Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT

BOARD OF DIRECTORS

AGENDA

Monday, May 3, 2010 – 5:30 p.m.

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 and present to the District Clerk. This will ensure your opportunity to speak. Please make your comments clear and concise, limiting your remarks to no more than three (3) minutes.

I. Call to Order **(5:30 p.m. – 2 East Board Room)** Jordan Battani

II. Roll Call Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A.	Approval of Closed Session Minutes	
B.	Medical Executive Committee Report and Approval of Credentialing Recommendations	H & S Code Sec. 32155
C.	Board Quality Committee Report (BQC)	H & S Code Sec. 32155
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.	Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions	Gov't Code Sec. 54957.6
G.	Discussion of Report Involving Trade Secrets	H & S Code Sec. 32106
H.	Public Employee Performance Evaluation Title: Chief Executive Officer	Gov't Code Sec 54957

V. Reconvene to Public Session **(Expected to start at 7:30 p.m. – Dal Cielo Conference Room)**

A. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

A. Approval of April 12, 2010 Minutes **ACTION ITEM** [enclosure] (PAGES3-9)

B. Approval of April 16, 2010 Minutes **ACTION ITEM** [enclosure] (PAGE 10)

C. Acceptance of March 2010 Financial Statements **ACTION ITEM** [enclosure] (PAGES 11-29)

D. Approval of Administrative Policies and Procedures **ACTION ITEM** [enclosure] (PAGES 30-31)

E. Approval of Administrative Policy No. 83 - Community Care Guidelines and No. 83a - Self Pay or Uninsured Patient Cash Payment Discounts **ACTION ITEM** [enclosure] (PAGES 32-47)

VI. Regular Agenda

A. President's Report — Jordan Battani

1. Request to Move June 2010 District Board Meeting

B. Chief Executive Officer's Report — Deborah E. Stebbins

1. SB 1953 Project Cost Estimates [enclosure] (PAGES48-49)
2. Approval to Enter into Agreement for Project / Construction Management Services **ACTION ITEM** [enclosure] (PAGES50-55)
3. Monthly Statistics

C. Community Relations and Outreach Report

1. Committee Report – April 27, 2010 — Rob Bonta, Michael McCormick

D. Finance and Management Committee Report

1. Committee Report – April 28, 2010 — Jordan Battani
2. Capital Financing Update — David Neapolitan

E. Medical Staff President Report — Alka Sharma, MD

VIII. General Public Comments

IX. Board Comments

X. Adjournment

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

April 12, 2010

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD
J. Michael McCormick
Leah Williams

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

Medical Staff Present:
Jim Yeh, D.O.

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:
Alka Sharma, M.D.

Submitted by:
Jaclyn Yuson

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 6:12 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
3. Adjourn into Executive Closed Session	At 6:13 p.m. the meeting adjourned to Executive Closed Session.	

4. Reconvene to Public Session	**A. Announcements from Closed Session** Director Battani reconvened the meeting into public session at 8:22 p.m. The following closed session announcements were made. [1] Closed Session minutes –March 1, 2010, and March 16, 2010 [2] Medical Executive Committee Report and Approval of Credentialing Recommendations [3] The Board Quality Committee (BQC) Report – January 2010	[1] The Closed Session Minutes for March 1, 2010, and March 16, 2010 were approved. [2] The Medical Executive Committee Report and Credentialing Recommendations were approved as presented below. [3] The January 2010 BQC report was accepted as presented.

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period
○ Rolando Arroyo, MD	Anesthesiology	Courtesy	05/01/10 - 04/30/12
○ Darien Behraven, MD	Pain Management	Courtesy	05/01/10 - 04/30/12
○ Eric Dovichi. MD	Radiology	Courtesy	05/01/10 - 04/30/12
○ Hop Le, MD	Plastic Surgery	Courtesy	05/01/10 - 04/30/12
○ Charles Shih, MD	Otolaryngology	Courtesy	05/01/10 - 04/30/12
○ William Sellman, MD	Family Medicine	Active	05/01/10 - 04/30/12

Resignations

Name	Specialty
○ John Cummins, MD	Orthopedics
○ David Fisher, MD	General Surgery
○ Hester Lee, MD	Ophthalmology
○ Niceto Lopez, MD	Internal Medicine / Hospitalist
○ Karin Selbach, RNFA	RN First Assistant

○ Miranda Von Dornum, MD	Internal Medicine / Hospitalist	
○ Htay Win, MD	Internal Medicine / Hospitalist	
○ Kenneth Wong, DDS	Dental / Maxillofacial Surgery	
○ Karen Yokoo, MD	Plastic Surgery	

5. Consent Agenda	[A] Approval of March 1, 2010 [B] Approval of March 16, 2010 Minutes [C] Acceptance of February 2010 Financial Statements [D] Acceptance of the 2009 Environment of Care Annual Report [E] Approval of Administrative Policies and Procedures [F] Approval of Department Specific Policies and Procedures [G] Approval of Medical Staff 2010 Mission Statement for Continuing Medical Education Program [H] Approval of Amendments to Medical Staff Rules and Regulations	Director McCormick moved to approve the Consent Agenda items A-H as presented. Director Bonta seconded the motion. The motion carried unanimously with the exception to item [I] on the Consent Agenda.
	[I] Approval of Capital Expenditure for Acquisition of Kaiser Surgery Equipment Director Bonta pulled item [I] from the Consent Agenda for further discussion. Management recommended to the Board to approve the capital expenditure of $155,000 for surgery equipment purchased from Kaiser. The net cash impact of this expenditure will be $81,050 due to offsetting reimbursement from Kaiser for past purchases of surgical supplies. The fair market value of the equipment was assessed by an independent medical equipment appraisal firm who evaluated the surgical equipment and confirmed that new equipment would be more expensive considering the price management has negotiated with Kaiser.	Director Bonta moved to approve item [I] on the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried unanimously.

6. Regular Agenda

A. President's Report

No report at this time.

B. Chief Executive Officer's Report

1. Joint City Council / District Board Committee Discussion

Ms. Stebbins stated that on February 16, 2010 the Alameda City Council took an action recommending that the Hospital and City Council members set up a joint liaison committee in an effort to work together as budgets get tighter.

Director Battani mentioned it would be a good idea to apprise the City Council members with an update and a presentation at a City Council meeting entailing details of projects and initiatives underway at the Hospital.

City Council meetings are held bi-weekly. Director Williams proposed to management to ask the City Council for a standing quarterly update on their agenda from the Hospital. Management will look into making presentations at the City Council meetings quarterly as well as requesting for City Council to make quarterly presentations at the Hospital during District Board Meetings. A letter will be drafted to Mayor Beverley Johnson as a response to the request from City Council regarding the joint liaison committee.

2. General Statistics

Ms. Stebbins reported the key statistics for March 2010. Average Daily Census was under budget at 86.9 versus a budget of 93.6. ER Visits were over budget by 1.8%, 1,466 compared to a budget of 1,440. Inpatient Surgeries and Outpatient Surgeries were over budget by 10.3% and 11.4%, respectively.

Statistics	March (Prelim)	March Budget	February Actual
Average Daily Census	86.9	93.6	86.9
Acute	30.4	34.4	31.2
Subacute	34.0	34.2	34.0
South Shore	24.1	21.5	21.7
Patient Days	2,742	2,794	2,433
ER Visits	1,466	1,440	1,417

OP Registration	2,650	3,129	2,524
Total Surgeries	523	470	469

Ms. Stebbins provided an update to the Board regarding The Joint Commission's (TJC) recent survey of the Hospital. TJC arrived at the Hospital on Monday morning (4/12/2010) unannounced as they do triennially. PBX Operators followed protocol by checking TJC's website at 7:30 AM to see the schedule list of events for our facility. Operators promptly called key personnel as indicated on the hospital's phone tree system.

TJC observed personnel during tracer processes. Surveyors also reviewed the Environment of Care (EOC) program at the Hospital. TJC indicated documentation regarding EOC has improved as well as the fire alarm process. However, sliding door windows need to be tested on a regular basis to ensure optimal safety during a fire.

TJC made a recommendation (which will not be included in the report) that architectural plans for the Hospital buildings are outdated. They also recommended that management create a policy on "patient flow".

3. Seismic Planning Status Update

Mr. Easthope updated the Board on the status on the seismic planning process. Management has received estimates on construction work. The kitchen relocation project is estimated around $3.3 million. The bridge removal, structural bracing, foundation work is estimated to be a little over $1 million. The estimated completion time for this project will be about 9 months once started. Completion of this project will make the Hospital 2013 compliant.

Management will also be meeting with construction management firms this month.

C. Strategic Planning and Community Relations Report

1. <u>Committee Report – March 23, 2010</u>

Director Bonta reported that the committee met on March 23, 2010. The committee discussed and recommended inviting specific people to join the committee. The committee viewed the Hospital's website and navigated

through the sites' various features. The Hospital's "Snapshot" document was provided to the committee providing a brief overview of the history of the organization, financials, strategic pillars, and health care services. A presentation was given by Mr. Corica, Director of Physician Relations, demonstrating what committee members can present to local organizations about the Hospital.

Director Bonta announced to the Board that the Alameda Hospital Foundation and Frank Bette Center for the Arts will be hosting an event on April 17, 2010 at the Rock Wall Wine Company. This event will consist of an exhibit and sale of Plein Air Paintings as well as a silent auction.

D. Finance and Management Committee Report

1. Committee Report – March 31, 2010

Director Battani reported that the Finance and Management Committee met on March 31, 2010. The Hospital's financials are stable and reimbursement from HMO and PPO contracts for the month of February was the second highest reimbursement rate; first being Medicare.

Management is currently in the process of developing the FY 2011 Budget and preliminary volume assumptions will be presented at the next Finance and Management Committee meeting.

2. PACS Financing Update

Mr. Neapolitan updated the Board on PACS financing. US Bankcorp and Go West declined to extend financing options to the Hospital for PACS and digital radiology equipment. Management has been looking into other lenders, such as: GE, Bank of America, and Bank of Alameda. Management is actively assessing various financing options these lenders (i.e. operating lease vs. capital lease, shorter operating lease payments with higher monthly payments, etc.).

E. Medical Staff President's Report

Dr. Yeh reported that the medical staff made recommendations on the medical staff rules and regulations that were presented on the Consent Agenda.

7. General Public Comments	None at this time.	
8. Board Comments		
9. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:37 p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

Special Meeting
April 16, 2010

Directors Present:
Jordan Battani (by teleconference)
Robert Bonta (by teleconference)
Robert Deutsch, MD
J. Michael McCormick(by teleconference)
Leah D. Williams(by teleconference)

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

Medical Staff Present:

Legal Counsel Present:
Thomas Driscoll, Esq. (by teleconference)

Excused:
Alka Sharma, MD

Submitted by:
Kristen Thorson

Topic	Discussion	Action / Follow-Up
I. 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 3:08 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that all Directors were present.	
III. Adjourn into Executive Closed Session	At 3:09 p.m. the meeting adjourned to Executive Closed Session.	
IV. Reconvene to Public Session	A. Announcements from Closed Session	Jordan Battani reconvened the meeting into public session at 3:36 a.m. and reported that no action was taken during Closed Session.
V. Regular Agenda	A. General Public Comments - None at this time. B. Board Comments - None at this time. C. Adjournment	A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 3:37 p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING MARCH 31, 2010

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
MARCH 31, 2010

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
MARCH, 2010

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 March 31, 2010 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 March 31, 2010

- Gross patient revenue was less than budget by $564,000 or 2.1%. Inpatient revenue was less than budgeted by 3.3% and outpatient revenue was 0.4% less than budgeted. On an adjusted patient day basis gross patient revenue was 1.5% less than budgeted at $5,438 compared to a budgeted amount of $5,522.

- Total patient days were 2,742 compared to the prior month's total patient days of 2,433 and the prior year's 2,770 total patient days. The average daily acute care census was 30.4 compared to a budget of 34.4 and an actual average daily census of 31.2 in the prior month; the average daily Sub-Acute census was 34.0 versus a budget of 34.2 and 34.0 in the prior month and the Skilled Nursing program had an average daily census of 24.1 versus a budget of 21.5 and prior month census of 21.7, respectively.

- Emergency Care Center visits were 1,466 or 1.8% greater than the budgeted 1,440 visits and were less than the prior year's visits of 1,507.

- Total surgery cases were 11.3% greater than budget, with Kaiser surgical cases making up 70.2% of the 523 total cases in their final month of the contract. Alameda physician surgical cases were slightly higher that than the prior month at 156 cases versus 152 cases in February.

- Outpatient registrations were 15.3% below budgeted targets at 2,650 but were slightly better than the prior year's 2,609 registrations.

- Combined excess revenues over expense (profit) for March was $25,000 versus a budgeted excess of revenues over expenses (profit) of $29,000.

- Total assets decreased by $994,000 from the prior month as a result of a decrease in current assets of $963,000, an increase in net fixed assets of $75,000 and a decrease in restricted contributions of $107,000. The following items make up the increase in current assets:

  - Total unrestricted cash and cash equivalents for February decreased by $566,000. This decrease was primarily the result of the use of $1/12^{th}$ allocation of the annual parcel tax funds. Day's cash on hand decreased to 9.9 at March 31, 2010 from February's 12.8 days.

  - Net patient accounts receivable decreased in March by $308,000 compared to an increase of $374,000 in January. Despite an increase in collections of patient accounts of $809,000 over the prior month, day's in outstanding receivables increased to 53.7 as compared to 51.5 in February. The increase is the result of increased revenues generated over the last two months of the fiscal year that have not yet been collected and has resulted in total gross accounts receivable increasing to $44.1 million versus $42.5 million in the prior month. It is anticipated that this measure will improve over the last quarter of the fiscal year.

- Restricted contributions decreased by $107,000 in March as a result of the use of Jaber Funds for the reimbursement for the purchase of several pieces of medical equipment during fiscal year 2010.

- Total liabilities decreased by $1,031,000 compared to an decrease of $421,000 in the prior month. This decrease was the result of the following:

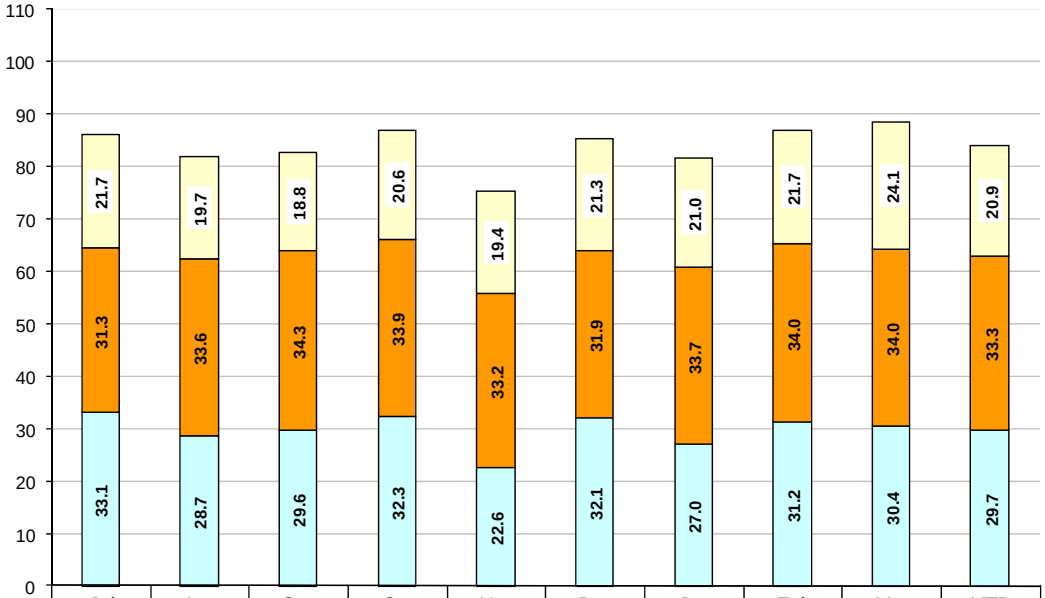
  - Accounts payable decreased by $6,000 from the prior month. As a result of this slight decrease offset by an increase in accrued payroll and benefits liabilities of $349,000 the average payment period increased in March to 64.4 from 62.5 as of February 28, 2010.

  - Payroll and benefit related accruals increased by $349,000 from the prior month. This increase was primarily the result of an increase payroll and related payroll tax accruals of $328,000, additional accruals for group health benefit accruals of $51,000 offset by reduced accruals for retirement plan contributions of $26,000.

  - Other liabilities decreased by $1,300,000 as a result of the amortization of the final month of the Kaiser contract prepayment ($800,000) and one month's deferred revenue related to the 2009/2010 parcel tax revenues ($477,000).

Volumes

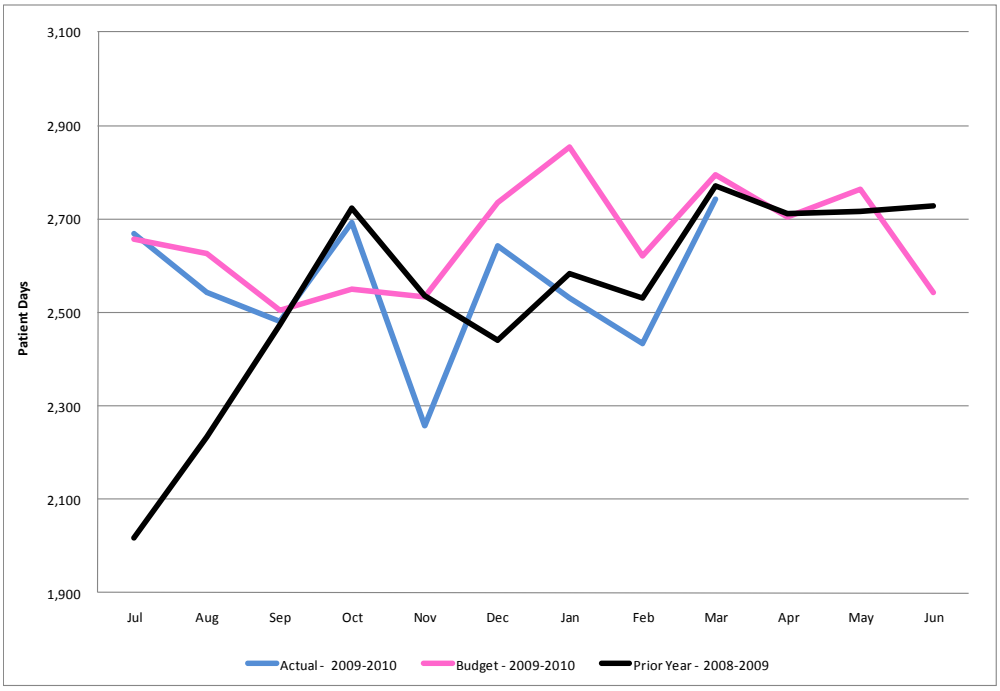
The combined actual daily census was 88.5 versus a budget of 90.1. March's lower than budgeted census was primarily a result of lower than budgeted census in the acute care program which was 11.8% lower than budgeted with an average daily census of 30.4 versus the budgeted 34.4. The Sub-Acute program was almost right on budget while the Skilled Nursing program was 12.0% better than budgeted with an average daily census of 24.1 versus a budgeted census of 21.5.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Actual SNF	21.7	19.7	18.8	20.6	19.4	21.3	21.0	21.7	24.1	20.9
Actual Sub-Acute	31.3	33.6	34.3	33.9	33.2	31.9	33.7	34.0	34.0	33.3
Actual Acute	33.1	28.7	29.6	32.3	22.6	32.1	27.0	31.2	30.4	29.7

Total patient days in March were 1.9% less than budgeted and were only 0.1% less than prior year volumes. The graph on the following page shows the total patient days by month for fiscal year 2010.

Total Patient Days

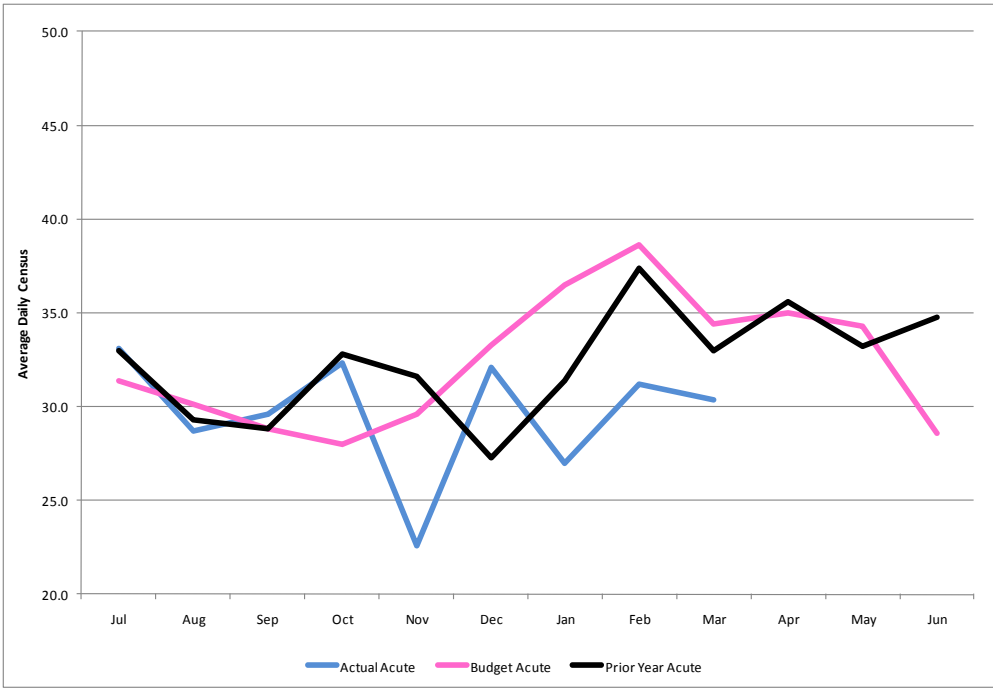


The various inpatient components of our volumes for the month of March are discussed in the following sections.

Acute Care

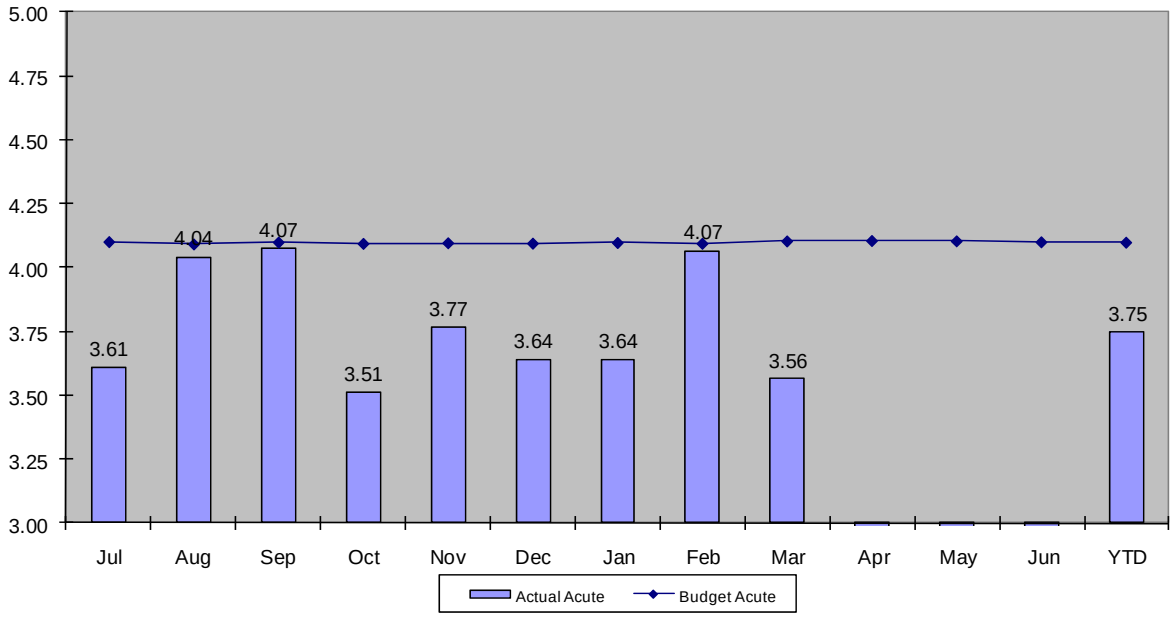
The acute care patient days were 11.8% (136 days) less than budgeted and were 8.0% less than the prior year's average daily census of 33.0. The acute care program was comprised of Critical Care Unit (4.6 ADC, 4.5% favorable to budget), Definitive Observation Unit (8.4 ADC, 33.1% unfavorable to budget) and Med/Surg Units (0.2 ADC, 0.1% unfavorable to budget).

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) decreased from that of the prior month at 3.56 days for the month of March. This brings the year-to-date ALOS to 3.75 which remains lower than our projected year to date ALOS of 4.10, and is shown in the graph below.

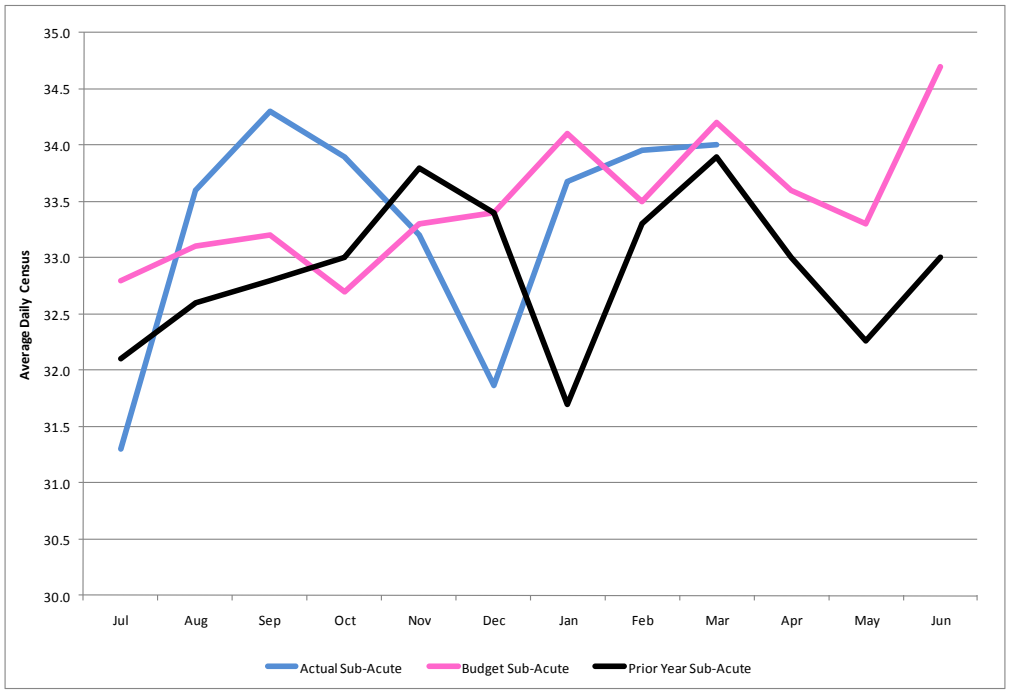
Average Length of Stay



Sub-Acute Care

The Sub-Acute program patient days were slightly less than budget by 0.6% or 6 patient days for the month of March. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

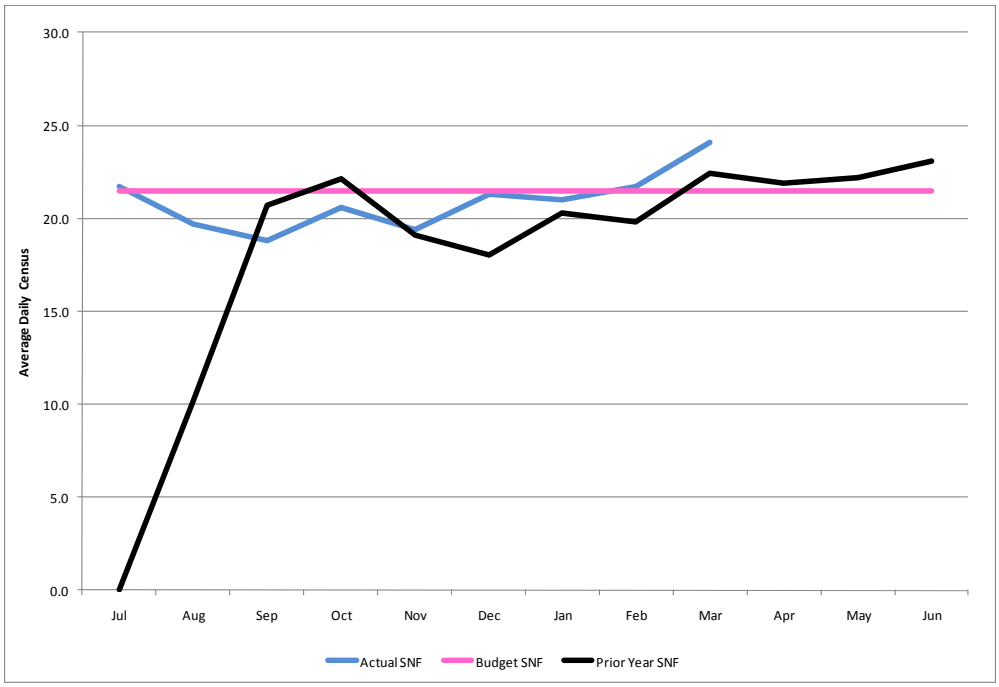
Sub-Acute Care Average Daily Census



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 12.0% or 80 patient days greater than budgeted for the month of March. Comparing performance to the prior year this program was better than March 2009 with an average daily census of 24.1 versus 22.4. The following graph show the Skilled Nursing Unit average daily census as compared to budget by month.

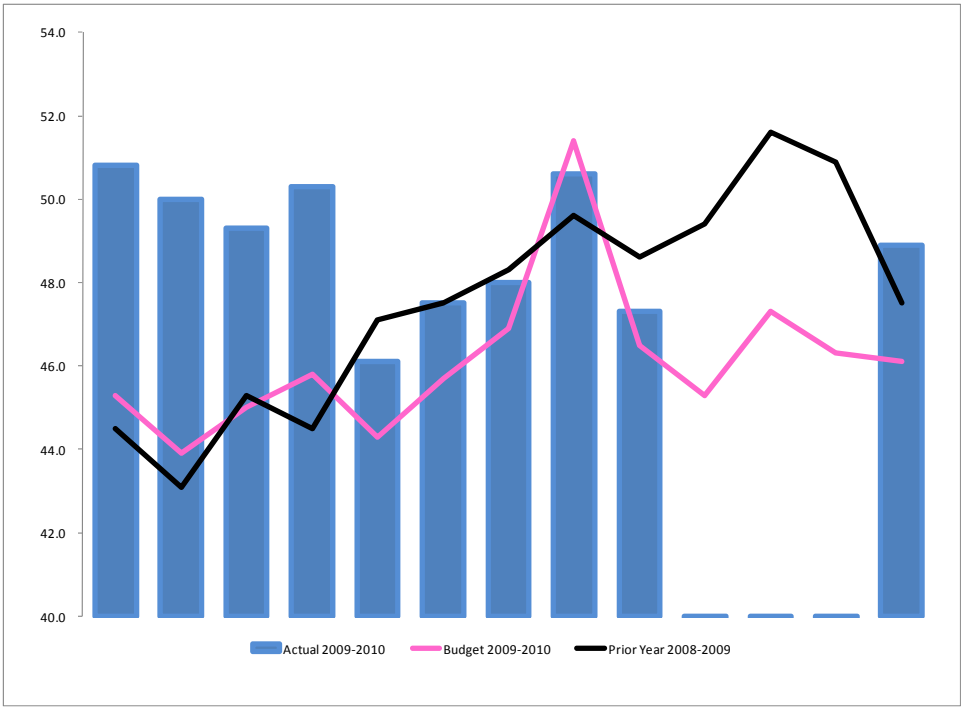
Skilled Nursing Unit Average Daily Census



Emergency Care Center

Emergency Care Center visits at 1,466 were 1.8% greater than budgeted for the month of March and 16.9% of these visits resulted in inpatient admissions versus 16.6% in February. In March there were 235 ambulance arrivals versus 210 in the month of February, an increase of 11.9% from the prior month. Of the 235 ambulance arrivals 191 or 81.3% were from Alameda Fire Department ambulances. The graph on the following page shows the Emergency Care Centers average visits per day for fiscal year 2010 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day



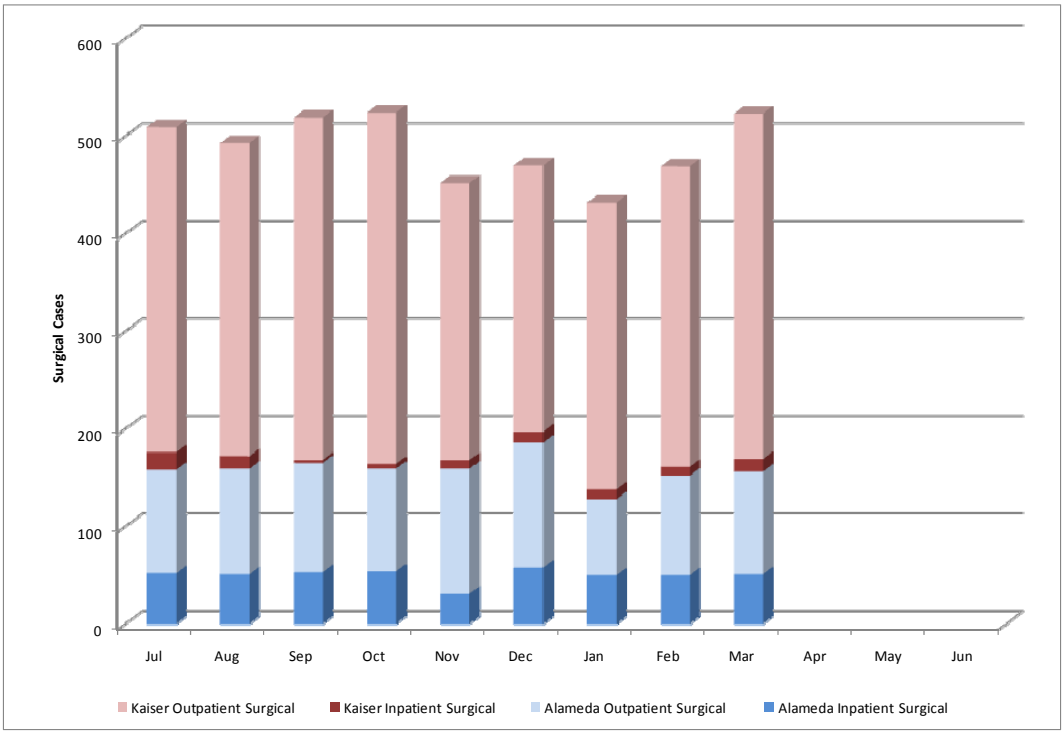
Surgery

Surgery cases were 523 versus the 470 budgeted and 517 in the prior year. In March, Alameda physician cases increased slightly to 156 cases or 2.6% greater than the prior month. The increase of 4 cases over the prior month was split evenly between inpatient and outpatient services. Inpatient and outpatient cases totaled 52 and 104 versus 50 and 102 in February, respectively.

On the inpatient side Orthopedic, General and Gynecology cases increased by five (5), four (4) and one (1) case respectively. These increases were offset by decreases in Vascular, Gastroenterology and Ophthalmology cases of four (4), three (3) and one (1), respectively. Outpatient cases increased in Ophthalmology (7), Gastroenterology (5), Gynecology (3) and Urology (3). These increases in outpatient cases were offset by decreases in General (6), Pain Management (4), Orthopedic and Podiatry (2 each) and Plastics and Pulmonary (1 each).

Kaiser related cases in March increased to 367 as compared to the 308 cases performed in February or 70.2% of the total surgical volume. As a result of this increase in Kaiser Same Day volume Kaiser Same Day, surgery revenue increased by $861,000 from February and resulted in an decrease in the Kaiser Same Day Surgery net revenue percentage to 18.4% from 23.0% in the prior month. The graph on the following page shows the number of surgical cases by month for fiscal year 2010.

Surgical Cases

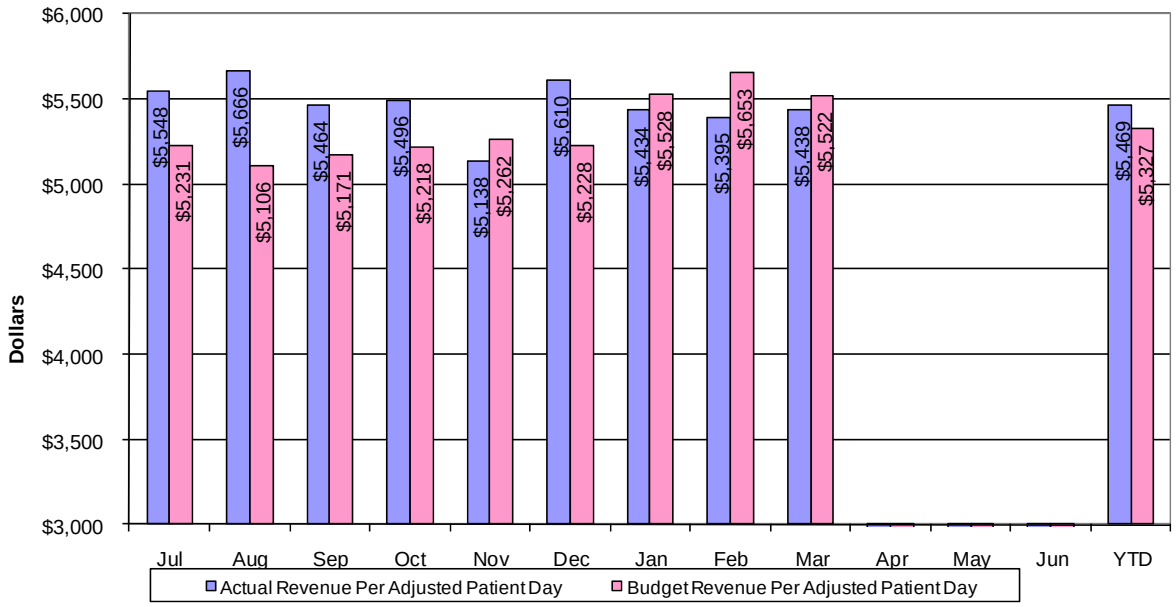


Income Statement

Gross Patient Charges

Gross patient charges in March were less than budgeted by $564,000. This unfavorable variance was comprised of unfavorable variances of $517,000 and $47,000 in inpatient and outpatient revenues respectively. On an adjusted patient day basis total patient revenue was $5,438 versus the budgeted $5,522 or a 1.5% unfavorable variance from budget for the month of March. On a year to date basis charges per adjusted patient day are 2.7% better than budgeted

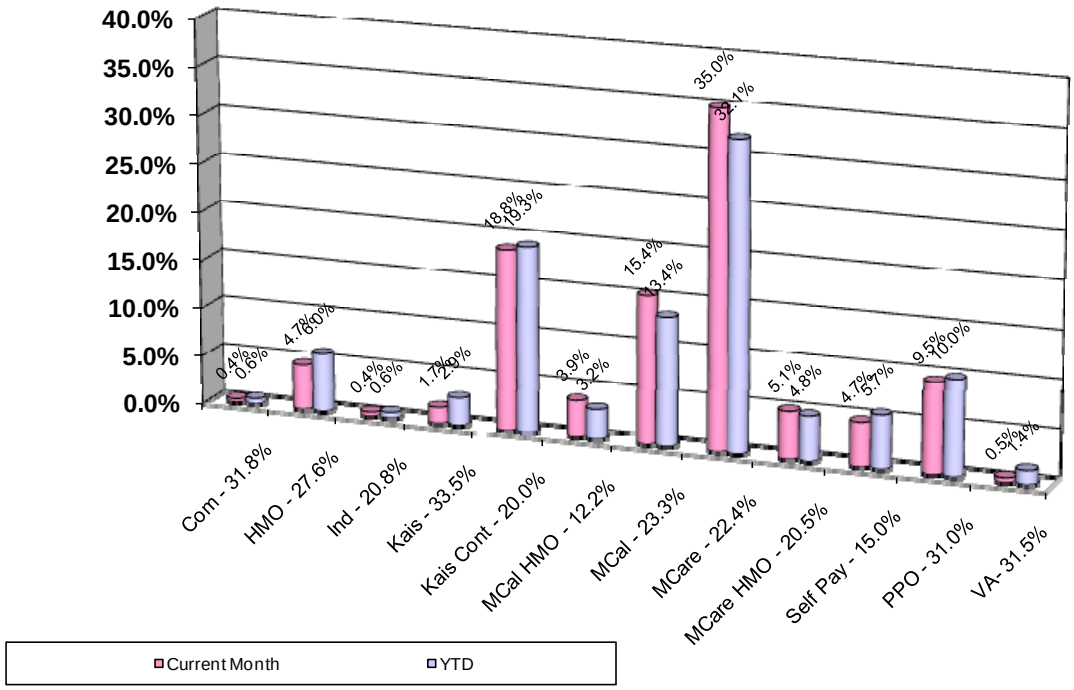
Gross Charges per Adjusted Patient Day



Payor Mix

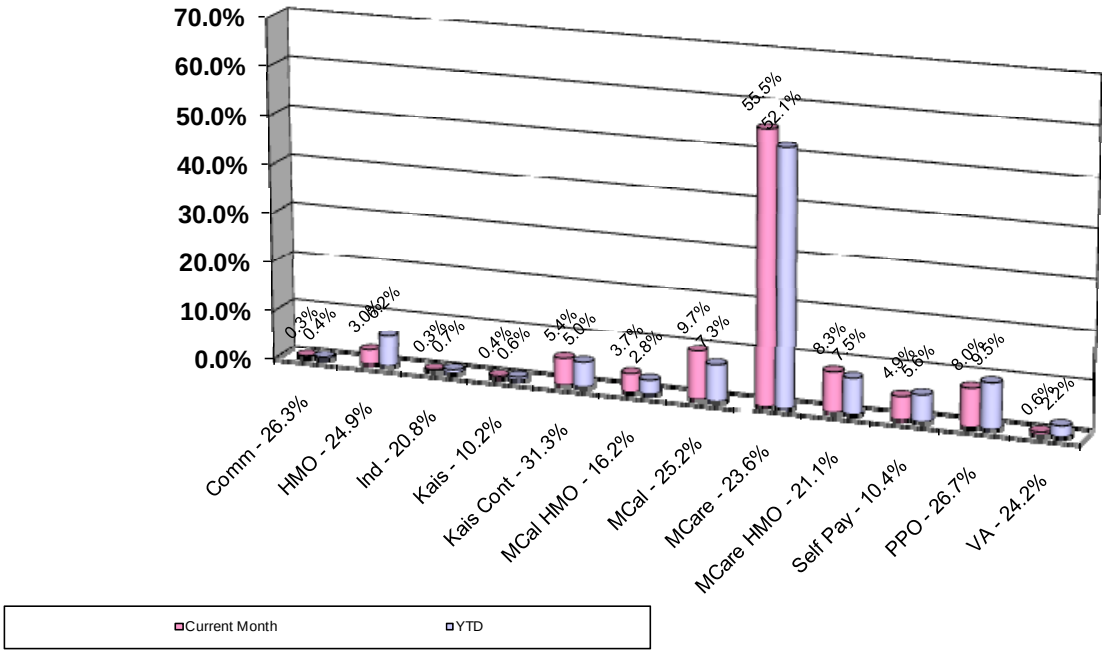
Medicare Traditional total gross revenue in March made up 35.0% our total gross patient. HMO/PPO utilization fell back into the fourth largest contributor of gross patient revenues in March at 14.1%. Kaiser retook second with patient revenues of 20.5% and Medi-Cal utilization was third at 15.4%. The graph below shows the percentage of revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor.

Combined Payor Mix



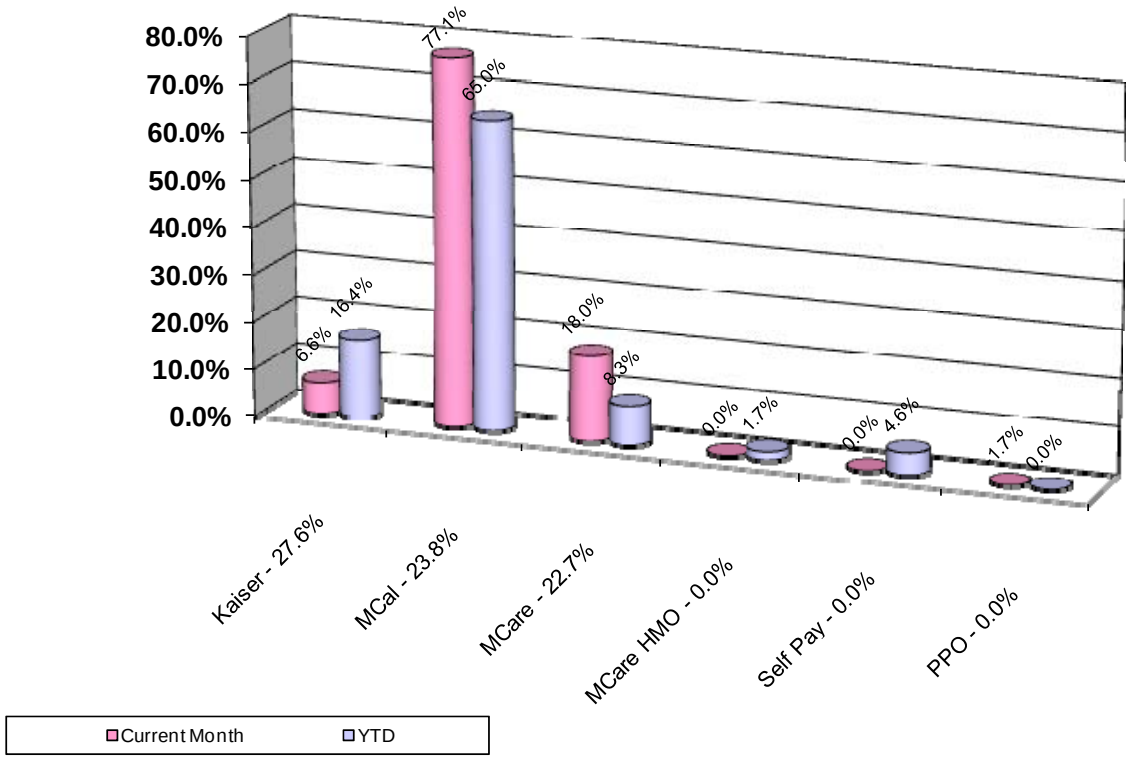
Current month gross Medicare charges made up 55.5% of our total inpatient acute care gross revenues followed by HMO/PPO at 11.0% and Medi-Cal at 9.7%. The hospitals overall Case Mix Index (CMI) decreased to 1.3156 from 1.3723 in the prior month. The Medicare CMI also decreased over the prior month from 1.4047 in February to 1.3679 in March. Despite, the decrease in the Medicare CMI there was one outlier case in the month. The result of these items was a decrease in overall Medicare reimbursement from February's estimate of 29.9% to 23.6% in March. The overall inpatient acute net patient revenue percentage decreased from the prior month as a result of the change in payor mix and lower acuity level of inpatients treated in March resulting in the overall estimated inpatient acute care reimbursement at 21.4% versus 4.1% in February. The graph on the following page shows the current month and year to date payor mix and current month estimated net revenue percentage for fiscal year 2010.

Inpatient Acute Care Payor Mix



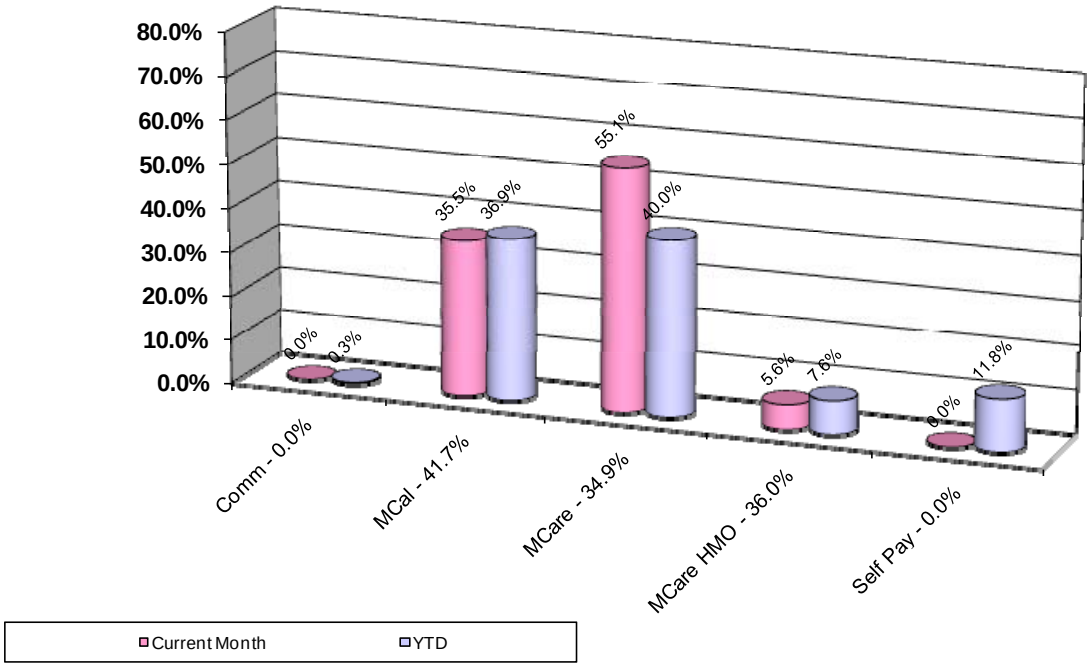
In March the Sub-Acute care program again was dominated by Medi-Cal utilization of 77.1% versus 77.3% in February. The following graph shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



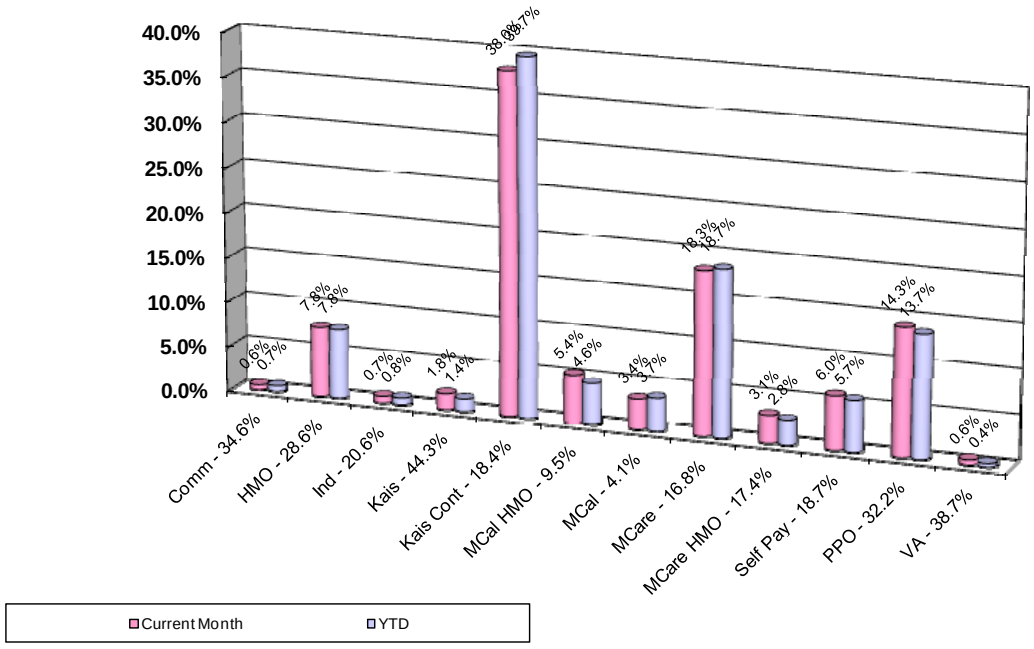
In March the Skilled Nursing program was again comprised of Medicare 55.1% and Medi-Cal 35.5%. The graph on the following page shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix



The outpatient gross revenue payor mix for March was comprised of 39.8% Kaiser, 18.3% Medicare, 14.3% PPO and 7.8% HMO. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix

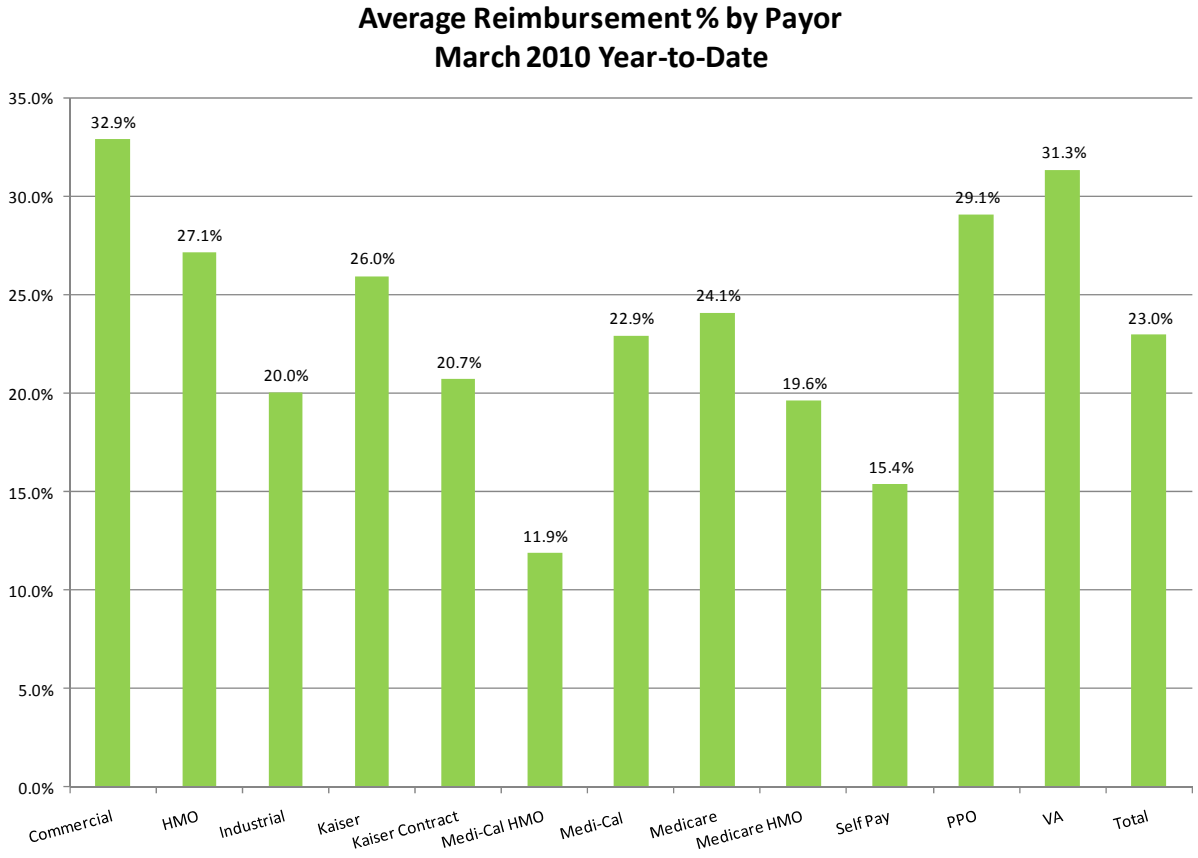


Deductions from Revenue

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 March contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 78.6% versus the budgeted 78.4%.

Net Patient Service Revenue

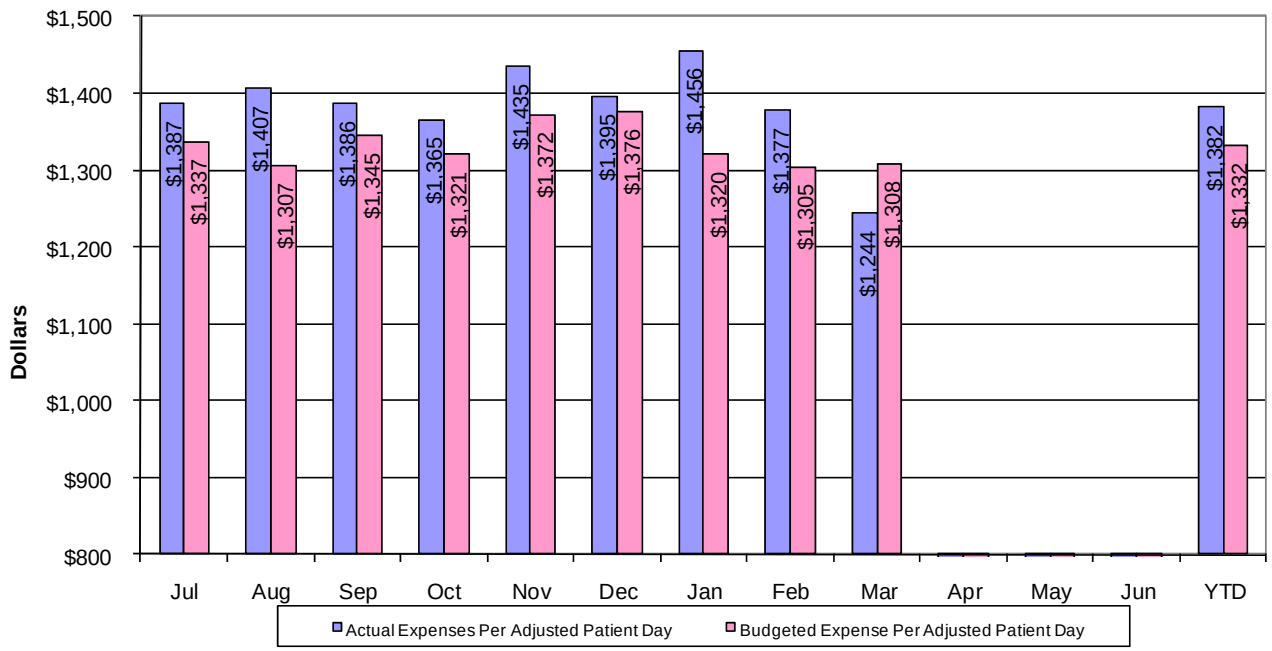
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph below shows the level of reimbursement that the Hospital has estimated for fiscal year 2010 by major payor category.



Total Operating Expenses

Total operating expenses were less than the fixed budget by $186,000 or 3.0%. On an adjusted patient day basis, our cost per adjusted patient day was $1,275 which was $31 per adjusted patient day favorable to budget. This variance in expenses per adjusted patient day was the result of favorable variances in virtually all expense categories. The graph on the following page shows the hospital operating expenses on an adjusted patient day basis for the 2010 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.

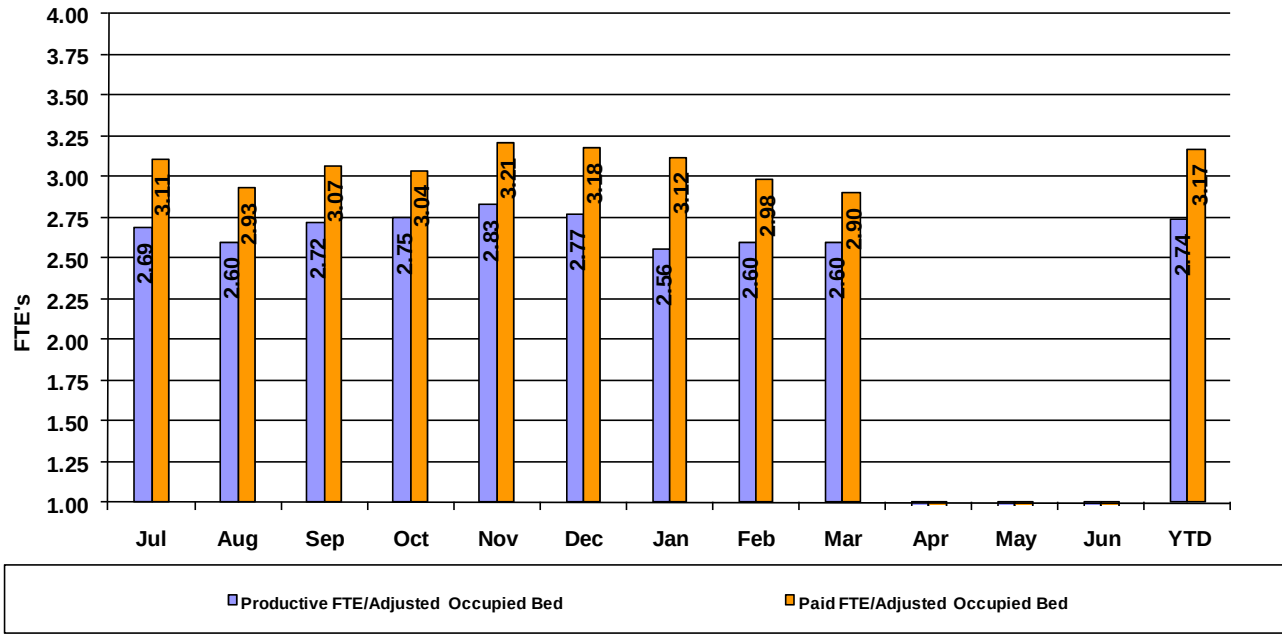
Expenses per Adjusted Patient Day



Salary and Registry Expenses

Salary and registry costs combined were favorable to the fixed budget by $26,000 and were slightly favorable to budgeted levels on a per adjusted patient day basis in March by $1. On an adjusted occupied bed basis, productive FTE's were 2.60 in March versus the budgeted 2.54. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2010 by month and year to date.

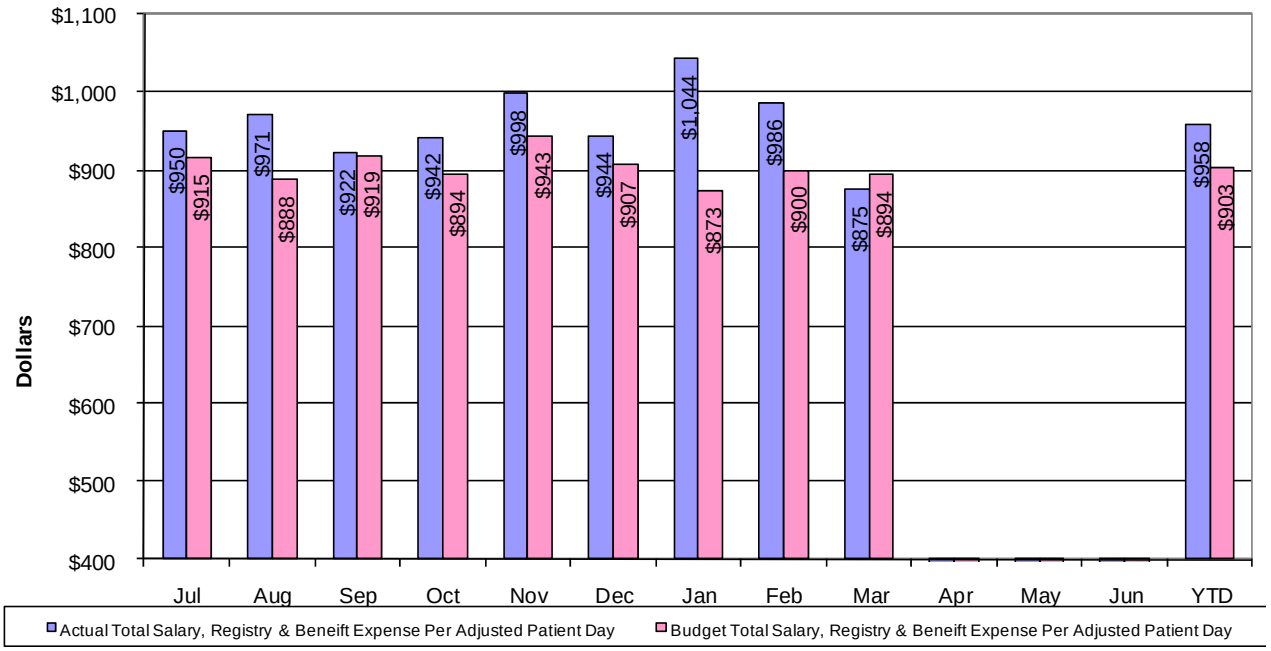
FTE's per Adjusted Occupied Bed



Benefits
Benefit costs were $25,000 favorable to the fixed budget and were $4 favorable to budget on an adjusted patient day basis in March. Benefit costs were favorable to the fixed budget as a result of the receipt of $37,000 in stop loss recoveries in the month of March.

The following graph shows the combined salary, registry and benefit costs on an adjusted patient basis for FY 2010 by month.

Salary, Registry and Benefit Cost per APD



Rents and Leases
Rents and lease expense as unfavorable to budget by $11,000 or $2 per adjusted patient day as a result of expenses for the rental of medical equipment.

Depreciation Expense
Depreciation expense was $55,000 or $11 per adjusted patient day favorable to budget as a result of five additional pieces of equipment ($25,000) becoming fully depreciated in addition to the equipment that became fully depreciated in June 2009. The majority of the new equipment was our CT Scanner which became fully depreciated in the current month.

Other Operating Expense
Other operating expenses were $41,000 or $8 per adjusted patient day favorable to budget as a result of favorable variances in travel and training ($12,000) and the other category ($29,000).

The following pages include the detailed financial statements for the nine months ended March 31, 2010.

ALAMEDA HOSPITAL
Balance Sheet
March 31, 2010

	March 31,2010	February 28,2010	Audited June 30, 2009
Assets			
Current assets:			
Cash and cash equivalents	$ 1,966,969	$ 2,533,067	$ 1,866,540
Net Accounts Receivable	9,652,474	9,960,616	10,069,536
Net Accounts Receivable %	21.87%	23.44%	22.15%
Inventories	1,300,143	1,300,332	1,291,072
Est.Third-party payer settlement receivable	277,830	344,386	351,648
Other assets	4,214,360	4,236,376	6,920,987
Total Current Assets	17,411,776	18,374,777	20,499,783
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	446,882	553,789	468,209
Total Non-Current Assets	446,882	553,789	468,209
Fixed Assets:			
Land	877,945	877,945	877,945
Depreciable capital assets, net of accumulated depreciation	5,828,826	5,753,338	6,029,967
Total fixed assets, net of accumulated depreciation	6,706,771	6,631,283	6,907,912
Total Assets	$ 24,565,429	$ 25,559,849	$ 27,875,904
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 423,305	$ 427,364	$ 436,733
Accounts payable and accrued expenses	6,444,343	6,450,623	6,244,967
Payroll and benefit related accruals	5,639,114	5,289,674	3,765,683
Est.Third-party payer settlement payable	193,412	193,412	306,588
Other liabilities	2,244,101	3,544,249	7,274,242
Total Current Liabilities	14,944,275	15,905,322	18,028,213
Long-Term Liabilities.			
Debt borrowings net of current maturities	1,377,979	1,448,404	1,733,631
Total Long-Term Liabilities	1,377,979	1,448,404	1,733,631
Total Liabilities	16,322,254	17,353,726	19,761,844
Net Assets			
Unrestricted Funds	7,726,293	7,585,659	7,615,851
Restricted Funds	516,882	620,464	498,209
Net Assets	8,243,175	8,206,123	8,114,060
Total Liabilities and Net Assets	$ 24,565,429	$ 25,559,849	$ 27,875,904

City of Alameda Health Care District

Statements of Operations

March 31, 2010

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 14,911	$ 15,428	$ (517)	-3.3%	$ 15,031	$ 125,814	$ 127,223	$ (1,409)	-1.1%	$ 117,915
Gross Outpatient Revenues	11,161	11,208	(47)	-0.4%	11,298	94,219	93,051	1,169	1.3%	88,831
Total Gross Revenues	26,072	26,636	(564)	-2.1%	26,329	220,033	220,273	(241)	-0.1%	206,746
Contractual Deductions	19,931	20,287	356	1.8%	20,102	163,950	165,268	1,317	0.8%	153,690
Bad Debts	461	508	46	9.2%	686	4,820	4,136	(684)	-16.5%	5,583
Charity and Other Adjustments	103	98	(4)	-4.4%	24	527	800	273	34.1%	816
Net Patient Revenues	5,577	5,743	(166)	-2.9%	5,516	50,736	50,070	666	1.3%	46,657
Net Patient Revenue %	21.4%	21.6%			21.0%	23.1%	22.7%			22.6%
Net Clinic Revenue	14	64	(51)	-78.7%	-	95	514	(419)	-81.6%	-
Other Operating Revenue	49	15	34	226.9%	12	420	136	284	209.2%	136
Total Revenues	**5,640**	**5,822**	**(182)**	-3.1%	**5,529**	**51,251**	**50,720**	**531**	1.0%	**46,793**
Expenses										
Salaries	3,163	3,213	50	1.6%	2,999	28,505	28,074	(431)	-1.5%	25,848
Registry	203	179	(24)	-13.1%	296	1,551	1,540	(11)	-0.7%	1,978
Benefits	895	920	25	2.7%	870	8,526	8,086	(440)	-5.4%	7,369
Professional Fees	332	349	16	4.7%	296	2,687	3,082	395	12.8%	2,707
Supplies	802	816	14	1.7%	779	7,687	7,025	(662)	-9.4%	6,747
Purchased Services	399	405	6	1.5%	325	3,483	3,550	67	1.9%	3,017
Rents and Leases	82	71	(11)	-15.1%	69	618	632	13	2.1%	546
Utilities and Telephone	65	79	14	17.7%	68	637	701	64	9.1%	641
Insurance	47	46	(1)	-1.8%	75	400	408	9	2.2%	413
Depreciation and amortization	79	134	55	41.1%	115	895	1,176	280	23.8%	1,086
Other Opertaing Expenses	47	88	41	46.7%	70	730	775	44	5.7%	675
Total Expenses	**6,114**	**6,300**	**186**	3.0%	**5,961**	**55,719**	**55,048**	**(670)**	-1.2%	**51,026**
Operating gain (loss)	**(474)**	**(478)**	**4**	0.8%	**(432)**	**(4,468)**	**(4,328)**	**(139)**	3.2%	**(4,233)**
Non-Operating Income / (Expense)										
Net Non-Operating Income / (Expense)	**499**	**507**	**(7)**	**-1.5%**	**495**	**4,463**	**4,562**	**(99)**	**-2.2%**	**4,425**
Excess of Revenues Over Expenses	**$ 25**	**$ 29**	**$ (4)**	**-12.2%**	**$ 62**	**$ (5)**	**$ 233**	**$ (238)**	**-102.1%**	**$ 192**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

March 31, 2010

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,110	$ 3,198	$ (88)	-2.8%	$ 3,098	$ 3,129	$ 3,077	$ 51	1.7%	$ 3,015
Gross Outpatient Revenues	2,328	2,324	4	0.2%	2,329	2,343	2,251	92	4.1%	2,272
Total Gross Revenues	5,438	5,522	(84)	-1.5%	5,426	5,472	5,328	144	2.7%	5,287
Contractual Deductions	4,157	4,206	48	1.2%	4,143	4,077	3,998	(80)	-2.0%	3,930
Bad Debts	96	105	9	8.6%	141	120	100	(20)	-19.8%	143
Charity and Other Adjustments	21	20	(1)	-5.0%	5	13	19	6	32.3%	21
Net Patient Revenues	1,163	1,191	(27)	-2.3%	1,137	1,262	1,211	51	4.2%	1,193
Net Patient Revenue %	21.4%	21.6%			21.0%	23.1%	22.7%			22.6%
Net Clinic Revenue	3	13	(10)	-78.6%	-	2	12	(10)	-81.1%	-
Other Operating Revenue	10	3	7	228.9%	3	10	3	7	217.9%	3
Total Revenues	**1,176**	**1,207**	**(31)**	-2.5%	**1,139**	**1,275**	**1,227**	**48**	3.9%	**1,197**
Expenses										
Salaries	660	666	6	1.0%	618	709	679	(30)	-4.4%	661
Registry	42	37	(5)	-13.8%	61	39	37	(1)	-3.5%	51
Benefits	187	191	4	2.1%	179	212	196	(16)	-8.4%	188
Professional Fees	69	72	3	4.1%	61	67	75	8	10.4%	69
Supplies	167	169	2	1.1%	161	191	170	(21)	-12.5%	173
Purchased Services	83	84	1	0.9%	67	87	86	(1)	-0.9%	77
Rents and Leases	17	15	(2)	-15.8%	14	15	15	(0)	-0.6%	14
Utilities and Telephone	14	16	3	17.2%	14	16	17	1	6.6%	16
Insurance	10	10	(0)	-2.5%	15	10	10	(0)	-0.6%	11
Depreciation and Amortization	16	28	11	40.7%	24	22	28	6	21.7%	28
Other Operating Expenses	10	18	8	46.4%	14	18	19	1	3.1%	17
Total Expenses	**1,275**	**1,306**	**31**	2.4%	**1,229**	**1,386**	**1,332**	**(54)**	-4.1%	**1,305**
Operating Gain / (Loss)	**(99)**	**(99)**	**0**	0.2%	**(89)**	**(111)**	**(104)**	**(6)**	6.1%	**(108)**
Net Non-Operating Income / (Expense)	**104**	**105**	**(1)**	**-0.9%**	**102**	**111**	**110**	**1**	**0.6%**	**113**
Excess of Revenues Over Expenses	**$ 5**	**$ 6**	**$ (1)**	-11.7%	**$ 13**	**$ 0**	**$ 6**	**$ (6)**	-98.1%	**$ 5**

ALAMEDA HOSPITAL
KEY STATISTICS
MARCH 2010

	ACTUAL MARCH 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	MARCH 2009	YTD MARCH 2010	YTD FIXED BUDGET	VARIANCE	%	YTD MARCH 2009
Discharges:										
Total Acute	264	260	4	1.5%	225	2,169	2,157	12	0.6%	2,085
Total Sub-Acute	-	4	(4)	-100.0%	1	11	33	(22)	-66.7%	28
Total Skilled Nursing	9	13	(4)	-30.8%	8	96	116	(20)	-17.2%	89
	273	277	(4)	-1.4%	234	2,276	2,306	(30)	-1.3%	2,202
Patient Days:										
Total Acute	941	1,067	(126)	-11.8%	1,023	8,127	8,838	(711)	-8.0%	8,646
Total Sub-Acute	1,054	1,060	(6)	-0.6%	1,052	9,127	9,145	(18)	-0.2%	9,030
Total Skilled Nursing	747	667	80	12.0%	695	5,738	5,894	(156)	-2.6%	4,628
	2,742	2,794	(52)	-1.9%	2,770	22,992	23,877	(885)	-3.7%	22,304
Average Length of Stay										
Total Acute	3.56	4.10	(0.54)	-13.1%	4.55	3.75	4.10	(0.35)	-8.6%	4.15
Average Daily Census										
Total Acute	30.35	34.42	(4.06)	-11.8%	33.00	29.66	32.26	(2.59)	-8.0%	31.55
Total Sub-Acute	34.00	34.19	(0.19)	-0.6%	33.94	33.31	33.38	(0.07)	-0.2%	32.96
Total Skilled Nursing	24.10	21.52	2.58	12.0%	22.42	20.94	21.51	(0.57)	-2.6%	22.42
	88.45	90.13	(1.68)	-1.9%	90.43	83.91	87.14	(2.66)	-3.1%	89.35
Emergency Room Visits	1,466	1,440	26	1.8%	1,507	13,390	12,615	775	6.1%	12,728
Outpatient Registrations	2,650	3,129	(479)	-15.3%	2,609	23,078	23,557	(479)	-2.0%	22,349
Surgery Cases:										
Inpatient	64	58	6	10.3%	55	541	503	38	7.6%	502
Outpatient	459	412	47	11.4%	462	3,838	3,580	258	7.2%	3,812
	523	470	53	11.3%	517	4,379	4,083	296	7.2%	4,314
Kaiser Inpatient Cases	13	11	2	-	11	91	79	12	-	81
Kaiser Eye Cases	194	160	34	21.3%	177	1,461	1,355	106	7.8%	1,435
Kaiser Outpatient Cases	160	168	(8)	-4.8%	171	1,417	1,336	81	6.1%	1,419
Total Kaiser Cases	367	339	28	8.3%	359	2,969	2,770	199	7.2%	2,935
% Kaiser Cases	70.2%	72.1%			69.4%	67.8%	67.8%			68.0%
Adjusted Occupied Bed	154.55	155.61	1.06	0.7%	153.51	146.79	150.86	(4.07)	-2.7%	142.36
Productive FTE	401.84	395.28	(6.56)	-1.7%	400.16	393.41	386.99	(6.42)	-1.7%	373.24
Total FTE	449.52	444.84	(4.68)	-1.1%	445.71	449.12	445.25	(3.87)	-0.9%	424.85
Productive FTE/Adj. Occ. Bed	2.60	2.54	(0.06)	-2.4%	2.61	2.68	2.57	(0.11)	-4.5%	2.62
Total FTE/ Adj. Occ. Bed	2.91	2.86	(0.05)	-1.7%	2.90	3.06	2.95	(0.11)	-3.7%	2.98

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 3, 2010

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Approval of Administrative Policies and Procedures

The following Administrative Policies and Procedures have been updated to reflect current practices, regulatory language and information. Policies and Procedures will be brought to the Board of Directors quarterly for approval. Management requests approval of the Administrative Policies and Procedures listed below.

Policy #	Policy Title & Purpose Statement
No. 22	Language For Employees • To state the language standard for all communication between and among all Hospital Employees
No. 23	Employee Referral Program • Recruiting and hiring of qualified employees is essential to maintain a viable work force at Alameda Hospital. The Employee Referral Program will help fulfill organizational recruitment and employment goals and give employees an opportunity to become involved in the recruitment process by recognizing and rewarding their efforts.
No. 50	Licensing and Primary Sourcing • Appropriate validation of licensure, certification or other credentials as required by regulatory bodies including Federal and State laws and accrediting agencies
No. 57	Interdisciplinary Rounds • To provide a forum for communicating the patients individual needs with an interdisciplinary perspective. To coordinate in hospital care with post hospital care or home care with early identification of needs prior to discharge.
No. 63	Reporting Violence Against Hospital Personnel • Under Health and Safety Code 1257.7(d) acts of or battery against on-duty hospital personnel are subject to reporting requirements: a. Required Reports; Authorized Reports: ➢ <u>Required Reports:</u> Any act of assault or battery against any on-duty hospital personnel that results in injury or invokes the use of a firearm or

Policy #	Policy Title & Purpose Statement

other dangerous weapon must be reported to the local law enforcement agency.

- Authorized Reports: Any other act of assault or battery against on-duty hospital personnel may be reported to the local law enforcement agency.

No. 80 Employee Retiree Recognition

- To consistently recognize dedicated, tenured employees who are retiring from the workplace or leaving Alameda Hospital.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 3, 2010

TO: City of Alameda Health Care District, Board of Directors

FROM: David A. Neapolitan

SUBJECT: Approval of Administrative Policy No. 83 - Community Care Guidelines and No. 83a - Self Pay or Uninsured Patient Cash Payment Discounts

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Recommendation:

Management is recommending that the Board of Directors approve the revised Community Care Guidelines, formerly Charity Care and Self Pay or Uninsured Patient Cash Payment Discounts Policies which are attached.

Background:

California Assembly Bill (AB) 774 became effective January 1, 2007. The law mandates that as a condition of obtaining or holding an acute care hospital license, Hospitals must limit bills to the uninsured with family incomes at or below 350% of the Federal Poverty Level (FPL) and individuals with high cost medical bills compared to their family income. Bills are limited to what a hospital would receive from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program in which it participates, whichever is greater, for comparable health services.

The bill further requires that hospitals are to submit a copy of its charity care policy, discount payment policy, eligibility procedures for these policies, review process and its application forms for the charity care and/or discount payment programs at lease biennially, or when a significant change is made to any required documentation. The definition of a "significant change" is any change that may be considered significant from a patient's perspective. For example, many hospital fair pricing policies contain the dollar amounts of family income used to determine eligibility for charity care and/or payment discounts. Most dollar amounts are based upon the federal poverty level (FPL) guidelines established by the U.S. Department of Health and Human Services, which are updated each year. Thus, a change in the FPL guidelines would constitute a significant change to the policies and require the submission of revised documents.

Discussion:

Alameda Hospital has offered charity care for generations and continues to make great strides in improving the health and well-being of the residents of the City of Alameda. The Alameda Hospital Community Care Program is applicable to any patient that does not have coverage from a third-party insurer and who completes the Community Care Application Form.

As required by AB 774 we have updated our Community Care Guidelines to insure compliance with the requirements of this law which became effective January 1, 2007 and were last updated in March 2008. Over the past three years Alameda Hospital has provided over $2.8 million in charity care services to patients treated in our inpatient and outpatient programs.

The primary basis for the determination of a patients eligibility is the Federal Poverty Table which defines the income levels based on family size used to determine whether or not a person or family qualify for various federal and state benefit programs. The 2009 Federal Poverty table below is in effect until at least May 31, 2010 as approved by the United States Congress.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family	**Poverty guideline**
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

As required by AB 774, we are required to limit expected reimbursement from patients whose annual income is equal to or less than 350% of these guidelines. As an example, a family of four (4) would qualify for Alameda Hospital Community Care if the families annual income was less than or equal to $77,175. The amount that we attempt to collect from patients that meet the Community Care Guidelines cannot be an amount greater than what our best governmental payor, which includes; Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program.

In establishing the percentages used to determine a patients' eligibility for 100% Community Care coverage, we reviewed the policies of other health care organizations in the Bay area coupled with Alameda Hospital's ability to subsidize the cost of care to those patients that meet the income levels established in AB 774. These levels ranged from 100% to 250% of the FPL for 100% of the patients charges to be written off as charity care. Based upon Alameda Hospital's financial condition we set the rate for 100% coverage at 100% of the FPL. However, for partial coverage, reductions to the best governmental rate, we have set our policy to reduce expected payment to those requesting Community Care benefits to any person / family whose annual income ranges from 101% to 350% of the FPL. Other Bay area provider's discounts to their best governmental reimbursement rates take effect when a patient / family annual income ranges from 200% to 250% of the FPL.

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY No. 83

TITLE: ~~Charity~~ Community Care Guidelines

PURPOSE: California Assembly Bill 774 became effective January 1, 2007. The law mandates that as a condition of obtaining or holding an acute care hospital license, Hospitals must limit bills to the uninsured with family incomes at or below 350% of the Federal Poverty Level (FPL) and individuals with high cost medical bills compared to their family income. Bills are limited to what a hospital would receive from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program in which it participates, whichever is greater, for comparable health services.

SCOPE: Administration, Finance, Business Services and Admissions, Emergency Department

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A. Procedure – Financially Qualified Patient:

1. "Financially Qualified Patient" means a patient who is both of the following:

    a. A patient who is a self-pay patient,
    b. A patient who has a family income that does not exceed 350 percent of the federal poverty level.

2. Who is a Self-Pay Patient?

    a. "Self-Pay Patient" means a patient who **does not have** third-party coverage from a health insurer, health care service plan, Medicare, Medi-Cal or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.
    ~~b. Self-Pay Patients may include charity care patients.~~

3. Who is a High Cost Medical Patient?

    a. "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level and who does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

        1. Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.
        2. Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

4. Eligibility for financial assistance under the Alameda Hospital "Community Care Program" will be considered for all patients who meet the above criteria. The granting of financial assistance shall be based on an individualized determination of financial need and shall not take into account age, gender, race, socio-economic or immigrant status, sexual orientation, or religious affiliation. Factors for determining financial need may include but are not limited to family size, assets, scope and extent of a patient's medical bills, and employment status~~, ability to pay~~.

5. For purposes of this determination, monetary assets **shall not** include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans.

6. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility.

7. Alameda Hospital recognizes that there may be unusual or extenuating circumstances which may exceed the specific criteria as established in this policy and warrant special consideration. In such cases, a description of the unusual circumstances should be forwarded by Hospital staff to the Patient Financial Services Director, Revenue Cycle Director, or Chief Financial Officer or designee who will make the determination as to the amount, if any, of charitable or financial assistance allowance to be granted.

8. Alameda Hospital recognizes that the financial status of patients may change over time. Hospital Financial Counselors or other designated personnel will actively assist families in securing eligibility for any medical financial assistance from County, State, Federal or other program with the cooperation of patients and their families.

9. The Patient Financial Services Director or designee will review all applications to determine eligibility for the ~~Charity~~Community Care Program. Reasonable efforts will be made to verify financial data. All financial information provided will be considered confidential and staff will respect each circumstance with dignity.

10. The Patient Financial Services Director or designee will use the following table to determine the amount of ~~Charity~~Community Care allowed excluding deductibles, co-pays, share of cost, or elective procedures. This schedule will be maintained and updated annually by the Patient Financial Services Director or designee.

Federal Poverty Level~~l~~	**~~Charity~~Community Care Allowance [write off]**
a. Below 100%	100% write off
b. 101% to ~~185~~350%	Discount charges down to Medicare rates.~~90%~~
~~c. 186% to 250%~~	~~Discount charges down to Medicare rate~~80%
~~d. 251% to 350%~~	~~Discount charges down to Medicare rate~~70%

~~e.~~c. 351% +	See Self Pay or Uninsured Patient Cash Payment Discounts – Policy No. 83 A.

11. Any other type of discount not adhering to the above schedule is not considered a ~~Charity~~Community Care discount and will follow the terms and conditions set forth in the Discount Policy.

12. In all cases Alameda Hospital will not collect more than the ~~average~~ reimbursement ~~of its government payors which includes but is not limited to~~allowable under Medicare guidelines~~, Medi-cal, and Healthy Family Programs~~.

13. Patient guarantors must complete a ~~Financial Hardship (Charity~~Community Care Program~~)~~ Application within 10 (ten) days of hospital discharge. The hospital will have 10 days to determine the ~~charity~~Community ~~care~~Care discount level available to the patient guarantor. The patient portion may be paid in full or the Hospital can arrange for a payment plan that is agreeable by both parties.

14. In the absence of a completed ~~Charity~~Community Care Program ~~a~~Application the hospital will follow the regular collection steps and accounts may be assigned to a third party billing agency at full billed charges. The third party billing agency may charge interest on the balance assigned by the hospital to the agency.~~.~~

    a. Written notification of the determination of eligibility or non-eligibility for ~~charity~~Community Care Program ~~/~~financial assistance will be forwarded to the applicant by the Financial Counselor within 10 days of receipt of the ~~Financial Hardship Charity~~Community Care Program Application.
    b. Patients or guarantors have the right to appeal a non-eligible decision within 10 days of the denial letter. Appeals will be forwarded to either ~~of~~ the Patient Financial Services Director, Revenue Cycle Director or the CFO who will jointly decide to uphold or overturn the original decision within 10 days.

B. Procedure – ~~Charity~~Community Care Program Qualifications & Calculations

1. Financial obligations not eligible for consideration for ~~charity~~Community Care Program are co-pays, deductibles, indemnity balances, Medi-Cal share of cost, and balances due from ~~those whose injury is not a compensable injury for the purposes of~~ workers' compensation or auto insurance coverage's.
2. Not all services are eligible for ~~financial assistance~~the Community Care Program,~~.~~ such as elective cosmetic procedures or services denied by available funding sources as not medically necessary are not eligible. Special consideration may be made by the Patient Financial Services Director~~s~~, their designee, Chief Financial Officer, or Chief Executive Officer.

3. A patient may qualify for the ~~charity~~Community Care Program or financial assistance prior to admission, after admission, after discharge, or during the course of the financial assistance process. Every attempt will be made to identify all available funding sources prior to or at time of visit. If a funding source cannot be identified after full compliance by the patient or guarantor, an allowance or discount may be provided.

4. A ~~Financial Hardship and Charity~~Community Care Program Application, provided by Alameda Hospital staff, ~~must~~ may be completed with the assistance of a Financial Counselor or by completing, signing and returning it to an Alameda Hospital Financial Counselor. This document must be completed within 10 calendar days from date of discharge.

5. The ~~Financial Hardship and Charity~~Community Care Program Application shall remain valid for services rendered within a 180 day period if the Financial Counselor determines that the patient or Guarantors income will not change during this time period.

6. The financial assessment will include a review of the family's gross income, number of family members, employment status, outstanding balances of ~~the~~ medical bills, and assets when appropriate. A credit report may also be required. Copies of prior year tax return (preferred documentation), W-2 Forms, most current pay stubs, or other proof of income are required. Other documents proving status of assets may be required as needed.

7. ~~Charity~~Community Care ~~and Financial assistance~~Program information is available from Alameda Hospital through various means, including the publication of notices in patient bills and by posting notices in high volume areas such as the Emergency Department, Clinics, Admitting, Patient Financial Services and other places as Alameda Hospital may determine. Such information shall be provided in English and Spanish, and will be translated for patients/guarantors who speak other languages.

8. Any patient account recommended for partial or total ~~charity~~Community Care Program, allowance, after meeting the guidelines set forth in this policy, requires the following signature approval process to be followed:

a.	Up to $1,999	Supervisor or Lead
b.	$2,000 - $24,999	PFS Director
c.	$25,000 - $49,999	Revenue Cycle Director
d.	$50,000 or greater	CEO/Associate Administrator /CFO

9. Alameda Hospital will assign any financial obligation to a debt collector after 60 calendar days of non-payment of an established payment plan or 90 calendar days of non-payment on an account where the patient guarantor is not in process with an eligibility application for a government sponsored insurance program or is not attempting in good faith to settle an outstanding bill.

10. Interest or finance charges will not be added to any account that has been approved for the ~~Charity~~Community Care Program.

11. In the course of debt collection involving low-income uninsured patients who are at or below 350% of the Federal Poverty Level, Alameda Hospital will follow all guidelines established by AB 774. This provision will not preclude Alameda Hospital from pursuing reimbursement from third party liability settlements.

12. All documentation will be maintained by Financial Counselors in accordance with regulatory guidelines.

13. This policy does not apply to professional services provided to Hospital patients by physicians or other medical providers including but not limited to Radiology, Anesthesiology, Pathology or Emergency Room services.

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY No. 83 A

TITLE: Self Pay or Uninsured Patient Cash Payment Discounts

PURPOSE: To encourage prompt payment, a cash discount shall be offered to patients with no insurance who are self pay that do not qualify or choose not to ~~for~~apply for ~~Charity~~Community Care Program discounts. The following guidelines are established.

SCOPE: Administration, Finance, Business Services and Admissions, Emergency Department

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1. Self pay, Prompt Payment Discount Structure ~~for Ancillary Services~~:

~~a. Alameda Hospital ancillary services charges may be discounted up to 30~~35% ~~if paid prior to services are being rendered or within 30 days from the date of service.~~

~~b. The 30% discount may be extended when one half of the estimated charges are paid prior to service and the balance is paid within 30 days from the date of discharge.~~

~~c. Hospital charges may be discounted up to 20% if payment is made within 31 to 60 days from the discharge date **or 15**~~**25% if paid by credit card**~~.~~

~~d. Hospital charges may be discounted up to 15% if payment is made within 61 to 90 days from the discharge date **or 10**~~**15% if paid by credit card**~~.~~

~~e.~~a. There will be no discounts on payments made ~~over the~~after 90 days from the date of discharge, unless prior arrangements were made and approved by the CEO, CFO, Director of Revenue Cycle, Business Office Manager or their designee~~, or unusual circumstance prevented the patient or the guarantor or other responsible party from paying within the designated times.~~.

~~f.~~b. No discount will be given when setting up a payment plan unless financial hardship is determined by ~~the~~ hospital staff.

~~g.~~c. No discount will be given if an account was assigned to an outside collection agency. The patient may be responsible for any collection costs and interest charged by the collection agency. This rule may be waived and the ~~charity~~Community Care ~~policy~~ Program may be applied if financial hardship is determined by the hospital or by the collection agency.

~~h.~~d. Discounts are offered only if the balance due is $300 or greater.

~~i.~~e. The hospital CEO, CFO, Director of Revenue Cycle, Business Office Manager or their designee may authorize other discount(s) on a case-by-case basis or as business necessitates or when the ~~Charity~~Community Care Program policy applies.

~~j.~~f. Patients that have been approved for discounts ~~may~~will not be eligible for a cash discount ~~if the bank did not honor their private check (NSF)~~ if their payment is returned by the bank for non sufficient funds. The patient ~~may~~ will be responsible for all charges for returned checks.

~~2. Self pay prompt discount for Outpatient Surgery and In-Patient services:~~

The following guidelines will be used to discount Self Pay and Prompt Pay accounts~~Alameda Hospital out-patient surgery and in-patient services may be discounted based on guidelines established below~~:

a.

~~**Total Charges** **Discount Amount**~~

~~$1 – $10,000 30~~40~~%~~

~~$10,001 - $30,000 40~~50~~%~~

~~$30,001 - $60,000 50~~55~~%~~

~~$60,001 - $100,000 60~~60~~%~~

~~$100,001 + to be determined on a case by case basis~~.

NON ~~CHARITY~~COMMUNITY CARE - SELF PAY PROMPT PAY DISCOUNT TABLE - POLICY # 83A				
Days from Discharge	**Balance ~~$1~~300 – $10,000e**	**Balance $10,001 – $30,000**	**Balance $30,001 – $60,000**	**Balance $60,001 – $100,000**
~~Discharge~~	**~~$1 - $10,000~~**	**~~$10,001 - $30,000~~**	**~~$30,001 - $60,000~~**	**~~$60,001 - $100,000~~**
30 days	40% Discount	50% Discount	55% Discount	60% Discount
31-60 days	30% Discount	30% Discount	30% Discount	30% Discount
61-90 days	20% Discount	20% Discount	20% Discount	20% Discount
91+ days	No Discount	No Discount	No Discount	No Discount

~~a.~~b. The discount amount on account balances over $100,000 will be determined on a case by case basis by the CEO, CFO or their designee.

~~b.~~c. As an alternative to discounts stated above, the hospital may choose to apply one of the hospital's most favorable insurance contract rates~~. –~~.

d. If the above discounted rate is below the Medicare reimbursement, the Medicare reimbursement and not the discount will apply.

~~The discount applied to individuals with incomes over 350% of Federal Poverty level should not be below the Medicare reimbursement rate.~~

e. Elective out-patient surgical procedures with no implants will require a minimum of 25% deposit of estimated gross charges prior to the scheduling of these procedures.

f. Elective out-patient surgical procedures with implant(s) will require ~~the~~a minimum deposit of 25% of estimated gross charges plus 100% of the actual cost of the implant(s).

~~3.~~2. Payment Plan Arrangements

a. The hospital may allow payment plan arrangements on an as needed basis based on patient circumstances, income, outstanding balance, past payment history with the hospital and other factors including the hospital's ~~Charity~~Community Care Program.

b. When payment plan arrangements are made the patient or guarantor may be asked to sign a contract and or a promissory note that states the terms of the payment arrangements.

c. The CEO, CFO or their designees may chose to outsource accounts with payment plan arrangements over a 12 month period to an agency that will monitor these accounts. Such accounts may incur interest at a rate of 10%.

d. The hospital may choose to sell or to assign such payment plan arrangements to a third party for monitoring and collections as needed.

~~4.~~3. Other Considerations

a. Due to various applicable laws, compliance procedures and insurance contracts, routine waivers of insurance co-payments or deductibles ~~may~~ will not be allowed unless financial hardship or ~~Charity~~Community Care Program eligibility is determined. This rule applies to all payor sources.

b. On any balances outstanding after insurance payments have been applied, no further discount will be offered as this balance is part of an already discounted rate.

c. Patients on long term payment plans who may become able to pay their balances in full may be extended a discount. The discount amount will be determined at that time based on account balance and other applicable conditions.

d. The above guidelines are applicable to those with an ability to pay. Those with demonstrated hardship shall be ~~referred~~ evaluated for ~~Charity~~Community Care Program discounts in accordance with Policy No. 83.

e. Questions concerning any aspect of this policy/guideline should be referred to Administration or their designee.

f. This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Approval / Review Path	Management Team, Administration, District Board

City of Alameda Health Care District Policy No. 83 & 83a		
Action:	***Date:***	**By:**
Created	10/03	Finance
Reviewed/ Revised	**10/04, 09/06, 3/08, 04/10**	Management Team
Approvals	N/A	MEC
	10/04, 09/06, 3/08, 04/10	Administration
	10/04, 09/06, 3/08, 05/10	District Board

ALAMEDA HOSPITAL

Application for Community Care Program

Alameda Hospital encourages you to apply for the Alameda Hospital sponsored, Community Care Program. The Community Care Program is for individuals and families that meet the programs qualifications for low income and / or need help paying for your hospital bill for inpatient or outpatient care. If you qualify, the Community Care Program may offer reduced-price care and or a monthly payment program according to your income and ability to pay. If you have questions or need help completing this application, please call (510) 814-4645.

To apply for the Community Care Program, please complete the application on the following pages and return it along with all necessary supporting documentation to:

Alameda Hospital - Community Care Program Application
2070 Clinton Avenue
Alameda, CA 94501

Alameda Hospital
Community Care Program Application

Please Print

Personal Information

Patient's Name: _____SS#: _____Date Birth: _____

If patient is a minor or a dependent, print name, date of birth and relationship of parent or other responsible party.

Name: _____Date of Birth: _____

SS#: _____Relationship: _____

Mailing Address: _____

Telephone Number: Home ( ) _____Cell No: ( ) _____Work ( ) _____

Name of employer: _____Telephone: _____

Number of individuals residing in household: _____

Name _____ Age_____ Relationship_____

Name _____ Age_____ Relationship_____

Name _____ Age_____ Relationship _____

If additional space is needed please use back of page.

Health Insurance or Car Insurance information

Medical Insurance? Yes _____ No_____ If "yes,"

Print name of insurance company: _____ID Number: _____

Other Coverage? Yes ____ No ____ if yes, please identify other coverage: _____

Is the medical treatment because of a car accident or other third party injury? Yes ____No_____

Name of Car Insurance Provider: _____Policy Number: _____

Is the medical treatment because of an on-the-job injury or accident? Yes _____ No _____

If yes, Name the employer and place of where the injury took place: _____

_____

_____

Income: Applications without supporting documentation will be denied.
Be sure to **include** with your application documents that support the income amounts you list below.
For example:

- Pay stubs from all employment for the last two (2) months
- Last year's income tax return (including schedule C if self employed)
- Letters approving or denying Medicaid, medical assistance, other benefits
- Letters approving or denying unemployment compensation
- Written statements from employers or welfare agents.
- Students receiving financial aid, copy of award letter
- Copy of last two (2) months of Bank Statements.

	Person 1	**Person 2**	**Person 3**
Monthly Wages/Salary (before tax)	_____	_____	_____
Unemployment	_____	_____	_____
Social Security Pension	_____	_____	_____
SSI	_____	_____	_____
Food Stamps	_____	_____	_____
Alimony /Child Support	_____	_____	_____
Other (stocks, bonds, IRA's, etc.)	_____	_____	_____

Monthly Expenses:
Rent Payment: _____ Taxes and Insurance: _____
Tax Value: _____ Insurance (health, life, home, car): _____
Mortgage _____Car Payment: _____
Make and Model of vehicle: _____
Food: _____ Utilities: _____
Medication: _____ Phone: _____
Other: _____ Other: _____

Does your household have a checking account? Y N If yes name of bank: _____
Does your household have a savings account? Y N If yes name of bank: _____
Balance in checking: _____Balance in savings: _____

Has your family had any seasonal or temporary increases or decreases in income? _____

Or, do you expect your income to change in the next three months? Yes ____ No ____
If yes, please describe:

_____

_____

_____

_____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?

Yes ____ No _____ if yes, please explain: _____

_____

_____

_____

Do the documents that you are including with this application show your current financial situation correctly? Yes _____ No ____ if no, why not?

_____

_____

_____

If you are asking for Community Care for services already provided by Alameda Hospital, please list dates of services and what services you received:

Patient name	Account Number	Date of Service	Balance
1-			
2-			
3-			
4-			
5-			

Other Information you would like to give us: _____

_____

I understand that the information I am giving will be verified by Alameda Hospital and or may be reviewed by state and/or federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____Date _____

Mail this application with all supporting documentation to:

Alameda Hospital - Community Care Program Application
2070 Clinton Avenue
Alameda, CA 94501

This section is not mailed to the patient

ALAMEDA HOSPITAL BUSINESS OFFICE USE ONLY

ELIGIBILITY DETERMINATION WORKSHEET

Patient Account Number _____

Date Application Received: _____Income Verified? Yes ____ No ____

Current Federal Poverty Guidelines for family of _____ is $_____ per month.

The patient's gross family income is at or below 100% of the current federal poverty level: Y__N__

The patient's gross family income is at or below 350% of the current federal poverty level: Y__N__

Decision: [ ] A-100% Community Care Discount. **[ ] B-** Patient is to pay Medicare allowable amount.

Medicare Discount Calculations:

1-Alameda Hospital Charges: $_____

2- Medicare Allowable (Attach details) $_____

3- Discount provided as Community Care: (3=1 – 2) $_____

OTHER CALCULATIONS:

Beginning balance of patient's account $_____

Less medical coverage/amount payable by third party sources $_____

Less Community Care Discount $_____

Patient responsibility **$_____**

Expected payment in full: $_____

Monthly Payments: $_____

The applicant's request for Community care has been denied for the following reason(s):

[ ] The application is incomplete. [ ] No supporting documentation. [ ] Income can not be verified.

[ ] Over the income and property level. [ ] Loss of contact. [ ] Account in bad debt agency.

Other: _____

_____

Date of determination: _____Date applicant notified: _____

Prepared by: _____ Date: _____

Reviewed by: _____ Date: _____

Approved by: _____Date:_____

Revised 3/26/2010

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 3, 2010

TO: City of Alameda Health Care District, Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: SB 1953 Project Cost Estimates as of April 2010

The following update on the status of our seismic planning process is provided for information only.

The following fee proposals have been approved as indicated in the March 16, 2010 Board Meeting.

Fugro Liquefaction Study	$71,000	authorized & complete
Ratcliff – Phase I Kitchen Design	$75,000	authorized & complete
Thornton Tomasetti NPC & SPC	$369,265	authorized & near complete
Ratcliff – Kitchen project	$575,750	authorized & in process
Total A&E Fees to date:	**$1,091,105**	

May 3, 2010 Board Meeting Recommendation

Construction mgmt – Phase I	**$150,000**

The following are initial construction cost estimates **only** for the scope of work outlined in the structural and kitchen relocation plans. New construction cost estimates will be obtained when the kitchen construction drawings are 75% complete.

Note: There are a number of exclusions from these cost estimates, such as building permits, construction insurance, unforeseen obstructions, moving expenses, plan checks, legal, accounting and finance fees, hazardous materials abatement, loose FF&E, rework of roof water drainage construction management fees etc. In addition, there are several unknown variables at this stage of the project that may change based upon OSHPD review and acceptance of the plans *(alternative means method)*.

Seismic Work, Faithful Gould	$1,110,708
Addtl contingency (Fugro)	$ 50,000
Kitchen Relocation, Davis Langdon	$3,325,000
Addtl scope (ER offices)	$ 200,000
Total	**$4,685,708**

The following are additional known items that will be forthcoming and/or further developed with the assistance of a construction management firm that are associated with this project.

This information is only for disclosure purposes of other items that will need to be considered and budgeted for once more specific information is available.

Fairly Certain Items:

• Ratcliff – Prime roll on entire SB1953 project	$30,000
• Ratcliff – reimbursable expenses (allowance)	$10,000
• Construction mgmt – Phase II	$225,000

Not as Certain Items:

• Permits, OSHPD Fees, Easements, Utility	$100,000
• NPC Construction Work	$500,000
• Relocation of existing services, temporary housing, staging etc	$300,000
• Business disruption of existing services during construction	$250,000
• Decommission (B occ.) & remodel of 1925 building	$1.5 million
• Other unknown components (contingency)	$250,000
Subtotal	**$3,165,000**

Project Rough Estimate as of April 2010	**$9.1 million**

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 3, 2010

TO: City of Alameda Health Care District, Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval to Enter into an Agreement for Project Management / Construction Management Services

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Recommendation:

Management is recommending that the City of Alameda Health Care District Board of Directors authorize the Chief Executive Officer to enter into a contract with a qualified project /construction management firm for an amount not to exceed $150,000. The scope of work and time period covered by this recommendation is discussed in more detail in this memorandum, but in summary would cover project management services from May 2010 through the public bidding and actual selection of a contractor and subcontractors, which is anticipated to occur as early as January - February 2011. A subsequent proposal and scope of work will be forthcoming to engage a project/construction management firm to assist with project oversight once the construction actually begins.

Background:

The City of Alameda Health Care District has engaged the services of architects, engineers and other professional consultants to advance the planning and development of construction design plans that will need to be submitted to the Office of Statewide Health Planning and Development (OSHPD) in order to comply with the January 2013 seismic retrofit requirements as required under SB 1953. The District is moving this process forward as soon as possible to comply with the new progress timelines allowed for under SB499, which went into effect in February 2010. Under SB499 building plans need to be submitted to OSHPD by June 30, 2010.

The District's seismic retrofit project, although relatively small in terms of dollars and scope of work, it is complex and will affect departments and services in many areas of the Hospital. Careful planning, coordination, scheduling and oversight of this process are essential and will require professional expertise.

Discussion:

As the seismic planning process moves forward and has become more refined, it has become apparent that we have a need for professional project/construction management assistance. Hospital Administration does not have the resources, skill or expertise to properly manage this project from this point forward. Recognizing this, we have discussed this project with the following project/construction management firms:

- Jtec HCM
- Nova Partners
- Cambridge CM
- Pound Management
- Western Medical Properties

These firms vary in size, complexity and experience with acute hospital OSHPD projects.

During our meetings with these firms, we have presented them with background on the District and our current operations. We have also brought them up to date on where we are at with this project and what we are looking for in a project/construction management services. (Attached are the three documents presented as a discussion guideline with each firm.)

Most firms understood our needs, anticipated our concerns and were able to provide additional commentary on the expertise and experience that they could bring to the table to help ensure a successful project. They commented that the "Construction Management Needs" document, although not all inclusive was very well thought through and demonstrated an understanding of what service we need from a project management firm.

We expect to have proposals from all interested firms by May 5th and will have a follow up meeting with the two firms that are competitive with their cost estimates, are comprehensive and thoughtful in their proposal documentation and that have the best professional (experience & skill compliment) and cultural match for this project.

The scope of this initial request for proposal is from May 1, 2010 through the bid process and selection of a general contractor and/or subcontractors. The general scope of services to be provided are primarily to serve as "Owners Representative" in working with architects, engineers, OSHPD and contractors. We will look to the selected firm to basically manage most aspects of this project: including master planning and pre construction activities, plan review, A&E proposal review, preparation of a complete project budget and timeline (Gantt Chart), sign off on invoices, answering and coordinating technical questions that need to be addressed through the planning and plan review process, and assistance with the project bid process. We have requested that proposals be submitted on a time and materials basis with a not to exceed amount. In the proposals received to date, they have included the individuals that will be assigned to this project with their estimation on the amount of time that will be required at each stage and/or month of this project. However the proposals do provide for latitude in the amount of assistance that we need.

A subsequent second proposal would provide for construction management once the work begins and would take us through final sign off and occupancy of the renovated space and decommission of the 1925 building.

This project is moving forward very rapidly and professional project management experience is greatly needed at this time. Please let me know if I can provide additional information.

Construction Management Needs

1. To review Architect & Engineering work proposals for completeness, accuracy, reasonableness.
    a. Are there important items or that have been omitted, or not adequately addressed and need additional attention.

2. To review project timelines for reasonable. Assist owner in working with A&E firms to address concerns.
    a. Because there are two projects being submitted, prepare a Master project schedule that incorporates both project, plus pre-construction service relocation activities that need to occur.
    b. Identify any issues with project schedule and work with owner to prepare a work plan to address these issues.
    c. Assist owner with work plan for space reconfigurations and relocations.
        i. Work schedule, cost estimates, etc.

3. To review project cost estimates (Budget) for reasonableness and completeness.
    a. Identify other project costs that the owner needs to take into account and budget for as part of this project.

4. Constructively participate in planning meetings for both the seismic & kitchen projects.

5. Review all related project documents (e.g. schematic design plans, OSHPD submittals, work schedules, quotes, etc). Advise the owner of any identified issues and work on behalf of the owner, as requested, to interact with the A&E firms to resolve concerns.

6. Work with the owner to help ensure a thorough implementation plan to help ensure a successful, timely & on budget project.

7. Assist the owner & Architect in preparing bid documents.
    a. Contractor pre-qualification criteria & documents.
    b. Bid packet documents (actual RFP)
    c. Review of bidder submittals
    d. Assist owner in selecting a general contractor for the projects.

8. A firm with experience in California seismic upgrade (retrofit of existing structure) projects for acute care hospitals.

9. Anything else that we should be considering up to the Actual construction Management phase?

Alameda Hospital
Seismic Scope of Work
April 2010

NPC Work $500,000

Seismic $1.1 Million

Bridge Removal
Foundation – liquefaction mitigation
Sheer Wall reinforcement

Kitchen & Cafeteria $3.4 Million
Relocate kitchen and cafeteria from 1925 building to Stephen's Wing.

1925 Building OSHPD decommission to City Building Occupancy. Cost ?

A&E Fees $1.2 Million

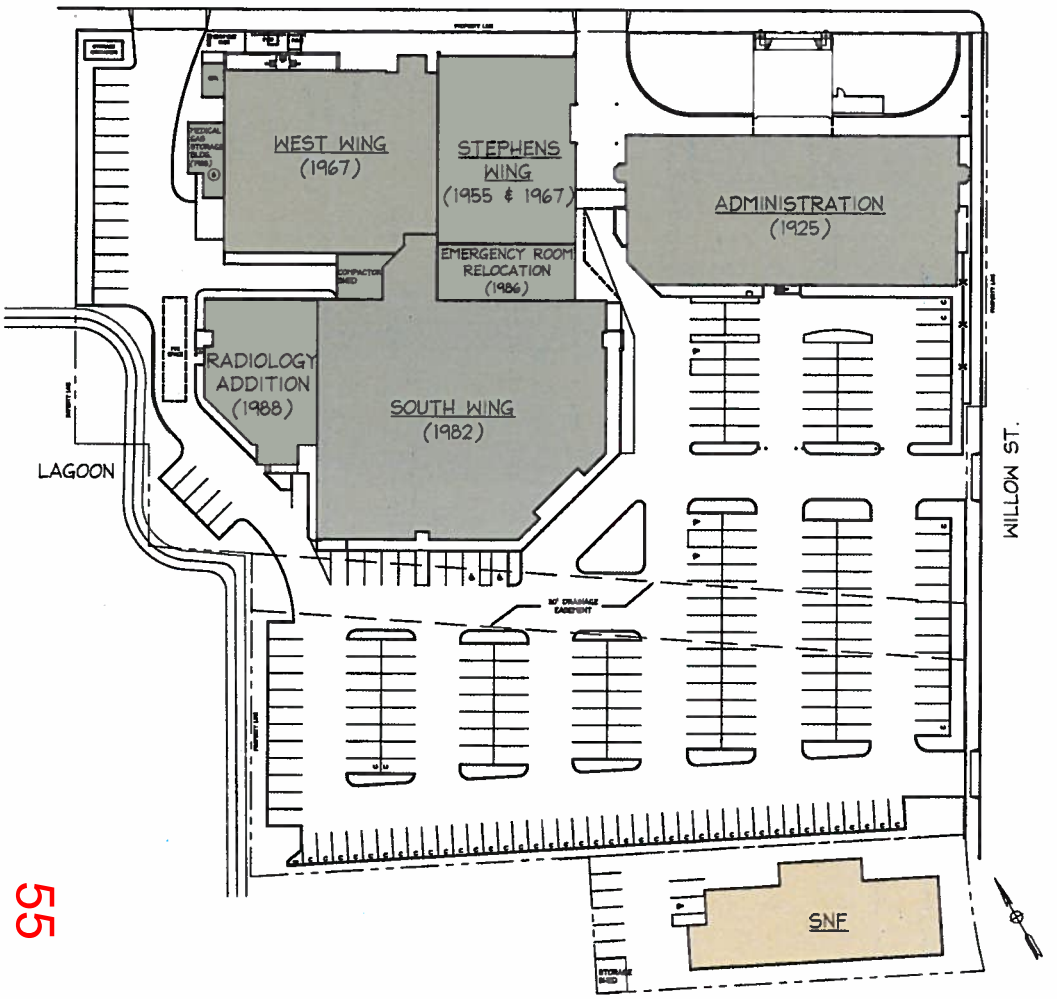
Other Services relocation space modifications $300,000

Other Considerations:

- Relocate Medical Records
- Relocate Morgue
- Identify "Administrator" office
- Relocation of existing services located on first floor of Stephens Wing (SW).
- Temporary relocation and/or suspension of service areas during construction (ED, 2nd & 3rd floor of SW

Time Frame:

1. Plans to OSHPD by mid June 2010
2. Relocate (SW) services by January 2011.
3. Get financing by January 2011
4. Building Permit by January 2011
5. Complete Construction by July 2012 (18 months)
6. Obtain CDPH review and Certificates of Occupancy by November 2012


CLINTON AVE.
WEST WING
(1967)
STEPHENS
WING
(1955 & 1967)
ADMINISTRATION
(1925)
EMERGENCY ROOM
RELOCATION
(1986)
COMPACTOR
SHED
RADIOLOGY
ADDITION
(1988)
SOUTH WING
(1982)
LAGOON
WILLOW ST.
SNF
STORAGE
SHED