MARIN HEALTHCARE DISTRICT

100-B Drake's Landing Road, Suite 250, Greenbrae, CA 94904 **Telephone: 415-464-2090** **Fax: 415-464-2094**
www.marinhealthcare.org info@marinhealthcare.org

TUESDAY, MAY 10, 2016

CLOSED SESSION @ 6:30 PM
REGULAR OPEN MEETING @ 7:00 PM

Board of Directors:
Chair: Harris Simmonds, MD
Vice Chair: Ann Sparkman, JD
Secretary: Jennifer Rienks, PhD
Directors: Larry Bedard, MD
Jennifer Hershon, RN, MSN

Location:
Marin General Hospital
Conference Center
250 Bon Air Road
Greenbrae, CA 94904

Staff:
Lee Domanico, CEO
Colin Coffey, District Counsel
Louis Weiner, Executive Assistant

AGENDA Tab #

CLOSED MEETING, 6:30 pm

1. Call to Order and Roll Call — Simmonds

2. General Public Comment — Simmonds
   Any member of the audience may make statements regarding any items on the agenda. Statements are limited to a Maximum of three (3) minutes. Please state and spell your name if you wish it to be recorded in the minutes.

3. Closed Session
   a. Approval of minutes of previous Closed Session (action) — Simmonds
   b. Potential Litigation pursuant to Government Code Section 54956.9(d)(2) — Coffey

4. Adjournment of Closed Session — Simmonds
   Regular Meeting to follow.

A copy of the agenda for the Regular Meeting will be posted and distributed at least 72 hours prior to the meeting.
In compliance with the Americans with Disabilities Act, if you require accommodations to participate in a District meeting please contact the District office at 415-464-2090 (voice) or 415-464-2094 (fax) at least 48 hours prior to the meeting.
Meetings open to the public are audio-recorded; the recordings are posted on the District web site and retained for 1 year.

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TUESDAY, MAY 10, 2016

CLOSED SESSION @ 6:30 PM
REGULAR OPEN MEETING @ 7:00 PM

AGENDA

		Tab #
REGULAR MEETING, 7:00 PM		
1. Call to Order and Roll Call	Simmonds	
2. General Public Comment *Any member of the audience may make statements regarding any items NOT on the agenda. Statements are limited to a maximum of three (3) minutes. Please state and spell your name if you wish it to be recorded in the minutes.*	Simmonds	
3. Approval of Agenda (action)	Simmonds	
4. Approval of the Minutes of the Regular Meeting of April 12, 2016 (action)	Simmonds	#1
5. Approval of 4Q 2015 MGH Performance Metrics & Core Services Quarterly Report (action)	Domanico	#2
6. Biannual MGH Bylaws Review (action)	Coffey	#3
7. Committee Meeting Reports		
a. MHD Finance and Audit Committee (met April 26)	Hershon	
(1) Review and Approve Report of Independent Auditors and Financial Statements for Marin Healthcare District, Six Months Ended December 31, 2015 and Year Ended June 30, 2015 (action)		#4
(2) Approve Loan Modification Agreement and Reaffirmation of Collateral Assignment of Contracts (action)		#5
b. MHD Lease and Building Committee (met April 27)	Sparkman	
8. Reports		
a. District CEO's Report	Domanico	
b. Hospital CEO's Report	Domanico	
c. Chair's Report	Simmonds	
d. Board Members' Reports	All	
9. Agenda Items Suggested for Future Meetings	All	
10. Adjournment of Regular Meeting	Simmonds	

Next Regular Meeting: Tuesday, June 14, 2016, 7:00 p.m.

A copy of the agenda for the Regular Meeting will be posted and distributed at least 72 hours prior to the meeting.
In compliance with the Americans with Disabilities Act, if you require accommodations to participate in a District meeting please contact the District office at 415-464-2090 (voice) or 415-464-2094 (fax) at least 48 hours prior to the meeting.
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Tab 1

BOARD OF DIRECTORS
REGULAR MEETING
Tuesday, April 12, 2016
Marin General Hospital, Conference Center

MINUTES

1. **Call to Order and Roll Call**
Chair Simmonds called the Regular Meeting to order at 7:04 pm.

Board Members Present: Chair Harris Simmonds, MD; Vice Chair Ann Sparkman; Director Larry Bedard, MD; Director Jennifer Hershon
Board Member Absent: Secretary Jennifer Rienks
Staff Present: Lee Domanico, CEO; Jon Friedenberg, CAO; Jim McManus, CFO; Linda Lang, CHRO; Mark Zielazinski, CITIO; Karin Reese, VP Nursing; Colin Coffey, District Counsel

2. **General Public Comment**
Public comment: Barb Ryan, RN.

3. **Approval of Agenda**
Vice Chair Sparkman moved to approve the Agenda as submitted. Director Bedard seconded. Vote: all ayes.

4. **Consent Agenda**
The Consent Agenda comprised the minutes of the Special Open Meeting of March 8, 2016 and the minutes of the Regular Meeting of the same date. Director Bedard moved to approve the Consent Agenda as submitted. Vice Chair Sparkman seconded. Vote: all ayes.

5. **Review and Approve Resolution #2016-02 Calling for Election**
Counsel Coffey presented MHD Resolution #2016-02 "Requesting election services by the Marin County Elections Department." Two regular term positions on the Marin Healthcare District Board are up for election in the General Election on November 8, 2016. To allow and ensure these positions be put on the ballot, this Resolution is legally required to be approved, signed and submitted by the District Board to the County Department of Elections.

Vice Chair Sparkman moved to approve MHD Resolution #2016-02 as submitted. Director Hershon seconded. There was no further discussion. Vote: all ayes.

6. **Committee Reports**
A. MHD Finance and Audit Committee: (met March 29)
(1) Review and Approve Recruitment Incentives for Dr. Anand Soni and the Income Guarantees for Dr. Anand Soni and Dr. Benedict Ancock for Cardiology Services in the District's 1206(b) Cardiology Clinics

This was reviewed and recommended by the Finance and Audit Committee, and discussed in the Closed Session preceding this Regular Meeting. Director Hershon moved to approve. Director Bedard seconded. There was no further discussion. Vote: all ayes.

(2) Review and Approve Terms of Professional Services Agreement for Rheumatologists for 1206(b) Clinic

This new program was reviewed and recommended for approval by the Finance and Audit Committee. The Board has discussed the need for the record to reflect that the District payments to the physicians for services to the Marin Community Clinic will be reimbursed to the District by the Marin Community Clinic. Thus the following two document additions were recommended:

- On the Memo from Mr. Domanico, an additional sentence is added at the end of the second paragraph to read: "The compensation paid to the physicians for their services at the Marin Community Clinic will be reimbursed by the Marin Community Clinic."
- On the Transaction Summary, under item 3, "Compensation" a final sentence will be added: "The compensation paid to the physicians for their services at the Marin Community Clinic will be reimbursed by the Marin Community Clinic."

It was commented that this agreement is further evidence of the benefit to the community of extending programs collaboratively with other community agencies.

Director Hershon moved to approve, with the two changes. Vice Chair Sparkman seconded. Vote: all ayes.

B. MHD Lease and Building Committee: (to meet April 27)
Vice Chair Sparkman noted there is nothing to report, and that the next meeting of the Committee will be April 27 in the format of Special Study Session of the full Board of Directors.

7. <u>MHD Board Annual Retreat: Friday, April 15, 2016</u>

Mr. Domanico reported that the agenda of the Special Closed Session of the Retreat this week will include an update report of the MGH Strategic Plan, a review of the MHD strategies in light of the current two-year commitment to Behavioral Health program support, and a look at other healthcare districts' community benefit programs. The Special Open Session will consist of a discussion of the California End of Life Option Act (ABX2-15) led by Susan Penney, JD, of UCSF Medical Center, and Matthew Katics, DO, MGH's new Director of Palliative Care.

8. <u>Reports</u>

A. District CEO Report:
Project MGH 2.0 continues on time and on budget. The temporary lobby is now open, and the new parking garage will be open on time in June.

(1) Review of MHD Web Site
The Marin County Grand Jury had given an unfavorable evaluation of the MHD web site. Mr. Weiner projected the web site's pages on the screen and noted that each point of their perceived deficiency is either unfounded or has been remedied. Mr. Domanico will submit the response to the Grand Jury by the required date of June 10, 2016.

B. Hospital CEO Report:
MGH showed good financial performance in February with a favorable payer mix. A new program to improve patient experience has daily bedside rounding by hospitalists and nurses together; the program has begun on the 5th floor medical unit, and patient satisfaction scores there already have shown marked improvement and should improve further as teamwork develops. Dr. Matthew Katics, the new palliative care physician, has begun work with patients and their families. The Paragon clinical IT computer system has had a major upgrade, the first upgrade favorably reviewed by users. The partnership with Phillips has allowed for scheduling installation of the second MRI, a second CT scan, and digital radiography.

Public comment: Barb Ryan, RN.

C. Chair's Report:
Chair Simmonds commended Mr. Domanico for his published letter in the IJ's "Marin Voice" about political candidates not addressing public health issues. He commended Director Hershon for her work in her new role as Chair of the MHD Finance and Audit Committee.

D. Board Member's Reports:
Director Bedard attended an Americans for Safe Access educational program in Washington, DC, regarding international research about the use of medical marijuana.

9. <u>Agenda Suggestions for Future Meetings</u>
No suggestions submitted.

10. <u>Adjournment</u>
Chair Simmonds adjourned the meeting at 7:40 pm

Tab 2

MARIN GENERAL HOSPITAL

250 Bon Air Road, Greenbrae, CA 94904
t » 415-925-7000

Marin General Hospital

Performance Metrics and Core Services Report

4th Quarter 2015

Submitted 05-03-2016

Marin General Hospital

Performance Metrics and Core Services Report: **4th Quarter 2015**

TIER 1 PERFORMANCE METRICS

In accordance with Tier 1 Performance Metrics requirements, the MGH Board is required to meet each of the following minimum level requirements:

		Frequency	Status	Notes
(A) Quality, Safety and Compliance	1. MGH Board must maintain MGH's Joint Commission accreditation, or if deficiencies are found, correct them within six months.	Quarterly	In Compliance	Joint Commission granted MGH an "Accredited" decision with an effective date of 7/16/2013 for a duration of 36 months. Next survey to occur in 2016.
	2. MGH Board must maintain MGH's Medicare certification for quality of care and reimbursement eligibility.	Quarterly	In Compliance	MGH maintains its Medicare Certification.
	3. MGH Board must maintain MGH's California Department of Public Health Acute Care License	Quarterly	In Compliance	MGH maintains its license with the State of California.
	4. MGH Board must maintain MGH's plan for compliance with SB 1953.	Quarterly	In Compliance	MGH remains in compliance with SB 1953 (California Hospital Seismic Retrofit Program).
	5. MGH Board must report on all Tier 2 Metrics at least annually.	Annually	In Compliance	4Q 2015 (Annual Report) was presented to MGH Board and to MHD Board in May 2016.
	6. MGH Board must implement a Biennial Quality Performance Improvement Plan for MGH.	Annually	In Compliance	MGH Performance Improvement Plan for 2016 was presented for approval to the MGH Board in May 2016.
	7. MGH Board must include quality improvement metrics as part of the CEO and Senior Executive Bonus Structure for MGH.	Annually	In Compliance	CEO and Senior Executive Bonus Structure includes quality improvement metrics.
(B) Patient Satisfaction and Services	MGH Board will report on MGH's HCAHPS Results Quarterly.	Quarterly	In Compliance	**Schedule 1**
(C) Community Commitment	1. In coordination with the General Member, the MGH Board must publish the results of its biennial community assessment to assess MGH's performance at meeting community health care needs.	Annually	In Compliance	**Schedule 2**
	2. MGH Board must provide community care benefits at a sufficient level to maintain MGH's non-profit tax exempt status.	Quarterly	In Compliance	MGH continues to provide community care and has maintained its tax exempt status.
(D) Physicians and Employees	MGH Board must report on all Tier 1 "Physician and Employee" Metrics at least annually.	Annually	In Compliance	**Schedule 3** **Schedule 4**
(E) Volumes and Service Array	1. MGH Board must maintain MGH's Scope of Acute Care Services as reported to OSHPD.	Quarterly	In Compliance	All services have been maintained.
	2. MGH Board must maintain MGH's services required by Exhibit G to the Loan Agreement between the General Member and Marin County, dated October 2008, as long as the Exhibit commitments are in effect.	Quarterly	In Compliance	All services have been maintained.
(F) Finances	1. MGH Board must maintain a positive operating cash-flow (operating EBITDA) for MGH after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric.	Quarterly	In Compliance	**Schedule 5**
	2. MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.	Quarterly	In Compliance	**Schedule 5**

Marin General Hospital

Performance Metrics and Core Services Report: **4th Quarter 2015**

TIER 2 PERFORMANCE METRICS

In accordance with Tier 2 Performance Metrics requirements, the General Member shall monitor and the MGH Board shall provide necessary reports to the General Member on the following metrics:

		Frequency	Status	Notes
(A) Quality, Safety and Compliance	MGH Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in MGH's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CLABSI, preventive care programs).	Quarterly	In Compliance	**Schedule 6**
(B) Patient Satisfaction and Services	1. MGH Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.	Quarterly	In Compliance	**Schedule 1**
	2. MGH Board will report external awards and recognition.	Annually	In Compliance	**Schedule 7**
(C) Community Commitment	1. MGH Board will report all of MGH's cash and in-kind contributions to other organizations.	Quarterly	In Compliance	**Schedule 8**
	2. MGH Board will report on MGH's Charity Care.	Quarterly	In Compliance	**Schedule 8**
	3. MGH Board will maintain a Community Health Improvement Activities Summary to provide the General Member, providing a summary of programs and participation in community health and education activities.	Annually	In Compliance	**Schedule 2**
	4. MGH Board will report the level of reinvestment in MGH, covering investment in excess operating margin at MGH in community services, and covering funding of facility upgrades and seismic compliance.	Annually	In Compliance	**Schedule 5**
	5. MGH Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.	Annually	In Compliance	**Schedule 9**
(D) Physicians and Employees	1. MGH Board will provide a report on new recruited physicians by specialty and active number of physicians on staff at MGH.	Annually	In Compliance	**Schedule 10**
	2. MGH Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.	Annually	In Compliance	**Schedule 3** **Schedule 4**
	3. MGH Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at MGH.	Quarterly	In Compliance	**Schedule 11**
(E) Volumes and Service Array	1. MGH Board will develop a strategic plan for MGH and review the plan and its performance with the General Member.	Annually	In Compliance	The updated MGH Strategic Plan was presented to the MGH Board on October 24, 2015.
	2. MGH Board will report on the status of MGH's market share and Management responses.	Annually	In Compliance	MGH's market share and management responses report was presented to the MGH Board on October 24, 2015.
	3. MGH Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.	Quarterly	In Compliance	**Schedule 5**
	4. MGH Board will report on current Emergency services diversion statistics.	Quarterly	In Compliance	**Schedule 12**
(F) Finances	1. MGH Board will provide the audited financial statements.	Annually	In Compliance	The MGH 2015 Independent Audit was completed on April 29, 2016.
	2. MGH Board will report on its performance with regard to industry standard bond rating metrics, e.g., current ratio, leverage ratios, days cash on hand, reserve funding.	Quarterly	In Compliance	**Schedule 5**
	3. MGH Board will provide copies of MGH's annual tax return (form 990) upon completion to General Member.	Annually	In Compliance	The MGH 2014 Form 990 was filed on November 12, 2015.

Schedule 1: HCAHPS

(Hospital Consumer Assessment of Healthcare Providers & Systems)

- **Tier 1, Patient Satisfaction and Services**
  The MGH Board will report on MGH's HCAHPS Results Quarterly.
- **Tier 2, Patient Satisfaction and Services**
  The MGH Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.

Marin General Hospital
Overall Hospital HCAHPS
Trending by Quarter

Scores displayed here are based on interviews from CMS submitted data for the selected time periods.
Mode adjustments and ESTIMATED Patient Mix Adjustments have been applied to the dimension scores.
Scores for the individual questions do not have adjustments applied.

FY 2017 VBP Thresholds				1Q 2015	2Q 2015	3Q 2015	4Q 2015
70.02	78.12	84.60	**Overall rating**	**61.82**	**64.40**	**61.69**	**62.36**
			Would Recommend	**70.27**	**66.68**	**73.52**	**63.78**
78.19	82.87	86.61	**Communication with Nurses**	**70.12**	**68.78**	**71.28**	**66.58**
			Nurse Respect	86.04	80.95	84.75	79.13
			Nurse Listen	74.89	70.69	73.42	71.26
			Nurse Explain	68.33	73.59	74.58	68.24
80.51	85.12	88.80	**Communication with Doctors**	**77.52**	**74.18**	**77.97**	**74.79**
			Doctor Respect	86.04	79.83	88.94	83.00
			Doctor Listen	78.54	75.32	77.97	77.73
			Doctor Explain	78.18	77.59	77.22	73.83
65.05	73.36	80.01	**Responsiveness of Staff**	**59.44**	**58.03**	**58.63**	**55.88**
			Call Button	65.63	62.74	62.63	59.83
			Bathroom Help	68.46	68.53	69.84	67.13
70.28	74.75	78.33	**Pain Management**	**66.70**	**66.39**	**68.91**	**63.22**
			Pain Controlled	70.48	70.62	73.13	66.67
			Help with Pain	77.71	76.97	79.50	74.57
62.88	68.70	73.36	**Communication about Medications**	**52.72**	**54.87**	**57.57**	**58.36**
			Med Explanation	77.86	74.65	76.52	76.26
			Med Side Effects	38.58	46.10	49.62	51.47
65.30	73.13	79.39	**Hospital Environment**	**47.04**	**47.39**	**51.98**	**49.53**
			Cleanliness	62.44	58.01	62.93	64.14
			Quiet	45.95	51.07	55.32	49.21
85.91	88.60	91.23	**Discharge Information**	**82.82**	**80.80**	**85.20**	**83.59**
			Help After Discharge	83.25	81.90	86.88	81.59
			Symptoms to Monitor	87.38	84.69	88.53	90.60
			Number of Surveys	**223**	**234**	**239**	**257**

Thresholds Color Key:
National 95th percentile
National 75th percentile
National average, 50th percentile

Scoring Color Key:
At or above 95th percentile
At or above 75th percentile
At or above 50th percentile
Below 50th percentile

Official VPB (Value-Based Purchasing) monthly trending HCAHPS results are distributed by MGH Quality Management on the 15th of each month.

Schedule 2: Community Health & Education

- **Tier 1, Community Commitment**
  In coordination with the General Member, the Board must publish the results of its triennial community survey to assess MGH's performance at meeting community health care needs.
- **Tier 2, Community Commitment**
  The Board will maintain a Community Health Improvement Activities Summary to provide the General Member, providing a summary of programs and participation in community health and education activities.

Community Health Improvement Services			
Event	**Description**	**Recipients**	**Presenter**
Breastfeeding Telephone Line	Free education, counseling and breastfeeding support available to the community	General Public	Women, Infants & Children (WIC)
Center for Integrative Health & Wellness (CIHW) Events	Various education and support group events for the community	General Public	CIHW
Diabetes Fall Fest	Free health education	General Public	CIHW
Community RD Phone Line	Free advice line open to the community for nutrition info	General Public	Nutrition Services
Community Patient Navigator	Free information and referral to community resources	General Public	CIHW
The Mom's Group	Free support group to the community that discusses newborn care, breastfeeding, parenting, etc.	General Public	WIC
The New Father Class	Free class for new fathers on having a newborn	General Public	WIC
Low Cost Mammo Day	Mammograms offered to underserved women	Patients in need	Breast Health Center
Indigent Funded Services for Behavioral Health	Includes transportation	Patients in need	Behavioral Health
Indigent Funded Services for Case Management	Including transportation, housing, and medications	Patients in need	Case Management
Shuttle Program for Senior Partial Hospitalization Program	Free shuttle service for Behavioral Health program	Patients in need	Behavioral Health / Security & Shuttle

Schedule 2, continued

Health Professions Education			
Event	**Description**	**Recipients**	**Presenter**
Grand Rounds	Education programs open to community doctors	Physicians	Medical Office Staff
Nursing Student Placement and Clinical Supervision	Time spent from Education placing student nurses	Student Nurses	Clinical Education
Chaplain Resident Program	Supervision and training hours provided by MGH	Residents	Spiritual Care
Preceptorship for Nutrition Students	Training hours provided by staff	Dietitian Students	Nutrition Services
Case Management Social Work Students	Supervision and training hours provided by MGH	Social Work Students	Care Coordination and Behavioral Health
Occupational Health Interns	Supervision and training hours provided by MGH	Occupational Therapy students	Behavioral Health
Pharmacy Student Clinical Rotations	Supervision and training hours provided by MGH	Pharmacy students	Pharmacy
Radiology Student Internships	Supervision and training hours provided by MGH	Radiology students	Radiology
Rehabilitation Student Internships	Supervision and training hours provided by MGH	Physical, Occupational and Speech Therapists students	Rehabilitation Services
Respiratory Therapy Student Internships	Supervision and training hours provided by MGH	Respiratory Therapy students	Respiratory Therapy
IT Internships	Supervision and training hours provided by MGH	IT students	Information Technology
Trauma: The Marin Series	Education classes for paramedics, EMTs, fire department and other health care workers	Health care and emergency response workers	Trauma Center

Community Building			
Event	**Description**	**Recipients**	**Presenter**
San Rafael Chamber of Commerce	Membership, events	Community	MGH
Healthy Marin Partnership	Collaborative that advances community health improvement initiatives	Community	MGH

Schedule 3: Physician Engagement

- **Tier 1, Physicians and Employees**
  The Board must report on all Tier 1 Physician and Employee Metrics at least annually.
- **Tier 2, Physicians and Employees**
  The Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.

The overall MGH 2016 Medical Staff Perception Study results are indicated below.
Source: PRC (Professional Research Consultants, Inc.)

Asked of Physicians:
"OVERALL, WOULD YOU RATE THE QUALITY OF CARE AT MARIN GENERAL HOSPITAL:"

Rank	*# Responses*	*% of Responses*
Excellent	**66**	**26.2%**
Very Good	**116**	**46.4%**
Good	**50**	**20.2%**
Fair	**16**	**6.5%**
Poor	**2**	**0.8%**

Percentile Ranking: 20th
Total Number of Responses: 250 (85.9%)

Asked of Physicians:
"OVERALL, WOULD YOU RATE MARIN GENERAL HOSPITAL AS A PLACE TO PRACTICE MEDICINE:"

Rank	*# Responses*	*% of Responses*
Excellent	**57**	**22.7%**
Very Good	**95**	**38.1%**
Good	**62**	**24.7%**
Fair	**32**	**13.0%**
Poor	**4**	**1.6%**

Percentile Ranking: 13th
Total Number of Responses: 250 (85.9%)

Schedule 4: Employee Engagement

- **Tier 1, Physicians and Employees**
  The Board must report on all Tier 1 Physician and Employee Metrics at least annually.
- **Tier 2, Physicians and Employees**
  The Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.

The overall MGH 2015 Employee Engagement Study results are indicated below.
Source: PRC (Professional Research Consultants, Inc.)

Asked of Employees:
"OVERALL, AS A PLACE TO WORK, WOULD YOU SAY MARIN GENERAL HOSPITAL IS:"

Rank	*# Responses*	*% of Responses*
Excellent	**209**	**22.2%**
Very Good	**263**	**27.9%**
Good	**234**	**24.8%**
Fair	**164**	**17.4%**
Poor	**72**	**7.7%**

Percentile Ranking: 22nd
Total Number of Responses: 942 (59.6%)

Schedule 5: Finances

- **Tier 1, Finances**
  The MGH Board must maintain a positive operating cash-flow (operating EBIDA) for MGH after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric. The MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.
- **Tier 2, Volumes and Service Array**
  The MGH Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.

Financial Measure	1Q 2015	2Q 2015	3Q 2015	4Q 2015
EBIDA $	$13,625	$9,224 ($22,849 YTD)	$8,645 ($31,494 YTD)	$4,293 ($35,787 YTD)
EBIDA %	14.28%	11.90%	10.96%	9.32%

Loan Ratios				
Current Ratio	2.85	2.82	2.83	3.40
Debt to Capital Ratio	29.7%	27.5%	32.0%	29.1%
Debt Service Coverage Ratio	3.98	4.44	4.96	4.50
Debt to EBIDA %	1.40	1.26	1.43	1.54

Key Service Volumes				
Acute discharges	2,203	2,183 (4,386 YTD)	2,185 (6,571 YTD)	2,203 (8,774 YTD)
Acute patient days	10,500	10,343 (20,843 YTD)	9,843 (30,686 YTD)	10,427 (41,113 YTD)
Average length of stay	4.77	4.75	4.67	4.69
Emergency Department visits	9,858	9,433 (19,291 YTD)	9,238 (28,529 YTD)	9,226 (37,755 YTD)
Inpatient surgeries	539	632 (1,171 YTD)	509 (1,680 YTD)	412 (2,092 YTD)
Outpatient surgeries	1,076	1,140 (2,216 YTD)	1,080 (3,296 YTD)	1,131 (4,427 YTD)

Schedule 5, continued

- **Tier 2, Community Commitment**

  The Board will report the level of reinvestment in MGH, covering investment in excess operating margin at MGH in community services, and covering funding of facility upgrades and seismic compliance.

MGH
Major Capital Expenditure Report
For the Period January - December 2015

Major Capital Expenditures	
Truebeam Linear Accelerator	2,248,850
Pyxis MedStation Cap Lease	1,143,661
Implement Integrated Cardiology Solution	769,647
40 Monitors and Defibrillators	362,911
Paragon ORM/Resource Scheduling Optimization	257,617
Patient/Guest Furniture:3 Year replacement program	187,829
Philips Intellivue MP5	180,823
End User Device Upgrade Project	171,479
EPIQ7G Ultrasound System	159,572
Stryker Ultrasonic Aspirator	153,966
ECMO System	151,316
Bed-tracking system	141,927
10 V60 Ventilators	133,724
Bronchoscope	133,720
Vocera Care Rounds License & Implementation	108,599
Medtronic Dual Chamber Temp Pacemaker	106,062
Other Capital Under $100K	1,796,749
Total Major Capital Expenditures	**8,208,453**

Construction in Progress	
EDIS	1,225,788
1350 Linear Accelerator Project	1,067,600
SPD Sterilizer/Washers/DI System	916,371
3950 Hospital Offload	702,308
Network Upgrade 2015	578,225
End User Devices 2015	552,858
1350 S. Eliseo Roof	474,163
Internal Moves for Hospital Replacement	403,034
McKesson Upgrades 2015	356,791
2nd Floor ICU Flex	301,145
2 Bon Air TIs Cardiovascular	237,764
ICD 10 Readiness	218,804
Perimeter Access Control	206,714
2 Belvedere NBIM/23 Reed	206,399
MGH IT Data Center	189,990
Data Center Expansions	182,556
1350 S. Eliseo Ste 300 Kelley/GynOnc	161,614
2014 Emergency services Master Planning	153,683
Perioperative Access Control	143,132
No Lift Linen Collection System	138,198
Interventional Radiology	133,625
OR Flooring /Wall Protection	129,695
West Wing AC-1 for Elevator Room	100,158
Other CIP Under $100K	593,046
Total Construction in Progress	**9,373,659**

Total Capital Expenditures	**17,582,112**

Schedule 6: Clinical Quality Reporting Metrics

- **Tier 2, Quality, Safety and Compliance**
  The MGH Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in MGH's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CLABSI, preventive care programs).

CLINICAL QUALITY METRICS DASHBOARD

Metrics are publicly reported on CalHospital Compare (www.calhospitalcompare.org), and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

Abbreviations and Acronyms Used in Dashboard Report

Term	Title/Phrase
Abx	Antibiotics
ACC	American College of Cardiology
ACE	Angiotensin Converting Enzyme Inhibitor
AMI	Acute Myocardial Infarction
APR DRG	All Patient Refined Diagnosis Related Groups
ARB	Angiotensin Receptor Blocker
ASA	American Stroke Association
C Section	Caesarian Section
CHART	California Hospital Assessment and Reporting Task Force
CLABSI	Central Line Associated Blood Stream Infection
CMS	Centers for Medicare and Medicaid Services
CT	Computerized Axial Tomography (CAT Scan)
CVP	Central Venous Pressure
ED	Emergency Department
HF	Heart Failure
Hg	Mercury
hr(s)	hour(s)
ICU	Intensive Care Unit
LVS	Left Ventricular Systolic
LVSD	Left Ventricular Systolic Dysfunction
NHSN	National Healthcare Safety Network
PCI	Percutaneous Coronary Intervention
PN	Pneumonia
POD	Post-op Day
Pt	Patient
SCIP	Surgical Care Improvement Project
ScVO2	Central Venous Oxygen Saturation
STEMI	ST Elevated Myocardial Infarction (ST refers to the EKG tracing segment)
VAP	Ventilator Associated Pneumonia
VHA	Voluntary Hospitals of America
VTE	Venous Thromboembolism

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

METRIC	CMS**	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Q4-Qtr %	Q4-2015 Num/Den	Rolling %	Rolling Num/Den
♦ Venous Thromboembolism (VTE) Measures																	
VTE prophylaxis	100%	98%	83%	84%	97%	95%	97%	95%	100%	100%	95%	100%	97%	**97%**	109/112	**95%**	467/492
ICU VTE prophylaxis	100%	93%	100%	89%	100%	100%	89%	100%	100%	100%	100%	100%	100%	**100%**	28/29	**97%**	98/101
VTE patients with anticoagulation overlap therapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	12/12	**100%**	62/62
VTE warfarin therapy discharge instructions	100%	83%	100%	33%	80%	100%	75%	33%	50%	100%	0%	100%	25%	**33%**	2/6	**65%**	28/43
Hospital acquired potentially-preventable VTE +	0%	N/A	0%	0%	N/A	N/A	0%	N/A	N/A	N/A	0%	N/A	0%	**0%**	0/4	**0%**	0/10
♦ Global Immunization (IMM) Measures																	
* Influenza immunization	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	93%	90%	91%	**91%**	229/251	**91%**	449/509
♦ Stroke Measures																	
Venous thromboembolism (VTE) prophylaxis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	41/41	**100%**	157/157
Thrombolytic therapy	100%	N/A	100%	100%	100%	100%	N/A	100%	100%	100%	100%	100%	100%	**100%**	6/6	**100%**	15/15
Discharged on statin medication	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	**100%**	34/34	**99%**	95/96
Stroke education	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	**95%**	21/22	**99%**	68/69
♦ ED Inpatient (ED) Measures																	
Median time ED arrival to ED departure - Minutes	260***	326.00	271.50	307.00	328.00	355.00	290.00	296.00	312.00	289.00	298.00	311.00	282.00	**297.00**	167--cases	**305.46**	702--cases
Admit decision median time to ED departure time - Minutes	89***	125.00	111.00	127.00	139.50	127.00	87.00	111.50	101.50	96.00	104.00	171.00	133.00	**136.00**	167-cases	**119.46**	696--cases
♦ ED Outpatient (ED) Measures																	
Median time ED arrival to ED discharge +	139***	157.00	160.00	16.00	103.50	178.00	133.50	150.00	151.00	153.00	188.00	118.00	146.00	**150.67**	101--cases	**153.33**	404--cases
Door to diagnostic evaluation by qualified medical personnel +	29***	37.00	32.50	33.00	21.00	33.00	24.50	16.00	133.00	13.00	11.00	13.50	13.00	**12.50**	101--cases	**31.71**	405--cases
♦ Outpatient Pain Management Measure																	
Median time to pain management for long bone fracture - Mins +	54***	56.50	71.00	73.00	74.50	82.00	56.00	44.00	55.50	61.50	72.00	76.00	41.00	**63.00**	59--cases	**63.58**	191--cases
♦ Outpatient Stroke Measure																	
Head CT/MRI results for stroke patients within 45 mins of ED arrival	66%***	57%	83%	84%	80%	79%	83%	57%	60%	62%	79%	80%	76%	**80%**	4/5	**73%**	8/11

* CMS Reduction Program (shaded in blue)
** CMS Top Decile Benchmark
*** National Average
TJC: The Joint Commission measures may be CMS voluntary
+ Lower number is better

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

♦ Acute Care Readmissions - 30 Day Risk Standardized

METRIC	CMS National Average	July 2008 - June 2011	July 2009 - June 2012	July 2010 - June 2013	July 2011 - June 2014
* Acute Myocardial Infarction Readmission Rate	17.00%	18.00%	16.70%	15.90%	16.10%
* Heart Failure Readmission Rate	22.00%	24.70%	22.60%	23.00%	22.80%
* Pneumonia Readmission Rate	16.90%	17.90%	16.20%	15.00%	14.10%
* COPD Readmission Rate	20.20%			19.00%	18.40%
Stroke Readmission Rate	12.70%			12.10%	11.10%
* Total Hip Arthoplasty and Total Knee Arthoplasty Readmission Rate	4.80%		5.80%	5.30%	4.60%
Coronary Artery Bypass Graft Surgery (CABG)	14.90%				15.60%
Hospital-Wide All-Cause Unplanned Readmission (HWR)	15.20%			14.40%	14.90%

♦ Outpatient Measures (Claims Data)

METRIC	CMS National Average	Jan 2011 - Dec 2011	July 2012 - June 2013	July 2013 - June 2014	
Outpatient with low back pain who had an MRI without trying recommended treatments first, such as physical therapy	37.20%	Not available	Not available	Not available	
Outpatient who had follow-up mammogram, ultrasound, or MRI of the breast within 45 days after the screening on the mammogram	8.90%	7.70%	7.40%	6.70%	
Outpatient CT scans of the abdomen that were "combination" (double) scans +	9.40%	6.00%	5.60%	6.10%	
Outpatient CT scans of the chest that were "combination" (double) scans +	2.40%	1.40%	0.40%	0.30%	
Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery +	5.00%	5.56%	2.60%	2.90%	
Outpatients with brain CT scans who got a sinus CT scan at the same time +	2.80%	1.70%	2.30%	1.80%	
METRIC	**CMS National Average**			**Jan 2013 - Dec 2013**	
Patient left Emergency Dept. before being seen	2.00%			1.00%	

♦ Agency for Healthcare Research and Quality Measures (AHRQ-Patient Safety Indicators)

METRIC	CMS National Average	Oct 2010 - June 2012	July 2011 - June 2013	July 2012 thru June 2014	
* Complication / Patient Safety Indicators PSI 90 (Composite)	0.81	Worse than National Average	Worse than National Average	No different than National Average	
Death Among Surgical Patients with Serious Complications	117.52 per 1,000 patient discharges	No different than National Average	No different than National Average	No different than National Average	

* CMS Reduction Program (shaded in blue)

\+ Lower Number is Better

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

♦ Surgical Site Infection

METRIC	National Standardized Infection Ratio (SIR)	July 2013 - June 2014	Oct 2013 - Sep 2014	Jan 2014 - Dec 2014	April 2014 - March 2015	
* Colon surgery	1	1.19	0.54	0.58	0.00	No Different than U.S. National Benchmark
* Abdominal hysterectomy	1	not published**	not published**	not published**	not published**	

♦ Healthcare Associated Infections (ICU)

METRIC	National Standardized Infection Ratio (SIR)	July 2013 - June 2014	Oct 2013 - Sep 2014	Jan 2014 - Dec 2014	April 2014 - March 2015	
* Central Line Associated Blood Stream Infection Rate (CLABSI)	1	0.27	0.29	0.30	0.00	No Different than U.S. National Benchmark
* Catheter Associated Urinary Tract Infection (CAUTI)	1	1.10	1.41	2.09	1.76	No Different than U.S. National Benchmark

♦ Healthcare Associated Infections (Inpatients)

METRIC	National Standardized Infection Ratio (SIR)	July 2013 - June 2014	Oct 2013 - Sep 2014	Jan 2014 - Dec 2014	April 2014 - March 2015	
* Clostridium Difficile	1	1.16	1.20	1.29	1.25	No Different than U.S. National Benchmark
* Methicillin Resistant Staph Aureus Bacteremia	1	1.63	2.04	1.95	1.59	No Different than U.S. National Benchmark

♦ Healthcare Personnel Influenza Vaccination

METRIC	CMS National Average	Oct 2013 - March 2014	Oct 2014 - March 2015			
Healthcare Personnel Influenza Vaccination	84%	71%	81%			No Different than U.S. National Benchmark

♦ Surgical Complications

METRIC	CMS National Average	July 2009 - March 2012	April 2010- March 2013	April 2011 - March 2014		
Hip/knee complication: Hospital-level risk -- Standardized complication rate (RSCR) following elective primary total hip/knee arthoplasty	3.1%	4.0%	4.4%	3.6%		

♦ Cost Efficiency

METRIC	CMS National Average	Jan 2013 - Dec 2013	July 2010 - June 2013	July 2011 thru June 2014	Jan 2014 thru Dec 2014	
*Medicare spending per beneficiary (All)	0.98	1.01			1.00	
Acute Myocardial Infarction payment per episode of care	$21,791		$20,850	$22,019		
Heart Failure payment per episode of care	$15,223			$16,871		
Pneumonia payment per episode of care	$14,294			$14,889		

♦ Mortality Measures - 30 Day

METRIC	CMS National Average	July 2008 - June 2011	July 2009 - June 2012	July 2010 - June 2013	July 2011 - June 2014	
* Acute Myocardial Infarction Mortality Rate	14.2%	13.5%	13.3%	12.60%	11.70%	
* Heart Failure Mortality Rate	11.6%	12.9%	13.8%	12.0%	12.6%	
* Pneumonia Mortality Rate	11.5%	10.7%	10.9%	12.2%	12.3%	
* CABG 30-day Mortality Rate (PD 2017)	3.2%				2.6%	
COPD Mortality Rate	7.7%			7.8%	7.3%	
Stroke Mortality Rate	14.8%			15.2%	13.4%	

* CMS Reduction Program (shaded in blue)

** Insufficient data to calculate SIR

Schedule 7: External Awards & Recognition

- **Tier 2, Patient Satisfaction and Services**
  The Board will report external awards and recognition.

External Awards and Recognition – 2015
Healthgrades *Distinguished Hospital Award for Clinical Excellence.* *A complete list of 5-star ratings and additional excellence awards are published on the Marin General Hospital website.*
American Heart/Stroke Association *Get With the Guidelines-Stroke Gold Plus Quality Achievement Award*
Leapfrog Group "A" Grade for Hospital Safety
Intersocietal Accreditation Commission *Echocardiography 3-year Accreditation*
The Joint Commission *Top Performer on Key Quality Measures*
North Bay Business Journal *Bay Area's Healthiest Employers*
Marin Magazine *Top Doctors 2015* *Over 250 physicians in 42 specialties practicing at MGH on the Top Doctor List*
American College of Radiology (ACR) *MRI & Ultrasound 3-year Accreditation*
American College of Surgeons *Commission on Cancer Outstanding Achievement Award*
Beta Healthcare *Quest for Zero: Excellence in ED* *Quest for Zero: Excellence in OB*

Schedule 8: Community Benefit Summary

- **Tier 2, Community Commitment**
  The Board will report all of MGH's cash and in-kind contributions to other organizations.
  The Board will report on MGH's Charity Care.

Cash & In-Kind Donations (these figures are not final and are subject to change)					
	1Q 2015	**2Q 2015**	**3Q 2015**	**4Q 2015**	**Total 2015**
American Cancer Society (Relay for Life)	5,000	0	0	0	5,000
American Heart Association (Heart Walk)	2,500	0	0	0	2,500
Coastal Health Alliance	0	32,500	0	0	32,500
Community Institute for Psychotherapy	0	15,000	0	0	15,000
ExtraFood.org	0	0	3,000		3,000
Healthy Aging Symposium	1,000	0	0	0	1,000
Homeward Bound	0	65,000	65,000	0	130,000
Hospice by the Bay (Ball)	0	0	2,200	0	2,200
Marin Brain Injury Network	638	0	0	0	638
Marin City Health and Wellness	0	20,000	0	0	20,000
Marin Community Clinics	55,830	165,170	0	0	221,000
Marin Community Clinics, Summer Solstice	0	1,000	0	0	1,000
Marin Senior Fair	0	0	2,000	0	2,000
MHD 1206(b) Clinics	1,128,298	1,538,856	1,344,880	1,779,484	5,791,518
Prima Medical Foundation	1,550,000	1,692,692	3,380,103	2,954,955	9,577,750
Ritter Center	0	20,000	0	0	20,000
RotaCare San Rafael	0	0	15,000	0	15,000
San Rafael Streets Team	0	10,000	0	0	10,000
Slide Ranch	0	1,500	0	0	1,500
To Celebrate Life	15,000	0	0	0	15,000
Whistlestop	0	15,000	0	0	15,000
Wine, Women & Song Breastival	0	0	0	5,000	5,000
Zero Breast Cancer Foundation	0	2,200	0	0	2,200
Total Cash Donations	**$2,758,266**	**$3,578,918**	**$4,812,183**	**$4,739,439**	**$15,888,806**
Compassionate discharge medications	655	830	1,168	454	3,107
Meeting room use by community based organizations for community-health related purposes.	2,430	2,750	2,708	2,002	9,890
Food donations	992	913	913	913	3,731
Total In Kind Donations	**$4,077**	**$4,493**	**$4,789**	**$3,369**	**$16,728**
Total Cash & In-Kind Donations	**$2,762,343**	**$3,583,411**	**$4,816,972**	**$4,742,808**	**$15,905,534**

Schedule 8, continued

Community Benefit Summary

(these figures are not final and are subject to change)

	1Q 2015	2Q 2015	3Q 2015	4Q 2015	Total 2015
Community Health Improvement Services	36,278	32,638	66,447	20,823	156,186
Health Professions Education	343,188	236,619	104,894	222,507	907,208
Cash and In-Kind Contributions	2,762,343	3,583,411	4,816,972	4,742,808	15,905,434
Community Benefit Operations	14,517	22,537	20,198	38,243	95,495
Traditional Charity Care *Operation Access total is included	322,987	512,723	656,076	532,068	2,023,853
Government Sponsored Health Care (includes Medi-Cal & Means-Tested Government Programs)	3,950,638	4,069,476	3,898,387	3,749,544	15,668,044
Community Benefit Subtotal (amount reported annually to State & IRS)	**$7,429,951**	**$8,457,404**	**$9,562,974**	**$9,305,993**	**$34,756,320**
Community Building Activities	2,813	2,274	0	0	5,087
Unpaid Cost of Medicare	19,735,612	19,475,248	17,453,845	17,744,654	74,409,359
Bad Debt	526,063	377,401	514,394	336,337	1,754,196
Community Benefit, Community Building, Unpaid Cost of Medicare and Bad Debt Total	**$27,694,439**	**$28,312,327**	**$27,531,213**	**$27,386,984**	**$110,924,962**

Operation Access

Though not a Community Benefit requirement, MGH has been participating with Operation Access since 2000. Operation Access brings together medical professionals and hospitals to provide donated outpatient surgical and specialty care for the uninsured and underserved.

	1Q 2015	2Q 2015	3Q 2015	4Q 2015	Total 2015
*Operation Access charity care provided by MGH (waived hospital charges)	439,833	89,090	233,091	246,088	1,008,102
Costs included in Charity Care	90,984	18,429	48,217	50,906	208,537

Schedule 9: "Green Building" Status

- **Tier 2, Community Commitment**
  The Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.

Leadership in Energy and Environmental Design (LEED)

Leadership in Energy and Environmental Design (LEED) is a third-party nationally accepted certification program that consists of a suite of rating systems for the design, construction and operation of high performance "green buildings." This ensures that the buildings are environmentally compatible, provide a healthy work environment, and are profitable.

LEED-certified buildings are intended to use resources more efficiently when compared to conventional buildings simply built to code. LEED-certified buildings often provide healthier work and living environments, which contributes to higher productivity and improved employee health and comfort.

MGH LEED Status
MGH Hospital Replacement Project is registered with the United States Green Building Council (USGBC) as a New Construction Project
MGH Hospital Replacement Project has retained Thornton Tomasetti, specializing in LEED requirements
All key members of the Design Team are LEED certified
Through Design Development of the Hospital Replacement Project, the Project has maintained LEED Silver status
The Project Team will conduct cost benefit analysis on LEED requirements in order to achieve a certification higher than LEED Silver (LEED Gold)

Schedule 10: Physicians on Staff

- **Tier 2, Physicians and Employees**
  The Board will provide a report on new recruited physicians by specialty and active number of physicians on staff at MGH.

As of December 31, 2015, there were a total of 493 physicians on MGH staff:

- 264 Active
- 79 Provisional
- 42 Courtesy
- 62 Consulting
- 46 Office-Based

New Physician Appointments
January 1, 2015 – December 31, 2015

	Name	Appointment Date	Specialty
1	Aviado, Domingo G.	11/24/2015	Family Medicine
2	Aghayan, Aric S.	11/24/2015	Surg-Plastic
3	Allison, Stephen C.	2/24/2015	Psychiatry
4	Anderson, Kristin N.	10/27/2015	Med-Oncology
5	Brown, Elizabeth R.	10/27/2015	Obst-OBGYN
6	Chakrabarti, Anindita	11/24/2015	Med-Medical Hospitalist
7	Chang, Helen P.	1/27/2015	Pediatrics
8	Chen, James C.	3/24/2015	Radiology
9	CooperVaughn, Margaret V.	2/24/2015	Obst-OBGYN
10	Debayle, Melissa M.	10/27/2015	Radiology
11	Desai, Tina R.	8/25/2015	Surg-Vascular
12	DiMaio, Michael A.	6/23/2015	Pathology
13	Elmi, Eman	8/25/2015	Surg-Podiatry
14	Fromont, Sebastien C.	12/1/2015	Psychiatry
15	Gandhe, Renu M.	6/23/2015	Pediatrics
16	Greenberg, Harvey M.	8/25/2015	Radiology
17	Greenspan, Stacey L.	12/29/2015	Radiology
18	Jaeger, Amber L.	10/27/2015	Obst-OBGYN
19	Kamal, Oendrila	10/27/2015	Surg-Podiatry
20	Kim, Paul H.	10/27/2015	Orthopedic Surgery
21	Kubrican, Tomas	1/27/2015	Family Medicine
22	Maliro, Tennyson M.	6/23/2015	Radiology
23	Martin, Joshua H.	10/27/2015	Pediatrics
24	Meisel, Lauren W.	2/24/2015	Pediatrics
25	Naderi, Nadia	11/24/2015	Pathology

Schedule 10, continued

26	Newman, Patrick M.	6/23/2015	Pediatrics
27	Norwood, Aliza	4/8/2015	Med-Internal Medicine
28	Otto, Tara M	3/24/2015	Radiology
29	Sanders, Timothy A.	10/27/2015	Pediatrics
30	Santucci, Stephen A.	6/23/2015	Pediatrics
31	Satterwhite, Thomas S.	2/24/2015	Surg-Plastic
32	Schmidt, Katherine E.	3/24/2015	Med-Medical Hospitalist
33	Shah, Tushar V.	12/29/2015	Med-Medical Hospitalist
34	Shimotake, Janet C.	10/27/2015	Pediatrics
35	Ullah, Nushrat J.	10/27/2015	Med-Internal Medicine
36	Westphal, Suzanne L.	8/25/2015	Med-Dermatology
37	Whetsell, William M.	4/28/2015	Radiology

Schedule 11: Nursing Turnover, Vacancies, Net Changes

- **Tier 2, Physicians and Employees**
  The MGH Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at MGH.

Turnover Rate				
Quarter	Number of Clinical RNs	Terminated		Rate
		Voluntary	Involuntary	
1Q 2015	534	9	6	2.81%
2Q 2015	536	13	5	3.36%
3Q 2015	522	32	6	7.28%
4Q 2015	515	12	7	3.69%

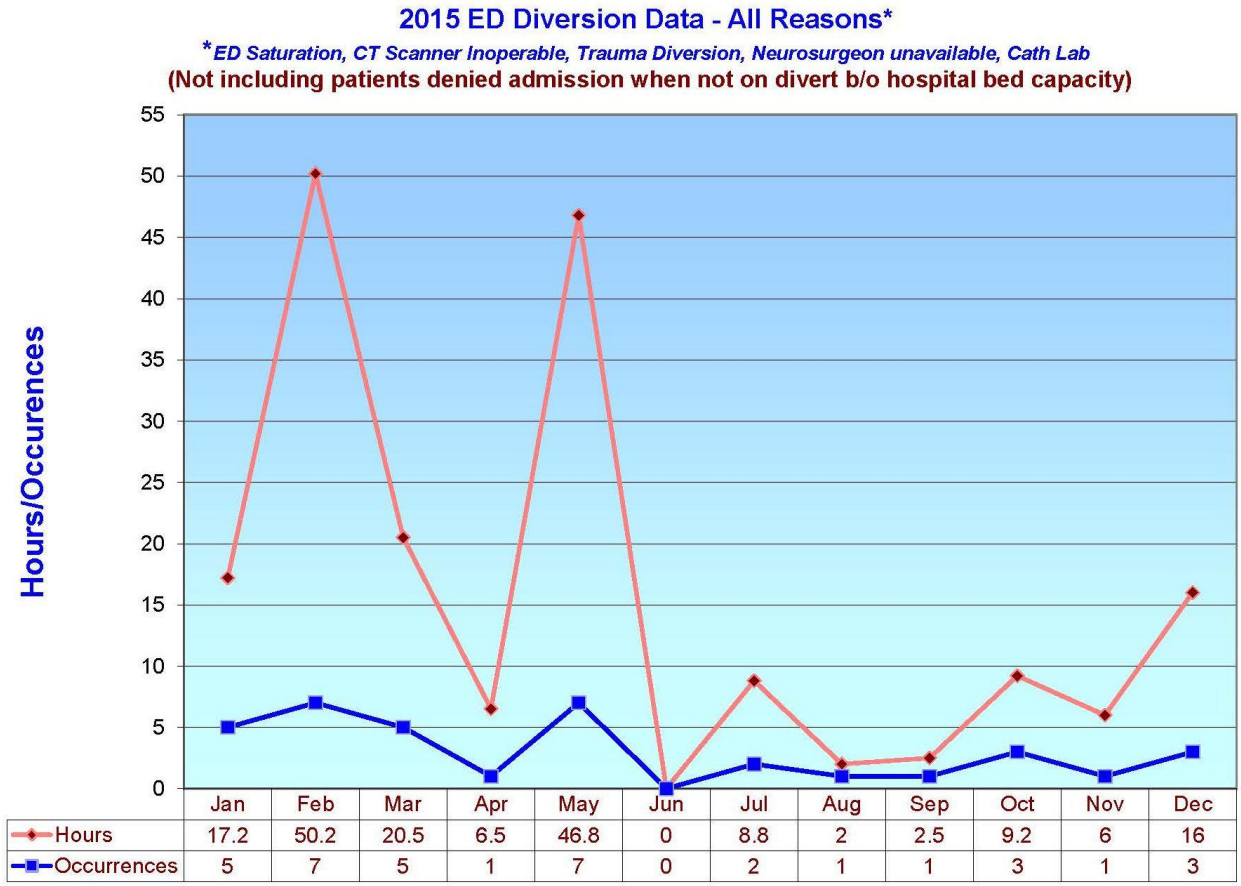
Vacancy Rate									
Period	Per Diem Postings	Benefited Postings	Per Diem Hires	Benefited Hires	Benefited Headcount	Per Diem Headcount	Total Headcount	Benefited Vacancy Rate	Per Diem Vacancy Rate
1Q 2015	13	53	3	7	412	122	534	12.86%	10.66%
2Q 2015	26	79	2	22	419	117	536	18.85%	22.22%
3Q 2015	30	77	3	23	424	98	522	18.16%	30.61%
4Q 2015	37	96	7	17	422	93	515	22.75%	39.78%

Hired, Termed, Net Change			
Period	Hired	Termed	Net Change
1Q 2015	10	15	(5)
2Q 2015	24	18	6
3Q 2015	26	38	(12)
4Q 2015	24	19	5

Schedule 12: Ambulance Diversion

- **Tier 2, Volumes and Service Array**
  The MGH Board will report on current Emergency services diversion statistics.

Quarter	Date	Time	Diversion Duration	Reason	ED Census	Waiting Room Census	ED Admitted Patient Census
4Q 2015	Oct 25	1303-1620	3hr, 17mn	ED saturation	16	15	n/a
4Q 2015	Oct 26	2000-2355	3hr, 55mn	ED saturation	35	10	n/a
4Q 2015	Oct 28	1856-2056	2hr	ED saturation	38	12	8
4Q 2015	Nov 29	1651-2251	6hr	ED saturation	22	5	6
4Q 2015	Dec 1	1837-2235	4hr	ED saturation	33	6	10
4Q 2015	Dec 21	1617-2017	4hr	ED saturation	35	7	3
4Q 2015	Dec 22	0045-0854	8hr	ED saturation	12	0	6



Tab 3

TENTH RESTATEMENT OF BYLAWS

OF

MARIN GENERAL HOSPITAL,

a California nonprofit public benefit corporation

Includes Revisions effective June 30, 2010, and amendments of August 5, 2010, November 3, 2011, ~~and~~ September 5, 2013, December 5, 2013, March 6, 2014, December 4, 2014, and _____ 2016

TENTH RESTATEMENT OF BYLAWS

OF

MARIN GENERAL HOSPITAL,
a California nonprofit public benefit corporation

ARTICLE I
NAME AND PRINCIPAL OFFICE

1.1 Name. The name of the Corporation shall be as listed in the Articles of Incorporation, namely, Marin General Hospital ("MGH"), a nonprofit public benefit corporation organized under the laws of the State of California.

1.2 Principal Office and Place of Business. This Corporation shall have and continuously maintain a registered office in Marin County and may have other offices within the State of California, as the Board may from time to time determine.

ARTICLE II
PURPOSES

This Corporation was formed for the purposes set forth in its Articles of Incorporation.[1] The property of the Corporation is irrevocably dedicated to public, charitable, educational and hospital purposes which meet the requirements of Section 501(c)(3) of the Internal Revenue Code and

[1] As of the date of the adoption of this Tenth Restatement of Bylaws, Paragraph B of Article SECOND of the articles of incorporation provides as follows:

B. The primary purposes of this corporation are:

1. To establish, equip and maintain one or more nonprofit hospitals, medical centers, institutions or other places for the reception and care of the sick, injured and disabled, with permanent facilities that include inpatient beds and medical services; to provide diagnosis and treatment for patients; and to provide associated services, outpatient care and home care in furtherance of this corporation's charitable purposes;

2. To promote and carry on educational activities related to the care of the sick, injured and disabled, or to the promotion of health;

3. To promote and carry out scientific research related to the care of the sick, injured and disabled; and

4. To promote or carry out such other activities as may be deemed advisable for the betterment of the general health of the community served.

Sections 23701 and 214 of the California Revenue and Taxation Code.

ARTICLE IIIMEMBERSHIP

3.1 General Member. There shall be one member of this Corporation who shall be the Marin Healthcare District, a political subdivision of the State of California (the "General Member"). The General Member, and only the General Member, shall be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the California Nonprofit Public Benefit Corporation Law, and all other applicable laws. The rights and powers of the General Member shall also include, without limitation, the following: the limitation on liabilities described in Section 3.3 of these Bylaws; the right to reject selection of all of the members of the Board of this Corporation, subject to Sections 4.4 (g) of these Bylaws; and the exercise of all of the rights set forth in Articles X and XI of these Bylaws. The General Member may not be expelled or suspended as the General Member without its consent. Any reference in these Bylaws to the "member," "Member," "general member," "General Member," "corporate member," or "Corporate Member" of this Corporation, or any similar such reference, shall mean the Marin Healthcare District, a political subdivision of the State of California. By reason of the rights or status of the General Member herein, there has been no express or implied delegation of any public agency authority from the General Member to this Corporation.

3.2 Exercise of Membership Rights. The General Member shall exercise its membership rights through its own Board of Directors. Subject to the provisions of the General Member's own bylaws, and except as otherwise provided in these Bylaws, the Board of Directors of the General Member may, by resolution, authorize a person or committee of persons to exercise its vote on any matter to come before the membership of this Corporation. In addition, the General Member may exercise its membership rights at any regular or special meeting of the Board of Directors of the General Member. The functions required by law or by these Bylaws to be performed at the annual membership meeting or any regular or special meeting of the members of this Corporation may be performed at any regular or special meeting of the General Member's own Board of Directors. ~~.~~

3.3 Liabilities and Assessments. The General Member shall not be liable for the debts of this Corporation. The Board of this Corporation shall have no power to levy and collect assessments on the General Member. The provisions of this paragraph cannot be amended in any manner.

ARTICLE IV
BOARD OF DIRECTORS

4.1 Responsibility. Except as otherwise provided by the Articles of Incorporation or by

these Bylaws, the management of the affairs of this Corporation shall be vested in a Board of Directors (the "Board"). Specifically, the Board of Directors shall be empowered as follows:

(a) To control and be responsible for the overall governance of MGH, including the provision of management and planning.

(b) To make and enforce all rules and regulations necessary for the administration, governance, protection and maintenance of MGH and other facilities under its jurisdiction and to ensure compliance with all applicable laws.

(c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the Hospital, and affiliated entities, as specified herein and consistent with Board of Directors' Policies.

(d) To periodically review and develop a strategic plan for the Hospital.

(e) To determine policies and approve procedures for the overall operation and affairs of the Hospital and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

(f) To evaluate the performance of the Hospital in relation to its vision, mission and goals.

(g) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

(h) To be ultimately accountable for the safety and quality of care, treatment and services.

(i) To review and approve annual operating and capital budgets as may be further specified herein and within financial policies adopted by the Board.

(j) All powers of the Board of Directors, which are not otherwise restricted by law, agreement, or herein, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed or engaged by or with responsibilities to the Corporation, to be exercised in accordance with that delegation.

(k) To implement Compliance Program oversight consistent with Hospital wide Compliance programs and procedures, including, responsibility for an effective Compliance Program and adoption of related policies, review of routine and special

Compliance reports or a regular basis, appropriate delegation of implementation to senior management, and Board training on Compliance Program oversight and implementation.

(l) To adopt operational policies designed to promote the responsible use of healthcare resources while striving for the best outcomes for quality, services and costs.

(m) To do any and all other act and things necessary to carry out the provisions of these Bylaws or of the provisions of the California Nonprofit Public Benefit Corporation Law.

4.2 Number. The Board shall, until changed by amendment to these Bylaws, consist of a maximum of thirteen (13) members and no less than nine (9) voting members.

4.3 Composition of the Board.

(a) Community Directors. Six to ten of the members of the Board shall be persons who reside or have their principal place of business in Marin County (the "Community Directors").

(b) Physician Directors. Two members of the Board shall be licensed physicians who are active members in good standing of the Medical Staff. In addition to his or her representative status as set forth in Section 7.1 below, at the discretion of the Board, the Chief of the Medical Staff may be designated an ex officio non-voting member of the Board.

(c) Chief Executive Officer. The Chief Executive Officer of the Corporation shall serve ex officio as a voting member of the Board.

4.4 Nomination and Selection of the Board.

(a) Nominating Committee. The Board shall establish, as a standing committee, a Nominating committee to identify and present candidates to the Board for selection by the Board to the Board (**"Nominating Committee"**). If the Nominating Committee becomes other than a standing committee, the Board shall establish the Nominating Committee whenever a vacancy on the Board exists, or at least ninety (90) days prior to the expiration of the term of any Community Director or Physician Director. The members of the Nominating Committee shall serve at the discretion of the Board. Potential Director names can be submitted at any time to the Committee by the General Member, its officers and directors, the Board and its officers, self nominations, or other community resources solicited by the Board or the Committee. The Committee shall evaluate candidates based on qualifications and criteria set forth in Section 4.4 (e) below.

(b) Nomination of Physician Directors. For the nomination of the Physician

Directors, the MGH Medical Staff shall propose nominees to the Nominating Committee. For each vacant position the Medical Staff shall propose to the Nominating Committee at least three (3) physicians. The Nominating Committee shall select a physician nominee from the candidates forwarded by the Medical Staff, or from other nominees, and present the candidate to the Board.

(c) Exclusion from Nominations. Persons who serve on the Nominating Committee shall not be nominated by that committee for a Director position.

(d) Exclusion from Vote. If a nominee is currently a Director, that Director shall not vote or be present for the vote regarding any of the nominees (including him or herself), and shall not be included for purposes of counting the total number of Directors eligible to vote for the election of Directors, but shall be counted for purposes of a quorum.

(e) Qualifications and Criteria. Directors shall be experienced and successful in professional, organizational, and community activities, and shall be selected for their willingness and ability to participate effectively in fulfilling the Board's responsibilities and working with existing Directors. Directors shall demonstrate dedication to MGH and professional and functional expertise in identified skill mix needs of the Board. Directors shall, in addition, meet criteria adopted by the General Member, which criteria are attached hereto and incorporated into these Bylaws as Attachment A. Potential Directors will be vetted by the Nominating Committee for ability to comply with the Board's Conflict of Interest Policy.

(f) Board Selection. The Nominating Committee shall advance candidates and supporting information to the Board one month or more in advance of a regular Board meeting. Unscheduled appointments will be considered as candidates are identified and presented to the Board at a regular meeting. The Board shall select candidates so advanced by a two-thirds vote of members voting. Board members so re-appointed shall assume Board membership upon commencement of their new term. New Board candidates selected by the Board shall be submitted to the General Member for approval. Candidates approved after submission to the General Member shall assume Board membership.

(g) General Member Right to Reject**.** The Board shall select new members based upon its nominating and Nominating Committee process outlined in Section 4.4 (a) through (f) above. The Nominating Committee shall, prior to making its selection, seek in good faith the input of the General Member through its officers regarding candidates under its consideration. The Nominating Committee shall also maintain a dialogue with the General Member through its officers during the nomination process. Once such a selection has been made by the Board following the Nominating Committee process, the Board shall notify the General Member of its selection at least 20 days prior to a scheduled General Member Board meeting, and the General Member shall have two meeting cycles after the candidate's submission to approve or reject the Corporation's selection. The General Member may interview the candidate submitted by the Board. Failure of the General Member to act on a candidate within one meeting cycle of the

candidate's submission shall be deemed approval. If such selection is rejected, then the Board shall select another candidate, and the notification and acceptance/rejection process shall be repeated.

If the second candidate is also rejected, and the minimum Board membership cannot be maintained without General Member approval of a new Board member, then the Board shall forward two selections to the General Member and the General Member shall approve one such selection. If the General Member fails within one meeting cycle to approve one such selection, then the parties shall submit the matter to binding arbitration by one arbitrator in Marin County, California, in accordance with the commercial arbitration rules of the American Arbitration Association. The standard for the arbitrator shall be whether the Corporation reasonably followed the criteria established herein. If the arbitrator determines that the Corporation did reasonably follow the criteria, and the arbitrator determines that only one of the two candidates meets these criteria, that person shall be deemed the new Director. If both are held by the arbitrator to meet the criteria, then the first one selected of those who meet the standard shall be the new Director. If neither are held by the arbitrator to have met
the standard, both shall be considered rejected and the process outlined above shall commence again (i.e., two rights to reject, followed by arbitration).

4.5 Term. Directors, other than the CEO and Chief of Staff (if an ex officio member), shall serve four year terms. Director's terms shall be considered commenced in January of the calendar year of appointment. Directors can serve, if reappointed, a maximum of three terms. If Board membership is less than 11 members upon the expiration of a Director's third term, the Board may appoint the Director to an additional one year term, up to a maximum of three such extensions. No Director may serve more than 15 years or be appointed to a term that would result in service of more than 15 years. Notwithstanding the foregoing, to promote staggered incumbent terms, the Directors first seated in 2010, or Directors replacing members first seated in 2010, shall by a rotation determined by the Board prior to the expiration of their terms in 2018, each serve successive terms according to the following schedule:

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
CEO		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
General	1					●				▲				●					
Directors	2					●				▲				●					
	3					●				●	▲				●				
	4					●				●	▲				●				
	5					●				●		▲				●			
	6					●				●		▲				●			
	7					●				●			▲				●		
	8					●				●			▲				●		
	9					●				●				▲				●	
	10					●				●				▲				●	
	11		▲				●				●				▲				●
	12		▲				●				●				▲				●

● = Reconfirmation
▲ = New Director Appointment (Seats 11 and 12 to commence terms in actual year of appointment)

To maintain staggered incumbent terms after 2018 consistent with the above chart's established seat terms, and upon the recommendation of the Nominating Committee, new Directors, other than the CEO, appointed to serve initial terms or to fill vacancies created prior to expiration of the former Director's term, shall be appointed to hold office for an initial term designated by the Board at the time of appointment of 1 to 4 years. At the time of appointment the Board shall also designate whether the new Director may serve, if re-appointed, 1 to 3 additional three year terms; however, no Director shall be eligible for, or appointed to, a new term that would cause the Director to serve more than 15 consecutive years. Former Directors are eligible for new appointments to the Board after having left the Board for at least two full years.

4.6 Vacancies. Any vacancy occurring on the Board of this Corporation shall be filled if it would render the Board with less than 9 members. The Board shall elect whether to declare a vacancy and fill vacancies when at least 9 members remain on the Board. Vacancies shall be filled by the nominating process provided in Section 4.4 and with terms as provided in Section 4.5.

4.7 Removal. Upon the majority vote of the remaining members of the Board, the Board may declare vacant the office of any Director who has: been declared of unsound mind by a final order of court; been convicted of a felony or a crime of moral turpitude; been found by a final order or judgment of any court to have breached any duty of a director under these Bylaws, the Articles of Incorporation or the California Corporations Code; failed to attend meetings according to attendance requirements established by the Board, or for such other cause, including but not limited to: (1) repeated and continuing conduct disruptive to the operation of the Board, which in the opinion of the majority of the remaining members of the Board renders such director unable or unfit to properly discharge his or her duties and responsibilities to this Corporation; (2) failure to comply with the Board' s Conflict of Interest or Fiduciary Policies, failure to continue to meet on-going Director qualifications (e.g., moves residence and/or business out of the community); or (3) as authorized or permitted by applicable non-profit corporation law.

The General Member may remove a Director for (1) violation of the Board's Conflict of Interest Policy and failure of the Board to enforce compliance with the Policy; (2) a conviction for a felony or crime of moral turpitude and failure of the Board to remove the Director; (3) failure of a Director to vacate a board seat after expiration of his or her term without eligibility for re-appointment and failure of the Board to remove the Director, and (4) upon termination or expiration of that certain Lease entered into between the Corporation and the General Member ~~dated _____, 201_~~ commencing December 2, 2015. The Corporation shall notify the General Member within five business days of the Corporation's becoming aware that a Director has or may have violated the Board's Conflict of Interest Policy, has been convicted of a felony or crime of moral turpitude, or has or may have failed to vacate a Board seat after expiration of his or her term without eligibility for re-appointment. Except as provided in Article XI, Performance Metrics and Core Services Policy, Section 11.1 (c), and Article XIV (General Member Remedies Upon Violation of Certain Bylaws Provisions), there are no other grounds for General Member removal of a Director. Prior to

exercising its Director removal rights under this Section 4.7, the General Member must notify the Board Chairperson, or Vice Chairperson if the concern relates to the Chairperson, at least forty-five (45) days in advance of considering action. The Chair of the General Member will initiate a special Ad Hoc Committee comprised of two General Member Board Directors and the MGH Board Chairperson plus additional MGH Board Directors as deemed necessary by the MGH Board Chairperson. The Ad Hoc Committee will be responsible to evaluate the concerns (i.e., suggested grounds for potential removal) and relevant Director situation. The Ad Hoc Committee will recommend action to the General Member if necessary. The Ad Hoc Committee will encourage the MGH Board to convene and take appropriate actions, if necessary, prior to making any recommendations to the General Member.

4.8 Voting Rights. Each voting director shall be entitled to one vote on all matters before the Board. There shall be no voting by proxy.

4.9 Organizational Meeting. As soon as reasonably possible after the Marin Healthcare District becomes the General Member, the Board of Directors shall meet for the purposes of organizing the Board, the election of officers, and the transaction of such other business as may come before the meeting.

4.10 Regular Meetings. The Board shall hold meetings at least quarterly at such time and place as the Board shall from time to time determine.

4.11 Special Meetings. Special meetings of the Board for any purpose or purposes shall be called by the Secretary upon the request of the Chair, the Chief Executive Officer or any two (2) directors.

4.12 Notice of Meetings. Notice of the time and place of any meeting shall be delivered personally, communicated by telephone or electronic mail, or sent to each director by first-class mail, charges prepaid, addressed to the director either at his or her address as it is shown on the records or if it is not so shown or is not readily ascertainable, to the place where the principal office of the Corporation is located. If sent by mail, such notice shall be mailed at least four (4) days prior to the meeting.

4.13 Quorum. A majority of the voting members of the Board then serving shall constitute a quorum at any meeting of the Board provided that the minimum number of voting members of the Board which may constitute a quorum shall be seven (7). The act of the majority of the voting power present at any meeting at which a quorum is present shall be considered the act of the Board.

4.14 Place. The Board shall hold its meetings at the principal office of the Corporation, or the principal office of the General Member, or such other place as the Chair or the directors requesting the meeting may designate.

4.15 Validation of Transactions. The transactions of the Board of Directors at any meeting, however called or noticed, or wherever held, shall be as valid as though had at a meeting duly held after regular call and notice, if a quorum be present and if, either before or after the meeting, each director entitled to vote at the meeting for that purpose not present signs a written waiver of notice, a consent to the holding of such meeting, or an approval of the minutes thereof. All such waivers, consents or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

4.16 Action Without Meeting. Any action required or permitted to be taken by the Board under the provisions of the California Corporations Code, the Articles of Incorporation, or these Bylaws may be taken without a meeting, if all members of the Board shall individually or collectively consent in writing to such action. Such action by written consent shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of such directors. Any certificate or other document filed on behalf of the Corporation relating to an action taken by the Board without a meeting shall state that the action was taken by a unanimous written consent of the Board without a meeting, and that the Bylaws of this Corporation authorize its directors to so act.

4.17 Quorum Initially Present. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of directors if any action is approved by at least a majority of the required quorum for such meeting, or such greater number as is required by the California Corporations Code, the Articles of Incorporation or these Bylaws.

4.18 Telephonic Meetings. Members of the Board may participate in a meeting through use of a conference telephone or similar communications equipment, so long as each director participating in such meeting can simultaneously hear all other directors so participating. Participation in a meeting pursuant to this Section constitutes presence in person at such meeting.

4.19 Public Input Session. At all of its regular meetings the Board shall conduct a session to be open to the public. The Board shall set guidelines for such sessions and shall generally conduct them for the purpose of conveying updates on Hospital affairs and performance to the community, and for receiving input from the community on matters pertaining to MGH and Marin healthcare. In conjunction with periodic reporting requirements set forth in Article 11 [Performance Metrics] herein and other General Member forums held for General Member and public input, upon request by the General Member the Hospital leadership (among Board, Management, and Medical Staff) shall attend an annual public forum for a general report on MGH performance, programs and services, with an opportunity for public input on these and other topics concerning the healthcare needs of the communities served by this Corporation.

4.20 Interested Directors. Not more than forty-nine percent (49%) of the persons serving on the Board at any time may be interested persons. An “interested person” is (i) any person being compensated by the Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or

otherwise (excluding any reasonable compensation paid to a Director for serving in such capacity); and (ii) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, mother-in-law, or father-in-law of any such person. However, any violation of the provisions of this paragraph shall not affect the validity or enforceability of any transaction entered into by the Corporation.

4.21 Hospital Board Director Review and Re-confirmation. In addition to periodic full Board evaluations, the Board shall review Directors annually and in connection with Nominating Committee consideration of re-appointments. All Directors will be reviewed on an annual basis by the Chairperson and / or the Executive Committee. The purpose of the review is to reconfirm commitment and capacity to continue to serve on the Board including evaluation of participation, preparation, fitness to serve, conformance to fiduciary, confidentiality and conflict of interest policies, Board Member criteria (Attachment A) and other requirements. The review may also identify any personal development or education needs for the upcoming year. Prior to the end of a Director's four-year term, the Executive Committee must review the Director's performance, continued qualifications and commitment to serve, and discuss any issues directly with the Director.

4.22 Conflict of Interest Policy**.** The Board shall develop and adhere to a conflict of interest policy that incorporates the provisions of Section 5233 of California Nonprofit Corporation Law. The initial Conflicts Policy shall be that adopted by the General Member prior to adoption of these Bylaws.

4.23 Self-Dealing. Prior to conducting a business session at a meeting of the Board, Board members shall disclose and discuss their individual conflicts or potential conflicts and that of other members of the Board. Actual conflicts shall be subject to resolution pursuant to the Conflicts Policy and applicable federal and state non-profit corporation laws. In the exercise of voting rights by members of the Board, no individual shall vote on any issue, motion, or resolution which directly or indirectly inures to his or her benefit financially or with respect to which he or she has any other conflict of interest, except that such individual may be counted in order to qualify a quorum and, except as the Board may otherwise direct, may participate in the discussion of such an issue, motion, or resolution if he or she first discloses the nature of his or her interest. Board members shall adhere to the Conflict of Interest Policy enacted pursuant to Section 4.22 of these Bylaws, and the Fiduciary Policy developed and implemented by the Board.

4.24 Access to Board Records and Reports. Upon request, officers of the General Member shall have access to Hospital documents for review (but not possession) that have been reviewed by the Board of Directors. Such review shall be subject to the officer executing an agreement to maintain the confidentiality (no disclosure beyond officers of the General Member) of information reviewed. Documents that are protected by legal privileges and confidentiality (e.g., personnel, peer review, legal, vendor contractual confidentiality), those containing pending competitive business transaction information, and physician agreements, shall not be subject to review. Subject to the execution of an agreement to maintain confidentiality, Board member and

Board selected candidate conflict disclosure filings shall be available for review at the Corporation's offices only to the chief executive or designated legal counsel of the General Member upon request.

4.25 Bylaw Review. Consistent with regulatory and industry standards, the Board shall periodically conduct a review of these Bylaws in order to update and improve them. At least every two years, commencing in June 2011, the Board shall seek the input of the General Member in connection with such a review.

ARTICLE V
OFFICERS

5.1 Officers of this Corporation. The officers of the Corporation shall be a Chair, a Vice Chair of the Board, a Chief Executive Officer, a Secretary, and a Treasurer (which office shall be separate from the Corporation's Chief Financial Officer). No officer may hold more than one office at a time.

5.2 Officers Elected by the Board. The Chair of the Board, Vice Chair of the Board, Treasurer, and the Secretary shall be elected annually by the Board at its organizational meeting. Nominations shall be submitted in advance of the selection by the Nominating Committee. Each officer elected by the Board shall hold office at the pleasure of the Board and until his or her successor shall be elected and qualified to serve. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board for the unexpired term at any meeting of the Board.

5.3 Resignation or Removal. Any officer of the Board may resign at any time or be removed as follows: (a) any officer elected pursuant to Section 5.2 may be removed by the vote of the Board; and (b) any officer appointed by the Chief Executive Officer may be removed by the Chief Executive Officer.

5.4 Vacancies in Office. A vacancy in any office because of death, resignation, removal, or any other cause shall be filled in the manner prescribed in these Bylaws for regular appointments.

5.5 Chair. The Chair of the Board shall preside at all meetings of the Board. Unless the signature of the Chief Executive Officer is required by law, the Chair of the Board shall possess the same power as the Chief Executive Officer to sign all certificates, contracts, or other instruments of this Corporation when he is so authorized by the Board. The Chair of the Board shall exercise and perform such other powers and duties as may be prescribed by the Board from time to time. The Chair of the Board shall serve as the Board's liaison to the Chief Executive Officer.

5.6 Vice Chair. In the absence of the Chair of the Board or in the event of the Chair's disability, inability, or refusal to act, the Vice Chair of the Board shall perform all of the duties of the Chair and in so acting shall have all of the powers of the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or by the Chair.

5.7 Chief Executive Officer.

(a) Appointment and Removal. The Chief Executive Officer of this Corporation shall be engaged by the Board and shall serve at the pleasure of the Board, which may terminate the services of the Chief Executive Officer of this Corporation subject to any employment agreement.

(b) Responsibilities and Authority. The Chief Executive Officer shall be the general manager, administrator and Chief Executive Officer of this Corporation. The Chief Executive Officer shall be given the necessary authority and responsibility to operate this Corporation in all of its activities, including without limitation, quality of services, safety matters, cost effectiveness and economic performance, subject to the following: with respect to safety and quality of care, treatment and services, policy development, program planning, employee and community relations, the Chief Executive Officer shall be subject to such policies as may be adopted and such orders as may be issued by the Board of this Corporation or by any of its committees to which the Board has delegated the power for such action; with respect to program execution and overall management performance, the Chief Executive Officer shall be subject to the authority of and shall report to the Board. The Chief Executive Officer shall act as the duly authorized representative of the Board of this Corporation in all matters in which the Board has not formally designated some other person to so act.

5.8. Treasurer. The Treasurer of this Corporation shall keep and maintain or cause to be kept and maintained adequate and correct account of the properties and business transactions of the corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any Board member. The Treasurer shall be charged with safeguarding the assets of the corporation and he or she shall sign financial documents on behalf of the corporation in accordance with the established policies of the corporation. He or she shall have such other powers and perform such other duties as may be prescribed by the Board from time-to-time. The Treasurer may fulfill these responsibilities and perform his or her duties through appropriate delegation, with Board oversight, to individuals or firms charged with the financial management of the Corporation.

5.9 Secretary. The Secretary shall keep or cause to be kept a book of minutes at the principal office or at such other place as the Board may order of all meetings of the Board with the time and place of holding, whether regular or special, and if special how authorized, the notice thereof given, the names of those present at the Board meetings, and the proceedings thereof. The Secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given, and the Secretary shall keep the seal of this Corporation in safe

custody and shall have such other powers and perform such other duties as may be prescribed by the Board from time to time.

ARTICLE VI
COMMITTEES

6.1 Establishment of Committees. The Corporation shall have the standing committees set forth in Section 6.5 of these Bylaws, and such other standing committees or special committees as may be established by the Board from time to time in accordance with these Bylaws.

6.2 Composition of Committees**.** Unless otherwise stated (e.g., the Executive Committee), standing committees shall not be limited to members of the Board, but consistent with California Nonprofit Corporation Law shall include at least two (2) members of the Board (other than ex officio members). Special committees and any subcommittees of any standing committee or special committee that may be established from time to time shall not be limited to members of the Board but may, by direction of the Board, include any number of persons the majority of whom need not be directors. The Chair of the Board shall recommend committee members and Chairs of the committees to the Board, subject to the approval of the Board. The Board shall create committees as deemed necessary. Member's interests in appointment to certain committees shall be considered by the Chair. The Board may appoint alternate members of any committee who shall act on behalf of any committee member who is absent from a committee meeting. The Board or the committee may select other persons, whether or not members of the Board, to attend meetings of the committee and to participate in the discussion and activities of the committee; provided, however, that such additional persons attending the committee meeting shall not be entitled to vote and shall attend only at the discretion of the committee. The Chair and the CEO of the Corporation shall each serve ex officio as voting members on each standing committee, unless specifically excluded or otherwise specifically made members of the committee by these Bylaws or by appointment.

6.3. Powers; Restrictions and Limitations**.**

(a) Standing Committees. Subject to the duty of the Board to exercise ultimate direction over the activities and affairs of the Corporation, the Board may delegate to any standing committee the power, subject to applicable law, to manage or direct any activity of the Corporation. In addition to powers so delegated and the general duties of the standing committees described in the provisions of these Bylaws, the standing committees shall undertake duties or specific tasks assigned by the Board, the Chair, or the Executive Committee of the Board of Directors, and shall consider matters requested by other committees or the CEO of the Corporation.

(b) Special Committees. The Board may authorize any special committee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board shall require, but no special committee shall have the authority to determine Corporation

policy or otherwise exercise any powers of the Board with respect to the business and affairs of the Corporation.

(c) Subcommittees. The Board or any standing or special committee may authorize any subcommittee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board or any such committee shall require, but no subcommittee shall have the authority to determine Corporation policy or otherwise exercise any powers of the Board with respect to the business and affairs of the Corporation.

6.4 Meetings and Actions of Committees**.**

(a) Meetings. Meetings and actions of any standing committee, special committee or subcommittee shall be governed by, and held and taken in accordance with, the provisions of these Bylaws concerning meetings of the Board, with such changes in the content of these Bylaws as are necessary to substitute the committee or subcommittee and its members for the Board and its members, except a quorum of a committee shall be a majority of the voting members of the committee. The time for regular meetings of any committee or subcommittee may be determined either by direction of the Board or by direction of such committee or subcommittee. Special meetings of any committee or subcommittee may also be called by direction of the Board. Notice of special meetings of any committee or subcommittee shall also be given to any and all alternate members, who shall have the right to attend such meetings, subject to the discretion of the committee or subcommittee. Minutes shall be kept of meetings of any committees and subcommittees and shall be filed with the corporate records. The Board may adopt rules for the governing of any committee or subcommittee not inconsistent with the provisions of these Bylaws.

(b) Subcommittee membership**.** Subject to Board approval, each standing or special committee may establish such subcommittees as it deems necessary, the members of which need not be members of the Board. The Chair of the parent committee shall recommend to the Board formation of any subcommittee and shall nominate initial membership and the proposed chair of any new subcommittee to the Board for approval. Thereafter, the Chair of a subcommittee shall recommend to the Chair of the parent committee annual appointments or reappointments to the subcommittee, or recommend individuals to fill vacancies. The Chair of the parent committee shall have discretion to accept or reject such recommendations, and shall submit nominations for annual subcommittee membership (including appointment of the subcommittee chair), or nominations to fill vacancies on subcommittees, to the Board of Directors for approval.

6.5. Establishment of Standing Committees. Standing Committees of the Board of Directors as established and appointed pursuant to these Bylaws shall be (ex officio members shall not count toward the designated number of members of the Committee):

(a) Executive Committee. The Executive Committee shall consist of five (5) voting members of the Board: (1) the Chair of the Board, (2) the Vice Chair, (3) the Treasurer, (4) the

Secretary, and (5) the CEO of the Corporation. The Executive Committee shall, subject to the Articles, these Bylaws, applicable law, and the ultimate authority of the Board, exercise the power of the Board to transact all the regular business of the Corporation when there is a urgent situation if the Chair of the Board, the Corporation CEO, or any two Board members, believe that it would be in the best interests of the Corporation for the Executive Committee to meet in order to resolve the issue prior to the next Board meeting. The Chair of the Board or the Corporation CEO shall call upon the Executive Committee for advice and recommendations on matters of major importance, including matters they intend to take to the full Board. This Committee shall oversee the following for the Corporation: revisions to the Articles and Bylaws of the Corporation; governance policies addressing the Board of Directors and its committees; business and compliance review of executive officer compensation and benefits including any performance or incentive based compensation (no member of this Committee who is either a member of the Medical Staff or an "interested director" [defined in Section 4.20] shall participate in executive compensation matters); Board development and education; the Board of Directors' periodic self-evaluations (which shall include assessment of resolution of safety and quality issues), the performance of the Board and its committees; and establishment of Board and committee performance goals. Internal conflicts concerning Medical Staff affairs shall be referred to the Executive Committee on an as needed basis for resolution. Consistent with requirements of these Bylaws and any applicable Hospital policies and procedures, the Executive Committee is delegated authority to take action on behalf of the Board in circumstances in which it is not reasonably practicable to obtain full Board approval before action is needed upon contracts or transactions subject to Board approval under applicable conflicts laws and regulations and the Board Conflicts of Interest Policy. Committee action on conflicts matters shall be subject to Board ratification at its next meeting following the action.

(b) Finance Committee. The Finance Committee shall consist of a minimum of two (2) voting Board members, with up to ~~six~~eight (~~6~~8) persons. The Finance Committee shall include the Treasurer (if not otherwise appointed as a voting member of the Finance Committee). The Finance Committee shall oversee all financial matters for the Corporation including operating and capital budgets, borrowings and capital planning, audits, material contracts and leases, business plan development and implementation, and facilities and equipment.

(c) Strategic Planning and Marketing Committee. This Strategic Planning and Marketing Committee shall consist of a minimum of two (2) voting Board members, with up to nine (9) persons. The Committee shall include at least one physician as a member. The Strategic Planning and Marketing Committee shall oversee marketing and strategic planning, integration of the Corporation operations and facilities, service changes or adjustments, physician development, facility planning, and strategic alliances and ventures. The Committee shall oversee development and implementation of the Corporation's community benefit programs and shall seek input into its work from the General Member. The Committee shall also facilitate coordination of its community benefit programs with similar programs undertaken by the General Member.

(d) Nominating Committee. The Nominating Committee shall consist of a minimum of two (2) Board members, with up to four (4) persons. In addition to nominating new Board members

and existing members for new terms, the Committee shall recommend individuals for appointment by the Board to vacant positions on standing or special committees. By the December Board meeting of each year, the Committee shall nominate members to fill Board officer positions with new terms commencing the following January.

(e) Human Resources Committee. The Human Resources Committee shall consist of a minimum of two (2) voting Board members, with up to four (4) persons. The Human Resources Committee shall consider human resource issues and policies as warranted and shall review and recommend for Board approval employee compensation, pension and benefits programs (other than executive officer level).

(f) Quality and Patient Safety Committee. The Quality and Patient Safety Committee shall consist of a minimum of two (2) voting Board members, with up to nine (9) persons. The Committee will be assisted in its work by the CEO (a voting ex officio member), the CNO (Chief Nursing Officer), the Safety Officer, and the Medical Staff as needed. The Quality and Patient Safety Committee shall include at a minimum: two (2) physician Board Members. Non-voting, ex officio members shall include: the Chief of Staff (if not a physician Board Member), Chief Medical Officer and the CNO. The Quality and Patient Safety Committee shall oversee effective functioning of activities related to: provision of quality patient care, patient and staff safety, performance improvement, risk management, regulatory and accreditation standards, and strategic direction for quality expenditures. The Quality and Patient Safety Committee shall forward Quality Reports and recommendations to the Board of Directors. This Committee shall also be responsible for developing and implementing the Board's annual action plan for resolution of safety and quality issues. In addition, the Committee shall:

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

(3) Review and recommend to the Board on its oversight of all applications for appointment and reappointment to the Medical Staff, including privileges to be granted (except applications for temporary appointments and privileges which have been granted by the CEO pursuant to applicable procedures).

(4) Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

• completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;

• completed applications for reappointment of medical staff, staff category, clinical privileges;

• establishment of categories of Allied Health Professionals permitted to practice at the hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(5) Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(6) Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(7) Analyze findings and recommendations from the Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(8) Assess the effectiveness and results of the quality review, utilization review, performance improvement, and risk management programs.

(9) Perform such other duties concerning safety and quality of care matters as may be necessary.

(g) Audit Committee. This Committee shall consist of a minimum of two voting Board members and not more than five (5) members as determined by the Board. The CEO shall not be a member of this Committee. The Committee shall be guided by the Committee's Charter as approved or further amended by the Board of Directors.

This Committee shall oversee effective functioning of the Corporation's financial auditors, including approving their engagement by the General Member and fee, their qualifications and independence, adequacy of the Corporation's internal control systems, and provide oversight of the integrity of financial statements and reports. The Committee shall further assume such powers and responsibilities as specifically assigned or delegated from time to time by the Board of Directors, either directly or through development or amendment of the Committee's Charter.

The Committee shall meet at least once during each fiscal quarter, or more frequently as circumstances dictate and as necessary to fulfill the Committee's responsibilities and duties.

(h) Board Credentialing Committee. Consistent with requirements of these Bylaws and applicable Hospital policies and procedures, and consistent with procedures for the appointment and reappointment of Medical Staff members based on Joint Commission

accreditation standards, the Board of Directors delegates authority to take action on behalf of the Board on such appointments or reappointments to a standing committee of the Board, designated the Board Credentialing Committee. The Committee shall consist only of Board members and have at least two voting members of the Board who are also members of the Quality and Patient Safety Committee. The Chair and Vice Chair of the Committee shall be the Chair and Vice Chair of the Quality and Patient Safety Committee.

Applications for appointments, reappointments and the granting of clinical privileges are eligible for such review by the Committee, except that applications in the following circumstances are not eligible for expedited processing:

(i) incomplete applications (which shall not be processed in any event); and

(ii) applications as to which the Medical Executive Committee has made a final recommendation that is adverse or has limitations.

Applications showing any of the following circumstances shall be evaluated on a case-by-case basis and may be processed on an expedited basis only where, in the judgment of the Board Credentialing Committee, they do not present facts indicating any potential threat to patient safety:

(1) a current challenge or successful past challenge to licensure or registration;

(2) an involuntary termination of medical staff membership at another hospital;

(3) an involuntary termination, limitation, reduction, denial, or loss of clinical privileges at any other hospital or other entity; or

(4) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

In assessing whether expedited processing is appropriate for applications presenting facts in conformance with Items 1 - 4 above, the Board Credentialing Committee may take into account the time that has elapsed since the circumstances occurred, the frequency of such circumstances, and the severity of such circumstances, as well as other relevant information. Applications not so eligible shall be reviewed by the full Board. Any decision reached by the Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

~~(i) Investment Committee. The Investment Committee shall consist of a minimum of two (2) voting Board members with up to five (5) persons. The Investment Committee shall include a member of the Marin General Hospital Foundation Board. The Investment Committee shall oversee the investment activities of the Corporation and the Marin General Hospital~~

~~Pension Plan. Duties of the committee will include maintenance of the investment policies of this corporation, investment advisor selection, investment manager selection approval and investment portfolio performance. The Investment Committee will make itself available to any affiliated organization that desires it to undertake a role in that organization's investment decisions.~~

[To be reconstituted as a subcommittee of Finance. New subcommittee status to be established per 6.4(b) above]

6.6 Vacancies. Vacancies in any committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

6.7 Expenditures. Except as expressly delegated, any expenditure of corporate funds by a committee or any commitment by a committee to expend corporate funds shall require prior approval of the Board.

ARTICLE VII
MEDICAL STAFF

7.1 Organization. The Board of Directors shall appoint the Medical Staff which derives its authority from the Board of Directors and which shall function in accordance with Medical Staff Bylaws, Rules and Regulations and policies that have been approved by the Medical Staff and Board of Directors. The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded full access to the Board through the Board's regular meetings and committees described herein. Medical Staff membership shall be composed of physicians, dentists, podiatrists, clinical psychologists and other practitioners granted practice privileges in Marin General Hospital. Proposed bylaws, rules and regulations may be recommended by the Medical Staff, but only those approved by the Board of Directors and consistent with these Bylaws shall become effective. The Medical Staff shall be self-governing with respect to professional work performed in the Hospital and shall be responsible to the Board of Directors for the quality, treatment, and services rendered to Hospital's patients. It shall be organized into departments and divisions as may be deemed necessary. Only members of the Medical Staff shall admit patients to the Hospital; except that the Chief Executive Officer, on recommendations of those officers and individuals specified in the Medical Staff bylaws, shall have authority to grant temporary privileges to a physician, dentist, podiatrist, clinical psychologist or other practitioner who is not a member of the Staff under conditions specified in Staff bylaws.

7.2 Authority Delegated to Staff. The Medical Staff shall be responsible for providing appropriate professional care to the Hospital's patients. Each member of the Medical Staff shall have appropriate authority and responsibility for the care of his or her patients, subject to such limitations as are contained in these Bylaws and in the Bylaws and Rules and Regulations of the

Medical Staff, and subject, further, to any limitations attached to his or her appointment.

7.3 Appointments. The Board of Directors, after considering recommendations of the Medical Staff, shall appoint to the Staff, in numbers consistent with the physical capacity of the Hospital's facilities, physicians, dentists, podiatrists, clinical psychologists and other practitioners who meet the qualifications for membership set forth in the bylaws of the Medical Staff. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as provided in this Section 7.3 and Section 7.6. The Medical Staff shall adopt and forward to the Board, or committee of the Board, specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors. All appointments to the Medical Staff shall be for a maximum of two (2) years, renewable by the Board. All procedures for the appointment and reappointment of Medical Staff shall comply with the standards of the Joint Commission.

7.4 No Discrimination. No person applying for professional staff membership or privileges shall be discriminated against based on sex, race, color, religion, ancestry or national origin. Likewise, there shall be no discrimination based on such additional criteria as may be prescribed by statute, regulation or case law.

7.5 Medical Staff Appeal to the Board. There shall be a process for appealing to the Board a decision of the Medical Staff Judicial Review Committee regarding an applicant or member of the Medical Staff. This process shall be described in the Medical Staff bylaws.

7.6 Initiation of Corrective Action and Suspension. Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Medical Staff executive Committee immediately of any such action.

The Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual and when no person authorized to take such action by the Medical Staff is available,

provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized.

7.7 Medical Care and Its Evaluation. Members of the Medical Staff shall be responsible for the medical supervision of each hospital patient, and in the exercise of that responsibility, each shall observe all the ethical principles of his or her profession. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital, and shall be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital. Adequate and complete medical records shall be prepared and maintained for all patients and such records shall be an indispensable part of such review and appraisal. The Chief Executive Officer shall provide the Medical Staff with necessary assistance to facilitate regular comprehensive peer analysis of the clinical practice and to facilitate utilization review activities within the Hospital.

7.8 Chief of Staff. The Chief of Staff shall be medical advisor to the Board and the Chief Executive Officer. He or she shall be responsible for the proper functioning of the medical organization of the Hospital and shall maintain effective supervision over medical work in all departments and divisions. The Chief of Staff shall be an *ex officio* member or a member of all Medical Staff committees and boards, and shall perform such other duties as may be required by these bylaws, the Medical Staff bylaws, or the Board.

7.9 Medical Staff Meetings. The Medical Staff shall hold periodic meetings in accordance with the minimum meeting requirements of the Joint Commission.

7.10. Hospital Professional Contracts. Physicians, dentists, podiatrists and clinical psychologists employed by or under contract to the Hospital shall be duly appointed and qualified members of the Medical Staff and the final decision regarding their selection, renewal, or termination, consistent with Medical Staff Bylaws, shall reside with the Board of Directors. Medical Staff membership may not be made contingent on the continuation of a contract; however, the exercise of clinical privileges which involve the use of Hospital equipment and facilities may be limited to holders of an exclusive contract.

ARTICLE VIII
THE VOLUNTEER SERVICES

8.1 Organization. Auxiliary and other hospital service organizations may be formed in Marin General Hospital. The formation, constitution, bylaws, and operating procedure of such organizations shall be subject to approval and control by the Board of Directors. Each such organization shall cooperate with the Board and Chief Executive Officer in the best interests of the Hospital and its patients. Periodic and annual reports shall be made to the Board covering its activities by each organization.

8.2 Funds and Fund Raising. No volunteer service organization may undertake any fund raising or other project in the name of or for the benefit of the Hospital which might impose a liability on the Hospital or any affiliated entity without prior approval of the Board, nor undertake any activity on Hospital premises without the approval of the Chief Executive Officer.

Funds collected or otherwise acquired on behalf of the Hospital or by any activities purporting to assist the Hospital or its patients, shall be reported to and be subject to control by the Board. No funds, other than operating funds, shall be disbursed without prior approval of the Board.

ARTICLE IX
RESERVED HOSPITAL BOARD AUTHORITY

No approvals granted and no assignment, referral, or delegation of authority by the Board of Directors to hospital management, the Medical Staff, volunteer service organizations, or anyone else shall preclude the Board from exercising the authority required to meet is responsibility for the conduct of the Hospital. The Board retains the right to rescind any such approval or delegation.

ARTICLE X
ACTIONS REQUIRING GENERAL MEMBER APPROVAL

10.1 Approval or Action Requirement. Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of this Corporation may take any of the following actions, or approve a subsidiary or an affiliate taking any of the following actions, without the prior approval, or any of the specified actions, of the General Member:

(a) Any corporate merger, consolidation, reorganization, or dissolution of this Corporation that would change the General Member's status as sole corporate member or owner of the land and assets leased by this Corporation.

(b) Any transaction requiring the consent or approval of the General Member pursuant to the ~~1985~~ lease of the MGH campus and facilities by the General Member to this Corporation, commencing December 2, 2015, as it has been or may be amended ("the lease"). No provision in these Bylaws shall be construed as altering or limiting any approvals or consents required of the General Member pursuant to the lease.

(c) Any material transfer by sale, lease, debt or encumbrance, or other disposition, of any of the assets of the Corporation, real or personal, outside the ordinary course of hospital business. Notwithstanding the foregoing the following will not require the prior approval of the General Member:

(i) any transaction amounting to a transfer of less than ten percent (10%) of the assets of the Corporation (approximately $~~15~~____ million in ~~2010~~2015), as of the month immediately preceding the transaction, to another legal entity in connection with an affiliation or joint venture investment or service operation off the MGH campus.

(ii) a financing transaction, including, but not limited to, debt financing or borrowings, equity financings, capitalized leases and installment contracts, expected to amount in total principal value to less than ten percent (10%) of net patient services revenue (approximately $~~30~~___ million in ~~2010~~2015), as of the month immediately preceding the transaction.

(iii) the General Member shall in its discretion consider extending the above threshold requirements based on additional percentages of total assets or patient revenue, and any such allowance shall comply with applicable California laws or regulations governing transfers of assets of a healthcare district (e.g., Health & Safety Code Section 32121 (p)).

(d) In addition to thresholds for approvals required for individual transactions described in subsection (c) above, approval of the General Member shall be required for any transaction which, on a proforma basis, would cause the Corporation to be in violation of any financial loan or bond covenant, as they exist at the time of the transaction, or that would cause the Corporation's Debt to Capitalization Ratio to exceed 50%.

(e) Any transactions with long-term (more than three-year) land or facility impacts (e.g., new construction or renovation) requiring General Member approval pursuant to the lease or costing the equivalent of ten percent (10%) or more of MGH then existing total assets (approximately $~~13~~___ million in ~~2008~~year end 2015).

(f) Any long-term campus development plan that restricts future land use options or requires regulatory changes to land use permits/designations will require General Member approval.

(g) Any transaction that causes or is anticipated to cause a downgrade in bond rating by a standard rating agency requires General Member approval regardless of size of the transaction.

(h) The General Member shall retain an independent audit firm consistent with standard industry financial practice on behalf of the Corporation. The audit firm will then provide services to MGH management and its Board as overseen by the MGH Board Audit subcommittee. Final audit reports will be presented to the General Member (subject to public review), the Board and management of MGH.

(i) Contracting with an unrelated third party for all, or substantially all (50 percent or greater), of the management of the assets or operations of this Corporation or any subsidiary or affiliate entity.

(j) Amendment or restatement of the Articles of Incorporation.

(k) Bylaw approvals as may be required by Article XIII of these Bylaws.

(l) Any changes to the Mission Statement of the Corporation for MGH.

(m) Any changes to the corporate dissolution rights (initiation of dissolution and disposition of assets) of the General Member.

(n) Approval of individuals for Board membership.

10.2 Record of Approval or Disapproval. The General Member's approval or disapproval of matters described in Section 10.1 shall be recorded in or filed with the minutes of this Corporation.

ARTICLE XI
PERFORMANCE METRICS AND CORE SERVICES POLICY

11.1. Performance Metrics and Core Services Policy.

(a) Terms of Policy. In coordination with the General Member, the Corporation has established the Performance Metrics and Core Services Policy, the terms of which are attached to these Bylaws as Attachment B and incorporated into and made a part of these Bylaws.

(b) Tier 1 Metrics Mandatory Performance. These metrics have defined levels of minimum performance targets for MGH. Specific metrics are defined based on current industry standards or laws and regulations; specifically, The Joint Commission, California Department of Health Services, IRS Tax Code, and Center for Medicare and Medicaid Services. If changes to a specific metric cause it to cease to function as a reasonable performance requirement, the metric will be discontinued and the process in subsection (c) below to establish a new metric will be initiated.

(c) General Member Corrective Action on Tier 1 Performance Metrics.

(1) Phase 1 Indicator and Monitoring. All Tier 1 metrics (initial and new metrics) have a Phase 1 and Phase 2 "Indicator" assigned in the attached Performance Metrics and Core Services Policy. Within 10 days of this Corporation's Board or Management becoming aware of a Phase 1 indicator event, the General Member will be so notified. The Corporation will submit to the General Member within 20 days of identification of a Phase 1 event a Corrective Action Plan ("CAP"), which shall at a minimum include:

- Background and current status underlying the indicator event.
- Corrective Action Plan steps underway and to be implemented.

- Timeframe for actions and completion of improvements and compliance.

The General Member will review and comment on the CAP and, if desired, create an oversight committee to monitor the implementation of the CAP with full cooperation by the Board and Management. The General Member will continue monitored oversight until performance meets requirements and no Phase 2 indicator has occurred. If performance is maintained in compliance for two ordinary cycles of performance the CAP and monitored oversight shall cease.

(2) Phase 2 Indicator and Corrective Action. All Tier 1 metrics (initial and new) have a Phase 2 trigger also assigned in the Policy. In addition, if three or more Tier 1 metrics have concurrently experienced Phase 1 indicators, this combined status will trigger a Phase 2 event. This Corporation's Board or Management will inform the General Member immediately upon knowledge of a Phase 2 indicator event. Upon a Phase 2 indicator event the General Member may, at its option and upon its own determination of need and timeframe for action, take step including, but not limited to, the below. Nothing herein shall be construed to limit the General Member's remedies or options where applicable under the ~~1985~~ lease.

(i) Upon evaluation of the issue, and upon the advice or assistance of consultants associated with the evaluation, the General Member may (at this Corporation's expense) direct the Board and Management with respect to the management and operation of this Corporation and its operations. The Board and Management shall follow all such directives.

(ii) Upon evaluation of the issue, the General Member may direct the Board to terminate and replace the existing senior management of the Corporation with specific replacements, and/or it may determine to remove and replace members of the Board.

(iii) Upon evaluation of the issue, the General Member may reorganize the Corporation's governance by unilateral amendment or repeal of these Bylaws and adoption of new, restated, or amended Bylaws for the Corporation. Such a reorganization may include implementing new Board membership or structures.

(d) Core Service Closure and Service Reduction Report Process. The Performance Metrics and Core Services Policy provides that maintenance of the scope of MGH OSHPD reported acute care clinical services (a "service") are a Tier 1 metric. Prior to exercising the options available for corrective action pursuant to subsection (c) above, the General Member and the Board shall complete a MGH service closure review and shall only proceed with corrective action if service closure occurs and was not approved pursuant to this subsection (d) or approved by reason of an arbitration as provided herein. Service closure without such approval shall be considered a Phase 2 indicator. The Board and Management are committed to maintaining MGH with its scope of acute care services. There are factors in the external environment including regulatory oversight requirements, patient volumes, medical practice and technology changes, payer reimbursement rates, and competition that may render it infeasible to maintain individual services. This Bylaw process anticipates a future need for the Board to evaluate services and determine the need to

change the scope of services. Based on service admission volumes in 2010, should a service thereafter experience a sustained 50 percent reduction in volume for any non-cyclical/seasonal reason for a period of one fiscal quarter, the Corporation shall provide a report on this volume status to the General Member, including background information on the reasons for the volume reductions. If the same service volume reduction experience reaches 75 percent for a sustained period of one fiscal quarter, the Corporation shall report this status to the General Member and both shall conduct a joint leadership committee (Board chairs and executive staff) review of the circumstances, based on all available data, leading to the service reduction, and the joint leadership committee may make recommendations based on its review to the Board. The following shall constitute reasons for initiating a review with the General Member of possible discontinuation of an acute care service subject to Tier 1 maintenance:

- Economic Infeasibility: The direct revenues and expenses of the service result in a financial loss and MGH overall operations cannot sufficiently maintain the required subsidy without negatively impacting the hospital. This includes changes due to payer reimbursement rates and structure as well as service contracts or grant awards.

- Low Volumes Resulting in Quality Risks: The low volume of patients does not meet industry quality guidelines or provide sufficient clinical cases to ensure care providers maintain competency levels. This may be indicated by unsatisfactory service outcomes and/or quality level concerns, as well as compliance with standards.

- Lack of Community Need: Due to changes in medical treatments or availability from other providers, there is no unmet community need for the services in its absence at MGH.

If a service review is thereby merited, the following process will be followed:

(1) The Board will review and discuss the clinical, utilization and economics of the service in detail to understand and consider the viability of attempts to ameliorate the issue. If unsuccessful, the Board may vote to proceed with the service discontinuation process.

(2) The Board will notify the General Member of the plan to discontinue services at least 120 days prior to planned closure. The required regulatory bodies will also be notified at that time, or consistent with any appropriate notification requirement.

(3) The General Member's Chair or ad hoc committee and the Board's Executive Committee will meet to review the service situation. Any potential additional remedies available from the General Member will be discussed (e.g., bond or other public agency funding, conducting public agency and other provider

coordination discussions). If no viable remedy to cure the original basis for discontinuation is found within 60 days, the General Member's Board will consider the plan for discontinuation.

(4) At least 60 days prior to the proposed closing, the General Member must vote to approve the closure if this corporation demonstrates: 1) the service meets one of the three reasons for service discontinuation, and 2) no viable remedy has been identified.

(5) Upon General Member approval, the Board and MGH Management will proceed with the plan to close the service after a 60-day period to scale down operations. If the General Member disapproves closure because in its judgment this Corporation does not make the necessary showing in step 4 above, the service will be continued and no new closure process may be again initiated for a period of one year.

(6) Arbitration of disapproval: If the General Member disapproves closure because in its judgment this Corporation does not make the necessary showing in step 4 above, this Corporation may submit the General Member's decision to binding arbitration to determine whether or not it has made the necessary showing in step 4 above.

(i) Selection of Arbitrator. Unless the Corporation and General Member agree otherwise, the arbitrator shall be an independent, nationally recognized healthcare accounting, financial, or healthcare consultant or expert, or Judicial Arbitration and Mediation Services ("JAMS") arbitrator with experience in healthcare and healthcare-related accounting and financial matters. If they are unable to agree on an arbitrator, then either party may apply ex-parte to the Superior Court of Marin County to appoint the arbitrator. A copy of any ex parte application made pursuant to this Section shall be provided to the other party and at least three (3) business days prior to submission to the court.

(ii) Rules. Arbitration hearings shall be held in Marin County, California, pursuant to the then current provisions of the California Arbitration Act, §§ 1280 – 1294.2 of the California Code of Civil Procedure, or any successor statute(s) thereto. Discovery shall be allowed in accordance with California Code of Civil Procedure §1283.05, provided that all discovery shall be completed within thirty (30) days of appointment of the arbitrator. The decision of the arbitrator shall be final and conclusive upon all parties. Any arbitration pursuant to this provision shall be completed not later than one hundred twenty (120) days from the appointment of the arbitrator and the arbitrator shall render his or her award within ten (10) days after completion of the arbitration.

(iii) Determination. The arbitrator shall determine whether or not the General Member is obligated to approve the termination of the service because this Corporation has demonstrated to the General Member, by a preponderance of the evidence and in accordance with the provisions and guidance of this Section 11.1 (d): 1) the service meets one of the three reasons for service discontinuation, and 2) no viable remedy has been identified. If the arbitrator so determines with respect to the service proposed for termination, the General Member shall be deemed to have approved such termination as of the date of the arbitrator's decision.

(iv) Binding Decision. The decision of the arbitrator shall be binding upon the parties and judgment upon the award may be entered or confirmed in any court of competent jurisdiction. As part of the decision, the arbitrator may award reasonable and necessary costs actually incurred by the General Member in connection with the arbitration if its determination prevails, including attorneys' and consultants' fees and its share of the arbitrator's fees, costs, and expenses, as well as any administration fees. This Corporation shall bear its own costs regardless of the outcome of the arbitration.

(e) Tier 2 Metrics Performance. These metrics do not have required minimum levels of performance but provide for General Member monitoring of MGH performance. These metrics focus on performance measures and improvement goals and related improvement plans. As set forth in the Policy, the Board and/or Management will report to the General Member pursuant to Section 11.2 on these metrics to provide information on performance and related improvement plans. The General Member will review these metrics, deliberate as it deems appropriate, and provide input to the Board. If MGH has continuous negative performance in specific areas, the General Member may initiate a special review committee as it deems appropriate to further study the issue and contribute to developing improvement plans for submission to the Board and management. Additional Tier 2 metrics, as they increase transparency of performance, should be considered for adoption with consideration given to expanding General Member information access, while avoiding overly onerous reporting. While there are a very large number of metrics that could be considered, additions should be based on a public policy and General Member information need basis.

(f) Adding Tier 1 or Tier 2 Metrics. This process is based on mutual agreement with the General Member. The Chair of the General Member's Board, or an ad hoc committee thereof, will work with the Executive Committee and CEO to identify and discuss potential new metrics. This process may occur at any time but no more frequently than annually. In the event of definitional or industry changes that result in discontinuation of a metric or rendering it unreasonable as a performance metric, this process will be initiated to develop a replacement metric. This work group will conduct joint development of the metric definition, target performance, evaluation of current MGH performance, reporting frequency and phase-in period. The Board will consider, discuss and vote to approve or reject the metric addition based on a recommendation from

the Executive Committee. If the Board approves the proposal, it will then advance to the General Member for consideration. Alternatively the General Member may submit the proposal to the Board for its approval. If the proposal is rejected, the Ad Hoc work group will further discuss and amend the proposal and seek Board adoption with changes. For proposals approved first by the Board, the General Member Board Chair will present the recommendation for metric addition and supporting detail to the General Member Board for consideration. The metric must be approved by both this Corporation's Board and the General Member Board. The maximum total new Tier 1 metrics is two per year, excluding any to replace metrics discontinued due to industry wide changes. Addition of Tier 1 metrics are limited to one metric in any one of the six metric topic areas each year. The guidelines for the minimum process for Tier 1 and 2 additions are defined as:

- A three month development process for consideration, development, and review of the metric(s).

- Upon adoption, a phase-in period with a monitoring period within 6 months; during this period performance on Tier 1 additions will not be required to meet the required minimum level.

- For Tier 1 additions, MGH performance will be required to be at or above target levels within 1 year of mutual adoption of the metric (s). This period may be shortened by mutual agreement of the General Member and the Board if the metric and performance level is at or near the target (example: if the metric has been a Tier 2 metric with regular performance history).

(g) Removing Tier 1 or Tier 2 Metrics. To remove Tier 1 metrics or Tier 2 metrics, the General Member's Chair or the Board's Chair may initiate the removal process by identifying the metrics for potential discontinuation. The General Member's Chair or an ad hoc committee, and the Board Executive Committee will review and discuss the metric considered for removal. If agreed that removal should be further considered, the General Member will be notified and will review relevant information and recommendations from the forgoing review process. The General Member will vote to either adopt the discontinuation or reject it and maintain the metric. Upon the General Member's determination, metrics removed from Tier 1 may continue to be monitored at a Tier 2 level. The removal process of a Tier 1 Metric should coincide with either a process to add a new metric or during the course of a prescribed reporting frequency.

11.2. Reporting Tier 1 and Tier 2 Metrics to the General Member. The Board will report to the General Member on Tier 1 and Tier 2 Performance Metrics according to the Policy schedule. The Board will provide a written submission to the General Member no less than three days prior to review in a public or closed session meeting, but no sooner than thirty days after the end of the reporting period. The CEO and Board Chair will present performance reports results and answer General Member Directors' questions on the reports. The General Member will be responsible for determining the scope and means of any public input on reported matters. The Board will provide or report public data submitted by MGH to a public source at the time or before the public

submission (e.g., OSHPD filings).

ARTICLE XII
GENERAL PROVISIONS

12.1 Compensation of Board Members. The members of the Board shall receive no compensation as such, except that they may be reimbursed from time to time for all expenses incurred on behalf of this Corporation.

12.2 Indemnification. This Corporation shall indemnify any director, officer, employee or agent of this Corporation for liability incurred by such person in the exercise of his or her duties with respect to this Corporation to the extent permitted by Section 5238 of the California Corporations Code or any successor statute.

12.3 Fiscal Year. The fiscal year of this Corporation shall end on December 31 of each year.

12.4 Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the preceding sentence, the masculine gender includes the feminine and neuter, the singular number includes the plural, the plural number includes the singular and the term "person" includes both a legal entity and a natural person.

ARTICLE XIII
AMENDMENTS

13.1 Board Amendments. These Bylaws may be amended at any regular meeting of the Board or at any special meeting called for that purpose. The General Member may repeal, amend, and adopt new bylaws as set forth in the corrective action provision of Section 11.1 (c).

13.2 Amendments Requiring General Member Approval. The following provisions of these Bylaws (Articles including all Subsections or individual Sections) may not be amended or effective unless and until approved by the General Member: Article III (General Member status), Sections 4.2 (Board number), 4.3 (Board composition), 4.4 and Attachment A (nomination and selection), 4.5 (term), 4.6 (vacancies), 4.7 (removal), 4.19 (partial open meetings), 4.21 (board evaluation), 4.22 (conflict of interest policy), 4.23 (Conflicts Disclosure), 4.24 (Access to records), 4.25 (Bylaw review), 6.5(c) (Strategic Planning Committee), Article X (Actions Requiring Member Approval), Article XI and Attachment B (Performance Metrics / Core Services Policy), Article XIII (amendment of bylaws) and Article XIV (General Member Remedies Upon Violation of Certain Bylaws Provisions).

13.3 Process for Amendment of Provisions Impacting General Member Rights. Applicable amendment changes will be identified for review with the General Member, and the General Member so notified. The Board will create a special Bylaw Review Committee consisting of two Board members and two members of the General Member's Board of Directors, which Committee will be charged with reviewing the proposal and background need for the change. Upon Committee approval, the Bylaw change will be presented to this Corporation's Board for approval. Upon Board approval, the Committee shall present the amendment to the Board of the General Member for approval or rejection. The Board of the General Member will not vote on the amendment until it has held two public sessions on the proposal.

ARTICLE XIV
GENERAL MEMBER REMEDIES
UPON VIOLATION OF CERTAIN BYLAWS PROVISIONS

14.1 The Corporation shall notify the General Member in writing within five business days of its becoming aware that it has or may have violated Section 4.4(g), Section 10.1, or Section 13.2 of these Bylaws, which notice shall specifically describe the violation.

14.2 If the Board violates Section 4.4(g), Section 10.1, or Section 13.2 of these Bylaws, the General Member shall have, among other remedies that may be available to it under law or equity, the following remedies for such violation; provided, however, that the provisions of this Article XIV shall apply only to any such violations occurring after final adoption and approval of an amendment or restatement of these Bylaws incorporating this Article XIV in accordance with Article XIII:

(a) If the violation is an action that is capable of being voided, rescinded, or cured without subjecting the Corporation or the General Member to any material liability, the General Member may, within ninety (90) days after the Corporation has notified the General Member pursuant to Section 14.1 above of a violation or possible violation of any of Sections 4.4(g), 10.1, or 13.2 of these Bylaws, direct the Board by written notice to void, rescind and/or cure the violation, which voidance, rescission or cure the Board must be completed within a reasonable period of time after the date of the General Member's written notice, but in any event not to exceed thirty (30) days. If the violation or possible violation involves a deal or agreement with a third party, then the deadline for the General Member to notify the Corporation of its direction to rescind shall be thirty (30) days after the Corporation has notified the General Member pursuant to Section 14.1 above of a violation or possible violation, provided that such deadline shall be extended for up to an additional thirty (30) days if reasonably necessary to allow the General Member to investigate and evaluate the violation or possible violation and such extension will not preclude the Corporation from voiding, rescinding, or curing the violation without subjecting the Corporation or the General Member to any material liability. (By way of example, an extension for up to an additional thirty (30) days may be reasonably

necessary if the General Member has not received all information that is appropriate and necessary for its Board of Directors to make an informed decision within such initial thirty (30) days period, or if the General Member's Board of Directors is unable to schedule a meeting within the initial thirty (30) days period after it has received the information.) If the Board voids, rescinds and/or cures the violation within the required time period, or if the General Member fails to direct the Board to void, rescind and/or cure the violation before the applicable deadline (in which case the General Member will be deemed to have consented to the action, whether or not its constituted a violation), then the General Member shall have no further remedies with respect to such violation or possible violation. If the General Member directs the Board to remedy a curable violation and the Board fails to void, rescind and/or cure such violation within the period provided above, then the General Member shall have the additional remedy set forth in Section 14.2(b) below.

(b) If the violation is an action that is incapable of being voided, rescinded, or cured without subjecting the Corporation or the General Member to any material liability, or if the Board has failed to void, rescind and/or cure a curable violation within the time period allowed under Section 14.1(a) above, then the General Member may, in its discretion, remove any Director who either (1) voted in favor of the action that constituted the violation, and/or (2) voted to refuse to void, rescind or cure the violation after the General Member directed the Board to remedy same or abstained from such vote. Any Director so removed shall be replaced in accordance with Article IV.

14.3 Any dispute between the General Member, on the one hand, and the Corporation and/or the Board, on the other hand, with respect to any matter arising under this Article XIV, including, without limitation, as to whether (1) a Director qualifies to be a Director pursuant to Section 4.4(g) of these Bylaws, or (2) an event requires the approval of the General Member pursuant to Section 10.1 of these Bylaws, shall be resolved in accordance with the following provisions after a good faith attempt to resolve the dispute has been made by both parties, and either party determines the dispute is not capable of informal resolution.

(a) If either party determines that a dispute, other than a dispute involving a deal or agreement with a third party, is not capable of informal resolution, the party may initiate mediation of the dispute in accordance with the Commercial Arbitration Rules of the American Arbitration Association, except as modified by this Section 14.3, and the following rules and procedures:

(1) each party may commence mediation by giving written notice to the other party demanding arbitration;

(2) the mediation hearing shall commence within twenty (20) days after appointment of the mediator ("Mediator"); and

(3) the mediation will be conducted in Marin County, State of California. The Mediator will be registered with and appointed by the Judicial Arbitration and

Mediation Service ("JAMS") and will have not less than (10) years' experience in the area of expertise on which the dispute is based. If the parties are unable to mutually agree upon a Mediator within ten (10) business days after the date of the mediation notice, each party will offer five Mediators to the other party, and then each party will strike out three Mediator names such that two Mediator names remain per party, whereupon JAMS will appoint a Mediator from those four Mediator names. The potential mediators designated by each party shall each be located in California, shall not be an employee or former employee of either Party, and shall have at least ten (10) years' experience in the area of expertise on which the dispute is based. Mediation will consist of an informal, nonbinding conference or conferences between the parties and the mediator jointly, then in separate caucuses in which the mediator will seek to guide the parties to a resolution of the dispute. The mediation process will continue until such time as either party determines that the dispute is not capable of resolution by mediation. The fees of the mediator will be shared equally by the parties. The parties will each pay their own legal costs in connection with such mediation (including attorneys' fees) and the fees of the mediator designated by it to select the actual mediator (if applicable).

(4) Neither party may initiate mediation with respect to any dispute that involves a deal or agreement with a third party. For all such disputes, the parties shall arbitrate same in accordance with the expedited arbitration procedures set for below without first resorting to mediation of such dispute.

(b) If either party reasonably determines that a dispute subject to mediation is not capable of resolution by mediation, the party shall notify the other party in writing of such determination (the "Mediation Termination Notice"). If a party has given a Mediation Termination Notice, or if the dispute involves a deal or agreement with a third party, then either party may require, by written notice to the other party (the "Arbitration Notice"), that such dispute be submitted to final and binding arbitration in Marin County, California, administered by an independent arbitrator (the **"**Arbitrator**"**). The Arbitrator will be registered with and appointed by the Judicial Arbitration and Mediation Service ("JAMS") and will have not less than (10) years' experience in the area of expertise on which the dispute is based. For a dispute that does not involve a deal or agreement with a third party, if the parties are unable to mutually agree upon an Arbitrator within ten (10) business days after the date of the Arbitration Notice, each party will offer five (5) Arbitrators to the other party, and then each party will strike out three (3) Arbitrator names such that two (2) Arbitrator names remain per party, whereupon JAMS will appoint an Arbitrator from those four (4) Arbitrator names. For a dispute that involves a deal or agreement with a third party, if the parties are unable to mutually agree upon an Arbitrator within five (5) business days after the date of the Arbitration Notice, each party will name two (2) Arbitrators by no later than one (1) day after the expiration of the five (5) business day period, whereupon JAMS will appoint an Arbitrator from those four (4) Arbitrator names. All arbitrations hereunder shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association, except that any dispute involving a deal or agreement with a third party shall be conducted using AAA's expedited arbitration rules, as modified by this Section 14.3.

(c) The Arbitration Notice will be in writing, with a copy to the other party, and in no event will it be made after the date that is thirty (30) days after a party has provided a Mediation Termination Notice (for disputes that do not involve a deal or agreement with a third party), or for disputes that involve a deal or agreement with a third party, three (3) business days after either party declares the that dispute is not capable of informal resolution. The parties may apply to the Arbitrator for relevant discovery consistent with the Federal Rules of Civil Procedure, which the Arbitrator is authorized to order, deny and/or enforce in the Arbitrator's reasonable judgment; provided, however, that the Arbitrator will expedite discovery in any dispute involving a third party deal or agreement in such a manner so as to preserve as much as possible the capability of the action being voided, rescinded, or cured without subjecting the Corporation or the General Member to any material liability. A party may request that the Arbitrator's award include findings of fact and conclusions of law.

(d) For disputes that do not involve a deal or agreement with a third party, the arbitration will be held within thirty (30) days after the delivery of the Arbitration Notice unless the parties mutually agree to a later date. For disputes that involve a deal or agreement with a third party, the arbitration will be held as soon as reasonably practicable after the delivery of the Arbitration Notice, unless the parties mutually agree to a later date. The arbitration will conclude within two (2) business days unless the parties mutually agree to a longer period. For disputes that do not involve a deal or agreement with a third party, the decision of the Arbitrator will be delivered within thirty (30) days after conclusion of the arbitration. For disputes that involve a deal or agreement with a third party, the decision of the Arbitrator will be delivered as soon as reasonably practicable after conclusion of the arbitration, but in any event within five (5) business days after conclusion of the arbitration.

(e) The Arbitrator will have no authority to vary or ignore the terms of these Bylaws and will be bound by controlling law. All proceedings, awards and decisions under any arbitrations proceedings shall be strictly private and confidential except as required by applicable law or as necessary to enforce any such decision.

(f) The decision of the arbitrator shall be binding upon the parties and judgment upon the award may be entered or confirmed in any court of competent jurisdiction. As part of the decision, the arbitrator may award reasonable and necessary costs actually incurred by the General Member in connection with the arbitration if its determination prevails, including attorneys' and consultants' fees and its share of the arbitrator's fees, costs, and expenses, as well as any administration fees. This Corporation shall bear its own costs regardless of the outcome of the arbitration.

(g) The parties agree that the existence and substance of any dispute subject to this Article XIV and the of any related dispute resolution proceedings hereunder, or any other information regarding any such dispute, are to remain totally and completely confidential and are not to be revealed or disclosed to any person or party whatsoever, except: (i) with the consent of the other party; (ii) as may be disclosed to a party's attorneys, present and future Board members, or other representatives that are involved in such party's activities with respect to the

dispute; or (iii) as may be required by applicable law. Notwithstanding the above, the Parties understand that General Member is subject to the California Public Records Act ("**PRA**") as set forth at California Government Code Section 6250, et seq. Given General Member's obligations under the PRA, Corporation understands that from time to time records related to matters arising under this Article XIV may be subject to production as required by PRA, but that any release of records will be in accordance with the PRA and other applicable federal and state laws and regulations protecting personal, private, confidential or proprietary information. The General Member agrees to cooperate with Corporation in responding to PRA requests. Such cooperation includes, if a third party submits a request to the General Member pursuant to the PRA requesting confidential information, that the General Member will (i) notify the Corporation of such request within five (5) days after the General Member's receipt of such request, and (ii) the Corporation, at its cost, may seek to enjoin the examination of any specific public record requested by a third-party to the extent such record contains confidential information protected under this subsection (g).

SECRETARY'S CERTIFICATE

I certify that I am the Secretary of Marin General Hospital, a California nonprofit pubic benefit corporation, and that the attached Tenth Restatement of Bylaws of Marin General Hospital are the current bylaws of this Corporation containing all the amendments as adopted by the Board of Directors of Marin General Hospital, and, as applicable, approved by the General Member, the Marin Healthcare District, through those amendments adopted March 6, 2014.

Dated: _____, ~~2014~~2016

_____

Mara Perez, PhD, Secretary

ATTACHMENT A

Marin General Hospital Corporation
Board Member Criteria

The prospective Board member must be considered on the basis of his or her ability to commit to the Marin General Hospital Mission and Values.

Mission: We build a healthier community through education and access to quality health care.

Values:
- Excellence in Performance • Honesty & Integrity • Caring & Compassion
- Local Control/Access to Care • Stewardship of Resources
- Mutual Respect & Teamwork

Board Operating Philosophy: Policy Level Role of Board
Community Thinking Emphasis

General Criteria:

- Commitment to Mission, Values and Board Operating Philosophy
- Ability to be a public and visible representative and spokesperson for the organization
- Ability to function at a policy level and distinguish between the roles of the Board and Management
- Ability to participate effectively in policy deliberations, articulating one's own views while respecting the views of others
- Skill in group process and group decision making
- Willingness to take risks and/or support group decisions, even when not in full agreement
- Lack of actual or legal conflicts of interest
- Ability and willingness to commit time for meetings, reading and special events
- Reflective of the communities we serve

Experience in Board Responsibility

- Strategic planning
- Facilities / Construction Oversight
- Finance oversight
- Quality assessment
- CEO appointment/evaluation
- Community relations
- Board organization, procedures, self-evaluation

Leadership

- Listening to diverse points of view and needs
- Articulating a vision on how the group can achieve its goals
- Fostering a sense of commitment and satisfaction among others in pursuing goals
- Helping the board as a group achieve its goals

Expectations

- Develops an understanding of a Community Hospital Operations
- Develops an understanding of Healthcare Reimbursement
- Develops an understanding of Medical Staff Organization and Development
- Develops an understanding of Quality Assessment and Performance Improvement

ADDITIONAL CONSIDERATIONS FOR POTENTIAL CANDIDATES

1. Potential legal or actual Conflicts of interest
   - Competing business
   - Business with Hospital

2. Holding/running for political office
   - Sensitive area for not-for-profit organizations
   - Devotion is to the patient base, not to a cause, political group, or to a constituency

3. Contribute to the diversity of the Board

4. Time commitment is critical / Attendance record will be noted

5. Balance between those involved in the community and those with corporate experience

6. Past experience working with corporate and not-for-profit Board governance

7. Capacity to be a Chair of the Board and/or Chair of standing Board Committees

8. Previous/current participants in related organizations
    - Hospital Foundations
    - Community Health Organizations
    - Advisory Groups
    - Medical Staff Experience
    - Physician Organization Experience

9. Objective Selection Criteria
    - Past Board/governance experience
    - Professional/personal achievements
    - Team Player

10. Ability to represent healthcare consumers

(Representative Skill Mix For Board)

Major Areas of MGH Oversight	Skills/Experience Needed
Building Programs	Financial Strategic, related experience
Joint Ventures / Physician & Other Provider	Financial, business marketing, legal
Quality/Patient Safety	Clinical, Business, Statistical, Computers
Information Technology	Computer, High Tech, Business
Physician Integration and Physician Partnerships	Physician relationships, business, strategic planning, marketing
Highly Regulated Industry	Legal, other regulated industries
260 Million Dollar Organization	Corporate CEO, Finance CFO, Marketing SVP, Strategic Planning SVP, business, healthcare provider
Large Employee Base	Corporate CEO, Corporate HR, Legal, clinical, provider
Public / Community Relations	Public Service Business, Community Services Organization, Publishing, public relations, government service
Philanthropy	Fundraising, charitable organizations

ATTACHMENT B

PERFORMANCE METRICS AND CORE SERVICES POLICY

I. TIER 1 PERFORMANCE METRICS

In accordance with Tier 1 Performance Metrics requirements, the Board is required to meet each of the following minimum level requirements:

(A) *Quality, Safety and Compliance*

1. The Board must maintain Marin General Hospital's Joint Commission accreditation, or if deficiencies are found, correct them within six months.
2. The Board must maintain Marin General Hospital's Medicare certification for quality of care and reimbursement eligibility.
3. The Board must maintain Marin General Hospital's California Department of Public Health Acute Care License.
4. The Board must maintain Marin General Hospital's plan for compliance with SB 1953.
5. The Board must report on all Tier 2 Metrics at least annually.
6. The Board must implement a Biennial Quality Performance Improvement Plan for Marin General Hospital.
7. The Board must include quality improvement metrics as part of the CEO and Senior Executive Bonus Structure for Marin General Hospital.

(B) *Patient Satisfaction, and Services*

The Board will report on Marin General Hospital's HCAHPS Results Quarterly.

(C) *Community Commitment*

1. In coordination with the General Member, the Board must publish the results of its ~~biennial~~triennial community ~~survey~~needs assessment conducted with other regional providers pursuant to SB 697 (1994) to assess Marin General Hospital's performance at meeting community health care needs and its planning for meeting those needs.
2. The Board must provide community care benefits at a sufficient level to maintain Marin General Hospital's non-profit tax exempt status.

(D) *Physicians & Employees*

The Board must report on all Tier 2 "Physician & Employee" Metrics at least annually.

(E) *Volumes and Service Array*

1. The Board must maintain Marin General Hospital's Scope of Acute Care Services as reported to OSHPD.
2. The Board must maintain Marin General Hospital's services required by Exhibit G to the Loan Agreement between the General Member and Marin County, dated October 2008, as long as the Exhibit commitments are in effect.

(F) *Finances*

1. The Board must maintain a positive operating cash-flow (operating EBITDA) for Marin General Hospital after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric.
2. The Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of Marin General Hospital.

II. TIER 2 PERFORMANCE METRICS

In accordance with Tier 2 Performance Metrics requirements, the General Member shall monitor and the Board shall provide necessary reports to the General Member on the following metrics:

(A) *Quality, Safety & Compliance*

The Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in Marin General Hospital's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CABSI, preventive care programs).

(B) *Patient Satisfaction, & Services*

1. The Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.
2. The Board will report external awards and recognition.

(C) *Community Commitment*

1. The Board will report all of Marin General Hospital's cash and in-kind contributions to other organizations.
2. The Board will report on Marin General Hospital's Charity Care.
3. The Board will maintain a Community Health Improvement Activities Summary to provide the General Member, providing a summary of programs and participation in community health and education activities.
4. The Board will report the level of reinvestment in Marin General Hospital, covering investment of excess operating margin at MGH in community services, and covering funding of facility upgrades and seismic compliance.
5. The Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.

(D) *Physicians & Employees*

1. The Board will provide a report on new recruited physicians by specialty and active number of physicians on staff at Marin General Hospital.
2. The Board will provide a summary of the results of the Annual Physician and Employee Survey at Marin General Hospital.
3. The Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at Marin General Hospital.

(E) *Volumes & Service Array*

1. The Board will develop a strategic plan for Marin General Hospital and review the plan and its performance with the General Member.
2. The Board will report on the status of Marin General Hospital's market share and Management responses.
3. The Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.
4. The Board will report on current Emergency services diversion statistics.

(F) *Finances*

1. The Board will provide the audited financial statements.
2. The Board will report on its performance with regard to industry standard bond rating metrics, e.g., current ratio, leverage ratios, days cash on hand, reserve funding.
3. The Board will provide copies of Marin General Hospital's annual tax return (form 990) upon completion to General Member.

III. TIER 1 & TIER 2 REPORTING REQUIREMENTS AND PROCESS

The Board will report to the General Member on Tier 1 and Tier 2 Performance Metrics according to the following frequency schedule, except where specific reporting times are called for, e.g., biennial Performance Quality Improvement Plans. The CEO, or his/her designees, shall attend General Member meetings addressing these reports.

(A) *Quality, Safety & Compliance*

The Board will report on Tier 1 and Tier 2 performance metrics pertaining to Quality, Safety, & Compliance at least annually.

(B) *Patient Satisfaction & Services*

The Board will report on Tier 1 and Tier 2 performance metrics pertaining to Patient Satisfaction & Services at least annually.

(C) *Community Commitment*

The Board will report on Tier 1 and Tier 2 performance metrics pertaining to Community Commitment at least annually.

(D) *Physicians & Employees*

The Board will report on Tier 1 and Tier 2 performance metrics pertaining to Physicians & Employees at least annually.

(E) *Volumes & Service Array*

The Board will report on Tier 1 and Tier 2 performance metrics pertaining to Volumes & Service Array at least quarterly.

(F) *Finances*

The Board will report on Tier 1 and Tier 2 performance metrics pertaining to Finances at least quarterly.

~~**(G)** *Post-Transfer*~~

~~During the first year after transfer of MGH corporate membership, July 1, 2010 to June 30, 2011, the Board will provide more frequent updates on key performance metrics. Reports to the General Member will be provided at least quarterly with data on the following matters: discharges, patient days, emergency visits, inpatient/outpatient surgeries, nurses hired and leaving, physician recruitment and departure, physician, nursing and employee surveys, patient safety and quality status and performance improvement reports, financial performance.~~

IV. TIER 1 PERFORMANCE METRICS CORRECTIVE ACTION INDICATORS

(A) *Community* Commitment: Publish results of a MGH ~~Biennial~~triennial community survey (SB 697) to assess performance meeting community health care needs.

Phase 1 Indicator: Must be published within 15 days of regular reporting schedule (e.g. 30 days after quarter end for quarterly).

Phase 2 Indicator: Must be published within 30 days of regular reporting schedule.

(B) *Community* Commitment: MGH must continue to provide benefits sufficient to maintain tax exemption.

Phase 1 Indicator: MGH receives notice of intent to remove tax-exempt status.

Phase 2 Indicator: Revocation of non-profit tax-exempt status.

(C) *Physicians & Employees:* Report on all Tier 2 metrics at least annually.

Phase 1 Indicator: Must be published within 15 days of regular reporting schedule.

Phase 2 Indicator: Must be published within 30 days of regular reporting schedule.

(D) *Patient Satisfaction & Services:* Report Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) results quarterly.

Phase 1 Indicator: Must be published within 15 days of regular reporting schedule.

Phase 2 Indicator: Must be published within 30 days of regular reporting schedule.

(E) *Quality, Safety & Compliance:* Maintain Joint Commission accreditation.

Phase 1 Indicator: Provisional Accreditation Status is issued by The Joint Commission.

Phase 2 Indicator: An Adverse Decision – The Joint Commission is considering and given notice of Conditional Accreditation or Preliminary Denial of Accreditation Status.

(F) *Quality, Safety & Compliance:* Maintain Medicare Certification.

Phase 1 Indicator: Statement of Deficiencies is issued by CMS based on survey.

Phase 2 Indicator: Rejection of Plan of Correction and publication of public notice of decertification or other removal from Medicare program.

(G) *Quality, Safety & Compliance:* Maintain State (OSHPD) Acute Care License.

Phase 1 Indicator: Statement of Deficiencies / Notice of adverse survey and pending potential revocation of acute care license by State.

Phase 2 Indicator: Rejection of Plan of Correction and notice from State of intent to complete procedure or proceeding for revocation of license.

(H) *Quality, Safety & Compliance:* Maintain plan for SB 1953 compliance.

Phase 1 Indicator: An OSHPD intermediate deadline is missed.

Phase 2 Indicator: Plan is denied by OSHPD or fails to meet regulatory requirements and is not accepted by statutory or regulatory deadline.

(I) *Quality, Safety & Compliance:* Include Quality Improvement metrics as part of bonus structure for the CEO and Senior Executives.

Phase 1 Indicator: Change to bonus structure eliminates quality improvement metrics; MGH has 30 days to correct omission.

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Phase 2 Indicator: Not included in bonus structure.

(J) *Quality, Safety & Compliance:* Implement Biennial Quality Performance Improvement Plan.

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Phase 1 Indicator: Must be published within 15 days of regular reporting schedule.

Phase 2 Indicator: Must be published within 30 days of regular reporting schedule.

(K) *Quality, Safety & Compliance:* Report on all Tier 2 Metrics at least annually.

. Phase 1 Indicator: Must be published within 15 days of regular reporting schedule.

Phase 2 Indicator: Must be published within 30 days of regular reporting schedule.

(L) *Volumes & Service Array:* Maintain OSHPD Defined Scope of Acute Care Services.

Phase 1 Indicator: OSHPD annual filing indicates an unapproved change in scope of services.

Phase 2 Indicator: MGH action to end service or actual non-provision of service.

(L) *Volumes & Service Array:* Maintain current MGH services as required by Exhibit G to the County Loan Agreement .

Phase 1 Indicator: OSHPD annual filing indicates an unapproved change in scope of services.

Phase 2 Indicator: MGH action to end service or actual non-provision of service.

(M) *Finances:* Maintain positive operating cash flow (Operating EBITDA).

Phase 1 Indicator: Fiscal year-end decline in operating income and total cash flow reduction of 50% from previous year.

Phase 2 Indicator: Fiscal year-end negative operating cash flow.

(N) *Finances:* Maintain all financial covenants related to debt financing arrangements.

Phase 1 Indicator: Fiscal year-end declining trend on majority of covenant metrics.
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Phase 2 Indicator: Receives notice of potential action related to covenant default.

Tab 4

Report of Independent Auditors
and Financial Statements

Marin Healthcare District

Six Months Ended December 31, 2015
and Year Ended June 30, 2015

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

CONTENTS

Marin Healthcare District
MANAGEMENT'S DISCUSSION AND ANALYSIS
For the Six Months Ended December 31, 2015 and Years Ended June 30, 2015 and 2014

This section of Marin Healthcare District's (the District) financial statements presents management's discussion and analysis of the financial activities of the District for the six months ended December 31, 2015 and fiscal years ended June 30, 2015 and 2014. The financial year end of the District was changed from June 30 to December 31 so as to coterminous with MGH. Accordingly, the current financial statements are prepared for the six month period July 1, 2015 to December 31, 2015. We encourage the reader to consider the information presented here in conjunction with the financial statements as a whole.

Introduction to the Financial Statements

This discussion and analysis is intended to serve as an introduction to the District's audited financial statements. This annual report is prepared in accordance with the Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments.*

The required financial statements include the Statement of Net Position, the Statement of Revenues, Expenses, and Changes in Net Position, and the Statement of Cash Flows. The Notes to Financial Statements, and this summary, provide support to these statements. All information must be considered together to obtain a complete understanding of the financial picture of the District.

Statement of Net Position

This statement includes all assets and liabilities using the accrual basis of accounting as of the statement date. The difference between the two classifications is represented as "Net Position;" this section of the statement identifies major categories of restrictions on these assets and reflects the overall financial position of the District as a whole.

Statement of Revenues, Expenses, and Changes in Net Position

This statement presents the revenues earned and the expenses incurred during the year using the accrual basis of accounting. Under the accrual basis, all increases or decreases in net position are reported as soon as the underlying event occurs, regardless of the timing of the cash flow. Consequently, revenues and/or expenditures reported during this fiscal year may result in changes to cash flows in a future period.

Statement of Cash Flow

This statement reflects inflows and outflows of cash, summarized by operating, capital, financing, and investing activities. The direct method was used to prepare this information, which means gross rather than net amounts were presented for the year's activities.

Notes to Financial Statements

This additional information is essential to a full understanding of the data reported in the financial statements.

The District is a political sub-division of the state of California. It is the sole member of Marin General Hospital (MGH) and is governed by a publicly-elected Board of Directors.

ANALYTICAL REVIEW

The Statement of Net Position and Statement of Revenues, Expenses, and Changes in Net Position present a summary of the District's activities.

Condensed Statements of Net Position

	DECEMBER 31,	JUNE 30,	
	2015	2015	2014
Current and other assets	$ 169,759,524	$ 7,135,518	$ 6,684,483
Capital assets, net of accumulated depreciation	47,413,171	6,000,622	6,609,601
Total assets	217,172,695	13,136,140	13,294,084
Current portion of bond payable	12,615,000	-	-
Current other liabilities	12,184,054	3,088,858	3,639,317
Bond payable, net of current portion	166,035,045	-	-
Long-term debt and other long-term liabilities	557,333	883,333	1,626,055
Total liabilities	191,391,432	3,972,191	5,265,372
Net position			
Net investment in capital assets, net of related debt	18,914,321	5,050,622	5,342,934
Unrestricted net position	6,866,942	4,113,327	2,685,778
Total net position	25,781,263	9,163,949	8,028,712
Total liabilities and net position	$ 217,172,695	$ 13,136,140	$ 13,294,084

Total assets increased by 1,553% or $204,036,555 at December 31, 2015 compared to June 30, 2015, primarily related to the proceeds from the sale of bonds and expenditures for construction costs related to the hospital facility. Total assets decreased by 1% or $157,944 at June 30, 2015 compared to June 30, 2014, primarily related to the reduction in capital assets.

Liabilities increased by 4,718% or $187,419,241 at December 31, 2015 compared to June 30, 2015, as a result of the issuance of bonds. Liabilities decreased by 25% or $1,293,181 at June 30, 2015 compared to June 30, 2014, as a result of the reduction of notes and loans payable and deferred lease revenue.

The overall change to net assets is an increase of $16,617,314, resulting in a December 31, 2015 balance of $25,781,263.

Condensed Statement of Revenue, Expenses, and Changes in Net Position

	SIX MONTHS ENDED DECEMBER 31, 2015
Operating revenues	$ 8,592,780
Operating expenses	11,449,302
Operating loss	(2,856,522)
Support from Marin General Hospital (MGH)	3,241,058
Bond issuance costs	(1,203,408)
Tax revenue	17,428,863
Interest expense	(10,500)
Other revenue	17,823
Total non-operating revenues	19,473,836
Change in net position	$ 16,617,314

Operating Revenues and Expenses

Operating losses are primarily due to the losses incurred from the 1206(b) Clinics. The 1206(b) Clinic operating deficits are funded by MGH.

Non-Operating Revenues and Expenses

Under terms of an agreement with the District, MGH provides support to the District equal to the losses incurred by the 1206(b) Clinics. Also included in support is $85,141 paid by MGH under terms of an agreement entered into in 1999 wherein MGH agreed to reimburse the District for certain overhead expenses. That agreement expired on December 1, 2015 and was superseded by the new lease agreement effective December 2, 2015.

Bond issuance costs related to expenses incurred in connection with the issuance of $170,000,000 of bonds in November 2015.

Tax revenue represents property tax assessments by Marin County on District property owners, which will be used to make bond interest and principal payments in the future.

ECONOMIC OUTLOOK AND MAJOR INITIATIVES

The Hospital Facilities Seismic Upgrade Act (SB 1953)

The District has assumed responsibility for compliance with the Hospital Facilities Seismic Upgrade Act (SB 1953) classification SPC2 and through Hazus 2010. The District has received an extension to 2030.

Payments from Federal and State Health Care Programs

Entities doing business with governmental payors, including Medicare and Medi-Cal, are subject to risks unique to the government-contracting environment that are difficult to anticipate and quantify. Revenues are subject to adjustment as a result of examination by government agencies as well as auditors, contractors, and intermediaries retained by the federal, state, or local governments. Resolution of such audits or reviews often extends (and in some cases does not even commence until) several years beyond the year in which services were rendered and/or fees received.

Measure F

On November 5, 2013, the voters of the District passed Measure F, which authorized the District to issue $394,000,000 in bonds to improve the Marin General Hospital facility and related facilities with new construction, acquisitions, and renovations.

In November 2015, the District issued $170,000,000 of bonds, at a premium, resulting in total proceeds of $178,687,120. A portion of those proceeds were used to reimburse MGH for the construction of a parking structure and for design and site improvements preparatory to the commencement of construction of the new hospital facility.

CONTACTING THE DISTRICT'S FINANCIAL MANAGEMENT

This financial report is intended to provide citizens, taxpayers, and creditors with a general overview of the District's finances. Questions about this report should be directed to Marin Healthcare District to the attention of the Chief Financial Officer or the Chair of the Finance and Audit Committee at 415-464-2090.

BUDGET RESULTS

The Board of Directors approves the operating budget of the District. The budget remains in effect the entire period, but is updated as needed for internal management use to reflect changes in activity and approved variances. A budget comparison and analysis for the six months ended December 31, 2015 is presented below.

	SIX MONTHS ENDED DECEMBER 31,	
	2015	2015
	Actual	Budget
Operating revenues	$ 8,592,780	$ 8,748,076
Operating expenses	11,449,302	11,788,918
Operating loss	(2,856,522)	(3,040,842)
Support from Marin General Hospital (MGH)	3,241,058	3,194,999
Bond issuance costs	(1,203,408)	(1,309,291)
Tax revenue	17,428,863	17,428,863
Interest expense	(10,500)	(10,500)
Other revenue	17,823	1,513
Non-operating revenues	19,473,836	19,305,584
Change in net position	$ 16,617,314	$ 16,264,742

The budget above is a combination of the budget for the operations of the 1206(b) Clinics and the budget for the operations of the District, which includes bond related revenue and expenses.

Operating revenues – When new Clinic physicians are projected to be added, assumptions are made as to how quickly they will be able to increase the volume of patients treated. The actual timing of these "ramp-ups" leads to variations in revenue. As with any medical practice, the precise payer mix of patients seen is difficult to predict and often leads to variances. Clinic operating revenues were $164,463 under budget and District operating revenues were $9,167 in excess of budget.

Operating expenses – In addition to budgeting for Clinic activity, the District also conducts programs outside of the Clinics such as community healthcare education and support for hospital programs. During the current operating period, the District deferred to future years certain budgeted programs and support, resulting in a reduction of actual expenses of approximately $223,247. In the aggregate, Clinic actual expenses were $116,369 favorable to budget.

Support from Marin General Hospital – By agreement, MGH provides support to the District equal to the net losses incurred by the Clinics. As a result, the amount of support provided varies directly with the Clinic operating losses.

Bond issuance costs – The budgeted costs were estimates provided prior to the issuance of the bonds and represent management's best estimates at the time.

Other Revenue – The District earned interest income from the accounts in which the bond proceeds are held.

CAPITAL ASSETS

At December 31, 2015, the District had $47,413,171 invested in a variety of capital assets, as reflected in the following schedule, which represent a net increase (additions less depreciation) of $41,412,549 from June 30, 2015. The net capital assets decreased by $608,979 from June 30, 2014 to June 30, 2015, as a result of depreciation expensed during the year.

	Balance at December 31, 2015	Balance at June 30, 2015	Balance at June 30, 2014
Land and improvements	$ 2,498,287	$ 2,498,287	$ 2,498,287
Construction in progress	41,505,721	-	-
Building	25,079,033	25,079,033	25,079,033
Equipment	20,961,144	20,765,143	20,765,143
Less accumulated depreciation	(42,631,014)	(42,341,841)	(41,732,862)
Capital assets, net of accumulated depreciation	$ 47,413,171	$ 6,000,622	$ 6,609,601

Construction in progress – Upon the issuance of the bonds, the District reimbursed MGH for expenditures incurred related to planning and design costs of the new hospital facility and for construction of the new parking garage. Additional expenditures were made from the bond proceeds for site preparation in relation to the new facility.

LONG-TERM DEBT

The increase in long-term debt from June 30, 2015 to December 31, 2015 is primarily due to the issuance of bonds for the construction of the new hospital facility. Of the total bonds sold, $12,615,000 is to be repaid in 2016 and is included in current liabilities.

The change in long term debt from June 30, 2014 to June 30, 2015 is from principal payments made on Clinic related obligations for asset purchases and working capital loans.

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors
Marin Healthcare District

Report on Financial Statements
We have audited the accompanying financial statements of Marin Healthcare District (the District), which comprise the statements of net position as of December 31, 2015 and June 30, 2015, and the related statements of revenues, expenses, and changes in net position and cash flows for the six-month period ended December 31, 2015, and the related notes to the financial statements.

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

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

Opinion
In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Marin Healthcare District as of December 31, 2015 and June 30, 2015, and the results of its operations and its cash flows for the six-month period ended December 31, 2015 in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that Management's Discussion and Analysis on pages 1 through 6 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Stockton, California
April 26, 2016

FINANCIAL STATEMENTS

MARIN HEALTHCARE DISTRICT
STATEMENTS OF NET POSITION

	DECEMBER 31, 2015	JUNE 30, 2015
ASSETS		
Current assets		
Cash and cash equivalents	$ 4,110,687	$ 3,205,998
Patient accounts receivable, net of allowance for doubtful accounts of $15,903 and $25,494 as of December 31, 2015 and June 30, 2015, respectively	1,892,394	2,019,832
Tax revenue receivable	10,442,259	-
Other receivables	1,145,691	649,003
Prepaid expenses	19,920	13,920
Inventory	15,692	15,692
Total current assets	17,626,643	5,904,445
Deposits	585,472	572,906
Capital assets, net of accumulated depreciation	47,413,171	6,000,622
Bond assets held in trust	150,917,862	-
Intangible assets, net of accumulated amortization	629,547	658,167
Total assets	$ 217,172,695	$ 13,136,140
LIABILITIES		
Current liabilities		
Accounts payable	$ 2,634,326	$ 1,602,542
Accrued expenses	790,771	583,094
Accrued construction costs	7,126,786	-
Accrued interest expense	849,504	10,500
Current portion of note payable	782,667	566,667
Current portion of bond payable	12,615,000	-
Current portion of deferred lease revenue	-	326,055
Total current liabilities	24,799,054	3,088,858
Note payable, net of current portion	557,333	883,333
Bond payable, net of current portion	166,035,045	-
Total liabilities	191,391,432	3,972,191
NET POSITION		
Net investment in capital assets, net of related debt	18,914,321	5,050,622
Unrestricted	6,866,942	4,113,327
Total net position	25,781,263	9,163,949
Total liabilities and net position	$ 217,172,695	$ 13,136,140

See accompanying notes

MARIN HEALTHCARE DISTRICT
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

	SIX MONTHS ENDED DECEMBER 31, 2015
OPERATING REVENUE	
Net patient service revenue	$ 8,030,606
Lease income	562,174
Total operating revenues	8,592,780
OPERATING EXPENSES	
Salaries and benefits	7,741,296
Rent	696,679
Purchased services	1,508,260
Depreciation and amortization	317,793
Supplies	415,437
Insurance	22,495
Charitable contributions	55,000
Other	692,342
Total operating expenses	11,449,302
OPERATING LOSS	(2,856,522)
NON-OPERATING REVENUES (EXPENSES)	
Support from Marin General Hospital (MGH)	3,241,058
Bond issuance costs	(1,203,408)
Tax revenue	17,428,863
Interest expense	(10,500)
Other revenue	17,823
Total non-operating revenues	19,473,836
INCREASE IN NET POSITION	16,617,314
NET POSITION, beginning of year	9,163,949
NET POSITION, end of year	$ 25,781,263

MARIN HEALTHCARE DISTRICT
STATEMENTS OF CASH FLOWS

	SIX MONTHS ENDED DECEMBER 31, 2015
CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from tenants	$ 236,119
Receipts from patients	8,158,044
Payments to employees and physicians	(7,419,263)
Payments to suppliers and others	(2,491,351)
Net cash from operating activities	(1,516,451)
CASH FLOWS FROM NON-CAPITAL AND RELATED FINANCING ACTIVITIES	
Proceeds from MGH for operations	2,634,370
Net cash from non-capital and related financing activities	2,634,370
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES	
Proceeds from issuance of bonds	178,687,120
Purchases of capital assets	(33,762,507)
Proceeds from tax revenue related to general obligation bonds	6,986,604
Bond issuance costs	(1,203,408)
Principal payments for Cardiovascular Associates of Marin and San Francisco Medical Group, Inc. (CAMSF)-related note payable	(200,000)
Proceeds from loan for CAMSF asset acquisition	200,000
Payment to physician	(80,000)
Proceeds from MGH loan for physician	80,000
Interest payments on notes payable	(21,000)
Net cash from capital and related financing activities	150,686,809
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchase of bond assets held in trust	(184,484,369)
Proceeds from sales and maturities of bond assets held in trust	33,566,507
Interest income on bond assets held in trust	14,053
Interest earned	3,770
Net cash from investing activities	(150,900,039)
NET CHANGE IN CASH AND CASH EQUIVALENTS	904,689
CASH AND CASH EQUIVALENTS, beginning of year	3,205,998
CASH AND CASH EQUIVALENTS, end of year	$ 4,110,687

See accompanying notes

	SIX MONTHS ENDED DECEMBER 31, 2015
RECONCILIATION OF OPERATING LOSS TO NET CASH FROM OPERATING ACTIVITIES	
Operating loss	$ (2,856,522)
Adjustments to reconcile operating loss to net cash from operating activities:	
Depreciation and amortization	317,793
Provision for bad debts	84,652
Changes in certain assets and liabilities:	
Patient accounts receivable	42,786
Deposits and other receivables	(12,566)
Prepaid expenses	(6,000)
Accounts payable	1,031,784
Other long-term liabilities	(326,055)
Accrued expenses	207,677
Net cash from operating activities	$ (1,516,451)
SUPPLEMENTAL NON-CASH ACTIVITIES INFORMATION	
Loan forgiveness from MGH	$ (190,000)

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES

Reporting entity – Marin Healthcare District (the District) is a political subdivision of the state of California. District directors are elected officials whose sole mission is to promote the health and welfare of the residents of the communities served by the District. The District operated the Marin General Hospital facility (the Hospital Facility) until 1985, when it reorganized in compliance with local hospital district law of the state of California.

The District's principal asset is hospital property, plant, and equipment. The Hospital Facility is a general acute-care facility located in Marin County, California, and provides inpatient and outpatient healthcare services. Inpatient facilities consist of medical-surgical, pediatrics, maternity, nursery, intensive care, coronary, psychology, radiology, and laboratory services. The Hospital Facility is leased to MGH. The financial information of MGH is not included in these financial statements.

Effective June 30, 2010, the District became the sole member of MGH and appointed its initial Board of Directors. The MGH Board is responsible for oversight of the operations of MGH and the District has certain ongoing reserve powers and governance oversight responsibilities.

The District is also a forum for discussion of local healthcare issues, promotes healthcare services within the community, and acts on behalf of the public as an advocate of high quality, reasonably priced healthcare services.

The financial statements of the District include the accounts of the District and healthcare clinics (the Clinics) formed pursuant to California Health and Safety Code Section 1206(b). The Clinics contract with physicians to provide health care services within the communities served by the District.

It is in the District's nature to continue to expand its clinic network to contract with physicians and provide healthcare services within the communities served by the District. Marin Medical Practice Concepts (MMPC), a management company, provides billing and collection services for the 1206(b) clinics of the District. MMPC also provides the District with management and administrative services for the clinics pursuant to a management services agreement. There were no new clinics added in 2015. As of December 31, 2015 and June 30, 2015, there were nine clinics operating.

The financial year end of the District was changed from June 30 to December 31 so as to coterminous with MGH. Accordingly, the current financial statements are prepared for the six month period July 1, 2015 to December 31, 2015.

Proprietary fund accounting – The activities of the District are accounted for as an Enterprise Fund. Enterprise Funds are accounted for on the flow of economic resources measurement focus and use the accrual basis of accounting. Under the method, revenues are recorded when earned and expenses are recorded at the time obligations are incurred. Tax revenue is recognized in the period in which the property tax is levied. Tax revenue is collected by the County for payment, when due, of the principal and interest on the bonds.

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES (CONTINUED)

Accounting standards – Pursuant to Government Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 Financial Accounting Standards Board (FASB) and American Institute of Certified Public Accountants (AICPA) Pronouncements*, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989 and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

Proprietary fund operating revenues, such as charges for services, result from exchange transactions associated with the principal activity of the fund. Exchange transactions are those in which each party receives and gives up essentially equal values. Non-operating revenues, such as subsidies, property tax revenue, and investment earnings, result from non-exchange transactions or ancillary activities.

The District may fund programs with a combination of cost-reimbursement grants, categorical block grants, and general revenues. Thus, both restricted and unrestricted net positions may be available to finance program expenditures. The District's policy is to first apply restricted grant resources to such programs, followed by general revenues, if necessary.

Reclassifications – Certain amounts reported in the June 30, 2015 financial statements have been reclassified to conform to the December 31, 2015 presentation. These reclassifications were required for comparability to the current year's financial statements and must be considered when comparing the financial statements of this report with those of prior reports.

Use of estimates – The financial statements have been prepared in conformity with U.S. generally accepted accounting principles, and as such, include amounts based on informed estimates and judgments of management with consideration given to materiality. Actual results could differ from those estimates.

Net position – Net position is the excess of all the District's assets over all its liabilities, regardless of fund. Net position is divided into three components. These captions apply only to net position, which is determined only at the government-wide level and are described below:

Net investment in capital assets: The portion of the net position that is represented by the current net book value of the District's capital assets, less the outstanding balance of any debt issued to finance these assets.

Restricted: The portion of net position that is restricted as to use by the terms and conditions of agreements with outside parties, governmental regulations, laws, or other restrictions, which the District cannot unilaterally alter. The District has no restricted net positions.

Unrestricted: The portion of net position that is not restricted to use.

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES (CONTINUED)

Cash and cash equivalents – Cash and cash equivalents include cash in bank checking, money market funds, and investments in highly liquid debt instruments with a maturity of three months or less when purchased.

Bond assets held in trust – The District reports all investments at fair value. The fair value of investments is based on published market prices and quotations from major investment brokers.

Capital assets – Capital assets are recorded at cost. Depreciation is provided for on the straight-line basis over the estimated useful lives of the assets. The capitalization threshold is $5,000.

Capital assets are considered impaired when their service utility declines significantly and unexpectedly. An impairment loss is recognized for the difference between the carrying value of the asset and its fair value or adjusted depreciated value, depending on the nature of the impairment. No impairment was recorded for the six months ended December 31, 2015.

Asset impairment – The District also evaluates the carrying value of its long-lived assets other than capital assets for potential impairment. The evaluations address the estimated recoverability of the assets' carrying value. When events or changes in circumstances indicate that the carrying value may not be recoverable, the excess of the carrying value over the fair value is recorded as impairment. No impairment was recorded for the six months ended December 31, 2015.

Note receivable – The District entered into a note receivable with a professional medical corporation for advances up to $94,000 in December 2012. The note has an interest rate of 6% and is unsecured. The District is to receive monthly payments of principal and interest of $4,041 until maturity in 2015. The total balance of the note was paid off as of June 30, 2015.

The District entered into a note receivable with an individual physician for $80,000 in July 2015. The note has an interest rate of 6.5% and is secured by residential property. The District is to receive monthly payments of principal and interest of $1,565 until maturity in 2020. In accordance with the agreement between the District and the physician, the entire monthly amount, including principal and accrued interest, shall be forgiven each month.

Risk management – The District is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; and natural disasters for which the District carries commercial insurance.

The Clinics, while operated by the District, are insured under MGH's insurance policy. MGH is insured for professional and general liability. The professional and general liability coverage is for a claims-made policy, which limits coverage to claims that are reported to the insurance company during the policy year.

Deferred revenue - lease – Deferred revenue represents capital expenditures by MGH in excess of the current commitment, which will be recognized as rental revenue in future years (see Note 5).

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES (CONTINUED)

Lease income – The District recognizes lease income and reimbursement of operating expenses when earned. The District derives substantially all of its lease income from MGH (see Note 5).

Net patient service revenue and credit concentrations – The District's patient service revenues are recognized when health care services are provided to patients at the Clinics. Net patient service revenue is reported at the estimated net realizable amount from patients, governmental programs, health maintenance, and preferred provider organizations and insurance contracts under applicable laws, regulations, and program instructions. Net realizable amounts are generally less than the District's established rates.

The District provides estimated losses on patient accounts receivable based on prior bad debt experience. No interest is charged on past due balances. Past due status is based on the date of services provided. Recoveries from previously charged-off accounts are recorded when received. Amounts written off to bad debt expense included in net patient service revenue totaled approximately $85,000 for the six months ended December 31, 2015.

The mix of gross receivables from patients and third-party payors is as follows:

	DECEMBER 31, 2015	JUNE 30, 2015
Medicare	43%	45%
Medi-Cal	15%	13%
Commercial	27%	26%
Self-pay	11%	13%
Other	4%	3%
	100%	100%

Charity care – The District provides medically-necessary care to all patients regardless of the patient's ability to pay. Certain patients may meet eligibility criteria under its charity care policy, and no payment is collected from those patients. During the six months ended December 31, 2015, the District provided approximately $2,700 in free services for the poor and underserved. This includes services provided to persons who cannot afford healthcare because of inadequate resources and/or are uninsured or underinsured. Costs are computed based on a relationship of costs to charges similar to a Medicare cost to charge ratio.

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES (CONTINUED)

Operating revenues and expenses – The District's statement of revenues, expenses, and changes in net position distinguishes between operating and non-operating revenues and expenses. Operating revenues result from leasing the Hospital Facility to MGH and providing health care services to patients at the Clinics. Non-exchange revenues, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as non-operating revenues. Operating expenses are all expenses incurred in order to lease the Hospital Facility and to provide health care services, other than financing costs.

Grants and contributions – The District may periodically receive grants and contributions from other governmental entities, individuals, or private organizations; revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after non-operating revenues and expenses.

Amortization of bond premiums – Premiums arising from the issuance of bonds are capitalized and amortized using the straight line amortization method, which approximates the effective interest method.

NOTE 2 – CASH, CASH EQUIVALENTS, AND BOND ASSETS HELD IN TRUST

The District's cash, cash equivalents, and bond assets held in trust as of December 31, 2015 and June 30, 2015 were as follows:

	DECEMBER 31, 2015	JUNE 30, 2015
Cash in bank	$ 3,809,646	$ 2,905,477
State of California's Local Agency Investment Fund (LAIF)	301,041	300,521
Cash and cash equivalents	4,110,687	3,205,998
Bond assets held in trust		
Money market funds	150,917,862	-
Total	$ 155,028,549	$ 3,205,998

Cash balances from all funds are combined and invested to the extent possible pursuant to the District Board approved Investment Policy and Guidelines and Statement Government Code. The District's investments are carried at fair value.

Cash in bank – Cash in the bank represents amounts held in the District's general operating accounts.

NOTE 2 – CASH, CASH EQUIVALENTS, AND BOND ASSETS HELD IN TRUST (CONTINUED)

LAIF – The District places certain funds with the state of California's Local Agency Investment Fund (LAIF). The District is a voluntary participant in LAIF, which is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the state of California and the Pooled Money Investment Board. The state Treasurer's office pools these funds with those of other governmental agencies in the state and invests the cash. The fair value of the District's investment in this pool is reported in the accompanying financial statements based upon the District's pro-rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The monies held in the pooled investment funds are not subject to categorization by risk category. The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on the amortized cost basis. Funds are accessible and transferable to the master account with 24 hours' notice. Financial statements for LAIF can be obtained from the California State Treasurer's Office, 915 Capitol Mall, Suite 110, Sacramento, California, 95814.

The management of the state of California Pooled Money Investment Account has indicated to the District that as of December 31, 2015 and June 30, 2015, the estimated market value of the pool (including accrued interest) was $27,666,772 and $27,325,365, respectively. The District's proportionate share of that value is $301,041 and $300,521 as of December 31, 2015 and June 30, 2015, respectively.

Bond assets held in trust – Investments from proceeds of bond issuances are restricted by applicable California law and the various bond resolutions associated with each issuance, generally, to certain types of investments. These investments include obligations of the United States of America, Federal Housing Administration debentures, obligations of government-sponsored agencies, unsecured certificates of deposits, demand deposits, time deposits and bankers' acceptances, deposits the aggregate amount of which are fully insured by the Federal Deposit Insurance Corporation in banks, commercial paper, money market funds, state obligations, the Marin County Investment Pool, and LAIF.

The District's investments include amounts held in trust by the Paying Agent. The District currently only invests in money market funds issued by highly rated investment companies, and management regularly monitors the credit rating of the investment companies issuing the money market funds as part of monitoring the District's exposure to credit risk.

NOTE 2 – CASH, CASH EQUIVALENTS, AND BOND ASSETS HELD IN TRUST (CONTINUED)

Investment risk factors – Many factors can affect the value of investments such as credit risk, custodial credit risk, and concentration of credit risk.

Credit risk – Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The District's investment policy requires that, to be eligible for investment, money market funds shall be rated "AAm" or "AAm-G" by S & P or better and the investment pool maintained by the county in which the District is located or other investment pools, in either case, so long as such pool is rated in one of the two highest rating categories by S&P and Moody's. At December 31, 2015, the investments held are all considered investment grade and are rated equal to or greater than AAm or AAm-G by S&P and Moody's.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, the District will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party.

California law requires banks and savings and loan associations to pledge government securities with a market value of 110% of the District's cash on deposit or first trust deed mortgage notes with a value of 150% of the deposit as collateral for these deposits. Under California law, this collateral is held in the District's name and places the District ahead of general creditors of the institution.

Concentration of credit risk – Concentration of credit risk is the risk associated with a lack of diversification, such as having substantial investments in a few individual issuers, thereby exposing the District to greater risks resulting from adverse economic, political, regulatory, geographic, or credit developments. The securities purchased by the money market fund the District is invested in at December 31, 2015 are subject to the quality, diversification, and other requirements of Rule 2a-7 under the Investment Company Act of 1940, as amended and other rules of the Securities and Exchange Commission. The money market fund will only purchase securities that present minimal credit risk.

NOTE 3 – CAPITAL ASSETS

The following is a summary of changes in capital assets during the six months ended December 31, 2015 and year ended June 30, 2015:

	Life (Years)	Balance, June 30, 2015	Additions	Deletions	Balance, December 31, 2015
Non-depreciable					
Land	N/A	$ 865,701	$ -	$ -	$ 865,701
Construction in progress	N/A	-	41,505,721	-	41,505,721
Total non-depreciable		865,701	41,505,721	-	42,371,422
Depreciable					
Equipment	3 – 20	18,784,416	-	-	18,784,416
Hospital buildings	40	24,974,084	-	-	24,974,084
Parking structure	40	2,324	-	-	2,324
Phase 1 building	40	102,625	-	-	102,625
Other improvements	40	851,182	-	-	851,182
Parking improvements	40	781,404	-	-	781,404
Moveable equipment	3 – 20	1,980,727	196,001	-	2,176,728
Total depreciable		47,476,762	196,001	-	47,672,763
Accumulated depreciation		(42,341,841)	(289,173)	-	(42,631,014)
Depreciable, net		5,134,921	(93,172)	-	5,041,749
Total capital assets, net		$ 6,000,622	$ 41,412,549	$ -	$ 47,413,171

	Life (Years)	Balance, June 30, 2014	Additions	Deletions	Balance, June 30, 2015
Non-depreciable					
Land	N/A	$ 865,701	$ -	$ -	$ 865,701
Total non-depreciable		865,701	-	-	865,701
Depreciable					
Equipment	3 – 20	18,784,416	-	-	18,784,416
Hospital buildings	40	24,974,084	-	-	24,974,084
Construction in progress (not depreciated)	N/A	-	-	-	-
Parking structure	40	2,324	-	-	2,324
Phase 1 building	40	102,625	-	-	102,625
Other improvements	40	851,182	-	-	851,182
Parking improvements	40	781,404	-	-	781,404
Moveable equipment	3 – 20	1,980,727	-	-	1,980,727
Total depreciable		47,476,762	-	-	47,476,762
Accumulated depreciation		(41,732,862)	(608,979)	-	(42,341,841)
Depreciable, net		5,743,900	(608,979)	-	5,134,921
Total capital assets, net		$ 6,609,601	$ (608,979)	$ -	$ 6,000,622

NOTE 4 – INTANGIBLE ASSETS

The District acquired intangible assets as part of the acquisition of assets from CAMSF (see Note 6).

The following is a summary of changes in intangible assets during the six months ended December 31:

	Life (Years)	Balance, June 30, 2015	Additions	Deletions	Balance, December 31, 2015
Intangible assets:					
Other intangible assets	15	$ 675,660	$ -	$ -	$ 675,660
Medical records – CAM	15	182,844	-	-	182,844
Total intangible assets		858,504	-	-	858,504
Less accumulated amortization		(200,337)	(28,620)	-	(228,957)
Intangibles, net of accumulated amortization		$ 658,167	$ (28,620)	$ -	$ 629,547

NOTE 5 – LEASE OF MARIN HEALTHCARE DISTRICT FACILITY

Annual rental payments – Effective December 1, 1985, the District leased the Marin General Hospital facility to MGH for a term of 30 years pursuant to Section 32126 of the Local Hospital District Law. Per the amended lease agreement dated August 25, 1987, as further amended by the subsequent agreements, the annual rent payments comprise of capital expenditures made by MGH and quarterly payments of approximately $97,000 for the six months ended December 31, 2015. The minimum cash payment, which is payable in quarterly installments, increases annually by 5% throughout the lease term. The lease matured on December 1, 2015 and a new lease commenced on December 2, 2015.

Due to the significant capital investment required for the hospital modernization program completed in June 1989, MGH's rental payment commitment for capital expenditures due under the entire lease has been satisfied. The advanced capital commitment (including the excess capital commitment) has been recorded as deferred revenue. The total deferred lease revenue was $0 and $326,055 as of December 31, 2015 and June 30, 2015, respectively.

In August 2014, a new lease was executed, effective December 2, 2015. The District leased the Marin General Hospital facility to MGH for a term of 30 years. The base rent is $500,000 annually, plus an annual CPI increase. Additional rent is conditional on MGH achieving certain financial benchmarks. The total rent received for the six months ended December 31, 2015 was $41,667.

NOTE 5 – LEASE OF MARIN HEALTHCARE DISTRICT FACILITY (CONTINUED)

Annual rental payments (continued) – The minimum future rental income under the agreement, exclusive of any increases related to the CPI, is as follows:

Years ending December 31,	
2016	$ 500,000
2017	500,000
2018	500,000
2019	500,000
2020	500,000
Thereafter	12,458,333
	$ 14,958,333

NOTE 6 – NOTES PAYABLE AND ACQUISITION

In January 2012, the District and MGH entered into an affiliation and co-management arrangement (CMMA) with CAMSF. The District has thereupon established 1206(b) Clinics for cardiology and vascular surgery services, in conjunction with MGH, by entering into professional services agreements (PSA) with CAMSF and Laura K. Pak, M.D., Inc. for physician services to Clinic patients. As a part of that transaction, the District acquired an outpatient diagnostic services business from CAMSF on terms described in an Asset Purchase Agreement dated January 1, 2012. The Asset Purchase Agreement provided for the District to purchase most of CAMSF practice assets (with the exception of accounts receivable) in the amount of $1,750,000. This has been implemented in the form of an initial payment of $750,000 on closing and $200,000 per year for each of five subsequent years with interest at the prime rate of interest plus 2% per year on the unpaid principal balance.

In accordance with an agreement between the District and MGH, MGH loaned $750,000 to cover the District's payment to CAMSF as described above. As part of the acquisition of CAMSF, MGH agreed to fund the District's financial obligations to CAMSF. A portion of the loan will be forgiven each month over the five-year term of the contract with CAMSF.

In July 2015, in accordance with the agreement between the District and MGH, MGH loaned $80,000 to cover the District's payment to a physician who is associated with the Marin Urology Center Clinic. A portion of the loan will be forgiven each month over the five-year term of the contract with the physician.

In April 2012, MGH loaned the District $500,000 as an advance to fund the monthly outside billing and management services company service fee. The vendor pays the administrative overhead of the Clinics and then bills the District for reimbursement. The advance is meant to ensure that the vendor has adequate cash on hand to meet its obligations. The outstanding balance of $500,000 is payable to MGH at the termination of the agreement for outside billing and management services and has been classified as long-term at December 31, 2015.

NOTE 6 – NOTES PAYABLE AND ACQUISITION (CONTINUED)

The activity for notes payable for the year ended December 31, 2015 is as follows:

	Balance, June 30, 2015	Additions	Deletions	Balance, December 31, 2015	Due Within One Year
Note payable to CAMSF	$ 400,000	$ -	$ (200,000)	$ 200,000	$ 200,000
Note payable to MGH	1,050,000	280,000	(190,000)	1,140,000	582,667
	$ 1,450,000	$ 280,000	$ (390,000)	$ 1,340,000	$ 782,667

The activity for notes payable for the year ended June 30, 2015 is as follows:

	Balance, June 30, 2014	Additions	Deletions	Balance, June 30, 2015	Due Within One Year
Note payable to CAMSF	$ 600,000	$ -	$ (200,000)	$ 400,000	$ 200,000
Note payable to MGH	1,166,667	200,000	(316,667)	1,050,000	366,667
	$ 1,766,667	$ 200,000	$ (516,667)	$ 1,450,000	$ 566,667

Debt service requirements for notes payable are as follows:

Years ending December 31,	Principal	Interest
2016	$ 782,667	$ 5,500
2017	516,000	-
2018	16,000	-
2019	16,000	-
2020	9,333	-
	$ 1,340,000	$ 5,500

NOTE 7 – BONDS PAYABLE

On November 10, 2015, the District issued $157,385,000 of Marin Healthcare District General Obligation Bonds, Election of 2013, Series 2015A, and $12,615,000 of Marin Healthcare District General Obligation Bonds, Election 2013, Series 2015B. The 2015A and 2015B bonds bear interest at rates of 2.00% to 5.00% and 0.40%, respectively. Interest on the bonds will accrue from the date of delivery and is payable semiannually on February 1 and August 1 each year, commencing on February 1, 2016. Principal amounts will be paid on August 1. The bonds were authorized at an election held in the District on November 5, 2013, at which more than two-thirds of the qualified electors voting on the proposition voted to authorize the issuance and sale of up to $394,000,000 principal amount of general obligation bonds of the District (Measure F). The bond proceeds are authorized to be used to make seismic upgrades to MGH to meet stricter California earthquake standards; to expand and enhance emergency and other medical facilities; to provide the latest lifesaving medical facilities for treatment of heart, stroke, and other diseases, to reduce emergency room wait times; to improve MGH and related facilities with new construction, acquisitions, and renovations; pay all necessary legal, financial, engineering, and contingent costs in connection therewith.

The Series 2015A Bonds maturing on or before August 1, 2025 are not subject to redemption prior to their respective stated maturity dates. The Series 2015A Bonds maturing on or after August 1, 2026 are subject to redemption prior to their respective stated maturity dates, at the option of the District, from any source of funds, in whole or in part, on August 1, 2025 or on any date thereafter at par amount thereof, without premium, together with interest accrued thereon to the date of redemption. The Series 2015A Bonds maturing on August 1, 2040 and on August 1, 2045 shall be subject to redemption prior to maturity, without a redemption premium, in part by lot, from mandatory sinking fund payments, beginning August 1, 2036 and August 1, 2041, respectively. The Series 2015B Bonds are not subject to redemption prior to maturity.

The general obligation bonds represent the general obligation of the District. The Board of Supervisors of the County has the power and is obligated to cause annual ad valorem taxes to be levied upon all property within the District, subject to taxation by the District, and collected by the County for payment, when due, of the principal and interest on the bonds.

The activity for bonds payable for the year ended December 31, 2015 is as follows:

	Outstanding July 1, 2015	Issued	Matured / Redeemed During Year	Outstanding December 31, 2015	Due Within One Year
General obligation bonds	$ -	$ 170,000,000	$ -	$ 170,000,000	$ 12,615,000
Plus					
Premium	-	8,687,120	(37,075)	8,650,045	-
Total	$ -	$ 178,687,120	$ (37,075)	$ 178,650,045	$ -

NOTE 7 – BONDS PAYABLE (CONTINUED)

A summary of debt service requirements for the next five years and to maturity as of December 31, 2015 is as follows:

Years ending December 31,	Principal	Interest
2016	$ 12,615,000	$ 4,813,863
2017	2,645,000	6,589,350
2018	-	6,510,000
2019	-	6,510,000
2020	190,000	6,510,000
2021 – 2025	4,885,000	32,300,400
2026 – 2030	13,705,000	30,464,250
2031 – 2035	26,630,000	25,836,500
2036 – 2040	43,625,000	18,681,000
2041 – 2045	65,705,000	8,290,000
Total	$ 170,000,000	$ 146,505,363

NOTE 8 – COMMITMENTS AND CONTINGENCIES

Compliance with the Hospital Facilities Seismic Upgrade Act – The District has assumed responsibility for compliance with the Hospital Facilities Seismic Upgrade Act (SB 1953) classification SPC2 and through Hazus 2010. The District has received an extension to 2030.

Regulatory environment – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to periodic government review, interpretation, and audits, as well as regulatory actions unknown and unasserted at this time.

Litigation – The District is party to various claims and legal actions in the normal course of business. In the opinion of management, the District has substantial meritorious defenses to pending or threatened litigation and, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the District's financial statements.

Professional and clinic management services agreements – MHD has entered into various Professional and Clinic Management Services Agreements with the 1206(b) Clinics. In general, the agreements provide for compensation and benefits allowance for the physicians as well as a compensation level guaranty for new physicians. The agreements also include a cap on total payments the physicians can receive for services.

NOTE 9 – RELATED PARTY TRANSACTIONS

The following transactions are conducted with affiliated entities:

Effective June 30, 2010, the lease agreement between the District and MGH was amended. The amended lease agreement requires that MGH provide financial support to the District relating to the operation of the Clinics through December 1, 2015. MGH provided $3,155,917 to the District for the operation of the Clinics during the six months ended December 31, 2015. Additionally, the lease agreement also requires MGH to reimburse a portion of the District's administrative, rent, and non-clinic expenses. The new 30-year lease agreement between the District and MGH, effective as of December 2, 2015, includes similar provisions.

The District has a receivable of $1,037,481 and $605,915 due from MGH, as of December 31, 2015 and June 30, 2015, respectively, included in the statements of net position.

NOTE 10 – OPERATING LEASES

The District leases office facilities under a non-cancelable operating lease. The total cost for the leases were $677,347 for the six months ended December 31, 2015. The future minimum lease payments were as follows:

Years ending June 30,	
2016	$ 1,131,302
2017	1,070,098
2018	823,722
2019	753,820
2020	766,656
Thereafter	667,729
	$ 5,213,327

Communication of
Internal Control Related Matters

Marin Healthcare District

December 31, 2015

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

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COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS

To the Board of Directors
Marin Healthcare District

In planning and performing our audit of the financial statements of Marin Healthcare District (the District) as of and for the six months ended December 31, 2015, in accordance with auditing standards generally accepted in the United States of America, we considered the District's internal control over financial reporting (internal control) as a basis for designing our auditing procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the District's financial statements will not be prevented, or detected and corrected, on a timely basis.

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

We did identify another matter that is an opportunity for strengthening internal control and operating efficiency. The attachment to this letter summarizes our other comment and suggestion regarding that matter. This letter does not affect our report dated April 26, 2016 on the financial statements of the District.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

Moss Adams LLP

Stockton, California
April 26, 2016

Valuation of 1206(b) Clinics Patient Accounts Receivables – Observation

Based on our audit procedures, we noted that unbilled revenue accrual included charges posted during December; therefore, unbilled revenue and patient service revenue were overstated. The charge file utilized in creating the accrual included parameters which allowed for December charges to be included, these charges had already been posted to revenue and accounts receivable in the current month. Additionally, the file provided by the third party biller and utilized by management in their analysis was not reviewed for accuracy prior to performing the analysis. Management currently has a process in place whereby charges billed after year-end but that relate to services rendered during the year are accrued for at year-end. Additionally, Management investigates any large variations from month-to-month.

Recommendation

We recommend that during the monthly closing process, management review the data provided by the third party biller for accuracy to ensure the data utilized in preparing the accrual is accurate.

Tab 5

Creating a healthier Marin together.

TO: MHD Board of Directors

FROM: James P. McManus, Chief Financial Officer

RE: Board Approval of the Loan Modification to the Amended and Restated Loan Agreement dated December 19, 2013 among Marin General Hospital, Prima Medical Foundation, and MUFG Union Bank, N.A.

Board Approval of the Reaffirmation of Collateral Assignment of Contracts, Security Agreement and Environmental Compliance Agreement between Marin General Hospital (assignor) and MUFG Union Bank, N.A. (assignee).

DATE: March 29, 2016

BACKGROUND

Pursuant to a Loan Agreement dated December 19, 2013, MUFG Union Bank, N.A. provided Marin General Hospital (MGH), with $100M in funding for the purpose of ensuring access to cash, should needs arise. This $100M is detailed as follows:

- $30M term loan
- $40M revolving line of credit
- $30M non-revolving line of credit

The Loan Agreement expires on January 2, 2017 and both MUFG Union Bank, N.A. and MGH wish to modify the Agreement by extending the Agreement until January 2, 2020. MGH will need to also execute a document reaffirming the collateral assignment of contracts & security in the assets of MGH. As a result, MGH is required under Bylaw sections 10.1(c)ii and 10.1(d) to both notify and obtain approval from the General Member (Marin Healthcare District) prior to executing this Agreement.

ANALYSIS

Over the past four years, MGH has been successful in continually improving operations which has led to building a stronger cash position on the balance sheet. Some of this improvement has been achieved by making strategic investments in growth opportunities & technology (joint ventures, clinics, medical foundation, equipment, etc.) Funding provided by MUFG Union Bank, N.A. has ensured continual cash flow when significant investments have been made. It is prudent to ensure that MGH has timely access to funding should the need arise. The extension of the Agreement with MUFG Union Bank, N.A. does not increase the amount of liability to either MGH or MHD. There are no other changes to the original Loan Agreement being requested.

Marin Healthcare District

Creating a healthier Marin together.

RECOMMENDATION

It is the recommendation of Management that the Loan Modification and the Reaffirmation Agreements be approved which will extend the term loan, revolving & non-revolving lines of credit to January 2, 2020.

REQUESTED ACTION BY THE BOARD

Motion based on management's recommendation: "To approve the Loan Modification Agreement among Marin General Hospital, Prima Medical Foundation, and MUFG Union Bank, N.A. as presented.

Motion based on management's recommendation: "To approve the Reaffirmation of Collateral Assignment of Contracts, Security Agreement and Environmental Compliance Agreement between Marin General Hospital and MUFG Union Bank, N.A., as presented.