Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE
CITY OF ALAMEDA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
AGENDA

Monday, March 2, 2009

Location:

Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue
Alameda, CA 94501

Office of the Clerk: (510) 814-4001

Regular Meeting

Members of the public who wish to comment on agenda items will be given an opportunity before or during the consideration of each agenda item. Those wishing to comment must complete a speaker card indicating the agenda item that they wish to address.

I. **Call to Order** ***(6:00 p.m.)** — Jordan Battani

II. **Roll Call** — Kristen Thorson

III. **Regular Agenda**

IV. **General Public Comments**

V. **Closed Session**

A. Approval of Closed Session Minutes

1. January 27, 2009
2. February 2, 2009

B. Discussion of Report Involving Trade Secrets — H & S Code Sec. 32106

C. Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions — Gov't Code Sec. 54957.6

D. Consultation with Legal Counsel Regarding Pending Litigation — Gov't Code Sec. 54956.9(a)

E. Discussion of Pooled Insurance Claims — Gov't Code Sec. 54956.95

F. Quality Improvement Committee Report (QIC) — H & S Code Sec. 32155

G. Public Employee Performance Evaluation — Gov't Code Sec 54957
Title: Chief Executive Officer

VI. Reconvene to Public Session *(Expected to start at approximately 7:30 p.m.)

A. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

A. Approval of January 27, 2009 Minutes **ACTION ITEM** [enclosure]

B. Approval of February 2, 2009 Minutes **ACTION ITEM** [enclosure]

C. Approval of Revisions to Administrative Policy No. 47 – Resources for Interpretive, Hearing Impaired and Deaf Patients **ACTION ITEM** [enclosure]

D. Approval Executive Incentive Compensation Criteria and Formula **ACTION ITEM** [enclosure]

VII. Regular Agenda

A. Finance and Management Committee Report

1. February 25, 2009 Committee Report — Steve Wasson
2. Acceptance of January 2009 Financial Statements **ACTION ITEM** [enclosure] — David A. Neapolitan
3. Approval for Authorization to Apply for Help II Funding **ACTION ITEM** [enclosure] — David A. Neapolitan

B. Strategic Planning and Community Relations Committee Report

1. February 17, 2009 Committee Report — Robert Bonta
2. Update on Board Meeting Video / Broadcasting Options — Deborah E. Stebbins
3. Update of Public Bid and Planning Process for Alameda Towne Center Medical Office Space — Kerry Easthope

C. Chief Executive Officer's Report

1. Representation at California Special District Association Annual Dinner [enclosure] — Deborah E. Stebbins

2. Foundation Matching Funds Campaign — Dennis Eloe

D. Medical Staff President Report — James Yeh, DO

1. Approval of Amendments to Medical Staff Rules and Regulations, Article 2. *Anesthesia Service*

   ACTION ITEM [enclosure]

2. Approval of Amendments to Medical Staff Rules and Regulations, Article 16. *Medical Records*

   ACTION ITEM [enclosure]

E. General Public Comments

F. Board Comments

G. Adjournment

The next regularly scheduled board meeting will be on Monday, April 6, 2009.
Closed Session will begin at 6:00 p.m. Open Session will follow at approximately 7:30 p.m.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

January 27, 2009

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD
Steve Wasson
J. Michael McCormick

Management Present:
Deborah E. Stebbins
David A. Neapolitan
Kerry Easthope

Medical Staff Present:
Alka Sharma, M.D.

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
1. Call to Order	Jordan Battani called the Open Session of the Special Meeting of the Board of Directors of the City of Alameda Health Care District to order at 6:35 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that all Director were present.	
3. General Public Comments	None at this time.	
4. Closed Session	At 6:36 p.m. the meeting adjourned to Executive Closed Session.	
5. Reconvene to Public Session & Adjournment	Jordan Battani reconvened the meeting into public session at 8:00 p.m. and made the following closed session announcements.	
6. Closed Session Announcements	No Announcements	
7 . Regular Agenda	**Approval of Resolution 2009-1G – Formation of a 1206 (b) Community Clinic** The majority of discussion regarding the formation of the Community Clinic took place in Executive Closed Session and being no further discussion, the Board agreed to take action as the formation of the clinic would provide significant benefit to the Hospital and to the community.	Director Wasson moved to approve Resolution 2009-1G – Formation of a 1206 (b) Community Clinic. Director Bonta seconded the motion. The motion approved unanimously.

Topic	Discussion	Action / Follow-Up
8. General Public Comments	None at this time.	
10. Board Comments	None at this time.	
11. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 8:05 p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

February 2, 2009

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD

Management Present:
Deborah E. Stebbins
David A. Neapolitan
Kerry Easthope

Medical Staff Present:
Alka Sharma, M.D.

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:
Steve Wasson
J. Michael McCormick

Submitted by: Kristen Thorson

Action		
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:04 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
3. General Public Comments	None at this time.	
4. Adjourn into Executive Closed Session	At 6:05 p.m. the meeting adjourned to Executive Closed Session.	

5. Reconvene to Public Session	Jordan Battani reconvened the meeting into public session at 7:33 p.m. and made the following closed session announcements.	
6. Closed Session Announcements	**[1] Minutes** **[3] Medical Executive Committee Report and Approval of Credentialing Recommendations**	[1] The Closed Session Minutes for the January 5, 2009 meeting were approved. [3] Medical Executive Committee Report and Approval of Credentialing Recommendations were approved as presented.

Initial Appointment:

Name	Specialty	Affiliation
o Joshua Gitter, MD	Internal Medicine / Hospitalist	AIM
o Laura Goetz, MD	Anesthesiology	Kaiser
o Chen I. Huang, MD	Hematology / Oncology	Northern Calif. Hem/Onc Consultants
o Sang-Ho You, MD	Anesthesiology	Solo Practitioner

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period End
o Eric Bain, MD	Radiology	Courtesy	11/30/09
o Robert Binder, MD	Radiology	Courtesy	02/28/10
o Jimmy Cardoza, MD	Radiology	Courtesy	01/31/11
o Barry Chantrelle, MD	Nephrology	Courtesy	06/30/10
o Jacqueline DeCayette, MD	Anesthesiology	Courtesy	06/30/10
o Eric Dovichi, MD	Radiology	Courtesy	04/30/10
o Kenneth Hsiao, MD	Urology	Courtesy	06/30/09
o Ying Fung, MD	Radiology	Courtesy	01/31/11
o Ming Kuan, MD	Oncology	Courtesy	01/31/11
o Hon-Wai Lam, MD	Family Practice	Active	09/30/09
o Scott Lipson, MD	Radiology	Courtesy	01/31/11
o Jimmy Pak, MD	Vascular Surgery	Courtesy	01/31/11
o Catherine Pyun, DO	Internal Medicine	Active	01/31/11
o Jack Stehr, MD	Orthopedics	Active	01/31/11

o Donato Stinghen, MD	General Surgery	Active	01/31/11
o Phillip Wong, MD	Radiology	Courtesy	07/31/10

Reappointment – Allied Health Professional Status

Name	Specialty	Appointment Period End
o Katlin Le, PA-C	Physician Assistant	07/31/09
o Kay Tran, PA-C	Physician Assistant	01/31/11

Resignations

Name	Specialty
o Gary Becker, MD	Radiology
o Jody Balich, MD	Radiology
o Douglas Boakye, Do	Internal Medicine
o Beverly Bolinger, MD	General Surgery
o Yolanda Cuadros, MD	Internal Medicine
o Mrinal Dutia, MD	Internal Medicine
o Zarlasht Fakiri, DO	Internal Medicine
o William West	Orthopedics

7. Consent Agenda	[1] Approval of January 5, 2009 Minutes	Director Deutsch moved to approve the consent agenda as presented. Director Bonta seconded the motion. The motion carried unanimously.
8. Regular Agenda	Finance and Management Committee Report *Acceptance of November & December 2008 Financial Statements* David Neapolitan reported on the December 2008 Financial Statements. Preliminary November 2008 results were reported to the Board at the January 5, 2009 Board Meeting and remained the same in the final unaudited statements. December Average Daily Census was 78.7 versus a budget of 89.7. Total gross patient revenue was less than budget by $957,469. Surgery Cases were above budget at 414 versus a budget of 397 cases.	Director Bonta moved to accept the November and December 2008 Financial Statements as presented. Director Deutsch seconded the motion. The motion carried unanimously.

	Patient days were below budget at 2,041 versus a budget of 2,780 but were higher than prior year. Acute care census was 27.3 versus a budget of 34.3 and were below budget from prior year as well. Subacute census is tracking right on budget for the first 6 months. South Shore Skilled Nursing Unit census is below budget at 18 but revenue is higher than budget due to higher Medicare patient mix on the unit. Surgical cases as stated above are 414 for the month of December. Overall reimbursement for Kaiser Surgical cases are higher in December and November due to lower utilization form Kaiser for the two months. Emergency Care Visits are slightly better than prior years at 1,471 versus 1,466. but still below the budget of 1,533. Despite decreases in emergency visits, there has been an increase in admissions from the emergency room for the first 6 months of the fiscal year. FTE (Full Time Equivalents) per adjusted occupied bed and paid FTE's increased slightly for the month of December, but overall tracking to budget for the year. In Summary November and December had a profit of $29,745 and $20,129 respectively. December Days Cash on Hand increased from 4.7 to 18.2 due to receipt of the approximately $2.8 million in parcel tax funds. Day in accounts receivable dropped slightly in December but will increase to 57 in January. Management is looking at several reasons for the increase and will report to the Board and Finance committee the reasons for the increase. Year-to-date there is a profit of $90,534 versus a budgeted loss of $84,861. President Battani stated that in October there was an increase in Medi-Cal and inquired if there was a similar trend in November and December. Mr. Neapolitan stated that Medi-Cal dropped in November back to expected levels and there has not been a significant increase. *Authorization to renew Bank of Alameda Letter of Credit and Note* Alameda Hospital currently has a revolving line of credit with the Bank of Alameda for $1.5 million and a term loan of $2.5 million at 5.5% interest and both maturing on February 15, 2009. The Term loan has a current balance of $2.28 million and nothing has been drawn on the line of credit. Any draw down	Director Bonta moved to authorize the renewal of the Line of Credit as proposed with the Bank of Alameda. Director Deutsch seconded the motion. The motion carried

	on the line of credit requires Board approval. The term loan requires a balloon payment on February 15. Management is asking for authorization for replacement financing on both the line of credit and the term loan. The Bank of Alameda is proposing to renew the Line of Credit at the current amount of $1.5 million with the following: Maturity: 2/15/2010 Rate: Variable at Prime Start Rate: 3.9% Floor Access to these funds would continue to require Board approval. The Line of Credit includes $250,000 Guidance line to be used for capital purchases. The current West Coast WSJ Prime Rate is 3.25%. The Line of Credit would only be used for emergency cases and would require Board approval. The Board agreed to make a motion on the Line of Credit. The Bank of Alameda is proposing the following two options for the Term Loan: Option 1 Term: 48-60 Months Rate: Variable at Prime + 50 bps Start Rate: 4.3% Floor Monthly Payment: $51,787 (48 Months) $42,299 (60 Months) Option 2 Term: 48-60 Months Fixed Rate: 4.8% Start Rate: 4.3% Floor Monthly Payment: $52,300 (48 Months) $42,811 (60 Months) Mr. Neapolitan compared the two options noting that there is not a significant difference in interest cost between the variable rate and fixed rate. Comparisons assumed that rates would increase by 1% in year 2 and increase to 5.75% by year 4 with a total interest cost of $226,502. Management recommended that the Board approve and authorize the renewal of the revolving line of credit and Option 1 as stated above for the Term Loan. Director Deutsch felt that the fixed interest rate would be safer for the District even though the difference between the fixed and	unanimously. Director Deutsch made a motion to authorize management to renew the Term Loan with the Bank of Alameda under Option 2 (fixed interest Rate and 60 months). Director Bonta seconded the motion. The motion carried unanimously.

	variable interest costs were relatively small. Director Bonta shared the same opinion that the fixed interest rate would be the better route to proceed with. President Battani preferred the variable interest rate but agreed with Director Bonta and Deutsch that the District, as a public entity, should be more conservative and was fine with the fixed rate. Director Bonta asked Ms. Stebbins her opinion on what she preferred. Ms. Stebbins stated that she would be comfortable with either option. Any authorization by the Board of Directors would be subject to Bank of Alameda Credit Committee approval on Thursday, February 5, 2009. *Strategic Planning and Community Relations Committee Report* Director Bonta reported that the committee met on January 20, 2009 and discussed master planning options for the Hospital and focused on three different scenarios on the current hospital site with Ratcliff Architects. The committee discussed different issues with each of the scenarios including phasing, public easement issues, beds, and parking. Director Bonta stated that it was a good starting point for discussions. Ratcliff Architects will be at the next committee meeting of February 17, 2009 with estimated costs for the three different options. As a result of the Strategic Plan discussions, the Hospital sponsored two focus groups on Bay Farm Island. The Focus groups were of Asian demographics on access to health care and perceptions of Alameda Hospital. The results indicated that the Hospital can do more in educating the community on what services are available and what physicians practice at Alameda Hospital. A satellite facility of some kind on Bay Farm Island was also of interest in the two groups. *Marketing and Communications Plans* The Committee also briefly discussed marketing and communications plans such as website enhancements. Director Bonta stated that he felt the committee should continue to focus on the community relations aspects due to the large amount of good news to share about the Hospital. Ms. Stebbins reported that the marketing plan will focus more on featuring physicians instead of the hospital itself and also health educational opportunities in the community and at the	

Hospital.

Chief Executive Officer's Report

Deborah E. Stebbins, CEO reported on the following preliminary statistics for the month of January, January budgeted numbers and December 2008 Actual numbers:

Statistics:	**January (Prelim)**	**January Budget**	**December Actual**
Average Daily Census	83.1	94.23	78.74
Patient Days	2,575	2,921	2,441
ER Visits	1,1496	1,602	1,471
OP Registrations	2,325	3,004	2,306
Total Surgeries	496	417	414

Approval to enter into an Agreement with Crestcom International for Management Training

Enclosed in the Board packet was a proposal from Crestcom International for management training. Due to the dollar amount of the program, board action is required. Ms. Stebbins stated that the Executive Team has interviewed and had an opportunity to participate in a scaled back version of the training. Crestcom has a training franchise that is operated locally out of Danville. The Training will involve 27 middle management and senior management from the Hospital. The training will be conducted at the Hospital over a 12 month period for 1/2 a day a month. The cost of the program is approximately $2,100 per person. Ms. Stebbins stated that there are a lot of new managers at the Hospital and with the amount of progress we are making there are higher expectations of the managers for greater productivity and enhanced skills. The Board asked how Crestcom was chosen. Ms. Stebbins reported that Crestcom approached the Hospital with a proposal and after checking references; Crestcom has many healthcare clients in the area and is very well regarded. President Battani stated that management development was one of the goals identified in the Strategic Plan and that the cost of the program seemed reasonable. The program will span over two fiscal years and payments have been negotiated on a monthly basis to help with cash flow. The program will be a mandatory program for all managers, and if a

Director Bonta moved to approval to enter into an agreement with Crestcom International for management training. Director Deutsch seconded the motion. The motion carried unanimously.

	session is missed, they will be required to make up the session at an alternate location in the Bay Area. Director Bonta asked if there were monies available in this year's budget for training. While there are monies set aside for training in the budget, the budgeted amounts do not cover the cost of the training, Ms. Stebbins reported. Ms. Stebbins felt confident that this year's budget would tolerate the expense. Human Resources Director Phyllis Weiss stated that the Executive Team felt that the content was good and those presenters that come on-site for training typically cost more. Director Deutsch stated that he liked the fact that senior management would also be involved in the training and that it would reinforce what is taught to everyone. *Service Excellence - C.A.R.E. Program* Ms. Stebbins stated that last week at Town Hall meetings, the Service Excellence C.A.R.E. Program was presented to staff. The Service Excellence program enforces 12 service standards for providing excellent care to patients, visitors and families. Reception from staff was good and there seems to be a lot of enthusiasm about the program. *Alameda Hospital Snapshot* Ms. Stebbins also presented a one page snapshot of Alameda Hospital. The document has information on the strategic plan, physician specialties, financial data, and other information about the Hospital. The document can be easily updated and will be available on the website. Ms. Stebbins thanked Louise Nakada for her assistance in putting the document together. *Foundation Board Retreat* Dennis Eloe, Foundation Executive Director updated the Board on a recent Alameda Hospital Foundation Retreat held on January 24. 17 members of the Foundation and staff were present at the retreat. Dennis Eloe handed out a one page summary to the Board and explained that they reviewed the questions and developed responses so that Foundation members could respond easily to public inquires about the Foundation and about the Hospital. They also reviewed Goals and activities for 2009 which included a fundraising goal of $375,000. Interesting to note, that out of the 20 Foundation board members, 11 had joined within the past year. Mr. Eloe gave the dates of the two major fundraisers for the Foundation, May 16, 2009 for the Annual Tea / Luncheon and September 12,	No action taken. No action taken. No action taken.

	2009 for the Annual Fall Gala. *Medical Staff President Report* Dr. Alka Sharma was happy to announce that Dr. Michael Zimmerman was back practicing in Alameda at the Alameda Towne Center medical office building. She also stated that Dr. Olivia Butt, who will be joining Dr Gerdes in July 2009, visited the Medical Staff and the Medical Staff is looking forward to working with her.	No action taken.
9. General Public Comments	None at this time.	
10. Board Comments	Director Bonta stated that with the issue of becoming more transparent to the community that the Board should consider filming the District Board meetings to be viewed on a variety of different venues, which may include the government access channel or our website. The meeting could be either broadcast live or previously recorded. He wanted to bring the subject to the Board for their input and thought. Director Bonta also stated that the District should think of itself as the 3rd governmental agency in the city that contributes significantly to the quality of life in Alameda. Filming the meetings would contribute to access to information about the District and increase transparency to the community. Another possibility and preliminary idea would be to use the City Council Chambers and their audio / visual equipment. President Battani felt that the idea falls within our overall communication strategy that we are developing and as a result of our Strategic Plan. President Battani expressed concern over the cost and allocation of resources to undertake this project and did not want the cost and resources of filming the Board Meetings to divert from patient safety and patient care project that need to be completed. She also stated that the District has come a long way and has become increasingly transparent with information available to the public. President Battani stated that we currently record the audio of each meeting and that could be broadcast on the website for the public as well. She stated that she would	Ms. Stebbins stated again that management and staff would research the options.

	want to know the cost and resource allocation of different options before moving forward. CEO, Deborah E Stebbins, stated that management would research different options and report back to the Board at the March 2, 2009 District Board Meeting. Director Deutsch stated that the idea seems simple enough that someone at the Hospital could tape the meeting and then give to the Government access channel for broadcasting.	
11. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 8:32. p.m.

Attest:

Jordan Battani	Robert Bonta
President	Secretary

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY No. 47

TITLE: Resources for Interpretive, Hearing Impaired and Deaf Patients

PURPOSE: **Effective January 1st, 2009,** Alameda Hospital shall comply with the language assistance program requirements approved under Title 28 of the California Code of Regulation, Rule 1300.67.04. To the extent applicable, Alameda Hospital shall provide interpreters and other aids for persons with hearing, vision or speech impairments, or who have limited English proficiency at no cost to the patient.

SCOPE: Hospital wide including all services and departments.

A. **POLICY:**

1. If a patient, or his/her legal representative, cannot communicate with the physician and other care givers because of a language or communication barrier, the hospital shall arrange for an interpreter. At the Minimum the interpreter is to provide the following information:

    a. Adequately inform the patient of their medical condition and the available medical care options, so that the patient or the patient's legal representative is able to make an informed decision with regard to the patient's medical care.

2. A competent, skilled interpreter shall meet the plan's proficiency standards outlined below:

    a. An interpreter can be any person who is certified to be fluent (able to accurately speak and read) in both English and the language used by the patient or the patient's legal representative.
    b. Have the ability to communicate with a hearing impaired patient by sign language.
    c. A fundamental knowledge in health care terminology and concepts relevant to health care delivery systems.
    d. Education and training in interpreting ethics, conduct and confidentiality.

B. <u>Special Instructions</u>

1. Alameda Hospital shall provide qualified interpretation services at no cost to the patient, at all points of contact, including when a patient is accompanied by a family member or friend that can provide interpretation services.

2. Upon request of the patient, the patient's family member or friend may serve as an interpreter limited to simple demographic or primary complaint questions, if doing so does not compromise the effectiveness of the service or violate the patient's confidentiality. If a family member or friend is used as interpreter, the offer of a hospital provided interpreter should be documented in the patient's medical records.

3. If for any reason the offer of a qualified interpreter is declined, this information should also be documented in the patient's medical record

4. Employee participation to act as an interpreter is voluntary and should be limited to simple demographic or primary complaint questions.

5. **If there is any question about the interpreter's ability to adequately translate the necessary information, The Language Line service should be used. In any case The Language Line services should be used in issues related to informed consent.**

C. Alameda Hospital has contracted with the following agencies for interpretation services:

1. The Language Line service for non-English speaking patients. Interpretation is done over the telephone. The Language Line services have access to interpreters who speak more than 158 languages and maintain a 24 hour communications center.

2. Hands on Services for the hearing impaired. Services are available 24 hours per day. It is recommended that Hands on Services is requested at least five (5) days in advance; however, it maybe possible to get an interpreter at short notice.

D. **BASIC PROCEDURE:**

1. The following instructions apply when using The Language Line services.

   a. Have patient identify the language needed using The Language Line Language Identification Card located in each department..
   b. Call The Language Line at 1-800-752-6096 and request the language spoken by the person you are dealing with.
   c. The Language Line will then ask for your client I.D. number (201156) and the last name of the person placing the call..
   d. The Language Line Service operator will connect the interpreter into your line.

e. The interpreter will identify himself/herself by their I.D. number (jot down this number).
f. Inform the interpreter what organization you are with and what information you need to obtain from the non-English speaking person.
g. The interpreter will then obtain the information requested and relay it back to you. This will continue until you have all the necessary information.
h. When you wish to terminate the call, state, "End of call."
i. Record the call, including the interpreter's I.D. number, on the appropriate document, i.e., progress notes, etc.

2. The following instructions apply when using Hands on Services - sign language interpreting.

a. It is recommended that you call Hands on Services as far in advance as possible (preferably 5 days).
b. To cancel an interpreter, call Hands On 48 hours (two full working days) before your appointment. If you do not cancel the interpreter before 48 hours, Hands On will send a statement.
c. Record the service, including the name of the interpreter, on the appropriate document, i.e., progress notes.
d. To make an appointment with Hands on, call 1-800-900-9478 voice, or 1-800-900-9479 TDD, and provide them with the following information: (Authorization must be obtained from a supervisor).

1. Date.
2. Time.
3. Address (including department).
4. Phone number.
5. Reason for the appointment.
6. Name of the patient.

E. **FORMS:**

1. Generic forms are also available in Spanish in the California Healthcare Association Consent Manual.

F. **POSTINGS:**

1. The patient's primary language and dialect will be posted on the Kardex by the admitting nurse.
2. Notices advising patients and their families of the availability of interpreters and the procedure for obtaining an interpreter will be posted in:
   a. Admissions/Business Office.
   b. Emergency Care Center.

c. All patient rooms including the Skilled Nursing Facility.
d. Public Area/Lobby - 2nd Floor.
e. Public Area/Lobby - 3rd Floor.
f. Radiology Department.

G. **TRANSLATION TOOLS:**

1. Standardized graphic phrases cards for non-bilingual staff in Spanish and Chinese (Cantonese) may be found on all nursing units, ECC and Subacute Unit and Skilled Nursing Unit.

City of Alameda Health Care District Policy No. 47		
Action:	**Date:**	**By:**
Created	06/91	Nursing
Reviewed/ Revised	10/91, 12/92, 04/94, 03/95, 01/96, 08/03, 03/07, 5/08, 2/09	Nursing, Patient Financial Services
Approvals	N/A	MEC
	03/07, 5/08, 3/09	Administration
	11/03, 9/06, 4/07, 3/09	District Board

ADMINISTRATIVE STATEMENTS/NO.47 RESOURCES INTERPRETIVE HEARING IMPAIRED.09

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY No. 47

TITLE: Resources for Interpretive, Hearing Impaired and Deaf Patients

PURPOSE: **Effective January 1st, 2009,** Alameda Hospital shall comply with the language assistance program requirements approved under Title 28 of the California Code of Regulation, Rule 1300.67.04. To the extent applicable, Alameda Hospital shall provide interpreters and other aids for persons with hearing, vision or speech impairments, or who have limited English proficiency at no cost to the patient.

SCOPE: Hospital wide including all services and departments.

A. **POLICY:**

1. If a patient, or his/her legal representative, cannot communicate with the physician and other care givers because of a language or communication barrier, the hospital shall arrange for an interpreter. At the Minimum the interpreter is to provide the following information:

   a. Adequately inform the patient of their medical condition and the available medical care options, so that the patient or the patient's legal representative is able to make an informed decision with regard to the patient's medical care.

2. A competent, skilled interpreter shall meet the plan's proficiency standards outlined below:

   a. An interpreter can be any person who is certified to be fluent (able to accurately speak and read) in both English and the language used by the patient or the patient's legal representative.
   b. Have the ability to communicate with a hearing impaired patient by sign language.
   c. A fundamental knowledge in health care terminology and concepts relevant to health care delivery systems.
   d. Education and training in interpreting ethics, conduct and confidentiality.

B. Special Instructions

1. Alameda Hospital shall provide qualified interpretation services at no cost to the patient, at all points of contact, including when a patient is accompanied by a family member or friend that can provide interpretation services.

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2. Upon request of the patient, the patient's family member or friend may serve as an interpreter limited to simple demographic or primary complaint questions, if doing so does not compromise the effectiveness of the service or violate the patient's confidentiality. If a family member or friend is used as interpreter, the offer of a hospital provided interpreter should be documented in the patient's medical records.

3. If for any reason the offer of a qualified interpreter is declined, this information should also be documented in the patient's medical record.

4. Employee participation to act as an interpreter is voluntary and should be limited to simple demographic or primary complaint questions.

5. **If there is any question about the interpreter's ability to adequately translate the necessary information, The Language Line service should be used. In any case The Language Line services should be used in issues related to informed consent.**

C. Alameda Hospital has contracted with the following agencies for interpretation services:

1. The Language Line service for non-English speaking patients. Interpretation is done over the telephone. The Language Line services have access to interpreters who speak more than 158 languages and maintain a 24 hour communications center.

2. Hands on Services for the hearing impaired. Services are available 24 hours per day. It is recommended that Hands on Services is requested at least five (5) days in advance; however, it maybe possible to get an interpreter at short notice.

D. **BASIC PROCEDURE:**

1. The following instructions apply when using The Language Line services.

   a. Have patient identify the language needed using The Language Line Language Identification Card located in each department.
   b. Call The Language Line at 1-800-752-6096 and request the language spoken by the person you are dealing with.
   c. The Language Line will then ask for your client I.D. number (201156) and the last name of the person placing the call.
   d. The Language Line Service operator will connect the interpreter into your line.

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e. The interpreter will identify himself/herself by their I.D. number (jot down this number).
f. Inform the interpreter what organization you are with and what information you need to obtain from the non-English speaking person.
g. The interpreter will then obtain the information requested and relay it back to you. This will continue until you have all the necessary information.
h. When you wish to terminate the call, state, "End of call."
i. Record the call, including the interpreter's I.D. number, on the appropriate document, i.e., progress notes, etc.

2. The following instructions apply when using Hands on Services - sign language interpreting.

a. It is recommended that you call Hands on Services as far in advance as possible (preferably 5 days).
b. To cancel an interpreter, call Hands On 48 hours (two full working days) before your appointment. If you do not cancel the interpreter before 48 hours, Hands On will send a statement.
c. Record the service, including the name of the interpreter, on the appropriate document, i.e., progress notes.
d. To make an appointment with Hands on, call 1-800-900-9478 voice, or 1-800-900-9479 TDD, and provide them with the following information: (Authorization must be obtained from a supervisor).

1. Date.
2. Time.
3. Address (including department).
4. Phone number.
5. Reason for the appointment.
6. Name of the patient.

E. **FORMS:**

1. Generic forms are also available in Spanish in the California Healthcare Association Consent Manual.

F. **POSTINGS:**

1. The patient's primary language and dialect will be posted on the Kardex by the admitting nurse.
2. Notices advising patients and their families of the availability of interpreters and the procedure for obtaining an interpreter will be posted in:
   a. Admissions/Business Office.
   b. Emergency Care Center.

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c. All patient rooms including the Skilled Nursing Facility.
d. Public Area/Lobby - 2nd Floor.
e. Public Area/Lobby - 3rd Floor.
f. Radiology Department.

G. **TRANSLATION TOOLS:**

1. Standardized graphic phrases cards for non-bilingual staff in Spanish and Chinese (Cantonese) may be found on all nursing units, ECC and Subacute Unit and Skilled Nursing Unit.

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City of Alameda Health Care District Policy No. 47		
Action:	**Date:**	**By:**
Created	06/91	Nursing
Reviewed/ Revised	10/91, 12/92, 04/94, 03/95, 01/96, 08/03, 03/07, 5/08, 2/09	Nursing, Patient Financial Services
Approvals	N/A 03/07, 5/08, 3/09	MEC Administration
	11/03, 9/06, 4/07, 3/09	District Board

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28 CA ADC § 1300.67.04

Term

28 CCR § 1300.67.04

Cal. Admin. Code tit. 28, § 1300.67.04

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 28. MANAGED HEALTH CARE
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 7. STANDARDS
This database is current through 2/13/09, Register 2009, No. 7

§ 1300.67.04. Language Assistance Programs.

(a) Application.

(1) Every health care service plan, including specialized health care service plans (plans), shall comply with the requirements of this section. The requirements of this section shall not apply to plan contracts for the provision of services to Medi-Cal enrollees or to contracts between plans and the federal government for the provision of services to Medicare enrollees.

(2) If a plan has both Medi-Cal and non-Medi-Cal lines of business, then the plan will be in compliance with the requirements of this section as to its non-Medi-Cal lines of business if:

(A) The Medi-Cal standards for providing language assistance services, including standards for timeliness and proficiency of interpreters, are equivalent to or exceed the standards set forth in Section 1367.04 of the Act and this section;

(B) The plan applies the Medi-Cal standards for language assistance programs to the plan's non-Medi-Cal lines of business; and

(C) The Department of Managed Health Care (Department) determines, as described in Section 1367.04(h)(3) of the Act, that the plan is in compliance with the Medi-Cal standards.

(3) A plan that seeks the Department's determination of compliance as provided in subsection (a)(2) shall request such determination as part of its filing pursuant to subsection (e)(2) and provide documentation sufficient to support and verify the request to the Department's satisfaction. The Department's determination pursuant to subsection (a)(2) shall apply only to the enrollees in a plan's non-Medi-Cal lines of business to which the plan actually applies the plan's Medi-Ca program standards.

(b) Definitions.

(1) Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity.

(2) Interpretation: the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

(3) Limited English Proficient or LEP Enrollee: an enrollee who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

(4) Point of Contact: an instance in which an enrollee accesses the services covered under the plan contract, including administrative and clinical services, and telephonic and in-person contacts.

(5) Threshold Language(s): the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act.

(6) Translation: replacement of a written text from one language (source language) with an equivalent written text in another language (target language).

(7) Vital Documents: the following documents, when produced by the plan (plan-produced documents) including when the production or distribution is delegated by a plan to a contracting health care service provider or administrative services provider:

(A) Applications;

(B) Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan;

(C) Letters containing important information regarding eligibility and participation criteria;

(D) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal;

(E) Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees;

(F) A plan's explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee; and

(G) Subject to subsection (c)(2)(F)(ii), the enrollee disclosures required by Section 1363(a)(1), (2) and (4) of the Act.

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(1) Enrollee Assessment. Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees. In assessing its enrollee population each plan shall, at a minimum:

(A) Develop a demographic profile of the plan's enrollee population for the purposes of calculating threshold languages

and reporting to the Department pursuant to Section 1367.07 of the Act. All plans shall apply statistically valid methods for population analysis in developing the demographic profile and plans may utilize a variety of methods for collecting demographic data for this purpose, including census data, client utilization data from third parties, data from community agencies and third party enrollment processes;

(B) Survey its enrollees in a manner designed to identify the linguistic needs of each of the plan's enrollees, and record the information provided by a responding enrollee in the enrollee's file. Plans may utilize existing processes and methods to distribute the linguistic needs survey, including but not limited to, existing enrollment and renewal processes, subscriber newsletters, mailings and other communication processes. A plan may demonstrate compliance with the survey requirement by distributing to all subscribers, including all individual subscribers under group contracts, a disclosure explaining, in English and in the plan's threshold languages, the availability of free language assistance services and how to inform the plan and relevant providers regarding the preferred spoken and written languages of the subscriber and other enrollees under the subscriber contract; and

(C) Collect, summarize and document enrollee demographic profile data in a manner that enables the plan to maintain confidentiality of personal information and to disclose the information to the Department on request for regulatory purposes and to contracting providers on request for lawful purposes, including language assistance purposes and health care quality improvement purposes. This section is not intended to limit or expand existing law regarding confidentiality of medical records.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(A) All points of contact where the need for language assistance may be reasonably anticipated.

(B) The types of resources needed to provide effective language assistance to the plan's enrollees.

(C) The plan's processes for informing enrollees of the availability of language assistance services at no charge to enrollees, and how to access language assistance services. At a minimum, these processes shall include the following:

(i) Processes to promote effective identification of LEP enrollee language assistance needs at points of contact, to ensure that LEP enrollees are informed at points of contact that interpretation services are available at no cost to the LEP enrollee, and to facilitate individual enrollee access to interpretation services at points of contact.

(ii) Processes for including the notice required by Section 1367.04(b)(1)(B)(v) with all vital documents, all enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. If documents are distributed in an LEP enrollee's preferred written language the notice need not be included.

(iii) Processes for including statements, in English and in threshold languages, about the availability of free language assistance services and how to access them, in or with brochures, newsletters, outreach and marketing materials and other materials that are routinely disseminated to the plan's enrollees.

(D) Processes to ensure the plan's language assistance program conforms with the requirements of section 1300.68(b)(3) and (7) of these regulations, including standards to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation.

(i) All plans shall ensure that grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

(ii) All plans shall inform contracting providers that informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. The notice and translations can

be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

(E) Processes to ensure that contracting providers are informed regarding the plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and to ensure that LEP language needs information collected by the plan is made available to contracting providers.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

(v) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's enrollees.

(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees

can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(aa) Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting;

(bb) Hiring staff interpreters who are trained and competent in the skill of interpreting;

(cc) Contracting with an outside interpreter service for trained and competent interpreters;

(dd) Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting; and

(ee) Contracting for telephone, videoconferencing or other telecommunications supported language interpretation services.

(vii) As used in this section, "trained and competent in the skill of interpreting," "qualified interpretation services" and "qualified interpreter" means that the interpreter meets the plan's proficiency standards established pursuant to subsection (c)(2)((H).

(H) The plan's policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan's language assistance proficiency standards shall require:

(i) A documented and demonstrated proficiency in both English and the other language;

(ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

(iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

(3) Staff training.

Every plan shall implement a system to provide adequate training regarding the plan's language assistance program tc all plan staff who have routine contact with LEP enrollees. The training shall include instruction on:

(A) Knowledge of the plan's policies and procedures for language assistance;

(B) Working effectively with LEP enrollees;

(C) Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and

(D) Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

(4) Compliance Monitoring.

(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

(d) In reviewing a plan's proposed language assistance program, the Department will evaluate the totality of the plan's language assistance program to determine whether the program as a whole provides meaningful access for LEP enrollees, and may consider relevant operational and demographic factors, including but not limited to:

(1) Whether the plan is a full service plan or specialized health care service plan;

(2) The nature of the points of contact;

(3) The frequency with which particular languages are encountered;

(4) The type of provider network and methods of health care service delivery;

(5) The variations and character of a plan's service area;

(6) The availability of translation and interpretation services and professionals;

(7) The variations in cost of language assistance services and the impact on affordability of health care coverage; and

(8) A plan's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaborating with other plans to share a pool of interpreters, and other methods and technologies.

(9) Specialized dental, vision, chiropractic, acupuncture and employee assistance program plans that demonstrate adequate availability and accessibility of qualified bilingual contracted providers and office staff to provide meaningful access to LEP enrollees, will be in compliance with the requirements of subsection (c)(2)(G)(iii) and (v). For the purposes of this subsection, specialized dental, vision, chiropractic, acupuncture and employee assistance program plans may demonstrate adequate availability and accessibility of competent and qualified bilingual providers and office staff if:

(A) The plan identifies within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English;

(B) The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers and/or office staff by submitting new language capability disclosure forms, and the plan updates its provider directories accordingly, and consistent with Section 1367.26 of the Act; and

(C) The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.

(e) Implementation.

(1) Within one year of the effective date of this section, every plan shall complete the initial enrollee assessment required by Section 1367.04 of the Act and this section. Every plan shall update its assessment of enrollee language needs and enrollee demographic profile at least once every three years following the initial assessment.

(2) By July 1, 2008, every plan shall file, in accordance with Section 1352 of the Act, an amendment to its quality assurance program providing its written language assistance program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Section 1367.04 of the Act and this section. The filing shall include the plan's Section 1367.04(b)(1)(B)(v) notices. All materials filed with the Department that contain documents in non-English languages shall include the following minimum supporting documentation:

(i) The English version of each non-English document

(ii) An attestation by the translator or, if applicable, by an authorized officer of the organization providing translator services, outlining the qualifications of the translator making the translation and affirming that the non-English translation is an accurate translation of the English version.

(3) By January 1, 2009 every plan shall have established and implemented a language assistance program in compliance with the requirements of Section 1367.04 of the Act and this section.

(4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after January 1, 2009, shall require compliance with the plan's language assistance program standards developed pursuant to Section 1367.04 of the Act and this section.

(A) A plan shall retain financial responsibility for the implementation of the language assistance program required by Section 1367.04 of the Act and this section, except to the extent that delegated financial responsibility has been separately negotiated and specifically documented in written contracts. This subsection does not create an exception to Section 1367 of the Act and delegation shall not constitute a waiver of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section.

(B) Delegation to contracting providers of any part of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section constitutes a material change to a provider contract subject to the requirements of Section 1375.7 of the Act.

(f) The Department will periodically review plan compliance with the standards and requirements of Section 1367.04 of the Act and this section by methods that may include, but are not limited to, the medical survey process, reviews of consumer grievances and complaints to the Department's HMO Help Center, and provider complaints submitted to the Department's provider complaint line. The Department may also periodically request that plans submit information and data regarding enrollee language needs and demographic profile.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Sections 1344 and 1367.04, Health and Safety Code. Reference: Sections 1259, 1342, 1363,

1365.5, 1367, 1367.04, 1367.07, 1368, 1368.01, 1370 and 1375.7, Health and Safety Code.

HISTORY

1. New section filed 1-24-2007; operative 2-23-2007 (Register 2007, No. 4).

28 CCR § 1300.67.04, **28 CA ADC § 1300.67.04**
1CAC

28 CA ADC § 1300.67.04

END OF DOCUMENT

Term

Docs In Sequence

Alameda Hospital FY2009 Executive Incentive Compensation

INTRODUCTION

Payment of any incentive compensation to an executive is predicated upon a performance evaluation of "meets expectations" or above.The base percentage bonus (based on % base compensation) for the Chief Executive Officer is established by the Board. The Incentive compensation levels for other participating executives are estabiiished by the CEO. Metrics are approved each year by the Board, including any target or high stretch financial objectives.

The Chief Executive Officer (CEO) is responsible for recommending additional executive participants in an incentive Plan to the Board. The CEO is responsible for structuring the terms of their incentive in a manner consistent with the Executive incentive compensation system In FY 2009, the full incentive compensation target for the CEO and other participating executives has been **accrued** at the "target" financial level and at full achievement of the other three areas to ensure that the incentive payments are appropriately funded. Since the accrual was not in the original FY 2009 budget, the accrued amount should be removed from the year-end expenses to determine the actual net income. In FY 2010, we will include a projected expense for incentive payments in the budget. The Excess Revenue over Expense will include the Hospital and South Shore only and exclude CWS and the 501(c)3 corporation.

The proportion of pay-out of the bonus is based on the achievement of the metrics outlined below in the following areas:

	Weighting
Financial Success	70%
Quality / Satisfaction	10%
Workforce Success	10%
Operational Success	10%
Total	100%

Metrics for FY 2009 are suggested; in some cases, metrics for FY 2010 are also suggested which build upon the 2009 metrics.

Goals	Actions	Measures			Weighting Points
Financial Success					**70**
Achieve our FY10 Financial Targets & Goals	**Tripwire: Excess Revenues over Expenses. Must meet threshold or no incentive compensation paid**	Threshold	Target	High	**60**
		Breakeven	$275,000	$550,000 or >	
	Total Operating Revenues	Total Operating Revnue at Budget Levels (2009)			**10**

Note for Additional Bonus at "Target" or "High" Financial Performance:

There is a potential for an upside gain beyond an executive's base bonus in the event of extraordinary achievement in the actual net income for the year. These levels are highlighted in the yelow boxes above, for FY 2009.

Participant	Base Bonus (% base salary)	Threshold	Target (% base salary)	High (% base salary)	Total Potential Bonus (% base salary)
Stebbins	25% (previously approved)	25%	6.25%	6.25%	37.5%

Goals	Actions	Measures	Weighting Points
Quality / Satisfaction Success			**10**
Improve Customer Satisfaction, Engagement & Referenceability	Establish and disseminate Code of Conduct (2009)	Maintain willingness to recommend hospital at 80% (2009): Improve willingness by 2% (2010)	**4**
Overall Quality	Organize preparation for 2010 Joint Commission Survey	Joint Commission Accreditation to acceptable level (2010)	**4**
Specific Quality	Implement customer service excellence program	Improve HCAHPS score on noise levels by 2% (2010)	**2**

Goals	Actions	Measures	Weighting Points
Workforce Success			**10**
Invest in employee training, development and engagement	Establish or select a commerciallly available employee satisfaction tool. Design employee reward /recognition program geared to code of conduct	Measure baseline (2009) Target Improvement (2010) Employee turnover rates < Bay Area average	**5**
Build the strength and depth of our leadership teams to support future growth	Implement middle manager training program (2009-2010)	75% middle managers complete training by 2010	**5**
Goals	**Actions**	**Measures**	**Weighting Points**
Operational Success			**10**
Develop Critical Capabilities in Planning, Product Development & Marketing Effectiveness		Complete at least 3 service line analyses (2009) and recommend action / improvement Develop physician recruitment vehicle (2009)	**3**
Simplify Core Business Processes and Build a Scalable, Cost-Efficient Infrastructure	Establish marketing program directed to Bay Farm residents (2009)	Market Share growth in Bay Farm Area by 2% (2010)	**3**
Reduce Waste & Drive Operational Efficiency		Formulate Master Plan options by 06/30/09 Finalize master facility plan (late 2009)	**4**

Alameda Hospital
Incentive Compensation Analysis - Assuming Excess of Revenue Over Expenses at **Threshold**
FY 2009

Executive: Executive A
Base Compensation: $ 200,000

Goals	Measures	Category Weight	Goal Weight	Threshold	Target	High	Goal Result	Weighted Incentive %	Bonus Amount
Incentive Compensation Percentage:			25.00%	6.25%	6.25%				
Financial Success		70.0%							
A. Excess of Revenue Over Expense			60.0%	Breakeven	$275K - $550K	>$550K	Threshold	15.00%	$ 30,000.00
B. Total Operating Revenue	Equal to or greater than budget		10.0%	Budget	N/A	N/A	Not Met	0.00%	$ -
Quality / Satisfaction Success		10.0%							
A. Improve customer satisfaction, engagement & reference ability	Establish and disseminate Code of Conduct		4.0%	Met Goal	N/A	N/A	Threshold	1.00%	$ 2,000.00
B. Overall quality	Organize preparation for 2010 Joint Commission Survey		4.0%	Met Goal	N/A	N/A	Threshold	1.00%	$ 2,000.00
C. Specific quality	Implement customer service excellence program.		2.0%	Met Goal	N/A	N/A	Threshold	0.50%	$ 1,000.00
Workforce Success		10.0%							
A. Invest in employee training, development and engagement	Establish or select a commercially available employee satisfaction tool								
	Design employee reward / recognition program geared to code of conduct		5.0%	Met Goal	N/A	N/A	Threshold	1.25%	$ 2,500.00
B. Build the strength and depth of our leadership teams to support future growth	Implement middle manager training program (2009 - 2010)		5.0%	Met Goal	N/A	N/A	Threshold	1.25%	$ 2,500.00
Operational Success		10.0%							
A. Develop critical capabilities in planning, product development & marketing effectiveness	Complete at least 3 service line analyses (2009) and recommend action / implementation								
	Develop physician recruitment vehicle		3.0%	Met Goal	N/A	N/A	Threshold	0.75%	$ 1,500.00
B. Simplify core business process and build a scalable, cost-efficient infrastructure	Establish marketing program directed to Bay Farm residents		3.0%	Met Goal	N/A	N/A	Threshold	0.75%	$ 1,500.00
C. Reduce waste & drive operation efficiency	Formulate Master Plan Options (06/30/09)								
	Finalize master facility plan (late 2009)		4.0%	Met Goal	N/A	N/A	Threshold	1.00%	$ 2,000.00
Totals		100.0%						22.50%	$ 45,000.00
							Additional Incentive for Achieving Target or Better Gross Margin:	0.00%	$ -
							Total Incentive Compensation:	22.50%	$ 45,000.00

Weighted Incentive = Incentive Compensation Percentage x Sub-Goal Weight

Alameda Hospital
Incentive Compensation Analysis - Assuming Excess of Revenue Over Expenses at **Target**
FY 2009

Executive: Executive A
Base Compensation: $ 200,000

Incentive Compensation Percentage: 25.00% 6.25% 6.25%

Goals	Measures	Category Weight	Goal Weight	Threshold	Target	High	Goal Result	Weighted Incentive %	Bonus Amount
Financial Success		70.0%							
A. Excess of Revenue Over Expense			60.0%	Breakeven	$275K - $550K	>$550K	Target	15.00%	$ 30,000.00
B. Total Operating Revenue	Equal to or greater than budget		10.0%	Budget	N/A	N/A	Not Met	0.00%	$ -
Quality / Satisfaction Success		10.0%							
A. Improve customer satisfaction, engagement & reference ability	Establish and disseminate Code of Conduct		4.0%	Met Goal	N/A	N/A	Threshold	1.00%	$ 2,000.00
B. Overall quality	Organize preparation for 2010 Joint Commission Survey		4.0%	Met Goal	N/A	N/A	Threshold	1.00%	$ 2,000.00
C. Specific quality	Implement customer service excellence program.		2.0%	Met Goal	N/A	N/A	Threshold	0.50%	$ 1,000.00
Workforce Success		10.0%							
A. Invest in employee training, development and engagement	Establish or select a commercially available employee satisfaction tool								
	Design employee reward / recognition program geared to code of conduct		5.0%	Met Goal	N/A	N/A	Threshold	1.25%	$ 2,500.00
B. Build the strength and depth of our leadership teams to support future growth	Implement middle manager training program (2009 - 2010)		5.0%	Met Goal	N/A	N/A	Threshold	1.25%	$ 2,500.00
Operational Success		10.0%							
A. Develop critical capabilities in planning, product development & marketing effectiveness	Complete at least 3 service line analyses (2009) and recommend action / implementation								
	Develop physician recruitment vehicle		3.0%	Met Goal	N/A	N/A	Threshold	0.75%	$ 1,500.00
B. Simplify core business process and build a scalable, cost-efficient infrastructure	Establish marketing program directed to Bay Farm residents		3.0%	Met Goal	N/A	N/A	Threshold	0.75%	$ 1,500.00
C. Reduce waste & drive operation efficiency	Formulate Master Plan Options (06/30/09)								
	Finalize master facility plan (late 2009)		4.0%	Met Goal	N/A	N/A	Threshold	1.00%	$ 2,000.00
Totals		100.0%						22.50%	$ 45,000.00
							Additional Incentive for Achieving Target or Better Gross Margin:	6.25%	$ 12,500.00
							Total Incentive Compensation:	28.75%	$ 57,500.00

Weighted Incentive = Incentive Compensation Percentage x Sub-Goal Weight

Alameda Hospital
Incentive Compensation Analysis - Assuming Excess of Revenue Over Expenses at **Threshold**
FY 2009

Executive: Executive B
Base Compensation: $ 100,000

				Incentive Compensation Percentage:	15.00%	3.75%	3.75%			
Goals	Measures	Category Weight	Goal Weight	Threshold	Target	High	Goal Result	Weighted Incentive %	Bonus Amount	
Financial Success		70.0%								
A. Excess of Revenue Over Expense			60.0%	Breakeven	$275K - $550K	>$550K	Threshold	9.00%	$	9,000.00
B. Total Operating Revenue	Equal to or greater than budget		10.0%	Budget	N/A	N/A	Not Met	0.00%	$	-
Quality / Satisfaction Success		10.0%								
A. Improve customer satisfaction, engagement & reference ability	Establish and disseminate Code of Conduct		4.0%	Met Goal	N/A	N/A	Threshold	0.60%	$	600.00
B. Overall quality	Organize preparation for 2010 Joint Commission Survey		4.0%	Met Goal	N/A	N/A	Threshold	0.60%	$	600.00
C. Specific quality	Implement customer service excellence program.		2.0%	Met Goal	N/A	N/A	Threshold	0.30%	$	300.00
Workforce Success		10.0%								
A. Invest in employee training, development and engagement	Establish or select a commercially available employee satisfaction tool									
	Design employee reward / recognition program geared to code of conduct		5.0%	Met Goal	N/A	N/A	Threshold	0.75%	$	750.00
B. Build the strength and depth of our leadership teams to support future growth	Implement middle manager training program (2009 - 2010)		5.0%	Met Goal	N/A	N/A	Threshold	0.75%	$	750.00
Operational Success		10.0%								
A. Develop critical capabilities in planning, product development & marketing effectiveness	Complete at least 3 service line analyses (2009) and recommend action / implementation									
	Develop physician recruitment vehicle		3.0%	Met Goal	N/A	N/A	Threshold	0.45%	$	450.00
B. Simplify core business process and build a scalable, cost-efficient infrastructure	Establish marketing program directed to Bay Farm residents		3.0%	Met Goal	N/A	N/A	Threshold	0.45%	$	450.00
C. Reduce waste & drive operation efficiency	Formulate Master Plan Options (06/30/09)									
	Finalize master facility plan (late 2009)		4.0%	Met Goal	N/A	N/A	Threshold	0.60%	$	600.00
Totals		100.0%						13.50%	$	13,500.00
							Additional Incentive for Achieving Target or Better Gross Margin:	0.00%	$	-
							Total Incentive Compensation:	13.50%	$	13,500.00

Weighted Incentive = Incentive Compensation Percentage x Sub-Goal Weight

Alameda Hospital
Incentive Compensation Analysis - Assuming Excess of Revenue Over Expenses at **Target**
FY 2009

Executive: Executive B
Base Compensation: $ 100,000

Incentive Compensation Percentage: 15.00% 3.75% 3.75%

Goals	Measures	Category Weight	Goal Weight	Threshold	Target	High	Goal Result	Weighted Incentive %	Bonus Amount
Financial Success		70.0%							
A. Excess of Revenue Over Expense			60.0%	Breakeven	$275K - $550K	>$550K	Target	9.00%	$ 9,000.00
B. Total Operating Revenue	Equal to or greater than budget		10.0%	Budget	N/A	N/A	Not Met	0.00%	$ -
Quality / Satisfaction Success		10.0%							
A. Improve customer satisfaction, engagement & reference ability	Establish and disseminate Code of Conduct		4.0%	Met Goal	N/A	N/A	Threshold	0.60%	$ 600.00
B. Overall quality	Organize preparation for 2010 Joint Commission Survey		4.0%	Met Goal	N/A	N/A	Threshold	0.60%	$ 600.00
C. Specific quality	Implement customer service excellence program.		2.0%	Met Goal	N/A	N/A	Threshold	0.30%	$ 300.00
Workforce Success		10.0%							
A. Invest in employee training, development and engagement	Establish or select a commercially available employee satisfaction tool								
	Design employee reward / recognition program geared to code of conduct		5.0%	Met Goal	N/A	N/A	Threshold	0.75%	$ 750.00
B. Build the strength and depth of our leadership teams to support future growth	Implement middle manager training program (2009 - 2010)		5.0%	Met Goal	N/A	N/A	Threshold	0.75%	$ 750.00
Operational Success		10.0%							
A. Develop critical capabilities in planning, product development & marketing effectiveness	Complete at least 3 service line analyses (2009) and recommend action / implementation								
	Develop physician recruitment vehicle		3.0%	Met Goal	N/A	N/A	Threshold	0.45%	$ 450.00
B. Simplify core business process and build a scalable, cost-efficient infrastructure	Establish marketing program directed to Bay Farm residents		3.0%	Met Goal	N/A	N/A	Threshold	0.45%	$ 450.00
C. Reduce waste & drive operation efficiency	Formulate Master Plan Options (06/30/09)								
	Finalize master facility plan (late 2009)		4.0%	Met Goal	N/A	N/A	Threshold	0.60%	$ 600.00
Totals		100.0%						13.50%	$ 13,500.00
							Additional Incentive for Achieving Target or Better Gross Margin:	3.75%	$ 3,750.00
							Total Incentive Compensation:	17.25%	$ 17,250.00

Weighted Incentive = Incentive Compensation Percentage x Sub-Goal Weight

ALAMEDA HOSPITAL - COMBINED
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	**Budget**	**Variance**	**Var %**	**FY08**	**Actual**	**Budget**	**Variance**	**Var %**	**FY08**
Operating revenues:										
IP Revenue	$ 13,012,259	$ 15,346,129	$ (2,333,870)	-15.2%	$ 12,449,620	$ 89,170,471	$ 92,445,516	$ (3,275,045)	-3.5%	$ 78,694,509
OP Revenue	10,101,348	10,130,512	(29,164)	-0.3%	8,590,572	68,194,725	65,172,338	3,022,387	4.6%	59,515,742
Total revenue	$ 23,113,607	$ 25,476,641	$ (2,363,034)	-9.3%	$ 21,040,192	$ 157,365,196	$ 157,617,854	$ (252,658)	-0.2%	$ 138,210,251
Less: Deductions from Revenue	(17,231,561)	(19,345,965)	2,114,404	10.9%	(15,133,336)	(116,146,167)	(116,572,211)	426,044	0.4%	(103,882,558)
Bad Debt	(295,082)	(265,574)	(29,508)	-11.1%	(843,318)	(4,367,113)	(3,844,338)	(522,775)	-13.6%	(2,699,812)
Charity	(289,203)	(260,283)	(28,920)	-11.1%	(202,945)	(767,156)	(750,154)	(17,002)	-2.3%	(701,723)
Net patient service revenue	$ 5,297,760	$ 5,604,819	$ (307,059)	-5.5%	$ 4,860,593	$ 36,084,759	$ 36,451,150	$ (366,392)	-1.0%	$ 30,926,158
	22.92%	22.00%			23.10%	22.93%	23.13%			22.38%
Other revenue	19,333	10,040	9,293	92.6%	9,564	113,381	70,280	43,101	61.3%	71,253
Total operating revenues	$ 5,317,094	$ 5,614,859	$ (297,765)	-5.3%	$ 4,870,157	$ 36,198,139	$ 36,521,430	$ (323,291)	-0.9%	$ 30,997,411
Operating expenses:										
Salaries	$ 3,079,168	$ 3,252,116	$ 172,948	5.3%	$ 2,989,388	$ 20,120,431	$ 20,912,337	$ 791,906	3.8%	$ 19,091,806
Registry	114,751	122,081	7,330	6.0%	117,614	1,434,703	812,997	(621,706)	-76.5%	861,150
Benefits	792,198	918,279	126,081	13.7%	1,118,926	5,608,763	6,157,891	549,128	8.9%	5,128,353
Professional Fees	358,906	282,408	(76,498)	-27.1%	288,769	2,209,152	1,975,484	(233,668)	-11.8%	2,375,669
Supplies	759,779	792,119	32,340	4.1%	592,691	5,250,756	5,214,958	(35,798)	-0.7%	4,890,591
Purchase Services	329,277	345,294	16,017	4.6%	258,904	2,347,839	2,414,815	66,976	2.8%	2,080,105
Rents and Leases	69,937	54,926	(15,011)	-27.3%	50,673	419,179	372,704	(46,475)	-12.5%	334,950
Utilities and Telephone	68,838	75,634	6,796	9.0%	73,637	499,349	521,228	21,879	4.2%	470,227
Insurance	48,393	67,366	18,973	28.2%	59,917	288,358	429,559	141,201	32.9%	417,231
Interest Expense	9,612	12,132	2,520	20.8%	14,108	83,863	84,922	1,059	1.2%	53,726
Depreciation and amortization	116,990	113,450	(3,540)	-3.1%	132,467	854,337	792,611	(61,726)	-7.8%	1,133,080
Other Operating Expenses	48,369	67,071	18,702	27.9%	62,353	501,403	466,080	(35,323)	-7.6%	374,059
Total operating expenses	$ 5,796,220	$ 6,102,876	$ 306,656	5.0%	$ 5,759,447	$ 39,618,134	$ 40,155,586	$ 537,452	1.3%	$ 37,210,947
Operating gain (loss)	$ (479,126)	$ (488,017)	$ 8,891	1.8%	$ (889,290)	$ (3,419,995)	$ (3,634,156)	$ 214,161	5.9%	$ (6,213,536)
Non-operating revenues (expenses):	$ 499,507	$ 510,213	$ (10,706)	-2.1%	$ 524,705	$ 3,530,910	$ 3,571,491	$ (40,581)	-1.1%	$ 3,661,137
Excess of revenues over expenses	20,381	22,196	(1,815)	8.2%	(364,585)	110,915	(62,665)	173,580	277.0%	(2,552,399)

Excess Revenues over Expenses = Bottom Line = Total Operating Revenue - Total Operating Expenses + Non-Operating Revenues

Total Operating Revenues = Total (Gross) INP + OP Revenue - Deductions from Revenue (C/A) - Bad Debt - Charity + Other Revenue

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED

FINANCIAL STATEMENTS

FOR THE

PERIOD ENDING

01/31/09

2070 Clinton Avenue • Alameda, CA 94501 • TEL (510) 522-3700 • www.alamedahospital.org

ALAMEDA HOSPITAL
City of Alameda Health Care District
January 31, 2009

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ALAMEDA HOSPITAL

January 31, 2009

The management of the Alameda Hospital (the Hospital) has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending January 31, 2009 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of January 31, 2009

- Total assets on the balance sheet decreased by $131,439 from the prior month as a result of an increase in net accounts receivable of $1,287,695 offset by a decrease in cash and cash equivalents of $1,379,882.

- Total cash and cash equivalents for January decreased by $1,379,882 which resulted in a decrease in our day's cash on hand from the prior month's 18.2 to 10.5 at January 31, 2009. The decrease in cash and cash equivalents was primarily the result of a decline in collections of open patient account receivables. The decline in patient account receivable collections resulted from the redeployment of business office staff to allow for better follow-up activities. This redeployment paid dramatic dividends during the first weeks of February. In addition, the hospital implemented the new Emdeon electronic claims submission software (formerly done by SSI Group, Inc.) that allows Patient Financial Services management to more effectively edit and track claims submitted electronically from a web based portal.

- Net patient accounts receivable increased in January by $1,287,695 compared to an increase of $220,736 in December. As a result days in outstanding receivables increased to 57 as compared to 50 in December. This increase in outstanding receivables at month end was the result of the decline in patient accounts receivable collections described above.

- Total liabilities decreased by $244,232 compared to a decrease of $305,240 in the prior month. This decrease was the result of a decrease of $477,000 in other liabilities and $76,030 in accounts payable. These decreases were offset by an increase of $346,644 in payroll and benefit related accruals.

- Accounts payable at January 31st was $4,515,614, which represents a decrease of $76,030 from the prior month. As a result of this slight decrease in outstanding payables from December, days in accounts payable remained at 84.

- Payroll and benefit related accruals increased by $346,644 from the prior month. This increase was primarily the result of requiring fourteen (14) days of payroll accruals at month-end versus only eleven (11) days at December 31st.

- Other liabilities decreased by $477,000 as a result of the amortization of one month's deferred revenue related to the 2008/2009 parcel tax revenues.

- Combined total revenue was less than budget by $2,363,034 or 9.3% and net patient revenue was unfavorable to budget by $287,059 or 5.1%. Inpatient revenue, excluding South Shore, was less than budgeted by 15.4% while outpatient revenue, excluding South Shore, was only slightly less than budgeted by 0.3%. On an adjusted patient day basis total revenue, excluding South Shore, was $6,458 compared to a budgeted amount of $6,757.

- Total patient days were 2,582 and included 628 patient days from the South Shore facility as compared to the prior month's total patient days of 2,441 (559 South Shore days included) and the prior year's 1,964 total patient days. The average daily acute care census was 31.4 compared to a budget of 37.2 and an actual average daily census of 27.3 in the prior month; the average daily Sub-Acute census was 31.7 versus a budget of 34.1 and 33.4 in the prior month and the South Shore unit had an average daily census of 20.3 versus a budget of 23.0 and prior month census of 18.0, respectively.

- ER visits were 1,496 or 6.6% less than the budgeted 1,602 visits but were again slightly greater, (32), than the

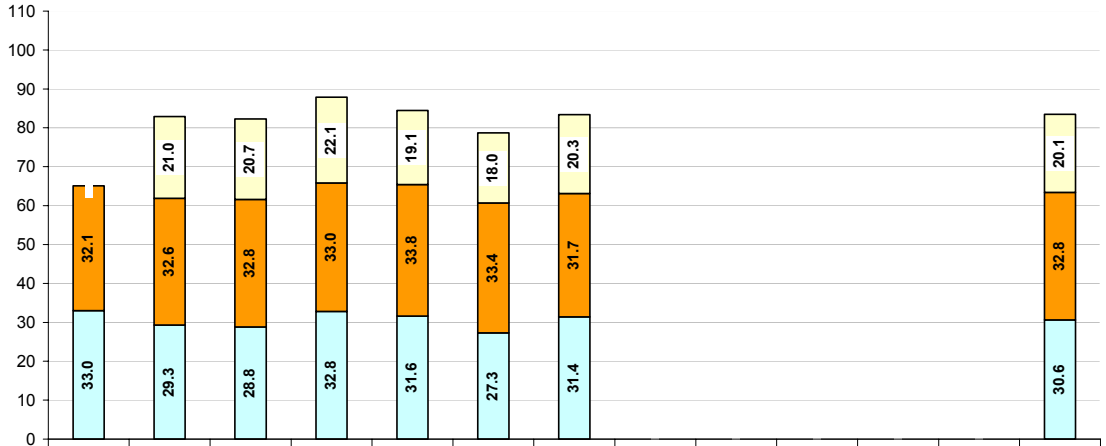
prior year's visits of 1,464.

- Total surgery cases were 17.5% greater than budget, with Kaiser surgical cases making up 347 or 70.8% of the total cases. Alameda physician surgical cases remained consistent with the prior month level at 143 versus 142 cases in December.

- Combined excess revenues over expense (profit) for January was $20,381 versus a combined budgeted excess of revenues over expense of (profit) of $22,196. This brings the year-to-date excess of revenues over expenses (profit) to $110,915 or $173,580 better than budgeted.

Volumes

Overall actual daily census was 83.4 versus a budget of 94.2. Acute average daily census was 31.4 versus a budget of 37.2, Sub-Acute average daily census was 31.7 versus a budget of 34.1 and the South Shore unit had an average daily census of 20.3 versus a budget of 23.0.

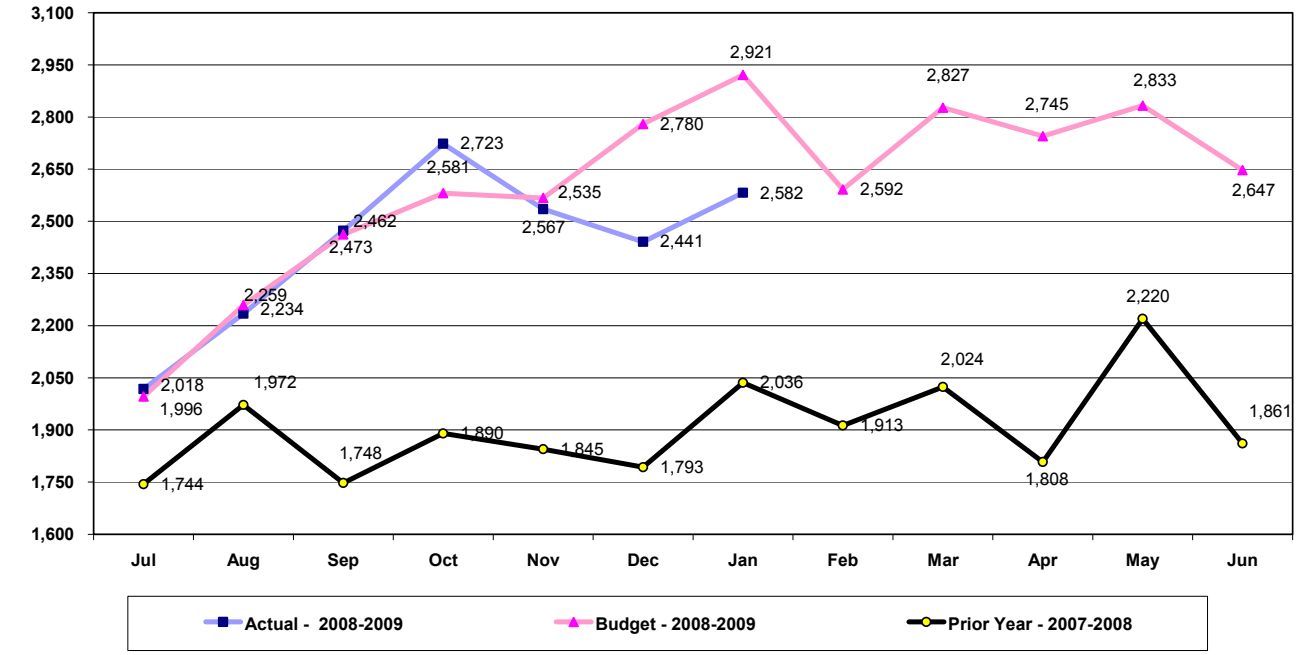


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Actual SNF		21.0	20.7	22.1	19.1	18.0	20.3						20.1
Actual Sub-Acute	32.1	32.6	32.8	33.0	33.8	33.4	31.7						32.8
Actual Acute	33.0	29.3	28.8	32.8	31.6	27.3	31.4						30.6

Actual	65.1	82.9	82.3	87.9	84.5	78.7	83.3						83.5
Budget	64.4	83.2	82.1	83.3	85.6	89.7	94.2						85.1

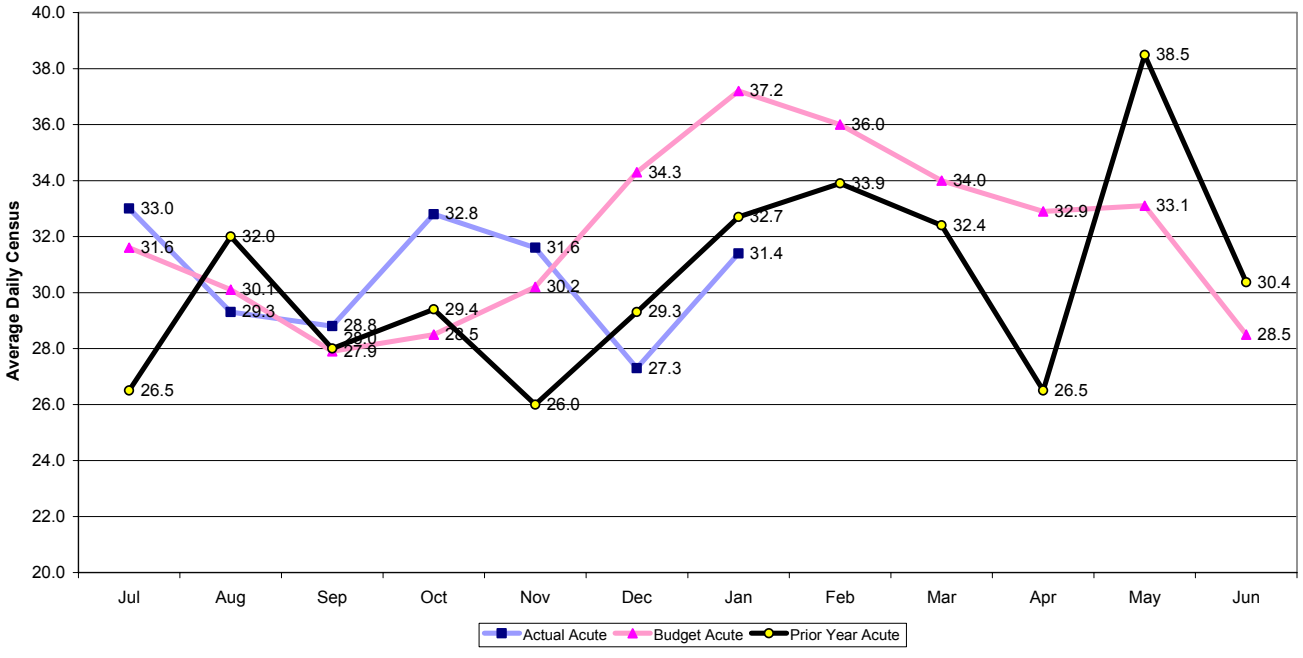
Total patient days in January were 11.6% less than budgeted and were 0.5% less than the prior year after removing the South Shore patient days from the current year total patient day count. The graph on the following page shows the total patient days for the month of January including South Shore.

Total Patient Days



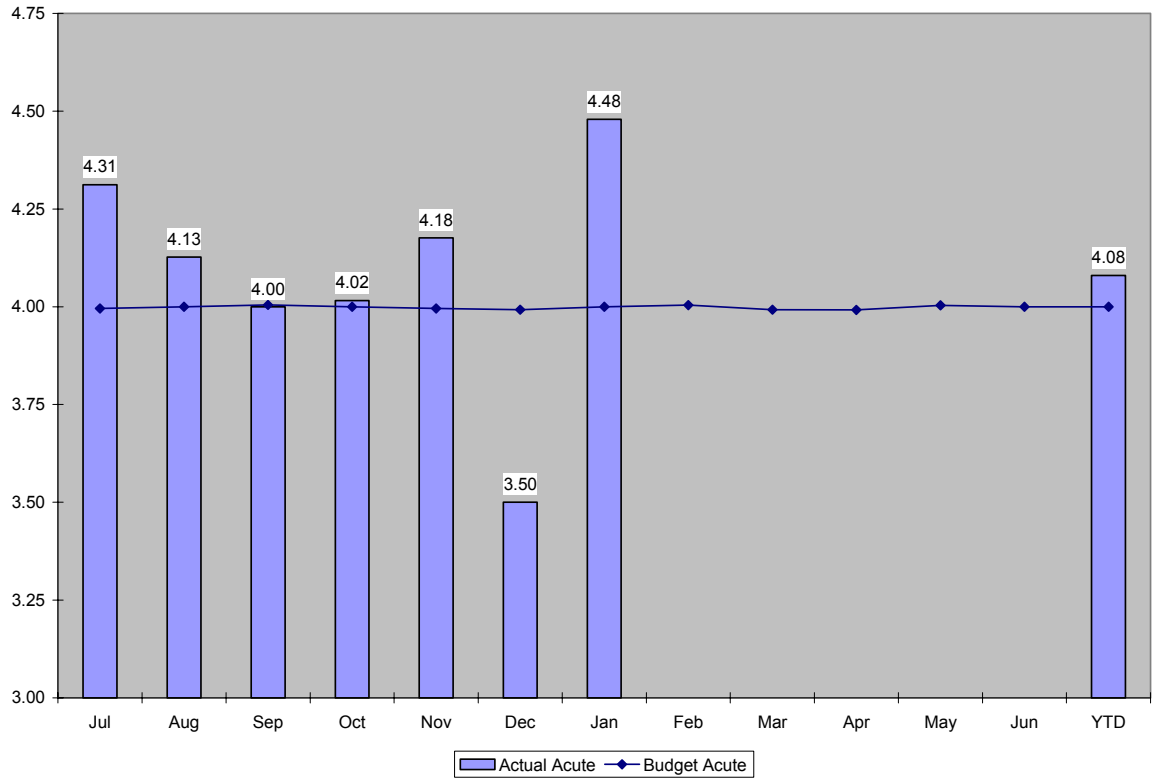
As we look at the various components of our volumes for the month of January we see that acute care patient days were 15.6% (180 days) less than budgeted but only 4.2% (43 days) less than the prior year.

Inpatient Acute Care Average Daily Census



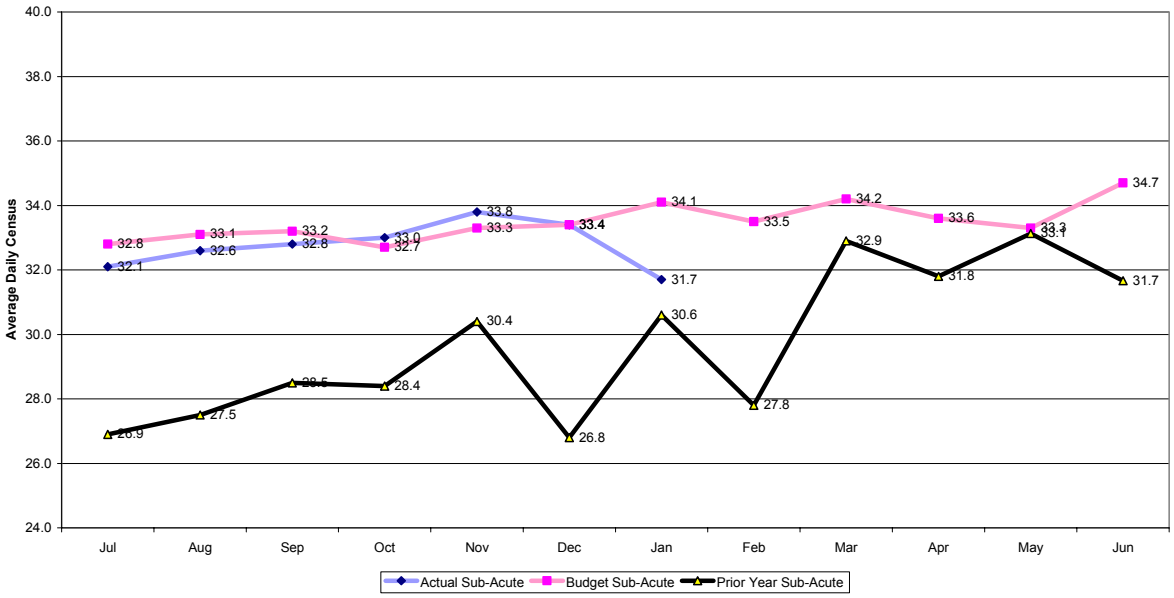
Our year to date average length of stay (ALOS) remains very close to budgeted levels at 4.08. However, in January our ALOS was influenced by two acute care accounts that had longer than normal length of stays. Had these two accounts been removed from the statistics for January the ALOS would have approximated 4.05 versus the ALOS for our acute care population shown below.

Average Length of Stay



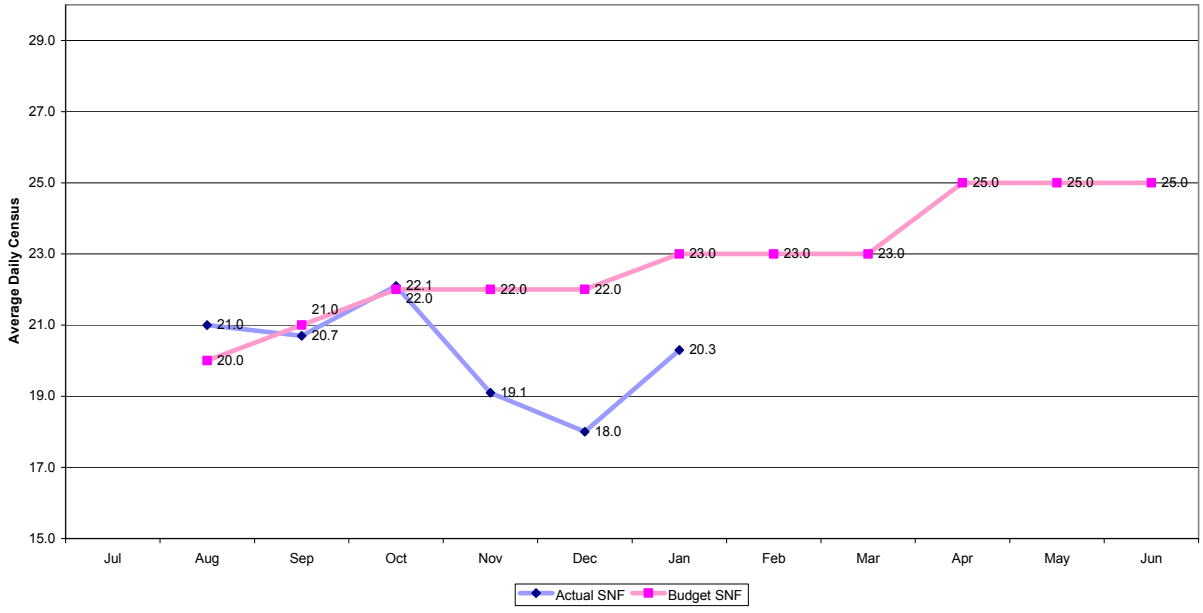
Sub-Acute patient days were below budget by 7.0% or 74 days but continue to exceed the prior year performance. The decline in census during January was the result of three (3) patients that expired during the last week of December and three (3) more patients that were transferred to other facilities due to the level of care that they required. While we were able to replace this discharges with five (5) new patients those admissions did not occur until the later part of the month. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



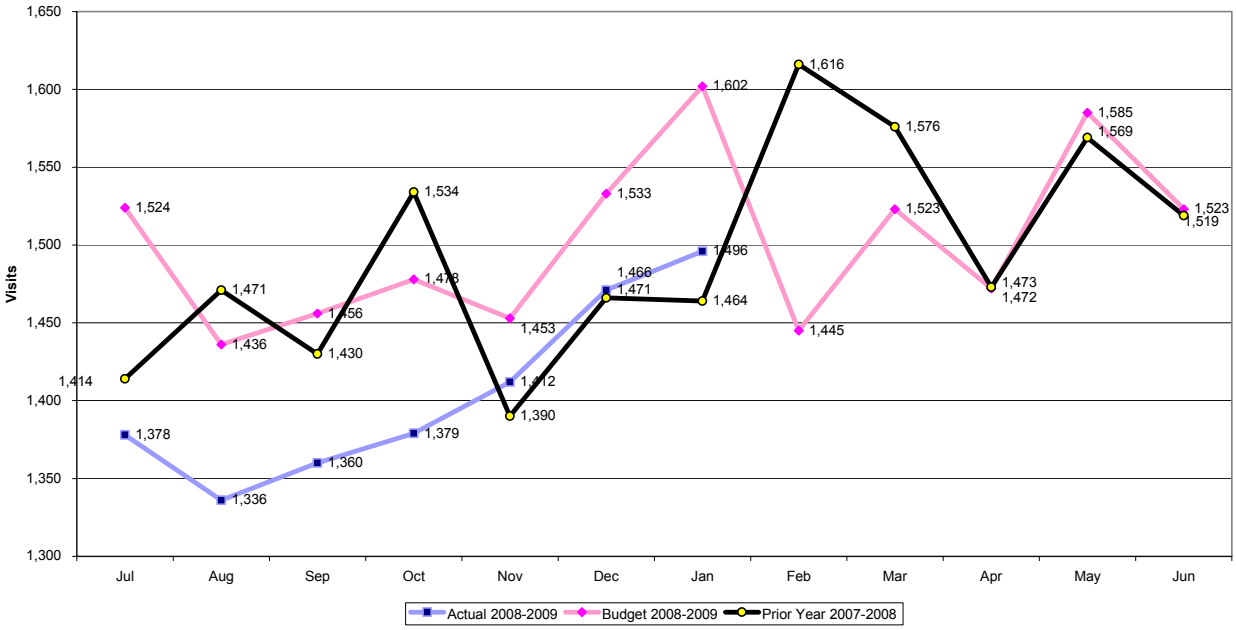
The Skilled Nursing Unit (South Shore) patient days were 11.9% less than budgeted for the month of January and are 7.9% less than budgeted for the first six months (August 17th through January 31st) of operations. This unfavorable variance from our budgeted patient day expectations continues to be the result of shorter length of stay cases. While this has negatively impacted our volume measure (patient days) we have experienced a higher level of net reimbursement as we move from custodial care type patients to patients requiring a higher level of skilled nursing and ancillary care. The following graph shows the Skilled Nursing Unit average daily census as compared to budget by month.

Skilled Nursing Unit Average Daily Census



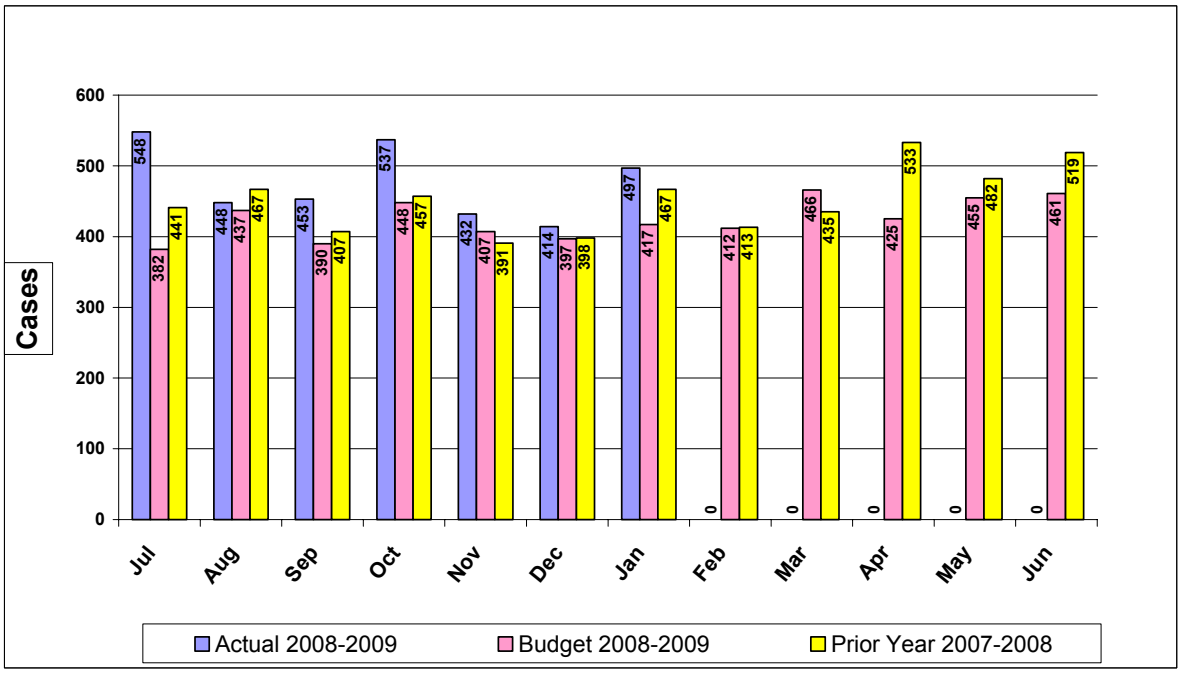
January ER visits were 6.6% less than budgeted but were slightly greater than the prior year's activity of 1,464.

Emergency Care Center Visits



Surgery cases were 490 versus the 417 budgeted and 467 in the prior year. In January, Alameda physician cases remained constant at 143 cases versus 142 in the prior month. However, Kaiser related cases in January increased to 347 as compared to the 271 cases performed in December. This increase in the number of cases resulted in an increase in Kaiser same day surgery revenue of $666,229 over the prior month. As a result of this increase our reimbursement for Kaiser Outpatient cases in January decreased to 18.8% as compared to 22.5% of gross charges in December.

Surgical Cases



Income Statement – Hospital Only

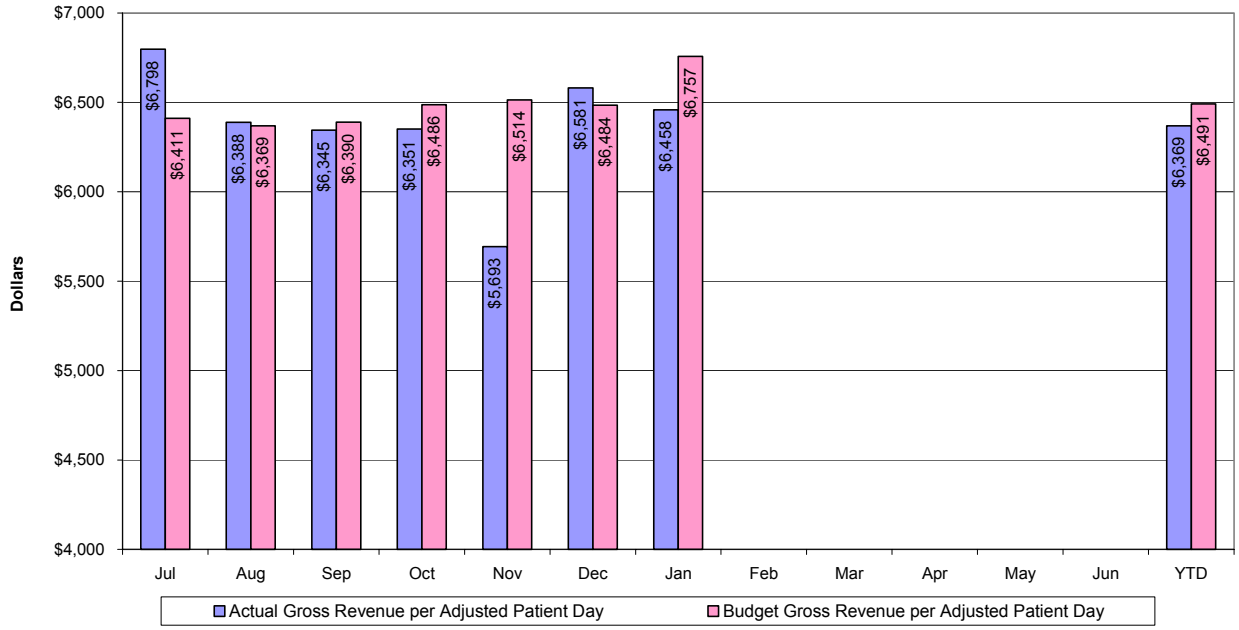
Gross Patient Charges

Gross patient charges in January were less than budgeted by $2,329,125 and were comprised of unfavorable variances in both inpatient and outpatient services of $2,299,960 and $29,164, respectively. On an adjusted patient day basis total patient revenue was $6,458 versus the budgeted $6,757 or a 4.4% favorable variance from budget.

The unfavorable variance from budgeted gross inpatient revenues was driven by several factors. The first factor was the result of a delay in implementing the January 1, 2009, budgeted 5% price increase to March 1, 2009. This delay was necessary as a result of difficulties in capturing accurate data from the Meditech application that would allow us to evaluate the impact of our pricing strategies across the organizations revenue cycle. As a result of this delay budgeted gross inpatient and outpatient charges were lower than budgeted by $650,915 and $505,067, respectively. However, despite the two month delay we were able to strategically increase prices to mitigate the impact of this delay to only one month and thereby keep the impact on net patient revenue to a minimum.

The second factor was our lower than budgeted average daily census and the lower acuity level of patients that were in-house during the month. Our overall case mix index declined to 1.1554 versus 1.2081. On a positive note our Medicare case mix index increased slightly to 1.2448 in January versus 1.2239 versus December.

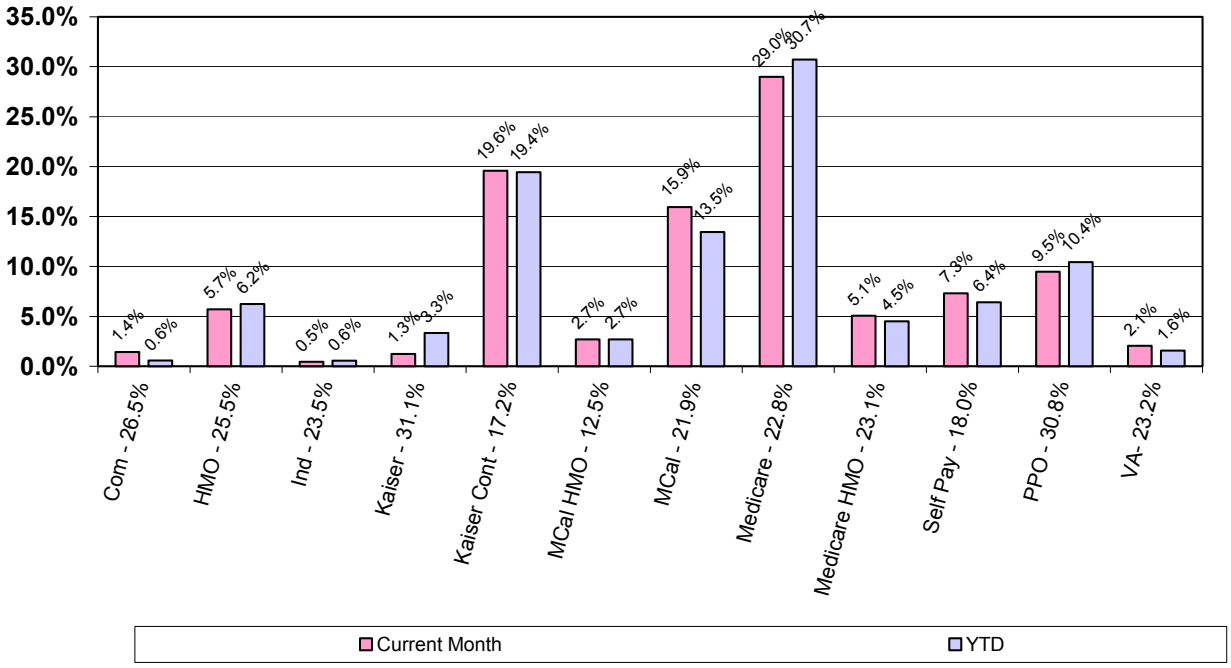
Gross Charges per Adjusted Patient Day



Payor Mix

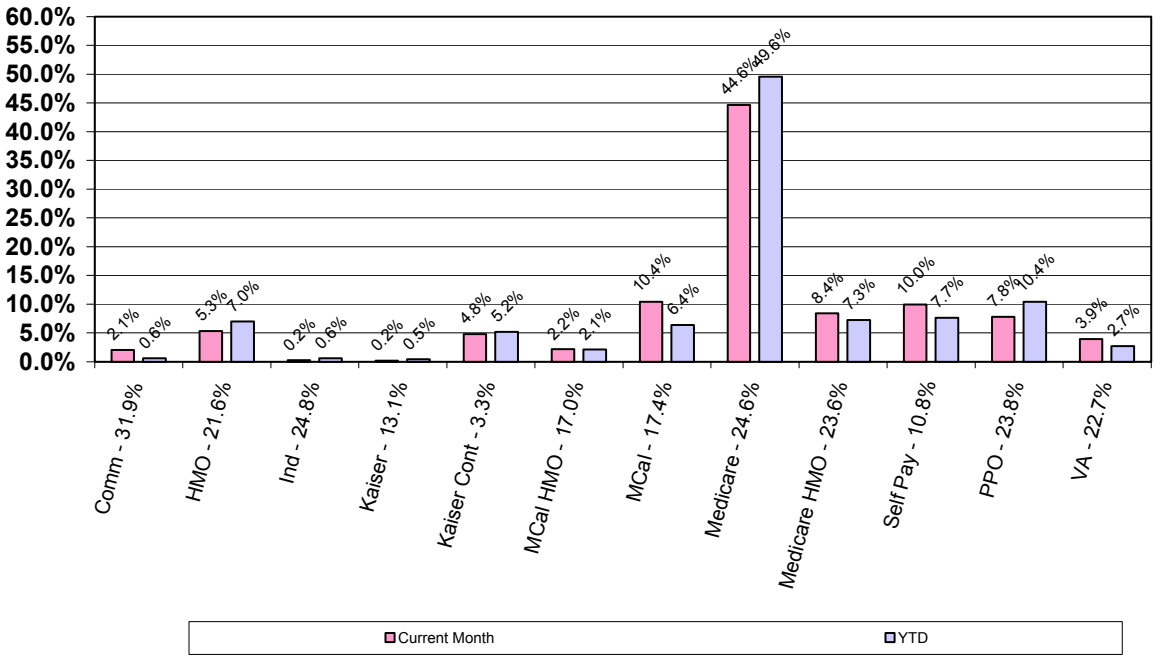
Medicare total gross revenue in January made up 29.0% our total gross patient charges with Kaiser again the second largest source of gross patient revenues at 20.9%. The graph on the following page shows the percentage of revenues generated by each of the major payors for the current month and year-to-date as well as the current months expected reimbursement for each.

Combined Payor Mix



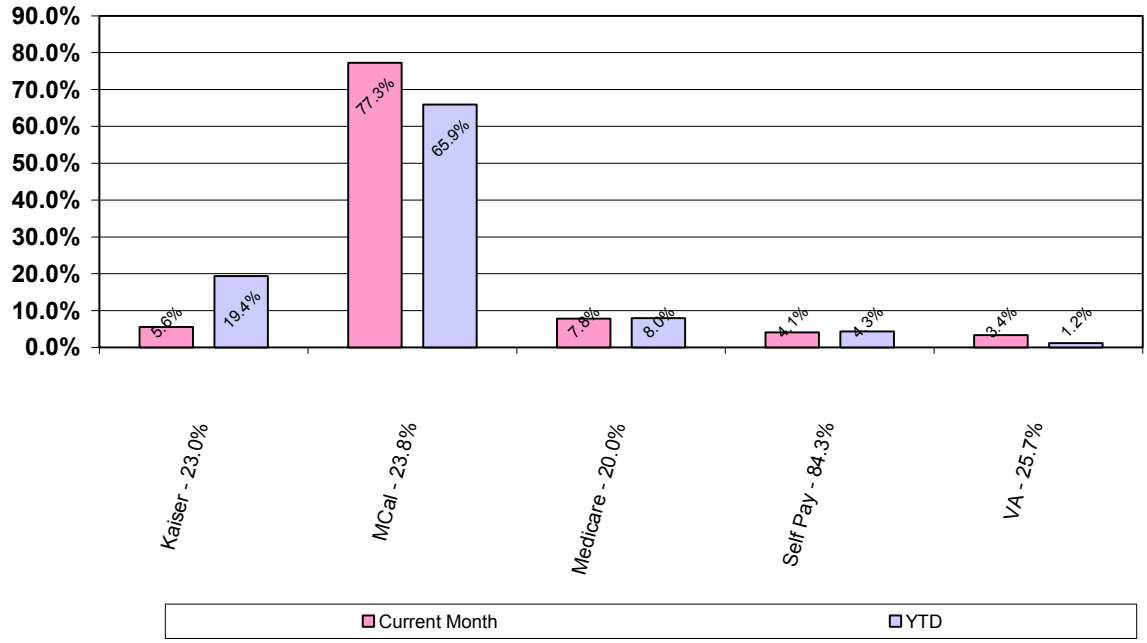
On the Hospital's inpatient acute care business, current month gross Medicare charges remained below 50% of our total inpatient acute care gross revenues for the second consecutive month at 44.6%. This months decline in Medicare gross charges brings the year to date average to slightly below 50%. This is being caused by a lower Medicare case mix index over the last several months and few or no outlier cases. As a result of January's actual Medicare utilization our expected reimbursement for Medicare inpatient cases was estimated to be 24.6% which is 1.3% lower than Decembers estimate.

Inpatient Acute Care Payor Mix



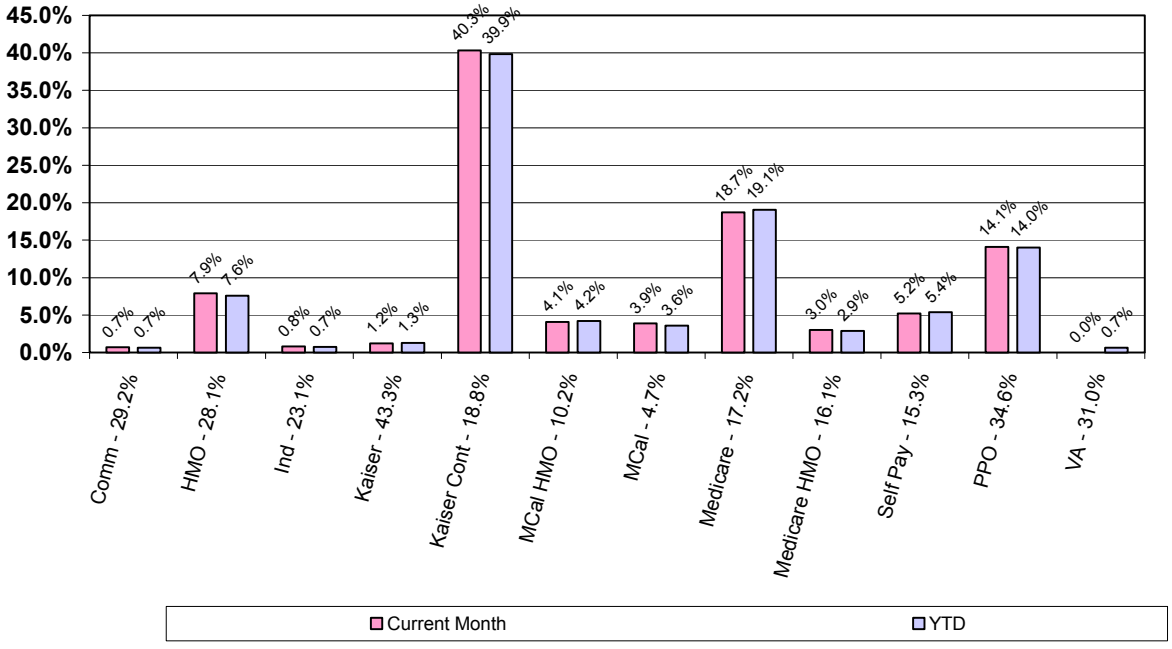
In January the Sub-Acute care program was again was dominated by Medi-Cal utilization of 77.3% based on gross revenue.

Inpatient Sub-Acute Care Payor Mix



Outpatient gross revenue payor mix for January was comprised of 41.5% Kaiser, 18.7% Medicare, 14.1% PPO and 7.9% HMO and is shown on the following graph. The large amount generated from Kaiser is primarily attributable (40.2%) to our current surgery services contract.

Outpatient Services Payor Mix



Deductions From Revenue

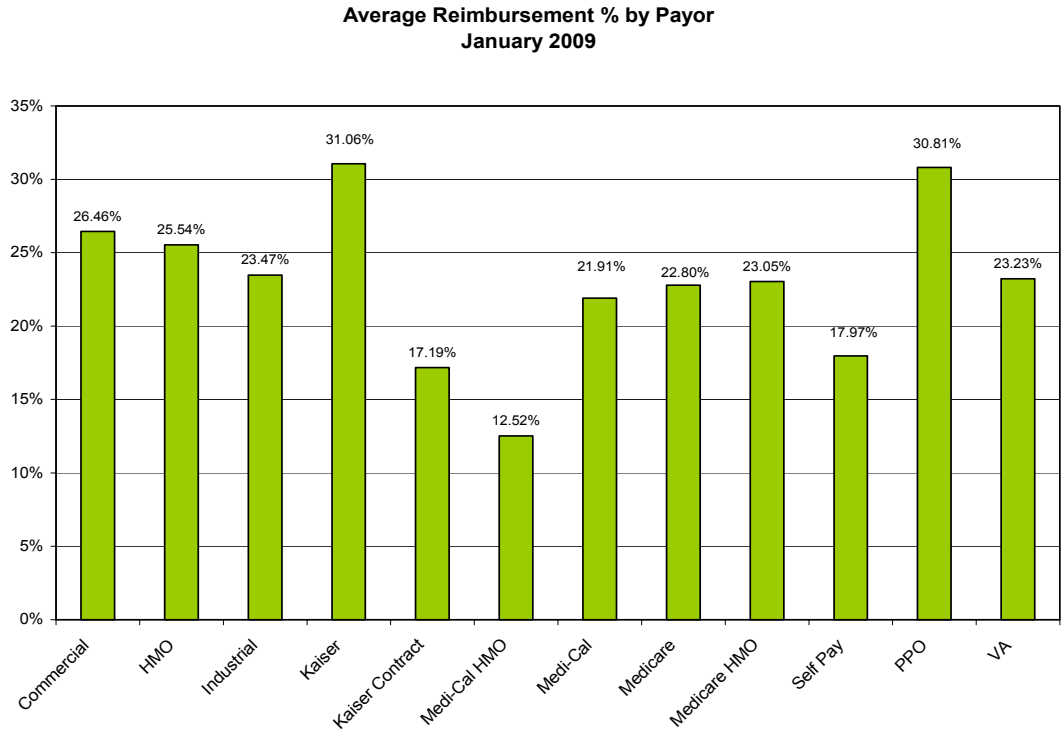
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross.

In the month of January contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 77.1% versus the budgeted 78.5%. Contractual reserves in the month of January include additional reserves attributable to recently enacted legislation, AB 1183, the Health Budget Trailer Bill, which requires a reduction to the interim payment for inpatient services provided by hospitals that do not participate in the Selective Provider Contracting Program (commonly known as non-contract hospitals), unless the hospital meets exemption criteria contained in the bill. Effective October 1, 2008, AB 1183 requires the Department of Health Care Services (DHCS) to limit the amount paid to non-contract hospitals for inpatient services to the lesser of the interim per diem rate (28% of gross Medi-Cal patient charges) reduced by 10%, or the applicable regional average per diem contract rate for tertiary and non-tertiary hospitals ($1,682 per Medi-Cal patient day) reduced by 5%. This resulted in additional contractual reserves of approximately $62,000.

In January there were again no DRG "take backs" associated with the Recovery Audit Contractor (RAC) project. The new National Recovery Audit program is to be phased in state-by-state starting in the fall of 2008. A new RAC contractor has been selected by CMS for California, HealthDataInsights, Inc., with California RAC audits slated to resume some time in the Spring of 2009. It is anticipated that we will begin to see requests for information under this program in the upcoming months and are working on developing appropriate mechanisms to ensure compliance with our rights to ensure timely responses to these requests.

Net Patient Service Revenue

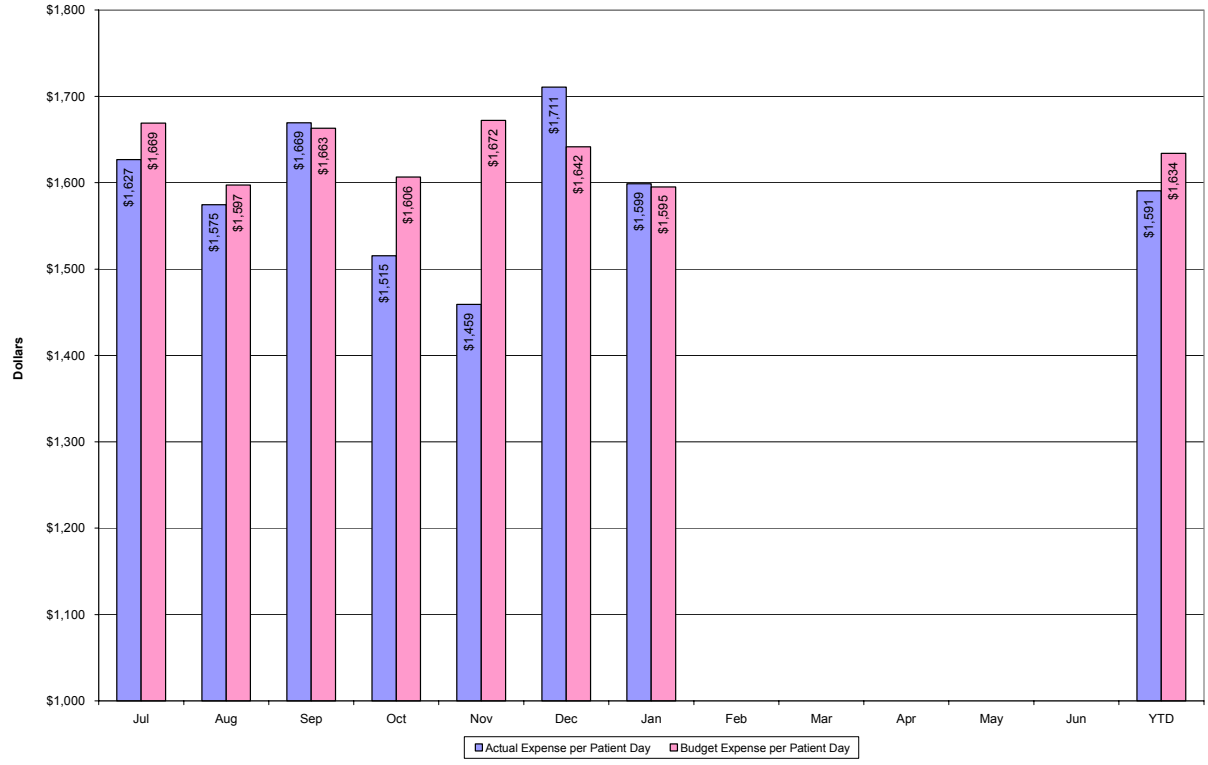
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is to receive for the services provided. The graph below shows the level of estimated reimbursement that the Hospital has estimated for the current month of fiscal year 2009 by major payor category.



Total Operating Expenses

Total operating expenses were less than the fixed budget by $288,166 or 4.9%. On an adjusted patient day basis, our cost per adjusted patient day decreased to $1,599 for the month which was only slightly higher than budgeted despite the 11.5% decline in acute and sub-acute volume experienced in the month. On a year to date basis our cost per adjusted patient day is 2.8% better than budgeted. The graph below shows the hospital operating expenses on an adjusted patient day basis for the 2009 fiscal year by month and is followed by explanations of the significant areas of variance.

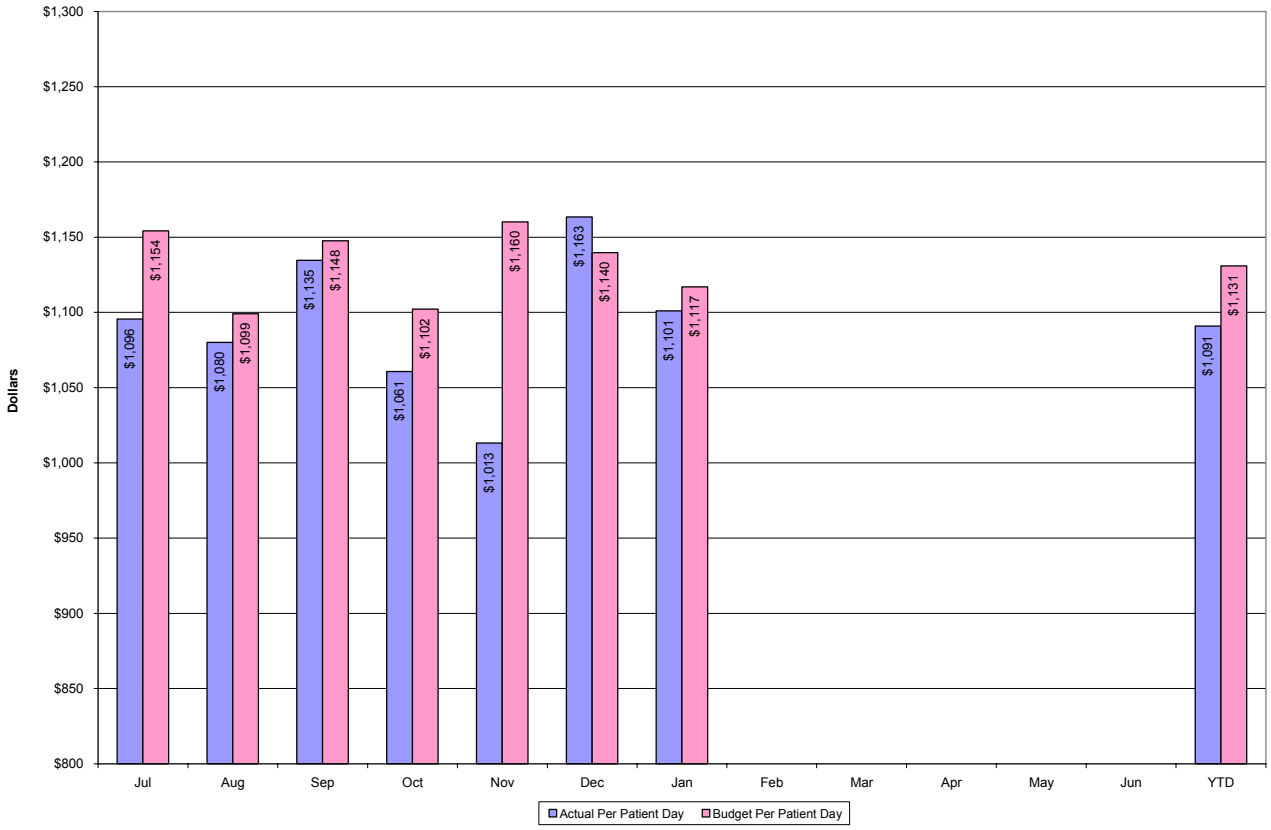
Expenses per Adjusted Patient Day



Salary and Registry Expenses

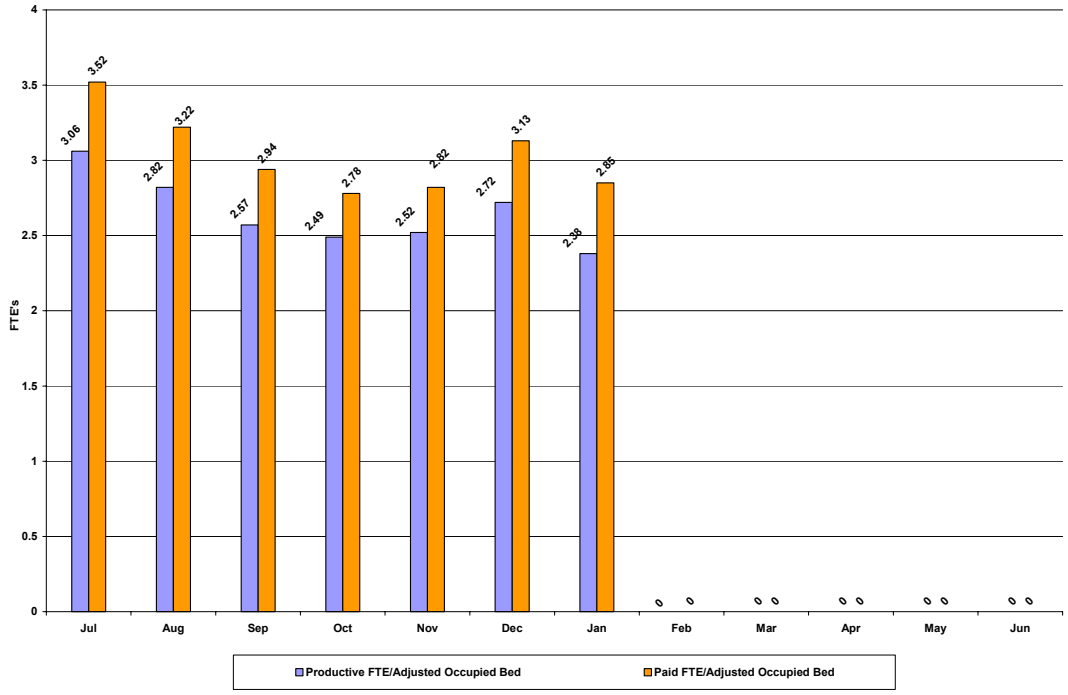
Salary and registry costs combined were again favorable to the fixed budget by $160,336 and $16 per adjusted patient day favorable to budget in January. This favorable variance from budget is primarily the result of the decrease in inpatient acute care days experienced in January and management's ability to flex staff accordingly. For the seven months ending January 31, 2009, the hospital is $97,557 favorable to the fixed budget and $18 per adjusted patient day favorable to budgeted expectations as seen on the graph of the next page.

Salary, Registry and Benefit Cost per APD



Combined productive FTE's per adjusted occupied bed was 2.38 in January versus the budgeted 2.39. The graph below shows the combined (Hospital including South Shore) productive and paid FTE's per adjusted occupied bed for FY 2009.

FTE's per Adjusted Occupied Bed



Benefits
For the month of January benefit costs were favorable to budget by $106,954 as a result of the favorable adjustment of our health insurance IBNR ($70,000) to the latest lag analysis which declined to $700,648.

Professional Fees
Professional fees were unfavorable to budget by $69,929 primarily as a result of additional consulting fees of $24,000 and $$12,500 associated with additional resources required to appropriately manage the laboratory department during the recruitment of anew manager and the analysis of the existing Kaiser contract, respectively.

Purchased Services
Purchased services were under budget by $23,570 for the month of January. This favorable variance is primarily related to lower than budgeted collection agency fees that have not been required this fiscal year.

Rents and Leases
Rents and leases were over budget by $14,711 as a result of bed rentals from the month of December ($7,500) that was not accrued in December.

Insurance
Insurance costs continue to be under budget as result of the favorable experience in our professional liability insurance program. We expect that for FY 2009 a savings of approximately 25% will be achieved in professional liability insurance rates over that of the prior year due to improved loss experience.

Other Operating Expenses
This category was favorable to budget by $19,132 as a result of the reversal of an expense accrual that was not reversed in December when the actual invoice was processed for payment.

ALAMEDA HOSPITAL
Balance Sheet
January 31, 2009

	January 31, 2009	December 31, 2008	Audited June 30, 2008
Assets			
Current assets:			
Cash and cash equivalents	$ 1,865,103	$ 3,244,985	$ 4,520,157
Net Accounts Receivable	9,838,278	8,550,583	7,944,522
Net Accounts Receivable %	23.65%	23.26%	20.17%
Inventories	1,014,263	1,011,128	1,048,503
Est.Third-party payer settlement receivable	507,957	497,872	245,115
Other assets	3,950,466	3,931,531	7,270,116
Total Current Assets	17,176,066	17,236,099	21,028,413
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	546,916	534,921	602,817
Total fixed assets, net of accumulated depreciation	7,069,309	7,152,711	7,450,244
Total Assets	$ 24,792,292	$ 24,923,731	$ 29,081,474
Liabilities and Net Assets			
Current Liabilities:			
Accounts payable and accrued expenses	4,515,614	4,591,644	5,423,290
Loans Payable	2,280,000	2,300,000	2,400,000
Payroll and benefit related accruals	4,913,150	4,566,506	4,099,642
Est.Third-party payer settlement payable	1,953,826	1,954,597	1,893,006
Other liabilities	3,253,051	3,729,860	7,351,860
Total Current Liabilities	16,915,641	17,142,607	21,167,798
Long-Term Liabilities:			
Long-term pension liabilities	(43,814)	(58,150)	(65,212)
Long-term IBNR reserves	120,000	120,000	120,000
Capitalized Lease payable	113,030	124,632	425,862
Total Long-Term Liabilities	189,216	186,482	480,650
Total Liabilities	17,104,857	17,329,089	21,648,448
Net Assets			
Unrestricted Funds	7,140,518	7,039,721	6,830,209
Restricted Funds	546,916	554,921	602,817
Net Assets	7,687,434	7,594,642	7,433,026
Total Liabilities and Net Assets	$ 24,792,292	$ 24,923,731	$ 29,081,474

ALAMEDA HOSPITAL - COMBINED
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	FY08	Actual	Budget	Variance	Var %	FY08
Operating revenues:										
IP Revenue	$ 13,012,259	$ 15,346,129	$ (2,333,870)	-15.2%	$ 12,449,620	$ 89,170,471	$ 92,445,516	$ (3,275,045)	-3.5%	$ 78,694,509
OP Revenue	10,101,348	10,130,512	(29,164)	-0.3%	8,590,572	68,194,725	65,172,338	3,022,387	4.6%	59,515,742
Total revenue	$ 23,113,607	$ 25,476,641	$ (2,363,034)	-9.3%	$ 21,040,192	$ 157,365,196	$ 157,617,854	$ (252,658)	-0.2%	$ 138,210,251
Less: Deductions from Revenue	(17,231,561)	(19,345,965)	2,114,404	10.9%	(15,133,336)	(116,146,167)	(116,572,211)	426,044	0.4%	(103,882,558)
Bad Debt	(295,082)	(265,574)	(29,508)	-11.1%	(843,318)	(4,367,113)	(3,844,338)	(522,775)	-13.6%	(2,699,812)
Charity	(289,203)	(260,283)	(28,920)	-11.1%	(202,945)	(767,156)	(750,154)	(17,002)	-2.3%	(701,723)
Net patient service revenue	$ 5,297,760	$ 5,604,819	$ (307,059)	-5.5%	$ 4,860,593	$ 36,084,759	$ 36,451,150	$ (366,392)	-1.0%	$ 30,926,158
	22.92%	22.00%			23.10%	22.93%	23.13%			22.38%
Other revenue	19,333	10,040	9,293	92.6%	9,564	113,381	70,280	43,101	61.3%	71,253
Total operating revenues	$ 5,317,094	$ 5,614,859	$ (297,765)	-5.3%	$ 4,870,157	$ 36,198,139	$ 36,521,430	$ (323,291)	-0.9%	$ 30,997,411
Operating expenses:										
Salaries	$ 3,079,168	$ 3,252,116	$ 172,948	5.3%	$ 2,989,388	$ 20,120,431	$ 20,912,337	$ 791,906	3.8%	$ 19,091,806
Registry	114,751	122,081	7,330	6.0%	117,614	1,434,703	812,997	(621,706)	-76.5%	861,150
Benefits	792,198	918,279	126,081	13.7%	1,118,926	5,608,763	6,157,891	549,128	8.9%	5,128,353
Professional Fees	358,906	282,408	(76,498)	-27.1%	288,769	2,209,152	1,975,484	(233,668)	-11.8%	2,375,669
Supplies	759,779	792,119	32,340	4.1%	592,691	5,250,756	5,214,958	(35,798)	-0.7%	4,890,591
Purchase Services	329,277	345,294	16,017	4.6%	258,904	2,347,839	2,414,815	66,976	2.8%	2,080,105
Rents and Leases	69,937	54,926	(15,011)	-27.3%	50,673	419,179	372,704	(46,475)	-12.5%	334,950
Utilities and Telephone	68,838	75,634	6,796	9.0%	73,637	499,349	521,228	21,879	4.2%	470,227
Insurance	48,393	67,366	18,973	28.2%	59,917	288,358	429,559	141,201	32.9%	417,231
Interest Expense	9,612	12,132	2,520	20.8%	14,108	83,863	84,922	1,059	1.2%	53,726
Depreciation and amortization	116,990	113,450	(3,540)	-3.1%	132,467	854,337	792,611	(61,726)	-7.8%	1,133,080
Other Operating Expenses	48,369	67,071	18,702	27.9%	62,353	501,403	466,080	(35,323)	-7.6%	374,059
Total operating expenses	$ 5,796,220	$ 6,102,876	$ 306,656	5.0%	$ 5,759,447	$ 39,618,134	$ 40,155,586	$ 537,452	1.3%	$ 37,210,947
Operating gain (loss)	$ (479,126)	$ (488,017)	$ 8,891	1.8%	$ (889,290)	$ (3,419,995)	$ (3,634,156)	$ 214,161	5.9%	$ (6,213,536)
Non-operating revenues (expenses):	$ 499,507	$ 510,213	$ (10,706)	-2.1%	$ 524,705	$ 3,530,910	$ 3,571,491	$ (40,581)	-1.1%	$ 3,661,137
Excess of revenues over expenses	20,381	22,196	(1,815)	8.2%	(364,585)	110,915	(62,665)	173,580	277.0%	(2,552,399)

ALAMEDA HOSPITAL - HOSPITAL ONLY
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	FY08	Actual	Budget	Variance	Var %	FY08
Operating revenues:										
IP Revenue	$ 12,618,291	$ 14,918,251	$ (2,299,960)	-15.4%	$ 12,449,620	$ 86,844,509	$ 90,238,276	$ (3,393,767)	-3.8%	$ 78,694,509
OP Revenue	10,101,348	10,130,512	(29,164)	-0.3%	8,590,572	68,194,725	65,172,338	3,022,387	4.6%	59,515,742
Total revenue	$ 22,719,638	$ 25,048,763	$ (2,329,125)	-9.3%	$ 21,040,192	$ 155,039,234	$ 155,410,614	$ (371,380)	-0.2%	$ 138,210,251
Less: Deductions from Revenue	(17,005,178)	(19,128,881)	2,123,703	11.1%	(15,133,336)	(114,782,226)	(115,464,213)	681,986	0.6%	(103,882,558)
Bad Debt	(295,082)	(265,574)	(29,508)	-11.1%	(843,318)	(4,367,113)	(3,834,677)	(532,436)	-13.9%	(2,699,812)
Charity	(289,203)	(260,283)	(28,920)	-11.1%	(202,945)	(767,156)	(748,286)	(18,870)	-2.5%	(701,723)
Net patient service revenue	$ 5,130,175	$ 5,394,025	$ (263,850)	-4.9%	$ 4,860,593	$ 35,122,738	$ 35,363,438	$ (240,700)	-0.7%	$ 30,926,158
	22.58%	21.53%			23.10%	22.65%	22.75%			22.38%
Other revenue	19,333	10,040	9,293	92.6%	9,564	113,381	70,280	43,101	61.3%	71,253
Total operating revenues	$ 5,149,508	$ 5,404,065	$ (254,557)	-4.7%	$ 4,870,157	$ 35,236,118	$ 35,433,718	$ (197,600)	-0.6%	$ 30,997,411
Operating expenses:										
Salaries	$ 2,980,771	$ 3,133,777	$ 153,006	4.9%	$ 2,989,388	$ 19,568,023	$ 20,287,286	$ 719,263	3.5%	$ 19,091,806
Registry	114,751	122,081	7,330	6.0%	117,614	1,434,703	812,997	(621,706)	-76.5%	861,150
Benefits	777,735	884,689	106,954	12.1%	1,118,926	5,556,641	5,975,707	419,066	7.0%	5,128,353
Professional Fees	338,935	269,006	(69,929)	-26.0%	288,769	2,086,055	1,883,044	(203,011)	-10.8%	2,375,669
Supplies	743,677	782,124	38,447	4.9%	592,691	5,182,117	5,160,223	(21,894)	-0.4%	4,890,591
Purchase Services	320,244	343,814	23,570	6.9%	258,904	2,313,740	2,406,710	92,970	3.9%	2,080,105
Rents and Leases	61,905	47,194	(14,711)	-31.2%	50,673	374,239	330,361	(43,878)	-13.3%	334,950
Utilities and Telephone	66,533	73,088	6,555	9.0%	73,637	484,697	507,286	22,589	4.5%	470,227
Insurance	47,551	66,512	18,961	28.5%	59,917	283,002	424,882	141,880	33.4%	417,231
Interest Expense	9,612	12,132	2,520	20.8%	14,108	83,863	84,922	1,059	1.2%	53,726
Depreciation and amortization	116,115	112,448	(3,667)	-3.3%	132,467	849,532	787,123	(62,409)	-7.9%	1,133,080
Other Operating Expenses	46,813	65,945	19,132	29.0%	62,353	492,460	459,913	(32,547)	-7.1%	374,059
Total operating expenses	$ 5,624,644	$ 5,912,810	$ 288,166	4.9%	$ 5,759,447	$ 38,709,073	$ 39,120,454	$ 411,381	1.1%	$ 37,210,947
Operating gain (loss)	$ (475,136)	$ (508,745)	$ 33,609	6.6%	$ (889,290)	$ (3,472,955)	$ (3,686,736)	$ 213,781	5.8%	$ (6,213,536)
Non-operating revenues (expenses):	$ 499,507	$ 510,213	$ (10,706)	-2.1%	$ 524,705	$ 3,530,910	$ 3,571,491	$ (40,581)	-1.1%	$ 3,661,137
Excess of revenues over expenses	24,371	1,468	22,903	-1560.2%	(364,585)	57,955	(115,245)	173,200	150.3%	(2,552,399)

ALAMEDA HOSPITAL - SOUTH SHORE ONLY
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	FY08	Actual	Budget	Variance	Var %	FY08
Operating revenues:										
IP Revenue	$ 393,969	$ 427,878	$ (33,909)	-7.9%	$ -	$ 2,325,962	$ 2,207,240	$ 118,722	5.4%	$ -
OP Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total revenue	$ 393,969	$ 427,878	$ (33,909)	-7.9%	$ -	$ 2,325,962	$ 2,207,240	$ 118,722	5.4%	$ -
Less: Deductions from Revenue	(226,383)	(217,084)	(9,299)	-4.3%	-	(1,363,941)	(1,107,999)	(255,942)	-23.1%	-
Bad Debt	-	-	-	0.0%	-	-	(9,661)	9,661	100.0%	-
Charity	-	-	-	0.0%	-	-	(1,869)	1,869	100.0%	-
Net patient service revenue	$ 167,586	$ 210,794	$ (43,208)	-20.5%	$ -	$ 962,021	$ 1,087,712	$ (125,691)	-11.6%	$ -
	42.54%	49.26%			0.00%	41.36%	49.28%			0.00%
Other revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total operating revenues	$ 167,586	$ 210,794	$ (43,208)	-20.5%	$ -	$ 962,021	$ 1,087,712	$ (125,691)	-11.6%	$ -
Operating expenses:										
Salaries	$ 98,397	$ 118,339	$ 19,942	16.9%	$ -	$ 552,408	$ 625,051	$ 72,643	11.6%	$ -
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	14,463	33,590	19,127	56.9%	-	52,122	182,184	130,062	71.4%	-
Professional Fees	19,971	13,402	(6,569)	-49.0%	-	123,097	92,440	(30,657)	-33.2%	-
Supplies	16,102	9,995	(6,107)	-61.1%	-	68,639	54,735	(13,904)	-25.4%	-
Purchase Services	9,033	1,480	(7,553)	-510.3%	-	34,099	8,105	(25,994)	-320.7%	-
Rents and Leases	8,032	7,732	(300)	-3.9%	-	44,940	42,343	(2,597)	-6.1%	-
Utilities and Telephone	2,305	2,546	241	9.5%	-	14,652	13,942	(710)	-5.1%	-
Insurance	842	854	12	1.4%	-	5,356	4,677	(679)	-14.5%	-
Interest Expense	-	-	-	0.0%	-	-	-	-	0.0%	-
Depreciation and amortization	875	1,002	127	12.7%	-	4,805	5,488	683	12.4%	-
Other Operating Expenses	1,556	1,126	(430)	-38.2%	-	8,943	6,167	(2,776)	-45.0%	-
Total operating expenses	$ 171,576	$ 190,066	$ 18,490	9.7%	$ -	$ 909,061	$ 1,035,132	$ 126,071	12.2%	$ -
Operating gain (loss)	$ (3,990)	$ 20,728	$ (24,718)	-119.3%	$ -	$ 52,960	$ 52,580	$ 380	-0.7%	$ -
Non-operating revenues (expenses):	$ -	$ -	$ -	0.0%	$ -	$ -	$ -	$ -	0.0%	$ -
Excess of revenues over expenses	(3,990)	20,728	(24,718)	-119.3%	-	52,960	52,580	380	-0.7%	-

ALAMEDA HOSPITAL - COMBINED
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	FY08	Actual	Budget	Variance	Var %	FY08
Operating revenues:										
IP Revenue	$ 2,837	$ 3,165	$ (328)	-10.4%	$ 3,751	$ 2,972	$ 3,087	$ (115)	-3.7%	$ 3,484
OP Revenue	2,203	2,089	114	5.5%	2,588	2,273	2,176	97	4.5%	2,635
Total revenue	$ 5,040	$ 5,254	$ (214)	-4.1%	$ 6,339	$ 5,245	$ 5,263	$ (18)	-0.3%	$ 6,119
Less: Deductions from Revenue	(3,757)	(3,990)	233	5.8%	(4,560)	(3,871)	(3,892)	21	0.5%	(4,599)
Bad Debt	(64)	(55)	(9)	-16.4%	(254)	(146)	(128)	(18)	-14.1%	(120)
Charity	(63)	(54)	(9)	-16.7%	(61)	(26)	(25)	(1)	-4.0%	(31)
Net patient service revenue	$ 1,156	$ 1,155	$ 1	0.1%	$ 1,464	$ 1,202	$ 1,218	$ (16)	-1.3%	$ 1,369
	22.94%	21.98%			23.10%	22.92%	23.14%			22.37%
Other revenue	4	2	2	100.0%	3	4	2	2	100.0%	3
Total operating revenues	$ 1,160	$ 1,157	$ 3	0.3%	$ 1,467	$ 1,206	$ 1,220	$ (14)	-1.1%	$ 1,372
Operating expenses:										
Salaries	$ 671	$ 671	$ -	0.0%	$ 901	$ 671	$ 698	$ 27	3.9%	$ 845
Registry	25	25	-	0.0%	35	48	27	(21)	-77.8%	38
Benefits	173	189	16	8.5%	337	187	206	19	9.2%	227
Professional Fees	78	58	(20)	-34.5%	87	74	66	(8)	-12.1%	105
Supplies	166	163	(3)	-1.8%	179	175	174	(1)	-0.6%	217
Purchase Services	72	71	(1)	-1.4%	78	78	81	3	3.7%	92
Rents and Leases	15	11	(4)	-36.4%	15	14	12	(2)	-16.7%	15
Utilities and Telephone	15	16	1	6.3%	22	17	17	-	0.0%	21
Insurance	11	14	3	21.4%	18	10	14	4	28.6%	18
Interest Expense	2	3	1	33.3%	4	3	3	-	0.0%	2
Depreciation and amortization	26	23	(3)	-13.0%	40	28	26	(2)	-7.7%	50
Other Operating Expenses	11	14	3	21.4%	19	17	16	(1)	-6.3%	17
Total operating expenses	$ 1,265	$ 1,258	$ (7)	-0.6%	$ 1,735	$ 1,322	$ 1,340	$ 18	1.3%	$ 1,647
Operating gain (loss)	$ (105)	$ (101)	$ (4)	-4.0%	$ (268)	$ (116)	$ (120)	$ 4	3.3%	$ (275)
Non-operating revenues (expenses):	$ 109	$ 105	$ 4	3.8%	$ 158	$ 118	$ 119	$ (1)	-0.8%	$ 162
Excess of revenues over expenses	4	4	-	0.0%	(110)	2	(1)	3	300.0%	(113)

ALAMEDA HOSPITAL - HOSPITAL ONLY
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	FY08	Actual	Budget	Variance	Var %	FY08
Operating revenues:										
IP Revenue	$ 3,587	$ 4,024	$ (437)	-10.9%	$ 3,751	$ 3,571	$ 3,770	$ (199)	-5.3%	$ 3,484
OP Revenue	2,871	2,733	138	5.0%	2,588	2,804	2,723	81	3.0%	2,635
Total revenue	$ 6,458	$ 6,757	$ (299)	-4.4%	$ 6,339	$ 6,375	$ 6,493	$ (118)	-1.8%	$ 6,119
Less: Deductions from Revenue	(4,834)	(5,160)	326	6.3%	(4,560)	(4,720)	(4,824)	104	2.2%	(4,599)
Bad Debt	(84)	(72)	(12)	-16.7%	(254)	(180)	(160)	(20)	-12.5%	(120)
Charity	(82)	(70)	(12)	-17.1%	(61)	(32)	(31)	(1)	-3.2%	(31)
Net patient service revenue	$ 1,458	$ 1,455	$ 3	0.2%	$ 1,464	$ 1,443	$ 1,478	$ (35)	-2.4%	$ 1,369
	22.58%	21.53%			23.10%	22.64%	22.76%			22.37%
Other revenue	5	3	2	66.7%	3	5	3	2	66.7%	3
Total operating revenues	$ 1,463	$ 1,458	$ 5	0.3%	$ 1,467	$ 1,448	$ 1,481	$ (33)	-2.2%	$ 1,372
Operating expenses:										
Salaries	$ 847	$ 845	$ (2)	-0.2%	$ 901	$ 805	$ 848	$ 43	5.1%	$ 845
Registry	33	33	-	0.0%	35	59	34	(25)	-73.5%	38
Benefits	221	239	18	7.5%	337	228	250	22	8.8%	227
Professional Fees	96	73	(23)	-31.5%	87	86	79	(7)	-8.9%	105
Supplies	211	211	-	0.0%	179	213	216	3	1.4%	217
Purchase Services	91	93	2	2.2%	78	95	101	6	5.9%	92
Rents and Leases	18	13	(5)	-38.5%	15	15	14	(1)	-7.1%	15
Utilities and Telephone	19	20	1	5.0%	22	20	21	1	4.8%	21
Insurance	14	18	4	22.2%	18	12	18	6	33.3%	18
Interest Expense	3	3	-	0.0%	4	3	4	1	25.0%	2
Depreciation and amortization	33	30	(3)	-10.0%	40	35	33	(2)	-6.1%	50
Other Operating Expenses	13	18	5	27.8%	19	20	19	(1)	-5.3%	17
Total operating expenses	$ 1,599	$ 1,596	$ (3)	-0.2%	$ 1,735	$ 1,591	$ 1,637	$ 46	2.8%	$ 1,647
Operating gain (loss)	$ (136)	$ (138)	$ 2	1.4%	$ (268)	$ (143)	$ (156)	$ 13	8.3%	$ (275)
Non-operating revenues (expenses):	$ 142	$ 138	$ 4	2.9%	$ 158	$ 145	$ 149	$ (4)	-2.7%	$ 162
Excess of revenues over expenses	6	-	6	#DIV/0!	(110)	2	(7)	9	128.6%	(113)

ALAMEDA HOSPITAL - SOUTH SHORE ONLY
Summary Statement of Revenues, Expenses
For the Seven Months Ended January 31, 2009

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	FY08	Actual	Budget	Variance	Var %	FY08
Operating revenues:										
IP Revenue	$ 627	$ 600	$ 27	4.5%	$ -	$ 688	$ 602	$ 86	14.3%	$ -
OP Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total revenue	$ 627	$ 600	$ 27	4.5%	$ -	$ 688	$ 602	$ 86	14.3%	$ -
Less: Deductions from Revenue	(360)	(304)	(56)	-18.4%	-	(404)	(302)	(102)	-33.8%	-
Bad Debt	-	-	-	0.0%	-	-	(3)	3	100.0%	-
Charity	-	-	-	0.0%	-	-	(1)	1	100.0%	-
Net patient service revenue	$ 267	$ 296	$ (29)	-9.8%	$ -	$ 284	$ 296	$ (12)	-4.1%	$ -
	42.58%	49.33%			0.00%	41.28%	49.17%			0.00%
Other revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total operating revenues	$ 267	$ 296	$ (29)	-9.8%	$ -	$ 284	$ 296	$ (12)	-4.1%	$ -
Operating expenses:										
Salaries	$ 157	$ 166	$ 9	5.4%	$ -	$ 163	$ 170	$ 7	4.1%	$ -
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	23	47	24	51.1%	-	15	50	35	70.0%	-
Professional Fees	32	19	(13)	-68.4%	-	36	25	(11)	-44.0%	-
Supplies	26	14	(12)	-85.7%	-	20	15	(5)	-33.3%	-
Purchase Services	14	2	(12)	-600.0%	-	10	2	(8)	-400.0%	-
Rents and Leases	13	11	(2)	-18.2%	-	13	12	(1)	-8.3%	-
Utilities and Telephone	4	4	-	0.0%	-	4	4	-	0.0%	-
Insurance	1	1	-	0.0%	-	2	1	(1)	-100.0%	-
Interest Expense	-	-	-	0.0%	-	-	-	-	0.0%	-
Depreciation and amortization	1	1	-	0.0%	-	1	1	-	0.0%	-
Other Operating Expenses	2	2	-	0.0%	-	3	2	(1)	-50.0%	-
Total operating expenses	$ 273	$ 267	$ (6)	-2.2%	$ -	$ 267	$ 282	$ 15	5.3%	$ -
Operating gain (loss)	$ (6)	$ 29	$ (35)	-120.7%	$ -	$ 17	$ 14	$ 3	-21.4%	$ -
Non-operating revenues (expenses):	$ -	$ -	$ -	0.0%	$ -	$ -	$ -	$ -	0.0%	$ -
Excess of revenues over expenses	(6)	29	(35)	-120.7%	-	17	14	3	-21.4%	-

ALAMEDA HOSPITAL
KEY STATISTICS
January, 2009

	ACTUAL JANUARY 2009	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	JANUARY 2008	YTD JANUARY 2009	YTD FIXED BUDGET	VARIANCE	%	YTD JANUARY 2008
Discharges:										
Total Acute	217	288	(71)	-24.7%	248	1,612	1,689	(77)	-4.6%	1,618
Total Sub-Acute	3	2	1	50.0%	2	25	14	11	78.6%	10
Total Skilled Nursing	10	10	-	0.0%	4	68	49	19	38.8%	56
	230	300	(70)	-23.3%	254	1,705	1,752	(47)	-2.7%	1,684
Patient Days:										
Total Acute	972	1,152	(180)	-15.6%	1,015	6,577	6,753	(176)	-2.6%	6,293
Total Sub-Acute	982	1,056	(74)	-7.0%	877	7,046	7,146	(100)	-1.4%	5,976
Total Skilled Nursing	628	713	(85)	-11.9%	72	3,379	3,667	(288)	-7.9%	592
	2,582	2,921	(339)	-11.6%	1,964	17,002	17,566	(564)	-3.2%	12,861
Average Length of Stay										
Total Acute	4.48	4.00	0.48	12.0%	4.09	4.08	4.00	0.08	2.0%	3.89
Average Daily Census										
Total Acute	31.35	37.16	(5.81)	-15.6%	32.74	30.59	31.41	(0.82)	-2.6%	29.27
Total Sub-Acute	31.68	34.06	(2.39)	-7.0%	28.29	32.77	33.24	(0.47)	-1.4%	27.80
Total Skilled Nursing	20.26	23.00	(2.74)	-11.9%	2.32	20.11	21.83	(1.71)	-7.9%	2.75
	83.29	94.23	(10.94)	-11.6%	63.35	83.48	86.47	(1.28)	-1.5%	59.82
Emergency Room Visits	1,496	1,602	(106)	-6.6%	1,464	9,832	10,482	(650)	-6.2%	10,169
Outpatient Registrations	2,705	3,004	(299)	-10.0%	2,867	17,442	17,917	(475)	-2.7%	18,606
Surgery Cases:										
Inpatient	52	54	(2)	-3.7%	54	393	398	(5)	-1.3%	386
Outpatient	438	363	75	20.7%	413	2,929	2,480	449	18.1%	2,642
	490	417	73	17.5%	467	3,322	2,878	444	15.4%	3,028
Kaiser Inpatient Cases	8	-	8	-	5	60	-	60	-	30
Kaiser Eye Cases	164	130	34	26.2%	150	1,090	850	240	28.2%	937
Kaiser Outpatient Cases	175	130	45	34.6%	158	1,091	878	213	24.3%	882
Total Kaiser Cases	347	260	87	33.5%	313	2,241	1,728	513	29.7%	1,849
% Kaiser Cases	70.8%	62.4%			67.0%	67.5%	60.0%			61.1%
Adjusted Occupied Bed	147.95	156.53	8.58	5.5%	107.07	139.56	139.47	0.09	0.1%	104.32
Productive FTE	351.61	374.15	22.54	6.0%	347.29	366.75	344.08	(22.67)	-6.6%	347.23
Total FTE	421.30	446.43	25.13	5.6%	404.30	419.90	406.10	(13.80)	-3.4%	404.71
Productive FTE/Adj. Occ. Bed	2.38	2.39	0.01	0.6%	3.24	2.63	2.47	(0.16)	-6.5%	3.33
Total FTE/ Adj. Occ. Bed	2.85	2.85	0.00	0.2%	3.78	3.01	2.91	(0.10)	-3.3%	3.88

ALAMEDA HOSPITAL

12 MONTH CASH PROJECTION

PERIOD COVERED:1/1/09 THRU 12/31/09

	COLLECTIONS		PROPERTY	W/C REFUND	OTHER	FY 2008		EST.	
MONTH	NON-KAISER	KAISER -USE	TAX[1]	NET		AB 915	TRANSFERS	DISBURSEMENTS	BALANCE[2]
JAN 09	3,171,083	760,000	477,000		263,691		590,188	5,599,790	(525,287)
FEB 09	4,236,718	760,000	477,000		65,000		(110,000)	5,316,493	(413,062)
MAR 09	4,510,000	760,000	477,000		140,000		(110,000)	5,245,981	117,958
APR 09	4,620,000	790,000	477,000		50,000		(610,000)	5,245,981	198,977
MAY 09	4,410,000	790,000	477,000		50,000		990,000	6,818,428	97,549
JUNE 09	4,730,000	790,000	477,000		50,000	180,000	(810,000)	5,381,785	132,764
JULY 09	4,730,000	790,000	477,000		50,000		(110,000)	5,988,367	81,397
AUG 09	4,620,000	790,000	477,000		50,000		90,000	5,988,367	120,029
SEP 09	4,620,000	790,000	477,000		50,000		40,000	5,988,367	108,662
OCT 09	4,950,000	790,000	477,000		50,000		(110,000)	6,099,854	165,808
NOV 09	4,370,000	790,000	477,000		50,000		290,000	5,988,367	154,441
DEC 09	5,060,000	790,000	477,000		50,000		(410,000)	5,988,367	133,073
TOTALS	54,027,801	9,390,000	5,724,000	0	918,691	180,000	(269,812.00)	69,650,149	

Notes:

1. Property tax receipts will be held in an interest bearing investment account and transferred to the operating account as needed each month.
2. Reflects only cash held in concentration and disbursement accounts at month-end. Additional funds are held on deposit in money market accounts at the Bank of Alameda and Merrill Lynch, respectively.

12 Month Cash Projection - Disbursement Detail

PERIOD COVERED:1/1/09 THRU 12/31/09

	DISBURSEMENTS								TOTAL CASH
			10%						
MONTH	PAYROLL	PENSION	PAYROLL RELATED	Total Payroll	Health expense	Refund	A/P	Debt Service	OUTLAYS
JAN 09	2,683,665	64,697	257,966	3,006,329	385,002	3,000	2,157,043	48,417	5,599,790
FEB 09	2,722,288	64,353	253,751	3,040,392	278,000	20,000	1,929,591	48,511	5,316,493
MAR 09	2,722,288	64,353	261,340	3,047,981	278,000	20,000	1,837,441	62,559	5,245,981
APR 09	2,722,288	64,353	261,340	3,047,981	278,000	20,000	1,851,707	48,293	5,245,981
MAY 09	4,137,708 a	85,500	397,220	4,620,428	278,000	20,000	1,855,987	44,013	6,818,428
JUNE 09	2,758,472	60,500	264,813	3,083,785	278,000	20,000	1,955,933	44,067	5,381,785
JULY 09	3,311,923	60,500	317,945	3,690,367	278,000	20,000	1,955,891	44,109	5,988,367
AUG 09	3,311,923	60,500	317,945	3,690,367	278,000	20,000	1,955,842	44,158	5,988,367
SEP 09	3,311,923	60,500	317,945	3,690,367	278,000	20,000	1,955,788	44,212	5,988,367
OCT 09	4,967,884 a	85,500	476,917	3,801,854	278,000	20,000	1,955,744	44,256	6,099,854
NOV 09	3,311,923	60,500	317,945	3,690,367	278,000	20,000	1,955,690	44,310	5,988,367
DEC 09	3,311,923	60,500	317,945	3,690,367	278,000	20,000	1,957,912	42,088	5,988,367
TOTALS	39,274,208	791,755	3,763,069	42,100,585	3,443,002	223,000	23,324,568	558,993	69,650,149

a) 3 pay periods in the month

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 25, 2009

To: City of Alameda Health Care District Board of Directors

From: David A. Neapolitan, Chief Financial Officer

Subject: Approval for Authorization to Apply for Help II Funding

---

The California Health Facilities Financing Authority (CHAFFA) offers assistance to health facilities in expanding and improving services to the people of California by providing low cost financing for much needed capital projects through the HELP II or Healthcare Expansion Loan Program II. Details of the program include the following:

- Eligibility for the program:
  1. Must be one of the following:
     a. A corporation with no more than $30 million in annual gross revenues
     b. Located in a rural Medical Service Study Area
     c. A District Hospital
  2. Provided same types of services during the last three years.
  3. Provide three years audited financial statements.
  4. Evidence of fiscal soundness and ability to repay loan
  5. Readiness to begin projects shortly after funding for construction and remodeling projects.
  6. Provide for consumer savings and community benefit.

- Permitted Uses of the Funds:
  1. Purchase, construct, renovate or remodel property
  2. Perform feasibility studies, site tests and surveys associated with real property
  3. Pay permit fees, architectural fees and other pre-construction costs
  4. Purchase equipment and furnishings
  5. Refinance existing debt, but only where any single obligation is paid in full.

  *Funds may not be used for day-to-day operational expenses, reimbursement of prior project expenditures or refinancing part of a single outstanding obligation.

- Terms of the Loan:
  1. 3% fixed interest rate
  2. Loan amounts of $25,000 to $750,000
  3. Maximum LTV ratio of 95%
  4. Maximum loan term:

    a. Real Estate – 15 years
    b. Equipment – Maximum of 5 years
5. Revenue pledge required
6. No prepayment penalties
7. Funding in approximately 60 days from application date.

Management is requesting authorization by the Board of Directors to apply for the HELP II funds to assist with the renovations to the Alameda Towne Centre Medical Office Space.

Alameda County Chapter
California Special Districts Association

cordially invites you to attend our

18th Annual Dinner Meeting

Thursday, March 26, 2009

Marriott Hotel, Pleasanton
(map and directions on back)

6:00p.m. No-host social hour
7:00p.m. Dinner and Program

Guest Speaker:

Ralph Heim

Sacramento Legislative Advocate
California Special Districts Association

RSVP by Wednesday, March 18. If you need to cancel a reservation, please let us know no later than Wednesday March 18, 2009, by calling Sharon Clay at 510/544-2002. Please note, you will be responsible for payment of your un-cancelled reservation.

✂----------

Name: _____ Agency: _____ Guest: _____

___ Prime Rib-Oven Roasted with Roasted Yukon Gold Potatoes & Grilled Asparagus

___ Vegetarian entrée available by Request

____ Grilled Salmon with Lemon Butter Dill Sauce, Garlic Roasted Yukon Gold Potatoes & Grilled Asparagus

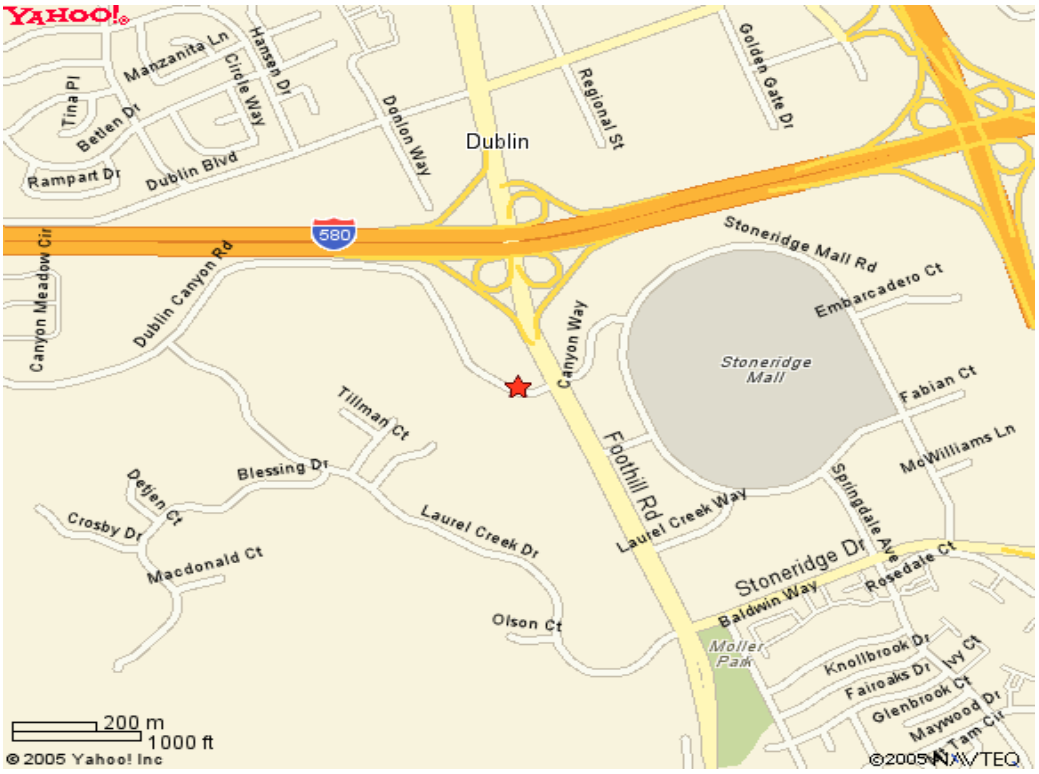
Amount enclosed: _____

Please complete and return this section, along with your check for **$42.00** per person made payable to **ACSDA**, by Wednesday, **March 18**, to:

Sharon Clay
East Bay Regional Park District
P.O. Box 5381

PLEASANTON MARRIOTT

11950 Dublin Canyon Road, Pleasanton, CA 94588 ♦925-847-6000♦FAX 925-463-2585



FROM SAN JOSE INTERNATIONAL AIRPORT:

Exit the airport to 880 North. Continue on 680 North for approximately 30-40 miles to I-580. Take 580 West to Foothill Road/San Ramon Road Exit (the first exit). Go back over the freeway and proceed to the first light and turn right onto Dublin Canyon Road. The Marriott is on the corner of Foothill Road and Dublin Canyon Road. Approximately 45 minutes in good traffic.

FROM OAKLAND INTERNATIONAL AIRPORT:

Exit the airport and follow the signs to 1-880 South. Proceed to 238 eastbound, to I-580 East (towards Stockton)/ Proceed to Foothill Road exit (on the other side of the hill). At the first light turn right onto Dublin Canyon Road. The Marriott is on the other corner of Foothill Road and Dublin Canyon Road. Approximately 18 miles/ 20minutes.

***Please note: There are two other Foothill Exits, one in Oakland and one in Hayward which you do not want to take.**

Proposed amendment: Article 2

ALAMEDA HOSPITAL
MEDICAL STAFF RULES & REGULATIONS

TITLE:	EFFECTIVE DATE:
ARTICLE 2: ANESTHESIA SERVICE	6/1/97 06/12/01
	PAGE: 1 OF 1

A. **Medical Director**

. The Anesthesia Service in under the direction of the Medical Director of Anesthesia as appointed by the Medical Executive Committee and approved by the Board of Trustees with individual anesthesiologists functioning as independent contractors.

B. **Organization**

The Anesthesia Service is organized, directed and integrated with other related departments or services of the hospital.

C. **Administrative Responsibilities**

The Medical Director of Anesthesia shall have the administrative responsibility for anesthesia services. This will include assignment of surgical cases on an equitable basis among staff anesthesiologists. Requests by surgeons or patients for a specific anesthesiologist will be honored **whenever possible.**

D. **Policies and Procedures**

Anesthesia Policies and Procedures shall be reviewed by the Surgery/Gynecology Committee and approved by the Medical Executive Committee and the Board of Trustees. Copies of the Policies and Procedures are to be maintained in the Surgery Office.

E. **Administration of General Anesthesia**

~~All g~~ **G**eneral anesthesia shall be directly administered by an anesthesiologist **or by a qualified individual who has been granted privileges and is legally authorized to administer general anesthesia.**

F. Pre-Anesthesia Evaluation

A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services.

G. Post Anesthesia Evaluation

1. Requirement Defined

A post-anesthesia evaluation is required any time general, regional or monitored anesthesia has been administered to a patient. The American Society of Anesthesiology (ASA) guidelines do not define moderate or conscious sedation as anesthesia. Current practice dictates that a patient receiving conscious sedation must be monitored and evaluated before, during and after the procedure by trained practitioners, however, a postanesthesia evaluation is not required (71 FR 68691).

2. Responsibility Defined

A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

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TITLE:	EFFECTIVE DATE:
ARTICLE 16: MEDICAL RECORDS	06/12/01 05/24/05 05/31/06
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A. Medical Record Pertinence

The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and results accurately.

B. Patient Record Content

The format, forms, and abbreviations used in the medical record are approved by the appropriate Medical Staff Service Committees and the Medical Executive Committee.

1. Identification data and medical record number
2. Medical history of the patient
3. As appropriate, a summary of the patient's psychosocial needs.
4. Reports of relevant physical examination
5. Diagnostic and therapeutic orders; verbal orders must be countersigned within 48 hours.
6. Appropriate informed consents.
7. Clinical observations, including results of therapy (progress notes)
8. Reports of procedures, tests and their results
9. Conclusions at termination of hospitalization or evaluation/treatment.

C. History and Physical Exam

~~A history and physical examination including a plan of care is recorded by an attending physician within 24 hours of admission to inpatient services and prior to outpatient surgery.~~

A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

1. A durable, legible copy of a history and physical examination recorded in the physician's office within thirty (30) days prior to admission may be accepted. An interval medical history and physical examination must be performed and recorded at the time of admission~~/surgery~~, **but prior to surgery or a procedure requiring anesthesia services,** if the H&P was completed more

than 24 hours prior to admission or surgery. **The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.**

2. For readmissions within 30 days for the same or related problem, an interval history and physical examination, reflecting any subsequent changes is acceptable, provided the original information is readily available. **The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. In all cases involving surgery or a procedure requiring anesthesia services, the update must be completed and documented prior to the surgery or procedure./**