

RATE SHEET

DRG	Description	Case Rate
104	Cardiac valve procedure with cardiac cath	\$57,373.58
105	Cardiac valve procedure without cardiac cath	\$41,684.25
106	Coronary bypass with PTCA	\$53,431.51
107	Coronary bypass with cardiac cath	\$38,659.30
108	Other cardio thoracic procedures	\$39,311.44
109	Coronary bypass without PTCA or cardiac cath	\$28,569.99
110	Major cardiovascular procedures with cc	\$29,590.92
111	Major cardiovascular procedures without cc	\$17,646.84
115	Perm cardiac pacemaker implant w/AMI, heart failure or shock	\$24,743.64
116	Other Perm card pacemaker implant or PTCA with coronary artery stent implant	\$16,568.58
117	Cardiac pacemaker revision except devise replacement	\$9,581.01
118	Cardiac pacemaker devise replacement	\$11,263.82
124	Circulatory disorders exc AMI with card cath & complex diag	\$10,348.87
125	Circulatory disorders exc AMI with card cath without complex diag	\$7,784.64
514	Cardiac Defibrillator Implant w Cardiac Cath (no longer valid)	
515	Cardiac Defibrillator Implant without Cardiac Cath	\$36,299.47
516	Percutaneous Cardiovascular Proc with AMI	\$19,579.48
517	Perc Cardio Proc with Coronary Artery Stent without AMI	\$15,642.82
518	Perc Cardio Proc without Coronary Artery Stent or AMI	\$12,417.78
526	Percutaneous Cardiovascular Proc W Drug Eluting Stent W AMI	\$22,381.64
527	Percutaneous Cardiovascular Proc W Drug Eluting Stent without AMI	\$18,192.99
535	Cardiac Defibrillator Implant with Cardiac Cath with AMI/HF/SHOCK	\$62,475.00
536	Cardiac Defibrillator Implant with Cardiac Cath without AMI/HF/SHOCK	\$47,514.60

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called the "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a or b)

- a. Employs fewer than 15 persons.
- b. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

Mark Okashima

Name of 504 Person - Type or Print

Seton Medical Center

Name of Contractor(s) - Type or Print

1900 Sullivan Avenue

Street Address or P.O. Box

Paly City, CA 94015

City, State, Zip Code

I certify that the above information is complete and correct to the best of my knowledge.

[Signature]

Signature

VP/CHIEF FINANCIAL & STRATEGY OFFICER

Title of Authorized Official

12-6-06

Date

*Exception: DHHS regulations state that:

"If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."

**County of San Mateo
Contractor's Declaration Form**

I. CONTRACTOR INFORMATION

Contractor Name:	Seton Medical Center	Phone:	650-991-6555
Contact Person:	mark okashima	Fax:	650-991-6024
Address:	1900 Sullivan Avenue Daly City, CA 94015		

II. EQUAL BENEFITS (check one or more boxes)

Contractors with contracts in excess of \$5,000 must treat spouses and domestic partners equally as to employee benefits.

- Contractor complies with the County's Equal Benefits Ordinance by:
- offering equal benefits to employees with spouses and employees with domestic partners.
 - offering a cash equivalent payment to eligible employees in lieu of equal benefits.
 - Contractor does not comply with the County's Equal Benefits Ordinance.
 - Contractor is exempt from this requirement because:
 - Contractor has no employees, does not provide benefits to employees' spouses, or the contract is for \$5,000 or less.
 - Contractor is a party to a collective bargaining agreement that began on _____ (date) and expires on _____ (date), and intends to offer equal benefits when said agreement expires.

III. NON-DISCRIMINATION (check appropriate box)

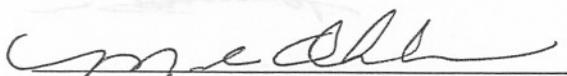
- Finding(s) of discrimination have been issued against Contractor within the past year by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or other investigative entity. Please see attached sheet of paper explaining the outcome(s) or remedy for the discrimination.
- No finding of discrimination has been issued in the past year against the Contractor by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or any other entity.

IV. EMPLOYEE JURY SERVICE (check one or more boxes)

Contractors with original or amended contracts in excess of \$100,000 must have and adhere to a written policy that provides its employees living in San Mateo County up to five days regular pay for actual jury service in the County.

- Contractor complies with the County's Employee Jury Service Ordinance.
- Contractor does not comply with the County's Employee Jury Service Ordinance.
- Contractor is exempt from this requirement because:
 - the contract is for \$100,000 or less.
 - Contractor is a party to a collective bargaining agreement that began on _____ (date) and expires on _____ (date), and intends to comply when the collective bargaining agreement expires.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.


Signature

MARK OKASHIMA
Name

12-6-06
Date

VP/CHIEF FINANCIAL & STRATEGY OFFICER
Title

Marillac Insurance Company, LTD

P.O. Box 69GT
720 West Bay Road, 2nd Floor Buckingham Square
George Town, Grand Cayman, Cayman Islands
(345) 945-2888, Fax (345) 945-2889

THIS IS TO CERTIFY TO

DATE OF CERTIFICATE ISSUANCE:

December 19, 2006

NAME AND ADDRESS OF CERTIFICATE HOLDER:

ORIGINAL DATE OF ISSUANCE:

12/16/2006

San Mateo Medical Center
Attn: Ms. Tere Larcina
222 West 39th Avenue
San Mateo, CA 94403

CERTIFICATE OF INSURANCE

that the described insurance coverages as provided by the indicated policy and issued by the company has been issued to:

Named Daughters of Charity Health System
Insured Seton Medical Center
1900 Sullivan Avenue
Address Daly City, CA 94015

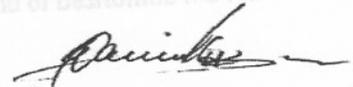
The Policy identified below by a policy number is in force on the date of Certificate issuance. Insurance is afforded only with respect to those coverages for which a specific limit of liability has been entered and is subject to all the terms of the Policy having reference thereto. This Certificate of Insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded under any policy identified herein.

POLICY NUMBER	POLICY PERIOD
DOC07010304-1	EFF. 12/31/06 EXP. 12/31/07

TYPE OF INSURANCE DESIGNATED BELOW	COVERAGES	LIMITS OF LIABILITY*	
		OCCURRENCE	SHARED AGGREGATE
Primary Claims-Made Professional Liability	Retroactive Date: 12-01-01	\$2,000,000 Each Claim	\$10,000,000 Annual Aggregate
Primary General Liability	Retroactive Date: N/A	\$2,000,000 Each Claim	\$10,000,000 Annual Aggregate

SPECIAL CONDITIONS/OTHER COVERAGES

Cancellation: Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the above named certificate holder, but failure to mail such notice shall impose no obligation or liability of any kind upon the company.



Authorized Representative

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
07/06/2006

PRODUCER
Aon Risk Services, Inc. of Wisconsin
330 E. Kilbourn Avenue
Suite 450
Milwaukee WI 53202-3179 USA

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

PHONE: (866) 283-7122 FAX: (847) 953-5390

INSURED
Daughters of Charity Health System
Seton Medical Center
1900 Sullivan Avenue
Daly City CA 94015 USA

INSURERS AFFORDING COVERAGE		NAIC #
INSURER A:	Old Republic Ins Co	24147
INSURER B:		
INSURER C:		
INSURER D:		
INSURER E:		

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE(MMDDYY)	POLICY EXPIRATION DATE(MMDDYY)	LIMITS																	
		GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY CLAIMS MADE <input type="checkbox"/> OCCUR <hr/> GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				EACH OCCURRENCE																	
		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON OWNED AUTOS <hr/>				COMBINED SINGLE LIMIT (Ea accident)																	
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO <hr/>				BODILY INJURY (Per person)																	
		EXCESS /UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <hr/> <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION				BODILY INJURY (Per accident)																	
A		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	MWC11187000	07/01/06	07/01/07	AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY : EA ACC AGG																	
		OTHER				EACH OCCURRENCE AGGREGATE																	
						<table border="1"> <tr> <td>X</td> <td>WC STATU-TORY LIMITS</td> <td>OTH-ER</td> <td></td> </tr> <tr> <td></td> <td>E.L. EACH ACCIDENT</td> <td></td> <td>\$1,000,000</td> </tr> <tr> <td></td> <td>E.L. DISEASE-EA EMPLOYEE</td> <td></td> <td>\$1,000,000</td> </tr> <tr> <td></td> <td>E.L. DISEASE-POLICY LIMIT</td> <td></td> <td>\$1,000,000</td> </tr> </table>	X	WC STATU-TORY LIMITS	OTH-ER			E.L. EACH ACCIDENT		\$1,000,000		E.L. DISEASE-EA EMPLOYEE		\$1,000,000		E.L. DISEASE-POLICY LIMIT		\$1,000,000	
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	E.L. DISEASE-POLICY LIMIT		\$1,000,000																				

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

CERTIFICATE HOLDER

Tere Larcina
222 W. 39th Ave
San Mateo CA 94403 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

James R. Johnson

Holder Identifier :

Certificate No : 570018643629



