✓Included in the PDF posted on February 3, 2012.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, February 6, 2012

6:00 p.m. (Closed) | 7:30 p.m. (Open)

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

Members of the public who wish to comment on agenda items will be given an opportunity before or during the consideration of each agenda item. Those wishing to comment must complete a speaker card indicating the agenda item that they wish to address and present to the District Clerk. This will ensure your opportunity to speak. Please make your comments clear and concise, limiting your remarks to no more than three (3) minutes.

I. Call to Order (6:00 p.m. – 2 East Board Room) — Jordan Battani

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes

1. January 9, 2012 (Regular)

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

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

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

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

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

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

1. Discussion of Hospital Trade Secrets applicable to healthcare organization affiliations. No action will be taken.

   Estimated Date of Public Disclosure: *Not known at this time*

2. Discussion of Hospital Trade Secrets applicable to healthcare organization affiliations. No action will be taken.

   Estimated Date of Public Disclosure: *Not known at this time*

3. Discussion of Hospital Trade Secrets applicable to physician recruitment. No action will be taken.

   Estimated Date of Public Disclosure: *April 2012*

4. Discussion of Hospital Trade Secrets applicable to long-term care expansion. No action will be taken.

   Estimated Date of Public Disclosure: ***April 2012***

I. Adjourn into Open Session

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. General Public Comment

VII. Regular Agenda

A. Consent Agenda — **ACTION ITEMS**

✔ 1) Approval of January 9, 2012 Regular Meeting Minutes [enclosure] **(PAGES 4-11)**

✔ 2) Approval of Annual Committee Membership of the Board Quality Committee [enclosure] **(PAGES 12-13)**

✔ 3) Approval of Annual Committee Membership of the Finance and Management Committee [enclosure] **(PAGES 14-15)**

B. Action Items

✔ 1) Acceptance of December 2011 Unaudited Financial Statements and January 25, 2012 Finance and Management Committee Report [enclosure] **(PAGES 16-37)** — J. Michael McCormick

✔ 2) Approval to Enter into an Agreement with Select Therapies for Management of Rehabilitation Services at Alameda Hospital [enclosure] **(PAGES 38-40)** — Kerry Easthope

✔ 3) Approval of Resolution No. 2012-1J: Approval to Access Additional Funding of Jaber Estate As Set Forth Therein [enclosure] **(PAGES 41-43)** — Deborah E. Stebbins

C. District Board President Report **INFORMATIONAL** — Jordan Battani

D. Medical Staff President Report **INFORMATIONAL** — James Yeh, DO

E. Community Relations and Outreach Committee Report **INFORMATIONAL**

1) January 24, 2012 Committee Report — Stewart Chen, DC

F. Chief Executive Officer Report **INFORMATIONAL** — Deborah E. Stebbins

✔ 1) Monthly CEO Report [enclosure] **(PAGES 44-53)**

2) Bank of Alameda Line of Credit and Wound Care Loan Update

(Deborah E. Stebbins, Kerry Easthope, Bob Anderson)

3) Monthly Quality Metrics

a) Core Measures (Donna Marchetti, RN) [to be distributed]

✓Included in the PDF posted on February 3, 2012.

G. Operations and Facilities Report INFORMATIONAL — Kerry J. Easthope

1) Waters Edge Update

2) Wound Care Update

VIII. General Public Comments

IX. Board Comments

X. Adjournment

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Monday, January 9, 2012 Regular Meeting

Board Members Present	Management Present	Legal Counsel Present	Guests
Jordan Battani Stewart Chen, DC Robert Deutsch, MD Elliott Gorelick	Deborah E. Stebbins Kerry J. Easthope Robert Anderson	Thomas Driscoll, Esq.	N/A
		Medical Staff Present	Excused
		Jim Yeh, DO	J. Michael McCormick
Submitted by: Erica Ponce, Administrative Secretary			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:08 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present.	
Director Gorelick made an objection to the Closed Session Agenda, *Public Performance Evaluation Title: Senior Executives*, indicating that discussion regarding compensation should occur in open session and not in Closed Session. Director Battani stated the evaluation of performance criteria is appropriate to discuss in Closed session, however the material that was distributed combined both performance evaluation criteria and compensation in the document that was distributed in the Closed Session packet. The purpose of the discussion tonight is to talk about performance evaluation criteria because staff has recommended a change to the way the evaluation criteria for awarding the bonus will work. All discussion relating to compensation will be discussed in closed session. Mr. Driscoll confirmed that it was appropriate to have these discussions in Closed Session.			
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 6:10 p.m.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 7:07 p.m.	
A.	Announcements From Closed Session Director Battani stated that the Minutes were approved from December 5, 2011. No other action was taken.		
I.	General Public Comment		

Topic	Discussion	Action / Follow-Up
a.	Irene Dieter: Ms. Dieter wanted to clarify that the comments she made at the November 2011 District Board Meeting. She suggested that the Alameda Health Care District Board of Directors follow the format that other Boards and Commissions in Alameda follow. Ms. Deiter suggested that on the alamedahospital.org website, the Agenda should be only one to two pages with links to each agenda item, with a separate PDF associated with each agenda item.	
II.	Regular Agenda	
A.	Consent Agenda	
1)	Acceptance of December 5, 2011 Regular Meeting Minutes	Director Deutsch made a motion to approve the Consent Agenda as presented. Director Chen seconded the motion. The motion carried unanimously.
2)	Approval of Administrative Policy No. 83 – Community Care Guidelines and No. 83a – Self Pay or Uninsured Patient Cash Payment Discounts	
B.	Action Items	
1)	Acceptance of October 2011 Unaudited Financial Statements and November 30, 2011 Finance and Management Committee Report. Director Deutsch reviewed the notes from the January 4th committee meeting noting the following: November Unaudited Financial Statements were reviewed, noting the Average daily census (ADC) was 81.5 versus 83.8 budgeted, Acute ADC was 28.3 versus 29.6 budgeted, Sub-Acute ADC was 31.1 versus 33.0 budgeted, and Skilled Nursing ADC was 22.1 versus 21.2 budgeted. Outpatient registrations were 1,996 versus 1,948 budgeted. Overall gross revenue was $1.5M unfavorable to budget. Case Mix Index showed a marked improvement from October and was higher than prior November; year to date was below prior year to date due to low September/October 2011Operating expenses were $111,000 under budget with unfavorable variances in salaries, benefits and professional fees that were offset by favorable variances in registry and supplies. The operating loss for the month was $681,000 versus budgeted loss of $71,000. In the CEO Report, Ms. Stebbins and Teresa Jacques (HFS Consultant and project manager) reviewed the Revenue Cycle Work plan highlighting key areas of focus such as in department reorganization, billing issues and tasks, Collections, Bad, debt and Charity Care as well as other areas. Associate Administrator Kerry Easthope updated the Committee on Waters Edge as well as the Wound Care Center. Ms. Stebbins informed the committee that CHA filed for an injunction on AB 97 and the judge acted in favor of the injunction. The hospital will continue to book the lower rate in case the injunction is reversed. Finance Report: The Daily Reporting tool was reviewed by Bob Anderson. The tool helps management monitor key statistics on a daily basis. Bob Anderson, Interim CFO provided a brief update on the Case Mix Index and some areas that he has identified that may be affecting the	Director Gorelick made a motion to accept the November 2011 Unaudited Financial Statements as presented. Director Chen seconded the motion. The motion carried unanimously.

Topic	Discussion	Action / Follow-Up
	case mix as compared to prior years. There was discussion amongst the committee members, specifically the physicians regarding this topic. The next Finance and Management Committee will be held on January 25th. Discussion took place at the Board meeting concerning the October Case Mix Index, acuity levels, registration issues, collection of revenue, and ratio comparisons. Director Battani suggested that Interim CFO Bob Anderson make a presentation at the next Finance and Management Committee for an explanation of the Case Mix Index.	
2)	Approval to Enter into a Contract with Rossi Builders for Construction of Wound Care Center Kerry Easthope reviewed the bid process noting that plans and a bid packet for the Wound Care Center Project at Marina Village were provided to contractors in December. A bid conference was held on December 8, 2011. The bid deadline was December 29, 2011 at 4:00 p.m. at which time four of the seven prequalified bidders submitted bids for review. One of the bidders, retracted their bid, which left three bidders, Rossi Builders, Q| Builders, and BNBuilders. Rossi Builders was the lowest responsible bid and is being recommended as the contractor for the project. The bid is $755,609 higher than budgeted due to previously unknown factors such as the HVAC system expenses. Discussion took place involving Directors Battani, Gorelick, and Chen along with Mr. Easthope regarding financing with the Bank of Alameda, cost of the project, timing of payments, inspections from the City, permits, and contingency plans.	Director Deutsch made a motion to approve entering into a contract with Rossi Builders contingent upon securing building permit and financing as originally described. Further, if there is a change in the financing with the Bank of Alameda, the Board of Directors will be so apprised before the award of the contract. Director Chen seconded the motion. The motion carried unanimously.
3)	Approval of Election of District Board Officers Nominations were made for the Board Officer positions: a. Director Deutsch nominated Jordan Battani for President. Director Gorelick abstained from voting. The nomination carried. b. Director Chen nominated Robert Deutsch, MD for 1st Vice President. Director Gorelick abstained from voting. The nomination carried. c. Director Gorelick nominated Stewart Chen, DC for 2nd Vice President. The nomination carried unanimously. d. Director Deutsch nominated J. Michael McCormick for Treasurer. The nomination carried unanimously. e. Director Chen nominated Elliott Gorelick for Secretary. Director Gorelick asked if a nomination could be declined and if a Director could hold multiple offices. Mr. Driscoll confirmed that a Director could decline a nomination and could hold multiple offices. The nomination carried unanimously.	
The Board recessed for a brief break and returned session at 8:30 p.m.		

Topic	Discussion	Action / Follow-Up

4) Approval of Board Member Appointment and Committee Chair Selection for Board Designated Committees

Director Battani noted that two Board members are needed for each committee. Nominations were made for the Board Officer positions:

a) Board Quality Committee:

i) Director Chen nominated Director Deutsch to be Committee Chair and a Voting Member. The nomination carried unanimously.

ii) Director Deutsch nominated Director Chen to be a Voting Member. The nomination carried unanimously.

b) Finance and Management Committee:

i) Director Deutsch nominated J. Michael McCormick to be Committee Chair and Voting Member. The nomination carried unanimously.

ii) Director Chen nominated Elliott Gorelick to be a Voting Member. Director Chen, Director Gorelick, and Director Battani voted to approve this nomination. The nomination carried.

iii) Director Deutsch nominated himself to be a Voting Member. Director Deutsch voted to approve this nomination. The nomination did not carry.

c) Community Relations and Outreach Committee:

i) Director Deutsch nominated Stewart Chen, DC to be Committee Chair and Voting Member. The nomination carried unanimously.

ii) Director Chen nominated Jordan Battani to be a Voting Member. The nomination carried unanimously.

The following table represents the approved committee membership.

	Finance & Management Committee	**Board Quality Committee**	**Community Relations & Outreach Committee**
Committee Chair	**Michael McCormick**	**Robert Deutsch, MD**	**Stewart Chen, DC**
Voting Member	**Elliott Gorelick**	**Stewart Chen**	**Jordan Battani**
Ex-Officio	**Jordan Battani**	**Jordan Battani**	**N/A**

5) District Board Participation on ACHD Standing Committee

Director Battani stated that ACHD is looking for volunteers to participate on their standing

Director Gorelick made a motion to approve District Board Members be authorized to apply for participation in volunteer

Topic	Discussion	Action / Follow-Up
	committees. ACHD is asking that hospital boards authorize their Board Members to participate. Director Battani clarified that District Board Members do not act on behalf of the District individually, only as a whole Board. She proposed that the Board approve any Board Members to participate if they so choose on an ACHD standing committee. If they are selected and invited to participate, the District Board to ratify that appointment. If there is an appointment, the District Board will decide what responsibilities would be in regards to informing the Board of the activities and information from ACHD. Participation on an ACHD standing committee would be in addition to the responsibilities of the District Board Committees that Board Members are a part of.	opportunities with ACHD committees. Director Chen seconded the motion. The motion carried unanimously.
	6) Acceptance of FY 2011 Executive Performance Metrics Summary	Item was deferred to a future meeting.
C.	President's Report Director Battani had no President's Report to present at this meeting.	No action taken.
D.	Medical Staff President Report The Medical Staff CME program for January will be "Hearing Loss: New Causes – Need for Early Amplification: An Update for the General Practitioner" by Melissa Amorn, MD. This event will take place on Tuesday, January 24, 2012 at 12:15 pm in Conference Room A. The Medical Staff Party on Friday, January 6, 2012 was a great success. Thank you to Dr. Deutsch for organizing the event.	No action taken.
E.	Community Relations and Outreach Committee Report Director Chen presented the following report. • The Community Relations Committee did not meet in December. • Community Outreach Organizer Intern Program is ready to be implemented. The Intern candidate has completed a "Tola" Fellowship program and is expected to start the week of January 17, 2012. The intern will work approximately eight hours per week for 12-16 weeks and will focus on outreach, social media and communication activities. • Management had an initial meeting with representatives from FACES for the Future, the Public Health Institute and AUSD regarding the possibility of instituting a volunteer/mentoring program for high school students. Discussions are continuing. • Alameda Hospital will be hosting an international student contingency from Shanghai on January 25, 2012. The university students will be learning about public organizations in the U.S. and comparing them with China. • Free Stroke Risk Assessments is being offered again on Friday, January 27, 2012 from 8:30 to 11:30 a.m. • The next Community Relations Committee meeting is scheduled for January 24, 2012.	Stewart Chen, DC
F.	Chief Executive Officer's Report	

Topic	Discussion	Action / Follow-Up
1)	Monthly CEO Report Ms. Stebbins thanked Dr. Deutsch and the Medical Staff for organizing and underwriting the Holiday Party. It went well and included over 40 people from the Waters Edge staff. Ms. Stebbins informed the Board that Alameda Hospital Foundation President, Bill Withrow's wife, Peggy Withrow, passed away; arrangements are being handled by Greer Mortuary. Ms. Stebbins included a written CEO report, which will be a standing report each month and asked if there were any questions regarding the material presented. Director Gorelick asked for clarification regarding the IGT numbers. Management answered his questions, spoke about the statistics, and highlighted Case Mix Index information. Ms. Stebbins reported that Alameda Hospital is talking with Select Therapies to manage physical therapy program which will add to the quality of patient care. When finalized, that information will be brought the District Board for approval.	No action taken.
2)	Monthly Volume Statistics Ms. Stebbins reviewed the monthly volume statistics.	No action taken.
3)	Monthly Quality Metrics a) SNF/SA Data and Findings of State Survey Alice Martin, RN, MSA, Sub-Acute Nurse Manager reported on SNF/SA Data and Findings of State Survey. Ms. Martin spoke about quality improvement, error reduction and infection prevention. A handout was distributed to the Board and will be included with the original Board packet.	No action taken.

	December Preliminary	December Budget	% Δ compared to Budget	% Δ compared to November	November Actual
Average Daily Census	83.2	84.94	-3.1%	1.0%	81.47
Acute	28.29	30.23	-6.4%	0.1%	28.27
Subacute	33.00	33.00	0.0%	6.0%	31.13
South □hore	21.03	21.71	-3.1%	4.7%	22.07
Patient Days	2,552	2,633	-3.1%	4.4%	2,444
ER Visits	1,409	1,426	-1.2%	4.4%	1,349
OP Registrations	1,698	1,929	-12.0%	-14.9%	1,996
Total Surgeries	167	186	-10.2%	-15.2%	197
Inpatient Surgeries	36	44	-18.2%	-2.7%	37
Outpatient Surgeries	131	142	-7.7%	-18.1%	160
Case Mix Index	1.2841				1.3230

Topic	Discussion	Action / Follow-Up
	4) Recommendation relating to December 5, 2011 District Board Referral – Assessment of Cost and Operational Impact of Implementing Changes to Public Notice and Disclosure Standards Management recommended continued compliance with public records requirements by staying with our current schedule of information distribution. Finance Committee is the exception: The report for that committee will be distributed 5.5 days in advance rather than the current distribution schedule of 4.5 days in advance. Director Battani suggested that Management and Staff strive to improve the timing of all meeting notices and information when possible.	No action taken.
	5) Recommendation relating to December 5, 2011 District Board Referral – Assessment of Cost and Operational Impact of Improving the Alameda Hospital Website Functionality and Access to Public Documents Management recommended Option One (see enclosure), which will allow ease of access to agenda items. The cost is modest in comparison with the other options. Refer to enclosure for full information. Discussion took place regarding the website and updates. Management and staff will implement the changes identified.	No action taken.
G.	Operations and Facilities Report 1) Waters Edge Transition Planning Update Mr. Easthope updated the District Board regarding the licensing application status and the transition of Waters Edge. Target date was for the transition is anticipated for early February, but most likely will be later than that. The Human Resource Department will be processing employees from Waters Edge this week. Management is looking at three candidates for the Long Term Care Director. Director Gorelick inquired about the tracking of self-pay census. Mr. Easthope replied that the census was down slightly for self-pay and that it would be a good idea to begin tracking that specifically. Director Gorelick also inquired as to what will be done to communicate to, market to and reach out to other area hospitals. Mr. Easthope replied that those areas of communication will be an important part of the Director's job. There will be also be someone hired as a marketing director (or similar role) whose responsibility will be to go out and visit referral sources and build relationships. Director Gorelick inquired as to the St. Rose situation and asked if they were shutting down their facility. Management replied that they are unsure of that situation. 2) Wound Care Center Update Due to the discussion of the Wound Care Center earlier in the meeting, Mr. Easthope did not have anything further to report.	No action taken.

Topic		Discussion	Action / Follow-Up
VII.	General Public Comments No public comments were given.		
VIII.	Board Comments A. Director Gorelick spoke about self-pay accounts being an issue for the Hospital. He suggests that negotiating early and often while offering discounts could help to gain a higher collection rate. Ms. Stebbins replied that it was a good suggestion and discussed strategies that Management is implementing through the Business Office improve patient accounts and increase payments. B. Director Chen requested that Management consider people of diversity when hiring for top level executive positions.		
IX.	Adjournment	Being no further business, the meeting was adjourned at 9:30 p.m.	

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

Date: January 20, 2012

For: February 6, 2012 District Board Meeting

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

Through: Board Quality Committee

From: Robert Deutsch, MD, Chair – Board Quality Committee
Kristen Thorson, District Clerk

Subject: Approval of Membership to the Board Quality Committee for CY 2012

RECOMMENDATION:

The Board Quality Committee recommends the following slate of committee members be reappointed for calendar year 2012.

Medical Staff Representation	Name	Voting Member
Medical Staff President	Jim Yeh, DO	✔
Hospitalist Representative	Emmons Collins, MD	✔
Quality Resource Management Medical Director	Alka Sharma, MD	✔
Medical Staff At-Large Representative	Joseph Marzouk, MD	✔

BACKGROUND:

The Board of Directors, on January 9, 2012, appointed Robert Deutsch, MD as Chair of this committee and Stewart Chen, DC as the second voting member from the Board of Directors. Per the approved committee structure, committee membership shall be appointed annually.

The following structure has been approved by this committee as well as the District Board of Directors. Similar committee structures have been developed for other two board designated committees (Finance and Management Committee and Community Relations and Outreach Committee).

1. Board Quality Committee:

    a. Primary Purpose:

i. To review monitoring activity and accept or reject the periodic summary of performance improvement data submitted by the Performance Improvement Committee (PIC).

ii. To assure the measurements, assessments and improvements are consistent with the design of the Performance Improvement Program and the hospital's mission, vision and values.

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

i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee.

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

iii. Up to four members of the Alameda Hospital Medical Staff (physicians) all of whom shall be voting members of the committee as designated below. In instances where a physician qualifies as one or more of the following designations, an additional physician will not be needed.

1. Medical Staff President
2. Hospitalist Representative
3. Quality Resource Management Medical Director
4. Medical Staff At-Large Representative

iv. The City of Alameda Health Care District Chief Executive Officer, Chief Financial Officer, Associate Administrator, Director of Quality Resource Management, and Executive Director of Nursing Services, and other hospital management as delegated, who shall not be voting members of the committee.

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: Committee shall meet monthly.

Date: January 26, 2012

For: February 6, 2012 District Board Meeting

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

Through: Finance and Management Committee

From: Michael McCormick, Chair – Finance and Management Committee
Kristen Thorson, District Clerk

Subject: Approval of Membership to the Finance and Management Committee for CY 2012

RECOMMENDATION:

The Finance and Management Committee recommends the following slate of committee members be reappointed to the Finance and Management Committee for calendar year 2012.

	Name	Voting Member
Medical Staff Representative	William Sellman, MD	✔
Medical Staff Representative	Jim Yeh, DO	✔
At Large Representative	Ann Evans	✔
At Large Representative	Ed Kofman	✔
At Large Representative	Jim Oddie	✔

BACKGROUND:

The Board of Directors, on January 9, 2012, appointed Michael McCormick as Chair of this committee and Elliott Gorelick as the second voting member from the Board of Directors. Per the approved committee structure, committee membership shall be appointed annually.

The following structure has been approved by this committee as well as the District Board of Directors. Similar committee structures have been developed for other two board designated committees (Board Quality Committee and Community Relations and Outreach Committee).

1. Finance and Management Committee:

    a. Primary Purpose: The primary purpose of the Finance and Management Committee is to review and recommend the annual budget, review performance relative to budget, and review other aspects of the district's financial performance. The Committee shall also serve the function of reviewing the annual report from the Hospital's external auditor, including the annual presentation of audit findings. The committee may also review and advise regarding operational issues, management systems issues, management information systems, and other aspects of the district's overall operational management.

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

        i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee.

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

        iii. Two members of the Alameda Hospital Medical Staff both of whom shall be voting members of the committee.

        iv. Up to three at large members chosen for expertise needed by the district each of whom shall be voting members of the committee.

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

    c. Terms: The committee shall be appointed annually.

    d. Meeting Frequency: Committee shall meet monthly.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING DECEMBER 31, 2011

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

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
DECEMBER, 2011

The management of 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 December 31, 2011 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments*. The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Highlights

Low activity in the month of December caused the hospital to experience a negative bottom line. A negative bottom line of ($39K) was budgeted and ($316k) was realized. Year to date (YTD) the hospital now has a loss of ($1,312) versus a budget of $206K.

Activity, generally, has followed patterns that have developed over the past six months. The number of inpatient admissions were at or above both budget and the prior year, however, patient days were below budget. The reason for this is because of a low length of stay. The length of stay was 9.9% below budget while admissions were up 4.5%. Therefore there were more patients. Since those patients stayed a shorter period of time, both patient days and associated revenues were down.

Inpatient surgeries cases were below budget. This month inpatient surgeries were down 18.2%. YTD they are down 15.1%. Since surgical admissions tend to generate higher revenues, this variance has a significant impact on inpatient revenues.

Outpatient surgeries were down for the month, however, continue above budget YTD.

Emergency activity was slightly below budget this month. YTD emergency visits are relatively close to budget. However emergency revenues have been down more than activity would indicate. It was determined that this was due to a change in the method of charging for emergency cases instituted in late fiscal year 2011. The charge methodology was changed back to the original method and it is expected that emergency revenues will track closer to budget for the remainder of this year.

December was similar to previous months where both gross and net revenues were below what activity would seem to indicate. This month's gross revenues were down $1.7M or 7.8%. The inpatient component was down 6.0% and outpatient was down 11.8%. This type of variance has been a continuing trend this year.

Both the Case Mix Index (CMI) and collection ratio ran close to YTD averages. The collection ratio is slightly below budget for the month and YTD. The CMI continues about 7% below last year. This is in part is due to the low surgical volumes along with less intensive cases in 3West and the DOU.

The net result of these revenue related influences caused net revenues to fall ($413k) or 8.6% below budget. YTD net revenues are now down ($1.9M) or 4% below budget.

Expenses continue to run below budget. This month overall expenses were 2.3% below budget. Savings in labor, supplies and rents were offset by increased costs in professional fees. The negative professional fee variance is largely due to fees associated with outsourcing much of the revenue cycle function along with contracting for a number of key management employees. This variance is partially offset by lower labor costs.

Cash improved dramatically compared to the previous month. It increased from $407k to $2.1M. This was due to the receipt of both tax monies along with IGT funds. These two totaled $3.5M. Expressed in days cash on hand, the hospital went from 5 days in November to 15 days in December. Though cash has improved, both of these values are extraordinarily low.

Accounts receivable (AR) grew in December. This was disappointing in that management had expected a major reduction in AR due to high billings going out over the past 6 weeks. Unfortunately this did not occur in December as AR increased $481k. AR days increased from 59.2 to 62.7 days. AR increases are fairly typical during the holiday season. Therefore it is expected that cash collections should increase significantly in January.
Because of the increased cash from the Tax and IGT sources, management was able to reduce accounts payable. However, because of AR and bottom line issues, AP was not reduced nearly as much as management had hoped. Though AP was reduced by $677k, AP days still remain over 150. Only bottom line improvement and AR reduction will allow for a significant drop in AP.

Lastly, the current ratio fell to .97. As with AP, this value will increase with improvement in the hospital's bottom line. However this month current ratio may prove to be problematic in negotiating a new line of credit. Note that the addition of Water's Edge should provide for a boost and cause the current ratio to climb above 1.0 in future months.

ACTIVITY

ACUTE, SUBACUTE AND SNF SERVICES

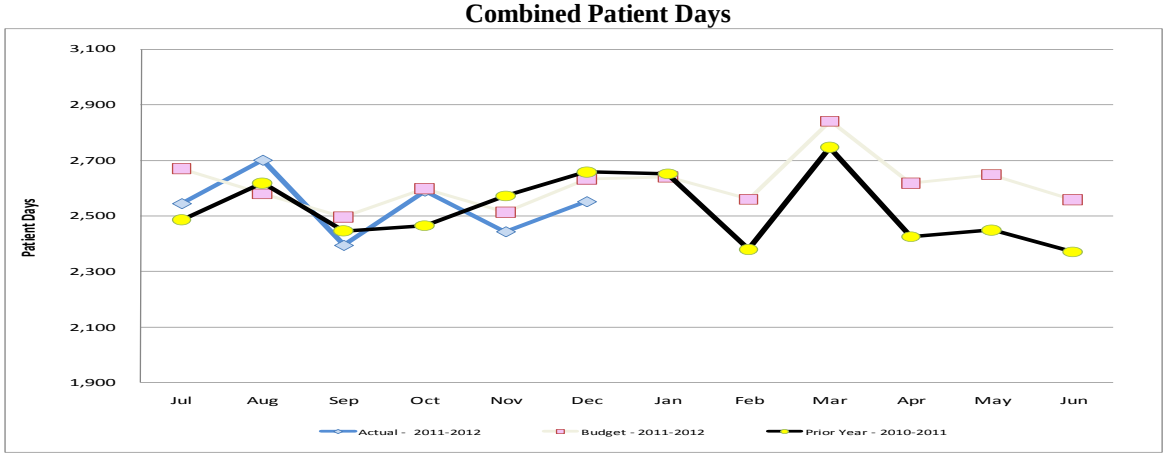
Patient days, while below budget, are also below last year's volumes. Total patient days for the month were 2,552, 3.1% below the budget of 2,633, and YTD days of 15,227 are 266 days (1.7%) under budget. These figures represent a decrease from the prior month of 2,590 and prior year's December of 2,658 total patient days but is consistent with December 2010 YTD of 15,246.

The average daily acute care census was 28.29, unfavorable to a budget of 30.23 by 2.0 ADC (6.6%), and even with the acute ADC of 28.27 in the prior month; the average daily Sub-Acute census was 33.0. This is right on budget, The Skilled Nursing program had an average daily census of 21.03 versus a budget of 21.71. Year-to-date ADC is 2.1% below the budget of 84.2 at 82.76, just .1 ADC (.12%) below the 2010 YTD ADC of 82.86.

The acute care patient days were 6.4% (60 days) less than budgeted and 9.6% below the prior year's average daily census of 31.29 for December. The acute care program is comprised of the Critical Care Unit (2.8 ADC, 43.5% unfavorable to budget) which was closed for part of the month due to no critical patients, Definitive Observation Unit (11.2 ADC, right at budget) and Med/Surg Units (14.2 ADC, 1.8% favorable to budget).

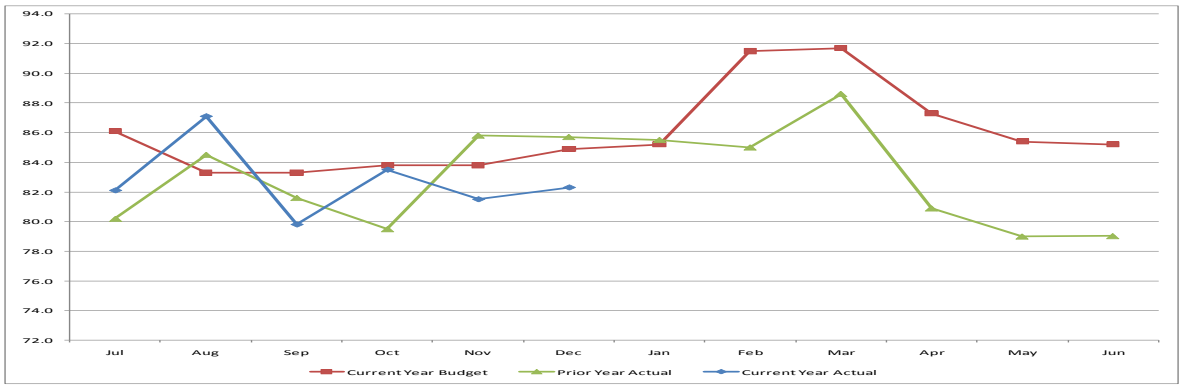
The graph on the next page shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

Combined Patient Days



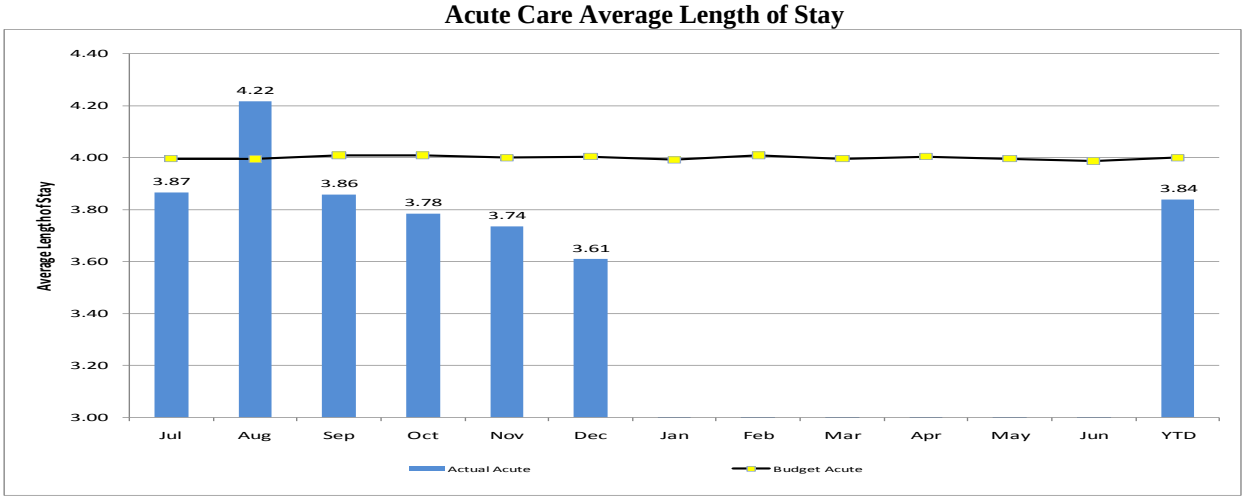
The combined actual average daily census was 82.32 versus a budget of 84.94 an unfavorable variance of 3.2%.

Combined Average Daily Census



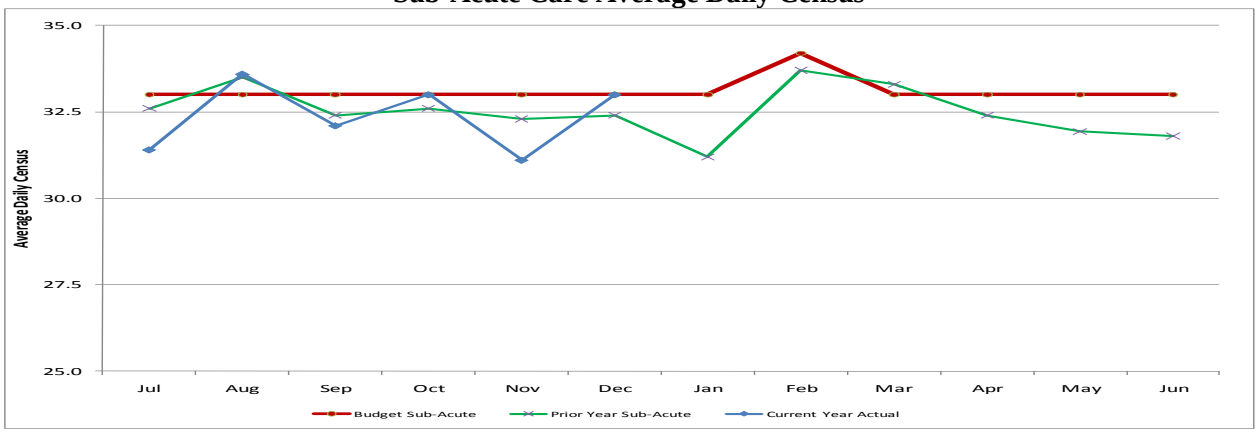
The acute average length of stay (ALOS) decreased from the November low of 3.74 to 3.61 in December, which is also below December in the prior year of 4.53. Budgeted acute ALOS is 4.0. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month and the budgeted ALOS for fiscal year 2012.

Acute Care Average Length of Stay



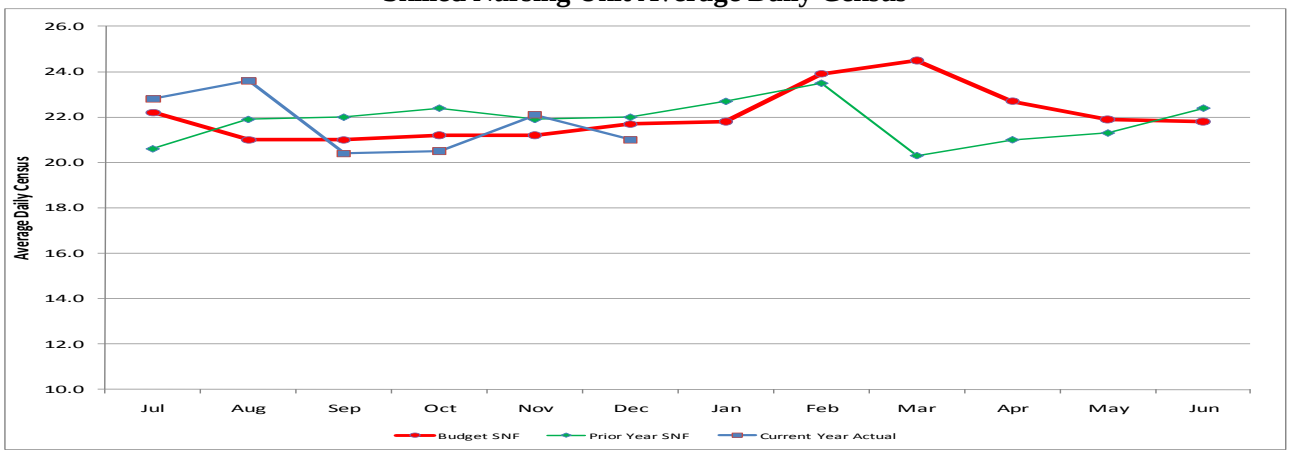
The Sub-Acute program average daily census of 33.0 in December was right at budgeted projections. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



The Skilled Nursing Unit (South Shore) patient days were 3.1% or 21 patient days lower than budgeted for the month of December, and down 10 days or 1.5% from November. This program's volume is just below the prior year-to date, with December 2012 year-to-date patient days lower than December 2011 year-to-date by 11 days or .27% and a year-to-date average daily census of 21.74 versus 21.80 in fiscal year 2011. The following graph shows the Skilled Nursing Unit monthly average daily census as compared to budget and the prior year.

Skilled Nursing Unit Average Daily Census

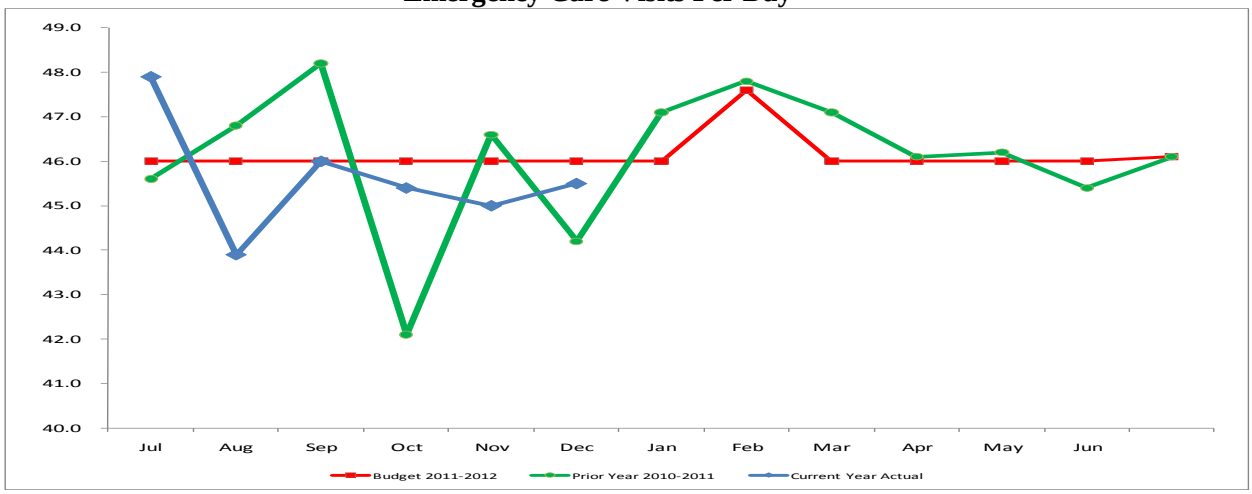


ANCILLARY SERVICES

Outpatient Services

The Emergency Care Center visits in December totaled 1,409, 17 visits (1.2%) under the budget of 1,426. 18.5% of these visits resulted in inpatient admissions versus 18.4% in November. On a per day basis, the total visits represent a increase of 1.09% from the prior month daily average. In December, there were 315 ambulance arrivals versus 276 in the prior month. Of the 315 ambulance arrivals in the current month, 193 or 61.3% were from Alameda Fire Department (AFD) ambulances.

Emergency Care Visits Per Day

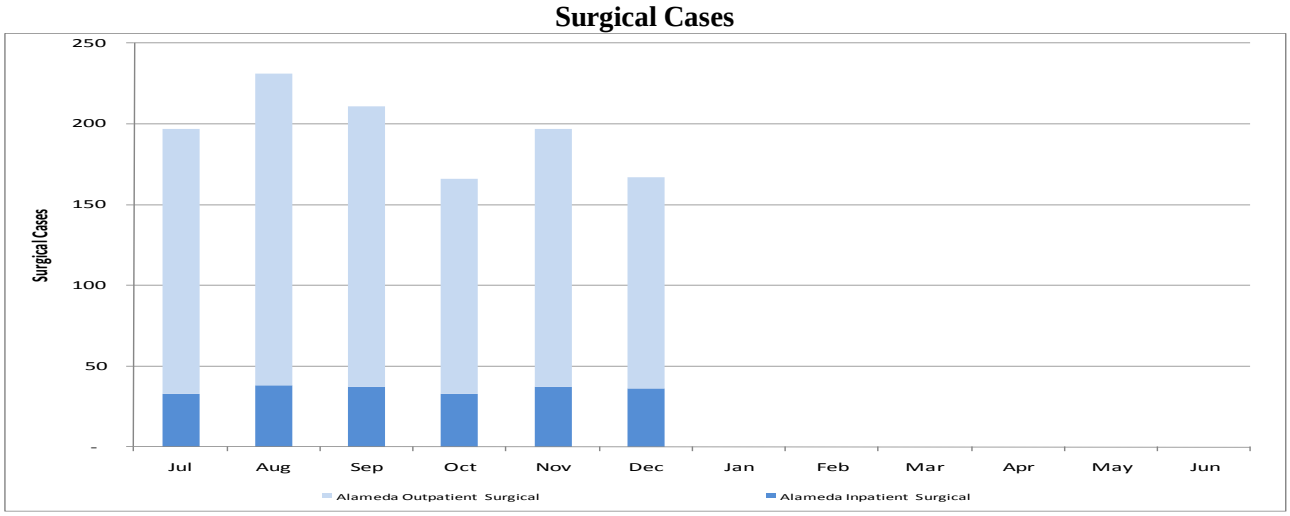


Outpatient registrations were 1,698, or 12.0% below budget and 298 or 14.9% below prior month. The average of 54.8 visits per day was 17.6% lower than the prior month's 66.5 visits per day. YTD outpatient registrations are below budget by 8.3% at 10,933 versus the budget of 11,926. The outpatient visits were below budget in IVT Therapy (51 visits), Ultrasound (30 visits), CT Scan (31 visits), and EKG (21 visits).

Surgery

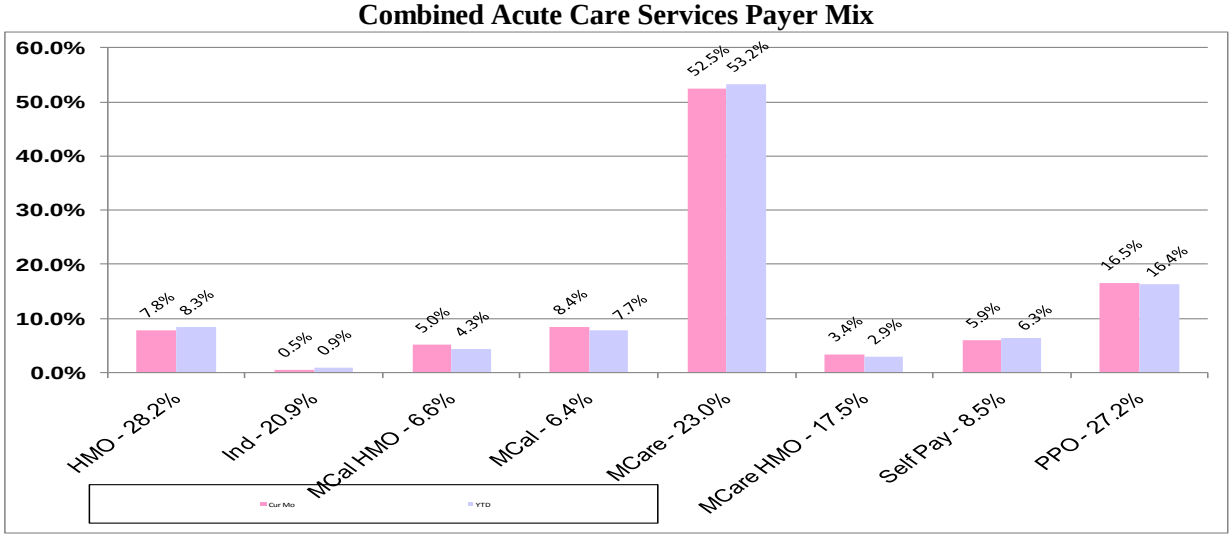
The year-to-date surgery cases were 1,175 or 2.8% above the budget of 1,143, and above prior YTD of 1,155. For the month, total surgery cases were below budgeted expectations by 10.2% at 167 cases versus the budgeted 186 cases; inpatient cases were 8 (18.2%) under budget while outpatient cases were 11 (7.7%) below budget. Surgery volume was considerably lower than November. Inpatient and outpatient cases totaled 36 and 131 versus 37 and 160 in December and November, respectively.

The graph below shows the number of inpatient and outpatient surgical cases by month for fiscal year 2012.

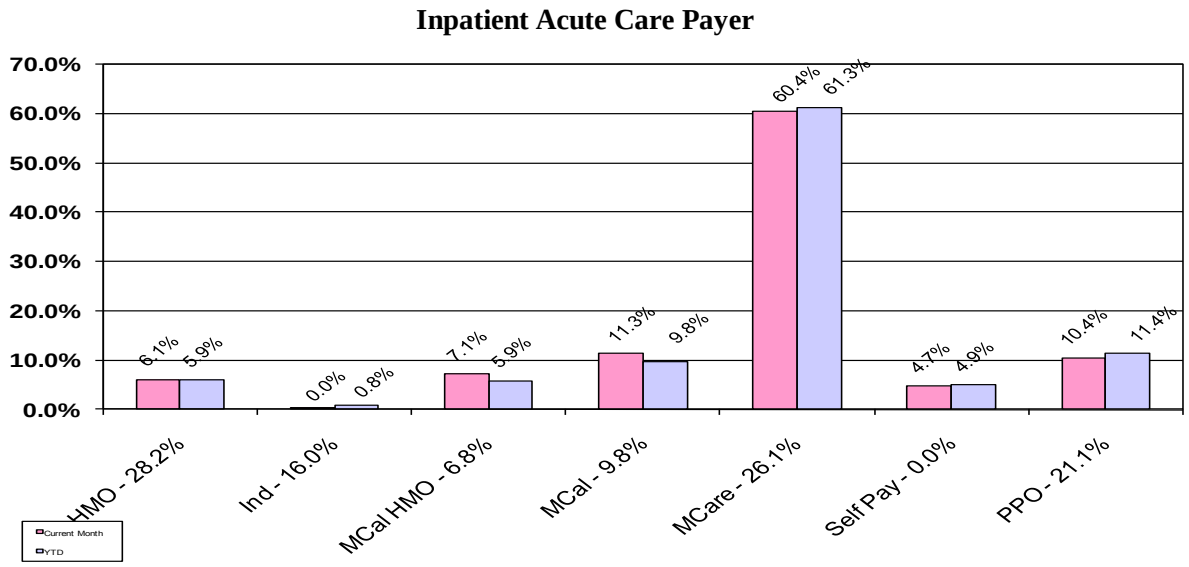


Payer Mix

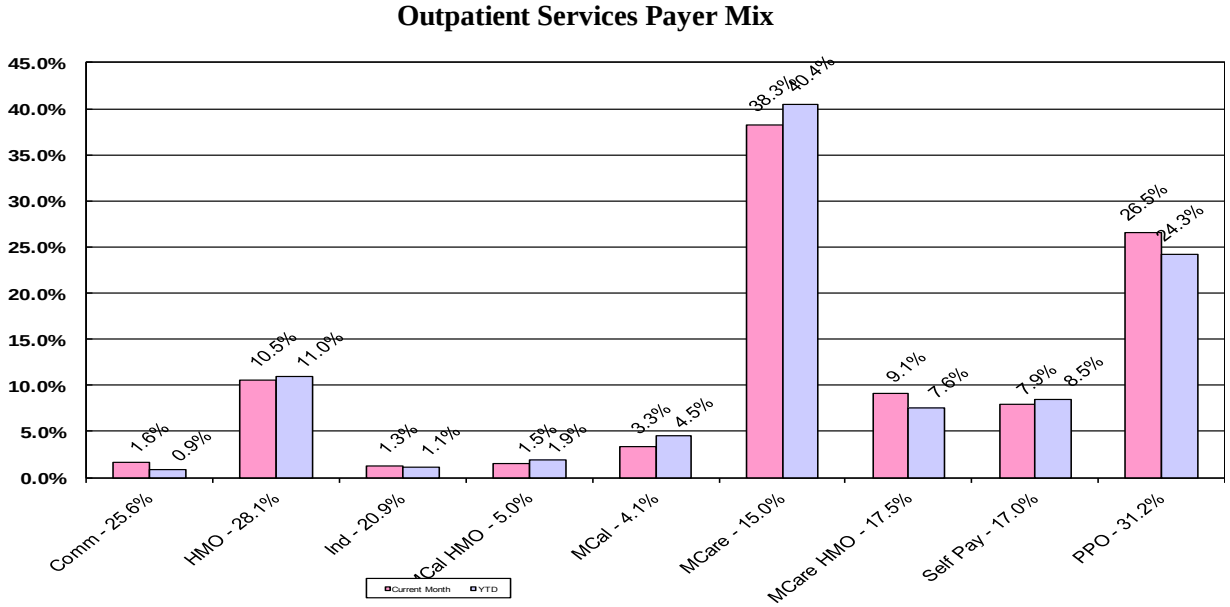
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in December made up 55.9% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 24.3%, Medi-Cal Traditional and Medi-Cal HMO utilization at 13.4% and self pay at 5.9%. The graph below shows the percentage of gross revenues generated by each of the major payers for the current month and fiscal year to date as well as the current month's estimated reimbursement for each payer for the combined inpatient and outpatient acute care services.



The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 65.1% of our total inpatient acute care gross revenues followed by HMO/PPO at 21.4%, Medi-Cal and Medi-Cal HMO at 16.5% and Self Pay at 4.7% of the inpatient acute care revenue. The graph below shows inpatient acute care current month and year to date payer mix and current month estimated net revenue percentages for fiscal year 2012.

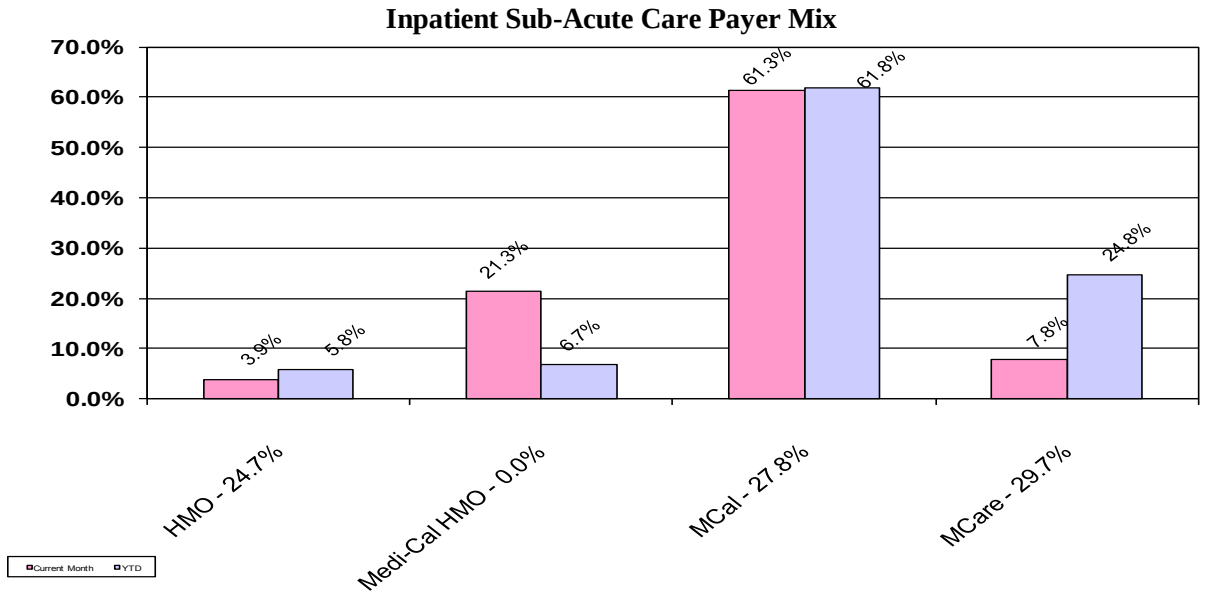


The outpatient gross revenue payer mix for December was comprised of 47.4% Medicare and Medicare Advantage, 38.6% HMO/PPO, 4.8% Medi-Cal and Medi-Cal HMO, and 7.9% self pay. The graph below shows the current month and fiscal year to date outpatient payer mix and the current months estimated level of reimbursement for each payer.

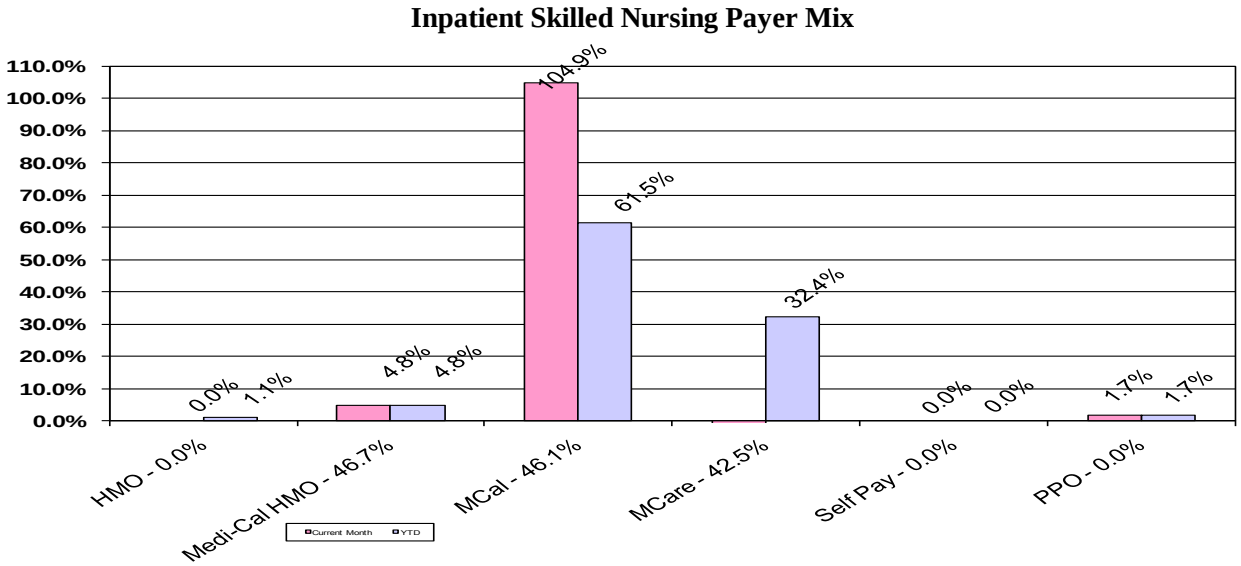


In December, the Sub-Acute care program again was dominated by Medi-Cal utilization of 82.1%, up from 69.6% in

November. One anomaly in long term care patients is they are registered as Medicare, usually exhaust their benefits and transition to Medi-Cal. The financial class is now being changed when this occurs, where in the past the financial class had not been changed. Medicare was 7.8% and HMO/PPO rounds out the unit at 3.9%. The graph below shows the payer mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payer.



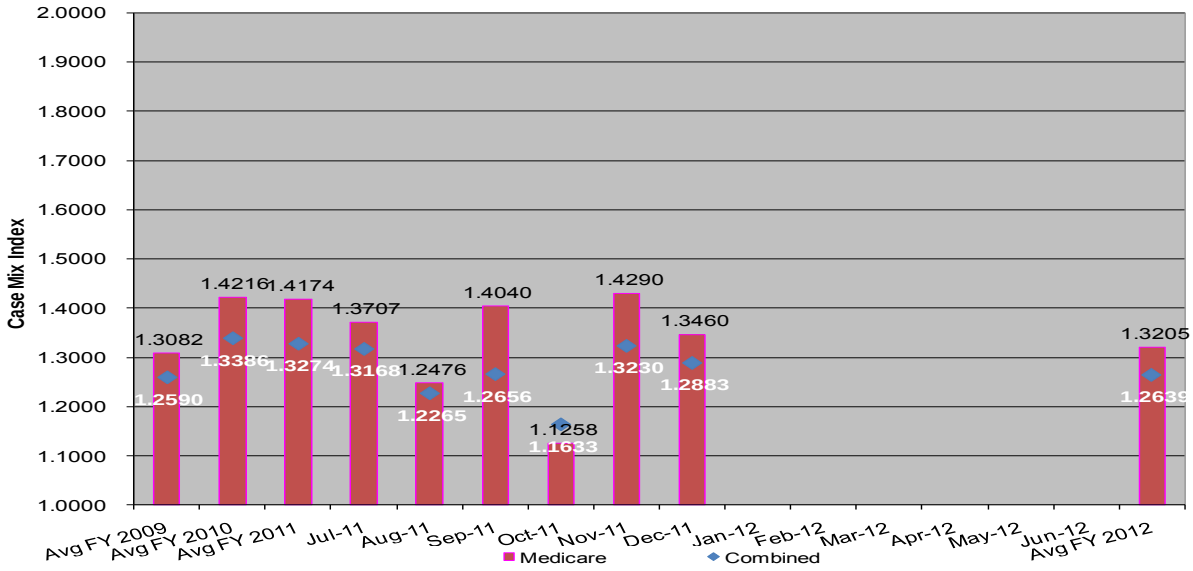
In December, the Skilled Nursing program gross revenues were comprised primarily of Medi-Cal at more than 100% due to payer reclassifications. The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. In December accounts were properly reclassified from Medicare to Medi-Cal if they had exhausted their long-term care Medicare benefits and are Part B only. This is an anomaly in the current month but will adjust on a year-to-date basis and will have the patients registered in the proper payer when reimbursement is received.



Case Mix Index

The hospital's overall Case Mix Index (CMI) decreased to 1.2883, down from the prior month of 1.3230, and below the prior year December of 1.3531. The Medicare CMI decreased from 1.4290 in November to 1.3460 in December. January overall CMI is back up over 1.3. The graph below shows the Medicare CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Trend



The CMI at the time of forecasting this year's budget was 1.3758. Year-to-date December 2011 the CMI was 1.2652. This represents a 7.7% decline compared to the same time frame last year. However, the month of December 2011 is again above the year-to-date average, and CMI is continuing to swing back up in January. Note that payers with lower volume can have substantial swings in CMI from one period to another. See the table below that compares the CMI by payer for the three periods.

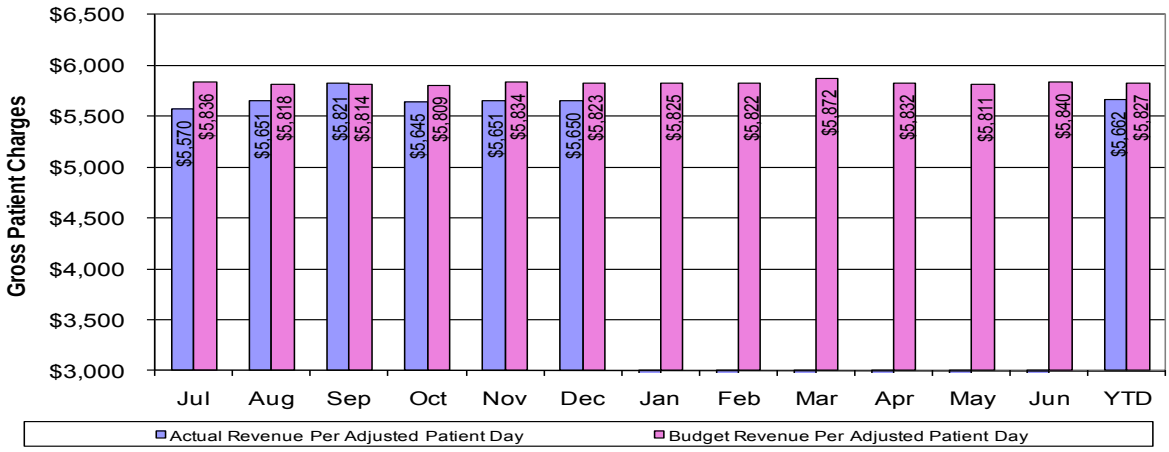
Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Dec 10 YTD	Dec 11 YTD	Dec 11 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.1928	0.7788	3
HMO	1.2522	1.2050	1.3401	66
Industrial	1.8373	1.2257	1.3856	8
Kaiser	1.8412	1.9879	2.0106	6
Medi-Cal HMO	1.0008	1.0128	0.9970	73
Medi-Cal	1.2724	1.1972	1.2088	98
Medicare	1.4724	1.4736	1.3187	709
Medicare HMO	1.3568	1.4000	1.3671	123
Personal Pay	1.0105	1.0305	1.0541	102
Medi-Cal Pending	1.8334	1.9673	2.0751	4
PPO	1.2613	1.3011	1.1470	145
VA	1.4051	1.3191	1.3033	29
Combined	**1.3758**	**1.3705**	**1.2652**	1,366

Revenue

Gross patient charges in December were less than budget by $1.8 million, or 8.1%, mostly driven by lower inpatient volumes, surgeries and outpatient registrations. This unfavorable variance was comprised of an unfavorable variance to inpatient of $915,000 and unfavorable variance to outpatient of $905,000. The decrease in inpatient gross revenues was driven by lower volume in Acute Care and Skilled Nursing, as well as inpatient surgery. Outpatient revenues were lower than budgeted as a result of lower than expected volume in Surgery, CT Scan and Pharmacy. On an adjusted patient day basis, total patient revenue was $5,650 below the budget of $5,823 for the month of December consistent with the November gross revenue per APD of $5,651. The following table shows the hospital's monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2012 compared to budget.

Gross Charges per Adjusted Patient



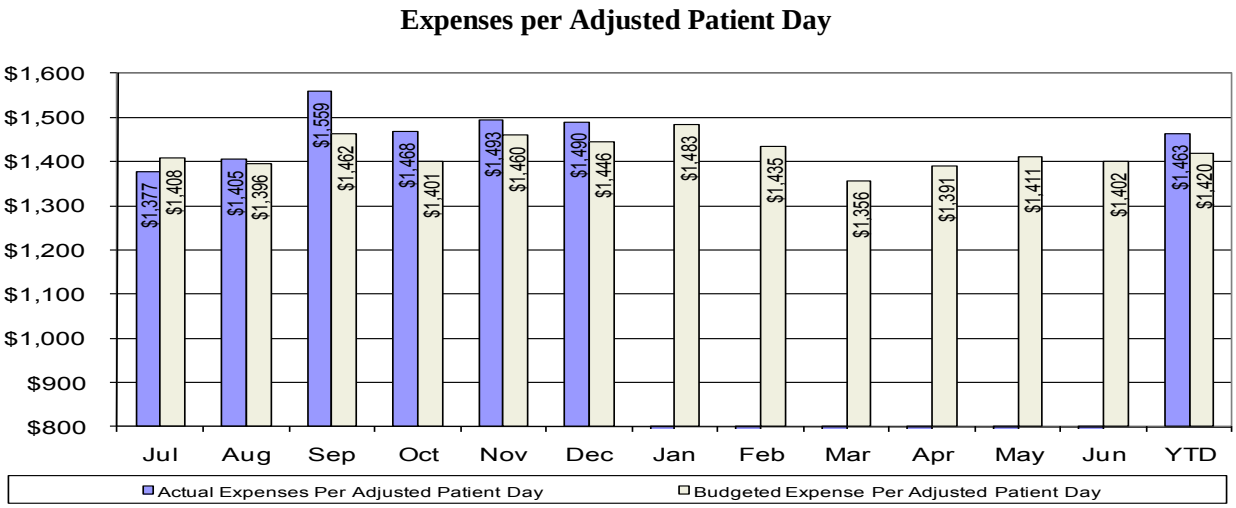
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of November contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 77.6% right on the budget. There will be an ongoing favorable variance of roughly $150,000 per month for the Sub-Acute reserve that is included in the budget deductions from revenue but not in actual results.

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. Net patient revenue for the month of December was 22.4%, also equal to the budget.

Expenses

Total Operating Expenses

Total operating expenses were lower than the fixed budget by $129,000 or 2.3%. On an adjusted patient day basis, our cost per adjusted patient day was $1,490 which was $44 (3.04%) per adjusted patient day unfavorable to budget but $3 lower than the prior month. This variance in expenses per adjusted patient day was primarily the result of unfavorable variances in non-medical professional fees due to consulting fee accruals and fees related to Water's Edge. The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2012 fiscal year by month as compared to budget and is followed by explanations of the significant areas of variance that were experienced in the current month.



Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were favorable to the fixed budget by $47,000 and were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $37 or 5.0%.

Productive salaries in the CCU were 34.5% above the flexed budget, productive salaries in the DOU were 22.5% above the flexed budget, and productive salaries in Sub-Acute were 9.5% above the flexed budget. Salaries in the Emergency Care Center were again above budget by 13.5% while the volume in the ECC was below budget by 2.2, and Radiology productive salaries were 23.75% above budget yet their visits were over budget by 7%.

Benefits

Benefits were favorable to the fixed budget by $34,000 or 4.3%, and favorable to budget by $9 or 22% per adjusted patient day.

Professional Fees

Professional fees were unfavorable to budget by $128,000 in December due to $18,000 from Medical Professional Fees (ER and Clinic physician expenses) and $110,000 from Non-Medical Professional Fees related to HFS fees for Accounting $34,000, Revenue Cycle $33,000,Pharmacy $15,000 and Administration $28,000.

Supplies

Supplies were favorable to budget by $176,000 (23.4%) or $38 or 19.3% per adjusted patient day in December. As in prior months, this favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies, and prosthetics due to lower patient volume, acuity and below budget surgeries.

Purchased Services

Purchased services were above budget by $4,000 compared to fixed budget and $4 unfavorable PAPD.

Rents and Leases

Rents and leases were below the fixed budget by $35,000, and under budget $8 PAPD in December at $15 per adjusted patient day versus a budget of $23.

Other Operating Expense

Other operating expenses were $27,000 over budget due to recruiting fee for an Anesthesia tech of $16,320 and

physician forgiveness of $6,500 not in the budget.

Balance Sheet

Total assets decreased by $1.3 million from the prior month, mostly all of which was in current assets. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for December increased by $1,663,000 and days cash on hand including restricted use funds increased to 15.0 days on hand in December from 5 days on hand in November. The increase in cash was the result of receipt of property tax monies.

- Net patient accounts receivable increased in December by $481,000 compared to an increase of $157,000 in November. Days in outstanding receivables were 62.7 at December month end, an increase from 59.2 days in November. Collections in December were $4.1 million compared to $3.9 million in November.

- Other Receivables decreased by $3.5 million from November to December due to the receipt of district tax monies.

Total liabilities decreased by $997,000 compared to a decrease of $701,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses decreasing $677,000 due to payment of delayed accounts.

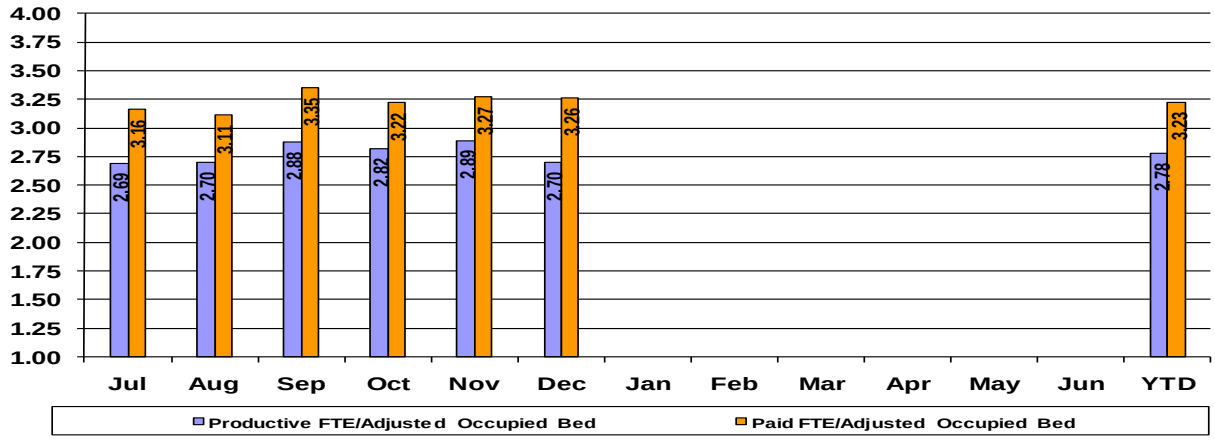
- Payroll related accruals increased by $151,000 as a result of the timing of pay period end in relation to the month end.

- Deferred revenues decreased again by $477,000 due to the recognition of one-twelfth of the 2011/2012 parcel tax revenues of $5.7 million.

Key Statistics

FTE's per Adjusted Occupied Bed

On an adjusted occupied bed basis, productive FTE's were 2.70, below the budget of 2.72 FTE's by .8%, and paid FTE's were 3.26 or .2% above budget. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2012 by month.



Current Ratio

The current ratio for December is at .97. We are working to bring this up to an even 1.0.

A/R days

Net days in Accounts Receivable are currently at 62.7, up again from prior month. We are working hard to bring this number down to 51, which will help our cash position and current ratio.

Days Cash on Hand

Days cash on hand for December is 15.0. This has increased from prior month due to receipt of property tax money. Increased billings in December (catch up) should net a further increase in cash collections in January. We would like this ratio to be closer to the FY 2010 number of over 20 days.

The following pages include the detailed financial statements for the five (6) months ended December 31, 2011, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
DECEMBER 2011

	ACTUAL DECEMBER 2011	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	DECEMBER 2010	YTD DECEMBER 2011	YTD FIXED BUDGET	VARIANCE	%	YTD DECEMBER 2010
Discharges:										
Total Acute	243	234	9	3.8%	214	1,372	1,371	1	0.1%	1,242
Total Sub-Acute	-	2	(2)	-100.0%	4	12	9	3	33.3%	12
Total Skilled Nursing	13	9	4	44.4%	3	50	52	(2)	-3.8%	43
	256	245	11	4.5%	221	1,434	1,432	2	0.1%	1,297
Patient Days:										
Total Acute	877	937	(60)	-6.4%	970	5,268	5,487	(219)	-4.0%	5,230
Total Sub-Acute	1,023	1,023	-	0.0%	1,005	5,958	6,072	(114)	-1.9%	6,004
Total Skilled Nursing	652	673	(21)	-3.1%	683	4,001	3,934	67	1.7%	4,012
	2,552	2,633	(81)	-3.1%	2,658	15,227	15,493	(266)	-1.7%	15,246
Average Length of Stay										
Total Acute	3.61	4.00	(0.40)	-9.9%	4.53	3.84	4.00	(0.16)	-4.1%	4.21
Average Daily Census										
Total Acute	28.29	30.23	(2.00)	-6.6%	31.29	28.63	29.82	(1.19)	-4.0%	28.42
Total Sub-Acute	33.00	33.00	-	0.0%	32.42	32.38	33.00	(0.62)	-1.9%	32.63
Total Skilled Nursing	21.03	21.71	(0.70)	-3.2%	22.03	21.74	21.38	0.36	1.7%	21.80
	82.32	84.94	(2.70)	-3.2%	85.74	82.76	84.20	(1.81)	-2.1%	82.86
Emergency Room Visits	1,409	1,426	(17)	-1.2%	1,368	8,391	8,464	(73)	-0.9%	8,381
Outpatient Registrations	1,698	1,929	(231)	-12.0%	1,911	10,933	11,926	(993)	-8.3%	11,810
Surgery Cases:										
Inpatient	36	44	(8)	-18.2%	42	220	259	(39)	-15.1%	271
Outpatient	131	142	(11)	-7.7%	142	955	884	71	8.0%	884
	167	186	(19)	-10.2%	184	1,175	1,143	32	2.8%	1,155
Adjusted Occupied Bed (AOB)	118.30	124.86	(6.56)	-5.3%	122.57	152.87	125.48	27.39	21.8%	123.65
Productive FTE	319.13	339.55	(20.42)	-6.0%	370.60	343.80	341.62	2.18	0.6%	363.39
Total FTE	385.45	406.18	(20.73)	-5.1%	430.29	396.52	402.86	(6.34)	-1.6%	418.03
Productive FTE/Adj. Occ. Bed	2.70	2.72	(0.02)	-0.8%	3.02	2.25	2.72	(0.47)	-17.4%	2.94
Total FTE/ Adj. Occ. Bed	3.26	3.25	0.00	0.2%	3.51	2.59	3.21	(0.62)	-19.2%	3.38

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

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 2,070,300	$ 407,543	$ 1,784,141
Patient Accounts Receivable, net	9,582,145	9,100,768	7,249,185
Other Receivables	3,646,114	7,138,269	8,090,457
Third-Party Payer Settlement Receivables	481,578	481,578	150,000
Inventories	1,183,395	1,170,330	1,183,358
Prepaids and Other	323,373	309,899	262,359
Total Current Assets	17,286,905	18,608,387	18,719,500
Assets Limited as to Use, net	546,203	534,502	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,435,271	43,427,774	43,383,571
Construction in progress	3,388,457	3,304,736	2,921,048
Depreciation	(39,304,382)	(39,221,507)	(38,862,494)
Property, Plant and Equipment, net	8,397,291	8,388,948	8,320,070
Total Assets	**$ 26,230,399**	**$ 27,531,837**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,632,934	$ 1,659,619	$ 746,074
Accounts Payable and Accrued Expenses	8,312,816	8,989,766	6,987,765
Payroll Related Accruals	4,134,636	3,983,973	3,991,254
Deferred Revenue	2,863,707	3,340,777	5,725,900
Employee Health Related Accruals	652,505	633,906	343,382
Third-Party Payer Settlement Payable	308,307	255,809	(3,930)
Total Current Liabilities	17,904,905	18,863,850	17,790,445
Long Term Debt, net	883,778	921,904	1,142,109
Total Liabilities	18,788,683	19,785,754	18,932,554
Net Assets:			
Unrestricted	6,725,513	7,041,581	8,037,015
Temporarily Restricted	716,203	704,502	553,716
Total Net Assets	7,441,716	7,746,083	8,590,731
Total Liabilities and Net Assets	**$ 26,230,399**	**$ 27,531,838**	**$ 27,523,286**

City of Alameda Health Care District

Statements of Operations

December 31, 2011

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,552	2,633	(81)	-3.1%	2,658	15,227	15,493	(266)	-1.7%	15,246
Discharges	256	245	11	4.5%	221	1,434	1,432	2	0.1%	1,297
ALOS (Average Length of Stay)	9.97	10.75	(0.78)	-7.2%	12.03	10.62	10.82	(0.20)	-1.9%	11.75
ADC (Average Daily Census)	82.3	84.9	(2.61)	-3.1%	85.7	83	84.2	(1.45)	-1.7%	82.9
CMI (Case Mix Index)	1.2883				1.3531	1.2637				1.3589
Revenues										
Gross Inpatient Revenues	$ 14,418	$ 15,333	$ (915)	-6.0%	$ 14,866	$ 86,229	$ 90,094	$ (3,865)	-4.3%	$ 83,281
Gross Outpatient Revenues	6,302	7,149	(847)	-11.8%	6,521	40,665	43,828	(3,163)	-7.2%	41,108
Total Gross Revenues	20,720	22,482	(1,762)	-7.8%	21,387	126,895	133,923	(7,028)	-5.2%	124,389
Contractual Deductions	15,074	16,558	1,484	9.0%	15,389	94,665	98,609	3,944	4.0%	89,176
Bad Debts	683	718	35	4.9%	670	2,985	4,253	1,268	29.8%	3,774
Charity and Other Adjustments	363	173	(190)	-109.5%	78	1,123	1,023	(100)	-9.8%	885
Net Patient Revenues	4,601	5,033	(432)	-8.6%	5,251	28,122	30,038	(1,916)	-6.4%	30,553
Net Patient Revenue %	22.2%	22.4%			24.6%	22.2%	22.4%			24.6%
Net Clinic Revenue	46	23	22	97.0%	26	208	90	118	130.4%	175
Other Operating Revenue	7	10	(3)	-29.9%	12	209	61	148	244.8%	59
Total Revenues	**4,653**	**5,066**	**(413)**	-8.2%	**5,289**	**28,539**	**30,189**	**(1,650)**	-5.5%	**30,787**
Expenses										
Salaries	2,885	2,893	8	0.3%	3,045	17,126	16,876	(250)	-1.5%	17,659
Temporary Agency	111	150	39	25.9%	258	616	892	277	31.0%	1,139
Benefits	765	799	34	4.3%	694	5,106	4,769	(338)	-7.1%	4,597
Professional Fees	421	293	(128)	-43.8%	309	2,278	1,728	(550)	-31.8%	1,828
Supplies	578	755	176	23.4%	626	3,559	4,546	988	21.7%	4,411
Purchased Services	369	373	4	1.0%	412	2,091	2,218	126	5.7%	2,271
Rents and Leases	54	89	35	39.1%	72	457	499	42	8.4%	408
Utilities and Telephone	67	65	(2)	-2.7%	59	392	389	(3)	-0.8%	356
Insurance	25	17	(8)	-47.2%	31	167	101	(66)	-65.5%	188
Depreciation and amortization	71	69	(2)	-2.4%	79	442	411	(31)	-7.6%	488
Other Opertaing Expenses	120	93	(27)	-29.6%	61	553	469	(84)	-18.0%	443
Total Expenses	**5,466**	**5,596**	**130**	2.3%	**5,645**	**32,786**	**32,897**	**111**	0.3%	**33,787**
Operating gain (loss)	**(813)**	**(529)**	**(283)**	-53.6%	**(356)**	**(4,247)**	**(2,708)**	**(1,539)**	56.8%	**(3,000)**
Non-Operating Income / (Expense)										
Parcel Taxes	488	478	9	2.0%	478	2,891	2,868	23	0.8%	2,868
Investment Income	0	0	0	135.7%	1	3	(72)	75	-104.1%	7
Interest Expense	(15)	(11)	(3)	-30.0%	(11)	(99)	(13)	(86)	677.0%	(52)
Other Income / (Expense)	23	23	0	1.3%	22	141	131	10	7.7%	128
Net Non-Operating Income / (Expense)	**497**	**490**	**7**	**1.4%**	**491**	**2,936**	**2,914**	**22**	**0.7%**	**2,951**
Excess of Revenues Over Expenses	**$ (316)**	**$ (39)**	**$ (277)**	**704.1%**	**$ 135**	**$ (1,312)**	**$ 206**	**$ (1,517)**	**-738.2%**	**$ (49)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

December 31, 2011

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,931	$ 3,972	$ (40)	-1.0%	$ 3,887	$ 3,848	$ 3,912	$ (64)	-1.6%	$ 3,657
Gross Outpatient Revenues	1,718	1,852	(133)	-7.2%	1,705	1,815	1,903	(88)	-4.6%	1,805
Total Gross Revenues	5,650	5,823	(174)	-3.0%	5,593	5,663	5,815	(152)	-2.6%	5,462
Contractual Deductions	4,110	4,289	179	4.2%	4,024	4,225	4,282	57	1.3%	3,916
Bad Debts	186	186	(0)	-0.1%	175	133	185	51	27.9%	166
Charity and Other Adjustments	99	45	(54)	-120.5%	20	50	44	(6)	-12.8%	39
Net Patient Revenues	1,254	1,304	(49)	-3.8%	1,373	1,255	1,304	(49)	-3.8%	1,342
Net Patient Revenue %	22.2%	22.4%			24.6%	22.2%	22.4%			24.6%
Net Clinic Revenue	12	6	6	107.4%	7	9	4	5	136.8%	8
Other Operating Revenue	2	3	(1)	-26.2%	3	9	3	7	254.4%	3
Total Revenues	**1,269**	**1,312**	**(43)**	-3.3%	**1,383**	**1,274**	**1,311**	**(37)**	-2.8%	**1,352**
Expenses										
Salaries	787	749	(37)	-5.0%	796	764	733	(31)	-4.3%	775
Temporary Agency	30	39	9	22.0%	67	27	39	11	29.1%	50
Benefits	209	207	(2)	-0.8%	181	228	207	(21)	-10.1%	202
Professional Fees	115	76	(39)	-51.3%	81	102	75	(27)	-35.5%	80
Supplies	158	195	38	19.3%	164	159	197	39	19.6%	194
Purchased Services	101	97	(4)	-4.2%	108	93	96	3	3.1%	100
Rents and Leases	15	23	8	35.9%	19	20	22	1	5.9%	18
Utilities and Telephone	18	17	(1)	-8.1%	15	17	17	(1)	-3.6%	16
Insurance	7	4	(2)	-54.9%	8	7	4	(3)	-70.1%	8
Depreciation and Amortization	19	18	(1)	-7.8%	21	20	18	(2)	-10.5%	21
Other Operating Expenses	33	24	(9)	-36.4%	16	25	20	(4)	-21.2%	19
Total Expenses	**1,490**	**1,449**	**(41)**	-2.8%	**1,476**	**1,463**	**1,428**	**(35)**	-2.4%	**1,484**
Operating Gain / (Loss)	**(222)**	**(137)**	**(85)**	-61.6%	**(93)**	**(189)**	**(117)**	**(72)**	61.3%	**(132)**
Non-Operating Income / (Expense)										
Parcel Taxes	133	124	9	7.3%	125	129	125	4	3.6%	126
Investment Income	0	0	0	148.1%	0	0	0	0	145.8%	0
Interest Expense	(4)	(3)	(1)	-36.8%	(3)	(4)	(3)	(1)	40.6%	(2)
Other Income / (Expense)	6	6	0	6.6%	6	6	6	1	10.7%	6
Net Non-Operating Income / (Expense)	**135**	**127**	**9**	**6.7%**	**128**	**131**	**127**	**4**	**3.0%**	**130**
Excess of Revenues Over Expenses	**$ (86)**	**$ (10)**	**$ (76)**	746.5%	**$ 35**	**$ (58)**	**$ 10**	**$ (68)**	-697.6%	**$ (2)**

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

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (316,068)	$ (1,311,503)
Items not requiring the use of cash:		
Depreciation and amortization	70,805	$ 441,887
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(481,377)	(2,332,960)
Other Receivables	3,492,155	4,444,343
Third-Party Payer Settlements Receivable	52,498	(19,341)
Inventories	(13,065)	(37)
Prepaids and Other	(13,474)	(61,014)
Accounts payable and accrued liabilities	(676,950)	1,325,051
Payroll Related Accruals	150,663	143,382
Employee Health Plan Accruals	18,599	309,123
Deferred Revenues	(477,070)	(2,862,193)
Cash provided by (used in) operating activities	1,806,716	76,738
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,701)	(62,487)
Additions to Property, Plant and Equipment	(79,149)	(519,108)
Other	(0)	1
Cash provided by (used in) investing activities	(90,850)	(581,594)
Cash flows from financing activities		
Net Change in Long-Term Debt	(64,811)	628,529
Net Change in Restricted Funds	11,701	162,487
Cash provided by (used in) financing and fundraising activities	(53,110)	791,016
Net increase (decrease) in cash and cash equivalents	1,662,756	286,160
Cash and cash equivalents at beginning of period	407,543	1,784,141
Cash and cash equivalents at end of period	$ 2,070,299	$ 2,070,301

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	FY 2009	FY 2010	Unaudited Results FY 2011	YTD 12/31/2011
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.16%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-2.70%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-12.83%
Operating Margin	-3.75%	1.03%	2.74%	-2.61%	-4.15%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	0.97
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	62.70
Days cash on hand (with restricted)	30.61	13.56	21.60	14.14	16.43
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	103.97%
Average pay period	58.93	58.03	57.11	62.68	74.30
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.44)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.25
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-17.62%
Debt to number of beds	20,932	13,481	10,482	11,515	15,632

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	FY 2009	FY 2010	Unaudited Results FY 2011	YTD 12/31/2011
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	15,227
Patient days (acute only)	11,276	11,787	10,579	10,443	5,268
Discharges(acute only)	2,885	2,812	2,802	2,527	1,372
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.84
Average daily patients (all sources)	61.99	83.46	83.85	82.93	82.76
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.40%
Average length of stay	3.91	4.19	3.78	4.13	3.84
Emergency Visits	17,922	17,337	17,624	16,816	8,391
Emergency visits per day	48.97	47.50	48.28	46.07	45.60
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	59.42
Surgeries per day[Note 1]	14.78	16.12	13.46	6.12	,.

Notes:

1. Includes Kaiser Outpatient Sugercial volume in Fiscal Years 2008, 2009 and through March 31, 2010.
2. In addition to these general requirements a feasibility report will be required.
3. Based upon Moody's FY 2008 preliminary single-state provider medians.
4. EBIDA - Earnings before Interest, Depreciation and Amoritzation
5. EBIDAP - Earnings before Interest, Depreciation and Amortization and Parcel Tax Proceeds

Glossary of Financial Ratios

Term	What is it? Why is it Important?	How is it calculated?
EBIDA	A measure of the organization's cash flow	Earnings before interest, depreciation, and amortization (EBIDA)
Operating Margin	Income derived from patient care operations	Total operating revenue less total operating expense divided by total operating revenue
Current Ratio	The number of dollars held in current assets per dollar of liabilities. A widely used measure of liquidity. An increase in this ratio is a positive trend.	Current assets divided by current liabilities
Days cash on hand	Measures the number of days of average cash expenses that the hospital maintains in cash or marketable securities. It is a measure of total liquidity, both short-term and long-term. An increasing trend is positive.	Cash plus short-term investments plus unrestricted long-term investments over total expenses less depreciation divided by 365.
Cash to debt	Measures the amount of cash available to service debt.	Cash plus investments plus limited use investments divided by the current portion and long-term portion of the organization's debt insruments.
Debt service coverage	Measures total debt service coverage (interest plus principal) against annual funds available to pay debt service. Does not take into account positive or negative cash flow associated with balance sheet changes (e.g. work down of accounts receivable). Higher values indicate better debt repayment ability.	Excess of revenues over expenses plus depreciation plus interest expense over principal payments plus interest expense.
Long-term debt to fund balance	Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt. A declining trend is positive.	Long-term debt divided by long-term debt plus unrestricted net assets.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: February 2, 2012

FOR: February 6, 2012 District Board Meeting

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval to Enter into an Agreement with Select Therapies for Management of Rehabilitation Services at Alameda Hospital

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RECOMMENDATION:

It is being recommended that the District Board of Directors authorize management to enter into a Management Service Agreement with Select Therapies to provide professional management to the hospital Rehabilitation Services Program. These services include Physical Therapy, Occupational Therapy and Speech Therapy services provided at South Shore Skilled Nursing Unit, the Sub-acute Units and the Acute Inpatient Nursing Units, as well as, the Outpatient Therapy Department.

The term of the contract is for one year and will renew for successive terms if mutually agreed to. After the initial one year term, the contract can be terminated by either party with or without cause by providing 90 days written notice.

The cost of the contract will be for the salary of the working manager, 29% for benefits and a fixed monthly Select Therapies management fee of $6,000 per month. The estimated annual cost of this contract is $210,000.

BACKGROUND:

Management has been deliberating on how to enhance the level of service, the quality of care, the efficiency and profitability of our Rehabilitation Services Program at the hospital for several months.

The department has approximately 8 full time equivalent (FTE) employees and has been managed by the Director of Respiratory Care Services for the past 3 to 4 years. Because of the demanding time needs of both Rehab Services and Respiratory Services, and given the specific clinical expertise that is needed to effectively manage and grow each of these programs, we have determined that distinct management for Rehabilitation Services would best achieve the operational and financial needs of this department. The desire for

more hands on management has also been brought to our attention by the staff working in the Rehabilitation Department, other clinical managers and members of the medical staff.

DISCUSSION:

The Rehabilitation Service needs at Alameda Hospital are unique. With an active outpatient program, acute inpatient services, and long term care needs with the Sub-acute Unit and the South Shore Skilled Nursing Unit, each of these service locations have different types of patients with unique rehabilitation needs. All of these unique needs require more comprehensive management and an understanding of the nuances of each of these service lines which Select Therapies provides through their experience and expertise.

In addition, we are moving forward with expansion of our long term care service line by adding the Waters Edge Skilled Nursing Facility to our license. Select Therapies became the provider of Rehabilitation Services at Waters Edge as of January 1, 2012. We plan to retain Select Therapies as our rehabilitation service provider at Waters Edge once the operation is transitioned to the hospital.

In developing a comprehensive rehabilitation program across the spectrum of care (outpatient, acute inpatient and post acute), it will be imperative to have the all rehabilitation services managed by the same organization. In addition, this will allow for the continuity of care and consistent quality standards as the patient moves through different service areas of the organization.

An important component to having a quality orthopedic program is a comprehensive rehabilitation services program. To that end, we are actively recruiting two orthopedic surgeons in order to better serve the orthopedic needs in Alameda and the greater service area. The two orthopedists that we are currently talking to will complete their fellowships in July 2012 so prompt attention to this program is important.

Select Therapies is a local rehabilitation services company. Most of their experience is with long term care, but they also have experience with acute inpatient and outpatient rehabilitation programs as well. They will introduce a clinical software program, Casamba, which is an effective tool in monitoring patient care plans, ensuring proper charge capture and accurate billing and has the ability to interface with Meditech. Select Therapies will also provide additional training and skill development to help our staff achieve their potential.

We have outlined eleven specific goals and objectives that we want to have accomplished under this management agreement. Many have to do with enhancing the scope and quality of services provided but others focus on growing the level of rehabilitation care provided and improving our financial performance in this department.

For the current fiscal year, it is estimated that Rehabilitation Services Department will have a negative annual contribution margin. One of the goals for Select Therapies will be

to produce a positive contribution margin by the end of first year, progress to be monitored each month. This positive contribution margin is to include the cost of this contract and will be accomplished through achieving operational efficiencies through improved processes and procedures, more accurate and complete billing and by growing the service lines that we currently have, especially outpatient services. It is anticipated that given the size of our Rehabilitation Department that the manager will spend a portion of their time providing direct patient care.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: February 2, 2012

FOR: February 6, 2012 District Board Meeting

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

FROM: Deborah E. Stebbins, CEO

SUBJECT: Approval of Resolution No. 2012-1J: Approval to Access Additional Funding of Jaber Estate As Set Forth Therein

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RECOMMENDATION:

Management requests the Board of Directors to approve the attached resolution authorizing management to use the cash portion of the Jaber Funds for operations and, if necessary, encumber the real property portion of the Jaber funds as collateral for a long term capital loan.

BACKGROUND:

The Jaber Fund is the result of a donation given to Alameda Hospital in 1992 by Mrs. Alice Jaber. The cash portion of the fund, $546,000, has been built up through rental income from two pieces of real estate (a retail storefront on Encinal Avenue and an apartment building on Pearl Street). Title to both properties is held by the hospital. Historically, the hospital has used about 20 percent of the rental income to fund a variety of capital needs each year.

The Jaber Fund however also provides that the Board of Directors may determine, at their sole discretion, may use a greater amount of the Fund than this customary draw-down, up to the whole thereof, for the purpose of maintaining Alameda Hospital at, or restore Alameda Hospital to, its level of operation in its prior year, when there are no other reasonably available resources for this purpose.

Alameda Hospital is experiencing a cash flow problems exacerbated by a couple of months of low volume and recent cash collection problems. This has led to an increase in Accounts Payable and strained our vendor relationships. It also places us out of compliance with financial ratio thresholds required by our Bank of Alameda Line of Credit and upcoming Wound Care Loan. In discussions between management and the Bank of Alameda, the Jaber Fund has been identified as a unique resource both from a standpoint of providing cash and as security for a long term loan of about 75% of the value of the two properties to begin to restore our ratios and reduce Accounts Payable. The Bank of Alameda Loan Committee is reviewing our update on our financial statements, new programs and the terms of the Jaber Fund, to determine their position on both the line of credit and the Wound Care loan.

Management intends to use all the proceeds (approximately $1.5 million) to restore our current ratio to 1.1 and for the pay-down of accounts payable. It is expected that our present financial condition will markedly improve when the Waters Edge transition is complete and the Wound Care program opens in late Spring.

Resolution No. 2012-1J

A RESOLUTION OF THE
CITY OF ALAMEDA HEALTH CARE DISTRICT
BOARD OF DIRECTORS

*** * ***

Providing for Increased Distributions from the

Abraham Jaber and Mary A. Jaber Memorial Fund

* * *

WHEREAS, Ms. Alice Jaber developed a personal interest in health care issues and the availability of quality health care in the Alameda community; and

WHEREAS, Ms. Jaber established her Trust in 1992, naming Alameda Hospital as a major beneficiary. Upon her death, and pursuant to the terms of the Trust, (1) certain Trust assets were distributed to the City of Alameda Health Care District, as the successor-in-interest to Alameda Hospital (the nonprofit corporation), and (2) those assets were placed in the "Abraham Jaber and Mary A. Jaber Memorial Fund" (the "Jaber Fund") in appreciation of the care given by Alameda Hospital; and

WHEREAS, Among the assets in the Fund are cash as well as two parcels of real property located in the City of Alameda, namely, 1359 Pearl Street, an apartment complex, and 2711 Encinal Street, a retail store. Both properties generate rental income that is placed back into the Fund and used, as specified in the original Trust (and as carried over to the Jaber Fund), to fund an annual distribution to the Hospital; and

WHEREAS, Under said terms of the Jaber Fund, Alameda Hospital annually receives certain cash distributions. Specifically, and except as noted in the next sentence, the Fund is to be used for the purchase of capital equipment directly related to the diagnosis and treatment of patients at Alameda Hospital. However, if the District Board of Directors determines, in its sole discretion, that that a greater amount of the Fund needs to be used to maintain Alameda Hospital at, or to restore Alameda Hospital to, its level of operation in its prior fiscal year, and there are no other reasonably available resources for this purpose, a greater amount of the Fund, up to the whole thereof, may be drawn upon to maintain or restore the level of operation; and

WHEREAS, As discussed previously by the Board, a number of unanticipated operational changes and uncontrollable reimbursement reductions have had an adverse effect on Alameda Hospital's financial condition and operations over the last two fiscal years; and

WHEREAS, Since there are no other reasonably available resources for this purpose, the Board of Directors of the City of Alameda Health Care District has determined, in the exercise of its sound discretion, that is in the best interests of Alameda Hospital, to draw down a greater amount of the Fund (as and to the extent described below) so as to restore Alameda Hospital to its level of operation in its prior fiscal years.

NOW THEREFORE BE IT RESOLVED, that upon approval of this resolution, the sum of $546,000 shall be transferred from the Fund to the Alameda Hospital operating account for use in restoring Alameda Hospital to its level of operation in its prior fiscal years; and

BE IT FURTHER RESOLVED, that upon approval of this resolution, management of Alameda Hospital shall endeavor to mortgage the 1359 Pearl Street and 2711 Encinal Street properties, on commercially reasonable terms, such that upon repayment of such mortgages, the net equity in such properties shall be restored to the Fund for future uses in accordance with the terms of the Jaber Fund. Any and all loan proceeds realized by the District in connection with such borrowing shall be used to restore Alameda Hospital to its level of operation in its prior fiscal years; and

BE IT FURTHER RESOLVED, that the CEO of the District is, and those under her direction are, authorized and empowered to take such actions as may be necessary of convenient in order to effectuate the terms of this resolution.

PASSED AND ADOPTED on February 6, 2012 by the following vote:

AYES:_____NOES: _____ ABSENT:_____

ATTEST:

_____ _____

Jordan Battani
President

Elliott Gorelick
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 2, 2012

For: February 6, 2012 District Board Meeting

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

From: Deborah E. Stebbins, Chief Executive Officer

Subject: February CEO Report to the Board of Directors

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1. Supplementary Information to December Financials

There have been a number of developments since the presentation of the December Financial Statements at the January Finance Committee. Most of these adjustments will be incorporated into the January, 2012 Financial Statements:

a. Results of Medicare Cost Report for FY 2010-2011: The report was prepared by our cost report consultants, PHM, and sent to CMS on January 31, 2012. The total amount owed **to** Alameda Hospital was **$260,334** (Inpatient: $138,334 and Outpatient $122,000). In past years, the final Medicare settlement has been in this range as a result of submission of the Annual Cost Report. It is projected this amount will be received in 60-90 days. The settlement will be booked to the P & L in January, 2012.

b. In their last bulletin to providers, Medical indicated they will not be decreasing fees for the DP SNF services, as called for by AB 97 at this time. The reason is the fact that a temporary injunction against implication of the rate change has been filed by CHA. Despite an initial appeal against the injunction by the State, the court hearing the appeal referred the matter back to the court that originally imposed the injunction. We have accrued a reduction in reimbursement from the original effective date of June, 2011. We will reverse this accrual, totaling **$273,000** for seven months in January, 2012.

c. Level of Care Prior Medical Rate Adjusted MediCal Rate

Our sub-acute rates were effectively frozen last year as a result of the terms of AB 97. The subacute rate reduction component of AB 97 was subsequently not approved by CMS due to CHA and Alameda Hospital's feedback that a dramatic rate reduction would have an adverse effect on access to service by sub-acute patients. On January 31, 2012, we received notification from DHCS that our new rates effective August 1, 2011 for would be:

Type of Patient	Current Rate	New Rate
Ventilator Dependent	$879.18	$913.90
Non-Ventilator Dependent	$846.00	$907.63

The State has authorized their intermediary to reprocess the claims affected. The total revenue pick up for the five months YTD FY 2012 is approximately **$125,000.** This change will also favorably increase revenue budgeted for the last 7 months of FY 2012.

In summary, the three adjustments to changes in reimbursement total a favorable adjustment to the net income of **$658,334** which will be reflected on the YTD financial statements in January, 2012.

2. Waters Edge Update:

We have filed the application for the addition of the 120 Waters Edge beds to our license shortly after Thanksgiving. The staff member at the State who will grant approval has been on a three week vacation. Due to the delay we have revised our projected transition date to early March, 2012. Meanwhile, we have processed all Waters Edge staff to transition to the Alameda Hospital payroll. In addition, we have made arrangements for the transition of various third party agreements from Waters Edge to Alameda Hospital.

We have interviewed three candidates for the Long Term Care Administrator and have offered the position to Richard Espinoza, who is currently the Administrator of Bay View in Alameda. In addition to sixteen years if experience in long term care, Richard has most recently been the Administrator at the Kindred Bay View Convalescent facility on Otis Drive in Alameda and has well established relationships with referral sources in our market. Richard will start on February 6, 2012 and his resume is attached.

3. Revenue Cycle:

A meeting of the Revenue Cycle Task Force of the Finance Committee was held on January 31, 2012. Ann Evans was the only Committee member who was able to attend, although we had an excellent review of where we are with all steps in the process. A project matrix outlining the status of all components of the project is attached. We have seen an increase in cash collections in the last several weeks.

We are actively recruiting for a permanent Business Office Manager, which will allow us to eliminate on-site leadership for the Department currently provided by HFS Consultants.

While we are about to embark on a comprehensive review and update of our Charge Description Master (CDM), we implemented a change in our charge system for the Emergency Department wherein significant decreases in revenue generation were observed as a result of changes made by the former Revenue Cycle Director. Since changing back to our previous system, volume- adjusted

revenue in the department has increased by almost 8%. An analysis of the impact on revenue had we had the revised rates in place since the beginning of the fiscal year showed that gross revenue would have increased by over $900,000. Hence this adjustment should enhance revenue for the last six months of the year.

4. RAC Audit:

We have established a management committee as well as a monitoring process to follow the impact of the RAC audit.

We have updated our process of recording and following RAC inquiries. Since the inception of the permanent RAC system (a system created by Medicare to identify and recover improper payments paid to healthcare providers), we have been asked to produce 202 records for review. The RAC organizations can pull up to 10% of discharges every 45 days. The records pulled to date account for $3,575,051 in gross revenue and $1,239,358 in net revenue. Of the total net revenue, HDI (our RAC contractor) has taken back approximately $250,000 in payments while the review process takes place. The remaining claims had no finding. Using our RAC consultant (EHR), we are appealing all the claims which have had payment taken back. EHR has a track record of winning 90% of their appeals. The take-back has had an estimated impact of at least $250,000 on net revenue and cash so far in FY2012. We are not making adjustments at this time to the financials, but it is likely some of this revenue will be returned when the appeals are resolved.

5. HCAHPS Results:

Since environmental cleanliness has remained a problem for the last couple of years, a multidisciplinary team chaired by Phyllis Weiss, Director of Human Resources and Ancillary Services has been formed to address the issue of hospital cleanliness. The group has established a performance improvement charter, is assessing all departments and will meet biweekly and develop monitoring tools until we receive an improved score.

6. JANUARY STATISTICS:

January volume was strong on almost every level of service against budget and in relationship to December. Case Mix Index (overall and Medicare only) was at the highest level since the start of the fiscal year. A preliminary operating margin for January should be available early in the week following the Board meeting.

	January Preliminary	January Budget	% Δ compared to Budget	% Δ compared to December	December Actual
Average Daily Census	84.97	85.16	-0.2%	3.2%	82.32
Acute	33.10	30.39	8.9%	17.0%	28.29
Subacute	33.13	33.00	0.4%	0.4%	33.00
South Shore	18.74	21.77	-13.9%	-10.9%	21.03

(Continued)	January Preliminary	January Budget	% Δ compared to Budget	% Δ compared to December	December Actual
Patient Days	2,634	2,640	-0.2%	3.2%	2,552
ER Visits	1,474	1,426	3.4%	4.6%	1,409
OP Registrations	1,917	2,053	-6.6%	12.9%	1,698
Total Surgeries	136	149	-8.7%	-18.6%	167
Inpatient Surgeries	32	45	-28.9%	-11.1%	36
Outpatient Surgeries	104	104	0.0%	-20.6%	131
Case Mix Index	1.4347				1.2883

7. CALAFCO Presentation:

On February 3, I will be presenting at an educational seminar "Understanding Health Care Districts and the Role of LAFCo" sponsored by the California Association of Local Agency Formation Commissions (LAFCo). The presentation will focus on building partnerships and generating growth for the District.

8. Assembly Candidate Meetings:

I have recently met with two of the candidates for the California State Assembly for the 16th District, Robert Bonta and Joel Young. Both meetings were organized by the Hospital Council and involved leadership from other healthcare facilities in our district. The main objectives of the meetings were to meet the candidates and share critical issues with them relating to healthcare and our organizations.

9. Chinese Student Delegation:

On January 25, 2012, the hospital hosted a delegation of Chinese university students to learn about the American healthcare system. Myself and other members of management participated in a discussion after a presentation on healthcare and the District. The students were taking part in a workshop called "Sociological Research in America" in which they compared public agencies in China with their counterparts in the United States.

Richard Espinoza

Licensed Nursing Home Administrator:

History of providing efficient and profitable operations of multiple facilities simultaneously; complying with company polices and State and Federal rules and regulations while providing the highest level of quality care possible.

Experience in Nursing Home Administration:

Kindred Healthcare, Inc.: 12/1999 - Current

Nursing Home Administrator: 9/2006 –Current

Bay View Nursing and Rehabilitation Center, Alameda, California 94501

- Successfully directing a 180 bed facility and overseeing the facility's $15 million annual budget. Prepare annual budgets for Senior Regional Management, exceeded EBITDARM by 750,000 in 2007, 1.3 million for 2008, 1 million for 2009, and 400,000 in 2010 with a 100% increase in EBITDARM from 2008 to the 2011 budget. Facility was not making EBITDARM in 2006.
- Recruited, hired, trained, and evaluated a top-performing nursing home staff while reducing its turnover rate from 49% in 2006 to 16% in December 2011 under former management.
- Improved employee satisfaction scores from 46% in 2006 to its current score of 85% in June 2011.
- Ensured full adherence to all company policies and state/federal regulations, with survey outcomes for 2008 with seven deficiencies, two deficiencies in 2009 and deficiency free in 2010. Facility's best survey outcome prior to 2008 was 15 deficiencies and was 25 deficiencies in 2006.
- Managed all aspects of state and federal government survey processes with a pass on the first visit from officials, and fostered a successful working relationship with the Department of Public Health, Licensing and Certification.
- Served as the primary officer for enforcing HIPAA, Affirmative Action Plan, Equal Employment Opportunity, Performance Improvement Committee, as well as the Corporate Compliance Liaison.
- Planned and directed all of the facility's programs and operations from its current restaurant style dining with choice menu options, to Tai Chi classes and guided imagery, to providing meals for Alameda Meals on Wheels (roughly 40,000 meals per year with revenue which offsets controllables with a positive variance for raw food and supply lines). Designed the Art Auction for the Alzheimer Association – art created by our residents and auctioned off to raise an excess of $4,000 which was donated to the Alzheimer Association.

- Closed a 54 bed secured dementia unit --opening up the facility for more short term rehabilitation. Negotiated and captured the Health-Net Preferred Provider Contract (only four buildings in Alameda County have this contract – based on RUG scores), and re-contracted with Kaiser.

- Implemented a Pulmonary Program in May 2011 and have successfully decannulated 10 patients since program implementation. Implemented an Orthopedic Program in June 2011, with increase revenue and patient admissions. Oversees the Rehabilitation Program and Case Management department tightly with a focus on quality outcomes as well as revenue based RUG rate management. Oversight of training and competencies of the nursing department for new programs to ensure nursing is delivering excellent care.

- Changed the mix of the facility from 90% traditional long term to 60% with 40% short term rehabilitation, with growth occurring with the two additional short term rehabilitation contracts of Health-Net and Kaiser which were captured in October and November 2009. Politically engaged in healthcare reform and letter campaigning to our politicians.

- Developed two short term rehabilitation units in the facility, added two rehabilitation gyms, remodeled and upgraded patient rooms to increase overall development of business for the facility.

Nursing Home Administrator: 12/1999 – 9/2006

Fifth Avenue Healthcare Center, San Rafael, California 94901

- Ran the facility under the Director of Operations license until licensed in 2001. Successfully directed a 57 bed facility and oversaw the facility's $5 million annual budget. Prepared annual budgets for Senior Regional Management; exceeded EBITDARM by no less than 250,000 for all years after 2001. Facility was not making EBITDARM in 1999 and was utilizing 90% registry.

- Recruited, hired, trained, and evaluated a top-performing nursing home staff while reducing its registry use from 90% in 1999-2000 to 0% by 2001-2006; reduced turnover rate from 80% in 2000 to a rate of 15% by 2006.

- Improved employee satisfaction scores from 44% in 2001 to a score of 88% in 2006. Ensured full adherence to all company policies and state/federal regulations, with survey outcomes alternating year after year between 3 and 6 deficiencies during my tenure. The survey in 2006 was deficiency free.

- Selected as Executive Director of the Year for 2006 by Kindred Healthcare, Inc..

- Managed all aspects of state and federal government survey processes; passed survey on first visit; fostered a successful working relationship with the Department of Public Health officials.

- Served as the primary officer for enforcing HIPAA, Affirmative Action Plan, Equal Employment Opportunity, Performance Improvement Committee, as well as the Corporate Compliance Liaison.

- Captured the Kaiser contract for the facility in 2002, which it still maintains. Ran three additional facilities during my tenure at Fifth Avenue: Golden Gate Healthcare Center, 120 beds, for over a year (1/2005-3/2006 while also running Fifth Avenue and with less than the state average number of deficiencies and surpassing EBITDARM for both facilities), Lawton Healthcare Center, 61 beds for six months (2/2004 – 7/2004 while running Fifth Avenue) until a new Administrator could be hired, and Victorian Healthcare Center, 99 beds, from 10/2003 -1/2004 also with a survey outcome less than the state average number of deficiencies and until an Administrator could be hired.

Education and Credentials:

Licensed Nursing Home Administrator in California since 2001

University of California at Berkeley 1995 – Majors in Legal Studies and Rhetoric

Nominated by Kindred Healthcare, Inc. in 2009 for the Young Hispanic Corporate Achievers Award by the Hispanic Association for Corporate Responsibility – only Fortune 500 companies are allowed to participate

Languages spoken: English and Spanish

	Work Plan for Business Office and Revenue Cycle Updated as of 1/27/12					
	Area	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Status
1	Billing Issues and Tasks	**Auto-bill Emdeon.**	Gwynn Smith	This function has been turned off.		Complete
2	Billing Issues and Tasks	**Disposition codes** -	Diane Gramse	Reviewed tables and they look okay. Awaiting more examples of old dispo codes.		On-going
3	Billing Issues and Tasks	Not billing on Medi/Cal ancillaries for LTC		Researched no reimbursement opportunity		Complete
4	Billing Issues and Tasks	Call Emdeon about the 4 ED levels splitting the gross amount	Diane Gramse	AH IT and Diane are working with Meditech	Continue to work on this issue Meditech was able to resolve this issue on some but not all claims. Continue to look for what the outstanding claims have in common.	In process
5	Billing Issues and Tasks	Review claim scrubber	Teresa Jacques, Gwynn Smith, Diane Gramse	As we gather information on the issues with Emedeon, we will be looking at whether this is the correct system for AH.	Contact has been made with DSG about a demonstration and proposal	Outstanding
6	Billing Issues and Tasks	**Review what Kaiser pays fo**r. Special focus on LTC and ancillary charges.	Diane Gramse			Outstanding
7	Billing Issues and Tasks	**Review all LTC patients** for proper primary and secondary payors. Re-register if necessary.	Diane Gramse	All LTC patients with Medi/Cal are now registered as Medical primary.		Complete
8	Billing Issues and Tasks	**Review credit balance reports**. Recommend repayment strategy if necessary.	Teresa Jacques	This task will be assigned to the Financial Counselor and Escheatment laws will be reviewed.	One staff is working some credits and additional staff have been identified and training is expected to start in the next 10 days.	In process
9	Billing Issues and Tasks	**Day-to-day management of the business office**. The goals are to expedite cash collections, correct system problems, and make recommendations for the long term organization and staffing of the department. A time frame and budget needs to be submitted.	Diane Gramse	Review and make changes to current processes from issues sent from the Fresno Billing Office.	In the process of interviewing for a Business Office Manager. An offer for the Financial Counselor will be offered by Feb 1.	On-going
10	Billing Issues and Tasks	**Assess current functions** including registration, billing, cash posting, and billing follow-up. Provide final recommendations for organization and staffing levels.	Teresa Jacques	Registration has been evaluated and a plan is being developed. Cash posting has been evaluated and will be in place by January 6. Organization and staffing levels are still outstanding. Beginning Tuesday all Registrations/Admissions will be reviewed/audited by a co-worker and	Additional 1 on 1 training will be completed by 2/17/12 to include proper registration of Medicare and Medi-Cal patients vs. Managed Medicare and Medi-Cal. All clerks will be required to sign off that they received and understand the material. Additionally, we are going to review last quarter's registration errors with January's With respect to the organization and staffing plan we are waiting to incorporate the new Business Office Director for support of the reorganization.	In process
11	Billing Issues and Tasks	**Redesign the cash posting system**. Incorporate appropriate checks and balances, reassign to staff member who possesses understanding of third party contracts.	Teresa Jacques	Cash posting will remain in Business Office. Accounting will take responsibility for deposit and banking. Other positions will take responsibility for opening checks, balancing cashiering drawers, and mail.	Cash Posting was been addressed in a temporary fashion. Accounting is waiting for an additional staff member that will take on some of the banking and deposit responsibilities, in the interim we have separated the duties amongst the business office staff.	In process

	Area	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Status
12	Billing Issues and Tasks	**Review relationships between business office and operating departments.** Affirm functions are being covered. Evaluate certain registration functions as being more effective if handled by operating departments.	Teresa Jacques	Have met HIM, IT, Quality, ED to evaluate needs and processes	Met with Janet Dike and Julie Green to understand where coding issues are originiating. We are going to develop algorithms for communicating coding issues and quality assurance. Additionally, thus far we have met with the Directors of ED and Medical Imaging meeting to start this process. Alameda will provide the staff to produce the algorithms and we expect that this project will be completed in the next 6 weeks.	In process
13	Billing Issues and Tasks	**Determine the duties of verification clerks**. How does this relate to Health Advocates? How are authorizations and TARs obtained? Does the system work well?	Diane Gramse, Gwynn Smith, Teresa Jacques	Met with all of the verification clerks and developing a work plan. Refining the TAR process and working to electronically submit TARS. In addition to AH staff, the Fresno Office is checking for TAR approval daily.	HFS is working with IP Verification clerks on authorizations and TARS. A new TAR log has been developed and training on maintaining the log. Electronic TARS has been put on hold for now and will be revisited in March.	In process
14	Billing Issues and Tasks	**Determine who will assume supervisory business office responsibilities**. AH Administration?		Prepared a new Job descriptions for Business Office Supervisor and will be posting the position by Dec 30th.	Interviews are in process	In process
15	Billing Issues and Tasks	**Reports.** Which ones will be provided daily to monitor progress? Schedule weekly update meetings.	Gwynn Smith, Teresa Jacques, Diane Gramse	We have weekly meetings with Admin staff, new QM tool for Admitting, Daily billing log, developing cash projection logs, developed improved ATB tools. In process of developing monthly analysis reporting tools.	Cash projection log has been built, reviewing how billing information can be reported in a format that will work for cash projection.	In process
16	Billing Issues and Tasks	**Pursuing payment of patient share of costs.** LTC focus.	Diane Gramse	Developed LTC share of cost log, checking LTC patient eligibility monthly, LTC Share of costs letters are going out monthly.		Complete
17	Billing Issues and Tasks	**Eligibility and authorization process**. Recommendations for improvement. Check Assist being used? TAR process?	Teresa Jacques, Diane Gramse	Feedback received on Check Assist. Not a reliable tool. Individual websites are more up to date. Have emailed accounting to find out what the Check Assist program costs to see if we should keep the program. Evaluation of the responsibilities has been completed plan for correction is pending. TAR process will be addressed in the plan.	HFS will recommend that the Check Assist be turned off do to its unreliable information. HFS will get into place the necessary website access and training in the next month. HFS has developed a new TAR log and trained Alameda IP Intake staff. HFS is evaluating the Intake/Verification clerk duties to determine the needs of the facility.	In process
18	Billing Issues and Tasks	**Coordination of authorizations**. Surgery, imaging.	Diane Gramse, Teresa jacques	HFS staff need to meet with authorization clerk and Imaging and Lab Directors.	1/27/12 HFS has will be meeting with Imaging Director the week of Jan 30th to discuss the authorization process. A meeting with the Lab Director has not yet been scheduled.	In process
19	Billing Issues and Tasks	**Workflow for PBX.**	Diane Gramse, Teresa jacques	Working through the process of PBX staff duties and how this will relate to the duties of the Financial Counselor and Cash posting positions.	We have assigned some cash posting duties to this position and are going to evaluate further after the Financial Counselor has been hired.	In process
20	Billing Issues and Tasks	Interdepartmental Procedures	Gwynn Smith	HFS staff are reviewing and updating policies for the department		In process
21	Billing Issues and Tasks	**Develop Cash projection model**	Teresa Jacques		Have built the model no data available to differentiate government billings from commercial to estimate cash.	In process
22	Billing Issues and Tasks	**Complete ER CDM review**. Reports to be provided by Katy Silverman.	Gwynn Smith	New ED level calculation in place on 12/27/11.		Complete

	Area	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Status
23	Billing Issues and Tasks	**ITS balloon charge capture.**	Teresa Jacques, Jackie Epps			Outstanding
24	Billing Issues and Tasks	**CDM and revenue usage report.**	Teresa Jacques, Gwynn Smith	Reports have been given to an outside vendor. Alameda has run the CDM through code correct 28 invalid codes were identified. HFS will be doing a market pricing survey.	A contract has been signed for an outside vendor to perform a CDM review.	In process
25	Billing Issues and Tasks	**Bad Debt -** Evaluate BD contracts, review BD contractors collections, choose contracts, evaluate BD write offs, campaign for charity care, campaign for additional one-time discounts starting in Feb 2012. Goal to get self pay to manageable level	Teresa Jacques	Contracts have been evaluated, CFO is going to evaluate all contractual and BD reserves, CFO waiting for AR reports from Teresa. Rash Curtis will be the early out and bad debt provider this process will start the week of Jan 16. Campaign will start in February. Goal for self pay not set yet.	CFO has received requested information and is now looking for additional information from Analyst staff in order to evaluate. We are still waiting for the report to be built on our side, credit card contract to be signed, and Emdeon to make the necessary corrections on the statements.	In process
26	Billing Issues and Tasks	**Charity Care -** Review and revise charity care P & P, strengthen charity care policies to maximize charity contributions by AH	Teresa Jacques Diane Gramse	Charity Care policy temporarily revised. A new policy is recommended and will be included with the new policies for the department. Will also campaign for Charity care in February along with self pay discount.		Complete
27	Billing Issues and Tasks	Compliance	Diane Gramse, Teresa jacques, Gwynn Smith	As we go through the reorganization process we are looking at potential compliance issues and addresssing them as they present. HFS will be instituting Billing compliance policies and procedures.		On-going
28	Billing Issues and Tasks	**Review contracts** with outside vendors that provide revenue cycle related functions. Make recommendations for continuation or modification of services.	Teresa Jacques	All bad debt and early out contracts have been reviewed and Rash Curtis is going to provide both services. Still evaluating Health Advocates and will look further into this service as we grow the Financial Counseling position.	Rash Curtis contract has been signed. We are still in the process of developing a report to transmit the self pay accounts on a weekly basis. All self pay will be turned over and worked before going to bad debt. A discount will be offered in late February on all self pay and bad debt balances with Rash Curtis.	In process
29	Billing Issues and Tasks	**Impact of change in fiscal intermediaries for MediCal.**	Teresa Jacques, Bob Anderson	Diane is tracking total charges and payments received for this financial class to ensure that payments are correct. Found that current R & B rates were not on file at Medi/Cal submitted form.		Complete
30	Billing Issues and Tasks	**Contract payments** - assess P & P for identifying 3rd party shortfalls	Teresa Jacques, Gwynn Smith, Diane Gramse	This task has been assinged to Mahera.	The long term solution is to set up and use the proration module in Meditech. This task is assigned to Mahera.	In process
31	Billing Issues and Tasks	**Wrong insurances classes reporting to the general ledger under self pay**	Teresa Jacques	HFS has ran a report to identify where all insurances are reporting.	Analyst staff has been working through this task.	In process
32	Billing Issues and Tasks	**Unbilled** - research causes for unbilled amounts over goal by $1.5m, reduce unbilled to goal of $3.5 to $4m for all accounts except LTC	Teresa Jacques	Met with HIM about $2m in unidentified accounts that are not the responsibility of HIM. Needs further attention.	We have identified the unbilled accounts and met again with HIM staff. All uncoded/unbilled are listed with issues. We are working to resolve issues ie physician queries, accounts with no charges, accounts with no reports.	In process

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Handouts & Presentations from February 6, 2012 District Board Meeting

Cash Flow Forecast
February 6, 2012

Presented by:
Bob Anderson, Interim CFO

February 6, 2012
Board Meeting

Alameda Hospital

Assumptions

- Forecast Income and Balance Sheets Maintaining Cash @ $1M.
- Vary Accounts Payable
- Forecast Jan – June:
  - Use Current Budget
  - Adjust Actual for Items that distort the trend
  - Develop % Variance Between the Adjusted Actual vs. Budget
  - Apply % Variance to the Remaining Budget
  - Adjust Budget for One-Time Income Events
- Forecast Jul – Dec using an Average of the Last 3 Months Forecasted Budget

Assumptions

- Add Waters Edge & the Wound Care Center to the Adjusted Hospital Budget.
- Forecast the Balance Sheet by Adjusting Components That Have a Major Impact on Cash
- Assume AR Days Decrease From 66 to 51 Over the Next 7 Months

Assumptions

- Assume an $880k Payment for IGT in March & Receipt of $1.387M in May
- Assume the Jaber Fund is Liquidated.
- Assume the Jaber Fund Properties Will be Used for Collateral on a $1.0M Loan for Operations.

Assumptions

- Assume the CWS Loan will be Repaid in June
- Assume to LOC will Repaid in May. No Additional Borrowings.
- Assume Waters Edge Working Capital will be Provided in May/June and Paid Back in May.
- Assume a $1.0M Loan for Wound Care Capital Improvements

Significant Trend Adjustments

- AB 97 Accrual $273k
- Sub-Acute Rate Change $203k
- ECC Charges $185k
- Imaging Charges None
- RAC Audits None

Alameda Hospital

Significant Income Adjustments

- AB 97 Accrual $273k
- Sub-Acute Rate Change $203k
- 2011 Cost Report $180k
- January Revenues $200k

Alameda Hospital

Critical Values

	FORECAST											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
NET INCOME	306	61	134	(44)	(75)	(9)	57	61	111	111	109	128
CASH BALANCE	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
AR DAYS	66	63	61	59	57	55	53	51	51	51	51	51
AP DAYS	161	151	133	89	89	91	93	89	95	98	105	72
AP BALANCE	8,974	8,757	8,754	6,323	6,328	6,580	6,708	6,309	6,917	7,160	7,662	5,224
CURRENT RATIO	0.99	1.02	1.08	1.10	1.11	1.11	1.08	1.09	1.10	1.11	1.12	1.16

Questions and Comments

CASH FLOW FORECAST
Jan - Jun 2012
ASSUMPTIONS

1 Forecast Income and Balance Sheets maintaining Cash at $1M. Vary AP accordingly.

2. Forecast January through June income by first adjusting actual performance to date with known factors that will not repeat in the forecast period. Then develop an actual to budget performance ratio for the various income components. Apply these ratios to the final six months budget to arrive at an adjusted budget.

3. Add known or reasonably predicted one-time income events to the forecasted budget.

4. Forecast Jul - Dec 2012 income by using the average adjusted income for the preceding 3 budget months.

5. Add the Waters Edge and Wound Care Center proformas to the adjusted budget.

6. Develop a balance sheet/cash forecast by adjusting balance sheet accounts for major cash impacts. Balance sheet accounts with minor cash impacts were not adjusted.

7. Assume Accounts Receivable will be reduced from 66 to 51 days over the next 7 mos.

8. Assume a $800k payment will be made for IGT in March and a receipt of $1.387M will be received in May

9. Assume the Jaber Fund will be liquidated to reduce Accounts Payable. Also Jaber properties will be used as collateral for a $1M loan to also reduce Accounts Payable.

10. Assume the CWS loan for $265K will be paid in June.

11. Assume the LOC of $750K will be paid off in May. No additional borrowings are forecasted.

12. Assume Waters Edge Working Capital will be provided in Mar/Apr and Paid in May.

13, Assume a $1M loan to fund Wound Care capital improvements.

CASH FLOW FORECAST
6-Feb-12

SIGNIFICANT TREND ADJUSTMENTS

o	AB 97 Accrual.	$ 273,000
o	Sub-Acute Rate Revision	$ 202,819
o	ECC Charges	$ 185,000
o	Imaging Charges	No Adjustment
o	RAC	No Adjustment

SIGNIFICANT INCOME ADJUSTMENTS

o	AB 97 Accrual.	$ 273,000
o	Sub-Acute Rate Revision	$ 202,819
o	2011 Cost Report	$ 180,000
o	Estimated January Performance	$ 200,000

Jaber Real Estate

This involves two properties which are providing roughly $10k/mo to the hospital in income, Using a 7% cap rate, the value of these properties is approximately $1.7M. It is proposed that these properties be used to secure a $1M LT loan that would be used to reduce accounts payable.

Trend:	$60k	Reduce non-op income. Assume the future income would fund the loan pmts.
Income	-$60K	Reduce non op income for reduction of Jaber income to service new debt
Balance Sheet	$1M	Establish $1M LT debt less current portion. Assume 10 year loan at 7%

Waters Edge

Assume Waters Edge will be integrated with the hospital beginning in March.

Trend:		None
Income		Add Waters Edge P&L beginning in March
Balance Sheet		Waters Edge will fund the first 2 payrolls and first two months lease payments. These will be paid back to Waters Edge principals in May.

Wound Care Program

Assume construction will start in March and the Program will begin in July. The forecast in in annual increments. A monthly budget was developed using first year values divided by 12. A construction loan from the Bank of Alameda for $1M will be required. Interest expense will be capitalized during the construction timeframe and the remainder is included as Other Expense in the Wound Care Budget.

Trend:		None
Income		Included in WC Budget
Balance Sheet	$1M	Establish $1M LT debt less current portion. Assume 10 year loan at 7%

Month of January

The month of January gross revenues are $1.014M higher than the adjusted budget and $1.168 higher than the average of the previous six months. If this is paid at a collection ratio of 20.0%, this would add approximately $200k to budgeted income.

Trend:		None
Income	$200k	Adjust January Income
Balance Sheet		

RAC

RAC has resulted in approximately $250K in recoupment by Medicare YTD. Initially these take backs were recorded as decreased income when the take-backs occurred. This practice was changed sometime before November and resulted in a re-establishment of the patient account. Therefore a certain amount of this resulted in decreased income while the remainder has a cash but no income impact. Since the actual amounts have yet to be quantified, it is not practical to adjust future trends for RAC given the unknowns at this time. Since a certain portion of RAC is not included in AR, AR will be reduced when and if the hospital is successful in it's appeal. If not, then income will be reduced as these accounts are written off. Since RAC appears to be a continuing practice by Medicare, it is assumed this will have a minor impact on future trends.

Trend:	Minor
Income	Minor
Balance Sheet	??

Sub-Acute Rate Revision

Sub Acute rates were frozen because of AB 97. The governments position has been challenged by the hospital industry. Recently the hospital was notified that CMS will not hold rates at the current level and will implement new rates retro-actively to August 1, 2011. The rates will increased as noted below. When this occurs the hospital should receive a retro-active payment.

	Old Rate	New Rate	Increase	Aug-Dec Days	Income
Vent	879.18	913.00	33.82	5,997	202,819
Non-Vent	845.62	879.43	33.81		

Trend:	$203K	
Income	$203k	Assume this will be paid in February
Balance Sheet	Natural	

ECC Charges

ECC charging mythadology was changed at the end of last year. This resulted in approximately a full step down of charge levels within the ECC. This methodology was changed back to the old method in December. Had the old method been in place, the ECC would have generated an additional $927k in gross revenues. Assume a 20% collection rate on these lost charges

Trend:	$927k	Increase Gross OP Revenues
Trend:	$742k	Increase Contractual Allowances
Income		None outside of the adjusted trend
Balance Sheet		

Jaber Fund

Management is requesting the monies held in the Jaber fund ($546K) be liquidated and provided to the hospital to be used to pay down accounts payable.

Trend:	None
Income	
Balance Sheet	Reclass to Cash

ADJUSTMENTS TO THE BUDGET JAN-DEC 2012

Income projections for the timeframe Jan - June 2012

Assume the YTD performance to budget will continue for the second half of the year with certain adjustments. The basic methodology was to develop a percentage variance of actual to budget though December and apply those percentage variances to the Jan - Jun budget values. This assumes the budget was developed using proper seasonal variations. However, included in the actual performance to date are several known factors that have influenced the actual performance that will not repeat and, as such distort the historical performance. These factors have bee quantified below and used to adjust historical actual performance prior to developing the performance percentage which was used to adjust the budget going forward.

Some of these factors will result in adjustments to income at the time they are recognized. As such they will either add or subtract from income in the future budget periods. These are identified as "income" below.

In order to project the unbudgeted timeframe July - December 2012, an average of adjusted budget for the last three months of FY 2012 was developed and used to project revenues and expenses for these months.

New programs including Waters Edge and the Wound Care Program were budgeted separately and added to the base adjusted hospital projections.

Adjustments to the Budget Trends:

AB 97 ACCURAL

AB97 accurals total $273k to date. This will be reversed in Jan as Medi-Cal will not be decreasing fees. This reversal should change both the trend in January going forward and result in a Jan income event for the accrual reversal.

Trend:	$273	Adj Contractuals Jul-Dec by $234k to adjust contractuals going forward
Income	$273	Reduce Contractuals in Jan to recognize the reversal
Balance Sheet		Natural

2011 COST REPORT

Filed 2011 Cost report equals $260K. $80k was booked as a receivable in June. Assume $160k will be realized in Jan with 80% of the filed amount paid in Aug.

Trend:		None
Income	$180	Increase Income in Jan
Balance Sheet		Reclass $180k from BS contractuals to Settlement in Jan
		Assume $208k payment in Aug

CASH FLOW FORECAST - Maintain Cash @ $1 Million

Jan - Jun 2012

February 4, 2012

	Actual	Forecast						Extended Forecast					
Assets	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Current Assets:													
Cash and Cash Equivalents	2,070	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Patient Accounts Receivable, net	9,582	10,791	11,002	11,473	11,670	11,127	10,828	10,478	10,092	10,357	10,421	10,404	10,420
Other Receivables	3,646	4,133	4,620	5,907	3,784	2,884	3,251	3,738	3,975	4,462	4,949	5,436	3,274
Third-Party Payer Settlement Receivables	482	482	482	482	482	482	482	482	482	482	482	482	482
Inventories	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183
Prepaids and Other	323	323	323	323	323	323	323	323	323	323	323	323	323
Total Current Assets	17,287	17,912	18,610	20,368	18,443	17,000	17,068	17,204	17,055	17,808	18,358	18,828	16,682
Assets Limited as to Use, net	546	556	10	10	10	10	10	10	10	10	10	10	10
Fixed Assets													
Land	878	878	878	878	878	878	878	878	878	878	878	878	878
Depreciable capital assets	43,435	43,435	43,435	43,435	43,435	43,435	43,435	43,435	43,435	43,435	43,435	43,435	43,435
Construction in progress	3,388	3,388	3,388	4,388	4,388	4,388	4,388	4,388	4,388	4,388	4,388	4,388	4,388
Depreciation	(39,304)	(39,387)	(39,470)	(39,553)	(39,637)	(39,721)	(39,805)	(39,889)	(39,978)	(40,067)	(40,155)	(40,244)	(40,333)
Property, Plant and Equipment, net	8,397	8,315	8,232	9,148	9,065	8,981	8,897	8,813	8,724	8,635	8,546	8,457	8,369
Total Assets	26,230	26,783	26,852	29,527	27,518	25,991	25,974	26,027	25,789	26,453	26,915	27,296	25,061
Liabilities and Net Assets													
Current Liabilities:													
Current Portion of Long Term Debt	1,633	1,560	1,487	2,044	2,040	598	252	723	642	561	480	399	320
Accounts Payable and Accrued Expenses	8,313	8,974	8,757	8,754	6,323	6,328	6,580	6,708	6,309	6,917	7,160	7,662	5,224
Payroll Related Accruals	4,135	3,963	4,250	4,324	4,784	4,760	4,835	4,774	4,737	4,753	4,932	4,773	4,916
Deferred Revenue	2,864	2,864	2,864	2,864	2,864	2,864	2,864	2,864	2,864	2,864	2,864	2,864	2,864
Employee Health Related Accruals	653	663	673	683	693	703	713	723	733	743	753	763	774
Third-Party Payer Settlement Payable	308	128	128	128	128	128	128	128	336	336	336	336	336
Total Current Liabilities	17,905	18,152	18,159	18,796	16,832	15,380	15,372	15,920	15,621	16,174	16,524	16,797	14,433
Long Term Debt, net	884	884	884	2,788	2,788	2,788	2,788	2,236	2,236	2,236	2,236	2,236	2,236
Total Liabilities	18,789	19,036	19,043	21,584	19,619	18,168	18,160	18,155	17,857	18,409	18,760	19,032	16,669
Net Assets:													
Unrestricted	6,726	7,031	7,093	7,227	7,182	7,107	7,098	7,156	7,217	7,328	7,439	7,547	7,676
Temporarily Restricted	716	716	716	716	716	716	716	716	716	716	716	716	716
Total Net Assets	7,442	7,747	7,809	7,943	7,899	7,823	7,815	7,872	7,933	8,044	8,155	8,264	8,392
Total Liabilities and Net Assets	26,230	26,783	26,852	29,527	27,518	25,991	25,974	26,027	25,789	26,453	26,915	27,296	25,061
CURRENT RATIO	0.97	0.99	1.02	1.08	1.10	1.11	1.11	1.08	1.09	1.10	1.11	1.12	1.16
AP DAYS	151	161	151	133	89	89	91	93	89	95	98	105	72
CASH ON HAND	2,070	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000

INCOME STATEMENT - ACTUAL + FORECAST

February 6, 2012

	Actual	Forecast													
	6 Mos	Jan	Feb	Mar	Apr	May	Jun	6 Mos	FY 2012	Jul	Aug	Sep	Oct	Nov	Dec	6 Mos
Patient Days	15,227	2,595	2,516	5,458	5,155	5,518	5,394	26,636	41,863	5,726	5,684	5,819	5,819	5,744	5,850	34,641
Discharges	1,434	247	243	277	247	247	239	1,502	2,936	245	245	245	245	245	245	1,468
Average Daily Census	496	84	87	91	86	84	84	517	1,013	85	85	85	85	85	85	510
Adjusted Patient Days	22,409	3,729	3,648	4,086	3,848	3,928	3,833	23,071	45,480	3,870	3,870	3,870	3,870	3,870	3,870	23,218
Adjusted ADC	731	120	126	132	128	127	128	760	1,491	128	128	128	128	128	128	765
Adjusted Discharges	2,109	356	353	406	370	373	365	2,222	4,331	369	369	369	369	369	369	2,215
Outpatient Visits	19,324	3,297	3,082	3,504	3,331	3,358	3,368	19,940	39,264	3,352	3,373	3,373	3,373	3,373	3,373	20,219
Average Length of Stay	64	11	10	96	99	105	107	427	491	113	115	116	116	117	117	691
Routine Inpatient	44,673	7,623	7,405	9,320	8,500	8,670	8,421	49,939	94,612	8,691	8,677	8,753	8,753	8,732	8,772	52,378
Ancillary Inpatient	41,557	7,296	6,860	7,611	7,056	7,140	6,940	42,905	84,462	7,046	7,046	7,046	7,046	7,046	7,046	42,273
Total Inpatient Revenue	86,230	14,919	14,265	16,931	15,557	15,810	15,362	92,844	179,074	15,737	15,723	15,798	15,798	15,778	15,817	94,651
Outpatient Revenue	40,665	6,590	6,569	7,566	7,393	7,651	7,652	43,421	84,086	7,566	7,818	7,818	7,818	7,818	7,818	46,657
Total Patient Revenue	126,895	21,509	20,834	24,497	22,950	23,461	23,013	136,265	263,160	23,302	23,541	23,617	23,617	23,596	23,636	141,308
Contractual Allow	94,619	15,390	15,284	17,535	16,411	16,699	16,381	97,700	192,319	16,497	16,692	16,692	16,692	16,692	16,692	99,955
Bad Debts	2,985	502	488	537	503	509	498	3,037	6,022	503	503	503	503	503	503	3,019
Charity	1,123	190	185	205	190	192	187	1,150	2,273	190	190	190	190	190	190	1,138
Total Adj to Revenue	98,728	16,083	15,957	18,277	17,104	17,399	17,066	101,887	200,615	17,190	17,385	17,385	17,385	17,385	17,385	104,112
Other Operating Revenue	371	94	94	100	100	106	107	599	970	104	104	104	104	104	104	623
Total Operating Revenue	28,539	5,520	4,971	6,319	5,946	6,168	6,054	34,977	63,516	6,216	6,260	6,336	6,336	6,316	6,355	37,819
Productive Salaries	14,384	2,512	2,318	2,994	2,855	2,971	2,860	16,509	30,893	2,931	2,946	2,960	2,960	2,949	2,960	17,707
Non-Prod Salaries	2,742	536	436	415	402	477	402	2,668	5,410	427	427	427	427	427	427	2,563
Outside Labor	616	101	97	112	103	103	102	619	1,235	103	103	103	103	103	103	616
Employee Benefits	5,106	866	843	997	986	1,005	993	5,689	10,795	1,005	1,004	1,008	1,008	1,005	1,008	6,038
Professional Fees	2,279	406	413	453	464	480	490	2,706	4,985	478	481	481	481	481	481	2,883
Supplies - Medical & Drug	2,578	406	414	529	515	532	531	2,926	5,504	536	540	544	544	542	545	3,251
Supplies - Other	980	163	161	170	163	164	164	984	1,964	163	165	165	165	165	165	990
Purchased Service	1,779	294	294	404	393	402	410	2,196	3,975	412	410	414	414	412	415	2,477
Repairs & Maintenance	311	50	50	50	50	50	50	299	610	50	50	50	50	50	50	299
Rents & Leases	457	94	106	183	183	183	183	931	1,388	183	188	188	188	188	188	1,122
Utilities	392	66	66	81	81	81	81	454	846	81	81	81	81	81	81	487
Insurance	167	28	28	45	45	45	45	235	402	45	45	45	45	45	45	268
Depreciation	443	82	83	83	83	84	84	501	944	84	89	89	89	89	89	528
Other	554	95	84	154	154	154	154	796	1,350	148	155	155	155	155	155	924
Total Operating Expense	32,787	5,699	5,392	6,670	6,475	6,728	6,548	37,512	70,299	6,644	6,685	6,710	6,710	6,692	6,712	40,154
Operating Profit	(4,248)	(179)	(421)	(350)	(529)	(561)	(494)	(2,535)	(6,783)	(428)	(424)	(374)	(374)	(377)	(357)	(2,335)
Non-Operating Income	2,936	485	483	485	485	485	486	2,908	5,844	485	485	485	485	485	485	2,912
Net Income / (Loss)	(1,311)	306	61	134	(44)	(75)	(9)	373	(938)	57	61	111	111	109	128	577
Collection Ratio	22.2%	25.2%	23.4%	25.4%	25.5%	25.8%	25.8%	25.2%	23.8%	26.2%	26.2%	26.4%	26.4%	26.3%	26.4%	26.3%

CASH FLOW FORECAST
CRITICAL VALUES

	FORECAST											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
NET INCOME	306	61	134	(44)	(75)	(9)	57	61	111	111	109	128
CASH BALANCE	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
AR DAYS	66	63	61	59	57	55	53	51	51	51	51	51
AP DAYS	161	151	133	89	89	91	93	89	95	98	105	72
AP BALANCE	8,974	8,757	8,754	6,323	6,328	6,580	6,708	6,309	6,917	7,160	7,662	5,224
CURRENT RATIO	0.99	1.02	1.08	1.10	1.11	1.11	1.08	1.09	1.10	1.11	1.12	1.16

City of Alameda Health Care District | Alameda Hospital

CORE MEASURES

Quality measures are used by the Centers for Medicare and Medicaid Services (CMS) to gauge how well an entity provides care to its patients. Measures are based on scientific evidence and reflect guidelines, standards of care, or practice parameters. A quality measure converts medical record information from patient records into percentages that allow facilities to assess their performance. For 2011, Alameda Hospital was required to select four (4) Inpatient Core Measure Sets from the following list: **Acute Myocardial Infarction (AMI); Heart Failure (HF); Pneumonia (PN); Surgical Care Improvement Project (SCIP); Venous Thromboembolism (VTE); Stroke (STK)**.
Alameda Hospital's selected Core Measures: AMI; HF; PN; SCIP

Measure Indicators	Aggregate Scores Q2-10 - Q1-11	Current Scores Q3-11	Comments
AMI			- Value Based Purchasing affects reimbursement. - Performance requires at least ten (10) cases to be scored for VPB. - Excellent scores in those indicators measured.
• Aspirin on Arrival (AMI-1)	100%	100%	
• Aspirin Prescribed at Discharge (AMI-2)	100%	100%	
• ACEI/ARB Medication for Left Ventricular Systolic Dysfunction (LVSD) (AMI-3)	100%	N/A	
• Adult Smoking Cessation Counseling (AMI-4)	88%	100%	
• Beta Blocker Prescribed at Discharge (AMI-5)	100%	100%	
• Fibrinolytic Therapy 30 Minutes After Arrival (AMI-7a)	100%	N/A	
• Statin Prescribed at Discharge (AMI-10)	90%	100%	
HF			- Discharge Instructions, specifically discharge medication list, continues to need improvement. - Initiated a Discharge Order Form. - Discharge Timeout to improve discharge process, effective 7/11/11.
• Discharge Instructions (HF-1)	64%	76%	
• Evaluation of *Left Ventricular (*LV) Function (HF-2)	98%	96%	
• ACEI/ARB Medication for *(*LVSD) (HF-3)	91%	100%	
• Adult Smoking Cessation Counseling (HF-4)	94%	100%	
PN			- Continued improvement needed. - Medical and Nursing Staff education is ongoing.
• Pneumococcal Vaccination (PN-2)	92%	89%	
• Blood Cultures Prior to Antibiotic (ABX) (PN-3b)	98%	94%	
• Adult Smoking Cessation Counseling (PN-4)	82%	60%	
• ABX Received Within 6 Hours of Arrival (PN-5c)	96%	100%	
• ABX Selection in Immunocompetent Patient (PN-6)	96%	92%	
• Influenza Vaccination (PN-7)	92%	N/A	
SCIP			- In Q3-11, scores improved for both SCIP-CARD-2 and SCIP-INF-9. - Other indicators are below goal, needs improvement. - Pre-printed post-op orders revised to trigger best practice. - Medical and Nursing Staff education is ongoing.
• ABX Within 1 Hour Prior to Incision (SCIP-INF-1)	97%	91%	
• ABX Selection (SCIP-INF-2)	97%	100%	
• ABX Discontinued Within 24 Hours After Surgery (SCIP-INF-3)	92%	80%	
• Appropriate Hair Removal (SCIP-INF-6)	100%	100%	
• Urinary Catheter Removed by Post-Op Day 2 (SCIP-INF-9)	67%	100%	
• Beta Blocker Received Peri-Op (SCIP-CARD-2)	95%	100%	
• Temperature Management (SCIP-INF-10)	99%	100%	
• VTE Prophylaxis Ordered (SCIP-VTE-1)	97%	90%	
• VTE Prophylaxis Received (SCIP-VTE-2)	97%	86%	

*** Indicators retired in 2012**

*** Value Based Purchasing (VPB) Indicators – Affect Medicare Reimbursement**