Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Friday, July 16, 2010 at the hour of 9:30 A.M., at John H. Stroger, Jr. Hospital of Cook County, 1901 W. Harrison Street, in the fifth floor conference room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Muñoz called the meeting to order.

Present: Chairman Luis Muñoz, MD, MPH and Director Heather O’Donnell, JD, LLM (2)
Board Chairman Warren L. Batts (Ex-Officio)

Absent: Director Benn Greenspan, PhD, MPH, FACHE (1)

Additional attendees and/or presenters were:

- Michael Ayres
- Cathy Bodnar
- Daniel Brennan, Jr.
- Patrick T. Driscoll, Jr.
- Christina Eng-Tran
- William T. Foley
- Martin Grant
- Tracey Guidry
- Helen Haynes
- Tim Heinrich
- Daniel Howard
- Randolph Johnston
- Tricia Routh
- Deborah Santana
- Thomas Schroeder

II. Public Speakers

Chairman Muñoz asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore Concerned Citizen

III. Report from System Corporate Compliance Officer

A. Activity Report

B. Board Goal Update – Develop and Implement a Corporate Compliance Function

Cathy Bodnar, System Corporate Compliance Officer, presented updates (Attachment #1) on the following subjects: Reporting of Compliance Issues by Category; Status of Compliance Issues; Updated Hot Line Script; and Compliance Education. Additionally, she presented an update on the goal of developing and implementing a corporate compliance function. The Committee reviewed and discussed the information.

With regard to compliance issues, Board Chairman Batts inquired whether there are any patterns relating to the types of issues. Ms. Bodnar responded that they continue to have questions regarding the Health Insurance Portability and Accountability Act (HIPAA).

During the update on Compliance Education, Ms. Bodnar stated that recently, while trying to utilize an electronic format for the compliance education sessions, some difficulties were experienced. She noted that there is currently a module within Cerner that allows for electronic learning management. Daniel Howard, System Chief Information Officer, provided additional information. He stated that they are currently working with Cerner to resolve the problem.
IV. Report from System Director of Internal Audit

A. Activity Report

B. Board Goal Update – Develop and Implement an Internal Audit Function

Tom Schroeder, System Director of Internal Audit, presented the Internal Audit Activity Update and an update on the goal of developing and implementing an internal audit function (Attachment #2). The Committee reviewed and discussed the information.

The Committee discussed the subject of information technology system access and security. Mr. Schroeder noted that this audit had been completed and reported upon to the Committee a few months ago; he added that there should be an annual assessment on security.

V. Recommendations, Discussion/Information Items

A. Minutes of the Audit and Compliance Committee Meeting, June 8, 2010

Director O'Donnell, seconded by Chairman Muñoz, moved to accept the minutes of the Audit and Compliance Committee Meeting of June 8, 2010. THE MOTION CARRIED UNANIMOUSLY.

B. Proposed CCHHS Corporate Compliance Program Policy (Attachment #3)

Director O'Donnell, seconded by Chairman Muñoz, moved to approve the proposed CCHHS Corporate Compliance Program Policy, with the note that Legal will review prior to finalization. THE MOTION CARRIED UNANIMOUSLY.

C. Report from Deloitte and Touche

Tracey Guidry and Trisha Routh, of Deloitte and Touche, presented an update on audit activities (Attachment #4). Ms. Guidry noted that they are still in the process of working on the County piece; there are still some open items related to long-term debt. She expects that they will be moving into the reporting process for the County in the next week or so. The timeline that the County has set is to be completed by August 31st.

D. Report from RSM McGladrey

Tim Heinrich, of RSM McGladrey, presented an update on the status of the internal audits (Attachment #5). The Committee reviewed and discussed the information.

Chairman Muñoz requested an update on the subject of the proposed draft agreement with Hektoen to formally establish the relationship between it and the System. Mr. Ayres responded that Legal has sent the draft agreement to the representatives of Hektoen; they are working to set meetings to discuss the draft agreement with Hektoen representatives. It is his hope to have an executed agreement by December 1st.

VI. Action Items

A. Any items listed under Sections V, VI and VII
VII. Closed Session Discussion/Information Items

A. Approval of the payment of Medicaid overpayments in the amount of $460,441.60
B. Approval of agreement with the State of Illinois and payment of $10,000.00
C. Discussion of Personnel Matters

Director O’Donnell, seconded by Chairman Muñoz, moved to recess the regular session and convene into closed session, pursuant to the following exception to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(1), regarding “the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity,” and 5 ILCS 120/2(c)(11), regarding “litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting.” THE MOTION CARRIED UNANIMOUSLY.

Chairman Muñoz declared that the closed session was adjourned. The Committee reconvened into regular session.

Director O’Donnell, seconded by Chairman Muñoz, moved to accept and file the matters discussed in closed session. THE MOTION CARRIED UNANIMOUSLY.

VIII. Adjourn

As the agenda was exhausted, Chairman Muñoz declared the meeting ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXX
Luis Muñoz, MD, MPH, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary
JULY 16, 2010 REPORT

to the

AUDIT AND COMPLIANCE COMMITTEE

from the

CHIEF COMPLIANCE OFFICER
COMPLIANCE ISSUES (REACTIVE)
BY CATEGORY

F-YTD 2010 Statistics
12/01/2009 – 06/30/2010
91 Issues – 30% increase in 1-month

Privacy (HIPAA) 24
Conflict of Interest 13
Political Activity 12
Human Resources 11
False Claims 9
Accurate Books & Records 5
Fraud 3
Theft 1
Other 13

1 Assumed ownership of the Shakman Political Contact Log from the Office of General Counsel. Reports entered into compliance program database.
Status of Compliance Issues

Summary of Resolved Issues

→ 62% were potential compliance issues

Of the potential compliance issues,

→ 72% were identified as valid, substantiated issues that required additional investigation and
  o guidance to prevent or resolve the compliance issue,
  o re-education to prevent the recurrence, and/ or
  o implementation of corrective action plans.
# Follow Up
## Updated Hot Line Script

### CCHHS Telephonic Hot Line Greeting

**Version 3**

This is the greeting that your reporters will hear when they call your hot line number.

### Script

Thank you for calling the Cook County Health and Hospitals System corporate compliance hot line. My name is ________.

Please listen carefully. Confidentiality is very important to us and to the Cook County Health & Hospitals System. This call is not being recorded. Your calling location and number are not known to us.

We will ask you for your name and phone number; however, if you wish to remain anonymous, we will honor your request.

Before we begin, you should know your organization hired us to gather information and submit it to them as a way to further protect the confidentiality of callers. I am not an employee of your organization; I work for a company called EthicsPoint. We do not investigate reported issues. It is up to your organization to resolve issues submitted.

It is CCHHS’ policy that there is no retaliation for reporting “good faith” concerns.

Please keep in mind that providing false or misleading information is against CCHHS policy, it can result in disciplinary action up to and including termination.

How may I help you?”

### Would you like more information?

If yes →
Operator will read the privacy and confidentiality statement (EthicsPoint standard language). They will also direct the caller to the EthicsPoint webpage.

If no →
Do you wish to proceed?
New Resident / Fellow Orientation

to

Corporate Compliance

&

HIPAA

developed by
Cook County Health & Hospitals System
Corporate Compliance Program

Corporate Compliance:
the Educational Goals

- To Increase Your Awareness of Government Requirements in a Health Care Setting
- To Realize that Compliance is an Important Component of Health Care
- To Recognize You Have a Role and Responsibility
What are government requirements?

Laws and Regulations, and they come from everywhere!

- Locally
  - from the city of Chicago and Cook County
- The state of Illinois
  - and
- The federal government

And they can make your head spin
In addition to laws and regulations

You now work within the
Cook County Health & Hospitals System

We have a mission,

- To deliver integrated health services with dignity and respect regardless of a patient’s ability to pay;
- To foster partnerships with other health providers and communities to enhance the health of the public; and
- To advocate for policies which promote and protect the physical, mental and social well being of the people of Cook County.

It’s a Balancing Act

Practicing medicine in a highly regulated environment

But…how to survive?! *(It’s actually quite simple)*

1. Recognize it’s there.
2. Know you have somewhere to turn when you have questions or concerns.
The Office of Corporate Compliance

We’re here
- to provide guidance and
- function as your resource.

If you have questions about laws and regulations.

We are accessible.
We can be reached by phone, in writing (intra-office, snail, or e-mail), through our hot line, or in person.

The scope is huge, let’s break it down

Think about corporate compliance as business or operational ethics; and here are the basic categories.

- Health care funds are for health care services and nothing else – protection against fraud and abuse is needed.
- Financial incentives should not cloud clinical decision-making or create unfair competitive advantage.
- Patients’ rights to privacy and emergency treatment should be protected.
And how does this relate to me?

- **Clinical documentation** and billing for those services.
  - Documentation must always accurately reflect a patient’s condition, diagnosis and treatment.
  - Documentation must reflect the actual care provided and must be medically necessary.
  - Documentation is critical and it must support what appears on a bill.

Physician bills for services never provided

Nebraska physician sentenced to five years of probation and six months of electronically monitored home confinement, and he was ordered to pay $107,244 in restitution after pleading guilty to one count each of health care fraud and mail fraud.

Clinical Decision-Making

- Should never be clouded by personal or financial benefit.
  - Think twice about financial and personal relationships with vendors.
  - Consider what you give or do in return, directly or indirectly.
  - Consider whether your actions or judgments could be influenced or your objectivity could appear to be compromised.

Senator Grassley conducting conflict of interest Congressional inquiries

Investigation continues to explore the drug industry and device manufacturer influence on the practice of medicine.

Financial relationships with industry from academic physicians, medical schools, medical journals, continuing medical education, and the patient advocacy community is under scrutiny.
You Have a Duty & Responsibility to Protect Patient’s Privacy

- Ensure any and all personally identifiable information is protected.
  - Be sensitive to the fact that others may overhear patient related discussions; move to private areas to talk.
  - Only discuss patient information with the patient and ask the patient permission before releasing any information to anyone else.
  - Keep patient information secure; logoff computers when you’re finished.

First criminal prosecution for HIPAA violation

A physician and 2 employees of a medical center in Arkansas, pleaded guilty to misdemeanor violations of the privacy provisions of the HIPAA. The records that were illegally accessed related to a local television personality who was brutally beaten by a home intruder on October 20, 2008 and subsequently died on October 25. Each of the individuals faces up to a year in jail and a $50,000 fine.

Privacy is incredibly important!

Not only because it’s the right thing to do, it’s also because it’s a Federal law.

That law is also known as HIPAA, the Health Insurance Portability and Accountability Act of 1996.

This law regulates privacy, confidentiality and electronic security of protected health information (also known as PHI).
### What are some examples of PHI?

<table>
<thead>
<tr>
<th><strong>Personal information</strong></th>
<th><strong>Medical information</strong></th>
<th><strong>Technical information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
<td>Medical record numbers</td>
<td>Biometric identifiers such as finger and voice prints</td>
</tr>
<tr>
<td>Birth date, admission date, discharge date, date of death</td>
<td>Health plan beneficiary numbers</td>
<td>Full-face photographic images and comparable images</td>
</tr>
<tr>
<td>Social Security numbers</td>
<td>Procedure Information</td>
<td>Device identifiers and serial numbers</td>
</tr>
<tr>
<td>Certificate/license numbers</td>
<td>Test results</td>
<td>Web URLs</td>
</tr>
<tr>
<td>Geographic subdivisions smaller than a state</td>
<td>Clinical notes</td>
<td>Internet Protocol (IP) addresses</td>
</tr>
<tr>
<td>Telephone numbers</td>
<td>Care plans</td>
<td>Account numbers</td>
</tr>
<tr>
<td>Fax numbers</td>
<td>Diagnoses</td>
<td></td>
</tr>
<tr>
<td>Electronic mail addresses (e-mail)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automobile vehicle identifiers and serial numbers, including license plate numbers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Here are a couple important definitions

- **Minimum Necessary**
  You should only review or request the minimal amount of protected health information (PHI) that’s necessary for you to do your job.

- **Need to Know**
  You should only have access to PHI if it’s part of your job.
How do we use and share patient information?

Under HIPAA, patient information can be used for,

- **Treatment**
  
  *For Example:* Doctors, nurses, or other health care providers may review a patient’s record to treat their injury or illness. A patient’s health information also may be shared with other health care professionals outside CCHHS to decide on the best treatment or to coordinate care.

- **Payment**
  
  *For Example:* We may contact Medicare, Medicaid, an insurance company, or other company or program that arranges for or pays the cost of some or all of a patient’s health care, and to find out if a service is covered.

- **Operations**
  
  *For Example:* We may use health information to make sure that patients get the best possible quality care and to review the performance of our doctors, nurses or other health care professionals. Patient information may be used as part of training for students and help to meet hospital licensing and accreditation.
Under HIPAA, patients have the right to

- Access their own medical records.
- Ask to amend or correct their records.
- Request a restriction limiting access.
- File a complaint if they believe their privacy has been violated.

The security of PHI is your responsibility

- Don’t look up information about your family or your friends;
- Don’t look up your own information;
- Don’t look up information about other employees;
- Don’t look up information about people in the public eye; and
- Don’t look up patient information for research purposes without IRB approval.

Ask yourself – Do I have a “Need to Know”? 
In reality, compliance is very basic…

It’s about
Doing the Right Thing
because
It’s the Right Thing to Do!
(Even when no one’s looking!)

Compliance is about **following the rules**

The rules are found in our
- polices and procedures
  (this includes our Standards of Conduct)
and
- in laws and regulations.

It’s about knowing your limits
and asking questions when you don’t know the answer.
Compliance is about **respect**

- for our patients, their families and significant others, and for patients’ rights to make informed decisions about their care.
- for privacy, confidentiality, and security of information about patients, colleagues and visitors.
- for our co-workers and other members of the Cook County Health & Hospitals System, whether they are directly involved in patient care or not - for example in administrative, support areas, education or research.

Compliance is about **honesty**

Honesty in dealing with

- our patients,
- the public, and
- the government.

It includes honesty in the way we do our work day in and day out.
Compliance is about

Us collectively, as a health care organization and
it’s about You individually.

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We have a responsibility as individuals and as a group to behave honestly with professional responsibility.

One last thing…

As a new member of the Cook County Health & Hospitals System,

Patient care is incredibly important, but there are other things to consider as well…

Corporate Compliance is one of those things!
The **BIG** Take Away

➔ **Remember…**

the Office of Corporate Compliance is here to provide guidance; we are available as your resource when it comes to questions about laws and regulations.

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Here are a few ways to contact Corporate Compliance

- Call our confidential, toll-free hot line 866-489-4949
- Call our office 312-864-0903
- Send an e-mail to the Chief Compliance Officer cbodnar@ccbhs.org
- Write or Visit
  The Corporate Compliance Program
  Cook County Health & Hospitals System
  1900 West Polk, Suite 123
  Chicago, IL  60612
For now,

You need to get credit for participating in this session.

You must sign the Compliance & HIPAA Education Attestation.

Welcome!

to the

Cook County Health & Hospitals System
III B
BOARD GOAL UPDATE –
DEVELOP AND IMPLEMENT A CORPORATE COMPLIANCE FUNCTION
### Cook County Health & Hospitals System
#### Operations Stoplight Report-2010

<table>
<thead>
<tr>
<th>Ops Number</th>
<th>Description</th>
<th>Assignee</th>
<th>Co-Assigee</th>
<th>Due Date</th>
<th>Revised Due Date</th>
<th>Comments</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>14</td>
<td>Develop and implement a comprehensive Corporate Compliance function within CCHHS</td>
<td>Chief Compliance Officer</td>
<td>Compliance Committee of Board</td>
<td>6/30/2010</td>
<td></td>
<td>Director has presented overview of process to build and implement function.</td>
<td>C</td>
</tr>
</tbody>
</table>

The color in the far right column denotes the progress of the operational initiative.

- **Significant Issue (SI) Red**
- **Outstanding Issue/On Track (OI/OT) Yellow**
- **Complete (C) Green**
### CCHHS Internal Audit Activity Update *

<table>
<thead>
<tr>
<th>Audit/Project</th>
<th>Complete</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<tbody>
<tr>
<td>Mail Order Pharmacy</td>
<td>x</td>
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<td></td>
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<tr>
<td>Impark</td>
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<tr>
<td>Risk Assessment</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Management</td>
<td>Planning</td>
<td>Field work</td>
<td>Reporting</td>
<td></td>
<td></td>
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<tr>
<td>Radiology Contract</td>
<td>Planning</td>
<td>Field work</td>
<td>Reporting</td>
<td></td>
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<tr>
<td>Fixed Assets</td>
<td></td>
<td>Planning</td>
<td>Field work</td>
<td>Reporting</td>
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<tr>
<td>Compliance Project</td>
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<td>TBD</td>
<td></td>
<td></td>
<td></td>
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</table>

*Projects managed by CCHHS Internal Audit. McGladrey will provide a separate update on the projects they are managing.*

Mail Order Pharmacy – review of operational controls for SAV-Rx, CCHHS’s prescription mail order vendor
Impark – review of operational controls for Impark, Stroger and CORE parking facility manager
Risk Assessment – development of 2011 internal audit plan
Cash Management – review of safeguarding of cash
Radiology Contract – review of service volumes and invoicing by CCHHS’s radiology vendor
Fixed Assets – review of safeguarding and accounting for fixed assets
Compliance Project – to be discussed in private session
### Cook County Health & Hospitals System Operations Stoplight Summary - 2010

<table>
<thead>
<tr>
<th>Ops Number</th>
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<th>Due Date</th>
<th>Revised Due Date</th>
<th>Comments</th>
<th>Status</th>
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<tbody>
<tr>
<td>12</td>
<td>Develop and implement a comprehensive Internal Audit function within CCHHS</td>
<td>Director of Internal Audit</td>
<td>Audit Committee of Board</td>
<td>6/30/2010</td>
<td></td>
<td>Audit department is functioning and has a comprehensive plan</td>
<td>C</td>
</tr>
</tbody>
</table>

The color in the far right column denotes the progress of the operational initiative.

- **Significant Issue (SI) Red**
- **Outstanding Issue/On Track (OI/OT) Yellow**
- **Complete (C) Green**
Develop and Implement a Comprehensive Internal Audit Function Within CCHHS

The following elements, resources, and work products were completed by CCHHS Internal Audit and McGladrey in support of the goal to develop and implement a comprehensive internal audit function within CCHHS.

Foundational Elements Reviewed and Approved by the Audit and Compliance Committee

- Risk Assessment – foundation for 2 year audit plan developed by McGladrey
- Internal Audit Mission and Vision – developed with CCHHS stakeholder input
- Internal Audit Strategic Plan – 3 year plan including initiatives to develop CCHHS Internal Audit
- Audit and Compliance Committee Charter – governance document for the Audit and Compliance Committee
- Internal Audit Charter – governance document for CCHHS Internal Audit
- Internal Audit Policies and Procedures – guidance for CCHHS Internal Audit Department

Enabling Resources Acquired by CCHHS Internal Audit

- Membership in Professional Associations (Institute of Internal Auditors, American Institute of Certified Public Accountants, Information System Audit and Control Association)
- Knowledge Resources – online tools for professional guidance (KnowledgeLeader.com)
- Productivity Tool – automated work paper tool (Auditor Assistant)
- CCHHS Internal Audit Staff – currently 3 members

Work Product Delivered By CCHHS Internal Audit and McGladrey

- Performance against audit plan
- Management Requests
CCHHS Compliance Program Policy
Summary Document

Introduction:
Compliance policies are integral to the development of a Compliance Program that meets Federal, State, and local requirements. The following summary includes an overview of the CCHHS Compliance Program policy developed by the Corporate Compliance Program.

Scope:
This policy and all compliance program policies apply to all CCHHS personnel, including officers, directors, members of committees with Board-delegated authority, employees, and members of the CCHHS medical staff or house staff, researchers, students and agency personnel. These policies also affect independent contractors, consultants and other business partners (vendors) who are not employed by CCHHS.

Management and senior leaders are responsible to assure that CCHHS personnel are aware of the Corporate Compliance Program policies and that all CCHHS personnel have access to the policies.

The Compliance Program Policy:
→ Describes the purpose and design of the Corporate Compliance Program to prevent and detect violations of applicable laws and regulations, Standards of Conduct (Code of Conduct), and organizational policies.

→ This policy establishes the scope of activities, authority, reporting, committee and governance structure, and assessment guidelines for the CCHHS Corporate Compliance Program.

→ Focuses responsibility for compliance activities with the Office of the Chief Compliance Officer (CCO), with reporting to the Audit & Compliance Committee of the Board of Directors and to the Chief Executive Officer (CEO).

→ Establishes the CCO as the CCHHS Privacy Officer, responsible for assuring compliance with HIPAA requirements, including protection of patient health information.

→ Establishes governance and responsibility for the Corporate Compliance Program for all CCHHS entities with the Audit & Compliance Committee of the Board of Directors. The Committee advises the Board regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management.

Policy Owner: Chief Compliance Officer
Approval Parties: Audit & Compliance Committee of the Board
CEO
I. Purpose

It is the policy of Cook County Health & Hospitals System and all affiliated organizations (collectively, “CCHHS”) to establish and support a system-wide Corporate Compliance Program. CCHHS is committed to conducting business in a manner that is ethical and in compliance with all applicable federal, state and local laws. To that end, the Cook County Health & Hospitals System Board of Directors through the Audit and Compliance Committee of the Board established and continues to maintain a Corporate Compliance Program.

II. Policy Guidelines

The Corporate Compliance Program is based on the Compliance Mission Statement. In addition, the Corporate Compliance Program is designed to prevent and detect violations of applicable laws and regulations, CCHHS Standards of Conduct (Code of Conduct), and organizational policies.

While it is expected that CCHHS personnel will comply with applicable laws and regulations, the CCHHS Standards of Conduct (Code of Conduct) and policies, CCHHS management and directors understand that the implementation of the Corporate Compliance Program cannot eliminate all risk of improper conduct. In the event that CCHHS becomes aware of possible violations of law or the Standards of Conduct (Code of Conduct) or policies, the Chief Compliance Officer will investigate the matter with management and, where appropriate, act as a resource for Human Resources regarding recommended disciplinary action to deter future violations.

This policy establishes the scope of activities, authority, reporting, committee and governance structure, and assessment guidelines for the CCHHS Corporate Compliance Program.

III. Areas Affected

This policy applies to all affiliates and business units of CCHHS, and to all Business Associates and contractors associated with CCHHS.

IV. Definitions

A. CCHHS Personnel: This includes officers, directors, members of committees with Board-delegated authority, employees, volunteers and members of the medical staff or house staff, researchers, students, and agency personnel. It also affects independent contractors, consultants and other business partners (vendors) who are not employees but are working for CCHHS.

B. Business Associate: A third party engaged to perform work on behalf of CCHHS.

C. Chief Compliance Officer: The CCHHS Chief Compliance Officer or his/her staff as designated by the Chief Compliance Officer.

V. Policy and Procedures

The Corporate Compliance Program upholds the mission, vision, and core goals of Cook County Health & Hospitals System by establishing and supporting a system-wide culture of honesty and respect to guide everyone’s actions by developing standards, increasing awareness, and promoting honest behavior and professional responsibility through education, awareness and shared accountability that promotes compliance with applicable laws, regulations, and system policies.
Seven Elements of an Effective Compliance Program

The seven (7) Elements of an effective compliance program, as described by the U.S. Sentencing Commission Guidelines, include:

A. Written policies and procedures
B. Designated Compliance Officer and Compliance Committee
C. Effective Training and Education
D. Effective Lines of Communication
E. Standards enforced through well-publicized disciplinary guidelines
F. Auditing and monitoring; and
G. Response to detected offenses and corrective action plans

Scope of Activities for the Corporate Compliance Program

The Corporate Compliance Program incorporates professional ethics and responsibility; regulatory compliance, that includes but is not limited to the following categories:

A. Accurate Books and Records,
B. Anti-Kickback,
C. Conflict of Interest,
D. Emergency Medical Treatment and Labor Act (EMTALA),
E. False Claims,
F. Healthcare Fraud & Abuse,
G. Marketing & Purchasing,
H. Patient Privacy, Confidentiality and Security (HIPAA or the Health Insurance Portability and Accountability Act of 1996),
I. Political Activity (including Shakman compliance),
J. Research,
K. Tax Exemption, and
L. Theft.

As well as adherence to the CCHHS Standards of Conduct (Code of Conduct) and organizational policies.

The Office of the Chief Compliance Officer serves as the focal point for compliance activities. The primary duties of the Chief Compliance Officer include the following:

A. Serving as an internal consultant and resource for compliance matters;
B. Overseeing and monitoring the ongoing functions of the Corporate Compliance Program;
C. Participating in regular, CCHHS-wide risk assessments to understand potential vulnerabilities;
D. Serving as the Privacy Officer for CCHHS to assure compliance with HIPAA regarding protection of patient health information;
E. Reporting on a regular basis to the CCHHS governing bodies;
F. Periodically revising the Corporate Compliance Program, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management in light of changes directed to the needs of CCHHS and the laws and policies of federal, state, and county bodies;
G. Developing, coordinating and participating in training programs that focus on the elements of the Corporate Compliance Program and providing training such that workforce members are knowledgeable of and comply with the Standards of Conduct (Code of Conduct), compliance policies, laws and regulations;

H. Coordinating and overseeing compliance auditing and monitoring activities;

I. Responding to reports of issues or suspected violations related to compliance by independently investigating these matters, as appropriate, and working with department managers, Human Resources, and General Counsel in the determination of corrective action that must be taken;

J. Assuring, through consultation with Human Resources and General Counsel, that the CCHHS disciplinary policies and actions are applied fairly, equitably, appropriately, and consistently; and

K. Developing policies and programs that encourage CCHHS personnel to report suspected fraud and other improprieties without fear of retaliation or retribution.

Authority and Reporting

A. The Chief Compliance Officer reports to the Audit & Compliance Committee of the Board of Directors and to the CCHHS Chief Executive Officer.

B. The Audit & Compliance Committee of the Board of Directors has the responsibility for the Corporate Compliance Program for all CCHHS affiliates. The Committee, composed of independent directors, provides oversight to the CCHHS Corporate Compliance Program. The Committee advises the Board regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management.

C. The Chief Compliance Officer reports regularly to the Audit & Compliance Committee. The reports to the Committee may include the following:
   1. The annual compliance work plan, including the auditing and monitoring plan and priorities;
   2. Summaries of ongoing auditing and monitoring activities, including tracking of recommendations and corrective actions;
   3. Results of specific compliance audits;
   4. Summaries of calls received by the Compliance Hot Line and remediation efforts;
   5. Summaries of investigations conducted by the Corporate Compliance Office and results/remediation;
   6. Areas of compliance risk, including patient privacy and confidentiality;
   7. Information regarding the results of any governmental audits, investigations, or activities undertaken at CCHHS;
   8. Education for the Audit & Compliance Committee on topics related to Compliance, Privacy, or new regulatory initiatives affecting CCHHS; and/or
   9. Discussions of specific topics that are of special concern or risk.

D. The Chief Compliance Officer has the authority to access and review all documentation and other information that is relevant to CCHHS compliance activities, including, but not limited to, patient records, billing records, employee records, computer audit files, and arrangements between the hospitals and other parties, including employees, professionals on staff, independent contractors, suppliers, agents and physicians.

Standards of Conduct (Code of Conduct)

A. CCHHS will have a uniform Standards of Conduct (Code of Conduct) that provides policies and guidelines for all CCHHS personnel.
B. The Standards of Conduct (Code of Conduct) will be distributed to CCHHS personnel and updated as necessary. Training on the Standards of Conduct (Code of Conduct) will be included in the new hire orientation program. Staff will be asked to attest to receiving the Code. The Code will also be available on the CCHHS Intranet.

C. The Chief Compliance Officer will regularly review the Standards of Conduct (Code of Conduct) to assure that it covers significant risks caused by changing regulation and practices. Recommendations for changes to the Standards of Conduct (Code of Conduct) will be forwarded to the Chief Executive Officer and to the Audit & Compliance Committee of the Board of Directors, which has the authority to change the Standards of Conduct (Code of Conduct) and inform CCHHS personnel of these changes.

Periodic Assessment

A. The Corporate Compliance Program will be assessed internally, on an ongoing basis, or at a minimum once per year. An assessment by an outside consultant shall occur every 3 to 5 years to assure that the Corporate Compliance Program is current, accurately assesses the risk areas facing CCHHS, and devotes the appropriate amount of resources required to provide an effective compliance program.

POLICY OWNER: Cathy Bodnar, MS, RN, CHC
Chief Compliance Officer
Cook County Health & Hospitals System

APPROVAL PARTY (IES): Audit & Compliance Committee of the Cook County Health & Hospitals System Board of Directors
Chief Executive Officer

EFFECTIVE DATE: <<Insert>>

REGULATORY REFERENCES: Federal Sentencing Guidelines

POLICY REFERENCES: Charter, Audit & Compliance Committee of the Board of Directors
Compliance Reporting to the Audit & Compliance Committee and the Chief Executive Officer
CCHHS Standards of Conduct (Code of Conduct)
Deloitte

Cook County Health and Hospitals System

Required auditor communications
Fiscal year ended November 30, 2009

July 16, 2010

Deloitte & Touche LLP

This report is intended solely for the information and use of management and the Audit Committee of Cook County Health and Hospitals System and is not intended to be, and should not be, used by anyone other than these specified parties.
Scope and service team

• Scope
  – Cook County Health and Hospitals System (CCHHS) — Financial statement audit
  – Cook County — Financial statement County-wide audit (CAFR)
  – County-wide single audit of federal funds — Performed by Washington, Pittman & McKeever

• Deloitte service team
  – Mike Mayo, Advisory Director
  – Tracey Guidry, Director
  – Trisha Routh, Manager
  – James Annerino, Senior

• Notes
  – Minority Participation Goal of 35% will be met (overall County-wide)
  – Odell Hicks & Company LLC served as MBE subcontractor for CCHHS fieldwork
Cook County Health and Hospitals System audit

• CCHHS audit significant audit areas
  – Patient accounts receivable
  – Contractual allowance and bad debt reserves
  – Patient revenue cycle
  – Deferred revenue
  – Sales tax revenue
  – Third-party reimbursement

• Additional significant audit areas tested at the County
  – Self-insurance liabilities
  – Pension obligation
  – Cash and Investments
  – Payroll expenditures and related liabilities
  – Debt transactions
  – Capital transactions
  – JD Edwards financial system
Cook County Health and Hospitals System audit (cont.)

- Audit specialists used
  - Information technology — Understand Cerner and Siemens system controls (and JD Edwards at County)
  - Medicaid reimbursement — Analyze cost report settlement activity
  - Actuaries — Review outside actuary's report on medical malpractice and pension
Required communications

• Our responsibility under Generally Accepted Auditing Standards (GAAS) and Generally Accepted Government Auditing Standards (GAGAS)
  – Our responsibility under GAAS has been described to you in our engagement letter dated February 17, 2010. As described in that letter, those standards require, among other things, that we obtain an understanding of CCHHS' internal controls sufficient to plan the audit and to determine the nature, timing, and extent of audit procedures to be performed
  – The objective of an audit conducted in accordance with GAAS is to express an opinion on the fairness of the presentation of CCHHS' financial statements for the year ended November 30, 2009, in conformity with U.S. GAAP, in all material respects

• Alternative accounting treatments
  – We had no discussions with management regarding alternative accounting treatments for policies and practices related to material items including recognition, measurement, and disclosure considerations related to the accounting for specific transactions or general accounting policies, related to the year ended November 30, 2009
Required communications (cont.)

• Independence
  – We confirm that, in our professional judgment, Deloitte & Touche LLP is independent with respect to Cook County and its affiliates, within the meaning of the standards promulgated by the American Institute of Certified Public Accountants.
Required communications (cont.)

• Additional matters — According to U.S. GAAS, there are certain additional matters that should be communicated to the audit committee in connection with the performance of an audit
  – We have not had any disagreements with management related to matters that are material to CCHHS' 2009 financial statements
  – Significant difficulties encountered in dealing with management related to the performance of the audit
• In our judgment, we received full cooperation of CCHHS' management and staff and had unrestricted access to its senior management in the performance of our audit
Required communications (cont.)

• Additional matters — According to U.S. GAAS, there are certain additional matters that should be communicated to the audit committee in connection with the performance of an audit (cont.)
  – Our views on consultations with other accountants
    • We are not aware of any consultations that management may have had with other accountants about auditing and accounting matters during 2009
  – Major issues discussed with management prior to our initial selection or retention as auditors
    • Throughout the year, routine discussions regarding the application of accounting principles or auditing standards were held with management in connection with transactions that occurred, transactions that were contemplated, or reassessment of current circumstances. In our judgment, such discussions were not held in connection with our retention as independent auditors
Required communications (cont.)

• Other material written communications
  – The following presents those written communications between management and us that we believe represent material written communications related to the audit of the financial statements for the year ended November 30, 2009
  • Engagement letter, dated February 17, 2010
  • Management representation letter, draft provided
  • Management letter of recommendations on internal controls, draft provided

• Management judgments and accounting estimates
  – Revenue recognition and related allowances for patient care receivables
  – Third-party reimbursements
  – Self-insurance liabilities
  – Pension obligations and actuarial required contributions
  – During the year ended November 30, 2009, we are not aware of any significant changes in accounting estimates or in management’s judgments relating to such estimates
Required communications (cont.)

• Significant audit adjustments
  – Recorded audit adjustments
    • Correct understatement of bad debt allowance $47.3 million
    • Correct understatement of amounts due to the state related to recoupment $2.4 million
    • Correct overstatement of accrued payroll $5.9 million
    • Correct understatement of accounts payable $3.8 million
Management recommendations on internal control

Please see separate report, with management responses.

• Topics
  – Accounts receivable and bad debt reserves
  – Financial reporting
  – Third-party reimbursement
  – Inventory management
  – Information technology
ATTACHMENT #5
CCHHS Internal Audit Timeline

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<thead>
<tr>
<th>Audit</th>
<th>Audit Timeline</th>
<th>General Note</th>
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<tbody>
<tr>
<td>Grants</td>
<td>Planning</td>
<td>The Planning Phase consists of all planning activities that take place prior to on-site visits. Activities include, but are not limited to reviewing the applicable sections of the 2009 CCHHS Risk Assessment, relevant committee meeting minutes on the CCHHS website and any background information we have on file; creating a process understanding questionnaire, creating a document request list; identifying risks we believe exist/applicable to the area; coordinating the timing for the audit and have the interviews lined up; reviewing the documents/information provided by the auditee in response to the information request list, etc.</td>
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<td>Third Party Settlement Accounts</td>
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<td>Financial Statement Preparation</td>
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The Fieldwork Phase consists of conducting process walkthroughs, obtaining detailed understanding of the process/area, documenting our understanding, fine-tuning risks and identifying controls in place to mitigate the risks identified, performing control gap analysis, developing and executing the audit program with specific focus on testing key controls, documenting test results, and reporting/discussing audit results with auditee.

The Reporting Phase consists of finalizing audit results with auditee and reporting audit results to executive management and Audit & Compliance Committee, etc.

Excerpt from the 2009 CCHHS Risk Assessment

Internal Audit Priorities

In order to address the higher risk activities and other areas of concern identified during the risk assessment process, the following internal audit activities should occur in the near future. These audits are not in any specific order, but RSM McGladrey recommends that these projects be the first 10 internal audits completed by CCHHS:

- Grants audit with focus on the Helenio Institute entity
- Human Resources and Payroll audit for Stroger Hospital
- Audit of Third Party Settlement Accounts
- Revenue audit of Stroger Hospital with emphasis on Medicare/Medicaid revenue
- IT audit of System Access and Security
- IT audit of System Integration
- Audit of monthly Financial Statement Preparation process.
- Revenue audit of Stroger Hospital with focus on inventories
- IT audit of System Access and Security
- IT audit of System Integration
- Audit of monthly Financial Statement Preparation process.

These internal audits can be performed in any order that the Audit & Compliance Committee deems proper, or can be changed at any time the Audit & Compliance Committee receives additional information on risks to CCHHS.