response to changes in that individual's clinical practice patterns);

(c) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may also be granted limited privileges to order certain outpatient therapies (e.g., infusion therapy injections), but should these privileges be requested, (i) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies in the discretion of the MEC, and (ii) they must also establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients, should that be necessary;

(k) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, write progress notes, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(l) may actively participate in the professional practice evaluation and performance improvement processes;

(m) may refer patients to the Hospital's diagnostic facilities and order such tests;

(n) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(o) must pay application fees, dues, and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy the response time requirements set forth in Section 2.A.1(d) of the Credentials Policy, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as department chairs or committee chairs; and

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote).

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, and the Immediate Past President.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the Governing Body. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years at any MSHA Hospital;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, Governing Body members, or department chairs at any other non-MSHA hospital and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CMO and the CEO in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the CEO and the Governing Body;

(c) be accountable to the Governing Body and the CEO, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) appoint all committee chairs and committee members;

(f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio,* without vote;

(g) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(h) recommend Medical Staff representatives to Hospital committees after presentation to the MEC for discussion;

(i) be the spokesperson for the Medical Staff in its external professional and public relations; and

(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice-President:

The Vice-President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the MEC; and

(c) assume all such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the MEC;

(b) cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;

(c) call Medical Staff meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the office of Secretary-Treasurer;

(d) be responsible for the collection of, accounting for, and disbursements of, any funds collected, donated, or otherwise assessed and present in the Medical Staff account and report to the Medical Staff; and

(e) perform such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.4. Immediate Past President:

The Immediate Past President shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.D. NOMINATIONS

(1) The Nominating Committee for all general and special elections shall consist of the President of the Medical Staff and the two most recent Past Presidents, when available and willing to serve.

(2) The Nominating Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve.

(4) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Candidates receiving a majority of the written votes cast at the meeting shall be elected, subject to Governing Body confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, at the discretion of the MEC, the election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Governing Body confirmation.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected. Officers may be reelected for one additional term.

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice-President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff shall be organized into departments as listed in the Medical Staff Organization Manual. Subject to the approval of the Governing Body, the MEC may create new departments, eliminate departments, create divisions within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges or a scope of practice in a given department, and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND VICE CHAIRS

Each department chair and vice chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Governing Body after considering the recommendation of the MEC.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Except as otherwise provided by contract, department chairs and vice chairs shall be elected by the voting members of the department, subject to approval by the MEC and the Governing Body.

(2) Department chairs and vice chairs shall serve a term of two years. They may be reelected for one additional term.

(3) Any department chair or vice chair may be removed by a two-thirds vote of the Active Staff members of the department, subject to Governing Body confirmation; or by a two-thirds vote of the MEC, subject to Governing Body confirmation; or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(4) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be considered. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

4.F. DUTIES OF DEPARTMENT CHAIRS AND VICE CHAIRS

Department chairs and vice chairs are responsible for the following, either individually or in collaboration with Hospital personnel:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(7) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating interdepartmental and intradepartmental services;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the department;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the department;

(15) making recommendations for space and other resources needed by the department; and

(16) performing all functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Governing Body.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairs and members shall be appointed for a term of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO. All such representatives shall serve on the committees, without vote.

(4) The President of the Medical Staff, the CMO, and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, the Immediate Past President, and the department chairs.

(b) The President of the Medical Staff shall chair the MEC.

(c) The CEO and the CMO shall be *ex officio* members of the MEC, without vote.

(d) Other individuals may be invited to MEC meetings (without vote).

5.D.2. Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to the Governing Body on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(1) If delegated to do so by the voting members of the organized medical staff, the MEC may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(h) providing and promoting effective liaison among the Medical Staff, Administration, and the Governing Body; and

(i) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Governing Body.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may, by resolution and upon approval of the Governing Body and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least annually, at which meeting the officers are elected.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the CEO, the Governing Body, or by a petition signed by not less than one-fourth of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, each department and committee shall meet as necessary to accomplish their functions, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the MEC, the CEO, or by a petition signed by not less than one-fourth of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC and the Professional Practice Evaluation Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for any amendments to these Medical Staff Bylaws that are presented to the voting members of the Medical Staff, at least 10% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the Presiding Officer for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC, the CEO, and the Governing Body.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC and the Professional Practice Evaluation Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in Medical Staff meetings and applicable department and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials and Allied Health Professionals Policies.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The MEC then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the Governing Body. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Governing Body for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The MEC then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the Governing Body. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Governing Body for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with educational or training requirements; or

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the CEO and CMO.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, or the chair of a clinical department, in conjunction with either the CMO or the CEO, or the MEC is authorized to suspend or restrict all or any portion of an individual's clinical privileges, as a precaution, pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO and the CMO or the MEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

8.F. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

8.G. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Governing Body.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Governing Body shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 10% of the voting members of the Medical Staff.

(3) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present proposed amendments to the Medical Staff by written ballot or e-mail, to be returned to the Medical Staff Services Department by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Governing Body.

(7) If the Governing Body has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Governing Body and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Governing Body's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These documents include, but are not limited to, the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Medical Staff Credentials Policy or the Policy on Allied Health Professionals may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Proposed amendments to these policies shall be reviewed in advance by the four MSHA Virginia MECs prior to a vote on the amendment(s) by the MEC. If any MSHA Virginia MEC has an objection to such an amendment, it shall be shared with each of the four MECs for discussion. Any disputes over any proposed amendments to these Policies shall be discussed and resolved during a joint meeting of the four MSHA Virginia MECs. Following review by the four MSHA Virginia MECs, notice of all proposed amendments shall then be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting where the amendment will be considered for adoption. Any voting member of the Medical Staff may submit written comments to the MEC prior to the vote.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(4) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(5) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Governing Body for its final action.

(6) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when

approved by the Governing Body. Approval may not be unreasonably withheld by any of these groups. Any disputes over any proposed amendments shall be discussed and resolved during a joint meeting of the four MSHA MECs and the Governing Body.

(7) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the MEC; or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 10% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Governing Body for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Governing Body. Communication from Medical Staff members to the Governing Body will be directed through the CEO, who will forward the request for communication to the Chair of the Governing Body. The CEO will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Governing Body will determine the manner and method of the Governing Body's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Governing Body, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

March 21, 2013 _____
(Date)

_____
President of the Medical Staff
Russell County Medical Center

Approved by the Governing Body:

May 20, 2013 _____
(Date)

_____
Chair
Governing Body

APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record a complete history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

(d) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

(e) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

APPENDIX B

[To be added – chart summarizing rights and obligations of each staff category]

MOUNTAIN STATES HEALTH ALLIANCE MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

SMYTH COUNTY COMMUNITY HOSPITAL

MEDICAL STAFF BYLAWS

Adopted by the Medical Staff: February 26, 2013

Approved by the Board: March 25, 2013

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.

(2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff and the Secretary-Treasurer.

(4) The dues collected shall be used for Medical Staff education and leadership responsibilities.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix B to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least 24 patient contacts per two-year appointment term; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Community Affiliate, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Governing Body;

(b) vote in all general and special meetings of the Medical Staff and applicable service and committee meetings;

(c) hold office, serve as service chiefs, serve on Medical Staff committees, and serve as chairs of committees;

(d) exercise such clinical privileges as are granted to them; and

(e) attend meetings of the MEC (without vote) so long as notice is given to the President of the Medical Staff. Attendance and participation at such meetings shall be at the discretion of the President of the Medical Staff. The Active Staff members shall leave for any discussion of confidential peer review issues.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) accepting inpatient consultations, when requested;

(g) paying application fees, dues, and assessments; and

(h) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in more than six, but fewer than 24, patient contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than six patient contacts during his/her two-year appointment term must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting or Community Affiliate).

** Any member who has more than 24 patient contacts during his/her two-year appointment term must request Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff and service meetings (without vote);

(b) may not hold office or serve as service chiefs or committee chairs, unless waived by the Governing Body;

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician, and

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes;

(f) shall exercise such clinical privileges as are granted to them; and

(g) shall pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments);

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as service chiefs or committee chairs, unless waived by the MEC and the Governing Body;

(c) may attend meetings of the Medical Staff and applicable service meetings (without vote) and applicable committee meetings (with vote);

(d) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients, unless the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes; and

(f) shall pay application fees, dues, and assessments.

2.D. COMMUNITY AFFILIATE STAFF

2.D.1. Qualifications:

The Community Affiliate Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital. Except as noted in (b), it is a membership-only category, with no clinical privileges being granted. The primary purpose of the Community Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care;

(b) may wish to request only limited outpatient-related therapies for the care and treatment of their patients at the Hospital; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Affiliate Staff as outlined in Section 2.D.2.

2.D.2. Prerogatives and Responsibilities:

Community Affiliate Staff members:

(a) may attend meetings of the Medical Staff and applicable services but cannot vote at these meetings unless the individual was previously a member of the Active Staff for a period of at least four years and transitioned to the Community Affiliate Staff in response to changes in the individual's clinical practice patterns

(in order to maintain voting rights, such individuals must attend at least 50% of applicable Medical Staff, service and committee meetings each year);

(b) may not hold office or serve as service chiefs or committee chairs unless waived by the MEC and Governing Body (the MEC may only consider waivers of this provision for members of the Community Affiliate Staff who had previously been appointed to the Active Staff for a period of at least four years, and who only transitioned to the Community Affiliate Staff in response to changes in that individual's clinical practice patterns);

(c) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may also be granted limited privileges to order certain outpatient therapies (e.g., infusion therapy injections), but should these privileges be requested, (i) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies in the discretion of the MEC, and (ii) they must also establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients, should that be necessary;

(k) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, write progress notes, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(l) may actively participate in the professional practice evaluation and performance improvement processes;

(m) may refer patients to the Hospital's diagnostic facilities and order such tests;

(n) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(o) must pay application fees, dues, and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy the response time requirements set forth in Section 2.A.1(d) of the Credentials Policy, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service

care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and service meetings (without vote);

(d) may not hold office or serve as service chiefs or committee chairs; and

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote).

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and service meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as service chiefs or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, and the Immediate Past President.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the Governing Body. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years at any MSHA Hospital;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, Governing Body members, or department chairs at any other non-MSHA hospital and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CMO and the CEO in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the CEO and the Governing Body;

(c) be accountable to the Governing Body and the CEO, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) appoint all committee chairs and committee members;

(f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio,* without vote;

(g) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(h) recommend Medical Staff representatives to Hospital committees after presentation to the MEC for discussion;

(i) be the spokesperson for the Medical Staff in its external professional and public relations; and

(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice-President:

The Vice-President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the MEC; and

(c) assume all such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the MEC;

(b) cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;

(c) call Medical Staff meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the office of Secretary-Treasurer;

(d) be responsible for the collection of, accounting for, and disbursements of, any funds collected, donated, or otherwise assessed and present in the Medical Staff account and report to the Medical Staff; and

(e) perform such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.C.4. Immediate Past President:

The Immediate Past President shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.D. NOMINATIONS

(1) The Nominating Committee for all general and special elections shall consist of the President of the Medical Staff and the two most recent Past Presidents, when available and willing to serve.

(2) The Nominating Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve.

(4) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Candidates receiving a majority of the written votes cast at the meeting shall be elected, subject to Governing Body confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, at the discretion of the MEC, the election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Governing Body confirmation.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected. Officers may be reelected for one additional term.

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice-President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL SERVICES

4.A. ORGANIZATION

Due to the small size of the Medical Staff, the organizational structure of the Medical Staff is non-departmentalized. However, the Medical Staff is divided into less formal sections that reflect those specialty areas as deemed appropriate by the MEC. Current sections shall include, at a minimum, Medicine and Surgery.

4.B. ASSIGNMENT TO SERVICES

Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical service. Assignment to a particular service does not preclude an individual from seeking and being granted clinical privileges typically associated with another service area.

4.C. QUALIFICATIONS OF SERVICE CHIEFS

Each service chief shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Governing Body after considering the recommendation of the MEC.

4.D. APPOINTMENT AND REMOVAL OF SERVICE CHIEFS

(1) Except as otherwise provided by contract, service chiefs shall be elected by the voting members of the service, subject to approval by the MEC and the Governing Body.

(2) Service chiefs shall serve a term of three years. They may be reelected for one additional term.

(3) Any service chief may be removed by a two-thirds vote of the Active Staff members of the service, subject to Governing Body confirmation; or by a two-thirds vote of the MEC, subject to Governing Body confirmation; or by the Governing Body. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(4) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be considered. The individual shall be afforded an opportunity to speak to the service, the MEC, or the Governing Body, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Governing Body.

4.E. DUTIES OF SERVICE CHIEFS

Service chiefs are responsible for the following, either individually or in collaboration with Hospital personnel:

(1) coordinating all clinically-related activities of the service;

(2) coordinating all administratively-related activities of the service, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the service who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the service;

(5) evaluating requests for clinical privileges for each member of the service;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the service or the Hospital;

(7) integrating the service into the primary functions of the Hospital;

(8) coordinating and integrating interdepartmental and intradepartmental services;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the service;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the service;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the service;

(15) making recommendations for space and other resources needed by the service; and

(16) performing all functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Governing Body.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairs and members shall be appointed for a term of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO. All such representatives shall serve on the committees, without vote.

(4) The President of the Medical Staff, the CMO, and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary-Treasurer, the Immediate Past President, and the service chiefs.

(b) The President of the Medical Staff shall chair the MEC.

(c) The CEO, CNO, and the CMO shall be *ex officio* members of the MEC, without vote.

(d) Other individuals may be invited to MEC meetings (without vote).

5.D.2. Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to the Governing Body on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, services, and other groups, as appropriate;

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(h) providing and promoting effective liaison among the Medical Staff, Administration, and the Governing Body; and

(i) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Governing Body.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may, by resolution and upon approval of the Governing Body and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least annually, at which meeting the officers are elected.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the CEO, the Governing Body, or by a petition signed by not less than one-fourth of the Active Staff.

6.C. SERVICE AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, each service and committee shall meet as necessary to accomplish their functions, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any service or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the MEC, the CEO, or by a petition signed by not less than one-fourth of the Active Staff members of the service or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of services and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a service, and/or a committee is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, service, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC and the Professional Practice Evaluation Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for any amendments to these Medical Staff Bylaws that are presented to the voting members of the Medical Staff, at least 10% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, services, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a service, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, service, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the Presiding Officer for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, service, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, services, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, services, and committees shall be transmitted to the MEC, the CEO, and the Governing Body.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC and the Professional Practice Evaluation Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in Medical Staff meetings and applicable service and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, service chiefs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials and Allied Health Professionals Policies.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable service chief, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The MEC then reviews the chief's assessment, the application, and all supporting materials and makes a recommendation to the Governing Body. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Governing Body for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable service chief, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The MEC then reviews the chief's assessment, the application, and all supporting materials and makes a recommendation to the Governing Body. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Governing Body for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with educational or training requirements; or

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the CEO and CMO.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, or the chief of a clinical service, in conjunction with either the CMO or the CEO, or the MEC is authorized to suspend or restrict all or any portion of an individual's clinical privileges, as a precaution, pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO and the CMO or the MEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

8.F. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

8.G. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Governing Body.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Governing Body shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 10% of the voting members of the Medical Staff.

(3) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present proposed amendments to the Medical Staff by written ballot or e-mail, to be returned to the Medical Staff Services Department by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Governing Body.

(7) If the Governing Body has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Governing Body and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Governing Body's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These documents include, but are not limited to, the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Medical Staff Credentials Policy or the Policy on Allied Health Professionals may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Proposed amendments to these policies shall be reviewed in advance by the four MSHA Virginia MECs prior to a vote on the amendment(s) by the MEC. If any MSHA Virginia MEC has an objection to such an amendment, it shall be shared with each of the four MECs for discussion. Any disputes over any proposed amendments to these Policies shall be discussed and resolved during a joint meeting of the four MSHA Virginia MECs. Following review by the four MSHA Virginia MECs, notice of all proposed amendments shall then be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting where the amendment will be considered for adoption. Any voting member of the Medical Staff may submit written comments to the MEC prior to the vote.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(4) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(5) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Governing Body for its final action.

(6) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when

approved by the Governing Body. Approval may not be unreasonably withheld by any of these groups. Any disputes over any proposed amendments shall be discussed and resolved during a joint meeting of the four MSHA MECs and the Governing Body.

(7) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the MEC; or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 10% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Governing Body for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Governing Body. Communication from Medical Staff members to the Governing Body will be directed through the CEO, who will forward the request for communication to the Chair of the Governing Body. The CEO will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Governing Body will determine the manner and method of the Governing Body's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Governing Body, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

2/26/13
(Date)

President of the Medical Staff
Smyth County Community Hospital

Approved by the Governing Body:

3/25/2013
(Date)

Chair
Governing Body

APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record a complete history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

(d) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

(e) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

APPENDIX B

[To be added – chart summarizing rights and obligations of each staff category]

Exhibit E-1E

Lonesome Pine Credentialing Policies

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF WELLMONT HEALTH SYSTEM LONESOME PINE HOSPITAL

CREDENTIALS POLICY

December 17, 2012

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GLOSSARY

ARTICLE 1

GENERAL

1.A. PREAMBLE

All Medical Staff and Allied Health Staff members commit to working cooperatively and professionally with each other and Hospital employees and management to promote safe, appropriate patient care. Medical Staff and Hospital leaders will strive to address professional practice issues fairly, reasonably, and collegially in a manner that is consistent with quality care and patient safety.

1.B. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff and Hospital leaders will strive to be fair under the circumstances.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the peer review committees, except:

(a) to another authorized individual for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality will result in appropriate sanctions.

1.D.2. Peer Review Protection:

(a) All professional review activity will be performed by peer review committees. Peer review committees include, but are not limited to:

(1) all standing and ad hoc committees;

(2) all departments;

(3) hearing and appellate review panels;

(4) the Board and its committees; and

(5) any individual acting for or on behalf of any such entity, including, but not limited to, Medical Staff leaders, and experts or consultants retained to assist in professional review activities.

(b) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law.

1.E. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, Medical Staff leaders, peer review committees, members, and authorized representatives when engaged in professional review activity, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff or the Allied Health Staff, and for clinical privileges, an individual must, as applicable:

(a) have a current, unrestricted license and registration, which is not subject to any probationary terms or conditions not generally applicable;

(b) have a current, unrestricted DEA registration;

(c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their responsibilities and to provide timely and continuous care for their patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form satisfactory to the Hospital and as required by state law;

(e) have not been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse;

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

(g) have not had medical staff or allied health staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have not resigned medical staff or allied health staff appointment or relinquished privileges during an investigation or in exchange for not conducting an investigation;

(i) have not been convicted of, or entered a plea of guilty or no contest, to any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(j) agree to fulfill all responsibilities regarding emergency call for their specialty;

(k) have or agree to make coverage arrangements with other members of the Medical Staff;

(l) demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;

(m) for members appointed after February 18, 2013, have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(n) for members appointed after February 18, 2013, have obtained or obtain board certification in their primary or related area of practice at the Hospital within five years from the date of completion of their residency or fellowship training;

(o) if seeking to practice as an allied health professional, have a written agreement with a member of the Medical Staff to provide the requisite supervision or collaboration.

2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Waivers of threshold eligibility criteria will not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment or clinical privileges will not be processed unless the Board has granted the requested waiver.

(b) A request for a waiver will only be considered if the applicant provides information sufficient to demonstrate that his or her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.

(c) The Medical Executive Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant department chairperson, and the best interests of the Hospital and the communities it serves. The Medical Executive Committee will forward its recommendation, including the basis for such, to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation

(d) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted only that processing of the application can begin.

2.A.3. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, a commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No one is entitled to receive an application for appointment or reappointment to the Medical Staff or Allied Health Staff, or be granted particular clinical privileges merely because he or she:

(a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, medical staff or allied health staff appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, health maintenance organization, preferred provider organization, or other entity.

2.A.5. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

2.B.1. Basic Responsibilities and Requirements:

(a) As a condition of appointment, reappointment, and the grant of privileges, every applicant and member of the Medical Staff and Allied Health Staff specifically agree to the following, as applicable:

(1) to provide continuous and timely care;

(2) to abide by the bylaws, policies, and rules and regulations of the Medical Staff and the Hospital and any revisions or amendments thereto;

(3) to participate in medical staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(4) to provide emergency call coverage, consultations, and care for unassigned patients;

(5) to comply with applicable clinical practice protocols and guidelines or document the clinical reasons for variance;

(6) to participate, as requested, in risk management and quality assurance activities designed to increase patient safety and prevent medical malpractice claims;

(7) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and the Chief Executive Officer) are concerned about the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing or evaluations will be determined by the Medical Staff leaders;

(8) to participate in interviews in regard to an application for initial appointment, reappointment, or clinical privileges, if requested;

(9) to use the Hospital sufficiently to allow continuing assessment of current competence;

(10) to seek consultation whenever necessary;

(11) to complete in a timely manner all medical and other required records;

(12) to perform all services and to act in a cooperative and professional manner;

(13) to promptly pay any applicable dues, assessments, or fines;

(14) to satisfy continuing medical education requirements as established by the Hospital and consistent with state law; and

(15) to maintain a current e-mail address with the Centralized Verification Office, which will be the official mechanism used to communicate information to the member other than peer review information pertaining to the member and/or protected health information of patients.

(b) The Board may, in its discretion, upon review by the Medical Executive Committee, waive any of the conditions, responsibilities and requirements set forth above.

(c) In addition to the above, as a condition of appointment and privileges, every individual seeking appointment to the Allied Health Staff will specifically agree, as applicable, to the following:

(1) any privileges granted by the Board will be performed in the Hospital under the supervision of, or in collaboration with, a Supervising/Collaborating Physician;

(2) the number of allied health professionals employed by or under the supervision of, or working in collaboration with, a member of the Medical Staff will be consistent with state law and the rules and regulations of the Medical Staff; and

(3) to give notice, within three days, to the Chief Executive Officer of any revisions or modifications that are made to the supervision/collaboration agreement.

(d) Additional collaboration and supervision requirements for members of the Allied Health Staff are included in Appendix B.

2.B.2. Burden of Providing Information:

(a) Applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Applicants must acknowledge that all the statements made and information given on the application are accurate, complete, and true.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been received, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Notification of any change in status or any change in the information provided on the application form will be given to the President of the Medical Staff or the Chief Executive Officer. This information must be provided, with or without request, at the time the change occurs.

(f) Failure to provide this information will render the individual ineligible for staff membership or clinical privileges and may result in automatic relinquishment of appointment and privileges.

2.C. APPLICATION

2.C.1. Information:

Applications for appointment and reappointment will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy. The applicant will sign the application and certify that he or she is able to perform the privileges requested and to fulfill the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff and Chief Executive Officer will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished.

(c) No action taken pursuant to this Section will entitle the applicant or member to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant:

(a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff, Allied Health Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, any member of the Medical Staff, Allied Health Staff or the Board, their representatives, or third parties in the course of credentialing and

peer review activities. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The applicant authorizes the Hospital, Medical Staff, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

The applicant agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If an applicant institutes legal action challenging any professional review action and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff, Allied Health Staff, or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information within the System:

The applicant specifically authorizes the Hospital and its affiliates to share information pertaining to the applicant's clinical competence and professional conduct within the System.

(g) Scope of Section:

All of the provisions in this Section are applicable in the following situations:

(1) whether appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or the Allied Health Staff about his/her tenure at the Hospital.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

(a) Applications for appointment and clinical privileges will be in writing and will be on forms approved by the Board, upon recommendation by the Medical Executive Committee.

(b) Prospective applicants will be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents should be returned to the Centralized Verification Office within 30 days after receipt. The application must be accompanied by the application fee, if applicable.

(b) As a preliminary step, the application will be reviewed by the Centralized Verification Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(c) The Centralized Verification Office will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.

(d) Before an application is considered complete, the Centralized Verification Office will request from every hospital where the applicant has had privileges, been associated with, and/or been employed by, information concerning: (i) any pending professional medical conduct proceedings or any pending medical malpractice actions, in this state or another state; (ii) any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this state or another state; and (iii) any information required to be reported by hospitals.

(e) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chairperson at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(f) Prior to action on an application, at least one interview with the applicant will be conducted by one or a combination of any of the following: the department chairperson, members of the Medical Executive Committee, the President of the Medical Staff, Chief Nursing Officer, or the Chief Executive Officer.

(g) Members of the Medical Staff and Allied Health Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

(h) The Chief Nursing Officer will review and report on the application for appointment to the Allied Health Staff submitted by applicants with nursing degrees.

3.A.3. Department Chairperson Procedure:

The chairperson in each department in which the applicant has requested clinical privileges will review the application and all supporting materials and prepare a report.

3.A.4. Medical Executive Committee Procedure:

(a) The Medical Executive Committee will consider any report from the Chief Nursing Officer and the report prepared by the department chairperson(s) and will make a recommendation.

(b) The Medical Executive Committee may use the expertise of the department chairperson(s), or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) The Medical Executive Committee may require a physical or mental examination by a physician(s) satisfactory to the Medical Executive Committee. The results of this examination will be made available to the committee. Failure to undergo an examination within a reasonable time after a written request from the Medical Executive Committee will be considered a voluntary withdrawal of the application.

(d) The Medical Executive Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Medical Executive Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.

(e) If the recommendation of the Medical Executive Committee is delayed longer than 60 days, the President of the Medical Staff will send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

(f) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board.

(g) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send special notice to the applicant. The Chief Executive Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.5. Board Action:

(a) Upon receipt of a recommendation of the Medical Executive Committee for appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended by the Medical Executive Committee; or

(2) refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

(3) disagree with or modify the recommendation.

(b) If the Board disagrees with a favorable recommendation of the Medical Executive Committee, it should first discuss the matter with the President of the Medical Staff. If the Board's determination remains unfavorable, the Chief Executive Officer will promptly send special notice that the applicant is entitled to request a hearing.

(c) Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

3.B. PROVISIONAL PERIOD

(1) Initial appointment (regardless of the staff category) and initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of appointment, will be provisional.

(2) During the provisional period, the exercise of clinical privileges will be evaluated by the department chairperson or by a practitioner designated by the Medical Executive Committee. This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The numbers and types of cases to be reviewed will be determined by the Medical Executive Committee.

(3) The duration of the provisional period for initial appointment and privileges will be from 12 to 24 months, as recommended by the Medical Executive Committee. The duration of the provisional period for other initial grants of privileges will be as recommended by the Medical Executive Committee.

(4) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed.

(5) A newly appointed member will automatically relinquish his or her appointment and privileges at the end of the provisional period if he or she fails, during the provisional period, to:

(a) participate in the required number of cases;

(b) cooperate with the monitoring and review conditions; or

(c) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two years.

(6) If a member who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges will be automatically relinquished at the end of the provisional period. The member may not reapply for the privileges in question for two years.

(7) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria.

(c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the applicable contract.

(d) Recommendations for clinical privileges will be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical and clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team, and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

(e) Requests for increased privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2. Privilege Waivers:

(a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)

(b) In limited circumstances, the Hospital may consider a waiver of the requirement that privileges are granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Centralized Verification Office. The request must indicate the specific privileges that the individual does not want to be granted, good cause for the waiver request, and evidence that he or she does not provide the relevant patient care services in any health care facility.

(c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.

(d) The following factors, among others, may be considered in deciding whether to grant a waiver:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(3) the expectations of members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

(5) an undue burden on other members who serve on the call roster in the relevant specialty; and

(6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(e) If the Board grants a waiver related to privileges, it will specify the effective date.

(f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

4.A.3. Resignation of Privileges:

A request to resign all clinical privileges must specify the desired date of resignation and provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President of the Medical Staff, the Chief Executive Officer will act on the request.

4.A.4. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the privilege have been adopted.

(b) The relevant department chairperson(s) will recommend whether a procedure or technique is new or an extension of a procedure or technique already being offered. The following factors will be considered in making this recommendation:

(1) whether there are greater risks to the patient in performing the procedure;

(2) whether different equipment is required and whether different skills are required;

(3) whether the procedure requires additional training for the staff;

(4) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(5) clinical indications for when the new procedure is appropriate;

(6) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(7) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(8) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(9) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

(c) The department chairperson(s) will prepare a report based on the above factors and make a recommendation regarding the new procedure and revise the appropriate clinical privilege form to present to the Medical Executive Committee that addresses the new procedure and its criteria. The Medical Executive Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

(d) If the preliminary recommendation is favorable, the Medical Executive Committee will review the threshold credentialing criteria as proposed by the department chairperson(s) to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Medical Executive Committee may conduct additional research and consult with experts, as necessary, and develop recommendations.

(e) The Medical Executive Committee will forward its recommendations to the Board for final action.

4.A.5. Clinical Privileges that Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) The individual seeking the privilege will submit a report to the Medical Executive Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those

other hospitals. The Medical Executive Committee will then conduct additional research and consult with experts, as necessary.

(c) The Medical Executive Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations.

(d) The Medical Executive Committee will forward its recommendations to the Board for final action.

4.A.6. Telemedicine Privileges:

(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.

(b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff.

(c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Chief Executive Officer in consultation with the President of the Medical Staff:

(1) A request for telemedicine privileges may be processed through the same process for medical staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in the state where the Hospital is located;

(ii) a current list of privileges granted to the practitioner;

(iii) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(iv) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(v) any other attestations or information required by the agreement or requested by the Hospital.

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(d) Telemedicine privileges, if granted, will be for a period of not more than two years.

(e) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the distant hospital or telemedicine entity.

(f) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.A.7. Training:

(a) Physicians, podiatrists, and allied health professionals in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of individuals in training, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Executive Committee and the Graduate Medical Education Committee of the Hospital. The applicable program director will be responsible for verifying and evaluating the qualifications of each individual who is in training.

(b) Individuals who are in training who wish to moonlight (outside of the training program) may be granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the Guidelines of the Graduate Medical Education Committee Moonlighting Policy. Loss of employment in the training program will result in the automatic relinquishment of clinical privileges without a right to the hearing and appeal procedures.

4.B. TEMPORARY CLINICAL PRIVILEGES

(1) Temporary privileges may be granted by the Chief Executive Officer, upon recommendation of the President of the Medical Staff, to:

(a) applicants for initial appointment whose complete application is pending review by the Medical Executive Committee and Board. In order to be eligible for temporary privileges, an applicant must have demonstrated ability to perform the privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of staff membership or clinical privileges at another health care facility.

(b) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

(ii) when necessary to prevent a lack of services in a needed specialty area;

(iii) proctoring; or

(iv) locum tenens for a member of the Medical Staff or Allied Health Staff.

(2) The following verified information will be considered prior to the granting of any temporary privileges: current licensure, relevant training, experience, current competence, professional liability coverage acceptable to the Hospital and results of a query to the National Practitioner Data Bank.

(3) The grant of temporary clinical privileges will not exceed 120 days. For non-applicants the days need not be consecutive and may be renewed.

(4) Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols adopted by the Hospital.

(5) The granting of temporary privileges is a courtesy. Temporary privileges may be withdrawn for any reason by the Chief Executive Officer, after consulting with the President of the Medical Staff, the department chairperson, or the Chief Nursing Officer. The individual may be afforded an opportunity to refrain from exercising privileges.

(6) The department chairperson or the President of the Medical Staff will assign to another member responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

(7) The denial of a request for temporary privileges will not entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the department chairperson or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteers who are licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts for the performance of clinical and administrative services. All individuals functioning pursuant to such contracts will obtain and maintain clinical privileges, as needed, in accordance with the terms of this Policy.

(2) To the extent that a contract confers the exclusive right to perform specified services to one or more practitioners, or the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates, no other practitioner, except those authorized by the exclusive contract or Board resolution, may exercise clinical privileges to perform the specified services while the contract or resolution is in effect.

(3) Only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications will be processed.

(4) If any such exclusive contract or Board resolution would have the effect of preventing an existing member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

(a) The affected member will be given at least 30 days advance notice of the exclusive contract or Board resolution, and have the right to meet with a committee designated by the Board prior to the contract being signed or the resolution becoming effective.

(b) At the meeting, the affected member will be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract, or enact the resolution, the affected member will be ineligible to continue to exercise the clinical privileges covered by the contract or resolution, unless a waiver is granted.

(c) The ineligibility begins to run as of the effective date of the exclusive contract or Board resolution, and continues for as long as the contract or resolution is in effect.

(d) The affected member will not be entitled to any other procedural rights beyond those outlined above.

(e) The inability of a physician to exercise clinical privileges because of an exclusive contract, or Board resolution, is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) In the event of any conflict between this Policy or the medical staff bylaws and the terms of any contract, the terms of the contract will control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT AND RENEWAL

5.A. ELIGIBILITY FOR REAPPOINTMENT AND RENEWAL

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have:

(1) completed all medical records;

(2) completed all continuing medical education requirements;

(3) satisfied all Staff responsibilities, including payment of any dues, fines, and assessments;

(4) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(5) paid reappointment processing fee, if applicable*;* and

(6) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further.

5.B. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered, as will the following additional factors relevant to the member's previous term:

(1) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

(2) participation in medical staff duties, including committee assignments and emergency call;

(3) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(4) any focused professional practice evaluations;

(5) verified complaints received from patients or staff; and

(6) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT APPLICATION

(1) Reappointment will be for a period of not more than two years.

(2) An application for reappointment will be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Centralized Verification Office within 30 days.

(3) Failure to return a completed application within 30 days may result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at least 60 days prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(4) The application will be reviewed by the Centralized Verification Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(5) The Centralized Verification Office will oversee the process of gathering and verifying relevant information. The Centralized Verification Office will also be responsible for confirming that all relevant information has been received.

5.D. POTENTIAL ADVERSE RECOMMENDATION AND

CONDITIONAL REAPPOINTMENTS

(1) If the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the general tenor of the possible recommendation and will invite the member to meet prior to any final recommendation being made.

(2) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

(3) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

(4) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.

(5) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(6) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of Medical Staff leaders and Hospital management, but is not mandatory.

(2) Collegial intervention is a part of the Hospital's professional review activities and may include counseling, education, and related steps, such as the following:

(a) advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(3) The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Executive Committee for further action.

(4) The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

(5) All ongoing and focused professional practice evaluations will be conducted in accordance with the peer review policy. Matters that cannot be appropriately resolved through collegial intervention or through the peer review policy will be referred to the Medical Executive Committee.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the President of the Medical Staff, the department chairperson, the chairperson of a standing committee, the Chief Executive Officer, or the chairperson of the Board:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Medical Staff or the Hospital; or

(3) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, the Medical Staff, or the Allied Health Staff, including the inability of the member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member, the matter will be referred to the President of the Medical Staff or the Chief Executive Officer.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Executive Committee.

(d) No action taken pursuant to this Section will constitute an investigation.

6.B.2. Initiation of Investigation:

(a) The Medical Executive Committee will review the question, may discuss the matter with the individual, and determine whether to conduct an investigation or direct that the question be handled pursuant to another policy. An investigation will commence only after a determination by the Medical Executive Committee.

(b) The Medical Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee will not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff or the Allied Health Staff.

(b) The Investigating Committee may:

(1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(c) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(d) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a

hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(e) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations.

6.B.4. Recommendation:

(a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the President of the Medical Staff, the chairperson of the relevant clinical department, the Medical Executive Committee, or the Board Chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(b) A precautionary suspension can be imposed at any time including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer and the President of the Medical Staff. A precautionary suspension will remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

(e) Within three days of the imposition of a suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), will be provided to the individual.

6.C.2. Medical Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 30 days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension.

(b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.

(c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while an investigation is conducted.

(d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Medical Executive Committee will also determine whether to begin an investigation.

(e) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

(g) Upon the imposition of a precautionary suspension, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Failure to Complete Medical Records:

(a) Each medical record will be completed within 30 days following the patient's discharge or they will be considered delinquent. If a medical record is incomplete 15 days after discharge, the medical records department will notify the member, in writing, of the delinquency and inform the member that the record must be completed within 15 days from the date on the notification. If the record remains incomplete 30 days following discharge, the physician will be notified in writing that his or her clinical privileges have been automatically relinquished. The relinquishment will remain in effect until all of the physician's records are no longer delinquent and a $250 reinstatement fee has been paid.

(b) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges and pay the reinstatement fee within 60 days from the relinquishment of such privileges will result in an automatic resignation of appointment from the Medical Staff and of all clinical privileges at all Wellmont

Hospitals. In order to reapply for appointment and clinical privileges after an automatic resignation, the individual must have completed all delinquent medical records and paid all outstanding fines.

(c) Any requests for special exceptions to the above requirements will be submitted by the physician to the medical records department and considered by the Medical Executive Committee.

6.D.2. Action by Government Agency or Insurer and

Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the Chief Executive Officer or President of the Medical Staff.

(b) An individual's appointment and clinical privileges will be automatically relinquished, without right to hearing or appeal, if any of the following occur:

(1) Licensure: Revocation, probation, expiration, suspension, or the placement of conditions or restrictions on an individual's license or registration.

(2) DEA Registration: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, indictment, conviction or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence.

(c) An individual's appointment and clinical privileges will be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or perform his or her responsibilities during the provisional period.

(d) Automatic relinquishment will take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated.

(e) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment will result in an automatic resignation from the Medical Staff or the Allied Health Staff.

(f) Requests for reinstatement will be reviewed by the relevant department chairperson, the President of the Medical Staff, the Chief Executive Officer and, if applicable, the Chief Nursing Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Medical Executive Committee and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Medical Executive Committee and Board for review and recommendation.

6.D.3. Failure to Provide Information:

Appointment and clinical privileges will be deemed to be relinquished upon the occurrence of:

(a) failure to notify the President of the Medical Staff or Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment, after the President of the Medical Staff and Chief Executive Officer consider any written or oral explanation provided by the individual; or

(b) failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the Medical Executive Committee, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.

6.D.4. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff leaders may require the individual to attend a special meeting.

(b) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(c) Failure of the individual to attend the meeting will be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee, upon a showing of good cause, failure to attend will result in the automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment will remain in effect until the individual attends the special meeting.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

(a) A leave of absence of up to one year must be requested, in writing, and submitted to the Chief Executive Officer. The request must state the beginning and ending dates of the leave and the reasons for the leave. Except in extraordinary circumstances, this request should be submitted at least 30 days prior to the anticipated start of the leave.

(b) The Chief Executive Officer will determine whether a request for a leave of absence will be granted, after consulting with the President of the Medical Staff and the relevant department chairperson. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of medical records.

(c) Members of the Medical Staff and Allied Health Staff must report to the Chief Executive Officer anytime they are away from the Hospital or patient care responsibilities for longer than 30 days and the reason for their absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Chief Executive Officer, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.E.2. Duties of Member on Leave and Reinstatement:

(a) During the leave of absence, the individual will not exercise any clinical privileges and will be excused from all Medical and Allied Health Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations, *payment of dues*). All medical records must be completed as soon as reasonably possible.

(b) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested. Requests for reinstatement will then be reviewed by the relevant department chairperson, the President of the Medical Staff, and the Chief Executive Officer, and in accordance with the practitioner health policy, if applicable.

(c) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Medical Executive Committee and Board. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual will be entitled to request a hearing and appeal.

(d) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment concurrent with the request for reinstatement.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual who is covered by this Policy is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment or clinical privileges;

(3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

No other recommendations will entitle the individual to a hearing.

(b) If the Board makes any of these recommendations without an adverse recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions constitute grounds for a hearing. These actions take effect without a hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

(a) a letter of guidance, counsel, warning, or reprimand;

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse or decision not to grant or not to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) a requirement for additional training or continuing education;

(f) precautionary suspension or restriction;

(g) denial of a request for leave of absence or for an extension of a leave;

(h) determination that an application is incomplete;

(i) determination that an application will not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

The Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the Chief Executive Officer, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer will schedule the hearing and provide, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable) and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.

(b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Chief Executive Officer, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.

(2) The Hearing Panel may include any combination of:

(i) any member of the Medical Staff or Allied Health Staff, or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(5) The Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing;

(iii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The Chief Executive Officer will appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive or that causes undue delay;

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

(vi) rule on all matters of procedure and the admissibility of evidence; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the Chief Executive Officer, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, the Hearing Officer, or the Presiding Officer will be made in writing, within ten days of receipt of notice, to the Chief Executive Officer, and must include the basis for the objection. A copy of such written objection will be provided to the President of the Medical Staff. The President of the Medical Staff will be given a reasonable opportunity to comment on any objection. The Chief Executive Officer will rule on the objection and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree, in writing, that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the Medical Executive Committee;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding any other member. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

(e) Neither the individual nor any other person acting on behalf of the individual may contact Hospital employees or members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or members and confirmed their willingness to meet. Any employee or medical staff or allied health member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

(a) The Presiding Officer will require the individual and the Medical Executive Committee, along with their representatives, to participate in a pre-hearing conference.

(b) All objections to documents and witnesses will be submitted in writing five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

(e) The Presiding Officer will establish the time to be allotted to each witness' testimony and cross-examination.

(f) It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.5. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be forwarded to the Board for final action.

7.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may be present but may not call, examine, and cross-examine witnesses or present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

7.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer or the President of the Medical Staff.

7.C.7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she will read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria and other factors for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

7.D.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the Chief Executive Officer. The Chief Executive Officer will send a copy of the report to the individual who requested the hearing by special notice. The Chief Executive Officer will also provide a copy of the report to the President of the Medical Staff.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested, the Chairperson of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chairperson of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing Panel and any other information that it deems relevant.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument, not to exceed 30 minutes.

(d) The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

(e) The Review Panel will recommend final action to the Board.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

(a) The Board will take final action within 30 days after it (i) considers the appeal as a Review Panel; (ii) receives a recommendation from the Review Panel; or (iii) receives the Hearing Panel's report when no appeal has been requested.

(b) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(c) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the President of the Medical Staff.

(d) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

(a) No individual will be entitled to more than one hearing and one appeal on any adverse recommendation.

(b) The action of the Board will be effective, with respect to appointment and privileges, throughout the System.

(c) If the Board denies initial appointment or reappointment or revokes appointment or clinical privileges, that individual may not apply for appointment or clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFLICTS OF INTEREST

(a) When performing a function outlined in this Policy, the Bylaws, the Organization and Functions Manual, or the Rules and Regulations, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the President of the Medical Staff (or the President-Elect of the Medical Staff if the President is the person with the potential conflict) or the applicable department or committee chairperson. The President of the Medical Staff or the applicable department or committee chairperson will make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a department chairperson or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(d) The fact that a department or committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 9

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____

Approved by the Board: February 18, 2013

APPENDIX A

ALLIED HEALTH PROFESSIONALS

The Allied Health Professionals currently practicing are as follows:

APPENDIX B

CONDITIONS OF PRACTICE APPLICABLE TO

ALLIED HEALTH PRACTITIONERS

1. Oversight by Supervising/Collaborating Physician:

(a) As permitted by their license and Hospital policy, certain categories of allied health professionals may function in the Hospital only so long as they have a Supervising/Collaborating Physician.

(b) Any activities permitted to be performed at the Hospital by an allied health professional may be required to be performed only under the oversight of the Supervising/Collaborating Physician.

(c) If the medical staff appointment or clinical privileges of the Supervising/Collaborating Physician are resigned, revoked or terminated, or the allied health professional fails, for any reason, to maintain an appropriate supervision/collaboration relationship as required, the allied health professional's clinical privileges will be automatically relinquished, unless another Supervising/Collaborating Physician is approved as part of the credentialing process.

(d) As required by law and Hospital policy, allied health professionals must provide the Hospital with notice of any revisions or modifications that are made to their supervision/collaboration agreement. This notice must be provided to the Chief Executive Officer within three days of any such change.

2. Questions Regarding the Authority of an Allied Health Professional:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an allied health professional to act or issue instructions outside the presence of the Supervising/Collaborating Physician, such individual will have the right to request that the Supervising/Collaborating Physician validate, either at the time or later, the instructions of the allied health professional. Any act or instruction of the allied health professional will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the individual.

(b) Any question regarding the conduct of an allied health professional will be reported to the President of the Medical Staff, the relevant department chairperson, or the Chief Executive Officer for appropriate action. The individual

to whom the concern has been reported will also discuss the matter with the Supervising/Collaborating Physician.

3. Responsibilities of Supervising/Collaborating Physicians:

(a) Physicians who wish to utilize the services of an allied health professional in their clinical practice at the Hospital must notify the Centralized Verification Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy.

(b) The number of allied health professionals acting under the supervision of, or in collaboration with, one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising/Collaborating Physician will make all appropriate filings with the State regarding the supervision and responsibilities of the allied health professional, to the extent that such filings are required.

GLOSSARY

The following definitions apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" means individuals other than members of the Medical Staff (including residents who are moonlighting) who are authorized by law to provide patient care services and are granted clinical privileges to practice by the Hospital.

(2) "ALLIED HEALTH STAFF" means all allied health professionals who have been appointed to the Allied Health Staff by the Board.

(3) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(4) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Orthopedics and Primary Medicine, or the American Board of Podiatric Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual's area of clinical practice.

(5) "CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Executive Committee and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(7) "COMPLETED APPLICATION" means that all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time.

(8) "CORE PRIVILEGES" or "CORE" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Executive Committee and Board to require closely related skills and experience.

(9) “CREDENTIALS POLICY” means the Hospital’s Medical Staff Credentials Policy.

(10) “DAYS” means calendar days.

(11) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).

(12) “HOSPITAL” means [INSERT NAME].

(13) “MEDICAL EXECUTIVE COMMITTEE” means the Medical Executive Committee of the Medical Staff.

(14) “MEDICAL STAFF” means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.

(15) “MEDICAL STAFF LEADER” means any Medical Staff officer, department chairperson, or committee chairperson.

(16) “MEMBER” means any physician, dentist, or podiatrist who has been granted appointment to the Medical Staff or any allied health professional who has been granted appointment to the Allied Health Staff, by the Board to practice at the Hospital.

(17) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

(18) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

(19) “PEER REVIEW COMMITTEES” includes professional review bodies, as defined in the Health Care Quality Improvement Act (“HCQIA”), that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.

(20) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

(21) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).

(22) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA.

(23) “PROFESSIONAL REVIEW ACTIVITY” has the meaning defined in the HCQIA, that is, activity to determine whether an individual may be granted, to determine the scope or conditions of, or to change or modify, appointment or clinical privileges. All such activity is also intended to be encompassed within the scope of any applicable federal or state privilege, and includes but is not limited to credentialing, privileging, reappointment, ongoing and focused professional practice evaluations, collegial intervention, performance improvement plans, investigations and hearings.

(24) “RESTRICTION” means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients.

(25) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(26) “SUPERVISING/COLLABORATING PHYSICIAN” means a member with clinical privileges, who has agreed in writing to supervise an allied health professional.

(27) “SUPERVISION” means the supervision of an allied health professional by a Supervising/Collaborating Physician, that may or may not require the actual presence of the Supervising/Collaborating Physician, but that does require, at a minimum, that the physician be readily available for consultation. The requisite level of supervision will be determined at the time each allied health professional is credentialed and will be consistent with any applicable written supervision/collaboration agreement.

(28) “SYSTEM” means the Wellmont Health System.

(29) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

Exhibit E-1F

Lonesome Pine Medical Staff Bylaws

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF WELLMONT HEALTH SYSTEM

LONESOME PINE HOSPITAL

MEDICAL STAFF BYLAWS

December 17, 2012

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

1.C. MEDICAL STAFF DUES

(1) Annual Medical Staff dues may be recommended by the Medical Executive Committee and may vary by category.

(2) Any applicable dues shall be payable annually upon request or as otherwise indicated by the Medical Executive Committee.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff will consist of members who:

(a) are involved in at least 25 patient contacts per appointment term, at the Hospital; OR

(b) have demonstrated a commitment to the Medical Staff through service on Medical Staff or Hospital committees or active participation in performance/quality improvement functions of at least 20 documented hours per appointment term; and

(c) have completed the one-year period on the Associate Staff.

2.A.2. Prerogatives:

Active Staff members:

(a) may attend Medical Staff and applicable department and committee meetings (with vote); and

(b) may serve as an officer of the Medical Staff, a chairperson of a department, or a chairperson of a committee.

2.A.3. Responsibilities:

Active Staff members must:

(a) assume all the responsibilities of membership on the Active Staff, including committee service, emergency call, care for unassigned patients, and evaluation of members during the provisional period;

(b) actively participate in the peer review and performance improvement process;

(c) accept consultations when requested;

(d) attend applicable meetings; and

(e) pay application fees, dues, and assessments, as applicable.

2.B. ASSOCIATE STAFF

2.B.1. Qualifications:

(a) All new appointments to the Medical Staff will be to the Associate Staff. Associate Staff members must satisfy the qualifications and conditions for appointment and reappointment to the Medical Staff contained in the Credentials Policy.

(b) Upon completing one year on the Associate Staff, individuals who meet the applicable qualifications may seek to be transferred to another staff category.

2.B.2. Prerogatives:

Associate Staff members:

(a) may exercise the clinical privileges granted;

(b) may attend Medical Staff meetings and applicable department and committee meetings (without vote); and

(c) may not serve as an officer of the Medical Staff, a chairperson of a department, or a chairperson of a committee.

2.B.3. Responsibilities:

Associate Staff members will assume all the responsibilities of appointment to the Active Staff, including committee service, emergency call, and active participation in the peer review and performance improvement process.

2.C. AFFILIATE STAFF

2.C.1. Qualifications:

(a) The Affiliate Staff will consist of members who desire to be associated with, but who do not intend to establish an inpatient practice at, the Hospital.

(b) Appointment to the Affiliate Staff is a courtesy, which may be granted or terminated by the Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

2.C.2. Prerogatives and Responsibilities:

Affiliate Staff members:

(a) may visit their hospitalized patients and review their medical records, but may not admit or attend patients, exercise any clinical privileges, make any notations in the medical record, or actively participate in the provision of care to patients at the Hospital;

(b) may not hold office or serve as a department chairperson;

(c) may attend Medical Staff meetings and applicable department meetings (without vote) and serve on committees (with vote);

(d) must accept referrals from the Emergency Department for follow-up care of patients treated there; and

(e) must pay application fees, dues, and assessments, as applicable.

2.D. CONSULTING STAFF

2.D.1. Qualifications:

The Consulting Staff will consist of members who:

(a) are of recognized professional ability and expertise and provide a service that is not available on the Active Staff; and

(b) are appointed to the Active Staff at another hospital where they are currently practicing (an exception to this qualification may be made for individuals whose clinical specialty does not support an active inpatient practice).

2.D.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may treat (but not admit) patients in conjunction with another physician on the Active Staff;

(b) may attend meetings of the Medical Staff and applicable department meetings (without vote) and serve on committees (with vote);

(c) may not serve as an officer of the Medical Staff or a chairperson of a department; and

(d) must pay application fees, dues, and assessments, as applicable.

2.E. COURTESY STAFF

2.E.1. Qualifications:

The Courtesy Staff will consist of members who have fewer than 25 patient contacts, per appointment term, at the Hospital.

2.E.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff and department meetings (without vote);

(b) may not hold office or serve as a department chairperson;

(c) may be invited to serve on committees (with vote);

(d) must accept responsibilities and assignments as deemed appropriate and necessary based on current medical needs of the Hospital and Medical Staff, as determined by the Medical Executive Committee, including, but not limited to, participating in unassigned call coverage rotation, providing consultations when requested for inpatients, and accepting committee appointments;

(e) must cooperate in the peer review and performance improvement process; and

(f) must pay application fees, dues, and assessments, as applicable.

2.F. HONORARY STAFF

2.F.1. Qualifications:

The Honorary Staff will consist of practitioners who are recognized for outstanding or noteworthy contributions to the medical sciences, or have a record of previous long-standing service to the Hospital, and have retired from the active practice of medicine.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not admit, consult, or attend to patients;

(b) may attend Medical Staff and department meetings (without vote) and committee meetings (with vote); and

(c) may not hold office or serve as a department chairperson.

2.G. ALLIED HEALTH STAFF

2.G.1. Qualifications:

The Allied Health Staff consists of allied health professionals who satisfy the qualifications and conditions for appointment to the Allied Health Staff contained in the Credentials Policy. The Allied Health Staff is not a category of the Medical Staff, but is included in this Article for convenient reference.

2.G.2. Prerogatives and Responsibilities:

Allied Health Staff members:

(a) may attend applicable department meetings (without vote);

(b) may not hold office or serve as a chairperson of a department or a committee;

(c) may serve on a committee, if requested (with vote);

(d) must cooperate in the peer review and performance improvement process; and

(e) must pay application fees, dues, and assessments, as applicable.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The Medical Staff will have the following officers:

(1) President of the Medical Staff;

(2) President-Elect of the Medical Staff;

(3) Secretary-Treasurer; and

(4) Immediate Past President.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least one year unless these criteria are waived at the recommendation of the Nominating Committee and as approved by the Medical Executive Committee and CEO;

(2) not presently be serving as a Medical Staff officer, Board member, department chairperson, or Credentials Committee Chairperson at any other non-Wellmont affiliated hospital and will not so serve during their term of office;

(3) have no pending adverse recommendations concerning appointment or clinical privileges; and

(4) have demonstrated an ability to work well with other peers and communicate effectively with other members of the Hospital and Medical Staffs.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff will:

(a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the Chief Executive Officer and the Board;

(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;

(d) appoint all committee members and chairpersons, subject to approval by the Medical Executive Committee;

(e) serve as chairperson of the Medical Executive Committee (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, with vote;

(f) promote adherence to the Bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(g) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. President-Elect:

The President-Elect will:

(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;

(b) assume all such additional duties as are assigned by the President of the Medical Staff or the Medical Executive Committee; and

(c) automatically succeed the President at the beginning of the next Medical Staff year or sooner should the office become vacated.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer will:

(a) be responsible for providing notices as specified in these Bylaws;

(b) cause to be kept accurate and complete minutes of all meetings of the Medical Executive Committee and Medical Staff; and

(c) supervise the collection of and accounting for any funds that may be collected and make disbursements authorized by the Medical Executive Committee.

3.C.4. Immediate Past President:

The Immediate Past President will serve as an advisor to other Medical Staff leaders and perform any other duties as are assigned by the President of the Medical Staff.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Committee:

The President of the Medical Staff will appoint a Nominating Committee, subject to the approval of the Medical Executive Committee. Potential candidates for office may not serve on the Nominating Committee.

3.D.2. Nominating Process:

(a) Not less than 30 days prior to the annual meeting of the Medical Staff, the Nominating Committee will prepare a slate of nominees. Notice of the nominees will be provided to the members of the Medical Staff.

(b) Additional nominations may be submitted by a petition signed by at least 50% of voting members of the Medical Staff. The petition must be presented to the Nominating Committee at least ten days prior to the annual meeting.

(c) In order for a nomination to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Nominating Committee, satisfy the qualifications in Section 3.B of these Bylaws.

(d) Nominations from the floor will not be accepted.

3.D.3. Election:

(a) If there are two or more candidates for any office or position, the vote will be by written or electronic ballot.

(b) If any voting member of the Medical Staff is unable to attend the meeting, the member may vote by electronic ballot. Such ballots must be returned to the Medical Staff Office by noon on the date of the annual meeting. The absentee ballots will be counted prior to the meeting and will be included in the vote at the meeting.

(c) The candidates receiving a majority of votes cast will be elected.

(d) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

3.E. TERM OF OFFICE, VACANCIES AND REMOVAL

3.E.1. Term of Office:

Officers will assume office on the first day of the medical staff year. Medical Staff officers will serve a two-year term. Officers may be reappointed, but no individual may serve in the same position for more than two consecutive terms unless this term limit is waived at the recommendation of the Nominating Committee and as approved by the Medical Executive Committee and CEO.

3.E.2. Vacancies:

(a) A vacancy in the office of President of the Medical Staff will be filled by the President-Elect, who will serve until the end of the unexpired term of the President of the Medical Staff.

(b) A vacancy in the office of President-Elect will be filled by a special election using the general nomination and election process described in these Bylaws.

(c) A vacancy in the office of Secretary-Treasurer will be filled by the Medical Executive Committee.

3.E.3. Removal:

(a) Removal of an elected officer may be initiated by a petition signed by 50% of the Active Staff or a majority of the Medical Executive Committee for:

(1) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital; or

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(b) The individual subject to removal will be given at least ten days' special notice of the date of the meeting at which removal will be considered. The individual will be afforded an opportunity to speak to the relevant body prior to the vote.

(c) In order to be effective, a vote on removal must be approved by two-thirds of the Active Medical Staff or three-fourths of the Medical Executive Committee. Removal proceedings will be effective when approved by the Board.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1.Organization of Departments:

(a) The Medical Staff will be organized into the clinical departments as listed in the Organization and Functions Manual.

(b) Subject to the approval of the Board, the Medical Executive Committee may create new departments, eliminate departments, or otherwise reorganize the department structure, including but not limited to the creation of sections or service lines.

4.A.2. Assignment to Departments:

Upon initial appointment, each member will be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

4.A.3. Functions of Departments:

(a) Departments will be organized for the purpose of monitoring and evaluating the quality and appropriateness of care, and for monitoring the practice of all those with clinical privileges in the department.

(b) Each department will oversee emergency call coverage for all patients who present to the Emergency Department, as may be needed.

4.B. DEPARTMENT CHAIRPERSONS

4.B.1. Qualifications:

Each department chairperson will be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process andsatisfy the eligibility criteria in Section 3.B.

4.B.2. Selection and Term of Appointment for Department Chairperson:

(a) When there is a vacancy in a department chairperson position, the Medical Executive Committee will submit a list of individual(s) eligible to serve as department chairpersons to the department for election.

(b) Initial appointment and reappointment of a department chairperson will be for a period of two years or as otherwise set forth in the chairperson's contract.

4.B.3. Duties of Department Chairpersons:

Each department chairperson is responsible for the following functions, either personally or in collaboration with Hospital personnel:

(a) all clinically-related activities of the department;

(b) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(c) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(e) evaluating requests for clinical privileges for each member of the department;

(f) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(g) the integration of the department into the primary functions of the Hospital;

(h) the coordination and integration of interdepartment and intradepartment services;

(i) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

(j) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(k) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(l) continuous assessment and improvement of the quality of care, treatment, and services provided;

(m) maintenance of quality monitoring programs, as appropriate;

(n) the orientation and continuing education of all persons in the department; and

(o) recommendations for space and other resources needed by the department.

4.B.4. Removal of Department Chairpersons:

(a) A department chairperson may be removed by a two-thirds vote of the department or the Medical Executive Committee.

(b) If a department chairperson is removed from office, an appropriate person selected by the Chief Executive Officer will assume responsibility for the department until a new chairperson can be selected as set forth above.

4.C. SECTIONS

4.C.1. Qualifications, Selection, Removal and Duties of Section Chiefs:

(a) If the Medical Executive Committee recognizes any sections, the section chief will meet the same qualifications as department chairpersons.

(b) The selection and removal process for section chiefs will be the same process followed for the selection and removal of department chairpersons.

(c) The section chief will carry out the duties requested by the department chairperson.

4.C.2. Functions of Sections:

(a) Sections may perform any of the following activities:

(1) discussion of policy;

(2) discussion of equipment needs;

(3) development of recommendations to the department chairperson or the Medical Executive Committee; and

(4) discussion of a specific issue at the special request of a department chairperson or the Medical Executive Committee.

(b) No minutes or reports will be required reflecting the activities of a section, except when a section is making a formal recommendation.

(c) Sections will not be required to hold regularly scheduled meetings.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL

5.A.1. Appointment:

(a) Except as otherwise provided by these Bylaws or the Organization and Functions Manual, the President of the Medical Staff will appoint the chairperson and members of each committee. These appointments are subject to approval by the Medical Executive Committee. Committee chairpersons will be selected based on the criteria set forth in Section 3.B of these Bylaws.

(b) The Chief Executive Officer will make appointments of administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote.

(c) Chairpersons and members of standing committees will be appointed for an initial term of two years, but may be reappointed for additional terms.

(d) Chairpersons and members of standing committees may be removed and vacancies filled at the discretion of the person who initially appointed them.

(e) The President of the Medical Staff will be an *ex officio* member, with vote, on all Medical Staff committees. The Chief Executive Officer will be an *ex officio* member, without vote, on all Medical Staff committees.

5.A.2. Medical Staff Functions:

The Medical Executive Committee will oversee the effective performance of Medical Staff functions through committees. The composition, duties and meeting requirements of additional committees are in the Organization and Functions Manual.

5.B. MEDICAL EXECUTIVE COMMITTEE

5.B.1. Composition:

(a) The Medical Executive Committee will include the Medical Staff Officers. The officers may also appoint three additional members to facilitate active participation by the various clinical specialties on the Medical Executive Committee. These additional members will also be selected based on the criteria set forth in Section 3.B of these Bylaws.

(b) The President of the Medical Staff will serve as chairperson of the Medical Executive Committee.

5.B.2. Duties:

(a) The Medical Executive Committee is delegated the primary authority over activities related to functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies.

(b) The Medical Executive Committee is responsible for the following:

(1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

(2) recommending directly to the Board on at least the following:

(i) the Medical Staff's structure;

(ii) the mechanism used to review credentials and to delineate individual clinical privileges;

(iii) applicants for Medical Staff appointment and reappointment;

(iv) delineation of clinical privileges for each eligible individual;

(v) participation of the Medical Staff in performance improvement activities, utilization review activities and the quality of professional services being provided by the Medical Staff;

(vi) the mechanism by which appointment may be terminated;

(vii) hearing procedures;

(viii) reports and recommendations from committees, departments, and other groups, as appropriate; and

(ix) hospital operations, problems, and procedures;

(3) consulting with administration on quality-related aspects of contracts for patient care services;

(4) providing oversight and guidance pertaining to continuing medical education activities;

(5) reviewing quality indicators to ensure uniformity regarding patient care services;

(6) providing leadership in activities related to patient safety;

(7) providing oversight in the process of analyzing and improving patient satisfaction;

(8) reviewing, at least every three years, the Bylaws, policies, rules and regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable;

(9) ensuring that the Medical Staff is kept abreast of requirements of accreditation program and informed of the accreditation status of the Hospital;

(10) recommending action to the Chief Executive Officer on matters of a medical administrative nature;

(11) taking reasonable steps to ensure that members engage in ethical professional conduct and initiating appropriate action as necessary;

(12) directing and evaluating the effectiveness of continuing medical education programs for the staff;

(13) evaluating requests for new texts and journals, as well as all requests to discard existing texts and journals; and

(14) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies.

5.B.3. Meetings:

The Medical Executive Committee will meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment and improvement of the following:

(a) medical assessment and treatment of patients;

(b) use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process;

(c) medication usage;

(d) the use of blood and blood components;

(e) operative and other procedures;

(f) appropriateness of clinical practice patterns;

(g) significant departures from established patterns of clinical practice;

(h) the use of developed criteria for autopsies;

(i) sentinel event data;

(j) patient safety data;

(k) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services core measures; and

(l) the required content and quality of history and physical examinations, as well as the time frames required for completion, as set forth in these Bylaws.

(2) The Medical Staff participates in the following activities:

(a) education of patients and families;

(b) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(c) accurate, timely, and legible completion of patient's medical records;

(d) review of findings of the assessment process that are relevant to an individual's performance. The Medical Staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence; and

(e) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

ARTICLE 6

MEETINGS

6.A. GENERAL

6.A.1. Meetings:

(a) The Medical Staff will meet at least quarterly. The time and place of the meetings will be determined by the Medical Executive Committee.

(b) For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of July and ends on the 30th day of June each year.

(c) Departments will meet quarterly, or more often if needed to perform their designated functions.

(d) Committees will meet as often as necessary to fulfill their responsibilities.

(e) Meetings may be conducted by telephone conference or by other electronic means at the discretion of the applicable chairperson.

6.A.2. Special Meetings:

(a) The annual meeting of the Medical Staff will be the last meeting before the end of the year.

(b) A special meeting of the Medical Staff may be called by the President of the Medical Staff, a majority of the Medical Executive Committee, the Chief Executive Officer, or by a petition signed by at least 50% of the voting members of the Medical Staff.

(c) A special meeting of a department or committee may be called by the President of the Medical Staff, the relevant chairperson, or by a petition signed by at least 50% of the voting members of the department or committee.

(d) No business will be transacted at any special meeting except that stated in the meeting notice.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1. Notice:

(a) The notice of regular and special meetings will state the date, time, and place of the meeting.

(b) Notice of any regular or special meeting of the Medical Staff, or of a department, or committee, will be sent to each voting member via regular U.S. mail, e-mail, or Hospital mail. Notice of regular or special meetings should be provided at least seven days in advance of the meeting.

(c) The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.2. Quorum:

(a) Except as otherwise provided in these Bylaws, for any regular or special meeting of the Medical Staff, department, or committee, the presence of at least 25% of the voting members will constitute a quorum.

(b) For meetings of the Medical Executive Committee, the presence of at least 50% of the voting committee members will constitute a quorum.

(c) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.

6.B.3. Voting:

(a) Any individual, regardless of position or staff category, will be entitled to only one vote.

(b) Recommendations and actions of the Medical Staff, departments, and committees will be by consensus. Except as otherwise provided in these Bylaws, in the event it is necessary to vote on an issue, the issue will be determined by a majority of the voting members.

(c) Members of the Medical Staff and members of any department or committee may also be presented with a question by some other means (i.e., mail, e-mail, or telephone), and their votes returned to the chairperson by the method designated in the notice. A quorum, for the purpose of these votes, will be the number of responses returned by the date indicated and the question will be determined in the affirmative if a majority of the responses so indicate.

6.B.4. Agenda:

(a) The President of the Medical Staff will set the agenda for Medical Staff meetings.

(b) The chairperson of each department and committee will set the agenda for meetings of the respective department and committee.

6.B.5. Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at meetings and elections, but will not be binding. Specific provisions of these Bylaws and Medical Staff, department, and committee custom will prevail at meetings, and the President of the Medical Staff, department chairperson, or committee chairperson will have the authority to rule definitively on matters of procedure.

6.B.6. Minutes:

(a) Minutes of Medical Staff, department, and committee meetings will include a record of the attendance and the recommendations made and will be prepared and signed by the presiding officer.

(b) Meeting minutes for the Medical Staff, departments, and committees will be forwarded to the Medical Executive Committee. The Chief Executive Officer will also receive a copy of the meeting minutes. A permanent file of the meeting minutes will be maintained by the Hospital.

6.C. ATTENDANCE

6.C.1. Regular and Special Meetings:

(a) Active Staff members are required to attend at least fifty percent (50%) of all general Medical Staff meetings. Active Staff members who are on the staff of more than one Wellmont hospital are required to satisfy this attendance requirement at their primary Wellmont hospital. Failure to meet this requirement will result in the assessment of a fee, as determined by the Medical Executive Committee.

(b) Members of the Medical Executive Committee are expected to attend all meetings and are required to attend at least one-half of the meetings held during the year.

6.C.2. Required Meetings:

(a) Whenever there is a suspected deviation from standard clinical practice, or professional conduct, involving any individual, the department chairperson or the President of the Medical Staff may require the individual to attend a meeting with Medical Staff Leaders or with a committee of the Medical Staff.

(b) The procedures for, and consequences of failing to abide by, these special attendance requirements are addressed in the Credentials Policy.

ARTICLE 7

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy.

7.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or the Allied Health Staff, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

Complete applications for appointment and privileges will be transmitted to the applicable department chairperson, who will prepare a written report. This report will be forwarded, along with the department chairperson's report, to the Medical Executive Committee for review and recommendation. The recommendation of the Medical Executive Committee will be forwarded to the Board for final action.

7.C. AUTOMATIC RELINQUISHMENTOF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges will be automatically relinquished if an individual:

(a) fails to do any of the following:(i)timely complete medical records;(ii) satisfy threshold eligibility criteria;(iii)meet provisional period requirements;(iv) provide requested information; or(v) attend a special conference to discuss issues or concerns;

(b) is arrested, indicted, convicted, or pleads guilty or no contest pertaining to any felony, or to certain misdemeanors;

(c) makes a misstatement or omission on an application form; or

(d) in the case of an allied health professional, fails to maintain an appropriate supervision/collaborative relationship.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

7.D. PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the President of the Medical Staff, the chairperson of the relevant clinical department, the Medical Executive Committee, or the Board Chairperson is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee. The individual will be provided a brief written description of the reason(s) for the precautionary suspension.

(3) The Medical Executive Committee will review the reasons for the suspension within a reasonable time. Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee.

7.E. PROFESSIONAL REVIEW ACTIONS

Following an investigation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

7.F. HEARING AND APPEAL PROCESS

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties. The Hearing Panel will consist of at least three members or there will be a Hearing Officer. The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply. A stenographic reporter will be present to make a record of the hearing.

(2) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness; (d) to have representation by counsel who may be present but may not call, examine, and cross-examine witnesses or present the case; (e) to submit a written statement at the close of the hearing; and (f) to submit proposed findings, conclusions and recommendations to the Hearing Panel. The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(3) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence. The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by (i) the Medical Executive Committee or (ii) a petition signed by 25% of the voting members of the Medical Staff.

(2) All proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee will provide notice of all proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.

(3) The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The Medical Executive Committee may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 25% of the staff eligible to vote.

(5) The Medical Executive Committee will have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(6) All amendments will be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there will be policies, procedures, and rules and regulations that are applicable to all members and other individuals who have been granted clinical privileges.

(2) An amendment to the Credentials Policy may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to the Credentials Policy will be provided to each voting member of the Medical Staff at least 30 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(3) An amendment to the Medical Staff Organization and Functions Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to these documents will be provided to each voting member of the Medical Staff at least 30 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(4) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the rules and regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments will be provided to each member of the Medical Staff as soon as possible. The Medical Staff will have 30 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.

(5) All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.

(6) Amendments to the Credentials Policy, or any other Medical Staff policy, the Medical Staff Organization and Functions Manual, or the Medical Staff Rules and Regulations may also be proposed by a petition signed by at least 25% of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Executive Committee at least 30 days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.

(7) Adoption of and changes to the Credentials Policy, Medical Staff Organization and Functions Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(8) Amendments to Medical Staff policies are to be distributed or otherwise made available to Medical Staff members and those otherwise holding clinical privileges in a timely and effective manner.

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed by the Medical Executive Committee; or

(c) proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

a special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to attempt to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

(2) If the differences cannot be resolved at the meeting, the Medical Executive Committee will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the Chief Executive Officer, who will forward the request for communication to the Board Chairperson. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the President of the Medical Staff of all such exchanges. The Board Chairperson will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 9

HISTORY AND PHYSICAL

(a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals. The scope of the medical history and physical examination will include, as pertinent:

(1) patient identification;

(2) chief complaint;

(3) history of present illness;

(4) review of systems, to include at a minimum:

(i) cardiovascular;

(ii) respiratory;

(iii) gastrointestinal;

(iv) neuromusculoskeletal; and

(v) skin;

(5) personal medical history, including medications and allergies;

(6) family medical history;

(7) social history, including any abuse or neglect;

(8) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

(9) data reviewed;

(10) assessments, including problem list;

(11) plan of treatment; and

(12) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment.

In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, provided that the patient has been reassessed within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.

(c) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

(d) A Short-Form history and physical, containing the chief complaint or reason for the procedure, relevant history of the present illness or injury, and the patient's present clinical condition/physical findings, may be used for ambulatory or same-day procedures as approved by the Medical Executive Committee.

(e) The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

ARTICLE 10

ADOPTION

(a) These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

(b) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended. To the extent they are inconsistent, the Medical Staff Rules and Regulations are of no force or effect.

Adopted by the Medical Staff on:

Date:_____

_____
President of the Medical Staff

Approved by the Board:

Date:_____

_____
Chair, Board of Trustees

Exhibit E-1G

Lonesome Pine Medical Staff Rules and Regulations

MEDICAL STAFF
RULES AND REGULATIONS

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ARTICLE I

GENERAL

1.1. Definitions:

The definitions that apply to terms used in all the Medical Staff documents, including these Rules and Regulations, are set forth in the Medical Staff Bylaws.

1.2. Delegation of Functions:

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND

CARE, TREATMENT AND SERVICES

2.1. Admissions:

(a) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges.

(b) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.

2.2. Responsibilities of Attending Physician:

(a) The attending physician will be responsible for the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care, the prompt and accurate completion of the portions of the medical record for which he or she is responsible, and necessary patient instructions.

(b) "Attending physician" means any physician on the Medical Staff who is actively involved in the care of a patient at any point during the patient's treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include the preparation of complete and legible medical record entries related to the specific care/services he or she provides.

(c) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician, a note covering the transfer of responsibility will be entered on the orders of the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.

(d) The attending physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

2.3. Care of Unassigned Patients:

(a) All unassigned patients will be assigned to the appropriate on-call physician or to the Hospitalist service.

(b) An "unassigned patient" means any individual who comes to the Hospital for care and treatment who does not have a primary physician, or whose primary physician or designated alternate is unavailable to attend the patient, or who does not want the prior primary physician to provide him or her care while a patient at the Hospital.

2.4. Availability and Alternate Coverage:

(a) Physicians will provide professional care for their patients in the Hospital by being personally available, or by making arrangements with an alternate member who has appropriate clinical privileges to care for their patients.

(b) The attending physician (or his or her alternate) will comply with the following patient care guidelines regarding availability:

(1) Pages from the Emergency Department and/or a Patient Care Unit – must respond by telephone within 30 minutes of being paged. If requested, **Surgical Consults** must personally see a patient at the Hospital within 4 hour of the request; **Medical Consults** must personally see a patient at the Hospital within 12 hours of request.

(2) Patients Admitted from the Emergency Department – must personally see the patient within 12 hours of admission;

(3) All Other Inpatient Admissions – must personally see the patient within 24 hours of admission;

(4) ICU Patients – must personally see the patient within 12 hours of being admitted to the ICU, unless the patient's condition requires that the physician see him or her sooner;

(5) Critical Care Consults – must be completed within 4 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., "stat," "urgent," "today," or similar terminology – must also include personal contact by the requesting individual to the consulting physician);

(6) Routine Consults – must be completed within 24 hours of the request; and

(7) Patients Subject to Restraints or Seclusion – pursuant to Hospital policy.

(c) If an attending physician does not participate in an established call coverage schedule with known alternate coverage and is unavailable to care for a patient, or knows that he or she will be out of town,

(d) If an attending physician or his or her alternate is not available, the Chief Executive Officer or the Medical Staff President will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.5. Continued Hospitalization:

(a) The attending physician will provide whatever information may be requested by the Utilization Management Department with respect to the continued hospitalization of a patient, including:

(1) an adequate record of the reason for continued hospitalization, including appropriate patient status (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the Hospital; and

(3) plans for post-hospital care.

This response will be provided to Utilization Management within 24 hours of the request. Failure to comply with this requirement will be reported to the Medical Executive Committee for appropriate action.

(b) If the Utilization Management Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, the Medical Staff President will be consulted.

ARTICLE III

MEDICAL RECORDS

3.1. General:

(a) The attending physician will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

(b) Only authorized individuals may make entries in the medical record in accordance with state law. All handwritten entries will be legible in blue or preferably black ink. All entries must be timed, dated and signed.

(c) All documentation will be authenticated, dated and timed.

(d) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations should be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

3.2. Access and Retention of Record:

(a) The Hospital will retain medical records in their original or legally reproduced form in accordance with retention of records policy.

(b) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

(c) Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and Hospital policy.

(d) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless the attending physician documents that such a release would have an adverse effect on the patient.

(e) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(f) Subject to the discretion of the Chief Executive Officer, Chief Compliance Officer, and/or hospital legal council, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

3.3. Content of Record:

(a) Medical records will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(b) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures. Stamped signatures are not permitted in the medical record.

(c) All medical records will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the attending physician and the Hospital:

(1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(2) legal status of any patient receiving behavioral health services;

(3) patient's language and communication needs, including preferred language for discussing health care;

(4) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;

(5) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

(6) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(7) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;

(8) allergies to foods and medicines;

(9) reason(s) for admission of care, treatment, and services;

(10) diagnosis, diagnostic impression, or conditions;

(11) goals of the treatment and treatment plan;

(12) diagnostic and therapeutic orders, procedures, tests, and results;

(13) progress notes made by authorized individuals;

(14) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(15) consultation reports;

(16) response to care, treatment, and services provided;

(17) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(18) reassessments and plan of care revisions;

(19) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;

(20) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and whether the patient left against medical advice; and

(21) medications dispensed or prescribed on discharge, that have been reconciled with home medication list.

(d) Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Hospital:

(1) time and means of arrival;

(2) record of care prior to arrival;

(3) results of the Medical Screening Examination;

(4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

(5) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

(6) whether the patient left against medical advice; and

(7) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

3.4. History and Physical:

The requirements for histories and physicals, including general documentation requirements and timing requirements are contained in Article 9 of the Medical Staff Bylaws.

3.5. Progress Notes:

(a) Progress notes will be completed daily by the attending physician or his or her covering practitioner. They may also be completed by allied health professionals as permitted by their clinical privileges or scope of practice. When appropriate, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

(b) Progress notes will be legibly completed, dated, timed, and authenticated by an attending physician at least daily for all patients who have been admitted to the Hospital.

3.6. Authentication:

(a) Authentication means to establish authorship by written signature or identifiable initials and may include written signatures, written initials, or computer entry using unique electronic signatures.

(b) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.

(c) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.7. Informed Consent:

Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record.

3.8. Delinquent Medical Records:

(a) It is the responsibility of any physician caring for a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital.

(b) Medical records will be completed concurrently but within 30 days following the patient's discharge or they will be considered delinquent. If the record remains incomplete 30 days post discharge, the physician will be notified weekly by the Health Information Management (HIM) Department. If incomplete records are not completed within thirty (30) days post discharge, the physician's clinical privileges are subject to automatic suspension in accordance with the Credentials Policy. The suspension will remain in effect until all of the physician's records are no longer delinquent.

(c) Failure to complete the medical records that caused the automatic suspension of clinical privileges three months from the suspension will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

(d) A medical record will not be permanently filed or electronically completed until it is completed by the responsible physician or it is ordered filed by the Medical Executive Committee. Except in rare circumstances, and only when approved by the Medical Executive Committee, no physician or other individual will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

(e) When a physician is no longer a member of the Medical Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the physician's credentials file and divulged in response to any future credentialing inquiry concerning the physician.

(f) Any requests for special exceptions to the above requirements will be submitted by the physician to the Health Information Management (HIM) Department and considered by the Medical Executive Committee.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

(a) All written orders will be dated, timed, and authenticated at the time of entry by the ordering practitioner.

(b) Orders will be entered clearly, legibly, and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

(c) Orders for tests and therapies will be accepted only from:

(1) members of the Medical Staff;

(2) allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses; and

(3) other individuals not on the Medical Staff who have been granted permission to order services pursuant to Hospital policy.

(d) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.

(e) Orders for "daily" tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering physician at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be rewritten in the same format in which it was originally recorded if it is to be continued.

(f) All orders are automatically cancelled and will be completely rewritten when a patient is transferred from one physician to another, when a patient is transferred from the critical care unit, and when a patient emerges from surgery.

(g) No order will be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

(h) All orders for medications administered to patients will be:

(1) reviewed by the attending physician at least weekly to assure the discontinuance of all medications no longer needed;

(2) canceled automatically when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

(3) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.

(i) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be rewritten. All PRN medication orders must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

(j) Allied health professionals may be authorized to write medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders written by an allied health professional will be countersigned/authenticated by the supervising physician by the close of the medical record.

4.2. Verbal Orders:

(a) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the responsible practitioner.

(b) All verbal and telephone orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated by the ordering physician or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law.

(c) For verbal and telephone orders, or for the reporting of critical test results over the telephone, the complete order or test result will be verified by having the person receiving the information record and "read-back" the complete order or test result.

(d) All verbal and telephone orders will be countersigned/authenticated with date and time by the ordering physician, or another practitioner who is responsible for the patient's care in the Hospital, within **[48 hours (TN)/72 hours (VA)]** hours.

(e) The following are the personnel authorized to receive and record verbal and telephone orders:

(1) a licensed nurse;

(2) a pharmacist who may receive a verbal order pertaining to medications and monitoring;

(3) a respiratory therapist who may receive a verbal order pertaining to respiratory therapy treatments;

(4) a physical therapist who may receive a verbal order pertaining to physical therapy treatments;

(5) a radiology or imaging technologist (i.e., nuclear medicine, diagnostic medical sonographer) who may receive a verbal order pertaining to tests and/or therapy treatments in their specific areas of expertise;

(6) an occupational therapist who may receive a verbal order pertaining to occupational treatments;

(7) a speech therapist who may receive a verbal order pertaining to speech therapy; and

(8) a dietician who may receive a telephone/verbal order pertaining to diet and nutrition.

4.3. Standing Order Protocols:

(a) For all standing orders, order sets and protocols, review and approval of the Medical Executive Committee and the Hospital's nursing and pharmacy departments is required. Prior to approval, the Medical Executive Committee will confirm that the standing order, order sets, and protocols are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is periodic and regular review of such orders and protocols. All standing orders, order sets and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

(b) If the use of a standing order, order set or written protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient only by an order from a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.

(c) When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

4.4. Orders for Drugs and Biologicals:

(a) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

(b) All orders for medications and biologicals will be entered in electronic order system and authenticated by the practitioner responsible for the care of the patient, with the exception of influenza and pneumococcal vaccines, which may be administered per protocol after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Hospital policies.

4.5. Orders for Radiology and Diagnostic Imaging Services:

(a) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state law, other practitioners authorized by the Medical Staff and governing body to order services.

(b) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

4.6. Orders for Respiratory Care Services:

(a) Respiratory care services may be ordered by a qualified and licensed practitioner who is responsible for the care of the patient, either independently or working in conjunction with a member of the Medical Staff.

(b) Orders for respiratory care services must include: (i) the patient's name; (ii) the name and signature of the ordering individual; (iii) the type, frequency, and, if applicable, duration of treatment; (iv) the type and dosage of medication and diluents; and (v) the oxygen concentration or oxygen liter flow and method of administration.

ARTICLE V

CONSULTATIONS

5.1. Requesting Consultations:

(a) The attending physician shall be responsible for requesting a consultation when indicated and for calling in a qualified consultant.

(b) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will make reasonable attempts to personally contact the consulting physician to discuss the consultation request. However, for emergent consults, the attending physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.

(c) Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed through the professional practice evaluation policy or other applicable policy.

(d) Where a consultation is required for a patient in accordance with Section 5.3 or 5.4 or is otherwise determined to be in the patient's best interest, the President of the Medical Staff, or the appropriate clinical Department Chairperson shall have the right to call in a consultant.

5.2. Responding to Consultation Requests:

(a) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.

(b) For non-critical care consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For critical care consults, the attending physician and consultant shall agree on a specific time frame for the consultation to be performed.

(c) The physician who is asked to provide the consultation may ask an Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an Allied Health Professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the

consultation agrees that the evaluation by the Allied Health Professional is sufficient.

(d) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the Professional Practice Evaluation Policy or other applicable policy.

5.3. Recommended and Required Consultations – General Patient Care Situations:

(a) Consultations are recommended in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incompetent.

(b) Consultations are required in all cases which, in the judgment of the attending appointee:

(1) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(2) there is doubt as to the best therapeutic measures to be used;

(3) unusually complicated situations are present that may require specific skills of other practitioners;

(4) the patient exhibits severe symptoms of mental illness or psychosis; or

(5) the patient is not a good medical or surgical risk.

Additional requirements for consultation may be established by the Hospital as required.

5.4. Mental Health Consultations:

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

5.5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, a written notation from the consultant, including relevant findings and reasons, appears in the patient's medical record. If a relevant consultation is not available for review, surgery and anesthesia will not proceed.

5.6. Content of Consultation Report:

(a) Each consultation report will be completed in a timely manner and will contain a dictated or legible written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record.

(b) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.7. Concerns:

(a) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending physician that nurse will notify his or her nursing supervisor who, in turn, will contact the attending physician. The nursing supervisor may then bring the matter to the attention of the Department Chairperson in which the member in question has clinical privileges. Thereafter, the Department Chairperson or Medical Staff President may request a consultation after discussion with the attending physician.

(b) A Medical Staff member who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with his or her Department Chairperson or the President of the Medical Staff.

ARTICLE VI

SURGICAL SERVICES

6.1. Pre-Procedure Protocol:

(a) The physician responsible for the patient's care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any indicated diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies.

(b) The following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

(1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(2) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(3) the attending physician is in the Hospital; and

(4) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.

6.2. Post-Procedure Protocol:

(a) An operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include:

(1) the patient's name and hospital identification number;

(2) pre- and post-operative diagnoses;

(3) date and time of the procedure;

(4) the name of the surgeon(s) and assistant surgeon(s) responsible for the patient's operation;

(5) procedure(s) performed and description of the procedure(s);

(6) description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;

(7) findings;

(8) estimated blood loss;

(9) any unusual events or any complications, including blood transfusion reactions and the management of those events;

(10) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;

(11) specimen(s) removed, if any;

(12) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(13) the signature of the surgeon.

(b) If a dictated report cannot be entered into the record immediately after the operation or procedure, a progress note containing the information below must be entered in the medical record immediately after the procedure and authenticated by the surgeon. The note must record:

(1) the names of the physician(s) responsible for the patient's care and physician assistants;

(2) the name and description of the procedure(s) performed;

(3) findings;

(4) estimated blood loss, when applicable or significant;

(5) specimens removed; and

(6) post-operative diagnosis.

ARTICLE VII

ANESTHESIA SERVICES

7.1. General:

(a) Anesthesia may only be administered by the following qualified practitioners:

(1) an anesthesiologist;

(2) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;

(3) a dentist, oral surgeon or podiatrist, in accordance with state law;

(4) a CRNA who is supervised by the operating practitioner or an anesthesiologist who is immediately available; or

(5) an anesthesiologist's assistant under the supervision of an anesthesiologist who is immediately available, if needed.

(b) An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA (e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).

(c) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal, moderate or conscious sedation, or analgesia via epidurals/spinals for labor and delivery.

(d) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or conscious sedation, a qualified practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

(e) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

(a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.

(b) The evaluation will be recorded in the medical record and will include:

(1) a review of the medical history, including anesthesia, drug and allergy history;

(2) an interview, if possible, pre-procedural education, and examination of the patient;

(3) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

(5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

(6) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) and (2) must be performed within the 48-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

(c) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.3. Monitoring During Procedure:

(a) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

(b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(1) the name and Hospital identification number of the patient;

(2) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

(3) the name, dosage, route time, and duration of all anesthetic agents;

(4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(5) the name and amounts of IV fluids, including blood or blood products, if applicable;

(6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(7) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

7.4. Post-Anesthesia Evaluations

(a) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(b) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record.

(c) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(1) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(2) cardiovascular function, including pulse rate and blood pressure;

(3) mental status;

(4) temperature;

(5) pain;

(6) nausea and vomiting; and

(7) post-operative hydrations.

(d) Patients will be discharged from the recovery area by a qualified practitioner or according to criteria approved by the clinical leaders. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(e) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

(f) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

7.5. Minimal, Moderate or Conscious Sedation:

All patients receiving minimal, moderate or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations are required.

7.6. Direction of Anesthesia Services:

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE VIII

PHARMACY

8.1. General Rules:

(a) Orders for drugs and biologicals are addressed in the Medical Orders Article.

(b) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.

(c) Adverse medication reactions, transfusion reactions, and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.

(d) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.

(e) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, or the American Hospital Formulary Service.

(f) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the Medical Executive Committee and the Institutional Review Board and as outlined in the approved Hospital formulary.

(g) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Hospital staff.

8.2. Storage and Access:

(a) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.

(1) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

(2) Medications listed in Schedules II, III, IV, and V by State and Federal law will be kept locked within a secure area.

(3) Only authorized personnel may have access to locked or secure areas.

(b) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer.

8.3. Self-Administration of Medications:

(a) The self-administration of medications (either hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:

(1) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;

(2) a practitioner responsible for the care of the patient has issued an order permitting self-administration;

(3) in the case of a patient's own medications, the pharmacist, physician, or nursing staff may utilize electronic resources that are made available by the facility to verify the patient's home medications, if they are to be used during hospitalization.

(4) the patient's first self-administration is monitored to determine whether additional instruction is needed on the safe and accurate administration of the medications.

(b) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).

(c) All self-administered medications (whether hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.

(d) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative.

8.4. Stop Orders:

A physician is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders.

ARTICLE IX

RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

Restraints, seclusion, and behavior management programs will be governed by the Hospital Policy addressing restraints, seclusion, and behavior management.

ARTICLE X

EMERGENCY SERVICES

10.1. General:

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

10.2. Medical Screening Examinations:

(a) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

(1) Emergency Department:

(i) members of the Medical Staff with clinical privileges in Emergency Medicine;

(ii) other Active Staff members; and

(iii) appropriately credentialed allied health professionals.

(2) Labor and Delivery:

(i) members of the Medical Staff with OB/GYN privileges;

(ii) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

10.3. On-Call Responsibilities:

It is the responsibility of the scheduled on-call physician or attending physician to respond to calls from the Emergency Department and/or Patient Care Unit. The on-call physician or attending physician must respond by telephone within 30 minutes of being paged, and if requested, must personally see a patient at the Hospital within 1 hour of the request.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.1. Who May Discharge:

(a) Patients will be discharged only upon the written order of the attending physician. Should a patient insist on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

(b) At the time of discharge, the attending physician will review the record for completeness, state the principal and secondary diagnosis (if one exists) and authenticate the entry.

11.2. Identification of Patients in Need of Discharge Planning:

(a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.

(b) Criteria to be used in making this evaluation include:

(1) functional status;

(2) cognitive ability of the patient; and

(3) family support.

11.3. Discharge Planning:

(a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The attending physician is expected to participate in the discharge planning process.

(b) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

11.4. Discharge Summary:

(a) A concise, dictated discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries will include the following and should be completed as soon as possible post discharge, not to exceed thirty (30) days post discharge:

(1) reason for hospitalization;

(2) significant findings;

(3) procedures performed and care, treatment, and services provided;

(4) condition and disposition at discharge;

(5) information provided to the patient and family, as appropriate;

(6) provisions for follow-up care; and

(7) discharge medication reconciliation.

(b) For outpatient or patients seen for minor problems or interventions, an abbreviated discharge summary, final progress note may be substituted, so long as the note contains the outcome of the hospitalization, disposition of case, and provisions for follow-up care.

11.5. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.

11.6. Discharge Instructions:

(a) Upon discharge, the attending physician, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged, educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.

(b) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.

(c) The attending physician, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

(d) When the Hospital determines the patient's transfer or discharge needs, the attending physician, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.

(e) When continuing care is needed after discharge, the attending physician, along with the Hospital staff, will provide appropriate information to the other health care providers, including:

(1) the reason for discharge;

(2) the patient's physical and psychosocial status;

(3) a summary of care provided and progress toward goals;

(4) community resources or referrals provided to the patient; and

(5) discharge medications.

ARTICLE XII

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

12.1. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

(a) assessing the reason(s) for transfer;

(b) establishing the conditions under which transfer can occur;

(c) evaluating the mode of transfer/transport to assure the patient's safety; and

(d) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

12.2. Procedures:

(a) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The attending physician will take the following steps as appropriate under the circumstances:

(1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

(2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

(3) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and

(4) provide the following information to the patient whenever the patient is transferred:

(i) the reason for the transfer;

(ii) the risks and benefits of the transfer; and

(iii) available alternatives to the transfer.

(b) When patients are transferred, appropriate information will be provided to the accepting practitioner/facility, including:

(1) reason for transfer;

(2) significant findings;

(3) a summary of the procedures performed and care, treatment and services provided;

(4) condition at discharge;

(5) information provided to the patient and family, as appropriate; and

(6) working diagnosis.

(c) When a patient requests a transfer to another facility, the physician will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in paragraph (b) above.

12.3. EMTALA Transfers:

The transfer of a patient with an emergency medical condition from the emergency department to another hospital will be made in accordance with the Hospital's applicable EMTALA policy.

ARTICLE XIII

MISCELLANEOUS

13.1. Autopsies:

(a) The Medical Staff should attempt to secure autopsies in accordance with state and local laws, including all cases of unusual deaths and of medical-legal and educational interest. The attending physician must be notified when an autopsy is to be performed.

(b) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. The attending physician must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of the attending physician, an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this must be documented in the medical record.

(c) Any request for an autopsy by the family of a patient who died while at the Hospital will be honored, if at all possible, after consulting with the pathologist. The payment for such autopsies is the responsibility of the patient's family or legal guardian. Difficulties or questions that arise with such a request will be directed to the Chief Executive Officer and/or the Medical Staff President.

(d) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

13.2. Patient Deaths and Death Certificates:

(a) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the attending physician, his or her designee, or the Emergency Department physician, within a reasonable time frame. Death certificates are the responsibility of the attending physician and will be completed within 24 hours of when the certificate is available to the attending physician.

(b) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the attending physician or other designated member of the Medical Staff.

(c) It is the responsibility of the attending physician to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

13.3. Treatment of Family Members:

(a) No member of the Medical Staff will admit, treat or participate in the surgery of a member of his or her immediate family, including spouse, parent, child, or sibling, unless otherwise approved by the Chief of Staff or the Chief Executive Officer. This prohibition is not applicable to in-laws or other relatives.

(b) An exception to this prohibition will be made (1) if the patient's disease is so rare or exceptional and the physician is considered an expert in the field or (2) in an emergency where no other Medical Staff member is readily available to care for the family member, and a transfer is believed to be detrimental to the patient's health.

13.4. Orientation of New Physicians:

Each new physician will be provided an overview of the Hospital and its operations. As a part of this orientation, the Health Information Management (HIM) Department and nursing service will orient new physicians as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties. In addition, an electronic medical records class by a certified trainer must be attended.

13.5. Birth Certificates:

Birth certificates are the responsibility of the delivering physician and will be completed upon availability of the physician. The Health Information Management (HIM) Department facilitates completion and state reporting for birth certificates.

ARTICLE XIV

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 8 of the Medical Staff Bylaws.

ARTICLE XV

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on:

Date: _____

_____

President of the Medical Staff

Approved by the Board on:

Date: _____

_____

Chairperson, Board of Directors