UMC Governing Board Meeting

Wednesday, November 19, 2025

Delta Point Building - Emerald Conference Room - 1st Floor

Las Vegas, NV

AGENDA

University Medical Center of Southern Nevada
Meeting of the
GOVERNING BOARD
November 19, 2025, 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Emerald Conference Room (1st Floor)

Notice is hereby given that a Meeting of the UMC Governing Board has been called and will be held on Wednesday, November 19, 2025, commencing at 2:00 p.m. at the location listed above to consider the following:

This meeting has been properly noticed and posted online at University Medical Center of Southern Nevada's website http://www.umcsn.com and at Nevada Public Notice at https://notice.nv.gov/ and at 901 Rancho Lane. Las Vegas, NV

- The main agenda is available on University Medical Center of Southern Nevada's website http://www.umcsn.com, For copies of agenda items and supporting back-up materials, please contact Stephanie Ceccarelli, Governing Board Secretary, at (702) 765-7949. The Board may combine two or more agenda items for consideration.
- Items on the agenda may be taken out of order.
- The Board may remove an item from the agenda or delay discussion relating to an item at any time.
- Consent Agenda - All matters in this sub-category are considered by the Board to be routine and may be acted upon in one motion. Most agenda items are phrased for a positive action. However, the Board may take other actions such as hold, table, amend, etc.
- Consent Agenda items are routine and can be taken in one motion unless a Board member requests that an item be taken separately. For all items left on the Consent Agenda, the action taken will be staff's recommendation as indicated on the item.
- Items taken separately from the Consent Agenda by Board members at the meeting will be heard in order.

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

PLEDGE OF ALLEGIANCE

INVOCATION

TRANQUILITY MOMENT

1. Public Comment.

   PUBLIC COMMENT. This is a period devoted to comments by the general public about items on ***this*** agenda. If you wish to speak to the Board about items within its jurisdiction but not appearing on this agenda, you must wait until the "Comments by the General Public" period listed at the end of this agenda. Comments will be limited to three minutes. Please step up to the speaker's podium, clearly state your name and address, and please ***spell*** your last name for the record. If any member of the Board wishes to extend the length of a presentation, this will be done by the Chair or the Board by majority vote.

2. Approval of Minutes of the regular meeting of the UMC Governing Board held on October 29, 2025. *(Available at University Medical Center, Administrative Office) (For possible action)*

3. Approval of Agenda. *(For possible action)*

SECTION 2: CONSENT ITEMS

4. Accept the Fiscal Year 2025 Basic Financial Statements from BDO USA, LLP, Certified Public Accountants for University Medical Center of Southern Nevada; and take action as deemed appropriate. *(For possible action)*

5. Approve the revisions to the Physician & Non-Physician Provider Traditional Compensation and Benefits Plan as recommended by the Human Resources and Executive Compensation Committee; and take action as deemed appropriate. *(For possible action)*

6. Ratify the Amendment to the Facility Agreement with Anthem Blue Cross and Blue Shield and HMO Colorado, Inc. for Managed Care Services; or take action as deemed appropriate. *(For possible action)*

7. Approve and authorize the Chief Executive Officer to sign Amendment 28 to Software License and Services Agreement with Solventum Health Information Systems, Inc.; or take action as deemed appropriate. *(For possible action)*

8. Recommend for approval by the Board of Hospital Trustees for University Medical Center of Southern Nevada the settlement in the matter of District Court Case No. A-24-895947-C, entitled *Amy Isaacson v. University Medical Center of Southern Nevada, et al*; and authorize the Chief Executive Officer to execute any necessary settlement documents. *(For possible action)*

9. Recommend for approval by the Board of Hospital Trustees for University Medical Center of Southern Nevada, a settlement between University Medical Center of Southern Nevada and the Department of Health and Human Services; and authorize the Chief Executive Officer to execute any necessary settlement documents. *(For possible action)*

SECTION 3: BUSINESS ITEMS

10. Receive a presentation from Corey McDaniel, UMC Compliance and Privacy Officer, regarding annual Compliance Training; and direct staff accordingly. *(For possible action)*

11. Review and discuss the Governing Board 2025 Action Plan, to include a presentation from Sabrina Holloway, Director of Health Information Management, regarding the

Health Information Management (HIM) Program at UMC; and direct staff accordingly. *(For possible action)*

12. Receive a report from the Governing Board Human Resources and Executive Compensation Committee; and take any action deemed appropriate. *(For possible action)*

13. Receive a report from the Governing Board Audit and Finance Committee; and take any action deemed appropriate. *(For possible action)*

14. Receive a report from the Governing Board Special Nominating Committee; and take any action deemed appropriate. *(For possible action)*

15. Discuss and consider qualified individuals for appointment and/or reappointment to the UMC Governing Board for a three-year term commencing on January 1, 2026 from the following list of interested individuals: Laura Lopez-Hobbs, Christian Haase, John Fildes, M.D., Donald Burnette, Richard McCann, and Bobbette Bond; and recommend three candidates to the Board of Hospital Trustees for appointment; and take any action deemed appropriate. *(For possible action)*

16. Receive an update from the Dean of the Kirk Kerkorian, School of Medicine at UNLV; and take any action deemed appropriate. *(For possible action)*

17. Receive an update from the Hospital CEO; and take any action deemed appropriate. *(For possible action)*

18. Determine future meeting dates and times through calendar year 2026; and take any action deemed appropriate. *(For possible action)*

SECTION 4: EMERGING ISSUES

19. Identify emerging issues to be addressed by staff or by the Board at future meetings; and direct staff accordingly. *(For possible action)*

SECTION 5: CLOSED SESSION

20. Go into closed session pursuant to NRS 241.015(4)(c), to receive information from the General Counsel regarding potential or existing litigation involving matters over which the Board had supervision, control, jurisdiction or advisory power, and to deliberate toward a decision on the matters; and direct staff accordingly. *(For possible action)*

21. Go into closed session pursuant to NRS 450.140(3) to discuss new or material expansion of UMC's health care services and hospital facilities.

COMMENTS BY THE GENERAL PUBLIC

A period devoted to comments by the general public about matters relevant to the Board's jurisdiction will be held. No action may be taken on a matter not listed on the posted agenda. Comments will be limited to three minutes. Please step up to the speaker's podium, clearly state your name, and address and please ***spell*** your last name for the record.

All comments by speakers should be relevant to the Board's action and jurisdiction.

UMCSN ADMINISTRATION KEEPS THE OFFICIAL RECORD OF ALL PROCEEDINGS OF UMCSN GOVERNING BOARD. IN ORDER TO MAINTAIN A COMPLETE AND ACCURATE RECORD OF ALL PROCEEDINGS, ANY PHOTOGRAPH, MAP, CHART, OR ANY OTHER DOCUMENT USED IN ANY PRESENTATION TO THE BOARD SHOULD BE SUBMITTED TO UMCSN ADMINISTRATION. IF MATERIALS ARE TO BE DISTRIBUTED TO THE BOARD, PLEASE PROVIDE SUFFICIENT COPIES FOR DISTRIBUTION TO UMCSN ADMINISTRATION.

THE BOARD MEETING ROOM IS ACCESSIBLE TO INDIVIDUALS WITH DISABILITIES. WITH TWENTY-FOUR (24) HOUR ADVANCE REQUEST, A SIGN LANGUAGE INTERPRETER MAY BE MADE AVAILABLE (PHONE: 702-765-7949).

University Medical Center of Southern Nevada
Governing Board Meeting
October 29, 2025

Emerald Conference Room (1st Floor)
Delta Point Building
901 Rancho Lane
Las Vegas, Clark County, Nevada
Wednesday, October 29, 2025
2:00 PM

The University Medical Center Governing Board met in regular session, at the location and date above, at the hour of 2:00 PM. The meeting was called to order at the hour of 2:10 PM by Chair O'Reilly. The following members were present, which constituted a quorum of the members thereof:

CALL TO ORDER

Board Members:

Present:
John O'Reilly, Chair
Harry Hagerty, Vice Chair
Donald Mackay, M.D.
Mary Lynn Palenik
Robyn Caspersen
Chris Haase
Laura Lopez-Hobbs (Teams)

Ex-Officio Members:

Present:
Dr. Meena Vohra, Chief of Staff
Alison Netski, Dean of Kirk Kerkorian SOM at UNLV

Absent:
Renee Franklin (Excused)
Bill Noonan (Excused)
John Fildes, MD, Ex-Officio (Excused)

Others Present:
Tony Marinello, Chief Operating Officer
Jennifer Wakem, Chief Financial Officer
Deb Fox, Chief Nursing Officer
Janella Green, Lean Transformation Specialist
Marsha Al-Sayegh, Employee Experience Program Manager
Susan Pitz, General Counsel
Stephanie Ceccarelli, Governing Board Secretary
UMC Tranquility Nursing Team

SECTION 1: OPENING CEREMONIES

CALL TO ORDER

PLEDGE OF ALLEGIANCE

INVOCATION

TRANQUILITY MOMENT

The Board members participated in an interactive exercise related to the healing power of dance and movement.

ITEM NO. 1 PUBLIC COMMENT

Chair O'Reilly asked if there were any persons present in the audience wishing to be heard on any item on this agenda.

Speakers:

Vick Gill – Las Vegas, Nevada – Presented the ACHE Senior Careerist Healthcare Executive Award to Tony Marinello, UMC Chief Operating Officer. Congratulations!

ITEM NO. 2 Approval of Minutes of the regular Meeting of the UMC Governing Board held on September 24, 2025. *(Available at University Medical Center, Administrative Office) (For possible action)*

FINAL ACTION:

A motion was made by Member Mackay that the minutes be approved as presented. Motion carried by unanimous vote.

ITEM NO. 3 Approval of Agenda *(For possible action)*

FINAL ACTION:

A motion was made by Member Hagerty that the agenda be approved as presented. Motion carried by unanimous vote.

SECTION 2: CONSENT ITEMS

ITEM NO. 4 Approve the October 2025 Medical and Dental Staff Credentialing Activities for University Medical Center of Southern Nevada (UMC) as authorized by the Medical Executive Committee (MEC) on October 28, 2025; and take action as deemed appropriate. (For possible action)

DOCUMENT(S) SUBMITTED:
- Credentialing Activities

ITEM NO. 5 **Approve the UMC Policies and Procedures Committee's activities of August 6, 2025, and September 3, 2025, including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate.** ***(For possible action)***

DOCUMENT(S) SUBMITTED:
- Policies and Procedures for August and September

ITEM NO. 6 **Approve and recommend approval by the Board of Hospital Trustees, the proposed amendments to the UMC Medical and Dental Staff Bylaws and Rules & Regulations as approved and recommended by the Medical Executive Committee at its July 22, 2025 meeting; and take any action deemed appropriate.** ***(For possible action)***

DOCUMENT(S) SUBMITTED:
- Medical and Dental Staff Bylaws

ITEM NO. 7 **Approve and authorize the Chief Executive Officer to sign the Amendment One to the Provider Group Services Agreement with Optum Health Networks, Inc. for Managed Care Services; or take action as deemed appropriate.** ***(For possible action)***

DOCUMENT(S) SUBMITTED:
- Group Services Agreement – Amendment 1 – redacted
- Disclosure of Ownership

ITEM NO. 8 **Ratify the Fifth Amendment to the Facility Participation Agreement with United Healthcare Insurance Company for Managed Care Services; or take action as deemed appropriate.** ***(For possible action)***

DOCUMENT(S) SUBMITTED:
- Facility Agreement - Amendment 5
- Disclosure of Ownership

ITEM NO. 9 **Approve and authorize the Chief Executive Officer to sign the Master Services Agreement and Order Forms with Bluesight, Inc. for pharmacy procurement, inventory management and compliance solutions; exercise any extension options and execute future amendments and Order Forms within his yearly delegation of authority; or take action as deemed appropriate.** ***(For possible action)***

DOCUMENT(S) SUBMITTED:
- Master Services Agreement and Order Forms
- Disclosure of Ownership

ITEM NO. 10 **Approve and authorize the Chief Executive Officer to sign the Agreement for Construction Management Services with Grand Canyon Construction, Inc.; execute future amendments and extensions; or take action as deemed appropriate.** ***(For possible action)***

DOCUMENT(S) SUBMITTED:
- Services Agreement
- Disclosure of Ownership

ITEM NO. 11 Approve and authorize the Chief Executive Officer to sign the Purchaser Specific Agreement with Laboratory Corporation of America; execute future amendments and extensions; or take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED:
- Purchaser Specific Agreement – Redacted
- Sourcing Letter
- Disclosure of Ownership

ITEM NO. 12 Approve and authorize the Chief Executive Officer to sign the Equipment Schedule No. 019 to Master Agreement 21237667 with Flex Financial, a division of Stryker Sales, LLC; or take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED:
- Equipment Schedule No. 019 to Master Services Agreement
- Disclosure of Ownership

ITEM NO. 13 Approve and authorize the Chief Executive Officer to sign the Terms and Conditions of Appointment for Resident Physician template agreement; exercise any extension options and amendments; or take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED:
- Terms of Appointment

ITEM NO. 14 Approve and authorize the Chief Executive Officer to sign the First Amendment to Professional Services Agreement (Individual Diagnostic Teleradiology Coverage) with Nicholas M. D'Alesio, DO; or take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED:
- Professional Services Agreement– Amendment 1
- Disclosure of Ownership

FINAL ACTION:
A motion was made by Member Mackay that Consent Items 4-14 be approved as presented. Motion carried by unanimous vote.

SECTION 3: BUSINESS ITEMS

ITEM NO. 15 Receive a presentation from, regarding Information Technology program updates at UMC; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint Presentation

DISCUSSION:

Don Barnwell, UMC Executive Director of Information Technology, provided a high-level overview of the activities of the IT Department.

The mission is to create innovative and reliable information technology solutions to enhance patient care and operational efficiency, as well as to provide secure, seamless, and user-friendly IT services that support UMC's goal of improving healthcare delivery. The department partners with healthcare professionals to deliver exceptional care and improve patient outcomes by fostering a culture of collaboration, continuous improvement, and excellence. Strategic goals and initiatives of the department were provided as informational.

The IT Division is made up of four departments, Analytics, IT Security, Epic and Operations. Mr. Barnwell briefed the Board on the items implemented during 2025 and future integrations for 2026, including UMC Online Care, Payer Platform, UKG upgrade, Epic service account refresh, AI employee awareness training and internet and intranet redesign, as well as other operations upgrades. The team meets with local government entities quarterly to improve collaboration and communication to discuss applications and issues related to cybersecurity. Mr. Barnwell next reviewed the statistics related to production storage, physician and virtual servers and email storage.

In cyber security, there have been approximately 33K threat related detections, with 239 escalated for personnel to investigate, but no incidents were noted.

Mr. Barnwell next discussed the use of augmented artificial intelligence, which does not replace human intelligence, but is a tool to assist in decision making. On the Gardner AI Maturity Model, UMC is between Levels 2 and 3, meaning although AI is actively being used, it is still in the process of creating value, and we are expanding with multiple initiatives. Key achievements and impacts in service delivery were discussed.

Member Hagerty asked how the team is staying ahead of technology trends. Mr. Barnwell noted that UMC is updating network infrastructure and the Windows system.

Chair O'Reilly inquired about the UKG time clock system and if all employees are capable of using the system and if Epic billing is used for professional services. Mr. Barnwell responded that all hourly employees use the UKG system. He next explained the use and process of using the Epic billing system by the providers.

Discussions ensued regarding project management, Windows upgrades, Epic community connect and collaboration with other entities regarding cyber security.

FINAL ACTION:
None

ITEM NO. 16 Receive and discuss the Governing Board 2025 Action Plan, to include a presentation from Shana Tello, UMC Academic and External Affairs Administrator and Lynn Heather, Academic Affiliation Analyst, regarding the Annual Institutional Review (AIR) Summary for Graduate Medical Education; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint Presentation

DISCUSSION:

Shana Tello, UMC Academic and External Affairs Administrator and Lynn Heather, Academic Affiliation Analyst, provided an update regarding the Annual Institutional Review (AIR) Summary for Graduate Medical Education. The ACGME requires that the DIO provides the Board with an update regarding the sponsoring institution and its activities. The GMEC Committee members were reviewed.

Ms. Tello stated that although UMC has received accreditation, two citations were received, and action plans were immediately implemented.

Institutional performance indicators are core focus areas and interviews have begun. Surveys for residents and faculty were listed. Six action plans are in place to ensure compliance. The GMEC will ensure compliance with updates and review of the action plans at each GMEC meeting until voted and approved that all action items have been successfully accomplished.

FINAL ACTION:

None

ITEM NO. 17 Receive a report from the Governing Board Clinical Quality Committee; and take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- None

DISCUSSION:

Member Mackay provided a report on the meeting, which was held on Wednesday, October 6, 2025, at 2:00 p.m. A quorum was in attendance. There was no public comment, and the minutes and agenda were both approved unanimously as presented.

An educational presentation was received by Tory Begay, Emergency Preparedness Coordinator, regarding emergency preparedness program at UMC. Program accomplishments, trainings, engagements, and exercises were reviewed and discussed. Goals for 2025 were outlined.

Patty Scott, Quality, Safety and Regulatory Officer provided an update on the Quality, Safety and Regulatory program. There were 11 safety events reported in Q2, and all matters were reported within the required time frames. Corrective actions were taken on all cases. There were 48 grievances for Q1 and Q2 of 2025.

Next, the committee received an update on the FY2026 Organizational Performance Goals. All goals are in progress to improve hand hygiene compliance.

The Committee reviewed and approved the Policies and Procedures activities and the Medical and Dental Staff Bylaws, both of which are a part of today's consent agenda.

There was one emerging issue identified, no public comment, and the meeting adjourned.

FINAL ACTION:
None

ITEM NO. 18 Receive a report from the Governing Board Strategic Planning Committee; and take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- None

DISCUSSION:

Member Hagerty provided a report on the meeting, which was held on Thursday, October 9th at 2:00 p.m. A quorum was in attendance. There was no public comment, and the minutes and agenda were both approved unanimously as presented.

The Committee reviewed the competitive landscape in Las Vegas for healthcare services, as compared to other facilities in the valley.

Next, the Committee reviewed trends highlighting growth, improvements, and challenges in the focused service lines, which included surgery, orthopedics, cardiac services, ambulatory care, women's and children's services.

There were no emerging issues identified, no public comment, and the meeting adjourned after the closed session. Due to timing constraints, the closed session was continued in a special meeting on October 16, 2025.

FINAL ACTION:
None

ITEM NO. 19 Receive a report from the Governing Board Audit and Finance Committee; and take action as deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- None

DISCUSSION:

Member Caspersen provided a report on the meeting, which was held on Wednesday, October 22, 2025, at 2:00 p.m. A quorum was in attendance. There was no public comment, and the minutes and agenda were both approved unanimously as presented.

The CFO presented a report on the monthly financial results and the fiscal year-end financials for September 2025. The discussion covered factors affecting financial outcomes, comparisons to the budget, as well as operating and financial metrics, and organizational goals. Ms. Wakem also discussed the performance of the Crisis Stabilization Center and remediation steps, as well as any possible impacts received due to the shutdown of the Federal Government.

The other business items were reviewed and approved or ratified by the Committee during the meeting. All of the contracts that were approved during the meeting are a part of today's consent agenda.

There were no emerging issues identified, no public comment, and the meeting adjourned after the closed session.

FINAL ACTION:
None

ITEM NO. 20 Receive the monthly financial report from the Chief Financial Officer for the September FY26 financial report; and take any action deemed appropriate. ***(For possible action)***

DOCUMENT(S) SUBMITTED**:**

- August FY26 Financial Report

DISCUSSION:

Ms. Wakem provided a summary of the monthly financial reports for September FY26.

The key indicators for September year-to-date showed admissions below budget 1,888. There were 732 observation cases. The AADC was 361. Average length of stay was 5.71 days. Overall hospital acuity was 1.88 and Medicare CMI was 2.08. Inpatient surgeries were above budget by 14 cases and outpatient surgeries were below budget 31 cases. There were 17 transplant cases. Approximately 21% of ER patients are being admitted. Quick cares and primary cares were below budget for the month. There were 342 telehealth visits and orthopedic clinic were up significantly, with 811 more patients than expected. There were 109 deliveries. The Crisis Stabilization Center had 162 visits for the month.

The income statement for the month showed operating revenue was $2.5 million below budget. Total operating expenses were $2.9 million below budget. Total

EBITDA was $1.4 million, compared to a budget of $1.3 million, exceeding budget by $153K. Year-to-date statistics were reviewed.

Salaries, wages, and benefits for September showed labor down $1.25 million. Overtime was managed well, but contract labor was up due to radiology. All other expenses were $1.7 million favorable to budget due to supplies.

A conversation ensued regarding the focus on increasing deliveries at the hospital and performance improvement plans to increase births. Additionally, the Board briefly discussed the increase in volume at the Crisis Stabilization Center.

FINAL ACTION:
None

ITEM NO. 21 Receive an update from the Dean of the Kirk Kerkorian School of Medicine at UNLV; and take any action deemed appropriate. (For possible action)

DOCUMENT(S) SUBMITTED**:**
- None

Dean Alison Netski provided highlights on the activities for the School of Medicine.

The Dean shared the following highlights:

The school completed the LCME site visit, the accreditation body of the AAMC for the MD Program. Final feedback will be received by June 2026.

GME: The annual surgical cadaver lab specialty training was held at the school, covering general surgery, plastic surgery, trauma, and OBGYN specialties. A total of 100 fellows, residents, and faculty received specialty training.

The school has hosted 10 Medical Education Program activities, allowing physicians to gain CME credits.

Lastly, the Dean highlighted clinical trial of the MIRA Robot, which will be performed by Dr. Nadia Gomez.

FINAL ACTION:
None

ITEM NO. 22 Receive an update from the Hospital CEO; and take any action deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint Presentation

DISCUSSION:

Tony Marinello, UMC COO, provided the following updates:

- Magnet Health Links prep survey November 3-5th – Thank you to Deb Fox, CNO and the team for your hard work.
- The Magnet survey November 17-19th
- APP Appreciation Breakfast – November 4th
- 8th Annual Research Symposium – November 5th
- DNV Cardiology survey – Nov 4th and 5th
- ACGME Accreditation for UMC's Radiology Program – interviewing residents
- Laughlin's "Connection to UMC Online Care" – Grand opening today at 3:00 p.m.
- Successful "Halloween Safetacular" – hosted over 2000 people for safety event

FINAL ACTION:
None

SECTION 4: EMERGING ISSUES

ITEM NO. 23 Identify emerging issues to be addressed by staff or by the Board at future meetings; and direct staff accordingly. *(For possible action)*

DISCUSSION:
None

FINAL ACTION:
None

COMMENTS BY THE GENERAL PUBLIC:

Comments from the general public were called for:

Speakers: None

A motion was made by Member Mackay that the Board go into the closed sessions.

FINAL ACTION TAKEN:
At this time, Member Hagerty moved to go into the closed session, pursuant to NRS 241.015(4)(c)), as outlined in the agenda. The motion was carried by unanimous vote.

At this time, Member Hagerty moved to go into the closed session, pursuant to NRS 450.140(3), as outlined in the agenda. The motion was carried by unanimous vote.

At 3:39 p.m., the Board recessed to go into closed session.

The meeting reconvened in closed session at 3:48 p.m.

SECTION 5: CLOSED SESSION

ITEM NO. 24 Go into closed session, pursuant to NRS 241.015(4)(c), to receive information from the General Counsel regarding potential or existing litigation involving matters over which the Board had supervision, control, jurisdiction or advisory power, and to deliberate toward a decision on the matters; and direct staff accordingly. *(For possible action)*

ITEM NO. 25 Go into closed session pursuant to NRS 450.140(3) to discuss new or material expansion of UMC's health care services and hospital facilities.

FINAL ACTION:

At the hour of 4:38 p.m., the closed sessions on the above topics ended and the meeting was adjourned.

APPROVED:
Minutes Prepared by: Stephanie Ceccarelli, Governing Board Secretary

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Audit Report of Fiscal Year Ending June 30, 2024**	**Back-up:**
Petitioner:	**Mason Van Houweling, Chief Executive Officer**	**Clerk Ref. #**

Recommendation:

That the Governing Board accept the Fiscal Year 2025 Basic Financial Statements and Single audit Information from BDO USA, LLP, Certified Public Accountants for University Medical Center of Southern Nevada; and take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

Under state law NRS 354.624, UMC is required to obtain an independent audit of all financial records on an annual basis. The firm conducting this financial audit is required to publicly report their findings to the University Medical Center of Southern Nevada Governing Board.

BDO USA, LLP, Certified Public Accountants conducted the audit for the Fiscal Year Ending June 30, 2025. The basic financial statements present fairly, in all material respects, the financial position of the Hospital as of June 30, 2025, and the results of its operations and its cash flows for the years then ended, in conformity with the Generally Accepted Accounting Principles in the United States. All recommendations from the auditor will be addressed.

The Governing Board Audit and Finance Committee reviewed the audited financials at their November 12, 2025 meeting.

Cleared for Agenda
November 19, 2025

Agenda Item #

4

REPORT TO THOSE CHARGED WITH GOVERNANCE

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

AUDIT WRAP UP:
YEAR ENDED JUNE 30, 2025

Contents

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The following communication was prepared as part of our audit, has consequential limitations, and is intended solely for the information and use of those charged with governance (e.g., Board of Directors) and, if appropriate, management of the Company, and is not intended and should not be used by anyone other than these specified parties.

Welcome

BDO USA, P.C.
8548 Rozita Lee Ave., Suite 300
Las Vegas, NV 89113
Tel. 702-784-0000
www.bdo.com

November 6, 2025

Those Charged With Governance
University Medical Center of Southern Nevada

Professional standards require us to communicate with you regarding matters related to the audit, that are, in our professional judgment, significant and relevant to your responsibilities in overseeing the financial reporting process. We presented management an overview of our plan for the audit of University Medical Center of Southern Nevada ("UMC" or the "Hospital") as of and for the year ended June 30, 2025, including a summary of our overall objectives for the audit, and the nature, scope, and timing of the planned audit work.

This communication is intended to elaborate on the significant findings from our audit, including our views on the qualitative aspects of the UMC's accounting practices and policies, management's judgments and estimates, financial statement disclosures, and other required matters.

We are pleased to be of service to UMC and look forward to discussing our audit findings, as well as other matters that may be of interest to you, and to answer any questions you might have.

Respectfully,

BDO USA, P.C.

Executive Summary

Status of Our Audit

We have completed our audit of the financial statements as of and for the year ended June 30, 2025. Our audit was conducted in accordance with auditing standards generally accepted in the United States of America and Government Auditing Standards. This audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

- The objective of our audit was to obtain reasonable - not absolute - assurance about whether the financial statements are free from material misstatements.
- The scope of the work performed was substantially the same as our audit plan.
- We issued an unmodified opinion on UMC's financial statements and released our report on the financial statement audit on November 6, 2025.
- We plan to issue our report for the single audit after the 2025 Compliance Supplement has been released and our procedures completed in accordance with such Compliance Supplement.
- Our responsibility for other information in documents containing UMC's audited financial statements does not extend beyond the financial information identified in the audit report, and we are not required to perform procedures to corroborate such other information. However, in accordance with professional standards, we have read the information included by UMC and considered whether such information, or the manner of its presentation, was materially inconsistent with its presentation in the financial statements. Our responsibility also includes calling to management's attention any information that we believe is a material misstatement of fact. We have not identified any material inconsistencies or concluded there are any material misstatements of facts in the other information that management has chosen not to correct.
- All records and information requested by BDO were freely available for our inspection.
- Management's cooperation was excellent. We received full access to all information that we requested while performing our audit, and we acknowledge the full cooperation extended to us by all levels of Company personnel throughout the course of our work.

Results of the Audit

ACCOUNTING PRACTICES, POLICIES, AND ESTIMATES

The following summarizes the more significant required communications related to our audit concerning the UMC's accounting practices, policies, and estimates:

The UMC's significant accounting practices and policies are those included in Note 1 to the financial statements. These accounting practices and policies are appropriate, comply with generally accepted accounting principles and industry practice, were consistently applied, and are adequately described within Note 1 to the financial statements.

- A summary of recently issued accounting pronouncements is included in Note 2 to the UMC's financial statements.
- There were no other changes in significant accounting policies and practices during fiscal year 2025.

Significant estimates are those that require management's most difficult, subjective, or complex judgments, often as a result of the need to make estimates about the effects of matters that are inherently uncertain. The UMC's significant accounting estimates, including a description of management's processes and significant assumptions used in development of the estimates, are disclosed in Note 1 of the financial statements

Significant Accounting Estimates
Patient Accounts Receivable and Revenue
DSH/MDSP Recoupment Estimate
Medical Malpractice and Worker's Compensation Liabilities
Pension and Other Post employment Benefits

- Management did not make any significant changes to the processes or significant assumptions used to develop the significant accounting estimates in 2025.

Results of the Audit

QUALITY OF THE HOSPITAL's FINANCIAL REPORTING

A discussion was held regarding the quality of the Hospital's financial reporting, which included:

Results of the Audit

CORRECTED AND UNCORRECTED MISSTATEMENTS

There were no corrected misstatements to accounts and/or disclosures that we brought to the attention of management.

There were no uncorrected misstatements related to accounts and/or disclosures that we presented to management.

Internal Control Over Financial Reporting

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the UMC's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the UMC's internal control. Accordingly, we do not express an opinion on the effectiveness of the UMC's internal control.

Our consideration of internal control was for the limited purpose described above and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses.

We are required to communicate, in writing, to those charged with governance all material weaknesses and significant deficiencies that have been identified in the UMC's internal control over financial reporting. The definitions of control deficiency, significant deficiency and material weakness follow:

Category	Definition
Control Deficiency	A deficiency in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.
Significant Deficiency	A deficiency or combination of deficiencies in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.
Material Weakness	A deficiency or combination of deficiencies in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of UMC's financial statements will not be prevented or detected and corrected on a timely basis.

In conjunction with our audit of the financial statements, we noted no material weaknesses.

Additional Required Communications

Other Required Communications

Following is a summary of other required items, along with specific discussion points as they pertain to the Company:

Requirement	Discussion Point
Significant changes to planned audit strategy or significant risks initially identified	There were no significant changes to the planned audit strategy or significant risks initially identified and previously communicated to those charged with governance as part of our Audit Plan communications.
Obtain information from those charged with governance relevant to the audit	There were no matters noted relevant to the audit, including, but not limited to: violations or possible violations of laws or regulations; risk of material misstatements, including fraud risks; or tips or complaints regarding UMC's financial reporting that we were made aware of as a result of our inquiry of those charged with governance.
Nature and extent of specialized skills or knowledge needed related to significant risks	There were no specialized skills or knowledge needed, outside of the core engagement team, to perform the planned audit procedures or evaluate audit results related to significant risks.
Consultations with other accountants	We are not aware of any consultations about accounting or auditing matters between management and other independent public accountants. Nor are we aware of opinions obtained by management from other independent public accountants on the application of generally accepted accounting principles.
Significant findings and issues arising during the audit in connection with the Hospital's related parties	We have evaluated whether the identified related party relationships and transactions have been appropriately identified, accounted for, and disclosed and whether the effects of the related party relationships and transactions, based on the audit evidence obtained, prevent the financial statements from achieving fair presentation.
Significant findings or issues arising during the audit that were discussed, or were the subject of correspondence, with management	There were no significant findings or issues arising during the audit that were discussed, or were the subject of correspondence, with management.

Other Required Communications (cont.)

Following is a summary of other required items, along with specific discussion points as they pertain to the Company:

Requirement	Discussion Point
Disagreements with management	There were no disagreements with management about matters, whether or not satisfactorily resolved, that individually or in aggregate could be significant to UMC's financial statements or to our auditor's report
Significant difficulties encountered during the audit	There were no significant difficulties encountered during the audit.
Matters that are difficult or contentious for which the auditor consulted outside the engagement team	There were no difficult or contentious matters that we consulted with others outside the engagement team that we reasonably determined to be relevant to those charged with governance regarding their oversight of the financial reporting process.
If applicable, other matters significant to the oversight of the Hospital's financial reporting process, including complaints or concerns regarding accounting or auditing matters	There are no other matters that we consider significant to the oversight of UMC's financial reporting process that have not been previously communicated.
Representations requested from management	Please refer to the management representation letter.

Independence

Our engagement letter to you dated May 5, 2025, describes our responsibilities in accordance with professional standards and certain regulatory authorities with regard to independence and the performance of our services. This letter also stipulates the responsibilities of UMC with respect to independence as agreed to by UMC. Please refer to that letter for further information.

Appendix

BDO's System of Quality Management

An audit firm's effective system of quality management ("SoQM") is crucial for supporting the consistent performance of high-quality audits and reviews of financial statements, or other assurance or related services engagements under professional standards, and applicable legal and regulatory requirements.

Accordingly, BDO has implemented a SoQM designed to provide reasonable assurance that its professionals fulfill their responsibilities and conduct engagements in accordance with those standards and requirements. The firm's SoQM supports the consistent performance of quality audits through many ongoing activities including, at least annually, certification by leaders with responsibility for key controls and related processes. Our Assurance Quality Management team performs regular reviews and testing of key controls and processes throughout the SoQM and identifies and communicates areas for improvement. In addition, our Audit Quality Advisory Council supports our SoQM by providing guidance and input on audit quality initiatives.

As required by International Standard on Quality Management 1 (ISQM 1) under the International Auditing and Assurance Standards Board (IAASB), BDO has conducted an evaluation of the effectiveness of its system of quality management and concluded, as of July 31, 2024, that, except for certain deficiencies related to the execution of its issuer audits, that system provides the reasonable assurance that our professionals will perform audits and reviews of financial statements or related assurance services engagements in accordance with professional standards, and applicable legal and regulatory requirements. BDO has either implemented or is designing remedial actions to address those deficiencies prior to our next evaluation.

We will continue to provide you with updates on our progress. Currently, you may find discussion of BDO's system of quality management within our annual Audit Quality Reports, the most recent of which is accessible here.

About BDO USA

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Material discussed is meant to provide general information and should not be acted on without professional advice tailored to your needs.

UNIVERSITY MEDICAL CENTER

BASIC FINANCIAL STATEMENTS

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

(A COMPONENT UNIT OF CLARK COUNTY, NEVADA)

YEARS ENDED JUNE 30, 2025 AND 2024

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
(A COMPONENT UNIT OF CLARK COUNTY, NEVADA)

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Independent Auditor's Report

UMC Governing Board
University Medical Center of Southern Nevada
Las Vegas, Nevada

Report on the Audit of the Financial Statements

Opinions

We have audited the financial statements of the University Medical Center of Southern Nevada ("UMC"), a component unit of Clark County, Nevada as of and for the years ended June 30, 2025 and 2024, and the related notes to the financial statements, which collectively comprise UMC's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of UMC, as of June 30, 2025 and 2024, and the respective changes in financial position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of UMC and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about UMC's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 UMC's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the UMC's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis and Schedule of the Hospital's Proportionate Share of the Net Pension Liability Public Employees' Retirement System of Nevada, Schedule of Hospital's Contributions Public Employees' Retirement System of Nevada, and Schedule of Changes in Total OPEB Liability and Related Ratios on pages 4 through 14 and 70 through 73 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's

responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the UMC's basic financial statements. The Statements of Revenues and Expenses Budget to Actual Comparison, Statements of Cash Flows Budget to Actual Comparison, and Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards are presented for purposes of additional analysis and are not a required part of the basic 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 basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the accompanying Statements of Revenues and Expenses Budget to Actual Comparison, Statements of Cash Flows Budget to Actual Comparison, Schedule of Expenditures of Federal Awards is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 6, 2025 on our consideration of the UMC's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the UMC's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the UMC's internal control over financial reporting and compliance

BDO USA, P.C.

Las Vegas, Nevada
November 6, 2025

Management's Discussion and Analysis

This section of the annual financial report of the University Medical Center of Southern Nevada (the Hospital) presents background information and our analysis of the Hospital's financial performance during the fiscal years ended June 30, 2025, 2024, and 2023 which management believes is relevant for an understanding of our financial condition and results of operations. This discussion should be read in conjunction with the basic financial statements and the related notes included in this report. This discussion and analysis is designed to focus on current activities, resulting changes, and currently known facts. The financial statements, notes thereto, and this discussion and analysis are the responsibility of the Hospital's management.

Overview of the Financial Statements

This annual report consists of financial statements prepared in accordance with the provisions of Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements and Management's Discussion and Analysis — for State and Local Governments* as amended by GASB Statement No. 37, *Basic Financial Statements — and Management's Discussion and Analysis — for State and Local Governments: Omnibus* and GASB Statement No. 38, *Certain Financial Statement Note Disclosures*. These standards establish comprehensive financial reporting standards for all state and local governments and related entities.

The Hospital's financial statements are prepared on the accrual basis in accordance with accounting principles generally accepted in the United States of America as promulgated by the GASB. The Hospital is structured as a single enterprise fund with revenues recognized when earned, not when received. Expenses are recognized when incurred, not when paid. Capital assets are capitalized and are depreciated (except land and construction in progress) over their estimated useful lives. See the *Notes to Financial Statements* for a summary of the Hospital's significant accounting policies.

Following this discussion and analysis are the basic financial statements of the Hospital together with the notes, which are essential to a complete understanding of the data. The Hospital's basic financial statements are designed to provide readers with a broad overview of the Hospital's finances.

The *Statements of Net Position* presents information on all of the Hospital's assets and liabilities, with the difference between the two reported as net position. Over time, increases and decreases in net position may serve as a useful indicator of the Hospital's financial position; however, other nonfinancial factors such as change in economic conditions, population growth, including uninsured and underinsured patients, and new or changed government legislation should also be considered.

The *Statements of Revenues, Expenses, and Changes in Net Position* presents information showing how the Hospital's net position changed during each year. All changes in net position are reported as soon as the underlying event giving rise to the change occurs, regardless of timing of related cash flows. Thus, revenues and expenses are reported in the statement for some items that will result in cash flows in future periods.

The *Statements of Cash Flows* relates to the flows of cash and cash equivalents. Consequently, only transactions that affect the Hospital's cash accounts are presented in this statement. A reconciliation is provided at the bottom of the *Statements of Cash Flows* to assist in the understanding of the difference between cash flows from operating activities and operating income or loss.

The Hospital is the public health care facility for Clark County, Nevada (the County). The Board of County Commissioners is, ex officio, the Board of Hospital Trustees, per Chapter 450 of the Nevada Revised Statutes. The seven-member Board of Commissioners is elected from geographic districts on a partisan basis for staggered four-year terms. Commissioners elect a chairperson who serves as the Commission's presiding officer. In 2014 the Commissioners created the UMC Governing Board and selected nine individuals from the community to serve on the board. The UMC Governing Board provides oversight of the Hospital and reports back to the Board of Hospital Trustees.

In accordance with GASB Statement No. 14, *The Reporting Entity* and GASB Statement No. 39, *Determining Whether Certain Organizations are Component Units*, the Hospital's financial statements are included, as a blended component unit, in the County's Annual Comprehensive Financial Report (ACFR). A copy of the ACFR can be obtained from Anna Danchik, Comptroller, 500 South Grand Parkway, Las Vegas, Nevada 89155.

Financial and Operating Highlights for Fiscal 2025

- Overall activity at the Hospital as measured by patient days adjusted for outpatient services (adjusted patient days) increased by 2.9% from prior year levels.
    - Hospital patient days increased by 1.0% from the prior year.
    - Outpatient visits decreased by 1.7% from the prior year.

- The Hospital experienced loss from operations of $11.0 million, and total net position increased by $4.8 million.
    - The Upper Payment Limit (UPL) and Indigent Accident Fund (IAF) revenues decreased $12.3 million from the prior year to $105.6 million.
    - The Medicaid State Directed Payment (MSDP) revenues increased $13.5 million from the prior year to $245.0 million.

- Total operating revenues increased by 7.3% to $1,043 million.
- Operating expenses, including other postemployment benefits (OPEB) and provision for NPL (GASB 68), increased by 5.6% to $1,054 million as compared to the prior year.

- Total employee full-time equivalents (FTEs) increased by 96, or 2.5%, from fiscal 2024.

- The Hospital invested $36.8 million in the following capital acquisitions:
  - Ventilator Replacements
  - DaVinci 5 Single Console System
  - Ortho Clinic Phase 2
  - Cath Lab # 3 Imaging Equipment
  - Hospital Wide Computer Refresh

Financial and Operating Highlights for Fiscal 2024

- Overall activity at the Hospital as measured by patient days adjusted for outpatient services (adjusted patient days) decreased by 9.6% from prior year levels.
  - Hospital patient days decreased by 13.3% from the prior year.
  - Outpatient visits decreased by 0.6% from the prior year.

- The Hospital experienced loss from operations of $26.5 million, and total net position decreased by $13.4 million.
  - The Upper Payment Limit (UPL) and Indigent Accident Fund (IAF) revenues increased $11.7 million from the prior year to $118.0 million.
  - The Medicaid State Directed Payment (MSDP) revenues increased $80.2 million from the prior year to $231.5 million.
  - Total operating revenues increased by 13.1% to $972.0 million.
  - Operating expenses, including other postemployment benefits (OPEB) and provision for NPL (GASB 68), increased by 16.0% to $998.5 million as compared to the prior year.

- Total employee full-time equivalents (FTEs) increased by 216, or 5.9%, from fiscal 2023.

- The Hospital invested $51.5 million in the following capital acquisitions:
  - CPH Infrastructure Installation
  - 710 S. Tonopah Building and Parking Garage Purchase
  - 5755 E. Charleston Building Purchase

- 820 Rancho Lane Building Purchase
- CT Scan IR X-Ray Trauma Project

Financial Analysis of the Hospital for June 30, 2025 and 2024

In fiscal 2025, net position increased $4.8 million to a deficit of $196.4 million, from a deficit of $201.2 million in fiscal 2024, primarily due to loss from operations, being offset by contributions from the County. In fiscal 2024, net position decreased $13.4 million to a deficit of $201.2 million, from a deficit of $187.8 million in fiscal 2023, primarily due to loss from operations, being offset by contributions from the County.

(Remainder of page intentionally left blank)

A summary of the Hospital's Statements of Net Position as of June 30, 2025, 2024 and 2023 is presented in Table 1 below:

Table 1
Condensed Statements of Net Position (Deficit)
(In Thousands)

	2025	2024	2023
Current assets	$ 381,079	$ 384,409	$ 439,369
Restricted and other assets	65,813	77,678	65,772
Capital assets	368,692	312,199	255,387
Total assets	$ 815,584	$ 774,286	$ 760,528
Deferred outflows of resources	354,903	331,739	298,253
Current liabilities	164,828	157,415	160,796
Other liabilities (a)	978,084	979,455	897,618
Total liabilities	1,142,912	1,136,870	1,058,414
Deferred inflows of resources	223,949	170,330	188,154
Net investment in capital assets	302,211	271,162	253,941
Restricted	4,476	4,320	4,363
Unrestricted (deficit)	(503,061)	(476,656)	(446,091)
Total net position (deficit)	(196,374)	(201,174)	(187,787)
Total liabilities, deferred inflows and net position (deficit)	$ 1,170,487	$ 1,106,026	$ 1,058,781

(a) Other liabilities include the long-term portion of accrued benefits, self-insured liabilities, intergovernmental, lease payable, subscription payable, and net pension liabilities.

Summary of Revenues, Expenses, and Changes in Net Position

The following table presents a summary of the Hospital's revenues and expenses for the years ended June 30, 2025, 2024, and 2023.

Table 2
Condensed Statements of Revenues, Expenses, and
Changes in Net Position
(In Thousands)

	2025	2024	2023
Net patient revenues	$ 993,620	$ 926,667	$ 818,955
Other operating revenues	49,320	45,315	40,176
Total operating revenues	1,042,940	971,982	859,131
Operating expenses	1,004,472	950,883	816,390
Depreciation and amortization	49,456	48,106	44,108
	1,053,928	998,989	860,498
Operating income/(loss)	(10,988)	(27,007)	(1,367)
Nonoperating revenues, net	10,233	3,620	6,953
Transfers In	5,554	10,000	31,000
Change in net position (deficit)	4,799	(13,387)	36,586
Total net position (deficit), beginning of year	(201,174)	(187,787)	(224,385)
GASB No. 96 / 87 Adjustment	-	-	12
Total net deficit, end of year	$ (196,375)	$ (201,174)	$ (187,787)

During fiscal 2025, 2024 and 2023, the Hospital derived approximately 98.9%, 99.6% and 99.2% respectively, of its total revenues from operating revenues. Operating revenues include, among other items, revenues from the Medicare and Medicaid programs, the Clark County Social Services program, patients or their third-party carriers that pay for their care in the Hospital's facilities, and grant revenues.

Table 3 presents the relative percentages of gross charges billed for patient services by payer for the years ended June 30, 2025, 2024 and 2023.

Table 3
Payer Mix by Percentage

	2025	2024	2023
Medicare	32 %	32 %	32 %
Medicaid, and self-pay	40	41	41
Commercial, HMO, PPO	22	22	22
Other	6	5	5
Total patient revenue	100 %	100 %	100 %

During fiscal 2025, 2024 and 2023, the Hospital derived 1.09%, 0.49% and 0.98%, respectively, of its total revenues from interest income on its general funds, capital funds, restricted funds, debt service and malpractice funds. The Hospital's cash is deposited with the County Treasurer and funds in the custody of the County Treasurer are invested as a pool. Other non-operating revenues in fiscal 2025, 2024 and 2023 include $5.6 million, $10 million and $31 million, respectively, in contributions from the County used primarily to defray operating, capital and debt service costs.

Fiscal 2025 Activity

In fiscal 2025, overall activity at the Hospital as measured by patient days adjusted for outpatient services increased by 2.9% to 224,610 compared to 218,184 in fiscal 2024. This increase was due primarily to a 1.0% increase in patient days.

In fiscal 2025, the Hospital had patient days and discharges of 139,665 and 23,997, respectively. This was an increase of 1.0% and 3.1%, respectively, as compared to fiscal 2024. Outpatient and emergency visits were 487,195 or 1.7% below 2024 levels of 495,495. The decrease in outpatient volume occurred primarily due to a decrease in Primary Care and Quick Care registrations of 9.1%, being offset by an increase in emergency registrations of 2.0%.

In fiscal 2025, net patient revenue increased compared to fiscal 2024 by $67.0 million due primarily to improved patient volume.

Excluded from net patient revenue are charges foregone for uncompensated and charity care patient services. Based on established rates, gross charges of $115,733,984 million were foregone during fiscal 2025, a 7.7% increase from fiscal 2024. The Hospital's level of uncompensated and charity care continues to reflect the Hospital's status as a safety net facility in the County.

In fiscal 2025, total operating expenses including OPEB and pension increased by $55.4 million, or 5.6%. The increase was mainly due to a $90.1 million increase in operating expense and being offset by a $34.9 million decrease in OPEB and pension provision.

In fiscal 2025, employee compensation and benefits increased $74.8 million, or 12.9%, primarily due to increases in physician pay, paid time off to cover nursing shifts, and a 13% increase in retirement contributions. The number of paid FTEs increased by 2.5% from 3,882 in fiscal 2024 to 3,978 in fiscal 2025. There was a 3% cost of living increase in fiscal 2025, and 3% cost of living increase in fiscal 2024.

Professional fees for contracted physician services to provide coverage for emergency services, trauma services, and for indigent patients decreased $6.9 million, or 19.4%, in fiscal 2025. This is primarily due to reduced anesthesia service due to in-house service at the Hospital.

In fiscal 2025 the cost of supplies increased by $23.3 million, or 13.4%, primarily due to increases in cost related to chargeable medical supplies and implantables.

Purchased services expense increased by $8.7 million or 9.9% in fiscal year 2025 primarily due to increases in purchasing professional service and software support and maintenance.

Non-operating revenue (expense) consists of gain on the change of the investments, interest of capital leases and right to use subscriptions, and disposals of fixed assets.

The County contributed a total of $5.6 million to the Hospital in fiscal 2025 for additional capital equipment and hospital operation.

Net position increased $4.8 million to a deficit of $196.4 million in fiscal 2025 primarily due to a loss from operations, being offset by contributions from the County.

Fiscal 2024 Activity

In fiscal 2024, overall activity at the Hospital as measured by patient days adjusted for outpatient services decreased by 9.6% to 218,184 compared to 241,399 in fiscal 2023. This decrease was due primarily to a 13.3% decrease in patient days.

In fiscal 2024, the Hospital had patient days and discharges of 138,231 and 23,276, respectively. This was a decrease of 13.3% and 0.5%, respectively, as compared to fiscal 2023. Outpatient and emergency visits were 495,495 or 0.6% below revised 2023 levels of 498,688. The increase in outpatient volume occurred primarily due to an increase in Primary Care and Quick Care registrations of 9.3%, being offset by a decrease in emergency registrations of 4.0%.

In fiscal 2024, net patient revenue increased compared to fiscal 2023 by $107.7 million due primarily to increased supplemental payments.

Excluded from net patient revenue are charges foregone for uncompensated and charity care patient services. Based on established rates, gross charges of $107.5 million were foregone during fiscal 2024, a 9.5% decrease from fiscal 2023. The Hospital's level of uncompensated and charity care continues to reflect the Hospital's status as a safety net facility in the County.

In fiscal 2024, total operating expenses including OPEB and pension increased by $138.0 million, or 16.0%. The increase was mainly due to a $98.5 million increase in operating expense and $39.5 million increase in OPEB and pension provision.

In fiscal 2024, employee compensation and benefits increased $71.8 million, or 14.1%, primarily due to increases in registered nurses pay, in-house radiology physician services, bonus pay, paid time off to cover nursing shifts, and a mandated 3.75% increase in retirement contributions. The number of paid FTEs increased by 5.9% from 3,666 in fiscal 2023 to 3,882 in fiscal 2024. There was a 3% cost of living increase in fiscal 2024, and 3% cost of living increase in fiscal 2023.

Professional fees for contracted physician services to provide coverage for emergency services, trauma services, and for indigent patients decreased $3.5 million, or 9.1%, in fiscal 2024. This is primarily due to reduced anesthesia service due to in-house service at the Hospital.

In fiscal 2024 the cost of supplies increased by $19.2 million, or 12.4%, primarily due to increases in cost related to chargeable medical supplies and implantables.

Purchased services expense increased by $0.9 million or 1.0% in fiscal year 2024 primarily due to increases in advertising and ad hoc services.

Non-operating revenue (expense) consists of gain on the change of the investments, interest of other bonds, interest of capital leases and right to use subscriptions, and disposals of fixed assets.

The County contributed a total of $10 million to the Hospital in fiscal 2024 for additional capital equipment and hospital operation.

Net position decreased $13.4 million to a deficit of $201.2 million in fiscal 2024 primarily due to a loss from operations, being offset by contributions from the County.

Capital Assets

During fiscal 2025 and 2024, the Hospital invested $36.8 million and $51.5 million, respectively, in a broad range of capital assets. Gross capital assets increased in fiscal 2025 due to an increase in ventilator replacements, DaVinci 5 Single Console System, Ortho Clinic Phase 2, Cath Lab # 3 Imaging Equipment, and Hospital Wide Computer Refresh.

The Hospital's fiscal 2026 capital budget included up to $48.9 million for capital projects, consisting of critical patient-related equipment replacement items, facility remodeling and repairs, IT software and infrastructure upgrades, operational equipment, and service line enhancements.

The Hospital is subject to several contracts and commitments relating to construction projects and services. These commitments are not expected to significantly affect the availability of fund resources for future use.

Long-Term Debt

At June 30, 2025 and 2024, the Hospital had no debt on book due to final payoff in September 2023.

Economic Factors

The most recent unemployment statistics, as of August 28 2025, indicated that the unemployment rate for the Las Vegas, Nevada metropolitan area was 6.0%, which was a 0.4% decrease from a year ago. The unemployment rate for the State of Nevada and the United States was 5.6% and 4.6%, respectively.

Inflationary trends in the County are comparable to the United States national indices.

All of these factors affected the fiscal year 2025 operating and financial performance. The focus of management in the near term is to develop a multi-year plan that will emphasize revenue generation, cost control, fiscal discipline, capital requirements, and financing in support of net asset stability and a focus on the core services provided to patients.

Contacting the Hospital's Financial Management

This financial report is designed to provide our citizens, customers, and creditors with a general overview of the Hospital's finances and to demonstrate the Hospital's accountability for the money it receives. If you have any questions about this report or need additional financial information, contact the Finance Department, University Medical Center of Southern Nevada, 1800 West Charleston Blvd., Las Vegas, Nevada 89102.

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada

Statements of Net Position

	June 30 2025	June 30 2024
Assets		
Current assets:		
Cash and cash equivalents	**$ 61,038,072**	**$ 159,715,101**
Assets limited as to use, current portion	**5,950,338**	**9,959,659**
Patient receivables, net of allowance for uncollectible accounts of $170,113,495 in 2025 and $161,918,030 in 2024	**280,943,014**	**183,022,599**
Other receivables, net	**8,394,229**	**8,469,941**
Inventories	**19,374,223**	**17,503,188**
Prepaid expenses and other	**5,378,764**	**5,738,598**
Total current assets	**381,078,640**	**384,409,086**
Non-current assets:		
Assets limited as to use, net of current portion:		
Contributor or grantor restricted:		
Cash and cash equivalents	**4,342,520**	**3,710,239**
Grants receivable	**200,324**	**537,909**
Internally designated cash and cash equivalents	**67,139,150**	**83,257,477**
	71,681,994	**87,505,625**
Less amount required to meet current obligations	**(5,950,338)**	**(9,959,659)**
Total assets limited as to use, net of current portion	**65,731,656**	**77,545,966**
Land	**10,204,997**	**10,204,997**
Depreciable property and equipment, net	**214,725,973**	**207,630,261**
Construction in progress	**78,529,326**	**53,112,703**
Leased assets, net	**46,902,639**	**21,653,025**
Subscription assets, net	**18,329,005**	**19,598,319**
Deposits	**81,656**	**131,656**
Total assets	**$ 815,583,892**	**$ 774,286,013**
Deferred outflows of resources		
Related to pensions	**$ 289,066,699**	**$ 268,233,124**
Related to OPEB (postemployment benefits other than pensions)	**65,836,184**	**63,506,131**
Total deferred outflows of resources	**$ 354,902,883**	**$ 331,739,255**

(Continued)

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada

Statements of Net Position (continued)

	June 30 2025	June 30 2024
Liabilities, deferred inflows of resources and net position		
Current liabilities:		
Accounts payable	**$ 73,383,182**	**$ 72,585,294**
Accrued compensation and benefits	**59,091,072**	**54,014,440**
Other accrued expenses	**820,700**	**852,556**
Current portion of lease payable	**7,551,957**	**7,178,822**
Current portion of subscription payable	**9,405,787**	**7,493,060**
Due to related party	**7,317,595**	**7,274,464**
Current portion of self-insurance liability	**7,257,333**	**8,016,022**
Total current liabilities	**164,827,626**	**157,414,658**
Non -current liabilities:		
OPEB liability	**223,063,598**	**206,347,989**
Lease payable, net of current portion	**40,800,092**	**15,549,064**
Subscription payable, net of current portion	**5,971,715**	**8,377,265**
Self-insurance liability, net of current portion	**10,059,138**	**14,667,167**
Intergovernmental liability	**21,511,629**	**17,674,428**
Net pension liability	**676,678,238**	**716,838,932**
Total liabilities	**1,142,912,036**	**1,136,869,503**
Deferred inflows of resources		
Related to lease	**27,805**	**177,370**
Related to pensions	**102,829,561**	**29,968,440**
Related to OPEB	**121,091,742**	**140,183,948**
Total deferred inflows of resources	**223,949,108**	**170,329,758**
Net position:		
Net investment in capital assets	**302,211,275**	**271,162,035**
Restricted:		
Donations, various programs	**2,201,900**	**2,245,853**
Research programs	**918,572**	**738,535**
Educational programs	**1,355,213**	**1,335,209**
	4,475,685	**4,319,597**
Unrestricted (deficit)	**(503,061,330)**	**(476,655,625)**
Total net position (deficit)	**$ (196,374,370)**	**$ (201,173,993)**

See accompanying notes.

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada

Statements of Revenues, Expenses, and Changes in Net Position (Deficit)

	Years Ended June 30	
	2025	**2024**
Operating revenues:		
Net patient revenues (net of provisions for bad debts of $42,286.202 and $38,682,343 in 2025 and 2024, respectively)	**$ 993,620,259**	**$ 926,666,768**
Other operating revenues	**49,319,946**	**45,314,675**
Total operating revenues	**1,042,940,205**	**971,981,443**
Operating expenses:		
Nursing and other professional services	**754,063,013**	**670,116,099**
Administrative and fiscal services	**165,154,201**	**167,449,609**
General services	**73,490,570**	**66,617,607**
Depreciation and amortization	**49,455,802**	**48,105,549**
Total operating expenses	**1,042,163,586**	**952,288,864**
Income (loss) from operations before provision for OPEB and net pension liabilities	**776,619**	**19,692,579**
Provision for OPEB	**(102,650)**	**1,462,544**
Provision for net pension liabilities	**11,866,853**	**45,237,765**
Income (loss) from operations	**(10,987,584)**	**(27,007,730)**
Nonoperating revenues (expenses):		
Gain on the change of the investments	**11,382,309**	**4,807,097**
Rental income (loss)	**(2)**	**(46,972)**
Interest expense	**(1,062,148)**	**(1,143,264)**
Other nonoperating revenues (expenses)	**(87,175)**	**3,563**
Total nonoperating revenues, net	**10,232,984**	**3,620,424**
Income before transfers	**(754,600)**	**(23,387,306)**
Transfers in	**5,554,223**	**10,000,000**
Change in net position	**4,799,623**	**(13,387,306)**
Net position, beginning of year	**(201,173,993)**	**(187,786,687)**
Net position, end of year	**$ (196,374,370)**	**$ (201,173,993)**

See accompanying notes.

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada

Statements of Cash Flows

	Years Ended June 30	
	2025	**2024**
Cash flows from operating activities		
Cash received from patients and third-party payers	**$ 899,537,045**	**$ 1,088,392,162**
Cash payments to suppliers for goods and services	**(414,707,670)**	**(384,385,733)**
Cash payments to employees for services and benefits	**(631,334,909)**	**(561,547,634)**
Other operating receipts	**49,657,531**	**45,431,295**
Net cash provided by (used in) operating activities	**(96,848,003)**	**187,890,090**
Cash flows from noncapital financing activities		
Contributions and transfers in from Clark County	**5,554,223**	**10,000,000**
Net cash provided by noncapital financing activities	**5,554,223**	**10,000,000**
Cash flows from capital and related financing activities		
Purchase of property and equipment, net	**(34,164,429)**	**(67,139,224)**
Principal paid on long-term debt	**–**	**(6,556,361)**
Interest paid on long-term debt	**–**	**(104,971)**
Other	**(87,175)**	**3,564**
Net cash used in capital and related financing activities	**(34,251,604)**	**(73,796,992)**
Cash flows from investing activities		
Gain on change of the investments	**11,382,309**	**4,807,097**
Increase (decrease) in cash and cash equivalents	**(114,163,075)**	**128,900,195**
Cash and cash equivalents, beginning of year	**246,682,817**	**117,782,622**
Cash and cash equivalents, end of year	**$ 132,519,742**	**$ 246,682,817**
Unrestricted cash and cash equivalents	**$ 61,038,072**	**$ 159,715,101**
Contributor or grantor restricted cash and cash equivalents	**4,342,520**	**3,710,239**
Internally designated cash and cash equivalents	**67,139,150**	**83,257,477**
Total cash and cash equivalents	**$ 132,519,742**	**$ 246,682,817**

(Continued)

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada

Statements of Cash Flows (continued)

	Years Ended June 30	
	2025	**2024**
Reconciliation of loss from operations to net cash provided by (used in) operating activities		
Loss from operations	**$ (10,987,584)**	**$ (26,519,195)**
Adjustments to reconcile loss from operations to net cash used in operating activities:		
Depreciation and amortization	**49,455,802**	**48,105,549**
Provision for uncollectible accounts	**42,286,202**	**38,682,343**
Changes in operating assets and liabilities:		
Decrease (increase) in:		
Patient receivables	**(140,206,617)**	**134,604,073**
Inventories	**(1,871,036)**	**(1,683,225)**
Prepaid expenses and other	**773,128**	**253,341**
Deferred outflows of resources	**(23,163,627)**	**(33,494,950)**
Increase (decrease) in:		
Deposits	**50,000**	**50,000**
Accounts payable and accrued expenses	**(21,319,340)**	**(35,150,371)**
Self-insurance liability	**(5,366,718)**	**5,491,253**
Due to related party	**43,131**	**(11,042,946)**
Deferred inflows of resources	**13,458,656**	**68,594,218**
Net cash provided by (used in) operating activities	**$ (96,848,003)**	**$ 187,890,090**

See accompanying notes.

Overview of the Financial Statements

This annual report consists of financial statements prepared in accordance with the provisions of Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements and Management's Discussion and Analysis — for State and Local Governments* as amended by GASB Statement No. 37, *Basic Financial Statements — and Management's Discussion and Analysis — for State and Local Governments: Omnibus* and GASB Statement No. 38, *Certain Financial Statement Note Disclosures*. These standards establish comprehensive financial reporting standards for all state and local governments and related entities.

1. Description of Reporting Entity and Summary of Significant Accounting Policies

Reporting Entity

University Medical Center of Southern Nevada (the Hospital), the public health care facility for Clark County, Nevada (the County), is a blended component unit of the County, and is reflected as an enterprise fund of the County. The Hospital is organized and operated by The Board of County Commissioners, ex officio, the Board of Hospital Trustees, per Chapter 450 of the Nevada Revised Statutes. The seven-member commission is elected from geographic districts on a partisan basis for staggered four-year terms. Commissioners elect a chairperson who serves as the Commission's presiding officer. In 2014 the Commissioners created the UMC Governing Board and selected nine individuals from the community to serve on the board. The UMC Governing Board provides oversight of the Hospital and reports back to the Board of Hospital Trustees. As the Hospital is a component unit of the County, it is exempt from income tax and, accordingly, no provision for income taxes is required.

In accordance with GASB Statement No. 14, *The Reporting Entity* and GASB Statement No. 39, *Determining Whether Certain Organizations are Component Units*, the Hospital's financial statements are included, as a blended component unit, in the County's Annual Comprehensive Financial Report (ACFR). A copy of the ACFR can be obtained from Anna Danchik, Comptroller, 500 South Grand Parkway, Las Vegas, Nevada 89155.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Summary of Significant Accounting Policies

The financial statements of the Hospital are prepared under accounting principles generally accepted in the United States of America applicable to state and local governmental entities on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred. Substantially all revenues and expenses are subject to accrual.

The Hospital is accounted for as a proprietary fund (enterprise fund) using the flow of economic resources measurement focus and the accrual basis of accounting. With this measurement focus, all assets and all liabilities associated with the Hospital's operations are included in the *Statement of Net Position*. Revenue is recognized in the period in which it is earned and expenses are recognized in the period in which incurred.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ materially from those estimates.

Cash, Cash Equivalents, and Investments

Cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less at date of purchase, excluding amounts held under trust agreements. The Hospital's restricted and unrestricted cash is deposited with the County Treasurer (the Treasurer) in a fund similar to an external investment pool that is reported at fair value. Because the amounts deposited with the Treasurer are sufficiently liquid to permit withdrawals in the form of cash at any time without prior notice or penalty, they are deemed to be cash equivalents. GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*, requires the County to adjust the carrying amount of its investment portfolio to reflect the change in fair market values. Interest revenue is increased or decreased in relation to this adjustment of unrealized gain or loss. Net interest income reflects this positive or negative market value adjustment. Financial information required by GASB Statements No. 3, No. 40 and No. 72 regarding the accounting and financial reporting for the Hospital's investment pool, held by the Clark County Treasurer, has been disclosed in the Clark County Annual Comprehensive Financial Report (ACFR) for the years ended June 30, 2025, and June 30, 2024.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market, generally determined on the first-in, first-out method.

Restricted Assets

Restricted assets are cash and cash equivalents and investments whose use is limited by legal or other requirements. Restricted cash and cash equivalents represent monies received from donors or grantors to be used for specific purposes, as well as the Hospital's proportionate share of collateral assets held under securities lending transactions and those whose purpose was limited by the contributor and/or grantor. The Hospital has elected to use restricted assets before unrestricted assets when an expense is incurred for a purpose for which both resources are available.

Capital Assets

Capital assets are stated at historical cost or, if donated, at estimated fair value at the date of the gift. Capital assets are defined by the Hospital as assets with an initial individual cost of more than $5,000 and an estimated useful life in excess of one year. Depreciation and amortization of assets are recorded in amounts sufficient to amortize the cost of the related assets over their estimated useful lives using the straight-line method. The following are the most commonly used estimated useful lives:

Buildings	10-40 years
Building improvements	5-20 years
Equipment	3-20 years
Land improvements	15 years
Furniture and fixtures	5 years

Expenditures that substantially increase the useful lives or functionality of existing assets are capitalized. Routine maintenance, repairs, and minor improvements are expensed as incurred. The cost of property retired and related accumulated depreciation is removed from the accounts, and any gain or loss recognized in non-operating revenues (expenses).

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Management reviews the recoverability of its capital assets in accordance with the provisions of GASB Statement No. 42, *Accounting and Financial Reporting for Impairment of Capital Assets and Insurance Recoveries*. GASB Statement No. 42 requires recognition of impairment of long-lived assets in the event the asset's service utility has declined significantly and unexpectedly. Accordingly, management evaluates assets' utility annually or when an event occurs that may impair recoverability of the asset. No impairments were identified as of June 30, 2025.

Leases

Lessee:

The Hospital is party to multiple leases of nonfinancial assets as a lessee. The Hospital recognizes a lease liability and an intangible right-to-use lease asset (lease asset) in the financial statements.

At the commencement of a lease, the Hospital initially measures the lease liability at the present value of payments expected to be made during the lease term. Subsequently, the lease liability is reduced by the principal portion of lease payments made. The lease asset is initially measured as the initial amount of the lease liability, adjusted for lease payments made at or before the lease commencement date, plus certain initial direct costs. Subsequently, the lease asset is amortized on a straight-line basis over its useful life.

Key estimates and judgments related to leases include how the Hospital determines (1) the discount rate used to discount the expected lease payments to present value, (2) lease term, and (3) lease payments. The Hospital uses the interest rate charged by the lessor as the discount rate. When the interest rate charged by the lessor is not provided, the Hospital generally uses its estimated incremental borrowing rate as the discount rate for leases. The lease term includes the noncancellable period of the lease. Lease payments included in the measurement of the lease liability are composed of fixed payments and purchase option price that the Hospital is reasonably certain to exercise.

The Hospital monitors changes in circumstances that would require a remeasurement of its leases and will remeasure lease assets and liabilities if certain changes occur that are expected to significantly affect the amount of any lease liability. Lease assets are reported with other capital assets and lease liabilities are reported with long-term debt on the statement of net position.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Lessor:

The Hospital has leased multiple nonfinancial assets to third-parties. The Hospital recognizes a lease receivable and a deferred inflow of resources in its financial statements where applicable.

At the commencement of the lease, the Hospital initially measures the lease receivable at the present value of payments expected to be received during the lease term. Subsequently, the lease receivable is reduced by the principal portion of lease payments received. The deferred inflow of resources is initially measured as the initial amount of the lease receivable, adjusted for lease payments received at or before the lease commencement date. Subsequently, the deferred inflow of resources is recognized as revenue over the life of the lease term.

Key estimates and judgments include how the Hospital determines (1) the discount rate it uses to discount the expected lease receipts to present value, (2) lease term, and (3) lease receipts. The Hospital uses its estimated incremental borrowing rate as the discount rate for leases. The lease term includes the noncancellable period of the lease. Lease receipts included in the measurement of the lease receivable is composed of fixed payments from the lessee. The Hospital monitors changes in circumstances that would require a remeasurement of its lease and will remeasure the lease receivable and deferred inflows of resources if certain changes occur that are expected to significantly affect the amount of the lease receivable.

Bond and Debt Issue Costs

Financing costs represent debt issuance expenses on long-term debt obligations and are expensed as incurred in accordance with GASB Statement No. 65.

Cost of Borrowing

Interest costs incurred on debt during the construction or acquisition of assets are expensed and not capitalized as a component of the cost of acquiring those assets as incurred in accordance with GASB Statement No.89.

Deferred Outflows/Inflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to a future period and is not recognized as expense until then. In the Hospital financial statements, unamortized loss on refunding and pension and OPEB contributions are reported as deferred

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

outflows of resources. The unamortized loss on refunding results from the difference between the reacquisition price and the net carrying amount of the refunded debt. This amount is deferred and amortized over the life of the refunding debt. The pension and OPEB contributions in deferred outflows are related to those contributions made after the measurement period.

Deferred inflows of resources represent an acquisition of net position that applies to a future period(s) and will not be recognized as an inflow of resources until that time. In the Hospital financial statements, future resources yet to be recognized in relation to the pension and OPEB actuarial calculations are reported as deferred inflows of resources. These future resources arise from differences in the estimates used by the actuary to calculate the pension and OPEB liability and the actual results. The amounts are amortized over a predetermined period. In the hospital financial statements prepared using the current financial resources measurement focus, a lessor should recognize a lease receivable and a deferred inflow of resources to account for a lease. A lessor should measure the deferred inflow of resources at the initial value of the lease receivable plus the amount of any payments received at or before the commencement of the lease term that relate to future periods. A lessor subsequently should recognize the deferred inflow of resources as inflows of resources in a systematic and rational manner over the term of the lease.

Postemployment Benefits Other Than Pensions

For purposes of measuring the Hospital's OPEB liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the OPEB Plans and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by the Plan. For this purpose, the Plan recognizes benefit payments when due and payable in accordance with the benefit terms. Investments are reported at fair value, except for money market investments and participating interest earning investment contracts that have a maturity at the time of purchase of one year or less, which are reported at cost.

Compensated Absences

It is the Hospital's policy to permit employees to accumulate earned, but unused vacation and sick leave benefits. Such benefits were accrued when incurred as a current liability in both fiscal 2025 and 2024.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Self-Insured Liability

The self-insured liability represents the provision for estimated self-insured professional liability claims, general liability claims, and workers' compensation claims. The provision includes estimates of the ultimate costs for both reported claims and claims incurred but not reported based on the recommendations of an independent actuary.

Net Position

GASB Statement No. 34 requires the classification of net position into three components: net investment in capital assets; restricted; and unrestricted. These classifications are defined as follows:

- Net investment in capital assets: This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

- Restricted: This component of net position results from restrictions placed on net position use through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, laws or regulations of other governments, or constraints imposed by law through constitutional provisions or enabling legislation.

- Unrestricted: This component of net position consists of all net position that does not meet the definition of restricted or net investment in capital assets.

Statements of Revenues, Expenses, and Changes in Net Position

All revenues and expenses directly related to the delivery of health care services are included in operating revenues and expenses in the *Statements of Revenues, Expenses, and Changes in Net Position*. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing activities, non-exchange transactions, or investment income.

Net Patient Revenue, Accounts Receivable, and Allowance for Uncollectible Accounts

Net patient revenue is reported at the estimated realizable amount from patients, third-party payors, and others for services provided including the provision for bad debts and includes estimated

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

retroactive adjustments under reimbursement agreements with third-party payors. Revenue under certain third-party payor agreements is subject to audit, retroactive adjustments, and significant regulatory actions. Provisions for third-party settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined.

As part of the Hospital's mission to serve the community, the Hospital provides care to patients even though they may lack adequate insurance or may participate in programs that do not pay established rates. Uncompensated care is defined as write-offs on patient accounts without insurance payment. Charity care is a subset of uncompensated care representing those patients that are approved by the Hospital for a discount under its charity policy guidelines. Throughout the admission, billing, and collection processes, certain patients are identified by the Hospital as indigent or qualifying for charity care. The Hospital provides care to these patients without charge or at amounts less than its established rates or actual costs. Net patient revenue is reflected net of the charity care reserves. Charity care reserves are based on gross revenue foregone. The actual costs for charity care in accordance with the Hospital's charity care policy aggregated $22,417,673 and $20,996,592 for the years ending June 30, 2025 and 2024, respectively. The Hospital has estimated the cost of charity care based on a ratio of cost to charges of operating expenses excluding interest expense.

The Hospital has agreements with third-party payors that provide for payment at amounts different from established charge rates. A summary of the basis of payment by major third-party payors follows:

- Medicare and Medicaid: The Hospital renders services to patients under contractual arrangements with the U.S. Federal Medicare and the State of Nevada (State) Medicaid programs. Inpatient acute care services rendered to Medicare and Medicaid program beneficiaries and Medicare capital costs are paid at prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. As an academic medical center, medical education payments in addition to disproportionate share entitlements are received from Medicare and Medicaid. Medicare utilizes a prospective payment system for inpatient rehabilitation services and psychiatric services.

  Medicare outpatient claims are reimbursed under the Ambulatory Payment Classification based prospective payment system. The payments are based on patient assessment data

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

classifying patients into one of the Medicare Ambulatory Payment Classifications. Inpatient rehabilitation and psychiatric services are reimbursed at a prospectively determined per diem rate. Certain outpatient services related to Medicare beneficiaries and capital costs for Medicaid beneficiaries are reimbursed based on a cost-based methodology subject to certain limitations. The Hospital is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare and Medicaid fiscal intermediaries.

The Hospital's classification of patients under the Medicare and Medicaid programs and the appropriateness of their admission, and therefore, the revenues received are subject to an independent review and retroactive adjustment. Differences between the estimated amounts accrued at interim and final settlements are reported in the *Statement of Revenues, Expenses, and Changes in Net Position* in the year of settlement. Medicare cost reports have been finalized through fiscal year 2020. Provisions for estimated retroactive adjustments for cost report years that have not been finalized have been provided, where applicable. The Hospital recorded a favorable adjustment of $4,758,215 in fiscal 2025, and a favorable adjustment of $6,085,687 in fiscal 2024, respectively, due to prior year retroactive adjustments to amounts previously estimated and changes in estimates.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, governmental program participation, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as repayment of patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs unknown or unasserted at this time. As a result, there is at least a reasonable possibility that recorded estimates could change by a material amount in the near term. Management believes that the Hospital is in compliance with fraud and abuse statutes, as well as other applicable government laws and regulations, and that adequate provision has been made in the financial statements for any adjustments that may result from final settlements.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

- Upper payment limit: On September 22, 2002, the amendment to the State Medicaid program to allow for supplemental Medicaid payments as provided under federal regulations, referred to as the Upper Payment Limit program (UPL), was approved by the Center for Medicare and Medicaid Services (CMS). Effective January 1, 2003, the amendment revised the State's plan to provide access to supplemental Medicaid payments up to 100% of the Medicare upper payment limits for inpatient hospital services rendered by public hospitals in the State to State Medicaid consumers. The State fiscal 2015 budget also included an expansion of the UPL program to outpatient services.

  These funds are distributed prospectively on a quarterly basis. Funding for the UPL program is generated through intergovernmental transfers and matching funds from the federal government. The gross amount recorded in net patient revenue for UPL and Indigent Accident Fund (IAF) were $105,643,149 and $117,964,230 in fiscal 2025 and 2024, respectively. As of June 30, 2025 and 2024, $31,817.307 and $3,929,839, respectively, were recorded as receivable.

- Disproportionate share: As a public health care provider, the Hospital renders services to residents of the County and others regardless of ability to pay. The Hospital is classified as a disproportionate share provider by the Medicare and Medicaid programs due to the volume of low-income patients it serves. Accordingly, the Hospital receives additional payments from these programs as a result of this status totaling $0 in fiscal 2025 and $0 in fiscal 2024, respectively, which are included in net patient revenue. As of June 30, 2025 and 2024, the Hospital has reserved approximately $5,945,947 and $16,680,554, respectively, for possible future adjustments, which is reflected in intergovernmental liabilities on the accompanying statements of net position. Normal estimation differences between final settlements and amounts accrued in previous periods are reflected in net patient revenues in the period of settlement. These estimation differences between final settlements and amounts previously accrued resulted in an increase of $10,251,866 and an increase of $251,118, respectively, in net patient revenues during the years ended June 30, 2025 and 2024. Funding for the disproportionate share program is generated through intergovernmental transfers and matching funds from the federal government.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

- Directed Payments: In 2016, CMS updated the regulations for Medicaid managed care and created a new option for states, allowing them to direct managed care organizations (MCOs) to pay providers according to specific rates or methods. Typically, these Medicaid State Directed Payment (MSDP) arrangements are used to establish minimum payment rates for certain types of providers or to require participation in value-based payment arrangements. However, a few states use the directed payment option to require MCOs to make additional payments to providers similar to supplemental payments in fee for service Medicaid. Effective for calendar year 2020, the Hospital worked with the State of Nevada to establish MSDP arrangements for both Hospital and Professional Services. The MSDP arrangements, which must be recertified by the State and approved by CMS annually, generally require quarterly payments and an annual reconciliation using actual utilization as a basis. Accordingly, the Hospital receives additional payments from these arrangements totaling an increase of $244,950,380 in fiscal 2025 and an increase of $231,458,637 in fiscal 2024, respectively, which are included in net patient revenue. As of June 30, 2025 and 2024, the Hospital has reserved approximately $993,874 and $993,874, respectively, for possible future adjustments, which is reflected in intergovernmental liabilities on the accompanying statements of net position. Normal estimation differences between final settlements and amounts accrued in previous periods are reflected in net patient revenues in the period of settlement. Funding for MSDP arrangements is generated through intergovernmental transfers and matching funds from the federal government. The Hospital also provides major trauma services to the region, and the ability to continue these levels of service and programs is contingent upon the continuation of various funding sources.

- Other payors: The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes prospectively-determined rates-per-discharge, discounts from established charges, and prospectively-determined per diem rates.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

The approximate percentage of gross patient revenues by major payor group for the fiscal years ended June 30 follows:

	2025	2024
Medicare	32 %	32 %
Medicaid, and self-pay	40	41
Commercial, HMO, PPO	22	22
Other	6	5
Total	100 %	100 %

The provision for bad debts is based upon management's assessment of expected net collections considering economic conditions, historical experience, trends in health care coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category, including those amounts not covered by insurance. The results of this review are then used to make any modifications to the provision for bad debts to establish an appropriate allowance for uncollectible accounts. Extensive efforts are made to collect all amounts owed to the Hospital. Several avenues are pursued including direct collections efforts, assistance in finding pay sources, and assistance in compliance with the County's uninsured discount program. After satisfaction of amounts due from insurance and reasonable efforts to collect from the patient have been exhausted, the Hospital follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the Hospital. These accounts are then followed up by collection agencies.

For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for bad debts, allowance for contractual adjustments, provision for bad debts, and contractual adjustments on accounts for which the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients or with balances remaining after the third-party coverage has already paid, the Hospital records a significant provision for bad debts in the period of services on the basis of its historical collections, which indicates that many patients ultimately do not pay the portion of their

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

bill for which they are financially responsible. The difference between the discounted rates and the amounts collected after all reasonable collection efforts have been exhausted is charged off against the allowance for bad debts. The change in the allowance for bad debts was as follows for the fiscal years ended June 30:

	2025	2024
Reserve-Beginning Balance	$ (161,918,030)	$ (137,231,409)
Provision	(158,020,186)	(146,191,773)
Write-Offs	155,581,585	127,505,227
Bad Debt Recovery	(5,756,864)	(6,000,075)
Reserve-Ending Balance	$ (170,113,495)	$ (161,918,030)

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor arrangements. Significant concentrations of patient accounts receivable at June 30, 2025 and 2024 include:

	2025	2024
Medicare	22 %	24 %
Medicaid, and self-pay	42	39
Commercial, HMO, PPO	31	32
Other	5	5
Total	100 %	100 %

Grants and Contributions

The Hospital receives financial assistance from federal agencies, the State, and the County, in the form of grants, as well as contributions from individuals and private organizations. The expenditure of funds received under these programs generally requires compliance with terms and conditions specified in the grant agreements and is subject to audit by the grantor agencies. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes and are reported as other operating revenues.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Other such audits could be undertaken by federal and state granting agencies and result in the disallowance of claims and expenditures; however, in the opinion of management, any such disallowed claims or expenditures will not have a material effect on the overall financial position of the Hospital.

Defined Benefit Plan

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Public Employees' Retirement System of Nevada (NVPERS) and additions to/deductions from NVPERS fiduciary net position have been determined on the same basis as they are reported by NVPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Concentrations of Credit and Economic Risks and Uncertainties

Financial instruments that potentially subject the Hospital to concentrations of credit risk consist principally of cash and cash equivalents, patient accounts receivable, and investments.

The Hospital's cash and cash equivalents on deposit with financial institutions, including cash and cash equivalents in the custody of the Treasurer or a fiscal agent, are often in excess of federally insured limits, and the risk of losses related to such concentrations may be increasing as a result of continuing economic conditions including, but not limited to, weakness in the commercial and investment banking systems. The extent of a future loss, if any, to be sustained as a result of uninsured deposits in the event of a future failure of a financial institution; however, is not subject to estimation at this time.

Concentration of credit risk relating to patient accounts receivable is limited to some extent by the diversity and number of the Hospital's patients and payors. Patient accounts receivable consist of amounts due from government programs, commercial insurance companies, private pay patients, and other group insurance programs. One payor source, self-pay, comprises approximately 15% and 15% of gross patient accounts receivable at June 30, 2025 and 2024, respectively. The Hospital maintains an allowance for losses based on the expected collectability of patient accounts receivable.

1. Description of Reporting Entity and Summary of Significant Accounting Policies (continued)

Because the Hospital operates in the health care industry exclusively in southern Nevada, realization of its receivables, inventories, and its future operations could be affected by adverse economic conditions in the area. In addition, the Hospital receives the majority of its supplies from a limited number of suppliers and any reduction or interruption of such sources could adversely affect future operations. The majority of the Hospital's employees are covered by collective bargaining agreements entered into with the Service Employee International Union (SEIU) and the International Union of Operating Engineers (IUOE). The SEIU contract was ratified, effective on October 15, 2024 and will expire on June 30, 2028.

Subsequent Events

The Hospital evaluates the impact of subsequent events, which are events that occur after the statement of net position date but before the financial statements are issued, for potential recognition in the financial statements as of the statement of net position date. For the year ended June 30, 2025, the Hospital evaluated subsequent events through November 6, 2025, representing the date the accompanying audited financial statements were issued. During this period the Hospital determined there were no subsequent events that needed to be disclosed.

2. Recent Accounting Pronouncements

The GASB has recently issued the following statements, which the Hospital is assessing the impact of the implementation, if any, on its financial statements.

GASB Statement No. 102, *Certain Risk Disclosures*

- This Statement provide users of government financial statements with essential information about risks related to a government's vulnerabilities due to certain concentrations or constraints.

- Effective for Fiscal Years Beginning After June 15, 2024.

- Statement No. 102 defines a concentration as a lack of diversity related to an aspect of a significant inflow of resources or outflow of resources.

- A constraint is a limitation imposed on a government by an external party or by formal action of the government's highest level of decision-making authority.

- Concentrations and constraints may limit a government's ability to acquire resources or control spending.

- Statement No. 102 requires a government to assess whether a concentration or constraint makes the primary government reporting unit or other reporting units that report a liability for revenue debt vulnerable to the risk of a substantial impact.

- This Statement requires a government to assess whether an event or events associated with a concentration or constraint that could cause the substantial impact have occurred, have begun to occur, or are more likely than not to begin to occur within 12 months of the date the financial statements are issued.

- If a government determines that those criteria for disclosure have been met for a concentration or constraint, it should disclose information in notes to financial statements in sufficient detail to enable users of financial statements to understand the nature of the circumstances disclosed and the government's vulnerability to the risk of a substantial impact.

- The disclosure should include descriptions of the following:

    - The concentration or constraint

2. Recent Accounting Pronouncements (continued)

- Each event associated with the concentration or constraint that could cause a substantial impact if the event had occurred or had begun to occur prior to the issuance of the financial statements
- Actions taken by the government prior to the issuance of the financial statements to mitigate the risk.

- Management has adopted this GASB statement and there was no material impact on the financial statements on adoption.

GASB Statement No.103, *Financial Reporting Model Improvements*

- This statement aims to bolster key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability.

- Effective for Fiscal Years Beginning After June 15, 2025

- GASB 103 focuses on improvements in the following areas:
  - Management discussion and analysis (MD&A)
  - Unusual or infrequent items
  - Presentation of proprietary fund statement of revenues, expenses and changes in fund net position
  - Major component unit information
  - Budgetary comparison information
  - Financial trends information in the statistical section

- Management's Discussion and Analysis (MD&A)

  The requirement for MD&A remains, but the statement has refined its structure. MD&A now focuses on five specific sections:

  - Overview of the Financial Statements
  - Financial Summary
  - Detailed Analyses

2. Recent Accounting Pronouncements (continued)

- Significant Capital Asset and Long-Term Financing Activity
- Currently Known Facts, Decisions, or Conditions

This format is designed to avoid redundancy and provide clear, relevant information. The analysis should distinguish between the primary government and its discretely presented component units.

- Unusual or Infrequent Items

Statement No. 103 describes unusual or infrequent items as transactions and other events that are either unusual in nature or infrequent in occurrence. Governments are required to separately present the inflows and outflows related to each unusual or infrequent item as the last presented flow(s) of resources before the net change in resource flows in the government-wide, governmental fund, and proprietary fund statements of resource flows. This distinct presentation helps stakeholders understand the impact of these items on the financial position and operations of the government entity.

- Presentation of the Proprietary Fund Statement of Revenues, Expenses, and Changes in Fund Net Position

This statement requires that the proprietary fund statement of revenues, expenses, and changes in fund net position continue to distinguish between operating and nonoperating revenues and expenses. Operating revenues and expenses are defined as revenues and expenses other than nonoperating revenues and expenses. Nonoperating revenues and expenses include:

- Subsidies received and provided (subsidies are defined in the statement)
- Contributions to permanent and term endowments
- Revenues and expenses related to financing
- Resources from the disposal of capital assets and inventory
- Investment income and expenses

Additionally, a subtotal for operating income (loss) and noncapital subsidies must be presented before reporting other nonoperating revenues and expenses.

- Major Component Unit Information

2. Recent Accounting Pronouncements (continued)

Governments should present each major component unit separately in the reporting entity's statements of net position and activities if it does not reduce the readability of the statements. If presenting each major component unit separately reduces readability, combining statements of major component units should be included in the reporting entity's basic financial statements after the fund financial statements.

- Budgetary Comparison Information

  Budgetary comparison schedules must be presented as Required Supplementary Information (RSI) for the general fund and each major special revenue fund with a legally adopted annual budget. Variances between original and final budget amounts, and between final budget amounts and actual results, should be detailed, along with explanations for significant variances in the notes to RSI.

- Financial Trends Information

  In the statistical section of separately issued financial reports, governmental entities engaged solely in business-type and fiduciary activities are required to present revenues by major source, distinguishing between operating, noncapital subsidy, and other nonoperating revenues and expenses

- Management is currently evaluating the implementation of this GASB statement to determine the impact, if any, on the financial statements.

GASB Statement No. 104, *Disclosure of Certain Capital Assets*

- This statement provides (1) separate disclosure of certain capital assets and (2) capital assets held for sale.

- Effective Date – Fiscal Years Beginning after June 15, 2025.

- Separate Disclosure of Certain Capital Assets - Within capital asset note disclosures, governments should disclose capital assets related to intangible assets separately. This includes:

  - Intangible right-to-use assets associated with GASB 87 (leases) by major class of underlying assets

  - GASB 94 (right-to-use assets recognized by an operator) by major class of underlying public-private and public-public partnership assets

2. Recent Accounting Pronouncements (continued)

- GASB 96 (subscription assets)
- Other intangible assets

- Capital Assets Held for Sale - GASB 104 establishes that capital assets held for sale should be identified and disclosed within the notes to the financial statements.

- The Statement establishes two conditions a government should consider in determining whether a capital asset should be disclosed as held for sale:
  - the government has decided to pursue the sale and
  - it is probable the sale will be finalized within one year of the financial statement date.

- The evaluation as to whether a capital asset is held for sale should occur each reporting period.

- Factors to consider as to whether it is probable a sale will be finalized within one year of the financial statement date include, but are not limited to:
  - whether the asset is available for immediate sale in its present condition
  - whether there is an active program to locate a buyer
  - whether present market conditions support a sale of that type of asset whether there are regulatory approvals necessary for a sale to occur

- Capital assets held for sale should continue to be reported within the appropriate major class of capital asset and continue to be depreciated, if applicable.

- The notes to the financial statements should also include a separate disclosure of the historical cost and accumulated depreciation or amortization by major class of capital asset held for sale.

- For capital assets held for sale that are pledged as collateral, the carrying amount of debt should be disclosed by major class of asset.

- Management is currently evaluating the implementation of this GASB statement to determine the impact, if any, on the financial statements.

3. Cash, Cash Equivalents, and Investments

Substantially all cash (including cash equivalents) and investments of the Hospital are under control of the Treasurer and are included in the Treasurer's investment pool. The Hospital's cash and investments generally are reported at fair value, as discussed in Note 1. As of June 30, 2025 and 2024, these amounts were as follows:

	2025	2024
Clark County investment pool	$ 132,498,642	$ 246,662,317
Cash on hand	21,100	20,500
Total cash and investments	$ 132,519,742	$ 246,682,817

The Treasurer invests monies held both by individual funds and through a pooling of monies. The pooled monies, referred to as the investment pool, are invested as a whole and not as a combination of monies from each fund belonging to the pool. In this manner, the Treasurer is able to invest the monies at a higher interest rate for a longer period of time. Interest is apportioned monthly to each fund in the pool based on the average daily cash balance of the fund for the month.

According to Statutes, County monies must be deposited with federally insured banks, credit unions, or savings and loan associations within the County. The Treasurer is authorized to use demand accounts, time accounts, and certificates of deposit. Statutes do not specifically require collateral for demand deposits, but do specify that collateral for time deposits may be of the same type as those described for permissible investments. Permissible investments are similar to allowable County investments described below, except that statutes permit a longer term and include securities issued by municipalities within Nevada. The County's deposits are fully covered by federal depository insurance or collateral held by the County's agent in the County's name. The County has written custodial agreements with the various financial institutions' trust banks for demand deposits and certificates of deposit. These custodial agreements pledge securities totaling 102% of the deposits with each financial institution. The County has a written agreement with the State Treasurer for monitoring the collateral maintained by the County's depository institutions.

Due to the nature of the investment pool, it is not possible to separately identify any specific investment as being that of the Hospital. It is not feasible to allocate the level of risk to the various component units of the County, including the Hospital, due to the co-mingling of assets in the investment pool. Details on the County investment policies including the level of risk are included in the Clark County Annual Comprehensive Financial Report. Instead, the Hospital owns a proportionate share of each investment, based on the Hospital's participation percentage in the investment pool. As of June 30, 2025 and 2024, $132,498,642 and $246,662,317, respectively, of Hospital investments in the investment pool were as follows:

3. Cash, Cash Equivalents, and Investments (continued)

	2025		2024	
Investment Type	Allocation	Duration in Years	Allocation	Duration in Years
U.S. Treasury Obligations	28.89%	2.71	35.16%	1.68
U.S. Agencies	20.46%	3.78	34.03%	2.75
Corporate Notes	16.20%	2.67	13.38%	1.96
Asset-Backed Securities	14.12%	4.17	6.75%	3.25
Commercial Paper Discounts	8.48%	0.20	3.89%	0.44
Negotiable Certificates of Deposit	4.89%	0.69	1.30%	0.29
Money Market Funds	4.41%	-	2.88%	-
NV Local Gov Investment Pool	2.55%	-	2.61%	-
	100.00%		100.00%	
Average Portfolio Duration		2.10		1.75

Credit Risk

Credit risk is defined as the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The County's investment policy applies a prudent-person rule, which is: "In investing the County's monies, there shall be exercised the judgment and care under the circumstances then prevailing, which persons of prudence, discretion, and intelligence exercise in the management of their own affairs, not for speculation, but for investment, considering the probable safety of their capital as well as the probable income to be derived."

As of June 30, 2025 and 2024, the County's investments were rated by Standard and Poor's and Moody's Investors Service, respectively, as follows:

3. Cash, Cash Equivalents, and Investments (continued)

	2025	2024
U.S. Treasury Obligations	A-1+,AA+/Aa,P-1	A-1+,AA+/Aaa,P-1
Bonds of U.S. Agencies	AA+/Aa	AA+/Aaa, Unrated (1)
Corporate Obligations or Corporate Notes	A-, A, A+, AA-, AA, AA+,AAA/Aaa, Aa, A	A-, A, A+, AA-, AA, AA+/Aaa, Aa, A
Commercial Paper Discounts	A-1/P-1	A-1/P-1
Negotiable Certificates of Deposit	A-1, A-1+/P-1	A-1, A-1+/P-1
Money Market Mutual Funds	AAA/Aaa	AAA/Aa, Aaa
Asset-Backed Securities	AA+,AAA/Aa,Aaa, Unrated (2)	AAA/Aaa, Unrated (2)
NV Local Gov Inv Pool	(3)	(3)
Callable Commercial Paper	(4)	A-1/P-1
Federal Agency Discounts	(4)	A-1+/P-1

(1) Unrated U.S. federal agency securities are Farmer Mac securities not rated by either Moody's or Standard & Poor's
(2) Unrated asset backed securities are rated AAA by Standard & Poor's
(3) Nevada Local Government Investment Pool (NV LGIP) is an unrated external pool.
(4) No investment in Callable Commercial Paper, and Federal Agency Discounts

The County investments in U.S. Treasury obligations carry no measurable credit risk because they are backed by the U.S. federal government. The State Investment Pool does not have a credit rating.

Concentration of Credit Risk

Concentration of credit risk is defined as the risk of loss attributed to the magnitude of a government's investment in a single issuer. The County's investment policy limits the amount that may be invested in obligations of any one issuer, except direct obligations of the U.S. government or federal agencies, to be no more than 5% of the County investment pool. At June 30, 2025 and 2024, the following investments exceeded 5% of the investment pool:

	2025		2024	
U.S. Treasury obligations	27.69	%	36.58	%
Morgan Stanley Govt MMF	7.66			
Federal Home Loan Bank (FHLB)	7.51		16.71	
Federal Home Loan Mortgage Corporation (FHL	6.24			
Federal Farm Credit Bank (FFCB)	5.45			

3. Cash, Cash Equivalents, and Investments (continued)

Interest Rate Risk

Interest rate risk is defined as the risk that changes in interest rates will adversely affect the fair value of an investment. Through its investment policy, the County manages its exposure to fair value losses arising from increasing interest rates by limiting the weighted average duration of its investment portfolio to less than 2.5 years. Duration is a measure of the present value of a fixed income's cash flows and is used to estimate the sensitivity of a security's price to interest rate changes. Accordingly, the County's investment policy limits investment portfolio maturities for certain investment instruments as follows: U.S. Treasury and U.S. agencies to less than ten years; bankers' acceptances to 180 days; commercial paper to 270 days; certificates of deposit to one year; corporate notes and bonds to five years; and repurchase agreements to 90 days.

Interest Rate Sensitivity

At June 30, 2025 and 2024, the County invested in floating rate, callable, asset-backed, and mortgage-backed securities that have a higher sensitivity to interest rates, which represented 38% and 28%, respectively, of total investment securities.

4. Other Receivables, Net

The Hospital has agreements with third-party payors that provide for payment of amounts different from established rates. 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. See Note 1, *Net Patient Revenue, Accounts Receivable, and Allowance for Uncollectible Accounts* for additional information. As of June 30, 2025 and 2024, third-party settlements recorded were, $0 and $3,200,991 respectfully.

Other receivables also include accounts receivable that are not directly related to patient receivables, as a result of invoicing clients for various services rendered and implementing GASB Statement No. 87 as a lessor to record leases receivable. See Note 1, *Leases* for additional information.

A summary of other receivables, net at June 30, follows:

	2025	2024
Third-party settlements	$ -	$ 3,200,991
Leases receivable	28,177	183,700
Other	8,366,052	5,085,250
	$ 8,394,229	$ 8,469,941

5. Internally Designated Assets

The Hospital's internally designated assets consist of the following as of June 30:

	2025	2024
Debt service funds	$ -	$ 2
Capital acquisition funds	67,139,150	83,257,475
	$ 67,139,150	$ 83,257,477

6. Capital Assets

Capital asset additions, retirements, and balances for the fiscal years ended June 30, 2025 and 2024, were as follows:

2025	Beginning Balance	Additions	Retirements/ Transfers	Ending Balance
Nondepreciable capital assets:				
Land	$ 10,204,997	$ -	$ -	$ 10,204,997
Construction in progress	53,112,703	40,572,944	(15,156,321)	78,529,326
Total nondepreciable capital assets	63,317,700	40,572,944	(15,156,321)	88,734,323
Depreciable capital assets:				
Land improvements	4,846,132	-	-	4,846,132
Buildings and building improvements	285,186,169	17,257,660	(27,170)	302,416,659
Equipment	334,908,126	18,308,261	(441,183)	352,775,204
Furniture and fixtures	10,247,539	1,260,373	-	11,507,912
Infrastructure	1,538,209	-	-	1,538,209
LVA-IT hardware	143,391	-	-	143,391
Leased land and buildings	31,743,577	30,093,237	-	61,836,814
Leased equipment and other	14,571,686	3,339,427	(176,046)	17,735,067
Right of use equipment	44,206,236	10,353,825	212,407	54,772,468
Total depreciable capital assets	727,391,065	80,612,783	(431,992)	807,571,856
Less accumulated depreciation and amortization:				
Land improvements	(3,863,879)	(151,136)	-	(4,015,015)
Buildings and building improvements	(144,052,192)	(8,534,793)	1,245	(152,585,740)
Equipment	(274,767,205)	(19,785,968)	361,423	(294,191,750)
Furniture and fixtures	(5,825,341)	(1,096,296)	-	(6,921,637)
Infrastructure	(587,298)	(56,703)	-	(644,001)
LVA-IT hardware	(143,391)	-	-	(143,391)
Leased land and buildings	(15,835,600)	(4,451,834)	-	(20,287,434)
Leased equipment and other	(8,826,637)	(3,802,117)	246,871	(12,381,883)
Right of use equipment	(24,607,917)	(11,807,070)	-	(36,414,987)
	(478,509,460)	(49,685,917)	609,539	(527,585,838)
Total depreciable capital assets, net	248,881,605	30,926,866	177,547	279,986,018
Total capital assets, net	$ 312,199,305	$ 71,499,810	$ (14,978,774)	$ 368,720,341

Estimated costs to complete the construction in progress are approximately $34 million as of June 30, 2025.

6. Capital Assets (continued)

2024	Beginning Balance	Additions	Retirements/ Transfers	Ending Balance
Nondepreciable capital assets:				
Land	$ 10,204,997	$ -	$ -	$ 10,204,997
Construction in progress	17,298,356	53,165,288	(17,350,941)	53,112,703
Total nondepreciable capital assets	27,503,353	53,165,288	(17,350,941)	63,317,700
Depreciable capital assets:				
Land improvements	4,846,132	-	-	4,846,132
Buildings and building improvements	249,737,784	35,448,385	-	285,186,169
Equipment	320,444,416	14,585,287	(121,577)	334,908,126
Furniture and fixtures	8,828,707	1,418,832	-	10,247,539
Infrastructure	1,538,209	-	-	1,538,209
LVA-IT hardware	143,391	-	-	143,391
Leased land and buildings	31,471,360	-	272,217	31,743,577
Leased equipment and other	10,330,874	4,261,168	(20,356)	14,571,686
Right of use equipment	31,123,320	13,698,582	(615,666)	44,206,236
Total depreciable capital assets	658,464,193	69,412,254	(485,382)	727,391,065
Less accumulated depreciation and amortization:				
Land improvements	(3,712,743)	(151,136)	-	(3,863,879)
Buildings and building improvements	(136,713,495)	(7,338,697)	-	(144,052,192)
Equipment	(253,765,298)	(21,123,484)	121,577	(274,767,205)
Furniture and fixtures	(4,878,668)	(946,673)	-	(5,825,341)
Infrastructure	(522,927)	(64,371)	-	(587,298)
LVA-IT hardware	(143,391)	-	-	(143,391)
Leased land and buildings	(11,431,174)	(4,404,426)	-	(15,835,600)
Leased equipment and other	(5,737,435)	(3,089,202)	-	(8,826,637)
Right of use equipment	(13,674,544)	(10,635,810)	(297,563)	(24,607,917)
	(430,579,675)	(47,753,799)	(175,986)	(478,509,460)
Total depreciable capital assets, net	227,884,518	21,658,455	(661,368)	248,881,605
Total capital assets, net	$ 255,387,871	$ 74,823,743	$ (18,012,309)	$ 312,199,305

7. Long-term Debt

The Hospital's long-term debt consists of the following as of June 30:

	2025				
	Beginning Balance	Additions	Payments/ Reductions	Ending Balance	Due Within One Year
Clark County, Nevada General Obligation Hospital Refunding Bonds, Series 2013	$ -	$ -	$ -	$ -	$ -
Long-term debt	$ -	$ -	$ -	$ -	$ -

On September 9, 2013, Clark County, Nevada issued $26,065,000 in General Obligation (Limited Tax) Hospital Refunding Bonds (the 2013 Bonds) with an interest rate of 3.10%, which are collateralized with pledged gross revenues. The proceeds of the bonds were used to: (i) refund $8,585,000 aggregate principal amount of the County's General Obligation Hospital Improvement and Refunding Bonds, Series 2003; (ii) refund $17,920,000 aggregate principal amount of the County's General Obligation Hospital Refunding Bonds, Series 2007; (iii) pay the cost of issuing the 2013 Bonds. As a result, the previously outstanding refunded bonds are considered to be defeased and the liabilities for those bonds have been extinguished. As a result of the advance refunding, the Hospital reduced its total debt service requirements by $2,884,644 which resulted in an economic gain (difference between the present value of the debt service payments on the old and new debt) of $2,455,999. The issuance of the 2013 Bonds resulted in a deferred loss of $513,998, which will be amortized over the life of the new bonds. Principal and interest of the 2013 Bonds are due semiannually on March 1st and September 1st. All required payments on the bonds are guaranteed by Clark County, Nevada in the event that the Hospital is unable to make required payments. The Bonds matured and were paid off in fiscal 2024.

The Hospital's general obligation bond ordinances contain the usual and customary covenants associated with such bonds. Management believes it is in compliance with all such covenants.

The Tax Reform Act of 1986 imposes an arbitrage rebate requirement with respect to bonds issued by the County. Under this act, an amount may be required to be rebated to the United States Treasury, so that all interest on the bonds qualifies for exclusion from gross income for federal income tax purposes. The Hospital is current on all required arbitrage payments. As of June 30, 2025 and 2024, there is no estimated potential arbitrage liability.

8. Other long-term Liabilities

Operating Leases

The Hospital has operating leases with lease terms shorter than one year or leases not subject to GASB Statement No.87 presentation. Operating leases primarily consist of medical and office equipment used in Hospital operations, as well as other occupancy costs such as common area maintenance and utilities related to real property leases for off-campus outpatient clinic and business office facilities.

Total rent expense under all operating leases was $2,100,813 and $1,862,030 in fiscal 2025 and 2024, respectively. Future commitments under operating leases extending beyond June 30, 2025, were as follows:

FY 2026	$	345,894
FY 2027		313,340
FY 2028		255,708
FY 2029		28,195
FY 2030		-
FY 2031 and after		-
Grand total	$	943,137

8. Other long-term Liabilities (continued)

The Hospital as Lessee

As of June 30, 2025 University Medical Center of Southern Nevada has 14 lessee financing leases for buildings and 19 lessee financing leases for equipment.

Buildings are leased primarily for cash flow management purposes while equipment is leased primarily to have access to the latest technology.

The 14 lessee building leases have terms ranging from three years to twenty years. All building leases have monthly payments with three of the building leases having fixed payments throughout the lease term while the remaining eleven have annual increases ranging from 1.7% to 5.0%. The value of the right-to-use assets and lease payable for buildings as of June 30, 2025 and 2024 was $61,836,813 and $31,743,577, respectively, with accumulated amortization for buildings of $20,287,434 and $15,835,600, respectively.

The 19 lessee equipment leases have terms ranging from one year to four years. All equipment leases have fixed monthly payments except for one that has quarterly payments. The value of the right-to-use assets and lease payable for equipment as of June 30, 2025 and 2024 was $17,735,066 and $14,571,686, respectively, with accumulated amortization of $12,381,807 and $8,826,638, respectively.

The future principal and interest lease payments for buildings as of June 30, 2025, were as follows:

Fiscal Year Ending June 30	Principal	Interest	Total
2026	$ 4,045,637	$ 1,205,197	$ 5,250,834
2027	3,879,338	1,096,453	4,975,791
2028	3,682,176	980,712	4,662,888
2029	3,393,817	875,950	4,269,767
2030	3,285,388	780,899	4,066,287
2031-2035	17,797,922	2,326,976	20,124,898
2036-2040	5,663,625	517,079	6,180,704
2041-2045	829,179	32,899	862,078
Total	$ 42,577,082	$ 7,816,165	$ 50,393,247

8. Other long-term Liabilities (continued)

The future principal and interest lease payments for equipment as of June 30, 2025, were as follows:

Fiscal Year Ending June 30	Principal	Interest	Total
2026	$ 3,506,320	$ 162,009	$ 3,668,329
2027	1,315,998	53,894	1,369,892
2028	602,159	25,792	627,951
2029	307,737	8,098	315,835
2030	42,753	412	43,165
Total	$ 5,774,967	$ 250,205	$ 6,025,172

The Hospital as Lessor

As of June 30, 2025, the Hospital has one lessor financing lease for buildings. Building space is leased out for academic medical education and research purposes. The lease is with the University of Nevada, Las Vegas, School of Medicine. The current lease term is nine months with monthly payments and annual increases of approximately 3%. Total amount of revenue (lease and interest) recognized in FY 2025 is $399,811 and the lease receivable at June 30, 2025 associated with these building leases is $28,177.

The Hospital recognized a deferred inflow of resources associated with the lease of $27,805 at June 30, 2025 that will be recognized as revenue over the remainder of the lease terms.

8. Other long-term Liabilities (continued)

The future principal receipts and interest revenue for buildings as of June 30, 2025, were as follows:

Fiscal Year Ending June 30	Principal Receipt	Interest Revenue	Total
2026	$ 28,177	$ 94	$ 28,271
After	-	-	-
Totals	$ 28,177	$ 94	$ 28,271

Subscription-Based Information Technology Arrangements

As of June 30, 2025, the Hospital has 128 subscription based information technology arrangements. The terms range from one to five years and implicit interest rates range from 1.68% to 7.3%.

The future principal payments and interest payments for subscription based information technology arrangements as of June 30, 2025, were as follows:

Fiscal Year Ending June 30	Principal	Interest	Total
2026	$ 9,405,787	$ 323,431	$ 9,729,218
2027	3,920,880	102,360	4,023,240
2028	1,718,910	33,972	1,752,882
2029	266,829	7,064	273,893
2030	65,096	748	65,844
Total	$ 15,377,502	$ 467,575	$ 15,845,077

8. Other long-term Liabilities (continued)

Liability Insurance

The Hospital is exposed to various risks of loss related to theft of, damage to and destruction of assets, errors and omissions, injuries to employees and patients, and natural disasters. These risks are covered by the Hospital's self-insured professional and general liability insurance policy, commercial insurance purchased from independent third parties, and the County's worker's compensation program. Settled claims have not exceeded commercial insurance coverage in any of the past three fiscal years.

On January 20, 1987, the Board approved self-insured professional and general liability and workers' compensation insurance programs. In lieu of maintaining insurance coverage, the Board created the professional and general liability fund and the workers' compensation fund. The Hospital has accrued an undiscounted liability for estimated future settlements and claims losses for professional liability, general liability, and workers' compensation using its best estimate of these losses in accordance with actuarially determined amounts. At June 30, 2025 and 2024, the Hospital has accrued professional and general liability of $11,500,004 and $17,022,632, respectively. In the opinion of management, there are no claims or lawsuits asserted or unasserted that would not be adequately covered by insurance and/or the professional and general liability accrual.

8. Other long-term Liabilities (continued)

A summary of changes in the self-insurance liability during fiscal 2025 and 2024 were as follows:

2025

	Beginning Balance	Claims Incurred/ Changes in Estimates	Claims Paid	Ending Balance	Due Within One Year
Professional liability	$ 17,022,632	$ (5,472,088)	$ (50,540)	$ 11,500,004	$ 2,852,866
Workers' compensation	5,660,557	3,385,364	(3,229,454)	5,816,467	4,404,467
	$ 22,683,189	$ (2,086,724)	$ (3,279,994)	$ 17,316,471	$ 7,257,333

2024

	Beginning Balance	Claims Incurred/ Changes in Estimates	Claims Paid	Ending Balance	Due Within One Year
Professional liability	$ 12,354,846	$ 4,774,771	$ (106,985)	$ 17,022,632	$ 3,767,465
Workers' compensation	4,837,090	3,276,928	(2,453,461)	5,660,557	4,248,557
	$ 17,191,936	$ 8,051,699	$ (2,560,446)	$ 22,683,189	$ 8,016,022

9. Related Party Transactions

The Hospital receives payments from the County under a contractual arrangement to provide care for qualifying indigent and emergency care. For the years ended June 30, 2025 and 2024, the Hospital received $2,289,513 and $1,375,034, respectively, for such care. Amounts received for qualifying indigent and emergency care are included in net patient revenues in the fiscal year the services are rendered.

The County charges for legal and financial services provided to the Hospital. The Hospital recorded costs of $1,124,554 and $962,752 for these services during fiscal 2025 and 2024, respectively. At June 30, 2025 and 2024, there were no non-interest bearing amounts due to the County for such services.

The Hospital is billed by the County for its portion of self-insurance premiums for health, dental, and vision insurance. Since the Hospital is affiliated with the County, this liability is reported in the due to related party line on the statement of net position.

A summary of changes in related party liability balances during fiscal 2025 and 2024 follows:

2025	Beginning Balance	Additions	Reductions	Ending Balance
Current liabilities				
Clark County Worker's Compensation	$ 1,655,585	$ 4,131,143	$ (3,000,000)	$ 2,786,728
Clark County Automotive	22,758	128,200	(133,761)	17,197
Clark County Enterprise/Physical	11,172	121,477	(152,715)	(20,066)
Clark County Treasurer	-	82,699	(82,699)	-
Clark County Self-Funded	5,584,950	56,051,793	(57,103,006)	4,533,737
	$ 7,274,465	$ 60,515,312	$ (60,472,181)	$ 7,317,596

2024	Beginning Balance	Additions	Reductions	Ending Balance
Current liabilities				
Clark County Worker's Compensation	$ 1,248,964	$ 3,406,621	$ (3,000,000)	$ 1,655,585
Clark County Automotive	-	158,008	(135,250)	22,758
Clark County Enterprise/Physical	19,747	128,124	(136,699)	11,172
Clark County Treasurer	-	76,740	(76,740)	-
Clark County Self-Funded	17,048,700	49,999,256	(61,463,006)	5,584,950
	$ 18,317,411	$ 53,768,749	$ (64,811,695)	$ 7,274,465

10. Employee Benefits Plans

Retirement Plan

Substantially all of the Hospital's employees are participants in a retirement plan (the Plan) that is part of the Public Employees' Retirement System (PERS) for public employees in the State. The Plan was established on July 1, 1948, by the Legislature and is governed by the Public Employees' Retirement Board whose seven members are appointed by the Governor. All public employees who meet certain eligibility requirements may participate in the Plan. The Plan is a cost sharing, multiple-employer, defined benefit plan of PERS.

The Hospital does not exercise any control over the Plan and NRS 286.110 states, "Respective participating public employers are not liable for any obligation of the system." Benefits, as required by State Statute, are determined by the number of years of credited service at the time of retirement and the participants' highest average compensation in any 36 consecutive months. Benefit payments to which participants may be entitled under the Plan include pension benefits, disability benefits, and death benefits.

Monthly benefit allowances for regular participants are computed at 2.25% (on or after July 1, 2015), 2.5% (January 1, 2010 – June 30, 2015), 2.67% (July 1, 2001 – December 31, 2009), and 2.5% (prior to July 1, 2001) of average compensation (average of 36 consecutive months of highest compensation) for each credited year of service prior to retirement up to a maximum of 90% of the average compensation for employees entering the system prior to July 1, 1985, and 75% for those entering after that date. The Plan offers several alternatives to the unmodified service retirement benefit which, in general, allows the retired employee to accept a reduced service retirement benefit payable monthly during the employee's life and various optional monthly payments to a named beneficiary after the employee's death. Regular members entering the system prior to January 1, 2010 are eligible for retirement benefits at age 65 with 5 years of service, at age 60 with 10 years of service or at any age with 30 years of service. Regular members entering the system on or after January 1, 2010 are eligible for retirement benefits at age 65 with 5 years of service, or age 62 with 10 years of service or at any age with 30 years of service. Regular members entering the system on or after July 1, 2015 are eligible for retirement benefits at age 65 with 5 years of service, at age 62 with 10 years of service or at age 55 with 30 years of service or at any age with 33 1/3 years of service.

NRS 286.410 establishes the required contribution rates and provides for yearly increases until such time as the actuarially determined unfunded liability of the Plan is reduced to zero. The Hospital is obligated to contribute all amounts due under the Plan. The contribution rate, based on covered payroll, was 33.50%, 33.50%, and 29.75% for each of three years ended June 30, 2025, 2024, and 2023, respectively.

10. Employee Benefits Plans (continued)

The Hospital's contributions to the Plan for the years ended June 30, 2025, 2024, and 2023 were $123,246,272, $107,785,956, and $91,032,509, respectively, and were equal to the required contributions for each fiscal year. At June 30, 2025, 2024, and 2023, accrued compensation and benefits include $12,851,785, $11,448,383, and $12,110,387, respectively, due to PERS.

An annual report containing financial statements and required information for the Plan may be obtained by writing to PERS, 693 West Nye Lane, Carson City, Nevada 89703-1599 or by calling (775) 687-4200.

Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

Pension Liabilities

At June 30, 2025, the Hospital reported a liability of $676,678,238 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2024, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Hospital's proportion of the net pension liability was based on a projection of its long-term share of contributions to the pension plan relative to the projected contributions of all participating reporting units, actuarially determined. At June 30, 2024, the Hospital's proportion was 3.75 percent.

At June 30, 2024, the Hospital reported a liability of $ 716,838,932 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2023, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Hospital's proportion of the net pension liability was based on a projection of its long-term share of contributions to the pension plan relative to the projected contributions of all participating reporting units, actuarially determined. At June 30, 2023, the Hospital's proportion was 3.93 percent.

10. Employee Benefits Plans (continued)

Pension Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

For the year ended June 30, 2025, the Hospital recognized pension expense increase of $73,489,989. At June 30, 2025, the Hospital reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of assumptions	$ 43,663,523	$ -
Changes in proportion	40,225,167	36,168,039
Differences between expected and actual experience	143,554,873	-
Net difference between projected and actual investment earnings on pension plan investments	-	66,661,522
Hospital contributions subsequent to the measurement date	61,623,136	-
Total	$ 289,066,699	$ 102,829,561

$61,623,136, reported as deferred outflows of resources related to pensions resulting from Hospital employer contributions subsequent to the measurement date, will be recognized as a reduction of the net pension liability in the year ended June 30, 2026.

Other amounts reported as deferred outflows of resources and (deferred inflows) of resources related to pensions will be recognized in pension expense as follows:

10. Employee Benefits Plans (continued)

Year ended June 30	Amount
2026	$ 16,024,251
2027	86,845,506
2028	12,042,415
2029	1,707,211
2030 and after	7,994,615
	$ 124,613,998

Actuarial Assumptions

The total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation rate	2.50%
Investment rate of return	7.25%
Productivity pay increase	0.50%
Projected salary increases	Regular: 4.20% to 9.10%, depending on service, Rates include inflation and productivity increases
Other assumptions	Same as those used in the June 30, 2024 funding actuarial valuation

The actuarial assumptions used in the June 30, 2024, valuation were based on the results of the experience study covering the period from July 1, 2016, to June 30, 2020.

The discount rate used to measure the total pension liability was 7.25%, 7.25%, and 7.25% as of June 30, 2024, 2023, and June 30, 2022, respectively. The projection of cash flow used to determine the discount rate assumed that employee and employer contributions will be made at the rate specified in statute. Based on the assumption, the pension plans' fiduciary net position at June 30, 2024, was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension Plan investments was applied to all periods of projected benefit payments to determine the total pension liability as of June 30, 2024, June 30, 2023, and June 30, 2022.

10. Employee Benefits Plans (continued)

The target allocation and best estimates of arithmetic real rates of return for each major class are summarized in the following table:

Asset Class	Target Allocation	Long-Term Geometric Expected Real Rate of Return*
U.S. stocks	34%	5.50%
International stocks	14%	5.50%
U.S. bonds	28%	2.25%
Private markets	12%	6.65%
Short-term investments	12%	0.50%
Total	**100%**	

*As of June 30, 2024, PERS' long-term inflation assumption was 2.50%

Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the Hospital as of June 30, 2024, calculated using the discount rate of 7.25%, as well as what the Hospital's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.25%) or 1-percentage-point higher (8.25%) than the current discount rate:

	1% Lower (6.25%)	Discount Rate (7.25%)	1% Higher (8.25%)
Hospital's proportionate share of the net pension liability	$ 1,088,180,526	$ 676,678,238	$ 337,184,370

10. Employee Benefits Plans (continued)

Pension Plan Fiduciary Net Position

Detailed information about the pension plan's fiduciary net position is available in the PERS Annual Comprehensive Financial Report, available on the PERS website (www.nvpers.org).

Deferred Compensation Plan

The Hospital offers its employees a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The Hospital does not exercise any control over the assets of the deferred compensation plan. The deferred compensation plan, available to all Hospital employees, permits them to defer a portion of their salary until future years. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency.

Postemployment Benefits Other Than Pensions (OPEB)

Plan Description: The Hospital subsidizes eligible retirees' contributions to the Public Employees' Benefits Plan (PEBP), a non-trust, agent multiple-employer defined benefit postemployment healthcare plan administered by the State of Nevada. NRS 287.041 assigns the authority to establish and amend benefit provisions to the PEBP nine-member board of trustees. The plan is now closed to future retirees, however, district employees who previously met the eligibility requirement for retirement within the Nevada Public Employee Retirement System had the option upon retirement to enroll in coverage under the PEBP with a subsidy provided by the Health District as determined by their number of years of service. The PEBP issues a publicly available financial report that includes financial statements and required supplementary information. That report may be obtained by writing to Public Employee's Benefits Program, 901 S. Stewart Street, Suite 1001, Carson City, NV, 89701, by calling (775) 684-7000, or by accessing the website at www.pebp.state.nv.us/informed/financial.htm.

The Retiree Health Program Plan (RHPP) is a non-trust, single-employer defined benefit postemployment healthcare plan administered by Clark County, Nevada. Retirees may choose between Clark County Self-Funded Group Medical and Dental Benefits Plan (Self-Funded Plan) and a health maintenance organization (HMO) plan.

10. Employee Benefits Plans (continued)

Benefits Provided

PEBP plan provides medical, dental, prescription drug, Medicare Part B, and life insurance coverage to eligible retirees and their spouses. Benefits are provided through a third-party insurer. RHPP provides medical, dental, prescription drug, and life insurance coverage to eligible active and retired employees and beneficiaries. Benefit provisions are established and amended through negotiations between the respective unions and the Health District.

Employees Covered by Benefit Terms

At June 30, 2025, the following employees were covered by the benefit terms:

	PEBP	RHPP	Total all Plans
Inactive employees or beneficiaries currently receiving benefit payments	202	535	737
Active employees	-	3,639	3,639
Covered spouses	-	134	134
Total	202	4,308	4,510

As of November 1, 2008, PEBP was closed to any new participants.

Total OPEB Liability

The Hospital total OPEB liability of $223,063,598 as of June 30, 2025 was measured at June 30, 2024, and was determined by an actuarial valuation as of that date.

Changes in the Total OPEB Liability

	PEBP	RHPP	Total OPEB Liability
Balance recognized at June 30, 2024	$ 12,310,714	$ 194,037,275	$ 206,347,989
Changes Recognized for the Fiscal Year			
Service Cost	-	7,747,306	7,747,306
Interest cost	438,627	7,289,123	7,727,750
Differences between expected and actual experience	(3,121,071)	8,098,587	4,977,516
Changes in assumptions or other inputs	488,190	527,060	1,015,250
Benefit payments	(587,064)	(4,165,149)	(4,752,213)
Net Changes	(2,781,318)	19,496,927	16,715,609
Balance recognized at June 30, 2025	$ 9,529,396	$ 213,534,202	$ 223,063,598

10. Employee Benefits Plans (continued)

Actuarial assumptions and other inputs: The total OPEB liability for all plans as of June 30, 2025 was determined using the following actuarial assumptions and other inputs, applied to all periods included in the measurement, unless otherwise specified:

Salary increases rate	3.5% per annum
Discount rate	3.65% per annum (BOY), 3.93% per annum (EOY)
Health care cost trend rate:	
Pre-Medicare Medical and Rx Benefits	Select: 7.75%, ultimate: 4.0%
Medicare Benefits	Select: 6.75%, ultimate: 4.0%
Dental	Select: 4.0%, ultimate: 4.0%
Stop Loss Fees	Select: 7.75%, ultimate: 4.0%
Administrative Fees/Dental	Select: 4.0%, ultimate: 4.0%
Per Capita Health Claim Cost:	
PPO	$12,582 at age 60; $8,257 at age 70; $16,345 at age 70 with no Medicare
EPO	$12,737 at age 60; $8,358 at age 70; $16,546 at age 70 with no Medicare

Post-Retirement Mortality Rates:

Pub-2010 headcount weighted base mortality table, projected generationally using Scale MP-2021, applied on a gender-specific and job class basis (teacher, safety, or general, as applicable).

Key Assumption Changes from the Prior Valuation

- The discount rate was updated from 3.65% to 3.93%;
- The trend rates were updated to an initial rate of 7.75% (6.75% for Post-65) grading down to an ultimate rate of 4.00%. The Select trend rates are updated to reflect the higher than anticipated rising healthcare costs environment;
- The termination and retirement rates were updated to the rates from the Nevada PERS Actuarial Valuation report as of June 30, 2023;
- The salary scale was updated from 3.0% to 3.5% based on the wage growth assumption from the 2023 NVPERS.

Sensitivity of the total OPEB liability to changes in the discount rate. The following presents the total OPEB liability of the Hospital, as well as what the Hospital's total OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.93 percent) or 1 percentage point higher (4.93 percent) than the current discount rate:

10. Employee Benefits Plans (continued)

	1% Decrease 2.93%	Discount Rate 3.93%	1% Increase 4.93%
PEBP	$ 10,578,000	$ 9,529,000	$ 8,642,000
RHPP	257,178,000	213,534,000	179,366,000
Total OPEB Liability	$ 267,756,000	$ 223,063,000	$ 188,008,000

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rates. The following presents the total OPEB liability of the Hospital, as well as what the Hospital's total OPEB liability would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower or 1- percentage-point higher than the current healthcare cost trend rates:

	1% Decrease	Current Trend	1% Increase
PEBP	$ 8,685,000	$ 9,529,000	$ 10,506,000
RHPP	176,370,000	213,534,000	262,292,000
Total OPEB Liability	$ 185,055,000	$ 223,063,000	$ 272,798,000

OPEB Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

For the year ended June 30, 2025, the Hospital recognized OPEB negative expense of $231,436. The breakdown by plan is as follows:

	PEBP	RHPP	Total OPEB Total All plans
OPEB Expense	$ (2,194,254)	$ 1,962,818	$ (231,436)

10. Employee Benefits Plans (continued)

At June 30, 2025, the Hospital reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

		Deferred Outflows of Resources	Deferred Inflows of Resources
PEBP			
	Contributions made in fiscal year ending 2025 after July 1, 2024 measurement date	$ 562,000	$ -
Total PEBP		$ 562,000	$ -
RHPP			
	Differences between expected and actual experience	$ 35,977,315	$ 61,283,096
	Changes of assumptions or other inputs	25,254,869	59,808,646
	Contributions made in fiscal year ending 2025 after July 1, 2024 measurement date	4,042,000	-
Total RHPP		$ 65,274,184	$ 121,091,742
Total All Plans			
	Differences between expected and actual experience	$ 35,977,315	$ 61,283,096
	Changes of assumptions or other inputs	25,254,869	59,808,646
	Contributions made in fiscal year ending 2025 after July 1, 2024 measurement date	4,604,000	-
Total All Plans		$ 65,836,184	$ 121,091,742

The amount of $4,604,000 reported as deferred outflows of resources related to OPEB from Hospital contributions subsequent to the measurement date will be recognized as a reduction of the OPEB liability in the year ended June 30, 2026. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

For the Year ending June 30,	RHPP
2026	$ (10,391,659)
2027	(8,841,871)
2028	(8,841,871)
2029	(8,841,871)
2030	(8,841,871)
Thereafter	(14,100,416)
	$ (59,859,559)

11. Commitments and Contingencies

Litigation

The Hospital is involved in litigation and regulatory investigations arising in the ordinary course of business. The Hospital does not accrue for estimated future legal and defense costs, if any, to be incurred in connection with outstanding or threatened litigation and other disputed matters, but rather records such as period costs when services are rendered.

HIPAA

The Health Insurance Portability and Accountability Act ("HIPAA") was enacted on August 21, 1996, to assure health insurance portability, reduce healthcare fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Effective August 2009, the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") was introduced imposing notification requirements in the event of certain security breaches relating to protected health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in these laws and accompanying regulations.

Cyber Security Incident

During June 2021, the Hospital's cybersecurity team recognized suspicious activity on the Hospital's computer network and responded by immediately restricting external access to its computer servers. The Hospital worked with law enforcement and cybersecurity professionals to investigate this activity. Based upon this investigation, the Hospital believes cybercriminals accessed a server used to store data. This type of attack has become increasingly common in the healthcare industry, with hospitals worldwide experiencing similar situations. The cyber-attack and internal response did not result in disruptions to patient care or the Hospital's clinical systems.

Although the Hospital has no reason to believe cybercriminals accessed any clinical systems, in accordance with applicable federal regulations, the Hospital notified patients and employees that their personal information may be at risk. The Hospital provided patients and staff with access to complimentary identity protection and credit monitoring services and contacted patients and staff directly to provide information about how to access the complimentary services.

11. Commitments and Contingencies (continued)

As a result of the June 14, 2021, cyberattack, two (2) separate class action lawsuits were filed. On September 15, 2023, the two (2) separate class action lawsuits were consolidated in state court, and both cases were remanded from federal court after UMC had previously removed the cases to federal court. The following causes of action are being asserted: (1) Negligence; (2) Invasion of Privacy; (3) Breach of Contract; (4) Breach of Implied Contract; (5) Violation of Deceptive Trade Practices Act; (6) Negligent Misrepresentation; and (7) Violation of NRS 41.600, i.e., fraud and deceptive trade acts. On June 17, 2025, the Court issued a new Order Setting Jury Trial, setting the trial date of August 4, 2026. Expert Disclosures are due by December 9, 2025, and Discovery will close on March 9, 2026. UMC's main exposure remains the allegation that UMC's IT security systems did not meet industry and technical safeguard standards (e.g., NIST, ISO/IEC 27001, HIPAA, etc.) on the date of the attack.

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada
Statements of Revenues and Expenses, Budget to Actual Comparisons
For the fiscal year ended June 30, 2025
(With comparative actual for the fiscal year ended June 30, 2024)

	2025				2024
	Original Budget	**Final Budget**	**Actual**	**Variance**	**Actual**
Operating revenues:					
Intergovernmental revenues:					
Grants	$ 2,944,703	$ 2,944,703	$ 3,023,119	$ 78,416	$ 3,023,119
Charges for services:			-		-
Total patient revenue	974,720,137	972,090,469	993,620,259	21,529,790	926,666,768
Other operating revenues	39,485,883	39,485,883	46,296,827	6,810,944	42,291,556
Total operating revenues	**1,017,150,723**	**1,014,521,055**	**1,042,940,205**	**28,419,150**	**971,981,443**
Operating expenses:					
Salaries and wages	448,734,357	458,002,514	445,086,476	12,916,038	393,486,122
Employee benefits	170,464,230	177,497,282	186,721,066	(9,223,784)	166,386,537
Services and supplies	183,674,592	183,279,031	197,734,785	(14,455,754)	174,432,200
Professional fees	30,948,402	27,790,281	28,425,712	(635,431)	35,277,630
Purchased services	80,004,513	82,052,933	119,562,424	(37,509,491)	107,974,791
Other	33,527,569	33,594,654	13,232,734	20,361,920	24,764,004
Rent	1,588,636	1,864,715	1,944,587	(79,872)	1,862,030
Depreciation/amortization	47,732,409	47,847,766	49,455,802	(1,608,036)	48,105,549
	996,674,708	**1,011,929,176**	**1,042,163,586**	**(30,234,410)**	**952,288,863**
Nonoperating revenues (expenses):					
Interest earnings	9,887,677	9,887,677	11,382,309	1,494,632	4,807,097
Interest expense	(719,299)	(719,298)	(1,062,148)	(342,850)	(1,143,264)
Provision for OPEB and net pension liabilities	(13,330,191)	(13,330,191)	(11,764,203)	1,565,988	(46,700,309)
Other nonoperating revenue (expenses)	-	-	(87,177)	(87,177)	(43,410)
Total nonoperating revenues (expenses), net	**(4,161,813)**	**(4,161,812)**	**(1,531,219)**	**2,630,593**	**(43,079,886)**
Income (Loss) before transfers	**16,314,202**	**(1,569,933)**	**(754,600)**	**815,333**	**(23,387,306)**
Transfers In	**554,223**	**5,554,223**	**5,554,223**	**-**	**10,000,000**
Change in Net Position	**$ 16,868,425**	**$ 3,984,290**	**$ 4,799,623**	**$ 815,333**	**$ (13,387,306)**

University Medical Center of Southern Nevada
A Component Unit of Clark County, Nevada
Statements of Cash Flows Budget to Actual Comparisons
For the fiscal year ended June 30, 2025
(With comparative actual for the fiscal year ended June 30, 2024)

	2025				2024
	Original Budget	**Final Budget**	**Actual**	**Variance**	**Actual**
Cash flows from operating activities:					
Cash received from patients and third-party payers	$ 974,720,137	$ 972,090,470	$ 899,537,045	$ (72,553,425)	$ 1,088,392,162
Cash payments to employees for services and benefits	(632,528,778)	(648,829,987)	(631,334,909)	17,495,078	(561,547,634)
Cash payments to suppliers for goods and services	(329,743,712)	(328,581,614)	(414,707,670)	(86,126,056)	(384,385,733)
Other operating receipts	42,430,586	42,430,586	49,657,531	7,226,945	45,431,295
Net cash provided by (used in) operating activities	**54,878,233**	**37,109,455**	**(96,848,003)**	**(133,957,458)**	**187,890,090**
Cash flows from noncapital financing activities:					
Contributions and transfers in from Clark County	554,223	5,554,223	5,554,223	-	10,000,000
Net cash provided by noncapital financing activities	**554,223**	**5,554,223**	**5,554,223**	**-**	**10,000,000**
Cash flows from capital and related financing activities:					
Purchase of property and equipment, net	(51,770,733)	(51,770,733)	(34,164,429)	17,606,304	(67,139,224)
Principal paid on long-term debt	-	-	-	-	(6,556,361)
Interest paid on long-term debt	-	-	-	-	(104,971)
Other	-	-	(87,175)	(87,175)	3,564
Net cash used in capital and related financing activities	**(51,770,733)**	**(51,770,733)**	**(34,251,604)**	**17,519,129**	**(73,796,992)**
Cash flows from investing activities					
Gain on change of the investments	9,887,677	9,887,677	11,382,309	1,494,632	4,807,097
Net (decrease) increase in cash and cash equivalents	**13,549,400**	**780,622**	**(114,163,075)**	**(114,943,697)**	**128,900,195**
Cash and cash equivalents:					
Beginning of year	**260,490,840**	**260,490,840**	**246,682,817**	**(13,808,023)**	**117,782,622**
End of year	**$ 274,040,240**	**$ 261,271,462**	**$ 132,519,742**	**$ (128,751,720)**	**$ 246,682,817**

Employee Benefit Retirement Plan
Net Pension Liability
Required Supplementary Information

Schedule of the Hospital's Proportionate Share of the Net Pension Liability
Public Employees' Retirement System of Nevada
(Amounts Were Determined as of 6/30 of Each Prior Fiscal Year)*

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Hospital's proportion of net pension liability (%)	3.74%	3.93%	3.49%	3.44%	3.66%	3.82%	3.76%	3.58%	3.49%	3.47%
Hospital's proportionate share of net pension liability	$ 676,678,238	$ 716,838,932	$ 630,420,958	$ 313,924,210	$ 510,283,540	$ 521,536,183	$ 512,951,016	$ 476,011,834	$ 469,010,768	$ 397,580,372
Hospital's covered-employee payroll	$ 362,931,044	$ 325,847,737	$ 307,612,768	$ 258,994,712	$ 247,058,515	$ 263,088,842	$ 264,122,683	$ 250,244,531	$ 230,360,225	$ 213,368,871
Hospital's proportionate share of net pension liability as a percentage of its covered-employee payroll	186.45%	219.99%	204.94%	121.21%	206.54%	198.24%	194.21%	190.22%	203.60%	186.33%
Plan fiduciary net position as a percentage of total pension liability	78.11%	76.16%	75.12%	86.51%	77.04%	76.46%	75.24%	74.40%	72.20%	75.10%

This schedule is presented to illustrate the requirement to show information for 10 years.

* The amounts are determined from the prior fiscal year for the current reporting year.

Employee Benefit Retirement Plan
Note to Required Supplementary Information

Schedule of Hospital's Contributions
Public Employees' Retirement System of Nevada
(Amounts Were Determined as of 6/30 Prior Fiscal Year)

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Statutorily required contributions	$ 61,623,136	$ 53,892,978	$ 45,516,255	$ 38,411,410	$ 36,017,847	$ 38,205,556	$ 36,785,296	$ 35,026,725	$ 31,952,786	$ 59,262,299
Contributions in relations to statutorily required contributions	$ 61,623,136	$ 53,892,978	$ 45,516,255	$ 38,411,410	$ 36,017,847	$ 38,205,556	$ 36,785,296	$ 35,026,725	$ 31,952,786	$ 59,262,299
Contributions deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hospital's covered-employee payroll	$ 362,931,044	$ 325,847,737	$ 307,612,768	$ 258,994,712	$ 247,058,515	$ 263,088,842	$ 264,122,683	$ 250,244,531	$ 230,360,225	$ 213,368,871
Contributions as a percentage of covered-employee payroll	16.98%	16.54%	14.80%	14.83%	14.58%	14.52%	13.93%	14.00%	13.87%	27.77%

This schedule is presented to illustrate the requirement to show information for 10 years.

Changes of benefit terms: There were no changes of benefit terms in 2025.

Changes of assumptions: There were no changes of benefit assumptions in 2025.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
(A COMPONENT UNIT OF CLARK COUNTY, NEVADA)

Other Postemployment Benefits
Required Supplementary Information

Schedules of Changes in the Total OPEB Liability and Related Ratios
For the Year Ended June 30 of Each Prior Fiscal Year

PEBP Plan

	2025	2024	2023	2022	2021	2020	2019	2018
Total OPEB Liability								
Service cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest	438,627	438,674	423,836	437,416	712,888	754,777	837,289	752,369
Changes of benefit terms	-	-	-	-	-	-	-	-
Difference between actual and expected experience	(3,121,071)	-	(4,823,125)	-	(3,738,844)	-	(6,654)	50,232
Changes of assumptions or other inputs	488,190	(200,203)	(2,163,355)	94,725	3,217,101	941,195	(4,153,809)	(2,555,531)
Benefit payments	(587,064)	(639,383)	(695,509)	(709,878)	(823,720)	(838,318)	(910,344)	(943,003)
Net Change in Total OPEB Liability	(2,781,318)	(400,912)	(7,258,153)	(177,737)	(632,575)	857,654	(4,233,518)	(2,695,933)
Total OPEB Liability - Beginning	12,310,714	12,711,626	19,969,779	20,147,516	20,780,091	19,922,437	24,155,955	26,851,888
Total OPEB Liability - Ending	$ 9,529,396	$ 12,310,714	$ 12,711,626	$ 19,969,779	$ 20,147,516	$ 20,780,091	$ 19,922,437	$ 24,155,955
Covered Payroll	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total OPEB Liability as a Percentage of Covered Payroll	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

RHPP

	2025	2024	2023	2022	2021	2020	2019	2018
Total OPEB Liability								
Service cost	$ 7,747,306	$ 7,624,942	$ 8,833,263	$ 8,937,345	$ 8,093,442	$ 6,766,369	$ 17,486,880	$ 18,335,102
Interest	7,289,123	6,838,826	4,382,094	4,227,380	5,552,088	5,423,405	9,615,301	8,032,804
Changes of benefit terms	-	-	-	-	-	-	-	-
Difference between actual and expected experience	8,098,587	-	36,194,916	-	(6,056,494)	-	(116,492,033)	5,259
Changes of assumptions or other inputs	527,060	(4,101,522)	(54,635,189)	1,687,151	28,178,688	9,761,359	(24,138,375)	(35,408,967)
Benefit payments	(4,165,149)	(3,774,404)	(2,734,210)	(3,580,284)	(4,336,810)	(5,236,733)	(3,154,125)	(3,220,455)
Net Change in Total OPEB Liability	19,496,927	6,587,842	(7,959,126)	11,271,592	31,430,914	16,714,400	(116,682,352)	(12,256,257)
Total OPEB Liability - Beginning	194,037,275	187,449,433	195,408,559	184,136,967	152,706,053	135,991,653	252,674,005	264,930,262
Total OPEB Liability - Ending	$ 213,534,202	$ 194,037,275	$ 187,449,433	$ 195,408,559	$ 184,136,967	$ 152,706,053	$ 135,991,653	$ 252,674,005
Covered Payroll	$ 325,847,737	$ 307,612,768	$ 258,994,712	$ 247,058,515	$ 263,088,842	$ 231,341,937	$ 231,341,937	$ 231,533,548
Total OPEB Liability as a Percentage of Covered Payroll	66%	63%	72%	79%	70%	66%	59%	109%

Fiscal year 2018 is the first year of implementation, therefore only eight years are shown.
As it becomes available this schedule will ultimately present information for the ten most recent fiscal years.

Other Postemployment Benefits
Note to Required Supplementary Information

There are no assets accumulated in a trust to pay related benefits.

Changes of Assumptions

With reporting date of June 30, 2025, key assumption changes since the prior valuation were as follows:

- The discount rate was updated from 3.65% to 3.93%;
- The trend rates were updated to an initial rate of 7.75% (6.75% for Post-65) grading down to an ultimate rate of 4.00%. The Select trend rates are updated to reflect the higher than anticipated rising healthcare costs environment;
- The termination and retirement rates were updated to the rates from the Nevada PERS Actuarial Valuation report as of June 30, 2023;
- The salary scale was updated from 3.0% to 3.5% based on the wage growth assumption from the 2023 NVPERS.

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Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

UMC Governing Board
University Medical Center of Southern Nevada
Las Vegas, Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of University Medical Center of Southern Nevada (UMC), a component unit of Clark County, Nevada, which comprise UMC's statement of financial position as of June 30, 2025, and the related statements of revenues, expenses, and changes in Net Position, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 6, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered UMC's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the UMC's internal control. Accordingly, we do not express an opinion on the effectiveness of UMC's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the UMC's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the UMC's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the UMC's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BDO USA, P.C.

Las Vegas, Nevada
November 6, 2025

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue: **Physician & Non-Physician Provider Traditional Compensation Plan**	**Back-up:**
Petitioner: Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board approve the revisions to the Physician & Non-Physician Provider Traditional Compensation Plan as recommended by the Human Resources and Executive Compensation Committee; and take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The substantive changes to this Compensation Plan are:

1. Revised the Work Schedules language on page 2 to reflect an average of 15 shifts per month.
2. Revised Appendix 2 (page 9) – pursuant to an FMV that was conducted for Radiology Provider classifications.
   a. Modified base salary ranges for all classifications
   b. Created designations for Core Faculty and Faculty to support the Radiology Residency Program
   c. Added night shift differential
3. We anticipate the revisions to be effective on January 1, 2026, and will cover existing and future employees within the identified classifications.

This Plan was reviewed by the Governing Board Human Resources and Executive Compensation Committee at their November 10, 2025 meeting and recommended for approval by the Governing Board.

5

2025

PHYSICIAN AND NON-PHYSICIAN PROVIDER TRADITIONAL COMPENSATION AND BENEFITS PLAN

UMC
UNIVERSITY MEDICAL CENTER

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

PHYSICIAN AND NON-PHYSICIAN PROVIDER TRADITIONAL COMPENSATION AND BENEFITS PLAN

Revision Effective Date: January 1, 2026
Original Implementation Date: July 1, 2023

Mason Van Houweling - Chief Executive Officer

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA ("UMC")

PHYSICIAN AND NON-PHYSICIAN PROVIDER TRADITIONAL COMPENSATION AND BENEFITS PLAN (the "Compensation Plan")

Compensation Plan and Employees Covered

This Compensation Plan identifies the compensation and benefits structure for Physician and Non-Physician provider employees in the following classifications:

• Medical Director, Anesthesiologist	• Medical/Program Director, Radiologist
• Anesthesiologist - Obstetric, General/OR, Pediatric, CVT, Trauma	• Certified Registered Nurse Anesthetists (CRNA)
• Radiologist – Diagnostic, Interventional, Neurointerventional	• Radiology APP
• Medical Director, General Medicine Hospitalist • General Medicine Hospitalist	• Hospitalist APP
• Medical Director, Emergency Physician • Emergency Physician	

Such employees will be referred to as "employee" or "employees" in this document. This document replaces all previous communications regarding Physician and Mid-Level compensation and benefits under an existing compensation model or an employee's offer of employment letter; provided however, the terms and conditions of the employee's at-will employment agreement, if any, shall control in the event of a conflict between the two documents.

University Medical Center retains the rights to add, modify, or eliminate any compensation or benefit contained within this plan document with the final approval of the UMC Governing Board and/or in accordance with the terms and conditions of the employee's contract for employment.

Fair Labor Standards Act (FLSA) Exemption:

Employees covered by this plan document are not authorized overtime compensation under the FLSA due to their professional exemption.

At-Will Employment:

All employees covered by this plan document are considered At-Will and will serve at the pleasure of the Chief Executive Officer.

Voluntary Resignation:

All employees covered by this plan document are encouraged to provide a minimum of sixty (60) days notice of a voluntary resignation.

Compensation and Benefits

Compensation:

During the term of employment, Physicians and Non-Physician Providers shall be eligible for a compensation package at a rate consistent with the pay ranges listed in the Appendices, as may be amended from time to time. The Appendices further sets forth a compensation package that will not exceed the 75th percentile (or 90th percentile when factors such as shortages or otherwise hard-to-fill positions justify) based upon national and regional physician and midlevel compensation survey benchmarks (e.g., Sullivan Cotter, MGMA).

Unless modified by the provisions of this Compensation Plan and/or at-will employment agreement, employees will be granted the same benefits provided through the Human Resources Policies and Procedures.

The employee's base salary shall be re-evaluated bi-annually (i.e., every other year), consistent with the methodology set forth above.

The CEO (or designee) may authorize bonuses (e.g., sign-on, relocation, etc.), subject to existing UMC Human Resources Policies and Procedures, and provided it is consistent with fair market value.

Work Schedules:

All full & part-time Physicians and Non-Physician Providers are salaried, exempt employees, while per-diem are hourly, non-exempt employees. Work schedules are determined based on a designated Full Time Equivalent (FTE) status. Employees designated as less than a 1.0 FTE are eligible for salary and benefits prorated based on FTE status. Employees are expected to be available to work their full, designated FTE status.

Unless otherwise set forth on the applicable service line Appendix, Employee's work schedules will be set by the Practice Plan Administrator or designee or as set forth in any at-will employment agreement or signed offer letter. Except as otherwise set forth herein, it is anticipated that full-time employees will work a minimum of fifteen (15) shifts per month, while part-time will work a minimum of seven (7) shifts per month. Notwithstanding the minimum shift requirement, it is understood that based on the length of a calendar month, and service line specific scheduling requirements, the fifteen (15) shift requirement is an approximate amount and may be spread over a two-month period (or as much as five (5) pay periods) and the same will not violate the requirements under this section.

Extra Shift/Hours Compensation:

In the event an employee works in excess of their regular and on-call shifts he or she shall be entitled to the additional shift compensation set forth in the Appendices. Additionally, in the event an employee is required to stay over a scheduled shift more than two (2) hours, the employee will receive additional hourly compensation consistent with their regular hourly rate of compensation for hours above and beyond the scheduled shifts. ***Example:*** Employee works 12.5 hours in a 10-hour scheduled shift will entitle such employee to two and one half hours of additional pay at the next regularly scheduled pay period.

With the exception of per-diem status employees, any excess time less than the two-hours over the scheduled shift does not entitle the employee to any additional hourly compensation.

On-Call Coverage:

Physicians and Non-Physician Providers, who provide on-call coverage, may receive additional shift compensation at the rates set forth in the Appendices, for on-call coverage over and above a pre-determined amount, as set forth by the Medical Director, or in the employee's offer of employment letter or At-Will contract for employment. An employee who is on unrestricted call, who is called to return to the facility to perform work, will receive callback pay consistent with the rates set forth in the Appendices.

Annual Evaluations:

Employee performance will be evaluated on an annual basis. The annual evaluation cycle shall be based on fiscal year (July 1 - June 30). All Compensation Plan employees shall have a common review date of September 1st unless otherwise established by the CEO. Employees under this Compensation Plan are not subject to merit or cost of living increases as their compensation is subject to bi-annual (i.e., every other year) fair market value reviews consistent with the terms of this Compensation Plan and their employment agreement.

Consolidated Annual Leave (CAL) / Administrative Leave Days (ALDs):

The Chief Executive Officer (or designee) shall determine if a Physician Provider classification covered by this Compensation & Benefits Plan will:

1. Accrue CAL in accordance with the hospital's standard human resources policies & procedures; or,
2. Participate in the ALD program as defined below.

Physicians

Physician Providers in a classification designated to participate in the ALD program will not accrue CAL as set forth in the hospital's Human Resources Policies and Procedures. Instead, each part-time or full-time Physician Provider under this Compensation Plan designated as such shall receive Administrative Leave Days (ALDs).

Appropriate use of ALDs include sick days, and leave of absences. ALDs do not roll over year to year, may not be converted to compensation, transferred to other ineligible classifications or statuses, nor are they paid out upon separation of employment. Requests to use ALDs shall be submitted to the Medical Director (or designee) over the service line.

ALDs will be awarded on a pro-rated basis upon the first year of hire. Thereafter, the employee will receive their allotment of ALDs each January 1st. Eligible employee's under this Compensation Plan will receive ALDs as follows:

Employment Status*	# Regularly scheduled shifts per month	# of ALDs
Part-Time	Up to 14	7
	15-19	15
Full-Time	Up to 19	15
	20+	30

*- an Employee's employment status is determined by UMC Human Resources and is set forth in the applicable offer letter/contract of employment.

An employee's time-off may differ in accordance with their at-will employment agreement. Physicians accruing CAL upon final approval and implementation of this September 1, 2023 Compensation Plan will retain any accrued CAL time and will be required to exhaust such time prior to the use of any ALDs. CAL accrued prior to implementation of this September 1, 2023 Compensation Plan may not be converted to compensation, nor is it paid out upon separation of employment.

Non-Physician Providers

Full & part-time Non-Physician Providers (e.g., CRNAs) under this Compensation Plan will continue to accrue and use CAL consistent with the hospital's Human Resources Policies and Procedures.

Extended Illness Bank (EIB):

Eligible employees under this Compensation Plan will accrue Extended Illness Bank (EIN) as set forth in hospital's Human Resources Policies and Procedures. The rules governing the use of EIB leave time shall be consistent with those set forth by Human Resource Policies and Procedures.

Miscellaneous Leaves:

Miscellaneous Leaves, such as jury/court duty, military leave, bereavement leave, family leave, etc., are administered in accordance with Human Resources Policies and Procedures.

Group Insurance:

UMC provides medical, dental, and life insurance to all eligible employees covered by this plan. To be eligible for group insurance, an employee must occupy a regular budgeted position and work the required hours to meet the necessary qualifying periods associated with the insurance program.

Employees will have deducted each pay period an approved amount from their compensation for employee insurance, or other elected coverages. Amounts are determined by UMC and approved by the UMC Governing Board. Rules governing the application and administration of insurance benefits shall be consistent with those set forth by Human Resource Policies and Procedures.

Retirement:

Employees are covered by the Nevada Public Employees Retirement System. UMC pays the employee's portion of the retirement contribution under the employer-pay contribution plan in the manner provided for by NRS Chapter 286. Any increases in the percentage rate of the retirement contribution above the rate set forth in NRS 286.421 on May 19, 1975, shall be borne equally by UMC and the employee in the manner provided by NRS 286.421. Any decrease in the percentage rate of the retirement contribution will result in a corresponding increase to each employee's base pay equal to one-half (1/2) of the decrease. Any such increase in pay will be effective from the date the decrease in the percentage rate of the retirement contribution becomes effective. Retirement contribution does not include any payment for the purchase of previous credit service on behalf of any employee.

Continuing Medical Education (CME):

UMC will pay a $2,500 CME stipend (Stipend), less appropriate withholdings each calendar year in January, for a qualified employee upon the employee's execution of UMC's CME Stipend Attestation form. The Stipend is available to a UMC employed licensed independent provider including, but not limited to, physician, nurse practitioner, physician assistant, CRNA, and dentist. At its sole discretion, UMC may identify other independent providers that qualify for the Stipend. Qualified employees may also request up to 40 hours of paid release time each calendar year to attend CME related activities. Approval of such time is at the sole discretion of UMC leadership.

All training, travel, and lodging must be pre-approved by the Chief Operating Officer, Medical Director, and such other person(s) as may be required by the COO and Medical Director pursuant to the hospital's training and travel policy. In the event an employee is on leave or FMLA, the employee is not eligible to take CME release time.

Conflict of Interest:

Physicians are expected to comply with applicable Medicare and Medicaid and other applicable federal, state, and/or local laws and regulations, as-well-as, hospital policies and procedures and Medical and Dental Staff Bylaws. In so doing, it is emphasized that each employee must refrain from using his/her position as a UMC employee to secure personal gain and/or endorse any particular product or service. This includes seeking or accepting additional employment or ownership in a business outside UMC that represents a conflict of interest as defined in the Ethical Standards Policy.

The referral of patients to individuals or practices which compete with or do not support UMC is considered a conflict of interest. However, it is understood that patients have the right to choose where to be referred upon full disclosure by the attending physician of all relevant information. All referrals must go through the UMC Referral Office where they will be processed accordingly.

All other provisions of the conflict of interest policy shall be as defined and described in the Human Resources Policy and Procedures Manual titled Ethical Standards and the UMC Medical and Dental Staff Bylaws.

Professional Standards:

Quality and safe patient care and the highest professional standards are the major goals of UMC and its facilities. To that end, UMC agrees to make every reasonable effort to provide a work environment that is conducive to allowing employees to maintain a professional standard of quality, safe patient care, and patient confidentiality. Employees shall be required to conduct themselves in a professional manner at all times.

UMC is a teaching facility. To that extent, physician employees may be required to supervise or co-sign medical records for mid-level providers or residents who are in a recognized residency program, such as the UNLV School of Medicine Residency Program.

UMC shall provide interpretive services in designated exam rooms. Physician employees are required to use the interpretive services provided through UMC.

No Physician employee shall unreasonably and without good cause fail to provide care to patients. Any patient complaint received in writing shall be administered pursuant to UMC Administrative Policy, as modified from time to time. The employee shall be required to meet with the Patient Advocate and/or the Medical Director so that a response, if any, may be prepared. The affected employee shall receive a copy of any written response. If any discipline is administered, just cause standards and the appropriate sections of the Human Resources Policies and Procedures Manual shall apply.

All Physicians will follow the UMC Code of Conduct for Corporate Compliance. This includes completing a Medicare Enrollment Application – Reassignment of Medicare Benefits (CMS-855R) form.

UMC is an equal opportunity employer and will not tolerate discrimination on the basis of race, color, religion, sex, national origin, age, disability, sexual orientation, gender identity or expression, and/or genetic information in employment. In accordance with state and federal laws, the UMC Governing Board is committed to an Equal Opportunity, Affirmative Action and Sexual Harassment Policy to prohibit unlawful discrimination.

Pursuant to Nevada Revised Statutes Chapter 41, UMC will indemnify an employee whose acts or omissions are within the course and scope of their employment and will thereafter continue to cover (without cost to the employee) the employee under the hospital's self-funded insurance policy. As such, each employee is covered for professional liability and general liability purposes, in accordance with Chapter 41 of the Nevada Revised Statutes, by the certificate of insurance and statement of indemnification.

Appendix 1*

Anesthesiology - Pay Grades/Ranges & Additional Compensation

Position	Base Salary Range[1]	Additional Work Shift Rate[5]	Additional On-Call Shift Rate[2]	Call-Back Rate[3]	Per-Diem Rate[4]
SPECIALTY – Anesthesia					
Medical Director	$524,160-$744,640	N/A	N/A	N/A	N/A
General / OR	$468,000-$673,920	EEs regular hourly rate	$36.00 p/h.	EEs hourly rate if on-call and called back to facility	$327.00 p/h
Pediatric	$468,000-$673,920		$35.00 p/h.		$327.00 p/h
Trauma	$491,400-$707,616		$38.00 p/h.		$343.00 p/h
OB	$468,000-$673,920		$36.00 p/h.		327.00 p/h
CVT	$515,840-$678,080		$40.00 p/h.		$329.00 p/h
CRNA	$162,240-$235,040		$17.00 p/h.		$140.00 p/h

*Appendix 1 may be amended from time to time, with Board approval, to reflect new employment physician specialties based upon compensation rates that are consistent with FMV.

[1] Based on years of experience
*[2] On-call unrestricted shifts in excess of the number required per agreement – **note:** If an employee is placed on a restricted call shift (i.e., where employee is required to be onsite) the employee will be paid at their standard base hourly rate of pay.*
[3] EE must be on an On-call shift and called to return to facility to perform work
[4] Applicable only to those hired into a per-diem classification
[5] See extra shift/hours on page 2 of this document

Appendix 2*

Radiology - Pay Grades/Ranges & Additional Compensation

Position/Specialty	Base Salary Range	Additional Work Shift Rate[5]	Additional On-Call Shift Rate[6]	Call-Back Rate[7]	Per Diem Rate[8]
Medical/Program Director[1]	$602,208-$876,158	See below	See below	See below	N/A
Associate Program Director[2]	$536,640 - $805,020	See below	See below	See below	N/A
Core Faculty[3]					
Diagnostic Radiologist	$454,884 - $794,033	EEs Regular Hourly Rate of Pay	$54.25 p/h	EEs hourly rate if on-call and called back to facility	N/A
Interventional Radiologist	$525,174 - $794,611		$55.77 p/h		N/A
Neuro-IR Radiologist	$470,331-$807,137		$58.33 p/h		N/A
Night Differential[9]	$50 p/h		N/A		N/A
Faculty[4]					
Diagnostic Radiologist	$495,214 - $821,842	EEs Regular Hourly Rate of Pay	$54.25 p/h	EEs hourly rate if on-call and called back to facility	N/A
Interventional Radiologist	$576,540 - $822,493		$55.77 p/h		N/A
Neuro-IR Radiologist	$514,842-$836,585		$58.33 p/h		N/A
Night Differential[9]	$50 p/h		N/A		N/A
Non-Academic					
Diagnostic Radiologist	$537,544 - $800,946		$54.25 p/h		$401 p/h
Interventional Radiologist	$627,906 - $811,844		$55.77 p/h		$411 p/h
Neuro-IR Radiologist	$559,353 - $810,947		$58.33 p/h		$403 p/h
Night Differential[9]	$50 p/h		N/A		$50 p/h
APP	$128,122 - $190,901		$13.00 p/h		$81 p/h

*Appendix 2 may be amended from time to time, with Board approval, to reflect new employment physician specialties based upon compensation rates that are consistent with FMV.

[1] Medical/Program Director compensation is based upon a 0.6 Clinical FTE (CFTE) and the remainder of the 1.0 FTE being dedicated to academic/administrative time. At a 0.6 CFTE, the Director will be responsible for nine (9) shifts per month. Note, compensation is subject to adjustment if the Director's specialty differs from neurointerventional radiology or interventional radiology.

[2] The Associate Program Director compensation is based upon a 0.7 Clinical FTE (CFTE) and the remainder of the 1.0 FTE being dedicated to academic/administrative time. At a 0.7 CFTE, the Associate Program Director will be responsible for eleven (11) shifts per month. Compensation is subject to adjustment if Associate Program Director's specialty differs from diagnostic radiology.

[3] Core Faculty compensation is based upon a 0.8 Clinical FTE (CFTE) and the remainder of the 1.0 FTE in the specialties identified in the categories listed. Core faculty is responsible for 13 clinical shifts per month.

[4] Faculty compensation is based upon a 0.9 Clinical FTE (CFTE) and the remainder of the 1.0 FTE in the specialties identified in the categories listed. Faculty is responsible for fourteen (14) clinical shifts per month.

[5] See extra shift/hours on page 2 of this document

*[6] On-call unrestricted shifts in excess of the number required per agreement – **note:** If an employee is placed on a restricted call shift (i.e., where employee is required to be onsite) the employee will be paid at their standard base hourly rate of pay.*

[7] EE must be on an On-call shift and called to return to facility to perform work

[8] Applicable only to those hired into a per-diem classification. The hourly rates listed are not-to-exceed amounts.

[9] Night Shift differential paid an additional $50 per hour above the employee's regular hourly rate of pay for shifts starting at or after 7:00pm.

Appendix 3*

Hospitalist - Pay Grades/Ranges & Additional Compensation

Position	Base Salary Range[1]	Additional Work Shift Rate[5]	Additional On-Call Shift Rate[2]	Call-Back Rate[3]	Per-Diem Rate[4]
SPECIALTY – General Medicine					
GM Medical Director	$306,000 - $358,368	N/A	N/A	N/A	N/A
GM Hospitalist	$285,000 - $327,767	EEs regular hourly rate	N/A	EEs hourly rate if on-call and called back to facility	EEs Hourly Rate plus 15%
GM APP	$126,040- $147,841		N/A		

*Appendix 3 may be amended from time to time, with Board approval, to reflect new employment physician specialties based upon compensation rates that are consistent with FMV.

[1] Based on years of experience
*[2] On-call unrestricted shifts in excess of the number required per agreement – **note:** If an employee is placed on a restricted call shift (i.e., where employee is required to be onsite) the employee will be paid at their standard base hourly rate of pay.*
[3] EE must be on an On-call shift and called to return to facility to perform work
[4] Applicable only to those hired into a per-diem classification
[5]See extra shift/hours on page 2 of this document

Appendix 4*

Emergency Medicine - Pay Grades/Ranges & Additional Compensation

Position	Base Salary Range[1]	Additional Work Shift Rate[5]	Additional On-Call Shift Rate[2]	Call-Back Rate[3]	Per-Diem Rate[4]
SPECIALTY – Emergency Medicine					
EM Medical Directors	$315,732-$486,303	EEs regular hourly rate	N/A	N/A	N/A
(FT) EM Physician	$315,732-$437,672				PT EEs Hourly Rate plus 15%
(PT) EM Physician *(1456 hrs.) * **	$207,452-$323,983				
EM APP	$109,652-$177,252				

*Appendix 4 may be amended from time to time, with Board approval, to reflect new employment physician specialties based upon compensation rates that are consistent with FMV.

***Part-time employment is determined to be 1456 hours /0.7 FTE (182 8-hour shifts annually).*

[1] Based on years of experience
*[2] On-call unrestricted shifts in excess of the number required per agreement – **note:** If an employee is placed on a restricted call shift (i.e., where employee is required to be onsite) the employee will be paid at their standard base hourly rate of pay.*
[3] EE must be on an On-call shift and called to return to facility to perform work
[4] Applicable only to those hired into a per-diem classification
[5] See extra shift/hours on page 2 of this document

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Ratification of the Amendment to the Facility Agreement with Anthem Blue Cross and Blue Shield and HMO Colorado, Inc.**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board ratify the Amendment to the Facility Agreement with Anthem Blue Cross and Blue Shield and HMO Colorado, Inc. for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Center: 3000850000
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term: Auto renews annually until terminated
Amount: Revenue based on volume
Out Clause: 180 days without cause

Fund Name: UMC Operating Fund
Funded Pgm/Grant: N/A

BACKGROUND:

UMC entered into a Facility Agreement with Anthem Blue Cross and Blue Shield, effective September 1, 2014, which provides for the delivery of healthcare services to Anthem's covered beneficiaries. This request is for ratification of the Amendment to the Facility Agreement, which enables UMC to participate in the Enhanced Personal Health Care Essentials program, a quality incentive program with Anthem. Ratification was necessary to take advantage of the incentive dollars.

UMC's Director of Managed Care has reviewed and recommends ratification of this amendment, which has also been approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

This amendment was reviewed by the Governing Board Audit and Finance Committee at their November 12, 2025, meeting and recommended for ratification by the Governing Board.

Cleared for Agenda
November 19, 2025

Agenda Item #
6

AMENDMENT TO THE ANTHEM
PROVIDER AGREEMENT

This Amendment is to the Provider Agreement ("Agreement") dated September 1, 2014 and entered into between Rocky Mountain Hospital and Medical Service, Inc. doing business as Anthem Blue Cross and Blue Shield and HMO Colorado, Inc. doing business as HMO Nevada (hereinafter referred to as "Anthem") and (hereinafter referred to as "Anthem") and University Medical Center of Southern Nevada (hereinafter "Provider") and is incorporated into the Agreement as follows:

NETWORKS/PRODUCTS/PLAN PROGRAMS

- Enhanced Personal Health Care Essentials Program Participation Attachment

Except as expressly set forth herein, nothing contained herein shall be construed to modify the Agreement. To the extent this Amendment conflicts with any provision of the Agreement, this Amendment shall control.

Each party to this Amendment warrants that it has full power and authority to enter into this Amendment and the person signing this Amendment on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Amendment.

THE EFFECTIVE DATE OF THIS AMENDMENT IS: January 1, 2026.

PROVIDER NAME: University Medical Center of Southern Nevada

By: _____ Nov 12, 2025
Signature, Authorized Representative of Provider(s) — Date

Printed: Mason Van Houweling — Chief Executive Officer
Name — Title

Address: 1800 W. Charleston Blvd. — Las Vegas Nevada 89102
Street — City State Zip

Tax Identification Number (TIN): 88-6000436

Phone Number: (702) 383-3982

Email Address: Kimberly.Carroll@umcsn.com

Anthem

By: _____
Signature, Authorized Representative of Anthem — Date

Printed: Ashley DeLanis — RVP Provider Solutions
Name

Address: 9133 West Russell Road — Las Vegas NV 89148
Street — City State Zip

ENHANCED PERSONAL HEALTH CARE PROGRAM
PARTICIPATION ATTACHMENT TO THE ANTHEM
PROVIDER AGREEMENT

This Enhanced Personal Health Care Essentials Program Participation Attachment, including its Exhibits, Appendices, Attachments, Addenda and the Program Description (collectively, the "Attachment") to the Anthem Provider Agreement (the "Agreement") entered into between Anthem and Provider (individually a "Party" and collectively, the "Parties") is incorporated into the Agreement effective January 1, 2026 (the "Program Attachment Effective Date").

ARTICLE I
RECITALS

Whereas, Anthem and Provider and its Represented Providers as defined below, are dedicated to the development of a more effective health delivery system which emphasizes continuous improvement and increased patient access to high quality, cost-effective health care; and

Whereas, Anthem's Enhanced Personal Health Care Essentials Program (the "Program") is designed to provide financial rewards to Provider for implementation and execution of collaborative processes which result in high quality care that is patient-centered; and

Whereas, the transformation to a patient-centered care model requires a collaborative relationship between Anthem and Provider on behalf of itself and its Represented Providers where both Parties leverage the other Parties' unique assets, whether clinical, administrative or data, to support coordinated care with a focus on risk stratified care management, wellness and prevention, improved access and shared decision making with patients and their caregivers; and

Whereas, Provider and its Represented Providers desire to participate in the Program subject to the terms set forth below;

Now, therefore, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

This Attachment applies to Commercial Business, unless amended.

ARTICLE II
DEFINITIONS

The following definitions shall apply to this Attachment. All other defined terms used in this Attachment shall have the same meaning set forth in the Exhibits, Addenda, and Attachments hereto and in the Agreement, including the PCS.

"**Affiliate(s)"** means any entity owned or controlled, either directly or through a parent or subsidiary entity, by either Party, or any entity which is under common control with either Party.

"**Attributed Members**" means those Covered Individuals who are attributed by Anthem to Represented Providers for Program purposes using the Attribution Methodology and adjusted for retroactive enrollment changes (as applicable). The term "Attributed Members" shall not include any Covered Individuals whom Anthem, in the exercise of its sole discretion, does not include on the attribution reporting tools that are made available to Provider. By way of example, if the attribution reporting does not include Covered Individuals in certain employer groups, then those Covered Individuals will not be considered Attributed Members for the purposes of the Program. Covered Individuals whose Anthem coverage is secondary under applicable laws or coordination of benefit rules or which is provided under a supplemental policy (e.g., Medicare supplement) shall never be Attributed Members. It is Anthem's goal to continue to expand the Covered Individuals included in monthly attribution reports as operationally feasible and contractually permitted**.**

"**Attribution Methodology**" means a process whereby Anthem, in the exercise of its sole discretion, will assign Covered Individuals to the Represented Providers in one of the following manners:

i) based on the formal selection of a Primary Care Provider by the Covered Individual; or
ii) based on the formal assignment of a Represented Provider to the Covered Individual by Anthem or employer group; or
iii) based on a Covered Individual's prior utilization of evaluation and management services with a Represented Provider.

Provider agrees and acknowledges that such assignment of a Covered Individual to Provider utilizing the Attribution Methodology will not impose any limitations or constraints on the freedom of such Covered Individuals to refer themselves for Health Services except as may otherwise be set forth in the Health Benefit Plan. The Attribution Methodology is described further in the Program Description.

"**Baseline Period"** means a defined period preceding a Measurement Period determined by Anthem used to set targets and/or give the Provider an indication of their performance at the start of the Measurement Period.

"BlueCard" means the national program sponsored by the Blue Cross Blue Shield Association that enables members of one Blue Cross and/or Blue Shield (BCBS) Plan to obtain healthcare services while in another Blue Cross and/or Blue Shield Plan's service area.

"Commercial Business" means, for purposes of this Attachment and its Exhibits only, i) Plan's Federal Employees Health Benefits Program (FEHBP) business and (ii) Plan's fully insured and self-funded business with companies or individuals, as determined by Anthem, where there is a Health Benefit Plan between or covering the Parties and the funding for such business is provided by non-governmental sources. Except as otherwise provided above, "Commercial Business" does not include, without limitation, any government business such as Medicare (including Medicare Advantage) and Medicaid. However, notwithstanding the foregoing, there may be Commercial Business products that are excluded as described in Exhibit B.1.

"Efficiency Measurement Period (EMP)" means the actual cost experience in the Member Population during a relevant performance period, calculated taking into account the risk adjusted PMPM costs during the performance

period, but excluding Claims amounts identified as set forth in Section 1 EMP Adjustments and Exclusions of Article I, Exhibit B. The EMP calculation includes consideration of Anthem product type (e.g. HMO, PPO, etc.). Provider may have multiple EMPs, which will aggregate membership separately by product type (e.g. HMO, PPO, etc.). "Efficiency Measurement Period (EMP)" may be used interchangeably with the term "Measurement Period" and the meaning of each is synonymous with any such other.

"Market" means the comparison population of Covered Individuals with a selected or assigned Primary Care Physician or office based evaluation and management visit Claims in the various regions of a state or geographical area during the prior twenty-four (24) month look back period. The comparison population within the various regions is weighted based on the Provider's attributed population across those regions and is defined at the region, product swim lane, and age level of detail. Age, high cost, and other exclusion criteria are applied to the comparison population under the same rules applied to the Provider's medical panel. On an annual basis, Anthem conducts an assessment of the appropriateness of current Market configurations, using updated healthcare cost and risk experience.

"Member Months" means the number of the Member Population's complete months enrolled in the Program during a Measurement Period.

"Member Population" means the group of Attributed Members assigned to Provider and Represented Providers pursuant to the Program (subject to criteria established by Anthem.

"Normalized Risk Score" means Provider's average Risk Score relative to the Market's average Risk Score. The Normalized Risk Score is calculated as follows:

Normalized Risk Score = Provider average Risk Score/Market average Risk Score

The Market is defined by Anthem and may be inclusive of a region or state. The Market average will be calculated using Risk Scores derived from the Claims incurred during the Measurement Period, limited to Covered Individuals with assigned attribution or office based evaluation and management visit Claims in the Market. If exclusions apply to the Provider average Risk Score (for example removal of transplant cases as outlined in MCB, and MCP definitions), these exclusions may also apply to the Market average Risk Score calculation as determined by Anthem. So, the Market average is calculated as follows:

Market Average Risk Score = Sum of Covered Individual Risk Scores for the defined Market/number of Covered Individuals for the defined Market weighted by months of eligibility.

The average Risk Score of the Provider's Attributed Members will be calculated using Risk Scores derived from the Measurement Period Claims for the EMP, weighted by months of eligibility. If exclusions apply to the Provider average Risk Score (for example removal of transplant cases as outlined in the EMP definition), identified members are excluded from the risk score calculation. The Provider average Risk Score is calculated as follows:

Provider Average Risk Score = Sum of Provider's Attributed Member Risk Scores/number of Provider's Attributed Members weighted by months of eligibility.

Risk scores are based on a diagnosis based cost model, which uses diagnosis and demographic information from medical Claims, as well as an adjustment allowing for consistency between pediatric and adult populations. The approach to determining Risk Scores may be adjusted by Anthem from time to time. If such adjustments are material in nature, Anthem will provide notice to Provider. Anthem will monitor Attributed Members' Risk Scores to determine if there are any industry coding changes that inappropriately or disproportionately affect the overall Normalized Risk Score. Anthem has the option to neutralize payment results that are driven by such coding changes and not by changes in Attributed Members' health risk and will notify Provider if such action is taken

"**Performance-Based Incentive**" means the annual incentive payment to support care management and care coordination practice transformation activities and Program Requirements as set forth in Exhibit A, and earned based on scorecard performance, including both quality and efficiency components. Any Performance-Based PMPM earned will be calculated based on Member Months for the Measurement Period. The Performance-Based Incentive is calculated on a per member per month basis (PMPM).

"**Primary Care Provider(s) (PCP(s))**" means all of the physicians in the Provider's practice whose primary specialty, as indicated in the Anthem Provider files, is internal medicine, pediatrics, family practice/medicine, general practice/medicine or geriatrics, and nurse practitioners] who participate in the Program by virtue of being covered under the Agreement and this Attachment.

"**Program Description**" is a description of certain aspects of the Program, prepared by Anthem, as revised from time to time by Anthem, including the patient-centered practice support offered by Anthem to support Represented Providers in creating a patient-centric practice environment and care model for their Covered Individuals as well as Program terms, conditions, quality measures, and requirements. A current copy of the Program Description and periodic updates thereto, is incorporated by reference into this Attachment.

"**Program Requirements**" means the Program requirements as set forth in Exhibit A.

"Quality Gate" means the minimum quality standards that Provider must achieve in order to retain any payment. The Quality Gate applicable to Provider is shown in Table 3 in Exhibit B.1.A.

"**Represented Provider(s**)" means the Primary Care Providers that are Network/Participating Providers with Anthem, are represented by Provider and are bound to the terms of this Agreement by the actions and representations of the Provider who bill under the tax identification number(s), shown in Exhibit C, and who participate in the Program by virtue of being covered under this Agreement and this Attachment.

"Risk Score" means the indicators of the health status of an Attributed Member based on the evaluation of diagnosis and demographic information derived from Claims and Member eligibility detail. Anthem uses industry standard methods to determine Risk Scores.

ARTICLE III
PROGRAM AND OBLIGATIONS OF Anthem

3.1 Program Administration. Anthem shall administer the Program as described in this Attachment and shall remit any payment that may be due under the Program to Provider in the manner and within the timeframes specified herein.

3.2 Performance Assessment. Anthem will periodically assess the compliance of Represented Providers with the Program Requirements that are specified in Exhibit A , by monitoring Claims and Provider reported data and, at Anthem's discretion, by auditing applicable Provider records. If Anthem determines that any Represented Provider is not adhering to the Program Requirements, Anthem will share its findings with Provider.

3.3 Data and Reporting. Anthem shall make available data and reports to Provider in support of the Program as specified in 4.5.

ARTICLE IV
PROGRAM AND OBLIGATIONS OF PROVIDER

4.1 Program Participation. Provider and its Represented Providers shall participate in the Program throughout the term of this Attachment and, during this time, shall comply with all of its terms and conditions. Failure to comply with these terms and conditions or to provide Anthem with all data requested or required to assess compliance with the Program Requirements or a Represented Provider's performance against any Program measures may result in the following actions at the option of Anthem:

i) Termination of the Attachment as provided in Article VI below; and/or
ii) Suspension of Program related payments under this Attachment

4.2 Listing of Represented Provider(s). Exhibit C provides the list of the tax identification numbers for Represented Providers covered under the Program. If Provider desires to modify Exhibit C, it shall provide written notice to Anthem at least 90 (ninety) days prior to the beginning of a new Measurement Period. If Anthem approves such request, it shall send Provider an updated Exhibit C that includes the list of the tax identification numbers for the Represented Providers, that shall become covered under the Program effective at the beginning of the next Measurement Period.

4.3 Warranties and Representations. Provider warrants and represents that:

i) It is a lawfully authorized agent for all of the Represented Providers and that it has full authority to bind them to the terms of this Agreement and this Attachment pursuant to written Agreements between Provider and the Represented Providers (copies of which Provider shall provide to Anthem within 10 (ten) days of Anthem's request);
ii) All of the Represented Providers are legally bound to the terms of this Attachment through Provider's actions and representations (subject to all provisions of this Agreement and this Attachment);
iii) It is acting as an agent of and a representative for the Represented Providers in full compliance with all state and federal laws, regulations and ordinances;
iv) All of the Represented Providers or their duly authorized agent(s) have reviewed and approved this Agreement prior to its execution;
v) All of the Represented Providers have assigned their right to receive payment of any incentive amounts due under the Exhibits to Provider in writing (copies of which Provider shall provide to Anthem within 10 (ten) days of Anthem's request), and that such assignment shall be in force for at least as long as this Agreement and this Attachment is in force; and
vi) It has full authority and permission to provide to and receive from Anthem all information, reports and data of any kind that is required under the terms of this Agreement, including Represented Provider-related, generated or owned information.

4.4 Requests for Records and Audit. Provider and Represented Provider(s) shall comply with all requests from Anthem or Plan for any information and data related to the Program and will fulfill such requests at no cost to Anthem or Covered Individuals. Anthem or Plan reserves the right to examine, audit, excerpt and transcribe any books, documents, papers, records and Claims related to Covered Services or the operation of Represented Provider's practice to ensure Represented Provider's compliance with the Program. Further, the Parties agree that upon request from Anthem, Provider shall supply evidence of compliance with the Program Requirements defined herein.

4.5 Data and Reporting. Provider and Represented Provider(s) shall make available data and reports to Anthem in support of the Program. Provider will make best efforts to work with Anthem when requested to enable supplemental/clinical electronic medical record (EMR) data, optimally in a bi-directional fashion, in order to

facilitate the delivery of quality care to Anthem Covered Individuals. This obligation includes, but is not limited to:

i) Identifying key contacts within Provider's organization who will engage in data-sharing work;

ii) Working with Anthem to establish connectivity and address any initial and ongoing issues as applicable;

iii) Providing two (2) years of historical data and engaging in ongoing data sharing using accepted formats.

4.6 Collaborative Patient Centered Primary Care Model. Anthem will offer and Provider shall utilize, as appropriate, a variety of tools designed to support patient centered care, and Represented Providers shall cooperate with Anthem by accessing such tools and related services, as appropriate, in the management of their Covered Individuals.

4.7 Network Provider Utilization and Cost-Effective Care. Whenever clinically appropriate, and unless a Covered Individual requests otherwise, Provider and/or Represented Provider will make best efforts to refer Covered Individuals only to Network/Participating Providers. This includes, but is not limited to:

i) Inpatient and outpatient services;
ii) Anesthesiology care performed in the office or in an ambulatory surgical center; and
iii) Assistant surgeons and co-surgeons in all settings.

In addition, whenever clinically appropriate, and unless a Covered Individual requests otherwise, Provider and/or Represented Provider will make reasonable efforts to:

i) Refer Covered Individuals who require laboratory services, and send all laboratory specimens collected in their offices, to participating freestanding laboratory providers except where the laboratory services required by the Covered Individuals cannot be provided by these laboratory providers;
ii) Refer Covered Individuals who need radiology or imaging services to participating freestanding radiology and imaging providers;
iii) Prescribe cost-effective generic medications;
iv) Reduce the frequency of avoidable admissions and readmissions through the activities required and described in Exhibit A, as well as through implementation of comprehensive readmission reduction plans;
v) Refer Covered Individuals who require surgeries to lower cost settings when the hospital setting is not Medically Necessary; and
vi) Refer Covered Individuals who require infusion services to participating infusion centers.

ARTICLE V
JOINT PROGRAM OBLIGATIONS

5.1 Steering Committee. The Parties will establish a Steering Committee that will discuss, review, and make recommendations with respect to enhancing the Parties' performance under this Attachment. The Steering Committee shall function in an advisory capacity with respect to all matters related to this Attachment. For recommendations of the Steering Committee to be binding, the Parties will be required to mutually agree to implement such recommendations in writing between the Parties. The Steering Committee shall have equal numbers of Provider and Anthem representatives, the number of which will be mutually agreed upon by the Parties from time to time. Each Party shall designate one representative as a Co-Chair of the Committee. The Co-Chairs shall be responsible for the coordination of the Steering Committee's activities. Each Party shall appoint its representatives to the Steering Committee at its discretion. A Party may replace any of its own representatives at any time. Members of the Steering Committee may participate in person or through a proxy, so long as the proxy is an employee of the same entity as the Steering Committee member and is aware of and abides by applicable confidentiality obligations. The Anthem Regional Vice President, Provider Engagement and Contracting and Provider Clinically Integrated Network Executive Director may participate in meetings and activities of the Steering Committee regardless of whether these representatives are on the Steering Committee.

i) If requested by Anthem, the Steering Committee shall meet at least monthly continuing through the first twelve (12) months of this Attachment and thereafter at such frequency as the Parties determine to be necessary to complete their duties and responsibilities, but no less than quarterly. The meetings shall be held at times and locations mutually acceptable to the Parties.
ii) The Parties recognize that due to the specialized nature of the requirements under this Attachment, Subcommittees of the Steering Committee shall be formed by the Steering Committee for addressing issues such as Provider's quality performance, financial performance, actuarial issues, data and information sharing and other specialized areas deemed appropriate by the Steering Committee. The Steering Committee and Subcommittees shall maintain a summary of decisions, actions, and follow-up assignments. If either Party identifies an issue related to the Program, the issue shall be presented to the Steering Committee for review and resolution in a timely manner. The Steering Committee shall assign specific responsibilities to Subcommittees as it deems appropriate consistent with the terms of this Attachment.

5.2 Proprietary Information. Except as otherwise provided herein, all information and material provided by either Party in contemplation of or in connection with this Attachment remains proprietary to the disclosing Party. This Attachment and its contents are Anthem's proprietary information. Neither Party shall disclose any information proprietary to the other, or use such information or material except:

i) as otherwise set forth in this Attachment;
ii) as may be required to perform obligations hereunder;
iii) as required to deliver Health Services or administer a Health Benefit Plan;
iv) to Plan or its designees;
v) upon the express written consent of the Parties; or
vi) as required by law or regulation, except that either Party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain the confidentiality of such information.

ARTICLE VI
TERM AND TERMINATION

6.1 Term. The initial term of this Attachment shall begin on the Program Attachment Effective Date and end one (1) year thereafter. This Attachment shall automatically renew for consecutive one (1) year terms after the initial term until the Attachment is terminated as provided herein.

6.2 Termination.

i) Either Party may terminate this Attachment at any time for any reason or for no reason at all, by giving at least ninety (90) days prior written notice to the other Party and, except as provided below, the effective date of such termination shall be the last day in the Measurement Period which immediately follows the expiration of the full ninety (90) day notice period.

ii) Notwithstanding any provision to the contrary contained in this Attachment or in the Agreement, if, in connection with this Program, Provider or a Represented Provider engages in behavior that Anthem determines is likely to violate an applicable law, regulation or any material requirement of an Anthem accreditation organization, or if Anthem reasonably believes, based on Provider's or a Represented Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of any patient may be jeopardized then Anthem may terminate this Attachment immediately by giving Provider written notice of termination.

iii) Further, this Attachment and Provider's participation in the Program shall automatically terminate immediately upon the termination, nonrenewal or expiration of the Agreement.

6.3 Effects of Termination. Except as otherwise provided below, in the event of any termination of this Attachment for any reason by either Party during a Measurement Period, Anthem shall calculate amounts due to Anthem or to Provider upon conclusion of the Measurement Period. No amount shall be payable to Provider by Anthem upon termination if:

1) this Attachment is terminated for a reason described in 6.2 ii); or
2) Provider's fee for service agreement terminates under 6.2 iii) and such termination results in an incomplete Measurement Period; or
3) termination pertaining to 7.4 of this Attachment that results in an incomplete Measurement Period.

ARTICLE VII
MISCELLANEOUS

7.1 Provider's Authority. Provider represents and warrants that it has full authority to bind itself and its Represented Providers to the terms of this Attachment.

7.2 Release of Provider Information. Provider agrees that Anthem may use, publish, disclose, and display information and disclaimers, as applicable, relating to Provider's and Represented Provider's Program participation and performance.

7.3 Prioritization of Documents. Except as otherwise expressly stated in this Attachment, if there is an inconsistency between terms of this Attachment and the terms and conditions set forth in the Agreement, the terms and conditions of the Agreement shall govern. Further, except as otherwise expressly stated in this Attachment, if there are any inconsistencies between the terms and conditions of this Attachment and the terms and conditions of the Program Description, the terms and conditions of the Attachment shall govern. Except as set forth in this Attachment, all other terms and conditions of the Agreement shall remain in full force and effect.

7.4 Amendment. Except as otherwise provided for in this Attachment, Anthem retains the right to amend this Attachment and/or any exhibits, attachments or addenda by providing notice to Provider at least ninety (90) days in advance of the effective date of the amendment. If Provider decides not to accept the amendment, Provider has the right to terminate this Attachment without the amendment taking effect by providing written notice within thirty (30) days after the marked date associated with the corresponding delivery method of the amendment (e.g., postmark date of amendment notice). Provider's termination shall take effect on the amendment effective date identified by Anthem. Failure of Provider to provide such notice to Anthem within the time frames described herein will constitute acceptance of the amendment by Provider.

7.5 Appropriateness of Care. Provider and Represented Provider(s) and Anthem all desire and intend that medically appropriate services be provided to Covered Individuals. Provider and Represented Providers will use their own expertise and best judgment to evaluate and treat patients. Nothing in this Attachment is intended to affect Provider's or Represented Providers' best judgment and responsibility to provide quality health care services at medically appropriate levels in accordance with professionally recognized standards. Under no circumstances should this Attachment be construed to suggest or incentivize the withholding of medically necessary services or the withholding of approved benefits to which a Covered Individual is entitled.

7.6 Improper Payment. Anthem may recover any amount paid by Anthem to Provider and/or Represented Providers including amounts that were paid to the Provider and/or Represented Providers under this Attachment that are determined subsequently by Anthem to have been an improper payment, by notifying Provider and/or Represented Providers, as applicable, within the timeframe required by state or federal law, of the date of the improper payment and requesting a refund from Provider and/or Represented Providers, as applicable, to be payable to Anthem within ninety (90) calendar days of Anthem's notice of the improper payment. If Provider refuses to refund the improper payment within the ninety (90) days, Anthem may offset such amount from any future amounts otherwise owing to Provider or take any other remedy permitted by law.

7.7 Exhibits. The Recitals in Article I and all of the Exhibits, including those referenced below, are made part hereof and incorporated herein by reference:
Exhibits A, B, C
Exhibits B.1
Exhibit B.1.A

7.8 This section is left intentionally blank.

EXHIBIT A
PROGRAM REQUIREMENTS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT B

PERFORMANCE-BASED INCENTIVE PAYMENTS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT B.1

PROVIDER'S CONTRACTED ARRANGEMENT

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT B.1.A

QUALITY PERFORMANCE COMPONENTS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT C

TAX IDENTIFICATION NUMBERS(S) FOR REPRESENTED PROVIDERS COMMERCIAL BUSINESS

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	X Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	Rocky Mountain Hospital and Medical Service, Inc.	
(Include d.b.a., if applicable)	d/b/a Anthem Blue Cross and Blue Shield and HMO Colorado, Inc., d/b/a HMO Nevada and Community Care Health Plan of Nevada, Inc.	
Street Address:	9133 W. Russell Rd.	**Website: www.anthem.com**
City, State and Zip Code:	Las Vegas, NV 89148	**POC Name: Ashley DeLanis** **Email: ashley.delanis@anthem.com**
Telephone No:	702-271-0648	**Fax No: N/A**
Nevada Local Street Address: **(If different from above)**	Same a above	**Website: Same as above**
City, State and Zip Code:	Same as above	**Local Fax No: N/A**
Local Telephone No:	Same as above	**Local POC Name: Same as above** **Email: Same as above**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? X Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes X No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes X No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signature	Ashley DeLanis Print Name
RVP, PSO Title	9/9/2025 Date

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Amendment 28 to Software License and Services Agreement with Solventum Health Information Systems, Inc.**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board approve and authorize the Chief Executive Officer to sign Amendment 28 to Software License and Services Agreement with Solventum Health Information Systems, Inc.; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5420.000 Fund Name: UMC Operating Fund
Fund Center: 3000854000 Funded Pgm/Grant: N/A
Description: Software Schedule
Bid/RFP/CBE: NRS 332.115(1) (h) – Software
Term: Software Schedule – Extend through 7/24/2026
Amount: Additional $957,308.04
Out Clause: Subject to Sections 9.1.2 (Early Termination) and 9.2 (Termination and Non-Renewal, Rights and Obligations)

BACKGROUND:

Since 1986, UMC has had an agreement with Solventum Health Information Systems, Inc., formerly known as 3M Health Information Systems, Inc. ("Solventum"), to utilize its patient coding software products. These software products are employed throughout UMC's main campus and various QC/PC locations to identify the diagnosis and procedure codes needed for patient billing.

This Amendment 28 requests to extend the software schedule term through July 24, 2026, and increase the funding by an additional amount of $957,308.04 for the 360 Encompass System. This software automates coding, improves the accuracy of patient care documentation, ensures compliance with regulations, and supports informed, data-driven decision-making. Ultimately, these enhancements lead to increased operational efficiency and improved financial performance for UMC.

UMC's Information Technology Executive Director has reviewed and recommends approval of this Amendment. This Amendment has been approved as to form by UMC's Office of General Counsel.

This Amendment was reviewed by the Governing Board Audit and Finance Committee at their November 12, 2025, meeting and recommended for approval by the Governing Board.

Cleared for Agenda
November 19, 2025

Agenda Item #
7

AMENDMENT 28
TO THE
SOFTWARE LICENSE AND SERVICES AGREEMENT

THIS AMENDMENT to the **Software License and Services Agreement**, dated **December 13, 2007** (the "Agreement") between **Solventum Health Information Systems, Inc.** ("Solventum") having an office at 575 West Murray Boulevard, Murray, Utah 84123-4611 and **University Medical Center of Southern Nevada** ("Client") with offices at **1800 W. Charleston Boulevard**, **Las Vegas**, **NV 89102-2386,** is effective as of the date last signed **("Effective Date").**

Client and Solventum agree that the above referenced Agreement is amended as follows:

1. **Except as provided in this Amendment, all terms and conditions of the above referenced Agreement will remain in full force and effect.**
2. **DELETE Section 9.1.1 of the terms and conditions in its entirety and REPLACE it with the following:**

   9.1.1 **License Term Extension**. Customer agrees to license the Software listed in this Agreement from Solventum for an extended **one (1) year** term beginning **July 25, 2025**, and ending **July 24, 2026** ("Extended Term"). After the Extended Term, this Agreement, and the License granted under Section 2.5, shall **automatically terminate** unless Customer, upon sixty (60) days prior written notice, requests renewal. Such renewal, if any, would be priced at Solventum's then-current list price, less any applicable discount. Solventum, at its option, may elect not to renew the Agreement.

3. **AMEND Exhibit B, the Software Schedule, with the actions contained in the schedule below.**

Client has read this Amendment, and when applicable, each Exhibit, and Attachment hereto. To indicate the parties' acceptance and agreement to be bound by the terms and conditions of this Amendment, Solventum and Client have executed this Amendment on the date(s) indicated below, to be effective as of the date first indicated above.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA	SOLVENTUM HEALTH INFORMATION SYSTEMS, INC.
BY:	BY: John C. Mathison S/S
NAME: Mason Van Houweling	NAME: John C. Mathison
TITLE: Chief Executive Officer	TITLE: HIS Operations
DATE:	DATE: October 8, 2025

PLEASE EMAIL YOUR PURCHASE ORDER IN THE AMOUNT OF **$957,308.04** AND THE SIGNED AMENDMENT TO:
HISCONTRACTSUBMISSION@SOLVENTUM.COM

FOR SOLVENTUM INTERNAL USE ONLY						
ISSUE DATE / BY:	GPO:		BATCH NUMBER:	CLIENT SITE ID:	AGREEMENT NUMBER:	CLIENT EMR:
04/09/25 AD	*****		14111	2880004	07-0940	
REVISION DATE/BY:	SLA TYPE:	CMR NO:				
		N/A				

EXHIBIT B

SOFTWARE SCHEDULE

S/O ITEM	CPU ACTION	SKU	AUTHORIZED SITE / PRODUCT DESCRIPTION	SITE TYPE / LIST PRICE	TOTAL 1ST YR ANNUAL & ONE TIME FEE
397286	WEB	------	**UNIVERSITY MEDICAL CENTER--1800 WEST CHARLESTON BLVD, LAS VEGAS, NV , HI2880004**		
1	Renew	360E CAC INPATIENT	360 Encompass System - Computer Assisted Coding Inpatient	[redacted]	
2	Renew	360E CAC OUTPATIENT	360 Encompass System - Computer Assisted Coding Outpatient	[redacted]	
3	Renew	360E CDI EHR LAUNCH	360 Encompass System Clinical Documentation Integrity - EHR User Launch-In to 360	[redacted]	
4	Renew	360E CODING EXCELLNC	360 Encompass System - Coding Excellence	[redacted]	
5	Renew	APCTRICARE	APCfinder for TRICARE	[redacted]	
6	Renew	C&RS-TESTPALTDIR	Coding & Reimbursement Permanent Test Directory	[redacted]	
7	Renew	CDI A-S OB INTFC	Clinical Documentation Integrity Auto-Suggested Data Outbound Interface	[redacted]	
8	Renew	CGS-APC	CGS CMS Medicare APC Grouper with Medicare HOPD & FQHC Reimbursement	[redacted]	
9	Renew	CONNSFT TCP	Connections Software TCP/IP Server	[redacted]	
10	Renew	MNAPC NV A&B	Medical Necessity for APCfinder NV Part A&B	[redacted]	
11	Renew	PSUS-360	Update Services 360 Encompass**	[redacted]	
12	Renew	TRICAREGRP	TRICARE Grouper	[redacted]	
			SITE SUBTOTAL:		**$957,308.04**

The License Start Date for the above products is July 25, 2025.

FEE SUMMARY:

ANNUAL SOFTWARE LICENSE, SERVICES & SUPPORT FEES:	**$957,308.04**
***TOTAL ONE TIME, IMPLEMENTATION & TRAINING FEES:**	**$0.00**
TOTAL THIS SCHEDULE:	**$957,308.04**

The fees stated above are guaranteed for a period of sixty (60) days from the Issue Date of this Schedule or December 31, 2025, whichever occurs first, unless this Schedule is fully executed prior to such date. Client acknowledges and agrees the fees shown above include discounts for Client's commitment to a term. Solventum reserves the right to rescind the multi-year discount and re-price the Solventum Product(s) on this Schedule in the event Client elects a term less than stated above.

In the event Client delays implementation of any module of Software or scheduling of Services, at no fault of Solventum, for more than one hundred fifty (150) days from the execution date of being added to this Schedule, Solventum may, at its option, increase the price of such Solventum Product(s) to the then-current list price or Solventum may terminate any such Solventum Product(s) from this Schedule.

I&T = Implementation and Training **PI** = Phone Installed **CI** = Customer Installed

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

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Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
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- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply) None of the Below						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	Solventum Health Information Systems, Inc.	
(Include d.b.a., if applicable)		
Street Address:	575 West Murray Blvd	**Website:** www.solventum.com
City, State and Zip Code:	Murray, Utah 84123	**POC Name:** Diane Cantorna **Email:** dvcantorna@solventum.com
Telephone No:	801-265-4400	**Fax No: N/A**
Nevada Local Street Address: **(If different from above)**	N/A	**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
See attachment below with response		

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☒ Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No (If yes, please note that University Medical Center of Southern Nevada employee(s) or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

John C. Mathison JM
Signature

John C. Mathison
Print

Title: HIS Operations

Date: October 30, 2025

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

DISCLOSURE OF RELATIONSHIP

Solventum HIS Officers

Title	Officer
Director/President	Garri Garrison
Director	Detlef Koll
Director/Vice President	Quinn Weidall
Officer/Treasurer	Rodolfo Espinosa-Casaubon
Officer/Assistant Treasurer	Justin P. McGough
Officer/Secretary	Marcela Kirberger
Officer/Assistant Secretary	Carl Rychcik

Disclosure Statement:

* Solventum is a publicly traded company. Because Solventum (i) does not know the identities of all the University Medical Centers or Solventum employees, directors, officers, and members of its Board of Directors, their immediate families and financial and investment activities and (ii) cannot poll all of its or the University Medical Centers employees for other employment, investment or other activities, it is not possible for Solventum to indicate with absolute certainty that by conducting business with the University Medical Center, Solventum would be entering into any situation in which a conflict of interest may exist.

However, Solventum is a highly ethical company known for its integrity and fair dealings. Solventum would not intentionally enter into a business relationship under which there would be a conflict of interest without advising the other party of the conflict.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AGENDA ITEM

Petitioner: Mason Van Houweling, Chief Executive Officer

Recommendation:

That the Governing Board recommend for approval by the Board of Hospital Trustees for University Medical Center of Southern Nevada, the settlement in the matter of District Court Case No. A-24-895947-C, entitled *Amy Isaacson v. University Medical Center of Southern Nevada, et al*; and authorize the Chief Executive Officer to execute any necessary settlement documents. (For possible action)

FISCAL IMPACT:

Fund #: 7640.000
Fund Center: 3000867500

Fund Name: UMC Malpractice and Liability Fund
Amount: $100,000.00

BACKGROUND:

A professional negligence action was commenced in Clark County District Court on June 21, 2024, against University Medical Center of Southern Nevada ("UMC"), named UMC employees, and various other medical providers.

In order to resolve the District Court action against UMC and its employees, UMC seeks approval to settle the action for the total amount of One Hundred Thousand Dollars ($100,000.00), inclusive of all attorney's fees and costs, with no admission of wrongdoing, and to mitigate the unknown costs of protracted litigation. The settlement is recommended by UMC Administration, UMC retained litigation counsel, and UMC's Office of General Counsel.

Cleared for Agenda
November 19, 2025

Agenda Item #

8

SETTLEMENT AGREEMENT AND RELEASE OF ALL CLAIMS

This Settlement Agreement and Release ("Agreement") is made and entered into between Plaintiff, AMY ISAACSON ("ISAACSON"), and Defendants, MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA ("UMC") , for themselves and for the benefit of the UMC Governing Board, the UMC Board of Hospital Trustees, and County of Clark, Nevada, and each of the aforementioned's present/former officers, directors, shareholders, Commissioners, Board members, employees, agents, attorneys, representatives, assigns, and any related entities (collectively "UMC"). ISAACSON and UMC are sometimes referred to individually as "Party" and are sometimes collectively referred to herein as "Parties".

I. Recitals

A. Whereas, there is currently pending in the United States District Court, District of Nevada, in an action entitled *Amy Isaacson v. Karen Freeman, NP; Michael Hansen, MD; Maiz Luisa Pacumbaba, APRN; Michael Thomas, MD; Desert Valley Pediatrics, LLP; University Medical Center, dba UMC Quick Care; and Nevada Orthopedic & Spine Center, LLP,* Case No. A-24-895947-C (hereinafter "Subject Action").

B. After extensive negotiations, the Parties have reached an arms-length settlement of all Claims asserted or raised in the Subject Action, or related to the Subject Incident, as between the Parties.

C. Whereas, in making this Agreement, which involves disputed facts and issues, MICHAEL HANSEN, DO; MARIZ LUISA PACUMBABA, APRN, and UMC do not admit the truth or sufficiency of any of the Claims or allegations asserted by ISAACSON and does not admit liability for any of ISAACSON's alleged damages. The Parties intend by this Agreement to settle, finally and completely, all Claims, demands, actions, causes of action, known and unknown, asserted by ISAACSON in the Subject Actions and with respect to the Subject Incident.

D. Whereas, the Parties wish to memorialize the terms and conditions of their settlement made for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and they hereto agree as follows:

II. Definitions

As used in this Agreement, the following phrases and words shall have the following meanings:

A. "Claim" or "Claims" shall refer to any and all claims whether in tort, contract or otherwise, at common law or by statute, including but not limited to demands, liabilities, damages, complaints, causes of action, intentional or negligent acts, intentional or negligent omissions, fraud, breach of contract, breach of warranty, breach of duty including any statutory duty, economic damages, non-economic damages, indemnity, contribution, property damage or loss, personal or bodily injury, wrongful death, loss of consortium, compensatory, emotional, consequential, pecuniary, general, special, economic, hedonic, punitive, or exemplary damages, loss of use, loss of income, fraudulent and intentional misrepresentation, attorneys' fees, costs, prejudgment or post-judgment interest, investigative costs, expert costs, and any other actionable omission, conduct or

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damage of every kind and nature whatsoever, whether known or unknown, alleged or which could have been alleged or asserted, of any kind whatsoever, and any other measure or theory of damages actually or allegedly recoverable under law or equity, whether or not actually alleged in the Subject Actions, or arising out of or in any way relating to the Subject Incident and Subject Actions, as defined herein.

B. "Parties" shall refer to ISAACSON and MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC as defined in the first paragraph of this Agreement.

C. "Related Persons and Entities" shall refer to the respective Parties' agents, legal representatives, heirs, administrators, trustors, trustees, executors, beneficiaries, creditors, assigns, successors, insurers, attorneys, experts, and persons or classes of persons as applicable or related to the Parties and to the specific Related Persons and Entities of a Party.

D. "Subject Action" shall refer to the Eighth Judicial District Court, Clark County, Nevada in an action entitled *Amy Isaacson v. Karen Freeman, NP; Michael Hansen, MD; Maiz Luisa Pacumbaba, APRN; Michael Thomas, MD; Desert Valley Pediatrics, LLP; University Medical Center, dba UMC Quick Care; and Nevada Orthopedic & Spine Center, LLP,* Case No. No. A-24-895947-C.

E. "Subject Incident" shall refer to the alleged incidents alleged in ISAACSON's Complaint, in the Eighth Judicial District Court, Clark County, Nevada, and any resultant injuries and damages alleged to have been sustained by ISAACSON therefrom.

III. Release

A. Monetary Consideration

1. For and in consideration of the total payment of **ONE HUNDRED THOUSAND DOLLARS AND ZERO CENTS ($100,000.00)** payable to Plaintiff's (hereinafter "ISAACSON", "Releasor", or "Plaintiff") counsel, MURDOCK & ASSOCIATES, CHTD.'s Client Trust Account, by University Medical Center of Southern Nevada ("UMC" or "Payor"), the undersigned does hereby release, acquit, and forever discharge MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, UMC, the UMC Governing Board, the UMC Board of Hospital Trustees, and County of Clark, Nevada, and each of the aforementioned's present/former officers, directors, shareholders, Commissioners, Board members, employees, agents, attorneys, representatives, assigns, and any related entities (hereinafter "Releasees") from any consequences resulting from alleged wrongdoing and any and all causes of action arising from allegations contained in Plaintiff's Complaint, and as more particularly described in Case No. A-24-895947-C, filed in the Eighth Judicial District Court, Clark County, Nevada.

2. Upon full execution of this Settlement Agreement and Release of All Claims by Plaintiff and within fourteen (14) days of approval by the UMC Governing Board and the UMC Board of Hospital Trustees, and upon receipt from Plaintiff's counsel of an appropriate IRS W-9 form, settlement payment in the amount of $100,000.00 by UMC will be made payable MURDOCK & ASSOCIATES, CHTD's Client Trust Account.

3. In consideration for payment as herein described, each party thereto shall pay their own attorneys' fees and costs.

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4. ISAACSON and her counsel acknowledge and agree that MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC have made no representations to ISAACSON or her counsel regarding the tax consequences of any amounts received by ISAACSON pursuant to this Agreement. ISAACSON agrees to pay taxes, if any, which are required by law to be paid with respect to this settlement payment and Agreement. ISAACSON further agrees to hold MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC harmless from any claims, demands, deficiencies, levies, assessments, executions, judgments or recoveries by any governmental entity against MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC for any amounts claimed due on account of this Agreement or pursuant to claims made under any laws for MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC's failure to pay any taxes that she is legally obligated to pay, and any costs, expenses or damages that she is legally obligated to pay, and any costs, expenses or damages sustained by MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC by reason of any such claims, including any amounts paid by MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC as taxes, attorneys' fees, deficiencies, levies, assessments, fines, penalties interest or otherwise

5. In a simultaneous exchange for receipt of payment, ISAACSON or her counsel will sign the dismissal of the Case No. A-24-895947-C, with prejudice, of MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC, with each party to bear its own fees and costs. ISAACSON further acknowledges that the Subject Action and each of the claims and causes of action asserted therein or that could have been asserted, are fully and finally settled and resolved. ISAACSON acknowledges that the dismissal of the Subject Action is a condition of this settlement and of the payments and conditions described herein.

6. ISAACSON expressly acknowledges and agrees that she would not otherwise be entitled to the consideration set forth herein, if not for her covenants, promises, and releases set forth hereunder and that the payment and conditions constitute good and valuable consideration for the release by ISAACSON. ISAACSON expressly acknowledges that MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC are providing good and valuable consideration to support this Agreement above and beyond any amounts or subjects that may have been disputed.

7. ISAACSON expressly acknowledges and agrees that this Agreement is contingent upon and subject to the approval of the UMC Governing Board and the UMC Board of Hospital Trustees and only becomes effective upon such approval. Furthermore, this Agreement is subject to disclosure in accordance with NRS Chapter 241, NRS Chapter 41, NRS 633.527(1)(c), or as otherwise imposed by law.

8. ISAACSON expressly acknowledges and agrees that this Agreement is contingent upon the District Court granting MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC's Motion for Determination of Good Faith Settlement if required.

B. Voluntary Release of Claims

ISAACSON understands and agrees that by signing this Agreement, she is knowingly and voluntarily agreeing to waive and release any and all claims she has had or may have against UMC. ISAACSON is advised of the following:

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1. Consultation with Counsel. ISAACSON acknowledges that this Agreement constitutes written notice from UMC that she should consult with an attorney before signing this Agreement. ISAACSON acknowledges that she has had an opportunity to fully discuss all aspects of this Agreement with an attorney to the extent she desires to do so. ISAACSON agrees that she has carefully read and fully understands all of the provisions of this Agreement, and that she is voluntarily entering into this Agreement.

C. ISAACSON's Release

ISAACSON agrees to dismiss with prejudice the Subject Action, Case No. A-24-895947-C. Further, ISAACSON agrees and covenants not to sue or institute or cause to be instituted any action, claim, or lawsuit in any federal or state court against UMC arising through the date of ISAACSON's signature on this Agreement.

ISAACSON acknowledges that certain medical providers, insurance providers, Medicare, Medicaid, the Centers for Medicare and Medicaid Services ("CMS"), or other persons or entities may have lien or subrogation rights resulting in payments to or on behalf of ISAACSON with regard to the incident described herein. ISAACSON expressly agrees that she is solely responsible for satisfying any and all liens and/or reimbursements and ISAACSON agrees to satisfy any and all liens and/or reimbursements from the proceeds of the settlement and hereby agrees to hold harmless and indemnify Releasees from any demands, actions, causes of action, liens, or claims of lien based upon any lien claim or subrogation rights claimed by any person or entity with respect to the incident described herein. By entering into this Settlement Agreement and Release of All Claims, Plaintiff and Releasees do not intend to shift responsibility of future medical benefits to the Federal Government or CMS, and the parties intend all responsibility for future medical benefits to befall Plaintiff.

If ISAACSON is required to set aside or repay any portion or all of the settlement amount to reasonably protect Medicare's interest under the Medicare Secondary Payer Statute (MSP), ISAACSON shall be solely responsible for setting aside or repaying such monies from their own funds. ISAACSON also agrees to defend, indemnify and hold harmless Releasees and its attorneys for the consequences of ISAACSON's loss of Medicare benefits or for any recovery the CMS may pursue against Releasees and their attorneys. In addition, ISAACSON waives and releases any right to bring any action against Releasees and their attorneys under § 1395(y) of the MSP.

By signing this Agreement, ISAACSON is bound by it. Anyone who succeeds to ISAACSON's rights and responsibilities, including but not limited to ISAACSON's spouse, heirs, executor of ISAACSON's estate, assignee or any entity claiming by, through or under ISAACSON, is also bound by this Agreement. ISAACSON covenants and confirms that she is not married and that no one else has a right to the settlement proceeds other than her counsel.

If ISAACSON breaches any of ISAACSON's obligations under this Agreement or as otherwise imposed by law, UMC shall be entitled to (a) cease any payment to be made under this Agreement; (b) obtain all other relief provided by law or equity, including recovery of monetary damages, and/or (c) apply for and receive an injunction to restrain any violation of this Agreement. In such event, ISAACSON agrees that ISAACSON will be required to pay MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC's legal costs and expenses, including reasonable attorneys' fees, associated with such lawsuit and enforcing this Agreement.

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IV. No Admissions

By signing this Agreement, MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC are not admitting to any inappropriate, unlawful, or tortuous conduct and, in fact, MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC deny that any such conduct has occurred.

V. Covenant Not to Sue

The Parties hereto promise to never commence, prosecute or cause to be commenced or prosecuted any action or proceeding against the other Party based upon any claim, lawsuit, demand, cause of action, obligation or liability relating to the Subject Action and/or covered by this Agreement, except for claims to enforce a breach of the terms of this Agreement. If any action is commenced or prosecuted in violation of this Agreement, the Party commencing or prosecuting the action shall be liable for all damages sustained by the opposing Party as a result of the action, including, but not limited to, reasonable attorneys' fees and costs incurred in defending the action and during appeal.

VI. Governing Law

By executing this Agreement, MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, UMC and ISAACSON agree that its performance is to occur in Las Vegas, Clark County, Nevada, and that the terms of this Agreement will be interpreted under the laws of the State of Nevada and any applicable laws of the United States.

VII. Exclusive Jurisdiction

The parties agree that the appropriate state or federal courts in Las Vegas, Clark County, Nevada have exclusive jurisdiction over any dispute, regardless of any conflict or choice of law provision or statute.

VIII. Entire Agreement

Upon the effective date of this Agreement, all prior (oral or written) agreements, if any, between ISAACSON and MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC are terminated. The terms stated in this Agreement are all of the terms to which MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, UMC and ISAACSON have agreed. By executing this Agreement, ISAACSON acknowledges that there are no other agreements (oral or written) between ISAACSON and MICHAEL HANSEN, DO, MARIZ LUISA PACUMBABA, APRN, and UMC, or any other topic covered by this Agreement.

IX. Waiver

The failure of any party to enforce or to require timely compliance with any term or provision of this Agreement shall not be deemed to be a waiver or relinquishment of rights or obligations arising hereunder, nor shall such failure preclude or stop the subsequent enforcement of such term or provision or the enforcement of any subsequent breach.

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X. Severability

Every part, term or provision of this Agreement is severable from the others. This Agreement has been made with the clear intention that the validity and enforceability of the remaining parts, terms and provisions shall not be affected by any possible future finding of a duly constituted authority that a particular part, term or provision is invalid, void or unenforceable. If a provision in this Agreement is later found to be unlawful by a proper authority, the parties agree to construe the Agreement as if the unlawful provision did not exist.

XI. Construction

This Agreement shall be deemed drafted equally by the parties. Its language shall be construed as a whole and according to its fair meaning. Any presumption or principle in law or equity that the language is to be construed against any party shall not apply. The headings in this Agreement are for convenience and are not intended to affect construction or interpretation. The plural includes the singular, and the singular includes the plural; "and" and "or" are each used both conjunctively and disjunctively; "any" and "all" each mean "any and all"; "each" and "every" each mean "each and every"; and "including" and "includes" are each "without limitation."

XII. Legal Counsel

ISAACSON is advised to consult with an attorney prior to executing this Agreement.

XIII. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

XIV. Section Headings

The section and paragraph headings contained in this Agreement are for reference purposes and shall not affect in any way the meaning or interpretation of this Agreement.

XV. Compliance with Terms

The failure to insist upon compliance with any term, covenant or condition contained in this Agreement shall not be deemed a waiver of that term, covenant or condition, nor shall any waiver or relinquishment of any right or power contained in this Agreement at any one time or more times be deemed a waiver or relinquishment of any right or power at any other time or times.

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XVI. Understanding

By executing this Agreement, ISAACSON acknowledges that ISAACSON has carefully read it; that ISAACSON has had an opportunity to review it with an attorney of ISAACSON's own choice, if ISAACSON chooses to do so; that the waiver and release set forth herein is part of an agreement that is written in a manner calculated to be understood by ISAACSON and ISAACSON in fact fully and completely understands the terms and the binding effect of this Agreement; that the only promises and representations made to ISAACSON that have led to ISAACSON executing this Agreement are those stated in this Agreement; that ISAACSON is executing this Agreement knowingly and voluntarily and under ISAACSON's own free will, without any threat or coercion by any entity, including UMC; and that ISAACSON is legally and mentally competent to enter into this Agreement.

IN WITNESS WHEREOF, Plaintiff, AMY ISAACSON, hereby executes the instant Settlement Agreement and Release of All Claims as follows:

DATED this ___ day of _____, 2025.

Signed by:
Amy Isaacson
281D448CC24C466...
11/14/2025

AMY ISAACSON

DATED this 14th day of November, 2025.

MURDOCK & ASSOCIATES, CHTD.

ROBERT E. MURDOCK, ESQ.
Nevada Bar No. 4013
SYDNEY M. KOREN, ESQ.
Nevada Bar No. 15291
521 South Third Street
Las Vegas, NV 89101
Attorneys for Plaintiff

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AGENDA ITEM

Petitioner: Mason Van Houweling, Chief Executive Officer

Recommendation:

That the Governing Board recommend for approval by the Board of Hospital Trustees for University Medical Center of Southern Nevada, a settlement between University Medical Center of Southern Nevada and the Department of Health and Human Services; and authorize the Chief Executive Officer to execute any necessary settlement documents. (For possible action)

FISCAL IMPACT:

Fund #: 5420.000
Fund Center: 3000867500

Fund Name: Operating Fund
Amount: $945,993.36

BACKGROUND:

Pursuant to the OIG Self Disclosure Protocol, University Medical Center of Southern Nevada ("UMC") made a submission to the Department of Health and Human Services ("DHHS") regarding: (1) Medicare reimbursement erroneously paid at a higher rate; (2) matters related to unpaid physician rent; and (3) payments made to practitioners based on inaccurate invoices submitted to UMC.

This matter will be resolved and UMC will be released from claims or causes of action under applicable law, including the Civil Monetary Penalties Law, in exchange for a payment of Nine Hundred Forty-Five Thousand Nine Hundred Ninety-Three Dollars and 36/100 cents ($945,993.36). This resolution is not an admission of liability by UMC.

UMC is requesting authority for the CEO to execute any necessary documents for the payment and resolution of the above matters.

Cleared for Agenda
November 19, 2025

Agenda Item #
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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Education – Privacy Program**	**Back-up:**
Petitioner:	Mason VanHouweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board receive a presentation from Corey McDaniel, UMC Privacy and Compliance Officer, regarding annual Compliance Training; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive their annual compliance training from Corey McDaniel, UMC Compliance and Privacy Officer.

Cleared for Agenda
November 19, 2025

Agenda Item #
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UMC
UNIVERSITY MEDICAL CENTER

The **Highest Level of Care** in Nevada

Compliance Program Elements and Framework

Corey McDaniel, JD, CHC, CHPC

Core Federal Healthcare Compliance Laws

False Claims Act (FCA)

Prohibits false or fraudulent claims to the government.
Includes treble damages and whistleblower actions.

Stark Law

Prohibits physicians from referring patients for designated health services to an entity with which they or their immediate family have a financial relationship, unless a specific exception applies.

Anti-Kickback Statute (AKS)

Bans value-for-referral inducements for items or services.
Applies to all federal health programs.

Civil Monetary Penalties Law

Allows HHS OIG to impose financial penalties and program exclusions for misconduct.
Covers claims, inducements, and EMTALA.

No Surprises Act

Prevents unexpected balance bills for out-of-network emergency and some elective care situations.
Requires transparent cost estimates, dispute-resolution processes, and good-faith billing practices.

Hospital Price Transparency

Requires hospitals to publicly post clear, accessible pricing information in pricing files.
Includes machine-readable files of standard charges and consumer-friendly shoppable service tools

HHS-OIG's Semiannual Report to Congress

https://www.cms.gov/fraud

CMS ACCOMPLISHMENTS

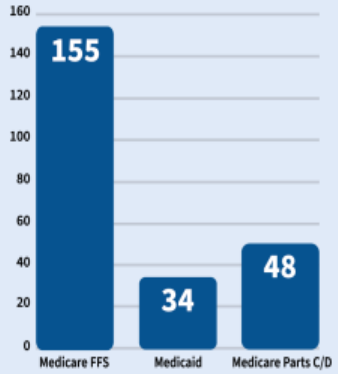
JANUARY 1, 2025 -AUGUST 31, 2025

Through medical review activities, CMS fraud contractors identified **$1.6 billion** in overpayments across **2,241 Medicare providers**

CMS imposed **315 Medicare payment suspensions** on providers

INVESTIGATIONS AND REFERRALS

CMS Referrals Accepted by Law Enforcement



Law enforcement accepted **213 CMS fraud referrals** for potential legal action

These referrals encompassed **$2.6 billion** in billing

CMS revoked the ability of **4,242 providers and suppliers** to bill the Medicare program due to inappropriate behavior.^

Hospital Compliance Regulatory Environment

- The DOJ's FY 2024 civil-fraud statistics show that the False Claims Act continues to yield large recoveries — over $2.9 billion in total, with approximately $1.6 billion attributed to the healthcare sector.[1]
- In 2024, the National Health Care Fraud Enforcement Action charged 193 defendants in schemes totaling approximately $2.75 billion in intended losses across 32 federal districts. This illustrates the breadth and geographic scale of current enforcement efforts.[2]
- Whistle-blower activity continues to rise, with ~979 new whistle-blower filings in FY 2024, reflecting increased individual-initiated actions and sustained national attention on healthcare fraud and abuse.[3]

[1] DOJ, False Claims Act FY 2024 Results, Jan 2025
[2] DOJ, National Health Care Fraud Enforcement Action, Jun 2024
[3] Whistleblower News Network, Qui-Tam Filings FY 2024

Governing Board and Compliance

The governing board "shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation of the compliance and ethics program."

U.S. Sentencing Guidelines, §8B2.1(b)(2)(A), Nov. 1, 2024 –
Rules that set out a uniform sentencing policy for individuals and organizations convicted of felonies and misdemeanors in the United States Federal Court system.

UMC Compliance Program

- The UMC compliance program includes all seven core elements as set out in the U.S. Sentencing Commission, United States Code, and OIG Guidelines
- UMC should never be in a position to have to justify non-compliance with the seven core elements
- The program provides defense and support for mitigation of fines and penalties
- The program improves the speed and quality of responses to governmental investigations
- The program helps prevent investigations in the first place

The Seven Elements

Elements

- **Program Oversight**
  - UMC has a designated Compliance Officer (CO)
  - CO is responsible for coordinating the planning, implementation and monitoring of the compliance program
  - CO has direct access to the Governing Board and Board of Trustees
  - CO chairs the Corporate Compliance Committee
  - CO handles all compliance-related guidance, investigations, policies, training, communication, and reviews

- **Code of Conduct and Policies/Procedures**
  - UMC has compliance policies and procedures which were developed for the hospital as a whole, and for the high-risk areas

Elements

- **Education and Training**
  - Required of all UMC staff, employees, physicians, and independent contractors
  - Mandatory annual training provided
  - Targeted training provided
  - New employees are educated at orientation

- **Reporting and Communication**
  - All workforce members have access to the Compliance Officer
  - UMC has whistleblower, non-retaliation, and confidentiality policies
  - Workforce members are required to report all suspected misconduct
    - Anonymous hotline exists

Elements

- **Monitoring and Auditing**
  - OIG workplan is reviewed for potential risk areas
  - Prior issues and current UMC risks are assessed for high-risk areas
  - Self-monitoring activities take place at various departments along with corrective action plans that are monitored by Corporate Compliance
  - UMC annual workplan is developed and submitted to the CEO for review
    - Contains auditing and monitoring activities for the calendar year

- **Response and Corrective Actions**
  - Steps are taken to immediately stop the cause of the problems detected
  - Investigate suspected violations as soon as identified
  - Corrective actions are taken
  - If required, UMC reports misconduct to the appropriate governmental agency
  - Identified overpayments are promptly refunded within 60 days of quantification.

Elements

- <u>Enforcement and Discipline</u>
  - Management is required to implement disciplinary action for violation
    - Sanction policies exist
  - UMC conducts appropriate screening to ensure there is no violation of the Medicare exclusionary provisions

Board and Senior Management Role in the Compliance Framework

- Limited Board or Senior Management emphasis on compliance
- A common process and approach to compliance by Leadership and management is not evident
- Investment in compliance is lacking

- Board and Senior Management support
- Enterprise-wide coordination of compliance activities by management Ongoing compliance assessments by divisions
- Tone at the Top support of compliance and compliance outcomes/responses

- Proactive Board and Senior Management involvement
- Embed compliance activities into on-going business processes
- Compliance activities management and assessed across a common culture
- Compliance maturity is optimized and reporting to Board and Senior Leadership
- A culture of accountability and responsibility exists

QUESTIONS?

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue: **2025 Governing Board Action Plan**	**Back-up:**
Petitioner: Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board review and discuss the Governing Board 2025 Action Plan, to include a presentation from Sabrina Holloway, Director of Health Information Management, regarding the Health Information Management (HIM) Program at UMC; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive an update regarding UMC's Health Information Management Program.

November 19, 2025

Agenda Item #

11

UMC
UNIVERSITY MEDICAL CENTER

The **Highest Level of Care** in Nevada

Health Information Management Update
Timely Completion of Death Certificates

Death Certificate Completion Overview

- Providers are required to complete death certificates in the Nevada Vital Records System (NVRS), within 48 hours of assignment
  - This timeline is per Nevada statutes (NAC 440.160, 440.162, 440.165, 440.170, 440.180)
  - Providers must create and maintain an active profile within the NVRS (extensive communications and tip sheets have been previously provided)
- Funeral homes enter the provider's name (sourced from the Body Release Form, completed by nursing) into NVRS
  - The provider receives an email notification, stating a death certificate requires their attention
    - Providers must log into the NVRS, upon notification, and complete all required fields of the death certificate
- Issue - untimely completion
  - Causes significant delays which results in a negative impact to patient funeral services and creates undue burden on the patient's family
  - HIM is actively working to implement process improvements to address and resolve this compliance issue

HIM Initiatives: Improving Death Certificate Compliance

- Direct access to NVRS
  - HIM now has direct access to NVRS to monitor and track incomplete death certificates
    - This eliminates the previous reliance on external calls from funeral homes for notification
- Proactive follow-up
  - HIM proactively monitors incomplete certificates and contacts the assigned provider for timely completion
    - We partner with Medical Staff Services for necessary provider escalations
- NVRS UMC provider listing
  - A comprehensive list of UMC-credentialed providers, with active NVRS profiles, has been created and shared with Medical Staff Services
- Death Certificate Escalation policy drafted (slide 4)
  - The policy has been drafted and sent to appropriate parties for approval. Once approved, the policy will be submitted to the Policy and Procedure Committee
- A representative from Nevada Vital Records is scheduled to attend the General Medical Staff meeting on 12/15/2025. They will provide an overview of the process, discuss the importance of timely death certificate completion and be available for questions

	POLICY /GUIDELINE TITLE: Death Certificate Escalation
MANUAL: Medical Staff	**POLICY OWNER: HIM/Nursing/Med Staff Services/Medical Staff**
ORIGINATION DATE: 10/2025	**FINAL APPROVAL DATE:**

SCOPE
This policy applies to all University Medical Center of Southern Nevada (UMC) privilege credentialed providers who pronounce patient deaths.

PURPOSE
A death certificate is required to be completed in the Nevada Department of Vital Records software, by providers, within 48 hours from being assigned, per Nevada statutes (NAC 440.160, 440.162, 440.165, 440.170, 440.180).

POLICY
When healthcare providers pronounce a patient's death, the nursing staff must fill out a body release form to accompany the patient to the funeral home. If the nurse, completing the form, is unable to reach the primary attending physician, to validate their name being placed on the form, or the provider refuses to sign the death certificate, the nurse will escalate to the Department Chief, as directed by this policy and the appropriate provider must then be listed on the form.
Using the completed body release form, the funeral homes initiate the death certificate in the Nevada Electronic Death Registry System (EDRS) and enters the name of the provider recorded on the Body Release form, per the documentation completed on this form by clinical staff. The assigned provider receives electronic notification from the EDRS that the death certificate needs to be completed and the provider must log into the system and complete all required information within 48 hours. Delay in completing the death certificate is not only against Nevada statutes but it also causes interruptions for the patient's family. In order to assist in timely completion, UMC staff will escalate as necessary,

PROCEDURE
- Monday-Friday, HIM staff will log into the EDRS and determine which death certificates are overdue (based on assigned date)
- HIM will contact the provider listed in EDRS, required to complete death certificate
- Next day, HIM will review EDRS to see if the provider completed the death certificate
- If provider did not complete the death certificate, HIM will make a second attempt to contact the provider listed in EDRS, required to complete death certificate.
- Next day, HIM will review EDRS to see if the provider completed the death certificate
- If provider did not complete the death certificate, HIM will escalate to Medical Staff Services
- Medical Staff Services will contact assigned provider and notify HIM when the provider was contacted so that HIM can review EDRS
- If the provider does not complete the death certificate the day of notification, the following day, the funeral home will be notified to change the assigned provider to the Department Chief (per bylaws).

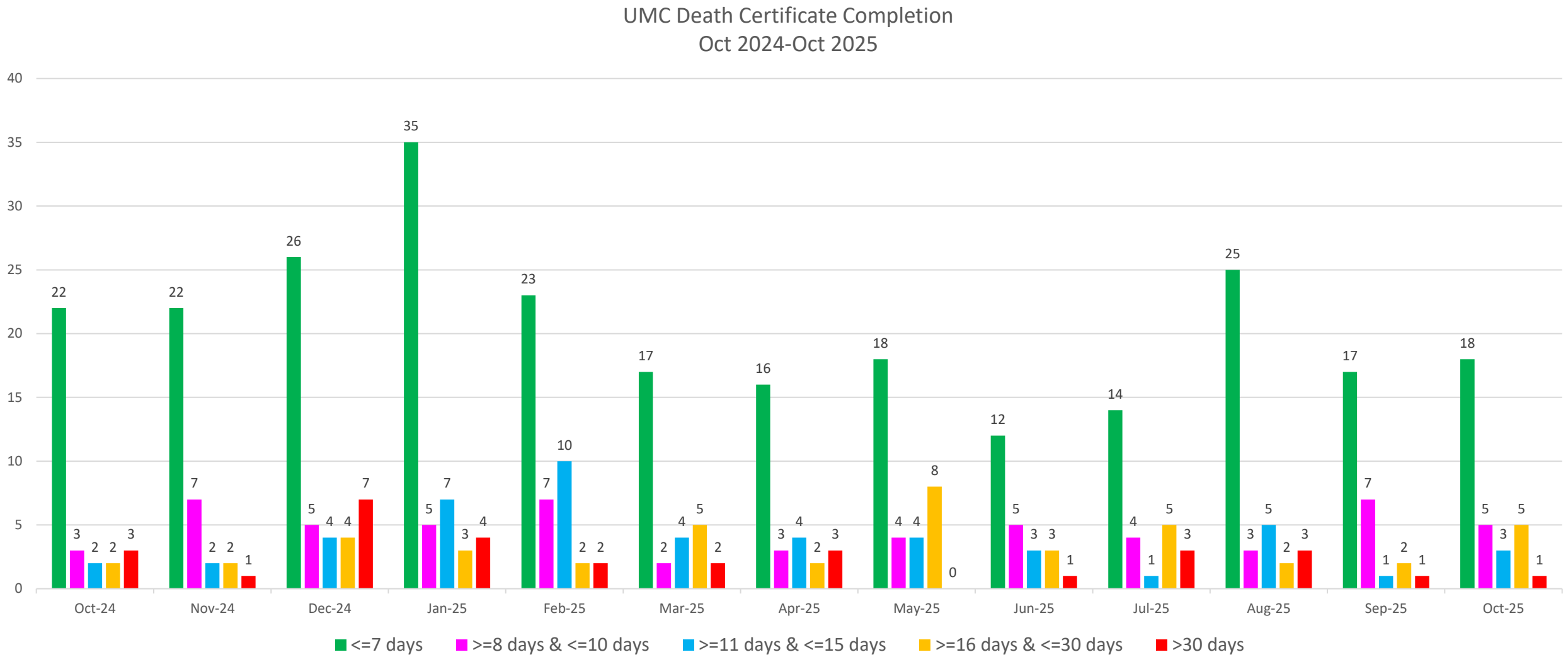
	POLICY /GUIDELINE TITLE: Death Certificate Escalation

  - HIM will notify Medical Staff Services that this was completed
  - Medical Staff Services will notify the Department Chief
  - HIM to be notified by Medical Staff Services in order to review EDRS
- If the Department Chief does not complete the death certificate the day of notification, the following day the funeral home will be notified to change the assigned provider to the Chief of Staff (per bylaws).
  - HIM will notify Medical Staff Services that this was completed
  - Medical Staff Services will notify the Chief of Staff
  - HIM to be notified by Medical Staff Services in order to review EDRS
- For any death certificates that have not been finalized after all steps of escalation, HIM and Medical Staff Services will contact Administration to ensure completion

DEFINITIONS

REFERENCES
Nevada statutes (NAC 440.160, 440.162, 440.165, 440.170, 440.180)
UMC Medical and Dental Staff Bylaws

Review Date:	By:	Description:


UMC Death Certificate Completion
Oct 2024-Oct 2025
40
35
30
25
20
15
10
5
0
22 3 2 2 3
22 7 2 2 1
26 5 4 4 7
35 5 7 3 4
23 7 10 2 2
17 2 4 5 2
16 3 4 2 3
18 4 4 8 0
12 5 3 3 1
14 4 1 5 3
25 3 5 2 3
17 7 1 2 1
18 5 3 5 1
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
<=7 days
>=8 days & <=10 days
>=11 days & <=15 days
>=16 days & <=30 days
>30 days

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Report from Governing Board Human Resources and Executive Compensation Committee**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board receive a report from the Governing Board Human Resources and Executive Compensation Committee; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive a report on the November Governing Board Human Resources and Executive Compensation Committee meeting.

Cleared for Agenda
November 19, 2025

Agenda Item #
12

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Report from Governing Board Audit and Finance Committee**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board receive a report from the Governing Board Audit and Finance Committee; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive a report on the November Governing Board Audit and Finance Committee meeting.

Cleared for Agenda
November 19, 2025

Agenda Item #
13

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Report from Governing Board Special Nominating Committee**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board receive a report from the Governing Board Special Nominating Committee; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive a report from the Governing Board Special Nominating Committee.

Cleared for Agenda
November 19, 2025

Agenda Item #
14

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue: **Governing Board Appointment/Reappointment**	**Back-up:**
Petitioner: Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board discuss and consider qualified individuals for appointment and/or reappointment to the UMC Governing Board for a three-year term commencing on January 1, 2026 from the following list of interested individuals: Laura Lopez-Hobbs, Christian Haase, John Fildes, M.D., Donald Burnette, Richard McCann, and Bobbette Bond; and recommend three candidates to the Board of Hospital Trustees for appointment; and take any action deemed appropriate. (For possible action)

FISCAL IMPACT:

None

BACKGROUND:

The Clark County Board of Commissioners, acting in its capacity as the UMC Board of Hospital Trustees enacted Clark County Ordinance No. 4145, establishing the UMC Governing Board. In accordance with the Ordinance, on December 7, 2013, the Board of Hospital Trustees approved and appointed a slate of nine members to the Governing Board. On April 15, 2025, the Clark County Ordinance was amended by Ordinance No. 5242.

On November 6, 2025, a Special Nominating Committee Meeting was held to discuss and consider applications of qualified candidates. The Special Nominating Committee recommends the following individuals for consideration: Laura Lopez-Hobbs, Christian Haase, John Fildes, M.D., Donald Burnette, Richard McCann, and Bobbette Bond.

From the above list, the Governing Board will discuss, consider, and recommend three (3) qualified individuals to the Board of Hospital Trustees for appointment and/or reappointment to the UMC Governing Board for a three-year term commencing on January 1, 2026. As dictated by Ordinance and Governing Board Bylaws, Members shall be selected by a majority vote of the Board of Hospital Trustees at a future duly noticed public meeting.

Cleared for Agenda
November 19, 2025

Agenda Item #
15

Bobbette Bond, MPH

Employment
Vice President, Healthcare Policy
Culinary Health Fund, and National Unite HERE Health
702-860-6089

- Responsible for the strategic implementation of health care reform initiatives within the Fund
- Oversight of Plan development for new markets in Hospitality Plan and Alaska Plan.
- Responsible for operational support of Culinary Health Fund
- Responsible for strategic direction of state and federal policy work
- Spearheading drug and hospital price transparency legislation in Nevada.
- Community Liaison for Nevada legislature
- Leadership team for Trustee and stakeholder presentations regarding policy issues.

Community Board and Affiliations for application to UMC Board 10/12/2025

Southern Nevada Health District, At Large Member 2020-Current
Nevada Supreme Court Access to Justice, Member 2019-Current
Nevada Patient Protection Commission, Member 2019-2023
Health Services Coalition Member, Executive Committee, 2011 – Current; Co-Chair, 2021 – Current
Governor's Workforce Investment Board (GWIB), Member 2013 - 2016
UNLV Medical School Community Advisory Board, Member 2015-2016
UMC Hospital Advisory Board, Member 2010 - 2011
Governor's Blue Ribbon Committee on HITECH, Member 2009
Clark County Community Priorities Board, Member 2009
Nevada Academy of Health, Member 2007-2009
Southern Nevada Immunization Coalition, Member 2007-2009
Clark County Health Access Coalition, Board of Directors 2004-2005
Southern Nevada Oral Health Coalition, Member 2004-2008
Clark County Children's Hospital Task Force, Member 2001
Nevada State Governor's Task Force on Access to Public Health Services, Member
Regional Trauma Advisory Board, Founding Member

CHRISTIAN D. HAASE

Christian Haase is co-founder, owner and operator of several Las Vegas based companies including Burnett Haase Construction, 24/Seven Xpress Convenience Stores and Liquor Library, LLC at McCarran Airport. In addition, he has principal experience in all areas of commercial real estate development, management and feasibility analysis.

Mr. Haase recently served as President of the Nevada Chapter Board of Directors for the Juvenile Diabetes Research Foundation (JDRF) where he co-founded and chaired the annual "Rock the Walk" outdoor family concert event at the Springs Preserve which raised over $1 million for diabetes research.

He currently serves the community as a member of the UMC Board of Governors, along with the Boards of The Nathan Adelson Hospice, JDRF. And YPO Gold Nevada,. He is a member of Young President's Organization (YPO-Gold). He has also been active in and supported The National Association for Office and Industrial Parks, the Las Vegas Chamber of Commerce, Nevada Development Authority, the Lied Institute for Real Estate Studies mentoring program, Child Haven, The Sam Schmidt Paralysis Foundation, One Drop, Links for Life Foundation. the CDMC real estate advisory board to UNLV and as an adult leader in the Boy Scouts

Mr. Haase received his bachelor's degree from the Miami University in Oxford, Ohio. In his free time he enjoys reading, gardening and most of all spending time with his wife and kids doing family travel or any outdoor sporting activity.

Statement of interest:

During my 26 plus years in the Clark County, County Manager's Office, I witnessed the growth of the health care industry in Southern Nevada, and I have a great deal of personal history with UMC over the last 16 years of my time with the County. During my 6 years of service as County Manager, I helped craft the County Code creating the UMC Governing Board, I oversaw the appointment process of the first Governing Board members, and I supported the transition of governance from the Board of County Commissioners to the UMC Governing Board. While it has been nearly 9 years since my retirement from the County, my passion for UMC has not diminished. As a member of the Governing Board, I believe I can help shape UMC's future, and effectively address the challenges and opportunities that lie ahead.

BACKGROUND AND EXPERIENCE

A. Health Industry Experience

As County Manager, I supervised the CEO of UMC up until the time that governance responsibilities were transitioned to the UMC Governing Board. Prior to the transition, I was directly involved in matters of policy and administration at UMC including, but not limited to collective bargaining, capital planning, negotiation of UMC's pre-affiliation agreement with the UNLV School of Medicine, the siting of the UNLV School of Medicine, deployment of UMC's electronic health system, and the negotiation of Medicaid funding (County's IGT program, voluntary contributions, supplemental payments, etc …). Additional experiences can be shared upon request.

B. Other Professional Experience

Regarding my education, I have a Bachelor's of Science degree in Public Administration from Northern Arizona University and a Masters of Public Administration from New Mexico State University. Upon graduation from New Mexico State University in 1990, I accepted a Management Intern position in Clark County under a 1 year contract. I spent the following 26 plus years in the County Manager's Office, with the final 15 years in the Senior Executive positions of Chief Administrative Officer and then County Manager. Over the last 9 years, I have operated Burnette Consulting and have provided a wide range professional and consulting services to a broad range of private and non-profit entities, as well as one public entity.

C. Public and Nonprofit Board Affiliation

Since 2014, I have served on the Board of Directors of Opportunity Village, a non-profit organization that serves adults in Southern Nevada with intellectual and related disabilities. Opportunity Village is the largest non-profit in the State of Nevada, with facilities located in Clark County, Las Vegas, Henderson and North Las Vegas. From 2018 to 2020, I served as Chairman of the Board of Directors, and for the last 18 months I have also served in the capacity of Treasurer on the Board of Directors. I also serve as the Chairman of the Finance Committee, and have previously served as the Chair of the Board Development Committee, the Governance Committee, the Advocacy Committee and the Executive Committee. My

term as Treasurer is set to expire later this year, and I am up for reappointment to the Board in early 2026.

D. Financial Oversight, Capital Formation & Philanthropic Fundraising

In my capacity as County Manager, I was responsible for the financial oversight of the County's $6 billion annual operating and capital budgets which included reviewing and recommending approval of the County's operating, capital and supplemental budgets to the Board of County Commissioners. As part of the County's budgeting process, I also negotiated with the Sheriff over the County's annual contribution to the Metropolitan Police Department's budget.

As it relates to UMC's budget, I worked closely with the CEO of UMC on UMC's annual budget (or more specifically UMC's annual budget deficit, and the corresponding County general fund contribution to UMC's budget). I was also actively involved in the negotiation of the County's Agreements with the State of Nevada to fund the State's Medicaid budget, to the benefit of UMC.

Finally, as stated, I am the Chair of the Finance Committee under the Opportunity Village Board of Directors, where I lead the Committee's efforts to oversee the preparation and monitoring of Opportunity Village's annual budget. Additionally, Opportunity Village has a pretty significant philanthropy program led by the Opportunity Village Foundation Board of Directors. I work closely with the Senior Management of Opportunity Village and the Foundation Board to help support the philanthropy program and the related initiatives to the extent I can.

John Fildes, MD, FACS, FCCM, FPCS (Hon)

Dr. John Fildes MD, FACS, FCCM, FPCS (Hon) is an Acute Care Surgeon, the combination of trauma, surgical critical care, and emergency general surgery. He served as the University Medical Center (UMC) Medical Director for the Trauma Center and Chief of the Department of Trauma and Burns (1996-2019). In addition, he served on the Medical Executive Committee (1996-2019) and was the Vice Chief of Staff and Interim Chief of Staff (2010-2016). Under his leadership, UMC became Nevada's only Level 1 Trauma Center, only Pediatric Trauma Center, and only verified Burn Center. Dr. Fildes established the first American Association for the Surgery of Trauma (AAST) approved Acute Care Surgery Fellowship *in the nation* and was its program director for over a decade. He is an internationally renowned trauma surgeon, researcher, educator, and administrator in the fields of medicine, surgery, and medical education.

A leader of the medical response to the 1 October 2017 shootings in Las Vegas, Dr. Fildes and his surgical team were commended by President Donald Trump for their care of the shooting victims. He continues to be a 1 October spokesperson at the regional, national, and international level. In addition, he was a consultant to DHS, FEMA, CDP, HHS, OS, ASPR, and EMMO -- agencies developing a disaster-training program for the medical response to a no-notice, overwhelming, large-scale, mass shooting event.

Dr. Fildes is also an Emeritus Professor of Surgery at the Kirk Kerkorian School of Medicine at UNLV. He was the inaugural chair of surgery and the former associate dean for external affairs at UNLV. Dr. Fildes also served as the school's interim dean from September 2019 through April 2020.

His research has appeared in 67 peer-reviewed publications, including the American Journal of Surgery, the Journal of Trauma and Acute Care Surgery, Critical Care Medicine, Academic Emergency Medicine, Plastic and Reconstructive Surgery, Journal of Surgical Research, Cancer Medicine, and Circulatory Shock. In addition, he has authored 72 invited publications and book chapters.

Dr. Fildes is the recipient of several honors and awards. He received the Las Vegas Chamber of Commerce's Achievement Award (1998), was named Nevada's Distinguished Physician (2006), Healthcare Hero (2012), Best Doctors of Southern Nevada six times (2013-2018), and honored by the Mayor of Las Vegas who proclaimed May 12th as Dr. John Fildes Day in the city of Las Vegas (2017). He also received the Dean's Distinguished Service Award (2007), Foundation Professor Award (2012), and

was named an Outstanding Teacher/Professor on numerous occasions by medical students, residents, and fellows from several training programs. Dr. Fildes is the recipient of certificates of appreciation from the White House Medical Unit (1998, 2017), the Centers for Disease Control (2009, 2012), and the U.S. Air Force (USAF) (2016).

He received his BS degree, cum laude, in biomedical engineering from Union College in Schenectady, NY (1973-1977). He received his MD degree, *meritissimus (top 2%)*, from the University of Santo Tomas in Manila (1978-1982). Dr. Fildes completed his residency in general surgery at the Bronx-Lebanon Hospital in Bronx, NY (1982-1987). He completed his fellowship in trauma, burns, and surgical critical care at the Cook County Hospital in Chicago, IL (1988-1989).

An American College of Surgeons (ACS) Fellow since 1990, Dr. Fildes made significant contributions to the creation of the National Trauma Data Bank® (NTDB®) and the Trauma Quality Improvement Project® (TQIP®). In the wake of the 9/11 terrorist attacks on the U.S., Dr. Fildes was asked to testify before the U.S. Senate on the readiness of the nation's trauma centers. He was appointed National Chair of the ACS Committee on Trauma (COT) (2006-2010) and was promoted to ACS Medical Director of Trauma Programs in the Division of Research and Optimal Patient Care (2010-2014). He served as ACS Governor for the state of Nevada (2015-2018). Dr. Fildes received the Trauma Achievement Award (2018) for exceptionally meritorious service and lifetime achievement from the ACS and COT.

Dr. Fildes has been a member of the AAST since 1994. He served as AAST Chair of the Injury Assessment and Outcome Committee (2004-2006). He also served as the chair of the Acute Care Surgery Committee (2010-2013) where he made significant contributions to the growth and development of acute care surgery as a new surgical specialty. He also served as the national chair of the Acute Care Surgery Program Directors Group (2013-2019).

For more than two decades, Dr. Fildes has collaborated with the United States Air Force. He was a senior visiting surgeon and consultant at Landstuhl Regional Medical Center in Germany and at Bagram and Kandahar Air Bases in Afghanistan (2008). He embedded active-duty residents into general surgery and emergency medicine residencies at the Kerkorian School of Medicine and University Medical Center. Dr. Fildes collaborated and led the efforts to establish the STARS-P (Sustainment of Trauma and Resuscitation Skills – Program) and more recently the SMART (Sustained Medical and Readiness Training) programs to sustain and improve the readiness of attending surgeons and medical personnel for battlefield medicine.

Dr. Fildes was a committee member for the Southern Nevada Health District from 1996 to 2020. He served on the Medical Advisory Board (MAB) (1996-2005) and served twice as the chair of the Regional Trauma Advisory Board (RTAB) (2006-2008, 2017-2020). The RTAB is responsible for oversight of the Southern Nevada Trauma System (SNTS). He was selected to chair the Needs Based Assessment Taskforce (NBAT), a community wide stakeholder group, to determine the need for new trauma centers in the SNTS (2016-2017). Dr. Fildes was invited to address these issues at the joint meeting of the Clark County Board of Commissioners, Las Vegas City Council, and Southern Nevada Board of Health in 2024.

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CURRICULUM VITAE
JOHN FILDES, MD, FACS, FCCM, FPCS (Hon)

Current Position:

Professor Emeritus in Surgery, Kirk Kerkorian School of Medicine at University of Nevada Las Vegas (KKSOM UNLV), 2022- present

Past Positions:

Associate Dean for External Affairs, 2020- 2022
Professor and Inaugural Chair, Department of Surgery 2017- 2022
1701 W Charleston Blvd, Suite 490
Las Vegas, NV 89102
Office phone: (702) 671-2201
Email: john.fildes@unlv.edu

Past Positions:

Interim Dean, UNLV School of Medicine 9/2019 to 4/2020
Chair, University of Nevada Reno (UNR) Department of Surgery 2015-17
Vice Chair, UNR Department of Surgery 2002-15
Chief, Division of Acute Care Surgery 1996-2018
Program Director for the General Surgery residency 2002-13
Program Director for the Surgical Critical Care fellowship 2004-13
Program Director for the Acute Care Surgery fellowship 2007-19

Medical Director of Trauma Services at the University Medical Center (UMC) of Southern Nevada, Las Vegas 1996-2019
Chair, Department of Trauma and Burns at UMC 1996-2019

Education:

BS, cum laude, in Biomedical Engineering 1977
Union College, Schenectady, NY

MD, meritisimus* 1982
University of Santo Tomas, Manila, Philippines
(*8 of 350)

Internship & Residency:

Intern in General Surgery 1982-83
Resident in General Surgery 1983-87
Chief Resident in General Surgery 1986-87
Bronx-Lebanon Hospital, Bronx, NY

Fellowship Training:

Fellow in General Surgery 1987-88
Bronx-Lebanon Hospital, Bronx, NY

Fellow in Surgical Critical Care, Burns, & Trauma 1988-89
Cook County Hospital, Chicago, IL

Professional Development:

Financial Management for Clinical Chairs, June 2021
Led by Clayton Tellers, ECG Management Consultants, San Diego, CA

Executive Development Seminar for Deans, Jan 2020
Association of Medical Colleges, Washington, DC

CultureSync Leadership Program, 2018-2019
Led by Dave Login author of *Tribal Leadership*, Los Angeles, CA

Program for Chiefs of Clinical Services, Jan 2013
Harvard School of Public Health, Boston, MA

Professional Development (cont.):

ULEAD Executive Leadership Training, 2013
GE Healthcare and the American College of Surgeons, Chicago, IL

Medical Executive Committee Institute, Jan 2014
The Greeley Corporation, Danvers, MA

Physicians in Management Seminar (PIMS), July 2012
Essentials of Healthcare Law, July 2014
American Association for Physician Leadership, Tampa, FL

Licensure:

Nevada is active (7717)
New York & Illinois are inactive

Board Certification:

Certified in General Surgery 1988-2027
Re-Certification in General Surgery 1998, 2008, and 2017

Certified in Surgical Critical Care 1990-2024
Re-Certification in Surgical Critical Care 2000, 2010, and 2021

Fellowships:

Fellow in the American College of Surgeon, FACS, 1990
Fellow in the American College of Critical Care Medicine, FCCM, 1995
Honorary Fellow in the Philippine College of Surgeons, FPCS (Hon), 2012
Fellow, Academy of the Asian Collaboration for Trauma, 2021

Academic Appointments:

Assistant Professor of Surgery 1989-1995
University of Illinois College of Medicine at Chicago

Lecturer in General Surgery 1990-1992
Visiting Assistant Professor in General Surgery 1992-1995
Assistant Professor in General Surgery 1995-1996
Rush Medical College, Chicago, IL

Lecturer in Health Sciences and Professional Studies 1992-1996
Malcolm X College, City Colleges of Chicago

Professor of Surgery 1996
Tenure granted 2001
Foundation Professor 2012
University of Nevada Reno (UNR) School of Medicine

Adjunct Professor 2016
Professor with tenure of title 2017
University of Nevada Las Vegas (UNLV) School of Medicine

Hospital Appointments:

Attending Surgeon in Trauma and Critical Care 1989-1996
Cook County Hospital, Chicago, IL

Attending Surgeon in General Surgery 1989-1996
University of Illinois Hospital, Chicago, IL

Attending Surgeon in Trauma, Critical Care, and General Surgery 1996-2022
University Medical Center (UMC) of Southern Nevada, Las Vegas, NV

Professional Societies:

Current

American Association for the Surgery of Trauma
American College of Critical Care Medicine, Fellow since 1995
American College of Surgeons, Fellow since 1990
American Surgical Association
Eastern Association for the Surgery of Trauma
International Association for Trauma Surgery and Intensive Care (IATSIC)
International Society of Surgery (ISS)
Society of Critical Care Medicine
Western Surgical Association
Western Trauma Association

Past & Honorary Societies:

American Association for Physician Leaders
American Burn Association
American Medical Association
American Hernia Society
American Trauma Society
American Society Parenteral and Enteral Nutrition
Association for Academic Surgery
Biologic Photographic Association
Chicago Surgical Society
Illinois Surgical Society
Karl Meyer Surgical Society (Cook County Hospital Alumni)
Mackenzie Society (Oregon Heath & Science University)
Philippine College of Surgeons
    Honorary Fellow since 2012
Society of Laparoscopic Surgeons
Society of Surgical Chairs
Southwest Surgical Congress
Society of Philippine Surgeons in America
Warren H. Cole Society (University of Illinois Chicago Alumni)

Professional Society Leadership Positions:

Chicago Metropolitan Trauma Society
    Secretary/Treasurer 1990-1992
    Board of Directors 1991-1996
    President (2 terms) 1992-1994
Metropolitan Chicago Committee on Trauma of the American College of Surgeons
    Regional ATLS Director 1993-1996
    Vice Chair 1994-1996
Metropolitan Chicago Chapter of the American College of Surgeons
    Executive Council 1994-1996
    Interim Vice Chair 1995-1996
Nevada Committee on Trauma of the American College of Surgeons
    Regional ATLS Director 1996-2001
    Vice Chair 1996-1997
    Chair 1997-2001
Nevada Chapter of the American College of Surgeons
    Council Member 1997-2004
    Secretary/Treasurer 2004-2006
    Vice President 2006-2008
    President 2008-2010
    Governor 2015-2018
Southwest Surgical Congress
    State Councilor 1998-2003

Professional Society Leadership Positions (cont.):

American College of Surgeons (ACS) Committee on Trauma
- Chair, National Trauma Data Bank Committee 2001-2006
- Site Visitor for the Verification Review Committee
- National Chair, ACS Committee on Trauma 2006-2010

American Association for the Surgery of Trauma
- Chair, Injury Assessment and Outcome Committee 2004-2006
- Chair, Committee on Acute Care Surgery 2010-2013
- Chair, Program Directors in Acute Care Surgery 2014-2019

American Board of Surgery
- Trauma, Burns, Critical Care Advisory Council 2006-2010
- Associate Examiner for the Certifying Examination 2012 and 2017

American College of Surgeons
- Medical Director, Trauma Programs in the Division of Research and Optimal Patient Care 2010-2014

Other Professional Activities:

Hektoen Institute for Medical Research, Chicago, IL
- Director, Trauma Basic Science Research Laboratory 1989-1996

National Center for Advanced Medical Education (formerly the Cook County Graduate School of Medicine), Chicago, IL
- Faculty 1989-1996

Advanced Trauma Life Support
- Instructor 1989
- State Faculty 1994
- National Faculty 2006- Present

Advanced Burn Life Support
- Instructor 1990-2001

Department of Surgery, Cook County Hospital, Chicago, IL
- Coordinator, Post Graduate Medical Education 1991-1995
- Department of Trauma, Cook County Hospital, Chicago, IL
- Chief, Division of Trauma Education & Research1991-1996
- Program Director of the Trauma Fellowship 1991-1996

Department of Surgery, Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL
- Surgical Research Committee 1994-1996
- Residency Program Advisory Committee 1996

University of Nevada School of Medicine
- Graduate Medical Education Committee, 2002-2019
- Department of Surgery
  - Program Director in General Surgery 2002-2013
  - Associate Program Director in General Surgery 2013-2015
  - Program Director in Surgical Critical Care 2004-2013
  - Program Director in Acute Care Surgery 2007-2019
  - Chief, Division of Trauma & Surgical Critical Care 1996-2007
  - Chief, Division of Acute Care Surgery 2007-2019
  - Vice Chair, Department of Surgery 2002-2016
  - Chair, Department of Surgery 2016-2022

University Medical Center of Southern Nevada, Las Vegas, NV
- Hospital-Wide Performance Improvement Committee 1996-2016
- Medical Executive Committee 1996-2020
- Vice Chief of Staff 2010-2016

Southern Nevada Health District, Las Vegas, Clark County, NV
- Medical Advisory Board for EMS 1996-2005
- Quality Assurance Committee for EMS 1996-1999
- Regional Trauma Advisory Board (RTAB) for system oversight 2006-2020
  - Chair in 2006 and 2018

Trauma Medical Audit Committee (TMAC) for system PI 2006-2020
Trauma Procedure/Protocol Review Committee 2012-2015
Chair, Needs Based Assessment Taskforce (NBAT) to determine the need for new trauma centers in the trauma system 2016-2017

State of Nevada Department of Health and Human Services
Injury Prevention Task Force 2001-2006

Nevada State Health Division's Office of Emergency Medical Services
Committee on Emergency Medical Services (NRS 450B.151-154) 2001-2019

Fundamentals of Laparoscopic Surgery
Provider 2009-2012

Fundamental Critical Care Support
Instructor candidate 2010

Practice Plan of the University of Nevada Reno (UNR) School of Medicine
Practice Plan Executive Committee, 2010-2014
Compliance and QA Committee of the Practice Plan, 2012-2014
Southern Regional Executive Committee (SREC)
Board member, 2012-2014 & 2016-2017
Medical School Associates South
Vice President, 2016-2017

Centers for Disease Control, Atlanta, GA
Served on the National Expert Panel on Field Triage that created the Guidelines for Field Triage of Injured Patients in 2005 and again in 2012. These were published in the MMWR January 13, 2012 / 61(RR01);1-20

National Center for Health Statistics
Panel member of the national steering committee, Jan 2011

Senior Visiting Surgeon
Sponsored by the American Association for the Surgery of Trauma, American College of Surgeons, and the Department of Defense.
Landsthul Regional Medical Center, Germany October 2008
Base Hospitals in Bagram and Kandahar, Afghanistan October 2008

STARS-P (Sustainment of Trauma and Resuscitation Skills – Program)
I partnered with the US Air Force at Nellis Air Force Base to stand up a STARS-P program that embeds medical personnel into our trauma service to maintain critical wartime readiness skills. This required a change in NV state statute before operationalization. 2010-2014

Joint Service Graduate Medical Education (JSGME) selection board
As the civilian program director who directs the training of active duty residents from the USAF I have been invited to serve on this selection board. It matches military medical students with residencies, 2010-2013

National Quality Forum
Panel member for the steering committee on Regionalization of Emergency Care, 2011-2012

SMART (Sustained Medical and Readiness Training - Program)
I was the civilian director for this new program where USAF Surgeons. The Air Force will rotate surgeons and surgical teams at the University of Nevada and the University Medical Center to sustain and improve their readiness for battlefield medicine. 2015

American Board of Surgery, Associate Examiner in the Certifying Exam, in 2012 and 2017

Medical Response to a Large-Scale Event at the FEMA Center for Domestic preparedness, Noble Training Facility in Anniston. AL, 2018-2019
I served as an invited consultant to evaluate and plan disaster-training programs for DHS, FEMA, CDP, HHS, OS, ASPR, EMMO.

Department of Defense, Joint Trauma System Consultation. May 2023
I served as an invited consultant to evaluate the military trauma system.

Honors & Awards:

Resident Paper Competition Award 1984
Presented by the Bronx Chapter of the American College of Surgeons

The Olga Jonasson Award 1991
Presented by the surgical residents of the University of Illinois and Cook County Hospital for exceptional personal commitment to resident education in surgery, academic and clinical excellence, and enthusiastic personal support of resident surgical research

The Stergios Award 1992
Presented by the Department of Surgery of the University of Illinois for excellence in basic research

Excellence in Teaching Award 1993
Presented by the emergency medicine residents of the Cook County Hospital

Plaque of Appreciation 1994
Presented by the Philippine College of Surgeons and the Department of Health, Republic of the Philippines, for invaluable contributions to the National Trauma Prevention and Management Program of the Republic of the Philippines

Affiliated Surgical Attending of the Year Award 1995
Presented by the surgical residents of Rush-Presbyterian-St. Luke's Medical Center in recognition of outstanding contributions to resident education

Safe Community Partnership Award 1997
Presented by the Clark County Safe Community Partnership for continued dedication to public safety within the field of emergency medicine

Outstanding Full-Time Clinical Professor 1998
Presented by the University of Nevada School of Medicine Class of 1998 in tribute to the pursuit of excellence and dedication to teaching.

White House Medical Unit 1998
Certificate of Appreciation for outstanding support provided during the President's visit to Las Vegas

Las Vegas Chamber of Commerce's Achievement Award 1998
For professional service as Director of the Trauma Unit at University Medical Center

Outstanding Teaching Award 1999
Presented by the Surgical Residents of the Department of Surgery, University of Nevada School of Medicine in recognition of outstanding contributions to resident education

The ACS COT Millennium Commitment Award 2000
Presented by the American College of Surgeons Committee on Trauma in recognition of exceptional dedication and service to the Committee on Trauma and the care of the injured

Outstanding Clinical Teacher 2001
Presented by the University of Nevada School of Medicine Class of 2001 in honor and appreciation for the time, commitment, and knowledge to the teaching and mentoring of medical students

Honors & Awards (cont.):

Honorary Fire Chief, Las Vegas Fire Department 2001

The highest honor given by the fire department for outstanding service in saving the life of Captain Nathan Pechacek

Most Outstanding Alumnus in Academic Achievement 2001

Presented by the University of Santo Tomas Medical Alumni Association in America

Nevada's Distinguished Physician 2006

Awarded by the Nevada State Medical Association in recognition of outstanding service to the Nevada medical community

Most Influential Person in Healthcare 2006

Awarded by In Business Las Vegas Magazine for work as Director of the Level-One Trauma Center, University Medical Center

Dean's Distinguished Service Award 2007

University of Nevada School of Medicine award bestowed annually to recognize special friends of the School of Medicine who have supported the philosophy and goals of the medical school and have made significant contributions to the healthcare field in Nevada.

Heart of Community Award, 2007

Presented during the American Heart Association's 2007 Heart of Gold Ball for care administered to Roy Horn, of Siegfried & Roy, after his October 2003 stroke following a tiger bite onstage, and for continuing service to the community.

Most Outstanding Alumni of the Medical School class of 1982, December2007

Each year the Dean of the University of Santo Tomas Faculty of Medicine & Surgery chooses the most outstanding alumni from the class celebrating its 25th reunion from medical school. The criteria include academic achievement and service. As a result, I was invited to deliver the 26th Dr Mariano Alimurung Memorial Lecture on the "Global Burden of Injury"

U.S. Department of Health and Human Services Centers for Disease Control and Prevention Certificate of Appreciation March, 2009

Presented for leadership as Chair of the American College of surgeon Committee on Trauma in forging collaborations with the Centers for Disease Control and Prevention, resulting in the Morbidity and Mortality weekly report: Recommendations and Reports "Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage."

American Academy of Nurse Practitioners, June 2009

State Award for Excellence for increasing awareness and acceptance of Nurse Practitioners,

First Annual Strategic Highway Safety Plan Awards, 2011

Presented in conjunction with the Safe Community Partnership Awards; honoring dedication to improving the safety of Nevada residents and for willingness to lend time and expertise for education/outreach and media events.

U.S. Department of Health and Human Services Centers for Disease Control and Prevention Certificate of Appreciation, January, 2012.

Presented for leadership, expertise and contributions as a member of the National Expert Panel on Field Triage of Injured Patients.

Foundation Professor 2012

Presented by the University of Nevada, Reno as one of the highest honors bestowed on a tenured professor. I am only the second physician selected for this award in its 34-year history.

Honors & Awards (cont.):

Election to the Alpha Omega Alpha, National Medical Honor Society, April 2012
Recognition by students, residents, and faculty for excellence in scholarship and the highest ideals in the profession of medicine.

Nevada Healthcare Hero in Technology & Research, August 2012
Selected by peers for this statewide award from the Nevada Business Magazine and Blue Cross and Blue Shield Nevada.

American College of Surgeons, March 2014
For your commitment, service, and dedication as medical director to the Trauma Programs of the American College of Surgeons 2010-2014.

American College of Surgeons Committee on Trauma, March 2014
Recognition and thanks for nineteen years of dedicated service and leadership to the Committee on Trauma.

2016 Top Doc in Trauma by University Medical Center

The Graduating Class of the University of Nevada School of Medicine, June 2016
Outstanding Full-Time Professor in Las Vegas

U.S Air Force 99th Medical Group at Nellis Air Force Base, Nevada, June 2016
Presented for exceptional service and in appreciation for the efforts and dedication to support the USAF Surgeon General's Sustained Medical And Readiness Training (SMART) Program

Proclaimed May 12th as Dr. John Fildes Day in the City of Las Vegas 2017
Proclaimed by Mayor Carolyn G. Goodman in recognition of his 20 years of service to the care of the injured people of Las Vegas.

White House Medical Unit, October 2017
For outstanding achievement in support of the White House Medical Unit and the President of the United States during the One October Shootings in Las Vegas

American College of Surgeons Committee on Trauma, Trauma Achievement Award, March 9, 2018
For exceptionally meritorious service and lifetime achievement as a member of a regional committee on trauma.

Best Doctors of Southern Nevada by the Desert Companion and the National Public Radio, 2013, 2014, 2015, 2016, 2017, 2018

Outstanding Service Recognition 2019
Awarded by the leadership, faculty and staff of the school of medicine for outstanding service to UNLV Medicine.

Healthcare Hero for Lifetime Achievement by the Nevada Business Magazine, 2020
Awarded to one physician each year in Nevada for lifetime achievement in their field of medicine.

The President's Award for Lifetime Achievement from the Clark County Medical Society, 2020
Awarded to one physician each year in Clark County for unselfishly giving back to Southern Nevada.

Norman McSwain Leadership Award 2021
Awarded to one physician at the *2021 World Trauma Symposium* for lifetime contributions to trauma care as a surgeon, a pioneer in education, and development in the trauma field, an advocate for prehospital care, as an educator teaching and mentoring prehospital care providers, as a trauma spokesperson at the regional, national, and international stage, as an author, and for significant contributions to the creation of the National Trauma Data Bank® (NTDB®) and the Trauma Quality Improvement Project® (TQIP®).

Most Outstanding Alumnus of the Year, July 2022
Presented by the University of Santo Tomas (UST) Medical Alumni Association to one physician each year. It is inscribed "A distinguished physician who has led

locally and nationally in the field of Trauma Surgery. He has exemplified the highest virtues of a Thomasinong Manggagamot (translation: a UST Physician)."

Thomasian Outstanding Medical Alumni (THOMAS) Award for Medical Education, Dec 2022. The Faculty of the University of Santo Tomas School of Medicine selects one medical school alumni to receive this award for outstanding contributions and lifetime achievement in medical education.

Past Manuscript Reviewer:

Joint Commission Journal on Quality and Patient Safety
Journal of the American College of Surgeons
Journal of Trauma and Acute Care Surgery
Critical Care Medicine
World Journal of Surgery
The Western Journal of Medicine
Medical Journal of Brunei

Invited Presentations (partial list):

1. Yemeni College of Surgeons, 1994
2. Philippine College of Surgeons 51st Annual Clinical Congress, 1995
3. Institute of Medicine, The Future of Emergency Care, 2006
4. Royal Australasian College of Surgeons Annual Scientific Congress, May 2007
5. University of Santo Tomas, invited to deliver the 26th Dr Mariano Alimurung Memorial Lecture, Dec 2007 Royal College of Surgeons of Thailand, July 2008
6. Philippine College of Surgeons 64th Annual Clinical Congress, December 2008
7. Institute of Medicine, Regionalization of Emergency Care, May 2009
8. The 8th Jonathan Hiatt, MD Trauma & Critical Care Lectureship, Cedars-Sinai Medical Center, May 2009
9. Pan American Trauma Congress in Brazil, November 2009
10. The Presidential Invited Lecturer of the American Society for Reconstructive Microsurgery, January 2010
11. The Office of National Drug Control Policy at the White House, April 2010
12. Dartmouth Medical Center, April 2010
13. American College of Emergency Physicians, July 2010
14. Rush Medical Center, November 2011
15. National Association of EMS Physicians, January 2012
16. Duke University, June 2012
17. The 1st World Trauma Congress in Brazil, August 2012
18. The Emergency General Surgery Research Agenda at the AAST, October 2012
19. NCTC/DHS/FBI/Las Vegas Joint Counterterrorism Awareness Workshop, Las Vegas, NV, October 2012
20. Report on the Committee on Trauma, Board of Regents of the American College of Surgeons, June 2013
21. American College of Osteopathic Surgeons Clinical Congress, November 2013
22. Moderator of the Trauma Quality Improvement Program (TQIP) national annual meeting, November 2013
23. Report on the Committee on Trauma, Board of Regents of the American College of Surgeons, February 2014
24. Pediatric Trauma III global webcast, February 2014
25. The 41st Annual Preston A. Wade Lectureship, Weill Cornell Medical College and New York-Presbyterian/Weill Cornell Medical Center, April 2014
26. The 2nd Annual Kasian A. Lim Memorial Lecture, University of Santo Tomas, Manila, Philippines, December 2016
27. Philippine College of Surgeons 72nd Annual Clinical Congress, December 2016
28. University of Florida, Jacksonville, September 2017
29. American College of Surgeons Clinical Congress, October 2017
30. Stanford University Combined Trauma & Emergency Medicine Grand Rounds, January 2018

31. SSAT/AAST/SAGES Winter Conference Keynote Speaker, January 2018
32. ATLS 40th Anniversary Celebration Keynote Speaker, March 2018
33. Healthcare Response to a No-Notice Incident: Las Vegas, ASPR & TRACIE (Assistant Secretary for Preparedness and Response & ASPR's Technical Resources, Assistance Center, and Information Exchange), March 2018
34. Conference Medical Disaster Management in the Netherlands, April 2018
35. European Society for Trauma & Emergency Surgery in Valencia, Spain, May 2018
36. Australasian College of Surgeons in Sydney, Australia, May 2018
37. Union College Distinguished Alumni Lecture, May 2018
38. Albany Medical College Grand Rounds, May 2018
39. The Olga Jonasson Lecture at the University of Illinois Chicago, June 2018
40. Scripps Clinic in La Jolla, CA Grand Rounds, June 2018
41. The Freeark Lecture at Loyola University in Chicago, June 2018
42. The Peter Mucha Lecture at the Mayo Clinic, Rochester, MN, August 2018
43. The Donald Trunkey Lecture at Oregon Health Sciences University, September 2018
44. The Use of Registries for Maintenance of Certification at the American Board of Medical Specialties, September 2018
45. The Maj. John Pryor, MD, FACS Lecture at the Pennsylvania Trauma System Foundation, October 2018
46. Keynote speaker at the 15th Annual ADVOCATE Trauma Symposium in Chicago, November 2018
47. Visiting Professor at the University of Toronto, February 2019
48. American Academy of Orthopedic Surgeons panel on disaster management, March 2019
49. Trauma Center Association of America annual meeting, April, 2019
50. NYU Department of Surgery Grand Rounds, May 2019
51. Opening speaker for the International Association for Trauma and Critical Care Surgery (IATSIC) at the World Congress of Surgery in Krakow, Poland, August 2019
52. Keynote Speaker at the 75th Annual Clinical Congress of the Philippine College of Surgeons, Manila, November 2019
53. Speaker for the Trauma Association of Canada Multi-Center Grand Rounds, March 2021
54. Opening Speaker at the Asian Collaboration for Trauma, October 2021
55. Reflections on the Impact of the Committee on Trauma 100th Anniversary. As a Past Chairs I spoke on Quality Initiatives. March 2022
56. Responding to the National Rise in Violence, The American Trauma Society annual meeting. April 2022
57. The University of Santo Tomas Alumni Annual Meeting. June 2022
58. Inova Health's Emergency General Surgery, Surgical Critical Care, & Trauma Symposium. April 2024
59. Clark County Commission, Las Vegas City Council, and the Southern Nevada Health District Joint Meeting. September 2024
60. Advocate Health Annual Trauma Symposium. November 2024

Grants:

1. Co-Investigator. A prospective randomized comparison of surgical versus percutaneous tracheostomies in critically ill, mechanically ventilated patients. Cook Medical Products. 1991-1992

2. Principal Investigator. A prospective, randomized, multi-center trial of Dexon II versus conventional sutures in the development of wound infection. Davis & Geck. 1991-1993

3. Principal Investigator. Teaching surgical skills for trauma care with cadavers. Lederle Labs. 1991-1993

4. Principal Investigator. A prospective, randomized, multicenter comparison of ampicillin/sulbactam versus cefoxitin as early empiric therapy following penetrating and blunt abdominal trauma. Pfizer Pharmaceutical. 1991-1995

5. Co-Investigator. Open label trial of Centoxin (HA-1A) treatment of presumed gram negative sepsis. Centocor, Inc. 1992-1993

6. Principal Investigator. Hypotensive resuscitation in an uncontrolled hemorrhage model. Hektoen Institute for Medical Research, Chicago, IL. 1992-1994

7. Co-Investigator. Randomized, placebo-controlled trial of E5 monoclonal antibody in patients with severe sepsis. Pfizer Pharmaceuticals. 1993-1994

8. Principal Investigator. The use of diaspirin cross-linked hemoglobin in the hospital management of hemorrhagic hypovolemic shock. Baxter Healthcare. 1994-1995

9. Principal Investigator. Multicenter study to evaluate the safety and effectiveness of PEG-superoxide dismutase in severe closed head injury. Sterling Winthrop Pharmaceuticals. 1994-1995

10. Co-Investigator. To develop and conduct two educational training programs to improve identification and documentation of domestic violence occurrences in Clark County. Office of the Attorney General, State of Nevada. 1996

11. Principal Investigator. The efficacy trial of diaspiril cross-linked hemoglobin (DCLHB) in the treatment of severe traumatic hemorrhagic shock. Baxter Healthcare 1996-1997

12. Co-Principal Investigator. Crash Outcome Data Evaluation System (CODES). Develop linkages of statewide databases to evaluate crash outcome data for the State of Nevada. ($257,000) National Highway Traffic Safety Administration 1997-2000

13. Co-Principal Investigator. Domestic Violence Data Initiative. Perform an epidemiological analysis of Nevada using probabilistic linkage methodology to join existing databases to identify patterns of domestic violence. ($123,000) State of Nevada Office of the Attorney General 1997-1998

14. Co-Principal Investigator. Nevada CODES Project. Continuation and a Demonstration of Expanded Crash File Electronic Capture. Provide accurate compilation and analysis of traffic crash data collected from multiple sources throughout Nevada. ($75,000) State of Nevada Department of Motor Vehicle and Public Safety, Office of Traffic Safety 1998-2000

15. Co-Principal Investigator. Nevada Emergency Medical Services for Children Data Collection and Information Solidify and institutionalize the emerging Nevada EMSC infrastructure ($95,500) Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau 1998-2000

16. Co-Principal Investigator. Suicide Research Prevention Center. Formation of an injury control center. Will focus on data driven evaluation of suicide occurrence, its epidemiology and prevention. ($1,500,000) Centers for Disease Control and Injury Prevention 1998-2001

17. Co-Principal Investigator. Domestic Violence Data Initiative. To continue data efforts to take existing electronic databases to create an epidemiological baseline for incidence of domestic violence in Nevada. ($75,000) State of Nevada Office of the Attorney General 1998-2001

18. Co-Principal Investigator. Nevada EMSC Partnership. For Infrastructure, Data and Education. Continue to institutionalize the emerging Nevada EMSC infrastructure; further refine and standardize EMS data collection and develop a pre-hospital computer-based distance learning strategy. ($97,600) Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau 2000-2003

19. Co-Director. National Trauma Data Bank. To support the data accrual and quality efforts of the NTDB. ($170,000) National Highway Traffic Safety Administration 2001.

20. Co-Principal Investigator. Emergency Medical Services for Children Trauma/EMS Systems Assessment. Initiate efforts to create a statewide strategic plan for trauma care systems by gathering data to document systems and challenges with the State of Nevada; coordinate and complete a standardized trauma system needs assessment -

statewide. ($45,000) Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau 2001-2002

21. Co-Principle Investigator. Nevada CODES Data Network. Collaborative effort among NHTSA, state and local agencies to continue the expansion and maintenance of the CODES linked data. ($94,000) National Highway Transportation Safety Administration 2001-2003

22. Co-Investigator. Suicide Prevention Research Center. Conduct, evaluate and publish suicide prevention research; identify, design, implement and evaluate suicide prevention programs with primary geographic focus in the inter-mountain west. ($1,200,000) Center for Disease Control and Prevention/DHHS Grant # U49\CCU915983-06. 2001-2005

23. Co-Director. National Trauma Data Bank. To support the NTDB data accrual through the development of trauma registry software conversion programs. ($200,000) National Highway Traffic Safety Administration 2003

24. Co-Director. National Trauma Care Data Standardization Project. To develop a minimum trauma care dataset that state trauma systems can adopt to enhance the quality of national trauma care data and preparedness. ($99,700) Health Resources Services Administration 2003-2005

25. Co-Principal Investigator. Nevada EMSC Partnership Grant for Date and Disaster Preparedness Activities. Solidify and institutionalize Nevada EMSC infrastructure, assess state guidelines, develop a pediatric disaster training handbook, refine EMS data collection in Nevada. ($300,000) Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau 2003-2007
26. Co-Director. National Trauma Care Data Standardization Project and NTDB Online. To continue work on the data standardization project and enhance the dissemination of the NTDB information over the Internet. ($99,100) Health Resources Services Administration 2004-2005

27. Co-Director. NTDB National Sample Project. To develop a nationally and regionally representative sample of data collected on patients treated in US trauma centers. ($99,080) Centers for Disease Control and Prevention 2005

28. Co-Director. National Trauma Care Data Standardization Project and NTDB Online. To promote use of the standard dataset among state trauma registries and individual trauma centers, and to develop software for the collection of the dataset. ($99,375) Health Resources Services Administration 2005-2006

29. Co-Director. NTDB National Sample Project. To continue the sample project through the recruitment of sample centers and support of a case definition survey. ($75,000) Centers for Disease Control and Prevention 2005-2006

30. Co-Principal Investigator. High Speed Blood and Fluid Transfusion Equipment. Research and development of a lightweight, portable, and minimal power requirement high speed blood and fluid transfusion device. ($1,500,000) Office of Naval Research 2005-2006

31. Co-Principal Investigator. High Speed Blood and Fluid Transfusion Equipment. Research and development of a lightweight, portable, and minimal power requirement high speed blood and fluid transfusion device. ($2,011,000) Office of Naval Research 2007-2010

32. Principal Investigator, Browder, T, Faculty Mentor, Fildes, JJ: The Effect of Induced Hypothermia on Hepatic and Pulmonary Apoptosis during Hemorrhagic Shock ($35,850.00) The American Association for the Surgery of Trauma Research Scholarship, 2008-2009

33. Principal Investigator, Center for Traffic Safety Research. Linkage of crash records and trauma records to create a database that includes crash scene data and trauma information. ($390,000) Nevada Office of Traffic Safety, 2008 - 2011

34. Principal Investigator. High Speed Blood and Fluid Transfusion Equipment. Research and development of a lightweight, portable, and minimal power requirement high speed blood and fluid transfusion device. ($3,088,200) Office of Naval Research 2010-2013

35. Co-Principal Investigator: Center for Traffic Safety Research. ($90,000.00 annually) Nevada Office of Traffic Safety, Department of Public Safety 2011–2013

36. Co-Investigator: Portable Body Temperature Conditioner, Phase I. ($2,096,000.00) US Army Medical Research ACQ Acquisition Activity/US Army Research 2011–2014

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Peer Reviewed Publications

1. Gerst PH; **Fildes JJ**; Baylor P; Zonszein J: Long-acting B-adrenergic antagonists as preparation for surgery in thyrotoxicosis. *Arch Surg* 1986; 121:838-840.

2. **Fildes JJ**; Narvaez GP; Baig KA; Pai N; Gerst PH: Pulmonary tumor embolization after peritoneovenous shunting for malignant ascites. *Cancer* 1988; 61:1973-1976.

3. Gerst PH; **Fildes JJ**; Rosario PG; Schorr JB: Risk of human immunodeficiency virus infection in patients and health care personnel. *Crit Care Med* 1990; 18:1440-1448.

4. **Fildes JJ**, Bannon MP, Barrett J.: Soft-tissue infections after trauma. *Surg. Clin. North Am.* 1991, 71(2):371-84

5. **Fildes JJ**; Reed LL; Jones N; Martin M; Barrett JA: Trauma: Leading cause of maternal mortality. *J Trauma* 1992; 32:643-645.

6. **Fildes JJ**; Sheaff C; Barrett J: Very hot intravenous fluid used in the treatment of hypothermia. *J Trauma* 1993; 35:683-687.

7. Nagy KK; Davis J; Duda J; **Fildes JJ**; Roberts R; Barrett J: A comparison of pentastarch and lactated Ringer's solution in the resuscitation of patients with hemorrhagic shock. *Circ Shock* 1993; 40:289-294.

8. Nagy KK; Massad M; **Fildes JJ**; Reyes H: Missel embolization revisited: A rationale for selective management. *Am Surg* 1994; 60:975-979.

9. **Fildes JJ**; Betlej TM; Manglano R; Martin M; Rodgers F; Barrett JA: Limiting cardiac evaluation in patients with suspected myocardial contusion. *Am Surg* 1995;61:832-835.

10. Nagy KK; **Fildes JJ**; Sloan E; Kim DO; Smith RF; Roberts RR; Krosner SM; Joseph K; Barrett JA: Aspiration of free blood from the peritoneal cavity does not mandate immediate laparotomy. *Am Surg* 1995;61:790-795.

11. Inabnet WB; **Fildes JJ**; Barrett JA: Perfusion patterns in uncontrolled hemorrhagic shock and limited resuscitation. *Surgical Forum* 1995.

12. **Fildes JJ**; Betleg TM; Barrett JA: Buckshot colic: Case report and review of the literature. *J Trauma* 1995;39:1181-1184.

13. Sheaff CM; **Fildes JJ**; Keogh P; Smith RF; Barrett JA: Safety of 65°C/149°F intravenous fluid for the treatment of hypothermia. *Am J Surg* 1996;172:52-55.

14. Nagy KK; **Fildes JJ**; Mahr C; Roberts RR; Krosner SM; Joseph KT; Barrett JA: Experience with three prosthetic materials in temporary abdominal wall closure. *Am Surg* 1996;62:331-335.

15. Friedman Y; **Fildes JJ**; Mizock B; Patel S; Samuel J; Appavu S; Roberts RR; O'Neill CM: Comparison of percutaneous and surgical tracheostomies. *Chest* 1996;110:480-485.

16. Nagy KK; Gilkey SH; Roberts RR; **Fildes JJ**: Computed tomography screens stable patients at risk for penetrating cardiac injury. *Academic Emergency Medicine* 1996;3/11:1024-1027.

17. Friedman Y, **Fildes JJ**, Mizock B, Patel S, Samuel J, Appavu S, Roberts RR, O'Neill CM: Comparison of percutaneous and surgical tracheostomies. *Chest* 1996;110:480-485.

18. Sheaff CM, **Fildes JJ**, Keogh P, Smith RF, Barrett JA: Safety of 65°C/149°F intravenous fluid for the treatment of hypothermia. *Am J Surg* 1996;172:52-55.

19. Mahr CC; **Fildes JJ**; Becker EJ; Nagy KK; Krosner SM; Roberts RR; Smith RF; Joseph K; O'Neill, CM; Barrett JA: Recovery rate of candidiasis in critically ill trauma patients with unresolved sepsis. *Complications in Surgery* 1997; 16(4)

20. Nagy KK, Brenneman FD, Krosner SM, **Fildes JJ,** Roberts RR, Joseph KT, Smith RF, Barrett J.: Routine preoperative "one-shot" intravenous pyelography is not indicated in all patients with penetrating abdominal trauma. *J Am Col Surgery* 1997: 185:530-533

21. **Fildes JJ**, Fisher S, Sheaff CM, Barrett JA: Effects of short heat exposure on human red and white blood cells. *J Trauma*, 1998;45:479-84.

22. Rogers FB, Rozycki GS, Osler TM, Shackford SR, **Fildes JJ**, et al: A multi-institutional study of factors associated with fetal death in injured pregnant patients. *Arch Surg*, 1999, 134:1274-7.

23. Nagy KK, Perez F, **Fildes JJ**, Barrett J: Optimal prosthetic for acute replacement of the abdominal wall. *J Trauma*, 1999;47:529-32

24. **Fildes JJ**, Inabnet WB, Barrett JA: Perfusion patterns in uncontrolled hemorrhagic shock and resuscitation. *Brunei International Medical Journal*, 1999; 1:139-146.

25. Mazolewski PJ, Curry JD, **Fildes JJ**: Computed tomography can be used for surgical decision making in zone II penetrating neck injuries. *J Trauma*, 2001; 51:315-9

26. Cohen M, Morales R, **Fildes JJ**, Barrett J: Staged reconstruction after gun shot wounds to the abdomen. *Plast. Reconstr. Surg*. 2001; 108: 83-92.

27. Curry JD, Recine CA, Snavely E, Orr M, **Fildes JJ**: Periaortic hematoma on abdominal CT as an indicator of thoracic aortic rupture in blunt trauma. *J Trauma*, 2002;52:699-702.

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Editor

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Invited Publications

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2. **Fildes JJ**: Contributing Editor for Trauma. Parrillo JE, Balk RA, Calvin JE, Franklin CM, and Shapiro BA eds. Year Book of Critical Care Medicine® 1995. St. Louis, Mosby-Year Book, Inc. 1995.

3. **Fildes JJ:** Contributing Editor for Critical Care. Economou SG, Deziel DJ, Witt TR, Bines SD, Saclarides TJ, Staren ED, Velasco JM eds. Rush University Review of Surgery, 2nd Edition. WB Saunders Company. 1994

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Other Publications

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6. Fantus RJ, **Fildes JJ**: The driving Force behind injury. Bulletin of the American College of Surgeons, 88, 10:32, 2003.

7. Fantus RJ, **Fildes JJ**: To drive or not to drive? Bulletin of the American College of Surgeons, 88, 11:43, 2003.

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14. Fantus RJ, **Fildes JJ**: "I'll drink to that". Bulletin of the American College of Surgeons, 89, 6:49, 2004.

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21. Fantus RJ, **Fildes JJ**: "NTDB Breaks the 1 million record mark". Bulletin of the American College of Surgeons, 90, 1:39, 2005

22. Fantus RJ, **Fildes JJ**: "Can we insure the future of trauma?". Bulletin of the American College of Surgeons, 90, 2:33, 2005

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28. Fantus RJ, **Fildes JJ**: "I've fallen and I can't get up." Bulletin of the American College of Surgeons, 90, 8:43, 2005

29. Fantus RJ, **Fildes JJ**: "Down on the farm". Bulletin of the American College of Surgeons, 90, 9:63, 2005

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31. Fantus RJ, Fildes JJ: "A-hunting we will go". Bulletin of the American College of surgeons, 90, 11:44, 2005

32. Fantus RJ, **Fildes JJ**: "Who needs rehab?" Bulletin of the American College of Surgeons, 90, 12:43, 2005

33. Fantus RJ, **Fildes JJ**: "Annual report 2005, dataset version 5.0". Bulletin of the American College of Surgeons, 91, 1:64, 2006

34. Fantus RJ, **Fildes JJ**: "The National Sample Project: A new application of the NTDB". Bulletin of the American College of Surgeons, 91, 2:44, 2006

35. Fantus RJ, **Fildes JJ**: "For whom the bell tolls?" Bulletin of the American College of Surgeons, 91, 3:55, 2006

36. Fantus RJ, **Fildes JJ**: "Come fly with me". Bulletin of the American College of Surgeons, 91, 4:69, 2006

37. Fantus RJ, Fantus J, **Fildes JJ**: "What I learned in school" Bulletin of the American College of Surgeons, 91, 5:55, 2006

38. Fantus RJ, **Fildes JJ**: "Deposit the bull's-eye". Bulletin of the American College of Surgeons, 91, 6:58, 2006

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41. Fantus RJ, **Fildes JJ**: "Trauma season". Bulletin of the American College of Surgeons, 91, 9:58, 2006

42. Fantus RJ, **Fildes JJ**: "Peds 2: Twice as large". Bulletin of the American College of Surgeons, 91, 10:42, 2006

43. Fantus RJ, **Fildes JJ**: "Horse sense" Bulletin of the American College of Surgeons, 91, 11:67, 2006

44. Fantus RJ, **Fildes JJ**: "Zeus on the 18th hole". Bulletin of the American College of surgeons, 91, 12:34, 2006

45. Fantus RJ, **Fildes JJ**: "Can we insure the future of trauma?" Journal of Health Disparities Research and Practice, Volume 1, Number 3, Summer 2007, p 89-92

46. Fantus RJ, **Fildes JJ**: "NTDB data points: Annual Report 2008: Don't overlook the appendix, Bulletin of the American College of Surgeons, 94, 3:55, 2009

47. Fantus RJ, **Fildes JJ**, Nathens, AB, NTDB data points: Another national chapter, Bulletin of the American College of Surgeons, 95, 5:42, 2010

48. **Fildes J**, Weireter LJ Jr. Experience in Haiti allows college to better prepare for future crises. Bull Am Coll Surg. 2010 Sep;95(9):15-7.

49. **Fildes JJ**, Fantus, RJ, "NTDB data points: The working wounded", 96, 6:62, 2011

Books and Book Chapters

1. **Fildes JJ**: Histological structure of the female reproductive system - a photo atlas. 1980. Hardbound volume containing color photomicrographs and text.

2. **Fildes JJ** and Robin AP: Preoperative and Postoperative Care. Condon RE and Nyhus LM eds. Manual of Surgical Therapeutics, 8th edition, Boston, Little, Brown and Company, 1992.

3. **Fildes JJ:** Critical Care and Physiologic Monitoring. Economou SG, Bines SD, Deziel DJ, and Witt TR eds. Rush University Review of Surgery, 2nd edition. Philadelphia, WB Saunders, 1993.

4. **Fildes JJ**: Assessment of Abdominal Trauma. Nyhus LM, Vitello JM, and Condon RE eds. Abdominal Pain - A Guide to Rapid Diagnosis. Norwalk, Appleton & Lange, 1995.

5. **Fildes JJ**: Traumatic Diaphragmatic Hernia. Nyhus LM and Condon RE eds. Hernia, 4th edition. Philadelphia, JB Lippincott, 1995.

6. **Fildes JJ:** and Robin AP: Preoperative and Postoperative Care. Condon RE and Nyhus LM eds. Manual of Surgical Therapeutics, 9th edition. Boston, Little, Brown and Company, 1996.

7. **Fildes JJ:** and Browder T: Trauma in Pregnancy. Demetriades, D and Asencio, JA eds. Trauma Management. Landes Bioscience, 2000.

8. **Fildes JJ**: Trauma Registry. Resource for Optimal Care of the Injured Patient. Committee on Trauma, American College of Surgeons 2006.

9. Nessen S, **Fildes JJ**: Scoring Systems for Injury & Emergency General Surgery. Britt LD, Barie PS, Jurkovich GJ, Peitzman AB eds. Acute Care Surgery. Elsevier, 2012

10. Kwon E, **Fildes JJ**: Scoring for Injury and Emergency Surgery. Pietzman AB ed. The Trauma Manual: Trauma and Acute Care Surgery / Edition 4. Lippincott Williams & Wilkins, 2012

11. McNickle A, **Fildes JJ**: Chapter 39 - Surgeon of the Modern Hospital. Latifi, R ed. The Modern Hospital: Patients Centered, Disease Based, Research Oriented, Technology Driven. Springer, 2018

Photographs and Videos:

1. **Fildes JJ**: Contributed slides and photographs to the fifth edition of the American College of Surgeons Advanced Trauma Life Support® course, 1993, 1997, 2000, 2008, and 2012.

2. **Fildes JJ**; Krosner S; Simon R: Resuscitative thoracotomy: Procedural principles in surgical techniques, presented at the Trauma Motion Picture Session, 1994 Clinical Congress of the American College of Surgeons. Included in the American College of Surgeons - Davis & Geck Surgical Video Library. This video was selected and re-presented in 2004 in a session for the Best Videos of all time.

3. **Fildes JJ**: Contributed slides and photographs on trauma in pregnancy to Color Atlas of Emergency Medicine, Kevin Knoop (ed), McGraw-Hill.

4. Gies WP; Salvino C; **Fildes JJ**: Formal diagnostic exploratory laparoscopy for trauma. Presented at the Trauma Motion Picture Session, 1995 Clinical Congress of the American College of Surgeons.

5. **Fildes JJ**: Contributed slides and photographs on trauma in pregnancy to EMT In Action, McGraw-Hill Higher Education, Dubuque, Iowa.

Laura Lopez Hobbs

SUMMARY

Retired Senior Vice President of Human Resources and Administration at Southwest Gas Corporation, Hobbs was responsible for human resources, executive compensation and benefits, organizational development, executive leadership and development, corporate administrative services, content management and corporate communications. Her accomplishments included: centralization of human resources, realignment of the compensation structure, transition from fully insured medical plans to self-insured and from a PPO model to an account based plan with a health savings account, creation of the company leadership development program, cost containment strategies as it related to employee headcount and medical expenses and developing and implementing an employee giving program.

Hobbs is a Board member of the University Medical Center Governing Board. She currently Chairs the Executive Compensation and Human Resources Committee and serves on the Clinical Quality and Audit Committees. Hobbs served on the Audit Committee. She also serves on the Carpenters International Certification Board.

EXPERIENCE

Southwest Gas Corporation, Las Vegas, Nevada

Senior Vice President, Human Resources and Administration (2012 to 2014)

Vice President, Administration (2010 - 2012)

Vice President, Human Resources (2008 - 2010)

Director, Human Resources (2005 - 2008)

Senior Manager, Human Resources (2001 - 2005)

Investor Relations Manager (1993 - 2001)

Investor Relations Specialist (1989 - 1993)

Benefits Administrator (1987 - 1989)

Human Resources Analyst (1984 - 1987)

EDUCATION

Master of Business Administration – December 1990
University of Nevada, Las Vegas

Bachelor of Science in Business Administration – December 1981
University of Nevada, Las Vegas
Major: Finance/Investments

COMMUNITY INVOLVEMENT

Member, Governing Board, University Medical Center, (2014 to Current)

Latin Chamber of Commerce (1995 to 2014)

Nevada International Women's Forum (2000 to 2018)

Treasurer (2002-2004)

Leadership Las Vegas (2009 graduate)

Board of Directors, United Way of Southern Nevada (2008 - 2012)

Director, National Charity League, Inc. (2009 - 2011)

National Charity League, Las Vegas Chapter

Corresponding Secretary (2008 - 2009)

Treasurer (2006 - 2008)

Founding President, (2002 - 2004)

U.S. Youth Soccer of Nevada (2006 - 2007)

Member, Board of Regents, University and Community College System of Nevada, appointed by Governor Kenny Guinn (February 2002 - December 2002)

Board of Directors, Boulder Dam Area Council, Boy Scouts of America (2001 - 2002)

Junior League of Las Vegas (1985 - 1994)

University Medical Center of Southern Nevada
Governing Board Application

General Information and Expression of Interest

** Addendum to application submitted by Richard P. McCann, J.D.

Name:	Richard P. McCann, J.D.
Home address:	[redacted]
Mailing address:	
Home phone:	
Cell phone:	
Work phone:	
Fax number:	N/A
Email address:	[redacted]
Employer:	
Employer phone:	
Occupation:	Consultant and lobbyist
Previous employer:	Nevada Association of Public Safety Officers (until Jan. 2022)
References:	Professional: [redacted]
	Personal: [redacted]
Current Resume:	Please see attached

Statement of Interest:

I have been a resident of the Las Vegas area since 1980. My son was born at the old Southern Nevada Memorial Hospital (now UMC). I have been treated with excellent care at UMC. During my more than 25 years representing law enforcement officers throughout Nevada, I have accompanied injured officers to UMC, including its Trauma Center.

Prior to representing law enforcement officers, I was a litigator in law firms involving personal injury, insurance defense, medical malpractice and business cases. UMC has always been the gold standard for medical care and treatment in Nevada.

I would like to give back to UMC by serving on the UMC Governing Board to help strengthen its ties with the community. I believe my long-term residence and involvement in the Las Vegas valley, my legal education and experiences, my interaction with hospitals and medical practitioners, my representation of our first responders all over the state, together with my lobbying experience, make me qualified to offer ideas, insight, and experiences that would be a positive influence on UMC's operations.

Health industry experience:

I currently represent healthcare agencies that lobby regulatory issues before the Nevada legislature. I have represented HealtHIE Nevada regarding statewide Health Information

Exchanges, and I have represented the American Optometric Association regarding Vision Benefit Plans.

Other professional experience:

Please see attached Curriculum Vitae.

Public and nonprofit board affiliations:

I was the founder, past executive director and current government affairs director of the Nevada Association of Public Safety Officers (NAPSO), a nonprofit organization representing law enforcement personnel across Nevada in matters involving disciplinary charges, collective bargaining, officer involved shootings, and lobbying. I am the founder and current president and government affairs director of the Nevada Law Enforcement Coalition (NLEC), a nonprofit organization representing law enforcement for their political and lobbying needs.

I am the founder and current president of the Public Employee Retirement Coalition (PERC), a for profit organization that seeks to bridge gaps between the Public Employee Retirement System, public employees and employers, and the Nevada legislature. I am the founder and current president of the Nevada Labor Alliance (NLA), a for profit organization that works with Nevada labor groups involving their legislative needs.

I have served on other nonprofit boards and as a consultant with the original Make-a-Wish Foundation. I am currently a Governor's appointee and commissioner on the Nevada State Board of Human Resources (formerly the Nevada State Personnel Commission).

Financial Oversight, Capital Formation & Philanthropic Fundraising

As the executive director of NAPSO, I was tasked with the preparation and oversight of its operating budgets, and reviewing financial statements prepared by our financial advisors.

Potential Conflicts of Interest –

Business relationships with UMC:

Any business transactions with UMC? No. Not in the past nor anticipated in the future.

Competition with UMC? No.

Relationships with Clark County Government: No relationships.

Richard P. McCann, J.D.

[redacted]

I am originally from the Philadelphia, Pennsylvania area. I received my B.A. degree in 1977 from The Ohio State University and my Juris Doctorate degree in 1980 from Western State University College of Law in San Diego, California. I moved to Las Vegas in 1980, at which time I joined one of Nevada's largest and most distinguished law firms. For nearly 25 years, I worked as a litigator with firms emphasizing insurance, self-insured, personal injury, medical malpractice, contracts and business disputes.

In 2000, my work started focusing more on police and fire personnel involving disciplinary, wrongful termination, and labor/management issues. I became highly experienced in representing peace officers during all phases of interrogation and administrative hearings pursuant to Nevada's Peace Officer Bill of Rights, including representation at Internal Affairs interviews; pre-disciplinary and pre-termination hearings; arbitration hearings; mediations; actions filed on behalf of peace officers before Nevada's Employee-Management Relations Board (EMRB); lawsuits filed for peace officers before state and federal courts; and I provided on-scene representation for Officer Involved Shootings, in-custody deaths and other critical incidents. I also represented public safety unions in collective bargaining negotiations, and I acted as a full-time lobbyist before the Nevada Legislature, while also consulting with Nevada's federal delegation in the United States Congress.

As a result of this experience and success in representing law enforcement personnel, I founded the *Nevada Association of Public Safety Officers (NAPSO)* in 2009, where I was the Executive Director, chief labor representative and legislative lobbyist until my retirement at the end of 2021. NAPSO became the largest affiliation of AFL-CIO public safety unions in the State of Nevada. In 2017, I also founded the *Nevada Law Enforcement Coalition (NLEC)*, a statewide group that has represented thousands of members in Nevada and acts as a collective voice for law enforcement's legislative and political action needs.

Following my retirement from NAPSO, I became the founder and President of McCann Consulting, LLC, where I continue to handle NAPSO's political endorsements and lobbying needs. I am now the Director of Government Affairs for NAPSO and the NLEC. I also provide lobbying and consulting services to other unions, public and private organizations, and political campaigns, while expanding my policy management portfolio. My clients have included, among others, the International Brotherhood of Teamsters, NV Energy, Howard Hughes Corporation, Healthie Nevada, American Wild Horse Conservation, and the American Optometric Association, ranging in subjects involving public safety, administrative and regulatory matters, strategic planning, workers' rights, and healthcare issues.

With a law degree and more than 40 years of litigation experience, I have remained a point of contact and spokesperson for local and national media regarding issues involving gun rights, statewide ballot initiatives, officer involved tragedies, and questions about political candidates and campaigns. I am also a current Director of the Nevada State Law Enforcement Memorial Commission, overseeing the Capitol grounds monument and events honoring law enforcement officers who have died in the line of duty. I currently sit as a Governor appointed member of the State of Nevada Human Resources Commission, and I have been honored to receive recognition by Marquis Who's Who and Continental Who's Who for excellence in leadership and professionalism in American business.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Kirk Kerkorian School of Medicine Dean's Update**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board receive an update from the Dean of the Kirk Kerkorian School of Medicine at UNLV; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive an update from the Dean of the Kirk Kerkorian School of Medicine at UNLV.

Cleared for Agenda
November 19, 2025

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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue: **CEO Update**	**Back-up:**
Petitioner: Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board receive an update from the Hospital CEO; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board will receive the CEO update.

Cleared for Agenda
November 19, 2025

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UMC
UNIVERSITY MEDICAL CENTER

CEO Update

November 2025

- Magnet survey underway this week
- Nursing Poster Symposium
- Comprehensive Cardiology
- Oncology update
- F1 preparations and training exercises
- Nevada Legislative Special Session
- UMC in the news – E-bike safety education
- General Medical Executive Meeting – December 15th at 5:00 pm

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue: **Determine future meeting dates and times through calendar year 2026**	**Back-up:**
Petitioner: Mason VanHouweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board determine future meeting dates and times through calendar year 2026; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

Determine future meeting dates and times of the UMCSN Governing Board and Committees through calendar year 2026 and direct staff accordingly. These dates are subject to change.

Cleared for Agenda
November 19, 2025

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2026 Governing Board - 2:00 PM WEDNESDAYS

Wednesday, January 28
Wednesday, February 25
Wednesday, March 25
Wednesday, April 29
Wednesday, May 27
Wednesday, June 24
Wednesday, July 29
Wednesday, August 26
Wednesday, September 30
Wednesday, October 28
Wednesday, November 18
Wednesday, December 16

1. John O'Reilly – Chair
2. Harry Hagerty - Vice Chair
3. Chris Haase
4. Robyn Caspersen
5. Renee Franklin
6. Laura Lopez-Hobbs
7. Dr. Donald Mackay
8. Mary Lynn Palenik
9. Bill Noonan
10. Non-Voting –John Fildes, M.D.

2026 Audit and Finance - *2:00 PM WEDNESDAYS*

Wednesday, January 21
Wednesday, February 18
Wednesday, March 18
Wednesday, April 22
Wednesday, May 21
Wednesday, June 17
Wednesday, July 22
Wednesday, August 19
Wednesday, September 23
Wednesday, October 21
Thursday, November 12
Wednesday, December 9

1. Robyn Caspersen – Chair
2. Harry Hagerty
3. Bill Noonan
4. Chris Haase
5. Mary Lynn Palenik

2026 STRATEGIC PLANNING

9:00 AM THURSDAYS

Thursday, February 12
Thursday, April 9
Thursday, June 11
Thursday, August 13
Thursday, October 8
Thursday, December 10

Harry Hagerty – Chair
Robyn Caspersen
Dr. Mackay
Renee Franklin
Chris Haase
Mary Lynn Palenik

2026 CLINICAL QUALITY AND PROFESSIONAL AFFAIRS

2:00 PM MONDAYS

Monday, February 2
Monday, April 6
Monday, June 1
Monday, August 3
Monday, October 5
Monday, December 7

Renee Franklin – Chair
Laura Lopez-Hobbs
Bill Noonan

2026 HUMAN RESOURCES AND EXECUTIVE COMPENSATION

2:00 PM Mondays

Monday, January 12
Monday, March 9
Monday, May 11
Monday, July 13
Monday, August 10
Monday, November 9

Laura Lopez-Hobbs - Chair
Renee Franklin
Dr. Donald Mackay
Bill Noonan

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue: **Emerging Issues**	**Back-up:**
Petitioner: Mason VanHouweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board identifies emerging issues to be addressed by staff or by the Board at future meetings; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None.

Cleared for Agenda
November 19, 2025

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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Closed Door Session**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board go into closed session, pursuant to NRS 241.015(4)(c), to receive information from the General Counsel regarding potential or existing litigation involving matters over which the Board had supervision, control, jurisdiction or advisory power, and to deliberate toward a decision on the matters; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
November 19, 2025

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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD
AGENDA ITEM

Issue:	**Closed Door Session**	**Back-up:**
Petitioner:	Mason Van Houweling, Chief Executive Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board go into closed session pursuant to NRS 450.140(3) to discuss new or material expansion of UMC's health care services and hospital facilities.

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
November 19, 2025

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