Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

REVISED

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT

BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, May 9, 2011

(RESCHEDULED FROM MONDAY, MAY 2, 2011)

6:00 p.m. (Closed)

7:30 p.m. (Open)

Location: Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue, Alameda, CA 94501
Office of the Clerk: (510) 814-4001

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 **(6:00 p.m. – 2 East Board Room)** — Jordan Battani

II. Roll Call — Kristen Thorson

III. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes

1. April 4, Regular Meeting
2. April 27, 2011 Special Meeting

C. Medical Executive Committee Report and Approval of Credentialing Recommendations — H & S Code Sec. 32155

D. Board Quality Committee Report (BQC) — H & S Code Sec. 32155

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

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

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

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

3. Discussion of Hospital Trade Secrets applicable to development of new hospital services, programs and facilities. No action will be taken
4. Discussion of Hospital Trade Secrets applicable to development of new hospital services, programs and facilities. No action will be taken
5. Discussion of Hospital Trade Secrets applicable to development of new hospital services, programs and facilities. No action will be taken

I. Adjourn into Open Session

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

A. Announcements from Closed Session — Jordan Battani

V. Regular Agenda

A. Consent Agenda — **ACTION ITEMS**

1) Approval of April 4, 2011 Regular Meeting Minutes [enclosure] (PAGES 4-12)
2) Approval of April 27, 2011 Special Meeting Minutes [enclosure] (PAGE 13)
3) Acceptance of March 2011 Financial Statements [enclosure] (PAGES 14-33)
4) Approval of Tentative Agreement with ILWU, Local #6 [enclosure] (PAGES 34-35)
5) Approval of FY 2011 Auditor Engagement [enclosure] (PAGES 36-40)
6) Approval of Revisions of Committee Relations and Outreach Committee Structure and Purpose [enclosure] (PAGES 41-42)
7) Approval of New Procedure: Minimally Invasive Lumbar Decompression (MILD®) Procedure [enclosure] (PAGES 43)
8) Approval of Bank of Alameda's Modifications to the Terms and Conditions of the Line of Credit and Construction Loan for the Wound Care Program [enclosure] (PAGES 44-48)

B. Action Items

1) Approval of FY 2012 Goals and Objectives to Board of Directors [enclosure] (PAGES 49-55) — Deborah E. Stebbins
2) Appointment of Members to Community Relations and Outreach Committee [enclosure] (PAGES 56-57) — Stewart Chen, DC

C. President's Report — Jordan Battani

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

1) Monthly Statistics INFORMATIONAL
2) Hospital Updates / Events INFORMATIONAL [enclosure] (PAGES 58-60)
3) Stroke Certification Update INFORMATIONAL

E. Operations and Facilities Report — Kerry Easthope

1) Seismic Update (Structural and Non-Structural) INFORMATIONAL [enclosure] (PAGES 61-64)
2) Marina Village Lease Update INFORMATIONAL

F. Medical Staff President Report INFORMATIONAL — James Yeh, DO

G. Community Relations and Outreach Committee Report — Stewart Chen, DC

1) April 26, 2011 Committee Meeting Report **INFORMATIONAL**

H. Finance and Management Committee Report — J. Michael McCormick

1) April 27, 2011 Committee Meeting Report **INFORMATIONAL**

VI. General Public Comments

VII. Board Comments

XIII. Adjournment

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

DRAFT

Minutes of the Board of Directors

April 4, 2011

Directors Present:		Medical Staff Present:	Legal Counsel Present:	Management Present:	Excused:
Jordan Battani	Elliott Gorelick	James Yeh, DO	Thomas Driscoll, Esq.	Deborah E. Stebbins	Kerry J. Easthope
Stewart Chen, DC	J. Michael McCormick			David Neapolitan	
Robert Deutsch, 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 6:14 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
III. Closed Session Agenda	The meeting was adjourned into Executive Closed Session at 6:15 p.m.	
IV. Reconvene to Public Session	The meeting was reconvened into public session at 7:42 p.m. Director Battani reported that the following actions were taken in Closed Session. A. Announcements from Closed Session 1. Closed Session Minutes – March 9, 2011 (Regular) 2. Board Quality Committee (BQC) Report – January 2011 3. Medical Executive Committee Report and Approval of Credentialing Recommendations	 The Closed Session Minutes were approved. The BQC report was accepted as presented. The Medical Executive Committee Report and Credentialing Recommendations were approved as presented below.

Initial Appointments – Medical Staff

Name	Specialty	Affiliation
○ Mark Tu, MD	Teleradiology	Bay Imaging Consultants
○ Vivian Wing, MD	Teleradiology	Bay Imaging Consultants
○ David Woo, MD	Teleradiology	Bay Imaging Consultants

Reappointments – Medical Staff

Name	Specialty	Staff Status	Appointment Period
○ Herkanwal Khaira, MD	Urology	Courtesy	05/01/11 – 04/30/13
○ Diane Lee, MD	Neurology	Courtesy	05/01/11 – 04/30/13
○ Bill Longwell, MD	Internal Medicine	Courtesy	05/01/11 – 04/30/13
○ Lana Louie, MD	Breast Surgery	Courtesy	05/01/11 – 04/30/13
○ Paul Suding, MD	General Surgery	Courtesy	05/01/11 – 04/30/13
○ Crystal Terry, MD	Anesthesiology	Active	05/01/11 – 04/30/13
○ Lilian Tsao, MD	Family Medicine	Active	05/01/11 – 04/30/13

Resignations

Name	Specialty
○ Gary Clark, MD	General Surgery
○ Mathew Dixon, MD	General Surgery
○ Timothy Huie, MD	Ophthalmology
○ Terry Hunter, MD	Ophthalmology
○ Suzanne Ishi, DPM	Podiatry
○ Subroto Kundu, MD	Neurology
○ Tsuan Li, MD	Otolaryngology
○ Donald Liberty, DDS	Oral/Maxillofacial Surgery

V. Regular Agenda	A. Consent Agenda 1. Approval of March 9, 2011 Regular Meeting Minutes 2. Acceptance of Annual Environment of Care Report	Director Gorelick removed Consent Agenda Items 3 and 4 for further discussion. Director Deustch made a motion to approve the balance of the

3. Acceptance of February 2011 Financial Statements

Director Gorelick had questions regarding what had changed in the collections for the month of February and inquired if something had changed in accounts receivable / accounts payable process in February versus previous months. Ms. Stebbins commented that cash collections were extensively higher in February and March. Mr. Neapolitan stated that there were some delays in payments in January that were received in February which contributed to the $5.4 million in collections for the month. The hospital has also been more prudent in the accounts payable process in order to conserve cash in anticipation of an IGT transfer between now and the end of the year.

Director Gorelick noted that the February bottom line was unexpectedly positive, in light of what we know about the IGT funds. He inquired as to what drove the decline. Mr. Neapolitan stated that the primary reason was the significant decline in CCU census. Ms. Stebbins stated that there were also some higher than expected expenses in February, specifically where staffing did not flex down during low census times and registry expenses were higher than anticipated. She stated that there have been a lot of efforts to correct the variances in registry and staffing going forward.

Director Battani inquired about possible reasons for higher cash collections in February and March, if the hospital anticipated higher than normal cash collections in April and if processes had changed within the hospital regarding cash collections. Mr. Neapolitan stated that the increased collections were primarly attributable to the flow of payments from the State of California and that processes have not changed within the hospital as in pertains to cash collections. He stated that it was too early to know what April cash collections would be.

consent agenda (Items 1., 2., 5.). Director McCormick seconded the motion. The motion carried unanimously.

Being no further discussions on the February Financials, Director Gorelick made a motion to accept the February Financial Statements as presented. Director Chen seconded the motion. The motion carried unanimously.

4. Approval to Renew Angelica Textile Service Agreement

Director Gorelick had questions regarding guarantees or cancellation charges if the hospital decided to cancel the agreement early and the financial implications of cancellation. Discussion was deferred to later in the meeting while a copy of the contract was retrieved.

Mr. Driscoll reviewed the agreement stating that the contract was a 4 year contract. If it is terminated early for any reason, hospital is required to buy back non-standard linens (i.e. scrubs) as well as linen carts that are used. If the contract is terminated other than for cause that hospital is required to pay 40% of the average weekly cost of the service times the remaining term of the agreement. Director McCormick stated that there were discussion in the Finance and Management Committee regarding the increases in cost of service based on the Consumer Price Index (CPI).

Being no further discussions, Director McCormick made a motion to approve the renewal of the Textile Services Agreement with Angelica. Director Chen seconded the motion. The motion carried unanimously.

	Ms. Stebbins stated that Angelica does a good job with the linen service for the Hospital. 5. Request to Move May 2011 District Board Meeting 6. Approval to Annual Use of Jaber Funds	
	A. President's Report 1. Update on Discussion with City Officials Director Battani stated she recently met with Mayor Marie Gilmore regarding potential areas of collaboration between the City and the District specifically as it relates to economic development opportunities and potentially to the Social Services and Human Relations Board (SSHRB). She and the Mayor agreed to stay closer in touch to help facilitate conversations between Hospital and City management. She stated that they agreed that there was no need to form a special committee at this time, but when areas of collaboration and mutual interest were identified, that Board members and management would likely be called upon to help with such projects. Director Battani stated that she participated in the City Manager interview process as a representative from the Health Care District. Director McCormick asked if there were examples of what kind of projects that were discussed at the meeting with Mayor Gilmore. Projects and topics of conversation ranged from building a Hospital on Alameda Point, to working more closely with the SSHRB by using hospital and district expertise to work on issues as access to healthcare to the best way to field questions about the district that are presented by the community in City Council meetings. B. Chief Executive Officer's Report 1. Monthly Statistics Ms. Stebbins reported on the monthly statistics, noting that the March acute census was 34.1 versus a budgeted 30.9 and 22.6% better than February acute census. Subacute census was essential on budget at 33.3 versus 33.5. South Shore census was slightly below budget at 20.3 versus 23.0. Patient days were slightly above budget by 0.3%. Emergency Room Visits were below budget by 3.8% at 1,461 but were higher that February volumes of 1,337 or 9.3%. Total surgeries were 186 which was12% better than February volumes. Outpatient surgeries were 16% better than February volumes.	No action taken No action taken

	2. Hospital Updates / Events Ms. Stebbins stated that there have been some underlying challenges with nurse staffing guidelines / ratios and the budget. Increased attention to the interpretation on of backfilling breaks to be in compliance with nurse staff ratios as well as other areas has been a priority at the hospital. She stated that we will also be focusing more on this area in the budgeting process for FY 2012. She also stated that the hospital needs a better budgeting process to identify staffing at a higher level of detail. Ms. Stebbins gave an update on the State Budget and the impact on hospitals. There is a provisions in the Budget that the Governor has signed to put reduce Medi-cal reimbursement levels to 2008-2009 levels minus 10%. This means a 18-24 % shift in rates and in the aggregate a $2.2 million loss in net revenue to the hospital. Letters have been written to state representatives as well as Governor Brown. CMS will ultimately have to approve the cuts. She stated that this will have a severe impact on long-term care in the State of California overall. These budget cuts will also make the budget process even more challenging for the hospital. The Hospital has entered into a relationship with Executive Health Resources (EHR) to work with the hospitals to evaluate the appropriateness observation admissions versus inpatients admissions and will also assist with RAC requests received by the hospital. There was discussion by the Board and Management regarding observation admissions compared to inpatient admissions and the process used at the Hospital.	No action taken
	3. Stroke Certification Update Ms. Stebbins provided an update as to the status of Stoke Certification. The hospital continues with the mandatory Stroke training as required for all employees. There were 47 community members that participated in the March stroke screenings at the hospital. In June, there will be a stroke screening held at Harbor Bay as suggested by Director Gorelick. The Joint Commission Application will be submitted to the Joint Commission on April 5, 2011. Director Chen asked what the timeframe for Joint Commission Survey was. Ms. Stebbins reported that the survey is dependent on the Joint Commission and their schedule. Ms. Bond stated that a lot of progress has been made toward certification and indicated that she did not for see any problems with certification.	No action taken
	D. Finance and Management Committee Report 1. March 30, 2011 Committee Meeting Report Director McCormick stated that for the 8 months ending February 28, 2011 the combined excess expense over revenues (loss) was $337,000 versus a budgeted	

profit of 564,00, a $901,000 unfavorable variance. Net patient revenue was also unfavorable due to lower and expected volumes in acute census and surgical cases.

2. FYE 2011 Year End Projections

No action taken.

Mr. Neapolitan presented the fiscal year ending June 30, 2011 projections. As stated in the memorandum, the projection is based upon the first eight (8) months of actual financial performance with the remaining four (4) months of operations projected using the first seven (7) months of financial results. As a result Management is projecting that the revenue in excess of expenses will be approximately $196,000 for FY 2011. The significant modifications made and that have been incorporated into the projections included the following:

- Removal of one half of the estimated Fiscal Year 2011 Intergovernmental Transfer (IGT), $1,098,000 from the budget.
- Removal of the budgeted Wound Care program, $59,000 net income, that was budgeted to begin operations in January 2011 as the program will not begin operations until January 2012.
- Inclusion of the write-off of a third party liability of $1,451,000 that has reached the statute of limitations

Director Battani asked if the remainder of the IGT is at risk due to State budget changes. She stated that going forward there will be changes to how the IGT program will work which will affect the Hospital. Ms. Stebbins stated that there is still a slight risk and will know moiré after attending Legislative Day in Sacramento on April 5-6.

In addition to the modifications Mr. Neapolitan reviewed the there have been material variances from the budget in gross revenues, salaries and registry expenses, benefits, and supply costs and were outlined in the memo. The Board and Management discussed the specific variances as noted in the memo. Mr. Neapolitan reviewed the historical operating statistics and projected statistics for FY 2011. The projections of Excess of Revenue over Expenses were reviewed as well, noting the year-end profit of $196,000 versus a budgeted profit of $490,000.

Director Gorelick stated that that based on the Excess of Revenue over Expense of $1,348 (in thousands), excluding the other income line of $1,473, the loss for the month is projected to be approximately $125,000. He asked Management to comment on the possibility of March being better than projected based on the increased volumes reported by Ms. Stebbins in the CEO Report. Ms. Stebbins reported that although the volumes increased there is also a corresponding increase in

expenses but she hopes that the month will be positive as projected.

Director Battani asked what plans were in place through the end of the fiscal year to make the Board more confident, based on fact that there were the errors forecasting the budget in certain areas as well as issues with controlling the expense side. Ms. Stebbins and Ms. Bond commented on opportunities in the nursing department that would keep salary expense in line through the end of the fiscal year and going forward, such as limiting use of certified nurse assistants and sharing staff between nursing units when possible. Ms. Stebbins stated there has been increased monitoring of staffing ratios.

Director Chen asked about the surgical supply cost of implants. Mr. Neapolitan stated that a process for reviewing surgery cases at time of scheduling will be reinstituted to evaluate the cost of the surgery prior to the case being done.

Director Gorelick asked if management thought that registry expenses would be favorable to budget considering initiatives put in place to control registry and salary costs as it is projected to be flat through the end of the fiscal year. Ms. Stebbins stated the projections are conservative and she hopes that initiatives put in place should result in better than projected numbers. Ms. Bond stated that registry personnel are also used in some instances for vacant positions that are unable to be filled. Use of registry throughout various departments of the hospital allows the hospital to continue to provide all services to patients and meet staffing ratios.

Director Gorelick asked about the expense of the Banc of America Master Lease in reference to a memorandum presented at the Finance and Management Committee. He stated that when the lease was fully operation and in effect the cost per month would be approximately $38,000, and asked if the cost would be incurred in this fiscal year. Mr. Neapolitan stated that the interest expense associated with the Master lease is currently reported in Interest Expense and will be reflected in Rents and Leases when the project is implemented which is estimated to be late May 2011 or later.

3. FYE 2012 Budget Calendar

Mr. Neapolitan stated that the Budget Calendar had been modified from what was presented at the Finance and Management Committee to include key dates relating to strategic goals for the upcoming fiscal year. On May 9, the FY 2012 Goals and Objectives will be presented to the Board. On June 6 the Operating and Capital Budgets will be presented to the Board and the Audited Financial Statements will be brought to the Board in October 2011. In addition, there will be an annual price increase on July 1.

Director Gorelick inquired about the capital budget in light of the host of challenges

	the hospital faces this year and the next fiscal year. Ms. Stebbins stated that the Capital Budget is a meant to be rolling 5 year budget to keep track of major capital projects and equipment. She stated there will be a focus on information technology related the electronic health record in the next fiscal year while still keeping track of other capital need as identified. Director Chen asked about the reasoning related annual price increase. Mr. Neapolitan stated that the hospital does benefit from price increases based on the type of contract relationship with third party payors.	
	E. Community Relations and Outreach Committee Report Director Chen reported that the Committee did not meet since the last Board meeting. He stated that the Co-Chairs and Management will be meeting on April 12 to discuss committee membership and has identified several community members that have expressed interest in serving on the committee. There was discussion on the committee membership and size of the committee in which Director Chen stated that he will be looking at the size of the committee and membership during discussions with management and the other co-chair, Terrie Kurrasch. Director Chen is also interested in having joint committee meeting with other organizations such as Social Services and Human Relations Board, to collaborate on various ideas and projects. He announced two outreach activities that the hospital will be involved with. On May 22, There will be an inaugural Alameda Asian Street Festival on Webster Street. The Hospital will also be participating in the Oakland China Town Health Fair. Ms. Stebbins stated that there has been an increase in the number of outreach activities in spite of the lack of a quorum at committee meetings in recent months.	
	F. Medical Staff President Report Dr. Yeh informed the Board that the April 12 continuing Medical Education (CME) program would be presented by Marcia Peck, MD an endocrinologist, on Outpatient Diabetes Management.	
VI. General Public Comments	None.	
X. Board Comments	Director Gorelick asked if the Board agendas and packets could be posted earlier for public review. Director Battani stated that we are currently meeting Brown Act requirements. She asked what would be better timeline. Director Gorelick suggested five days. He stated that it has been expressed by the public that earlier posting of agendas would be beneficial. Director Battani suggested 72 hours not including the weekend. The Board and Management discussed possible options for ways to post and distribute the Board packets in advance of the required 72	

	hour notice. Management and staff will work toward advanced posting of the Board agenda and packet. Director Gorelick also asked if a separate PDF of the calendar of dates of the Board meetings posted on the website. Management and staff will update the website with a separate link to a master calendar of Board meeting dates. In addition, Director Gorelick asked about notifying the local newspapers about upcoming meetings. Ms. Stebbins stated that we checked with the Alameda Journal about posting meeting notices and there was not much interest in doing so as they do not typically do this. Management and staff will continue to work with the local newspapers as well as local online news resources for posting of meeting dates.	
XII. Adjournment	A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:14 p.m.	

Attest:

Jordan Battani	Elliott Gorelick
President	Secretary

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

April 27, 2011
SPECIAL MEETING

Directors Present:		Legal Counsel Present:	Guests:	Excused:
Jordan Battani	Elliott Gorelick	Thomas Driscoll, Esq.	Bill Hopkins, Integrated Healthcare Strategies	James Yeh, DO
Stewart Chen, DC	J. Michael McCormick			
Robert Deutsch, 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 7:05 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
III. Closed Session Agenda	The meeting was adjourned into Executive Closed Session at 7:06 p.m.	
IV. Reconvene to Public Session	The meeting was reconvened into public session at 10:00 p.m. Director Battani reported that the following actions were taken in Closed Session. A. Announcements from Closed Session There were no announcements from closed session.	
X. Board Comments	None	
VI. General Public Comments	None	
XII. Adjournment	A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 10:02 p.m.	

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING MARCH 31, 2011

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
MARCH 31, 2011

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
MARCH, 2011

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, 2011 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, 2011

- For the nine months ended March 31, 2011, combined expense over revenues (loss) is $689,000 before the inclusion of $1,451,000 of other non-operating income. This additional other non-operating income, which was recorded in March 2011, was the result of the elimination of a liability that was established in fiscal year 2006. The liability was the result of a dispute over contractual language related to the amounts due under the terms of an insurance contract. After inclusion of the elimination of this liability the year to date revenue over expense (profit) is $762,000 versus budgeted revenue over expenses (profit) of $646,000.

- Gross patient revenue for the month of March was greater than budget by $890,000 or 4.0%. This favorable variance was the result of a favorable variance of $1,434,000 in inpatient programs offset by an unfavorable variance of $543,000 from outpatient services. On adjusted patient day basis gross patient revenue was 8.2% greater than budgeted at $5,883 compared to a budgeted amount of $5,437 for the month of March.

- Total patient days for the month were 2,747 compared to the prior month's total patient days of 2,380 and the prior year's 2,742 total patient days. The average daily acute care census was 35.0 compared to a budget of 30.9 and an actual average daily census of 27.8 in the prior month; the average daily Sub-Acute census was 33.3 versus a budget of 33.5 and 33.7 in the prior month and the Skilled Nursing program had an average daily census of 20.3 versus a budget of 23.0 and prior month census of 23.5, respectively.

- Emergency Care Center (ECC) visits were 1,461 or 3.8% less than the budgeted 1,519 visits and were only 0.3% less than the prior year's visits of 1,466.

- Total surgery cases were greater than budgeted expectations for the month at 186 cases versus the budgeted 182 cases. The current month's surgical volume was 19.2% greater than the same month prior year's 156 cases.

- Outpatient registrations were 12.0% below budgeted targets at 21,197 and at 70.9 visits per day were 6.4% greater than the prior month's 66.6 visits per day.

- Combined excess revenue over expenses (profit) for March was $1,099,000 versus a budgeted excess of revenue over expenses (profit) of $82,000 and include in other non-operating income the elimination of a $1,451,000 liability.

Total assets increased by $446,000 from the prior month as a result of increases in current assets of $284,000, net fixed assets of $153,000 and restricted contributions of $9,000. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for March increased by $1,035,000 and days cash on hand including restricted use funds increased to 14.1 days on hand in March from 8.5 days on hand in February.

- Net patient accounts receivable decreased in March by $429,000 compared to a decrease of $937,000 in February. Day's in outstanding receivables decreased to 58.5 at March 31, 2011 from 59.7 at February 28, 2011. Collections in March totaled $5.5 million compared to $5.4 million in February.

Total liabilities decreased by $662,000 compared to an increase of $179,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses decreased by $486,000. This decrease was primarily driven by the elimination of the $1,451,000 liability discussed previously offset by an increase in trade payables. As a result of this decrease the average payment period decreased in March to 68.0 from 69.4 as of February 28, 2011.

- Payroll related accruals increased by $280,000 from the prior month primarily as a result of three additional days of payroll accruals resulting from the timing of the organizations bi-weekly payroll periods.

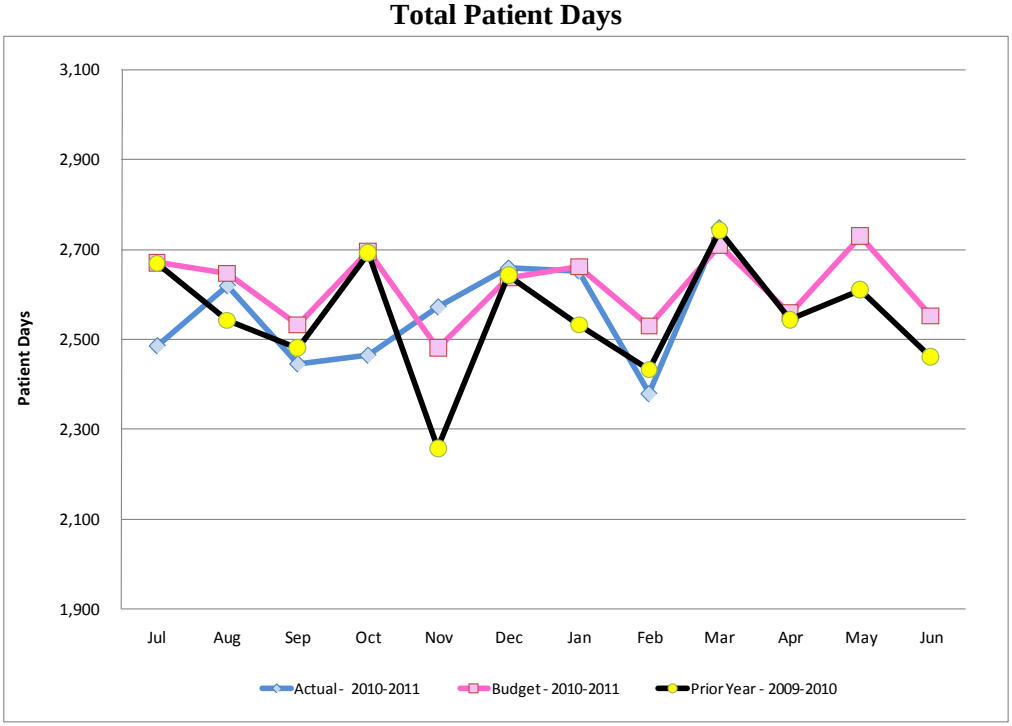
- Deferred revenues decreased by $478,000 as a result of the amortization of one-twelfth of the annual parcel tax revenues for the 2011 fiscal year.

- Long term debt decreased by $37,000 as a result of the monthly payment of the principle portion of the note payable to the Bank of Alameda.

Volumes

The combined actual daily census was 88.6 versus a budget of 87.4 or a favorable variance of 1.4%. The current month's overall favorable variance from the budgeted census was the result of an acute care services average daily census that was favorable to budget in the acute care areas by 4.3 patients per day or 13.8%. The Sub-Acute and Skilled Nursing programs were unfavorable to budgeted expectations with an average daily census of 33.3 versus the budgeted 33.5 and 20.3versus the budgeted average daily census of 23.0, respectively.

The graph below shows the total patient days by month for fiscal year 2011 compared to the operating budget and fiscal year 2010 actual.

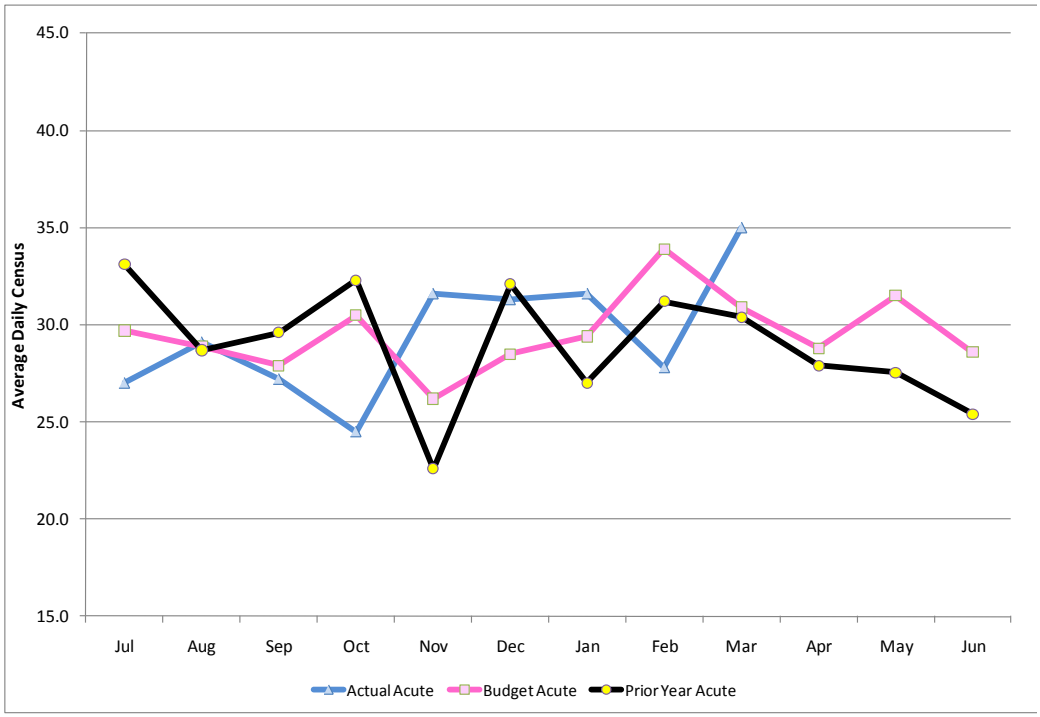


The various inpatient components of our inpatient volumes for the month of March are discussed in the following sections.

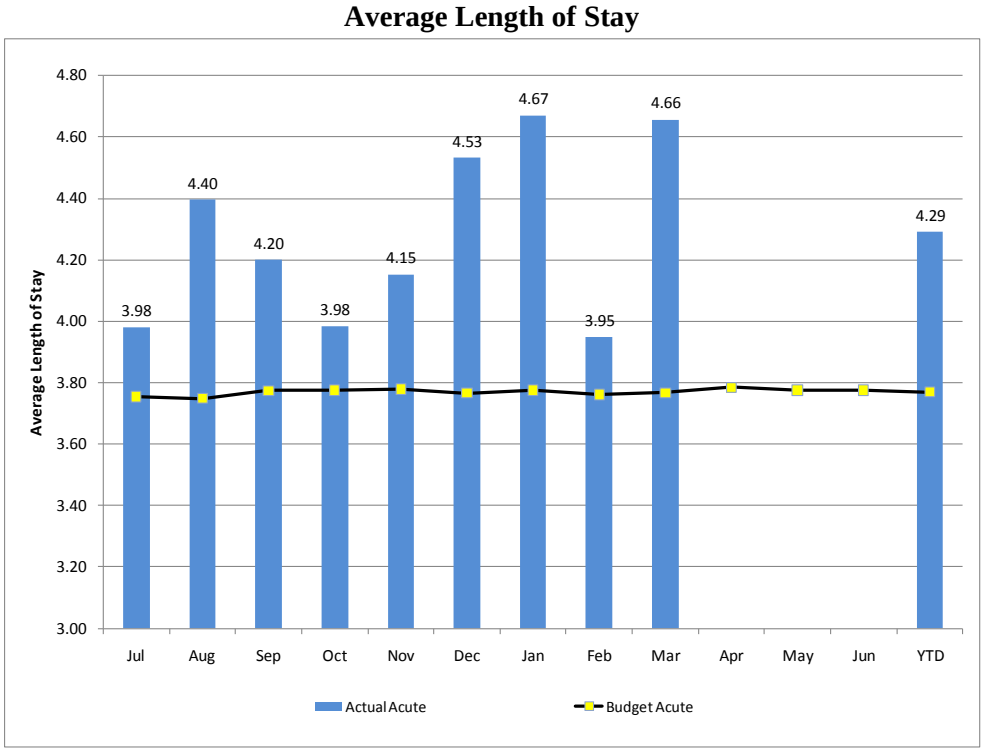
Acute Care

The acute care patient days were 13.4% (128 days) greater than budgeted and were 15.3% greater than the prior year's average daily census of 30.4 for March. The acute care program is comprised of the Critical Care Unit (5.2 ADC, 15.7% favorable to budget), Definitive Observation Unit (9.7 ADC, 18.9% unfavorable to budget) and Med/Surg Units (20.1 ADC, 39.9% favorable to budget). The graph below shows the inpatient acute care census by month for the current fiscal year, the operating budget and prior fiscal year actual.

Inpatient Acute Care Average Daily Census

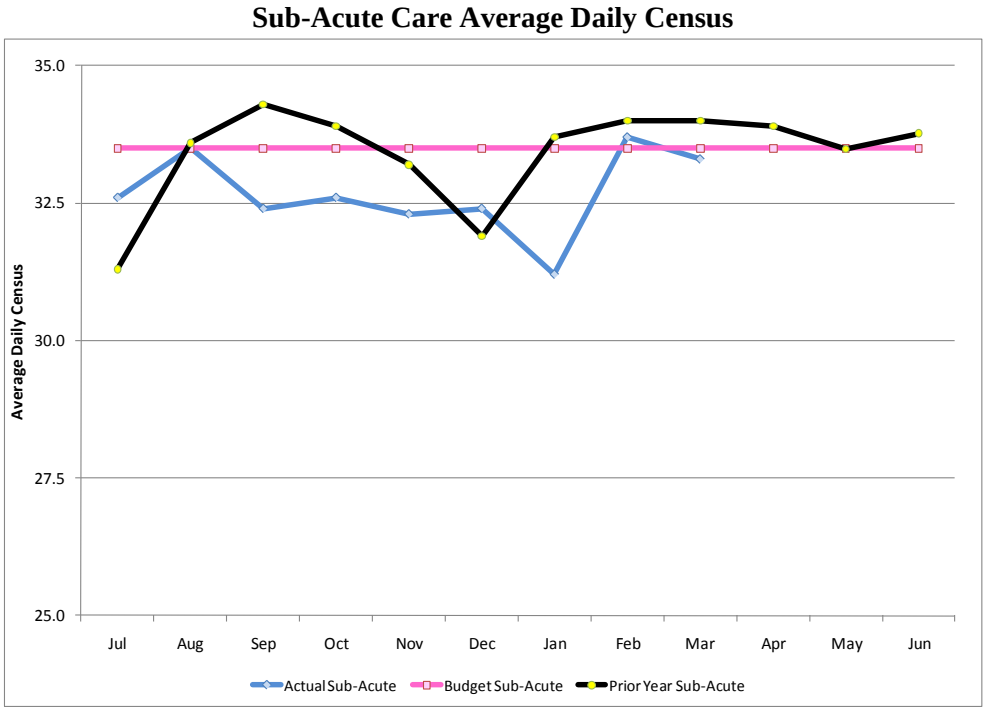


The average length of stay (ALOS) increased from that of the prior month to 4.66 days for the month of March bringing the year-to-date average to 4.29 versus the budgeted FY 2011 average of 3.77. The graph on the following page shows the ALOS by month and the budgeted ALOS for fiscal year 2011.



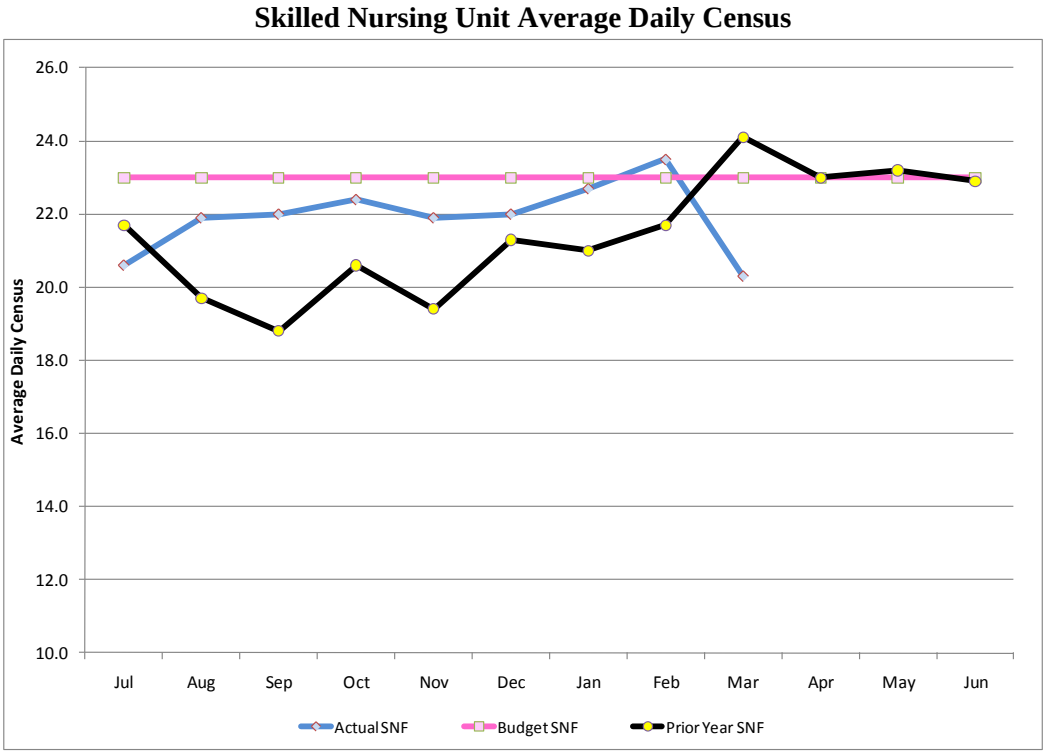
Sub-Acute Care

The Sub-Acute program patient days were slightly less than budgeted projections with an average daily census of 33.3 for the month of March which was budgeted for an average daily census of 33.5. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.



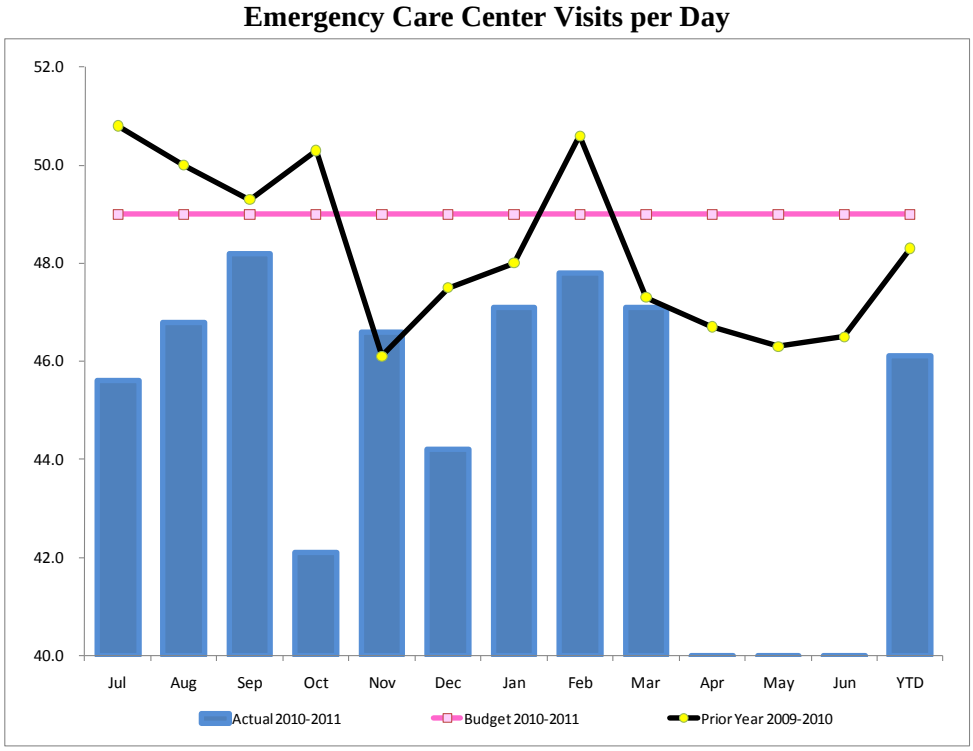
Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 11.6% or 83 patient days less than budgeted for the month of March. Comparing performance to the prior year this programs volume remains greater than the prior year's performance for the first nine months of fiscal year 2011 that has had an average daily census of 21.9 versus 20.9 in fiscal year 2010. The following graph shows the Skilled Nursing Unit monthly average daily census as compared to budget and the prior year.



Emergency Care Center (ECC)

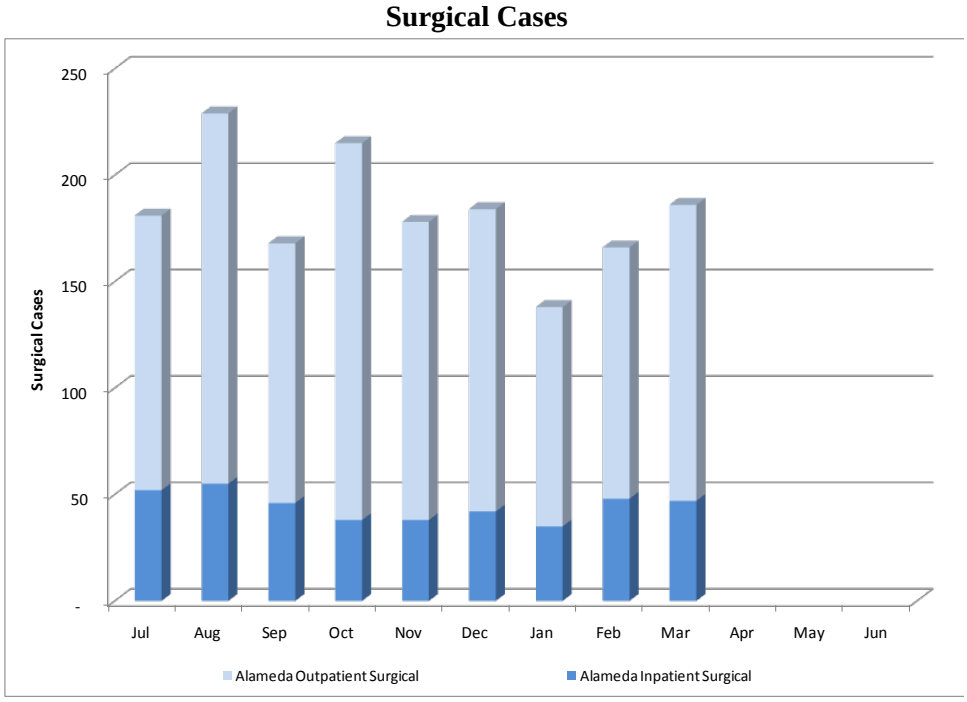
Emergency Care Center visits in March totaled 1,461 and were 3.8% or only 58 visits less than budgeted for the month with 16.2% of these visits resulting in inpatient admissions versus 15.6% in February. In March there were 318 ambulance arrivals versus 267 in the prior month, on a per day basis this represents an increase of 8.4% over the prior months daily average. Of the 318 ambulance arrivals in the current month 187 or 58.8% were from Alameda Fire Department (AFD) ambulances. The graph on the following page shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.



Surgery

Surgery cases were 186 versus the 182 budgeted cases and 156 cases in the prior year. In March, surgery cases increased over the prior month by 12.0%. The increase of 20 cases over the prior month was the result primarily of an increase of 21 outpatient cases, respectively. Inpatient and outpatient cases totaled 47 and 139 versus 48 and 118 in March and February, respectively. The increase in cases from the prior month was driven by increases in Ophthalmology (21), Gynecology (9) and Orthopedic (4) cases offset by decreases in Gastrointestinal (8), Plastics (3), General (2) and Vascular (1) cases.

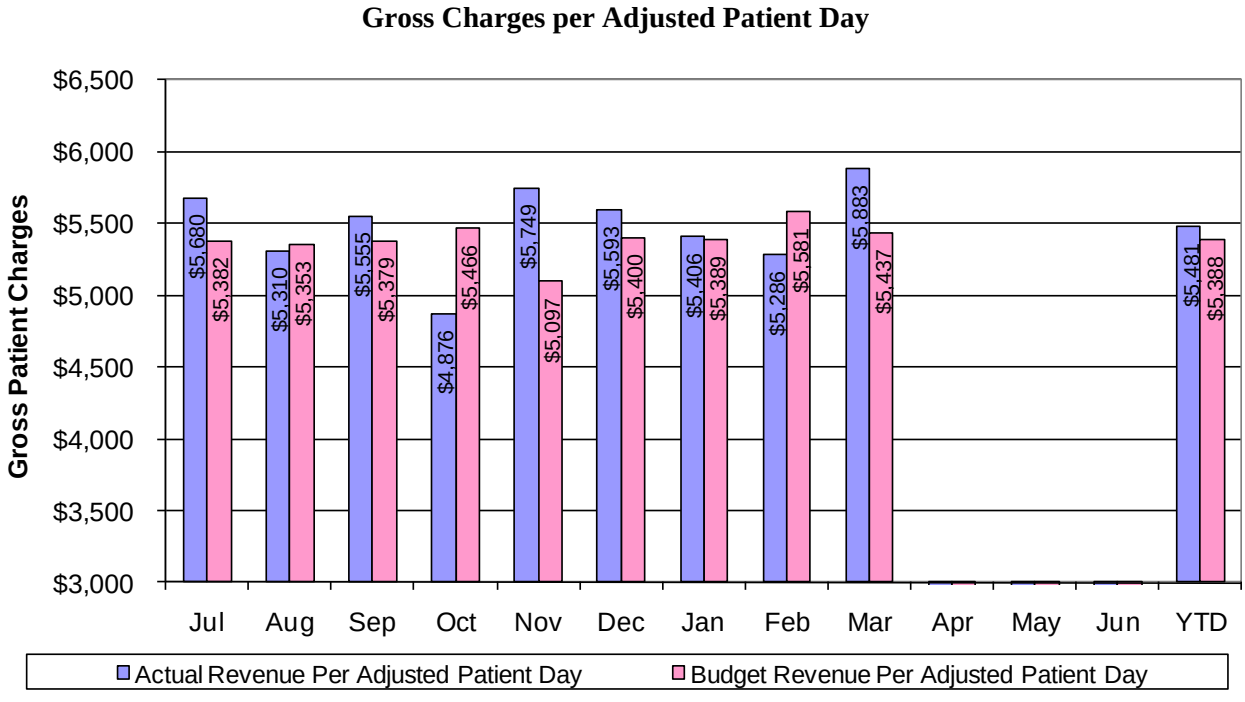
The graph on the following page shows the number of inpatient and outpatient surgical cases by month for fiscal year 2011.



Income Statement

Gross Patient Charges

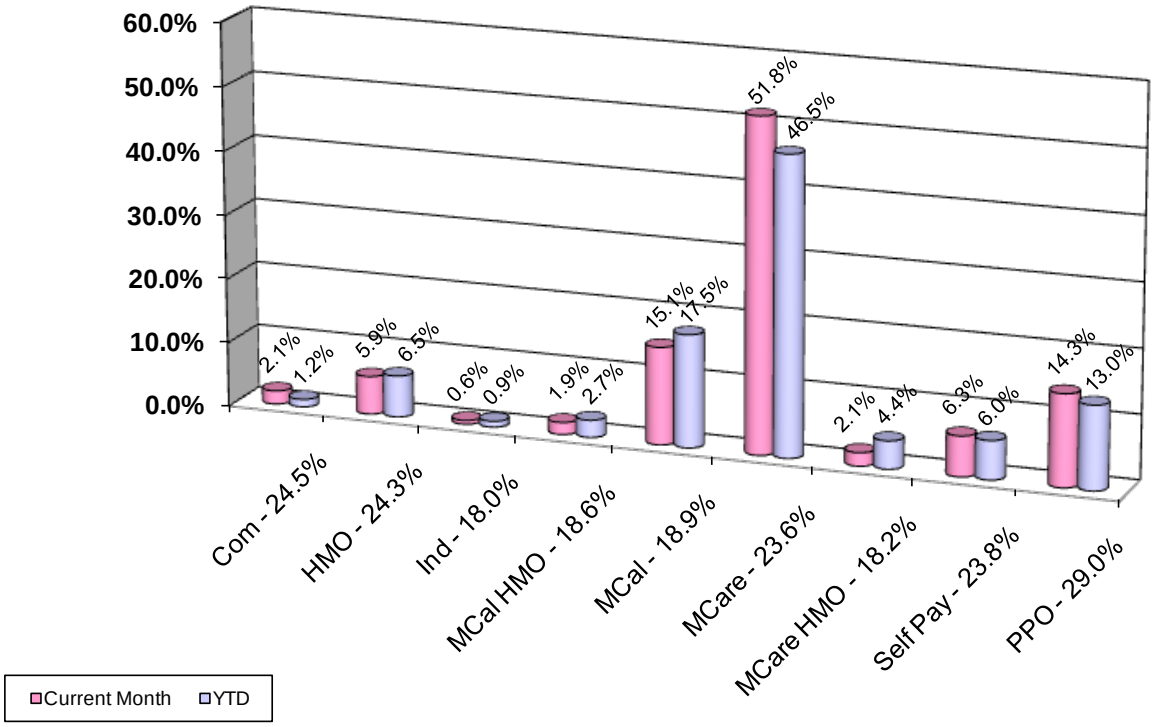
Gross patient charges in March were greater than budgeted by $890,000. This favorable variance was comprised of a favorable variance of $1,434,000 and an unfavorable variance of $543,000 in inpatient and outpatient revenues, respectively. On an adjusted patient day basis total patient revenue was $5,883 versus the budgeted $5,437 for the month of March. The following table shows the hospitals monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2011 compared to budget.



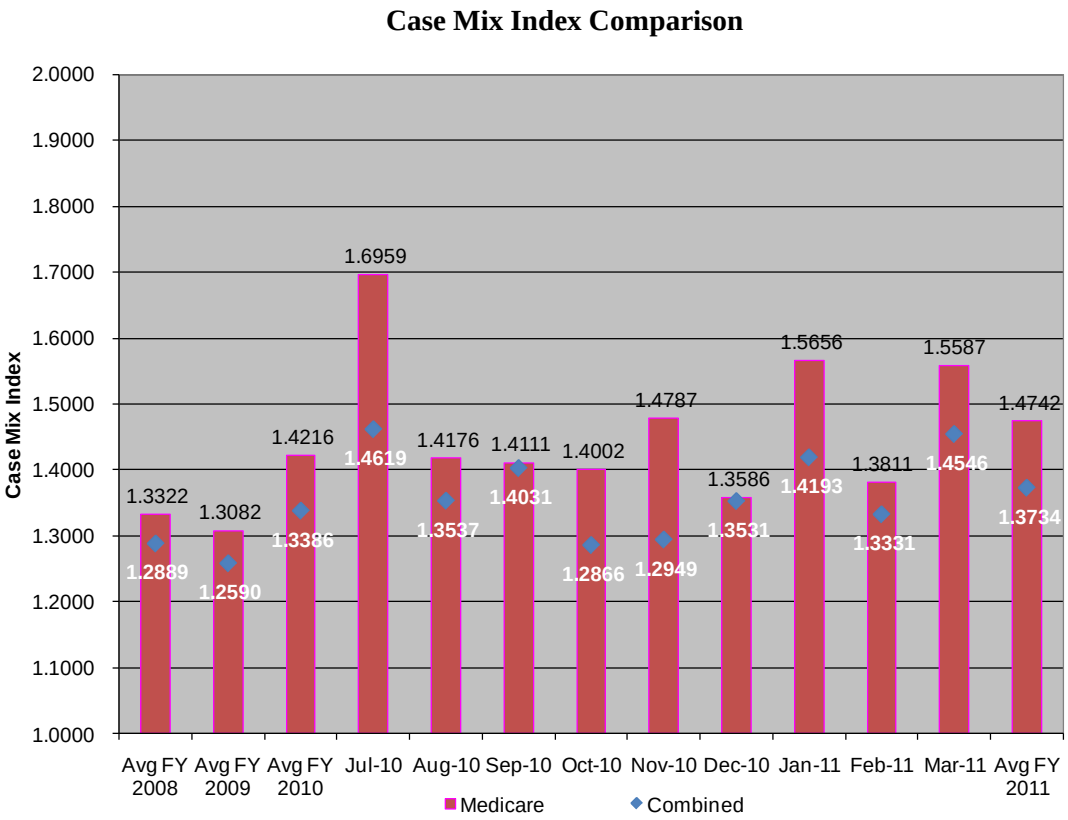
Payor Mix

Combined inpatient and outpatient acute care Medicare and Medicare Advantage total gross revenue in March made up 53.9% of the months total gross patient revenue. Combined Medicare revenue was followed by HM0/PPO utilization at 20.2, Medi-Cal Traditional and Medi-Cal HMO utilization at 17.0% and self pay at 6.3%. The graph below shows the percentage of gross 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 for the combined inpatient and outpatient acute care services.

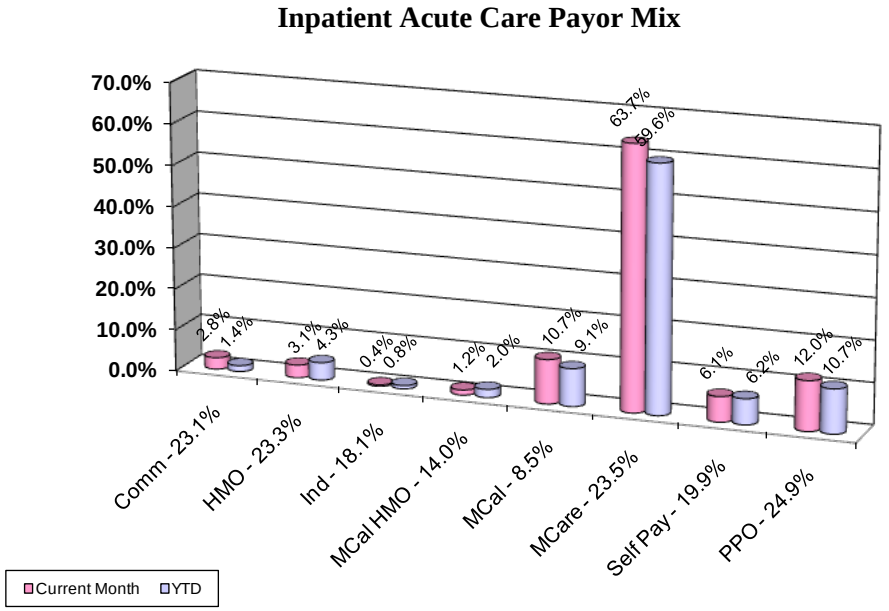
Combined Acute Care Services Payor Mix



The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 63.7% of our total inpatient acute care gross revenues followed by HMO/PPO at 15.1%, Medi-Cal and Medi-Cal HMO at 11.9% and Self Pay at 6.1% of the inpatient acute care revenue. The hospitals overall Case Mix Index (CMI) increased to 1.4546 from 1.3331 in the prior month and the Medicare CMI increased over the prior month from 1.3811 in February to 1.5587 in March. In March there were (2) outlier cases in the month. The estimated Medicare reimbursement decreased to 23.6% in March versus 27.1% in February. The graph on the following page shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

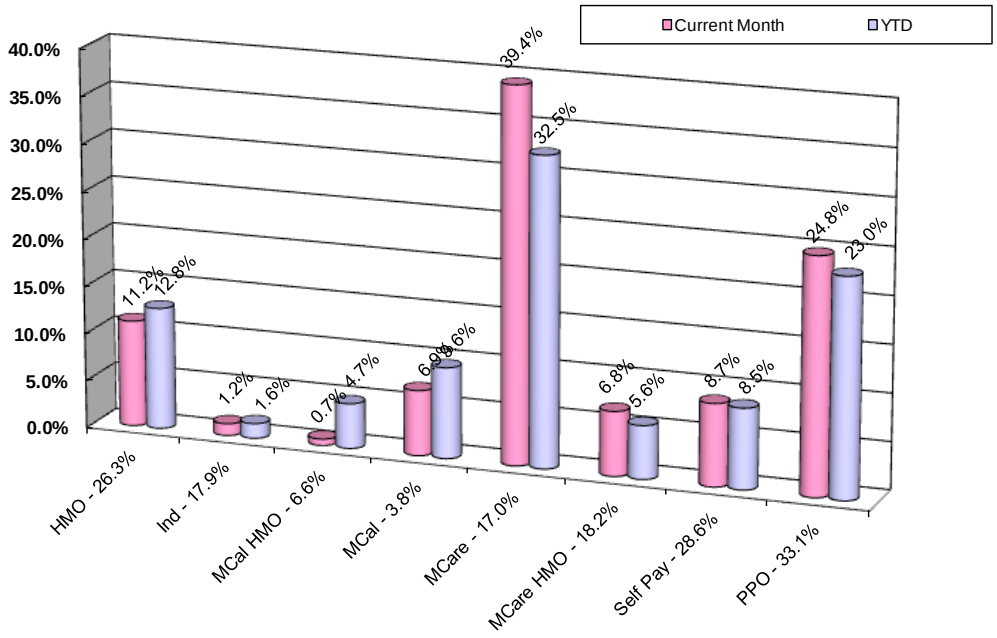


The overall net inpatient revenue percentage decreased from the prior month to 21.7% in March versus 23.7% in February. The graph below shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.



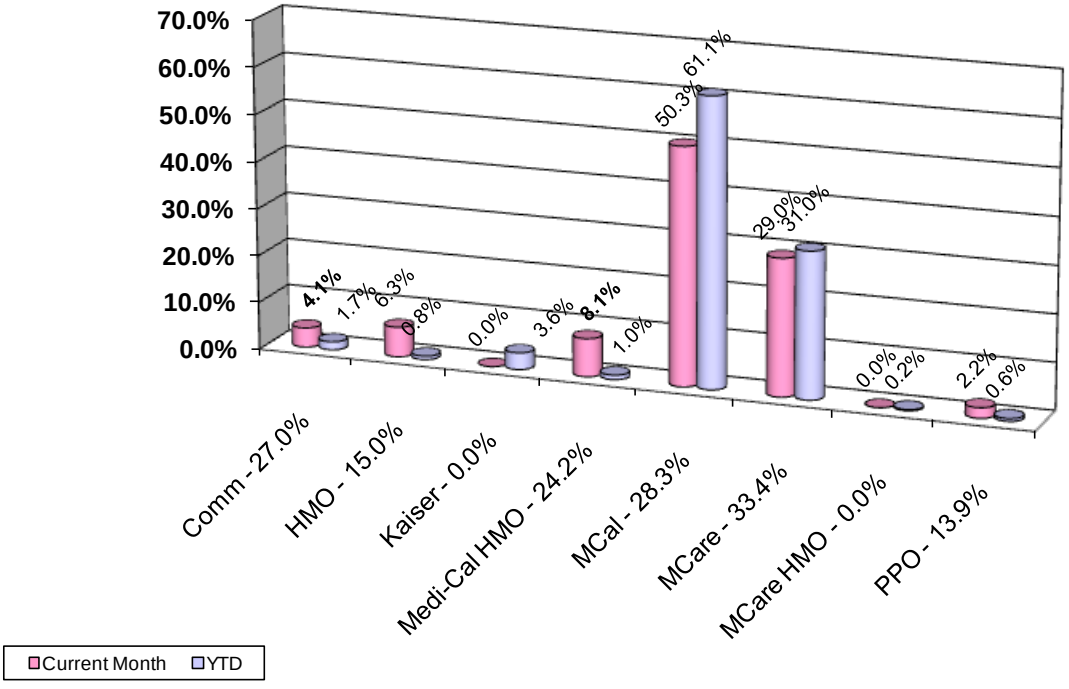
The outpatient gross revenue payor mix for March was comprised of 45.2% Medicare and Medicare Advantage, 36.0% HMO/PPO, 6.9% Medi-Cal and Medi-Cal HMO, and 8.7% self pay. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



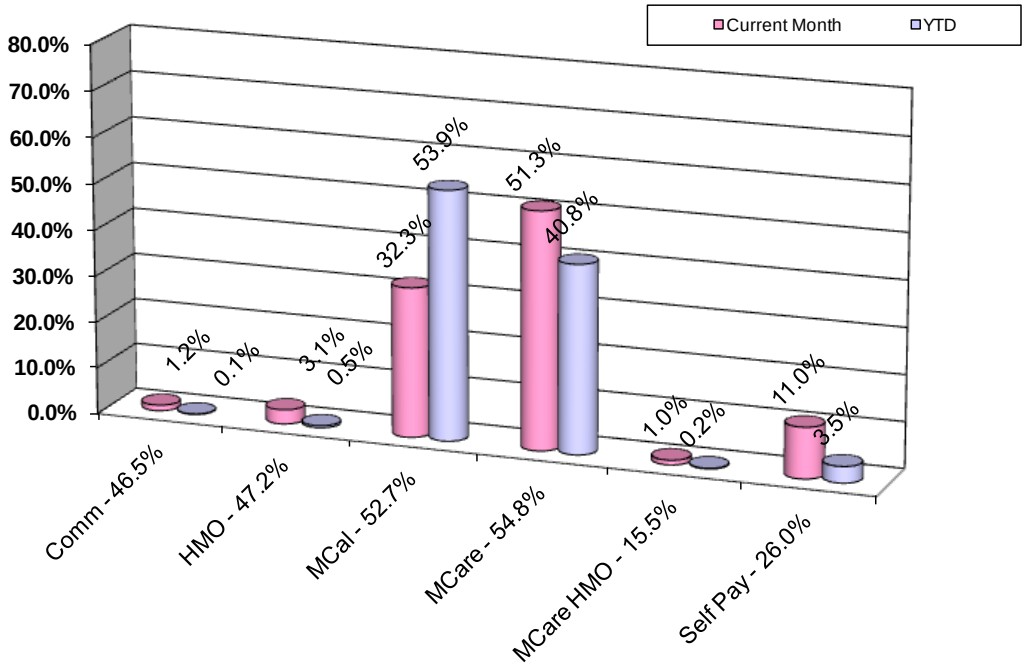
In March the Sub-Acute care program again was dominated by Medi-Cal utilization of 58.4% versus 60.9% in February. The graph below shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



In March the Skilled Nursing program was again comprised primarily of Medicare at 52.3% and Medi-Cal at 32.3%. The graph below 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



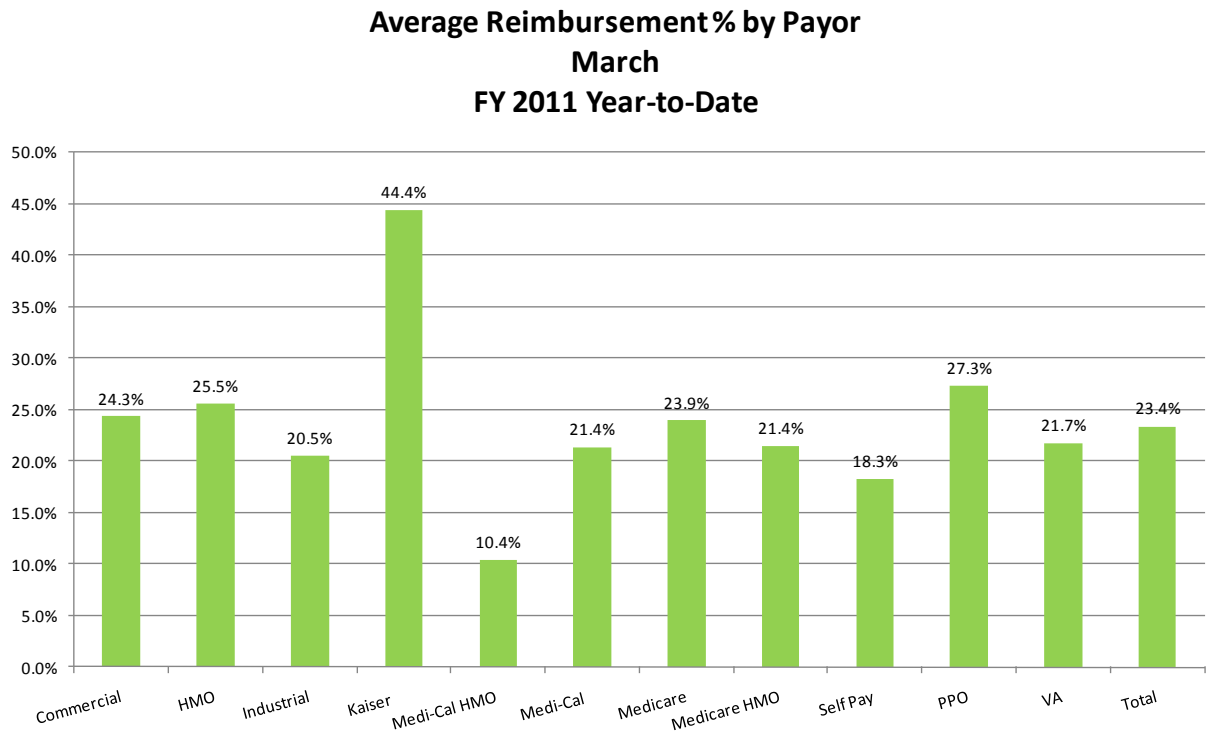
Deductions from Revenue

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 78.1% versus the budgeted 75.9%. A major factor causing this increase in this percentage were higher bad debt write-offs in the month which exceeded budget by $228,000 and greater than budgeted charity care write-offs that also exceeded budget by $24,000.

Net Patient Service Revenue

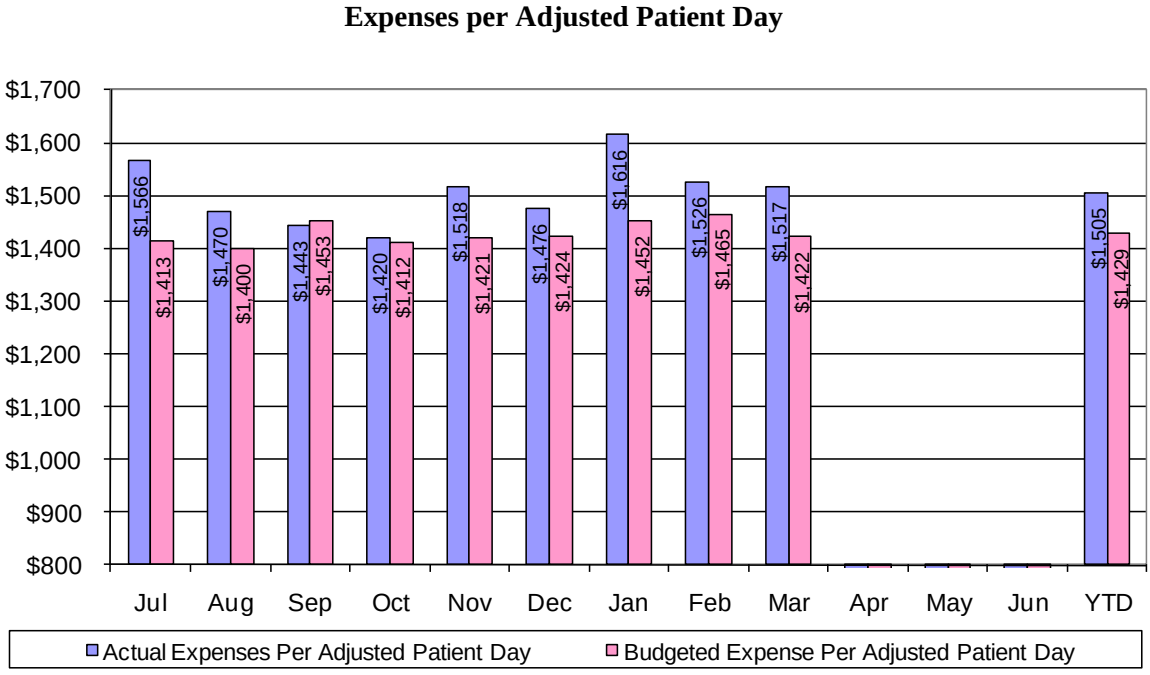
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. In addition, included in year to date net patient service revenue are the estimated amounts to be received from participation in the State of California's FY 2011 Intergovernmental Transfer (IGT) Program, $180,000 per month and $1,080,000 for the six month ended December 31, 2010. As a result of the inclusion of all forty-six (46) California district hospitals in the fiscal year 2011 IGT program no additional accruals have been included since December 2010 as it is estimated that the amount accrued through December 31, 2010 will approximate the ultimate amount to be received in fiscal year 2011.

The graph on the following page shows the level of reimbursement that the Hospital has estimated for fiscal year 2011 by major payor category.



Total Operating Expenses

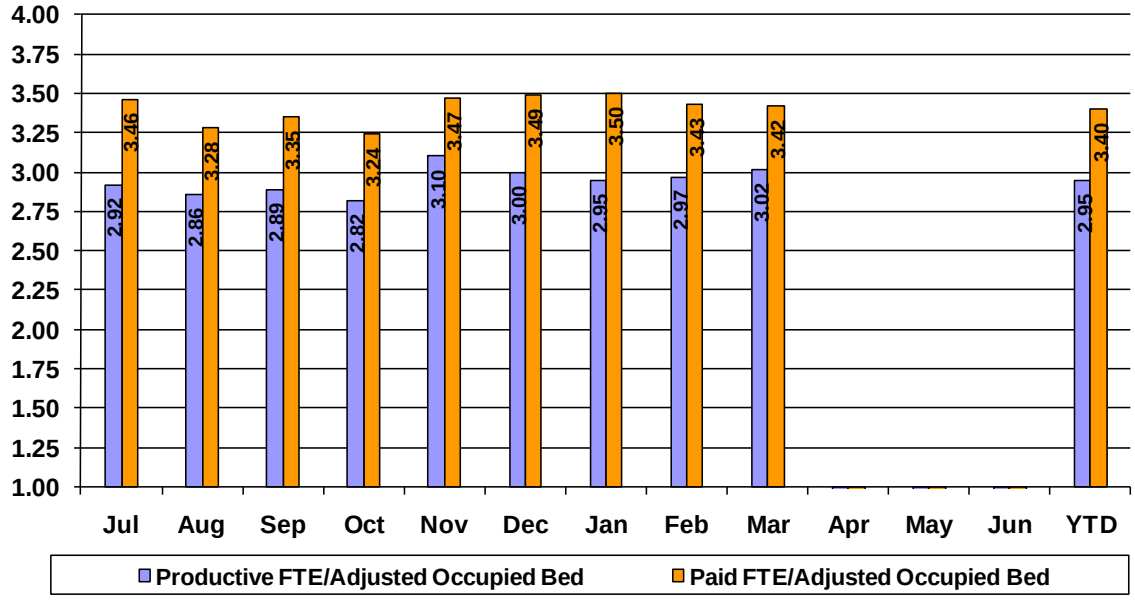
Total operating expenses were greater than the fixed budget by $148,000 or 2.5%. On an adjusted patient day basis, our cost per adjusted patient day was $1,517 which was $96 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in salaries benefit and registry costs of $99 per adjusted patient day. The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month as compared to budget and is followed by explanations of the significant areas of variance that were experienced in the current month.



Salary and Registry Expenses

Salary and registry costs combined were unfavorable to the fixed budget by $217,000 and were unfavorable to budgeted levels on a per adjusted patient day basis by $85 or 11.3%. This unfavorable variance was the result of unfavorable variances in salary costs of $125,000 and greater than budgeted registry utilization in several hospital departments of $92,000. On an adjusted occupied bed basis, productive FTE's were unfavorable to budget by 9.6% at 3.05 FTE's versus the budgeted 2.78 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month.

FTE's per Adjusted Occupied Bed



Benefits

Benefits were unfavorable to the fixed budget by $20,000 or 2.2% and $14 or 6.4% on an adjusted patient day basis. This unfavorable variance was the result of unfavorable variances in health benefit costs of $42,000, paid time off accruals $13,000 and payroll taxes of $11,000. These unfavorable variances were offset by favorable variances in workers compensation insurance of $25,000 and lower pension contributions of $20,000.

Supplies

Supplies were unfavorable to budget by $31,000 or $15 per adjusted patient day in March. This unfavorable variance was the result of greater than budgeted medical supplies expense of $22,000 which was comprised of unfavorable supply variances in surgery ($48,000) and radiology ($4,000). These were offset by a favorable supply variance in pharmaceuticals ($17,000). Non-medical supplies were unfavorable to budget by $9,000.

Rents and Leases

Rents and leases were $38,000 favorable to the fixed budget and $8 per adjusted patient day favorable to budget for the month of March. This favorable variance was primarily the result of lower than budgeted rental expense related to the PACS and Digital Radiology upgrade project ($31,000). This project will not be completed until the end of the fiscal year due to Office of Statewide Health Planning delays.

The following pages include the detailed financial statements for the nine (9) months ended March 31, 2011, of fiscal year 2011.

ALAMEDA HOSPITAL
KEY STATISTICS
MARCH 2011

	ACTUAL MARCH 2011	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	MARCH 2010	YTD MARCH 2011	YTD FIXED BUDGET	VARIANCE	%	YTD MARCH 2010
Discharges:										
Total Acute	233	254	(21)	-8.3%	264	1,882	2,146	(264)	-12.3%	2,169
Total Sub-Acute	2	2	-	0.0%	-	18	14	4	28.6%	11
Total Skilled Nursing	19	12	7	58.3%	9	79	110	(31)	-28.2%	96
	254	268	(14)	-5.2%	273	1,979	2,270	(291)	-12.8%	2,276
Patient Days:										
Total Acute	1,085	957	128	13.4%	941	8,074	8,084	(10)	-0.1%	8,127
Total Sub-Acute	1,032	1,039	(7)	-0.7%	1,054	8,946	9,179	(233)	-2.5%	9,127
Total Skilled Nursing	630	713	(83)	-11.6%	747	6,005	6,302	(297)	-4.7%	5,738
	2,747	2,709	38	1.4%	2,742	23,025	23,565	(540)	-2.3%	22,992
Average Length of Stay										
Total Acute	4.66	3.77	0.89	23.6%	3.56	4.29	3.77	0.52	13.9%	3.75
Average Daily Census										
Total Acute	35.00	30.87	4.27	13.8%	30.35	29.47	29.50	(0.04)	-0.1%	29.66
Total Sub-Acute	33.29	33.52	(0.23)	-0.7%	34.00	32.65	33.50	(0.85)	-2.5%	33.31
Total Skilled Nursing	20.32	23.00	(2.77)	-12.0%	24.10	21.92	23.00	(1.08)	-4.7%	20.94
	88.61	87.39	1.27	1.4%	88.45	84.03	86.00	(0.89)	-1.0%	83.91
Emergency Room Visits	1,461	1,519	(58)	-3.8%	1,466	12,640	13,429	(789)	-5.9%	13,390
Outpatient Registrations	2,197	2,496	(299)	-12.0%	2,650	17,881	19,982	(2,101)	-10.5%	23,078
Surgery Cases:										
Inpatient	47	51	(4)	-7.8%	64	401	450	(49)	-10.9%	541
Outpatient	139	131	8	6.1%	459	1,244	1,270	(26)	-2.0%	3,838
	186	182	4	2.2%	523	1,645	1,720	(75)	-4.4%	4,379
Kaiser Inpatient Cases	-	-	-	-	13	-	-	-	-	91
Kaiser Eye Cases	-	-	-	-	194	-	-	-	-	1,461
Kaiser Outpatient Cases	-	-	-	-	160	-	-	-	-	1,417
Total Kaiser Cases	-	-	-	-	367	-	-	-	-	2,969
% Kaiser Cases	0.0%	0.0%			70.2%	0.0%	0.0%			67.8%
Adjusted Occupied Bed	126.87	133.53	6.66	5.0%	154.55	124.69	129.88	(5.19)	-4.0%	146.79
Productive FTE	386.79	371.53	(15.26)	-4.1%	401.84	368.67	367.57	(1.10)	-0.3%	393.41
Total FTE	438.55	422.48	(16.07)	-3.8%	449.52	425.48	418.24	(7.24)	-1.7%	449.12
Productive FTE/Adj. Occ. Bed	3.05	2.78	(0.27)	-9.6%	2.60	2.96	2.83	(0.13)	-4.5%	2.68
Total FTE/ Adj. Occ. Bed	3.46	3.16	(0.29)	-9.3%	2.91	3.41	3.22	(0.19)	-6.0%	3.06

City of Alameda Health Care District
Statements of Financial Position
March 31, 2011

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 1,756,993	$ 721,546	$ 3,480,668
Patient Accounts Receivable, net	10,092,275	10,520,865	9,558,147
Other Receivables	4,406,065	4,349,139	6,654,035
Third-Party Payer Settlement Receivables	581,670	683,455	374,557
Inventories	1,158,531	1,155,112	1,149,706
Prepaids and Other	393,075	674,119	453,872
Total Current Assets	18,388,609	18,104,236	21,670,985
Assets Limited as to Use, net	567,899	558,398	476,630
Property, Plant and Equipment, net	7,813,368	7,660,831	6,993,735
Total Assets	**$ 26,769,876**	**$ 26,323,465**	**$ 29,141,350**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 416,000	$ 416,000	$ 450,831
Accounts Payable and Accrued Expenses	6,948,676	7,434,886	6,112,296
Payroll Related Accruals	5,109,484	4,829,367	4,351,133
Deferred Revenue	1,434,503	1,912,349	5,736,951
Employee Health Related Accruals	554,371	562,840	645,750
Third-Party Payer Settlement Payable	357,474	290,000	500,000
Total Current Liabilities	14,820,508	15,445,442	17,796,961
Long Term Debt, net	931,024	967,720	1,236,831
Total Liabilities	15,751,532	16,413,162	19,033,792
Net Assets:			
Unrestricted	10,322,869	9,224,329	9,560,928
Temporarily Restricted	695,475	685,974	546,630
Total Net Assets	11,018,344	9,910,303	10,107,558
Total Liabilities and Net Assets	**$ 26,769,876**	**$ 26,323,465**	**$ 29,141,350**

City of Alameda Health Care District

Statements of Operations

March 31, 2011

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,747	2,709	38	1.4%	2,742	23,025	23,565	(540)	-2.3%	22,992
Discharges	254	268	(14)	-5.2%	273	1,979	2,268	(289)	-12.7%	2,275
ALOS (Average Length of Stay)	10.81	10.11	0.71	7.0%	10.04	11.63	10.39	1.24	12.0%	10.11
ADC (Average Daily Census)	88.6	87.4	1.23	1.4%	88.5	84	86.0	(1.97)	-2.3%	83.9
CMI (Case Mix Index)	1.4546				1.3156	1.3734				1.3193
Revenues										
Gross Inpatient Revenues	$ 16,162	$ 14,728	$ 1,434	9.7%	$ 14,911	$ 126,322	$ 126,973	$ (650)	-0.5%	$ 125,814
Gross Outpatient Revenues	7,206	7,750	(543)	-7.0%	11,161	61,083	64,544	(3,461)	-5.4%	94,219
Total Gross Revenues	23,368	22,478	890	4.0%	26,072	187,405	191,517	(4,111)	-2.1%	220,033
Contractual Deductions	17,161	16,224	(937)	-5.8%	19,931	134,157	137,722	3,564	2.6%	163,950
Bad Debts	891	663	(228)	-34.3%	461	5,845	5,716	(128)	-2.2%	4,820
Charity and Other Adjustments	190	166	(24)	-14.5%	103	1,447	1,429	(17)	-1.2%	527
Net Patient Revenues	5,127	5,425	(298)	-5.5%	5,577	45,957	46,649	(693)	-1.5%	50,736
Net Patient Revenue %	21.9%	24.1%			21.4%	24.5%	24.4%			23.1%
Net Clinic Revenue	45	28	17	61.8%	14	303	251	52	20.6%	95
Other Operating Revenue	10	14	(4)	-28.2%	49	91	125	(33)	-26.8%	420
Net Assets Released	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**5,182**	**5,467**	**(285)**	-5.2%	**5,640**	**46,351**	**47,025**	**(674)**	-1.4%	**51,251**
Expenses										
Salaries	3,048	2,923	(125)	-4.3%	3,163	26,756	25,424	(1,333)	-5.2%	28,505
Registry	271	179	(92)	-51.2%	203	1,876	1,547	(329)	-21.2%	1,551
Benefits	948	928	(20)	-2.2%	895	7,255	7,985	730	9.1%	8,526
Professional Fees	342	367	25	6.7%	332	2,715	2,946	231	7.9%	2,687
Supplies	744	713	(31)	-4.3%	802	6,589	6,293	(296)	-4.7%	7,687
Purchased Services	369	394	25	6.3%	399	3,331	3,492	161	4.6%	3,483
Rents and Leases	74	111	38	33.8%	82	618	744	126	16.9%	618
Utilities and Telephone	64	73	9	12.9%	65	566	646	80	12.4%	637
Insurance	31	36	5	12.9%	47	285	323	37	11.6%	400
Depreciation and amortization	77	74	(3)	-4.5%	79	719	658	(61)	-9.3%	895
Other Opertaing Expenses	58	79	21	26.9%	47	763	737	(27)	-3.6%	730
Total Expenses	**6,026**	**5,878**	**(148)**	-2.5%	**6,114**	**51,472**	**50,794**	**(678)**	-1.3%	**55,719**
Operating gain (loss)	**(844)**	**(411)**	**(433)**	-105.4%	**(474)**	**(5,122)**	**(3,769)**	**(1,353)**	35.9%	**(4,468)**
Non-Operating Income / (Expense)										
Parcel Taxes	479	479	(1)	-0.1%	477	4,307	4,316	(9)	-0.2%	4,314
Investment Income	0	-	0	0.0%	7	9	-	9	0.0%	20
Interest Expense	(9)	(8)	(1)	-11.0%	(8)	(80)	(100)	20	-20.3%	(76)
Other Income / (Expense)	1,473	22	1,451	6540.7%	23	1,648	200	1,449	725.6%	205
Net Non-Operating Income / (Expense)	**1,943**	**493**	**1,450**	**293.9%**	**499**	**5,884**	**4,415**	**1,468**	**33.3%**	**4,463**
Excess of Revenues Over Expenses	**$ 1,099**	**$ 82**	**$ 1,016**	**1238.3%**	**$ 26**	**$ 762**	**$ 646**	**$ 116**	**17.9%**	**$ (5)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

March 31, 2011

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 4,069	$ 3,562	$ 507	14.2%	$ 3,110	$ 3,698	$ 3,572	$ 126	3.5%	$ 3,129
Gross Outpatient Revenues	1,814	1,874	(60)	-3.2%	2,328	1,788	1,816	(28)	-1.5%	2,343
Total Gross Revenues	5,883	5,437	447	8.2%	5,438	5,486	5,388	98	1.8%	5,472
Contractual Deductions	4,321	3,924	(397)	-10.1%	4,157	3,927	3,875	(53)	-1.4%	4,077
Bad Debts	224	160	(64)	-39.8%	96	171	161	(10)	-6.4%	120
Charity and Other Adjustments	48	40	(8)	-19.2%	21	42	40	(2)	-5.3%	13
Net Patient Revenues	1,291	1,312	(21)	-1.6%	1,163	1,345	1,312	33	2.5%	1,262
Net Patient Revenue %	21.9%	24.1%			21.4%	24.5%	24.4%			23.1%
Net Clinic Revenue	11	7	5	68.4%	3	9	7	2	25.5%	2
Other Operating Revenue	3	3	(1)	-25.2%	10	3	4	(1)	-23.9%	10
Total Revenues	**1,305**	**1,322**	**(18)**	-1.3%	**1,176**	**1,357**	**1,323**	**34**	2.6%	**1,275**
Expenses										
Salaries	767	707	(60)	-8.5%	660	783	715	(68)	-9.5%	709
Registry	68	43	(25)	-57.4%	42	55	44	(11)	-26.1%	39
Benefits	239	225	(14)	-6.4%	187	212	225	12	5.5%	212
Professional Fees	86	89	3	2.9%	69	79	83	3	4.1%	67
Supplies	187	173	(15)	-8.6%	167	193	177	(16)	-8.9%	191
Purchased Services	93	95	2	2.5%	83	98	98	1	0.7%	87
Rents and Leases	19	27	8	31.1%	17	18	21	3	13.6%	15
Utilities and Telephone	16	18	2	9.3%	14	17	18	2	8.9%	16
Insurance	8	9	1	9.3%	10	8	9	1	8.0%	10
Depreciation and Amortization	19	18	(2)	-8.8%	16	21	19	(3)	-13.8%	22
Other Operating Expenses	15	19	5	23.9%	10	22	21	(2)	-7.8%	18
Total Expenses	**1,517**	**1,422**	**(96)**	-6.7%	**1,275**	**1,507**	**1,429**	**(78)**	-5.4%	**1,386**
Operating Gain / (Loss)	**(213)**	**(99)**	**(113)**	-113.8%	**(99)**	**(150)**	**(106)**	**(44)**	41.5%	**(111)**
Non-Operating Income / (Expense)										
Parcel Taxes	121	116	5	4.0%	100	126	121	5	3.8%	107
Investment Income	0	-	0	0.0%	2	0	-	0	0.0%	1
Interest Expense	(2)	(2)	(0)	-15.6%	(2)	(2)	(3)	0	-17.1%	(2)
Other Income / (Expense)	371	5	366	6812.5%	5	48	6	43	759.1%	5
Net Non-Operating Income / (Expense)	**489**	**119**	**370**	**310.1%**	**104**	**172**	**124**	**48**	**38.7%**	**111**
Excess of Revenues Over Expenses	**$ 277**	**$ 20**	**$ 257**	1293.1%	**$ 5**	**$ 23**	**$ 18**	**$ 4**	22.4%	**$ 0**

City of Alameda Health Care District
Statement of Cash Flows
For the Nine Months Ended March 31, 2011

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ 1,098,540	$ 761,942
Items not requiring the use of cash:		
Depreciation and amortization	76,866	$ 719,149
Write-off of Kaiser liability	(1,451,597)	$ (1,451,597)
Changes in certain assets and liabilities:		
Patient accounts receivable, net	428,590	(534,128)
Other Receivables	(56,926)	2,247,970
Third-Party Payer Settlements Receivable	169,259	(349,639)
Inventories	(3,419)	(8,825)
Prepaids and Other	281,044	60,797
Accounts payable and accrued liabilities	965,387	2,287,977
Payroll Related Accruals	280,117	758,351
Employee Health Plan Accruals	(8,469)	(91,379)
Deferred Revenues	(477,846)	(4,302,448)
Cash provided by (used in) operating activities	1,301,546	98,170
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(9,501)	(91,269)
Additions to Property, Plant and Equipment	(229,403)	(1,538,782)
Other	-	(1)
Cash provided by (used in) investing activities	(238,904)	(1,630,052)
Cash flows from financing activities		
Net Change in Long-Term Debt	(36,696)	(340,638)
Net Change in Restricted Funds	9,501	148,845
Cash provided by (used in) financing and fundraising activities	(27,195)	(191,793)
Net increase (decrease) in cash and cash equivalents	1,035,447	(1,723,675)
Cash and cash equivalents at beginning of period	721,546	3,480,668
Cash and cash equivalents at end of period	$ 1,756,993	$ 1,756,993

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 9, 2011

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

FROM: Kerry Easthope, Associate Administrator
Phyllis Weiss, Director, Human Resources Dept.

SUBJECT: Tentative Settlement with ILWU, Local #6
Surgical Techs (newly incorporated into this agreement)
Wage Opener dated December 31, 2010

Recommendation:

It is the recommendation of Administration that the Board of Director's approve the Tentative Agreements reached with ILWU, Local #6 as a result of:

A. the Surgical Techs being incorporated into this Agreement and,

B. the "Wage Opener" scheduled for 12/31/10 for the balance of the bargaining unit members (Radiology Techs, Ultrasound Techs, Mammography Techs, Nuclear Med Tech, Radiology Aides and Radiology Receptionist).

We received notification from ILWU, Local #6 that the bargaining unit ratified the Tentative Agreements on April 14, 2011.

Background:

This unit historically included the Radiology Techs only.

In the Master Agreement covering the period from July 1, 2009 – June 30, 2013, the Radiology Aides and Radiology Receptionist were included. This Master Agreement was previously approved by the Board of Directors.

Then in December 2010, the Surgical Techs voted to become members of this bargaining unit. Negotiations for the wages, hours and working conditions for this classification of employee have been ongoing since that date and concluded on March 15, 2011.

Discussion:

A. Inclusion of the Surgical Techs into the bargaining unit:

The Hospital and the Union reached an agreement to establish a wage scale for the Surgical Techs at the low to mid-point of Hospital's in the area. In addition, the new wage scale created some equity adjustment based upon years of experience.

This resulted in very minor increases for the four (4) Surgical Techs with an annual impact under $3,000. The balance of the Tentative Agreements all relate to adding this classification title to existing sections of the current master agreement.

The only additional financial impact of this agreement was to increase the Surgical Techs in the Stand-by and Call-Back provisions of the current Agreement so that there was more uniformity in payment which again amounted to an annual financial impact of under $3,000.

B. Wage Opener 12/31/10:

The Hospital and the Union reached an agreement that, due to the financial condition of the Hospital, there would be no general wage increase in response to the December 31, 2010 wage opener.

The one exception is that the Hospital and the Union reached an agreement to extend a $100.00/month stipend payment to the current, Per Diem, Nuclear Med Tech in consideration for the duties performed as the Radiation Safety Officer for the Hospital.

Note: There are two more "openers" in this contract scheduled for June 30, 2011 and June 30, 2012 that will include both Wages and Group Health Benefits.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 9, 2011

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

THROUGH: Finance and Management Committee

FROM: David A. Neapolitan, Chief Financial Officer

SUBJECT: Approval of FY 2011 Auditor Engagement

Recommendation:

The Finance and Management Committee and Executive Management recommend that the City of Alameda Health Care District Board of Directors approve the engagement letter of TCA Partners, LLP to provide audit services for the fiscal year ending June 30, 2011.

Background:

TCA Partners, LLP was selected to conduct the annual financial statement audit for the City of Alameda Health Care District beginning with the 2008 fiscal year. At that time in addition to TCA Partners, LLP, we considered the audit services of Stonefield Josephson, Inc. and Thomas Camp, CPA. Mr. Camp had been the Hospitals auditor for the prior three (3) fiscal years.

After evaluating each firms experience in the auditing field, their knowledge of the hospital district environment, their approach to working with their clients and the cost of their respective services, management recommended that the District award the FY 2008 audit engagement to TCA Partners, LLP.

TCA Partners, LLP

A Certified Public Accountancy Limited Liability Partnership
1111 East Herndon Avenue, Suite 211, Fresno, California 93720
Voice: (559) 431-7708 Fax: (559) 431-7685 Email: rjctcpa@aol.com

March 30, 2011

David Neopolitan, CFO
City of Alameda Health Care District
2070 Clinton Avenue
Alameda, CA 94501

RE: City of Alameda Health Care District Audit Engagement for June 30, 2011

We are pleased to confirm our understanding of the services we are to provide for the City of Alameda Health Care District (the Hospital) for the year ended June 30, 2011. We will audit the balance sheet of the City of Alameda Health Care District as of June 30, 2011 and the related statements of revenues, expenses and changes in net assets, and cash flows for the year then ended.

Our audit will be made in accordance with U.S. generally accepted auditing standards and will include tests of the accounting records of the Hospital and other procedures we consider necessary to enable us to express an unqualified opinion that the financial statements are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. If our opinion is other than unqualified, we will fully discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit, we will not issue a report as a result of the respective year and engagement.

Our procedures will include tests of documentary evidence that support the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of cash, investments, and certain other assets and liabilities by correspondence with customers, creditors, and financial institutions. Also, we will request written representations from your attorneys as part of the engagement, and they may bill you for responding to that inquiry. At the conclusion of our audit, we will also request certain written representations from you about the financial statements and related matters.

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Our audit is designed to provide reasonable, not absolute, assurance about whether the financial statements are free of material misstatement, whether due to

error, fraudulent financial reporting, misappropriation of assets, or violations of laws or governmental regulations. Because of this concept of reasonable assurance and because we will not examine all transactions, there is a risk that material misstatements may exist and may not be detected by us. The Hospital's management is responsible for establishing and maintaining a sound system of internal controls, which is the best means of preventing or detecting errors, fraudulent financial reporting, misappropriation of assets, or violations of laws or governmental regulations. Our responsibility as auditors is limited to the period covered by our audit and does not extend to matters that might arise during any later periods for which we are not engaged as auditors.

Our audit is not specifically designed to provide assurance on internal controls and cannot be relied on to disclose reporting conditions; that is, significant deficiencies in the design or operation of the internal controls. However, during the audit, if we become aware of such reportable conditions or ways that we believe management practices can be improved, we will communicate them to you in a separate letter.

We understand that you will provide us with the basic information required for our audit and that you are responsible for the accuracy and completeness of that information. We will advise you about appropriate accounting principles and their application and will assist in the preparation of your financial statements, but the responsibility for the financial statements remains with you. This management responsibility includes: (a) establishing and maintaining adequate records and related internal control policies and procedures, (b) selecting and applying accounting principles, (c) safeguarding assets, and (d) identifying and ensuring that the entity complies with applicable laws and regulations applicable to its activities.

Management is also responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements, resulting from errors or fraud, aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. In addition, management is responsible for: (a) the design and implementation of programs and controls to prevent and detect fraud, (b) for informing us about any fraud or suspected fraud affecting the entity involving management, employees who have significant roles in internal control, or others where the fraud could have a material effect on the financial statements, and (c) for informing us about allegations of fraud or suspected fraud affecting the entity received in communications from employees, former employees, analysts, regulators, short sellers, or others.

We understand that your employees will locate any documents or invoices selected by us for testing.

If you intend to publish or otherwise reproduce the financial statements and make reference to our firm, you agree to provide us with printers' proofs or masters for our review and approval before printing. You also agree to provide us with a copy of the final reproduced material for our approval before it is distributed.

The timing of our audit may be scheduled for performance for the year and completion as follows:

	Begin	***Complete***
Document internal controls and preliminary tests	May	June
Mail confirmations	June	June
Perform year-end audit procedures	July	August
Issue audit report	September	September

Our fees are based on the amount of time required at various levels of responsibility, plus actual out-of-pocket expenses. Invoices will be rendered periodically and are payable upon presentation. Based upon the proposal accepted, our fees for the June 30, 2011 audit will be $32,000. All travel and out-of-pocket expenses, estimated at $4,500 for the June 30, 2011 audit, will be billed separately.

We will notify you immediately of any circumstances we encounter that could significantly affect these fees. Whenever possible, we will attempt to use the Hospital's personnel to assist in the preparation of schedules and analyses of accounts. This effort helps to reduce time requirements and facilitate the timely conclusion of the audit.

During the course of the audit we may observe opportunities for economy in, or improved controls over, your operations. We will bring such matters to the attention of appropriate level of management, either orally or in writing.

If the foregoing is in accordance with your understanding, please indicate your agreement by signing the final page of this letter and returning it to us. If you have any questions, please let us know.

We appreciate the opportunity to be your certified public accountants and look forward to working with you and your staff.

Very truly yours,

TCA Partners, LLP

TCA Partners, LLP

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RESPONSE:

This letter correctly sets forth the understanding of the City of Alameda Health Care District.

Approved by:_____

Title:_____

Date:_____

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 9, 2011

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

Through: Community Relations and Outreach Committee

From: Stewart Chen, DC, Committee Co-Chair / District Board Member
Terrie Kurrasch, Committee Co-Chair

Subject: Approval of the Revisions to the Community Relations and Outreach Committee Structure and Purpose

---

Recommendation:

To approve the revisions to the standing committee structure as outlined below.

STRUCTURE AND PURPOSE:

1. Community Relations Committee:

    a. Primary Purpose: The primary purpose of the Community Relations Committee is to develop a community engagement and outreach plan that supports the hospital's strategic plan and annual goals. The Committee advises the board on strategies and programs to enhance health care services to the community, increase the district's (hospital's) market share, effectively position the hospital for success based on information flow with the community and elected officials and support the fund-raising objectives of the Alameda Hospital Foundation.

    b. Committee Composition and Voting Rights: The committee shall be comprised of the following members:

        i. At least two members of the City of Alameda Health Care District Board of Directors all of whom shall be voting members of the committee. One of these members also shall be appointed to serve as the committee co-chair. The other co-chair will be an at large member from the community who will be elected each year.

        ~~i.~~ii. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-noting member, unless the President is serving as a voting member of the committee.

~~ii.~~iii. Up to three members of the Alameda Hospital Medical Staff all of whom shall be voting members of the committee.

~~iii.~~iv. Up to eleven at large members chosen for expertise needed by the district all of whom shall be voting members of the committee. At least one member at large shall also be a member of the Alameda Hospital Foundation Board.

~~iv.~~v. The City of Alameda Health Care District Chief Executive Officer, and other hospital management as delegated, who shall not be voting members of the committee.

~~v.~~vi. The Executive Director of the Alameda Hospital Foundation and the Director of Community Relations shall serve as staff to the Committee and collaborate with the Committee co-chairs on the preparation of agenda.

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: The committee shall meet at least quarterly.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 9, 2011

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

From: James Yeh, D.O.
President, Medical Staff

Re: Approval of New Procedure: Minimally Invasive Lumbar Decompression (MILD®) Procedure

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RECOMMENDATION:

The Medical Executive Committee respectfully requests your approval to add the *MILD®* procedure to the procedures approved to be performed at Alameda Hospital. The request to add this procedure has been reviewed and approved by members of the Surgery Committee and the Medical Executive Committee.

BACKGROUND:

The *Mild®* procedure offers a low risk treatment for patients who suffer with pain from lumbar spinal stenosis (LSS). LSS results from the gradual degeneration of the bones, discs, muscles and ligaments that make up the spine. The condition is characterized by compression of either the spinal cord in the neck or the spinal nerve roots in the lower back. The most common symptoms of LSS include leg pain, weakness, and tingling or numbness that radiate from the lower back down through the legs.

Treatment for LSS includes exercise, pain medications, activity modification and epidural steroid injections. The decision to have surgery for LSS depends on the degree of physical disability and disabling pain. Patients who have stopped responding to pain medications and other conservative treatments will often consider surgery such as a laminectomy or spinal fusion.

The *MILD®* procedure is performed under fluoroscopic guidance in an outpatient setting under local anesthesia or moderate sedation. The procedure is minimally invasive and usually takes less than one hour. The incision is approximately the diameter of a pencil into which the surgeon will insert a special device to remove small pieces of bone and the tissue causing the pressure on the nerves.

The Finance Department performed an analysis of the cost and reimbursement to the hospital. Based on the analysis, the procedure projects a positive reimbursement.

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Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 9, 2011

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

THROUGH: Finance and Management Committee

FROM: David A. Neapolitan, Chief Financial Officer

SUBJECT: Approval of Bank of Alameda Modifications of the Terms and Conditions of the Line of Credit and Construction Loan for the Wound Care Program

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Recommendation:

The Finance and Management Committee and Executive Management recommend that the City of Alameda Health Care District Board of Directors approve the Bank of Alameda's modifications to the terms and conditions of the proposed line of credit agreement and the proposed construction loan to fund the development of the Hospitals Wound Care Center at Marina Village.

Additionally, Executive Management is requesting that the District's Chief Executive Officer and Chief Financial Officer are authorized to execute the final agreements on behalf of the District.

Background:

On March 9, 2011 the City of Alameda Health Care Board of Directors approved management to enter into loan agreements with the Bank of Alameda to renew an existing line of credit and a new $900,000 construction and equipment loan to provide financing for the construction and equipping of a Wound Care Center in Marina Village.

The terms of these loans as originally presented included the following:

Specific Terms	Wound Care Center Construction Loan	Revolving Line of Credit (RLOC)
Rate	During the construction period (up to 1 year), interest only at Prime + 1% with a minimum rate of 5.5%. At construction completion conversion to a fixed rate based upon the then current Prime Rate + 1% with a minimum rate of 5.5%.	Variable rate of Prime + 1% with a minimum rate of 5.5%.

Term	Up to a one (1) year draw period or until construction is complete, whichever is sooner. Upon completion the outstanding balance converts to a fixed five (5) year term loan.	Line of credit available through February 2012.
Payments	During the construction period interest only payments. Upon completion equal installments of principal and interest until loan is paid in full.	Interest only during term with outstanding principal balance due prior to expiration of the line of credit.
Covenants & Conditions	1. Borrower to submit: a. Annual CPA audited financial statements within 120 days of fiscal year end. b. Annual company prepared financial statements due within 180 days of fiscal year end. c. Quarterly company prepared financial statements due within 60 days of quarter ends. d. Company prepared receivables and payables reports due within 60 days of fiscal year end. e. Company prepared receivables and payables reports due within 60 days of quarter ends. f. Company prepared budgeted financials for succeeding years due within 60 days of fiscal year end. 2. Compliance with the following covenants: a. Proforma Debt Service Coverage Ratio (DSCR) Test per occurrence of 1.75:1.00 b. Minimum actual DSCR (quarterly) of 1.00:1.00 c. Minimum Actual DSCR (annually) of 1.20:1.00 d. Minimum Actual Net Income (annually) of $1.00. e. RLOC includes 30 day out of debt provision. 3. Negative Pledge at all times. 4. Borrower must maintain primary operating accounts with the Bank of Alameda.	

	5. For any new additional indebtedness that exceeds $1 million (per occurrence) that the Borrower wishes to incur after closing, Borrower must demonstrate to the Bank a proforma DSCR of 1.75x based on the proforma indebtedness (existing and new) for the succeeding rolling four (4) quarters and actual total cash flow for the latest historical rolling four (4) quarters. 6. Security interest in the Accounts Receivable and other assets that do not already have an existing security interest.

Subsequent to the Boards approval the Bank reviewed an attorney opinion letter prepared by the District's legal counsel, Thomas Driscoll, related to the banks concern about its security interest in the District's annual parcel taxes as security for these loans. As a result of this review the Bank identified two areas that required modification to the loan agreements in order for the Bank to perfect its security interest in the parcel taxes in the event of a default on the loan(s). These modifications included:

1. A specific reference to the banks security interest in the annual parcel tax receivables for both of these debt instruments.

2. The total term of the construction period loan and the related term loan could not exceed a five (5) year total term.

As a result the terms of these loans will be modified (changes identified in red) in order to finalize these loans with the Bank of Alameda.

Specific Terms	**Wound Care Center Construction Loan**	**Revolving Line of Credit (RLOC)**
Rate	During the construction period (up to 1 year), interest only at Prime + 1% with a minimum rate of 5.5%. At construction completion conversion to a fixed rate based upon the then current Prime Rate + 1% with a minimum rate of 5.5%.	Variable rate of Prime + 1% with a minimum rate of 5.5%.
Term	Up to a one (1) year draw period or until construction is complete, whichever is	Line of credit available through February 2012.

Specific Terms	Wound Care Center Construction Loan	Revolving Line of Credit (RLOC)
	sooner. Upon completion the outstanding balance converts to a fixed ~~five (5) year~~ term loan **that does not exceed a total of five (5) years including the construction period loan**.	
Payments	During the construction period interest only payments. Upon completion equal installments **based on a five (5) year amortization** of principal and interest **paid over a four (4) term** ~~until loan is paid in full~~ **with the balance due in a balloon payment at the end of the fourth year.**	Interest only during term with outstanding principal balance due prior to expiration of the line of credit.
Covenants & Conditions	1. Borrower to submit: a. Annual CPA audited financial statements within 120 days of fiscal year end. b. Annual company prepared financial statements due within 180 days of fiscal year end. c. Quarterly company prepared financial statements due within 60 days of quarter ends. d. Company prepared receivables and payables reports due within 60 days of fiscal year end. e. Company prepared receivables and payables reports due within 60 days of quarter ends. f. Company prepared budgeted financials for succeeding years due within 60 days of fiscal year end. 2. Compliance with the following covenants: a. Proforma Debt Service Coverage Ratio (DSCR) Test per occurrence of 1.75:1.00	

Specific Terms	Wound Care Center Construction Loan	Revolving Line of Credit (RLOC)
	b. Minimum actual DSCR (quarterly) of 1.00:1.00 c. Minimum Actual DSCR (annually) of 1.20:1.00 d. Minimum Actual Net Income (annually) of $1.00. e. RLOC includes 30 day out of debt provision. 3. Negative Pledge at all times. 4. Borrower must maintain primary operating accounts with the Bank of Alameda. 5. For any new additional indebtedness that exceeds $1 million (per occurrence) that the Borrower wishes to incur after closing, Borrower must demonstrate to the Bank a proforma DSCR of 1.75x based on the proforma indebtedness (existing and new) for the succeeding rolling four (4) quarters and actual total cash flow for the latest historical rolling four (4) quarters. 6. Security interest in the Accounts Receivable **including the annual parcel tax revenues** and other assets that do not already have an existing security interest.	

May 9, 2011

City of Alameda Health Care District

2009-2013 Goals and Objectives

FYE 2012 Update

Financial Strength	
Achieve long-term financial viability	
Measures of success:	
■ Achievement of positive operating margin = 3% of net revenues by 2013	
■ Generate operating profitability levels necessary to support capital needs/service debt	
■ Raise $500,000 per year through Foundation fundraising initiatives	
■ Shift reliance on parcel tax from support of operations to support for capital investments and strategic development projects	
■ Sustain Performance vis-à-vis operating benchmarks at 90th percentile levels (e.g., FTE/Adj. Occupied Bed, Length of Stay, Costs per UOS)	
Initiatives	**Status**
(A) STRATEGY: Seek $250,000 contribution from Alameda County to assist with capital improvements of clinic space at Marina Village designed to serve low income patients	
(B) STRATEGY: Seek $1 million from Alameda County to underwrite uncompensated care delivered in Alameda Hospital Emergency Department	
(C) STRATEGY: Improve Revenue Cycle Metrics	
1. Reduce Gross Days in Accounts Receivable, excluding unbilled by 5% to 47.1 days from the current 49.6 days (4th Qtr HARA Report indicated the National Average at 49.4 days).	
2. Reduce volume of late charges as a percentage of gross charges (posted after bill drop) by 10%. (Current baseline: 0.9% for the last 4 months)	
3. Increase percentage of AR less 60 days to 65% from current 60%	
4. Achieve Reimbursement in compliance with contract terms to ____% (TBD)	
5. Reduce percentage of self pay to ____% (TBD)	
(D) STRATEGY: Improve aggregate HCAHPS scores (willingness to recommend) to 66%	
(E) STRATEGY: Reduce readmission rates from 29% to 26% by the end of FY 2012	
(F) STRATEGY: Convert 30% of Observation patients to inpatient status with assistance of Executive Healthcare Resources	

Growth	
Pursue fiscally responsible growth in services that target the most pressing acute and non-acute healthcare needs of the community.	
Measures of success:	
■ Market share growth. ■ From 31.25 percent to 35.0 percent – Alameda Island (ZIP Codes 94501 and 94502). ■ From 0.94 percent to 1.10 percent - Off-Island.	
■ Service line growth: volume targets defined by service line.	
■ Development of new access points and locations.	
■ Increase inpatient census by 5 ADC by 2013 to offset loss of Kaiser revenue and to support basic INP/ER infrastructure.	
Initiatives	**Status**
(A) STRATEGY: Secure partnership with one additional long-term care facility within the District	
(B) STRATEGY: Complete implementation of Wound Care Program, achieving volumes (IP and OP) services as projected in pro forma	
1. For 6 months of FY 2012: 125 patients, 1,250 patient visits, $26,000 Net Income	
(C) STRATEGY: Implement one new surgical program reflecting an integrated continuum of services from pre-surgical to post surgical care. Programs to be considered include orthopedics and plastic surgery. This should contribute to the 5 % increase in surgeries.	
(D) STRATEGY: Increase selective higher outpatient services by the following:	
1. Diagnostic Imaging – 2% Increase	
2. Therapy: 5% Increase	
3. Surgery: 5% Increase	
(E) STRATEGY: Increase admissions from nursing homes from 22% (baseline) to 24% through improved transfer systems and quarterly communication with nursing home leadership	

Facilities and Technology	
Enhance our facility and technological capabilities to foster the achievement of our goals.	
Measures of success:	
■ Percentage of physicians who sign up for electronic access.	
■ Volume of hits to hospital website.	
■ Fund depreciation to TBD% in order to create capital reserve fund .	
Initiatives	Status
(A) STRATEGY: Develop master plan for Marina Village Space	
(B) STRATEGY: Improve HCAHPS scores for cleanliness of facility to 67.5% (quarterly average)	
(C) STRATEGY: Improve signage and way-finding systems in the following areas to improve image and reduce traffic through inpatient areas.	
1. South Shore Skilled Nursing Unit	
2. Alameda Towne Centre Medical Office Building	
3. East Building (Clinton and Doctor's parking lot entrance)	
(D) STRATEGY: Implement ECHO System upgrade	
(E) STRATEGY: Finalize scope and budget for implementation of required NPC-2 work. Meet reporting milestones for seismic extension provided by SB90	
(F) STRATEGY: Evaluate all Meditech modules which are currently being underutilized (ESS, PCS, EDM)	
(G) STRATEGY: Evaluate formation of a dedicated surgical inpatient unit as mechanism to enhance quality of patient care and to increase surgical volume	
(H) STRATEGY: Explore use of Hospital website for improved patient accessibility and access to information, including online registration and appointment scheduling.	

Physicians	
Ensure that the Hospital attracts qualified and capable physicians through collaboration and alignment.	
Measures of success:	
■ Increase number and reduce average age of active physicians through targeted recruitment.	
■ Achieve annual recruitment goals.	
■ Increase volume of work by Alameda surgeons.	
Initiatives	**Status**
(A) STRATEGY: Continue to strengthen partnerships with key physician groups (Affinity, ABMG, Hill, AFP) to secure referral patterns, improve patient management, and coordinate approach to health plans.	
1. Enhanced use of long term care placement to reduce acute care utilization	
2. Coordinated management of patients with chronic disease (e.g. CHF, Diabetes)	
3. Quarterly meetings	
(B) STRATEGY: Complete an inventory of physician practice based information systems and establish plan for gradual implementation of connectivity with MediTech system	
(C) STRATEGY: Establish data collection system for tracking admission and referral patterns by physician and/or institution (e.g. SNF's) or point of entry (e.g. Emergency Department	
(D) STRATEGY: Track utilization under new contracts (e.g. Alameda Alliance, Medi-Cal, Blue and Gold Plan, etc)	
(E) STRATEGY: Complete first physician satisfaction survey by 4th quarter of FY 2012	
(F) STRATEGY: Maintain regular contact with East Bay physicians who are seeking practice setting alternatives other than those offered by existing large multispecialty groups.	
(G) STRATEGY: Complete evaluation of outsourcing management of 1206 (B) clinic to practice management company	

Quality/Service	
Achieve superior clinical and service results on a consistent basis.	
Measures of success:	
■ Patient satisfaction (patient experience) as measured by 95% or more willing to recommend hospital to a friend	
■ Joint Commission Core Measure compliance	
■ Joint Commission/CMS/CDPH Accreditation	
■ QI/Risk Reports that demonstrate improvement in problem areas	
■ Improve accuracy of information collection at time of registration	
Initiatives	**Status**
(A) STRATEGY: Improve aggregate HCAHPS scores (willingness to recommend) to 66%. Current baseline:	
(B) STRATEGY: Redesign hospital website functionality as portal for patient service	
1. Evaluate on-line registration and appointment scheduling	
2. Add testimonials from patients and physicians	
3. Report key quality data on website	
4. Add key educational and instructional material for patients discharged or treated as outpatients	
(C) STRATEGY: Improve HCAHPS scores for cleanliness and noise and communication by 10%.	
(D) STRATEGY: All Core Measure scores above the 90th percentile	
(E) STRATEGY: Provide additional resources to patients upon discharge to raise awareness of hospital as broad health resource (e.g. Vial of Life, battery operated or crank radio or flash light, etc.)	
(F) STRATEGY: Complete The Joint Commission (TJC) certification process for Primary Stroke Program	
(G) STRATEGY: Implement childhood obesity prevention program in conjunction with schools (Let's Move Alameda)	

People	
Foster a culture of exemplary performance through recruitment and retention practices that are founded on adherence to core performance standards and the continual development and celebration of our employees.	
Measures of Success:	
■ Increase number of Staff Nurse III among nursing staff by 2 in FY 2010-11 and by 1 each year thereafter (4 SN III in FY 2010).	
■ Maintain employee vacancy rates below regional benchmarks.	
■ Develop and monitor employee satisfaction surveys.	
■ Turnover rates of ***15%*** or less (Q42009 = 3.58%).	
■ Less comments about non-English in the workplace.	
■ Annual performance evaluations include aggregate measurement of service excellence.	
Initiatives	**Status**
(A) STRATEGY: Establish annual master calendar of quarterly Town Hall Meetings with employees to communicate effectively and maintain employee confidence and inclusiveness	
(B) STRATEGY: Conduct quarterly update forums for medical staff at one of medical staff educational conferences	
(C) STRATEGY: In addition to maintaining ongoing annual events, consider increasing key employee morale building events that may include:	
1. Annual picnic for employees, medical staff, auxiliary and their families	
2. Administrative Hospital Rounding for all shifts / departments	
3. Weekend Pet parade	
4. Fall Pumpkin Carving contest	
(D) STRATEGY: Hold quarterly lunches with new employees (approximately 90 days after employment) and executive staff to communicate further and obtain input from new hires	

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 9, 2011

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

Through: Community Relations and Outreach Committee

From: Stewart Chen, D.C., Committee Co-chair / District Board Member
Terrie Kurrasch, Committee Co-chair

Subject: Appointment of Members to Community Relations and Outreach Committee

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Recommendation:

After review of prospective committee members, the Community Relations and Outreach Committee recommend the following four (4) community members for appointment to the Committee at this time:

- Hien Doan, Attorney, active in the Vietnamese community
- Shubha Fanse Chairperson of League of Women Voters Health Care Committee, active in the Indian community
- Monica Valerio, Active in CERT program (Alameda community disaster preparedness) and volunteer for schools
- Tracy Zollinger, Licensed Acupuncturist in Alameda, active in local schools, offers community health programs

This recommendation reflects the diversity of the District's community and can provide expertise and influence in our outreach efforts.

Background:

The City of Alameda Health Care District Community Relations and Outreach Committee's primary purpose is to develop a community engagement and outreach plan that supports the Hospital's strategic plan and annual goals. The current structure allows for up to eleven (11) community members. Currently four (4) community members sit on the committee.

The Community Relations Committee vetted seven potential community members at its April 26, 2011 meeting. Prospective members were asked to provide a brief introduction of themselves and their interest in serving on the committee and had the opportunity to ask questions about the Hospital and the committee's community initiatives. Current committee members were then asked to provide their recommendations/feedback to Committee Co-chair, Stewart Chen, D.C.

The following member qualifications were considered in the committee membership recommendation:

- Willingness to communicate with the community about current news and events at Alameda Hospital.
- Representative of the diverse population of the hospital service area.
- Awareness of community demographics and Hospital market potential.
- Actively involved with community organizations or businesses.
- Supportive of Alameda Hospital's Mission, Goals, and Objectives.

The Committee will evaluate additional membership periodically based on interest from the members of the community.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 9, 2011

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

From: Deborah E. Stebbins, CEO

Subject: Complimentary Letter

Attached is a complimentary letter received from a patient's family regarding the care and service at Alameda Hospital. The letter has been redacted to protect patient health information.

This letter has been modified to protect patient privacy.

Toby Douglas
Director of California Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

To: Toby Douglas

My name is … and I am a mother and a grandmother. I have a sister who has lived on the streets for several years. She has been in and out of programs for Drug and Alcohol Abuse without success. She currently lives on the street, receives SSI and Medical.

I am contacting you and have attached several people on copy due to **success** and **failure** in our Healthcare System. My father was awakened with a telephone call from 'X' Hospital. The Emergency Room was requesting he pick her up from the Hospital. He refused and the emergency room put her in a taxi to his home.

She was taken to a Clinic by our father. From there she was rushed by ambulance to X Hospital. She was admitted by a Doctor and diagnosed with pneumonia.

I became involved with her medical care due to my father's failing health. Every day I was on the phone with social workers and nurses. The Doctor would not give me much information but another Doctor made me aware of my sister's condition. My sister has liver disease, failing kidneys and is HIV positive.

She is unable to care for herself and needs assistance to walk. I spoke with her social worker about placement when she was released from the hospital. He had contacted his supervisor with concerns that the hospital would release her to a shelter. He knew my sister needed a nursing care for a period of time and then a rehabilitation facility.

I was then referred to another person who was supposed to help me find a nursing facility. He referred me to the hospital's social service representative. Since I was dealing with a different person every day, the conversations discussing my sister's needs became very repetitive.

Later, I made my morning calls to the nurses and was informed that social services were going to release my sister from the hospital to a shelter. Immediately I was on the phone with the Social Services person of the day. He would not listen to me and stated I have seven people on this floor just like your sister. I explained my sister can't walk without assistance and there is no way she can take care of herself. He said the Doctor is releasing her and she is fine to go to a shelter. He then said to talk with the Doctor; he's in charge and it was his decision to release her to a shelter.

I placed calls to two people begging for help. They both said they were trying to find a place for my sister. Both said they had contacted their supervisors for help. My father and I were told by the hospital that she would be transported from the hospital in an ambulance to a shelter.

Instead she was transported late in the evening by taxi to the shelter. Within 24 hours she was rushed to Alameda Hospital by Paramedics. She was admitted by a Doctor and diagnosed with 2 types of pneumonia, liver and kidney failure, hepatitis C and B. My sister was dying!!

THE SUCCESS I mentioned in the beginning of my letter:

The care that Alameda Hospital provided my sister was amazing. The doctors, nurses, and social workers did not give up. They help us to get my sister into a nursing facility.

My sister is receiving special care from the nurse and will spend her last days in a nursing facility thanks to the professional caring team at Alameda Hospital.

THE FAILURE:

SHAME ON YOU 'X' Hospital.

The service and medicine my sister received from you was negated by sending her to a facility they knew could not care for her and within 24 hours Paramedics were called to rush her to Alameda Hospital.

The commercial you spent so much money on to preach you're a community hospital for **all** the people is just that: a COMMERCIAL.

I guess you forgot to inform your doctors and social service staff of your MISSION STATEMENT to the community. My sister was dying, your staff knew this and refused to provide her with adequate help that she needed, not once but twice.

My intentions in writing this letter and copying the attached list was to compliment professionals on providing the healthcare that was needed and pointing out those who do not honor their professional responsibilities and the ethics of the Hippocratic Oath.

This letter has been modified to protect patient privacy.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 9, 2011

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Alameda Hospital – Non-Structural Seismic Update

The following is an update on the Hospital's non-structural performance category (NPC) status.

Following several discussions with Bill Dasher, our structural engineer with Thornton Tomasetti and a meeting with representatives from the Office of Statewide Health Planning and Development (OSHPD) on March 8, 2011, it is our firm understanding the following items are open items that need to be completed to comply with the NPC-2 seismic retrofit requirement.

Bulk Oxygen Tank Anchorage:

There are two possible approaches for addressing this item. The first is to relocate the vessel to a new location on the campus. This approach would provide a new larger oxygen tank and reserve that would be much more efficient and increase our low level reordering from 24 hour to 96 hour point. It would require a complete new set of plans for OSHPD and fire marshal review. The cost estimate is $250,000 - $300,000.

The second approach is to anchor and fortify the existing vessel. The structural engineer would need to perform testing to determine the existing concrete pad strength and thickness, rebar strength and to verify the capacity of the existing bolts. New bracing could be designed to anchor the top of the vessel to the wall of the hospital. Finally, additional base fortification would be required at the base of the vessel. If feasible, this would be the less expensive approach. There has been a meeting with the vessel owner; Air Liquide, our chief engineer and our structural engineer have met to discuss this option. Air Liquide is providing specifications on the tank and Bill Dasher will be providing a quote and cost estimate for the testing, plan design, submittal and project construction cost. I do not yet have this number, but am informed that it would be considerably timelier and less expensive than a vessel replacement.

Radiator / Emergency Generator:

One of our emergency generators is currently cooled via city water supply. The water line that feeds this system is original and prone to disruption in a major earthquake. This needs to be replaced with a radiator cooling mechanism that will be more reliable. Professional fee cost estimates for this project are approximately $25,000. Total project cost is estimated at $200,000.

Phone Switch Anchorage:

This project should be relatively easy. The phone switch was anchored without an approved permit. We would need to submit basic plans to get a permit and then field verify and pull test the existing anchorage to ensure that it is up to code.

Decommission the 1925 Administrative building:

This remains the largest obstacle with regards to our non-structural and structural seismic compliance. The 1925 building will not meet the SPC 2 structural requirements and therefore all essential services need to be moved into a compliant building. It would be costly to bring the non-structural components up to code and there has been no intent to perform this work since it will eventually need to be decommissioned as an OSHPD building. However, provided the feasibility of a structural extension under SB90, we may want to assess what will be required to perform the necessary non-structural work in this building.

Once the first three items on this report are complete, the Hospital will remain non-compliant with NPC 2 until the 1925 building is either decommissioned or the necessary NPC 2 work is performed.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: March 9, 2011

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: SB 90 Seismic Relief Prerequisites and Proposed Schedule

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The following is an extract from a memo prepared by Roger Richter, Senior Vice President, Professional Services with the California Hospital Association that was sent to all hospitals on April 27, 2011. I believe this summarizes well the seismic implications contained in SB 90.

On April 13, Governor Brown signed SB 90 and AB 113, which create a six-month Medi-Cal hospital fee program that will benefit hospitals by an expected $858 million, and establish a financing mechanism for non-designated and designated public hospitals that will result in a net benefit of approximately $80 million for the same period. The bills contain a number of other provisions, including one in SB 90 that provides hospitals with an extension of up to seven years to the 2013 seismic deadline if prescribed prerequisites are met.

SB 90 Prerequisites

For SB 90's seismic-relief component to become effective, the following must occur:

- SB 335 (Hernandez, D-Los Angeles), which would establish the 2011-12 Medi-Cal hospital fee program, must be enacted. Because SB 335 is not an urgency bill, it will not go into effect until January 1, 2012.

- The federal government must approve the federal match for the 2011-12 hospital fee program.

- The Office of Statewide Health Planning and Development (OSHPD) must develop emergency regulations to implement SB 90. However, the regulations will not be effective until SB 335 is enacted and the federal government approves the 2011-12 hospital fee program.

SB 90 Implementation Schedule

For hospitals to meet the deadlines established in SB 90, both OSHPD and hospitals must be prepared to implement SB 90 prior to the passage of SB 335.
The SB 90 extension is for up to seven years and cannot extend beyond 2020. It does not affect the 2030 deadline. The extension is optional for hospitals. Hospitals can choose to maintain their current extension schedule. Hospitals can extend their Non-Structural Performance Category requirements to conform with the structural extensions they receive under SB 90.

Following is the proposed schedule for SB 90 implementation:

May-August 2011

OSHPD drafts SB 90 regulations in conjunction with the Hospital Building Safety Board's (HBSB) SB 90 Committee.

OSHPD must consider public safety when determining whether to grant an extension or length of an extension on a case-by-case basis using the following criteria:

- Structural integrity of the building based on its HAZUS score.
- Community access to health care if the hospital building closed.
- Financial capacity of hospitals to complete the construction project.

Factors to be considered in the regulations include:

- OSHPD's authority to grant, deny or modify extensions.
- Whether it is appropriate to weight the criteria or thresholds for the various criteria.
- Amount of time reasonably necessary to complete the construction project.
- Provisions for a hospital to appeal an extension to HBSB.
- Revocation of an extension when it is determined that information submitted is false.
- Process for hospitals to pay for the costs of reviewing extension applications.

September 2011

The final proposed regulations will appear in an OSHPD Policy Intent Notice (PIN), so hospitals can meet the March 31, 2012, SB 90 requirements.

No later than March 31, 2012, a hospital shall:

- Submit a letter requesting an extension.
- Specify what the project will be (rebuild, retrofit, other).
- Specify the time necessary for the project.
- Submit a schedule detailing the extension work.
- Specify how the project will stay on track as proposed.

No later than September 30, 2012, a hospital shall:

- Submit a HAZUS application ready for review.

No later than January 1, 2015, a hospital shall:

- Submit plans and a schedule for the project identified.
- Submit a financial report describing the ability to complete the project.

No later than July 1, 2018, a hospital shall:

Obtain a building permit for the project, so there is ample time to meet the deadline.