Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

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

Monday, June 1, 2009

Location:

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

Office of the Clerk: (510) 814-4001

Regular Meeting

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

IV. Closed Session Agenda

A. Approval of Closed Session Minutes

1. May 4, 2009

B. Consideration of Performance Evaluation of District Employees — Gov't Code Sec. 54957

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

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

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

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

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

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

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

A. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

A. Approval of May 4, 2009 Minutes **ACTION ITEM** [enclosure]

B. Acceptance of April 2009 Financial Statements **ACTION ITEM** [enclosure]

C. Approval of Deposit in Meditech Applications **ACTION ITEM** [enclosure]

D. Approval of Amendment No. 7 to the Alameda Hospital Pension Plan and Resolution No. 2009-2G – Amendment No. 7 to the Alameda Pension Plan
ACTION ITEM [enclosure]

VII. Regular Agenda

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

1. Employee Satisfaction Survey [enclosure]

2. Update on Alameda Towne Center Renovation Update

3. Plans for July, 2009 Board Videotaping

B. Finance and Management Committee Report

1. Committee Report

- May 27, 2009 Meeting — Robert Deutsch, MD

2. Approval of FYE 2010 Operating Budget — David A. Neapolitan
ACTION ITEM [enclosure]

C. Strategic Planning and Community Relations Committee Report

1. Committee Report — Robert Bonta

- May 19, 2009
- Meetings with Assemblyman Swanson and State Senator Loni Hancock — Deborah E. Stebbins

D. Medical Staff President Report — Alka Sharma, MD

VIII. General Public Comments

IX. Board Comments

X. Adjournment

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

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

Regular Meeting
May 4, 2009

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD
Steve Wasson

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

Medical Staff Present:
Alka Sharma, MD

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:

J. Michael McCormick

Submitted by: Kristen Thorson

Action		
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 5:41 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors was present and that Director McCormick was absent from the meeting.	
3. Adjourn into Executive Closed Session	At 5:42 p.m. the meeting adjourned to Executive Closed Session.	
4. Reconvene to Public Session	Jordan Battani reconvened the meeting into public session at 7:36 p.m. and made the following closed session announcements.	

5. Closed Session Announcements	[A] Minutes [B] Quality Improvement Committee [C] Medical Executive Committee Report and Approval of Credentialing Recommendations	[A] The Closed Session Minutes for the March 2, 2009 and March 12, 2009 meetings were approved. The Quality improvement Reports were accepted as presented for the months of February and March 2009. The 4th Quarter 2008 Risk Management Report was also accepted as presented. [C] Medical Executive Committee Report and Approval of Credentialing Recommendations were approved as presented.

Initial Appointment:

Name	Specialty	Affiliation
○ Darien Behravan, MD	Pain Management	Solo Practice
○ David Fisher, MD	General Surgery	Kaiser
○ Hester Lee, MD	Ophthalmology	Kaiser
○ Hop Le, MD	Plastic Surgery	Kaiser
○ Miranda co Dornum, MD	Internal Medicine / Hospitalist	AIM
○ Karen Yokoo, MD	Plastic Surgery	Kaiser

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period
○ Calvin Benton, MD	General Surgery	Courtesy	05/01/09 – 05/31/11
○ Joseph Chan, MD	Radiology	Courtesy	05/01/09 – 10/31/09
○ Leroy Custer, MD	Radiology	Courtesy	05/01/09 – 01/31/11
○ Robert Hoffman, MD	Orthopedics	Courtesy	05/01/09 – 04/30/11
○ Timothy Huie, MD	Orthopedics	Courtesy	05/01/09 – 04/30/11
○ Terry Hunter, MD	Ophthalmology	Courtesy	05/01/09 – 04/30/11
○ William Lichtman, MD	Orthopedics/Assist	Courtesy	05/01/09 – 04/30/11
○ William Longwell, MD	Internal Medicine	Courtesy	05/01/09 – 04/30/11

○ Richard Nolan, MD	Orthopedics	Active	05/01/09 – 05/31/11
○ Liesl Pavlic, MD	Internal Medicine	Active	05/01/09 – 05/31/10
○ Jason Pollard, DPM	Podiatry	Courtesy	05/01/09 – 04/30/11
○ Geetha Pugashetti, MD	Anesthesiology	Courtesy	05/01/09 – 05/31/11
○ Veronica Shim, MD	General Surgery	Courtesy	05/01/09 – 04/30/11
○ Crystal Terry, MD	Anesthesiology	Active	05/01/09 – 04/30/11
○ Nailah Thompson, MD	Internal Medicine	Courtesy	05/01/09 – 01/31/11
○ Lilian Tsao, MD	Family Medicine	Active	05/01/09 – 04/30/11

Reappointment – Allied Health Professional Status

Name	Specialty	Appointment Period
○ Patricia Wilson, CRNA	Nurse Anesthetist	06/01/09 – 05/31/11

6. Consent Agenda	A. Approval of March 2, 2009 & March 12, 2009 Minutes B. Approval of Annual Report for Environment of Care C. Approval of Administrative Policy No. 86 - Identity Theft Prevention Program D. Approval of Annual Compliance Report E. Acceptance of February 2009 Financial Statements F. Approval of Selection of FYE June 30, 2009 Auditor G. Approval of Mission Statement for CME Program H. Approval of Revisions to Medical Staff Application for Medical Privileges I. Approval of Amendments to Medical Staff Rules and Regulations Article 16: Medical Records –Elements of H&P J. Approval of Amendments to Medical Staff Rules and Regulations Article 34 (New): Medical Staff Professional Practice Evaluation	Director Deutsch moved to approve the consent agenda as presented. Director Bonta seconded the motion. The motion carried unanimously.

7. Regular Agenda	A. **Chief Executive Officer's Report** *1.* *Recommendation for Approval of SEIU Collective Bargaining Agreement* Associate Administrator, Kerry Easthope reported to the Board on the SEIU Collective Bargaining Agreement. He stated that Management recommended approval by the Board of Directors of the Memorandum of Understanding (MOU) between SEIU and Alameda Hospital as presented. Mr. Easthope highlighted the bargaining process which began in November, 2008. The enclosure in the Board packet highlights the key terms of the changes to the MOU. The term of the new contract is from May 1, 2008 through April 30, 2012. Management stated that an important part of the contract for the Hospital was the introduction of employees participating in the cost of health benefits through the premium coverage for dependents. The Hospital is believed to be one of the first hospitals in the Bay Area in which SEIU employees have been asked to contribute to health care coverage. Also there are additions to the health plan such as flexible spending account (FSA), preventative screenings, and mammograms. And immunizations for children. Wages will increase in year one 3% (retro to May 1, 2008), and increase years 2-4 by 2.5% every 6 months. There are modest increases to pension contribution which is commensurate with what other hospital employees receive. Management was satisfied with the process and with the union during the negotiation process. Mr. Easthope stated that the terms of the MOU are commensurate with what the Union has received in prior contracts. The contract covers employees in Environmental Services, Food And Nutrition Services, Certified Nurses Assistants, OR Porters, and Licensed Vocational Nurses or approximately 100-120 employees at the Hospital. Director Wasson asked if the wage increase was offset by the health benefit concession, would management characterize this being in line with the trend of what we have seen in the past for this union. Mr. Easthope stated that, yes, terms are similar and in line with what has been negotiated in prior contracts. Director Battani commented on the cost associated with providing health benefits at the Hospital and in the workplace in general. She stated that non-contracted employees are also making contributions toward healthcare	Director Wasson move to approve the SEIU Collective Bargaining Agreement. Director Bonta Seconded the motion. The motion carried unanimously.

	premiums to help counteract the single most rapidly increasing cost/expense for the Hospital. Ms. Battani also stated that the flexible spending plan helps the Hospital, by reducing payroll taxes, and also helps the employee with child care costs and out-of-pocket medical expenses. 2. *Preparations for Hospital Swine Flu Outbreak* Ms. Stebbins asked Dr. Sharma to make a few comments on medical staff preparations for a possible H1N1 outbreak. Dr. Sharma stated that infection control specialist, Dr. Marzouk, has been working closely with staff and physicians and emergency room and we have been following the guidelines for screening. There have been a low number of cases in Alameda County with no cases in the City of Alameda. Staff and Management has participated on conference calls and been receiving updates from the county on a regular basis. Clinical symptoms have been very mild with very few hospitalizations. Dr. Sharma stated that it has been a great opportunity to remind everyone about hand washing. 3. *Foundation 2009 Action Plan* Foundation Director, Dennis Eloe, commented on the 2009 Actin Plan for the Foundation. The Plan included the main fundraising events that the Board is aware of and also other activities that are planned for the rest of 2009. Mr. Eloe invited the Board to the Spring Luncheon which will be held on Saturday, May 16, 2009. 4. *Key Statistics* Ms. Stebbins reported on the key statistics for March volumes, April volumes and April budgeted volumes as indicated below.	

Statistics:	**April (Prelim)**	**April Budget**	**March Actual**
Average Daily Census	90.33	91.50	89.35
Acute	35.43	32.87	33.0
Subacute	33.0	33.63	33.94
South Shore	21.9	25.0	22.42
Patient Days	2,710	2,745	2,770
ER Visits	1,485	1,472	1,507
OP Registrations	2,555	2,572	2,609
Total Surgeries (Approx)	496	425	517

5. *Informational Items*

- San Leandro Hospital Update
- California Hospital Association Summary of ARRA

Ms. Stebbins provided for the Board of Directors a written summary on the American Recovery and Reinvestment Act (ARRA) as well as some information on the status of San Leandro Hospital.

B. **Finance and Management Committee Report**

1. *Committee Report (March 25, 2009 & April 29, 2008 Meetings)*

Committee Reports were deferred to Mr. Neapolitan to present the March Financial Statements.

2. *Acceptance of March 2009 Financial Statements*

The overall census was 89.3 versus a budget of 91.2. The acute census was 33 compared to a budgeted census of 34. YTD census slightly below budget at 85 versus 87.7 primarily due to lower skilled nursing census at South Shore.

Surgical cases for the month of March were 517 versus a budget of 466. There was a large increase in Kaiser cases, but fortunately we did not see the same increase in charges/expenses due to the nature of the case mix. There was also a higher incidence of Alameda physicians performing cases which was spread across most service lines in the Surgery department.

Director Deutsch moved to accept the March 2009 Financial Statements as presented. Director Wasson seconded the motion. The motion carried unanimously.

	Emergency visits were 1.1% below of budget. Mr. Neapolitan stated that there have not been increases in self pay or Medi-Cal patients in the Emergency room when compared to prior years. The Finance Committee had inquired if there were increases in these areas due to the economy. Overall the month of March had a profit $62,063 versus a budget of $144,696 with a year-to-date profit of $191,927.	
	C. **Strategic Planning and Community Relations Committee Report** *1. Committee Report (March 17, 2009 & April 21, 2009)* Mr. Bonta reported on the committee meetings of March and April 2009. At the March meeting the committee did ongoing work on master planning, and looked at a fourth scheme that involved a retrofitting the West Wing of the Hospital at a significantly less cost. The committee also reviewed different types of video and broadcasting options for the Board meetings to increase transparency to the public. The committee made a recommendation to the Board for approval. The Committee received a report on community relations. A postcard featuring the primary care physicians has been sent to the community and the reaction has been positive. At the March meeting Ms. Stebbins provided the committee with a metrics update on the progress of the strategic plan and goals. At the April meeting the committee did more work and analysis on master planning. The committee heard about the progress being made on the Medical office space at Alameda Towne Center. The Committee may do a walk through of the facility when the remodel is completed. An additional direct mail piece for general surgeons was reviewed along with new website enhancements thanks to the work of Louise Nakada. Director Wasson asked how the staff is measuring the response from the direct mail pieces. Director of Community Relations, Louise Nakada stated that there has been an increase in the number of website hits to the highlighted physician pages on the website and has also seen an increase in primary care referral calls. *2. Approval of Board Meeting Video / Broadcasting Option* Ms. Stebbins stated that the Strategic Planning and Community Relations Committee reviewed four options for video taping the Board meetings.	Director Deutsch made a motion to approve Option 1 as

	Options range from $5,200 to approximately $29,000 for the first year. The higher cost options included significant up front capital costs. The Committee and Management are recommending the Board approve Option 1 – Videographer + Web Posting of Video as a starting point. A videographer will tape the board meetings and then post on the web for viewing by the community. Management also recommended that this process begin with the new fiscal year in July 2009. 3. *Update of Public Bid and Planning Process for Alameda Towne Center Medical Office Space* Mr. Easthope reported to the Board the status of the Medical office space at Alameda Towne Center. Three bidders submitted competent bids as outlined in the memorandum to the Board. The lowest bidder, Euro Style Management has been awarded the contract at a bid amount of $139,000. Work has begun on the project and is expected to be completed at the end of June, 2009.	outlined in the memo to begin with the new fiscal year. Director Bonta seconded the motion. The motion carried unanimously.
	D. **Medical Staff President Report** Medical Staff President, Dr. Alka Sharma, reported to the Board that the Medical Staff has adopted a universal screening protocol for all inpatients for Methicillin resistant Staphylococcus aureus (MRSA). A new procedure, implanting cardiac defibrillators, has been approved by the Medical Staff. The application for the Continuing Medical Education certification is being prepared. Dr. Sharma also reported that Dr. Raskin is involved in a study for a new agent to treat Congestive Heart Failure. Director Battani asked is the Hospital and physicians had participated in studies in the past. Dr. Sharma stated that the medical staff and hospital have been involved in studies for many years.	
9. General Public Comments	None	
10. Board Comments	Director Battani stated that Director McCormick has had conflicts with the Board meetings on Monday nights. She asked that management and staff work with him and other Board members to possibly move the nights on which Board	

	meetings are held to ensure that all board members can attend.	
11. Adjournment into Executive Closed Session	The Board did not need to adjourn back into Executive Closed Session.	
12. Reconvene to Public Session	There were no announcements made as the Board did not need to adjourn into Executive Closed Session.	
13. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 8:22 p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED

FINANCIAL STATEMENTS

FOR THE

PERIOD ENDING

04/30/09

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

ALAMEDA HOSPITAL

City of Alameda Health Care District

April 30, 2009

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ALAMEDA HOSPITAL

April 30, 2009

The management of the Alameda Hospital (the Hospital) has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending April 30, 2009 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of April 30, 2009

- Total assets on the balance sheet decreased by $705,121 from the prior month as a result of an increase in cash and equivalents of $1,398,886, offset by a decrease in net accounts receivable of $11,782, other assets of $2,062,282 and net fixed assets of $50,610.

- Total cash and cash equivalents for April increased by $1,398,886 which resulted in an increase in our day's cash on hand from the prior month's 8.7 to 12.6 at April 30, 2009. This increase was the result of the receipt of the second installment of the 2008/2009 parcel taxes of $2,575,595 offset bye the use of 1/12 of our annual parcel tax proceeds ($477,000) and a delay in receipt of the May Kaiser prepayment for contracted services. This slight delay was the result Kaiser's failure to update their automatic transfer of funds request to reflect the increase in monthly payments from $760,000 to $800,000 that took effect April 1, 2009. The May prepayment was received on Friday, May 1st. Had this been received before the end of the month our days cash on hand would have been 17.0 at April 30th.

- Net patient accounts receivable decreased in April by $11,782 compared to an increase of $638,575 in March. Days in outstanding receivables increased to 53.1 as compared to 51.2 in February. This increase in day's outstanding receivables at month end was the result of the increase in gross outstanding receivables from $41.6 million to $44.5 million at April 30, 2009. This increase was attributable to the price increase which took effect March 1st and a decline in collections per business day during the month of approximately 9% from the fiscal year average of $235,000 per business day.

- Other assets decreased by $2,062,282 as a result of the receipt of the second installment of the parcel tax funds $2,575,595 for 2008/2009.

- Total liabilities decreased by $736,306 compared to a decrease of $270,410 in the prior month. This decrease was the result of a decrease of $1,235,882 in other liabilities and was offset by increases of $194,107 in accounts payable and other expenses and $312,947 in payroll and benefit related accruals.

- Accounts payable at April 30th was $6,319,566, which represents an increase of $194,107 from the prior month. Despite this increase days in accounts payable remained at 83 days at month end.

- Payroll and benefit related accruals increased by $312,947 from the prior month. This increase was primarily the result of an increase in accrued PTO/Vacation payable of $42,181 and seventeen (17) days of accrued payroll amounting to $227,244 at April 30, 2009.

- Other liabilities decreased by $1,235,882 as a result of the amortization of one month's deferred revenue related to the 2008/2009 parcel tax revenues and the reversal of $800,000 of deferred revenue related to the Kaiser contract that was not received until May 1st.

- Combined total revenue was greater than budget by $750,000 or 3.1%. Inpatient revenue, excluding South Shore, was greater than budgeted by 3.5% and outpatient revenue, excluding South Shore, was greater than budgeted by 1.5%. On an adjusted patient day basis total gross revenue, excluding South Shore, was $6,762 compared to a budgeted amount of $6,738 or a 0.4% favorable variance.

- Total patient days were 2,715 and included 657 patient days from the South Shore facility as compared to the prior month's total patient days of 2,770 (695 South Shore days included) and the prior year's 1,808 total patient

days. The average daily acute care census was 35.6 compared to a budget of 32.9 and an actual average daily census of 33.0 in the prior month; the average daily Sub-Acute census was 33.0 versus a budget of 33.6 and 33.9 in the prior month and the South Shore unit had an average daily census of 21.9 versus a budget of 25.0 and prior month census of 22.4, respectively.

- ER visits were 1,483 or 0.7% greater than the budgeted 1,472 visits and were slightly greater than the prior year's visits of 1,473.

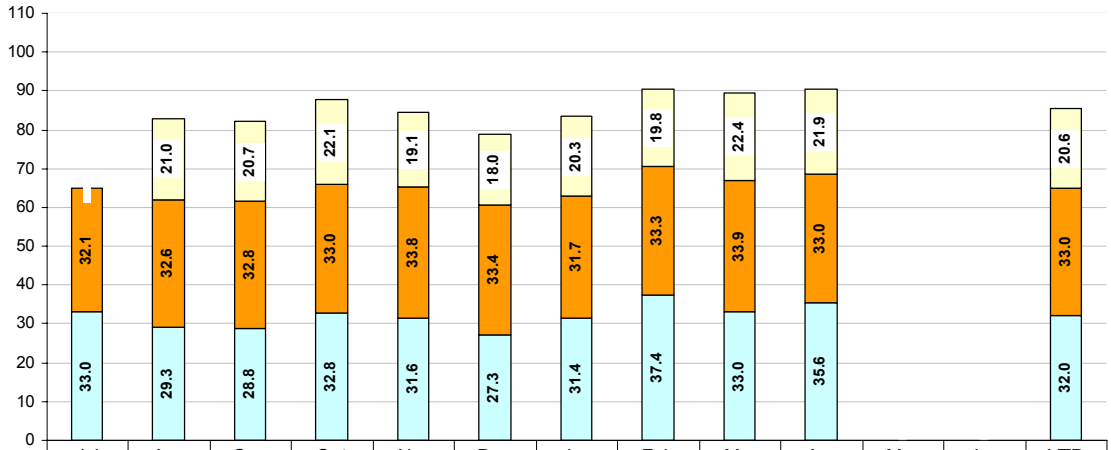
- Total surgery cases were 20.0% greater than budget, with Kaiser surgical cases making up 659 or 69.8% of the total cases. Alameda physician surgical cases decreased slightly to 154 cases as compared to 154 cases in March.

- Combined excess revenues over expense (profit) for April was $60,000 versus a combined budgeted excess of revenues over expense of (profit) of $53,000. This brings the year-to-date excess of revenues over expenses (profit) to $252,000 or $121,000 better than budgeted.

Volumes

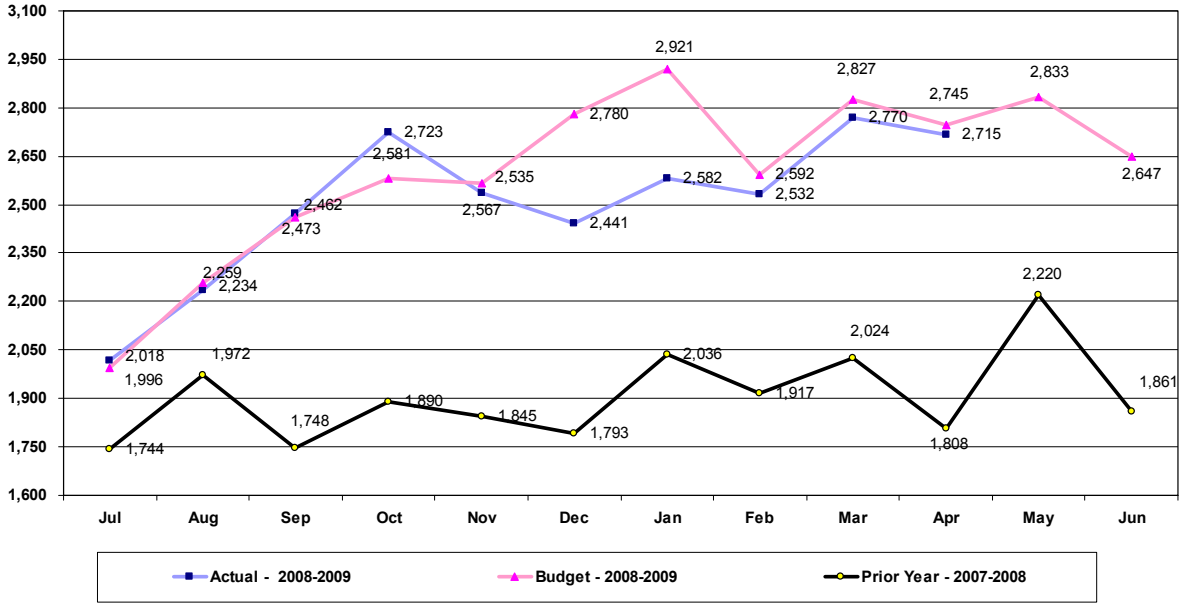
Overall actual daily census was 90.5 versus a budget of 91.5. The Acute care average daily census was 35.6 versus a budget of 33.0, Sub-Acute average daily census was 33.0 versus a budget of 33.6 and the South Shore unit had an average daily census of 21.9 versus a budget of 25.0.

Total patient days in April were 1.1% less than budgeted and were 13.8% better than the prior year after removing the South Shore patient days from the current year total patient day count. The graph on the following page shows the total patient days by month for fiscal year 2009 including South Shore.



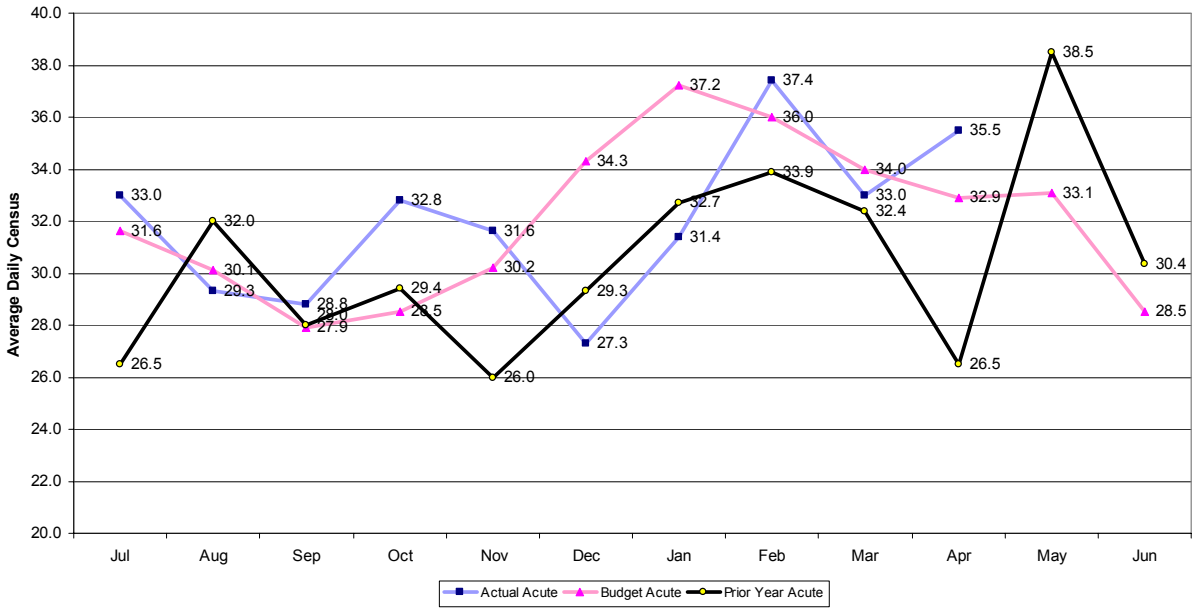
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Actual SNF		21.0	20.7	22.1	19.1	18.0	20.3	19.8	22.4	21.9			20.6
Actual Sub-Acute	32.1	32.6	32.8	33.0	33.8	33.4	31.7	33.3	33.9	33.0			33.0
Actual Acute	33.0	29.3	28.8	32.8	31.6	27.3	31.4	37.4	33.0	35.6			32.0

Total Patient Days



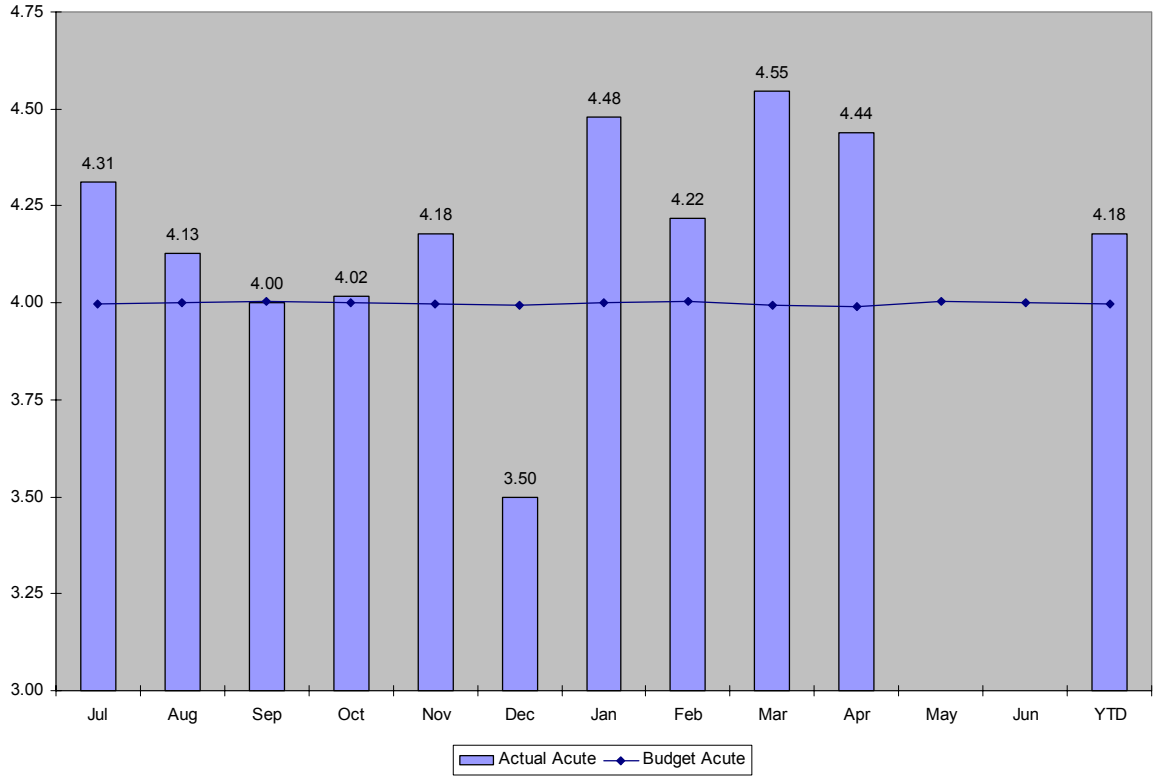
As we look at the various components of our volumes for the month of April we see that the acute care patient days were 8.3% (82 days) greater than budgeted and 29.8% better than the prior year's average daily census.

Inpatient Acute Care Average Daily Census



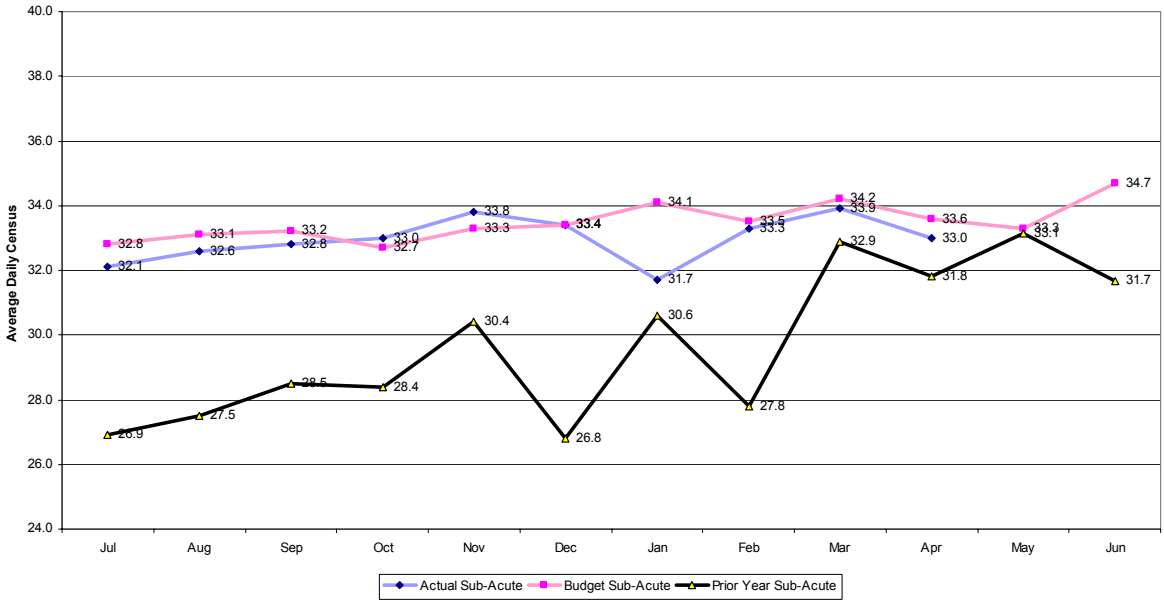
Our year to date average length of stay (ALOS) remains slightly higher than budgeted levels at 4.18. However, the first four months of calendar 2009 our ALOS has been influenced by thirty-one (31) acute care accounts that length of stays that exceeded fifteen (15) days. Had these accounts (eight in April, eight in March, eight in February and three in January) been removed from the statistics for those months the ALOS would have approximated 4.21, 4.02, 3.43 and 3.84, respectively, versus the ALOS for our acute care population shown below.

Average Length of Stay



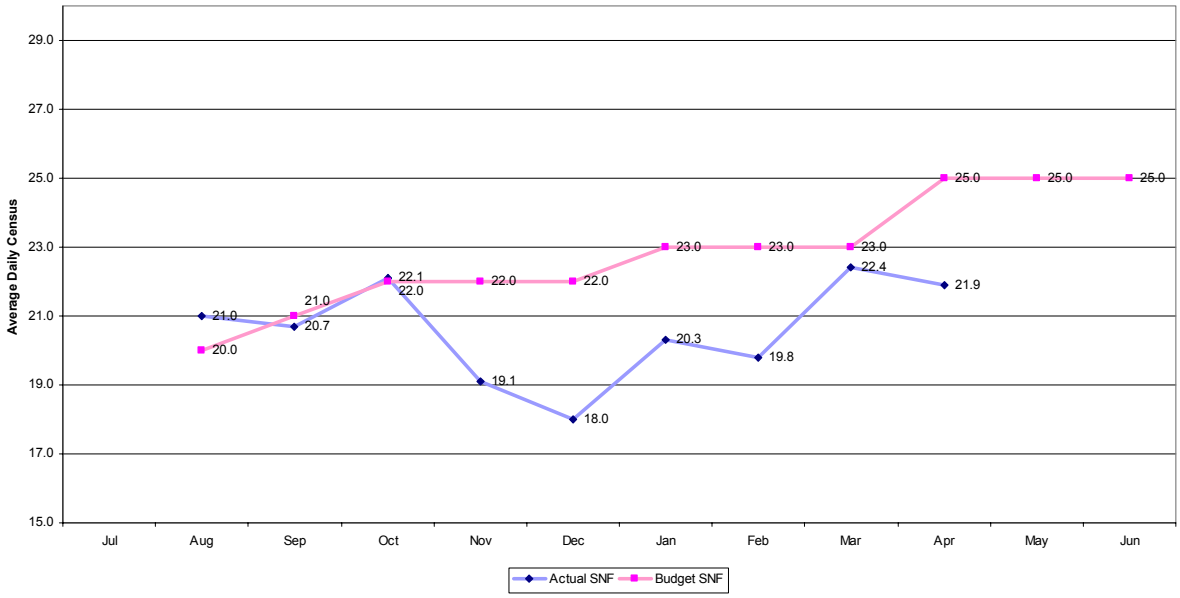
Sub-Acute patient days were 1.9% below budget or 19 days and are consistent with the prior year performance. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census

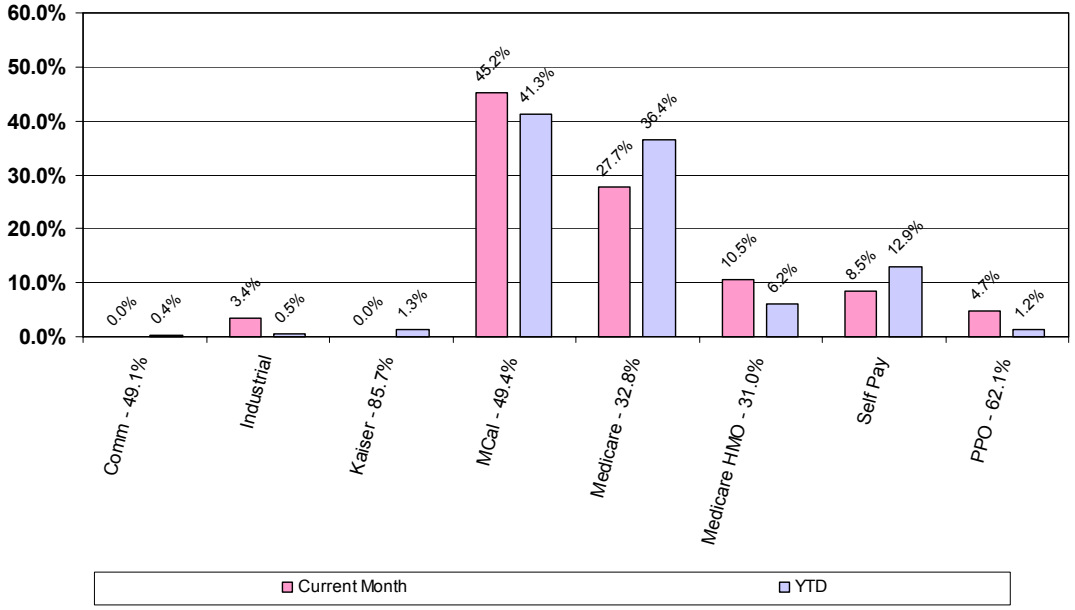


The Skilled Nursing Unit (South Shore) patient days were 12.4% less than budgeted for the month of April and are 8.5% less than budgeted for the first nine months (August 17th through April 30th) of operations. The following graphs show the Skilled Nursing Unit average daily census as compared to budget by month and the payor mix experienced during the current month and year-to-date.

Skilled Nursing Unit Average Daily Census

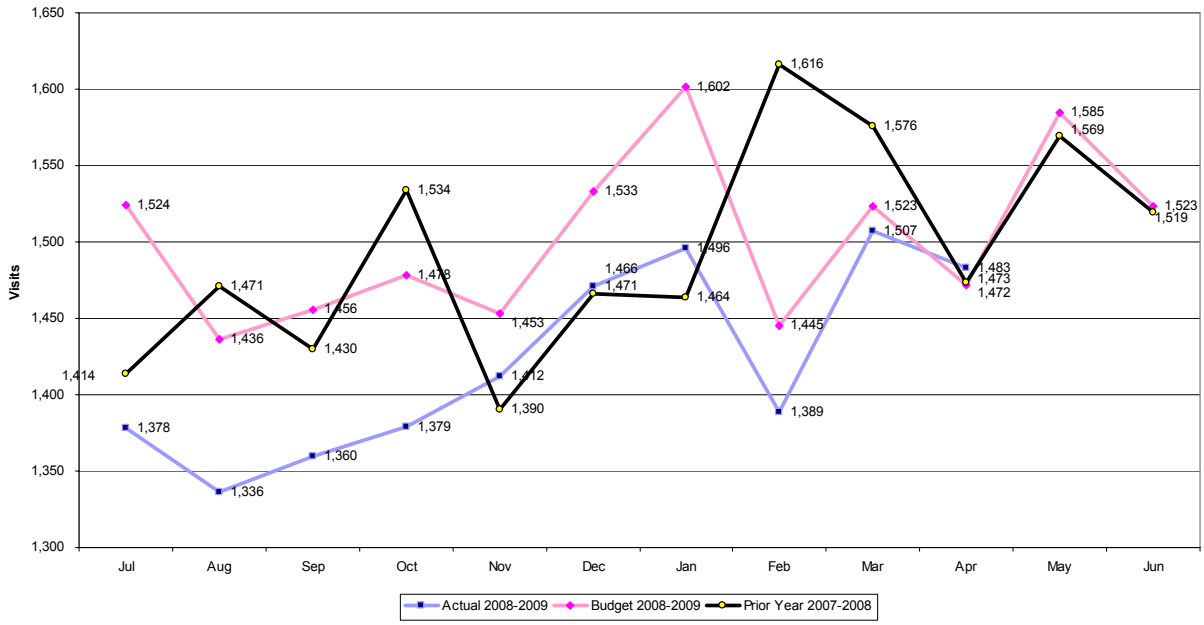


Skilled Nursing Unit Payor Mix



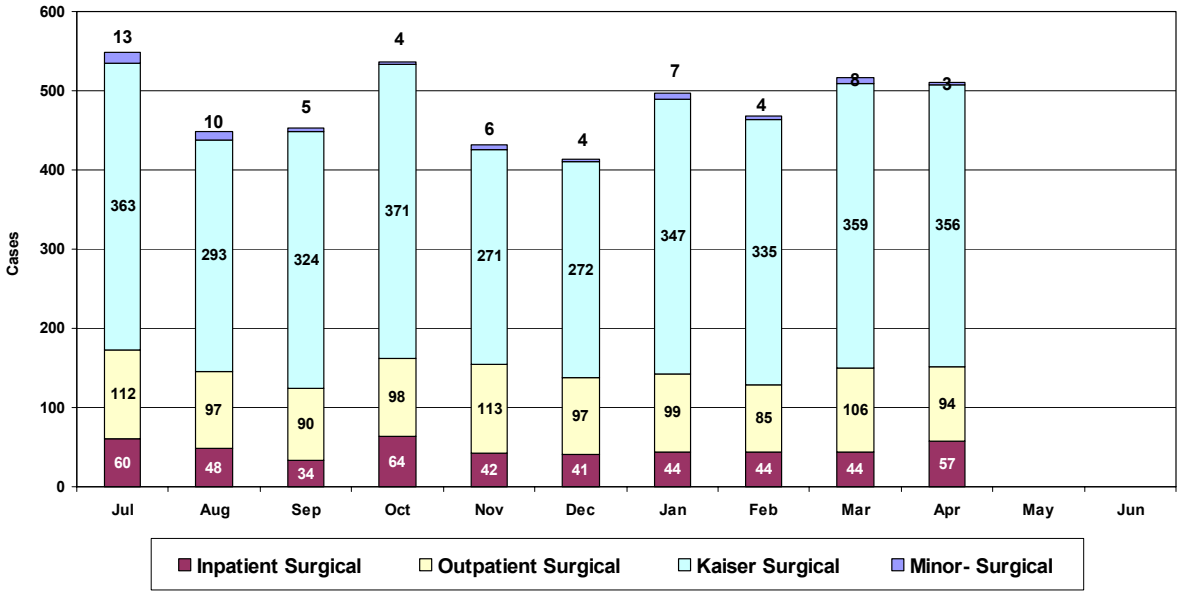
April ER visits were 0.7% greater than budgeted and were only 10 visits greater than the prior year's activity of 1,473.

Emergency Care Center Visits



Surgery cases were 510 versus the 425 budgeted and 533 in the prior year. In April, Alameda physician cases decreased slightly to 154 cases versus 158 in the prior month. Kaiser related cases in April decreased to 356 as compared to the 359 cases performed in March. Despite this increase in the number of cases Kaiser Same Day Surgery revenue decreased by $114,347 from the prior month. As a result of this months activity and the increase in the monthly reimbursement from Kaiser ($40,000) our reimbursement for Kaiser Outpatient cases in April improved to 19.6% as compared to 18.1% of gross charges in March.

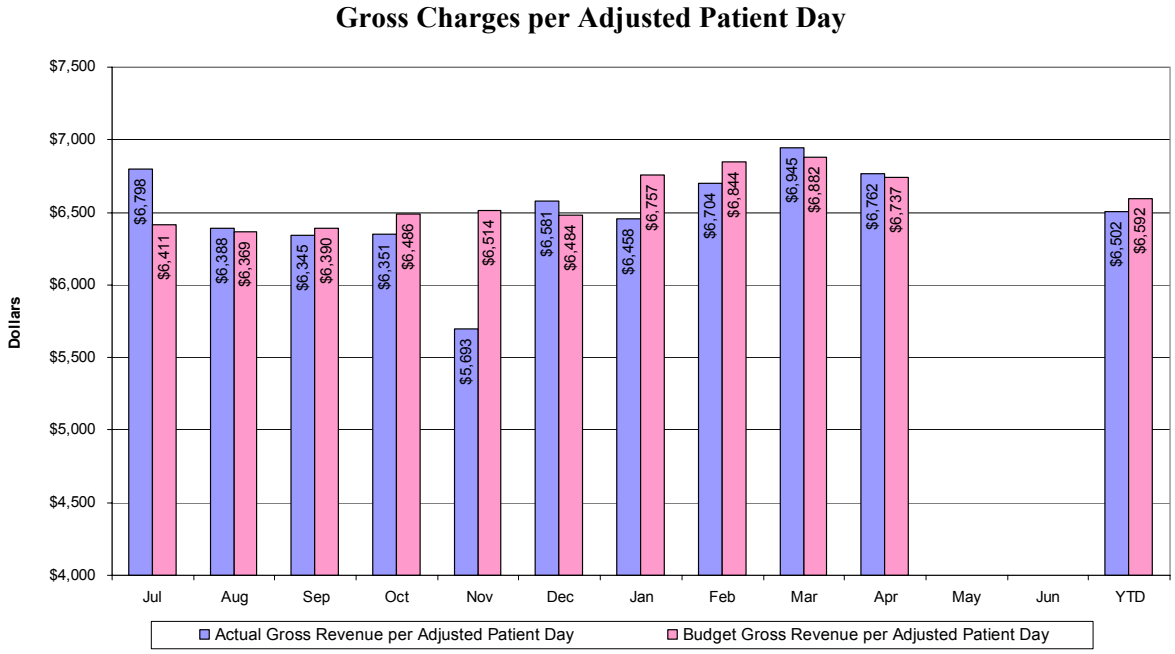
Surgical Cases



Income Statement – Hospital Only

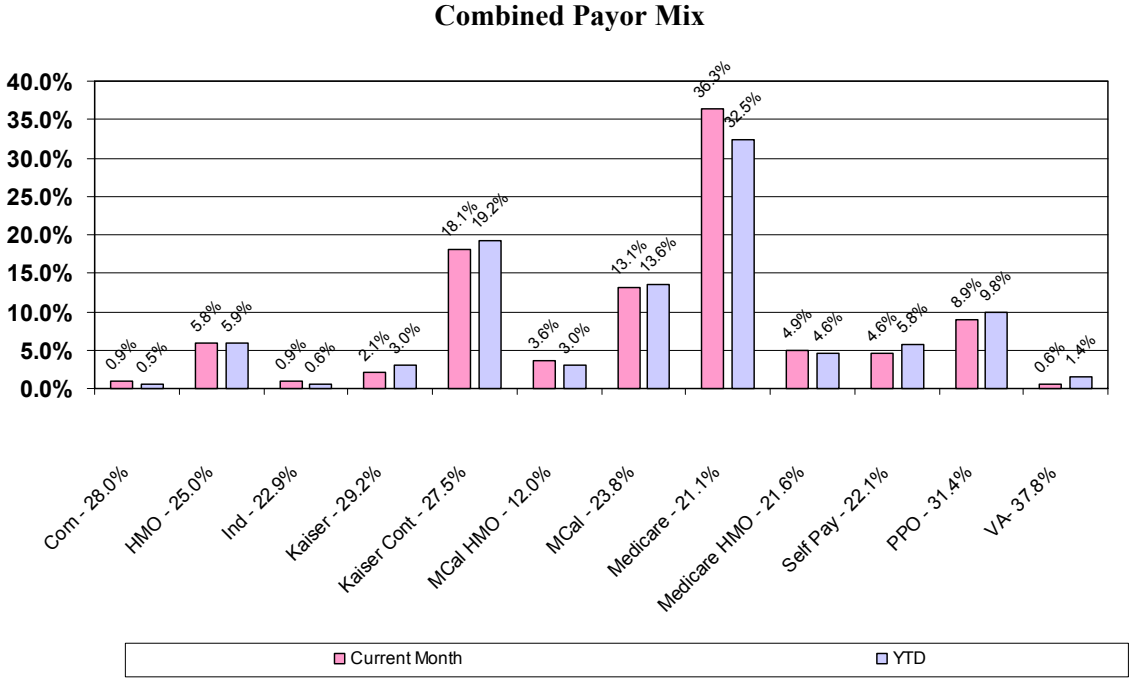
Gross Patient Charges

Gross patient charges in April were greater than budgeted by $619,000 and were comprised of favorable variances in inpatient services of $475,000 and $145,000 in outpatient services. On an adjusted patient day basis total patient revenue was $6,762 versus the budgeted $6,738 or a 0.4% favorable variance from budget (See graph on next page).



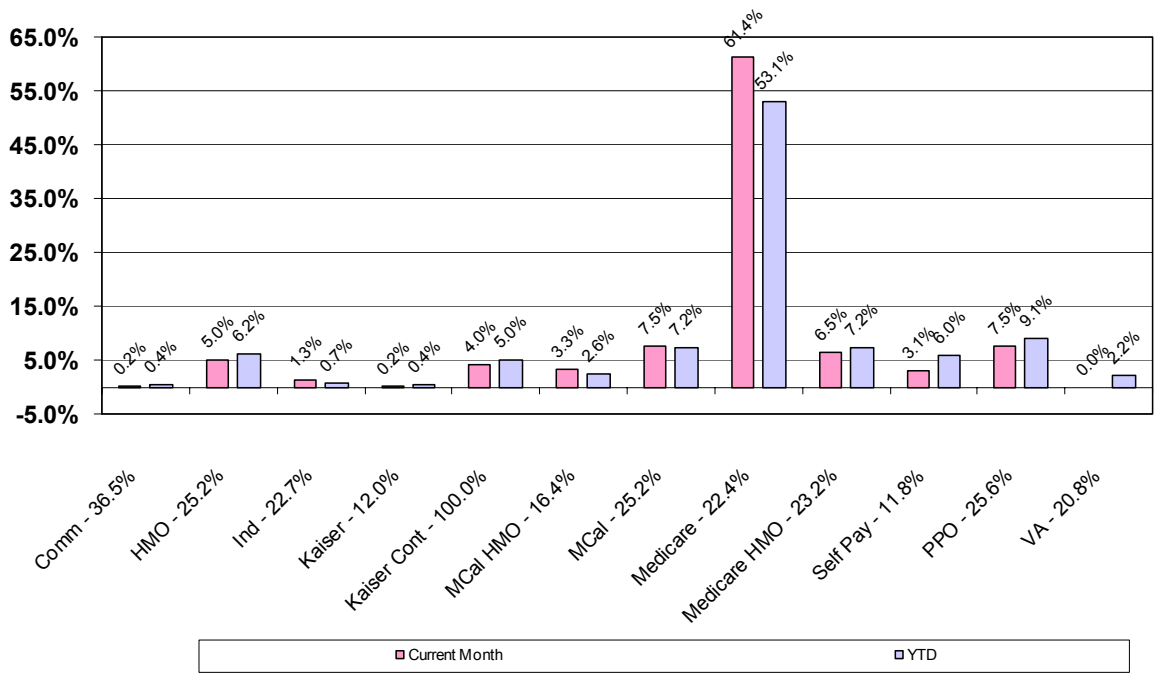
Payor Mix

Medicare total gross revenue in April made up 36.3% our total gross patient charges up from 36.3% in the prior month. Kaiser was again the second largest source of gross patient revenues at 20.2%. The graph on the following page shows the percentage of revenues generated by each of the major payors for the current month and year-to-date as well as the current months expected reimbursement for each.



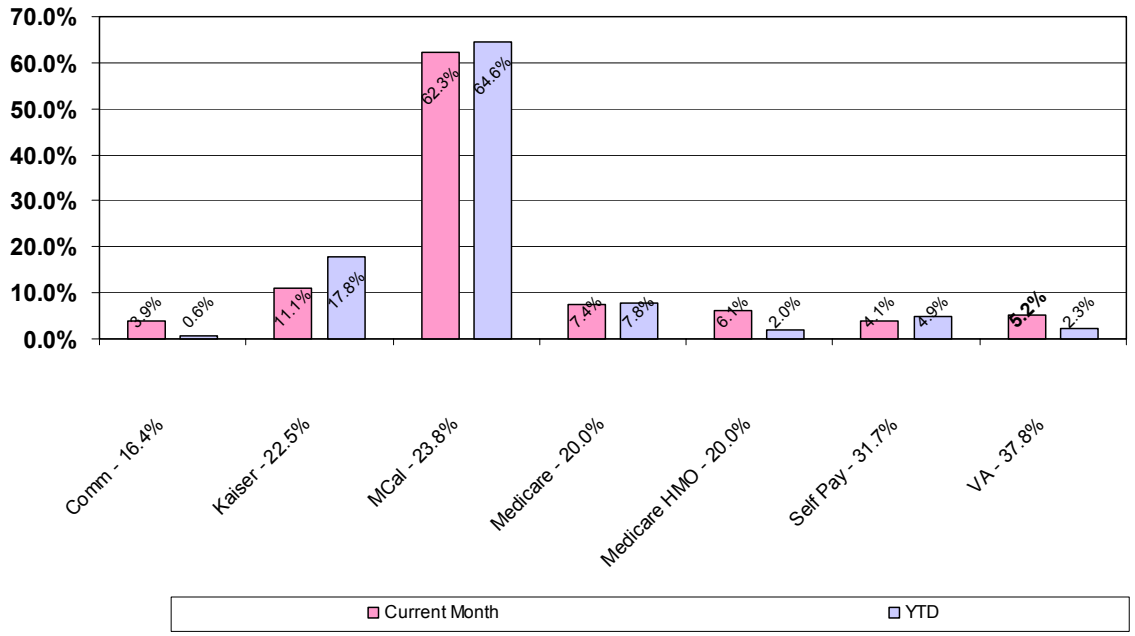
On the Hospital's inpatient acute care business, current month gross Medicare charges were 61.4% of our total inpatient acute care gross revenues bringing the year-to-date average to 53.1%. There were four (4) cases that hit outlier thresholds coupled with an increase in the Medicare Case Mix Index (CMI) to 1.4169 from 1.3577 in March, our expected reimbursement for Medicare inpatient cases was estimated to be 22.4% which is 6.6% higher than March's estimate.

Inpatient Acute Care Payor Mix



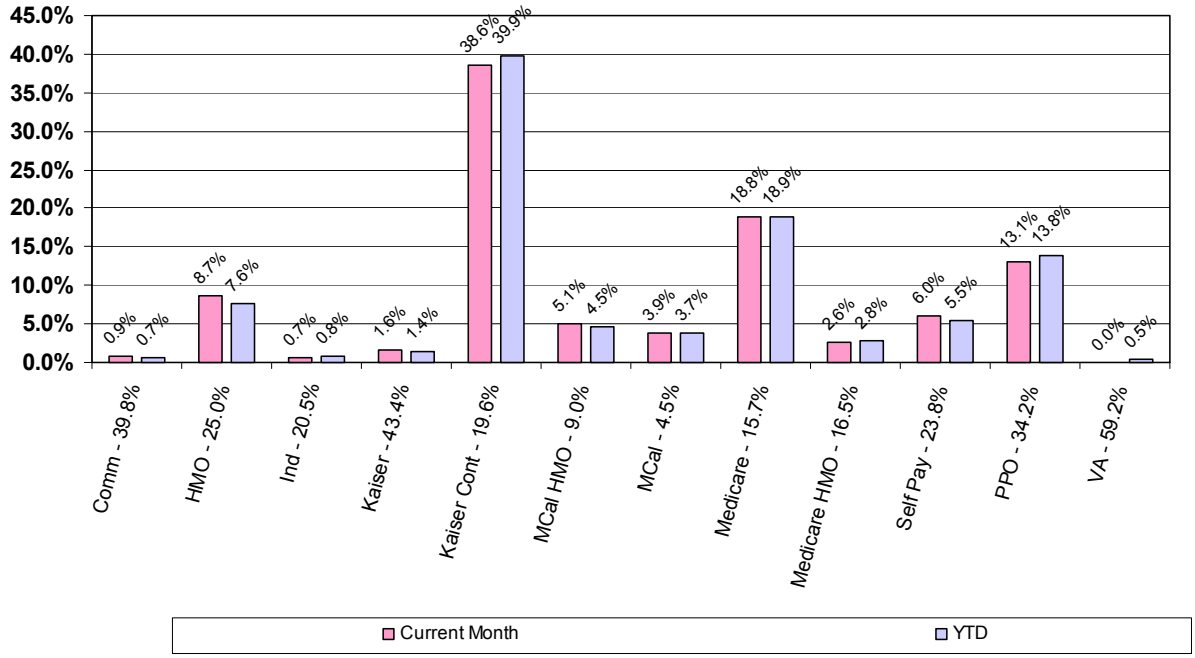
In April the Sub-Acute care program was again was dominated by Medi-Cal utilization of 62.3% based on gross patient revenue.

Inpatient Sub-Acute Care Payor Mix



Outpatient gross revenue payor mix for April was comprised of 40.2% Kaiser, 18.8% Medicare, 13.1% PPO and 8.7% HMO and is shown on the following graph.

Outpatient Services Payor Mix



Deductions from Revenue

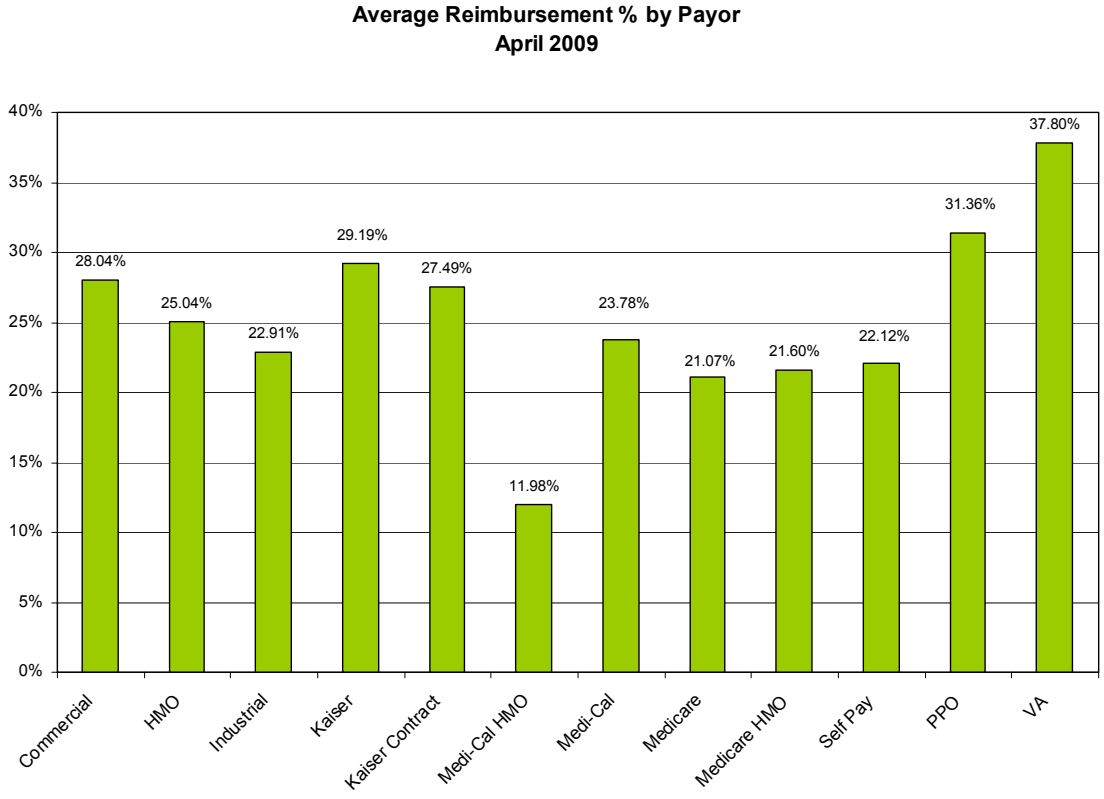
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue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

In the month of April contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 78.0% versus the budgeted 78.3%. Contractual reserves in the month of April continue to include additional reserves attributable to AB 1183, the Health Budget Trailer Bill, which requires a reduction to the interim payment for inpatient services provided by hospitals that do not participate in the Selective Provider Contracting Program (commonly known as non-contract hospitals), unless the hospital meets exemption criteria contained in the bill. Effective October 1, 2008, AB 1183 requires the Department of Health Care Services (DHCS) to limit the amount paid to non-contract hospitals for inpatient services to the lesser of the interim per diem rate (28% of gross Medi-Cal patient charges) reduced by 10%, or the applicable regional average per diem contract rate for tertiary and non-tertiary hospitals ($1,682 per Medi-Cal patient day) reduced by 5%. However, effective April 6, 2009 the California Hospital Association was successful in having the lesser of portion suspended from this date pending further litigation of the matter in the Court of Appeals.

In April there were again no DRG “take backs” associated with the Recovery Audit Contractor (RAC) project. The new National Recovery Audit program is to be phased in state-by-state starting in the fall of 2008. A new RAC contractor has been selected by CMS for California, HealthDataInsights, Inc., with California RAC audits slated to resume some time in the early portion of the summer of 2009.

Net Patient Service Revenue

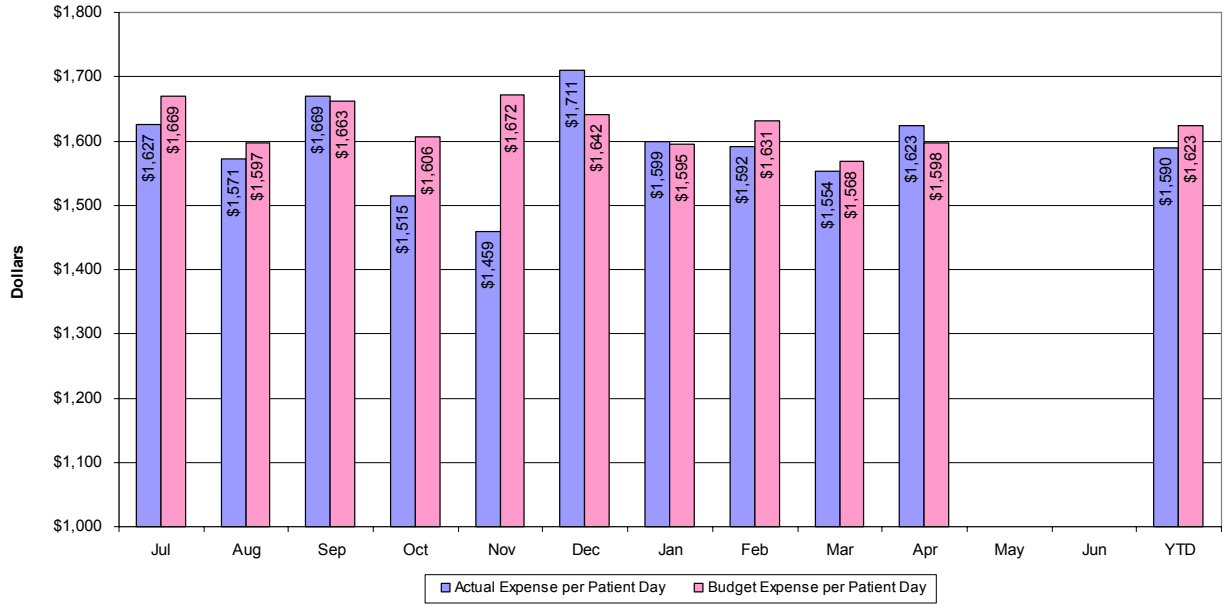
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is to receive for the services provided. The following graph shows the level of estimated reimbursement that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



Total Operating Expenses

Total operating expenses were greater than the fixed budget by $216,000 or 3.9%. On an adjusted patient day basis, our cost per adjusted patient day was $1,623 for the month which was $25 per adjusted patient day higher than budgeted. On a year to date basis our cost per adjusted patient day is 2.4% better than budgeted. The graph on the following page shows the hospital operating expenses on an adjusted patient day basis for the 2009 fiscal year by month and is followed by explanations of the significant areas of variance.

Expenses per Adjusted Patient Day

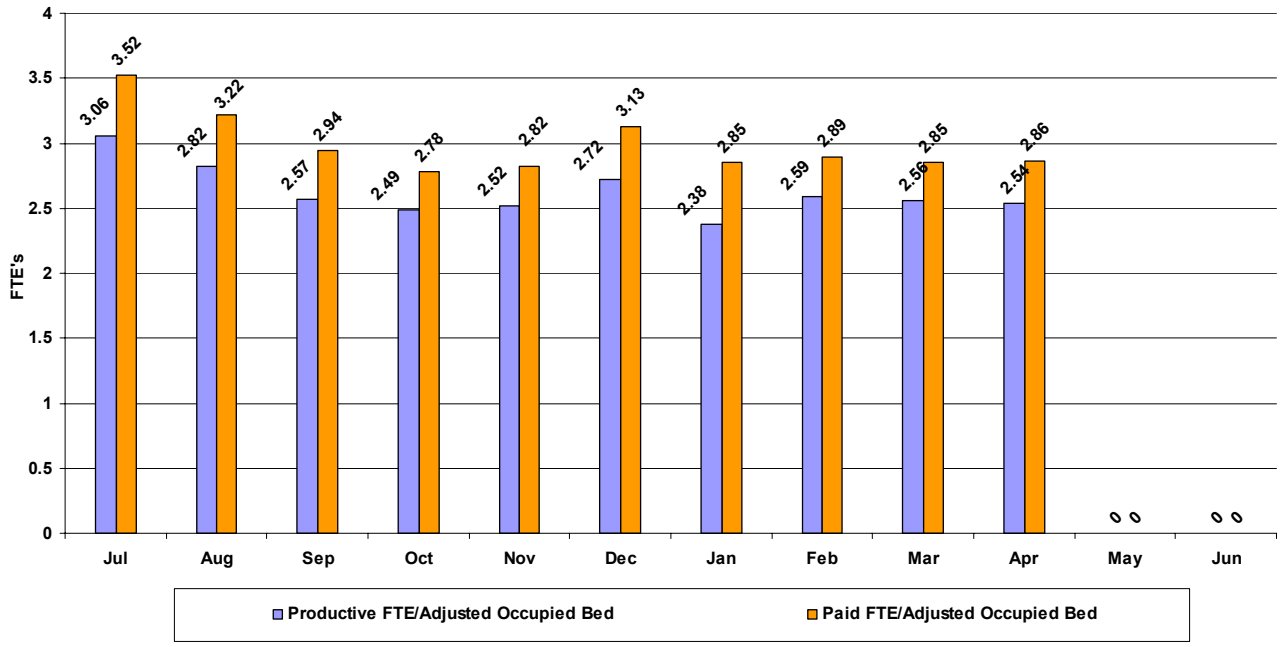


Salary and Registry Expenses

Salary and registry costs combined were unfavorable to the fixed budget by $32,000 but were $10 per adjusted patient day favorable to budget in April. Despite this unfavorable variance in April for the ten months ending April 30, 2009, the hospital is $22,000 favorable to the fixed budget and $13 per adjusted patient day favorable to budgeted expectations as seen on the graph of the next page.

Combined productive FTE's per adjusted occupied bed was 2.54 in April versus the budgeted 2.38. The graph below shows the combined (Hospital including South Shore) productive and paid FTE's per adjusted occupied bed for FY 2009.

FTE's per Adjusted Occupied Bed



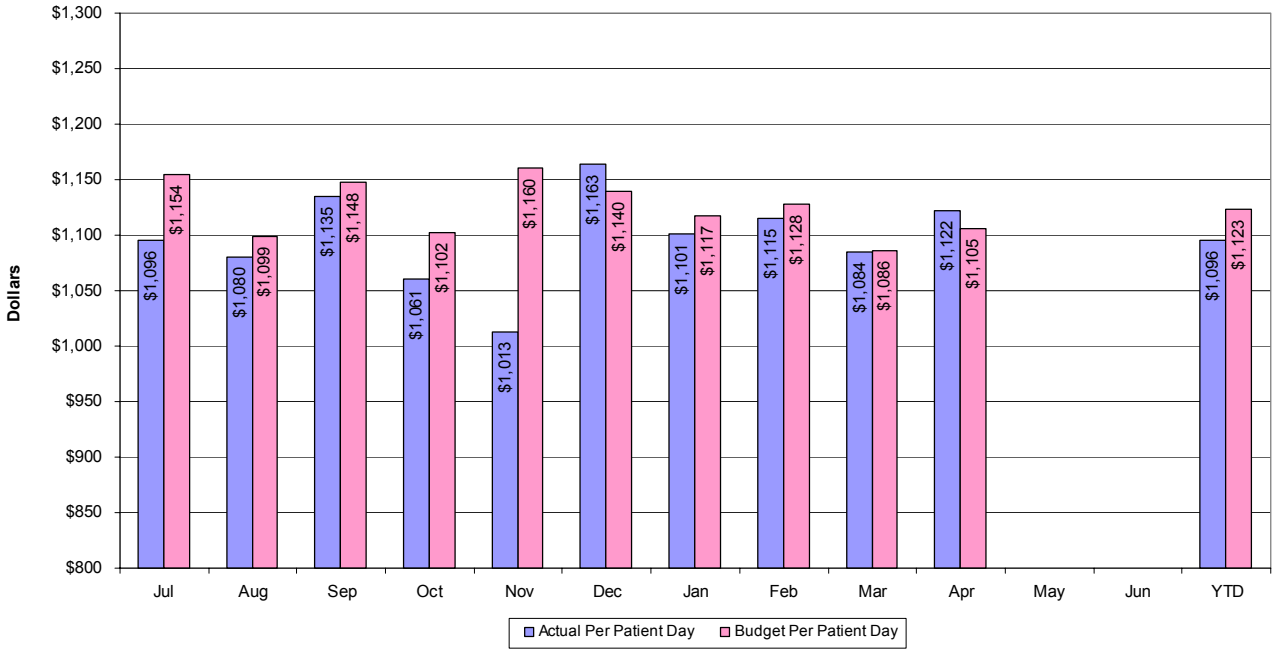
Benefits

For the month of April benefit costs were unfavorable to budget by $113,000 as a result of the following:

- Accrual of $52,000 of PTO/Vacation expense accruals.
- Additional workers compensation expense of $64,930 related to the recent analysis of our closed self insured plans claim experience related to fiscal years 2007 and 2008.
- Higher than budgeted employee health insurance claims of $64,000.
- Offsetting these unfavorable variances was the reclassification of $36,000 in costs associated with physician fees that were reclassified from the workers compensation insurance natural class to the professional fees natural class within the employee benefits cost center.

The graph below shows the combined salary, registry and benefit costs on an adjusted patient basis for FY 2009 by month and for the ten (10) months ended April 30, 2009.

Salary, Registry and Benefit Cost per APD



Professional Fees

Professional fees were greater than budget by $20,000 as a result of the reclassification of physician fees mentioned above offset by a favorable variance from anesthesia professional fees ($18,500).

Supplies

Supply costs were $72,000 unfavorable to budget as a result of higher than budgeted costs associated with surgery, blood bank, pharmacy and other medical care supplies.

The following pages include the detailed financial statements for the ten (10) months of operations ended April 30, 2009.

ALAMEDA HOSPITAL
Balance Sheet
April 30, 2009

	April 30, 2009	March 31, 2009	Audited June 30, 2008
Assets			
Current assets:			
Cash and cash equivalents	$ 2,283,919	$ 885,033	$ 4,520,156
Net Accounts Receivable	10,774,596	10,786,378	7,944,522
Net Accounts Receivable %	24.08%	25.88%	20.17%
Inventories	1,021,238	1,015,565	1,048,503
Est.Third-party payer settlement receivable	538,212	528,127	245,115
Other assets	1,731,557	3,793,839	7,270,116
Total Current Assets	16,349,522	17,008,942	21,028,412
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	571,558	566,649	602,817
Total Non-Current Assets	571,558	566,649	602,817
Fixed Assets:			
Land	877,945	877,945	877,945
Depreciable capital assets, net of accumulated depreciation	5,987,807	6,038,416	6,572,299
Total fixed assets, net of accumulated depreciation	6,865,751	6,916,361	7,450,244
Total Assets	$ 23,786,831	$ 24,491,952	$ 29,081,473
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 457,823	$ 465,301	$ 2,744,870
Accounts payable and accrued expenses	6,319,566	6,125,459	7,057,073
Payroll and benefit related accruals	5,037,698	4,724,751	3,133,574
Est.Third-party payer settlement payable	502,229	502,229	441,409
Other liabilities	1,774,675	3,010,557	8,190,530
Total Current Liabilities	14,091,991	14,828,297	21,567,456
Long-Term Liabilities:			
Debt borrowings net of current maturities	1,834,726	1,867,952	80,992
Total Long-Term Liabilities	1,834,726	1,867,952	80,992
Total Liabilities	15,926,718	16,696,249	21,648,448
Net Assets			
Unrestricted Funds	7,288,555	7,229,054	6,830,209
Restricted Funds	571,558	566,649	602,817
Net Assets	7,860,113	7,795,703	7,433,025
Total Liabilities and Net Assets	$ 23,786,831	$ 24,491,952	$ 29,081,473

City of Alameda Health Care District

Statements of Operations - Combined

April 30, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 14,496	$ 13,891	$ 605	4.4%	$ 11,728	$ 132,410	$ 135,033	$ (2,622)	-1.9%	$ 131,901
Gross Outpatient Revenues	10,102	9,957	145	1.5%	10,419	98,933	95,283	3,650	3.8%	71,425
Total Gross Revenues	24,598	23,848	750	3.1%	22,147	231,344	230,316	1,028	0.4%	203,325
Contractual Deductions	18,556	18,067	(489)	-2.7%	16,026	172,246	171,675	(571)	-0.3%	152,274
Bad Debts	493	444	(49)	-11.1%	770	6,076	5,382	(694)	-12.9%	4,641
Charity and Other Adjustments	55	50	(6)	-11.1%	143	871	844	(27)	-3.2%	953
Net Patient Revenues	5,494	5,287	206	3.9%	5,208	52,150	52,415	(264)	-0.5%	45,457
Net Patient Revenue %	22.3%	22.2%			23.5%	22.5%	22.8%			22.4%
Other Operating Revenue	13	10	3	28.8%	12	149	100	48	48.3%	101
Total Revenues	**5,507**	**5,298**	**209**	4.0%	**5,220**	**52,299**	**52,515**	**(216)**	-0.4%	**45,559**
Expenses										
Salaries	2,921	2,994	72	2.4%	2,561	28,769	29,934	1,165	3.9%	26,787
Registry	202	116	(86)	-74.4%	180	2,180	1,161	(1,019)	-87.7%	1,322
Benefits	986	884	(102)	-11.5%	1,508	8,354	8,816	462	5.2%	8,030
Professional Fees	305	282	(22)	-7.9%	241	3,012	2,823	(189)	-6.7%	3,125
Supplies	823	751	(72)	-9.6%	694	7,571	7,490	(81)	-1.1%	7,081
Purchased Services	352	345	(7)	-2.0%	336	3,369	3,451	81	2.4%	3,004
Rents and Leases	46	55	9	16.5%	54	592	537	(54)	-10.1%	477
Utilities and Telephone	71	73	3	3.6%	79	711	739	28	3.8%	692
Insurance	48	62	14	22.2%	60	461	617	156	25.3%	601
Depreciation and amortization	114	113	(1)	-0.8%	127	1,201	1,133	(68)	-6.0%	1,523
Other Opertaing Expenses	71	66	(4)	-6.5%	67	745	664	(81)	-12.3%	539
Total Expenses	**5,939**	**5,742**	**(196)**	-3.4%	**5,907**	**56,964**	**57,366**	**401**	0.7%	**53,179**
Operating gain (loss)	**(432)**	(445)	**13**	2.9%	**(688)**	**(4,665)**	**(4,851)**	**186**	-3.8%	**(7,620)**
Net Non-Operating Income / (Expense)	**492**	**498**	**(7)**	**-1.3%**	**405**	**4,917**	**4,981**	**(64)**	**-1.3%**	**4,997**
Excess of Revenues Over Expenses	**$ 60**	**$ 53**	**$ 6**	**12.1%**	**$ (283)**	**$ 252**	**$ 130**	**$ 121**	**93.1%**	**$ (2,623)**

City of Alameda Health Care District

Statements of Operations - Hospital Only

April 30, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 13,916	$ 13,442	$ 475	3.5%	$ 11,728	$ 128,435	$ 131,560	$ (3,125)	-2.4%	$ 131,901
Gross Outpatient Revenues	10,102	9,957	145	1.5%	10,419	98,933	95,283	3,650	3.8%	71,425
Total Gross Revenues	24,018	23,399	619	2.6%	22,147	227,368	226,843	525	0.2%	203,325
Contractual Deductions	18,185	17,840	(346)	-1.9%	16,026	169,855	169,914	59	0.0%	152,274
Bad Debts	493	444	(49)	-11.1%	770	6,076	5,382	(694)	-12.9%	4,641
Charity and Other Adjustments	55	50	(6)	-11.1%	143	871	844	(27)	-3.2%	953
Net Patient Revenues	5,285	5,066	219	4.3%	5,208	50,566	50,703	(137)	-0.3%	45,457
Net Patient Revenue %	22.0%	21.7%			23.5%	22.2%	22.4%			22.4%
Other Operating Revenue	13	10	3	28.8%	12	149	100	48	48.3%	101
Total Revenues	**5,298**	**5,076**	**222**	4.4%	**5,220**	**50,715**	**50,804**	**(89)**	-0.2%	**45,559**
Expenses										
Salaries	2,819	2,873	54	1.9%	2,561	27,921	28,962	1,041	3.6%	26,787
Registry	202	116	(86)	-74.4%	180	2,180	1,161	(1,019)	-87.7%	1,322
Benefits	963	850	(113)	-13.3%	1,508	8,217	8,534	317	3.7%	8,030
Professional Fees	289	269	(20)	-7.3%	241	2,833	2,690	(143)	-5.3%	3,125
Supplies	813	741	(72)	-9.7%	694	7,472	7,405	(67)	-0.9%	7,081
Purchased Services	345	344	(1)	-0.3%	336	3,304	3,438	134	3.9%	3,004
Rents and Leases	38	47	9	18.9%	54	522	472	(50)	-10.6%	477
Utilities and Telephone	68	71	3	4.7%	79	684	718	34	4.7%	692
Insurance	48	61	13	21.4%	60	455	610	155	25.4%	601
Depreciation and Amortization	114	112	(2)	-1.7%	127	1,194	1,124	(70)	-6.2%	1,523
Other Operating Expenses	67	65	(2)	-2.5%	67	729	654	(74)	-11.3%	539
Total Expenses	**5,766**	**5,550**	**(216)**	-3.9%	**5,907**	**55,510**	**55,769**	**259**	0.5%	**53,179**
Operating Gain / (Loss)	(468)	(474)	6	1.2%	(688)	(4,794)	(4,965)	171	-3.4%	(7,620)
Net Non-Operating Income / (Expense)	492	498	(7)	-1.3%	405	4,917	4,981	(64)	-1.3%	4,997
Excess of Revenues Over Expenses	**$ 24**	**$ 25**	**$ (1)**	-3.9%	**$ (283)**	**$ 123**	**$ 16**	**$ 106**	655.4%	**$ (2,623)**

City of Alameda Health Care District

Statements of Operations - South Shore

April 30, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 579	$ 449	$ 130	29.0%	$ -	$ 3,975	$ 3,473	$ 503	14.5%	$ -
Gross Outpatient Revenues	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Gross Revenues	579	449	130	29.0%	-	3,975	3,473	503	14.5%	-
Contractual Deductions	371	228	(143)	-62.7%	-	2,391	1,761	(630)	-35.8%	-
Bad Debts	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity and Other Adjustments	-	-	-	0.0%	-	-	-	-	0.0%	-
Net Patient Revenues	209	221	(12)	-5.6%	-	1,584	1,711	(127)	-7.4%	-
Net Patient Revenue %	36.0%	49.3%			0.0%	39.8%	49.3%			0.0%
Other Operating Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**209**	**222**	**(13)**	-5.7%	**-**	**1,584**	**1,712**	**(127)**	-7.4%	**-**
Expenses										
Salaries	102	121	19	15.5%	-	848	972	124	12.8%	-
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	22	34	11	33.6%	-	138	282	145	51.2%	-
Professional Fees	16	13	(3)	-19.4%	-	179	133	(46)	-34.7%	-
Supplies	10	10	0	0.7%	-	99	85	(14)	-16.7%	-
Purchased Services	8	1	(6)	-407.5%	-	65	13	(52)	-418.3%	-
Rents and Leases	8	8	0	1.7%	-	69	66	(4)	-6.0%	-
Utilities and Telephone	3	3	(1)	-27.5%	-	27	22	(6)	-25.8%	-
Insurance	0	1	1	78.3%	-	6	7	1	10.3%	-
Depreciation and amortization	-	1	1	100.0%	-	7	8	2	22.5%	-
Other Operating Expenses	4	1	(3)	-237.6%	-	17	10	(7)	-76.1%	-
Total Expenses	**173**	**192**	**20**	10.3%	**-**	**1,455**	**1,597**	**142**	8.9%	**-**
Opertaing Gain / (Loss)	**37**	**29**	7	-24.9%	**-**	**129**	**115**	**15**	13.0%	**-**
Net Non-Operating Income / (Expense)	-	-	-	**0.0%**	-	-	-	-	**0.0%**	-
Excess of Revenues Over Expenses	**$ 37**	**$ 29**	**$ 7**	24.9%	**$ -**	**$ 129**	**$ 115**	**$ 15**	13.0%	**$ -**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - Combined

April 30, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,146	$ 2,947	$ 199	6.7%	$ 3,435	$ 3,029	$ 3,077	$ (48)	-1.6%	$ 4,599
Gross Outpatient Revenues	2,193	2,113	80	3.8%	3,052	2,263	2,171	92	4.2%	2,490
Total Gross Revenues	5,339	5,060	279	5.5%	6,487	5,292	5,248	44	0.8%	7,089
Contractual Deductions	4,028	3,834	(194)	-5.1%	4,694	3,940	3,912	(29)	-0.7%	5,309
Bad Debts	107	94	(13)	-13.7%	226	139	123	(16)	-13.3%	162
Charity and Other Adjustments	12	11	(1)	-13.7%	42	20	19	(1)	-3.7%	33
Net Patient Revenues	1,192	1,122	71	6.3%	1,525	1,193	1,194	(1)	-0.1%	1,585
Net Patient Revenue %	22.3%	22.2%			23.5%	22.5%	22.8%			22.4%
Other Operating Revenue	3	2	1	31.8%	3	3	2	1	48.9%	4
Total Revenues	**1,195**	**1,124**	**71**	6.3%	**1,529**	**1,197**	**1,197**	**(0)**	0.0%	**1,589**
Expenses										
Salaries	634	635	1	0.2%	556	658	682	24	3.5%	934
Registry	44	25	(19)	-78.4%	39	50	26	(23)	-88.5%	46
Benefits	214	188	(26)	-14.0%	327	191	201	10	4.9%	280
Professional Fees	66	60	(6)	-10.4%	71	69	64	(5)	-7.1%	109
Supplies	179	159	(19)	-12.1%	203	173	171	(3)	-1.5%	247
Purchased Services	76	73	(3)	-4.4%	73	77	79	2	2.0%	105
Rents and Leases	10	12	2	14.6%	16	14	12	(1)	-10.5%	17
Utilities and Telephone	15	16	0	1.4%	23	16	17	1	3.4%	24
Insurance	10	13	3	20.4%	18	11	14	4	25.0%	21
Depreciation and Amortization	25	24	(1)	-3.1%	37	27	26	(2)	-6.4%	53
Other Operating Expenses	15	14	(1)	-8.9%	20	17	15	(2)	-12.7%	19
Total Expenses	**1,289**	**1,218**	**(71)**	-5.8%	**1,382**	**1,303**	**1,307**	4	0.3%	**1,854**
Operating Gain / (Loss)	**(94)**	**(94)**	**1**	0.7%	**146**	**(107)**	**(110)**	4	-3.4%	**(265)**
Net Non-Operating Income / (Expense)	**107**	**106**	**1**	**1.0%**	**119**	**112**	**113**	**(1)**	**-0.9%**	174
Excess of Revenues Over Expenses	**$ 13**	**$ 11**	**$ 2**	14.5%	**$ 265**	**$ 6**	**$ 3**	**$ 3**	87.3%	**$ (91)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - Hospital Only

April 30, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,918	$ 3,870	$ 47	1.2%	$ 3,435	$ 3,676	$ 3,823	$ (147)	-3.8%	$ 4,599
Gross Outpatient Revenues	2,844	2,867	(23)	-0.8%	3,052	2,832	2,769	63	2.3%	2,490
Total Gross Revenues	6,762	6,738	24	0.4%	6,487	6,508	6,593	(84)	-1.3%	7,089
Contractual Deductions	5,120	5,137	17	0.3%	4,694	4,862	4,938	76	1.5%	5,309
Bad Debts	139	128	(11)	-8.6%	226	174	156	(18)	-11.2%	162
Charity and Other Adjustments	16	14	(1)	-8.6%	42	25	25	(0)	-1.7%	33
Net Patient Revenues	1,488	1,459	29	2.0%	1,525	1,447	1,474	(26)	-1.8%	1,585
Net Patient Revenue %	22.0%	21.7%			23.5%	22.2%	22.4%			22.4%
Other Operating Revenue	4	3	1	26.0%	3	4	3	1	46.0%	4
Total Revenues	**1,492**	**1,462**	**30**	2.0%	**1,529**	**1,452**	**1,477**	**(25)**	-1.7%	**1,589**
Expenses										
Salaries	794	827	34	4.1%	750	799	842	42	5.0%	934
Registry	57	33	(24)	-70.5%	53	62	34	(29)	-84.9%	46
Benefits	271	245	(26)	-10.8%	442	235	248	13	5.2%	280
Professional Fees	81	77	(4)	-5.0%	71	81	78	(3)	-3.7%	109
Supplies	229	213	(16)	-7.3%	203	214	215	1	0.6%	247
Purchased Services	97	99	2	1.9%	98	95	100	5	5.3%	105
Rents and Leases	11	14	3	20.7%	16	15	14	(1)	-8.9%	17
Utilities and Telephone	19	20	1	6.8%	23	20	21	1	6.1%	24
Insurance	13	18	4	23.1%	18	13	18	5	26.6%	21
Depreciation and Amortization	32	32	0	0.6%	37	34	33	(2)	-4.6%	53
Other Operating Expenses	19	19	(0)	-0.2%	20	21	19	(2)	-9.7%	19
Total Expenses	**1,623**	**1,598**	**(25)**	-1.6%	**1,730**	**1,589**	**1,621**	**32**	2.0%	**1,854**
Operating Gain / (Loss)	**(132)**	**(136)**	**5**	3.4%	**(201)**	**(137)**	**(144)**	**7**	-4.9%	**(265)**
Net Non-Operating Income / (Expense)	**138**	**143**	**(5)**	**-3.5%**	**119**	**141**	**145**	**(4)**	**-2.8%**	**174**
Excess of Revenues Over Expenses	**$ 7**	**$ 7**	**$ (0)**	-5.8%	**$ (83)**	**$ 4**	**$ 1**	**$ 3**	440.9%	**$ (91)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - South Shore

April 30, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 882	$ 599	$ 283	47.3%	$ -	$ 752	$ 601	$ 151	25.1%	$ -
Gross Outpatient Revenues	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Gross Revenues	882	599	283	47.3%	-	752	601	151	25.1%	-
Contractual Deductions	564	304	(260)	-85.7%	-	452	305	(147)	-48.3%	-
Bad Debts	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity and Other Adjustments	-	-	-	0.0%	-	-	-	-	0.0%	-
Net Patient Revenues	318	295	23	7.7%	-	300	296	3	1.1%	-
Net Patient Revenue %	36.0%	49.3%			0.0%	39.8%	49.3%			0.0%
Other Operating Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**318**	**295**	**23**	7.7%	**-**	**300**	**297**	**3**	1.1%	**-**
Expenses										
Salaries	155	161	6	3.5%	-	160	168	8	4.7%	-
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	34	45	11	24.2%	-	26	49	23	46.7%	-
Professional Fees	24	18	(6)	-36.3%	-	34	23	(11)	-47.2%	-
Supplies	15	13	(2)	-13.4%	-	19	15	(4)	-27.5%	-
Purchased Services	11	2	(9)	-479.3%	-	12	2	(10)	-466.3%	-
Rents and Leases	12	10	(1)	-12.2%	-	13	11	(2)	-15.8%	-
Utilities and Telephone	5	3	(2)	-45.6%	-	5	4	(1)	-37.4%	-
Insurance	0	1	1	75.3%	-	1	1	0	2.0%	-
Depreciation and amortization	-	1	1	100.0%	-	1	1	0	15.4%	-
Other Operating Expenses	6	2	(4)	-285.4%	-	3	2	(2)	-92.4%	-
Total Expenses	**263**	**257**	**(6)**	-2.4%	**-**	**275**	**277**	**1**	0.5%	**-**
Operating Gain / (Loss)	**55**	**39**	**17**	-42.6%	**-**	**25**	**20**	**5**	22.6%	**-**
Net Non-Operating Income / (Expense)	-	-	-	**0.0%**	-	-	-	-	**0.0%**	-
Excess of Revenues Over Expenses	**$ 55**	**$ 39**	**$ 17**	42.6%	**$ -**	**$ 25**	**$ 20**	**$ 5**	22.6%	**$ -**

ALAMEDA HOSPITAL
KEY STATISTICS
April, 2009

	ACTUAL APRIL 2009	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	APRIL 2008	YTD APRIL 2009	YTD FIXED BUDGET	VARIANCE	%	YTD APRIL 2008
Discharges:										
Total Acute	240	247	(7)	-2.8%	236	2,325	2,452	(127)	-5.2%	2,393
Total Sub-Acute	4	2	2	100.0%	4	32	20	12	60.0%	75
Total Skilled Nursing	9	10	(1)	-10.0%	-	98	78	20	25.6%	-
	253	259	(6)	-2.3%	240	2,455	2,550	(95)	-3.7%	2,468
Patient Days:										
Total Acute	1,068	986	82	8.3%	823	9,714	9,802	(88)	-0.9%	9,172
Total Sub-Acute	990	1,009	(19)	-1.9%	985	10,020	10,154	(134)	-1.3%	9,434
Total Skilled Nursing	657	750	(93)	-12.4%	-	5,285	5,774	(489)	-8.5%	-
	2,715	2,745	(30)	-1.1%	1,808	25,019	25,730	(711)	-2.8%	18,606
Average Length of Stay										
Total Acute	4.45	3.99	0.46	11.5%	3.49	4.18	4.00	0.18	4.5%	3.83
Average Daily Census										
Total Acute	35.60	32.87	2.73	8.3%	27.43	31.95	32.24	(0.29)	-0.9%	30.07
Total Sub-Acute	33.00	33.63	(0.63)	-1.9%	32.83	32.96	33.40	(0.44)	-1.3%	30.93
Total Skilled Nursing	21.90	25.00	(3.10)	-12.4%	-	20.41	22.29	(1.89)	-8.5%	-
	90.50	91.50	(1.00)	-1.1%	60.27	85.32	87.94	(0.73)	-0.8%	61.00
Emergency Room Visits	1,483	1,472	11	0.7%	1,473	14,211	14,922	(711)	-4.8%	14,834
Outpatient Registrations	2,555	2,572	(17)	-0.7%	2,593	24,904	26,013	(1,109)	-4.3%	26,097
Surgery Cases:										
Inpatient	62	53	9	17.0%	51	564	573	(9)	-1.6%	564
Outpatient	448	372	76	20.4%	482	4,260	3,608	652	18.1%	3,845
	510	425	85	20.0%	533	4,824	4,181	643	15.4%	4,409
Kaiser Inpatient Cases	5	-	5	-	7	86	-	86	-	52
Kaiser Eye Cases	190	139	51	36.7%	166	1,625	1,263	362	28.7%	1,339
Kaiser Outpatient Cases	161	133	28	21.1%	178	1,580	1,304	276	21.2%	1,338
Total Kaiser Cases	356	272	84	30.9%	351	3,291	2,567	724	28.2%	2,729
% Kaiser Cases	69.8%	64.0%			65.9%	68.2%	61.4%			61.9%
Adjusted Occupied Bed	153.40	157.32	3.92	2.5%	113.81	143.45	144.43	(0.98)	-0.7%	107.34
Productive FTE	390.06	374.79	(15.27)	-4.1%	344.60	374.88	364.84	(10.04)	-2.8%	347.79
Total FTE	439.66	427.55	(12.11)	-2.8%	388.37	426.31	425.22	(1.09)	-0.3%	401.57
Productive FTE/Adj. Occ. Bed	2.54	2.38	(0.16)	-6.7%	3.03	2.61	2.53	(0.09)	-3.5%	3.24
Total FTE/ Adj. Occ. Bed	2.87	2.72	(0.15)	-5.5%	3.41	2.97	2.94	(0.03)	-0.9%	3.74

ALAMEDA HOSPITAL

12 MONTH CASH PROJECTION

PERIOD COVERED: 5/1/09 THRU 4/30/10

	COLLECTIONS		PROPERTY	W/C REFUND	OTHER	FY 2008		EST.	
MONTH	NON-KAISER	KAISER -USE	TAX[1]	NET		AB 915	TRANSFERS	DISBURSEMENTS	BALANCE[2]
MAY 09	5,096,771	800,000	367,000		50,000		1,400,000	7,136,948	228,720
JUNE 09	5,500,000	800,000	477,000		50,000	180,000	(1,400,000)	5,527,466	308,254
JULY 09	5,280,000	800,000	477,000		50,000		(500,000)	6,134,048	281,207
AUG 09	4,725,000	800,000	477,000		50,000		100,000	6,134,048	299,159
SEP 09	4,725,000	800,000	477,000		50,000		100,000	6,134,048	317,111
OCT 09	5,060,000	800,000	477,000		50,000		(250,000)	6,099,854	354,257
NOV 09	4,370,000	800,000	477,000		50,000		400,000	6,134,048	317,209
DEC 09	5,060,000	800,000	477,000		50,000		(200,000)	6,199,808	304,401
JAN 10	5,060,000	800,000	477,000		50,000		(200,000)	6,199,808	291,593
FEB 10	4,140,000	800,000	477,000	100,000	50,000		550,000	6,199,808	208,785
MAR 10	5,280,000	800,000	477,000		50,000		(300,000)	6,199,808	315,978
APRIL 10	5,040,000	800,000	477,000		50,000		(200,000)	6,199,808	283,170
TOTALS	59,336,771	9,600,000	5,614,000	100,000	600,000	180,000	(500,000)	74,299,498	

Notes:

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

ALAMEDA HOSPITAL

12 Month Cash Projection - Disbursement Detail

PERIOD COVERED: 5/1/09 THRU 4/30/10

	DISBURSEMENTS								TOTAL CASH
			10%						
MONTH	PAYROLL	PENSION	PAYROLL RELATED	Total Payroll	Health expense	Refund	A/P	Debt Service	OUTLAYS
MAY 09	4,337,088 a	85,500	416,360	4,838,948	278,000	20,000	1,955,987	44,013	7,136,948
JUNE 09	2,891,392	60,500	277,574	3,229,466	278,000	20,000	1,955,933	44,067	5,527,466
JULY 09	3,444,843	60,500	330,705	3,836,048	278,000	20,000	1,955,891	44,109	6,134,048
AUG 09	3,444,843	60,500	330,705	3,836,048	278,000	20,000	1,955,842	44,158	6,134,048
SEP 09	3,444,843	60,500	330,705	3,836,048	278,000	20,000	1,955,788	44,212	6,134,048
OCT 09	5,167,264 a	85,500	496,057	3,801,854	278,000	20,000	1,955,744	44,256	6,099,854
NOV 09	3,444,843	60,500	330,705	3,836,048	278,000	20,000	1,955,690	44,310	6,134,048
DEC 09	3,504,843	60,500	336,465	3,901,808	278,000	20,000	1,957,912	42,088	6,199,808
JAN 10	3,504,843	60,500	336,465	3,901,808	278,000	20,000	1,957,870	42,130	6,199,808
FEB 10	3,504,843	60,500	336,465	3,901,808	278,000	20,000	1,957,817	42,183	6,199,808
MAR 10	3,504,843	60,500	336,465	3,901,808	278,000	20,000	1,963,968	36,032	6,199,808
APRIL 10	3,504,843	60,500	336,465	3,901,808	278,000	20,000	1,963,954	36,046	6,199,808
TOTALS	43,699,331	776,000	4,195,136	46,723,498	3,336,000	240,000	23,492,397	507,603	74,299,498

a) 3 pay periods in the month

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

To: City of Alameda Health Care District Board of Directors

From: David A. Neapolitan
Chief Financial Officer

Date: May 27, 2009

Subject: Request for Approval for Refundable Deposit for the purchase Meditech Application Software

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As a result of the American Recovery and Reinvestment Act of 2009 (ARRA), it is imperative that Alameda Hospital begin now on the journey to implement a system that provides the necessary applications to develop an Electronic Health Record (EHR) as required under the ARRA. We believe that based upon the language in this bill we must complete this journey by no later than June 30, 2013 in order to receive the maximum amount of reimbursement allowable under the plan which is currently estimated to be between $3.5 and $4.0 million. Furthermore, if we fail to act the hospital will be subjected to reduced reimbursement under the Medicare program beginning July 1, 2015

As you are aware the Hospital implemented the Meditech system in 1999 and has used this application almost exclusively for its clinical and financial record keeping needs. However, in order to continue to move toward a completely electronic health record we must implement the following Meditech applications, copies of the Meditech Functionality Briefs are included for your reference:

- PCS – Patient Care and Safety System
- EDM – Emergency Department Management
- PCM – Physician Care Manager
- ORM – Operating Room Management
- Scanning and Archiving System

While there is much work still to be done, including a no cost upgrade to version 5.6 of the Meditech Client Server platform and additional due diligence related to the additional Meditech clinical applications that are listed above, the Finance and Management Committee recommends that the Board of Directors approve the payment of a 10% refundable deposit, amounting to approximately $83,000, to the Meditech Corporation, subject to Meditech meeting the following conditions:

1. Guarantee that the Meditech applications listed above will ensure that Alameda Hospital will meet or exceed the standards required by the ARRA.

2. Guarantee delivery of these applications with sufficient lead time to completely implement and test the applications in order to receive the maximum reimbursement under the ARRA.
3. Provide a site visit for the Alameda Hospital Selection Committee, at Meditech's expense, to a site using the applications listed above in order to properly evaluate the functionality of the systems being considered.

MEDITECH
Patient Care
functionality brief

The Patient Care functionality in MEDITECH's Patient Care and Patient Safety product is an electronic documentation system offering care providers interdisciplinary Plans of Care required for a patient-focused care delivery system. Automated worklists allow care providers to document care using a point-of-care-device. PCS display panels provide the ability to observe up-to-date patient information.

Dynamic electronic links to MEDITECH's Enterprise Medical Record (EMR) offer care providers another resource for their clinical decisions. These links support critical data review during the assessments and outcomes documentation process.

Highlights:

Patient Care functionality establishes and generates the clinical tools needed to manage the delivery of patient care. It enables a care provider to:

- Create a patient assignment and identification lists. A care provider assignment list displays a particular care provider's patients
- Initiate a Patient Standard of Care for delivery of protocol or location-specific patient care
- Generate a suggestion list of problems from assessments. This list can be included on a patient's Plan of Care
- Establish a Plan of Care for an individual patient. This can be a Care Plan or a Critical Path for the generation of worklists and assessments.

Standard Features

Patient Care Management

The Patient Care functionality enables a care provider to:

- Create a patient assignment and identification lists. A care provider assignment list displays a particular care provider's patients.
- Initiate a Patient Standard of Care for delivery of protocol or location-specific patient care
- Generate a suggestion list of problems from assessments. This list can be included on a patient's Plan of Care
- Establish a Plan of Care for an individual patient. This can be a care plan or a critical path for the generation of worklists and assessments.

To facilitate the transition of automating patient care planning and on-line documentation, standard care plans are delivered during installation of the functionality.

Clinical Content

Dictionaries serve as the foundation for automating patient care management. This clinical content, developed by expert clinicians, comprises the standard Plans of Care. The standard system dictionaries include:

- The Assessment Dictionary, which is used to define the input screens that appear during the documentation of a particular intervention from the worklist. Assessments are associated with interventions in the Intervention Dictionary
- The Intervention Dictionary, which is used to define functions, treatments, or tasks that a care provider performs on behalf of the patient. Interventions are associated with out-comes on the Plan of Care
- The Outcome Dictionary, which assists the care provider in defining measurable patient goals and achievements. The outcomes are based on interventions for a particular problem on the patient's Plan of Care
- The Problem Dictionary, which defines the nature of the patient's health disorder. Problems are associated with a particular Plan of Care. Problems may be added independently to a particular plan or triggered based on a response to an assessment query
- The Plan of Care Dictionary, which includes the group of problems, outcomes, interventions, and assessments associated with a particular plan.

Documentation of Patient Information
The Patient Care functionality allows care providers to electronically view, update, and process relevant patient information components of a Plan of Care. It supports the delivery of a patient-focused care system and offers a means to capture clinically significant data on the patient's progress. Documentation features enable care providers to document:
• Interventions and assessments on a worklist. A worklist contains the interventions or tasks that the care provider will perform for the patient
• Spreadsheet Documentation, used as a tool for simultaneous data review and data entry, allows for:
  – care providers to document assessments, intake and outputs, medications, laboratories, and wave forms to be included
  – drag and drop capabilities for rearranging data for care providers viewing preference
  – graphing upon demand
  – data documented to enter EMR in real-time.
• Outcome evaluations, including EMR data review capabilities
• Variances from a Critical Path indicating source, subtype, and status
• Free text notes and templates that may be linked to a problem, outcome, intervention, or order
• Medication Administration Record (MAR). The on-line MAR documents activity related to patient medications such as:
  – administration, entering a comment, entering reason medication wasn't given, and adjusting actual dosages
  – changing a medication's order, viewing a medication's order and dose instruction
  – clinical indicator, monograph, and associated data for a specific medication
  – Allergy Management, and the patient's Enterprise Medical Record
• Resident Assessment Instrument (RAI), which includes Minimum Data Sets (MDS), Resident Assessment Protocols (RAPS), and the Resource Utilization Group (RUG) questionnaires. This documentation gives skilled nursing facilities and other long-term care providers the ability to develop a patient Plan of Care and to report patient information to health care agencies.

Reporting and Printing Capabilities
The Patient Care functionality features extensive reporting and printing capabilities. The reports enable care providers and organizations to summarize information in various formats. Users have the flexibility to specify the level of detail to be included on these reports for printing. The functionality enables users to print and report:
• Patient profiles, including data screens, orders, current medications, interventions, notes, and data histories
• Up-to-date Plans of Care, care provider worklists, and patient care summaries and output formats capturing documentation data
• Variance Reports from Critical Pathways, tracking individual patient variance information and cross patient statistical data
• Audit Reports listing documented patient care. These reports can be created in an unlimited number of formats.

Benefits
• Patient data is presented in a logical and concise format through standard screens and panels for clinical decision making
• Point-of-care documentation reduces transcription time and inaccuracies
• Point-of-care documentation allows users to view real-time recording of patient data in the EMR for timely decision making
• EMR data can be viewed during documentation process to view patient's progress
• Plan of Care worklists and assessments are automatically generated for a specific care provider discipline, which allows care providers to easily facilitate day-to-day patient care management.

For more information about us, contact a MEDITECH Marketing Representative.

MEDITECH
Medical Information Technology, Inc.
MEDITECH Circle

Westwood, MA 02090
781-821-3000
www.meditech.com

MEDITECH
Bedside Verification
functionality brief

Bedside Verification functionality in MEDITECH's Patient Care and Patient Safety product allows caregivers to utilize bar code scanning technology prior to administering medications and blood products. During the medication administration process, Bedside Verification is used to confirm patient identity and medication information against data readily available via MEDITECH's on-line Medication Administration Record. Immediate access to a patient's current results and medication administration information greatly reduces preventable medication errors. The use of bar code scanning increases accuracy and efficiency of caregivers administering medications, providing physicians faster and easier access to critical information to manage patient care. MEDITECH's Bedside Verification functionality also utilizes bar code scanning prior to administering blood products, to confirm patient identity, ensure the right unit is transfused to the right patient, and verify information available in the Transfusion Administration Record.

Highlights:
- View critical patient information such as allergies, test results, and vital signs
- Document the administration of medications
- Enter comments relating to the administration of medications
- Enter reasons why a medication is not being administered
- Adjust the actual dose being administered
- View and change a medication's scheduled administrations
- View a medication's order and dose instructions
- View a medication's label comments
- View a medication's clinical indicator
- View a medication's monograph
- View patient allergies
- View associated data for specific medications
- Notify nurses of blood product availability
- Document the administration of blood products
- Document the blood transfusion in the Transfusion Administration Record, which is integrated with MEDITECH's Blood Bank application.

Standard Features
Bar Code Scanning
Caregivers scan bar codes on patient wristbands and medications to correctly identify the patient and the appropriate medication. Medications are identified by NDC numbers or the appropriate prescription number generated by the Pharmacy. Bedside Verification processes the data contributing to safe administration by ensuring the "Five Rights" of safe medication administration: Right Patient, Right Medication, Right Dosage, Right Route, and Right Time.

Bar code scanning is also utilized to ensure safe blood transfusions. Blood products and unit information-- including unit blood type and product-- are also bar coded, to accurately reconcile the correct unit and correct blood product with the correct blood type being administered to the patient.

Decision Support
The latest test results, allergies, and medication orders are immediately available through the patient profile to alert the caregiver to any potential problems prior to medication administration. If the scanned medication is not on the patient profile, the caregiver is given the option within the system to enter a new order and to record administration documentation. Since medication information is scanned and matched to the hospital's formulary dictionary - checking for drug interactions, allergies, and duplications - dose ranges can be performed prior to administering medications to the patient.

Likewise, the latest laboratory data is presented to the care provider when administering blood products, providing an additional safety check and identifying any potential problems before the blood is transfused to the patient.

Audit Trails
Details of the patients and medications scanned during the process of completing the on-line Medication Administration Record are made available through audit reports as well as details of the transfusion verification and administration process.

Dictionaries
Bedside Verification users can access dictionaries to identify appropriate NDC and prescription numbers that will be recognized by the bar code scanner. Alternate NDC numbers can also be set up in the dictionary to link drugs that are equal in every way except for manufacturer. Both primary and alternate NDC numbers are recognized by the system to match bar code information with the medication associated with prescriptions on the patient profile.

Power of Integration
Because the MEDITECH HCIS is fully integrated across the enterprise, data in the Medication Administration Record, Transfusion Verification Record, the patient Enterprise Medical Record, and Physician Order Management can be used to help coordinate the efforts of physicians, pharmacists, blood bank technologists, nurses, and other caregivers. Such integration enables quick access to patient-centric records, provides clinical decision support at the point of care, and allows records to be updated in real time, contributing to your efforts to improve patient safety.

For more information about us, contact a MEDITECH Marketing Representative.

MEDITECH
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Westwood, MA 02090
781-821-3000
www.meditech.com

MEDITECH
Emergency Department Management
product brief

MEDITECH's Emergency Department Management application assists Emergency Department clinicians and staff in the critical task of managing patients quickly and efficiently.

Highlights:
- Integrated desktop and patient tracking system
- Documentation
- Reception
- Discharge Management
- Registration
- Comprehensive medical record
- Patient documentation and triage
- Security
- Quick order entry, prescriptions, and medications
- Follow-up and call management.

Standard Features

Integrated Desktop and Patient Tracking System
The Patient Tracker Integrated Desktop allows the Emergency Department staff to document the daily functions performed in their care/treatment of patients and manage patient flow from a central point of entry.

Reception
During periods of peak activity, patients often enter the Emergency Department simultaneously. When this occurs, a triage nurse needs to quickly create a worklist so patients are triaged in proper order.

Our Reception routine allows triage nurses to record the small number of data fields necessary to get Emergency patients into the system quickly. Patients are then able to have orders placed, assessments performed, and documentation filed (even before patients are fully registered).

Registration
The Registration routine collects demographic and biographic information, as well as insurance, next of kin, and incident information.

Patient Documentation and Triage
Documentation is an important part of health care. Our assessment functionality provides access to neatly organized nursing assessments through routines specifically designed for the Emergency Department's workflow. The assessment data flows seamlessly into the MEDITECH Nursing application, providing a superior level of medical record continuity.

Efficient Management of Ambulatory Orders
MEDITECH's Ambulatory Order Management routine provides a health care network with the ability to track a patient's complete ambulatory profile. This can include prescriptions that were generated from the MEDITECH system in outpatient settings, from the provider's office, discharge from inpatient visits, or upon departure from the Emergency Department. Diagnostic procedures can also be generated to and communicated to appropriate ancillary services to ensure the proper follow-up care is provided to patients. Clinical staff can even identify prescriptions that are from outside of their network, so that they can be accounted for and incorporated into the patient's accurate ambulatory profile.

Ambulatory Order Management utilizes a wide range of patient safety measures to ensure the safe and effective distribution of prescriptions. The high level dynamic integration between Ambulatory Order Management and Provider Order Management allows Emergency Department staff to quickly and safely convert ambulatory prescriptions into current medication orders and vice versa. This inherent integration allows Emergency Department clinicians to effectively reconcile a patient's "at home" medications and gives them a greater understanding of a patient's chronic and acute medical conditions.

Documentation
The application's Documentation routine allows clinicians to enter free text notes and reports into the system. The routine provides quick and easy means to complete documentation, while at the same time, providing many of the same features found in our Departmental application. Users are able to enter fields and load canned text entries.

Additionally, users can customize the Emergency Department Tracker which allows for quick and efficient clinical documentation. With the Emergency Department Tracker documentation routine, users can arrange documentation screens and fields to appear on a single template or on specific choices of templates. Users navigate through the documentation process by clicking on questions and responding either with hard coded data or by using the MEDITECH text editor.

Users also have the ability to retrieve specified results, such as Laboratory results, medication orders, and vital signs, to incorporate into the documentation.The documentation entered in the Emergency Department appears in PCI or EMR for the attending physician to review.

Discharge
We provide an Advanced Discharge/Departure routine to help staff complete required paper work when patients are ready to leave. This feature includes the ability to automatically provide patient care instructions. When a clinician files the discharge screen, the system automatically departs the patient while discharge instructions, follow-up reminders, referrals, forms, and prescriptions are printing.

Comprehensive Medical Record
The Emergency Department Management application feeds data to our Patient Care Inquiry application to produce an integrated medical record throughout the Health Care Information System. A patient's Emergency Department visit data is available online from any client or terminal within the HCIS, for any user with access to view this information.

Security
Control of information and confidentiality of patient data are common concerns among health care organizations. The Emergency Department Management application provides user- and group-controlled access to information. A double key password system and custom menus supplied by the MIS application helps prevent unauthorized access. Dictionary controlled settings and audit trails provided by the application further help your IS staff control authorized access and potentially reduce security breaches.

Follow-Up and Call Management
We anticipate that clinical staff might elect to electronically mark selected patients for follow-up (F/U) calls, revisits, or other types of intervention by placing reminders. A reminder queue within the application allows users to document the follow-up management. The system can be used to log incoming calls and record them on patients' records.

For more information about us, contact a MEDITECH Marketing Representative.

MEDITECH
Medical Information Technology, Inc.

MEDITECH Circle
Westwood, MA 02090
781-821-3000
www.meditech.com

MEDITECH
Physician Care Manager
product brief

MEDITECH's Physician Care Manager enables physicians to direct care for a wide range of patient populations through a single, easy-to-use desktop portal. Physicians can manage care for patients who are being attended to in hospitals, emergency departments, physician offices, and clinics, with greater efficiency than ever before.

The Physician Care Manager provides physicians direct access to the information and functions they use daily to direct their patients' care.

Highlights:
MEDITECH's Physician Care Manager organizes a wide scope of software functionality and patient information into a cohesive package. The application includes:
- A streamlined desktop for managing patient populations
- Physicians' lists of active patients
- Patient care records, including outpatient visit information
- Electronic Signature features
- CPOE functionality including patient and drug-specific decision support
- Integration with Zynx Health, Inc. for accessing and importing evidence-based reference information
- Ambulatory ordering of prescriptions and care orders for departing emergency room patients
- Care documentation tools
- Secure, Internet-based access to information
- Physician rounding through a Web-based pocket PC or smart phone device.

Standard Features

Physician Desktop
The Physician Care Manager product displays the information physicians need on an electronic dashboard, so physicians have one destination from which they access information within the MEDITECH Health Care Information System. Through this desktop, physicians can manage their workloads, review patients' results, manage orders, document care, and electronically sign documents.

Patient-Specific Care Records
The Physician Care Manager includes both quick clinical review panels of information collected during a patient's current visit, as well as comprehensive electronic records for physicians' patients. Records provide information from visits conducted anywhere within the organization's continuum of care. This could include hospitals, emergency departments, physicians' offices, home health agencies, long-term care and behavioral health facilities, and satellite laboratories. Patients' electronic records are updated automatically when new results and visit information are entered.

Physicians have direct access to patient-specific:
- Problem Lists
- Progress Notes
- Current care results, diagnostic results, medications, documentation, orders, and reports
- Previous visit information with abstracts and demographic information
- Medical histories, including allergies, occupations, and social histories
- Care information from outpatient services
- Demographics, insurance, diagnostic, and procedural code assignments
- Graphs to display trends and abnormalities.

Computerized Physician Order Entry (CPOE)
Physicians enter and manage orders from the hospital, home, or while traveling. Capabilities from throughout the

MEDITECH HCIS are integrated to ensure a coordinated and safe ordering process. Pharmacists, nurses, laboratory and radiology technicians, and the rest of the care team are all tied into the physician-initiated process. What's more, physicians can sign any verbal orders and view results from wherever they may be.

The order management process is integrated with the Pharmacy to instantly compare formulary data against a patient's record during the clinical decision making process. Patient and drug information is presented to the physician at the time of ordering, thereby assisting with safety and efficiency. Decision support rules and physician preferences are embedded in the ordering process. Orders automatically appear on nurses' patient status boards.

The Physician Care Manager's CPOE component includes:
- Order sets based on physician preferences
- Integration with Zynx Health Inc. for importing evidence-based order sets
- Drug information from hospital formulary services
- Dose checking, dose calculator, conflict checking
- Duplicate order checks
- Patient's allergies, adverse reactions, medication checks
- Relevant clinical information such as vitals and test results
- Historical patient information
- Support for organization's standards of care and safety initiatives
- Direct link to MAR to update the patient's record.

Ordering Ambulatory Prescriptions and other Services
Physician Care Manager provides physicians with the ability to generate discharge orders for Emergency Department patients as well as those admitted to the hospital as inpatients. Physicians can manage prescriptions, follow-ups and diagnostics, durable medical equipment, and other orders for Emergency Department patients in the same manner by which they manage inpatient orders. Physicians furthermore are able to automatically convert inpatient orders to ambulatory orders, and likewise convert ambulatory orders to inpatient orders.

Physician Documentation
Physician Care Manager includes a comprehensive set of features for documenting the care patients receive. Physicians can create their own templates to streamline the documentation process using point and click queries, annotated images, free text, and canned text. System-wide integration also enables physicians to highlight key results in patients' records and include these results in care notes. Responses to queries will automatically generate detailed documentation. Physicians even have the option to store dictations or generate comments via voice recognition software through Dragon NaturallySpeaking software, provided by Nuance.

Physician Rounding
Physician Rounding allows physicians to access and update their patient lists from a Web-based pocket PC or smart phone device. From this device physicians can access the latest clinical data on their patients, including results, vital signs, intake and output, allergies, active medications, and documents (reports and notes). Physicians can also enter encounter notes and document Evaluation and Management (E&M) information while rounding on their patients.

Internet Access
With MEDITECH's support of three-tier solutions such as Windows Terminal Services and Citrix, physicians have fast, secure access to Physician Care Manager from office and home, as well as from the hospital.

Optional Access to Office Patients
MEDITECH's Physician Care Manager product is designed to work seamlessly with the Medical and Practice Management suite available for physicians' offices. For example, physicians are able to access patient charts and manage care for office and clinic patients directly through the Physician Desktop when the Physician Care Manager product is combined with the Medical and Practice Management product.

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MEDITECH
Medical Information Technology, Inc.
MEDITECH Circle
Westwood, MA 02090
781-821-3000
www.meditech.com

MEDITECH
Operating Room Management
product brief

MEDITECH's Operating Room Management application is designed to provide functionality for all aspects of running a hospital operating room including:
- Materials management
- Scheduling
- Clinical documentation
- Complete statistical and reporting capabilities.

In addition, the system automatically calculates billing charges based upon a set of rules established by the individual organization.

Highlights:
The application provides routines for:
- Integrated desktop and patient tracking system
- Operating room scheduling
- Scheduling equipment and resources
- Printing daily operating lists
- Documenting pre-op instructions and assessments
- Tracking patient risks
- Entering real-time peri-operative documentation
- Managing inventory
- Generating surgeon preference cards with costing information
- Tracking implants.

Standard Features

Scheduling
The application accommodates all aspects of scheduling by:
- Scheduling the visit, physician, room, and equipment from a single entry point
- Checking for scheduling conflicts with:
  - patient's schedule
  - physician's schedule
  - equipment availability
  - room availability.
- Calculating the average time it takes each physician to perform a specific procedure
- Maintaining physician privileges/specialties on-line
- Maintaining patient's confidential status during scheduling, based upon Registration parameters.

Preference Cards
Preference cards provide support to surgeons with features such as:
- Real-time updating and changing cost analysis
- Continuous analysis of surgical suite inventory and cost management
- Reports for analyzing usage and turnover
- Implant tracking routines:
  - document implant in the patient's profile
  - track device expiration date
  - records device serial number
  - continuous analysis of surgical suite inventory and cost management

- simplified "Just-In-Time" inventory through picks generation list.

Surgical Profile
Surgical Profile features include:
- Ability to view nursing assessments from pre-testing to recovery
- Routines for identifying and maintaining patient risks for future care
- Reports for capturing outcome data used in risk management and quality assurance
- Ability to document deferred cases.

Documentation
The application allows users to document the entire peri-operative episode. The system automatically captures who entered the information and the time of documentation. The information that is entered becomes part of the patient's surgical profile, as well as part of the statistical database of operating room events.

Reporting
Some standard reports included in the application include:
- Operating lists
- Daily log
- Acuity lists
- Delayed cases
- Unplanned cases
- Procedure counts
- Complications reports
- Anesthesia reports
- Block utilization
- Surgical profile audit trail.

An additional Compiled Report feature allows users to create their own reports.

Billing
The application also provides facilities with the ability to automatically generate billing information for operating room use. Users define the costs related to surgical cases including:
- Procedure
- Equipment use
- Operating room time
- Clinician rates
- Anesthesia or other drugs administered during surgery.

Other billing features include the ability to have preference card data automatically sent to the billing system and flat-rate charging capabilities.

Inventory Control
In order to assist operating room personnel in managing their inventories, the application:
- Generates pick lists based upon what was specified at the time the appointment was booked, and what is specified on the preference cards
- Prints pick lists by room(s), date(s), surgeon(s), specialty, or patient(s) and sorts by inventory, inventory location, or materials management location
- Provides flexibility within the pick list routines so that hospitals print pick lists using the criteria that best matches the inventory set-up
- Supports "Just-In-Time" inventory
- Prints pick lists in Central Supply or Materials Management, allowing for greater communication among departments
- Offers the ability to combine preference cards for patients having multiple surgeries, thereby avoiding the issuance of duplicate items and costs.

Operating Room Management runs under Microsoft Windows ® format on an Intel® based server. Operating Room Management is also available to customers running the MAGIC Release of MEDITECH's HCIS and integrates tightly with MEDITECH's MAGIC software applications.

Client/Server or 6.0 HCIS
Health care organizations running the Client/Server or 6.0 Releases of MEDITECH's HCIS realize additional functionality by integrating Operating Room Management with the following applications:
- Enterprise Medical Record: sets up unverified orders
- Supply Chain Management: creates on-line requisitions to manufacturers
- Health Information Management: identifies patient and resource conflicts, creates an account in the Registration system, and updates patient's visit history with operating room visit information.

The application also offers integration with MEDITECH's General Accounting product.

MAGIC HCIS
Health care organizations running the MAGIC Release of MEDITECH's HCIS realize additional functionality by integrating Operating Room Management with the following applications:
- Health Information Management: creates account in Registration application, which is accessed by Operating Room Management, identifies patient conflicts, and updates patient's visit history with operating room visit information
- Revenue Cycle: processes charges for staff time, procedures, operating times, supplies, and equipment
- Enterprise Medical Record: displays surgical profile information from Operating Room Management.

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Medical Information Technology, Inc.
MEDITECH Circle
Westwood, MA 02090
781-821-3000
www.meditech.com

MEDITECH
Scanning and Archiving
product brief

MEDITECH's Scanning and Archiving solution enables health care organizations to move toward a paperless environment by storing all health care information on-line. This application provides customers with an organization-wide solution to their document scanning and imaging needs, enabling staff members to quickly scan documents into their system, review the quality of images, associate documents with patient records, and incorporate the resulting digital documents directly into users' workflow. The Scanning and Archiving application enables customers to generate and maintain complete, secure, legal medical records. Tools are incorporated to efficiently organize and manage enterprise-wide documents, resulting in an increase in the quality of patient care and safety, and improved revenue cycle as well as a reduction in the risk of liability due to paper loss.

Highlights:
The Scanning and Archiving application provides organizations with:
- Enterprise-wide paperless capabilities
- More timely completion of the legal medical record post-discharge
- More expedient record processing by Health Information Management (HIM) staff and clinicians
- More efficient reproduction of the legal medical record
- More streamlined electronic document management and indexing, as forms electronically generated by the system are already part of the patient record
- Immediate access to scanned images in the Electronic Medical Record, improving the quality of patient care
- Improved revenue cycle via electronic data capture at the time of registration and billing.

Standard Features

Document Scanning
Users have the ability to scan documents in both portrait and landscape formats, individually or in batches.

Image Viewing
An image viewer provides a full page display of images. Users are able to rotate, flip, and zoom in and out of images as well as review the quality of imaging.

Archived Data and Image Storage
Organizations have the ability to store data on any device that presents itself to the MEDITECH system as a Microsoft® Windows®-accessible platform storage device.

Bar Code Recognition
The application is capable of recognizing bar code labels or codes on pre-printed forms to identify document type and/or patient identification to allow automatic indexing of documents.

Improved Revenue Cycle Management
Users have the ability to scan patient information such as drivers' licenses and insurance cards into their information system and to link this information to patient billing records to enhance the revenue cycle. This scanning and indexing of information is incorporated into the registration process to expedite workflow. Some of the information that can be scanned at the point of registration includes legally identified documents, such as surgical consent forms and living wills, in addition to clinically relevant data, including values from outside laboratories.

Streamlined Health Information Management Processes

The Scanning and Archiving solution streamlines the release-of-information process within the Health Information Management Department. Requests are honored without the cumbersome tasks of finding and copying documents, and reassembling the charts.

The use of scanned documents results in the reduction of storage issues and inherent costs of retrieving paper charts. In addition, chart requests are dramatically reduced with the capability for clinicians to review patients' comprehensive medical histories on-line.

Clinicians benefit from immediate access to scanned images in the on-line medical record. Physicians also have the ability to complete all chart deficiencies from any workstation. Scanned images are linked to the incomplete record notifications to alert physicians of any deficiencies. Physicians may simultaneously view and electronically sign documents, which immediately updates deficiencies. This automatic transaction does not require the intervention of a Health Information Management analyst, thus streamlining workflow.

Streamlined Coding Workflow and Tools for Monitoring Coder Productivity
The Scanning and Archiving application helps to ensure medical records are comprehensive and complete by the efficient incorporation of images into the workflow. Patients' complete charts are available to coders through MEDITECH's Enterprise Medical Record application while the coders perform their work, enabling on-site or remote coding in a paperless environment. Coders have worklists, based on their user profiles, to navigate through charts while coding. In addition, Health Information Management professionals are able to manage and prioritize patient charts as well as assign workload.

Simplified Creation of a Legal Record
Any documents or forms generated in the system via clinical and/or administrative documentation are automatically indexed into the electronic chart in a defined order, which facilitates the easy creation of an electronic record. Additional printing and re-scanning of these forms is not necessary. Using this electronic record, your health care organization ultimately produces a facility-defined legal record.

Portable Medical Records on CD
MEDITECH customers are able to easily generate complete legal records on CDs. This subsequently contributes to the ease in reproducing the legal medical record. With the legal record available on CD, patients have a portable medium on which to access their personal health information.

Administrative Tools
Reports are provided for users to track the movement of images in the system, and to monitor staff performance.

Business Office Scanning
A future Business Office component of the Scanning and Archiving product will incorporate document scanning into the workflow of MEDITECH's financial applications so that organizations can include scanned documents into their financial solutions such as Human Resources, Accounts Payable, and Materials Management.

MEDITECH
Medical Information Technology, Inc.
MEDITECH Circle
Westwood, MA 02090
781-821-3000
www.meditech.com

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 21, 2009

To: City of Alameda Health Care District Board of Directors

From: Phyllis Weiss, Director of Human Resources

Subject: Approval of Amendment No. 7 to the Alameda Hospital Pension Plan and Resolution No. 2009-2G – Amendment No. 7 to the Alameda Pension Plan

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Alameda Hospital's Pension Plans require the Board approval to make any amendments.

The Alameda Hospital (frozen) Pension Plan requires amending in order incorporate the following:

- IRS Final #415 regulations
  - Regulates the limit on the size of an annual benefit a participant can earn under the plan, payable between age 62 and 65.

- Updates as required by the Pension Protection Act (PPA) including:
  - Adopting updated interest rate and mortality tables for lump sum calculations
  - Offering new Qualified Optional Survivor Annuities
  - Expanding notice period to 180 days of distribution options
  - Allowing for non-spouse beneficiary roll-over lump sum payment into an IRA

- Clarifying that the language related to calculating total compensation going forward is inapplicable due to the frozen status of this plan.

The deadline to have the IRS Final #415 regulations incorporated into this plan is June 30, 2009.

Management is recommending that the Board approve Resolution 2009-2G and Amendment No. 7 to the Pension Plan in order to comply with regulations/requirements.

AMENDMENT No. 7
TO THE ALAMEDA HOSPITAL PENSION PLAN

City of Alameda Health Care District (the "District"), pursuant to Article X, Section A of the Alameda Hospital Pension Plan (the "Plan"), hereby adopts the following amendments to bring the Plan into compliance with the final regulations under Internal Revenue Code Section 415 and the Pension Protection Act of 2006 (PPA).

1. Article I, Section B, of the Plan is hereby amended effective July 1, 2008 to add the following to the end of the second paragraph:

> Effective July 1, 2008, the present value of any distribution, including a single sum (other than a nondecreasing lifetime annuity), shall equal the present value calculated using the Applicable Interest Rate and the Pension Protection Act applicable mortality table pursuant to Code Section 417(e)(3). The PPA applicable interest rate is the adjusted first, second, and third transitional segment rates, as published by the Secretary for the third calendar month preceding the month that contains the annuity starting date. The PPA applicable mortality table means the 2008 Applicable Mortality Table prescribed by the Secretary in Revenue Ruling 2007-67, or such other table as the Secretary may prescribe from time to time.

2. Article I, Section F, of the Plan is hereby amended effective July 1, 2008 to add the following to the end thereof: "Effective July 1, 2008, the Applicable Interest Rate is the adjusted first, second, and third transitional segment rates, as published by the Secretary for the second calendar month preceding the Plan Year that contains the annuity starting date."

3. Article I, Section T of the Plan is amended by adding the following sentence to the end thereof: "This definition is inapplicable after the assumption of this plan by the City of Alameda Health care District."

4. Article IV, Section O, is hereby amended effective July 1, 2008 to add the following paragraph 7:

> 7. Effective July 1, 2008, in lieu of the Qualified Joint and Survivor Annuity in Article II, Section AP, the Participant with spousal consent as required by Article IV, Section P, may elect an annuity for the life of the Participant, with a survivor annuity for the life of his Spouse which is 75% of the amount payable during the joint lives of the Participant and his Spouse (a qualified optional survivor annuity).

5. Article IV, Section P, is hereby amended effective July 1, 2008 to add the following to the end of Paragraph 1:

> Notwithstanding the foregoing, effective July 1, 2008, the written statement of a Participant's right not to elect a Qualified Joint and Survivor Annuity as his form of payment shall be provided no more than 180 days and no less than 30 days prior to the Annuity Starting Date (subject to the waiver of the 30-day requirement provided for in this Article IV, Section Q).

6. Article IV, Section R, is hereby amended effective July 1, 2008 to add the following paragraph 3:

> 3. Effective with respect to distributions made after July 1, 2008, if, with respect to any portion of a distribution from this Plan on behalf of a deceased Participant, a direct trustee-to-trustee transfer is made to an individual retirement plan described in Code Section 402(c)(8)(B)(i) or (ii) established for the purposes of receiving the distribution on behalf of an individual who is a designated beneficiary (as defined in Code Section 401(a)(9)(E)) of the Participant and who is not the surviving Spouse of the Participant, then (1) the transfer shall be treated as an eligible rollover distribution, (2) the individual retirement plan shall be treated as an inherited individual retirement account or individual retirement annuity (within the meaning of Code Section 408(d)(3)(C)), and (3) Code Section 401(a)(9)(B) (other than clause (iv) thereof) shall apply to such plan.

7. Article V, Section A of the Plan, as previously amended, is hereby amended to restate paragraphs 4 and 5 thereof, effective as of the dates stated herein:

> 4. Notwithstanding any other provision contained in this Plan, the applicable provisions of Code Section 415, as applicable to a governmental plan effective November 1, 2002, as amended from time to time, and the regulations issued thereunder, are hereby incorporated into the Plan.
>
> 5. For distributions made after December 31, 1994, but prior to July 1, 2008, in a mode of payment (e.g. life annuity) not subject to Section 417(e) of the Code, actuarial equivalence of the Defined Benefit Dollar Limitation shall the greater of the equivalent amount computed using (i) the interest rate and mortality table or tabular factor specified in the Plan (Article II, Section B) for actuarial equivalence for the particular form of benefit available, or (ii) an interest rate of five percent (5%) and the applicable mortality table. If the mode of payment of the Annual Benefit is a lump sum or other mode subject to 417(e)(3), actuarial equivalence shall be the greater of the amount computed using (i) the Plan interest rate and Plan mortality table for determining

actuarial equivalence, or (ii) the Applicable Interest Rate and mortality table (Article II, Sections B and F). For purposes of determining the Actuarial Equivalent straight life annuity for any form of benefits subject to Code Section 417(e)(3): (i) for Limitation Years beginning on or after January 1, 1999 but prior to July 1, 2008, the interest rate shall be the greater of the rate specified in Article I, Section B or the Applicable Interest Rate; (ii) for Limitation Years beginning in 2004 and 2005, the interest rate shall be the greater of 5.5% or the rate specified in Article I, Section B; (iii) for Limitation Years beginning after December 31, 2005, the interest rate shall be the greater of 5.5%, the rate specified in Article I, Section B, or the rate that provides a benefit of 105% of the benefit that results from using the Applicable Interest Rate.

8. Article V of the Plan, is hereby amended by adding the following new Section B, effective as of July 1, 2008:

B. Maximum Permissible Benefits Under IRC § 415 – Effective July 1, 2008. This Section B is effective as indicated herein for the respective provisions. This Section B is adopted to reflect certain changes in the qualification requirements for plans intended to qualify under Section 401(a) of the Internal Revenue Code. This Section B is adopted as good faith compliance with such requirements and with the intent of maintaining the qualified status of the Plan and is intended to be "interim amendments" as those are described in Internal Revenue Procedure 2007-44 and to extend the remedial amendment period for all provisions herein to the date established by such Revenue Procedure. This Section B shall supplement and not replace Article V, Section A, paragraph 4.

1. Annual Benefit.

(a) Effective date. The limitations of this Article apply in "Limitation Years" beginning on or after July 1, 2008, except as otherwise provided herein.

(b) "Annual Benefit". The "Annual Benefit" otherwise payable to a Participant in the Plan at any time shall not exceed the "Maximum Permissible Benefit." If the benefit the Participant would otherwise accrue in a "Limitation Year" would produce an "Annual Benefit" in excess of the "Maximum Permissible Benefit," then the benefit under the Plan shall be limited (or the rate of accrual reduced) to a benefit that does not exceed the "Maximum Permissible Benefit."

2. Definitions. For purposes of this Section B, the following definitions apply.

(a) Annual Benefit. "Annual Benefit" means a benefit that is payable annually in the form of a "Straight Life Annuity." Except as provided below, where a benefit is payable in a form other than a "Straight Life Annuity," the benefit shall be adjusted to an actuarially equivalent "Straight Life Annuity" that begins at the same

time as such other form of benefit and is payable on the first day of each month, before applying the limitations of this Article. For a Participant who has or will have distributions commencing at more than one Annuity Starting Date, the "Annual Benefit" shall be determined as of each such Annuity Starting Date (and shall satisfy the limitations of this Article as of each such date), actuarially adjusting for past and future distributions of benefits commencing at the other Annuity Starting Dates. For this purpose, the determination of whether a new Annuity Starting Date has occurred shall be made without regard to Regulations Section 1.401(a)-20, Q&A 10(d), and with regard to Regulations Section 1.415(b)1(b)(1)(iii)(B) and (C).

No actuarial adjustment to the benefit shall be made for (a) survivor benefits payable to a surviving spouse under a qualified joint and survivor annuity to the extent such benefits would not be payable if the Participant's benefit were paid in another form; and (b) benefits that are not directly related to retirement benefits (such as a qualified disability benefit, preretirement incidental death benefits, and postretirement medical benefits.

Effective for distributions in Plan Years beginning after December 31, 2003, the determination of actuarial equivalence of forms of benefit other than a "Straight Life Annuity" shall be made in accordance with (1) or (2) below.

(1) Benefit Forms Not Subject to Code Section 417(e)(3).

The "Straight Life Annuity" that is actuarially equivalent to the Participant's form of benefit shall be determined under this subsection (1) if the form of the Participant's benefit is either (a) a nondecreasing annuity (other than a "Straight Life Annuity") payable for a period of not less than the life of the Participant (or, in the case of a qualified pre-retirement survivor annuity, the life of the surviving spouse), or (b) an annuity that decreases during the life of the Participant merely because of (1) the death of the survivor annuitant (but only if the reduction is not below 50% of the benefit payable before the death of the survivor annuitant), or (2) the cessation or reduction of Social Security supplements or qualified disability payments (as defined in Code Section 401(a)(11)).

(i) "Limitation Years" beginning before July 1, 2008. For "Limitation Years" beginning before July 1, 2008, the actuarially equivalent "Straight Life Annuity" is equal to the annual amount of the "Straight Life Annuity" commencing at the same Annuity Starting Date that has the same actuarial present value as the Participant's form of benefit computed using whichever of the following produces the greater annual amount: (I) the interest rate and mortality table (or other tabular factor) specified in Article II, Section B for adjusting benefits in the same form; and (II) 5% interest rate assumption and the applicable mortality table defined in Article II, Section B for that Annuity Starting Date.

(ii) "Limitation Years" beginning on or after July 1, 2008. For "Limitation Years" beginning on or after July 1, 2008, the actuarially equivalent "Straight Life Annuity" is equal to the greater of (I) the annual amount of the "Straight Life Annuity" (if any) payable to the Participant under the Plan commencing at the same Annuity Starting Date as the Participant's form of benefit; and (II) the annual

amount of the “Straight Life Annuity” commencing at the same Annuity Starting Date that has the same actuarial present value as the Participant’s form of benefit, computed using a 5% interest rate assumption and the applicable mortality table defined Article II, Section B for that Annuity Starting Date.

(2) Benefit Forms Subject to Code Section 417(e)(3).

The "Straight Life Annuity" that is actuarially equivalent to the Participant’s form of benefit shall be determined under this paragraph if the form of the Participant’s benefit is other than a benefit form described in Section B.2(a)(1) above. In this case, the actuarially equivalent "Straight Life Annuity" shall be determined as follows:

(i) Annuity Starting Date in Plan Years Beginning After 2005. If the Annuity Starting Date of the Participant’s form of benefit is in a Plan Year beginning after 2005, the actuarially equivalent "Straight Life Annuity" is equal to the greatest of (I) the annual amount of the "Straight Life Annuity" commencing at the same Annuity Starting Date that has the same actuarial present value as the Participant’s form of benefit, computed using the interest rate and mortality table (or other tabular factor) specified in Article II, Section B for adjusting benefits in the same form; (II) the annual amount of the "Straight Life Annuity" commencing at the same Annuity Starting Date that has the same actuarial present value as the Participant’s form of benefit, computed using a 5.5 percent interest rate assumption and the applicable mortality table defined in Article II, Section B; and (III) the annual amount of the "Straight Life Annuity" commencing at the same Annuity Starting Date that has the same actuarial present value as the Participant’s form of benefit, computed using the Applicable Interest Rate defined in Code Section 417(e)(3) and applicable mortality table defined in Article II, Section B, divided by 1.05.

(ii) Annuity Starting Date in Plan Years Beginning in 2004 or 2005. If the Annuity Starting Date of the Participant’s form of benefit is in a Plan Year beginning in 2004 or 2005, the actuarially equivalent "Straight Life Annuity" is equal to the annual amount of the "Straight Life Annuity" commencing at the same annuity starting date that has the same actuarial present value as the Participant’s form of benefit, computed using whichever of the following produces the greater annual amount: (I) the interest rate and mortality table (or other tabular factor) specified in Article II, Section B for adjusting benefits in the same form; and (II) a 5.5% interest rate assumption and the applicable mortality table defined in Article II, Section B.

(b) Defined Benefit Dollar Limitation. “Defined Benefit Dollar Limitation” means, effective for “Limitation Years” ending after December 31, 2001, $160,000, automatically adjusted under Code Section 415(d), effective January 1 of each year, as published in the Internal Revenue Bulletin, and payable in the form of a “Straight Life Annuity.” The new limitation shall apply to “Limitation Years” ending with or within the calendar year of the date of the adjustment, but a Participant’s benefits shall not reflect the adjusted limit prior to January 1 of that calendar year.

(c) Limitation Year. "Limitation Year" means the Plan Year.

(d) Maximum Permissible Benefit. "Maximum Permissible Benefit" means the "Defined Benefit Dollar Limitation" (adjusted where required, as provided below).

(1) Adjustment for Less Than 10 Years of Participation: If the Participant has less than 10 years of participation in the Plan, the "Defined Benefit Dollar Limitation" shall be multiplied by a fraction -- (i) the numerator of which is the number of "Years of Participation" in the Plan (or part thereof, but not less than one year), and (ii) the denominator of which is ten (10).

(2) Adjustment of "Defined Benefit Dollar Limitation" for Benefit Commencement Before Age 62 or after Age 65: Effective for benefits commencing in "Limitation Years" ending after December 31, 2001, the "Defined Benefit Dollar Limitation" shall be adjusted if the Annuity Starting Date of the Participant's benefit is before age 62 or after age 65. If the Annuity Starting Date is before age 62, the "Defined Benefit Dollar Limitation" shall be adjusted under section B.2(d)(2)(i), as modified by Section B.2(d)(2)(iii). If the Annuity Starting Date is after age 65, the "Defined Benefit Dollar Limitation" shall be adjusted under Section B.2(d)(2)(ii), as modified by Section B.2(d)(2)(iii).

(i) Adjustment of "Defined Benefit Dollar Limitation" for Benefit Commencement Before Age 62 (not applicable to death or disability benefits as defined in Treas. Reg. 1.415(b)-1(d)(4):

(I) "Limitation Years" Beginning Before July 1, 2008. If the Annuity Starting Date for the Participant's benefit is prior to age 62 and occurs in a "Limitation Year" beginning before July 1, 2008, the "Defined Benefit Dollar Limitation" for the Participant's Annuity Starting Date is the annual amount of a benefit payable in the form of a "Straight Life Annuity" commencing at the Participant's Annuity Starting Date that is the actuarial equivalent of the "Defined Benefit Dollar Limitation" (adjusted under Section B.2(d)(1) for years of participation less than ten (10), if required) with actuarial equivalence computed using whichever of the following produces the smaller annual amount: (1) the interest rate and mortality table (or other tabular factor) specified in the Plan; or (2) a five-percent (5%) interest rate assumption and the applicable mortality table as defined in the Plan.

(II) "Limitation Years" Beginning on or After July 1, 2008. If the Annuity Starting Date for the Participant's benefit is prior to age 62 and occurs in a "Limitation Year" beginning on or after July 1, 2008, and the Plan does not have an immediately commencing "Straight Life Annuity" payable at both age 62 and the age of benefit commencement, the "Defined Benefit Dollar Limitation" for the Participant's Annuity Starting Date is the annual amount of a benefit payable in the form of a "Straight Life Annuity" commencing at the Participant's Annuity Starting Date that is the actuarial equivalent of the "Defined Benefit Dollar Limitation" (adjusted under Section B.2(d)(1) for years of participation less than ten (10), if required) with actuarial equivalence computed using a five-percent (5%) interest rate assumption and the applicable mortality table for the Annuity Starting Date as defined in Article II, Section B (and expressing the Participant's age based on completed calendar months as of the Annuity Starting Date).

(ii) Adjustment of "Defined Benefit Dollar Limitation" for Benefit Commencement After Age 65:

(I) "Limitation Years" Beginning Before July 1, 2008. If the Annuity Starting Date for the Participant's benefit is after age 65 and occurs in a Limitation Year beginning before July 1, 2008, the "Defined Benefit Dollar Limitation" for the Participant's Annuity Starting Date is the annual amount of a benefit payable in the form of a "Straight Life Annuity" commencing at the Participant's Annuity Starting Date that is the actuarial equivalent of the "Defined Benefit Dollar Limitation" (adjusted under Section B.2(d)(1) for years of participation less than ten (10), if required) with actuarial equivalence computed using whichever of the following produces the smaller annual amount: (1) the interest rate and mortality table (or other tabular factor) specified in the Plan; or (2) a five-percent (5%) interest rate assumption and the applicable mortality table as defined in the Plan.

(II) "Limitation Years" Beginning After July 1, 2008. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a "Limitation Year" beginning on or after July 1, 2008, and the Plan does not have an immediately commencing "Straight Life Annuity" payable at both age 65 and the age of benefit commencement, the "Defined Benefit Dollar Limitation" at the Participant's Annuity Starting Date is the annual amount of a benefit payable in the form of a "Straight Life Annuity" commencing at the Participant's Annuity Starting Date that is the actuarial equivalent of the "Defined Benefit Dollar Limitation" (adjusted under Section B.2(d)(1) for years of participation less than 10, if required), with actuarial equivalence computed using a 5% interest rate assumption and the applicable mortality table for that Annuity Starting Date as defined in Article II, Section B (and expressing the Participant's age based on completed calendar months as of the Annuity Starting Date).

(iii) Notwithstanding the other requirements of this Section B.2(d)(2), no adjustment shall be made to the "Defined Benefit Dollar Limitation" to reflect the probability of a Participant's death between the Annuity Starting Date and age 62, or between age 65 and the Annuity Starting Date, as applicable, if benefits are not forfeited upon the death of the Participant prior to the Annuity Starting Date. To the extent benefits are forfeited upon death before the Annuity Starting Date, such an adjustment shall be made. For this purpose, no forfeiture shall be treated as occurring upon the Participant's death if the Plan does not charge Participants for providing a qualified preretirement survivor annuity, as defined in Code Section 417(c), upon the Participant's death.

(e) Straight Life Annuity. "Straight Life Annuity" means an annuity payable in equal installments for the life of a Participant that terminates upon the Participant's death.

(f) Year of Participation. "Year of Participation" means, with respect to a Participant, each accrual computation period (computed to fractional parts of a year) for which the following conditions are met: (1) the Participant is credited with at least the number of Hours of Service (or Period of Service if the Elapsed Time Method is used) for benefit accrual purposes, required under the terms of the Plan in order to accrue a benefit for the accrual computation period, and (2) the Participant is included as a Participant under the eligibility provisions of the Plan for at least one day of the accrual computation period. If these two conditions are met, the portion of a "Year of

Participation" credited to the Participant shall equal the amount of benefit accrual service credited to the Participant for such accrual computation period. A Participant who is permanently and totally disabled within the meaning of Code Section 415(c)(3)(C)(i) for an accrual computation period shall receive a "Year of Participation" with respect to that period.

Dated this _____ day of _____, 2009.

CITY OF ALAMEDA HEALTH CARE DISTRICT

By _____
Its Chief Executive Officer

RESOLUTION NO. 2009-2G

AMENDMENT NO. 7
TO THE ALAMEDA PENSION PLAN

WHEREAS, the City of Alameda Health Care District ("District") has reserved the right to amend the Alameda Hospital Pension Plan ("Pension Plan"); and

WHEREAS, the Pension Plan has implemented new assumptions for calculation of lump sum payments in accordance with the Pension Protection Act of 2006; and

WHEREAS, the IRS has also issued final regulations under Code section 415 that apply to the Pension Plan; and

WHEREAS, the Board desires to amend the Pension Plan to comply with these requirements and adopt other administrative changes permitted by the Pension Protection Act of 2006, generally effective as of July 1, 2008;

NOW, THEREFORE, it is hereby resolved by the Board of Directors of the District that :

1. Amendment No. 7 attached hereto as Exhibit 1 is hereby approved and adopted to implement the changes to the Pension Plan under the Pension Protection Act of 2006 and final 415 regulations.

2. The Chief Executive Officer of the District shall execute the amendment prior to June 30, 2009.

This resolution adopting Amendment No. 7 to the Alameda Hospital Pension Plan has been adopted by the Board of Directors of the City of Alameda Health care District at a duly constituted meeting of the Board held in the City of Alameda, California on June 1, 2009 by the following vote:

AYES: _____ NOES: _____ ABSENT: _____

_____ _____

President Secretary

Alameda Hospital
Quality Care - Close To Home

Please use the enclosed envelope and mail the completed survey to:
NRC Picker
Survey Processing Center
PO BOX 82660
Lincoln, NE 68501-2660
1-800-733-6714

** 0060421-A12345 **
MR CHRISTOPHER JOHNSON
1245 Q ST STE 400
LINCOLN, NE 68508-1430

Dear Alameda Hospital Staff Member:

I am writing to ask for your help in completing the enclosed survey. This survey will support our efforts to deliver preeminence for our patients, community, and associates. Your responses to this survey will also help us understand how the employees at Alameda Hospital see their work. It will assist us in identifying any area where we can work together to improve our workplace and make it better for employees and patients. We value and need your participation.

For the survey to be successful we must have everyone in the organization complete a survey. Please take some time to answer the survey questions so that your viewpoints are included. After the survey is completed, the results will be compiled and shared with all employees. Action plans will then be developed to begin work on the areas identified for improvement.

Please be assured that your answers to the survey will remain confidential. You may mail your completed survey directly to NRC Picker, a company who is assisting us with the survey, or complete your survey on-line. To complete your survey on-line, please go to:

http://nrcpicker.com/survey
The password assigned for your exclusive use is:

NRC Picker will prepare a written summary of all responses and will not give Alameda Hospital any individual feedback, i.e. they will not reveal who wrote what. If you need any help in completing the survey, or if you have any questions, please feel free to contact your manager.

Understanding your thoughts and feelings is important for the future of Alameda Hospital. Please let us know what you think by completing the survey. Many thanks for not only taking the time to answer this survey, but for all you do for Alameda Hospital and our patients each and every day.

Sincerely,

Deborah E. Stebbins
Chief Executive Officer

Alameda Hospital
Quality Care - Close To Home

Please use the enclosed envelope and mail the completed survey to:
NRC Picker
Survey Processing Center
PO BOX 82660
Lincoln, NE 68501-2660
1-800-733-6714

1. Please indicate which Department(s) you work in?

- ⬭ 3 West
- ⬭ Administration
- ⬭ Business Office (Admitting & Patient Accounting)
- ⬭ Central Service and Supply
- ⬭ Clinical Laboratory / Cardiology
- ⬭ CCU
- ⬭ Definitive Observation Unit (DOU)
- ⬭ Dietary Services
- ⬭ Emergency Care Center
- ⬭ Engineering / Plant Maintenance
- ⬭ Environmental Service
- ⬭ Accounting/Finance
- ⬭ Health Information Management
- ⬭ Human Resources
- ⬭ Information Systems
- ⬭ Infusion Therapy
- ⬭ Nursing Administration
- ⬭ Pharmacy
- ⬭ Purchasing and Stores
- ⬭ Quality Resource Management / UR
- ⬭ Imaging Services
- ⬭ Rehabilitation Services
- ⬭ Respiratory Therapy
- ⬭ Short Stay Surgery
- ⬭ South Shore Skilled Nursing Facility
- ⬭ Sub Acute Unit
- ⬭ Surgery and Recovery
- ⬭ Other
- ⬭ I Choose Not To Disclose My Home Department

IMPROVING YOUR WORKPLACE

Section 1: How would you rate your workplace?

Please rate your organization on the following items by filling in the oval that corresponds to your answer choice.

2. **COMMUNICATION**

a. Your organization's efforts to ensure quality of care as a principal goal
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

b. Your involvement in decisions that affect your work
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

c. How clear the mission and goals of your organization are
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

d. How clearly defined your role and work expectations are
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

e. How openly and honestly the person you report to or receive daily instruction from communicates
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

f. How well informed are you about the hospitals Strategic Plan and Strategic Direction?
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

3. **RESPECT**

a. How well the person you report to or receive daily instructions from responds to your ideas and concerns
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

b. Fair and equal treatment by the person you report to or receive daily instruction from
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent ⬭ Not Applicable

3. **RESPECT**

c. How well your organization respects staff diversity
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

d. Recognition and support for your role
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

4. **COMPENSATION**

a. Your pay (compared to other similar organizations)
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

b. Your benefits package
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

c. Your job security
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

5. **TEAMWORK**

a. How well staff work together and help each other out
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

b. Interdepartmental/team support and communication
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

6. **WORK PRACTICE**

a. How manageable your workload is
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

b. Flexibility in your scheduling/work hours
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

c. How well you are trained and supported on the job
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

d. Freedom to make improvements to how your work is done
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

e. A positive and fun environment to work in
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

f. Your opportunities for education and training
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

7. **PHYSICAL ENVIRONMENT AND SAFETY**

a. The cleanliness of the environment you work in
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

b. How well the layout of the work area lets you do your job
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

c. A safe and hazard-free environment for you to work in
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

d. Your personal security and safety in your work place
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

e. Up-to-date computer technology for you to use
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

f. Up-to-date equipment for you to use
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent ○ Not Applicable

8. **TRAINING**

a. Do you and your supervisor discuss plans for your training and development?
Never Sometimes Usually Always

b. How often do you have the opportunity to attend training that can help you do your job better?
Never Sometimes Usually Always

c. Are you generally satisfied with the training opportunities provided to you?
Never Sometimes Usually Always

d. Are you generally satisfied with the in-house education and training provided at Alpha Hospital?
Never Sometimes Usually Always

e. Do you feel that you understand the current Joint Commission standards as they apply to your job?
Never Sometimes Usually Always

f. Are you kept aware of your departments Performance Improvement initiatives and of the goals for improvement?
Never Sometimes Usually Always

9. What **three things** could Alpha Hospital do to improve the safety of your work environment? (**Select three only**)

- Safe lift and transfer education and training
- Ongoing training and management of challenging/aggressive behaviour
- Yearly safety protocol training and drills
- Increase visibility and number of security personnel
- Improve/up-date equipment/ensure proper functioning equipment
- Ergonomic assessments of work stations and equipment
- Improve cleanliness of work environment
- Increase number of security cameras
- Increase skills training to manage high risk care situations
- Increase training and information related to safety hazards
- Reduce accessibility to work areas
- Training on working safely in the community
- Infection control/routine practices training
- Don't know
- Other

10. What are your **three most important** training needs? (**Select three only**)

- Clinical aspects of my job
- Computer training
- Quality improvement
- Personal leadership skills
- Time management
- Non-clinical skills specific to my job task
- Management in the workplace
- Conflict resolution
- Leading a team
- Effective communication
- Team work
- Risk management
- Strategies of running effective meeting
- Abuse policies
- Performance management
- Coaching
- Patient/client safety
- Stress management
- Assertiveness
- Emergency response
- Staff safety
- No training needs
- Don't know
- Other

11. What **three things** could Alpha Hospital do to reduce work stress? (**Select three only**)
- ⬭ Provide relaxation or yoga sessions
- ⬭ Improve staff lounges
- ⬭ Permit flexible hours or scheduling
- ⬭ Provide stress management training
- ⬭ Ensure appropriate vacation or time off is taken
- ⬭ Have someone staff can talk to: e.g. employee ombudsperson, councilor, etc.
- ⬭ Improve equipment
- ⬭ Provide an Employee Assistance Program (EAP)
- ⬭ Don't Know
- ⬭ Other
- ⬭ Work stress is not an issue for me

12. **DIVERSITY**

a. Alpha Hospital demonstrates that it values people of different racial and ethnic backgrounds.
⬭ Strongly Disagree ⬭ Disagree ⬭ Neither ⬭ Agree ⬭ Strongly Agree

b. Do staff and patients have trouble communicating because of language differences?
⬭ Never ⬭ Sometimes ⬭ Usually ⬭ Always

Section 2: Organizational Commitment and Career Plans

Please fill in the oval that best reflects what you think about each statement.

13. I talk up this organization to my friends as a great organization to work for
⬭ Strongly disagree ⬭ Slightly disagree ⬭ Slightly agree ⬭ Strongly agree
⬭ Moderately disagree ⬭ Neither agree nor disagree ⬭ Moderately agree

14. I am proud to tell others that I am part of this organization
⬭ Strongly disagree ⬭ Slightly disagree ⬭ Slightly agree ⬭ Strongly agree
⬭ Moderately disagree ⬭ Neither agree nor disagree ⬭ Moderately agree

15. I find that my values and the organization's values are similar
⬭ Strongly disagree ⬭ Slightly disagree ⬭ Slightly agree ⬭ Strongly agree
⬭ Moderately disagree ⬭ Neither agree nor disagree ⬭ Moderately agree

16. This organization really inspires the very best in me in the way of job performance
⬭ Strongly disagree ⬭ Slightly disagree ⬭ Slightly agree ⬭ Strongly agree
⬭ Moderately disagree ⬭ Neither agree nor disagree ⬭ Moderately agree

17. I am extremely glad that I chose this organization to work for over others I was considering at the time I joined
⬭ Strongly disagree ⬭ Slightly disagree ⬭ Slightly agree ⬭ Strongly agree
⬭ Moderately disagree ⬭ Neither agree nor disagree ⬭ Moderately agree

18. How likely is it that you will actively look for a new job in the next year?
⬭ Very Unlikely ⬭ Somewhat Unlikely ⬭ Somewhat Likely ⬭ Very Likely

Overall Impressions

19. Overall, how would you rate Alpha Hospital as a place to work?
⬭ Poor ⬭ Fair ⬭ Good ⬭ Very Good ⬭ Excellent

20. How likely would you be to recommend your organization to a family member or friend looking for employment?
⬭ Very Unlikely ⬭ Somewhat Unlikely ⬭ Somewhat Likely ⬭ Very Likely

21. In your staff position, do you typically have direct interaction or contact with patients? Please mark only ONE answer.
⬭ Yes, I typically have direct interaction or contact with patients
⬭ No, I typically do NOT have direct interaction or contact with patients

If you answered "No" in question 20, please skip to question 35.

Section 3: Patient Centered Work Environment

22. Do you believe your work unit provides top quality patient care?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

23. Do you feel that you have the right materials and equipment available to give patients the best treatment for their symptoms or conditions?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

24. Do you feel that you have enough help from other staff to give patients the best treatment for their symptoms or conditions?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

25. Overall, is your work unit well organized to meet the needs of your patients?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

26. Are you able to get timely information about your patients' medical condition, treatment or tests?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

27. Do you have the time you need to talk with your patients to make sure they get the information they want about their medical condition, treatment, or tests?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

28. Do you have the time and information to prepare patients for leaving the hospital/program?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

29. How often is communication between your unit/department and other unit/departments about a patient a problem?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

30. Are you able to support and involve family members when requested by the patient?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

31. Are you able to involve patients in decisions about their care?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

32. Are you able to treat patients as individuals with unique needs and preferences?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

33. Is senior management at Alpha Hospital committed to providing high quality, patient-centered care?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

34. How often do managers in your work unit set clear standards for quality?
    ○ Never ○ Sometimes ○ Usually ○ Always ○ Not applicable

35. **Think about your hospital work area/unit…**

    a. It is just by chance that more serious mistakes don't happen around here
       ○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

    b. Patient safety is never sacrificed to get more work done
       ○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

    c. We have patient safety problems in this unit
       ○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

    d. Our procedures and systems are good at preventing errors from happening
       ○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

    e. People support one another on this unit
       ○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

    f. When a lot of work needs to get done quickly, we work together as a team to get the work done
       ○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

35. **Think about your hospital work area/unit…**

g. In this unit, people treat each other with respect
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

h. When one area in this unit gets really busy, others help out
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

i. We are actively doing things to improve patient safety
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

j. Mistakes have led to positive changes here
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

k. After we make changes to improve patient safety, we evaluate their effectiveness
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

l. When an event is reported, it feels like the person is being written up, not the problem
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

m. Staff worry that mistakes they make are kept in their personnel file
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

n. Staff feel like their mistakes are held against them
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

o. We work in "crisis mode" trying to do too much, too quickly
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

p. We use more agency/temporary staff than is best for patient care
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

q. We have enough staff to handle the workload
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

r. Staff in this unit work longer hours than is best for patient care
○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly Agree

Section 4: Information about you

36. How long have you worked in your present position?
○ Less than 1 year ○ 1 to 2 years ○ 3 to 5 years ○ More than 5 years

37. What is your current employment status at Alpha Hospital?
○ Full-time ○ Part-time (4/5 or 3/5) ○ Other

38. Are you a temporary, per-diem, or standby worker?
○ Yes ○ No

39. Do you have management or supervisory responsibilities in this organization?
○ Yes ○ No

40. **How can Alameda Hospital improve?**
We would like to know how you feel about Alameda Hospital. Please write your comments in the blank space provided on what you think could be improved. Please note that your comments will be provided back to the organization as you write them. Please do not write anything that would identify you as an individual.

ALAMEDA HOSPITAL
FISCAL YEAR 2010
JULY 1, 2009 – JUNE 30, 2010
PROPOSED BUDGET NARRATIVE

Attached is the Fiscal Year 2010 Alameda Hospital Operating Budget as prepared by hospital management. Upon approval by the City of Alameda Health Care District Board of Directors, this budget will constitute the spending authority for management for fiscal year 2010.

Even though the City of Alameda Health Care District is a governmental agency, this budget should be considered a business plan and projection of what is anticipated for fiscal year 2010 rather than a fixed authority to spend.

Fiscal Year 2010 Budget Assumptions

Utilization

In February 2009, the hospital opened an offsite primary care clinic located at the medical office building in the Alameda Towne Center approximately six months earlier than anticipated due to the sudden death of an independent physician that previously practiced at this location. In July of this year, as part of the organizations plan to develop a 1206(b) Community Clinic a GYN practice will be opened and a time share clinic is expected to be operational by January of 2010. The fiscal year 2010 budget anticipates that these new programs will produce additional inpatient and outpatient hospital volumes during the 2010 fiscal year.

The hospitals acute average daily census (ADC) is expected to increase by 0.4 patients per day, to 32.3. This increase is attributable to expected increased inpatient admissions generated from the Community Clinic. Outpatient procedures are expected to increase by approximately 5,400 registrations, also from Community Clinic operations. Emergency visits are expected to remain relatively flat during fiscal year 2010. Both inpatient and outpatient surgeries generated by Alameda surgeons have also been projected to remain constant for fiscal year 2010.

The current Kaiser contract is scheduled to expire as of March 30, 2010. While management has been actively attempting to work with Kaiser to extend this agreement, as of the date of this budget submission, Kaiser's progress has been slow regarding the renegotiation of this contract. Management has submitted proposed terms and conditions for a new agreement, has responded to follow-up inquiries from Kaiser, and currently awaits a response from Kaiser to meet and discuss the development of revised expectations and terms for the extension of this agreement. For this budget proposal, the surgical volumes, revenues and expense generated from Kaiser are

projected at current levels through the end of the 2010 fiscal year. Management will reforecast the budget once we have had an opportunity to establish more definitive terms of the new contract.

The South Shore Skilled Nursing Unit anticipates an ADC of 21.5, an increase of 1.4 over April YTD which is primarily driven by a full year of operations at normalized levels. Also assisting in the increase in volume is that staff nurses and LVN's have been trained to care for IV patients and this capability will allow the unit to care for a greater number of patients with slightly more complex medical needs. The 35 bed Sub-Acute unit is projected to have an ADC of 33.5 which is consistent with the current fiscal year.

Revenue

A charge specific price increase was implemented effective March 1, 2009. This increase is expected to generate an additional $14.8 million in annual gross charges which has been factored into the fiscal year 2010 operating budget. In addition, management will propose an across-the-board price increase of 5%, effective January 1, 2010. This price increase is anticipated to generate an additional $7.2 million in gross revenues over the final six months of fiscal year 2010. The new Community Clinic is budgeted to generate an additional $2 million in gross revenue based on the utilization projections discussed previously.

Net Revenue

As a result of the annual market basket adjustment for the Federal 2010 fiscal year the budget includes a 1.5% increase to Medicare and Medicare HMO program net patient revenue, generating approximately $288,000 in additional net patient revenue. As a result of the vigilant contract negotiations on the hospital's HMO and PPO contracts coupled with continued improvements in charge capture, billing coding and adjudication of claims in accordance with contract terms, these payor categories are budgeted to yield an additional 9% in net patient revenue during the fiscal year. This 9% equates to approximately $1.24 million in net patient revenue. Additional net patient revenue from the Community Clinic is expected to be approximately $706,000 from primary care and OB/GYN services plus an additional $391,000 from increased hospital service utilization. A full year of South Shore Skilled Nursing Unit, together with the increased average daily census will yield and additional $361,000 in net patient revenues. The remaining net patient revenue increases are the result of reimbursement improvements associated with the hospital price increases ($2.9 million).

Labor and Benefits Expense

During fiscal year 2009, the hospital has experienced positive budget variances in both FTE levels and salary costs (including registry). Management's efforts to control labor costs through reorganization of operations and changes in staffing procedures continue to be successful in maintaining this positive variance. The budget proposal includes negotiated or proposed salary increases for each of the five labor unions and for unrepresented employees.

Total full time equivalents for fiscal 2010 are budgeted at 445.0, an increase of 18.7 FTE's from the actual fiscal year 2009 total of 426.3 FTE's (See Table IV). Of these, 5.3 FTE represent support positions in the new Community Clinic. With the increased hospital volume generated from the new Community Clinic, another 3.3 FTE have been added in Med/Surg Nursing areas. Another 4.0 FTE are new positions that are being added to meet overall demand in various support departments. A new Nurse Manager position (1.0 FTE) which had been eliminated in the previous year's budget in an effort to consolidate the management of the Medical/Surgical floors has been reinstated for fiscal year 2010. The remaining 2.7 FTE represent the full year complement of vacant positions that were filled during 2009 and new positions that were added during the year.

No additional employees were budgeted in conjunction with the implementation of an Electronic Health Record (EHR) or PACS system in Radiology. The cost of these positions will be considered as part of the Capital Budget cost during the implementation of these projects. Overall, both paid and productive FTE per Adjusted Occupied Bed at 2.92 and 2.54 respectively is budgeted to be lower that the current year's actual of 2.97 and 2.62 respectively, and remains among of the lowest ratios in the Bay Area.

Non-Labor Expenses

The following are the assumptions for the various categories of the operating budget non-labor expense categories:

Professional Fees

- Medical related professional fees will increase by approximately $633,000 in fiscal 2010. The majority of the increase is from physician fees of $433,550 related to the new Community Clinic. Management is also in the process of renegotiating on-call and directorship fees for Emergency Department coverage allowing CEP to pay a more competitive rate per hour for ER physicians staffing our emergency rooms.

- Non-medical related professional fees will decrease by approximately $120,000 or 8%. This decrease in consulting services was related to the purchase of the South Shore Convalescent Home in the current year which was a one time cost in fiscal year 2009. Laboratory management fees were also eliminated as a new Director was hired in mid 2009.

Supplies

- Supply categories have been adjusted for expected volumes and 3.0% for increases related to the cost of medical supplies. This resulted in increased supply costs of approximately $363,000.

- Minor Equipment is expected to increase by $87,500 or 66% due to the change in the Capital Purchase policy which changed the cost of a capitalized item from $3,000 to $5,000. The impact of this change will effect the purchase of certain IS hardware, and minor Laboratory equipment which was previously capitalized. In addition the South

Shore Skilled Nursing Unit is budgeted for several minor furnishing and equipment upgrades.

Purchased Services

- Non-medical will increase by approximately $570,800 or 24% in fiscal 2010. The Community Clinic will utilize billing services and other professional purchased services. Financial Services will utilize billing compliance, budgeting, contracting and costing software and expects to select software to assist in the maintenance of RAC requests and appeals. In addition, external coding compliance reviews will be conducted during fiscal 2010. Online educational software will also be used for mandatory annual training and other required staff education and training programs. Finally, community and Asian outreach efforts are expected to increase during the next fiscal year.

- Repairs and Maintenance will increase by approximately $101,000 or 13%. Maintenance fees for new IS servers were included. Other general repair and maintenance expenditures related to both the hospital and the south shore skilled nursing unit are also anticipated in order to support the ageing facilities.

Rents and Leases

- This category will increase by approximately $120,000 or 16.6%. This is the result of a full year's rental expense at the new five year lease rate for the medical office building which houses the Community Clinic and Satellite Laboratory at the Alameda Town Center. However, some of this increase will be offset by related rental income from time share operations and leased space to other non-related parties. In addition, rental expense for the Pyxis Profile Drug Storage and Dispensing System has increased by approximately $50,000 per year as a result of a recently purchased software upgrade.

Other Operating Expenses

- Travel and Training will increase by approximately $66,000 or 49.5%. The increase relates to the implementation of the Time and Attendance System, the financial forecasting software, and continued efforts to educate staff on the various Meditech modules which are utilized throughout the facility. Additionally, the management training program which was kicked off in mid 2009 will continue into mid 2010.

- The remainder of the other operating expense category includes increases in expenses related to the Community Clinic and Governing Board expenses for video taping of board meetings and at least one board retreat. In addition, this category includes reserves for depositions and other litigation matters that may arise during the course of the fiscal year ($33,000).

Summary

Management believes that in fiscal year 2010 the hospital will continue to provide quality patient care, excellent customer service and accommodations, and maintain a high caliber work force. While we continue to face challenges related to uncertainties with the economy, ongoing issues with the State of California's ability to fund its operating budget, reimbursement levels, cost

increases attempted to be driven by various bargaining units, continued and increased compliance requirements, such as the RAC Program, and the uncertainties related to the renegotiation of the Kaiser contract.

Management has also been presented with potential opportunities that will help to improve the operating performance of Alameda Hospital. These opportunities include the potential closure of the San Leandro Hospital, the potential acquisition of another local skilled nursing facility the island, the potential development of a cancer center and the development of a proposal to redistribute Medi-Cal funds based on a tax that will be levied on all California hospitals in order to ensure the maximization of Federal monies available for the Medi-Cal program. As these challenges and opportunities come to fruition management will recast the FY 2010 Operating Budget as necessary to account for the impact of these initiatives.

Management is confident that with proper measurement of these and by taking assertive action on the opportunities that are on the horizon, that Alameda Hospital to be successful into the future and we look forward to another successful fiscal year.

TABLE I

ALAMEDA HOSPITAL
2009/2010 Fiscal Year Budget
OPERATING STATISTICS

	2006/2007 Actual	2007/2008 Actual	2008/2009 Budget	Projected 2008/2009 Actual	Proposed 2009/2010 FY Budget	Projected Variance from Proj.
PATIENT DAYS						
Medical Surgical	13,070	11,276	11,683	11,657	11,810	1.3%
Sub-Acute	9,022	10,789	12,228	12,024	12,228	1.7%
SNF	1,010	622	-	6,353	7,848	23.5%
Total	23,102	22,687	23,911	30,034	31,886	6.2%
DISCHARGES						
Medical Surgical	3,209	2,885	2,921	2,843	2,881	1.3%
Sub-Acute	15	24	20	38	41	7.9%
SNF	94	60	-	155	158	1.9%
Total	3,318	2,969	2,941	3,036	3,080	1.4%
AVG. LENGTH OF STAY						
Medical Surgical	4.1	3.9	4.0	4.1	4.1	0.0%
SNF	10.7	10.4	-	41.0	49.7	21.2%
AVG. DAILY CENSUS						
Medical Surgical	35.8	30.9	32.0	31.9	32.4	1.3%
Sub-Acute	24.7	29.6	33.5	32.9	33.5	1.7%
SNF	2.8	1.7	-	17.4	21.5	23.5%
Total	63.3	62.2	65.5	82.3	87.4	6.2%
OUTPATIENT VISITS						
Emergency	18,187	17,922	18,030	16,832	16,830	0.0%
Outpatient Registrations	32,185	30,943	31,558	29,610	34,659	17.1%
IP Surgeries-Non Kaiser	735	629	684	566	560	-1.1%
IP Surgeries - Kaiser	253	73	0	105	103	-1.9%
OP Surgeries - Non Kaiser	1,280	1,399	1,255	1,187	1,187	0.0%
OP Surgeries - Kaiser Eye	1,629	1,665	1,560	1,887	1,887	0.0%
OP Surgeries - Kaiser Amb.	1,516	1,644	1,598	1,872	1,872	0.0%
ADJUSTED OCCUPIED BED	104.85	108.41	113.60	143.35	152.50	6.4%
PAID FTE	447.61	400.47	403.40	426.31	445.02	4.4%
PROD. FTE	388.46	347.71	346.40	374.88	388.10	3.5%
PAID FTE/AOB	4.27	3.69	3.55	2.97	2.92	-1.9%
PROD. FTE/AOB	3.70	3.21	3.05	2.62	2.54	-2.7%

TABLE II

ALAMEDA HOSPITAL
2009/10 OPERATING BUDGET
STATEMENT OF REVENUE AND EXPENSE
$'s in Thousands

	2006/07 Audited	2007/08 Audited	2008/09 Budget	Projected 2008/09 Actual	Proposed 2009/10 Budget	Dollar Change Proposed from 08/09 Act	Pct. Change Proposed from 08/09 Act
Revenues							
Gross Revenue	261,208	250,228	278,818	282,364	298,120	15,756	5.6%
Less: Contractual Allowances,							
Bad Debt and Charity	(204,908)	(193,986)	(215,651)	(219,344)	(231,167)	11,823	5.4%
Net Patient Service Revenue	56,300	56,242	63,167	63,020	66,953	3,933	6.2%
Net Patient Revenue %	21.6%	22.5%	22.7%	22.3%	22.5%		
Net Clinic Patient Revenue					707	707	100.0%
Other Operating	135	144	121	169	181	12	7.1%
Total Revenues	56,435	56,386	63,288	63,189	67,841	4,652	7.4%
Expenses							
Salaries	33,598	31,904	36,011	34,845	37,487	2,642	7.6%
Registry	2,499	1,864	1,397	2,580	2,066	(514)	-19.9%
Benefits	9,282	10,003	10,596	10,134	10,783	649	6.4%
Professional Fees	3,676	4,030	3,388	3,592	4,105	513	14.3%
Supplies	8,506	8,482	9,023	9,080	9,467	387	4.3%
Purchased Services	4,068	3,652	4,141	4,060	4,737	677	16.7%
Rents and Leases	502	581	647	721	841	120	16.6%
Utilities and Telephone	837	866	889	861	933	72	8.4%
Insurance	643	720	740	557	544	(13)	-2.3%
Other Operating Expenses	735	784	797	889	1,034	145	16.3%
Depreciation and Amortization	2,103	1,780	1,360	1,429	1,568	139	9.7%
Total Operating Expenses	66,449	64,666	68,989	68,748	73,565	4,817	7.0%
Operating Gain/(Loss)	(10,014)	(8,280)	(5,701)	(5,559)	(5,724)	(165)	3.0%
Non-operating revenues (expenses)							
Property Taxes	5,704	5,745	5,746	5,759	5,759	-	0.0%
Other	420	173	231	134	324	190	141.8%
Total Non-operating revenues (expenses)	6,124	5,918	5,977	5,893	6,083	190	3.2%
Excess/(deficit) of revenues over exp	(3,890)	(2,362)	276	334	359	25	7.5%

TABLE III

ALAMEDA HOSPITAL
2009-2010 FISCAL YEAR BUDGET
GROSS/NET REVENUE BY FINANCIAL CLASS

	GROSS REVENUE INPATIENT	GROSS REVENUE SUBACUTE	GROSS REVENUE SKILLED NURSING	GROSS REVENUE EMERGENCY	GROSS REVENUE OUTPATIENT	TOTAL GROSS REVENUE	TOTAL NET REVENUE
COMMERCIAL	515	108	36	317	443	1,419	419
HMO	8,113	-	-	2,961	8,337	19,411	5,329
INDUSTRIAL	773	-	-	691	424	1,888	403
KAISER	644	6,648	109	1,497	10	8,908	2,310
KAISER CONTRACT	6,568	-	-	4	47,472	54,044	10,000
MEDI-CAL HMO	3,219	-	-	3,512	1,695	8,426	1,061
MEDI-CAL	9,143	23,287	2,092	2,188	1,675	38,385	9,399
MEDICARE	67,222	2,803	2,353	5,530	20,489	98,397	20,926
MEDICARE HMO	9,401	575	327	1,901	2,838	15,042	3,191
SELF PAY	8,113	1,797	1,146	4,261	3,045	18,362	3,148
PPO	12,105	-	-	58	11,925	24,088	10,089
VA	2,962	719	-	5,870	197	9,748	680
SUB-TOTAL HOSPITAL	128,778	35,937	6,063	28,790	98,550	298,118	66,955
							22.5%
SATELLITE CLINIC					2,019	2,019	707
							35.0%
GRAND TOTAL	128,778	35,937	6,063	28,790	100,569	300,137	67,662
							22.5%

TABLE IV

Alameda Hospital
Fiscal Year 2009-10 Budget
Comparison of FTE

	2007-08 Actual	2008/09 Budget	2008-09 Projected	2009-10 Proposed	Variance Projected vs Proposed
Total Nursing Services	213.45	234.33	234.49	237.29	2.80
Total Ancillary Services	66.92	70.49	67.04	74.54	7.50
Total Support Services	51.11	52.48	54.70	54.99	0.29
Total Administrative Services	69.08	69.37	70.06	78.20	8.14
Grand Total	400.56	426.67	426.29	445.02	18.73

Summary of Variance	New Positions	Volume Related	Previously Unfilled/ Vacant
Nurse Manager - 3 West	1.00		
RN's (Medical/Surgical)		3.30	
Skilled Nursing		2.46	
Staffing Coordinator			0.50
Ancillary Services:			
Laboratory Director			0.50
Imaging Director			0.25
Support/Administrative Services:			
HR Assistant	1.00		
Verification Clerk	1.00		
Accounting Clerk	1.00		
Social Worker -QRM			0.75
Administrative Assistant			0.25
Quality Abstractor - QRM	1.00		
Satellite Clinic			
Nurse Practitioner - Clinic	2.00		
Medical Office Assistant -Clinic	2.30		
Office Manager - Clinic	1.00		
Other Miscellaneous Depts.			0.42
	10.30	5.76	2.67