✓Included in the PDF posted October 4, 2013
CLICK ON THE ORANGE ENCLOSURE LINK TO GO
DIRECTLY TO THE AGENDA ITEM MATERIALS IN THIS PDF

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

WEDNESDAY, OCTOBER 9, 2013

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) — J. Michael McCormick

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes

1. September 4, 2013 (Regular)

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

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

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

F. Consultation with Legal Counsel Regarding Pending and Threatened Litigation — Gov't Code Sec. 54957.6

G. Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions — Gov't Code Sec. 54956.9(a)

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

I. Adjourn into Open Session

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

A. Announcements from Closed Session — J. Michael McCormick

VI. General Public Comment

VII. Regular Agenda

✓Included in the PDF posted October 4, 2013
CLICK ON THE ORANGE ENCLOSURE LINK TO GO
DIRECTLY TO THE AGENDA ITEM MATERIALS IN THIS PDF

A. Consent Agenda **ACTION ITEMS**

✓ 1) Approval of September 4, 2013 Regular Meeting Minutes [enclosure] (pages 3-8)

✓ 2) Approval of Proposed Amendments to Medical Staff Bylaws [enclosure] (pages 9-12)

B. Special Presentations | Education Sessions

1) Bay Area Bone and Joint Center Presentation

- James DiStefano, MD, Nicholas Prinia, MD

2) Patient Centered Experience Committee Report and Follow-Up on HCAHPS

- Clint Barnes, RN, Mary Pat Skropeta, Louise Nakada

C. Action Items

✓ 1) Acceptance of August 2013 Unaudited Financial Statements and September 26, 2013 Finance and Management Committee Report [enclosure] (pages 13-36) — Robert Deutsch, MD; Kerry Easthope

C. District Board President's Report INFORMATIONAL — J. Michael McCormick

D. Community Relations and Outreach Committee Report INFORMATIONAL — Jordan Battani

1) September 24, 2013 Committee Report

E. Medical Staff President Report INFORMATIONAL — Emmons Collins, MD

F. Affiliation Updates INFORMATIONAL — Deborah E. Stebbins

1) Due Diligence | Transition and Transaction Planning Update

2) Report on Communication and Community Input Plan

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

✓ 1) Monthly CEO Report [enclosure] (pages 37-53)

- Affiliation Plan Update, Status of Communication Plan regarding Affiliation, Legislative Update, Supplemental IGT Funding, District Hospital Leadership Forum (DHLF) Update, Joint Commission Stroke Survey, Quality Management Update, Get With The Guidelines® Heart Failure Gold Plus Quality Achievement Award, Bay Area Bone and Joint Center, Community Relations & Foundation Update, Information Technology Update and Meaningful Use, August Preliminary Statistics, Covered California Resources

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
Wednesday, September 4, 2013 Regular Meeting

Board Members Present	Management Present	Legal Counsel Present	Guests
Jordan Battani Lynn Bratchett Robert Deutsch, MD Tracy Jensen	Deborah E. Stebbins Kerry Easthope Richard Espinoza Bruce Matthias Tony Corica	Thomas Driscoll, Esq. **Medical Staff Present** Emmons Collins, MD	**Excused** J. Michael McCormick
Submitted by: Kristen Thorson, District Clerk and Sheroza Haniff, Administrative Receptionist			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:07 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present, excluding the presence of Director McCormick.	
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 6:08 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 Deustch stated the Board reviewed and accepted the Board Quality Committee Report and Minutes of August 7, 2013. Additional topics of discussion in the Closed Session included pending litigation, labor issues and trade secrets. Director Deustch noted the active involvement the Board has with Management to ensure an affiliation with Alameda Health System in the future.

VI. **General Public Comments**

There were no public comments.

Topic		Discussion	Action / Follow-Up
VII.	**Regular Agenda**		
	A.	Consent Agenda	Noting the pending corrections, Director Bratchett made a motion to approve the Consent Agenda. Director Jensen seconded the motion. The motion carried.
		1) Approval of August 7, 2013 Regular Meeting Minutes Director Battani requested corrections to be made to the minutes that had been given to the District Clerk.	
	B.	Action Items	
		1) Acceptance of July 2013 Unaudited Financial Statements and August 28, 2013 Finance and Management Committee Report. Director Deutsch reported a net operating loss of $384,000 against a budgeted loss of $301,000 for the month of July. due to lower inpatient/outpatient volume and higher than budgeted expenses, despite expenses being lower in previous months. A request for change in committee meeting dates was made by Director Bratchett due to conflicting schedules. After discussion, the Board agreed, the Finance and Management Committee will be held on the last Thursday of each month through the end of calendar year 2013. Mr. Easthope noted exceptions would be made to the dates falling on or around a holiday and requested to present the November Financials at the January 2014 Board Meeting to avoid a delay in discussion. The new Finance and Management Committee are listed below. • September 27, 2013 • October 31, 2013 • November 21, 2013 • No meeting in December • January 30, 2014 Ms Stebbins and Director Battani stated forthcoming meeting dates should not be scheduled on major non-federally observed holidays or dates local schools hold events as to comply with the needs of any community members who would like to attend Board meetings. The District Clerk will take this into consideration when proposing future dates District board meetings, committee meetings and special meetings.	Director Bratchett made a motion to accept the July 2013 Unaudited Financial Statements and August 28, 2013 Finance and Management Committee Report. Director Battani seconded the motion. The motion carried.
		2) Acceptance of FYE June 30, 2013, 4th Quarter (Year End) Goals and Objectives Update.	Director Battani made a motion to accept the June 30, 2013, 4th Quarter

Topic		Discussion	Action / Follow-Up
		Ms. Stebbins presented 4th Quarter, Year End Goals and Objectives report as found in the Board packet on pages 35-44. Ms. Stebbins highlighted key accomplishments under each of the six pillars of the strategic plan; Financial Strength, Growth, Facilities and Technology, Physicians, Quality and Service, and People. Overall, performance fell short in the financial goals, but some specific areas of Net Revenue increased, Water's Edge did exceed its Proforma Annual Net Income goal, netting $3,441,585 an increase of 41.25% over goal. Director Battani noted the impressive performance of the program. Performances in the Orthopedic Proforma Annual Net Income were attributed to the delayed start of the program. Billing and collection issues resulted in Wound Care not meeting its targets. As a result, management is working with Accelecare to improve collections. Director Battani questioned if the performance was solely dependent on billing and collections. Mr. Easthope stated Wound Care's supply expenses, revenue issues and over time expenses as contributing factors. Ms. Stebbins stated management is attempting to recoup the cost of supplies through better billing and collections going forward. Cash Collections at or Above Actual Net Revenue fell short of the baseline goal of $73.6 M, netting $72.1M, however Ms. Stebbins noted removing the TriCare billing adjustment would have increased our Net Revenue to an amount closer to the goal. Director Jensen questioned if cash collections were up to date, Ms. Stebbins stated our collections were up to date. Securing financing to cover for short term capital needs was accomplished through Foundation funding and collaboration with AHS on the affiliation Letter of Intent. There was an increase in annual acute net revenue, which surpassed its baseline goal of $16.2 M by 27.7%. South Shore also surpassed its Medicare A net revenue goal, reaching $684.21 per Medicare A day, a 41.25% increase. Director Battani questioned if the increase of acute commercial net revenue was related to the improvement of payer mix. Ms. Stebbins responded that the private payer mix has remained constant, but rates have changed. Director Battani noted the impressive performance. Other goals that were met pertained to the implementation of Kate Creedon Center for Advanced Wound Care, partnership discussions, outreach to the Asian residents from on and off the island, the transition of Water's Edge, making progress on the NPC2 and Sprinkler project, developing a plan for the leased space at Marina Village, setting technological proficiency goals amongst management, an increase volume of visits to the Orthopedic Program, establishing a baseline to measure satisfaction and improvement in hospital-physician relationships and the effectiveness of the Board Quality Committee structure, specialists recruitment, and the implementation of new	(Year End) Goals and Objectives Update. Director Bratchett seconded the motion. The motion carried.

Topic		Discussion	Action / Follow-Up
		program specific websites. Ms. Stebbins also reported on positive attendance of the employee Town Halls regarding the affiliation with AHS, the development of the hospital wide Rising Star Recognition Program for outstanding performance by an Alameda Hospital employee and the implementation of the Cheer Card rotation by the Executive Team. Ms. Stebbins also discussed a culture of accountability that has been in development. Director Jensen requested clarification on the struggle to increase coverage in primary care to five days a week at the1206 (b) Clinic. Mr. Corica, Director of Physician Relations stated one Primary Care Provider is no longer associated with Alameda Hospital and therefore the clinic has been short one primary care provider for the majority of the fiscal year. Possible replacement options are to hire a Nurse Practitioner or a part time another primary care physician.	
		3) Approval of FY 2014 – Six (6) Month Goals and Objectives Ms. Stebbins reviewed the Goals and Objectives for FY 2014, developed by the Executive Staff. She referred to the draft on pages 45-49 of the Board packet. There was a focus on key areas that affect service and operations as well as financial performance for the 6 months of the FY 2014 Budget as well as key areas related to the affiliation with Alameda Health System (AHS). Ms. Stebbins admitted that not all goals were as measurable as prior year goals, but she and the executive team felt that focus on these areas would help achieve the 6 month budget goals as well as a successful affiliation with AHS. Director Battani suggested that the goals be reviewed again and be revised as needed to include only goals that needed Board level scrutiny. She also requested volume information for the 1206(b) Clinic, to monitor the volume performed by the newly recruited General Surgeon. Director Deutsch suggested a review of expenses and reimbursement be performed for Wound Care program and to research cheaper and effective options in materials to help reduce expenses. Director Battani inquired about increasing the net to gross collections to 1.5 % and if that will solve the problem. Mr. Easthope stated that the 1.5% increase is what we should be collecting based on the overall payor mix and reimbursement. Ms. Stebbins added that it needed to be looked at in conjunction with e expenses. She reminded the Board that the new programs would still be track in the monthly financial statements. Director Battani referenced the long term goal of completing the EHR system selection for Long Term Care, stating it should be coordinated with AHS during the affiliation. Ms Stebbins stated the plan was to do so in conjunction with AHS. There was discussion regarding the EHR development, attestation and strategic planning fro integration of IT systems through an affiliation.	Subject to changes as requested by the Board, Director Jensen made a motion to approve the FY 2014 – Six (6) Month Goals and Objectives. Director Bratchett seconded the motion. The motion carried.
	C.	District Board President's Report	No action taken.

Topic		Discussion	Action / Follow-Up
		No report was made.	
	D.	Community Relations and Outreach Committee Report Director Battani reported the major announcements pertaining to the Community Relations and Outreach Committee were mentioned in the CEO Report. Director Battani also noted the need for sponsors for the Annual Foundation Fall Gala.	No action taken.
	E.	Medical Staff President Report Dr. Collins announced the CME programs for September: a discussion on plant based diets and effects on coronary artery disease (09/10/2013) and a discussion on colon rectal cancer management (09/24/2013).	No action taken.
	F.	Chief Executive Officer Report Affiliation Updates Ms Stebbins briefly discussed activities pertaining to the affiliation with AHS noting that the An aggressive communication plan which consisted of many community forums with positive feedback overall. The progression of the due diligence process has consisted of submitting information at AHS's request. The Steering Committee, consisting of key executives from both organizations, has been meeting frequently. Integration teams have been working toward a goal of establishing a bridge contract to obtain services prior to the affiliation in Surgery and Medical Inpatient Services. CEO Report Ms. Stebbins briefly reviewed the Chief Executive Officer Report, noting a correction of page 51 of the Report; 11 surgeries were performed by Bay Area Bone and Joint in August and not 5 as stated. She stated Wound Care and Long Term Care did well, with ER volumes below budget for the month. Director Jensen requested clarity of the communication plan in regards to the Review of the Telephone poll. Ms Stebbins stated the telephone poll was presented at a number of forums, as it conveyed the community support for the hospital. No additional surveys have been completed.	No action taken.
VIII.		**General Public Comments** No comments.	
IX.		**Board Comments**	

Topic	Discussion	Action / Follow-Up
	No comments.	
X.	**Adjournment** Being no further business the meeting was adjourned at 9:02 p.m.	

Attest:

J. Michael McCormick
President

Tracy Jensen
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: October 3, 2013

For: October 9, 2013 District Board Meeting

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

From: Emmons Collins, MD
President, Alameda Hospital Medical Staff

Subject: Approval of Proposed Amendments to Medical Staff Bylaws

---

RECOMMENDATION:

It is recommended that the Board of Directors approve the proposed amendments to the Medical Staff Bylaws as set forth on the enclosed attachments.

BACKGROUND:

The first of the two proposed amendments is to the section entitled "Definitions." If approved, electronic mail will be considered a legitimate form of communication unless the bylaws specify that the communication be sent certified or registered mail.

The second proposed amendment is to Article III, "Categories of the Medical Staff." Tremendous changes have taken place over the years in the ways in which physicians choose to serve patients and interact with hospitals, including Alameda Hospital. Many of our Medical Staff members are actively and substantially involved in supporting the mission of Alameda Hospital and the Medical Staff through admissions, referrals, consultations, service on Hospital and Medical Staff committees, providing continuing medical education and serving as speakers on behalf of the Hospital at community functions. It is important that a member's involvement be reflected by an appointment to the appropriate staff status category. The amendment, if approved, will:

1) increase the length of appointment on the Provisional Staff to two (2) years. This corresponds to the length of appointment for members on the Courtesy and Active Staffs and

2) define the expectations of practitioners appointed to the Medical Staff, regardless of category, in order for the Medical Staff to satisfy its responsibilities for delivering quality patient care.

Finally, it is important to recognize that category assignment will have no impact on the assignment of hospital privileges.

In accordance with Article XI, the Medical Executive Committee respectfully requests your consideration in approving the proposed amendment to the Medical Staff Bylaws.

ALAMEDA HOSPITAL

MEDICAL STAFF

PROPOSED AMENDMENT TO MEDICAL STAFF BYLAWS (10/13)

ARTICLE/SECTION	*TITLE*	*STATUS*	*REFERENCE*
--	**Definitions**	***Revision***	**None**

In the **Definitions** section, revise the definition of "Date of Receipt" as follows:

5. Date of Receipt means the day any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice or communication was **either : (a)** deposited, postage prepaid, in the United States mail **or (b) sent by electronic mail.**

   Then add the following new definition and renumber the remaining definitions:

9. **Mail** means first class United States mail or electronic mail; provided, however, that if these bylaws specify certified or registered mail, "mail" shall not include electronic mail.

(Note: this amendment was not approved until 10/13)

ALAMEDA HOSPITALMEDICAL STAFF

PROPOSED AMENDMENT TO MEDICAL STAFF BYLAWS (10/13)

ARTICLE/SECTION	*TITLE*	*STATUS*	*REFERENCE*
Article III **Sections 1.1 & 1.2**	**Categories of the Medical Staff**	***Revision***	**None**

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be recommended by the Medical Executive Committee for final action to the Board and shall be to one (1) of the following categories of the staff. Changes in medical staff category not requested by the member shall not be grounds for a hearing unless such change adversely affects the member's privileges.

1.1 PROVISIONAL STAFF

The Provisional Staff shall consist of those currently licensed physicians, dentists and podiatrists who have met the initial requirements for appointment as defined in Article VI. Provisional Staff appointment shall be for a period of not less than ~~one~~ two years. Each appointee to the Provisional Staff shall be a person of demonstrated competence who agrees to assume certain functions and responsibilities of appointment, including, where appropriate, patient care, emergency service care, consultation and teaching assignments. Persons appointed to the Provisional Staff shall not be entitled to vote at any general or special meeting of the medical staff, hold office or serve as chairman of medical staff committee, but may serve as members on Medical Staff committees. Provisional Staff members must provide call coverage to the emergency department on a fair and equitable basis with other members of the same specialty, unless excused from such obligation by the Medical Executive Committee.

1.2 ACTIVE STAFF

The Active Staff shall consist of those currently licensed physicians, dentists and podiatrists who: (a) regularly care for patients in the hospital or (b) maintain an active medical practice in the Alameda Healthcare District. Each appointee to the Active Staff shall be a person of demonstrated competence who agrees to assume all the functions and responsibilities of appointment to the Active Staff, including, where appropriate, patient care, proctoring, emergency service care, consultation and teaching assignments. These requirements may be modified by the Medical Executive Committee in special circumstances. Persons appointed to the Active Staff shall be entitled to vote, to hold office, to serve on Medical Staff committees, and serve as chairmen of such committees. They shall be required to attend Medical Staff meetings. [Active Staff members must provide call coverage to the emergency department on a fair and equitable basis with other members of the same specialty, unless excused from such obligation by the Medical Executive Committee.]

1.3 COURTESY STAFF (No changes proposed)

The Courtesy Staff shall consist of currently licensed physicians, dentists and podiatrists who have demonstrated competence qualified for staff appointment under Part A of Article VI, only occasionally use the hospital and have completed their provisional period. They shall not be entitled to vote or to hold office and need not attend Medical Staff meetings, but may serve on Medical Staff committees and vote on matters before such committees. Courtesy Staff members are strongly encouraged to be on the Active Staff or be in the process of acquiring Active Staff Status at another hospital.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING August 31, 2013

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
AUGUST 31, 2013

Table of Contents **Page**

ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
AUGUST, 2013

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 August 31, 2013 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

Overall for the month of August, the second month of fiscal 2014, the hospital experienced a combined net operating loss of $399,000 against a budgeted loss of $121,000. This loss is driven again by the lower acute census so it is encouraging to see the acute census has climbed back up in September. Waters Edge had a positive net contribution of $138,000 this month.

August discharges were 215, which was 46 or 17.5% below budget, and total patient days were 6,066 or 49 (0.8%)% greater than budget. With the lower discharges and higher patient days, the acute ALOS increased from prior 3.6 in the prior month to 4.03 in the current month. Total patient days for inpatient acute services were again down 14.1%; subacute days were up 4.6%, skilled nursing days were up at South Shore by 1.9% and Waters Edge were up by 3.7%.

Overall outpatient activity was mixed again this month. Outpatient registrations were down 10.5% ,Emergency Room visits were 226 or 15.0% below budget. Outpatient surgeries were below budget for the month by 23 or 16.1%.

The Wound Care program had 459 visits in August compared to a budget of 350, or 31.1% above budget. In August there were 78 HBO treatments compared to 84 in July.

Total gross and net revenue in August was consistent with activity. The overall inpatient component was below budget by 4.4% (driven again by the lower acute census) and outpatient was below budget 7.8% (driven by lower outpatient and emergency room registrations).

The overall Case Mix Index (CMI) in August was 1.2611, below the prior month and also below the FY 2014 average of 1.2936. Total expenses were just over $7.0 million in August, which is $230,000 or 3.2% below budget.

Rents and leases were over budget while salaries, temporary agency, benefits, professional fees, supplies and purchased services were under budget. All other categories were close to budget. Please see the Expense section for futher explanation of the expense variances.

Cash and cash equivalents were $5.2 million at the end of August, down from prior month due to the timing of three payrolls hitting in August. Cash collections in August were lower than the previous month high but still strong at just over $6 million, consistent with recent net revenue numbers.

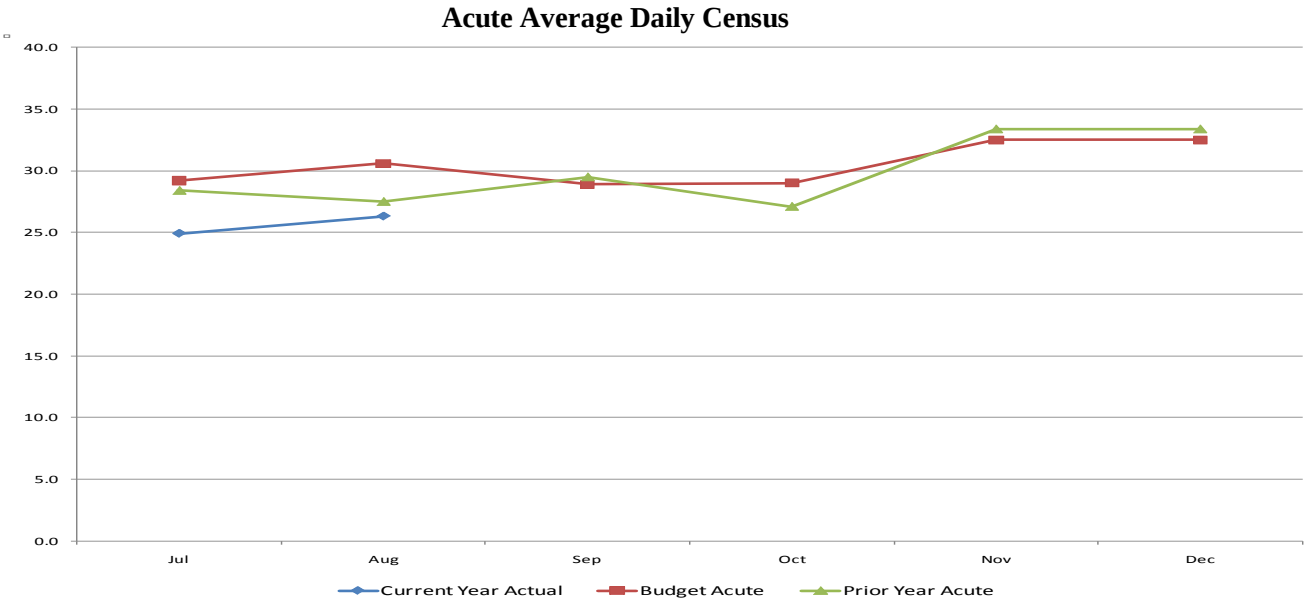
Lastly, the current ratio dipped to .86 below the required 1.0 of our bank covenants. Net Assets also dropped slightly to almost $4.0 million.

ACTIVITY

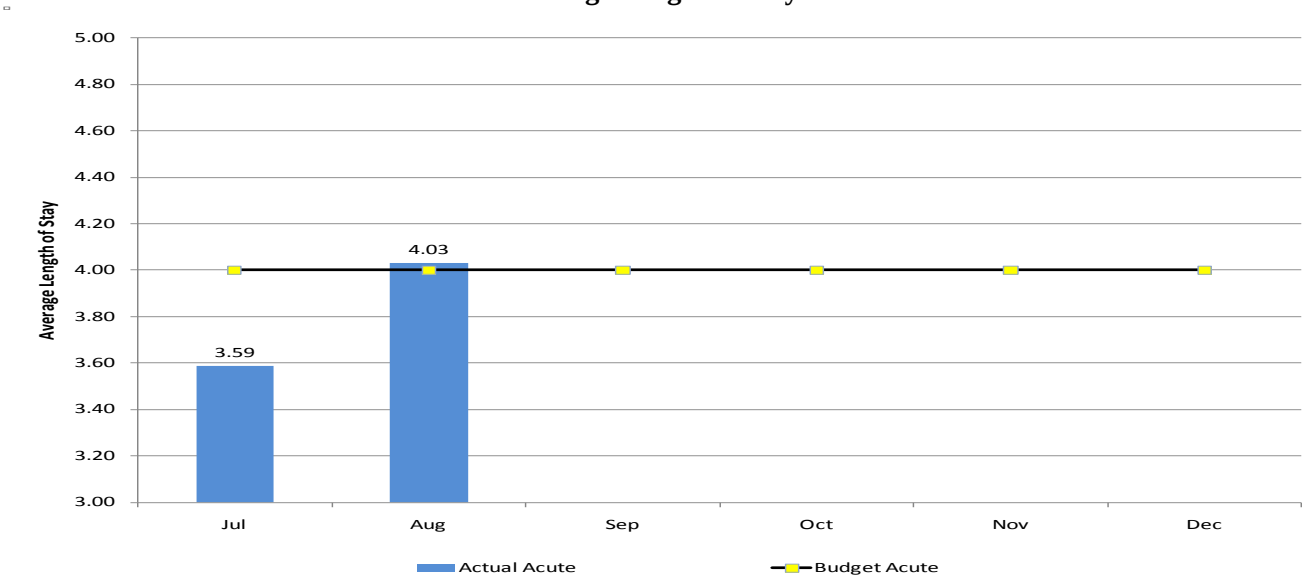
ACUTE, SUBACUTE AND SNF SERVICES

Overall, patient days were 0.8% above budget for the month and above August of last year. This month's acute days were below budget by 14.1%, Subacute was up 4.6%, South Shore was up 1.9% and Waters Edge was up 3.7%.

August's acute patient days were again 134 days or 14.1% lower than budget for the month and 4.6% lower than August 2012. Contributing to the lower acute census was that 3 West (our Med/Surg unit) was closed for 11 days during August. The acute care program is comprised of the Critical Care Unit (3.8 ADC, 12.0% below budget), Telemetry / Definitive Observation Unit (14.1 ADC, 17.4% above budget) and Med/Surg Unit (8.4 ADC,14.1% below budget).

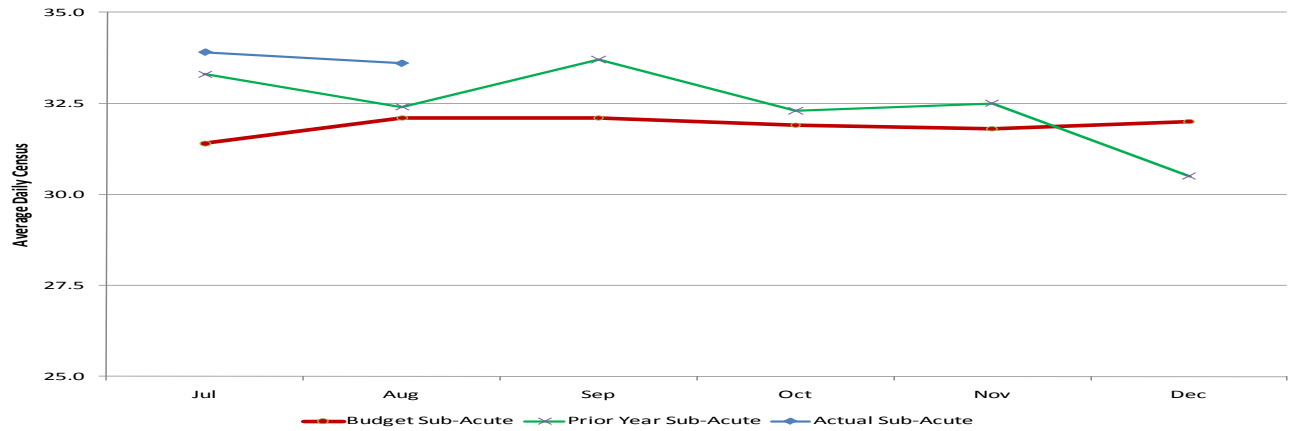


The acute Average Length of Stay (ALOS) increased from 3.59 in July to 4.03 in August and is just above the budget of 4.00. The graph below shows the ALOS by month compared to the budget.



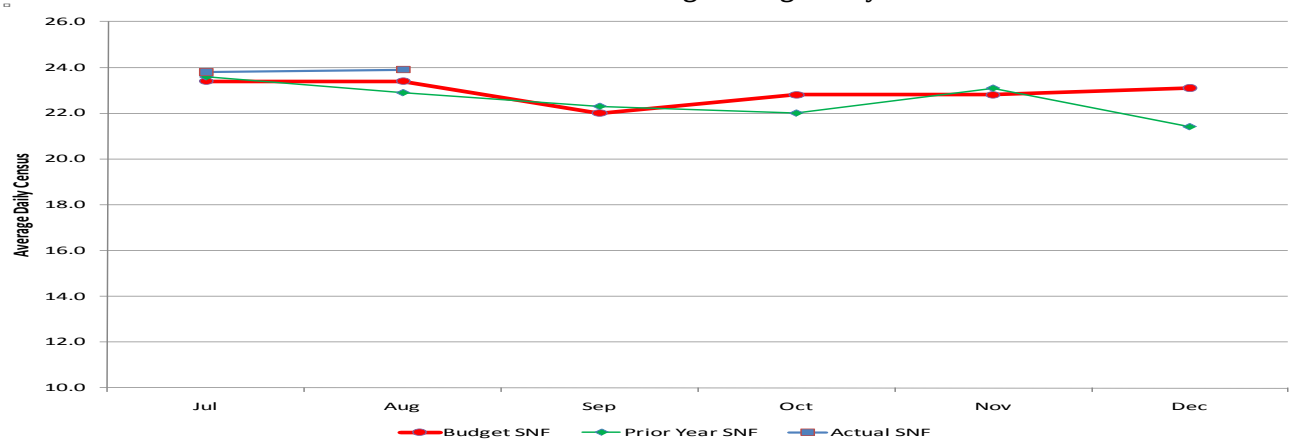
The Subacute program ADC of 33.6 was above the budget by 1.48 ADC or 4.6%. The census has stabilized as the construction moves are complete. The graph below shows the Subacute ADC for the current fiscal year as compared to budget and the prior year.

Subacute Average Daily Census



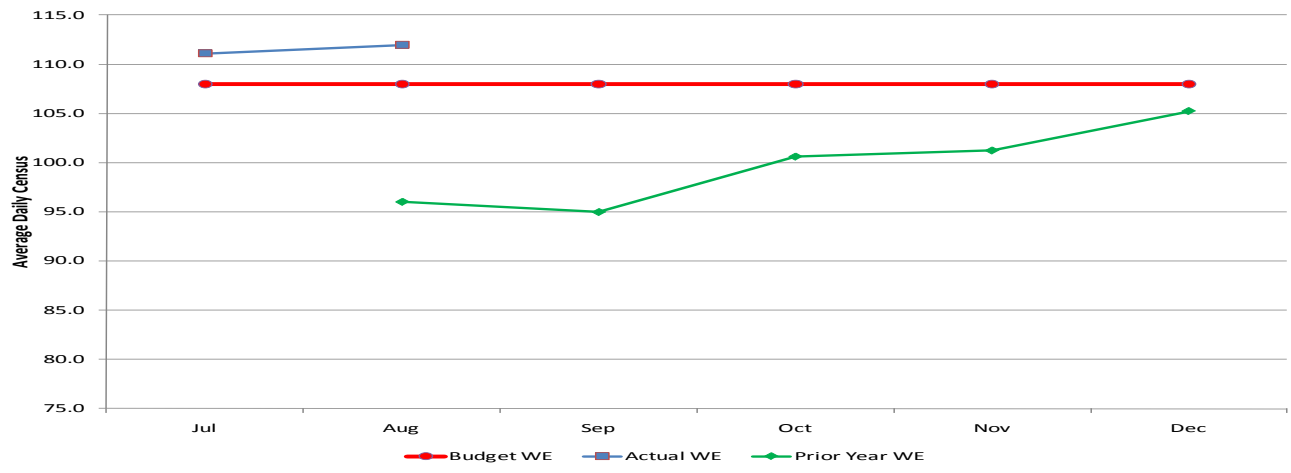
The South Shore ADC was above budget again by 14 patient days (1.9%) for the month of August. The graph below shows the South Shore monthly ADC as compared to budget and the prior year. In August the number of Medicare A skilled patients was 2.77 ADC, below the 4.4 ADC in July and below the budget of 4.1.

South Shore Skilled Nursing Average Daily Census



Waters Edge census was 111.97 ADC or 3.7% above the budget of 108.0 in August. The Medicare census was 12.13 ADC even with the 12.1 ADC in the prior month, but below the Medicare ADC budget of 16.2.

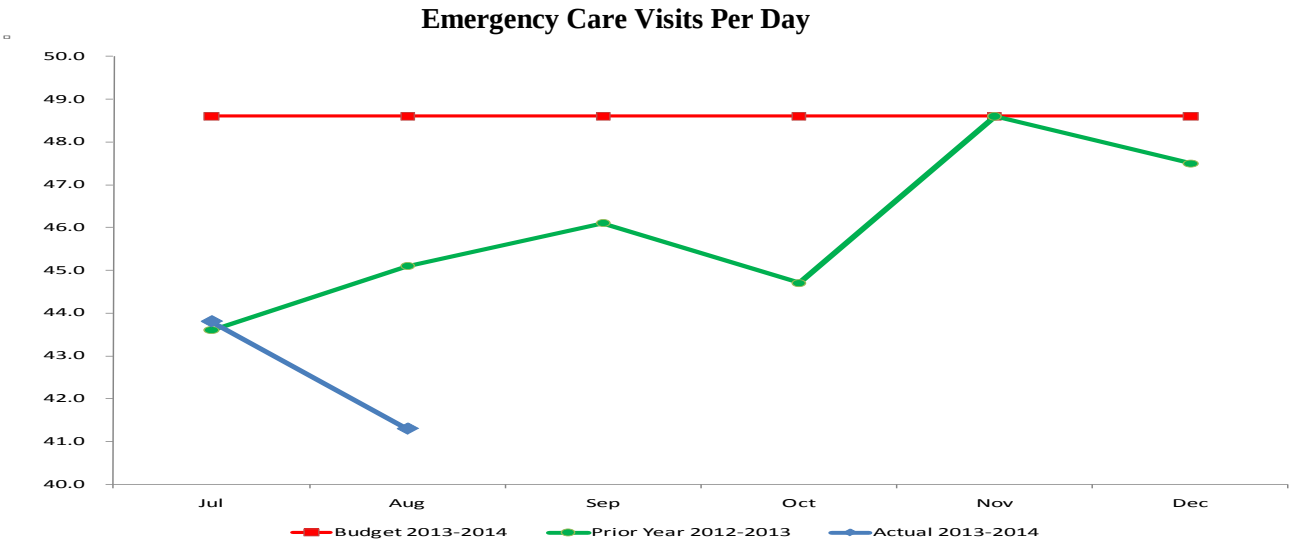
Waters Edge Skilled Nursing Average Daily Census



ANCILLARY SERVICES

Outpatient Services

Emergency Care Center (ECC) visits in August were 1,281, or 226 visits (15.0%) below the budget of 1,507. The inpatient admission rate from the ECC was 17.6% above the 16.6% admit rate in July. On a per day basis, the total visits represent a decrease of 5.7% from the prior month daily average. In August, there were 279 ambulance arrivals versus 266 in the prior month. Of the 279 ambulance arrivals in the current month, 198 or 70.9% were from Alameda Fire Department (AFD).

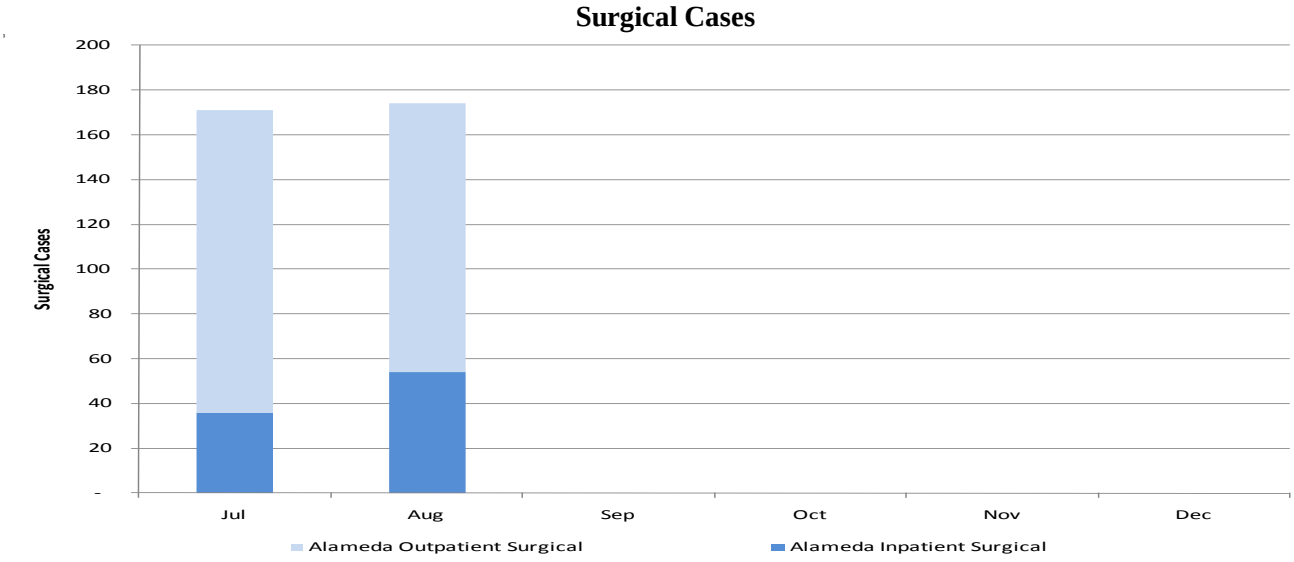


Outpatient registrations totaled 1,990 or 10.5% below the budget. This month the number of patient visits were down in Radiology (93), Laboratory (98), IV Therapy (39) and Physicial Therapy (24). However, visits were up in EKG (12), MRI (12), and Occupational Therapy (9) . In August there were 153 Therapy visits and 120 Imaging procedures from the new orthopedic clinic, compared to 230 and 128 respectively in July.

In August, Wound Care was above the budget of 350 with 459 visits, or 31.1% over budget. Hyperbaric Oxygen treatments accounted for 78 of those visits, compared to 84 in July.

Surgery

The total number of surgery cases in August were 174 or 11.7% below the budget of 197 and just below last year's case volume of 180. Inpatient cases of 54 right at budget and outpatient was below budget by 23 (16.1%) at 120 cases. Lower outpatient cases were attributed to less minor room procedures, specifically YAG laser cases.



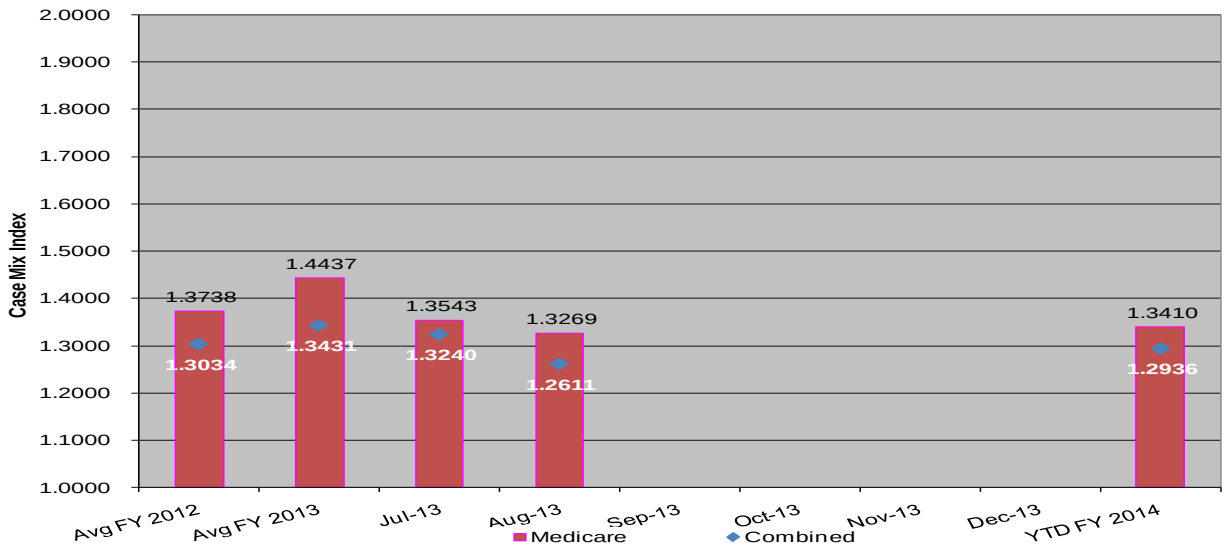
Payer Mix

The Hospital's overall payer mix compared to budget is illustrated below. This is inclusive of the Waters Edge revenue.

	Aug Actual	Aug Budget
Medicare	49.7%	47.2%
Medi-Cal	29.9%	27.1%
Managed Care	13.5%	16.5%
Other	3.6%	2.9%
Commerical	0.9%	1.3%
Self-Pay	2.4%	5.0%
Total	100.0%	100.0%

Case Mix Index

The Hospital's overall Case Mix Index (CMI) for August was 1.2611, down from the prior month of 1.3240 (4.75%). The Medicare CMI was 1.3269 in August, just below the prior month of 1.3543 (2.02%). The graph below shows the Medicare CMI for the Hospital during the current fiscal year as compared to the prior two years.



Revenue

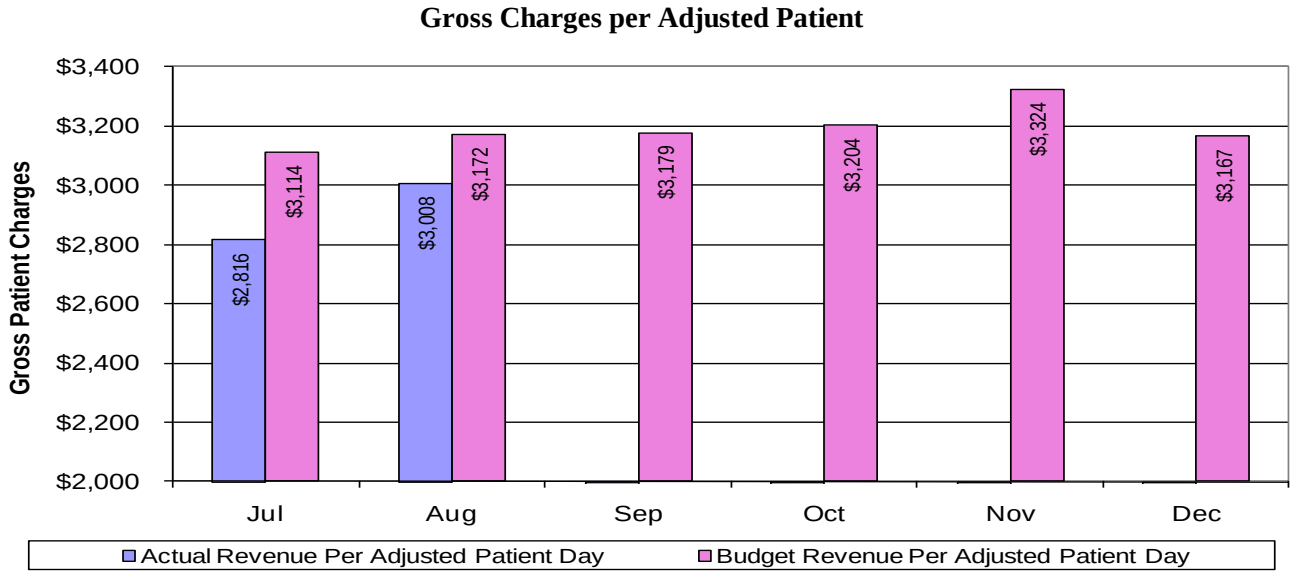
Gross patient charges in August were below budget by more than $1.5 million or 5.5%. Inpatient gross revenues were almost $850,000 below budget and outpatient gross revenues were down almost $700,000. Acute inpatient days were134 (14.1%) below budget and acute gross revenue was also down 12.5%. Inpatient ancillary service charges were below budget in Laboratory, Pharmacy, Respiratory Therapy and Emergency.

Waters Edge gross and net revenue were above budget in August consistent with the volume. The ancillary revenue was above budget 37.1% (again mostly due to therapy services) and the routine daily room and board revenue was above budget by 5.9%.

Outpatient gross revenues were lower than budget by almost $700,000 (7.8%). Emergency,Laboratory, Imaging and Pharmacy were the largest contributors to this being below budget while the Wound Care and Rehab were above budget.

Wound Care volume was above budget 31.1% and the gross revenue was above budget by $285,000, resulting in Net Revenue coming in $58,000 above budget for the month. The higher volume has continued in August after the unusual low volume seen back in June.

On an adjusted patient day basis, total patient revenue was $3,008 below the budget of $3,172 for the month of August. The table below shows the Hospital's monthly gross revenue per adjusted patient day by month and year-to-date for Fiscal Year 2014 compared to budget.



Contractual Allowances and Net Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payers such as Blue Cross. A Net Revenue percentage of 23.2% was budgeted and 22.7% was realized. Medi-Cal reimbursement at both South Shore and Waters Edge were calculated at a per diem rate of $316 which is consistent with budget and AB97 rate reduction.

Overall, Net Revenue was just over $6.1 million, $487,000 below the budget of $6.6 million. The lower than budgeted inpatient acute census, and lower emergency, outpatient surgery, and radiology visits are key drivers to the lower Net Revenue. Beginning April 1, 2013, the Federal budget sequestration goes into effect. This is a 2% reduction in all Medicare reimbursements which equate to about $40,000 per month for Alameda Hospital.

Waters Edge had Net Revenues of $1.34 million, above the budget by $110,000 or 8.9%. Although census was higher than budgeted overall census, we had less of the higher payer Medicare patients and more of the lower payer Medi-Cal patients driving this negative variance. Waters Edge net revenue was about $50,000 better in August as a couple of older accounts pending medi-cal coverage were approved and paid. We had a contingency reserve on these accounts until eligibility was finalized.

Expenses

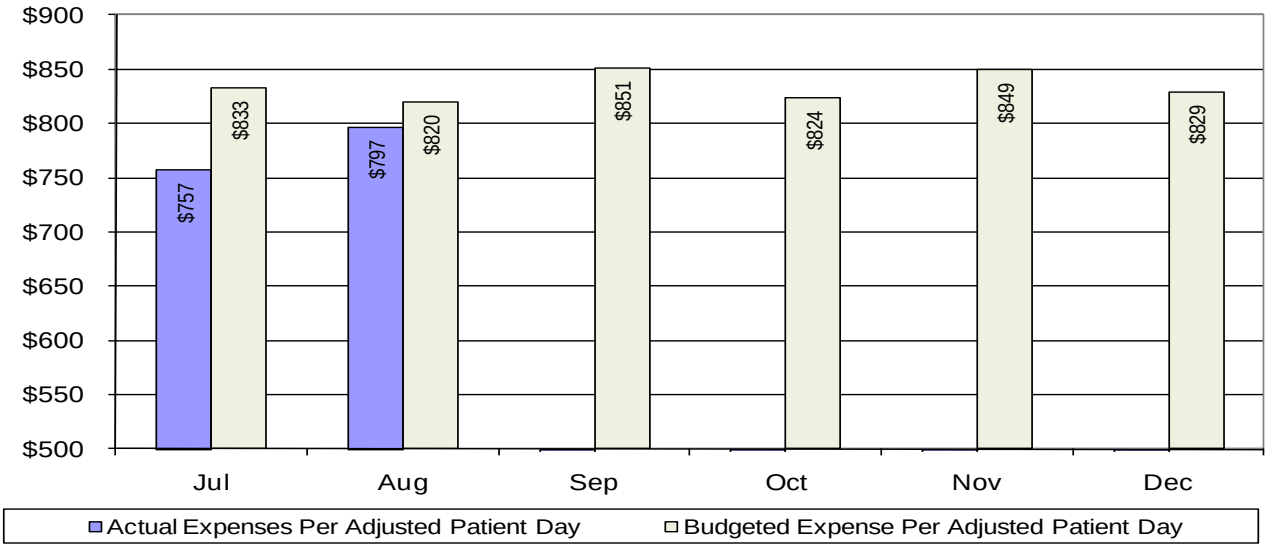
Total Operating Expenses

Total operating expenses were $7.0 million which was lower than the fixed budget by $231,000 or 3.2%. This is a welcome change from the prior year negative expense variances. Expenses are lower to a great extent because of the lower acute census in August.

Rents and leases were above budget while salaries, temporary agency, benefits, professional fees, supplies and purchased were under budget. All other expense categories were reasonably close to budget.

The graph on the below shows the actual Hospital operating expenses on an adjusted patient day basis for the fiscal year by month as compared to budget.

Expenses per Adjusted Patient Day



The following are explanations of the significant areas of variance that were experienced in the current month.

Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were favorable to the fixed budget by $49,000 (1.18%). Total salaries are below budget $35,000 while Registry (temporary agency services) is below budget $14,000.

The $35,000 favorable salary expense variance is comprised of productive salaries being $138,000 (4.5%) below budget while non-productive salaries were $108,000 over budget.

Although productive salaries were below budget in most acute nursing units, salaries were higher in subacute, southshore, wound care, all due to higher patient activity in these areas.

Non-productive being over budget is off-set, in part, by benefits expense being $83,000, most of this coming from reduction in PTO / Vacation accrual as employees continue to take time off. The expense benefit comes from those positions that do not need to be replaced when off e.g. administration. In addition, non-productive was high due to two employee termination settlements totaling $19,000, new hire employee orientations in the Emergency department, PCS training in DOU & CCU, and HIPAA and MAT training on the acute nursing units contributed to additional non-productive salary expense.

The use of overtime and double time premium pay has dropped by approximately $90,000 from the prior six month average as we strive to get better control of this expensive component of the total salaries. There were some overtime incureed with the above mentioned PCS training as well as premium pay needed to cover sick calls and break coverage on some weekend shifts. The productive salaries per adjusted patient day (APD) were $335 compared to a budget of $350. Total salaries per APD were $400 compared to a budget of $403 per APD.
Registry expense was lower mainly due to the acute units using less staff due to the lower census, as well as lower in the Laboratory.

While the overall temporary agency expense was below budget there were a few departments utilizing temporary staff higher than budgeted such as Rehab and Waters Edge.

Benefits

Benefits were below the fixed budget by $83,000. While these numbers fluctuate from month to month, benefits are down this month due higher usage of PTO/Vacation accrual. We have been encouraging employees to use their PTO/Vacation time which thus reduces the amount of accrual needed. Accrual for PTO / Vacation was $70,000 under budget in August, and is a direct offset to the higher non-productive wages discussed above. Overall, health claim expense was about $20,000 below budget, unemployment insurance $10,000 and FICA taxes $5,000. Although we did have a very large claim processed in August, it will be covered under our health insurance stop loss coverage and will not have an effect on benefit expense. Offsetting the higher PTO/Vacation accrual is the pension expense that was under budgeted about $20,000 per month.

Professional Fees

Professional fees were just under budget by $10,000 or 2.0%. While Pharmacy increased use of Night Hawk pharmacy service and Wound Care Clinic management fees (due to volume) were above budget, Administration was under budget resulting in a positive variance overall. The 1206 b clinic was over budget almost $6,800 due to prior month missed an accruals for the Neurology clinic.

Supplies

Supplies expense were $72,000 under budget. This variance is primarily due to Medical Supplies, but there are smaller variances under budget in many departments, including acute nursing and long term care as well as surgery, respiratory therapy and environmental services. Lower outpatient surgery, emergency room visits, and acute cencus all attribute to the lower supply utilization. Wound care supplies were higher than budget as was patient visits in the clinic. Many of wound cares supply expenses are reimbursable and reflected in net revenue estimations. Lower

Purchased Services

Purchased services were below budget for the month of August by $29,000 or 5.0%. While there were some departments higher than budget such as Waters Edge and the Clinics, there were several departments under budget such as Accounting, Evironmental Services, Engineering and Community Relations resulting in the overall variance being positive to budget.

Rents and Leases

Rents and lease expense was $19,000 over budget in the month. While Respiratory Therapy and Engineering were below budget this month, Central Supply and Administation were over budget. We continue to have higher equipment rental expense, primarily for bed/mattress rentals. We are obtaining quotes to purchase the needed mattresses vs. continuing to rent. In addition, the annual rent increase for the south shore building was about $2,500 per month higher than budgeted (taxes and fees assessments) and Waters Edge rent has increased $2,800 per month as well.

Other Operating Expense

Other Operating Expenses were over budget this month by $4,000. This variance is due mostly to the signing bonus for the new surgeon (that was budgeted evenly but expensed in August) plus higher license and tax expenses (annual expenses hitting in the month for Imaging DHCS equipment license fees, QRM Interqual fees and Laboratory CLIA license fees) offset by lower dues and subscription expsenses.

Depreciation Expense

Depreciation Expenses was $5,000 over budget. We are reviewing the detailed accounts to see why there is a difference between what we are recordingmonthly and have budgeted and should be able to clarify this difference in September.

Non-Operating Income / (Expnese):

Other Income was $22,000 under budget. We had assumed in the budget a contribution from the Foundation during this six month budget period of $150,000. We have not recorded a portion of the receivable for this but will do so once a contribution is made later in the year. In addition, Parcel tax accrual has been recorded at about $10,000 under budget in July and August. We will catch this accrual up in September as thee budget for parcel tax is in line with what was actually received in fiscal year 2013, including the final tail payment received in late August.

Balance Sheet

Total assets decreased by almost $1.3 million from the prior month. The following items make up the decrease in assets:

- Total unrestricted cash and cash equivalents for August decreased by approximately $1.2 million and days cash on hand including restricted use funds also decreased to 23.7 days cash on hand in August from the 30.0 days cash on hand in July. Patient collections in August averaged just over $193,000 per day, lower than the prior month but still strong. It is important to note that of the 5.2 million in Cash, we are holding $2.3 million for LTC medi-cal overpayment for the period August 2012 – April 2013. The state has began recoupment of this money the week of September 16th.

  - Net patient accounts receivable was $10.8 million, down about $100,000 from $10.9 million at the end of July.

- Days in outstanding receivables were back down to 55.9 at August month end, a slight decrease from the July number of 56.5 days. Cash collections in August were $6.0 million compared to $7.2 million in July.

Overall, total liabilities decreased by $880,000 from the prior month:

- Accounts payable increased almost $500,000 in August to approximately $11.6 million which equates to 159 AP Days, up from the 151 days in July.

- Payroll related accruals decreased over $800,000 due to the timing the the pay periods in the month.

- Deferred revenues decreased by $472,000 due to the recognition of one-twelfth of the 2013/2014 parcel tax revenues, which will be realized over the course of the fiscal year.

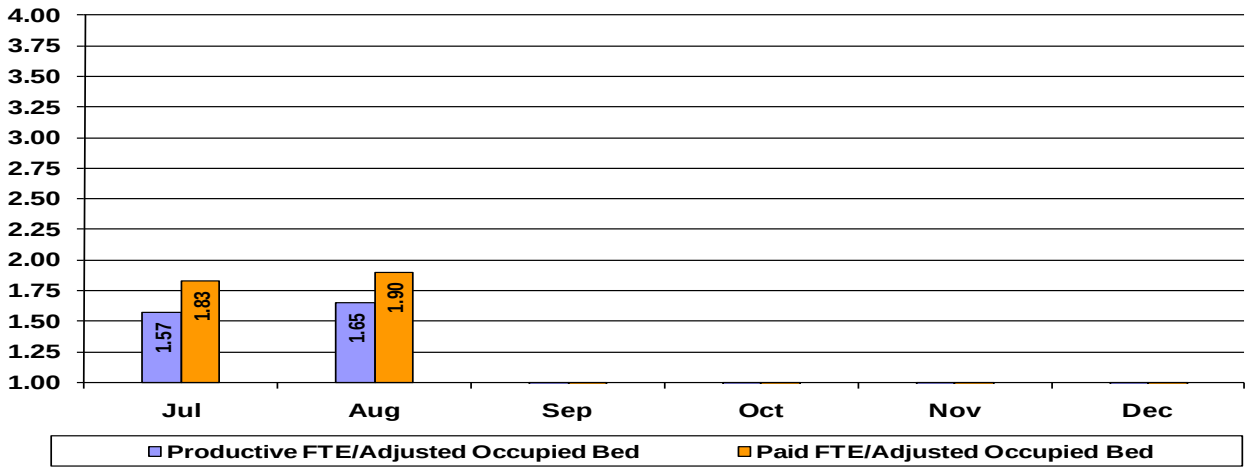
- Current Portion of Long Term Debt in the month of August remained consistent with prior month.

- Third Paty Payer Settlement also remained fairly consistent with prior month as well.

Key Statistics

FTE's Per Adjusted Occupied Bed

For the month of August Productive FTE's per Adjusted Occupied Bed were 1.65,below the budget of 1.70 FTE's by 3.1%. Paid FTE's per Adjusted Occupied Bed were 1.90 or 1.7% below the budget. The graph below shows the productive and paid FTE's per Adjusted Occupied Bed for FY 2014 by month.



Current Ratio

The current ratio for August dropped slightly to 0.86. We have received a waiver to the 1.0 loan covenant from the Bank of Alameda through the quarter ending September 30, 2013.

A/R days

Net days in accounts receivable (A/R) are currently at 55.9. This is again down from the prior month of 56.5. Net A/R days are down due to the higher cash collections as Medi-Cal payments have increased to normal levels in July.

Days Cash on Hand

Days cash on hand for July were 23.7, a decrease from prior month of 30.0. The decrease is primarily due to the timing of three payrolls in August.

The following pages include the detailed financial statements for the two (2) months ended August 31, 2013, of Fiscal Year 2014.

ALAMEDA HOSPITAL
KEY STATISTICS
AUGUST 2013

	ACTUAL AUGUST 2013	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	AUGUST 2012	YTD AUGUST 2013	YTD FIXED BUDGET	VARIANCE	%	YTD AUGUST 2012
Discharges:										
Total Acute	202	237	(35)	-14.8%	214	417	463	(46)	-10.0%	439
Total Sub-Acute	1	3	(2)	-66.7%	2	2	6	(4)	-66.7%	4
Total South Shore	3	6	(3)	-50.0%	5	7	12	(5)	-41.7%	7
Total Waters Edge	9	15	(6)	-40.0%	10	21	30	(9)	-30.0%	10
	215	261	(46)	-17.6%	231	447	511	(64)	-12.6%	460
Patient Days:										
Total Acute	814	948	(134)	-14.1%	853	1,585	1,853	(268)	-14.5%	1,734
Total Sub-Acute	1,041	995	46	4.6%	1,003	2,092	1,967	125	6.4%	2,035
Total South Shore	740	726	14	1.9%	709	1,478	1,450	28	1.9%	1,440
Total Waters Edge	3,471	3,348	123	3.7%	2,977	6,915	6,696	219	3.3%	2,977
	6,066	6,017	49	0.8%	5,542	12,070	11,966	104	0.9%	8,186
Average Length of Stay										
Total Acute	4.03	4.00	0.03	0.7%	3.99	3.80	4.00	(0.20)	-5.0%	3.95
Average Daily Census										
Total Acute	26.26	30.58	(4.32)	-14.1%	27.52	25.56	29.89	(4.32)	-14.5%	27.97
Total Sub-Acute	33.58	32.10	1.48	4.6%	32.35	33.74	31.73	2.02	6.4%	32.82
Total South Shore	23.87	23.42	0.45	1.9%	22.87	23.84	23.39	0.45	1.9%	23.23
Total Waters Edge	111.97	108.00	3.97	3.7%	96.03	111.53	108.00	3.53	3.3%	96.03
	195.68	194.10	1.58	0.8%	178.77	194.68	193.00	(2.31)	-1.2%	180.05
Emergency Room Visits	1,281	1,507	(226)	-15.0%	1,399	2,638	2,930	(292)	-10.0%	2,751
Wound Care Clinic Visits	459	350	109	31.1%	96	905	700	205	29.3%	103
Outpatient Registrations	1,990	2,223	(233)	-10.5%	2,023	4,189	4,250	(61)	-1.4%	3,864
Surgery Cases:										
Inpatient	54	54	-	0.0%	48	90	94	(4)	-4.3%	83
Outpatient	120	143	(23)	-16.1%	132	255	234	21	9.0%	214
	174	197	(23)	-11.7%	180	345	328	17	5.2%	297
Adjusted Occupied Bed (AOB)	283.42	284.33	(0.90)	-0.3%	261.00	289.60	279.33	10.27	3.7%	193.06
Productive FTE	467.56	483.97	(16.41)	-3.4%	556.12	467.77	480.45	(12.68)	-2.6%	405.08
Total FTE	539.09	550.07	(10.99)	-2.0%	517.30	541.26	545.41	(4.15)	-0.8%	467.53
Productive FTE/Adj. Occ. Bed	1.65	1.70	(0.05)	-3.1%	2.13	1.62	1.72	(0.10)	-6.1%	2.10
Total FTE/ Adj. Occ. Bed	1.90	1.93	(0.03)	-1.7%	1.98	1.87	1.95	(0.08)	-4.3%	2.42

City of Alameda Health Care District
Statements of Financial Position
August 31, 2013

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 5,200,500	$ 6,439,805	$ 4,861,959
Patient Accounts Receivable, net	10,807,792	10,902,164	12,041,516
Other Receivables	6,070,036	6,250,816	6,301,762
Third-Party Payer Settlement Receivables	-	-	-
Inventories	1,267,733	1,276,129	1,266,892
Prepaids and Other	640,622	572,320	450,309
Total Current Assets	23,986,684	25,441,235	24,922,439
Assets Limited as to Use, net	212,549	200,778	189,755
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	45,505,551	45,495,434	45,422,895
Construction in progress	3,794,069	3,546,741	3,583,725
Depreciation	(40,756,285)	(40,668,979)	(40,581,813)
Property, Plant and Equipment, net	9,421,280	9,251,141	9,302,752
Total Assets	**$ 33,620,512**	**$ 34,893,153**	**$ 34,414,946**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 2,326,007	$ 2,326,007	$ 826,007
Accounts Payable and Accrued Expenses	11,581,511	11,085,668	11,823,357
Payroll Related Accruals	4,608,312	5,444,798	5,195,271
Deferred Revenue	4,782,392	5,253,942	5,731,269
Employee Health Related Accruals	725,147	708,148	714,297
Third-Party Payer Settlement Payable	3,738,204	3,771,493	3,796,593
Total Current Liabilities	27,761,573	28,590,056	28,086,794
Long Term Debt, net	1,869,120	1,926,176	1,578,289
Total Liabilities	29,630,693	30,516,232	29,665,083
Net Assets:			
Unrestricted	3,567,271	3,966,143	4,350,108
Temporarily Restricted	422,549	410,778	399,755
Total Net Assets	3,989,819	4,376,922	4,749,863
Total Liabilities and Net Assets	**$ 33,620,512**	**$ 34,893,154**	**$ 34,414,946**

City of Alameda Health Care District

Statements of Operations

August 31, 2013

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	6,066	6,018	48	0.8%	5,542	12,070	11,966	104	0.9%	8,186
Discharges	215	261	(46)	-17.6%	231	447	510	(63)	-12.4%	460
ALOS (Average Length of Stay)	28.21	23.06	5.16	22.4%	23.99	27.00	23.45	3.55	15.1%	17.80
ADC (Average Daily Census)	195.7	194.1	1.55	0.8%	-	194.7	193.0	1.68	0.9%	132.0
CMI (Case Mix Index)	1.2611				1.4229	1.2936				1.3355
Revenues										
Gross Inpatient Revenues	$ 18,245	$ 19,091	$ (846)	-4.4%	$ 17,225	$ 35,154	$ 37,611	$ (2,457)	-6.5%	$ 31,389
Gross Outpatient Revenues	8,181	8,875	(693)	-7.8%	7,885	17,095	16,829	266	1.6%	14,458
Total Gross Revenues	26,426	27,966	(1,540)	-5.5%	25,110	52,250	54,440	(2,190)	-4.0%	45,847
Contractual Deductions	19,480	20,232	752	3.7%	15,852	38,950	39,319	370	0.9%	30,900
Bad Debts	775	1,102	326	29.6%	3,108	1,014	2,204	1,190	54.0%	3,925
Charity and Other Adjustments	159	133	(26)	-19.4%	122	297	267	(30)	-11.2%	246
Net Patient Revenues	6,011	6,498	(487)	-7.5%	6,029	11,990	12,650	(661)	-5.2%	10,775
Net Patient Revenue %	22.7%	23.2%			24.0%	22.9%	23.2%			23.5%
Net Clinic Revenue	91	88	4	4.4%	38	166	175	(9)	-5.1%	77
Other Operating Revenue	9	12	(4)	-29.5%	8	18	24	(6)	-25.1%	15
Total Revenues	**6,111**	**6,598**	**(487)**	-7.4%	**6,075**	**12,174**	**12,850**	**(676)**	-5.3%	**10,867**
Expenses										
Salaries	3,513	3,548	35	1.0%	3,323	7,098	7,028	(71)	-1.0%	6,330
Temporary Agency	166	180	14	7.7%	195	271	360	89	24.8%	349
Benefits	979	1,062	83	7.8%	1,005	1,882	2,104	223	10.6%	1,583
Professional Fees	491	501	10	2.0%	351	980	1,002	22	2.2%	686
Supplies	748	820	72	8.8%	808	1,529	1,576	47	3.0%	1,456
Purchased Services	543	571	29	5.0%	531	1,097	1,143	45	4.0%	990
Rents and Leases	239	221	(19)	-8.4%	214	472	442	(30)	-6.8%	329
Utilities and Telephone	70	83	14	16.2%	83	149	167	18	11.0%	150
Insurance	36	38	2	5.3%	46	74	76	2	2.6%	80
Depreciation and amortization	87	83	(5)	-5.7%	77	175	165	(10)	-5.8%	143
Other Operating Expenses	129	126	(4)	-2.9%	88	217	236	19	8.0%	170
Total Expenses	**7,002**	**7,233**	**231**	3.2%	**6,723**	**13,944**	**14,299**	**355**	2.5%	**12,267**
Operating gain (loss)	**(891)**	**(635)**	**(256)**	-40.3%	**(648)**	**(1,771)**	**(1,450)**	**(321)**	22.1%	**(1,400)**
Non-Operating Income / (Expense)										
Parcel Taxes	477	487	(10)	-2.0%	477	954	974	(20)	-2.0%	954
Investment Income	1	-	1	0.0%	1	2	-	2	0.0%	3
Interest Expense	(15)	(16)	1	7.0%	(18)	(25)	(31)	6	-20.1%	(27)
Other Income / (Expense)	28	43	(14)	-33.9%	27	56	85	(29)	-33.9%	55
Net Non-Operating Income / (Expense)	**492**	**514**	**(22)**	**-4.3%**	**488**	**988**	**1,028**	**(40)**	**-3.9%**	**985**
Excess of Revenues Over Expenses	**$ (399)**	**$ (121)**	**$ (278)**	**229.9%**	**$ (159)**	**$ (783)**	**$ (422)**	**$ (361)**	**85.4%**	**$ (415)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

August 31, 2013

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 2,077	$ 2,166	$ (89)	-4.1%	$ 2,132	$ 1,960	$ 2,172	$ (212)	-9.8%	$ 2,625
Gross Outpatient Revenues	931	1,007	(76)	-7.5%	976	953	972	(19)	-1.9%	1,209
Total Gross Revenues	3,008	3,172	(165)	-5.2%	3,108	2,913	3,143	(231)	-7.3%	3,834
Contractual Deductions	2,217	2,295	78	3.4%	1,962	2,171	2,270	99	4.4%	2,584
Bad Debts	88	125	37	29.4%	385	57	127	71	55.6%	328
Charity and Other Adjustments	18	15	(3)	-19.8%	15	17	15	(1)	-7.4%	21
Net Patient Revenues	684	737	(53)	-7.2%	746	668	730	(62)	-8.5%	901
Net Patient Revenue %	22.7%	23.2%			24.0%	22.9%	23.2%			23.5%
Net Clinic Revenue	10	10	0	4.8%	5	9	10	(1)	-8.3%	6
Other Operating Revenue	1	1	(0)	-29.2%	1	1	1	(0)	-27.7%	1
Total Revenues	**696**	**748**	**(53)**	-7.1%	**752**	**679**	**742**	**(63)**	-8.5%	**909**
Expenses										
Salaries	400	403	3	0.7%	411	396	406	10	2.5%	529
Temporary Agency	19	20	2	7.4%	24	15	21	6	27.4%	29
Benefits	111	120	9	7.5%	124	98	122	24	19.4%	132
Professional Fees	56	57	1	1.6%	43	55	58	3	5.6%	57
Supplies	85	93	8	8.5%	100	85	91	6	6.3%	122
Purchased Services	62	65	3	4.7%	66	61	66	5	7.3%	83
Rents and Leases	27	25	(2)	-8.8%	27	26	26	(1)	-3.1%	28
Utilities and Telephone	8	9	2	15.9%	10	8	10	1	14.1%	13
Insurance	4	4	0	5.0%	6	4	4	0	5.9%	7
Depreciation and Amortization	10	9	(1)	-6.0%	10	10	10	(0)	-2.2%	12
Other Operating Expenses	15	14	(0)	-3.2%	11	12	14	2	11.2%	14
Total Expenses	**797**	**820**	**24**	2.9%	**832**	**770**	**826**	**55**	6.7%	**1,026**
Operating Gain / (Loss)	**(101)**	**(72)**	**(29)**	-40.8%	**(80)**	**(91)**	**(83)**	**(8)**	9.6%	**(117)**
Non-Operating Income / (Expense)										
Parcel Taxes	54	55	(1)	-1.7%	59	53	56	(3)	-5.4%	80
Investment Income	0	-	0	0.0%	0	0	-	0	0.0%	0
Interest Expense	(2)	(2)	0	6.7%	(2)	(1)	(2)	0	-22.8%	(2)
Other Income / (Expense)	3	5	(2)	-33.6%	3	3	5	(2)	-36.2%	5
Net Non-Operating Income / (Expense)	**56**	**58**	**(2)**	**-4.0%**	**60**	**55**	**59**	**(4)**	**-7.2%**	**82**
Excess of Revenues Over Expenses	**$ (45)**	**$ (14)**	**$ (32)**	231.0%	**$ (20)**	**$ (36)**	**$ (24)**	**$ (12)**	50.8%	**$ (35)**

Wound Care - Statement of Operations
August 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits	459	350	109	31.1%	905	700	205	29.3%
Revenue								
Gross Revenue	974,819	689,761	285,058	41.3%	1,941,725	1,379,522	562,203	40.8%
Deductions from Revenue	758,409	531,392	227,017		1,512,596	1,062,784	449,812	
Net Revenue	216,410	158,369	58,041	36.6%	429,129	316,738	112,391	
Expenses								
Salaries	24,712	15,775	(8,937)	-56.7%	43,321	31,673	(11,648)	-36.8%
Benefits	7,913	4,712	(3,201)	-67.9%	12,591	9,461	(3,130)	-33.1%
Professional Fees	93,000	73,306	(19,694)	-26.9%	188,935	146,612	(42,323)	-28.9%
Supplies	41,865	28,239	(13,626)	-48.3%	72,472	56,478	(15,994)	-28.3%
Purchased Services	5,597	4,000	(1,597)	-39.9%	10,190	8,000	(2,190)	-27.4%
Rents and Leases	5,686	5,686	-	0.0%	11,809	11,372	(437)	-3.8%
Depreciation	8,834	8,685	(149)	-1.7%	17,668	17,370	(298)	-1.7%
Other	4,089	2,079	(2,010)	-96.7%	5,795	4,158	(1,637)	-39.4%
Total Expenses	191,696	142,482	(49,214)	-34.5%	362,781	285,124	(77,657)	-27.2%
Excess of Revenue over Expenses	24,714	15,887	8,827	55.6%	66,348	31,615	34,734	109.9%

City of Alameda Health Care District
Waters Edge Skilled Nursing - Statement of Operations
August 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Patient Days								
Medicare	376	502	(126)	-25.1%	754	1,004	(250)	-24.9%
Medi-Cal	2,961	2,576	385	14.9%	5,962	5,152	810	15.7%
Managed Care	4	68	(64)	-94.1%	47	136	(89)	-65.4%
Self Pay/Other	130	202	(72)	-35.6%	140	404	(264)	-65.3%
Total	3,471	3,348	123	3.7%	6,903	6,696	207	3.1%
Revenue								
Routine Revenue	2,767,982	2,613,836	154,146	5.9%	5,499,398	5,227,672	271,726	5.2%
Ancillary Revenue	402,111	293,277	108,834	37.1%	822,436	579,753	242,683	41.9%
Total Gross Revenue	3,170,093	2,907,113	262,980	9.0%	6,321,834	5,807,425	514,409	8.9%
Deductions from Revenue	1,827,238	1,674,497	(152,741)	-9.1%	3,740,310	3,345,077	(395,233)	-11.8%
Net Revenue	1,342,855	1,232,616	110,239	8.9%	2,581,524	2,462,348	119,176	4.8%
Expenses								
Salaries	440,757	478,078	37,321	7.8%	908,034	952,643	44,609	4.7%
Temporary Agency	32,195	20,067	(12,128)	-100.0%	44,398	40,134	(4,264)	-100.0%
Benefits	96,087	97,576	1,489	1.5%	194,786	194,883	98	0.1%
Professional Fees	4,712	5,200	488	9.4%	5,605	10,400	4,795	46.1%
Supplies	75,600	63,380	(12,220)	-19.3%	142,845	126,761	(16,084)	-12.7%
Purchased Services	135,351	129,300	(6,051)	-4.7%	255,289	258,600	3,311	1.3%
Rents and Leases	78,383	75,400	(2,983)	-4.0%	155,426	150,800	(4,626)	-3.1%
Utilities	2,369	11,767	9,398	79.9%	14,576	23,534	8,958	38.1%
Insurance	-	2,392	2,392	100.0%	-	4,784	4,784	100.0%
Other	5,794	16,308	10,514	64.5%	18,038	32,616	14,578	44.7%
Total Expenses	871,248	899,468	28,220	3.1%	1,738,997	1,795,155	56,159	3.1%
Excess of Revenue over Expenses	471,607	333,148	138,459		842,527	667,193	175,334	

City of Alameda Health Care District
Orthopedic Clinic - Statement of Operations
August 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits	283	302	(19)	-6.3%	543	604	(61)	-10.1%
Revenue								
Gross Revenue	82,814	128,652	(45,838)	-35.6%	175,290	257,304	(82,014)	-31.9%
Deductions from Revenue	45,269	90,069	(44,800)		95,770	180,138	(84,368)	
Net Revenue	37,545	38,583	(1,038)		79,520	77,166	2,354	
Expenses								
Salaries	32,684	32,905	221	0.7%	65,086	65,808	722	1.1%
Benefits	8,217	9,829	1,612	16.4%	16,363	19,657	3,294	16.8%
Professional Fees	25,823	25,000	(823)	-3.3%	50,400	50,000	(400)	-0.8%
Supplies	994	3,467	2,473	71.3%	2,287	6,934	4,647	67.0%
Purchased Services	5,734	6,083	349	5.7%	10,016	12,166	2,150	17.7%
Rents and Leases	4,660	4,667	7	0.1%	9,320	9,334	14	0.1%
Depreciation	-	-	-	0.0%	-	-	-	0.0%
Other	4,359	2,608	(1,751)	-67.1%	5,408	5,216	(192)	-3.7%
Total Expenses	82,471	84,559	2,088	2.5%	158,880	169,115	10,235	6.1%
Excess of Revenue over Expenses	(44,926)	(45,976)	1,050	2.3%	(79,360)	(91,949)	12,589	13.7%
Hospital Based Activity:								
Inpatient Days	12	22	(10)	-45.5%	37	44	(7)	-15.9%
Inpatient Surgeries	2	5	(3)	-60.0%	4	10	(6)	-60.0%
Outpatient Surgeries	7	9	(2)	-22.2%	13	18	(5)	-27.8%
							-	
Therapy Referred Visits	153	175	(22)	-12.6%	383	350	33	9.4%
Imaging Referred Procedures	120	110	10	9.1%	248	220	28	12.7%
Inpatient Gross Charges	246,668	309,500	(62,832)	-20.3%	672,905	619,000	53,905	8.7%
Inpatient Net Revenue	37,109	69,500	(32,391)	-46.6%	78,324	139,000	(60,676)	-43.7%
Outpatient Gross Charges	340,487	324,775	15,712	4.8%	842,315	630,530	211,785	33.6%
Outpatient Net Revenue	57,883	70,885	(13,002)	-18.3%	128,139	137,778	(9,639)	-7.0%
Total Gross Charges	587,155	634,275	(47,120)	-7.4%	1,515,220	1,249,530	265,690	21.3%
Total Net Revenue	94,992	140,385	(45,393)	-32.3%	206,463	276,778	(70,315)	-25.4%

City of Alameda Health Care District
1206b Clinic - Statement of Operations
August 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits								
Primary Care	119	138	(19)		221	276	(55)	
Surgery	63	53	10		126	106	20	
Neurology	30	31	(1)		58	62	(4)	
Total Visits	212	222	(10)	-4.5%	405	444	(39)	-8.8%
Revenue								
Gross Revenue	121,454	129,400	(7,946)	-6.1%	195,082	258,800	(63,718)	-24.6%
Deductions from Revenue	67,642	77,650	(10,008)		108,476	155,300	(46,824)	
Net Revenue	53,812	51,750	2,062		86,606	103,500	(16,894)	
Expenses								
Salaries	32,362	32,526	164	0.5%	64,031	57,504	(6,527)	-11.4%
Temporary Agency	-	-	-	-100.0%	-	-	-	-100.0%
Benefits	8,136	9,716	1,580	16.3%	16,097	17,176	1,079	6.3%
Professional Fees	24,834	18,000	(6,834)	-38.0%	28,608	36,000	7,392	20.5%
Supplies	731	1,356	625	46.1%	7,298	2,712	(4,586)	-169.1%
Purchased Services	7,346	6,468	(878)	-13.6%	15,421	12,936	(2,485)	-19.2%
Rents and Leases	15,194	12,661	(2,533)	-20.0%	30,388	25,322	(5,066)	-20.0%
Depreciation	494	182	(312)	-171.4%	988	364	(624)	-171.4%
Other	11,077	5,167	(5,910)	-114.4%	17,171	10,334	(6,837)	-66.2%
Total Expenses	100,174	86,076	(14,098)	-16.4%	180,002	162,348	(17,654)	-10.9%
Excess of Revenue over Expenses	(46,362)	(34,326)	(12,036)	35.1%	(93,396)	(58,848)	(34,548)	58.7%

Note:
Clinic Hours by Physician
Dr. Celada - M,W,F Mornings only
Dr. Brimer - M & Th full days, plus T Mornings
Dr. Dutaret - T & W full days

City of Alameda Health Care District
Statement of Cash Flows
For the Two Months Ended August 31, 2013

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (398,874)	$ (782,839)
Items not requiring the use of cash:		
Depreciation and amortization	87,306	$ 174,883
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	94,372	1,233,724
Other Receivables	180,780	231,726
Third-Party Payer Settlements Receivable	(33,289)	(58,389)
Inventories	8,396	(841)
Prepaids and Other	(68,301)	(190,312)
Accounts payable and accrued liabilities	495,843	(241,846)
Payroll Related Accruals	(836,486)	(586,959)
Employee Health Plan Accruals	16,999	10,850
Deferred Revenues	(471,550)	(948,877)
Cash provided by (used in) operating activities	(924,805)	(1,158,880)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,771)	(22,794)
Additions to Property, Plant and Equipment	(257,445)	(293,410)
Other	1	1
Cash provided by (used in) investing activities	(269,214)	(316,203)
Cash flows from financing activities		
Net Change in Long-Term Debt	(57,056)	1,790,831
Net Change in Restricted Funds	11,770	22,794
Cash provided by (used in) financing and fundraising activities	(45,286)	1,813,624
Net increase (decrease) in cash and cash equivalents	(1,239,305)	338,541
Cash and cash equivalents at beginning of period	6,439,805	4,861,959
Cash and cash equivalents at end of period	$ 5,200,502	$ 5,200,501

City of Alameda Health Care District
Ratio's Comparison

	Audited Results			Unaudited	YTD
Financial Ratios	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**8/31/2013**
Profitability Ratios					
Net Patient Revenue (%)	24.16%	23.58%	22.90%	23.34%	22.95%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	4.82%	-1.01%	-1.48%	-1.48%	-1.48%
EBIDAP[Note 5]	-3.66%	-13.41%	-11.22%	-9.39%	-12.63%
Total Margin	2.74%	-2.61%	-3.21%	-3.13%	-6.43%
Liquidity Ratios					
Current Ratio	1.23	1.05	0.96	0.89	0.86
Days in accounts receivable ,net	51.83	46.03	55.21	60.35	55.89
Days cash on hand (with restricted)	21.6	14.1	17.7	21.8	24.2
Debt Ratios					
Cash to Debt	249.0%	123.3%	123.56%	210.11%	129.03%
Average pay period (includes payroll)	57.11	62.68	72.94	78.69	76.03
Debt service coverage	5.98	(0.70)	(0.53)	(1.21)	(0.25)
Long-term debt to fund balance	0.14	0.18	0.28	0.33	0.51
Return on fund balance	18.87%	-19.21%	-27.35%	-48.16%	-19.62%
Debt to number of beds	10,482	11,515	16,978	9,728	9,728

City of Alameda Health Care District
Ratio's Comparison

	Audited Results			Unaudited	YTD
Financial Ratios	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**8/31/2013**
Patient Care Information					
Bed Capacity	161	161	161	281	281
Patient days(all services)	30,607	30,270	30,448	66,645	12,070
Patient days (acute only)	10,579	10,443	10,880	11,559	1,585
Discharges(acute only)	2,802	2,527	2,799	2,838	417
Average length of stay (acute only)	3.78	4.13	3.89	4.07	3.80
Average daily patients (all sources)	83.85	82.93	83.19	182.59	194.68
Occupancy rate (all sources)	52.08%	51.51%	51.67%	64.98%	69.28%
Average length of stay	3.78	4.13	3.89	4.07	3.80
Emergency Visits	17,624	16,816	16,964	17,175	2,638
Emergency visits per day	48.28	46.07	46.35	47.05	42.55
Outpatient registrations per day[Note 1]	79.67	65.19	60.67	64.07	67.56
Surgeries per day - Total	13.46	6.12	6.12	5.52	5.56
Surgeries per day - excludes Kaiser	5.32	6.12	6.12	5.52	5.56

Notes:

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

Glossary of Financial Ratios

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

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: October 3, 2013

FOR: October 9, 2013 District Board Meeting

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

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: CEO Report to the Board of Directors

---

1. Affiliation Plan Update

The continued work toward finalizing an affiliation with Alameda Health System continues to proceed on three tracks with the assistance of the consulting firm of Kaufman Hall:

a. **Transaction Management** (Due Diligence, Definitive Agreement Drafting, Licensure, Permits and Certifications).

b. **Project Management** (Work and Business Plan development, reporting and tracking, oversight of the project and data room management).

c. **Transition Management** (Synergy Identification, Oversight of the Integration Teams, Creation of Action Plans.)

2. Status of Communication Plan Regarding Affiliation:

Since the last meeting of the Board of Directors, management made a presentation for the Alameda Association of Realtors. There were many questions at the presentation but no real negative issues have arisen.

3. Legislative Update

As a result of the advocacy of CHA and participating hospitals, Senate Bill 239 passed both bodies of the State legislature and includes provisions that prospectively restore rates for distinct part skilled nursing facilities effective October 1, 2013 that were reduced earlier as a part of AB 97. While this has no direct financial impact on Alameda Hospital, since our rates were already reduced based on the effect of a diluted cost per average resident day with the addition of Waters Edge in 2012, it was a victory for other California hospitals. It also reflects the legislature's recognition of the undue hardship from future DP SNF reimbursement reductions.

4. Supplemental IGT Funding

On September 18, 2013 the Hospital was notified that it would be eligible to participate in a Non-Designated Public Hospital (NDPH) Intergovernmental Transfer (IGT) Supplemental Payment Program for Fiscal Year 2012/2013. For Alameda Hospital, $475,944 was transferred to the State prior to September 30, 2013. Fees totaling $42,839 are taken out and the balance of $433,155 will be matched through this Federal IGT matching program. It is our understanding that all funds should be returned to the Hospital by the end of October.

5. District Hospital Leadership Forum (DHLF) Update

As part of the DHLF federal advocacy plan, nine DHLF members participated in an advocacy trip to Washington D.C. earlier this week. The purpose of the trip was to begin the education of our Congressional representatives and U.S. Senators about the importance of district/municipal hospitals in their communities and why these facilities must be included in both the current and subsequent California Medi-Cal 1115 hospital waivers.

The attached document was used during the visit to Washington D.C. and is provided to the Board as information. It also includes a map depicting the California's District/Municipal Hospitals.

The next step in the federal advocacy plan is to conduct webinars with CMS staff so they better understand the 1115 Waiver and the DHLF request. However, due to the government shutdown, some key staff at CMS are on furlough so this step also will be delayed somewhat. DHLF had hoped for another trip to D.C. later this month to meet with CMS (after they've heard from the California Congressional Delegation), but again the shutdown has affected the timeline. DHLF will continue its work at the state level, both legislatively and administratively.

DHLF has encouraged districts to meet with their Congressional representatives to get them to the individual hospitals. It is very effective for members of Congress to see first-hand the work you all are doing in your communities. Congresswoman Barbara Lee toured our Emergency Room and met with management and physicians in August.

Additional information on the timeline and other efforts (such as the signing of AB 498, the state legislation that would allow district/municipal hospitals to access funding in recognition of care provided to the uninsured in 2013-14 and 2014-15 will be provided to DHLF members as it becomes known and will be discussed at the November DHLF Board meeting.

6. Joint Commission Stroke Survey

I am pleased to announce that on October 19, 2013 a Joint Commission Nurse Surveyor completed the scheduled 1 day Disease-Specific Care Certification Survey of our Primary Stroke Center. The organization received re-certification for two years with only 2 minor ("indirect") findings identified. Evidence of Standard Compliance for these findings will be submitted on November 18, 2013.

The surveyor was very complimentary of our program and commented that "the staff was confident, well prepared and fearless when sharing information with her". As a compliment to Michaele Baxter, RN, our Stroke Program Coordinator, the surveyor asked that Michaele post a copy of the Mega Code Stroke Practice that she developed to the Joint Commission Best Practices Learning Center Website. She noted that this request, recognizing a particularly excellent aspect of a program, is not something she does often, even when surveying much larger resource intensive hospitals. This document could then be shared with other accredited hospitals and Primary Stroke Centers.

I would like to thank Michaele Baxter, Dr. Dutaret, the members of the Stroke Committee and medical staff for their hard work in organizing a stroke program that clearly is a resource to our community.

7. Quality Management Update

Employee Health hiring changes were implemented in September to streamline the process to make it easier to hire employees within 10 – 14 days. This will assist the patient care unit with getting much needed staff available in a timely manner.

The Quality/Risk & Resource Management Department continues to seek a qualified Utilization Management Director who will be able to oversee the reduction of readmission program that will be implemented in the next 3- 6 months. This program is expected to reduce readmissions by follow up phone calls from the acute care and long term care units, increase in the intensity of social worker interactions, and other interventions. Some interventions have been initiated and are expected to reach full implementation in 2014.

Leapfrog Hospital Safety Report 4th release is expected to be released on October 7, 2013. The Leapfrog Group is a national non-profit organization of employers and other purchasers of health care committed to encouraging safe and high quality care in hospitals. Calculating a letter grade that publicly reports patient safety at approximately 2,500 general care hospitals around the U.S. is the goal of Leapfrog Group in providing usable public information. The information is gathered from CMS billing, AHRQ, AHA annual survey, and self submitted survey data purchased from CMS. Alameda Hospital did not submit any self survey data in 2013.

8. Get With The Guidelines® - Heart Failure Gold Plus Quality Achievement Award

The American Heart Association and American Stroke Association recognized Alameda Hospital for achieving 85% or higher adherence to all Get With The Guidelines Heart Failure Performance Achievement indicators for consecutive 12 month intervals and 75% or higher compliance with 4 of 9 all Get with The Guidelines Heart Failure Quality Measures to improve quality of patient care and outcomes.

9. Bay Area Bone & Joint Center

There were 224 orthopedic visits at the Bay Area Bone and Joint Center (BABJC) during September as compared to the 327 visits projected in the eleventh month of the pro forma. On the positive side, 14 surgeries were performed during the month, only an unfavorable variance of one case compared with the pro forma expectations.

In affiliation talks between Alameda Hospital and Alameda Health Services (AHS), outpatient orthopedic surgery is projected to be one of the first joint ventures. Discussions with Drs DiStefano and Pirnia, the Orthopedists at AHS, and executives at both facilities are taking place. It is anticipated that AHS patients may receive services from the BABJC doctors at Alameda Hospital beginning November 15.

Drs. Pirnia and Di Stefano remain active in the community. They have an upcoming evening presentation to the staff and members of the Harbor Bay Isle Club in mid-October. They are also scheduled to participate in the Hospital's annual Health Faire for the community.

10. Community Relations and Foundation Update

The Annual Community Health Fair will be held on Saturday, October 19, 2013 from 9 a.m. – 12 noon. A variety of health screenings, exhibits and activities for the entire family will be offered. Free flu shots (while supplies last), free bike helmets, and information about Covered CA are among the many activities planned.

The Alameda Hospital Foundation is holding its annual Fall Gala, Kings of Hearts, on October 12, 2013, honoring cardiologists Denis Drew, MD and Stephen Raskin, MD as the recipients of the 2013 Kate Creedon Award.

11. Information Technology Update and Meaningful Use

a. Citrix Server Replacement

Our new Citrix Server, which provides remote access to hospital applications, is now LIVE.

b. NAS and SQL Server replacements

We have 2 new servers in place one for Network Attached Storage and the other for our Databases, mainly MEDITECH data. We are in the process of migrating the files to the new servers which may take several weeks.

c. MEDITECH 5.66 Update

Our new TEST ring for the latest MEDITECH update to version 5.66 has been created. We are beginning the testing of the changes October 2. Testing will take approximately 10 weeks with an anticipated LIVE date of January 8, 2014.

d. AHS Affiliation

The IT Task Force has been meeting to discuss potential future state options for our IT infrastructure and EH post.

e. **Meaningful Use**

The Attestation period for Meaningful Use Stage I is completed – We have met the criteria and will be submitting the data in the next week.

Meaningful Use Stage I - Attestation 6-26 thru 9-23	
Required Core Objectives	
Criteria	% - threshold
CPOE	82% - met
Problem List (captured by ABS, results delay	99% - met
BMI & BP	97% - met
Smoking Status	83% - met
Advanced Directives	100% - met
Demographics	84% - met
Lab Data	100% - met
Med List	100% - met
Allergies	99% - met
eHR provided on request	100% (no requests) - met
eDISCHARGE provided on request	100% (no requests) - met
All other criteria does not have a required threshold for stage I	

12. August Preliminary Statistics

	September Preliminary	September Budget	% Δ compared to Budget	% Δ compared to August	August Actual
Average Daily Census	200.20	191.00	4.8%	2.3%	195.68
Acute	33.43	28.90	15.7%	27.3%	26.26
Subacute	32.90	32.10	2.5%	-2.0%	33.58
South Shore	23.80	22.00	8.2%	-0.3%	23.87
Waters Edge	110.07	108.00	1.9%	-1.7%	111.97
Patient Days	6,006	5,731	4.8%	-1.0%	6,066
ER Visits	1,309	1,458	-10.2%	2.2%	1,281
Wound Care Visits	392	350	12.0%	-14.6%	459
OP Registrations (excl WC)	1,867	1,849	1.0%	-6.2%	1,990
Total Surgeries	156	186	-16.1%	-10.3%	174
Inpatient Surgeries	58	55	5.5%	7.4%	54
Outpatient Surgeries	98	131	-25.2%	-18.3%	120
Case Mix Index	1.3024				1.2611

13. Covered California Resources

As public Officials, the attached Key Fact Sheets are being provided to the Board as reference materials and may be beneficial to you in your outreach to the community.

Covered California has released a variety of materials in 11 different languages for its partners. The resources include a series of fact sheets that cover topics ranging from general information about Covered California, to coverage changes in 2014 and financial assistance instructions. The materials are available in English, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Lao, Russian, Spanish, Tagalog and Vietnamese.

DISTRICT HOSPITAL LEADERSHIP FORUM

1215 K Street
Suite 800
Sacramento, CA 95814
(916) 443-7401 T
(916) 552-7606 F

California's District/Municipal Hospitals Talking Points
October 2013

Summary:

- **We urge you to help district/municipal hospitals in your Congressional districts by letting the California Health and Human Services Agency and Centers for Medicare and Medicaid Services (CMS) know the importance of including these facilities in California's current and subsequent Medi-Cal 1115 waivers.**

- California's district and municipal hospitals face both the same and unique challenges with health care reform as county/University of California (UC) hospitals, **but to date, have received no waiver funding (in the 2005 or 2010 waiver) for preparation and/or for delivery system improvements**.

- **The upcoming California Medi-Cal 1115 waiver (which could be renewed in or before 2015) must include programs and funding for *all* California public hospitals.** To ensure access to hospital services remain available in geographic areas of California beyond those served by the county/UC hospitals (15 urban counties), waiver funding and programs must be made available to ***all*** public hospitals.

Background:

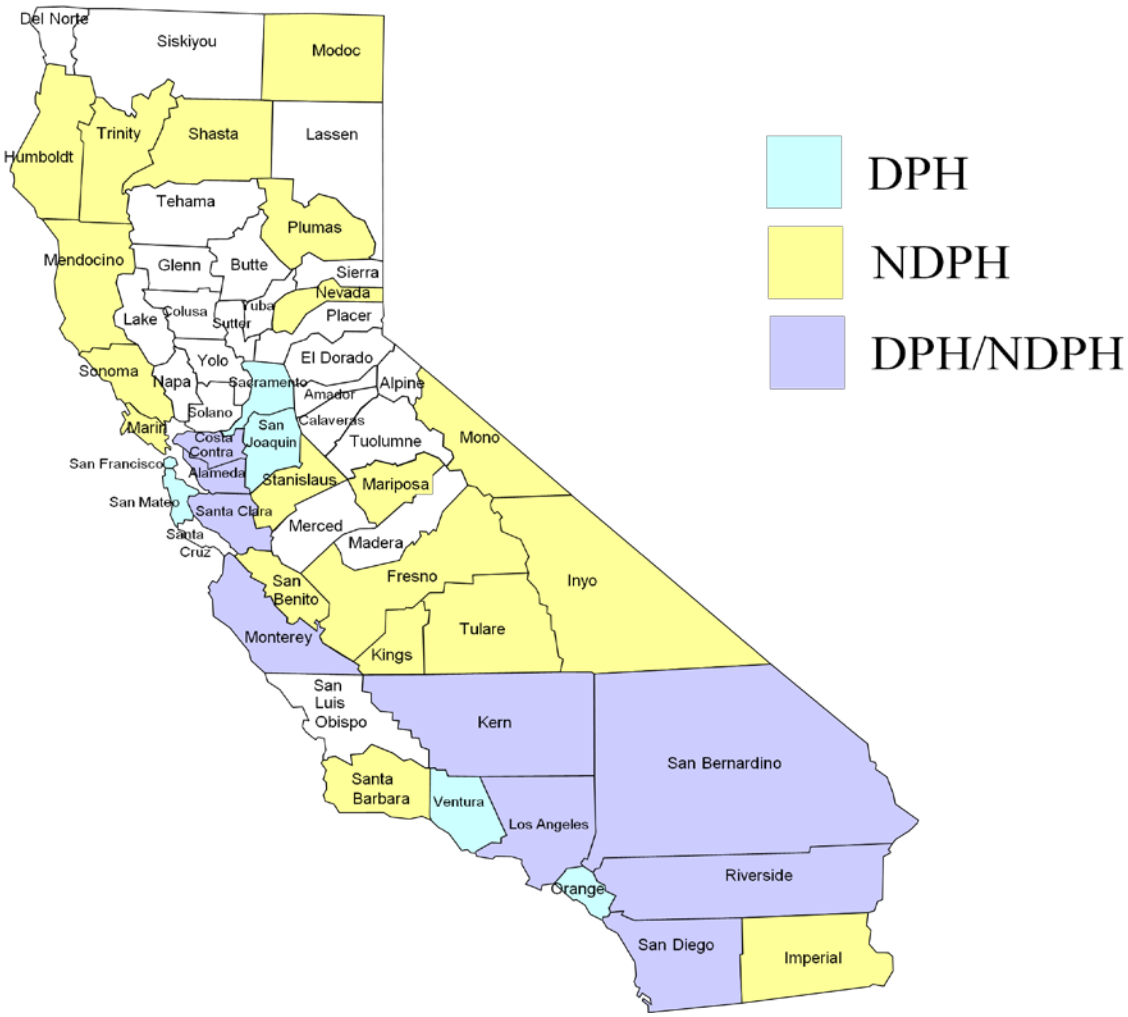
- District/municipal hospitals, with publicly elected Boards of Directors, are local governments responsible for providing for the healthcare needs of their communities. California's public district hospitals provide significant levels of care to the uninsured and Medi-Cal populations (approximately 20 percent of all Medi-Cal public hospital care is provided in district/municipal hospitals and approximately 14 percent of all public hospital care to the uninsured is provided by district/municipal hospitals). In 19 counties, district hospitals are the only public hospitals within the county. In addition, in the other 9 counties with both public district hospitals along with a county or UC hospital there is a significant geographic separation. (See map on reverse.)

- In 2005, county/UC hospitals were "designated" in that 1115 waiver to use certified public expenditures (CPEs) as the non-federal share for Medi-Cal. All other public hospitals (the district and municipal hospitals) became known as non-designated public hospitals. California's 45 "nondesignated public hospitals" (district/municipal) payer mix is 65 percent government payer (21 percent is Medi-Cal) with 7 percent uninsured patients. These hospitals are operating in the red in aggregate (-2 percent) and almost three-fourths are located in rural California.

- The current California Medi-Cal 1115 Waiver (implemented in 2010) is worth $10 billion to the state. Of this, $8 billion is allocated to county/UC hospitals in recognition of care provided to low-income Californians and to provide funding for delivery system improvements.

- Making funding available to district/municipal hospitals in the current waiver will require an amendment that includes discussions and "budget neutrality" recalculations between the state and the Centers for Medicare and Medicaid Services (CMS). We respectfully request you encourage these efforts be undertaken to ensure Californians who live and visit the areas of the state are able to access necessary hospital services, especially as implementation of health care reform nears.
    - The California Legislature recently passed AB 498 (Chavez; still awaiting the governor's signature) which would provide for $105 million in 2013-14 and 2014-15 in recognition of the cost of care provided to the uninsured by district/municipal hospitals. We are concerned that due to competing priorities (associated with larger amounts of funding) at the state, the effort with CMS may fall short.

- District/municipal hospitals are eager to craft innovative, unique programs that will meet the needs of all stakeholders – beneficiaries/patients, the state, the hospitals and the federal government – in the same way that the Delivery System Reform Incentive Program (benefitting county/UC hospitals in the current California waiver) does.



California's District/Municipal Hospitals:

Alameda Hospital, Alameda
Antelope Valley Hospital, Lancaster
Bear Valley Community Hospital, Big Bear Lake
Coalinga Regional Medical Center, Coalinga
Corcoran District Hospital, Corcoran
Doctors Medical Center, San Pablo
Eastern Plumas Health Care, Portola
El Camino Hospital, Mountain View
El Centro Regional Medical Center, El Centro
Fallbrook Hospital, Fallbrook
Hazel Hawkins Memorial Hospital, Hollister
Healdsburg District Hospital, Healdsburg
Hi-Desert Medical Center, Joshua Tree
Jerold Phelps Community Hospital, Garberville
John C. Fremont Healthcare District, Mariposa
Kaweah Delta Health Care District, Visalia
Kern Valley Healthcare District, Lake Isabella
Lompoc Valley Medical Center, Lompoc
Mammoth Hospital, Mammoth Lakes
Marin General Hospital, Greenbrae
Mayers Memorial Hospital District, Fall River Mills
Mendocino Coast District Hospital, Fort Bragg
Modoc Medical Center, Alturas
Northern Inyo Hospital, Bishop
Oak Valley Hospital District, Oakdale
Palm Drive Hospital, Sebastopol
Palo Verde Hospital, Blythe
Palomar Medical Center, Escondido
Pioneers Memorial Healthcare District, Brawley
Plumas District Hospital, Quincy
Pomerado Hospital, Poway
Salinas Valley Memorial Healthcare System, Salinas
San Bernardino Mountains Community Hospital, Lake Arrowhead
San Gorgonio Memorial Hospital, Banning
Seneca Healthcare District, Chester
Sierra View District Hospital, Porterville
Sonoma Valley Hospital, Sonoma
Southern Inyo Hospital, Lone Pine
Surprise Valley Health Care District, Cedarville
Tahoe Forest Hospital District, Truckee
Tehachapi Valley Healthcare District, Tehachapi
Tri-City Medical Center, Oceanside
Trinity Hospital, Weaverville
Tulare Regional Medical Center, Tulare
Washington Hospital Healthcare System, Fremont

FACT SHEET

Covered California

Affordable Insurance Is a National Priority

In 2010, the federal government approved a law — the Patient Protection and Affordable Care Act (Affordable Care Act) — to increase the number of Americans with health insurance and cut the cost of health care.

The law is important to Californians because it provides financial assistance to help individuals and small businesses pay for health insurance. Those who already have affordable health insurance don't need to take any action, unless they lose their coverage for certain reasons, such as the loss of a job.

To help those without health insurance get covered, the Affordable Care Act included a requirement that states either set up their own marketplace for people to buy health insurance or have one set up by the federal government. These marketplaces will offer one-stop shops where people can compare health insurance plans and buy the plan that works best for them, their family and their budget. California chose to set up its own marketplace — Covered California™ — as its doorway to health coverage.

The law requires that most adults have health insurance or pay a fine starting in 2014.

Getting California Covered

Covered California was created to develop an easy-to-use marketplace where most Californians can buy health coverage that cannot be denied by health insurance companies or canceled if they are sick or have a pre-existing health condition, such as asthma or diabetes.

By 2014, about 2.6 million Californians will be able to access financial assistance through Covered California to pay for their health insurance. An additional 2.7 million will benefit from coverage that is guaranteed whether they buy an insurance plan through Covered California or on their own. An estimated 2.3 million California residents will enroll in a health plan through Covered California by 2017.

All health insurance plans purchased through Covered California must cover certain services called essential health benefits. These include doctor visits, hospital stays, emergency care, maternity care, children's care, prescriptions, medical tests and mental health care. Health insurance plans also must cover preventive care services, like mammograms and colonoscopies, for free. All plans being sold in the Covered California marketplace, as well as those sold outside it, will be required to include these benefits.

A Short History, an Ambitious Future

California has an important role to play in ensuring that Covered California is successful. Working together with federal, state and community partners, Covered California wants millions of Californians to buy affordable health care coverage. With more Californians covered, the state, our neighbors and our families will all be able to make healthy choices that benefit us all.

A Commitment to Californians

Covered California is committed to making sure that everyone is aware of their health insurance coverage options and can easily compare health insurance plans and choose the right one.

We know that choosing health insurance can be confusing, and we are here to help. We will be providing support in person, by phone and online. We are training people in local communities across the state who will help Californians learn about the new health insurance options available. These trained professionals will be able to offer help in many different languages.

The Health Insurance Marketplace

On Oct. 1, 2013, Covered California will begin enrolling eligible Californians for health insurance coverage that will begin in January 2014. Residents who do not have health insurance from their employer or another government program, or for whom that insurance is not affordable, may qualify for help with premiums.

Californians will be able to buy the same health insurance plan in the private market that will be offered through Covered California. One advantage of purchasing insurance through Covered California is that it is easy to compare different plans. For the first time ever, it is possible to make apples-to-apples comparisons across different health insurance plans, thanks to new standard benefits that were designed to work for consumers — not for health insurance companies. Also, Covered California is the only place where Californians can use premium assistance from the federal government to reduce their health care costs.

Covered California also will help small businesses provide affordable health coverage to their employees. Through Covered California, businesses with one to 50 eligible employees will be able to purchase health insurance. Businesses with 25 or fewer full-time employees could qualify for tax credits. Starting in 2016, Covered California will be open for larger employers with 100 or fewer eligible employees.

For the first time ever, it is possible to make apples-to-apples comparisons across different health insurance plans.

For more information, visit www.CoveredCA.com or call (888) 975-1142.

COVERED CALIFORNIA™

CoveredCA.com

Covered California is the new online "marketplace" that will make it simple and affordable to purchase quality health insurance and get financial assistance to help pay for it.

Version: August 2013

FACT SHEET

Changes Coming to Health Care in 2014

COVERED CALIFORNIA

New Improvements in the Health Insurance Market

The Patient Protection and Affordable Care Act (Affordable Care Act) is the federal law passed in 2010 that provide affordable health insurance to more Americans.

The historic law will change the way health insurance companies provide coverage, as well as the way consumers purchase coverage. This fact sheet describes a few of the changes happening in health insurance.

Important Changes for Consumers

More Health Insurance Options. The Affordable Care Act establishes state marketplaces, where individuals and small businesses can shop for health insurance on the Internet, in person or by phone. These marketplaces will help make health insurance much more reasonably priced and easier to get. California's marketplace, named Covered California™, will offer millions of Californians a variety of health insurance plans available for purchase.

Affordable Coverage and Financial Assistance. Covered California will help individuals and families determine whether they may get federal financial assistance that will cut the cost of health insurance or whether they qualify for free health insurance through Medi-Cal. Many small businesses also will be able to provide employee health insurance, using federal tax credits to reduce premium costs.

Protections for Consumers. All health insurance plans (not counting most plans sold before March 10, 2010) must provide health insurance for individuals and their families even if someone has a health condition such as diabetes or asthma. That health insurance cannot be dropped if someone gets sick. Consumers also cannot be denied a health insurance plan if they make an honest mistake when filling out the application.

Increased Coverage. The Affordable Care Act strengthens Medicare, Medicaid (Medi-Cal in California) and other very important programs for millions. In addition, those who have not yet turned 26 and whose parents have health insurance can now be included in their parents' health insurance plan.

Fines for No Coverage. Starting in January 2014, most adults will be required to have public or private health insurance or pay a fine. The fine becomes more costly over a three-year period. In 2014, the fine will be 1 percent of yearly income or $95 per person, whichever is greater. For adults with children, the fine for lack of coverage for the child is $47.50. By 2016, the fine will be 2.5 percent of income or $695 for an individual, $2,085 for a family, whichever is greater.

What Businesses Will Need to Do. Employers with 50 or more full-time employees that do not offer health insurance that employees can afford, or that offer a health insurance plan that does not meet certain requirements, may receive a fine starting in 2015.

These changes to health insurance have been put in place to make sure consumers get the care they need, when they need it.

Some Changes for Health Insurance Plans

The Affordable Care Act requires that health insurance companies change some of their practices. At the same time, it protects the consumers' rights to keep the coverage they already had before the law was passed.

Under the Affordable Care Act, all health insurance plans must follow certain rules.

Rate Increases. Health insurance companies must give a reason for any increase in premiums. Insurance companies must spend 80 percent of the money they receive from premiums on delivering quality health care, not on costs such as salaries and advertising.

No Limits to Health Care an Individual Receives in His or Her Lifetime. Health insurance companies cannot set a dollar amount limit for key health benefits during a person's lifetime.

Preventive Care. All new health insurance plans must cover preventive care and medical screenings, like mammograms and colonoscopies, as well as women's services such as breast-feeding support, contraception and domestic violence screening. Health insurance companies cannot charge copayments, coinsurance or deductibles for such services.

Essential Health Benefits. Newly sold health insurance plans must cover services that fall into these 10 categories of essential health benefits:

- **ambulatory patient care**
- **emergency services**
- **hospitalization**
- **maternity and newborn care**
- **mental health and substance abuse disorder treatment**
- **prescription drugs**
- **rehabilitation and habilitation services and devices**
- **lab services**
- **preventive and wellness services and chronic disease support**
- **children's services, including dental and vision care**

New Tools to Choose. Covered California insurance plans will be grouped by cost and value, using consistent information so that Californians can make apples-to-apples comparisons among plans, see expected costs more easily and get the coverage they need.

There will be four basic levels of coverage: Platinum, Gold, Silver and Bronze. As the coverage increases, so does the monthly premium payment, but the cost when a person receives medical care is usually lower. Californians can choose to pay a higher monthly cost so that when they need medical care, they pay less. Or they can choose to pay a lower monthly cost, which means that when they need medical care, they pay more. Each person has the choice.

For more information,
visit www.CoveredCA.com
or call (888) 975-1142.

COVERED CALIFORNIA™

CoveredCA.com

Covered California is the new online "marketplace" that will make it simple and affordable to purchase quality health insurance and get financial assistance to help pay for it.

Version: August 2013

FACT SHEET

Getting Yourself and Your Family Covered

COVERED CALIFORNIA

Getting Californians Covered

Covered California's™ mission is to improve health care in our state by increasing the number of Californians with health insurance, improving the quality of health care for all of us, reducing health care costs and ensuring that California's diverse population has fair and equal access to quality health care.

Beginning in October 2013, legal residents of California will be able to buy health coverage through a new, easy-to-use marketplace called Covered California. Covered California will offer health insurance plans, which cannot be canceled or denied, at an affordable price. Californians can shop for the plans online, and Covered California will provide in-person and phone assistance for those who need it.

Improvements to Health Insurance Plans

As part of the federal health care law, the Patient Protection and Affordable Care Act (Affordable Care Act), all newly sold health insurance plans must meet certain requirements. They must cover essential health benefits such as doctor visits, hospital stays, emergency care, maternity care, children's care and prescriptions.

Health insurance plans will be much easier to compare. There will be four basic levels of coverage: Platinum, Gold, Silver and Bronze. This will make it easier to compare plans in the same category or across categories. As your coverage increases, so does your monthly premium payment, but your costs are lower when you receive medical care. You can choose to pay a higher monthly premium so that when you need medical care, you pay less. Or you can choose to pay a lower monthly premium, which means that when you need medical care, you pay more. **You have the choice.**

The New Marketplace

In the marketplace, health insurance companies will compete for your business. Covered California opens for enrollment Oct. 1, 2013, for coverage beginning Jan. 1, 2014.

When you visit Covered California's marketplace, you will be able to make apples-to-apples comparisons among different health insurance plans and choose the plan that best meets your needs and those of your family.

Covered California is the only place where you can access assistance in paying your insurance premium, offered by the federal government to reduce the cost of health insurance. If you qualify for premium assistance, this money will reduce what you pay for your insurance.

Covered California will make it simple and more affordable for you and millions of other Californians to purchase health insurance.

Affordable Health Coverage

Many people know they need health insurance but are concerned about the price. To make sure health coverage is affordable, Covered California will help people find out whether they qualify for federal financial assistance that will reduce their costs.

There are three financial assistance programs to help ensure everyone can afford health care. These programs are available to individuals and families who make a certain amount of money and do not have affordable health insurance, which covers certain benefits, from an employer or another government program.

1. **Premium assistance** helps reduce the cost of your insurance premium, which is the amount you pay to buy health insurance, usually each month.

2. **Cost-sharing assistance** reduces the amount of health care expenses an individual or family has to pay when getting care. These expenses include copayments, coinsurance and deductibles incurred when, for example, you visit your doctor.

3. **Medi-Cal** is a free health insurance program for those who qualify, including people with disabilities and those with incomes of less than $15,860 a year for a single individual and $32,500 for a family of four.

How Financial Assistance Works

In the chart below, you can see how different people qualify for assistance to pay for health insurance. These are examples only; you may fall into a different category.

Number of People In the Household	If Your Income* Is LESS THAN...	If Your Income* Is BETWEEN...
1	$15,860	$15,860 - $45,960
2	$21,400	$21,400 - $62,040
3	$26,950	$26,950 - $78,120
4	$32,500	$32,500 - $94,200
5	$38,050	$38,050 - $110,280
You may qualify for:	**Medi-Cal**	**Premium assistance through Covered California**

** Income levels are based on the year 2013*

When you visit Covered California's marketplace, you will be able to make apples-to-apples comparisons among different health insurance plans and choose the plan that best meets your needs and those of your family.

Penalties if You Do Not Have Insurance

The federal Affordable Care Act also requires most adults to have public or private health insurance by January 2014 or face a financial penalty. The fine increases over three years. In 2014, the fine will be 1 percent of yearly income or $95 per person, whichever is greater. For adults with children, the fine for lack of coverage for the child is $47.50. By 2016, the fine will be 2.5 percent of income or $695 per person, whichever is greater. The fine will be assessed based on the number of months without coverage.

To make sure you are covered in 2014, you must buy health insurance before March 31, 2014, or you must wait until the next open-enrollment period begins, in October 2014, for coverage in 2015. You must enroll during open enrollment unless you have a life-changing event, such as the loss of a job, the death of a spouse or the birth of a child, in which case you would qualify for special enrollment.

Choosing health insurance is an important decision, and Covered California is here to help. Part of our mission is to reach out to your community by partnering with people at the local level. We are training local people in your community right now to help you learn about the new options for health insurance. There will be plenty of opportunities for you to get help in person, by phone or online.

If You Need Coverage Before 2014

If you do not currently have health insurance, you do not have to wait until Covered California opens to get covered.

You may be able to purchase private insurance for yourself by contacting a health insurance company directly or working with an agent. You may be eligible right now for health coverage under Medi-Cal. For more information on enrolling in the Medi-Cal program, you can contact your local county social services office.

If you have not yet turned 26 years old, and your parents have health insurance, you can be added to your parents' plan. If you are 65 or older or have certain disabilities, you can receive coverage under Medicare.

On Oct. 1, 2013, Covered California will open its marketplace to provide Californians the option of purchasing affordable health insurance. For many, this will be their first opportunity to obtain coverage for themselves and their families. We believe more covered Californians is the key to ensuring the health and well-being of our state.

For more information, visit www.CoveredCA.com or call (888) 975-1142.

COVERED CALIFORNIA™

Version: August 2013

If Your Income Changes

Californians without insurance can shop through Covered California for coverage, regardless of income. Your income level helps determine whether you qualify for Medi-Cal or any financial assistance to help pay for your coverage. If your income changes over the year, your assistance level will be adjusted. You are responsible for making sure Covered California is aware of the income change so that you do not have to pay the difference at tax time.

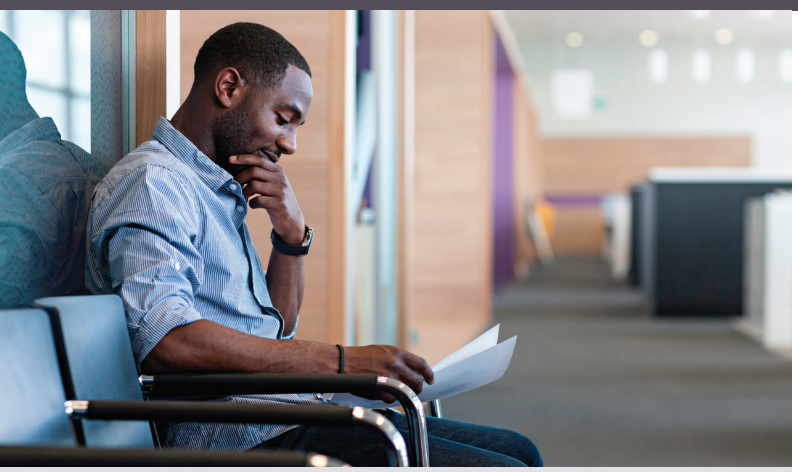
If you have Medi-Cal coverage, and your income increases to more than $15,860 a year for an individual or $32,500 for a family of four, you would no longer qualify for this no-cost insurance plan. However, through Covered California, you could find affordable coverage and assistance to help pay the premiums.

CoveredCA.com

Covered California is the new online "marketplace" that will make it simple and affordable to purchase quality health insurance and get financial assistance to help pay for it.

FACT SHEET

Getting Financial Help



Making Health Insurance Affordable

Covered California™ will make it simple and more affordable for millions of Californians to get health insurance.

Legal residents of California will be eligible to buy health coverage through a new marketplace established by Covered California. Starting in 2014, there will be several new and expanded government programs that offer financial assistance to reduce the cost of health insurance.

1. **Premium assistance —** Federal help will be available to reduce the cost of an individual's or family's monthly health insurance payments.

2. **Cost-sharing assistance —** Cost-sharing subsidies reduce the amount of health care expenses an individual or family has to pay at the time of medical care.

3. **Medi-Cal assistance —** Starting in 2014, Medi-Cal will cover more people under age 65, including people with disabilities and those with income of less than $15,860 a year for a single individual and $32,500 for a family of four. Medi-Cal is free for those who meet the requirements and is part of the changes included in the Patient Protection and Affordable Care Act (Affordable Care Act).

Qualifying for Premium Assistance

Premium assistance is available for individuals and families who make less than a certain amount a year and who do not have other options for obtaining affordable health insurance that meets certain coverage requirements, such as health coverage offered through their employer or another government program.

The amount of premium assistance depends on an individual's income and age and where the person lives. The Affordable Care Act sets a monthly maximum that people will pay for health care, based on where their income falls in the federal poverty level scale. In general, the less income someone makes, the less he or she will have to pay for health insurance and the more the federal government will help.

For example, individuals who make up to $45,960 and families of four that make up to $94,200 may qualify for financial assistance.

Here are some key facts about premium assistance.

- Premium assistance reduces the cost of an individual's or family's health insurance plan premium.
- Premium assistance (a federal subsidy) is applied directly to the premium at the time an individual or family enrolls in health insurance. Enrollees do not need to wait until they file a tax return at the end of the year.
- Premium assistance is only available through Covered California. Californians must purchase their health insurance plan from Covered California if they want to get premium assistance.
- Premium assistance is paid to the health plans. The assistance is paid by the federal government directly to the health plan an individual or family chooses through Covered California.

Estimating Premium Assistance

The amount of premium assistance provided depends on household income and family size. Below are some examples of potential costs to families in California. Later this year, Covered California will make available the exact premium and plan choices, so everyone can know exactly what their insurance will cost.

Annual Income for a Family of 4	Monthly Premium After Federal Subsidy
$23,550 – $35,325	$39 – $118
$35,326 – $47,100	$119 – $247
$47,101 – $58,875	$248 – $395
$58,876 – $94,200	$396 – $746

Premium assistance is available when people buy insurance, so no one has to pay all of the premium costs up front and wait for reimbursement. The premium assistance will be available to everyone who is eligible for it, whether they file taxes or not.

Covered California has an online calculator at www.CoveredCA.com that can help people estimate how much they will pay per year for health insurance coverage and the amount of any federal financial support.

Premium assistance is available when people buy insurance, so no one has to pay all of the premium costs up front and wait for reimbursement.

Qualifying for Cost-Sharing Subsidies

While premium assistance can help reduce premium payments, cost-sharing subsidies protect lower-income people from high out-of-pocket costs at the time of service. Those with incomes that are less than about $28,725 for a single person and less than about $58,875 for a family of four in 2013 may be eligible for those subsidies. Anyone who qualifies for cost-sharing subsidies will pay less for health care expenses, including costs incurred when they receive medical care.

Covered California can help people find out whether they qualify for assistance in person, by phone and online.

For more information, visit www.CoveredCA.com or call (888) 975-1142.

COVERED CALIFORNIA™

CoveredCA.com

Covered California is the new online "marketplace" that will make it simple and affordable to purchase quality health insurance and get financial assistance to help pay for it.

Version: August 2013