CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, March 5, 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. <u>Closed Session Agenda</u>

A. Call to Order

B. Approval of Closed Session Minutes

1. February 6, 2012 (Regular)

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

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

E. Discussion of Pooled Insurance Claims — <u>Gov't Code Sec. 54956.95</u>

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

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

H. Discussion of Report Involving Trade Secrets — <u>H & S Code Sec. 32106</u>

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 physician recruitment.

   No action will be taken.

   Estimated Date of Public Disclosure: April 2012

3. Discussion of Hospital Trade Secrets applicable to long-term care expansion.

   No action will be taken.

   Estimated Date of Public Disclosure: April 2012

4. Discussion of Hospital Trade Secrets applicable to future financing for seismic retrofit.

   No action will be taken.

   Estimated Date of Public Disclosure: Not known at this time

I. Public Employee Performance Evaluation, Title: Chief Executive Officer and Senior Executives

J. 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 February 6, 2012 Regular Meeting Minutes [enclosure] (PAGES 4-11)

✔ 2) Approval of Administrative Policy No. 45 – Smoke Free Environment [enclosure] (PAGES 12-21)

B. Action Items

✔ 1) Acceptance of January 2012 Unaudited Financial Statements and February 29, 2012 Finance and Management Committee Report [enclosure] (PAGES 22-42) — J. Michael McCormick

✔ 2) Adoption of Resolution No. 2012-2J – "*Amending Resolution No. 2002-10X of the Board of Directors of the City of Alameda Hospital Health Care District Relating to Employee Relations for the City of Alameda Health Care District*" relating to the addition of Waters Edge Employee Association Bargaining Unit [enclosure] (PAGES 43-55) — Kerry Easthope, Phyllis Weiss

✔ 3) Approval of the Waters Edge Employee Association Memorandum of Understanding / Handbook (Associated with the Waters Edge Transition) [enclosure] (PAGES 56-64) — Kerry Easthope, Phyllis Weiss

C. District Board President Report INFORMATIONAL — Jordan Battani

1) Special Board Meeting Scheduling for March – April 2012

D. Chief Executive Officer Report INFORMATIONAL — Deborah E. Stebbins

✔ 2) Monthly CEO Report [enclosure] (PAGES 65-69)

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

4) Monthly Quality Metrics

a) Medication Errors (Lee Headley, PharmD) [to be distributed]

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

✔ 1) SB90 Seismic Extension Application and Presentation [enclosure] (PAGES 70-72)

✔ 2) Approach to Assessing Management Options and Opportunities of Rehab Services at Alameda Hospital [enclosure] (PAGES 73-74)

F. Community Relations and Outreach Committee Report INFORMATIONAL

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

VIII. General Public Comments

IX. Board Comments

X. Adjournment

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Monday, February 6, 2012 Regular Meeting

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

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Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:05 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present.	
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 6:06 p.m.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 7:36 p.m.	

A. Announcements From Closed Session

Director Battani stated that the Minutes were approved from January 9, 2012 meeting. The Board Quality Committee Reports for October 2011 and November 2011 were accepted as presented. The Board approved the Credentialing Recommendations of the Medical Staff as outlined below. No other action was taken.

Initial Appointments – Medical Staff

	Name	Specialty	Affiliation	

Topic	Discussion		Action / Follow-Up	
	• Elizabeth Anthony, MD	Family Medicine	Alliance Medical Group	
	• Grace Chou, MD	Family Medicine	Alliance Medical Group	
	• Robert Snyder, MD	Family Medicine	Alliance Medical Group	
<u>Reappointments – Medical Staff</u>				
	Name	Specialty	Staff Status	Appointment Period
	• Prabha Bhatnagar, MD	General Medicine	Active	03/01/12 – 02/28/14
	• Robert Binder, MD	Radiology	Courtesy	03/01/12 – 02/28/14
	• David Bonovich, MD	Neurology	Courtesy	03/01/12 – 02/28/14
	• John Carper, MD	Family Practice	Active	03/01/12 – 02/28/14
	• Richard Graham, MD	Dermatology	Courtesy	03/01/12 – 02/28/14
	• Barry Gustin, MD	Emergency Medicine	Courtesy	03/01/12 – 02/28/14
	• Michael Ingegno, MD	Vascular Surgery	Courtesy	03/01/12 – 02/28/14
	• John Iocco, MD	Pathology	Active	03/01/12 – 02/28/14
	• David Irwin, MD	Hematology/Onc	Courtesy	03/01/12 – 02/28/14
	• David Levin, MD	Pathology	Courtesy	03/01/12 – 02/28/14
	• Joseph Marzouk, MD	Infectious Diseases	Active	03/01/12 – 02/28/14
	• James McDonald, DPM	Podiatry	Courtesy	03/01/12 – 02/28/14
	• James Mooney, MD	Urology	Courtesy	03/01/12 – 02/28/14
	• Jacob Rosenberg, MD	Pain Management	Courtesy	03/01/12 – 02/28/14

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Topic	Discussion				Action / Follow-Up
	• Robert Wu, MD	Otolaryngology	Courtesy	03/01/12 – 02/28/14	
	• James Yeh, DO	Internal Med/Hosp	Active	03/01/12 – 02/28/14	

Reappointment - Allied Health Professional

There were no applications submitted for reappointment to Allied Professional status.

Proctoring/FPPE

- Darien Behravan, MD
- Jennifer Taylor, MD

Modification of Privileges

- Kimberly Bumberg, MD

Resignations

	Name	Specialty		
	• Marsha Roberts, MD	Teleradiology		

VI. Regular Agenda

A. Consent Agenda

Discussion	Action / Follow-Up
1) Acceptance of January 9, 2012 Regular Meeting Minutes	Director Deutsch made a motion to approve the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried.
2) Approval of Annual Committee Membership of the Board Quality Committee Meeting	
3) Approval of Annual Committee Membership of the Finance and Management Committee	

B. Action Items

Discussion	Action / Follow-Up
1) Acceptance of December 2011 Unaudited Financial Statements and January 25, 2012	Director Gorelick made a motion to accept the December 2011 Unaudited

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Topic	Discussion	Action / Follow-Up
	Finance and Management Committee Report Director McCormick reviewed his notes from the January 25th committee meeting noting the following: The Committee recommended approval of the community and physician membership to the committee. See consent agenda for Board approval. The December Unaudited Financial Statements were reviewed in detail noting the following key points. Average daily census (ADC) of 82.3 versus 84.9 budgeted, with an Acute ADC at 28.3 versus 30.2 budgeted, a Sub-Acute ADC at 33.0 versus 33.0 budgeted, and Skilled Nursing ADC at 21.0 versus 21.7 budgeted. Emergency Care visits were 1, 409 versus 1,426 budgeted and total outpatient registrations were 1,698 versus 1,929 budgeted. Overall gross revenue for the month of December was unfavorable to budget, with both Inpatient and Outpatient revenues down. Net Patient Revenue was $0.4 M or 8.6% less than budget. Excess Expense Over Revenues for the month was a negative $316,000 versus budgeted loss of $39,000. YTD Operating loss was $1.3 million versus a budgeted profit of a $200,006. Ms. Stebbins gave an update on the revenue cycle and Mr. Easthope noted that the Blue Cross contract had been re-negotiated in December with a 10% increase in year 1 and 3% increase in years two and three of the contract term. Mr. Anderson discussed cash flow projections and contractual calculations which management is prepared to present at the February 7th Board meeting. The next committee meeting will be held on February 29, 2012 At the Board meeting, there was discussion regarding reports included in the packet, specifically regarding Medi-Cal reimbursement, historic numbers, drop in surgical volume, variances in lab volumes, and cash flow. Robert Anderson, Interim CFO, gave a Cash Flow Analysis presentation. Details of the analysis were distributed during the meeting, and can be found in the Board Packet. Topics of the Cash Flow Forecast included assumptions, significant trend adjustments, significant income adjustments, income projections for the timeline of January – June 2012, adjustments to the budget trends, and critical values. There was also discussion about the specific terms of the Wound Care Loan with the Bank of Alameda and the Jaber Fund (refer to pages 41-43). The Jaber Properties are not being considered to finance the Wound Care Project; they are simply being used to solidify the terms and conditions of the current loan. This will help current ratios, and the Bank of Alameda is comfortable with these terms. Discussion continued with clarification of the terms of a Wound Care Loan, and potential options related to future	Financial Statements as presented. Director Deutsch seconded the motion. The motion carried.

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Topic	Discussion	Action / Follow-Up
	lending by the Bank, which could include encumbrance of the Jaber Properties.	
The agenda order was modified from the original order.		
	3) Approval of Resolution No. 2012-1J: Approval to Access Additional Funding of Jaber Estate As Set Forth Therein Ms. Stebbins presented a recommendation to access additional funding of the Jaber Estate (refer to pages 41-43) There was discussion regarding the terms of a potential loan with the bank (assuming that the properties were encumbered), the cash flow impact of accessing the funds, rental income received from the properties, and the value/condition of the properties. The terms of the fund were discussed and clarified by Mr. Driscoll. Ms. Stebbins clarified that the resolution is for Management to access the cash balance of the fund in the amount of $546,000 and to endeavor to mortgage the properties.	Director Gorelick made a motion to approve Resolution No. 2012-1J as presented. Director Chen seconded the motion. The motion carried 4-0-1 (Deutsch - absent).
The Board recessed for a brief break at 8:57 p.m. and returned to session at 9:07 p.m.		
	2) Approval to Enter into an Agreement with Select Therapies for Management of Rehabilitation Services at Alameda Hospital Mr. Easthope reviewed the terms stated in the recommendation, background and discussion located on pages 38-40 of the Board Packet to enter into an agreement with Select Therapies for the management of the Rehab Services Department. After discussion and questions from Board Members, Director Battani requested a more detailed analysis, including financial impact relating to the recommendation. Ms. Stebbins requested that this item be deferred for discussion and consideration at a future meeting.	Agenda item was deferred to a future Board Meeting.
C. Board President Report	Director Battani did not have a report.	
D. Medical Staff President Report	James Yeh, DO, Medical Staff President, stated that the CME programs for February are slated for February 14 and February 28 with the following speakers presenting: • Stephen Raskin, MD – Prosthetic Valve Endocarditis • Anna Frick, MD – Management of Urinary Incontinence	No action taken.

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Topic	Discussion	Action / Follow-Up
	He also spoke about their efforts to update policies for turnaround times for completion of medical records.	
E.	Community Relations and Outreach Committee Report	
	Director Chen reported on his notes from the January 24, 2012 Community Relations and Outreach Committee meeting noting the following. Angela Klein is a new intern with the Community Relations Department. She will focus on communications and community outreach during the next few months of her internship. Modifications and updates have been made to the AlamedaHospital.org website, making the site more user friendly. On January 25, 2012 Alameda Hospital partnered with community member Mike Robles-Wong to host a dean along with ten Chinese students studying various facets of American culture and government including the American health care system. Dennis Eloe, Foundation Director, coordinated a tour, presentation by Deborah Stebbins, and luncheon. Ms. Stebbins gave an update regarding the Wound Care Center, Waters Edge and Revenue Cycle projects. Mr. Eloe announced that the Hospital Auxiliary team is launching a telephone outreach program for patients who wish to receive follow up calls by a volunteer. The calls will be non-medical in nature and will provide encouragement and a friendly voice to discharged patients of the Hospital. Tony Corica, Physician Relations Director, updated the committee noting that Alameda Hospital has recently met with six physicians with a goal to increase surgical volume.	No action taken.
F.	Chief Executive Officer Report	
	1) Monthly CEO Report Ms. Stebbins introduced Richard Espinoza, the Director of Long Term Care. Ms. Stebbins also called attention to her written report included in the Board Packet and asked if there were any questions regarding the materials. There were no questions. She also added information regarding statistics noting that there were slight changes to the statistics found on page 47. Outpatient registration totaled 1,933 and total surgeries were over budget for the month with 45 inpatient and 106 outpatient surgeries. There was a slight drop in the Case Mix Index to 1.41, but it was higher	No action taken.

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Topic		Discussion	Action / Follow-Up
		than it has been for over a year.	
	2)	Bank of Alameda Line of Credit and Wound Care Loan Update Ms. Stebbins referred to the discussion earlier in the meeting (refer to sections B-1 and B-3).	
	3)	Monthly Quality Metrics: Core Measures A report on Core Measures was presented by Donna Marchetti, RN. Information was handed out and is included in the Board Packet.	
G.	Operations and Facilities Report		
	1)	Waters Edge Mr. Easthope also recognized Richard Espinoza as the newest staff member and Director of Long Term Care. Our application for licensure is under review by the State of California. Weekly transition meetings continue. Our Human Resources Department has performed a payroll test-run successfully and all Waters Edge employees have passed employment screenings. The average daily census at Waters Edge is holding steady at approximately 95 and is being monitored daily.	No action taken.
	2)	Wound Care The Wound Care Center progress is based on the progression of the Wound Care Loan with Bank of Alameda. Due to the approval by the Board this evening of Resolution No. 2012-1J, the Jaber funds may be used as collateral for the Wound Care Loan.	
VII.	General Public Comments Phyllis Weiss, Director of Human Resources, invited Board Members to attend the Alameda Hospital Tenure Event scheduled to take place on Tuesday, February 28, 2012 in the Dal Cielo Conference Room.		
VIII.	Board Comments There were no comments.		
IX.	Adjournment	Being no further business, the meeting was adjourned at 9:47 p.m.	

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Attest:

	Jordan Battani President	Elliott Gorelick Secretary

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Date: February 29, 2012

For: March 5, 2012 District Board Meeting

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

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Approval of Administrative Policy No. 45 – Smoke Free Environment

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Recommendation:

Management requests approval of Administrative Policy No. 45 – Smoke Free Environment.

Background:

The Policy No. 45 has been updated in order to comply with the City of Alameda Ordinance No. 3038 and for the health and wellness of all visitors, patients, residents, medical staff, volunteers and employees of Alameda Hospital.

The Hospital and affiliated sites are now **100% SMOKE FREE**. On February 22, 2012, employees, physicians and auxiliary members were notified of the new policy (See Attachment 1). Signage around the hospital campus and buildings is being ordered and installed to identify and notice to the public the Smoke Free Environment change.

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY & PROCEDURE
No. 45

TITLE: **SMOKE FREE ENVIRONMENT**

PURPOSE: The purpose of this policy is to provide a smoke free environment within the hospital, surrounding and adjacent to the hospital property and at all affiliated sites within the District to comply with the City of Alameda Municipal Code, Ordinance No. 3038.

SCOPE: All Hospital buildings, grounds, public sidewalks surrounding and adjacent to the hospital property including all affiliated sites. See Exhibit A.

All visitors, patients, residents, medical staff, volunteers and employees of Alameda Hospital.

POLICY:

Alameda Hospital is a **SMOKE FREE ENVIRONMENT** in compliance with the City of Alameda Municipal Code, Ordinance No. 3038, and in accordance with California Health & Safety Codes, California Code of Regulations, Title 22 and the Joint Commission Environment of Care Standards.

For the health and safety of all of our visitors, patients, residents, medical staff, volunteers and employees, Alameda Hospital has created a smoke free environment. Smoking in and around the hospital premises and affiliated sites is prohibited. All outdoor designated smoking areas have been eliminated. The Hospital is not requiring visitors, patients, residents, medical staff, volunteers and employees to quit smoking, only that they do NOT smoke on Alameda Hospital property including all Hospital buildings, grounds, public sidewalks surrounding and adjacent to the hospital property and all affiliated sites as described in the Scope of the policy.

Compliance with this policy is the responsibility of employees, volunteers, and medical staff, and is enforced by leadership. All departments are to implement and support this policy fully and consistently. Violations by employees may result in progressive disciplinary action. Others refusing to comply with this policy may be escorted from the hospital by security or supervisory personnel.

PROCEDURE:

A. Patients Who Smoke:

a. Patients in the Hospital are discouraged from smoking.

b. Patients who smoke may receive nicotine replacement therapy by a physician order; order should include frequency or limits to nicotine replacement therapy.

B. Skilled Nursing Facility Residents:

a. Residents in the Skilled Nursing Facility units are discouraged from smoking.

b. Residents who smoke may receive nicotine replacement therapy by a physician order while in the Skilled Nursing unit(s); order should include frequency or limits to nicotine replacement therapy.

SUPPORTING DOCUMENTATION:

C. City of Alameda Municipal Code, Ordinance 3038 (excerpts)

a. Effective Date: January 2, 2012

b. Definitions (Section 21-11.1)

i. "Health Care Facility" means an office or institution providing care or treatment of diseases, whether physical, mental, or emotional, or other medical, physiological, or psychological conditions, including but not limited to hospitals, rehabilitation hospitals or other clinics, including weight control clinics nursing homes, long-term care facilities, homes for the aging or chronically ill, laboratories, and offices of surgeons , chiropractors, physical therapists, physicians, psychiatrists, dentists, and all specialists within these professions. This definition shall include all waiting rooms, hallways, private rooms, semiprivate rooms, and wards within health care facilities.

c. Duty of Person, Employer, Business, or Non-Profit (Section 24-11.5)

i. The owner, operator, manager, or other Person in control of a public place or place of employment where Smoking is prohibited by this Section shall:

1. Clearly and conspicuously post "No Smoking" signs within or adjacent to Unenclosed Dining Areas, or by other means necessary to clearly indicate that Smoking is prohibited in the Dining Area.

2. Remove all ashtrays from any area where Smoking is prohibited by this Section, except for ashtrays displayed for sale and not for use on the premises.

ii. No Person, Employer, Business, or Nonprofit Entity shall knowingly permit the Smoking of Tobacco Products in an area which is under the legal or de facto control of the Person, Employer, Business, or Nonprofit Entity and in which Smoking is prohibited by law and the Person, Employer, Business or Nonprofit Entity is not otherwise compelled to act under state or federal law.

iii. No Person, Employer, Business, or Nonprofit Entity shall knowingly or intentionally permit the presence or placement of ash receptacles, such as, for example, ash trays or ash cans, within an area which is under the legal or de facto control of the Person, Employer, Business, or Nonprofit. Entity and in which Smoking is prohibited, including, without limitation, inside the perimeter of any Reasonable Distance required by this Section.

iv. Notwithstanding any other provision of this Section, any owner Employer, Business, Nonprofit Entity, or other Person who controls any property, establishment, or Place of Employment regulated by this Section may declare any part of such area in which Smoking would otherwise be permitted to be a non-smoking area.

d. Violations, Penalties and Enforcement (Section 24-11.6)

i. It shall be unlawful for any Person to smoke in any area where Smoking is prohibited under this Section.

ii. It is unlawful for any Person who owns, manages, operates or otherwise controls the use of any premises subject to regulation under this Section to refuse to comply with any of its provisions, or to permit any Employee or patron to violate this Section.

iii. Causing, permitting, aiding, abetting, or concealing a violation of any provision of this chapter shall also constitute a violation of this Section.

iv. Any Person who violates any provision of this Section shall be deemed guilty of an infraction, punishable by:

1. A fine not exceeding one hundred dollars ($100.00) for the first violation.

2. A fine not exceeding two hundred dollars ($200.00) for a second violation within one year.

3. A fine not exceeding five hundred dollars ($500.00) for each additional violation of this Section within one year.

v. Violations of this Section are subject to a civil action brought by the City Attorney, punishable by a civil fine not less than two hundred fifty dollars ($250.00) and not exceeding one thousand dollars ($1,000.00) per violation.

vi. Notwithstanding any other provision of this Section, a private citizen may bring legal action to enforce the requirements of this Section.

Reference: City of Alameda Municipal Code, Ordinance No. 3038, Joint Commission Comprehensive Accreditation Manual for Hospitals (EC02.01.03); California Health & Safety Code 1234; 1286; 118875-118915; California Code of Regulations, Title 22. Social Security, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, Chapter 3. Skilled Nursing Facilities, Article 5. Administration, 72507. Smoking and Chapter 1. General Acute Care Hospitals, 70745. Fire Safety.

Approval / Review Path	Safety Committee, Management Team, Medical Staff Service Committees. Medical Executive Committee, District Board

City of Alameda Health Care District Policy No. 45		
Action:	**Date:**	**By:**
Created	08/97	Administration
Reviewed/ Revised	11/97, 01/98, 01/01, 10/03, 09/06, 07/09, 02/12	Management Team
Approvals	11/97, 01/98, 01/01, 10/03, 09/06, 07/09, 02/12	MEC
	1/97, 01/98, 01/01, 10/03, 09/06, 08/09, 02/12	Administration
	1/97, 01/98, 01/01, 10/03, 09/06, 09/09, 03/12	District Board

EXHIBIT A

(Updated February 7, 2012)

Current Locations and Affiliated Sites:

Alameda Hospital
2070 Clinton Avenue, Alameda, CA 94501

South Shore Skilled Nursing Unit
625 Willow Street, Alameda, CA 94501

1206 (b) Community Clinic (Medical Office Building)
501 South Shore Center West, Alameda, CA 94501

Additional Affiliated Sites (add upon licensure)

Alameda Hospital at Waters Edge
2401 Blanding Avenue, Alameda, CA 94501

Wound Care Center
815 Atlantic Avenue, Alameda, CA 94501

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 22, 2012

To: Alameda Hospital Employees

CC: Alameda Hospital Medical Staff
Alameda Hospital Auxiliary

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Announcement of a Smoke Free Environment at Alameda Hospital

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In order to comply with the City of Alameda Ordinance No. 3038 and for the health and wellness of all visitors, patients, residents, medical staff, volunteers and employees of the Alameda Hospital, the Hospital and affiliated sites are now **100% SMOKE FREE**. The City Ordinance went into effect on January 1, 2012, and the new hospital policy on providing a 100% smoke free environment is effective immediately.

Smoking in and around the hospital premises and affiliated sites is prohibited and all outdoor designated smoking areas have been eliminated. The Hospital is not requiring visitors, patients, residents, medical staff, volunteers and employees to quit smoking, only that they DO NOT smoke on Alameda Hospital property including all hospital buildings, grounds, public sidewalks surrounding and adjacent to the hospital property and all affiliated sites within the District.

Compliance with this policy is the responsibility of all employees, volunteers, and medical staff, and will be enforced by leadership. All departments are to implement and support this policy fully and consistently. Others refusing to comply with this policy may be escorted from the hospital property by security or supervisory personnel.

For your reference, a copy of Administrative Policy No. 45 – Smoke Free Facility and Campus is available on the hospital's intranet site or available through Administration. A City of Alameda Smoking Ordinance Fact Sheet is attached for your reference.

Your assistance and cooperation in making the City of alameda Health Care District and Hospital a smoke free environment is greatly appreciated.

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

FREQUENTLY ASKED QUESTIONS | RESOURCES FOR EMPLOYEES:

1. Are there resources available for employees who smoke?

   Yes. There are a variety of resources available through our Employee Assistance Program (EAP) such as on-site smoking cessation workshops, one-on-one sessions with employees (3 sessions free), and online tools / info for employees. Please contact Karen Hopkins, Benefits Coordinator (510-814-4084) if you need assistance contacting EAP or are interested in on-site smoking cessation workshops.

   Employee Assistance Program:
   Managed Health Network (MHN)
   1-800-226-1060
   www.Members.mhn.com

   There are additional resources available by calling 1-877-44U-QUIT or visiting www.smokefree.gov.

2. Are nicotine replacement products, such as nicorette gum, patch or e-cigarettes, covered by our health plan?

   No.

3. Can employees submit nicotine replacement products as part of their flexible spending plan?

   Nicotine replacement products can be submitted as part of the flexible spending plan, but **requires** a letter from a physician that treatment is medically necessary for treating a specific medical condition.

4. If I do smoke, where can I smoke?

   The Hospital cannot tell you where you can smoke, only that you cannot smoke in the designated areas as outline below and in Policy No. 45 and according to City Ordinance No. 3038

   Current Locations and Affiliated Sites:

   - Alameda Hospital, 2070 Clinton Avenue, Alameda, CA 94501
   - South Shore Skilled Nursing Unit, 625 Willow Street, Alameda, CA 94501
   - 1206 (b) Community Clinic (Medical Office Building), 501 South Shore Center West, Alameda, CA 94501

   Additional Affiliated Sites (added upon licensure)

   - Alameda Hospital at Waters Edge, 2401 Blanding Avenue, Alameda, CA 94501
   - Wound Care Center, 815 Atlantic Avenue, Alameda, CA 94501

City of Alameda
Secondhand Smoke Ordinance
Fact Sheet

To protect Alameda residents and visitors from the health hazards of secondhand tobacco smoke, the Alameda City Council has adopted a Secondhand Smoke Ordinance. The majority of the provisions take effect on January 2, 2012 and limits exposure to secondhand smoke in places of employment, public places, and multi-unit housing. This fact sheet provides a brief overview of the ordinance. Additional information, including a copy of the ordinance and free downloadable "No Smoking" signs is available on the City's website:
http://www.cityofalamedaca.gov/Residents/Secondhand-Smoke-Policies

Smoking is prohibited in the following places of employment not covered by California State Law:

- Hotel/Motel lobbies, meeting and banquet facilities
- Ninety percent (90%) or more of hotel/motel guest rooms
- Retail and wholesale tobacco shops, and hookah bars
- Taxi cabs, cabs of trucks, tractors, or other vehicles used for work
- Warehouse, theatrical production and medical research facilities
- Private residences licensed as child care, adult care, and health care facilities
- Small businesses with fewer than five employees
- Owner-operated businesses open to the public
- Outdoor worksites, including construction sites, arenas, and convention halls, or anywhere where working crews may be

Smoking is prohibited in the following outdoor public places:

- Dining areas: examples include outdoor seating at restaurants and other establishments serving food or drinks (*Bars with rear outside areas are excluded from the prohibition)*
- Public events: examples include farmers' markets, fairs, and concerts
- Recreation areas: examples include parks, trails, beaches, and sports fields
- Service areas: examples include bus stops, ATM lines, and movie lines
- Commercial-area sidewalks: defined as public sidewalks in downtown shopping and business areas designated with a "C" prefix on the City's official Zoning Map
- Shopping malls: defined as collection of retail or professional establishments and includes the public walkway or hall areas that serve to connect them
- Entryways (reasonable distance): defined as within 20 feet of doors, windows, and other openings into enclosed areas

Responsibilities of business owners, managers, and operators:

- "No Smoking" signs must be clearly and conspicuously posted at entrances to unenclosed dining areas where smoking is prohibited
- Remove all ashtrays and not allow in any area where smoking is prohibited
- Not knowingly allow smoking in prohibited areas

In multi-unit housing (defined as two or more units), smoking is prohibited as follows:

- 100% of new units of rental and common interest complexes (condos, co-ops, PUDs), including balconies and porches
- Common areas of rental and common interest complexes, except that designated smoking areas meeting certain criteria in outdoor common areas may be established
- Smoking within 20 feet of enclosed areas (smoking buffer zones)

<u>Beginning on January 1, 2013, smoking will be prohibited inside the units of all rental and common interest complexes</u>

Responsibilities of landlords and homeowners' associations:

- Clearly and conspicuously post "No Smoking" signs in common areas, at every entrance, and on every floor where smoking is prohibited
- Remove all ashtrays and or other receptacles for disposing of smoking material not allow from any area where smoking is prohibited, except for designated smoking areas
- If the option to have a designated outdoor smoking area is chosen, all requirements as described in the ordinance must be complied with.
- Not knowingly allow smoking in prohibited areas
- Disclose to prospective tenants and buyers the requirements of the Secondhand Smoke Ordinance, as it pertains to multi-unit housing
- All newly leased units in apartments after Jan. 2, 2012 shall include a non-smoking requirement in the lease or agreement for occupancy. By Jan. 1, 2013, all lease agreements for occupancy will state that smoking is prohibited inside units
- Maintain diagrams that illustrate the precise location of designated smoking areas, if applicable. This diagram must also accompany leases and rental agreements beginning January 1, 2013

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING JANUARY 31, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
JANUARY 31, 2012

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
JANUARY, 2012

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 January 31, 2012 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

Higher activity in the month of January as well as some extraordinary items with positive impact made it possible for the hospital to exceed budget. A negative bottom line of $206,000 was budgeted and a positive $425,000 was realized. Year to date (YTD) the hospital has a loss of ($886,000) versus a budgeted loss of ($1,000).

Activity, was generally much better in January compared to previous months. The number of inpatient admissions was above both budget 10.5% and patient days were just above budget. The length of stay continues below budget. Therefore the hospital had more patients but they stayed a shorter length of time. This is positive for Medicare patients whose payment is based on a case rate, but not as favorable for payers that pay based on a per diem.

Inpatient surgeries cases were at budgeted volume of 45 but YTD they are down 12.2%. Since surgical admissions tend to generate higher revenues, this variance could have a significant impact on revenues. YTD inpatient revenues are down $3.6 million or 3.4%.

Outpatient surgeries were above budget for the month by 1.9%, and, continue above budget YTD by 7.4%.

Emergency activity was above budget this month. YTD emergency visits were very 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 in late December and this month generated a marked improvement in outpatient gross ECC revenues. The average gross revenue since the charge restructure has increased over 10%. This increase is expected to continue for the balance of the fiscal year.

In previous months both gross and net revenues were below what activity would seem to indicate. This month was different in that the revenues generated were more in line with activity. This month's gross revenues were above budget for the first time this year. The inpatient component was up 1.6% and outpatient was up 1.4%. This is encouraging and the trend appears to be continuing in February as well.

Both the Case Mix Index (CMI) and collection ratio ran above prior month averages. The collection ratio was 24.7. It was up largely due to YTD adjustments made to reverse the AB 97 accural ($273,000) along with a revision to the 2011 costs report settlement ($180,000). Without these adjustments the collection ratio would have been 22.7 vs. a budget of 22.3.

The overall CMI climbed from 1.2863 last month to 1.4123 this month. This is in part is due to the higher surgical volumes along with more acute cases in 3West and the DOU.

The net result of these revenue related influences caused net revenues to be $661,000 or 13.2% above budget. YTD net revenues however are down ($1M) or 2.8% below budget.

Expenses ran slightly over budget this month which is to be expected given higher volume. Overall expenses were 0.8% above budget. Savings in labor and supplies were offset by increased costs in employee benefits, professional fees and purchased services. YTD expenses continue to outperform budget by $68,000..

Cash is down slightly from the previous month. It decreased from $2.1M to $2.0M. Expressed in days-cash-on-hand, the hospital went from 15 days in December to 13.8 days in January. Though cash has been improving, these values are still low. Net accounts receivable (AR) grew by $300,722 in January. This is in part due to higher revenues and activity in January and is consistent with the cash flow projections made last month. AR days remain at basically the same level as the previous month. This is disappointing in that the efforts made to turn around accounts receivable should have resulted in a decrease in the AR position.

Lastly, the current ratio was .99. This is an improvement over the previous month but still below the 1.0 threshold necessary to meet Bank of Alameda's criteria for funding the Wound Care project and extending the hospitals line of credit. However, in February the transfer of Jaber Fund monies to current assets will cause this ratio to climb above 1.0. Additionally, the addition of Waters Edge should improve operating performance and allow for continued growth in this ratio.

ACTIVITY

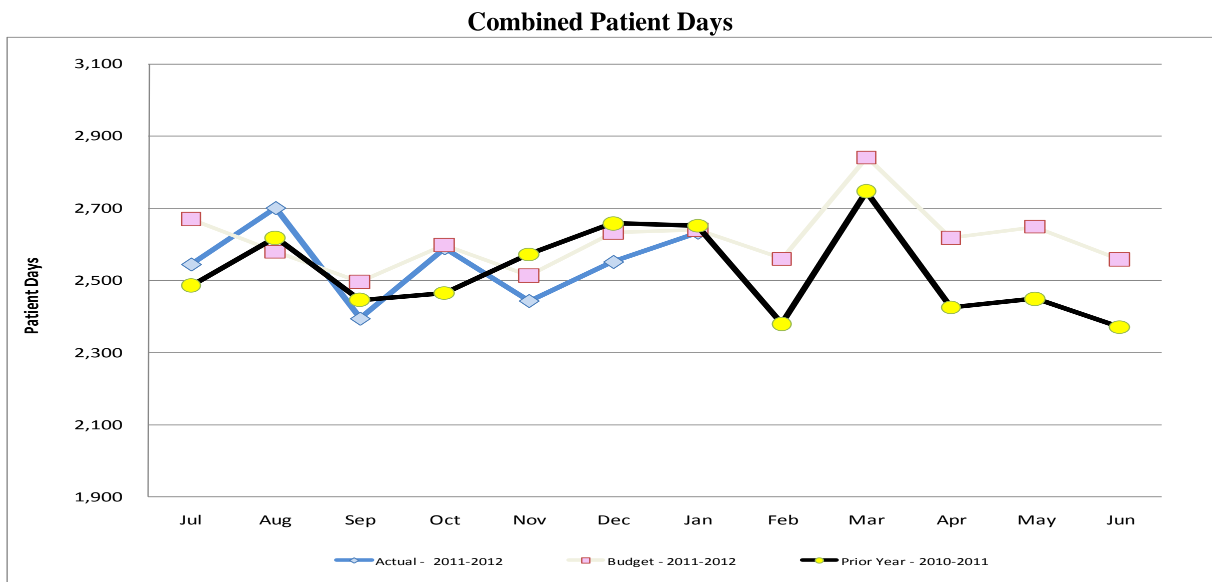
ACUTE, SUBACUTE AND SNF SERVICES

Patient days were slightly below budget for the month as well as last year at this time. YTD days are (1.5%) under budget. This month Acute days were up 8.8%, Sub-Acute was up .4% and Skilled Nursing was down 13.9%.

The acute care patient days were 9.1% (83 days) more than budgeted for the month and 4.5% above the prior year's average daily census of 31.65 for January. The acute care program is comprised of the Critical Care Unit (4.6 ADC, right on budget), Definitive Observation Unit (12.5 ADC, 6.3% above budget) and Med/Surg Units (16.0 ADC, 13.8% above budget).

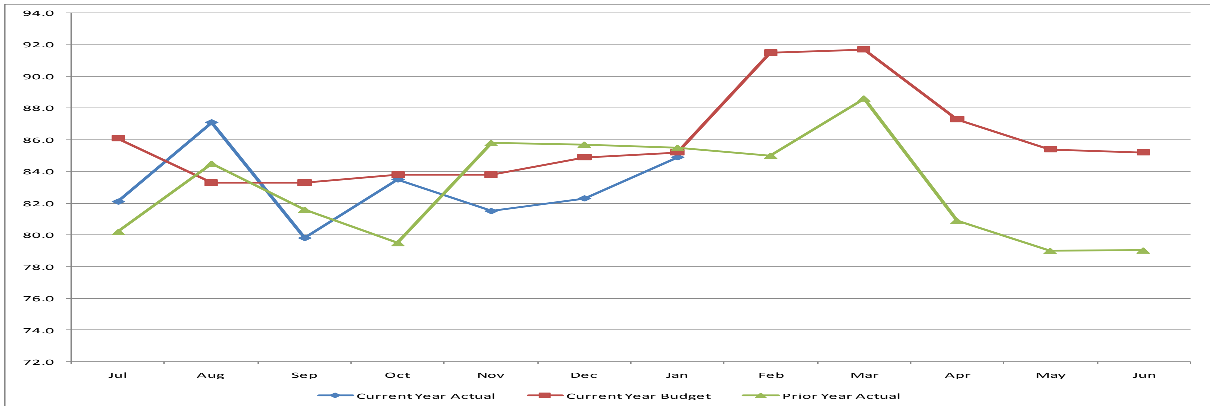
The graph, below, shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

Combined Patient Days



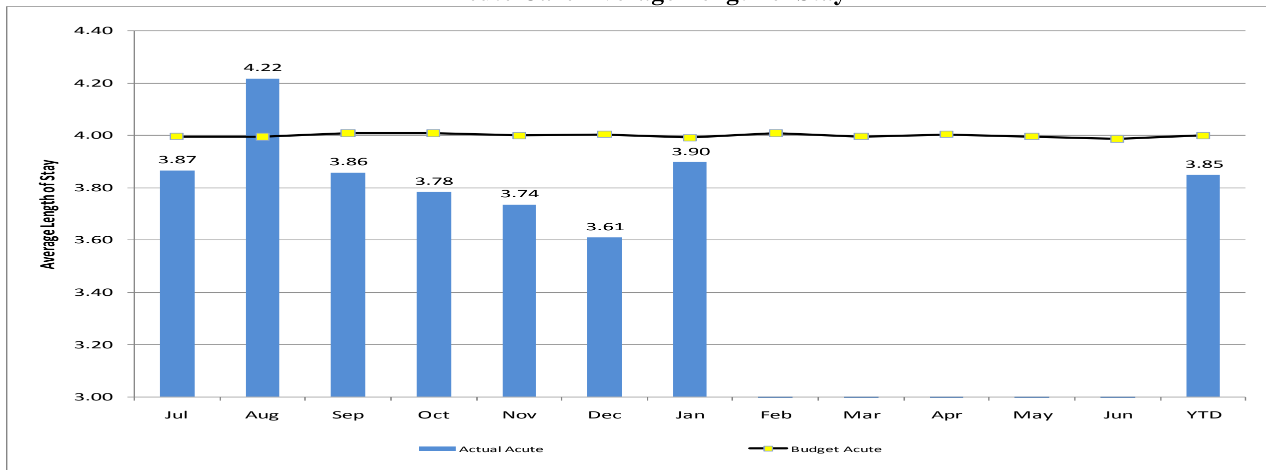
The graph below shows the average daily census for all inpatient services. The actual ADC was 84.94 versus budget of 85.16 an unfavorable variance of 0.3%.

Combined Average Daily Census



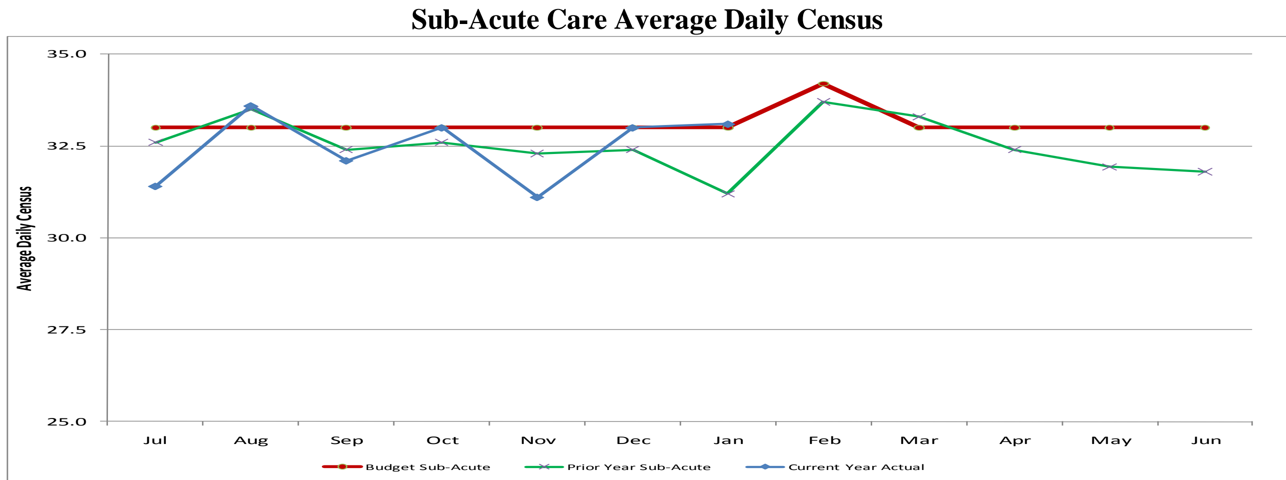
The acute average length of stay (ALOS) increased from the Decembers low of 3.61 to 3.90 in January, but is still significantly below January in the prior year of 4.67. Budgeted acute ALOS is 4.0. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month and the budgeted ALOS for fiscal year 2012.

Acute Care Average Length of Stay



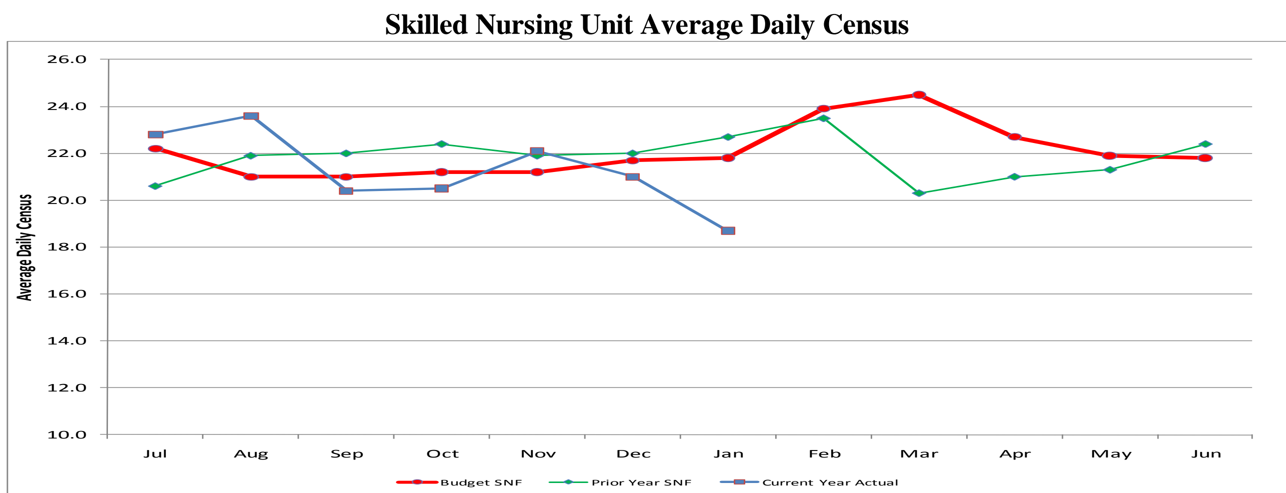
The Sub-Acute programs average daily census of 33.13 in January was just above budgeted projections by 0.4%. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



The Skilled Nursing Unit (South Shore) patient days were 13.9% or 94 patient days lower than budgeted for the month of January, and down 71 days or 10.9% from December. YTD days are also down compared to both budget and the prior year. Efforts are underway to enhance the esthetics of the unit. As well, marketing efforts have been enhanced in order to potentially gain additional referrals. 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



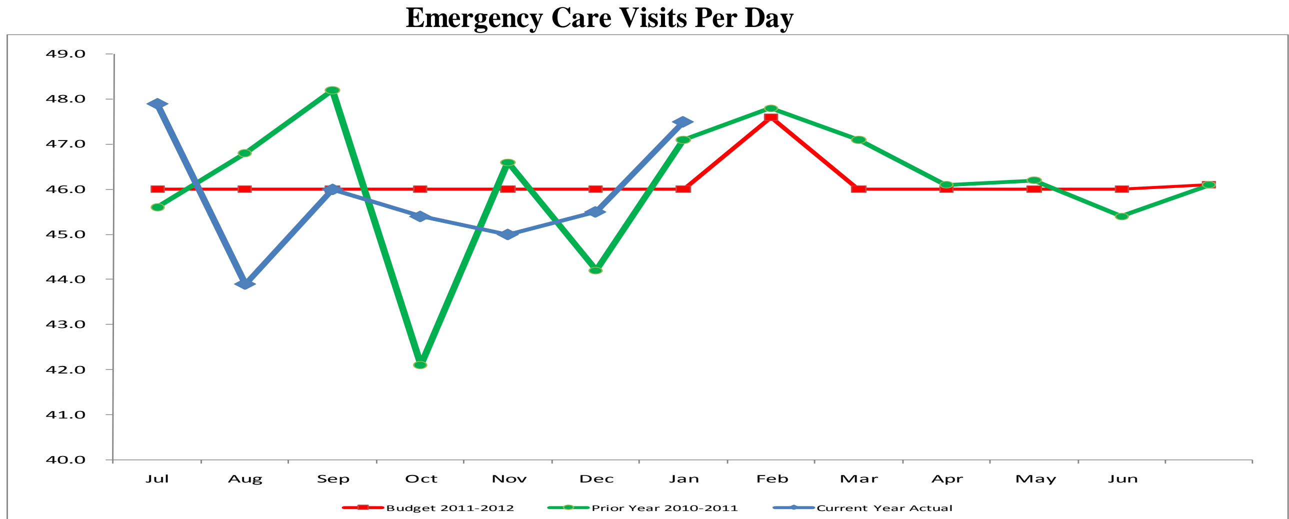
ANCILLARY SERVICES

Outpatient Services

The Emergency Care Center visits in January were 1,473, 47 visits (3.3%) over the budget of 1,426. 17.9% of these visits resulted in inpatient admissions versus 18.5% in December. On a per day basis, the total visits represent an

increase of 4.4% from the prior month daily average. In January, there were 338 ambulance arrivals versus 315 in the prior month. Of the 338 ambulance arrivals in the current month, 218 or 64.5% were from Alameda Fire Department (AFD) ambulances.

Emergency Care Visits Per Day



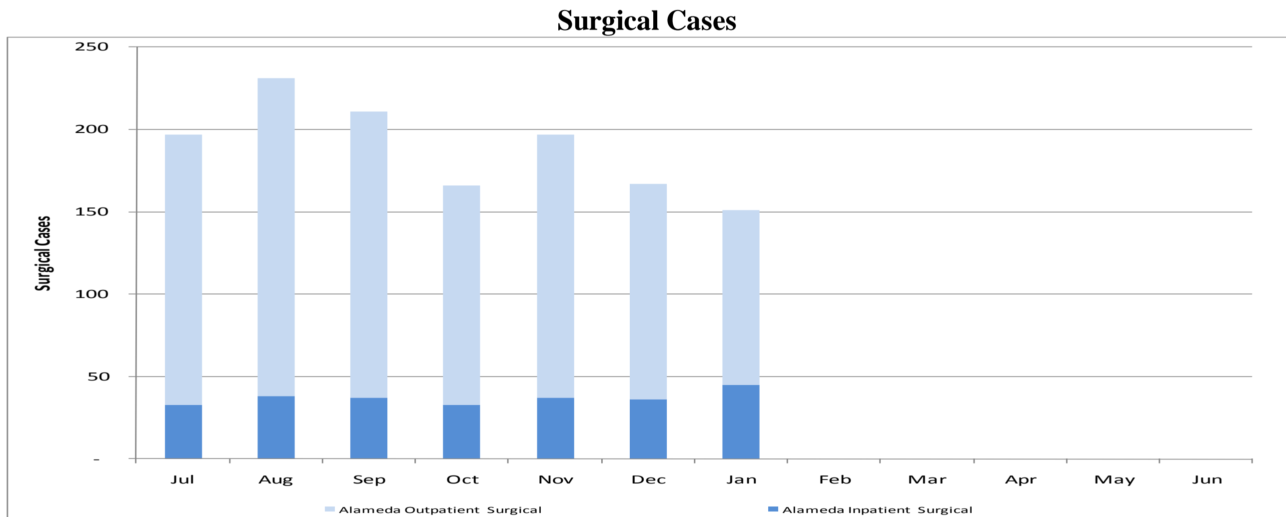
Outpatient registrations were 1,933, or 5.8% below budget but 235 or 13.8% above prior month. The average of 62.4 visits per day was 13.9% higher than the prior month's 54.8 visits per day. YTD outpatient registrations are below budget by 8.0% at 12,866 versus the budget of 13,979. The outpatient visits were below budget in IVT Therapy (27 visits), Laboratory (163 visits) and Occupational Therapy (20 visits). Outpatient visits were up in Radiology (34 visits) and Physical Therapy (26 visits).

Surgery

The year-to-date surgery cases were 1,328 or 2.8% above the budget of 1,292, and above prior YTD monthy averages of 1,293. For the month, total surgery cases were above budgeted expectations by 1.3% at 151 cases versus the budgeted 149 cases; inpatient cases were right on budget while outpatient cases were 2 (1.9%) above budget. Inpatient and outpatient cases totaled 45 and 106 in January versus 36 and 131 last month.

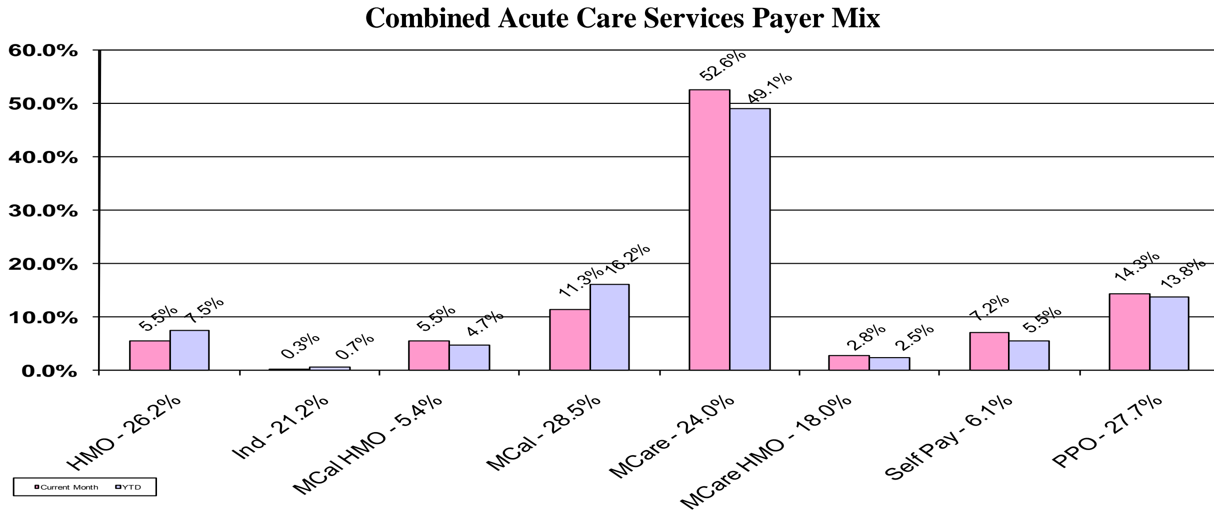
The graph below shows the number of inpatient and outpatient surgical cases by month for fiscal year 2012.

Surgical Cases

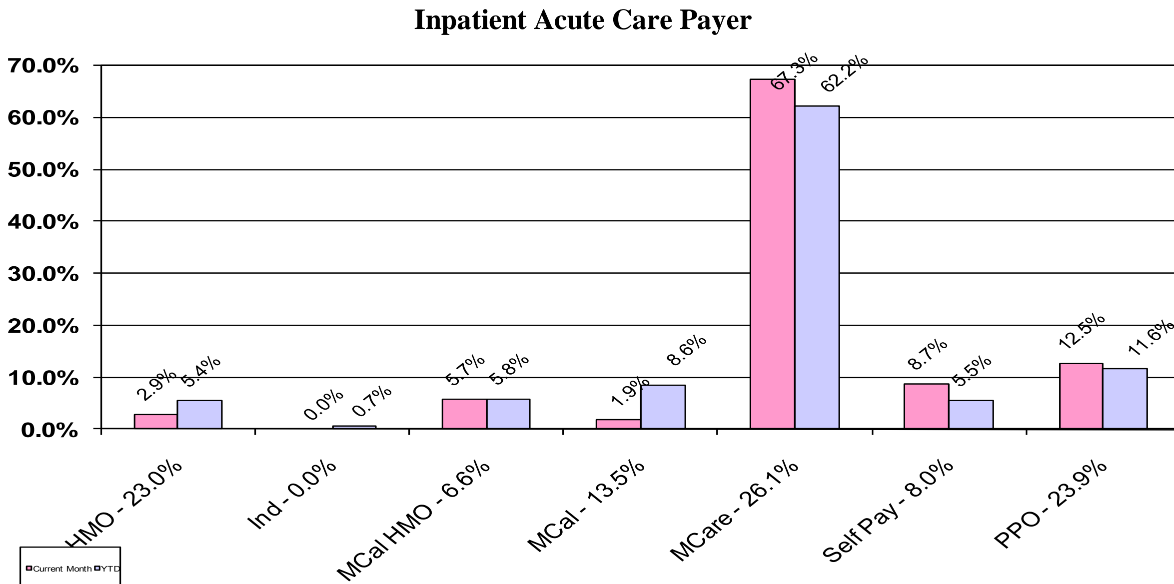


Payer Mix

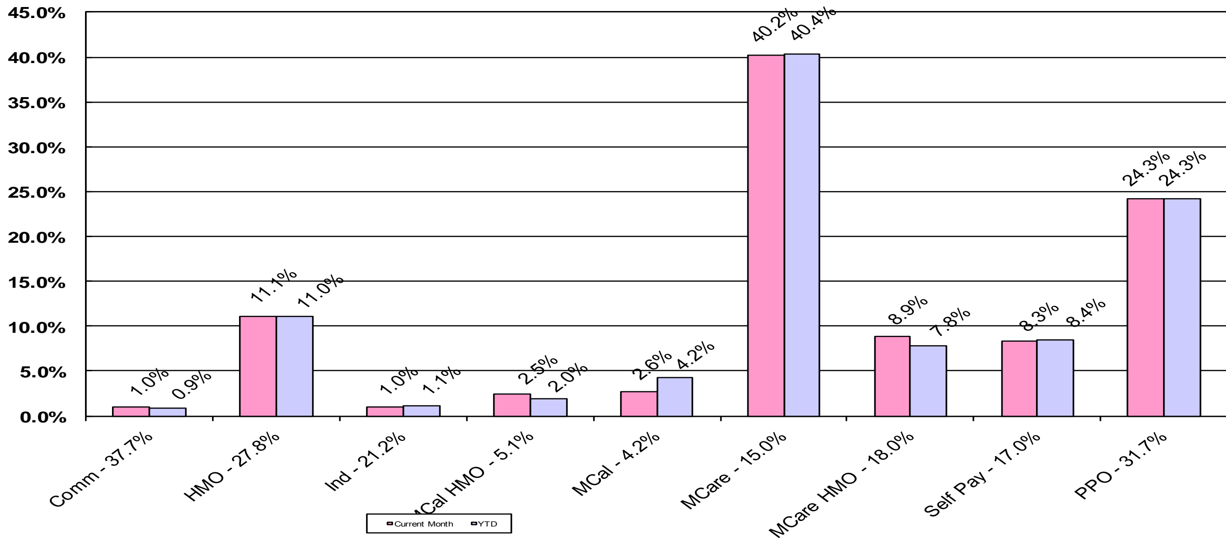
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in January made up 55.4% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 19.8%, Medi-Cal Traditional and Medi-Cal HMO utilization at 19.8% and self pay at 7.2%. 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.



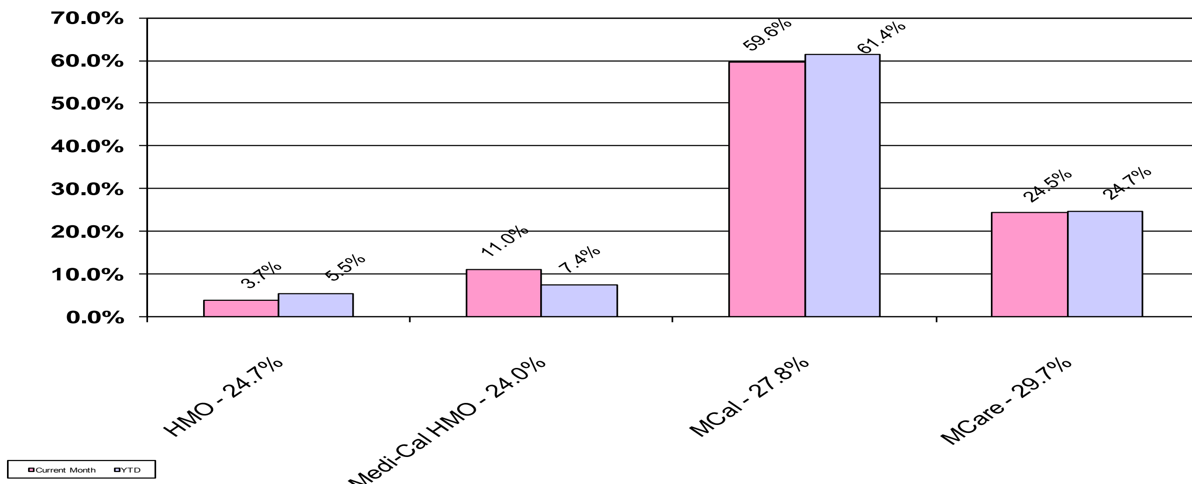
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 67.3% of our total inpatient acute care gross revenues followed by HMO/PPO at 15.4%, Medi-Cal and Medi-Cal HMO at 7.6% and Self Pay at 8.7% of the inpatient acute care revenue. The graph below shows inpatient 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 January was comprised of 49.1% Medicare and Medicare Advantage, 35.4% HMO/PPO, 5.1% Medi-Cal and Medi-Cal HMO, and 8.3% 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.

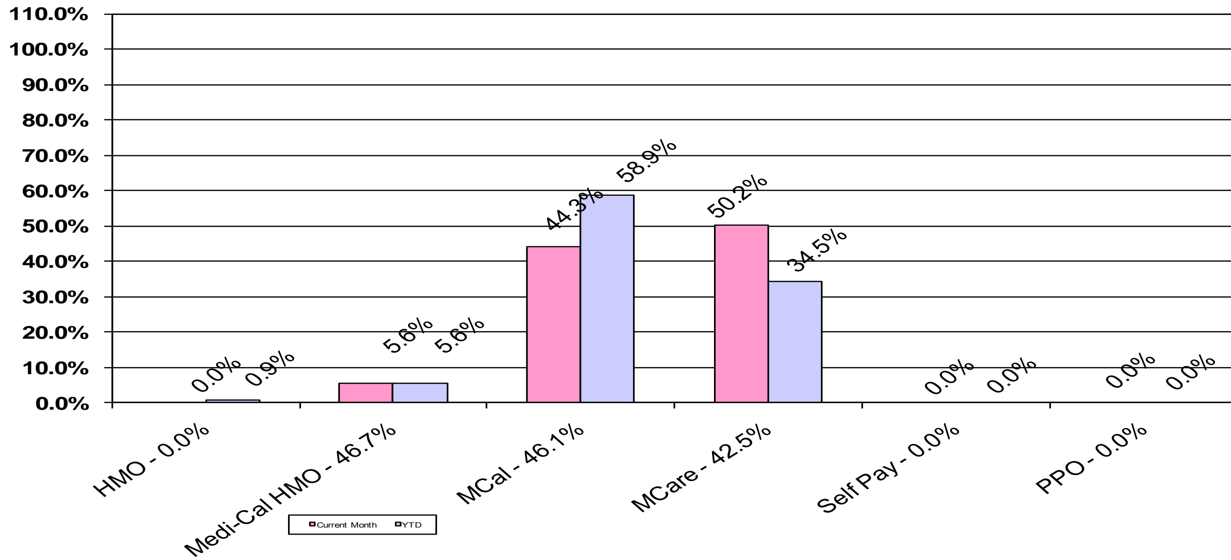


In January, the Sub-Acute care program again was dominated by Medi-Cal utilization of 70.6%, down from a high of 82.1% in December. One anomaly in long term care patients is they are registered as Medicare, usually exhaust their benefits and transition to Medi-Cal. The financial class is now being changed when this occurs, whereas in the past the financial class had not been changed. Medicare was 24.5% and HMO/PPO rounds out the unit at 3.7%. 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 January, the Skilled Nursing program gross revenues were comprised primarily of Medi-Cal at 49.8% and Medicare patient revenue was 50.2%. 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.

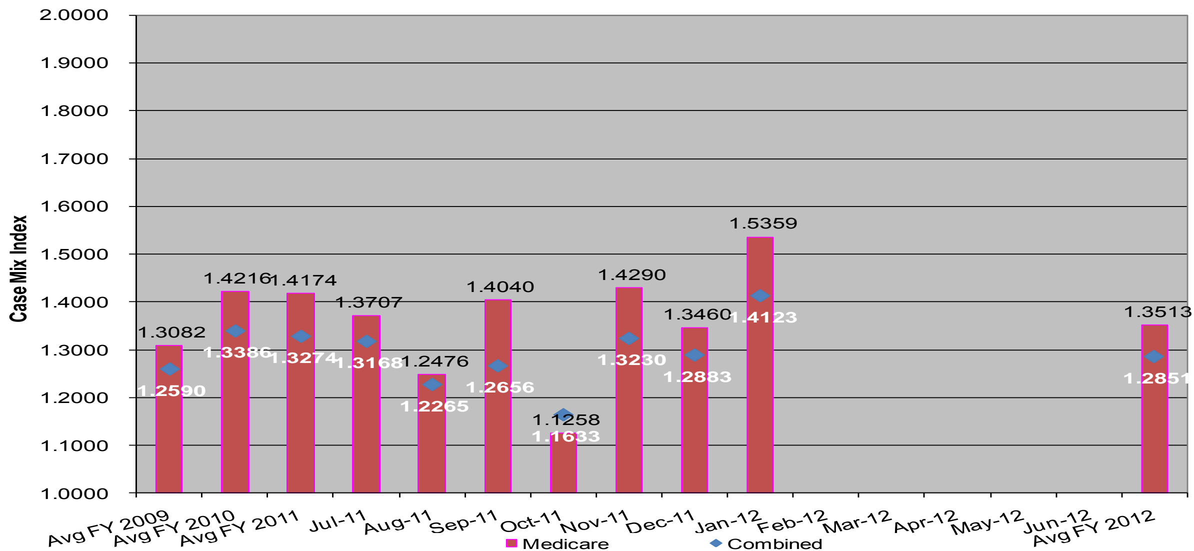
Inpatient Skilled Nursing Payer Mix



Case Mix Index

The hospital's overall Case Mix Index (CMI) increased to 1.4123, up from the prior month of 1.2883, and above the prior year January of 1.4108. The Medicare CMI increased from 1.3460 in December to 1.5359 in January. 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 January 2012 the CMI was 1.2915. This represents a 6.2% decline compared to the same time frame last year. However, the month of January 2012 continues the climb above the year-to-date average. 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.

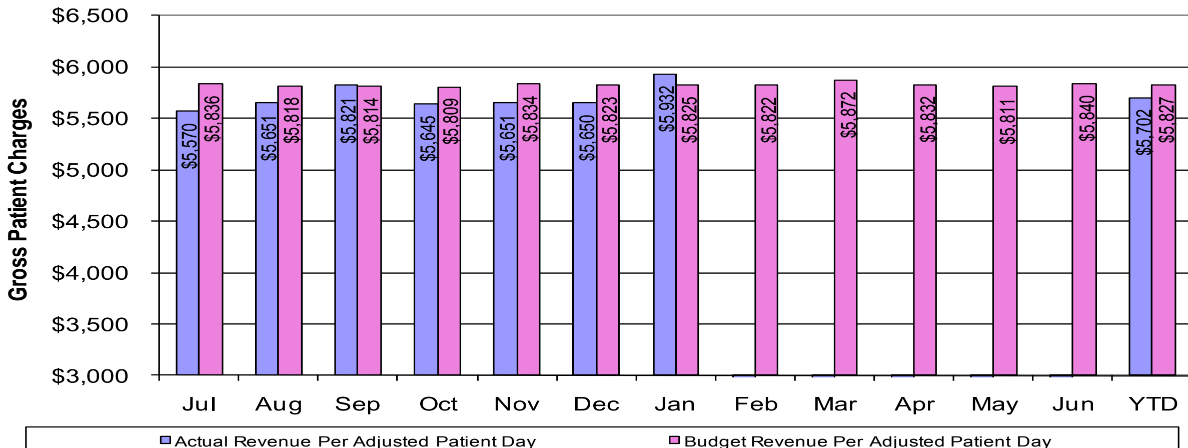
Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Jan 11 YTD	Jan 12 YTD	Jan 12 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.4374	1.0430	5
HMO	1.2522	1.1754	1.3254	69
Industrial	1.8373	1.5805	1.3856	8
Kaiser	1.8412	1.7929	1.8197	8
Medi-Cal HMO	1.0008	0.9783	0.9836	89
Medi-Cal	1.2724	1.2871	1.1995	104
Medicare	1.4724	1.4879	1.3590	861
Medicare HMO	1.3568	1.3518	1.4244	148
Personal Pay	1.0105	1.0238	1.1184	117
Medi-Cal Pending	1.8334	1.8123	2.0751	4
PPO	1.2613	1.3019	1.1105	175
VA	1.4051	1.3002	1.3496	35
Combined	**1.3758**	**1.3776**	**1.2916**	1,623

Revenue

Gross patient charges in January were above budget by $340,000, or 1.5%. Inpatient revenues were up $241,000 over budget and outpatient were up $99,000. Most inpatient volumes, surgeries and emergency visits were on budget. Outpatient registrations were just 6% under budget. Outpatient revenues were slightly higher than budget as a result of higher emergency visits plus a restructuring of the emergency room level charges. On an adjusted patient day basis, total patient revenue was $5,932, above the budget of $5,825 for the month of January and higher than December gross revenue per APD of $5,650. 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



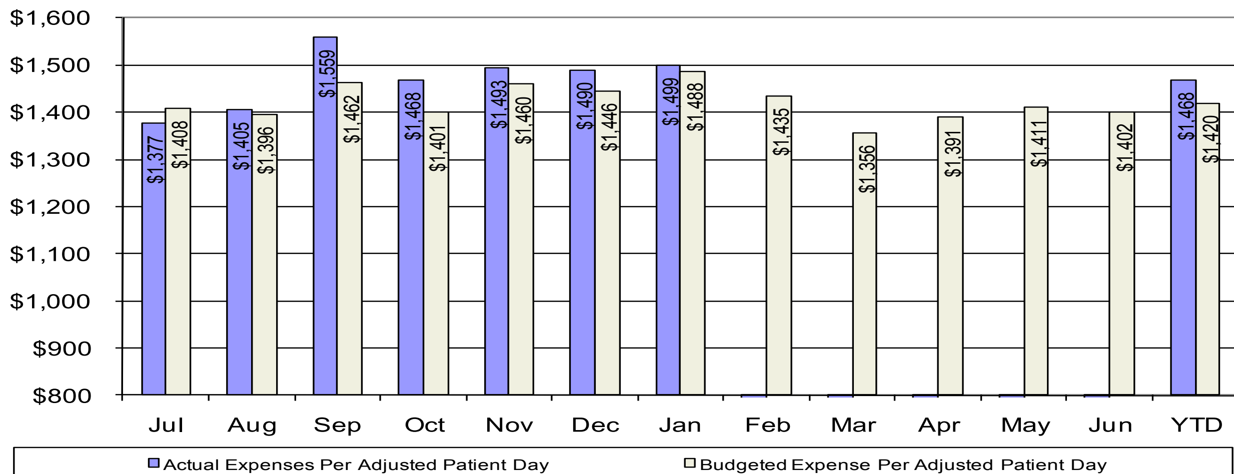
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. As mentioned in the highlights, contractual allowances were reduced due to the reversal of the Skilled Nursing accrual along with recording a lower than expected cost report settlement. As such net revenues as a percentage of gross revenues were higher than normal; 22.3% was budgeted and 24.7% was realized. However, if the one-time adjustments for the Skilled Nursing accrual and cost report settlement are excluded, the actual percentage would have been 22.7% which is much closer to budget and the historical ratio.

Expenses

Total Operating Expenses

Total operating expenses were higher than the fixed budget by $43,000 or 0.8%. On an adjusted patient day basis, cost per adjusted patient day were $1,499 which was ($11,000) or (0.8%) per adjusted patient day unfavorable to budget and $9,000 higher than the prior month. This variance in expense 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, purchased services as well as rents and leases. 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.

Expenses per Adjusted Patient Day



Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were favorable to the fixed budget by $124,000 and were favorable to budgeted levels on a per adjusted patient day (PAPD) basis by $32 or 3.9%.

Productive salaries were below the flexed budget. Productive salaries in most departments were favorable to the flexed budget, while a few departments like Surgery, Dietary and Human Resources were unfavorable.

Benefits

Benefits were unfavorable to the fixed budget by $90,000 or 8.2%, and favorable to budget by $3,000 or 8.2% per adjusted patient day. Vacation accruals for month of January were $74,000 higher than budgeted. Health expenses were also over budget $17,000.

Professional Fees

Professional fees were unfavorable to budget by $86,000 in January due to $37,000 from Medical Professional Fees (ER and Clinic physician expenses) and $48,000 from Non-Medical Professional Fees related to HFS fees for Accounting $13,000, Revenue Cycle $30,000, Pharmacy $15,000 and Administration $11,000.
Non-medical pro fees for Wound care and Employee benefit are favorable to budget by 18k and 11k respectively.

Supplies

Supplies were favorable to budget by $114,000 (15.7%) or $30 or 15.7% per adjusted patient day in January. As in prior months, this favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies associated with the IVT program (low IVT program volumns), and prosthetics.

Purchased Services

Purchased services were above budget by $62,000 compared to fixed budget and $16 unfavorable PAPD. Purchase services medical is favorable to budget by $31k due to the reversal of an over accrual made in December 2011. Additionally, imaging expenses were lower than budget by $11k because of activity. Purchase services – non medical are unfavorable because of HFS expenses for business office services in December 2011 and January 2012.

Rents and Leases

Rents and leases were above the fixed budget by $19,000, and above budget $5 PAPD in January at $32 per adjusted patient day versus a budget of $27. A new operating lease for Radiology starting January 2012 for $36,000 is offset by no lease expenses for telemetry and hospital administration for $13,000.

Other Operating Expense

Other operating expenses were $19,000 over budget due to physician forgiveness of $6,500 (not budgeted) and license fees for equipment from Beckman Coulter and Care Fusion.

Balance Sheet

Total assets increased almost $400,000 from the prior month, largely because of increases in accounts receievable. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for January decreased slightly by $88,000 and days cash on hand including restricted use funds decreased to 13.8 days on hand in January from 15 days on hand in December.

- Net patient accounts receivable increased in January by $304,000 compared to an increase of $481,000 in December. Days in outstanding receivables were 62.9 at January month end, an increase from 62.7 days in December. Collections in January were $4.8 million compared to $4.1 million in December.

- Other Receivables, Third Party Settlements, Inventories and Prepaids remained fairly constant from one month to the next.

Total liabilities decreased by only $42,000 compared to a decrease of $997,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses increased $420,000 due to a normal slow down of payables in January compared to December. December payments were high due to cash received from parcel tax distribution.

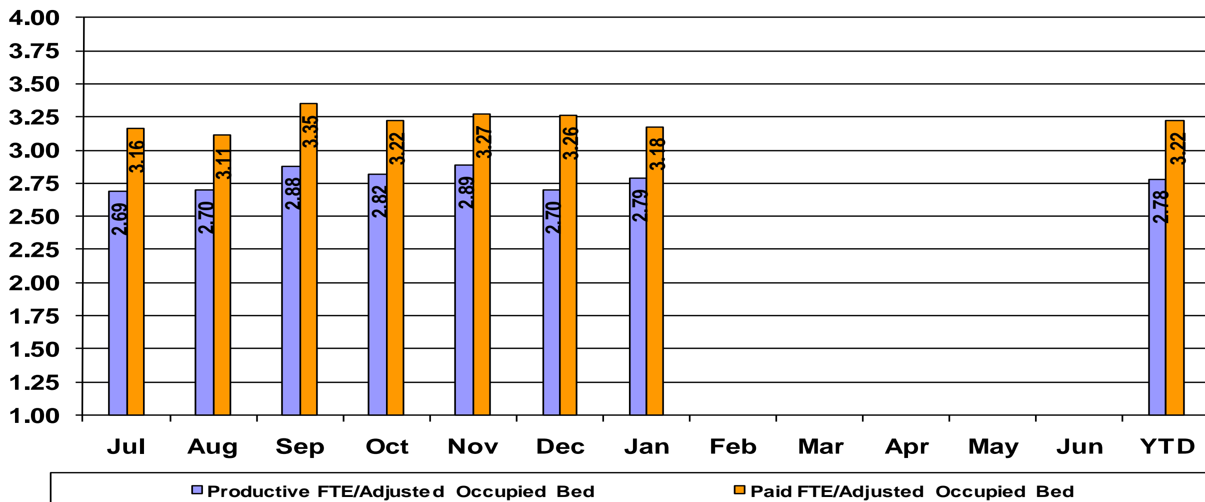
- Payroll related accruals increased by $386,000 as a result of the timing of pay period end in relation to the month end.

- 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 2.79, just below the budget of 2.80 FTE's by .3%, and paid FTE's were 3.18 or 5.1% below 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 January is at .99. With the reclassification of the Jabor cash, this will increase in subsequent months to at or above 1.0.

A/R days

Net days in Accounts Receivable are currently at 62.9, up slightly 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 January is 13.8. This has decreased slightly from prior month due to continued catch up in accounts payable. 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 seven (7) months ended January 31, 2012, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
JANUARY 2012

	ACTUAL JANUARY 2012	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	JANUARY 2011	YTD JANUARY 2012	YTD FIXED BUDGET	VARIANCE	%	YTD JANUARY 2011
Discharges:										
Total Acute	263	236	27	11.4%	210	1,635	1,607	28	1.7%	1,452
Total Sub-Acute	-	2	(2)	-100.0%	3	12	11	1	9.1%	15
Total Skilled Nursing	10	9	1	11.1%	7	60	61	(1)	-1.6%	50
	273	247	26	10.5%	220	1,707	1,679	28	1.7%	1,517
Patient Days:										
Total Acute	1,025	942	83	8.8%	981	6,293	6,429	(136)	-2.1%	6,211
Total Sub-Acute	1,027	1,023	4	0.4%	967	6,985	7,095	(110)	-1.6%	6,971
Total Skilled Nursing	581	675	(94)	-13.9%	704	4,582	4,609	(27)	-0.6%	4,716
	2,633	2,640	(7)	-0.3%	2,652	17,860	18,133	(273)	-1.5%	17,898
Average Length of Stay										
Total Acute	3.90	3.99	(0.09)	-2.4%	4.67	3.85	4.00	(0.15)	-3.8%	4.28
Average Daily Census										
Total Acute	33.06	30.39	2.77	9.1%	31.65	29.27	29.90	(0.63)	-2.1%	28.89
Total Sub-Acute	33.13	33.00	0.13	0.4%	31.19	32.49	33.00	(0.51)	-1.6%	32.42
Total Skilled Nursing	18.74	21.77	(3.13)	-14.4%	22.71	21.31	21.44	(0.13)	-0.6%	21.93
	84.94	85.16	(0.23)	-0.3%	85.55	83.07	84.34	(1.14)	-1.4%	83.25
Emergency Room Visits	1,473	1,426	47	3.3%	1,461	9,864	9,890	(26)	-0.3%	9,842
Outpatient Registrations	1,933	2,053	(120)	-5.8%	2,008	12,866	13,979	(1,113)	-8.0%	13,818
Surgery Cases:										
Inpatient	45	45	-	0.0%	35	267	304	(37)	-12.2%	306
Outpatient	106	104	2	1.9%	103	1,061	988	73	7.4%	987
	151	149	2	1.3%	138	1,328	1,292	36	2.8%	1,293
Adjusted Occupied Bed (AOB)	123.61	124.00	(0.39)	-0.3%	124.15	152.87	125.48	27.39	21.8%	123.65
Productive FTE	344.61	347.34	(2.73)	-0.8%	366.17	343.80	341.62	2.18	0.6%	363.39
Total FTE	391.85	415.29	(23.44)	-5.6%	434.54	396.52	402.86	(6.34)	-1.6%	418.03
Productive FTE/Adj. Occ. Bed	2.79	2.80	(0.01)	-0.5%	2.95	2.25	2.72	(0.47)	-17.4%	2.94
Total FTE/ Adj. Occ. Bed	3.17	3.35	(0.18)	-5.3%	3.50	2.59	3.21	(0.62)	-19.2%	3.38

City of Alameda Health Care District
Statements of Financial Position
January 31, 2012

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 1,981,838	$ 2,070,300	$ 1,784,141
Patient Accounts Receivable, net	9,885,867	9,582,145	7,249,185
Other Receivables	3,616,054	3,646,114	8,090,457
Third-Party Payer Settlement Receivables	661,578	481,578	150,000
Inventories	1,182,028	1,183,395	1,183,358
Prepaids and Other	324,645	323,373	262,359
Total Current Assets	17,652,009	17,286,905	18,719,500
Assets Limited as to Use, net	558,983	546,203	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,397,622	43,435,271	43,383,571
Construction in progress	3,476,290	3,388,457	2,921,048
Depreciation	(39,336,772)	(39,304,382)	(38,862,494)
Property, Plant and Equipment, net	8,415,085	8,397,291	8,320,070
Total Assets	**$ 26,626,077**	**$ 26,230,399**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,606,237	$ 1,632,934	$ 746,074
Accounts Payable and Accrued Expenses	8,734,064	8,312,816	6,987,765
Payroll Related Accruals	4,520,785	4,134,636	3,991,254
Deferred Revenue	2,386,689	2,863,707	5,725,900
Employee Health Related Accruals	617,641	652,505	343,382
Third-Party Payer Settlement Payable	35,075	308,307	(3,930)
Total Current Liabilities	17,900,491	17,904,905	17,790,445
Long Term Debt, net	845,722	883,778	1,142,109
Total Liabilities	18,746,213	18,788,683	18,932,554
Net Assets:			
Unrestricted	7,150,875	6,725,513	8,037,015
Temporarily Restricted	728,988	716,203	553,716
Total Net Assets	7,879,863	7,441,716	8,590,731
Total Liabilities and Net Assets	**$ 26,626,077**	**$ 26,230,400**	**$ 27,523,286**

City of Alameda Health Care District

Statements of Operations

January 31, 2012

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,633	2,640	(7)	-0.3%	2,652	17,860	18,133	(273)	-1.5%	17,898
Discharges	273	247	26	10.5%	220	1,707	1,679	28	1.7%	1,517
ALOS (Average Length of Stay)	9.64	10.69	(1.04)	-9.8%	12.05	10.46	10.80	(0.34)	-3.1%	11.80
ADC (Average Daily Census)	84.9	85.2	(0.23)	-0.3%	85.5	83	84.3	(1.27)	-1.5%	83.2
CMI (Case Mix Index)	1.4123				1.4193	1.2849				1.3675
Revenues										
Gross Inpatient Revenues	$ 15,619	$ 15,379	$ 241	1.6%	$ 14,301	$ 101,849	$ 105,473	$ (3,624)	-3.4%	$ 97,582
Gross Outpatient Revenues	7,113	6,944	169	2.4%	6,509	47,778	50,772	(2,994)	-5.9%	47,616
Total Gross Revenues	22,732	22,323	409	1.8%	20,810	149,627	156,245	(6,618)	-4.2%	145,198
Contractual Deductions	16,942	16,465	(478)	-2.9%	14,432	111,607	115,074	3,467	3.0%	103,608
Bad Debts	36	716	680	94.9%	490	3,021	4,969	1,947	39.2%	4,264
Charity and Other Adjustments	133	173	40	23.1%	183	1,256	1,196	(60)	-5.0%	1,069
Net Patient Revenues	5,620	4,969	652	13.1%	5,704	33,742	35,007	(1,265)	-3.6%	36,258
Net Patient Revenue %	24.7%	22.3%			27.4%	22.6%	22.4%			25.0%
Net Clinic Revenue	40	28	12	43.4%	32	248	118	130	109.8%	207
Other Operating Revenue	8	10	(2)	-23.6%	11	216	71	146	206.5%	69
Total Revenues	**5,668**	**5,007**	**661**	13.2%	**5,747**	**34,207**	**35,196**	**(989)**	-2.8%	**36,534**
Expenses										
Salaries	2,896	3,008	112	3.7%	3,225	20,022	19,884	(138)	-0.7%	20,884
Temporary Agency	135	147	12	8.2%	251	750	1,039	289	27.8%	1,390
Benefits	899	809	(90)	-11.1%	942	6,005	5,578	(427)	-7.7%	5,538
Professional Fees	394	308	(86)	-27.9%	290	2,672	2,036	(636)	-31.2%	2,118
Supplies	610	724	114	15.7%	703	4,169	5,270	1,102	20.9%	5,114
Purchased Services	426	364	(62)	-16.9%	362	2,517	2,582	65	2.5%	2,633
Rents and Leases	122	103	(19)	-19.0%	68	579	601	23	3.8%	476
Utilities and Telephone	70	65	(5)	-7.8%	76	462	454	(8)	-1.8%	432
Insurance	25	17	(8)	-48.6%	32	192	118	(74)	-63.1%	220
Depreciation and amortization	69	76	8	10.1%	78	511	487	(23)	-4.8%	565
Other Opertaing Expenses	99	80	(19)	-23.1%	194	652	550	(103)	-18.7%	637
Total Expenses	**5,745**	**5,702**	**(43)**	-0.8%	**6,219**	**38,531**	**38,599**	**68**	0.2%	**40,006**
Operating gain (loss)	**(76)**	**(695)**	**618**	89.0%	**(472)**	**(4,324)**	**(3,403)**	**(921)**	27.1%	**(3,472)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	478	(0)	-0.1%	481	3,368	3,346	22	0.7%	3,349
Investment Income	1	0	1	272.0%	1	4	(88)	91	-104.3%	8
Interest Expense	(15)	(15)	1	3.6%	(10)	(114)	(13)	(101)	790.7%	(63)
Other Income / (Expense)	38	25	13	50.8%	25	179	156	23	14.7%	153
Net Non-Operating Income / (Expense)	**502**	**488**	**14**	**2.8%**	**496**	**3,437**	**3,402**	**36**	**1.0%**	**3,447**
Excess of Revenues Over Expenses	**$ 425**	**$ (206)**	**$ 632**	**-306.2%**	**$ 24**	**$ (886)**	**$ (1)**	**$ (885)**	**91987.0%**	**$ (26)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

January 31, 2012

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 4,076	$ 4,013	$ 63	1.6%	$ 3,706	$ 3,882	$ 3,927	$ (45)	-1.1%	$ 3,664
Gross Outpatient Revenues	1,856	1,812	44	2.4%	1,687	1,821	1,890	(69)	-3.7%	1,788
Total Gross Revenues	5,932	5,825	107	1.8%	5,393	5,703	5,817	(114)	-2.0%	5,452
Contractual Deductions	4,421	4,297	(125)	-2.9%	3,740	4,254	4,284	30	0.7%	3,890
Bad Debts	9	187	177	94.9%	127	115	185	70	37.7%	160
Charity and Other Adjustments	35	45	10	23.1%	48	48	45	(3)	-7.5%	40
Net Patient Revenues	1,467	1,297	170	13.1%	1,478	1,286	1,303	(17)	-1.3%	1,361
Net Patient Revenue %	24.7%	22.3%			27.4%	22.6%	22.4%			25.0%
Net Clinic Revenue	10	7	3	43.4%	8	9	4	5	114.8%	8
Other Operating Revenue	2	3	(1)	-23.6%	3	8	3	6	213.8%	3
Total Revenues	**1,479**	**1,307**	**173**	13.2%	**1,489**	**1,304**	**1,310**	**(7)**	-0.5%	**1,372**
Expenses										
Salaries	756	785	29	3.7%	836	763	740	(23)	-3.1%	784
Temporary Agency	35	38	3	8.2%	65	29	39	10	26.1%	52
Benefits	235	211	(23)	-11.1%	244	229	208	(21)	-10.2%	208
Professional Fees	103	80	(22)	-27.9%	75	102	76	(26)	-34.3%	80
Supplies	159	189	30	15.7%	182	159	196	37	19.0%	192
Purchased Services	111	95	(16)	-16.9%	94	96	96	0	0.2%	99
Rents and Leases	32	27	(5)	-19.0%	18	22	22	0	1.5%	18
Utilities and Telephone	18	17	(1)	-7.8%	20	18	17	(1)	-4.2%	16
Insurance	7	4	(2)	-48.6%	8	7	4	(3)	-67.0%	8
Depreciation and Amortization	18	20	2	10.1%	20	19	18	(1)	-7.3%	21
Other Operating Expenses	26	21	(5)	-23.1%	50	25	20	(4)	-21.5%	24
Total Expenses	**1,499**	**1,488**	**(11)**	-0.8%	**1,612**	**1,468**	**1,437**	**(32)**	-2.2%	**1,502**
Operating Gain / (Loss)	**(20)**	**(181)**	**161**	89.0%	**(122)**	**(165)**	**(126)**	**(38)**	30.1%	**(130)**
Non-Operating Income / (Expense)										
Parcel Taxes	125	125	(0)	-0.1%	125	128	125	4	3.1%	126
Investment Income	0	0	0	272.0%	0	0	0	0	164.2%	0
Interest Expense	(4)	(4)	0	3.6%	(3)	(4)	(3)	(1)	33.0%	(2)
Other Income / (Expense)	10	7	3	50.8%	6	7	6	1	17.4%	6
Net Non-Operating Income / (Expense)	**131**	**127**	**4**	**2.8%**	**129**	**131**	**127**	**4**	**3.0%**	**129**
Excess of Revenues Over Expenses	**$ 111**	**$ (54)**	**$ 165**	-306.2%	**$ 6**	**$ (34)**	**$ 1**	**$ (34)**	-4775.2%	**$ (1)**

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results			Unaudited Results	
					YTD
	FY 2008	FY 2009	FY 2010	FY 2011	1/31/2012
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.55%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-0.77%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-10.61%
Operating Margin	-3.75%	1.03%	2.74%	-2.61%	-2.35%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	0.99
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	62.99
Days cash on hand (with restricted)	30.61	13.56	21.60	14.14	15.91
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	103.62%
Average pay period	58.93	58.03	57.11	62.68	78.21
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.15)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.24
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-11.25%
Debt to number of beds	20,932	13,481	10,482	11,515	15,230

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results			Unaudited Results	
	FY 2008	FY 2009	FY 2010	FY 2011	YTD 1/31/2012
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	17,860
Patient days (acute only)	11,276	11,787	10,579	10,443	6,293
Discharges(acute only)	2,885	2,812	2,802	2,527	1,635
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.85
Average daily patients (all sources)	61.99	83.46	83.85	82.93	83.07
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.60%
Average length of stay	3.91	4.19	3.78	4.13	3.85
Emergency Visits	17,922	17,337	17,624	16,816	9,864
Emergency visits per day	48.97	47.50	48.28	46.07	45.88
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	59.84
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.

DATE: February 28, 2012

FOR: March 5, 2012 District Board Meeting

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

FROM: Deborah E. Stebbins, CEO
Kerry Easthope, Associate Administrator
Phyllis J. Weiss, Director, Human Resources & Ancillary Services

SUBJECT: Adoption of Resolution No. 2012-2J – "*Amending Resolution No. 2002-10X of the Board of Directors of the City of Alameda Hospital Health Care District Relating to Employee Relations for the City of Alameda Health Care District*" relating to the addition of Waters Edge Employee Association Bargaining Unit

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RECOMMENDATION:

It is recommended that the Board of Directors adopt Resolution No. 2012-2J - Amending Resolution No. 2002-10X of the Board of Directors of the City of Alameda Hospital Health Care District Relating to Employee Relations for the City of Alameda Health Care District.

BACKGROUND:

For many years, Alameda Hospital had its employee relations governed by the National Labor Relations Act (NLRA). In becoming a health care district, the NLRA was replaced by the Meyers-Milias-Brown Act (MMBA). MMBA provides for the development of an Employee Relations Ordinance (ERO) for the public entity to adopt a consistent approach to employee relations. As a result, Resolution No. 2002-10X entitled "A Resolution of the Board of Directors of the City of Alameda Health Care District relating to Employee Relations for the City of Alameda Health Care District" was created and approved by the Board of Directors in 2003.

Resolution No. 2002-10X provided the framework for adopting the then five existing Memoranda of Understanding at Alameda Hospital (Section 7 - Establishment of Exclusive Representative Status) which were a combination of "conforming" and "historical non-conforming" bargaining units. However it did not anticipate the adoption of an additional non-conforming unit.

Resolution No. 2012-2J amending Resolution No. 2002-10X adds, as an appropriate unit, all employees of Alameda Hospital at Waters Edge excluding any management employees and any confidential employees as currently identified in their employee association.

DISCUSSION:

Several steps were taken in preparation for the inclusion of the Waters Edge Employee Association into the District's employee relations ordinance including the approval of the proposed resolution and approval the Waters Edge Employee Association Memorandum of Understanding, which is being presented as a separate action item at the March 5, 2012 District Board meeting.

In February, 2012 management met with representatives of the Waters Edge Employee Association to create an agreement to be signed by both parties which provided the framework for recognizing this unit and the process required to reach that goal, hereto referred to as the Memorandum of Understanding (MOU). Concurrently, a petition was created for signature by the Waters Edge employees that affirmed their desire to have the Waters Edge Employee Association as their "exclusive representative" for purposes of bargaining their "wages, hours and other terms and conditions of employment". This petition had to be signed by a majority of those employees currently covered by this MOU, excluding management employees and the Human Resources and Payroll staff who are considered "confidential employees" and whom will be excluded from the bargaining unit. The petition was signed by a majority of employees and signatures were verified to be true and accurate.

The next steps to recognize this unit is for the Board of Directors to adopt the attached resolution and then approve the MOU as presented in a separate action item at the March 5, 2012 District Board meeting.

Upon approval of the resolution and MOU, management will take the following steps to negotiate a new agreement with the Waters Edge Employee Association.

1. Upon the closing of the transaction with Waters Edge, including licensure by all appropriate regulatory agencies, the Hospital would provide sixty days (60) notice to the Waters Edge Employee Association of its desire to open the MOU for negotiations. Both parties could meet earlier than sixty days by mutual agreement.

2. The hospital would also send a notice of opening to the State Mediation and Conciliation Service (SMCS) of the intent to modify the existing MOU.

3. Representatives from the Hospital and the Waters Edge Employee Association would meet to negotiate a new agreement between the two parties.

4. When negotiations conclude, management would present a recommendation to the Board of Directors to approve the newly negotiated Waters Edge Employee Association MOU, which is the same process for all of our current bargaining units.

RESOLUTION NO. ~~2002-10X~~2012-2J_______

~~A~~AMENDING RESOLUTION NO. 2002-10X OF THE BOARD OF DIRECTORS OF THE CITY OF ALAMEDA HEALTH CARE DISTRICT RELATING TO EMPLOYEE RELATIONS FOR THE CITY OF ALAMEDA HEALTH CARE DISTRICT

WHEREAS, the primary mission of the CITY OF ALAMEDA HEALTH CARE DISTRICT is the provision of full and effective health services to citizens in the community; and

WHEREAS, the orderly conduct of employee relations matters involving employees of the District is conducive to the fulfillment of the District's primary mission; and

WHEREAS, the adoption of uniform regulations concerning employee relations matters provides a means of assuring the orderly conduct of such matters;

NOW, THEREFORE, pursuant to the provisions of section 3500 to 3511 of the Government Code of the State of California, THE BOARD OF DIRECTORS OF THE CITY OF ALAMEDA HEALTH CARE DISTRICT DOES HEREBY FIND, DETERMINE AND RESOLVE THE FOLLOWING:

SECTION 1. TITLE OF RESOLUTION

This Resolution shall be known as the Amended Employee Relations Resolution of the CITY OF ALAMEDA HEALTH CARE DISTRICT. This Amended Employee Relations Resolution amends Resolution No. 2002-10X originally adopted by the Board of Directors of the City of Alameda Health Care District on April 14, 2003.

SECTION 2. DEFINITIONS

As used in this Resolution, the following terms shall have the meanings indicated:

(A) "BOARD" means the Board of Directors of the CITY OF ALAMEDA HEALTH CARE DISTRICT.

(B) "DAY" means calendar day unless expressly stated otherwise.

(C) "DISTRICT" means the CITY OF ALAMEDA HEALTH CARE DISTRICT, and where appropriate herein, "District" refers to any duly authorized management representative as herein defined.

(D) "DISTRICT EMPLOYEE RELATIONS OFFICER" means the District's principal representative in all matters of employee relations, or his or her duly authorized representative.

(E) "EMPLOYEE" means any person regularly employed by the District, except those persons elected by popular vote.

(F) "EMPLOYEE ORGANIZATION" means any organization whose membership includes employees of the District, and which has as one of its primary purposes the representation of such employees in their employment relations with the District.

(G) "EMPLOYEE RELATIONS" means the relationship between the District and its employees and a recognized Employee Organization or when used in a general sense, the relationship between District management and employees or Employee Organizations.

(H) "IMPASSE" means a situation where, after a reasonable period of time, representatives of the District and an exclusive majority representative have failed to reach agreement concerning mandatory subjects within the scope of representation.

(I) "MANAGEMENT REPRESENTATIVE" means the District Employee Relations Officer or his designated representative.

(J) "MANAGEMENT TEAM" means any persons appointed by the Board who will represent District in employer-employee relations pursuant to the provisions of this policy.

(K) "MEET AND CONFER IN GOOD FAITH" (sometimes referred to herein as "meet and confer" and "meeting and conferring") means performance by the Management team and duly authorized representatives of a Recognized Employee Organization in an appropriate unit, of their mutual obligation to meet at reasonable times promptly upon request of either party, and to confer in good faith for a reasonable period of time regarding matters within the scope of representation, including wages, hours, and other terms and conditions of employment, in an effort to:

(1) Reach agreement on those matters within the authority of such representatives, and

(2) Reach written agreement (sometimes referred to as a Memorandum of Understanding) on matters to be presented to the Board.

This does not require either party to agree to a proposal or to make a concession.

(L) "RECOGNIZED EMPLOYEE ORGANIZATION" means an Employee Organization that has been recognized or certified pursuant to the provisions of this Resolution as the exclusive representative of employees in an appropriate unit. Provided, however, that the certification of an Employee Organization as the exclusive representative of employees in a particular unit shall not deprive employees in that unit of their right to represent themselves individually in their employee relations with the District. A Recognized Employee Organization shall also sometimes be referred to as an Exclusive Majority Representative.

(M) "RESOLUTION" means, unless the context indicates otherwise, the Amended Employee Relations Resolution of the CITY OF ALAMEDA HEALTH CARE DISTRICT.

(M)(N)“CONFIDENTIAL EMPLOYEE” means an employee who, in the course of his or her duties, has access to information relating to the District’s administration of employer-employee relations.

SECTION 3. EMPLOYEE RIGHTS

Employees shall have the right to form, join and participate in the activities of Employee Organizations of their own choosing for the purpose of representation on all matters of employee relations within the scope of bargaining, and shall also have the right to refuse to join, participate in the activities of Employee Organizations; and the right to represent themselves with the District, except as may be limited by a memorandum of understanding.

SECTION 4. DISTRICT RIGHTS

The rights of the District include, but are not limited to:

(A) MANAGEMENT DECISIONS. It is the exclusive right of the District to determine the mission of each of its constituent departments, board, and committees, set standards of services to be offered to the public, exercise control and discretion over the organization and technology of performing work and all of its facilities and operations, and take such other and further action as may be necessary to organize and operate the District in the most efficient and economical manner and in the best interest of the public it serves.

(B) MANAGEMENT DIRECTION. Except where specifically limited by a memorandum of understanding, it is the exclusive right of the District to determine the size and composition of its workforce, direct its employees which shall include, but not be limited to, assigning work, scheduling, classifying positions, establishing and revising classifications and specifications, hiring, promoting, demoting, transferring, laying off, taking disciplinary action, relieving its employees from duty because of lack of work or for other reasons, or for no reason at all (employment with the District being, except where limited by a memorandum of understanding, terminable at the will of either the District or the employee), and to determine the methods, means and personnel by which the District’s operations are to be conducted.

(C) EMERGENCIES. It is the exclusive right of the District to take whatever action it deems may be necessary and in the public interest in an emergency situation. Emergency shall be defined as an Act of God or some other unanticipated calamity which the District has not proximately caused.

SECTION 5. MEET AND CONFER IN GOOD FAITH; SCOPE

The District shall meet and confer in good faith with representatives of recognized Employee Organizations regarding matters within the statutory scope of representation and over which the District and the Employee Organization are required to meet and confer and shall endeavor to reach agreement on such matters as required by law.

SECTION 6. ADVANCE NOTICE

Reasonable written notice shall be given as required by law to each recognized Employee Organization of any ordinance, rule, resolution or regulation directly relating to

matters within the recognized Employee Organization's scope of representation proposed for adoption by the Board, or in the event of a proposed amendment to this Resolution, and each such organization shall be given the opportunity to meet with the District prior to adoption. When the District determines that an emergency requires that an ordinance, rule, resolution or regulation must be adopted immediately without prior notice or meeting with such recognized Employee Organization(s), the District shall provide such notice and opportunity to meet and confer at the earliest practicable time following the adoption of such ordinance, rule, resolution or regulation.

SECTION 7. ESTABLISHMENT OF EXCLUSIVE REPRESENTATIVE STATUS

The District will continue to recognize the Employee Organizations who were the exclusive representatives of those historical units in existence immediately before the inception of District operations ("the historical units"). With the exception of the historical units, petitions for an Employee Organization to be certified as an Exclusive Majority Representative must be brought with the Public Employment Relations Board and must satisfy any applicable requirements set forth in the Meyers Milias Brown Act, Government Code § 3500 et seq., the regulations promulgated pursuant thereto by the Public Employment Relations Board, and case law interpreting any applicable provisions of the Meyers Milias Brown Act or those regulations. Nothing in this provision shall preclude an Employee Organization from seeking to represent employees in an appropriate unit based on authorization cards or union membership cards in compliance with the provisions of Section 3507.1(c) of the Meyers Milias Brown Act.

SECTION 8. REPRESENTATIONAL UNITS

Except for the historical units or as set forth specifically herein below, pursuant to 8 Cal. Code Regs. § 61000, appropriate bargaining units will be determined by the Public Employment Relations Board pursuant to any applicable provisions set forth in the Meyers Milias Brown Act, Government Code § 3500 et seq., the regulations promulgated pursuant thereto by the Public Employment Relations Board, and case law interpreting any applicable provisions of the Meyers Milias Brown Act or those regulations.

Except in extraordinary circumstances or in circumstances where there are historical non-conforming units, the following shall be appropriate units, and the only appropriate units, for the purposes of recognizing Employee Organizations pursuant to Section 7 of this resolution, except that, if sought by an Employee Organization or recognized Employee Organization, various combinations of units may also be appropriate: (1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; (8) all nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees and guards; ~~and~~ (9) all supervisors; and (10) all employees of Alameda Hospital at Waters Edge excluding any management employees and any Confidential Employees. Confidential Employees and management employees shall not represent the unit of Alameda Hospital at Waters Edge employees. A unit of five or fewer employees shall constitute an extraordinary circumstance. Where there are historical non-conforming units comprising a portion of a presumptively appropriate unit as set forth herein, and a petition for an additional unit or units is filed pursuant

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to section 7 of this resolution, only those additional units that comport, insofar as practicable, with the appropriate units set forth herein shall be appropriate.

SECTION 9. ELECTIONS TO CERTIFY OR DECERTIFY EXCLUSIVE EMPLOYEE REPRESENTATIVES

Pursuant to 8 Cal. Code Regs. § 61000, elections to certify an organization as an Exclusive Majority Representative will be conducted under the auspices of the Public Employment Relations Board pursuant to the applicable provisions of the Meyers Milias Brown Act, Government Code § 3500 et seq., the regulations promulgated pursuant thereto by the Public Employment Relations Board, and case law interpreting any applicable provisions of the Meyers Milias Brown Act or those regulations.

Elections to decertify an Exclusive Majority Representative will likewise be conducted under the auspices of the Public Employment Relations Board pursuant to the applicable provisions of the Meyers Milias Brown Act, Government Code § 3500 et seq., the regulations promulgated pursuant thereto by the Public Employment Relations Board, and case law interpreting any applicable provisions of the Meyers Milias Brown Act or those regulations.

SECTION 10. DESIGNATION OF DISTRICT EMPLOYEE RELATIONS OFFICER

The Board shall designate a District Employee Relations Officer who shall be the District's principal representative in all employee relations matters, and who shall have the authority to administer the provisions of this resolution. The name of the District Employee Relations Officer shall be sent to recognized Employee Organizations.

SECTION 11. VOLUNTARY IMPASSE PROCEDURE

(A) The impasse procedure may be invoked only after the opportunity of agreement by direct discussion has been exhausted.

(B) Any recognized Employee Organization may initiate the impasse procedure by filing a written request with the Board and a copy to the Management Representatives for an impasse meeting together with a statement of its position on all disputed issues.

(1) The Board, at its next regular Board meeting, shall direct that an impasse meeting be scheduled within ten days with the Management Representatives, with written notice to all parties affected, unless it determines a different mode of resolution is preferable, such as mediation.

(2) The purpose of such impasse meeting is to permit a review of the position of all parties in a final effort to reach agreement on disputed issues.

(3) If the matter is submitted to mediation, all mediation proceedings shall be private and the mediator shall make no public recommendations, nor take any public position at any time concerning the

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issue. The costs for the services of a mediator and other mutually incurred costs of mediation shall be borne equally by the District and the recognized Employee Organization. All other costs shall be borne separately by the party incurring same.

(C) If no impasse meeting is held pursuant to B (l) above, or if agreement is not reached at an impasse meeting or through mediation, both the recognized Employee Organization and management representative may submit a final written statement to the Board who shall take such action regarding the impasse as it in its discretion deems appropriate as in the public interest. The Board may make a recommendation to the parties on a resolution of the impasse.

(D) This Section shall not be construed as precluding the District from entering into a separate agreement or memorandum of understanding, at any time, with any recognized Employee Organization whereby the disputed terms of existing or future contracts are settled by other mutually-agreed-upon means.

SECTION 12. MEMORANDA OF UNDERSTANDING

(A) Where there is in effect a memorandum of understanding covering employees at the District no party shall terminate or modify such memorandum of understanding unless the party desiring termination or modification:

(1) Serves a written notice upon the other party of the proposed termination or modification sixty days prior to the expiration date thereof, or, in the event such memorandum of understanding contains no expiration date, ninety days prior to the time it is proposed to make such termination or modifications;

(2) Offers to meet and confer with other party for the purposes of negotiating a new memorandum of understanding or a memorandum of understanding containing the modifications;

(3) Notifies the State Mediation and Conciliation Service ("SMCS") within thirty days after such notice of the existence of a dispute; and

Any employee who engages in a strike within any notice period specified in this subsection or who engages in any strike within the appropriate period specified in Section 17.B of this Ordinance, shall lose his/her status as an employee of the District, but such loss of status for such employee shall terminate if and when he/she is reemployed by the District.

(B) Where bargaining is for an initial agreement following certification or recognition, at least thirty days' notice of the existence of a dispute shall be given by the Employee Organization to SMCS.

(C) When the District and an Employee Organization are engaged in the meet and confer process for a new memorandum of understanding, the parties shall participate fully

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and promptly in such meetings as may be undertaken by the State Mediation and Conciliation Service ("SMCS") for the purpose of aiding in the settlement of the dispute.

(D) When the meeting and conferring process is concluded between the District and a recognized Employee Organization, all agreed-upon matters shall be incorporated in a written memorandum of understanding, which shall be signed by the duly authorized representatives of the District and the recognized Employee Organization.

(E) All memoranda of understanding shall be submitted to the Board for ratification.

SECTION 13. SOLICITATION AND DISTRIBUTION OF WRITTEN MATERIAL ON DISTRICT PREMISES

Except as governed by the specific terms of a memorandum of understanding with a recognized Employee Organization, solicitation and the distribution of literature on District premises, including the grounds, premises and parking areas, shall conform to the guidelines established by the Employee Relations Officer or other appropriate District official and shall be in accordance with applicable law.

SECTION 14. ACCESS TO WORK LOCATIONS

(A) Reasonable access to employee work locations shall be granted any officially designated representative of a recognized Employee Organization for the purpose of processing grievances or contacting members of the organization concerning business within the scope of representation. Except as governed by the specific terms of a memorandum of understanding or by recognized past practice, the representative shall not enter any work area or location without advance notification to the District Employee Relations Officer. Access shall be restricted so as not to unduly interfere with the normal operations of the District or with patient care or established safety or security requirements.

(B) Except as governed by the specific terms of a memorandum of understanding or by recognized past practice, communication with members of a recognized Employee Organization related to (and activities concerned with) the internal management of the recognized Employee Organization (such as holding membership meetings, campaigning for office and conducting elections) shall not be conducted upon District premises without the advance written approval of the District Employee Relations Officer.

SECTION 15. DUES CHECK OFF

(A) An employee's earnings must be sufficient after other legal and required deductions are made to cover the amount of any dues check-off authorized. When a member in good standing of a recognized Employee Organization is in a nonpaid status for an entire pay period, no dues withholding shall be made to cover that pay period from future earnings nor shall the member deposit the amount with the District which would have been withheld if the member had been in paid status during that period. If an employee is in a nonpaid status during only a part of the pay period but the earnings are not sufficient to cover the full withholding, no

deduction shall be made. All other legal and required deductions shall have priority over Employee Organization dues.

(B) Any Employee Organization that receives dues check-off shall indemnify, defend, and hold the District and its agents harmless against any claims made and against any suit instituted against the District on account of check-off of Employee Organization dues, including but not limited to all costs of defending against any such claims or suits. In addition, any such Employee Organizations shall refund to the District any amounts paid to it in error upon presentation of supporting documentation or other evidence.

SECTION 16. REASONABLE TIME OFF TO MEET AND CONFER

(A) The District shall allow a reasonable number of employee representatives of recognized Employee Organizations reasonable time off without loss of compensation or other benefits when formally meeting and conferring with representatives of the District on matters within the scope of representation. Where circumstances warrant, the District representatives may approve the attendance at such meetings of additional employee representatives with or without loss of compensation. The Employee Organization shall, whenever practicable, submit the names of all such employee representatives to the District representatives at least three working days in advance of such meetings, *provided that* (1) No employee representative shall leave his or her duty or workstation or assignment without specific approval of the department head or other authorized District management official; and (2) Any such meeting is subject to scheduling by District management and the Employee Organization in a manner consistent with operating requirements and work schedules.

(B) Nothing provided herein shall require compensation of employee representatives who attend such meetings during their off duty hours or shall limit or restrict District management and Employee Organizations from scheduling such meetings before or after regular duty or work hours.

SECTION 17. EMPLOYEE STRIKES

(A) This section which sets out the procedures and rules under which District Employees may exercise their right to strike, is designed to protect the public's health and safety.

(B) In the case of employees not represented by a recognized Employee Organization, each such employee must give the District at least ten days' advance written notice of his/her intention to strike. The employee or employees may, on twelve hours written notice to the District, postpone the commencement of such a strike, provided such postponed strike commences within seventy two (72) hours of the original time and date in the ten day notice. In the case of employees in a unit which is represented by a recognized Employee Organization, the recognized Employee Organization shall be responsible for giving the required ten days' advance written notice. The Employee Organization may, on twelve hours written notice to the District, postpone the commencement of such a strike, provided such postponed strike commences within seventy two (72) hours of the original time and date in the ten day notice. If an employee or employees or Employee Organization, as the case may be, do not engage in a strike at the noticed date and time, or at the postponed date and time, a new ten day notice must be given

before they may engage in a strike on any other date, or at any other time, unless the District has agreed in writing to waive this requirement or extend the effect of the notice.

(C) Within two days after receiving a ten-day strike notice, the District's Employee Relations Officer will determine whether the noticed strike poses a serious threat to public health and safety. If the Employee Relations Officer determines that the proposed strike will pose a threat to public health and safety, he/she shall notify the employee(s) or recognized Employee Organization in question of his/her determination. If the employee(s) or recognized Employee Organization in question disagrees with the Employee Relations Officer's determination, they may, within two days, request an emergency meeting of the District Board in which they may appeal the Employee Relations Officer's determination.. If the Employee Relations Officer, or the Board, following an appeal, has determined that a proposed strike will pose a threat to public health and safety, the District may, among other things, initiate court proceedings to enjoin the proposed strike. In any such proceeding, the District may seek injunctive relief against any employee(s) who propose to engage in, or engage in, and injunctive and monetary relief against any recognized Employee Organization that calls, endorses or encourages an unlawful strike.

SECTION 18. SEVERABILITY

If any provision of this Resolution, or the application of such provision to any person or circumstance, shall be held invalid, the remainder of this Resolution, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

SECTION 19. CONSTRUCTION

(A) Nothing in this Resolution shall be construed to deny any person or employee any rights granted by federal or state laws.

(B) The rights, powers, duties and authority of the District in all matters, including the right to maintain any legal action, shall not be modified or restricted by this Resolution.

(C) The provisions of the Resolution are not intended to conflict with, but rather to carry out, the provisions of Chapter 10, Division 4, Title 1 of the Government Code of the State of California (Sections 3500, et seq.).

SECTION 20. IMPLEMENTATION

Upon adoption of this Resolution by the Board, it shall be immediately effective in all its terms.

ADOPTED, SIGNED AND APPROVED this 5th14th day of April 2003March 2012.

I, Kevin FarrellElliott Gorelick, Secretary of CITY OF ALAMEDA HEALTH CARE DISTRICT and of the Board of Directors thereof, do hereby certify that the foregoing Amended Resolution was duly adopted by the Board of Directors of said District at a regular meeting of said Board held on the 5th14th day of April, 2003March 2012, and that it was adopted by the following vote:

AYES: _______________

NOES: _______________

ABSENT: _______________

ABSTAIN: _______________

STATE OF CALIFORNIA

COUNTY OF ALAMEDA

Dated:

____
Kevin FarrellElliott Gorelick, Secretary of CITY OF ALAMEDA HEALTH CARE DISTRICT and of the Board of Directors thereof.

STATE OF CALIFORNIA

COUNTY OF ALAMEDA

I, Kevin FarrellElliott Gorelick, Secretary of CITY OF ALAMEDA HEALTH CARE DISTRICT and of the Board of Directors thereof, do hereby certify that the above is a full, true and correct copy of Amended Resolution No. 2002-10x 2012-2J of the Board and that the same has not been further amended or repealed.

Dated:

____
Kevin FarrellElliott Gorelick, Secretary of CITY OF ALAMEDA HEALTH CARE DISTRICT and of the Board of Directors thereof.

____
~~Jeptha T. Boone, MD~~Jordan Battani
President

ATTEST:

____
~~Kevin Farrell~~Elliott Gorelick
Secretary

~~DISTRICT/RESOLUTIONS/2002-10X.EMPLOYEE RELATIONS.FINAL~~

DATE: February 24, 2012

FOR: March 5, 2012 District Board Meeting

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

FROM: Deborah E. Stebbins, CEO
Kerry Easthope, Associate Administrator
Phyllis J. Weiss, Director Human Resources & Ancillary Services

SUBJECT: Approval of Waters Edge Employee Association Memorandum of Understanding | Handbook

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RECOMMENDATION:

Upon approval of Resolution 2012-2J, which recognizes the addition of the Waters Edge Employee Association as a bargaining unit of the District, management recommends that the Board of Directors approve the Waters Edge Employee Association Memorandum of Understanding (MOU) / Handbook.

The Waters Edge Employee MOU / Handbook (Attachment A as referenced in Exhibit A) is available for review upon request.

BACKGROUND:

As part of the transaction between Alameda Elders, Inc. and the City of Alameda Health Care District dba Alameda Hospital, the District agreed to recognize the Waters Edge Employee Association as the exclusive bargaining representative of the employees at the facility upon the transfer of the license to the District.

Waters Edge Employee Association has operated under an Employee Handbook dated 2009. The MOU/Handbook contains the wages, hours, and other terms and conditions of employment for all employees of Waters Edge. The Hospital met with representatives of the Waters Edge Employee Association and has reached an agreement amending the existing Waters Edge Employee MOU / Handbook. The amendments (See Exhibit A) to the MOU / Handbook were limited to minor changes such as the change in the name of the employer and identification of excluded employees.

DISCUSSION:

Upon the closing of the transaction with Waters Edge, including licensure by all appropriate regulatory agencies, the Hospital would provide sixty days (60) notice to the Waters Edge

Employee Association of its desire to open the MOU for negotiations. Both parties could meet earlier than sixty days by mutual agreement. The hospital would also send a notice of opening to the State Mediation and Conciliation Service (SMCS) of the intent to modify the existing MOU. Representatives from the Hospital and the Waters Edge Employee Association would meet to negotiate a new agreement between the two parties. When negotiations conclude, management would present a recommendation to the Board of Directors to approve the newly negotiated Waters Edge Employee Association MOU, which is the same process for all of our current bargaining units.

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

Amendments to the Waters Edge Employee Association Handbook/MOU

The following are Amendments intended to modify the attached "Waters Edge Nursing Home Employee Handbook" ("the Handbook") (**Attachment 1**) in order to accurately reflect the wages, hours and other terms and conditions of employment of the non-exempt employees (excluding any "confidential" employees") of Waters Edge represented by the Waters Edge Employee Association.

Note: For ease of reference, these Amendments are listed in the order the subject appears in the Handbook.

Introductory Statement – Page 5:
Amend this section to replace "Waters Edge, Inc. (the "Company") with "The City of Alameda Health Care District, dba Alameda Hospital at Waters Edge (the "Hospital") and replace all references thereafter from "Waters Edge, Inc." and/or "the Company" to "the Hospital".

Right to Revise – Pages 7 & 8:
Amend this section by adding the following: "The Right to Revise section is subject to the obligation under California law (Meyers-Milias-Brown Act) of The City of Alameda Health Care District dba Alameda Hospital to bargain with the collective bargaining representatives of employees regarding their wages, hours and other terms and conditions of employment."

Classifications – Page 10:
Amend this section to add the current practice of requiring an employee to work 30 hours per pay period in order to be classified as a regular full-time or regular part-time employee and qualify for benefits (Handbook currently states 32 hours per pay period).
(Also reference this change in Insurance Benefits – page 27, third paragraph to state 60 hours rather than 64 hours printed in that paragraph.)

Basic Policies – Page 11:
Amend this section to add: "All employees are subject to the policies of the Company, modified only by any relevant language in the Waters Edge Employee Handbook/MOU."

Waters Edge Employee Association – Page 11:
Amend this section to add the following: "Upon the closing of the business transaction and subject to the receipt prior to that date of a petition signed by a majority of the non-exempt, non-confidential Waters Edge employees, and subject to that petition being verified by a neutral third party mutually selected by the Hospital and the Waters Edge Employee Assn., Alameda Hospital will recognize the Waters Edge Employee Assn. as the exclusive bargaining unit for all employees of Waters Edge, excluding any management employees and excluding "confidential employees," who are defined as 'an employee who, in the course of his or her duties, has access to information relating to the Hospital's administration of employer-employee relations.' Management and confidential employees will not serve as bargaining representatives of the Waters Edge Employee Association.

"The Hospital agrees that, subject to the satisfaction of the above conditions, as of the date of the transaction, the Hospital and the Waters Edge Employee Assn. will recognize the Waters Edge Employee Handbook, together with these Amendments and Attachments to the Waters Edge Employee Handbook, collectively, as the

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Memorandum of Understanding and as setting forth the initial terms and conditions of employment of the bargaining unit employees for up to one (1) year from the date of the closing of the Hospital's transaction with Waters Edge or until such earlier date when modified by mutual agreement between The City of Alameda Health Care District, dba Alameda Hospital and the Waters Edge Employee Association."

<u>Association Committee – Page 12:</u>
Amend third paragraph to add: "Members of the Association Committee shall not include any confidential employees, consisting of employees who have Human Resources or Payroll responsibilities."

<u>Jury Duty – Page 22:</u>
Amend this section to reflect continuous coverage by the Health/Dental/Vision plans for any covered employee while on Jury Duty (no requirement to extend coverage under COBRA at the employee's expense after 30 days).

<u>Insurance Benefits – Page 27:</u>
Amend reference in the third paragraph to working 60 hours per pay period to maintain eligibility for insurance benefits (document currently states 64 hours).
(Also reference this change in Classification of Employees – Page 10.)

<u>Company Provided Physician – Page 28:</u>
Amend this section to state "Alameda Centre Physicians" (instead of US Healthworks).

<u>Names and Addresses – Page 33:</u>
Amend this language to advise: "Under the California Public Records Act, the Hospital is obligated to respond to legitimate requests for information on all employees, including the release of wage information."

<u>Smoking – Page 36:</u>
Amend this language to incorporate the tenants of the City of Alameda Ordinance No. 3038 (see the City of Alameda Secondhand Smoke Ordinance Fact Sheet – **Attachment 2**).

<u>Payment of Wages – Page 52:</u>
Amend this language to exclude the $30.00 stop payment fee for a replacement pay check.

<u>Deductions for Exempt Employees – Pages 54-55:</u>
Amend to exclude this section (exempt employees are not represented by the Waters Edge Employee Association or covered by the MOU).

<u>Health and Safety - Page 57:</u>
Amend this language to advise that the Injury and Illness Prevention Program is available for review in the Administrator's office.

<u>Involuntary Termination and Discipline – Page 60:</u>
Amend to include reference to the Disciplinary/Counseling Report form – **Attachment 3.**

<u>Confirmation of Receipt – Page 1 of 1 (last):</u>
Amend to change reference to the "President" to "the Chief Executive Officer" (three places in second paragraph).

The preceding Amendments are intended to modify the attached "Waters Edge Nursing Home Employee Handbook" ("the Handbook" - Attachment 1) in order to accurately reflect the wages, hours and other terms and conditions of employment of the non-exempt employees (excluding any "confidential" employees") of Waters Edge represented by the Waters Edge Employee Association.

Mutually agreed upon on this 22nd day of Jul., 2012:

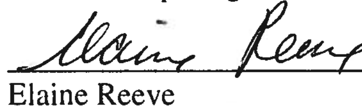
The City of Alameda Health Care District:
dba Alameda Hospital:

Richard Espinoza, Administrator
Long Term Care

Phyllis J. Weiss, Director
Human Resources & Ancillary Services

Waters Edge Employee Association:

Ma Elena Yparraguirre



Elaine Reeve

Sean O'Shea

Jonard Espinosa

Rolando Villanueva

City of Alameda
Secondhand Smoke Ordinance
Fact Sheet

To protect Alameda residents and visitors from the health hazards of secondhand tobacco smoke, the Alameda City Council has adopted a Secondhand Smoke Ordinance. The majority of the provisions take effect on January 2, 2012 and limits exposure to secondhand smoke in places of employment, public places, and multi-unit housing. This fact sheet provides a brief overview of the ordinance. Additional information, including a copy of the ordinance and free downloadable "No Smoking" signs is available on the City's website:
http://www.cityofalamedaca.gov/Residents/Secondhand-Smoke-Policies

Smoking is prohibited in the following places of employment not covered by California State Law:

- Hotel/Motel lobbies, meeting and banquet facilities
- Ninety percent (90%) or more of hotel/motel guest rooms
- Retail and wholesale tobacco shops, and hookah bars
- Taxi cabs, cabs of trucks, tractors, or other vehicles used for work
- Warehouse, theatrical production and medical research facilities
- Private residences licensed as child care, adult care, and health care facilities
- Small businesses with fewer than five employees
- Owner-operated businesses open to the public
- Outdoor worksites, including construction sites, arenas, and convention halls, or anywhere where working crews may be

Smoking is prohibited in the following outdoor public places:

- Dining areas: examples include outdoor seating at restaurants and other establishments serving food or drinks (*Bars with rear outside areas are excluded from the prohibition)*
- Public events: examples include farmers' markets, fairs, and concerts
- Recreation areas: examples include parks, trails, beaches, and sports fields
- Service areas: examples include bus stops, ATM lines, and movie lines
- Commercial-area sidewalks: defined as public sidewalks in downtown shopping and business areas designated with a "C" prefix on the City's official Zoning Map
- Shopping malls: defined as collection of retail or professional establishments and includes the public walkway or hall areas that serve to connect them
- Entryways (reasonable distance): defined as within 20 feet of doors, windows, and other openings into enclosed areas

Responsibilities of business owners, managers, and operators:

- "No Smoking" signs must be clearly and conspicuously posted at entrances to unenclosed dining areas where smoking is prohibited
- Remove all ashtrays and not allow in any area where smoking is prohibited
- Not knowingly allow smoking in prohibited areas

In multi-unit housing (defined as two or more units), smoking is prohibited as follows:

- 100% of new units of rental and common interest complexes (condos, co-ops, PUDs), including balconies and porches
- Common areas of rental and common interest complexes, except that designated smoking areas meeting certain criteria in outdoor common areas may be established
- Smoking within 20 feet of enclosed areas (smoking buffer zones)

Beginning on January 1, 2013, smoking will be prohibited inside the units of all rental and common interest complexes

Responsibilities of landlords and homeowners' associations:

- Clearly and conspicuously post "No Smoking" signs in common areas, at every entrance, and on every floor where smoking is prohibited
- Remove all ashtrays and or other receptacles for disposing of smoking material not allow from any area where smoking is prohibited, except for designated smoking areas
- If the option to have a designated outdoor smoking area is chosen, all requirements as described in the ordinance must be complied with.
- Not knowingly allow smoking in prohibited areas
- Disclose to prospective tenants and buyers the requirements of the Secondhand Smoke Ordinance, as it pertains to multi-unit housing
- All newly leased units in apartments after Jan. 2, 2012 shall include a non-smoking requirement in the lease or agreement for occupancy. By Jan. 1, 2013, all lease agreements for occupancy will state that smoking is prohibited inside units
- Maintain diagrams that illustrate the precise location of designated smoking areas, if applicable. This diagram must also accompany leases and rental agreements beginning January 1, 2013

Alameda Hospital

ATTACHMENT 3

DISCIPLINARY/COUNSELING REPORT

CITY OF ALAMEDA HEALTH CARE DISTRICT

Employee Name:______________________________ **Dept.:**_____________ **Date:**____________________
(Print please)

Date of Occurrence:__________ Time:______[ ]AM [ ]PM Location:______________________

ACTION TAKEN:

1) [ ] COUNSELING 3) [ ] WRITTEN WARNING 5) [ ] TERMINATION
2) [ ] VERBAL WARNING 4) [ ] SUSPENSION ___ day(s)

(Depending on the nature of the offense, Alameda Hospital reserves the right to advance discipline steps at the Hospital's discretion)

DESCRIPTION OF ISSUE:

[ ] ABSENCE* [ ] SAFETY VIOLATION [ ] OTHER________________
[ ] TARDINESS [ ] POLICY VIOLATION
[ ] CONDUCT [ ] SUBSTANDARD PERFORMANCE

Explanation (Please attach additional pages if needed):

____

____

Goals/Corrective Behavior:______________________________________

____

____

Should your record continue to be unacceptable in the above area(s), Alameda Hospital will find it necessary to take the following disciplinary action (or more depending on the severity of the situation):

[ ] WRITTEN WARNING [ ] FINAL WARNING [ ] SUSPENSION___day(s)
[ ] TERMINATION [ ] OTHER___________________________________

Employee Comments:______________________________________

____

____

This notice serves as your formal warning and to bring to your attention the severity of this situation(s). Failure to correct this behavior and/or violation of Alameda Hospital policy will result in additional disciplinary action up to and including termination. By signing the below you acknowledge that you have received this notice.

Signatures:

Employee (or Witness):_________________________________Date:_____________
Supervisor/Manager: _________________________________Date:_____________
H.R. Director: _________________________________Date:_____________

*Your record was checked to confirm you were not on an official leave status for any protected leave, prior to this counseling/discipline being administered. If you feel that your time off is under a protected leave, please contact Human Resources for details. If it is found that any of the time off was for reasons that would qualify as a protected leave, and that you were qualified for such a leave, the counseling/disciplinary action will be reconsidered on that basis.

(See Over)

DISCIPLINARY/COUNSELING REPORT

CITY OF ALAMEDA HEALTH CARE DISTRICT

ABSENCES

Alameda Hospital depends on it's employees in order to provide very good care for our patients and their families. Regular and dependable attendance and punctuality is an essential function of an employee's job and is required for continued employment. This establishes consistent guidelines for unscheduled absences and tardiness.

1. Protected Absence: Protected absences are defined as family medical leave; leave taken pursuant to the American with Disabilities Act; bereavement leave; time off to care for a bona fide illness of a parent, child, domestic partner, spouse; jury duty or witness service; an approved absence due to a work-related injury or illness; military leave; pregnancy related time off; pre-approved appointments; common holidays; and scheduled paid time off (PTO)/vacation.
2. Occurrence: Relates to how many "times" an employee missed scheduled work during a specific period. An occurrence includes partial days and leaving a shift early. The calculation of an occurrence does not consider the total number of days missed, but only counts the first day missed, should the person be absent for consecutive days.
3. Call-In Guidelines: It is every employee's responsibility to make sure their supervisor (or designee) is notified promptly about an unscheduled absence. Employees are required to contact their supervisor at least two (2) hours before the start of their shift, unless an emergency prevents such call.
4. General Guidelines for Unscheduled Absences

Number of Occurrences	Action
6 occurrences in a 12-month period	Counseling
8 occurrences in a 12-month period	Documented Verbal Warning
10 occurrences in a 12-month period	Final Written Warning
12 occurrences in a 12-month period	Termination

5. General Guidelines for Tardiness Occurrences

Number of Occurrences	Action
8 occurrences in a 12-month period	Counseling
10 occurrences in a 12-month period	Documented Verbal Warning
12 occurrences in a 12-month period	Final Written Warning
14 occurrences in a 12-month period	Termination

6. Patterns of Absences: Equally important as the number of days missed can be the manner in which the unscheduled absences occur. Below are several examples of "patterns" a supervisor/manager should look for in assessing whether or not the unscheduled absences may be a problem:
    a. Series of Friday, Monday or other days that follow a pattern
    b. Weekend absence(s)
    c. Days preceding or following holidays or scheduled days off
    d. Absent on days that were requested off, but could not be accommodated
7. Absence Note: An employee who has been sick for three (3) or more consecutively scheduled days must, upon return to work, give the Hospital a doctor's excuse for the absence.
8. SDI Integration: The Hospital with automatically integrate an employee's pay with State Disability Insurance (SDI) benefits. See Human Resources for any illness that extends beyond seven (7) days.

DATE: March 2, 2012

FOR: March 5, 2012 District Board Meeting

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

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: March CEO Report to the Board of Directors

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1. **Upcoming Events:**

CHA Legislative Day is being held in Sacramento on March 27-28. At least one member of the management team will attend and we would like to invite any member of the Board who is interested in joining us on March 28 for a legislative briefing and opportunity to meet our legislative representatives and/or their staff. It is customary for each CHA representative to discuss specific issues with our representatives that have been identified as having industry wide impact and upon which we are briefed on the morning of March 28. In addition, it is an excellent opportunity to strengthen our on-going relationship with the legislator and staff. If you are interested in participating, please let Kristen Thorson know.

State of the City briefing:

As a member of the Chamber of Commerce, the Hospital has been invited to participate in a briefing by City Manager John Russo on March 21 at 12 noon. The hospital is sponsoring a table of eight at the event which will be held at the Rock Wall Winery Dome. Again, let Kristen know if you would like to attend.

2. **District Hospital Leadership Forum:**

On February 15, I attended the Board meeting of the District Hospital Leadership Forum (DHLF), of which I am a member. Like CHA Legislative Day described above, this was not only a chance to discuss updates on issues specifically affecting the District Hospitals, but also an opportunity to brief legislators in the afternoon on issues and pending legislation. I met with a staff member of Assemblyman Swanson and with Senator Loni Hancock and her legislative director, Marla Cowan. Specifically, I updated Senator Hancock on our interest in expanding our Subacute capacity in the context of the growing shortage of subacute beds in the East Bay.

At the Board meeting, we learned that as a result of the injunctions filed by CHA against implementation of AB 97, reducing DP SNF reimbursement in our case by up to 25%, the State is not likely now to implement even the non-subacute DP SNF reimbursement cuts, originally slated to be retroactive to June, 2011. This means a pickup of about $180,000 more for us. In addition, we were notified last month, from our cost report firm, of a rate **increase** in our cost-based reimbursement for DP SNF from$385.74 to $416.95 per day effective August, 2011. We have not received the official letter from DHCS regarding the new rate.

While our cash position will be enhanced by receiving this higher rate retroactively and between now and August, 2012, we know that our new cost-based rate, with the addition of Waters Edge, is substantially lower (estimated at $325/day in our pro forma). Therefore we will book the difference between our interim and final reimbursement as a reserve against our net revenue.

The FY 2012 IGT process has begun for District Hospitals. The gross program amount for all California District Hospitals is $61 million with a net of $27 million. The estimated Alameda Hospital portion will be $800,000 gross and $580,000 net. The IGT amounts will be transferred to the State in March with the distribution of matching payments made in April, 2012.

DHLF is introducing legislation in 2012 to allow district hospitals to use certified public expenditures to access 2010 waiver funding in recognition of any uncompensated care they provide. Previously only public hospitals such as the County and the UC hospitals have had access to waiver funds. The legislation will be controversial since, if passed, could dilute the pool of waiver funds to the designated public hospitals.

3. **Revenue Cycle Project**:

The revenue cycle project continues to be the focus of a lot of management attention. While the facilitation of getting bills out the door has improved our cash collections markedly over the last month, this has been neutralized by impact of a slower processing and audits of billing by Medicare and MediCal. These two payors are a large proportion of billings that is in our collection pipeline. For example, almost $1.5 million in Medicare billings are tied up in Additional Data Requests, wherein Medicare payments are held pending the receipt of additional components of the patient chart. Medicare is questioning claims where there is not distinct order by a physician “to admit” the patient as an inpatient, even though the process and orders upon admission are documented in the chart. We educate our physicians, coders and discharge planners to improve their documentation as we identify the issues Medicare is questioning. However, this does mean cash collections from payors who pay regularly on an electronic basis are now coming in slower. This is a phenomenon experienced by all hospitals. We have established a well defined system to track our claims undergoing a RAC review at each stage of the review. We look at these statistics weekly and again

give staff feedback on the trends with the issues being raised. We currently have $4.7 million in gross billings under RAC review; $470,000 in net revenue has actually been taken back by Medicare, thereby reducing our net revenue year to date. Even the later claims however are being appealed by the hospital if we feel there was an appropriate level of care provided and billed.

This month we also began a comprehensive review of our charge description master, including associated billing codes. Not only is this an important effort since the payors regularly update the codes associated with certain procedures, but we are also verifying our charges are reflective of our costs and cover all the services and products, such as implants, we provide.

4. **Long Term Care Development and Waters Edge Transition:**

Since Richard Espinoza has joined us as our Long Term Care Administrator we have joined an internet-based service, Allscripts, which tracks both bed availability and patients needing placement in SNF's from acute care. This tool will vastly improve our process for maintaining waiting lists for our SNF and subacute beds. In the last month, our census at South Shore has grown over 10%; 38% of our total census at South Shore is Medicare, which attests to our ability to serve the short term stay post acute patients.

On February 13, we received approval of the amendment of the hospital license with the addition of 120 beds at Waters Edge. However, the transfer of the operation ("transition date") will only commence upon notification that CMS has certified the beds, thereby making us eligible to receive payment of services. We expect that notification within the next couple of weeks.

We have held additional meetings with all Waters Edge staff, all of whom have been processed to be transferred to our payroll as of the transition date. With the exception of a handful of employees who were leaving the organization to pursue further education or are remaining with the Zimmerman network of facilities, all Waters Edge staff qualified for hire by Alameda Hospital. The employment process has gone very smoothly.

We also held additional meetings with residents and their families to discuss transition. A higher number of self-pay patients, approximately 15 patients, are choosing to remain at Waters Edge despite the increased room rates necessitated by our cost-based Medi-Cal rate. This is higher than expected and higher than we experienced during the South Shore transition. Many of the self-pay patients have chosen to stay because they are close to spending down their assets in order to be Medi-Cal eligible.

Mr. Espinoza regularly participates with the Waters Edge leadership in morning patient rounds in order to be thoroughly familiar with the Waters Edge residents and families at the time of transition. The Zimmerman's have also been generous

with their time, meeting with us to go over the myriad of details necessary to finalize the transaction.
Richard is completing a plan to make a number of modest renovations to the interior space; a new sign "Alameda Hospital at Waters Edge", also indicating that a physician is not on duty, has been ordered. The current census at Waters Edge is 91, very close to the number projected at the start of our pro formas.

We met this week with representatives from Kaiser to discuss continued service to their patients, either as Kaiser beneficiaries or who covered by Medi-Cal once they become custodial, but are still seen my Kaiser physicians. All those physicians are already on our medical staff. Given our intent to augment staffing numbers and skills, we anticipate being able to care for more Kaiser patients on a **post acute** basis, a category of resident that Waters Edge did not historically serve.

At my request, the Medical Staff is planning to form a new committee to oversee policies, procedures and monitor quality of care in each of our three long term care areas. Given that 64% of our licensed bed capacity and 77% of our average patient census will be long term care, we feel it is important that these services receive an appropriate focus by the medical staff.

5. **<u>Wound Care Clinic:</u>**

Since the receipt of approval from the Bank of Alameda for the construction loan for the Wound Care program, we have signed the contract with the general contractor, Rossi Builders. Construction is expected to commence in mid-March and take approximately four months.

We have been interviewing candidates for the Program Director and the Clinical Manager. Both of these will be Accelecare employees but it is essential that they be a good fit with our organization integrate into the hospital management team just as other "outsourced" service managers do.

Seven physicians have completed an introductory Wound Care training course. One physician has attended the week-long management training course. The remaining physicians will be scheduled to attend during the months of April, May and June. An educational session to which all interested physicians were invited was held on February 29, 2012. Interviews for the Medical Director, who will be under contract with the hospital, are expected to begin in April. We expect there will be multiple applicants for this role from the hospital medical staff.

Marketing

One of the responsibilities of the Program Director, whose employment will commence approximately 90-days prior to opening, is to be involved in marketing and developing physician referrals. The Director will work closely with Louise

Nakada, Director of Community Relations, on marketing activities beginning in April 2012.

6. February Statistics:

	February Preliminary	February Budget	% Δ compared to Budget	% Δ compared to January	January Actual
Average Daily Census	86.59	88.28	-1.9%	1.9%	84.94
Acute	35.07	32.21	8.9%	6.1%	33.06
Subacute	32.79	33.00	-0.6%	-1.0%	33.13
South Shore	18.72	23.07	-18.8%	-0.1%	18.74
Patient Days	2,511	2,560	-1.9%	-4.6%	2,633
ER Visits	1,382	1,334	3.6%	-6.2%	1,473
OP Registrations	1,854	1,918	-3.3%	-4.1%	1,933
Total Surgeries	174	164	6.1%	15.2%	151
Inpatient Surgeries	58	44	31.8%	28.9%	45
Outpatient Surgeries	116	120	-3.3%	9.4%	106
Case Mix Index	1.3544				1.4123

**Reported as of 03/12/212*

DATE: March 1, 2012

FOR: March 5, 2012 District Board Meeting

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Senate Bill 90 - Seismic Extension Application

This informational memorandum is to provide the City of Alameda Health Care District, Board of Directors an overview of Senate Bill 90 (SB90). SB 90 is new legislation that provides an opportunity for hospitals to receive up to a seven year extension to the current January 1, 2013 seismic compliance deadline. We want to inform the District Board of the key components of this new regulation and provide a summary with important dates and milestone of Alameda Hospital's extension application.

Senate Bill 90:

Senate Bill 90 is a modified Risk-Based Extension for a non compliant building up to a total extension of seven (7) years from the current January 2013 compliance deadline, based on consideration of Community Access to essential hospital services and Financial Hardship.

Upon approval of the submitted application, Office of Statewide Health Planning and Development (OSHPD) can grant up to a two year Administrative Extension while the hospital's application for an extension is being reviewed by OSHPD.

Application must be submitted to OSHPD no later than March 31, 2012. All non compliant building (SPC-1), must also have a HAZUS collapse risk assessment performed and submitted to OSHPD no later than September 30, 2012. This risk assessment provides information to OSHPD regarding the structural integrity and occupancy of each building. This risk assessment must be complete even if the basis for the extension is based on being a Critical Community Provider or based upon Financial Hardship.

Provided the definitions in the extension regulation, Alameda Hospital will be requesting an extension based upon both the Critical Community Provider and Financial Hardship criteria.

The next milestone in the Regulation is January 1, 2015. By this date, hospitals must have construction plans submitted to OSHPD ready for their review. In addition, the construction documents must be accompanied by a financial report that demonstrates the hospital owner's financial capacity to implement the construction plans submitted.

The next milestone is July 1, 2018 by which date, the hospital owner receives a building permit and is ready to begin construction work.

Hospitals must comply with their approved extension timeline. If for some extenuating circumstance the hospital realizes that it will not meet a schedule milestone, it must notify OSHPD at that time to review and discuss such circumstance.

Determination of Extension Eligibility:

A hospital may be eligible for an extension based on considerations of the factors described above (Critical Community provider, Financial Hardship and Risk Based Extension). These factors shall be considered together to determine the extension on a case by case basis. In no case shall the extension be longer than that required to complete the implementation plan and schedule provided and approved. The maximum allowed extension is seven (7) years to January 1, 2020.

Alameda Hospital Application:

Alameda Hospital will be applying on the on its eligibility under both the Critical Community Provider and Financial Hardship criteria. We will be submitting all of the required supporting documentation outlined in the regulation to support our qualification for an extension under these criteria.

The Hospital actually began working on its seismic construction plans back in 2010. The project was submitted in June 2010 and is comprised of four increments to be reviewed by OSHPD. Two of the four increments have been approved and the remaining two are close to being approved. *(One of the remaining increments is for additional materials testing in the Stephens Wing. This project has been approved, but needs to have the testing complete. This data will be used to complete OSHPD's approval of the final increment).*

Given that we have already advanced preparation of the construction plans, much of our extension request focuses on the need for additional time to secure the funding necessary to finance the construction work and the importance of Alameda Hospital in the community.

The following is a summary of the key milestone dates that we are requesting in our extension application:

Alameda Hospital – Stephens Wing (Building #02)
First Floor Renovations – SPC 2 Upgrade (IS 101131-01) Increment #1 & #2
Facility # 11210

TASKS	START	FINISH	DURATION	COMMENTS
Geotechnical Report	-	-	-	Complete
A/E Design	-	-	-	Complete
Local Approvals	-	-	-	Complete
Office Review, Approval & Permit	06/01/2010	01/01/2015*	54 months	-
CDPH Licensing and Certification	N/A	N/A	N/A	-
Permanent Relocation	N/A	N/A	N/A	-
Temporary/Interim Relocation	N/A	N/A	N/A	-

TASKS	START	FINISH	DURATION	COMMENTS
Public Bid Process	01/01/2015	06/30/2015	6 months	-
Construction	07/01/2015	06/30/2017	24 months	-
Beneficial Occupancy	07/01/2017	09/30/2017	3 months	-

Note: Increment #1, pending minor back checks and materials testing. Requesting permit date of 01/15/2015.
Note: Increment #2, OSHPD approval (12/16/2011) but no permit as of this date.

Alameda Hospital – Original Hospital (Building #01)
Decommissioning Building
Facility # 11210

TASKS	START	FINISH	DURATION	COMMENTS
Geotechnical Report	N/A	N/A	-	
A/E Design	N/A	N/A	-	
Local Approvals	06/01/2017	12/31/2017	6 months	
Office Review, Approval & Permit	N/A	N/A	N/A	
CDPH Licensing and Certification	06/01/2017	12/31/2017	6 months	
Permanent Relocation	10/01/2017	12/31/2017	3 months	
Temporary/Interim Relocation	N/A	N/A	-	
Construction	N/A	N/A	-	
Beneficial Occupancy	N/A	N/A	-	

The Hospital has engaged Thorton Tomasetti, a structural Engineering firm that has been part of the seismic planning team to complete the application and data submission for the HAZUS collapse risk assessment by September 30, 2012 as required.

We anticipate that if this plan is accepted by OSHPD that we will be meeting with them sometime during the next year to discuss the compliance time frames requested in our application and obtain an approved extension for Alameda Hospital.

DATE: February 29, 2012

FOR: March 5, 2012 District Board Meeting

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approach to Assessing Management Options and Opportunities of Rehab Services at Alameda Hospital

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For the past several years, the Rehabilitation Services Department has been managed, along with the Respiratory Therapy Department, by our Director of Respiratory Care Services. This consolidation was done in part, to reduce budgeted expenses of these two departments. However, running an effective Rehab Service, complimenting outpatient and long-term care, needs leadership with more depth of knowledge about this specialized service line. We have received feedback from clinical managers on the long term care units that such knowledge and leadership could be improved. Given the time requirement and service specific experience that is required to properly manage these two distinct services, management believes that department specific management is needed at this time in order for the Rehab Services to achieve its clinical and financial potential.

We have been looking at different management options for the past several months. We have had meetings with employees of the Rehab Services and with members of the Medical Staff to solicit their input on their perceived needs in management. We will take their thoughts and ideas into consideration as part of our recommendation.

The type of leadership skills needed for our Rehab Service Department are somewhat unique in that we have four very distinct patient types that we provide care for: inpatient acute, outpatient, subacute residents and long-term custodial / post acute residents at South Shore Skilled Nursing Facility. Each of these service areas requires a distinct approach to how rehab services are provided in order to meet the needs of the patients/residents. Effective leadership and understanding of the nuances of each is important in order to implement the best clinical protocols, training and staff education, policy & procedures, and efficiencies required to achieve positive financial results. A professional management company that has experience with each of these types of programs and who has a proven track record is key to the success of this type of program.

We will also look at the financial performance and potential growth opportunity of our Rehab Services Department. The Hospital's Finance Department will develop a base line profit and loss statement for this service. The analysis will also look at growth scenarios especially within the realm of outpatient and skilled nursing service lines to understand

what new revenue opportunity may exist. One of our primary goals of restructuring management is to improve operational efficiency (productivity) of the department based upon current activity levels, while concurrently expanding these services in a way that will make the department and the hospital more profitable. Once again, this will require knowledgeable and experienced management in the department.

Lastly, we want to consider the future program development goals of the Hospital. One key component of the Hospital's Strategic Plan has been to increase the amount of orthopedic surgery performed at the Hospital. An essential component of a comprehensive orthopedic program is a strong rehabilitation service program to support the physicians and their patients in order to have the best outcomes possible. Knowledgeable and experienced management over rehab services will also be essential to make this happen.

We will be prepared to present our analysis and recommendation at the March 28, 2012 Finance and Management Committee and at the April 2, 2012 District Board meeting that incorporates all of these considerations.