DOCTORS MEDICAL CENTER

West Contra Costa Healthcare District
Doctors Medical Center
Governing Body
Board of Directors

Wednesday, June 27, 2012
4:30 PM
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
JUNE 27, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

Board of Directors
Eric Zell, Chair
Supervisor John Gioia, Vice Chair
Irma Anderson
Wendel Brunner, M.D.
Deborah Campbell
Nancy Casazza
Sharon Drager, M.D.
Pat Godley
Richard Stern, M.D.
William Walker, M.D.
Beverly Wallace

AGENDA

1. **CALL TO ORDER** — E. Zell

2. **ROLL CALL**

3. **APPROVAL OF MAY 23, 2012 MINUTES** — E. Zell

4. **PUBLIC COMMENTS** — E. Zell
   [At this time persons in the audience may speak on any items not on the agenda and any other matter within the jurisdiction of the of the Governing Body]

5. **STROKE PROGRAM UPDATE** — D. Carson
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For Information Only*

6. **QUALITY REPORT** — K. Taylor
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of Quality Report*

7. **FINANCIALS – MAY 2012** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the May 2012 Financials*

8. **AUTHORIZIATION OF SIGNATORIES** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of Resolution# 2012-03 for Authorization of Signatories*

9. **HUMAN RESOURCES ANNUAL REPORT** J. Hardy
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Acceptance of HR Annual Report

10. **CORPORATE COMPLIANCE PROGRAM** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: Approval of Resolution# 2012-04, Corporate Compliance Program and Corporate Compliance Officer*

11. **CEO REPORT** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. ACTION: For Information Only.

12. **MEDICAL EXECUTIVE REPORT** L. Hodgson, M.D.
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: 1. Acceptance of the Medical Staff Report and Approval of Appointments, Reappointments and Changes of Staff Status and Procedure*
    2. Approval of changed amendment to Rules and Regulations Article 5.16

ADJOURN TO CLOSED SESSION

A. Reports of Medical Staff Audit and Quality Assurance Pursuant to Health and Safety Code Sec. 32155.

B. Conference with Legal Counsel: Pending Litigation pursuant to Government Code Section 54956.9(a): Pitchford vs DMC & West Contra Costa Healthcare District Case# 10-000360, Cabugos vs DMC & West Contra Costa Healthcare District Case# 11-01197, Crosby (Wells) vs DMC & West Contra Costa Healthcare District Case# C-12-01159.

C. Quality Assurance Matters (pursuant to Health & Safety Code Section 32155)

D. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: John Hardy, Vice President of Human Resources: California Nurses Association, NUHW, Local 1.

E. Personnel Exceptions (pursuant to code section 54957), Personnel, Permanent CEO Discussion.

ANNOUNCEMENT OF REPORTABLE ACTION(S) TAKEN IN CLOSED SESSION, IF ANY.

DOCTORS
MEDICAL CENTER

MINUTES

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DMC GOVERNING BODY
BOARD OF DIRECTORS

MAY 23, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

MINUTES

1. **CALL TO ORDER**

The meeting was called to order at 4:35 P.M.

2. **ROLL CALL**

Quorum was established and roll was called:

Present: Eric Zell, Chair
Supervisor John Gioia, Vice Chair
Irma Anderson
Deborah Campbell
Nancy Casazza
Sharon Drager, M.D.
Pat Godley
Richard Stern, M.D.
William Walker, M.D.
Beverly Wallace

Excused: Wendel Brunner, M.D.

3. **APPROVAL OF APRIL 25, 2012 MINUTES**

The motion made by Dr. Sharon Drager and seconded by Director Anderson to approve the April 25, 2012 minutes passed unanimously.

4. **PUBLIC COMMENTS**

There were no public comments.

5. **QUALITY REPORT**

Ms. Karen Taylor, Director of Quality and Risk Management presented and sought acceptance of the following Quality Report:

- Stroke Core Measures: Received certification in September 2011 from the Joint Commission, which is required to be in compliance with State regulations.
    - Stoke 1 VTE prophylaxis - problem was identified with one hospitalist, not using the stroke order sets. Dr. Carson, Director of the Stroke program met with the physician and has been educated regarding process. Improvements to be expected in the next quarter report.
    - Stroke 6 DC on Statins – Hospitalists were not consistently ordering lipid prior to patient discharge. The Hospitalists has been educated and improvements to be expected in the next quarter report.
    - Stroke 8 Stroke Education – There continues to be noncompliance with nursing staff on the 4th floor providing patient education. The Stroke Coordinator will meet with nursing leaders to help improve process. Ms. Gideon informed the group that Dr. Carson has been invited to the June Board meeting to go over a much more detailed presentation on where we stand.
- California Transplant Donor Network: The organ donations report provides details of referrals and donors in our hospital. There were a total of 91 for Q1 2012. The organ conversion rate is 0%. There were 4 tissue donors.

The motion made by Director Nancy Casazza and seconded by Supervisor John Gioia to accept the Quality Report passed unanimously.

6. **FINANCIALS – APRIL 2012**

Mr. James Boatman, CFO presented and sought approval for the April 2012 Financials. Mr. Boatman reported a loss of $450k in the month of April, better than what was budgeted by $230k for the month, and $190k better year-to-date. Net operating revenues were $1.3M under budget. Expenses were under budget by $544k. We received a onetime income from CMAC of $1.2M. Net Patient Revenue was under budget by $1.1M. Salaries and Benefits were under budget by $412k and professional fees were over budget by $150k. Cash position is at 2.7M or 7 days. The total restricted cash is $29M. Accounts receivables decreased to 77 days.

The motion was made by Directly Beverly Wallace and seconded by Director Irma Anderson to accept the April 2012 Financials passed unanimously.

7. **CAPITAL EQUIPMENT: Voicemail System Replacement**

Mr. Boatman, CFO sought approval and authorization to execute on behalf of DMC to purchase a new voicemail system, due to failure of the existing system. The system manufacturer is no longer in business and software is no longer supported. The cost of parts, labor, installation and shipping of the new system provided by MedTell Services is $28,908.91.

The Motion was made by Director Anderson and seconded by Director Casazza to approve the CFO to execute purchase of the new voicemail system passed unanimously.

8. **PHYSICIAN TRANSACTIONS AND ARRANGEMENTS:**
   - Robert A. Fox, M.D., Neurology Services Contract, Effective 6/1/12
   - East Bay Cardiology Medical Group, Stemi Coverage Agreement, Effective 6/1/12

Ms. Gideon, CEO sought approval of contract services for Dr. Robert A. Fox, to provide neurology and stroke on call coverage on a 24 hour/7day basis to meet the emergency medical needs of the community, effective June 1, 2012.

The motion made by Director Wallace and seconded by Director Campbell to approve the Neurology Services Contract Agreement passed unanimously.

Ms. Gideon also sought approval of the Stemi Coverage Agreement Contract to provide invasive cardiology on a 24 hour/7 day basis to meet the emergency medical needs of the community, effective June 1, 2012.

The motion made by Director Casazza and seconded by Director Anderson to approve the East Bay Cardiology Medical Group, Stemi Coverage Contract Agreement passed unanimously. Dr. Stern was abstained from the vote.

9. **BOARD POLICIES**

Ms. Gideon reviewed for the Governing Body the policies that will be presented to the District Board for approval. Once approved, each Director and Governing Body member will receive a binder of the policies, and they will be posted on the District website. Included in the packet, were the following new policies: Ethics Training, Chief Executive Officer Hiring/Compensation and Investment Policy. Other policies were edited and/or updated.

The Governing Body recommended that additional edits be made to the following policies prior to approval by the Board of Directors:

- Bidding Policy
- Heath Benefits Policy
- Board and Committee Conduct Policy
- Travel and Expense Policy
- Use of Consent Calendar

10. **CEO REPORT**

An update by Ms. Gideon was provided as follows:

- CEO Search: Members of the Governing Body and medical staff will be contacted by Lani Cantu to schedule interviews of three potential candidates for presentation to the Board. Concurrent discussion with a management firm continues.

- Board Committees: At the April Board meeting committees were appointed and changes were made to the bylaws to support a new committee. All three committees met in the past month.

- Board Report Submission: An adjustment in the process for material submission to this group is undergoing changes to simplify procedure. (i.e, Ms. Taylor's presentation on quality will be submitted in the form of a report that will come from the Quality Committee with minutes from the Committee to be provided to the Board). This remains a work in progress.

- Daisy Award: DMC continues to move with the Daisy Award, recognizing excellence in nursing, scheduled June 7, 2012. Invitations will go out to the Board.

- $16B State Deficit and Impact on Health Care: The latest calculation on the District Association tells us that we're going to have an impact on a balance of the 2012 and 2013 calendar of $1.4M.

11. MEDICAL EXECUTIVE REPORT

Dr. Laurel Hodgson sought approval for the April Credentials Report.

The motion made by Director Casazza and seconded by Dr. Drager to approve the April Credentials Reports/Medical Executive Report passed unanimously.

The meeting adjourned to closed session.

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STROKE PROGRAM UPDATE

TAB 5

DMC Stroke Program Update

Dr. Desmond Carson, Program Director

Susila Patel, Program Coordinator

June 27, 2012

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History

- DMC was certified by the Joint Commission as a Primary Stroke Center on September 29, 2011
- Oct 2011-Apr 2012: DMC treated 112 Stroke patients (excluding TIA cases)
  - 23 patients were given tPA
  - 6 patients were transferred to another facility for interventional care
  - 1 bleed post-tPA

DOCTORS MEDICAL CENTER

Data Summary for Q1 2012

Indicator	Jan-12	Feb-12	Mar-12	Q1 12	Benchmark	Comments
STK-1 VTE prophylaxis	85.7%	94.1%	80.0%	87.8%	90%-100%	STK-1 (VTE prophylaxis): Problem was identified with one hospitalist who was not utilizing the stroke order sets. Dr. Carson, Medical Director for the Stroke Program, met with with the physician regarding the use of the order sets. Hospitalists were not consistently ordering lipid or cardiac risk panels prior to patient discharge, therefore, not knowing whether to prescribe a statin at discharge. The Hospitalists have been educated on this. Improvement should be seen in the next quarter.
STK-2 DC on Antithrombotic	100.0%	100.0%	100.0%	100.0%	90%-100%	
STK-3 AntiCoags for Atrial Fib/Flutter	100.0%	100.0%	100.0%	100.0%	90%-100%	
STK-4 Thrombolytics	100.0%	100.0%	100.0%	100.0%	90%-100%	
STK-5 Antithrombotics by end of Hospital Day 2	100.0%	100.0%	100.0%	100.0%	90%-100%	
STK-6 DC on STATINS	87.5%	91.7%	85.7%	88.9%	90%-100%	STK-6 (DC on STATINS):Hospitalists were not consistently ordering lipid or cardiac risk panels prior to patient discharge, therefore, not knowing whether to prescribe a statin at discharge. The Hospitalists have been educated on this. Improvement should be seen in the next quarter.
STK-8 Stroke Education	77.8%	80.0%	85.7%	80.8%	90%-100%	STK-8 (Stroke Education): The improvement noted in the 4th quarter of 2011 and 1st quarter this year is due to the stroke coordinator doing the stroke education with the patients and or family. There continues to be noncompliance with nursing staff providing patient education. Much needed improvement is needed in this area. Stroke Coordinator will meet with Nursing Leaders.
STK-10 Assessed for Rehab	85.7%	100.0%	100.0%	95.0%	90%-100%	

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Clinical Stroke Rounds

- Every Mondays at 3:30pm in addition to the monthly Stroke Committee meeting
- Attendees for the Rounds are Desmond Carson, Susila Patel, Robert Fox, Galen Physician representative
- Group discusses active patient cases

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Community Outreach

- Program presentation by Director and Coordinator at local community council meetings:
  - City of Hercules
  - City of Pinole
  - City of Richmond
  - City of San Pablo
  - City of El Cerrito
  - City of Kensington
- Free health screenings and stroke education at community events
  - Cinco de Mayo Festival at the City of San Pablo
  - Cinco de Mayo Festival at the City of Richmond
  - Juneteenth Festival in Richmond
  - BP & Glucose screenings of over 650 community members total
- Other Events
  - Stroke and heart education at Pinole Senior Center
  - Upcoming events: Coordination with Dr. Laurel Hodgson on Stroke and STEMI education at various community centers

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Cinco de Mayo Outreach at San Pablo

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Community Outreach at Pinole Senior Center

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Findings and Resolutions

- Post-tPA patient documentation opportunity
  - New post-tPA flow sheet implemented
  - Education of all nursing staff
- Patient education
  - Nurses now document education in Paragon
  - Education of nurses on importance of patient education

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DMC Board Support of Stroke Program

- Support of yearly academic stroke education for the Stroke Team
- Continual education for all nursing staff (ie. guest speakers)
- Small budget for community outreach events (supplies, fees, equipment, etc)
- Continued support of Program Director and Program Coordinator

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QUALITY

TAB 6

TJC Accreditation Assessment Report – May 2012

Karen Taylor, RN, MSN BBA CPHQ LNC
Director Integrated Quality Services/Risk Manager

Who Is The Joint Commission?

- The Joint Commission (TJC) visits DMC every three years
  - Lab every 2 years
  - Stroke every 2 years
- TJC surveys for Medicare & Medicaid – "Deemed Status' for Payment & Billing
- Using standards by TJC ensures that DMC patients receive safe patient care according to national standards
- Participation in TJC compares DMC with other hospitals for our payers.
- DMC can display the gold seal of TJC Accreditation to the community and for marketing.

What Is Being Done Well:

- Overall handling of Chemicals & Medications
- Focus on Patient Care/Well Being in Cancer Center/Breast Care
- Centralized Sterile Processing – “Best Practice”
- Traveler Staff Oversight & Record Keeping

Opportunities for Improvement

- Documentation – Staff & Medical Staff
- Medical Staff Standards
- CMS (Medicare & MediCal) Standards for "Deemed Status"

Actions Taken:

- Opportunities Assigned to Chapter Leaders
- Town Hall Meetings
- Increased Focused Nursing Education
- TJC (The Joint Commission) Education Fair scheduled July 26th

DOCTORS
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FINANCIALS
MAY 2012

TAB 7

DOCTORS MEDICAL CENTER

Board Presentation

May 2012 Financial Report

Statement of Activity – Summary

For the Period Ending

May 31, 2012

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
10,585	11,049	(464)	**Net Operating Revenues $**	51,112	55,459	(4,347)
12,541	12,141	(400)	**Total Operating Expenses $**	60,165	62,690	2,525
(1,956)	(1,092)	(864)	**Income/(Loss) from Operations $**	(9,053)	(7,231)	(1,822)
287	443	(156)	**Income from Other Sources $**	3,387	2,390	997
(1,669)	(649)	(1,020)	**Net Income / (Loss) $**	(5,666)	(4,841)	(825)
2,431	2,384	47	**Patient Days**	11,793	12,855	(1,062)
536	533	3	**Discharges**	2,568	2,689	(121)
6,257	6,782	(525)	**Outpatient Visits**	31,800	33,121	(1,321)
628	626	(2)	**Worked FTE's**	625	651	26
1.49	1.57	0.08	**Medicare CMI**	1.53	1.57	0.03

Budget Variances – **Net Revenue**

- Medi-Cal / Medi-Cal HMO - ($625K).
- Medicare / Medicare HMO - $585K.
- Government / Workers Comp -($745K)
- Blue Cross Settlement - $594K

Budget Variances - Expenses

- **Salaries & Benefits** $(202K) - Unbudgeted Retro Pay to NIHW employees ($224K), overlap in nursing for new hires ($250K)
- **Professional Fees** ($232K) - Emergency Physician contract ($41K), four unbudgeted consultants ($191K).
- **Supplies** $262K - Reduction in implants.

Cash Position
May 31, 2012

(Thousands)

	May 31, 2012	December 31, 2011
Unrestricted Cash	$4,924	$13,972
Restricted Cash	$26,441	$29,847
Total Cash	$31,365	$43,819
Days Unrestricted Cash	12	33
Days Restricted	67	72
Total Days of Cash	79	106

California Benchmark Average	34
Top 25%	82
Top 10%	183

Accounts Receivable

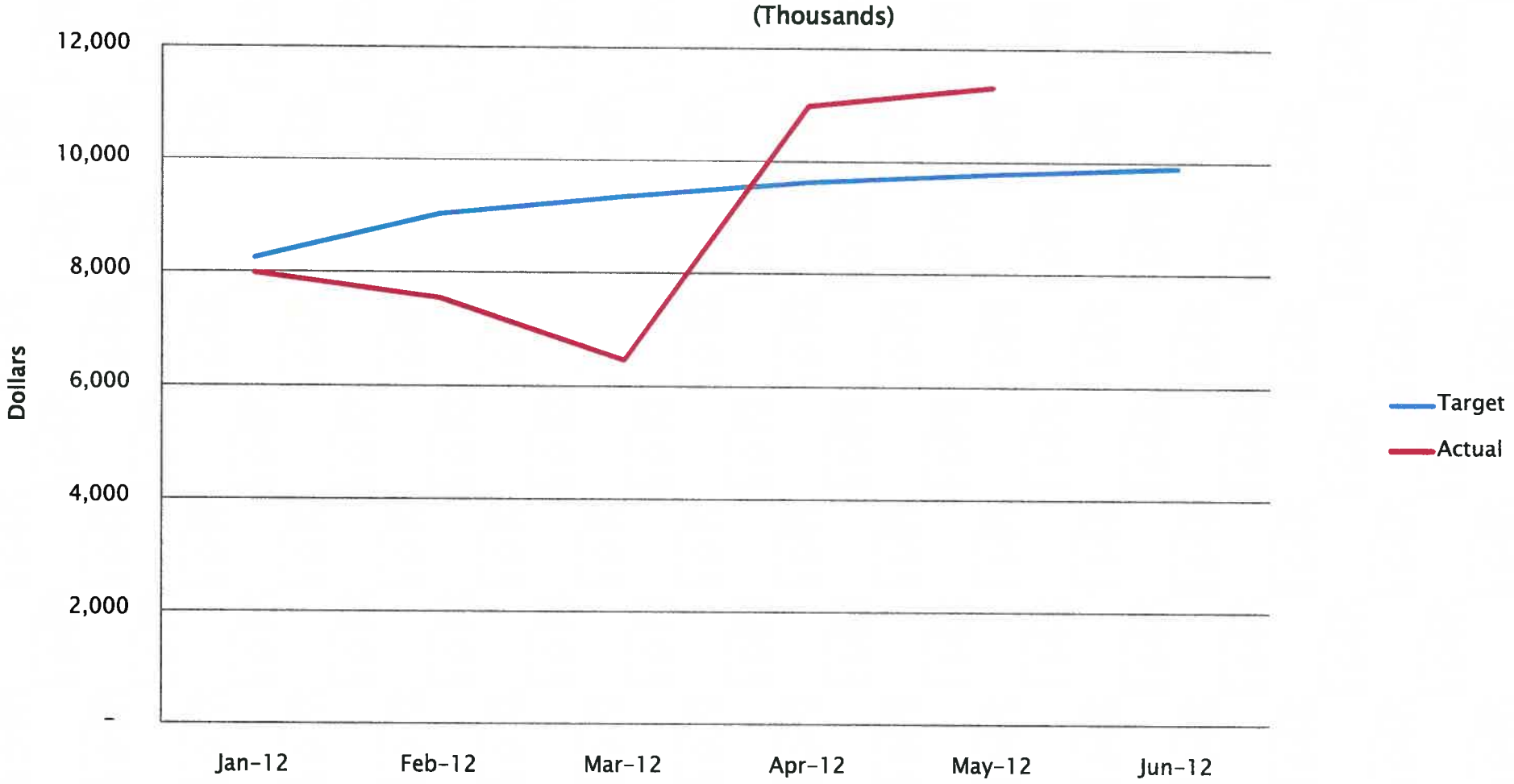
May 31, 2012

(Thousands)

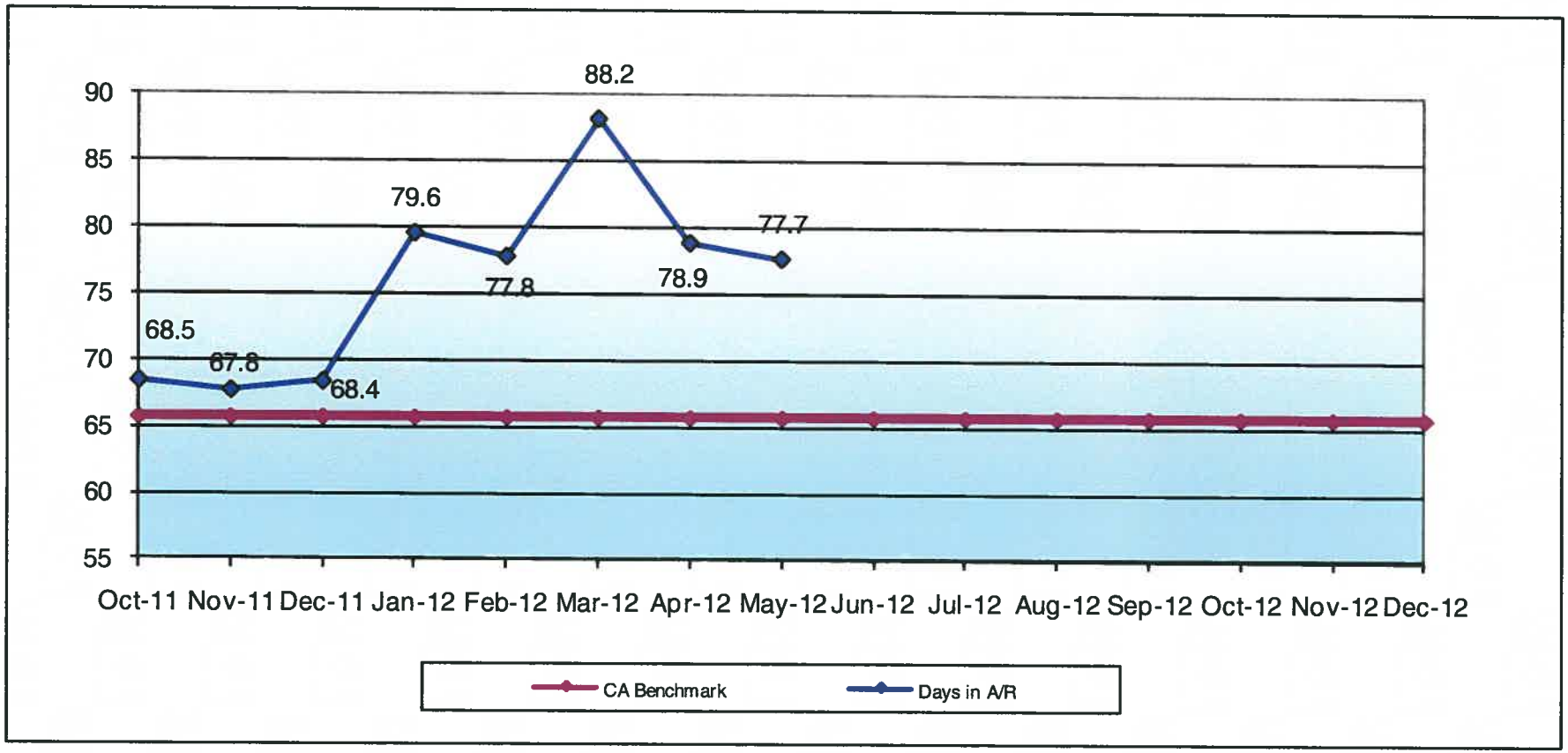
	May 31, 2012	December 31, 2011
Net Patient Accounts Receivable	$26,046	$19,177
Net Days in Accounts Receivable	77.7	60.7

California Benchmark Average	65.7 days
Top 25%	45.2 days
Top 10%	35.5 days

2012 Year to Date Cash Collections / Projected vs. Target



Accounts Receivable
Net Days in A/R



Financial Report Key Points

- Net Loss was $1.7M in May.
- Expenses $400K over budget.
- Accounts receivable decreased in the Month.

DOCTORS MEDICAL CENTER

May 2012 Executive Report

Doctors Medical Center had a Net Loss of $1,669,000 in the month of May. As a result, net income was under budget by $1,020,000. The following are the other factors leading to the Net Income variance:

Net Patient Revenue Factors	**Positive / (Negative)**
Government/ Workers Compensation	($745,000)
Medi-Cal / Medi-Cal HMO	($625,000)
Medicare / Medicare HMO	$585,000
Blue Cross Settlement	$594,000
Expenses	
Salaries & Benefits	($202,000)
Professional Fees	($232,000)
Supplies	$262,000

Net patient revenue was under budget by $218,000. Gross charges were under budget in May 10.7%. Patient days were 2.0% over budget and discharges were 0.6% over budget. Ancillary outpatient visits were 14.3% under budget and outpatient surgeries were 11.3% under budget. Total Medi-Cal days have fallen from a budget of 464 days to 136 actual days. Most of those days 57% are Medi-Cal Managed Care days. Our days from both the Government programs and Workers Compensation are also down as total budgeted days were 222 compared to the actual in May of 52.

Salaries and Benefits combined were over budget $202,000 in May. Worked FTE's were over budget by 0.3% and salaries were 9.2% over budget while patient days were only 2.0% over budget. Salaries were over budget due to a retro pay for employees represented by NUHW of $224,000 and a temporary overlap of nursing staff by utilizing contract labor to train new employees. Our benefit costs were under budget in May and we are still under our year to date goal by $756,000.

Professional Fees were $232,000 over budget in May. Of this overage, $41,000 is for an unbudgeted contract for the Emergency Department. The balance of this overage incurred are for four consultants that are not in the current budget. Some of these costs (approx. $40,000) are budgeted in salaries and wages.

Supplies continue to be under budget in May by $262,000. The supply reduction was for a reduction in the use of implants.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
May 31, 2012
(Amounts in Thousands)

	CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
						OPERATING REVENUE					
1	10,495	10,713	(218)	-2.0%	9,301	Net Patient Service Revenue	49,612	54,422	(4,810)	-8.8%	52,650
2	90	336	(246)	-73.2%	92	Other Revenue	1,500	1,037	463	44.6%	450
3	10,585	11,049	(464)	-4.2%	9,393	**Total Operating Revenue**	51,112	55,459	(4,347)	-7.8%	53,100
						OPERATING EXPENSES					
4	5,662	5,186	(476)	-9.2%	5,262	Salaries & Wages	26,453	26,457	4	0.0%	27,723
5	2,375	2,649	274	10.4%	2,921	Employee Benefits	13,054	13,810	756	5.5%	13,763
6	1,098	866	(232)	-26.8%	1,064	Professional Fees	4,852	4,391	(461)	-10.5%	4,363
7	1,442	1,704	262	15.4%	1,685	Supplies	7,241	8,693	1,452	16.7%	8,920
8	978	965	(13)	-1.3%	855	Purchased Services	3,862	4,838	976	20.2%	4,307
9	235	268	33	12.3%	280	Rentals & Leases	1,208	1,339	131	9.8%	1,141
10	402	369	(33)	-8.9%	340	Depreciation & Amortization	1,958	1,845	(113)	-6.1%	1,726
11		(222)	(222)			Collaboration Savings	-	(444)	(444)		
11	349	355	6	1.6%	430	Other Operating Expenses	1,537	1,762	225	12.8%	1,713
12	12,541	12,141	(400)	-3.3%	12,837	**Total Operating Expenses**	60,165	62,690	2,525	4.0%	63,656
13	(1,956)	(1,092)	(864)	79.1%	(3,444)	**Operating Profit / Loss**	(9,053)	(7,231)	(1,822)	25.2%	(10,556)
						NON-OPERATING REVENUES (EXPENSES)					
14	-	-	-	0.0%	-	Other Non-Operating Revenue	1,200	-	1,200	0.0%	1,085
15	708	706	2	-0.3%	708	District Tax Revenue	3,540	3,531	9	-0.3%	3,583
16	8	4	4	88.7%	4	Investment Income	22	21	1	3.8%	21
17	(429)	(268)	(161)	0.0%	(121)	Less: Interest Expense	(1,375)	(1,162)	(213)	18.3%	(578)
18	287	443	(156)	-35.2%	591	**Total Net Non-Operating**	3,387	2,390	997	41.7%	4,111
19	(1,669)	(649)	(1,020)	157.1%	(2,853)	**Income Profit (Loss)**	(5,666)	(4,841)	(825)	17%	(6,445)
						Profitability Ratios:					
20	-18.5%	-9.9%	186.4%		-36.7%	Operating Margin %	-17.7%	-13.0%	41.9%		-19.9%
21	-15.8%	-5.9%	-9.9%		-30.4%	Profit Margin %	-11.1%	-8.7%	-2.4%		-12.1%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
May 31, 2012
(Amounts in Thousands)

22	2,149	2,087	(62)	-3.0%	2,272	SWB / APD	2,170	2,120	(50)	-2.3%	2,145
23	64.1%	64.5%			63.7%	SWB / Total Operating Expenses	65.7%	64.2%			65.2%
24	3,353	3,234	(120)	-3.7%	3,564	Total Operating Expenses / APD	3,304	3,301	(4)	-0.1%	3,292
25	35,983	39,356	(3,373)	-8.6%	38,449	I/P Gross Charges	176,433	216,422	(39,989)	-18.5%	218,475
26	19,373	22,625	(3,252)	-14.4%	19,765	O/P Gross Charges	95,960	103,322	(7,362)	-7.1%	97,961
27	**55,356**	**61,980**	**(6,624)**	**-10.7%**	**58,214**	**Total Gross Charges**	**272,393**	**319,744**	**(47,351)**	**-14.8%**	**316,436**
						Payor Mix (IP and OP)					
28	44%	39%	5%		38%	Medicare %	42%	40%	2%		40%
29	3%	14%	-11%		15%	Medi-Cal %	6%	15%	-9%		15%
30	15%	13%	2%		6%	Managed Care HMO / PPO %	13%	12%	1%		9%
31	12%	9%	3%		10%	Medicare HMO %	11%	9%	1%		9%
32	13%	9%	4%		15%	Medi-Cal HMO %	14%	9%	5%		11%
33	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
34	1%	2%	-1%		2%	Worker's Comp %	1%	1%	0%		1%
35	2%	4%	-2%		3%	Other Government %	3%	3%	-1%		4%
36	10%	10%	0%		11%	Self Pay /Charity %	10%	10%	1%		10%
						STATISTICS					
37	544	544	-	0.0%	519	Admissions	2,583	2,698	(115)	-4.3%	2,706
38	536	533	3	0.6%	526	Discharges	2,568	2,689	(121)	-4.5%	2,709
39	2,431	2,384	47	2.0%	2,379	Patient Days	11,793	12,855	(1,062)	-8.3%	13,352
40	78.4	76.9	1.5	2.0%	76.7	Average Daily Census (ADC)	77.6	84.6	(7.0)	-8.3%	88.4
41	4.54	4.47	(0.06)	-1.4%	4.52	Average Length of Stay (LOS)- Accrual Based	4.59	4.78	0.19	3.9%	4.93
42	31	31			31	Days in Month	152	152			151
43	825	839	(15)	-1.8%	796	Adjusted Discharges (AD)	3,965	3,973	(8)	-0.2%	3,924
44	3,740	3,754	(15)	-0.4%	3,602	Adjusted Patient Days (APD)	18,207	18,992	(785)	-4.1%	19,339
45	121	121	(0)	-0.4%	116	Adjusted ADC (AADC)	120	125	(5)	-4.1%	128
46	80	96	(16)	-16.7%	96	Inpatient Surgeries	361	481	(120)	-24.9%	481
47	86	97	(11)	-11.3%	97	Outpatient Surgeries	462	460	2	0.4%	460
48	**166**	**193**	(27)	-14.0%	**193**	**Total Surgeries**	**823**	**941**	(118)	-12.5%	**941**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
May 31, 2012
(Amounts in Thousands)

49	3,041	3,033	8	0.3%	3,183	ED Outpatient Visits	15,181	14,186	995	7.0%	15,237
50	3,130	3,652	(522)	-14.3%	3,652	Ancillary Outpatient Visits	16,157	18,475	(2,318)	-12.5%	18,475
51	86	97	(11)	-11.3%	97	Outpatient Surgeries	462	460	2	0.4%	460
52	**6,257**	**6,782**	(525)	-7.7%	**6,932**	**Total Outpatient Visits**	**31,800**	**33,121**	(1,321)	-4.0%	**34,172**
53	493	442	51	11.5%	454	Emergency Room Admits	2,345	2,321	24	1.0%	2,361
54	16.2%	14.6%			14.3%	% of Total E/R Visits	15.4%	16.4%			15.5%
55	90.6%	81.3%			87.5%	% of Acute Admissions	90.8%	86.0%			87.3%
56	628	626	(2)	-0.3%	677	Worked FTE	625	651	26	4.0%	703
57	714	704	(10)	-1.4%	763	Paid FTE	721	732	11	1.6%	804
58	5.21	5.17	(0.03)	-0.7%	5.83	Worked FTE / AADC	5.22	5.24	0.03	0.5%	5.49
59	5.92	5.81	(0.11)	-1.8%	6.57	Paid FTE / AADC	6.02	5.99	(0.03)	-0.4%	6.28
60	2,806	2,853	(47)	-1.6%	2,582	Net Patient Revenue / APD	2,725	2,865	(141)	-4.9%	2,723
61	14,802	16,508	(1,707)	-10.3%	16,162	I/P Charges / Patient Days	14,961	16,836	(1,875)	-11.1%	16,363
62	3,096	3,336	(240)	-7.2%	2,851	O/P Charges / Visit	3,018	3,120	(102)	-3.3%	2,867
63	1,514	1,381	(133)	-9.6%	1,461	Salary Expense / APD	1,453	1,393	(60)	-4.3%	1,434
64	5.0	5.3	0.30	5.6%	5.3	Medicare LOS - Discharged Based	4.8	5.7	0.88	15.4%	5.2
65	1.49	1.57	0.08	5.1%	1.57	Medicare CMI	1.53	1.57	0.03	2.1%	1.6
66	3.37	3.39	0.02	0.5%	3.40	Medicare CMI Adjusted LOS	3.13	3.62	0.49	13.6%	3.29
67	4.5	4.5	(0.01)	-0.3%	4.52	Total LOS - Discharged Based	4.6	4.9	0.30	6.2%	4.87
68	1.416	1.500	0.08	5.6%	1.50	Total CMI	1.463	1.500	0.04	2.5%	1.50
69	3.20	3.02	(0.19)	-6.2%	3.01	Total CMI Adjusted LOS	3.16	3.28	0.12	3.8%	3.25

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
May 31, 2012
(Amounts in Thousands)

		Current Month	Dec. 31, 2011
	ASSETS		
70	Cash	4,924	13,972
71	Net Patient Accounts Receivable	26,046	19,177
72	Other Receivables	422	1,160
73	Inventory	2,163	2,109
73	Current Assets With Limited Use	26,441	29,847
74	Prepaid Expenses and Deposits	1,074	999
75	**TOTAL CURRENT ASSETS**	**61,070**	**67,264**
76	**Assets With Limited Use**	**642**	**642**
	Property Plant & Equipment		
77	Land	12,120	12,120
78	Bldg/Leasehold Improvements	29,432	33,733
79	Capital Leases	10,926	10,926
80	Equipment	41,673	34,074
81	CIP	2,186	3,129
82	Total Property, Plant & Equipment	96,337	93,982
83	Accumulated Depreciation	-51,132	-49,200
84	**Net Property, Plant & Equipment**	**45,205**	**44,782**
85	**Intangible Assets**	**1,491**	**1,517**
86	**Total Assets**	**108,408**	**114,205**

87	Current Ratio (CA/CL)	***1.65***	***1.89***
88	Net Working Capital (CA-CL)	***24,111***	***31,750***
89	Long Term Debt Ratio (LTD/TA)	***0.58***	***0.55***
90	Long Term Debt to Capital (LTD/(LTD+TE)	***0.94***	***0.87***
91	Financial Leverage (TA/TE)	***27.1***	***11.8***
92	Quick Ratio	**0.84**	**0.93**
93	Unrestricted Cash Days	**12**	**33**
94	Restricted Cash Days	**67**	**72**
95	Net A/R Days	**77.7**	**60.7**

		Current Month	Dec. 31, 2011
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,660	1,634
97	Accounts Payable and Accrued Expenses	14,268	16,021
98	Accrued Payroll and Related Liabilities	16,869	13,639
99	Deferred District Tax Revenue	2,880	2,880
100	Estimated Third Party Payor Settlements	1,282	1,340
101	**Total Current Liabilities**	**36,959**	**35,514**
	Other Liabilities		
102	Other Deferred Liabilities	4,905	6,105
103	Chapter 9 Bankruptcy	0	0
	Long Term Debt		
104	Notes Payable - Secured	62,057	62,067
105	Capital Leases	2,141	2,481
106	Less Current Portion LTD	-1,660	-1,634
107	**Total Long Term Debt**	**62,538**	**62,914**
108	**Total Liabilities**	**104,402**	**104,533**
	EQUITY		
109	Retained Earnings	9,672	28,400
110	Year to Date Profit / (Loss)	-5,666	-18,728
111	**Total Equity**	**4,006**	**9,672**
112	**Total Liabilities & Equity**	**108,408**	**114,205**

DOCTORS
MEDICAL CENTER

AUTHORIZATION SIGNATORIES RESOLUTION# 2012-03

TAB 8

DOCTORS MEDICAL CENTER
WEST CONTRA COSTA HEALTHCARE DISTRICT
GOVERNING BODY

RESOLUTION #2012-03
AUTHORIZATION OF SIGNATORIES

Whereas, the West Contra Costa Healthcare District (hereinafter "the WCCHD") Doctors Medical Center Governing Body has to execute documents and enter into agreements from time to time, during the normal course of business; and

Whereas, it is cumbersome to notice and call a board meeting for the sole purpose of getting the Governing Board to authorize the signing of a document whose intent and purpose may already have been approved,

Now, Therefore, be it resolved that the following persons be and are hereby authorized to execute documents and other instruments necessary for the usual conduct of business including but not limited to opening bank accounts, signing leases, approving loan documents and operating such bank accounts, including signatory authority for checks and wire transfers as authorized by the Governing Board and included in the normal course of their duties, and whose names and signatures are affixed below:

Eric Zell	Chair, Governing Body Board of Directors	_____
John Gioia	Vice Chair, Governing Body Board of Directors	_____
Deborah Campbell	Treasurer, WCCHD Board of Directors	_____
Dawn Gideon	Interim Chief Executive Officer	_____
James Boatman	Chief Financial Officer	_____
Vickie Scharr	Controller	_____

Passed and Adopted on this 27th day of June 2012, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____

Eric Zell, Chairperson
WCCHD DMC Governing Body

DOCTORS
MEDICAL CENTER

HUMAN RESOURCES ANNUAL REPORT

TAB 9

Human Resources Twelve Month Report
Doctors Medical Center Governing Body
May 2011 to May 2012

Labor Relations:

Approximately sixty (60%) of DMC's total work force is represented by collective bargaining units, and the organization continues to focus on managing the contracts with these unions in a productive fashion. We have five contracts currently open for bargaining: NUHW, Local One Clerical, Local One Laboratory, Local 39 Stationary Engineers, and California Nurses Association-Case Managers. California Nurses Association-Nurses will expire June 30, 2013.

Labor Relations continue to improve as a result of communications prior to sensitive meetings to understand both managements and labors agendas. The pre-meetings are also used to revisit the parties commitment to conduct ourselves with dignity and respect.

All employees, both represented and non represented Managers and Directors are encouraged to visit HR with or without appointments in order to address issues or concerns at the lowest level before they escalate. HR also maintains high visibility throughout the hospital so that employees have the opportunity to discuss issues.

Workforce Development:

As part of our ongoing efforts to develop our middle management staff, and consistent with our patient satisfaction objectives to create a quality culture, a new management education program has been developed and offered to Managers and Directors. Sessions have included:

1) Building Effective Teams
2) Leadership and Leading
3) Managing Challenging Workplace Behaviors
4) Ethics and Integrity in the Workplace
5) Creating a Positive Work Environment
6) Sexual Harassment Training

Additional course offers are being developed and will be sponsored over the course of the coming months.

To further support the development of an improved culture for both employee and patient relations, we have recruited Bob Redlo to the position of Vice President of Patient Relations, Labor Relations And Workforce Development. A resident of Hercules, Bob has spent the past 15 years with Kaiser Permanente, and since 2005 has been their Senior Director of Strategic Workforce Initiatives and Director of National Workforce Planning and Development. In these

leadership roles, he participated on a national level in the development of education and training opportunities for employees and physicians.

As we strengthen our commitment to our people –both our patients and our staff –one of Bob's primary goals will be to develop Labor management partnership incentives and long term education programs to manifest improved patient family satisfaction, improved job performance and improved employee satisfaction

Other:

Human Resources continue to focus on mandatory compliance in order for employees to work in our acute care setting. Please see attached summary of statistics for your reference.

June 2012 Board Meeting Report 6/18/2012
Summary Report_ May 2011 to May 2012

Annual Performance Eval. Compliance Rate	73%
Annual Licensure Compliance Rate	98.25%

Annual I-9 Compliance Rate	100%

Employees by Union	Annual Average # of Ees
CNA	345
Executive	5
Local1C	107
Local1T	23
Local39	17
Manager	39
NUHW	317
NUnionNMgmt	106
Grand Total	958

DMC Turnover Rate Summary_May 2011 to May 2012	
Total Annual Involuntary Terminations	46
Total Annual Lay off	12
Total Annual Uncontrollable Terminations	2
Total Annual Voluntary Resignations	108
Grand Total Terminated Employees	168
Annual Average # of Employees	959
Annual Turnover Rate	17.49%

New Hire Report_May 2011 to May 2012	Grand Total
Total RN New Hire	49
Total DMC New Hire	107

As of 6/15/12: Total # of EEs on Performance Improvement Plan by Department	4

Annualized Payroll and Benefit Cost	$96 Million

Employee Health May 2011 to May 2012 Fit Testing & PPD Compliance Rate	93%

Workers Compensation (Apr 2011 - Mar 2012)	
# of Cases	Cost/Severity
46	$262,544

DOCTORS
MEDICAL CENTER

CORPORATE COMPLIANCE PROGRAM and RESOLUTION 2012-04

TAB 10

DOCTORS MEDICAL CENTER
WEST CONTRA COSTA HEALTHCARE DISTRICT
GOVERNING BODY

RESOLUTION #2012-04

CORPORATE COMPLIANCE PROGRAM

WHEREAS, it is the policy of Doctors Medical Center to comply with all laws which apply to its business and activities and to conduct its affairs in a way that is both ethical and in accordance with applicable laws; and

WHEREAS, the Governing Body believes that it is important to document and demonstrate this commitment to the Hospital's customers, our employees, and the communities we serve;

BE IT RESOLVED that Governing Body hereby approves the Corporate Compliance Program as presented to prevent and detect violations of the law by the Hospital and its employees, contractors, agents, and professional staff members; and

BE IT FURTHER RESOLVED that the Governing Body grants the Chief Executive Officer ("CEO") of the Hospital the authority and responsibility for overseeing the implementation of the Corporate Compliance Program; and

BE IT FURTHER RESOLED the Governing Body approves the appointment of Karen Taylor as the Compliance Officer. The Compliance Officer will have the authority and responsibility to assist the CEO with the implementation of the Corporate Compliance Program and will oversee the implementation of the Program on an ongoing basis.

This Resolution shall take effect upon its adoption by this Board.

Passed and Adopted on this 27th day of June 2012, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____

Eric Zell, Chairperson
WCCHD DMC Governing Body

DOCTORS MEDICAL CENTER

Doctors Medical Center
Hospital Compliance Program

DOCTORS MEDICAL CENTER

Dear Colleague:

Doctors Medical Center (the Hospital) is fully committed to compliance with the law and ethical standards and believes that a high level of commitment to compliance is essential. As a public hospital, we hold ourselves to an even higher level of transparency and accountability than most, and expect our Board, management, employees, volunteers and medical staff to support and share that commitment.

The Hospital has developed this Compliance Program to further our mission to provide high-quality patient care in a manner that ensures compliance with the law and the highest business ethics. This Compliance Program includes a comprehensive discussion of certain laws, the hospital's policies, and expectations about your conduct. However, no written program or policy can cover all circumstances. We therefore ask that you read this Compliance Program carefully to understand not only its written words, but its purpose and meaning as well.

If you have any questions about this Compliance Program or think an event has occurred that violates this Compliance Program, you should contact our Chief Compliance Officer, Mr. Jim Boatman. Alternatively, you can anonymously contact our Compliance Hotline by calling _____ or sending a fax to _____. You are encouraged to ask questions and to report violations of this Compliance Program.

You can count on the Hospital to provide the support and environment necessary to make this Compliance Program a success. Similarly, the Hospital is counting on you to take this Compliance Program seriously and conduct yourself accordingly.

Sincerely,

Dawn M. Gideon

Dawn M. Gideon
Interim President and Chief Executive Officer

SECTION 1 — COMPLIANCE PROGRAM SUMMARY

Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Hospital"** means Doctors Medical Center.
- **"Personnel"** means all employees and volunteers of the Hospital, and all contractors or others who are required to comply with this Compliance Program. Each of these persons must sign an Acknowledgment of Receipt of Hospital Compliance Plan and a Conflict of Interest Certification Form.

Purpose of this Compliance Program

The Hospital is committed to ensuring compliance with all applicable statutes, regulations and policies governing our daily business activities. To that end, the Hospital created this Compliance Program to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. This Compliance Program is intended to further our day-to-day commitment that our operations comply with federal and state laws, to provide guidance for all employees, and to serve as a mechanism for preventing and reporting any violation of those laws.

While this Compliance Program addresses policies regarding the business of the Hospital, it does not address every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. The Hospital maintains other policies with which employees are required to comply. You should discuss with your supervisor any questions regarding which policies apply to you.

It is the policy of the Hospital that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of retribution; and
- Mechanisms exist to investigate, discipline and correct noncompliance.

Who is Affected

Everyone employed by the Hospital is required to comply with the Compliance Program. Because not all sections of the Compliance Program will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this Compliance Program is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that end, agreements with contractors may incorporate certain provisions of this Compliance Program.

This Compliance Program is effective only if everyone takes it seriously and commits to comply with its contents. It is important that you not only understand and comply with the written words of this Compliance Program, but that you also understand and appreciate the spirit and purpose of this Compliance Program. When in doubt, ask your supervisor, review the appropriate section of this Compliance Program, or take other steps to ensure that you are following the Compliance Program.

Compliance requirements are subject to change as a result of new laws. We must all keep this Compliance Program current and useful. You are encouraged to let your supervisor know when you become aware of changes in law or hospital policy that might affect this Compliance Program.

How to Use This Compliance Program

The Hospital has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this Compliance Program manual is organized follows.

Section I – Compliance Program Summary

Section II – Code of Conduct
This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel will receive training on this section.

Section III – Compliance Program Systems and Processes
This section explains the roles of the Chief Compliance Officer and the Compliance Committee. It also contains information about Compliance Program education and training, auditing and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Hospital's Compliance Hotline at _____ or sending a fax to _____ _____. All Personnel will receive training on this section.

Here are some tips on how to effectively use this Compliance Program:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to quickly locate the topic you are looking for.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that can be referred to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.
- **Read it in Context.** The Hospital has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about if or how a policy applies to you, ask your supervisor.
- **Keep it Handy.** Keep this Compliance Program manual easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are being uniformly applied. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

SECTION II — CODE OF CONDUCT

Our Compliance Mission

The Hospital's Governing Body adopted the Compliance Program, including this Code of Conduct, to provide standards by which Personnel must conduct themselves in order to protect and promote the Hospital's integrity and to enhance the Hospital's ability to achieve its objectives. The Hospital believes this Code of Conduct will significantly contribute to a positive work environment for all.

No written policies can capture every scenario or circumstance that can arise in the workplace. The Hospital expects Personnel to consider not only the words written in this Code of Conduct, but the meaning and purpose of those words as well. You are expected to read this Code of Conduct and exercise good judgment. You are encouraged to talk to your supervisor or the Hospital's Chief Compliance Officer if you have any questions about this Code of Conduct or what is expected of you.

All Personnel are expected to be familiar with the contents of this Code of Conduct. Training and education will be provided periodically to further explain this Code of Conduct and its application.

Compliance With Laws

It is the policy of the Hospital, its affiliates, contractors and employees to comply with all applicable laws. When the application of the law is uncertain, the Hospital will seek guidance from legal counsel.

Open Communication

The Hospital encourages open lines of communication between Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the Hospital's attention. Your supervisor is the best place to start, but you can also contact the Hospital's Chief Compliance Officer or call the Compliance Hotline to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The Hospital does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

Your Personal Conduct

The Hospital's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the Hospital. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say that the Hospital's integrity and reputation are in your hands.

The Hospital's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the Hospital, the Hospital may be required to take action.

The Work Environment

The Hospital strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately report to your to supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion,

sex, sexual orientation, age, national origin, disability, veteran status or other factors that are unrelated to the Hospital's legitimate business interests. The Hospital will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, you should bring such activity to the attention of the Hospital, either by informing your supervisor, Human Resources, the Hospital's Chief Compliance Officer, or by calling the Compliance Hotline. The Hospital considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale or possession of illegal drugs or any other controlled substance, except to the extent permitted by law for approved medical purposes.

In addition, Personnel may not be on the Hospital premises or in the Hospital work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed.

Employee Privacy

The Hospital collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the Hospital or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the Hospital's Personnel policies or practices.

Use of Hospital Property

Hospital equipment, systems, facilities, corporate charge cards and supplies must be used only for conducting Hospital business or for purposes authorized by management.

Personal items, messages or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, work spaces, desks, credenzas or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on Hospital equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at Hospital work locations, the question of making personal use of them frequently arises. The answer is clear: employees may not use Hospital supplies for personal use.

Use of Hospital Computers

The increasing reliance placed on computer systems, internal information and communications facilities in carrying out Hospital business makes it absolutely essential to ensure their integrity. Like other Hospital

assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting Hospital business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of Hospital assets.

While the Hospital conducts audits to help ensure that Hospital systems, networks and databases are being used properly, it is your responsibility to make sure that each use you make of any Hospital system is authorized and proper.

Personnel are not allowed to load or download software or data onto Hospital computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use Hospital e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on Hospital premises or computer, information, or communication systems.

Use of Proprietary Information

Proprietary Information

Proprietary information is generally confidential information that is developed by an organization as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with that organization's services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; business and product plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

As a governmental entity, the public has a general right to Hospital information and documents that may otherwise be considered proprietary and confidential. However, it is the responsibility of the Executive Management, the Board of Directors and the Governing Body to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports. Therefore, it is very important not to use or disclose proprietary information except as authorized by the Hospital.

Direct Requests for Information

If someone outside the Hospital asks you questions about the Hospital or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the Hospital. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the Hospital's business, you should refer the request to the office of the Hospital's Chief Executive Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the Hospital or the industry, direct the person to your supervisor.

Disclosure and Use of Hospital Proprietary Information

Besides your obligation not to disclose any Hospital proprietary information to anyone outside the Hospital, you are also required to use such information only in connection with the Hospital's business. These obligations apply whether or not you developed the information yourself.

Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the Hospital (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten,

miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the Hospital is also strictly prohibited and could lead to civil or even criminal liability for you and the Hospital. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the Hospital.

Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

Gifts and Entertainment

The Hospital understands that vendors and others doing business with the Hospital may wish to provide gifts, promotional items and entertainment to Hospital Personnel as part of such vendors' own marketing activities. The Hospital also understands that there may be occasions where the Hospital may wish to provide reasonable business gifts to promote the Hospital's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

General Policy

It is the general policy of the Hospital that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting Hospital business. It is the intent of the Hospital that this policy be construed broadly such that all business transactions with vendors, contractors and other third parties are transacted to avoid even the appearance of improper activity.

Spending Limits — Gifts, Dining and Entertainment

All Personnel are strictly prohibited from making any expenditures of Hospital or personal funds for gifts, dining or entertainment in any way related to Hospital business, unless such expenditures are made in strict accordance with Hospital policies.

Marketing and Promotions in Health Care

As a provider of health care services, the marketing and promotional activities of the Hospital may be subject to anti-kickback and other laws that specifically apply to the health care industry. The Hospital has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the Hospital that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the Hospital.

Marketing

The Hospital has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Part of those efforts involve advertising, marketing and other promotional activities. While such activities are important to the success of the Hospital, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the Hospital closely monitor and regulate advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with Hospital objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the Hospital. In addition to those policies, it is the general policy of the Hospital that no Personnel engage in any

advertising, marketing or other promotional activities on behalf of the Hospital unless such activities are approved in advance by the appropriate Hospital representative. You should ask your supervisor to determine the appropriate Hospital representative to contact. In addition, no advertising, marketing or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the Hospital's legal counsel.

All content posted on Internet websites maintained by the Hospital must be approved in advance by the Hospital's Chief Executive Officer or legal counsel.

Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the Hospital's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the Hospital's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

Outside Employment and Business Interests

You are not permitted to work on any personal business venture on the Hospital premises or while working on Hospital time. In addition, you are not permitted to use Hospital equipment, telephones, computers, materials, resources or proprietary information for any outside work. You must abstain from any decision or discussion affecting the Hospital when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the Hospital's Chief Executive Officer or legal counsel.

Contracting with the Hospital

You may not contract with the Hospital to be a supplier, to represent a supplier to the Hospital, or to work for a supplier to the Hospital while you are an employee of the Hospital. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the Hospital.

Required Standards

All decisions and transactions undertaken by Personnel in the conduct of the Hospital's business must be made in a manner that promotes the best interests of the Hospital, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed above.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.
2. Personnel must disclose any activity, relationship or interest that may be perceived to be a conflict of

interest so that these activities, relationships and interests can be evaluated and managed properly.

3. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the Hospital. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation or entertainment valued in excess of $100 from vendors, contractors or other third parties that have current or prospective business with the Hospital. Questions regarding the gift limitations should be directed to the Hospital's Chief Compliance Officer.
4. Any involvement by Personnel in a personal business venture shall be conducted outside the Hospital work environment and shall be kept separate and distinct from the Hospital's business in every respect.
5. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the Hospital, the use of any of the Hospital's equipment, supplies or property, or any direct relationship with the Hospital's business or operation.
6. Personnel must guard patient and Hospital information against improper access or use by unauthorized individuals.
7. The Hospital's materials, products, designs, plans, ideas and data are the property of the Hospital and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
8. Personnel must avoid any appearance of impropriety when dealing with clinicians and referral sources.
9. All vendors and contractors who have or desire business relationships with the Hospital must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the Hospital must report these to their supervisor or manager.
10. Personnel shall not sell any merchandise on Hospital premises without the prior approval of the Hospital's Chief Compliance Officer.
11. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the Hospital's Chief Compliance Officer.
12. Personnel may not endorse any product or service without explicit prior approval to do so by the Hospital's Chief Compliance Officer.

Disclosure of Potential Conflict Situations

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Certification Form within 90 days of being subject to this Code of Conduct (that is, being hired by the Hospital, beginning to volunteer at the Hospital, or assuming any responsibilities at the Hospital). At least annually thereafter, you must review this Code of Conduct and your most recent Conflict of Interest Certification. You are not required to file a Conflict of Interest Certification Form annually unless there is a change in your circumstances that you have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your certification form and contact the Hospital's Chief Compliance Officer. It is your responsibility to promptly report any actual or potential conflicts.

All certification forms must be sent to the Hospital's Chief Compliance Officer. The Chief Compliance Officer will review all disclosures and determine which disclosures require further action. The Chief Compliance Officer will consult with the Hospital's Chief Executive Officer or legal counsel if it is unclear whether an actual conflict of interest exists or if the Chief Compliance Officer determines that an actual conflict of interest exists. The outcome of these consultations will result in a written determination, signed by all decision-makers involved, stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of

interest which may include that:

1. The conflict of interest is permitted;
2. The conflict of interest is permitted with modification or oversight, including such steps as reassignment of responsibilities or establishment of protective arrangements;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest; or
4. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Chief Compliance Officer will review any written determination with you, discuss any necessary action you are to take, and ask you to sign the written determination. The signed written determination will be kept with your certification form.

Reporting Violations

The Hospital supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies or this Code of Conduct.

The Hospital has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the Hospital Compliance Program, including this Code of Conduct, must report the improper conduct to their departmental compliance officer or the Chief Compliance Officer. That officer, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

Hospital policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the Hospital that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to disciplinary action if after an investigation the Hospital reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts to either cause harm to someone else or to protect or benefit themselves.

SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the Hospital has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the Hospital has established for the purpose of providing structure and support to the Compliance Program.

Compliance Officers and Committee

Chief Compliance Officer

The Hospital has a Chief Compliance Officer who serves as the primary supervisor of this Compliance Program. The Chief Compliance Officer is responsible to support the Chief Executive Officer in assuring that the Compliance Program is implemented and to ensure that the Hospital at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Chief Executive Officer, through the Chief Compliance Officer, reports to the Governing Body about the Compliance Program and compliance issues. The Governing Body is ultimately responsible for supervising the work of the Chief Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Body oversees all of the Hospital's compliance efforts and takes any appropriate and necessary actions to ensure that the Hospital conducts its activities in compliance with the law and sound business ethics.

The Chief Compliance Officer consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

Responsibilities of the Chief Compliance Officer

The Chief Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Body on the progress of implementation and operation of the Compliance Program and assisting the Governing Body in establishing methods to reduce the Hospital's risk of fraud, abuse and waste.
- Periodically revising the Compliance Program in light of changes in the needs of the Hospital and changes in applicable statutes, regulations and government policies.
- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the Hospital are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the Hospital have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any other federal or state heath care program.
- Ensuring that the Hospital does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation

in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.

- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Chief Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Chief Compliance Officer has direct access to the Governing Body, Chief Executive Officer and other senior management, and to legal counsel. The Chief Compliance Officer has the authority to retain, as he or she deems necessary, outside legal counsel.

Compliance Committee

The Hospital has established a Compliance Committee to advise the Chief Compliance Officer and assist in monitoring this Compliance Program. The Compliance Committee provides the perspectives of individuals with diverse knowledge and responsibilities within the Hospital.

Members of the Compliance Committee

The Compliance Committee is a committee of the Hospital, and consists those individuals designated below and other members, including representatives of senior management, chosen by the Hospital's Chief Executive Officer in consultation with the Chief Compliance Officer:

- Chief Compliance Officer
- Chief Executive Officer
- Chief Operating Officer
- Chief Financial Officer
- Chief Nursing Officer
- Medical Staff Representative
- Human Resources Executive
- Quality/Risk Management Director (if different from the Chief Compliance Officer)
- Health Information Director

The Chief Compliance Officer serves as the chairperson of the Compliance Committee. The Compliance Committee serves in an advisory role and has no authority to adopt or implement policies. The Chief Compliance Officer will consult with members of the Compliance Committee on a regular basis and may call meetings of all or some members of the Compliance Committee.

Functions of the Compliance Committee

The Compliance Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Chief Compliance Officer to develop further standards of conduct and policies to promote compliance.
- Recommending and monitoring, in conjunction with the Chief Compliance Officer, the

development of internal systems and controls to carry out the standards and policies of this Compliance Program.

- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Chief Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate and respond to complaints and problems related to compliance.
- Assisting the Chief Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance Committee work.
- Consulting with vendors of the Hospital on a periodic basis to promote adherence to this Compliance Program as it applies to those vendors and to promote their development of formal Compliance Programs.

The tasks listed above are not intended to be exhaustive. The Compliance Committee may also address other compliance-related matters as determined by the Chief Compliance Officer or Chief Executive Officer.

Compliance as an Element of Performance

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all Hospital employees. Personnel will be trained periodically regarding the Compliance Program, and new compliance policies that are adopted. In particular, all managers and supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following:

- Discuss, as applicable, the compliance policies and legal requirements described in this Compliance Program with all supervised Personnel.
- Inform all supervised Personnel that strict compliance with this Compliance Program is a condition of continued employment.
- Inform all supervised Personnel that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and thus would have provided the Hospital with the opportunity to take corrective action.

Training and Education

The Hospital acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the Hospital requires all Personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by the Hospital for its departments based on the needs and requirements of each department . Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be conducted by qualified internal or external personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at a minimum the identification of the Personnel participating in the training, the subject matter of the

training, the length of the training, the time and date of the training, the training materials used, and any other relevant information.

The Chief Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the Hospital's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the Hospital's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Chief Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The Hospital expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

Lines of Communicating and Reporting

Open Door Policy

The Hospital recognizes that clear and open lines of communication between the Chief Compliance Officer and Hospital Personnel are important to the success of this Compliance Program. The Hospital maintains an open door policy in regards to all Compliance Program related matters. Hospital Personnel are encouraged to seek clarification from the Chief Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

Submitting Questions or Complaints

The Hospital has contracted with an outside vendor to establish a telephone hotline for use by Hospital Personnel to report concerns or possible wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Hotline." An external vendor is used to ensure confidentiality and integrity in the process.

The Compliance Hotline contact numbers are:

Phone: _____
Fax: _____

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Chief Compliance Officer at the following address:

Chief Compliance Officer
Doctors Medical Center
2000 Vale Road
San Pablo, CA

The Compliance Hotline numbers are posted in conspicuous locations throughout the Hospital's facilities.

Calls to the Compliance Hotline are treated confidentially and are not traced. The caller need not provide his

or her name. The Hospital's Chief Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Hotline and letters mailed to the Chief Compliance Officer or the Hospital's Hotline vendor are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Hotline, or in writing, that suggest violations of compliance policies, statutes or regulations, are documented and investigated promptly. A log is maintained by the Chief Compliance Officer and the Hotline vendor of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Chief Compliance Officer to the Hospital's Governing Body and Chief Executive Officer.

Non-Retaliation Policy

It is the Hospital's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, Hospital Personnel cannot use complaints to the Chief Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

Enforcing Standards and Policies

Policies

It is the policy of the Hospital to appropriately discipline Hospital Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include oral warnings, suspension or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with applicable laws, will also result in sanctions.
- Disciplinary action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in disciplinary action.

Because the Hospital takes compliance seriously, the Hospital will respond to Personnel misconduct.

Discipline Procedures

Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the Hospital. Any such discipline is within the sole discretion of the Hospital. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Chief Compliance Officer. Nothing in this Program regarding discipline procedures is intended to violate an employee's rights to due process as provided by law or collective bargaining agreements, all of which will continue in full force and effect throughout any Compliance Program related disciplinary proceeding.

Upon determining that an employee of the Hospital has committed a violation of this Compliance Program, such employee shall (along with their representative in the case of employees belonging to a collective bargaining unit) meet with his or her supervisor to review the conduct that resulted in violation of the

Compliance Program. The employee and supervisor will contact the Chief Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Chief Compliance Officer during the investigation of the violation. Legal counsel will be consulted prior to final actions or disciplinary measures, as appropriate.

Auditing and Monitoring

The Hospital conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Chief Compliance Officer.

The Chief Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the Hospital, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission (including an assessment of the Hospital's billing system), reimbursement and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The Hospital shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the Hospital shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

Corrective Action

Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the Hospital's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the Hospital's business and reputation, and can lead to serious sanctions against the Hospital. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Chief Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Chief Compliance Officer may create a response team to review suspected noncompliance.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation with legal counsel.

Depending upon the nature of the alleged violations, the Chief Compliance Officer's internal investigation

could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Chief Compliance Officer to assist in an investigation where the Chief Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Chief Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Chief Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

Reporting

If the Chief Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over such matter. Such reports will be made by the Chief Compliance Officer on a timely basis.

All overpayments identified by the Hospital shall be promptly disclosed and/or refunded to the appropriate public or private payer or other entity.

APPENDIX A
Acknowledgment of Receipt of Hospital Compliance Program

I, _____ , am a/an:
☐ Employee ☐ Volunteer ☐ Contractor of the Hospital.

By my signature below, I acknowledge that I have received a copy of the following sections of the Hospital Compliance Program.

☐ Compliance Program Summary *(see Section I of the Model Hospital Compliance Program)*

☐ Code of Conduct *(see Section II of the Model Hospital Compliance Program)*

☐ Compliance Program Systems and Processes *(see Section III of the Model Hospital Compliance Program)* which includes information on how to report a suspected violation of law or hospital policy

Compliance Policies as follows:

☐ Required Policies and Procedures (federal and state false claims laws and whistleblower laws)

☐ Other: _____

☐ Other: _____

I further acknowledge that I have been informed about where to locate a complete copy of the Hospital Compliance Program if I so desire.

Date: _____

Print Name: _____

Signature: _____

APPENDIX B
Conflict of Interest Certification Form

Please initial the Attestations below indicating agreement as appropriate, and then complete the Disclosure of Interest section to disclose any actual or potential conflicts of interests you may have with the Hospital or that you are required to report by the Hospital's Code of Conduct [and Conflict of Interest policy]:

ATTESTATIONS

_____ I hereby attest that neither I nor any relative[1] now has, nor since my date of employment or association with the Hospital has had, any significant financial interest[2] in any organization or enterprise with which the Hospital has done or now does business, or any interest in any business transaction involving the Hospital.

_____ I hereby attest that I am not in an employed or consulting position outside the Hospital that would potentially constitute a conflict of interest.

_____ I hereby attest that I do not serve as an officer or member of the board of directors or trustees in any professional, community, or charitable activities that would potentially constitute a conflict of interest.

DISCLOSURE OF INTEREST

Please explain in detail the activity, relationship, interest, or financial interest being reported:

_____

_____

_____

_____

_____

CERTIFICATION

I hereby certify that this accurately and completely describes, to the best of my knowledge and belief, all activities, relationships, interests, and financial interests, which present actual or potential conflicts of interest with the Hospital or that are required to be reported under the provisions of the Hospital's Code of Conduct [and Conflict of Interest Policy]. I hereby further certify that I agree to comply with the conflict of interest provisions in the Hospital's Code of Conduct [and Conflict of Interest Policy] and to report any actual or potential conflicts of interest to the Hospital's Chief Compliance Officer when they arise.

1 For purposes of this Conflict of Interest Certification Form, a relative is any person who is related to you by blood or marriage, or whose relationship with you is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in your household.

2 For purposes of this Conflict of Interest Certification Form, there are two types of significant financial interests: (1) Receipt of anything of monetary value from a single source in excess of $100 annually (examples include salary, royalties, gifts, and payments for services including consulting fees and honoraria); (2) Ownership of an equity interest exceeding 5% in any single entity, excluding stocks, bonds, and other securities sold on a national exchange, certificates of deposit, mutual funds, and brokerage accounts managed by third parties.

Your Signature: _____

Your Typed/Printed Name: _____

Your Relationship to the Hospital (Employee, Volunteer, or Contractor): _____

Date:

CHIEF COMPLIANCE OFFICER REVIEW

I have reviewed this certification form and determined that (check one):

☐ No activities, relationships, interests, or financial interests were disclosed so there are no actual or potential conflicts of interest.

☐ The activities, relationships, interests, or financial interests that were disclosed do not pose actual or potential conflicts of interest.

☐ Based on the activities, relationships, interests, or financial interests that were disclosed, it is unclear whether actual or potential conflicts of interest exist. Therefore, the Hospital's Chief Executive Officer and/or legal counsel will be consulted and a written determination will be made with respect to whether actual or potential conflicts of interest exist, and, if actual or potential conflicts of interest are found to exist, the written determination will include a plan to manage the actual or potential conflicts of interest.

☐ The activities, relationships, interests, or financial interests that were disclosed do pose actual or potential conflicts of interest. Therefore, the Hospital's Chief Executive Officer and/or legal counsel will be consulted and a written plan will be developed to manage the actual or potential conflicts of interest.

Reviewed by:

Title:

Date:

REVIEW OF WRITTEN DETERMINATION AND MANAGEMENT PLAN BY EMPLOYEE, VOLUNTEER, OR CONTRACTOR

I have reviewed and understand the attached written determination and/or plan to manage the actual or potential conflicts of interest identified. I further agree to comply with the plan to manage the actual or potential conflicts of interest identified, if any.

Your Signature: _____

Your Typed/Printed Name: _____

Date:

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 12

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT TO THE BOARD

May 2012

The following practitioners' applications for appointment and/or reappointment have been reviewed by the appropriate committees of the Medical Staff and have been deemed as complete and are recommended for approval by the Credentials Committee (05/24/12) and the Medical Executive Committee (06/11/12).

CREDENTIALS REPORT TO THE BOARD MAY 2012	
REAPPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
Tanaka, Ted, DPM	Surgery/Podiatry
Tuffail, Humayun, MD	Medicine/Family Practice/Internal Medicine
Haque, Mofiz, MD	Medicine/Family Practice/Internal Medicine
RESIGNATIONS	
Watkins, Melanie, MD	Medicine/Family Practice/Psychiatry

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD
EXECUTIVE SUMMARY

JUNE 2012

TOPIC

DMC Patient Summit: Medical Staff members who are participating in the Patient Summit Conferences report that a variety of attendees from all aspects of hospital care, including patients and Board Members are contributing significantly to a very positive movement to improve patient satisfaction.

Paragon/CPOE Implementation: Dr. Humayun Tufail and Dr. Richard Stern, physician champions for computerized physician order entry (CPOE), continue to provide input regarding identified issues and recommendations for change and/or program enhancements. Medical Staff is also participating in the weekly phone conferences being held with McKesson Executives and Hospital Administration to ensure issues are addressed and resolved appropriately and timely. Hospitalists and Intensivists currently are the only physicians utilizing CPOE, as further additions of medical staff users has been deferred pending the resolution of all current problems and system stabilization. Updates as necessary.

ITEM REQUIRING ACTION

General Rules & Regulations Amendment: 5.16 Critical Care Committee: The attached document (Attachment A) represents the proposed reorganization of the Critical Care Committee, a standing committee of the Medical Staff. This revision provides for a multidisciplinary forum to conduct medical staff oversight and coordination of all critical care areas, and is consistent with regulatory requirements.

The Medical Executive Committee has approved this revision in its entirety, and requests Board approval of this amendment to the Rules & Regulations.

PROPOSED AMENDMENT TO GENERAL RULES & REGULATIONS

ARTICLE 5.16 CRITICAL CARE COMMITTEE

5.16 CRITICAL CARE COMMITTEE

5.16-1 Composition

The committee should consist of at least seven members of the Medical Staff, appointed by the Chief of Staff, and will be co-chaired by the Medical Directors of the Critical Care Unit and Emergency Services. Surgery, Cardiology, Nephrology and Hospitalist Services shall be represented. Non-physician members will include the Clinical Directors of Perioperative/GI/Critical Care Services, Emergency Services, Critical Care Educator and Chief Nursing Officer. Staff representing various ancillary services will attend on an ad hoc basis.

5.16-2 Duties

(a) To provide a multidisciplinary forum to conduct oversight and coordination of all critical care areas

(b) To establish policies and procedures that comply with local, state and federal regulations and accreditation standards for the appropriate services and to oversee their implementation. Policies shall include, but not be limited to:

(1) Admission, discharge and transfer

(2) Staffing requirements

(3) Routine and emergency procedures

~~(b)~~**(c)** To conduct and support performance improvement efforts that involve the care delivered in the critical care areas

(d) To provide educational programs in the area of critical care for both physicians and nursing personnel

~~(c)~~**(e)** To review staff development plans to assure that competent staff are available for the provision of care.

~~(d)~~**(f)** To assure that adequate equipment and supplies are available at all times.

~~(e)~~**(g)** To review all Code Blue and Rapid Response Team procedures.

~~(f)~~**(h)** To utilize evidence-based medicine when providing recommendations regarding changes in clinical practice

5.16-3 Meetings

The committee shall meet as often as necessary to carry out its duties, but at least quarterly. It shall maintain a record of its activities and report to the Medical Executive Committee.